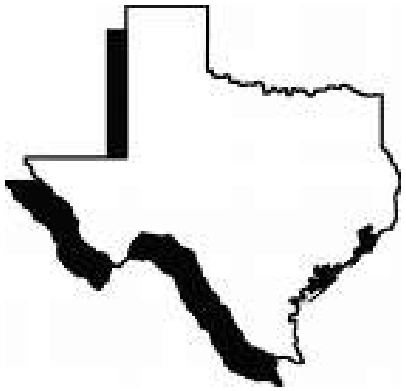
REPORT

Texas
State Public Health System Assessment

www.dshs.state.tx.us/sphsa



September 29, 2006

Prepared by:
State Public Health System Assessment Steering Committee

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BACKGROUND

The State Public Health System (SPHS) in Texas is defined as -
"All public, private and voluntary organizations that contribute to the public's health and the well being in Texas."

This report documents results from the State Public Health System Assessment (SPHSA) Conference held on 07/17/06 – 07/18/06 in Austin, Texas in which 127 individuals representing 68 organizations from 23 Texas cities attended.

This report represents a significant first step by public health partners across Texas to improve the SPHS in Texas using the National Public Health Performance Standards (NPHPS).

Based on the strengths and weaknesses identified in the SPHSA, a SPHS Improvement Plan will be developed and implemented.

In February 2006, Dr. Eduardo Sanchez, Commissioner of the Texas Department of State Health Services (DSHS), convened a group of public health organization representatives in Texas and charged them with planning and implementing Texas' first SPHSA based on NPHPS. The SPHSA Steering Committee (APPENDIX D) included representatives from: Texas Association of Local Health Officials, DSHS, Texas Health Institute, Texas Public Health Association, Texas Public Health Training Center, Texas Strategic Health Partnership, and the University of Texas School of Public Health.

The goals of the SPHSA were:
- Describe the SPHS in Texas;
- Identify and define the roles and contributions of the participants in the SPHS;
- Establish an assessment process that includes participants in the public health system;
- Measure the performance of the state agency and the system across the Ten Essential Public Health Services (EPHS);
- Identify areas of improvement; and
- Promote development of plans and policies that will sustain, strengthen and improve the SPHS that serves Texas residents.

In 1994, the challenges of describing and assessing public health performance in the United States lead to the creation of the Ten EPHS:

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose** and investigate health problems and health hazards in the community.
3. Inform, **educate**, and empower people about health issues.
4. Mobilize community **partnerships** and action 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 competent public 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.

In 2004, Dr. Paul Wiesner (Milne & Associates, LLC) developed a user-friendly language for the EPHS titled - *The Non-Public Health Professional Version or The 10 Essential Services in English.*

1. What's going on in my community? How healthy are we?
2. Are we ready to respond to health problems or threats in my county? How quickly do we find out about problems? How effective is our response?
3. How well do we keep all segments of our community informed about health issues?
4. How well do we really get people engaged in local health issues?
5. What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6. When we enforce health regulations, are we technically competent, fair, and effective?
7. Are people in my community receiving the medical care they need?
8. Do we have a competent public health staff? How can we be sure that our staff stays current?
9. Are we doing any good? Are we doing things right? Are we doing the right things?
10. Are we discovering and using new ways to get the job done?

In 1997, a coalition of national public health organizations, lead by the Centers for Disease Control and Prevention (CDC), developed NPHPS with the purposes of:

- Improving quality and performance;
- Increasing accountability; and
- Increasing the scientific base for practice.

NPHPS consists of three assessment instruments that primarily focus on the public health system, with secondary attention to the public health agency:

- SPHSA Instrument;
- Local Public Health System Assessment Instrument; and
- Local Public Health Governance Assessment Instrument.

In 2001, forty-seven local health departments in Texas used a modified version of the Local Public Health System Assessment Instrument to determine their performance and develop quality improvement plans.

In 2003, a statewide assessment of the public health system that provides diabetes services in Texas was conducted based on the EPHS.

For more information on the SPHSA, please refer to www.dshs.state.tx.us/sphsa.

ASSESSMENT PROCESS

After reviewing SPHSA models used in other states and lessons learned from these experiences, the SPHSA Steering Committee adopted the statewide conference model, to be implemented over a two-day period. The committee consulted with CDC, Association of State and Territorial Health Officials (ASTHO), National Network of Public Health Institutes, Arkansas, Colorado, Florida, Illinois, Mississippi, Montana, New Hampshire, New Mexico, Oregon, and Washington. The Center for Program Coordination at DSHS provided support to the steering committee in planning and implementing the SPHSA Conference.

175 individuals representing organizations that play a key role in the provision of EPHS were invited to participate in the conference. Three categories of organizations were identified to participate in the conference:

- Core governmental organizations,
- Other governmental organizations, and
- Non-governmental organizations.

During the first day of the conference, participants learned about the purpose and process of the SPHSA through presentation and panel discussions with Dr. Eduardo Sanchez, Dr. Virginia Kennedy (SPHSA Steering Committee Co-Chair), Klaus Madsen (SPHSA Steering Committee Co-Chair), Laura Landrum (ASTHO) and Ursula Phoenix-Weir (CDC).

On the first day of the conference, participants engaged in an interactive exercise ("*Mapping the State Public Health System*") designed to create a conceptual map of all the organizational roles and relationships in the Texas SPHS represented by those in attendance. The public health system was defined as all public, private and voluntary organizations that contribute to the delivery of essential public health services within a designated geographic area. The EPHS describe the actions that should be undertaken in every public health system. Participants visited ten tables, one for each EPHS, marked with concentric circles representing a target or bulls-eye. The first task was to select a location on the target representing the extent to which this particular service describes the work of their organization: major involvement (primary role), some involvement (secondary role), or minimal involvement (supporting role). The second task for participants was to complete a brief form describing their organization's activities relevant to each EPHS and identifying other organizations they relate to in these activities.

On the second day of the conference, participants were assembled in five groups of 15-20 individuals, based on their EPHS roles (e.g., knowledge and experience), to carry out an assessment of:

- SPHS performance, that is, the extent to which the four model standards associated with each EPHS are met by the system collectively, and
- DSHS' contribution to system performance.

The SPHSA instrument used was a revised (2006) field test version of the original instrument provided by CDC.

Each EPHS was assessed based on four indicators:

1. Planning & Implementation;
2. State-Local Relations;
3. Performance Management & Quality Control; and
4. Public Health Capacity & Resources.

Participants assigned a value to each model standard using the following scale:

- "Optimal" = 76-100% of the optimal standards are met;
- "High partial" = 51-75% of the optimal standards are met;
- "Low partial" = 26-50% of the optimal standards are met;
- "Minimal" = 1-25% of the optimal standards are met; and
- "No activity" = 0% of the optimal standards are met.

The Conference Agenda is in APPENDIX B.

SUMMARY, RESULTS AND ANALYSIS

SPHS Performance

Collectively, the SPHS was assessed as:
- "Minimal" for 18 of the 40 model standards,
- "Low Partial" for 15 of the 40 model standards, and
- "High Partial" for 7 of the 40 model standards.

No standard was assessed as "No Activity" or "Optimal" levels of performance.

SPHS performance was rated **highest** for:
- Enforce Laws and Regulations that Protect Health and Ensure Safety (EPHS #6),
- Mobilize Community Partnerships and Action to Identify and Solve Health Problems (EPHS #4), and
- Develop Policies and Plans that Support Individual and Community Health Efforts (EPHS #5).

SPHS performance was rated **lowest** for:
- Assure Competent Public and Personal Health Care Workforce (EPHS #8),
- Inform, Educate and Empower People About Health Issues (EPHS #3), and
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services (EPHS #9).

SPHS scores were highest for state-local relationships and lowest for performance management and quality improvement.

DSHS' Performance

DSHS' contribution to SPHS performance was assessed as:
- "Minimal" for 17 of the 40 model standards,
- "Low Partial" for 12 of the 40 model standards,
- "High Partial" for 10 of the 40 model standards and
- "Optimal" for one (1) of the 40 model standards.

No standard received the "No Activity" level of performance.

DSHS' contribution to SPHS performance was rated **highest** for:
- Diagnose and Investigate Health Problems and Health Hazards in the Community (EPHS #2) and
- Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable (EPHS #7).

DSHS' contribution to SPHS performance was rated **lowest** for:
- Assure Competent Public and Personal Health Care Workforce (EPHS #8),
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services (EPHS #9), and
- Research for New Insights and Innovative Solutions to Health Problems (EPHS #10).

DSHS' contribution to SPHS performance was highest for planning and implementation and lowest for state-local relationships.

More details on the assessment results follow on pages 10-31.

APPENDIX A represents all the assessment questions and scores.

EPHS #1: Monitor Health Status to Identify Health Problems

More than one-half of respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service. Governmental public health agencies at the federal, state, regional and local levels played key roles as primary system members, while non-governmental entities saw themselves as playing secondary roles.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS measures, analyzes and reports on the health status of the state's population. The state's health status is monitored through data describing critical indicators of health, illness, and health resources. Monitoring health is a collaborative effort involving many state public health partners and local public health systems. The effective communication of health data and information is a primary goal of all systems partners that participate in this effort to generate new knowledge about health in the state.	**26-50%** **Low Partial**	**51-75%** **High Partial**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources to local efforts to monitor health status and to identify health problems.	**1-25%** **Minimal**	**26-50%** **Low Partial**
3. Performance Management and Quality Improvement: The SPHS partners with local public health systems and provides assistance, capacity building, and resources to local efforts to monitor health status and to identify health problems.	**1-25%** **Minimal**	**26-50%** **Low Partial**
4. Public Health Capacity and Resources. The SPHS effectively invests in and utilizes its human, information, technology, organization and financial resources to monitor health status and to identify health problems in the state.	**26-50%** **Low Partial**	**26-50%** **Low Partial**

SPHS means State Public Health System
SPHA means State Public Health Agency

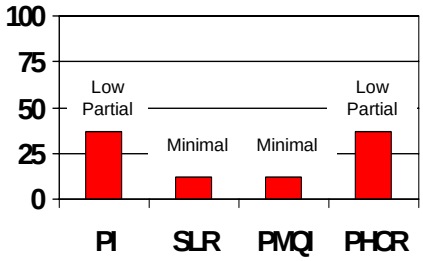
*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #1: Monitor Health Status to Identify Health Problems

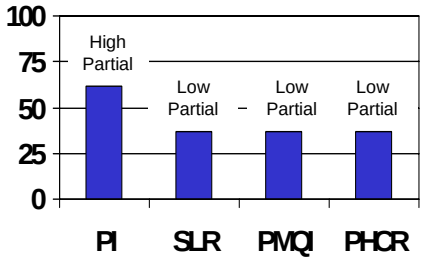
- Assessment of statewide health status and its determinants, including the identification of health threats and the determination of health service needs.
- Analysis of the health of specific groups that are at higher risk for health threats than the general population.
- Identification of community assets, resources, which support the State Public Health System 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 for systems.

