

# **REPORT**

## **Texas Heart Disease and Stroke State Public Health System Assessment**

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## INTRODUCTION

This report documents results from the Heart Disease and Stroke State Public Health System Assessment (HDSSPHSA) held on 11/1/06 – 11/2/06 in Austin, Texas.

- 97 individuals participated in the conference;
- 51 organizations were represented at the conference; and
- Conference participants came from 25 cities across Texas. (Conference participants are listed in APPENDIX C.)

This report<sup>1</sup> represents a significant first step by public health partners across Texas to improve the Heart Disease and Stroke State Public Health System (HDSSPHS) in Texas using the National Public Health Performance Standards (NPHPS). (For information about NPHPS, refer to: [www.cdc.gov/od/ocphp/nphps/](http://www.cdc.gov/od/ocphp/nphps/).) The HDSSPHS is defined as all public, private and voluntary organizations in Texas that contribute to the public's health and the well being in regards to heart disease and stroke. This system collectively, rather than the Texas Department of State Health Services (DSHS) was the focus of the assessment conference. The assessment tools and process were patterned after the Texas State Public Health System Assessment (TSPHSA) held in July 2006.

Based on the strengths and weaknesses identified in the HDSSPHSA, a HDSSPHS Improvement Plan will be developed and implemented. The plan will place emphasis on providing decision-makers with “business cases” to assist them in improving the HDSSPHS in Texas.

In September 2006, Jennifer Smith, MSHP, Manager, Adult Health and Chronic Disease Group, Department of State Health Services (DSHS) welcomed representatives from key health related organizations in Texas as the steering committee to implement the HDSSPHSA. (Steering committee members are listed in APPENDIX D.)

After reviewing “lessons learned” from the TSPHSA, and the Texas Diabetes Program who previously implemented the national

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<sup>1</sup> Information/updates concerning the HDSSPHSA will be posted on the Texas Council on Cardiovascular Disease and Stroke website: [www.texascvdcouncil.org](http://www.texascvdcouncil.org). For questions regarding the HDSSPHSA and/or this report, please contact Jennifer Smith at [Jennifer.smith@dshs.state.tx.us](mailto:Jennifer.smith@dshs.state.tx.us) or Brett Spencer at [brett.spencer@dshs.state.tx.us](mailto:brett.spencer@dshs.state.tx.us) (512) 458-7200.

performance standards assessment in 2003 for diabetes in Texas, the steering committee decided to implement the SPHSA during a three-day CVD and Stroke Summit. The steering committee identified 248 subject matter experts from 167 public and private organizations across Texas to invite to the Summit. The steering committee assigned individuals to an assessment group based on their expertise and experience. For example, individuals with expertise or experience in health policy issues were assigned to the “policy” assessment group.

During the first day of the summit, participants learned about the burden of heart disease and stroke in the U.S. and Texas from Dr. Darwin Labarthe, Director, (Centers for Disease Control and Prevention Health Disease and Stroke Division), Mark Schoeberl, Vice President, (American Heart Association and Vice Chair of the National Forum on Heart Disease and Stroke) and Dr. Bob Hillert, Cardiologist, (Member of the Texas Medicaid Program Pharmaceutical and Therapeutic Committee). Additional presentations were made to discuss the purpose and process of the HDSPHSA by Mike Gilliam and Mike Messinger, Program Staff, (Center for Program Coordination, DSHS)

On the second day, participants were divided into five assessment groups to complete the HDSSPHSA Instrument. The HDSSPHSA Instrument was a revised versions of the revised (2006) field test version of the original instrument used at the TSPHSA conference, provided by CDC. (Summit agenda is listed in APPENDIX B.)

## ASSESSMENT PROCESS

HDSSPHSA assessed the Ten Essential Public Health Services (ES) for heart disease and stroke:

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

Each ES was assessed based on four indicators:

1. Planning & Implementation;

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

Three to five assessment questions were associated with each indicator, and each assessment question was assigned one of the five values below. The value assigned to the assessment question was based on assessment group consensus.

- A. Optimal (means 76-100% of the optimal standards are met);
- B. High Partial (means 51-75% of the optimal standards are met);
- C. Low Partial (means 26-50% of the optimal standards are met);
- D. Minimal (means 1-25% of the optimal standards are met); and
- E. No Activity (means 0% of the optimal standards are met).

Each of the four indicators were also assigned a value for the following two questions:

1. “How much of this Model Standard/indicator (e.g., Planning & Implementation) is achieved by the HDSSPHS collectively?”
2. “How much of this Model Standard/indicator (e.g., Planning & Implementation) is achieved through the direct contribution of the state public health agency (DSHS)?”

