BRANCH-HILLSDALE-ST. JOSEPH

COMMUNITY HEALTH AGENCY

Strategic Plan

FY 2015-2019

Adopted 02/26/2015

Dear Community:

I am pleased to share with you the Branch-Hillsdale-St. Joseph Community Health Agency's **Strategic Plan for 2015 – 2019**. This plan outlines how the Agency will move forward as it seeks to maximize its performance as a public health organization of excellence and assures the delivery of public health services that address the community's health needs and result in health status improvement. Included are our new mission, vision and value statements which redefine our purpose, direction and the guiding principles of our Agency. You will find two strategic priorities and six strategic goals which have been identified as the most meaningful and impactful way to improve the Agency, as well as support community health improvement efforts.

Throughout the Strategic Plan you will notice the Agency's commitment to the use of evidence-based and/or best practice models, quality improvement and collaboration which we believe are integral to fulfilling the public health core functions of assessment, assurance and policy development. This plan will provide guidance for decisions about future activities and resource allocations. It is a working document and as such, it will be revisited often and modified when needed to reflect new opportunities, emerging threats and environmental changes that are occurring around us.

I express appreciation to the Board of Health members for their participation in the process. I would also like to acknowledge our stakeholders, customers, partners and members of other local health organizations who responded to our request for information. Your feedback was invaluable in informing our future direction. Most importantly, I would like to thank the staff, who not only provided input, time and talents, but are now charged to find creative ways to incorporate the key themes of this plan into their daily work life. All staff have a part to play in ensuring the plan's implementation as we work together to promote optimal health, prevent disease and assure the protection of the public's health in our community and environment.

Sincerely,

Stephen R. Todd, MPA, RS
Health Officer/Administrator

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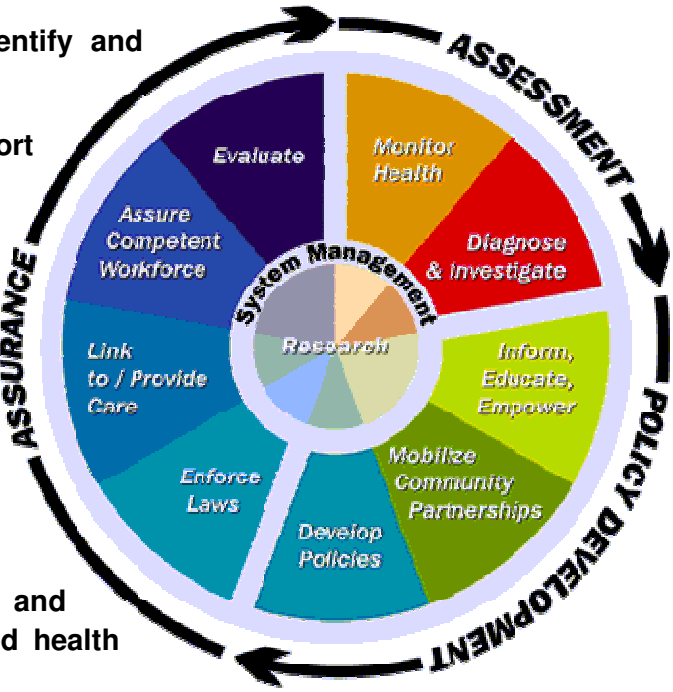
INTRODUCTION

The Branch-Hillsdale-St. Joseph Community Health Agency is a district health department organized in accordance with the Public Health Code (P.A. 368 of 1978) in 1971 as a not-for-profit, local governmental entity. The health department is overseen by a six member board of health which consists of representatives assigned from each of the three local county commissions. The district health department provides a broad spectrum of public health services to the tri-county residents who reside in Branch, Hillsdale and St. Joseph Counties. These three counties are located in Michigan's south/southwestern tier of border counties. Combined, the three counties are home to more than 150,714 people. (Vital Records, MDCH, 2013)

Since the mid-1990's, the tri-county health department has been actively engaged in the three core functions of public health: assessment, assurance and policy development (The Future of Public Health Report, IOM Report, 1988). A review of the agency's current programming and past track record demonstrates its capacities for fulfilling the 10 Essential Services of Public Health as found within those three core functions: (See Figure 1)

Figure 1. 10 Essential Svcs. of Public Health, 1994 - Public Health In America Statement

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



10. **Conduct research for new insights and innovative solutions to health problem**

These 10 Essential Services provide the framework that delineate the core functions and when undertaken within communities, help to fulfill the purpose of public health which, according to the Centers for Disease Control, is to:

- Prevent epidemics and spread of disease;
- Protect against environmental hazards;
- Prevent injuries;
- Promote and encourage healthy behaviors;
- Respond to disasters and assist communities in recovery; and
- Assure the quality and accessibility of services.

This purpose is also clearly articulated by the Michigan Public Health Code (PA 368 of 1978) which states that a local health department's role is to "… continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs…". The tri-county health department works to assure compliance with the State Public Health Code in the administration of services and the public's funds. The health department provides the eight mandated public health services:

- Immunizations
- Hearing Screening
- Vision Screening
- Food Protection
- Infection Control
- Private Groundwater/Public Water Supply
- On Site Sewage Disposal Management
- Sexually Transmitted Disease Control and Prevention

In addition to these services, the health department provide all required services and basic services, along with categorical funded programs, as stipulated by the Michigan Public Health code and related mandates. The department demonstrates compliance through its participation in the Michigan Local Public Health Accreditation Program. Every three years, since the accreditation program's inception, the health department has earned full accreditation status, which serves to assure its compliance with the applicable minimum program requirements.

PLANNING

In order to assure the most effective and efficient use of public funds and resources, the Agency actively participates in several planning initiatives which seek to improve the health status of the community, the quality of its services and the use of its most valuable resources in both the long and short-terms. These initiatives are detailed below:

Community Health Needs Assessment/Community Health Improvement Plans (CHNA.CHIP):

Between 2012 and 2014, the tri-county agency partnered with each of its four local hospitals to complete county-specific CHNA/CHIPs. The health department's participation in each of these initiatives included: assistance with the development and distribution of a survey instrument in both paper and electronic form to local community residents to measure community perceptions and priorities; augmentation of community perceptions data through the compilation and analysis of quantitative data sources including vital records, behavioral health survey data, socio-economic factors, hospitalization and health care delivery system; participation in expert panels to review data collected and establish priorities; and implementation of specific segments of the plan in collaboration with the hospitals and other community partners. Information gleaned from the CHNA/CHIP became a cornerstone of the subsequent planning initiatives the health department has undertaken.

Strategic Plan:

Strategic Planning is the process used to determine what the agency does, what it will become in the future and how to get there. The plan consists of strategic priorities, strategic goal statements and measureable objectives. The tri-county agency completed a Strategic Plan for the period of 2010-2012. Due to various factors, the agency continued to operate under the previous Strategic Plan until January, 2015, when the Board of Health adopted the revised Strategic Plan for 2015-2019.

New IRS Requirement for Non-Profit Hospitals: The *Affordable Care Act (ACA)*, enacted March 23, 2010, added new requirements that non-profit hospital organizations must satisfy in order to maintain their 501(c)(3) statuses. One of the requirements, which became effective for tax years beginning after March 23, 2012, mandated the hospital to work with its local public health department to conduct a community health needs assessment (CHNA) and to adopt an implementation strategy at least once every three years. The passage of this law afforded the tri-county agency the opportunity to work together with its local hospitals and other community partners to develop and implement a needs assessment process that was more comprehensive and reflective than had been previously achieved. In addition, the resultant CHIPs are far more collaborative in nature as they seek to share both responsibilities and resources in their implementation. Completing the CHNA/CHIP prior to initiation of the strategic planning process allows the tri-county agency to link back to the CHNA/CHIP and to reflect these plans in their own strategies.

Changes in Key Administrative Positions: During FY 2013, the health department saw the departure of three key administrative positions due to retirement: Prevention Services Director, Chief Financial Officer and Medical Director. FY 2014 was a time of recruitment and training of new staff that were hired in their place. Given the need for people to adequately understand their new roles and responsibilities prior to engaging in Strategic Planning, it was determined that delaying the new Strategic Planning process was in the agency's best interest.

The 2015-2019 Strategic Planning process began in October of 2014 and throughout the process has been informed by both the CHNA and CHIP. In addition, the Strategic Plan also incorporates components of each of the tri-counties' CHIP as noted.

Agency Action Plan/Workplans:

Agency Action Plan: The Agency Action Plan is an annual work plan which describes how the agency will move forward in implementing the Agency's Strategic Plan. This plan details annual SMART (specific, measurable, achievable, realistic and time-sensitive) objectives and specifies the necessary implementation steps, responsible parties, needed resources and expected outcomes.

Workplans: Individual program-specific workplans are developed as required by funders. These workplans specify program goals, SMART objectives, implementation steps, responsible parties and resources and serve as the basis for required progress reporting.

Quality Improvement (QI) Plan:

Quality improvement is a systematic approach to assessing services and improving them on a priority basis. The Branch-Hillsdale-St. Joseph Community Health Agency approach to quality improvement is based on the following principles:

- Customer Focus
- Employee Empowerment
- Leadership Involvement
- Data Informed Practice
- Statistical Tools
- Prevention instead of Correction
- Continuous Improvement

In order to comply with new Michigan Public Health Accreditation Program standards implemented in Cycle 6, the Agency's QI plan is under review and being updated to assure that appropriate linkages to both the CHNA/CHIP and the Strategic Plan have been incorporated, as applicable.

STRATEGIC PLANNING PARTNERS & PROCESS

Strategic Planning Partners:

The Strategic Planning process was an inclusive process which sought input from a number of Agency personnel, community decision makers and community partners. Initially, a 22 member strategic planning committee (SPC) was identified that represented administration, board of health and agency staff (See Attachment A for a SPC Roster). Special attention was paid to assure that both middle-management and line staff members were involved in the process. In addition, efforts were also made to assure that each of the three offices was represented. Video-conferencing was encouraged to foster participation.

The process sought to use group consensus techniques in its decision-making process and worked hard to assure that the process emphasized active participation among all its members and stakeholders and was built upon cooperation and collaboration. Efforts were also made to assure that agreement was reached by all SPC members prior to moving to the next step.

An executive committee oversaw the process made up of the Health Officer, Environmental Health Director, Health Education/Promotion Director and the Area Agency on Aging Coordinator. Group facilitation was provided internally by the HE/P Director and the AAA Coordinator.

In addition to SPC attended meetings, all agency employees, as well as community partners that participate in the county-specific multi-purpose collaborative bodies, food service owners, decision-makers, school superintendents and health care providers were afforded the opportunity to provide input through a series of electronic surveys. Surveys were distributed to an estimated 605 individuals through various listservs, of which 226 responded. These responses helped to inform the process.

Strategic Planning Process:

The Strategic Planning Process was initiated in early October with a meeting of the Executive Committee which approved the planning process outlined in the Strategic Planning Work Plan (see Attachment B). During the next three months, SPC members and/or its Executive Committee, subcommittees and adjunct workgroups met to:

- Review key information and identify missing information,
- Develop surveys and discuss results;
- Review/develop mission/vision/value statements;
- Conduct an Environmental Scan;
- Perform a SWOC (Strengths, Weaknesses, Opportunities and Challenges) Analysis
- Identify strategic issues;
- Establish a Strategic Plan; and
- Develop an Annual Action Plan.

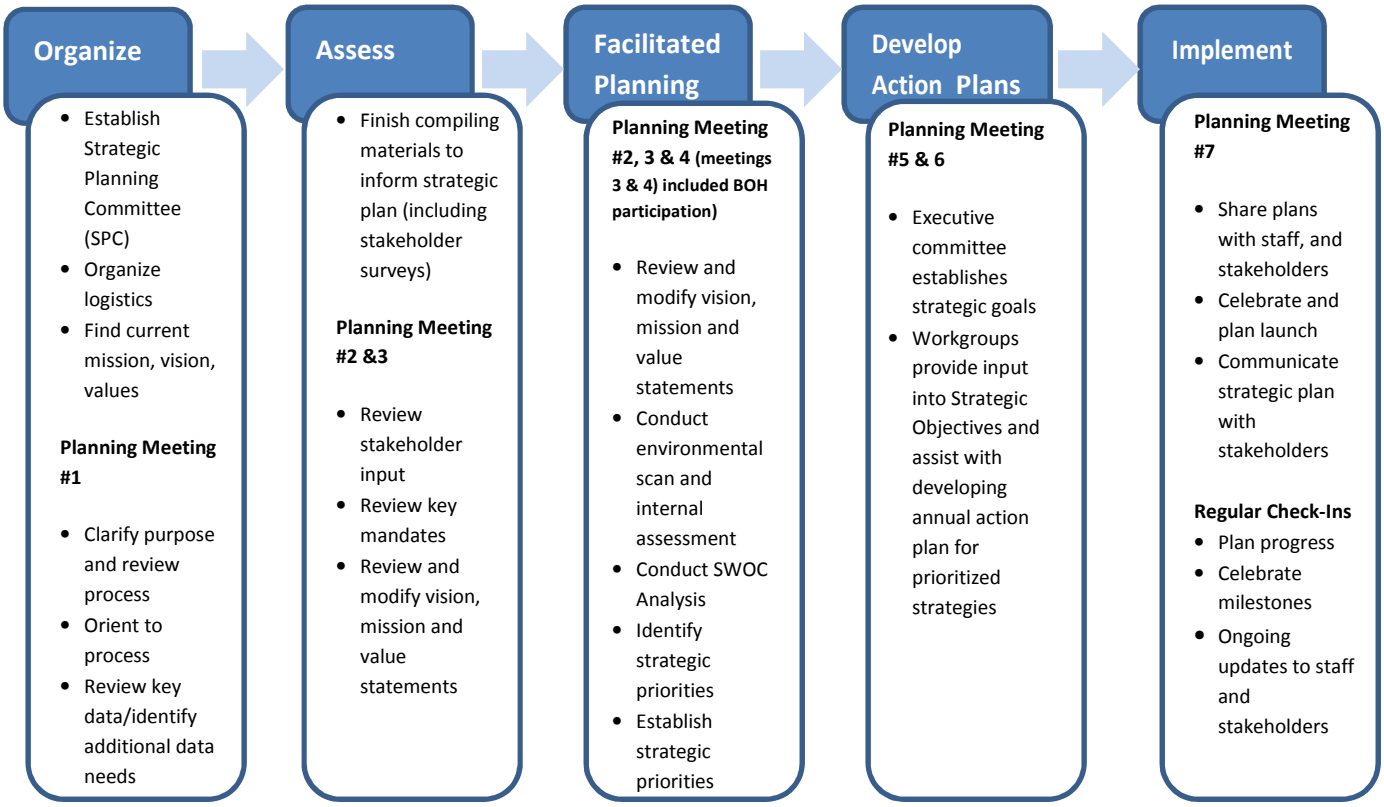
(See Figure 2)

Upon the completion of the development of the Strategic Plan and Annual Action Plan, the SPC committee will continue to meet on a semi-annual basis to assure that the Annual Action plans are reviewed and revised as needed and that ample progress is being made towards their full implementation. At the second meeting, the SPC will also review and update the Strategic Plan in order to assure that it remains current and relevant.

