



State Public Health System Performance Assessment

Report of Results

Kansas Department of Health And Environment - External

11/29/2012



Our Vision: Healthy Kansans living in safe and sustainable environments.

Our Mission: To protect and improve the health and environment of all Kansans

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The following national and local health department representatives were critical partners in planning and convening the Kansas state assessment. The KDHE NPHPSP Planning Committee acknowledges their contributions.

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Disclaimer

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National Public Health Performance Standards Program State Assessment – External Partners

Executive Summary

The Kansas Department of Health and Environment (KDHE) conducted the National Public Health Performance Standards Program (NPHPSP) State Assessment November 2, 2012 concurrently with the Healthy Kansans 2020 (HK2020) process that began August 25, 2012. The HK2020 process <http://healthykansans2020.org/#&panel1-1> is a “collaborative, strategic planning effort aimed at identifying and adopting health priorities that will improve the health of all Kansans . . . [and] builds on the comprehensive, nationwide health promotion and disease prevention agenda, Healthy People 2020, to establish state-specific measures and initiatives” (HK2020, 2012, no page number). The NPHPSP uses assessment instruments developed collaboratively with national public health partners that represent organizations and individuals that use the performance standards in evaluating how a public health system or organization compares to a set of *optimal* standards. The standards are based on the Ten Essential Public Health Services (EPHS) (Appendix D) and are aligned with the Public Health Accreditation Board Standards and Measures <http://phaboard.org/>.

In 2008, the KDHE conducted the NPHPSP State Assessment Version 2.0 with an internal group of agency management and staff (Phase I) with the intent to conduct Phase II with external private and public entities using the same instrument spring 2009. That assessment was not conducted. The 2012 NPHPSP State Assessment was the opportunity to engage those key state agencies and partner organizations external to state health department which together with KDHE, comprise the state public health system. Version 2.0 of the NPHPSP State Assessment was selected as the 2012 assessment instrument due to the availability of online data submission and report generation. This would also provide some comparative data from the 2008 Phase I assessment which was completed by KDHE.

A core planning committee within KDHE began preparations for the NPHPSP State Assessment May 2012 working closely with the Centers for Disease Control’s (CDC) National Public Health Improvement Initiative (NPHII) <http://www.cdc.gov/stltpublichealth/nphii/index.html> Performance Officer with the Office for State, Tribal, Local, and Territorial Support (OSTLTS) to secure technical assistance to conduct the assessment. Denise Pavletic, Association of State and Territorial Health Officials (ASTHO), was the consultant to the KDHE and served as the keynote speaker at the retreat. Brenda Joly, University of Southern Maine and a consultant with ASTHO, conducted facilitator training for KDHE staff and local public health partners serving in as facilitators, time keepers, or note takers. Local public health department staff registered as participants in the state assessment was invited to participate in this training to strengthen their understanding of the process should they want to use the NPHPSP Local Assessment in their communities.

Dr. Robert Moser, KDHE Secretary, sent a letter of invitation (Appendix B) to 91 private and public key stakeholders (Appendix A) in October 2012. Immediately prior to the assessment, registered participants were sent information and resources to familiarize themselves with the NPHPSP process. Wichita State University was contracted to provide conference management services for the one-day retreat.

The November 2 retreat was held at the Topeka Ramada Inn. Each participant received an assigned packet that included an agenda (Appendix F), a list of invited and attending participants (Appendix A and C), a copy of the Ten Essential Services, and color coded voting cards to objectively score individual indicators (See Figure 1: Scoring of Essential Services, page 7). There were 68 total external partner participants (Appendix C) welcomed by Aaron Dunkel, KDHE Deputy Secretary followed by the keynote presentation by Denise

Pavletic, ASTHO. An overview of the day's agenda and the assessment process was provided by the KDHE's Center for Performance Management Director, Brenda Nickel and Office of Local Public Health Director, Jane Shirley. Participants were then directed to breakout rooms to join their assigned EPHS group (Appendix E) for the remainder of the retreat. The EPHS group assignments were based on the participant or their organization's expertise, knowledge, and experience with the public health standards being measured (Appendix D) with each group assigned a facilitator, a primary note taker, and a time-keeper/note taker. Subjective data regarding assets and barriers to attaining the standards was captured from participant comments (Appendix G). At the completion of the retreat, participants were invited to complete evaluations of the process (Appendix H).

The assessment data was submitted to the NPHPSP office at the CDC for tabulation immediately following the retreat with the final report generated by the CDC November 29, 2012. This document contains the full report which reflects the overall scoring of the Kansas Public Health System which is comprised of all public, private and voluntary entities that contribute to the delivery of essential population-level health services at the county, regional, and state-level. The 2012 NPHPSP results document the current performance of the Kansas public health system providing a baseline for future NPHPSP state assessments and a foundation for quality improvement activities to be implemented within the state's public health system, including the KDHE.

The opportunity to evaluate the current status of our state public health system from multiple internal and external perspectives will provide:

- Guidance as key stakeholders, policy makers, and Kansans identify leading health indicators to be addressed through the HK2020 process
- Opportunities to work collaboratively to develop improvement strategies for the state public health system to effectively implement the state health improvement plan
- Identify gaps in the state public health system which can be addressed through quality improvement with key partners to strengthen both the state health department and the community public health systems for a more integrated, effective system.

For additional information about the NPHPSP and to access a copy of the Kansas report, go to the KDHE Center for Performance Management's webpage <http://www.kdheks.gov/cpm/index.htm>

References

HK2020 (Healthy Kansans 2020). (2012). *What is Healthy Kansans 2020?* Retrieved from <http://healthykansans2020.com/index.asp#&panel1-2>



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The National Public Health Performance Standards Program

Kansas State Public Health System Performance Assessment

A. The NPHPSP Report of Results

I. INTRODUCTION

The National Public Health Performance Standards Program (NPHPSP) assessments are intended to help users answer questions such as "What are the activities and capacities of our public health system?" and "How well are we providing the Essential Public Health Services in our jurisdiction?" The dialogue that occurs in answering these questions can help to identify strengths and weaknesses and determine opportunities for improvement.

The NPHPSP is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites 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.

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
- Local Public Health Governance Performance Assessment Instrument.

The NPHPSP is a collaborative effort of seven national partners:

- Centers for Disease Control and Prevention, Office of Chief of Public Health Practice (CDC/OCPHP)
- 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)
- Public Health Foundation (PHF)

This report provides a summary of results from the NPHPSP State Public Health System Assessment (OMB Control number 0920-0557, expiration date: September 30, 2013). The report, including the charts, graphs, and scores, are intended to help sites gain a good understanding of their performance and move on to the next step in strengthening their public health system.

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II. ABOUT THE REPORT

Calculating the scores

The NPHPSP assessment instruments are constructed using the Essential Public Health Services (EPHS) as a framework. Within the State Instrument, each EPHS includes four 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. Each site's responses to these questions should indicate how well the model standard - which portrays the highest level of performance or "gold standard" - is being met.

Sites responded to assessment questions using the following response options below. These same categories are used in this report to characterize levels of activity for Essential Services and model standards.

Figure 1

Scoring of Essential Services

NO ACTIVITY	0% or absolutely no activity.
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.
SIGNIFICANT ACTIVITY	Greater than 50%, but no more than 75% of the activity described within the question is met.
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.

Using the responses to all of the assessment questions, a scoring process generates scores for each first-tier or "stem" question, model standard, Essential Service, and one overall score. The scoring methodology is available from CDC or can be accessed on-line at <http://www.cdc.gov/nphpsp/conducting.html>.

Understanding data limitations

Respondents to the self-assessment should understand what the performance scores represent and potential data limitations. All performance scores are a composite; stem question scores represent a composite of the stem question and sub question responses; model standard scores are a composite of the question scores within that area, and so on. 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 can be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes can 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

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interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Because of the limitations noted, the results and recommendations associated with these reported data should be used for quality improvement purposes. More specifically, results should be utilized for guiding an overall public health infrastructure and performance improvement process for the public health system. These data represent the collective performance of all organizational participants in the assessment of the state public health system. The data and results should not be interpreted to reflect the capacity or performance of any single agency or organization.

Presentation of results

The NPHPSP has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. Results are presented in a Microsoft Word document, which allows users to easily copy and paste or edit the report for their own customized purposes. Original responses to all questions are also available.

For ease of use, many figures in tables use short titles to refer to Essential Services, model standards, and questions. If in doubt of the meaning, please refer to the full text in the assessment instruments.

Sites may choose to complete two optional questionnaires - one which asks about priority of each model standard and the second which assesses the state public health agency's contribution to achieving the model standard. Sites that submit responses for these questionnaires will see the results included as an additional component of their reports. Recipients of the priority results section may find that the scatter plot figures include data points that overlap. This is unavoidable when presenting results that represent similar data; in these cases, sites may find that the table listing of results will more clearly show the results found in each quadrant.

III. TIPS FOR INTERPRETING AND USING NPHPSP ASSESSMENT RESULTS

The use of these results by respondents to strengthen the public health system is the most important part of the performance improvement process that the NPHPSP is intended to promote. Report data may be used to identify strengths and weaknesses within the state public health system and pinpoint areas of performance that need improvement. The NPHPSP User Guide describes steps for using these results to develop and implement public health system performance improvement plans. Implementation of these plans is critical to achieving a higher performing public health system. Suggested steps in developing such improvement plans are:

1. Organize Participation for Performance Improvement
2. Prioritize Areas for Action
3. Explore "Root Causes" of Performance Problems
4. Develop and Implement Improvement Plans
5. Regularly Monitor and Report Progress

Refer to the User Guide <http://www.cdc.gov/NPHPSP/PDF/UserGuide.pdf>, "After We Complete the Assessment, What Next?" for details on the above steps.

Assessment results represent the collective performance of all entities in the state public health system and not any one organization. Therefore, system partners should be involved in the

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discussion of results and improvement strategies to assure that this information is appropriately used. The assessment results can drive improvement planning within each organization as well as system-wide. In addition, coordinated and statewide use of the Local Instrument or Governance Instrument with the use of the State Instrument can lead to more successful and comprehensive improvement plans to address more systemic statewide issues.

Although respondents will ultimately want to review these results with stakeholders in the context of their overall performance improvement process, they may initially find it helpful to review the results either individually or in a small group. The following tips may be helpful when initially reviewing the results, or preparing to present the results to performance improvement stakeholders.

Examine performance scores

First, sites should take a look at the overall or composite performance scores for Essential Services and model standards. These scores are presented visually in order by Essential Service (Figure 1) and in ascending order (Figure 2). The report also provides composite scores for the four common model standards found in the State Instrument (Planning and Implementation; State-Local Relationships; Performance Management and Quality Improvement; and Public Health Capacity and Resources). Additionally, Figure 3 uses color designations to indicate performance level categories. Examination of these scores can immediately give a sense of the state public health system's greatest strengths and weaknesses.

Review the range of scores within each Essential Service and model standard

The Essential Service score is an average of the model standard scores within that service, and, in turn, the model standard scores represent the average of stem question scores for that standard. If there is great range or difference in scores, focusing attention on the model standard(s) or questions with the lower scores will help to identify where performance inconsistency or weakness may be. Some figures, such as the bar charts in Figure 4, provide "range bars" which indicate the variation in scores. Looking for long range bars will help to easily identify these opportunities.

Also, refer back to the original question responses to determine where weaknesses or inconsistencies in performance may be occurring. By examining the assessment questions, including the sub questions and discussion toolbox items, participants will be reminded of particular areas of concern that may most need attention.

Consider the context

The NPHPSP User Guide and other technical assistance resources strongly encourage responding jurisdictions to gather and record qualitative input from participants throughout the assessment process. Such information can include insights that shaped group responses, gaps that were uncovered, solutions to identified problems, and impressions or early ideas for improving system performance. This information should have emerged from the general discussion of the model standards and assessment questions, as well as the responses to discussion toolbox topics.

The results viewed in this report should be considered within the context of this qualitative information, as well as with other information. The assessment report, by itself, is not intended to be the sole "roadmap" to answer the question of what a state public health system's performance improvement priorities should be. The original purpose of the assessment, current issues being

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addressed by the state, and the needs and interests for all stakeholders should be considered.

Some sites have used a state public health improvement process or strategic plans to incorporate NPHPSP results into broader efforts. This often looks similar to process outlined in the community strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), which guides users in considering NPHPSP data within the context of three other assessments - community health status, community themes and strengths, and forces of change - before determining strategic issues, setting priorities, and developing action plans. See "Resources for Next Steps" for more about MAPP.

Use the optional priority rating and agency contribution questionnaire results

Sites may choose to complete two optional questionnaires - one which asks about priority of each model standard and the second which assesses the state public health agency's contribution to achieving of the model standard. The supplemental priority questionnaire, which asks about the priority of each model standard to the public health system, should guide sites in considering their performance scores in relationship to their own system's priorities. The use of this questionnaire can guide sites in targeting their limited attention and resources to areas of high priority but low performance. This information should serve to catalyze or strengthen the performance improvement activities resulting from the assessment process.

The second questionnaire, which asks about the contribution of the public health agency to each model standard, can assist sites in considering the role of the agency in performance improvement efforts. Sites that use this component will see a list of questions to consider regarding the agency role and as it relates to the results for each model standard. These results may assist the state public health agency in its own strategic planning and quality improvement activities.

IV. FINAL REMARKS

The challenge of preventing illness and improving health is ongoing and complex. The ability to meet this challenge rests on the capacity and performance of public health systems. Through well equipped, high-performing public health systems, this challenge can be addressed. Public health performance standards are intended to guide the development of stronger public health systems capable of improving the health of populations. The development of high-performing public health systems will increase the likelihood that all citizens have access to a defined optimal level of public health services. Through periodic assessment guided by model performance standards, public health leaders can improve collaboration and integration among the many components of a public health system, and more effectively and efficiently use resources while improving health intervention services.

