National Public Health Performance Standards

Riley County Local Public Health Systems Assessment

October 2014

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Executive Summary

On June 11, 2014, approximately 100 community members (including facilitators and staff assistants) with a demonstrated area of expertise and an interest or stake in improving the local public health system met to help answer question such as "what are the activities and capacities of our public health system?" and "what are the gaps?" Invitees included over 200 representatives of all cities and school districts within Riley County, as well as many segments of the community, including hospitals, clinics, physicians, schools, child care providers, public safety and response agencies, faith-based organizations, employers, Kansas State University, Fort Riley, elected officials, and others.

To complete the Local Public Health Systems Assessment (LPHSA), a national, standardized tool was used to score activity level related to the 10 essential public health services:

1. Monitor Community Health Status
2. Diagnose and Investigate Health Problems and Hazards
3. Inform and Educate about Health Issues
4. Mobilize Community Partners to Solve Health Problems
5. Develop Policies and Plans that Support Health Efforts
6. Enforce Laws that Protect Health and Safety
7. Link People to Services, Assure Provision of Healthcare
8. Assure Competent Public Health and Healthcare Workforce
9. Evaluate Personnel and Population-Based Health Services
10. Research Innovative Solutions to Health Problems

For each essential services, "model standards" were scored based on the level of activity of each standard in our community. Following the process outlined by the instrument, there was a facilitated discussion and consensus scoring of the model standards based on the expertise and perceptions of those stakeholders present.

Looking at composite scoring by essential service, Riley County's local public health system scored very favorably:

- No essential services scored in the "No Activity" or "Minimal Activity" level range.
- Six services scored in the "Moderate Activity" range.
- Three services (4 – Mobilize Partnerships, 6 – Enforce Laws, and 7 – Link to Health Services) scored in "Significant Activity" range
- One (2, Diagnose and Investigate) scored highest, in the "Optimal Activity" range.

Perhaps even more valuable than the numerical scores themselves were the discussions generated among participants; identification of strengths, weaknesses, and opportunities for our public health system; and connections made among organizations represented.

As a follow-up activity crucial to upcoming planning processes, members of the Riley County Health Department leadership team completed the optional agency contribution questionnaire on October 16th. Both these results and those from the broad community process are detailed in standardized report generated from the assessment tool, which is included with the full report.

Going forward, the LPHSA will provide a baseline for future assessments and a foundation for public health system improvement. It will be used in conjunction with the community needs assessment data and other information to help set priorities, address gaps, formulate health improvement strategies, and develop a local health department strategic plan.

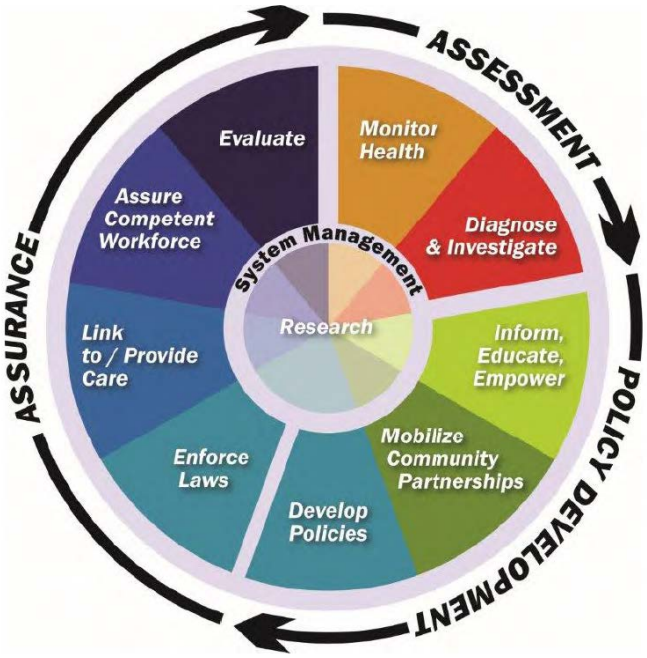
Background and Process

Introduction

How is our local public health system doing? How are essential public health services being provided to our community? A Local Public Health Systems Assessment (LPHSA) involving many community stakeholders and partners was held to help answer those questions. Invitees included representatives of all cities and school districts within Riley County, as well as the many segments of our community, including hospitals, clinics, physicians, schools, child care providers, public safety and response agencies, K-State, faith-based organizations, employers, elected officials, and others. We used the Local Assessment Instrument of the National Public Health Performance Standards. This instrument is a national, standardized tool created by the National Association of County and City Health Officials (NACCHO) to score our activity level related to the 10 essential public health services.

10 Essential Public Health Services

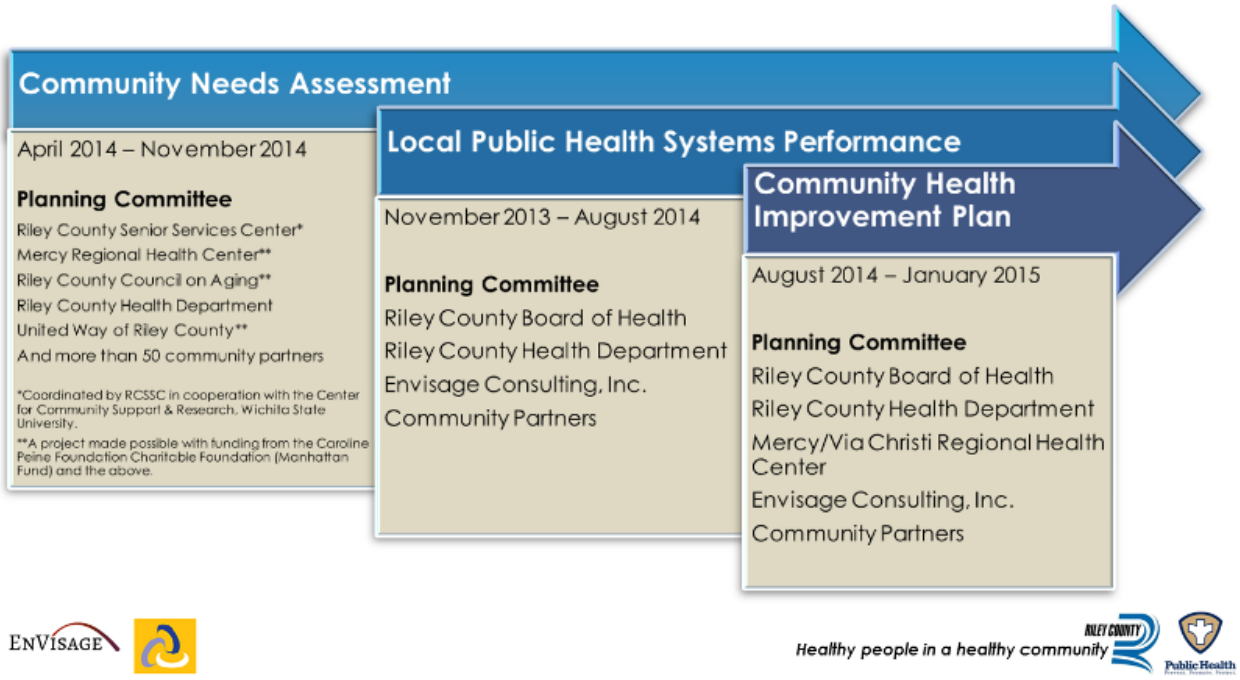
The 10 Essential Public Health Services provide the framework for the local instrument by describing the public health activities that should be undertaken by all communities. The below figure shows the essential services within the context of the three core public health functions of assessment, policy development, and assurance.



The 10 Essential Public Health Services and the related performance standards describe an optional level of performance and capacity. The LPHSA instrument is designed to provide any local public health system with benchmarks identifying strengths, weaknesses, and short- and long-term improvement opportunities. Here is a more complete listing of the essential services and the questions the assessment helps address.

1. Monitor Community Health Status
    - What is going on in our community?
    - Do we know how healthy we are?
2. Diagnose and Investigate Health Problems and Hazards
    - Are we ready to respond to health problems and hazards?
    - How quickly do we find out about the problems?
    - How effective is our response?
3. Inform and Educate about Health Issues
    - How well do we keep all segments of our community informed about health issues?
4. Mobilize Community Partners to Solve Health Problems
    - How well do we truly engage people in local health issues?
5. Develop Policies and Plans that Support Health Efforts
    - What local policies in both the government and private sector promote health in my community?
    - How well are we setting local health policies?
6. Enforce Laws that Protect Health and Safety
    - When we enforce health regulations, are we competent, fair, and effective?
7. Link People to Services, Assure Provision of Healthcare
    - Are people in my community receiving the health services they need?
8. Assure Competent Public Health and Healthcare Workforce
    - Do we have competent public health and healthcare staff?
    - How can we be sure that our staff stays current?
9. Evaluate Personnel and Population-Based Health Services
    - Are we meeting the needs of the population we serve?
    - Are we doing things right?
    - Are we doing the right things?
10. Research Innovative Solutions to Health Problems
    - Are we discovering and using new ways to get the job done?

The LPHSA complements other assessments and health improvement planning process, which are also taking place in our community during 2014-2015. These include the Community Needs Assessment (CNA) and the Community Health Improvement Plan (CHIP). Not only will these assessments bring to light information necessary for our community's health to move forward, but will additionally propel the Riley County Health Department on the track to public health department accreditation.

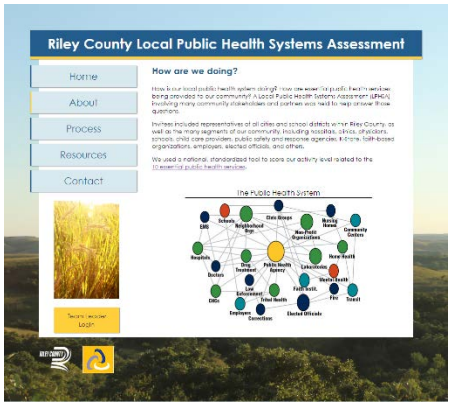


Planning

Initial Planning

Planning for the Riley County LPHSA began in January 2014. Riley County Health Department acted as the convener for the event.

- Community members were identified and invited to serve on the Planning Committee
- The LPHSA website was set-up to facilitate information dissemination among assessment planners and provide a place for the community to learn more about the assessment www.datacounts.net/lphsa/
- Searching began to find a venue that could accommodate the assessment with at least 75 people



Riley County LPHSA Website

Planning Committee

Planning Committee Members were identified because of their:

- Broad knowledge of the community
- Many connections to other community stakeholders
- Interest or stake in maintaining and improving our local public health system

Planning Committee Members were invited in February and the first Planning Committee Meeting was in March. (See Appendix A for a copy of the planning committee invitation letter.) Planning Committee Members met to begin determining the participants to be invited, the best date for the assessment, and what the agenda for the assessment day would look like.

Planning Committee Members:

- Robert Boyd, Riley County Commissioner
- Dr. Paul Benne, Fort Riley Public Health
- Kris Bourland, Fort Riley Public Health
- Dr. Michael Cates, K-State Master of Public Health Program
- Robbin Cole, Pawnee Mental Health Services
- Pat Collins, LEPC Chair
- Kristin Cottam, Mercy Regional Health Center
- Larry Couchman, Riley County EMS
- Lee Ann Smith Desper, United Way
- Dr. Cary Herl, RCHD Medical Director
- Vern Henricks, Greater Manhattan Community Foundation
- Karen McCulloh, Manhattan City Commissioner
- Margie Michal, Mercy Regional Health Center
- Brenda Nickel, Riley County Health Department
- Debbie Nuss, Community Member, Public Health Advisory Committee
- Katy Oestman, Riley County Health Department
- Beverly Olson, Shepherd's Crossing
- Connie Satzler, EnVisage Consulting, Inc.

Facilitator, Timekeeper, and Recorders

One Facilitator, Timekeeper, and Recorder were assigned to each Team.

Facilitators lead the groups through the NPHPS Local Assessment Instrument to discuss, evaluate, and score model standards within each essential service.

Timekeepers monitored the time spent on each step in a model standard and let the facilitator and team know when it was time to move on by holding up colored cards (yellow 1-minute warning card, red STOP card). They were given team specific

itineraries with suggested times for each step. Timekeepers were also asked to act as a secondary recorder and capture discussion information.

Recorders captured key discussion information and maintained the official score sheet. They were given the option to take notes manually or electronically. Information recorded included:

- Partners participating
- Discussion question comments
- Performance Measure Score
- Strengths, weaknesses, short-term opportunities, long-term opportunities

Team Leaders (Facilitators, Timekeepers, and Recorders)

Facilitators were selected because of their broad knowledge of public health systems and ability to guide group discussions to accomplish specific outcomes.

Facilitators:

- Sarah Hartsig, KHI – Team Aggie
- Katy Oestman, Riley County Health Department – Team Bluemont
- Dr. Paul Benne, Ft. Riley Public Health – Team Goodnow
- Jane Shirley, KDHE – Team Kansa

Timekeepers and Recorders were selected from the Riley County Health Department staff.

Timekeepers:

- Beth Kellstrom – Team Aggie
- Shannon Hoff – Team Bluemont
- Amy Chaplin – Team Goodnow
- Marsha Tannehill – Team Kansa

Recorders:

- Jan Scheideman – Team Aggie
- Cindy Mott – Team Bluemont
- Lisa Ross – Team Goodnow
- Jason Orr – Team Kansa

Training

Training for the Facilitator, Timekeeper, and Recorder roles was held at the Riley County Health Department on June 4th, 2014, one week before the assessment.

The training was scheduled for 4 hours, 11am – 3pm. Feedback from the training suggested that more time would have been preferred.

Topics covered in the training included:

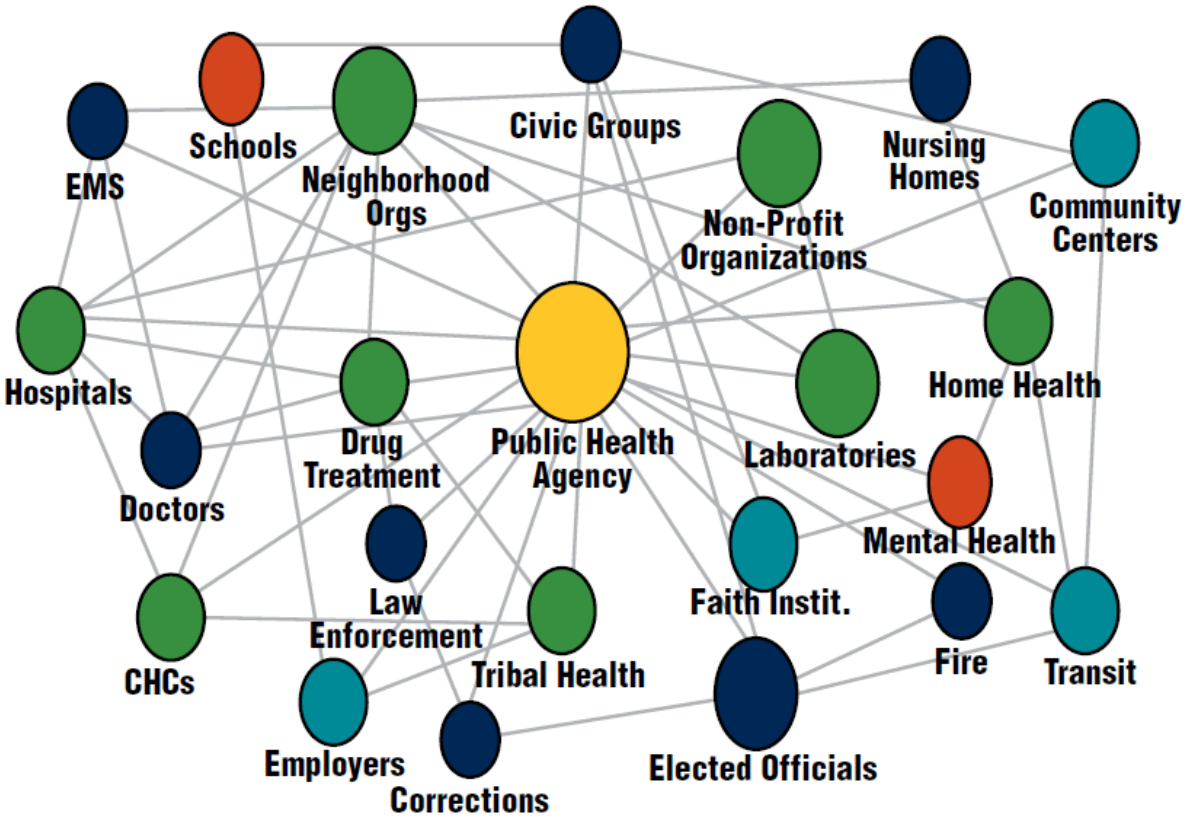
- The process of a Local Public Health System Assessment
- Practical guidance and helpful tips for facilitation of the LPHSA
- Definition of roles and responsibilities for facilitators, recorders, and timekeepers
- Team meetings for the facilitator, recorder, and timekeeper in each group to discuss how they plan to work together
- Suggestions and questions from the groups for the assessment planners (i.e. additional requested resources, tweaks to the process, etc.)

Facilitator Training; June 4, 2014

Invitees

Over 216 individuals in the Riley County and surrounding area were invited to participate in the Local Public Health System Assessment. The list of suggested participants was compiled by the Planning Committee, based on recommended expertise and perspectives needed for the LPHSA discussion and scoring measures, as indicated by the National Public Health Performance Standards Local Implementation Guide. Efforts were made to invite people from each suggested category and a wide variety of sectors. Invitees included representatives of all cities and school districts within Riley County, as well as many segments of the community, including hospitals, clinics, physicians, schools, child care providers, public safety and response agencies, faith-based organizations, employers, Kansas State University, Fort Riley, elected officials, and others. (See list of invitees in Appendix A)

Broad representation was important because many organizations are key to a strong and active public health system. (See below chart, referred to as the "jelly bean" chart.)



"Jelly bean" Chart of the Local Public Health System

Invitations were mailed and emailed in early May. (See Appendix A for a copy of the invitation letter.) Invitees were asked to RSVP by taking an online survey. Email and phone call RSVPs were also accepted.

Follow-up calls and emails were made in late May and continued through early June to encourage invitees to RSVP. This played an important role in boosting attendance numbers.

103 individuals sent a positive RSVP indicating they planned to attend (including staff). Additional materials about the assessment were emailed a few days before the assessment to those who planned to attend.

Participants

The sign-in sheet from the assessment day showed that 91 individuals attended the assessment as participants or staff (see list of participants in Appendix A).

Participants were placed into teams that discussed essential services that LPHSA organizers perceived would best relate to their background and experience. Because of this, some teams were larger than others. Feedback from facilitators, note takers, and recorders suggested that a group size of 20-25 participants is ideal.

Some participants were unable to attend the entire day, but were welcomed to attend during the times they were available.

Team Aggie: 22

Team Bluemont: 30

Team Goodnow: 29

Team Kansa: 17

Participant counts include the facilitator, timekeeper, and recorder.

Assessment Day Details

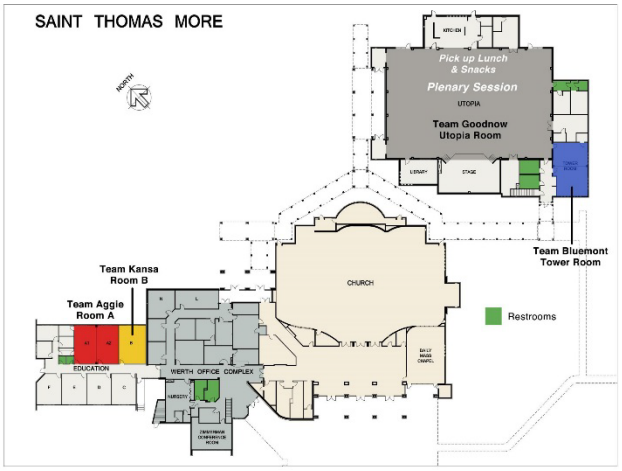
Venue and Set-Up

The LPHSA was held at the St. Thomas More Catholic Church in Manhattan, Kansas. This venue met the needed space specifications necessary to host the event. St. Thomas More graciously donated the space.

Participants were provided with a healthy continental breakfast, lunch, and snacks throughout the day.

A very large room was used for the opening plenary session with a theatre style setup, serving breakfast and lunch, and housed Team Goodnow's breakout "room" in a divided section of the room.

Three other breakout rooms were utilized for the other three teams. Every breakout room was setup in a horseshoe to promote conversation among the participants.



Agenda

Both a one day and two-day agenda were considered. A one-day agenda was decided on for logistical, financial, and attendance reasons.

Agenda	
7:30 a.m.	Registration and Check-in, Breakfast
8:00 a.m.	Welcome and Introductions
8:10 a.m.	Overview of Process
8:25 a.m.	Orientation to 10 Essential Services
9:00 a.m.	Proceed to Team Rooms for Essential Service Sessions
9:10 a.m.	Begin Team Sessions
11:30 a.m.	*Suggested Lunch Break Time (30 minutes)*
12:00 p.m.	Continue Essential Service Sessions in Team Rooms • Teams may adjourn when finished • Teams may take a 15-minute afternoon break
5:00 p.m.	Adjourn

Plenary Session

The plenary session gave LPHSA organizers the opportunity to provide a brief overview including:

- What a Local Public Health System Assessment is and why we are conducting
- How much **all** of the participants' perspectives were appreciated because each of them play a unique role in the local public health system
- How the LPHSA will be utilized along with other assessment processes going forward

Brenda Nickel, RCHD Director, introducing participants to the LPHSA

Materials

As participants arrived at the assessment location and stopped at the registration table they were given a nametag and folder (both color coded to match their team color). Inside the folder were handouts and materials pertaining to the assessment.

Participant Materials:

- Overall Agenda for the Day
- List of Invited Participants
- List of Expected Participants for Each Team
- Map of St. Thomas More with Color Coded Team Rooms
- Descriptions of the 10 Essential Public Health Services and their Model Standards
- Copy of the Instrument for their specific team's essential services
- Colored Scoring Cards

Timekeepers were also given:

- Team specific itinerary with times for each step in the Instrument

Recorders were also given:

- Blue official scoring copy of the Instrument

Copies of selected materials from the day are provided in Appendix B.

Using the Instrument

The instrument, developed by NACCHO (National Association of County and City Health Officials), was user-friendly and did not require too much prior knowledge, experience, or training to use effectively.

All participants were given copies of the instrument to follow along. Facilitators used a version of the instrument that included tips for keeping discussion focused and timely.

Each Essential Service is divided into Model Standards. Within each Model Standard are discussion questions and performance measures, following this general format:

- Essential Service
  - Model Standard 1
    - Discussion Questions
    - Performance Measures
  - Model Standard 2
    - Discussion Questions
    - Performance Measures

Discussion questions were asked by the facilitator, who continued to thoughtfully lead and provoke the discussions.

Sample of discussion questions included:

- What types of resources are available to support health problem and health hazard surveillance and investigation activities within the LPHS?
- What types of partnerships exist in the community to maximize public health improvement activities?
- What type of public health workforce assessments have been conducted within the community?

After a given amount of time for discussion on a Model Standard (about 15-20 minutes), the group would move on to the Performance Measures to score the Local Public Health System.

As an example, a copy of the instrument for one essential service is provided in Appendix C. The complete local instrument is available here: http://datacounts.net/lphsa/resources.asp

Discussion Notes

Recorders were given the option to take notes electronically with a laptop or by hand on paper. Most preferred taking electronic notes.

Electronic note taking forms specialized for each team (created in Microsoft Excel) were provided to aid recorders in the note-taking process. These were modeled after the note-taking forms provided in the instrument.

In these forms, each model standard had the following note-taking sections:

- Discussion Questions
- Strengths
- Weaknesses
- Short-Term Improvement Opportunities
- Long-Term Improvement Opportunities

- Scoring Notes
- Role/Organization/Program Notes

Timekeepers took additional notes using flip charts.

Participants were encouraged to write additional comments on post-it notes and place them on designated posters (white flip chart paper) hung on walls. This allowed for all thoughts to be heard and considered in the assessment, even if time did not allow for them to be thoroughly discussed during the event.

Both the timekeeper notes and participant post-it notes were incorporated into the official recorder notes to comprise the complete team notes. Key information from the team notes (strengths, weaknesses, and opportunities) are included in the complete generated report (Appendix D). Due to the length of the complete version of these notes, they are not included in this report, but are available on the website: www.datacounts.net/lphsa.

Scoring

Every participant had a set of six colored score cards to use for voting on the Performance Measures.

- **Green – Optimal Activity 76-100%**
- **Blue – Significant Activity 51-75%**
- **Yellow – Moderate Activity 26-50%**
- **Orange – Minimal Activity 1-25%**
- **Pink – No Activity 0%**
- **White – More Discussion Needed**

Participants also were provided a table tent that described each of the scoring cards in more detail. (See picture, above right)

The facilitator would read the Performance Measure then ask the group to each raise the card with their vote at the same time.

The facilitator observed the room for the dominant color. If the voting card colors varied widely, the facilitator would allow a couple more minutes for discussion to promote consensus among the group, then ask for a revote. The recorder would mark the final score for each Performance Measure on the official score sheet.

Exact numbers of colored cards were not recorded since this process focused on obtaining group consensus on the score for each performance measure. Consensus is not the same as unanimity, but does require that those who are not in total agreement with the group can "live with" the score recorded.

Post-Assessment Processing and Review

Performance Measure Scores

Within one week of completing the assessment, the performance measure scores were compiled into a document that was posted on the LPHSA website. These scores were available from the home page, so any visitor to the website could view the scores.

LPHSA Team Leader Debrief Meeting

A debrief and follow-up meeting was held on June 16th. LPHSA staff and team leaders (facilitators, recorders, and time keepers) were requested to attend.

The meeting covered the following topics:

- Perspective sharing: "How did the assessment go?"
- Reflection and evaluation on the Facilitator Training and LPHSA process
- Development of the Evaluation Survey

Comments, suggestions, positive feedback and constructive criticism were discussed to determine what aspects of the assessment were effective and what could be improved.

Formatting and questions for the Evaluation Survey were determined.

Reviewing of Team Notes

The complete team notes (including the official recorder notes, timekeeper notes, and participant post-it notes) were posted to the log-in portion of the LPHSA website. Team leaders (facilitators, recorders, and timekeepers) were asked to review the notes for clarity and corrections to be sure the notes were accurate reflections of the assessment day discussions.

After team leaders reviewed the notes, they emailed their edits to an LPHSA organizer. As soon as the edits were applied to the team notes documents, newest versions of the documents were uploaded to the log-in portion of the LPHSA website.

While processing through the team notes, common themes discussed among teams became evident. These themes were recorded in a document which was sent to LPHSA staff and team leaders for discussion and reflection, in addition to being posted on the log-in portion of the LPHSA website.

NPHPS Generated Report

A macro-enabled Excel workbook developed by NPHPS was used to generate a results report for the assessment.

Performance scores and summary notes (strengths, weakness, and short-term/long term improvement opportunities) were entered into the Excel workbook by LPHSA staff, and the results report (Appendix D) generated was posted on the log-in portion of the LPHSA website.