Reports regarding both the annual action plan and strategic plan will be shared with the Board of Health during the June and January meetings. In addition, staff will receive regular updates in regards to the status of the annual plans and strategic plans through semi-annual reports that will be posted on the Agency Employee website and through Agency's Employee newsletter. Information will also be shared through the regularly scheduled staff meetings that occur on a

program/division level basis. Annual Action plan updates will be initiated upon the close of the calendar year by the appropriate division and administration staff who will share these updates with the SPC. The SPC will review and post the annual action plan updates. It will use this information to review and inform the annual strategic plan updates **(See Attachment F).**

Figure 2: BHSJ CHA Strategic Planning Flow Chart, FY 14/15



Assessment Findings:

Upon initiation of the Strategic Planning process, each member of the committee received a three-ring binder which included the following preliminary information:

- Preliminary Meeting Materials (i.e., work plan, forms, flowchart, glossary and roster)
- Community Assessment for each of the three counties completed in conjunction with the health department
- Satisfaction data (i.e., division/program specific satisfaction data and employee satisfaction data)
- Agency materials (i.e., past strategic and action plans, Quality Improvement plan, most current annual report and budget)
- Community Monitor 2013 (i.e., tri-county health status report which reports on 100 indices of health)

This information was reviewed by the SPC, both individually and during group sessions, so as to assure a common understanding and interpretation of the information and how it applied to strategic planning. As additional information was compiled, it was distributed to the SPC who were asked to incorporate it into their binders.

Core Functions: A diverse staff that represented nursing, technicians, health education, environmental health, finance, information technology, emergency preparedness, medicine, administration and county commissioners served on the SPC. Given the diversity of the committee, a review of the core functions of public health that included an overview of the 10 Essential Public Health Services was provided during the kick-off meeting. This review sought to establish correlations between the agency's current programming and the type of activities identified in the 10 essential services that serve as a framework for understanding what constitutes local public health efforts within a community.

CHNA/CHIP: Because the community-based needs assessment and health improvement planning activities are integral to the agency's own planning initiatives and are reflective of the agency's core functions as a public health department, the committee spent time reviewing the community needs assessment materials and the resultant CHIPs. Since the health department's ***"Community Health Monitor: 100 Indices of Health"*** was utilized in each of the county specific assessment/health improvement processes, participants walked through the document noting key indicators in each of the following sections: demographics, social/economic indicators, behavioral risk factors, mortality, morbidity, maternal/infant health, and health care systems. A review of this information was deemed an important part of an external assessment because it provided context for where the communities have been in the past and where they may be headed in the future, as well as for understanding the communities' perceptions, their individual priorities and the health department's role as the community works together to address its issues. Figure 3 states the individual county's health priorities as identified through their community health needs assessment.

	Figure 3. CHNA Priority Health Issues Identified
Branch County	**Top 9 issues**: **Smoking Prevention, Unwed/Teen Mothers, Suicide Prevention, Parenting Skills, Obesity, Family Planning Services for Low Income Population, Senior Citizen Adult Daycare, Childhood Mental Health, Drug Abuse**
Hillsdale County	**Top 4 issues: Affordable Healthcare** (including: free or reduced cost health screenings; educating people on affordable or free health insurance options; partnerships to lower re-admission rates.); **Urgent Care Facility**; **Woman's health and prenatal clinic**; **Substance abuse** issues with adults and minors (including: prescription drugs)

St. Joseph County	**Top 5 Issues**: Improving **Access to Care** (including: insurance, health professional recruitment/retention, accessible health services); Reducing **Chronic Diseases** (including: CVD risk reduction, Cancer Screenings; Hypertension Screenings, Diabetes Screenings); **Promoting Healthy Behaviors** (including: Smoking Prevention, Healthy Eating/Physical Activity, Alcohol & Substance Abuse); **Improving Maternal/Infant Health** (including Teen Pregnancy, Infant Mortality; Prenatal Smoking, Parent Education); **Addressing Mental Health & Substance Abuse** (including programs/practices/policies that target children and adults and methamphetamines)

In total, nearly 2,000 residents provided input into the three Community Health Needs Assessments. Figures 4.A-C delineate the agency's active involvement in the implementation of each of the county-specific community health improvement plans which were devised in conjunction with local stakeholders; and reflect the agency's ongoing commitment to community health improvement activities.

Figure 4 A: BHSJ CHA Involvement in Branch County's Health Improvement Plan (CHIP)

Priority Health Issues	BHSJ CHA Programming/Initiatives – 7 out of 9 issues
Smoking Prevention	• Smoke-free schools and quitline promotion
Unwed/Teen Mothers	• WIC program – supplemental nutrition program • School-linked clinics
Suicide Prevention	• Member of Suicide Prevention Coalition
Obesity	• School-linked clinics – youth advisory council & school health education; WIC program • Member of Pediatric Subcommittee of Great Start working to address obesity and inactivity in families with small children
Family Planning for Low Income Population	• Assist with Medicaid Enrollment, provide STI/HIV/AIDS testing and counseling, maintain list of referrals for family planning needs • Training to become certified reproductive health educators for local schools
Childhood Mental Health	• School-linked clinics – Working with CHC and Pines to develop a Mental Tele-health program
Drug Abuse	• Member of Substance Abuse Task Force and work with Sheriff on Meth clean-ups as requested.

Figure 4 B: BHSJ CHA Involvement in Hillsdale County's Health Improvement Plan (CHIP)

Priority Health Issues	BHSJ CHA Programming/Initiatives – 3 out of 4 issues
Affordable Healthcare (including: free or reduced cost health screenings; educating people on affordable or free health insurance options; partnerships to lower re-admission rates.)	• Assisted with Federally Qualified Health Center (FQHC) application • Navigator and Certified Application Counselor Agency for Marketplace • Certified DHS Navigator – Community Partner • Michigan Access Benefit Program
Woman's Health & Prenatal Clinic	• Assisted with FQHC application • WIC Clinic • Immunization Clinic
Substance Abuse issues with adults and minors (including: prescription drugs)	• Member of Substance Abuse Coalition • TIPS Trained Health Educator who offers Staff skills-based training program designed to prevent intoxication, underage drinking, and drunk driving • Served as fiduciary for Substance Abuse Coalition on AMA Prescription Drug Prevention Grant

Figure 4 C: BHSJ CHA Involvement in St. Joseph County's Health Improvement Plan (CHIP)

Priority Health Issues	BHSJ CHA Programming/Initiatives - 5 out of 5 issues
Improving Access to Care	• Maintain Public Health Dental Clinic • Assisted with Federally Qualified Health Center application • Assisted with obtaining funding for two school-linked clinics • Navigator and Certified Application Counselor Agency for Marketplace • Certified DHS Navigator – Community Partner • Michigan Access Benefit Program
Reducing Chronic Diseases	• Monitor Chronic Disease Incidence • Newly received PATH Program for Diabetes Grant (AAA) • Reduce Re-admission Rates Pilot Project (AAA)
Promoting Health Behaviors	• Member of Substance Abuse Coalition • Smoke free schools and quitline promotion/Submitted grant for tobacco cessation • Establishing 4x4 Healthy Lifestyles campaign (Access to Care)

Improving Maternal & Child Health	• Immunizations • WIC • Co-Chair of Child Death Review • Promoting Quitline for Pregnant Women; Submitted grant for Tobacco Cessation Program • STI/HIV/AIDS Testing and Counseling
Addressing Mental Health & Substance Abuse	• Member of Substance Abuse Committee • EH assists with Meth clean-up as requested

By understanding the scope of the work and the level of engagement it maintains in these community health improvement processes, the agency can work to assure that these efforts are institutionalized and integrated both into its internal and external strategies.

Customer Satisfaction Surveys: The Agency seeks, on a regular basis, feedback regarding its services from its customers through a variety of survey instruments. In total, five different customer surveys' results were issued and considered during the strategic planning process which represents the opinions of 802 respondents. By including a review of customer satisfaction survey data sets as part of the agency's strategic assessments, the SPC assured customer involvement in the process. The following customer satisfaction survey results were reviewed:

- **Environmental Health's Well and Septic Permit Customer Satisfaction Survey.** This survey is distributed once every two years via mail to customers, both homeowners and contractors, who completed the permit process during the past six to nine months. During FY 2014, 199 surveys were distributed and 53 (27%) returned. Overall, 95% of customers were satisfied with experience and 90% felt their services were performed in a timely manner.

- **Environmental Health's Food Handlers Customer Satisfaction Survey.** The need for this survey was determined by the SPC. Survey questions were developed by a SPC committee and a SurveyMonkey tool was distributed via email to 281 food handlers identified through the SWORD database. From this list, 73 responses (26%) were collected. Of those, 94% responded staff provided good to very good technical assistance. 97% responded good to very good for staff professionalism. 99% responded that the inspections were thorough and consistent. 94% were satisfied with program overall.

- **Prevention Services' Customer Satisfaction Survey.** A paper survey is distributed during the month of May to all prevention service clients seen at each of the four clinic sites (Coldwater, Hillsdale, Three Rivers and Sturgis). Surveys are collected and analyzed by members of the health education staff, who generate the final report. For FY 2014, 508 surveys were collected. 99% of respondents were satisfied with the quality of services they received. 97% would recommend this clinic to others.

- **Health Education's Children's Special Health Care Services (CSHCS) Customer Satisfaction Survey.** An annual paper survey is distributed to all families with children who are active on the program. In FY 2013, 668 responses were collected, which represents a 25% response rate. Of those respondents, 95% were satisfied with their overall experience while on the program and 91% felt their paperwork was processed in a timely manner.

In each of the specified programs, respondents rated their overall satisfaction high and expressed positive comments regarding the services and the agency staff.

Employee Satisfaction Survey: Employees are another 'customer' group whose input was deemed important to consider when setting strategic directions for the future. In July, 2014, the agency reissued its employee satisfaction survey. The original survey, issued in 2011, had been developed by a private contractor and issued in paper form. This survey was replicated but offered through SurveyMonkey.

While the overall mission of the agency is viewed positively by staff and they are actively engaged in fulfilling it, only half the staff responded that the Agency practices effective fiscal management. Less than half the staff members are satisfied with their salary and benefits and an equal number responded that the agency is slow to adopt new technology or employ public health best practices. Issues of trust were also identified by staff in relation to management, hiring practices and agency priorities.

Strategic Planning Surveys: Satisfied with the quantitative and qualitative information collected regarding customers and employees, the SPC identified additional questions and stakeholders from which information was missing. Information from the community regarding its health needs and priorities had been collected through the CHNA/CHIP. Input from customers regarding their satisfaction with the agency's services and staff had been obtained through satisfaction surveys. However, information concerning the perceptions of governing officials, health care providers, schools and community partners in regards to the public health department, its services and staff was lacking. In addition, the SPC determined that additional information from the employees related to mission, vision and values was needed in order to move forward. In November, SPC subcommittees developed and distributed three additional surveys that targeted these stakeholders. Cumulatively, this meant an additional 226 responses which have been reviewed and used to inform the strategic planning process.

- **Governmental Stakeholders Perception Survey.** An electronic survey was distributed via email to 94 government officials which represented county commissioners, city and township officials. From these, 38 responses (40%) were collected. When asked to rank their awareness of 17 health department programs, more than two-thirds of respondents indicated they were knowledgeable of the Area Agency on Aging, Immunizations, WIC, Food Protection and Public/Private Water Supply. Less than 50% knew the health department offered Community Health Assessment and Demography services, Hearing and Vision Screenings, Children's Special Health Care program, or Tuberculin Skin Tests. Over two-third of government officials rated the health department high when asked questions about accessibility, knowledgeable and helpful staff and costs.

