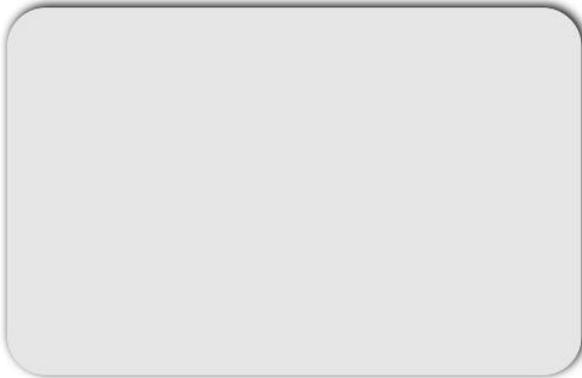


2014

Secretary of Health's
Annual Meeting
SUMMARY



INTRODUCTION

The Secretary of Health has the legal responsibility under [RCW 43.70.140](#) to convene an annual meeting of local health officers. The purpose of the meeting is to 'receive the assistance and advice of local health officers' about how to carry out the duties and responsibilities as Secretary of Health for all people in Washington.

On Friday, September 19, 2014, Washington State's Secretary of Health John Weisman convened this meeting. Health officers from all 35 local health jurisdictions were invited. Local health directors, the Washington State Association of Local Health Officials (WSALPHO) Board of Directors, and senior leaders from the Department of Health (DOH) also attended the meeting. Altogether, about 70 public health leaders were present.

The purpose of the meeting was to hold a forward-looking conversation about public health in Washington. In clarifying the need and purpose of the meeting, the Secretary acknowledged that we have a lot to be proud of. On many fronts, our state is a national model demonstrating the creative ways state and local public health collaborate to find solutions to issues. At the same time, the world we know today is rapidly changing. Our role as leaders is to seize the opportunities and innovate during this time of rapid, major system change to create the future of public health in Washington and in our local communities.

The invitation for the meeting asked participants to bring their experiences, expertise and critical thinking to engage deeply around the central framing question:

'What does a reformed public health system that creates and sustains optimal health for all people in Washington look like and what does it take to get there?'

The question prompted a powerful discussion around innovative steps public health leaders in Washington must take together. The day included individual, small group, and large group exercises. A graphic artist helped capture the discussion visually. The notes from each segment of the day are summarized next.

REFLECTION

Following a round of introductions, each participant reflected on the question:

'What is the passion that brought you to this work?'

Next, participants shared their stories with the person sitting next to them. A handful of individuals volunteered to share their own with everyone:

These are some of their thoughts:

- I realized I wanted more than traditional clinical track
- I saw an opportunity to make change and be changed
- I love science and am motivated by social justice. I realized that the clinical track is about fixing one patient at a time.
- I discovered my passion mid-career
- I found that 'heart and mission' met through this work. It was a chance to help people in the community.
- Through public health I can make an impact/difference
- Public health provides an opportunity to strive for common good. Its philosophy is that a chance for an optimal life is a basic human right. We should all work for people.
- I wanted to affect the health outcomes of those with behavioral health issues
- I wanted to work with the community (its strengths and weaknesses) to build health community

VISIONING

The next segment of the meeting focused on participants envisioning a fully healthy public health system in Washington. Groups of four people engaged together around the question:

‘What does the public health – health care system in Washington look like in our communities in 20 years?’

Following this exercise, one person from each group reported out to the larger group. Themes emerged from the collective conversation which suggested a future public health system that maximizes health for all. The system preserves past successes, but is also effective in responding to both community and global issues. It is a resilient and adaptive system that takes Washington to a place of achieving the Triple Aim. Public health is a major influencer in health policy. Specific system attributes were described as follows:

Leadership

Public health is a key leader to shape health in communities. It is trusted as a neutral convener. Health is in all policies and conversations. Public health leaders are adaptive and experts. They assure that public health is at the table with partners.

Integration and Structure

Public health and the health care delivery system are fully integrated and combined into one health system. Artificial barriers and silos are gone. There is less dependence on traditional ‘brick and mortar’ public health. Public health delivery is based on ‘centers,’ in collaborative, concentric rings.

Data and Information

Public health is the trusted lead broker of data and information. It provides assessment and evaluation expertise. Data systems are highly integrated. Technology leverages real-time data updates about health status.

Community Development and Engagement

Public health supports communities and community wellness. It understands that communities play a big role in determining health as well as driving change and spending. Businesses in communities spend money on prevention.

Funding and Payment Reform

Payment reform means the public health system is funded so it can focus on root causes and the public health’s mission.

Outcomes

People have a shared idea of ‘health systems’ and a common definition of health. Values are realigned and corporate interests shift to understand investment in healthy communities. Poverty no longer determines health. People think about and want optimal health. Washington achieves the Triple Aim.

The transcribed notes from this session can be found in [Appendix A](#).

LEARNING AND LEADING

Co-learning and co-leading in the era of complexity was next on the agenda. The purpose of the exercise was to have participants think about current and future challenges, and to start thinking about how to approach those challenges.

The group learned about a model called the Cynefin Framework, or framework as a tool to think about how to approach future problem-solving actions. The Cynefin Framework collects challenges and problems based on the type of problem confronted.

Simple and Complicated problems are ordered and knowable, and with knowledge, these problems can be solved. Typically some level of simple planning, doing, or more expert engineering will solve these problems. **Complex and Chaotic** problems are characterized by high levels of unknown and emergent factors and require a more emergent approach to addressing them (such as using prototypes, experiments, or novel ideas). Finally, **Disordered** problems seem to defy our ability to define and understand them and we simply need agreement on what they are.

Sorting issues across this framework can help sort issues into groups, and develop new approaches to communication, leadership, decision-making, and policy-making in complex social environments such as public health.

