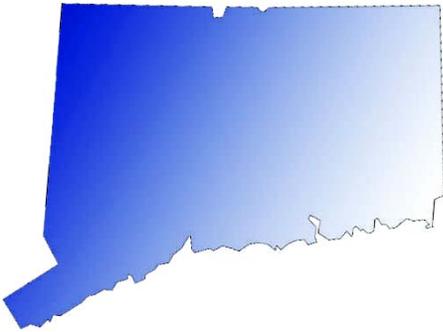


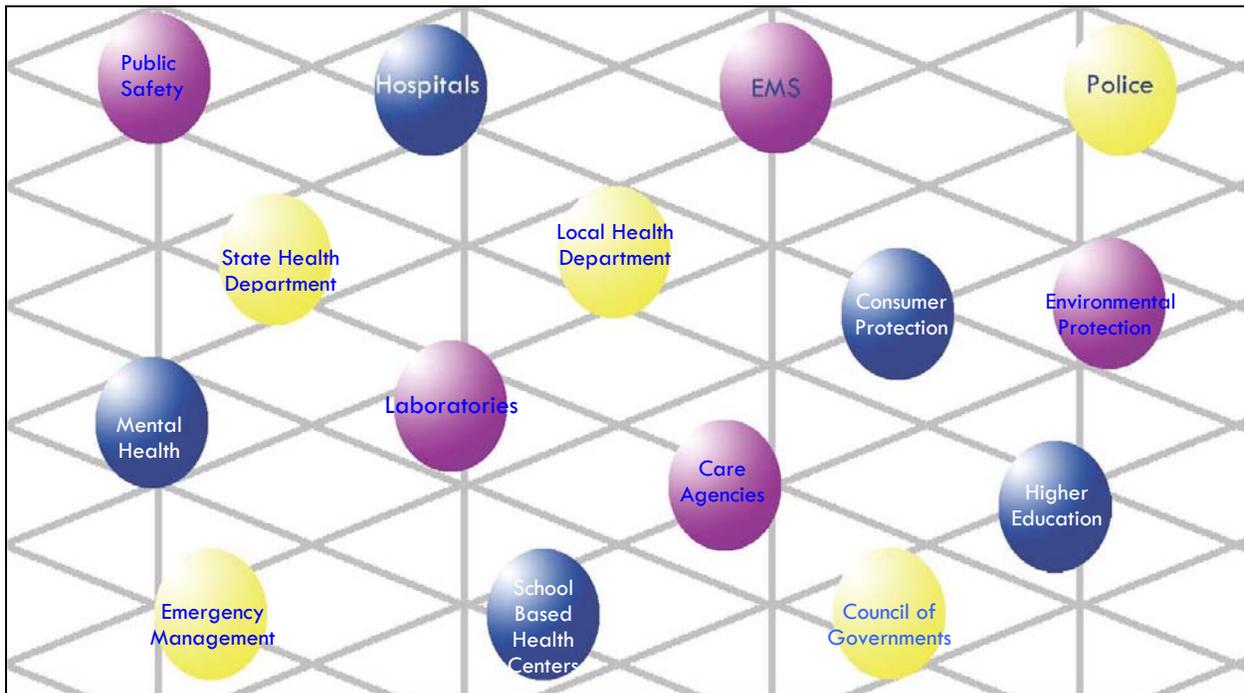
# CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

## FROM SILOS TO SYSTEMS: ASSESSING CONNECTICUT'S STATE PUBLIC HEALTH SYSTEM



### National Public Health Performance Standards Program

October 2008



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Connecticut Department of Public Health  
Local Health Administration Branch  
410 Capitol Avenue, MS #11LOC  
Hartford, CT 06134-0308  
Telephone: (860) 509-7660  
Fax: (860) 509-7782

E-mail: [lora.Shannon@ct.gov](mailto:lora.Shannon@ct.gov) or [barbara.dingfelder@ct.gov](mailto:barbara.dingfelder@ct.gov)

## ACKNOWLEDGEMENTS

*Report prepared by:*

Kathi J. Traugh, MPH  
Yale Center for Public Health Preparedness

*Project funded by:*

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*Cover designed by:*

Lauren Babcock-Dunning  
Yale Center for Public Health Preparedness

*In addition, more than 115 participants representing various organizations affiliated with Connecticut's public health system were engaged to complete the Connecticut National Public Health Performance Standards Program's State Assessment. A special thanks goes to these public health system partners for their participation and insightful input.*

Pamela Kilbey-Fox, MPH  
Branch Chief

Barbara Dingfelder, RN, MPH, PHNCNS-BC, CHES  
Project Coordinator

Connecticut Department of Public Health  
Local Health Administration Branch

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## EXECUTIVE SUMMARY

To address growing concerns about an eroding public health infrastructure as well as the need to improve the quality of services and efficient use of resources, state and local health departments around the nation have embraced the development and use of national public health performance standards. The Centers for Disease Control and Prevention's *National Public Health Performance Standards Program* (NPHSP) grew out of these performance standards initiatives and now provides state and local health departments with a set of standard measurement tools for each level of governance, as well as technical assistance in systems planning.

In June of 2008, the Connecticut Department of Public Health (DPH) conducted the *State Public Health System Performance Assessment*, becoming the 24th state in the nation to participate in the NPHSP program. DPH is the lead administrative agency for public health activities in the state and is mandated by the Connecticut legislature as the lead agency for public health planning. This charge includes assisting in the development of collaborative health planning activities for regional or state-wide health issues.

The assessment conference was titled, *From Silos to Systems: Assessing Connecticut's State Public Health System*. DPH's stated goal for participation in the NPHSP was to "...promote the enhancement of Connecticut's public health infrastructure through the use of performance management principles and a systems approach based on the national core standards." The specific objectives for conducting the assessment conference were to:

- Engage partners in discussions to improve understanding of their role in the public health system
- Engage partners in discussions to rate Connecticut's state public health system's performance based on national performance standards
- Identify strengths of the current state system and identify the less than optimal areas of performance
- Collect data systematically for a baseline measure to inform efforts for strategic planning to strengthen Connecticut's public health system and initiate quality improvement efforts

### Overview of the National Public Health Performance Standards Program (NPHSP)

The NPHSP is a collaborative effort to enhance the nation's public health systems. The stated mission and goals of the NPHSP are to:

- Provide performance standards for public health systems
- Improve the quality and accountability of public health practice
- Conduct systematic collection and analysis of performance data
- Develop a science-base for public health practice improvement

NPHSP assessments help 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 national standards are structured around the *Ten Essential Services of Public Health* (ESPHS), a description of the public health activities that should be undertaken in all communities.

#### The Ten Essential Public Health Services

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

## From Silos to Systems: Assessing Connecticut’s State Public Health System

Connecticut’s statewide assessment was conducted on June 24 and July 1, 2008 at the Marriott in Farmington Connecticut. There were 117 participants, all pre-selected to represent key partners in Connecticut’s statewide public health system. Overall, 50% of participants were from the state or local health departments, 25% were from other state agencies and 25% were from community or statewide health organizations, including hospitals, community based health centers, emergency medical services, academia and planning or health advocacy groups. Participants were pre-assigned to a concurrent breakout session on each day of the conference to assess one of the Essential Services. The response options and corresponding score number range are listed below.

Score Category	Definition	Score Number
NO ACTIVITY	0% or absolutely no activity.	0
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.	1 - 25
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.	26- 50
SIGNIFICANT ACTIVITY	Greater than 50%, but no more than 75% of the activity described within the question is met.	51 - 75
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.	76 - 100

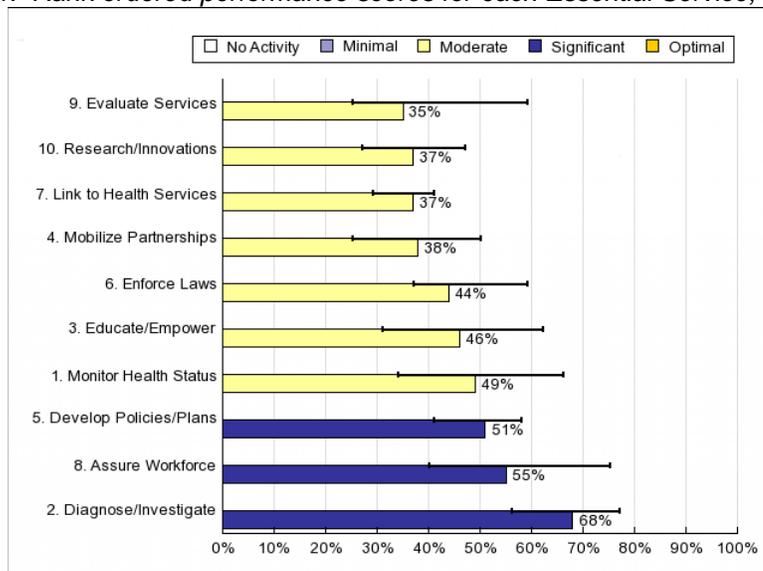
### Overall Performance of State System

Connecticut’s overall score for activity levels in each of the ESPS areas was 46 out of 100, representing a moderate level of activity. Table 1 below lists the consolidated score for each of the ten EPHS areas. The range of scores is from a high of 68 For EPHS 2 (Diagnose and Investigate) to a low of 35 for EPHS 9 (Evaluate Effectiveness). Figure 1 on the next page ranks the services in order of their scores. It also indicates by color the performance category and a bar line shows the range of scores for the four model standards within the EPHS. Seven overall EPHS scores fall in the “moderate activity” category and three scores fall in the “significant activity” category. No EPHS overall scores were in the “no activity,” “moderate activity” or “optimal activity” categories.

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

EPHS		Score
1	Monitor Health Status to Identify Community Health Problems	49
2	Diagnose and Investigate Health Problems and Health Hazards	68
3	Inform, Educate, and Empower People about Health Issues	46
4	Mobilize Community Partnerships to Identify and Solve Health Problems	38
5	Develop Policies and Plans that Support Individual and Community Health Efforts	51
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	44
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	37
8	Assure a Competent Public and Personal Health Care Workforce	55
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	35
10	Research for New Insights and Innovative Solutions to Health Problems	37
<b>Overall Performance Score</b>		<b>46</b>

Figure 1: Rank ordered performance scores for each Essential Service, by level of activity



### Overall Performance of the Model Standards by the State System

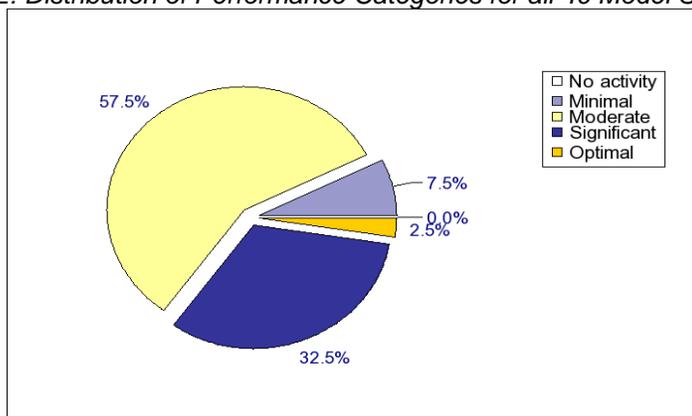
The State Instrument uses the following four model standard titles within each Essential Service, for a total of 40 model standards. Each model standard is followed by assessment questions that serve as measures of performance.

1. Planning and Implementation
2. State-Local Relationships
3. Performance Management and Quality Improvement
4. Public Health Capacity and Resources

The average of all scores for the four Model Standard Topic Areas across all 10 EPHS shows that Connecticut’s SPHS had the greatest amount of activity in the area of Planning and Implementation (55%), followed by State-Local Relationships (45%) and Performance Management and Quality Improvement (44%). The lowest level of activity (40%) was found in standards measuring Public Health Capacity and Resources.

Figure 2 shows the performance category rating of all 40 Model Standards. There were no Model Standard areas showing “no activity.” Most standards (57.5%) showed “moderate activity” and almost one-third (32.5%) were found to have “significant activity”. Fewer numbers of standards fell into the “minimal activity” category (7.5%) and “optimal activity” category (2.5%).

Figure 2: Distribution of Performance Categories for all 40 Model Standards



## **Common Qualitative Themes**

The qualitative data collected at the conference session reflected participants' commitment to the assessment process and improving performance. Many participants commented on how much they enjoyed meeting and interacting with partners from different parts of the public health system. The idea of a state "public health system" was new to many and even more challenging was voting on assessment questions from a systems performance perspective. In the conference evaluation, many mentioned the difficulty of evaluating the system based on their own limited knowledge. Within the EPHS breakout discussions there were numerous instances when the groups struggled to determine a collective interpretation of the assessment question.

Other overarching themes:

- There is a need for better understanding of what constitutes the collective state public health system vs. the state public health agency (DPH).
- DPH was viewed as a ready source of expertise and accessible resources. However, partnering with DPH can be difficult due to its regulatory authority over system partners.
- Mechanisms for organized/systematic sharing of information across the SPHS are needed.
- Many organizations contribute to the provision of the EPHS in Connecticut and are committed to improving their performance.
- The current "system" is fragmented, with public health activities largely taking place in categorical silos. A common vision and SPHS strategic plan are needed.

## **Recommendations**

The Connecticut Department of Public Health considers the 2008 Assessment as the first phase in the ongoing strategic planning for the state's public health system. The results from this assessment should be regarded as baseline and a call to action. Recommendations for the state to move forward with performance standards improvement efforts to take Connecticut's SPHS from "silos" to "systems" include:

- Sharing the results of this report with public health system partners and policymakers to encourage additional dialogue and communication within and between partners and about the state's public health "system."
- Continuing collaboration with Connecticut's Local Health Departments regarding initiatives on national performance standards for local public health systems.
- Convening a core team to complete the *Priority Questionnaire*. The questionnaire, which asks about the priority of each model standard to the public health system, can link performance scores in this report to system priorities and help target limited resources for performance improvement.
- Completing the additional *Agency Contribution Questionnaire*. This second questionnaire, which asks about the contribution of the public health agency to each model standard, can assist the public health system in considering each role in performance improvement efforts.
- Using the findings of this assessment to inform state health planning, evaluation and assessment initiatives to: 1) increase accountability and efficient use of scarce resources; 2) promote a shared vision of expectations across organizations; 3) align Connecticut's SPHS performance with national efforts; and 4) advance a systematic approach that uses results to drive performance improvement.

## SECTION 1: INTRODUCTION

### Overview

To address growing concerns about an eroding public health infrastructure as well as the need to improve the quality of services and efficient use of resources, state and local health departments around the nation have embraced the development and use of national public health performance standards. Use of performance standards has many perceived benefits, including:

- Improved accountability
- Better resource deployment
- Enhanced capacity building
- Strengthening of partnerships and “systems thinking”
- More widespread use of best practices
- Greater focus on mission and goals

The Centers for Disease Control and Prevention’s *National Public Health Performance Standards Program* (NPHSP) grew out of performance standards initiatives begun in the 1990s and now provides state and local health departments with a set of standard measurement tools for each level of governance, as well as technical assistance in systems planning. The national standards are structured around the *Ten Essential Services of Public Health*, a description of the public health activities that should be undertaken in all communities.

*“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.”* (Source: NPHPSP State Public Health System Report of Results for Connecticut)

The Connecticut Department of Public Health (DPH) recognized the challenge and conducted the State Public Health System Performance Assessment, becoming the 24th state in the nation to participate in the NPHSP program. The June 2008 conference was titled, *From Silos to Systems: Assessing Connecticut’s State Public Health System*. DPH’s stated goal for participation in the NPHSP was to “...promote the enhancement of Connecticut’s public health infrastructure through the use of performance management principles and a systems approach based on the national core standards.” The specific objectives for conducting the assessment conference were to:

- Engage partners in discussions to improve understanding of their role in the public health system
- Engage partners in discussions to rate Connecticut’s state public health system’s performance based on national performance standards
- Identify strengths of the current state system and identify the less than optimal areas of performance
- Collect data systematically for a baseline measure to inform efforts for strategic planning to strengthen Connecticut’s public health system and initiate quality improvement efforts

DPH is the lead administrative agency for public health activities in the state. Current provision of services and programs is based on Federal mandates, Connecticut Public Health Code and General Statutes, and additional contractual agreements for program services. Agency activities are monitored and evaluated based on the regulatory criteria, categorical programs, or contract deliverables. DPH provides direct services in a limited number of areas, such as laboratory services and health care system regulation. Many other state agencies play a role in the health of Connecticut residents and provision of health care

services. DPH provides services to specific populations through the *Breast and Cervical Cancer Early Detection Program*, *Title V Children and Youth with Special Needs Program*, and others.

Population-based essential public health services are primarily provided by local health departments (LHDs) in Connecticut. At the time of this report, there are 80 LHDs in Connecticut, 20 of which are multi-town departments called health districts. LHDs and health districts are governmental entities linked to DPH by statute. All municipalities must be served by a local health department/district, and local government has significant control and authority over local health functions.

## Health Planning in Connecticut

DPH is mandated by the Connecticut legislature as the lead agency for public health planning. This charge includes assisting in the development of collaborative health planning activities for regional or state-wide health issues. Comprehensive state health plans were released by DPH in 1986 (*Health Connecticut: Looking Ahead, Planning Ahead*) and again in 1999 (*Looking Towards 2000: An Assessment of Health Status and Health Services*, which is available at the following url <http://www.ct.gov/dph/cwp/view.asp?a=3130&q=3896978>). The 1999 report emphasized the dramatic changes to the organization, delivery and financing of personal health care services, the resultant stress those changes have placed on the state's public health and "safety net" providers, and overall threats to quality and access to care posed by escalating health care costs. The report also noted that the ten essential public health services must be performed at all levels of governmental public health and called for public health to take a "...systematic approach to anticipate, control and prevent disease and injury, as well as diagnose and treat occurrences." (p 24)

The most recent assessment of public health services was the *Legislative Program Review and Investigations Committee Preparedness for Public Health Emergencies Report* in 2004 (available at [http://www.cga.ct.gov/2004/pridata/Studies/Public\\_Health\\_Prep\\_Final\\_Report.htm](http://www.cga.ct.gov/2004/pridata/Studies/Public_Health_Prep_Final_Report.htm)). The scope of the study was limited to assessing the current status of public health preparedness planning and the process of capacity building for response. A more "systems-based" approach was taken in the assessment and many different system partners were included in the review, including acute care and emergency medical services. The report's authors noted that the lack of agreed upon national standards in public health preparedness was an important limitation in the study and called for DPH to define relevant performance measures for the public health emergency preparedness system and to use assessments of system performance to guide future spending priorities.

Presently, the Governor's Office is leading an initiative to coordinate the efforts of seven state agencies with statutory responsibility for health planning (the Office of Health Care Access and the Departments of Children and Families, Mental Retardation, Mental Health and Addition Services, Social Services, Emergency Management and Homeland Security and Public Health). This initiative aims to identify common strategies among these divergent agencies and align planning around five strategic goals:

- Access to health services
- Enforcement authority
- Improved health status and quality
- Organized resources
- Utilization of public/private practices

On the local level, 15 local health departments in Connecticut have conducted the NPHPSP local assessment and one local board of health has completed the NPHPSP assessment for governance since 2001.