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B. Performance Assessment Instrument Results

I. How well did the system perform the ten Essential Public Health Services (EPHS)?

Table 1: *Summary of performance scores by Essential Public Health Service (EPHS)*

EPHS		Score
1	Monitor Health Status To Identify Community Health Problems	69
2	Diagnose And Investigate Health Problems and Health Hazards	81
3	Inform, Educate, And Empower People about Health Issues	45
4	Mobilize Community Partnerships to Identify and Solve Health Problems	41
5	Develop Policies and Plans that Support Individual and Community Health Efforts	75
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	47
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	45
8	Assure a Competent Public and Personal Health Care Workforce	32
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	38
10	Research for New Insights and Innovative Solutions to Health Problems	30
Overall Performance Score		50

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Figure 1: Summary of EPHS performance scores and overall score

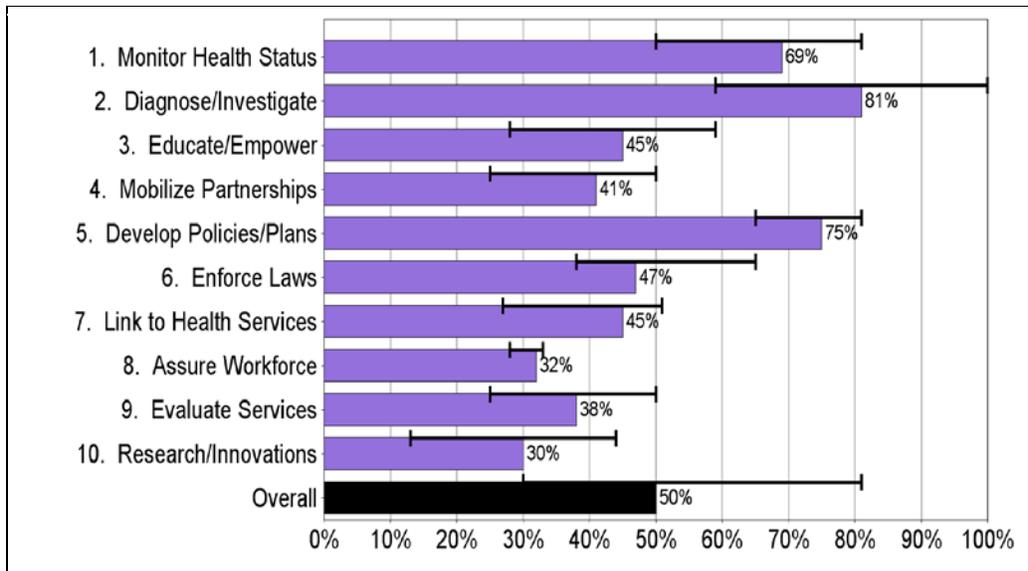


Table 1 (above) provides a quick overview of the system's performance in each of the 10 Essential Public Health Services (EPHS). Each EPHS score is a composite value determined by the scores given to those activities that contribute to each Essential Service. These scores range from a minimum value of 0% (absolutely no activity is performed pursuant to the standards) to a maximum of 100% (all activities associated with the standards are performed at optimal levels).

Figure 1 (above) displays performance scores for each Essential Service and an overall score for the average performance level for all 10 Essential Services. The range bars show the minimum and maximum value of responses within the Essential Service and overall score. Areas of wide range may warrant a closer look in **Figure 4** or the raw data.

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Figure 2: Rank ordered performance scores for each Essential Service

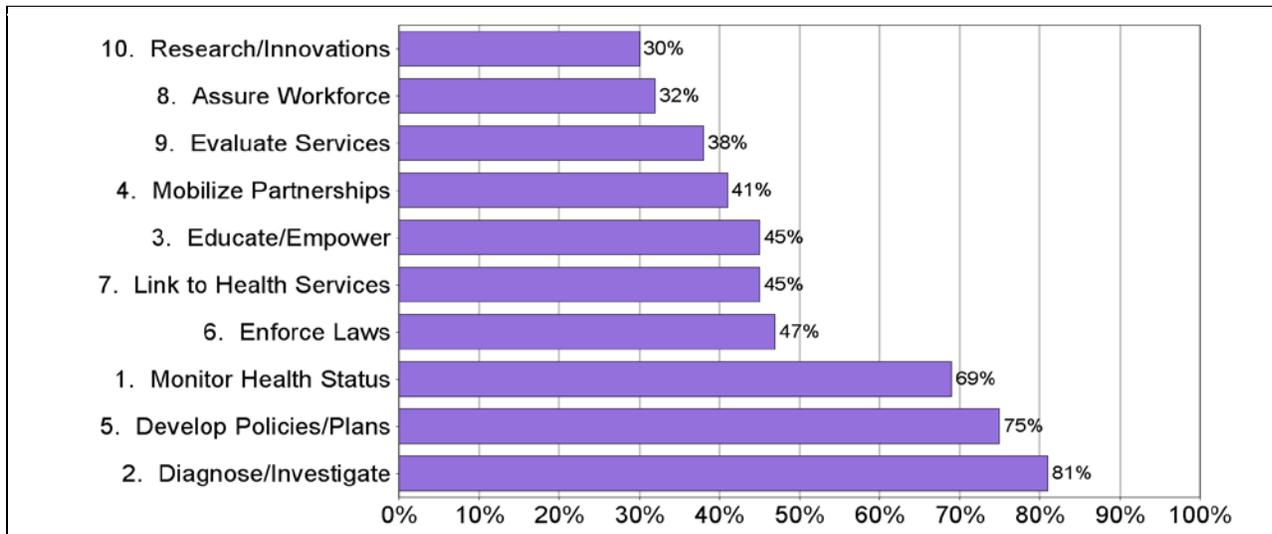


Figure 3: Rank ordered performance scores for each Essential Service, by level of activity

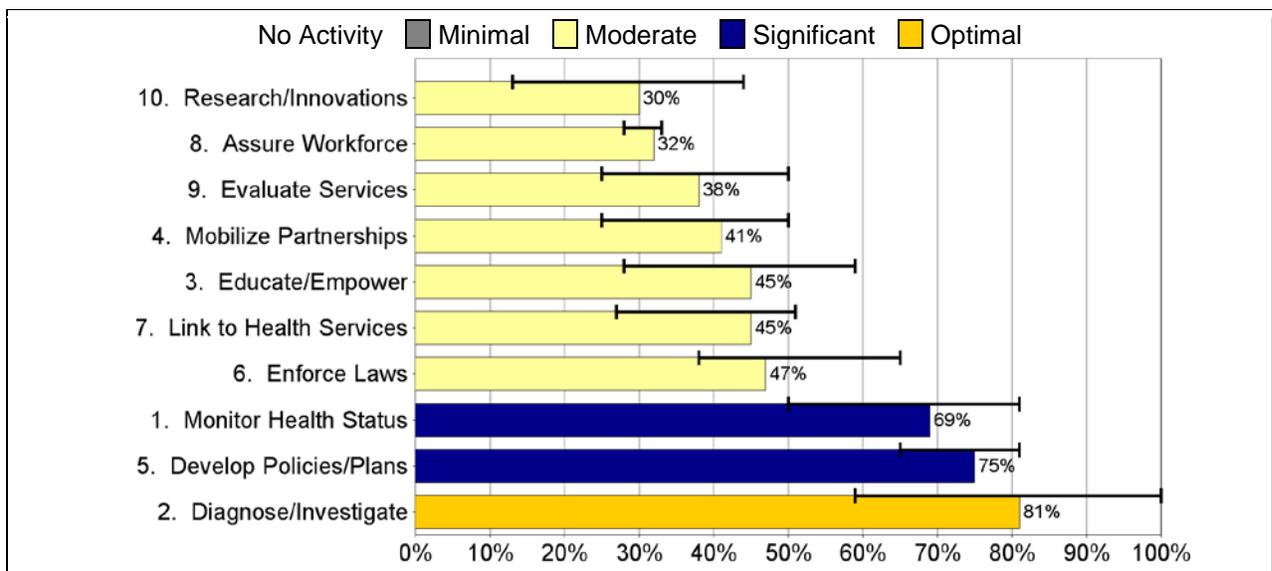


Figure 2: (above) displays each composite score from low to high, allowing easy identification of service domains where performance is relatively strong or weak.

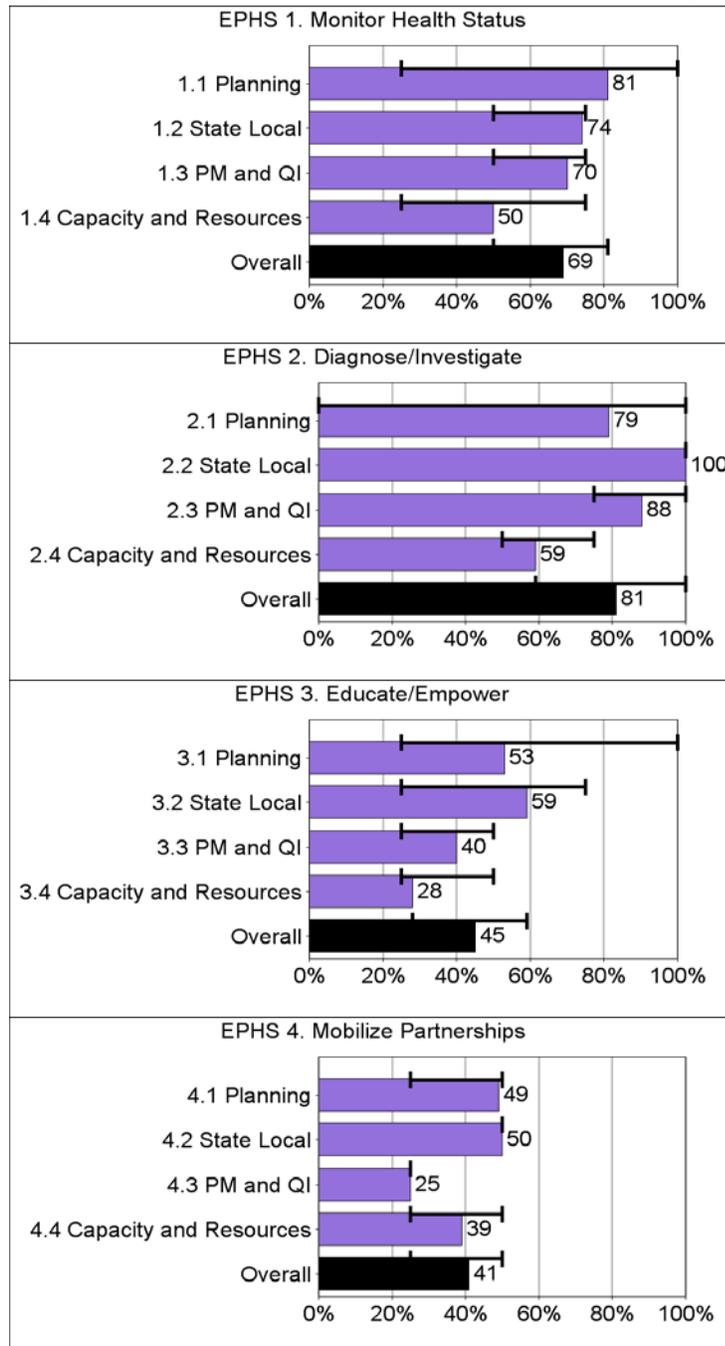
Figure 3: (above) provides a composite picture of the previous two graphs. The range lines show the range of responses within an Essential Service. The color coded bars make it easier to identify which of the Essential Services fall in the five categories of performance activity.

Figure 4: (next page) shows scores for each model standard. Sites can use these graphs to pinpoint specific activities within the Essential Service that may need a closer look. Note these scores also have range bars, showing sub-areas that comprise the model standard.

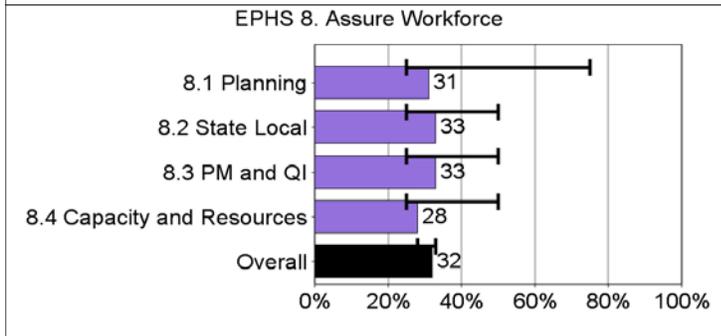
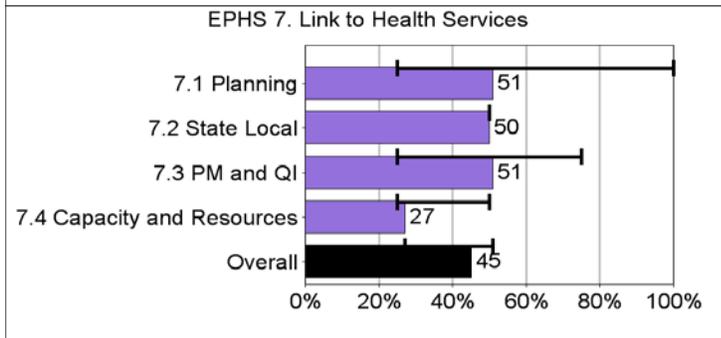
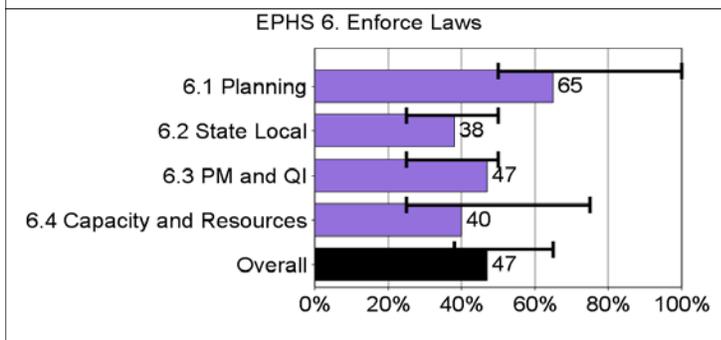
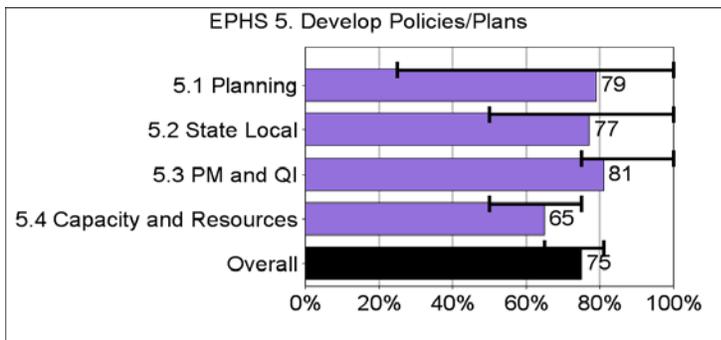
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II. How well did the system perform on specific model standards?