The Cynefin Framework's five domains and problem solving approaches are summarized as:

- **Simple:** The relationship between cause and effect is obvious to all. The approach is to **Sense – Categorize – Respond** and we can apply best practice.
- **Complicated:** The relationship between cause and effect requires analysis or some other form of investigation and/or the application of expert knowledge. The approach is to **Sense – Analyze – Respond** and we can apply good practice.
- **Complex:** The relationship between cause and effect can only be perceived in retrospect, but not in advance. The approach is to **Probe – Sense – Respond** and we can sense emergent practice.
- **Chaotic:** There is no relationship between cause and effect at systems level. The approach is to **Act – Sense – Respond** and we can discover novel practice.
- **Disorder:** The state of not knowing what type of causality exists, in which state people will revert to their own comfort zone in making a decision.

During this highly engaging exercise, each participant was asked to write down one thing that is already happening or working, but needs some additional time, attention, or resources in order to bring the vision fully to fruition.

Next, participants were asked to write down one thing that is not currently planned or underway, however, still needs attention.

Finally, participants were asked to place what they had written into one of four quadrants pertaining to simple, complicated, complex and chaotic contexts.

The following diagram contains synthesized input from the participants in the exercise. Most topics/projects fall under the complex and complicated domains.

Cynefin Framework

Complex

Probe – Sense – Respond

Applying emergent practice

Accountable Communities of Health (1)

Collaboration (11)

Funding Models (16)

Influence/Health Policy (15)

Integration (2)

Role of Public Health (11)

Using Data (5)

Workforce (3)

Complicated

Sense – Analyze – Respond

Applying good practice

Accountable Communities of Health (8)

Collaboration (14)

Funding Models (5)

Influence/Health Policy (6)

Integration (7)

Role of Public Health (3)

Using Data (9)

Workforce (1)

Chaotic

Act – Sense – Respond

Discover novel practice

Accountable Communities of Health (0)

Collaboration (0)

Funding Models (12)

Influence/Health Policy (4)

Integration (1)

Role of Public Health (1)

Using Data (0)

Workforce (1)

Simple

Sense – Categorize – Respond

Applying best practice

Accountable Communities of Health (0)

Collaboration (0)

Funding Models (1)

Influence/Health Policy (2)

Integration (1)

Role of Public Health (5)

Using Data (0)

Workforce (4)

The transcribed notes from this session can be found in [Appendix B](#).

ENGAGEMENT

In the afternoon, participants held empowering and engaging small group conversations using the World Café process. Each group focused on the following questions:

'What would it look like to be continually in inquiry, working as a learning community around this issue?'

and

'What would help you feel more fully engaged with a collaborative effort to move public health into the future in Washington State? What do you want to see more of?'

Participants were asked to come up with action statement that they could commit to, and that would move toward the vision created earlier in the day. The list below highlights the needs for:

- Sufficient time and dedicated resource
- Training and culture building
- Trust, respect and transparency
- Keeping an open dialogue and actions
- Building meaningful partnerships and collaborations
- Engaging more in conversations about population health
- Sharing successes and failures
- Whole state engagement

The transcribed notes from this session can be found in [Appendix C](#).

PASSION

As a last exercise, the group was introduced to a process called Open Space. Participants were asked to write down a topic, issue or question they would like to host a conversation on which has to do with the vision for the day's central framing question:

'What does a reformed public health system that creates and sustains optimal health for all people in Washington look like and what does it take to get there?'

Participants who wanted to host a conversation wrote down and read their topic, issue or question to the group. People self-selected which topic they would like to participate in. Following two rounds of conversations, each host summarized the key themes and insights to the whole group.

The following is a summary of the different topics discussed:

- Public health structure
- Common future for managed care and public health
- Reinvestment into prevention
- Public health in 5 years
- Public health – primary care alignment
- Promoting health to our children and families
- DOH and WSALPHO collaboration on funding, policy and legislative decisions
- Identifying the root causes of good health and what should be done next
- Maintaining focus on population health and policy based on public health
- The role of public health assessment, research and data
- Effective and efficient collaborations with community partners

The transcribed notes from this session can be found in [Appendix D](#).

WHAT'S NEXT?

Much of the feedback, input, thoughts and ideas shared throughout this day helped shape the Secretary Wiesman's address at the Annual Meeting of the Washington State Public Health Association (WSPHA) in October, 2014.

What became clear from the September 19, 2014, meeting was that Washington State's public health system has an opportunity to lead a paradigm shift. There is a great deal of agreement across the public health network today that we have work to do together in order to move toward health system focused on health equity and the whole person across the lifespan, and a system that is community centered and population based. The notes from the day provide a solid starting point for identifying common ground and specific action items for moving forward. Public health in Washington has a strong history of taking great ideas, like many identified in this meeting, from concept all the way through operationalized system change.

Working together, the Department of Health, WSALPHO, and the Public Health Improvement Partnership can use the output from this first annual Health Officers' meeting with the Secretary to develop an action plan and realize the vision of a 'reformed public health system that creates and sustains optimal health for all people in Washington.'

APPENDICES

Appendix A: [Visioning Exercise Comments](#)

Appendix B: [Cynfin Framework](#)

Appendix C: [World Café Comments](#)

Appendix D: [Open Space Comments](#)

Appendix E: [John Wiesman's WSPHA Annual Conference Address](#)

Appendix F: [List of Participants](#)

APPENDIX A: Visioning Comments

Below are participant responses from a visioning exercise. The group was asked:

'What does the public health-health care system in Washington look like in our communities in 20 years?'

Group 1	<ul style="list-style-type: none">• Public health is a key leader• Public health is the grease and the glue. Less brick and mortar public health.• Public health now free to focus on root causes• Roles: 1) Respond to threats; 2) Plan, convene, coordinate, analyze (data)• Public health the neutral convener• Public health = leader/convener• Public health is at the table with all partners
Group 2	<ul style="list-style-type: none">• Public health and health care are combined into health system• No silos – artificial barriers are gone• Integration of public health and health care through a 1-payer system. Medical education reform.• Integration with health care and within public health. Assure public health expertise and leadership that is adaptive.• Payment to public health come from patient care• Public health integrated with other health purveyors. Logistics to help everyone...? Information, collaboration infrastructure. Different community values to support.
Group 3	<ul style="list-style-type: none">• Basic services will continue – water, infectious disease, etc.• Environmental health may be same
Group 4	<ul style="list-style-type: none">• Public health is broker of data, analysis, information• Public health = data/info source• Public health the assessment and evaluation expert• Highly integrated systems for data, marketing• Patient has her/his data on a mobile device available anywhere. Data updates in real time.

