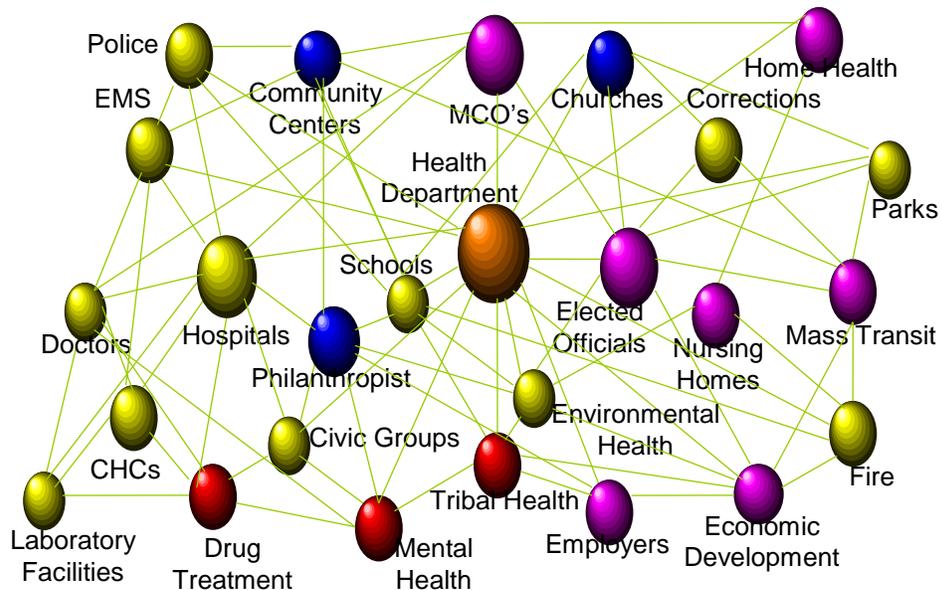


# ***Assessment of the Health System in New Mexico***



## **Final Report**

Prepared by:  
**Institute for Public Health  
University of New Mexico**

**For the New Mexico Department of Health  
October 2003**

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## **I. EXECUTIVE SUMMARY**

### **A. Background**

This report describes the first-ever systematic assessment of New Mexico's health system.\* Beginning in December 2002 and continuing through August 2003, the state's overall health system and the local systems operating in 21 counties were examined. Nationally developed performance standards were utilized to gain an understanding of the system's effectiveness and to see if the elements exist to assure the health of the people in New Mexico.

In late summer 2002, the New Mexico Department of Health (DOH) contracted the University of New Mexico Institute for Public Health (IPH) to initiate and lead the assessment process. The project was funded through the New Mexico Department of Health, Center for Disease Control (CDC) Cooperative Agreement on Public Health Preparedness and Response to Bioterrorism.

The health systems to be assessed were defined as all public, private and voluntary entities that contribute to health and well being, including the delivery of health services.

New Mexico's health system has multiple components: agencies of state government including the Departments of Health, Environment, Human Services, Children Youth and Families, and Aging, the Indian Health Service, tribal health entities, agencies of county and local government, hospitals and integrated health care delivery systems, laboratories, private health agencies, advocacy groups, universities, and others. (See "Egg Diagram" on cover of this report.) In order to assure a healthier New Mexico, all these components must work together.

New Mexico's performance assessment took place within the context of the 15 years of national efforts to define the components of a fully functioning public health system and to develop performance standards to measure the capacity of agencies, organizations, and communities to provide those components. The National Public Health Performance Standards Program at the Centers for Disease Control and Prevention (CDC) developed specific instruments to measure performance against these standards. The instruments are organized around the Ten Essential Public Health Services (see box on next page), a well-established and nationally accepted framework that outlines what a health system should optimally provide.

### **B. Methodology**

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\* The assessment addresses the health system in its broadest sense. In the language of the assessment tools "public health system" is used. This phrase, however, is commonly construed to refer to public health agencies and their activities. Such agencies, however, are only a part of the broader system being assessed. Therefore, the more general designation, "health system" is used in this report.

The assessments health systems occurred in several phases. Beginning in the spring 2002, Albuquerque Area Indian Health Service (AAIHS) initiated the assessment process in the state by assessing the ability to serve Native Americans. This initial assessment was followed in December 2002 when the Department of Health began Phase One of its assessment, which looked at the performance of the system statewide. Phase Two was a series of local system assessments conducted at the county level, which concluded in August 2003. Phase Three concluded the process with a pair of meetings on at the end of August to review the Native American, state and local data and develop preliminary recommendations. Representatives from all the assessments attended the Phase Three meetings.

In total, over 600 people representing a broad base of the health system participated in the Native American, state and local assessments. Using qualitative methods, participants attended meetings to score system performance against the optimal standards, thereby identifying areas of relative strength and weakness.

The structured assessment process is designed to emphasize performance of the collective system. It does not specifically assess the performance of individual agencies, such as a Department of Health. It is possible, therefore, that agencies may individually function within the domains of their responsibilities, and still the collective system may or may not be working effectively.

#### **Ten Essential Services**

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

### **C. Results of state and local assessments**

#### **1. Phase One: State Assessment**

Following the statewide assessment in December 2002 an Interim Report highlighted some essential service areas as relative strengths. Such areas include assessment of health status, investigation and control of infectious diseases, laboratory services, provision of primary care safety net services, and EMS. Other areas, however, scored poorly.

General concerns regarding the overall statewide system included the following. The public health enterprise is fragmented and piecemeal. System components link poorly with one another and work in relative isolation. Only a few areas of service function under a coherent, statewide system.

- There are no processes for statewide planning and prioritization of health issues or needs.
- Health related policy is developed in a fragmented manner without order or coherence. There is no collaborative mechanism to develop overall policy for New Mexico.
- There is little evaluation of outcome or effectiveness of program or assessment of impact on health status.
- There is inadequate planning to assure numbers and skills for the professional workforce.
- There is no coordinated planning to assure that public health practice is supported by the best available science and research.

TAs concluded in the Interim Report concluded, the current system's potential for effectively improving health status or reducing disparities is limited.

## 2. Phase Two: Local Assessments

The local assessments, which were completed in the months that followed the Interim Report, generally support that report's conclusions. As expected, there was considerable variation from one county to another, meaning that follow-up activities will have to be specific for each county. In many instances, the counties rated their own performances somewhat higher than the scores for the statewide assessment (see graphs in Appendix A). The same issues that appeared in the statewide system, however, reappeared at the county level.

In addition to confirming the lack of a functioning system, the local assessments emphasized the negative consequences of the "silo" phenomenon whereby agencies and organizations, both state and local, are internally accountable and may not respond to locally perceived needs and priorities.

Most expressed concern about the system weaknesses identified and voiced strong support for system improvements. Many of the problems identified can be traced to a lack of system-wide planning, evaluation, and accountability. A repeated observation was the need for a comprehensive statewide health plan with improvements in structure and organization. The Ten Essential Health Services were seen to provide a useful way of organizing what needs to be delivered by the state's health infrastructure.

The recent collaboration among cabinet secretaries of the state's agencies was praised as an encouraging start on reforming the process. This does not substitute for introducing structural elements that pull the system into coherence, accountability beyond the agencies, and accountability for improved outcomes.

### 3. Phase Three: Final Meetings

On the end of August, people who had participated in the assessments met to review summaries of the results of the Native American, state and local assessments and the established performance standards. Several themes were identified as fundamental underpinnings to planning for system improvement:

- Address the social determinants, including poverty and racism, that underlie many of the state's health statistics and disparities,
- Strengthen the alignment between state and local systems on priority health problems, and
- Strengthen evaluation mechanisms to understand what effectively improves health.

Participants discussed priorities and identified recommendations for system improvements (see Appendix C). This information should be viewed as a beginning to an ongoing planning process. More input, time, and analysis are necessary to prioritize and align improvements that can yield the strongest improvements for the system.

#### **D. Recommendations**

##### Recommendations for State Agencies:

- Identify or create a structure (not a bureaucracy) that represents the major components of the greater health system as well as the public's interests in order to develop a coherent statewide system and identify priorities based on measures of health status and needs, planning, and evaluation.
- Find avenues for state agencies and programs to be locally accountable.
- Develop a communication mechanism so state and local system improvements are known among all system participants.
- Continue and enhance the current efforts by state agencies to plan and work together.
- Focus on cultural competency within the Department of Health and in health care settings.
- Acknowledge and address the fundamental importance of social conditions including poverty and racism as determinants of health status, outcomes, and disparities.

##### Recommendations for District Public Health Offices, health councils and others locally:

- Offer the assessment in counties where it has not yet been used.
- Provide assistance to communities to develop planning capacity. Work with communities to review assessment results and build a process for system improvements. Use the county-specific results to initiate local action.
- Strengthen local authority for making decisions and setting priorities.
- Repeat the assessments periodically as a measure of change in the health system.

##### Recommendations for Comprehensive State Health Planning:

- Develop and include a shared vision for health in New Mexico.
- Use the Ten Essential Health Services as headings for organizing what the state's health infrastructure needs to deliver.
- Preserve and enhance existing areas of infrastructure excellence, including systems that monitor overall health status, respond to outbreaks and acute problems, the State Laboratory and forensic services, emergency medical services, and support for primary care systems.
- Include goals for improving measures of health status in the population and create a context of ethics and urgency in addressing health disparities.
- Include in the plan effective, sustainable strategies for access and financing of personal health care services
- Emphasize primary prevention as well as secondary and tertiary prevention.
- Include in the plan necessary infrastructure and planning for the following:
  - a. comprehensive health policy focusing on health and health care priorities
  - b. evaluation of systems performance targeted at goals and priorities.
  - c. workforce development
  - d. an agenda for health system research

#### **D. Conclusion**

The assessments clearly indicate a need for system wide improvements in order to serve the people of New Mexico in the best possible way and ultimately improve health status. While the system functions adequately in some areas, it hardly functions at all in others. Many of the problems can be traced to a lack of comprehensive, system wide planning, evaluation, and accountability, particularly between state agencies and local agencies and service organizations. Areas of needed improvement include infrastructure, organization, and basic operations to improve the overall health system. Improvements should aim at better alignment of resources and priorities. Current consideration of a new comprehensive state health plan is timely and provides opportunity to improve and better align the health system.

## **II. BACKGROUND OF THE ASSESSMENT PROCESS**

New Mexico's performance assessment initiative takes place within the context of the last 15 years of national efforts to define the components of a fully functioning public health system and to develop performance standards to measure the capacity of agencies and communities to provide those components.

In 1988, the Institute of Medicine (IOM) Report, The Future of Public Health, outlined and defined the three core functions of public health as assessment, policy development, and assurance. In the late 1980s, the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (DHHS) funded the Faculty-Agency Forum. The Forum published a report with recommendations on linking academia and practice, including the need for a shared understanding of the public health competencies needed by practitioners to fulfill the core functions. Four core work groups outlined both universal and discipline-specific public health competencies, and recommended the creation of an oversight group to foster implementation of the recommendations. A follow-up steering committee became The Council on Linkages, with representatives from the American Public Health Association (APHA), the Association of Schools of Public Health (ASPH), HRSA, the Centers for Disease Control and Prevention (CDC), the Association of State and Local Health Officers (ASTHO), the National Association of County and City Health Officials (NACCHO), and others.

While the core functions of assessment, policy development, and assurance were a useful framework in public health, the terms themselves were not uniformly understood by policy-makers, public health professionals, and the public. Various groups continued to use different terms and concepts, causing confusion among practitioners. In 1994, recognizing the need for a common language, representatives of the practice community participated in the Public Health Functions Work Group and prepared a consensus document on the Ten Essential Services of Public Health. This document was approved by the Public Health Functions Steering Committee.

Since that time, the DHHS Office of Disease Prevention and Health Promotion has funded a number of Public Health Foundation initiatives to strengthen the public health infrastructure and to support the incorporation of the Ten Essential Public Health Services. The language of core functions, Ten Essential Services, and corresponding core competencies began to be used more widely and consistently. The Ten Essential Services and the core public health competencies were incorporated in national reports and activities such as The Public Health Workforce: Agenda for the 21<sup>st</sup> Century, and used in requests for proposals for the HRSA Public Health Training Centers and the CDC Public Health Preparedness Training Centers.

Recently, HRSA funded the Council on Linkages Competencies Project. A work group reviewed 30 documents over a one-year period, received over 1000 public comments, revised the list of public health competencies, and linked it to the Ten Essential Health Services. This new cross-referenced list was adopted and published in April 2001. (Go to <http://www.trainingfinder.org> for list of related resources.)

The CDC Public Health Practice Program Office (PHPPO), National Public Health Performance Standards Program used the Ten Essential Health Services framework for its performance measurement work and developed state, local and international public health system assessment tools. The tools assess performance of the overall public health system, using model standards that describe an optimal level of performance and supports a process of quality improvement.

Over the past few years, seven states across the country pilot-tested the performance assessment tools, and some are now implementing strategies to address the identified gaps. For instance, the Florida Department of Health developed a committee to address workforce quality issues. The planning committee for the assessment conducted in Palm Beach County, Florida used the assessment results to develop local public health system priorities and an action plan. The State of New York conducted the local performance assessment in all 57 counties and New York City and is using the information to create a statewide public health improvement plan.

At this time, 900 sites have piloted the assessment instruments. Ten states, including New Mexico, 41 international sites and 3 Indian Health Service sites have completed assessments to determine their capacity to provide the Ten Essential Health Services. New Mexico used both the state and local performance instruments to assess the combined capacity of its local and state public health systems.

### **III. METHODOLOGY**

#### **A. Native American Assessment**

The public health system assessment process in New Mexico began in February 2002 with the Albuquerque Area Indian Health Service (AAIHS). The AAIHS was interested in assessing its ability to serve Native Americans. The purpose was two-fold. First, budget issues at Indian Health Service (IHS) and tribal withdrawals of all or portions of their IHS funding under Public Law 93-638 have necessitated the increased involvement of partners in the provision of public health services to Native Americans around the country, the system becoming increasingly de-centralized. Second, the IHS was interested in conducting health capacity assessments in many of its area offices. AAIHS, which serves most of New Mexico as well as two tribes in Texas and Colorado, was willing to serve as a pilot site for the first assessment.

The AAIHS and the New Mexico Department of Health DOH conducted the assessment process, which was completed in March through May with meetings scheduled every other Thursday. Two related Essential Services were addressed at each meeting, using the State Public Health System assessment instrument. There were approximately twenty participants completing the assessment. While this assessment process was not part of the subsequent contract between DOH and IPH, it provided opportunity for tribal and IHS partners in the New Mexico health system to become familiar with the Ten Essential Services and the performance assessment process. Some of the tribal assessment participants later participated in the DOH assessment process.

The lessons from the AAIHS assessment, including what did and didn't work in the process, were utilized in the planning and implementation of the process for the state and local assessments.

#### **B. State and Local Assessment Process**

In late summer 2002, the New Mexico Department of Health (DOH) contracted the University of New Mexico Institute for Public Health (IPH) to initiate and lead a process to assess the state and local public health systems in New Mexico. The contract was funded through the New Mexico DOH/CDC Cooperative Agreement on Public Health Preparedness and Response to Bioterrorism. The public health systems to be assessed were defined as all public, private and voluntary entities that contribute to the delivery of public health services. This included all entities that contribute to the health and well being of a community.

The assessment process was conceptualized in three phases: Phase One, an assessment of the State Public Health System (SPHS), Phase Two, assessments of the Local Public Health Systems (LPHS), and Phase Three, a review of the data from the state and local assessments of each Essential Service, and identification of priorities to strengthen the health system.

In the fall 2002, an Advisory Committee was formed to guide the assessment process. Representatives from the NM DOH including the Division Director, Deputy Directors, Office of Epidemiology, and IPH were part of the Committee. This Committee provided oversight for the three phases.

### **C. Phase One: State Public Health System Assessment**

An invitation list was developed for the State Public Health System (SPHS) assessment meeting held December 5 and 6, 2002. The people invited to participate included representatives from a diverse group of agencies, organizations, hospitals, universities and individuals that represent the SPHS. A total of 98 individuals were invited to participate. Of the 98 invitations, 79 participated.

The two-day session began with an overview of the assessment instrument, a review of the Ten Essential Health Services, and an explanation of “health system” and the partners included in the system. After the background information was provided, participants were divided into five groups to begin the assessment process.

Each of the five groups had approximately 15 participants. Each of the five groups was assigned two of the Essential Health Services. Participants were assigned to groups based on their areas of expertise and in a manner to promote diversity of views. Using the State Public Health System instrument from the CDC National Public Health Performance Standards Program, each group was given approximately three and a quarter hours to complete the assessment for each Essential Service.

A facilitator, scribe, and expert were assigned to each of the five groups. The facilitator’s role was to assure that the group completed the assessment in the time allowed and to encourage the participation of all participants. The scribe recorded the scores on a spreadsheet in a laptop computer and collected participant comments about the topics they were scoring. The expert was a person from outside the state who had experience in the assigned public health Essential Service and offered reflections about the Essential Service during the session. The expert also clarified questions and provided definitions and explanations for the questions. Experts also later provided written reports about their observations.

### **D. Phase Two: Local Public Health System Assessment**

After the state assessment, District Directors and their representatives were included in the Advisory Committee meetings to prepare for the local assessments. Each of the four DOH Public Health Districts was asked to develop a plan to conduct Local Public Health System (LPHS) assessments in their Districts. Each District was given the flexibility to develop a plan that made sense to the District given existing priorities and plans in their counties. The unique and diverse plans for each District are described in the District sections below. The IPH worked with each District to support meeting logistics, supplies, printing, mailings, and, when needed, per diem and travel expenses for participants.

To prepare for the local assessments, orientation sessions were held in each of the four Districts. The orientation consisted of the background of the development of the Ten Essential Health Services and Model Standards; the goals of the National Public Health Performance Standards Program; discussion about who should participate in the assessment; and guidance about using the assessment instrument including the roles needed to complete the assessment process such as facilitators, scribes and experts.