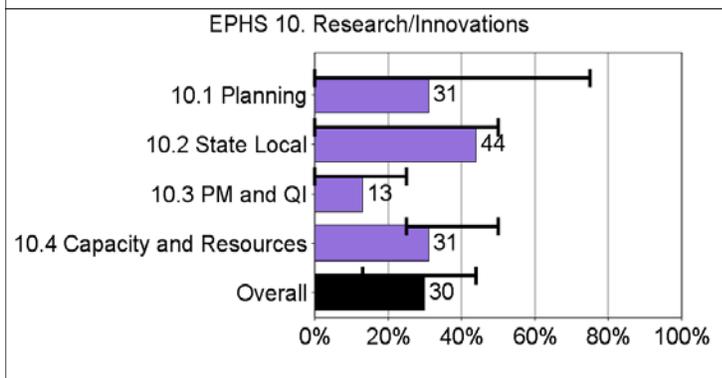
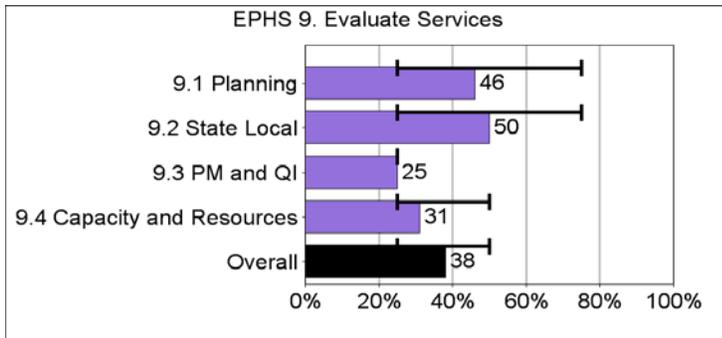
Figure 4: Performance scores for each model standard, by Essential Service



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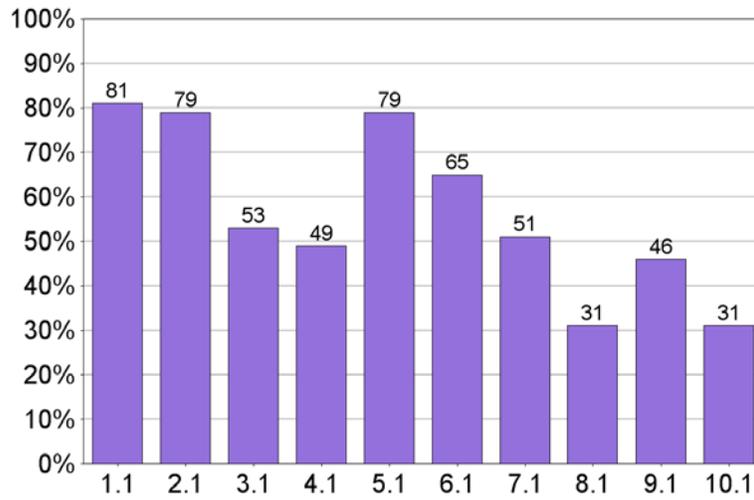


Figure 5: Model Standard 1 scores (Planning and Implementation) by Essential Service

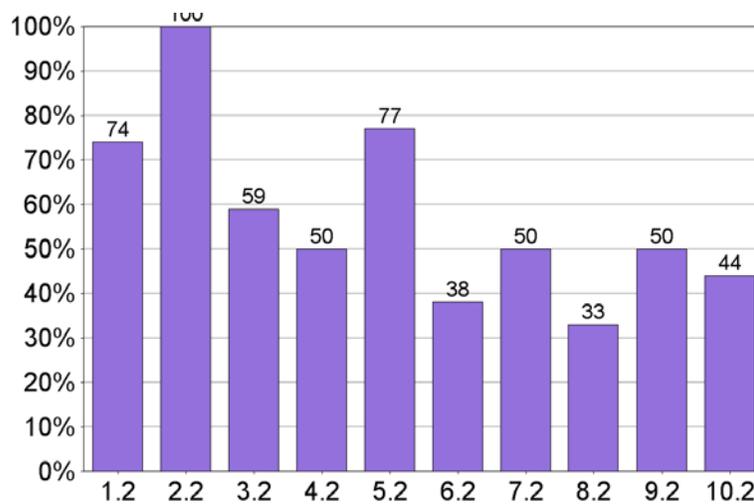


Figure 6: Model Standard 2 scores (State-Local Relationships) by Essential Service

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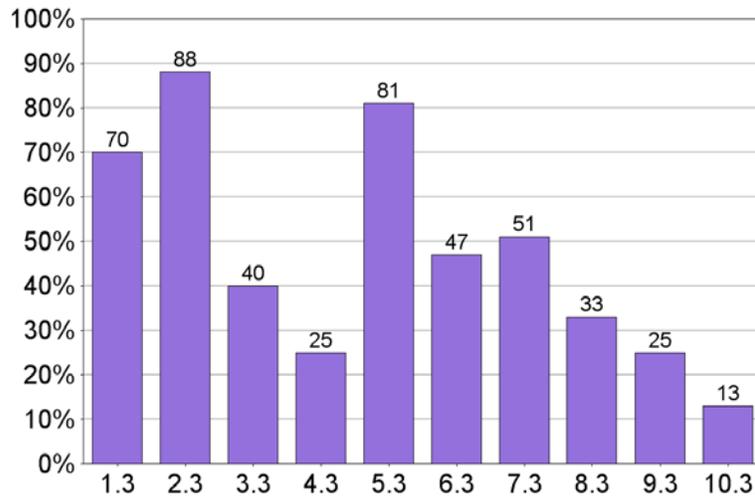


Figure 7: Model Standard 3 scores (Performance Management and Quality Improvement) by Essential Service

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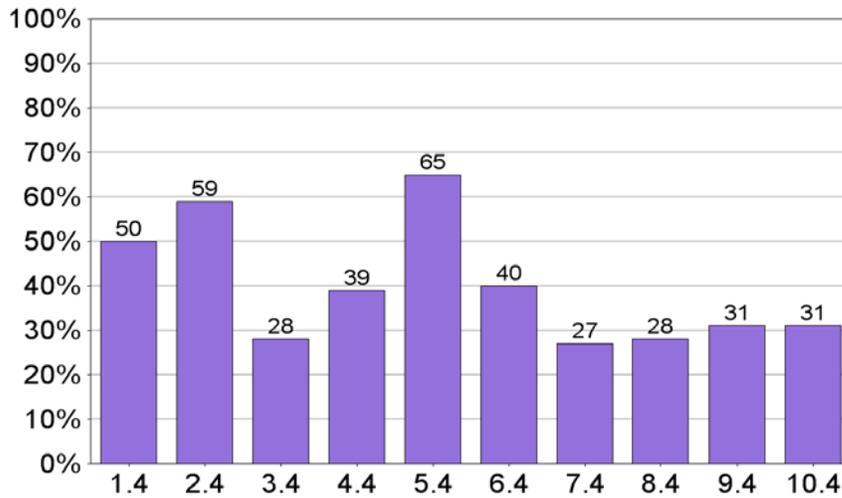


Figure 8: Model Standard 4 scores (Public Health Capacity and Resources) by Essential Service

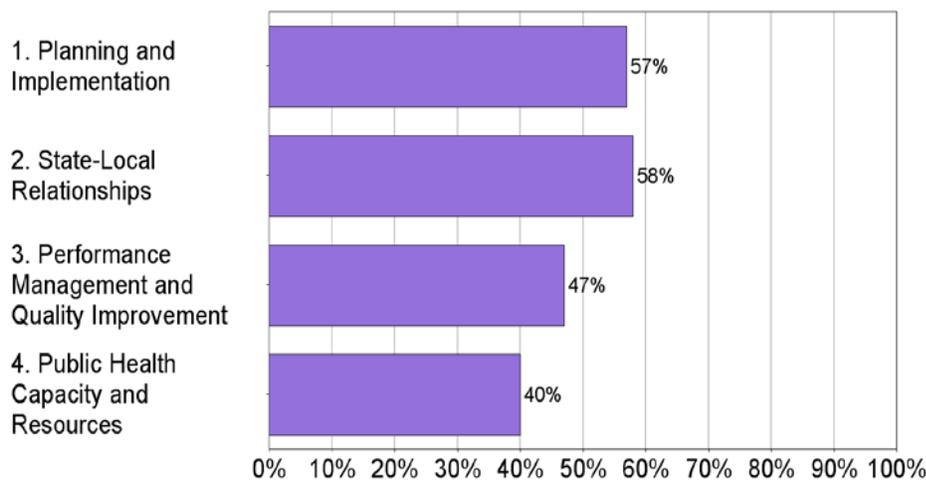


Figure 9: Summary of average scores across Model Standards

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Table 2: *Summary of performance scores by Essential Public Health Service (EPHS) and model standard*

Essential Public Health Service	Score
EPHS 1. Monitor Health Status To Identify Community Health Problems	69
1.1 Planning and Implementation	81
1.1.1 Surveillance and monitoring programs	69
1.1.2 Health data products accessible to data users	66
1.1.3 State health profile	75
1.1.4 Disease reporting system	97
1.1.5 Protection of personal health information	96
1.2 State-Local Relationships	74
1.2.1 Assistance in interpretation and use of health data	75
1.2.2 Uniform set of timely community-level health data	71
1.2.3 Assistance with local information and monitoring systems	75
1.3 Performance Management and Quality Improvement	70
1.3.1 Review effectiveness in monitoring efforts	66
1.3.2 Active performance management	75
1.4 Public Health Capacity and Resources	50
1.4.1 Commit financial resources	50
1.4.2 Coordinate system-wide organizational efforts	50
1.4.3 Workforce expertise	50
EPHS 2. Diagnose And Investigate Health Problems and Health Hazards	81
2.1 Planning and Implementation	79
2.1.1 Broad scope of surveillance programs	56
2.1.2 Enhanced surveillance capability	98
2.1.3 Statewide public health laboratory system	72
2.1.4 Laboratory analysis capabilities	75
2.1.5 Investigations of health problems	95
2.2 State-Local Relationships	100
2.2.1 Assistance with epidemiologic analysis	100
2.2.2 Assistance in using laboratory services	100
2.2.3 Guidance in handling public health problems and threats	100
2.2.4 Capability to deploy response teams to local areas, when needed	100
2.3 Performance Management and Quality Improvement	88
2.3.1 Review surveillance and investigation procedures	100
2.3.2 Active performance management	75
2.4 Public Health Capacity and Resources	59
2.4.1 Commit financial resources	50
2.4.2 Coordinate system-wide organizational efforts	71
2.4.3 Workforce expertise	56

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Essential Public Health Service	Score
<i>EPHS 3. Inform, Educate, And Empower People about Health Issues</i>	45
3.1 Planning and Implementation	53
3.1.1 Health education and promotion programs	50
3.1.2 Health communication programs	31
3.1.3 Emergency communications capacity	77
3.2 State-Local Relationships	59
3.2.1 Assistance with health communication and health education/promotion programs	43
3.2.2 Assistance in developing local emergency communication capabilities	75
3.3 Performance Management and Quality Improvement	40
3.3.1 Review effectiveness of health communication and health education/promotion efforts	30
3.3.2 Active performance management	50
3.4 Public Health Capacity and Resources	28
3.4.1 Commit financial resources	25
3.4.2 Coordinate system-wide organizational efforts	29
3.4.3 Workforce expertise	31
<i>EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems</i>	41
4.1 Planning and Implementation	49
4.1.1 Building statewide support for public health	48
4.1.2 Partnership organization and development	50
4.2 State-Local Relationships	50
4.2.1 Assistance in building collaborative skills	50
4.2.2 Incentives for local partnerships	50
4.3 Performance Management and Quality Improvement	25
4.3.1 Review effectiveness of partnerships	25
4.3.2 Active performance management	25
4.4 Public Health Capacity and Resources	39
4.4.1 Commit financial resources	25
4.4.2 Coordinate system-wide organizational efforts	47
4.4.3 Workforce expertise	44

State Public Health System Performance Assessment - Report of Results
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Essential Public Health Service	Score
EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts	75
5.1 Planning and Implementation	79
5.1.1 Convene collaborative planning processes	68
5.1.2 State health improvement plan	69
5.1.3 State all-hazards preparedness plan and emergency response capacity	100
5.1.4 Policy development activities	78
5.2 State-Local Relationships	77
5.2.1 Assistance and training for local planning	78
5.2.2 Assistance in integrating statewide strategies in community health improvement plans	50
5.2.3 Assistance in development of local preparedness plans	100
5.2.4 Assistance in local policy development	79
5.3 Performance Management and Quality Improvement	81
5.3.1 Monitor progress in health improvement	75
5.3.2 Review policies for public health impact	75
5.3.3 Exercises and drills to test preparedness plans	100
5.3.4 Active performance management	75
5.4 Public Health Capacity and Resources	65
5.4.1 Commit financial resources	75
5.4.2 Coordinate system-wide organizational efforts	71
5.4.3 Workforce expertise in planning	56
5.4.4 Workforce expertise in policy development	56
EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety	47
6.1 Planning and Implementation	65
6.1.1 Review of public health laws	50
6.1.2 Emergency powers	100
6.1.3 Cooperative relationships to support compliance	56
6.1.4 Customer-centered administrative processes	52
6.2 State-Local Relationships	38
6.2.1 Assistance on enforcement of laws	47
6.2.2 Assistance to local governing bodies in developing local laws	28
6.3 Performance Management and Quality Improvement	47
6.3.1 Review effectiveness of regulatory activities	44
6.3.2 Active performance management	50
6.4 Public Health Capacity and Resources	40
6.4.1 Commit financial resources	25
6.4.2 Coordinate system-wide organizational efforts	46
6.4.3 Workforce expertise	50

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Essential Public Health Service	Score
EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	45
7.1 Planning and Implementation	51
7.1.1 Assessment of access to care	72
7.1.2 Delivery of services and programs to improve access	52
7.1.3 SPHS entity responsible for monitoring and coordination	25
7.1.4 Mobilizes to reduce health disparities, including during emergency events	56
7.2 State-Local Relationships	50
7.2.1 Assistance in assessment and service delivery	50
7.2.2 Assistance for providers serving underserved populations	50
7.3 Performance Management and Quality Improvement	51
7.3.1 Review effectiveness of programs in improving access, appropriateness of personal health care, and health care quality	52
7.3.2 Active performance management	50
7.4 Public Health Capacity and Resources	27
7.4.1 Commit financial resources	25
7.4.2 Coordinate system-wide organizational efforts	25
7.4.3 Workforce expertise	31
EPHS 8. Assure a Competent Public and Personal Health Care Workforce	32
8.1 Planning and Implementation	31
8.1.1 Assessment of population-based and personal health care workforce needs	50
8.1.2 Statewide workforce development plan	25
8.1.3 Programs to enhance workforce skills	25
8.1.4 Assure excellence in professional practice of workforce members	28
8.1.5 Incentives for life-long learning	27
8.2 State-Local Relationships	33
8.2.1 Assistance with workforce assessment	25
8.2.2 Assistance with workforce development	25
8.2.3 Education and training to enhance local workforce skills	50
8.3 Performance Management and Quality Improvement	33
8.3.1 Review workforce development efforts	25
8.3.2 Review whether academic-practice partnerships are effective in preparing the workforce	50
8.3.3 Active performance management	25
8.4 Public Health Capacity and Resources	28
8.4.1 Commit financial resources	25
8.4.2 Coordinate system-wide organizational efforts	29
8.4.3 Workforce expertise	31

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Essential Public Health Service	Score
EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	38
9.1 Planning and Implementation	46
9.1.1 Evaluate population-based health programs	27
9.1.2 Evaluate personal health care services	54
9.1.3 Assess the performance of the public health system	58
9.2 State-Local Relationships	50
9.2.1 Assistance on evaluation	75
9.2.2 Share state evaluation results to assist local planning	25
9.3 Performance Management and Quality Improvement	25
9.3.1 Review the effectiveness of evaluation activities	25
9.3.2 Active performance management	25
9.4 Public Health Capacity and Resources	31
9.4.1 Commit financial resources	25
9.4.2 Coordinate system-wide organizational efforts	25
9.4.3 Workforce expertise	44
EPHS 10. Research for New Insights and Innovative Solutions to Health Problems	30
10.1 Planning and Implementation	31
10.1.1 Academic-practice collaboration to disseminate and use research findings in practice	23
10.1.2 Public health research agenda	0
10.1.3 Conduct and participate in research	71
10.2 State-Local Relationships	44
10.2.1 Assistance in research activities, including community-based participatory research	45
10.2.2 Assistance in using research findings	44
10.3 Performance Management and Quality Improvement	13
10.3.1 Review research activities for relevance and appropriateness	0
10.3.2 Active performance management	25
10.4 Public Health Capacity and Resources	31
10.4.1 Commit financial resources	25
10.4.2 Coordinate system-wide organizational efforts	25
10.4.3 Workforce expertise	44

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III. Overall, how well is the system achieving optimal activity levels?