Performance Standards Assessment Results

State Public Health System



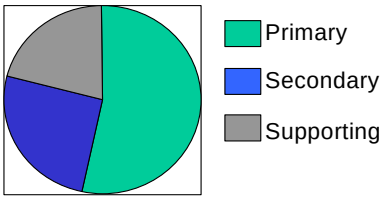
State Public Health Agency (DSHS)



PI = Planning & Implementation
PMQI = Performance Management & Quality Improvement
SLR = State-Local Relationships
PHCR = Public Health Capacity & Resources

EPHS #1: Monitor Health Status to Identify Health Problems

System Member Roles



Assessment Group Participants

- Public health agencies (federal, state, regional, local)
- Other governmental agencies
- Non-governmental organizations (associations, universities, others)

Participant Comments

- "Vital statistics is our strength along with chronic and infectious disease… on mental health, we need definitions"
- "We are collecting a lot of data, but much of it goes undetected/unanalyzed"
- "There are many ways to share information, but there is not necessarily a formal process that everyone is using"
- "If the law requires it, then it is reported – a lot of threats are not reported"

EPHS #2: Diagnose and Investigate Health Problems and Health Hazards

Nearly one-half of respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service. Governmental public health agencies at the federal, state, regional and local levels played key roles as primary system members, while non-governmental entities identified supporting roles for their organizations.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS works collaboratively to identify and respond to public health threats, including infectious disease outbreaks, chronic disease prevalence, the incidence of serious injuries, environmental contaminations, the occurrence of natural disasters, the risk of exposure to chemical and biological hazards, and other threats.	**51-75%** **High Partial**	**51-75%** **High Partial**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources for local efforts to identify, analyze, and respond to public health problems and threats to the health of the public.	**26-50%** **Low Partial**	**76-100%** **Optimal**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its activities to diagnose and to investigate health problems to improve the quality and responsiveness of its efforts.	**1-25%** **Minimal**	**51-75%** **High Partial**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, organizational, and financial resources to diagnose and investigate health problems and hazards that affect the state's population.	**26-50%** **Low Partial**	**51-75%** **High Partial**

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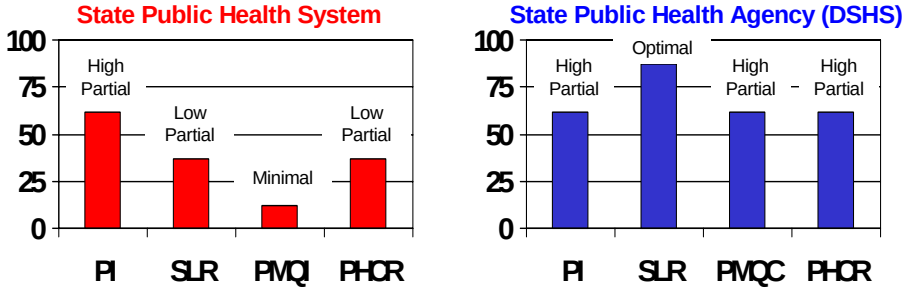
SPHA means State Public Health Agency

*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #2:
Diagnose and Investigate Health Problems and Health Hazards

- 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 epidemiological investigations.

Performance Standards Assessment Results



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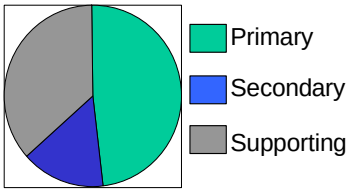
EPHS #2:
Diagnose and Investigate Health Problems and Health Hazards

System Member Roles



Assessment Group Participants

- Public health agencies (federal, state, regional, local)
- Other governmental agencies
- Non-governmental organizations (associations, universities, others)

Participant Comments

- "DSHS has surge capacity – it has MOUs (Memorandum of Understandings) with more than twenty (20) labs"
- "The public lab list is complete – private labs are not as well connected"
- "Common protocols are set, but operations can differ"
- "Training is the weakest link"
- We need to do better on diagnosis and investigation function – particularly concerning maternal and child health and chronic disease"

EPHS #3: Inform, Educate and Empower People about Health Issues

Three-fourths of all respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service. Governmental public health agencies at the state, regional and local levels, as well as non-governmental entities, played key roles as primary system members.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS actively creates, communicates, and delivers health information and health interventions using customer-centered and science-based strategies to protect and promote the health of diverse populations. The state's population understands and uses timely health information and interventions to protect and promote their health and the health of their families and communities.	**1-25% Minimal**	**1-25% Minimal**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources for local efforts to inform, educate and empower people about health issues.	**1-25% Minimal**	**1-25% Minimal**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its performance in informing, educating, and empowering people about health issues.	**1-25% Minimal**	**1-25% Minimal**
4. Public Health Capacity and Resources: The SPHS effectively invests, manages, and utilizes its human, information, organizational, and financial resources to inform, educate, and empower people about health issues.	**26-50% Low Partial**	**26-50% Low Partial**

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SPHA means State Public Health Agency

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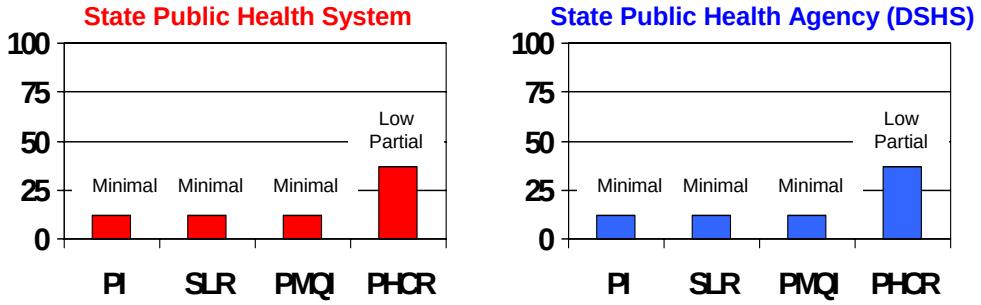
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #3:
Inform, Educate and Empower People About Health Issues

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

Performance Standards Assessment Results



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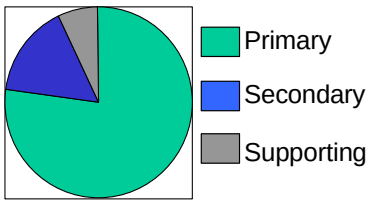
EPHS #3:
Inform, Educate and Empower People About Health Issues

System Member Roles



Assessment Group Participants

- Public health agencies (federal, state, regional, local)
- Other governmental agencies
- Non-governmental organizations (associations, universities, others)

Participant Comments

- "System is in place – everything is there – it is not coordinated"
- "Turf issues – cities and counties – no one talks to each other"
- "Key word is effective – plan in place but not effective"
- "Only recently has mental health been able to get into the whole system"
- "For amount of money they get – they're doing a good job"

EPHS #4: Mobilize Partnerships to Identify and Solve Problems

About one-half of respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service. Governmental public health agencies at the federal, state, regional and local levels played key roles as primary system members, while non-governmental entities identified both primary and secondary roles for their organizations.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS conducts a variety of statewide community-building practices to identify and to solve health problems. These practices include community engagement, constituency development, and partnership mobilization, which is the most formal and potentially far-reaching of these practices.	**51-75%** **High Partial**	**26-50%** **Low Partial**
2. State-Local Relationships: The SPHS engages in a robust partnership with local public health systems to provide technical assistance, capacity building and resources for local community partnership development.	**51-75%** **High Partial**	**26-50%** **Low Partial**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its partnerships to assure their effectiveness.	**1-25%** **Minimal**	**1-25%** **Minimal**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to assure that its mobilization of partnerships meets the needs of the state's population.	**26-50%** **Low Partial**	**26-50%** **Low Partial**

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*SPHS = How much of this model standard is achieved by the SPHS collectively?
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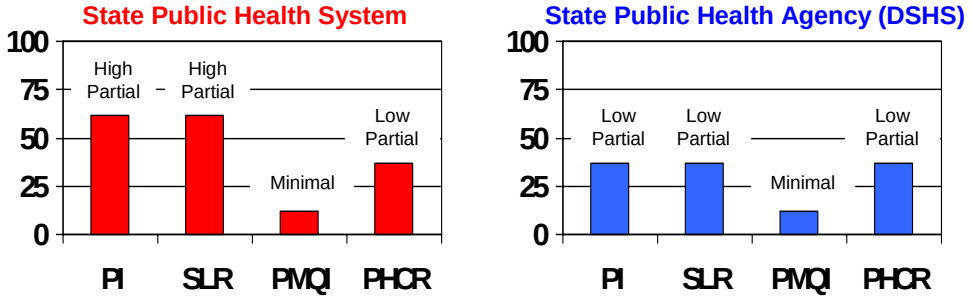
EPHS #4:
Mobilize Partnerships to Identify and Solve Health Problems

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

Performance Standards Assessment Results



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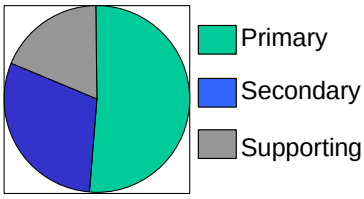
EPHS #4:
Mobilize Partnerships to Identify and Solve Health Problems

System Member Roles



Assessment Group Participants

- Public health agencies (federal, state, regional, local)
- Other governmental agencies
- Non-governmental organizations (associations, universities, others)

Participant Comments

- "Texas Strategic Health Partnership helps"
- "Some things are better at local level – some at state level"
- "Some statewide messages have to be addressed at the local level"
- "Lots of interagency coordination – based on grant requirements"
- "We don't have time, because we have to go from one legislative session to another"

EPHS #5: Develop Policies and Plans that Support Individual and Statewide Efforts

Thirty-six percent of respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service, while forty percent, including governmental public health agencies, claimed secondary roles. Non-governmental entities were about evenly divided among primary, secondary and supporting roles.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS conducts comprehensive and strategic health improvement planning and policy development that integrates health status information, public input and communication, analysis of policy options, and recommendations for action based on the best evidence. Planning and policy development are conducted for public health programs, for organizations and for the public health system, each with the purpose of improving public health performance and effectiveness.	**51-75% High Partial**	**51-75% High Partial**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources for their efforts to develop local policies and plans that support individual and statewide health efforts.	**26-50% Low Partial**	**26-50% Low Partial**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its policy and planning efforts to assure their effectiveness in supporting individual and statewide health efforts.	**26-50% Low Partial**	**26-50% Low Partial**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to assure that its health planning and policy practices meet the needs of the state's population.	**26-50% Low Partial**	**26-50% Low Partial**

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SPHA means State Public Health Agency

*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

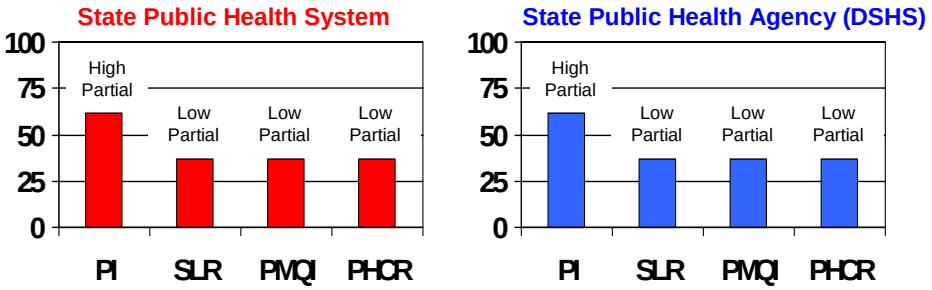
EPHS #5: Develop Policies and Plans that Support Individual and Statewide Health Efforts

• Systematic health planning that relies on appropriate data, develops and tracks measurable health objectives, and establishes strategies and actions to guide community health improvement at the state and local levels.

• 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.