Just as in the SPHS assessment, facilitators were used to assure that the group completed the assessment in the time allowed and to encourage the participation of all participants. Scribes recorded the scores on a spreadsheet in a laptop computer and collected participant comments about the topic they were scoring. The expert was a person from DOH or the IPH who had experience and knowledge about the topic and added information as needed to the assessment process.

Concurrently with the implementation of this system assessment process, assessments were being developed and implemented to determine needs, gaps and barriers to prepare for a public health emergency. These assessments were also being conducted through funding from the New Mexico DOH/CDC Cooperative Agreement on Public Health Preparedness and Response to Bioterrorism. In order to minimize duplication and maximize the use of the public health system assessment data, the CDC survey instrument was reviewed (specifically Essential Service #2: Diagnose and Investigate Health Problems and Health Hazards in the Community) to determine whether data could be used to meet the public health emergency assessment needs. It was determined that data from Essential Service #2 could be used for the public health emergency assessment process. To complete the needs of the public health emergency assessment, four supplemental questions were added to Essential Service #2 for participants to answer.

In total, over 500 people representing a variety of players in the public health systems of 21 counties participated in the local assessments. The following descriptions reflect the diverse plans each District developed and implemented. The sequence of the descriptions that follow reflects the sequence of the implementation.

## 1. District IV

The six members of the District IV Health Promotion Team were charged by the District Director with implementing the assessment of the LPHS in each of the nine counties in the District. The Team developed a broad based invitation list. Participants were invited to a two-day assessment meeting. Follow-up postcards were also sent. At the assessment meetings, after a brief overview of the instrument and discussion about the health system, all participants worked together to assess all Ten Essential Health Services using the LPHS Assessment Instrument.



In April and May 2003, District IV completed assessments in nine counties. The counties include: Chaves, Curry, DeBaca, Eddy, Guadalupe, Lea, Lincoln, Quay and Roosevelt.

Over 100 people participated, representing the variety of entities that contribute to the health system.

Members of the Health Promotion Team facilitated the assessment and documented the qualitative comments. Participants voted using the color code method (described in subsection #5, below), and marked their vote in their assessment instrument. After the assessment was complete, members of the Health Promotion Team compiled the votes and submitted them for entry into the CDC website.

Currently, results have been sent to all participants. Plans have been made for Health Promotion staff to attend local health council meetings over the next few months to discuss the results.

## 2. District II

The multi-disciplinary teams from each of the nine counties in District II attended the orientation session and then organized and implemented the assessments. After the multi-disciplinary team developed a broad-based invitation list, a letter was mailed to the potential participants inviting them to a two-day assessment process. Similar to District IV, an overview of the instrument and a discussion about the health system occurred before participants began using the LPHS assessment instrument to assess the system. In the larger counties like Taos and Santa Fe, participants were divided into five groups to assess two essential services per group. In smaller counties such as Harding, participants assessed all Ten Essential Health Services together.



Between April and June 2003, assessments were completed for nine counties. The counties include: Colfax, Harding, Los Alamos, Mora, Rio Arriba, San Miguel, Taos, Santa Fe, and Union. Over 200 people representing a variety of organizations, agencies and individuals who contribute to the public health system participated in the assessment. Members of the multi-disciplinary team or District staff facilitated the assessment and served as scribes to document the qualitative comments and to record the votes. Experts were also utilized from within the District or DOH.

Counties have begun to distribute and discuss the assessment results. Some discussions will occur at health council meetings and others at meetings scheduled with participants.

## 3. District III

The District III Epidemiologist and a Health Promotion Team member were assigned to organize the local assessment for Dona Ana County. The decision was made to begin the assessment process in Dona Ana County, as it is the most populated in the District. Other counties would be assessed at a later time. An administrative assistant was assigned to the project and a team of six assisted with project logistics and details. In addition to the orientation



session held in June, videotape was made of the session for people who were unable to attend.

The assessment was conducted on July 9 and 10, 2003. After discussions with those who participated in the State Assessment and local assessments in other counties, a decision was made to conduct the assessment over two days, with five Essential Services covered each day. Different participants were invited to participate from 8:30am-2:30pm on each day. This method was chosen to not overwhelm attendees and ensure participation. Using a previously generated list of potential participants, the team assigned participants to those services that best met their areas of expertise. Initial “contact” calls were made to every participant. The purpose of the call was to extend a personal invitation, answer any questions, and verify the correct mailing address and FAX number. Following the calls, participants were mailed a formal invitation with background information on the health system assessment and the questions from the Essential Service(s) to which they were assigned. Follow up “reminder” postcards were sent to all those who received a packet. Upon confirmation of their attendance, participants received a confirmation postcard. Over 100 people attended the assessment over the two days.

A District employee has been assigned by the District Director to follow-up on the assessment results along with several other system players who volunteered.

#### **4. District I**

Local assessments were conducted in two counties: Bernalillo and Sandoval. The Sandoval County assessment was coordinated by the Sandoval Alliance, a comprehensive Health Council. This was the only assessment implemented by a Health Council. The assessment was held on July 17 and 18, 2003. The Alliance organized the assessment meeting and invited a wide range of participants. Similar to the other assessments, after a brief orientation to the public health system and to the survey instrument, participants were divided into five groups to assess two Essential Services each. Approximately seventy-five participants attended. Facilitators, scribes and experts were from DOH and IPH.



The Bernalillo County assessment was coordinated through a special Advisory Committee. Prior to the commitment to conduct an assessment, the District Director held several meetings with people from Bernalillo County who had participated in the SPHS assessment. The District Director wanted to determine along with colleagues if there was interest to conduct a local assessment including a commitment to follow-up on the results. After several meetings, the Advisory Committee decided to proceed with the assessment, which was scheduled for August 5 and 6. Approximately ninety-five participants attended and were divided into five groups that assessed two Essential Services each. A keynote speaker was invited to make introductory and concluding remarks at the assessment. Facilitators from outside DOH were identified and compensated for their time. The scribes were people from within the District. Experts were provided by the IPH.

A follow-up meeting is in the process of being scheduled with the Advisory Committee and other participants who expressed an interest during the assessment.

## **5. Scoring and Analysis**

The same scoring methodology was used for all the assessments. In their groups, participants had (brief) opportunity to discuss the question, use the glossary as needed, and use the expert for clarification (if available) and then vote. Each participant used colored cards to register his/her vote. A red card was used if no more than 25% of the activity described in the question is met within the health system and this translated to “no” on the scoring sheet; a yellow card if the activity was done 26-50% of the time or a “low partial”, a blue if the activity was done 51-75% of the time or a “high partial” or a green card if the activity was done greater than 75% of the time or a “yes”. Also a white card was available that indicated the person needed more information and alerted the facilitator that more time was needed for discussion. These colored descriptions were placed on the walls of the room for participant reference.

The scribe recorded the number of votes at each level of response for each question. The Excel spreadsheets were given to the IPH to enter the votes, demographic information, and participant information into the CDC website for analysis. The analysis from CDC resulted in a numerical score based on the votes.

The data analysis reduced the 882 state assessment questions and the 693 local assessment questions in the assessment tool into summary scores for each of the 10 Essential Services, the indicators within each Essential Service and the stem questions within each indicator. The indicators reflect the Model Standards for public health within each Essential Service. The total score for each of the Essential Services is a possible 100. A score of 100 would indicate that the “gold standard” for public health had been perfectly achieved.

## **6. Phase Three: Final Meetings**

On August 26, 2003, a meeting was held including participants from the state, Native American and local assessments. Ninety-three people attended. Of those attending, 38 participants (40%) were from agencies or organizations other than the Department of Health. The purpose of the meeting was to review the assessment findings and to identify key priorities to strengthen the New Mexico health system and contribute to the development of a state health plan. The words “health system” were specifically chosen instead of “public health system” to use language that is perceived as being more inclusive. Results from this meeting will be recommended for inclusion in the state health plan that is currently being considered.

At the meeting, the assessment processes used in the Native American, State, and Local assessments were reviewed including the limitations of the process. The common themes from the assessments and details by Essential Service were provided. A panel of state

agency representatives was included to offer perspective about how state agencies could do a better job of working together and strengthen the health system as a result.

After this background was provided, five groups were formed representing two Essential Services per group. Participants were assigned to groups that best represented their area of expertise. The groups reviewed the state Model Standards and results for the assigned Essential Services. Based on this review, two priorities per Essential Service and the key partners to help DOH implement the priorities were identified. Guidance was given to assist with the prioritization including achievability and what is most important and lasting. Facilitators and scribes from different agencies within the health system were identified and trained to work with the groups.

The following day on August 27<sup>th</sup>, there was a meeting of DOH, Public Health Division employees. They reviewed the priorities identified on the 26<sup>th</sup> and in small groups, developed further action steps to put the priorities into operation.

## **7. Limitations**

There are several limitations worth noting in this process. Although over 600 people participated in the state, Native American and local assessments, there were obvious participant omissions during the assessment process. Despite considerable outreach efforts, adequate representation and expertise was consistently lacking from hospitals, physicians, faith-based organizations and state agency representation beyond the DOH. Known barriers to participation included the amount of time required to participate and scheduling conflicts, and not being invited to participate. The results of the assessment reflect the opinions of the individuals involved in the assessment. Not always having all the people with the necessary information participating in the assessment made it difficult to knowledgeably complete all the questions in the assessment.

Participants found it difficult to think as a “public health system”. The definition of the public system often needed to be re-visited and discussed because of uncertainty as the assessment progressed. Part of the confusion related to how the New Mexico Department of Health and the Districts are organized.

The length and the complexity of the tool were discouraging to some participants. Questions were left to interpretation of the people present and resulted in concerns about the comparability of data obtained across separate counties.

While participants in the process found using the assessment instrument to be laborious, most nevertheless found the Ten Essential Health Services a useful way of organizing the assessment and the performance standards a useful set of goals for the system.

While there are these obvious limitations with the survey instrument, this assessment opportunity opens the door to build public health capacity. This was the first time that a comprehensive assessment has been done at the state and local levels using the Model Standards and nationally standardized performance tools. Thinking as a system has

obvious positive implications to strengthen the health system and to build capacity at the state, tribal and local level. Additionally, the increased awareness of the existence of the Ten Essential Services and Model Standards is a step in the right direction to strengthen our health system.

## **IV. ASSESSMENT RESULTS**

Overall, the scores for New Mexico are low, as found in many other states that have conducted the assessments. There are multiple ways to analyze and view the data from the assessments. Each view provides information necessary to develop improvements to strengthen the system. This section includes:

- A. An overview of the combined scores for each Essential Service from the state, local and Native American assessment
- B. Details and scores for each Essential Service from the state, local, and Native American assessments
- C. Common themes from the qualitative participant comments
- D. The priorities recommended by participants on August 26

### **A. Overview of Combined Scores of State, Local and Native American Assessments**

To gain a broad sense of the strengths and weaknesses in the overall public health system, the scores from the State, Local and Native American assessments were averaged to determine a high, medium or low ranking. See Figures in Appendix A (the combined average scores). The three highest scores are rated high, the next three ranking scores as intermediate and last four in the low group. While it is understood that a score of 100 indicates perfect achievement of the model standard, the high, intermediate and low criteria were utilized to gain a perspective on the results for New Mexico. The specific scores for the State, Native American, and each of the Local Assessments are in Appendix A. Review and utilization of specific results for an assessment are important since aggregated scores can obscure important individual assessment results. As plans are made for improvement within in the state or local systems, the individual results should be reviewed, discussed, and understood.

#### High ranking Essential Services:

Essential Service #2: Diagnose and investigate health problems and health hazards in the community

Essential Service #3: Inform, educate, and empower people about health issues

Essential Service #7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

#### Intermediate ranking Essential Services:

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

Essential Service #4: Mobilize community partnerships to identify and solve health problems

Essential Service #6: Enforce laws and regulations that protect health and ensure safety

#### Low ranking Essential Services:

Essential Service #5: Develop policies and plans that support individual and community health efforts

Essential Service #8: Assure a competent public and personal health care workforce  
Essential Service #9: Evaluate effectiveness, availability, and quality of personal and population-based health services  
Essential Service #10: Research for new insights and innovative solutions to health problems

## **B. Details and Scores For Each Essential Service**

The following information is based on the quantitative scores and qualitative comments from the State, Native American and Local assessments. The quantitative scores for the assessments are noted at the end of each Essential Service. The scores for the local assessments have been aggregated.

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

**This service includes the assessment of statewide health status and its determinants; attention to the health status of specific groups; identification of community assets and resources, which support promoting health; utilization of technology to interpret and communicate health information; and collaboration in integrating and managing public health related information systems.**

#### **State Assessment Summary**

The State Public Health System (SPHS) has relative strength in its statewide capacity for assessment of health status and determinants. It does less well identifying community assets and resources, communicating health information to diverse audiences or locally to communities, and managing the components of the monitoring process as an integrated information system.

Highlights include:

- A strong SPHS surveillance system exists to measure the population's health status. This system could be improved by measuring a wider range of data elements that coincides with community needs.
- A state health profile exists and reports trends in health status and could be used more to identify emerging health problems.
- A standard set of health indicators exists to describe the health of the state's population but the information does not always coincide with community needs.
- Support to local public health systems and other state partners to prepare and publish local health data for the media and health planners could be much stronger.

- The SPHS rates low in efficiently utilizing and sharing its resources to monitor health status and identify health problems in the state. Data are submitted and surveys performed but there were concerns about their not being effectively utilized.
- Technology exists in the SPHS to monitor statewide health resources.

#### Local Assessment Summary

Local participants are aware of some of the data and the data systems that exist in the state but perceive barriers to accessing the data. Local participants believe state data are poorly disseminated and interpreted to local entities. Improvement is needed to compare data to other areas/populations and monitoring process toward health related objectives. A community health assessment has been done in some communities, but if participants were not on a health council there was general lack of awareness of its existence or intent to complete one.

#### Native American Assessment Summary

- A Native American health status report does not exist.
- Adequate technical assistance is needed.

#### Essential Service Score Ranking from Quantitative Data

State Score: 33 out of 100 (third highest ranked Essential Service)

Local: 45 out of 100 (third lowest ranked Essential Service)

Native American: 25 out of 100

### **Essential Service #2: Diagnose and investigate health problems and health hazards**

**This service includes: epidemiologic investigation of disease outbreaks, injuries, and patterns of infectious and chronic diseases, population-based screening, case finding, investigation and the scientific analysis of health problems.**

#### State Assessment Summary

Managed largely by the Department of Health, Public Health Division, the State Community Health System does particularly well in terms of investigation of outbreaks, patterns of infectious and chronic disease, injuries, and other adverse health conditions. It works effectively with the State Laboratories and other laboratories. Capacities for population-based screening and case finding, investigation and analysis are less developed.

Highlights include:

- NM maintains a strong surveillance system and reporting system that recognizes and reports threats to public health.
- Strong collaboration occurs with private and public laboratories to analyze specimens in the event of suspected exposure and disease outbreaks.

- Plans are developed to investigate and respond to public health threats; roles of collaborators in a public health threat could be better defined.
- The effectiveness of the state surveillance system needs to be reviewed periodically.
- The capacity exists to provide screening in response to exposures to health hazards, but the state's capacity may be inadequate in emergencies, and plans for strengthening are needed.

#### Local Assessment Summary

There is lack of overall coordination and communication among local entities. There is general lack of knowledge and dissatisfaction about the access to surveillance databases. It is unclear which agencies track what and how it is available to local communities. Much coordination has occurred to prepare for an emergency and more preparation is needed. Concerns were expressed about the lack of resources available outside Albuquerque in the event of an emergency.

#### Native American Assessment Summary

- Excellent resources for lab and epidemiology investigations.
- Weak planning around responding to threats.

#### Essential Service Score Ranking from Quantitative Data

State Score: 53 out of 100 (Second highest ranked Essential Service)

Local: 78 out of 100 (Highest ranked Essential Service)

Native American: 42 out of 100 (Highest ranked Essential Service)

### **Essential Service #3: Inform, educate, and empower people about health issues**

**This service includes: health information, education and promotion activities designed to promote health, health communication plans and activities, and partnerships in health education programs to reinforce messages.**

#### State Assessment Summary

Programs offer health education and health promotion. Identified needs are to increase involvement of target audiences, provide culturally, adapted materials, and provide greater assistance to local partners. Evaluation of quality and outcomes of efforts are often lacking.

Highlights include:

- Some evidence-based programs are used to accomplish health program objectives but are not available in all program areas.
- Health communication and education programs need more emphasis on inclusion of target audiences. This includes culturally and linguistically appropriate material.
- More assistance needs to be available to improve health communication and effective health education interventions.

- Resources need to be targeted to high priority areas for health education.
- More expertise is needed for effective health communication. This includes strengthening risk communication skills, media advocacy and social marketing.

#### Local Assessment Summary

Many community partnerships were identified, however questions were raised regarding whether all populations were adequately included or reached. Populations such as non-English speaking, rural elderly, and rural youth were cited. Information is given to the public but it is unknown whether the messages are effective. Products are seldom formally evaluated and are often responding only to “hot issues”. More culturally appropriate education is needed. Efforts to inform the public and policy makers occurs but is fragmented and the effectiveness is uncertain.

#### Native American Assessment Summary

- Strong in providing health education materials through multiple channels.
- More culturally and linguistically appropriate materials are needed.

#### Essential Service Score from Quantitative Data

State Score: 23 out of 100

Local: 64 out of 100 (Second highest ranked Essential Service, tied with #6)

Native American: 26 out of 100

#### **Essential Service #4: Mobilize partnerships to identify and solve health problems**

**This service includes: leadership to collaborate with statewide partners (including those not typically considered to be health-related) to identify public health priorities and solutions, build a statewide partnership to collaborate in the performance of essential functions to improve the state’s health status, and assist partners and communities to improve the health of the state’s communities.**

#### State Assessment Summary

There is considerable effort to develop partnerships and linkages to the community level and within the health care sector. Participation by business, labor and other economic sectors is weak. Major areas for improvement include the need to engage policy leaders on priority issues, the need to sustain partnerships, and the evaluation of impact and quality improvement.

Highlights include:

- The SPHS is strong in establishing and communicating the purpose for dialogue and action from partners and community.
- Partnerships are built to identify and solve health problems.
- A review of activities to mobilize partnerships needs to occur on a predetermined, periodic basis; this includes a review of participation and commitment of the partners.

