

# 2012 West Virginia State Public Health System Assessment

*Shaping safe and healthy communities*



# **West Virginia State Public Health System Assessment**

Coordinated by the West Virginia Bureau for Public Health's  
Center for Performance Management

Draft report prepared for the West Virginia Bureau for Public Health

by

Purdue University  
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This assessment is supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support, under #5U58CD001315-03. The content of this document are those of the authors and do not necessarily represent the official position of or endorsement by the Centers for Disease Control and Prevention.

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## EXECUTIVE SUMMARY

In 2012, the West Virginia Bureau for Public Health conducted a State Public Health System Assessment, a Public Health System Partner Survey, and created a State Health Profile. Together, these documents will be used to identify priorities and drive our State Public Health Improvement Plan. This report focuses specifically on the State Public Health System Assessment. The assessment served as one of a variety of opportunities the West Virginia Bureau for Public Health employs to better understand various aspects of the existing public health system in West Virginia.

Planning for the West Virginia State Public Health System Assessment was guided by an Advisory Group comprised of 12 public health system partners and the West Virginia Bureau for Public Health (BPH) leadership and staff. The Advisory Group consisted of individuals from diverse backgrounds, including the Charleston Area Medical Center, Mid-Ohio Valley Health Department, West Virginia Children's Health Insurance Program, West Virginia Healthcare Authority, West Virginia Medical Institute, the West Virginia School of Public Health and BPH leadership and staff, including the Deputy State Health Officer. The Advisory Group provided input on site selection, scheduling, and general assessment planning for the assessment that was consistent with BPH objectives.

Participation in the assessment process was offered to over 275 West Virginia state public health system partners and 40 BPH staff using a variety of methods. Partners invited were inclusive of, but not limited to, Department of Health & Human Resources staff, state and local health department staff, healthcare providers, elected officials, hospital and community health clinic partners, school nurses, emergency management directors, non-profit organizations, social service agencies, academic partners, law enforcement, public health and public safety officials. A series of ten half-day meetings (one for each essential public health service) were held from November 27, 2012 through December 6, 2012, to convene partners to complete the assessment using the CDC, National Public Health System Assessment, v2.0 assessment tool.

The purpose of the West Virginia State Public Health System Assessment process was to evaluate state performance on the delivery of the ten essential public health services for the state overall. This included discussion around how data was collected and used, surveillance, informing and educating the public on health issues, partnerships and planning to improve health, enforcement and regulation of public health policy, workforce development, evaluation and research. For each of these topic areas, a SWOP analysis (strengths, weaknesses, opportunities for immediate improvement, and priorities for long term investments) was completed to identify what was being accomplished well, what is needed to deliver essential public health services and where improvements could be made for the future. A primary outcome of the assessment process was to explore and measure the capability and capacity of the West Virginia State Public Health System to respond in an effective and efficient manner to promote and protect the public's health in the state.

During the ten half-day assessment meetings, a total of 196 partners and BPH staff attended. Partners represented 20 of West Virginia's 55 counties, with populations ranging in size from 14,810 to 97,435. At the beginning of each of the ten sessions, a brief plenary session was provided, with welcome and opening remarks by BPH leadership. An additional presentation was provided by Purdue Healthcare Advisors to review and describe the public health system and orient participants to the assessment process.

Following the brief plenary session, each half-day assessment focused on one of the ten essential public health services.

Complete findings of the assessment of West Virginia's state public health system assessment are summarized in this report. The report contains scores for each question, for each of the ten essential services and for each model standard. Scores can be categorized by the level of activity they represent, from 0% (No Activity) to 100% (Optimal Activity), signifying where performance improvement may be indicated.

Results of West Virginia's state-wide public health system performance, by Essential Service and using a scale of 0% to 100% were:

- 1) Monitoring Health Status to Identify and Solve Community Health Problems (32.1%)
- 2) Diagnosing and Investigating Health Problems and Health Hazards in the Community (69%)
- 3) Informing, Educating and Empowering People About Health Issues (51%)
- 4) Mobilizing Community Partnerships and Action to Identify and Solve Health Problems (35.4%)
- 5) Developing Policies and Plans that Support Individual and Community Health Efforts (45.4%)
- 6) Enforcement of Laws and Regulations that Protect Health and Ensure Safety (46.4%)
- 7) Linking People to Needed Personal Health Services and Assuring the Provision of Health Care When Otherwise Unavailable (42.8%)
- 8) Assuring a Competent Public and Personal Health Care Workforce (29.2%)
- 9) Evaluating the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Service (37.5%)
- 10) Research for New Insights and Innovative Solutions to Health Problems (21.9%)

The overall State Public Health System Assessment process was a series of meetings with broad-based partnership attendance. Public health system partners contributed to the overall success of the assessment with their input, expertise and recommendations. The quantitative and qualitative data derived from the assessment report reflects the dialogue and input among participating partners and the West Virginia Bureau for Public Health. This data will be used to further inform the development of the West Virginia

State Public Health Improvement Plan. Results may also be used by state public health system partners across the state to protect and improve the public's health in West Virginia.

## **PROCESS OVERVIEW**

Purdue Healthcare Advisors (PHA) was awarded a grant by the West Virginia Bureau for Public Health (BPH) to conduct a statewide public health system assessment for purposes of evaluating overall public health system performance in the state. The stated goal of the assessment was to assist the BPH in developing primary data to inform the development of the West Virginia State Public Health Improvement Plan.

Purdue Healthcare Advisors agreed to complete the following project tasks:

- a) Complete the state public health system assessment using the National Public Health Performance Standards, State Public Health System Assessment, Pilot Version 2.0 to examine public health practice, system performance, and infrastructure capability for the BPH within the framework of the ten essential services of public health
- b) Prepare a written State Public Health System Assessment Report reflecting overall, direct and rank-ordered scores for each essential service and model standard, and percentage of essential service and model standard scored by response category.

Key steps in planning for the assessment included:

- 1) Establishment of an Advisory Group
- 2) Selection of assessment participants by the Advisory Group
- 3) Conducting online participant registration
- 4) Development of the assessment team, training and materials
- 5) Establishing a standardized assessment methodology
- 6) Data analysis and final report preparation.

## **ASSESSMENT PLANNING AND IMPLEMENTATION**

Based upon information provided by CDC staff, and information provided about the *NPHPSP v2.0 Assessment*, an assessment procedure was developed via a process of ongoing planning between the Purdue project team and the WV BPH Center for Performance Management and Systems Development.

### **Establishing a planning committee**

The West Virginia Bureau for Public Health identified key public health system partners to serve on an Advisory Group (Appendix A). This Group provided input on site selection, scheduling and general assessment planning of the SPHS Assessment, consistent with BPH objectives. The Group also provided input to the BPH on identification of key stakeholders to participate in the assessment. The Advisory Group initially met in person on August 21st, 2012.

### **Selection of assessment participants**

Assessment participants were identified by the Advisory Group. Participants were individuals representing all sectors of the public health system and contributing to the public's health in West Virginia and had specific content expertise in a specific essential public health service area (Appendix B). These individuals included, but were not limited to, those who represented state and local public health agencies, healthcare providers, public health safety agencies, charity organizations, educational and youth organizations, recreation and arts-related organizations, economic and philanthropic organizations and environmental agencies. Final selection of all participating organizations and representative individuals were reviewed and approved by the Bureau's leadership.

### **Conducting online participant registration**

Participants received an invitation with a brief written explanation of the assessment and link to register online for the assessment meeting they were identified to participate in (Appendix C). Each participant received an email confirmation of their registration, as well as a link to a copy of the assessment instrument, prior to the assessment meeting. More than 275 partners and BPH staff were invited to attend at least one essential service assessment meeting. Partners represented 20 of West Virginia's 55 counties, with populations ranging in size from 14,810 to 97,435 (Appendix D).

### **Establishing a standardized assessment methodology**

During the essential service meetings, participants were asked to engage in discussion to exchange appropriate perspectives, opinions, and information that would lend to consensus of a response for voting questions. Participants were then shown a series of projected questions, which were presented by the facilitator. Partners were asked to respond with the best response by selecting a corresponding button on their individual hand-held keypad. Only one consensus response for the entire group of participants was recorded for each question. Agreement on one level of activity by at least 60% of participants was defined as reaching consensus and was recorded as the final response, unless additional discussion was prompted or requested by participants. When voting totals indicated that consensus was not reached, facilitators prompted additional discussion and directed re-voting among participants until consensus occurred. No individual responses were recorded and no shared voting (more than one participant sharing a keypad) was allowed. This voting process continued until one response was recorded for all questions included in the assessment instrument.

## Data Analysis

The CDC's National Public Health Performance Standards Program, State Public Health System Assessment Instrument, Version 2.0 (referred to as the "assessment instrument") was used for the series of essential service assessment meetings held from November 27, 2012 through December 6, 2012. This assessment instrument was constructed using the ten Essential Public Health Services (EPHS) as a framework. These essential services provide a working definition of public health and a guiding framework for the responsibilities of public health systems. The strength of a public health system rests on its capacity to effectively deliver these ten Essential Public Health Services. The assessment instrument consisted of 116 questions (items) grouped into ten sections, based on the ten essential public health services (Table 1). Based on recommendation of the Centers for Disease Control and Prevention to the West Virginia Bureau for Public Health, only stem questions were assessed and scored. Sub-questions were used for discussion and informing the consensus process.

Table 1. Number of Items in Assessment Instrument Sections.

	Description of Essential Service	Number of items
1	Monitor health status to identify and solve community health problems.	13
2	Diagnose and investigate health problems and health hazards in the community.	14
3	Inform, educate and empower people about health issues.	10
4	Mobilize community partnerships and action to identify and solve health problems.	9
5	Develop policies and plans that support individual and community health efforts.	16
6	Enforce laws and regulations that protect health and ensure safety.	10
7	Link people to needed personal health services and ensure the provision of healthcare when otherwise unavailable.	11
8	Assure a competent public and personal workforce.	14
9	Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	10
10	Research for new insights and innovative solutions to health problems.	9

Each essential service area included four Model Standards, where a Model Standard described the key aspects of an optimally performing public health system. Each of these Model Standards must be performed well in an optimally-functioning public health system. The four Model Standards included in each essential service were:

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

Model Standards were followed by a set of assessment questions that served as measures of performance. Responses to these questions by participants indicated how well the Model Standard - which portrayed the highest level of performance or "gold standard" – was being met. One of five response options, ranging from 0% (No Activity) to 100% (Optimal Activity) was selected for each question (Table 2).

Table 2. Assessment instrument response options.

<b>No Activity</b>	<b>0% or absolutely no activity</b>
<b>Minimal Activity</b>	<b>Greater than zero, but no more than 25% of the activity described within the question is met.</b>
<b>Moderate Activity</b>	<b>Greater than 25%, but no more than 50% of the activity described within the question is met.</b>
<b>Significant Activity</b>	<b>Greater than 50%, but no more than 75% of the activity described within the question is met.</b>
<b>Optimal Activity</b>	<b>Greater than 75% of the activity described within the question is met.</b>

Data analysis was completed using a Microsoft Excel-based approach recommended by the CDC. Scores were constructed from the responses to reflect the degree to which the West Virginia public health system was performing with regard to meeting national public health performance standards. Scores were calculated as follows:

*Calculation for each Model Standard:* An average of the items was obtained for each of the Model Standards in each Essential Service, by dividing the sum of the scores of the items included in that Model Standard by the number of questions. For example, the score for Model Standard 1.1, *Monitor Health Status to Identify Community Health Problems*, was calculated by dividing the sum of the responses for questions 1.1.1, 1.1.2, 1.1.3, 1.1.4 and 1.1.5 by the total number of questions which was five.

*Calculation for each Essential Service:* Scores for each Essential Service were obtained by dividing the sum of the Model Standard scores included in that Essential Service by the number of Model Standards in each Essential Service, which was four for all essential services.

*Calculation for the Overall Score:* The Overall score was then calculated by dividing the sum of all ten essential service composite scores by 10, the number of essential services. All scores ranged from 0% to 100%.

## **ASSESSMENT FINDINGS**

Quantitative and qualitative data analyses were performed on the responses collected from the West Virginia State Public Health System Assessment process conducted from November 27, 2012 through December 6, 2012. Results are presented by scores for individual questions, model standards and the overall essential service, followed by the qualitative SWOP data (strengths, weaknesses, opportunities for immediate improvement and priorities for long term investments).

## Overview of individual essential public health service scores

### Essential Service 1: Monitor health status to identify health problems.

Essential Service 1 includes the assessment of statewide health status and its determinants, including the identification of health threats and the determination of health service needs; analysis of the health of specific groups that are at higher risk for health threats than the general population; identification of community assets and resources which support the SPHS in promoting health and improving quality of life; interpretation and communication of health information to diverse audiences in different sectors; and collaboration in integrating and managing public health related information systems.

The overall score for Essential Service 1 was 32.1% (Table 3). This indicates that overall performance is in the Moderate Activity range. Scores for individual questions, as determined by participants participating in the assessment of Essential Service 1, are found below. Participants rated performance for all but four questions as being 'Minimal Activity.'

Table 3. Essential Service 1 assessment questions and scores.

