# Maricopa County 2017 CCHNA Local Public Health System Assessment Report

Maricopa County Department of Public Health
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## INTRODUCTION

The National Public Health Performance Standards (NPHPS) is a tool created to assess the performance of public health systems throughout the United States, and is a result of partnership and collaboration between the Centers for Disease and Control (CDC) and several other partner organizations[1]. There are three separate assessments, each of which is used to identify areas in which to improve, assess the quality of public health programs and assistance, and to strengthen the relationships existing between various agencies, organizations and governing bodies. The three assessments assess the quality of public health program delivery in the state, local, and public sectors.

The main goals as stated by the NPHPS are as follows:

- Identify partners and community members in the public health system;
- Engage those partners in health assessment and health improvement planning; and
- Promote improvement in agencies, systems and communities.

The NPHPS assesses the quality of public health services and programs with the use of the 10 Essential Public Health Services, by focusing on the overall public health system as a whole, and by being used for the intent of a continuous quality improvement process.

The benefits of implementing the NPHPS include:

- Identifying areas for system improvement by identifying strengths and weaknesses;
- Strengthening state and local partnerships;
- Ensuring a strong system exists and can respond effectively to daily public health issues as well as public health emergencies;
- Improving upon organizational and community communication and collaboration;
- Educating participants in public health concepts and how various sectors in public health intertwine; and
- Providing a benchmark for public health practice and quality improvements.

From the three separate assessment pieces to the NPHPS framework, the Maricopa County Department of Public Health completed the *Local Public Health System Assessment (LPHSA)*, which was developed and is continually being updated by the CDC, the National Association of County and City Health Officials (NACCHO), and the Office for State, Tribal, Local and Territorial Support. The local piece of the public health assessment centers its focus on the entities – or, organizations and agencies – that collectively make up the public health system within the local community.

**Figure 1. The 10 Essential Public Health Services**
Source: https://www.cdc.gov/nphpsp/essentialservices.html

[1] Partner organizations of the National Public Health Performance Standards: CDC, American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), National Network of Public Health Institutes (NNPHI), and the Public Health Foundation (PHF)

In order to measure the level of quality the local public health system operates at, the assessment tool focuses on the 10 Essential Public Health Services. It does so by assessing how often and how well these services are provided in the local system, as well as determining and defining components, activities, competencies and capacities of the local public health system.

The local public health system performance assessment is then implemented by involving community partners from varying organizations and agencies – both public and private. Examples of community partner organizations can be directly health-related such as local healthcare providers, local schools and educational organizations, as well as those not necessarily associated with health such as public safety agencies and youth development organizations. Through the local public health system, all kinds of roles within the community intertwine with one another and indirectly affect the health of those living within the community. In a collaborative manner, these agencies are able to network with one another, identifying components of the local public health system they may have not been aware of prior, which results in agencies becoming more aware of how exactly their role in the community impacts other organizations and the health and wellness of community members, and vice-versa.

Organizations other than the public health department at the national, state, and local levels are able to utilize the NPHPS and its results to their benefit, in terms of expanding upon public health and its impact across the nation. The Mobilizing for Action through Planning and Partnerships (MAPP) utilizes the LPHSA in a community-wide strategic planning process, focused on improving public health within communities. The Internal Revenue Service (IRS) can use LPHSA data and results when reviewing community health needs assessments (CHNAs) from all non-profit hospitals, which was mandated by the Patient Protection and Affordable Care Act (PPACA) in 2010. Also, the Public Health Accreditation Board (PHAB) is able to use the LPHSA to fulfill guidelines which must be completed by public health departments in order to become, or stay, accredited.

See https://www.cdc.gov/nphpsp/index.html for further information regarding the NPHPS and its three assessment pieces.

## METHODS

The Arizona Public Health Association (AzPHA) invited its membership to participate in this assessment, and Vitalyst Health Foundation also promoted participation in the assessment. To initiate the local assessment piece of the National Public Health Performance Standards (NPHPS), community partner organizations who had worked with and among MCDPH in the past were contacted and invited to participate in the 2016 Local Public Health Systems Assessment (LPHSA). Invitations were sent directly to partner organizations, as well as sent to internal MCDPH supervisors to distribute to any other known partner organizations they have personal and networking connections with. The invitation linked to a Qualtrics survey, which was designed to ask questions about the participant's daily work, in order to categorize them into one of three[2] designated community meetings, based on the sector and specific Essential Public Health Service they fall into. The invitations to the community meetings also provided an option for participants to complete the assessment online in Qualtrics, if time and schedules did not permit attending in-person.

There were 67 assessments completed by professionals in various public health-related organizations and agencies within the Maricopa, Arizona area. Ten assessments were completed via the online (Qualtrics) format; the remaining 57 participants attended one of the three community meetings.

Participants were asked to complete the assessment section for which they were most familiar and had the most experience working in, specifically within Maricopa County. The breakdown of the assessment is as follows:

- Group 1: Essential Public Health Services 1 & 2
  - ES #1: Monitor Health; ES #2: Diagnose & Investigate
- Group 2: Essential Public Health Services 3, 4 & 7
  - ES #3: Inform, Educate, Empower; ES #4: Mobilize Community Partnerships; ES #7: Link to & Provide Care
- Group 3: Essential Public Health Services 5 & 6
  - ES #5: Develop Policies; ES #6: Enforce Laws
- Group 4: Essential Public Health Services 8, 9 & 10
  - ES #8: Assure Competent Workforce; ES #9: Evaluate; ES #10: Research and Innovation

[2]There were initially four community meetings organized, but due to lack of registration for this meeting by community partners, one was cancelled. This meeting was set to focus on Essential Public Health Services #5 and 6, Developing Policies and Enforcing Laws.

The assessment was structured in the way that a brief description of each essential service was provided and then between 2-5 model standards for each essential service were explained. In the assessment, each model standard had between 3-7 questions related to public health in Maricopa County. Each participant was then asked to rank how well the Maricopa County Local Public Health System (MCLPHS) achieved each question addressed, on a scale of 1-5 (scale shown below).

| **Rank** | **Score** | **Extent to which Standard is Met** |
|---|---|---|
| 1 | No Activity | 0% |
| 2 | Minimal Activity | 1-25% |
| 3 | Moderate Activity | 26-50% |
| 4 | Significant Activity | 51-75% |
| 5 | Optimal Activity | 76-100% |

The online version of the assessment was presented to participants as one of four segments of the whole assessment, based on the essential service that the participant works within. In each section, a brief description of each essential public health service was introduced, followed by a brief description of each model standard (2-5 per Essential Service), then the set of questions. Participants were asked to answer each question by providing a rank score which represented how well they believed the Maricopa County Local Public Health System (MCLPHS) addressed the question being asked. There were also areas in which to leave comments, explanations, and/or questions pertaining to each set of standards and questions. Three free text boxes were provided where the participant was asked to identify strengths, weaknesses, and improvement opportunities for each model standard.

Participants attending the in-person meetings also provided a rank score which represented how well they believed the MCLPHS addressed the question being asked for each essential service and its corresponding model standards. A brief open discussion followed each ranking activity where participants discussed any strengths, weakness, and potential improvement opportunities for the local public health system and for each model standard as outlined by NPHPS.

After the assessments from both live and online settings were completed, the quantitative ranking data were analyzed. These data were compiled into a report format provided by the Public Health Foundation (PHF), resulting in representative tables and graphs. The qualitative (comments) data were analyzed by examining the themes identified in each individual comment, and then compiling trends which were also identified for each essential service.

## FINDINGS

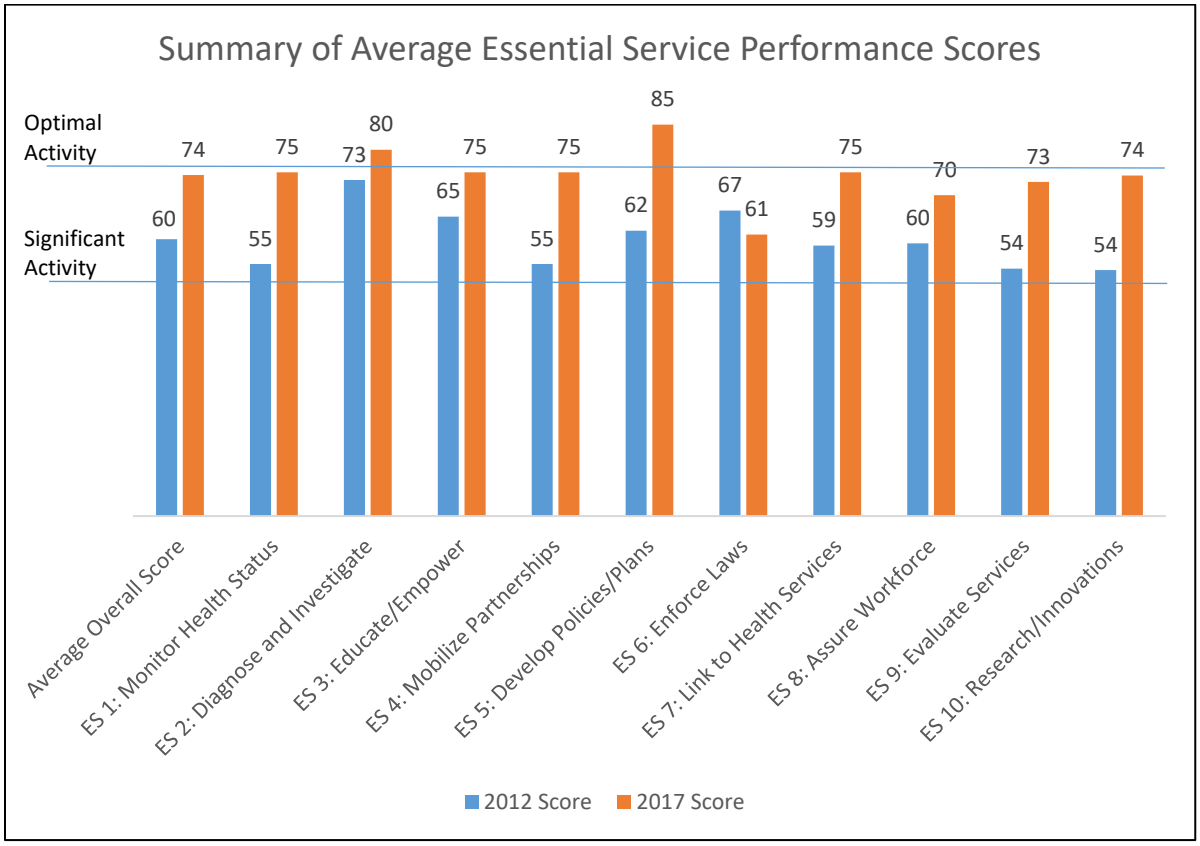
After collection of the quantitative data obtained in the local assessment, the tool provided by the Public Health Foundation (PHF) was used to obtain the results for the local assessment. Based on these

findings, the Maricopa County Public Health System was overall shown to be operating at the "significant activity" level with scores for each essential public health service ranging between 61% and 85% activity, with an average score of 74.4% activity across all ten essential public health services.

The original Local Public Health Systems Assessment conducted in Maricopa County took place in 2012. The overall score for that assessment was also at the "significant activity" level. However, the scores for each essential public health service ranged between 54% and 73% activity, with an average score of 60.4%.

The comparison of both the overall level of activity within the Maricopa County Public Health System and the scores for each essential service from both the initial (2012) and current (2017) LPHSA assessments can be seen below, in Figure 2.

**Figure 2. Levels of Public Health Performance in per Essential Public Health Service**



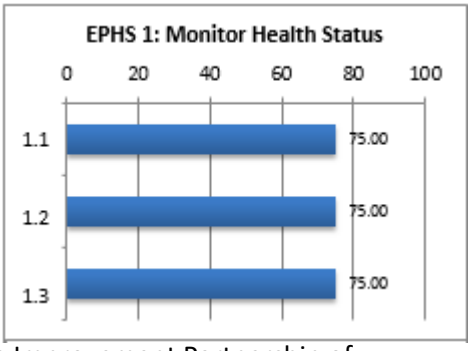

As seen above in Figure 2, the Maricopa County Local Public Health System has seen an increase of approximately 14% activity towards achieving "optimal activity" overall (ranking between 76-100% performance), and each essential service's level of activity has increased by between 6% and 12% respectively – with the exception of ES #6, which decreased by 6% over the five-year span.

## Trends according to Essential Service

### *Essential Service #1:* Monitor Health Status to Identify and Solve Community Health Problems

As seen in Figure 3, each of the three model standards for essential service (ES) #1 were scored at 75%, which means that the Maricopa County Public Health System is operating at "significant," and nearly "optimal," performance when performing ES #1.

Figure 3. Performance Score by Model Standard for Essential Public Health Service #1




Essential Service #1 Model Standards:

1- Community Health Assessment
2- Current Technology
3- Registries

In ES #1, the top theme from participant responses was that *partnership* within the Maricopa County public health system is evident. Participants perceived Maricopa County as achieving community partnership to a high regard, specifically by the Health Improvement Partnership of Maricopa County (HIPMC).

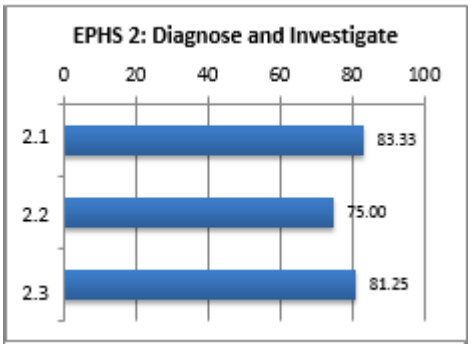
The next theme in ES #1 shows that participants believe that efforts within the public health system have been *non-collaborative* in nature. These comments noted that various agencies and organizations may be collecting heath status data and figures, but are not sharing it with one another to create a composite health status model.

The third theme was that events and public health efforts are *aligned with the overall Community Health Assessment* (CHA) and the corresponding Community Health Improvement Plan (CHIP). These comments show that public health efforts, as according to the CHIP process, are coordinated.

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

Shown in Figure 4, both model standard (MS) #1 and #3 operate with "optimal" performance when being performed within the Maricopa County Public Health System, while MS #2 though with a slightly lower score, is still operating at the level of "significant" performance.

Figure 4. Performance Score by Model Standard for Essential Public Health Service #2




Essential Service #2 Model Standards:

1- Identification/Surveillance
2- Emergency Response
3- Laboratories

The most common theme from participant comments in ES #2 is that *efficient methods are being used*. Participants perceived that various components of the Maricopa County Public Health System are performing their individual duties such as disease investigation and laboratory research in an efficient and worthwhile manner.

The second theme of ES #2 was that there are *barriers to collecting data*. Here, participants recognized a need for, and a lack of, specific types of data; however, they also recognized that these data are not

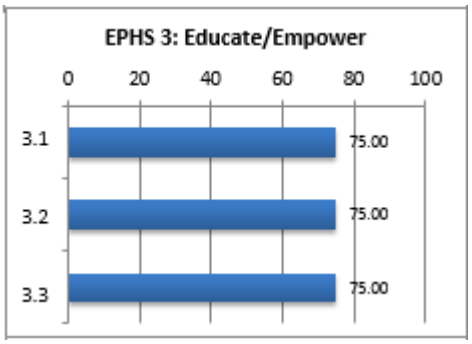
attainable due to specific reasons, such as with special and hard-to-reach populations, lack of community participation, or attributable to the fact that data collection in a county as large, expansive and diverse as Maricopa is difficult to obtain

The third theme of ES #2 showed that participants are aware of various *protocols and procedures in place* when it comes to disease investigation and reporting and saw the county as being prepared and having a direct response, were a disease outbreak to occur.

### *Essential Service #3:* Inform, Educate, & Empower People about Health Issues

As seen in Figure 5, each of the three model standards for essential service (ES) #3 were scored at 75%, which means that the Maricopa County Public Health System is operating at "significant," and nearly "optimal," performance when performing ES #3.

Figure 5. Performance Score by Model Standard for Essential Public Health Service #3




Essential Service #3 Model Standards:

1- Health Education/Promotion
2- Health Communication
3- Risk Communication

In ES #3, the top theme from participants was that in terms of being prepared for a public health emergency, there is *effective communication of the local public health services that address this*. This theme was also related back to Maricopa County's readiness to handle local public health threats (or potential emergencies), specifically with hard-to-reach and special populations, and how they are specifically targeted to provide them with public health information and education – which has been effective.

The second theme of ES #3 was that *barriers exist to providing health education and promotion* to all of Maricopa County residents. Participants felt that this may be due to a lack of community engagement and active participation in public health services, specifically with cultural beliefs of mistrust for health professionals and services and a lack of cultural understanding for health services. Participants also recognized that the public health system may not have appropriate funding to solve this.

The third theme of ES #3 was that the system is *ineffective in communicating available public health services to the communities they were developed to specifically target.* Within the system as a whole comments included sending out too much communication that is inconsistent and without follow-through, and not incorporating input from the targeted communities when developing programs and services uniquely for them.

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

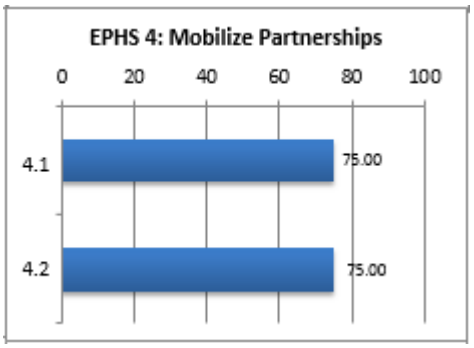
As seen in Figure 6, both of the model standards for essential service (ES) #4 were scored at 75%, which means that the Maricopa County Public Health System is operating at "significant," and nearly "optimal," performance when performing ES #4.

Essential Service #4 Model Standards:

Figure 6. Performance Score by Model Standard for Essential Public Health Service #4

1- Constituency Development

2- Community Partnerships




The first theme of ES #4 comments was that Maricopa County *benefits from its partnerships*, as well as from the resources partner organizations can provide. Participants specifically mention the Health Improvement Partnership of Maricopa County (HIPMC) group, and how they have been instrumental in maintaining and strengthening partnerships, bringing in new organizations and coalitions to collaborate with, and future partner support as a result.

