Columbus Public Health

STRATEGIC & OPERATIONAL PLAN

Created May 2012

Updated October 2014

THE CITY OF COLUMBUS

MICHAEL B. COLEMAN, MAYOR

COLUMBUS PUBLIC HEALTH

TABLE OF CONTENTS

INTRODUCTION

Columbus Public Health (CPH) approached its strategic planning in 2011-2012 with a number of objectives in mind. The primary objective was to refresh the agency's mission, vision, and values as well as affirm the organization's commitment to addressing community health needs that had been articulated for central Ohio through the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP). In addition, the organization hoped to create a framework which the organization could build upon in partnership with the greater Columbus community. Finally, the agency wanted to conduct this process in a way that was inclusive and interactive – that provided an opportunity for input from the organization and community.

A Strategic Planning Team was organized to coordinate the development of an updated Strategic Plan for CPH. Team members included: The Health Commissioner, the Accreditation Coordinator, the Planning and Accreditation Division Director, Epidemiology Program Manager, the Planning Coordinator, and an external consultant. This team gathered and coordinated all information collected to this point starting with assessment data (including the CHA) and community information (including the CHIP). Trend data and information captured through health equity and staff competency surveys was gathered from both agency staff members and community-based partner organizations and individuals. This framework provided baseline information from which the Strategic Planning Team could work together with all levels of staff to provide updated vision and mission statements. The Team held multiple meetings and analyzed various assessments and surveys in order to develop the strategic and operational plans.

The agency's management team (40-plus individuals) held monthly meetings to provide information and give feedback to the Strategic Planning Team. The managers, in turn, gathered information from the frontline staff. To develop a set of values for CPH, individual managers facilitated discussions with their teams, working through a process that provided the opportunity to reflect on personal values and their relationship to organizational values and behaviors. The feedback from the managers and their staff was pivotal in forming the final document.

The Health Commissioner, the Assistant Health Commissioners, and the Division Directors, which comprise the Strategic Advisory Team (SAT) (12-plus), held various meetings over several months to provide direction and feedback to the Strategic Planning Team. The SAT also drafted the revised vision and mission statements, which were then submitted to the Program Managers for feedback and to the Board of Health for feedback and approval. The SAT worked with both the managers and the Board of Health in order to assure that input from various levels of leadership were heard and utilized.

The Board of Health was actively involved in the entire process, including three strategic planning retreat sessions with the SAT. This iterative process included traditional strategic planning activities, such as identification of strengths, weaknesses, opportunities, trends and external forces, and visioning exercises that projected agency accomplishments twenty years into the future. In addition, the process took advantage of strategic thinking tools, such as the "hedgehog exercise" developed by Jim Collins. The use of these tools resulted in discussions of the mission, vision, strengths, weakness,

opportunities and threats in terms of passions, core competencies, and driving forces.[1] This built upon the active review of the Board of Health of the National Public Health Performance Standards governance module during 2010 and 2011.

Every meeting over a five-month period built on the work of the last and culminated with approval of the revised mission and vision statements, a set of agency values, agency goals and strategic priorities by the Board of Health in April 2012. This became the department's Strategic Plan. Follow-up work then began to develop programmatic objectives to be used to guide performance on a daily basis. Each division or center director worked with their programs to craft smart objectives that guide programs and staff towards achieving the approved vision, mission and goals. This is now the Operational Plan component of this document.

