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State Public Health System Performance Assessment *for New Jersey*



*Final Report Prepared by
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A. BACKGROUND

The state of New Jersey completed the State Public Health System Performance Assessment (SPHSPA). New Jersey is the 25th state in the country to utilize the state assessment instrument. The SPHSPA is one of three assessments that make up the National Public Health Performance Standards Program (NPHPSP). The NPHPSP is a collaborative effort of seven national partners, the U.S. Centers for Disease Control and Prevention (CDC), Association of State and Territorial Health Officials (ASTHO), and National Association of County and City Health Officials (NACCHO) among them.

The NPHPSP efforts aim to improve the practice of public health and the performance of public health systems. The primary purpose of the assessments is to answer questions such as “What are the activities and capacities of our public health system” and “How well are we providing the Essential Public Health Services?” The instrument results guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. The overarching goal of the assessment is to strengthen and improve the public health system.

The SPHSPA is based on the framework of the ten Essential Public Health Services. The Essential Services represent the spectrum of public health activities that should be provided in any jurisdiction. Therefore, the instrument itself is divided into ten sections – one for each of the Essential Services. The ten Essential Services are as follows.

1. **Monitor** health status to identify community health problems
2. **Diagnose and investigate** health problems and health hazards in the community
3. **Inform, educate, and empower** people about health issues
4. **Mobilize** community partnerships to identify and solve health problems
5. **Develop policies and plans** that support individual and community health efforts

6. **Enforce** laws and regulations that protect health and ensure safety
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable
8. **Assure** a competent public and personal health care workforce
9. **Evaluate** effectiveness, accessibility and quality of personal and population-based health services
10. **Research** for new insights and innovative solutions to health problems

The audience for the state assessment is the state public health system. This may include organizations and entities such as the state public health agency, other state governmental agencies, statewide associations of local public health agencies, hospitals and health professionals, schools and universities, state chapters of voluntary or non-profit organizations, transportation providers, environmental organizations and many others. Any organization or entity that contributes to the health or well-being of a state is considered part of the public health system. For the New Jersey assessment, participants included representatives of State and local public health agencies, public health associations, healthcare provider associations, local and state human service agencies, local boards of health, and other government agencies and non-profit associations with public health involvement (e.g. Department of Agriculture, American Cancer Society).

There are 40 Model Standards within the state instrument - four for each of the ten Essential Public Health Services (EPHS). Each Model Standard represents an ideal or optimal standard of performance. The same four Model Standards are assessed within each Essential Service:

- Planning and Implementation: focuses on collaborative planning and implementation of key activities to accomplish the Essential Services.
- State-Local Relationships: examines the assistance, capacity building, and resources that the state public health system provides to local public health systems in efforts to implement the Essential Services.
- Performance Management and Quality Improvement: focuses on the state public health system's efforts to review the effectiveness of its

performance and the use of these reviews to continuously improve performance.

- **Public Health Capacity and Resources:** examines how effectively the state public health system invests in and utilizes its human, information, organizational and financial resources to carry out the Essential Services.

The full instrument includes several hundred items, organized in a structure of multiple sections and subsections. The following pictures depict the general structure of the state assessment.

The image shows a screenshot of the 2009 SPHSPA assessment instrument. It is divided into three main sections, each highlighted with a red oval and a blue arrow pointing to a label on the right:

- Essential Service:** The top section is titled "Essential Service #3: Inform, Educate, and Empower People about Health Issues". It lists several activities such as health information, health education, health promotion, health communication plans, and accessible health information resources.
- Model Standard:** The middle section is titled "Governance Model Standard 3: Oversight of Public Health Information, Education, and Empowerment Activities". It describes the role of the governing body in ensuring the implementation of health education and promotion activities.
- Stem Question:** The bottom section contains a question: "3.1 Does the BOH assess the availability of national, state, or local resources required for community health education and promotion programs?". Below the question is a "Discussion Toolbox" with checkboxes for "Financial resources?" and "Personnel resources?".

At the bottom left, the text "New Jersey 2009 SPHSPA" is visible. At the bottom right, the page number "5" is displayed.

Respondents were asked to rate each item according to the response options outlined below.

NO ACTIVITY	0% or absolutely no activity.
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.
SIGNIFICANT ACTIVITY	Greater than 50%, but no more than 75% of the activity described within the question is met.
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.

Further information on the National Public Health Performance Standards Program can be found at <http://www.cdc.gov/od/ocphp/nphpsp>.

B. PROCESS

On April 23 and 24, 2009, 97 individuals from throughout the state of New Jersey convened to participate in the State Public Health System Performance Assessment (SPHSPA). The initial day of the exercise began with a presentation by representatives from CDC and ASTHO. The presentation provided an overview of the NPHPSP initiative and oriented participants to the two-day process. Following the orientation and overview, participants were assigned to smaller breakout groups for the remaining day and a half. Each group consisted of between 16 and 21 individuals and there were a total of five breakout groups. Each of the five groups was assigned to two of the ten Essential Public Health Services (EPHS), completing one each day. Participants were designated to the respective breakout groups depending on their background and ability to contribute to their particular EPHS.

Within each breakout group, participants spent time discussing each model standard and “stem” questions associated with the EPHS. Each group was facilitated by a representative from Holleran, a Lancaster, Pennsylvania-based research and consulting firm. The objectivity of the facilitators allowed for a non-biased implementation of the assessment. Following the information sharing and discussion, participants then responded to the instrument questions via a wireless keypad voting system. Following the vote, the group responses were shown. On occasions where the group was highly divided, the item was discussed again and a re-vote occurred. The determination of whether to re-vote or not was dependent on the spread of votes and the group consensus as to whether a re-vote was needed.

Upon completion of the two-day exercise, the individual ratings were tallied and interpreted. The response to each question that was designated as the group’s consensus answer was the median response to each question. All responses were then entered into the NPHPSP web-based data entry system. A quantitative report was then generated to demonstrate average ratings within a model standard, EPHS scores, etc. The remainder of the current report integrates both the quantitative ratings generated from that report and the qualitative feedback that was provided during the assessment. Note takers in each breakout group captured the “whys” behind the various ratings, which provides additional perspective on high and low scores.

It should also be noted that following the completion of each model standard, participants were asked to answer an “agency contribution” question. This question assesses to what extent the state public health agency contributes to that particular model standard. The agency contribution ratings can be found on page 53.

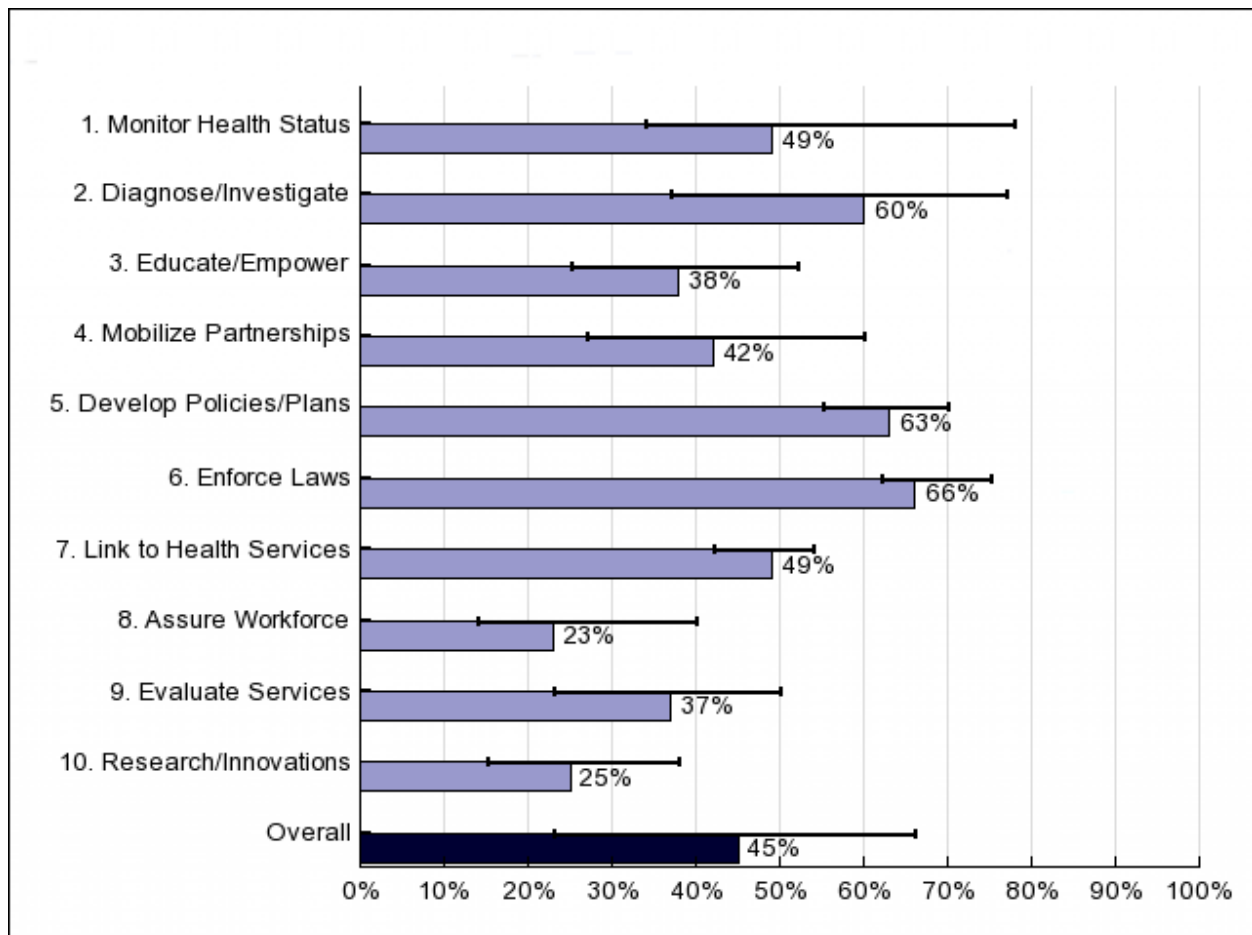
Model Standard Number	Question	Response <i>(please circle)</i>
Essential Service #1 - Monitor health status to identify health problems		
A1.1	How much of this model standard - Planning and Implementation around Essential Service #1 - is achieved through the direct contribution of the state public health agency?	0-25% 26-50% 51-75% 76-100%
A1.2	How much of this model standard - State-Local Relationships around Essential Service #1 - is achieved through the direct contribution of the state public health agency?	0-25% 26-50% 51-75% 76-100%
A1.3	How much of this model standard - Performance Management and Quality Improvement around Essential Service #1 - is achieved through the direct contribution of the state public health agency?	0-25% 26-50% 51-75% 76-100%
A1.4	How much of this model standard - Public Health Capacity and Resources around Essential Service #1 - is achieved through the direct contribution of the state public health agency?	0-25% 26-50% 51-75% 76-100%

C. ASSESSMENT SUMMARY

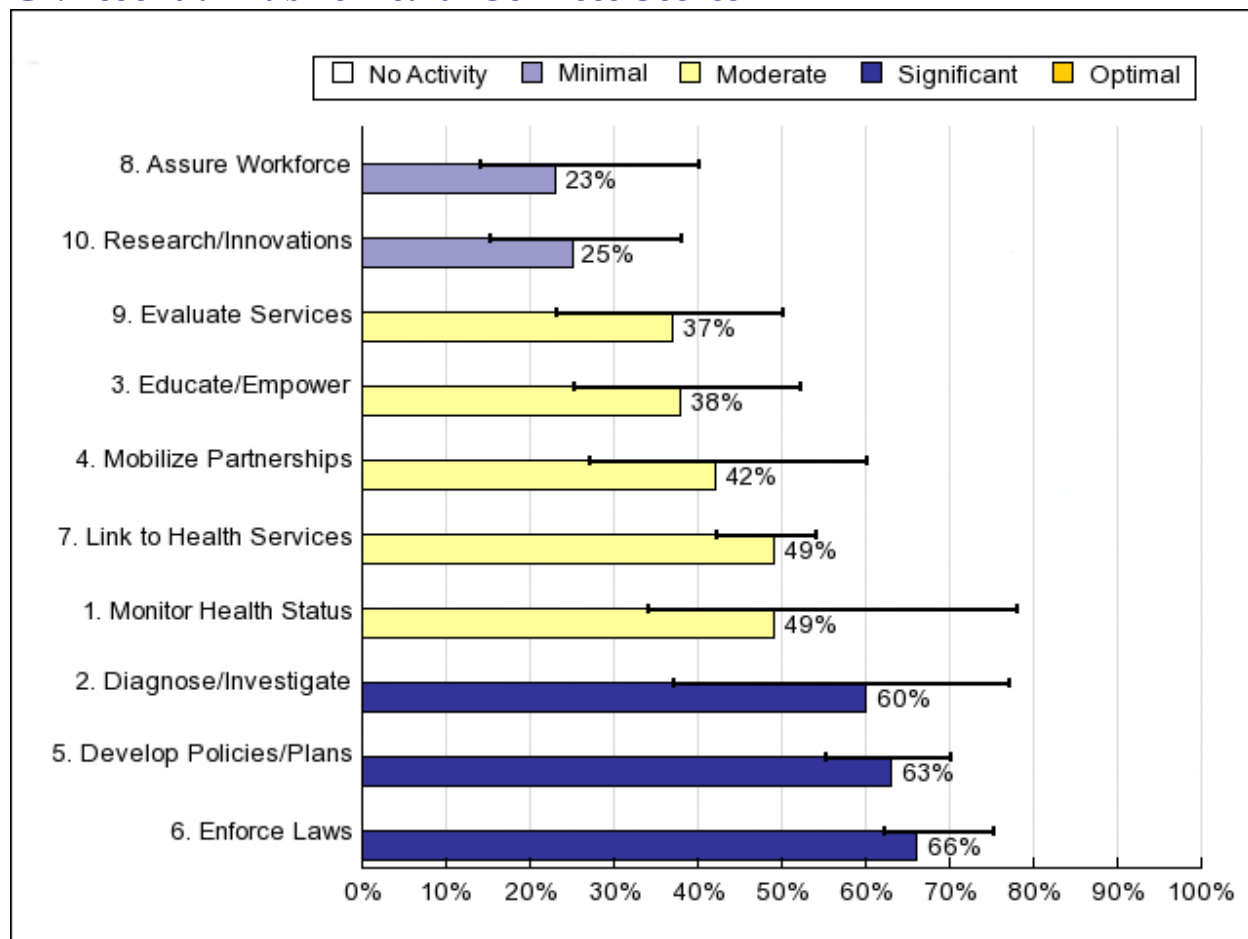
Overall trends

The following bar graphs (C1, C2) outline the average score within each of the ten EPHS. These scores can potentially range from a minimum value of 0% (absolutely no activity is performed pursuant to the standards) to a 100% (all activities associated with the standards are performed at optimal levels). The range bars show the minimum and maximum values of the four Model Standard scores within each Essential Service.