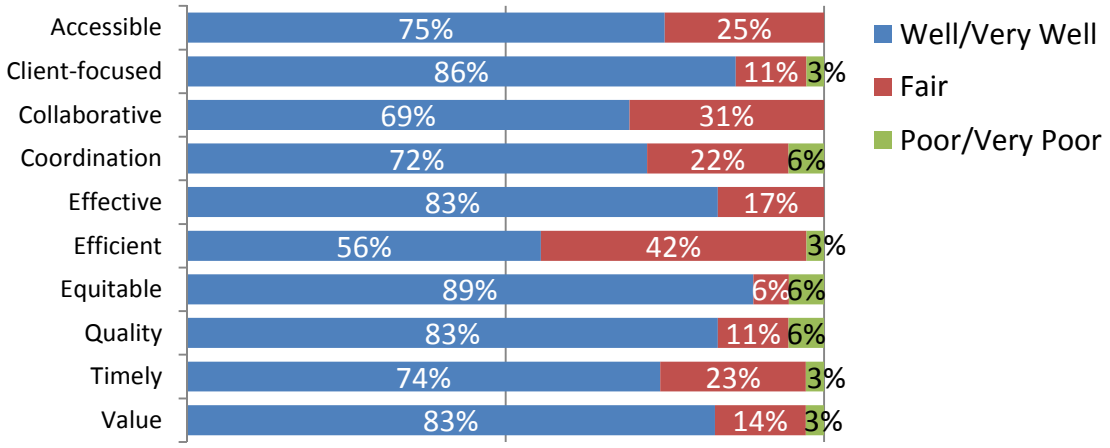
- **Community Partners Survey.** An electronic survey was distributed via email to a combined total of 162 school superintendents, multi-purpose collaborative partners and health care providers. From this, 75 responses (46%) were received. When asked to rank their awareness of 17 health department programs, more than two-thirds of respondents indicated they were knowledgeable of Immunizations and WIC. Less than 50% knew the health department offered Community Health Assessment and Demography services, Health Education, Hearing and Vision Screenings, Children's Special Health Care program, Food Protection Reviews, Onsite Sewage, Public/Private Water or Tuberculin Skin Tests. Over two-thirds of community partner respondents found staff helpful during information seeking/referral processes and nearly three–fourths found staff knowledgeable and able to assist. The lack of knowledge of public health programming among the community partners was identified as an area of concern. (See Figure 5)

Figure 5. Ranking of Program by Stakeholder Awareness

Programs	Com. Partners	Rank	Govt. Officials	Rank
Area Agency on Aging	64%	3	78%	1
Car Seat Program	53%	7	57%	4
Communicable Disease/Prevention Control	61%	4	57%	4
Community Assessment/Demography	27%	13	24%	11
Community Outreach/Health Insurance	57%	6	54%	5
CPR Training/Certification	40%	10	51%	6
CSHCS	37%	12	38%	9
Dental Clinics	60%	5	54%	5
Emergency Preparedness	39%	11	54%	5
Food Protection	41%	9	65%	3
Health Education	44%	8	43%	8
Hearing and Vision	41%	9	32%	10
Immunizations	74%	1	70%	2
On-Site Sewage	19%	14	57%	4
Private & Public Water Supply	37%	12	65%	3
Tuberculin Skin Test	44%	8	49%	7
WIC	73%	2	70%	2

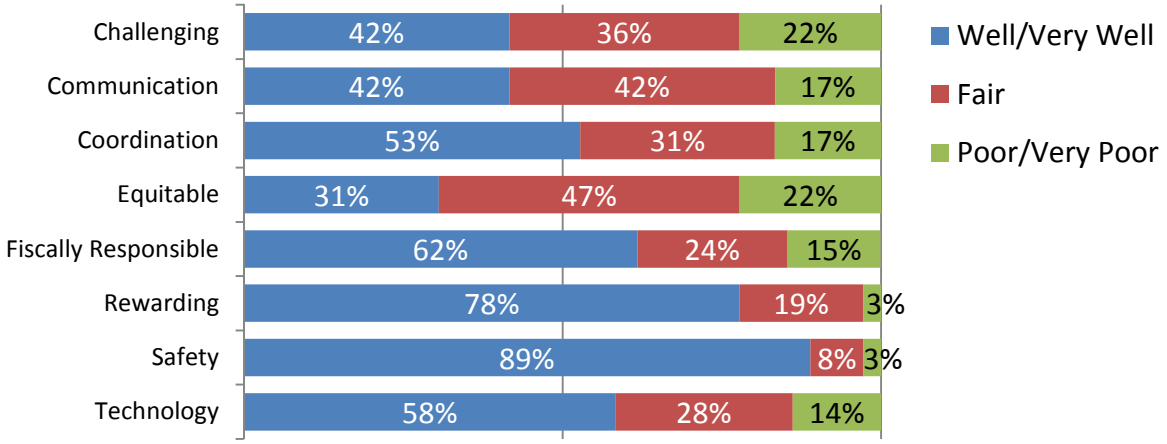
- **Employees' Strategic Planning Survey.** Given the lack of definitive information concerning employee views on the Strategic Planning process which was obtained through the employee satisfaction survey, the SPC initiated a separate Employee Strategic Planning Survey. The purpose of the survey was to identify employee attitudes towards its values as they are demonstrated to customers and to staff. Two sets of attributes were identified as being reflective of the agency's values. For customers, staff were asked to rate how well they agency demonstrated attributes associated with accessibility, client-focused, collaboration, coordination, effectiveness, efficiency, equity, quality, timeliness and value. (See Figure 6). Only in the areas of collaboration, efficiency, coordination and timeliness did less than 75% of the staff agree that the agency did well or very well.

Figure 6. Staff Ranking of Key Attributes as Demonstrated to its Customers



For staff, the attributes of challenging, communication, coordination, equity, fiscal responsibility, rewarding career, safety and technology were identified as relating back to the agency values. Only in the areas of rewarding career and safety did 75% of the staff agree that the agency did well/very well. (See Figure 7)

Figure 7. Staff Ranking of Key Attributes as Demonstrated to its Employees



Agency Programmatic Trends: As part of the agency's internal assessment, the SPC reviewed agency service delivery data and trends. Comparisons of outputs, as reported in the annual reports by the divisions for FY 10/11 and FY 12/13 were made and the percentage of growth or decrease was calculated. (See Figure 8) These two fiscal periods were selected because they reflect the most accurate information available for the previous strategic planning period.

Figure 8. Service Delivery Comparison, FY 10/11 to FY 12/13

Program	FY 10/11	FY 12/13	% Diff.
ENVIRONMENTAL HEALTH			
Well/Septic Evaluations	20	27	35%
Construction Permits	333	394	18%
Septic System Inspected	285	323	13%
Vacant Land Evaluations	19	21	11%
Well Construction Permits Issued	464	485	5%
Well Permits Inspected	420	447	6%
New Water Supplies Approved	284	340	20%
Non-community Water Supply	44	55	25%
Food Establishment Inspections	955	967	1%
Facility Plans Reviewed	23	16	-30%
Vending Inspections	86	89	3%
Temporary Establishment Inspections	267	282	6%
HEALTH EDUCATION			
Community Events	46	42	-9%
Educational Presentations	73	87	19%
Safe Kids Events	19	26	37%
Car Seat Checks	243	635	161%
CSHCS – Individuals Enrolled	651	692	6%
CSHCS - Assessment	775	917	18%
CSHCS – Referrals for Medical Care	25	20	-20%
Hearing Screens Provided	6,969	7,108	2%
Vision Screens Provided	13,126	13,255	1%
PREVENTION SERVICES			
Infectious Diseases Reported	13,758	14,116	3%
STD Testing/Contact Follow-up	470	284	-40%
HIV/AIDS Testing & Contact Follow-up	135	111	-18%
Children Vaccinated	10,866	7,521	-31%
Adults Vaccinated	6,895	4,184	-39%
Travel Vaccines	171	250	46%
Total Vaccines Given	17,932	12,192	-33%
WIC – Ave. Monthly Participation	6,076	5,475	-10%
WIC Breastfeeding Class Participants	210	288	37%

AREA AGENCY ON AGING			
Nutrition	204,648	206,188	1%
In-Home	42,875	63,041	47%
Community	23,520	28,230	20%
Access	19,618	40,306	105%
Legal	282	236	-16%

Most notable in the comparison of output data sets includes those services that experienced a percent difference of ±25%. Output increases of this magnitude have occurred in Environmental Health which experienced substantial growth in its Well and Septic Evaluation and Non-community Water Supply permits. One decrease that was noted occurred in its Facility Plan Review which saw a drop in the number of applicants who want to start new food establishments. Health Education experienced substantial growth in the number of Car Seats checked and Safe Kids Events it helped to organize. Car seat checks nearly tripled during the period. Prevention Services saw substantial decreases in its personal services, including: STD/Testing/Contact Follow-up Services and the number of Adult and Children vaccinated Travel shots was the only area that Prevention Services reported a substantial increase. Overall, the health department was involved in the provision of more than 382,579 units of services which represented a 12% increase since FY 10/11.

Because of the collaborative nature of public health and the public health system, some time was spent also reviewing the agency's accomplishments during the past five years as a way to demonstrate its capacity to partner with others to address important community health issues. To date, 57 accomplishments were identified. Of these accomplishments, some of the more noteworthy ones include:

- 2 school-linked clinics and 3 school tele-health clinics
- Establishment of Vulnerable Adult Protocols for Branch and St. Joseph
- Opening of a MCDC Public Health Dental Clinic in Hillsdale
- Opening of a WIC Satellite Clinic in Sturgis
- Receipt of 3 MDCH's Director's Awards
- Receipt of 3 Public Health Hero Awards and 2 Public Health Champion Awards
- Participation in a Multi-Jurisdictional Food-borne Disease Surveillance Project
- Participation in a grant submission for 2 Federally Qualified Health Centers (FQHCs)
- Successful move to voice-over-internet phone system and the utilization of fiber optics for electronic communication

As a result of these and other accomplishments, the health department helped to secure for itself and its communities, over $2 million in funding which provides jobs, health services and other resources that were lacking.

Budgetary and Staffing Trends: Finally, to complete its internal assessment of the agency and its capabilities, the SPC reviewed budget and staffing trends. Comparisons were made between the FY 2010 budget and the FY 2014 budget. (See Figure 9) An aging staff,

increasing retirement and health care costs combined with decreased allocations from local government have led to a 15% budget reduction and a downsizing of programs. County allocations are back to 1993 levels and programs have been downsized from 26 to 18. Staffing levels have also declined in both full-time equivalents and contractual employees. In 2010, the agency employed 74 FTEs, in 2014, the number was 62 FTEs. A review of staff training expenditures reveals that the cost of training staff has been limited to a total of $263 per person for a total of $16,330.

Figure 9. Financial Assessment, 2010 and 2014 Comparison

	2010	2014	Diff.
No. of FTEs	74.05	62.23	-16%
Total Budget	$7,141,861	$6,096,270	-15%
No. of Employees taking Health Ins.	55	38	-31%
County Allocations/per person	$5.16	$4.42	-14%
Programs	26	18	-31%
Funding Percentages by Budget Categories			
Federal/State Revenues %	30%	45%	15%
State LPHO %	10%	15%	5%
County Allocation %	11%	10%	-1%
Fee/Other %	49%	26%	-23%
Fund Balance %	0%	4%	4%
Salaries/Wages %	39%	43%	4%
Fringe Benefits %	22%	16%	-6%
Supplies/Materials %	5%	6%	1%
Contractual %	11%	1%	-10%
Travel/Communication/Space %	9%	11%	2%
Other %	14%	23%	9%

Environmental Scan: In addition to assessing the agency's capacities related to services, resources, personnel and finances, the Agency also undertook an environmental scan which sought to identify both formal and informal mandates, as well as identify the forces of change that exist. (See Attachment C for a brief description of issues identified). Four main themes emerged and a brief description is provided below. Issues related to staffing and funding issues were identified as cross-cutting across all emerging themes.

- **Service Delivery:** Issues related to the protection of health and personal information, as well as confidentiality need to be continually addressed as mandates change and/or are added. Possible impacts of the Affordable Care Act on prevention programming were discussed, including the health insurance mandate and the establishment of medical homes. Will higher rates of insurance and improved access to primary care result in a shift in the agency's delivery model from that of a service provider to that of a service assurer for some of its most traditional programs? Models of service integration within our local communities (i.e., school clinics, behavioral health and primary care, etc.) and occurring both within the state and nationally (i.e., LHD/hospital models or downsized LHD models) were described.
- **Technology:** New accounting software, along with billing and payment issues, rose quickly to the top as priority items and led to further discussions about the need for an electronic health record (EHR) system. Electronic system integration of existing databases combined with an EHR and document imaging capabilities were brought to light in connection to community health assessment and community health improvement needs and the new regional business intelligence project.
- **Collaboration:** Assessing the impact of regionalization as initiated by the Governor through his Prosperity Regions was a major discussion. Speculations as to local public health regionalization and how it is being envisioned by state level decision makers quickly ensued. Descriptions of current multi-jurisdictional and collaborative efforts between schools, hospitals and other organizations in the areas of access to care, community health needs assessment and communicable and chronic disease initiatives continue to demonstrate the need for ongoing partnerships to accomplish significant public health goals.
- **Communication:** The need for social media as part of a communication strategy was emphasized. Internal communication needs are a concern for any multi-office agency. The need to revisit referral processes and networks was identified and how to assure that information was communicated to the line staff in need of this information was discussed. In addition, how to keep stakeholders informed of the agency services was also highlighted.

Strengths, Weaknesses, Opportunities and Challenges (SWOC) Analysis: Informed by the results of the internal assessments and environmental scan, the SPC conducted a SWOC analysis. This meeting, held by teleconference, sought to answer the questions:

- Strengths:
  - What makes us better than others?
  - What actions do we do well?
  - What are our competencies?
  - What knowledge, skills and attitudes do we have that can help us?
  - What do other people say we do well?
  - Why should we undertake this mission/vision?

- Weaknesses:
  - What could we improve in order to achieve this mission?
  - In what ways are we not efficient?
  - What don't we do well?

- Where are we incompetent?
- What knowledge, skills and attitudes are we missing?
- What should we avoid doing?
- Why shouldn't we undertake this mission/vision?

- Opportunities
  - What real opportunities are present today?
  - What is going on around us that seems to be useful?
  - From which recurring tendencies can we profit and how?
  - What could be done today that isn't being done?
  - What is going on in the community that we can uniquely provide?
  - Who can support us and how?

- Challenges
  - What are the negative tendencies in play today?
  - What obstacles do we face in fulfilling our mission right now?
  - What is the competition doing that might cause difficulties for us?

Based upon the Strength, Weaknesses, Opportunities and Challenges (SWOC) Analysis, the following information was gathered:

- **Strengths:** The staff members are seen as the Agency's greatest asset. The staff members are knowledgeable, well-educated and provide quality services. The staff members provide the basis for the collaborative relationships which are fundamental to its community health improvement strategies, as well as seen as its greatest opportunity. Shrinking staff levels, workload distribution issues, lack of time afforded to pursue client education, and inconsistencies in the application of program policies and procedures threaten to diminish the effectiveness of good staff.

  In addition, because OMB time-reporting mandates prevent staff from being as flexible as they would like and these mandates complicate cross-training and program staffing considerations. As a result, while staff members work well in their program areas, they do not always understand the scope of public health activities, the Agency's services or the services available within the community. This can impact their ability to make appropriate referrals to other services (both internally and externally), to coordinate services and to work together as a team.

- **Weaknesses:** Weaknesses center around three areas – communication, quality and service delivery. Communication problems are both internal and external. Internal communication problems are the product of the agency's name, the size of the jurisdiction and the number of offices that exist. In order to be community sensitive, the health department maintains three separate county offices and one satellite clinic. Maintaining adequate communication across four offices and four divisions is formidable task. Staff members have expressed concerns over not being heard. They also have expressed

concerns that they are not in the information loop when it comes to the distribution of important information.

External communication problems have existed since the late 1990's when the agency's name was changed from the 'District Health Department' to the 'Community Health Agency.' This change has led to some confusion within the community, because the name change was so similar to the names of other local health organizations (i.e., Community Mental Health, Community Health Center, etc.) Marketing and branding have been identified through these discussions on weaknesses as ways to improve the community's knowledge and perception of its services.

Closely connected to communication weaknesses are quality and service delivery weaknesses. Many of the weaknesses in the area of quality relate to workforce development issues. They also relate to assuring staff remain client-focused, culturally appropriate and deliver excellent customer service. In addition, there is a need for better knowledge about how to conduct quality improvement and to implement a quality improvement program. Weaknesses in the service delivery system were closely aligned and reflect needs for more standardized applications of policies and procedures for all offices, improved resource/referral processes and the need for cross-training.