It is against this backdrop that DPH made the decision to conduct the state NPHPSP assessment in the spring of 2008. First, DPH Local Health Administration Branch (LHAB) viewed the assessment and determined that it constituted a "valuable jumping off point" to build on prior state and local assessment and planning initiatives that had focused on quality improvement. Second, it offered the potential to establish long-term performance improvement efforts and an overarching strategic planning process. And

finally, the assessment provided the opportunity for system stakeholders to learn about services provided by others and to look at the system as a whole.

DPH LHAB contracted with the Yale Center for Public Health Preparedness (YCPHP) to 1) provide technical assistance with the planning and implementation of the assessment conference; 2) manage the data collection and submission to the NPHPSP and 3) write a report of the assessment results, in collaboration with DPH. This report from YCPHP provides a summary of results from the *NPHPSP State Public Health System Assessment Report of Results for Connecticut* and also includes qualitative data captured during the conference's deliberative process that provide context for the NPHPSP data analysis. The purpose of this report is to help Connecticut gain a solid understanding of the performance of its public health system and move on to the next step in strengthening their public health system. Some sections of this report's narrative are excerpted from NPHPSP user documents and the NPHPSP Connecticut report.

## **Overview of the National Public Health Performance Standards Program**

The National Public Health Performance Standards Program (NPHPSP) is a collaborative effort to enhance the nation's public health systems. Seven national public health organizations (see below) have partnered to develop national performance standards for state and local public health systems. The stated mission and goals of the NPHPSP are to improve the quality of public health practice and the performance of public health systems by:

1. Providing performance standards for public health systems
2. Improving quality and accountability of public health practice
3. Conducting systematic collection and analysis of performance data
4. Developing a science-base for public health practice improvement

There are three distinct sets of performance standards, each contained in an assessment instrument: state system, local system and local public health governance (i.e., local board of health). 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.

### **The NPHPSP 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)

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 Framework**

There are four concepts that frame the NPHPSP, which are described next.

### 1. The Essential Public Health Services

The Essential Public Health Services (Essential Services or EPHS) provide the fundamental framework for the NPHPSP instruments by describing the public health activities that should be undertaken in all states and communities. The Essential Services were first set forth in a statement called *Public Health in America* and were developed by the Public Health Functions Steering Committee in 1994 (convened by U.S. Department of Health and Human Services). The *Public Health in America* statement includes a vision, mission, purpose, and responsibilities for public health (See Appendix A).

#### **The Ten Essential Public Health Services (Essential Services)**

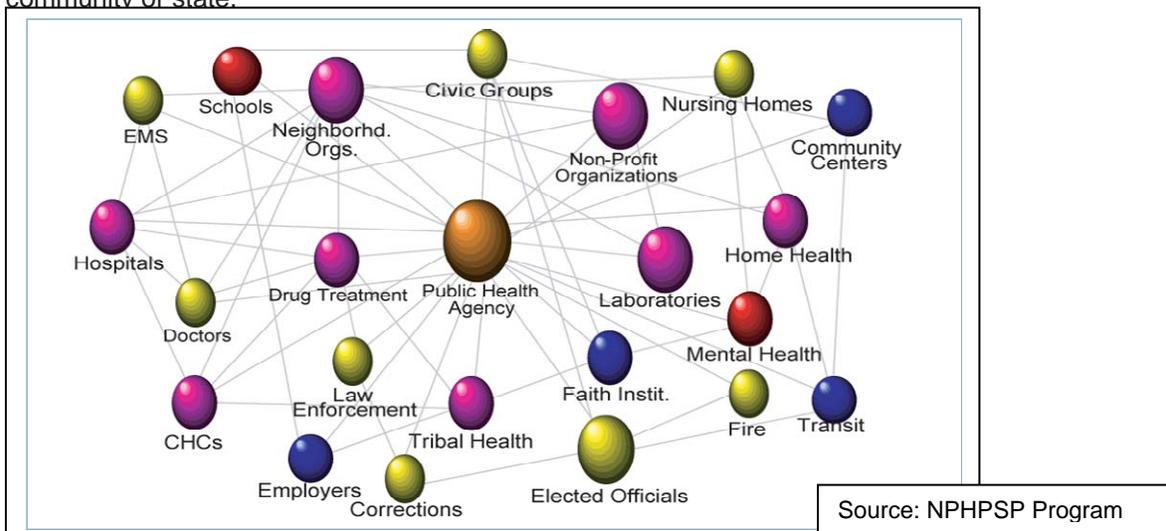
1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Source: Public Health Functions Steering Committee: *Public Health in America*. July 1994

### 2. Focus on the Public Health System

The second concept is a focus on the overall “public health system.” This ensures that the contributions of all entities are recognized in assessing the provision of public health services. Clearly, the governmental public health agency – either at the state or local level – is a major contributor in the public health system, but these agencies alone cannot provide the full spectrum of Essential Services.

Public health systems are commonly defined as “all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.” These systems are a network of entities with differing roles, relationships, and interactions and are depicted in the graphic below. All the entities within a public health system contribute to the health and well-being of the community or state.



### 3. Optimal Level of Performance

Frequently, performance standards are based on a minimum set of expectations. However, these types of standards may not stimulate organizations to strive for higher levels of achievement. It is for this reason that the NPHPSP describes an optimal level of performance and capacity to which all public health systems should aspire. Optimal standards provide every public health system – whether more or less sophisticated – with benchmarks by which the system may be judged. In comparing the current status to optimal benchmarks, systems are able to identify strengths and areas for improvement. In addition, optimal standards provide a level of expectation for use in advocating for new resources or needed improvements in order to better serve the population within a jurisdiction.

### 4. Quality Improvement

Last, the NPHPSP promotes and stimulates quality improvement. As a result of the assessment process, the responding jurisdiction is able to identify strengths and weaknesses within the state or local public health system or the governing entity and may use this information to pinpoint areas that need improvement. If the results of the assessment process are merely filed away or sit idly on a shelf, much of the hard work that is devoted to completing the instrument will be wasted. The responding jurisdiction must develop and implement system improvement plans to realize the full benefit of the NPHPSP.

## ***NPHPSP State Instrument: Model Standards Areas***

The State Instrument uses the following four model standard titles within each Essential Service, for a total of 40 model standards. 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.

1. **Planning and Implementation** – focuses on collaborative planning and implementation of key activities to accomplish the Essential Services.
2. **State-Local Relationships** – examines the assistance, capacity building and resources that the state public health system provides to local public health systems in efforts to implement Essential Services.
3. **Performance Management and Quality Improvement** – focuses on the state public health system's efforts to review the effectiveness of its performance and the use of these reviews to continuously improve performance.
4. **Public Health Capacity and Resources** – examines how effectively the state public health system invests in and utilizes its human, information, organizational and financial resources to carry out the Essential Services.

## **From Silos to Systems: Assessing Connecticut's State Public Health System**

Connecticut's statewide assessment was conducted on June 24 and July 1, 2008 at the Marriott in Farmington Connecticut. There were 117 participants, all pre-selected to represent key partners in Connecticut's statewide public health system. Overall, 50% of participants were from the state or local health departments, 25% were from other state agencies and 25% were from community or statewide health organizations, including hospitals, community based health centers, emergency medical services, academia and planning or health advocacy groups. A list of participants with their affiliations and assessment facilitators can be found in Appendix B.

On Day One (see Appendix C for conference agendas), participants were provided with an orientation to the NPHPSP and the discussion and voting format to be used in the assessment. Participants then went to their pre-assigned concurrent breakout sessions to assess one of the Essential Services 1 through 5. The assignment of participants was made by DPH to help assure that key system partners in the provision of an essential service were represented in each breakout assessment. On Day Two, participants assessed one of Essential Services 6 through 10. When possible, DPH maintained the same cohorts of participants in the breakout sessions on both days.

Facilitation of the assessment was coordinated by YCPHP. A unique feature of the Connecticut assessment was to use the services of a team of experienced facilitators from the state of New Jersey to lead the assessment process in each room. The New Jersey team members had considerable experience with the local NPHPSP tool, as well as the discussion and voting process. They also brought objectivity to the guiding of the conversation in each room. Also assisting in the facilitation was a recorder that captured key points on easel pads; a note taker that took down major elements of the discussion and a score-keeper that recorded the votes on each assessment question.

The Connecticut assessment used the NPHPSP State Performance Assessment instrument only. States are encouraged by NPHPSP to also complete two optional questionnaires as a part of the SPHP assessment: the *Priority Questionnaire*, which asks about priority of each model standard, and the *Agency Contribution Questionnaire*, which assesses the state public health agency's contribution to achieving each model standard. Due to time constraints, DPH elected not to complete these questionnaires at the time of the statewide performance assessment.

### **Scoring System**

Each participant was provided with a hard copy of the assessment instrument and a set of score cards that reflected the response options found on page 12. To maintain consistency, these same categories are used in this report to characterize levels of activity for Essential Services and model standards.

Following the conference, the score for each performance measure was submitted to CDC for analysis. [The scoring methodology is available from CDC or can be accessed on-line at <http://www.cdc.gov/od/ocphp/nphpsp/Conducting.htm>] This report contains the results from the CDC analysis in the form of user friendly figures and tables, as well as qualitative analysis conducted by YCPHP of the important discussion surrounding the “vote” for each performance measure.

<b>Score Category</b>	<b>Definition</b>	<b>Score Number</b>
NO ACTIVITY	0% or absolutely no activity.	0
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.	1 - 25
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.	26- 50
SIGNIFICANT ACTIVITY	Greater than 50%, but no more than 75% of the activity described within the question is met.	51 - 75
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.	76 - 100

*Assessment Scoring Options*

Following the conference, YCPHP submitted the average rating for each measure to the NPHPSP online data and reporting system maintained by the CDC, which analyzed the data and provided summary performance scores for each EPHS and model standard area in the form of an electronic report. Selections from this NPHPSP report are included in the body of this report. The complete CDC Performance Assessment Results for Connecticut can be found in Appendix D.

### **Data Limitations**

The performance scores in this report are composite scores. They are based on the stem question scores, which represent a composite of the stem question and sub-question responses. Model standard scores are a composite of the question scores within that area.

While every effort was made to have all key system partners represented in each EPHS assessment, the

entire public health system was not represented. Gaps in information and perspectives were noted in all EPHS assessment discussions, but were particularly profound in EPHS 2 (Diagnose and investigate health problems) and ESPS 7 (Link people to needed personal health services). In addition, it must be emphasized that the performance score votes represent the personal judgments of those individuals in attendance, introducing a level of subjectivity.

There were differences in knowledge about the public health system across the groups of participants. This may have led to difference in interpretations of the assessment questions. Participants frequently expressed difficulty ascertaining if they were voting for the level of activity in that ESPS from a “systems” perspective, or if their vote reflected the level of activity provided by their agency/sector. Some noted it was difficult to interpret the meaning of some questions in the context of the SPHS, as this was the first time they had looked at public health in Connecticut as a “system.”

The group assessing ESPH 9 decided as a group not to respond to the set of questions in Section 3, Performance Management and Quality Improvement. The facilitator and participants were unable to reach a common interpretation of the questions. The NPHPSP online data reporting system requires that all questions have a response in order for the state’s assessment report to be complete. Upon the advice of ASTHO, which has been charged by CDC to provide technical assistance to States using the state assessment tool, YCPHP determined the median score for the other performance areas in EPHS 9 and assigned that value to each of the questions in section 9.3.

Due to the limitations noted, the NPHPSP Office recommends that 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. The data and results should not be interpreted as reflecting the capacity or performance of any single agency or organization.

### ***Consider the Context***

States have been strongly encouraged by NPHPSP to gather and record qualitative input from participants throughout the assessment process. This 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. In the Connecticut assessment, participant comments were captured by two members of the facilitation team: a recorder that wrote down themes and consensus points on a flip chart at the front of the room and a notetaker that captured more detailed comments on the process and served as a “back-up” to the recorder. A complete list of comments from each EPHS assessment, categorized into strengths, weaknesses, priorities and recommendations, can be found in Appendix E.

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.

### ***Presentation of Results***

This report provides the results of the Connecticut state public health system assessment conducted on June 24 and July 1, 2008 and includes the following information.

#### **I. Overall Summary of Connecticut’s Assessment Results**

- Summary of performance scores by EPHS
- Summary of ranking of EPHS performance scores and overall score
- Summary of the average score across the four model standard areas
- Common qualitative themes across EPHS assessment discussions

## II. Summary

- Summary of the services included in ESPS
- The model standards associated with that service
- Summary of the performance score by indicator
- The highest and lowest scoring performance measures in the ESPS
- Participant observations on the EPHS

## III. Recommendations

## IV. Appendices

- Appendix A: The *Public Health in America* statement
- Appendix B: Participants, *From Silos to Systems, Assessing Connecticut's State Public Health System*
- Appendix C: Conference Agendas, *From Silos to Systems, Assessing Connecticut's State Public Health System*
- Appendix D: NPHPSP State Public Health System Report of Results for Connecticut
- Appendix E: Recorder Notes Summary from Breakout Sessions: EPHS 1 – 10

## SECTION 2: PERFORMANCE ASSESSMENT RESULTS

Section 2 of this report provides the results of the Connecticut Statewide Assessment using selected tables and figures from the Connecticut NPHPSP Report of Results found in Appendix D and comments and observations from assessment participants captured during the two conference sessions. A more detailed list of comments can be found in Appendix E.

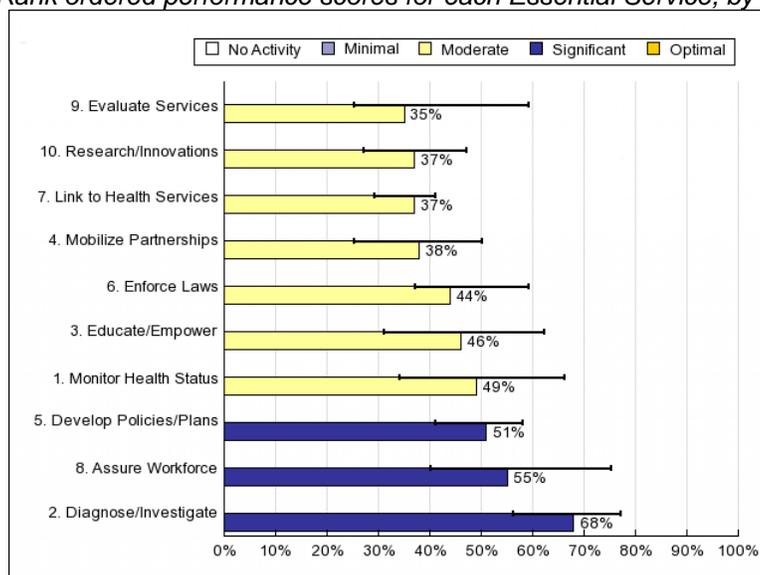
### Overall Performance of State System

Connecticut's overall score for activity levels in each of the ESPS areas was 46 out of 100, representing a moderate level of activity. Table 1 below lists the consolidated score for each of the ten EPHS areas. The range of scores is from a high of 68 for EPHS 2 (Diagnose and Investigate) to a low of 35 for EPHS 9 (Evaluate Effectiveness). Figure 1 below ranks the services in order of their scores. It also indicates by color the performance category and a bar line shows the range of scores for the four model standards within the EPHS. Seven overall EPHS scores fall in the "moderate activity" category and three scores fall in the "significant activity" category. No EPHS overall scores were in the "no activity," "moderate activity" or "optimal activity" categories.

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

EPHS		Score
1	Monitor Health Status to Identify Community Health Problems	49
2	Diagnose and Investigate Health Problems and Health Hazards	68
3	Inform, Educate, and Empower People about Health Issues	46
4	Mobilize Community Partnerships to Identify and Solve Health Problems	38
5	Develop Policies and Plans that Support Individual and Community Health Efforts	51
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	44
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	37
8	Assure a Competent Public and Personal Health Care Workforce	55
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	35
10	Research for New Insights and Innovative Solutions to Health Problems	37
<b>Overall Performance Score</b>		<b>46</b>

*Figure 1: Rank ordered performance scores for each Essential Service, by level of activity*



## Overall Performance of the Model Standards by the State System

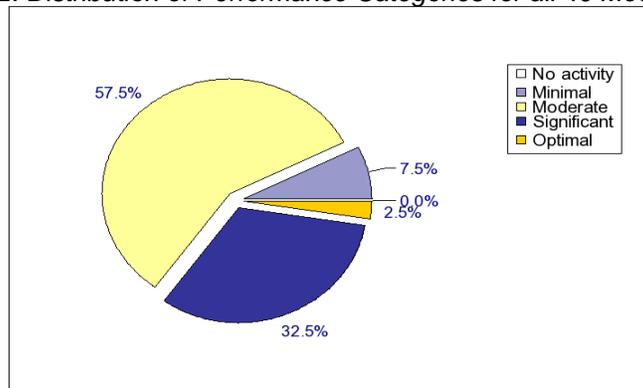
The State Instrument uses the following four model standard titles within each Essential Service, for a total of 40 model standards. Each model standard is followed by assessment questions that serve as measures of performance.

1. Planning and Implementation
2. State-Local Relationships
3. Performance Management and Quality Improvement
4. Public Health Capacity and Resources

The average of all scores for the four Model Standard Topic Areas across all 10 EPHS shows that Connecticut's SPHS had the greatest amount of activity in the area of Planning and Implementation (55%), followed by State-Local Relationships (45%) and Performance Management and Quality Improvement (44%). The lowest level of activity (40%) was found in standards measuring Public Health Capacity and Resources.

Figure 2 below shows the performance category rating of all 40 Model Standards. There were no Model Standard areas showing "no activity." Most standards (57.5%) showed "moderate activity" and almost one-third (32.5%) were found to have "significant activity". Fewer numbers of standards fell into the "minimal activity" category (7.5%) and "optimal activity" category (2.5%).

Figure 2: Distribution of Performance Categories for all 40 Model Standards



## Common Qualitative Themes

The qualitative data collected at the conference session reflected participants' commitment to the assessment process and improving performance. Many participants commented on how much they enjoyed meeting and interacting with partners from different parts of the public health system. The idea of a state "public health system" was new to many and even more challenging was voting on assessment questions from a systems performance perspective. In the conference evaluation, many mentioned the difficulty of evaluating the system based on their own limited knowledge. Within the EPHS breakout discussions there were numerous instances when the groups struggled to determine a collective interpretation of the assessment question.

Other overarching themes:

- There is a need for better understanding of what constitutes the collective state public health system vs. the state public health agency (DPH).
- DPH was viewed as a ready source of expertise and accessible resource. However, partnering with DPH can be difficult due to its regulatory authority over system partners.
- Mechanisms for organized/systematic sharing of information across the SPHS are needed.
- Many organizations contribute to the provision of the EPHS in Connecticut and are committed to improving their performance.