<b>ESSENTIAL SERVICE 1</b>		
<b>Monitor Health Status to Identify Community Health Problems</b>		
<b>1.1</b>	<b>Model Standard: Planning and Implementation</b>	
1.1.1	Does the SPHS use surveillance and monitoring programs designed to measure the health status of the state's population?	50%
1.1.2	Does the SPHS regularly compile and provide health data in useable products to a variety of health data users?	25%
1.1.3	Does the SPHS publish or disseminate health-related data into one or more documents that collectively describe the prevailing health of the state's population (i.e., a state health profile)?	25%
1.1.4	Does the SPHS operate a data reporting system designed to identify potential threats to the public's health?	50%
1.1.5	Does the SPHS enforce established laws and the use of protocols to protect personal health information and other data?	75%
<b>1.2</b>	<b>Model Standard: State-Local Relationships</b>	
1.2.1	Does the SPHS offer technical assistance (e.g., training, consultations) to local public health systems in the interpretation, use, and dissemination of health-related data?	25%
1.2.2	Does the SPHS regularly provide local public health systems a uniform set of local health-related data?	25%
1.2.3	Does the SPHS offer technical assistance in the development of information systems needed to monitor health status at the local level?	25%
<b>1.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
1.3.1	Does the SPHS review the effectiveness of its efforts to monitor health status?	25%
1.3.2	Does the SPHS actively manage and improve the overall performance of its health status monitoring activities?	25%
<b>1.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
1.4.1	Does the SPHS commit financial resources to health status monitoring efforts?	25%
1.4.2	Do SPHS organizations align and coordinate their efforts to monitor health status?	25%
1.4.3	Does the SPHS have the professional expertise to carry out health status monitoring activities?	50%
	<b>Overall Score</b>	<b>32.1%</b>

Table 4 below summarizes the score for each of the four Model Standard areas. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 1 include: 'State-Local Relationships,' 'Performance Management and Quality Improvement' and 'Public Health Capacity and Resources.' Additional evaluation of 'Planning and Implementation' may be warranted based on the goals and benchmarks established by the system or for performance related to individual assessment questions.

Table 4. Essential Service 1 model standard descriptions and scores.

Model Standard	Description	Score	Activity
1.1	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 general new knowledge about health in the state.	45%	MODERATE
1.2	State-Local Relationships: The SPHS works with local public health systems to provide assistance, capacity building and resources for local efforts to monitor health status and identify health problems.	25%	MINIMAL
1.3	Performance Management and Quality Improvement: The SPHS reviews the effectiveness of its performance in monitoring health status. Members of the SPHS actively use the information from these reviews to continuously improve the quality of monitoring efforts.	25%	MINIMAL
1.4	Public Health Capacity and Resources: The SPHS effectively invests in and utilizes its human, information, technology, organizational and financial resources to monitor health status and to identify health problems in the state.	33.4%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 1 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 5 below summarizes the data provided by participants related to Essential Service 1, which will be utilized by the SHIP Committee for subsequent state health improvement planning.

Table 5. Essential Service 1 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 1.1 Planning and Implementation</b>			
<p>Organizations willing to share data</p> <p>Increase discussion on need for data collection and sharing</p> <p>Moving toward standardized data</p> <p>State responsive to requests for data</p>	<p>BRFSS data lumped outside populated areas</p> <p>Cannot target interventions</p> <p>Race and ethnicity hard to find</p> <p>Hard to find data and who collects – not accessible</p> <p>Lack of funding</p> <p>Lack off coherent vision</p> <p>No statewide collection of data – no clearing house for data</p> <p>Timely data an issue</p> <p>Incomplete reporting</p>	<p>Regional data collection teams</p> <p>Strengthen quality improvement by using data</p> <p>Relate data to providers for QI</p> <p>Use health exchange to improve standardization</p> <p>Bring groups together to improve standardization</p> <p>Communication of data</p>	<p>Need to collect and analyze data to get grants and show outcomes</p> <p>'Data Summit'</p> <p>Make investment to make data improvements</p>
<b>Model Standard 1.2 State-Local Relationships</b>			
<p>Push to increase use of registries from national level</p> <p>Training provided by state to locals for registries</p> <p>Moving to merging immunization records with education registry</p> <p>Increased focus on communities asking for data and outcomes</p>	<p>Smaller counties use multiple years to collect data rather than annual (less timely)</p> <p>Reactive response by state to providing data rather than proactive</p> <p>Restrictive funding or lack of funding</p> <p>Lack of communication with local level</p> <p>Programs presented</p>	<p>Bring grass root groups into sharing data and planning</p> <p>Utilize data</p> <p>Increase coordination with BPH and new School of PH</p>	<p>Global view of public health that encompasses a wider view rather than silos</p> <p>Look at bottom up view rather than top down</p> <p>Utilize resources of new School of PH for WV public health</p> <p>Collaboration of all entities in SPHS</p>

State requires local health assessments	based on funding streams and programs prepared rather than community wants/needs		
<b>Model Standard 1.3 Performance Management and Quality Improvement</b>			
State assessment	Monitoring in silos	Develop a plan for improving the data  Communicating that a draft plan has been developed	Look at the way the state uses and collects data as one entity
<b>Model Standard 1.4 Capacity and Resources</b>			
Increase the number of epidemiologists (push from Federal)  WV has three universities that have qualified individuals to utilize	A belief that funding alone will solve problems  Lack of vision from state priorities for epidemiology funding. Short term funding and vision  Barriers to hiring and retaining qualified staff  Qualified individuals not working collectively  Lack of awareness of who is qualified and available to help  Barriers with contracts for outside assistance	Prove data is useful with existing data and program outcome so state will then commit to allocating funds  Utilize experts at the universities  Coordination of expertise  Utilizing free expertise of national health organizations  Solve contracting issues that state has with universities	Expert database from questions – especially from universities and state agencies and other agencies (cross-trainings)

## Essential Service 2: Diagnose and Investigate Health Problems and Hazards.

Essential Service 2 includes epidemiologic investigation of disease outbreaks and patterns of infectious and chronic diseases, injuries and other adverse health conditions; population-based screening, case finding, investigation and the scientific analysis of health problems; and rapid screening, high volume testing and active infectious disease epidemiologic investigations.

The overall score for Essential Service 2 was 69.3% (Table 6). This indicates that overall performance is in the Significant Activity range. Scores for individual questions, determined by participants completing Essential Service 2, are found below. Performance was rated as 'Significant Activity' for all but three questions.

Table 6. Essential Service 2 assessment questions and scores.

<b>ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards</b>		
<b>2.1</b>	<b>Model Standard: Planning and Implementation</b>	
2.1.1	Does the SPHS operate surveillance system(s) and epidemiology activities that identify and analyze health problems and threats to the health of the state's population?	75%
2.1.2	Does the SPHS have the capability to rapidly initiate enhanced surveillance when needed for a statewide/regional health threat?	75%
2.1.3	Does the SPHS organize its private and public laboratories (within the state and outside of the state) into a well-functioning laboratory system?	75%
2.1.4	Does the SPHS have laboratories that have the capacity to analyze clinical and environmental specimens in the event of suspected exposure or disease outbreak?	75%
2.1.5	Do SPHS organizations use defined roles and responsibilities in responding to public health threats for SPHS organizations, including local public health systems?	75%
<b>2.2</b>	<b>Model Standard: State-Local Relationships</b>	
2.2.1	Does the SPHS provide assistance (through consultations and/or training) to local public health systems in the interpretation of epidemiologic findings?	75%
2.2.2	Does the SPHS provide laboratory assistance to local public health systems?	75%
2.2.3	Does the SPHS provide local public health systems with information and guidance about public health problems and potential public health threats (e.g., health alerts, consultations)?	75%
2.2.4	Does the SPHS provide trained personnel, as needed, to assist local communities in the investigations of public health problems and threats?	50%
<b>2.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
2.3.1	Does the SPHS periodically review the effectiveness of the state surveillance and investigation system?	75%
2.3.2	Does the SPHS actively manage and improve the overall performance of its activities to diagnose and investigate health problems and health hazards?	75%
<b>2.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
2.4.1	Does the SPHS commit financial resources to support the diagnosis and investigation of health problems and hazards?	50%
2.4.2	Do SPHS organizations align and coordinate their efforts to diagnose and investigate health hazards and health problems?	75%
2.4.3	Does the SPHS have the professional expertise to identify and analyze public health threats and hazards?	50%
	<b>Overall Score</b>	<b>69.3%</b>

Table 7 below summarizes the score for each of the four Model Standard areas for Essential Service 2. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

No priority areas are identified for immediate attention by the West Virginia State Public Health System for Essential Service 2. Recognition should be given to the strong performance in all four model standard areas for this Essential Service. However, additional evaluation may be warranted based on the goals and benchmarks established by the system for performance.

Table 7. Essential Service 2 model standard descriptions and scores.

Model Standard	Description	Score	Activity
2.1	<b>Planning and Implementation:</b> 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 disaster, the risk of exposure to chemical and biological hazards and other threats.	75%	SIGNIFICANT
2.2	<b>State-Local Relationships:</b> The SPHS works with local public health system to provide assistance, capacity building, and resources for local efforts to identify, analyze and respond to public health problems and threats.	68.8%	SIGNIFICANT
2.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of the performance in diagnosing and investigating health problems. Members of the SPHS actively use the information from these reviews to continuously improve the quality and responsiveness of their efforts.	75%	SIGNIFICANT
2.4	<b>Public Health Capacity and Resources:</b> 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.	58.4%	SIGNIFICANT
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 2 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 8 below summarizes data provided by participants related to Essential Service 2, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 8. Essential Service 2 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 2.1 Planning and Implementation</b>			
Cardiac Project data for 15 years is available  Working on accessibility  A lot of data on health systems in WV	General public may be confused about who to report environmental hazards to  Protocols need to be written and/or updated and communicated  Radiological events – lab services  More to be done in chronic disease accessibility of data  Increased awareness of mold and water testing for communities  Quality is variable and not available (locked up)	Consistency in collection of data  Meth lab response needs to be addressed  Strengthen relationships between behavioral health and BPH surveillance and response of chronic disease	Occupational development  Regional partnership for radiologic testing  Interpretation and development of rapid response teams
<b>Model Standard 2.2 State-Local Relationships</b>			
Working on competitive salaries, etc.  From local health departments, trainings are provided in interpretation of epidemiology findings  State lab is available for questions from local health departments  Bureau of Public Health stand up and take a bow in reference to response to providing information in	Changes in staff  Interpretation of findings  Reactive vs proactive	Need to look at data according to benchmarks  State Bureau engage local and regional partners (e.g. academia)  Check gaps in chronic disease, injuries and environmental	Use of social media to address issues

a timely fashion			
<b>Model Standard 2.3 Performance Management and Quality Improvement</b>			
<p>Director of Performance Management at the Bureau level is a strength</p> <p>CDC selected WV for 2 years EIS officer</p> <p>Behavioral Health included with public health</p>	<p>Assess if implemented change as proposed</p> <p>Not enough staff or lack of funding</p> <p>Consistent funding</p>	<p>Ongoing process</p> <p>Stewardship of money</p>	<p>Continue to fund Center for Performance Management, beyond grant funding, to foster quality improvements</p> <p>Collaboration to do state assessment</p>
<b>Model Standard 2.4 Capacity and Resources</b>			
<p>Electronic reporting – they do well with what they have but could use more</p> <p>Behavioral health example of collaboration (e.g. suicide prevention and hospital infectious disease collaboration)</p> <p>Increased use of technology – share environmental data with academia</p>	<p>95% state funds and 5% federal funds for example – with restricted uses and funding formulas</p> <p>Same measures as large cities – rural vs urban based on population</p>	<p>Grants and other opportunities</p> <p>Strategic planning and emergency planning</p> <p>Utilize local media and professional staff</p> <p>Pilot projects with academia</p>	<p>Public information and share success stories</p> <p>Underutilization of websites and newsletters</p>

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

This service includes 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; and 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.

The overall score for Essential Service 3 was 51% (Table 9). This indicates that overall performance is in the very low ‘Significant Activity’ range. Scores for individual questions, as determined by participants completing Essential Service 3, are found below. Participants rated performance for all but two questions as being ‘Moderate Activity’ or ‘Significant Activity.’

Table 9. Essential Service 3 assessment questions and scores.

<b>ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues</b>		
<b>3.1</b>	<b>Model Standard: Planning and Implementation</b>	
3.1.1	Does the SPHS design and implement health education and health promotion interventions?	50%
3.1.2	Does the SPHS design and implement health communications?	25%
3.1.3	Does the SPHS have a crisis and emergency communications plan?	75%
<b>3.2</b>	<b>Model Standard: State-Local Relationships</b>	
3.2.1	Does the SPHS provide technical assistance to local public health systems (through consultations, training, and/or policy changes) to develop skills and strategies to conduct health communication, health education and health promotion interventions?	50%
3.2.2	Does the SPHS support and assist local public health systems in developing effective emergency communications capabilities?	75%
<b>3.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
3.3.1	Does the SPHS periodically review the effectiveness of health communication, including emergency communication, health education and promotion interventions?	50%
3.3.2	Does the SPHS actively manage and improve the overall performance of its activities to inform, educate and empower people about health issues?	50%
<b>3.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
3.4.1	Does the SPHS commit financial resources to support health communication and health education and health promotion efforts?	50%
3.4.2	Do SPHS organizations align and coordinate their efforts to implement health communication, health education, and health promotion services?	25%
3.4.3	Does the SPHS have the professional expertise to carry out effective health communications, health education and health promotion services?	50%
	<b>Overall Score</b>	<b>51%</b>

Table 10 below summarizes the scores for each of the four Model Standard areas for Essential Service 3. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 3 may include ‘Public Health Capacity and Resources’ as the lowest scored model standard for this essential service. Additional evaluation of the remaining model standards may be warranted based on the goals and benchmarks established by the system for performance.

Table 10. Essential Service 3 model standard descriptions and scores.