Group 5	<ul style="list-style-type: none"> ● Business spends money on prevention ● Changes have come to corporate interests: they benefit from altruism
Group 6	<ul style="list-style-type: none"> ● Communities drive change and money spending ● Public health has disappeared into the community. Social media took over messaging. ● Community resiliency – healthy families, communities, not dependent on government services ● Communities play a big role in determining health ● Community – seamless, integrated system supporting health. Less costly and better. ● People will think about and want and expect optimal health ● Public health = Community wellness ● Poverty no longer determines health ● System will be resourced toward prevention
Group 7	<ul style="list-style-type: none"> ● Capitated service approach ● Headed toward a capitated payment model
Group 8	<ul style="list-style-type: none"> ● Not focusing so much energy on funding. Instead helping with public health mission. ● Payment reform ● Economy and education maximize health not profit. Everyone belongs. Roles for everyone. Funding pays for doing what's good. ● Money will be captured and reinvested in prevention – housing, retirement ● Integration 'skills', knowledge, methodology integrated into all sectors (housing, etc.)
Group 9	<ul style="list-style-type: none"> ● Washington achieves the triple aim! ● Health in all conversations and policies ● Strong appreciation of environment's importance ● Public health helps people with education ● Our public health system responds effectively to the world's problems. Responsive to community needs. ● Focus on community health, determinants of health

Group 10

- Community health may be in 'health care'
 - Public health = the major influencer of health policy
 - Focus shifted from money; redirect the energy
 - Payment reform: 'public health' Rx
 - People resilient so not dependent on the government
 - Public health integrated; not siloes; public health provides information and 'state' for all other sectors which impact health
 - Don't forget clean water, air, etc.
 - Based on 'centers' collaborative; concentric rings (academia, etc.); social investments; multidisciplinary professions; government public health role is coordinator; regulation; create level playing field
 - People have shared idea of 'health systems'; common definition of health; realignment of values
 - People will have a shared definition of what healthy systems are. Are we resilient? Inclusive? Well-resourced? Our system maximizes health of all.
 - Responsibility of the commons; goal of all (public health, education, etc.) = health
-

APPENDIX B: Cynefin Comments

Below are participant responses from a Cynefin exercise.

Integration

Simple	<ul style="list-style-type: none">• Large integrated systemic medical providers are becoming the norm
Complicated	<ul style="list-style-type: none">• What is needed is to have the door open wider and recognition that our communities and patients will not achieve optimal health without public health healthcare integration
Complex	<ul style="list-style-type: none">• Not happening – needs – health care integration across sections, both medical, oral, behavioral/mental. 'No silos'.• Improved systems of integrated communication among health and other community entities – local, state, national, global levels
Chaotic	<ul style="list-style-type: none">• Public health moving into the health care system

Workforce

Simple	<ul style="list-style-type: none">• Already a workforce in place that wants to see it is willing to push for integrated and beneficiary access to and better health• A present workforce that wants to achieve real results• Skilled workforce• 100+ years of public health success and institutional knowledge
Complicated	<ul style="list-style-type: none">• Public health training and expertise of work force to support integration with primary care providers and quality care
Complex	<ul style="list-style-type: none">• A well-resourced, clearly defined, widely deployed and well trained community health worker workforce in all communities in Washington State• What we don't have is a passionate, competent, dedicated, knowledgeable public health workforce to replace those retirements in the next 10 years• Leadership succession planning
Chaotic	<ul style="list-style-type: none">• We already have a passionate, competent, dedicated, knowledgeable public health workforce in Washington State and we need to work to keep them employed in public health

Collaboration

Simple	<ul style="list-style-type: none">• NA
Complicated	<ul style="list-style-type: none">• Collaboration between community leaders and employers, health care providers, mental health providers and public health• Integration/collaboration activities between public health and personal health• There has been an increase in primary care. Public hospitals and large clinics and public health cooperation. (Assessment, some important issues like STD, tobacco, WAFP strategic plan.)• Public health collaborating with health care• Leadership and community engagement is happening around health – social determinants of health and collective impact with priorities• Sustainable community involvement in health improvement planning• Needs more focus on community coalitions, involvement of all age groups, across all businesses?• Much better engagement with cross sector leaders, including non-traditional partners• Community active in promoting public health, hospitals, healthy community partnerships• Community health planning does not usually include the legal system or law enforcement• Now we have started a broader discussion of health and health outcomes and priorities involving the 'entire' community, or at least a much broader segment of the community including hospital systems and others to accomplish a community health assessment and CHP priorities and a regional accountable community of health even without a planning group or money• Communities are creating health improvement plans with many partners, i.e., public health, education, healthcare and faith communities• Community health partnerships, i.e., LHJs, hospitals, and others, to do sustainable community health assessment• Community health improvement plan as a model for collaboration/collective impact

Complex	<ul style="list-style-type: none"> • Already happening – collaborative work across the systems (schools, hospitals, social services, public health, clinical care, etc.) • Research populations and communities to improve population health • We need to better leverage community development and housing existing funding to optimally improve community health • Need is to bring all players to the table • Increasing collaboration with nontraditional partners and stakeholders • Community coalitions working on common goals • Closer public health/social services, provide one pagers on chronic disease prevention • Massive community engagement – common goals, integration of all prevention services • Community voice and engagement • Conversations/planning between public health and healthcare
Chaotic	<ul style="list-style-type: none"> • NA
Accountable Communities of Health	
Simple	<ul style="list-style-type: none"> • NA
Complicated	<ul style="list-style-type: none"> • The developmental ACHs (accountable communities of health) to integrate services and get community voice for change • Public health leadership within ACHs and state health care innovation work • Informed regions large enough to have a voice in policies • Accountable communities of healthcare being formed • Regions plans integrating behavioral health and health care • Step 1. State has already embraced the integration of healthcare and behavioral health • New ideas and structures are being developed • Partnerships emerging to regional level from county level with communities of health
Complex	<ul style="list-style-type: none"> • Need to clarify role of public health in ACHs
Chaotic	<ul style="list-style-type: none"> • NA