C1. Essential Public Health Services Scores



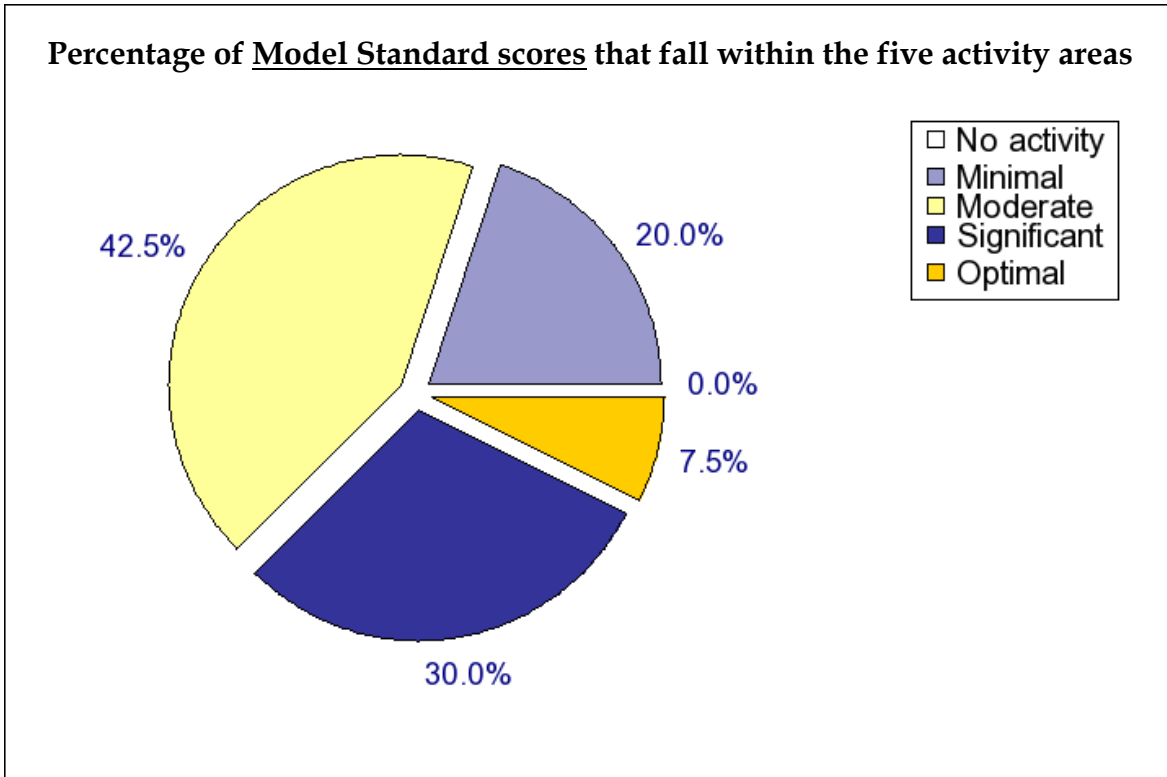
C2. Essential Public Health Services Scores



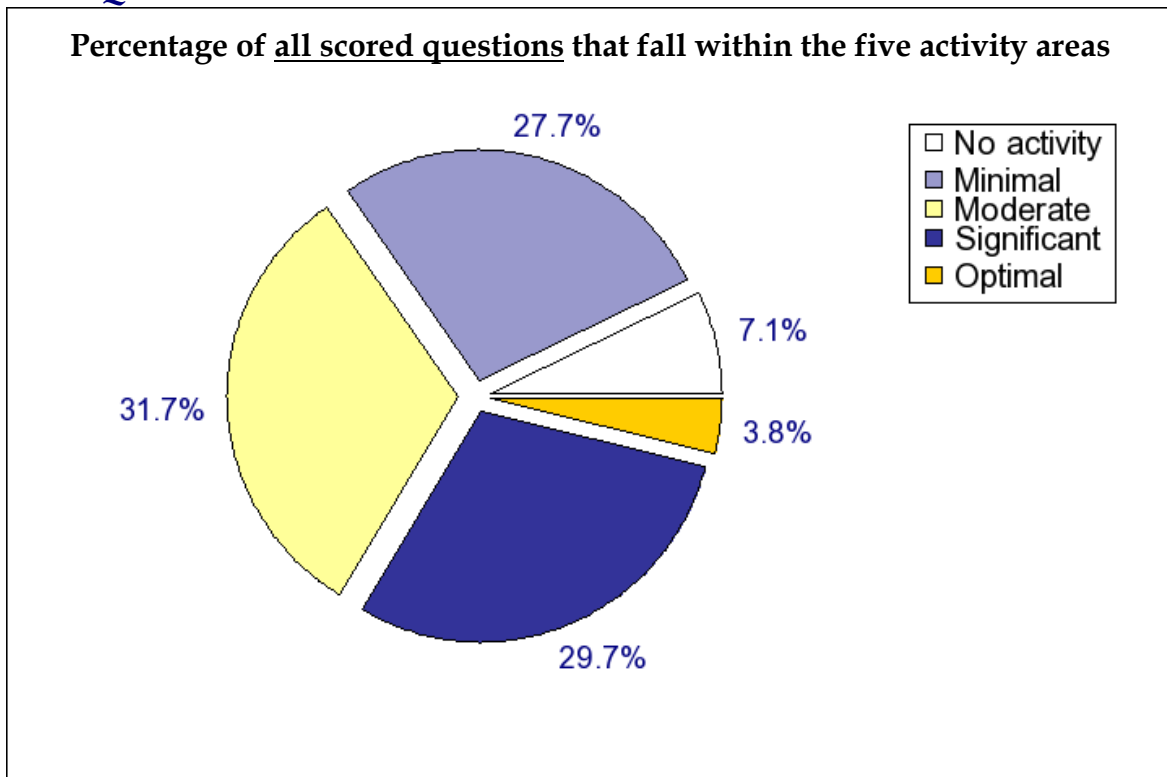
Examination of the graphs shows that the overall average for the entire assessment is 45%. This translates into the “moderate activity” category of attainment. Half of the EPHS fall into the “moderate activity” category, three in the “significant activity” designation and two of the Essential Services reveal ratings of “minimal activity.” The EPHS with the greatest variation across the four Model Standard ratings is Essential Service 1, “Monitor Health Status.” The least variation is seen with Essential Service 6 (Enforcement of Laws) and Essential Service 7 (Link to Health Services).

The two following graphs show a breakdown of all Model Standard ratings and ratings for all questions in total along with their respective categories of attainment. For the Model Standard ratings, no ratings of “no activity” were given and the largest proportion was rated as “moderate activity.” On a positive note, 7.5% were viewed as “optimal activity.”

C3. Model Standard Performance

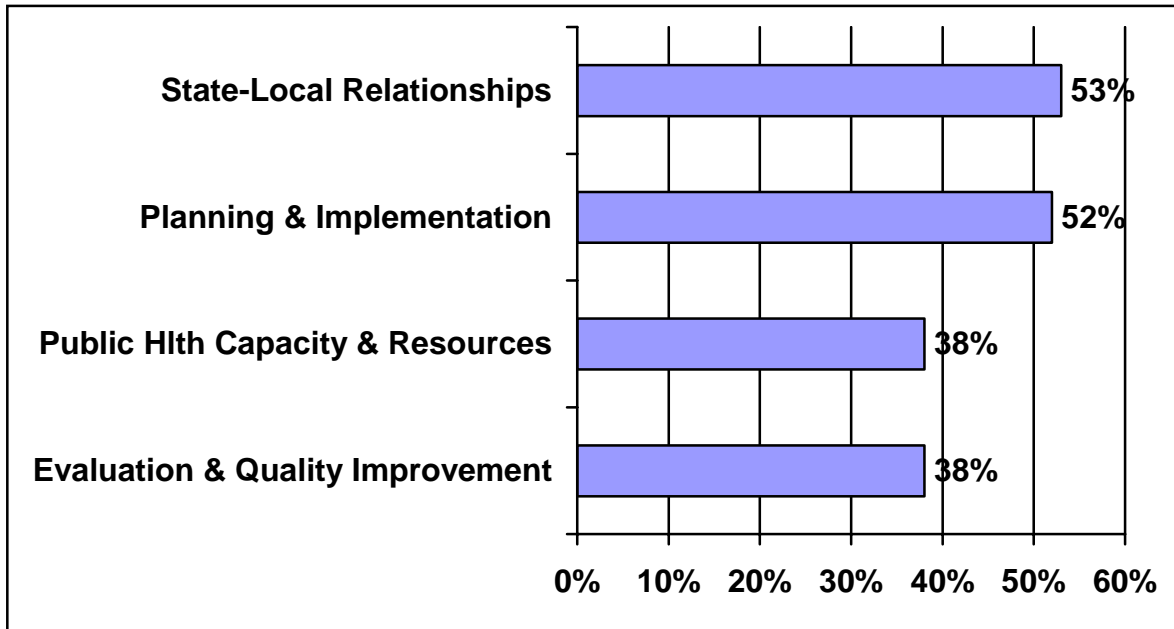


C4. All Questions Performance



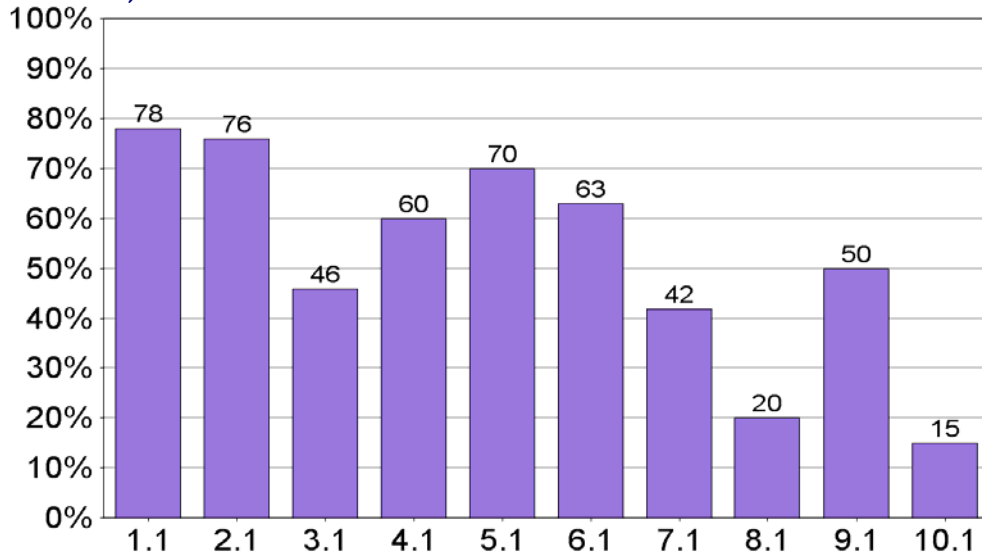
As outlined by the graph below (C5), of the four Model Standards, “State-Local Relationships” garnered the highest ratings, although only slightly higher than the “Planning and Implementation” Model Standard. “Performance Management and Quality Improvement” along with “Public Health Capacity and Resources” were tied for the lowest rating.

C5. Model Standard Ratings

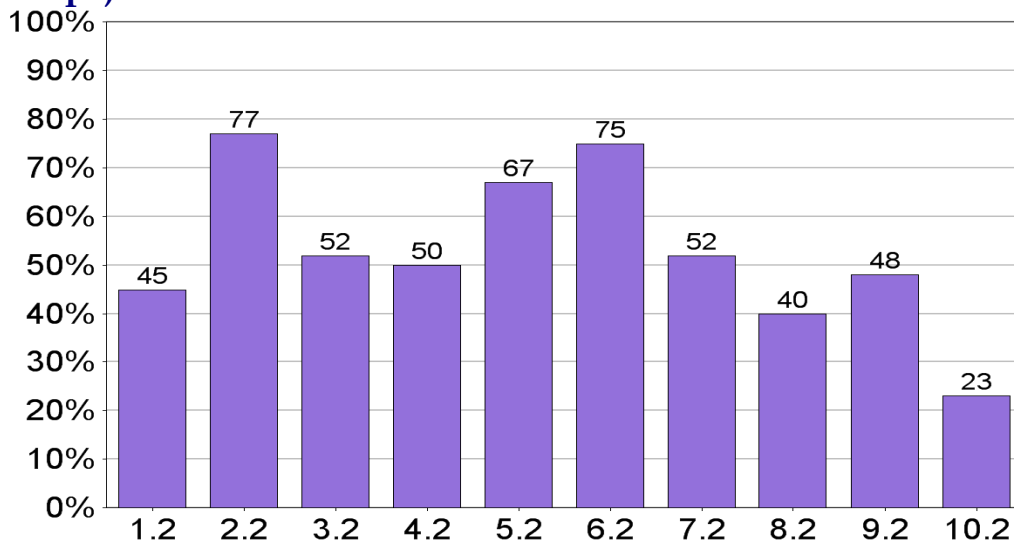


Tables C6 through C9 detail the rating for each of the ten Essential Services within each of the four Model Standards.

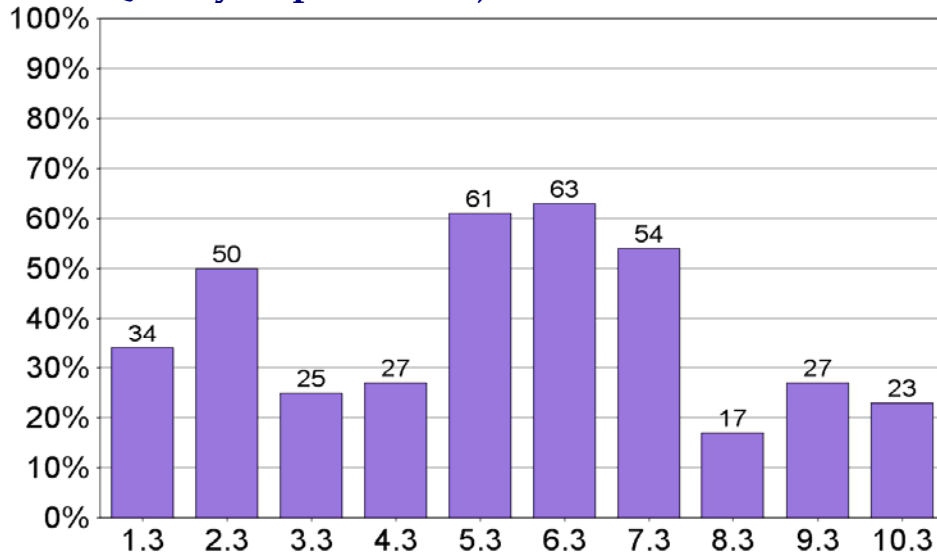
C6. Essential Service ratings for Model Standard 1 (Planning & Implementation)



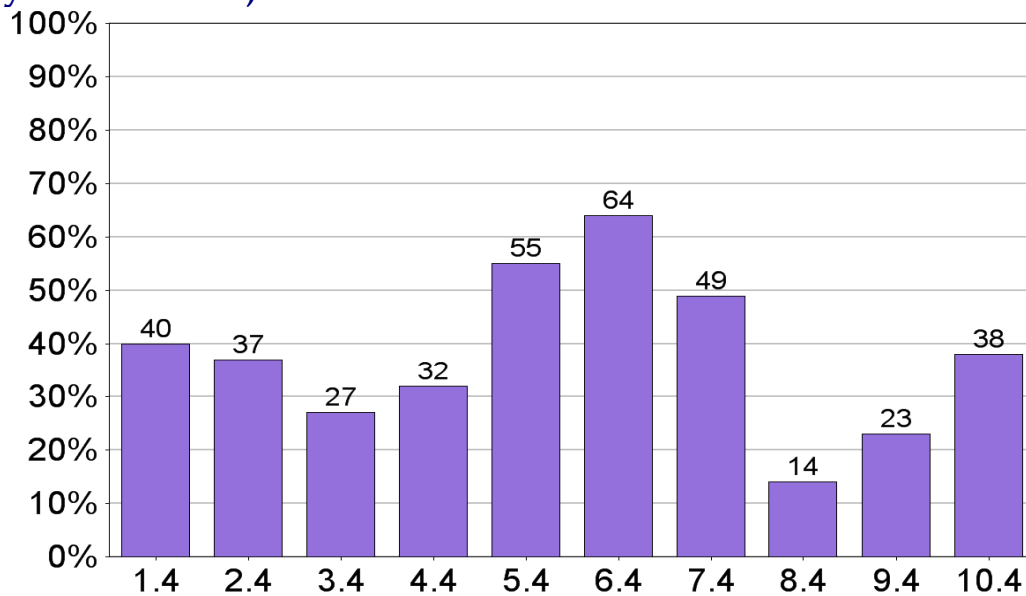
C7. Essential Service ratings for Model Standard 2 (State-Local Relationships)



C8. Essential Service ratings for Model Standard 3 (Performance Management & Quality Improvement)



C9. Essential Service ratings for Model Standard 4 (Public Health Capacity & Resources)



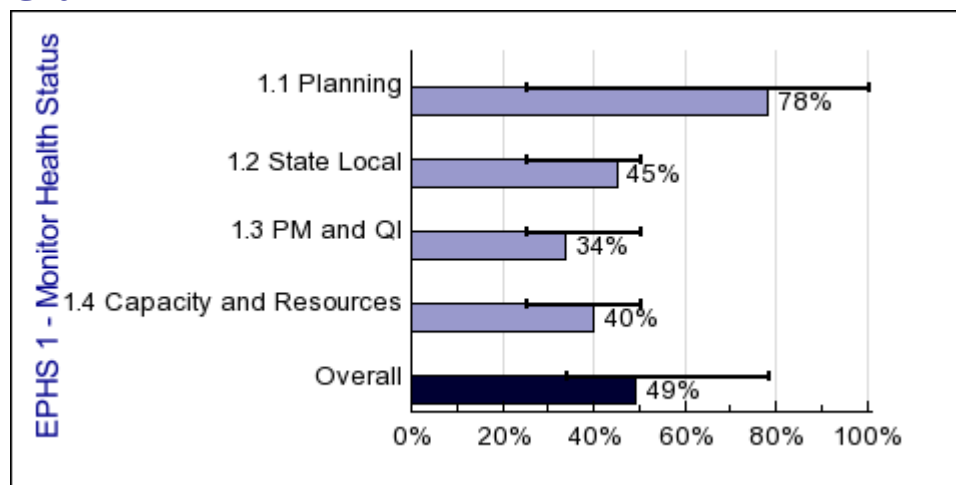
EPHS 1: Monitor Health Status to Identify Community Health Problems

This service includes:

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

Essential Service 1 was the fourth highest rated section on the assessment, with an average rating of 49%. The 49% equates to “moderate activity,” but is borderline for “significant activity” (50-75%). Interestingly, this section also had the largest variation across stem section scores. The scores ranged from two perfect (100%) scores to two ratings of 25%. The following table outlines the range of scores across the four Model Standards.

