



# **Cincinnati Health Department Strategic Plan 2016-2021**

*Working the Plan to Make Cincinnati the Healthiest City in the Nation*

**Noble Maseru, Health Commissioner, Ph.D. MPH  
O'dell M. Owens, Medical Director MD, MPH**

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## Strategic Planning Committee and Process

### STRATEGIC PLANNING COMMITTEE MEMBERS

Noble Maseru, PhD, MPH	Health Commissioner
O'dell M. Owens, MD, MPH	Medical Director
Regina Hutchins, PhD, BSN, RN	Accreditation Coordinator - Director, Quality Management
Samuel E. Lynch, BS	Volunteer – Strategic Planning Coach
Marilyn Crumpton, MD, MPH	Director, School and Adolescent Health
Camille Jones, MD, MPH	Assistant Health Commissioner Community and Environmental Services
Joyce Tate, MPA	Assistant Health Commissioner/CEO Population Health and Clinical Services
Patricia Carlyn, RN, BSN, MHA	Director, Nursing/Quality, Compliance, Privacy Officer
Jennifer L. Mooney, PhD, MS	Interim Director, Maternal and Infant Health
Harry Barnes, MBA, PHR	Director, Human Resources
Robert Schlantz, CPA	Chief Finance & Technical Resources
Marla Fuller, BA	Director, Communications and Governmental Affairs
Denisha Porter, MPH, RS, HHS	Director, Health Promotions
Tunu Kinebrew, MPA	Vital Records Coordinator
Maryse Amin, PhD, MS	Supervising Epidemiologist
Ashley Auciello, BS	Clerk to the Board of Health
Staci Wagner, MSA	Chief Operating Officer, City of Cincinnati Primary Care
Geneva Goode, MSN, RN	Nursing Supervisor, Clement Health Center

Lawrence Holditch, MD	Medical Director – Consultant
Allison Franklin	Lead Program/Healthy Homes
Steven Englender, MD, MPH	Director, Public Health Preparedness
Nancy Carter, RDH, MPH	Associate Dental Director
Alvenia Ross, MS	Administrative Technician, Millvale Health Center & Walnut Street Health Center
Joy Maxi	Administrative Technician, Nursing Administration
Malcolm Timmons	Chairman, Board of Health
Timothy Collier	Board of Health Member
Herschel Chalk	Board of Health Member
Minette Cooper	Board of Health Member
John Kachuba	Chairman, City of Cincinnati Primary Care Board of Governors
Kathleen Clark, MSW, MPH	City of Cincinnati Primary Care Board of Governors Member
Pamela J. Adams	City of Cincinnati Primary Care Board of Governors Member

## A Message from the Health Commissioner



We are delighted to provide you with the CHD 2016-2021 Strategic Plan.

This Strategic Plan on the Department's future program direction and initiatives has been especially prepared for alignment with the Public Health Accreditation Board (PHAB) requirements for accreditation. The rigor required to achieve accreditation assures our Department will meet performance and quality improvement standards appropriate for our Department.

The PHAB process like our Department's operations is committed to improving population health with the end goal of achieving health equity through public health practice. Moreover this effort maintains our commitment to continually improve a return on investment through service and accountability to those who visit, work, play and reside in Cincinnati.

The Health in All Policies framework is laden in this Strategic Plan and our companion documents: The Community Needs Assessment and Community Health Improvement Plan.

Right now we are embarking on a path where we will join more than 1500 local, county and state health departments in meeting standards that will strengthen our capability in fulfilling the legacy of public health - improving the conditions in which people can live healthy.

Sincerely,

Noble Maseru, Ph.D. MPH  
Health Commissioner

## A Message from the Medical Director



The Cincinnati Health Department will strive, over the next three years, to showcase how we are going to put “public” back into the Health Department. This will be accomplished by a series of low cost, but highly effective, messaging to the general population.

For example, the Health Department will enhance community partnerships with the general public to educate them on proper hand washing techniques, including the correct way, and how often, to wash their hands. This simple procedure will have a tremendous impact on the rate of flu transmission, some forms of diarrhea, and other communicable diseases that are passed through poor hand washing practices.

With high incidences of respiratory issues, we will also be working more aggressively to combat asthma flare-ups and emergency room visits caused by air pollutants, through the creation of an alert system. This alert system targeted to physicians, especially pediatricians, notifies them of weather forecasts that predict poor air quality. Such notifications, encourages care givers to remind their asthmatic patients to avoid common triggers that lead to worsening symptoms.

Additionally, the Cincinnati Health Department will work diligently with local daycare centers to inform them when incidences like Shigella and other medical issues, are on the early rise in daycare and public schools. This will again allow the centers to review their policy on hand washing and to be on alert for an increase in incidences of diarrhea.

These initiatives are simple, highly effect and inexpensive, and yet they will have tremendous impact on incidences, and the quality of care and overall health of the community at large.

Sincerely,

O'dell M. Owens, MD, MPH  
Medical Director

## Introduction

The Cincinnati Health Department (CHD) July 2013 initiated the process to achieve Public Health Accreditation standards in 2013. Our goal: to accomplish Public Health Accreditation Board (PHAB) pre-requisites in 2016 and accreditation in 2017. The pre-requisites include submitting the following: a Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and the CHD production of the organizational Strategic Plan (SP) which addresses the community needs and priorities identified in the CHA/CHIP reports. In addition, CHD SP supports and aligns with the county and state CHIP priorities.

CHD staff are proud of their progress and effort to become PHAB accredited. Accreditation is important for our citizenry, community stakeholders, and visitors because it is a demonstration of our local health department's (LDH) commitment to best practices and continuous quality improvement. In addition, it is an organization- wide plan for collaboration and state of the art public health practices. A collateral benefit of the PHAB Accreditation process, is that our LHD adheres to a plan that promotes efficient, effective, and intentionality for maximizing agency and community resources.