- The current “system” is fragmented, with public health activities largely taking place in categorical silos. A common vision and SPHS strategic plan are needed.

**Performance of Model Standards by Essential Public Health Service**

**Essential Public Health Service 1**  
***Monitor Health Status to Identify Health Problems***

This service includes:

- Assessment of statewide health status and its determinants, including the identification of health threats and the determination of health service needs
- Analysis of the health of specific groups that are at higher risk for health threats than the general population
- Identification of community assets and resources, which support the state public health system (SPHS) in promoting health and improving quality of life
- Interpretation and communication of health information to diverse audiences in different sectors.
- Collaboration in integrating and managing public health related information systems

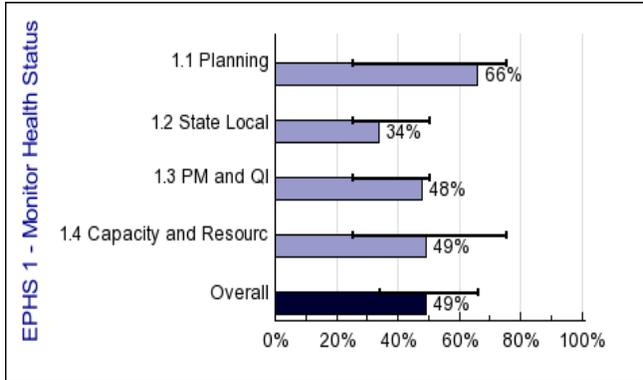
**Model Standards Summary**

<b>1.1 Planning and Implementation</b>	<b>1.2 State-Local Relationships</b>	<b>1.3 Performance Management and Quality Improvement</b>	<b>1.4 Public Health Capacity and Resources</b>
Measure, analyze and report on the health status of the state by- <ul style="list-style-type: none"> <li>• Developing and maintaining population health-related data collection programs</li> <li>• Producing a state health profile and other useful data and information products</li> <li>• Operating a data reporting system for reportable diseases and other potential health threats</li> <li>• Protecting confidentiality</li> </ul>	Work with local public health systems to- <ul style="list-style-type: none"> <li>• Offer technical assistance in interpretation, use, and dissemination of local health data</li> <li>• Provide a standard set of health-related data and assist in access, interpretation, and use of these data</li> <li>• Assist in the development of information systems for health monitoring</li> </ul>	Periodically review and improve monitoring activities by- <ul style="list-style-type: none"> <li>• Determining sufficiency and relevance of health monitoring efforts</li> <li>• Using results of review for quality improvement</li> </ul>	Monitor health status and identify health problems by- <ul style="list-style-type: none"> <li>• Investing in and utilizing all available resources</li> <li>• Committing adequate financial resources</li> <li>• Using workforce expertise in collecting and analyzing data and managing data systems</li> <li>• Aligning organizational relationships to focus assets on monitoring health status</li> </ul>

**Connecticut’s Summary Performance Scores for EPHS 1**

Overall, Connecticut scored 49 (moderate activity) on EPHS 1. This service is ranked 4 among the 10 essential services.

### Performance Score by Model Standard for EPHS 1



- 1.1 Planning and Implementation – Significant Activity**
- 1.2 State-Local Relationships – Moderate Activity**
- 1.3 Performance Management and Quality Improvement – Moderate Activity**
- 1.4 Public Health Capacity and Resources – Moderate Activity**

### Key Measures (Range: high score 75; low score 25)

The highest scoring measures for EPHS 1

- Uses surveillance and monitoring programs designed to measure the health status of the state’s population
- Regularly compiles and provides health data in useable products to a variety of health data users
- Operates a data reporting system designed to identify potential threats to the public’s health
- Enforces established laws and the use of protocols to protect personal health information and other data
- Has the professional expertise to carry out health status monitoring activities

The lowest scoring measures for EPHS 1 (each with a score of 25)

- Regularly provides local public health systems a uniform set of local health-related data
- Offers technical assistance in the development of information systems needed to monitor health status at the local level
- Aligns and coordinates the efforts of SPHS organizations to monitor health status

### Participant Observations:

Much “great” data are available, i.e., CT Cancer Registry
DPH is a great facilitator in accessing data
We have the data but they’re not always presented/formatted/packaged in a way that is useful
Better coordination of resources and efforts; “silos” exist
Lack of standardization in data collection at the local level
Difficulty coordinating and implementing new approaches to data collection
No final determination in where responsibility for collecting certain data lie (e.g., childhood obesity)
Public health lacks behind other agencies in use of GIS and retaining staff with expertise
Medical professionals and general public need better understating of use of community data
Timeliness of data reporting (2 year lags)
Resources committed to monitoring mental health and infection control seen as minimal
Lack of understanding of HIPPA
Ease of data transmission ~ electronic systems

**Essential Public Health Service 2**  
**Diagnose and Investigate Health Problems and Health Hazards**

This service includes:

- Epidemiological 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 epidemiologic investigations

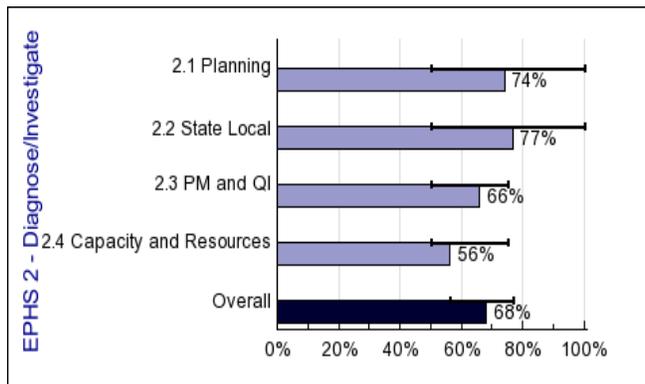
**Model Standards Summary**

2.1 Planning and Implementation	2.2 State-Local Relationships	2.3 Performance Management and Quality Improvement	2.4 Public Health Capacity and Resources
Identify and respond to public health threats (including infectious disease, chronic disease, injury, disasters, and environmental exposures) by - • Establishing and maintaining enhanced surveillance capability • Organizing public and private laboratories capable of analyzing clinical and environmental specimens into a functional system • Investigating and responding to public health problems and hazards	Work with local public health systems to provide assistance, capacity building, and resources for local efforts, including:- • Technical assistance in epidemiologic analysis • Assistance in using public health laboratory services • Information about possible public health threats and appropriate responses to these threats • Trained personnel on-site to assist in the investigation of disease outbreaks and other health threats	Periodically review and improve diagnosis and investigation activities by - • Reviewing the effectiveness of state surveillance and investigation procedures, using published guidelines. • Using results of review for quality improvement	Manage resources to diagnose and investigate threats by - • Committing adequate financial resources for diagnosis and investigation of health problems and hazards • Aligning organizational relationships to focus statewide assets on diagnosis and investigation activities • Using a workforce skilled in epidemiology and laboratory science

**Connecticut's Summary Performance Scores for EPHS 2**

Overall, Connecticut scored **68 (significant activity)** on EPHS 2. This service is **ranked 1** among the 10 essential services.

**Performance Score by Model Standard for EPHS 2**



- 2.1 Planning and Implementation – Significant Activity**
- 2.2 State-Local Relationships – Optimal Activity**
- 2.3 Performance Management and Quality Improvement – Significant Activity**
- 2.4 Public Health Capacity and Resources – Significant Activity**

**Key Measures (Range: High score 100; Low score 50)**

The highest scoring measures for EPHS 2

- Has laboratories that have the capacity to analyze clinical and environmental specimens in the event of suspected exposure or disease outbreak
- Provides laboratory assistance to local public health systems

The lowest scoring measures for EPHS 2

- Operates surveillance system(s) and epidemiology activities that identify and analyze health problems and threats to the health of the state's population
- Provides trained personnel, as needed, to assist local communities in the investigations of public health problems and threats
- Periodically reviews the effectiveness of the state surveillance and investigation system
- Commits financial resources to support the diagnosis and investigation of health problems and hazards
- Aligns and coordinates the efforts of SPHS organizations to diagnose and investigate health hazards and health problem.

**Participant Observations**

Electronic disease reporting is a success, but not fully implemented
Reportable disease: CT is strong in infectious diseases and cancer, but weaker in other areas, such as chronic disease
There is a need to improve epidemiologic surge capacity
Health communication within the SPHS is strong, i.e., HAN and WANS, but weakens when communication is needed across other systems
Regional epidemiologist program is a strength
Local health departments depend on expertise from DPH for investigations, but DPH may not always have the resources and staff to assist when needed
CT has a strong laboratory infrastructure, particularly the State Lab, but the lab is located far away from some local jurisdictions
While DPH provides some epidemiologic training to locals, more training is needed

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

This service includes:

- Health information, education, and promotion activities designed to reduce health risk and promote better health
- Health communication plans and activities such as media advocacy and social marketing
- Health education and promotion partnerships with schools, faith communities, work sites, personal care providers, and others to implement and reinforce health promotion programs and messages

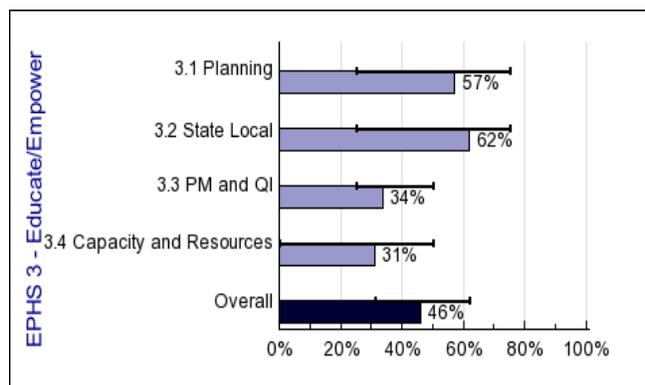
#### Model Standards Summary

3.1 Planning and Implementation	3.2 State-Local Relationships	3.3 Performance Management and Quality Improvement	3.4 Public Health Capacity and Resources
Create, communicate, and deliver health information and interventions by - <ul style="list-style-type: none"> <li>• Designing and implementing interventions to meet the state’s health improvement objectives</li> <li>• Designing and implementing health communications to reach diverse audiences</li> <li>• Maintaining emergency communications capacity</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Providing technical assistance to develop skills and strategies for health communication, education, and promotion</li> <li>• Supporting and assisting local public health systems in developing emergency communication capabilities</li> </ul>	Periodically review and improve activities to inform, educate and empower people by- <ul style="list-style-type: none"> <li>• Reviewing effectiveness and appropriateness of its health communication, education, and promotion interventions</li> <li>• Using results of review for quality improvement</li> </ul>	Manage resources to inform, educate and empower people by - <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on health communication, education, and promotion services</li> <li>• Using a workforce skilled in developing and implementing health communication, education, and promotion interventions</li> </ul>

#### Connecticut’s Summary Performance Scores for EPHS 3

Overall, Connecticut scored **46 (moderate activity)** on EPHS 3. This service is **ranked 5** among the 10 essential services.

**Performance Score by Model Standard for EPHS 3**



**3.1 Planning and Implementation – Significant Activity**

**3.2 State-Local Relationships – Significant Activity**

**3.3 Performance Management and Quality Improvement – Moderate Activity**

**3.4 Public Health Capacity and Resources – Moderate Activity**

**Key Measures (Range: High score 75; Low score 25)**

The highest scoring measures for EPHS 3

- Designs and implements health education and health promotion interventions
- Has a crisis and emergency communications plan
- Provides technical assistance to local public health systems (through consultations, training, and policy changes) to develop skills and strategies to conduct health communication, health education, and health promotion interventions
- Supports and assists local public health systems in developing effective emergency communications capabilities

The lowest scoring measures for EPHS 3

- Actively manages and improves the overall performance of its activities to inform, educate, and empower people about health issues
- Commits financial resources to support health communication, health education and health promotion services
- Aligns and coordinates efforts of SPHS organizations to implement health communication, health education and health promotion service

**Participant Observations**

A lot goes on but it isn't very coordinated
Much of the workforce does not have formal public health training and does not use theory in designing health messages
Many health education programs are funding driven, not needs driven
Many organizations have strategic plan, but some do not
Need for more culturally and linguistically appropriate materials
Many partners are unaware of community emergency response plans
There is much duplication of efforts and services, but not sure who would determine what is "too much"
There is not enough evaluation and when there is, it is not shared
DPH plans are NIMS compliant, but not all local/regional ESF plans are compliant
Many disparate entities; not really a "system"
Need to define public health system and system roles, as well as public health workforce; then can build relationships and assets

**Essential Public Health Service 4**  
***Mobilize Partnerships to Identify and Solve Health Problems***

This service includes:

- 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 communities to organize and undertake actions to improve the health of the state’s communities

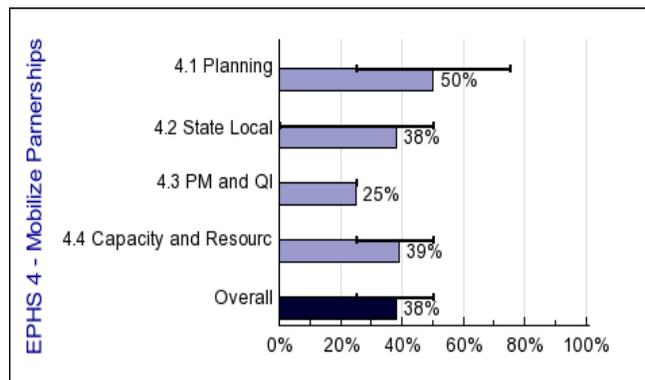
**Model Standards Summary**

4.1 Planning and Implementation	4.2 State-Local Relationships	4.3 Performance Management and Quality Improvement	4.4 Public Health Capacity and Resources
Conduct statewide community-building practices to identify and solve health problems by- <ul style="list-style-type: none"> <li>• Identifying, convening, and communicating with organizations</li> <li>• Organizing partnerships for public health to foster the sharing of resources, responsibilities, decision-making, and accountability for delivering Essential Public Health Services</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Assisting in building competencies in community development, advocacy, collaborative leadership, and partnership management</li> <li>• Providing incentives for local partnership development</li> </ul>	Review the effectiveness of SPHS’s performance in mobilizing partnerships by- <ul style="list-style-type: none"> <li>• Reviewing the effectiveness of its partnership efforts</li> <li>• Using results of review for quality improvement</li> </ul>	Assure that partnership mobilization efforts meet the needs of the state’s population by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on partnerships</li> <li>• Using a workforce skilled in assisting partners to organize and act on behalf of the health of the public</li> </ul>

**Connecticut’s Summary Performance Scores for EPHS 4**

Overall, Connecticut scored 38 (moderate activity) on EPHS 4. This service is ranked 7 among the 10 essential services.

**Performance Score by Model Standard for EPHS 4**



**4.1 Planning and Implementation – Significant Activity**

**4.2 State-Local Relationships – Moderate Activity**

**4.3 Performance Management and Quality Improvement – Minimal Activity**

**4.4 Public Health Capacity and Resources – Moderate Activity**

**Key Measures (Range: High score 50; Low score 25)**

The highest scoring measures for EPHS 4

- Builds statewide support for public health issues
- Organizes partnerships to identify and to solve health problems
- Provides incentives to local partnerships through grant requirements, financial incentives, and/or resource sharing
- Commits financial resources to sustain partnerships
- Has the professional expertise to carry out partnership development activities

The lowest scoring measures for EPHS 4

- Provides assistance (through consultations and/or trainings) to local public health systems to build partnerships for community health improvements
- Reviews its partnership development activities
- Actively manages and improves the overall performance of its partnership activities; and
- Aligns and coordinates efforts of SPHS organizations to mobilize partnerships

**Participant Observations**

SPHS partners good at “pitching in” and supporting one another but not at building skills and capacity
More than one system partner is providing the same types of services.
Decision-making capacity of collaborations lacking (e.g., authority, funding streams)
SPHS partners are willing to help, but there is no sustained, systematic effort to <u>improve</u>
Funders are not always aligned with values of partnerships
Perspectives and priorities change with each administration
Lack of a State Strategic Plan – partners cannot align their organization’s plans with State’s priorities
Turf issues hurt collaborations that could work
Minimal contact between emergency medical services and local public health system
Limited funding, competing demands and equitable distribution of resources – who defines expectations?
Substantial statewide support for coalescing around topical public health issues
There is a lack of integration of issues for larger public health good
CT SPHS system historically organized around disease entities, not functions

**Essential Public Health Service 5**  
**Develop Policies and Plans that Support Individual and Statewide Health Efforts**

This service includes:

- 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
- 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
- The process of dialogue, advocacy, and debate among groups affected by the proposed health plans and policies prior to adoption of such plans or policies

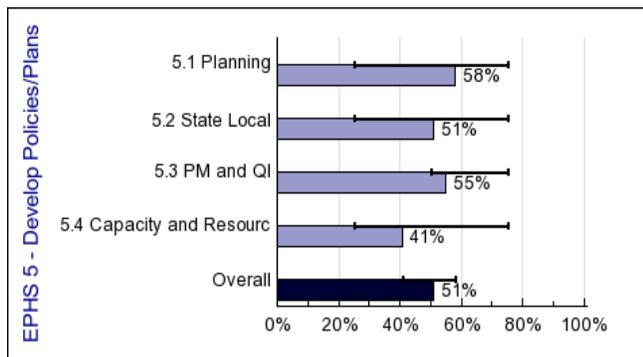
**Model Standards Summary**

5.1 Planning and Implementation	5.2 State-Local Relationships	5.3 Performance Management and Quality Improvement	5.4 Public Health Capacity and Resources
Conduct health improvement planning and policy development by- <ul style="list-style-type: none"> <li>• Developing statewide health improvement processes</li> <li>• Producing a state health improvement plan</li> <li>• Establishing and maintaining public health emergency response capacity</li> <li>• Engaging in health policy development activities</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Providing technical assistance and training for development of community health improvement plans and local health policy development</li> <li>• Assisting in adapting and integrating statewide improvement strategies to the local level</li> <li>• Providing assistance in developing local All-Hazards Preparedness Plans</li> </ul>	Review effectiveness of SPHS’s performance in policy and planning by- <ul style="list-style-type: none"> <li>• Monitoring the state’s progress towards accomplishing its health improvement objectives</li> <li>• Reviewing policies to determine their public health impact</li> <li>• Conducting exercises and drills to test preparedness response capacity</li> <li>• Manages overall performance for the purpose of quality improvement</li> </ul>	Assure that health planning and policy practices meet the needs of the state’s population by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on health planning and policy development</li> <li>• Using the skills of the SPHS workforce in planning and health policy development</li> </ul>

**Connecticut’s Summary Performance Scores for EPHS 5**

Overall, Connecticut scored 51 (significant activity) on EPHS 5. This service is ranked 3 among the 10 essential services.