This document is divided into five main sections:

1. Mission, Vision, Values List, Goals and Strategic Priorities
2. Overview of Columbus Public Health
3. Strategic Priority Measures
4. Operational Plan (Program Objectives)
5. Assessment or Background Documentation Used to Develop the Strategic Plan

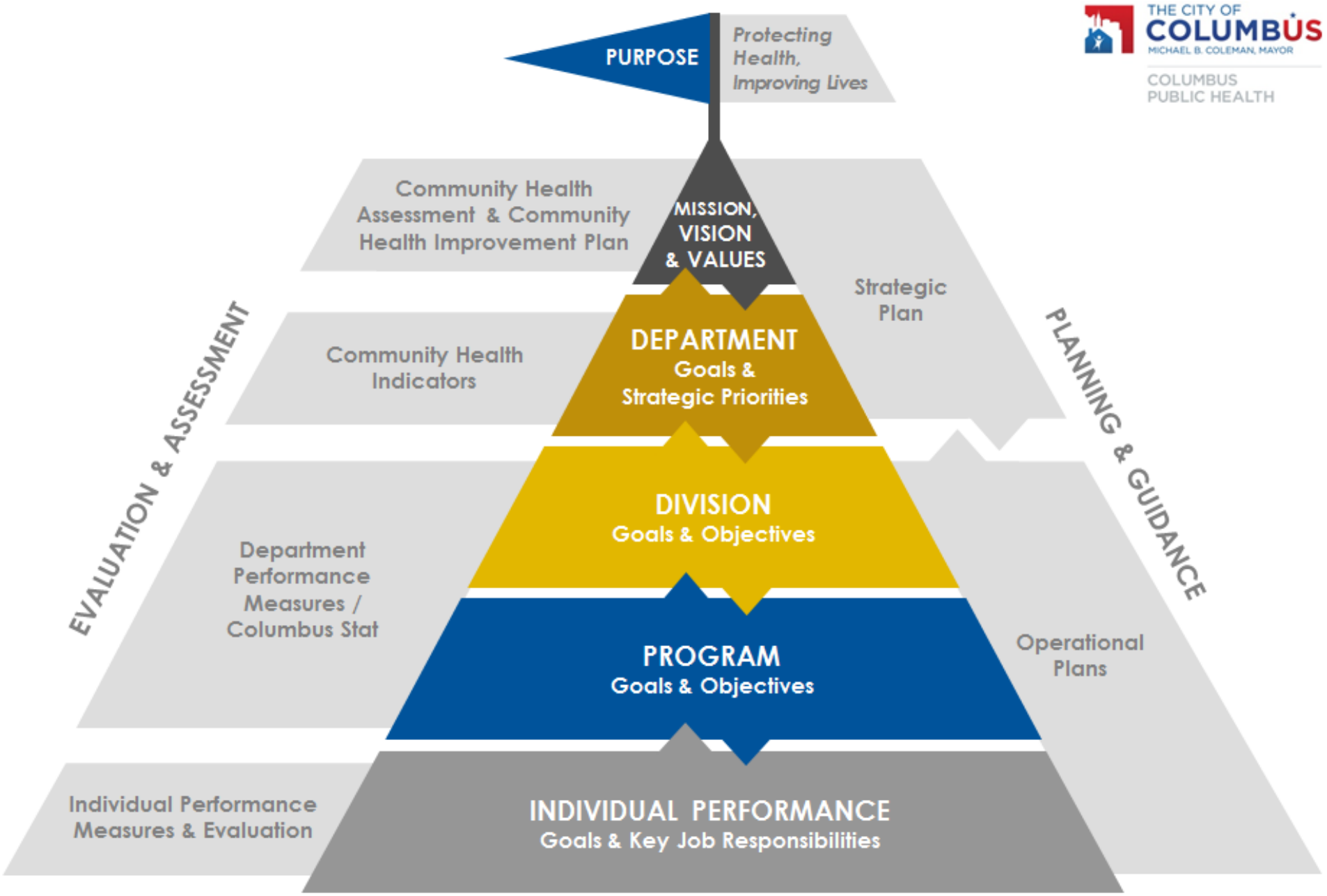
It is important to note, there is no attempt in this document to detail all of the programs or services that exist in the Department. The Strategic Plan is intended to provide a focus for the staff and the Board over the next three years. The Strategic Priority Measures and the Operational Plan are intended to be updated on a yearly basis in order to continue progress towards the stated vision, mission and departmental goals. While all staff have current individual performance objectives and regular results already, the next step will be to revise and tie them into the updated Strategic and Operational Plans.

