



## State Public Health System Performance Assessment

### Report of Results

Kansas Department of Health and Environment - Internal

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

Curtis State Office Building, 1000 SW Jackson, Topeka, Kansas 66612  
<http://www.kdheks.gov/>



## **Kansas Department of Health and Environment (KDHE) NPHPSP Planning Committee**

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- Aaron Dunkel, Deputy Secretary
- Teri Caudle – Division of Health (DOH)
- Sheryl Ervin – Division of Environment (DOE)
- Linda Frazee – DOH
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- Brenda Nickel – DOH, Performance Improvement Manager  
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- Miranda Steele – Office of the Secretary (OOS)

### **Acknowledgments**

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.

- **Association of State and Territorial Health Officials (ASTHO)**
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  - Brenda M. Joly, PhD, MPH, Associate Research Professor, Muskie School of Public Service, University of Southern Maine
- **Centers for Disease Control and Prevention, Office for State, Tribal, Local, and Territorial Support**
  - LCDR Monica Leonard, MPH, U.S. Public Health Service, Performance Officer Division of Public Health Performance Improvement, Health Department and Systems Development Branch
- **Kansas NPHPSP State Assessment Breakout Session Essential Services Facilitators**
  - Aiko Allen – Primary Note Taker Group 1
  - Teri Caudle – Primary Note Taker Group 2
  - Julie Coleman – Primary Note Taker Group 3
  - Sheryl Ervin – Time Keeper and Note Taker Group 1
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  - Brenda Nickel – Facilitator Group 1
  - Debbie Nickels – Time Keeper and Note Taker Group 3
  - Jane Shirley – Facilitator Group 3

### **Disclaimer**

Funding for the Kansas National Public Health Performance Standard Program (NPHPSP) State Assessment was made possible (in part) by the Centers for Disease Control and Prevention. The views expressed in written meeting materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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## **National Public Health Performance Standards Program State Assessment – Internal Partners (KDHE Staff)**

### **Executive Summary**

The Kansas Department of Health and Environment (KDHE) conducted the National Public Health Performance Standards Program (NPHPSP) State Assessment November 1-2, 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 repeat the internal assessment process with staff and members of the management team November 1, 2012 and then to convene public health system external key state agencies and partner organizations. The 2012 NPHPSP baseline results from both internal and external partner assessments document the current Kansas public health system performance providing a foundation for quality improvement activities to be implemented within the state’s public health system, including the lead public health agency: The Kansas Department of Health and Environment.

A core planning committee within KDHE began preparing 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. Version 2.0 of the NPHPSP State Assessment was selected as the 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. 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, primary note takers, and time keepers/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.

The planning committee worked closely with the KDHE Office of the Secretary to assure there was broad representation from the agency’s three divisions. Dr. Robert Moser, KDHE Secretary, sent a letter of invitation (Appendix B) to 97 division, bureau, and program staff (Appendix A) in October 2012. Immediately prior to the assessment, the 61 registered participants (Appendix C) were sent information and resources to familiarize themselves with the NPHPSP process.

Wichita State University was contracted to provide conference management services. The one-day retreat was held November 1 at the Washburn University Student Union. The internal assessment was conducted in one large meeting room separated into three EPHS groups. Each attendee was assigned to a group based their own expertise, knowledge, and experience with the public health standards being measured (Appendix D). 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).

Secretary Moser welcomed participants and Denise Pavletic, ASTHO, provided a keynote presentation. 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 then proceeded to conduct the assessment in their assigned EPHS groups (Appendix E) with the trained facilitator, 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. 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>

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

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

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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 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

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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 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

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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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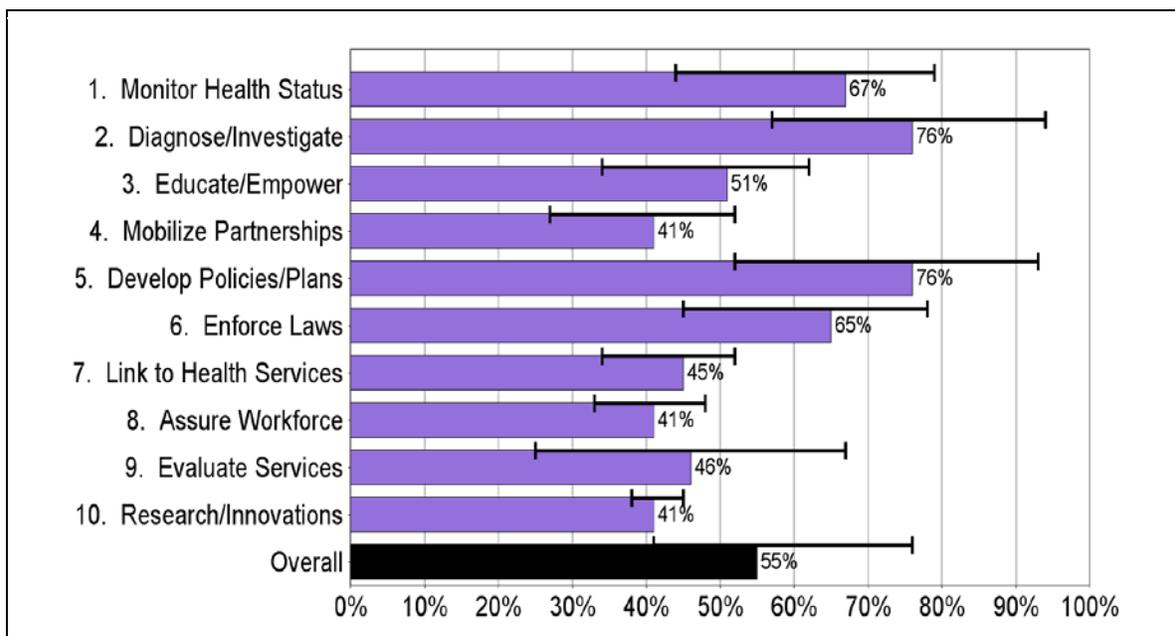
### B. Performance Assessment Instrument Results

#### 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	67
2 Diagnose And Investigate Health Problems and Health Hazards	76
3 Inform, Educate, And Empower People about Health Issues	51
4 Mobilize Community Partnerships to Identify and Solve Health Problems	41
5 Develop Policies and Plans that Support Individual and Community Health Efforts	76
6 Enforce Laws and Regulations that Protect Health and Ensure Safety	65
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	41
9 Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	46
10 Research for New Insights and Innovative Solutions to Health Problems	41
Overall Performance Score	55

**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

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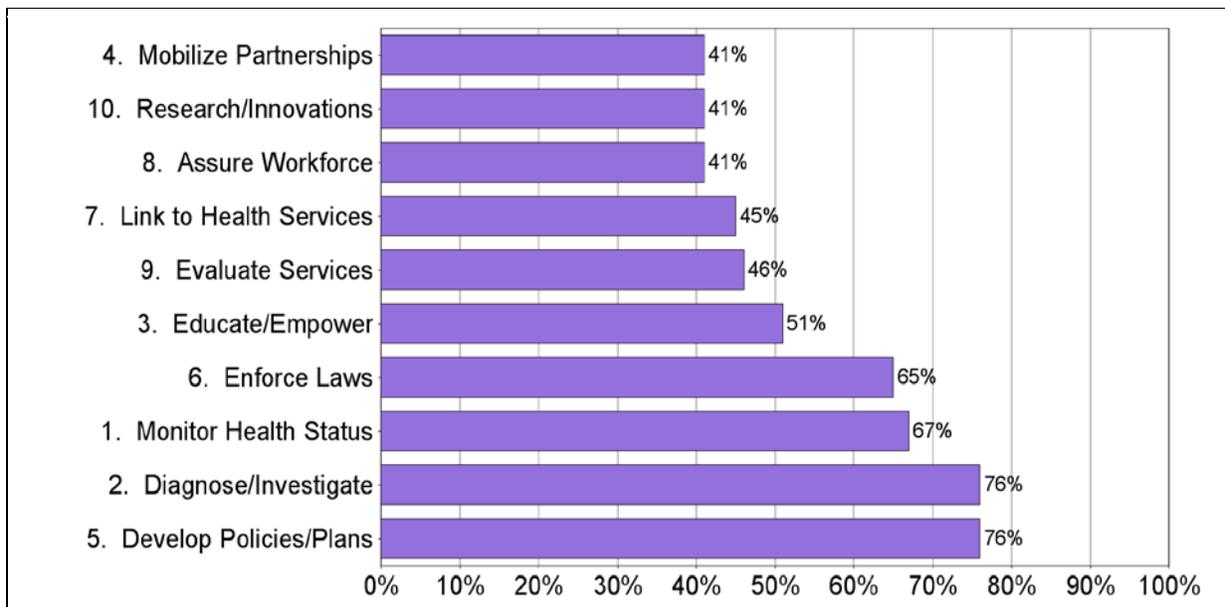
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activities that contribute to each Essential Service. These scores range from a minimum value of 0% (absolutely no activity is performed pursuant to the standards) to a maximum of 100% (all activities associated with the standards are performed at optimal levels).