We are confident that these actions will result in improved population health and a greater return on investment (ROI) for our city. in our community. Community health issues are addressed using the collective impact framework which places an emphases on the triple aim to community health. The *Triple Aim* focuses on contributions from public health, hospitals, and community population health management (i.e. stakeholder and community partner support). This community response is broader, more inclusive, and requires intentional and effective stakeholder engagement from all sectors of the community. Research shows and it is well documented that such deliberate collective community response is more likely to result in better community and population health outcomes and cost value rankings.

In 2013, Ohio ranked 47<sup>th</sup> out of (Health Policy Institute Ohio – HPIO, 2014) all United States health rankings on a composite measure of health value – the contribution of health care costs and population health. This ranking is not acceptable to state, county or city public health and public policy leaders. In response and in addition to other corrective action, Ohio Department of Health (ODH) mandated all public health departments in the state that receive funding from ODH become PHAB accredited by 2020. Such process and achievement requirements by local health departments (LHD) would ensure that every ODH supported LHD is practicing public health utilizing and implementing the *Triple Aim approach* to community and population health.

CHD, The Health Collaborative – Collective Impact (hospital systems, LHDs, and health plan providers), Cincinnati Creating Healthy Communities Coalition (CCHC - over 75 community stakeholder members), Interact for Health, and other community stakeholder organizations collectively conducted the 2016 regional CHA and developed phases two of the CHIP selected priorities. CHIP priorities are identified and listed in The Health Collaborative's - Health Generation (GEN-H) Plan. The GEN-H plan provides the community's 2020 health goals and strategic plan. CHD's Strategic Plan provides support for GEN-H, our community's CHIP, and designed to align with ODH's *2014-2018 Plan to Prevent and Reduce Chronic Disease*.

It is with great pleasure that we provide our 2016-2021 strategic plan for review. Finally, I extend a *Special Thank You* to National Association of City and County Officials (NACCHO) for generous financial support and Mr. Samuel E. Lynch of Global Lead/Novation Management Consulting for in kind contributions making it possible for CHD to prepare and complete our accreditation package, culminating in our application submission to PHAB.

## Key Terms and Definitions

**Community:** A group of people who share some or all of the following characteristics: socio-demographics, geographic boundaries, sense of membership, culture, language, common norms, and interests.

**Culture:** A dynamic pattern of learned values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not.

**Culture of Health Equity:** A dynamic process that considers shared values, and diverse beliefs, customs, and behaviors, to ensure that all individuals have fair and equitable opportunities to attain their highest potential for social, physical, and mental well-being

**Disparity:** A noticeable and often unfair difference between people or things.

**Equal:** 1) Of the same measure, quantity, amount, or number as another. 2) Regarding or affecting all objects in the same way

**Equality:** Equal treatment that may or may not result in equitable outcomes

**Equity:** Providing all people with fair opportunities to attain their full potential to the extent

**Equity Lens:** The perspective through which one views conditions and circumstances to understand who receives the benefits and who bears the burdens of any given program, policy, or practice.

**Gen-H:** “Collective Impact” is a structured approach to developing coordinated solutions to complex social problems. The Collective Impact on Health in Greater Cincinnati, now known as Gen-H, is comprised of a diverse group of key leaders representing many sectors of our community. The Health Collaborative convened this team to achieve better health, better health care, and a lower overall cost of care, a three-part goal known as The Triple Aim.

**Health:** A state of complete physical, mental, and social well-being, not merely the absence of disease.

**Health Collaborative:** Health Collaborative: In April 2015, the Health Collaborative, the Greater Cincinnati Health Council, and Health Bridge merged into a single organization called The Health Collaborative. The three well-respected, long-standing nonprofit health and health care improvement organizations are working together under a single management structure, which more efficiently aligns our services and more effectively meets the needs of the communities, stakeholders, and members they serve.

**Health Disparities:** The avoidable differences in health that result from cumulative social disadvantage. Specifically, "...the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence."

**Health Equity:** Equity in health refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. Efforts to promote equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill.

**Health Inequity:** An unfair and avoidable difference in health status seen within and between communities.

**Inequity:** A difference or disparity between people or groups that is systematic, avoidable, and unjust

**Leadership Team:** Comprises the Division Directors, Assistant Health Commissioners, Human Resources Program Manager, Associate Dental Director, Medical Director, Special Assistant to the Health Commissioner, Chief Operating Officers, Director of Public Health Preparedness, Director of School and Adolescent Health Services and the Health Commissioner.

**Public Health Accreditation Board (PHAB) Standards:** A set of national benchmarks for public health agencies, which are recognized, practice-focused and evidenced-based. Health department performance is measured against these standards, and national accreditation is granted to those meeting standards within a specified time frame. PHAB's goal is to improve and protect the health of the public by advancing the quality and performance of public health departments. • PHAB Standard 11.1: "Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions." Measure 11.1.4

**Local Health Department:** "Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes."

**Social determinants of health (SDOH):** The conditions in which people are born, grow, live, work, age and die, including the health system. These circumstances are shaped by the distribution of money, power, and other resources at global, national and local levels.

The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between communities.

**Socially disadvantaged:** Those populations “who have persistently experienced social disadvantage or discrimination...and systematically experience worse health or greater health risks than more advantaged social groups...” conversely, socially advantaged refers to a group’s relatively high “...position in a social hierarchy determined by wealth, power, and/or prestige.”

**Triple AIM:** The triple aim focus on better health, better care, and lower cost. The Triple Aim is The Greater Cincinnati Health Collaborative efforts to improve health status and value in health care delivery using the triple aim three prong approach.