- Established processes to brief policy leaders on priority health issues need to be strengthened.
- More resources need to be committed to sustain partnerships.

#### Local Assessment Summary

Many community partnerships exist including health councils. Some questions were raised about the partnerships and whether or not they were representative of all key stakeholders in a community. Identification of key constituents is fragmented. Funding often dictates constituents, priorities, and activities. The lack of multi-year funding has a great and sustained negative effect on communities' ability to generate and sustain efforts in this Essential Service. Competing agendas, differing opinions and politics prevent effective partnerships. At times there is a fear of collaboration because funding may be eliminated.

#### Native American Assessment Summary

- More resources need to be committed to sustain partnerships.
- Evaluation of partnerships is not occurring.

#### Essential Service Score from Quantitative Data

State Score: 31 out of 100

Local: 62 out of 100 (Third highest ranked Essential Service)

Native American: 13 out of 100

### **Essential Service #5: Develop policies and plans that support individual and statewide health efforts**

**This service includes: systematic health planning that relies on data and establishes measurable health objectives and strategies to guide community health improvement, development of legislation and policies to enable the performance of Essential Public Health Services, and the democratic process of dialogue and debate between groups affected by proposed health plans.**

#### State Assessment Summary

There is no recognized collective process for planning, prioritizing, or developing health policies on behalf of the needs of the State. While the Department of Health's "Vision of Health" is a useful guide targeting outcomes, there is no actual statewide plan for health improvement with input from multiple stakeholders that includes measurable objectives and strategies. Nor is there a system for linking state planning with local efforts.

Highlights include:

- A stronger statewide health improvement process needs to be implemented that includes measurable objectives and strategies along with input from more stakeholders.
- More assistance is needed to develop local operational plans to address a state improvement plan.
- New and existing policies need to be reviewed to determine their impact.

- Workforce expertise needs to be strengthened in health policy and strategic, long-range health planning.
- The system needs to strengthen the ability to obtain public input and analyze policy options for local health policy development.

#### Local Assessment Summary

Many agencies do not combine or share information with each other as it relates to policies and plans. Many agencies conduct strategic planning but the plans are often not coordinated nor aligned with a larger community health improvement process. There is a lack of coordination of the efforts between groups. This results in fragmented attempts to address health policy. Some of the partners have more input on policy decisions than others. There is inadequate funding to meet mandates and to assure services. Communication and collaboration between county entities and Native American communities either are lacking or need strengthening. Pueblo representatives expressed wish to be included, or better involved, in county health profile and plan processes.

#### Native American Assessment Summary

- Technical assistance in health policy development is weak.
- Current health planning resources adequate.

#### Essential Service Score from Quantitative Data

State Score: 12 out of 100

Local: 58 out of 100

Native American: 33 out of 100

### **Essential Service #6: Enforce laws and regulations that protect health and ensure safety**

**This service includes: the review and evaluation of laws and regulations designed to protect health and safety, education of persons to enforce laws and regulations, and enforcement activities in areas of public health concern such as protection of drinking water, clean air standards, laws governing sale of alcohol and tobacco to minors and childhood immunizations.**

#### State Assessment Summary

Technical resources and advocacy for developing statute and regulations are available and deemed an asset in the State. There is little by way of review of state laws and regulations to assess whether they reflect advances in public health science and reflect best practices of public health enforcement. The enforcement process tends to be reactive.

The highlights include:

- Reviews of state laws and regulations designed to protect the public's health and safety need to address whether they reflect current public health science and if they reflect best practices of public health enforcement.

- More education and direct assistance is needed to strengthen enforcement practices and also to develop local ordinances.
- The ability to conduct enforcement functions around the state needs to be reviewed and the findings utilized to make improvements.

#### Local Assessment Summary

Different agencies and organizations assess their compliance at different intervals and not always regularly. The review when done is not done together nor are the results shared. Laws and regulations can be accessed but are often difficult to understand. Compliance and enforcement are weak and not timely. There is access to legal counsel, however it is not always timely.

#### Native American Assessment Summary

- Excellent written guidelines around enforcement.
- Sharing of enforcement resources is poor.

#### Essential Service Score from Quantitative Data

State Score: 7 out of 100

Local: 64 out of 100 (Second highest ranked Essential Service, tied with #3)

Native American: 36 out of 100 (Second highest ranked Essential Service)

#### **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 and availability of quality personal health care services, assurances that access is available to a coordinated system of quality care, 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.**

#### State Assessment Summary

There are strengths in this Essential Service. Shortage areas are identified and steps taken to address needs such that care is available for many people in otherwise underserved areas or sectors. Attention needs to be given to identifying gaps in the safety-net provider system and in the distribution of specialty care and to assessing the utilization of personal health care services.

Highlights include:

- Through collaboration with local public health systems and other state partners, medically underserved populations are identified throughout the state.
- More attention needs to be given to identify the gaps in the safety-net provider system and to assess the utilization of personal health care services.
- Existing resources are applied to high priority areas in health care provision and plans are made for the development of new resources.

### Local Assessment Summary

Deficiencies include the lack of comprehensive and consistent initiatives, programs and/or services to address barriers and coordinated delivery of personal health services. Some agencies have addressed the barriers some populations experienced, but assessing or addressing these barriers has not been done comprehensively. Some of the barriers include: appropriate materials and services in different languages, healthcare system is fragmented and difficult to navigate, lack of providers, enrolling in and maintaining Medicaid coverage. There is insufficient education, prevention, treatment and outreach among people with mental health and substance abuse problems.

### Native American Assessment Summary

- Technical assistance around linking is adequate.
- Evaluation activities not occurring.

### Essential Service Score

State Score: 54 out of 100 This is the highest ranked essential service.

Local: 58 out of 100

Native American: 35 out of 100

### **Essential Service #8: Assure competent public and personal health care workforce**

**This service includes: education, training, development and assessment of health professionals, 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.**

### State Assessment Summary

Steps are taken to address workforce development at the state and local levels, but there is no integrated planning, strategic allocation of resources, or evaluation of effectiveness in addressing prioritized needs. A plan to guide statewide workforce development is needed and should address the determinants of health and the competencies to deliver the Essential Health Services as well as provide personal health services.

Highlights include:

- A plan to guide statewide workforce development is needed and should address understanding the determinants of health and core competencies to deliver the Essential Health Services.
- A better review of the workforce is needed to determine if there are adequate numbers of skilled personal care and public health workers to fill the state's current and future needs.
- In-service education is used to extend the competencies of the state's health services workforce.

- More coordination is needed between partners to leverage system-wide resources to effectively conduct workforce development activities.

#### Local Assessment Summary

Agencies and institutions work to address their respective needs and requirements for licensure and accreditation. However there are many unlicensed personnel and unregulated lay workers who are not covered by standards. Often agencies and organizations do their own training, and it is not coordinated. Unlicensed personnel and lay workers need to be included in training. No systematic workforce assessment has been completed. Only fragmented pieces of the workforce have been assessed and then dissemination of the results was fragmented.

#### Native American Assessment Summary

- Resources for workforce development plan need to be increased.
- Evaluation of this activity is limited.

#### Essential Service Score

State Score: 19 out of 100

Local: 51 out of 100

Native American: 26 out of 100

### **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 provides information to allocate resources, and assessment of and quality improvement in the state health system's performance and capacity.**

#### State Assessment Summary

There is very little by way of on-going evaluation of adequacy, effectiveness, or quality of personal health services or of population-based services. Evaluation is needed of the appropriateness, outcomes and the effectiveness of population-based health services. Reviews of evaluation and quality improvement activities are needed on a periodic, predetermined basis, and results should be used to make improvements. More expertise and assistance is needed to monitor the performance and capacity of the state health system.

Highlights include:

- Evaluation is needed of the appropriateness, outcomes and the effectiveness of population-based health services.
- Reviews of evaluation and quality improvement activities are needed on a periodic, predetermined basis and results should be used to make improvements.

- More expertise and assistance is needed to monitor the performance and capacity of the state health system.

#### Local Assessment Summary

Evaluation of the public health system occurs in some counties through their comprehensive health profile and plan processes. More often individual assessments of organizations in the system have been done but it is inconsistent, scattered, and fragmented. Information from individual assessments is not distributed or known among system players. Client surveys have been done but tend to be fragmented across agencies and comprehensive results not obtained.

#### Native American Assessment Summary

- Quality improvement activities are occurring.
- Monitoring of multi-year interventions is not occurring.

#### Essential Service Score

State Score: 19 out of 100

Local: 51 out of 100

Native American: 26 out of 100

### **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 improve public health practice to formal scientific research, linkage with research institutions, and internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.**

#### State Assessment Summary

From a systems perspective, this Essential Service ranked lowest. There are examples of high-level research being conducted within agencies and the universities. However, these touch only on small pieces of the overall need for applied and translational research. There is no planning process to develop a research agenda that assures the most pressing needs are addressed. The ability to utilize research findings and apply the findings to the Essential Health Services needs to be strengthened. Resources including analytical tools are needed to support a research function.

#### Highlights include:

- A public health research agenda needs to be written and developed through a collaborative process.
- The ability to utilize research findings and apply the findings to the Essential Health Services needs to be strengthened.
- Resources including analytical tools are needed to support a research function.

### Local Assessment Summary

Individual assessment participants identified some innovative solutions, however, other system participants were unaware of the innovations. Universities and others are doing some research, but generally, there is little that seems to connect the research agendas and results to local needs or informational priorities. Some counties had information and research available from schools of higher learning while others did not. The experts in their categorized areas often drive research. Better communication is needed about what research is happening and to share the research once completed.

### Native American Assessment Summary

- Technical assistance to help with research is available.

### Essential Service Score

State Score: 3 out of 100

Local: 38 out of 100

Native American: 29 out of 100

## **C. Common themes from Qualitative Comments**

Through the qualitative recorded comments, common themes were present across all the assessments. These themes included:

- Committed very busy people working at both the state and local levels, but participants had difficulty finding examples of system-wide approaches to:
  - problem assessment
  - priority setting
  - planning
  - program integration
  - evaluation
  - research
- The components of the health system link poorly with another
- There is no system at either the state or local level
- Competition for resources exists between parts of the system
- There are minimal incentives to work together
- Good information and products exist but awareness varies among system players
- There is an appreciation of the importance of the interconnectivity among agencies
- Participants expressed a strong desire to work together to create a system that can truly make a positive impact on the health of the people in the state

## **D. Priorities Recommended By Participants**

On August 26<sup>th</sup>, the data and the State Model Standards for each essential service were reviewed and discussed by participants. Based on the discussion, a multi-voting prioritization process was utilized to identify top priorities and key partners per essential service. On August 27<sup>th</sup>, Public Health Division (PHD) staff and others reviewed the priorities and recommended action steps to address them. The following information

reflects the priorities identified. (The priorities are not listed in order of importance.)  
(The action steps identified in the PHD workgroups that met on August 27 are listed in Appendix C.)

**Essential Service #1: Monitor health status to identify and solve community health problems**

Priorities

- Improve data sharing inter-agency, intra-agency, and via central repositories.
- Market data to enhance ability of local entities to access and use data.
- Centralize and analyze data and improve capacity at local level using Office of Epidemiology staff.

**Essential Service #2: Diagnose and investigate health problems and health hazards in the community**

Priorities

- Apply the “outbreak approach” to other health and social issues (analyze, mobilize, communicate, zoom-in, etc.).
- Enhance the ability of local levels to interpret information and respond.

**Essential Services #3 and #4: (3) Inform, educate and empower people about health issues and (4) mobilize community partnerships and action to identify and solve health problems**

Priorities

- Improve cultural competence in health education, promotion, community mobilization, and service delivery.
- Improve evaluation (includes evaluation of partnerships’ effectiveness in changing health status).
- Increase awareness of social determinants as key variables in health status in all venues and levels (e.g., sustained cooperation between Secretaries of Health and Economic Development).
- Commit consistent funding to maintain community health improvement processes.

**Essential Service #5: Develop policies and plans that support individual and community health efforts**

Priorities

- Institutionalize planning process to include annual local forums to provide input to DOH decision makers (input not just advisory) and to include community health council priorities in developing the state health plan.
- Design a system that ensures public input into policy development and review.

**Essential Service #6: Enforce laws and regulations that protect health and ensure safety**

Priorities

- Ensure cross-agency collaboration in regulation review, regulation development and enforcement.

- Evaluate the capacity of state and local agencies to enforce policies and regulation including human and financial resource capacity.

**Essential Service #7: Link people to needed personal health services and ensure the provision of healthcare when otherwise unavailable**

Priorities

- Address the fragmentation and problems of trying to navigate the health care system; address the poor communication (between players).
- Evaluate the system (including its quality), and increase awareness of what's available.

**Essential Service #8: Assure a competent public and personal workforce**

Priorities

- Conduct a comprehensive and coordinated health assessment and include in strategic plan. Build database with relevant provider and other system information.
- Assure recruitment and retention of providers. Identify best practices.
- Prioritize workforce development in strategic plan with better ties to universities and continuing education resources.

**Essential Service #9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services**

Priorities

- Develop a statewide evaluation system.
- Develop education consortium with all institutions and maximize the use of resources statewide.
- Establish an evaluation training institute by pooling resources of partners.

**Essential Service #10: Research for new insights and innovative solutions to health problems**

Priorities

- Establish statewide research agenda, emphasizing community based participatory research.
- Establish health research system that is similar to state agricultural research system.

## **V. RECOMMENDATIONS**

### **A. Recommendations for state agencies**

- Identify or create a structure (not a bureaucracy) that represents the major components of the greater health system as well as the public's interests in order to develop a coherent statewide system and identify priorities based on measures of health status and needs, planning and evaluation.
- Find avenues for State agencies and programs to be locally accountable.
- Develop a communication mechanism so state and local system improvements are known among all system participants.
- Continue and enhance the current efforts by state agencies to plan and work together.
- Focus on cultural competency within the DOH and in health care settings.
- Acknowledge and address the fundamental importance of social conditions including poverty and racism as determinants of health status, outcomes, and disparities.

### **B. Recommendations for district public health offices, health councils, and others locally**

- Offer the assessment in localities where it has not yet been used. Repeat the assessment periodically as a measure of change in the health system.
- Provide assistance to communities to develop planning capacity. Work with local communities to review results, including their validity and limitations, and build processes necessary for system improvement. Use the county-specific results to initiate local action.
- Some system improvements will require reallocation of resources or new resources. DOH needs to develop a process to infuse the resources when needed for system improvement and measure the impact.
- Strengthen local authority for making decisions and setting priorities.
- Convene all community providers to coordinate care for individuals and families who have multiple health problems to manage.

### **C. Recommendations for comprehensive state health planning**

- Develop and include a shared vision for health in New Mexico.
- Use the Ten Essential Services as headings for organizing what needs to be delivered by the State's health infrastructure.
- Preserve and enhance existing areas of infrastructure excellence, including systems that monitor overall health status, respond to outbreaks and acute problems, the State Laboratory and forensic services, emergency medical services, support for primary care systems.
- Include goals for reducing health disparities in the population and create a context of ethics and urgency in addressing these health disparities.

- Include in the plan effective, sustainable strategies for access and financing of personal health care services.
- Emphasize primary prevention as well as secondary and tertiary prevention.
- Include in the plan necessary infrastructure and planning for the following:
  - a. comprehensive health policy focusing on health and health care priorities
  - b. evaluation of systems performance targeted at goals and priorities.
  - c. workforce development
  - d. an agenda for health system research

#### **D. General recommendation**

- “Health system” should replace “public health system” in order to avoid inappropriate narrowing of the focus of the system and the scope of the essential services.
- The Ten Essential Services work well as a tool for assessing and describing programs. Encourage program managers to evaluate and describe program operations using the headings of the Ten Essential Services.
- Use the information in Section III, Assessment Results, and the Participant Recommendations, Appendix C, as starting points for planning within the Department of Health, prioritize the suggested system improvements, and develop a timeline for implementation.
- Celebrate and acknowledge the work that has been done to make system improvements and in two to three years, apply for a Quality New Mexico Award.

#### **E. Comment**

Based on the assessment results, the state and local systems must address the steps needed to strengthen the health system. Awareness among all system players across the state about the improvements is important to build capacity in the systems, promote continuous learning, and know what improvements have worked and those that haven't. Improvements that have been successful may be applicable in another location.

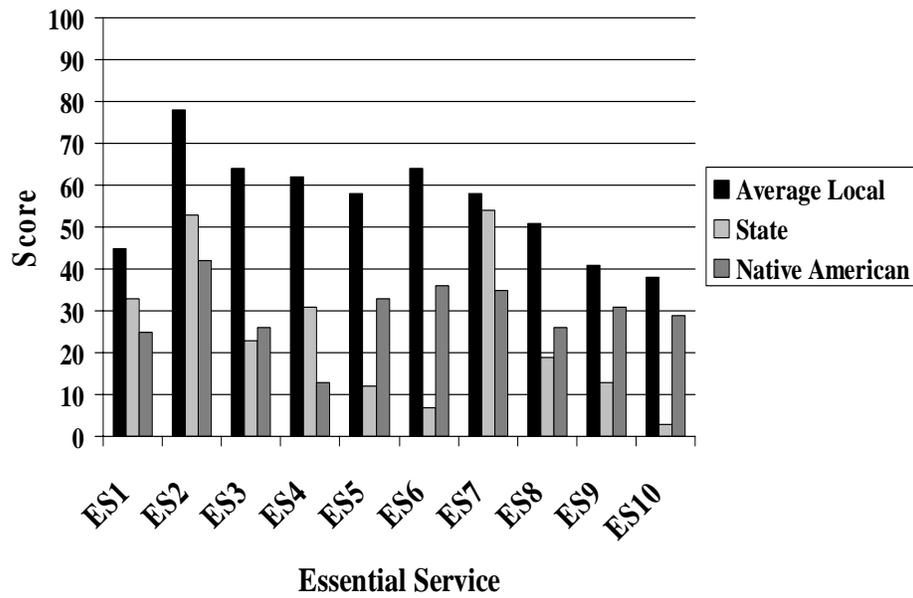
While the assessment identified components that are working well, an overarching conclusion of the assessment is that New Mexico does not have a health system. One structural feature that impedes system development is the dominance of the silo-like operations of the major state agencies. Presently, accountability within state agencies overwhelmingly flows vertically within the respective silos. A consequence is the strongly perceived lack of connection between state operations and local problems, issues, and priorities.