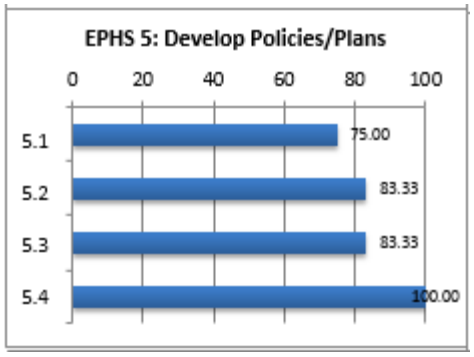
The second theme from ES #4 was that there are *barriers existing* in terms of what partnerships strive to improve. Participants mentioned that though partnerships provide public health services and programs, they are not necessarily utilized, due to both lack of access such as transportation or other disparities, and lack of engagement by the target communities. Also mentioned by participants was that it is difficult for the system to keep up with organizational changes, for both organizations as a whole and in resources.

The third theme from ES #4 was that there is a general *lack of system-wide collaboration* when it comes to identifying and solving community health issues. Participants reported this for specifically for partnerships that aim to improve the health status of a community but do not identify the correct health issues and do not consider cultural and environmental factors that may be the reason for the issue.

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

Shown in Figure 7, model standards (MS) #2-4 within Essential Service (ES) #5 operate at "optimal" performance with the Maricopa County Public Health System (noting MS #4 operates at the highest possible level of "optimal" performance), and MS #1 operates at "significant," and nearly "optimal" performance within the system.

Figure 7. Performance Score by Model Standard for Essential Public Health Service #5




Essential Service #5 Model Standards:

1- Governmental Presence
2- Policy Development
3- CHIP/Strategic Planning
4- Emergency Plan

The first theme for ES #5 is that the local system seems to use *ineffective processes* when developing policies and regulations. Participants noted that policies are often not pushed or backed by public health workers in the system, and that the efforts of health plans do not align with the community's actual needs.

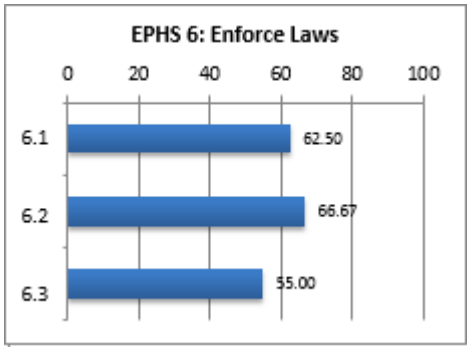
The second theme of ES #5 is that the system is *poorly organized*. Participants discussed that health is not seen as a priority within local government, that all stakeholders are not unified, and do not have a unifying objective or goal.

The third theme of ES #5 was that there is *no central focus* for policy to improve health status in Maricopa County. Participants perceived the system as being too focused on accreditation, rather than implementing strategies and programs, and that the objectives of the system do not align with the needs of the community statistically.

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

Shown in Figure 8, each of the three model standards within Essential Service (ES) #6 operate at (the lower end of the spectrum within) "significant" performance for the Maricopa County Public Health System.

Figure 8. Performance Score by Model Standard for Essential Public Health Service #6




Essential Service #6 Model Standards:

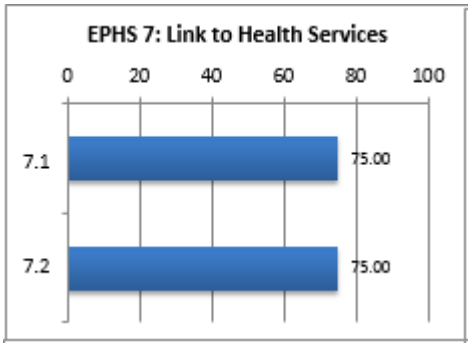
1- Review Laws
2- Improve Laws
3- Enforce Laws

No participant comments were provided in the online nor in-person session, therefore, only quantitative data is available.

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

As seen in Figure 9, both of the model standards for Essential Service (ES) #7 were scored at 75%; meaning that the Maricopa County Public Health System is operating at "significant," and nearly "optimal," performance when performing ES #7.

Figure 9. Performance Score by Model Standard for Essential Public Health Service #7




Essential Service #7 Model Standards:

1- Personal Health Service Needs
2- Assure Linkage

The first theme of ES #7 was that there are *barriers to accessing care* for special populations. Participants mentioned that there are factors such as lack of transportation and proper health education (in that individuals do not believe they need any type of health care), as well as populations such as those with mental illness, those who may be deaf or blind, as well as elderly populations. For these populations specifically, participants reiterated that these populations experience factors that the system does not account for when providing public health services and programs.

The second theme of ES #7 was that the system is *ineffective when linking health services* to the community. Participants mentioned that programs are offered to those such as the homeless population and provide them with health care, but then these individuals are expected by the health care provider to come in for a follow-up or maintain their medications – and this population is unable to do either on their own. Another reason frequently brought up by participants when saying why they believe health services are not effectively linked to the populations needing them is that special or underserved populations do not consistently classify themselves as such - homeless, low-income, elderly, etc. When

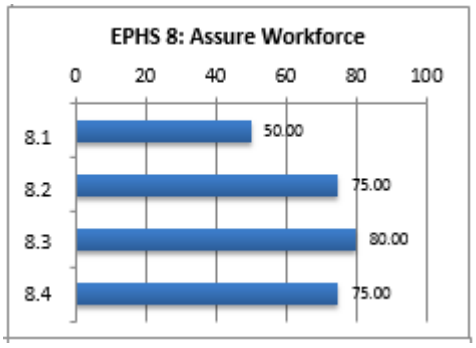
underserved populations do not identify themselves as underserved in public health outreach efforts i.e., community forums or community surveys; actual needs can go unnoticed, or needs can be falsely identified. This ends up impacting the system by not realizing the actual needs of the community, while the community still requires further resources and services.

The third theme of ES #7 was that communities are *provided access to resources.* Participants mentioned how hospitals have social workers whose role it is to make the transition from a care facility to their own home easier. Also noted are agencies that are able to provide community members with resources that they request through an assistance organization – for example, Find Help Phoenix.

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

Shown in Figure 10, model standard (MS) #1 of Essential Service (ES) #8 operates at "moderate" and nearly achieves "significant" performance, whereas MS #2 and #4 operate at "significant," nearly achieving "optimal" performance, and MS #3 is "optimal" performance.

Figure 10. Performance Score by Model Standard for Essential Public Health Service #8




Essential Service #8 Model Standards:

1- Workforce Assessment
2- Workforce Standards
3- Continuing Education
4- Leadership Development

There were only two themes noted for ES #8 from the qualitative data. The first theme of Essential Service (ES) #8 was that the public health workforce throughout Maricopa County is *not held to a system-wide standard, or practices*. Participants discussed how various organizations and agencies that may be similar, such as labs, have their own separate training and workforce plans, but that someone at a different facility may have a completely different workforce training plan. Participants recommended that for organizations in the same sector, there should be a set standard for workforce training and implementation.

The second theme of Essential Service (ES) #8 was that the *methods used for workforce training and education are ineffective*. Participants stated that some organizations do offer training targeted at various professions or people from specific backgrounds, but it is a small group of organizations who do so. They also stated that when there are specialized trainings, the public health professional community does not often take advantage of them due to time constraints.

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

Within the Maricopa County Public Health System and as shown in Figure 11, model standards (MS) #1 and #2 of Essential Service (ES) #9 operate at "significant" performance with MS #2 nearly qualifying as "optimal" performance, and MS #3 operates at "optimal" performance.

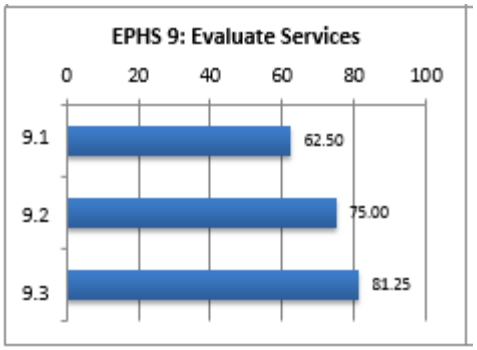
Essential Service #9 Model Standards:

1- Evaluation of Population Health
2- Evaluation of Personal Health

3- Evaluation of LPHS

The first theme of Essential Service (ES) #9 was that the methods the local system is using are *ineffective in evaluating public health services*. The main reason for this was due to the fact that separate entities are evaluating services individually, but not collectively, and for the system as a whole. Participants also discussed the fact that there are often duplications of public health services being evaluated, and therefore wasting valuable resources and time.

Figure 11. Performance Score by Model Standard for Essential Public Health Service #9



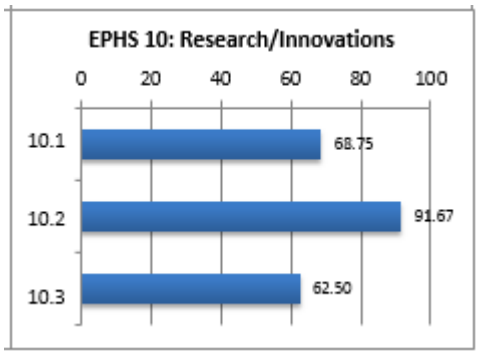

The second theme of ES #9 was that the system is *effective in evaluating resources* and communicating their evaluation results to others. Participants agreed that performing customer satisfaction surveys and focus groups to discuss issues at hand are valuable as evaluation tools and effective.

The third theme of ES #9 was that the *results and data found through evaluation are inconsistent*. Participants here again mentioned multiple organizations duplicating similar work, and within customer satisfaction surveys, the participants likely are not representative of the whole group.

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

Seen in Figure 12, both model standards (MS) #1 and #3 operate at "significant" performance, and MS #2 operates at "optimal" performance.

Figure 12. Performance Score by Model Standard for Essential Public Health Service #10




Essential Service #10 Model Standards:

1- Foster Innovation
2- Academic Linkages
3- Research Capacity

The first theme of Essential Service (ES) #10 was that *resources are available* for conducting research that will result in data to help develop improvement plans for the community's health. Participants mentioned that even if the methods for conducting research or surveillance are not available to the entire system, they are being utilized for research as intended, and do provide quality results for future use.

Slightly contradictory, the second theme of ES #10 was that there is *a lack of resources* in the local system. Participants attributed this mainly to insufficient funding for a larger scope of research and surveillance, as well as again bringing up smaller organizations that are unable to perform research due to lack of equipment, training, support and time.

The third theme seen in ES #10 is similar to that of the second, in that there is a *lack of system-wide collaboration*. Participants discussed how many organizations seemed to be "on their own" rather than working as a collaborative effort to further research and surveillance as a system.

## NEXT STEPS

The Local Public Health System Assessment is one component of a comprehensive Community Health Assessment (CHA), identifying areas of the public health system that are in need of improvement. A CHA collects and analyzes data from various members and organizations of the local community to determine the health needs for the community, including its risk factors and root causes.

The LPHSA is also a component of the framework recommended when conducting a CHA, by the Mobilizing Action through Planning and Partnerships (MAPP) process. The MAPP process includes not only the LPHSA, but also:

- *Community Themes and Strengths Assessment* – implements community surveys to address community residents what they think would improve their health status that is missing, what factors are important to them for health status, and other questions to assess how the community perceives their own health status and factors, as well as concerns they may have.
- *Community Health Status Assessment* – utilizes systemic and statistical quantitative data analysis on health indicators for the community to determine which factors affect the health status of the community itself. These indicators can include demographics, social determinants of health when looking at health equity, behavioral and/or environmental risk factors, morbidity and mortality rates, and many more.
- *Forces of Change Assessment* – requires a systematic analysis of external factors that both negatively and positively affect the health status of the local community, the organization of the public health system, and the delivery of health services to the community. These factors can be trends of the surroundings such as weather, population events such as a sudden increase in a minority or special population, technology as used in health services, passage of new legislation as related to health, among many more.

This study was conducted as part of the MAPP process for the 2017 Maricopa County Community Health Assessment. This assessment has included gathering data from focus groups, community surveys, key informant interviews, creating a community health profile, and lastly the Local Public Health System Assessment. The result of this data collection is a strategic and objective prioritization by the HIPMC Steering Committee to determine the County's new health priorities. The Maricopa County Department of Public Health (MCDPH) has facilitated the remaining MAPP pieces, in a continuous process from March to October 2016. Advisory committees for the CHA periodically meet to strategize how to narrow down each of the sources of data, in order to create a rubric for which health priorities that are relevant in Maricopa County are scored, weighted against each other, discussed, the relationships between them analyzed, and synthesized into various reports. In mid-2017, MCDPH will be finishing the prioritization of these health priorities, which will become the official priorities for Maricopa County over the next three years, from 2018-2020.

See http://www.naccho.org for more information on Community Health Assessments and their Improvement Planning strategies, and http://www.arizonahealthmatters.org for Maricopa County's progression through the CHA and in developing and implementing the upcoming CHIP.

## APPENDICES

### Appendix A. Performance Score Averages for Each Essential Service & Model Standard

Table 1. Overall Performance by Essential Public Health Service and Corresponding Model Standard

| Model Standards by Essential Services | Performance Scores |
|---|---|
| **ES 1: Monitor Health Status** | **75.0** |
| 1.1 Community Health Assessment | 75.0 |
| 1.2 Current Technology | 75.0 |
| 1.3 Registries | 75.0 |
| **ES 2: Diagnose and Investigate** | **79.9** |
| 2.1 Identification/Surveillance | 83.3 |
| 2.2 Emergency Response | 75.0 |
| 2.3 Laboratories | 81.3 |
| **ES 3: Educate/Empower** | **75.0** |
| 3.1 Health Education/Promotion | 75.0 |
| 3.2 Health Communication | 75.0 |
| 3.3 Risk Communication | 75.0 |
| **ES 4: Mobilize Partnerships** | **75.0** |
| 4.1 Constituency Development | 75.0 |
| 4.2 Community Partnerships | 75.0 |
| **ES 5: Develop Policies/Plans** | **85.4** |
| 5.1 Governmental Presence | 75.0 |
| 5.2 Policy Development | 83.3 |
| 5.3 CHIP/Strategic Planning | 83.3 |
| 5.4 Emergency Plan | 100.0 |
| **ES 6: Enforce Laws** | **61.4** |
| 6.1 Review Laws | 62.5 |
| 6.2 Improve Laws | 66.7 |
| 6.3 Enforce Laws | 55.0 |
| **ES 7: Link to Health Services** | **75.0** |
| 7.1 Personal Health Service Needs | 75.0 |
| 7.2 Assure Linkage | 75.0 |
| **ES 8: Assure Workforce** | **70.0** |
| 8.1 Workforce Assessment | 50.0 |
| 8.2 Workforce Standards | 75.0 |
| 8.3 Continuing Education | 80.0 |
| 8.4 Leadership Development | 75.0 |
| **ES 9: Evaluate Services** | **72.9** |
| 9.1 Evaluation of Population Health | 62.5 |
| 9.2 Evaluation of Personal Health | 75.0 |
| 9.3 Evaluation of LPHS | 81.3 |
| **ES 10: Research/Innovations** | **74.3** |
| 10.1 Foster Innovation | 68.8 |
| 10.2 Academic Linkages | 91.7 |
| 10.3 Research Capacity | 62.5 |
| **Average Overall Score** | **74.4** |
| **Median Score** | **75.0** |

## Appendix B. Compilation of Questions used in Quantitative Analysis

**Essential Service #1 Monitor Health Status to Identify Community Health Problems**

Model Standard 1: Population-based community health assessment

1. How many of you have participated in the *current* assessment?
2. How well does the system conduct regular CHAs?
3. How well does the system continuously update the CHA with current information?
4. How well does the system promote the use of the CHA among community members and partners?

Model Standard 2: Current technology to manage and communicate population health data

1. Have you used the Maricopa Health Matters website to access CHA information?
2. How well does the system use the best available technology and methods to display data on the public's health?
3. How well does the system analyze health data, including geographic information, to see where health problems exist?
4. How well does the system use computer software to create charts, graphs and maps to display complex public health data (trends over time, sub-population analyses, etc.)?

Model Standard 3: Maintaining population health registries

1. Which population health registries exist/maintained within Maricopa County?
2. How well does the system collect timely data consistent with current standards on specific health concerns in order to provide the data to population health registries?
3. How well does the system use information from population health registries in CHAs or other analyses?

**Essential Service #2 Diagnose & Investigate Health Problems & Health Hazards**

Model Standard 1: Identifying and monitoring health threats

1. Who is aware of surveillance system(s) designed to monitor health problems and identify health threats?
2. How well does the system participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor and share information and understand emerging health problems and threats?
3. How well does the system provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?
4. How well does the system ensure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?

Model Standard 2: Investigating & responding to public health threats & emergencies

1. How does the county mobilize volunteers during a disaster?
2. How well does the system maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?
3. How well does the system develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?

4. How well does the system designate a jurisdictional Emergency Response Coordinator?
5. How well does the system prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?
6. How well does the system identify personnel with the technical expertise to rapidly respond to possible biological, chemical, and/or nuclear public health emergencies?
7. How well does the system evaluate incidents for effectiveness and opportunities for improvement (such as After Action Reports, Improvement Plans, etc.)?

Model Standard 3: Laboratory support for investigating health threats

1. How does Maricopa County use laboratory services for investigations of public health threats, hazards, and emergencies?
2. How well does the system have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?
3. How well does the system maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?
4. How well does the system use only licensed or credentialed laboratories?
5. How well does the system maintain a written list of rules related to laboratories, for handling samples, determining who is in charge of the samples at what point, and reporting the results?

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

Model Standard 1: Health education & promotion

1. How many of you provide information on community health to the general public, policymakers, and public and private stakeholders?
2. How well does the system provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?
3. How well does the system coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?
4. How well does the system engage the community throughout the process of setting priorities, developing plans, and implementing health education and health promotion activities?

Model Standard 2: Health communication

1. How many of your organizations have developed health communication plans?
2. How well does the system develop health communication plans for media and public relations and for sharing information among LPHS organizations?
3. How well does the system use relationships with different media providers (e.g., print, radio, television, the internet) to share health information, matching the message with the target audience?
4. How well does the system identify and train spokespersons on public health issues?