C10



Model Standard 1: Planning & Implementation

New Jersey was rated quite high (78%) in its planning and implementation activities for monitoring health status. For example, “optimal” (100%) scores were obtained for the state’s operation of data reporting systems to identify potential health threats and for the enforcement of established laws and protocols to protect personal health information. Significant activity was also observed in the state’s use of monitoring and surveillance programs to measure the health status of the population along with the publication of health-related data for the state in one or more reports. While there appears to be a good deal of monitoring of health status, participants observe a fragmented system across divisions and jurisdictions.

Discussion

- *Systems are not always linked and may be difficult to obtain/share data across jurisdictions. Communication across divisions is not always good.*
- *Still too much of a mix of paper and electronic records.*
- *Entering data into the state systems can be cumbersome.*
- *Some data (mental health, substance abuse) doesn’t capture private sector, only reflects those using state subsidized services.*
- *Data is often dated. Real-time or more up-to-date would be ideal.*
- *Often collect data, but feel nothing is done with it. Data collection is mandated, but no mandate to do anything with it.*
- *The various divisions publish annual reports, but there is no statewide annual report that crosses all sectors.*
- *Many people are unaware of what is on the state’s health statistics website or how to navigate through it.*
- *There is a good communication system for communicable diseases in New Jersey.*
- *Some computer systems are dated, but funds are limited to upgrade.*
- *The hospitals have a clear reporting system, but there are problems with the access to the data and dissemination to multiple health departments.*
- *Some monitoring only comes about because of a crisis.*
- *HIPPA and confidentiality issues can be a barrier to accessing data.*
- *State does not even share annual reports among divisions.*

Model Standard 2: State & Local Relationships

The relationship between the state public health system and the local system was rated 45%, which translates into “moderate activity.” There was little variation within this group of items as the participants generally agreed that technical assistance, data dissemination, and assistance with the development of information systems is provided in moderate amounts by the state to the locals. The primary concerns relate to electronic data dissemination, particularly the lack of technological capabilities across jurisdictions.

Discussion

- *Sometimes computer systems are difficult for locals, particularly when systems are developed at the federal level (confusing and difficult).*
- *Would like more local-level reports available (cancer, heart disease).*
- *Concern about the lack of technology. The state has cut back on staff and technical resources, which is frustrating.*
- *In general, the state and locals work well together, but always room for improvement.*
- *Support can vary. With some things, the state provides a lot of support, but with others, the support is non-existent.*
- *Other than health departments, not many health-monitoring systems at the local level, so that question not terribly relevant.*
- *In particular, occupational health feels disconnected to the state/local health.*

Model Standard 3: Performance Management & Quality Improvement

Even though the performance management and quality improvement standard garnered the lowest rating within this Essential Service (34%), the score equates to “moderate activity.” Participants stated that the system lacks regular quality reviews of its monitoring systems, particularly reviews that solicit feedback from the local system and look for feedback on changes needed to improve the usefulness of health data.

Discussion

- *There has been some growth with quality improvement efforts, but there is still a long way to go.*

- *Often things are added, but nothing is ever removed.*
- *This can depend on the jurisdiction. Some are much further evolved with systematic evaluations than others.*

Model Standard 4: Public Health Capacity & Resources

The final Model Standard that focuses on capacity and resources obtained a score of 40% (“moderate” activity). The most significant issue as part of this discussion revolved around the current economic climate and subsequent staffing and financial limitations. Each of the ratings was skewed by this current trend. Setting the economy aside, participants agreed that silos across divisions remain a barrier. Participants rated the state with “minimal activity” (25%) for alignment and coordination of efforts to monitor health status.

Discussion

- *For some programs (e.g. the AIDS program), the funds come right from the federal level to the locals, so the questions about the state involvement do not apply.*
- *There have been some improvements and investments in technology, but not enough and it is too slow.*
- *Need experts to collaborate more on quality improvement.*
- *Skills are there, but many in the field are about the same age. There is going to be a challenge in five years when these people retire. Need more workforce development.*

EPHS 1: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • <i>Planning and implementation activities</i> <i>~reporting systems to identify health threats</i> <i>~enforcement of laws to protect health information</i> <i>~surveillance and monitoring programs designed to measure health status of state’s population</i> <i>~publication of health-related data that describes the health of the state’s population</i> 	<ul style="list-style-type: none"> • <i>Active management and improvement of health status monitoring activities</i> <i>~ongoing evaluation of monitoring systems</i> <i>~elicit feedback on ways to improve</i> <i>~increase technological capacity</i> <i>~data collected, but distribution not ideal</i> • <i>SPHS organizational alignment and coordination of efforts to monitor health status</i> <i>~need fewer silos</i> <i>~need systems to communicate</i> <i>~alignment needed across annual reports</i>

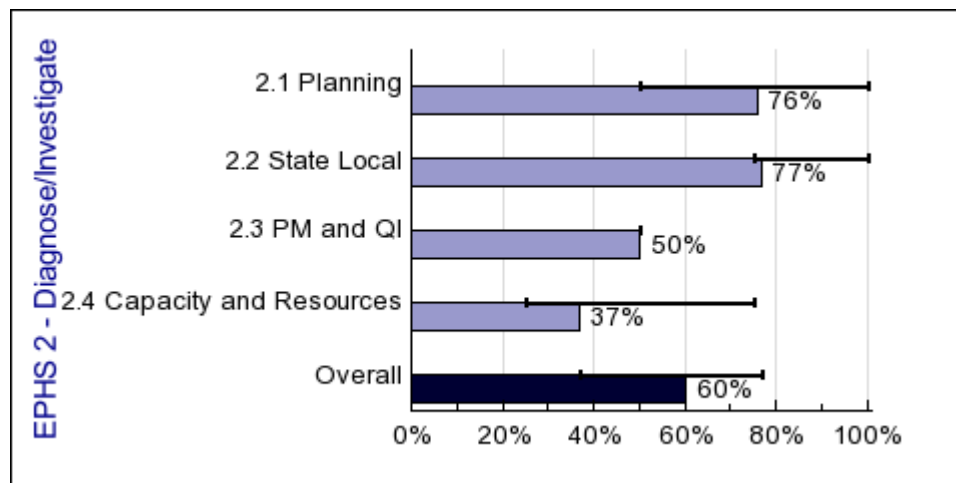
EPHS 2: Diagnose and Investigate Health Problems and Health Hazards

This service includes:

- Epidemiologic investigation of disease outbreaks and patterns of infectious and chronic diseases, injuries, and other adverse health conditions.
- Population-based screening, case finding, investigation, and the scientific analysis of health problems.
- Rapid screening, high volume testing, and active infectious disease epidemiologic investigations.

With an average rating of 60%, this Essential Service was the third highest rated service on the survey. The 60% score translates into a “significant” level of activity. Additionally, two of the four Model Standards within this section garnered “optimal” ratings. The following bar graph outlines the section scores across the four Model Standards.

C11



Model Standard 1: Planning & Implementation

One of the Model Standards that received an “optimal” rating of performance was Planning and Implementation, with a rating of 76%. There was no single question in this section that was rated lower than “moderate activity.” In general, attendees agreed that the state of New

Jersey has the capacity to operate effective surveillance activities with the systems, communication vehicles, and laboratory support and expertise that is necessary.

Discussion

- *Most departments/divisions described their systems as “robust.”*
- *Hospital admissions are highly monitored.*
- *Injury surveillance could be improved.*
- *Surveillance is limited on ALL potential hazards and threats as there are tens of thousands, but currently >36,000 chemicals are monitored on a small percentage.*
- *Some issues exist around communication. Some systems are not in real-time and may take several days or three weeks to hear anything.*
- *Would like to see more protocols in writing. Still some confusion with jurisdictional issues.*
- *Too much information gathered on individuals. Need more population-based statistics.*
- *Infectious disease monitoring is good, but occupational health, injury, and chronic disease could be improved.*
- *The immunization reporting system is not compatible with physician systems.*

Model Standard 2: State & Local Relationships

The state and local relationships and the diagnosis of health problems and hazards was rated a 77%, which also equates to “optimal” performance. All of the questions within this section were rated as “significant” or “optimal.” The state system is perceived as providing adequate assistance to the locals in the form of laboratory support, skilled personnel, training, and information about potential health threats.

Discussion

- *At times, the assistance is passive and the locals need to ask for help, but when asked, it is available.*
- *Locals want more access to their data, but often have to jump through hoops (Institutional Review Board), which is a hassle and prolongs it.*
- *Training in interpreting laboratory results would be helpful as not everyone can always interpret the statistics.*

- *Sometimes the alerts will go to the industries and not always the local health departments.*
- *Not always enough personnel at the state level to provide all the trainings needed. This is even more pronounced given the current economic constraints.*
- *Technological assistance is probably the most needed.*
- *Appreciate that federal funds are used to provide an epidemiologist in every county.*
- *Some perceive that the state needs to require more monitoring by the locals.*

Model Standard 3: Performance Management & Quality Improvement

The scores took a drop with the remaining two Model Standards in this section. When the group rated performance management and quality improvement within this section, the rating dropped to 50% overall. The 50% equates to “moderate activity.” There was little variation in the ratings within this Model Standard, with every question garnering a rating of “moderate activity.” The qualitative feedback shows that there appears to be a great deal of variation across divisions and departments.

Discussion

- *When grant money is received, there are generally evaluation components that are built-in.*
- *Sometimes surveillance is continued beyond its period of usefulness.*
- *Some departments have never conducted any type of formal review or evaluation of its systems.*
- *Reviews only tend to take place in a reactionary mode rather than proactively. One attendee stated, “We are crisis oriented, not preventive.”*
- *Some frustration exists with the fact that so much data is collected, but the state doesn’t always look at it or utilize it in an efficient manner.*
- *Among those divisions who are starting to evaluate their systems, there is still along way to go.*

Model Standard 4: Public Health Capacity & Resources

The final Model Standard in this section, capacity and resources, was the lowest rated standard for this essential service. New Jersey was rated 37%, which is “moderate activity.” This section received a combination of both minimal and moderate ratings across various areas. The state was perceived as having the professional expertise necessary to carry out these

functions, but recent economic challenges have led to a decrease in staff and resources. Additional challenges for the state system include a perceived lack of alignment and coordination to diagnose and investigate health problems.

Discussion

- *Some disappointment among local health departments that the state is not contributing more to public health.*
- *Resources from the state are “woefully” lacking right now.*
- *Need more investment in technological capacity as the technology between the state and local systems are not always compatible.*
- *Hospitals do not perceive coordination among agencies and associations.*
- *State public health systems minimally align efforts to diagnose and investigate health problems.*
- *Prevention, in particular, is under-funded.*

EPHS 2: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Operation of effective surveillance systems for health problems and threats • Ability to rapidly respond to a health threat • Laboratory capacity, support, and expertise • Assistance to locals for surveillance (personnel, lab support, training, information on health alerts) 	<ul style="list-style-type: none"> • Capacity and resources ~ <i>commitment of financial resources to diagnosis and investigation of health problems and hazards</i> ~ <i>not sufficiently staffed to carry out activities</i> • Lack of alignment and coordination across SPHS organizations ~ <i>alignment of strategic plans</i> ~ <i>coordination of technologies and monitoring of systems</i>

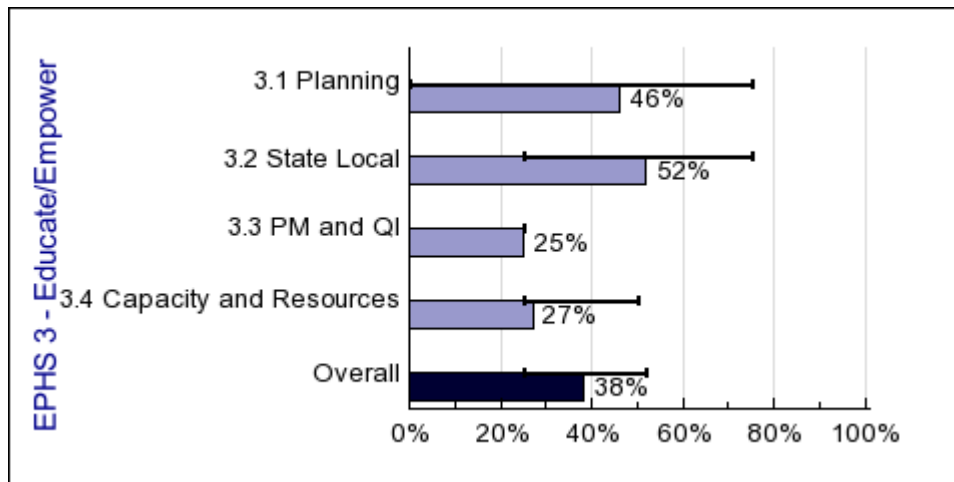
EPHS 3: Inform, Educate, and Empower People about Health Issues

This service includes:

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

Overall, this Essential Service was rated 38%, which translates into “moderate” activity within New Jersey. As detailed below, the four Model Standards range in score from 25% to 52%. Two of the Model Standards were rated with “minimal” activity while the remaining two garnered “moderate” activity ratings.

C12



Model Standard 1: Planning & Implementation

The initial Model Standard, planning and implementation, was rated 46%. The ratings within this section were varied. New Jersey was rated the highest on its crisis and emergency communications plan (75%). The lowest rating (21%) was for the state system’s design and implementation of

health communications. Specifically, there were concerns that health communications are not designed based on proven best practices, do not actively focus on understanding the target population, do not utilize a coordinated media strategy, and are not developed collaboratively among SPHS organizations.

Discussion

- *There is an abundance of literature and information, but new methods of distribution are needed.*
- *Schools often deliver health information, but not always health education interventions. School staff needs more preparation and education.*
- *Too often, initiatives are not based on evidence or proven theory.*
- *Tend to be reactive rather than proactive with educational efforts.*
- *New Jersey does not “toot” its own horn. There are some great efforts at the local level, but they are not always tracked and communicated effectively.*
- *Public health waits too long to act. The health care workforce is “held back” many times in getting the message out.*
- *LINCS system is limited in getting the message out, as it is a limited audience.*
- *There are no unified communication efforts, which lead to too many individual messages.*
- *Some monies are given to out of state media, not local efforts.*
- *Need more effort to clarify “poor health messages,” such as autism or hormone usage or media exploits.*
- *“The state works with groups and agencies, but what about people in the community?”*

Model Standard 2: State & Local Relationships

The state and local relationships around education were the highest rated within this Essential Service, garnering a score of 52% (“significant” activity). Again, mixed results were seen. The state system was rated the highest in its support to the local system in developing effective emergency communications capabilities (75% rating). Conversely, the state received a 30% rating for its efforts to provide technical assistance to local public health systems (consultations, trainings, policy changes) to develop skills and strategies to conduct health communication, education, and promotion interventions.

Discussion

- *Need to be better at the local level with measurement and goal setting, so state assistance would be helpful. Direction from the state on evaluation of communication and education efforts is needed.*
- *Much of the state trainings and support come through national associations and organizations.*
- *More marketing and promotion assistance is needed at the local level. Educators are not always great promoters and marketers.*
- *Need support on how to best reach target populations who are at high risk.*

Model Standard 3: Performance Management & Quality Improvement

Performance management and quality improvement was rated the lowest (25%) within this essential service. This translates into “minimal” activity. All questions within this section were rated “minimal.” New Jersey’s public health system was perceived as needing improvement in its evaluation of its education and promotion activities in the following areas: assurance that content is accurate and current, assessment of the effectiveness and appropriateness of programs and interventions, participation of populations service by intervention efforts, assurance that efforts are culturally and linguistically appropriate, and evaluation of the effectiveness of media strategies.

Discussion

- *There is a perception that federally funded materials are tested and evaluated, but state materials are not always evaluated.*
- *There is a “glimmer” of more quality improvement to come with the MLC-3 (Multi-State Learning Collaborative-3) grant.*
- *Silos impact success with quality improvement, as results are not always communicated effectively.*

Model Standard 4: Public Health Capacity & Resources

The final Model Standard within this service focuses on capacity and resources. This standard obtained a rating that falls within the “moderate” category of activity (27%). As with other essential services, this section

received lower ratings largely because of a lack of funding, which is exacerbated by the poor economy. The issue is not as much with the skill level of existing staff, but whether or not there is sufficient staff.