Influence Health Policy

Simple

- Health in all policies
- Personal responsibility for health

Complicated

- Engagement in health in all policies
- Evidenced informed practices, i.e., NFP, that is building resiliency in families
- Developing delivery systems in rural areas is lagging behind
- Evidence based services to reduce childhood trauma, improve parenting skills and promote resiliency (NFP, Early Head Start)
- Dentistry lagging behind in developing large systemic providers
- ACEs

Complex

- Not current structure to foster public health and health care to achieve overall health
- Integrated wellness approach (physical and mental wellness are not separate) 'whole person', 'whole community'
- Need adequate policy development and community programming to address chronic disease and injury prevention
- Beginning to focus on life course perspective (science of health development across the lifespan) cumulative impacts of trauma and role of protective factors
- Policy makers valuing population health
- Values of community responsibility
- Need a better organizing structure
- Meaningful focus on health equity – not just words, but actions
- Health as a policy priority
- Focus on interdependence of environment and health in policy discussions
- Agreed upon priorities and strategies to address State (Department or Board) of Health
- Not focusing on root cause
- System is being redesigned
- We are not putting enough pressure on decision makers to allocate resources effectively
- Increasing civic engagement in public health policy from diverse segments of our communities – equity and democratization of public health

Chaotic

- Enlightened, courageous, political leadership dealing with real determinants of health
- Health equity – honest, cooperative conversation about steps to take to reach equity
- The political will to prioritize and affect meaningful, but difficult reform in the health system
- Mitigation of effects of major environmental and social challenges (climate change, draught, wealth disparity, balkanization/tribalism)

Funding Models

Simple

- Funding public health prevention as a percent of health care system payment

Complicated

- Programs that had been developed that produced good results (like tobacco) but backslide when the funding is decreased or gone
- Development of foundational public health services
- An adequately resourced upstream prevention system
- Sustainable funding (working towards)
- Foundational public health services workgroup is working toward identifying essential core services that must be available to all Washingtonians. To migrate and evolve toward a new relationship with the rest of the health sector, we all must give up trying to do everything, so that we can do what we need to do well.

Complex

- No standard agreement on funding/resources for public health/population based activities or what these actually should be
 - Money is not yet reinvested into system
 - Recapture savings in system and reinvest in prevention
 - Funding silos are gone
 - Resolution to adequate and sustainable funding which currently consumes significant resources (time, people, etc.) in an ongoing way to try to resolve. We are spending a lot of money trying to resolve funding public health system, money that could better focus on health improvement.
 - Identifying and distributing shared savings from health care or public health intervention
-

- Silos need to be abridged, but not eliminated
- We are not using resources currently available to the best effect
- Still struggling with funding for this integrated health system. Spending too much time chasing too little funding with little to show for our efforts.
- Funding silos and payment reform
- Programs that don't stay sustainable (community or not) when support/funding leaves
- Infusion of new money into the public health system
- Public health sustainability, workforce, financial
- Incentives or mechanisms to embed public health in other sectors and to hold them accountable for active adoption of a prevention/perspective upstream
- DE categorization of funding for public health and behavioral health services - so much is chasing the money and only providing services that have money attached
- Non-categorical public health funding

Chaotic

- Not happening – shared funding base – public health and medical care
- Money saved by prevention goes back into prevention
- Global budgeting that's value based
- State funding source
- Progress on population health does not result from partner meetings and cumbaya alone. It takes money. It has to be someone's job, not just everyone's hobby. We've mostly just talked about this since the 1970's. Still as a nation not funding it in a meaningful way.
- Investment in social determinants and economic opportunity development
- Adequate funding for public health
- Entities paying for prevention reap the benefits or vice versa

Flexible Funding

Simple	<ul style="list-style-type: none"> • NA
Complicated	<ul style="list-style-type: none"> • NA
Complex	<ul style="list-style-type: none"> • Incentives or mechanisms to embed public health in other sectors and to hold them accountable for active adoption of a prevention/perspective upstream • DE categorization of funding for public health and behavioral health services - so much is chasing the money and only providing services that have money attached • Non-categorical public health funding
Chaotic	<ul style="list-style-type: none"> • Needs to happen – freedom to use financial resources flexibly to purchase common-sense, needed services, quickly (Reduced \$ for admin, increased \$ for impact) • Not happening – collaboration without dictatorial and fiscal constraints for self-organization • Non-categorical funding/local control • Categorical funding decreases progress towards innovation

Role of Public Health

Simple	<ul style="list-style-type: none"> • Communicable disease reporting and response (connect with ERR, primary care, prophylaxis) • Local public health is a catalyst leader in ACA discussion even though not charged to be that by HCA or any intent (tenuous leadership at best now - not consensual) • Septic system compliance • Immunization penetrance/acceptance • Responding to epidemic
Complicated	<ul style="list-style-type: none"> • Community health workers are becoming a practical strategy for policy decisions and a voice for the community • Community health indicators tied to data and need of state health. DOH or subcontracts (king county) needs to represent public health at the state table modeling EPI, public health expertise and identify problems, tract indicators and improvements. • Community supported agricultural and increased nutritional awareness

Complex

- What leverage will public health have in Medicaid procurement (e.g., designing system metrics/outcomes responsibilities)
- Public health is 'poor' and not seen as a capable partner in a system build around money. We are not viewed as the experts on 'all things health. (because this system does not reward this expertise)
- Public health as facilitator of community health issues
- We are aligning to embrace the changes to make a better system
- Unsoiled shared vision/role
- Public health not a leader in behavioral health thinking yet
- Changes are in the air
- Population management in healthcare reform
- Focus on prevention in all aspects of health delivery services
- Adequate funding science based rural intervention
- Science based/wellness based funding
- Public health as a convener