Model Standard 3: Risk communication

1. Who is involved in or aware of the LPHS emergency communications plans?
2. How well does the system develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?

3. How well does the system make sure resources are available for a rapid emergency communication response?
4. How well does the system provide risk communication training for employees and volunteers?

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

Model Standard 1: Constituency development

1. How well does the system maintain a complete and current directory of community organizations?
2. How well does the system follow an established process for identifying key constituents related to overall public health interests and particular health concerns?
3. How well does the system encourage constituents to participate in activities to improve community health?
4. How well does the system create forums for communication of public health issues?

Model Standard 2: Community partnerships

1. How well does the system establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?
2. How well does the system establish a broad-based community health improvement committee?
3. How well does the system assess how well community partnerships and strategic alliances are working to improve community health?

**Essential Service #5 Develop Policies & Plans that Support Individual and Community Health Efforts**

Model Standard 1: Governmental presence at the local level

1. How well does the system support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?
2. How well does the system see that the local health department is accredited through the PHAB's voluntary, national public health department accreditation program?
3. How well does the system ensure that the local health department has enough resources to do its part in providing essential public health services?

Model Standard 2: Public health policy development

1. How well does the system contribute to public health policies by engaging in activities that inform the policy development process?
2. How well does the system alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?
3. How well does the system review existing policies at least every three to five years?

Model Standard 3: Community health improvement process & strategic planning

1. How well does the system establish a CHIP, with broad-based diverse participation, that uses information from the CHA, including the perceptions of community members?
2. How well does the system develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?
3. How well does the system connect organizational strategic plans with the CHIP?

Model Standard 4: Plan for public health emergencies

1. How well does the system support a workgroup to develop and maintain emergency preparedness and response plans?
2. How well does the system develop an emergency preparedness and response plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?
3. How well does the system test the plan through regular drills and revise the plan as needed, at least every two years?

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

Model Standard 1: Reviewing & evaluating laws, regulations, and ordinances

1. How well does the system identify public health issues that can be addressed through laws, regulations, or ordinances?
2. How well does the system stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?
3. How well does the system review existing public health laws, regulations, and ordinances at least once every three to five years?
4. How well does the system have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?

Model Standard 2: Involvement in improving laws, regulations, and ordinances

1. How well does the system identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?
2. How well does the system participate in changing exiting laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?
3. How well does the system provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?

Model Standard 3: Enforcing laws, regulations, and ordinances

1. How well does the system identify organizations that have the authority to enforce public health laws, regulations, and ordinances?
2. How well does the system ensure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?
3. How well does the system ensure that all enforcement activities related to public health codes are done within the law?
4. How well does the system educate individuals and organizations about relevant laws, regulations, and ordinances?
5. How well does the system evaluate how well local organizations comply with public health laws?

**Essential Service #7 Link People to Needed Personal Health Services and Assure the Provision of Health Care when otherwise Unavailable**

Model Standard 1: Identifying personal health service needs of populations

1. How well does the system identify groups of people in the community who have trouble accessing or connecting to personal health services?
2. How well does the system identify all personal health service needs and unmet needs throughout the community?
3. How well does the system define partner roles and responsibilities to respond to the unmet needs of the community?
4. How well does the system understand the reasons that people do not get the care they need?

Model Standard 2: Ensuring people are linked to personal health services

1. How well does the system connect or link people to organizations that can provide personal health services they may need?
2. How well does the system help people access personal health services in a way that takes into account the unique needs of different populations?
3. How well does the system help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?
4. How well does the system coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?

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

Model Standard 1: Workforce assessment, planning & development

1. How well does the system complete a workforce assessment, a process to track the numbers and types of LPHS jobs – both public and private sector – and the associated knowledge, skills and abilities required of the jobs?
2. How well does the system review the information from the workforce assessment and use it to identify and address gaps in the LPHS workforce?
3. How well does the system provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?

Model Standard 2: Public health workforce standards

1. How well does the system ensure that all members of the local public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and comply with legal requirements?
2. How well does the system develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the 10 Essential Public Health Services?
3. How well does the system base the hiring and performance review of members of the public health workforce in public health competencies?

Model Standard 3: Life-long learning through continuing education, training & mentoring

1. How well does the system identify education and training needs and encourage the public health workforce to participate in available education and training?
2. How well does the system provide ways for public health workers to develop core skills related to the 10 Essential Public Health Services?

3. How well does the system develop incentives for workforce training, such as tuition reimbursement, time off for attending class, and pay increases?
4. How well does the system create and support collaborations between organizations within the LPHS for training and education?
5. How well does the system continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?

Model Standard 4: Public health leadership development

1. How well does the system provide access to formal and informal leadership development opportunities for employee's at all organizational levels?
2. How well does the system create a shared vision of community health and the LPHS, welcoming all leaders and community members to work together?
3. How well does the system ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?
4. How well does the system provide opportunities for the development of leaders who represent the diversity of the community?

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

Model Standard 1: Evaluating population-based health services

1. How well does the system evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?
2. How well does the system assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?
3. How well does the system identify gaps in the provision of population-based health services?
4. How well does the system use evaluation findings to improve plans, processes, and services?

Model Standard 2: Evaluating personal health services

1. How well does the system evaluate the accessibility, quality, and effectiveness of personal health services?
2. How well does the system compare the quality of personal health services to established guidelines?
3. How well does the system measure user satisfaction with personal health services?
4. How well does the system use technology, like the internet or electronic health records, to improve quality of care?
5. How well does the system use evaluation findings to improve services and program delivery?

Model Standard 3: Evaluating the local public health system

1. How well does the system identify all public, private, and voluntary organizations that contribute to the delivery of the 10 Essential Public Health Services?
2. How well does the system evaluate how well the LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to the delivery of the 10 Essential Public Health Services?

3. How well does the system assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?
4. How well does the system use results from the evaluation process to improve the LPHS?

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

Model Standard 1: Fostering innovation

1. How do LPHS organizations identify and stay current with best practices?
2. How well does the system provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?
3. How well does the system suggest ideas about what currently needs to be studied in public health to organizations that conduct research?
4. How well does the system keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?
5. How well does the system encourage community participation in research, including deciding what will be studied, conducting research, and sharing results?

Model Standard 2: Linking with institutions of higher learning and/or research

1. How well does the system develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?
2. How well does the system partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?
3. How well does the system encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?

Model Standard 3: Capacity to initiate or participate in research

1. How well does the system collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?
2. How well does the system support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?
3. How well does the system share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc.?
4. How well does the system evaluate public health systems research efforts throughout all stages of work from planning to effect on local public health practice?

## Appendix C. Qualitative Data – Focused on Improvement Areas and Suggestions

**Essential Service #1 – Monitor health status to identify community health problems**

<u>Model Standard 1 – Population-based community health assessment</u>

- The systems are in place and available to the public. Make user friendly to the public. Some data is gathered from state to state, so the question is where did it come from?
- Still a disconnect with the private sector (i.e. HIPMC partners).
- HonorHealth didn't go beyond their walls to conduct their CHNA.

- Politics of taking on certain issues still a concern – some issues we can't take on because of political pressure. How do we begin taking on those issues?
- Partners still think of healthcare, not public health. Still interested in individual interventions rather than focusing on upstream interventions.
- Even though HIPMC partners are trying to update the CHIP as often as possible, they don't have access to real-time data.
- CHIP can be updated as often as possible, but the CHA data isn't real-time or updated very often.
- More frequent CHAs (short-term), improve inclusivity and external recruitment/publication/advertisement (short and long-term), include all public health practitioners (not only government entities).
- How do we make the data more accessible to nontraditional partners?
- We have the data, similar goals, but we're not talking the same language. How do we make that happen?

Model Standard 2 – Current technology to manage and communicate population health data

- Display data making it more user-friendly and looking at the reports differently.
- Reactionary vs proactive on how to move forward.
- Desires to improve Arizona Health Matters – mapping in job centers.
- CHNAs and MCDPH's CHA aren't on the same schedule – every 5 years vs every 3 years.
- Maricopa Health Matters has a ways to go before it can be considered user-friendly.
- HonorHealth's mapping capability might be a HIPPA violation.
- How can we start mapping clusters to identify them earlier?
- We might analyze the data, but it's not always at the forefront of our decision-making process.
- We should embrace different levels of technology.

Model Standard 3 – Maintaining population health registries

- I do not know from experience, but I heard a lot of talk about a list of the deceased with the voter registration list and other lists so that their names could be deleted. Families still get Social Security checks from deceased relatives, deceased people are counted as having voted, etc. An updated list should be made available on at least a monthly basis.
- An updated list of the deceased should be published, or made available on a monthly basis to every agency or company, e.g., voters registration, insurance companies, social security, etc. so they can update their lists. Too much money is being wasted by sending checks to, or counting votes from the deceased.
- Death certificates don't always show accurate cause of death.
- Need to provide education to providers filling out death certificates.

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

Model Standard 1 – Identifying and monitoring health threats

- Partnerships with healthcare organizations and schools are strong but not as strong in other areas.
- Our current surveillance systems watch a wide net of known threats but weak with emerging threats.
- The measles outbreak showed there are significant gaps in surveillance.

- We currently only have one or two contacts w/some of the partners so we need to create a standardization.
- With measles we were stretched thin with a smaller outbreak but if it would have been a wider outbreak we would have struggled to handle a larger issue.
- Labs inside hospitals often miss reportable diseases, and go undetected, sometimes better to send them to an outside lab.
- Arizona doesn't have a standard for CE (both a weakness and an opportunity).
- Room for improvement to help hospitals better track and report communicable disease outbreaks.
- Continuing education is key to helping solve the problem – support from CDC or local labs to provide education.
- Work with TAPI and MCDPH to provide education and continue the conversation on new testing trends.
- Work with MCDPH IPs (Infection Preventionists) to help educate and broaden awareness.
- Continually keep the public apprised of research and results.
- Recalibrate and/or replace equipment with current research equipment.

Model Standard 2 – Investigating and responding to public health threats and emergencies

- How do we prepare the staff to be trained to properly respond in an emergency?
- Pinal County has a good plan where all county employees can be used in an emergency; currently Maricopa County does not have a similar rule.
- Volunteers could be anyone not just public health affiliates.
- When you add all of the different written instructions as a system we are minimal because we have some plans in place but not all.
- We have basic instructions but we do not have written instructions for all of the different areas.
- The assumption is rules are written and maintained but no one is sure who ensures to be sure these are completed, updated, and maintained.
- Arizona as a whole is behind the curve about creating disease control laws compared to other states.
- Very minimal across the board because when we do drills it is a very small participation drill and not an across the board disease response outbreak drill.
- Starts with first responders to first identify and pass on info to necessary parties.
- Systems are in place to respond to public health threats and emergencies, but there's a tendency to wait for the CDC to pass down information to state agencies, and then local agencies.
- Evaluation of the incident hardly occurs.
- We need to build partnerships with the private sector in the event of an emergency – how do we create partnerships for the greater good?
- We do a good job of partnering with universities, but we should be looking for opportunities to reach out and work with the private sector.
- Can we use HIPMC to build partnerships with the private sector? – Currently all nonprofit sector.

Model Standard 3 – Laboratory support for investigating health threats

- ASL labs, support emergencies, confirmatory testing can use private, educational institutions, etc.
- ASL needs specific approved tests/assays, etc.
- Private/business: use only approved tests w/in its scope (credentials).
- We kind of defer to the state lab since they have more capabilities for testing. They are more

reliable, but there are limitations. They only operate on regular business hours.

- We have private labs and work with them.
- The private labs. We don't have 24/7 labs.
- Sonora Quest and other single labs do some testing but most are done at ADHS labs.
- Sonora Quest and Lab Core are available and everywhere.
- MIHS handles biochemical threats
- BSL3 lab in Arizona can test for almost anything – there are only a few labs at a higher level.

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

Model Standard 1 – Health education and promotion

- A lot of messaging & communication happening, but difficulty with engaging private sector - important area to work on.
- We do a lot of direct service education & interaction but hard to make leap from here (1:1, conferences, etc.) to health policy sector.
- In West Valley (Tolleson/Avondale) – provide many opportunities for the community to get involved; however, do not have a good buy-in so there is oftentimes reduced attendance.
- A lot of different organizations try to get information to the community but because it is inconsistent and varied it is confusing to the public.
- Sometimes when we try to work on being a big happy family internally we can then ignore public.
- The community has voiced they are tired of being surveyed and nothing changing which is causing a lot of disillusionment.
- Educate families – direct service (WIC, employers).
- Finding a pathway to communicate w/policy makers.
- How to sift out 'health' from 'PH'.
- Difficult to understand/find (info, reports).
- Trying & could use incentives/recognition.
- Health communications plan.
- Assessment first & plan to be completed.
- Value of time (recognition, incentive) = community members.
- Lots of messaging & communications going out, but aren't consistent & coordinated enough.
- Difficulty engaging private sector and getting representation on planning.
- Long-term: Public hall type meetings.
- Long-term: Open webinars for the public.
- To reach out in the community and promote appropriate cultural awareness on different health topics.
- Development of cultural competence, train the trainer model.
- Collaboration with key stakeholders that already have the model to provide training/education (short term and long term).
- Track outcomes of outreach on what other organizations are providing, share lessons learned and develop enhancement for future outreach (long term).
- Focus on two or three areas of need from the community to work on improving the outcomes of impacting healthy living style (long term).
- Tracking outcomes from the community about healthy lifestyle.
- Focusing on a specific area to target (long term).
- Targeting specific population (long term).

- Setting baselines for outcomes and metrics (long term).
- Working with stakeholders on topics of need for healthy living style (short term).
- Effectively engage community partners in public forums, set goals, (already trying to do this?).
- Prioritize 1-2 key initiatives to focus on with partners.
- LPH should provide trained experts and plan media campaigns but not be responsible for advertising, this is a role for community partners.
- Consider the gaps in data reporting, collection and dissemination. Information (data and assessments) is the starting point for informing policy makers, coordinating partners and engaging community, but we have so little reliable and timely health data available at the sub-county level.
- Perhaps create an advisory committee for community members and the information collected in those discussions can be transferred to the professional community to further discussion and planning.
- Positive input and encouragement on the individual level will help empower those to have a voice on the community level.
- To have training in order to keep those who are in charge knowledgeable of newly found emergencies.
- The Adverse Childhood Experiences movement should be a big player in HIPMC.

<u>Model Standard 2 – Health communication</u>

- We struggle with utilizing media providers – definitely something that can be improved upon.
- We do need to be proactive in getting the word out on resources and tools that the community may utilize; good reason for having media partners.
- Better to be proactive & talk directly to the media, letting people know what we say about our own organizations, rather than other people/organizations talking about us.
- Don't stray from the facts & start making things up – specific media training very important.
- We do a lot of radio interviews but they are played at days and times when few will hear it.
- It would be nice to create a good reciprocal relationship with media.
- Group agreed if you work with kids you receive a little better cooperation from the media, easier to access funding, etc.
- Training spokespeople – media – system
- Fear of media by health systems.
- Does it actually filter to the people who need it most? How do I know?
- You have a broader outreach (audience) through all the media available now days.
- Greater collaboration with community partners to fund ad campaigns.
- Work with community organizing and advocacy organizations to give them good data and information on important health issues here so they can bring it into the spotlight. Think about what they care about and how population health aligns.
- Set up more Educational Classes for Community Members to attend.
- We need trainings on how to make our Facebook accts. better and more interactive.

<u>Model Standard 3 – Risk communication</u>

- If too much information is disseminated, people become desensitized & the actual emergency would not be as big of a deal or as important to people; might cause reduction in trust, believing that certain things may not happen even if they are told they will, etc.
- Does the plan take into account those who don't have internet, phones, or disabled? Or what about in an outage?
- Are community members consulted in the making of plan?

- Sometimes miscommunication or too much communication will make the community confused.
- Requires communication and collaboration with all stakeholders.
- Again, collaborate with community partners, businesses, relief organizations who become part of the plan.
- If the communication plan waits too long, it's easy to forget.
- Short - term. Set up plan and do it right away.

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

Model Standard 1 – Constituency development

- 2-1-1 not as effective.
- Engaging constituents outside of meetings is difficult.
- After meetings & conferences, constituents need clearly defined roles so there is no "now what?" moment.
- Possibly an issue with duplication & maintaining any such list of resources; people unaware of possible resources even existing.
- No "process" existing for how to identify key constituents.
- Look at gaps in the network & try to reach out to these people.
- Mostly happen by word of mouth with no real established process.
- Not very much engagement outside of opportunities like HIPMC.
- We engage with surveys but what is the follow up?
- $25 Target gift card isn't going to gain engagement of higher socioeconomic status community members.
- It is difficult to evaluate programs internally because we are passionate about it. Passion can blind us from being able to make necessary course corrections.
- Community members not engaged and we need to be more aware of how we communicate because we need to avoid internal jargon/acronyms.
- Directory – there are gaps: complete, current, awareness, duplication.
- Established process: identify participants, encourage participation & delivery of communicated PH issues.
- Could increase engagement outside of meetings.
- Participants: the 'so what' after initial engagement such as surveys.
- Hard to change course of program/initiative that have been around a long time.
- I have heard comments that community engagement efforts often feel inauthentic to participants invited. Engage community in the beginning not after plans are made to meet a grant deliverables. Have a more coherent message as well; sometimes it's not clear.
- Consider strategies that make communities feel like their voice is being heard. Think about co-designing programs and stratifies (see best practices). Identify the needs of and/or motivators for agency partners and try to engage based on alignment.

Model Standard 2 – Community partnerships

- Evaluation & collective impact / evaluation of how all our groups are making an impact – this is a slightly weak area.
- Not a comprehensive approach to utilizing these partnerships to provide services to the community.
- Something missing in the puzzle; community needs empowerment and motivations as well as education & promotion.