Discussion

- *There has been a significant impact in funding with getting messages out (tobacco, cancer).*
- *The staff has been decreased by retirement and therefore much of the expertise is gone and has not been replaced.*
- *Academia will provide some expertise, but it is not necessarily less costly.*
- *Often strategic plans exist with goals, but no clear plan on how to achieve those goals.*
- *Some are fearful of taking ownership and therefore, plans do not always exist. There may be less fear if there is more collaboration.*
- *A question was posed as to whether results can be effective if there is not enough staff to implement the right way.*

EPHS 3: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Existence of a crisis and emergency communications plan ~ consistent with NIMS • SPHS support to locals in developing emergency communications plans ~plans include coordination among state and local agencies ~plans can be utilized in different types of outbreaks ~rapid communications response 	<ul style="list-style-type: none"> • SPHS design and implementation of health communications ~ messages that are appropriate for target populations ~communications that are based on best practices and established communication theories ~collaboration among SPHS organizations • Performance management and quality improvement ~periodic review of effectiveness of communications and health promotions ~active management and improvement of overall performance

	<i>Areas for Growth(cont.)</i>
	<ul style="list-style-type: none"> • Capacity and resources <ul style="list-style-type: none"> ~commitment of financial resources ~alignment of efforts across organizations ~sufficient staff to carry out activities

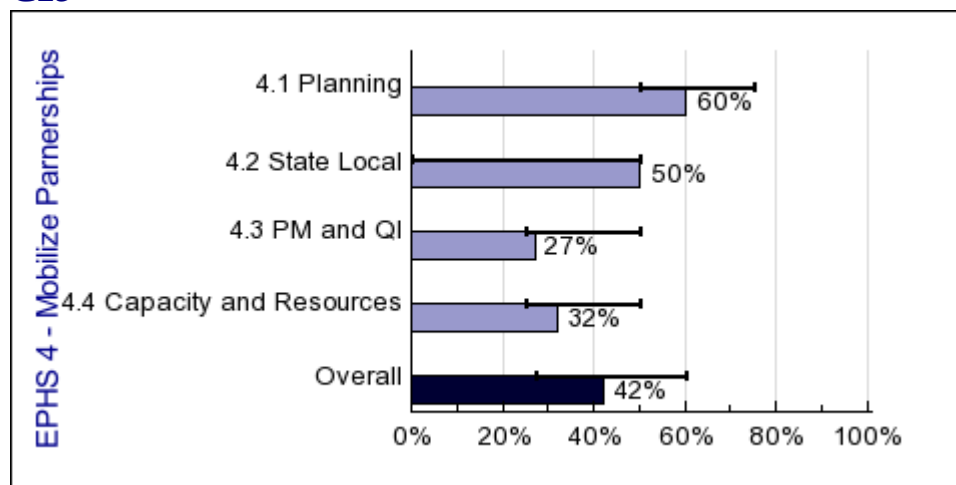
EPHS 4: Mobilize Community Partnerships to Identify and Solve Health Problems

This service includes:

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

The overall rating for this essential service is 42%, which translates into “moderate” activity for the state of New Jersey. The individual Model Standard scores range from 27% to 60% as detailed below.

C13



Model Standard 1: Planning & Implementation

The initial standard, planning and implementation, received the highest rating of the four standards, with a 60% average. This falls into the “significant” activity category. New Jersey was rated the highest for its ability to build statewide support for public health issues. Specifically,

attendees provided high ratings for the identification of new and existing partners for specific health concerns and maintaining linkages with existing stakeholders to facilitate communication and optimize resource sharing.

Discussion

- *Most collaboratives are at the local level. Often grassroots efforts end up creating total statewide efforts.*
- *The federal government is requiring and constantly encouraging networking and outreach to bring new people into the fold.*
- *There is no clearinghouse or network for communicating across various groups.*
- *Funding effects travel and capacity building.*
- *The discussion toolbox listed by the CDC is a helpful resource for building coalitions.*
- *Partnerships will often utilize and maximize people, but not necessarily resources.*
- *Need more statewide coordination with joint grant funding opportunities.*
- *Lack of understanding of what other departments do hampers partnership building.*
- *There is a misunderstanding among some groups of what public health does. The Mayors Wellness Campaign is an example of success, but public health is not recognized. Generally people do not see how public health fits into the picture.*

Model Standard 2: State & Local Relationships

The state and local relationships received a 50% average rating, which is “moderate” activity. Moderate activity was seen with the SPHS technical assistance to local systems to build partnerships and the offering of incentives to local partnerships through grant requirements, financial incentives, and/or resource sharing.

Discussion

- *Mental health is providing training to law enforcement to better understand the connection.*
- *The state has promoted a number of partnerships (MAPP: Mobilizing for Action through Planning and Partnerships, CEED: Cancer Education & Early Detection, OEM: Office of Emergency Management), but more*

communications are needed across the various organizations to increase awareness.

- *Partnerships often follow funding and once the funding is gone, the partnership absolves.*
- *The locals are in need of funding, but there needs to be realistic time frames for accomplishing goals as well.*
- *Some concerns were voiced that incentives are in some cases disincentives as partnerships become too dependent on funds for sustainability.*

Model Standard 3: Performance Management & Quality Improvement

New Jersey received a rating of 27% for performance management and quality improvement within this essential service. The stem sections within this Model Standard received ratings of 25% and 29%, which translates into “minimal” and “moderate” activity by the state. In general, it was perceived that the state system does not regularly conduct reviews to evaluate the effectiveness of partnership participation and commitment of its policy leaders and system partners.

Discussion

- *A few groups conduct satisfaction surveys (cancer), but in general, these are not conducted to serve as an evaluation piece.*
- *Most groups have never conducted any type of evaluation due to a lack of tools, guidance, and funding.*
- *Every grant that is awarded asks about sustainability.*
- *There is a lack of understanding at the local level with how to evaluate the effectiveness of partnerships.*
- *With the economic downturn, agencies are doing more to increase partnerships because there is a need to pool resources.*

Model Standard 4: Public Health Capacity & Resources

The final standard within this essential service, capacity and resources, is rated at 32%, which is “moderate” activity. New Jersey was rated the lowest for its commitment of financial resources to sustain partnerships and having the professional expertise to carry out partnership development activities. The highest rating was for the statewide alignment and coordination of efforts to mobilize partnerships.

Discussion

- *Some departments feel that there is a skilled workforce to address this essential service, but that funding cuts have limited agency abilities.*
- *It would be ideal if there were mandated trainings on coalition sustainability.*
- *Often the state agencies will recruit people with certain skills, train them, and then cut them when funding is cut. These individuals are not often replaced or it takes a long time to fill the position.*

EPHS 4: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • <i>SPHS builds statewide support for public health issues</i> <i>~ identifies new and existing partners for specific health concerns</i> <i>~maintains linkages with stakeholders to facilitate communication and optimize resource sharing</i> • <i>SPHS support to locals in developing emergency communications plans</i> <i>~plans include coordination among state and local agencies</i> <i>~plans can be utilized in different types of outbreaks</i> <i>~Rapid communications response</i> 	<ul style="list-style-type: none"> • <i>Performance management and quality improvement</i> <i>~ review of partnership development activities</i> <i>~active management and improvement of performance of partnership activities</i> • <i>Capacity and resources</i> <i>~commitment of financial resources to sustain partnerships</i> <i>~professional expertise to carry out partnership development activities</i>

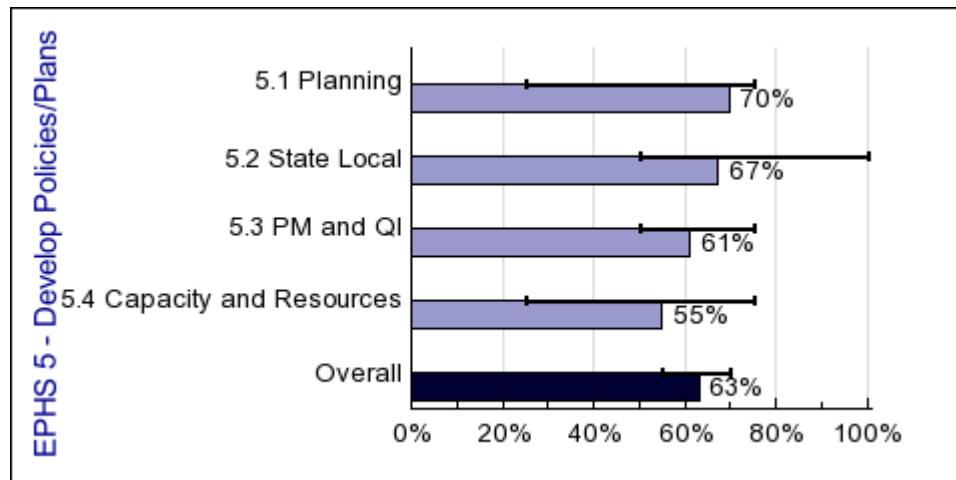
EPHS 5: Develop Policies and Plans that Support Individual and Statewide Health Efforts

This service includes:

- Systematic health planning that relies on appropriate data, develops and tracks measurable health objectives, and establishes strategies and actions to guide community health improvement at the state and local levels.
- Development of legislation, codes, rules, regulations, ordinances, and other policies to enable performance of the Essential Public Health Services, supporting individual, community, and state health efforts.
- The process of dialogue, advocacy and debate among groups affected by the proposed health plans and policies prior to adoption of such plans or policies.

This Essential Service was the second highest rated service on the assessment with a score of 63%. This score indicates that New Jersey is conducting a “significant” level of activity with policy and plan development. All four Model Standards received “significant” ratings and the lowest individual stem section rating was 50%, which reflects “moderate” activity.

C14



Model Standard 1: Planning & Implementation

New Jersey was rated a 70% for its planning and implementation efforts

around policy and plan development, the highest rating for a Model Standard within this Essential Service. The highest stem section rating (75%) was for the state's All Hazards Preparedness Plan that guides system efforts in the event of an emergency. The lowest ratings were for policy planning efforts that include populations who are the focus of health improvement efforts as well as agency health improvement plans that are combined into one single, unified state health improvement plan. Participants commented that any rating of coordination among plans assumes that all agencies have health improvement plans. This is not perceived to be the case.

Discussion

- *There is great planning and resource development within the silos, but information is not shared or communicated across the silos.*
- *The LINCS program needs to be evaluated as it is utilized differently in each county.*
- *There is often a reactive approach, rather than a proactive one with planning.*
- *Does a "state health profile" even exist? Several attendees perceived Healthy New Jersey 2010 to be a profile, while others disagreed.*
- *Reports are prepared that outline policy options, but they do not get to the public. These are there for review, but awareness is largely within the public health sector.*
- *Rules and regulations dictate standards for public comment, notification, etc.*
- *Policy changes are not identified in the state health improvement plan because there is no comprehensive state health improvement plan.*

Model Standard 2: State & Local Relationships

New Jersey's state and local relationships around policy and plan development stand at a rating of 67% ("significant" activity). All stem questions were rated 70% or higher with the exception of one, which was rated 50%. The state was rated 50% for its support and assistance in the development of community health improvement plans that are integrated with statewide health improvement strategies. Again, much of the rationale behind this lower rating was the lack of a state health improvement plan.

Discussion

- *Some stated that the level of technical assistance differs depending on the department.*
- *Some local health departments act on their own with either internal expertise or bringing in outside consultants.*
- *When there are disconnects between state and local agencies, it is often in the form of a personality conflict between individuals.*
- *There is not an ability to integrate local plans into state ones because there are not always state plans and there is not one unified state health improvement plan.*

Model Standard 3: Performance Management & Quality Improvement

The third Model Standard, performance management and quality improvement, garnered a score of 61%, which is in the “significant” category. Two of the four stem sections within this Model Standard received a rating of 70% or higher and two a rating of 50%. In general, the feedback was that reviews often happen, but the regularity of the reviews and systematic way in which plans are reviewed need refinement. Again, the impact of silos across divisions, departments, and organizations is perceived to be a significant barrier in effectively meeting this standard.

Discussion

- *Reviews will take place, but the impact assessment is not typically included in that review.*
- *There tends to be a focus on complaints, not necessarily impact and systematic quality improvement.*
- *Results within each division are not compiled to see where the entire state public health system is.*
- *There is a challenge with the political element in policy review. Often politics trump all other efforts.*
- *Private entities can tend to turn policy reviews around in a more timely fashion than state agencies.*
- *There has been some progress made with performance management, but there is still a lot of progress to make.*

Model Standard 4: Public Health Capacity & Resources

The capacity and resources Model Standard received the lowest rating of the four standards with a 55% average. Despite the lowest rating, the 55% translates into a “significant” amount of activity. This was largely a function of staffing cuts and budget cuts that are limiting the amount of work that can be done around this essential service. Professional, skilled staff are present, there is simply too few of them.

Discussion

- *Some financial resources are being committed for health planning, but not enough.*
- *State health planning is generally under-funded.*
- *Due to a lack of staff, individual skills are not utilized appropriately. Some of the better trained, professional staff is being used for other things to cover for staffing issues.*
- *There is often a lack of alignment between political entities and public health, which leads to unnecessary policies being put into place.*
- *“Politics trump science in New Jersey.”*

EPHS 5: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • <i>Planning and implementation ~ implement statewide improvement processes that convene partners ~development of multiple agency and disease-specific statewide health improvement plans ~have an All-Hazards plan in place ~conduct of policy development activities</i> • <i>State-local relationships ~technical assistance to states for developing local plans ~technical assistance with All-Hazards plan</i> 	<ul style="list-style-type: none"> • <i>SPHS is not sufficiently staffed to carry out planning activities</i> • <i>SPHS is not sufficiently staffed to carry out policy development activities</i> • <i>Coordination among agencies with state health plans</i>
<i>Strengths (cont.)</i>	

<ul style="list-style-type: none">• Performance management and quality improvement ~ review progress toward accomplishing health improvement ~conduct formal exercises and drills linked to All-Hazards plan• Professional expertise to carry out health planning and health policy development	
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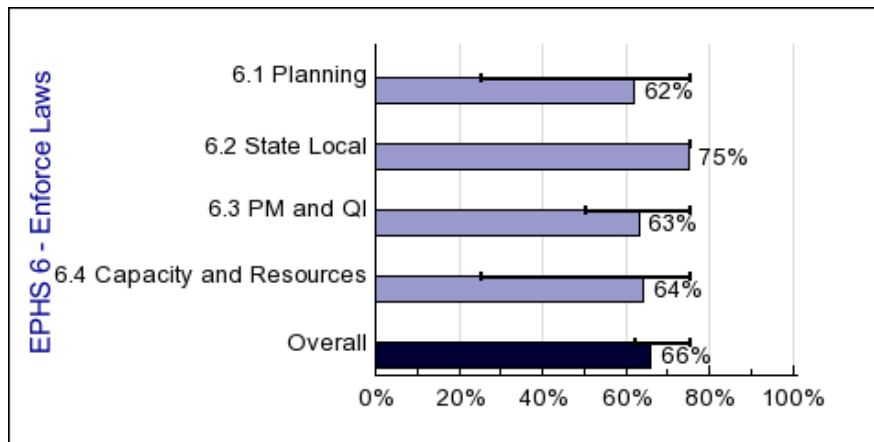
EPHS 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

This service includes:

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

With a score of 66% (“significant” activity), this was the highest-rated essential service for New Jersey. There was little variation in scores within this Essential Service, with all stem sections rated as either “moderate” or “significant.” The following graph shows the scores for the four Model Standards within this essential service.

C15



Model Standard 1: Planning & Implementation

The planning and implementation score for New Jersey is 63% (“significant” activity). A high ratings of 75% was garnered for New Jersey’s assurance that laws give state and local authorities the ability to prevent, detect, manage, and contain emergency health threats. The lowest stem section ratings were for the health system’s cooperative relationships between SPHS and persons and entities in the regulated environment as well as administrative processes that are customer-centered. While being the two lowest rating (50%), this still equates to “moderate” activity.