For example, on ES4 (Partnership), three indicators were given an assessment value of “minimal.” The assessment value “minimal” meant that between 1-25% of the “optimal standards” were met. One indicator was given an assessment value of “low partial”, which meant that between 26%-50% of the “optimal standards” were met.

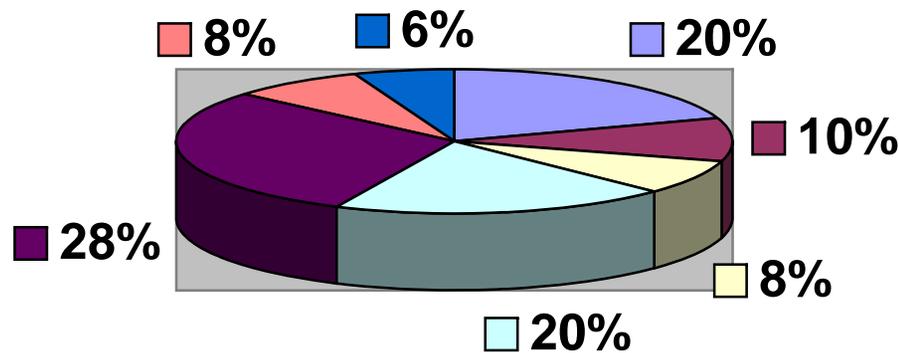
Each assessment question and score/value is in APPENDIX A. For example, all the assessment questions and scores regarding ES4 are listed.

Examples of comments captured during the assessment groups are outlined in the “Assessment Group Comments.” Assessment Group Comments are also listed in APPENDIX A.

RESULTS AND ANALYSIS

<b>SPHSA RESULTS</b>	<b>EPHS 1 Monitor</b>	<b>EPHS 2 Diagnosis</b>	<b>EPHS 3 Educate</b>	<b>EPHS 4 Partnership</b>	<b>EPHS 5 Policy</b>	<b>EPHS 6 Enforce</b>	<b>EPHS 7 Link</b>	<b>EPHS 8 Workforce</b>	<b>EPHS 9 Evaluation</b>	<b>EPHS 10 Research</b>
<b>A. Planning &amp; Implementation</b>										
<i>Met by SPHS Collectively</i>	Low Partial	Low Partial	Minimal	Minimal	Low Partial	Low Partial	Low Partial	Low Partial	Low Partial	High Partial
<i>DSHS' Contribution</i>	Minimal	Minimal	Minimal	Minimal	Low Partial	High Partial	Low Partial	Minimal	Minimal	Low Partial
<b>B. State-Local Relationships</b>										
<i>Met by SPHS Collectively</i>	Low Partial	Low Partial	Low Partial	Minimal	Low Partial	Low Partial	High Partial	Minimal	Minimal	Low Partial
<i>DSHS' Contribution</i>	Minimal	Minimal	Minimal	Minimal	Minimal	Low Partial	Low Partial	Minimal	Minimal	High Partial
<b>C. Performance Management &amp; Quality Control</b>										
<i>Met by SPHS Collectively</i>	Low Partial	High Partial	Minimal	Minimal	Low Partial	Minimal	Low Partial	Low Partial	Minimal	Low Partial
<i>DSHS' Contribution</i>	Low Partial	Minimal	Minimal	Minimal	Minimal	Low Partial	Minimal	Minimal	Minimal	Low Partial
<b>D. Public Health Capacity &amp; Resources</b>										
<i>Met by SPHS Collectively</i>	High Partial	Low Partial	Minimal	Low Partial	Low Partial	Minimal	Low Partial	Low Partial	Minimal	Low Partial
<i>DSHS' Contribution</i>	Low Partial	Minimal	Minimal	Low Partial	Low Partial	Minimal	Minimal	Minimal	Minimal	Low Partial

The figure below shows the types of organizations that participated in the HDSSPHSA Conference. The category of “State Agencies” include health related state agencies, state governmental councils or boards, and other state agencies that support cardiovascular health or health education. “Universities” includes universities and colleges, schools of public health, health science centers and medical schools. “Non-Profit/ Professional Associations” includes not for profit agencies such as the American Heart Association and Gateway to Care. This category also includes professional associations such as the Texas Public Health Association and the Black Nurses Association. The “Healthcare” category includes hospitals, health insurers, EMS Providers, and private practice health care providers. “Private Corporations” includes cardiovascular health related for-profit companies, such as pharmaceutical companies and ROI, Inc. “Other Organizations” includes health foundations such as the Paso del Norte Health Foundation and local agencies such as the El Paso Fire Department, and the Healthier Houston/Harris County Consortium.