- Having an ambassador within the community who is also in the organization is a very valuable asset – they are able to communicate news and announcements/invites, etc. directly to the community…. And things coming from a trustworthy source is VITAL.
- Even HIPMC is missing "resident input".
- In practical approaches, able to put people in groups and give them roles such as CEO, coordinator, & have them run through simulations of what they would do in any given situation, and they get very excited & engaged (in her work w/homeless youth).
- Outside of MCDPH – starting to create partner lists (may be duplications – not good).
- As a community member not as visible.
- HIMPC: proactive creating & bringing people together but struggle to get the comprehensive approach to join forces.
- Create a web-based directory, send reminders to participants every quarter? Semi-annually? To check/update their info. This will also increase traffic.
- Partners, groups may be reluctant to have the LPHS take the lead on establishing committees, perhaps partners need to do this and invite LPHS to be a part of the process.
- Work closely with partner organizations to provide direction/oversight in establishing committees.
- Convene organizations and facilitate linkages.

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

<u>All model standards</u>

- Too much focus is on accreditation, instead of implementing practices that are proven.
- Focus primary efforts on evidence based practices.
- Pick one or two special projects outside of proven evidence based practices.
- Staff often seem timid pushing policy.
- Should be more data driven.
- Use that data and aggressively pursue groups who are not at the table.

**Essential Service #7 – Link people to needed personal health services & assure the provision of healthcare when otherwise unavailable**

<u>Model Standard 1 – Identifying personal health service needs of populations</u>

- Leader in & have community base > ALTEC.
- Identification of/and a referral may not be enough- language & cultural needs.
- Many efforts focused on linking people to resources but lots of them have time limitations and the efforts are not able to be continued for funding reasons, time, interest, visible results etc.
- Maybe a generational issue? Some aged populations do not utilize assistance so maybe we should try reaching out to this type of population?
- Make sure that people are not only aware of service, but also take advantage of the services offered.
- We do a great job at identifying these types of things, but disconnect is within connecting the services/awareness to community members affected by the disparities.
- Issues in reaching out to various populations – we have a lack of data in these areas.
- For example – in immunizations, there is an option to provide demographic data (minority groups, disabled, etc.)
- People do not like to be called "special populations" – they want to be considered "normal".
- However, we are not able to "un-gap-ify" this specific issue – people will always feel this way,

possibly get offended, etc.

- "What are you doing with what I'm telling you?" "What is this data being used for?" very careful about over-sharing information.
- Cultural competency may be a gap or the key to bridging a gap.
- Defined roles & responsibilities – can be improved by increasing cultural competency among employees/community/partner agencies & organizations.
- Past negative experiences may impact the person & make them not want to participate in future opportunities & services provided to them.
- Cultural competency, time, trust all needed in these communities & to best communicate and reach out to them with services and opportunities offered and available to them.
- We are doing a good job of identifying needs but we can still improve at actually meeting those needs.
- Issue of resources, poor do not have the resources and wealthy do have resources.
- The resources of these programs are low and we need to focus on the needs of those who have fewer resources to access.
- The groups with the highest needs try to communicate and voice their needs but there is just not enough resources to do what we need to for meeting these needs.
- Use of data: criteria for identification is great, possible gaps in population identification.
- Not a strong connection: capacity, directory awareness & application, unique.
- How accurate is the data because people often do not share their demographic info.
- Organizing the organizations to help exposed to these needs.
- Tendency to focus on a select population.
- Assumptions of needs.
- The LPH should have/collect this data but it needs to be shared in a clear, comprehensible way for the general public, with suggested plans of action.
- Coordination of the system is where the work needs to be done.

<u>Model Standard 2 – Ensuring people are linked to personal health services</u>

- Hospital case managers *attempt* to connect patients with needs, but there is not really a follow-up to finish barrier in mental health.
- Cultural competency is a big key that needs to be trained upon & resources provided to all types of health care providers & stakeholders – not all have embraced this as a key component, which ends up delaying services needed.
- Health inequity is an area of increasing awareness, but some institutions are still resistant to this being an issue so not putting efforts forward.
- Weak in the area of actually connecting solutions to health issues & opportunities/services offered & available to people.
- Many gaps exist in connecting various services and in connecting services to one another.
- Need to walk community through the steps & explain how exactly the services available can be accessed.
- Connecting people to the available resources in their own communities is huge.
- Not good because we are not doing a good job, or not doing good because these communities are not willing to step out of their comfort zones and utilize something which is an entirely new concept; people who may not self-advocate or know how to best care for themselves – used to self-sufficiency, childhood trauma & its effect, immigration, literacy, self-esteem & all factors that contribute to these barriers.
- Behavioral health integration – is technically a "special population" perhaps now we can be doing a better job at bridging gaps which exist between these groups and their resources.

- Organizations do meet some of the community needs but can't always meet the full needs. Example: a food bank opens in the community but there isn't sufficient transportation to help the community reach the food bank.
- For example hospitals can't get an Uber for them because it can be viewed as them incentivizing use of their facility which is illegal. The use of taxi vouchers are hard because they usually give a 3 hour window to be picked up which isn't helpful to clients. We need policy changes in this area and need research too!
- A group member works at a hospital where they have case managers who review cases as they are discharged to suggest resources but it's really just here a paper and not real assistance in how to navigate resources.
- Hospitals are on bus routes but clinics generally are not as often on bus routes so people use hospitals for primary care needs because of their transportation accessibility.
- Seems like a lot of the orgs are assisting in this and cross promoting.
- Oral health & durable equip repairs hearing aids/visual aids – very difficult to access.
- Hard of/usually impaired growing – not prepared.
- Often care stops @ health insurance – bigger gaps.
- Big drift in independence of hearing/vision recovery aids, etc.
- Current challenges with integration of mental & physical health because it is still new.
- We have a way to go with homeless population.
- Broad strokes, sifting down to unique needs is a challenge.
- Cumbersome for people to get information.
- Accessing physical/mental health is challenging.
- Transportation issues.
- Zip code base funding is a huge challenge.
- Grassroots efforts, community-grown health ambassadors.
- Population identity: feeling vulnerable if they share too much.
- Negative experience does turn people away from connecting w/health services.
- Loss of communications & lack of resources.
- Mental health is still an issue, but making progress.
- Partnerships and knowing where to send people is key.
- Request funding to meet this need.

**Essential Service #8 – Assure a competent public health and personal healthcare workforce**

<u>Model Standard 1 – Workforce assessment, planning and development</u>

- Counties have much more rigid standards, but even those are somewhat limiting and I don't think other agencies that aren't forced to do it, actually do it.
- There was a broad generalized assessment done, but that may have not covered all the "Jelly bean" pieces. It is not a comprehensive system.
- We only do workforce assessment in public health, but we don't do any with other organizations.

<u>Model Standard 2 – Public health workforce standards</u>

- I feel like there are some organizations that should be required to have certain licenses and certificates, but there hasn't been much traction from the state to push the issues. Maybe some groups should have requirements, but they don't have them.
- You need to have enough people.
- There are places such as in the lab that do require, but in Education, you are required to have an

education benchmark.
- Most people don't even know what the 10 essential health services are.

Model Standard 3 – Life-long learning through continuing education, training, and mentoring

- I think at MCDPH, we are good at identifying the needs, but there's a gap being able to figure which pocket of people that need it.
- Encouraging the workforce to participate in the available workforce training.
- Sometimes even when they come to trainings, they are not fully engaged because they are answering emails, etc.
- To summarize, there are opportunities, educational needs that can be addressed but there are barriers. Sometimes, they are available, but not provided to the right audience.

Model Standard 4 – Public health leadership development

- I know AZPHA is working on a mentorship/leadership program for example. That is still one gap in connecting leaders.
- It doesn't seem there is opportunities for targeted groups. It is more for everyone in general, but it is not specific targeted groups. It seems opportunities are increasing, but it isn't there yet.

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

Model Standard 1 – Evaluating population-based health services

- Clarification of what is being evaluated, specifically what we have.
- There are systems for evaluation but many are not creating goals which are measurable.
- We don't have larger pieces of the system; not enough knowledge.
- Could have effectiveness, but small reach.
- Accessibility but not effectiveness measured at PHS level.
- Involving all entities; bounded network with SNA; difficult to have exhaustive list; always balancing network effectiveness and inclusion of other members.

Model Standard 2 – Evaluating personal health services

- Customer satisfaction survey only getting feedback from those who show up – may not be representative represent.
- Those who don't show have no opportunity to be satisfied or not satisfied.
- Hope that future community meetings will address.

Model Standard 3 – Evaluating the local public health system

- Often duplication exists and not filling gaps.
- Not good deliberately, formally, but could probably all identify similar gaps.
- If not evaluating well, not assessing community well, how can we identify gaps?
- May be done individually, but not at a systems level.
- Not centralized, but many of the jelly beans are doing it at their individual level.

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

Model Standard 1 – Fostering innovation

- Lacking resources/knowledge to pilot test; document.

Model Standard 2 – Linking with institutions of higher learning and/or research

- Emphasis on Community Based Participatory Research at the University of Arizona MEZCOPH.

Model Standard 3 – Capacity to initiate or participate in research

- Collaboration happens, but how often? Not as much as possible.

## Appendix D. Qualitative Data – Focused on Positive Feedback

**Essential Service #1 – Monitor health status to identify community health problems**

Model Standard 1 – Population-based community health assessment

- MCDPH & health system are doing a great job with the joint partnership.
- Everyone in public health makes sure the outside organizations are in the know – lots of outreach with other organizations.
- Eileen joined forces and took the lead *[of the past CHA]*, who had the expertise to do the work well. MCDPH is doing a tremendous job.
- Extremely well. Everyone is supportive with the communication. A lot of outreach to organizations not involved with public health.
- The county does a great job in communicating all types of data, very simple and understandable.

Model Standard 2 – Current technology to manage and communicate population health data

- CHA turned to registries because of their accuracy levels.
- Arizona Department of Education found the HIPMC partnership and data beneficial to their work.
- MCDPH provides data that helps us map out clusters earlier.

Model Standard 3 – Maintaining population health registries

- Birth/death registries – CHA turns to 1st for reliable data.
- Routinely. They do a significant job with it. Regular access and routinely!

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

Model Standard 1 – Identifying and monitoring health threats

- We are looking at morbidity and have the timeframe, and the healthcare provider missed a disease, we provide them the education needed to improve timeliness.
- We are well-prepared for known threats but difficult to be ready for any and all curveballs the unknown can give.
- Based on the tools currently available we utilize them all and try to use to our advantage.
- For instance it was interesting to see when the measles outbreak happened places like Banner Health joined to provide assistance and information.
- MCDPH OPR works well at state and federal levels.
- MCDPH received a grant to use an app that tracks influenza.

Model Standard 2 – Investigating and responding to public health threats and emergencies

- After action: action plans, hotwash for OBs, summary sent out.
- There is a plan or system of tasks. It comes down from FEMA and everyone needs to be trained once a year.
- We do hot washes where we discuss what was right, what was wrong, what we can do differently.

- If something needs to be modified, we will look at what we can fix from the hot washes. And incorporating them into the action plans.
- I feel like I get that info quickly and I am able to send it out to others very fast.
- We have a list of healthcare providers where we can send emails or text messages and notify them immediately if there is an emergency incident.
- And we can target those specific messages to certain healthcare providers (for example preschools).
- We have administrative rules/statutes which we continually look at ways to improve it through experiences.
- For instance our measles outbreak responses were limited because of the administrative statutes in place and have looked at improving in the wake.
- Post meeting after any disease outbreak includes a hot wash to plan more effectively for the next drill.
- OPR online volunteer application improved the recruitment process.
- MCDPH does a good job of communicating when issues need to be addressed. (i.e. Ebola)
- After the Ebola hot wash, hospitals changed their plan and included appropriate equipment required for an outbreak – MCDPH offered the support to find the right masks.

Model Standard 3 – Laboratory support for investigating health threats

- Responses & community meetings/trainings support efforts & increase use of resources like BioSense.
- With Zika they did a great job of rolling out the test so private labs could assist with testing. (Sonora Quest)
- Sonora Quest is always look at ways to improve their service.
- MCDPH has a relationship with MIHS for all of our titers.
- I know that the court employees must take a blood borne/airborne pathogens course every year. If we do, I am certain that everyone else in the health and research field has to do the same.

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

Model Standard 1 – Health education and promotion

- Within the school system, (Tolleson Elementary) there are health fairs and free health clinics – trying to provide health services to families who are otherwise unable to provide medical care.
- The system is getting better. Trying to improve the unified message to reach greater public but still only successful at a small level.
- I think there are good advocacy organizations here that know how to do this well, and they are beginning to focus on health more.
- Many public health departments have already make big changes to their programming, as well as medical clinics and schools.
- I love how Jhoana targets the populations that need extra outreach in her bi-weekly meetings (conference calls). She involves a lot of faith-based, monolingual Spanish providers, and mental health orgs.

Model Standard 2 – Health communication

- Leadership (in MCDPH) is very proactive – which is very important.
- We do well at communicating w/ media prior to the story coming out.
- Dr. Bob is very proactive & willing to speak to media providers.
- Very proactive in writing Spanish articles for print/online use by the public.

- Arizona Heart Association has been working on being more specific with messaging and engaging their target audience in creating message for specific audience.
- Proactive leadership – communicate with media well & often (trust exists).
- Many agencies involved – plans being made coordinated.
- Resources available.
- Proactive Dr. Bob.
- Spanish media – print articles.
- Probably an area that PH excels at best.

Model Standard 3 – Risk communication

- Much happening behind the scenes – probably a sign of it working well.
- System doing a pretty good job.
- Public health excels in this area, we have drills constantly.

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

Model Standard 1 – Constituency development

- 2-1-1 and Find Help Phoenix are very good.
- 2-1-1 and Find Help Phoenix are great resources.
- More direction from Chamber of Commerce trying to engage in public health efforts, so getting better at identifying & working with constituents.
- Find Help phoenix and HIPMC are great.
- There are resources available (2-1-1 Phoenix, Maricopa website) & proper resources are being maintained – although, there are still gaps existing.
- On the pathway to constituents being aware of their impact on the LPHS.
- Once you identify those groups and people, are they are willing to be leaders?
- Are these people able to realistically take this on, or organizations able to dedicate someone to this wholly?
- HIPMC is a great resource for networking & becoming aware of new organizations/coalitions.
- Find Help Phoenix is a great resource but things change all the time so it's hard to keep up to date.
- HIPMC is a great group.
- HIA assessment process is amazing and perfect.
- People don't know about all of partnerships but are on our way.
- However we are moving towards this w/HIPMC & CHA/CHIP.
- Find Help Phoenix – great example.
- Word of mouth is the go-to process – networking has improved.
- Assessment is a strength of LPHS.

Model Standard 2 – Community partnerships HIPMC is doing a great job at bringing partners together to collaborate & network

- HIPMC brings organizations together & strengthening partnerships.
- Much opportunity exists & is exciting.
- Business community (employers) are getting more involved in promoting health & healthy practices.
- We do a great job at HIA Process & lots of great engagement.
- HIPMC is great.
- JAG, community member & having an office donated to her: seeing weekly things on promoting

health, Avondale is actually doing a really great job.
- In creating community partnerships & bringing groups together, we do a good job.
- A lot of opportunities out there for strategic alliances.
- HIPMC and it has been very successful. There has been so much disconnect and this finally pulls it together.
- Newer at establishing partnerships – doing well w/community, health will take time.
- Compared to other jurisdictions, MC partners well.
- Amazed at how broad community base of diverse groups & people having input on a plan – made improvements.
- Great partnerships!
- Lots of coalitions, opportunities, HIAs.
- Specific coalitions – opportunities.
- Individual organizations find specific groups to join vs coalitions' proactively conducting outreach.
- HIPMC – pulls group together, reduces duplication of several groups meeting separately on similar issues.

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

<u>All model standards</u>

- Great support from many community partners for our CHA and CHIP work; excellent goodwill and support from many others. Good and expanding participation in our joint Community Health Needs Assessments from non-profit hospitals and Community Health Centers.
- Dedication of health department staff.

**Essential Service #7 – Link people to needed personal health services & assure the provision of healthcare when otherwise unavailable**

<u>Model Standard 1 – Identifying personal health service needs of populations</u>

- In the 0-3 undocumented population - many people coming from undocumented families are experiencing many more referrals.
- Different opportunities & programs which are unique & attempting to bridge gaps and make a positive health impact such as: paramedicine, telemedicine.
- More data in regards to hospitals is available.
- HIPMC gets a lot of information from hospitals, surveys, etc. & so we are able to identify disparities & health needs within the community.
- Have done a great job of portraying the message of being proactive about their own health; get the help you need; being able to take care of self.
- Part of improvement groups in Tolleson groups focusing on issues – as she grew up in, lives in, works in, has children in the area so is a valuable worker in coalitions as she can speak for and to the local community.
- Medicine programs have been working on informing the public on how to use 911 correctly, informing public on when to use 911 and when to call tele nurses.
- Cities/infrastructure is there: great job.
- Use of data: criteria for identification is great, possible gaps in population identification.
- This is being done very well in our LPHS.
- I think this is done very well and with a lot of sensitivity.

<u>Model Standard 2 – Ensuring people are linked to personal health services</u>

- There are efforts which hopefully may be changing and then implementing mental & behavioral health into physician health and wellness plans.
- So, good and bad but there is a lot of opportunity there.
- Improving the Affordable Care Act but change on this level takes a long time to implement.
- Paramedicine in Scottsdale looks at a patient's information to assess their health needs and to also give more strategic suggestions of what they need.
- Most ACO's are doing case management and hospitals on varying levels have case managers too.
- Find Help Phoenix is a great resource again for the public.
- Paramedicine programs were doing well then saw a spike in readmissions. They are good at connecting patients to food and housing services but struggle with behavioral health connections.
- The Affordable Care Act is helping with connecting physical and mental health needs.
- American Health association has seen improvement with the discussion of the link of mental health with cardiovascular issues.
- AHCCCS expansion better.
- Leader in & have community base > ALTEC.

**Essential Service #8 – Assure a competent public health and personal healthcare workforce**

Model Standard 2 – Public health workforce standards

- I feel very confident that for example an entity, ensures that person has the right credentials. Or that the license or certificates are met.

Model Standard 3 – Life-long learning through continuing education, training, and mentoring

- I think at MCDPH, we are good at identifying the needs, but there's a gap being able to figure which pocket of people that need it.
- We do very well at advertising trainings due to all the systems and connected networks.
- Even HIPMC does a lot for connecting people. This is happening more.
- ADHS and RHBS have had training built into the systems for a long time, they do that. I feel there is an emphasis in that area.