Model Standard	Description	Score	Activity
3.1	<b>Planning and Implementation:</b> The SPHS actively creates, communicates, and deliver 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.	50%	MODERATE
3.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building and resources for local efforts to inform, educate and empower people about health issues.	62.5%	SIGNIFICANT
3.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in informing, educating, and empowering people about health issues. Members of the SPHS actively use the information from these reviews to continuously improve the quality of their efforts in these areas.	50%	MODERATE
3.4	<b>Public Health Capacity and Resources:</b> The SPHS effectively invests, manages, and utilizes its human, information, organizational and financial resources to inform, educate and empower people about health issues.	41.7%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 3 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 11 below summarizes data provided by participants related to Essential Service 3, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 11. Essential Service 3 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 3.1 Planning and Implementation</b>			
<p>Science-based programs required for funding</p> <p>People do respond to improve health</p> <p>Hiring trained media people at BPH</p> <p>Crisis communication strong because not a shotgun approach</p>	<p>Programs not reaching people</p> <p>Silos instead of true collaboration</p> <p>Appropriate material/information to target groups – vision, hearing, education level, and culture</p> <p>Lack of funding for preventive care</p> <p>Practices not consistent with education and promotion (vending machine content for example)</p> <p>Missed opportunities for health education (example prisons, even by healthcare)</p> <p>Lack of prioritization</p> <p>Communication more reactive than proactive</p> <p>Press releases not consumer friendly, need to be written at 5<sup>th</sup> grade level</p> <p>Bureaucracy can impede timely messages</p>	<p>Health education materials appropriate for education level and more creative ways to educate</p> <p>Coordinate health promotion with providers</p> <p>Comparative effectiveness understood</p> <p>Utilize radio for health messages</p> <p>Prioritize health issues</p> <p>Develop crisis messages that are ready, approved and tested</p>	<p>Use of social media</p> <p>Evaluate laws/codes in view of promotion</p> <p>Promote healthy habits in prison</p> <p>Changing negative cultural attitudes about healthy habits</p> <p>Financial incentives to stimulate change of health habits</p>

<b>Model Standard 3.2 State-Local Relationships</b>			
Emergency communication plans well developed	Lack of personnel	Identify areas of concern	Funding increases for staff – consistent programs
Quality of personnel excellent	Some organizations have no access to social media	Oral health	Sustainable funding from both state and federal
Technical assistance in behavioral health based on data	Messaging inconsistent (changing standards)	Collaborate on consistent messages	
Technical assistance between BPH and locals very good		Increase state funding for diabetes	
<b>Model Standard 3.3 Performance Management and Quality Improvement</b>			
Funding source requires evaluation	Loss of institutional knowledge due to unsuccessful retention	Prioritize messaging to emerging and already ill, lack of preventive focus	Look at root causes of behaviors – collaborate with others to change root cause
BPH made commitment to increase staff for QI	Recruitment and retention of staff	Look at barriers (social, motivators) to change behaviors	
Some organizations strong in evaluation for QI (OMCFH and Behavioral Health)		Opportunity to create programs that are inclusive in rural areas	
		Focus programs on people ready to change	
<b>Model Standard 3.4 Capacity and Resources</b>			
Expertise very good	Grant funding restrictive for programming		Increase funds for staff and benefits

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

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

The overall score for Essential Service 4 was 35.4% (Table 12). This indicates that overall performance is in the Moderate Activity range. Scores for individual questions, as determined by participants completing Essential Service 4, are found below. Participants rated performance for all but three questions as being ‘Minimal Activity.’

Table 12. Essential Service 4 assessment questions and scores.

<b>ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems</b>		
<b>4.1</b>	<b>Model Standard: Planning and Implementation</b>	
4.1.1	Does the SPHS build statewide support for public health issues?	50%
4.1.2	Does the SPHS organize partnerships to identify and to solve health problems?	25%
<b>4.2</b>	<b>Model Standard: State-Local Relationships</b>	
4.2.1	Does the SPHS provide assistance (through consultations and/or trainings) to local public health systems to build partnerships for community health improvement?	25%
4.2.2	Does the SPHS provide incentives to local partnerships through grant requirements, financial incentives and/or resource sharing?	50%
<b>4.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
4.3.1	Does the SPHS review its partnership development activities?	25%
4.3.2	Does the SPHS actively manage and improve the overall performance of its partnership activities?	25%
<b>4.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
4.4.1	Does the SPHS commit financial resources to sustain partnerships?	50%
4.4.2	Do SPHS organizations align and coordinate their efforts to mobilize partnerships?	25%
4.4.3	Does the SPHS have the professional expertise to carry out partnership development activities?	50%
	<b>Overall Score</b>	<b>35.4%</b>

Table 13 below summarizes the score for each of the four Model Standard areas for Essential Service 4. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention and/or additional evaluation by the West Virginia State Public Health System for Essential Service 4 include all four Model Standard areas, 'Planning and Implementation,' 'State-Local Relationships,' 'Performance Management and Quality Improvement' and 'Public Health Capacity and Resources.'

Table 13. Essential Service 4 model standard descriptions and scores.

Model Standard	Description	Score	Activity
4.1	<b>Planning and Implementation:</b> The SPHS conducts a variety of state-wide 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.	37.5%	MODERATE
4.2	<b>State-Local Relationships:</b> 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.	37.5%	MODERATE
4.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in mobilizing partnerships. Members of the SPHS actively use the information from these reviews to continuously improve the quality of their partnership efforts.	25%	MINIMAL
4.4	<b>Public Health Capacity and Resources:</b> The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to assure that its partnership mobilization efforts meet the needs of the state's population.	41.7%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 4 included strengths, weakness, opportunities for immediate improvement and long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 14 below summarizes data provided by participants related to Essential Service 4, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 14. Essential Service 4 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 4.1 Planning and Implementation</b>			
<p>Kanawha Coalition for Community Health Improvement is example of local collaboration</p> <p>Support at local level from chronic disease at Bureau</p> <p>Bringing insurance people together. Example – mountains of Hope Cancer Coalition</p> <p>Medical schools</p>	<p>Do not know enough about good existing programs</p> <p>Disconnects exist</p> <p>Need for communications with stakeholders about priority health issues</p> <p>Collaboration not the same statewide</p> <p>Need to break down barriers to be more inclusive</p> <p>Need for funding and people – no funding for collaboration</p> <p>Loss of institutional knowledge</p>	<p>The assessment discussion is very different in that it is bringing people together</p> <p>Maintain a sustainable stakeholder statewide system</p> <p>Let people know what you are doing and how they can help</p> <p>Building trust between partners in statewide public health system</p> <p>Compile a database of organizations</p> <p>Use of technology and social media</p> <p>Include all partners at the table – not just healthcare</p>	<p>Formed vs. forming</p> <p>Accountability to an agency or department to partner with</p> <p>Terminology of health equity from disparity focus</p> <p>Bureau to take leadership role to share ideas and partnerships</p> <p>Sharing success stories</p>
<b>Model Standard 4.2 State-Local Relationships</b>			
<p>Block grant</p> <p>Some combining of agencies at federal level to combine funding</p>	<p>Fragmented funding sources driven by funding</p> <p>Lack of credibility – entire public health system</p> <p>Funding bureaucracy</p> <p>Bureau not at cabinet</p>	<p>Focus on one area – prioritize</p> <p>State Bureau leadership could help in critical mass</p> <p>Strengthen public health by making it a cabinet level</p>	<p>More creative strategy</p> <p>Consolidation of resources</p> <p>Bureau take a lead to build coalition training</p> <p>Block grants may allow programs to be redesigned</p>

	level	Further identification of partners	<p>Revamping of the Department fiscal system.</p> <p>Clear strategy, message and leadership</p> <p>One overriding theme to communicate</p>
<b>Model Standard 4.3 Performance Management and Quality Improvement</b>			
Monthly meetings between Bureau and local health departments	Bureau not at cabinet level	<p>Strengthen relationships with county health officers</p> <p>Acknowledge one piece of puzzle – talking to all partners, not just local health departments</p> <p>Include constituency in determining effectiveness</p> <p>Further identification of partners by leadership</p>	<p>Commitment to collaboration as a part of the interview process</p> <p>Make uniform approach</p> <p>Public health and providers agree on concept of medical home</p> <p>Incentives to increase primary care physicians</p>
<b>Model Standard 4.4 Capacity and Resources</b>			
State docs commit financial resources	<p>Delay in processing funding</p> <p>Professionals are leaving WV</p>	How do we explore looking at leadership expertise in carrying out partnership development activities?	<p>Capacity building in WV</p> <p>Development of criteria to decide when to bring in outside people or train current expertise</p> <p>Get more people in high powered positions to give back to WV</p>

## Essential Service 5: Develop Policies and Plans that Support Individual and Statewide Health Efforts.

This service includes systematic health planning that relies on appropriate data, develops and tracks measurable health objectives and establishes strategies and actions to guide community health improvement at 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; dialogue, advocacy and debate among groups affected by the proposed health plans and policies prior to adoption of such plans or policies.

The overall score for Essential Service 5 was 45.4% (Table 15), indicating overall performance is in the high Moderate Activity range. Scores for individual questions, determined by participants completing Essential Service 5, are below. A wide range of performance is noted (25% to 75%). Participants did not rate performance as 'No Activity' for any questions. Three questions were rated as having 'Significant Activity.'

Table 15. Essential Service 5 assessment questions and scores.

<b>ESSENTIAL SERVICE 5</b>		
<b>Develop Policies and Plans that Support Individual &amp; Statewide Health Efforts</b>		
<b>5.1</b>	<b>Model Standard: Planning and Implementation</b>	
5.1.1	Does the SPHS implement statewide health improvement processes that convene partners and facilitate collaboration among organizations contributing to the public's health?	50%
5.1.2	Does the SPHS develop one or more state health improvement plan(s) to guide its collective efforts to improve health and the public health system?	25%
5.1.3	Does the SPHS have in place an <u>All-Hazards Preparedness Plan</u> guiding system partners to protect the state's population in the event of an emergency?	75%
5.1.4	Does the SPHS conduct policy development activities?	75%
<b>5.2</b>	<b>Model Standard: State-Local Relationships</b>	
5.2.1	Does the SPHS provide technical assistance and training to local public health systems for developing local plans?	25%
5.2.2	Does the SPHS provide support and assistance for the development of community health improvement plans that are integrated with statewide health improvement strategies?	25%
5.2.3	Does the SPHS provide technical assistance in the development of local public health <u>all-hazards preparedness plans</u> for responding to emergency situations?	75%
5.2.4	Does the SPHS provide technical assistance in local health policy development?	50%
<b>5.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
5.3.1	Does the SPHS review progress towards accomplishing health improvement across the state?	25%
5.3.2	Does the SPHS review new and existing policies to determine their public health impacts?	25%
5.3.3	Does the SPHS conduct formal exercises and drills of the procedures and protocols linked to its All-Hazards Preparedness Plan?	75%
5.3.4	Does the SPHS actively manage and improve the overall performance of its planning and policy development activities?	25%
<b>5.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
5.4.1	Does the SPHS commit financial resources to health planning and policy development efforts?	50%
5.4.2	Do SPHS organizations align and coordinate their efforts to implement health planning and policy development?	25%

5.4.3	Does the SPHS have the professional expertise to carry out planning activities?	50%
5.4.4	Does the SPHS have the professional expertise to carry out health policy development?	50%
	<b>Overall Score</b>	<b>45.4%</b>

Table 16 below displays the score for each of the four Model Standard areas for Essential Service 5. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 5 include 'Performance Management and Quality Improvement.' Additional evaluation of the remaining model standards may be warranted based on the goals and benchmarks established by the system for performance.

Table 16. Essential Service 5 model standard descriptions and scores.

Model Standard	Description	Score	Activity
5.1	<b>Planning and Implementation:</b> 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.	56.3%	SIGNIFICANT
5.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building, and resources for their efforts to develop local policies and plans that support individual and statewide health efforts.	43.8%	MODERATE
5.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in policy and planning. Members of the SPHS actively use the information from these reviews to continuously improve the quality of policy and planning activities in supporting individual and statewide health efforts.	37.5%	MODERATE
5.4	<b>Public Health Capacity and Resources:</b> The SPHS effectively invests in and utilizes its human, information, organizational and financial resources to assure that its health planning and policy practice meet the needs of the state's population.	43.8%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 5 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 17 below summarizes data provided by participants related to Essential Service 5, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 17. Essential Service 5 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 5.1 Planning and Implementation</b>			
<p>State assessment good start</p> <p>Some groups collaborate at state level</p> <p>Issue based state plans (oral health, tobacco) in place</p> <p>Policies being developed to address some main issues</p>	<p>Lack of communication of what programs are available</p> <p>Lack of some inclusion of all population groups affected in state wide planning</p> <p>Recovery piece in emergency planning could be better coordinated with plan</p> <p>Emergency plans not always written or well-coordinated</p> <p>Lack of statewide coordinated activities</p> <p>Communication of current policy making is not optimal</p>	<p>Alignment of current plans and organizations to create coordinated messages and efforts</p> <p>Collaboration of groups working on same issue</p> <p>Communicate activities of policy making groups to be more inclusive</p> <p>Increase efforts to include groups not 'at the table'</p>	<p>Collaboration of system partners to create state health improvement plan</p> <p>Collaborate with other states where situations exist that a town/city in West Virginia is also in another state (i.e. Bluefield WV, Bluefield, VA.).</p> <p>Citizens are receiving conflicting information from the two states about what programs/services are available.</p>
<b>Model Standard 5.2 State-Local Relationships</b>			
<p>Capacity for planning at local level is increasing from support services</p> <p>All hazard preparedness planning</p>	<p>Lack of funding and time</p> <p>Varying strength in local health departments and systems</p>	<p>Utilize accreditation for state and local health departments</p> <p>Bring communities together for development of statewide programs</p> <p>Communication is key</p>	<p>Increase focus on policy development</p> <p>Develop some flexibility in planning so it targets special groups or situations</p>
<b>Model Standard 5.3 Performance Management and Quality Improvement</b>			
<p>Beginning to look at QI</p> <p>Have new QI staff</p>		<p>Maintain new QI staff</p>	

<b>Model Standard 5.4 Capacity and Resources</b>			
Universities have excellent collaboration and do want to be involved	Lack of funding and staff  No funding source for planning  Staffing continuity affects planning and follow up activities	Decrease barriers so capacity to develop plans is increased at state and local levels	Utilize data expertise to develop policy and present to legislature with emphasis on funding and cost of outcomes

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

This service includes review, evaluation and revision of laws, regulations, statutes, ordinances and codes designed to protect health and ensure safety, to assure they reflect current scientific knowledge and best practices for compliance; education of person/entities in the regulated environment to enforce laws designed to protect health and ensure safety; enforcement activities of public health concern, including but not limited to, enforcement of clean air standards; regulation of health care facilities; workplace safety inspections; review of new drug, biological and medical device applications; enforcement activities during emergency situations; and enforcement of laws governing sale of alcohol/tobacco to minors, seat belt and safety seat usage and childhood immunizations.

The overall score for Essential Service 6 was 46.4% (Table 18). This indicates that overall performance is in the high Moderate Activity range. Scores for individual questions, as determined by participants completing Essential Service 6, are found below. Participants rated performance as 'Minimal Activity' for two questions. All other questions were rated as higher performance of 'Moderate Activity' or 'Significant Activity.'