Whether one looks across the activities of state agencies or one looks at the relationship between state agencies and local concerns, the consequences having no meaningful health planning and no functioning system are evident. There is no shared vision. There is little collective planning. Serious problems are being addressed piecemeal without processes

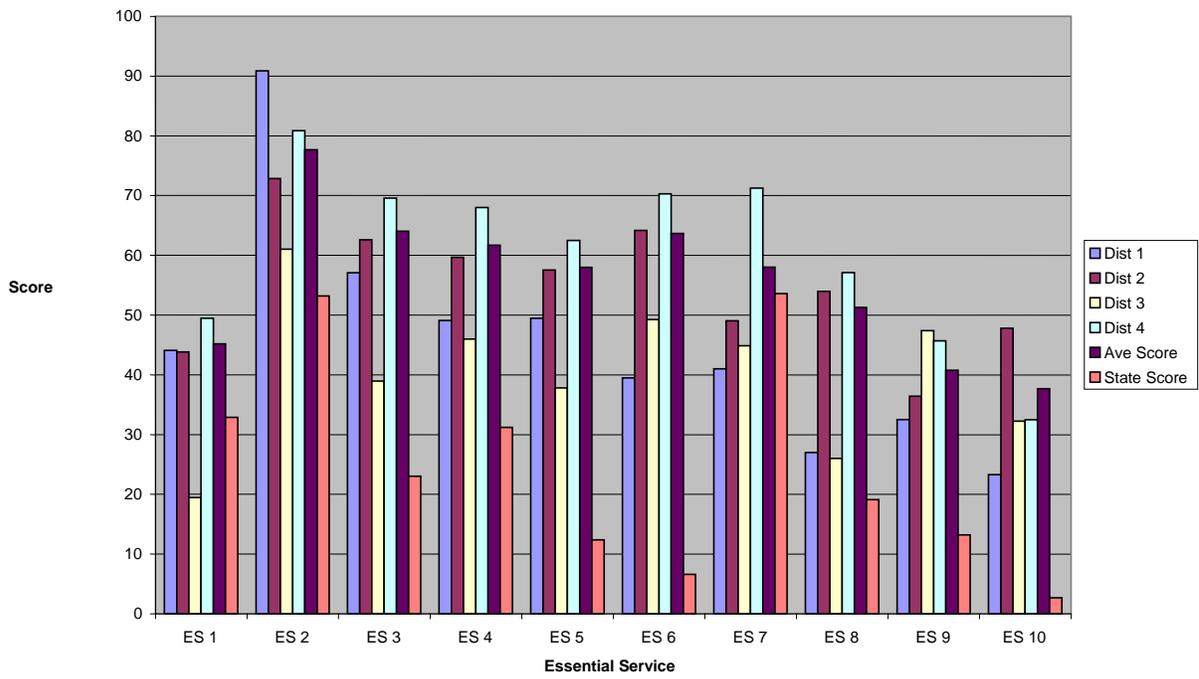
for prioritization, goal-setting, resource allocation, evaluation, or accountability.  
Capacity for local system organization varies across localities in the state.

APPENDIX A: ASSESSMENT RESULTS – GRAPHS

Graph I: Overall Essential Service Scores by  
Whether Local, State, or Native American



**Graph 2: District Scores Versus State Scores by Essential Service**



APPENDIX B: TABLES OF NUMERICAL SCORES BY PERFORMANCE STANDARD FOR EACH COUNTY BY DISTRICT

**DISTRICT I**

<b>Essential Services and Indicators</b>	<b>Bernalillo</b>	<b>Sandoval</b>	<b>Average Score</b>
<i>Description</i>			
<b>EPHS 1: Monitor Health Status</b>	32.38	55.82	44.1
<i>1.1 Population Based Community Health Profile</i>	14.29	74.62	44.455
1_1_1 Conducted community health assessment?	0	90.47	45.235
1_1_2 Compile data into community health profile?	0	69.72	34.86
1_1_3 Access to community demographic characteristics?	20	100	60
1_1_4 Access to community socioeconomic characteristics?	20	100	60
1_1_5 Access to health resource availability data?	20	66.67	43.335
1_1_6 Access to quality of life data for the community?	10	33.33	21.665
1_1_7 Access to behavioral risk factors for the community?	20	100	60
1_1_8 Access to community environmental health indicators?	10	66.67	38.335
1_1_9 Access to social and mental health data?	0	33.33	16.665
1_1_10 Access to maternal and child health data?	30	100	65
1_1_11 Access to death, illness, injury data?	30	100	65
1_1_12 Access to communicable disease data?	30	100	65
1_1_13 Access to sentinel events data?	10	43.33	26.665
1_1_14 Community-wide use of health assessment or CHP data promoted?	0	41.11	20.555
<i>1.2 Access to and Utilization of Current Technology</i>	15.33	20	17.665
1_2_1 State-of-the-art technology to support databases?	27.5	0	13.75
1_2_2 Access to geocoded health data?	0	0	0
1_2_3 Use geographic information systems (GIS)?	15.83	33.33	24.58
1_2_4 Use computer-generated graphics to identify trends and/or compare data?	33.33	66.67	50
1_2_5 CHP available in electronic version?	0	0	0

<i>1.3 Maintenance of Population Health Registries</i>	67.53	72.85	70.19
1_3_1 Maintain and/or contribute to one or more population health registries?	66.17	76.81	71.49
1_3_2 Used information from population health registries?	68.89	68.89	68.89
<b>EPHS 2: Diagnose and Investigate Health Problems</b>	89	92.77	90.885
<i>2.1 Identification and Surveillance of Health Threats</i>	62.1	77.76	69.93
2_1_1 Submit timely reportable disease information to state or LPHS?	66.67	66.67	66.67
2_1_2 Monitor changes in occurrence of health problems and hazards?	49.17	55	52.085
2_1_3 Have a comprehensive surveillance system?	0	67.33	33.665
2_1_4 Use IT for surveillance?	56.74	77.56	67.15
2_1_5 Access to Masters or Doctoral level epidemiologists and/or statisticians?	100	100	100
2_1_6 Procedure to alert communities about health threats/disease outbreaks?	100	100	100
<i>2.2 Plan for Public Health Emergencies</i>	99.17	99.65	99.41
2_2_1 Identified public health disasters and emergencies?	100	100	100
2_2_2 Have an emergency preparedness and response plan?	96.67	98.6	97.635
2_2_3 Plan been tested through one or more “mock events” in the past year?	100	100	100
2_2_4 Plan been reviewed or revised within the past two years?	100	100	100
<i>2.3 Investigate and Respond to Public Health Emergencies</i>	94.75	93.66	94.205
2_3_1 Designated an Emergency Response Coordinator?	90	100	95
2_3_2 Have current epidemiological case investigation protocols?	86.67	93.33	90
2_3_3 Written protocols for implementing program of source and contact tracing?	97.08	94.17	95.625
2_3_4 Roster of response personnel with technical expertise?	100	80.78	90.39
2_3_5 Evaluate public health emergency response incidents?	100	100	100
<i>2.4 Laboratory Support for Investigation of Health Threats</i>	100	100	100
2_4_1 Access to laboratory services to support investigations?	100	100	100
2_4_2 Access to laboratories capable of meeting routine diagnostic and surveillance needs?	100	100	100
2_4_3 Documentation that laboratories are licensed and/or credentialed?	100	100	100
2_4_4 Current guidelines or protocols for handling laboratory samples?	100	100	100

<b>EPHS 3: Inform, Educate, and Empower People</b>	54.24	59.92	57.08
<i>3.1 Health Education</i>	52.08	45.32	48.7
3_1_1 Information on community health to public and policy leaders?	38	72.07	55.035
3_1_2 Use media to communicate health information?	60.83	37.5	49.165
3_1_3 Sponsor health education programs?	56.17	71.72	63.945
3_1_4 Assessed public health education activities?	53.33	0	26.665
<i>3.2 Health Promotion Activities</i>	56.4	74.52	65.46
3_2_1 Implemented health promotion activities?	70.25	78.42	74.335
3_2_2 Collaborative networks for health promotion established?	60.83	76.67	68.75
3_2_3 Assessed health promotion activities?	38.13	68.48	53.305
<b>EPHS 4: Mobilize Community Partnerships</b>	30.53	67.66	49.095
<i>4.1 Constituency Development</i>	34.21	66.1	50.155
4_1_1 Process for identifying key constituents?	55	82.5	68.75
4_1_2 Encourage participation of constituents in improving community health?	45	62.58	53.79
4_1_3 Current directory of organizations that comprise the LPHS?	0	49.17	24.585
4_1_4 Use communications strategies to strengthen linkages?	36.83	70.17	53.5
<i>4.2 Community Partnerships</i>	26.85	69.22	48.035
4_2_1 Partnerships exist in the community?	35.56	76.67	56.115
4_2_2 Assure establishment of a broad-based community health improvement committee?	0	86	43
4_2_3 Assess the effectiveness of community partnerships?	45	45	45
<b>EPHS 5: Develop Policies and Plans</b>	43.31	55.63	49.47
<i>5.1 Governance Presence at Local Level</i>	62.78	95.2	78.99
5_1_1 Includes a local governmental public health entity?	88.33	85.61	86.97
5_1_2 Assures participation of stakeholders in implementation of community health plan?	33.33	100	66.665
5_1_3 Local governing entity (e.g., local board of health) conducts oversight?	0	0	0

5_1_4	Local governmental public health entity work with the state public health system?	66.67	100	83.335
<i>5.2 Public Health Policy Development</i>		47.78	43.5	45.64
5_2_1	Contribute to the development of public health policies?	55	75.5	65.25
5_2_2	Review public health policies at least every two years?	21.67	21.67	21.67
5_2_3	Advocate for the development of prevention and protection policies?	66.67	33.33	50
<i>5.3 Community Health Improvement Process</i>		17.44	49.82	33.63
5_3_1	Established a community health improvement process?	0	56.3	28.15
5_3_2	Developed strategies to address community health objectives?	34.89	43.33	39.11
<i>5.4 Strategic Planning and Alignment</i>		45.25	34.01	39.63
5_4_1	Each organization in the LPHS conduct a strategic planning process?	66.67	33.33	50
5_4_2	Each organization in the LPHS review its organizational strategic plan?	0	33.33	16.665
5_4_3	Local governmental public health entity conducts strategic planning activities?	69.08	35.37	52.225
<b>EPHS 6: Enforce Laws and Regulations</b>		42.25	36.73	39.49
<i>6.1 Review and Evaluate Laws, Regulations, and Ordinances</i>		50.91	55.74	53.325
6_1_1	Identify public health issues addressed through laws, regulations, or ordinances?	33.33	33.33	33.33
6_1_2	Access to current compilation of laws, regulations, and ordinances?	79.63	79.63	79.63
6_1_3	Review the public health laws and regulations every 5 years?	24	43.33	33.665
6_1_4	Access to legal counsel?	66.67	66.67	66.67
<i>6.2 Involvement in Improvement of Laws, Regs and Ordinances</i>		47.78	37.22	42.5
6_2_1	Identify local public health issues not adequately addressed through existing laws, regulations, and ordinance	43.33	33.33	38.33
6_2_2	Participated in the development or modification of laws, regulations or ordinances?	66.67	45	55.835
6_2_3	Provide technical assistance to legislative, regulatory or advocacy groups?	33.33	33.33	33.33
<i>6.3 Enforce laws, Regulations and Ordinances</i>		28.06	17.22	22.64
6_3_1	Authority to enforce public health laws, regulations, or ordinances?	51.11	10	30.555
6_3_2	Assure enforcement activities are conducted in a timely manner?	0	0	0
6_3_3	Provide information to individuals and organizations about public health laws, regulations, and ordinances?	25.56	25.56	25.56

6_3_4	Reviewed the activities of institutions and businesses in the community?	35.56	33.33	34.445
<b>EPHS 7: Link People to Needed Personal Health Services</b>		52.41	29.61	41.01
<i>7.1 Identification of Populations with Barriers to System</i>		83	40.33	61.665
7_1_1	Identify any populations who may encounter barriers?	83	40.33	61.665
<i>7.2 Identifying Personal Health Service Needs of Population</i>		47.56	21.93	34.745
7_2_1	Defined personal health service needs for all of its catchment areas?	66.67	33.33	50
7_2_2	Assessed the extent personal health services are being provided?	33.33	17.78	25.555
7_2_3	Identify the personal health services of populations who encounter barriers to personal health services?	42.67	14.67	28.67
<i>7.3 Assuring Linkage of People to Personal Health Services</i>		26.67	26.57	26.62
7_3_1	Assure the provision of needed personal health services?	0	17	8.5
7_3_2	Provide outreach and linkage services for the community?	33.33	15.83	24.58
7_3_3	Initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs?	100	66.67	83.335
7_3_4	Assure the coordinated delivery of personal health services?	0	0	0
7_3_5	Conducted an analysis of age-specific participation in preventive services?	0	33.33	16.665
<b>EPHS 8: Assure a Competent Public and Workforce</b>		31.54	22.45	26.995
<i>8.1 Workforce Assessment</i>		0	0	0
8_1_1	Conduct a workforce assessment within past three years?	0	0	0
8_1_2	Gaps within the public and personal health workforce been identified?	0	0	0
8_1_3	Results of the workforce assessment disseminated?	0	0	0
<i>8.2 Public Health Workforce Standards</i>		74.36	70.63	72.495
8_2_1	Aware of and in compliance with guidelines and/or licensure/certification requirements for personnel?	66.67	66.67	66.67
8_2_2	Organizations developed written job standards and/or position descriptions?	66.67	66.67	66.67
8_2_3	Agency developed job standards and/or position descriptions?	51.79	75.5	63.645
8_2_4	Organizations conduct performance evaluations?	100	100	100
8_2_5	Agency conducts performance evaluations?	86.67	44.33	65.5

8.3 <i>Continuing Education, Training and Mentoring</i>	46.78	16.67	31.725
8_3_1 Identify education and training needs?	77.13	33.33	55.23
8_3_2 Local governmental public health entity provide opportunities for personnel to develop core public health co	43.33	0	21.665
8_3_3 Incentives provided to the workforce to participate in educational and training experiences?	33.33	0	16.665
8_3_4 Opportunities for interaction between LPHS organization staff and faculty from academic and research institutes	33.33	33.33	33.33
8.4 <i>Public Health Leadership Development</i>	5	2.5	3.75
8_4_1 Promote the development of leadership skills?	10	0	5
8_4_2 Promote collaborative leadership?	10	10	10
8_4_3 Opportunities to provide leadership in areas of expertise or experience?	0	0	0
8_4_4 Opportunities to develop community leadership through and mentoring?	0	0	0
<b>EPHS 9: Evaluate Effectiveness, Accessibility and Quality</b>	29.5	35.53	32.515
9.1 <i>Evaluation of Population-Based Services</i>	37.39	54.06	45.725
9_1_1 Evaluated population-based health services?	27.89	49.56	38.725
9_1_2 Assess community satisfaction with population-based health services?	21.67	33.33	27.5
9_1_3 Identify gaps in the provision of population-based health services?	33.33	100	66.665
9_1_4 Use the results of the evaluation in the development of their strategic and operational plans?	66.67	33.33	50
9.2 <i>Evaluation of Personal Health Care Services</i>	38.33	21.16	29.745
9_2_1 Evaluated personal health services for the community?	43.33	51.11	47.22
9_2_2 Specific personal health care services in the community evaluated against established criteria?	55	38	46.5
9_2_3 Assess client satisfaction with personal health services?	26.67	16.67	21.67
9_2_4 Use information technology to assure quality of personal health services?	33.33	0	16.665
9_2_5 Use the results of the evaluation in the development of their strategic and operational plans?	33.33	0	16.665
9.3 <i>Evaluation of Local Public Health System</i>	12.78	31.39	22.085
9_3_1 Identified community organizations or entities that contribute to the delivery of the EPHS?	33.33	66.67	50
9_3_2 Evaluation of the LPHS conducted every three to five years?	17.78	0	8.89
9_3_3 Linkages and relationships among organizations that comprise the LPHS assessed?	0	25.56	12.78
9_3_4 Use results from the evaluation process to guide community health improvements?	0	33.33	16.665

<b>EPHS 10: Research for New Insights and Innovative Solutions</b>	13.23	33.38	23.305
<i>10.1 Fostering Innovation</i>	16.67	18.61	17.64
10_1_1 Encourage staff to develop new solutions to health problems in the community?	33.33	41.11	37.22
10_1_2 Proposed to research organizations one or more public health issues for inclusion in their research agenda?	0	0	0
10_1_3 Identify and/or monitor “best practices” developed by other public health agencies or organizations?	33.33	33.33	33.33
10_1_4 Encourage community participation in the development or implementation of research?	0	0	0
<i>10.2 Linkage with Institutions of Higher Learning and Research</i>	17.04	54.91	35.975
10_2_1 Partner with at least one institution of higher learning and/or research organization?	0	100	50
10_2_2 Develop relationships with institutions of higher learning and/or research organizations?	33.33	39.17	36.25
10_2_3 Encourage proactive interaction between the academic and practice communities?	17.78	25.56	21.67
<i>10.3 Capacity for Epidemiological, Policy and Service Research</i>	6	26.62	16.31
10_3_1 Access to researchers?	24	24	24
10_3_2 Resources to facilitate research within the LPHS?	0	82.5	41.25
10_3_3 Plan for the dissemination of research findings to public health colleagues?	0	0	0
10_3_4 Evaluate research activities?	0	0	0
<b>Average Total Performance Score</b>	41.84	48.95	45.395