Performance Standard Assessment Results



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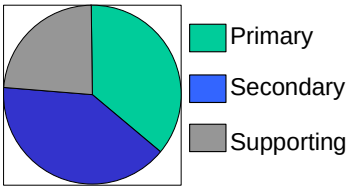
EPHS #5: Develop Policies and Plans that Support Individual and Statewide Health Efforts

System Member Roles



Assessment Group Participants

• Public health agencies (federal, state, regional, local)
• Other governmental agencies
• Non-governmental organizations (associations, universities, others)

Participant Comments

- "The input has broken down over the last few years because of advisory boards that have been eliminated"
- "There is great confusion, especially among the public, as to state agency versus local agency responsibilities"
- "Where there are local cuts in funding for services, the state is left trying to pick up the services"
- "The legislators come in with their own pet projects, regardless of the plan, due to their constituents pressing hot buttons"
- "The Governor and the Governor's staff are not always involved early enough with the stakeholders"

EPHS 6: Enforce Laws and Regulations That Protect Health and Ensure Safety

Most respondents in the system "mapping" exercise felt that their organizations played a supporting role in providing this essential service. Non-governmental entities were predominant in this role while governmental public health agencies identified primary and secondary roles for their organizations.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS assures that laws and enforcement activities are based on current public health science and best practices for achieving compliance. The SPHS emphasizes collaboration between those who enforce laws and those in the regulated environment and provides education to all those affected by public health laws.	**51-75% High Partial**	**51-75% High Partial**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources to local activities to enforce laws that protect health and safety.	**51-75% High Partial**	**26-50% Low Partial**
3. Performance Management and Quality Improvement: The SPHS manages its activities to enforce laws that protect health and safety to achieve effective performance and outcomes for the state's population.	**26-50% Low Partial**	**26-50% Low Partial**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, technology, organizational and financial resources to enforce laws that protect health and safety in the state.	**26-50% Low Partial**	**1-25% Minimal**

SPHS means State Public Health System
SPHA means State Public Health Agency

*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

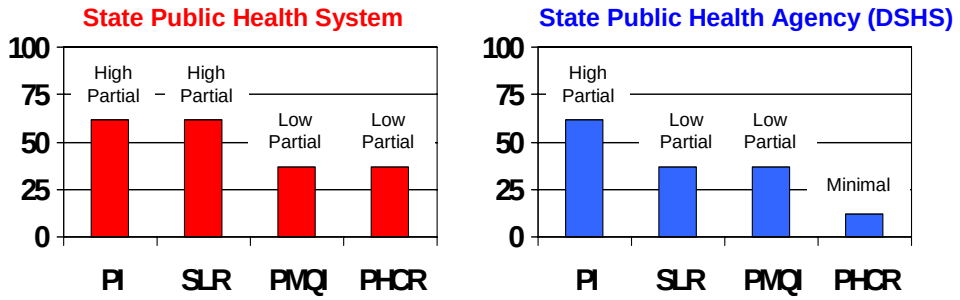
EPHS #6:
Enforce Laws and Regulations that Protect Health and Ensure Safety

• 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.

• The review, evaluation, and revision of laws (laws refer 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.

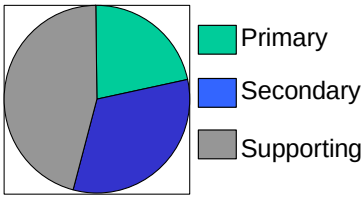
Performance Standards Assessment Results



PI = Planning & Implementation
PMQI = Performance Management & Quality Improvement
SLR = State-Local Relationships
PHCR = Public Health Capacity & Resources

EPHS #6:
Enforce Laws and Regulations that Protect Health and Ensure Safety

System Member Roles



Assessment Group Participants

• Public health agencies (federal, state, regional, local)
• Other governmental agencies
• Non-governmental organizations (associations, universities, others)

Participant Comments

- "DSHS has a procedure for receiving public comments on regulations – before document is written, after a draft is written and during a formal public comment period following publication in the Texas Register"
- "The state is working towards a one-stop shop approach for permitting…"
- "Because of Home Rule, the state cannot dictate laws"
- "One major problem is that fines/fees do not all go back to the program to fund enforcement activities – for example: money collected for specialized license plates that was supposed to go to promote vaccination of animals is not going to that program"
- "The state cannot pickup all the enforcement activities that the locals give up – even if this is what the law says"

EPHS #7: Link People to Needed Health Services and Assure the Provision of Care when Otherwise Unavailable

About forty percent of respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service. Governmental public health agencies at the state, regional and local levels played key roles as primary system members, while non-governmental entities identified both primary and supporting roles for their organizations.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS assesses the availability of personal health care services for the state's population and works collaboratively with state and local partners to assure that the entire state population has access to high quality personal health care.	**1-25% Minimal**	**51-75% High Partial**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources for local efforts to identify underserved populations and to develop innovative approaches for meeting their health care needs.	**51-75% High Partial**	**51-75% High Partial**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its performance in the provision of personal health care to the state's population, focusing on identifying barriers to health care access and gaps in the availability of personal health care, as well as its ability to assure the state's population receives appropriate and timely health care.	**1-25% Minimal**	**51-75% High Partial**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to assure the provision of personal health care to meet the needs of the state's population.	**26-50% Low Partial**	**51-75% High Partial**

SPHS means State Public Health System
SPHA means State Public Health Agency

*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #7: Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

• Assessment of access to and availability of quality personal health care services for the state's population.

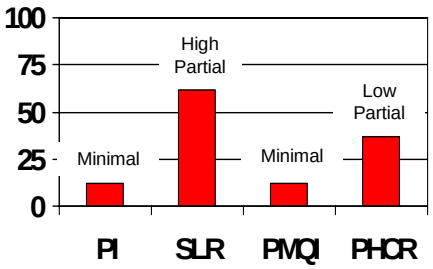
• Assurances that access is available in a coordinated system of quality care which includes outreach services to link populations to preventive and curative care, medical services, case management, enabling social and mental health services, culturally and linguistically appropriate services, and health care quality review programs.

• Partnership with public, private, and voluntary sectors to provide populations with a coordinated system of health care.

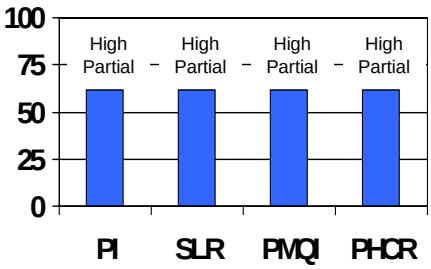
• Development of a continuous improvement process to assure the equitable distribution of resources for those in greatest need.

Performance Standards Assessment Results

State Public Health System



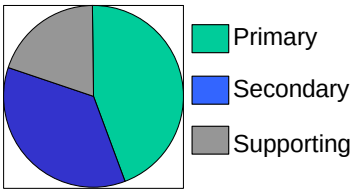
State Public Health Agency (DSHS)



PI = Planning & Implementation
PMQI = Performance Management & Quality Improvement
SLR = State-Local Relationships
PHCR = Public Health Capacity & Resources

EPHS #7: Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

System Member Roles



Assessment Group Participants

• Public health agencies (federal, state, regional, local)
• Other governmental agencies
• Non-governmental organizations (associations, universities, others)

Participant Comments

- "We need more consistent data points"
- "Heterogenous population in a large state is difficult"
- "Physical or mental disabilities are not assessed well"
- "Yes for natural disasters, but no on eliminating health disparities"
- "Need more resources (to provide technical assistance)"

EPHS #8: Assure a Competent Public and Personal Health Care Workforce

About one-half of respondents in the system "mapping" exercise felt that their organization played a primary role in providing this essential service. Governmental public health agencies at the federal, state, regional and local levels played key roles as primary and secondary system members, while non-governmental entities identified primary roles for their organizations.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS identifies the public health workforce needs of the state and implements recruitment and retention policies to fill those needs. The public health workforce is the array of personnel providing population-based and personal (clinical) health care services in public and private settings across the state, all working to improve the public's health through community prevention and clinical prevention services. The SPHS provides training and continuing education to assure that the workforce will effectively deliver the Essential Public Health Services.	**1-25% Minimal**	**1-25% Minimal**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources to local efforts to assure a competent population-based and personal health care workforce.	**1-25% Minimal**	**1-25% Minimal**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its activities to assure a competent population-based and personal care workforce to assure their effectiveness in delivering services within the SPHS.	**1-25% Minimal**	**1-25% Minimal**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to assure a competent population-based and personal health care workforce.	**1-25% Minimal**	**1-25% Minimal**

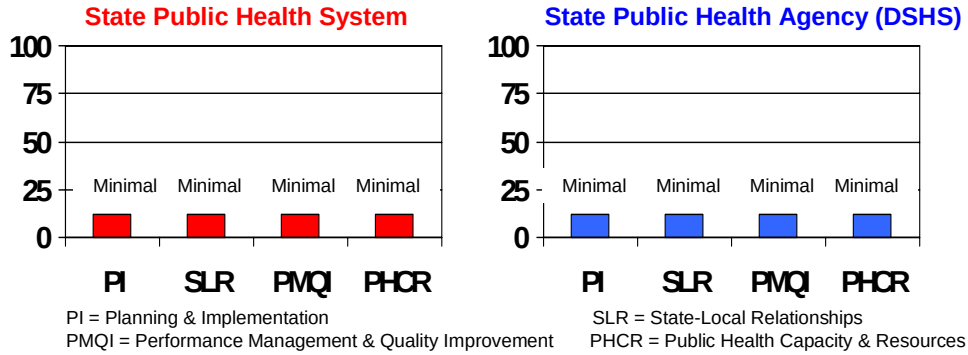
SPHS means State Public Health System
SPHA means State Public Health Agency

*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #8:
Assure a Competent Public and Personal Health Care Workforce

- Education, training, development, and assessment of health professionals—including partners, volunteers and other lay community health workers—to meet statewide needs for public and personal health services.
- 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.

Performance Standards Assessment Results



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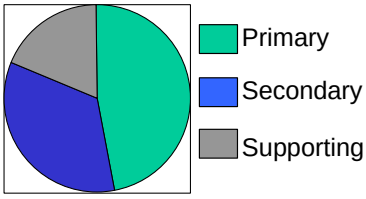
EPHS #8:
Assure a Competent Public and Personal Health Care Workforce

System Member Roles



Assessment Group Participants

- Public health agencies (federal, state, regional, local)
- Other governmental agencies
- Non-governmental organizations (associations, universities, others)

Participant Comments

- "Public health is most difficult workforce to assess"
- "Some leadership management training is available, but we don't do a good job utilizing it"
- "Harder to get people in continuing education due to budget cuts"
- "Hospitals do for an illness model – not wellness model"
- "Cannot get enough health care professionals in rural and underserved areas"

EPHS #9: Evaluate Effectiveness, Accessibility and Quality of Personal and Population-Based Health Services

Most respondents in the system "mapping" exercise felt that their organizations played a secondary role in providing this essential service. Both governmental public health agencies and non-governmental entities were about equally divided between primary and secondary roles.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS conducts evaluations to improve the effectiveness of population-based and personal health services within the state. Evaluation is considered a core activity of the public health system and essential to understand how to improve the quality of services to the state's population. Routine evaluations identify strengths and weaknesses in programs, services and the public health system overall and are actively used in quality and performance improvement.	**1-25% Minimal**	**1-25% Minimal**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources to local efforts to evaluate the performance and effectiveness of population-based programs, personal health care services, and local public health systems.	**26-50% Low Partial**	**1-25% Minimal**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its performance in evaluating the effectiveness, accessibility, and quality of population-based programs, personal health care services, and public health systems.	**1-25% Minimal**	**1-25% Minimal**
4. Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to evaluate the effectiveness, accessibility and quality of population-based and personal health care services. Evaluations are appropriately resourced so they can be routinely conducted.	**1-25% Minimal**	**1-25% Minimal**

SPHS means State Public Health System
SPHA means State Public Health Agency

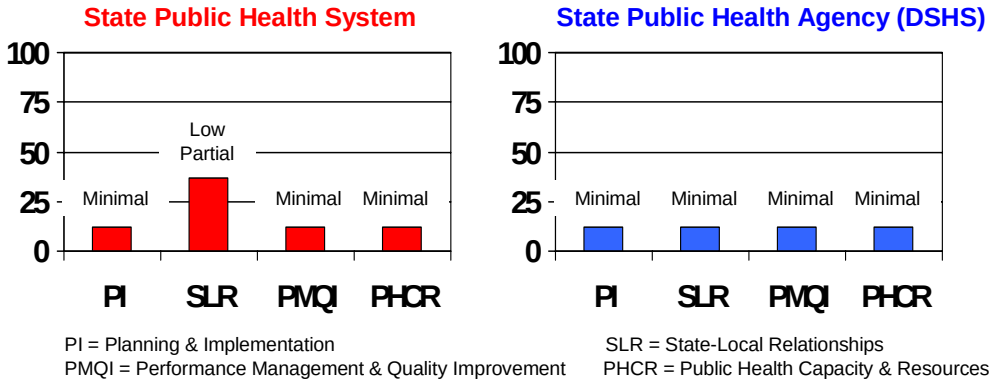
*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

• Evaluation and critical review of health programs, based on analyses of health status and service utilization data, 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.