**Turning Point Performance Management Framework:** A set of resource materials to help public health systems manage performance, which were first developed in 2003 by the Public Health Foundation (PHF). These materials were developed and revised over time, and in 2013, PHF released an updated Public Health Performance Management System Framework, which includes four key components: 1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement.

**Under-resourced:** Those populations that have insufficient capital or assets (e.g. economic, human or social), in part due to historical policies and systemic exclusion.

**Vulnerable:** Those populations that are “not well integrated into the health care system because of cultural, economic, geographic, or health characteristics...This isolation puts members of these groups at risk for not obtaining necessary medical care, and thus constitutes a potential threat to their health.”

## Strategic Planning Process

The CHD Strategic Plan was produced by following the recommended processes described in resources provided by National Association of City and County Health Officials (NACCHO) and required by Public Health Accreditation Board (PHAB).

The process included conducting and completion of an organizational environmental scan. The environmental scan process consisted of the CHD Strategic Planning Committee collectively reviewing community health assessments produced from local hospitals community health needs assessments, community organizations needs assessments and health status survey reports, county and state health ranking data, and CHD’s preventive and primary health care status and outcome reports produced during 2013 – 2016. In addition, the committee reviewed and applied consideration of the community health priorities identified by the Health Collaborative, in the Gen-H community health improvement plan (CHIP), and other health assessment and community plan reports.

The timeline for CHD’s planning process through 2021 is depicted in the following table.

### Accreditation and Strategic Plan Timeline

	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Official PHAB Accreditation Application</b>				PHAB Application Submission					
<b>Accreditation every (5 years)</b>					Goal for Official PHAB Accreditation Certification				Accreditation expires/ renewal in 2021
Community Health Needs Assessment (CHNA/ CHA)  (at least every 5 years)	Health Collab (HC)  produce regional/ county CHA		Engage in CHA process	HC produces new regional and county CHA report			HC Collective 3 yr. regional & county CHNA report		

<b>Community Health Improvement Plan (CHIP)</b>	HC produce regional/ county CHA			Revise/Up- dated  CHIP	Revise CHIP		Revise CHIP		Revise CHIP
<b>CHD Strategic Plan (must be current and dated within 5 years)</b>				Strategic Plan (SP) #1			Update SP		Revise/SP #2
<b>Comprehensive Quality Improvement Plan (CoQI)</b>			Start Co QI committee	Develop/write /Start Implement CoQI plan	Revise/ Update plan as needed		Revise/ Update plan as needed		Revise/ Update plan as needed
<b>Workforce Development Plan</b>				Strat creating and implementing  (WFP)  Workforce Development plan	Revise/ Update plan as needed		Revise/ Update plan as needed		Revise/ Update plan as needed
<b>*Mayoral Term Begin (4 years)</b>		*				*			

## Process for Developing the Strategic Plan

Accreditation Coordinator, Dr. Regina Hutchins, facilitated the strategic planning sessions. Dr. Hutchins received coaching and guidance from Mr. Samuel E. Lynch, a community volunteer who has over 30 years of organizational strategic planning and leadership consultation experience with boards such as: Urban League of Greater Cincinnati, Boy Scouts of America, African American Chamber of Commerce, Bank One, Museum Center, Junior Achievements, WCET and the Community Chest.

The strategic Planning process was officially launched in October 2015 after PHAB Accreditation Introduction was formally presented to the CHD Board of Directors and City of Cincinnati Primary Care (CCPC) Board of Governors. Dr. Hutchins presented PHAB Accreditation Introduction to CHD Leadership Team, middle managers, general staff, and Creating Healthy Communities Coalition partners over several meetings and special sessions from May 2015 - Feb 22, 2016 when the CHD PHAB Strategic Planning session series was launched.

The strengths, weaknesses, opportunities, and threats (SWOT) surveying process was developed and made available to staff (internal) and community (external) organizational stakeholders. Both stakeholders groups were provided two options for participations, either by hard copy (paper documentation) or electronic (*Survey Monkey*). SWOT orientation and participation instructions were provided in person, in print and electronically. The survey was open for participation for 3 1/2 months (Nov 2015 – mid Feb 2016) which was the time required to contact, schedule and present “Introduction to PHAB” and CHD SP process to all of CHD division/program staff and to present to community stakeholder groups. All groups were allowed a minimum of two weeks response/participation time to optimize participation rates. All staff were provided the opportunity to engage in the SWOT surveying process (see the SWOT Analysis section).

As described in SP recommendation tools, the strategic planning committee would be made up of staff including: front line rank and file, middle management and the Leadership Team.

The SP committee was made up of representation from each level of the organization: front line, rank and file, middle management, and the Leadership Team. All program and division directors were required to participate. Other front line, rank and file and middle management staff were recruited after they expressed interest from responses from a PHAB orientation and SWOT survey. Board members expressing interest in participation were extended an invitation to participate on the committee.

The strategic planning committee consisted of the accreditation coordinator - director, health commissioner, medical director, each CHD program/division director, and representatives from both the Board of Health (BOH) and CCPC board of Governors (see the list of SP committee members and program/community representative).

## Strategic Plan Meetings

The committee met for a series of seven 3-hour meetings from February 22 – May 11 2016 (see below).