## DISTRICT II

Essential Services and Indicators <i>Description</i>	Colfax	Harding	Los Alamos	Rio Arriba	San Miguel/Mora	Santa Fe	Taos	Union	Average Score
<b>EPHS 1: Monitor Health Status</b>	60.62	26.97	52.92	31.3	59.7	41.08	53.26	24.87	<b>44</b>
<i>1.1 Population Based Community Health Profile</i>	83.69	10	75.66	49.58	69.41	50.51	69.95	38.33	<b>56</b>
1_1_1 Conducted community health assessment?	93.47	0	75.31	54.14	87.05	54.49	87.05	30	<b>60</b>
1_1_2 Compile data into community health profile?	94.91	0	87.22	43.33	87.96	75.92	74.44	0	<b>58</b>
1_1_3 Access to community demographic characteristics?	100	30	100	43.33	100	66.67	100	100	<b>80</b>
1_1_4 Access to community socioeconomic characteristics?	100	0	100	66.67	100	66.67	100	100	<b>79</b>
1_1_5 Access to health resource availability data?	100	0	66.67	56.67	33.33	66.67	56.67	43.33	<b>53</b>
1_1_6 Access to quality of life data for the community?	100	0	66.67	33.33	33.33	33.33	66.67	33.33	<b>46</b>
1_1_7 Access to behavioral risk factors for the community?	100	30	90	66.67	66.67	33.33	100	20	<b>63</b>
1_1_8 Access to community environmental health indicators?	100	0	53.33	10	10	33.33	10	43.33	<b>32</b>
1_1_9 Access to social and mental health data?	43.33	10	76.67	33.33	43.33	33.33	33.33	53.33	<b>41</b>
1_1_10 Access to maternal and child health data?	100	10	100	100	100	76.67	100	53.33	<b>80</b>
1_1_11 Access to death, illness, injury data?	100	30	100	76.67	100	66.67	100	30	<b>75</b>
1_1_12 Access to communicable disease data?	53.33	0	53.33	43.33	100	66.67	100	30	<b>56</b>
1_1_13 Access to sentinel events data?	43.33	30	33.33	33.33	43.33	33.33	0	0	<b>27</b>
1_1_14 Community-wide use of health assessment or CHP data promoted?	43.33	0	56.67	33.33	66.67	0	51.11	0	<b>31</b>
<i>1.2 Access to and Utilization of Current Technology</i>	29.5	27.5	24.44	13.33	31.89	33.44	22.5	0	<b>23</b>
1_2_1 State-of-the-art technology to support databases?	0	0	33.33	0	41.67	33.33	15.83	0	<b>16</b>
1_2_2 Access to geocoded health data?	0	100	25.56	0	51.11	25.56	0	0	<b>25</b>
1_2_3 Use geographic information systems (GIS)?	0	37.5	0	0	0	21.67	0	0	<b>7</b>
1_2_4 Use computer-generated graphics to identify	100	0	33.33	66.67	66.67	66.67	66.67	0	<b>50</b>

trends and/or compare data?										
1_2_5 CHP available in electronic version?	47.5	0	30	0	0	20	30	0	<b>16</b>	
<i>1.3 Maintenance of Population Health Registries</i>	68.66	43.42	58.67	30.98	77.8	39.3	67.33	36.26	<b>53</b>	
1_3_1 Maintain and/or contribute to one or more population health registries?	45.1	66.84	56.23	28.63	78.93	27.49	73.56	36.97	<b>52</b>	
1_3_2 Used information from population health registries?	92.22	20	61.11	33.33	76.67	51.11	61.11	35.56	<b>54</b>	
<b>EPHS 2: Diagnose and Investigate Health Problems</b>	82.89	61.18	83.12	75.7	84.99	74.61	73.03	47.12	<b>73</b>	
<i>2.1 Identification and Surveillance of Health Threats</i>	85.34	66.67	65.05	74.88	71.31	49.87	64.07	51.67	<b>66</b>	
2_1_1 Submit timely reportable disease information to state or LPHS?	100	100	66.67	100	100	66.67	33.33	100	<b>83</b>	
2_1_2 Monitor changes in occurrence of health problems and hazards?	94.17	100	60.83	60.83	66.67	33.33	55	76.67	<b>68</b>	
2_1_3 Have a comprehensive surveillance system?	83	0	0	50.33	0	33.33	17	0	<b>23</b>	
2_1_4 Use IT for surveillance?	101.56	0	96.11	71.44	94.56	65.89	79.11	0	<b>64</b>	
2_1_5 Access to Masters or Doctoral level epidemiologists and/or statisticians?	100	100	100	66.67	100	66.67	100	100	<b>92</b>	
2_1_6 Procedure to alert communities about health threats/disease outbreaks?	33.33	100	66.67	100	66.67	33.33	100	33.33	<b>67</b>	
<i>2.2 Plan for Public Health Emergencies</i>	87.62	99.77	74.28	66.67	78.58	74.17	82.73	22.5	<b>73</b>	
2_2_1 Identified public health disasters and emergencies?	100	100	33.33	66.67	33.33	33.33	66.67	33.33	<b>58</b>	
2_2_2 Have an emergency preparedness and response plan?	83.8	99.07	63.8	66.67	81	63.33	64.27	56.67	<b>72</b>	
2_2_3 Plan been tested through one or more “mock events” in the past year?	66.67	100	100	66.67	100	100	100	0	<b>79</b>	
2_2_4 Plan been reviewed or revised within the past two years?	100	100	100	66.67	100	100	100	0	<b>83</b>	
<i>2.3 Investigate and Respond to Public Health Emergencies</i>	83.61	78.28	93.14	77.93	90.07	74.42	61.98	47.67	<b>76</b>	
2_3_1 Designated an Emergency Response	90	30	100	100	100	100	76.67	53.33	<b>81</b>	

Coordinator?										
2_3_2 Have current epidemiological case investigation protocols?	83.33	100	80	53.33	73.33	56.67	36.67	73.33	<b>70</b>	
2_3_3 Written protocols for implementing program of source and contact tracing?	100	73.75	87.08	73.75	82.5	72.5	88.33	45	<b>78</b>	
2_3_4 Roster of response personnel with technical expertise?	78.04	87.65	98.63	62.55	94.51	76.27	74.9	0	<b>72</b>	
2_3_5 Evaluate public health emergency response incidents?	66.67	100	100	100	100	66.67	33.33	66.67	<b>79</b>	
<i>2.4 Laboratory Support for Investigation of Health Threats</i>	75	0	100	83.33	100	100	83.33	66.67	<b>76</b>	
2_4_1 Access to laboratory services to support investigations?	66.67	0	100	66.67	100	100	66.67	66.67	<b>71</b>	
2_4_2 Access to laboratories capable of meeting routine diagnostic and surveillance needs?	100	0	100	66.67	100	100	66.67	66.67	<b>75</b>	
2_4_3 Documentation that laboratories are licensed and/or credentialed?	33.33	0	100	100	100	100	100	66.67	<b>75</b>	
2_4_4 Current guidelines or protocols for handling laboratory samples?	100	0	100	100	100	100	100	66.67	<b>83</b>	
<b>EPHS 3: Inform, Educate, and Empower People</b>	68.55	80.98	76.77	54.41	59.77	82.11	41.07	37.06	<b>63</b>	
<i>3.1 Health Education</i>	55.99	83.37	69.99	49.32	59.48	79.25	33.75	36.25	<b>58</b>	
3_1_1 Information on community health to public and policy leaders?	73.4	100	63.4	62	74.6	73.4	25.4	54.07	<b>66</b>	
3_1_2 Use media to communicate health information?	31.67	59.17	72.5	43.33	43.33	82.5	33.33	27.5	<b>49</b>	
3_1_3 Sponsor health education programs?	61.22	87.67	81.72	56.28	66.67	86.78	40.61	63.44	<b>68</b>	
3_1_4 Assessed public health education activities?	57.67	86.67	62.33	35.67	53.33	74.33	35.67	0	<b>51</b>	
<i>3.2 Health Promotion Activities</i>	81.11	78.59	83.55	59.49	60.06	84.96	48.39	37.86	<b>67</b>	
3_2_1 Implemented health promotion activities?	82.5	68.33	90.08	82.5	68.5	86	68.5	58.58	<b>76</b>	
3_2_2 Collaborative networks for health promotion established?	94.17	82.5	94.17	60.83	66.67	88.33	43.33	55	<b>73</b>	
3_2_3 Assessed health promotion activities?	66.67	84.94	66.41	35.15	45	80.56	33.33	0	<b>52</b>	

<b>EPHS 4: Mobilize Community Partnerships</b>	77.98	58.79	68.34	64.53	77.07	75.55	40.87	14.34	<b>60</b>
<i>4.1 Constituency Development</i>	70.96	84.25	74.12	76.62	77.92	79.54	38.62	16.83	<b>65</b>
4_1_1 Process for identifying key constituents?	70.83	94.17	66.67	66.67	76.67	72.5	39.17	0	<b>61</b>
4_1_2 Encourage participation of constituents in improving community health?	70.17	60.33	66.67	91.83	70.17	66.67	43.33	0	<b>59</b>
4_1_3 Current directory of organizations that comprise the LPHS?	66.17	82.5	96.5	89.5	86.5	87.17	46.83	67.33	<b>78</b>
4_1_4 Use communications strategies to strengthen linkages?	76.67	100	66.67	58.5	78.33	91.83	25.17	0	<b>62</b>
<i>4.2 Community Partnerships</i>	85	33.33	62.56	52.44	76.22	71.56	43.11	11.85	<b>55</b>
4_2_1 Partnerships exist in the community?	100	100	66.67	66.67	76.67	76.67	53.33	35.56	<b>72</b>
4_2_2 Assure establishment of a broad-based community health improvement committee?	100	0	76	57.33	85.33	71.33	42.67	0	<b>54</b>
4_2_3 Assess the effectiveness of community partnerships?	55	0	45	33.33	66.67	66.67	33.33	0	<b>38</b>
<b>EPHS 5: Develop Policies and Plans</b>	86.33	32.85	68.43	57.28	67.23	61.14	71.1	16.1	<b>58</b>
<i>5.1 Governance Presence at Local Level</i>	100	64.72	83.16	70.45	81.21	75.38	86.04	53.29	<b>77</b>
5_1_1 Includes a local governmental public health entity?	100	94.17	82.81	78.03	76.97	92.81	91.44	93.19	<b>89</b>
5_1_2 Assures participation of stakeholders in implementation of community health plan?	100	0	66.67	33.33	66.67	33.33	66.67	0	<b>46</b>
5_1_3 Local governing entity (e.g., local board of health) conducts oversight?	0	0	0	0	0	0	0	0	<b>0</b>
5_1_4 Local governmental public health entity work with the state public health system?	100	100	100	100	100	100	100	66.67	<b>96</b>
<i>5.2 Public Health Policy Development</i>	90.83	33.33	72.89	42.72	48.94	44.28	59.28	0	<b>49</b>
5_2_1 Contribute to the development of public health policies?	84.17	0	67.83	41.5	70.17	66.17	77.83	0	<b>51</b>
5_2_2 Review public health policies at least every two years?	88.33	0	50.83	20	10	0	0	0	<b>21</b>
5_2_3 Advocate for the development of prevention	100	100	100	66.67	66.67	66.67	100	0	<b>75</b>

and protection policies?

<i>5.3 Community Health Improvement Process</i>	89.75	0	60.75	58.45	55.13	41.86	61.3	0	<b>46</b>
5_3_1 Established a community health improvement process?	90.39	0	78.16	66.56	76.93	63.72	84.7	0	<b>58</b>
5_3_2 Developed strategies to address community health objectives?	89.11	0	43.33	50.33	33.33	20	37.89	0	<b>34</b>
<i>5.4 Strategic Planning and Alignment</i>	64.72	33.33	56.92	57.5	83.64	83.03	77.78	11.11	<b>59</b>
5_4_1 Each organization in the LPHS conduct a strategic planning process?	100	100	66.67	66.67	100	66.67	100	33.33	<b>79</b>
5_4_2 Each organization in the LPHS review its organizational strategic plan?	0	0	33.33	33.33	66.67	90	33.33	0	<b>32</b>
5_4_3 Local governmental public health entity conducts strategic planning activities?	94.17	0	70.75	72.5	84.25	92.42	100	0	<b>64</b>
<b>EPHS 6: Enforce Laws and Regulations</b>	<b>73.7</b>	<b>77</b>	<b>89.63</b>	<b>32.22</b>	<b>50.91</b>	<b>70.19</b>	<b>85.83</b>	<b>33.7</b>	<b>64</b>
<i>6.1 Review and Evaluate Laws, Regulations, and Ordinances</i>	66.67	97.67	100	33.33	59.67	66.67	81.39	41.67	<b>68</b>
6_1_1 Identify public health issues addressed through laws, regulations, or ordinances?	66.67	100	100	33.33	66.67	0	66.67	0	<b>54</b>
6_1_2 Access to current compilation of laws, regulations, and ordinances?	100	100	100	0	66.67	100	92.22	100	<b>82</b>
6_1_3 Review the public health laws and regulations every 5 years?	0	90.67	100	0	38.67	66.67	66.67	0	<b>45</b>
6_1_4 Access to legal counsel?	100	100	100	100	66.67	100	100	66.67	<b>92</b>
<i>6.2 Involvement in Improvement of Laws, Regs and Ordinances</i>	100	33.33	88.89	29.44	44.44	88.89	100	0	<b>61</b>
6_2_1 Identify local public health issues not adequately addressed through existing laws, regulations, and ordinance	100	43.33	100	33.33	43.33	66.67	100	0	<b>61</b>
6_2_2 Participated in the development or modification of laws, regulations or ordinances?	100	56.67	100	55	56.67	100	100	0	<b>71</b>
6_2_3 Provide technical assistance to legislative,	100	0	66.67	0	33.33	100	100	0	<b>50</b>

regulatory or advocacy groups?

<i>6.3 Enforce laws, Regulations and Ordinances</i>	54.44	100	80	33.89	48.61	55	76.11	59.44	<b>63</b>
6_3_1 Authority to enforce public health laws, regulations, or ordinances?	84.44	100	92.22	84.44	66.67	92.22	92.22	76.67	<b>86</b>
6_3_2 Assure enforcement activities are conducted in a timely manner?	66.67	100	66.67	0	33.33	33.33	66.67	0	<b>46</b>
6_3_3 Provide information to individuals and organizations about public health laws, regulations, and ordinances?	66.67	100	76.67	25.56	51.11	41.11	76.67	92.22	<b>66</b>
6_3_4 Reviewed the activities of institutions and businesses in the community?	0	100	84.44	25.56	43.33	53.33	68.89	68.89	<b>56</b>
<b>EPHS 7: Link People to Needed Personal Health Services</b>	54.74	45.54	58.46	52.8	44.46	50.88	38.46	47.19	<b>49</b>
<i>7.1 Identification of Populations with Barriers to System</i>	62	100	72	66.67	40.33	50.33	52.67	69	<b>64</b>
7_1_1 Identify any populations who may encounter barriers?	62	100	72	66.67	40.33	50.33	52.67	69	<b>64</b>
<i>7.2 Identifying Personal Health Service Needs of Population</i>	50.89	0	38	58.15	42.63	48.85	33.33	42.41	<b>39</b>
7_2_1 Defined personal health service needs for all of its catchment areas?	66.67	0	33.33	66.67	33.33	33.33	33.33	33.33	<b>37</b>
7_2_2 Assessed the extent personal health services are being provided?	33.33	0	33.33	41.11	58.89	48.89	33.33	48.89	<b>37</b>
7_2_3 Identify the personal health services of populations who encounter barriers to personal health services?	52.67	0	47.33	66.67	35.67	64.33	33.33	45	<b>43</b>
<i>7.3 Assuring Linkage of People to Personal Health Services</i>	51.33	36.62	65.38	33.58	50.42	53.45	29.37	30.17	<b>44</b>
7_3_1 Assure the provision of needed personal health services?	33.33	41	57.33	0	33.33	41	19.33	45	<b>34</b>
7_3_2 Provide outreach and linkage services for the	39.17	45	55	43.33	43.33	39.17	27.5	39.17	<b>41</b>

community?