- **Opportunities:** Both collaboration and technology were identified as the greatest sources for opportunities in the future. Within the area of collaboration, the SPC identified opportunities for health improvement through the completion of the CHNA/CHIP. They also identified further opportunities for service integration, working with the local hospitals, FQHCs and school clinics. The regionalization of local public health may create some financial incentives which could help to provide increased funding levels. Expansion of case management services through the Area Agency on Aging Care Consultant project and outreach efforts to underserved populations for public health services and health insurance enrollment were seen as untapped possibilities for the future.

  The adoption of new or through the expanded use of existing technology the health department hopes to: improve both the effectiveness and efficiency of its service delivery methods; improve its ability to communicate with clients and staff; improve its accounting, billing and payment processes; and improve its access to data for quality improvement.

- **Challenges:** Many of the challenges identified had to do with mandates and the unknown impact they may have on the Agency. The Affordable Care Act and its health insurance mandate could change the Agency's service delivery mix. Regulations changes and updates are difficult to monitor and could result in hefty fines if the Agency fails to comply. Regionalization, reorganization and restructuring of client benefits at the state level have had their impact in the past and will continue to impact the future as further changes are implemented.

STRATEGIC PLAN:

Value Statement Process: As part of the strategic planning process, the SPC undertook a visioning process which included a review of the organizational value statements, its mission and vision. Values communicate how business should be conducted and reflect the core values of the organization. SPC members were surveyed and asked to review the value statements from the previous strategic planning process. They were then asked to suggest behaviors that were expected if these values were practiced. A set of attributes was identified by the group as a result. Using a nominal group technique, the SPC worked to identify a new set of key values which reflect the current organization. A subcommittee developed statements that reflected the newly adopted values and the revised statements were adopted by consensus. Plans to distribute these statements throughout the agency in the forms of poster will help to remind staff and customers alike of the agency's fundamental beliefs.

Value Statements:

Client-Focused:

- Working with individuals to achieve their optimal health goals.
- Demonstrating a caring, respectful attitude to all.
- Assuring that information is meaningful and delivered in a culturally competent manner.

Collaboration:

- Sharing our time and talents to develop and implement positive outcomes in our community.
- Using many perspectives and approaches, internally and among community partners, to improve service coordination and delivery.
- Giving appreciation to all partners for their contributions.

Innovation:

- Utilizing evidence-based models and best-practices to develop programs and address needs.
- Utilizing technology to improve efficiency, effectiveness and outcomes.
- Recognizing opportunities, both financial and programmatic, and responding.

Communication:

- Exercising personal responsibility to stay informed, asking questions when needed, and following up accordingly.
- Being open, honest and respectful by saying what you mean and meaning what you say.
- Utilize positive, effective communication to carry out our mission and vision with every interaction.

Professionalism:

- Maintain standards of integrity, privacy and ethical conduct in all interactions.

- Being knowledgeable and staying up to date with emerging information.
- Contribute a positive attitude and strive to work as a team member.

Teamwork:

- Working together for the common good and common goals.
- Demonstrating mutual respect to others by both listening and speaking up.
- Honor and support each other's roles, requests, contributions, and needs.

Mission Statement Process: As part of this process, the SPC was surveyed and asked to review the mission statement adopted during the previous strategic plan process and if was still communicated our purpose. Of those that responded, 72% felt that the mission statement was out of date. Key concerns included:

- It lacked specificity;
- It did not accurately communicate what public health is; and
- It did not communicate an accurate picture of who the agency served.

Using an exercise that asks participants to identify 'Cause, Action and Impact', the SPC retooled the agency's mission statement to make it more reflective of its purpose.

Mission Statement:

Our Mission…

We promote optimal health to prolong life by preventing disease and assuring the protection of the public's health in our community and environment.

Vision Statement Process: After establishing values and mission, the SPC turned its attention to the future and where it wanted the health department to be in five to ten years. Once again, the SPC reviewed the vision statement adopted during the previous strategic planning process, participated in a visioning exercise that asked members to focus on media coverage of a future accomplishment. This process assisted the SPC in modifying the vision statement.

Vision Statement:

Our Vision…

We envision positively impacting the health of individuals, families, communities and the environment through responsiveness, competence and collaboration.

Establishing Strategic Priorities: Strategic priorities reflect the direction an organization takes in order to fulfill its mission and vision. Strategic priorities were determined by an expanded executive committee that included all agency administrators. Once established, the priorities were vetted back through the SPC which included all members of the Board of Health who provided final approval and adoption of the Strategic Plan.

Strategic Priority 1: Support and enhance the Agency's infrastructure to maximize its' performance as a public health organization of excellence.

Goal 1: Improve workforce development and strengthen systems and organizational capacities that support the workforce.

Obj. 1.1 By September 30, 2015, develop standardized policies, procedures and training materials for hiring and orientating employees to public health and the agency services.

Obj. 1.2 By September 30, 2015, develop and implement a succession plan for key organizational positions.

Obj. 1.3 By December 31, 2015, increase capacity of existing workforce.

Obj. 1.4. By December 31, 2016, identify and maintain a system for tracking and evaluating workforce needs and assure that 75% of employees have received required and program-specific training.

Obj. 1.5 By September 30, 2017, there will be a 25% improvement in staff engagement as measured through key workplace satisfaction indicators.

Obj. 1.6 By December 31, 2018, institute and maintain a performance management system that links to the Agency's planning processes.

Goal 2: Maximize business efficiencies and effectiveness through the use of technology.

Obj. 2.1 By December 31, 2015, identify strategies that lead to improvements in insurance billing.

Obj. 2.2 By December 31, 2015, examine current methods for accepting client payments using debit and credit cards and determine if improvements are needed.

Obj. 2.3 By May 31, 2016, purchase, install and maintain a new accounting system to replace the current accounting system.

Obj. 2.4 By September 30, 2017, utilize an Electronic Health Record for 100% of applicable customer services.

Obj. 2.5 By September 30, 2017, develop and maintain an Information Technology plan which will be used to guide the ongoing development and evolution of technology in support of the Agency's programs and its strategic directions.

Goal 3: Increase the Agency's capacity for conducting continuous quality improvement (CQI) and assurance activities.

Obj. 3.1 By December 31, 2015, provide CQI training on an annual basis to at least 75% of Agency employees.

Obj. 3.2 By December 31, 2015, implement and maintain a mandate/contract compliance process which will help to assure that the Agency is in compliance with all requirement mandated, contractual and program requirements.

Obj. 3.3 By December 31 2016, every Agency program will incorporate, monitor and report on quality improvement outcomes to the administration.

Obj. 3.4 By September 30, 2017, the Agency will develop a Quality Improvement Report which it will issue to the community and the Board of Health.

Strategic Priority 2: Assure and promote the delivery of high quality public health services that address community needs and result in health status improvements.

Goal 1: Develop and adopt communication strategies that will increase awareness of the Agency's public health services with its customers, its partners, its decision-makers and the communities it serves.

Obj. 1.1 By September 30, 2015, develop, implement and maintain a marketing plan which identifies the Agency's brand and informs its customers and the community it serves about its purpose, programs and services.

Obj. 1.2 By December 31, 2015, utilize social media as a way to communicate program and health information with customers and the community.

Obj. 1.3 By December 31, 2015, to improve the no-show rates of WIC clients, initiate text messaging with those clients that consent in order to facilitate rescheduling of appointments.

Goal 2: Continue to maintain and strengthen current collaborative relationships and pursue new endeavors that are based in evidence and/or best practices and address the communities' health needs.

Obj. 2.1 By May 30, 2015 identify and maintain collaborative relationships and explore opportunities to work together to address public health issues.

Obj. 2.2 By September 30, 2015, establish county-specific dash boards to monitor the community health improvement plans' implementations and outcomes.

Obj. 2.3 By May 31, 2016, collaborative with four local hospitals and other local partners on the completion of three-specific community health assessments that assess community health, physical health, health care systems and environmental health.

Obj. 2.4 By June 30, 2017, collaborate with local stakeholders in developing county-specific community health improvement plans and participate in their implementation.

Goal 3: Strengthen systems of care and develop organizational capacities that support service integration and cross-jurisdictional activities.

Obj. 3.1 By September 30, 2015, initiate a healthcare navigation program at off-site locations that improves access to health insurance and preventative health services.

Obj. 3.2 By July 31, 2016, develop a client-focused referral process that matches client's needs with available resources and establish baseline data for referral utilization.

Obj. 3.3 By March 31, 2017, implement and maintain an up-to-date resource and referral system that can assist staff and clients with accessing available resources.

Obj. 3.4 By September 30, 2018, maintain participation in appropriate cross-jurisdictional and regional efforts to integrate public health services.

See Attachment D for Annual Action Plans.

ATTACHMENT A: ROSTER OF STRATEGIC PLANNING COMMITTEE (SPC) FOR FY 14/15

NAME	TITLE	DIVISION	OFFICE LOCATION	PHONE	E - MAIL
AGENCY MEMBERS					
Deena Olds	Administrative Asst.	Operations	Coldwater	517-279-9561, ext. 112	oldsd@bhsj.org
Elizabeth Howard	Clerk	Operations	Three Rivers	269-273-2161, ext. 207	howarde@bhsj.org
Jim Cook	Emerg. Prepared. Coord.	Administration	Coldwater	517-279-9561, ext. 120	cookj@bhsj.org
Kim Wilhelm	Division Director	Prevention Services	Coldwater	517-279-9561, ext. 143	wilhelmk@bhsj.org
Laura Sutter	Coordinator - facilitator	Area Agency on Aging	Coldwater	517-279-9561, ext. 137	sutterl@bhsj.org
Maureen Petzko	Division Director	Operations	Coldwater	517-279-9561, ext. 107	petzkom@bhsj.org
Rebecca Burns	Division Director	Environmental Health	Three Rivers	269-273-2161, ext. 228	burnsr@bhsj.org
Rob Stauffer	Food Coordinator	Environmental Health	Coldwater	517-279-9561, ext. 109	staufferr@bhsj.org
Rochelle Bassage	Health Ed. – recorder	Health Education	Branch	517-279-9561, ext. 104	Bassager@bhsj.org
Steve Rutz	Division Director	Fin. & Info Technology	Coldwater	517-279-9561, ext. 128	rutzs@bhsj.org
Steve Todd	Health Officer	Administration	Coldwater	517-279-9561, ext. 148	todds@bhsj.org
Theresa Christner	Division Director	Health Ed./Promotion	Coldwater	517-279-9561, ext. 144	christnert@bhsj.org
Theresa Fisher	MIS Manager	Fin. & Info Technology	Coldwater	517-279-9561, ext. 102	fishert@bhsj.org
Valerie Newton	Coordinator	Health Ed./Promotion	Coldwater/Hillsdale	517-279-9561, ext. 110	newtonv@bhsj.org
Yvonne Atwood	Nurse	Prevention Services	Hillsdale	517-437-7395, ext. 307	atwoody@bhsj.org
Dr. Lauren Vogel	Medical Director	Administration	Coldwater		vogell@msu.edu
COMMISSIONERS					
Al Balog	Board of Health – Chair	Commissioner	St. Joseph	269-501-3977	ajinsur@aol.com
Brad Benzing	Board of Health	Commissioner	Hillsdale	517-254-4311	b.benzing@co.hillsdale.mi.us
Dale Swift	Board of Health – V. Chair	Commissioner	Branch	269-580-1768	Daleswift1@gmail.com
Mark Wiley	Board of Health	Commissioner	Hillsdale	517-869-2715	Wileyma1@yahoo.com
Robin Baker	Board of Health	Commissioner	St. Joseph	269-435-7980	Robin.baker51@comcast.net
Rod Olney	Board of Health	Commissioner	Branch	517-227-1960	rodjanolney@yahoo.com

ATTACHMENT B: STRATEGIC PLANNING WORK PLAN FY 2014/15 – WORKING DRAFT

Narrative Description of the Activities the LHD Will Undertake to Complete the Selected Deliverable	General Timeline for Completion of Deliverable (by week or month)	Brief Description of the Existing Resources that Support Work on the Deliverable	Brief Description of the Expected Outcomes as a result of Completion of Deliverable
1. **Convene an Executive Planning Committee made up of administrators to guide the process**	3/10/2014	• Executive Planning Committee will review the NACCHO strategic planning guide and the MALPH presentation.	• Steve, Rebecca, Laura and Theresa will make up the Executive Planning Committee.
2. Outline a process for completing the strategic plan.	10/10/2014	• Revisit NACCHO work plan in order to determine steps that need to occur in order for strategic plan to be completed in-house.	• Theresa will revise work plan for moving forward.
3. **Gain buy-in for work plan from Executive Planning committee.**	10/20/2014	• Executive Planning Committee will convene. • Executive Committee will assess readiness for strategic planning. • Executive Committee will review the revised work plan. • Executive Planning Committee will agree on strategic planning process.	• Theresa and Steve will convene the Executive Planning committee. • Meeting agenda and minutes.

4. **Identify strategic planning team of 12-14 people that includes the administration, coordinators, line staff and board of health member participation.**	10/20/2014	• Approve the following staff for representation on the Strategic Planning Committee:
		  • Val Newton, CSHCS/Hearing/Vision – Health Ed.
		  • Theresa Fisher, IT – Finance
		  • Rob Stauffer, CD and Food, Environmental Health
		  • Laura Sutter, AAA
		  • Yvonne Atwood, Prevention Services
		  • Deena Olds, Operations
		  • Steve Todd, Health Officer
		  • Rebecca Burns, EH Director
		  • Theresa Christner, Health Education
		  • Maureen Petzko, Operations
		  • Steve Rutz, Finance
		  • Kim Wilhelm, Prevention Services
		  • Elizabeth Howard, Tech
			• Executive Planning Committee will review and approve the strategic planning team.
			• Form completed – Assessing Readiness for Strategic Planning – NACCHO worksheet 1.
			• Roster of strategic planning committee.