Chaotic

- Carving out a niche in health reform

Using Data

Simple

- NA

Complicated

- Some limited, almost real time data systems that give us meaningful public health data that can be turned into meaningful information, i.e., syndromic surveillance
 - Real time access to public health data
 - Health data identification and collection need more used, shared
 - Use of personal technology, i.e., cell phones, to capture health/assessment information
 - We are sharing information we are using informatics
 - Bidirectional exchange of data with the healthcare system and other partners
 - Data sharing/interoperability
 - Data access, collection, analysis and translation into information
 - Electronic health records with 'meaning use' capabilities
-

Complex

- Not happening (or minimal) – strengthened (adaptive leadership) – rapid/real time data that supports response and planning of policies in public health. We need a better robust and improved way to collect data and share data in or near real time
- Better data sharing
- Big data opportunity to define needs and measure outcome.
- We are not using big data and modern informatics and analytics to enable our role as the go-to provider of health information
- We do not yet know how to use the collected information that we have

Chaotic

- NA
-

APPENDIX C: World Café Comments

Below are participant responses from a World Café process. Discussion was lead around the following questions:

'What would it look like to be continually in inquiry, working as a learning community around this issue?'

and

'What would help you to feel more fully engaged with a collaborative effort to move public health into the future in Washington State?'

What do you want to see more of?'

Group 1	<ul style="list-style-type: none">• Sufficient time/resources to allow leaders to get out of the building• Resources dedicated to getting this done (use SIM grant and model it soon)• Confidence that those with resources are at the table and have a shared vision
Group 2	<ul style="list-style-type: none">• Keep whole state engaged• Bag buzzwords• Training, culture building (graphic!)
Group 3	<ul style="list-style-type: none">• Freedom to fail• Need room to fail• Share success and failure.
Group 4	<ul style="list-style-type: none">• Central control stifles creativity• Build trust – meaningful collaboration, broaden work together• True partnership and collaboration; trust, respect, transparency• Engage more if felt heard more by state government and if others were talking: population health• System where all voices are heard and respected• Need for better relationships• Continued, open dialogue and actions!
Group 5	<ul style="list-style-type: none">• DOH is convener/leader to develop consensus in public health
Group 6	<ul style="list-style-type: none">• System of real-time data reporting
Group 7	<ul style="list-style-type: none">• Communications (LHJ – admin – docs; DOH – LHJs)• Good job (+ elevator speech) on public message

APPENDIX D: Open Space Comments

Below are participant responses from an Open Space discussion.

How should public health be structured?
(government, non-profit, region)

- Health care representatives
- Some services will stay the same. Go: Family Planning; Stay: Vaccination (partner w/medical care)
- Still shortage of health care providers, until funding
- Ach better defined + integrated medical providers accept +participate + rural counties work together to build plans
- New funding system: more to support LNJ's + flexible in 'allowed' use
- Advances in technology
- Charity care + other needs continue but changed (need funding to fill to the gaps)
- Rural public health will be smaller
- Partnerships will be stronger with funding sources to support

Managed care and public health-common future?

- N/A

Reinvest money to prevention; get rid of silos

- Transparency mutual respect; put all the cards on the table
- Germination of a concept; network; link to health
- Continually looking at systems to get optional health; i.e. transportation
- Constant change, moving targets, and unknown end
- Value everyone's contribution; changing staff over time
- Adapting, shaving best protocol, allows for open ongoing discussions
- New science is emerging; we need to determine how to incorporate this into new
- Continual process improvements
- Weaving, stretchy fabric
- Community; public health community or public community
- Learning community, this can mean a lot of things—small community, public health community, global community
- How do we create enthusiasm when it is not there?
- Community voice: optimal health

What will public health look like in 5 years?

- Managed care and public health common in the future
- Private may be happy for us to reduce their cost (penalty) chronic and infectious disease
- Penalties for not meeting goals
- State of Texas divert to public health (cost shifting)
- We may have more in common with managed care than the health care system
- Undo accumulated residents – target

Public health system annual exam.

DX: Growing pains or chronic malnutrition.

RX: ?

- Mass extinction event vs. natural selection
- Public health working in bygone era; take care of the poor and common good (epidemics)
- Public health system similar to education system; inadequate resources, privatization
- Not just lack of public health resources; Americans free to be unhealthy, social determinates of health in public health purview
- Programs, services, skills on decline

Primary care-public health alignment

- Opportunities: community wide understanding of issues
- Chronic vs. management programs
- Meaningful and timely information sharing
- Focus groups and discussion facilitation by public health; converting groups.
- Going to physician offices of offering help, asking for opportunities to help; physical presence on site
- Identifying common interests
- WAFP strategic plan 2014-2017
- Barriers: public health 'asks' cost money, we speak different languages, payment system not rewarding, cooperation, primary care overwhelmed
- Starting point?
- Formalized framework of cooperation, plan for population

What can we do to better promote health of our children and families?

- Every child a wanted child
 - Address health equity/inequity, health in all policies
 - Children's commission through Island County advisory to County, early learning 0-3, middle-free range kids, teen-healthy youth survey
 - Better immunization
 - Invest in quality early learning
 - Evidence based family services to intervene
 - Increase percent of children in licensed child care
 - Become policy advocates with data for children
 - When possible promote early childhood education
 - Decrease child screen time
 - Give youth voice to advocate for health
 - Building community residence
 - Increase completion of high school rates; early warning system in Spokane
 - Bring forward the healthy youth survey data
 - Focus on the science of human/child development and invest in creating healthy foundations
 - Focus funding in children and families
 - Have meaningful conversations with policy makers about children and families
 - Create the community capacity to address the gaps and needs, engage youth in discussions and efforts
 - Advocate for evidence based parenting support available for the community
-

How do we balance putting out all the fires and working on the big picture?

- NA

How can DOH and WSALPHO collaborate on budget, funding, policy and legislative decisions?