7_3_3 Initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs?	66.67	66.67	100	66.67	66.67	66.67	66.67	66.67	66.67	<b>71</b>
7_3_4 Assure the coordinated delivery of personal health services?	50.83	30.42	47.92	24.58	42.08	53.75	0	0		<b>31</b>
7_3_5 Conducted an analysis of age-specific participation in preventive services?	66.67	0	66.67	33.33	66.67	66.67	33.33	0		<b>42</b>
<b>EPHS 8: Assure a Competent Public and Workforce</b>	53.71	52.49	62.89	60.15	65.33	46.43	51.97	38.76		<b>54</b>
<i>8.1 Workforce Assessment</i>	19.33	19.33	56.07	35.37	40.04	8	8	0		<b>23</b>
8_1_1 Conduct a workforce assessment within past three years?	0	0	58.89	62.78	29.44	0	0	0		<b>19</b>
8_1_2 Gaps within the public and personal health workforce been identified?	58	58	52.67	43.33	57.33	24	24	0		<b>40</b>
8_1_3 Results of the workforce assessment disseminated?	0	0	56.67	0	33.33	0	0	0		<b>11</b>
<i>8.2 Public Health Workforce Standards</i>	97.33	97.33	92.67	91.78	76.59	70.69	79.08	87.92		<b>87</b>
8_2_1 Aware of and in compliance with guidelines and/or licensure/certification requirements for personnel?	100	100	100	66.67	100	100	66.67	100		<b>92</b>
8_2_2 Organizations developed written job standards and/or position descriptions?	100	100	66.67	100	66.67	33.33	66.67	100		<b>79</b>
8_2_3 Agency developed job standards and/or position descriptions?	100	100	100	92.22	75.31	51.11	73.08	86.29		<b>85</b>
8_2_4 Organizations conduct performance evaluations?	100	100	100	100	66.67	100	100	66.67		<b>92</b>
8_2_5 Agency conducts performance evaluations?	86.67	86.67	96.67	100	74.33	69	89	86.67		<b>86</b>
<i>8.3 Continuing Education, Training and Mentoring</i>	34.67	30.29	59.84	42.24	69.17	58.89	73.19	67.13		<b>54</b>
8_3_1 Identify education and training needs?	83.67	83.67	80.2	53.13	66.67	76.67	86.93	90.2		<b>78</b>
8_3_2 Local governmental public health entity provide opportunities for personnel to develop core public health co	0	0	66.67	33.33	66.67	58.89	66.67	100		<b>49</b>
8_3_3 Incentives provided to the workforce to participate in educational and training experiences?	55	37.5	59.17	49.17	76.67	66.67	72.5	45		<b>58</b>

8_3_4 Opportunities for interaction between LPHS organization staff and faculty from academic and research institutes	0	0	33.33	33.33	66.67	33.33	66.67	33.33	<b>33</b>
<i>8.4 Public Health Leadership Development</i>	63.52	63.01	42.96	71.22	75.51	48.12	47.61	0	<b>51</b>
8_4_1 Promote the development of leadership skills?	67.4	65.35	38.52	61.56	68.71	49.17	47.12	0	<b>50</b>
8_4_2 Promote collaborative leadership?	76.67	76.67	66.67	90	66.67	43.33	43.33	0	<b>58</b>
8_4_3 Opportunities to provide leadership in areas of expertise or experience?	66.67	66.67	33.33	66.67	100	66.67	66.67	0	<b>58</b>
8_4_4 Opportunities to develop community leadership through and mentoring?	43.33	43.33	33.33	66.67	66.67	33.33	33.33	0	<b>40</b>
<b>EPHS 9: Evaluate Effectiveness, Accessibility and Quality</b>	61.33	8.33	60.53	39.1	45.17	22.73	41.93	12.33	<b>36</b>
<i>9.1 Evaluation of Population-Based Services</i>	51.36	0	51.82	50	52.33	9.01	25	0	<b>30</b>
9_1_1 Evaluated population-based health services?	72.11	0	52.28	33.33	58.5	36.06	0	0	<b>32</b>
9_1_2 Assess community satisfaction with population-based health services?	66.67	0	55	33.33	50.83	0	0	0	<b>26</b>
9_1_3 Identify gaps in the provision of population-based health services?	33.33	0	33.33	66.67	66.67	0	66.67	0	<b>33</b>
9_1_4 Use the results of the evaluation in the development of their strategic and operational plans?	33.33	0	66.67	66.67	33.33	0	33.33	0	<b>29</b>
<i>9.2 Evaluation of Personal Health Care Services</i>	63.04	0	61.8	37.31	35.6	34.18	45.22	12	<b>36</b>
9_2_1 Evaluated personal health services for the community?	58.89	0	66.67	48.89	43.33	45.56	61.11	33.33	<b>45</b>
9_2_2 Specific personal health care services in the community evaluated against established criteria?	69.67	0	69	41	49.67	40.33	78.33	0	<b>44</b>
9_2_3 Assess client satisfaction with personal health services?	53.33	0	63.33	30	30	30	43.33	16.67	<b>33</b>
9_2_4 Use information technology to assure quality of personal health services?	66.67	0	43.33	0	21.67	21.67	10	10	<b>22</b>
9_2_5 Use the results of the evaluation in the development of their strategic and operational plans?	66.67	0	66.67	66.67	33.33	33.33	33.33	0	<b>38</b>

<i>9.3 Evaluation of Local Public Health System</i>	69.59	25	67.98	30	47.57	25	55.56	25	<b>43</b>
9_3_1 Identified community organizations or entities that contribute to the delivery of the EPHS?	100	100	100	100	100	100	100	100	<b>100</b>
9_3_2 Evaluation of the LPHS conducted every three to five years?	75.85	0	66.09	0	0	0	59.18	0	<b>25</b>
9_3_3 Linkages and relationships among organizations that comprise the LPHS assessed?	20	0	33.33	20	41.11	0	35.56	0	<b>19</b>
9_3_4 Use results from the evaluation process to guide community health improvements?	82.5	0	72.5	0	49.17	0	27.5	0	<b>29</b>
<b>EPHS 10: Research for New Insights and Innovative Solutions</b>	38.18	38.18	69.35	38.57	73.78	52.33	66.48	5.56	<b>48</b>
<i>10.1 Fostering Innovation</i>	37.78	37.78	33.33	48.61	62.78	46.11	53.89	0	<b>40</b>
10_1_1 Encourage staff to develop new solutions to health problems in the community?	84.44	84.44	66.67	61.11	51.11	51.11	48.89	0	<b>56</b>
10_1_2 Proposed to research organizations one or more public health issues for inclusion in their research agenda?	0	0	0	33.33	66.67	33.33	33.33	0	<b>21</b>
10_1_3 Identify and/or monitor “best practices” developed by other public health agencies or organizations?	66.67	66.67	33.33	66.67	66.67	66.67	66.67	0	<b>54</b>
10_1_4 Encourage community participation in the development or implementation of research?	0	0	33.33	33.33	66.67	33.33	66.67	0	<b>29</b>
<i>10.2 Linkage with Institutions of Higher Learning and Research</i>	54.26	54.26	88.89	41.94	88.98	70	84.35	0	<b>60</b>
10_2_1 Partner with at least one institution of higher learning and/or research organization?	33.33	33.33	100	33.33	100	100	100	0	<b>62</b>
10_2_2 Develop relationships with institutions of higher learning and/or research organizations?	78.33	78.33	100	39.17	82.5	66.67	94.17	0	<b>67</b>
10_2_3 Encourage proactive interaction between the academic and practice communities?	51.11	51.11	66.67	53.33	84.44	43.33	58.89	0	<b>51</b>
<i>10.3 Capacity for Epidemiological, Policy and Service Research</i>	22.5	22.5	85.83	25.17	69.58	40.89	61.19	16.67	<b>43</b>

10_3_1	Access to researchers?	0	0	100	24	76.67	38	62	0	<b>38</b>
10_3_2	Resources to facilitate research within the LPHS?	80	80	100	0	78.33	76.67	88.33	66.67	<b>71</b>
10_3_3	Plan for the dissemination of research findings to public health colleagues?	0	0	100	43.33	66.67	0	76.67	0	<b>36</b>
10_3_4	Evaluate research activities?	10	10	43.33	33.33	56.67	48.89	17.78	0	<b>28</b>
<b>Average Total Performance Score</b>		65.8	48.23	69.04	50.61	62.84	57.7	56.4	27.7	<b>55</b>

## DISTRICT III

<b>Essential Services and Indicators</b>	<b>Dona Ana</b>
<i>Description</i>	
<b>EPHS 1: Monitor Health Status</b>	19.48
	0
<i>1.1 Population Based Community Health Profile</i>	9.29
1_1_1 Conducted community health assessment?	10
1_1_2 Compile data into community health profile?	0
1_1_3 Access to community demographic characteristics?	20
1_1_4 Access to community socioeconomic characteristics?	20
1_1_5 Access to health resource availability data?	10
1_1_6 Access to quality of life data for the community?	0
1_1_7 Access to behavioral risk factors for the community?	0
1_1_8 Access to community environmental health indicators?	0
1_1_9 Access to social and mental health data?	0
1_1_10 Access to maternal and child health data?	20
1_1_11 Access to death, illness, injury data?	20
1_1_12 Access to communicable disease data?	30
1_1_13 Access to sentinel events data?	0
1_1_14 Community-wide use of health assessment or CHP data promoted?	0
	0
<i>1.2 Access to and Utilization of Current Technology</i>	6.67
1_2_1 State-of-the-art technology to support databases?	0
1_2_2 Access to geocoded health data?	0
1_2_3 Use geographic information systems (GIS)?	0
1_2_4 Use computer-generated graphics to identify trends and/or compare data?	33.33
1_2_5 CHP available in electronic version?	0
	0
<i>1.3 Maintenance of Population Health Registries</i>	42.48
1_3_1 Maintain and/or contribute to one or more population health registries?	33.86
1_3_2 Used information from population health registries?	51.11

	0
<b>EPHS 2: Diagnose and Investigate Health Problems</b>	61.02
	0
<i>2.1 Identification and Surveillance of Health Threats</i>	92.24
2_1_1 Submit timely reportable disease information to state or LPHS?	66.67
2_1_2 Monitor changes in occurrence of health problems and hazards?	100
2_1_3 Have a comprehensive surveillance system?	100
2_1_4 Use IT for surveillance?	86.78
2_1_5 Access to Masters or Doctoral level epidemiologists and/or statisticians?	100
2_1_6 Procedure to alert communities about health threats/disease outbreaks?	100
	0
<i>2.2 Plan for Public Health Emergencies</i>	57.5
2_2_1 Identified public health disasters and emergencies?	33.33
2_2_2 Have an emergency preparedness and response plan?	30
2_2_3 Plan been tested through one or more “mock events” in the past year?	100
2_2_4 Plan been reviewed or revised within the past two years?	66.67
	0
<i>2.3 Investigate and Respond to Public Health Emergencies</i>	13.33
2_3_1 Designated an Emergency Response Coordinator?	0
2_3_2 Have current epidemiological case investigation protocols?	0
2_3_3 Written protocols for implementing program of source and contact tracing?	33.33
2_3_4 Roster of response personnel with technical expertise?	0
2_3_5 Evaluate public health emergency response incidents?	33.33
	0
<i>2.4 Laboratory Support for Investigation of Health Threats</i>	81
2_4_1 Access to laboratory services to support investigations?	100
2_4_2 Access to laboratories capable of meeting routine diagnostic and surveillance needs?	100
2_4_3 Documentation that laboratories are licensed and/or credentialed?	100
2_4_4 Current guidelines or protocols for handling laboratory samples?	24
	0
<b>EPHS 3: Inform, Educate, and Empower People</b>	38.94
	0
<i>3.1 Health Education</i>	37.3

3_1_1	Information on community health to public and policy leaders?	36.6
3_1_2	Use media to communicate health information?	49.17
3_1_3	Sponsor health education programs?	63.44
3_1_4	Assessed public health education activities?	0
		0
	<i>3.2 Health Promotion Activities</i>	40.58
3_2_1	Implemented health promotion activities?	78.42
3_2_2	Collaborative networks for health promotion established?	43.33
3_2_3	Assessed health promotion activities?	0
		0
<b>EPHS 4: Mobilize Community Partnerships</b>		45.98
		0
	<i>4.1 Constituency Development</i>	59.96
4_1_1	Process for identifying key constituents?	76.67
4_1_2	Encourage participation of constituents in improving community health?	56.67
4_1_3	Current directory of organizations that comprise the LPHS?	56.17
4_1_4	Use communications strategies to strengthen linkages?	50.33
		0
	<i>4.2 Community Partnerships</i>	32
4_2_1	Partnerships exist in the community?	53.33
4_2_2	Assure establishment of a broad-based community health improvement committee?	42.67
4_2_3	Assess the effectiveness of community partnerships?	0
		0
<b>EPHS 5: Develop Policies and Plans</b>		37.82
		0
	<i>5.1 Governance Presence at Local Level</i>	68.64
5_1_1	Includes a local governmental public health entity?	72.58
5_1_2	Assures participation of stakeholders in implementation of community health plan?	33.33
5_1_3	Local governing entity (e.g., local board of health) conducts oversight?	0
5_1_4	Local governmental public health entity work with the state public health system?	100
		0
	<i>5.2 Public Health Policy Development</i>	38.61
5_2_1	Contribute to the development of public health policies?	49.17

5_2_2	Review public health policies at least every two years?	0
5_2_3	Advocate for the development of prevention and protection policies?	66.67
		0
	<i>5.3 Community Health Improvement Process</i>	21.79
5_3_1	Established a community health improvement process?	33.58
5_3_2	Developed strategies to address community health objectives?	10
		0
	<i>5.4 Strategic Planning and Alignment</i>	22.22
5_4_1	Each organization in the LPHS conduct a strategic planning process?	33.33
5_4_2	Each organization in the LPHS review its organizational strategic plan?	0
5_4_3	Local governmental public health entity conducts strategic planning activities?	33.33
		0
<b>EPHS 6: Enforce Laws and Regulations</b>		49.26
		0
	<i>6.1 Review and Evaluate Laws, Regulations, and Ordinances</i>	41.67
6_1_1	Identify public health issues addressed through laws, regulations, or ordinances?	33.33
6_1_2	Access to current compilation of laws, regulations, and ordinances?	66.67
6_1_3	Review the public health laws and regulations every 5 years?	0
6_1_4	Access to legal counsel?	66.67
		0
	<i>6.2 Involvement in Improvement of Laws, Regs and Ordinances</i>	55.56
6_2_1	Identify local public health issues not adequately addressed through existing laws, regulations, and ordinance	33.33
6_2_2	Participated in the development or modification of laws, regulations or ordinances?	66.67
6_2_3	Provide technical assistance to legislative, regulatory or advocacy groups?	66.67
		0
	<i>6.3 Enforce laws, Regulations and Ordinances</i>	50.56
6_3_1	Authority to enforce public health laws, regulations, or ordinances?	76.67
6_3_2	Assure enforcement activities are conducted in a timely manner?	0
6_3_3	Provide information to individuals and organizations about public health laws, regulations, and ordinances?	56.67
6_3_4	Reviewed the activities of institutions and businesses in the community?	68.89
		0
<b>EPHS 7: Link People to Needed Personal Health Services</b>		44.88
		0

<i>7.1 Identification of Populations with Barriers to System</i>	67.33
7_1_1 Identify any populations who may encounter barriers?	67.33
	0
<i>7.2 Identifying Personal Health Service Needs of Population</i>	33.85
7_2_1 Defined personal health service needs for all of its catchment areas?	33.33
7_2_2 Assessed the extent personal health services are being provided?	25.56
7_2_3 Identify the personal health services of populations who encounter barriers to personal health services?	42.67
	0
<i>7.3 Assuring Linkage of People to Personal Health Services</i>	33.47
7_3_1 Assure the provision of needed personal health services?	24
7_3_2 Provide outreach and linkage services for the community?	49.17
7_3_3 Initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs?	33.33
7_3_4 Assure the coordinated delivery of personal health services?	27.5
7_3_5 Conducted an analysis of age-specific participation in preventive services?	33.33
	0
<b>EPHS 8: Assure a Competent Public and Workforce</b>	26.01
	0
<i>8.1 Workforce Assessment</i>	0
8_1_1 Conduct a workforce assessment within past three years?	0
8_1_2 Gaps within the public and personal health workforce been identified?	0
8_1_3 Results of the workforce assessment disseminated?	0
	0
<i>8.2 Public Health Workforce Standards</i>	73.32
8_2_1 Aware of and in compliance with guidelines and/or licensure/certification requirements for personnel?	66.67
8_2_2 Organizations developed written job standards and/or position descriptions?	66.67
8_2_3 Agency developed job standards and/or position descriptions?	85.61
8_2_4 Organizations conduct performance evaluations?	66.67
8_2_5 Agency conducts performance evaluations?	81
	0
<i>8.3 Continuing Education, Training and Mentoring</i>	18.42
8_3_1 Identify education and training needs?	40.33
8_3_2 Local governmental public health entity provide opportunities for personnel to develop core public health	
co	0
8_3_3 Incentives provided to the workforce to participate in educational and training experiences?	0

8_3_4 Opportunities for interaction between LPHS organization staff and faculty from academic and research institutes	33.33
	0
<i>8.4 Public Health Leadership Development</i>	12.29
8_4_1 Promote the development of leadership skills?	15.83
8_4_2 Promote collaborative leadership?	0
8_4_3 Opportunities to provide leadership in areas of expertise or experience?	33.33
8_4_4 Opportunities to develop community leadership through and mentoring?	0
	0
<b>EPHS 9: Evaluate Effectiveness, Accessibility and Quality</b>	47.39
	0
<i>9.1 Evaluation of Population-Based Services</i>	58.07
9_1_1 Evaluated population-based health services?	65.61
9_1_2 Assess community satisfaction with population-based health services?	33.33
9_1_3 Identify gaps in the provision of population-based health services?	66.67
9_1_4 Use the results of the evaluation in the development of their strategic and operational plans?	66.67
	0
<i>9.2 Evaluation of Personal Health Care Services</i>	67.44
9_2_1 Evaluated personal health services for the community?	92.22
9_2_2 Specific personal health care services in the community evaluated against established criteria?	100
9_2_3 Assess client satisfaction with personal health services?	33.33
9_2_4 Use information technology to assure quality of personal health services?	45
9_2_5 Use the results of the evaluation in the development of their strategic and operational plans?	66.67
	0
<i>9.3 Evaluation of Local Public Health System</i>	16.67
9_3_1 Identified community organizations or entities that contribute to the delivery of the EPHS?	66.67
9_3_2 Evaluation of the LPHS conducted every three to five years?	0
9_3_3 Linkages and relationships among organizations that comprise the LPHS assessed?	0
9_3_4 Use results from the evaluation process to guide community health improvements?	0
	0
<b>EPHS 10: Research for New Insights and Innovative Solutions</b>	32.26
	0
<i>10.1 Fostering Innovation</i>	21.11
10_1_1 Encourage staff to develop new solutions to health problems in the community?	17.78

10_1_2	Proposed to research organizations one or more public health issues for inclusion in their research agenda?	0
10_1_3	Identify and/or monitor “best practices” developed by other public health agencies or organizations?	66.67
10_1_4	Encourage community participation in the development or implementation of research?	0
		0
<i>10.2</i>	<i>Linkage with Institutions of Higher Learning and Research</i>	49.63
10_2_1	Partner with at least one institution of higher learning and/or research organization?	33.33
10_2_2	Develop relationships with institutions of higher learning and/or research organizations?	66.67
10_2_3	Encourage proactive interaction between the academic and practice communities?	48.89
		0
<i>10.3</i>	<i>Capacity for Epidemiological, Policy and Service Research</i>	26.04
10_3_1	Access to researchers?	33.33
10_3_2	Resources to facilitate research within the LPHS?	60.83
10_3_3	Plan for the dissemination of research findings to public health colleagues?	0
10_3_4	Evaluate research activities?	10
		0
		0
	<b>Average Total Performance Score</b>	40.3