		• Jim Cook, Emergency Preparedness • Dr. Lauren Vogel, Medical Director • Board of Health Member Participation	

5. Schedule first meeting with strategic planning committee for the purpose of:
• **Reviewing process**
• **Distribute information**
• **Provide staff with synopsis of information distributed**
• **Identifying stakeholders**
• **Identifying information missing, source and how information should be collected.**
	10/31/2014
	9 a.m. to noon
		• Team will receive a short orientation to strategic planning.
		• Team will receive the following resources to review:
		  • Current Strategic Plan
		  • Annual Action Plan
		  • Mission, Vision and Values Statements
		  • Annual Reports
		  • Community Needs Assessment materials for Branch, Hillsdale and St. Joseph Counties
		  • Community Monitor
		  • Customer Satisfaction data
		  • Employee satisfaction data
		  • Budget
			• (3 hours – video conferencing) Staff will review materials and become familiar with strategic planning process, the data that they have received, and assist with brainstorming in what information is missing and what stakeholder input is needed.
			• Complete NACCHO Worksheets 2 &3

6. Compile missing data and gain stakeholder input and distribute to strategic planning committee for their review.	11/21/2014	• Health education will collect missing data from sources identified. • Health Education will administer survey monkey instrument(s) to gain stakeholder input based upon strategic planning team input. • Data and input will be distributed to strategic planning team.	• Complete NACCHO Worksheets 10 & 11 Missing data elements will be provided, as well as a synopsis of the findings. • Survey results from stakeholders will be compiled and shared.
7. Strategic Planning team will meet to develop vision, mission and values statement and draft plan.	12/5/2014 9 a.m. to noon	• Team will review organizational mandates • Team will review accomplishments. • Staff will identify significant changes • Team will complete assessment of internal and external conditions. • Team will develop vision , mission and value statements.	• (3 hours – video conferencing) Form completed: NACCHO Worksheets 5, 6, 7, 8, 9 • Vision, Mission and Values are drafted.

8. Strategic Planning team will meet to conduct the environmental scan, assessing internal capacities and external conditions, including: • **Organizational Mandates** • **Significant changes** • **Accomplishments** • **Priorities/Strengths** • **Priorities/Weaknesses** • **Needs/Risks** • **Opportunities** • **External Factors**	12/11/2014 10 a.m. to 2 p.m.	• Review vision, mission and value statements developed at previous meeting. • Conduct SWOT Analysis and identify strategic issues • Prioritize strategic issues as a result of SWOT analysis • Team will identify strategies to address strategic issues. • Team will select 3 to 5 strategic priorities. • Team will break into groups to develop goal statements	• (4 hours – in person) SWOT Analysis completed • Forms Completed: Summary of Reports and Key Trends & NACCHO Worksheet 12 • Strategies needed to reach vision are drafted • Strategies are prioritized. • 3 to 5 strategies are selected. • Strategic Plan is developed
9. Team approves draft report (3rd meeting)	12/19/2014 9 a.m.	• Health Education will draft report to distribute to team and get their feedback. • Strategic Planning Team will approve the draft report	• (2 hours - video conference). • Plan is finalized.
10. Division Directors will share strategic plan with staff and work with them in teams to develop annual action plans.	01/09/2015	• Division will develop annual action plans for their areas that relate to the strategic plan • Team will consider evidence-based programs and promising practices as they develop goals/objectives. • Team will develop SMART objectives.	• Action Plans are completed. (Form: action planning worksheets and work plan sheets completed)
11. Division Directors/staff teams will review QI plan to assure that action plans are linked to QI activities.	01/16/2015	• Divisions will link QI activities with plans to assure that plans are working in coordination	• QI plans are completed.
12. Health Officer will present Strategic Plan, Action Plan and QI Plan to BOH for approval.	01/22/2015	• Board of Health will reviews Strategic plans and will approve.	• (Board of Health meeting) Strategic Plan

13. Plan implementation and monitoring. Division Directors will report on the status of the plans on an annual basis.	02/01/2015 and ongoing	• Health Ed. will develop forms for division reporting that are based on the annual plan format and will include benchmark and QI data.	• Division directors will complete forms and submit to health officer for reports at June and Jan. meetings
14. Ongoing Communication Plans will be monitored and staff/BOH will receive communication updates regularly	07/01/2015 and ongoing	• Staff will receive semi-annual updates through the LIVEWire and posted on employee page • Staff will develop a dash board that reflects indicators from Strategic Plan, QI Plan and CHA/CHIP • BOH will receive semi-annual updates as part of the health officer's report in June and January. • Annual report format may be modified to reflect add strategic plan updates.	• Staff will receive updates through Agency's electronic newsletter. • BOH will receive a report as part of Health Officer's report. • Updated annual report will be presented and approved annually.
15. Divisions will update annual action plans.	01/2016, 01/2017, 01/2018, 01/2019	• Divisions will meet to review and update annual plans.	• Annual plans are updated with staff review and input.
16. Strategic Planning Initiation. New plan initiated.	06/01/2019	• Reconvene Executive Committee to being new plan.	• Reinitiate Strategic Planning Process

ATTACHMENT C - ENVIRONMENTAL SCAN RESULTS (12/11/2014)

During our environmental scan session we reviewed both internal issues and external factors related to our environment so we could understand how we can assure that our vision can be achieved. Our new vision statement is as follows:

We envision positively impacting the health of individuals, families, communities and the environment through responsiveness, competence and collaboration.

During the BHSJ CHA environmental scan, four themes emerged:
1. Service Delivery
2. Technology
3. Cross Jurisdictional/Multi-Jurisdictional/Collaboration
4. Communication

Issues related to staffing and funding were identified as cross cutting across all issues.

SERVICE DELIVERY		
Issue	*Implications*	*Source*
HIPAA/PPI (personal protected information)	Implementing new and/or additional technology can impact the existing rules and widen their scope. This recently occurred in October 2013 when specific Privacy and Security policies and procedures required updating because a component of HITECH became effective.	- HIPAA, HHS - PPI, IRS - Health Information Technology for Economic and Clinical Health (HITECH)/ARRA, HHS
MEDICAL HOMES	ACA supports patient-centered medical homes by assuring that people have access to health insurance. As part of ACA, health insurance programs are mandated to provide essential benefits which include: - Ambulatory patient services - Emergency services - Hospitalization - Maternity and newborn care - Mental health and substance use disorder services - Prescription drugs - Rehabilitative and habilitation services and devices - Laboratory services - Preventive and wellness services and chronic disease mgmt. - Pediatric services, including oral and vision How will the provision of these services at a medical home impact our prevention services (i.e., immunizations, STD screening, etc.)? Will this move us more into a regulatory role? Or create a more competitive environment for us? What will it do to current caseloads and how to we adjust for these changes?	- Affordable Care Act (ACA), HHS
HEALTH INSURANCE NAVIGATION	The health department has recently become a certified navigation organization for both the Healthcare Marketplace and for the Department of Human Services which has expanded our Medicaid Outreach focus and provided additional funding. This service seeks to assist individuals seeking to comply with health insurance	- ACA, HHS

	mandates specified by the ACA. Along with these programs come rules related to HIPAA and PPI. Funding is not guaranteed and no one is sure on how long it will last. With changes in Congress, the program may or may not continue. The future of the program is contingent upon any attempt by Congress to repeal all or certain components of the ACA.	
ICD 10	ICD stands for the International Classification of Disease. A new coding structure that is to be used for EMR, disease monitoring and billing purposes goes into effect on Oct. 1, 2015. BHSJ CHA is required to use this new coding structure for all HIPAA transactions.	- Centers for Medicare and Medicaid Services (CMS)/HHS
SYSTEM INTEGRATION	System integration refers to developing a network of health care providers and organizations which provide or arrange to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served. Movement in this area is already occurring as schools expand to provide clinics; primary care offices integrate with behavioral health organizations and hospitals and/or colleges work to integrate with public health departments; meaning new models are being developed in the effort to: improve quality and reduce costs, improve responsiveness to consumers and benefit the overall community. Internally, the agency has also focused on service integration which is best demonstrated through its involvement in the multi-jurisdictional food investigation program and in how it conducts disease investigations. These programs use shared disease protocols and staffing in order to identify and control disease outbreaks. Staff involved include: Prevention Services, Environmental Health, Emergency Preparedness and Health Education.	- ACA/HHS and SAMSHA/ HHS - MDARD
DECREASING UTILIZATION OF PREVENTION-BASED TRADITIONAL PUBLIC HEALTH PROGRAMS	During the environmental scan it was noted that the agency had experienced decreasing utilization numbers in some of its traditional programs (i.e., WIC, Immunizations, STD and HIV/AIDS Testing and Counseling). WIC, it was noted, was experiencing high enrollment rates, but lower utilization rates. It was also noted that this downward trend in utilization is occurring statewide. Lower WIC coupon utilization could be associated with a number of internal and external factors including: not communicating in a manner that reflects customer preferences (i.e., social media); not using text messages to remind clients of appointments; changes in food stamp policies for families receiving assistance; improved economic times; transportation; lower birth rates; etc. Lower rates of immunization were associated with school clinics; an increase in the number and scope of pharmacy-based vaccine programs; decreasing population, etc. Lower utilization in WIC may result in financial impacts for the agency. Lower immunizations may also impact billable services and revenues associated with providing vaccinations. However, if the number of vaccinators within the counties increase, there may be opportunities to shift our focus and provide more nurse education services and site visits. This could offset reduced revenue associated with giving shots directly.	- CPBC, MDCH

STAFFING	The agency maintains highly skilled staff. Many of the program's core staff members have been employed by the agency for many years. The staff is aging, however; and the need for succession planning is growing. The recruitment of qualified staff to replace staff who leave due to personal reasons or retirements, as well as their ongoing education and training needs, continue to pose challenges for the agency. The agency does not have a training plan or a staff development plan. Shrinking budgets result in shrinking programs and shrinking staff numbers, meaning more people wear more hats and require more expertise in a variety of areas. Alternative staffing approaches (i.e., the use of the contract employees) have been used when the needs fit IRS requirements. A statewide nursing shortage makes recruitment of nurses to a rural community difficult. Training and assuring the consistent implementation of skills and techniques learned across four sites is challenging.	- Adm. Rules, MDCH - Contractor Rules, IRS
FUNDING	Funding received by the agency is down by $1 million since 2010. County allocations are back to maintenance of effort levels established in 1993. Grant funding has been maximized. The agency has successfully applied for and received over $2.1 million dollars for the agency, the community and its partners. Unfortunately, the grants are time limited and very specific. Community benefits (i.e., improved access to care), good partnership and equipment needs met have resulted, which is good. The downside includes: additional work added to the current staff and administration, new/additional reporting requirements and collection methods, and fragmented programming. Billing limitations for commercial products also limits the target population to be served. In addition to the complex funding mix that includes state categorical, reimbursement and block grant funds, county allocations, fees for service and 3rd party insurers, there a number of unfunded mandates, which health departments are required to provide but for which they do not receive funding (i.e., lead screening, nuisance complaints, etc.) The agency has a fund balance which it has begun to use it for operational funding. Funding also impacts staffing, as staff express discontentment with wages and cost of living increases are not made available. How funding is accounted for, can be used, etc., is directed by a series of OMB circulars which are being rolled into one Super Circular which could result in more subrecipient monitoring.	- County Commissions - ACA, HHS - Public Act 152, 2011 - Michigan Public Health Code, State of Michigan

TECHNOLOGY		
Issue	*Implications*	*Source*
HIPAA/PPI (personal protected information)	The use of technology implies the generation, compilation and transmission of data. HIPAA and PPI have specific security requirements related to how data can be stored, transmitted and received which impact how we do business, how we release information, to whom we can release information and for what purpose.	- HIPAA, HHS - PPI, IRS - Health Information Technology for Economic and Clinical Health (HITECH)/ARRA, HHS
BILLING	Billing for services is a HIPAA transaction and is impacted by the replacement of ICD 9 with ICD 10 codes. How we bill for services must comply with all HIPAA requirements? How we document the services and account for the billing/payment of services are closely connected. As more people are insured, our ability to bill additional insurance providers may increase. In addition, CMHC, our current accounting system, will no longer be supported in 2017.	- HIPAA/HHS, - Centers for Medicare and Medicaid Services (CMS)/HHS
PAYMENT	We currently receive payments by check or credit card via GovPayNet.com. As more people use debit cards, credit cards and/or healthcare saving accounts to pay for services and/or co-pays, we may need to expand our payment options if we want to maximize our revenue and/or attract new customers.	- HIPAA, HHS - Centers for Medicare and Medicaid Services (CMS)/HHS
ELECTRONIC MEDICAL RECORDS	An electronic health record (EHR) is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users. While an EHR does contain the medical and treatment histories of patients, an EHR system is built to go beyond standard clinical data collected in a provider's office and can be inclusive of a broader view of a patient's care. EHRs can: Contain a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, laboratory and test results: Allow access to evidence-based tools that providers can use to make decisions about a patient's care; and Automate and streamline provider workflow. One of the key features of an EHR is that health information can be created and managed by authorized providers in a digital format capable of being shared with other providers across more than one health care organization. EHRs are built to share information with other health care providers and organizations – such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities, and school and workplace clinics – so they contain information from ***all clinicians involved in a patient's care***. This has implications related to HL#, billing, ICD 10 codes, meaningful use and system integration, as well as regionalization. Currently, the department has a fragmented data/medical recording approach – using MCIR, WIC, document imaging, MDSS, CHAMPS and its own online disease surveillance system and access databases to collect information, making it difficult to establish the current insurance mix, perform QI, and/or to transmit or receive data from other providers.	- HIPAA, HHS - Health Information Technology for Economic and Clinical Health (HITECH)/ARRA, HHS - Centers for Medicare and Medicaid Services (CMS)/HHS - ACA, HHS - ARRA, HHS -