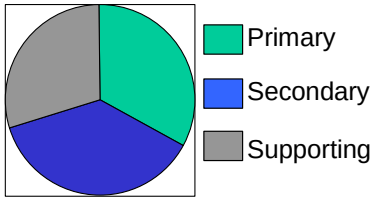
Performance Standards Assessment Results



PI = Planning & Implementation
PMQI = Performance Management & Quality Improvement
SLR = State-Local Relationships
PHCR = Public Health Capacity & Resources

EPHS #9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

System Member Roles



Assessment Group Participants

• Public health agencies (federal, state, regional, local)
• Other governmental agencies
• Non-governmental organizations (associations, universities, others)

Participant Comments

- "Not much evaluation of these things at state level – more based on funding source"
- "Process data not always good"
- "Some major evaluations take place for hospitals"
- "Substantial technical assistance to local health departments from DSHS"
- "Cannot do evaluation without resources"

EPHS #10: Research for New Insights and Innovative Solutions to Health Problems

Thirty-eight percent respondents in the system "mapping" exercise felt that their organizations played a primary role in providing this essential service. Non-governmental entities played key roles as primary system members while governmental public health agencies were about equally divided between primary and secondary roles.

The table below displays the four model standards for this EPHS and the ratings assigned to each standard by assessment conference participants.

Model Standard	***Assessment Results**	
	***SPHS**	***SPHA (DSHS)**
1. Planning and Implementation: The SPHS contributes to public health science by identifying and participating in research activities that address new insights in the implementation of the Essential Public Health Services. Member organizations of the SPHS foster innovation by continuously using best scientific knowledge and new knowledge about effective practice in their work to improve the health of the state's population.	**1-25% Minimal**	**1-25% Minimal**
2. State-Local Relationships: The SPHS partners with local public health systems and provides assistance, capacity building, and resources for local efforts to carry out research for new insights and innovative solutions to health problems.	**26-50% Low Partial**	**1-25% Minimal**
3. Performance Management and Quality Improvement: The SPHS reviews and continuously improves its performance in conducting and using research for new insights and innovative solutions to health problems.	**1-25% Minimal**	**1-25% Minimal**
4. Public Health Capacity and Resources: The SPHS effectively invests, manages, and utilized its human, information, organizational and financial resources for the conduct of research to meet the needs of the state's population.	**26-50% Low Partial**	**1-25% Minimal**

SPHS means State Public Health System
SPHA means State Public Health Agency

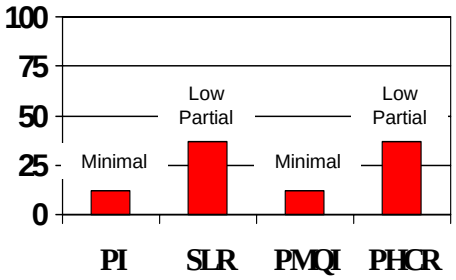
*SPHS = How much of this model standard is achieved by the SPHS collectively?
*SPHSA = How much of this model standard is achieved through the direct contribution of the SPHA (e.g., DSHS)?

EPHS #10:
Research for New Insights and Innovative Solutions to Health Problems

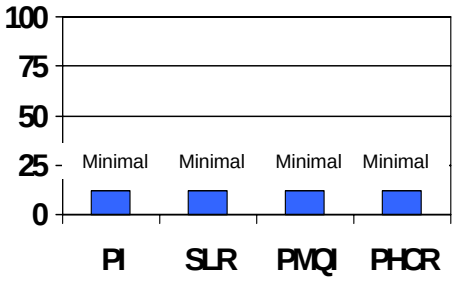
- A full continuum of research ranging from field-based efforts to foster improvements in public health practice to formal scientific research.
- Linkage with research institutions and other institutions of higher learning.
- Internal capacity to mount timely epidemiologic and economic analyses and conduct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

Performance Standard Assessment Results

State Public Health System



State Public Health Agency (DSHS)



PI = Planning & Implementation
PMQI = Performance Management & Quality Improvement
SLR = State-Local Relationships
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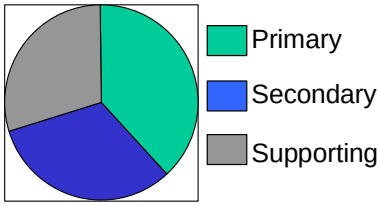
EPHS #10:
Research for New Insights and Innovative Solutions to Health Problems

System Member Roles



Assessment Group Participants

- Public health agencies (federal, state, regional, local)
- Other governmental agencies
- Non-governmental organizations (associations, universities, others)

Participant Comments

- "The Center for Health Statistics (DSHS) does quite a lot of work with data sharing"
- "There is good research in Texas but it is not based on a research agenda"
- "Quality of research is good, but it is not systemized"
- "Funding sources require that we review/report performance but not coordinate at higher level"
- "Could do more training"

Summary of SPHSA Results

SPHSA RESULTS	EPHS 1 **Monitor**	EPHS 2 **Diagnosis**	EPHS 3 **Educate**	EPHS 4 **Partnership**	EPHS 5 **Policy**	EPHS 6 **Enforce**	EPHS 7 **Link**	EPHS 8 **Workforce**	EPHS 9 **Evaluation**	EPHS 10 **Research**
A. Planning & Implementation										
Met by SPHS Collectively	**Low Partial**	**High Partial**	**Minimal**	**High Partial**	**High Partial**	**High Partial**	**Minimal**	**Minimal**	**Minimal**	**Minimal**
Met by SPHA (DSHS)	**High Partial**	**High Partial**	**Minimal**	**Low Partial**	**High Partial**	**High Partial**	**High Partial**	**Minimal**	**Minimal**	**Minimal**
B. State-Local Relationships										
Met by SPHS Collectively	**Minimal**	**Low Partial**	**Minimal**	**High Partial**	**Low Partial**	**High Partial**	**High Partial**	**Minimal**	**Low Partial**	**Low Partial**
Met by SPHA (DSHS)	**Low Partial**	**Optimal**	**Minimal**	**Low Partial**	**Low Partial**	**Low Partial**	**High Partial**	**Minimal**	**Minimal**	**Minimal**
C. Performance Management & Quality Control										
Met by SPHS Collectively	**Minimal**	**Minimal**	**Minimal**	**Minimal**	**Low Partial**	**Low Partial**	**Minimal**	**Minimal**	**Minimal**	**Minimal**
Met by SPHA (DSHS)	**Low Partial**	**High Partial**	**Minimal**	**Minimal**	**Low Partial**	**Low Partial**	**High Partial**	**Minimal**	**Minimal**	**Minimal**
D. Public Health Capacity & Resources										
Met by SPHS Collectively	**Low Partial**	**Low Partial**	**Low Partial**	**Low Partial**	**Low Partial**	**Low Partial**	**Low Partial**	**Minimal**	**Minimal**	**Low Partial**
Met by SPHA (DSHS)	**Low Partial**	**High Partial**	**Low Partial**	**Low Partial**	**Low Partial**	**Minimal**	**High Partial**	**Minimal**	**Minimal**	**Minimal**

CONFERENCE EVALUATION

Participants in the conference were asked to complete a formal two-page evaluation regarding the assessment process, the training and educational sessions and the overall organization of the conference. This evaluation provided useful information regarding the effectiveness of the conference in attaining the objectives. Fifty-seven percent of the participants completed the evaluation. Respondents generally agreed (>65%) that the plenary sessions gave them an understanding of the purpose of the conference, the NPHPS and the SPHS. Fifty-eight percent noted that they had a clear understanding of their organization's role in the public health system. Participants were asked five questions regarding the assessment process on the second day to ascertain whether they agreed that the format was understandable, the questions were clear, the discussion was high quality. Participants were also asked to determine if there was sufficient time for discussion and if the scoring and assessment questions were appropriate. Most respondents felt the format was understandable and the quality of the group discussion was high. They were less certain that the assessment questions were clear and the discussion time was sufficient. Sixty-one percent felt the scoring assessment questions and summary questions were appropriate.

The overall conference was rated as positive or very positive by 66 (92%) of the 72 respondents in: a) organization; b) facilitation and c) conference environment. Open-ended comments provided further detail about the effectiveness of the conference. Participants who offered comments revealed the following strengths of the conference: a) the participants and the diversity of the organizations and perspectives represented; b) the importance of the interaction of the participants and the group discussions; c) the opportunity to network with others from different agencies and d) the general organization of the conference. Limitations of the conference included: a) insufficient time for group discussions; b) lengthy plenary session; c) confusion and lack of clarity regarding the assessment instrument and d) lack of participation by groups and organizations, elected officials who influence the system.

While the conference objectives were met, two key themes emerged from the comments. First, the process identified system weaknesses that cannot be resolved all at once. Second, improvement in the system will require a process committed to identify a plan and priority areas with a timetable to accomplish the necessary actions.

More detailed information regarding the conference evaluation is in APPENDIX E.

DISCUSSION AND RECOMMENDATIONS

A limitation of the conference was that it was not well attended by elected officials, who are one of the major stakeholders in the SPHS. In addition, hospitals and employers were also not well represented at the conference. With these caveats, most participants felt that the conference provided an opportunity for exchanging information and expert opinion among important system partner organizations.

The conference also produced numerical estimates of collective system performance and the contribution of DSHS to that performance. The system's collective performance was judged to be less than optimal on most of the model standards contained in the assessment instrument. It is noteworthy that the assessment instrument used by participants was a field test version which has not yet been validated, and this may have affected the results. Furthermore, judgments about system performance ultimately reflect the qualitative and quantitative perceptions of those who participated in the assessment process. Verification of these perceptions was beyond the scope of this undertaking. When conference participants identified gaps in model standard performance it was unclear whether this should be attributed to the status of the system or to the participants' level of awareness about the system. Despite this ambiguity, performance gaps identified during the assessment conference provide a starting point for future efforts to improve system functioning.

In addition, the conference itself served as an important tool to improve the public health system by inviting a broad group of stakeholders together and have them reflect about their roles as system partners.

As this process moves beyond the system assessment phase into the system improvement planning phase, four recommendations can be advanced.

1. **Maintain Communication with System Partners Identified Through this Assessment**. If the diverse set of organizations involved in providing EPHS in Texas is to function as an integrated, collaborative system, they must see themselves as part of a community of common interest. The Texas Strategic Health Partnership is positioned to build and maintain that sense of identity. The SPHSA Conference was an initial step in the process. Assessment findings and "next steps" should be communicated as widely as possible to meeting participants and other interested stakeholders.

2. **Determine Priorities for System Improvement.** The assessment conference revealed many areas of less than optimal performance which might be addressed in an improvement plan. System partners should be reconvened promptly to participate in a priority-setting process. This process might identify a limited number of "high priority" essential services upon which to focus and result in an early round of action planning.

3. **Develop Strategies for Performance Improvement.** As part of this process, the system partners should set collaborative goals as well as individual organizational goals that are aligned with the overall system goals. It is essential that state agencies with responsibility for influencing the determinants of health are included in these planning efforts. The health of Texans is a collective responsibility, not just the responsibility of a single agency or organization. Performance assessment and improvement efforts should take place at all levels of the public health system: state, regional and local.

4. **Convene Partners around Priorities.** To coordinate how the system advances towards meeting "high-priority goals," partners should meet on a regular basis to report on progress.

APPENDIX A: ASSESSMENT QUESTIONS AND SCORES

Below are the assessment questions and the scores assigned to each question by participants of the SPHSA Conference.