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

Model Standard 1 – Evaluating population-based health services

- Processes are working.
- More than there was 10 years ago, increased from state and federal.
- Maricopa Family Support Alliance engages many people, local initiative with national standards.
- Some groups investing in telemedicine offering rural areas access; Mayo, UofA.
- Social Network Analysis tool with HIPMC, identification of orgs doing 10 E.S.

Model Standard 2 – Evaluating personal health services

- HIPMC asks if public health system is doing a good job; CHA survey good representation; as a community members never been asked about this.

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

Model Standard 2 – Linking with institutions of higher learning and/or research

- LPHS does a good job of engaging students and faculty and community; Faculty also wants to connect.
- We have solid resources; solid skills; good to work with; barriers are often financial; great track

record.

Model Standard 3 – Capacity to initiate or participate in research

- When it's done, its done well; often can't happen because of resource limitations.
- Public health research occurring in all stages of projects.

## Appendix E. Qualitative Data – Focused on Acknowledgment of Data Collection

**Essential Service #1 – Monitor health status to identify community health problems**

Model Standard 1 – Population-based community health assessment

- Comprehensive surveillance system – national/state/local. Ex: measles response.
- We get data from doctors, hospitals, citizen calls, providers, labs.
- The labs go directly to the state.
- We use BioSense to monitor trends.
- We have to report to the county and state. Different diagnoses get sent to the state or county.
- We get information from the state and CDC.
- CDC provides samples when there may be a case increase. They will look at the information then at the national level.
- The state and the CDC aggregate data.
- I think locally as well. We have a mechanism to report, typically to the state or AHCCCS.
- In terms of the information, when it gets reported, our job is to get the details. *[EPI]*
- OPR works a lot on preparedness, we do POD exercises, or drills. Flooding, etc. We have multiple databases in place. HDD and ER data.
- We do a lot of analysis, demographic information on them.
- We get Medsis (state info).
- We do it at the local level and then it goes to the state. Then gets funneled to CDC.
- We also have birth and death records through Vital Records.
- We also have poison control.
- Vector control data to look at mosquito pools. Chikungunya, dengue, Zika, etc.
- 2 of the 3 discussion participants are aware of surveillance systems designed to monitor health problems and identify health threats.
- BioSense – tracks health data, the most real-time data.
- BioWatch – detects biologic threats, including anthrax.
- BioSense - not sure if this is still being used.
- Water surveillance.
- Other data sets included in the surveillance system.
- Disease counts, geographical information, using real-time data to track overdoses.
- Multiple surveillance systems available including BioSense, MEDSIS, BioWatch, and others from ADHS.
- Tracking school absenteeism in Maricopa County.

Model Standard 2 – Current technology to manage and communicate population health data

- Volunteer database in OPR, pull from entire department, include in exercises, JIT training, FEMA trained in Epi/PH.
- Response coordinator: ICS, director.

- Bio/chem: designated person, comes from management. One contact in Epi (Ron).
- Natural disasters: Epi/OPR trained (FEMA).
- Collect timely & complete information on reportable diseases/emerging threats.
- The OPR group had a volunteer database.
- A lot of the volunteers participate in the PODS, etc. Otherwise, staff is trained to delegate.
- Just in time training is also very important & everyone is FEMA trained as well.
- Every person has a very specific role.
- We probably base it on the hard to reach populations. And it is more so evaluation for me.
- They send those to UA and probably ASU.

Model Standard 3 – Maintaining population health registries

- For H1N1 there were hundreds of samples to be tested so they were unable to test as quickly because of number.
- We have a good network of available labs but in rural communities not sure what options there are for labs outside of hospitals.
- Does MCDPH let community members know of lab services and how to handle, information is very siloed though.
- From a medical provider standpoint, lab services are not always available for immediate testing.
- State lab doesn't allow testing after 5pm.
- MIHS can only meet so many needs because ADHS doesn't provide 24/7.
- Hospital labs are 24/7 but can only address common diseases.
- Measles specimen was lost in transit due to limit hours at State lab.
- HonorHealth has a system in place, but not sure if there's a good enough chain of command. There should be a law passed that all the hospitals and/or surgical/health institutions, e.g., abortion clinics pass regular unscheduled health inspections.

**Essential Service #8 – Assure a competent public health and personal healthcare workforce**

Model Standard 1 – Workforce assessment, planning and development

- MC has a process to do some workforce assessment somewhere in our organization.

Model Standard 2 – Public health workforce standards

- There are places such as in the lab that do require, but in Education, you are required to have an education benchmark.

Model Standard 3 – Life-long learning through continuing education, training, and mentoring

- ADHS and RHBS have had training built into the systems for a long time, they do that. I feel there is an emphasis in that area.

Model Standard 4 – Public health leadership development

- I know AZPHA is working on a mentorship/leadership program for example. That is still one gap in connecting leaders.
- Some of our internship programs have the experience where they get to sit with leadership at MCDPH.
- I think there is staff who may not be supervisors, but if they are leading or coordinate a project, they are being a leader. I would say for Q3, I would rate it significant.

## Appendix F. Qualitative Data – All

Comments italicized are represented in Appendices B-D

**Essential Service #1 – Monitor health status to identify community health problems**

Model Standard 1 – Population-based community health assessment

- Experience in HIPMC & helping with the CHA, key informant interviews.
- Hospitals – business requirement, rated 2-3, doing okay.
- *MCDPH & health system are doing a great job with the joint partnership.*
- *Everyone in public health makes sure the outside organizations are in the know – lots of outreach with other organizations.*
- What, why & how to utilize: it's digestible.
- It is public information – people who access it know about it.
- This is a process.
- First you set a baseline & guidance; starting the guidance in 2017.
- Passive-heavy: depends on provider reporting.
- MCDPH's 2nd time conducting the CHA.
- Discussed barriers, timelines of real-time data.
- Promoting the CHA to community members & in community partnerships.
- Yes. Participated with Eileen on minority population.
- HIPMC- one in the past.
- The key informant interviews.
- For the hospital it is every two years and it is funded, and done fairly well. They are partnered with the Health Department.
- *Eileen joined forces and took the lead, who had the expertise to do the work well. MCDPH is doing a tremendous job*
- Every 3 years for Hospitals.
- *Extremely well. Everyone is supportive with the communication. A lot of outreach to organization not involved with PH.*
- *The County does a great a job in communicating all types of data, very simple and understandable.*
- Yes, it is public information. In the jelly bean system, some know about it and some do not e.g. the school districts. If it is not applicable, then it is not important to them. Schools need to be aware of the health disparities.
- It's a baseline. It provides guidelines. It is reported.
- Why is it 2017? It should be done earlier.
- What did we learn from the process? Parking Lot This.
- Tabletops, trials, exercises, works closely w/ Epidemiology, teams in facilities.
- *The systems are in place and available to the public. Make user friendly to the public. Some data is gathered from State from State, so the question is where did it come from?*
- Some MCDPH staff had little involvement with the CHA.
- TAPI was involved in CHA, but person participating in the discussion wasn't involved.
- HonorHealth wasn't directly involved in the first CHA, did a separate needs assessment.
- TAPI, HonorHealth are HIPMC partners.
- Other opportunities to be involved in the CHA – including being a partner of HIPMC and MCDPH.
- The second CHA process as a whole was better than the first CHA, other organizations within in the system have been conducting needs assessments for 10 years or more.
- Collectively coming together now.
- Hospitals often have support to take on those political issues.
- Established HIPMC/MCDPH partners are using the CHA/CHIP.
- *Still a disconnect with the private sector (i.e. HIPMC partners).*

- HonorHealth didn't go beyond their walls to conduct their CHNA.
- *Difficulty engaging faith-based organizations.*
- All of the other sectors are on board (with HIPMC) over the last several years because of similar goals.
- *Politics of taking on certain issues still a concern – some issues we can't take on because of political pressure. How do we begin taking on those issues?*
- *Partners still think of healthcare, not public health. Still interested in individual interventions rather than focusing on upstream interventions.*
- "It's easier to focus on healthcare over the Social Determinants of Health".
- *Even those HIPMC partners are trying to update the CHIP as often as possible, they don't have access to real-time data.*
- *CHIP can be updated as often as possible, but the CHA data isn't real-time or updated very often.*
- *More frequent CHA's, improve inclusivity and external recruitment/publication/advertisement, include all public health practitioners (not only government entities)*
- I am not aware that we even have a CHA. I never hear about it or about any results from their assessments. If we do have this, it's obviously a waste of the taxpayers' money since we do not have any knowledge of what we are paying them for.
- Ongoing disconnect within the private sector.
- State has made their primary care data available, but not at a local level.
- All HIPMC partners are trying to update the CHIP as often as possible.
- Community members were asked to participated in the survey process, but not part of the CHA/CHIP process.
- Reframe what health means to the general population – provide education.
- *How do we make the data more accessible to nontraditional partners?*
- Some partners within the system are further along and have access to databases that are helping them move in the right direction.
- Partners understand the need for data, but we're not there yet.
- *We have the data, similar goals, but we're not talking the same language. How do we make that happen?*

<u>Model Standard 2 – Current technology to manage and communicate population health data</u>

- Community members have used the system to access the data.
- *Display data making it more user-friendly and looking at the reports differently.*
- Some active surveillance initiatives.
- State mandates for outside agencies.
- Work w/health agencies, state, federal partners to report & monitor disease & investigations.
- Mapping is very important to look at the population for their tracking/trends/hotspots.
- *Reactionary vs proactive on how to move from.*
- Data & GIS mapping.
- *Desires to improve Arizona Health Matters – mapping in job centers.*
- CDC state level data is already available for 2015.
- TAPI, HonorHealth, MCDPH staff continue to use Maricopa Health Matters.
- HonorHealth uses GIS mapping.
- *CHA turned to registries because of the accuracy levels.*
- Local agencies/governments are aware and in communication about the data – MAG, City of Phoenix, ADE.
- *ADE found the HIPMC partnership/data was beneficial to their work.*

- *MCDPH provides data that helps us map out clusters earlier.*
- HonorHealth recently switched to ICD-10 – the discharge data collected is either unavailable or not applicable – the State decided to not use this moving forward because it wasn't quality information.
- What are you studying and the results thus far.
- Are you researching as well as assessing?
- *CHNAs and MCDPH's CHA aren't on the same schedule – every 5 years vs. every 3 years.*
- Current local data isn't as available as national data.
- Annual data is available more quickly, but doesn't always make sense at the local level.
- *Maricopa Health Matters has a ways to go before it can be considered user friendly.*
- *HonorHealth's mapping capability might be a HIPPA violation.*
- We tend to be more reactionary than proactive when it comes to communicable disease data – HonorHealth mapped stroke locations after the fact.
- *How can we start mapping clusters to identify them earlier?*
- *We might analyze the data, but it's not always at the forefront of our decision-making process.*
- ASIIS data can be difficult to comb through.
- Tend to use CDC data over state data due to accuracy.
- MAG data is available – Employment and Job Center Analysis.
- *We should embrace different levels of technology.*
- Others are collecting data (MAG), but need improved health indicators.

<u>Model Standard 3 – Maintaining population health registries</u>

- Health registries - poison control. Bite log, heat.
- Not a lot in these databases – however we have a very fluid data sharing process.
- Reporting on infectious diseases is ongoing. Other diseases are not the same in reporting due to processes.
- Regularly use the registry data for special projects.
- Medsis, HDD, birth/death records for surveillance
- *Birth/death registries – CHA turns to 1st for reliable data*
- Dog bites: Rabies data base annual report.
- Poison control.
- No idea. What are Population Health Registries? Be specific! Derms are not reporting data on skin cancer!
- ASIIS – ADHS system that capture immunization data for children from birth to 18, not always reliable.
- Skin cancer data – not always up to date or reliable.
- Vital Records – not always up to date, but still reliable.
- Have more faith in the accuracy of registry data.
- I do not know from experience, but I heard a lot of talk about a list of the deceased with the voter registration list and other lists so that their names could be deleted. Families still get Social Security checks from deceased relatives, deceased people counted as having voted, etc. An updated list should be made available on at least a monthly basis.
- An updated list of the deceased should be published, or made available on a monthly basis to every agency or company, e.g., voters registration, insurance companies, social security, etc. so they can update their lists. Too much money is being wasted by sending checks to, or counting votes from the deceased.

- Skin cancer data isn't accurate because providers aren't reporting Stage 0 – 1 cancer, this causes us to have the lowest skin cancer data.
- *Death certificates don't always show accurate cause of death.*
- *Need to provide education to providers filling out death certificates.*
- *Prescription overdose data now available and mandated, but not as familiar with the system.*
- Infrequency. Exclusion of certain health care providers (i.e. Planned Parenthood). Slow progress from data collection to plan the action. Not enough public participation in recruitment or involvement.
- Routinely. They do a significant job with it. Regular access and routinely!

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

Model Standard 1 – Identifying and monitoring health threats

- *Comprehensive surveillance system – national/state/local. Ex: measles response.*
- *We get data from doctors, hospitals, citizen calls, providers, labs.*
- *The labs go directly to the state.*
- It is important that reporters are accurate with their surveillance.
- *We use BioSense to monitor trends.*
- The active and passive surveillance is a fairly newish system.
- *We have to report to the county and state. Different diagnosis get sent to the state or county.*
- *We get info from the state and CDC.*
- *CDC provides samples when there may be a case increase. They will look at the information then at the National level.*
- *The state and then the CDC aggregate data.*
- *I think locally as well. We have a mechanism to report, typically to the state or AHCCCS.*
- There is a giant list of disease and timeframe established.
- The timeframe is based on the type of disease and the severity of it.
- *In terms of the information, when it gets reported, our job is to get to the details.*
- In terms of the emergency, we work closely with the OPR Department.
- *OPR work a lot on preparedness, we do POD exercises, or drills. Flooding, etc.*
- We have done 3-4 tabletop exercises a year.
- Even in EPI, we did a CASPER on heat with the community.
- They do send out notifications and build different response teams. And any time there is a disaster, you get called out.
- Even hospitals, they each have their own emergency plans.
- I couldn't speak to how well they are doing, but there are mechanisms in place by the CDC. But not sure how well it is working.
- *We are looking at morbidity and have the timeframe, and the healthcare provider missed a disease, we provide them the education needed to improve timeliness.*
- *We have multiple databases in place. HDD and ER data.*
- *We do a lot of analysis, demographic information on them.*
- *We get Medsis (state info).*
- *We do it at the local level and then it goes to the state. Then gets funneled to CDC.*
- *We also have birth and data records through Vital records.*
- *We also have poison control.*
- *Vector control data to look at mosquito pools. Chikungunya, dengue, Zika, etc.*

- *2 of the 3 discussion participants are aware of surveillance systems designed to monitor health problems and identify health threats.*
- *Partnerships with healthcare organizations and schools are strong but not as strong in other areas.*
- *Our current surveillance systems watch a wide net of known threats but weak with emerging threats.*
- *The measles outbreak showed there are significant gaps in surveillance.*
- *We currently have only one or two contacts with some of the partners so we need to create a standardization.*
- Locally we have a pretty strong system in place but we will never be ready for all diseases.
- *We are well prepared for known threats but difficult to be ready for any and all curveballs the unknown can give.*
- On a national engagement level the CDC is involved with giving guidance but doesn't force state and local levels to handle threats a specific way.
- The CDC could improve on being quicker to pull the trigger on a response when a threat is identified because we need to be a step ahead instead of being reactive to the threat.
- An example is our response to Zika. There has been a lot of bureaucracy with how to respond to it with money being the cause of the slow response.
- Locally for known diseases we are a well-oiled machine but nationally for the unknown threats we are not prepared.
- Locally depends on the size of the outbreak (moderate).
- *With measles we were stretched thin with a smaller outbreak but if it would have been a wider outbreak we would have struggled to handle a larger issue.*
- Everybody is in the same boat where we can handle small and known outbreaks but struggle with larger or unknown.
- There are meetings to bring people/organizations to the table and the state has an infectious disease workshop.
- *Based on the tools currently available we utilize them all and try to use to our advantage.*
- *For instance it was interesting to see when the measles outbreak happened places like Banner Health joined to provide assistance and information.*
- *BioSense – tracks health data, the most real-time data.*
- *BioWatch – detects biologic threats, including anthrax.*
- *BioSence – not sure if this is still being used.*
- *Water Surveillance.*
- *Other data sets included in the surveillance system.*
- *Disease counts, geographical information, using real-time data to track overdoses.*
- *Multiple surveillance systems available including BioSense, Medsis, BioWatch, and others from ADHS.*
- *Tracking school absenteeism in Maricopa County.*
- MCDPH works routinely with state partners.
- TAPI provides the touch points to national data for their partners – shares NIS data at their Coalition meetings.
- *MCDPH OPR works well at state and federal levels.*
- MCDPH meets fairly often, maybe quarterly with Palo Verde and other chemical plants.
- MCDPH previously used an app to track influenza using Google data, no longer utilizing that data because it was self-reported.

- Reporting communicable disease outbreaks disconnect for hospitals – Meningitis is an example of something often severely underreported.
- *Labs inside hospitals often miss reportable diseases, and go undetected, sometimes better to send to them to an outside lab.*
- Doctors aren't using a gold standard of testing, often only do swab tests instead of using new trends in testing.
- *Arizona doesn't have a standard for CE (both a weakness and an opportunity).*
- *MCDPH received a grant to use an app that tracks influenza.*
- Unsure of a jurisdictional Emergency Response Coordinator – mentioned Marcus Castle.
- *Room for improvement to help hospitals better track and report communicable disease outbreaks.*
- *Continuing education is key to helping solve the problem – support from CDC or local labs to provide education.*
- *Work with TAPI and MCDPH to provide education and continue the conversation on new testing trends.*
- *Work with MCDPH IPs (Infection Preventionists) to help educate and broaden awareness*
- We do get periodic information about our state's threat assessment regarding disease and/or the weather. We are not receiving alerts on our cell phones to take cover if bad weather is approaching.
- I do question whether they are using the best, most up-to-date equipment for the job. The government is known for cutting costs at the risk of lives.
- *Continually keep the public apprised of research and results.*
- *Recalibrate and/or replace equipment with current research equipment.*
- Put people above the almighty dollar.