For the HDSSPHS collectively, participants judged 12 of the 40 model standards performance as minimal (1-25%), 24 as low partial (26-50%) and 4 as high partial (51-75%). None of the standards were judged as either zero or optimal performance (76-100%). Across the essential services, system performance was rated highest for ES2 (Diagnose/Investigate) and lowest for ES3 (Inform/Educate), ES4 (Mobilize Partnerships) and ES9 (Evaluate). Across the model standards, scores were lowest for performance management and quality control.

DSHS' contribution to system performance was assessed as minimal (1-25%) for 26 model standards, low partial (26-50%) for 12 model standards, high partial (51-75%) for 2 standards. No standard received a score of zero or optimal. Across the essential services, DSHS' contribution was highest for ES10 (Research) and lowest for ES 3 (Inform), ES8 (Workforce), and ES9 (Evaluate). Across the model standards, DSHS contribution was lowest for state-local relationships and performance management -control and highest for public health capacity.

## SUMMARY AND RECOMMENDATIONS

This assessment collected information relevant to the performance of the Texas HDSSPHS by means of a statewide summit convened in November of 2006. The conference was attended by 97 individuals representing more than 51 organizations from 25 cities around the state. A limitation of the summit was that it was not well attended by more stakeholders, who may have been able to provide a more complete assessment of HDSPHS. With this caveat, most participants felt that the assessment provided an opportunity for exchanging information and expert opinion among important system partner organizations.

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

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

As this process moves beyond the system assessment phase into the system improvement planning, phase the Steering

Committee and summit organizers offer four recommendations.

**Maintain Communication with System Partners Identified Through this Assessment.** If the diverse set of organizations involved in providing essential public health services for heart disease and stroke awareness, detection, treatment and control in Texas is to function as an integrated, collaborative system, they must see themselves as part of a community of common interest. The Governor-appointed Texas Council on Cardiovascular Disease and Stroke, created by the Texas Legislature in 1999, is positioned to build and maintain that sense of identity. The HDSSPHSA Conference was an initial step in the process. Assessment findings and “next steps” should be communicated as widely as possible to meeting participants and other interested stakeholders.

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

**Develop Strategies for Performance Improvement.** As part of this process, the system partners will set collaborative goals as well as develop individual organizational goals that are aligned with the overall system goals. It is particularly essential that state agencies who impact determinants of health are continually included in these planning efforts. The health of Texans are a joint responsibility, not just one of a single agency or organization.

**Convene Partners around Priorities.** To coordinate how the system advances towards meeting “high-priority goals,” partners will meet on a regular basis to report on activities.

In conclusion, it is recommended that performance assessment and improvement efforts take place at all levels of the public health system: state, regional and local.

Please direct questions regarding the HDSSPHSA and/or this report to Jennifer Smith at [Jennifer.Smith@dshs.state.tx.us](mailto:Jennifer.Smith@dshs.state.tx.us) or Brett Spencer at [Brett.Spencer@dshs.state.tx.us](mailto:Brett.Spencer@dshs.state.tx.us) or by telephone at (512) 458-7200.

## APPENDIX A

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

ES1: Monitor Health Status to Identify Health Problems		Score(s)
Indicator 1: Planning and Evaluation	1A. Does the SPHS operate surveillance system(s) designed to measure the health status of the state's population for heart disease and stroke?	Low Partial (26-50%)
	1B. Does the SPHS publish health-related data into a state health profile describing the prevailing health of the state's population for heart disease and stroke ?	Minimal (1-25%)
	1C. Does the SPHS compile and provide health data on heart disease and stroke in useable products to a variety of health data users?	Minimal (1-25%)
	1D. Does the SPHS operate a data reporting system designed to identify potential threat to the public's health regarding heart disease and stroke?	No Activity (0%)
	1E. Does the SPHS enforce established laws and the use of protocols to protect personal health information and other data related to heart disease and stroke?	Optimal (76% - 100%)
	How much of the Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 2: State-Local Relations	2A. Does the SPHS offer technical assistance (e.g., training consultations) to local public health systems in the interpretation and use of health-related data on heart disease and stroke?	Minimal (1-25%)
	2B. Does the SPHS regularly provide local public health systems a uniformed set of local health-related data on heart disease and stroke?	Low Partial (26 - 50%)
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	Low Partial (26%-50%)
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review the effectiveness of its efforts to monitor health status on heart disease and stroke?	Low Partial (26-50%)
	3B. Does the SPHS manage the overall performance of its health status monitoring activities?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)

ES1: Monitor Health Status to Identify Health Problems (Continued)		
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to health status monitoring efforts on heart disease and stroke?	High Partial (51-75%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to monitor health status?	High Partial (51-75%)
	4C. Does the SPHS utilize workforce expertise to carry out health status monitoring activities?	Optimal (76-100%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	High Partial (51-75%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Assessment Group Comments	1A. Lack of communication between state health department and local communities.	
	2A. Participants thought there is a decent job on hear disease but not on stroke.	
	3B. There is no marketing team or any way to get the message out.	
	4B. Lots of leadership is out there from hospitals and other places.	