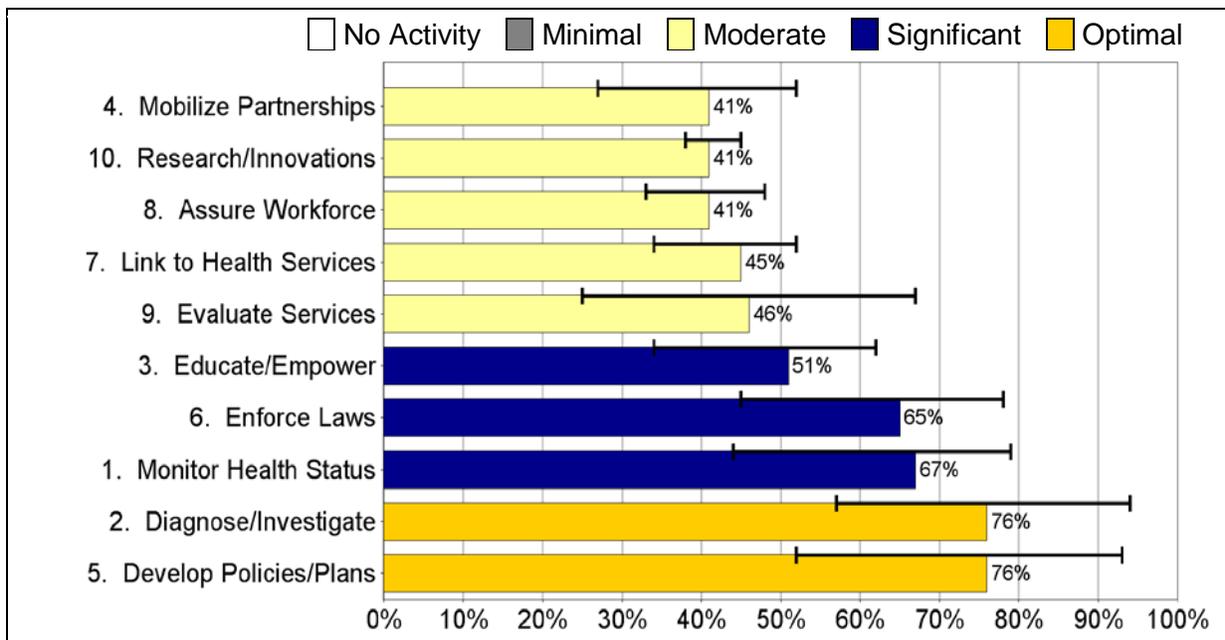
**Figure 1** (above) displays performance scores for each Essential Service and an overall score for the average performance level for all 10 Essential Services. The range bars show the minimum and maximum value of responses within the Essential Service and overall score. Areas of wide range may warrant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

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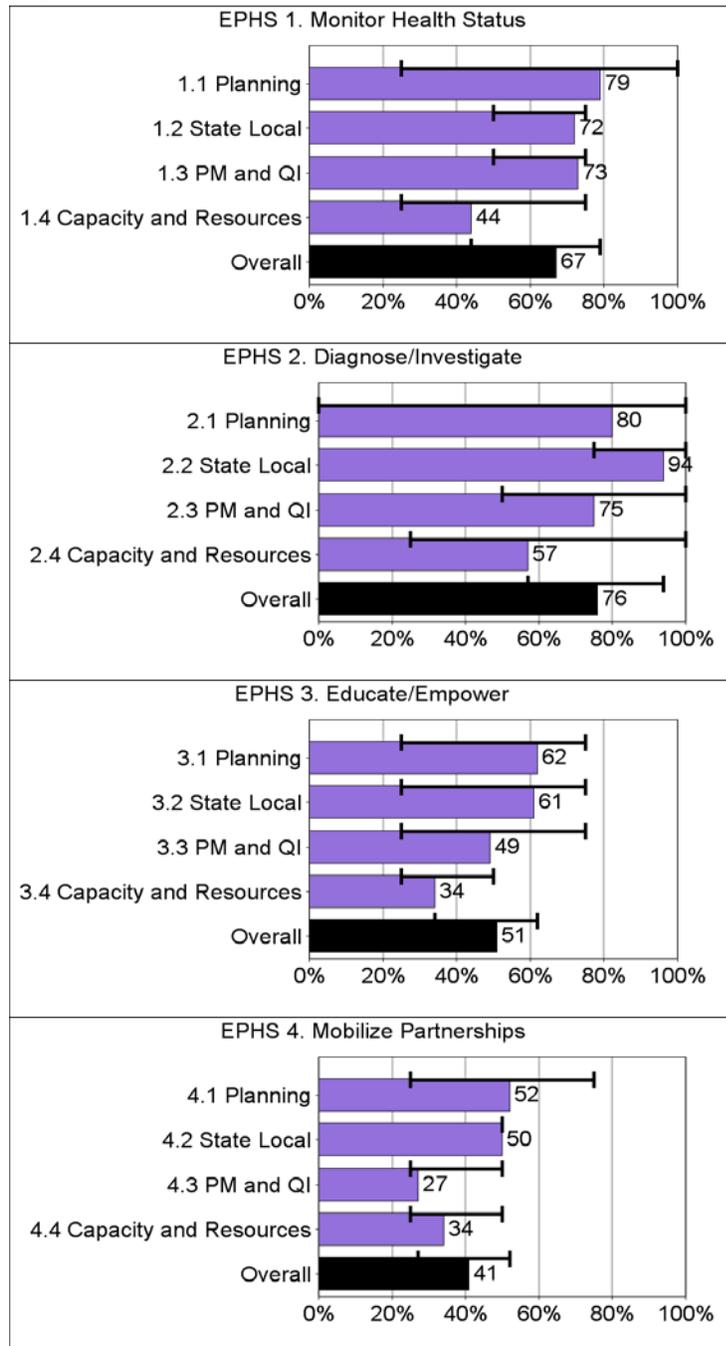
range of responses within an Essential Service. The color coded bars make it easier to identify which of the Essential Services fall in the five categories of performance activity.

**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.

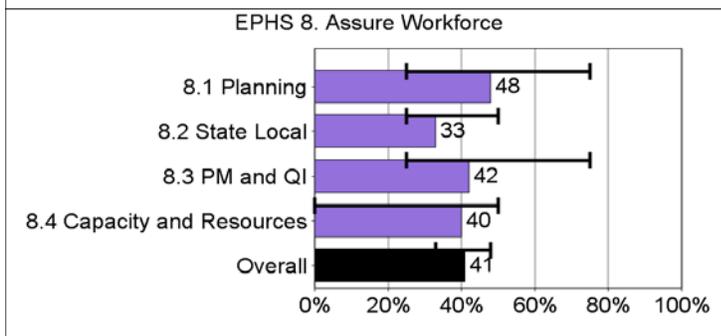
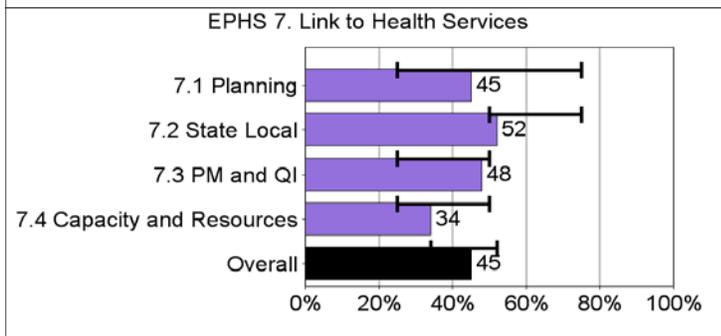
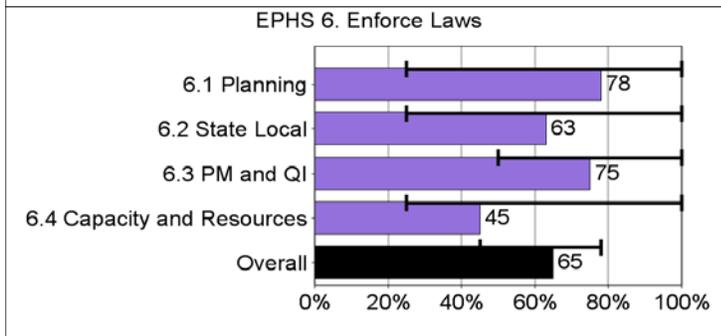
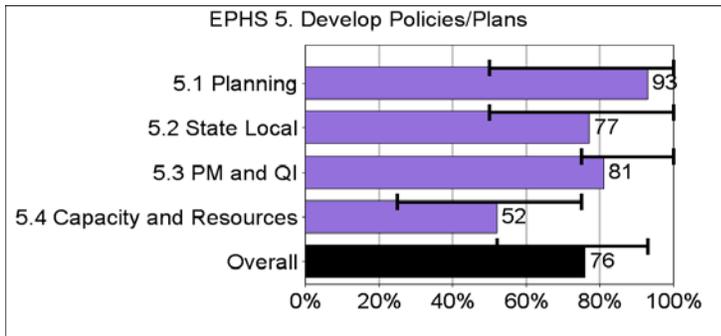
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**II. How well did the system perform on specific model standards?**

