

Cowlitz County

Public Health and Human Services

Strategic Plan Augmentation Community-based Planning Study

2010

**Cowlitz County H&HS
Strategic Plan Augmentation
Community-based Planning Study 2010**

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Introduction

The Cowlitz County Departments of Public Health and Human Services, under Director Carlos Carreon, adopted joint strategic management goals and objectives in 2009. During the same period changes were emerging at national and state levels with regard to the role of public health in communities. While there is no current effort to alter statutory obligations in Washington State, and much of the historical mission and array of essential public services remain intact, nevertheless certain significant shifts were in evidence in the public health literature and through formal dialogue among public health leaders throughout the State. In addition, interest in enhancing the relationship between public health and human services, and behavioral health and primary care was escalating. It was thought that integration might have value for increased effectiveness with regard to continuity of care. Generally, due to greater resource constraints, integration of services was gaining traction as a strategy for the purpose of increasing efficiency.

Evolving thought about the roles of health and human services include, for example, movement away from providing direct services to an expanded role as a coordinator of services, and/or as a convener of providers for the purpose of creating collaborative solutions for community health crises, such as access to medical and behavioral health care. At the same time newer innovative models of care, such as medical homes, were emerging as strategic links between public and behavioral health's historical charge in supporting the health of the population, and a more holistic and managed delivery of care to individuals in the private sector. In addition Federal health care reform, not yet well understood, was just starting to become a source of new questions about configuration of services in the future..

As noted above, concepts that were influencing the structure and function of public sector community health design featured integration of health services, with traditional focus on care to individuals and populations over time. In the private sector a renewed interest in vertical integration was very apparent, which typically resulted in a greater emphasis on integration of services. In addition to the pursuit of greater efficiency and effectiveness, both examples highlight concern about managing increased prevalence of chronic disease and the range of contributing factors in an aging population. Higher levels of integration and partnership, and other potentially transformational strategies appeared to support the idea of repositioning public health and human services away from a stand-alone public enterprise toward a role as a hub for alignment and coordination of health resources throughout a community.

Cowlitz County Health and Human Services (H&HS) leaders began to increase their exposure to current literature and participation in formal State sponsored collaborative groups, and engage in leadership activities at the National level.

These tactics were pursued to better understand the evolving realities, costs and benefits of current thought, options and models of change for public health and human services. Such knowledge and experience would help leadership calibrate its actions to the rate of change at the State and National levels, and take advantage of strategies with the highest likelihood for positive outcomes.

However, in order to consider an evolving role for Cowlitz County, and to further explore potential benefits of any specific change, H&HS leaders would need to change their strategic orientation. Given the critical place of community partnerships to any new strategy, a successful evaluation of possibilities would require increased exposure to the viewpoints of community health leaders in Cowlitz County, and a better understanding of the role of H&HS from the perspective of both potential partners and the community served.

For this reason, beginning in 2010, Health and Human Services leadership explored options to augment the strategic management goals and objectives through a community-based planning approach. The purpose of this work would be to further ground the work of Public Health and Human Services in the needs of the community while seeking opportunities for substantive community health leadership involvement and collaboration. A list of specific outcomes for this endeavor was proposed.

Outcomes Sought

1. Augment the Strategic Plan through
 - a. A process to include broad community participation for the purpose of expanding breadth and depth of information gathering
 - b. Accurately represent the range (scope and scale), of community need
 - c. Enlist support of community leaders and organizations
 - d. Find opportunity for complementary partnerships in plan execution
 - e. Cost-effectively extend the resources of the H&HS to deliver statutory, historical and elective community health
2. Within the framework of the approved Strategic Management Goals, modify objectives to be consistent with the findings of a community-based planning study
3. Integrate the Strategic Plan into the community
4. Serve as a Strategic Plan review process

Senior leaders identified additional outcomes to be realized as a logical consequence of the particular design they had adopted for the community-based planning work. These meta-outcomes are identified below.

Meta—Outcomes Identified by Senior Leaders

1. Broaden base of collaboration
2. Find partnership potential
3. Harness natural self interest for mutual benefit
4. Develop leadership potential
5. Externalize operations
6. Tie closely to Strategic Plan

Methodology

A community-based study was organized in five phases, listed below with 2010 time-line. The pace of the project was designed to allow sufficient time for higher levels of external, community organization and agency input and a high degree of interaction at all stages in the process. A Stakeholder Group would provide extensive community health leadership input through a structured interview process deployed by a large cadre of H&HS staff. A Steering Group comprised of community health leaders would act as a consulting body during the development, aggregation and analysis phases of the project. The time line would allow for dialogue about ongoing findings and coordination with research being conducted by senior leaders during these periods.

Phase I	Design	April
Phase II	Develop and field Survey	May
Phase III	Aggregation; integration	June
Phase IV	Analysis; synthesis; conclusions	August/September
Phase V	Communication	September/October

Initial Design Assumptions

The strategic planning augmentation design selected by H&HS leadership was a community-based “feedback approach” that would emphasize the following:

- ❖ Adherence to the basic structure of the Public Health and Human Services Strategic Management document and goals, summarized below:
 - Integrate services provided to the public
 - Collaborate with stakeholders to identify opportunities to improve the health of individuals and the community
 - Engage in ongoing community assessment (gather, analyze and use data)
 - Facilitate access to medical and mental health services
 - Develop and implement public health policy
- ❖ Obtaining direct feedback from community leaders, to include key organizations and agencies with community health missions that overlap with Public Health and Human Services
- ❖ Involvement of community leadership in the study development and design
- ❖ Involvement of internal H&HS staff and resources in the study process
- ❖ Involvement of community leadership in the interpretation of study results and in the formation of recommendations

Work Groups

Four work groups were created to lead and participate in community-based planning. The groups and their roles are here listed.

- ❖ Executive Committee Design and project implementation
- ❖ Steering Group Community health leadership in the role of a body of consultant for design, survey content, analysis and opportunity identification
- ❖ Interviewer cadre H&HS internal resources: to conduct a community-based survey through a structured interview process
- ❖ Stakeholder Group Study fielded to these community health leaders and organizations

Information Gathering and Consensus-building Study Process

An outline of methodology key process steps are listed below.

Information-Gathering

- **Identify desired range of community health constituents utilizing a combination of**
 - Community health recipients (citizen segments of the general population)
 - Community health contributors (organizational or sector entities)
 - H&HS functional accountabilities: internal stakeholder operations
 - Segments of the community impacted by H&HS accountabilities
 - Sources, internal and/or external, for historical, current and emerging perspectives
 - Other representative constituents including outside-county stakeholders
- **Create a stakeholder inventory based on categories above**
 - Keep in mind scaling of the project
- **Structure an informational gathering instrument through which feedback may be systematically acquired, aggregated and organized.**

Categories of inquiry may be derived from a number of sources; a brief set of examples follow.