ES2: Diagnose and Investigate Health Problems and Health Hazards		Score(s)
Indicator 1: Planning and Evaluation	1A. Does the SPHS operate surveillance system(s) that identify and analyze health problems and threats to the health of the state's population on heart disease and stroke?	Optimal (76-100%)
	1B. Does the SPHS have laboratories that have the capacity to analyze clinical and environmental specimens for heart disease and stroke?	Optimal (76-100%)
	1C. Does the SPHS implement plans to investigate and respond to identified public health threats?	Optimal (76-100%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide assistance to local public health systems in the interpretation of epidemiological findings on heart disease and stroke?	Low Partial (26-50%)
	2B. Does the SPHS provide laboratory assistance to local public health systems?	Not Applicable
	2C. Does the SPHS provide local public health systems with information and guidance about public health problems related to heart disease and stroke?	High Partial (51-75%)
	2D. Does the SPHS provide trained personnel on-site to assist local communities in the investigations of public health problems related to heart disease and stroke?	Low Partial (26-51%)
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (State-Local Relations) is achieved through the direct	Minimal (1-25%)

	contribution of the state public health agency (DSHS)?	
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS periodically review the effectiveness of the state surveillance and investigation system?	Low Partial (26-50%)
	3B. Does the SPHS actively manage the overall performance of its activities to diagnose and investigate health problems and health hazards related to heart disease and stroke?	High Partial (51-75%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	High Partial (51-75%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

ES2: Diagnose and Investigate Health Problems and Health Hazards (Continued)		Score(s)
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to support the diagnosis and investigation of health problems and hazards?	High Partial (51-75%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to diagnose and investigate health hazards and health problems?	Low Partial (26-50%)
	4C. Does the SPHS utilize workforce expertise to identify and analyze public health threats and hazards related to heart disease and stroke?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

Assessment Group Comments	1A. <i>We collect the data but then what?</i>
	2D. <i>There is not a single coordinate training entity.</i>
	3B. <i>We might need an overarching statewide group or committee that can manage quality efforts.</i>
	4C. <i>The ones we have are skilled, but there are not nearly enough.</i>

<b>ES3: Inform, Educate and Empower People About Health Issues</b>		<b>Score(s)</b>
Indicator 1: Planning and Evaluation	1A. Does the SPHS design and implement health education and promotion interventions for heart disease and stroke prevention?	Minimal (1-25%)
	1B. Does the SPHS design and implement effective health communications on heart disease and stroke?	Minimal (1-25%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems (e.g., through consultation, training and/or policy changes) to develop skills and strategies to conduct health communication and health education and promotion programs on heart disease and stroke?	Low Partial (26-50%)
	2B. Does the SPHS assist local public health systems to effectively target health communication and health education and promotion strategies for heart disease and stroke to populations at risk of poor health?	Minimal (1-25%)
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	Low Partial (26-51%)
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS periodically review the effectiveness of health communication, health education and promotion interventions?	Low Partial (26-51%)
	3B. Does the SPHS actively manage the overall performance of its activities to inform, educate and empower people about health issues?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to support health communication and health education and promotion efforts on heart disease and stroke?	Low Partial (26-50%)
	4B. Does the SPHS use its organizational leadership to align and coordinate system-wide efforts to implement health communication and health education and promotion services?	Minimal (1-25%)
	4C. Does the SPHS use a workforce skilled in delivering effective health communications and health education and promotion services?	High Partial (51-75%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

ES3: Inform, Educate and Empower People About Health Issues (Continued)	
Assessment Group Comments	1A. No coordination statewide - no sense that anyone knows what the others are doing.
	2B. There is no clear leader in this area.
	3A. This is minimal, parts of the system do this quite well, but not good as a whole.

ES4: Mobilize Partnerships to Identify and Solve Health Problems		Score(s)
Indicator 1: Planning and Evaluation	1A. Does the SPHS build statewide support for heart disease and stroke?	Low Partial (26-50%)
	1B. Does the SPHS organize partnerships to identify and solve health problems?	Minimal (1-25%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide assistance (e.g., through consultations, training, etc.) to local public health systems to build partnerships for community health improvement?	Low Partial (26-50%)
	2B. Does the SPHS take action to facilitate the development of local partnerships?	Minimal (1-25%)
	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review the participation and commitment of its partners?	Minimal (1-25%)
	3B. Does the SPHS evaluate its partnership development activities?	Minimal (1-25%)
	3C. Does the SPHS actively manage the overall performance of its partnership development activities?	No Activity (0%)
	How much of this Model Standard (Performance Management and Quality Improvement) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Improvement) is	Minimal (1-25%)

	achieved through the direct contribution of the state public health agency (DSHS)?	
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to sustain partnerships?	Low Partial (26-50%)
	4B. Does the SPHS exercise organizational leadership to align and coordinate its efforts to mobilize partnerships?	Minimal (1-25%)
	4C. Does the SPHS use a workforce skilled in partnership development?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)