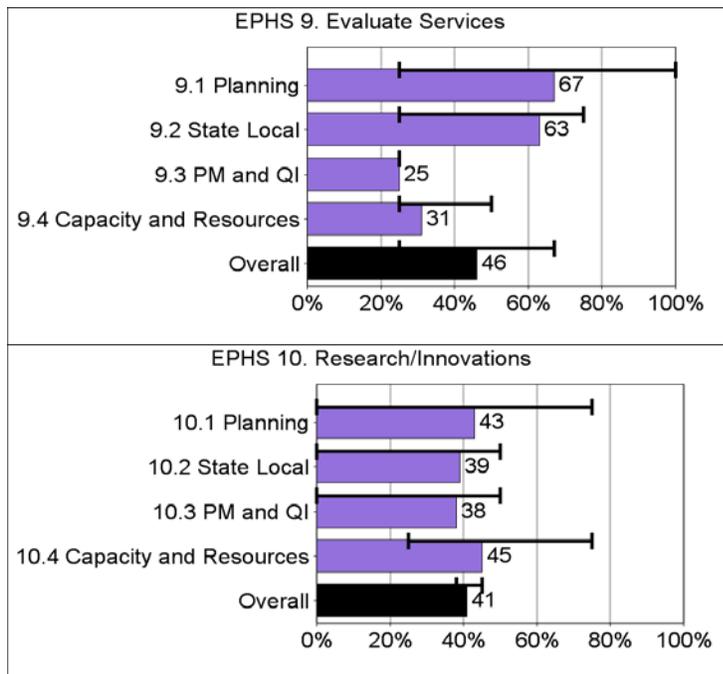
**Figure 4:** Performance scores for each model standard, by Essential Service



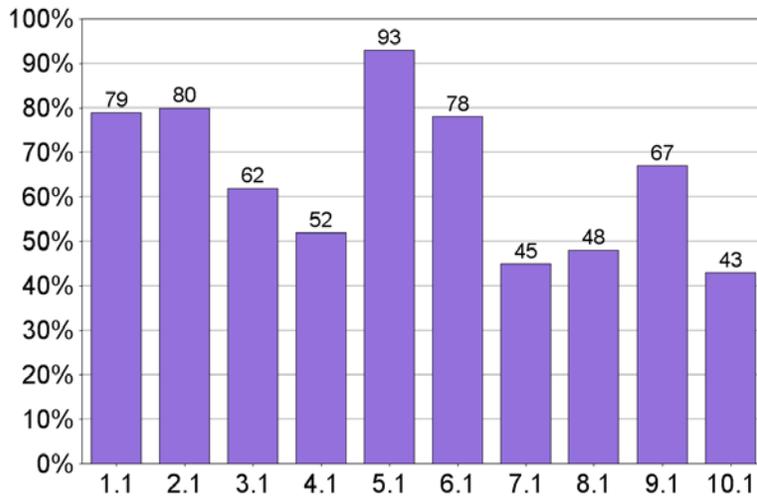
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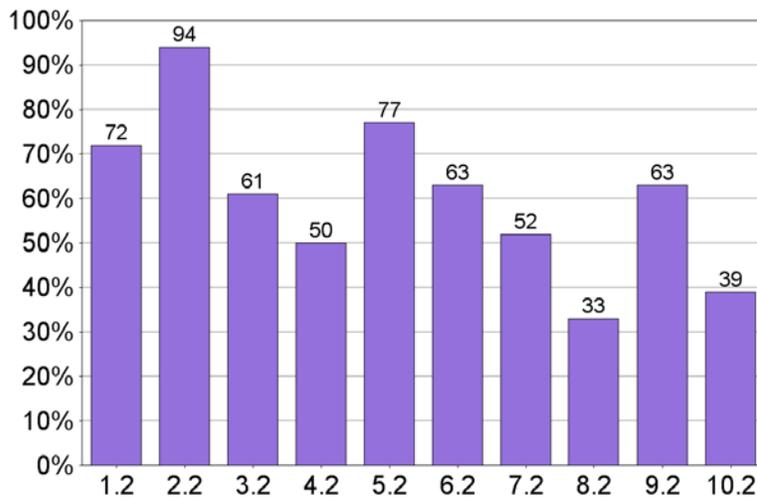
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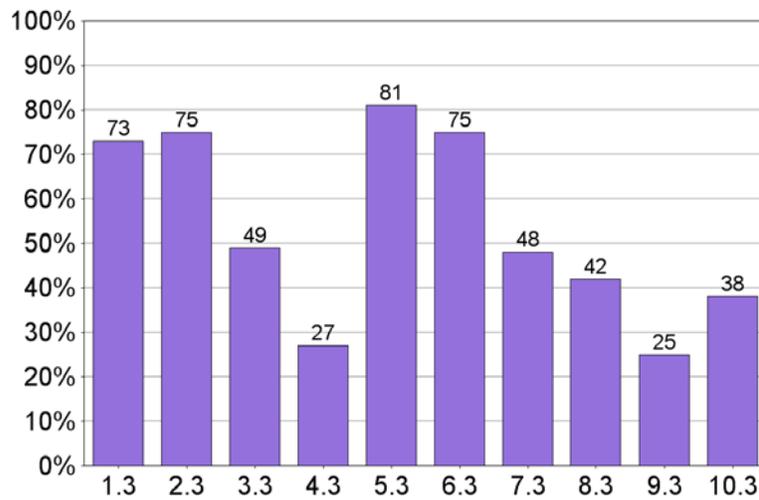


**Figure 5:** Model Standard 1 scores (Planning and Implementation) by Essential Service



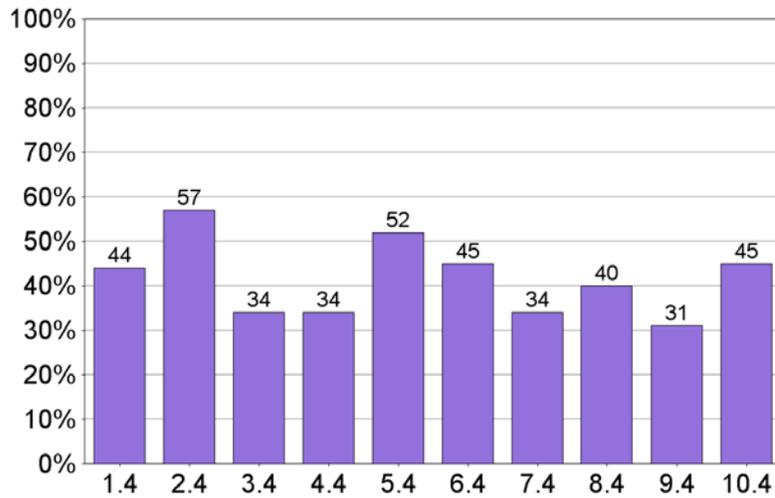
**Figure 6:** Model Standard 2 scores (State-Local Relationships) by Essential Service

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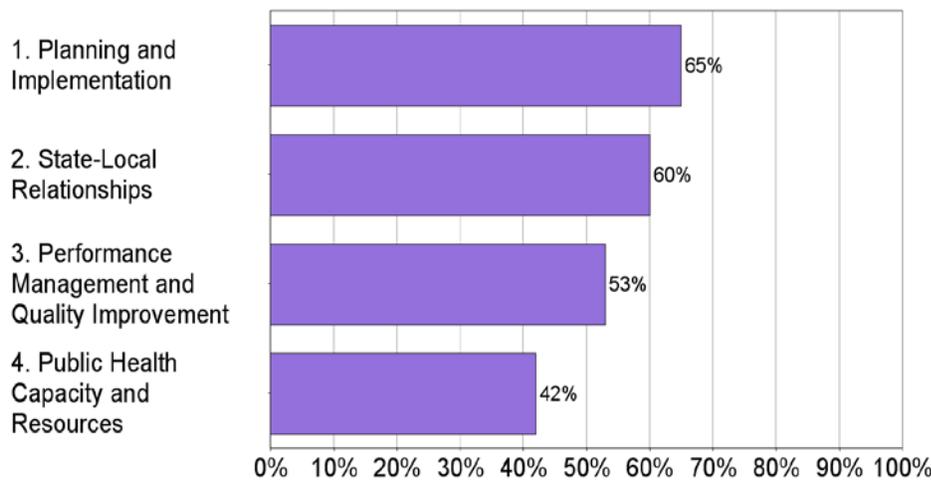