Table 18. Essential Service 6 assessment questions and scores.

<b>ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety</b>		
<b>6.1</b>	<b>Model Standard: Planning and Implementation</b>	
6.1.1	Does the SPHS assure existing and proposed state laws are designed to protect the public's health and ensure safety?	50%
6.1.2	Does the SPHS assure that laws give state and local authorities the power and ability to prevent, detect, manage, and contain emergency health threats?	50%
6.1.3	Are there cooperative relationships between the SPHS and persons and entities in the regulated environment to encourage compliance and assure that laws accomplish their health and safety purposes (e.g. hospitals and the state public health agency)?	50%
6.1.4	Does the SPHS ensure that administrative processes are customer-centered (e.g., obtaining permits and licenses)?	75%
<b>6.2</b>	<b>Model Standard: State-Local Relationships</b>	
6.2.1	Does the SPHS provide technical assistance to local public health systems on best practices in compliance and enforcement of laws that protect health and ensure safety?	50%
6.2.2	Does the SPHS partner with local governing bodies in reviewing, improving and developing local laws?	50%
<b>6.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
6.3.1	Does the SPHS review the effectiveness of its regulatory, compliance and enforcement activities?	50%
6.3.2	Does the SPHS actively manage and improve the overall performance of its regulatory programs and activities?	25%
<b>6.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
6.4.1	Does the SPHS commit financial resources to the enforcement of laws that protect health and ensure safety?	25%
6.4.2	Do SPHS organizations align and coordinate their efforts to comply with laws and regulations?	50%
6.4.3	Does the SPHS have the professional expertise to carry out enforcement activities?	50%
	<b>Overall Score</b>	<b>46.4%</b>

Table 19 below summarizes the score for each of the four Model Standard areas for Essential Service 6. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 6 include ‘Performance Management and Quality Improvement’ and ‘Public Health Capacity and Resources.’ Additional evaluation of the remaining model standards may be warranted based on the goals and benchmarks established by the system for performance.

Table 19. Essential Service 6 model standard descriptions and scores.

Model Standard	Description	Score	Activity
6.1	<b>Planning and Implementation:</b> 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 to encourage compliance.	56.3%	SIGNIFICANT
6.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building and resources for local efforts to enforce laws that protect health and safety.	50%	MODERATE
6.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in enforcing laws that protect health and safety. Members of the SPHS actively use the information from these reviews to continuously improve the quality of enforcement efforts.	37.5%	MODERATE
6.4	<b>Public Health Capacity and Resources:</b> 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.	41.7%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 6 included strengths, weakness, opportunities for immediate improvement and long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 20 below summarizes data provided by participants related to Essential Service 6, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 20. Essential Service 6 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 6.1 Planning and Implementation</b>			
National standards trigger reviews  Beginning a systematic review  Local health departments are success stories  Good cooperation between public health and DEP  Law enforcement learning about public health  FBI and State Police engaged	State level agency hours not as flexible as local agencies  Wide range of stakeholder involvement in regulations and law (e.g. immunizations)  Legislation may not be as strong as we would like/need additional buy-in  Those regulated have a voice  May have a problem fixing if enforcement not stated clearly. Might make a difference in emergency response  Allowable fees do not sustain program	Partnerships with judicial systems  Form an effective partnership between law enforcement and public health  Incentives for regulated providers  More available hours for access for permits	Forums/workgroups to discuss judicial relationships and decision-making bodies  Recognize those who have gone beyond training  Refine and build internal and external partnerships around already drafted public health emergency response legislation
<b>Model Standard 6.2 State-Local Relationships</b>			
Quarterly training sessions  Trust between state and local (e.g. environmental)  District sanitarians available for training  Regional epidemiologists	Technical assistance depends on funding  Varies from county to county  Local health departments do not have resources for routine legal advice	Immunization Suit	

<b>Model Standard 6.3 Performance Management and Quality Improvement</b>			
<p>Quarterly meetings to look at regulatory compliance</p> <p>Infrastructure is beginning to be put in place</p> <p>There is a willingness to collaborate</p>	<p>Including all stakeholders</p> <p>Do not have a regular review of effectiveness</p> <p>In past had no way to look at system (e.g. environmental)</p> <p>Time to get review process to make change</p>		
<b>Model Standard 6.4 Capacity and Resources</b>			
<p>C-Section rates an example of collaboration to change practice</p> <p>Seat belt safety and domestic violence collaboration and enforcement</p> <p>Strength around the table at assessment</p> <p>Overall work well together</p>	<p>Not enough resources for funding</p> <p>Legislature allocates funding</p> <p>Silos</p> <p>Targeted financial resources</p> <p>Lack of priorities</p> <p>Loss of institutional knowledge</p>	<p>What we do together to make an impact and share resources</p>	<p>Set environment to make compliance beneficial</p> <p>More creative ways to capture information</p>

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

This service includes: assessment of access to and availability of quality personal health services for the state’s population; assurance 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; and development of a continuous improvement process to assure the equitable distribution of resources for those in greatest need.

The overall score for Essential Service 7 was 42.8% (Table 21). This indicates that overall performance is in the Moderate Activity range. Scores for individual questions, as determined by participants completing Essential Service 7, are found below. A wide range of performance is noted (0% to 75%). Participants rated performance as ‘No Activity’ for one question. Two questions were rated as having ‘Significant Activity’.

Table 21. Essential Service 7 assessment questions and scores.

<b>ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable</b>		
<b>7.1</b>	<b>Model Standard: Planning and Implementation</b>	
7.1.1	Does the SPHS assess the availability of personal health services to the state’s population?	75%
7.1.2	Through collaborations with local public health systems and health care providers, does the SPHS take action to eliminate barriers to access to personal health care?	50%
7.1.3	Does the SPHS have an entity responsible for monitoring and coordinating personal health care delivery within the state?	0%
7.1.4	Does the SPHS mobilize its assets, including local public health systems, to reduce health disparities in the state?	25%
<b>7.2</b>	<b>Model Standard: State-Local Relationships</b>	
7.2.1	Does the SPHS provide technical assistance to local public health systems on methods to assess and meet the needs of underserved populations?	50%
7.2.2	Does the SPHS provide technical assistance to <u>providers</u> who deliver personal health care to underserved populations?	75%
<b>7.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
7.3.1	Does the SPHS review personal health care access, appropriateness and quality?	50%
7.3.2	Does the SPHS actively manage and improve the overall performance of its activities to link people to needed personal health care services?	25%
<b>7.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
7.4.1	Does the SPHS commit financial resources to assure the provision of personal health care?	50%
7.4.2	Do SPHS organizations align and coordinate their efforts to provide needed personal health care?	25%
7.4.3	Does the SPHS have the professional expertise to carry out the functions of linking people to needed personal health care?	25%
	<b>Overall Score</b>	<b>42.8%</b>

Table 22 below summarizes the score for each of the four Model Standard areas for Essential Service 7. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 7 include: ‘Planning and Implementation,’ ‘Performance Management and Quality Improvement’ and ‘Public Health Capacity and Resources.’ Additional evaluation of the remaining model standards may be warranted based on the goals and benchmarks established by the system for performance.

Table 22. Essential Service 7 model standard descriptions and scores.

Model Standard	Description	Score	Activity
7.1	<b>Planning and Implementation:</b> The SPHS assesses the availability of personal health 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.	37.5%	MODERATE
7.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building and resources for local efforts to identify underserved populations and develop innovative approaches for meeting their health care needs.	62.5%	SIGNIFICANT
7.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in the provision of personal health care to the state’s population. Members of the SPHS actively use the information from these reviews to continuously improve the quality of its efforts to link people to needed personal health services.	37.5%	MODERATE
7.4	<b>Public Health Capacity and Resources:</b> 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.	33.4%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 7 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 23 below summarizes data provided by participants related to Essential Service 7, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 23. Essential Service 7 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 7.1 Planning and Implementation</b>			
<p>Health Provider Shortage Area (HPSA) actively assesses provider availability</p> <p>Community health centers strong in WV (180 sites)</p> <p>Local collection of data on number served and could be served – then share with state and individual groups who collect data (private, and single service groups like family planning)</p> <p>Grants require assessments</p> <p>Collaborations for oral health, perinatal, cancer and others active</p> <p>Preparedness plans address vulnerable populations</p>	<p>Compilation of data not done</p> <p>Data collection not shared or communicated – people don’t know about it</p> <p>Collaboration in silos and not enough integration between organizations</p> <p>GoHELP not functioning due to political issues, lack of funding/personnel</p> <p>Lack of planning to reduce health disparities</p>	<p>Disability group would like to share data about gaps in personnel to deliver services</p> <p>Compile different sources of data together</p> <p>Collaborate between silos</p>	<p>Promotion of medical homes</p> <p>Promotion of integration of efforts</p>
<b>Model Standard 7.2 State-Local Relationships</b>			
<p>Technical assistance for EMR available to community health centers for chronic disease</p> <p>BPH – epidemiology provides technical assistance and OMCFH provides immunization TA to providers. Good</p>	<p>Not all resources of equal quality</p>	<p>Broaden availability of technical assistance already available to other groups</p> <p>Collaboration between child health and behavioral health – look for other new collaborations</p>	<p>Create web-based resource guides listing <u>quality</u> programs</p>

relevant info  Health Check very active and useful to providers for training and technical assistance			
<b>Model Standard 7.3 Performance Management and Quality Improvement</b>			
Some healthcare centers required to collect data, review it, and act to improve it  Children specialty care is assessed and receive feedback	Data not looked at and always used for improvement  Collection of data not standardized  Difficult to share collected data  Activity done is silos		Collaborate in a system to improve access
<b>Model Standard 7.4 Capacity and Resources</b>			
Private insurance investment in personnel for health education of members and community events  Small state - people know each other and communicate to find needed care  Expertise is present in the state	Poverty big factor in state health  Discovery of resources delay care  Staffing issue due to lack of funding and other issues	Create or find financial incentives	Define root causes of poverty which affects health and healthcare

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

This service includes: education, training, development, and assessment of health professionals—including partners, volunteers, and 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; and continuing education in management, cultural competence, and leadership development programs.

The overall score for Essential Service 8 was 29.2% (Table 24). This indicates that overall performance is in the low Moderate Activity range. Scores for individual questions, as determined by participants completing Essential Service 8, are found below. Participants rated performance as ‘Minimal Activity’ for all but two questions. The questions pertaining to assisting local public health system organizations with workforce development by assuring educational course work and training is available and committing financial resources to workforce development efforts were noted to be higher performance areas in the ‘Moderate Activity’ range.

Table 24. Essential Service 8 assessment questions and scores.

<b>ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce</b>		
<b>8.1</b>	<b>Model Standard: Planning and Implementation</b>	
8.1.1	Does the SPHS conduct assessments of its workforce needs to deliver effective population-based and personal health services in the state?	25%
8.1.2	Does the SPHS develop a statewide workforce plan(s) to guide its activities in workforce development? <i>(Note: the SPHS may have one or more workforce plans, but the plan(s) should address both population-based and personal health care workforce.)</i>	25%
8.1.3	Do SPHS human resources development programs provide training to enhance the technical and professional competencies of the workforce?	25%
8.1.4	Does the SPHS assure that individuals in the population-based and personal health care workforce achieve the highest level of professional practice?	25%
8.1.5	Does the SPHS support initiatives that encourage life-long learning?	25%
<b>8.2</b>	<b>Model Standard: State-Local Relationships</b>	
8.2.1	Does the SPHS assist local public health systems in completing assessments of their population-based and personal health care workforces?	25%
8.2.2	Does the SPHS assist local public health systems with workforce development?	25%
8.2.3	Does the SPHS assure educational course work and training is available and accessible to enhance the skills of the workforce of local public health systems?	50%
<b>8.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
8.3.1	Does the SPHS review its workforce development activities?	25%
8.3.2	Does the SPHS review the extent to which academic-practice partnership(s) address the preparation of personnel entering the SPHS workforce?	25%
8.3.3	Does the SPHS actively manage and improve the overall performance of its workforce development activities?	25%
<b>8.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
8.4.1	Does the SPHS commit financial resources to workforce development efforts?	50%
8.4.2	Do SPHS organizations align and coordinate their efforts to effectively conduct workforce development activities?	25%
8.4.3	Does the SPHS have professional expertise to carry out workforce development activities?	25%
	<b>Overall Score</b>	<b>29.2%</b>

Table 25 below summarizes the score for each of the four Model Standard areas for Essential Service 8. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 8 include all four Model Standards: ‘Planning and Implementation,’ ‘State-Local Relationships,’ ‘Performance Management and Quality Improvement’ and ‘Planning and Implementation.’

Table 25. Essential Service 8 model standard descriptions and scores.