Participant Evaluation Survey

Using SurveyMonkey, an electronic Evaluation Survey was created. A link to the survey was sent via email to all participants, staff, and team leaders on June 20th and was open for responses through July 8th.

The survey received 51 total responses.

- 84% of responses were from participants
- 16% of responses were from staff or team leaders

A copy of the evaluation survey instrument can be found in Appendix E, and a complete report of the survey results is in Appendix F.

Agency Contribution Questionnaire

On October 16, 2014 the optional "Agency Contribution" questionnaire of the NPHPS Local Instrument was completed by seven members of the Riley County Health Department leadership team. Two observers, a facilitator and an intern, were also present. Participants scored agency contribution using a consensus scoring process and scale similar to the LPHSA activity scoring:

- No Contribution (0%)
- Minimal Contribution (1-25%)
- Moderate Contribution (26-50%)
- Significant Contribution (51-75%)
- Maximum Contribution (76-100%)

An overview of the agency contribution results is provided later in the body of this report, with a complete report available in Appendix G.

Next Steps

Immediate next steps in this process include utilizing the results of this report as well as the Community Needs Assessment to help determine priorities for the Community Health Improvement Planning. A series of community meetings is planned for early 2015 to present results of assessments to-date and identify priorities.

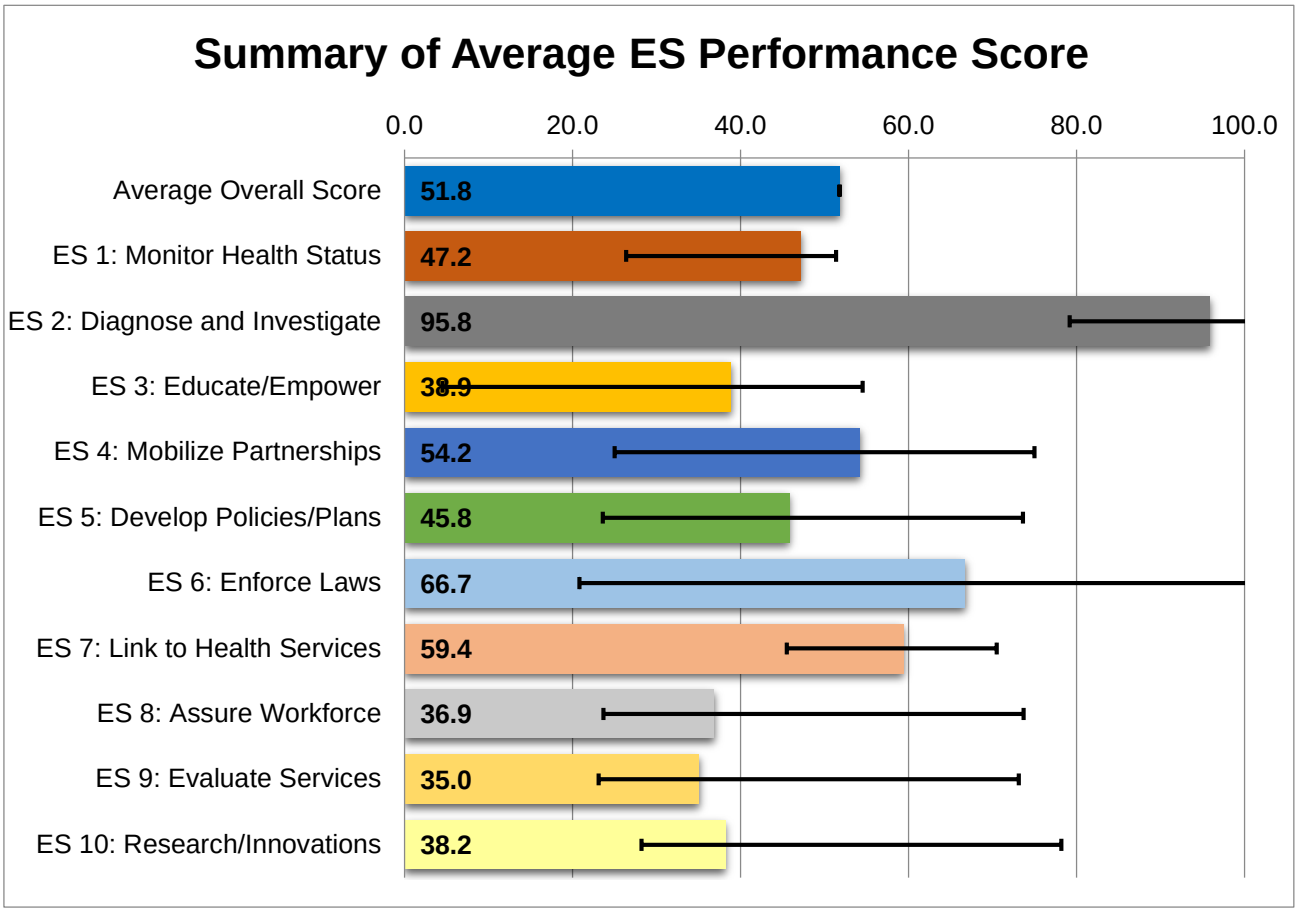
Results and Summary Observations

Local Public Health Systems Assessment Results

The National Public Health Performance Standards spreadsheet tool accompanying the Local Instrument generates a results report after the results are entered. Based on average Essential Service performance scores, Riley County's public health system scored very favorably:

- No essential services performed in the "No Activity" (0%) or "Minimal Activity" (1-25%) range.
- Six essential services averaged in the "Moderate Activity" (26-50%) range:
    - ES 9: Evaluate Services (35.0%)
    - ES 8: Assure Workforce (36.9%)
    - ES 10: Research/Innovations (38.2%)
    - ES 3: Educate/Empower (38.9%)
    - ES 5: Develop Policies/Plans (45.8%)
    - ES 1: Monitor Health Status (47.2%)

- Three essential services performed in the "Significant Activity" (51-75%) range:
  - ES 4: Mobilize Partnerships (54.2%)
  - ES 7: Link to Health Services (59.4%)
  - ES 6: Enforce Laws (66.7%)
- One essential service performed in the "Optimal Activity" (76-100%) range:
  - ES 2: Diagnose and Investigate (95.8%)



Common themes observed in the notes from the day include the following:

- Much work is being done (lots of resources, lots of organizations, doing a lot of good things)…but many (including community leaders, providers, organizations, and the public) don't know about it
- Take full advantage of the many resources and data available…but doing so requires additional time, people, resources, and coordination
- For some model standard activities, lacking central authority or lead organization to take fully implement or utilize resources in an intentional, coordinated way (e.g., public information officer for public health, utilizing data from state registries, etc.)

- Increase communication from the local public health system (LPHS) to the public; work to improve community members' awareness of the system
    - What services and resources are available?
    - How can they be accessed?
    - What are the key health issues?
- Increase communication, coordination, and linkages within the LPHS
    - Know who offers services and resources
    - Improve linkages of patients to needed health services
    - Bridge gaps/improve partnerships among organizations
- Expand LPHS ability to share and use data and informational resources
    - Multiple "resource guides"
    - A lot of data, but not all of it is regularly utilized by the LPHS and its constituents
    - Data is not completely accessible and in one place
- Resources in the community are not "silos"…yet they are not completely coordinated
- Challenges contributing to the lack of coordination and awareness are
    - Beyond Manhattan, communities are geographically "spread out"
    - Transient population and workforce
    - Independently resourceful organizations (e.g., K-State, Fort Riley, NBAF, Mercy Regional Health Center, USD 383, etc.) with their own distinct goals and purposes
    - Relatively diverse population
- Concerns related to mental health, including adequate capacity meet needs for mental health services
- General lack of awareness of the 10 essential services and the public health system, as well as how a strong public health system benefits the community
- Need more direct and broad-based involvement of local public health systems representatives in community meetings and decision-making processes (e.g., county and city commissions, boards of education, increase awareness of public health advisory council, etc.)

The full NPHPS LPHSA report is available in Appendix D. Complete, unabridged team notes are available on the website: http://datacounts.net/lphsa/default.asp

LPHSA Participant Evaluation Survey Results

Over half (51) of the LPHSA participants responded to a post-assessment evaluation survey. Survey results showed that while it was a long, intense day, most participants learned more about the public health system and anticipated following up on something they learned:

- 94% of respondents agreed or strongly agreed that the structured process allowed for constructive, informative discussion; fewer, but still a strong majority

(82%) agreed or strongly agreed the process provided for accurate, useful performance measure scoring
- 94% learned something new about the public health system
- 82% made a new connection with an individual or organization
- 82% planned to follow-up on something learned from the day (e.g., share information, raise awareness, connect with an individual/organization, etc.)
- 94% of respondents were interested in being involved in using the results to help improve our local public health system.

The full Participant Evaluation Survey report is available in Appendix F.

LPHSA Agency Contribution Results

Seven Riley County Health Department Leadership Team members completed the agency contribution scoring process on October 16th, 2014. The resulting average contribution scores by Essential Service are as follows:

- No essential services scored in the "No Contribution" (0%) or "Minimal Contribution" (1-25%) range.
- Eight essential services averaged in the "Moderate Contribution" (26-50%) range:
    - ES 6: Enforce Laws (25.0%)
    - ES 1: Monitor Health Status (33.3%)
    - ES 9: Evaluate Services (33.3%)
    - ES 10: Research/Innovations (33.3%)
    - ES 4: Mobilize Partnerships (37.5%)
    - ES 3: Educate/Empower (41.7%)
    - ES 8: Assure Workforce (43.8%)
    - ES 5: Develop Policies/Plans (50.0%)
- Two essential services averaged in the "Significant Contribution" (51-75%) range:
    - ES 2: Diagnose and Investigate (58.3%)
    - ES 7: Link to Health Services (62.5%)
- No essential services averaged in the "Maximum Contribution" (76-100%) range.

Summary observations from participants included:

- RHCD is moving toward being more public-health minded versus departmentally focused. Each staff member is going to be more a part of the whole public health system. This is a cultural shift for the agency away from a department/program focus.
- Once our community partnership, perception, reputation in the community improves, we can do this better [contribute more].
- Think the agency has come a long way. We may only have minimal to moderate contribution in some areas, but this is a long way from where we were!

- LPHSA was a teaching tool for community and think it was essential that we do this [contribution questionnaire] internally to see how we are doing [as a department]. In 5 years or so, it would be good to do as a whole staff and not just the leadership team. Hopefully the whole staff will then see the value of the whole public health system and ten essential services.
- Maximum contribution does not equal excellent work. It is the contribution to the system, not the quality of our work. We can't provide all things to all people.
- We have resource constraints so we couldn't get to maximum in some areas, plus in some areas we don't NEED to provide a maximum contribution. Another partner in the system is taking the lead.
- The facilitator and intern observers to the process both felt that the staff were very hard on themselves in scoring their current contribution.

The full Participant Evaluation Survey report is available in Appendix G.

Appendices

Appendix A

Invitees and Participants

Planning Committee Invitation Letter

LPHSA Invitation Letter

List of Invitees and Participants

RILEY COUNTY
Health Department

Brenda Nickel MS RN
Director & Local Health Officer
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
www.rileycountyks.gov/health

February 13, 2014

Dear Community Member,

I am pleased to invite you to serve on the Riley County Local Public Health System Assessment (LPHSA) Planning Committee. You have been identified as a community member who has broad knowledge of the community, as well as an interest or stake in maintaining and improving our local public health system.

The Riley County assessment will use a nationally standardized tool to help our community answer questions like, "what are the activities and capacities of our public health system?", "what are our gaps?", and "are people in my community receiving the health services they need?" Results of the assessment can be used to help inform the upcoming comprehensive community health needs assessment and will be made publicly available.

Your input is important to help us identify a complete and representative list of community participants to invite. You will also have an opportunity to review and provide input on the process. The assessment itself is tentatively scheduled to take place on two days in late June.

To learn more about the Riley County Local Public Health Systems Assessment, please see this website, which will be updated as our planning process moves forward of the next several months: http://www.datacounts.net/lphsa

Thank you for considering this invitation. Please RSVP to Katy Oestman at 776-4779 x7612 or koestman@rileycountyks.gov by Friday, February 28th and provide preferred method of contact. Our first planning meeting will be Tuesday, March 25th, 2:30 – 4:30 p.m. at the Health Department. If you are unable to attend, you are welcome to send a designee from your organization.

We hope you will be part of the Planning Committee and help make this a successful and comprehensive assessment of our local public health system.

Sincerely,

Robert Boyd, Jr.
Chair
Riley County Commissioner

Brenda Nickel, MS, RN
Director & Local Health Officer
Riley County Health Department

Health Department Clinics
2030 Tecumseh Road
Manhattan KS 66502
P: 785-776-4779
F: 785-565-6565

Family & Child Resource Center
2101 Claflin Road
Manhattan KS 66502
P: 785-776-4779
F: 785-587-2879

Fort Riley WIC
Soldier & Family Support
WIC Bldg 7264
Fort Riley KS 66442
P: 785-239-5730

RILEY COUNTY

Health Department

Brenda Nickel MS RN
Director & Local Health Officer
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
www.rileycountyks.gov/health

May 9, 2014

Dear Community Member:

I am pleased to invite you to help assess our community's health system via the Riley County Local Public Health System Assessment (LPHSA). You have been identified as a community member who has broad knowledge of the community, an interest or stake in maintaining and improving our local public health system, as well as demonstrated expertise in your area.

The Riley County assessment will use a nationally standardized tool to help our community answer questions like, "what are the activities and capacities of our public health system?", "what are our gaps?", and "are people in my community receiving the health services they need?" Results of the assessment will be used to help inform the upcoming comprehensive community needs assessment and improvement plan, and will be made publicly available. In order to best serve our residents and community, assessment of the health system as a whole is necessary.

To learn more about the Riley County Local Public Health Systems Assessment, please see this website, which will be updated as our planning process moves forward of the next couple of months: http://www.datacounts.net/lphsa

Prior to the assessment we will be sending out materials for your review in order to increase your understanding and familiarity with the items that you will be asked to discuss and score during the assessment. The LPHS Assessment location and date are as follows:

Location: St. Thomas More Catholic Church, 2900 Kimball Avenue, Manhattan, KS 66502
Date: Wednesday, June 11th
Time: 8:00 a.m. until 5:00 p.m.

- 7:30 a.m. Registration and continental breakfast
- Meeting will begin promptly at 8:00 a.m.
- Lunch will be provided

Thank you for considering this invitation. Please RSVP at https://www.surveymonkey.com/s/RCLPHSA. Contact Katy Oestman with questions at 776-4779 x7612 or koestman@rileycountyks.gov by Friday, May 16th, 2014. If you are unable to attend, please send a designee from your organization to ensure the assessment is thorough and complete.

We hope you will be part of the assessment to help make this a successful and comprehensive inventory of our local public health system.

Sincerely,

Robert Boyd, Jr.
Chair
Riley County Commissioner

Brenda Nickel, MS, RN
Director & Local Health Officer
Riley County Health Department

Invitees and Participants

Below is the list of all invited community members. Those who participated in the assessment are denoted by bold print.

Thank you to everyone who has been a part of this important step in moving public health in our community forward!

Ron Alexander, Kansas Leadership Center

Penny Alonso, Little Apple Optimist Club

John Alstadt, Florence Manufacturing

Trent Armbrust, Manhattan Chamber of Commerce

Michelle Ashburn, Riley County Site Council

Lynda Bachelor, Staley School of Leadership Studies - KSU

Rick Bailey, Sunflower State Health

David Baker, Douglass Community Center

Lonnie Baker, Meadowlark Hills

John Ball, City of Manhattan Social Services Advisory Board

Nancy Barnaby, St. Thomas More Catholic Church

Virginia Barnard, Health, Nutrition & Food Safety

Brady Bauman, Manhattan Mercury

Ricky Becker, Jewish Congregation

David Ben-Arieh, K-State Engineering

Paul Benne, Fort Riley

J Edgar Bennett, Amerigroup

Lori Bishop, RSVP of the Flint Hills, Inc.

Wendy Blank, Lafene Student Health Center

Christie Blenden, Blue Cross/Blue Shield

Lynne Bliss, Sunflower State Health

Don Bolerjack, Kansas First News

Mariah Boller, Ogden Community Center

Bob Boyd, Riley County Commission

John Broberg, Mercy Regional Health Center

Larry Brockson, St. Thomas More Catholic Church

Anne Brown

Rick Brunetti, Kansas Department of Health & Environment

Jo Brunner, Workforce Center

Brady Burton, USD 384

Lyle Butler, Manhattan Area Chamber of Commerce

Wynn Butler, Manhattan City Commission

Diana Caldwell, Cultural Enrichment Academy

Junnae Campbell, Boys & Girls Club of Manhattan

Leslie Campbell, Pottawatomie County Health Department

Sydney Carlin

Abby Cavender, Via Christi Village

Diana Chapel, Ogden Friendship House

Amy Chaplin, Riley County Health Department

Scott Chapman, Manhattan Surgical Center

Kimathi Choma, KSU - Vet Med

Becky Claus, MATC Nursing

Alice Clomegah, KDHE

Robbin Waldner Cole, Pawnee Mental Health Services

Abbi Collins, EnVisage Consulting, Inc.

Emily Collins, EnVisage Consulting, Inc.

Pat Collins, Riley County Emergency Management

Larry Couchman, Riley County Emergency Medical Services

Ann Cowan, Manhattan Alliance for Peace and Justice

Craig Cox, Manhattan Breakfast Optimist Club

Greg Crawford, Kansas Department of Health & Environment

Deb Crowley, Irwin Army Community Hospital

Diane Daldrup, March of Dimes Greater Kansas City Chapter

Willie Davila, City of Manhattan Animal Control & Shelter Services

Judy Davis, The Crisis Center

Karen Davis, City of Manhattan

Cathy Dawes, KMAN

Steven DeHart, Riley County

Shania Dekat, HCCI Manhattan Office

Dave Dreiling, GTM

Matt Droge, Riley County Police Department

Eddie Eastes, City of Manhattan Parks & Recreation Department

Robert Edleston, Manhattan Area Technical College

Joy Edwards, Via Christi Village

Aaron Estabrook, USD 383 Board of Education

Emily Farley, Kansas Department of Health & Environment

Ron Fehr, City of Manhattan

Lori Feldcamp, Big Lakes Development Center

Michelle Fell, Blue Cross/Blue Shield KS

Shannan Flach, Wamego Health Center

Mary Ann Fleming, League of Women Voters of Manhattan/Riley County

Ennelle Forester, League of Women Voters

Scott French, Manhattan Fire Department

Shannon Gabel, Kansas Department of Health & Environment

Penny Garber, Meadowlark Hills

Ingrid Garrison, Kansas Department of Health & Environment

Julie Gibbs, Lafene Student Health Center

Sarah Gill, Community Member

Tarah Gregory, CCSR

Ronnie Grice, K-State Police Department

Mark Gros, Women's Health Group

Patti Grub, Riley County Health Department

Krista Hahn, Community Health Ministries

Mary Jo Harbour, Riley County Council on Aging

Brian Hardeman, Eugene Field Neighborhood Association

Cathy Harmes, City of Manhattan

Suesan Harrington, NCFHAAA

Sarah Hartsig, Kansas Health Institute

Tom Hawk, Kansas

Carolyn Heafey, Community Member

Katie Heinrich, Kansas State University

Vern Henricks, Greater Manhatttan Community Foundation

Cary Herl, Candlewood Medical Group

Mike Herman, Flint Hills Human Rights Project

Curt Herrman, USD 383 Board of Education

Doug Hinkin, K-STAT

Diane Hinrichs, Highland Community College

Shannon Hoff, Riley County Health Department

Clancy Holeman, Riley County

Marcia Hornung, School of Leadership Studies

Debora Howser, USD 383 Manhattan-Ogden Public Schools

Patricia Hunter, Geary County Health Department

Brandon Irwin, Kansas State University - Kinesiology Dept

Jill Jacoby, Manhattan Area Housing Partnership

Leslie Jamar, United Healthcare

Rich Jankovich, Manhattan city commission

Michelle Johnson, Army Public Health Nursing

Mike Johnson, City of Leonardville

C. Clyde Jones, Community Member

Michele Jones, USD 383

Justin Kastner, Kansas State University

Al Keithley, Lion's Club

Beth Kellstrom, Riley County Health Department

Tandalayo Kidd, Kansas State University - College of Human Ecology

Maribeth Kieffer, Flint Hills Breadbasket

Jamie Kim, Kansas Department of Health & Environment

Tammy Koopman, Mercy Regional Health Center

Tom Langer, Kansas Department of Health & Environment

Robert Larson, Kansas State University - Vet Med

Tyler Lauer, GTM

John Leatherman, Kansas State Agricultural Economics Department

Dave Lewis, Riley County

Matt Lewiston, FBI

Dave Long, Kansas Gas Service, Manhattan

Victor Lopez, Amerigroup

Tiffane Loxterman, Amerigroup

Greg Lund, Riley County Parks and Recreation Department

Emily Mailey, K-State University

Michelle Martin, Catholic Charities of Northern Kansas

Shawn Martin, Manhattan Vet Center

Paul Marx, Kansas Department of Health & Environment

Helen Matthews, Catholic Charities of Northern Kansas

Karen McCulloh, City of Manhattan

Tim McDonald, Flint Hills Christian School

Duane McKinney, Shepherd's Crossing

Patrick McLaughlin, First United Methodist Church

Brian McNulty, Army Corps of Engineers

Judine Mecseri, Homecare & Hospice

Margie Michal, Mercy Regional Health Center

Julie Miller, Mercy Regional Health Center

Kurt Moldrup, Riley County Police Department

Jina Moon, Big Lakes Development Center

Ward Morgan, CivicsPlus

Jayme Morris-Hardeman, Sunflower CASA Project, Inc.

Linda Morse, League of Women Voters

Zac Morton, First Presbyterian Church

Cindy Mott, Riley County Health Department

Amanda Nall, Sexual Assault Response Team, Mercy Regional

Daniel Neises, Kansas Department of Health & Environment

Hank Nelson, Riley County Police Department

Brenda Nickel, Riley County Health Department

Debbie Nickels, Kansas Department of Health & Environment

Debbie Nuss, Riley County Seniors Service Center

Mohammad Obeidat, Islamic Center of Manhattan

Katherine Oestman, Riley County Health Department

Beverly Olson, Shepherd's Crossing

Jason Orr, Riley County Health Department

Carita Otts, Riley County Council on Aging

Tom Phillips, Kansas House of Representatives

Todd Pickering, Irwin Army Community Hospital

Michelle Ponce, Kansas Association of Local Health Departments

Maggie Rassette, Mercy Regional Health Center

Usha Reddi, Manhattan City Commission

Linda Redding, Family Connections of Riley County

Susan Reed, Flint Hills Community Clinic

Jody Reid, Ogden Community Center

Melissa Rickel-Morrill, UFM Community Learning Center

Dana Rickley, Clay County Health Department

Ric Rosenkranz, Kansas State University

Lisa Ross, Riley County Health Department

Marvin Roth, Manhattan Breakfast Optimist Club

Michelle Rutherford, Emergency Medical Services

Connie Satzler, Envisage Consulting, Inc.

Julia Satzler, Envisage Consulting, Inc.

Jan Scheideman, Riley County Health Department

Doug Schmitt, Leonardville Fire Department/Fire District 1

Audrey Schremmer, Three Rivers, Inc.

Gina Scroggs, Downtown Manhattan, Inc.

Kendra Seat, Army Wellness Center, Fort Riley

Penny Senften, Manhattan Arts Center

Bob Shannon, USD 383

Johnette Shepek, Riley County

Steve Shields, Action Pact

Paul Shipp, Kansas Legal Services

Jane Shirley, Kansas Department of Health & Environment

R. David Shover II, City of Riley

Lisa Sisley, Manhattan Konza Rotary Club

Anne Smith, Flint Hills Area Transportation Agency

Paul & Janet Smith, NAMI - Flint Hills Group

Lee Ann Smith Desper, Konza United Way

Breva Spencer, Riley County Health Department

Brad Starnes, USD 378

Kate Steeves, Kansas Department of Health & Environment

Kevin Stilley, Flint Hills Human Rights Project

Gary Stith, Flint Hills Regional Council

Donna Sullivan, Riley Countian

JoAnn Sutton, Manhattan Housing Authority

Effie Swanson, KSU ISC

Vern Swanson, Kansas

Marsha Tannehill, Riley County Health Department

Linda Teener, UFM Community Learning Center

Megan Umscheid, Wamego Chamber of Commerce

Rich Vargo, Riley County

Cindy Volanti, Riley County

Emily Wagner, Manhattan Emergency Shelter, Inc.

Stan Ward, USD 383

Monty Wedel, Riley County

Susan Weidenbach, Older Kansans Employment Program, Dept Commerce

Terry Weil, Restoration Center

Ron Wells, Riley County

Dick Wertzberger, Manhattan Rotary Club

Shelly Williams, Riley County Community Corrections

Jennifer Wilson, Riley County K-State Research & Extension

Lee Wolf, Konza Prairie Community Health Clinic

Carla Yost, Mercy Regional Health Center

Bruce Zimmer, City of Randolph

Appendix B

Selected Participant Materials

Agenda

Discussion Rules and Scoring Reference

10 Essential Public Health Services and Model Standards

Introductory Presentation

Local Public Health System Assessment

June 11, 2014
7:30 a.m. - 5:00 p.m.