Discussion

- *Laws often come out of public opinion rather than science.*
- *Political pressures appear to have a larger influence than effective health policy development.*
- *The regulation process works well, but the statutes process is a problem.*
- *Laws without funding are not necessarily carried out.*
- *The public health system tries, but it is not always under their control.*
- *There is a problem with the statewide emergency designation. If it is local or regional event, the statewide designation does not occur and thus, no funding.*
- *There is tremendous confusion about liability coverage for first responders.*
- *Enforcement in a collaborative way can depend on relationships and trust levels among individuals. In some areas, it is great, others, not so great.*
- *Administrative processes are not always customer-oriented. Some jurisdictions determine office hours, etc., while others do not.*
- *Private industry has much greater expertise than government with web-based and electronic records, billing, inquiries for licenses, etc.*
- *Funding is limited to go paperless and many agencies are considerably behind in implementing user-friendly, up-to-date systems.*

Model Standard 2: State & Local Relationships

The state-local relationships for enforcement of laws garnered a rating of 75%, which is borderline “optimal.” In general, attendees agreed that there is a great deal of support from the state system in providing technical assistance for compliance and enforcement and in partnering with local governing bodies to review, improve, and develop local laws.

Discussion

- *The local partners tend to let the state know what they need and it generally happens very well.*
- *The state-county relationship is better than the state-local in partnering with local governing bodies. "Municipalities don't have a great deal of latitude."*

Model Standard 3: Performance Management & Quality Improvement

New Jersey's performance management and quality improvement activities within this essential service also received a "significant" rating (63%). Generally positive comments were made about the state system.

Discussion

- *Most of the audits are at the local level and recommendations for improvements are made.*
- *The department was very decentralized and the programs were on their own. It is now centralized, which is perceived to be better.*

Model Standard 4: Public Health Capacity & Resources

The final Model Standard, capacity and resources, obtained a 64% ("significant") rating. As seen with the other Essential Services, there was some concern among participants with the lack of alignment among organizational strategic plans to improve system performance in compliance and enforcement. A lack of coordination with technology resources was also seen as an area of opportunity.

Discussion

- *"If there is a strength in the SPHS, this is it."*
- *Resources are not adequate, but what is there is very good.*
- *Most resources in New Jersey are directed toward enforcement and not always planning.*
- *There are pockets within the SPHS that are very coordinated with enforcement.*
- *As the public health system matures, so do the cooperation and sharing among divisions.*
- *Not certain how many agencies have strategic plans. Among those that do, there is little coordination and alignment across plans.*

EPHS 6: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Commitment of financial resources to enforcement • Appropriate enforcement of laws (without abuse of power) • Cooperative relationship with entities in the regulated environment • Assurance that local officials empowered to enforce • Partnerships that focus on improving local laws • SPHS provides technical assistance to local system on best practices, enforcement, etc. • Administrative processes that are administrative according to written guidelines 	<ul style="list-style-type: none"> • Alignment of strategic plans • Political influence and diminished control by SPHS • Technology with customer-oriented service (paperless, web-based inquiries, etc.)

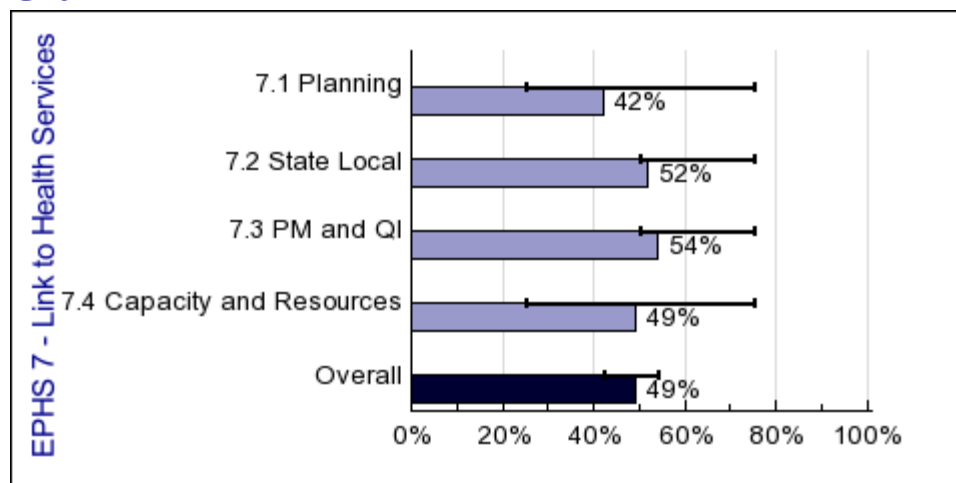
EPHS 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

This service includes:

- Assessment of access to and availability of quality personal health services for the state's population.
- Assurance that access is available in a coordinated system of quality care which includes outreach services to link populations to preventive and curative care, medical services, case management, enabling social and mental health services, culturally and linguistically appropriate services, and health care quality review programs.
- Partnership with public, private, and voluntary sectors to provide populations with a coordinated system of health care.
- Development of a continuous improvement process to assure the equitable distribution of resources for those in greatest need.

New Jersey was rated 49% for its ability to link people to needed personal health services and assure the provision of health care. This equates to a “moderate” level of activity within the state. As outlined below, there was little variation within this Essential Service across each of the four Model Standards, with a range of 42% to 54%, all within the “moderate” category.

C16



Model Standard 1: Planning & Implementation

The first Model Standard, planning and implementation, garnered a rating of 42% (“moderate” activity). The stem section scores within this Model Standard ranged from 28% (“moderate” activity) to 56% (“significant” activity). The lowest rated stem sections relate to the assessment of availability of personal health services to all of the state’s population and the presence of barriers to access to personal health care. Participants generally agreed that there is minimal activity around assessment for health professional shortages, identification of gaps in the safety-net provider network, and identification of barriers to access among populations with special needs. Favorable ratings were given for the state’s preparedness plan and its ability to meet the needs of vulnerable populations.

Discussion

- *There is a lack of advanced practices nurses in the state.*
- *Nursing jobs are being cut in New Jersey despite the awareness nationally that there is a shortage of nurses.*
- *Barriers to access are accessibility, geographic limitations, transportation, health literacy, and lack of insurance.*
- *Mental health conducts some assessments to evaluate gaps in services.*
- *Primary care is unstable due to funding cuts.*
- *Preparation for professional surge capacity is needed in the event of an emergency. This is happening now.*
- *Consumers, patients, and clients are calling 911 more since many hospitals have closed in New Jersey.*
- *New Jersey has a fragmented system whereby some areas are over-regulated and others not regulated enough (physicians offices).*
- *Different entities within the system monitor access to care, but no one entity does it all.*
- *There are significant efforts underway to address physical and mental disparities in the planning for a possible disaster.*

Model Standard 2: State & Local Relationships

The state’s relationship with the local system for access to care was rated 52% (“significant”). The state was rated as “moderate” for its assistance to locals in methods to assess and meet the needs of underserved populations

and its technical assistance to providers who deliver personal health care to underserved populations.

Discussion

- *Division of Family Services, WIC, Chronic Disease, DCF, and many others all provide technical assistance to the counties.*
- *Division of Addiction Services is using a public/private collaborative to improve access to and retention in addiction treatment.*

Model Standard 3: Performance Management & Quality Improvement

The third Model Standard, performance management and quality improvement, received the highest stem section rating for this Essential Service (54% “significant” activity). All questions within this Model Standard received either a “significant” or “moderate” rating. The highest ratings were given for hospital report cards, reports assessing patient safety, and state and national health care quality and disparities reports.

Discussion

- *Hospital report cards are readily available as well as provider-specific reports.*
- *Mental health Services is looking to make improvements which will look at outcomes data to guide quality and system improvement changes.*

Model Standard 4: Public Health Capacity & Resources

Public health capacity and resources is the final Model Standard with a score of 49% (“moderate” activity). Two questions within this standard garnered “minimal” ratings and appear to be the most in need of improvement. The two include the state system’s coordination of technology resources to more effectively conduct outreach to link people to needed care and a workforce that is sufficiently staffed to carry out activities to link people to needed personal health services. On the opposite end of the spectrum, the state received a “significant” rating for its ability to have workers who are skilled in health care monitoring, analysis, management and service delivery.

Discussion

- *The Division of Addiction Services has implemented population-specific voucher programs (based on individual need) in addition to funding traditional slotted services and expanding fee-for-service networks.*
- *The alignment and coordination of efforts to ensure the provision of needed personal health care could be improved.*
- *What is defined as behavioral health varies. For example, some mentioned that the Division of Family Services views obesity as a behavioral health issue.*
- *The United Way system is quite complicated and does not lend itself to coordination at this time.*
- *Participants agreed that state plans should align with local plans.*
- *It was recommended that the state coordinate efforts as the governmental public health partnerships do.*
- *Some progress being made with electronic medical records.*
- *Payment vouchers from the state are being turned around in two weeks compared to six weeks with the “old way.”*
- *There is a problem with educating people on information technology and how to use various computer systems.*
- *“We are probably only 10% of where we need to be” with going paperless.*
- *There is a level of expertise and professionalism, but resources and sufficient staffing are problems.*

EPHS7: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Performance management and quality improvement • State-local relationships • Preparedness for hospital and health professional surge capacity in the event of an emergency • Preparedness plan that considers the needs of vulnerable populations in the event of a natural disaster or other emergency 	<ul style="list-style-type: none"> • Assessments of the availability of personal health services • Collaborative partnerships to eliminate access barriers to personal health care • Coordinated technology resources to effectively conduct outreach to link people to needed care • Sufficient staff to carry out activities to link people to needed personal health svcs.

<i>Strengths (cont.)</i>	
<ul style="list-style-type: none"> • Reports such as: <ul style="list-style-type: none"> ~hospital report cards ~patient safety reports ~state or national health care quality and disparities reports • Skilled workforce in health care monitoring, analysis, management, and service delivery 	

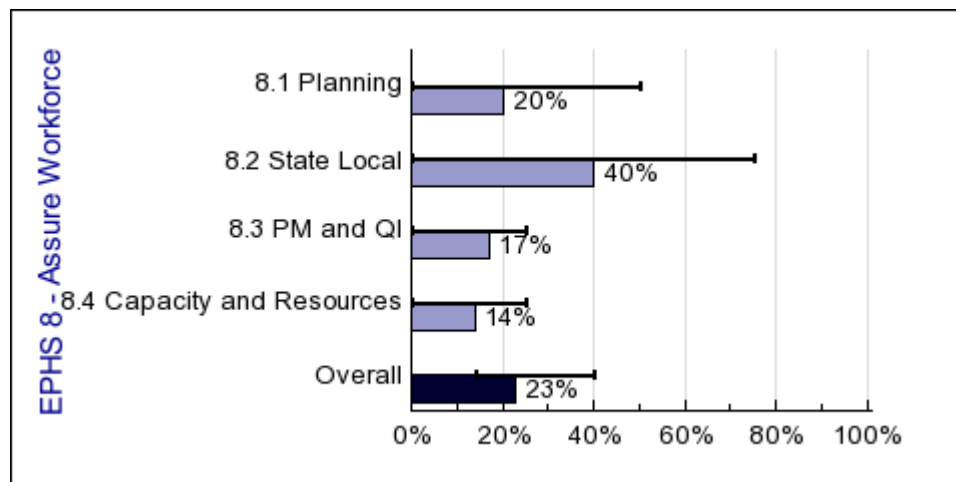
EPHS 8: Assure a Competent Public and Personal Health Care Workforce

This service includes:

- Education, training, development, and assessment of health professionals – including partners, volunteers and other lay community health workers – to meet statewide needs for public and personal health services.
- Efficient processes for credentialing technical and professional health personnel.
- Adoption of continuous quality improvement and life-long learning programs.
- Partnerships with professional workforce development programs to assure relevant learning experiences for all participants.
- Continuing education in management, cultural competence, and leadership development programs.

New Jersey received the lowest rating on the instrument for this Essential Service related to the health care workforce. The 23% rating equates to “minimal” activity within the state. Additionally, three of the four Model Standards were rated as “minimal” and the fourth was rated as “moderate.” The following graph details the individual Model Standard ratings for this service.

C17



Model Standard 1: Planning & Implementation

Within the planning and implementation standard the overall average rating is 23%, with one stem section was reporting no activity (0%). The stem section garnering the “no” activity rating was the state’s development of a statewide workforce plan(s) to guide its activities within workforce development. The highest ratings (“moderate”) within this model standard were for training that addresses individual and organizational roles in an incident command system, core competencies that include a basic understanding of public health and emergency management, competencies assured through educational requirements in the hiring process, and competencies assured through professional certifications, licenses, and credentialing.

Discussion

- *The issue has been raised, but there has not been a workforce assessment of the entire system.*
- *There are occasional salary and compensation surveys that take place, but nothing formal.*
- *Occasionally there are periodic assessments, but never anything done with them.*
- *May be more workforce assessments conducted among hospitals than health departments.*
- *Concerns exist about the aging public health workforce in New Jersey and too little “young blood” in the mix.*
- *Need more communication among schools of public health as each have their own accreditation recommendations.*
- *The state public health system does not necessarily encourage life-long learning.*
- *There is some training assistance from non-government agencies.*

Model Standard 2: State & Local Relationships

New Jersey’s highest rating within this Essential Service was with state-local relationships, garnering a 40% average rating (“moderate” activity). The relationship was rated the poorest with the state’s assistance to locals in employee recruitment and retention and its highest rating (“significant”) was for the state’s assurance that educational course work and training is

available to enhance the skills of the workforce of local public health systems.

Discussion

- *The state assesses competencies based on minimum standards.*
- *Some trainings that are offered are web-based, which is a positive for accessibility and cost.*
- *There are some gaps in communicating across agencies as to what trainings are provided.*

Model Standard 3: Performance Management & Quality Improvement

Performance management and quality improvement within this Essential Service was also rated “minimal” with a 17% rating. Two of the three sections within this Model Standard garnered ratings of 25% while one received a 0% rating by the participants. The 0% (“no” activity) was for the state’s active management and improvement of the overall performance of its workforce development activities. The “minimal” activity ratings were for the state’s review of workforce development activities and for reviews that assess the extent to which academic-practice partnership(s) address the preparation of the personnel entering the SPHS workforce.

Discussion

- *There is a general lack of any quality improvement process with workforce development.*
- *The state system does reviews to a certain degree, but primarily division-by-division.*
- *Environmental health appears to have the most reviews for workforce issues.*
- *Stockton College conducts surveys and has an advisory board for such issues and their interns with the state often turn into jobs.*
- *There are a lot of gaps and no continuity across departments.*

Model Standard 4: Public Health Capacity & Resources

The lowest scoring Model Standard within this Essential Service was capacity and resources with a rating of 14% (“minimal”). The state received “minimal” ratings for its financial commitment to workforce development efforts and for alignment of organizational strategic plans to improve system performance in workforce development and other coordination

across organizations. The attendees rated both the current skill levels and staffing levels of the public health workforce a “0%.”

Discussion

- *There is not enough time to develop the workforce.*
- *The current workforce does not have the skills to perform all the jobs they are being asked to do.*
- *Staff are doing things they were not originally hired to do, thus expertise is not always present.*

EPHS 8: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Training around individual and organizational roles in an incident command system • Competencies assured through: ~<i>educational requirements in hiring process</i> ~<i>professional certifications, licenses, or credentialing</i> • Assurance that educational course work and training is available and accessible to enhance the skills of the workforce of the local public health systems 	<ul style="list-style-type: none"> • Development of statewide workforce plan(s) to guide activities in workforce development • Bridging medicine and public health training in medical schools and schools of public health • Development initiatives that include: ~<i>career ladders and other programs to provide advancement opportunities</i> ~<i>coaching or mentoring programs funds or time off to help participate in educations programs that build additional skills</i> • State-local relationships ~<i>assistance with employee recruitment and retention</i> • Capacity and resources ~<i>alignment of organizational strategic plans</i> ~<i>sufficient staffing to carry out workforce development activities</i>

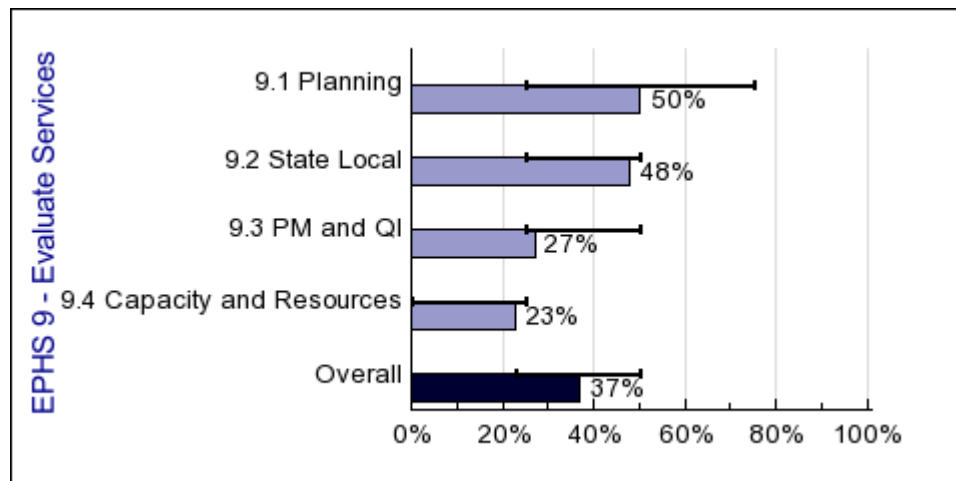
EPHS 9: Evaluate Effectiveness, Accessibility, and Quality of Personal Population-Based Health Services

This service includes:

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

The state received a 37% rating for this Essential Service, which translates into a score with "moderate" activity statewide. Three of the four Model Standards within this essential service garnered "moderate" scores, while one received a "minimal" score. The individual Model Standard ratings are displayed below.