- Inquiry pertinent to quantitative and qualitative aspects of each of the current Plan statements
- Inquiry related to the social determinants of community health
- Inquiry pertinent to each of the various constituencies
- Inquiry related to the seven core public health functions
- Inquiry related to the ten essentials of public health

➤ **Perform the survey**

Consensus-building: Aggregation, Analysis and Integration

➤ **Aggregate, integrate and analyze all feedback in relationship to potential augmentation of the existing Plan**

- ❖ Aggregation: extract feedback to each question with attention to accuracy, representing both majority and minority responses
- ❖ Integrate: edit in order to construct a single stream of feedback, ensuring in summarization the translation of meaning and weight of responses
- ❖ Analyze: draw conclusions about the relationship of feedback to the current Plan strategic elements; this may result in, for example:
 - Additional depth in understanding needs the existing plan addresses
 - More clarity of purpose for achievement of previously identified goals
 - Broader range of means by which to address existing strategies
 - New opportunities for collaboration and/or partnerships

Executive Summary

History

In 2009, a set of Strategic Management Goals and Objectives were developed and adopted by Cowlitz County Public Health and Human Services. Goals included the integration of H&HS services provided to the public; collaboration with stakeholders to identify opportunities to improve health; engaging in ongoing community assessment; facilitation of access to preventative medical and mental health services; and development and implementation of public health policy.

A set of strategic objectives were adopted for each of the goals. However, coincident to and following this effort, several factors converged to suggest a reevaluation of objectives: emerging community health literature; State of Washington leadership dialogues; pressing resource constraints; and Federal healthcare reform.

Process Outcomes

These factors led H&HS senior leadership to pursue a community-based planning effort to augment the Strategic Management Goals, specifically through a modified set of Objectives based on the findings from enhanced community health information gathering; assessment of the range of community need; enlisting support of community leaders and organizations; finding opportunity for partnerships; cost-effectively extending the resources of H&HS; and integrating the Strategic Plan into the community.

Additional outcomes were identified by senior leaders to be achieved as a logical consequence of community-based planning work such as broadening the base of community collaboration, and through involvement of H&HS internal resources for the purpose of developing leadership potential and externalizing operations.

Study Products

The primary product of the Study is a set of modified strategic objectives for each of the approved H&HS Strategic Management Goals. The objectives implement the Goals and are based on the aggregation, analysis and synthesis of Study content, along with current, reliable literature. The informational source of Study content is a large (nearly forty), representative group of community health leaders. Information was gathered one-on-one through a structured interview process. Processing of content was a joint effort between H&HS leadership and, importantly, a consortium of over twenty Cowlitz County community health leaders.

Each objective was tested by senior H&HS leadership with regard to clarity, and all objectives were judged to be actionable and measurable. By decreasing the number of tactical-level objectives and increasing the clarity of strategic objectives, increased focus should be obtained, thus potentially increasing the effectiveness of limited leadership and staff resources.

The secondary product of the Study is a large volume of very pertinent community-generated information specifically relevant to each of the Strategic Management Goals. This body of information provides the foundation for the primary insights generated by a community health leadership-based Steering Group, their suggestions for H&HS actions, and collaborative frameworks for a set of recommended actions attached to each Goal.

Additionally this body of information may be utilized as an encyclopedia of community-based perspectives to inform leadership about community health endeavors that emerge as work plans are developed to address the set of modified objectives. While not a substitution for epidemiological research and data, this information informs about the beliefs, theories and opinions of community health leaders in Cowlitz County with regard to sociological, economic, and psychological factors that impact the lives of community members, and in fact, the organizational entities each of the leaders represent. Such information is of tactical value in the formation of collaborations; the structuring of solutions; and the implementation of community health-related plans.

Modified Set of Objectives and Study Subjective Findings

Please consult the Conclusions section of this Study.

Community-based Study Questions

Integral to the community-based study were the H&HS Strategic Management Goals which served as a platform for development of Study questions, Study input, analysis and opportunity generation. Each Study question was designed by the team to test the meaning of the goal in relationship to the role of the study participant being interviewed; the relevance of the goal; and to expand the range of goal interpretation and application on the basis of the unique perspective of each Study participant.

The initial set of Study questions numbered forty-one, based on the range of information thought pertinent to the plan augmentation project. H&HS leadership then, through criteria-based testing, reduced the question set to nineteen questions which were provisionally adopted. This set of questions was then presented to the community-based Steering Group for further testing (shared meaning; relevancy; information burden; scaling), which resulted in a final set of twelve key questions, to include a key-driver question for each of the Strategic Goals.

The study was then fielded to the Stakeholder Group by an interviewer cadre comprised of H&HS senior and junior leaders (100% internal resources).

Summarized Strategic Plan Goals upon which Study Questions Were Based

1. Integrate services provided to the public
2. Collaborate with stakeholders to identify opportunities to improve health
3. Engage in ongoing community assessment (gather, analyze and use data)
4. Facilitate access to preventative medical and mental health services
5. Develop and implement public health policy

Community-based Study Questions in order of H&HS Strategic Management Goals

1. (Goal-1) To what degree do you believe the delivery of primary care; mental health; substance abuse; and preventative services should be linked?

2. (Goal-2) What do you believe is the most effective way for the H&HS to communicate with the community about Public Health issues and to provide public health information?
3. (Goal-2) Please identify at least one community partner for each issue, especially those other than the usual larger provider organizations or agencies.
4. (Goal-2) What do you believe are two ways for community partners to work in collaboration?
5. (Goal-3) What do you believe are the top three contributors to chronic disease impacting our community
6. (Goal-3) What do you believe are the two most significant contributors to poor health and well-being in our community for:
7. (Goal-4) What roles do you see H&HS should have to help ensure access to healthcare for those without insurance? (circle two)
8. (Goal-4) What is one way for H&HS to lead an effort to increase access to health and mental health services for the general population, and for the uninsured?
9. (Goal-5) What health issues could be addressed through public health policy?
10. (Goal-5) One of the priorities of public health is reducing communicable and chronic disease; how important do you believe this priority should be in Cowlitz County?
11. (Goal-5) How important do you think it is for H&HS to assess or evaluate community health on a regular basis?
12. (Goal-5) Poverty, lack of education, and limited access to healthcare services contribute to the high rate of chronic illness in Cowlitz County. However, with appropriate education, motivation and resources, would individuals have the power to manage their own well-being?

Aggregation and Synthesis of Study Input; Steering Group Top Insights; Suggested Actions for Key Questions; Potential Collaborative Partnerships

The community-based Study question input follows, organized by H&HS Strategic Management Goals. There were five key-driver critical questions, one for each Strategic Management Goal:

- ❖ **numbers 1; 4; 5; 8 and 9**

The community health leadership Steering Group was asked to

- ❖ **Identify top insights**
- ❖ **Suggest actions**
- ❖ **Recommend a collaborative framework for the suggested work**

For those critical questions, Steering Group top insights, suggested actions and collaborative framework recommendations immediately follow the questions,

GOAL-1 Integrate Services Provided to the Public

1. **The degree to which community health leaders believe the delivery of primary care; mental health; substance abuse; and preventative services should be linked was assessed. On a five-point scale (five being more so and one less so), the mean score was 4.7, and the range was 3 to 5.**

- Steering Group Input
 - Top insights
 - Most respondents believe linkage is desirable
 - Strong support for care integration
 - Strong endorsement for integrating/merging services
 - Efforts build off each other
 - Linked services result in better care
 - Achieving integration would be challenging and complex
 - Implementation challenges are large
 - Concern about loss of identity as a result of integration

- Action suggested by insights
 - Create a vision of what integrated care looks like in County
 - Create a community-based plan for linked services
 - Create mechanism to reward linkage rather than silo economics
 - Move ahead with integration of services

- Priority action
 - Create a common vision to include a call to action; buy-in by key stakeholders; definition of integrated services and target populations
 - Create a vision statement regarding what linked/integrated services should look like for Cowlitz County
 - Create and implement a community plan for integrated care