Agenda

7:30 a.m.	Registration and Check-in, Breakfast
8:00 a.m.	Welcome and Introductions
8:10 a.m.	Overview of Process
8:25 a.m.	Orientation to 10 Essential Services
9:00 a.m.	Proceed to Team Rooms for Essential Service Sessions
9:10 a.m.	Begin Team Sessions
11:30 a.m.	*Suggested Lunch Break Time (30 minutes)*
12:00 p.m.	Continue Essential Service Sessions in Team Rooms • Teams may adjourn when finished • Teams may take a 15-minute afternoon break
5:00 p.m.	Adjourn

Essential Service Breakout Groupings

Team Aggie* – Room A
- *Facilitator: Sarah Hartsig*
- *Recorder: Jan Scheideman*
- *Timekeeper: Beth Kellstrom*

#1 Monitor Health
#2 Diagnose & Investigate

Team Goodnow* – Utopia Room
- *Facilitator: Col. Paul Benne*
- *Recorder: Lisa Ross*
- *Timekeeper: Amy Chaplin*

#4 Mobilize Community Partnerships
#5 Develop Policies
#6 Enforce Laws

Team Bluemont* – Tower Room
- *Facilitator: Katy Oestman*
- *Recorder: Cindy Mott*
- *Time Keeper: Shannon Hoff*

#3 Inform, Educate, Empower
#7 Link to/ Provide Care

Team Kansa* – Room B
- *Facilitator: Jane Shirley*
- *Recorder: Jason Orr*
- *Time Keeper: Marsha Tannehill*

#8 Assure Competent Workforce
#9 Evaluate
#10 Research

** Do you know the significance of your team name related to Riley County history? See summaries on the back to check your knowledge!*

Planning Committee

- Robert Boyd, Riley County Commissioner
- Ginny Barnard, Riley County K-State Research & Extension, Public Health Advisory Committee
- Dr. Paul Benne, Fort Riley Public Health, Public Health Advisory Committee
- Kris Bourland, Fort Riley Public Health
- Dr. Michael Cates, K-State Master of Public Health program
- Robbin Cole and Shannon Hughston, Pawnee Mental Health Services
- Pat Collins, LEPC Chair
- Kristin Cottam and Margie Michal, Mercy Regional Health Center
- Larry Couchman, Riley County EMS
- Lee Ann Smith Desper, United Way
- Dr. Cary Herl, RCDH Medical Director
- Vern Henricks, Greater Manhattan Community Foundation
- Karen McCulloh, Manhattan City Commissioner
- Captain Hank Nelson, Riley County Police Department
- Brenda Nickel, Riley County Health Department
- Debbie Nuss, Community Member, Public Health Advisory Committee
- Katy Oestman, Riley County Health Department
- Beverly Olson, Shepherd's Crossing
- Connie Satzler, EnVisage Consulting

Aggie

The term "Aggies" (a common nickname for land-grant and agriculture colleges) was used for K-Staters for the first 19 athletic seasons. In 1915 Coach John Bender gave the team the nickname the "Wildcats" because of the teams "fighting spirit." The nickname changed in 1916 to "Farmers" but "Wildcats" was reinstated with Coach Charles Bachman in 1920, and remains to this day.

http://www.salina.k-state.edu/facultystaff/handbook/tradition02.html
http://bleacherreport.com/articles/639587-big-12-background-checks-the-origins-of-every-teams-nickname-and-mascot/page/3
http://www.kstatesports.com/trads/traditions.html

Kansa

The Kansa (also called Kaw or People of the Southwind) are North American Indians who traditionally lived in Kansas. They traditionally farmed and hunted, living a semi sedentary life. They used the Flint Hills as communal hunting grounds for bison. Multiple family groups would live in large dome shaped lodges either covered in bark or earth. Eventually the Kansa were forcibly relocated to Oklahoma, where many currently reside today. Today there are an estimated 2,000 people of Kansa descent.

http://www.nps.gov/tapr/historyculture/american-indian-culture.htm
http://www.britannica.com/EBchecked/topic/311285/Kansa

Goodnow

Isaac T. Goodnow was a founder of Manhattan and Kansas State University. He was the first president of Bluemont Central College, which later became Kansas State University. He was highly involved in the free-slave state dispute in Kansas. He used his connections in the east to raise money to enable him to co-found Bluemont Central College. When Bluemont transitioned into a state university, Goodnow was instrumental in developing the land given the university as well as selling portions of the land to support the further growth of the university. He was a member of the Kansas House of Representatives and the first Superintendent of Public Instruction in Kansas (1862).

http://www.kansasmemory.org/item/178
http://www.kshs.org/kansapedia/isaac-t-goodnow/16904

Bluemont

Bluemont Central College was the precursor to Kansas State University. Bluemont Central College was opened January 9th, 1860. Three years later, the Morrill Act, an act giving land to states for the sole purpose of starting and funding universities, was accepted by the state of Kansas. Soon after Kansas State Agricultural College opened September 2nd, 1863. The first graduating class was in 1867 and was a total of 5 people.

http://www.lib.k-state.edu/depts/spec/flyers/ksu-history.html

Ground Rules

- Stay present (phones on silent/ vibrate, limit side conversations).
- Speak one at a time.
- Be open to new ideas.
- Step up/ Step back (to make sure all participate).
- Avoid repeating previous remarks.
- Allow facilitator to move conversation along.
- Welcome all perspectives.
- Use voting cards to vote (everyone votes at the same time).
- Raise hand to request additional discussion before voting.
- Prepare to provide examples and explanation to inform group and increase understanding of your rating.

Discussion Principles

What is the collective picture of how we are doing across the jurisdiction related to this Essential Service?

- Consider responses to discussion questions.
- Keep focus on Model Standard.
- Stay focused on system as a whole, but share specific examples.
- Purpose is to get honest and accurate perception of system performance for quality improvement.
- Share concrete examples.
- Share strengths.
- Share weaknesses.
- Suggest recommendations for short- and long-term improvement opportunities.

Scoring

Optimal Activity (76%-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51%-75%)	Greater than 50% but not more than 75% of the activity described within the question is met.
Moderate Activity (26%-50%)	Greater than 25% but not more than 50% of the activity described within the question is met.
Minimal Activity (1%-25%)	Greater than zero but not more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

10 Essential Public Health Services

Essential Service 1: Monitor Health Status to Identify Community Health Problems

What is going on in our community? Do we know how healthy we are?

Model Standard 1.1: Population-Based Community Health Assessment
Model Standard 1.2: Current Technology to Manage and Communicate Population Health Data
Model Standard 1.3: Maintaining Population Health Registries

Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards

Are we ready to respond to health problems to health hazards in our county? How quickly do we find out about problems? How effective is out response?

Model Standard 2.1: Identifying and Monitoring Health Threats
Model Standard 2.2: Investigating and Responding to Public Health Threats and Emergencies
Model Standard 2.3: Laboratory Support for Investigating Health Threats

Essential Service 3: Inform, Educate, and Empower People about Health Issues

How well do we keep all segments of our community informed about health issues?

Model Standard 3.1: Health Education and Promotion
Model Standard 3.2: Health Communication
Model Standard 3.3: Risk Communication

Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems

How well do we truly engage people in local health issues?

Model Standard 4.1: Constituency Development
Model Standard 4.2: Community Partnerships

Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts

What local policies in both the government and private sector promote health in my community? How well are we setting healthy local policies?

Model Standard 5.1: Governmental Presence at the Local Level
Model Standard 5.2: Public Health Policy Development
Model Standard 5.3: Community Health Improvement Process and Strategic Planning
Model Standard 5.4: Planning for Public Health Emergencies

Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety

When we enforce health regulations are we technically competent fair, and effective?

Model Standard 6.1: Reviewing and Evaluating Laws, Regulations, and Ordinances
Model Standard 6.2: Involvement in Improving Laws, Regulations, and Ordinances
Model Standard 6.3: Enforcing Laws, Regulations, and Ordinances

Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable

Are people in my community receiving the health services they need?

Model Standard 7.1: Identifying Personal Health Service Needs of Populations
Model Standard 7.2: Ensuring People Are Linked to Personal Health Services

Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce

Do we have competent public health staff? Do we have competent healthcare staff? How can we be sure that our staff stays current?

Model Standard 8.1: Workforce Assessment, Planning, and Development
Model Standard 8.2: Public Health Workforce Standards
Model Standard 8.3: Life-Long Learning through Continuing Education, Training, and Mentoring
Model Standard 8.4: Public Health Leadership Development

Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

Are we meeting the needs of the population we serve? Are doing things right? Are we doing the right things?

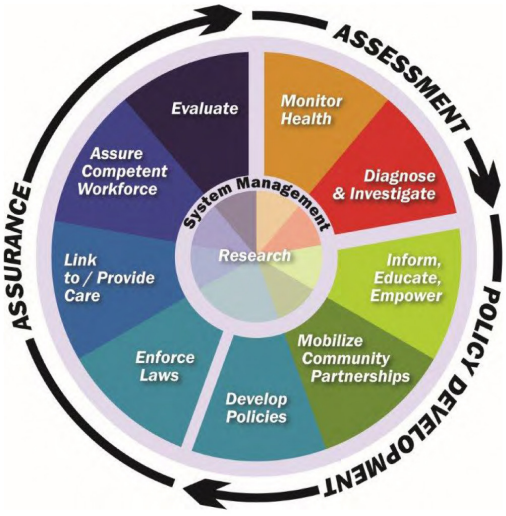
Model Standard 9.1: Evaluating Population-Based Health Services
Model Standard 9.2: Evaluating Personal Health Services
Model Standard 9.3: Evaluating the Local Public Health System

Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems

Are we discovering and using new ways to get the job done?

Model Standard 10.1: Fostering Innovation
Model Standard 10.2: Linking with Institutions of Higher Learning and/or Research
Model Standard 10.3: Capacity to Initiate or Participate in Research

The 10 Essential Public Health Services



1

RILEY COUNTY: LOCAL PUBLIC HEALTH SYSTEMS ASSESSMENT

June 11, 2014

St. Thomas More Catholic Church
2900 Kimball
Manhattan, KS 66502

Our Vision:
"Healthy people living in a health community"

2

The Riley County Board of Health Welcomes You!

Ron Wells
Robert Boyd, Chair
Dave Lewis

Welcome!

3

WELCOME & INTRODUCTIONS

Brenda Nickel, Director & Local Health Officer
Riley County Health Department

4

Planning Committee

- Robert Boyd, Riley County Commissioner
- Dr. Paul Benne, Fort Riley Department of Public Health
- Kris Bourland, Fort Riley Department of Public Health
- Dr. Michael Cates, K-State Master of Public Health Program
- Robbin Cole, Pawnee Mental Health
- Pat Collins, Local Emergency Planning Committee
- Kristin Cottam, Mercy Regional Health Center
- Larry Couchman, Riley County EMS
- Lee Ann Smith Desper, Konza United Way

5

Planning Committee

- Dr. Cary Herl, RCHD Medical Director & Candlewood Family Practice
- Vern Henricks, Greater Manhattan Community Foundation
- Karen McCulloh, Manhattan City Commissioner
- Margie Michal, Mercy Regional Health
- Brenda Nickel, Riley County Health Department
- Debbie Nuss, Riley County Senior Services
- Katy Oestman, Riley County Health Department
- Beverly Olson, Shepherd's Crossing
- Connie Satzler, EnVisage Consulting

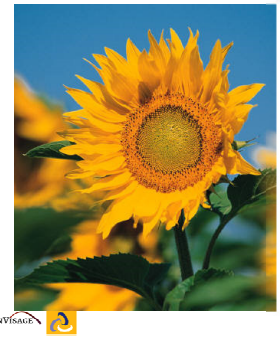
6

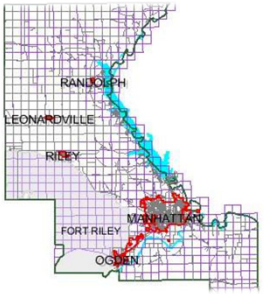
Special Recognition

- St. Thomas More
  - Amanda Larrabee
  - Alysia Baumann
  - Facilities Crew
- EnVisage Consulting Team
  - Claire Bascom
  - Emily Collins
- Riley County
  - Steve Oliver, Travis Gordon, and Cory Meyer Internet Technology
  - Darci Paull, GIS Department
  - Shelley Hays, Health Department
  - Cindy Mott, Health Department
- Denise Pavletic, Assoc. of State and Territorial Health Officials
- Kate Watson, Kansas Dept. of Health and Environment

7

And especially to YOU!





Healthy people in a healthy community

8

What is Public Health?

- Activities that society undertakes to assure the conditions in which people can be healthy
- This includes…organized community efforts to prevent, identify, and counter threats to the health of the public
- Today's Local Public Health System Assessment focuses on the ***system***!

Healthy people in a healthy community

9

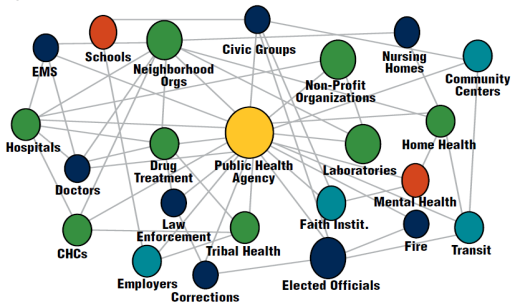
Focus on the "System"

- More than just the public health agency
- "Public Health System"
  - All public, private, and voluntary entities that contribute to public health in a given area
  - A network of entities with differing roles, relationships, and interactions
  - All entities contribute to the health and well-being of the community

Healthy people in a healthy community

10

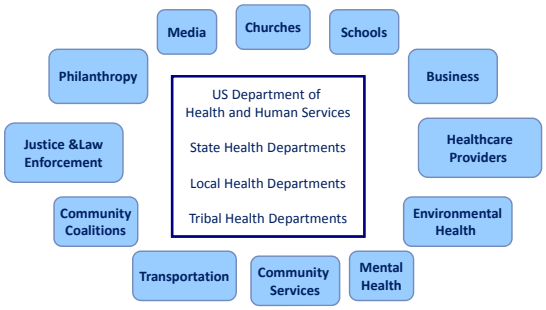
Who is part of the Public Health System?



Healthy people in a healthy community

11

A System of Partnerships That Includes, But Is Not Limited to . . .



Healthy people in a healthy community

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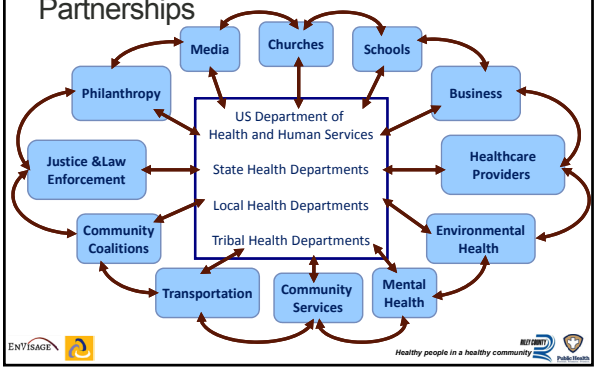
Our Goal Is an Integrated System of Partnerships



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As a partner, what hat do you wear today?

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OVERVIEW OF THE PROCESS

http://www.datacounts.net/lphsa/

National Public Health Performance Standards Program

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A Bit of History

- Key dates
  - 1998—2002: Development of Version 1 instruments
  - 2002: Release of Version 1 instruments
  - 2005—2007: Development of Version 2 instruments
  - 2007: Release of Version 2 instruments
  - 2010—2013: Development of Version 3 instruments
  - 2013: Release of Version 3 instruments

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Assessment Instruments

- State Public Health System Assessment
  - www.astho.org/Programs/Accreditation-and-Performance/National-Public-Health-Performance-Standards/
- Local Public Health System Assessment
  - www.naccho.org/topics/infrastructure/mapp/framework/phase3lphsa.cfm
- Public Health Governing Entity Assessment
  - Email phpsp@cdc.gov

State Instrument

Local Instrument

Local Governance Instrument

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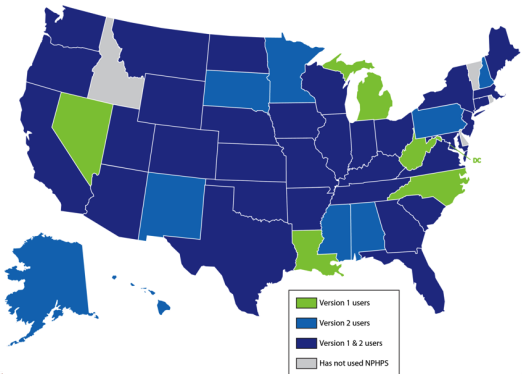
Background

- National Public Health Performance Standards Program (NPHPSP) designed to:
  - Improve practice
  - Improve performance of system
- Based on recognized performance standard
- A partnership effort

NPHPS Use by State Public Health Systems, Local Public Health Systems, and Governing Entities, as of 2013



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The Instrument

- National Public Health Performance Standards
  - Local Assessment Instrument
- Third Version
- National tool used by many communities
- Tool is well-validated
- Have confidence in the tool!

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Four Concepts Applied in NPHPS

- Based on the 10 Essential Public Health Services
- Focus on the overall public health system
- Describe an optimal level of performance
- Support a process of quality improvement

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Local Public Health System Assessment (LPHSA) Process

- Identify community participants/system partners
- Complete assessment system partners using a consensus process.
- Develop and share the report.
  - Dialogue helps identify strengths and weaknesses.
  - Opportunities for improvement identified.
- Results used towards quality and performance improvement of the public health system.
  - Community Health Improvement Planning.
  - Agencies use for strategic planning.

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Why am I here?

- Valued community stakeholder!
- Placed on teams so groups have diversity of roles represented
- Listen, learn, contribute expertise and your perceptions
- "Lack of awareness" of a particular service is also valuable information

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Desired LPHSA Outcomes

- Complete the assessment documenting discussion and scores for each performance measure
- Learn about our local public health system
- Identify partners and build relationships
- Foster interest, awareness, and planned collective action for performance improvement of the local public health system
- Contribute data for decision making and quality improvement!

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Building Consensus on Performance Measure Scoring

- "System" is scored, not a specific organization
- Honor different perceptions, experiences, and knowledge
- Be curious! Share and ask questions
- Discussion informs the collective and consensus-based vote

Image source: http://media.khi.org/img/photos/2012/11/02/michelle-ponce-state-assessment_t600.jpg?42b0fb247f69dabe2ae440581a34634cbc5420f3

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How do we score the assessment?

Optimal Activity (76–100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51–75%)	Greater than 50% but no more than 75% of the activity described within the question is met.
Moderate Activity (26–50%)	Greater than 25% but no more than 50% of the activity described within the question is met.
Minimal Activity (1–25%)	Greater than zero but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

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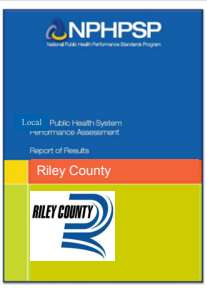
After Assessment: Scores Entered, Assessment Report Created



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How You Can Use Results for Performance Improvement

- The NPHPS performance assessments can help participants understand gaps between their current performance and the optimal level of performance as described by the Standards.
- Results of the assessments should be incorporated into a broader planning process, such as a community health improvement process like Mobilizing for Action through Planning and Partnerships (MAPP), a community health improvement process, or a local board of health strategic planning process.

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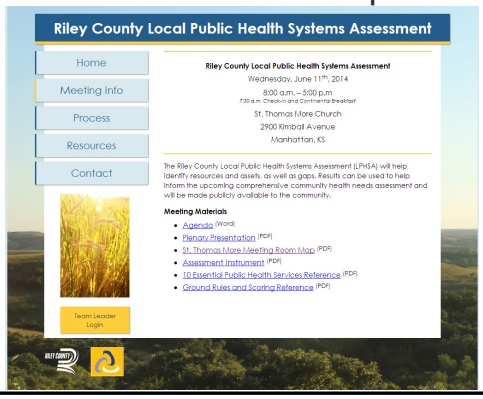
www.datacounts.net/lphsa



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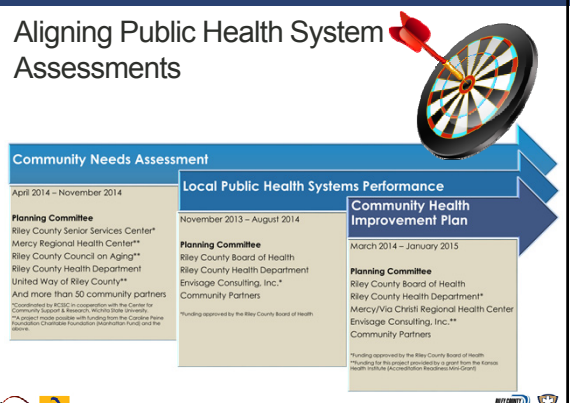
Aligning Public Health System Assessments



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Benefits of Using the NPHPS

- Improve organizational and community communication and collaboration
- Educate participants about public health and the interconnectedness of activities
- Strengthen the diverse network of partners within state and local public health systems
- Identify strengths and weaknesses to address in quality improvement efforts
- Provide a benchmark for public health practice improvements

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ORIENTATION TO 10 ESSENTIAL SERVICES

The Work of the Local Public Health System Assessment

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Key Questions

- What's going on in our county?
- How healthy are we?
- Are we ready to respond to health problems or threats?
- How well do we keep all people informed about health issues?
- How well do we really get people and organizations engaged in health issues?
- How effective are we in planning and setting health policies?

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More Key Questions

- When we enforce health regulations are we up-to-date, fair and effective?
- Are people receiving the medical care they need?
- Do we have a competent public health staff?
- Are we doing any good?
- Are we doing the right things?
- Are we discovering and using new ways to get the job done?

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So what will we be assessing?

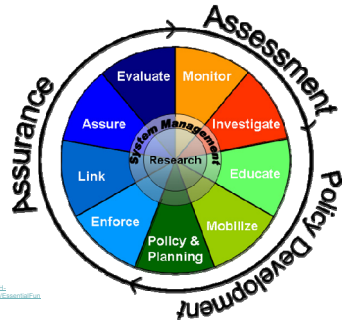

Image Source: http://sphweb.bumc.bu.edu/otlMPH-Modules/EPID/EPID715_DescriptiveEpi/Essential5.gif

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The 10 Essential Public Health Services as a Framework

- Provide a foundation for any public health activity
- Describe public health at both the state and local levels
- Serve as a structure for the NPHPS Instruments which include sections addressing each essential service
- Provide a foundation for accreditation standards and measures

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The Essential Public Health Services

1. **Monitor health status** to identify and solve community health problems
2. **Diagnose and investigate** health problems and health hazards in the community
3. **Inform, educate, and empower** people about health issues
4. **Mobilize** community partnerships to identify and solve health problems
5. **Develop policies and plans** that support individual and community health efforts

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The Essential Public Health Services

6. **Enforce laws and regulations** that protect health and ensure safety
7. **Link people to needed personal health services** and assure the provision of health care when otherwise unavailable
8. **Assure a competent** public and personal health care
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services
10. **Research** for new insights and innovative solutions to health problems

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ESSENTIAL SERVICE BREAKOUT GROUPINGS

Meet Your Team!

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Let's get our Teams ready!

- Packet Materials
- Room Assignments (see map in folder)
- Facilitators, Note Takers, and Time Keepers
- The "rest of the day"

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Meet your Team Facilitators!

Sarah Hartsig	Katy Oestman	Paul Benne	Jane Shirley
			
Team Aggie 1, 2	**Team Bluemont** 3, 7	**Team Goodnow** 4, 5, 6	**Team Kansa** 8, 9, 10

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PROCEED TO TEAM ROOMS FOR ESSENTIAL SERVICES SESSION

Thank you for your participation!

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For More Information

- Have a question about NPHPS assessments or processes? Use the list below to find the best organization to contact.
- State Public Health System Performance Assessment
  - Association of State and Territorial Health Officials
- Local Public Health System Performance Assessment
  - National Association of County and City Health Officials
- Public Health Governing Entity Performance Assessment
  - National Public Health Performance Standards Program
- General Questions
  - National Public Health Performance Standards Program

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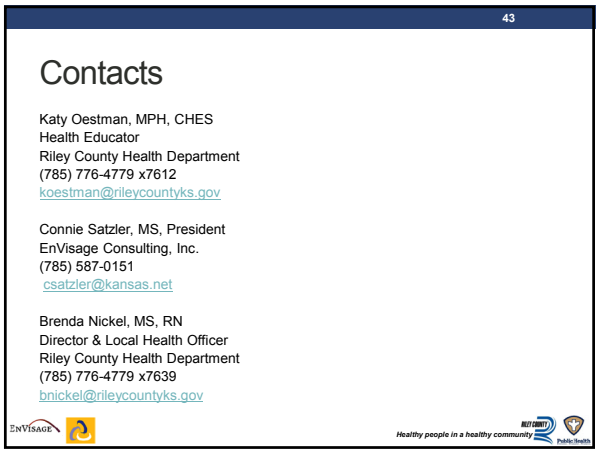
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RILEY COUNTY
Public Health

Appendix C

Sample Local Instrument for One Essential Service

Essential Service 7: Link to Health Services

Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable

Are people in my community receiving the health services they need?

Linking people to needed personal health services and assuring the provision of healthcare when otherwise unavailable (sometimes referred to as outreach or enabling services) encompass the following:

- Ensuring effective entry for socially disadvantaged and other vulnerable persons into a coordinated system of clinical care.
- Providing culturally and linguistically appropriate materials and staff to ensure linkage to services for special population groups.
- Ensuring ongoing care management.
- Ensuring transportation services.
- Orchestrating targeted health education/promotion/disease prevention to vulnerable population groups.

Partners gathered to discuss the performance of the local public health system (LPHS) in linking people to needed personal health services and ensuring the provision of healthcare when otherwise unavailable include:

- ☐ The local health department or other governmental public health agency.
- ☐ The local board of health or other local governing entity.
- ☐ Hospitals.
- ☐ Health service providers.
- ☐ Health service recipients.
- ☐ Managed care organizations.
- ☐ Non-profit organizations/advocacy groups.
- ☐ Nursing homes.
- ☐ Department of Veterans' Affairs.
- ☐ Faith-based organizations.
- ☐ Mental health and substance abuse organizations.
- ☐ Department of transportation and other transportation services.
- ☐ Federally Qualified Health Centers, community health centers, or look-alikes.
- ☐ Law enforcement agencies.
- ☐ Elected officials.
- ☐ Tribal and cultural leaders.
- ☐ United Way.
- ☐ Public assistance programs (e.g., public housing).
- ☐ Lesbian, gay, bisexual, transgender (LGBT) organizations.
- ☐ Social services.
- ☐ Public and private schools.
- ☐ Colleges and universities.
- ☐ Employment assistance organizations.

Model Standard 7.1: Identifying Personal Health Service Needs of Populations

The LPHS identifies the personal health service needs of the community and identifies the barriers to receiving these services, especially among particular groups that may have particular difficulty accessing personal health services. The LPHS has defined roles and responsibilities for the local health department (or other governmental public health entity) and other partners (e.g., hospitals, managed care providers, and other community health agencies) in relation to overcoming these barriers and providing services.

To accomplish this, members of the LPHS work together to:

- Identify groups of people in the community who have trouble accessing or connecting to personal health services.
- Identify all personal health service needs and unmet needs throughout the community.
- Define roles and responsibilities for partners to respond to the unmet needs of the community
- Understand the reasons that people do not get the health services and healthcare they need.

Discussion Questions for Model Standard 7.1	
Awareness (a) What does the LPHS do to understand which personal health services are used by populations who may experience barriers to care?	**Quality and Comprehensiveness** (a) How does the LPHS identify populations that may experience barriers to personal health services? (b) Which populations are taken into account? (c) How has the LPHS identified the personal health service needs of populations in its jurisdiction, including the needs of populations who may experience barriers to care? (d) Which types of personal health services has the LPHS assessed?

Performance Measures for Model Standard 7.1

At what level does the LPHS...

7.1.1 Identify groups of people in the community who have trouble accessing or connecting to personal health services?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

7.1.2 Identify all personal health service needs and unmet needs throughout the community?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

7.1.3 Defines partner roles and responsibilities to respond to the unmet needs of the community?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

7.1.4 Understand the reasons that people do not get the care they need?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

Discussion Notes for Model Standard 7.1			
Strengths	**Weaknesses**	**Short-Term Improvement Opportunities**	**Long-Term Improvement Opportunities**

Model Standard 7.2: Ensuring People Are Linked to Personal Health Services

The LPHS partners work together to meet the diverse needs of all populations. Partners see that persons are signed up for all benefits available to them and know where to refer people with unmet personal health service needs. The LPHS develops working relationships between public health, primary care, oral health, social services, mental health systems, and organizations that are not traditionally part of the personal health service system, such as housing, transportation, and grassroots organizations.

To accomplish this, members of the LPHS work together to:

- Connect (or link) people to organizations that can provide the personal health services they may need.
- Help people access personal health services, in a way that takes into account the unique needs of different populations.
- Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs).
- Coordinate the delivery of personal health and social services so that everyone has access to the care they need.