<u>Model Standard 2 – Investigating and responding to public health threats and emergencies</u>

- *Volunteer database in OPR, pull from entire department, include in exercises, JIT training, FEMA trained in Epi/PH.*
- Lots of protocols, ICS structure.
- Written rules: FEMA training, work w/MCDEM.
- *Response coordinator: ICS, director.*
- *Bio/chem: designated person, comes from management. One contact in Epi (Ron).*
- *After action: action plans, hotwash for OBs, summary sent out.*
- *Natural disasters: Epi/OPR trained (FEMA).*
- *Collect timely & complete information on reportable diseases/emerging threats.*
- Locally prepared for known reportable diseases, although unknown threats can drain systems.
- MCDPH/ADHS meet model standards, however it's uncertain how well the LPHS does as a whole, in meeting standards.
- *The OPR group had a volunteer database.*
- Anyone who wants to volunteer, gets trained and pulls for a case of emergency. We would pull from hospitals, community organizations.
- *A lot of the volunteers participate in the PODS, etc. Otherwise, staff is trained to delegate.*
- *Just in time training is also very important & everyone is FEMA trained as well.*
- *Every person has a very specific role.*
- We have protocols for everything, especially for outbreaks. When there is a large outbreak, we scale it up.

- *There is a plan or system of tasks. It comes down from FEMA and everyone needs to be trained once a year.*
- I have taken the ICD and ICS training and it's very thorough. Fire depts. and police depts. have a lot of systems in place for those types of things.
- We are part of the MCDEM team. Even if we have any type of outbreak, they are part of that communication team.
- I think it depends on the type of emergency. But if it is a serious emergency, someone from leadership called an ICS emergency and the appropriate action is taken.
- We are there right away as soon we find out about a disease.
- We have one EPI person who is between OPR and EPI (liaison position). I don't know how to answer it to tell you the truth.
- We do that every time we have an incident and we are supposed to write action plans.
- *We do Hot washes where we discuss what was right, what was wrong, what we can do differently.*
- People who have officer positions also are involved.
- Everyone is trained and attends exercise.
- *We probably base it on the hard to reach populations. And it is more so evaluation for me.*
- *They send those to UofA and probably ASU.*
- They are sent to different divisions, typically those who have a health background and get involved.
- Hot Wash and After Action Report. Those go to OPR and it is saved.
- *If something needs to be modified, we will look at what we can fix from the hot washes. And incorporating them into the action plans.*
- *I feel like I get that info quickly and I am able to send it out to others very fast.*
- *We have a list of healthcare providers where we can send emails or text messages and notify them immediately if there is an emergency incident.*
- *And we can target those specific messages to certain healthcare providers (for example preschools).*
- It is good to know because certain things are picked by media where some are not.
- We try to message out messages to the media.
- MCDPH host lots of drills for mock disaster trials where community organizations are encouraged to participate.
- It is a hard question because we work to get people trained to be prepared but the difficulty is how we keep them trained/prepared/updated.
- We have so many different offices in MCDPH where not everyone needs to be prepared for every outbreak but everyone will need to respond.
- *How do we prepare the staff to be trained to properly respond in an emergency?*
- *Pinal County has a good plan where all county employees can be used in an emergency; currently Maricopa County does not have a similar rule.*
- *Volunteers could be anyone not just public health affiliates.*
- One person has no idea, not their world because they deal with chronic disease.
- I am sure it is written down somewhere but have no clue.
- *When you add all of the different written instructions as a system we are minimal because we have some plans in place but not all.*
- *We have basic instructions but we do not have written instructions for all of the different areas.*

- *The assumption is rules are written and maintained but no one is sure who ensures to be sure these are completed, updated, and maintained.*
- *We have administrative rules/statutes which we continually look at ways to improve it through experiences.*
- *For instance our measles outbreak responses were limited because of the administrative statutes in place and have looked at improving in the wake.*
- Unsure of whom is providing oversight to the admin rules/statutes.
- Not sure what rules are with hospitals with HIPAA rules when there is an outbreak or what can or can't be shared.
- *Arizona as a whole is behind the curve about creating disease control laws compared to other states.*
- From FQHC perspective they must have someone but no clue who is doing what.
- Does every municipality know who handles what in an emergency (like Dr. Bob for Maricopa County) but do not know which rules to follow and how to coordinate. Is it one person for each jurisdiction?
- With larger system it would be minimal.
- Schools have minimal drills which are practiced other than fire and active shooter drills.
- *Very minimal across the board because when we do drills it is a very small participation drill and not an across the board disease response outbreak drill.*
- *Starts with first responders to first identify and pass on info to necessary parties.*
- State has a good broad range of people to pull in as experts in a variety of subject matters for different situations. Moderate level.
- Are we really prepared? As a whole system not sure how well we meet the standards.
- MCDPH OPR recruits volunteers on an ongoing basis, MCDPH staff also volunteer.
- EMS has systems in place – understanding of how to get from point A to point B in the event of a public health emergency.
- *Post meeting after any disease outbreak includes a hot wash to plan more effectively for the next drill.*
- OPR volunteers able to assist with Palo Verde, also prepared for Super Bowl and develop plans for large-scale events.
- *OPR online volunteer application improved the recruitment process.*
- MCDPH handled the measles outbreak well – had a large surveillance team (300 cases with 30-40 staff that contacted individuals), script was available for phone calls.
- HonorHealth IPs keep hospital staff up to date, post signs and educate staff on disease outbreaks, hospital uses CDC protocol for communication.
- *MCDPH does a good job of communicating when issues need to be addressed. (i.e. Ebola)*
- Hospitals are designed to be ready when MCDPH asks them to mobilize.
- *After the Ebola hot wash, hospitals changed their plan and included appropriate equipment required for an outbreak – MCDPH offered the support to find the right masks.*
- Not sure how that information is passed along to the public – we probably have plans in place to deal with heat, floods/monsoons.
- Guidelines for emergency operations coordination exist, but not sure if they are followed.
- *Systems are in place to respond to public health threats and emergencies, but there's a tendency to wait for the CDC to pass down information to state agencies, and then local agencies.*
- HonorHealth had an Ebola taskforce, but had to wait for MCDPH to mobilize before moving forward.

- Systems in place for public health emergencies, but there can be financial limitations that prevent the best and brightest from working at MCDPH – how do we recruit professionals from the private sector? How do we compete financially with the private sector?
- "No matter how many hot washes you do, old habits continue to play into the development of our plans."
- *Evaluation of the incident hardly occurs*
- "We're not thriving, because we're surviving." – Limited resources to evaluate incidents for effectiveness and opportunities for improvement.
- *We need to build partnerships with the private sector in the event of an emergency – how do we create partnerships for the greater good?*
- *We do a good job of partnering with universities, but we should be looking for opportunities to reach out and work with the private sector.*
- *Can we use HIPMC to build partnerships with the private sector? – Currently all nonprofit sector.*
- MCDPH offered staff training to deal with workplace incidents – procedures are in place, but not sure if I could put those trainings into action.
- Hospitals have codes but not sure how to handle a bomb threat or active shooter.

<u>Model Standard 3 – Laboratory support for investigating health threats</u>

- *ASL labs, support emergencies, confirmatory testing can use private, educational institutions, etc.*
- 24/7 access to labs: don't have constant routine access, ASL licensed/certified labs.
- *ASL needs specific approved tests/assays, etc.*
- *Private/business: use only approved tests w/in its scope (credentials).*
- Don't know what organization approves tests.
- Written protocols & trainings, only those trained can handle samples.
- Follow national guidelines.
- Criminal samples – coordinate w/ law enforcement to obtain samples.
- Utilization of best resources.
- *Responses & community meetings/trainings support efforts & increase use of resources like BioSense.*
- One single state lab significantly meets standards for LPHS in partnership with Sentinel Labs.
- *We kind of defer to the state lab since they have more capabilities for testing. They are more reliable, but there are limitations. They only operate on regular business hours.*
- If we were in the middle of an outbreak, they would extend those hours.
- We can also use other labs (private or ASU), but we can't use them as a diagnostic. We would contact the state and they give you a timeframe when they can give you the results back.
- We defer to the state labs. I don't know much about that.
- If we get word of GI outbreak, we can ask the lab to test several different things to try to find out a cause of illness.
- *We have private labs and work with them.*
- Things that are not clear are brought up the chain and taken to the state.
- A lot of the private labs are CDC certified and we can use those.
- *The private labs. We don't have 24/7 labs.*
- If there is a disaster, let's scale up. If there was an emergency, the state lab would be open 24 hours.
- I would say on the business side, if we request for pay, dependent on that type of lab, most labs know what they can and can't do. And if it is out of their scope. (very credentialed)

- They are accredited. I don't know. I mean you must do, you must be able to validate everything. I don't know what organization approves them.
- We do have protocol and trainings for based on the type of sample it is. I am not approved to carry samples because I am not trained. And they have different categories of it. They have everything written down.
- Sometimes if a person is not cooperating, we will take the police officers with us. And we would go through all the safety protocols.
- I wonder if the system is built in the legislation and it would be built out to support this. But I wonder if there are any gaps in it.
- If there is a public health emergency, that gives us more power. If the state declares it as a public emergency, at that point we would have a lot more authority. If it is criminal, we can request certain samples to protect the public safety.
- There are ADHS labs for certain diseases to send in for testing and confirmation but mostly for the more common ones with nothing available for new diseases to test.
- *Sonora Quest and other single labs do some testing but most are done at ADHS labs.*
- *With Zika they did a great job of rolling out the test so private labs could assist with testing.*
- *For H1N1 there were hundreds of samples to be tested so they were unable to test as quickly because of number.*
- Small number and common diseases we can handle but larger and unknown we have issues with testing.
- *Sonora Quest and Lab Core are available and everywhere.*
- *Sonora Quest is always look at ways to improve their service.*
- *We have a good network of available labs but in rural communities not sure what options there are for labs outside of hospitals.*
- On a statewide level we don't have ways to get samples from far away rural communities.
- Maricopa County though is spoiled with labs and their capacity.
- ADHS previously had training for private labs on what ADHS can handle but not sure if maintained.
- *Does MCDPH let community members know of lab services and how to handle, information is very siloed though.*
- Optimal because we have no other choice. ADHS lab is told by CDC that whatever they find it is taken as fact and samples do not need to be CDC tested also.
- Significant because there are certain rules ADHS has for labs.
- Yes there are. Chain of custody is used in health events either way.
- *MCDPH has a relationship with MIHS for all of our titers.*
- Also coordinate with ADHS during the measles outbreak for testing.
- *MIHS handles biochemical threats.*
- *BSL3 lab in Arizona can test for almost anything – there are only a few labs at a higher level.*
- If issue is big enough, then it's sent to CDC.
- Dr. Bob would be able to call on ADHS to use lab after hours if the need is critical.
- *From a medical provider standpoint, lab services are not always available for immediate testing.*
- Courier systems in place, but not quickly enough for immediate diagnosis.
- *State lab doesn't allow testing after 5pm.*
- Private practices aren't able to do simple diagnosis, needs to be sent off to a private lab.
- Private labs add on time and other layers for final diagnosis.
- *MIHS can only meet so many needs because ADHS doesn't provide 24/7 access.*

- *Hospital labs are 24/7 but can only address common diseases.*
- *Measles specimen was lost in transit due to limit hours at State lab.*
- Issues with licensing and credentials for labs – Minute Clinic, Take Care clinic, Theranos.
- *HonorHealth has a system in place, but not sure if there's a good enough chain of command.*
- Couriers sign over custody of specimen, knows there's a process in place, but not sure of the guidelines.
- Hospital labs are required to be credentialed, but are family practices using credentialed labs?
- *I know that the court employees must take a bloodborne/airborne pathogens course every year. If we do, I am certain that everyone else in the health and research field has to do the same.*
- They may do that for some labs.
- I don't believe they are required to do that in abortion clinics.
- There should be a law passed that all hospitals and/or surgical/health institutions, e.g., abortion clinics pass regular unscheduled health inspections.

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

Model Standard 1 – Health education and promotion

- *A lot of messaging & communication happening, but difficulty with engaging private sector. Important area to work on.*
- *We do a lot of direct service education & interaction but hard to make leap from here (1:1, conferences, etc.) to health policy sector.*
- We have the information we need and things we want to say, but policy makers need to want to be involved.
- In addition to the work happening, there is a lot of mistrust in services provided to various populations.
- All stakeholders are doing own education & promotion and it is meeting the target market; however, when you get down to the consumer level there are people wanting more information.
- Not sure where to get information needed – disconnect in communication.
- HIPMC, CHAs all very important.
- Mental vs physical health? – All equally important.
- Contributes to mental health.
- County produces Health Status Report annually – analyzes trends in health, demographics.
- The media often portrays various health indicators – very publicly visible; health discussion take place often; however, oftentimes generalized.
- *In W Valley (Tolleson/Avondale) – provide many opportunities for the community to get involved; however, do not have a good buy-in so there is oftentimes reduced attendance.*
- Hard to get people to participate & engage due to so many prior obligations & busy schedules.
- Don't want to always incentivize opportunities so that it doesn't become an expectation (they should want to participate regardless).
- *Within the school system, (Tolleson Elementary) there are health fairs and free health clinics – trying to provide health services to families who are otherwise unable to provide medical care.*
- Hard-to-reach populations have opportunities presented to them, but there is not always a good turn-out due to mistrust or not being educated… there is a lack in understanding of the reason for free health clinics and resources provided to them.
- Cultural perception of various health services, as well.

- Refugees oftentimes do not take advantage of resources provided to them, as they are used to not receiving these services, do not want to cause a burden or provide a reason for their refugee status to come up; also mistrust in this population.
- High coordination levels do exist – in programs such as in Avondale for adult groups; however, low participation due to parents not having much time to spare, not educated or aware of the reason for these services being provided to them.
- 4 out of 4 participants provide information on community health.
- *A lot of different organizations try to get information to the community but because it is inconsistent and varied it is confusing to the public.*
- The information and messages communicated are national and not local systems information.
- *The system is getting better. Trying to improve the unified message to reach greater public but still only successful at a small level.*
- There is a desire to partner more but the limitations are usually competing priorities and the limited funding and resources available.
- *Sometimes when we try to work on being a big happy family internally we can then ignore public.*
- There is a strong understanding internally what is going on and available but not sure what those on the outside who are not as involved think or know.
- Most of group agrees we are at a moderate rating here but they are unsure if that is because we are in the middle of it and the general public perceives we are more at a minimal rating? Do we represent the population well?
- Group consensus was current rating more towards the minimal level and most large cities are minimal.
- Organizations want community members to have a voice but it's hard for them to come to meetings in the evenings after work and can't during the day because of it.
- The community has voiced they are tired of being surveyed and nothing changing which is causing a lot of disillusionment.
- Coalition meetings during day most public can't make it because of work constraints.
- Engagement comes and goes based on certificate needs for orgs. How do we better maintain engagement levels? Minimal.
- Each individual "jelly bean" does a great job but not sure how well we are actually collaborating and communicating collectively.
- *Educate families – direct service (WIC, employers).*
- Social justice model quarterly magazines.
- Ability360
- Uphill battle w/legislators.
- *Finding a pathway to communicate w/policy makers.*
- Could always do more.
- *How to sift out 'health' from 'PH'.*
- One-sided – PH system able to provide – then needs to be an audience to tell the story.
- How do we support non-profits?
- Reports publicized, sometimes information is old.
- *Difficult to understand/find.*
- Coordinated: west valley coordination.
- Engage: mistrust in system/lack of cultural understanding; keep people in & out.
- *Trying - could use incentives/recognition.*

- *Health communications plan.*
- *Assessment first - plan to be completed.*
- Challenging for those of the community to find time to be involved & hard to buy-in; commitment & actively engaged.
- Within the school system – very well.
- Awareness & connecting.
- Hard to reach: mistrust disrupting engagement.
- Lack of understanding of community members – perspectives & cultural awareness.
- System doing things its own way = less engagement.
- *Value of time (recognition, incentive) = community members.*
- *Lots of messaging & communications going out, but aren't consistent & coordinated enough.*
- *Difficulty engaging private sector and getting representation on planning.*
- Not truly engaging the community with the interventions we are "planning" for them.
- Individual partners have communication plans, not sure about an integrated plan.
- *Need public hall type meetings.*
- *Need open webinars for the public.*
- *To reach out in the community and promote appropriate cultural awareness on different health topics.*
- *Development of cultural competency, train the trainer model.*
- Hard to track outcomes and impact.
- *Collaboration with key stakeholders that already have the model to provide training/education.*
- *Track outcomes of outreach on what other organizations are providing, share lessons learned and develop enhancement for future outreach.*
- *Focus on two or three areas of need from the community to work on improving the outcomes of impacting healthy lifestyle.*
- *Tracking outcomes from the community about healthy lifestyle.*
- *Focusing on a specific area to target.*
- *Targeting specific population.*
- *Setting baselines for outcomes and metrics.*
- *Working with stakeholders on topics of need for healthy lifestyle.*
- *Effectively engage community partners in public forums, set goals, (already trying to do this?).*
- *Prioritize 1-2 key initiatives to focus on with partners.*
- *LPH should provide trained experts and plan media campaigns but not be responsible for advertising, this is a role for community partners.*
- I think there is a recognition that the above activities are important and should be done, but I think we haven't figured out how to do it yet.
- Consider best practices in authentic community engagement (this means engaging them in the beginning and at all stages of the process).
- *Consider the gaps in data reporting, collection and dissemination. Information (data and assessments) is the starting point for informing policy makers, coordinating partners and engaging community, but we have so little reliable and timely health data available at the sub-county level.*
- There are too many people trying to do the same thing, everybody knows it but funding structures prevent us from truly breaking old patters or turfism, duplication, etc.
- *I think there are good advocacy organizations here that know how to do this well, and they are beginning to focus on health more.*