There are multiple ways that certain terms can be used in Strategic Planning. With this in mind, the following terms and corresponding definitions will be used throughout this document.

1. **Goals** – the overarching statements assigned to the agency. These are broad and are part of the Strategic Plan
2. **Strategic Priorities** – these are areas that have been determined as focal points for the agency based on data from the CHA and CHIP
3. **Measures** – Items that will be used to demonstrate whether or not an objective or strategic priority is being met.
4. **Objectives** – These are the measurable statements using the S.M.A.R.T. acronym
    a. **S**pecific
    b. **M**easurable
    c. **A**chievable
    d. **R**ealistic
    e. **T**ime

[1] See *Good to Great and the Social Sectors: A Monograph to Accompany Good to Great* for additional description.

STRATEGIC/OPERATIONAL FRAMEWORK



MISSION, VISION, VALUES, GOALS AND STRATEGIC PRIORITIES

2012 – 2015

Mission

The mission of Columbus Public Health is to protect health and improve lives in our community.

Tagline: Columbus Public Health
Protecting health, improving lives

Vision

The Columbus community is protected from disease and other public health threats, and everyone is empowered to live healthier, safer lives.

CPH is the leader for identifying public health priorities and mobilizing resources and community partnerships to address them.

Values

- **Customer Focus**: Our many, diverse customers, both in the community and within our organization, know that they will be treated with thoughtful listening and respect. They know that our first priority is the health and safety of our community, and we will do all that is within our abilities and resources to address their individual needs and concerns.

- **Accountability**: We understand that we are accountable for the health and safety of everyone in our community, and that as a publicly funded organization, we are all responsible for maintaining the public's trust through credible information, quality programming and services, and fiscal integrity. We know the scope of our programs and services and the critical role everyone plays in delivering our mission and achieving our vision.

- **Research / Science-based**: Credible science is the foundation of our policies and program decisions. The community knows that our decision-making is based on research and best practices, and is grounded in the most current scientific information available.

- **Equity and Fairness** – Our clients, partners and coworkers know that we will interact with them with fairness and equity, and that we strive to deliver our programs and services and operate in a manner that is just and free from bias or prejudice.

Columbus Public Health Goals

1. **Identify and respond to public health threats and priorities.**

2. **Collaborate with residents, community stakeholders and policy-makers to address local gaps in public health.**

3. **Empower people and neighborhoods to improve their health.**

4. **Establish and maintain organizational capacity and resources to support continuous quality improvement.**

2012-14 Columbus Public Health Strategic Priorities

- Reduce infant mortality
- Reduce overweight and obesity
- Reduce the spread of infectious diseases
- Improve access to public health care
- Implement departmental reorganization (completed 2013)

OVERVIEW OF COLUMBUS PUBLIC HEALTH

2012 (Updated 2014)

In 2010-2011, CPH conducted an assessment of all the clinical areas. One of the suggestions identified was to locate all clinical services within the same division. With this in mind, the SAT underwent a process to reorganize the entire health department in a way that would improve efficiency and to further organize related programs and services. The following organizational chart was accepted by the BOH on 3/13/2012.

Health Commissioner
Planning & Accreditation Division
Public Affairs & Communications
Assistant Health Commissioner/Medical Director
Assistant Health Commissioner/Chief Nursing Officer
Assistant Health Commissioner/Administration

These are the divisions/programs supervised by the specific Assistant Health Commissioners

Assistant Health Commissioner / Medical Director	
Employee Assistance Program	
Center for Epidemiology, Preparedness and Response (CEPR) Emergency Preparedness Epidemiology Infectious Disease Investigation Outbreak Response	**Clinical Health Division** Immunizations Laboratory Project LOVE Sexual Health Clinic STD Prevention Tuberculosis Women's Health