Meeting	Date	Topic covered
1	Feb 22	Introduction: Public Health, PHAB, Strategic Planning Process Current Mission, Vision, Values provided for review
2	Feb 29	Environmental Scan / Examine Data: CHA, CHIP, CHNAs,
3	March 7	SWOT CHD Primary Program Data Review Mission, Vision, Values
4	March 14	CHD Programs Financial Status Update Selection of Priority Areas Review of Instructions for writing SMART Objectives/Goals Imitation of writing SP Priority Areas using SMART Objectives/Goals
5	March 21	Continue writing SP Priority Areas using SMART Objectives/Goals All Four Priority Area Groups present SMART Objectives/Goals to entire SP committee for feed back Revision of Mission, Vision, Values
6	April 11	All Four Priority Area Groups present SMART Objectives/Goals to entire SP committee for fee back and/or vote for acceptance Revision of Mission, Vision, Values continued
7	May 9	Entire committee review of SP Plan draft for any final edits before final version sent to printing

8	May 11	Present final SP to CCPC Board
9	May 21 10am-3pm	Conduct Community Conversation Provide "State of Community Health Address": CHA,CHIP, CHD SP & CCHC Share CHD new Vision, Mission, Values Community Engagement: Conversation re: Minority Health & Priorities, Minority and Disparity Populations Barriers/Solutions/Strategies
10	May 24	Present final SP to CHD BOH

Initially the Strategic Planning process was planned for five 3-hour sessions. The Strategic Planning process required one extra meeting which was held April 11 due to revisions required to the *Organizational Values* list. The *Values* revision and recommendations were submitted to the organizational *Values* committee for vetting and adoption consideration. The *Values* committee made revisions and additions to the guiding principles. Following the initially planned five week meeting series conducted Feb 22-March 21 an additional meeting was required and held on April 11, 2016. The *Values* statements were voted to be expanded and revised by the *Values* Committee.

Three additional Values were added: Collaboration, Accountability, and Quality Management. There were few additional revisions.

During the final two meetings in the series, the SP priority focus areas were assigned as subcommittees and subcommittee leaders were selected. Committee leaders lead working groups in the respective priority areas. Each SP priority focus group worked to create SMART Objectives using the OGSMRT frame work: Objective, Goals, Strategies, Measures, Resources, and Timeframe. The OGSMRT requires that outcome indicators, performance indicators, and strategies be established for achieving each Priority Focused Area Objective.

## Vision, Mission and Core Values

### **VISION**

City of Cincinnati to become the healthiest city in the nation.

### **MISSION**

To achieve health equity & improve the health and wellness of all who live, work, and play in Cincinnati.

### **CORE VALUES (GUIDING PRINCIPLES)**

#### **Excellence**

We honor our mission by upholding excellence in personal, public health and patient care services.

#### **Commitment**

We foster a culture of compassion and mutual respect among our employees and clients, and recognize diversity as a strength in our organization and community.

#### **Communication**

We are dedicated to cultivating a sense of transparency both internally and with the general public through clear, intentional and effective communication.

#### **Accountability**

We demonstrate the highest level of respect, integrity and professionalism, guided by our sense of trust and morality.

#### **Leadership**

We strive to be the model for public health practice to continuously improve health and social equity for people of Cincinnati.

#### **Collaboration**

Through comprehensive engagement with multisector stakeholders, we strengthen partnerships to improve community health.

#### **Quality**

We measure performance outcomes and social determinants of health through quantitative and qualitative methods for continuous quality improvement.

## Strengths, Weaknesses, Opportunities and Threats (SWOT)

The Cincinnati Health Department conducted a Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis in preparation for accreditation readiness. The top five most commonly identified themes are presented in this report. The survey was provided by CHD's Accreditation Team for the Strategic Planning Process and Committee in accordance with Public Health Accreditation Board (PHAB) and National Association of County and City Health Officials (NACCHO) recommendations and standards for environmental scans. The findings presented here were reported to Strategic Planning Committee on March 4, 2016

### *Top five identified strengths and opportunities*

<b><u>CHD Strengths (Internal)</u></b>	<b><u>CHD Opportunities (External)</u></b>
<ol style="list-style-type: none"> <li>1. Good Care               <ol style="list-style-type: none"> <li>a. large variety of services and programs</li> </ol> </li> <li>2. Dedicated, Knowledgeable and Professional Staff</li> <li>3. Community Engagement               <ol style="list-style-type: none"> <li>a. Good Collaborative Efforts</li> <li>b. Community partnerships (CCHMC, CPS)</li> </ol> </li> <li>4. Mission and Visions Work               <ol style="list-style-type: none"> <li>a. PCMH (Patient Centered Medical Home) Certified</li> <li>b. Accreditation in process</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Improve Community Relationships/Relevance and Reputation               <ol style="list-style-type: none"> <li>a. mental health/substance abuse/violence</li> </ol> </li> <li>2. Expansion of Services</li> <li>3. Improve Marketing</li> <li>4. Increase our Engagement with our City Government Officials (council, mayor, county officials)</li> <li>5. Take a greater "Leadership Role" in Public Health Practices Overall (Increase publications, presentations, Intentional Efforts to Change as Public Health and Health Care Practices Change)</li> </ol>

*Top five identified weaknesses and threats*

<b><u>CHD Weaknesses (Internal)</u></b>	<b><u>CHD Threats (External)</u></b>
<ol style="list-style-type: none"> <li>1. Poor Communication internally and externally               <ol style="list-style-type: none"> <li>a. Lack of Inclusion in program</li> </ol> </li> <li>2. Lack of Community Collaboration</li> <li>3. Low Morale</li> <li>4. Lack of proper training               <ol style="list-style-type: none"> <li>a. lack Staff Develop Department (for 7 years)</li> <li>b. lack Tuition Reimbursement</li> <li>c. lack Incentives/ Encouragement/Appreciation</li> </ol> </li> <li>5. Lack of Leadership Development               <ol style="list-style-type: none"> <li>a. Need leadership training for all staff</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Improve Community Relationships/Relevance and Reputation               <ol style="list-style-type: none"> <li>a. mental health/substance abuse/violence</li> </ol> </li> <li>2. Expansion of Services</li> <li>3. Improve Marketing</li> <li>4. Increase our Engagement with our City Government Officials (council, mayor, county officials)</li> <li>5. Take a greater “Leadership Role” in Public Health Practices Overall               <ol style="list-style-type: none"> <li>a. (Increase Publications and Presentations, Intentional Efforts to Change as Public Health and Health Care Practices Change)</li> </ol> </li> </ol>