**Performance Score by Model Standard for EPHS 5**



- 5.1 Planning and Implementation – Significant Activity**
- 5.2 State-Local Relationships – Significant Activity**
- 5.3 Performance Management and Quality Improvement – Significant Activity**
- 5.4 Public Health Capacity and Resources – Moderate Activity**

**Key Measures (Range: high score: 75; low score: 25)**

The highest scoring measures for EPHS 5

- Has in place an All-Hazards Preparedness Plan guiding systems' partners to protect the state's population in the event of an emergency
- Provides technical assistance in the development of local public health all-hazards preparedness plans for responding to emergency situations
- Conducts formal exercises and drills of the procedures and protocols linked to its All-Hazards Preparedness Plan
- Has the professional expertise to carry out health policy development

The lowest scoring measures for EPHS 5

- Commits financial resources to health planning and policy development efforts
- Aligns and coordinates efforts of SPHS organizations to implement health planning and policy development

**Participant Observations**

Planning process good for some categories/disease areas, but not enough comprehensive health planning or state health <i>improvement</i> planning
DPH, NGO's good at identifying needed policy changes, but the system as a whole does not
Weakness- partners do not know of state health plan
Most in group do not think that affected populations are brought to the table in planning
Partners do not know data is available to DPH or what kinds of data
Partners do not know about DPH plans
No collective voice in the state on priorities for health policy issue
There may be data driven programming, but programs are not always evaluated
The state does convene stakeholders to address policy issues, but do not necessarily listen or respond to concerns
Weakness: partners do not know data is available

**Essential Public Health Service 6**  
**Enforce Laws and Regulations that Protect Health and Ensure Safety**

This service includes:

- The review, evaluation, and revision of laws (laws refers to all laws, regulations, statutes, ordinances, and codes) designed to protect health and ensure safety to assure that they reflect current scientific knowledge and best practices for achieving compliance
- Education of persons and entities in the regulated environment and persons and entities that enforce laws designed to protect health and ensure safety
- Enforcement activities of public health concern, including, but not limited to, enforcement of clean air and potable water standards; regulation of health care facilities; safety inspections of workplaces; review of new drug, biological, and medical device applications; enforcement activities occurring during emergency situations; and enforcement of laws governing the sale of alcohol and tobacco to minors, seat belt and child safety seat usage, and childhood immunizations

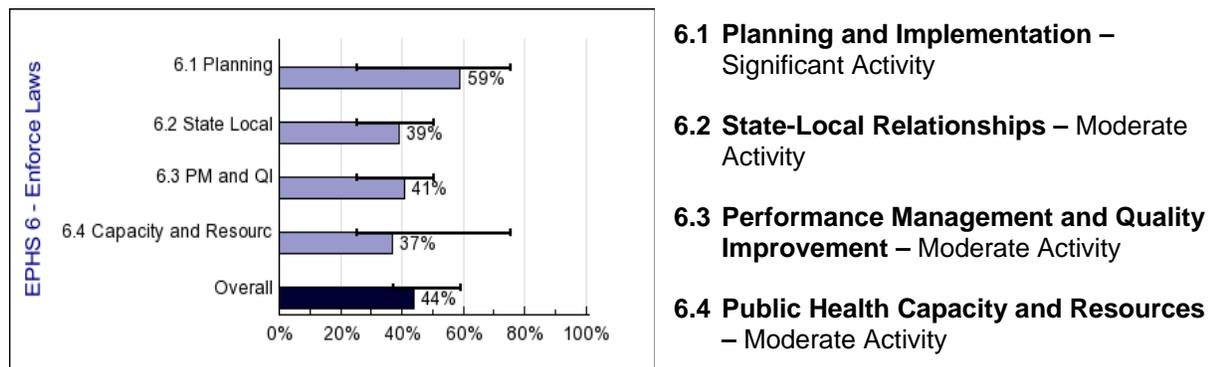
**Model Standards Summary**

6.1 Planning and Implementation	6.2 State-Local Relationships	6.3 Performance Management and Quality Improvement	6.4 Public Health Capacity and Resources
Conduct enforcement activities based on current sciences and best practices by - <ul style="list-style-type: none"> <li>• Reviewing existing and proposed laws and soliciting input from stakeholders.</li> <li>• Assuring appropriate emergency powers are in place</li> <li>• Fostering cooperation among persons and entities involved</li> <li>• Ensuring customer-centered administrative processes</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Providing technical assistance based on current scientific knowledge and best practices in achieving compliance in enforcement operations</li> <li>• Partnering with local governing bodies to provide assistance in developing local laws</li> </ul>	Review the effectiveness of SPHS's performance in enforcing laws by- <ul style="list-style-type: none"> <li>• Monitoring the effectiveness of its actions using written resources</li> <li>• Manages overall performance for the purpose of quality improvement</li> </ul>	Invests in and utilizes its resources to enforce laws by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on enforcement activities</li> <li>• Using workforce expertise to effectively carry out the review, development, and enforcement of public health laws</li> </ul>

**Connecticut's Summary Performance Scores for EPHS 6**

Overall, Connecticut scored 44 (moderate activity) on EPHS 6. This service is ranked 6 among the 10 essential services.

**Performance Score by Model Standard for EPHS 6**



**Key Measures (Range: High score 75; Low score 25)**

The three highest scoring measures for EPHS 6

- Assures existing and proposed laws are designed to protect the public’s health and ensure safety
- Assures that laws give state and local authorities the power and ability to prevent, detect, manage, and contain emergency health threats
- Has the professional expertise to carry out health policy development

The four lowest scoring measures for EPHS 6

- Partners with local governing bodies in reviewing, improving, and developing local laws;
- Reviews the effectiveness of its regulatory, compliance, and enforcement activities
- Commits financial resources to health planning and policy development efforts
- Aligns and coordinates efforts of SPHS organizations to comply with laws and regulations

**Participant Observations**

DPH may go to legislature with good scientific argument but politics determines if it gets attention of legislators
Enforcement of PH standards is not consistent; even when you are dealing with the state public health code, interpretation enforcement are very variable
Regulatory review process is designed to deal with balancing public health needs and individual rights but it is an awkward process
Weakness: periodic assessment regulations not done; reactive instead, usually initiated by special interest groups
State DPH has subject matter expertise – resource for others
There may be the legal authority but when funding goes away there may not be personnel to enforce on the local level
Every town/district has different laws; variation in code makes the scope of state training limited
Silos of strategic plans – not aligned may be at cross purposes
Evaluating the effectiveness of its regulatory, compliance and enforcement activities makes sense, but who would do this

## Essential Public Health Service 7

### ***Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable***

This service includes:

- Assessment of access to and availability of quality personal health services for the state’s population
- Assurances that access is available in a coordinated system of quality care which includes outreach services to link populations 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

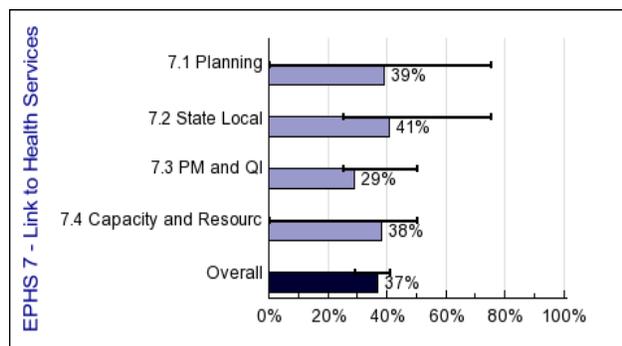
#### **Model Standards Summary**

<b>7.1 Planning and Implementation</b>	<b>7.2 State-Local Relationships</b>	<b>7.3 Performance Management and Quality Improvement</b>	<b>7.4 Public Health Capacity and Resources</b>
Assess and assure quality and availability of public health services by - <ul style="list-style-type: none"> <li>• Working collaboratively to deliver services and taking policy and programmatic action to assure availability.</li> <li>• Providing leadership and coordination</li> <li>• Mobilizing to reduce health disparities in the state and to meet needs in the event of an emergency</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Providing technical assistance in system approaches for identifying and meeting personal health care needs of underserved populations</li> <li>• Providing technical assistance in quality improvement of personal health care delivery and management</li> </ul>	Review the effectiveness of SPHS’s performance in the provision of personal health care to the state’s population by- <ul style="list-style-type: none"> <li>• Reviewing health care quality, access, and appropriateness</li> <li>• Manages overall performance of its activities to link people to needed health services for the purpose of quality improvement</li> </ul>	Invests in and utilizes its resources to assure provision of needed personal health care by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on linking people to health care and assuring provision of health care</li> <li>• Using a workforce skilled in evaluation, analysis, delivery, and management</li> </ul>

#### **Connecticut’s Summary Performance Scores for EPHS 7**

Overall, Connecticut scored 37 (moderate activity) on EPHS 7. This service is ranked 8 among the 10 essential services.

**Performance Score by Model Standard for EPHS 7**



**7.1 Planning and Implementation – Moderate Activity**

**7.2 State-Local Relationships – Moderate Activity**

**7.3 Performance Management and Quality Improvement – Moderate Activity**

**7.4 Public Health Capacity and Resources – Moderate Activity**

**Key Measures (Range: High score: 50; Low score: 0)**

The highest scoring measures for EPHS 7

- Assesses the availability of personal health services to the state's population
- Through collaborations with local public health systems and health care providers, SPHS takes action to eliminate barriers to access to personal health care
- Mobilizes its assets, including local public health systems, to reduce health disparities in the state
- Provides technical assistance to providers who deliver personal health care to underserved populations
- Commits financial resources to assure the provision of personal health care
- Has the professional expertise to carry out the functions of linking people to needed personal health care

The lowest scoring measures for EPHS 7

- Has an entity responsible for monitoring and coordinating personal health care delivery within the state
- Provides technical assistance to local public health systems on methods to assess and meet the needs of underserved populations
- Reviews personal health care access, appropriateness and quality
- Actively manages and improve the overall performance of its activities to link people to needed personal health care services
- Aligns and coordinates efforts of SPHS organizations to provide needed personal health care

**Participant Observations**

Clear legislative mandates for some programs/services (e.g., Husky)
Most healthcare organizations have some quality improvement processes (e.g. JACHO requirements)
Advocacy on health issues in Connecticut has proven track record of success
The one coordinating entity (Office of Health Care Access) is not all encompassing (an entity not “system”) and conducts reviews on a reactive basis
There are shortages of healthcare workers (i.e., nursing); data on current and future workforce needs are limited
Regulations are set around minimum standards and do not provide consistent benchmarks
Measures are based on quantity of services, not quality of services
Collaboration between public health and health care sector based on short term legislative priorities and does not foster long term collaboration about best practice models
Healthcare providers may be reluctant to provide performance data to public health partners; view them as regulators
Emergency preparedness planning efforts have led to improved communication between public health and medical care (ESF 8 structure)
The personal health care services delivery system is fragmented

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

This service includes:

- 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 service
- Efficient processes for credentialing technical and professional health personnel
- Adoption of continuous quality improvement and life-long learning programs
- Partnerships with professional workforce development programs to assure relevant learning experiences for all participants
- Continuing education in management, cultural competence, and leadership development programs

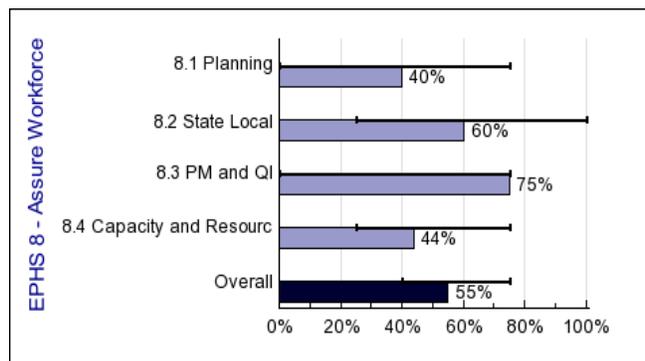
**Model Standards Summary**

<b>8.1 Planning and Implementation</b>	<b>8.2 State-Local Relationships</b>	<b>8.3 Performance Management and Quality Improvement</b>	<b>8.4 Public Health Capacity and Resources</b>
Identifies the public health workforce needs of the state by- <ul style="list-style-type: none"> <li>• Assessing numbers, qualifications, and locations of the workforce required</li> <li>• Developing a plan establishing strategies and needed actions</li> <li>• Providing human resource development programs</li> <li>• Assuring attainment of the highest level of knowledge and functioning</li> <li>• Supports continuous professional development</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Assisting local public health systems in assessing needs of population-based and personal health care workforces</li> <li>• Assisting in recruitment, retention, and performance-improvement strategies</li> <li>• Assuring availability of educational course work</li> </ul>	Review the effectiveness of SPHS’s performance in assuring a competent workforce by- <ul style="list-style-type: none"> <li>• Reviewing the implementation of development plans</li> <li>• Reviewing preparation of personnel entering the workforce</li> <li>• Manages overall performance for the purpose of quality improvement</li> </ul>	Invests in and utilizes its resources to assure a competent population-based and personal health care workforce by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on workforce development</li> <li>• Using the skills of the SPHS workforce management of human resources and workforce development programs</li> </ul>

**Connecticut’s Summary Performance Scores for EPHS 8**

Overall, Connecticut scored 55 (significant activity) on EPHS 8. This service is ranked 2 among the 10 essential services.

**Performance Score by Model Standard for EPHS 8**



**8.1 Planning and Implementation –**  
Moderate Activity

**8.2 State-Local Relationships –**  
Significant Activity

**8.3 Performance Management and Quality Improvement –** Significant Activity

**8.4 Public Health Capacity and Resources –** Moderate Activity

**Key Measures (Range: High score: 100; Low score: 0)**

The highest scoring measures for EPHS 8

- Assures educational course work and training is available and accessible to enhance the skills of the workforce of local public health systems

The lowest scoring measures for EPHS 8

- Develops a statewide workforce plan(s) to guide its activities in workforce development; and
- Assists local public health systems in completing assessments of their population-based and personal health care workforces

**Participant Observations**

If all the sectors in the egg chart are a part of the public health system, there are many different disciplines, training and credentialing systems and competency sets represented. Is the public health workforce everyone connected to the system? Seems unwieldy
There are many accessible resources available for public health continuing education, including DPH's online learning management system
Assessing workforce shortages and training needs is highly fragmented. Allied health and nursing are an exception. A comprehensive assessment is needed
There have been partnerships and collaborations formed around workforce development concerns and partners have been committed, despite limited funding
Workforce development is not given the importance as other public health activities -- there is a lack of financial resources and time for staff development
More is needed to attract students to public health and health professions, examples include mentoring and high schools career paths
Public health needs more standardization for titles (e.g. epidemiologist qualifications)
More training is needed on cultural competency skills
Public health needs to assure that their regulatory staff are highly trained and use consistent, standardized benchmarks
More resources should be dedicated to the student loan repayment program for community based health centers

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

This service includes:

- Evaluation and critical review of health programs, based on analyses of health status and service utilization data, are conducted to determine program effectiveness and to provide information necessary for allocating resources and reshaping programs for improved efficiency effectiveness, and quality
- Assessment of and quality improvement in the State Public Health System’s performance and capacity

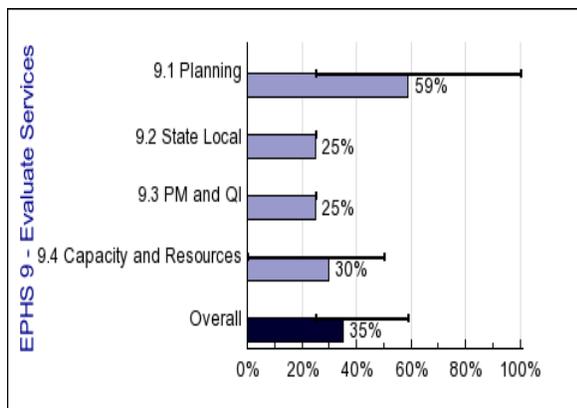
**Model Standards Summary**

9.1 Planning and Implementation	9.2 State-Local Relationships	9.3 Performance Management and Quality Improvement	9.4 Public Health Capacity and Resources
Evaluates and improves effectiveness of population-based and personal health services by- <ul style="list-style-type: none"> <li>• Evaluating availability, utilization, appropriateness and effectiveness of services, using national guidelines</li> <li>• Evaluates the performance of SPHS in delivering Essential Public Health Services to the state’s population</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Providing technical assistance in the evaluation of population-based programs, personal health services, and overall performance, using performance benchmarks</li> <li>• Sharing results of state-level evaluations with local public health systems</li> </ul>	Review the effectiveness of SPHS’s performance in evaluating effectiveness, accessibility, and quality of services by- <ul style="list-style-type: none"> <li>• Reviewing evaluation activities to assure their appropriateness, using nationally recognized resources</li> <li>• Manages overall performance for the purpose of quality improvement</li> </ul>	Invests in and utilizes its resources to evaluate population-based and personal health services by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on evaluating these services</li> <li>• Using a workforce skilled in monitoring and analyzing performance</li> </ul>

**Connecticut’s Summary Performance Scores for EPHS 9**

Overall, Connecticut scored 29 (moderate activity) on EPHS 9. This service is ranked 10 among the 10 essential services.