- Collaborative framework
 - Broad participation by providers, payers, community agencies, business, political and community entities (see detail)
 - Collaborators: PeaceHealth; FHC; Kaiser; providers; behavioral health; RSN; CCHD; SA; DSHS; education; policy makers and politicians; faith-based groups; business; Cowlitz Tribe
 - Must include consideration of National leadership and funding sources (CMS; HRSA); and healthcare reform
 - Collaborators: Healthcare providers (Kaiser, PeaceHealth; Cowlitz Tribe; FHC; private); Health Department and RSN; CBS, Link, DAPC, Providence; DSHS; LCC; Area Agency on Aging

- Advantages of co-location and integration
 - The more integration, the more complementary the effects of each service
 - Integration could or would include
 - Medical health including specialties
 - Mental health
 - Dental care
 - All ages; family care
 - Social and community needs
 - Spiritual care
 - A holistic approach
 - Recognizes linkages of conditions, such as chronic pain and substance abuse
 - Recipients more likely to receive needed services and follow up if linked

- Allows leveraging full spectrum of information for prevention
- A community-wide plan of care would allow sharing of information and more effectively facilitate and coordinate care
- Issues
 - Integration requires appropriate staff competencies & certifications
 - Because providers are independent redundant effort and duplication of services result which would be difficult to address
 - Direct linkages are less essential if communication is good
 - Some reinforcing but some conflicting logistics
 - Need more support for health coalitions
 - Advocacy is lost when separate identity is lost

GOAL-2 Collaborate with Stakeholders to Identify Opportunities to Improve Health

- 2. The Stakeholder Group was asked what community health leaders believe is the most effective way for the H&HS to communicate with the community about Public Health issues and to provide public health information.**
- General comments
 - Health Department should engage in formal marketing and advertising
 - Outreach by Health Department educators; medical director; directors
 - Should be a dedicated role at H&HS for communication & education
 - Training could be used as an educational strategy
 - Plan communication based on survey and analysis of community input
 - Should be an emphasis on inter-agency communication
 - Means of communication
 - Should pursue concurrent, multiple means of communication
 - Episodic, and/or ongoing campaigns to address current health issues
 - Newspaper; newspaper inserts; press releases
 - Avoid newspaper because some population segments do not have access
 - Internet; web site (improve H&HS website); e-mail list-serves
 - Social media (Facebook; Twitter; blogs)
 - Radio and television
 - Direct mail
 - Brochures
 - Poster campaigns
 - Community presentations; community forums/open house; community events
 - Integrate communication into existing programs and activities such as Mental Health Week; H&HS Book Club; etc.
 - Leverage community organizations such as Chamber of Commerce
 - Outreach to neighborhood associations; through door-to-door; including low socio-economic neighborhoods
 - For some populations must address venues where people connect: agencies; CFMC; Health Department; SS office; hospital ED; grocery stores
 - Planned, regular (monthly) communication to community partners

- Content-related
 - Strong emphasis on education with focus on prevention
 - Content targeted to specific outlets (providers; schools) & population groups
 - Multi-lingual content; age-related content and means (i.e. comic books!)

3. Community health leaders were asked to identify at least one community partner for each issue, especially those other than the usual larger provider organizations or agencies. Issues included communicable disease; teen pregnancy; smoking; childhood obesity; depression; substance abuse. The “for all issues” category were those potential partners that were most frequently mentioned in all categories (thus “universal partners”).

For all Issue Categories (i.e. “universal partners”)

- Health Department
- Strategic, wide-ranging coalitions driven by a logic model and strategic plan
- Healthcare coalitions
- Provider organizations and clinics of all types
- Daycares; Head Start
- Faith community; faith-based organizations
- Pathways 2020
- Schools, public and private; school counselors; college
- Cowlitz Tribe
- Large and small employers; industry; retail establishments; convenience stores; etc.

Communicable disease

- Infection control department of local hospital
- Cowlitz Free Medical Clinic
- Family Health Center
- Emergency Support Shelter
- Bars & cocktail lounges
- Localities with high foot traffic (coffee shops; malls; etc.)
- Retail pharmacies
- Food banks
- Law enforcement agencies; correctional agencies (Jail)
- Governmental agencies
- Substance abuse providers
- Community House

Teen Pregnancy

- Family Health Center
- Hospital
- Social service providers such as Youth & Family Link
- Service organizations (such as YMCA; scouting and other “mentoring” organizations)
- Community youth groups and programs
- Neighborhood-based associations
- DSHS
- Planned Parenthood
- Pharmacies
- Caring Pregnancy Center

Smoking

- Create dedicated position at Health Department for this issue
- Service organizations and agencies
- Chamber of Commerce
- Restaurants and bars
- Local government (all levels); law enforcement agencies; Juvenile Justice
- DSHS
- Media businesses (newspaper; radio stations; TV station)
- Substance abuse groups
- Conveners of any public event
- First responders
- Community House
- Youth organizations and programs

Childhood obesity

- School cafeterias; PTOs; Mothers of Preschoolers; sports programs; health class
- Restaurants; fast food restaurants; a coalition of these establishments
- Parenting courses; education targeted to parents
- Parks and Recreation
- Youth organizations and programs; youth sports organizations; YMCA; 4H
- Social service and care providers such as Y&FL; Parents Place; ACP; Progress Center

Depression

- CAP volunteer network
- NAMI
- Mental health and social service providers such as LCMH; CBS; Y&FL
- Substance abuse coalition
- First responders

- SW Agency on Aging and Disabilities
- Public agencies such as postal service and PUD
- Youth groups and organizations such as YMCA and Scouting
- Athletic clubs; weight loss clinics
- Neighborhood groups
- Related support groups
- Progress Center
- Mothers of Preschoolers
- Community House
- Employment services

Substance Abuse

- Substance abuse coalitions; meth action coalition; community-wide coalitions
- Substance abuse providers such as LCMH; DAPC; PARC
- AA; NA
- Child Protection Services
- Landlord associations; property management firms; landowner associations
- Homeless coalition (focus on delivery of social services in “neighborhood itself”)
- Grant implementers (i.e. Kelso STOP grant)
- Law enforcement agencies
- Sports organizations
- Community House

4. Community health leaders were asked to recommend two ways for community partners to work in collaboration.

- Steering Group Recommendations
 - Top insights
 - Promote “systems” change rather than relying on relationships
 - Need a formal strategic plan to address spectrum of problems
 - H&HS should facilitate partnerships
 - Need formal inter-agency agreements
 - Collaboration would require formal structure (MOU), to proceed
 - Identify entities that would realize the benefits of collaboration