## Priorities, Objectives, and Strategies

Based on extensive input from the general public, client community and stakeholders through 2013 and 2016, the Community -Health Assessment, the Health Collaborative's Collective Impact and GEN-H Community Health Improvement Plan priorities next phase plan developed in January 2016; ODH's mandate for accreditation, Strategic Plan, *Chronic Disease Management Plan*. and our SWOT analysis findings- CHD identified four overarching priority focus areas. The four priority areas hopefully will position CHD to contribute to better community health outcomes by maximizing collective impact using the triple aim approach: Public health, hospitals and community and population health management. The four priority areas were selected to begin to transition CHD by 1. System Alignment, 2. Data Driven Decisions/Performance 3. Work Force Development and Accountability, and by developing 4. Communication Plan.

The following sections outline each priority area objective, along with identification of specific goals, strategies to accomplish each goal, measures for determining process and outcome objectives, bench marks and resources required to accomplish the goals with a timeframe and/or target date for achievements.

The four priority areas are overarching program theme areas that are broad and accommodates the chronic disease priority areas selected by CHD strategic planning committee after week two, once the CHA/CHIP data was presented by the community partners. The ODH *Chronic Disease Management* priorities selected includes: Access, Chronic Disease Management, Infant Mortality, and Communications Improvement Plans to enhance both internal and external communication plans. These chronic disease priority action areas will be supported by CHD's other specialized/targeted programs that are prioritized to provide specific health promotion, preventive and health care interventions that are most needed for high risk, vulnerable and underserved population groups that we identified. The four priority areas will align to and accommodate other CHD programs that were developed to provide effective optimal and responsive services through funding from local, state, federal, and/or private sector grants.

Cincinnati is fortunate to be have multiple hospital systems, several local universities, philanthropic agencies, with a long and rich history for advocating the provision of safety net services for the most vulnerable and indigent populations. CHD's priority areas identified in this plan supports and correlates with the Ohio Department of Health Strategic Plan and efforts to improve and increase capacity to protect, promote, and improve the public health working cooperatively and collectively with community partners to make Cincinnati the healthiest city in the nation.

## Four Strategic Priority Focus Areas

CHD selected four Strategic Priority Focus Areas: 1. System Alignment 2. Data Driven Performance, 3. Work Force Development/Accountability, 4. Communication Plan.

### Priority Focus 1: System Alignment

<b>Specific Objective: Align with Funding Sources for Services</b>				
<i>Attainable Goals</i>	<i>Realistic Strategies</i>	<i>Measures</i>	<i>Resources</i>	<i>Timeline</i>
Maximize income for pay for performance	<p>Work with external parties with similar interests.</p> <p>Coordinate efforts with internal comprehensive quality improvement (CoQI) team.</p>	<p>Create list of operational definitions for measures.</p> <p>Receive payment for performance.</p> <p>Educating staff on how to maximize income and provide best services/care.</p>	CoQI team, all CHD staff, middle management, leadership, external partners	June 2016 – June 2017
Address social determinants of health	<p>Improve access (e.g., mental health, behavioral health, transportation, housing).</p> <p>Address food insecurity.</p>	<p>Change in scope for mental health services.</p> <p>Documentation of community engagement around social determinants.</p> <p>Documentation of improved outcomes for patients/clients/community.</p>	Community leaders, CoQI team, all CHD staff, middle management, leadership, external partners.	June 2016 – June 2017

**Specific Objective: Foster QI environment where continued QI initiatives can be developed to ensure efficient/effective processes**

Attainable Goals	Realistic Strategies	Measures	Resources	Timeline
Diversify group to include broader skill set.	Develop a comprehensive QI group.	Each program/division develops benchmarks.	leadership, middle management, all CHD staff	Group formed June 2016
Tie benchmarks to evaluate and improve performance.	Identify benchmarks that align with funding and employee performance evaluations.	CoQI plan for department would include these benchmarks.	leadership, middle management, all CHD staff	Benchmarks developed December 2016
Maximize understanding and use of all health department data systems (Epic/Acquire/Power School/Ahlers/etc.)	Utilize the epidemiology workgroup to understand existing data sources.	Periodic reporting from the epi workgroup.	leadership, middle management, all CHD staff	Epi group reports beginning June 2016
Use PDSAs	Develop a QI guide (step by step) for programs to set up PDSA cycles.	Documented PDSA cycles (including outcomes)	leadership, middle management, all CHD staff	June 2017

**Specific Objective: Lateral Alignment of Programs**

<i>Attainable Goals</i>	<i>Realistic Strategies</i>	<i>Measures</i>	<i>Resources</i>	<i>Timeline</i>
Measurement Crosswalk	<p>Data gathering process through the leadership team</p> <p>Introduce at Group of 50 for feedback –Post on J-Drive</p> <p>Reformat the intranet to be more user friendly for information</p>	<p>Leadership meeting minutes</p> <p>Listed as an agenda item on Group of 50 agenda</p> <p>Folder created on J-Drive with completed crosswalk</p> <p>Training on J-Drive about permission flexibility</p>	<p>Leadership Team</p> <p>Leadership Team and Middle Managers</p> <p>Middle Managers and IT</p>	December 2016 – December 2017
Strategic Plan for each program	Alignment of program strategic plan with CHD strategic plan	Completed Strategic Plan	Leadership, Middle Managers and Staff	July 2016 – December 2016
Utilize Group of 50 for inter-program collaboration (maximizing efficiency)	<p>Formalize agendas</p> <p>Use for leadership training, inter-collaborative design workshops</p>	Established 2-3 trainings per year	Leadership, Middle Managers	January 2017- January 2018