Assistant Health Commissioner / Chief Nursing Officer	
Clinical Quality Improvement (QI) Columbus Neighborhood Health Centers Dental Strategic Nursing Team	
Neighborhood Health Division <u>Health Equity Section:</u> Health Equity Healthy Neighborhoods Minority Health Neighborhood Services <u>Chronic Disease Prevention Section:</u> Active Living Creating Healthy Communities Healthy Children, Healthy Weights Healthy Places	**Family Health Division** Alcohol & Drug Dental Sealants Caring for 2 Home Visiting Injury Prevention Maternal Child Health Planning / Child Fatality Review WIC

Assistant Health Commissioner / Administration

- Billing
- Fiscal
- Human Resources
- MAC *(Medicaid Administrative Claiming)*
- Technology
- Vital Statistics

Environmental Health Division

Food Protection:

Food Protection / Healthy Schools

EH Disease Protection:

Healthy Homes / CEPAC / Smoke-Free Workplaces

Rabies & Dangerous Animals /Vector Control

Water & Land Protection / Hazmat / Body Art

Licensing/Support

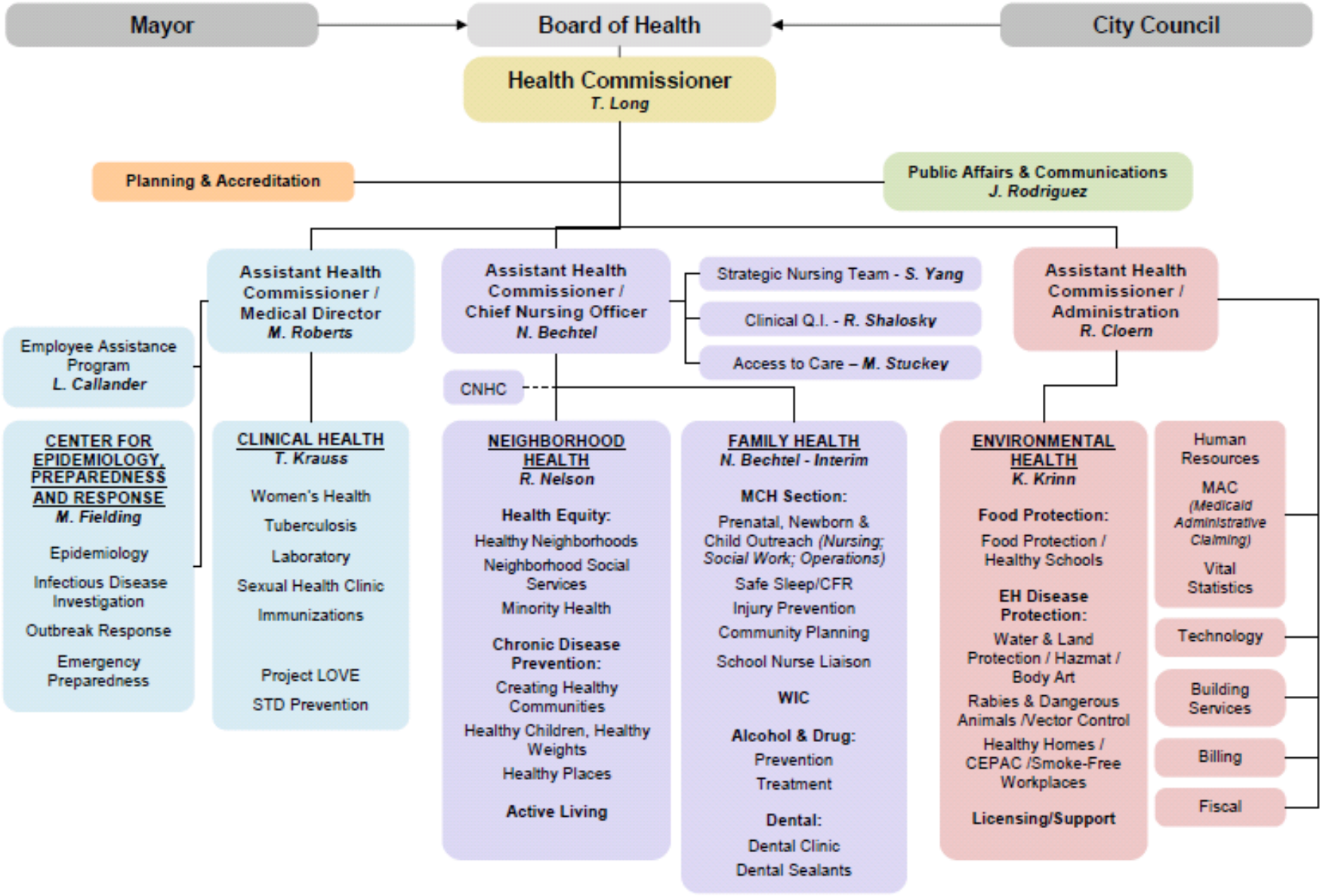
Licensing / Support

One of the Strategic Priorities was to implement a departmental reorganization. Since this time, the org chart has been updated various times to not only accommodate changes in the clinical area but to adjust to changes such as staff retirements. The latest org chart included below is from September 30, 2014.

City of Columbus

Columbus Public Health

9.30.2014



STRATEGIC PRIORITY MEASURES

2012-2014

CPH Strategic Priority Measures 2012-2014

The strategic priorities listed below do not cover all the work done at Columbus Public Health (CPH). CPH engages in a broad range of activities that help it achieve its overall mission and vision of a healthier Columbus. With all its work, CPH is committed to addressing racial and other health disparities. The strategic priorities were selected based on information gathered from the CHA and the CHIP. This section presents key strategies and measures to impact CPH's strategic priorities for the next year and a half.