ES4: Mobilize Partnerships to Identify and Solve Health Problems (Continued)		
Assessment Group Comments	4A. Resources not enough	
	4C. The people that are there are skilled, there are just not enough of them.	
	2A. this is being done a lot, there are a lot of collaboratives	
	3B. Evaluation may be happening in some areas, but it is uncommon.	
	3C. "We don't have time because we have to go from one legislative issue to another..."	

ES5: Develop Policies and Plans that Support Individual and Statewide Health Efforts		Score(s)
Indicator 1: Planning and Evaluation	1A. Does the SPHS implement statewide health improvement processes that convene partners and facilitate collaboration among organizations contributing to the public's health?	High Partial (51-75%)
	1B. Does the SPHS develop a state health improvement plan to guide its collective efforts to improve health and the public health system for heart disease and stroke?	High Partial (51-75%)
	1C. Does the SPHS conduct policy development activities?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance and training to local public health systems for developing local plans on heart disease and stroke?	Low Partial (26-50%)
	2B. Does the SPHS provide support and assistance for the development of community health improvement plans for addressing the statewide health improvement strategies?	Minimal (1-25%)
	2C. Does the SPHS provide technical assistance in local health policy development?	High Partial (51-75%)

	How much of this Model Standard (State-Local Relations) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (State-Local Relations) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review progress towards accomplishing health improvements across the state?	Low Partial (26-50%)
	3B. Does the SPHS review new and existing policies to determine the public health impacts of those policies on a predetermined, periodic basis?	High Partial (51-75%)
	3C. Does the SPHS actively manage the overall performance of its planning and policy development activities?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

ES5: Develop Policies and Plans that Support Individual and Statewide Health Efforts (Continued)		Score(s)
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to health planning and policy development efforts?	Low Partial (26-50%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to implement health planning and policy development?	Minimal (1-25%)
	4C. Does the SPHS utilize workforce expertise in planning?	High Partial (51-75%)
	4D. Does the SPHS use its workforce expertise in health policy?	High Partial (51-75%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Assessment Group Comments	1A. Assuming there is a State Public Health System is assuming alot.	
	2A. Lack of funding at the state level for CVD and stroke	
	3C. Not enough time/manpower issues	
	4B. Great Leaders in CVD, tobacco, obesity	

<b>ES6: Enforce Laws and Regulations that Protect Health and Ensure Safety</b>		<b>Score(s)</b>
Indicator 1: Planning and Evaluation	1A. Does the SPHS assure existing and proposed state laws are designed to protect the public's health and ensure safety for heart disease and stroke?	High Partial (51-75%)
	1B. Does the SPHS assure that laws give state and local authorities the power and ability to prevent, detect, manage, and contain emergency health threats related to heart disease and stroke, balanced with the right to due process?	No Activity (0%)
	1C. Does the SPHS provide education to encourage compliance with laws that protect health and ensure safety for heart disease and stroke?	High Partial (51-75%)
	1D. Does the SPHS ensure that administrative processes are customer-centered (e.g., obtaining permits and licenses)?	No Activity (0%)
	1E. Have collaborative relationships been developed between SPHS members and persons and entities in the regulated environment to support compliance activities?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	High Partial (51-75%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems in compliance and enforcement activities of laws that protect health and ensure safety?	Low Partial (26-50%)
	2B. Does training of local public health system members on the enforcement of laws incorporate current scientific knowledge and best practices from compliance?	Minimal (1-25%)
	2C. Does the SPHS partner with local governing bodies in reviewing, improving and developing local laws?	High Partial (51-75%)
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review the effectiveness of its regulatory programs and activities?	Low Partial (26-50%)
	3B. Does the SPHS actively manage the overall performance of its regulatory programs and activities?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)

<b>ES6: Enforce Laws and Regulations that Protect Health and Ensure Safety (Continued)</b>		<b>Score(s)</b>
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to the enforcement of laws that protect health and ensure safety?	Minimal (1-25%)
	4B. Does the SPHS use its organizational leadership to align and coordinate systemwide resources to implement enforcement activities?	Minimal (1-25%)
	4C. Does the SPHS use personnel with expertise in the enforcement of laws that protect health and ensure safety?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Assessment Group Comments	1A. <i>we are not good at changing behavior</i>	
	2B. <i>Not an effective public health system</i>	
	3A. <i>AHA monitors effectiveness of laws related to CVD and stroke every year</i>	
	4A. <i>Manpower investments to review not enforce</i>	