Model Standard	Description	Score	Activity
8.1	<b>Planning and Implementation:</b> 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 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.	25%	MINIMAL
8.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building and resources for local efforts to assure a competent population-based and personal health care workforce.	33.3%	MODERATE
8.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in assuring a competent population-based and personal health care workforce. Members of the SPHS actively use the information from these reviews to continuously improve the quality of workforce development efforts.	25%	MINIMAL
8.4	<b>Public Health Capacity and Resources:</b> 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.	33.3%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 8 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 26 below summarizes data provided by participants related to Essential Service 8, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 26. Essential Service 8 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 8.1 Planning and Implementation</b>			
<p>Competence of professionals assessed at Bureau</p> <p>Local HD employees assessed</p> <p>Center for Nursing conducted survey – is on website</p> <p>Academia and Bureau have met – need people with funding included</p>	<p>Time is needed for LHD staff to access training– this assessment did not assess need for additional training</p> <p>Information gathered for workforce project, but not put together</p> <p>No sharing of information</p> <p>No one taking responsibility for planning</p> <p>Lack of resources or generate revenue to get adequate workforce</p> <p>Employee practices – work under a contract</p> <p>In the state, have to move around to move up career ladder and lose program/departmental knowledge</p>	<p>Center for Nursing will put on website any data gathered regarding workforce</p>	<p>Standardized collection of workforce data</p> <p>Bureau could bring all of the information together</p> <p>Need to establish an accountable entity</p> <p>All level statewide workforce plan</p> <p>Program-based Human Resources development needed</p> <p>Utilize School of Public Health</p>
<b>Model Standard 8.2 State-Local Relationships</b>			
<p>Bureau trainings are being offered to improve workforce performance</p> <p>Success stories could be built upon</p> <p>LHD working with Health</p>	<p>Electronic medical records</p> <p>Hospitals invited but did not respond</p> <p>Have identified problems, but looking</p>	<p>Course that is required for re-certification</p> <p>Continuing education available</p> <p>Outline professional</p>	<p>Clearing house needed for bringing all components of continuing education together – incentives which will work best – what will work realistically</p>

<p>Alliance</p> <p>Bureau of PH working with School of Public Health</p> <p>Expertise is available in staff</p>	<p>for solutions</p> <p>Additional coursework available but not coordinated</p> <p>Low salaries = low retention</p> <p>Rural vs urban educational setting</p> <p>Disconnect between preparation and licensure of practitioners prepared to meet needs of the state</p>	<p>development</p> <p>Volunteer WV AmeriCorps</p> <p>Opportunities on Bureau website</p>	
<b>Model Standard 8.3 Performance Management and Quality Improvement</b>			
<b>Model Standard 8.4 Capacity and Resources</b>			
<p>Working School of Public Health</p> <p>School of Public Health has 3 programs available</p> <p>DHHR has online training</p> <p>DHHR Management System allows for tracking credentialing, etc.</p> <p>Public education and higher education funds committed</p> <p>Foundation funding</p> <p>State funding</p>			

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

This service includes: evaluation and critical review of health programs, based on analyses of health status and service utilization data, are conducted to determine program effectiveness and to provide information necessary for allocating resources and reshaping programs for improved efficiency, effectiveness and quality.

The overall score for Essential Service 9 was 37.5 (Table 27). This indicates that overall performance is in the mid Moderate Activity range. Scores for individual questions, as determined by participants completing Essential Service 9, are found below. Participants rated performance as ‘Minimal Activity’ for half of the questions in this essential service.

Table 27. Essential Service 9 assessment questions and scores.

<b>ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services</b>		
<b>9.1</b>	<b>Model Standard: Planning and Implementation</b>	
9.1.1	Does the SPHS routinely evaluate population-based health services within the state?	25%
9.1.2	Does the SPHS evaluate the effectiveness of personal health services within the state?	50%
9.1.3	Does the SPHS establish and/or use standards to assess the performance of the state public health system?	25%
<b>9.2</b>	<b>Model Standard: State-Local Relationships</b>	
9.2.1	Does the SPHS provide technical assistance (e.g., consultations, training) to local public health systems in their evaluations?	50%
9.2.2	Does the SPHS share results of state-level performance evaluations with local public health systems for use in local planning processes?	50%
<b>9.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
9.3.1	Does the SPHS regularly review the effectiveness of its evaluation activities?	25%
9.3.2	Does the SPHS actively manage and improve the overall performance of its evaluation activities?	25%
<b>9.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
9.4.1	Does the SPHS commit financial resources for evaluation?	50%
9.4.2	Do SPHS organizations align and coordinate their efforts to conduct evaluations?	25%
9.4.3	Does the SPHS have the professional expertise to carry out evaluation activities?	50%
	<b>Overall Score</b>	<b>37.5%</b>

Table 28 below summarizes the score for each of the four Model Standard areas for Essential Service 9. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 9 include ‘Planning and Implementation’ and ‘Performance Management and Quality Improvement.’ Additional evaluation of the remaining model standards may be warranted based on the goals and benchmarks established by the system for performance.

Table 28. Essential Service 9 model standard descriptions and scores.

Model Standard	Description	Score	Activity
9.1	<b>Planning and Implementation:</b> The SPHS conducts evaluations to improve the effectiveness of population-based services 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.	33.4%	MODERATE
9.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building, and resources for local efforts to evaluate the performance and effectiveness of population-based programs, personal health services, and local public health systems.	50%	MODERATE
9.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in evaluating the effectiveness, accessibility, and quality of population-based programs, personal health services, and public health systems. Members of the SPHS actively use the information from these reviews to continuously improve the quality of evaluation efforts.	25%	MINIMAL
9.4	<b>Public Health Capacity and Resources:</b> 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 services. Evaluations are appropriately resourced so they can be routinely conducted.	41.7%	MODERATE
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 9 included strengths, weakness, opportunities for immediate improvement and long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments.

Table 29. Essential Service 9 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 9.1 Planning and Implementation</b>			
Local health departments are autonomous  CMS collecting facility/personal data  WV good at building partnerships/coalitions	Baseline data not available across all disciplines  LHDs autonomous  Not measuring outcomes of programs  Not having a statewide clearinghouse for all data  Having more granulated data  State contracting process  Data not being shared  No leadership for collecting data in one place  Infrastructure for monitoring healthcare professional credentials and licenses	Establish baseline data  Forming a group of stakeholders	Using Medicaid match to increase funding  Develop central clearinghouse  Statewide health coalition (broad-based) formed and meets regularly
<b>Model Standard 9.2 State-Local Relationships</b>			
	Limited funding for evaluation training  CDC funding is categorical and only awarded annually  Insufficient capacity/staffing at local level	Publicize what data\evaluations are available	What you do with money (effectively using available funding)
<b>Model Standard 9.3 Performance Management and Quality Improvement</b>			
LHD annual program plans reviewed by BPH before state funding renewed			

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

This service includes: a full continuum of research ranging from field-based efforts to foster improvements in public health practice to formal scientific research; linkage with research institutions and other institutions of higher learning; and internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.

The overall score for Essential Service 10 was 21.9% (Table 30). This indicates that overall performance is in the 'Minimal Activity' range. Scores for individual questions, as determined by participants completing Essential Service 10, are found below. Participants rated performance for eight of the ten questions in this essential service as having performance of 'No Activity or 'Minimal Activity.'

Table 30. Essential Service 10 assessment questions and scores.

<b>ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems</b>		
<b>10.1</b>	<b>Model Standard: Planning and Implementation</b>	
10.1.1	Does the SPHS maintain an active academic-practice collaboration(s) to promote and organize research activities and disseminate and use research findings in practice?	25%
10.1.2	Does the SPHS have a public health research agenda?	0%
10.1.3	Does the SPHS participate in and conduct research relevant to public health services?	50%
<b>10.2</b>	<b>Model Standard: State-Local Relationships</b>	
10.2.1	Does the SPHS provide technical assistance to local public health systems with research activities?	25%
10.2.2	Does the SPHS assist local public health systems in their use of research findings?	25%
<b>10.3</b>	<b>Model Standard: Performance Management and Quality Improvement</b>	
10.3.1	Does the SPHS review its public health research activities?	25%
10.3.2	Does the SPHS actively manage and improve the overall performance of its research activities?	0%
<b>10.4</b>	<b>Model Standard: Public Health Capacity and Resources</b>	
10.4.1	Does the SPHS commit financial resources to research relevant to health improvement?	25%
10.4.2	Do SPHS organizations align and coordinate their efforts to conduct research?	0%
10.4.3	Does the SPHS have the professional expertise to carry out research activities?	50%
	<b>Overall Score</b>	<b>21.9%</b>

Table 31 below summarizes the score for each of the four Model Standard areas for Essential Service 10. These scores represent the average of the scores for the individual questions found in each Model Standard on the previous page.

Priority areas for additional attention by the West Virginia State Public Health System for Essential Service 10 include all four Model Standard areas, 'Planning and Implementation,' 'State-Local Relationships,' 'Performance Management and Quality Improvement' and 'Public Health Capacity and Resources.'

Table 31. Essential Service 10 model standard descriptions and scores.

Model Standard	Description	Score	Activity
10.1	<b>Planning and Implementation:</b> 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. SPHS organizations 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.	25%	MINIMAL
10.2	<b>State-Local Relationships:</b> The SPHS works with local public health systems to provide assistance, capacity building and resources for local efforts to carry out research for new insights and innovative solutions to health problems.	25%	MINIMAL
10.3	<b>Performance Management and Quality Improvement:</b> The SPHS reviews the effectiveness of its performance in conducting and using research for new insights and innovative solutions to health problems. Members of the SPHS actively use the information from these reviews to continuously improve the quality of research efforts.	12.5%	MINIMAL
10.4	<b>Public Health Capacity and Resources:</b> The SPHS effectively invests, manages and utilizes its human, information, organizational and financial resources for the conduct of research to meet the needs of the state's population.	25%	MINIMAL
No Activity 0%; Minimal Activity 1-25%; Moderate Activity 26-50%; Significant Activity 51-75%; Optimal Activity 76-100%			

Qualitative data collected during the assessment of Essential Service 10 included strengths, weakness, opportunities for immediate improvement and priorities for long term investments needed for optimal performance of this essential service. Strengths provide areas to build upon and weaknesses provide additional information where improvements are needed. Opportunities for immediate improvement include action steps not requiring long term investments. Table 32 below summarizes data provided by participants related to Essential Service 10, which will be utilized by the SHIP Committee for subsequent state public health improvement planning.

Table 32. Essential Service 10 qualitative data by model standard.

Strengths	Weaknesses	Opportunities for Immediate Improvement	Priorities for Long Term Investments
<b>Model Standard 10.1 Planning and Implementation</b>			
<p>Willingness of WV universities to work together on public health issues</p> <p>BPH beginning to build linkages to School of Public Health for research</p> <p>Federally funded research centers</p> <p>Use of community-based participatory research</p> <p>Federally recognized effective interventions</p> <p>Newly funded WV CTSI</p> <p>Willingness to collaborate across silos and agencies</p>	<p>CDC funding to BPH cannot be used for research</p> <p>PH system doesn't act like a system</p> <p>Communication throughout system (currently too silod)</p> <p>CDC does not integrate research people and program people</p> <p>Research too specialized and doesn't focus on effective strategies</p> <p>Research findings not widely shared</p> <p>Takes time to build relationships</p> <p>Disjointed system/lack of leadership</p> <p>Challenges at state level processes around contracts</p>		<p>Learn from existing models</p> <p>Work with extension services</p> <p>Invest time in building relationships</p> <p>Work together as a whole state</p>
<b>Model Standard 10.2 State-Local Relationships</b>			
<b>Model Standard 10.3 Performance Management and Quality Improvement</b>			
	<p>Group consensus was B, but % was only 1% for 10.3.1</p>		

**Model Standard 10.4 Capacity and Resources**

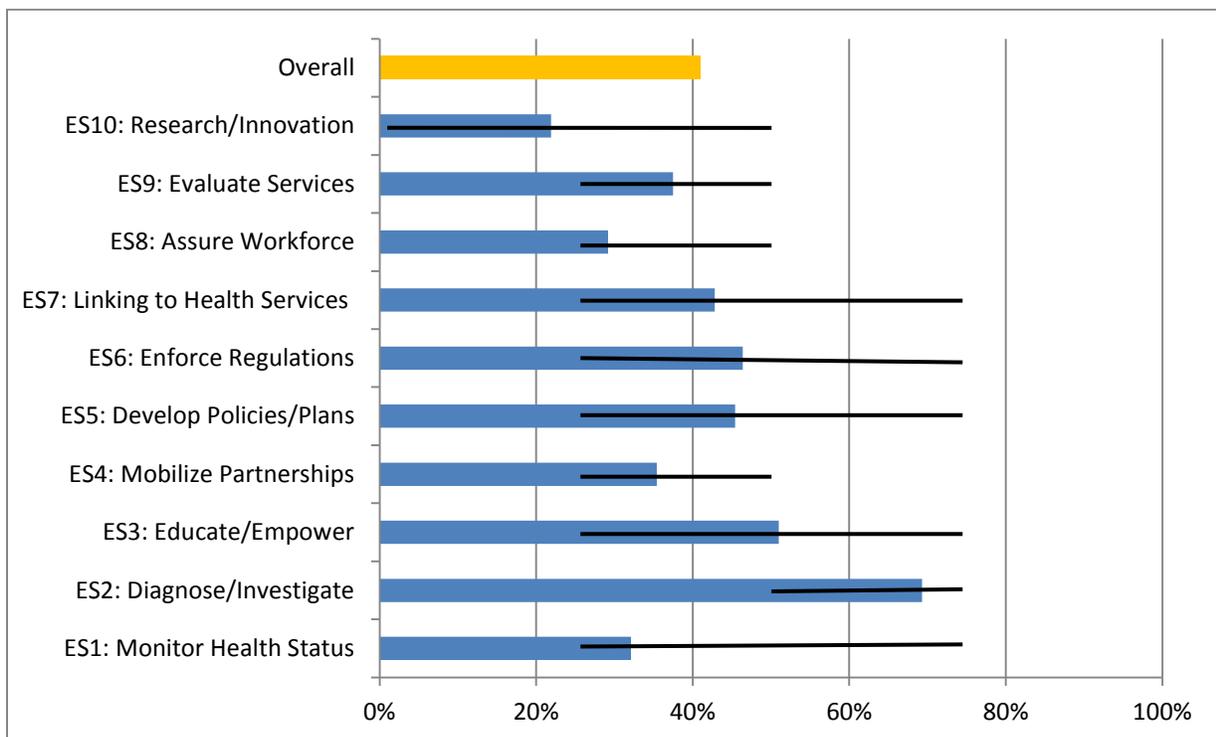
There is staff for research in WV		Have meetings to begin discussing research agenda/activities  Combine academic "lists of experts" at the state level	SPHS actively manage research agenda/activities by forming a committee or appointing a leader
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## Overview of overall essential service scores

Scores reflecting the overall performance for each of the ten essential public health services were computed from the responses given. Each score represents the average of the Model Standards and should be interpreted as the degree to which the public health system met the performance standards defined in the assessment instrument. Scores can range from 0%, if no activities are performed, to 100% if all activities are performed at optimal levels. Figure 1 displays average scores for each essential service along with an overall average score that indicates the performance level across all 10 essential services. The black line extending through each bar in the histogram represents the range of responses for the questions provided by participants for each Essential Service, respectively.

Overall, seven of the ten essential public health services were assessed as having performance of Moderate Activity (26-50%) (Table 33). Only Essential Service 10 was assessed as having lower performance of Minimal Activity (1-25%). Essential Services 2 and 3 were assessed as having performance in the Significant Activity range (51-75%).