## DISTRICT IV

Essential Services and Indicators	Chaves	Curry	De Baca	Eddy	Guadalupe	Lea	Lincoln	Quay	Roosevelt	Average Score
<i>Description</i>										
<b>EPHS 1: Monitor Health Status</b>	50.96	37.85	59.41	24	68.09	45.66	61.96	63.21	34.12	<b>49</b>
<i>1.1 Population Based Community Health Profile</i>	77.76	28.03	68.43	21.27	75.62	21.43	75.42	67.96	16.19	<b>50</b>
1_1_1 Conducted community health assessment?	87.21	32.36	46.76	15.56	85.14	0	82.31	74.76	0	<b>47</b>
1_1_2 Compile data into community health profile?	77.04	0	30.1	0	65.74	0	86.85	76.67	0	<b>37</b>
1_1_3 Access to community demographic characteristics?	100	30	76.67	20	100	30	100	66.67	30	<b>61</b>
1_1_4 Access to community socioeconomic characteristics?	100	43.33	76.67	30	66.67	30	100	66.67	20	<b>59</b>
1_1_5 Access to health resource availability data?	76.67	20	76.67	10	66.67	30	90	66.67	20	<b>51</b>
1_1_6 Access to quality of life data for the community?	66.67	20	100	0	66.67	20	33.33	66.67	20	<b>44</b>
1_1_7 Access to behavioral risk factors for the community?	76.67	33.33	76.67	43.33	90	30	100	66.67	10	<b>59</b>
1_1_8 Access to community environmental health indicators?	53.33	10	76.67	20	66.67	30	30	66.67	10	<b>40</b>
1_1_9 Access to social and mental health data?	33.33	33.33	30	20	66.67	30	33.33	66.67	10	<b>36</b>
1_1_10 Access to maternal and child health data?	100	43.33	76.67	30	100	30	100	66.67	0	<b>61</b>
1_1_11 Access to death, illness, injury data?	100	20	76.67	30	100	30	100	66.67	46.67	<b>63</b>
1_1_12 Access to communicable disease data?	100	20	76.67	30	100	30	100	66.67	30	<b>61</b>
1_1_13 Access to sentinel events data?	76.67	20	76.67	0	33.33	10	0	66.67	30	<b>35</b>
1_1_14 Community-wide use of health assessment or CHP data promoted?	41.11	66.67	61.11	48.89	51.11	0	100	66.67	0	<b>48</b>
<i>1.2 Access to and Utilization of Current Technology</i>	31.83	6.67	12.67	6.67	60.17	33.28	29.25	55	13.33	<b>28</b>

1_2_1 State-of-the-art technology to support databases?	0	0	10	0	49.17	50.83	0	60.83	0	<b>19</b>
1_2_2 Access to geocoded health data?	0	0	20	0	66.67	48.89	0	66.67	0	<b>22</b>
1_2_3 Use geographic information systems (GIS)?	0	0	0	0	31.67	0	0	21.67	0	<b>6</b>
1_2_4 Use computer-generated graphics to identify trends and/or compare data?	100	33.33	33.33	33.33	100	66.67	100	66.67	66.67	<b>67</b>
1_2_5 CHP available in electronic version?	59.17	0	0	0	53.33	0	46.25	59.17	0	<b>24</b>
<i>1.3 Maintenance of Population Health Registries</i>										
1_3_1 Maintain and/or contribute to one or more population health registries?	43.28	78.84	97.14	44.06	68.48	82.27	81.23	66.67	72.83	<b>71</b>
1_3_2 Used information from population health registries?	35.45	91.02	94.27	39.23	93.64	97.88	85.79	66.67	86.78	<b>77</b>
1_3_2 Used information from population health registries?	51.11	66.67	100	48.89	43.33	66.67	76.67	66.67	58.89	<b>64</b>
<b>EPHS 2: Diagnose and Investigate Health Problems</b>	89.72	92.33	63.54	92.09	76.12	68.43	88.33	69.15	88.12	<b>81</b>
<i>2.1 Identification and Surveillance of Health Threats</i>										
2_1_1 Submit timely reportable disease information to state or LPHS?	60.53	78.31	33.33	68.35	68.11	77.06	57.69	49.65	79.09	<b>64</b>
2_1_2 Monitor changes in occurrence of health problems and hazards?	33.33	66.67	33.33	100	33.33	100	66.67	33.33	66.67	<b>59</b>
2_1_3 Have a comprehensive surveillance system?	72.5	78.33	66.67	66.67	68.33	94.17	72.5	56.67	66.67	<b>71</b>
2_1_4 Use IT for surveillance?	0	56.67	0	0	0	0	0	0	90	<b>16</b>
2_1_5 Have a comprehensive surveillance system?	90.67	101.56	0	76.78	107	101.56	73.67	74.56	84.56	<b>79</b>
2_1_6 Access to Masters or Doctoral level epidemiologists and/or statisticians?	66.67	100	100	100	100	100	66.67	66.67	100	<b>89</b>
2_1_6 Procedure to alert communities about health threats/disease outbreaks?	100	66.67	0	66.67	100	66.67	66.67	66.67	66.67	<b>67</b>
<i>2.2 Plan for Public Health Emergencies</i>										
2_2_1 Identified public health disasters and emergencies?	100	91.67	38.82	100	57.73	25	100	52.15	98.92	<b>74</b>
2_2_1 Identified public health disasters and emergencies?	100	66.67	100	100	66.67	33.33	100	66.67	100	<b>81</b>

2_2_2 Have an emergency preparedness and response plan?	100	100	55.27	100	64.27	0	100	75.27	95.67	<b>77</b>
2_2_3 Plan been tested through one or more “mock events” in the past year?	100	100	0	100	33.33	33.33	100	33.33	100	<b>67</b>
2_2_4 Plan been reviewed or revised within the past two years?	100	100	0	100	66.67	33.33	100	33.33	100	<b>70</b>
<i>2.3 Investigate and Respond to Public Health Emergencies</i>	98.35	99.33	82	100	86.95	80	95.61	83.13	91.12	<b>91</b>
2_3_1 Designated an Emergency Response Coordinator?	100	100	53.33	100	100	0	100	100	90	<b>83</b>
2_3_2 Have current epidemiological case investigation protocols?	100	96.67	100	100	100	100	100	100	90	<b>99</b>
2_3_3 Written protocols for implementing program of source and contact tracing?	100	100	100	100	70.83	100	100	79.58	78.33	<b>92</b>
2_3_4 Roster of response personnel with technical expertise?	91.76	100	56.67	100	97.25	100	78.04	69.41	97.25	<b>88</b>
2_3_5 Evaluate public health emergency response incidents?	100	100	100	100	66.67	100	100	66.67	100	<b>93</b>
<i>2.4 Laboratory Support for Investigation of Health Threats</i>	100	100	100	100	91.67	91.67	100	91.67	83.33	<b>95</b>
2_4_1 Access to laboratory services to support investigations?	100	100	100	100	100	100	100	66.67	100	<b>96</b>
2_4_2 Access to laboratories capable of meeting routine diagnostic and surveillance needs?	100	100	100	100	100	66.67	100	100	66.67	<b>93</b>
2_4_3 Documentation that laboratories are licensed and/or credentialed?	100	100	100	100	66.67	100	100	100	66.67	<b>93</b>
2_4_4 Current guidelines or protocols for handling laboratory samples?	100	100	100	100	100	100	100	100	100	<b>100</b>
<b>EPHS 3: Inform, Educate, and Empower People</b>	44.61	79.62	66.72	50	92.62	90.44	53.15	85.34	63.68	<b>70</b>
<i>3.1 Health Education</i>	42.25	72.28	54.25	57.5	94.17	91.08	52.67	84.49	58.46	<b>67</b>

3_1_1 Information on community health to public and policy leaders?	54.07	76	62	54.07	100	100	76.67	90.67	62	<b>75</b>
3_1_2 Use media to communicate health information?	49.17	82.5	21.67	55	76.67	100	55	70.83	66.67	<b>64</b>
3_1_3 Sponsor health education programs?	65.78	73.94	66.67	76.28	100	100	79	84.44	68.5	<b>79</b>
3_1_4 Assessed public health education activities?	0	56.67	66.67	44.67	100	64.33	0	92	36.67	<b>51</b>
<i>3.2 Health Promotion Activities</i>	46.97	86.97	79.19	42.5	91.07	89.8	53.64	86.19	68.89	<b>72</b>
3_2_1 Implemented health promotion activities?	62.58	84.25	84.25	60.83	85.92	100	78.42	90.08	74.25	<b>80</b>
3_2_2 Collaborative networks for health promotion established?	78.33	88.33	76.67	66.67	94.17	100	82.5	100	66.67	<b>84</b>
3_2_3 Assessed health promotion activities?	0	88.33	76.67	0	93.13	69.39	0	68.48	65.76	<b>51</b>
<b>EPHS 4: Mobilize Community Partnerships</b>	64.82	76	75.31	39.03	78.31	45.21	77.92	83.16	72.15	<b>68</b>
<i>4.1 Constituency Development</i>	68.17	72.96	64.62	52.5	65.67	42.12	77.83	77.21	50.75	<b>64</b>
4_1_1 Process for identifying key constituents?	49.17	66.67	66.67	39.17	70.83	27.5	82.5	100	43.33	<b>61</b>
4_1_2 Encourage participation of constituents in improving community health?	76.67	66.67	66.67	46.83	83.67	46.83	75.5	80.17	55	<b>66</b>
4_1_3 Current directory of organizations that comprise the LPHS?	88.33	88.33	74.83	90.67	59.67	94.17	73.17	62	71.33	<b>78</b>
4_1_4 Use communications strategies to strengthen linkages?	58.5	70.17	50.33	33.33	48.5	0	80.17	66.67	33.33	<b>49</b>
<i>4.2 Community Partnerships</i>	61.48	79.04	86	25.56	90.96	48.3	78	89.11	93.56	<b>72</b>
4_2_1 Partnerships exist in the community?	84.44	84.44	76.67	43.33	92.22	92.22	100	76.67	100	<b>83</b>
4_2_2 Assure establishment of a broad-based community health improvement committee?	66.67	76	81.33	33.33	80.67	42.67	90.67	90.67	90.67	<b>73</b>
4_2_3 Assess the effectiveness of community partnerships?	33.33	76.67	100	0	100	10	43.33	100	90	<b>61</b>
<b>EPHS 5: Develop Policies and Plans</b>	55.9	74.85	73.85	43.64	68.74	49.56	60.25	67.09	68.65	<b>63</b>

<i>5.1 Governance Presence at Local Level</i>	86.17	98.19	97.28	86.62	99.09	99.09	97.28	81.11	98.64	<b>94</b>
5_1_1 Includes a local governmental public health entity?	91.83	94.56	91.83	93.19	97.28	97.28	91.83	76.67	95.92	<b>92</b>
5_1_2 Assures participation of stakeholders in implementation of community health plan?	66.67	100	100	66.67	100	100	100	66.67	100	<b>89</b>
5_1_3 Local governing entity (e.g., local board of health) conducts oversight?	0	0	0	0	0	0	0	0	0	<b>0</b>
5_1_4 Local governmental public health entity work with the state public health system?	100	100	100	100	100	100	100	100	100	<b>100</b>
<i>5.2 Public Health Policy Development</i>	22.22	67.44	51.06	29.06	59.28	57.33	33.33	58.5	67.06	<b>49</b>
5_2_1 Contribute to the development of public health policies?	0	69	53.17	53.83	77.83	72	0	75.5	73.67	<b>53</b>
5_2_2 Review public health policies at least every two years?	0	66.67	0	0	0	0	0	33.33	60.83	<b>18</b>
5_2_3 Advocate for the development of prevention and protection policies?	66.67	66.67	100	33.33	100	100	100	66.67	66.67	<b>78</b>
<i>5.3 Community Health Improvement Process</i>	73.95	70.98	93.45	0	72.82	0	86.78	86.25	46.11	<b>59</b>
5_3_1 Established a community health improvement process?	81.23	65.3	97.79	0	61.96	0	89.89	95.82	31	<b>58</b>
5_3_2 Developed strategies to address community health objectives?	66.67	76.67	89.11	0	83.67	0	83.67	76.67	61.22	<b>60</b>
<i>5.4 Strategic Planning and Alignment</i>	41.26	62.78	53.61	58.89	43.76	41.82	23.61	42.5	62.78	<b>48</b>
5_4_1 Each organization in the LPHS conduct a strategic planning process?	33.33	66.67	33.33	66.67	66.67	33.33	0	33.33	66.67	<b>44</b>
5_4_2 Each organization in the LPHS review its organizational strategic plan?	10	33.33	33.33	10	0	0	0	33.33	33.33	<b>17</b>
5_4_3 Local governmental public health entity conducts strategic planning activities?	80.46	88.33	94.17	100	64.62	92.12	70.83	60.83	88.33	<b>82</b>
<b>EPHS 6: Enforce Laws and Regulations</b>	63.24	87.74	73.61	42.31	84.35	75.46	54.54	74.94	76.22	<b>70</b>
<i>6.1 Review and Evaluate Laws, Regulations, and Ordinances</i>	50	97.67	58.33	83.33	66.67	75	50	69	87	<b>71</b>

6_1_1 Identify public health issues addressed through laws, regulations, or ordinances?	0	100	33.33	100	33.33	100	0	33.33	66.67	<b>52</b>
6_1_2 Access to current compilation of laws, regulations, and ordinances?	100	100	100	100	100	100	100	100	100	<b>100</b>
6_1_3 Review the public health laws and regulations every 5 years?	0	90.67	0	33.33	33.33	0	0	42.67	81.33	<b>31</b>
6_1_4 Access to legal counsel?	100	100	100	100	100	100	100	100	100	<b>100</b>
<i>6.2 Involvement in Improvement of Laws, Regs and Ordinances</i>	66.11	77.78	76.67	22.22	92.22	77.78	52.22	70	70.56	<b>67</b>
6_2_1 Identify local public health issues not adequately addressed through existing laws, regulations, and ordinance	43.33	66.67	53.33	33.33	76.67	100	56.67	66.67	66.67	<b>63</b>
6_2_2 Participated in the development or modification of laws, regulations or ordinances?	88.33	100	76.67	33.33	100	66.67	100	76.67	78.33	<b>80</b>
6_2_3 Provide technical assistance to legislative, regulatory or advocacy groups?	66.67	66.67	100	0	100	66.67	0	66.67	66.67	<b>59</b>
<i>6.3 Enforce laws, Regulations and Ordinances</i>	73.61	87.78	85.83	21.39	94.17	73.61	61.39	85.83	71.11	<b>73</b>
6_3_1 Authority to enforce public health laws, regulations, or ordinances?	100	100	100	45.56	100	100	100	100	84.44	<b>92</b>
6_3_2 Assure enforcement activities are conducted in a timely manner?	33.33	66.67	66.67	0	100	33.33	33.33	66.67	66.67	<b>52</b>
6_3_3 Provide information to individuals and organizations about public health laws, regulations, and ordinances?	100	92.22	100	20	100	76.67	66.67	100	66.67	<b>80</b>
6_3_4 Reviewed the activities of institutions and businesses in the community?	61.11	92.22	76.67	20	76.67	84.44	45.56	76.67	66.67	<b>67</b>
<b>EPHS 7: Link People to Needed Personal Health Services</b>	52.74	72.42	77.39	52.05	86.58	92.17	68.63	84.05	55.16	<b>71</b>
<i>7.1 Identification of Populations with Barriers to System</i>	80.67	88.33	100	71.33	100	100	100	97.67	66.67	<b>89</b>
7_1_1 Identify any populations who may encounter barriers?	80.67	88.33	100	71.33	100	100	100	97.67	66.67	<b>89</b>

<i>7.2 Identifying Personal Health Service Needs of Population</i>	44.44	68.22	100	37.22	100	100	63.33	100	44.44	<b>73</b>
7_2_1 Defined personal health service needs for all of its catchment areas?	33.33	66.67	100	33.33	100	100	33.33	100	33.33	<b>67</b>
7_2_2 Assessed the extent personal health services are being provided?	33.33	66.67	100	33.33	100	100	66.67	100	43.33	<b>71</b>
7_2_3 Identify the personal health services of populations who encounter barriers to personal health services?	66.67	71.33	100	45	100	100	90	100	56.67	<b>81</b>
<i>7.3 Assuring Linkage of People to Personal Health Services</i>	33.1	60.7	32.17	47.6	59.75	76.5	42.57	54.48	54.38	<b>51</b>
7_3_1 Assure the provision of needed personal health services?	26.33	52.67	0	59.67	45	66.67	28.67	52	35.67	<b>41</b>
7_3_2 Provide outreach and linkage services for the community?	39.17	55	21.67	55	33.33	76.67	33.33	33.33	43.33	<b>43</b>
7_3_3 Initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs?	100	100	66.67	33.33	100	100	100	66.67	100	<b>85</b>
7_3_4 Assure the coordinated delivery of personal health services?	0	62.5	39.17	56.67	53.75	72.5	50.83	53.75	59.58	<b>50</b>
7_3_5 Conducted an analysis of age-specific participation in preventive services?	0	33.33	33.33	33.33	66.67	66.67	0	66.67	33.33	<b>37</b>
<b>EPHS 8: Assure a Competent Public and Workforce</b>	57.84	60.52	53.4	40.95	56.34	64.62	58.38	63.79	58.22	<b>57</b>
<i>8.1 Workforce Assessment</i>	0	12.89	17.78	0	20.89	19.33	8	20.89	12.89	<b>13</b>
8_1_1 Conduct a workforce assessment within past three years?	0	0	0	0	0	0	0	0	0	<b>0</b>
8_1_2 Gaps within the public and personal health workforce been identified?	0	38.67	53.33	0	62.67	58	24	62.67	38.67	<b>38</b>
8_1_3 Results of the workforce assessment disseminated?	0	0	0	0	0	0	0	0	0	<b>0</b>