- Potential partners interdisciplinary, pursuing cross-system agendas
 - Survey feedback suggests not limiting creative possibilities
 - Action suggested by insights
 - Create a planning committee to identify cross-system actions
 - Determine one or two key systems and begin
 - Create a pilot project to demonstrate benefits of collaboration
 - Seek funding that would facilitate formal planning
 - Priority action
 - Create a pilot project to demonstrate the benefits of collaboration
 - Create a planning committee using the steps in “action suggested by insights” above
 - Identify one or two key systems (non-profit; for-profit; donation-based)
 - Collaborative framework
 - Dependent upon pilot
 - Use Steering Group to establish the planning committee, methods and work plan using existing data to select target health issue
 - Largest providers: PSI; PH; Kaiser; LCMH; CFMC; Health Department
- Structure and organization
 - Conduct system-wide planning: coordinate ideas across organizational silos
 - Work with existing or create new community-wide coalitions using organizational liaisons; focus on information sharing and collaboration
 - Create MOU agreements and/or organizational constructs that allow collaboration and communication about patient care and other critical issues
 - Facilitate directly through H&HS requirements (i.e. contracts), that bring about integration of kinds/levels of care and various provider groups
 - Formulate strategy to engage community including segments not usually represented or do not typically participate
 - Conduct annual prioritization of needs by community partners; followed by joint, focused effort
 - Establish an overarching, common H&HS advisory group
 - Create “steering groups,” “consensus groups” or “partnership forums” and conduct meetings of senior managers across

- disciplines and agencies with formal agenda and clear focus on specific issues
- Work within a structure similar to Incident Command
 - Leverage existing organizations such as Pathways 2020 and the Chamber
 - Create formal partnerships with “grass roots” organizations
 - Encourage cross-organization community board memberships
 - Conduct work exchange programs for purpose of discovering common goals
- Function and focus
 - Encourage partnering between agencies in relationship to resources; identify concerns; reduce duplicate effort; inventory and share resources
 - Focus on team-based, community-wide care coordination to include collaborative care plan development (across provider and agency entities)
 - For critical community health issues, address through system-building, for instance in access to care: coordinating resources and capacity
 - Develop a single message or vision for focus of collaborative efforts
 - Use internet-based, electronic information sharing (e-mail; web site; blogs)
 - Pursue mutually reinforcing goals, or diverse but complementary goals
 - Use need for collaboration in “crisis” as motivating force
 - Conduct and encourage joint grant writing (frequently noted)
 - Focus on public education, especially prevention and early intervention, to include, for instance, immunization and oral health
 - Sponsor health fairs and other community health events
 - Ensure stakeholders are involved in process, but also encourage agencies and organizations to “give up turf” and work together
 - Obtain counsel from and work with line staff of organizations
 - Conduct information exchange summits; commit to inter-agency communication
 - Utilize joint training on cross-over topics
 - Focus on key issues such as response to adverse community events

GOAL-3 Engage in Ongoing Community Assessment
(Gather, Analyze and Use Data)

5. **Community health leaders were asked what they believe are the top three contributors to chronic disease impacting our community.**
- Steering Group Recommendations
 - Top insights
 - Long-standing contributing factors; rates unchanged
 - There is poor community-level support to take on problems
 - Lack of community support for healthy living
 - Socio-economic factors drive many chronic illnesses
 - First contributor to chronic disease is daily life of the individual
 - Causes are many and complex
 - Socio-economics is a significant driver
 - Where is the “tipping point” or “broken window” approach
 - Action suggested by insights
 - Develop hard data to identify problems and root causes for application to a cross-system approach
 - Conduct project addressing specific issue; demonstrate impact
 - Develop policy agenda in conjunction with community partners
 - Plan to improve socio-economic conditions
 - Priority action
 - For the top three contributors to chronic disease, create a pilot project around increasing access to healthy choices, including behavioral choices, to include: educational resources and support; and an environmental component that makes the healthy choice the easy choice.
 - A planning group, using local data, selects a target health issue and creates an intervention (reference Goal-2, question 4)
 - Given top contributors to chronic disease include lack of education, lifestyle choices and socio-economic factors: encourage efforts to improve the local economy (which will result in healthier community)

- Collaborative framework
 - Pathways 2020; primary care clinics; behavioral health providers; H&HS; schools; businesses; faith-based organizations
 - Assess the capacity of local agencies to participate
 - Health Department. EDC and educational institutions
- Socio-economic factors
 - Poverty
 - Unemployment; underemployment; lack of “family-wage” jobs
- Life style choices
 - Tobacco use; smoking
 - Substance abuse (drugs and alcohol use), including during pregnancy
 - Decisions that result in poor diet choices (fast food)
 - Decisions that result in lack of physical exercise; sedentary lifestyle
- External factors
 - Poor environment; lack of positive attributes (trails; paths; bike lanes)
 - Poor work environment
 - Lack of access to healthy choices
 - Lack of general education
 - Lack of education about chronic disease, effects and interventions
 - Lack of housing and meeting of other immediate needs
 - Lack of support in form of strong role models
 - Certain cultural, social and generational norms
 - Policies that “make doing the right thing hard”
- Proximal causes
 - Hereditary factors
 - Poor nutrition; poor diet (when essentially not controllable)
 - Lack of access to affordable health care
 - Low educational achievement; functional illiteracy; poor health literacy
 - Obesity; childhood obesity
- Psychological factors
 - Fatalism; hopelessness
 - Stress
 - Apathy; lack of individual motivation; lack of individual responsibility
 - Fear; lack of “personal strength” and lack of confidence
 - Lack of concern for or focus on physical health
 - Detrimental influence of peers; influence of media

Notes:

- H&HS actions should be based on hard data, not what people “believe”
- There is poor community-level commitment to take on identified health problems

6. Interviewers asked what community health leaders believe are the two most significant contributors to poor health and well-being in our community for adults, and then children.

a. Adults

- Socio-economic and/or institutional factors
 - Economics; socio-economic status; poverty
 - Unemployment; underemployment
 - Lack of access to affordable health care or ability to navigate system
 - Lack of access to dental services
 - Low educational achievement
- Lifestyle choices
 - Poor lifestyle choices
 - Lack of lifestyle and health education (lifestyle effects)
 - Failure to act when knowledge or means are satisfied
 - Personal behavior: poor healthy behaviors
 - Tobacco use; smoking
 - Drug and alcohol abuse
 - Unwillingness to pursue preventative measures
- Proximal causes (physical or psychological)
 - Apathy (resulting in failure to make better choices)
 - Lack of social connections; lack of family support
 - Lack of physical activity
 - Poor nutrition; poor access to healthy foods
 - Mental health issues
 - Concomitant issues (chronic illness w/ mental health & substance abuse)
 - Stress; hopelessness
 - Obesity

b. Children

- Proximal causes including socio-economic
 - Socio-economic status; poverty
 - Unhealthy living conditions; poor sanitation; pollution

- Poor nutrition; poor access to healthy food and/or choices
- Lack of exercise; sedentary living (i.e. many forms of electronic devices)
- Lack of opportunities for exercise (i.e. weather)
- Lack of health insurance and/or lack of access to acute care
- Limited access to preventative care (immunizations)
- Second-hand smoke and/or children: smoking
- Children using drugs and alcohol
- Childhood obesity

- Related to parental conditions
 - Poor parenting skills; poor parental role models; parental dysfunction
 - Parents unable to promote healthy choices (exhausted; absent)
 - Parents socially isolated and/or without support impacting children
 - Perennial instability or insecurity at home
 - Child abuse and neglect; neglect of basic needs
 - Parental education level
 - Lack of nurturing; lack of quality time as family
 - Parents modeling unhealthy lifestyle and well-being
 - Lack of knowledge transfer to children about health

- Other
 - Deleterious peer pressure
 - Deleterious media content targeting kids
 - Lack of access to positive, healthy activities
 - Schools not sufficiently reinforcing activity and nutrition
 - Cultural, social and generational issues
 - Lack of key local services (inpatient psychiatric care)