**Performance Score by Model Standard for EPHS 9**



- 9.1 Planning and Implementation – Significant Activity**
- 9.2 State-Local Relationships – Minimal Activity**
- 9.3 Performance Management and Quality Improvement – Minimal Activity**
- 9.4 Public Health Capacity and Resources – Moderate Activity**

**Key Measures (Range: high score: 75; low score: 25)**

The highest scoring measures for EPHS 9

- Evaluates the effectiveness of personal health services within the state

The lowest scoring measures for EPHS 9

- Provide technical assistance (e.g., consultations, training) to local public health systems in their evaluations
- Share results of state-level performance evaluations with local public health systems for use in local planning processes
- Regularly reviews the effectiveness of its evaluation activities
- Manages and improves the overall performance of its evaluation activities
- Commit financial resources for evaluation
- SPHS organizations align and coordinate their efforts to conduct evaluations

**Participant Observations**

Need more evaluation of programs providing prevention and support services; no standards of what people can expect from public health system
SPHS evaluates personal health care services, less so for population based services
State system- individual systems have standards and evaluations (such as JCAHO for hospitals), but system as a whole doesn't necessarily have standards - doing an assessment like this one may help to set standards for the system to use
Communication and partnerships from areas like preparedness carry over into other areas
We do recognize holes in the system and make a concerted effort to improve in those areas, for example, oral health, not in "system" before (result of law suit though)
Need to build academic-practice partnerships to enhance evaluation capabilities - might be one of the quickest ways to improve evaluation
Need better interconnectedness of databases to assess outcomes of programs
There are lots of silos in evaluation driven by funding. But there are some examples of a more systems approach – for example, preparedness
We need to educate the public that there is a lack of standardization for local public health in CT - different size towns, different health districts/departments offer different services and services available in one health department may not be available in another
Need to look critically at our current SPHS infrastructure; it is not the most efficient or effective way to deliver EPHS; efforts to make changes need to be coordinated by DPH
Evaluation has been under-funded, but as a result of under-funding of the system, not just evaluation

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

This service includes:

- 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

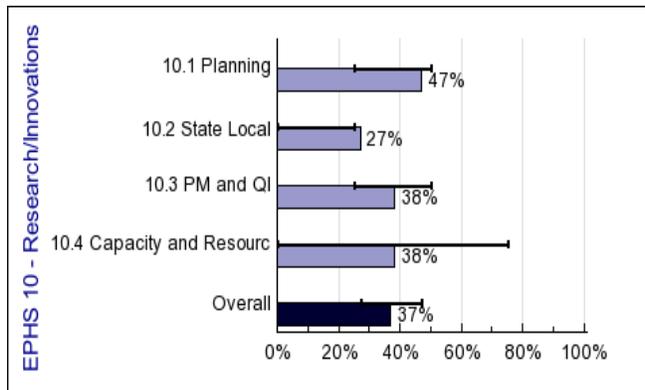
**Model Standards Summary**

<b>10.1 Planning and Implementation</b>	<b>10.2 State-Local Relationships</b>	<b>10.3 Performance Management and Quality Improvement</b>	<b>10.4 Public Health Capacity and Resources</b>
Use best scientific knowledge and best practices to improve the health of the state’s population by- <ul style="list-style-type: none"> <li>• Establishing a statewide public health academic-practice collaboration</li> <li>• Developing a public health research agenda</li> <li>• Conducting and participating in public health research</li> </ul>	Provide assistance, capacity building, and resources for local efforts by - <ul style="list-style-type: none"> <li>• Assisting research activities, including community-based participatory research</li> <li>• Assisting in the interpretation and application of research findings to improve public health practice</li> </ul>	Review the effectiveness of SPHS’s performance in conducting and using research by- <ul style="list-style-type: none"> <li>• Regularly monitoring its research activities for relevance and appropriateness</li> <li>• Manages overall performance of its activities for the purpose of quality improvement</li> </ul>	Invests in and utilizes its resources to conduct research by- <ul style="list-style-type: none"> <li>• Committing adequate financial resources</li> <li>• Aligning organizational relationships to focus statewide assets on research and applying new evidence to practice</li> <li>• Using a workforce skilled in conducting and applying research</li> </ul>

**Connecticut’s Summary Performance Scores for EPHS 10**

Overall, Connecticut scored 37 (moderate activity) on EPHS 10. This service is ranked 9 among the 10 essential services.

**Performance Score by Model Standard for EPHS 10**



**10.1 Planning and Implementation – Moderate Activity**

**10.2 State-Local Relationships – Moderate Activity**

**10.3 Performance Management and Quality Improvement– Moderate Activity**

**10.4 Public Health Capacity and Resources– Moderate Activity**

**Key Measures (Range: High score: 74; Low score: 25)**

The highest scoring measures for EPHS 10

- Maintains an active academic-practice collaboration(s) to promote and organize research activities and disseminate and use research findings in practice
- Has a public health research agenda
- Participates in and conducts research relevant to public health services
- Reviews its public health research activities
- Has the professional expertise to carry out research activities

The lowest scoring measures for EPHS 10

- Provides technical assistance to local public health systems with research activities
- Assists local public health systems in their use of research findings
- Actively manages and improves the overall performance of its research activities
- Commits financial resources to research relevant to health improvement
- Aligns and coordinates efforts of SPHS organizations to conduct research

**Participant Observations**

Almost all research being conducted in SPHS is through academic practice collaborations
Public health academic programs include community-based public health practice experience for students. Adjunct professors are also a great academic-practice link
Food protection research within the divisions of schools is a good example of a strong research agenda and collaboration with practitioners; outcomes may impact practice, such as change in food regulations
Public health is not good at marketing ourselves. There is no strong public health message. It is always the last thing you think about when you are dealing with services and regulations
No state public health improvement plan ~ no integration of research
Lead by federal funding > does not focus on the public Reporting to federal government > missing reporting back to citizens
Do not have the time to publish as much as we want > not a major focus in what we do
Have to find grant money at the local level to help design research projects > no state support No formal state mechanism for technical assistance to locals
SPHS organizations are not aligning strategic plans to improve research

### SECTION 3: RECOMMENDATIONS

The Connecticut Department of Public Health considers the 2008 Assessment as the first phase in the ongoing strategic planning for the state's public health system. The results from this assessment should be regarded as baseline and a call to action. Recommendations for the state to move forward with performance standards improvement efforts to take Connecticut's SPHS from "silos" to "systems" include:

- Share the results of this report with public health system partners and policymakers to encourage additional dialogue and communication within and between partners and about the state's public health "system."
- Continue collaboration with Connecticut's Local Health Departments regarding initiatives on national performance standards for local public health systems.
- Convene core team to complete the *Priority Questionnaire*. The questionnaire, which asks about the priority of each model standard to the public health system, can link performance scores in this report to system priorities and help target limited resources for performance improvement.
- Complete the optional *Agency Contribution Questionnaire*. This second questionnaire, which asks about the contribution of the public health agency to each model standard, can assist the public health system in considering each role in performance improvement efforts.
- Use the findings of this assessment to inform state health planning, evaluation and assessment initiatives to: 1) increase accountability and efficient use of scarce resources; 2) promote a shared vision of expectations across organizations; 3) align Connecticut's SPHS performance with national efforts; and 4) advance a systematic approach that uses results to drive performance improvement.

# **APPENDICES**

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## **APPENDIX A**

### Vision:

*Healthy People in Healthy Communities*

### Mission:

*Promote Physical and Mental Health and Prevent Disease,  
Injury, and Disability*

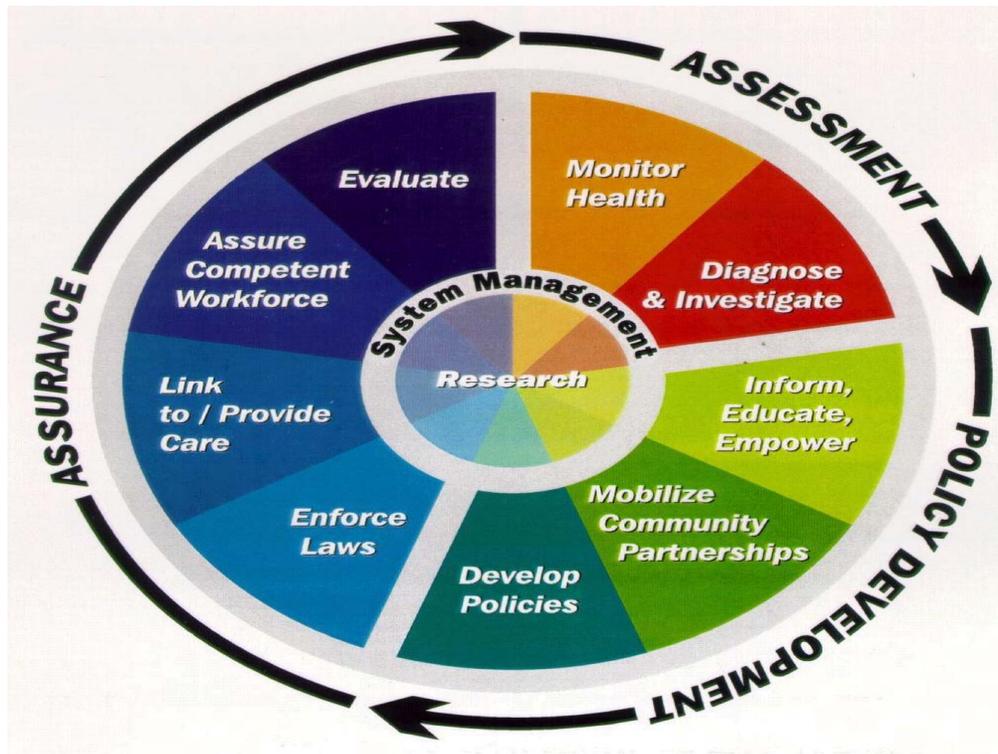
#### **Public Health**

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

#### **Essential Public Health Services**

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Develop policies and plans that support individual and community health efforts
- Enforce laws and regulations that protect health and ensure safety
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Assure a competent public health and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Research for new insights and innovative solutions to health problems

## Public Health Core Functions and the Ten Essential Public Health Services



Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995): American Public Health Association, Association of Schools of Public Health, Association of State and Territorial Health Officials, Environmental Council of the States, National Association of County and City Health Officials, National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Program Directors, Public Health Foundation, U.S. Public Health Service --Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office of the Assistant Secretary for Health Substance Abuse and Mental Health Services Administration

url: <http://www.health.gov/phfunctions/public.htm>

## APPENDIX B

### LIST OF PARTICPANTS AND ESSENTIAL SERVICE ASSIGNMENTS

Last Name	First Name	Agency	6/24- Attended Y/N	Essential Service	7/1- Attended Y/N	Essential Service
Andrews	Ann	CT Department of Public Health	Y	1		
Andrews	Ellen	CT Health Policy Project	Y	5	N	
Armah	Olga	Office of Health Care Access	Y	1	Y	10
Balch	Leslie	Quinnipiac Valley Health District	Y	3	Y	8
Baldwin	Katelynn	Ledge Light Health District	Y	4	Y	7
Begemann	Clarice	Fair Haven Community Health Center	Y	4	Y	7
Bidorini	Alfred	CT Department of Mental Health and Addiction Services	Y	2	Y	6
Blancaflor	Suzanne	CT Department of Public Health	Y	1	Y	10
Blaschinski	Ellen	CT Department of Public Health	Y	2	Y	6
Blitz	William	North Central District Health Dept	Y	2	Y	6
Boehm	Donna	Connecticut VNA	Y	2	N	
Bonjour	Melanie	CT Assoc. SBHC's	N		Y	10
Boone	David	Glastonbury Health Department	Y	5	Y	9
Borrero	Debra	Office of Governor M. Jodi Rell	Y	5	Y	9
Breiner	Carlton	Public Health Foundation of Connecticut, Inc.	Y	4	Y	7
Brooks	Richard	Department of Consumer Protection	N		Y	7
Brown	David	CT DEMHS	Y	4	N	
Buckley-Bates	Karen	CT Department of Public Health	Y	5	Y	9
Buzzetti	Alan	CT Department of Public Health	Y	2	Y	6
Callahan	Timothy	Norwalk Health Department	Y	4	Y	7
Cassavechia	Matthew	Danbury EMS	Y	1	N	
Cavacas	Marci	CT Department of Public Health	Y	1	Y	10
Centrella	Carmine	CRCOG/ CREPC	Y	3	N	
Ciccione	Eugene	Department of Health	N		Y	10
Collins	Bob	Torrington Area Health District	Y		Y	6
Cooney	Linda	CT Department of Public Health	Y	2	Y	6

Last Name	First Name	Agency	6/24- Attended Y/N	Essential Service	7/1- Attended Y/N	Essential Service
Culbert	Donna	Newtown Health District	Y	3	Y	8
Curran	Jeffrey	Regulatory Services	Y	3	Y	8
Duberek	Mary Rose	CT DEMHS	Y	1	Y	10
Dunbar- Rose	Shirelyann	Ledge Light Health District	Y	4	Y	7
Estrada	Juanita	CT Department of Public Health	Y	1	N	
Falk	Maurice	Middlebury Health Dept.	N		Y	6
Farrell	Maureen	American Red Cross of Western CT	Y	4	Y	7
Fleissner	Mary Lou	CT Department of Public Health	Y	2	Y	6
Fontana	John	CT Department of Public Health	N		Y	6
Freidenfelt	Peggy	CT Department of Public Health	Y	4	Y	7
Furniss	Wendy	CT Department of Public Health	Y	1	Y	10
Gadea	John	Department of Consumer Protection	N		Y	6
Gamba	Eileen	Department of Developmental Services	Y	3	Y	8
Garcia	Mario	CT Department of Public Health	Y	1	N	
Gardne	Dwayne	Department of Environmental Protection	N		Y	
Garrett	Josephine	Department of Developmental Services	Y	1	N	
Gervais	Linda	Department of Public Safety	Y	5	N	
Golebiewski	Eva	CT Department of Public Health	Y	5	Y	9
Greene	Frank	Department of Consumer Protection	N		Y	9
Gregorio	David	Academia- University of Connecticut	Y	4	Y	7
Guercia, Jr.	Leonard	CT Department of Public Health	Y	2	Y	6
Gustafson	John	South Central CT Regional Emergency Communications System	Y	5	Y	9
Gyle	Norma	CT Department of Public Health	Y	5	Y	9
Hendriks	Leah	Visiting Nurse Association of Southeastern Connecticut	Y	2	N	
Hogarty	Lucinda	CT Cancer Partnership	Y	4	Y	7
Hooper	Meg	CT Department of Public Health	N		Y	8
Horvath	Deborah	Naugatuck Valley Health District	Y	4	Y	7

Last Name	First Name	Agency	6/24- Attended Y/N	Essential Service	7/1- Attended Y/N	Essential Service
Huleatt	Steven	West Hartford-Bloomfield Health District	Y	4	N	
Hull	Douglas	Windham Community Memorial Hospital	Y	5	Y	9
Hunt	David	CT Department of Public Health	Y	5	Y	9
Hutcheon	Paul	Central CT Health District	Y	2	Y	6
Hynes	Margaret	CT Department of Public Health	Y	1	Y	10
Johnson	Debra	CT Department of Public Health	N		Y	7
Joseph	Deepa	City of Milford Health Department	Y	1	Y	10
Juncadella	Enrique	The Hospital of Central Connecticut	Y	4	N	
Kennelly	Catherine	CT Department of Public Health	Y	5	Y	9
Kerr	Melanie	CT DEMHS	Y	3	N	
Kertanis	Jennifer	CT Association of Directors of Health, Inc.	Y	5	Y	9
Kilbey-Fox	Pamela	CT Department of Public Health	Y	3	Y	8
Kramer	Edward	Hartford Hospital	Y	5	Y	9
Kremer	Elise	CT Department of Public Health	N		Y	7
LaFrance	Robert	CT Department of Environmental Protection	Y	2	Y	6
Lipwick	Phil	Quest Diagnostics Incorporated	Y	2	N	
Lockwood	Shane	Pomperaug District Department of Health	Y	5	Y	9
Lustig	Neal	Pomperaug District Department of Health	N		Y	7
Mansfield	Steve	Ledge Light Health District	Y	3	Y	8
Martone	Kimberly	Office of Health Care Access	Y	5	Y	7
Mascoli	Patty	City of Danbury WIC Program	Y	3	N	
Mathieu	Lori	CT Department of Public Health	Y	1	Y	10
McCormack	Patrick	Uncas Health District	Y	5	Y	9
McHugh	Michele	Quest Diagnostics Incorporated	N		Y	6
Meredith	Carol	CT Department of Mental Health and Addiction Services	Y	1	Y	10
Mierzwa	Sharon	CT Association of Directors of Health, Inc.	Y	4	N	
Muggeo	Jennifer	Ledge Light Health District	Y	4	Y	7

Last Name	First Name	Agency	6/24- Attended Y/N	Essential Service	7/1- Attended Y/N	Essential Service
Nasinnyk	Kris	Department of Consumer Protection	N		Y	8
Neville	David	St Francis Hospital and Medical Center	Y	3	Y	8
Nowakowski	Jay	CT Department of Public health	Y	2	Y	6
Palin	Jean	Community Health Center Inc	Y	1	Y	10
Park	Frances	Department of Developmental Services, South Region	Y	5	N	
Pascullia	Michael	Hartford Health and Human Services Department	N		Y	8
Peck	Stanley	CT Department of Public Health	Y	5	Y	9
Perez	William	East Hartford Fire Department	Y	2	N	
Perlin	Michael	Southern Connecticut State University	Y	3	Y	8
Petrillo, Jr.	Charles	Windsor Health Department	Y	3	Y	8
Pomarico	Diane	Hartford Hospital	Y	1	Y	10
Rivera	Carlos	Hartford Health and Human Services Department	Y	3	N	
Roby	Kathryn	Qualidigm	Y	2	N	
Roderick	Barbara	Department of Developmental Services, North Region	Y	4	Y	7
Shaw	John	Capitol Region MMRS	Y	5	Y	9
Shaw	Arvind	Generations Family Health Center	Y	3	Y	8
Siniscalchi	Alan	CT Department of Public Health	Y	1	Y	10
Sistare	Kent	Ledge Light Health District	Y	5	Y	9
Skehan	Kimberly	CT Association for Home Care & Hospice	Y	5	Y	9
Sproch	Jill	VNHC SW CT	Y	4	Y	7
Stack	Kathleen	Generations Family Health Center	Y	2	Y	6
Sulik	Patrice	Trumbull Monroe Health District	Y	2	Y	6
Sullivan	Kevin	CT Department of Public Health	Y	3	Y	8
Sullivan	Kristin	CT Department of Public Health	Y	5	Y	8
Sullivan	Raymond	Middlebury Health Dept.	Y	1		
Szalkiewicz	Scott	CT Department of Public Health	Y	3	Y	8
Tedford	Joyce	John Dempsey Hospital	Y	1	N	

Last Name	First Name	Agency	6/24-Attended Y/N	Essential Service	7/1-Attended Y/N	Essential Service
Tharnish	Sue	CT Department of Mental Health and Addiction Services	Y	4	Y	7
Veith	Karen	Community Health Center Inc	Y	3	Y	8
Veneziano	Virginia	Department of Consumer Protection	Y	1	Y	10
Walczok	Diane	The Hospital of Central Connecticut	N		Y	7
Wegrzyn	Thomas	Chesprocott Health District	Y	3	Y	8
Weeks	Tracy	CT Department of Public Health	N		Y	10
Wodatch	Tracy	VNA Health Care, Inc	Y	3	Y	8
Wright	Roseann	Waterbury Department of Public health	Y	3	Y	8
Wysocki	Carolyn	CCHD/NALBOH	Y	3	Y	9

### Staff and Facilitators

Last Name	First Name	Agency	6/24-Attended Y/N	Essential Service	7/1-Attended Y/N	Essential Service
Ali	Annie	YCPHP- intern (Facilitator)	Y	5		
Babcock-Dunning	Lauren	Yale Center for Public Health Preparedness (Facilitator)	Y	3		
Baron	Rebecca	NJ (Facilitator)	Y	2	Y	6
Bower	Carol	CT Department of Public Health (Facilitator)	Y	1	Y	10
Brown	Charles	CT Association of Directors of Health, Inc. (Facilitator)	Y	2	Y	6
Byrnes-Enoch	Hannah	YCPHP- intern (Facilitator)	Y	2	Y	6
Camardo	Marc	YCPHP- intern (Facilitator)	Y	1	Y	10
D'Amore	Deanna	CT Association of Directors of Health, Inc. (Facilitator)	Y	1	Y	1
Degutis	Linda	Yale Center for Public Health Preparedness (Facilitator)	Y	speaker	Y	9
Dingfelder	Barbara	CT Department of Public Health (Facilitator)	Y	4	Y	7
Durante	Amanda	Yale Center for Public Health Preparedness (Facilitator)	Y	2	Y	6
Foti	Kathryn	Yale Center for Public Health Preparedness (Facilitator)	Y	5	Y	9