Figure 1. Summary of average essential service performance scores.



## Ranked Performance Scores

Table 33 below provides ranking of the ten essential service performance scores, which can range from 0% to 100%. Essential Services 2, 3 and 6 were assessed as having the highest performance. Essential Services 1, 8 and 10 were assessed as having the lowest performance. Essential services containing questions related to public health emergency preparedness and response had the highest performance of the ten essential public health services.

Table 33. Summary of ranked average essential service performance scores.

Highest Ranking Essential Services		Score
2	Diagnose and investigate health problems and health hazards in the community	69.3%
3	Inform, educate, and empower people about health issues	51.0%
6	Enforce laws and regulations that protect health and ensure safety	46.4%
Intermediate Ranking Essential Services		
5	Develop policies and plans that support individual and community health efforts	45.4%
7	Link people to needed personal health services and assure provision of healthcare when otherwise unavailable	42.8%
9	Evaluate effectiveness, availability, and quality of personal and population-based health services	37.5%
4	Mobilize community partnerships to identify and solve health problems	35.4%
Lowest Ranking Essential Services		
1	Monitor health status to identify community health problems	32.1%
8	Assure a competent public and personal health care workforce	29.2%
10	Research for new insights and innovative solutions to health problems	21.9%

### Performance Relative to Optimal Activity

The figures below display the proportion of performance measures that exceeded specified thresholds of achievement in meeting performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legends below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level.

Figure 2. Percentage of the West Virginia public health system's Essential Services scores that fall within the five activity categories. (This chart provides a high level snapshot of the information found in Figure 2 below).

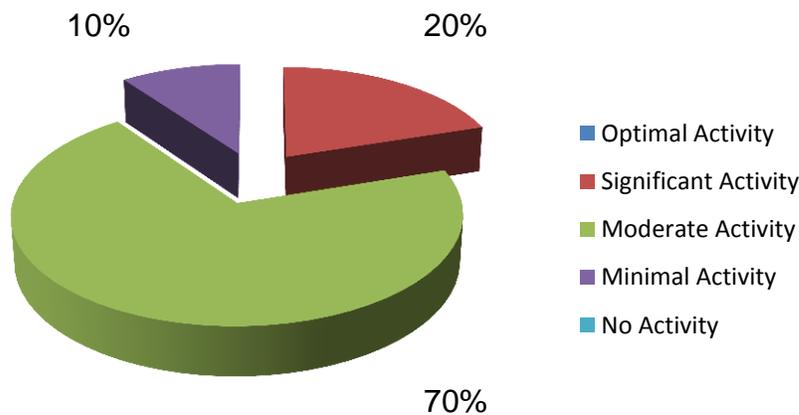
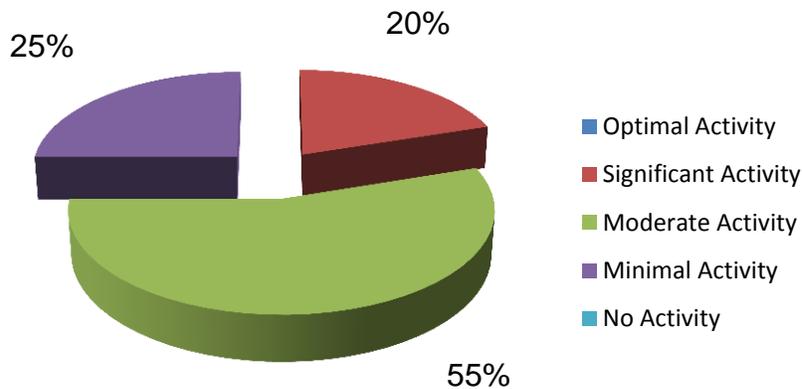


Figure 3. Percentage of the West Virginia public health system's Model Standard scores that fall within the five activity categories.



### **Summary of scores by essential service and model standard**

The following pages display the average scores for each of the Model Standards within the ten essential public health services. Figures 4 through 13 on the pages that follow display the performance scores for each of the 40 Model Standards, organized by essential service. These graphs provide opportunity to focus on each individual Model Standard, looking across the ten essential public health service areas.

Figure 4. Summary of average performance scores by model standard in Essential Service 1.

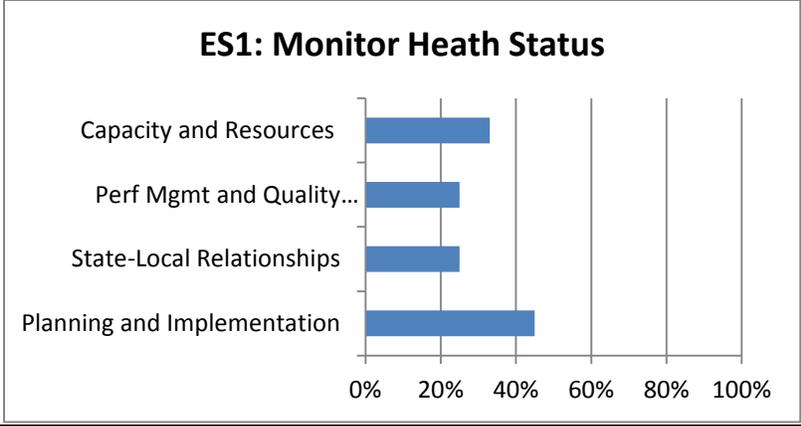


Figure 5. Summary of average performance scores by model standard in Essential Service 2.

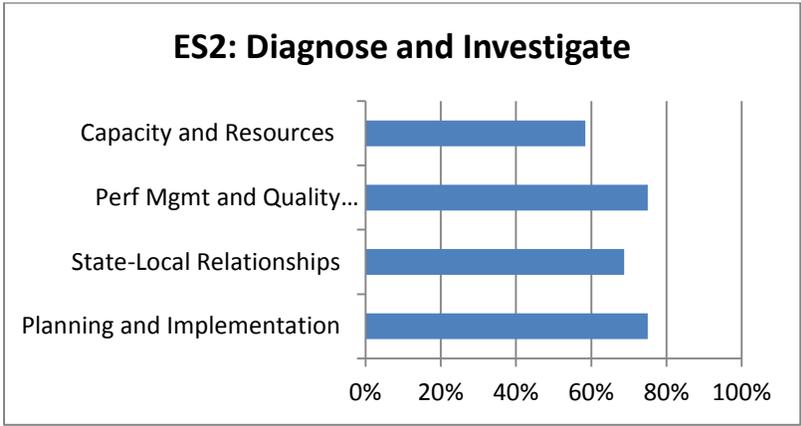


Figure 6. Summary of average performance scores by model standard for Essential Service 3.

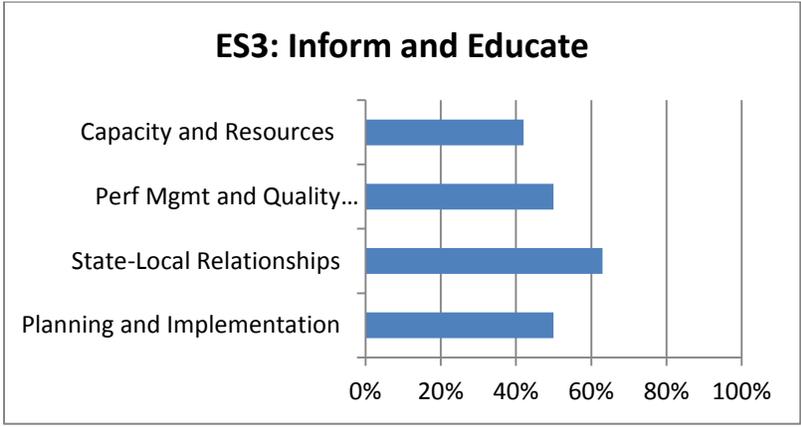


Figure 7. Summary of average performance scores by model standard for Essential Service 4.

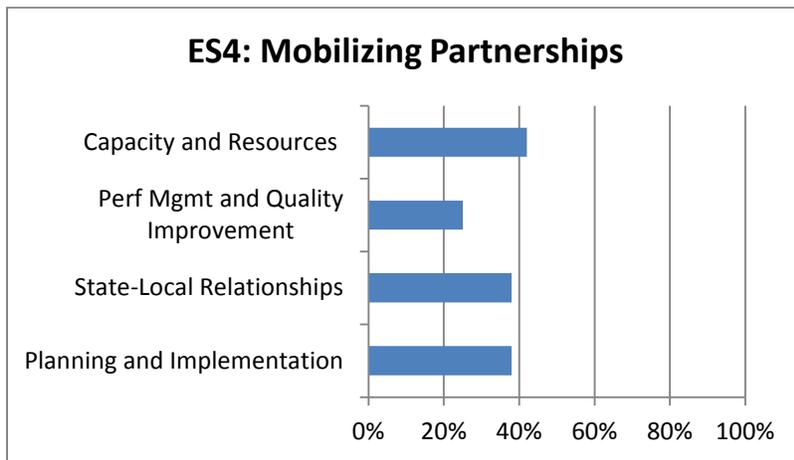


Figure 8. Summary of average performance scores by model standard for Essential Service 5.

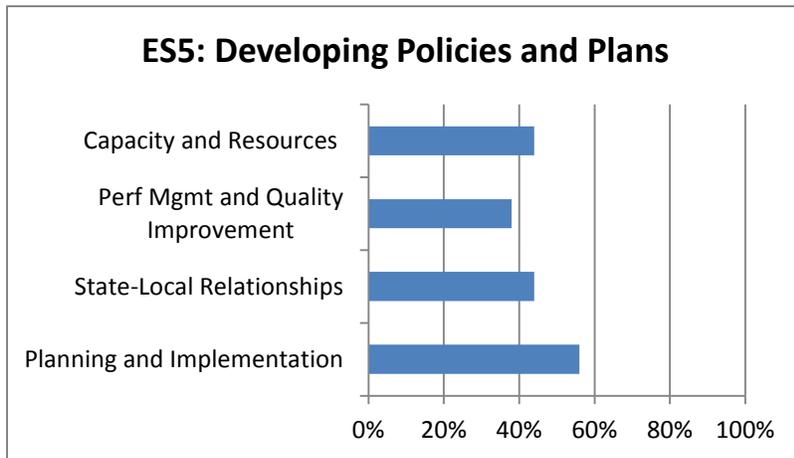


Figure 9. Summary of average performance scores by model standard for Essential Service 6.

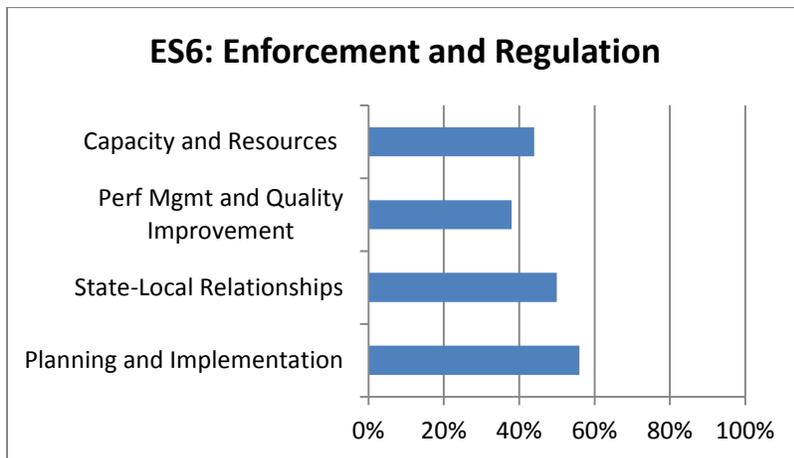


Figure 10. Summary of average performance scores by model standard for Essential Service 7.

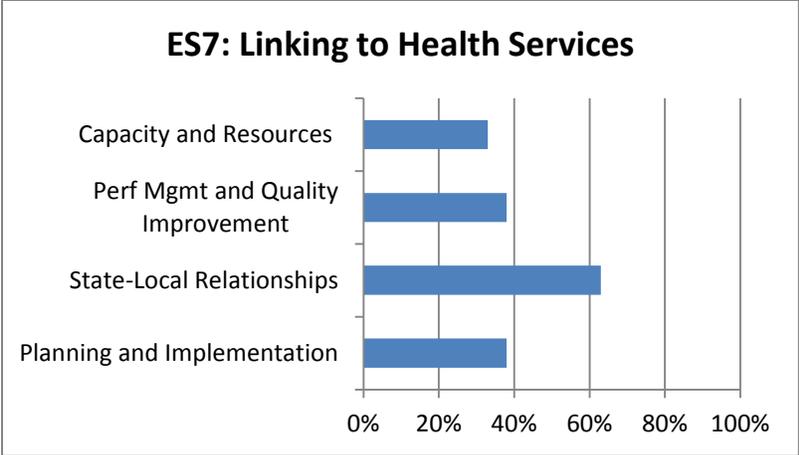


Figure 11. Summary of average performance scores by model standard for Essential Service 8.

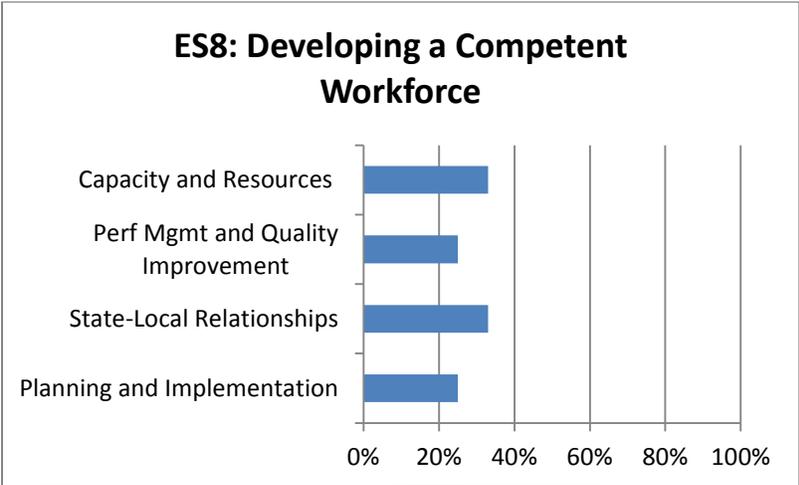


Figure 12. Summary of average performance scores by model standard for Essential Service 9.