Figure 10: *Percentage of Essential Services scored in each level of activity*

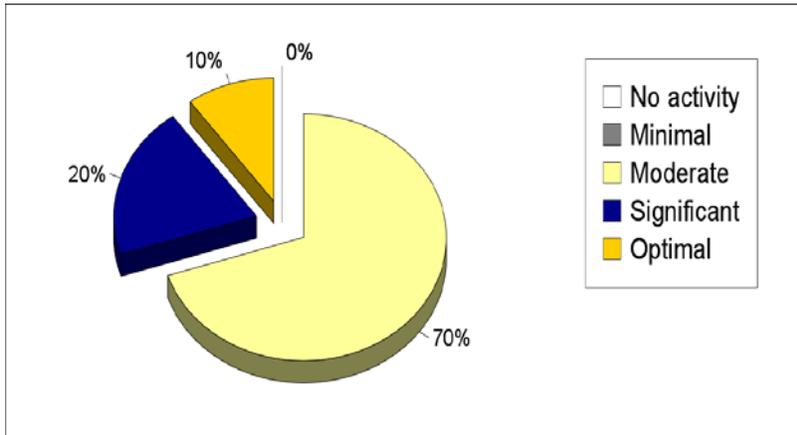


Figure 10: displays the percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides the site with a high level snapshot of the information found in **Figure 3**.

Figure 11: *Percentage of model standards scored in each level of activity*

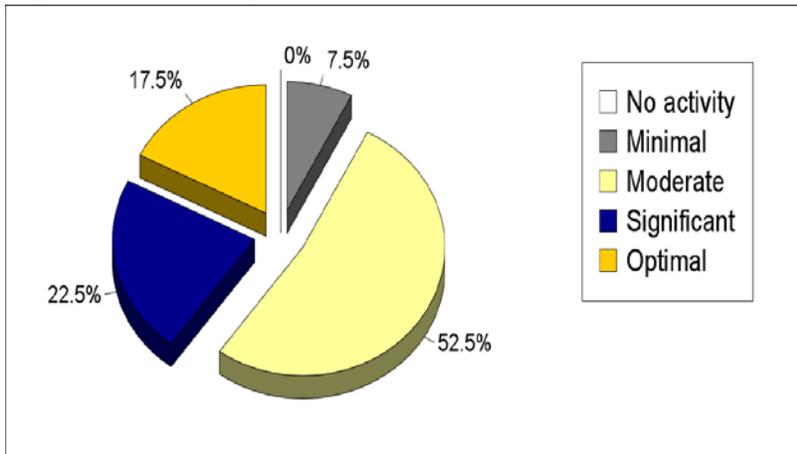


Figure 11: displays the percentage of the system's Model Standard scores that fall within the five activity categories.

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Figure 12: *Percentage of all questions scored in each level of activity*

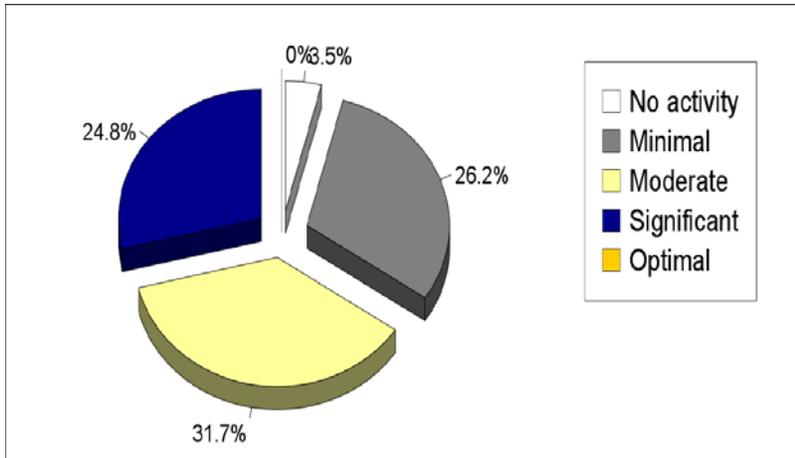


Figure 12: displays the percentage of all scored questions that fall within the five activity categories. This breakdown provides a closer snapshot of the system's performance, showing variation that may be masked by the scores in **Figures 10 and 11.**

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C. Resources for Next Steps

The NPHPSP offers a variety of information, technical assistance, and training resources to assist in quality improvement activities. Descriptions of these resources are provided below. Other resources and websites that may be of particular interest to NPHPSP users are also noted below.

- **Technical Assistance and Consultation** - NPHPSP partners are available for phone and email consultation to state and localities as they plan for and conduct NPHPSP assessment and performance improvement activities. Contact 1-800-747-7649 or phpsp@cdc.gov.
- **NPHPSP User Guide** - The NPHPSP User Guide section, "After We Complete the Assessment, What Next?" describes five essential steps in a performance improvement process following the use of the NPHPSP assessment instruments. The NPHPSP User Guide may be found on the NPHPSP website (<http://www.cdc.gov/NPHPSP/PDF/UserGuide.pdf>).
- **NPHPSP Online Tool Kit** - Additional resources that may be found on, or are linked to, the NPHPSP website (<http://www.cdc.gov/NPHPSP/generalResources.html>) under the "Post Assessment/ Performance Improvement" link includes sample performance improvement plans, quality improvement, priority-setting tools, and other technical assistance documents and links.
- **NPHPSP Online Resource Center** - Designed specifically for NPHPSP users, the Public Health Foundation's online resource center (www.phf.org/nphpsp) for public health systems performance improvement allows users to search for State, Local, and Governance resources by model standards, essential public health service, and keyword.
- **NPHPSP Monthly User Calls** - These calls feature speakers and dialogue on topic of interest to users. They also provide an opportunity for people from around the country to learn from each other about various approaches to the NPHPSP assessment and performance improvement process. Calls occur on the third Tuesday of each month, 2:00 - 3:00 ET. Contact phpsp@cdc.gov to be added to the email notification list for the call.
- **Annual Training Workshop** - Individuals responsible for coordinating performance assessment and improvement activities may attend an annual two-day workshop held in the spring of each year. Visit the NPHPSP website (<http://www.cdc.gov/nphpsp/annualTrainingWorkshop.html>) for more information.
- **Public Health Improvement Resource Center at the Public Health Foundation** - This website (www.phf.org/improvement) provides resources and tools for evaluating and building the capacity of public health systems. More than 100 accessible resources organized here support the initiation and continuation of quality improvement efforts. These resources promote performance management and quality improvement, community health information and data systems, accreditation preparation, and workforce development.
- **Mobilizing for Action through Planning and Partnerships (MAPP)** - MAPP has proven to be a particularly helpful tool for sites engaged in community-based health improvement planning. Systems that have just completed the NPHPSP may consider using the MAPP process as a way to launch their performance improvement efforts. Go to www.naccho.org/topics/infrastructure/MAPP to link directly to the MAPP website.

APPENDICES

A. Invitation from Robert Moser, MD, Secretary and State Health Officer

Curtis State Office Building
1000 SW Jackson St., Suite 540
Topeka, KS 66612-1367



Phone: 785-295-6161
Fax: 785-368-6188
www.kdheks.gov

Robert Moser, MD, Secretary

Department of Health & Environment

Sam Brownback, Governor

October 12, 2012

Dear Kansas Health Leader and Advocate,

The Kansas Department of Health and Environment (KDHE) is participating in the Centers for Disease Control and Prevention (CDC) National Public Health Performance Standards Program (NPHSP) to strengthen public health systems. It is my pleasure to invite you to participate in a one-day meeting to review, discuss, and evaluate the current status of our state public health system from your perspective as a Kansas health leader and advocate. We will be joined by Denise M. Pavletic MPH, Director, Public Health Systems Improvement, Association of State and Territorial Health Officers. The meeting location and date are as follows:

Location: Ramada Inn Topeka, 420 Southeast 6th Avenue, Topeka, KS 66607
Date: Friday, November 2, 2012
Time: 8:00 a.m. until 4:00 p.m.

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

The Kansas health system is made up of all public, private and voluntary entities that contribute to the delivery of essential population-level health services at the county, regional, and state-level. With input and support from your work and other partners in the Kansas, the information we gather will help to inform the Healthy Kansans 2020 (HK2020) <http://healthykansans2020.org/> Steering Committee's work to develop the blueprint for an integrated health system in which you play an important role. This important one-day meeting will also include KDHE staff that will be using the NPHSP state assessment tool on November 1 to identify state health department perspective of the system and will be available to answer questions about the core functions or essential services in a population health system.

The CDC will analyze both assessments with feedback provided in the form of two separate reports that can be used to identify strengths and weaknesses, and help for statewide planning to address the recommendations from the HK2020 process. The final report will be made available to all meeting participants. You can view information about the NPHSP at <http://www.cdc.gov/nphsp/index.html>. Registered participants will receive additional information prior to the meeting.

Please RSVP no later than Friday, October 19, 2012 at www.wichita.edu/conferences/ksnphsp. In order for our assessment to be thorough and complete, if you are unable to attend please delegate an appropriate replacement to register at the link above. If you have questions, please contact the meeting organizers: Brenda Nickel bnickel@kdheks.gov or Jane Shirley jshirley@kdheks.gov. I look forward to your participation in identifying those assets and opportunities for improving health of Kansans!

Sincerely,



Robert Moser, M.D.
Secretary/State Health Officer

KDHE External Stakeholder Invitation Letter_CPM

B. National Public Health Performance Standards Program Day 2- Invitees

Name	Organization
1. Kevin Walker	American Heart Association
2. Mary Beth Warren	Area Health Education Centers, KUMC
3. Matt All	Blue Cross Blue Shield of Kansas
4. Leadell Ediger	Child Care Aware, Inc.
5. Jim Redmon	Children's Cabinet
6. Jennifer Burns	Coventry Health Care of Kansas, Inc.
7. Mary Lou Jarmillo	El Centro, Inc.
8. John Armbrust	Governor's Military Council
9. Steve Roling	Health Care Foundation of Greater Kansas City
10. Deborah Boulware O'Neal	Health Literacy Kansas Advisory Council
11. Terri Williams	Juvenile Justice Authority
12. Christian Cupp	Kansas Academy of Family Physicians
13. Suzanne Wikle	Kansas Action for Children
14. Mildred Edwards	Kansas African American Affairs Commission
15. Cathy Harding	Kansas Association for the Medically Underserved
16. Michelle Ponce	Kansas Association of Local Health Departments
17. John Heim	Kansas Association of School Boards
18. Bob Hull	Kansas Center for Safe and Prepared Schools
19. Pam Shaw	Kansas Chapter of the American Academy of Pediatrics
20. Katherine Melhorn	Kansas Child Death Review Board
21. Angela Nordhus	Kansas Child Death Review Board
22. Vickie Roper	Kansas Children's Service League
23. Nicole Morrow	Kansas City Urban Youth Center
24. Martha Gabehart	Kansas Commission on Disability Concerns
25. Kevin Robertson	Kansas Dental Association
26. Jill Gottschamer	Kansas Dental Hygienist Association
27. Shawn Sullivan	Kansas Department for Aging and Disability Services
28. Phyllis Gilmore	Kansas Department for Children and Family Services
29. Sarah Green	Kansas Department of Agriculture
30. Pat George	Kansas Department of Commerce
31. Cindy Nau	Kansas Department of Commerce - Kansas Works
32. Sharon Watson	Kansas Department of Emergency Management
33. Lana Gordon	Kansas Department of Labor
34. Ed Kalas	Kansas Environmental Health Association
35. Steve Coen	Kansas Health Foundation
36. Bruce Miyahara	Kansas Health Foundation
37. Catherine C. Shoults	Kansas Health Institute
38. Tatiana Lin	Kansas Health Institute
39. Gianfranco Pezzino	Kansas Health Institute
40. Jim McLean	Kansas Health Institute
41. Scott Bruner	Kansas Health Institute
42. Adrienne Foster	Kansas Hispanic & Latino American Affairs Commission
43. Cindy Samuelson	Kansas Hospital Association
44. Tom Bell	Kansas Hospital Association
45. Sandy Praeger	Kansas Insurance Department
46. Sharon Wenger	Kansas Legislative Research Department
47. Jerry Slaughter	Kansas Medical Society
48. Chris Howell	Kansas Native American Affairs Office
49. Elaine Schwartz	Kansas Public Health Association
50. Shirley Orr	Kansas Public Health Association
51. Bryan Thompson	Kansas Public Radio
52. Doug Vance	Kansas Recreation and Parks Association