- Money
- Federal grant parameters
- DOH and WSALPHO have worked together on joint \$ allocations
- Funding formula/work jointly to select underfunded allocation
- Use LEAN between HOH/CHJ's
- Bottom up vs. top down
- Medicaid rates
- Compute with community partners and other CHJ's
- Population
- Need = disuse unhealthy
- Poverty: base + regions
- Percentage of pass through
- Informal relational

What is required to identify the root causes of good health and what should we do once we've done that?

- Good health
- Education, social connections, basic needs, healthy family functioning, nutrition, physical activity, air, clean air, and clean streets
- Healthy living; clean and safe environment
- Economic prosperity and equity
- Public health role: Create conditions that promote health, focus on 'thriving', building resilience, partner with faith, community and social groups

How do we maintain focus on population and policy focused direction based on public health?

- Utilizing policy as the vehicle
- Culture influences policy—need to change the culture before policy can be successful (i.e. legalization of marijuana)
- Should public health lead the way? (depends on topic) Not necessarily; could be facilitator, supply data/network, and 'neutral convener'.
- How do we address individuality of community plus make state policy that will work? Look at existing policy and figure out way to modify/improve to be beneficial—fair to all.
- Better communication with State Board of Health (i.e. WSAC)
- Fall meeting WSALPHO with WSAC

The role of public health assessment, research and data	<ul style="list-style-type: none"> • NA
Walking your talk!	<ul style="list-style-type: none"> • NA
How do we effectively and efficiently collaborate with community partners?	<ul style="list-style-type: none"> • Columbia—smaller • What extension would you like to host today? • Use public health staff as messenger • Message of week/month • Communications: Newspapers, local TV, and radio • Public health is NWCPHT • Social media: Facebook, Twitter, and text messaging • ‘Headlines’ • Message and action: events, community services clubs
How can we prepare for climate change, population displacement, and concentration of wealthy and power?	<ul style="list-style-type: none"> • Climate change: <ul style="list-style-type: none"> ○ Heat water availability ○ Horthy impacts ○ Local land use and flowage ○ National/global population displaceable ○ Healthy impact • Obstacles to planning/preparing? <ul style="list-style-type: none"> ○ Opportunities to build partnerships ○ To address/respond to other challenges

APPENDIX E: Secretary of Health Address

Washington State Public Health Association

Annual Conference October 14, 2014

John Wiesman

Let me start by saying that I am enthusiastic about our future. We have the opportunity to lead a paradigm shift—to participate in something we have long sought. An approach that is whole person, across the lifespan, community centered, focused on health equity, and population based. I am calling this the 'Community Wellness System', at least for today. In the community wellness system, housing folks, education, law enforcement, hospitals, clinics, human services, public health, behavioral health, governments, tribes, non-profits, and business come together with health as an actively sought goal. A goal in which we recognize that if we have a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and a backbone support organization, we can achieve a collective impact. That, my friends, is how I think we, as a community wellness system, can achieve healthy babies, healthy teenagers, healthy adults, healthy seniors, and healthy communities.

So, what would the results of a well-functioning Community Wellness System actually look like in 15 years?

Here is what I would see in a town or city that embraced this model, and I am sure it won't be whole lot different from yours. I would see murals of young children being read to by parents and grandparents. I would see kids singing in parks, kids exploring streams looking for stones and wildlife, and kids getting their knees scraped when they learned that one can tumble when jumping off a log that is a bit too high.

I would see baby friendly hospitals that support breastfeeding, I would see new moms and dads being offered home visits to help them in their new parenting journey, and I'd see that mom and dad had paid leave for that initial bonding time. Who knows, maybe we could even change the epigenetics of those offspring and their offspring.

I would see libraries rebranded as early learning centers where in addition to books there would be play exploration areas purposely designed for child development. And in this transformed library, there would be sounds of children screeching with delight as they discovered something new. No more librarians telling people to whisper.

I would see communities designed for social interaction and mobility. Safe places to bike, walk, and run, places for people to gather and socialize, places for people to play and worship. I would see people aging in place because their homes and neighborhoods were designed for the lifespan. And I'd see social interactions across the generations, with respect given to our elders.

I would see board of health, city council, and county council meetings where each proposal had, in addition to a fiscal note, a note about how this issue or policy impacts children, how it impacts health and equity and how it impacts the environment—not full scale impact assessments, but common sense implications or considerations. And if the proposals don't have those, I'd see a coalition of folks who took turns attending each meeting to ask about each of those impacts for every agenda item.

I would see 'Time Banks' where one hour of helping someone would earn an hour's credit and 'Tool Lending Libraries' where community hammers, pliers, and wrenches can be checked out. I would see urban fruit harvests where excess fruits are harvested from backyards to share with others, and heck—let's be so wild as to say front yard trees as well. These would support community networks that help build social coherence and connectedness.

I would see every community have a Community School like the one we virtually visited yesterday, schools would be community resources with walking school buses where retired folks, parents, principles teachers, and community leaders lead the children to school singing songs and yes, maybe even encouraging the jumping in a puddle or two.

I would see health questionnaires or screenings at clinic visits that ask about housing, employment, stress, violence, and behavioral and oral health as well as 'what brings you here today and your medical history.' I would see clinics that are community resources that focus on wellness delivery. To this end one would have a team of practitioners who can address your whole physical, behavioral, nutritional, and oral health needs. People would be on hand to help you navigate the health system and assist with your housing and legal needs as they relate to wellness. The coffee shop would be replaced with a farmer's market.

I could go on, but I think you get the picture. Wellness is something we nurture, something we build into our environments, something we build into our policies, something we come together as public health professionals, doctors, nurses, lawyers, transportation planners, neighborhood advocates, PTAs, and others to create, to achieve our wellness goal.

Now this scenario would be labeled a 'zone of high aspiration' one in which there is much preferability and one that many would say is less likely to happen. But if we are going to work hard, let's work hard for something aspirational. I would rather get to 80% of aspirational than 100% of mediocre. How about you?