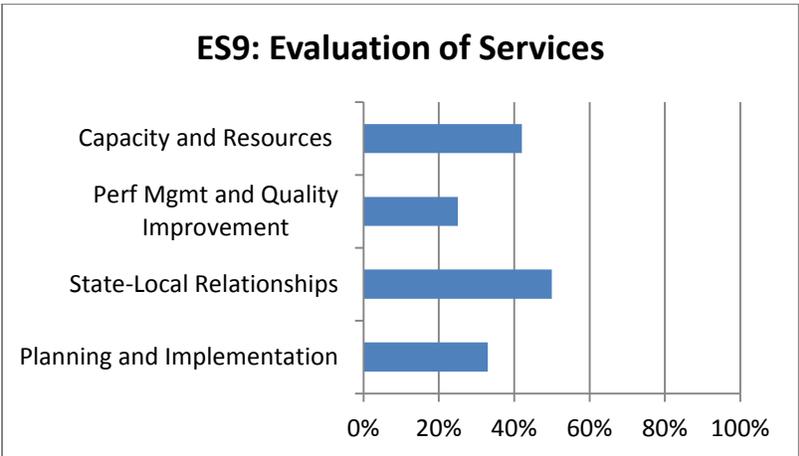


Figure 13. Summary of average performance scores by model standard for Essential Service 10.

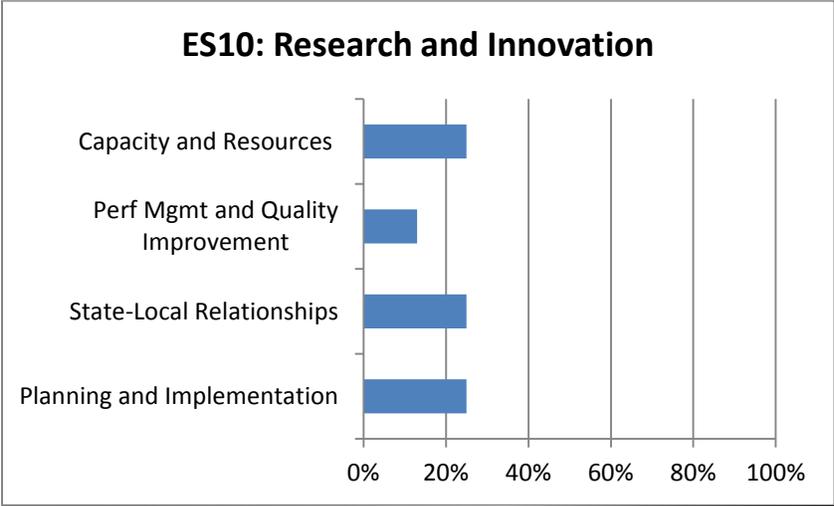


Figure 14. Summary of average performance scores by essential service for Model Standard 1.

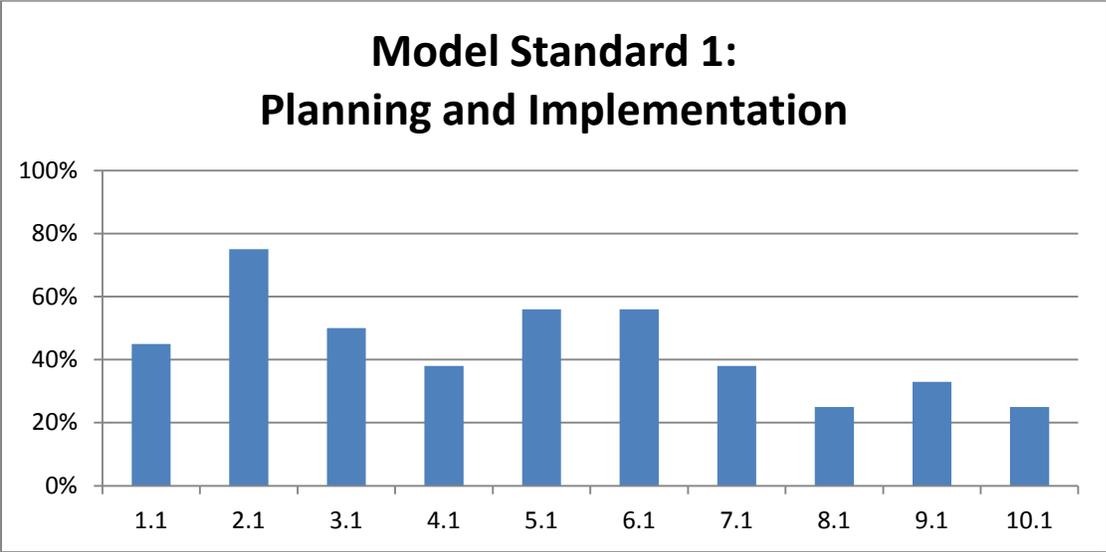


Figure 15. Summary of average performance scores by essential service for Model Standard 2.

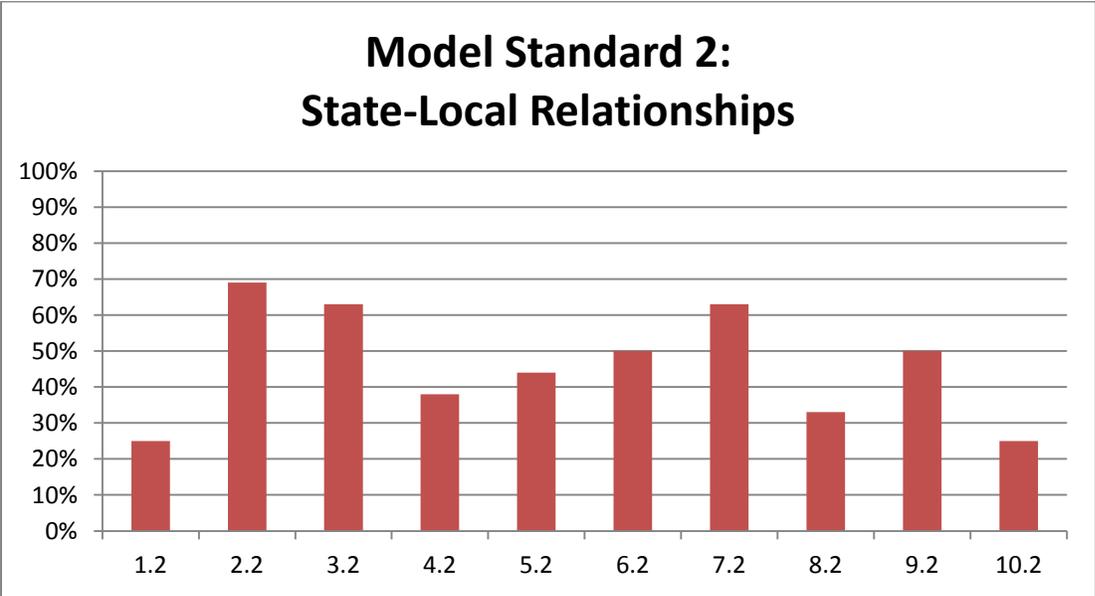


Figure 16. Summary of average performance scores by essential service for Model Standard 3.

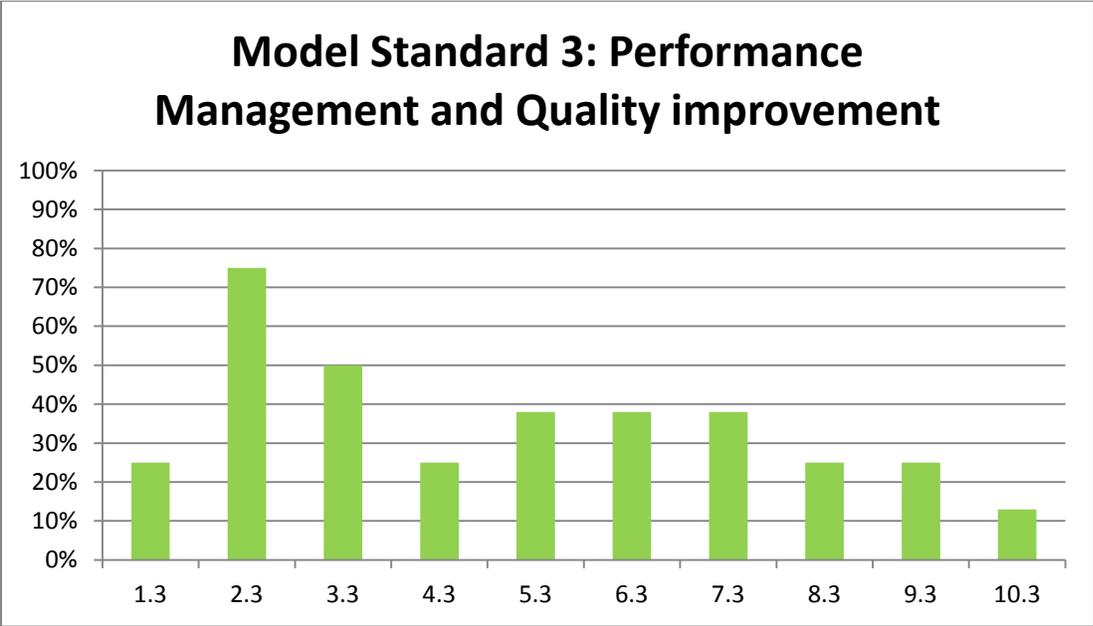
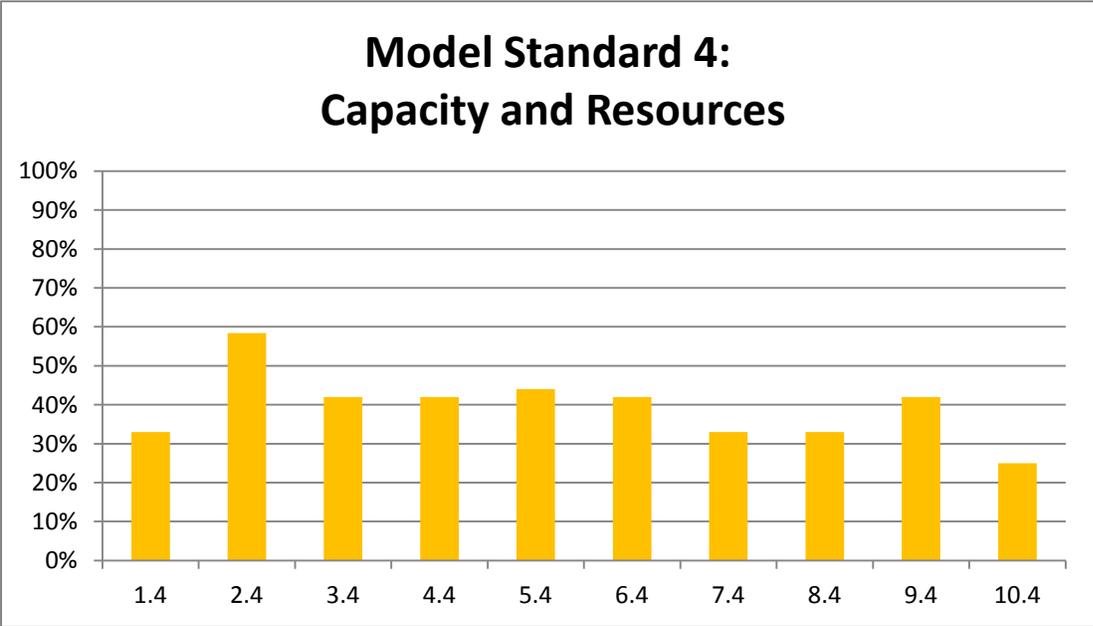


Figure 17. Summary of average performance scores by essential service for Model Standard 4.



## **Limitations**

Respondents to the assessment should understand what the scores represent and the potential data limitations. All responses represent self-assessment of the current capacity and capabilities of the West Virginia public health system. The responses to the questions within the assessment instrument are based upon processes that utilize input from diverse system participants with different experiences and perspectives. It is possible that external events and factors occurring prior to the data collection period could have impacted the assessment process and perspectives of participants. As a result, the gathering of input and the development of a response for each question during the assessment incorporates an element of subjectivity. This was controlled to the degree possible by standardizing the assessment process across all ten sessions.

It should also be acknowledged that the responses reported were only as accurate as the participants attending the assessment and the degree to which participants represented knowledge and expertise of the public health system. Every effort was made to identify and engage those partners with content expertise for specific essential service breakout sessions. All participation was voluntary.

Due to the limitations noted above, the results and findings associated with these reported assessment data should be used for performance improvement purposes. More specifically, results should be utilized for guiding overall public health improvement planning and performance improvement processes for the state. These data represent the collective performance of organizations which comprise the West Virginia state public health system. The data and results should not be interpreted to reflect the capacity or performance of any single agency or organization, including the West Virginia Bureau for Public Health.