53. Julie Mettenberg	Kansas Rural Center
54. Joann Wheeler	Kansas School Nurse Organization
55. Mary Blubaugh	Kansas State Board of Nursing
56. Laura Sidlinger	Kansas State Board of Nursing
57. Mark Thompson	Kansas State Department of Education
58. Diane DeBacker	Kansas State Department of Education
59. Michael Cates	Kansas State University MPH Program
60. Elaine Johannes	Kansas State University Research and Extension, College of Human Ecology
61. Kim Kimmineau	KUMC - Center for Community Health Improvement
62. Elaine Williams Domian	KUMC - School of Nursing
63. Ed Ellerbeck	KUMC Department of Preventive Medicine and Public Health Kansas City
64. Tanya L. Honderick	KUMC Department of Preventive Medicine and Public Health Kansas City
65. Tracie Collins	KUMC Wichita Preventive Medicine and Public Health
66. Diane M. Daldrup	March of Dimes
67. Wes Jones	Mental Health Center of East Central Kansas
68. Hope Krebill	Midwest Cancer Alliance
69. Kimathi Choma	One Health Kansas, Kansas State University
70. Jodi Freifeld	One Health Kansas, Kansas State University
71. Lisa Davies	Rural Lakes Region LEPP
72. Scott Harrington	Safe Kids Kansas
73. Tim Wagner	Sedgwick County Code Enforcement
74. Christy Schunn	SIDS Network of Kansas
75. Kyle Clark	South Central Local Environmental Protection Group
76. Scott Selee	Southwest Kansas Local Environmental Planning Group
77. Mary E. Homan	St. Francis Health Center
78. Richelle Rumford	Stormont Vail Trauma Program Manager/Education and Prevention Coordinator
79. Doug Farmer	Sunflower Foundation
80. Dee Smith	The Salvation Army
81. Linda DeCoursey	Tobacco Free Kansas Coalition
82. Jo Funk	Tri Rivers LEPP
83. Bronson Farmer	Tri Rivers LEPP
84. Laura Roberts	United Health Care
85. Kim Moore	United Methodist Health Ministry Fund
86. Beth Oaks	United Way of the Plains
87. Deb Kiker	Wamego Community Health Ministries
88. Monica Scheibmeir	Washburn University School of Nursing
89. Charlene Weiss	Weiss Water & Wastewater Consulting
90. Suzanne Hawley	Wichita State University College of Health Professions
91. Susan E. Wilson	Wichita-Sedgwick County Health Department, Healthy Babies

C. Attending Participants

Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment
 Sign-in Sheet
 Day 2, External Stakeholders

94 TOTAL

21

Last Name	First Name	Organization
<u>Allen</u>	Aiko	KDHE Center For Health Equity
<u>Armbruster</u>	Sonja	Sedgwick County Health Department
<u>Baldrige</u>	Kendra	KDHE
<u>Brunetti</u>	Rick	KDHE
<u>Caudle</u>	Teri	Kansas Department Of Health And Environment
<u>Choma</u>	Kimathi	Kansas State University
<u>Coleman</u>	Julie	KDHE
<u>Crawford</u>	Greg	KDHE BEPHI
<u>Daldrup</u>	Diane	March Of Dimes
<u>De Coursey</u>	Linda	Tobacco Free Kansas Coalition
<u>Deckert</u>	Carla	WSU
<u>Ediger</u>	Leadell	Child Care Aware Of Kansas
<u>Edwards</u>	Mildred	Kansas African American Affairs Commission
<u>Ellerbeck</u>	Edward	University Of Kansas School Of Medicine
<u>Ervin</u>	Sheryl	Kansas Department Of Health & Environment
<u>Farmer</u>	Bronson	Salina-Saline County Health Dept
<u>Frazee</u>	Linda	KDHE
<u>Funk</u>	Jo	Retired
<u>Gabehart</u>	Martha	Kansas Commission On Disability Concerns
<u>Gibbons</u>	Yvonne	Salina-Saline County Health Department
<u>Goedeke</u>	Janis	Crawford County Health Department

ATTENDED

Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment
Sign-in Sheet
Day 2, External Stakeholders

<u><i>Sarah Green</i></u>	Green	Sarah	Kansas Department Of Agriculture	
<u>EMAILED - COULDN'T ATTEND</u>	Hawley	Suzanne	Wichita State University	21
<u><i>Bob Hedberg</i></u>	Hedberg	Bob	Shawnee County Health Agency	
<u><i>Leo Henning</i></u>	Henning	Leo	Kansas Dept. Of Health & Environment	
<u><i>Greg Hill</i></u>	Hill	Greg	Kansas Dental Association	
<u><i>Mary Homan</i></u>	Homan	Mary	St. Francis Health Center	
<u><i>Tanya Honderick</i></u>	Honderick	Tanya	KU-Master Of Public Health Program	
<u>EMAIL SENT - COULDN'T ATTEND</u>	Howell	Chris	Office Of The Governor	
<u><i>Ed Kalas</i></u>	Kalas	Ed	Kansas Environmental Health Association	
<u><i>Deb Kiker</i></u>	Kiker	Deb	Community Health Ministry	
<u><i>Hope Krebill</i></u>	Krebill	Hope	The University Of Kansas Medical Center	
<u>_____</u>	LeClair	Barbara	Kansas Health Institute	
<u><i>Charlotte Marthaler</i></u>	Marthaler	Charlotte	Lawrence-Douglas County Health Department	
<u><i>Paul Marx</i></u>	Marx	Paul Gerard	Kansas Department Of Health And Environment	
<u><i>Jerry McNamar</i></u>	McNamar	Jerry	Barber County Government	
<u><i>Mike McNulty</i></u>	McNulty	Mike	KDHE	
<u><i>Mike McPherson</i></u>	McPherson	Mike	KDHE	
<u><i>Mike Michael</i></u>	Michael	Mike	KDHE	
<u>ATTENDED - SEE LAST PG.</u>	Moore	Kim	United Methodist Health Ministry Fund	
<u><i>Nicole Morrow</i></u>	Morrow	Nicole	KC Urban Youth Center	
<u><i>Mary Murphy</i></u>	Murphy	Mary	KDHE	

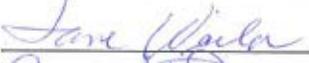
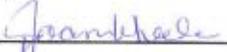
Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment
 Sign-in Sheet
 Day 2, External Stakeholders

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Signature	Last Name	First Name	Organization
<u>ATTENDED</u>	Myers	Del	Salina-Saline Co. Health Department
<u>Cindy Nau</u>	Nau	Cindy	KANSASWORKS State Board
<u>Brenda J Nickel</u>	Nickel	Brenda J	Kansas Department Of Health And Environment
<u>Emily Nickel</u>	Nickel	Emily	Kansas Department Of Health And Environment
<u>Angie Nordhus</u>	Nordhus	Angie	Office Of The Kansas Attorney General
<u>EMailed - COULDN'T ATTEND</u>	Orr	Shirley	KPHA
<u>Dan Partridge</u>	Partridge	Dan	Lawrence-Douglas County Health Department
<u>Michelle Ponce</u>	Ponce	Michelle	KALHD
<u>Janice Powers</u>	Powers	Janice	Butler County
<u>Mindee Reece</u>	Reece	Mindee	KDHE
<u>Sara Roberts</u>	Roberts	Sara	KDHE
<u>Vicki Roper</u>	Roper	Vicki	KS Children's Service League
<u>Paula Rowden</u>	Rowden	Paula	Stevens Co.
<u>Christy Schunn</u>	Schunn	Christy	SIDS Network Of Kansas, Inc
<u>EMailed - COULDN'T ATTEND</u>	Shaw	Pam	University Of Kansas Medical Center
<u>Marc Shiff</u>	Shiff	Marc	Kdhe
<u>Jane Shirley</u>	Shirley	Jane	Kansas Department Of Health And Environment
<u>Catherine Shoultz</u>	Shoultz	Catherine	Kansas Health Institute
<u>Brandon Skidmore</u>	Skidmore	Brandon	Kdhe
<u>Shawn Sullivan</u>	Sullivan	Shawn	KS Dept For Aging And Disability Services
<u>Michael Tate</u>	Tate	Michael	KDHE

Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment
 Sign-in Sheet
 Day 2, External Stakeholders

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	Tinsley	Kendra	Kansas Healthcare Collaborative
	Treaster	Cyndi	KDHE
	Weiler	Jane	Kansas Children's Cabinet & Trust Fund
	Weno	Katherine	Kansas Department Of Health And Environment
	Wheeler	Joann	Kansas School Nurse Organization
	Wilson	Susan	Sedgwick County Health Department
	Wood	Susan	KAMU
	Yancey	Glen	KDHE
	Jones	Wes	

Barbara Nuttall
 Cheryl Gray
 Kim Moore

Johnson County Dept. of Health & Environment
 Gove Co Health Dept.
 United Methodist Health Ministry Fund

D. Essential Public Health Services (EPHS) Explanation for Groups

The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local and state public health systems.

Group 1 – For the State Assessment this means:

Essential Service #1 - Monitor Health Status to Identify Community Health Problems

- Assessment of statewide health status and its threats and the determination of health service needs.
- Attention to the vital statistics and health status of specific groups that are at higher risk of health threats than the general population.
- Identification of community assets and resources which support the SPHS in promoting health and improving quality of life.
- Utilization of technology and other methods to interpret and communicate health information to diverse audiences in different sectors.
- Collaboration in integrating and managing public health related information systems.

Essential Service #2 - Diagnose and Investigate Health Problems and Health Hazards in the Community

- Epidemiologic investigation of disease outbreaks and patterns of infectious and chronic diseases, injuries, and other adverse health conditions.
- Population-based screening, case finding, investigation, and the scientific analysis of health problems.
- Rapid screening, high volume testing, and active infectious disease epidemiology investigations.

Essential Service #5 - Develop Policies and Plans that Support Individual and Community Health Efforts

- Systematic health planning that relies on appropriate data, develops and tracks measurable health objectives, and establishes strategies and actions to guide community health improvement at the state and local levels.
- Work with local public health systems in support of their efforts to develop local policies and plans that support individual and statewide health efforts.
- Conduct reviews of effectiveness and continuously work to improve the quality of policy and planning activities.
- Development of legislation, codes, rules, regulations, ordinances and other policies to enable performance of the Essential Public Health Services, supporting individual, community, and state health efforts.

To see all the Essential Services go to <http://www.cdc.gov/nphpsp/essentialservices.html>

The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local and state public health systems.

Group 2 – For the State Assessment this means:

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

- Health information, health education, and health promotion activities that are accessible and designed to reduce health risk and promote better health.
- Work with local public health systems to provide support to inform, educate and empower people about health issues.
- Continuous review and quality improvement of health communication plans and activities.
- Health education and promotion program partnerships with schools, faith communities, work sites, personal care providers, and others to implement and reinforce health promotion programs and messages.

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

- The organization and leadership to convene, facilitate, and collaborate with statewide partners (including those not typically considered to be health-related) to identify public health priorities and create effective solutions to solve state and local health problems.
- The building of a statewide partnership to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status.
- Assistance to partners and local public health systems to organize and undertake actions to improve the health of the state's communities.

Essential Service #7 - Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

- Assessment of access to and availability of quality personal health care services for the state's population.
- Assurances that access is available to a coordinated system of quality care which includes outreach services to link population to preventive and curative care, medical services, case management, enabling social and mental health services, culturally and linguistically appropriate services, and health care quality review programs.
- Partnership with public, private, and voluntary sectors to provide populations with a coordinated system of health care.
- Development of a continuous improvement process to assure the equitable distribution of resources for those in greatest need.

To see all the Essential Services go to <http://www.cdc.gov/nphpsp/essentialservices.html>

Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local and state public health systems.

Group 3 – For the State Assessment this means:

Essential Service #6 - Enforce Laws and Regulations that Protect Health and Ensure Safety

- The review, evaluation, and revision of laws and regulations designed to protect health and safety to assuring application of current scientific knowledge and best practices.
- Education of persons and entities obligated to obey or to enforce laws and regulations designed to protect health and safety in order to encourage compliance.
- Enforcement activities in areas of public health concern, including, but not limited to the protection of drinking water; enforcement of clean air standards; regulation of health care facilities and programs; reinspection of workplaces following safety violations; review of drug, biological, and medical device applications; enforcement of laws governing the sale of alcohol and tobacco to minors, seat belt and child safety seat usage, and childhood immunizations.

Essential Service #8 - Assure a Competent Public and Personal Health Care Workforce

- Education, training, development, and assessment of health professionals, including partners, volunteers and other lay community health workers, to meet statewide needs for public and personal health services, including management, cultural competence, and leadership development programs.
- Efficient processes for credentialing technical and professional health personnel.
- Adoption of continuous quality improvement and life-long learning programs.

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

- Evaluation and critical review of health programs, based on analyses of health status and service utilization data, to determine program effectiveness and to provide information necessary for allocating resources and reshaping programs for improved efficiency, effectiveness, and quality.

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

- A full continuum of research ranging from field-based efforts to foster improvements in public health practice to formal scientific research.
- Linkage with research institutions and other institutions of higher learning.
- Internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.

To see all the Essential Services go to <http://www.cdc.gov/nphpsp/essentialservices.html>



E. Group Assignments of Participants Based on EPHS

Wichita State University

FUNCTIONS LIST BY SUB CODE NO PAY CODES

Page: 1

2012 KDHE NPHPSP

Printed on Mon 22 October 12 at 10:57:18

Day 2

Blue

Id	Name	Organization	Num
23	Caudle, Teri	Kansas Department Of Health And	
96	Farmer, Bronson	Salina-Saline County Health Dept	
46	Gabeharta, Martha	Kansas Commission On Disability Concerns	
111	German, Angela	Kdhe	
70	Green, Sarah	Kansas Department Of Agriculture	
103	Kiker, Deb	Community Health Ministry	
51	Krebill, Hope	The University Of Kansas Medical Center	
108	Morrow, Nicole	KC Urban Youth Center	
74	Nordhus, Angie	Office Of The Kansas Attorney General	
72	Ponce, Michelle	Kdhd	
101	Powers, Janice	Butler County	
88	Schunn, Christy	SIDS Network Of Kansas, Inc	
42	Shaw, Pam	University Of Kansas Medical Center	
34	Sullivan, Shawn	KS Dept For Aging And Disability Services	
66	Wheeler, Joann	Kansas School Nurse Organization	
13	Wilson, Susan	Sedgwick County Health Department	
100	Wood, Susan	Kamu	
Total			17

Red

Id	Name	Organization	Num
112	Baldrige, Kendra	Kdhe	
97	Brunetti, Rick	Kdhe	
43	Deckert, Carla	Wsu	
87	Ediger, Leadell	Child Care Aware Of Kansas	
52	Eterbeck, Edward	University Of Kansas School Of Medicine	
20	Frazee, Linda	Kdhe	
27	Funk, Jo	Retired	
106	Hawley, Suzanne	Wichita State University	
21	Honderlick, Tanya	KU-Master Of Public Health Program	
50	Kalas, Ed	Kansas Environmental Health Association	
113	LeClair, Barbara	Kdhe	
44	McNamar, Jerry	Barber County Government	
109	Nau, Cindy	KANSASWORKS State Board	
110	Orr, Shirley	Kgha	
14	Partridge, Dan	Lawrence-Douglas County Health	
102	Roper, Vicki	KS Children's Service League	
67	Shirley, Jane	Kansas Department Of Health And	
48	Tinsley, Kendra	Kansas Healthcare Collaborative	

Wichita State University

FUNCTIONS LIST BY SUB CODE NO PAY CODES

Page: 2

2012 KDHE NPHPSP

Printed on Mon 22 October 12 at 10:57:18

Day 2

Red

Id	Name	Organization	Num
7	Warren, Mary Beth	University Of KS Med Center	
37	Weiler, Jane	Kansas Children's Cabinet & Trust Fund	
Total			20

Yellow

Id	Name	Organization	Num
58	Allen, Aiko	KDHE Center For Health Equity	
69	Choma, Kimathi	Kansas State University	
17	Daldrup, Diane	March Of Dimes	
49	De Coursey, Linda	Tobacco Free Kansas Coalition	
86	Edwards, Mildred	Kansas African American Affairs	
38	Ervin, Sheryl	Kansas Department Of Health &	
33	Goedeke, Janis	Crawford County Health Department	
105	Hedberg, Bob	Shawnee County Health Agency	
18	Homan, Mary	St. Francis Health Center	
31	Howell, Chris	Office Of The Governor	
55	Moore, Kim	United Methodist Health Ministry Fund	
63	Nickel, Brenda J	Kansas Department Of Health And	
94	Nickel, Emily	Kansas Department Of Health And	
82	Shoultz, Catherine	Kansas Health Institute	
83	Skidmore, Brandon	Kdhe	
Total			15

Function Code Total 52

F. Meeting Agenda

The National Public Health Performance Standards Program (NPHPSP)



Kansas State Assessment

Day 2 - November 2, 2012 External Partner Meeting

PURPOSE / OUTCOME:

Evaluate the current status of the Kansas state public health system to inform the Healthy Kansans 2020 (HK2020) <http://healthykansans2020.org/> Steering Committee's work to develop the blueprint for an integrated health system identifying capacity to address leading health indicators in Kansas.