To be further inspired, I would encourage all of you to go to the web and search: Public Health 2030: A Scenario Exploration. This is a project by the Institute for Alternative Futures, supported by the Robert Wood Johnson Foundation and the Kresge Foundation. I think you will find scenarios 3 and 4 to be inspiring.

So, what is a roadmap for this Community Wellness System and getting to a zone of high aspiration? First, we must transform our health departments to assume the role of Community Chief Health Strategist. The Public Health Leadership Forum published a short report in May of this year that was prepared by Resolve with Robert Wood Johnson Foundation funding that said:

'The core mission of public health remains the same: the reduction of the leading cause of preventable death and disability, with a special emphasis on underserved populations and health disparities. This is our perpetual north star. But how we achieve that mission has to change, and change dramatically, because the world in which we find ourselves is very different than just a few years ago, and it will continue to rapidly change. Unless we recognize the new circumstances and adapt accordingly, public health will not just be ineffective, it runs the risk of becoming obsolete.'

So what does it mean for a health department to be the chief health strategist? It means we retain our core environmental health, infectious disease control, all hazards preparedness and response programs.

In terms of what is different, the report says that health departments will 'be more likely to design policies than provide direct services; will be more likely to convene coalitions than work alone; and be more likely to access and have real-time data than await the next annual survey. Additionally, chief health strategists will lead their community's health promotion efforts in partnership with health care clinicians and leaders in widely diverse sectors, from social services to education to transportation to public safety and community development. The emphasis will be on catalyzing and taking actions that improve community well-being and such high achieving health departments will play a vital role in promoting the reorientation of the health care system towards prevention and wellness. Health departments will also be deeply engaged in addressing the causes underlying tomorrow's health imperatives.'

The report then identifies 7 practices that will be necessary of these departments. I will cover some of the elements of those in my next points but encourage you to look up the report on the web as well. Second, we must fully engage in the development and implementation of Accountable Communities of Health. This is the community table that we are creating with the state's health transformation and innovation work at which the social, behavioral, and physical determinants of health can be addressed. By bringing together the whole wellness system and focusing on community needs assessments and improvement plans, we can best leverage the knowledge, relationships, and resources of the entire wellness system.

I believe that each individual system understands that it can't get to wellness on its own. Let's take public health for example. We know that a high school education or higher improves our health, we know that having a job that pays a good wage improves our health and we know that having housing in a safe neighborhood with opportunity improves our health. Yet, in public health, we don't educate kids, we don't create jobs... but we might help identify and measure dropout early warning signs like Spokane Regional Health District did looking at attendance, behavior, and course completion data and then working with community support programs to work with the students displaying early warning signs. Spokane community's efforts have improved on-time graduation rates over 3 school years from 68 to 80%. I believe that if we do this right, the accountable communities of health will help us attain the WELLNESS system, not public health separate from health care separate from mental health separate from the chemical dependency separate from the education systems we have now, but a wellness system.

Third, we must present ourselves as leaders and winners in which others want to invest even more. Let that soak in...present ourselves as leaders and winners in which others want to invest even more. I get that we have a structural financing system problem in which our revenues don't keep up with inflation nor population growth. I get that we have had budget cuts of 30, 40, and 50%--I led one of those health departments. And I get that we have cut our workforce in large numbers and that many of us are doing double and triple duty. But, I believe that many of our policy makers, the ones who decide our funding, see us as whiners, not winners—our message for years now has been, we can't do our jobs because we don't have enough money and you must give us more. And yet, we do rise to the occasion...we do get the job done...we are going to respond to Ebola. That is the message we are not telling. I believe that if we tell that story... if we tell the story of what we are doing with the hundreds of millions of dollars in our system, not the tens of millions we have lost, we will be seen as people in which others want to invest. So how do we go about this?

I think we need to focus our message on two, and maybe, things—our public safety role, children's health, and probably senior health, especially as the baby boomers age. Most of our work can be tied to these messages. Now the hard truth is that most policy makers see our role as primarily about identifying and stopping disease outbreaks. And it is clearly a critical role that includes safe drinking water (just ask Mercer Island residents who just had a boil water order due to E coli), safe food, safe medical care (which I am certainly learning more about with my new responsibilities of regulating health care facilities), sexually transmitted diseases, and emerging infections such as Enterovirus D68 and Ebola.

In terms of children, most people are willing to say that we need to give kids a healthy start and that we need to protect them from things they can't control or from making bad decisions that they are not yet old enough to make for themselves (translated—their frontal cortex is not yet fully developed for higher reasoning, counteracting impulsive decision making). So, they are willing to support policy, environment, and system controls that they wouldn't for adults. We need to capitalize on that.

And I also believe that most people want to address health and wellness issues that are affected by aging. Whether that is efforts to reduce falls, prevent car crashes, or support healthy brain memory. To be seen as winners, we must also present our work in terms of Return on Investment. That ROI can be in dollars saved in the system or it can be in deaths or hospitalizations prevented or in quality of life. The point is, we have not fully embraced this and we are losing opportunities to make our case.

Finally, winners take every opportunity to highlight their work. Right now we have heightened awareness of the disease control work we do with the Ebola outbreak in Western Africa and the fear Americans have, as unfounded as it may be for most people. I've already mentioned the E coli in the Mercer Island drinking water system, but we could also talk about this summer's wild fires in North Central Washington or the SR530 mudslide. We simply need to better tell our story. To that end, Joby Winans, the Department of Health's interim communications director, is drafting a communications plan that is intended to change course.

The Fourth part of the roadmap is that we need to dramatically improve our use of technology and our data capacities. The technology world is advancing very rapidly with smart phones, smart watches, wearable biometric devices, 3D printers and so on. We are not taking full advantage of these tools for

health promotion programs. When we are using tools like apps in our personal life and not in our professional life, we have a problem.

An example of what I am talking about is something the Snohomish Health District is doing. They have a coalition of community leaders that has sponsored a project to increase physical activities among fifth graders, to reverse the decline in physical activity that occurs as students enter middle school. Accelerometers (devices that measure movement) were given to nearly every fifth grader in the county and the data from all these devices is providing a picture of physical activity across the county, enabling schools to learn from one another about what strategies motivate students to move. This kind of demonstration project gives real time information to know if our health promotion activities are making a difference. With this kind of data, BMI calculations from Health Youth Survey data that are two years old become obsolete.