MEANINGFUL USE	Meaningful Use refers to using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities; Engage patients and family; Improve care coordination, and population and public health; and Maintain privacy and security of patient health information. Requirements for meaningful use involve specific public health reporting criteria. By incorporating public health into the meaningful use requirements, epidemiological statistics and population health can be more accurately monitored. It also offers funding incentives to organizations that can meet a specific number of objectives.	- HIPAA, HHS
BUSINESS INTELLIGENCE PROJECT	By definition, business intelligence is the set of techniques and tools for the transformation of raw data into meaningful and useful information for business analysis purposes. BI technologies are capable of handling large amounts of unstructured data to help identify, develop and otherwise create new strategic business opportunities. The goal of BI is to allow for the easy interpretation of these large volumes of data. Identifying new opportunities and implementing an effective strategy based on insights can provide businesses with a competitive market advantage and long-term stability. This business intelligence project goes hand-in-hand with Accreditation and quality improvement requirements.	- HIPAA, HHS - Health Information Technology for Economic and Clinical Health (HITECH)/ARRA, HHS - Local Public Health Operations/MDCH - Michigan Local Public Health Accreditation
COMMUNITY NEEDS ASSESSMENT (CHNA)/ COMMUNITY HEALTH IMPROVEMENT PLANNING (CHIP)	CHNA and CHIP requires access and utilization to data for the purposes of analyzing health data, establishing benchmarks, conducting disease surveillance, monitoring outcomes and providing program evaluation. All of these require the use of raw data from a variety of sources, including Vital Records, Perceptions Surveys,	- County Health Rankings/RWJ
EMERGING TECHNOLOGY	Technology is continuously improving. Soon after equipment is purchased it is out of date. As software becomes obsolete and is no longer supported, changes are needed to stay current. The health department should establish processes to continuously evaluate its options and be prepared for changes that can occur as a result of changes in rules, regulations, contracts and/or program mandates.	-
STAFFING	IT staff also need to be involved in doing requirement sessions for emerging technology that is applicable to the department. IT Staff need time to develop RFPs in order to assess vendors for agency's hard and software needs. IT Staff need time to learn new technology and then be able to teach the technology to others. Staff members need time to learn the technology and then have time built into their schedules in order to apply the technology. As an example, the roll out of the document imaging project has been slowed because of conflicting priorities and competing demands.	-

FUNDING	There is no IT budget for replacement costs of existing technology. The department does have a healthy but decreasing fund balance which could be tapped for technology and automaton needs. To save money, the agency has opted for the development of internal databases that are functional but specific to their program needs.	-

CROSS JURISDICITION/MULTI-JURISDICTION/COLLABORATION		
Issue	*Implications*	*Source*
GOVERNOR'S PROSPERITY REGIONS	The Governor's Regional Prosperity Initiative is comprised of two parts, an effort by the State of Michigan to align around a common set of service delivery boundaries to create a better structure for collaboration and a local voluntary grant initiative to support collaboration where it is happening and encourage it where more can still be done. The Governor's regions split the health jurisdiction, aligning Hillsdale with Region 9 and Branch and St. Joseph Counties with Region 8.	- Governor's Executive Order
LOCAL PUBLIC HEALTH REGIONALIZATIO N	Michigan's public health code has allowed for the formation of city, county and district health department. Over the years, the number of local health department has remained stable at 45, as some districts have expanded and others have dissolved. Some current examples of regionalization efforts initiated by MDCH include: developing regional perinatal centers; Emergency Preparedness regions; and regional epidemiologists. Whether these regions reflect current healthcare delivery patterns is unsure New efforts to create more regional public health departments have resulted in the creation of a new map that features 15 regional health departments. BHSJ CHA would become part of the SW region. It would remain intact, but might lose its rural focus. Questions about how to maintain local control are unanswered.	- Local Public Health Operations/MD CH
COMMUNITY NEEDS ASSESSMENT (CHNA)/ COMMUNITY HEALTH IMPROVEMENT PLANNING (CHIP)	CHNA and CHIP are collaborative processes used to identify local health needs and are done jointly within each county by the local non-profit hospital(s), health department and other interested healthcare providers. In 2013, St. Joseph County's CHNA and CHIP were completed. In 2014, Hillsdale and Branch County's CHNA and CHIP were completed. Each county chose their own problem areas and devised strategies for improvement. The health department provided assistance in developing perception surveys, administering surveys and provided analysis of secondary data sources. It also participated in community forums that set priorities and developed strategies and is an active participant in the CHIP implementation. The department also provided county specific, regional, state and national data for comparative purposes.	- Michigan Local Public Health Accreditation, CPBC/MDCH
MULTI-PURPOSE COLLABORATIVE BODIES	The Multi-Purpose Collaborative Body (MPCB) is an inclusive planning and implementation body of stakeholders at the county or multi-county level. At one-time, MPCB were charged to foster collaboration with shared resources in order to develop community networks. Now, they exist to provide networking opportunities and promote services. BHSJ CHA is an active participant and dues paying member on all three, county-specific, MPCB groups.	- MDCH/Mental Health
BUSINESS INTELLIGENCE PROJECT	As described above, system integration, as well A business intelligence project is being initiated in Southwest Michigan among local health departments that will establish comparative data sets for outcome and quality monitoring. This project could result in the creation of a data warehouse and serve as a model for all local public health in Michigan. This has implications for system integration, as well as for regionalization.	- HIPAA, HHS - Health Information Technology for Economic and Clinical Health (HITECH)/AR RA, HHS

		- Local Public Health Operations/MDCH - Michigan Local Public Health Accreditation
FUNDING/INCENTIVES	More and more, funding is available only at the regional level or is used to promote the initiation of regional programming. Examples of this include: Public Health Emergency Preparedness provides funding at the regional level to the MCA regions; CDC has issues RFPs that specify target populations of 500,000; Both MDCH and RWJ are funding regional initiatives.	- CDC - MDCH - RWJ (Robert Wood Johnson Foundation)
MULTI-JURISDICTIONAL FOOD BORNE DISEASE INVESTIGATION PROGRAM	This is a cross disciplinary/cross jurisdiction initiative specific to food-borne outbreak investigations that seeks to integrate services internally between Emergency Preparedness, Prevention Services and Environmental Health Food Programs; and again, across health jurisdictions between health departments, so as to foster collaboration, common protocols, policies and communication mechanisms.	- MDARD - FDA
STAFFING	It is unsure how regionalization will occur and what it will look like. Will it occur through contractual relationships with departments or with counties? Michigan has several approaches in recent years. Detroit dismantled their health department and privatized the staff. CMHS were reorganized into regional entities and local CMHS continue to provide services under a contractual umbrella. Jackson shares administrative staff with the local hospital. Other surrounding states have restructures their health departments to include only core functions and environmental health services, leaving private providers and other healthcare providers to pick up direct personal services (i.e., immunizations, WIC, etc.) It is difficult to know what staffing patterns will be needed or the type of programming that will be offered.	

COMMUNICATION		
Issue	*Implications*	*Source*
SOCIAL MEDIA/EXTERNAL	Social media are a group of Internet-based applications that build on foundations of the web and allow for the creation and exchange of user-generated content. Social media depends on mobile and web-based technologies are interactive and allow individuals and communities to share, co-create, discuss, and modify user-generated content. Social media is different from traditional or industrial media in many ways, including quality, reach, frequency, usability, immediacy, and permanence. Pinterest, Facebook, Twitter, Instagram and texting are all forms of social media. Texting is especially important to young people in need of a reminder of an upcoming appointment. Currently the agency hosts a web page. While the webpage is very successful, it may not have the far reaching capabilities that social media has been reported to have – nor does it reflect the common communication modalities that our clients use to connect to the world and to each other. The agency did use texting within its home visitation program to assure that a person was home prior to driving out to the appointment. Health education works in conjunction with the school-linked clinics and its tobacco reduction partners to host Facebook pages. Many other health departments have Facebook pages and twitter accounts. There are no technology and/or training needs associated with management of these pages, but rather policy needs and staff needs related to keeping pages updated, assuring good messaging, monitoring content and growing membership. The agency publishes two additional newsletters: Health Professional Newsletter and a Food Newsletter. An additional bi-annual CSHCS newsletter is in the works. The agency also has developed a series of pamphlets and educational displays. While the agency does have its logo, it has not really branded itself. In FY 13, the agency distributed over 50 news releases to 12 local media contacts to keep the public informed about public health issues and the agency.	- HIPAA/PPI, HHS
INTERNAL COMMUNICATION	Problems associated with poor communication continue to result in relationship problems between staff and with management. Both the employee satisfaction survey and the employee strategic planning survey indicate that communication or lack of effective communication is an ongoing issue that needs to be addressed. Personnel changes, termination of programs, a funding deficit and lack of policies/procedures appear to be contributors and complicate the matter. The department has instituted an agency-wide electronic newsletter, moved to voice-over-internet and installed fiber optics as attempts to address some known communication issues. An expanded use of technologies is needed.	- Local Public Health Operations/ MDCH

INFORMATION, RESOURCE & REFERRAL	Information, resource and referral mean the ability to form networks for the purpose of sharing client information. It's about being known for the services you provide by other providers and knowing where to send people in need of services we don't provide. The agency maintains a database of providers which requires updating. Finding health education staff time for updating the database is difficult as health staff time becomes more focused to specific areas as required by grants. Many staff members who have direct client interactions do not know about the database or how to use it. Hillsdale and St. Joseph maintain 211 phone systems; however, it has been found that these are not fully utilized by the public. Most of the calls received by 211 are for food and shelter issues. Healthcare and public health service referrals have been underreported. Branch County has a domestic violence1-800 number that again, is primarily used for shelter and food needs. Issues related to internal referral processes have been identified as a result of focus groups and grant program mandates. Staff may need more information to learn what is occurring in different divisions and in different locations.	- HIPAA, HHS - Centers for Medicare and Medicaid Services (CMS)/HHS
ADVOCACY	The agency maintains membership with MALPH and on its various forums (including NAF, BHSF, MALEHA, Health Officers, Administrators, etc.) and works diligently to establish working relationships with legislators. Administration is actively participates in legislative days as organized by its association. The Agency's Association has been working on advocating for a return of funds which has led to a partial reinstatement of LPHO block grant.	
STAFFING	Staff may benefit from training within the agency to better understand the programs that the agency provides. Frontline staff members lack opportunities to learn about the programs that others provide within the community. Staff members need training updates on policies/procedures on a regular basis. Staff should receive training on QI and how to utilize techniques within the agency. Staff could benefit from receiving customer service training as well as motivational interviewing training.	
FUNDING	While program budgets do include funding for staff training specific to that allowed or mandated by the grant, there is no staff development fund. In the recent past, the agency has provided some scholarship assistance to employees who are returning to school, but funds are limited and not widely known.	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Strategic Direction #1: Support and enhance the Agency's infrastructure to maximize its' performance as a public health organization of excellence.					
Goal 1: Improve workforce development and strengthen systems and organizational capacities that support the workforce.					
Objectives	**Activities**	**Timeframe**	**Expected Outcomes**	**Responsible Parties**	**Progress Notes**
Obj.1.1 By September 30, 2015, develop standardized policies, procedures and training materials for hiring and orienting employees to public health and the agency's services	a. Review other agencies policies and procedures for hiring employees and orientation packets	March – April, 2015	• Model policies/procedures and orientation packets will be identified	**Human Resources (HR) Team**	
	b. Formalize Agency hiring and orientation processes by mapping out process, writing policies and procedures and developing applicable forms related to: job description development, job postings, candidate selection team, interview questions, reference checks, selection processes, job offers, required screenings/physicals, employee evaluations and orientation	April - June, 2015	• A formal process map will be developed to show step by step how hiring is done • Hiring procedures will be standardized across the Agency and policies and procedures will be incorporated into the supervisor's manual • Forms, along with a hiring/orientation packet will be available from HR	**HR & QI Teams**	
	c. Develop orientation packet, calendar and check off list which is tailored to staff responsibilities and may include: introduction to public health , agency services, blood borne pathogens, Medicaid Outreach reporting, internal referral processes, phone and email systems, purchasing requests, timekeeping, IT policies, and other applicable areas	June - August, 2015	• A multi-step orientation process will be developed which will include more one-on-one time with supervisor • Staff will demonstrate a better understanding of the interconnectivity of their programs with the overall goals of the agency and the goals of public health • Staff will be more knowledgeable about Agency business practices.	**HR & Admin Teams**	
	d. Monitor all new hires to assure check off list are complete and that staff is competent in their understanding of the information	September, 2015 and ongoing	• Improved monitoring of new staff to assure they are more completely integrated into the Agency	**HR Team, Supervisors & New Hires**	
Obj. 1.2 By September 30, 2015, develop and implement a succession plan for key organizational positions	a. Identify key management positions that will be vacated in the next five years	March, 2015	• Key positions will be assessed	**HR & Admin Teams**	
	b. Assess staff against competency requirements to identify talent and developmental needs	April, 2015	• Staff are identified who have potential for growth	**HR & Admin Teams**	
	c. Select candidates for development	May, 2015	• Staff are interviewed to assess interest	**HR & Admin Teams**	