Last Name	First Name	Agency	6/24- Attended Y/N	Essential Service	7/1- Attended Y/N	Essential Service
Fulcomer	Mark	NJ (Facilitator)	Y	1	Y	10
Kentfield	Jill	CT Department of Public Health (Facilitator)	Y	3	Y	8
Lazar	Christina	YCPHP- intern (Facilitator)	Y	3	Y	8
McNally	Kevin	New Jersey Dept of Health & Senior Services (Facilitator)	Y	4	N	
Mitchell	Peter	CT Department of Public Health (Technical Assistance)	Y	staff	Y	staff
Nathan	Chuck	CT Department of Public Health (Facilitator)	Y	5	Y	9
O'Keefe	Elaine	Yale University School of Public Health (Facilitator)	Y	4	Y	7
Olayokun	Rashidat	YCPHP- intern (Facilitator)	Y	4	Y	7
Ruiz	Ann Marie	NJ (Facilitator)	Y	3	Y	8
Sass	Marcia	NJ (Facilitator)	Y	5	Y	9
Scanny	Marge	NJ (Facilitator)	Y	4	Y	7
Syed	Imran	YCPHP- Intern (Facilitator)	N		Y	9
Traugh	Kathi	Yale Center for Public Health Preparedness (Facilitator)	Y	staff	Y	8
Walden	Sue	CT Department of Public Health (Facilitator)	Y	staff	Y	staff



**APPENDIX C**  
***National Public Health Performance  
Standards Program***  
**From Silos to Systems: Assessing  
Connecticut's State Public Health System**

**CONFERENCE AGENDA DAY ONE: JUNE 24, 2008**

- 8:00 am           REGISTRATION  
Continental Breakfast
- 9:00 am           WELCOMING REMARKS  
***J. Robert Galvin, Commissioner, Connecticut Department of Public Health***
- 9:15 am           INTRODUCTIONS  
***Linda C. Degutis, Director, Yale Center for Public Health Preparedness***
- 9:30 am           NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS PROGRAM  
***Trina Smith Pyron, Public Health Advisor, Centers for Disease Control and Prevention***  
***Teresa Daub, Public Health Advisor, Centers for Disease Control and Prevention***
- 10:30 am          MORNING BREAK
- 10:45 am          IMPLICATIONS FOR PUBLIC HEALTH PLANNING IN CONNECTICUT  
***Meg Hooper, Planning Branch Chief, Connecticut Department of Public Health***
- 11:15 am          CONDUCTING THE ASSESSMENT IN CONNECTICUT: OUR APPROACH  
***Marcia Sass, Assistant Professor Health Systems and Policy, University of Medicine and  
Dentistry of New Jersey School of Public Health***
- 11:45 am          QUESTIONS AND ANSWERS
- 12:00 pm          LUNCH
- 1:00 pm           PERFORMANCE STANDARDS ASSESSMENT: ESSENTIAL SERVICES ONE  
THROUGH FIVE  
*Pre-assigned, concurrent breakout sessions*
- |                     |               |
|---------------------|---------------|
| Essential Service 1 | Ballroom      |
| Essential Service 2 | Massachusetts |
| Essential Service 3 | New Hampshire |
| Essential Service 4 | Rhode Island  |
| Essential Service 5 | Vermont       |
- 2:45 PM          AFTERNOON BREAK
- 3:00 pm:          WRAP UP AND NEXT STEPS  
***Pamela Kilbey-Fox, Local Health Administration Branch Chief, Connecticut  
Department of Public Health***
- 3:30 pm          ADJOURN



***National Public Health Performance  
Standards Program***  
**From Silos to Systems: Assessing  
Connecticut's State Public Health System**

**CONFERENCE AGENDA DAY TWO: JULY 1, 2008**

- 8:00 am      REGISTRATION  
*Continental Breakfast*
- 9:00 am      WELCOMING REMARKS  
*J. Robert Galvin, Commissioner Connecticut Department of Public Health*
- 9:15 am      PULLING THE PIECES TOGETHER: REFLECTIONS AND DISCUSSION  
*Elaine O'Keefe, Executive Director, Yale School of Public Health Office of  
Community Health*
- 9:45 am      QUESTIONS AND ANSWERS
- 10:00 am:    MORNING BREAK
- 10:15 am:    PERFORMANCE STANDARDS ASSESSMENT: ESSENTIAL SERVICES SIX  
THROUGH TEN  
*Pre-assigned, concurrent breakout sessions*
- |                      |               |
|----------------------|---------------|
| Essential Service 6  | Ballroom      |
| Essential Service 7  | Massachusetts |
| Essential Service 8  | New Hampshire |
| Essential Service 9  | Rhode Island  |
| Essential Service 10 | Vermont       |
- 12:00 pm    LUNCH
- 12:45 pm    REPORTING BACK AND WRAP UP  
*Marcia Sass, Assistant Professor Health Systems and Policy, University of Medicine and  
Dentistry of New Jersey School of Public Health*
- 1:15 pm      NEXT STEPS FOR CONNECTICUT: A CALL TO ACTION  
*Pamela Kilbey-Fox, Local Health Administration Branch Chief, Connecticut  
Department of Public Health*
- 1:30 PM:    ADJOURN

APPENDIX D



State Public Health System  
Performance Assessment

Report of Results



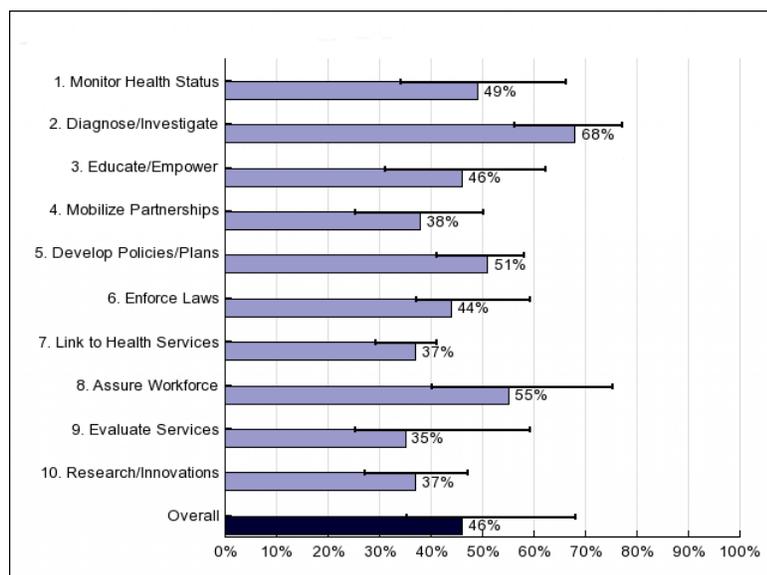
## Section B: Performance Assessment Instrument Results

### 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	49
2	Diagnose and Investigate Health Problems and Health Hazards	68
3	Inform, Educate, and Empower People about Health Issues	46
4	Mobilize Community Partnerships to Identify and Solve Health Problems	38
5	Develop Policies and Plans that Support Individual and Community Health Efforts	51
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	44
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	37
8	Assure a Competent Public and Personal Health Care Workforce	55
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	35
10	Research for New Insights and Innovative Solutions to Health Problems	37
Overall Performance Score		46

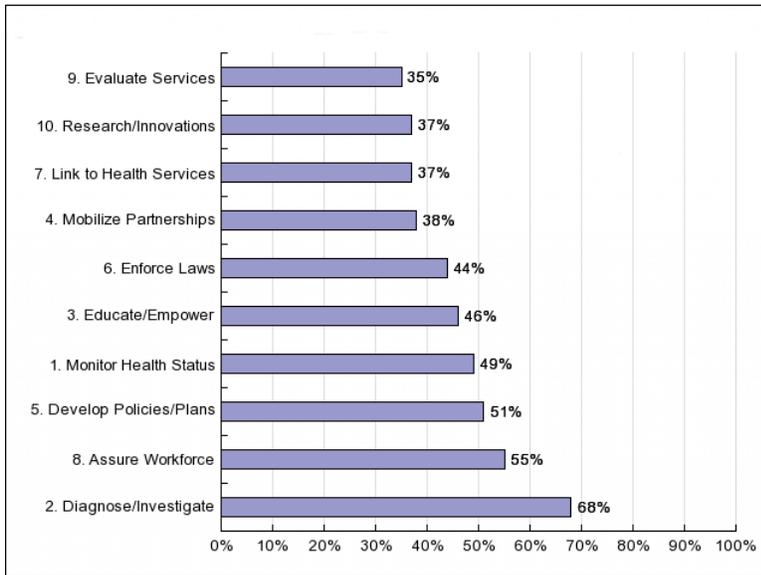
**Figure 1:** Summary of EPHS performance scores and overall score



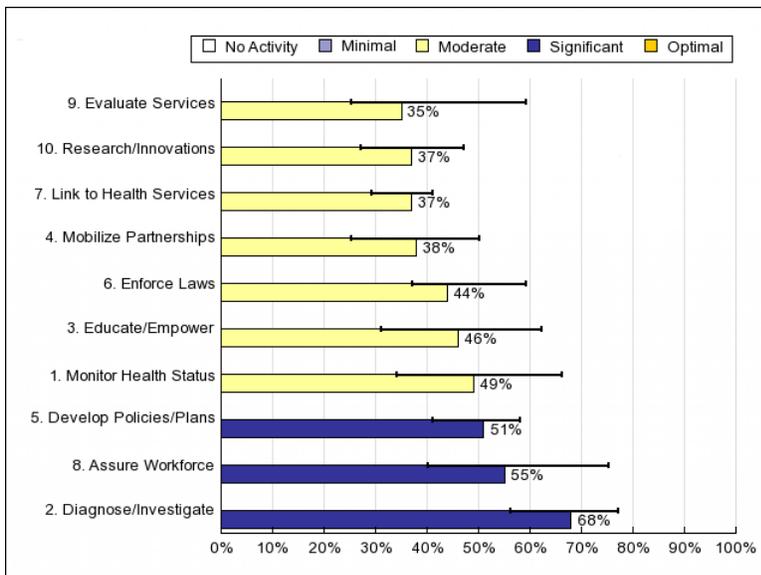
**Table 1** (above) provides a quick overview of the system's performance in each of the 10 Essential Public Health Services (EPHS). Each EPHS score is a composite value determined by the scores given to those activities that contribute to each Essential Service. These scores range from a minimum value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

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

**Figure 2:** Rank ordered performance scores for each Essential Service



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



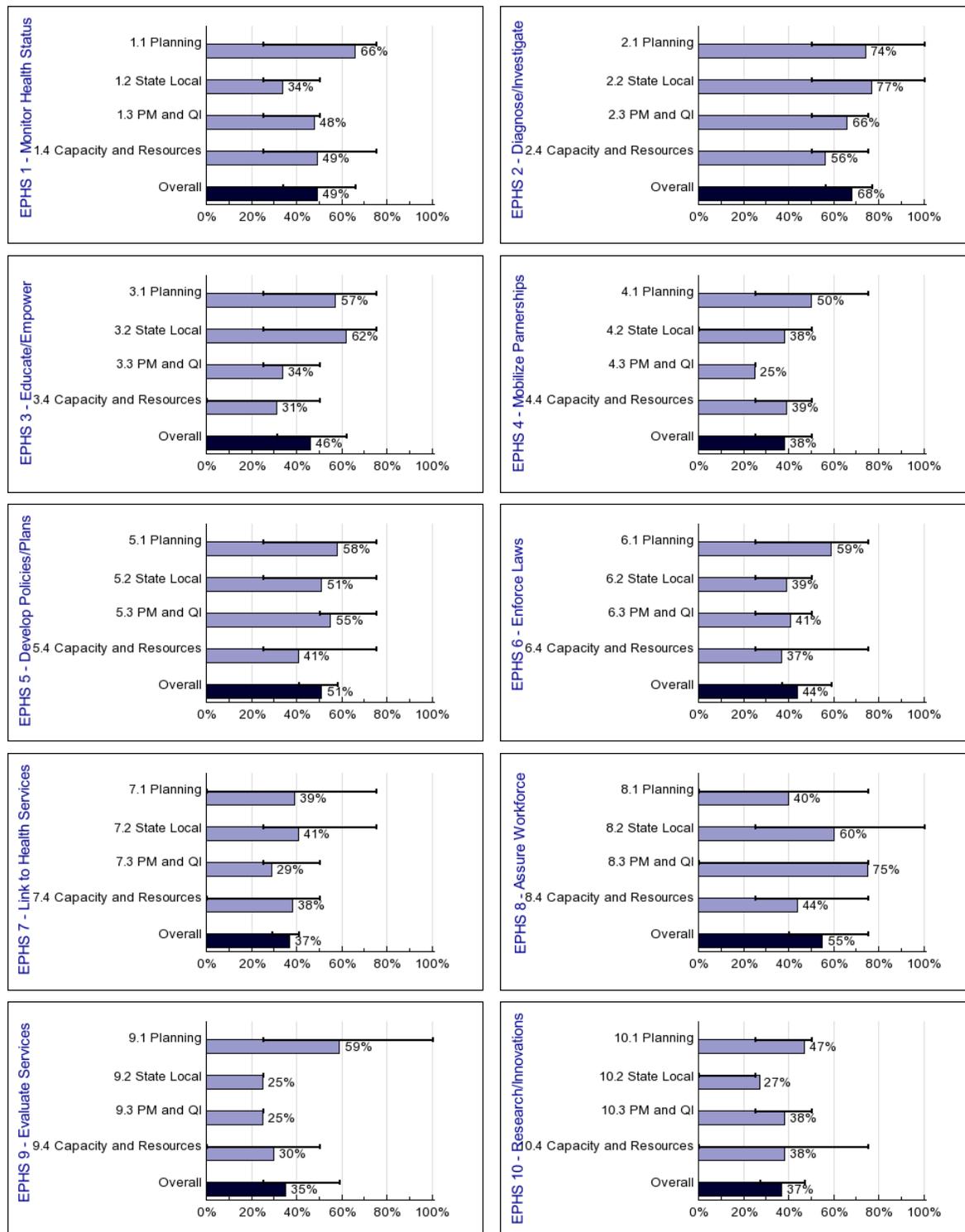
**Figure 2** (above) displays each composite score from low to high, allowing easy identification of service domains where performance is relatively strong or weak.

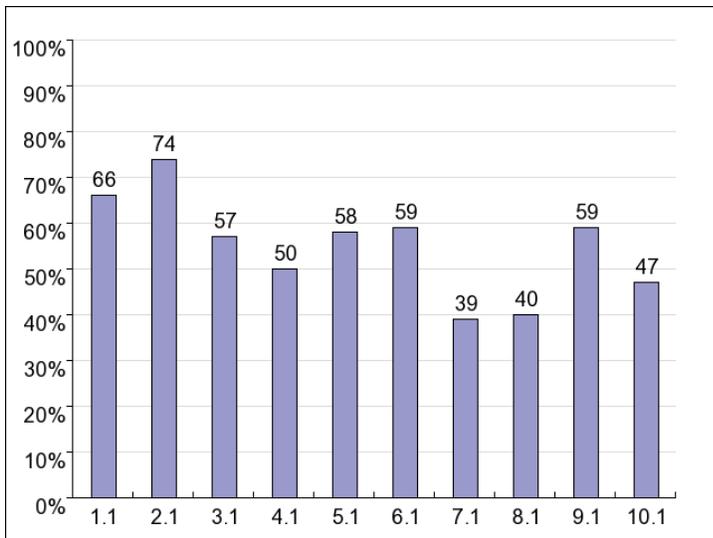
**Figure 3** (above) provides a composite picture of the previous two graphs. The range lines show the range of responses within an Essential Service. The color coded bars make it easier to identify which of the Essential Services fall in the five categories of performance activity.

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

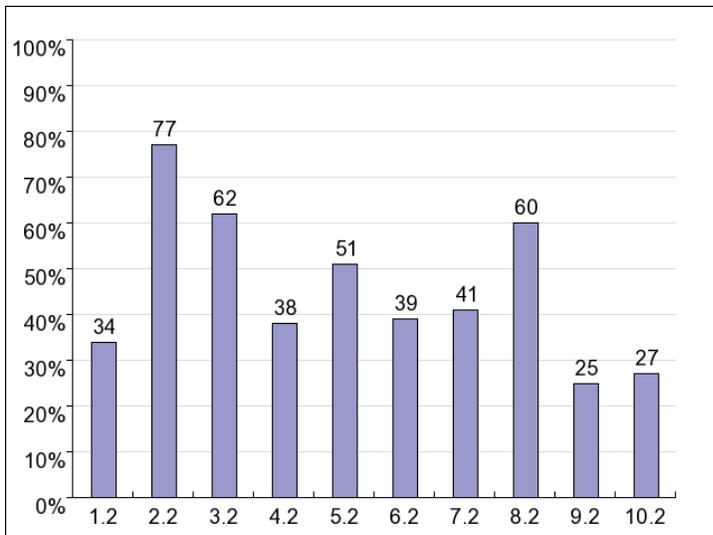
## II. How well did the system perform on specific model standards?