EPHS 1: **Monitor Health Status to Identify Health Problems**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS operate surveillance system(s) designed to measure the health status of the state's population?	**Low Partial (26-50%)**
	1B. Does the SPHS publish health-related data into a state health profile describing the prevailing health of the state's population?	**Minimal (1-25%)**
	1C. Does the SPHS compile and provide health data in useable products to a variety of health data users?	**Low Partial (26-50%)**
	1D. Does the SPHS operate a data reporting system designed to identify potential threat to the public's health?	**Low Partial (26-50%)**
	1E. Does the SPHS enforce established laws and the use of protocols to protect personal health information and other data?	**High Partial (51-75%)**
	How much of the Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Indicator 2: State-Local Relations	2A. Does the SPHS offer technical assistance (e.g., training consultations) to local public health systems in the interpretation and use of health-related data?	**Minimal (1-25%)**
	2B. Does the SPHS regularly provide local public health systems a uniformed set of local health-related data?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review the effectiveness of its efforts to monitor health status?	**Minimal (1-25%)**
	3B. Does the SPHS manage the overall performance of its health status monitoring activities?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**

EPHS 1: **Monitor Health Status to Identify Health Problems** (Continued)		
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to health status monitoring efforts?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to monitor health status?	**Minimal (1-25%)**
	4C. Does the SPHS utilize workforce expertise to carry out health status monitoring activities?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Assessment Group Comments	*1A. "Vital statistics is our strength along with chronic and infectious disease…"*	
	1A. "On mental health, we need definitions…"	
	1B. "We are collecting a lot of data, but much of it goes undetected/unanalyzed…"	
	1D. "There are many ways to share information, but there is not necessarily a formal process that everyone is using…"	
	1D. "If the law requires it, then it is reported – a lot of threats are not reported…"	

EPHS 2: **Diagnose and Investigate Health Problems and Health Hazards**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS operate surveillance system(s) that identify and analyze health problems and threats to the health of the state's population?	**Optimal (76-100%)**
	1B. Does the SPHS have the capability to rapidly initiate enhanced surveillance when needed for a statewide regional health threat?	**High Partial (51-75%)**
	1C. Does the SPHS organize its private and public laboratories (within the state and outside of the state) into a well-functioning laboratory system?	**High Partial (51-75%)**
	1D. Does the SPHS have laboratories that have the capacity to analyze clinical and environmental specimens in the event of suspected exposure or disease outbreak?	**High Partial (51-75%)**
	1E. Does the SPHS implement plans to investigate and respond to identified public health threats?	**Low Partial (26-50%)**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide assistance to local public health systems in the interpretation of epidemiological findings?	**Low Partial (26-50%)**
	2B. Does the SPHS provide laboratory assistance to local public health systems?	**High Partial (51-75%)**
	2C. Does the SPHS provide local public health systems with information and guidance about public health problems and potential public health threats?	**Minimal (1-25%)**
	2D. Does the SPHS provide trained personnel on-site to assist local communities in the investigations of public health problems and threats?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	**Optimal (76-100%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS periodically review the effectiveness of the state surveillance and investigation system?	**Minimal (1-25%)**
	3B. Does the SPHS actively manage the overall performance of its activities to diagnose and investigate health problems and health hazards?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**

EPHS 2: **Diagnose and Investigate Health Problems and Health Hazards** (Continued)		**Score(s)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to support the diagnosis and investigation of health problems and hazards?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to diagnose and investigate health hazards and health problems?	**High Partial (51-75%)**
	4C. Does the SPHS utilize workforce expertise to identify and analyze public health threats and hazards?	**Low Partial (26-50%)**
	4D. Does the SPHS utilize expertise from multiple disciplines to form rapid response teams to investigate adverse public health events?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Assessment Group Comments	*1B. "DSHS has surge capacity – it has MOUs (Memorandum of Understandings) with more than twenty (20) labs…"*	
	1C. The public lab list is complete – private labs are not as well connected…	
	1C. "Common protocols are set, but operations can differ…"	
	2B. "Training is the weakest link…"	
	4B. "We need to do better on diagnosis and investigation function – particularly concerning maternal and child health and chronic disease…"	

EPHS 3: **Inform, Educate and Empower People About Health Issues**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS design and implement health education and promotion interventions?	**Minimal (1-25%)**
	1B. Does the SPHS design and implement effective health communications?	**Minimal (1-25%)**
	1C. Does the SPHS have an effective crisis and emergency communications plan?	**Low Partial (26-50%)**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems (e.g., through consultation, training and/or policy changes) to develop skills and strategies to conduct health communication and health education and promotion programs?	**Low Partial (26-50%)**
	2B. Does the SPHS assist local public health systems to effectively target health communication and health education and promotion strategies to populations at risk of poor health?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS periodically review the effectiveness of health communication, health education and promotion interventions?	**Minimal (1-25%)**
	3B. Does the SPHS actively manage the overall performance of its activities to inform, educate and empower people about health issues?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to support health communication and health education and promotion efforts?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate system-wide efforts to implement health communication and health education and promotion services?	**Low Partial (26-50%)**
	4C. Does the SPHS use a workforce skilled in delivering effective health communications and health education and promotion services?	**Minimal (1-25%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**

EPHS 3: **Inform, Educate and Empower People About Health Issues** (Continued)	
Assessment Group Comments	*1B. "System is in place – everything is there – it is not coordinated…"*
	1C. "Turf issues – cities and counties – no one talks to each other…"
	1C. "Key word is effective – plan in place but not effective…"
	1C. "Only recently has mental health been able to get into the whole system…"
	4A. "For amount of money they get – they're doing a good job…"

EPHS 4: **Mobilize Partnerships to Identify and Solve Health Problems**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS build statewide support for public health issues?	**High Partial (51-75%)**
	1B. Does the SPHS organize partnerships to identify and solve health problems?	**High Partial (51-75%**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide assistance (e.g., through consultations, training, etc.) to local public health systems to build partnerships for community health improvement?	**Low Partial (26-50%)**
	2B. Does the SPHS take action to facilitate the development of local partnerships?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review the participation and commitment of its partners?	**Minimal (1-25%)**
	3B. Does the SPHS evaluate its partnership development activities?	**Minimal (1-25%)**
	3C. Does the SPHS actively manage the overall performance of its partnership development activities?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to sustain partnerships?	**Low Partial (26-50%)**
	4B. Does the SPSH exercise organizational leadership to align and coordinate its efforts to mobilize partnerships?	**Low Partial (26-50%)**
	4C. Does the SPHS use a workforce skilled in partnership development?	**Minimal (1-25%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**

EPHS 4: **Mobilize Partnerships to Identify and Solve Health Problems** (Continued)	
Assessment Group Comments	*1A. "Texas Strategic Health Partnership helps…"*
	1A. "Some things are better at local level – some at state level…"
	1A. "Some statewide messages have to be addressed at the local level…"
	3A. "Lot of interagency coordination – based on grant requirements…"
	3C. "We don't have time because we have to go from one legislative issue to another…"

EPHS 5: **Develop Policies and Plans that Support Individual and Statewide Health Efforts**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS implement statewide health improvement processes that convene partners and facilitate collaboration among organizations contributing to the public's health?	**High Partial (51-75%)**
	1B. Does the SPHS develop a state health improvement plan to guide its collective efforts to improve health and the public health system?	**Low Partial (26-50%)**
	1C. Does the SPHS have in place an all-hazards preparedness plan guiding system that partners to protect the state's population in the event of an emergency?	**Optimal (76-100%)**
	1D. Does the SPHS conduct policy development activities?	**High Partial (51-75%)**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance and training to local public health systems for developing local plans?	**Low Partial (26-50%)**
	2B. Does the SPHS provide support and assistance for the development of community health improvement plans for addressing the statewide health improvement strategies?	**Low Partial (26-50%)**
	2C. Does the SPHS provide technical assistance in the development of local health all-hazards preparedness plans for responding to emergency situations?	**High Partial (51-75%)**
	2D. Does the SPHS provide technical assistance in local health policy development?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review progress towards accomplishing health improvements across the state?	**High Partial (51-75%)**
	3B. Does the SPHS review new and existing policies to determine the public health impacts of those policies on a predetermined, periodic basis?	**Low Partial (26-50%)**
	3C. Does the SPHS conduct formal exercises and drills of the procedures and protocols linked to its all-hazards preparedness plan?	**Optimal (76-100%)**
	3D. Does the SPHS actively manage the overall performance of its planning and policy development activities?	**Low Partial (26-50%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**

EPHS 5: **Develop Policies and Plans that Support Individual and Statewide Health Efforts** (Continued)		**Score(s)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to health planning and policy development efforts?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to implement health planning and policy development?	**Low Partial (26-50%)**
	4C. Does the SPHS utilize workforce expertise in planning?	**High Partial (51-75%)**
	4D. Does the SPHS use its workforce expertise in health policy?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Assessment Group Comments	*1A. "The input has broken down over the last few years because of advisory boards that have been eliminated…"*	
	1A. "There is great confusion, especially among the public, as to state agency versus local agency responsibilities…"	
	1A. "When there are local cuts in funding for services, the state is left trying to pick up the services…"	
	1B. "The legislators come in with their own pet projects, regardless of the plan, due to their constituents pressing hot buttons…"	
	1D. "The Governor and the Governor's Staff are not always involved early enough with the stakeholders…"	

EPHS 6: **Enforce Laws and Regulations that Protect Health and Ensure Safety**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS assure existing and proposed state laws are designed to protect the public's health and ensure safety?	**High Partial (51-75%)**
	1B. Does the SPHS assure that laws give state and local authorities the power and ability to prevent, detect, manage, and contain emergency health threats, balanced with the right to due process?	**Optimal (76-100%)**
	1C. Does the SPHS provide education to encourage compliance with laws that protect health and ensure safety?	**Low Partial (26-50%)**
	1D. Does the SPHS ensure that administrative processes are customer-centered (e.g., obtaining permits and licenses)?	**Low Partial (26-50%)**
	1E. Have collaborative relationships been developed between SPHS members and persons and entities in the regulated environment to support compliance activities?	**High Partial (51-75%)**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems in compliance and enforcement activities of laws that protect health and ensure safety?	**High Partial (51-75%)**
	2B. Does training of local public health system members on the enforcement of laws incorporate current scientific knowledge and best practices from compliance?	**High Partial (51-75%)**
	2C. Does the SPHS partner with local governing bodies in reviewing, improving and developing local laws?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review the effectiveness of its regulatory programs and activities?	**Low Partial (26-50%)**
	3B. Does the SPHS actively manage the overall performance of its regulatory programs and activities?	**Low Partial (26-50%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**Low Partial (26-50%)**

EPHS 6: **Enforce Laws and Regulations that Protect Health and Ensure Safety** (Continued)		**Score(s)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to the enforcement of laws that protect health and ensure safety?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate systemwide resources to implement enforcement activities?	**Minimal (1-25%)**
	4C. Does the SPHS use personnel with expertise in the enforcement of laws that protect health and ensure safety?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Assessment Group Comments	*1A. "DSHS has a procedure for receiving public comments on regulations – before document is written, after a draft is written and during a formal public comment period following publication in the Texas Register…"*	
	1D. "The state is working towards a one-stop shop approach for permitting…"	
	2C. "Because of Home Rule, the state cannot dictate laws…"	
	4A. "One major problem is that fines/fees do not all go back to the program to fund enforcement activities – for example: money collected for specialized license plates that was supposed to go to promote vaccination of animals is not going to that program…"	
	4C. "The state cannot pickup all the enforcement activities that the locals give up – even if this is what the law says…"	

EPHS 7: **Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS assess the availability of personal health care services to the state's population?	**Low Partial (26-50%)**
	1B. Through collaborations with local public health systems, does the SPHS take action to eliminate barriers to access personal health care?	**High Partial (51-75%)**
	1C. Does the SPHS have an entity responsible for monitoring and coordinating personal health care delivery within the state?	**No Activity (0%)**
	1D. Does the SPHS mobilize its assets, including local public health systems, to reduce health disparities in the state?	**Low Partial (26-50%)**
	How much of this Model Standard (Planning and Implementation) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Implementation) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems on methods to assess and meet the needs of underserved populations?	**High Partial (51-75%)**
	2B. Does the SPHS provide technical assistance to safety-net providers who deliver personal health care to underserved populations?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	**High Partial (51-75%)**
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review programs that assure the provision of personal health care services within the state?	**Minimal (1-25%)**
	3B. Does the SPHS monitor personal health care quality and institute change in programs designed to assure personal health care based on findings?	**Minimal (1-25%)**
	3C. Does the SPHS actively manage the overall performance of its activities to link people to needed personal health care services?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**