OBJECTIVES:

1. Review the purpose of the National Public Health Performance Standards Program (NPHPSP) State Assessment, core functions of the public health system, and essential services needed at all levels for a healthy Kansas.
2. Describe what are "public or population health" and the interconnectedness of activities to improve the health and wellbeing of Kansans.
3. Identify the diverse network of partners within state and local public health systems, which can lead to more cohesion among partners, better coordination of activities and resources, and less duplication of services.
4. Identify strengths and weaknesses to addressing statewide public health system capacity.

AGENDA

8:00–8:30 a.m. Register and Continental Breakfast

8:30–8:45 a.m. Welcome and Introductions

Brenda Nickel, MS, RN, Director, Center for Performance Management, Kansas Department of Health and Environment

8:45–9:00 a.m. Welcome – State Health Improvement Planning: Aligning Current Initiatives to Improve Health in Kansas

Aaron Dunkel, Deputy Secretary, Kansas Dept of Health and Environment, Office of the Secretary

- 9:00–10:00 a.m. General Session – *The State NPHPSP Assessment: Purpose and Relevance***
Denise M. Pavletic MPH, RD, ASQ-CQIA, ASQ-CMQ/OE,
Director, Public Health Systems Improvement, Association of State and Territorial Health Officers
- 10:00–10:15 a.m. Beverage Break**
- 10:15 a.m.-4:00 p.m. Break Out Sessions (Groups are colored coded)**
- Room Alcoves 1 & 2 **YELLOW GROUP 1**
 - Room Alcoves 3 & 4 **BLUE GROUP 2**
 - Room Alcoves 5 & 6 **RED GROUP 3**
- 10:15-11:45 a.m. Session I
- 11:30 a.m.-2:00 p.m. Session II
- Noon–12:45 p.m. Boxed Lunches – Enjoy with Colleagues in Break Out Rooms**
- 2:15–3:15 a.m. Beverage Break**
- 2:15-4:00 p.m. Session III
- 4:00 p.m. Meeting Adjourns**

G. Data Notes from Participant Comments

1.1 Planning

1.1.1. Strength: Standardized reports; Informing the public; Good relationship between state and locals; BRFSS –KS well known compared to other states; Have county level data (core questions every time – BRFSS); County rankings reach a lot of people; Can access data quickly. Weakness: Have a lot of prevalence data but not so much incidence (no Diabetes Registry for example); Limited sample sizes; Health Information Exchange – public can't query.

1.1.1.1 Strength: Standardized, people are being informed, good relationship between state and locals about being informed, BRFSS-Kansas is known as being very good, consistency in data from year to year, turnaround time is good, county health ranking process. Weakness: Not a lot of information about incidences, limited sample sizes-cannot drill down very far (on its way but not there yet).

1.1.1.3 Comment: Clarification of roles – what does this mean? Knowing what we have, communities' needs known.

1.1.1.4 Strength: Access to lots of programs, agencies is trying to be transparent and get information out there. KANSASHealthMatters being pushed out to public; Non-traditional public health partners invited; in facilitating access, agencies trying to be transparent in getting data out there. Weakness: Integration is a challenge. Mental health and substance abuse data not easy to get access to; Helping people at the county level health departments to understand how data is integrated into programs; Trouble getting data from MEDICAID; Hospital data is not accessible – have to pay. Some integration challenges (mental health, etc) access becomes more of a challenge, helping them understand what to do with the data they have, getting agreements with KPHA and KDHE to get access to some information (can submit a form and get the data but it is not queryable).

1.1.2. Strength: KIC, Immunizations Registry; Kansas Health Matters; EpiTrax; Preparedness; BRFSS, Syndromic Surveillance System. Weakness: No good geo-coding (no layers); Data not easily shared. Comment: State products but can use products at county-level. Clarification - Still working forward on relationship with tribes for data exchange; smaller counties have to use regional data. Hard to get raw data; Registries such as Immunizations are voluntary.

1.1.2.1. Strength: KIC, immunization registry, Kansas Health Matters, EpiTrax, hospitals can let you know how many beds are available, Biosense. Weakness: No good geocoding.

1.1.2.5 Comment: Clarification – uniform set. Interpreted as Kansas Health Matters as an example

1.1.2.6 Comment: How defined – web-based data query system. Defined examples – Kansas Health Matters, BRFSS, KIC; if you look as someone from County-level would there be the same response? County is optimal grouping- now looking at regional level. Complete data is an issue in preparing statistics.

1.1.2.7 Immunization data reporting is voluntary.

1.1.4.1. Strength: EpiTrax. Weakness: Not queryable by most because of health privacy laws.

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1.2 State Local

1.2.1 Strength: Greg Crawford, funding through KHI, some collaboratives, locals call state-they answer the phone and help, state has process and protocol for processes. RWJ collaboration; Informal TA (phone calls, calls with Charlie Hunt and staff); BRFSS expansion; Regional meetings with local health departments; Process and protocols for responses. Weakness: Western Kansas - can be hard to reach really rural areas, sometimes they have to generate the own data-have to rely more on opinions rather than what the data says, effort to take care of people who only have cell phones. Reach into rural areas - must generate our own data (local health departments in these communities).

1.2.1.1. General discussion: Technical assistance exists even if data does not exist.

1.2.1.5 Comment: Local PIOs work well. KHI, UMHMF. Journalists need handholding to understand data though. Strength: Each KDHE bureau has an outreach expert, KHI, universities. Weakness: Educating journalists-found out they need a lot of hand holding (they don't really want to know).

1.2.2.2 Comment: Just because data is geo-coded doesn't mean data is in a format that others can use or that is functional. Can't conduct analysis with geo-coded information. Can geo-code at inaccurate level. Weakness: Just because it's geocoded does not mean it's in a data format that others can use (example: is not in a map layer), can be geocoded at a very inaccurate level.

1.2.3 Weakness: Birth defect system is unfunded (significant gap). Legislature gives authority but not funding. First time this has happened. Comment: Work with EpiTrax on mortality.

1.2.3.1 Comment: What does maintaining local health monitoring system mean?

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1.3 Performance Management and Quality Improvement

1.3.1 Strength: We trashed an old ineffective system and get a new one up and running within a year, this process, Brenda Nickel's program, KanPICH group, immunization registry, do our best to respond to requests, focus groups for KIC. EpiTrax, CRA system was quickly developed. Replaced with new system – HAWK with EpiTrax; KANPICH; Performance Improvement Center established; CDC comparison of states – trickle down to improvements (Immunizations); Response with localized BRFSS data; KIC user focus groups. Weakness: Don't do enough evaluation of efforts. Don't have the capacity to do evaluation at the levels we need. Timeliness of communication back to stakeholders. Monitoring health status – core set of indicators indicators collected but may not always is relevant. We don't do enough evaluation of what we've done to determine if it's what we really need, capacity development, how to communicate back to stakeholders, monitoring health status (required to collect a core set of indicators that may take away from what is really needed).

1.3.1.4 Strength: EpiTrax; H1N1 CRA system with WebIZ; Vital Statistics Reports, KIC, BRFSS

1.3.2 Strength: Coalitions to review efforts; Immunizations Registry; Added cell phones for BRFSS survey; KANPICH – bring stakeholders to the table; Funding from foundations; Preparedness. Collation to review the immunizations registry, KanPICH form to bring all partners to the table for opinions, TAR-dispensing medication during an emergency.

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1.4 Capacity and Resources

Need more skilled staff. Who beyond KDHE can add to capacity?

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2.1 Planning

2.1.1. Strength: Surveillance; Newborn screening; Lead screening; Infectious disease tracking; Trauma registry; Rabies; Lab screening; Blue-green algae; KS-HAN. Weakness: Need more incidence data for chronic disease, being able to drill down (hard to get into schools and get them to do the surveys), no surveillance program that does all hazards, systems don't share data easily so you quality of life profiles – not designed to share; No standards for data exchange; No semantics standards.

2.1.2 Strength: H1N1 was a situation where this worked very well, we have some quick and ready systems in place, have developed protocols. Weakness: Slower reporting by the medical community specifically physicians, counties are responsible for the first 48 hours - they are on their own, some of the smaller counties would run out of supplies within the first 24 hours. Red tape. General discussion: there has been a large investment in infrastructure in the last few years which is why this probably scores so high.

2.1.1.5 Comment: We don't have PRAMS and this is a big deal.

2.1.1.6 Comment: We have the DOC. Growing and doing more surveillance of extreme weather. We have to delineate between local and state levels. We're not as good at the local level. Discussion Toolbox 2.1.1.1-2.1.1.6 (Comment: Tool box is about disease and not all hazards)

2.1.2. Strength: Rolled out CRA module. Countermeasures were the first in the nation. Vaccines, masks, etc. tracked. Protocols developed. Weakness: Slow reporting by medical community (MDs). People ready to invest when perceived threat, but as times goes on, becomes a diminished priority. Comment: We are talking about capability and not capacity. We definitely suffer capacity to respond (LACKING).

2.1.2.5 Strength: Kansas response plan, every county has an ESF8, plans are exercised, TAR as to how they were executed - first vote was a tie.

2.1.2 Strength: H1N1 was a situation where this worked very well, we have some quick and ready systems in place, have developed protocols. Weakness: Slower reporting by the medical community specifically physicians, counties are responsible for the first 48 hours - they are on their own, some of the smaller counties would run out of supplies within the first 24 hours. Red tape. General discussion: there has been a large investment in infrastructure in the last few years which is why this probably scores so high.

2.1.2.5 Strength: Kansas response plan, every county has an ESF8, plans are exercised, TAR as to how they were executed - first vote was a tie.

2.1.3 Strength: Not a lot of gray area, are developing a network, regionally people know where they can go. Weakness: if a surge, would have to drop some stuff. General discussion: network - trying to improve in this areas, agreement with states around us where there was a surge the surrounding states could help support, also trying with private labs.

2.1.3.2 Comment: Need MOUs to make official

2.1.3.7 Strength: Lab in a large hospital the answer is yes. Weakness: Small hospitals may not have the capacity; we do not have a list of all clinical labs in the state. General discussion: It has been tested.

2.1.3.8 Weakness: Food is by itself and does not link up to the system well

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2.2 State Local

2.2.1 Strength: Epi team assigned. Chronic disease quarterly meeting at KDHE. Changing priorities in STDs shared and addressed

2.2.3.1 Comment: We collect good data on disease incidence but not other things. If not overwhelmed can do. We don't do surveillance of drop-outs, day care, prisons. Don't look at this.

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2.3 Performance Management and Quality Improvement

2.3.1 Strength: We have to send a report back to the federal level (hot washes, after action reports, etc.).

2.3.1.5 Strengths: Working on a new plan for the lab - are trying to improve this. Newborn screening - they track bad screenings and conduct ad hoc training. General discussion: Who else is doing this - CMS, insurers, a lot of partners have roles in diagnosing and investigating health problems.

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2.4 Capacity and Resources

2.4.1 Discussion Toolbox comment: What would health outcomes be with more money? Expanded BRFSS from few counties to more? Have more relevant county/community data. Don't know what problems re or data without resources. Health economics analysis is needed. Does good health improve where there is more funding towards public health? Weaknesses: Not enough funding is devoted to this, we are at a bare minimum and are putting patients at risk, ex: acrylic nails-two nurses with acrylic nails in one institution touched ten babies who died. There are not enough investigators. Sometimes there is barely enough information (ex: we know how many babies died but do we know why? Smoking moms, etc). Health economics is a gap. General discussion: Almost split vote, if I gave you every dime you asked for how would it improve-investment in expanded surveillance systems (collecting more data so you could drill down more, geocoding, reduced mortality and morbidity, better quality of life in senior years, productive citizens not involved in drugs. Is life expectancy longer if there is an increase in funding? There would never be enough money to be able to get to optimal. Need to know return on investment. All the surrounding states are better funded than Kansas is - is their health outcomes better as a result of this unknown.

2.4.2.1 Strength: We're getting the capacity to do that again but are not there yet. Weaknesses: We are not far enough along to state we have a strategic plan so how can we align.

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3.1 Planning

General discussion regarding strengths: There are many vehicles within KDHE to disseminate information i.e., social media, traditional media, KS Train, Newsletters (electronic and mailed), websites, TV, Radio, Marquees ,fact sheets and person to person e.g. Health Fairs, education, workshops, etc. The Community Health Assessment (CHA) is a collaborative effort with various community members like Primary Care, Hospitals, and Public Health. There is opportunity to educate the community on resources, for example through the Healthy Start Home Visitors Services moms &/or guardians are connected to support and resources all over the State. Collaborative efforts are going on within local communities and the State. Commission on Disability - position on employment. KanCare - sending emails so people will participate. Facebook based solely on breast feeding. County wide coalitions. Crisis communication planning. Web

based communication. Through partnerships with homeland security standards we can communicate during a crisis. Data is informative; it educates and empowers communities and state agencies. Community coalitions & preparing joint grant applications. Links with parish and school nurses as well as businesses. Kansas Kid Link website - statewide resource for mental health. Midwest regional Fetal Alcohol Syndrome is a great resource. Crisis communication for agricultural has a health component. Work with industry partners on healthy behaviors. Farm to School activities for education of health and environment. Many local health departments have their own WebPages now. K-FIT. There are alliances that develop relationships across the state and encourage partnerships with medical providers. Connecting providers to evidence based practices. Professional and local support groups are using televideo. There is statewide advocacy pertaining to oral health. Federal resources e.g. The Maternal Child Health Resource Center from the state level that can be shared across the state with different organizations. Kansas Association for Medically Underserved (KAMU) shares information and advocates for local clinics. Messaging for health information is sent to clinics weekly. The Kansas Resource Guide is housed in KDHE it is an online resource database and can be queried by zip code. Rural hospitals partner with local community organizations to educate residents, e.g., lunch and learn. Community Health Ministries collaborates with the local hospital, community recreation center and K-State for Get Fit Wamego. The Kansas Optimizing Health Program (KOHP) offers classes to equip people having chronic diseases with tools to cope and live intentional lives. Working with youth on prevention and see a shift on policy and advocacy. Try not to just include direct services to kids but involving parents as well. Focus on birth outcomes and looking at those across the lifespan. Breast Feeding Packet that is given to businesses in order to provide a place for mom's to breast feed, i.e. chair, walker, crib and breast pump. This opens the door for other discussions about health. We have connected people with Faith based organizations.