Discussion Questions for Model Standard 7.2

Involvement

(a) How does the LPHS coordinate the delivery of personal health and social services to optimize access to services for populations who may encounter barriers to care?

Usability

(a) How does the LPHS coordinate the delivery of personal health and social services to optimize access to services for populations who may encounter barriers to care?

Quality and Comprehensiveness

(a) How does the LPHS link populations to needed personal health services?

(b) How does the LPHS ensure the provision of services to populations who may encounter barriers to care?

(c) How does the LPHS provide assistance to vulnerable populations in accessing needed health services?

(d) What types of initiatives does the LPHS have available to enroll eligible individuals in public benefit programs, such as Medicaid and/or other medical or prescription assistance programs?

Performance Measures for Model Standard 7.2

At what level does the LPHS...

7.2.1 Connect or link people to organizations that can provide the personal health services they may need?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

7.2.2 Help people access personal health services in a way that takes into account the unique needs of different populations?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

7.2.3 Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

7.2.4 Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?

No Activity ○ Minimal ○ Moderate ○ Significant ○ Optimal ○

Discussion Notes for Model Standard 7.2			
Strengths	**Weaknesses**	**Short-Term Improvement Opportunities**	**Long-Term Improvement Opportunities**

Essential Service 7
Summary Notes

Use the space below to record notes on details, additional ideas, or synthesis across discussion notes that apply to the Essential Service as a whole. These notes may be helpful and applicable to some or all of the Model Standards in this Essential Service.

Appendix D

NPHPS Local Public Health Systems Assessment Generated Report

National Public Health Performance Standards

Local Assessment Report

Riley County Health Department

6/11/2014

Program Partner Organizations

American Public Health Association
www.apha.org

Association of State and Territorial Health Officials
www.astho.org

Centers for Disease Control and Prevention
www.cdc.gov

National Association of County and City Health Officials
www.naccho.org

National Association of Local Boards of Health
www.nalboh.org

National Network of Public Health Institutes
www.nnphi.org

Public Health Foundation
www.phf.org

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• Priority of Model Standards 12

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Acknowledgements
The National Public Health Performance Standards (NPHPS) was developed collaboratively by the program's national partner organizations. The NPHPS partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and then Public Health Foundation (PHF). We thank the staff of these organizations for their time and expertise in the support of the NPHPS.

Background
The NPHPS is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPS assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites can consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

The NPHPS assessments are intended to help users answer questions such as "What are the components, activities, competencies, and capacities of our public health system?" and "How well are the ten Essential Public Health Services being provided in our system?" The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- State Public Health System Performance Assessment Instrument,
- Local Public Health System Performance Assessment Instrument, and
- Public Health Governing Entity Performance Assessment Instrument.

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

Introduction

The NPHPS Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPS state, local, and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPS assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as Mobilizing for Action through Planning and Partnerships (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPHPS process also drives assessment and improvement activities that may be used to support a Health Department in meeting PHAB standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPS results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health. Figure 1 below shows how the ten Essential Services align with the three Core Functions of Public Health.

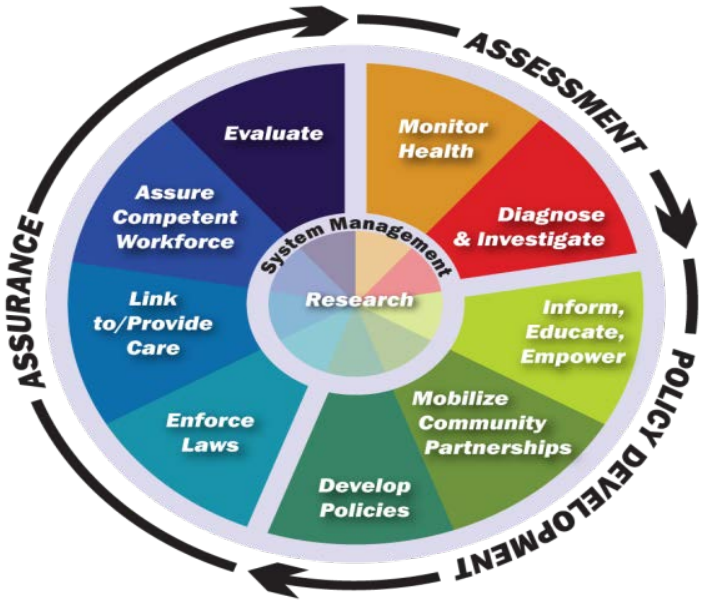


Figure 1. The ten Essential Public Health Services and how they relate to the three Core Functions of Public Health.

Purpose

The primary purpose of the NPHPS Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- Better understand current system functioning and performance;
- Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement;
- Articulate the value that quality improvement initiatives will bring to the public health system;
- Develop an initial work plan with specific quality improvement strategies to achieve goals;
- Begin taking action for achieving performance and quality improvement in one or more targeted areas; and
- Re-assess the progress of improvement efforts at regular intervals.

This report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

About the Report

Calculating the Scores

The NPHPS assessment instruments are constructed using the ten Essential Services as a framework. Within the Local Instrument, each Essential Service includes between 2-4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the Model Standard - which portrays the highest level of performance or "gold standard" - is being met.

Table 1 below characterizes levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates score for each Model Standard, Essential Service, and one overall assessment score.

Table 1. Summary of Assessment Response Options

Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met.
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

Understanding Data Limitations

There are a number of limitations to the NPHPS assessment data due to self-report, wide variations in the breadth and knowledge of participants, the variety of assessment methods used, and differences in interpretation of assessment questions. Data and resultant information should not be interpreted to reflect the capacity or performance of any single agency or organization within the public health system or used for comparisons between jurisdictions or organizations. Use of NPHPS generated data and associated recommendations are limited to guiding an overall public health infrastructure and performance improvement process for the public health system as determined by organizations involved in the assessment.

All performance scores are an average; Model Standard scores are an average of the question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Presentation of results

The NPHPS has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. For ease of use, many figures and tables use short titles to refer to Essential Services, Model Standards, and questions. If you are in doubt of these definitions, please refer to the full text in the assessment instruments.

Sites may have chosen to complete two additional questionnaires, the Priority of Model Standards Questionnaire assesses how performance of each Model Standard compares with the priority rating and the Agency Contribution Questionnaire assesses the local health department's contribution to achieving the Model Standard. Sites that submitted responses for these questionnaires will see the results included as additional components of their report.

Results

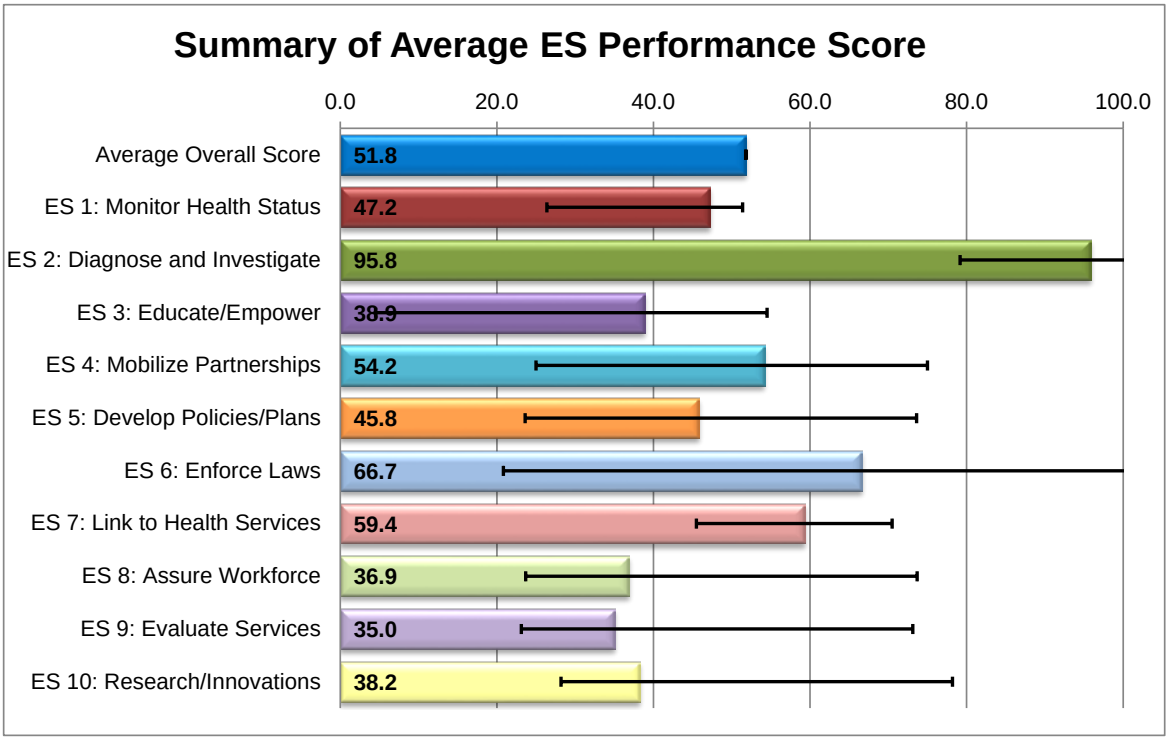
Now that your assessment is completed, one of the most exciting, yet challenging opportunities is to begin to review and analyze the findings. As you recall from your assessment, the data you created now establishes the foundation upon which you may set priorities for performance improvement and identify specific quality improvement (QI) projects to support your priorities.

Based upon the responses you provided during your assessment, an average was calculated for each of the ten Essential Services. Each Essential Service score can be interpreted as the overall degree to which your public health system meets the performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

Figure 2 displays the average score for each Essential Service, along with an overall average assessment score across all ten Essential Services. Take a look at the overall performance scores for each Essential Service. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of reported performance score responses within each Essential Service.

Overall Scores for Each Essential Public Health Service

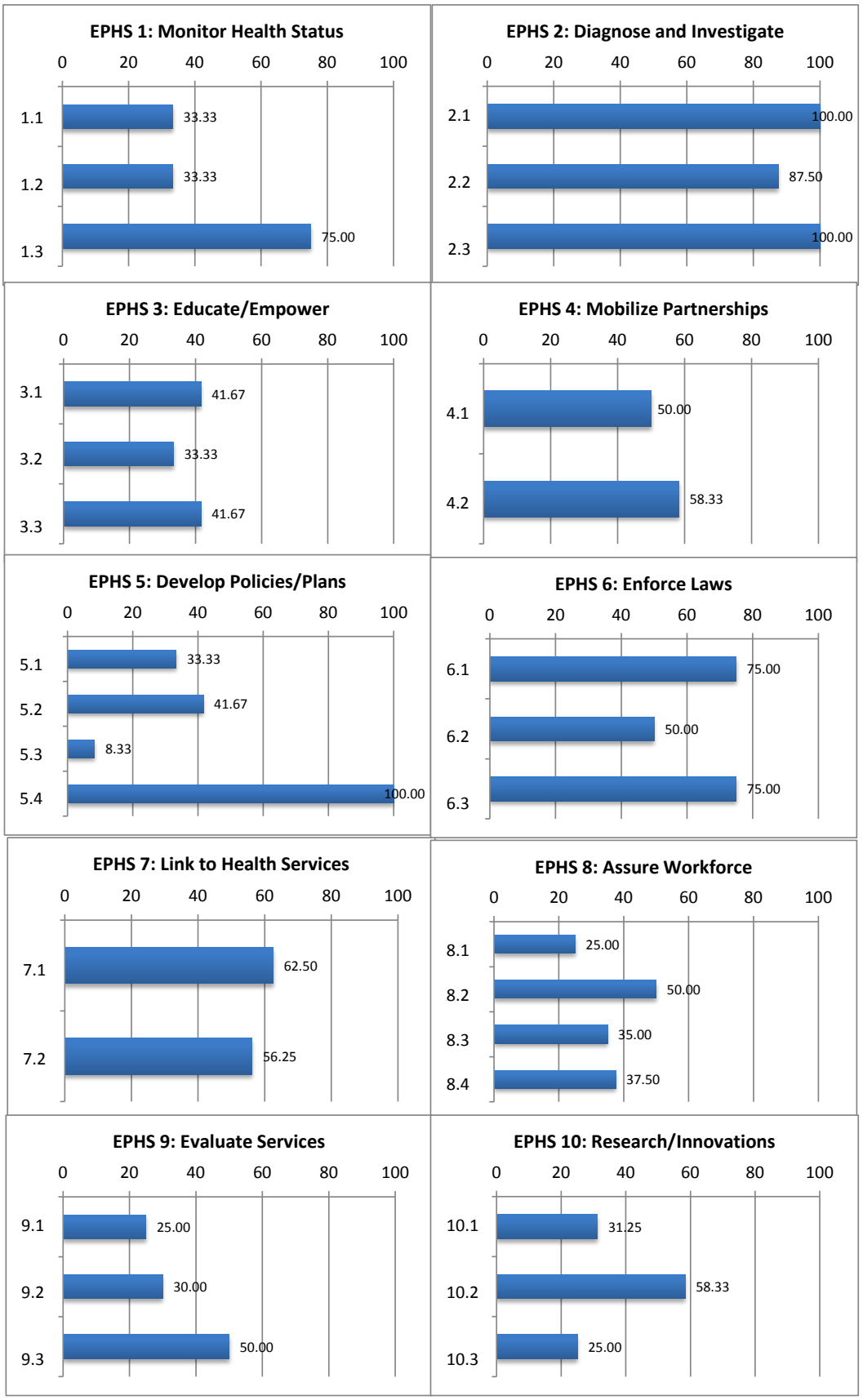
Figure 2. Summary of Average Essential Public Health Service Performance Scores



Performance Scores by Essential Public Health Service for Each Model Standard

Figure 3 and Table 2 on the following pages display the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Figure 3. Performance Scores by Essential Public Health Service for Each Model Standard



In Table 2 below, each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. Note – The priority rating and agency contribution scores will be blank if the Priority of Model Standards Questionnaire and the Agency Contribution Questionnaire are not completed.

Table 2. Overall Performance, Priority, and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Model Standards by Essential Services	Performance Scores	Priority Rating	Agency Contribution Scores
ES 1: Monitor Health Status	**47.2**		**33.3**
1.1 Community Health Assessment	33.3		50.0
1.2 Current Technology	33.3		25.0
1.3 Registries	75.0		25.0
ES 2: Diagnose and Investigate	**95.8**		**58.3**
2.1 Identification/Surveillance	100.0		75.0
2.2 Emergency Response	87.5		50.0
2.3 Laboratories	100.0		50.0
ES 3: Educate/Empower	**38.9**		**41.7**
3.1 Health Education/Promotion	41.7		50.0
3.2 Health Communication	33.3		50.0
3.3 Risk Communication	41.7		25.0
ES 4: Mobilize Partnerships	**54.2**		**37.5**
4.1 Constituency Development	50.0		25.0
4.2 Community Partnerships	58.3		50.0
ES 5: Develop Policies/Plans	**45.8**		**50.0**
5.1 Governmental Presence	33.3		75.0
5.2 Policy Development	41.7		25.0
5.3 CHIP/Strategic Planning	8.3		25.0
5.4 Emergency Plan	100.0		75.0
ES 6: Enforce Laws	**66.7**		**25.0**
6.1 Review Laws	75.0		25.0
6.2 Improve Laws	50.0		25.0
6.3 Enforce Laws	75.0		25.0
ES 7: Link to Health Services	**59.4**		**62.5**
7.1 Personal Health Service Needs	62.5		75.0
7.2 Assure Linkage	56.3		50.0
ES 8: Assure Workforce	**36.9**		**43.8**
8.1 Workforce Assessment	25.0		25.0
8.2 Workforce Standards	50.0		50.0
8.3 Continuing Education	35.0		50.0
8.4 Leadership Development	37.5		50.0
ES 9: Evaluate Services	**35.0**		**33.3**
9.1 Evaluation of Population Health	25.0		25.0
9.2 Evaluation of Personal Health	30.0		25.0
9.3 Evaluation of LPHS	50.0		50.0
ES 10: Research/Innovations	**38.2**		**33.3**
10.1 Foster Innovation	31.3		25.0
10.2 Academic Linkages	58.3		50.0
10.3 Research Capacity	25.0		25.0
Average Overall Score	**51.8**	**NA**	**41.9**
Median Score	**46.5**	**NA**	**39.6**

Performance Relative to Optimal Activity

Figures 4 and 5 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legend below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level.

Figure 4. Percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 2, summarizing the composite performance measures for all 10 Essential Services.

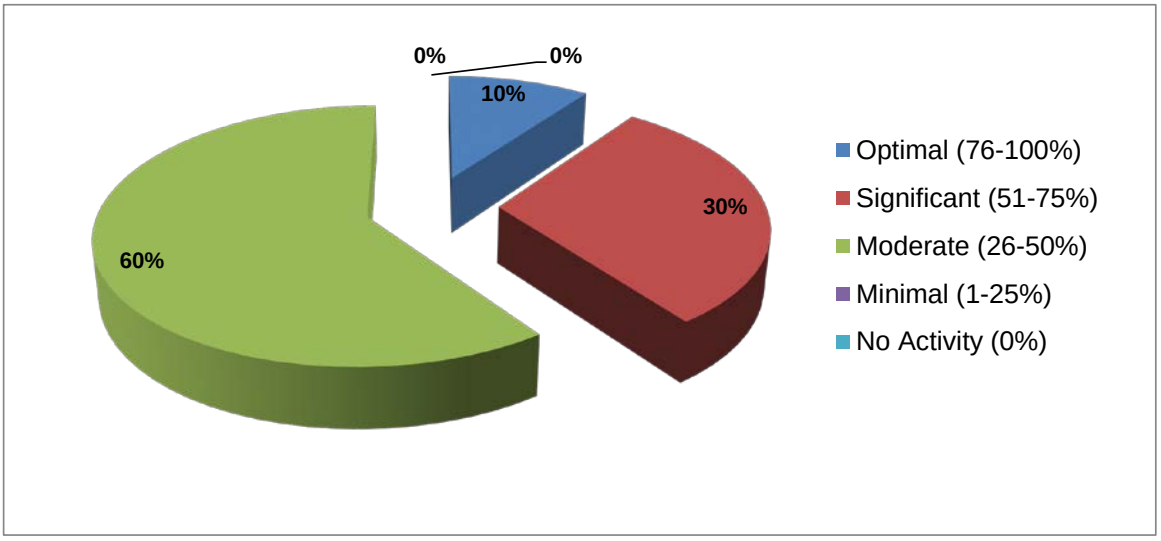
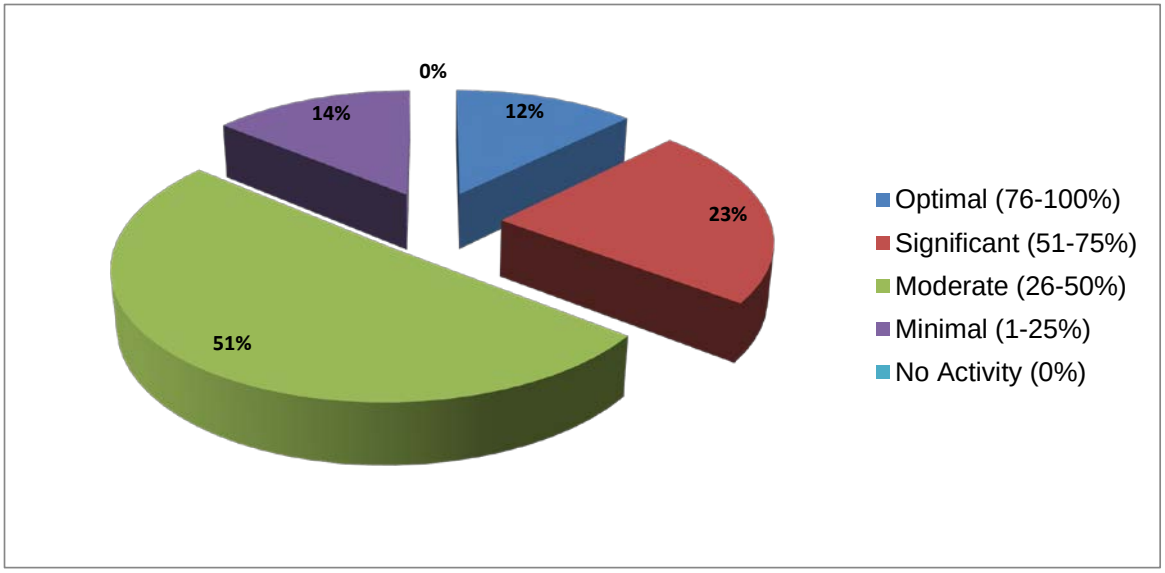


Figure 5. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3, summarizing the composite measures for all 30 Model Standards.



Agency Contribution Questionnaire Section (Optional Survey)

Table 4 and Figures 8 and 9 on the following pages display Essential Service and Model Standard Scores arranged by Local Health Department (LHD) contribution, priority and performance scores. Note – Table 4 and Figures 8 and 9 will be blank if the Agency Contribution Questionnaire is not completed.

Table 4. Summary of Contribution and Performance Scores by Model Standard

Quadrant	Model Standard	LHD Contribution (%)	Performance Score (%)
Quadrant A	9.3 Evaluation of LPHS	50.0	50.0
Quadrant A	8.4 Leadership Development	50.0	37.5
Quadrant A	8.3 Continuing Education	50.0	35.0
Quadrant A	8.2 Workforce Standards	50.0	50.0
Quadrant A	5.1 Governmental Presence	75.0	33.3
Quadrant A	3.2 Health Communication	50.0	33.3
Quadrant A	3.1 Health Education/Promotion	50.0	41.7
Quadrant A	1.1 Community Health Assessment	50.0	33.3
Quadrant B	10.2 Academic Linkages	50.0	58.3
Quadrant B	7.2 Assure Linkage	50.0	56.3
Quadrant B	7.1 Personal Health Services Needs	75.0	62.5
Quadrant B	5.4 Emergency Plan	75.0	100.0
Quadrant B	4.2 Community Partnerships	50.0	58.3
Quadrant B	2.3 Laboratories	50.0	100.0
Quadrant B	2.2 Emergency Response	50.0	87.5
Quadrant B	2.1 Identification/Surveillance	75.0	100.0
Quadrant C	6.3 Enforce Laws	25.0	75.0
Quadrant C	6.1 Review Laws	25.0	75.0
Quadrant C	1.3 Registries	25.0	75.0
Quadrant D	10.3 Research Capacity	25.0	25.0
Quadrant D	10.1 Foster Innovation	25.0	31.3
Quadrant D	9.2 Evaluation of Personal Health	25.0	30.0
Quadrant D	9.1 Evaluation of Population Health	25.0	25.0
Quadrant D	8.1 Workforce Assessment	25.0	25.0
Quadrant D	6.2 Improve Laws	25.0	50.0
Quadrant D	5.3 CHIP/Strategic Planning	25.0	8.3
Quadrant D	5.2 Policy Development	25.0	41.7
Quadrant D	4.1 Constituency Development	25.0	50.0
Quadrant D	3.3 Risk Communication	25.0	41.7
Quadrant D	1.2 Current Technology	25.0	33.3

Figure 8. Summary of Essential Public Health Service Performance Scores and Contribution Ratings

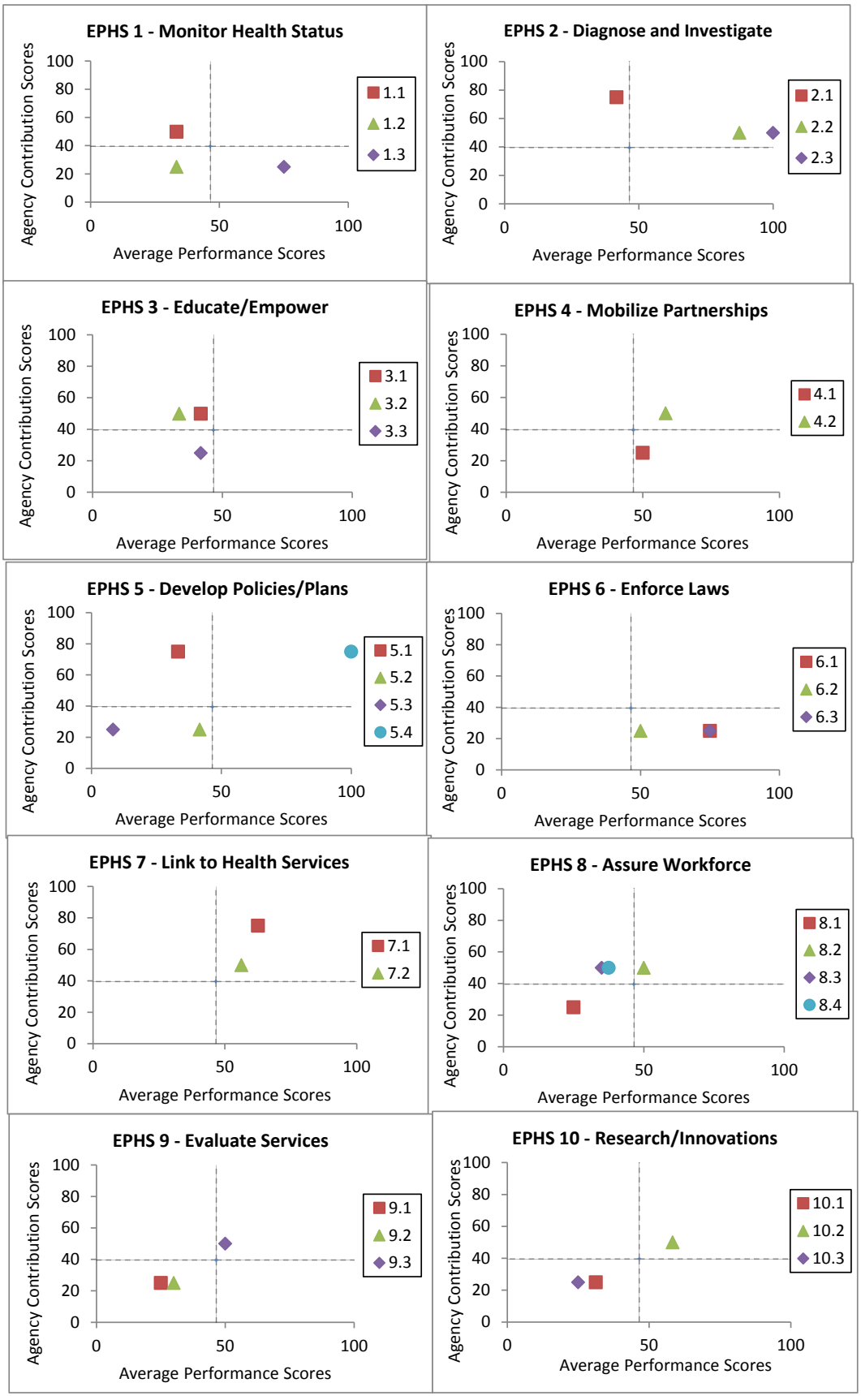
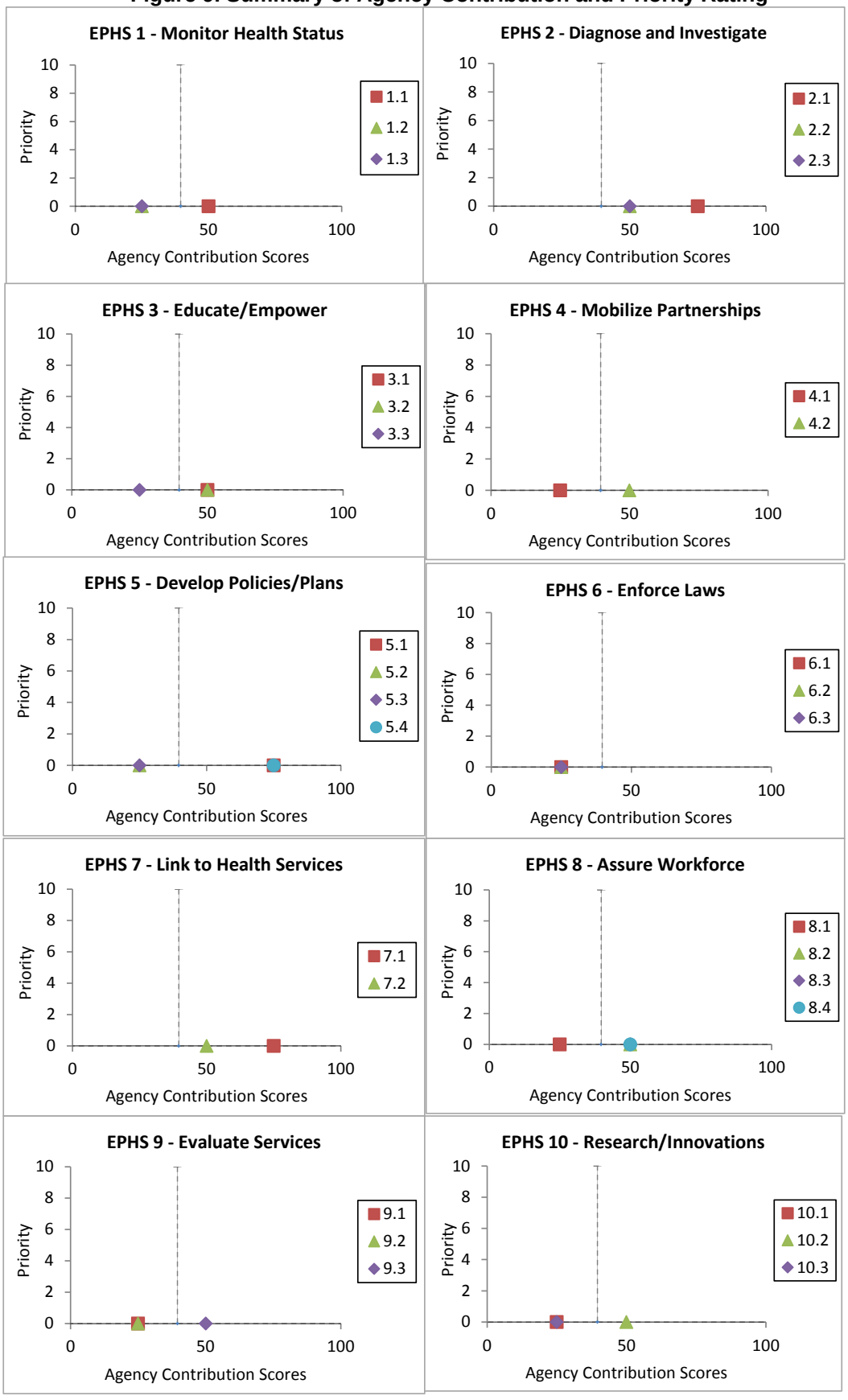


Figure 9. Summary of Agency Contribution and Priority Rating



Analysis and Discussion Questions

Having a standard way in which to analyze the data in this report is important. This process does not have to be difficult; however, drawing some initial conclusions from your data will prove invaluable as you move forward with your improvement efforts. It is crucial that participants fully discuss the performance assessment results. The bar graphs, charts, and summary information in the Results section of this report should be helpful in identifying high and low performing areas. Please refer to Appendix H of the Local Assessment Implementation Guide. This referenced set of discussion questions will to help guide you as you analyze the data found in the previous sections of this report.

Using the results in this report will help you to generate priorities for improvement, as well as possible improvement projects. Your data analysis should be an interactive process, enabling everyone to participate. Do not be overwhelmed by the potential of many possibilities for QI projects – the point is not that you have to address them all now. Consider this step as identifying possible opportunities to enhance your system performance. Keep in mind both your quantitative data (Appendix A) and the qualitative data that you collected during the assessment (Appendix B).

Next Steps

Congratulations on your participation in the local assessment process. A primary goal of the NPHPS is that data is used proactively to monitor, assess, and improve the quality of essential public health services. This report is an initial step to identifying immediate actions and activities to improve local initiatives. The results in this report may also be used to identify longer-term priorities for improvement, as well as possible improvement projects.

As noted in the Introduction of this report, NPHPS data may be used to inform a variety of organization and/or systems planning and improvement processes. Plan to use both quantitative data (Appendix A) and qualitative data (Appendix B) from the assessment to identify improvement opportunities. While there may be many potential quality improvement projects, do not be overwhelmed – the point is not that you have to address them all now. Rather, consider this step as a way to identify possible opportunities to enhance your system performance and plan to use the guidance provided in this section, along with the resources offered in Appendix C, to develop specific goals for improvement within your public health system and move from assessment and analysis toward action.

Note: Communities implementing Mobilizing for Action through Planning and Partnerships (MAPP) may refer to the MAPP guidance for considering NPHPS data along with other assessment data in the Identifying Strategic Issues phase of MAPP.

Action Planning

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.

Consider the following points as you build an Action Plan to address the priorities you have identified
• Each public health partner should be considered when approaching quality improvement for your system
• The success of your improvement activities are dependent upon the active participation and contribution of each and every member of the system
• An integral part of performance improvement is working consistently to have long-term effects
• A multi-disciplinary approach that employs measurement and analysis is key to accomplishing and sustaining improvements

You may find that using the simple acronym, 'FOCUS' is a way to help you to move from assessment and analysis to action.

F **Find** an opportunity for improvement using your results.

O **Organize** a team of public health system partners to work on the improvement. Someone in the group should be identified as the team leader. Team members should represent the appropriate organizations that can make an impact.

C **Consider** the current process, where simple improvements can be made and who should make the improvements.

U **Understand** the problem further if necessary, how and why it is occurring, and the factors that contribute to it. Once you have identified priorities, finding solutions entails delving into possible reasons, or "root causes," of the weakness or problem. Only when participants determine why performance problems (or successes!) have occurred will they be able to identify workable solutions that improve future performance. Most performance issues may be traced to well-defined system causes, such as policies, leadership, funding, incentives, information, personnel or coordination. Many QI tools are applicable. You may consider using a variety of basic QI tools such as brainstorming, 5-whys, prioritization, or cause and effect diagrams to better understand the problem (refer to Appendix C for resources).

S **Select** the improvement strategies to be made. Consider using a table or chart to summarize your Action Plan. Many resources are available to assist you in putting your plan on paper, but in general you'll want to include the priority selected, the goal, the improvement activities to be conducted, who will carry them out, and the timeline for completing the improvement activities. When complete, your Action Plan should contain documentation on the indicators to be used, baseline performance levels and targets to be achieved, responsibilities for carrying out improvement activities and the collection and analysis of data to monitor progress. (Additional resources may be found in Appendix C.)

Monitoring and Evaluation: Keys to Success

Monitoring your action plan is a highly proactive and continuous process that is far more than simply taking an occasional "snap-shot" that produces additional data. Evaluation, in contrast to monitoring, provides ongoing structured information that focuses on why results are or are not being met, what unintended consequences may be, or on issues of efficiency, effectiveness, and/or sustainability.

After your Action Plan is implemented, monitoring and evaluation continues to determine whether quality improvement occurred and whether the activities were effective. If the Essential Service performance does not improve within the expected time, additional evaluation must be conducted (an additional QI cycle) to determine why and how you can update your Action Plan to be more effective. The Action Plan can be adjusted as you continue to monitor and evaluate your efforts.

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems			
1.1	**Model Standard: Population-Based Community Health Assessment (CHA)** ***At what level does the local public health system:***		
1.1.1	Conduct regular community health assessments?	50	Moderate Activity (26-50%)
1.1.2	Continuously update the community health assessment with current information?	25	Minimal Activity (1-25%)
1.1.3	Promote the use of the community health assessment among community members and partners?	25	Minimal Activity (1-25%)
1.2	**Model Standard: Current Technology to Manage and Communicate Population Health Data** ***At what level does the local public health system:***		
1.2.1	Use the best available technology and methods to display data on the public's health?	50	Moderate Activity (26-50%)
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	25	Minimal Activity (1-25%)
1.2.3	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?	25	Minimal Activity (1-25%)
1.3	**Model Standard: Maintenance of Population Health Registries** ***At what level does the local public health system:***		
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	75	Significant Activity (51-75%)
1.3.2	Use information from population health registries in community health assessments or other analyses?	75	Significant Activity (51-75%)
ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards			
2.1	**Model Standard: Identification and Surveillance of Health Threats** ***At what level does the local public health system:***		
2.1.1	Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats?	100	Optimal Activity (76-100%)
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?	100	Optimal Activity (76-100%)
2.1.3	Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?	100	Optimal Activity (76-100%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
2.2	**Model Standard: Investigation and Response to Public Health Threats and Emergencies** ***At what level does the local public health system:***		
2.2.1	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	75	Significant Activity (51-75%)
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	75	Significant Activity (51-75%)
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	100	Optimal Activity (76-100%)
2.2.4	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	100	Optimal Activity (76-100%)
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	75	Significant Activity (51-75%)
2.2.6	Evaluate incidents for effectiveness and opportunities for improvement?	100	Optimal Activity (76-100%)
2.3	**Model Standard: Laboratory Support for Investigation of Health Threats** ***At what level does the local public health system:***		
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	100	Optimal Activity (76-100%)
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	100	Optimal Activity (76-100%)
2.3.3	Use only licensed or credentialed laboratories?	100	Optimal Activity (76-100%)
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	100	Optimal Activity (76-100%)
ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues			
3.1	**Model Standard: Health Education and Promotion** ***At what level does the local public health system:***		
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	50	Moderate Activity (26-50%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	50	Moderate Activity (26-50%)
3.1.3	Engage the community throughout the process of setting priorities, developing plans and implementing health education and health promotion activities?	25	Minimal Activity (1-25%)
3.2	**Model Standard: Health Communication** ***At what level does the local public health system:***		
3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	25	Minimal Activity (1-25%)
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	50	Moderate Activity (26-50%)
3.2.3	Identify and train spokespersons on public health issues?	25	Minimal Activity (1-25%)
3.3	**Model Standard: Risk Communication** ***At what level does the local public health system:***		
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	50	Moderate Activity (26-50%)
3.3.2	Make sure resources are available for a rapid emergency communication response?	50	Moderate Activity (26-50%)
3.3.3	Provide risk communication training for employees and volunteers?	25	Minimal Activity (1-25%)
ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems			
4.1	**Model Standard: Constituency Development** ***At what level does the local public health system:***		
4.1.1	Maintain a complete and current directory of community organizations?	50	Moderate Activity (26-50%)
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	25	Minimal Activity (1-25%)
4.1.3	Encourage constituents to participate in activities to improve community health?	75	Significant Activity (51-75%)
4.1.4	Create forums for communication of public health issues?	50	Moderate Activity (26-50%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
4.2	**Model Standard: Community Partnerships** ***At what level does the local public health system:***		
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	75	Significant Activity (51-75%)
4.2.2	Establish a broad-based community health improvement committee?	50	Moderate Activity (26-50%)
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	50	Moderate Activity (26-50%)
ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts			
5.1	**Model Standard: Governmental Presence at the Local Level** ***At what level does the local public health system:***		
5.1.1	Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided?	50	Moderate Activity (26-50%)
5.1.2	See that the local health department is accredited through the national voluntary accreditation program?	0	No Activity (0%)
5.1.3	Assure that the local health department has enough resources to do its part in providing essential public health services?	50	Moderate Activity (26-50%)
5.2	**Model Standard: Public Health Policy Development** ***At what level does the local public health system:***		
5.2.1	Contribute to public health policies by engaging in activities that inform the policy development process?	50	Moderate Activity (26-50%)
5.2.2	Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?	50	Moderate Activity (26-50%)
5.2.3	Review existing policies at least every three to five years?	25	Minimal Activity (1-25%)
5.3	**Model Standard: Community Health Improvement Process and Strategic Planning** ***At what level does the local public health system:***		
5.3.1	Establish a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members?	25	Minimal Activity (1-25%)
5.3.2	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?	0	No Activity (0%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan?	0	No Activity (0%)
5.4	**Model Standard: Plan for Public Health Emergencies** ***At what level does the local public health system:***		
5.4.1	Support a workgroup to develop and maintain preparedness and response plans?	100	Optimal Activity (76-100%)
5.4.2	Develop a plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?	100	Optimal Activity (76-100%)
5.4.3	Test the plan through regular drills and revise the plan as needed, at least every two years?	100	Optimal Activity (76-100%)
ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety			
6.1	**Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances** ***At what level does the local public health system:***		
6.1.1	Identify public health issues that can be addressed through laws, regulations, or ordinances?	75	Significant Activity (51-75%)
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?	75	Significant Activity (51-75%)
6.1.3	Review existing public health laws, regulations, and ordinances at least once every five years?	50	Moderate Activity (26-50%)
6.1.4	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	100	Optimal Activity (76-100%)
6.2	**Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances** ***At what level does the local public health system:***		
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	50	Moderate Activity (26-50%)
6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?	50	Moderate Activity (26-50%)
6.2.3	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	50	Moderate Activity (26-50%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
6.3	**Model Standard: Enforcement of Laws, Regulations, and Ordinances** ***At what level does the local public health system:***		
6.3.1	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	75	Significant Activity (51-75%)
6.3.2	Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	75	Significant Activity (51-75%)
6.3.3	Assure that all enforcement activities related to public health codes are done within the law?	100	Optimal Activity (76-100%)
6.3.4	Educate individuals and organizations about relevant laws, regulations, and ordinances?	50	Moderate Activity (26-50%)
6.3.5	Evaluate how well local organizations comply with public health laws?	75	Significant Activity (51-75%)
ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable			
7.1	**Model Standard: Identification of Personal Health Service Needs of Populations** ***At what level does the local public health system:***		
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	75	Significant Activity (51-75%)
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	75	Significant Activity (51-75%)
7.1.3	Defines partner roles and responsibilities to respond to the unmet needs of the community?	50	Moderate Activity (26-50%)
7.1.4	Understand the reasons that people do not get the care they need?	50	Moderate Activity (26-50%)
7.2	**Model Standard: Assuring the Linkage of People to Personal Health Services** ***At what level does the local public health system:***		
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	75	Significant Activity (51-75%)
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	50	Moderate Activity (26-50%)
7.2.3	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	75	Significant Activity (51-75%)
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	25	Minimal Activity (1-25%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce			
8.1	**Model Standard: Workforce Assessment, Planning, and Development** ***At what level does the local public health system:***		
8.1.1	Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?	25	Minimal Activity (1-25%)
8.1.2	Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?	25	Minimal Activity (1-25%)
8.1.3	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?	25	Minimal Activity (1-25%)
8.2	**Model Standard: Public Health Workforce Standards** ***At what level does the local public health system:***		
8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?	75	Significant Activity (51-75%)
8.2.2	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?	50	Moderate Activity (26-50%)
8.2.3	Base the hiring and performance review of members of the public health workforce in public health competencies?	25	Minimal Activity (1-25%)
8.3	**Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring** ***At what level does the local public health system:***		
8.3.1	Identify education and training needs and encourage the workforce to participate in available education and training?	50	Moderate Activity (26-50%)
8.3.2	Provide ways for workers to develop core skills related to essential public health services?	25	Minimal Activity (1-25%)
8.3.3	Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?	50	Moderate Activity (26-50%)
8.3.4	Create and support collaborations between organizations within the public health system for training and education?	25	Minimal Activity (1-25%)
8.3.5	Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?	25	Minimal Activity (1-25%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
8.4	**Model Standard: Public Health Leadership Development** ***At what level does the local public health system:***		
8.4.1	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	50	Moderate Activity (26-50%)
8.4.2	Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?	25	Minimal Activity (1-25%)
8.4.3	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	50	Moderate Activity (26-50%)
8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	25	Minimal Activity (1-25%)
ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services			
9.1	**Model Standard: Evaluation of Population-Based Health Services** ***At what level does the local public health system:***		
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?	25	Minimal Activity (1-25%)
9.1.2	Assess whether community members, including those with a higher risk of having a health problem, are satisfied with the approaches to preventing disease, illness, and injury?	25	Minimal Activity (1-25%)
9.1.3	Identify gaps in the provision of population-based health services?	25	Minimal Activity (1-25%)
9.1.4	Use evaluation findings to improve plans and services?	25	Minimal Activity (1-25%)
9.2	**Model Standard: Evaluation of Personal Health Services** ***At what level does the local public health system:***		
9.2.1	Evaluate the accessibility, quality, and effectiveness of personal health services?	25	Minimal Activity (1-25%)
9.2.2	Compare the quality of personal health services to established guidelines?	25	Minimal Activity (1-25%)
9.2.3	Measure satisfaction with personal health services?	25	Minimal Activity (1-25%)
9.2.4	Use technology, like the internet or electronic health records, to improve quality of care?	25	Minimal Activity (1-25%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
9.2.5	Use evaluation findings to improve services and program delivery?	50	Moderate Activity (26-50%)
9.3	**Model Standard: Evaluation of the Local Public Health System** ***At what level does the local public health system:***		
9.3.1	Identify all public, private, and voluntary organizations that provide essential public health services?	75	Significant Activity (51-75%)
9.3.2	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to essential public health services?	50	Moderate Activity (26-50%)
9.3.3	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	25	Minimal Activity (1-25%)
9.3.4	Use results from the evaluation process to improve the LPHS?	50	Moderate Activity (26-50%)
ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems			
10.1	**Model Standard: Fostering Innovation** ***At what level does the local public health system:***		
10.1.1	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?	25	Minimal Activity (1-25%)
10.1.2	Suggest ideas about what currently needs to be studied in public health to organizations that do research?	25	Minimal Activity (1-25%)
10.1.3	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	50	Moderate Activity (26-50%)
10.1.4	Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?	25	Minimal Activity (1-25%)
10.2	**Model Standard: Linkage with Institutions of Higher Learning and/or Research** ***At what level does the local public health system:***		
10.2.1	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?	75	Significant Activity (51-75%)
10.2.2	Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research?	50	Moderate Activity (26-50%)

Performance Scores

		Numerical Score for Purposes of NPHPS Standardized Report	Voting Score Label
10.2.3	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?	50	Moderate Activity (26-50%)
10.3	**Model Standard: Capacity to Initiate or Participate in Research** ***At what level does the local public health system:***		
10.3.1	Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?	25	Minimal Activity (1-25%)
10.3.2	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?	25	Minimal Activity (1-25%)
10.3.3	Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc?	25	Minimal Activity (1-25%)
10.3.4	Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?	25	Minimal Activity (1-25%)

APPENDIX B: Qualitative Assessment Data

Summary Notes

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
1.1	Model Standard: Population-Based Community Health Assessment (CHA)		
• Brenda communicates with state • Hospital has done a version about 3 years ago • Recent version was broader	• Past one focused on vulnerable pop • CHA not completed or updated regularly • Scoring difficult • Late in academic year –students not able to participate • Manhattan focused - less rural • Local awareness lacking • Big Lakes had no knowledge of assessment • Include more counties: more of Wildcat Region • Geary County * importance of Ft. Riley • North area of Riley underserved due to distance and transportation • Lack of updates? How often? Results shared? Who takes the lead?	• Delegate a lead organization • Engage for feedback - providers and agencies • Add Geary, Ft. Riley, Pottawatomie • Utilize the data • Develop communication strategy to engage agencies • Community health advisory council; Advertise, define, let people know how to participate, and add new members	• Systematic assessments • Local one year • Area next • Alternate models: geographic • Increase participation in CHA and awareness of Healthy People 2020 objectives

1.2	Model Standard: Current Technology to Manage and Communicate Population Health Data		
• Communicable Diseases • Reported – optimal system in place • Collect a lot of data • Mercy has system in place for infectious diseases • Everybody does the data collection • Via Christi is developing a linked system: phases, required federally	• We are not clear on best way to put it out and make it understandable • Lack of compatible platforms for data sharing • Methods, mechanisms • Rural area data • One size fits all websites • Sub county – more specific data? • Many in our population do not use computer • Mental Health data • Include Private provider data • Lack of computer data system	• Link data w/health department website • Better ID the data stewards • Stakeholders share what they have and where it is. • Distribute data to community in an informative and understandable way	• Develop central database for community health data • Learn from Massachusetts

1.3	Model Standard: Maintenance of Population Health Registries		
• Exists KDHE website – infinite • Prevention $ saved vs. treatment $ • Program evaluations contribute to planning and delivering strategic plan • There is a PHAC	• Not sure there is a mental health registry • No local registry to track diseases. There is one on KDHE site. • Lack ability to provide the information to policy makers • Who's responsible for collaborating this? • People aren't aware of the Public Health Advisory Council	• Agencies to work together to utilize the registries • Utilize the Health Ranking • Ability to provide the information to policy makers by using our collective voice • Create/engage people in the LPHS advisory health council • Incentives for coordinated care • Link data bases: physical / social services	• Engaged in shift to population health management – in acute care • Physicians need to be able to make home visits to diagnose and treat disease. • Hospital and Flinthills clinic could share information and compare data regarding ER visits, prenatal, etc. • Focus on prevention

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
2.1	Model Standard: Identification and Surveillance of Health Threats		
• IRIS • Identified potential threats • Lots of systems in place • Connections to local, state and federal • Hard-wired connections • Practice and drills • Share well / collaborate • EMS • Prepared even in the event of remote threats	• Communication about reporting systems – IRIS • Chemical threats • Prevalence of meth labs • "No-intrusion" policy	• Increase subscribers to IRIS • Apply lessons learned in strong emergency management to Essential Service 1 - need more coordination among agencies	• Develop disaster preparations for potential threats from NBAF • Prepare for threats even when they are not remote or probable • Local preparedness for zoonotic disease threats.

2.2	Model Standard: Investigation and Response to Public Health Threats and Emergencies		
• All Hazards plan updated yearly • Mitigation plan • Ft. Riley / Hospital drill together • 1 full scale exercise each year • 3 table top exercises each year •Airport exercise • Continuity of Operations	• Off-shift (evening & nights) training opportunities with police, etc. • Refine plans for tetanus shots prior to sandbagging • Work on step-by-step plans • Need to incorporate health department in Continuity of Operations	• State system data base capability • Meeting D: insure all entities are present when policies are being changed • Drill with intent to be proactive and meet unknown challenges • To be diligent in being proactive vs. reactive • Contact Steve Galliser with KSU • Fusion Center/Law Enforcement (Internal threat assessment)	• Training with law enforcement • Need to incorporate Health Department • Fort Riley is closeby, we could collaborate to benefit from their expertise • Highway Patrol – radiological expertise • Volunteers need to have a good seamless system to share / utilize their expertise and training

2.3	Model Standard: Laboratory Support for Investigation of Health Threats		
• Physicians are provided notebooks for reportable diseases • Protocols for screenings • Have 24 hr. day labs in community • Training	• Physicians need to utilize info • Lack of awareness of centralized authority to provide coordination of services and responsibilities - need a strict hierarchy	• Work well with physicians • Looking for other resources	• Grow ESF8 group – develop coordination of services

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
3.1	Model Standard: Health Education and Promotion		
• Assessment • Everybody Counts • Community spirit • Volunteer organizations • Environmental and system • Afterschool programs	• Manhattan vs. outer counties • Getting information • Outreach • No meals on wheels for out of town people	• Resources to pull together a guide that is the same (one guide for the community) • Structured communication and meetings • Referral policy or process (create one)	• International students • Improving the public transportation network • Strengthn client to client and agency to agency referral • Meals on Wheels for the Northern part of the county

3.2	Model Standard: Health Communication		
• Relationships • Focus groups • Aware for improvement • Celebrate but still much to be done • Have community commitment to health: Judge free zone, support community health needs, great community responsibility • Designated coordinator • Interconnected community team Cash emergency fund for HIV+ • Home Health local newsletter and support groups • USD 383 has Communications Officer (PIO) • Underage drinking campaign	• Lack of training • Lack of communication • Where it needs to be, target audience • Take initiative • More efforts to comprehend info • Better info structure • All information from higher level • Lack of mental health service providers (no more providers in-patient at Mercy)	• Training opportunities for PIOs • Wide-spread use of Mac Link (HMIS) • Utilizing public radio for health messages, perhaps • Measure reach of current media outlets • HIV/AIDS education starting younger, 9th grade	• Mental Health Improvement opportunities – services and providers • Figure out how to get health information to students.

3.3	Model Standard: Risk Communication		
• Current system is good • **Strong community desire to help • Quick to respond/mobilize • First step to get better • IRIS • United Way has a great statewide plan, a model practice	• Publicity • Lack of coordination between agencies • Practice • Learn from history	• Get more folks to the LEPC meetings • Coordinate plans between agencies, most seem to have their own plan already. • Have more people sign up for IRIS	• Strengthen communication between NBAF and community response

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
4.1	Model Standard: Constituency Development		
• Well educated professional populations	• Getting the word out • Transient population • Involving Northern Riley County	• Needing communications with schools and churches to outreach to entire families • Get businesses involved to encourage healthy behaviors • Include people from Northern Riley County • Education on healthy eating/habits for childcare providers so they can help children to make healthy decisions	• Needing central data base • Communication directory

4.2	Model Standard: Community Partnerships		
• Good partnerships with preparedness • Good community partnerships • Education of public health issues	• Outreach • Not a lot of constituents on boards • Mental Health representatives on board • Not a lot of community knowledge of health adv council • Not broad based	• Increase LPHS awareness of Public Health Advisory Council • Work towards an output goal during LPHS meetings	• More focus on mental health/substance abuse programs/patients • Increase LPHS outreach to high schools: STD prevention

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
5.1	Model Standard: Governmental Presence at the Local Level		
• Enforce policy • Local health department is working towards nation public department accreditation • Screening • Advisory Council • Codes	• Public involvement • The LPHS doesn't frequently ensure the health department has enough resources to contribute to provding 10EPHS • Stopped doing the primary care clinic • Rural area with no building/zoning codes	• Use the PHAC to ensure health department has enough resources. Increase awareness and participation in the PHAC.	• Continue having meetings (possibly annually) like this LPHSA

5.2	Model Standard: Public Health Policy Development		
• Sharing of data • LPHS works together to provide better facilities, improve walkability and bike friendliness, safe water • LPHS alerts policymakers/general public of public health impacts through school newsletters, press conferences, annual reports, public meetings/hearings, county commission meetings	• Measuring impact of programs • Absorbing cuts and the impact towards community	• Improve conduct reviews of public health policies • RCHD/LPHS can do a better job in coming to city or county for their needs and how to improve	• Develop ways to measure outcomes and impact of programs (Ex. Swimming pool, trails, dog park, etc.)

5.3	Model Standard: Community Health Improvement Process and Strategic Planning		
• Collaboration in CHA and improvement planning processes • Health Homes program (new implantation)	• Unaware what CHA and planning tools are used by the LPHS • Awareness of Healthy Kansans 2020 • Process involvement • Lack of financial support	• To identify organizations involved in the CHA • Should be city county meeting and address plans to revisit CHA and improvement planning processes • Figure out duplication of services	• Accountability for individuals and organziations implementing identified strategies

5.4	Model Standard: Plan for Public Health Emergencies		
• Emergency Preparedness • An After Action Review is created after any exercises/table top exercises are done. • All programs have some participation	• Social organizations and nonprofits are not included in the planning of emergencies • Need people involved in planning that are responsible for the ripple effect after the disaster	• Include social organizations and nonprofits in emergency planning	• More planning for the ripple effects after a disaster

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
6.1	Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances		
• We do have ordinances • Government entities in the LPHS have access to legal counsel to assist with laws, regulations, and ordinances	• There is more regulation/enforcement in urban areas than out in the rural areas • Limitations with enforcements • A lot of regulations are reactive events	• All regulations/ordinances etc. would be Reviewed 3-5 years	

6.2	Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances		
• LPHS organizations participate in developing/modifying laws, regulations, ordinances to ensure public health issues are considered	• Being aware and staying informed of the legislation	• RCHD needs to be at the table at NBAF • Counties link up with surrounding counties or other jelly beans on issues	• LPHS needs to continually be involved in the NBAF conversations to be aware of potential public health issues

6.3	Model Standard: Enforcement of Laws, Regulations, and Ordinances		
• Health department enforces laws, regulations, and ordinances regarding sanitation and child care	• Private citizens not always represented well by legal counsel – no legal right for a civil matter • Limited funding/resource • High Caseload • Dissemination of information on public health laws, regulations, and ordinances integrated with other public health activities are done for some organizations but not all • No legal rights to enforce rental units/ health situations (Ex. Bats)	• Integrate communication of public health laws, regulations, and ordinances with other public health communications (education, disease control, health assessments, etc.)	

ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
7.1	Model Standard: Identification of Personal Health Service Needs of Populations		
• Services are available • Military spends lots of money and time on PTSD	• Insurance coverage "hole." • Transportation (to get to services) • Lack of policies for some needs identified • Long wait for services • Sometimes excessively stringent eligibility guidelines	• Communication and ensuring that clients get in to see providers (don't just refer to a provider but also follow up) • Improve referral and follow up with clients to ensure that they are seen • Better marketing of services and providers	• Until public funds are reinvested in our communities' mental and physical health, public tragedies are going to take place. Nonprofits and churches cannot care for the public alone. • Fix insurance "hole" • Transportation to physically link folks to service providers • More practitioners (in various fields) • More local mental health resources

7.2	Model Standard: Assuring the Linkage of People to Personal Health Services		
• Good referral services-linking people to the services. We can get people to dental, acute care, physical care, and mental health resources. • USD 383 has a great food service program in the summer	• Not enough mental health staffing in our community • Transportation to services is still an issue	• Better communication between agencies	• Social clearing house-one stop for all services (one physical location)

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
8.1	Model Standard: Workforce Assessment, Planning, and Development		
• Mercy physician needs assessment (3yr) • MATC meeting gaps • MCoC assessments • MPH Accreditation	• Partnerships needed with Manhattan Tech Nursing Program (multiple partners) • Professions/services as barriers (i.e. dental for poor people) • New populations/population disparity as barrier • Access to resources (difficulty)	• Fire Department, EMS to have a shared department (already somewhat present)	• Develop partnerships with educational centers/programs to be on cutting edge • Autistic children's applied behavioral therapy to improve training

8.2	Model Standard: Public Health Workforce Standards		
• State Board of Nursing (KS) seems to be of benefit (reciprocity & speed of licensure) • Fort Riley programs to engage private sector • KSU MPH, MATC Nursing program, Mercy (every 3yr) Accreditation • Mercy requires grads from accredited school	• Bureaucratic barriers in portability of licensures/certifications between jurisdictions	• Using common language/vocabulary when describing 10EPHS activity	• Increase communication and standardization within LPHS in our community

8.3	Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring		
• Everybody Counts initiative to combat homelessness (semi-annual) • Tuition reimbursement programs (some agencies) • Free or reduced cost to remove barriers to training • Continuing education requirements expected for licensed professionals (required development)	• Budget cuts negatively affect resources • Need to improve communication to community partners of trainings/symposiums & services • Many agencies are isolationist in partnerships • Other agencies feel insulated to being linked to services/trainings • Each family in need may be in communication with multiple different service agencies • Difficulty in follow-up after services rendered • Transportation svcs. • Cultural competency gaps (new populations) • Internships: must have professionals present within agency at education level/licensure to oversee students	• Better coordination between service agencies in linking care/services • Participation in Everybody Counts	• Broad, jurisdictional cultural competency trainings to improve delivery of services (especially frontline staff) • Use of current technology (especially by younger generations) to reduce cultural barriers; specific to agencies or communities; delivery system to mobile devices (improves access)

8.4	Model Standard: Public Health Leadership Development		
• Community Needs Assessment includes Pott. Co. • Community Leadership Program with Manhattan and Flint Hills Regional Council • KSU Leadership Studies and Raising Riley Program • USD 383 Administrative jobs have emphasis on leadership development • Kansas Leadership Center underneath KHF • Great collaboration in shared vision and development within RL	• Funding/budgetary issues (public sector) barriers to professional development • Communication of opportunities • Lack of leadership presence in public health (outwardly viewed to be "public health leaders"; to include LHDs) • Health disparity issues present from "travelling population" between jurisdictions • Physicians (actively-practicing) not always present at "public health table"	• Have public health be included within regional/state councils (CoC Regional Leaders Retreat) • Increase opportunities/awareness to the under-represented (local medical providers, dentists, coroners, etc.) to be a part of public health discussions	• Building regional partnerships (i.e. coalition development) to bring public health "to the table" • Utilizing local resources for PPD, rather than outsourcing, may be more cost-effective

ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
9.1	Model Standard: Evaluation of Population-Based Health Services		
• Initiatives to improve health factors and health outcomes (RL is #2 in Kansas by healthy counties)	• Communication of outcomes (qualitative vs. quantitative; times to use which)	• Improve frequency of evaluation of population health (individual qualitative assessment • Better use of KS Health Matters data to direct LPHS priorities • Invite state Senators (or other elected officials) to attend meetings focused on health assessments and prioritization	• Adoption of KS Health Matters (and other assessments) by an entity (i.e. PHAC) to provide ongoing strategic planning and evaluation to improve the LPHS

9.2	Model Standard: Evaluation of Personal Health Services		
• Capabilities of the Flint Hills Breadbasket (and other LPHS agencies) to "champion" a massive project with minimal resources • Use of community initiatives (i.e. Everybody Counts, Delivering Change) to evaluate gaps to services • Mercy utilizing KHIE (could bring more providers on-board)	• Some misuse of services (appropriateness; i.e. patient visits ER for non-emergency condition) • Misunderstanding of process to care (i.e. cutting primary care physician out of process for emergency care) • Lack of evaluations for accessibility, quality, and effectiveness for certain personal health services	• Broad LPHS assistance in current evaluations (i.e. Everybody Counts)	• Strategic planning toward developing LPHS evaluations (public health AND personal health services)

9.3	Model Standard: Evaluation of the Local Public Health System		
• Breakdown of “silos” and development of collaborations and coalitions (i.e. HCCs) to improve LPHS in the face of funding shortages • Inclusion of LPHS agencies within committees/coalitions/task forces that may not directly support their “mission(s)”, but serves to improve the system as a whole (and themselves, indirectly)	• Lack of awareness of local councils/boards that meet for jurisdiction-wide ends (PHAC, Flint Hills Regional Council, etc.)	• Public Health Advisory Council (PHAC) to provide outreach to the LPHS agencies (especially communication on topics MOST relevant to agencies) • Development/cultivation of relationships with LPHS community partners to support information sharing processes • More inclusion/participation of LPHS agencies within Healthcare Coalitions (preparedness), Flint Hills Regional Council, etc. • LPHS agencies to work toward improvement planning	• LHDs to take role in developing recommendations and strategies for action toward identified gaps within improvement planning

ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
10.1	Model Standard: Fostering Innovation		
• KHF Healthy Communities Grant (vending machine options, etc.) • League of Women Voters promotes certain topics • Statewide evaluation of community mental health centers (Pawnee reviews quarterly) • Riley County (MHK as college town) provides frequent opportunities for research projects and applicable results	• Poor understanding of how to initiate research (who to contact, process/procedures) • Lack of funding prevents research endeavors	• KSU (similar organizations) to assist in obtaining grants or to perform assessments • Student/internship offerings for current projects	• Relationships to be developed to link students to opportunities/projects AND to reciprocate with generation of project ideas; to match funding opportunity with available personnel and available project • Better campaigns to promote the availability of research opportunities in jurisdiction • Local agency to maintain list of opportunities over time (KSU, RCHD, other)

10.2	Model Standard: Linkage with Institutions of Higher Learning and/or Research		
• Local academic institutions (KSU, KU, Washburn, WSU, MATC, Barton, etc.) have great prevalence of relationships with LPHS agencies (MATC w/ EMS, KU w/ Pawnee, WSU w/ RRR, Washburn w/ RCHD, etc.) • Fort Riley activity and provision of services (in general); Wildcat Region (Riley-Geary-Pott.) has military families spread throughout jurisdiction	• Provision of services resulting from direction by County vs. City vs. City-County (tax dollar foundations); elected official oversight of LHD services	• Need a system to maintain up-to-date opportunities as well as research results or local successes	• Sustainable relationship between LPHS (or individual agencies) and local academic institutions (or research institutions) to develop research opportunities • Collaborative relationships to maintain up-to-date repertoire of best practices

10.3	Model Standard: Capacity to Initiate or Participate in Research		
• Growth following NBAF development and K-State 2025 research strategic plans will serve to improve research capacities in RL • Political influence and direct effects on research support and activities (support [momentum] of certain projects, allocation of funding); funding source considerations • Board of Health/Board of County Commissioners (BOH/BOCC) interest and prioritization of public health activities • Board/Council/Task Force activity (Mental Health Task Force, Public Health Advisory Council (PHAC))	• Political influence and direct effects on research support and activities (skewed prioritization of relevant activities, restrictions on activities, use of outcomes); funding source considerations	• Having the "right person in the right place" (as it pertains to research project development or funding) is beneficial to cost-effective research resource access • Having Riley County present at more local policy discussions (i.e. Manhattan City Commission) • LPHS collaboration with K-State 2025 task force to have LPHS research priorities reflected within the 2025 strategic plan	• Develop process for evaluation of research activities within our LPHS

APPENDIX C: Additional Resources

General

Association of State and Territorial Health Officers (ASTHO)
http://www.astho.org/

CDC/Office of State, Tribal, Local, and Territorial Support (OSTLTS)
http://www.cdc.gov/ostlts/programs/index.html

Guide to Clinical Preventive Services
http://www.ahrq.gov/clinic/pocketgd.htm

Guide to Community Preventive Services
www.thecommunityguide.org

National Association of City and County Health Officers (NACCHO)
http://www.naccho.org/topics/infrastructure/

National Association of Local Boards of Health (NALBOH)
http://www.nalboh.org

Being an Effective Local Board of Health Member: Your Role in the Local Public Health System
http://www.nalboh.org/pdffiles/LBOH%20Guide%20-%20Booklet%20Format%202008.pdf

Public Health 101 Curriculum for governing entities
http://www.nalboh.org/pdffiles/Bd%20Gov%20pdfs/NALBOH_Public_Health101Curriculum.pdf

Accreditation

ASTHO's Accreditation and Performance Improvement resources
http://astho.org/Programs/Accreditation-and-Performance/

NACCHO Accreditation Preparation and Quality Improvement
http://www.naccho.org/topics/infrastructure/accreditation/index.cfm

Public Health Accreditation Board
www.phaboard.org

Health Assessment and Planning (CHIP/ SHIP)

Healthy People 2010 Toolkit:

- Communicating Health Goals and Objectives
  http://www.healthypeople.gov/2010/state/toolkit/12Marketing2002.pdf
- Setting Health Priorities and Establishing Health Objectives
  http://www.healthypeople.gov/2010/state/toolkit/09Priorities2002.pdf

Healthy People 2020:
www.healthypeople.gov

- MAP-IT: A Guide To Using Healthy People 2020 in Your Community
  http://www.healthypeople.gov/2020/implementing/default.aspx

Mobilizing for Action through Planning and Partnership:
http://www.naccho.org/topics/infrastructure/mapp/

- MAPP Clearinghouse
  http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/
- MAPP Framework
  http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm

National Public Health Performance Standards Program
http://www.cdc.gov/nphpsp/index.html

Performance Management /Quality Improvement

American Society for Quality; Evaluation and Decision Making Tools: Multi-voting
http://asq.org/learn-about-quality/decision-making-tools/overview/overview.html

Improving Health in the Community: A Role for Performance Monitoring
http://www.nap.edu/catalog/5298.html

National Network of Public Health Institutes Public Health Performance Improvement Toolkit
http://nnphi.org/tools/public-health-performance-improvement-toolkit-2

Public Health Foundation – Performance Management and Quality Improvement
http://www.phf.org/focusareas/Pages/default.aspx

Turning Point
http://www.turningpointprogram.org/toolkit/content/silostosystems.htm

US Department of Health and Human Services Public Health System, Finance, and Quality Program
http://www.hhs.gov/ash/initiatives/quality/finance/forum.html

Evaluation

CDC Framework for Program Evaluation in Public Health
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm

Guide to Developing an Outcome Logic Model and Measurement Plan (United Way)
http://www.yourunitedway.org/media/Guide_for_Logic_Models_and_Measurements.pdf

National Resource for Evidence Based Programs and Practices
www.nrepp.samhsa.gov

W.K. Kellogg Foundation Evaluation Handbook
http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx

W.K. Kellogg Foundation Logic Model Development Guide
http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx

Appendix E

Participant Evaluation Survey Tool

Copy of the Evaluation Survey Tool

General Information

Thank you for your participation in the Local Public Health Systems Assessment on June 11th! We would appreciate you taking a few minutes to give us some feedback on the day.

1. What team were you on?

- ☐ Aggie (Essential Services 1 & 2)
- ☐ Bluemont (Essential Services 3 & 7)
- ☐ Goodnow (Essential Services 4, 5 & 6)
- ☐ Kansa (Essential Services 8, 9 & 10)
- ☐ Support staff/No assigned team

2. What was your role?

- ◯ Participant
- ◯ Staff/Team Leader

3. Did you participate in the Community Needs Assessment Survey? (Note: This may have been via the website form (http://riley-pottsurvey.com/), a paper survey, a phone survey, or a focus group.)

- ◯ Yes
- ◯ No
- ◯ Not sure

Comment:

Organization, Location and Resources

4. Please rate each item.

	Excellent	Good	Fair	Poor	N/A or Not Sure
Pre-meeting communication	◯	◯	◯	◯	◯
Meeting facilities	◯	◯	◯	◯	◯
Meals & snacks	◯	◯	◯	◯	◯
Handouts	◯	◯	◯	◯	◯
Website	◯	◯	◯	◯	◯

Please share any additional comments related to these items.

Opening and Team Sessions

5. Opening Session

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
The opening session helped me understand the general objectives of the day.	◯	◯	◯	◯	◯	◯
The opening session provided me with a sufficient introduction to the 10 essential services.	◯	◯	◯	◯	◯	◯

Please share any additional comments related to the opening session.

6. Team Session

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
The team had sufficient expertise to effectively score performance measures (i.e., "we had the right people in the room")	◯	◯	◯	◯	◯	◯
We had enough time to complete our task	◯	◯	◯	◯	◯	◯
The structured process allowed for constructive, informative discussion	◯	◯	◯	◯	◯	◯
The structure process provided for accurate, useful performance measure scoring	◯	◯	◯	◯	◯	◯
Our facilitator and team leaders managed the process effectively	◯	◯	◯	◯	◯	◯

Please share any additional comments related to your team's session.

General Outcomes

7. How well do these statements describe your experience?

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not sure
I learned something new about the local public health system	◯	◯	◯	◯	◯	◯
I made a new connection with an individual or organization	◯	◯	◯	◯	◯	◯
I plan to follow-up on something I learned from the day (e.g., share information with others, learn more about a program, connect with an individual/organization, seek clarifying information on a topic, address a gap, raise awareness about a resource, etc.)	◯	◯	◯	◯	◯	◯
I am interested in being involved in using these results to help improve our local public health system	◯	◯	◯	◯	◯	◯

Please share any additional comments related to your team's session.

Reflections on the Day

8. What was your favorite part of the day?

9. What was your least favorite part?

10. What is one thing you would change?

11. Who or what perspectives were we missing?

12. What is one thing you learned?

13. Are there any other comments or suggestions you would like to share?

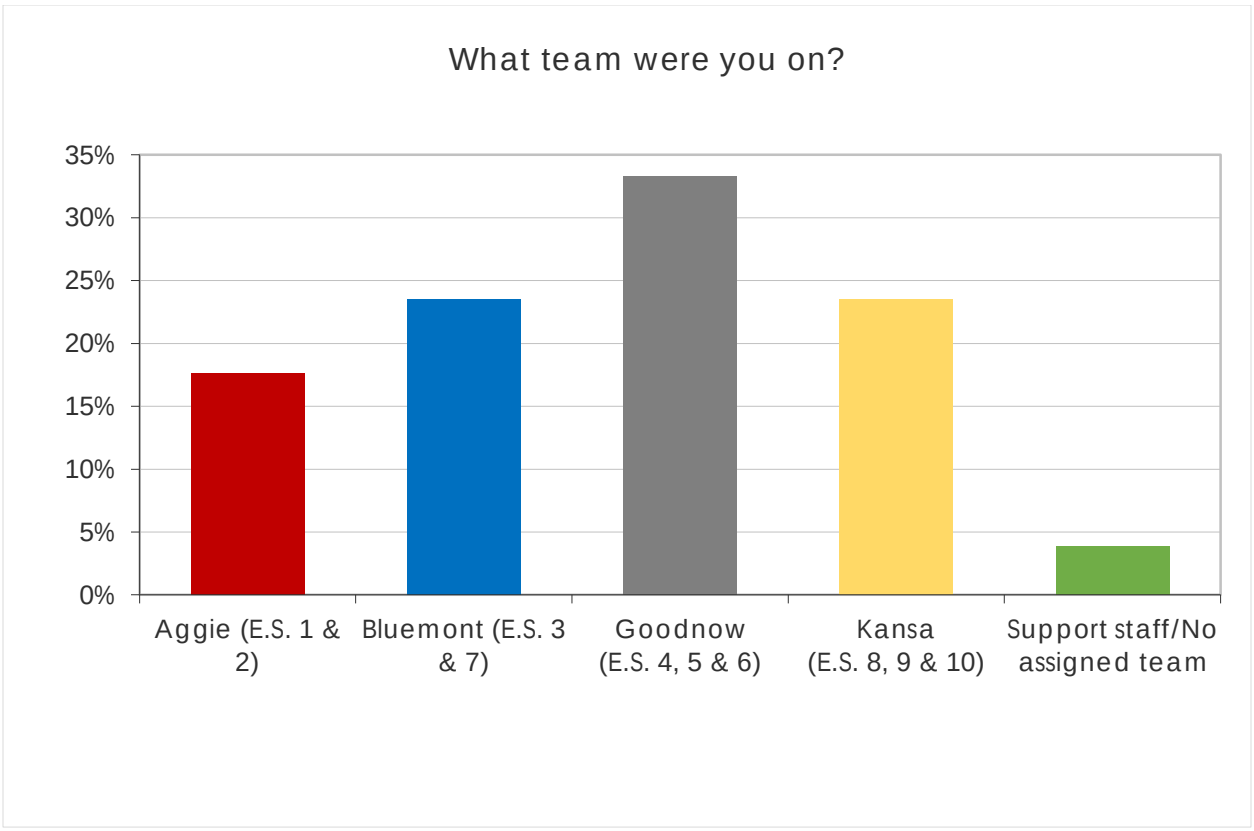
Thank you!

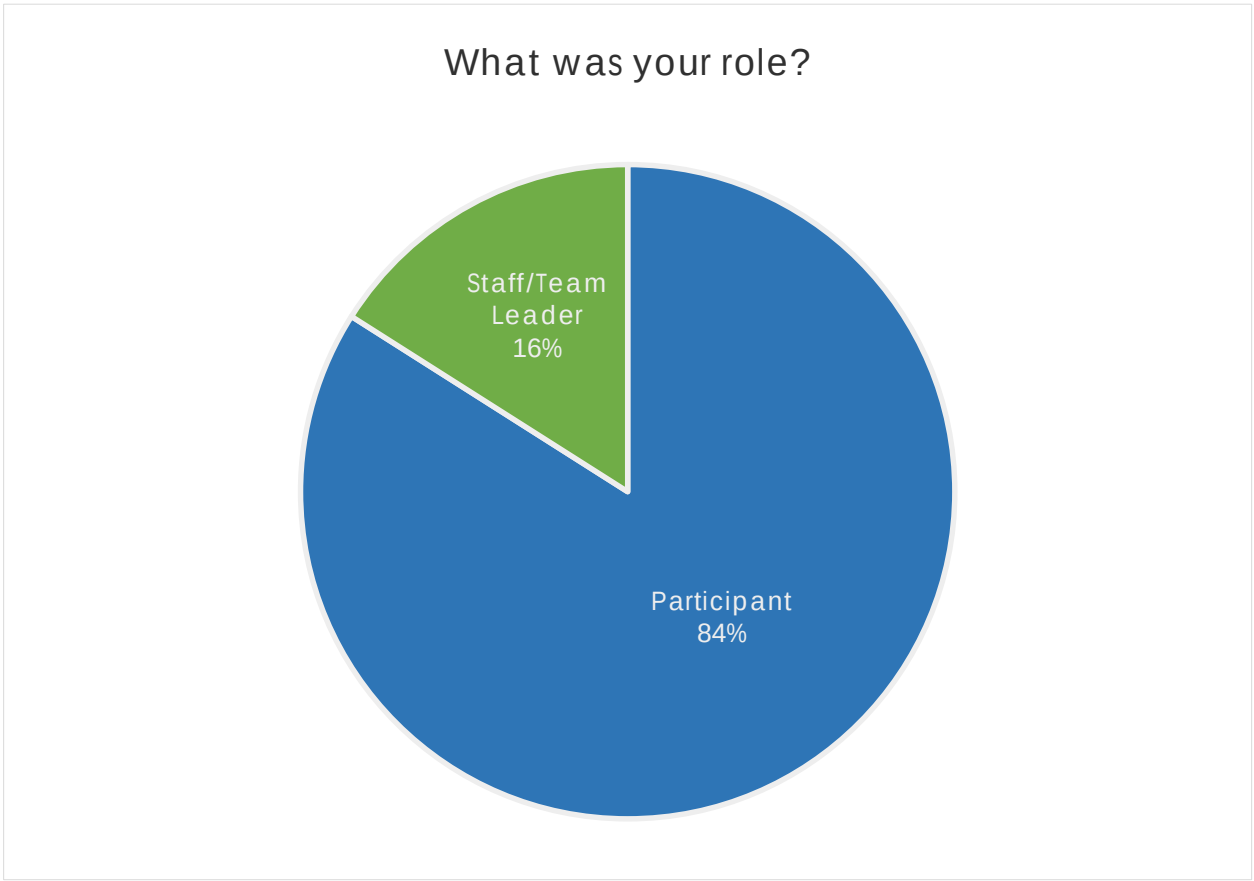
Thank you for your help!

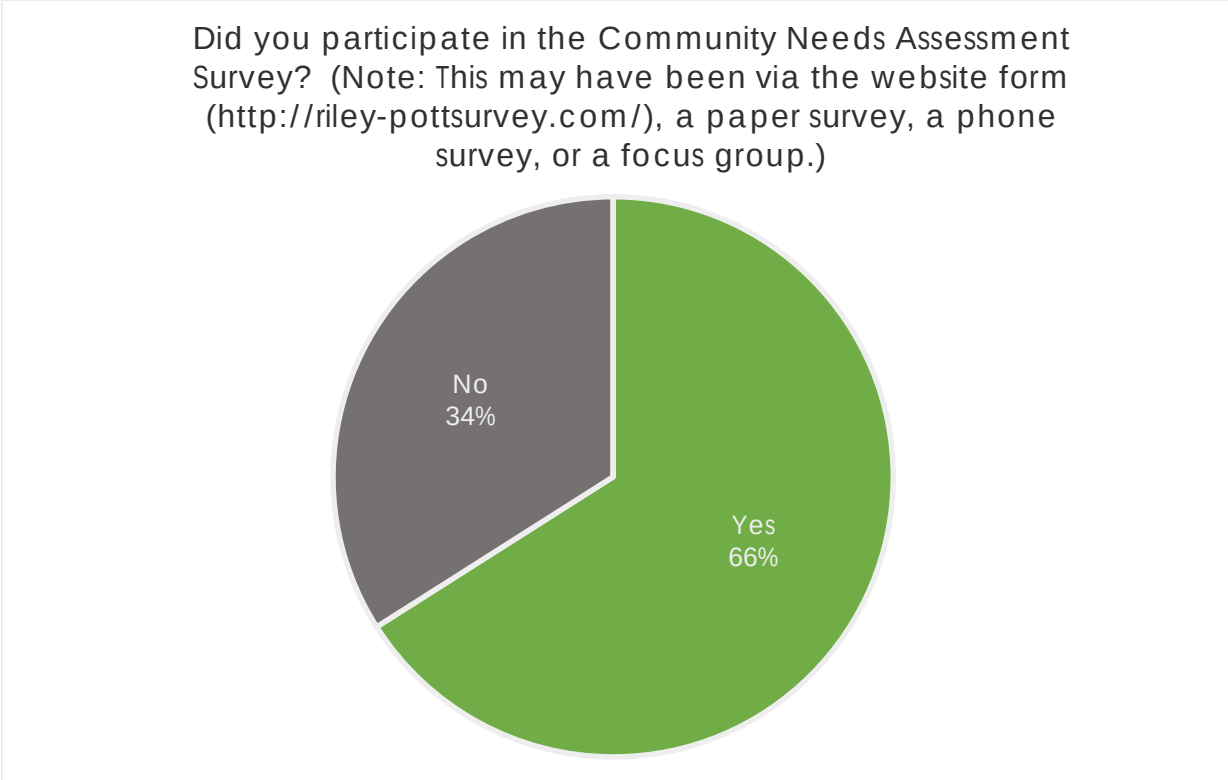
A preliminary report will be sent to participants in July.

Appendix F

Participant Evaluation Survey Results


What team were you on?
35%
30%
25%
20%
15%
10%
5%
0%
Aggie (E.S. 1 & 2)
Bluemont (E.S. 3 & 7)
Goodnow (E.S. 4, 5 & 6)
Kansa (E.S. 8, 9 & 10)
Support staff/No assigned team


What was your role?
Staff/Team Leader 16%
Participant 84%



Comments:

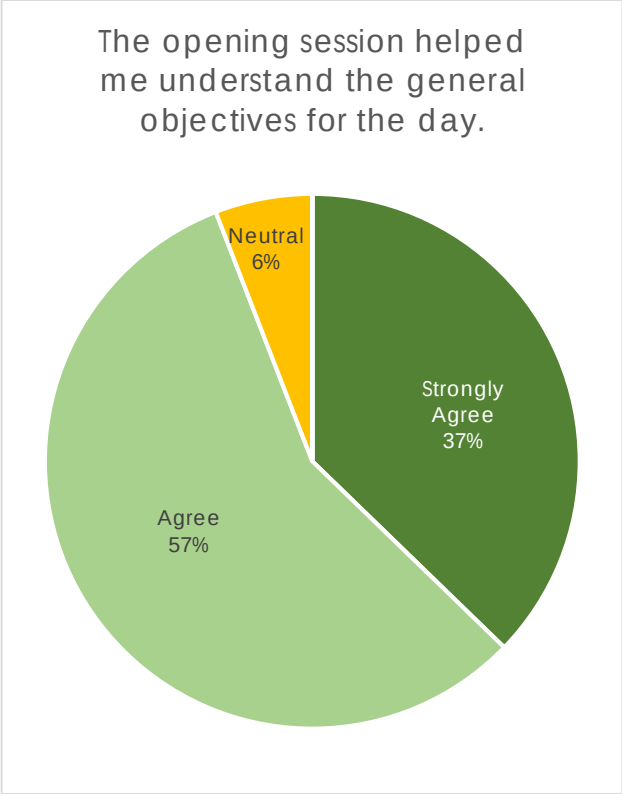
- NA
- Appreciated the opportunity to complete the comm needs assessment survey!

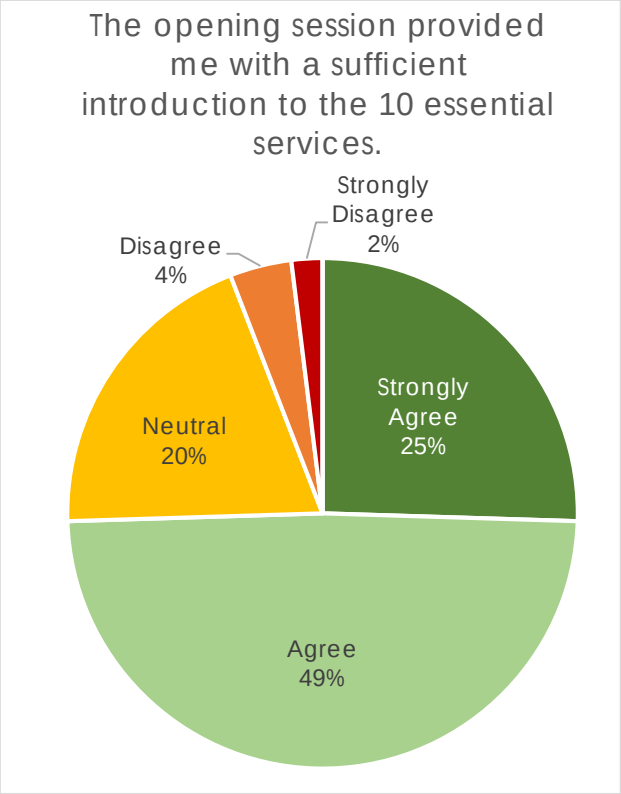
Ratings of Meeting Components

	Excellent		Good		Fair		Poor		N/A or Not Sure		Average Rating
	#	%	#	%	#	%	#	%	#	%	1-4
Pre-Meeting Communication	19	37%	26	51%	3	6%	0	0%	3	6%	3.33
Meeting Facilities	25	49%	24	47%	1	2%	1	2%	0	0%	3.43
Meals & Snacks	35	69%	14	27%	1	2%	0	0%	1	2%	3.68
Handouts	29	57%	20	39%	2	4%	0	0%	0	0%	3.53
Website	17	35%	19	39%	2	4%	0	0%	11	22%	3.39

Comments:

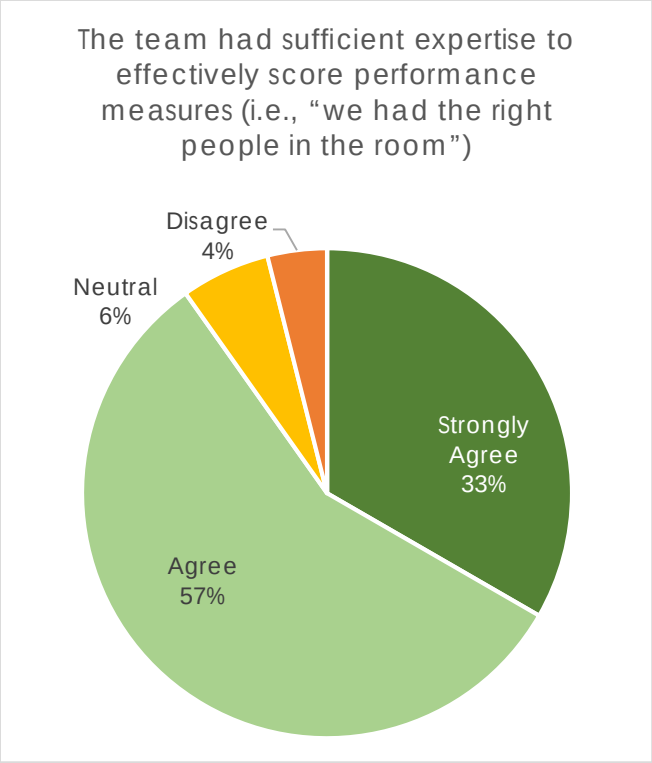
- Our room had us pretty close together (sitting) would have liked a bit more "personal space."
- Re handouts--very categorized--little possibility for nuance.
- I really didn't think I would be helpful in the process because I didn't know what it was about, but I did contribute and it was meaningful. We were subjected to noise from the larger meeting room, which interrupted the conversation.
- Chairs were too close together.
- The area was not ideal for hearing during certain times as it was in a common area and people taking breaks/lunch were noisy.
- The meeting space was partitioned off from a larger room and the noise from the other area was distracting.

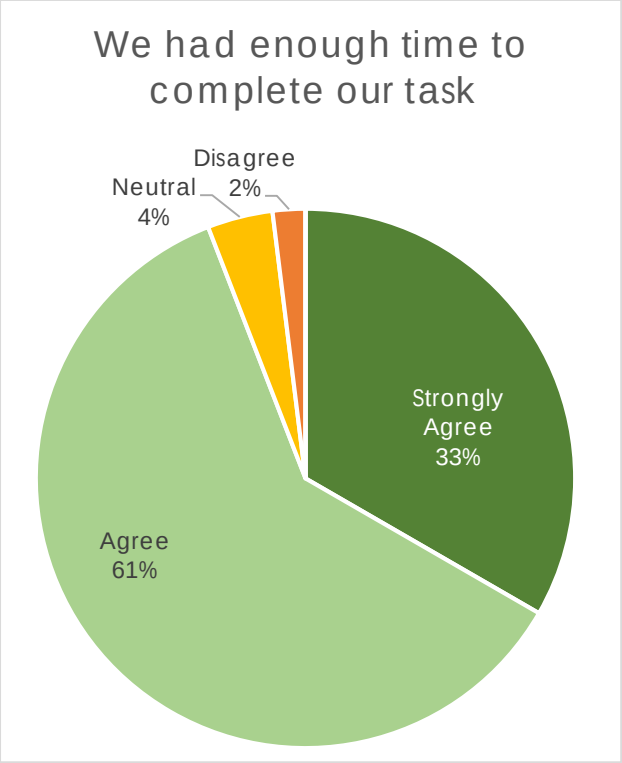


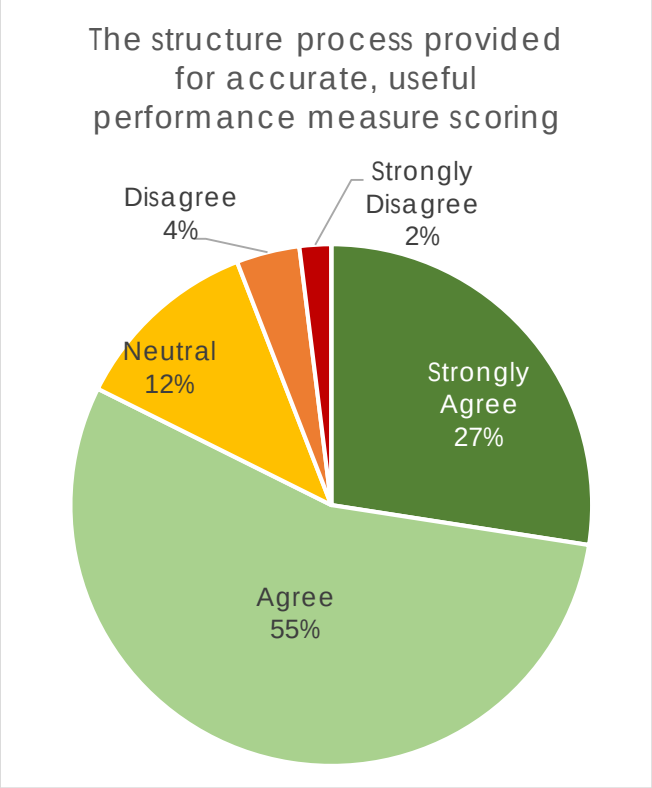


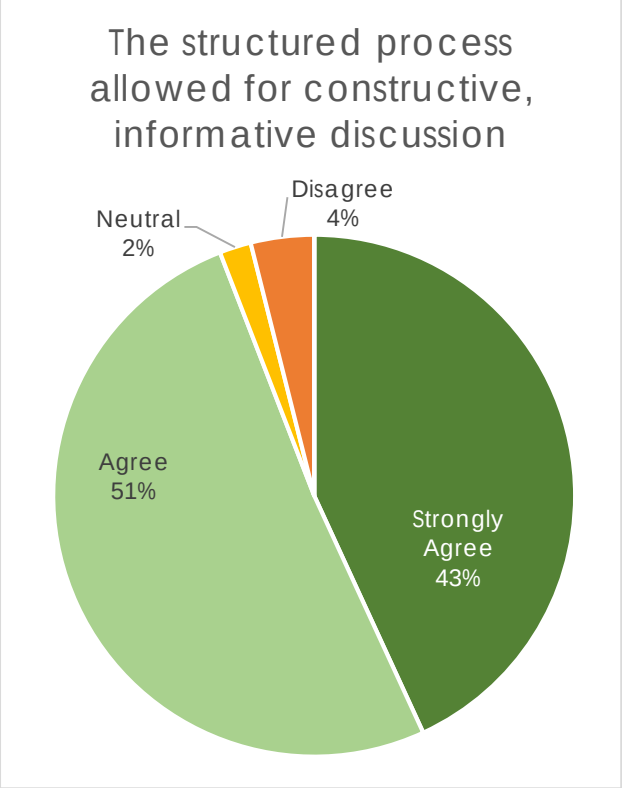
Comments:

- It was unclear why we were all there. The opening information explained some elements but wasn't about why the groups were broken down.
- I liked the smooth efficiency and organization that kept us to a schedule, but not having these handouts earlier made thoughtful response impossible.
- I really didn't understand what we were doing until we got in the group session.


The team had sufficient expertise to effectively score performance measures (i.e., “we had the right people in the room”)
Disagree 4%
Neutral 6%
Strongly Agree 33%
Agree 57%

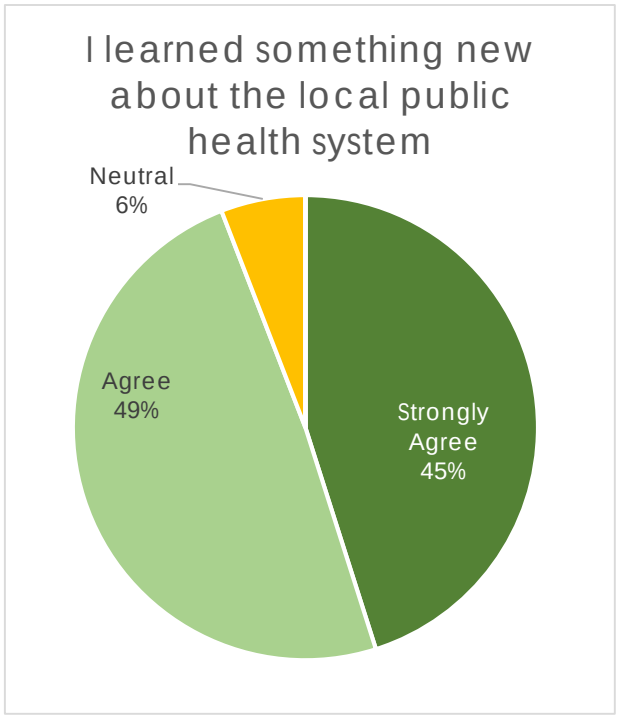

We had enough time to complete our task
Disagree 2%
Neutral 4%
Strongly Agree 33%
Agree 61%

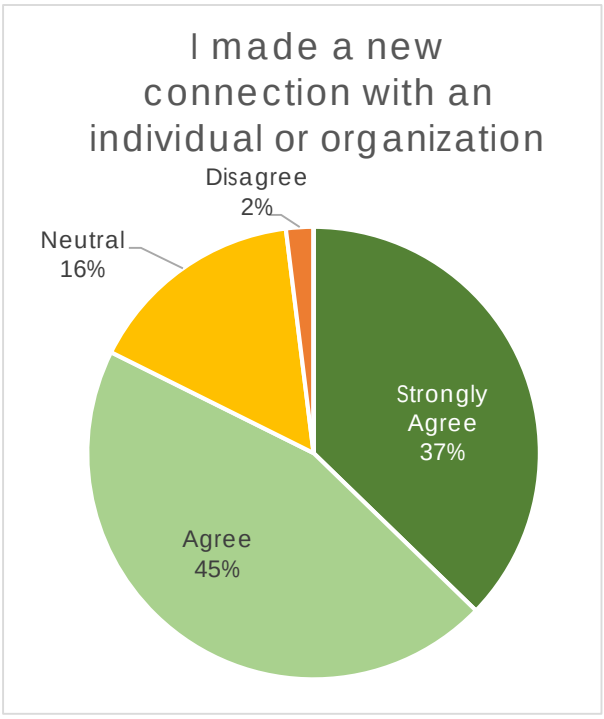

The structure process provided for accurate, useful performance measure scoring
Disagree 4%
Strongly Disagree 2%
Neutral 12%
Strongly Agree 27%
Agree 55%

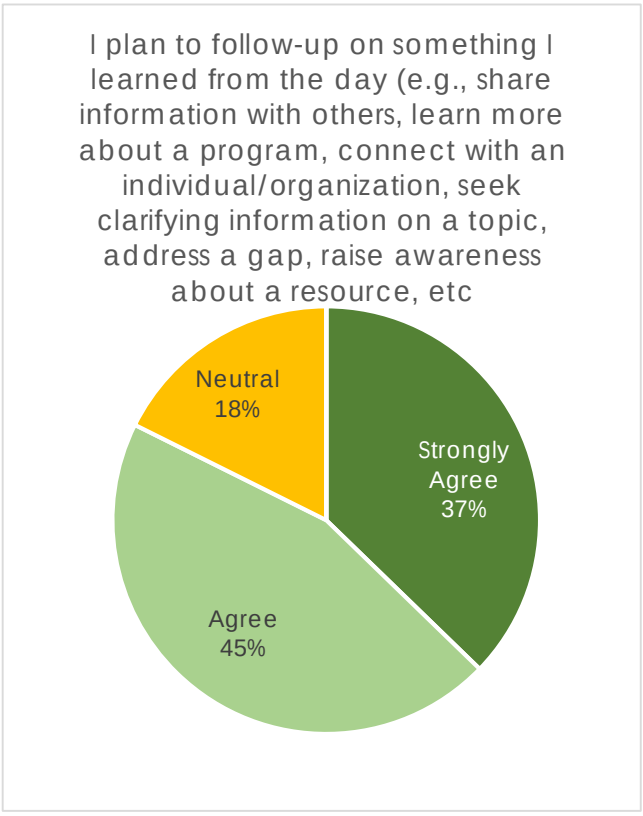

The structured process allowed for constructive, informative discussion
Neutral 2%
Disagree 4%
Agree 51%
Strongly Agree 43%

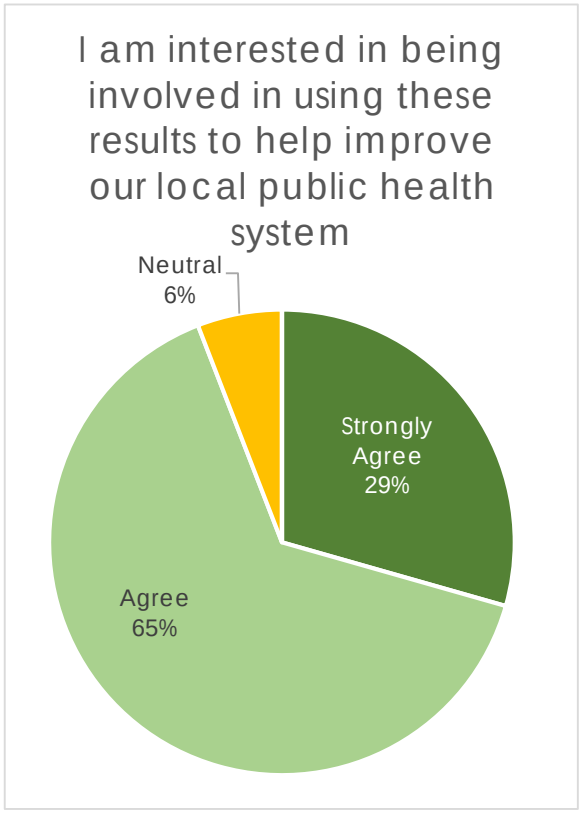
Comments:

- I'm not convinced we measured what we were trying to measure. Discussion was rich, but off-topic for most of the session.
- Identified one or more individuals that needed to be at the table to provide more information/data/experience.
- We were off-topic for most measures. I don't know if we measured what we intended to measure.
- Consider voting that would not allow matching the vote of others by watchful waiting.
- Would have liked law enforcement at the table. Very much liked our facilitator.
- I personally have not been in my position long enough to feel like I could speak on any one subject against other people, even though I came from a town that wasn't represented by anyone else in any other focus group. I would've been much more comfortable stating my position if I could've done it on paper and without having to speak in front of the group. I would've also preferred to vote on paper instead of having to all agree on something, because there are problems that some people can see that others can't.
- Few people seemed to have enough information to contribute. Not all their fault--asking people about emergency plans that few of us knew were in existence could hardly result in meaningful scoring.
- Sessions are too long. Add another group or two so less items are assigned to each group. Basically eight hours of discussion is exhausting and people lose interest towards the end - this could have affected the scoring of items discussed later in the day.
- The rating system was somewhat hard to understand. There were occasions where none of us understood parts of the system and we didn't understand how to score it.
- Since our session had 3 sections it made it go a little long. We lost members and those there were getting worn out.
- Needed representation from K-State.
- Disappointed no one from K-State participated...at least not on our team.
- Needed LE in the Aggie group!
- The questions were sometimes difficult to decipher. For example, if you considered the entire network as the system, it was hard to decide if the system was doing it only one part of it was.









Comment:

- I'm new to Manhattan and my job with a local service agency. I found this to be a very useful day, even though I don't feel I contributed much to the process!

What was your favorite part of the day?

- Meeting in small groups to discuss important trends in our County
- Discussion
- Team discussion
- Interaction with others
- Discussion of the various questions and issues. Educational and instructional.
- Conversation esp rural perspective
- Witnessing civic discourse in action was my favorite part of the day. It brought tears to my eyes - in a very good way! How wonderful to think that people with very differing points of views could gather and assess our assets and our needs as it relates to public health systems.
- Open discussion with other agencies. Very eye opening.
- The discussions were excellent
- Meeting directors of other organizations. Networking.
- The entire day was so informative!
- all day, this was very new for me and i learned a lot
- The conversation with the diversity group
- Discussion, But I really liked the plan that kept us to a day and not repeated meetings.
- Discussion of issues
- First session
- The sharing of participants' roles in public health and how we are all a component of the whole process. Learning our strengths and what areas we need to work on.
- Meeting everyone
- I enjoyed the group discussions and hearing from folks who I did not know previously.
- Early morning discussion - I felt the topic was something I could give adequate input on.
- Getting to know participants and learning more about the public health system overall.
- Group session
- Seeing broader perspective regarding Region
- Individual breakout sessions
- It was all good!
- break out group for assessing and scoring
- Group discussion, but I have to give much of the credit for this to: 1) effective group leadership and 2) the smaller size of size of the group I was in.
- Early discussions when everyone was engaged
- I enjoy the group interactions.
- Group discussion.
- Meeting all the new people and their function in our community

- Hearing from different individuals from the community and how they viewed our system and issues.
- Learning about other organizations
- Seeing enthusiasm from everyone, especially Bob the Commissioner!
- frank discussion among community members
- discussions by community members on health issues
- The discussion before the vote.
- Afternoon when we can down to talking about regulations and enforcement activities and how they are working.
- great facilitator & team leaders!

What was your least favorite part?

- room Space too tight for breakout sessions
- n/a
- Team discussion when we went off topic
- none
- The lack of various points of view. The vast majority of the group had a direct interest in expanding public services or fixing short falls and there wasn't a Manhattan "regular citizen" point of view or representative to balance unrestricted expansion.
- Time constraint and voting on topics learned first time that day
- My least favorite part of was knowing that more folks could not participate who were invited. You did an excellent job reaching out to the varying leaders in our community.
- Long day.
- It was a long day! At times the group wanted to move on but the facilitators kept asking questions.
- Reading in front of the group.
- N/A
- none
- N/A
- Sometimes feeling too rushed along an organizational timetable.
- It was a long day, sometime conversation dominated and we got off track.
- After the first session the topics seemed so linked that it felt like were just going over the same issues again and again.
- Nothing...the whole experience was wonderful.
- Not being able to contribute more effectively to the scoring process
- Some of the "bunny trails" were a bit heated and uncomfortable.
- The afternoon topics were not related to my knowledge-base and therefore, I simply sat there all afternoon.

- none
- Group session went to long.
- Opening plenary chairs were to close and no tables.
- N/A
- all was good...no "least" favorite
- discussion that lingered too long
- Late in the day it became very difficult to stay focused and it felt like everyone was running out of steam.
- Not knowing what to expect.
- working lunch, but not really, enjoyed all of it.
- It was a long day, even though we moved along efficiently.
- Nothing
- None.
- distracting discussions in the auditorium area outside our partitioned area
- the informal discussions in the auditorium area detracted from the quality of discussions in our partitioned area.
- Not being involved with the rest of the assessment?
- Early part of day when the conversation was less relevant to my experience and knowledge.

What is one thing you would change?

- More representation from Business Community - Large and Small Businesses
- use parking lot more
- Use parking lot more to help keep people on topic
- nothing
- Expand the points of view to balance the analysis and discussion.
- Meet in room to lessen sound
- More sitting/space, not sure how to shorten but one day was better than multiple days.
- Decrease the materials to discuss.
- I would have suggested that the one assessment group not be in the lunch room ~ felt bad we were noisy when they were working.
- registration in the morning, more people to check in and a little more time spent on that prior to people arriving
- Better communication in the community
- Maybe loosen the organizational time limits a bit--but I do not want repeated meetings. Perhaps they could have been more efficient with more information given out earlier.
- smaller groups

- Make it more factual and less what might be nice.
- My impression was that as a group we did not fully understand the voting cards in the beginning. When we used a grading system, A, B C, D, F we had more accurate scores.
- I thought we had to score more items than we had time for
- I would send more information to the participants prior to the assessment day.
- Make the sessions shorter or add more groups so less sessions have to be covered per group. People grow tired by the end of the day. You would achieve more accurate feedback if groups were only in discussion for 4 or 5 hours.
- A better understanding of the rating system.
- Lunch brought to rooms to facilitate conversation
- More knowledgeable facilitators who are more familiar with Manhattan's services
- Some people left early. I did not feel that was right. If they were going to be involved, they should have committed all day, until the end.
- more information on exactly what services we have locally
- Our group was smaller than the others but seemed heavily slanted toward K-State, three individuals. Two other community organizations would have added more depth to our discussion. Also, I know it is impracticable, but holding the meeting over two or three days would give everyone a chance to share the uniqueness of their expertise to all questions in ways that would strengthen the survey.
- Have an additional team so each team only has to review 2 essential services.
- Perhaps not having a group in the gym where the noise level was extremely loud.
- I wouldn't change anything.
- Nothing
- Have 2 instead of 3 focus areas.
- Nothing
- None.
- I would put out the questionnaire prior to the assessment and let people rate it and then see if the discussions change the answer.
- Make it clearer on how to look at the health system as a whole.

Who or what perspectives were missing?

- Needed Representation from Manhattan Technical College
- none
- nothing
- Manhattan "regular citizen" point of view or representative.
- Kdhe perspective at times

- 1.) Young people - those 25 and under. This is a crucial part of our Military/University community. They have intelligent voices that need to be heard. 2.) I would also say it would have been stronger had foreign students participated. 3.) The voices of immigrants - legal or otherwise - were missing. It was a pretty white, educated, middle class crowd, but there are many wonderful community leaders in our community that do not reflect this segment.
- LEO
- It would have been interesting to come together as a large group and get the information discussed in the other groups.
- Not sure
- I think we had a great number of perspectives just needed to stay on track
- No one
- Did you have representatives from hospice, child care, long term care, etc.?
- seemed like all were included
- Business, users
- None that I can recall.
- I thought "who" and "what" were pretty well represented.
- It would have been great to have had everyone who was invited, but I know that isn't realistic.
- As a representative from a local business, I thought most perspectives were present. However, I felt most topics didn't directly apply to me.
- I thought it would be beneficial for the personnel from Riley County Health Department to provide more guidance.
- Everyone there was aware of the various programs and in my opinion inaccurately assume that since we are aware of it, the whole community is. I did not agree.
- Local Providers - Safety Net Clinic
- Consumers
- Seems we had many experts form different factions which deal with public health (medical people, healthcare - related providers & connectors). Maybe we just needed a "regular" business person (I don't remember there being one) who was totally unrelated to anything health - wise (like a manufacturing firm owner) present for a "detached" perspective???
- more info. about local services
- The diversity of our community was conspicuously missing. In particular, there was no representation of our growing Hispanic population: no representation of non-university 18-25 year residents; and, little representation of low income elderly. All of which are in great need of better, more accessible public health services.
- A little more clarity on what was to be done with the information.
- not sure, thought everything was covered in our group
- N/a
- I think Connie and Brenda did excellent!

- K-State, NBAF, more private business representation
- K-State, NBAF
- We probably needed to have some agencies represented in multiple groups?
- Pretty broad based from what I could tell.
- More direct health care providers; more Northern Riley Co and Ogden representations; more school representatives (other districts; private schools); additional university/research personnel; additional population representatives (e.g., international communities)

What is one thing you learned?