- Collaborative in nature and inclusive of other public, non-profit, and private leaders.
- *Perhaps create an advisory committee for community members and the information collected in those discussions can be transferred to the professional community to further discussion and planning.*
- *Positive input and encouragement on the individual level will help empower those to have a voice on the community level.*
- Continuing to add policy to make a difference in all community member's lives.
- Reaching and engaging the public is vital to stopping or reducing communicable diseases.
- Misinformation or higher terminology used, medical terms, with those who do not speak the language or have lower levels of academic learning.
- *To have training in order to keep those who are in charge knowledgeable of newly found emergencies.*
- The training could be not fully received or understood by those serving in the official rank.
- Model is good but I don't see enough mental health entities at the table. Melody Hicks is awesome and is very persuasive in terms of tying in mental health and medical issues with early childhood trauma.
- *The Adverse Childhood Experiences movement should be a big player in HIPMC.*
- *Many public health departments have already make big changes to their programming, as well as medical clinics and schools.*
- Is Marcia Stanton involved in HIPMC? This is a movement everyone can get behind to improve health outcomes. Please ignore if you already have ACE representation at the HIPMC meetings!
- *I love how Jhoana targets the populations that need extra outreach in her bi-weekly meetings (conference calls). She involves a lot of faith-based, monolingual Spanish providers, and mental health organizations.*

<u>Model Standard 2 – Health communication</u>

- Having communication plans but not necessarily being involved in them.
- Media doesn't always spin health stories in the way we would like.
- Information is provided (either locally, nationally, etc.) but the public doesn't necessarily want to read further and investigate on what is being communicated.
- *Leadership (in MCDPH) is very proactive – which is very important.*
- *We do well at communicating w/media prior to the story coming out.*
- *We are doing a good job (i.e., H1N1, flooding) info gets out to public efficiently.*
- In the beginning stages of coming up with basic needs planning - targeted population is homeless & foster youth; engaging in health care is one of the main goals.
- Still trying to discover resources that may be available to these populations, then will begin to plan around these & implement the plan.
- *We struggle with utilizing media providers – definitely something that can be improved upon.*
- *We do need to be proactive in getting the word out on resources and tools that the community may utilize; good reason for having* ***media partners.***
- Able to build strong relationships, but it is difficult to get something to come of that partnership & have media representation of resources… due to possible lack of interest in health activities/important points we are trying to make.
- Many people would prefer not to talk to the media – due to possible "twisting of words" by the media.
- *Better to be proactive & talk directly to the media, letting people know what we say about our own organizations, rather than other people/organizations talking about us.*
- *Dr. Bob is very proactive & willing to speak to media providers.*

- *Very proactive in writing Spanish articles for print/online use by the public.*
- In radio media, Dr. Bob and other heads for the county try to be very proactive.
- Have to provide media outlets with "balancing act" between them needing to meet their deadlines & the issue of health issues and points taking much longer (sometimes months) to be able to come up with a statement.
- *Don't stray from the facts & start making things up – specific media training very important.*
- The local needs are different from national needs and are not communicated by the media.
- We do a good job of speaking but not sure if anyone hears, information is given but is it being disseminated effectively?
- *We do a lot of radio interviews but they are played at days and times when few will hear it.*
- Only time health issues have a bigger platform is when big national health issues break.
- We don't go to the media the media comes to us.
- We usually don't try to engage the media with health stories.
- The media relationship is more one sided and on an as needed basis for them. An example given was how every February the media wants doctors to talk about dark chocolate and wine and not the stories we would want to communicate on the platform.
- *It would be nice to create a good reciprocal relationship with media.*
- *Arizona Heart Association has been working on being more specific with messaging and engaging their target audience in creating message for specific audiences.*
- There are months/weeks/days for every health issue, just feels too saturated and it lessens public interest.
- *Group agreed if you work with kids you receive a little better cooperation from the media, easier to access funding, etc.*
- One group member asked if Maricopa County has spokespeople. Dr. Bob and Rebecca are usually the department spokespeople but we need to be more strategic about equipping people with the abilities to be prepared for when department faces move on.
- The group noted the dynamics of who becomes the spokesperson can be curious because it's not always those who are the most informed about the issue but are more known by the public.
- Struggle – proactive (fear of media, lack of planning).
- *Proactive leadership – communicate with media well & often (trust exists).*
- *Training spokespeople – media – system.*
- *Many agencies involved – plans being made coordinated.*
- *Resources available.*
- Difficult to discuss/communicate/execute.
- Room for improvement resources.
- Struggle w/more reactive due to trust, scale, & lack of time.
- *Fear of media by health systems.*
- *Proactive Dr. Bob.*
- *Spanish media – print articles.*
- Media prefers "fluff: stories – not necessarily what "we" want out there.
- There are plans; not necessarily communicated to the public in advance.
- *Probably an area that PH excels at best.*
- Everyone receives the same information.
- *Does it actually filter to the people who need it most? How do we know?*
- *You have a broader outreach (audience) through all the media available nowadays.*
- Campaigns are a great way to inform and make awareness in the community.

- You may not have a baseline to start of how many people will be impacted through these campaigns.
- LPHS does not have sufficient funding for media.
- *Greater collaboration with community partners to fund ad campaigns.*
- LPHS is in the best position to take the lead on this.
- May be inadequate funding for resources.
- It's very hard to get people impacted by an issue to tell their stories to legislatures or media, but those are the most compelling.
- *Work w/community, organizing and advocacy organizations to give them good data and information on important health issues here so they can bring it into the spotlight. Think about what they care about and how population health aligns.*
- *Set up more educational classes for community members to attend.*
- If there is no follow up, the model would easily fade away.
- Not enough media coverage.
- *We need trainings on how to make our Facebook accounts better.*

<u>Model Standard 3 – Risk communication</u>

- We do well in planning & information going into it; however, trickles down in ways that people/MCDPH people are involved in it.
- *Much happening behind the scenes – probably a sign of it working well.*
- Public doesn't necessarily need to know about all risks that *may* potentially happen.
- Resources tied to risks proactively.
- *System doing a pretty good job.*
- Social media is impacting the message the system is trying to communicate… people of the public may be posting without knowing all the information.
- OPR – so many agencies are involved.
- OPR definitely the main outlet for preparedness and response.
- OPR always running drills so that when the time comes, they are prepared (to be prepared!).
- Experience being a part of the command system & there are several agencies that are actively involved.
- Much more intricacy in the agencies involved with and also in OPR itself, than many people may think.
- Plans not often provided to the general public or explained in any public way – due to potential panic if people find out certain things that *may* happen.
- *If too much information is disseminated, people become desensitized & the actual emergency would not be as big of a deal or as important to people; might cause reduction in trust, believing that certain things may not happen even if they are told they will, etc.*
- The flu shot is offered everywhere, some places free. However, the flu shot is not guaranteed to work due to mutations in the strain of the virus – we need to plan for that, but it is difficult to do so just because of how many factors might be unknown to us prior to an event actually happening.
- Materials are available, but the important thing is making sure they have a local impact.
- Hard to communicate risks and things that may happen to the community with various diseases, etc. due to so many factors constantly changing, continuous increase in knowledge – i.e., Zika virus.
- 3 of the 4 group members are aware. If a public health issue we have collaboration to be informed and will assist with response.

- In theory everyone in the response tree knows what they are doing.
- Those who are in the response tree know but do greater public know the proper response and how to be informed in an emergency?
- Group couldn't think of ever seeing anything communicated to public on what to do in an emergency or informing them there is a plan.
- *Public health excels in this area, we have drills constantly.*
- *Does the plan take into account those who don't have internet, phones, or disabled? Or what about in an outage?*
- *Are community members consulted in the making of plan?*
- The biggest issue is the turnover of people and MCDPH has OPR to deal with issue though.
- Members here who aren't involved OPR or the response tree are not sure what happens and what they are to do.
- Train subject matter expertise.
- OPR = all departments within system.
- Core resource for response.
- Easy to find, not necessarily delivered.
- Media generalized information, but is frequent topic.
- It's crucial for the community to be aware of resources and how to respond in case of emergency, where to go and how to reach out.
- *Sometimes miscommunication or too much communication will make the community confused.*
- *Requires communication and collaboration with all stakeholders.*
- Communication and collaboration can be difficult!
- *Again, collaborate with community partners, businesses, relief organizations who become part of the plan.*
- Communication plans should be easy to attain.
- *If the communication plan waits too long, it's easy to forget.*
- *Set up plan and do it right away.*
- No clear evidence that this exists.

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

<u>Model Standard 1 – Constituency development</u>

- *2-1-1 and Find Help Phoenix are very good.*
- *2-1-1 not as effective.*
- Only half of people have even heard of these organizations. Maybe a good idea to promote community awareness of these?
- *2-1-1 and Find Help Phoenix are great resources.*
- Specific gaps existing are in awareness of them.
- The only non-MCDPH person at the table did not know about these directories.
- People unaware of existing directories may duplicate.
- How are we coordinating with NPOs & providing information to them/getting information from them?
- Freedom Work Program (w/ Ability360) which provides work opportunities to people with disabilities & they were unaware thus far (Ability360).
- *More direction from Chamber of Commerce trying to engage in public health efforts, so getting better at identifying & working with constituents.*
- *Find Health Phoenix & HIPMC are great.*

- *Engaging constituents outside of meetings is difficult.*
- *After meetings & conferences, constituents need clearly defined roles so there is no "now what?" moment.*
- From an outsider perspective, unsure about any such "list" existing.
- Important to develop this list in job searches – as a part of her position in providing access to possible jobs.
- *There are resources available (2-1-1 Phoenix, Maricopa website) & proper resources are being maintained – although, there are still gaps existing).*
- Difficult to maintain this type of "list".
- Difficult to find these resources sometimes, especially for certain interest groups or populations (i.e., 18-20 years homeless youth).
- There has to be a better way to bridge gaps between resources & public – their perception of ease of access.
- Homeless groups (case managers, social workers) ask Nicole about where to take homeless youth, what to do with them, how to navigate them to get to appointments, etc.
- *Possibly an issue with duplication & maintaining any such list of resources; people unaware of possible resources even existing.*
- Just as Dr. Bob stated, people are unaware that they are part of the bigger LPHS.
- *On the pathway to constituents being aware of their impact on the LPHS.*
- *Once you identify those groups and people, are they willing to be leaders?*
- *Are these people able to realistically take this on, or organizations able to dedicate someone to this wholly?*
- *No "process" existing for how to identify key constituents.*
- *Look at gaps in the network & try to reach out to these people.*
- *HIPMC is a great resource for networking & becoming aware of new organizations/coalitions*
- *Find Help Phoenix is a great resource but things change all the time so it's hard to keep up to date.*
- *HIPMC is a great group.*
- *Mostly happen by word of mouth with no real established process.*
- *Not very much engagement outside of opportunities like HIPMC.*
- *We engage with surveys but what is the follow up?*
- Phoenix is full of diverse communities and how do we meet health needs of both vulnerable and wealthy?
- *$25 Target gift card isn't going to gain engagement of higher socioeconomic status community members.*
- Focus groups aren't very well attended.
- Pretty good, problem is finding the time to be a part and there seems to be the same participants all the time. HIA assessments do a good job.
- *HIA assessment process is amazing and perfect.*
- Evaluation is always a weak point and outside evaluations are hard and expensive to do.
- *It is difficult to evaluate programs internally because we are passionate about it. Passion can blind us from being able to make necessary course corrections.*
- *Community members not engaged and we need to be more aware of how we communicate because we need to avoid internal jargon/acronyms.*
- 'Freedom to work program".
- People w/ chronic health conditions often move to Phoenix.

- Phoenix is sprawling out – not a strong sense of community.
- New to this - # of partnerships up & running.
- *People don't know about all of partnerships but are on our way.*
- Hard to think of this place as a community – everyone comes for such different reasons.
- 211, Find Help Phoenix, there are entities maintaining resources.
- *Directory – there are gaps: complete, current, awareness, duplication.*
- *Established process: identify participants, encourage participation & delivery of communicated PH issues.*
- *However we are moving towards this w/HIPMC & CHA/CHIP.*
- Lack awareness & capacity.
- *Find Help Phoenix – great example.*
- Labor intensive activity.
- HIPMC – over 100 organizations.
- *Word of mouth is the go-to process – networking has improved.*
- *Could increase engagement outside of meetings.*
- *Participants: the 'so what' after initial engagement such as surveys.*
- Diversity of community: focus on certain populations (vulnerable) – maybe not reaching everyone that has needs.
- Challenges with finding time.
- Evaluation of impact is a weak area.
- Funding challenges.
- *Hard to change course of program/initiative that have been around a long time.*
- A collaborative model should be more effective.
- *Assessment is a strength of LPHS.*
- The inventory is absolutely critical and it is encouraging that this is recognized. It's much harder than it sounds; therefore, understandable that it doesn't exist yet. But it's crucial.
- *I have heard comments that community engagement efforts often feel inauthentic to participants invited. Engage community in the beginning not after plans are made to meet a grant deliverable. Have a more coherent message as well; sometimes it's not clear.*
- *Consider strategies that make communities feel like their voice is being heard. Think about co-designing programs and stratifies (see best practices). Identify the needs and/or motivators for agency partners and try to engage based on alignment.*

<u>Model Standard 2 – Community partnerships</u>

- *HIPMC is doing a great job at bringing partners together to collaborate & network.*
- Easier to involve smaller organizations as opposed to larger hospitals, etc.
- *HIPMC brings organizations together & strengthening partnerships.*
- Gaps and disconnect are felt between planning/work and the people the work impacts.
- Because people move here from all over the country & world, it is difficult to tackle issues as we are not one "population" (demographically speaking).
- Broad diverse input in group conversations.
- *Much opportunity exists & is exciting.*
- *Business community (employers) are getting more involved in promoting health & healthy practices.*
- *We do a great job at HIA Process & lots of great engagement.*
- *HIPMC is great.*

- *Evaluation & collective impact / evaluation of how all our groups are making an impact – this is a slightly weak area.*
- *JAG, community member & having an office donated to her: seeing weekly things on promoting health, Avondale is actually doing a really great job.*
- As a community member, however, she would have been unaware of any of this communication – no invitation, information being spread, etc.
- Not a clear answer even to us; it is happening but at the same time it is not efficient.
- *In creating community partnerships & bringing groups together, we do a good job.*
- *Not a comprehensive approach to utilizing these partnerships to provide services to the community.*
- How do we let partners know what the community needs?
- *Something missing in the puzzle; community needs empowerment and motivations as well as education & promotion.*
- *Having an ambassador within the community who is also in the organization is a very valuable asset – they are able to communicate news and announcements/invites, etc. directly to the community…. And things coming from a* ***trustworthy*** *source is VITAL.*
- *Even HIPMC is missing "resident input".*
- There are gaps existing between health organizations, industries, and the community members experiencing health disparities.
- For example, there are groups for parents of children with disabilities who discuss the real major issues going on at home, consistent challenges, etc. that need to be prioritized.
- How do we get the community to be more active, so they are able to collaborate and share?
- *In practical approaches, able to put people in groups and give them roles such as CEO, coordinator, & have them run through simulations of what they would do in any given situation, and they get very excited & engaged (in her work w/ homeless youth).*
- *A lot of opportunities out there for strategic alliances.*
- Usually it is organizations seeking out coalitions and not the coalition's seeking out the strategic organizations who are the voices they need.
- *HIPMC and it has been very successful. There has been so much disconnect and this finally pulls it together.*
- HIPMC
- Non-profits have to coordinate w/ other groups.
- *Newer at establishing partnerships – doing well w/ community, health will take time.*
- *Compared to other jurisdictions, MC partners well.*
- *Amazed at how broad community base of diverse groups & people having input on a plan – made improvements.*
- HIPMC is trying to measure changes.
- This meeting assesses where we are at.
- Culture of collaboration.
- See how we evolve over the next 5 years.
- Business communication more involved in wellness.
- *Outside of MCDPH – starting to create (may be duplications – not good).*
- *Great partnerships!*
- *As a community member not as visible.*
- *HIMPC: proactive creating & bringing people together but struggle to get the comprehensive approach to join forces.*

- Barrier back to trust.
- Disconnect – organizations and lives impacted/those who have lived experience in engagement & design.
- *Lots of coalitions, opportunities, HIAs.*
- *Specific coalitions – opportunities.*
- *Individual organizations find specific groups to join vs coalitions' proactively conducting outreach.*
- *HIPMC – pulls group together, reduces duplication of several groups meeting separately on similar issues.*
- May be difficult to keep information current and manpower needed to plan events, engage partners, etc.
- *Create a web-based directory, send reminders to participants every quarter? Semi-annually? To check/update their information. This will also increase traffic.*
- Continue to partner w/ organizations to provide forums; AzPHA, Vitalyst, etc.
- *Partners, groups may be reluctant to have the LPHS take the lead on establishing committees, perhaps partners need to do this and invite LPHS to be a part of the process.*
- *Work closely w/partner organizations to provide directions/oversight in establishing committees.*
- *Convene organizations and facilitate linkages.*

**Essential Service #5 – Develop policies and plans that support individual and community health efforts**
<u>All model standards</u>

- *Great support from many community partners for our CHA and CHIP work; excellent goodwill and support from many others. Good and expanding participation in our joint CHNA from non-profit hospitals and Community Health Centers.*
- Too huge a community and too many partners to even begin to build relationships w/most of those we should (e.g., 58 school districts, >1000 schools, >20 cities and towns, etc.). Rapidly shifting environmental influences without adequate in-house expertise. Woefully underfunded by any standard. Longstanding lack of political support for resources.
- *Dedication of health department staff.*
- Inability to lobby.
- Disjointed coalition w/o unifying objective.
- *Too much focus is on accreditation, instead of implementing practices that are proven.*
- Configure objectives to align w/statistical need.
- *Focus primary efforts on evidence based practices.*
- *Pick one or two special projects outside of proven evidence based practices.*
- Seems like a wish list.
- Requires an elected official as champion and health is rarely a priority.
- *Staff often seem timid pushing policy.*
- *Should be more data driven.*
- *Use that data and aggressively pursue groups who are not at the table.*

**Essential Service #7 – Link people to needed personal health services & assure the provision of healthcare when otherwise unavailable**
<u>Model Standard 1 – Identifying personal health service needs of populations</u>

- The data is coming in, identifying populations is easy (hospitals, clinics, etc.); however, these populations being affected by disparities/barriers do not utilize the resources provided to them & will not due to past experiences.
- Having an ambassador from the community and also in the organization is great for trust purposes – having an advocate.
- *In the 0-3 undocumented population - many people coming from undocumented families are experiencing many more referrals.*
- Increase in this likely due to political climate.
- Feeling safe & being taken care of is a huge gap in the communities.
- People with disabilities have trouble accessing hearing aids/glasses, things they may need.
- *Different opportunities & programs which are unique & attempting to bridge gaps and make a positive health impact such as: paramedicine, telemedicine.*
- *Tend to make assumptions in determining needs of populations.*
- Hospitals now taking large health assessments which is great & providing much valuable data.
- *More data in regards to hospitals is available.*
- Much of the identification exists within individual organizations but not as an entire system.
- There is a lot of effort put into identifying & taking people to resources, but at the same time people need to take ownership and want the assistance.
- People need to overcome unwillingness & mistrust/not wanting to do something.
- *Identification of/and a referral may not be enough- language & cultural needs.*
- *Many efforts focused on linking people to resources buy lots of them have time limitations and the efforts are not able to be continued for funding reasons, time, interest, visible results etc.*
- HIPMC looks at data related to these populations which are experiencing greatest health disparities focused around the 5 Maricopa County Health Priorities.
- *HIPMC gets a lot of information from hospitals, surveys, etc. & so we are able to identify disparities & health needs within the community.*
- From a community aspect, able to visualize infrastructure existing for access to various health services, transportation, etc. so we are doing a good job in providing these types of things missing.
- *Have done a great job of portraying the message of being proactive about their own health; get the help you need; being able to take care of self.*
- *Maybe a generational issue? Some aged populations do not utilize assistance so maybe we should try reaching out to this type of population?*
- *Make sure that people are not only aware of service, but also take advantage of the services offered.*
- *We do a great job at identifying these types of things, but disconnect is within connecting the services/awareness to community members affected by the disparities.*
- *Issues in reaching out to various populations – we have a lack of data in these areas.*
- A reason for lack of data may be due to these types of people not wanting to be "labeled" or "categorized".
- We may need to collect this data in order to do things such as renewing grants, etc.
- *For example – in immunizations, there is an option to provide demographic data (minority groups, disabled, etc.).*
- *People do not like to be called "special populations" – they want to be considered "normal".*
- Gaps exist in population identity – people not necessarily wanting to share certain demographics.