## APPENDIX A

## Planning Committee Participants – Advisory Group

Amy Atkins	West Virginia Bureau for Public Health
Sharon Carte	West Virginia Children’s Health Improvement Plan
Dan Christy	West Virginia Bureau for Public Health
Chris Curtis	West Virginia Department of Health and Human Resources
Dr. Alan Ducatman	WVU, School of Public Health
Mary Emmett	Charleston Area Medical Center
Dr. Teresa Frazer	West Virginia Bureau for Public Health
Loretta Haddy	West Virginia Bureau for Public Health
Dave Lambert	West Virginia Medical Institute
Amanda McCarty	West Virginia Bureau for Public Health
Amy Wenmoth	West Virginia Health Care Authority
Anne Williams	West Virginia Bureau for Public Health
Dr. Richard Wittberg	Mid-Ohio Valley Health Department

## APPENDIX B

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 1**

Hersha Arnold Brown	American Cancer Society
Tom Bias	WVU School of Public Health
Dee Bixler	WV Bureau for Public Health, Epidemiology/Health Promotion
Mary Aldred-Crouch	WV Bureau for Behavioral Health & Health Facilities
Sherri Ferrell	WV Primary Care Association
Teresa Frazer	WV Bureau for Public Health
Karen Hannah	West Virginia Medical Institute
Arnie Hassen	WV School of Osteopathic Medicine
Sharon Hill	WV Bureau for Public Health, Health Statistics Center
Rebecca King	WV Department of Education
Amber Nary	WV Health Information Network
Tina Ramirez	Kanawha-Charleston Health Department
Tom Sims	Charleston, WV
Andrew Walker	WV Bureau for Behavioral Health & Health Facilities
Amy Wenmoth	WV Healthcare Authority
Cynthia Whitt	Mineral County Health Department

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 2**

Elliott Birkhead	WV Bureau for Behavioral Health & Health Facilities
Richard Crespo	Marshall University School of Medicine
Eloise Elliott	Cardiac Project, WVU
Joann Fleming	WV Bureau for Behavioral Health & Health Facilities
Teresa Frazer	WV Bureau for Public Health
Loretta Haddy	WV Bureau for Public Health, Epidemiology/Health Promotion
Debrin Jenkins	West Virginia Rural Health Association
Andrea Labik	WV Bureau for Public Health
Valerie Minor	West Virginia University, Cardiac Program
Mickey Plymale	Wayne County Health Department
Tina Ramirez	Kanawha Charleston Health Department
Charles Schade	West Virginia Medical Institute
Rebecca Schmidt	WV Bureau for Public Health, Threat Preparedness
Carolyn Stuart	WV Governor's Office – Office of Minority Affairs
Barb Taylor	WV Bureau for Public Health, Environmental Health Services
Mark Wigal	WV Bureau for Public Health, Emergency Medical Services
Tammy Hypes	WV Bureau for Medical Services

## ASSESSMENT PARTICIPANTS

### Essential Service 3

Robert Anderson	West Virginia University - Researcher
Joyce Broglio	National Association of Social Workers
Cathy Coontz	WV Bureau for Behavioral Health & Health Facilities
Kathy Cummons	WV Bureau for Public Health - Maternal, Child & Family Health
Elaine Darling	Center for Rural Health
Scott Eubank	WV Bureau for Public Health, OCHSHP - Communications
Cindy Fitch	WVU Extension, Family Health
Teresa Frazer	WV Bureau for Public Health
Ed Haver	Charleston Area Medical Center
Nidia Henderson	Public Employees Insurance Agency – Health Promotion
Debrin Jenkins	WV Rural Health Association
Cynthia Keely	WV Bureau for Public Health, OCHSHP – Asthma Program
Rebecca King	WV Department of Education, Public Health Practice
Kate Long	Charleston Gazette
Marc McCombs	West Virginia Medical Institute - Communications
Judy McGill	WV Bureau for Public Health, OCHSHP – Local Health
Ranjita Misra	WVU School of Public Health
Jason Roush	WV Bureau for Public Health
John Wilkinson	WV Bureau for Public Health

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 4**

John Ballengee	United Way
Juanita Conaway	WV Bureau for Public Health, OCHSHP – Comprehensive Cancer Program Charleston, WV
Reverend English	WV Bureau for Medical Services
Kim Fetty	Charleston Area Medical Center; WV State Senator
Dan Foster	Public Employees Insurance Agency – Health Promotion
Nidia Henderson	Beckley-Raleigh Health Department
Candy Hurd	Charleston Gazette
Kate Long	Highmark – Communications/Public Relations
Cathy McAlister	WVU School of Public Health
Ranjita Misra	Marion County Health Department
Jamie Moore	WV Bureau for Behavioral Health & Health Facilities
Kathy Paxton	WV Healthy Kids Coalition
Renate Pore	WV Governor’s Office – Office of Minority Affairs
Carolyn Stuart	Beckley-Raleigh Health Department
Stan Walls	WV Health Right
Patricia White	Mid-Ohio Valley Health Department
Richard Wittberg	

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 5**

Amy Atkins	WV Bureau for Public Health, OCHSHP – Local Health
Perry Bryant	West Virginians for Affordable Health Care
Martha Carter	Family Care Health Clinic
Debbie Curry	Robert C. Byrd Center for Rural Health
Eloise Elliott	WVU College of Physical Activity and Sport Sciences
Reverend English	Charleston, WV
Joann Fleming	WV Bureau for Behavioral Health & Health Facilities
Teresa Frazer	WV Bureau for Public Health – Deputy State Health Officer
Jane Harrington	Sisters of St. Joseph
Paul Howard	WV Division of Homeland Security
Jean Kranz	West Virginia Health Improvement Initiative
Lisa Marsh	Highmark Blue Cross Blue Shield of West Virginia
Sissy Price	Braxton County Health Department
Ron Stollings	WV State Senate
Carolyn Stuart	WV Governor’s Office – Office of Minority Affairs
Nancy Sullivan	WV Department of Health and Human Resources
Marian Swinker	WV Bureau for Public Health
Betsy Thornton	WV Bureau for Public Health, OCHSHP – Cardiovascular Program
Mark Wigal	WV Bureau for Public Health – Emergency Medical Services
Richard Wittberg	Mid-Ohio Valley Health Department

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 6**

Joe Barker	WV Bureau for Public Health, OCHSHP
Brad Cochran	WV Bureau for Public Health – Environmental Health
Nate Bowles	Society of Friends, Charleston
Chris Curtis	WV Department of Health and Human Services
Teresa Frazer	WV Bureau for Public Health
Ann Goldberg	WV Bureau for Public Health – Public Health Relations
Elizabeth Green	Mid-Ohio Valley Health Department
Loretta Haddy	WV Bureau for Public Health – Epidemiology/Health Promotion
Molly Jordan	WV Department of Health and Human Resources
Stan Mills	Cabell Huntington Health Department
Lisa Myles	Beckley-Raleigh Health Department
Tisha Reed	WV Bureau for Public Health, OMCFH – Family Planning
Cathy Slempp	Public Health Consulting
Ray Stonestreet	WV State Police Retiree
Carolyn Stuart	WV Governor’s Office – Office of Minority Affairs
Barb Taylor	WV Bureau for Public Health – Environmental Health
Steve Viglianco	FBI, Charleston

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 7**

Cindy Blake	Highmark Blue Cross Blue Shield of West Virginia
Sharon Carte	Children's Health Insurance Program
Ann Cather	WVU Student Health
Ronda Francis	Marshall County Health Department
Teresa Frazer	WV Bureau for Public Health – Deputy State Health Officer
Cindy Keely	WV Bureau for Public Health, OCHSHP – Asthma Program
Julie Monnig	Unicare
Beth Morrison	WV Bureau for Behavioral Health & Health Facilities
Peg Moss	WV Bureau for Behavioral Health & Health Facilities
Nancy O-Hara Tompkins	WVU School of Public Health
Isabel Pino	Marshall Mobile Clinics
Tina Ramirez	Kanawha Charleston Health Department
Heather Randolph	West Virginia Medical Institute
Louise Reese	WV Primary Care Association
Janet Richards	WV Bureau for Public Health – Deputy Commissioner
Ashli Slaven	Coventry Healthcare of WV
Carolyn Stuart	WV Governor's Office – Office of Minority Affairs
Anne Williams	WV Bureau for Public Health - Maternal, Child, Family Health
Gina Wood	WV Bureau for Public Health, OCHSHP – Diabetes Program
Chris Zinn	Hospice Council of West Virginia

## ASSESSMENT PARTICIPANTS

### Essential Service 8

Rachel Abraham	WVU School of Public Health
Amy Atkins	WV Bureau for Public Health, OCHSHP – Local Health
Dee Bixler	WV Bureau for Public Health – Epidemiology/Health Promotion
Laura Boone	WV Higher Education Policy Commission
Keith Burdette	WV Department of Education
Kristen Childress	WV Bureau for Public Health, OCHSHP – Local Health
Richard Crespo	Marshall University School of Medicine
Chris Curtis	WV Department of Health and Human Resources
Kim Fetty	WV Bureau for Medical Services
Teresa Frazer	WV Bureau for Public Health – Deputy State Health Officer
Sam Hickman	National Association of Social Workers
Debrin Jenkins	WV Rural Health Association
Karen McClain	Brooke County Health Department
Richard Meckstroth	WVU School of Dentistry
Stephanie Moore	WV Bureau for Public Health, OCHSHP – Health Promotion & Chronic Disease
Duane Napier	WV Center for Nursing
Kent Nowvskie	WV DHHR – Human Resource Management
Cynthia Persily	WVU School of Nursing
Gil Ramirez	WVU School of Public Health
Janet Richards	WV Bureau for Public Health
Melody Rickman	Mercer County Health Department
Dana Singer	Mid-Ohio Valley Health Department
Joyce Spiroff	WV Bureau for Public Health
Carolyn Stuart	WV Governor’s Office – Office of Minority Affairs
Louise Veselicky	WVU School of Dentistry

## ASSESSMENT PARTICIPANTS

### Essential Service 9

Adam Baus	WVU Office of Health Services Research
Stacy Brown	Barboursville Veterans Administration
David Campbell	WV GO Help/WV Primary Care Network
Sonia Chambers	WV Healthcare Authority
Sarah Chounaird	CCWV
Dan Christy	WV Bureau for Public Health – Health Statistics Center
Judy Crabtree	Kanawha Coalition for Community Health Improvement
Kathy Cummons	WV Bureau for Public Health – Maternal, Child, Family Health
Chris Curtis	WV Department of Health and Human Resources
Teresa Frazer	WV Bureau for Public Health, Deputy State Health Officer
Loretta Haddy	WV Bureau for Public Health – Epidemiology/Health Promotion
Arnie Hassen	WV School of Osteopathic Medicine
Charlene Hickman	WV Bureau for Public Health – Minority Health
Manfred Hollans	Charleston, WV
David Lambert	West Virginia Medical Institute
Valerie Frey-McClung	WV PRC
Rose Ann Michaels	Fayette County Health Department
Julie Palas	Governor’s Office – Grant Administration
Isabel Pino	West Virginia Children’s Health Project
Louise Reese	Primary Care Association
Tom Sims	WVU School of Public Health
Andrew Walker	WV Bureau for Behavioral Health & Health Facilities
Richard Wittberg	Mid-Ohio Valley Health Department
Jessica Wright	WV Bureau for Public Health, OCHSHP – Health Promotion & Chronic Disease

## **ASSESSMENT PARTICIPANTS**

### **Essential Service 10**

Michael Adelman	WV School of Osteopathic Medicine
Trina Bartlett	WVU School of Nursing
Lesley Cottrell	WVU Department of Pediatrics
Geri Dino	WVU School of Public Health
Jim Doria	WV Bureau for Public Health – Health Statistics Center
Mary Emmett	Charleston Area Medical Center – Outcomes Research
David Felton	WVU School of Dentistry
Jan Fox	Marshall University
Teresa Frazer	WV Bureau for Public Health
Kelly Gurka	WVU School of Public Health
Alana Hudson	WV Bureau for Public Health – Epidemiology/Health Promotion
Calvin Kent	Marshall University
Dana King	WVU School of Medicine, Department of Family Medicine
Michael Mills	WV Bureau for Public Health – Emergency Medical Services
Jim Nemitz	WV School of Osteopathic Medicine
Stephanie Southall	WV Bureau for Behavioral Health & Health Facilities
Carolyn Stuart	WV Governor’s Office – Office of Minority Affairs
Andrew Walker	WV Bureau for Behavioral Health & Health Facilities
Richard Wittberg	Mid-Ohio Valley Health Department

## APPENDIX C

# West Virginia Bureau of Public Health State Public Health System Assessment November 27, 2012

## What it is . . .

The West Virginia Bureau for Public Health is conducting an assessment with nearly 300 partners from across the state in a series of meetings from November 27<sup>th</sup> to December 6<sup>th</sup>. The purpose of the assessment is to evaluate how well essential public health services are being delivered in West Virginia. You have been identified as a key stakeholder and subject matter expert for participation in a half-day assessment meeting as part of this process. This invitation only assessment will entail using a CDC assessment tool in a very hands-on, interactive process. The data derived from the process will provide a foundation and direction to the State on improving West Virginia's capacity and capability to protect and promote the health of all West Virginians. Purdue Healthcare Advisors have been contracted by the West Virginia Bureau for Public Health (BPH) for technical assistance to plan and facilitate this assessment. Additional materials will be provided prior to the assessment for those who register.

## Agenda

- 8:00 am Registration and Continental Breakfast
- 8:30 am Welcome and Orientation
- 9:00 am Essential Service 1: Monitoring Health Status
- 12:00 pm Evaluation and Adjourn (box lunch provided)

## West Virginia Bureau for Public Health Mission

*Helping shape environments within which people and communities can be safe and healthy.*

## When and Where

### Date

November 27, 2012  
8:00 am – 12:00 pm

### Location

Centennial Salon D  
Holiday Inn & Suites Conference Center  
400 Second Avenue  
Charleston, WV 25303  
(Free parking available)

### Registration *(by invitation only)*

[https://purdue.qualtrics.com/SE/?SID=SV\\_3gv6SuQewCPldt3](https://purdue.qualtrics.com/SE/?SID=SV_3gv6SuQewCPldt3)

**Deadline to register is November 20, 2012**

### Lodging

**If lodging is needed please indicate this when completing the online registration.**



## APPENDIX D



## APPENDIX E

## AGENDA

### November 27, 2012

8:00 am – 12:00 pm

Essential Service 1: Monitoring Health Status to Identify and Solve Health Problems

12:30 pm – 4:30 pm

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

### November 28, 2012

8:00 am – 12:00 pm

Essential Service 3: Inform, Educate and Empower People About Health Issues

12:30 pm – 4:30 pm

Essential Service 4: Mobilize Community Partnerships and Action to Identify and Solve Health Problems

### November 29, 2012

8:00 am – 12:00 pm

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

12:30 pm – 4:30 pm

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

### November 30, 2012

8:00 am – 12:00 pm

Essential Service 7: Linking People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable

12:30 pm – 4:30 pm

Essential Service 8: Assure a Competent Public and Personal Healthcare Workforce

### December 6, 2012

8:00 am – 12:00 pm

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

12:30 pm – 4:30 pm

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



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