**Figure 7:** Model Standard 3 scores (Performance Management and Quality Improvement) by Essential Service

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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
<b>EPHS 1. Monitor Health Status To Identify Community Health Problems</b>	67
1.1 Planning and Implementation	79
1.1.1 Surveillance and monitoring programs	75
1.1.2 Health data products accessible to data users	70
1.1.3 State health profile	75
1.1.4 Disease reporting system	75
1.1.5 Protection of personal health information	100
1.2 State-Local Relationships	72
1.2.1 Assistance in interpretation and use of health data	75
1.2.2 Uniform set of timely community-level health data	67
1.2.3 Assistance with local information and monitoring systems	75
1.3 Performance Management and Quality Improvement	73
1.3.1 Review effectiveness in monitoring efforts	72
1.3.2 Active performance management	75
1.4 Public Health Capacity and Resources	44
1.4.1 Commit financial resources	50
1.4.2 Coordinate system-wide organizational efforts	50
1.4.3 Workforce expertise	31
<b>EPHS 2. Diagnose And Investigate Health Problems and Health Hazards</b>	76
2.1 Planning and Implementation	80
2.1.1 Broad scope of surveillance programs	58
2.1.2 Enhanced surveillance capability	98
2.1.3 Statewide public health laboratory system	74
2.1.4 Laboratory analysis capabilities	75
2.1.5 Investigations of health problems	95
2.2 State-Local Relationships	94
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	75
2.3 Performance Management and Quality Improvement	75
2.3.1 Review surveillance and investigation procedures	75
2.3.2 Active performance management	75
2.4 Public Health Capacity and Resources	57
2.4.1 Commit financial resources	50
2.4.2 Coordinate system-wide organizational efforts	71
2.4.3 Workforce expertise	50

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<b>Essential Public Health Service</b>	<b>Score</b>
<b><i>EPHS 3. Inform, Educate, And Empower People about Health Issues</i></b>	<b>51</b>
3.1 Planning and Implementation	62
3.1.1 Health education and promotion programs	69
3.1.2 Health communication programs	44
3.1.3 Emergency communications capacity	73
3.2 State-Local Relationships	61
3.2.1 Assistance with health communication and health education/promotion programs	50
3.2.2 Assistance in developing local emergency communication capabilities	73
3.3 Performance Management and Quality Improvement	49
3.3.1 Review effectiveness of health communication and health education/promotion efforts	48
3.3.2 Active performance management	50
3.4 Public Health Capacity and Resources	34
3.4.1 Commit financial resources	25
3.4.2 Coordinate system-wide organizational efforts	46
3.4.3 Workforce expertise	31
<b><i>EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems</i></b>	<b>41</b>
4.1 Planning and Implementation	52
4.1.1 Building statewide support for public health	55
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	27
4.3.1 Review effectiveness of partnerships	29
4.3.2 Active performance management	25
4.4 Public Health Capacity and Resources	34
4.4.1 Commit financial resources	25
4.4.2 Coordinate system-wide organizational efforts	47
4.4.3 Workforce expertise	31

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Essential Public Health Service	Score
<b>EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts</b>	76
5.1 Planning and Implementation	93
5.1.1 Convene collaborative planning processes	98
5.1.2 State health improvement plan	75
5.1.3 State all-hazards preparedness plan and emergency response capacity	100
5.1.4 Policy development activities	98
5.2 State-Local Relationships	77
5.2.1 Assistance and training for local planning	80
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	77
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	52
5.4.1 Commit financial resources	50
5.4.2 Coordinate system-wide organizational efforts	58
5.4.3 Workforce expertise in planning	50
5.4.4 Workforce expertise in policy development	50
<b>EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety</b>	65
6.1 Planning and Implementation	78
6.1.1 Review of public health laws	72
6.1.2 Emergency powers	100
6.1.3 Cooperative relationships to support compliance	69
6.1.4 Customer-centered administrative processes	73
6.2 State-Local Relationships	63
6.2.1 Assistance on enforcement of laws	78
6.2.2 Assistance to local governing bodies in developing local laws	47
6.3 Performance Management and Quality Improvement	75
6.3.1 Review effectiveness of regulatory activities	75
6.3.2 Active performance management	75
6.4 Public Health Capacity and Resources	45
6.4.1 Commit financial resources	25
6.4.2 Coordinate system-wide organizational efforts	42
6.4.3 Workforce expertise	69

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Essential Public Health Service	Score
<b>EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable</b>	45
7.1 Planning and Implementation	45
7.1.1 Assessment of access to care	56
7.1.2 Delivery of services and programs to improve access	50
7.1.3 SPHS entity responsible for monitoring and coordination	42
7.1.4 Mobilizes to reduce health disparities, including during emergency events	31
7.2 State-Local Relationships	52
7.2.1 Assistance in assessment and service delivery	54
7.2.2 Assistance for providers serving underserved populations	50
7.3 Performance Management and Quality Improvement	48
7.3.1 Review effectiveness of programs in improving access, appropriateness of personal health care, and health care quality	46
7.3.2 Active performance management	50
7.4 Public Health Capacity and Resources	34
7.4.1 Commit financial resources	25
7.4.2 Coordinate system-wide organizational efforts	46
7.4.3 Workforce expertise	31
<b>EPHS 8. Assure a Competent Public and Personal Health Care Workforce</b>	41
8.1 Planning and Implementation	48
8.1.1 Assessment of population-based and personal health care workforce needs	63
8.1.2 Statewide workforce development plan	25
8.1.3 Programs to enhance workforce skills	58
8.1.4 Assure excellence in professional practice of workforce members	50
8.1.5 Incentives for life-long learning	44
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	42
8.3.1 Review workforce development efforts	25
8.3.2 Review whether academic-practice partnerships are effective in preparing the workforce	75
8.3.3 Active performance management	25
8.4 Public Health Capacity and Resources	40
8.4.1 Commit financial resources	50
8.4.2 Coordinate system-wide organizational efforts	46
8.4.3 Workforce expertise	25

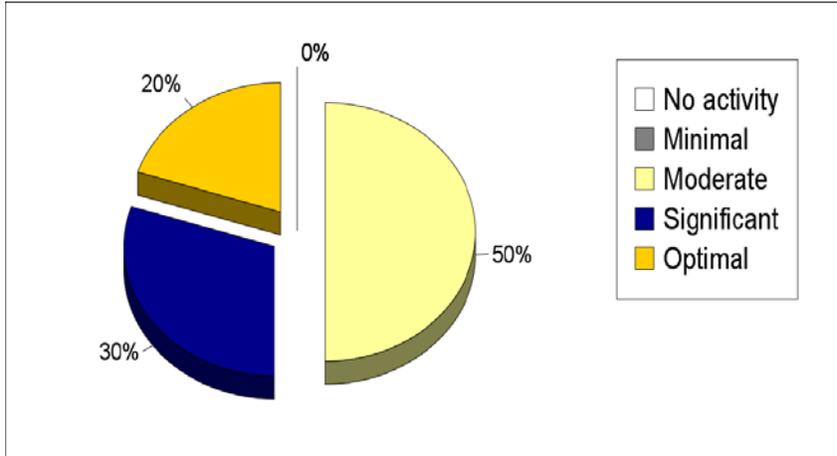
**State Public Health System Performance Assessment - Report of Results**  
*Kansas Department of Health and Environment - Internal 11/29/2012*

Essential Public Health Service	Score
<b><i>EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services</i></b>	46
9.1 Planning and Implementation	67
9.1.1 Evaluate population-based health programs	67
9.1.2 Evaluate personal health care services	83
9.1.3 Assess the performance of the public health system	50
9.2 State-Local Relationships	63
9.2.1 Assistance on evaluation	50
9.2.2 Share state evaluation results to assist local planning	75
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
<b><i>EPHS 10. Research for New Insights and Innovative Solutions to Health Problems</i></b>	41
10.1 Planning and Implementation	43
10.1.1 Academic-practice collaboration to disseminate and use research findings in practice	55
10.1.2 Public health research agenda	16
10.1.3 Conduct and participate in research	58
10.2 State-Local Relationships	39
10.2.1 Assistance in research activities, including community-based participatory research	28
10.2.2 Assistance in using research findings	50
10.3 Performance Management and Quality Improvement	38
10.3.1 Review research activities for relevance and appropriateness	25
10.3.2 Active performance management	50
10.4 Public Health Capacity and Resources	45
10.4.1 Commit financial resources	50
10.4.2 Coordinate system-wide organizational efforts	29
10.4.3 Workforce expertise	56