<b>ES7: Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable</b>		<b>Score(s)</b>
Indicator 1: Planning and Evaluation	1A. Does the SPHS assess the availability of personal health care services for heart disease and stroke to the state's population?	High Partial (51-75%)
	1B. Through collaborations with local public health systems, does the SPHS take action to eliminate barriers to access personal health care?	Low Partial (26-50%)
	1C. Does the SPHS have an entity responsible for monitoring and coordinating personal health care delivery within the state?	High Partial (51-75%)
	1D. Does the SPHS mobilize its assets, including local public health systems, to reduce health disparities in the state for heart disease and stroke?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Implementation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Implementation) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)

Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems on methods to assess and meet the needs of underserved populations?	High Partial (51-75%)
	2B. Does the SPHS provide technical assistance to safety-net providers who deliver personal health care to underserved populations?	High Partial (51-75%)
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	High Partial (51-75%)
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the SPHS review programs that assure the provision of personal health care services within the state?	Low Partial (26-50%)
	3B. Does the SPHS monitor personal health care quality and institute change in programs designed to assure personal health care based on findings?	High Partial (26-50%)
	3C. Does the SPHS actively manage the overall performance of its activities to link people to needed personal health care services?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

ES7: Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable (Continued)		Score(s)
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to assure the provision of personal health care?	Low Partial (26-50%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its system-wide resources to effectively provide needed personal health care?	Low Partial (26-50%)
	4C. Does the SPHS use workforce skilled in carrying out the functions of linking people to needed personal health care?	High Partial (51-75%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

<b>ES8: Assure a Competent Public and Personal Health Care Workforce</b>		<b>Score(s)</b>
<b>Indicator 1: Planning and Evaluation</b>	1A. Does the SPHS conduct assessments of its workforce needs to deliver effective population-based and personal health care services for heart disease and stroke in the state?	Low Partial (26-50%)
	1B. Does the SPHS develop a statewide workforce plan(s) to guide its activities in workforce development? (Note: the SPHS may have one or more workforce plans, but the plan(s) should address both population-based and personal health care workforce.	Low Partial (26-50%)
	1C. Does the SPHS human resources development programs provide training to enhance needed workforce skills?	Low Partial (26-50%)
	1D. Does the SPHS assure that individuals in the population-based and personal health care workforce achieve the highest level of professional practice in heart disease and stroke?	Minimal (1-25%)
	1E. Does the SPHS support initiatives that encourage life-long learning?	Minimal (1-25%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
<b>Indicator 2: State-Local Relations</b>	2A. Does the SPHS assist local public health systems in completing assessments of their population-based and personal health care workforces for heart disease and stroke?	Minimal (1-25%)
	2B. Does the SPHS assist local public health systems with workforce development?	Minimal (1-25%)
	2C. Does the SPHS assure the availability of educational course work and training to enhance the skills of the workforce of local public health systems?	Low Partial (26-50%)
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
<b>Indicator 3: Performance Management and Quality Improvement</b>	3A. Does the SPHS review its workforce development activities for heart disease and stroke?	Minimal (1-25%)
	3B. Does the SPHS evaluate its pre-service and in-service education and training programs?	Low Partial (26-50%)
	3C. Does the SPHS stimulate quality improvement of the personal health care and public health workforce?	Low Partial (26-50%)
	3D. Does the SPHS actively manage the overall performance of its workforce development activities?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

<b>ES8: Assure a Competent Public and Personal Health Care Workforce (Continued)</b>		<b>Score(s)</b>
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to workforce development efforts for heart disease and stroke?	Low Partial (26-50%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its system-wide resources to effectively conduct workforce development activities?	Minimal (1-25%)
	4C. Does the SPHS utilize expertise in management of human resource development programs?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Assessment Group Comments		

<b>ES9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services</b>		<b>Score(s)</b>
Indicator 1: Planning and Evaluation	1A. Does the SPHS routinely evaluate population-based health programs within the state for heart disease and stroke?	Low Partial (26-50%)
	1B. Does the SPHS evaluate the effectiveness of personal health services within the state?	High Partial (51-75%)
	1C. Does the SPHS establish and/or use standards to assess the performance of the state public health system for heart disease and stroke?	Minimal (1-25%)
	How much of this Model Standard (Planning and Implementation) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Planning and Implementation) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance (e.g., consultations, training) to local public health systems in their evaluations?	Low Partial (26-50%)
	2B. Does the SPHS share results of state-level performance evaluations with local public health systems for use in local planning processes?	Minimal (1-25%)
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS	Minimal (1-25%)

	collectively?	
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the state regularly monitor its evaluation activities for heart disease and stroke?	Minimal (1-25%)
	3B. Does the SPHS evaluate its evaluation and quality improvement activities when weaknesses in program or service quality become apparent?	Minimal (1-25%)
	3C. Does the SPHS actively manage the overall performance of its evaluation activities?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources for evaluation?	Low Partial (26-50%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its system-wide resources to effectively conduct evaluation activities?	Minimal (1-25%)
	4C. Does the SPHS use workforce skilled in carrying out evaluation activities?	Minimal (1-25%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Minimal (1-25%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)