**GOAL-4 Facilitate Access to Preventative
Medical and Mental Health Services**

7. **The Stakeholder Group was asked what roles they believe community health leaders see H&HS should have to help ensure access to healthcare for those without insurance.**

The distribution, in order of times mentioned follow

a. Community educator, trainer, and facilitator	(19)
b. As a coordinator of services	(15)
c. Information and resource provider	(11)
d. Facilitate provider contracting	(9)
e. Referral agency	(6)
f. Provide direct services	(5)
g. Other: political action; policy changes (access; etc.)	(2)
h. Other: Convener of community-wide planning	(1)
i. Other: facilitation of access (i.e. case management)	(1)
j. Other: fill in the gaps; things other don't/can't do	(1)

Notes:

- With regard to direct services: Health Department could fill gaps that existing clinics do not because they are “businesses”

8. **Requested was a recommendation of one way for H&HS to lead an effort to increase access to health and mental health services for the general population, and for the uninsured.**

- Steering Group Recommendations
 - Top insights
 - H&HS should be a convener of health care providers
 - Create collaboration on a community-wide basis
 - H&HS should make access to care happen (referrals; outreach)
 - H&HS should coordinate resources and services
 - H&HS has several service platforms possible; examine all
 - Disconnect between philosophy & responses of survey respondents
 - Role and scope of entities are not universally understood
 - Lack of resources is a universal barrier

- Action suggested by insights
 - Convene an executive summit of health care providers (identify gaps and response to gaps in access)
 - Convene a community-wide collaborative planning process to identify gaps, form strategies and plan actions
 - H&HS conduct strategic discussion to clarify roles, to include a full range of access to resources
 - Get started

- Priority action
 - H&HS facilitate access through a gap assessment culminating in convening a collaborative work group to implement actions to address specific identified access gaps
 - H&HS conducts a strategic discussion to clarify roles
 - H&HS as convener of health care providers to identify gaps in services and to respond to gaps

- Collaborative framework
 - Providers and provider groups
 - Create collaborations on a community basis, not agency or problem-based
 - H&HS, urgent care, health care providers (public and private), Cowlitz Tribe, mental health providers, faith-based community

- H&HS as convener and facilitator
 - Convene a healthcare summit (assessment; gap identification; strategy formation; action); include all healthcare providers, all aspects of healthcare
 - Facilitate interaction and substantive collaboration and coordination between community providers; facilitate planning
 - Create collaborations on a community basis, not agency or problem basis

- H&HS specific roles
 - Information
 - Advocate for and be a distributor of information to individuals
 - Become a “one-stop-shop” for resource information
 - Provide access information; disseminate information broadly using multiple means including through service providers such as PUD
 - Access
 - Health Department should “challenge the community to increase provider access”
 - Bring community members together to address access

- Ensure adequate “safety net” provision of care for County
 - Assist with access to healthcare for uninsured and the distribution of that population between community providers (sharing of burden)
 - Conduct outreach to uninsured for eligibility and enrollment
 - Support the expansion of the Free Clinic (CFMC)
 - Directly facilitate and coordinate access to medical/mental health
 - Perform referral role; become a clearinghouse for service availability
 - Lead focus of service coordination on component of population that consumes greatest resources, freeing up needed capacity
 - Lead in establishment of a community-wide medical home program
 - Provide active support of provider recruitment to the area
- Provide services
 - Become a small community health center; provide direct services
 - Facilitate “medical weekends” (periodic free clinics)
 - Conduct community outreach and staff community-level work;
 - Lead community effort focused on health screening
- H&HS tactics
 - Reduce need and demand through effective prevention strategies
 - Create dedicated position to lead public awareness and education
 - H&HS leadership visible in community: learn needs and promote resources
 - Break funding barriers between various funding flows
 - Pursue legislative advocacy and conduct other “behind-the-scenes” work to promote community health; needed services; and healthcare reform
 - Advocate for the 1/10th of 1% sales tax; direct to assist uninsured
 - Provide incentives (i.e. to dentists, to address “working poor” adults)

GOAL-5 Develop and Implement Public Health Policy

9. Assessed was what health issues community health leaders believed could be addressed through public health policy.

- Steering Group Recommendations
 - Top insights
 - Health Department has responsibility for the health of the community (in addition to responsibility of individual)
 - Health issues need to be prioritized
 - Explore methods to adequately and sustainably fund priority work
 - H&HS could lead policy effort for lifestyle related education
 - Create criteria to identify, evaluate and prioritize needs
 - Many competing interests and health issues
 - Lifestyle has an impact on all related issues
 - Make wellness a component of all treatment plans
 - Action suggested by insights
 - H&HS, in role of a community “broker,” facilitates collection of data, develops criteria and sets priorities for use by a collaborative (such as Pathways 2020), to examine priority issues
 - Create a community-based policy agenda (areas of focus; implementation feasibility; resources)
 - Mandate policies that require listing and posting of nutritional information in conspicuous public view
 - Meet with policy-makers and encourage policies/programs that promote wellness
 - Priority action
 - Create a community-based policy agenda to include areas of focus, feasibility, implementation and required resources
 - H&HS facilitates collection of data and sets priorities for policy
 - H&HS in role of broker, facilitates collection of data, develops criteria and sets priorities
 - Collaborative framework
 - List: PeaceHealth; FHC; Kaiser; providers; behavioral health; RSN; CCHD; SA; DSHS; education; policy makers and politicians; faith-based groups; business; Cowlitz Tribe
 - “Marc’s Planning Group” (reference Goals 2 & 3)

- List: EDC, faith-based community, health department, business, mental health, education
- Health
 - Access to resources and care: medical; mental health; chemical dependency; developmental disabilities
 - Coordination of resources (above), for all co-occurring conditions
 - Obesity; childhood obesity; reigning in the effect of media
 - Food nutrition levels and portion size; access to nutritional information
 - Smoking; tobacco use
 - Management of communicable disease & pandemics (H1N1)
 - Chronic disease
 - Lifestyle choices
 - Immunization and immunization education
 - Vaccination distribution and access
 - Health insurance
 - Public education: examples such as smoking; lifestyle; prenatal education
 - Prescription drug disposal (policy, not just opportunity)
 - STD education policy; and STD & birth control ed. for incarcerated youth
 - Select issues based on epidemiological information
 - Promoting best practices (i.e. “check list” uses by local providers)
- Environment; food; water
 - Built environment (bike lanes; community and neighborhood design)
 - Neighborhood designs (healthier lifestyles, i.e. “green streets”)
 - Community development standards (i.e. alternate transportation)
 - Water safety
 - Food safety
 - Ensure all County buildings are smoke-free zones
 - Improve regulation of processed food; saturated and trans-fat food levels
 - Policy related to availability of “choices” at points of sale
- Other
 - Developing protocols (strategies), to improve community action related to adolescent drug and alcohol use
 - County campaign for and designated as “drug free community”
 - Mental health through programs (i.e. Safe Schools/Healthy Students)
 - Policy regarding distribution and application of services in community crises
 - Promotion of flexible funding uses (Federal and State)

- H&HS as a “broker” of services that would place H&S staff in community to address “systems of care” and resource centers – including housing

10. It was suggested that one of the priorities of public health is reducing communicable and chronic disease. Community health leaders were asked, on a scale of one to five (five being high), how important they believe this priority should be in Cowlitz County. The mean score was 4.8, and the range was four to five.