Community Indicator: Infant Mortality Rate in Franklin County (2010) = 8.2 deaths per 1,000 births - RACIAL DISPARITY EXISTS

CPH Priority:	***Reduce Infant Mortality***		
CPH Objective/Goal	**CPH Strategies**	**CPH Program Measures**	**CPH Programs**
Reduce Infant Sleep-Related Deaths	Improve consistency of CPH messages on safe sleep environment	% of audited CPH materials that conform to guidelines	Health Communications, Family Health Division
Increase Breastfeeding Rates	Educate and support pregnant clients	% of eligible women who breastfeed newborn (at delivery)	WIC, Caring for 2 (Cf2), Women's Health Clinic

Community Indicator: Overweight among Franklin County Adults (2010) = 63.9% - RACIAL DISPARITY EXISTS
Overweight among Franklin County 3rd graders (2009-2010) =31.2%, Columbus City Schools 3rd graders (2010-2011) = 38%

CPH Priority:	***Reduce Overweight and Obesity***		
CPH Objective/Goal	**CPH Strategies**	**CPH Program Measures**	**CPH Programs**
Reduce Overweight among Children	Support WIC in providing healthy nutrition and physical activity guidance	% of 2-5 year-olds with BMI-for-age in 85th percentile or higher	WIC
	Assist restaurants with offering healthier menu items	# of restaurants participating in Healthier Choices Initiative	Institute for Active Living
	Increase breastfeeding initiation rates	% of eligible women who breastfeed newborn (at delivery)	WIC, Cf2, Women's Health Clinic
	Provide technical assistance on PSE (Policy, System, and Environmental) Change	Provide assistance to at least 10 not-for-profits	Healthy Children, Healthy Weights
Reduce Overweight among Adults	Connect community gardens in focus neighborhoods with local food pantries	# of community gardens partnering with food pantries	Creating Healthy Communities