<b>ES9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services (Continued)</b>		
Assessment Group	<i>1B. Weaknesses of all is the integration of evaluation findings into State Health Improvement Activities</i>	
Comments	<i>2A. QI training is being provided</i>	
	<i>3B. On the local level there is monitoring</i>	
	<i>4C. There is a disconnect between the local health departments and state health department</i>	

ES10: Research for New Insights and Innovative Solutions to Health Problems		Score(s)
Indicator 1: Planning and Evaluation	1A. Does the SPHS maintain an active academic-practice collaboration to promote and organize research activities and disseminate and use research findings in practice on heart disease and stroke?	High Partial (51-75%)
	1B. Does the SPHS have a public health research agenda on heart disease and stroke?	Minimal (1-25%)
	1C. Does the SPHS implement its public health research agenda by participating and conducting research?	No Activity (0%)
	How much of this Model Standard (Planning and Evaluation) is achieved by the SPHS collectively?	High Partial (51-75%)
	How much of this Model Standard (Planning and Evaluation) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Indicator 2: State-Local Relations	2A. Does the SPHS provide technical assistance to local public health systems with research activities?	Low Partial (26-50%)
	2B. Does the SPHS assist local public health systems in their use of research findings?	High Partial (51-75%)
	How much of this Model Standard (State-Local Relationships) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (State-Local Relationships) is achieved through the direct contribution of the state public health agency (DSHS)?	Minimal (1-25%)
Indicator 3: Performance Management and Quality Improvement	3A. Does the state monitor its public health research activities on heart disease and stroke?	Minimal (1-25%)
	3B. Does the SPHS actively manage the overall performance of its research activities?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Performance Management and Quality Control) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)
Indicator 4: Public Health Capacity and Resources	4A. Does the SPHS commit financial resources to research relevant to health improvement for heart disease and stroke?	High Partial (51-75%)
	4B. Does the SPHS use its organizational leadership to align and coordinate its efforts to conduct research activities?	Low Partial (26-50%)
	4C. Does the SPHS utilize its workforce expertise to conduct and participate in research activities?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved by the SPHS collectively?	Low Partial (26-50%)
	How much of this Model Standard (Public Health Capacity and Resources) is achieved through the direct contribution of the state public health agency (DSHS)?	Low Partial (26-50%)

ES10: <b>Research for New Insights and Innovative Solutions to Health Problems</b> (Continued)	
Assessment Group Comments	<i>1A. Heart Disease Research is mostly done non-collaboratively</i>
	<i>2A. Local public health does not have time to do research</i>
	<i>3B. Disconnection between the systems and associations (members of the system)</i>
	<i>4C. The research is not being driven by the system</i>

APPENDIX B

**2006 Cardiovascular Disease and Stroke Summit  
Texas Heart Disease and Stroke Prevention/Treatment Assessment  
November 1 – 3, 2006  
Summit Program**

**November 1, 2006**

11:30 - 1:00 pm	Conference check-in	
	<b>Opening Session</b>	
1:00 – 1:15 pm	<b>Welcome and Opening Remarks</b>	<b>Room 3.102</b>
	<b>Jennifer Smith, MSHP</b> , President, Texas Public Health Association	
1:15 – 2:00 pm	<b>National Actions on Heart Disease and Stroke</b>	
	<b>Darwin Labarthe, MD, MPH, PhD</b> , Director, Division for Heart Disease and Stroke Prevention, National Center for Chronic Disease and Health Promotion, Coordinating Center for Health Promotion, Centers for Disease Control and Prevention; Chair, National Forum for Heart Disease and Stroke Prevention	
	<b>Mark Schoeberl, MPA</b> , Executive Vice President, Advocacy, American Heart Association; Vice-Chair, National Forum for Heart Disease and Stroke Prevention	
2:00 – 2:45	<b>State Actions on Heart Disease and Stroke</b>	<b>Room 3.102</b>
	<b>Michael M Hawkins, MD</b> , Chair, Texas Council on Cardiovascular Disease and Stroke	
	<b>Melbert (Bob) C. Hillert, MD, FACC</b> , Cardiologist, Member, Medicaid Pharmaceutical and Therapeutic Committee	
2:45 – 3:00 pm	Break	
3:00 – 4:00 pm	<b>National Public Health Performance Standards and the Ten Essential Public Health Services</b>	<b>Room 3.102</b>
	<b>Mike Gilliam, Jr, MSW, MPH</b> , Texas Department of State Health Services, Center for Program Coordination	