Another example of the possibilities came on a phone call Kathy Lofy and I were on with CDC yesterday. Yes, it was about Ebola. We were talking about states getting the names of the travelers from the 3 Ebola endemic countries so we could have some situational awareness and make contact with them. CDC is contemplating developing an app that would allow those travelers to record and report their temperatures to public health. Real time data that can influence real time decision making that can impact the future course of a real time health emergency.

In terms of our data systems, we do need to look at the data collection systems that we in governmental public health 'own', such as disease reporting systems and vital records, to bring them into the 21st century. And we are doing that. We also need to examine the data we are collecting and ensure we really do need to collect it...and let go of those data that really don't bring value added or that become obsolete with new ways of get better information. But the frontier for public health is real time data and data analytics incorporating big data. One of those is to capitalize on the health care delivery system's move to electronic medical records. We must ensure that we can exchange health care information for public health purposes. This should decrease delays in public health responses and, again, give us more real time data on which we can act and determine if our interventions are making a difference. The analysis of big data across multiple sectors is an area in which we need strong partners in academia and industry. We are unlikely to be able to muster the financial resources and human capital needed for such work on our own. We shouldn't be afraid to let others take the lead with our ability to translate that data into meaningful information that others can act upon. To this end, we are developing an Informatics Unit in the Department of Health to help forge the path forward.

Finally, we do need to examine the capacities of our public health departments to fully implement the Community Chief Health Strategist role, we need a strong WSALPHO Board and Executive Leadership Committee, we need a strong WSPHA and we need a strong Tribal Public Health System. I am a firm believer that we need to keep pushing ourselves towards increasing appropriate shared services—services that should be provided across multiple health departments and/or the entire state. And we must maintain a presence in all of our communities. On my tour of local health departments driving the vast miles been many communities, people will be left out if we don't continue to have a local presence. We must preserve that. So this is another one of those 'AND' situations, not an 'OR' situation. Bottom line, we can't expect health departments of 5, 10, or 20 staff to do all the things I have outlined here, even if we can get more money—because, frankly, we could probably be more efficient with the additional resources. We need more dialogue and policy options on this one. I applaud Barry Kling for

gathering with local health departments' information on shared services and our practice-based public health research colleagues like Dr. Betty Bekemeier, who are helping us examine health outcomes under various practice structures. I look forward to more dialogue with you all about this.

At the Department of Health, we have implemented an overarching strategy in our strategic plan that says: 'Through collaborations and partnerships, we will leverage the knowledge, relationships and resources necessary to influence the conditions that promote good health and safety for everyone.'

In order for us to create a strong Community Wellness System, we need strong partners. Strong partners who can dedicate the time and resources necessary to system leadership in rapidly changing times. It is important to me that we have a strong WSALPHO Board of Directors and Executive Leadership Committee to be a statewide voice. Let me be clear, I am not saying that we shouldn't have other strong leadership coming from environmental public health directors, or nursing directors or assessment and chronic disease directors. We certainly must have that. At the same time, in a governmental hierarchical system, we need an ELC that can speak clearly and confidently for their entire departments and we need a WSALPHO Board of Directors that can speak and act for the entire local public health system. (Somewhere in here I alluded about welcoming a strong voice from ELC and the notion Joan Brewster shared at a WSALPHO meeting about a strong ELC that would come together like the college President's do. And that I/DOH am not threatened by that, but rather welcome it...it is needed).

We also need a strong WSPHA that can advocate for public health policy, and do so in ways that many of us can't in our jobs. If you are not a member of WSPHA, you should ask yourself why you aren't and join.

Finally, recognizing Tribes as sovereign nations with public health services that are even more under-resourced than some of our smallest health departments and recognizing that tribal members have some of the greatest health inequities, we need to work together, across nations, across cultures to shore up a critical entity to the health Community Wellness System of Washington State. Thank you for your attention and interest.

APPENDIX F: List of Participants

Agency	Participants
Adams	Tom Moody, Vicki Guse
Asotin	Lawrence Garges, Brady Woodbury
Benton-Franklin	Amy Person
Chelan-Douglas	Barry Kling
Clallam	Tom Locke
Clark	Alan Melnick
Columbia	Larry Jecha, Martha Lanman
Cowlitz	Carlos Carreon
Garfield	Tim Moody, Leta Travis
Grant	Alex Brzezny, Jeff Ketchel
Grays Harbor	Joan Brewster
Island	Brad Thomas, Keith Higman
Jefferson	Tom Locke, Jean Baldwin
Kitsap	Scott Daniels
Kittitas	Mark Larson, Robin Read
Klickitat	Chris Spitters
Lewis	Danette York
Lincoln	Ed Dzedzy
Mason	Diana Yu, Vicki Kirkpatrick
NE Tri	Sam Artzis, David Windom
Pacific	James Edstam, Mary Goelz
Public Health Seattle-King County	David Fleming, Dorene Hersh
San Juan	Mark Tompkins
Skagit	Howard Leibrand, Jennifer Johnson
Skamania	Kirby Richards
Snohomish	Gary Goldbaum
Spokane	Joel McCullough, Torney Smith, Elaine Conley
Tacoma-Pierce	Anthony Chen, Beth Wilson
Thurston	Don Sloma
Wahkiakum	Sue Cameron
Walla Walla	Larry Jecha, Harvey Crowder
Whatcom	Greg Stern, Regina Delahunt, Astrid Newell
Whitman	Troy Henderson
Yakima	Chris Spitters, Andre Fresco
Department of Health	Drew Bouton, Megan Davis, Simana Dimitrova, Marie Flake, Maryanne Guichard, Judy Hall, Karen Jensen, Scott Lindquist, Kathy Lofy, Pam Lovinger, Allene Mares, Martin Mueller, John Wiesman, Joby Winans, Dennis Worsham, Kim Zabel