Community Indicators: *Franklin County Incidence Rate (per 100,000 in 2011) of Chlamydia = 673 and Syphilis (primary and secondary) = 9.6*
Number of new HIV diagnoses in Franklin County (2010) = 255 - RACIAL DISPARITY EXISTS for all STIs

CPH Priority:	***Reduce the spread of Infectious Diseases***		
CPH Objective/Goal	**CPH Strategies**	**CPH Program Measures**	**CPH Programs**
Reduce Sexually Transmitted Infections (STIs)	Identify and treat cases and contacts	% of cases diagnosed by CPH who are treated according to guidelines	Sexual Health and Women's Health clinics
		% of early syphilis contacts treated within 30 days of interview with index case	Sexual Health and Women's Health clinics
Reduce Vaccine-Preventable Disease	Educate and vaccinate high-risk individuals against Hepatitis A&B	# of high-risk people receiving education and vaccination	Immunizations and Project L.O.V.E.

Community Indicator: *Uninsured Franklin County Adults (2010) = 13% - RACIAL DISPARITY EXISTS*
Prenatal Care received starting in first trimester (2009) = 43.8% (Births with unknown month of entry to care = 34.8%)

CPH Priority:	***Improve Access to Public Health Care***		
CPH Objective/Goal	**CPH Strategies**	**CPH Program Measures**	**CPH Programs**
Increase primary care capacity at CNHC	Improve outreach/marketing of CNHC services	# of CNHC clients seen, # of visits at CNHC clinics	CNHC clinics
Increase dental care capacity	Reformat dental sealant program	# of CCS students served in grades 2, 3, 6 and 7	Dental Sealants
	Coordinate CPH and CNHC equipment and personnel for emergency dental services	# of staff hours committed to Free Clinic, # of clients seen @CPH, Free Clinic and CNHC and % of these at each site who are uninsured	Dental Clinic and CNHC
Increase prenatal care capacity	Increase prenatal care slots available through Pregnancy Care Connection	# of 1st appointment slots available (as measured by COHMAB); annual # filled and % of those during first trimester at CPH and CNHC clinics	CPH and CNHC PNC clinics

CPH Priority:	***Implement departmental reorganization***		
CPH Objective/Goal	**CPH Strategies**	**CPH Program Measures**	**CPH Programs**
Build QI capacity	Provide QI training and guidance	% of QI projects implementing a change in process	Various, Planning and Accreditation
Build health equity capacity	Finalize health equity plan	Approval of plan by BOH	Neighborhood Health
Improved internal communication	Multiple vehicles (e.g., What's up CPH, weekly announcements, monthly birthdays, MMM)	Repeat baseline from self-assessment survey	Health Equity, Health Communications, Epidemiology

OPERATIONAL PLAN

Updated 2014

SMART Objectives

CPH OPERATIONAL PLAN

These are the programmatic objectives that have been developed based on the four goals in the Strategic Plan. They are S.M.A.R.T. objectives that will be tracked throughout the year to measure programmatic and organizational progress towards the vision, mission and broad goals. CPH updated their Programmatic Performance Dashboard system at the end of 2013 and implemented it in 2014. The measures selected for 2014 tied to at least one of the Strategic Plan Goals and/or Strategic Priorities.

Strategic Plan Goals	
Goal #1	**Identify and respond to public health threats and priorities**
Goal #2	**Collaborate with residents, community stakeholders and policy-makers to address local gaps in public health.**
Goal #3	**Empower people and neighborhoods to improve their health.**
Goal #4	**Establish and maintain organizational capacity and resources to support continuous quality improvement.**

Strategic Priorities	
SP#A	**Reduce infant mortality**
SP#B	**Reduce overweight and obesity**
SP#C	**Reduce the spread of infectious diseases**
SP#D	**Improve access to public health care**
SP#E	**Implement departmental reorganization**

# Measures Linked to Strategic Plan Goals (2014)				
1	**2**	**3**	**4**	**TOTAL**
51 measures	49 measures	48 measures	48 measures	**113 measures**

# