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.