**Mike Messinger**, Texas Department of State Health Services, Center for Program Coordination

4:00 – 5:00 pm

**Mapping Organizational Roles in Heart Disease  
and Stroke Public Health Services**

**Room 3.102**

**Brett Spencer**, Program Specialist, Cardiovascular Health and Wellness Program, Texas Department of State Health Services

**Reuben Parrish, MPH, CHES**, Program Specialist, Cardiovascular Health and Wellness Program, Texas Department of State Health Services

**November 2, 2006**

8:30 - 10:30am

**Breakout Groups:**

**ES 1** – Monitor Health Status to Identify Health Problems in Heart Disease and Stroke

**Room 3.110**

**ES 3** – Inform, Educate and Empower People about Heart Disease and Stroke Health Issues

**Room 3.102**

**ES 5** – Develop Policies and Plans that Support Individual and Statewide Heart Disease and Stroke Health Efforts

**Room 1.124**

**ES 7** – Link People to Needed Personal Health Services for Heart Disease and Stroke and Assure the Provision of Health Care for Heart Disease and Stroke When Otherwise Unavailable

**Room 3.122**

**ES 9** – Evaluate Effectiveness, Accessibility and Quality of Personal and Population-Based Health Services for Heart Disease and Stroke Prevention

**Room 1.126**

10:30–10:45 am

Break

10:45 – 12:00

**Breakout Group Reports**

**Room 3.102**

12:00–12:15 pm	<b>Break/Lunch Pick-up</b>	
12:15 - 2:15pm	<b>Working Lunch and Breakout Groups:</b>	
	<b>ES 2</b> – Diagnose and Investigate Heart Disease and Stroke Health Problems and Health Hazards	<b>Room 3.110</b>
	<b>ES 4</b> - Mobilize Partnerships to Identify and Solve Heart Disease and Stroke Health Problems	<b>Room 3.102</b>
	<b>ES 6</b> – Enforce Laws and Regulations that Protect Heart Disease and Stroke Health and Ensure Safety	<b>Room 1.124</b>
	<b>ES 8</b> – Assure Competent Public and Personal Healthcare Workforce for Heart Disease and Stroke	<b>Room 3.122</b>
	<b>ES 10</b> – Research for New Insights and Innovative Solutions to Heart Disease and Stroke Health Problems	<b>Room 1.126</b>
2:15 – 2:30 pm	Break	
2:30 - 3:45 pm	<b>Breakout Group Reports</b>	<b>Room 3.102</b>
3:45 pm	<b>Closing and Next Steps</b>	

**November 3, 2006**

8:30 - 9:45am	<b>Building a Heart and Stroke Healthy City/Community - Cities Assessments and Actions</b>	<b>Room 3.102</b>
	<b>Tom Tenner, PhD</b> , Vice Chair, Texas Council on Cardiovascular Disease and Stroke, Community Policy and Environmental Change Workgroup	
	<b>Panel of Representatives from Recognized Cities</b>	

**Devon Casey, MPA**, Program Specialist, Public Health Improvement, Department of State Health Services, Health Services Region 1

**Kelli Edmund, BS**, Health Services Coordinator, Waco-McClennan County Public Health District

**Michael Kelly, PhD, CHES**, Paso del Norte Health Foundation

**Larry Rascon, EMTP**, Administrative Medical Lieutenant, El Paso Fire Department, City of El Paso

**Debbie White, BS**, Health Educator, Waco-McClennan County Public Health District

**Indicator 1** - Media Campaigns on Heart Disease and Stroke

**Indicator 2** - Safe Physical Activity Areas

**Indicator 3** - Accessible Healthy Food Options

**Indicator 4** - Coordinated School Health Programs in Schools

**Indicator 5** - Moderate to Strong Smoking Ordinances

9:45-10:00 am

Break

10:00-11:45 am

**Indicator 6** - CPR Classes Are Available

**Indicator 7** - Plan to Reduce Health Disparities in Place

**Indicator 8** - Defibrillators are Available

**Indicator 9** - Stroke Treated as a Medical Emergency w/Protocols

**Indicator 10** - Healthcare Sites Provide Primary and Secondary Prevention

11:45-12:00 pm

**Review and Next Steps**

12:00pm

**Adjourn**

**12:30 – 6:00 pm**

Texas Council on CVD and Stroke Meeting

Room 3.102

## APPENDIX C

### Conference Participants

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