	Use meetings to explore Interdisciplinary talents, and for team Building			
Ensure organizational structure is aligned for effective and efficient use of resources	3rd party review of organizational structure  Internal audit (see where overlap occurs)	Measurement crosswalk completed and assessed for program redundancy  Committee development	Community Peer Review  External reviewer	June 2017-June 2018
Educate staff regarding Cultural Sensitivity and Customer Service  (i.e. drug users, mentally ill)	Develop partnerships with universities (e.g., chief diversity officer)  Trainings on embracing diversity  Form ethics committee	Customer service satisfaction surveys  (Ratings increased by 25%)	PEAP  Community Partners  Academic Institutions  Survey Monkey-IT  Mailer  Website comments	December 2016 – December 2017

**Specific Objective: Align with local and state agencies via state-community health improvement plan and community assessments**

Attainable Goals	Realistic Strategies	Measures	Resources	Timeline
Chronic Disease Plan for Health	Increase physical activity and prevent crime through: <ul style="list-style-type: none"> <li>Environmental Design</li> </ul>	Active Living, Healthy Eating, Tobacco Free Living policy	Creating Healthy Communities Coalition (CHCC)  Healthy Homes	December 2016 – December 2017

	<ul style="list-style-type: none"> <li>• Safe Routes to School</li> <li>• Safe Streets Principles</li> <li>• Connect Cincinnati</li> <li>• Public Transit improvements</li> <li>• Healthy Eating</li> <li>• Produce Perks</li> <li>• Community Supported Agriculture (CSA)</li> <li>• Healthy Food Retail</li> <li>• Water First for Thirst</li> <li>• Breastfeeding policy in the Workplace</li> <li>• Increase Tobacco Free Living</li> <li>• Tobacco Free Public Housing, Parks, Schools and Worksites</li> </ul>	<p>Abated Healthy Homes</p> <p>nuisance complaints</p> <p>breastfeeding in the workplace policies in effect</p> <p>Programs' benchmarks</p> <p>Coordination of these programs – submit data</p>	<p>Health Impact Assessment (HIA)</p> <p>Health Centers</p> <p>School Based Health Centers</p> <p>Adolescent Health</p> <p>WIC</p> <p>Home Health</p> <p>Staff Programs</p> <p>Data analysis</p>	
<p>State Health Improvement Plan (SHIP) and Community Health Improvement Plan (CHIP)</p>	<p>Identification of areas (Survey Monkey)</p> <p>Dissemination of plans</p> <p>Build infrastructure for gaps</p> <p>Utilize the identification plan to ensure each program</p>	<p>Identification of Programs that address SHIP and CHIP</p>	<p>Staff programs</p>	<p>December 2016 – December 2017</p>

	is addressing chronic disease			
Maintains meeting clinical needs of client base while exploring other needs of clients i.e. Health Education and measure improvements	<p>Identify opportunities for prevention including substance and alcohol abuse, mental health, and violence</p> <p>Find resources to implement</p> <p>Ongoing analysis of trends</p> <p>Utilize crosswalk</p> <p>Implement (non-medical) social determinant of health services or use interagency collaboration.</p>	<p>Identified opportunities</p> <p>Identified resources</p> <p>Annual trend analysis</p> <p>Identified partnerships</p>	<p>leadership, middle management, all CHD staff, external partners</p>	<p>June 2016 – June 2017</p>

## Priority Focus 2: Data Driven Performance

<b>Objective 1: Infrastructure / capacity for evaluation/as essment of programs</b>	<b>Attainable Goals:</b>	<b>Realistic Strategies:</b>	<b>Measures:</b>	<b>Resources:</b>	<b>Timeline:</b>
1	Identify all available and relevant databases.	Establish a central repository for program evaluation results		Repository will be put on J Drive	<b>2nd quarter 2016</b>
2	Assure adequate analytic capacity	Each program/ grant should allocate \$ for evaluation	# Analyses completed adequately (peer review) = publications. What equipment or software is available?	Staff, equipment, software	
3	Collect and maintain reliable, comparable and valid data that provide information on conditions of public health importance and on the health status of our population. (PHAB Standard 1.2)				

4	Develop infrastructure for QI for environmental programs			CincyStat group, Dr. Firesheets	
5	(Systems Alignment) Develop a measurements crosswalk for the data that we collect, including the systems/programs collecting the data, and a brief description.			Leadership Team, Group of 50 (middle managers)	
<b>Objective 2 : Conduct evaluation of at least 1-2 programs</b>	<b>Attainable Goals:</b>	<b>Realistic Strategies:</b>	<b>Measures:</b>	<b>Resources:</b>	<b>Timeline:</b>
1	Develop process to choose and prioritize which programs to evaluate in a particular year (grant requirements vs. scheduled				
2	Have a calendar to show times when programs are due for audit or evaluations				

3	Develop drilled-down information about patients served in CHD health centers and other venues, as a large sub-population with which we are deeply connected	Correlate quality/QI with total and detailed cost estimate, by center, to assist in meeting national and Ohio Medicaid initiative of providing bonuses in funding to centers that provide great outcomes at below median cost. Map our penetrance to show who we serve, geographically <sup>6</sup> displayed by zip code, census tract or neighborhood, with different colors for different types of services (and ability to overlay layers for each type of service)	Where patients are coming from, by neighborhood. Education and job information, by neighborhood. Access to fresh produce and meats, by neighborhood.	US Census data, other special data collections, CHD Fiscal, CHD Epidemiology	
<b>Objective 3: Documentation that evaluation is used for program development, including</b>	<b>Attainable Goals:</b>	<b>Realistic Strategies:</b>	<b>Measures:</b>	<b>Resources:</b>	<b>Timeline:</b>