EPHS 7: **Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable** (Continued)		**Score(s)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to assure the provision of personal health care?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its system-wide resources to effectively provide needed personal health care?	**High Partial (51-75%)**
	4C. Does the SPHS use workforce skilled in carrying out the functions of linking people to needed personal health care?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**High Partial (51-75%)**
Assessment Group Comments	*1A. "We need more consistent data points…"*	
	1A. "Heterogenous population in a large state is difficult…"	
	1A. "Physical or mental disabilities are not assessed well…"	
	1D. "Yes for national disasters, but no on eliminating health disparities…"	
	2A. "Need more resources (to provide technical assistance)…"	

EPHS 8: **Assure a Competent Public and Personal Health Care Workforce**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS conduct assessments of its workforce needs to deliver effective population-based and personal health care services in the state?	**Minimal (1-25%)**
	1B. Does the SPHS develop a statewide workforce plan(s) to guide its activities in workforce development? (Note: the SPHS may have one or more workforce plans, but the plan(s) should address both population-based and personal health care workforce.	**Minimal (1-25%)**
	1C. Does the SPHS human resources development programs provide training to enhance needed workforce skills?	**High Partial (51-75%)**
	1D. Does the SPHS assure that individuals in the population-based and personal health care workforce achieve the highest level of professional practice?	**Minimal (1-25%)**
	1E. Does the SPHS support initiatives that encourage life-long learning?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 2: State-Local Relations	2A. Does the SPHS assist local public health systems in completing assessments of their population-based and personal health care workforces?	**Minimal (1-25%)**
	2B. Does the SPHS assist local public health systems with workforce development?	**Minimal (1-25%)**
	2C. Does the SPHS assure the availability of educational course work and training to enhance the skills of the workforce of local public health systems?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review its workforce development activities?	**Minimal (1-25%)**
	3B. Does the SPHS evaluate its pre-service and in-service education and training programs?	**Low Partial (26-50%)**
	3C. Does the SPHS stimulate quality improvement of the personal health care and public health workforce?	**High Partial (51-75%)**
	3D. Does the SPHS actively manage the overall performance of its workforce development activities?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**

EPHS 8: **Assure a Competent Public and Personal Health Care Workforce** (Continued)		**Score(s)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to workforce development efforts?	**Minimal (1-25%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its system-wide resources to effectively conduct workforce development activities?	**Minimal (1-25%)**
	4C. Does the SPHS utilize expertise in management of human resource development programs?	**Minimal (1-25%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Assessment Group Comments	*1A. "Public health is most difficult workforce to assess…"*	
	1C. "Some leadership management training is available, but we don't do a good job utilizing it…"	
	1E. "Harder to get people in continuing education due to budget cuts…"	
	4B. "Hospitals do for an illness model – not wellness model…"	
	4C. "Cannot get enough health care professionals in rural and underserved areas…"	

EPHS 9: **Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS routinely evaluate population-based health programs within the state?	**Minimal (1-25%)**
	1B. Does the SPHS evaluate the effectiveness of personal health services within the state?	**Low Partial (26-50%)**
	1C. Does the SPHS establish and/or use standards to assess the performance of the state public health system?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Implementation) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Implementation) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance (e.g., consultations, training) to local public health systems in their evaluations?	**Low Partial (26-50%)**
	2B. Does the SPHS share results of state-level performance evaluations with local public health systems for use in local planning processes?	**Low Partial (26-50%)**
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the state regularly monitor its evaluation activities?	**Minimal (1-25%)**
	3B. Does the SPHS evaluate its evaluation and quality improvement activities when weaknesses in program or service quality become apparent?	**Minimal (1-25%)**
	3C. Does the SPHS actively manage the overall performance of its evaluation activities?	**No Activity (0%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources for evaluation?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its system-wide resources to effectively conduct evaluation activities?	**Minimal (1-25%)**
	4C. Does the SPHS use workforce skilled in carrying out evaluation activities?	**Minimal (1-25%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**

EPHS 9: **Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services** (Continued)	
Assessment Group Comments	*1A. "Not much evaluation of these things at state level – more based on funding source…"*
	1B. "Process data not always good…"
	1B. "Some major evaluation take place for hospitals…"
	2A. "Substantial technical assistance to local health departments from DSHS…"
	4A. "Cannot do evaluation without resources…"

EPHS 10: **Research for New Insights and Innovative Solutions to Health Problems**		**Score(s)**
Indicator 1: Planning and Evaluation	1A. Does the SPHS maintain an active academic-practice collaboration to promote and organize research activities and disseminate and use research findings in practice?	**Low Partial (26-50%)**
	1B. Does the SPHS have a public health research agenda?	**Minimal (1-25%)**
	1C. Does the SPHS implement its public health research agenda by participating and conducting research?	**No Activity (0%)**
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems with research activities?	**Low Partial (26-50%)**
	2B. Does the SPHS assist local public health systems in their use of research findings?	**Low Partial (26-50%)**
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 3: Performance Management and Quality Improvement	3A. Does the state monitor its public health research activities?	**Minimal (1-25%)**
	3B. Does the SPHS actively manage the overall performance of its research activities?	**No Activity (0%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	**Minimal (1-25%)**
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to research relevant to health improvement?	**Low Partial (26-50%)**
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to conduct research activities?	**Low Partial (26-50%)**
	4C. Does the SPHS utilize its workforce expertise to conduct and participate in research activities?	**High Partial (51-75%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	**Low Partial (26-50%)**
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	**Minimal (1-25%)**

EPHS 10: **Research for New Insights and Innovative Solutions to Health Problems** (Continued)	
Assessment Group Comments	*1A. "The Center for Health Statistics (DSHS) does quite a lot of work with sharing data…"*
	1C. "There is good research in Texas, but it is not based on a research agenda…"
	3B. "Quality of research is good but it is not systemized…"
	3B. "Funding sources require that we review/report performance but not coordinate at higher level…"
	4C. "Could do more training…"

APPENDIX B: CONFERENCE AGENDA

Conference Agenda
State Public Health System Assessment Conference
The Commons Building, Pickle Research Campus (Austin, TX)

Monday, July 17th

1pm – 3pm	Presentations: Assessment Purpose & Process	
	1pm – 1:10pm	Dr. Virginia Kennedy & Klaus Madsen (Co-Chairs, SPHSA Steering Committee)
	1:10pm – 1:25pm	Dr. Eduardo Sanchez (Commissioner of DSHS)
	1:25pm – 1:55pm	Ursula Phoenix Weir (Centers for Disease Control & Prevention)
	1:55pm – 2:25pm	Laura Landrum (Association of State & Territorial Health Officials)
	2:25pm – 2:45pm	Q&A (Ursula Phoenix Weir & Laura Landrum)
3:15pm – 5pm	Mapping the State Public Health System (Dr. Virginia Kennedy)	

Tuesday, July 18th

8:30am – 10:30am	Assessment Groups:	Group A…**Monitoring** Health Status
		Group B…Health **Education**
		Group C…Developing **Policies**
		Group D…**Linking** to Health Services
		Group E…**Evaluating** Health Services
10:45am – 12pm	Presentations: Summary of Assessment Group Results (Mike Gilliam, Steering Committee)	
12:15pm – 2:15pm	Assessment Groups:	Group A…**Diagnosing** Health Problems
		Group B…Mobilizing **Partnerships**
		Group C…**Enforcing** Laws
		Group D…Assuring Competent **Workforce**
		Group E…**Researching** Solutions to Problems
2:30pm – 3:45pm	Presentations: Summary of Assessment Group Results (Mike Messinger, Steering Committee)	
3:45pm – 4pm	Conference Closing Comments …Dr. Virginia Kennedy & Klaus Madsen …Dr. Eduardo Sanchez	

APPENDIX C: CONFERENCE PARTICIPANTS

Conference Participants

Name	Organization	City
Aldape, Lillie	Health Service Region 11 - DSHS	Harlingen
Andarza, Elvia	Texas Department of Agriculture	Austin
Anthony Adams, Mark	BioSignia	Houston
Bailey, Norman	University of Houston – College of Optometry	Houston
Berndt, Debbie	Hogg Foundation for Mental Health	Austin
Blakely, Craig	School of Rural Public Health – Texas A&M	College Station
Blass, Casey	Director, Disease Prevention & Intervention Section - DSHS	Austin
Bordelon, Rod	Public Counsel, Office of Public Counsel – TDI	Austin
Bujanda, Miryam	Methodist Healthcare Ministries	San Antonio
Burlinson, John	Health Service Region 7 - DSHS	Temple
Carlson, Rita	Parish Nursing	Austin
Chelsey, Dorothy	Parish Nursing	Austin
Conditt, Becky	East Texas Area Health Education Center	Austin
Cook, Sylvia	Texas Health Care Information Collection - DSHS	Austin
Cooksley, Catherine	Health Science Research – MD Anderson Cancer Center	Houston
Creel, Liza	Texas Health Institute	Austin
Cruz, Maria	Health Service Region 11 - DSHS	Harlingen
Cruz, Theresa	Texas Office of Rural and Community Affairs	Austin
Curry, Nick	Deputy Commissioner, DSHS	Austin
Dammann, Roxanne	Center for Program Coordination - DSHS	Austin
Danko, Rick	Center for Policy and Innovation – DSHS	Austin
Danner, Pam	Director, West Texas Area Health Education Center	Lubbock
Davis, Dixie	Office of Border Health - DSHS	Austin
Delgado, Evelyn	Asst. Commissioner, Family & Community Health – DSHS	Austin
Dingley, Jackie	Texas Public Health Association	Austin
Dix, Melissa	Center for Program Coordination - DSHS	Austin
Escobedo, Luis	Regional Director, DSHS Health Service Region 9/10	El Paso
Evans, Alexandra	Human Nutrition Center - UTSPH	Houston
Feagin, Pat	Regional & Local Health Services - DSHS	Austin
Fields, Brent	American Heart Association	Austin
Fisher, Donald	Tarrant County Public Health Department	Fort Worth

Flores, Starr	Coastal Bend Health Education Center	Corpus Christi
Fonseca, Vince	State Epidemiologist – DSHS	Austin
Fritz, Randy	Chief Operating Officer - DSHS	Austin
Fussell, Mark	CDC Senior Management Official	Austin
Garcia, Juanita	Texas A&M Health Sciences Center	College Station
Gilliam, Mike	Center for Program Coordination - DSHS	Austin
Grant, Georgia	Longview Wellness Center	Longview
Green, Gordon	UT Southwestern Medical Center	Dallas
Griffin, Susan	Texas Medical Association	Austin
Groesbeck, Natalie	Texas Association of Local Health Officials	Cedar Park
Guajardo, Esmeralda	Cameron County Health and Human Services	Harlingen
Gunn, Cindy	Memorial Hermann Health Care System	Houston
Hall, Iva	Lamar University – School of Nursing	Beaumont
Hankins, Teresa	Office of Public Insurance Counsel	Austin
Harvey, Carolyn	Texas Cancer Council and East Texas Baptist University	Tyler
Herron, Rebecca	Center for Consumer and External Affairs – DSHS	Austin
Hudson, Esmeralda	Waco-McLennan Public Health Department	Waco
Johnston, Dawn	Center for Program Coordination - DSHS	Austin
Keir, Barbara	Texas Council on Cardiovascular Disease and Stroke	Austin
Kennedy, Virginia	Director, Texas Public Health Training Center - UTSPH	Houston
Kern, Diana	National Alliance for the Mentally Ill – Texas Chapter	Austin
Khan, Aelia	Office of Public Insurance Counsel	Austin
Lacefield-Lewis, Lauren	Mental Health & Substance Abuse Services – DSHS	Austin
Lakey, David	UT Health Science Center	Tyler
Landrum, Laura	Association of State and Territorial Health Officials	Chicago, IL
Lane, Lee	Director, Texas Association of Local Health Officials	Cedar Park
Lawson, Janet	Director, Regional & Local Health Services – DSHS	Austin
Lloyd, Linda	UT School of Public Health at Houston	Houston
Loe, Hardy	Texas Public Health Association	Houston
Long, Sandra	President, Texas Environmental Health Association	Plano
Love, Gayle	Texas Medical Association	Austin
Lurie, David	Director, Austin/Travis County Health and Human Services	Austin
Macha, Tina	Health Service Region 1 - DSHS	Lubbock
Madsen, Klaus	Texas Health Institute	Austin
McClure, Karen	Texas Association for Clinical Lab Science	Houston
McConnell, Heidi	Governor's Advisor, Office of the Governor	Austin
McCoy-Daniels, Kimberly	Director, Office of the Elimination of Health Disparities – DSHS	Austin