C18



Model Standard 1: Planning & Implementation

Participants rated New Jersey's planning and implementation within EPHS 9 at 50%, which is "moderate" activity. There was little variation in scores within this Model Standard as all stem sections receiving a "moderate" rating. The highest individual question rating ("significant") was for

statewide evaluations that monitor the credentials and licenses of population-based health professionals. The state was rated the lowest for the existence of evaluations that examine the extent to which statewide organizations operate as a system.

Discussion

- *A number of different associations evaluate services (hospitals, public health nurse administrators, health centers, 211).*
- *Health departments can only go into a physician's office to evaluate services if there is a problem.*
- *There is a great deal of checking on credentials and licenses.*
- *Community volunteers are not always monitored, as credentialing is not always necessary. It depends on the division and sector.*
- *There are often reports and evaluations that are conducted, but not everyone has access to them or there is no awareness of the evaluation.*
- *Many of the divisions have formal complaint systems for consumer feedback.*
- *There is too little coordination between the department of health and the department of human services with planning and evaluation.*

Model Standard 2: State & Local Relationships

New Jersey's state and local relationships were rated 48%, which is "moderate" activity as well. All sections averaged "moderate" ratings. One area in particular received a "minimal" rating: assistance from the state to locals in evaluating personal health services.

Discussion

- *The MAPP (Mobilizing for Action through Planning and Partnerships) process has been a positive state-local relationship.*
- *Cancer plans appear to have a lot of resources for assistance and support.*
- *On some occasions, technical assistance is there, but it is not being asked for.*
- *Too few resources to provide training. Staff and funding limitations.*

Model Standard 3: Performance Management & Quality Improvement

The third Model Standard, performance management and quality improvement, was rated 27% for "minimal" activity. While one question within this standard received a "moderate" rating, all of the remaining items garnered "minimal" activity ratings. Specific areas of opportunity

include reviews that use robust evaluation methodologies, reviews that examine evaluation protocols used when weaknesses in program or service quality become apparent, and the state's active management and improvement of the overall performance of evaluation activities.

Discussion

- *Sometimes evaluations are done and data is gathered, but nothing happens with the data.*
- *"Why should we invest in evaluations if no changes will be made."*
- *(The process for) FQHCs are being held up by state entities. What entity is doing the evaluation and what is the result?*
- *There is some management and improvement of the overall performance of evaluation activities, but not "active" management and improvement.*

Model Standard 4: Public Health Capacity & Resources

The final Model Standard, capacity and resources, was rated 23%, which is a "minimal" activity rating. Low ratings were given for the state's commitment of financial resources for evaluation, coordination of technology resources to more effectively conduct evaluation, and overall alignment of SPHS organizations to conduct evaluations. New Jersey is also perceived to have too few staff who are skilled at carrying out evaluation activities.

Discussion

- *Staff should have a core set of competencies before doing an evaluation.*
- *There is simply too few staff to carry out evaluations.*

EPHS 9: Summary of Strengths & Areas for Growth

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Monitoring of credentials and licenses of population-based health professionals • Routine evaluation of population-based health services • Evaluation of effectiveness of personal health services within the state 	<ul style="list-style-type: none"> • Performance management and quality improvement <i>~reviews that examine robust evaluation methodologies</i> <i>~evaluation protocols used when weaknesses in program or service quality become apparent</i> <i>~regular review of the effectiveness of its evaluation activities</i> • Active management and improvement of the overall performance of evaluation activities • Commitment of financial resources for evaluation • Coordination of technology resources to more effectively conduct evaluation • A sufficient workforce skilled in evaluation

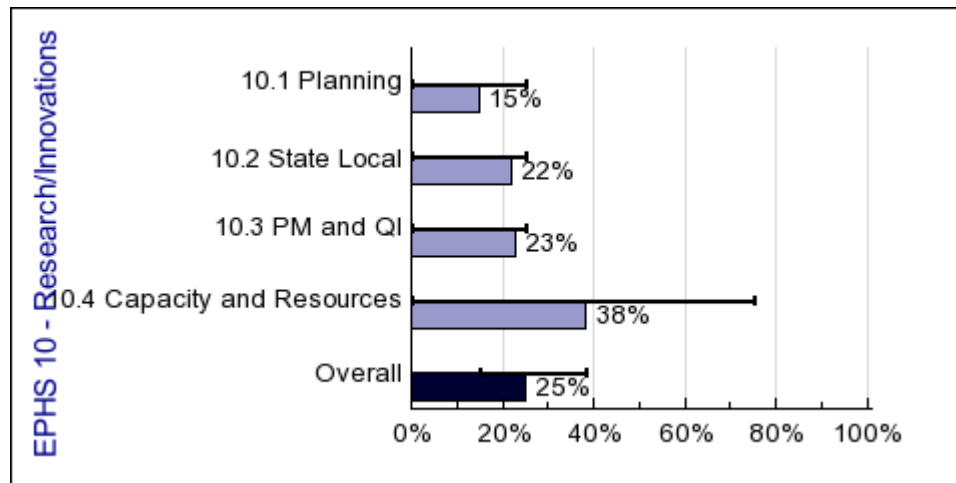
EPHS 10: Research for New Insights and Innovative Solutions to Health Problems

This service includes:

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

Essential service 10 was the second lowest rated service on the instrument with a rating of 25% (“minimal” activity). Three of the four Model Standards received scores in the “minimal” category and one was rated as “moderate” activity. Across the entire essential service, only one stem section received a “significant” rating: the state’s professional expertise to carry out research activities.

C19



Model Standard 1: Planning & Implementation

As demonstrated by the state’s rating of 15% for planning and implementation, participants shared a lack of activity in many areas throughout the state system. Participants agreed that the state does not have a public health research agenda and demonstrates little collaborative

work with academic institutions to conduct research. Little to no activity was perceived with joint research projects, faculty-staff exchanges, the organization of academic health departments, and reports that translate findings into specific practice applications.

Discussion

- *There are some activities with cancer and tobacco between the state and UMDNJ.*
- *There is minimal activity in smaller institutions due to lack of funding.*
- *Some interns will do research.*
- *“We need to be able to identify gaps of information before we even conduct research.”*
- *The mind set must change at the top level before we see more of a commitment to research.*
- *There are no incentives to conduct research.*

Model Standard 2: State & Local Relationships

State and local relationships received a rating of 23%, which also translates into “minimal” activity. Concerns were shared about the state’s lack of assistance to locals in building skills in research design and methods and community-based participatory research projects.

Discussion

- *There is some opportunity to request research data from the state, but this varies tremendously.*

Model Standard 3: Performance Management & Quality Improvement

Performance management and quality improvement received a 23% rating, which is in the “minimal” activity category for its research activities. The state was not perceived as being very active in reviews its public health research activities or in its ongoing management and improvement of its research activities.

Discussion

- *There is no coordination among leadership.*
- *“We are not part of a system. There is a missing link in the system.”*
- *Better data would lead to better research.*

- *Interaction between system partners with research is very limited.*

Model Standard 4: Public Health Capacity & Resources

The final Model Standard, capacity and resources, received a 38% rating, which translates into the only “moderate” score for this Essential Service. The state was not perceived as committed to investing financial resources in research for health improvement and was viewed as fragmented with little alignment and coordination among organizations for research purposes. The state was praised for having the professional expertise to carry out research activities.

Discussion

- *There are some funding opportunities for research, but very few.*
- *The state should coordinate all research projects with a mindset that research is important.*
- *Departments compete with one another for research monies.*

<i>Strengths</i>	<i>Areas for Growth</i>
<ul style="list-style-type: none"> • Professional expertise to carry out research activities 	<ul style="list-style-type: none"> • Planning and implementation • State-local relationships • Coordination of system-wide organizational efforts

Conclusions

As is clear with the size of the existing document, many areas of strength and opportunity were identified as a result of completing the assessment. Overall, the public health system for the state of New Jersey is demonstrating a “moderate” level of activity. Across the ten EPHS, 50% are rated as “moderate,” 30% as “significant,” and two as “minimal.” The following bullets outline overarching key areas of strength, as well as areas for potential growth, within New Jersey’s state public health system.

Areas of strength



Enforcement of laws and regulations



Development of policies and plans



Diagnosis and investigation of health problems and potential health threats, particularly the state-local relationships



Emergency preparedness activities



Planning and implementation efforts for monitoring health status

Areas for growth



Workforce planning and development activities



Research activities and innovations



Coordination among agencies and organizations (reduction of silos)



Technological capabilities

D. AGENCY CONTRIBUTION

As previously mentioned, following the completion of each model standard, participants were asked to answer an “agency contribution” question. This question assesses to what extent the state public health agency (New Jersey Department of Health & Senior Services) contributes to that particular model standard. The following pages outline the results of the agency contribution questions.

Essential Service by perceived SHA (state health agency) contribution and score:

Essential Service	SHA Contribution	Performance Score	Consider Questions for:
1. Monitor Health Status To Identify Community Health Problems	56%	Moderate (49)	Quadrant II
2. Diagnose And Investigate Health Problems and Health Hazards	81%	Significant (60)	Quadrant II
3. Inform, Educate, And Empower People about Health Issues	56%	Moderate (38)	Quadrant II
4. Mobilize Community Partnerships to Identify and Solve Health Problems	56%	Moderate (42)	Quadrant II
5. Develop Policies and Plans that Support Individual and Community Health Efforts	75%	Significant (63)	Quadrant II
6. Enforce Laws and Regulations that Protect Health and Ensure Safety	75%	Significant (66)	Quadrant II
7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	69%	Moderate (49)	Quadrant II
8. Assure a Competent Public and Personal Health Care Workforce	25%	Minimal (23)	Quadrant III
9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	56%	Moderate (37)	Quadrant II
10. Research for New Insights and Innovative Solutions to Health Problems	31%	Minimal (25)	Quadrant III

Quadrant		Questions to Consider
I.	Low Performance/High Department Contribution	<ul style="list-style-type: none"> • Is the Department's level of effort truly high, or do they just do more than anyone else? • Is the Department effective at what it does, and does it focus on the right things? • Is the level of Department effort sufficient for the jurisdiction's needs? • Should partners be doing more, or doing different things? • What else within or outside of the Department might be causing low performance?
II.	High Performance/High Department Contribution	<ul style="list-style-type: none"> • What does the Department do that may contribute to high performance in this area? Could any of these strategies be applied to other areas? • Is the high Department contribution appropriate, or is the Department taking on what should be partner responsibilities? • Could the Department do less and maintain satisfactory performance?
III.	High Performance/Low Department Contribution	<ul style="list-style-type: none"> • Who are the key partners that contribute to this area? What do they do that may contribute to high performance? Could any of these strategies be applied to other areas? • Does the low Department contribution seem right for this area, or are partners picking up slack for Department responsibilities? • Does the Department provide needed support for partner efforts? • Could the key partners do less and maintain satisfactory performance?
IV.	Low Performance/Low Department Contribution	<ul style="list-style-type: none"> • Who are the key partners that contribute to this area? Are their contributions truly high, or do they just do more than the Department? • Is the total level of effort sufficient for the jurisdiction's needs? • Are partners effective at what they do, and do they focus on the right things? • Does the low Department contribution seem right for this area, or is it likely to be contributing to low performance? • Does the Department provide needed support for partner efforts? • What else might be causing low performance?

Source: NPHPSP: New Jersey State Public Health System Performance Assessment-Report of Results

E. PRIORITIZATION

Background

On October 8, 2009, approximately 64 individuals participated in a facilitated discussion with the objective of prioritizing the 10 Essential Public Health Services and related Model Standards for New Jersey. The prioritization exercise took place as part of New Jersey's Annual Conference of State and Local Health Officials. Approximately 40% of the participants from the April statewide assessment also attended the October 8th conference.

As part of its suite of instruments, the NPHPSP provides assessment participants with an optional "Priority Questionnaire." The purpose of the tool is to assist states in identifying the model standards that are of the highest priority to their state public health system. While the survey instrument is standardized, implementation is at the discretion of the participating state. For the current prioritization, New Jersey elected to complete the survey via a combination of qualitative discussion and quantitative ratings.

The instrument is comprised of 40 questions, one for each Model Standard within each of the 10 Essential Services (*there are four Model Standards for each of the 10 Essential Services*). The process involved two steps: an open discussion where attendees could express their opinions regarding the state's priority for each of the 10 Essential Services, followed by voting via a wireless keypad technology. The overall pattern was to discuss the Essential Service, then vote on its respective four Model Standards, discuss the next Essential Service, then vote on its associated Model Standards, and so on. On a technical note, it should be mentioned that New Jersey utilized a 1 through 5 scale rather than the NPHPSP 1 through 10 scale because of technical limitations with the wireless keypads. For analysis and reporting of the ratings, the 5-point average was converted to the 10-point scale. For example, if the average rating from the exercise was a 4.2, that average was converted to an 8.4.

Interpreting the Results

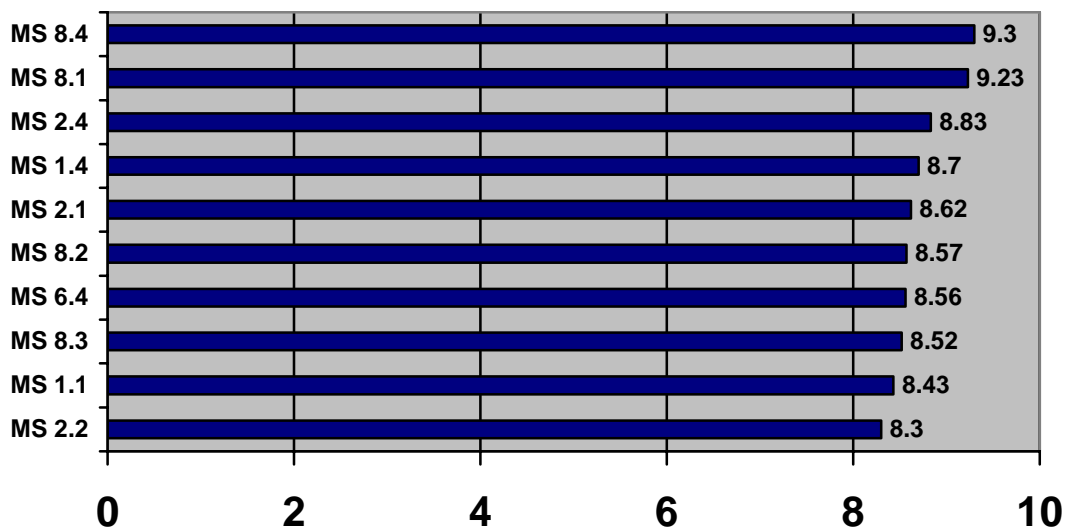
As mentioned above, the prioritization exercise focuses on Model Standards within the 10 Essential Services. The following graphs outline the 10 Essential Services and four Model Standards, where the Essential Service and Model Standard are denoted by its number. For example, the number 8.3 refers to Essential Service eight and Model Standard three.

Exercise Findings

While participants were encouraged to consider the relative importance and priority of each Model Standard, it should be noted that many attendees verbalized opinions that ALL the 40 Model Standards have a high level of importance. Though this resulted in many of the Model Standards being ranked equally as “highly important,” there was some differentiation across the forty standards. The following graphs reveal the 10 highest and 10 lowest priority rankings. The closer the rating is to 10, the higher the perceived priority.