**State Public Health System Performance Assessment - Report of Results**  
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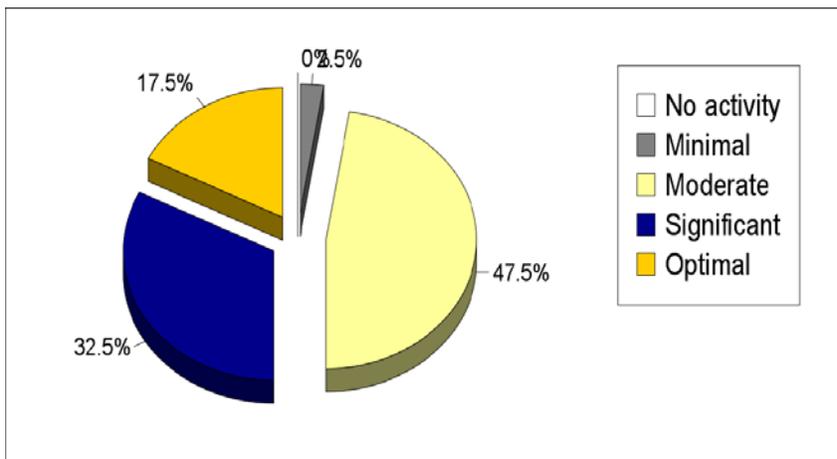
**III. Overall, how well is the system achieving optimal activity levels?**

**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**.

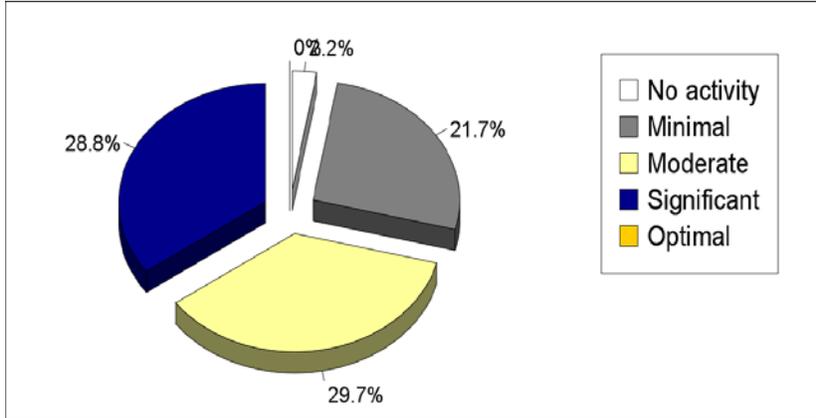
**Figure 11:** *Percentage of model standards scored in each level of activity*



**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](mailto: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 and 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](http://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](mailto: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](http://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



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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](http://www.naccho.org/topics/infrastructure/MAPP) to link directly to the MAPP website.

## Appendices

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

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**Kansas**  
Department of Health & Environment

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[www.kdheks.gov](http://www.kdheks.gov)

Robert Moser, MD, Secretary  
Sam Brownback, Governor

October 12, 2012

Dear KDHE Colleague,

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 (NPHPSP) 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 and through your work as a member of the KDHE team. 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: Washburn University, Student Union, Room Washburn B, 1700 Southwest College Avenue, Topeka, KS 66621

Date: Thursday, November 1, 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 in the KDHE and with partners throughout 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. On November 2, 2012 a second NPHPSP assessment will be conducted with external stakeholders at the Topeka Ramada Inn and will include staff from KDHE to assist people should there be 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. You can view information about the NPHPSP at <http://www.cdc.gov/nphpsp/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/ksnphpsp](http://www.wichita.edu/conferences/ksnphpsp). 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](mailto:bnickel@kdheks.gov) or Jane Shirley [jshirley@kdheks.gov](mailto: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 Internal Stakeholder Invitation Letter\_CPM

### C. Attending Participants

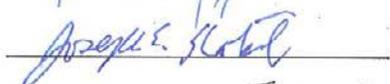
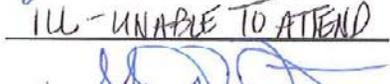
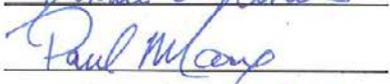
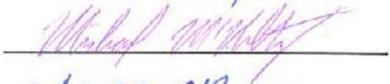
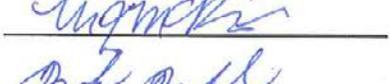
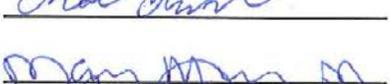
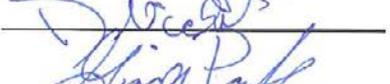
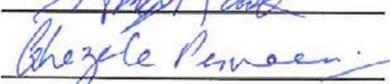
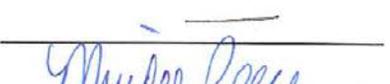
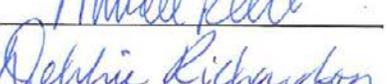
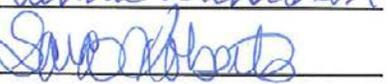
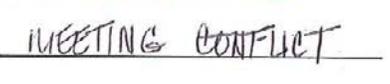
Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment  
 Sign-in Sheet

Day 1, KDHE Internal Stakeholders **67 TOTAL** 21

	Last Name	First Name
<u>Aiko Allen</u>	Allen	Aiko
<u>Nathan Bainbridge</u>	Bainbridge	Nathan
<u>Virginia Barnes</u>	Barnes	Virginia
<u>Rachel Berroth</u>	Berroth	Rachel
<u>Rick Brunetti</u>	Brunetti	Rick
<u>Teri Caudle</u>	Caudle	Teri
<u>Julie Coleman</u>	Coleman	Julie
<u>Martha Cooper</u>	Cooper	Martha
<u>Carol Cramer</u>	Cramer	Carol
<u>Greg Crawford</u>	Crawford	Greg
<u>April Dixon</u>	Dixon	April
<u>Brett Ellis</u>	Ellis	Brett
<u>Paul Endacott</u>	Endacott	Paul
<u>Sheryl Ervin</u>	Ervin	Sheryl
<u>Linda Frazee</u>	Frazee	Linda
<u>Angela German</u>	German	Angela
<u>Martha Hagen</u>	Hagen	Martha
<u>Patricia Haines-Lieber</u>	Haines-Lieber	Patricia
<u>Leo Henning</u>	Henning	Leo
<u>Barbara Hersh</u>	Hersh	Barbara
<u>Charles Hunt</u>	Hunt	Charles

Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment  
**Sign-in Sheet**

Day 1, KDHE Internal Stakeholders

	Keck	Timothy
	Kotsch	Joseph
ILL - UNABLE TO ATTEND	Langer	Tom
	Lechner	Missty
	Liscek	Bonnie
	Marx	Paul Gerard
	McNulty	Mike
	McPherson	Mike
	Michael	Mike
	Murphy	Mary
	Nickel	Brenda J
	Nickel	Emily
	Nickels	Debbie
	Park	Ginger
	Perveen	Ghazala
	Peterson	Colleen
	Randol	Mike
	Reece	Mindee
	Richardson	Debbie
	Roberts	Sara
MEETING CONFLICT	Rutkowski	Rosanne

21

Statewide Kansas National Public Health System Performance Standards Program (NPIIPSP) Assessment  
 Sign-in Sheet  
 Day 1, KDHE Internal Stakeholders

<u>Lou Saadi</u>	Saadi	Lou	
<u>Cherice</u>	Sage	Cherice	23
<u>Stacey Sandstrom</u>	Sandstrom	Stacey	
<u>Jennifer Schwartz</u>	Schwartz	Jennifer	
<u>Julie Sergeant</u>	Sergeant	Julie	
<u>Marc Shiff</u>	Shiff	Marc	
<u>ATTENDED - FACILITATOR</u>	Shirley	Jane	
<u>Sabra Shirrell</u>	Shirrell	Sabra	
<u>Brandon Skidmore</u>	Skidmore	Brandon	
<u>Daric Smith</u>	Smith	Daric	
<u>Heather Smith</u>	Smith	Heather	
<u>Joyce Smith</u>	Smith	Joyce	
<u>Miranda Steele</u>	Steele	Miranda	
<u>Lorrena Steelman</u>	Steeleman	Lorrena	
<u>Thomas Stiles</u>	Stiles	Thomas	
<u>Jane Stueve</u>	Stueve	Jane	
<u>Michael Tate</u>	Tate	Michael	
<u>Dave Thomason</u>	Thomason	Dave	
<u>Cyndi Treaster</u>	Treaster	Cyndi	
<u>Jennifer Vandavelde</u>	Vandavelde	Jennifer	
<u>Brenda Walker</u>	Walker	Brenda	
<u>Bill Bider</u>	Bider	Bill	
<u>Kean Burns</u>	Burns	Kean	