McGaha, Paul	Regional Director, DSHS Health Service Region 4/5	Tyler
McNab, Norma	Center for Health Statistics Unit – DSHS	Austin
Messinger, Mike	Center for Program Coordination - DSHS	Austin
Migala, Witold	City of Fort Worth	Fort Worth
Morgan, James	Director, Health Service Region 7 - DSHS	Temple
Munoz, Oscar	Presiding Officer, Texas Promotoro(a) Committee	Laredo
Neill, Susan	Director, Laboratory Services Section – DSHS	Austin
Nichols, Joan	Health Service Region 2/3 - DSHS	Arlington
O'Neill, Will	Governor's Division of Emergency Management - DPS	Austin
Pali, Terri	Executive Director, Texas Public Health Association	Austin
Payne, Vicky	Jasper-Newton County Public Health District	Jasper
Pendergrass, Peter	Regional Director, DSHS Health Service Region 1	Lubbock
Peranteau, Jane	St. Luke's Episcopal Health Charities	Houston
Peyson, Robin	Executive Director, National Alliance for the Mentally Ill - Texas	Austin
Pharr, Machelle	Chief Financial Officer, DSHS	Austin
Phoenix-Weir, Ursula	Centers for Disease Control and Prevention	Atlanta, GA
Pickens, Sue	Parkland Health & Hospital System	Dallas
Quill, Beth	UT School of Public Health	Houston
Quinn, Earlene	Health Service Region 2/3 - DSHS	Arlington
Ramos, Christina	Texas Association of Regional Councils	Austin
Rathbone, Marissa	Texas Education Agency	Austin
Rawlings, Sylvia	President, Texas Rural Health Association	Arlington
Reynolds, Kaye	Fort Bend County Health and Human Services	Richmond
Roberto Jaen, Carlos	UT Health Science Center at San Antonio	San Antonio
Rogers, Kasie	Office of Border Health - DSHS	Uvalde
Sanchez, Eduardo	Commissioner, DSHS	Austin
Sanders, Grace	Texas Department of Assistive and Rehabilitative Services	Austin
Scott, John	Center for Program Coordination - DSHS	Austin
Scott, Robin	Center for Program Coordination - DSHS	Austin
Smith, Jennifer	Texas Public Health Association	Austin
Soto, Mary	Center for Program Coordination - DSHS	Austin
Sowards, Dan	DSHS	Austin
Spears, Bill	UT School of Public Health at San Antonio	San Antonio
Speck, Nancy	President's New Freedom Commission on Mental Health	Nacogdoches
Spies, Don	Dallas County Health and Human Services	Dallas
Stabeno, Debra	Asst. Commissioner, Prevention & Preparedness – DSHS	Austin
Strawn, Joan	Center for Program Coordination - DSHS	Austin

Suarez, Lucina	Epidemiology & Surveillance Unit - DSHS	Austin
Sugarek, Julienne	Center for Program Coordination - DSHS	Austin
Talbert, Jeff	School of Public Health – UNTHSC at Fort Worth	Fort Worth
Trevino, Elizabeth	Texas Public Health Training Center – Univ. of North Texas HSC	Fort Worth
Trich, Michelle	Longview Wellness Center	Longview
Troisi, Cathy	Houston Department of Health and Human Services	Houston
Turney, Connie	Statewide Health Coordinating Council	Austin
V. Dorai	Center for Minority Health – M.D. Anderson Cancer Center	Houston
Valentine, Tom	Texas Health and Human Services Commission	Austin
Wanser, Dave	Deputy Commissioner, DSHS	Austin
Ward, Martha	Texas Health & Human Services Commission	Austin
Warner, Dave	Professor, LBJ School of Public Affairs	Austin
Waukechon, John	Internal Audit - DSHS	Austin
Webster, Amye	March of Dimes	Houston
Weizenbaum, Jon	Deputy Commissioner, TX Dept. of Disability and Aging Services	Austin
Willett, Gary	Health Service Region 2/3 - DSHS	Arlington
Williams, Josie	Rural and Community Health Institute – Texas A&M	College Station
Wilson, Barry	Deputy Director, Health Service Region 1 - DSHS	Lubbock
Wilson, Joanie	Jasper-Newton County Public Health District	Jasper
Wolverton, Marcia	City of Houston, Health and Human Services	Houston
Young, Mark	Longview Wellness Center	Longview
Zoretic, James	Regional Director, DSHS Health Service Region 2/3	Arlington

APPENDIX D: STEERING COMMITTEE

Steering Committee
State Public Health System Assessment Conference

Dr. Virginia Kennedy, Co-Chair (Texas Public Health Training Center)

Klaus Madsen, Co-Chair (Texas Health Institute)

Pat Feagin Czepiel (Regional & Local Health Services, DSHS)

Jackie Dingley (Texas Public Health Association)

Mike Gilliam (Center for Program Coordination, DSHS)

Lee Lane (Texas Association of Local Health Officials)

Dr. Janet Lawson (Regional & Local Health Services, DSHS)

Delia Mears (Texas Strategic Health Partnership)

Mike Messinger (Center for Program Coordination, DSHS)

Beth Quill (University of Texas School of Public Health)

Jennifer Smith (Texas Public Health Association)

Mary Soto (Center for Program Coordination, DSHS)

APPENDIX E: ASSESSMENT CONFERENCE EVALUATION

Assessment Conference Evaluation

Participants in the Texas SPHSA Conference, held July 17-18, 2006, in Austin, were asked to complete a two page evaluation regarding the assessment process, the training and educational sessions and the overall organization of the conference. Seventy-two participants completed the questionnaire.

Summary of Evaluation Questionnaires from the Participants

Of the 72 responding participants, 66 attended the plenary sessions on the first afternoon, and 63 (92%) attended the system "mapping" exercise (88%).

The responding participants attended the following assessment sessions, in the capacity shown:

Assessment Group	Morning Session	Afternoon Session
A	10 Invited Participants 4 Observer Participants	7 Invited Participants 3 Observer Participants
B	10 Invited Participants 4 Observer Participants	9 Invited Participants 1 Observer Participants
C	14 Invited Participants 4 Observer Participants	11 Invited Participants 3 Observer Participants
D	7 Invited Participants 2 Observer Participants	6 Invited Participants 1 Observer Participants
E	9 Invited Participants 2 Observer Participants	8 Invited Participants 3 Observer Participants

Only 19 of the responding participants identified themselves on the evaluation questionnaire.

Effectiveness of the Plenary Sessions:

The first questions asked for the effectiveness of the plenary sessions and "mapping" exercise in preparing the participants to take part in the assessment process.

In general, the responding participants answered that they agreed that the sessions gave them an understanding of the purpose of the conference, the state public health system, the assessment process and the role of their particular organization.

No more than 6 responding participants answered that they did not agree that any particular component of the orientation process benefited their preparation.

The following responses were given:

Question	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Did not Attend
As a result of the plenary presentations, I have a clear understanding of:						
…The purpose of this conference	25 (35%)	29 (41%)	7 (10%)	5 (7%)	0 (0%)	5 (7%)
…The National Public Health Performance Standards	24 (33%)	30 (42%)	11 (15%)	1 (1%)	1 (1%)	5 (7%)
…The State Public Health System Assessment	18 (25%)	30 (42%)	16 (22%)	3 (4%)	0 (0%)	5 (7%)
…My organization's role in the Texas SPHS	15 (22%)	25 (36%)	16 (23%)	5 (7%)	1 (1%)	7 (10%)

Evaluation of the Assessment Process:

The participants were asked to rate the assessment process as to whether they agreed that the format of the assessment was understandable, whether they agreed that the questions were clear, whether they agreed that there was a high quality of discussion, whether they agreed that the time for discussion was sufficient, and whether the system used to score the questions was appropriate.

The responding participants agreed that the format of the assessment was understandable. While 56 of the responding participants agreed or were neutral as to whether the questions were clear, there were 16 who disagreed. Only 3 of the responding participants disagreed that the quality of discussion in the groups was high. Most responding participants (48) agreed that the discussion time was sufficient or were neutral, however 24 disagreed. Only 10 responding participants disagreed that the scoring system was appropriate. There are several comments in the open-ended questions that explain some of the participants' reactions to the assessment process and will clarify these scores.

The following responses were received:

Question	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
The assessment format was understandable	16 (22%)	39 (54%)	15 (21%)	2 (3%)	0 (0%)
The assessment questions were clear	4 (6%)	25 (35%)	27 (38%)	13 (18%)	3 (4%)
The quality of group discussion was high	32 (44%)	27 (38%)	10 (14%)	3 (4%)	0 (0%)
Group discussion time was sufficient	15 (21%)	18 (25%)	15 (21%)	16 (22%)	8 (11%)
The system for scoring assessment questions and summary questions was appropriate	13 (18%)	31 (43%)	18 (25%)	8 (11%)	2 (3%)

Overall Conference Assessment

The participants were asked how they felt about the overall organization of the conference, the overall facilitation of the conference and the overall venue, refreshments and logistics. Sixty-six of the 72 responding participants felt positive or very positive about the conference overall. Only 1 participant felt negative about the overall facilitation.

The following responses were received:

Please rate the conference overall in terms of:	Very Positive	Positive	Undecided	Negative	Very Negative
…Organization	34 (48%)	32 (45%)	5 (7%)	0 (0%)	0 (0%)
…Facilitation	42 (60%)	24 (34%)	3 (4%)	1 (1%)	0 (0%)
…Venue, refreshments, logistics	36 (51%)	30 (43%)	4 (6%)	0 (0%)	0 (0%)

Participant Comments

Participants were invited to give comments in response to four questions, and to a final open-ended additional comments question. A complete list of the comments received is provided in the Appendix.

What did you like most about the conference? - Sixty participants responded to this question. The positive comments were most often about the following aspects of the conference:

- The variety of the participants
- The group discussions – interactions of all partners
- The opportunity to work with / network with people from many different agencies / perspectives
- The organization and keeping to the schedule of the conference.