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

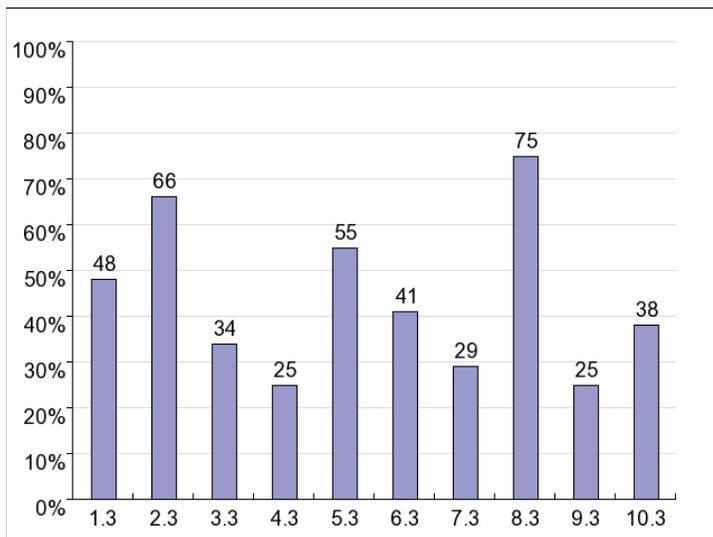




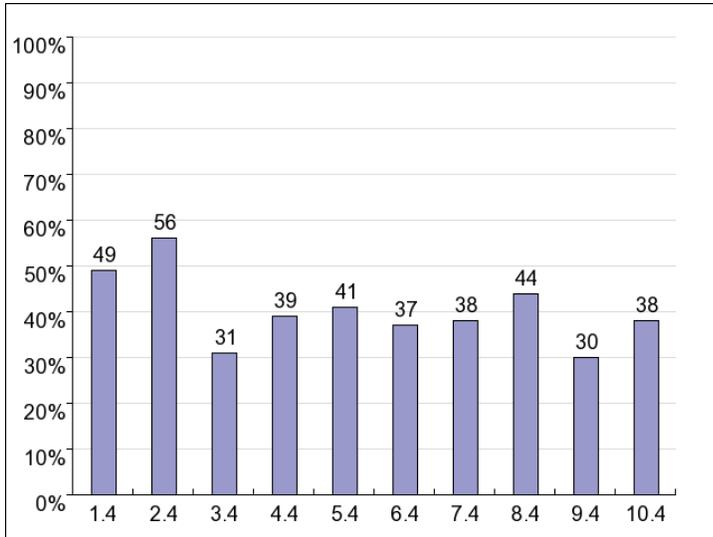
**Figure 5:** Model Standard 1 scores (Planning and Implementation) by Essential Service



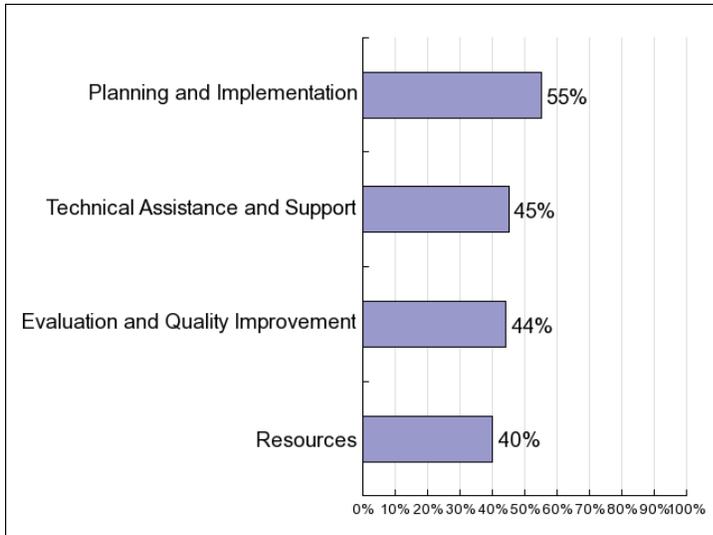
**Figure 6:** Model Standard 2 scores (State-Local Relationships) by Essential Service



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



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



**Figure 9:** Summary of average scores across Model Standards

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

Essential Public Health Service	Score
1. Monitor Health Status To Identify Community Health Problems	49
1.1 Planning and Implementation	66
1.1.1 Does the SPHS use surveillance and monitoring programs designed to measure the health status of the states population?	75
1.1.2 Does the SPHS regularly compile and provide health data in useable products to a variety of health data users?	75
1.1.3 Does the SPHS publish or disseminate health-related data into one or more documents that collectively describe the prevailing health of the states population (i.e., a state health profile)?	50
1.1.4 Does the SPHS operate a data reporting system designed to identify potential threats to the public's health?	75
1.1.5 Does the SPHS enforce established laws and the use of protocols to protect personal health information and other data?	75
1.2 State-Local Relationships	34
1.2.1 Does the SPHS offer technical assistance (e.g., training, consultations) to local public health systems in the interpretation, use, and dissemination of health-related data?	50
1.2.2 Does the SPHS regularly provide local public health systems a uniform set of local health-related data?	25
1.2.3 Does the SPHS offer technical assistance in the development of information systems needed to monitor health status at the local level?	25
1.3 Performance Management and Quality Improvement	48
1.3.1 Does the SPHS review the effectiveness of its efforts to monitor health status?	50
1.3.2 Does the SPHS actively manage and improve the overall performance of its health status monitoring activities?	50
1.4 Public Health Capacity and Resources	49
1.4.1 Does the SPHS commit financial resources to health status monitoring efforts?	50
1.4.2 Do SPHS organizations align and coordinate their efforts to monitor health status?	25
1.4.3 Does the SPHS have the professional expertise to carry out health status monitoring activities?	75
2. Diagnose And Investigate Health Problems and Health Hazards	68
2.1 Planning and Implementation	74
2.1.1 Does the SPHS operate surveillance system(s) and epidemiology activities that identify and analyze health problems and threats to the health of the states population?	50
2.1.2 Does the SPHS have the capability to rapidly initiate enhanced surveillance when needed for a statewide/regional health threat?	75
2.1.3 Does the SPHS organize its private and public laboratories (within the state and outside of the state) into a well-functioning laboratory system?	75
2.1.4 Does the SPHS have laboratories that have the capacity to analyze clinical and environmental specimens in the event of suspected exposure or disease outbreak?	100
2.1.5 Does the SPHS investigate and respond to identified public health threats?	75
2.2 State-Local Relationships	77

2.2.1 Does the SPHS provide assistance (through consultations and/or training) to local public health systems in the interpretation of epidemiologic findings?	75
2.2.2 Does the SPHS provide laboratory assistance to local public health systems?	100
2.2.3 Does the SPHS provide local public health systems with information and guidance about public health problems and potential public health threats (e.g., health alerts, consultations)?	75
2.2.4 Does the SPHS provide trained personnel, as needed, to assist local communities in the investigations of public health problems and threats?	50
2.3 Performance Management and Quality Improvement	66
2.3.1 Does the SPHS periodically review the effectiveness of the state surveillance and investigation system?	50
2.3.2 Does the SPHS actively manage and improve the overall performance of its activities to diagnose and investigate health problems and health hazards?	75
2.4 Public Health Capacity and Resources	56
2.4.1 Does the SPHS commit financial resources to support the diagnosis and investigation of health problems and hazards?	50
2.4.2 Do SPHS organizations align and coordinate their efforts to diagnose and investigate health hazards and health problems?	50
2.4.3 Does the SPHS have the professional expertise to identify and analyze public health threats and hazards?	75
3. Inform, Educate, And Empower People about Health Issues	46
3.1 Planning and Implementation	57
3.1.1 Does the SPHS design and implement health education and health promotion interventions?	75
3.1.2 Does the SPHS design and implement health communications?	50
3.1.3 Does the SPHS have a crisis and emergency communications plan?	75
3.2 State-Local Relationships	62
3.2.1 Does the SPHS provide technical assistance to local public health systems (through consultations, training, and policy changes) to develop skills and strategies to conduct health communication, health education, and health promotion interventions?	75
3.2.2 Does the SPHS support and assist local public health systems in developing effective emergency communications capabilities?	75
3.3 Performance Management and Quality Improvement	34
3.3.1 Does the SPHS periodically review the effectiveness of health communication, including emergency communication, health education and promotion interventions?	50
3.3.2 Does the SPHS actively manage and improve the overall performance of its activities to inform, educate and empower people about health issues?	25
3.4 Public Health Capacity and Resources	31
3.4.1 Does the SPHS commit financial resources to support health communication and health education and health promotion efforts?	25
3.4.2 Do SPHS organizations align and coordinate their efforts to implement health communication, health education, and health promotion services?	25
3.4.3 Does the SPHS have the professional expertise to carry out effective health communications, health education, and health promotion services?	50
4. Mobilize Community Partnerships to Identify and Solve Health Problems	38
4.1 Planning and Implementation	50

4.1.1 Does the SPHS build statewide support for public health issues?	50
4.1.2 Does the SPHS organize partnerships to identify and to solve health problems?	50
4.2 State-Local Relationships	38
4.2.1 Does the SPHS provide assistance (through consultations and/or trainings) to local public health systems to build partnerships for community health improvement?	25
4.2.2 Does the SPHS provide incentives to local partnerships through grant requirements, financial incentives and/or resource sharing?	50
4.3 Performance Management and Quality Improvement	25
4.3.1 Does the SPHS review its partnership development activities?	25
4.3.2 Does the SPHS actively manage and improve the overall performance of its partnership activities?	25
4.4 Public Health Capacity and Resources	39
4.4.1 Does the SPHS commit financial resources to sustain partnerships?	50
4.4.2 Do SPHS organizations align and coordinate their efforts to mobilize partnerships?	25
4.4.3 Does the SPHS have the professional expertise to carry out partnership development activities?	50
5. Develop Policies and Plans that Support Individual and Community Health Efforts	51
5.1 Planning and Implementation	58
5.1.1 Does the SPHS implement statewide health improvement processes that convene partners and facilitate collaboration among organizations contributing to the public's health?	50
5.1.2 Does the SPHS develop one or more state health improvement plan(s) to guide its collective efforts to improve health and the public health system?	50
5.1.3 Does the SPHS have in place an All-Hazards Preparedness Plan guiding systems partners to protect the states population in the event of an emergency?	75
5.1.4 Does the SPHS conduct policy development activities?	50
5.2 State-Local Relationships	51
5.2.1 Does the SPHS provide technical assistance and training to local public health systems for developing local plans?	50
5.2.2 Does the SPHS provide support and assistance for the development of community health improvement plans that are integrated with statewide health improvement strategies?	50
5.2.3 Does the SPHS provide technical assistance in the development of local public health all-hazards preparedness plans for responding to emergency situations?	75
5.2.4 Does the SPHS provide technical assistance in local health policy development?	50
5.3 Performance Management and Quality Improvement	55
5.3.1 Does the SPHS review progress towards accomplishing health improvement across the state?	50
5.3.2 Does the SPHS review new and existing policies to determine their public health impacts?	50
5.3.3 Does the SPHS conduct formal exercises and drills of the procedures and protocols linked to its All-Hazards Preparedness Plan?	75
5.3.4 Does the SPHS actively manage and improve the overall performance of its planning and policy development activities?	50
5.4 Public Health Capacity and Resources	41
5.4.1 Does the SPHS commit financial resources to health planning and policy development efforts?	25

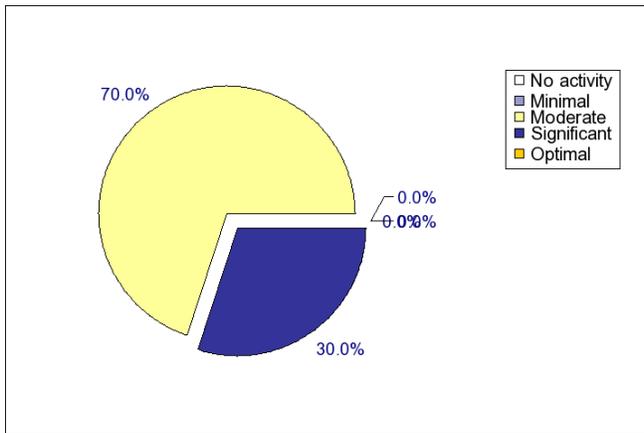
5.4.2 Do SPHS organizations align and coordinate their efforts to implement health planning and policy development?	25
5.4.3 Does the SPHS have the professional expertise to carry out planning activities?	75
5.4.4 Does the SPHS have the professional expertise to carry out health policy development?	50
6. Enforce Laws and Regulations that Protect Health and Ensure Safety	44
6.1 Planning and Implementation	59
6.1.1 Does the SPHS assure existing and proposed state laws are designed to protect the public's health and ensure safety?	75
6.1.2 Does the SPHS assure that laws give state and local authorities the power and ability to prevent, detect, manage, and contain emergency health threats?	75
6.1.3 Are there cooperative relationships between SPHS and persons and entities in the regulated environment to encourage compliance and assure that laws accomplish their health and safety purposes (e.g. hospitals and the state public health agency)?	50
6.1.4 Does the SPHS ensure that administrative processes are customer-centered (e.g., obtaining permits and licenses)?	50
6.2 State-Local Relationships	39
6.2.1 Does the SPHS provide technical assistance to local public health systems on best practices in compliance and enforcement of laws that protect health and ensure safety?	50
6.2.2 Does the SPHS partner with local governing bodies in reviewing, improving and developing local laws?	25
6.3 Performance Management and Quality Improvement	41
6.3.1 Does the SPHS review the effectiveness of its regulatory, compliance and enforcement activities?	25
6.3.2 Does the SPHS actively manage and improve the overall performance of its regulatory programs and activities?	50
6.4 Public Health Capacity and Resources	37
6.4.1 Does the SPHS commit financial resources to the enforcement of laws that protect health and ensure safety?	25
6.4.2 Do SPHS organizations align and coordinate their efforts to comply with laws and regulations?	25
6.4.3 Does the SPHS have the professional expertise to carry out enforcement activities?	75
7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	37
7.1 Planning and Implementation	39
7.1.1 Does the SPHS assess the availability of personal health services to the states population?	50
7.1.2 Through collaborations with local public health systems and health care providers, does the SPHS take action to eliminate barriers to access to personal health care?	50
7.1.3 Does the SPHS have an entity responsible for monitoring and coordinating personal health care delivery within the state?	0
7.1.4 Does the SPHS mobilize its assets, including local public health systems, to reduce health disparities in the state?	50
7.2 State-Local Relationships	41
7.2.1 Does the SPHS provide technical assistance to local public health systems on methods to assess and meet the needs of underserved populations?	25

7.2.2 Does the SPHS provide technical assistance to providers who deliver personal health care to underserved populations?	50
7.3 Performance Management and Quality Improvement	29
7.3.1 Does the SPHS review personal health care access, appropriateness and quality?	25
7.3.2 Does the SPHS actively manage and improve the overall performance of its activities to link people to needed personal health care services?	25
7.4 Public Health Capacity and Resources	38
7.4.1 Does the SPHS commit financial resources to assure the provision of personal health care?	50
7.4.2 Do SPHS organizations align and coordinate their efforts to provide needed personal health care?	25
7.4.3 Does the SPHS have the professional expertise to carry out the functions of linking people to needed personal health care?	50
8. Assure a Competent Public and Personal Health Care Workforce	55
8.1 Planning and Implementation	40
8.1.1 Does the SPHS conduct assessments of its workforce needs to deliver effective population-based and personal health services in the state?	50
8.1.2 Does the SPHS develop a statewide workforce plan(s) to guide its activities in workforce development?	0
8.1.3 Do SPHS human resources development programs provide training to enhance the technical and professional competencies of the workforce?	75
8.1.4 Does the SPHS assure that individuals in the population-based and personal health care workforce achieve the highest level of professional practice?	50
8.1.5 Does the SPHS support initiatives that encourage life-long learning?	50
8.2 State-Local Relationships	60
8.2.1 Does the SPHS assist local public health systems in completing assessments of their population-based and personal health care workforces?	25
8.2.2 Does the SPHS assist local public health systems with workforce development?	75
8.2.3 Does the SPHS assure educational course work and training is available and accessible to enhance the skills of the workforce of local public health systems?	100
8.3 Performance Management and Quality Improvement	75
8.3.1 Does the SPHS review its workforce development activities?	75
8.3.2 Does the SPHS review the extent to which academic-practice partnership(s) address the preparation of personnel entering the SPHS workforce?	75
8.3.3 Does the SPHS actively manage and improve the overall performance of its workforce development activities?	75
8.4 Public Health Capacity and Resources	44
8.4.1 Does the SPHS commit financial resources to workforce development efforts?	25
8.4.2 Do SPHS organizations align and coordinate their efforts to effectively conduct workforce development activities?	50
8.4.3 Does the SPHS have the professional expertise to carry out workforce development activities?	75
9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	35
9.1 Planning and Implementation	59
9.1.1 Does the SPHS routinely evaluate population-based health services within the state?	50

9.1.2 Does the SPHS evaluate the effectiveness of personal health services within the state?	75
9.1.3 Does the SPHS establish and/or use standards to assess the performance of the state public health system?	50
9.2 State-Local Relationships	25
9.2.1 Does the SPHS provide technical assistance (e.g., consultations, training) to local public health systems in their evaluations?	25
9.2.2 Does the SPHS share results of state-level performance evaluations with local public health systems for use in local planning processes?	25
9.3 Performance Management and Quality Improvement	25
9.3.1 Does the SPHS regularly review the effectiveness of its evaluation activities?	25
9.3.2 Does the SPHS actively manage and improve the overall performance of its evaluation activities?	25
9.4 Public Health Capacity and Resources	30
9.4.1 Does the SPHS commit financial resources for evaluation?	25
9.4.2 Do SPHS organizations align and coordinate their efforts to conduct evaluations?	25
9.4.3 Does the SPHS have the professional expertise to carry out evaluation activities?	50
10. Research for New Insights and Innovative Solutions to Health Problems	37
10.1 Planning and Implementation	47
10.1.1 Does the SPHS maintain an active academic-practice collaboration(s) to promote and organize research activities and disseminate and use research findings in practice?	50
10.1.2 Does the SPHS have a public health research agenda?	50
10.1.3 Does the SPHS participate in and conduct research relevant to public health services?	50
10.2 State-Local Relationships	27
10.2.1 Does the SPHS provide technical assistance to local public health systems with research activities?	25
10.2.2 Does the SPHS assist local public health systems in their use of research findings?	25
10.3 Performance Management and Quality Improvement	38
10.3.1 Does the SPHS review its public health research activities?	50
10.3.2 Does the SPHS actively manage and improve the overall performance of its research activities?	25
10.4 Public Health Capacity and Resources	38
10.4.1 Does the SPHS commit financial resources to research relevant to health improvement?	25
10.4.2 Do SPHS organizations align and coordinate their efforts to conduct research?	25
10.4.3 Does the SPHS have the professional expertise to carry out research activities?	75

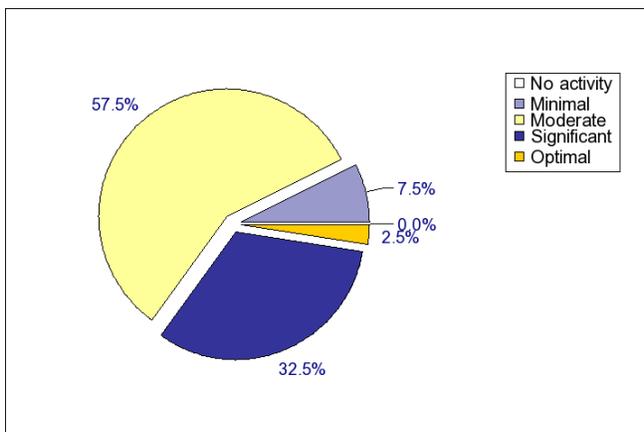
### III. Overall, how well is the system achieving optimal activity levels?

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



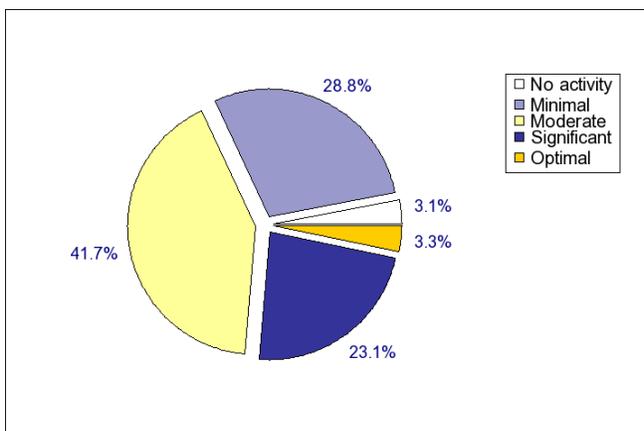
**Figure 10** displays the percentage of the system's Essential Services scores that falls within the five activity categories. This chart provides the site with a high level snapshot of the information found in **Figure 3**.