Statewide Kansas National Public Health System Performance Standards Program (NPHPSP) Assessment  
Sign-in Sheet  
Day 1, KDHE Internal Stakeholders

Ruth Werner

Werner

Ruth

John P. Tatehell

2

## D. Ten 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>

*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 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 10:56:33

#### Blue

Id	Name	Organization	Num
62	Berroth, Rachel	Kdhe	
23	Caudle, Teri	Kansas Department Of Health And	
65	Cooper, Martha	Kansas Department Of Health And	
54	Cramer, Carol	Kansas Department. Of Health And	
45	Dixon, April	Kdhe	
3	Hersh, Barbara	Kdhe	
16	Kotsch, Joseph	Kansas Dept. Of Health & Environment	
25	Park, Ginger	Kdhe	
28	Peterson, Colleen	Kdhe	
19	Richardson, Debbie	Kansas Dept. Of Health & Environment	
71	Ross, Becky	Kdhe	
88	Schunn, Christy	SIDS Network Of Kansas, Inc	
32	Shiff, Marc	Kdhe	
8	Shirrell, Sabra	Kdhe	
76	Steele, Miranda	Kansas Dept Of Health And Environment	
61	Treaster, Cyndi	Kdhe	
81	Walker, Brenda	KDHE-Bureau Of Disease Control And	
73	Werner, Ruth	Kdhe	
<b>Total</b>			<b>18</b>

#### Red

Id	Name	Organization	Num
97	Brunetti, Rick	Kdhe	
26	Coleman, Julie	Kdhe	
2	Ellis, Brett	Kansas Department Of Health &	
20	Fraze, Linda	Kdhe	
92	Hagen, Martha	Kdhe	
77	Marx, Paul Gerard	Kansas Department Of Health And	
78	Michael, Mike	Kdhe	
75	Murphy, Mary	Kdhe	
57	Nickels, Debbie	Kdhe	
56	Randolph, Mike	KDHE - Division Of Health Care Finance	
47	Rutkowski, Rosanne	Kdhe	
10	Sage, Cherie	Safe Kids Kansas	
67	Shirley, Jane	Kansas Department Of Health And	
15	Smith, Daric	KDHE; Bureau Of Family Health; CPA Adn	
35	Smith, Joyce	Kansas Department Of Health And	
98	Steelman, Lorrena	Kdhe	
79	Stiles, Thomas	Kansas Department Of Health &	
41	Tate, Michael	Kdhe	

Id	Name	Organization	Num
<b>Total</b>			<b>18</b>

#### Yellow

Id	Name	Organization	Num
58	Allen, Aiko	KDHE Center For Health Equity	
5	Bainbridge, Nathan	Kdhe	
6	Barnes, Virginia	Kdhe	
80	Crawford, Greg	Kdhe Bephi	
104	Endacott, Paul	KS Dept Of Health & Environment	
38	Ervin, Sheryl	Kansas Department Of Health &	
29	Haines-Lieber, Patricia	Kansas Department Of Health &	
95	Hunt, Charles	Kansas Dept Of Health & Environment	
40	Keck, Timothy	Kansas Department Of Health &	
99	Langer, Tom	Kdhe	
4	Liscek, Bonnie	Kansas Department Of Health &	
12	McPherson, Mike	Kdhe	
63	Nickel, Brenda J	Kansas Department Of Health And	
94	Nickel, Emily	Kansas Department Of Health And	
91	Perveen, Ghazala	Kdhe	
9	Sandstrom, Stacey	Kdhe	
36	Schwartz, Jennifer	Kansas Department Of Health And	
83	Skidmore, Brandon	Kdhe	
30	Smith, Heather	Kansas Department Of Health And	
53	Stueve, Jane	Kdhe	
90	Thomason, Dave	KDHE Bureau Of Family Health	
60	VandeVelde, Jennifer	Kansas Department Of Health &	
<b>Total</b>			<b>22</b>

Function Code Total 58

## F. Meeting Agenda

# The National Public Health Performance Standards Program (NPHPSP)



## Kansas State Assessment

### Day 1 - November 1, 2012 KDHE Internal Partner Meeting

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#### **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 is "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.
- 

*This meeting is sponsored by the Kansas Department of Health and Environment. Funding for this presentation was made possible (in part) by the Centers for Disease Control and Prevention through the National Public Health Improvement Initiative, Kansas Grant # 5U58CD001282-02.*

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# 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**  
Dr. Robert Moser, Secretary, Kansas Dept of Health and Environment
- 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: **Yellow** Group 1; **Blue** Group 2; **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.**      **Buffet lunch in room**
- 2:15–3:15 a.m.**      **Beverage Break**
- 2:15-4:00 p.m.      Session III
- 4:00 p.m.**      **Meeting Adjourns**

*This meeting is sponsored by the Kansas Department of Health and Environment. Funding for this presentation was made possible (in part) by the Centers for Disease Control and Prevention through the National Public Health Improvement Initiative, Kansas Grant # 5U58CD001282-02.*

## G. Data Notes from Participant Comments

### 1.1 Planning

1.1.1 Weakness: Mental health and substance abuse not well reviewed. Additional comments: In response to “weakness” there are other organizations that focus on mental health and substance abuse. While many agencies have some of this information- we haven’t figured out how to convey data to the public – and we have a lot. Have been trying to gather information on STDs from MEDICAID – hesitancy to share. Data not always available. We are not sharing data across the system. Facilitating access is the issue – we have the data. Our data doesn’t drill down far enough – small numerator issue may mask disparities.

1.1.1.2. Strength: A lot of strides in this area. Vital stats, infectious and chronic disease. Have done a pretty good job (BRFSS, KIC, etc.)

We all collect data and save in different ways. No one best practice.

1.1.1.3 Weakness: Tug of war over the roles of state and local government agencies. More room for discussion between state and local governments. Not significant yet. Holds us back from being optimal – local needs and communication of these needs to us at state level. Look at PHAB guidance – 10 essential services to know roles. Question: Why is someone collecting data (role) - reason versus the system?

1.1.1.4 Comments: Remember the range of these votes – hope we get at least 50%. Not a question of whether we collect data – but are we facilitating access? This is more of a problem. Who’s collecting data and how are we releasing data. We have countless sites for data. If you are at the local level, and don’t know these sites, what happens? How do you use and interpret data in daily practice?

1.1.2.2 Weakness: Developing these linked data from diverse sources but not there yet.

1.1.2.3 Comments: Smaller counties likely do not use geo-coded data.

1.1.2.5 Strength: Have agreed through KAN PICH to address a standard of data. 22 of 100 are priority indicators. As HK 2020, will have targets for the indicators.

1.1.3 Comment: Have a lot of documents but don’t synthesize into one report.

1.1.4 Strength: Written procedures for receiving information concerning reportable public health threats; receive info from organizations that may have first contacts with health threats. Weakness: MDs don’t report public health threats – first contact (supposed to but don’t). Daycare providers also don’t provide. Comments: System for reporting public health threats and capability to rapidly communicate with potential disease reporters with special alerts.

=====

### 1.2 State Local

1.2.2 Strength: Do provide geo-coded data right now. Weakness: A lot of rural areas may not see value of geo-coding but growing.

=====

### 1.3 Performance Management and Quality Improvement

1.3.1 Comments: How do we want to display HIV/STD data- don't report HIV deaths by county. We could do that and meet some of those needs. How do we imply to a county their relative risk? Sentinel indicators for syphilis. Don't issue a count but have a sentinel flag that can be used for this disease.  
Question: What is timely?

=====

### 1.4 Capacity and Resources

1.4.3.2 Comment: How do you interpret "are you sufficiently staffed"?

=====

### 2.1 Planning

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

2.1.1.6 Comment: We have the Department Operations Center (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.

2.1.2 Comment: We are talking about capability and not capacity. We definitely suffer capacity to respond (LACKING).

2.1.3.2 Comment: Need Memorandum of Understanding (MOUs) to make official.

2.1.4.1 Comment: Don't see distinction between two topics I this substandard. Does this include sending to CDC, etc? Capacity? If there is a huge outbreak the answer to this question is "No way." Trying to get MOUs with other states in case of surge.

2.1.4.2 Comment: Broader (air, water, etc. included). Have contracts in place on the environmental side. Clinical samples – don't have contracts on health side. Capability vs. capacity is important. Capacity: "yes" at current level. If there was a huge outbreak, NO. Newborn testing. If lab goes down, can't do in-state screening.