8.2 <i>Public Health Workforce Standards</i>	100	97.67	100	97.67	91.82	95.97	100	99.73	91	<b>97</b>
8_2_1 Aware of and in compliance with guidelines and/or licensure/certification requirements for personnel?	100	100	100	100	100	100	100	100	66.67	<b>96</b>
8_2_2 Organizations developed written job standards and/or position descriptions?	100	100	100	100	100	100	100	100	100	<b>100</b>
8_2_3 Agency developed job standards and/or position descriptions?	100	88.33	100	88.33	94.75	79.87	100	98.64	88.33	<b>93</b>
8_2_4 Organizations conduct performance evaluations?	100	100	100	100	66.67	100	100	100	100	<b>96</b>
8_2_5 Agency conducts performance evaluations?	100	100	100	100	97.67	100	100	100	100	<b>100</b>
8.3 <i>Continuing Education, Training and Mentoring</i>	83.33	71.47	66.67	47.5	70.03	85.35	71.04	73.06	67.22	<b>71</b>
8_3_1 Identify education and training needs?	100	83.67	100	56.67	70.13	100	90	76.67	66.67	<b>83</b>
8_3_2 Local governmental public health entity provide opportunities for personnel to develop core public health co	100	68.89	100	100	76.67	92.22	100	58.89	68.89	<b>85</b>
8_3_3 Incentives provided to the workforce to participate in educational and training experiences?	100	66.67	33.33	33.33	66.67	82.5	60.83	90	66.67	<b>67</b>
8_3_4 Opportunities for interaction between LPHS organization staff and faculty from academic and research institutes	33.33	66.67	33.33	0	66.67	66.67	33.33	66.67	66.67	<b>48</b>
8.4 <i>Public Health Leadership Development</i>	48.03	60.07	29.14	18.64	42.61	57.82	54.47	61.51	61.76	<b>48</b>
8_4_1 Promote the development of leadership skills?	58.79	63.6	39.9	41.21	37.12	64.62	41.21	56.02	57.04	<b>51</b>
8_4_2 Promote collaborative leadership?	33.33	43.33	10	0	33.33	33.33	53.33	66.67	66.67	<b>38</b>
8_4_3 Opportunities to provide leadership in areas of expertise or experience?	66.67	66.67	33.33	33.33	66.67	66.67	66.67	66.67	66.67	<b>59</b>
8_4_4 Opportunities to develop community leadership through and mentoring?	33.33	66.67	33.33	0	33.33	66.67	56.67	56.67	56.67	<b>45</b>
<b>EPHS 9: Evaluate Effectiveness, Accessibility</b>	19.11	62.28	38.36	38.16	56.71	44.67	46.71	58.54	46.65	<b>46</b>

**and Quality**

<i>9.1 Evaluation of Population-Based Services</i>	13.75	64.85	64.33	12.29	77.72	25	38.75	78.96	48.54	<b>47</b>
9_1_1 Evaluated population-based health services?	21.67	59.39	63.17	33.33	77.56	0	55	88.33	0	<b>44</b>
9_1_2 Assess community satisfaction with population-based health services?	0	66.67	60.83	15.83	66.67	0	0	94.17	60.83	<b>41</b>
9_1_3 Identify gaps in the provision of population-based health services?	33.33	66.67	66.67	0	66.67	66.67	66.67	66.67	66.67	<b>56</b>
9_1_4 Use the results of the evaluation in the development of their strategic and operational plans?	0	66.67	66.67	0	100	33.33	33.33	66.67	66.67	<b>48</b>
<i>9.2 Evaluation of Personal Health Care Services</i>	18.58	77	25.73	85.53	67.42	84	42.22	63.33	66.4	<b>59</b>
9_2_1 Evaluated personal health services for the community?	35.56	66.67	66.67	66.67	61.11	90	51.11	66.67	56.67	<b>62</b>
9_2_2 Specific personal health care services in the community evaluated against established criteria?	35.67	100	38.67	97.67	52.67	100	66.67	66.67	95.33	<b>73</b>
9_2_3 Assess client satisfaction with personal health services?	0	63.33	23.33	63.33	46.67	63.33	50	50	46.67	<b>45</b>
9_2_4 Use information technology to assure quality of personal health services?	21.67	88.33	0	100	76.67	100	10	66.67	66.67	<b>59</b>
9_2_5 Use the results of the evaluation in the development of their strategic and operational plans?	0	66.67	0	100	100	66.67	33.33	66.67	66.67	<b>56</b>
<i>9.3 Evaluation of Local Public Health System</i>	25	45	25	16.67	25	25	59.15	33.33	25	<b>31</b>
9_3_1 Identified community organizations or entities that contribute to the delivery of the EPHS?	100	100	100	66.67	100	100	100	100	100	<b>96</b>
9_3_2 Evaluation of the LPHS conducted every three to five years?	0	0	0	0	0	0	74.09	0	0	<b>8</b>
9_3_3 Linkages and relationships among organizations that comprise the LPHS assessed?	0	0	0	0	0	0	0	33.33	0	<b>4</b>

9_3_4 Use results from the evaluation process to guide community health improvements?	0	80	0	0	0	0	62.5	0	0	<b>16</b>
<b>EPHS 10: Research for New Insights and Innovative Solutions</b>	25.93	45.22	15.7	16.83	39.49	61.02	10.8	46.7	30.65	<b>32</b>
<i>10.1 Fostering Innovation</i>	33.33	27.5	16.67	0	33.33	62.78	16.67	39.72	37.78	<b>30</b>
10_1_1 Encourage staff to develop new solutions to health problems in the community?	66.67	43.33	0	0	66.67	84.44	0	58.89	51.11	<b>41</b>
10_1_2 Proposed to research organizations one or more public health issues for inclusion in their research agenda?	0	0	0	0	0	33.33	0	0	0	<b>4</b>
10_1_3 Identify and/or monitor “best practices” developed by other public health agencies or organizations?	66.67	66.67	66.67	0	33.33	100	66.67	66.67	66.67	<b>59</b>
10_1_4 Encourage community participation in the development or implementation of research?	0	0	0	0	33.33	33.33	0	33.33	33.33	<b>15</b>
<i>10.2 Linkage with Institutions of Higher Learning and Research</i>	44.44	56.3	15.09	37.78	46.39	44.44	15.74	45.19	12.5	<b>35</b>
10_2_1 Partner with at least one institution of higher learning and/or research organization?	66.67	0	0	0	0	0	0	0	0	<b>7</b>
10_2_2 Develop relationships with institutions of higher learning and/or research organizations?	66.67	100	27.5	56.67	72.5	66.67	21.67	76.67	37.5	<b>58</b>
10_2_3 Encourage proactive interaction between the academic and practice communities?	0	68.89	17.78	56.67	66.67	66.67	25.56	58.89	0	<b>40</b>
<i>10.3 Capacity for Epidemiological, Policy and Service Research</i>	0	51.87	15.33	12.71	38.75	75.83	0	55.18	41.67	<b>32</b>
10_3_1 Access to researchers?	0	90	61.33	0	66.67	100	0	76	100	<b>55</b>
10_3_2 Resources to facilitate research within the LPHS?	0	84.17	0	50.83	78.33	90	0	62.5	66.67	<b>48</b>
10_3_3 Plan for the dissemination of research findings to public health colleagues?	0	33.33	0	0	10	56.67	0	33.33	0	<b>15</b>
10_3_4 Evaluate research activities?	0	0	0	0	0	56.67	0	48.89	0	<b>12</b>

<b>Average Total Performance Score</b>	52.49	68.88	59.73	43.91	70.74	63.72	58.07	69.6	59.36	<b>61</b>
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## APPENDIX C: PARTICIPANT RECOMMENDATIONS FROM AUGUST 27

On August 27, the Public Health Division convened a meeting to make recommendations for what the Division and its partners could do to put the priorities identified on August 26. Shown here are the priorities by Essential Service and the recommendations for putting them into operation. Note, the bulleted lists of priorities and recommendations are not necessarily in order of importance

The formats for the meetings on August 26 and 27 were in the nature of brainstorming. The various suggestions should be regarded as the opening of a more deliberative planning process.

### **Essential Service #1 Monitor health status to identify and solve community health problems.**

#### Priorities

- Improve data sharing-inter-agency, intra-agency, and via central repositories
- Market data to enhance ability of local entities to access and use data
- Centralize and analyze data and improve capacity at local level using Epidemiology staff

To put these priorities into operation, the following recommendations were made:

- Maximize data sharing by removing barriers and improve data access by mandate and/or implementation of existing policy.
- Develop a data library
  - Have a full-time librarian by February 2004.
  - Develop an advisory group with broad representation. The group would create the full time librarian position.
  - Assure the workforce is aware of what resources exist and how to utilize them.
- Improve local capacity to get the data they need by having coordinated analysis at a central level (identify what local areas want and provide centrally). State Health Office to coordinate all data necessary for public health monitoring
  - Use the information to monitor health status in the state plan.
  - The hospital discharge database could be improved by the addition of federal hospitalizations and hospitalizations of a person from New Mexico hospitalized in a bordering state.

### **Essential Service #2 Diagnose and investigate health problems and health hazards in the community.**

#### Priorities

- Apply the “outbreak approach” to other health and social issues (analyze, mobilize, communicate, zoom-in, etc.).
- Enhance the ability of local levels to interpret information and respond.

To put these priorities into operation, the following recommendations were made:

- Develop and pilot an “outbreak” approach to non-infectious public health risks.

- Explore health disparities based on the Ten Essential Services and applied equally across populations for identified key health disparity problems.
- Strengthen staff risk communication skills to the public.

Mechanisms to enhance Public Health Essential Services:

Local: Engage local health councils.

State: Integrate the Ten Essential Services into the State Plan.

**Essential Service #3 Inform, educate and empower people about health issues, and Essential Service #4 Mobilize community partnerships and action to identify and solve health problems.**

Priorities

- Improve cultural competence in health education, promotion, community mobilization, and service delivery.
- Improve evaluation (includes evaluation of partnerships' effectiveness in changing health status).
- Increase awareness of social determinants as key variable in health status in all venues and levels (e.g., sustained cooperation between Secretaries of Health and Economic Development).
- Commit consistent funding to maintain community health improvement processes.

To put these priorities into operation, the following recommendations were made.

To improve cultural competence in health education, promotion, community mobilization and service delivery:

- Conduct an assessment of intercultural competency materials including people working on intercultural competence within PHD and DOH.
- Require the Intercultural Competence Module (include socioeconomic status, gay, lesbian etc..) for all PHD employees. Later extend to DOH. Identify opportunities to practice and discuss what is learned and meant by intercultural competency.
- Require cultural competency in Performance Appraisal Development (PAD) for PHD employees.
- Next step: Health Disparities Workgroup asks DOH Division Director Joyce to develop a memo from the Leadership Team to all PHD employees. The memo states that cultural competence training is a priority and must be on the competency list and development plan for PADs.
- Identify how many clients in programs need interpreters.
- Implement linguistic recommendations from the PHD Committee to include:
  - -interpreter service available to use for all clinics
  - -compensation for bi-lingual employees who have skills to interpret in a medical setting
- Have the Intercultural Competence Module become part of the Community Health Improvement Training Initiative (CHITI) curriculum for internal and community people. Next step: Ask Quality Council to review the Intercultural

Competence Module along with the Director's Office to include in CHITI curriculum.

- Each PHD Bureau and District develops an action plan to address intercultural competence. When strategic and operational program plans are developed cultural competency is included. Leadership needs to support cultural competence at all levels. It is a quality issue.
  - Take the intercultural competency conversation and previous action items to local offices and communities to get additional input and recommendations.
  - Engage the tribes in a discussion about intercultural competence.
  - Ask the Health Disparities Workgroup to document this intercultural competency process as it unfolds so successes can be replicated.

To improve evaluation (includes evaluation of partnerships' effectiveness in changing health status):

- Develop an overarching framework and priorities for evaluation and use in all program planning and contracts. Explore whether or not the adopted outcomes framework is the overarching framework. Participants include: the Office of Epidemiology, Program Planners, Quality Team, and Local Councils.
- Assess all the evaluation activities and people conducting within PHD. Action: Request the Leadership Team to identify people doing evaluation work at the Sept. Leadership Meeting Result: Develop a map of what we are doing throughout PHD.
- Develop a menu of evaluation resources including technical assistance available to programs and contractors.
- Offer training, better support and assistance for evaluation on the local level. In the training, address the misunderstanding of evaluation.
- Examine UNM model of having a centralized Office of Evaluation.
- Develop a better understanding of how performance measurement fits into evaluation.

The following should be included in the Health Plan:

- Improve the health status of all people living in New Mexico.
- Reduce health disparities in the population.
- Improve intercultural competence in the workplace.

**Essential Service #5 Develop policies and plans that support individual and community health efforts.**

Priorities

- Institutionalize planning process to include annual local forums to provide local input to department decision makers (input not just advisory) and to include community health council priorities in developing the state health plan.
- Design a system that ensures public input into policy development and review.

To put these priorities into operation, the following recommendations were made:

- Community Health Improvement Steering Committee (CHISC) is developing a community input process. The process needs to include all communities and local

- health councils in the entire state (not just DOH funded councils). Community input processes should include regular public forums on an annual basis (perhaps two per District). Timeframe: Within one month
- Develop mechanism to better coordinate the various PHD programs that support local Councils. Who: PHD Director and other Division Directors (BHSD)  
Timeframe: within two months
  - Local communities need to be given the responsibility for obtaining community input including arranging community forums.
  - Develop a communication plan to give feedback to communities on actions taken as a result of their input. Who: Districts and Joyce discuss with Senior Leadership Timeframe: within two months
  - Take data to communities. Local communities will decide what to do /how to improve their local health system. DOH gives direction and support with flexibility for implementation.
  - Give Districts funds to distribute to communities to fund their priorities. Based on data and on state and locally ranked priorities. Timeframe: Use FY 04-05 to develop mechanism for FY 06 to fund local priorities.
  - Resources must be provided for this ongoing public involvement effort. Put a moratorium on reducing district resources.

**Essential Service #6 Enforce laws and regulations that protect health and ensure safety.**

Priorities

- Ensure cross-agency collaboration in regulation review, regulation development and enforcement.
- Evaluate the capacity of state and local agencies to enforce policies and regulation including human and financial resource capacity.

To put these priorities into operation, the following recommendations were made:

- The DOH Office of General Counsel (OGC) will determine and articulate the specific PHD authority to enforce regulations. OGC will also articulate when other agencies have an enforcement role. Timeframe: 6-12 months to complete process
- Upon the receipt of the report, the PHD Leadership team will assess the human and financial resources necessary to do the enforcement.
- DOH Secretary will lead the development of a cabinet level interagency process to collaborate on enforcement of laws and regulations. This would increase effectiveness and reduce duplication. Develop a process for additional collaboration with Environment Department, Corrections, Public Safety, County Government and other entities needed for enforcement. Timeframe: 6-12 months to complete process.

**Essential Service #7 Link people to needed personal health services and ensure the provision of healthcare when otherwise unavailable.**

### Priorities

- Address the fragmentation and problems of trying to navigate the health care system; address the poor communication (between players).
- Evaluate the system (including its quality), and increase awareness of what's available.

To put these priorities into operation, the following recommendations were made:

- Facilitate process to assess services, gaps and future plans. Players should include the Assessment Development Forum.
- Identify opportunities for one stop shopping (i.e. Sandoval County) and information for collaboration and construction. Identify partners to maximize resources. Timeline: Ongoing basis Who: Local Public Health Office staff Resource: website-Governmental construction/leasing
- Convene community providers in a defined geographical area to identify and coordinate care (treatment plan, counseling in homes) for the 20% high risk (multi-issue families). Who: All Divisions should cooperate and collaborate and PHD needs to commit the resources.
- Develop statewide information resource such as a 211 services database with referrals for community services. Next steps: Convene group; agree on system database-design; develop and implement with multi-language capacity. Timeframe: Within three years.

To put these action steps into operation, the following needs to be addressed between the state, districts, and localities:

- Planning, coordination, and infrastructure activity must be considered essential for effective operations.
- Use the Public Health Assessment for action. Integrate evaluation throughout. Who: People of New Mexico, business community, ask universities to increase their communication around funding for evaluation. Timeline: within three years

### **Essential Service #8 Assure a competent public and personal workforce.**

#### Priorities

- Conduct a comprehensive and coordinated health assessment and include in Strategic Plan. Build database with in relevant provider and other system information.
- Assure recruitment and retention of providers. Identify best practices.
- Prioritize workforce development in Strategic Plan with better ties to universities and continuing education resources.

To put these action steps into operation, the following recommendations were made:

- Ask local health councils or develop a taskforce to focus on community workforce resource needs and retention. Who: Lt. Governor convenes a Workforce Commission to discuss health professional development.
- PHD to provide specific training to provide competency-based training for staff.

- Develop and use retiree pool. Bring back retired physicians, nurses and others health professionals. Incentives could include: the availability of malpractice insurance, money for CEU's and health insurance availability.
- Workforce development assessment would be done by accessing funding from available sources.
- Offer education and training broadly to communities.
- Agencies should mentor and precept students.
- Need staff for training, staff development and evaluations.
- Utilize District One model for preceptors in certain disciplines.
- Investigate feasibility for State Health Board and County Health Board (not county health departments) established by statute.
- Conduct PHD staff satisfaction survey and understand why people leave.
- Address the slow hiring process and need for a career ladder in PHD. Partners: SPO and DFA
- Conduct supervisor training on leadership, mentoring and coaching. Develop clinical supervision competencies.
- Fund Health Resources to assess the needs of other professionals more broadly than just physicians.

**Essential Service #9 Evaluate effectiveness, accessibility, and quality of personal and population-based health services.**

Priorities

- Develop a statewide evaluation system.
- Develop education consortium with all institutions and maximize the use of resources statewide.
- Establish evaluation training institute by pooling resources of partners.

To put these priorities into operation, the following recommendations were made:

- Inventory the evaluation capacity resources tools of DOH. Use the model standards 9.1-9.3 to develop questionnaire for the Division.
- Convene outside department partners that are focused on evaluation including universities to get consultation and direction for the Evaluation Plan.
- Recognize and articulate the distinction between contract monitoring and evaluating program effectiveness.

Who: Governor, DOH Secretary, and elected officials

Timeline: March 31, 2004

**Essential Service #10 Research for new insights and innovative solutions to health problems.**

Priorities

- VI. Establish statewide research agenda, emphasizing community based participatory research.
- VII. Establish health research system that is similar to state agricultural research system.

To put these priorities into operation, the following recommendations were made:

- Develop a formal research partnership with those organizations involved in personal, public and public health systems. Do research that focuses on reducing health disparities. Who: DOH Secretary's Office, Office of Epidemiology, Entities involved in Agriculture Research System. Timeline: June 2004