**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 falls within the five activity categories.

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



**Figure 12** displays the percentage of all scored questions that falls 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**.

## **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 [www.cdc.gov/od/ocphp/nphpsp](http://www.cdc.gov/od/ocphp/nphpsp).
- **NPHPSP Online Tool Kit** - Additional resources that may be found on, or are linked to, the NPHPSP website ([www.cdc.gov/od/ocphp/nphpsp/](http://www.cdc.gov/od/ocphp/nphpsp/)) under the "Post Assessment/ Performance Improvement" link include 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 standard, essential public health service, and keyword. Alternately, users may read or print the resource guides available on this site.
- **NPHPSP Monthly User Calls** - These calls feature speakers and dialogue on topics 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 ([www.cdc.gov/od/ocphp/nphpsp/](http://www.cdc.gov/od/ocphp/nphpsp/)) for more information.
- **Improving Performance Newsletter** and the **Public Health Infrastructure Resource Center at the Public Health Foundation** - This website ([www.phf.org/performance](http://www.phf.org/performance)) presents tools and resources that can help organizations streamline efforts and get better results. A five minute orientation presentation provides an orientation on how to access quality improvement resources on the site. The website also includes information about the Improving Performance Newsletter, which contains lessons from the field, resources, and tips designed to help NPHPSP users with their performance management efforts. Read past issues or sign up for future issues at: [www.phf.org/performance](http://www.phf.org/performance).
- **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.

## APPENDIX E

### Recorder Notes from the Breakout Sessions

#### **ESSENTIAL SERVICE #1 – MONITOR HEALTH STATUS TO IDENTIFY COMMUNITY HEALTH PROBLEMS**

- **Strengths**
    - Have the information
    - Know which data we want/need to collect
    - Department of IT working on standardizing data collection
    - Health data that is not specific to the individual is available
    - DPH a great facilitator in accessing data
    - Availability of data on DPH website
    - Hospitals frequently reporting data to the state
    - Linkages within DPH relating to child health (e.g., birth, WIC) available for querying
    - Geolab for emergency management – response side
    - Cancer based registry
    - VCADH HEI – health indicators
    - Professional expertise to carryout health status (maintaining)
    - State is looking to improve
  
  - **Weaknesses**
    - Visibility of data, packaging of data
    - Unsure of how to collect certain data or we do not collect (e.g., climate of change and PH, disparities)
    - Difficulty in coordinating different approaches – new strategies
    - No final determination in where responsibility lies (e.g., childhood obesity)
    - HIPPA a barrier in emergency situations (threat) –
      - Accessing information, at risk populations,
      - 9/11 and FOI laws that have been changed
        - Hospital data
        - Environmental groups
    - Lack of understanding with HIPPA
    - Ease of data transmission ~ electronic systems
    - Timeliness of data reporting (2 year lags)
    - Unaware of linked sources
      - Lack of access to GIS and geocoded data (state and local level)
    - Struggling to keep people/staffing with expertise in GIS – going to other state agencies
    - Do not provide data in a useable format/product to the public
    - EMS – no reporting mechanisms with DPH
    - Helping medical and public understand implications of community data
    - SPHS providing local health data and technical assistance
    - Moderately staffed to carry out activities
    - Minimal coordination of efforts
    - \*\*\* Resources are fragmented -- Silos
  
  - **Recommendations for Improvement**
    - Education on HIPPA
    - County health departments – examine regional
  
  - **Priority** – examination of state and local systems/relationships
-

## **ESSENTIAL SERVICE # 2 – Diagnose and Investigate Health Problems and Health Hazards**

- **Strengths**
  - Regional Epis
  - Some electronic reporting
  - Infectious disease surveillance
  - Some chronic disease surveillance
  - Environmental health tracking system
  - Private labs approved by STATE
  - \*\*Good lab infrastructure
  - Have trained people
  
- **Weaknesses**
  - Non-automated system
  - Different perspectives on “enhanced surveillance”
  - Not enough resources available to SPHS
  - Not enough staff
  
- **Recommendations**
  - Need to improve surge for Epi
  - Need more resources
  
- **Priorities**
  - Resources
    - ^
  - Utilization
    - ^
  - Efficient

## **Parking Lot – Question validity due to lack of representation from lab personnel**

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## **ESSENTIAL SERVICE #3 – INFORM, EDUCATE AND EMPOWER PEOPLE ABOUT HEALTH ISSUES**

- **Strengths**
  - Knowledge of partners
  - Many resources
  - Resource typing beginning through CEMHS ESF
  - Partnerships both local and community organization
  - Referral – local health, state. Hospitals, schools
  - Media relations
  - HAN
  
- **Weaknesses**
  - Duplication of efforts/services
  - Need for more culturally/linguistically appropriate to access for certain populations
  - Entities do not evaluate unless mandated; if mandated do not share
  - Many organizations have strategic plan, but some do not
  - Entities in place but not much of a “system”
  - Not enough public health partners represented today
  
- **Recommendations**
  - Define roles and public health system

- Define who public health workforce is. Who are we sharing? Who are we enforcing?
  - Recommend involving more partners (e.g., ACS, DEP)
  - Recognition of public health is an integral part of emergency management
  - Mapping of resources include all aspects such as insurance, peer educators
  - Asset management
  - SOP public health system roles using PHP model, ICS, NIMS
  - Knowledgeable DPH leaderships, esp. hospitals
  - Build relationships
  - State HD lead role with SME's
  - Emphasize – communication – core issues and include not-traditional health issues (e.g., arthritis, environmental health)
  - Cross communication
  - Collaboration
  - SOP (Standards of Operations) for disseminating information
- **Priorities** – Collective vision on what protecting public health is keeping the 10 essential public health functions in mind

**Additional notes from discussion (ESF #3)**

- Vote differs depending on entity
- Theories good, outcomes differ
- State DPH – receives mandates from legislation, federal – sometimes with short turn-around time
- Sometimes based on information assessments
- Certain areas and outcomes (e.g., HIV)
- Utilization of other media outlets (e.g., internet)
- Individual message not affiliated with DPH come out more often than DPH messages
- Not everyone in public health workforce is trained in public health
- If disseminating messages should be trained in public health
- HAN messages may target certain populations; yet may need to understand target population better
- Utilize 211 as community tool (DPH and other agencies)
- Governor's communication team created a manual to be used when EOC activated. Includes canned PRs, communication with 211, 211 does rumor control and reports back to EOC. However, not everyone knows this information
- DPH plans in compliance with NIMS; not all ESF's in compliance
- Still need help with inter-operable communication systems between partners
- DPH commits some funding but not enough
- Political influence

**ESSENTIAL SERVICE # 4 – MOBILIZE COMMUNITY PARTNERSHIPS TO IDENTIFY AND SOLVE HEALTH PROBLEMS**

- **Strengths**

- Number of broad coalitions formed (e.g., CT Cancer, Stroke, Dental, arthritis, obesity, asthma)—statewide support
  - Availability for expert consultation
  - Willingness to assist ad hoc
- Regional public health preparedness planning -- multidisciplinary
- Some change in focus to build broader/cross-cutting activities
- Collaborative relations when funding supports (e.g., immunizations)
- When collaborative relationship exist more information sharing
- Evidence of group's taking responsibility to increase broader representation in collaborative
- Interoperable communication plans for emergency preparedness – model for others
- Effective and timely dissemination of information

- Epi Newsletters, Diabetes/CT Cancer Newsletters
    - HAN Priority issues – real time
  - Other funding sources provide opportunities for statewide initiatives (e.g., Public Health Foundation)
  - Collaborations built on mutual values and commitments
  - Funding supports initial development/formation of focused collaborative and distribution to broad number of partners (i.e., fed/state grants)
  -
- **Weaknesses**
  - Limited funding, competing demands and equitable distribution of resources – who defines expectations?
  - Silo affect
    - Lack of integration and coordination – disease specific not “chronic disease” due to funding streams
    - Categorical programs vs primary disease interventions
    - Regulatory relationship vs. public health initiative/coalition building with many of the public health partners
  - Limited understanding of collective system vs DPH
  - Conflicting/competing demands for system-wide collaborative
  - No planning for integration across systems
  - No mechanisms for organized/systematic sharing of information (e.g., communicable disease reporting between LHD, hospital state, and other partners)
  - Lack of coordination of technology between systems-constructs, day-to-day operations
  - Flurry of activity sporadically vs continual updates
  - Perspectives and priorities change with administration
  - Sustainability not supported for long term efforts
  - Partnerships/collaborations infrequently ask who is missing from partnership? How this worked? What impact of collaboration?
  - Lack of State Strategic Plan – partners cannot align their organization’s plans when State’s priorities, goal and objectives not defined
  - Attitude and willingness for a mutually beneficial collaboration
    - Individual agendas vs collective vision
  - Decision-making capacity of collaborative lacking (e.g., authority, funding streams)
  - Competency of workforce across the board?
- **Recommendations**
  - Opportunities with funding to support programs

## **ESSENTIAL SERVICE # 5 -- DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS**

- **Strengths**
  - All hazards preparedness planning
- **Weaknesses**
  - Need to include mortuary services and higher education as part of public health system
  - Knowledge of data needs to be more widespread
  - Need knowledge of planning models

### **Recorder Notes from the Breakout Sessions** Essential Services 6-10

## **ESSENTIAL SERVICE # 6 – ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY**

- **Strengths**

- Basing public health on “sound science” may not be acted upon
- Districts base fees on analysis of business costs
- Well trained workforce
- State DPH has subject matter expertise – resource for others
- Legal structure for environmental protection
- **Weaknesses**
  - Public health infrastructure to enforce regulations
  - Funding issues
  - Legislative process can cause challenges for enforcement issues
  - Follow through with resources
  - No county government for “filtering” legislation
  - Charges at local level varied – based upon type of local health department/district
- **Recommendations**
  - Statutes need to generate regulations
  - Communicate about existing quality improvement projects better
  - Digitalization of information on enforcement actions – locally
- **Priorities**
  - Same regulations for all towns locally
  - Same application of State regulations
  - Uniform system

## **ESSENTIAL SERVICE #7 – LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTH CARE WHEN OTHERWISE UNAVAILABLE**

- **Strengths**
  - Three accredited academic institutions in state
  - Formal federal designation program
    - Systematic and periodic update
    - Geographic designation
  - Department of Consumer Protection – track and monitor employment and status of pharmacists
  - Factual information available
  - Most organizations have some quality improvement (e.g., hospitals based on JACHO requirements)
  - Legislative mandates for some programs/services (e.g., Husky)
  - Move forward as result of emergency preparedness ESF collaborations
  - Advocacy has proved track record
- **Weaknesses**
  - Shortages of health care workforces (e.g., nurses, etc)
  - Broad definitions for managed care
  - Limited access where workforce needs are – need more data
  - Limited awareness of assessment
  - Limited number of providers provide services to underserved
  - One coordinating entity (Office of Health Care Access) is not all encompassing (one entity not “system”
    - OCHA reviews on reactive basis
  - Fragmented – not “system-wide” or interconnected
  - Reluctance of provider to provide data
  - Measure quantity verses quality of services
  - Minimum standards (regulated) – no consistent bench markers

- Priorities verses best practice models fills short term needs verses fostering long term collaboration (e.g., public health preparedness – collaboration since 9/11)
- Political influence verses meeting genuine need
- **Other considerations**
  - Group missing representatives from regulatory office related to health services (hospitals, etc) and other content experts (e.g., Department of Social Services, DPH Family Health Section, etc)

## **ESSENTIAL SERVICE #8 – ASSURE A COMPETENT PUBLIC HEALTH AND PERSONAL HEALTH CARE WORKFORCE**

- **Strengthens**
  - Expertise
  - Opportunities for training
  - TrainCT
  - Discussion among groups
  - Loan repayment system
  - Development of partnerships
  - Willingness to participate at local level
  - Practice in program of public health schools
  - Medical > public health focus
  - Recognition to diversify workforce
- **Weaknesses**
  - Public health system does not exist yet attempting to answer based on this
  - Lack of standard definition state public health system workforce
  - Gap – competency level verses having degree
  - Time and money resources for staff development
  - Fractured pieces universal health care value
  - Lack of technology regarding data (e.g., local data bases do not talk to each other)
  - Assessment – outcomes, where do they go? How is data used? How captured?
  - Work force development is given the importance as other public health activities – lack of resources, dedication
  - Local of evaluation self development, staying current with issues --Lack of mentors and holding staff accountable
  - No state plan to attract students into health field
- **Recommendations**
  - Put systems in place to accomplish “egg chart”
    - Identify people who are a part of the system
    - Include other stakeholders to “egg chart” (e.g., private sector, pharmacy)
  - Determine what current services are in place to expand upon
    - Conduct assessment: hospitals, VAN Association level, DPH (pubic health workforce), Department of Development Services, Department of Consumer Protection (internal), LHD (for staffing)
  - Minimal standards titles
  - Cross-training
- **Additional Notes**
  - Gap in competency level verses having degree – highest level
  - System does not promote if advance training completed, further promotion within local public health and RN
  - Education is the main way we can ensure competency, but credentialing and education does not necessarily ensure competency
  - Marketing training opportunities

- Market public health better
- Create program for three public health schools to collaborate
- If defining the system that is public health workforce then ensure minimum competencies
- Cross-agency assessment of competency
- Mandatory CEUs for certain areas of public health workforce
- Need more standardization for titles (e.g., epidemiologist qualifications)
- DPH and local health departments work together
- Local Health does not receive Per Capita funding unless they do assessment
- If information not shared as to whether agencies are completing competencies, difficult to vote
- How does the advanced competency training lead to competent practice
- People not certified or licensed in public health – How do we ensure competency?
- Leadership and management programs offered to state agencies, LHDs, and hospitals
- Limited training regarding refugees
- Allied Health Policy Bd – assessment of nursing
- CHC rural – patients have to be treated in Farmington (long distance away), lack dental care, no assessment complete
- VNA – inner city- lack of staff to fill positions
- Beginning training but need better understand of certain populations
- Schools of PH evolved from just medical to today's
- DPH brings in medical students
- DPH employees speak at medical schools
- DPH loan repayment program, however, only 1.5 times persons dedicated
- What is allocated results in need to do best we can. Is it ever adequate?
- Some skills are not learned in education setting, picked up as life experience
- SPHS does not oversee and State does not mandate – left up to education system to decide
- At local health level a lot of work is done in this area
- 8.3.3. Allied Health, CSMS, and DPH partnership actively manages overall performance
- To improve need funding and resources, public health and hospitals (e.g., 2.5 people dedicated in DPH and surveyors that license entities
- Many entities have partnerships with organizations such as dental school, CPHA, etc

## **ESSENTIAL SERVICE # 9 EVALUATE EFFECTIVENESS, ACCESSIBILITY AND QUALITY OF PERSONAL AND POPULATIONS BASED HEALTH SERVICES**

### **• Strengths**

- (9.1) Immunizations tracked by schools
- Injury prevention programs with evaluation
- Some grants with evaluation components
- Good evaluations of practitioners
- Evaluation driven by funding
- Credentialing
- Availability of funding
- (9.2) Three schools of public health
- (9.4) Drills and exercises
- Hospital and surgicenter (?) evaluation

### **• Weaknesses**

- (9.1) Evaluation of some programs – needs standards
- Need evaluation of flu shot program success
- Evaluation driven by funding
- Availability of funding
- Lack of standardization across the system
- (9.2) Need to share results more
- (9.4) Lack of resources for systematic evaluation

- **Recommendations for Improvement**
  - (9.1) Expansions of licensing/credentialing
  - Need to explore what the 10 essential public health services are
  - Sub-state regional approach to assessment
  - Bring more subgroups to tale
  - (9.2) Simplify the message
  - Regional from grassroots up
  - Need to connect with schools and programs of public health
  - (9.4) Build on regional approaches
  - Critically look at pubic health infrastructure/system and involve all stakeholders
  - Develop/adapt/expand standards
- **Priorities**
  - Need to identify system partners and get to know about them
  - Mobilize community partners in evaluation
- **Other considerations**
  - (9.3) Do not have the information about what is being done to rate this – No grasp
  -

## **ESSENTIAL SERVICE #10 CONDUCT RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS**

- **Strengths**
  - Research study group at Yale
  - Diabetes plan, stroke, health disparities, CCP >academics involved
  - Health Care access research (CHA)
  - Public health practice experience for students; adjunct professors are a great academic-practice link
  - Use of local college students > benefits for both
    - Workforce development
  - Disease specific research
  - E-newsletter > dissemination ≈ communications office >translating research as advice to the public
  - CEHDL > dissemination to local communities
  - Food protection >specific agenda ≈ within divisions of schools > strong research agendas
  - Almost all research being conducted is through academic practice collaborations
  - Plans are by specific areas/divisions
  - Incorporating health disparities into research ≈ chronic disease > integrated within grants
  - Research designed to change practice (food regulations)
  - Academic partners conducting relevant research to public health services
  - Of the research that is being done within the DPH, they (i.e., department staff) are involved in the design
  - Health and mental health > inactive research
  - Mental health > providing technical assistance (strong area)
  - Evaluation within grants
  - Review pubic health services guided by feds, but in silos
  - DPH coordinating with DSS on data
    - Child and maternal health (e.g., Medicaid data)
  - Have professional expertise to carry out research
- **Weaknesses**
  - Statewide dissemination to the local level is not on a broad basis
  - Website under construction > labor intensive to get reports up
    - Change links

- Unaware of a SPHS research agenda > no integrated agenda
  - Marketing ourselves > no strong public health message > always the last thing you think about when you are dealing with services and regulations
  - Process, not outcomes
  - Have not defined the public health missions
  - No state public health improvement plan ≈ no integration of research
  - Lead by federal funding > does not focus on the public
    - Reporting to federal government > missing reporting back to citizens
  - Research on services
  - Do not have the time to publish as much as we want > not a major focus in what we do
  - Have to find grant money at the local level to help design research projects > no state support
    - No formal state mechanism for technical assistance to locals
  - Not provided assistance with designing evaluation > locals are asked to do this themselves
  - State does not provide assistance in applying research findings
  - No master plan to review public services ~ SPHS does not manage and improve the overall performance of research activities
  - Few resources committed to research relevant to health improvement
  - SPHS organizations are not aligning strategic plans to improve research
  - Collaboration focused in certain areas (e.g., food)
  - Dissemination of research findings > only within certain groups
  - Health care regulatory area > could use research – implication for the entire system
  - Mental health > service oriented, research not as high of a value as it is in the public health
  - Interest there from high school students, but do not know where it all fits with grant, work plan
    - Great effort in investing time in the students > finding the right experiences for them
- **Recommendations**
    - Figuring out where resources should be placed in a strategic way
      - Improvement plan would guide this