Notes:

- Fundamental role: core responsibility which and no one else is in a position to perform for community; should result in a community plan
- Health Department must take the lead; providers can only address acute needs
- Budgets should be aligned with statutory priorities
- Communicable disease affects whole community, i.e. social and economic effects
- Must focus on improving measures; address high rates in Cowlitz County
- Must be proactive: pursue prevention and early intervention

11. Respondents were asked how important they thought it is for H&HS to assess or evaluate community health on a regular basis on a scale of one to five (five being high). The mean score was 4.9, and the range was three to five.

Notes:

- Should be done strategically and funding aligned with strategic priorities; assessment should determine priorities and budgets
- Without data cannot make good decisions; data should drive policy decisions
- Needs to be ongoing, and near real-time; quarterly would not be too frequent to prompt early policy interventions; community response; individual actions; and to evaluate “what’s working”
- Core responsibility which and no one else is in a position to perform for community
- Support for community report card; Pathways 2020 Report Card has vital role; improve measures, data collection and analysis
- Leverage use of the County epidemiologist

12. It was proposed that poverty, lack of education, and limited access to healthcare services contribute to the high rate of chronic illness in Cowlitz County. However, with appropriate education, motivation and resources, would individuals have the power to manage their own well-being. The scale was one to five, five indicating agreement with the statement and one indicating disagreement. The mean score was 3.9, and the range was one to five.

Participant observations

- Limitations and complexities
 - Much complexity: unemployment; mental health, education, health issues
 - Those affected by severe conditions (mental health), may not have capacity to act; those who have capacity to act may not have access to assistance
 - There are other impacting factors, such as perception of control
 - People over-estimate individuals' ability to change: health determined by economic and physical environment
 - The "system" is not "friendly"
 - Addressing core causes helps but not all is within control of individual
 - Access to education is essential

- Resistance
 - People do not always take advantage of available resources
 - Some part of population will resist necessary behavior change
 - Motivation is a challenge; individuals "have the power" but are not motivated
 - Respondents often "did not entirely agree" with statement, related to issues of personal responsibility

- Strategies & tactics
 - Early, longitudinal, persistent lifestyle education can disrupt dysfunctional patterns; need more lifestyle-effects education; more direct involvement
 - Need educational emphasis in schools and early identification of issues
 - Education can be a powerful motivator; with education and motivation individuals would have the power; education should be very focused
 - Messages must be tailored to connect with realities of diverse individuals
 - Increase outreach of Health Department

- Healthcare services must be more accessible; insurance more accessible
- National Healthcare Reform is essential to augment current resources

STUDY CONCLUSIONS

Study conclusions in the form a modified set of Strategic Management Goal objectives were prepared by the Executive Committee, comprised of Cowlitz County Health and Human Services (H&HS) leadership. Conclusions were based on the original 2009 Strategic Plan Goals; survey raw information derived from structured interviews of over forty community health leaders (the Stakeholder Group); the analysis of information, and recommendations of over twenty community health leaders (the Steering Group), who participated in the Study; and other relevant information such as State and National dialogue content; epidemiological data; and selected public health literature.

The set of raw information provided by the Study reflects sociological, economic, and psychological perceptions about factors that impact the lives of community members, and to some degree the philosophy and operation of community health provider entities. The Study represents the expressed views of community health leaders and, while a valuable tool for understanding and evaluating community health needs and the application of resources to need, the Study is by design qualitative and subjective. One should keep in mind the service orientation of Cowlitz County H&HS as well the orientation of community individuals and organizations who participated in the Study.

Primary Product

As noted, Strategic Management Goals remain intact as approved. The modification of Objectives is the primary product of the Study. Modifications are rooted in the perspectives, analysis and judgment of a large representative sample of community health leaders working in partnership with H&HS senior leaders and managers and staff. The objectives serve an integrative function with respect to H&HS and its relationship to other Cowlitz County community health entities. It is believed that the modified objectives increases the relevance of H&HS work at the strategic level to the real and perceived needs of the community.

Secondary Product

The secondary product of the Study is the body of qualitative, subjective findings based on the large amount of raw information generated in the survey, organized around the Strategic Management Goals.

Modified Set of Objectives

The set of modified strategic objectives are presented here. Objectives have been tested by the senior H&HS leadership team with regard to clarity. All objectives are actionable and doable. All objectives are measureable.

1. Integrate services provided to the public by Cowlitz County Health and Human Services Department (HHSD)

Objective 1.1

Create an implementation plan for integration, by 6-30-11.

Objective 1.2

Create redundant public information officer systems for HHSD through joint training, by 9-1-01 (completed).

Objective 1.3

Complete Emergency Response joint planning and implementation for HHSD, by 8-9-10 (completed).

Objective 1.4

Formulate a joint training plan between Human Services and Health Department, by 12-31-10.

2. Collaborate with stakeholders and other service providers to identify the synergistic opportunities that result from working with the same clients to improve the health and well-being of the community

Objective 2.1

Complete a survey of stakeholders and other service providers to identify overlapping client groups, form conclusions, and complete the Mobilizing for Action through Planning and Partnership (MAPP) process, by 3-31-11.

Objective 2.2

Participate in Access to Care Café', 3-1-09 (completed).

Objective 2.3

Identify key training needs for the community in order to address an access crisis, and develop a collaborative plan, by 3-1-11.

Objective 2.4

Complete an assessment of potential benefits from working with Region IV (Clark; Wahkiakum; Skamania Counties), to improve Health Department and Human Services effectiveness, by 1-1-12.

Objective 2.5

Complete an opportunity assessment with Clark County Human Services, by 7-1-11.

3. Engage in an ongoing community assessment process to generate, gather, compile, analyze and utilize data for the benefit of the community

Objective 3.1

Complete a county-wide inventory of selected, pertinent categories providers and their sets of services (assess community health assets), by 7-1-11.

Objective 3.2

Increase the frequency of convening Cowlitz County Board of Health from bi-monthly to monthly, by 1-1-09 (completed)

4. Facilitate access to the continuum of preventative medical and mental health services available

Objective 4.1

Complete a plan to decrease access barriers in order to enhance access to needed services, by 12-31-11.

5. Develop and implement an annual public health policy agenda for the enhancement of community health and well-being

Objective 5.1

Create a policy team to brainstorm local health and human services issues that require governmental solutions, by 3-31-11.

Objective 5.2

Create an initial plan for the formulation and advancement of public health policy, by 12-31-11.

Qualitative, Subjective Findings

Informational content by design reflects the perspectives, beliefs, theories and judgment of Study participants. An attempt to draw concise conclusions from raw input may compound issues of reliability and consistency already inherent in the subjective nature of such information.

However, the value of Study raw subjective content is use as an encyclopedia of community-based perspectives that can inform leaders and collaborative groups of leaders as they build work plans for the set of modified objectives. Work plans sensitive to and built in the context of what leaders believe about any particular

community health realm could be written with consideration for differences in perspectives, and expected resistance to, or support for, change.

Some generalities are estimated about the sociological, economic, and psychological factors that impact the lives of community members; the perspectives of community health leaders; and the relationships between community health organizations. Such information may be of tactical value in forming collaborations; structuring solutions; and in the implementation of community health-related action plans.