E1. Ten Highest Rated Model Standards

MS=Model Standard



The ten Model Standards that were the most highly rated priorities are:

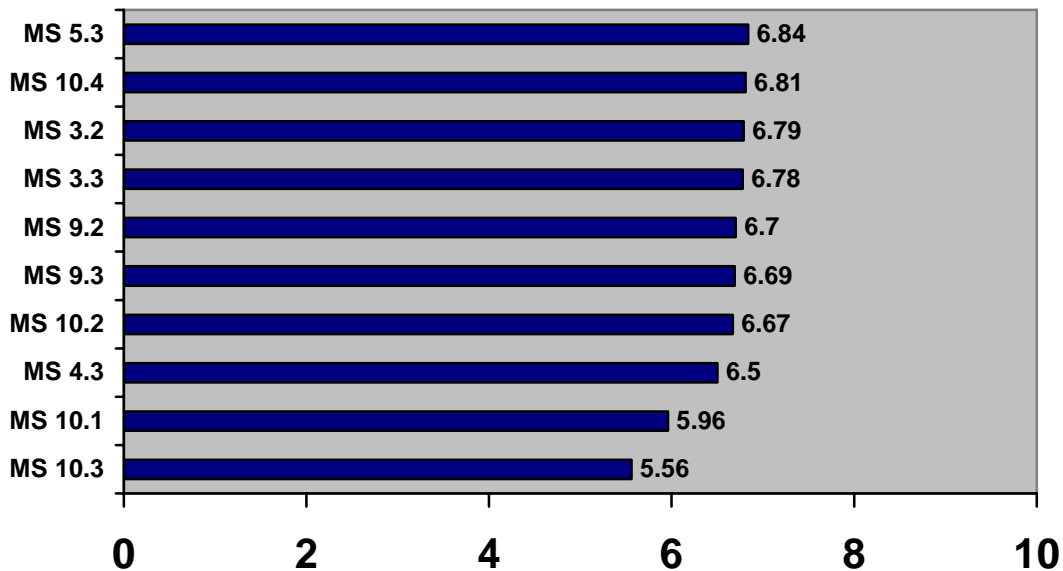
- 8.4 - Public health capacity and resources around assuring a competent public health and personal health care workforce
- 8.1 - Planning and implementation around assuring a competent public health and personal health care workforce
- 2.4 - Public health capacity and resources around diagnosing and investigating health problems and health hazards in the community
- 1.4 - Public health capacity and resources around monitoring health status to identify community health problems
- 2.1 - Planning and implementation around diagnosing and investigating health problems and health hazards in the community
- 8.2 - State-local relationships around assuring a competent public health and personal health care workforce
- 6.4 - Public health capacity and resources around enforcing laws and regulations that protect health and ensure safety
- 8.3 - Performance management and quality improvement around assuring a competent public health and personal health care workforce
- 1.1 - Planning and implementation around diagnosing and investigating health problems and health hazards in the community
- 2.2 - State-local relationships around diagnosing and investigating health problems and health hazards in the community

The two Model Standards that were ranked the highest were 8.4 and 8.1, with average ratings above a 9 on the 10-point scale. Both of these Model Standards are in Essential Service 8, which is “Assurance of a competent public and personal health care workforce.” It should also be noted that the remaining two Model Standards in Essential Service 8 (Model Standards 8.2 and 8.3) are also among the 10 highest rated. It can safely be concluded that the attendees view public health workforce development as a significant priority for New Jersey. Other highly prioritized Model Standards fall within Essential Service 2, which is “Diagnosing and investigating health problems and health hazards in the community.” Three of the four Model Standards from this Essential Service are among the 10 highest listed above. The final pattern emerging from the graph above is that two of the four Model Standards from Essential Service 1,

“Monitoring health status to identify community health problems,” were among the 10 most prioritized standards.

E2. Ten Lowest Rated Model Standards

MS=Model Standard



The Model Standards that were rated as lower priorities compared to the others are:

5.3 – Performance management and quality improvement around developing policies and plans that support individual and community health efforts

10.4 – Public health capacity and resources around research for new insights and innovative solutions to health problems

3.2 – State-local relationships around informing, educating, and empowering people about health issues

3.3 – Performance management and quality improvement around informing, educating, and empowering people about health issues

9.2 – State-local relationships around evaluating the effectiveness, accessibility, and quality of personal and population-based health services

- 9.3 – Performance management and quality improvement around
- 10.2 - State-local relationships around research for new insights and innovative solutions to health problems
- 4.3 – Performance management and quality improvement around mobilizing community partnerships to identify and solve health problems
- 10.1 – Planning and implementation around research for new insights and innovative solutions to health problems
- 10.3 - Performance management and quality improvement around research for new insights and innovative solutions to health problems

The one pattern that emerges when examining the list of the ten lesser-prioritized standards is with Essential Service 10, “Research for new insights and innovative solutions to health problems.” All four Model Standards from this Essential Service are among the least prioritized. Other Essential Services with more than one Model Standard in this grouping of 10 include Essential Service 3, “Informing, educating, and empowering people about health issues,” and Essential Service 9, “Evaluating the effectiveness, accessibility, and quality of personal and population based health services.”

It should be noted, however, that despite the relative lesser importance of the above standards relative to the remaining 30, these Model Standards were still viewed as important.

E3. Ratings for Ten Essential Services

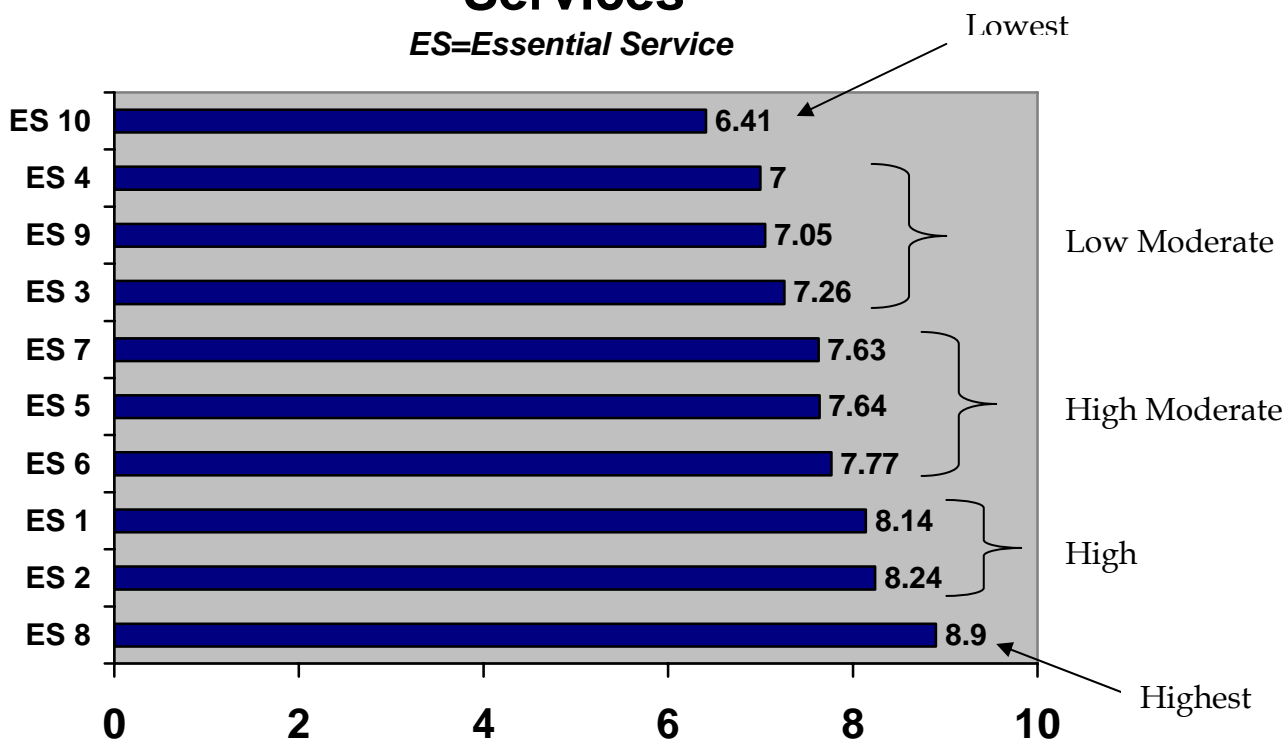


Figure E3 outlines the average rating within each of the 10 Essential Services whereas the two previous graphs (E1 and E2) detailed the Model Standard ratings within each of the 10 Essential Services. The Essential Service scores were calculated by taking an average of the four Model Standard ratings within each Essential Service (ES). The graph also displays the five prioritization categories.

The Essential Service garnering the highest priority rating is ES 8, which is “Assuring a competent public and personal health care workforce.” There was little group discussion on this topic as the attendees were all in agreement that New Jersey’s workforce issues are of utmost importance moving forward. As one attendee stated, “This has to be the top priority. Without the people, nothing else will happen.” This Essential Service also falls into the category of low performance, based on the results of the April assessment. Therefore, attendees view the workforce as an area of utmost

importance and one where New Jersey is under-performing compared to the optimal public health system.

Essential Services 1 and 2 garnered high priority ratings and Essential Services 5, 6, and 7 are within the high moderate priority rating.

Additionally, these five services also received higher performance ratings (ratings in the “moderate” and “significant” category). It was considered that these activities are being done well within New Jersey and important to maintain efforts. Specifically, these include the following:

1. **Monitor** health status to identify community health problems
2. **Diagnose and investigate** health problems and health hazards in the community
5. **Develop policies and plans** that support individual and community health efforts
6. **Enforce** laws and regulations that protect health and ensure safety
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable

The following comments were shared during the discussion of the above Essential Services.

Essential Service 1

- *“We need to get the data in order to substantiate the priorities.”*
- *“Evidence is needed to persuade legislators and others that these are priorities.”*
- *“We need to back up priorities with statistics/data to make it compelling.”*
- *“Some groups are difficult to measure, e.g. homeless, illegal immigrants.”*
- *“How can we improve until we know where we are now?”*
- *“Evidence needs to be current.”*

Essential Service 2

- *“This is the cornerstone of public health, the scientific data that supports public health.”*
- *“This is secondary prevention.”*

- *"This is needed in order to be able to evaluate."*
- *"This Essential Service is the 'means to an end.'"*
- *"It provides the tools for identifying issues and future monitoring."*
- *"This would be less of a priority if there was a better prevention of disease."*
- *"To make our communities healthy, we must be able to diagnose and investigate."*

Essential Service 5

- *"We need a road map to organize resources, otherwise you can get lost in the forest."*
- *"This is like creating a mission statement."*
- *"This is central to what we do. We need to understand this in order to be effective."*
- *"Legislators don't hear enough from public health."*
- *"Policies/plans legitimize the public health system. They define the issues."*

Essential Service 6

- *"This goes hand-in-hand with policy."*
- *"This is not even a question. This is a public obligation. There is really no choice."*
- *"We are the only ones who can do this."*
- *"Education about the laws reduces the need to enforce laws."*
- *"Trying to change behaviors may take years. Enforcement is more immediate."*
- *"The enforcers who educate as part of the process are the most effective. The best inspectors do 2/3 education and 1/3 enforcement."*
- *"Threat of enforcement is an incentive. Nothing gets a child immunized better than the threat of exclusion from school."*

Essential Service 7

- *"While important, local public health in New Jersey has traditionally not been involved with this."*
- *"Across the country, local health departments do more with access to care."*
- *"If this is not the top priority, then no one will listen to public health."*

- *“Until access to care is addressed, this becomes one of the paramount issues facing LHDs.”*
- *“This affects the public’s health. People need to be linked to services.”*
- *“Insurance and funding is critically important.”*
- *“If your area is medically underserved, it is part of your job to get services to the people.”*

There are four Essential Services that received lower priority ratings and also lower performance scores (“moderate” and “minimal” ratings). These include Essential Services 3, 4, 9, and 10. For these four services, the activities could be improved, but are of low priority and may need little or no attention at this time. These were:

- 3. Inform, educate, and empower** people about health issues
- 4. Mobilize** community partnerships to identify and solve health problems
- 9. Evaluate** effectiveness, accessibility and quality of personal and population-based health services
- 10. Research** for new insights and innovative solutions to health problems

Essential Service 10 was seen as the lowest priority among all the Essential Services ranked. Attendees described it as important, but a “nice to have” in many respects. The following comments reflect the sentiments of the group for the above four Essential Services.

Essential Service 3

- *“We need to communicate the results of ES1 and ES2. Otherwise, it won’t have an impact.”*
- *“We need to communicate to the Legislature.”*
- *“Policies cannot be effective without effective communication of them.”*
- *“Effective education depends on data on community health status and threats.”*
- *“Education of people making the policies is foundational.”*

Essential Service 4

- *“If you don’t have partners in public health, you cannot be successful because public health doesn’t have the capacity to do this alone.”*
- *“This avoids duplication of effort.”*

- *“Home rule means that local problems tend to get addressed locally.”*
- *“Partners provide feedback to make sure we are going down the right road.”*
- *“Economically, no one entity can do it all, and now, we especially need to leverage partnerships (fiscal and human resources).”*
- *“This encourages partners to take on responsibilities.”*
- *“Partnerships mobilize support for Legislative action.”*

Essential Service 9

- *“This closes the planning loop and is very important.”*
- *“We need to do this to check to see if programs are meaningful to the population being served.”*
- *“Documentation is time consuming.”*
- *“It’s a lot of work.”*
- *“Evaluation is a good thing, but being able to implement services is the hard part.”*
- *“This measures capacity and accountability within the system.”*
- *“This helps us determine how we use our capabilities.”*
- *“Benchmarking helps keep things objective.”*
- *“Elements of accountability, time, and expertise are needed and can create barriers to implementing.”*

Essential Service 10

- *“This is important for developing best practices, but lack of time and resources makes it difficult.”*
- *“The other Essential Services all feed into this, if properly addressed.”*
- *“This is an ideal role for a School of Public Health.”*
- *“Research belongs to an academic setting, which is only a small part of the system.”*
- *“Research must have a practical application.”*
- *“It’s gravy. If you can do it, that’s wonderful, but it’s not the highest priority.”*
- *“A lot of research is happening at the national level and is being presented at national meetings and in publications. It is not effectively being communicated to and used at the local level.”*
- *“Since we don’t have enough money, the funds need to go to the things that we know will work.”*
- *“It’s not going to happen if we don’t have adequate resources.”*

- *“Much research is out there, but there isn’t time to read it or integrate it into daily practice.”*

Conclusions

Based on the results of the priority questionnaire, the public health workforce was considered to be the highest priority and the area needing the most attention in New Jersey’s public health system. It was also perceived as an area where minimal improvement activity has taken place across New Jersey.

Assessment participants also felt it would be important to maintain the current level of activity covered in Essential Services 1, 2, 5, 6, and 7. This includes monitoring activities, diagnosis and investigation of health threats, policy and plan development, law/regulatory enforcement, and linking people to needed health services. These are areas where New Jersey rates high in its performance, which corresponds with the higher priority ratings.

Lastly, the remaining four Essential Services (3, 4, 9, and 10) demonstrate moderate to minimal performance activity, which according to the priority ratings, is acceptable in New Jersey. While some of these activities could be improved to increase the performance scores, their priority rankings were not as high as the other six Essential Services.