2.1.5.1 Comment: Infectious disease guidelines on website. KDHE and locals (roles and responsibilities).

=====

### 2.2 State Local

2.2.3 Comment: May have the system but don't have the workforce. Have lots of local health departments that don't have capacity/capability to investigate in a timely manner. Resources don't get devoted to areas where we are optimal. Have bare minimum capacity and in many cases, less than bare minimum.

2.2.3.3 Comment: Participation in KS-HAN – not enough. Need providers on board.

2.2.4 Comments: If not overwhelmed, can do. We don't do surveillance of drop-outs, day care, prisons. Don't look at this.

=====

### 2.3 Performance Management and Quality Improvement

2.3.1. Comment: Infectious disease – early in process of disease surveillance.

2.3.2 Comment: Conduct ongoing quality improvement – Responsibility of local health departments to improve effectiveness

2.3.4 Comment: We have a resource problem related to staff shortages.

2.3.5 Comment: We do work with local labs but not doing the work described in this substandard because of staff shortages. We do not have a list of minimal requirements (beyond what we have from CDC, etc.).

2.3.6 Comment: No portable and back-up off site.

2.3.8 Comment: What does “maintain” mean?

=====

### 2.4 Capacity and Resources

2.4.2 Comment: Should be included as a goal for what we do in the strategic plan.

2.4.2.1 Comment: Environment has strong partnership on their side.

2.4.2.3 Comment: One of our strengths!

2.4.3.2 Comment: We are not a sustainable level.

=====

### 3.1 Planning

Strength: All KDHE programs use media, KS Train, email, web pages, electronic news letters, and social media to provide health information to public

Healthy eating messages in media; Anti-smoking state laws discourage smoking; Green Teams; Foundations that support Built environment, i.e. walking paths, parks; Local communities: Health fairs, presentations to county commissioners and boards of health, community groups engaged to provide health messages via different venues: marquees, theater advertisements, electronic and printed newsletters. We have a variety of organizations with resources, i.e. Parents as Teachers, Healthy start programs, Child care aware of KS, Kansas Service league. Flu shots in a variety of venues; Screening programs(0-3years); Disaster response, blue green algae response; public water supply operator training, remedial task force (sunflower site in Lawrence); Federal agencies that work with us on environmental issues; Sodium Reduction Project, Bullying Prevention Program, Kansas Optimizing Health Program (KOHP), Walk with ease work with community groups, Choose Respect program, Tobacco quit line, worksite wellness, Coordinated School Health for healthier schools; Work with Local Health Departments, HWY Patrol and Police. Many counties are currently involved in Community Health Assessments (CHA) at the local level. This brings many partners to the table. Preparedness Health Coalitions are also being formed

Weakness: Avenues for information are not at peoples' finger tips. There are a lot of vehicles for dissemination of information, but how do we get behavior change. We need to improve on providing opportunities for clear consistent messages prioritized by programs. Adult learners need to hear things at

least 3 times and 3 different ways. Utilization of information, bringing resources together, Health Literacy - Providers doesn't have much time to talk about ways to improve your health. We can inform and educate, but if they don't have the built environment to do the activities there are barriers to empowering them. Many people are working 2 jobs and don't have opportunities to live healthy. Legislation: Fast food restaurants displaying calories, but the question is: How much legislation will society allow? There are language barriers; Many elderly don't use the web; Funding. Not everyone is literate. It is difficult to have information for all the ethnicities; people who have different customs. Limited understanding of the workforce. Lack capacity to incorporate all the education.

General Discussion of ES #3: 3.1.2 It is Important to know that KDHE does a good job, but the voting is reflective of the whole Public Health System in the State.

=====

### 3.2 State Local

3.2.2. We have done a great job in past years, but there is concern about vacant positions and workforce capacity effects and how we will proceed in the future (Not just State employees, but all over the State).

=====

### 3.3 Performance Management and Quality Improvement

Minimal score on Sub-question 3.3.2: Some of the programs do it well and others that do it all. Not consistent. It's about quantity, but it may be hidden. There are some who always do the same thing and don't look to improve their performance. Moderate: It affects some people, but not everyone. CDC tells us how to respond to improve from State to local.

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### 3.4 Capacity and Resources

3.4.1 Within KDHE there is a priority on healthy communities, but outside potential funding sources are pushing for outcomes and after the third and fourth year they drop it.

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### 4.1 Planning

Strength: We convene statewide coalitions about disease conditions. Maternal Child health is Systems focused. We are good at bringing health issues forward. Local agencies are collaborating, but there are problems beyond the scope of a particular program. Environment collaborates locally and regionally. Kan-PICH is a good example of how we pull together partnerships at a high-level that reaches regional and local levels. Partnerships with community based organizations to help solve regionalized problems. National conferences help us see what other states are doing. Healthy Kansas 20/20 brings in partners you don't expect (not usually suspects). Department of education Infant and Toddler Program, has regulations. Community Health Assessments (CHA). Local Public Health Department Regional meetings are bringing County Commissioners to the table and this funnels down.

Weakness: Traditional public partners inhibit seeing the clear link like partners that tie to health. There are opportunities to grow this. KDHE programs have a lot of formal agreements, but resources aren't there. There are new expectations like Electronic Health Records. Volunteer Systems: EMS across the State is

voluntary. Time is an issue. Geographic ally, the State is populated in such a way that there are not as many people in the western part of the State. With changing technology and the way the state is populated, we need to have a build-up in order to build up and get to sustainability.

General discussion: 4.1.1.5 there was a tie between Minimal and Moderate. Minimal: The key word is "established processes" Thinking of county and city officials. Moderate: It does happen in enough areas, but not as well as could be for those who think it is significant. Focused on established processes because we do have a mechanism in place

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#### 4.4 Capacity and Resources

4.4.3.2 There was a tie between Minimal and Moderate. Minimal: The State agency has had a decrease in staff and local decrease in resources. Focused on core functions; building and sustaining partnerships takes extra energy. From the workforce development side, change in staff, new staff, retired. Skill in collaborations takes another level. Moderate: struggling with the word "expertise". There is expertise, but it may be limited - so it is difficult to judge moderate over quantity. Sometimes we are directed to collaborate with people but we don't have any money. Also are we doing them out of necessity? It may be more efficient in some pockets. Moderate are 25 to 50% and I believe we have that amount of activity going on. Partnership development activities are going on.

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#### 5.1 Planning

5.1.2.1 Comment: We don't have a comprehensive state profile – questions are too specific.

5.2.4.3 Comment: KPHA, KALHD, KHI provides this support.

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#### 5.3 Performance Management and Quality Improvement

5.3.1. Comment: Don't do a lot of follow-up. Every 3-5 years.

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#### 6.1 Planning

6.1.1 Comment: "Public Health" and "safety" are not synonymous. Processes are in place, but outcomes may or may not be grounded in health.

6.1.1.1 Comment: We have control over our internal review processes, but Executive Branch review process is out of our control. We can be limited in how far we can go. In Kansas as a whole there is less opportunity for counties and cities to engage. Independence exercised by local government by Home Rule hampers a centralized process. There is a perception that public health professionals direct public health vs. legislators developing policies that are scientific.

6.1.1.2 Comment: There are built in reviews that identify potential negative impacts, like public hearings and cost/benefit analyses;

6.1.1.3 Comment: Solicitation may have some limitations.

6.1.1.4 Comment: Process is not standardized inside or outside the agency. State employees cannot advocate.

6.1.2 Comment: The Secretary has broad powers during emergencies.

6.1.3.2 Comment: There is no dialogue if a new practice is not required or there is no incentive to do it.

6.1.4.1 Comment: We could do better on-line.

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## 6.2 State Local

6.2.2. Decentralized is a barrier.

6.2.1 Comment: We don't have capacity to do this.

6.2.1.1 Comment: Do assist with rules and standards, but not with enforcement protocols.

6.2.1.3 Comment: Resource limited; try to with available resources.

6.2.1.4 Comment: Try to, but resource limited.

6.2.2 Comment: When appropriate.

6.2.2.2 Comment: Locals have strong sentiment of autonomy, and want local control – “State keeps your hands off”.

6.2.2.4 Comment: When there is a problem.

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## 6.3 Performance Management and Quality Improvement

6.3.1.1 Comment: Only when something is broken. There is a real difference between health and environment; environment is impeded by a legislature that does not want to exceed federal law. Activities “chase money”, i.e. are directed to wherever funding is available (economic balloon analogy).

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## 6.4 Capacity and Resources

6.4.2.1 Comment: Most organizations don't have strategic plans. Attitude is there is no money to do these things. State partners are doing it better now because budgets are shrinking.