What did you like least about the conference? – Forty-five participants responded with comments, including:

- Too short a time for the group discussions
- Too long for plenary sessions, and content repetitive
- Too lengthy reporting sessions, ad being forced to all make a comment
- Flaws in the assessment too, including

    - Confusion between individual vs population health issues
    - Ambiguous questions
    - Unclear questions
    - Too many variable in each question
- Missing groups, such as: more hospital representatives, and political leadership

What new information did you find most helpful? – Thirty-seven participants provided input, including:

- Sharing of information and best practices
- The focus on, and understanding of the system, not just DSHS
- That many components have the same problems and issues and have the same views of the system
- Clearer definition of essential services
- Hearing local perspectives

How could the conference have been improved? – Thirty-five participants offered suggestions such as the following:

- Allowing more time for discussion
- Including more participants, particularly
    - The affected communities
    - Private entities
    - Industry
    - Physician groups
    - Criminal justice system
    - Child protective services
- Receiving material to review ahead of time or in handouts in the breakout sessions
- Needing data to back up discussions

Additional Comments from 22 participants included:

- Compliments about the conference organization
- Encouragement to get the results out and moving forward to improve the system
- The need to include more focus on prevention and control, mental and behavioral health

Additional Comments

What did you like most about the conference?	
1.	Hearing input from long-time involved persons
2.	Well organized; good staff support
3.	The assessment group exercise - but, time was too short for the material being covered
4.	The coordination and commitment of participants
5.	Openness and honesty of participants
6.	Networking
7.	Very orderly and concise
8.	Revisiting and revitalizing the National Public Health Standards system in Texas after about a five year sabbatical. We need to proceed with development of the standards in TX. Also, having 70 plus agencies here a plus
9.	The plenary sessions were very informative. I particularly liked the diversity of the participants - from all perspectives
10.	Variety of view points
11.	Ability to meet a lot of different people who are all interested in Public Health
12.	Working with partners from other areas and/or agencies
13.	Networking. Mix of people. Landrum presented a good overview
14.	Discussion in the breakout sessions
15.	Kept to the schedule and finished the activity
16.	Input from different people
17.	Learning about what other entities do
18.	Group discussions

19.	Group discussions
20.	Having a voice
21.	Good discussion of participants
22.	The collaboration of the different entities
23.	Many different organizations came together for the process of sharing information in hopes of moving in the direction of improving the overall Public Health System in Texas
24.	Collaborations of various entities participating
25.	All the different partners brought together
26.	Assessment groups
27.	Sharing variety of input. Excellent mix of entities and agencies
28.	Excellent organization - great monitors (facilitators)
29.	The open format - i.e. allowing participation by all
30.	Open discussions in assessment groups
31.	Second day
32.	Variety of participants
33.	Learning the public health environment
34.	The voting process / mapping the health system, small groups
35.	Breakout groups and discussion
36.	The variety of groups invited to participate
37.	Broad audience
38.	Big group introductions of each participant. Group facilitators led a well organized discussion
39.	Diversity of participants

40.	Pulling people together and networking
41.	Group activities
42.	Great discussion within small groups; excellent representation!! Great job recruiting participants
43.	This was a true working conference in which I walked in with an understanding of NPHPS, yet confused on the tool. This conference allowed me to understand how it works - along with the presence of the many entities involved
44.	Always enjoy meeting with colleagues and talking and learning about the public health system
45.	Interactive participation
46.	Discussions about important public health issues with key state leaders and many learned members of our overall public health community
47.	Commissioner Sanchez. Breakout assessment groups - responses from participants was interesting
48.	The people / attendees and chance for discussion
49.	Diverse participant base. Logistics well done!
50.	Breakouts - discussions
51.	Appreciate systems approach to public health
52.	Well organized, on-schedule, clear expectations
53.	Chance to take the 30,000 foot view and think about our SPHS - and hear detail on a "Gold Standard" for which we can strive
54.	Representation from such a wide range of organizations
55.	Interaction of partners
56.	Group discussion was great - allowed for very positive interactions - information exchange; facilitators, recorders were excellent, terrific job, very effective
57.	Group work
58.	Diversity and quality of discussion
59.	Well organized

60.	Group discussions were excellent

What did you like least about the conference?

1.	Truncated meaningful conversation - what was the point - how will collected data be used and when and to what effect?
2.	The format for the reports back to the whole group was tedious - I think that's why so many people left
3.	Mix of public health individual vs population on the tool
4.	The exercise was too complicated because the questions were too broad - - Planning and Implementation are two entirely different things; trying to combine in one question is inappropriate We tried to do too much in too short a time frame Too many sub-parts to the assessment questions, complicating understanding and comprehensive answers
5.	Short time period
6.	I wasn't able to attend the first day
7.	Too much to get back to at the office
8.	Not enough time for discussions
9.	There was a little confusion at the beginning of our break out session, but we got on a roll after a while
10.	Assessments really did not allow enough time to fully discuss complex multi-faceted questions
11.	Cold room
12.	Not enough time for discussions
13.	Not long enough!! Could have used more time for discussion
14.	We needed more time for reviewing and discussing
15.	N/A
16.	0
17.	The "tool" had inherent flaws
18.	The first day needed less plenary topics

19.	To accomplish the overall task, could have had more time
20.	Time constraints / scoring somewhat limited
21.	The tool has ambiguous questions
22.	Seating
23.	The questions, reference to a State Public Health System, were very unclear. Session was dominated by one or two participants
24.	Too much time spent on first day/plenary sessions going over logistics of assessment
25.	1st day plenary sessions a little generic in nature - might have been better to focus more on the standards
26.	There was not enough time for the groups to comprehensively evaluate the system
27.	Not enough time for breakout groups to adequately discuss issues
28.	Lack of any objective data to make decisions on. This was little more than an opinion poll, and in several incidents opinions by strong willed individuals with little background
29.	Looking forward to the results and how to use the results
30.	Too warm
31.	N/A
32.	Would like to have seen more hospital representatives
33.	The overheads used could have been in larger font, it was difficult to read. The vagueness of the terms and questions of the tool. Introductions; specifically the ___ comments made. Time consuming
34.	Needed some pre-session planning; really would like handouts and better ____ in breakout room; would have liked to have had the information to read in my hand.
35.	Plenary session - CDC & ASTHO - presentations too long Both were good speakers but VERY DRY SUBJECT!
36.	Limited time for discussion; questions constrained us
37.	Political leadership not present (legislative staff?). Some of the assessment formats need work. A bit rushed on the break out sessions

38.	A great deal of the plenary sessions were repetitious and things I already knew by heart (i.e. essential public health services)
39.	The presentations by Ms Weir and Ms Landrum did not add value to the meeting
40.	Lack of printed back-up material (definitions, questions and details) Facilitator dominated discussion. Somewhat poor A/V - hard to see
41.	Nothing really (CDC presentations on 7/17 a little bit repetitive).
42.	Questions often included too many variables in one question
43.	Being forced to make a comment about the proceedings after the first assessment group report
44.	N/A
45.	Passing the microphone at the end of the first morning

What new information did you find particularly helpful?

1.	Discussion amongst participants
2.	The fact that using the 10 essentials, Texas seems far behind the curve -- lots of challenge, but also lots of opportunity for improvement
3.	The training session
4.	That public health professionals from all parts of the "system" have a similar view of the "system", but they do understand the constraints under which that system operates
5.	Best practices and sharing info
6.	An emphasis on the state public health system, not just DSHS, was important
7.	Clarification of need and benefits for assessing public health system on national and state level
8.	Dr. Sanchez is leaving - not good!
9.	That all areas/agencies have the same problems that we have
10.	What different organizations do
11.	N/A
12.	Networks. Public health department financial challenges
13.	Clearer definitions of essential services
14.	What other entities do
15.	The level of performance of the SPHS
16.	Hearing information from the other organizations
17.	Information on the different activities the different organizations perform - the breakout group process provided a lot of this information
18.	Other participants have same concerns as I do

19.	The broader definition of public health. The delineation of TX DSHS
20.	Collaboration of different entities into a SPHS
21.	Information provided by individuals based on that session's area of work were most helpful
22.	Local perspectives. Hospital perspectives
23.	The number of partners, and the varying points of view
24.	Group dynamics
25.	A better understanding of the "State Public Health System"
26.	That people are starting to recognize who all the partners in the public health system are - this is encouraging
27.	The involvement in the process to understand the tool
28.	Simply the fact that DSHS is seeking to assess (self) and presumably move constructively to improve the state's public health infrastructure
29.	A perspective on DSHS and how they see themselves
30.	Standards primer was very helpful
31.	Although presented as new, the system presented is the same system utilized in business beginning in the 60's, 70's and in medicine in the 80's. The approach is not new. But it is a useful approach to public health.
32.	More people shared my opinions than I expected
33.	Fact that an effort like this (+ accreditation proposal) is going on nationwide.
34.	The diversity of the state public health system. The current functionality/capacity of the state system
35.	Comprehensive approach to a better understanding "State Health System"
36.	Understanding public health system assessment concept / CDC presentation
37.	Let's move to a state health improvement!

How could the conference have been improved?	
1.	Hearing more from impacted community reps. Hearing what is working and how to replicate
2.	I understand that this assessment is a snapshot but I'm not sure the product will be very worthwhile
3.	Would like to see involvement of criminal justice and child protective services, They do a lot of public health (as it is more broadly defined)
4.	I think all improvement is incremental. Given the low scores, it is obvious that we should focus on some narrower issues, rather than trying to solve all the state's problems at once.
5.	More participants
6.	A better definition in the plenary about what the statewide public health system "looks like" in Texas
7.	I am wondering if follow up regional meetings with participants might be in order
8.	2 full days
9.	More time for the group meetings for discussion and collaboration of group participants
10.	It would have been helpful to receive a packet with the information on what we would be voting on ahead of time
11.	Providing all measures in advance and some info on how TDSHS sees its ruling in each area
12.	Maybe full day first - I think some that didn't come back would have seen great value in the 2nd day activities and didn't come back because they didn't know what was coming
13.	Did not have enough of the "private" health services, i.e. hospitals, nursing homes, home health agencies represented. Too many TX DSHS employees devaluing their work
14.	Providing or displaying the "egg" module of the SPHS
15.	Encourage participants who have dominated a sessions to allow others to share their perspectives
16.	More time for Q&A
17.	Have more stakeholders - missing industry, TDI, physician groups

18.	More variety and participants was good - should be expanded
19.	At least half a day longer for more discussion
20.	Bring data. Lack of data made this an opinion poll
21.	N/A
22.	You did a great job of organizing this!
23.	Perhaps given a copy of the tool so that we can write on and take notes
24.	Hand out some info in advance - hand out homework. I may have been better prepared especially in regard with priorities and responses
25.	Really need to get a better look at many of the relevant activities in place that we were asked to assess
26.	Shorter big group sessions, longer time in small groups
27.	A bit more time
28.	More time for discussion. Refinements of questions to discuss
29.	Probably needed more time devoted to assessment groups. Introductory session more focused on specific procedures that were to follow.
30.	?
31.	1) Use better (perhaps numerical / discreet) ranking system (1% is vastly different than 25% and 76% is vastly different than 100%). Everyone can pick a specific numerical rating and then final rating is based on simple average of responses 2) Pick competent raters
32.	A little less time on the introductory side - but overall this conference was well organized and flowed well.
33.	1) Scoring 0-25%: range too big, suggest 0-5%, 6-25%, 26-50%, 51-75%, *75% in the Capacity and resources section: 2) Separate workforce skill from quantity of skilled workers 3)Separate effective use of resources from amount of resources
34.	Done well
35.	Don't lose the momentum

Additional Comments	
1.	Like to see more rep for people of color
2.	I thought that the assessment instrument really had problems
3.	I hope that this is not the only session - I hope this has a follow-up session - and continues on an annual basis
4.	Thanks!
5.	Continue!
6.	Several of the assessment questions had two questions within the one stated. Not enough time for the discussions
7.	Hope that all participants will receive copies of any data / reports developed as a result of this conference and that we will be included in any follow-up conferences
8.	Would have been helpful to have a handout on standards to better respond to questions
9.	For Essential Service #8 Questions - Need to separate personal and population-based health workers
10.	It's exciting to learn that the Texas Public Health Department wants to or is ready to make improvements to improve the health of Texans
11.	Facilitators were excellent. Special thanks to Earline Quinn
12.	I think the tool needs to be simplified and questions more succinct and clear
13.	Please use the outcome to make real changes in the system
14.	Excellent job! Anxious to see overall evaluations
15.	Great first step in improving public health in Texas
16.	Looking forward to seeing the results in a few months
17.	Always enjoy the networking Perhaps can come up with some publishable documents that can help inform the political process
18.	Be nice to have some key legislative aides sitting in on this process

19.	I think the assessment tool need to be slightly revamped to put more emphasis on prevention and control as well as mental and behavioral health, substance abuse
20.	Very informative and useful conference - really felt like opinion valued - hope all this work results in visible outcomes
21.	The understanding of the assessment format and the clarity of the questions improved with time
22.	Confusion about starting time on Monday