General discussion regarding weaknesses: There is a lot of information to sort through. It is harder to reach diverse populations. The information world has advanced but we still have populations that rely on traditional media and youth who prefer electronic social media. We have a lot more information today but empowering people to use the information is a challenge. Is the information in a useable form? Rural areas don't have broadband and we still have farmers who come into town once a week to catch up on news. Most often focus groups are not conducted with the audience we are trying to reach. Then we don't know if people are in pre-contemplation stage or what. A study was done asking people who they get their health information from and the majority said from their health care provider, but there are issues around time and if they are giving the correct evidenced based information.

3.1.1.1 General discussion: The biggest issue was "reaching all populations", which is why I choose minimal. The Key word for me was "design" I don't think there is a design it happens randomly. Do we do a good job of using what is already there and not creating the wheel? Different programs have risk communication, but with decrease in funding we have less ability to do it. Are we keeping the health literacy piece for people to understand?

3.1.3 General discussion: Prior to voting someone asked for expert opinion from KDHE to explain the emergency system. Other comments: Each community has emergency mass casualty practices, but there are still gaps. We still need education on the health literacy component.

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3.2 State Local

3.2.1 Comments prior to voting: There use to be a lot more strength than current. It has been diluted. There is a strong relationship between the State and some local organizations like Tobacco and cancer. Early detection Works is often cut off early in the year due to lack of funding. Environmental health has diminishing capacity and support. We have the system and connection with local health departments, but don't have all



the primary care offices; Not for lack of trying. From the agriculture perspective - the emergency preparedness person has the money, but local partners don't show up. The state plays a key role in technical assistance (TA), but this varies across the spectrum. Human contact and capacity are important for TA. Primary Care and Oral Health have a lot of TA e.g., KAMU has strong rapport. Political support fluctuates. Anything with children and babies is hugely supported. He who has the most advocates sways legislators. New initiatives are often the newest option instead of looking at best practices. Across the board we see reduced funding and capacity at every level State, Regional, and county. Health education information is not a billable revenue building item and this has diminished.

3.2.2.1 Tie between significant and moderate; Second vote was Significant. Comments prior to the second vote: I thought of the range - greater the 75% looked at the State and the variety of partners. The community connections are there with emergency preparedness. I looked at how much we have improved. Schools and community facilities are more prepared because of resources that have been put in this area.

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3.3 Performance Management and Quality Improvement

3.3.2 Comments prior to voting: The state politically is not leaning toward health promotion and there is no reimbursement for it.

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3.4 Capacity and Resources

3.4.1 General discussion: KDHE has good skill sets, but they don't have enough staff. Crisis communication & emergency preparedness has focused on financial resources over the past ten years but they have to be maintained and in other areas there have not been as much funding and resources to build this capacity. There have been issues with commissioners wanting to cut programs related to health promotion. Our health care delivery system is focusing on paid for performance and health promotion is a key element of that as well as prevention. The reimbursement system is folding this in and we need to be prepared to train practices.

3.4.2.3 General discussion: Comments: The KDHE secretary has worked hard to collaborate with partners. Many locals find him approachable. We are working well with our silos. I agree that he works great in some areas, but excise tax, etc. are not his strong points. Also Dr. Moser is doing the job of 3 people which brings limitations to the position. Politically he has limitations on what he can focus on.

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4.1 Planning

General discussion of strengths: Rural Health relies on partnerships and we work a lot with rural hospitals, state associations, and local partners around performance improvement. Kansas Partners for improving community health has grown, i.e., KS Health Matters portal is one of the results of working together. We do a good job with problem identification but struggle in getting to the solution. Active state wide organizations charitable foundations and universities at state and local level. As a sanitarian people work in their silos. Emergency preparedness does a good job. Business and other health care organization partnerships and advocacy groups, Association for Medically Underserved. Use to be that some agencies didn't get involved in collaboration unless there was some kind of incentive, but now there is more of a community focus - We are all in this together. Nutrition and Physical Activity coalitions are merging into a county wide wellness coalitions. School Nurses have a lot of organizational resources and many organizations want to partner with



them; they have many list serves to disperse information. There are opportunities to improve public/private partnerships. The Oncology workforce is small as compared to other States and this is strength. Wichita has been dealing with the issue of water fluoridation; the community has been involved in this. KDHE Oral health is all about collaboration; they only have 4 staff so if they don't collaborate they can't get anything done. KAMU has strong collaboration efforts it is core to their very function. Mobilization of partnerships with other agencies and LHD's serving on councils and advisory boards helps to do this. This is especially important with the decrease in resources the state is experiencing. The State CVH/Stroke Council and the Diabetes Action Council are forming a joint council to share resources and people. Funders are asking specifically for collaborative efforts. The Governor created the coalition on infant mortality and there was legislation enacted on this, that doesn't just affect infant mortality but the whole life span.

General discussion of weaknesses: Integration of mental health and medical health still has some work to do for integration. Partnerships to organize Community Health Assessment are real tedious work. Disabilities want to be at the table, but they don't always have their purpose defined.

4.1.1.1 General discussion: There are so many strong examples of partners, but the key part of partners is that it requires people and that capacity needs to be a priority. Funders want collaboration to be part of their outcomes, but it takes time to build relationships and it takes staff to do this. We encounter the problem of building the relationships without resources to carry out the job. Activities around Community Health (CHA) Assessments and Community Health Improvement Plan (CHIP) facilitate a lot of these efforts.

4.1.2 General discussion: The discussion tool box is interesting because it helps one to think outside the box.

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4.2 State Local

4.2.1 General discussion: There is available funding at this time for collaborative efforts to provide incentives for building partnerships. Funding was given to the LHD's and Hospitals to collaborate and do a CHA and a CHIP for sustainability. The State often reaches out to local partners to provide activities they don't have the capacity to do. One person commented that the toolbox changed the initial response to their thoughts about this model. Linda asked them to read the Discussion Toolbox before voting.

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4.3 Performance Management and Quality Improvement

4.3.1 Comment: Time was given to read the toolbox before discussion. For KS Cancer partnership, evaluation is required along with identification of methods to strengthen partnerships.

4.3.2 General discussion: chose moderate because I think it is 27%; the word "actively" became a key word and moved me to vote for minimal. I am one of the agencies that the public health department manages and I'm not sure how I improve. I chose Moderate because we report on progress and measure improvement, but don't use bench marks and don't officially do QI. I work with a lot of partners and we discuss problems and work actively to improve it, but it is not standardized.

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4.4 Capacity and Resources

4.4.1 Comment: KDHE perspective - the philosophy is to blend like programs together to blend partnerships.

4.4.3 General discussion: Stem Question - Tie between Minimal/Moderate; Second vote is Moderate. Took time to read the toolbox. In some cases we under estimate our skills at the local level. I think I lean toward Moderate.

4.4.3.1 General discussion: Tie between Moderate/Minimal; second vote - Moderate. Minimal: We have been doing a lot of work with LHD's on CHA and time and again these needs come up. Moderate: I see a lot of things directly and indirectly and I wonder if Kansas Association of Local Health Departments (KALD) isn't aware of this. Many LHD's are hiring consultants to help them. I often have to contract outside the State to help me do this. On the Maternal Child Health (MCH) side, they have helped me convene partners. I am one collaborative and the State has been extremely helpful. The toolbox helped me think about the Public Health System. There is a lot of planning and coordination of events and we have some really good leaders and many effective coalitions. Do we have enough staff? No. But we do have some strong skills or we would have stopped a long time ago. There are some very skilled people but I heard someone from the State say, "Who owns this?" That makes me think that there are barriers still there. A person asked for clarification. And the answer was. "There are people who may have collaborative skills, but 'ownership' is not collaborative." I think sometimes people don't want to come to the table because they may be asked to take a position of responsibility or ownership.

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5.1 Planning

5.1.1 Strength: HK2020 most comprehensive health improvement plan and process. There are multiple processes going on. Weakness: We have a lot of silos but nothing that brings everything together; we do not have a statewide goal. We don't have all the populations included that are affected by health improvement effort. Comment: Working on it. Don't have one document but do have statewide plans for MCH, oral health, cancer, diabetes, etc.

5.1.1.2 Note on scoring record: We had 6 votes at minimal level. Comment: Have silos but nothing that brings everyone together. Do we have statewide goals? Make sure voices are at the table (FQHCs, OMH, and feet on the street). Weakness: Travel budget restrictions could affect the participation, not all groups (ethnic, socioeconomic, etc.) may be represented.

5.1.1.4 Strength: There is eventually an objective identified. Weakness: There are a lot of silos by program.

5.1.2.4 Comment: Not clear who is going to do the work -"accept responsibility". Problem: solution is that foundations will accept responsibility for implementing strategies. Weakness: Plans are adopted without a specific identification of who is authorized.

5.1.2.6 Comment: Note on scoring record. Vote by one for minimal for this substandard. Weakness: Healthy Kansans is only about halfway there.

5.1.4.5 Strength: Most of the funding provided provides funding to be able to participate.

5.1.4.6 Weakness: Many voices getting them all aligned are not quite there yet.

=====

5.2 State Local

5.2.1.1 Strength: Kansas Health Institute, Governor's Public Health Conferences. State plan informs local and local informs state. Weakness: Decentralized system – every community has a different approach.

5.2.2.2 Comment: Rationale for moderate score. We have limited money and we fund 50 counties (example-obesity reduction). Not solving obesity. Hard to provide assistance communities need. Have willingness and history of good will between local health departments and state.

5.2.4.2 Comment: KDHE must get public input at local level – survey for public input or other means?

5.2.4.7 Note on scoring – vote was for significant by one.

=====

5.3 Performance Management and Quality Improvement

5.3.1 Comment: Getting there (examples – Comprehensive Cancer plan – integrating Tobacco Free KS plan).

5.3.2 Comment: People don't realize what health is. Because there's so many types of legislation. KHIT has public health impact.

=====

5.4 Capacity and Resources

5.4.1. Strength: Comprehensive Cancer plan integrated Tobacco Free KS plan into its plan; Ryan White Program; KS Action for Children; Oral Health

5.4.2 Strength: WebIZ, KANSASHealthMatters. Weakness: Still in silos. Information systems outdated.

5.4.2.2 Weakness: No protocols in place.

5.4.3.1. Note on scoring – Significant by one. Comment: Unfair for staff to perform at a high level and we don't have a community health degree. What other comments do you have? Didn't talk about mental health today. Need to use good data at the state to talk about Return on Investment with legislators. Huge education issue with legislators ROI – must be translated into language legislators can understand and comes from our coordinated strategic plan. Put more information out there, empower groups to make intellectually based decisions on what they want (e.g., like number of newborn screenings due to March of Dimes initiatives).

=====

6.1 Planning

6.1.1.1 Where reviews are conducted they are science based, but there is no system for regular review. Are reviews really based in science, or instead on desired program outcomes? Major environmental laws undergo regular review based on public health science. Helmet law is not based on science; it allows unsafe conditions in face of evidence. Existing and proposed should be two, different questions. Locals don't do it so well.

6.1.1.2 Public hearings at state level allow regular, community participation. County codes are developed and reviewed by local committees, then submitted to the state for review. It depends on how many people you invite to the table. The public hearing process (both state and local) brings in the regulated community.

6.1.1.3 Opinions are diverse; do we really use that input? Yes, e.g. significant revisions were made to Lexi's Law based on public comment and advisory groups provide input throughout the process that is used to craft laws. State system solicits input through the statutory/ regulatory adoption process. Public hearings. Do we



ever go above and beyond? Environment solicits input from the regulated community up front and allows them to help craft the law

6.1.1.4 State associations routinely have access to state legislators. At the local level, there is a lot of variability between counties. Many programs don't have defined advocacy groups. It's hard at the grass roots/county level to find an advocacy group with access to Topeka

6.1.2 Law gives Secretary of KDHE broad power. Local powers and authority also well established. County health officers have broad power.

6.1.3.2 Locals have requirements but no funding; incentive is lost. Environment has compliance assistance visits and self-audit law (slight majority of votes were "moderate", with a close number of "minimal" votes).

6.1.4.3 Due to cuts in state funding, local Environmental Health fees are skyrocketing; they are not balanced, and vary across the state (10 moderate and 9 minimal votes).

6.1.4.5 Locally, usually based on tradition, which is OK as long as there is access to institutional memory: "this is how we did it before".

=====

6.2 State Local

6.2.1 Geography and budget reductions create challenges. Locals used to rely on KSU for Technical Assistance (TA) on private water and wastewater systems; now that source is gone. Local environmental health is on its own. No local connection with KDA on restaurant inspections. Local can be small populations a long distance from Topeka, and the big populations are close to Topeka; this presents big system challenges. Delivery varies based on geography; dilutes the further you are from Topeka.

6.2.2.4 Stronger on emergencies (e.g. disasters) and less on more routine, local health emergencies and role of local health officer.

=====

6.3 Performance Management and Quality Improvement

6.3.1.1 The gaps are known, but the time and effort required to change laws is an impediment. Legislature limits KDHE to what federal law requires. Very little ability to affect changes at the local level; more effort directed to compliance.

6.3.1.4 Difficulties with enforcement are effecting funding. Enforcement is professional, but enforcement can drag out.

6.3.2 In Topeka, agencies do it more often than not.

=====

6.4 Capacity and Resources

6.4.2.1 There is a skill set necessary to write and align strategic plans.

=====

7.1 Planning

General discussion of strengths: There a number of programs within and outside of special services with families that do not have managed care that receive services like assistance with early newborns and dental assistance. KAMU links people to needed services and we get services to the providers to link the people. Currently there is an initiative to align them with Patient Centered Medical Home and assistance with emergency preparedness planning. Oral Health Services has a priority of putting hygiene services into schools for kids with the highest need. Almost every day we get a call for someone who needs assistance with dental services and we try to connect them to someone like KAMU. Meeting needs in emergency: KDHE's web system can be accessed for people mobility or transportation issues so emergency response can factor this in for assisting people. WebIZ is a good program to give everyone a way to get into the system and try and raise the immunizations rates. When the funding is there for Early Detection Work that is a good resource. School Nurses do well with this one because we are always connecting families to some sort of service, like Lions club, dental services, school at WSU, Mental health Association, Free and sliding scale clinics, and professional organizations at the national level. School nurses can get vouchers for free vision screening at the eye doctor through the National School Nurse Organization. Agriculture is the State's biggest sector, but there is a lack of knowledge in this area. It is not as robust as it can be. Key building blocks are: Patient Centered Coordinated Care; Focus for primary preventive care; Increased opportunities that have happened like national performance standards; Telehealth; Key element for geographic issues in the future. The Rural health Program works with providers and there are a lot QI activities that take collaborative action with organizations, i.e., KFMC, KS Medical Society; KDHE programs. There is focus to improve essential services. We are in an interesting time. If KanCare works like we are hoping there will be a lot more case management. Affordable Care Act and Medicaid are going to increase access to care. There are things in the work to improve quality of care like EHR's, pay for performance.