F. APPENDICES

APPENDIX A

Attendee List

Breakout Group A

EPHS #1 – Monitor Health Status

EPHS #2 – Diagnose & Investigate health problems & health hazards

1. **Aimee DeLotto, REHS**, New Jersey Environmental Health Association (NJEHA)
2. **Beverly Stern, Executive Director**, NJ State School Nurses Association (NJSSNA)
3. **Dianna Lachman**, NJ Local Boards of Health Association (NJLBHA)
4. **Dr. Nancy Halpern**, NJ Department of Agriculture
5. **Gail Morchel, RN, President**, Association for Professionals in Infection Control (APIC) - Northern NJ Chapter
6. **Holly Funkhouser-Cucuzzella**, NJ Society for Public Health Education (NJSOPHE)
7. **Kevin Henry**, NJ Department of Health and Senior Services, Cancer Epidemiology Services
8. **Dr. Lakota Kruse**, NJ Department of Health and Senior Services, Division of Family Health Services
9. **Linda Dimasi**, NJ Department of Health and Senior Services, Division of AIDS Services
10. **James Blando, Ph.D**, NJ Department of Health and Senior Services, Occupational Health Service
11. **Margy Jahn, Health Officer**, NJ Health Officers Association, (NJHOA)
12. **Maria Baron**, NJ Department of Health and Senior Services, Center for Health Statistics
13. **Marilyn Bernstein, MSN, RN**, NJ Association of Public Health Nursing Administrators, (NJAPHNA)
14. **Amada Hessels**, Association for Professionals in Infection Control (APIC) - Southern NJ Chapter,
15. **Peter Summers, Health Officer**, NJ Association of County Health Officers, (NJACHO)
16. **Carol Genese**, NJ Department of Health and Senior Services, Office of the State Epidemiologist
17. **Robert Culleton**, NJ Department of Human Services, Division of Addiction Services
18. **Patti Holland**, NJ Department of Human Services, Division of Mental Health
19. **Dennis Flynn, Assistant Commissioner**, NJ Department of Health and Senior Services, Division of Public Health & Environmental Laboratories
20. **Richard F. Matzer, MPH**, NJ Department of Health and Senior Services, Office of Public Health Infrastructure

Facilitator: Connie Wolfe, Holleran

Recorders: Cinthia Weaver, Health Officer, NJ Environmental Health Association

Martha Smith, NJ Department of Health and Senior Services, Division of Public Health & Environmental Laboratories

Breakout Group B

EPHS #3 – Inform, Educate and Empower people about health issues

EPHS #4 – Mobilize community partnerships

1. **Sarah Kleinman, MPH, CHES**, NJ Department of Education, Office of Program Support Services
2. **Cathy Zuecher, BSN, RN, BC**, NJ Association of Public Health Nursing Administrators, (NJAPHNA)
3. **Clara Gregory**, NJ Department of Health and Senior Services, Division of AIDS Services
4. **Stephen Marcella**, NJ Pediatric Council on Research and Education, (NJPCORE)
5. **John Saccenti**, NJ Local Boards of Health Association, (NJLBOHA)
6. **Jose Gonzalez**, NJ Department of Health and Senior Services, Office of Minority and Multicultural Health
7. **Marconi Gapas, REHS**, NJ Environmental Health Association, (NJEHA)
8. **Roxanne Kennedy**, NJ Department of Human Services, Division of Mental Health
9. **Michelle Tropper, MPH**, American Cancer Society, (ACS)
10. **Patricia Diamond**, Health Officer, NJ Association of County Health Officers (NJACHO)
11. **Roslyn Council, MSW**, NJ Department of Health and Senior Services, Chronic Disease & Prevention Control Services
12. **Sharon Smith, MPH**, NJ Department of Health and Senior Services, Office of Cancer Control
13. **Sue Lachenmayr, MPH, CHES**, NJ Department of Health and Senior Services, Division on Aging and Community Services
14. **Tracey Storms**, NJ Society for Public Health Education, (NJSOPHE)
15. **Trevor Weigle, Health Officer**, NJ Health Officers Association, (NJHOA)
16. **Natasha Coleman, MPH**, American Cancer Society, (ACS)
17. **Colleen McKay Wharton**, NJ Public Health Association, (NJPHA)
18. **Dennis Donovan**, NJ Department of Human Services, Division of Addiction Services
19. **Teresa Lampmann**, Pediatric/Adult Asthma Coalition of NJ
20. **Dr. Susan Walsh, Deputy Commissioner**, NJ Department of Health and Senior Services
21. **Judy Doyle**, Mayor's Wellness Campaign

Facilitator: Michael Goodling, Holleran

Recorder: Donna Rue, NJ Society for Public Health Education (NJSOPHE)

Breakout Group C

EPHS #5 - Develop Policies and Plans

EPHS #6 - Enforce laws and regulations to protect health/safety

1. **Janet DeGraaf, Director**, NJ Department of Health and Senior Services, Communicable Disease Service
2. **Aline Holmes, RN**, NJ Hospital Association, (NJHA)
3. **Carole Hudson**, NJ Association of Public Health Nurse Administrators, (NJAPHNA)
4. **Herb Yardley, Health Officer**, NJ Association of County Health Officers, (NJHOA)
5. **Kevin Sumner, Health Officer**, NJ Health Officers Association, (NJHOA)
6. **Lisa Cummings**, NJ Department of Health and Senior Services, Division of AIDS Services
7. **Eric Elmore, Director**, NJ Dental Association, (NJDA)
8. **Michael Baier**, NJ Department of Consumer Affairs, Division of Codes and Standards
9. **Richard Censullo, Health Officer**, NJ Public Health Council
10. **Karen Blumfeld, Executive Director**, NJ Global Advisors on Smoke free Policy, (NJ GASP)
11. **Kevin Martone, Deputy Commissioner**, NJ Department of Human Services
12. **Suzanne Rose**, NJ Society for Public Health Education, (NJSOPHE)
13. **Uta Vorbach, MPH**, NJ Department of Health and Senior Services, Office of Tobacco Control
14. **Walter Stein**, NJ Local Boards of Health Association, (NJLBOHA)
15. **Deborah Pinto, Director**, NJ Department of Environmental Protection, CEHA
16. **Elliot Fishman**, NJ Department of Health and Senior Services, Office of Policy
17. **Joseph Eldridge**, NJ Department of Health and Senior Services, Consumer and Environmental Health Service
18. **Genevieve Raganelli**, NJ Department of Health and Senior Services, Office of Legal & Regulatory Affairs
19. **David W. Gruber, Senior Assistant Commissioner**, NJ Department of Health and Senior Services, Division of Health Infrastructure Preparedness and Emergency Response
20. **Audrey Miller**, NJ Department of Law and Public Safety, Office of Homeland Security & Preparedness
21. **William Dotts**, President, NJ Environmental Health Association, (NJEHA)

Facilitator: Lisa Lehman, Holleran

Recorder: Diane Anderson, New Jersey Hospital Association, (NJHA)

Breakout Group D

EPHS #7 – Link people to needed health services / assure health care

EPHS #9 – Evaluate personal and population-based health services

1. **Carlo DiLizia, Health Officer**, NJ Health Officers Association, (NJHOA)
2. **Robyn Gorman, Senior Director**, Mental Health Association in NJ, (MHANJ)
3. **Donna Fountain**, NJ Association of Public Health Nurse Administrators, (NJAPHNA)
4. **Emmanuel Noggoh, Director**, NJ Department of Health and Senior Services, Office of Healthcare Quality Assessment
5. **Firoozeh Vali, Vice President**, NJ Hospital Association, (NJHA)
6. **Kristin Reed, REHS**, NJ Environmental Association, (NJEHA)
7. **Linda Anderson**, NJ Department of Health and Senior Services, Office of Primary Care
8. **Maureen Wolski**, NJ Department of Health and Senior Services , Division of AIDS Services
9. **Selina Haq, Ph.D**, NJ Primary Care Association, (NJPCA)
10. **Jeffrey Beck, LPC, CCGC, JD, ABD**, Council on Compulsive Gambling of NJ, Inc.
11. **Dianne Litterer, MPA, CP**, NJ Prevention Network, Inc., (NJPN)
12. **Steve Papenberg, Health Officer**, NJ Local Boards of Health Association, (NJLBOHA)
13. **Sydelle Norris, Program Development Specialist**, NJ Department of Health and Senior Services, Division of Aging and Community Services
14. **John Hulick, Director**, National Council on Alcohol & Drug Dependence, (NCADD)
15. **Pamela Mastro**, NJ County Mental Health Administrators Association
16. **Kathleen Russo**, NJ Department of Human Services, Division of Addiction Services
17. **Laura Marx**, NJ 211
18. **Joseph Tricarico, Jr., Assistant Commissioner**, NJ Department of Health and Senior Services, Health Infrastructure Preparedness Bureau
19. **Karen Benjamin**, Prevent Child Abuse of NJ

Facilitator: Rebecca Gibbons, Holleran

Recorder: Elizabeth Moody, MA, NJ Department of Health and Senior Services, Office of Public Health Infrastructure

Breakout Group E

EPHS #8 – Assure a competent public and health care workforce

EPHS #10 – Research for new insights and innovative solutions

1. **Robert Gogats, Health Officer**, NJ Association of County Health Officers, (NJACHO)
2. **Colette Lamothe-Galette**, NJ Department of Health and Senior Services, Center for Health Statistics
3. **Ralph D'Aries, Health Officer**, NJ Health Officers Association, (NJHOA)
4. **Andrea Aughenbaugh, CEO**, NJ State Nurses Association, (NJSNA)
5. **Leslie Leonard**, NJ Association of Public Health Nurse Administrators, (NJAPHNA)
6. **Joan Valas**, NJ Local Board of Health Association, (NJLBHA)
7. **Dennis San Fillippo**, NJ Public Health Council
8. **Arlene Stoller**, NJ Society for Public Education, (NJSOPHE)
9. **Candice Davenport**, NJ Public Health Association, (NJPHA)
10. **Eugene Blicharz**, NJ Department of Labor and Workforce Development
11. **Paschal Nwako, REHS**, NJ Environmental Health Association, (NJEHA)
12. **Dr. Elizabeth Calaminis**, Richard Stockton College of New Jersey
13. **Mitchel Rosen**, University of Medicine and Dentistry of NJ (UMDNJ), School of Public Health
14. **Dr. Ronald Caplan**, Richard Stockton College of New Jersey
15. **Richard Bowe, Executive Director**, The Certification Board
16. **Parvin AhmadKhanlou, Ph.D**, NJ Department of Health and Senior Services, Office of Public Health Infrastructure

Facilitator: Cynthia Osborne, Holleran

Recorder: Angela Derry, NJ Department of Health and Senior Services, Office of Public Health Infrastructure

APPENDIX B

Itemized Summary Scores

Summary of performance scores by Essential Public Health Service (EPHS) and model standard.

Essential Public Health Service	Score
EPHS 1. Monitor Health Status To Identify Community Health Problems	49
1.1 Planning and Implementation	78
1.1.1 Surveillance and monitoring programs	69
1.1.2 Health data products accessible to data users	48
1.1.3 State health profile	75
1.1.4 Disease reporting system	100
1.1.5 Protection of personal health information	100
1.2 State-Local Relationships	45
1.2.1 Assistance in interpretation and use of health data	48
1.2.2 Uniform set of timely community-level health data	46
1.2.3 Assistance with local information and monitoring systems	42
1.3 Performance Management and Quality Improvement	34
1.3.1 Review effectiveness in monitoring efforts	44
1.3.2 Active performance management	25
1.4 Public Health Capacity and Resources	40
1.4.1 Commit financial resources	50
1.4.2 Coordinate system-wide organizational efforts	25
1.4.3 Workforce expertise	44
EPHS 2. Diagnose And Investigate Health Problems and Health Hazards	60
2.1 Planning and Implementation	76
2.1.1 Broad scope of surveillance programs	69
2.1.2 Enhanced surveillance capability	75
2.1.3 Statewide public health laboratory system	81
2.1.4 Laboratory analysis capabilities	81
2.1.5 Investigations of health problems	75
2.2 State-Local Relationships	77
2.2.1 Assistance with epidemiologic analysis	78

2.2.2 Assistance in using laboratory services	81
2.2.3 Guidance in handling public health problems and threats	75
2.2.4 Capability to deploy response teams to local areas, when needed	75
2.3 Performance Management and Quality Improvement	50
2.3.1 Review surveillance and investigation procedures	50
2.3.2 Active performance management	50
2.4 Public Health Capacity and Resources	37
2.4.1 Commit financial resources	25
2.4.2 Coordinate system-wide organizational efforts	29
2.4.3 Workforce expertise	56
EPHS 3. Inform, Educate, And Empower People about Health Issues	38
3.1 Planning and Implementation	46
3.1.1 Health education and promotion programs	50
3.1.2 Health communication programs	21
3.1.3 Emergency communications capacity	68
3.2 State-Local Relationships	52
3.2.1 Assistance with health communication and health education/promotion programs	30
3.2.2 Assistance in developing local emergency communication capabilities	75
3.3 Performance Management and Quality Improvement	25
3.3.1 Review effectiveness of health communication and health education/promotion efforts	25
3.3.2 Active performance management	25
3.4 Public Health Capacity and Resources	27
3.4.1 Commit financial resources	25
3.4.2 Coordinate system-wide organizational efforts	25
3.4.3 Workforce expertise	31
EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems	42
4.1 Planning and Implementation	60
4.1.1 Building statewide support for public health	68
4.1.2 Partnership organization and development	53
4.2 State-Local Relationships	50
4.2.1 Assistance in building collaborative skills	50
4.2.2 Incentives for local partnerships	50
4.3 Performance Management and Quality Improvement	27

4.3.1 Review effectiveness of partnerships	29
4.3.2 Active performance management	25
4.4 Public Health Capacity and Resources	32
4.4.1 Commit financial resources	25
4.4.2 Coordinate system-wide organizational efforts	47
4.4.3 Workforce expertise	25
EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts	63
5.1 Planning and Implementation	70
5.1.1 Convene collaborative planning processes	65
5.1.2 State health improvement plan	67
5.1.3 State all-hazards preparedness plan and emergency response capacity	75
5.1.4 Policy development activities	72
5.2 State-Local Relationships	67
5.2.1 Assistance and training for local planning	70
5.2.2 Assistance in integrating statewide strategies in community health improvement plans	50
5.2.3 Assistance in development of local preparedness plans	77
5.2.4 Assistance in local policy development	71
5.3 Performance Management and Quality Improvement	61
5.3.1 Monitor progress in health improvement	75
5.3.2 Review policies for public health impact	50
5.3.3 Exercises and drills to test preparedness plans	69
5.3.4 Active performance management	50
5.4 Public Health Capacity and Resources	55
5.4.1 Commit financial resources	50
5.4.2 Coordinate system-wide organizational efforts	50
5.4.3 Workforce expertise in planning	63
5.4.4 Workforce expertise in policy development	56
EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety	66
6.1 Planning and Implementation	63
6.1.1 Review of public health laws	69
6.1.2 Emergency powers	75
6.1.3 Cooperative relationships to support compliance	56
6.1.4 Customer-centered administrative processes	50
6.2 State-Local Relationships	75

6.2.1 Assistance on enforcement of laws	75
6.2.2 Assistance to local governing bodies in developing local laws	75
6.3 Performance Management and Quality Improvement	63
6.3.1 Review effectiveness of regulatory activities	75
6.3.2 Active performance management	50
6.4 Public Health Capacity and Resources	64
6.4.1 Commit financial resources	75
6.4.2 Coordinate system-wide organizational efforts	54
6.4.3 Workforce expertise	63
EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	49
7.1 Planning and Implementation	42
7.1.1 Assessment of access to care	28
7.1.2 Delivery of services and programs to improve access	35
7.1.3 SPHS entity responsible for monitoring and coordination	50
7.1.4 Mobilizes to reduce health disparities, including during emergency events	56
7.2 State-Local Relationships	52
7.2.1 Assistance in assessment and service delivery	54
7.2.2 Assistance for providers serving underserved populations	50
7.3 Performance Management and Quality Improvement	54
7.3.1 Review effectiveness of programs in improving access, appropriateness of personal health care, and health care quality	57
7.3.2 Active performance management	50
7.4 Public Health Capacity and Resources	49
7.4.1 Commit financial resources	50
7.4.2 Coordinate system-wide organizational efforts	46
7.4.3 Workforce expertise	50
EPHS 8. Assure a Competent Public and Personal Health Care Workforce	23
8.1 Planning and Implementation	20
8.1.1 Assessment of population-based and personal health care workforce needs	25
8.1.2 Statewide workforce development plan	0
8.1.3 Programs to enhance workforce skills	27
8.1.4 Assure excellence in professional practice of workforce members	31
8.1.5 Incentives for life-long learning	17
8.2 State-Local Relationships	40

8.2.1 Assistance with workforce assessment	25
8.2.2 Assistance with workforce development	21
8.2.3 Education and training to enhance local workforce skills	75
8.3 Performance Management and Quality Improvement	17
8.3.1 Review workforce development efforts	25
8.3.2 Review whether academic-practice partnerships are effective in preparing the workforce	25
8.3.3 Active performance management	0
8.4 Public Health Capacity and Resources	14
8.4.1 Commit financial resources	25
8.4.2 Coordinate system-wide organizational efforts	4
8.4.3 Workforce expertise	13
EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	37
9.1 Planning and Implementation	50
9.1.1 Evaluate population-based health programs	52
9.1.2 Evaluate personal health care services	50
9.1.3 Assess the performance of the public health system	48
9.2 State-Local Relationships	48
9.2.1 Assistance on evaluation	46
9.2.2 Share state evaluation results to assist local planning	50
9.3 Performance Management and Quality Improvement	27
9.3.1 Review the effectiveness of evaluation activities	29
9.3.2 Active performance management	25
9.4 Public Health Capacity and Resources	23
9.4.1 Commit financial resources	25
9.4.2 Coordinate system-wide organizational efforts	25
9.4.3 Workforce expertise	19
EPHS 10. Research for New Insights and Innovative Solutions to Health Problems	25
10.1 Planning and Implementation	15
10.1.1 Academic-practice collaboration to disseminate and use research findings in practice	20
10.1.2 Public health research agenda	0
10.1.3 Conduct and participate in research	25
10.2 State-Local Relationships	23
10.2.1 Assistance in research activities, including community-based	20

participatory research	
10.2.2 Assistance in using research findings	25
10.3 Performance Management and Quality Improvement	23
10.3.1 Review research activities for relevance and appropriateness	22
10.3.2 Active performance management	25
10.4 Public Health Capacity and Resources	38
10.4.1 Commit financial resources	25
10.4.2 Coordinate system-wide organizational efforts	21
10.4.3 Workforce expertise	69