<p><b>outcomes of use of the evaluation</b></p>					
<p>1</p>	<p>Develop an annual report which includes data about each programs performance, productivity, and billable hours</p>				
<p>2</p>	<p>Evaluation leads to quality improvement actions</p>	<p>Supervisor meeting to discuss measures. Establish an office of Planning Evaluation and Quality Assurance and Improvement.</p>	<p>Documented meaningful use of analyses.</p>	<p>Group of 50, rotating presentations, epi committee meetings, Co-QI standing committee.</p>	
<p>3</p>	<p>Analyze that public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health</p>		<p>EPHT</p>		

	(PHAB Standard 1.3)				
4	Provide and use the results of health data analyses to develop recommendations regarding public health policy, processes, programs, and interventions. (PHAB Standard 1.4)		HIA function exists in health department		
<b>Objective 4: Staff that can monitor and determine efficacy of programs in CHD</b>	<b>Attainable Goals:</b>	<b>Realistic Strategies:</b>	<b>Measures:</b>	<b>Resources:</b>	<b>Timeline:</b>
1	(Workforce development) Develop a strategy to deal with limitations of analytic infrastructure and analytic capacity	Train and develop internal capacity to utilize best practices for evaluation, within CHD programs		CDC Introduction to Program Evaluation for Public Health (document)	

<b>Objective 5: Data transparency</b>	<b>Attainable Goals:</b>	<b>Realistic Strategies:</b>	<b>Measures:</b>	<b>Resources:</b>	<b>Timeline:</b>
1.	Document how CHD goals align with the relevant community health assessments and community health improvement plan priorities		Policy, systems, and environmental changes. Tobacco, Healthy Eating, Active Living, Obesity (GCCCHSS changes). Other options for measures could include: Asthma (related to air quality, and to tobacco), Lead poisoning, Healthy social environments (associated with transportation, domestic and other violence, injury prevention, among other factors)	People, organizations including the CHCC, who have developed metrics to look at changes in HE, AL, and tobacco use.	
2	(Communication s) Data that we generate to share with stakeholders is presented in useable way	Prioritize Public Health Tracking portal development, Communications Committee coordination			

3	Audit or vetting process to assure data quality and accuracy is performed before analyses are initiated				
4	Post Divisional strategic plans, with goals, measures, and how they are aligned with CHD strategic plan, on an accessible portal for public viewing				

### Priority Focus 3: Workforce Development

	<b>Strategies</b>	<b>Measures</b>	<b>Resources</b>	<b>Timeline</b>
Workforce Development Plan	<ul style="list-style-type: none"> <li>• Focused Recruitment-public health trained &amp; oriented.</li> <li>• Establish an On-boarding Orientation process for each Div/Program for new employees.</li> <li>• Ensure that every employee meet/adhere to the Public Health Core Competencies within their respective discipline(s).</li> <li>• Enhance training and development in public health, customer service, etc. (on-line trainings/webinar/on-site workshops)</li> <li>• Solicit customer feedback</li> <li>• Solicit manager/supervisor feedback from employee.</li> </ul>	<p>Performance management/evaluations.</p> <p>The process will be evaluated by the completion of an evaluation form of the orientation.</p> <p>Employee will receive a mid-point performance evaluation to measure competency.</p> <p>Customer satisfaction surveys, suggestion/feedback boxes throughout various worksite locations.</p> <p>360 Degree Performance Review</p>	<p>Recruitment efforts through: OACHC, XU, UC, OSU, professional journals/organizations.</p> <p>Performance tools: evaluation forms. Creation of orientation form/feedback forms (survey monkey) /360 evaluation form.</p> <p>Provide continuing education opportunities.</p> <p>Program focused competency evaluations throughout the probationary period.</p> <p>Survey tools/feedback forms.</p>	TBD
<b>Workforce Development Plan</b>				
Workforce Development Plan	<ul style="list-style-type: none"> <li>• Provide each employee with the CHD Mission, Vision and Core Values of the organization.</li> </ul>	<p>As part of the program orientation process with their supervisor, each employee will receive the Mission, Vision, and Core Values documents for review.</p>	<p>Performance tools: evaluation forms.</p>	TBD

Workforce Development Plan				
Workforce Development Plan	<ul style="list-style-type: none"> <li>Determine how we can recognize our staff for accomplishments, exceptional service, birthdays, etc.</li> <li>Ensure that each location/division has the Mission, Vision, and Core values posted in common areas.</li> </ul>	<p>A developed program for awards and recognition detailing incentives and other ways employees can be recognized &amp; Rewarded.</p>	<p>Corporate sponsorships (possibly) i.e. MCOs, health care vendors in the industry, etc.</p> <p>Printed placard with Mission, Vision, and Core Values.</p>	TBD
Workforce Development Plan				
Workforce Development Plan	<ul style="list-style-type: none"> <li>Mentorship (UC, XU, OACHC-external &amp; internal partnerships) Managers should mentor staff.</li> <li>Training for supervisors/managers in conflict resolution</li> </ul>	<p>Audit of training forms</p> <p>Employee feedback (Follow up SWOT analysis within a year of implementation to evaluate improvement).</p>	<p>Trainings for conflict resolution and professional development (i.e. CEUs in leadership &amp; professional development).</p> <p>New SWOT analysis</p>	TBD
Workforce Development Plan				
Workforce Development Plan	<ul style="list-style-type: none"> <li>Community engagement: participate in community council meetings.</li> <li>Establish/continued partnerships with community agencies/social service agencies such as: CAA, Urban League, United Way, CFCHG, CPS, etc.</li> <li>Marketing/Brand CHD and accomplishments</li> </ul>	<p>Assessment of partnerships/collaboration regularly.</p> <p>Social media (tweets/#of people accessing the website).</p> <p>Advertisement to inform</p>	<p>CHD subject matter experts reference for the community (i.e. CHES).</p> <p>Increase our presence and engagement with community organizations.</p>	TBD