1. There is strong support for some level of integration or linkage between various healthcare delivery components, such as primary care, mental health, substance abuse and preventative care. While there are many compelling reasons to seek integration or at least strong linkages, structural fragmentation makes integration challenging. Elements of fragmentation include strong organizational identity; differing economic models and conflicting business models; and incompatible payment mechanisms. These elements create barriers to solutions that would require the cooperation of multiple entities. However, Study participants remain committed to a vision of greater integration, and some entities are experimenting with innovative models. These views inform H&HS about how their services are related, delivered and perceived and suggest greater integration of operations would be welcomed by the community, and potentially serve as a model for others. .
2. Communication is seen as critical to the mission of H&HS. There is a moderately strong voice for outreach. Means of communication must be multi-modal. While current technology offers elegant solutions, technology as well as traditional means fail to reach certain critical target populations.
3. The diversity and complexity of the set of all community health-related entities and combinations of potential partnerships is staggering. Mission overlap, competition for resources, mission divergence all conspire to make collaboration in many cases difficult. Nevertheless, opportunities for meaningful progress in many domains rest with the ability of organizations to find mutual reinforcing synergies, and to extend through cooperation their limited capacity to act beyond their defined operational boundaries. For the set of domains explored, a list of ten “universal partners” and/or partner categories emerged.
4. Ways for community partners to work in collaboration featured planning endeavors; the use of formal agreements; and “cross system” agendas. Study participants encouraged a pilot approach to demonstrate the value of collaboration, from which to build support for future efforts.

5. Factors contributing to high rates of chronic disease in Cowlitz County were perceived as many, diverse and complex, but can be organized into several categories, with examples which follow. Socio-economic factors include poverty and unemployment. Life style choices include tobacco use, substance abuse; poor diet choices and lack of exercise. External factors range from poor environment to lack of education and lack of role models. Proximal causes included lack of access to health care and childhood obesity. Psychological factors featured hopelessness, stress and apathy.
6. Significant contributors to poor health and well-being in this community for adults included socio-economic elements (unemployment; unaffordable health and dental care); lifestyle choices (personal behavior and unwillingness to pursue prevention measures); and proximal causes, both physical and psychological (including mental health issues). For children, proximal causes included socio-economic elements (poverty and lack of access to healthy choices); and numerous input regarding variations of poor parenting and/or disadvantageous home conditions.
7. Numerous roles for H&HS to play in the community were offered by survey respondents. The top six roles in order of mention were community educator and facilitator; coordinator of services; information and resource provider; facilitation of contracting; referral agency and provider of direct services. It is important to remember these were the perceptions and opinions of community health leaders, some who might have little or no knowledge about, for instance, statutory role requirements. Regardless, consideration for and management of such perceptions would need to be taken into account as H&HS reaches out more assertively into the community.

An additional insight offered was that H&HS fills gaps that other community health entities do not cover. A corollary to that observation is that H&HS, as a consequence of its “gap” roles, in some cases serves all the County (food safety), but in other areas (maternal-child), serves only a small segment of the community.

8. Ways for H&HS to lead an effort to increase access to health and mental health services was explored. Suggestions included roles related to convening and facilitating; information gathering and advocacy; access coordination, and providing direct services. Topping the list was H&HS as a convener of health care providers, and facilitating collaboration on a community-wide basis. Tactics as a function of a more traditional H&HS role included, in example, reducing need and demand through effective prevention strategies, perhaps through a dedicated position with focus on public awareness and education.

9. Respondents provided numerous recommendations with regard to target issues for public health policy in the areas of health, environment, food and water safety. One can observe in the range of suggestions the extremes of philosophical or political ideology, that is: governmental and regulatory “hands-on” versus a “hands-off” approach. Regardless, there was strong support for the Health Department to take a leadership role in generating, in partnership with the community, a health policy agenda. There were also some very specific suggestions, such as policy addressing the conspicuous posting of nutritional information in food outlets.
10. The community-based survey revealed extremely strong support for the Health Department’s role in reducing communicable and chronic disease. An exploration of comments would prompt discussion about the Health Department role-relationships with direct care providers. A key question might be how to leverage and/or augment the respective current roles of those who do provide direct care together with the Health Department’s current scope and focus, to enhance the impact of the parties’ effort for the good of the general population. The capacity of the Health Department to lead such an effort, with alignment of budgets and resources would be a component of that question.
11. Respondents rated extremely high the importance for H&HS to assess and evaluate community health on a regular basis. Two important comments were that information (data) should drive decisions; and assessment should be approached strategically, with funding aligned with strategic priorities. The vital role of the Pathways 2020 Report Card, which is substantially supported by the Cowlitz County Public Health epidemiologist, was noted.
12. It was proposed in a survey statement that poverty, lack of education, and limited access to healthcare services contribute to the high rate of chronic illness in Cowlitz County. Respondents were then asked whether, with appropriate education, motivation and resources, individuals would have the power to manage their own well-being. While the mean score was slightly shifted toward self-efficacy, the range of responses demonstrated a great tension between the impact of environmental elements (in the initial statement), and the exercise of personal responsibility. Participant observations included limitations and complexities of socio-economic factors; elements of resistance; and strategies & tactics related to interventions.

Communication Plan

Setting

H&HS is augmenting the H&HS Strategic Plan using a community-based planning methodology; coordinated by an Executive Committee and led by the H&HS Director.

Objectives

- ❖ Inform and set expectations about the project process and outcomes
- ❖ Reinforce on a regular basis the progress and developmental content of the project
- ❖ Report on the conclusion of the study: clear outcomes and proposed action

Strategy

- ❖ Communicate in multiple venues and by multiple means to ensure ongoing access to information and opportunity for input (clarity; visibility; frequency)
- ❖ Stay real; stay transparent (the good; the bad and the ugly; the known and the unknown)

Tactics (including input from clinician leader environmental assessment interviews)

- ❖ Time line public after completion of design phase
- ❖ Steering Committee invitations: 3-week lead time
- ❖ Regular updates to the Commissioners; Steering Group; and participating staff
- ❖ Knowledge leadership: Executive Committee members informed and equipped as primary ambassadors of the project, and carriers of input to the various constituencies
- ❖ Project tracking: through an iterative working document
- ❖ Reporting of proceedings and results, as appropriate, to various constituencies
- ❖ Public Information Officer creating and executing an implementation plan based on the following outline

Phase V – Communication Phase

- Audience: County Commissioners
 - Sequence: first
 - Primary content: summary of study conclusions
 - Means: Board of Health; PowerPoint presentation and Study document
- Audience: H&HS Management Team
 - Sequence: second
 - Content: Study in entirety
 - Means: work session; Study document; dialogue

- Audience: H&HS staff
 - Sequence: third
 - Primary content: summary of Study conclusions
 - Means: PowerPoint presentation at staff meeting and dialogue session

- Audience: Steering Group
 - Sequence: fourth
 - Primary content: summary of Study conclusions
 - Means: Director interface; PowerPoint; and Study document on selective basis

- Audience: Stakeholder Group (note list overlap with group above)
 - Sequence: fifth
 - Primary content: summary of Study conclusions
 - Means: Director interface; PowerPoint; and Study document on selective basis

- All audiences
 - Study PowerPoint on H&HS web site
 - Post progress on Strategic Plan objectives on quarterly basis

APPENDIX-1
Study Process Schedule (Critical Path)