	d. Offer leader and leadership development opportunities	June 2015 and ongoing	• Staff are provided opportunities	**HR & Admin Teams**	
	e. Evaluate outcomes of program	September 2015 and ongoing annually	• Staff leadership development is monitored.	**HR & Admin Teams**	
Obj. 1.3 By December 31, 2015, increase capability of existing workforce	a. Define target skills and competencies across all disciplines that are needed	April, 2015	• Positions are assessed in order to assure competencies and skill required. • Staff are assessed to assure they hold and maintain the proper credentials for positions	**HR Team**	
	b. Assure staff have access to needed training for identified skills and competencies	June, 2015	• Required staff trainings are identified to assure skills and competencies	**HR Team**	
	c. Assure access to web-based training opportunities via technology when possible	September, 2015	• Available webinars are compiled and posted as a document with hyperlinks on BHSJ CHA employee quick links website	**HR and IT Teams**	
	d. Develop training plan which includes mandatory and skill-building training as part of employee evaluation process	December 2015 and ongoing	• Training plans are developed as part of performance goals • Training plan adherence are reviewed during employee evaluation	**Supervisors and Employees**	
Obj. 1.4 By December 31, 2016, identify and maintain a system for tracking and evaluating workforce needs and assure 75% of employees have completed required and program specific trainings	a. Identify tracking software needs through requirement sessions with HR and Admin teams	October, 2015	• Requirements for software are determined	**Human Resources and IT Teams**	
	b. Obtain software and learn how to use	December, 2015	• Software is either developed or purchased/obtained	**Human Resources and IT Teams**	
	c. Develop policies, procedures regarding its purpose and how to use	January, 2016	• Policies and procedures are formalized and communicated to management and staff	**Human Resources and IT Teams**	
	d. Training encounters are entered into software	January, 2016 ongoing	• Data on training is complied	**Employees**	
	e. HR and Supervisors reviews reports to assure staff are completing their training	December, 2016 and ongoing	• HR Team & Supervisors review report to determine if staff are complying with training plan	**HR Team & Supervisors**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Obj. 1.5 By September 30, 2017, the agency will experience a 25% improvement in the engagement of staff as measured through key workforce satisfaction indicators.	a. Admin Team and Personnel Policies committee will work together to devise a more formal communication strategies with staff which may include: all staff meetings, Q & A coffee breaks with key administrators, Agency Update postings, etc.	June, 2015 and ongoing	• Communication plan will be developed which will include input from staff	**Health Officer and Personal Policies Team**	
	b. Admin Team and Personnel Policies will review employee satisfaction survey to identify key indicators of improvement	December, 2015	• Indicators to measure improvement will be identified • Baseline data will be determined	**Health Officer and Personal Policies Team**	
	c. Employees will be surveyed annually and indicators of improvement will be monitored and strategies adjusted.	June, 2016 and ongoing annually	• Staff engagement in the Agency will improve by 25%	**Health Officer and Personal Policies Team**	
Obj. 1.6 By December 31, 2018, institute and maintain a performance management system that links to the Agency's planning processes	a. Assess current employee appraisal process in light of agency and program goals and retool	September, 2016	• Retooled process that links to agency and program goals will be created	**HR & Admin Teams**	
	b. Identify and communicate appropriate expectations for staff that align with set goals	December, 2016	• Employees will better understand their the scope of their role and responsibilities within the agency and their programs	**HR & Admin Teams**	
	c. Explore ways to incentivize staff performance	December, 2017	• Incentivizing staff performance will lead to more staff investment in program/agency success	**Finance & HR Teams**	
	d. Monitor employee performance and goal attainment	December, 2017 and ongoing	• Employees performance will be tied to outcomes	**HR Teams and Supervisors**	
	e. Evaluate performance mgt. system and Agency goal attainment	December 2018 and ongoing	• Employees are rewarded for initiative and hard work • Employees are more engaged	**HR and Admin Teams**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Goal 2: Maximize business efficiencies and effectiveness through the use of technology					
Objectives	**Activities**	**Timeframe**	**Expected Outcomes**	**Responsible Parties**	**Progress Notes**
Obj. 2.1 By December 31, 2015, identify strategies that lead to improvements in insurance billing.	a. Assess which programs need billing and, working through MALPH forums, survey how other local health departments are handling credit and debit cards	April, 2015	• Potential issues and possible solutions related to handling payment transactions will be identified	**Finance Director**	
	b. Identify companies that assist with handling transactions and review fee structures, privacy, security and technology needed issues	June, 2015	• List of possible companies that already work with local public health will be identified • Solutions will be vetted	**Finance Director, IT and Admin Teams**	
	c. Select company and enter into an agreement.	August, 2015	• Company will be selected and agreement established	**Finance Director & Health Officer**	
	d. Develop appropriate policies, procedures and train front line and accounting staff on how to use	October, 2015	• Policies and procedures will be developed • Training materials developed and staff trained	**HR and IT Teams**	
	e. Implement process and evaluate annually	December 2015 and ongoing	• Clients will be able to use their debit and credit cards for payment of services	**Finance Director**	
Obj. 2.2 By December 31, 2015, examine current methods for accepting client payments using debit and credit cards and determine if improvements are needed.	a. Review current billing issues and identify areas of concern that need to be addressed	May, 2015	• Assessment of all billing issues are identified	**Finance Director and Admin Team**	
	b. Explore possible billing models which may include: outsourcing, hiring a medical biller or training existing staff and conduct a cost benefit analysis	July, 2015	• A review and cost associated with the various billing models is conducted	**Finance Director and Admin Team**	
	c. Determine most cost efficient and most effective solution and implement	September, 2015	• A billing model is selected that takes into account all costs and benefits to agency	**Finance Director and Admin Team**	
	d. Evaluate outcomes of new model	December 2015 and ongoing	• Quality indicators that measure efficiency, effectiveness and satisfaction are identified that are used to measure the on-going success.	**Finance Director and Admin Team**	

Obj. 2.3 By May 31, 2016, purchase, install and maintain a new accounting system to replace the current accounting system.	a. Conduct requirement sessions to determine accounting system needs.	April, 2015	• Requirements for new accounting system are established	**Finance Director, Accounting & IT Teams**	
	b. Review available accounting system packages used by other local health departments to determine other benefits/considerations	May, 2015	• Review of existing systems has been considered and a list of possible features developed	**Finance Director, Accounting, Admin & IT Teams**	
	c. Meet with vendors for onsite demonstrations	August 2015	• Vendors provide on-site demos which feature functionality, ease of use, reporting, hard-ware requirements, etc.	**Finance Director, Admin &Accounting & IT Teams**	
	d. Issue RFI to specify hardware/software, functionality and support needs	September, 2015	• RFI is crafted which reflects BHSJ needs and wants • RFI is distributed to at least 3 vendors	**Finance Director, Accounting & IT Teams**	
	e. Evaluate responses and make selection	December, 2015	• RFI responses are collected • RFI team reviews and evaluates findings	**Finance Director, Accounting & IT Teams**	
	f. Purchase, install software and assure privacy/security	January, 2015	• Software is purchased and installed in a test environment	**Finance Director & IT Teams**	
	g. Write policies and procedures for utilizing new system	February, 2015	• Policies and procedures are written	**Finance Director & Accounting & IT Teams**	
	h. Establish test environment and train staff	April, 2015	• Training of staff occurs. • Vendor provides support to assure that system is working	**Finance Director & Accounting & IT Teams**	

	i. Migrate historical/current data into system and go live	May, 2015	• Current data and historical data is available • System is utilized	**Finance Director & Accounting & IT Teams**	
	j. Evaluate system and make improvements	May, 2015 and ongoing	• CQI Indicators of success are established and financial process is monitored through record review	**Finance Director & Accounting & IT Teams**	
Obj. 2.4 By September 30, 2016, utilize an Electronic Health Record for 100% of applicable customer services	a. Identify the agency's Medicaid caseload and assess other LHDs EHR selections	June, 2015	• The Agency's Medicaid caseload will be established.	**Admin and IT Teams**	
	b. Explore options for meaningful use and other state funded programs to assist with EHR establishment	August, 2015	• The Agency will better understand the financial incentives and purpose of EHR	**Admin and IT Teams**	
	c. Conduct requirements sessions to establish program specific issues, compatibility and system integration issues (i.e., Finance, MCIR, WIC, I-synergy files, CSHCS, etc.)	October, 2015	• Agency will better understand its needs, as well as compatibility issues related to other programs it maintains and how to integrate systems.	**Admin, Prevention, Health Education and IT Teams**	
	d. Meet with vendors for onsite demonstrations	January, 2016	• Staff and Admin will better understand the types of functionality available and how it will improve their processes	**Admin, Prevention, Health Education and IT Teams**	
	e. Issue RFI to specify hardware/software, functionality and support needs	March, 2016	• RFI will be specific to Agency's predetermined needs.	**Admin and IT Teams**	
	f. Evaluate responses and make selection	April, 2016	• Product selected will be based on Agency's needs and desires	**Admin and IT Teams**	
	g. Develop roll out plan and purchase, install software and assure privacy/security	May, 2016	• Staged roll out will assure employee training opportunities, as well as provide opportunities for system integration control	**IT Teams**	
	h. Write policies and procedures for utilizing new system	June, 2016	• Documentation will be available to assist users on proper utilization	**IT Teams**	
	i. Establish test environment and train staff	July, 2016	• Test environment will help to assure that system is working properly and facilitate training opportunities	**IT, Prevention and Health Education Teams**	

	j. Evaluate system and make improvements	September, 2016 and ongoing	• CQI Indicators of success are established and financial process is monitored through record review	**IT, Prevention and Health Education Teams**	
Obj. 2.5 By September 30, 2017, develop and maintain an Information Technology Plan which will be used to guide the ongoing development and evolution of technology in support of the Agency's programs and strategic directions	a. Review Strategic plan and align with the various technology projects and goals	October, 2016	• Assures that technology projects are in alignment with Strategic planning efforts.	**SPC and IT Teams**	
	b. Interview Agency Admin team and staff to identify operational needs not met	November, 2016	• Operational needs and Admin needs are identified	**IT, Admin Teams and Division Staff**	
	c. Create benchmarks for IT and identify IT spending sources	January, 2017	• CQI Indicators of success are established and financial funding is budgeted for future needs/opportunities	**IT and CQI Teams and Finance Director**	
	d. Assess Agency's software and systems	April, 2017	• Future software and system needs are adequately planned for	**IT and Admin Teams**	
	e. Identify current gaps between strategic goals and current operations	June, 2017	• Gaps are identified and addressed	**IT and Admin Teams**	
	f. Develop short and long-term project plan and timelines	August, 2017	• Information Technology is planned for that supports Agency's strategic direction	**IT and Admin Teams**	
	g. Assure Technology Team maintains a focus for all future strategic efforts	September, 2017 and ongoing	• Technology is recognized as an important aspect of all future strategic planning initiatives	**Admin and IT teams and SPC**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Goal 3: Increase the Agency's capacity for conducting continuous quality improvement (CQI) and assurance activities					
Objectives	**Activities**	**Timeframe**	**Expected Outcomes**	**Responsible Parties**	**Progress Notes**
Obj. 3.1 By December 31, 2015, provide CQI training on an annual basis to at least 75% of Agency employees	a. Identify core curriculum for CQI and identify training models to be used	April, 2015 and ongoing	• Evidence-based CQI curriculum model will be identified, along with the best method for assuring its most effective delivery	**Health Ed. And HR Teams**	
	b. Schedule training and implement training model	October, 2015 and ongoing	• Initial training will be occur	**Health Ed. And HR Teams**	
	c. Evaluate outcomes of training based upon pre and post tests	December, 2015 and ongoing	• 75% of staff will complete training and will understanding basic CQI techniques • Training will be included as part of future required training and added to staff development plan	**Health Ed. And HR Teams and Staff**	
Obj. 3.2 By December 31, 2015, implement and maintain a mandate/contract compliance process which will help to assure that the Agency remains compliant with all required mandates, contracts and program requirements	a. Develop a time table related to mandates and assure that mandates/contracts/minimum program requirements are reviewed annually for updates.	December, 2015 and ongoing	• All contracts are reviewed annually and mandates are identified. • All legislative mandates updates are communicated • Programs assure they are in compliance with MPRs.	**Health Ed. And HR Teams and Staff**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Obj. 3.3 By December 31, 2016, every Agency program will incorporate, monitor and report quality improvement outcomes to the administration	a. Each program will identify staff to work in a CQI teams	June, 2015	• Each program will have established a CQI committee	**Health Ed and CQI Teams**	
	b. Each program area will identify an area of improvement that it wants to work on.	January, 2016	• Program specific improvements will be identified • Each program will seek to make improvements in line with CQI plan	**Health Ed and CQI Teams**	
	c. Each program will complete a process map and/or institute a CQI technique designed to identify needed improvements	February, 2016	• Staff will utilized CQI training to use CQI techniques	**Health Ed and CQI Teams**	
	d. Each program will identify indicators of success and set benchmarks and targets	April, 2016	• Indicators of success will be established	**Health Ed and CQI Teams**	
	e. Each program will monitor their improvement and report outcomes to Administration	December, 2016 and ongoing	• Program improvements will be reported upon to Admin Team • Employees will be more engaged in their program areas.	**Health Ed and CQI Teams**	
Obj. 3.4 By September 30, 2017, the Agency will develop a Quality Improvement Report which it will issue to the community and the Board of Health	a. Health Education will develop format for CQI report (i.e., written report, dashboard, etc.)	January, 2017	f. Format is developed	**Health Ed.**	
	b. Health Education will compile data for report and prepare report	March, 2017	c. Initial data is compiled, along with benchmark indicators	**Health Ed.**	
	c. Health Education will present report to Admin team	June, 2017	d. Report is approved by Admin Team	**Health Ed. And Admin Team**	
	d. Health Officer will present report to BOH for approval	July, 2017	e. Report is approved by BOH	**Health Officer and BOH**	
	e. Health Ed will assure approved report available and distributed to appropriate stakeholders	September, 2017 and ongoing	f. Report is available and publicized through the media	**Health Ed.**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Strategic Direction #2: Assure and promote the delivery of high quality public health services that address community needs and result in health status improvements.					
Goal 1: Develop and adopt communication strategies that will increase awareness of the Agency's public health services with its customers, its partners, its decision-makers and the communities it serves.					
Objectives	**Activities**	**Timeframe**	**Expected Outcomes**	**Responsible Parties**	**Progress Notes**
Obj.1.1 By September 30, 2015, develop, implement and maintain a marketing plan which identifies the Agency's brand and informs its customers and the community it serves about its purpose, programs and services.	a. Review best practices in marketing for non-profit agencies and local public health.	March – April, 2015	• Best practices are reviewed	**Health Ed**	
	b. Establish marketing team that can assist in identifying health department customers and in developing the various strategies that best target their interest and needs.	May, 2015	• Marketing team is formed to inform development of marketing plan and its implementation • Customers are identified • Strategies for reaching customers are identified and categorized	**Health Ed and Marketing Team**	
	c. Marketing team identifies how health department programs align with their interest and needs	July, 2015	• Programs are reviewed in light of customers to identify bestselling points.	**Health Ed and Marketing Team**	
	d. Marketing team develops health department branding that uniquely identifies materials as being from health department and standardizes educational materials using branding	August, 2015	• Agency branding is created and publications are standardized to reflect branding	**Health Ed and Marketing Team**	
	e. Marketing team formalizes marketing strategies into a plan and monitors plan's implementation to assure that it is reaching the targets in culturally sensitive, educationally appropriate ways.	September, 2015 and ongoing	• Marketing Plan is developed and approved by Admin team • Plan is implemented • Plan is monitored for effectiveness by through the established indicators of success • Standards are established for the development of educational and promotional materials	**Health Ed and Marketing Team**	