	<ul style="list-style-type: none"> <li>Enhance website (more user friendly)</li> </ul>		Engage the support and assistance of the Government Affairs & Public Information Officer	TBD
Workforce Development Plan	<ul style="list-style-type: none"> <li>Establish a concrete plan to develop and prepare for critical vacancies to ensure program consistency and continuity.</li> </ul>	Succession plans are developed and implemented.	Input from program leadership to develop plan.	TBD

## Priority Focus 4: Communication Plan

**Strategic Focus Areas:** Centralized focus areas include: Systems Alignment (Access, Chronic Disease and Infant Vitality), Data, Workplace Development and Communications.

**Objectives:** To **internally and externally** promote the CHD's affordable medical services, community health education and environmental programs, while providing educational information and resources to improve the quality of life in Cincinnati and being good stewards of the environment.

Goals	Strategies	Measures	Resources	Timeline
<p><b>Build Awareness</b> and generate attention through strategic communications, community engagement, relationship management and governmental relations</p>	<p>Develop systems to identify and assess health communication by creating and disseminating communication strategies, messages, materials and resources</p> <ul style="list-style-type: none"> <li>• Media Relations</li> <li>• Media Tours</li> <li>• Newsletters/Marketing Collateral</li> <li>• Special Events</li> <li>• Speaking Engagements</li> <li>• Sponsorships</li> <li>• Employee Relations</li> <li>• Community Engagement and Philanthropy</li> <li>• Publications</li> <li>• Database of clients to speak and advocate on our behalf</li> <li>• Suggestion box in all internal areas (patients and employees)</li> <li>• Community awards programs</li> <li>• National Public Health Week</li> </ul>	<ul style="list-style-type: none"> <li>• Number of media placements</li> <li>• Marketing collateral distributed</li> <li>• Meetings and events attended</li> <li>• Media and social media hits</li> <li>• Publications produced</li> <li>• Audience reached</li> <li>• Financial value of collateral</li> <li>• Annual report, community benefit report produced</li> <li>• Percentage of decreased incidence of disease in focus areas (specific desired behavior change goal),</li> <li>• New benefits offered, and the interventions that influenced or supported behavior/mind change</li> <li>• Suggestion box themes and number of ideas</li> </ul>	<ul style="list-style-type: none"> <li>• Public relations: press releases, press conferences, media advisories, pitch letters, wire services</li> <li>• Internal and external websites</li> <li>• Multichannel Network Marketing : social media, blogs</li> <li>• Marketing collateral: articles, brochures, fliers, tip sheets, white papers, ebooks, resource manuals, promo items, pharmacy bags, posters, reports, voicemail/email and on hold messaging</li> <li>• Broadcast: Television, radio, webinars, podcasts, DVDs,</li> </ul>	<p>In March:</p> <p>Review current communication materials</p> <p>Create boilerplate copy for approval, e.g. ABOUT US, service descriptions, etc.</p> <p>Confirm approval process for media interaction</p>

	(community awards, reception) <ul style="list-style-type: none"> <li>• Neighborhood Summit</li> </ul>		CDs, PSAs, YouTube <ul style="list-style-type: none"> <li>• Events: Speaking engagements, presentations, health fairs and forums, partnerships and collaborations</li> <li>• Video clips, display cases</li> <li>• Before and after survey results</li> <li>• Electronic blackboard</li> </ul>	Identify media resources  Develop or edit leadership bios and updated photos
<b>Create Interest</b> to entice targeted audiences to try our services	Promote engagement (programs, offerings, services and opportunities) and dissemination activities among specific internal and external population groups	Same as above	Same as above	2Q (ongoing)  Beginning in April, research and develop targeted contact lists
<b>Provide Educational Information</b> about the organization, programs and environmental services to broaden	Promote the adoption of health communication theories and practices in health care, disease prevention, health promotion and environmental health initiatives	Same as above	Same as above	2-3Q  Create and update events and training calendars

understanding and how to access services	Promote health skills training for health professionals and opportunities for learning and engagement			Research educational opportunities for general audiences -- schools, parents, media and non-medical personnel
<b>Stimulate Demand</b> by creating a discernable increase in support and clientele	Coordinate initiatives to develop a comprehensive awareness and engagement agenda	Same as above	Same as above	4Q  Evaluate results
<b>Reinforce the Brand</b> by maintaining positive relationships with key audiences to build a strong image that helps build the business	Foster networking and collaboration among health communicators, health educators, other health professionals, stakeholders (government and community), as well as potential and current patients and their families	Same as above	Same as above	Ongoing as developed

## Implementation and Tracking Plan

Each Strategic Priority Focus area's Lead and co-Lead is responsible for developing, maintaining and implementing associated work plans, activities, and tracking their committee's performance against stated objectives and targets.

The Accreditation Coordinator or other assigned strategic performance manager and will collect performance data from and meet with priority focus areas Leads monthly to track the performance against objectives and if, needed, work with them to develop improvement plans.

In the meantime, Leads and CHD Leadership Team and/or Strategic Planning Committee are encouraged to monitor and discuss performance data on a regular basis (monthly) throughout the year and implement improvement methods as needed. Leads are also asked to report on performance data at monthly program unit, middle manager or Leadership Team meetings.

NOTE: It is possible that performance indicators and targets may need to be adjusted each year. If so, the plan will be revised/updated accordingly.