- Growing Hispanic Population in our Local School District
- gained a better appreciation for how broad the public health system is
- How broad the ph system is
- how many different programs there are in our community to help those with health problems
- Challenges with local mental health care
- Most had a lot to learn
- We need to have more community conversations like this.
- More about some of the "holes" in our community that aren't as apparent.
- That there really needs to be some entity that has oversight and can bring together all the information from all areas.
- There is a great deal of "perception" of what different organizations do or provide, but these may not be accurate. There's also a perception that everyone has access to health insurance and health care, but that's not the case.
- that the community does want to find a way to help those in need
- What services are offered
- I learned a lot about United Way--she was a great representative.
- The health system is large and involves agencies one wouldn't think of..
- There are many groups working on the health issue and they aren't really communicating with each other. Kansas at the state level is doing as little as possible.
- To utilize GPS during disease outbreaks to help pinpoint possible source.
- How diverse the Manhattan community is.
- Actually, who all is part of the public health system and some of what they do.
- Community strengths
- ...that the LPHS is not just the health department nor health providers and related entities.
- no information was available about NBAF and emergency preparedness and response

- The meeting significantly broadened my concept of "Public Health Services."
- How extensive the public health system is
- That there are gaps in the Affordable Care Act.
- how decisions are made by several different entities
- The shift towards "community health" and the context which it is defined
- What all we offer in Riley County
- Wonderful to see the community and the Commissioner embrace Brenda Nickel.
- "The Riley Co Health Department is seeking accreditation
- The BOCC did not support funding for a Quality Improvement initiative for the Health Dep't"
- "The Riley Co Health Department is seeking accreditation.
- The BOCC would not fund a Quality Improvement effort for the Health Department."
- KDHE's Lab is not open 24/7/365
- Quite a lack of awareness of county regulations and enforcement.

Are there any other comments or suggestions you would like to share?

- Anxious to see how United Way's talks will evolve this fall.
- Overall it was a good day-good networking too.
- None at this time.
- Really enjoyed the process and the number of people attending! The organizers of the event did an outstanding job!
- Can't think of any right now.
- Give us more facts so we can make citizens understand what a lousy job the state is doing.
- I was very impressed on the whole process. The day went so smoothly and the time just flew.
- I really liked having the lunch set up in a separate almost "break room." I think it gave our group a real break for lunch and helped to recharge their energy.
- Good overall.
- Brenda did an excellent job of organizing this project along with RCHD staff.
- Continued momentum going forward.
- It was a wonderful opportunity-well organized. It may have been interesting an injected "new life" into each group by periodically making certain people from specified areas of expertise rotate out and into other groups...keeping fresh dynamics and ideas.

- When are we ever going to ask those who are most in need of public health services these same questions in a setting that encourages participation and discussion?
- I think this was a great initiative and I hope it leads to some improvements in the local public health system.
- No
- I will liked the structure and time control of the conversation
- Riley County needs a strong and committed Health Department. Reduced funding is NOT an option.
- This effort was very meaningful; the community has had an opportunity to have input into the future of the Health Department. I support their effort to obtain accreditation.

Appendix G

LPHSA Agency Contribution Report

Local Public Health System Assessment
Agency Contribution Scoring Results and Discussion Notes

Overview and Process

The Local Health Department Contribution Questionnaire portion of the Local Public Health Systems Assessment was completed Thursday, October 16th at the Riley County Health Department.

Invitees were the Riley County Health Department leadership team. Participants included the following team members: Brenda Nickel, Katy Oestman, Jason Orr, Andrew Swisher (intern; observer), Linda Redding, Gail Chalman, Lisa Ross, Jan Scheideman, and Connie Satzler (facilitator; observer). Brenda and Jason had to step out for a portion of essential services 5, 6, and 7, and Jan joined for the latter part of the process. All other participants were present for all essential service discussions.

The optional agency questionnaire from the National Public Health Performance Standards local instrument was utilized as the tool. Participants scored agency contribution by holding up score cards for each model standard, and a majority or consensus score was recorded. It was also noted that the high number in the range (e.g., 25% for minimal and 50% for moderate) is the number used by the National Public Health Performance Standards tool for calculating averages, so participants focused on this high number when determining the most appropriate score, especially when discussing how to break ties in scoring votes.

- No Contribution (0%)
- Minimal Contribution (1-25%)
- Moderate Contribution (26-50%)
- Significant Contribution (51-75%)
- Maximum Contribution (76-100%)
- *Further discussion needed*

Scoring color-codes and explanations provided on reference table tents to participants are as follows:

Maximum Contribution (76%-100%)	Greater than 75% of the model standard is achieved through direct contribution of the local health department.
Significant Contribution (51%-75%)	Greater than 50% but not more than 75% of the model standard is achieved through direct contribution of the local health department.
Moderate Contribution (26%-50%)	Greater than 25% but not more than 50% of the model standard is achieved through direct contribution of the local health department.
Minimal Contribution (1%-25%)	Greater than zero but not more than 25% of the model standard is achieved through direct contribution of the local health department.
No Contribution (0%)	0% or absolutely no contribution.

The level of agency contribution was scored based on what the agency is *directly* contributing *now*, rather than what the agency has the potential to contribute or might contributed in the future. It was acknowledged that, for some model services, it would not be appropriate or possible for the local health department to have a "maximum" contribution due to another partner in the public health system having a lead role for that model standard.

Results of the community-wide Local Public Health Systems Assessment were provided as a reference, and the questions under each model standard were considered in-depth when determining the agency contribution score. For example, the questions related to Model Standard 1.1 Population-Based Community Health Assessment (CHA) were "At what level does the local public health system: (1) conduct regular assessments? (2) continuously update the CHA with current information, and (3) promote the use of the CHA among community members and partners?"

While the LPHSA results were available as a reference, it is important to note that the agency contribution score is independent of the local public health system activity score determined at the June 11th community wide meeting. The activity score measures "at what level is this activity happening within our local public health system?" while the agency contribution score measures "how much of this model standard is achieved through direct contribution of the local public health agency?" In other words, it is possible to score low on activity and high on agency contribution and visa versa. Scoring for both questionnaires was dependent on the perceptions of the participants, which can be subject to biases and incomplete knowledge but nonetheless provide valuable insight for baseline measurements and opportunities for improvements.

Results

Here are the resulting scores for each model standard.

Standard Number	Question	Response
Essential Service #1 - Monitor health status to identify health problems: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A1.1	Population-based Community Health Assessment	Moderate Contribution (26%-50%)
A1.2	Current Technology to Manage and Communicate Population Health Data	Minimal Contribution (1%-25%)
A1.3	Maintenance of Population Health Registries	Minimal Contribution (1%-25%)
Essential Service #2 - Diagnose and investigate health problems and health hazards: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A2.1	Identification and Surveillance of Health Threats	Significant Contribution (51%-75%)
A2.2	Investigation and Response to Public Health Threats and Emergencies	Moderate Contribution (26%-50%)
A2.3	Laboratory Support for Investigation of Health Threats	Moderate Contribution (26%-50%)

Standard Number	Question	Response
Essential Service #3 - Inform, educate and empower people about health issues: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A3.1	Health Education and Promotion	Moderate Contribution (26%-50%)
A3.2	Health Communication	Moderate Contribution (26%-50%)
A3.3	Risk Communication	Minimal Contribution (1%-25%)
Essential Service #4 - Mobilize community partnerships to identify and solve health problems: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A4.1	Constituency Development	Minimal Contribution (1%-25%)
A4.2	Community Partnerships	Moderate Contribution (26%-50%)
Essential Service #5 - Develop policies and plans that support individual and community health efforts: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A5.1	Governmental Presence at the Local Level	Significant Contribution (51%-75%)
A5.2	Public Health Policy Development	Minimal Contribution (1%-25%)
A5.3	Community Health Improvement Process and Strategic Planning	Minimal Contribution (1%-25%)
A5.4	Plan for Public Health Emergencies	Significant Contribution (51%-75%)
Essential Service #6 - Enforce laws and regulations that protect health and ensure safety: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A6.1	Review and Evaluation of Laws, Regulations and Ordinances	Minimal Contribution (1%-25%)
A6.2	Involvement in the Improvement of Laws, Regulations, and Ordinances	Minimal Contribution (1%-25%)
A6.3	Enforcement of Laws, Regulations, and Ordinances	Minimal Contribution (1%-25%)
Essential Service #7 - Link people to needed personal health services and assure the provision of health care when otherwise unavailable: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A7.1	Identification of Personal Health Service Needs of Populations	Significant Contribution (51%-75%)
A7.2	Linkage of People to Personal Health Services	Moderate Contribution (26%-50%)

Standard Number	Question	Response
Essential Service #8 - Assure a competent public health and personal health care workforce: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A8.1	Workforce Assessment, Planning and Development	Minimal Contribution (1%-25%)
A8.2	Public Health Workforce Standards	Moderate Contribution (26%-50%)
A8.3	Life-Long Learning through Continuing Education, Training and Mentoring	Moderate Contribution (26%-50%)
A8.4	Public Health Leadership Development	Moderate Contribution (26%-50%)
Essential Service #9 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A9.1	Evaluation of Population-based Health Services	Minimal Contribution (1%-25%)
A9.2	How much of this model standard - Evaluation of Personal Health Services - is achieved through the direct contribution of the local health department?	Minimal Contribution (1%-25%)
A9.3	Evaluation of the Local Public Health System	Moderate Contribution (26%-50%)
Essential Service #10 - Research for new insights and innovative solutions to health problems: *How much of each model standard is achieved through the direct contribution of the local public health agency?*		
A10.1	Fostering Innovation	Minimal Contribution (1%-25%)
A10.2	Linkage with Institutions of Higher Learning and/or Research	Moderate Contribution (26%-50%)
A10.3	Capacity to Initiate or Participate in Research	Minimal Contribution (1%-25%)

Based on the average contribution scores by Essential Service:

- No essential services scored in the "No Contribution" (0%) or "Minimal Contribution" (1-25%) range.
- Eight essential services averaged in the "Moderate Contribution" (26-50%) range:
  - ES 6: Enforce Laws (25.0%)
  - ES 1: Monitor Health Status (33.3%)
  - ES 9: Evaluate Services (33.3%)
  - ES 10: Research/Innovations (33.3%)
  - ES 4: Mobilize Partnerships (37.5%)
  - ES 3: Educate/Empower (41.7%)
  - ES 8: Assure Workforce (43.8%)
  - ES 5: Develop Policies/Plans (50.0%)
- Two essential services averaged in the "Significant Contribution" (51-75%) range:
  - ES 2: Diagnose and Investigate (58.3%)
  - ES 7: Link to Health Services (62.5%)

The following table from the National Public Health Performance Standards generated report compares agency contribution scores to performance scores and sorts results by quadrant:

- Quadrant A: High Local Health Department (LHD) contribution score (50-100%), low performance score (0-49%)
- Quadrant B: High LHD contribution score (50-100%), high performance score (50-100%)
- Quadrant C: Low LHD contribution score (0-49%), high performance score (0-49%)
- Quadrant D: Low LHD contribution score (0-49%), low performance score (0-49%)

Quadrant	Model Standard	LHD Contribution (%)	Performance Score (%)
Quadrant A	9.3 Evaluation of LPHS	50.0	50.0
Quadrant A	8.4 Leadership Development	50.0	37.5
Quadrant A	8.3 Continuing Education	50.0	35.0
Quadrant A	8.2 Workforce Standards	50.0	50.0
Quadrant A	5.1 Governmental Presence	75.0	33.3
Quadrant A	3.2 Health Communication	50.0	33.3
Quadrant A	3.1 Health Education/Promotion	50.0	41.7
Quadrant A	1.1 Community Health Assessment	50.0	33.3
Quadrant B	10.2 Academic Linkages	50.0	58.3
Quadrant B	7.2 Assure Linkage	50.0	56.3
Quadrant B	7.1 Personal Health Services Needs	75.0	62.5
Quadrant B	5.4 Emergency Plan	75.0	100.0
Quadrant B	4.2 Community Partnerships	50.0	58.3
Quadrant B	2.3 Laboratories	50.0	100.0
Quadrant B	2.2 Emergency Response	50.0	87.5
Quadrant B	2.1 Identification/Surveillance	75.0	100.0
Quadrant C	6.3 Enforce Laws	25.0	75.0
Quadrant C	6.1 Review Laws	25.0	75.0
Quadrant C	1.3 Registries	25.0	75.0
Quadrant D	10.3 Research Capacity	25.0	25.0
Quadrant D	10.1 Foster Innovation	25.0	31.3
Quadrant D	9.2 Evaluation of Personal Health	25.0	30.0
Quadrant D	9.1 Evaluation of Population Health	25.0	25.0
Quadrant D	8.1 Workforce Assessment	25.0	25.0
Quadrant D	6.2 Improve Laws	25.0	50.0
Quadrant D	5.3 CHIP/Strategic Planning	25.0	8.3
Quadrant D	5.2 Policy Development	25.0	41.7
Quadrant D	4.1 Constituency Development	25.0	50.0
Quadrant D	3.3 Risk Communication	25.0	41.7
Quadrant D	1.2 Current Technology	25.0	33.3

Discussion Notes

Following are the discussion notes, which provide insight into the leadership team's rational for determining contribution scores, as well as highlights of the agency's strengths and challenges.

1.1. Population-based Community Health Assessment

- Have been tenacious in inserting ourselves into the community-wide process.
- Lots of activity now. Some historically.

1.2. Current Technology to Manage and Communicate Population Health Data

- Have technology capability, but don't necessarily use it completely or to its full potential.
- Headed in this direction.

1.3. Maintenance of Population Health Registries

- We are participating in what is required and what is set up with our systems (e.g., sharing WIC with the state is automatic.) Most registries are housed at the state.
- We do use some of these data for decision-making.

2.1. Identifying and Surveillance of Health Threats

- Epi team does a good job.
- Timeliness is main drawback in contribution score.

2.2. ***Investigation and Response to Public Health Threats and Emergencies***

- Investigation: good. But don't see ourselves doing a lot of these.
- Refer a lot. Know who to turn emergency over to. Don't do them [most emergency responses] directly.
- Don't currently list all resources on website for easy referral.

2.3. Laboratory Support for Investigation of Health Threats

- Use only licensed and credentialed labs, have access to what we need.
- Not 24/7, but if there were an urgent weekend or evening need, people probably wouldn't come here, they would go to an urgent care facility.
- Do a good job working with the labs during business hours.
- What we do, do well and completely, just don't do all the time (24/7).

3.1. Health Education and Promotion

- Doing this. We aren't seen in the community as the lead, but we should be.
- Katy is doing a lot related to physical activity and nutrition, but the RCHD is not always seen as a lead in this area and should be communicating more broadly on other issues.
- In our own little corner, need to get "out" in community more.
- Need to be more comprehensive.
- For upcoming, planning on doing 3.1.3 well. (3.1.3 is "engage the community throughout the process of setting priorities, developing plans and implementing health education and health promotion activities?")

3.2. Health Communication

- Good relationship with Manhattan Mercury and KMAN.
- We don't utilize K-State and smaller media outlets as much as could.
- Don't have a dedicated spokesperson. Because of this, things aren't as timely as they could be.

3.3. Risk Communication

- Resources are available for rapid communication response.
- Think we could do better at providing risk communication training for all volunteers. Status of plan, but not very "deep".
- Disappointed that fire department set up Ebola meeting but that we didn't. (RCHD was in the midst of forming a thoughtful response and didn't want to be reactionary.)
- Think our communication "out" related to risk isn't the best.
- Not as timely as we need to be.
- Social media – could be more regular and comprehensive if had someone dedicated.

4.1. Constituency Development

- Have some lists of constituents, but these are by program.
- Not completely coordinated.
- Don't have an established process.
- Have tried to encourage constituents.
- Do have Symposiums.
- Have Local public health advisory board.
- Flint Hills Wellness Coalition – but don't get a lot of community member support.

4.2. Community Partnerships

- Good strategic alliance for nutrition and physical activity, but this is one tiny area of community partnerships. It's not comprehensive. We do have good training on competencies for this grant.
- Comprehensive and broad based – think we are doing some things, but not comprehensive and not as broad as they need to be.
- Public Health Advisory Committee is not a cohesive group and this group does not even completely support the health department.
- Good relationship with Wildcat region, Ft. Riley.
- Geary County – perinatal health alliance.
- Mental health task force.
- Everything is very topical, but sometimes this is important – it is what moves people (i.e., particular interest areas) so need to build on this.

5.1. Governmental Presence at the Local Level

- Riley County was named Public Health County of the Year.
- Strong Board of Health.
- RCHD did provide initial budget report in 2013.
- We wouldn't be doing this work without the governmental presence at the local level, and RCHD staff initially made this case for this, then we were able to get this approved initially.
- We could be working more with other city commissioners and mayors.

5.2. Public Health Policy Development

- Developed policy for rabies.
- Not reviewing existing policies every 3-5 years because have some that haven't been reviewed within that time period (or ever). But…
- Breva does well with this (child care licensing); she reviews policies constantly.
- Title X policies are updated every year (except not in the last 2), then have to incorporate into our policies to match theirs (state/national).
- Kayla reviews and updates policies related to immunization.
- As policies become available through funding streams or programmatically, RCHD polices are updated as appropriate.
- Programmatic policies are reviewed annually. But health departmental-wide policies are non-existent or not reviewed on as regular a basis.
- Policies in the health department (versus programs) need to be either reviewed or created. Minimal of those types of policies
- Also rely on county personnel and fiscal policies (e.g., aging of accounts.)
- Health impact – haven't created a lot of voice in that. Potential to do more.
- Jason did the air quality assessment.
- 5.2.2 has been hard to do. ("Alert policymakers and the community of the possible public health impacts, both intended and unintended, from current and/or proposed policies.")

5.3. Community Health Improvement Process and Strategic Planning

- Currently in-process.
- Feel like we are light years away from updating a strategic plan to coincide with a CHIP, considering we don't have either one. But it's on our radar.

5.4. Plan for Public Health Emergencies

- Jason does a lot of this but people don't know what he does.
- Not on daily radar for most of staff.
- Jason trying to get the LHD staff prepared internally.
- Do regular drills.
- Workgroup meets monthly.

6.1. Review and Evaluation of Laws, Regulations and Ordinances

- Don't think we stay up on laws and regulations that could impact the public health system if not directly related or forwarded to us
- Current work is not comprehensive
- Do have access to legal council
- Rely on programs at the state level to inform what has and hasn't changed (e.g., immunization program at the state level).
- If relying on another source to keep us informed, this is not necessarily the best.
- We're all on listservs, but we don't always take action or share information.
- We are fragmented.
- Community doesn't look to us as a lead in advising on related policy and don't appreciate the knowledge base that we could offer.
- Funding also speaks a lot for policy.
- *Voting range/comments: Lower end of minimal – about 10%. Not 25%.*

6.2. Involvement in the Improvement of Laws, Regulations and Ordinances

- See several of above comments for 6.1.
- Patty did rabies ordinance.
- Brenda is working with Clancy on quarantine and isolation.
- Katy is working on smoke-free LHD campus and playgrounds in Riley Co.
- Contribute....would like to contribute more and our contributions are sometimes met with resistance.

6.3. Enforcement of Laws, Regulations, and Ordinances

- We don't have any laws for people to comply with...no, on the contrary, there are a lot of public health laws!
- Breva is enforcing regulations related to child care.
- TB, for example: if non-compliant, would have the right to have them arrested.
- Mandatorily monitor some activities.
- Can close down a daycare.
- No longer oversee restaurants.
- Have the laws to monitor but don't always initiate enforcement.
- Don't educate people about the laws *before* there is an issue.
- Don't evaluate.
- Struggle having physicians report for disease investigation. They don't always want to comply. This is difficult because they are also a partner.
- If disease is identified in manner other than laboratory, it can be a challenge. Labs are required to report, but physicians don't always.

7.1. Identification of Personal Health Service needs of Populations

- LHD does a good job of identifying need.
- Shortfall in agency contribution is assuring linkage.
- Disagree- think we do a good job with linkages.
- We do referrals, but we don't always have time to follow-up and assure that the linkage was actually made. Don't do follow-up.
  Have identified and understand partners' role.
- On community needs assessment survey, don't know if we did get saturation in that survey to fully understand needs.
- For people that come into the health department, do identify needs.
- We do know our resources in the community, though. We do identify.

7.2. Linkage of People to Personal Health Services

- Think we do this...not sure that we follow-up. For example, for WIC, can identify and connect people to infant-toddler services. Have done the referral to infant toddler services. Six months later when they come back in, that's when the follow-up takes place versus sooner. Timeliness of follow-up may not be happening. Level of referral depends on the situation (e.g., making an appointment or walking them over versus giving them info only.)
- For clinic area, we do great handoffs to other internal programs, do less great handoffs to other external programs.

8.1. Workforce Assessment, Planning and Development

- State did a workforce assessment.
- "I don't know anything about this."
- I don't know that we've done anything to address gaps in the local public health workforce.
- Interns, nursing students – helping to fill gaps by promoting public health and training the next generation.
- Think we are at workforce assessment stage because Brenda ideally wants us to use the tool to assess our gaps, but we aren't at the development part.
- 8.1.1 ("Set up a process and a schedule to track the numbers and types of LPHS jobs and knowledge…") don't see how this is useful because public health entity isn't one organization that hires people at public health
- Is the county doing this?
- Feel that we don't do this.
- What do we need, and what are we lacking in the health department? We need IT and epi. What competencies are we missing? Right now, we're at the assessment phase.
- KDHE sent out a LHD workforce competency type survey out.
- *Votes were NO and MINIMAL.*

8.2. Public Health Workforce Standards

- Job descriptions driven by task-based and needs-based rather than competencies.
- 8.2.3 ("Base the hiring and performance review of…public health workforce…in public health competencies?) Currently hiring based on technical tasks and abilities to perform tasks, but see that changing more towards competencies.
- Think leadership now is geared towards having staff think about public health vs. a particular program.
- Prior to this administration it was compartmentalized and you didn't go outside your dept. You were competent about what you did but you didn't know much outside your program. Now, moving towards broad public health competencies.
- Have to make sure we hire people who are certified/licensed in their tasks. We do this well. We do have job descriptions based on tasks.
- If created a health department to address all the essential services, it would look different than we look now…but think we are headed in that direction.

8.3. Life-Long Learning through Continuing Education, Training, and Mentoring

- Some of leadership team is highly encouraged to do education and training but it doesn't always trickle down to all staff.
- Think it is at the leadership level now, and leadership is supportive of training, but not everyone is doing training.
- More training opportunities are coming.
- Leadership is developing more of those skills.
- Some of the training has been technical or programmatic versus public health professional development.
- Have been very compartmentalized and departmentalized until the last several months.

8.4. Public Health Leadership Development

- Director telling people to participate in leadership development.

- Think doing a good job getting info out there.
- Providing opportunities for leadership, getting people to present to board.
- 8.4.4. ("Provide opportunities for the development of leaders representative of the diversity within the community") – not really doing this. Don't have a lot of diversity.
- Think we do well internally with 8.4.1 ("Provide access to formal and informal leadership development opportunities…") and 8.4.3 ("Ensure that organizations and individuals have opportunities to provide leadership…".
- 8.4.2 ("Create a shared vision…") tweets helped focus vision. Common theme. Expressed on website.
- Staff have been given opportunity to go out in public and share what we are doing.
- Much more significant than in the past.
- *Votes ranged from moderate to significant.*

9.1. Evaluation of Population-Based Health Services

- Are we doing this? Don't know much about this.
- Everybody Counts: does this provide any helpful info related to this model standard? Really specific to homeless population. What they captured in January (just counts) was reliable, but summer numbers were not reliable.
- Maybe MCH patient/client satisfaction survey cards…but this is not population-based.

9.2. Evaluation of Personal Health Services

- From our contribution, feels pretty good. Just got quarterly evaluation of personal health services data. Using technology. Looking at data. Staff using established guidelines.
- Now, if it is out how we contribute to the system, availability and effectiveness in overall system – there are gaps.
- As far as how we are doing internally with our services, doing well.
- Don't contribute to surveys for primary care and dental shortage areas, but not contributing to these data.
- What we are doing in house, how we are evaluating in house – good.
- How we are evaluating contributing to entire system – not as big a contribution.

9.3. Evaluation of the Local Public Health System

- What we did June 11th definitely contributes to this.
- In process of using results.

10.1. Fostering Innovation

- Inching towards this but not there.
- Depends on what sector of the public health system we're looking at.
- Linda's team getting ready to do research based on Becoming a Mom.
- Have we suggested research to KHI (for example)? Not really…

10.2. Linkage with Institutions of Higher Learning and/or Research

- Feel like we're doing a pretty good job with this.
- Don't see K-State as trickling down new evidence-based practices they are finding.
- Do link with students.

- Don't have many formal MOUs with K-State to have students. Has been mostly informal up to this point.
- Do have some formal arrangements with Baker, Manhattan Technical, plus also K-State. So, yes, some formalized written agreement with K-State and others.
- Have had some formal research questions, but don't have an IRB process.
- Have had requests from K-State to have WIC participants be part of a study.

10.3. Capacity to Initiate or Participate in Research

- Good intentions, but not doing this now.
- Starting some things.
- Haven't done a lot of evaluation on processes to be able to share best practices.
- Have not frequently written articles, presented posters, or given conference presentations, but think will do more of these activities going forward.
- MPH reports.
- Becoming a Mom data.
- Huge potential to do this but haven't really tapped into this yet.

Closing Observations from Participants

All participants were asked to provide their overall observations of the process or results. Here are their responses:

- Moving toward being more public-health minded versus departmentally focused. Each staff member is going to be more a part of the whole public health system. Is a cultural shift for the agency away from a department/program focus. This is where we are going, and it is a good place to go. Think people will be able to do their jobs better with more comprehensive knowledge of the public health system.
- Once our community partnership, perception, reputation in the community improves, we can do this better [contribute more].
- Think the agency has come a long way. We may only have minimal to moderate contribution in some areas, but this is a long way from where we were!
- Earning trust with Mercy Regional, earning trust with Women's Health Group – think these linkages are critical to health outcomes of babies in this community.
- Not just educating ourselves within the health department and how we all fit in, but also working with the community so they understand how all this fits in with the essential services and public health. We are doing this, and the first step is getting our staff to understand this.
- LPHSA was a teaching tool for community and think it was essential that we do this [contribution questionnaire] internally to see how we are doing [as a department]. Think in 5 years or so, it would be good to do as a whole staff and not just the leadership team. Hopefully the whole staff will then see the value of the whole public health system and ten essential services.
- Maximum contribution does not equal excellent work. It is the contribution to the system, not the quality of our work. We can't provide all things to all people.
- We have resource constraints so couldn't get to maximum in some areas, plus in some areas we don't NEED to provide a maximum contribution. Another partner in the system is taking the lead.

The facilitator and intern observers to the process both felt that the staff were very hard on themselves in scoring their current contribution.

Next Steps

Going forward, the director challenged staff to think about how these results are communicated. "Be prepared to answer that if we are doing minimal or moderate, why is that?"

The director also shared, "It will be good for staff to review results and talk about where our focus is, where our focus needs to be. This can be part of our strategic planning process."

On October 30th, the leadership team is traveling to KHI for strategic planning technical assistance. These results will be used to help inform strategic planning going forward.