Obj. 1.2 By December 31, 2015, utilize social media as a way to communicate program and health information with customers and the community.	a. Policies and procedures related to Agency's use of social media are developed	August, 2015	• Social media policies and procedures are developed	**Health Education and Admin. Team**	
	b. Appropriate staff are trained on how to use social media with the public	September, 2015	• Staff learn of Agency's adoption of Social Media as a communication strategy	**Health Ed and Marketing Team**	
	c. Social media is included as part of marketing strategies, including the number of social media websites developed and which ones to utilize	September, 2015	• Social media is incorporated into marketing plan	**Health Ed and Marketing Team**	
	d. Social media websites are launched per policy	September, 2015	• Sites are launched and monitored. • Staff promotes use of sites with clients. • Public is informed of social media sites	**Health Ed and Marketing Team**	
	e. Social media utilization is evaluated to assure it is effective	December, 2015 and ongoing	• Utilization and effectiveness of using social media is evaluated.	**Health Ed and Marketing Team**	
Obj. 1.3 By December 31, 2015, to improve the no-show rates of WIC clients, initiate text messaging with those clients that consent in order to facilitate the rescheduling of appointments.	a. Identify software needs to allow texting as part of email	April, 2015	• Software needs and providers are identified, including freeware software.	**HR Team and IT Teams**	
	b. Review program consent forms to assure that consent to texting is added	August 2015	• Consent forms are identified and when appropriate, revised to allow for texting of messages	**HR Team, Prevention Services and Health Education**	
	c. Modify HIPAA privacy and security policies and procedures as appropriate	January, 2016	• HIPAA policies and procedures are updated to reflect the addition of texting if needed.	**HR and IT teams**	
	d. Develop texting policies and procedures and train staff about appropriate use of text messaging	March, 2016	• Policies and procedures for staff texting are developed. • Staffs are trained on appropriate uses of texting.	**HR Teams and Health Education**	
	e. Implement texting as a form of communication when requested by customers and evaluate its effectiveness	May, 2016 and ongoing	• Texting is implemented and evaluated by indicators of success.	**Prevention Services and Health Education**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Goal 2: Continue to maintain and strengthen current collaborative relationship and pursue new endeavors that are based in evidence and/or best practice and address the communities' health needs.					
Objectives	**Activities**	**Timeframe**	**Expected Outcomes**	**Responsible Parties**	**Progress Notes**
Obj.2.1 By May 30, 2018, identify and maintain collaborative relationships and explore opportunities to work together to address public health issues.	a. Assess current collaborations, their purpose, targets and scope of collaboration and identify staff assignments for participation; and develop a reporting process for staffs who participate in order to assure that information gleaned from meetings is widely shared throughout agency.	February 2015	• Collaborations will be quantified and staff assignments will be complied • Reporting processes related to participation will be developed. • Information will be complied and shared throughout the agency on a quarterly basis	**Health Education**	
	b. Seek to develop at least three new or expanded collaborative initiatives with partners that support shared goals, are based upon community health needs and include evidence-based or best practice models that will improve the community's health status	April, 2015 and ongoing	• At a minimum, three new or expanded collaborative initiatives will begin and will include measurable and reportable outcomes	**Prevention Svc., EH and Health Education**	
	c. Identify financing strategies to support the initiatives	May, 2015 and ongoing	• Funding will be obtained for collaborative work.	**Prevention Svc., EH and Health Education**	
	d. Implement the initiatives and evaluate the outcomes	May, 2015 and ongoing	• Initiatives will be evaluated and replicated, if able.	**Prevention Svc., EH and Health Education**	
	e. Seek to enhance relationships with diverse community groups (i.e., Amish, Arab, Hispanic, and African American) to address targeted health needs	September 30, 2016 and ongoing	• Meetings with leaders of ministerial associations, church leaders and civic leaders representing racial and ethnic diverse groups will occur	**Health Officer, Division Directors**	
Obj. 2.2 By September 30, 2015, establish county-specific dash boards to monitor the community health improvement plans' implementations and outcomes.	a. Work with local partners to identify indicators of success for community health improvement.	April, 2015	• Indicators of success will be identified for the priorities established in the CHNA	**Health Education Team**	
	b. Identify appropriate data sources and baseline data	June, 2015	• Accurate and reliable data sets are identified and baselines are established	**Health Education Team**	

	c. Publish dashboards online	July, 2015	• Dashboards are published and publicized to create momentum. • MPCB are notified and provided updates, as is the community and its stakeholders	**Health Education Team**	
	d. Monitor and update on an annual basis	September, 2015 and ongoing	• Dashboards are updated annually.	**Health Education Team**	
Obj. 2.3 By May 31, 2016, collaborate with four local hospitals and other local partners on the completion of three-specific community health assessments that assess community health, physical health, health care systems and environmental health	a. Collaboration reviews the survey instruments and updates questions	November, 2015	• Survey instruments are updated.	**Health Education Team**	
	b. Collaborative partners issue survey and review results	December, 2015	• Electronic survey s are issued • Hard copies of surveys are made available to LHD clients	**Health Education Team**	
	c. Health Department releases its Community Monitor which serves as companion document to the surveys and provides context to survey results	October, 2015	• Community Monitor is updated and additional information is included re: Environmental Health	**Health Education Team**	
	d. Second tier of local experts are assembled, review outcomes of survey and Community Monitor and establish priorities	March, 2015	• Local input is provided to understanding survey and data results • Priorities are established and shared with hospital boards.	**Health Education, Environmental Health, Prevention Services**	
	e. CHNAs results are published and released to the community.	May, 31, 2016	• Community, decision-makers and stakeholders are informed of results.	**Health Education, Environmental Health, Prevention Services**	
Obj. 2.4 By June 30, 2017, collaborate with local stakeholders in developing county-specific community health improvement plans and	a. In collaboration, the tier of experts seek to identify ways to address the health needs of the community by developing a CHIP	March 2015	• CHIPS are developed and reflect community health needs	**Health Education, Environmental Health, Prevention Services**	

participate in their implementation.	b. CHIPs are shared with governing boards (i.e., Board of Health, hospital boards, etc.) and with SPC and used to inform strategic plan updates.	March, 2017	• CHIPS are shared with governing boards to identify resources	**Health Education, Environmental Health, Prevention Services**	
	c. Dashboards are updated to include or remove any indicators of success		• Dashboards remain linked to CHIPs	**Health Education**	
	d. SPC reviews current services and identifies other services the Agency should consider as ways to align with the CHIPs	June 30, 2017 and ongoing	• CHIPS are incorporated into Strategic Plan updates.	**Health Education, Environmental Health, Prevention Services**	

ATTACHMENT D – ACTION PLANS (WORK IN PROGRESS)

Goal 3: Strengthen systems of care and develop organizational capacities that support service integration and cross-jurisdictional activities.					
Objectives	**Activities**	**Timeframe**	**Expected Outcomes**	**Responsible Parties**	**Progress Notes**
Obj.3.1 By September 30, 2015, initiate a healthcare navigation program at off-site locations that improve access to health insurance and preventative health services.	a. Organize off-site locations for healthcare navigation program in remote locations that have low-income pockets and provide insurance enrollment and schedule Agency appointments for customers.	March, 2015	• Agency staffs schedule navigation program at 4 off-sites per month.	**Health Education and Prevention Team**	
	b. Identify target numbers that can be reached and set benchmarks	May 2015	• Agency staffs identify need and project demand. • Additional clients are informed of health department services • Health department is seen as more accessible and baseline data is established.	**Health Education and Prevention Team**	
	c. Update website and Facebook pages and market the off-sites locations, working with local community to encourage participation	September 30, 2015	• Off-site locations are incorporated into the Agency's marketing plan.	**Health Education Team**	
	d. Review outcomes of project and its benefits.	September 30, 2015 and ongoing	• Agency determines that off-sites are effective ways to reach hard-to-connect-to-populations.	**Health Education and Prevention Team**	
Obj.3.2 By July 31, 2016, develop a client-focused referral process that matches client's needs with available resources and establish baseline data for referral utilization	a. Process map how staffs handle referrals.	January, 2016	• Maps are completed by staff.	**Health Education and Prevention Team**	
	b. Staff are trained on how to use motivational interviewing techniques with clients	January, 2016	• Staffs incorporate motivational interviewing into their client interactions.	**Health Education and Prevention Team**	
	c. Identify improvements that can be made in referral processes and how it would benefit the organization	April, 2016	• Improvement areas are identified. • Improvements are made and referral processes work.	**Health Education and Prevention Team**	
	d. Implement change, evaluate results and identify benefits.	July, 2016	• Client retention and client utilization of health department services improves.	**Health Education and Prevention Team**	

Obj.3.3 By March 31, 2017, implement and maintain an up-to-date resource and referral system that can assist staff and clients with accessing available resources.	a. Resource and referral database is updated to include additional service types.	January, 2016	• Staff have access to up-to-date resources	**Health Education and Prevention Team**	
	b. Staffs work to verify existing resource information and update in database.	July, 2016	• Updates are made.	**Health Education and Prevention Team**	
	c. A rotating calendar by service type is created to guide future updates.	July, 2016	• Calendar will serve to assure that updating is done throughout the year. • Updating of resources will result in more accurate resources • Resource updating will be more manageable	**Health Education and Prevention Team**	
	d. Indicators of success as measured by referrals made and utilization of referral sources are identified and collected for program evaluation	March 2017 and ongoing	• Program is evaluated and found effective.	**Health Education and Prevention Team**	
Obj. 3.4 By September 30, 2018, maintain participation in appropriate cross-jurisdictional and regional efforts to integrate public health services	a. Continue participation in MDARD Multi-jurisdictional program and work to improve capabilities to adopt cross-disciplinary approaches and multi-disciplinary models in the area of food borne disease surveillance and investigation.	October, 2015	• Agreements for information sharing will be established. • Roles, responsibilities, contacts and processes for sharing information will be finalized.	**Environmental Health, Prevention Services, EPC and Health Officer**	
	b. Continue participation in regional Business Intelligence Project and identify/collect useful metrics which can be used to measure local public health impact.	October, 2017	• Agreements for information sharing will be established. • Roles, responsibilities, contacts and processes for sharing information will be finalized. • Reporting relationships will be established.	**IT Team, Health Education and Health Officer**	
	c. Continue participation in MALPH and its forums and provide input into regionalization/consolidation processes.	March 2015 and ongoing	• Agency will provide input into regionalization process.	**Division & Medical Director, Health Officer**	

Glossary

Action Plan
A written plan that communicates and ensures that the appropriate steps are accomplished. An action plan breaks down the steps that must be taken to implement the strategy successfully, as well as identify critical components such as the timeframe to complete the action step. An action plan identifies: who, what, when, resources, and communication. An action plan illustrates completely and clearly that there are dedicated staff assigned to action steps to ensure progress in meeting the organization's goals. The plan also helps prevent overlooking any details and increases the chances that people do what they need to accomplish in a set time frame. Remember, the action plan will always be a work in progress. It needs to remain visible, and as the health department changes and grows, the action plan will need to be revised to fit changing needs.

Community Health Assessment
Community health assessment (CHA) is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a CHA is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community CHA; the essential ingredients are community engagement and collaborative participation. *(Turnock, B. Public Health: What It Is and How It Works. Jones and Bartlett, 2009). This definition of a CHA also refers to a Tribal, state, or territorial CHA.*

Community Health Improvement Plan
A community health improvement plan (CHIP) is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community (*Adapted from: United States Department of Health and Human Services, Healthy People 2010. Washington, DC; Centers for Disease Control and Prevention, National Public Health Performance Standards Program, www.cdc.gov/nphpsp/FAQ.pdf). This definition of a CHIP also refers to a Tribal, state or territorial CHIP.*

External Assessment
An external assessment identifies external trends, events, or factors that may hinder or support the decisions the health department ultimately makes about its direction, objectives, and strategies. Restricting the analysis to areas relevant to the health department can assist in providing focus. For example, an external analysis tool that is divided into five areas: economic, technological, government, socio-cultural, and future can help facilitate this discussion. The impact on elements from these five areas can be big or small, but it is important to be aware of these potential factors that may affect your health department's direction and strategies.

Goals
Long-range outcome statements that are broad enough to guide the organization's programs, administrative, financial and governance functions. *(Allison & Kaye, 2005)*

Internal Assessment
An internal assessment helps to provide understanding about the department's strength, weaknesses, opportunities and threats in relationship to its internal operations and the environment in which it functions. SWOT analysis is an internal assessment often used. It is a simple, yet powerful, tool used for strategy development and takes into consideration the local health department's internal capabilities and key resources. When matched with an external assessment, the process of internal assessment provides the critical foundation for identifying and prioritizing strategies.

Mission
The organization's purpose; what the organization does and why.

Multi-Purpose Collaborative Bodies (MPCB)
The Multi-Purpose Collaborative Body (MPCB) is an inclusive planning and implementation body of stakeholders at the county or multi-county level.

Objectives
Short to intermediate outcome statements that are specifically tied to the goal. Objectives are clear, measurable and communicate how a goal will be achieved. Objectives may be referred to as outcome objectives.

Outcome Indicator
The measures of change at certain milestones to lead to the overall target.

Plan-Do-Check-Act
PLAN - Establish the objectives and processes necessary to deliver results in accordance with the expected output (the target or goals). By establishing output expectations, the completeness and accuracy of the spec is also a part of the targeted improvement. When possible start on a small scale to test possible effects.

DO - Implement the plan, execute the process, make the product. Collect data for charting and analysis in the following "CHECK" and "ACT" steps.

CHECK - Study the actual results (measured and collected in "DO" above) and compare against the expected results (targets or goals from the "PLAN") to ascertain any differences. Look for deviation in implementation from the plan and also look for the appropriateness and completeness of the plan to enable the execution, i.e., "Do". Charting data can make this much easier to see trends over several PDCA cycles and in order to convert the collected data into information. Information is what you need for the next step "ACT".

ACT - Request corrective actions on significant differences between actual and planned results. Analyze the differences to determine their root causes. Determine where to apply changes that will include improvement of the process or product. When a pass through these four steps does not result in the need to improve, the scope to which PDCA is applied may be refined to plan and improve with more detail in the next iteration of the cycle, or attention needs to be placed in a different stage of the process.

Process Indicator
The measure or documentation of the program or service provided.

Quality
Quality refers to 'fitness for purpose" – meeting or conforming to generally accepted standards as defined by an accrediting or quality assurance body. For the purpose of the Strategic Plan, high quality would mean obtaining and superseding the standards as defined by an accrediting or quality assurance body. One measure of 'high quality' would be 'accreditation with commendation'.

Quality Improvement
Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. *(Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. Journal of Public Health Management and Practice. January/February 2010).*

SMART Objectives
S pecific – specify what is to be achieved, by how much, and by when
M easurable – make sure the objective is measurable (i.e., data is/will be available for measurement)
A chievable - set objectives that are feasible for the agency
R elevant - align objectives with the mission and vision of the agency
T ime-oriented - establish a timeframe for achieving the objective

Stakeholder
A key stakeholder is someone who can help your planning effort succeed or fail – the person who has information you need, or other important resources for solving the problem – access to money or legislative or regulatory "fixes." Getting and keeping key stakeholders on board is one of the most important aspects of any project.

Strategic Plan
A strategic plan results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward. *(Swayne, Duncan, and Ginter. Strategic Management of Health Care Organizations. Jossey Bass. New Jersey. 2008).*

Vision
Futuristic view regarding the ideal state or conditions that the organization aspires to change or create.

Values
Principles, beliefs and underlying assumptions that guide the organization.

ATTACHMENT F – STRATEGIC PLAN REVISION LOG

Date	Section/Pages Affected	Responsible Staff