General discussion of weaknesses: Safety net clinics often get dumped on to do daily case management for large hospitals because this is big cumbersome care. People that need big things like operations and the big systems aren't willing because the dollars aren't there. Cancer research is limited. Safety net clinics often get dumped on to do daily case management for large hospitals because this is big cumbersome care. People that need big things like operations and the big systems aren't willing because the dollars aren't there. Cancer research is limited. Transportation is a huge obstacle for example with HIV case management, we have 2/3rds of the State that have cases but they don't have the transportation. We refer people to call 211 and constantly link people to mental health. If you are a WIC provider you have a resource list that is very extensive. There are a lot of specialty hospitals emerging and it is fracturing the system rather than brining it together. I am drawing on my experience with Social Services, but our community and faith based organizations are tapped out. It all comes back to resources. We don't really have health care for non-disabled adults. It is difficult to connect the vulnerable population. Healthy start is a great program to help people navigate the system. There are special problems for groups at risk like primary care providers not using interpreter services. There is becoming more of a problem with providers not taking new patients. There continues to be a problem with physical and financial access. Often when someone makes a referral they feel that they have done a job, but it is not a successful referral unless they follow-up and see if they actually got the appointment. It takes a lot of staff time to link people to services. Today we have more community health services and FQHC's but many of them have fragmented care. This is an area where we currently have gaps.

7.1.1 General discussion: I know that the dept. of commerce has been working hard at identifying shortages of health professionals. The KDHE Primary Care Program has a strong group to identify health professional shortage, but addressing the problems is difficult. One way to do this is that the Medical School is



recognizing a Rural Scholar and their tuition will be paid for. Oral health believes we are progressive in this area.

7.1.1.1 General discussion: The Health Professional Shortage Area (HPSA) Program has been in effect in the Primary Care Program for a number of years. Not all states do every county but we do.

7.1.1.3 Comment: BRFSS

7.1.2 Comment: Read Discussion Toolbox before voting.

7.1.2.6 Comment: Ideally we know what we need to do, but we don't have the people to do it. It's hard to prepare when you don't have enough bodies.

7.1.3 Comment: The word "an entity" was discussed it was determined that KDHE is responsible as the governing Board of health.

7.1.3.3 Comment: Capability is a key word.

7.1.4 Comment: Reinforced that we are talking now about the State PH System.

=====

7.2 State Local

7.2.1 General discussion: Is there partnership standardization between private and local health departments? It has a lot of local partnerships to address disparities - This is a strength. KU is looking to develop training for quality measures to impact change. I think it depends on who is at the table. The age of being a competitor with the LHD is gone. How do private providers fit into this? Community Health Ministries is a Model for the State. The private provider relationship is that the hospitals need the physician network to help cover their emergencies and other departments.

7.2.2 General discussion: Other than Potawatomie County who is the gold standard, are there any other things going on? Yes KHIN and KAMU support that. Our safety net clinics and FQHC's do reach out to vulnerable populations, but there are a lot of areas in the state where providers don't want to take on those difficult people who take more time and can't pay. I am looking at this question as TA to the providers, but if they aren't receptive to it, that is the missing piece. Primary care doctors are required to be knowledgeable about everything.

7.2.1.4 General discussion: There are reports available and UDS reports were recently reviewed. They are reviewed at Federal/State levels and in the media.

=====

7.3 Performance Management and Quality Improvement

7.3.1 General discussion: Does the State PH System include the Medicaid Agency? Yes. There are a small number of people who are doing a lot of work - 80/20 rule. The State reaches a broad spectrum of people across the state - from Urban to Rural. There is a lot of data gathering going on, but what about surveillance? We know the rates of breast cancer, but a surveillance system is not available. We assume screenings are being done, but often when you start entering data into an EHR you realize that you are not screening as many people as you think. What about Plan Do Study Act (PDSA) Cycles what are we doing with the data?

Are we doing a sprinkling approach? Touching a lot of people a little bit. Electronic Health Records is a huge milestone that will open the door to surveillance.

7.3.1.1 General discussion: What does managed care entail? We have Medicaid. PPO's are not technically Managed Care. We don't have good data on preventative services now. With KanCare this should improve. It was agreed to answer the question as it is now. It was stated that PPO's is managed care because they get reports on type of service and time spent. The HEDIS data set will look at the quality, but who is reviewing it? That's the question. Blue Cross Blue Shield Program offers a managed care program for people with chronic conditions, but it is volunteer and more like case management.

7.3.1.3 General discussion: There is a hospital engagement network. It is not required for Critical Access Hospitals but they are reporting it. Hospitals do internal reports.

7.3.2. Comment: This is similar to another question, I think we do the middle 2, but not the first or fourth.

=====

7.4 Capacity and Resources

7.4.1 General discussion: We commit as much as we can to personal health care, but it's not enough. I don't think the burden is on the system because if we had it we would do it. It helps to look at unusual wider partners. Hospitals do write off services. I don't think the difficulty is lack of resources as much as people don't ask for assistance. Still there are a lot of people going without health care.

7.4.2.3 Comment: Reviewed the Discussion Toolbox before answering. Can someone address "Leadership"? Partners try really hard to connect people. I think the State has strong leaderships for those on Medicaid or CHIP. There are mechanisms for special populations, but what about other people. Do they utilize the leadership of the state agency?

7.4.3 Comment: Reviewed the Discussion Toolbox before answering. We have people with significant skills, but we don't have enough people.

=====

8.1 Planning

8.1.1.1 There are many shortages that show up geographically.

8.1.1.2 Maps are available for each county that show nurses, dentists, physicians, etc...

8.1.2.2 There has been a workforce development work group comprised of agencies, institutions and universities meeting to discuss needs.

8.1.3.1 MPH offer leadership. Don't get any of this at the community college level. What about training offered through the system vs. through education institutions? Whatever happened to the Certified Public Health Program? It did this.

8.1.3.6 Dual MD/MPH program.

8.1.4.1 EH professional has no standard. The MQ for a recently advertised local health department administrator was a GED.

8.1.4.2 This addresses both population and personal health; responses differ by sector. There is no system to demonstrate competency. Radon certification requires a field exercise where you have to actually remediate a home to demo competency. When listed all the public health disciplines, did not mention Registered Sanitarians who have a very high level of competency.

8.1.5.6 Examples include KS Train and Grand Rounds.

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8.2 State Local

8.2.1 Its offered but eligibility requirements are/can be exclusive.

=====

8.3 Performance Management and Quality Improvement

No comments.

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8.4 Capacity and Resources

8.4.3 System has the skills and expertise but doesn't have enough people.

=====

9.1 Planning

9.1.3.1 Using PHAB and NPHPSP.

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9.2 State Local

9.2.2 it's hard for counties to get information /data about their county from the state. County has to ask repeatedly; no system for periodically providing new/updated data. Are there IT security issues that impede access/availability? Have to have a big enough population for data to be maintained; data may not be maintained for small counties.

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9.3 Performance Management and Quality Improvement

Comment: Model standard is hard to understand

9.3.1.2 What does this mean?

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9.4 Capacity and Resources

9.4.1 Does state public health system only commit financial resources that come with specific grants?

=====

10.1 Planning

10.1.1.1 There is a lot of research, but is it collaborative? Many partners in state public health system don't know what research is being done. Collaboration is a high standard: shared goals may require one partner to sacrifice personal goals/gains.

10.1.1.3 There is no definition of Academic Health Department that applies in Kansas. AHD is a mutual agreement to have a formal agreement between academia and the state public health system to perform collaborative research.

10.1.2.1 There is a unity of vision among public health agencies that constitutes an agenda.

10.1.3.1 Midwest Cancer Project. This does not ask if there is a strategy, just if there is SPHS input on research that is conducted.

10.1.3.2 Many examples provided, e.g., diabetes interventions and school a la carte menus.

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10.2 State Local

10.2.1.2 KHI working with KALHDs and local health departments.

10.2.1.4 Research in American Indian and Latino populations.

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10.3 Performance Management and Quality Improvement

No comment.

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10.4 Capacity and Resources

No comment.

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H. Participant Evaluation Report

**Kansas National Public Health System Performance Standards Program
(NPHPSP) Assessment
Evaluation Report
November 2, 2012**

51 Total Responses

Please rate your level of agreement with the following items:

Section #1: Meeting Preparation and Logistics

1. The registration process was well organized.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	2	17	32
% Questn Resp	0%	0%	3.92%	33.33%	62.75%

2. My participant packet was useful.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	2	29	20
% Questn Resp	0%	0%	3.92%	56.86%	39.22%

3. The purpose and objectives for the meeting were clear.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	3	24	24
% Questn Resp	0%	0%	5.88%	47.06%	47.06%

4. The venue was well suited for this type of assessment.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	0	23	28
% Questn Resp	0%	0%	0%	45.1%	54.9%

5. The one day format of the meeting was ideal.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	0	16	34
% Questn Resp	0%	0%	0%	32%	68%

Comments about meeting logistics:

Don't think the objectives were very clear prior to the meeting.
Excellent!
Excellent job.
Good location.
Setting was great compared to yesterday, lunch was great.
Thanks.

Section #2: Components

7. The welcoming remarks helped to create enthusiasm for the assessment (Brenda Nickel/ Aaron Dunkel).

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	7	30	14
% Questn Resp	0%	0%	13.73%	58.82%	27.45%

8. The orientation session provided a clear overview of the assessment (Denise Pavletic) .

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	10	28	13
% Questn Resp	0%	0%	19.61%	54.9%	25.49%

9. My group facilitator managed the assessment process effectively.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	0	2	18	31
% Questn Resp	0%	0%	3.92%	35.29%	60.78%

10. The process used to vote on the performance standards was effective.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	1	6	22	22
% Questn Resp	0%	1.96%	11.76%	43.14%	43.14%

11. The time allotted for discussion of the performance standards was sufficient.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	2	5	23	21
% Questn Resp	0%	3.92%	9.8%	45.1%	41.18%

Comments about meeting components:

Charlotte did a great job moderating the red group.
 Discussions with partners were helpful and would love it to be expanded.
 Excellent facilitation in group 2.
 Felt the PHS was underrepresented
 I think others sometimes voted what they saw others voting. It will be interesting to compare day 1 to day 2 for each essential service to see if they agree.
 I think the voting did not necessarily help build agreement if there was great disparity in the response.
 Voting- Instead of majority takes all, an average would be better (use the likert!)
 The group session was very informative and interactive. Staff did a great job keeping discussion focused and productive.

Section #3: Your Participation

13. I learned something new about our state public health system based on my participation in this assessment.

	<u>Strongly Disagree (1)</u>	<u>Disagree (2)</u>	<u>Neutral (3)</u>	<u>Agree (4)</u>	<u>Strongly Agree (5)</u>
# of responses	0	1	3	21	26
% Questn Resp	0%	1.96%	5.88%	41.18%	50.98%

14. As a result of this meeting, I identified new opportunities for collaboration.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
# of responses	0	0	8	24	19
% Questn Resp	0%	0%	5.88%	47.06%	37.25%

15. Participating in this statewide assessment was valuable.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
# of responses	0	0	3	24	24
% Questn Resp	0%	0%	5.88%	47.06%	47.09%

16. I was able to provide input about our statewide public health system during this assessment.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
# of responses	1	0	2	25	23
% Questn Resp	1.96%	0%	3.92%	49.02%	45.1%

17. I believe our group had the right composition to complete the tool.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
# of responses	0	2	7	29	12
% Questn Resp	0%	4%	14%	58%	30%

18. Please identify any segments of the public health system (if any) that were missing from your group.

- Business community, KU MPH/med, Substance Abuse, Mental Health
- Disability advocates and/or providers
- Education
- Foundations
- Foundations
- Foundations, Researchers, Kansas Leadership Center, KHI
- Funding groups
- HCFA
- Health Care Finance
- Health disparities
- Hospital
- Hospital representation
- Hospitals
- Hospitals, medical providers, insurance companies, businesses, pharmacies
- Hospital systems
- Independent living
- Insurance companies
- KDA, KSU, KAC
- Medical agency
- Insurance agency
- Mental Health
- Private contractors? In the environmental field
- Private healthcare providers
- Seemed heavy on KDHE staff
- Social services

State EPIs
 State epis, local disaster planning person, elected official
 We didn't have a lot of knowledge around hospital assessments

19. Comments about your participation:

Enjoyed the process!
 Great input and info.
 Great session!
 Hope I didn't push my portion too hard.
 I enjoy the process and was glad to be invited.
 I felt like my comments were welcome-because the group was welcoming!
 KDHE staff tended to monopolize the conversation.
 Sonja was AMAZING!
 Thank you for including me! I learned a lot!
 Thanks for the opportunity!
 Very well done! It was worthwhile.

Section #4: About You

20. What Essential Public Health Services (EPHS) session did you attend?

	Group 1	Group 2	Group 3	Other
# of responses	13	19	16	0
% Questn Resp	27.08%	39.58%	33.33%	0%

21. Did you leave early?

	Yes	No
# of responses	3	48
% Questn Resp	5.88%	94.12%

Section #5: General Feedback

22. Please share any ideas you have about using the information from the meeting to plan for improvements in the public health system.

Email back out to partners would be great.
 I feel that there should have been a lot more.
 I would like to meet with KDHE about ACEs implementation in Kansas. We have a CDC pilot project. Vicky Roper KCSL.
 I feel that these questions should have been parceled out to more appropriate agencies. It felt like we were guessing most of the time.
 Linda was an awesome facilitator.
 Post on kansashealthmatters.org.
 Widening the "Public Health Assessment".
 The instructions were daunting but the process was manageable.
 Will use on our local community health assessments.

23. Please share any additional comments you have.

An exemplary demonstration of the kind of work KDHE always provides on our behalf. Well worth a Friday!

Great experience!

Great sessions! Good job Sonya.

Sonja did a great job facilitating.

Thank you for being so inclusive.

Thanks.

Well facilitated session.

We need more activities like this. Linda was a great facilitator.