1. Send Steering Group invitation letter #1	4-1-10
2. Establish interviewer cadre training schedule	4-13-10
3. Matching Performed (interviewer/Stakeholder)	4-13-10
4. Notify interviewers (for training)	4-14-10
5. Steering Group session prep meeting	4-23-10
6. Convene Steering Group Session-1	4-26-10
7. Follow-up letters	4-28-10
8. Integration of Steering Group Question Set input	4-30-10
9. Interviewer training sessions begin	5-3-10
10. Deploy survey (start)	5-10-10
11. Complete survey process	5-21-10
12. Send Steering Group invitation letter #2	6-1-10
13. Aggregation/integration process complete	6-18-10
14. Exec Committee review complete	6-23-10
15. Convene Steering Group Session-2	6-28-10
16. Follow-up letters	6-30-10
17. Send Steering Group invitation letter #3	7-1-10
18. Integration of Steering Group input complete	7-13-10
19. Send advance materials to Steering Group	7-16-10
20. Exec Committee review complete	7-16-10
21. Convene Steering Group Session-3	7-26-10
22. Follow-up letters	8-9-10
23. Decision on document form; conclusions	7-27-10
24. Synthesis and study conclusions (First Draft)	8-6-10
25. Exec Cm: final decisions re: study conclusions	8-10-10
26. Second Draft delivered	8-12-10
27. Second Draft work session review	9-1-10
28. Review session with Director	9-2-10
29. Final document draft complete	9-5-10
30. Send out Final Draft to review team	9-5-10
31. Review period ends	9-17-10
32. PowerPoint presentation delivered	9-30-10
33. Final printed/bound documents delivered	9-30-10
34. Communication Phase plan implementation	To Follow

APPENDIX-2

Steering Group Invitation List

External

1. Sara Cave (PeaceHealth Strategy and Innovation)
2. Aaron Rust (PeaceHealth Medical Group Primary Care)
3. Lynn Van Brunt (SJMC Emergency Department)
4. Dian Cooper (Family Health Center)
5. Todd Broderius (Family Health Center)
6. Paul Youmans (Pathways 2020)
7. Karen Carter (Kaiser Permanente)
8. Mike Johnson (DSHS)
9. Grover Laseke (County Sheriff's Department –D.E.M.)
10. Chad Connors (Juvenile Justice)
11. Marin Fox-Hight (Corrections Department)
12. Mark Hottowe Education)
13. Mary Harding (Lower Columbia College)
14. Bob Gregory (City administration representative)
15. John Steppard (Faith community)
16. Jim Sherill (Cowlitz Tribe)
17. Lesley Bombardier (Community Health Partners)
18. Steve Watters (Mental Health representative)
19. Gus Nolte (Substance Abuse representative)
20. Bea Rush (Union representative)
21. Pete Paulin (Out-of-area representative)
22. Melissa Taylor (COG)
23. Bernie Altman (Ombudsman)

Internal

1. Carlos Carreon
2. Mark Bollinger
3. Kelli Bowen
4. Jennifer Vines, MD
5. Monica Monteon
6. Hillary Gillette-Walch
7. Consultant

Stakeholder Group Invitation List

EXTERNAL

1. Aaron Rust (PHMG primary care)
2. Brian Hoyt, M.D. (SJMC Emergency Department Medical Director)
3. Dian Cooper (FHC)
4. Paul Youmans (Pathways 2020)
5. Tom Hickey, M.D. (Kaiser Permanente)
6. Mike Johnson (DSHS)
7. Chad Connors (Juvenile Justice)
8. Marin Fox-Hight (Corrections Department)
9. Mark Hottowe (Education)
10. Mary Harding (Lower Columbia College)
11. Bob Gregory (city administration representation)
12. John Steppard (faith community)
13. Jim Sherill (Cowlitz Tribe representative)
14. Lesley Bombardier (Community Health Partners - CFMC)
15. Steve Watters (Youth and Family Link)
16. Gus Nolte (DAPC)
17. Grover Laseke (D.E.M.)
18. Hillary Gillette-Walch (consultant and epidemiologist)
19. Phyllis Cavens, M.D. (children)
20. Kris Keough (PeaceHealth Ethicist)
21. Bernie Altman (Ombudsman)
22. Sally Bartlett (Developmental Disability Advisory Board)
23. Audrey Shaver (Food Advisory Board)
24. Elmer Nozinger (Silver Lake Citizen's Group)
25. Dave LaFave (Cowlitz-2)
26. Castle Rock area representative
27. Woodland representative
28. Melissa Taylor (COG – housing)
29. Sandy Junker (Head Start)
30. Sister Amalia (PeaceHealth)
31. Ben Hamilton (Community Network)

Internal

1. Carlos Carreon
2. Mark Bollinger
3. Kelli Bowen
4. Jennifer Vines, MD
5. Monica Monteon
6. Audrey Shaver (Environmental health)
7. Jerusha Kash (Emergency preparedness)

Interviewer Cadre Primary Role Attributes

- Able to be an effective ambassador of H&HS
- Critical thinking skills
 - To assist participants in expressing answers in required format
 - To avoid interviewer bias
- Good verbal skills
- Engagement skills
- Focus (to manage structured questionnaire in allotted time)

Interviewer Cadre

1. Carole Harrison
2. Jim Bradley
3. April Stewart
4. Gayle Reid
5. Mindy Hegstad
6. Janis Housden
7. Kate Dugas
8. Guy Cochran
9. Jesse Smith
10. Ruby Stilson
11. Audrey Shaver
12. Laura Ebinger
13. Monica Monteon
14. Marc Bollinger
15. Kelli Bowen
16. Jerusha Kasch
17. Carlos Carreon

APPENDIX 3

Scorecard Reference for H&HS Performance Improvement Work

Purpose

- Plan surveillance
- Resource utilization surveillance (alignment between needed outcomes and use of resources)
- Opportunity monitor (“early warning system”)
- Plan accountability
- Leadership accountability

Process

1. Identify domains of accountability: relatively stable categories
 - a. Strategic element, category of outcome or output (“strategic management goals”)
 - b. Essential function (“objectives”)
2. Identify measurement statements (examples of types follow)
 - a. That would enable and/or develop the domain
 - b. Represent functional success in a domain
 - c. That in pursuit would accomplish an objective of the domain
3. Form of a measure: the measure statement --
 - a. Two parts to every measure
 1. Descriptive measurement statement
 2. The measure target: always a numerical result
 - b. May be a “stretch” goal but is nevertheless realistic
 - c. **Example** (which would require an increase in function/performance)

Measurement statement: Percentage of overlap between WA core public health function of Assessment and Evaluation and the Health Department performance

The measure target: 50%

- d. **Example** (would require minimum number of programs evaluated)

Measurement statement: The number of existing Departments formally evaluated, reported, and disposition determined.

The measure target: 5

4. Measurement process
 - a. The owner of the measure (the accountable leader), is identified
 - b. The individual responsible for performing the measurement is identified
 - c. The frequency of measurement is identified
 - d. The frequency of reporting is stipulated
 - e. The form of the “report-out” is identified
 - f. Distribution of the report is stipulated
 - g. Responsibility and priority for meeting measures is agreed upon
5. Planning cycle
 - a. The time line or cycle of the measurement process is typically one year (but could be shorter or longer)
 - b. Prior to the end of a planning cycle, typically when three quarters of data is available, the strategic planning process is revisited and
 - c. The scorecard is re-created consistent with renewed plan

APPENDIX-4
PowerPoint Presentation

Separate attachment.