- *However, we are not able to "un-gap-ify" this specific issue – people will always feel this way, possibly get offended, etc.*
- HIA experiences this issue as well, in needing to provide resources and awareness in a more general way.
- *"What are you doing with what I'm telling you?" "What is this data being used for?" very careful about over-sharing information.*
- Cultural diversity training is something we need to look into & be constantly vigilant of.
- *Cultural competency may be a gap or the key to bridging a gap.*
- *Defined roles & responsibilities – can be improved by increasing cultural competency among employees/community/partner agencies & organizations.*
- *Past negative experiences may impact the person & make them not want to participate in future opportunities & services provided to them.*
- *Cultural competency, time, trust all needed in these communities & to best communicate and reach out to them with services and opportunities offered and available to them.*
- *Part of improvement groups in Tolleson groups focusing on issues – as she grew up in, lives in, works in, has children in the area so is a valuable worker in coalitions as she can speak for and to the local community.*
- *Medicine programs have been working on informing the public on how to use 911 correctly, informing public on when to use 911 and when to call tele-nurses.*
- *We are doing a good job of identifying needs but we can still improve at actually meeting those needs.*
- *Issue of resources, poor do not have the resources and wealthy do have resources.*
- *The resources of these programs are low and we need to focus on the needs of those who have fewer resources to access.*
- Are we reassessing the needs to continually move to what community needs so we can adjust to meet unmet needs?
- *The groups with the highest needs try to communicate and voice their needs but there is just not enough resources to do what we need to for meeting these needs.*
- HIPMC uses data.
- *Cities/infrastructure is there: great job.*
- *Use of data: criteria for identification is great, possible gaps in population identification.*
- Cultural competency.
- *Not a strong connection: capacity, directory awareness & application, unique.*
- Identifying populations is easy from hospitals & surveys.
- *How accurate is the data because people often do not share their demographic info.*
- *Organizing the organizations to help exposed to these needs.*
- Understanding their personal barriers when it comes to being their own advocate, behavioral & mental barriers may cause them not to seek the medical attention they may need.
- *Tendency to focus on a select population.*
- *Assumptions of needs.*
- Community health workers.
- Hospital CHNAs.
- Population health at hospitals ACO.
- *The LPHS should have/collect this data but it needs to be shared in a clear, comprehensive way for the general public, with suggested plans of action.*
- *This is being done very well in our LPHS.*

- *Coordination of the system is where the work needs to be done.*
- *I think this is done very well and with a lot of sensitivity.*

Model Standard 2 – Ensuring people are linked to personal health services

- Obtaining many demographic data is difficult because people are reluctant to share this type of data (again, mistrust).
- People not wanting to be categorized or labeled a certain way.
- Big barrier in not seeking out mental/behavioral health resources!!
- Not being utilized; people feel they "can't".
- Self-advocacy is not there (generational gap?).
- We look at broad strokes and look down to specifics.
- Social service dignitaries are the main resources linking people to resources.
- Accessing mental/behavioral help is an issue (transportation access, etc.).
- Transportation is a big component – hospitals are very accessible for people to use EDs as their GP/primary care via ambulance.
- *People may not necessarily have access to transportation to and from clinics.*
- *Hospital case managers attempt to connect patients with needs, but there is not really a follow-up to finish barrier in mental health.*
- Many hospitals do have eligibility coordinators who discuss & look for factors involved with Medicare/Medicaid.
- Patients at hospitals not necessarily aware of patient assistance plans for payment – though they do exist at most hospitals.
- There are resources available and which provide such as food bank.
- Cover Arizona coalition linking people to exchange or access, organizations (hospitals) typically have enrollers/qualifiers/advocates for hospital programs.
- Special populations do have people focused on them but they are not systemic – issues do not get brought up.
- *Cultural competency is a big key that needs to be trained upon & resources provided to all types of health care providers & stakeholders – not all have embraced this as a key component, which ends up delaying services needed.*
- Doctor's instructions/follow-up/procedures may not necessarily line up with what a person know culturally, ethnically, etc.
- *Health inequity is an area of increasing awareness, but some institutions are still resistant to this being an issue so not putting efforts forward.*
- *Weak in the area of actually connecting solutions to health issues & opportunities/services offered & available to people.*
- *Many gaps exist in connecting various services and in connecting services to one another.*
- *There are efforts which hopefully may be changing and then implementing mental & behavioral health into physician health and wellness plans.*
- City Zoom Bus within West Valley (Tolleson, Avondale, etc.) is available but not necessarily utilized.
- *Need to walk community through the steps & explain how exactly the services available can be accessed.*
- *Connecting people to the available resources in their own communities is huge.*
- *Not good because we are not doing a good job, or not doing good because these communities are not willing to step out of their comfort zones and utilize something which is an entirely new concept; people who may not self-advocate or know how to best care for themselves – used to*

*self-sufficiency, childhood trauma & its effect, immigration, literacy, self-esteem → All factors that contribute to these barriers.*

- *Behavioral health integration – is technically a "special population" perhaps now we can be doing a better job at bridging gaps which exist between these groups and their resources.*
- *So, good and bad but there is a lot of opportunity there.*
- *Organizations do meet some of the community needs but can't always meet the full needs. Example a food bank opens in the community but there isn't sufficient transportation to help the community reach the food bank.*
- *For example hospitals can't get an uber for them because it can be viewed as them incentivizing use of their facility which is illegal. The use of taxi vouchers are hard because they usually give a 3 hour window to be picked up which isn't helpful to clients. We need Policy changes in this area and need research too!*
- *Improving the Affordable Care Act but change on this level takes a long time to implement.*
- *A group member works at a hospital where they have case managers who review cases as are discharged to suggest resources but it's really just here is a paper and not real assistance in how to navigate resources.*
- *Paramedicine in Scottsdale looks at a patient's information to assess their health needs and to also give more strategic suggestions of what they need.*
- *Most ACO's are doing case management and hospitals on varying levels have case managers too.*
- *Find Help Phoenix is a great resource again for the public.*
- *Hospitals are on bus routes but clinics generally are not as often on bus routes so people use hospitals for primary care needs because of their transportation accessibility.*
- *Paramedicine programs were doing well then saw a spike in readmissions. They are good at connecting patients to food and housing services but struggle with behavioral health connections.*
- *The Affordable Care Act is helping with connecting physical and mental health needs.*
- *American Heart Association has seen improvement with the discussion of the link of mental health with cardiovascular issues.*
- People are frightened to use the State Hospital unless there is no other choice.
- *Seems like a lot of the orgs are assisting in this and cross promoting.*
- Most nonprofit hospitals have financial assistance to assist on covering costs based on income levels and then work on checking on what clients might be eligible for.
- Change in 1st 8 years – 0-3 population may be undocumented.
- Used to have hundreds of referrals.
- Political environment changed.
- Even though referrals made by trusted sources, being able to gain trust of family is very difficult.
- Result – babies are not accessing care.
- *AHCCCS expansion better.*
- *Oral health & durable equip repairs hearing aids/visual aids – very difficult to access.*
- *Hard of/usually impaired growing – not prepared.*
- *Often care stops @ health insurance – bigger gaps.*
- *Big drift in independence of hearing/vision recovery aids, etc.*
- *Leader in & have community base > ALTEC.*
- *Current challenges with integration of mental & physical health because it is still new.*
- *We have a way to go with homeless population.*

- Have a lot of work to do around health insurance; next step: how are they utilizing.
- Health system – helping people sign up very helpful.
- *Broad strokes, sifting down to unique needs is a challenge.*
- *Cumbersome for people to get information.*
- Difficult for people to apply/utilize/understand their services.
- So complicated – how do you sign up.
- *Accessing physical/mental health is challenging.*
- *Transportation issues.*
- *Zip code base funding is a huge challenge.*
- Social service agencies are main source in lining people up to health.
- Integration
- Care first resource center
- Ensuring that the population is empowered to take responsibility for their own health & use the resources available.
- *Grassroots efforts, community-grown health ambassadors.*
- *Population identity: feeling vulnerable if they share too much.*
- *Negative experience does turn people away from connecting w/health services.*
- Paramedicine & telemedicine.
- *Loss of communications & lack of resources.*
- Lacking in transportation.
- Hospital case managers, paramedicine, Find Help Phoenix, 211, ACO.
- *Mental health is still an issue, but making progress.*
- Eligibility coordinators, FAP.
- *Partnerships and knowing where to send people is key.*
- *Request funding to meet this need.*

**Essential Service #8 – Assure a competent public health and personal healthcare workforce**

Model Standard 1 – Workforce assessment, planning and development

- Do we track the jobs?
- *MC has a process to do some workforce assessment somewhere in our organization.*
- I am not sure at the university where they have it- where students can look. I'm sure it is happening individually, so I would say at a moderate level.
- *Counties have much more rigid standards, but even those are somewhat limiting and I don't think other agencies that aren't forced to do it, actually do it.*
- *There was a broad generalized assessment done, but that may have not covered all the "Jelly bean" pieces. It is not a comprehensive system.*
- For our health department, we go along those health assessments and directly have trainings for that.
- There's no document that works with the whole system (not just the public health dept.).
- *We only do workforce assessment in public health, but we don't do any with other organizations.*
- It's not happening at the system wide level.
- To summarize, there is not a systems wide approach and even an individual level, it may or may not be shared.

Model Standard 2 – Public health workforce standards

- *I feel very confident that for example an entity, ensures that person has the right credentials. Or that the license or certificates are met.*

- *I feel like there are some organizations that should be required to have certain licenses and certificates, but there hasn't been much traction from the state to push the issues. Maybe some groups should have requirements, but they don't have them.*
- *You need to have enough people.*
- *There are places such as in the lab that do require, but in Education, you are required to have an education benchmark.*
- I hope most places are doing annual competency assessments.
- *Most people don't even know what the 10 essential health services are.*
- I know MC competencies are not spelled out clearly than other organizations.
- It can be aligned even if it is not explicitly stated. It can be multiple things, whether working for government entity or non-profit.
- How would you sum up ensuring, maintaining, and hiring and performance reviews?
- It may not be in the job description necessarily, but it is in the performance reviews. I'm curious on the first one.

<u>Model Standard 3 – Life-long learning through continuing education, training, and mentoring</u>

- *I think at MCDPH, we are good at identifying the needs, but there's a gap being able to figure which pocket of people that need it.*
- *Encouraging the workforce to participate in the available workforce training.*
- You can encourage people to do it, but if there aren't incentives or can't get time off work, it is more difficult.
- I think of as system barriers.
- The workload doesn't disappear. Yes I have the approval, but my workload won't go away.
- *Sometimes even when they come to trainings, they are not fully engaged because they are answering emails, etc.*
- *We do very well at advertising trainings due to all the systems and connected networks.*
- *Even HIPMC does a lot for connecting people. This is happening more.*
- *To summarize, there are opportunities, educational needs that can be addressed but there are barriers. Sometimes, they are available, but not provided to the right audience.*
- *ADHS and RHBS have had training built into the systems for a long time, they do that. I feel there is an emphasis in that area.*
- I agree with what's being said. We offer opportunities and trainings, but people don't take advantage. We offer credits for example, but sometimes people don't benefit or need those.

<u>Model Standard 4 – Public health leadership development</u>

- Developing leadership skills sometimes is not what we think. It could be for example developing communication skills, etc. And I'm struggling how to categorize that in my mind.
- *I know AZPHA is working on a mentorship/leadership program for example. That is still one gap in connecting leaders.*
- In terms of conversation, I am struggling with Q1. I think there's a lot of opportunities available, but I'm not sure there is enough diversity. But the first question, I'm not sure how to gage that.
- *Some of our internship programs have the experience where they get to sit with leadership at MCDPH.*
- I think it is difficult when you think of the corporate ladder. In health systems, there is typically not that ladder. It is more you jump in different positions and in a circular way where there are leadership opportunities.
- I see this more at a corporate level.
- I think nonprofits are better at promoting people.

- *I think there is staff who may not be supervisors, but if they are leading or coordinate a project, they are being a leader. I would say for Q3, I would rate it significant.*
- *It doesn't seem there are opportunities for targeted groups. It is more for everyone in general, but it is not specific targeted groups. It seems opportunities are increasing, but it isn't there yet.*
- How we engage communities with lived experience, at a system wide, we are good at engaging the community and finding their needs, but then are we involving community members as leaders who are harder to reach. If I look at it through that lens, I am not sure I struggle with that one.
- We are all white women in this room, I am not sure how representative we are in this group.

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

Model Standard 1 – Evaluating population-based health services

- *Clarification of what is being evaluated, specifically what we have.*
- Process goals are different than evaluation of how well they are working (intended impact).
- *Processes are working.*
- How many are doing evaluation?
- *Many orgs in HIPMC have not defined measurable outcomes.*
- Many orgs evaluating but what are they evaluating.
- Goals being met but goals don't indicate if services are working.
- Federal requirements for deliverables, state requirements.
- *More than there was 10 years ago, increased from state and federal.*
- *There are systems for evaluation but many are not creating goals which are measurable.*
- *We don't have larger pieces of the system; not enough knowledge.*
- *Could have effectiveness, but small reach.*
- *Maricopa Family Support Alliance engages many people, local initiative with national standards.*
- Hospitals have many quality improvement efforts; established guidelines; difficult to evaluate at systems level.
- Monitors gaps within medical professions; not sure if it's quality.
- *Accessibility but not effectiveness measured at PHS level.*
- ACA monitors reoccurring, admittance; personal health = public health effects.
- *Some groups investing in telemedicine offering rural areas access; Mayo, UofA.*
- Poison control, EMS data. Not yet analyzing data.
- *Social Network Analysis tool with HIPMC, identification of orgs doing 10 E.S.*
- *Involving all entities; bounded network with SNA; difficult to have exhaustive list; always balancing network effectiveness and inclusion of other members.*

Model Standard 2 – Evaluating personal health services

- Through focus groups/surveys.
- Customer satisfaction surveys.
- *HIPMC asks if public health system is doing a good job; CHA survey good representation; as a community members never been asked about this.*
- Not sure the CHA survey addressed satisfaction.
- Evaluation occurs through programs at most levels.
- Satisfaction assessed; not included on BRFSS.
- *Customer satisfaction survey only getting feedback from those who show up – may not be representative.*

- *Those who don't show have no opportunity to be satisfied or not satisfied.*
- *Hope that future community meetings will address.*

Model Standard 3 – Evaluating the local public health system

- *Often duplication exists and not filling gaps.*
- *Not good deliberately, formally, but could probably all identify similar gaps.*
- *If not evaluating well, not assessing community well, how can we identify gaps?*
- *May be done individually, but not at a systems level.*
- CHA is gap analysis.
- *Not centralized, but many of the jelly beans are doing it at their individual level.*
- Those that do have evaluation finding, they use them.

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

Model Standard 1 – Fostering innovation

- Many entities on jellybean diagram have ideas, but not involved in whole process; is it working the way it is supposed to work? Some do this, but many do not test before implementation; not collecting data.
- Some smaller agencies don't have training to develop evaluations or test; test is implementation; disconnect between best practice and innovation.
- *Lacking resources/knowledge to pilot test; document.*
- Surveillance techniques/academics are prepared for this type of research; maybe not system wide.

Model Standard 2 – Linking with institutions of higher learning and/or research

- *LPHS does a good job of engaging students and faculty and community; Faculty also wants to connect.*
- *We have solid resources; solid skills; good to work with; barriers are often financial; great track record.*
- *Emphasis on Community Based Participatory Research at the University of Arizona MEZCOPH.*

Model Standard 3 – Capacity to initiate or participate in research

- When it's done, it's done well; often can't happen because of resource limitations.
- System wide there are resources, there are also researchers looking for funding; is the money being used appropriately?
- Collaboration happens, but how often? Not as much as possible.
- Public health research occurring in all stages of projects.
- Research project example which lacks evaluation due to time and resource constraints.