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## 7.1 Planning

Strength: KanCare will increase coordination and increased access. The Affordable Care Act has movement in the right direction in a lot of fronts, but parts of the law being implemented now are more about capacity building of medical professionals, i.e., increase in age for coverage to 26, no rejection of children for pre-existing conditions. There are efforts being made to link people to care: Maternal Child does home visiting, early intervention and other avenues that link people to personal health services

across a variety of populations. We have a handful of grantees that provide direct prenatal services. We do a good job of linking. Early detection program links women and makes an appointment with the provider for them. The regional trauma program helps implement a regional strategy to get the right care at the right time; although it is not comprehensive. Quality of Care is working with rural hospitals coordinating with long-term care but it does not translate completely. Telemedicine is an opportunity or an avenue to connect people. Kansas Health Information Network (KHIN) is an asset.

Weakness: There is an increase of safety net clinics including community health centers, but those services are hit and miss with the certain programs they offer. They may not see children or pre-natal care. We have a variety of information through HealthWave, but are they linked with primary care providers. We do a good job of linking but not good job of assuring. There is a difference between linking and "connecting". We have good examples of linking and assuring, but it is not systematic from one age to the other or across income levels. There are gaps. The move toward patient center medical home is a string to help bridge this gap. Related to limitations in resources, mental health service access is bad but people are starting to learn about how to blend mental health services into primary care. Language is a major challenge, even though there are a lot of places that do better with Spanish, there are a lot of other languages and many providers don't understand their responsibility under the Federal law. Oral health is on the radar screen, but there are still provider issues there.

General discussion: This topic is politically dynamic and ties closely with policy: Coverage, physical access, mental health. It is a challenge to recognize that the current policy agenda affects this essential service. Need to look at: What is the systems responsibility is in this area? Where are we at today?

7.1.1.4 Working with KanCare - I would say that we do identify barriers. Kansas Health Institute comes out with information on people who are insured, but I'm not sure how it includes special populations.

7.1.3 Health Care Finance oversees the State. KMAU looks at the delivery among safety net clinics. Providers have governing associations. No one was aware of a specific coordinating body that monitors and coordinates personal health care and delivery within the state. "An entity" is the word that makes answering this difficult. This group based their answers on the lack of convening a specific entity. It was discussed that KDHE is the body that oversees this, but it is a multifaceted entity. A State Board of Health may be the entity, but we don't have one. KDHE is the State Policy Authority over health care. We asked Denise from ASTHO if she could give us clarification. She recommended that we vote using the word "entities" in place of "an entity". After further discussion, it was decided that we keep the wording as it is because this assessment will be compared to 2008. What is the intent of the question? We are going to compare ourselves with quality and performance improvement and we need to be consistent with the 2008. The final decision was to look at it as "entities responsible". Statute 65-101 is the first statute that says KDHE is the entity responsible. Voting was done again with the view of KDHE as the entity in place to monitor and coordinate personal health care delivery.

7.1.3.1 \* 7.1.3.2 there are so many activities, there is a Quality Improvement Coordinator in each state. These questions are a lot larger in scope and very complex. We need to keep in mind that we are a decentralized state and a lot of practices come from grass roots up.

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## 7.2 State Local

7.2.2 TA is provided, but it doesn't always improve care.

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## 7.4 Capacity and Resources

7.4.1 We commit as much as we can, but it is not adequate.

7.4.3 Discussed the wording of the question. Some group members didn't like the way it was worded. A lot of skills are leaving with people who have retired and we are not replacing them. Reviewed the Discussion Toolbox. Tried to sort through the question. There is professional expertise linking people to needed health services, but is there something to link them to? Does the word "SKILL" mean that one has all of the skills in all of the areas?

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## 8.1 Planning

8.1.1.1 Comment: Health side regularly assesses health care work force for shortages and contracts to recruit providers. Nothing in environment. What does "population based" mean? Environment structure is more to regulate. Locals don't want dictating/advising on what kind of personnel they need.

8.1.1.2 Comment: Health has some systems in place.

8.1.2 Comment: There are not resources to do this kind of planning.

8.1.4 Comment: System assures we meet minimal levels, not assure we achieve highest level.

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## 8.2 State Local

8.2.3 Make available, but don't have the capacity to assist.

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## 9.1 Planning

9.1.3.1 Comment: Are we talking "people" only, or are we talking environmental outcomes, e.g. MCLs, effluent limits, etc.?

9.1.3.2 Comment: Confusion about what the question really means.

9.1.3.4 Comment: Does this question expect that all organizations know they are part of the state public health system?

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## 9.4 Capacity and Resources

9.4.3.2 Comment: Evaluations only ask for confirmation of pre-determined conclusions.

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## 10.4 Capacity and Resources

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## H. Participant Evaluation Report

**Kansas National Public Health System Performance Standards Program  
(NPHPSP) Assessment  
Evaluation Report  
November 1, 2012**

50 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	1	1	2	21	25
% Questn Resp	2%	2%	4%	42%	50%

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	2	10	30	8
% Questn Resp	0%	4%	20%	60%	16%

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	3	4	24	19
% Questn Resp	0%	6%	8%	48%	38%

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	4	10	8	21	7
% Questn Resp	8%	20%	16%	42%	14%

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	3	1	31	15
% Questn Resp	0%	6%	2%	62%	30%

6. Comments about meeting logistics:

- All in one room was tiring at times.
- Breakout got loud and distracting.
- Couldn't hear too well- Others talking at the same time.
- Difficulty hearing because all 3 groups in 1 room.
- Hard to hear each other.
- Having all 3 groups in the same room was noisy and difficult to hear.
- Having all the groups in one room was not ideal. Hard to hear conversations.
- I wish the introductory power point was included in the packet.
- Instructions on what the meeting was for were not clear. Instructions on where to sit were not

clear.  
 It was difficult to hear.  
 It would have been nice to have groups meet in separate rooms.  
 More details regarding logistics-especially parking at least 2-3 days ahead.  
 Nice job!  
 Not enough time to discuss everything. Sending out info ahead of time would have been helpful.  
 Parking wasn't great. Been nice to separate the groups for noise.  
 Several items handed out later would have been best put into folder. It was way too noisy.  
 Should have breakouts in separate rooms, could not hear others in group.  
 The 3 large groups in one room made it difficult to hear, communicate and focus. I did not feel I had enough data, information and understanding to judge/vote on the standards in such a short time frame.  
 The registration process was confusing and disjointed. The venue was not appropriate for small group discussions- it was too hard to hear. Parking was bad. The room was too warm until after lunch. Typos in the meeting material were unfortunate.  
 Too much overall noise.  
 Too noisy.  
 Very good.  
 Would have been good to have groups in separate rooms. It made it hard to hear discussions.  
 Would've been helpful to have had a map of parking and rooms.

**Section #2: Components**

7. The welcoming remarks helped to create enthusiasm for the assessment (Brenda Nickel/ Dr. Robert Moser).

	<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	6	32	12
% Questn Resp	0%	0%	12%	64%	24%

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	1	7	33	9
% Questn Resp	0%	2%	14%	66%	18%

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	29	19
% Questn Resp	0%	0%	4%	58%	38%

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	1	1	1	25	22
% Questn Resp	2%	2%	2%	50%	44%

21. Did you leave early?

	Yes	No	
# of responses	1	49	(I left for about 90 minutes in the middle of the day.)
% Questn Resp	2%	98%	

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.

- All programs should use the questions at their level to do an assessment.
- Be sure to incorporate comments outside of voting.
- Communicate results effectively.
- Encouraging locals to do a better job planning for advocacy and evaluation.
- Excellent.
- How to break through barriers and engage partners.
- Need more focus on interoperability and data system infrastructure/exchange.
- Some questions should carry more weight than others, for example staffing issues should rank high.
- Still hard pressed to find useful nexus with core environment functions beyond statute and reg to facilitate health initiatives.
- Use separate breakout rooms.
- We must facilitate discussions with the private health care system to identify gaps/misunderstandings.
- We need to crosswalk the scores from these sessions with the KDHE's strategic plan. We also should look into talking with partners about linkages between strategic plans.
- We need to enlist our private sector partners to assist in evaluating and reviewing regulatory schemes.
- Share with participants-where does the recommendation to fill the gaps get addressed?

23. Please share any additional comments you have.

- Funding to do 22.
- Great opportunity.
- It will be interesting to see how the results of today's session will compare to the results from day two.
- Large venue to reduce cross chatter between groups.
- Need to make clear that not scoring "significant" or "optimal" is not necessarily bad. There are some things that KS may do differently, such as research. The agency is not charged to do research, that is typically the purview of the regent's institutions.
- Needed separate rooms for the groups-too noisy to hear.
- Prep work.
- Takes more time than needed- ask many questions that are similar in slightly different ways.
- Thank you for taking on this giant project.
- Thank you on a well-organized day!
- Very organized. Would have been good to be in separate rooms. One group was very loud making it difficult to always hear our group members.
- With 2 other groups talking at the same time, it was difficult to hear my peers.

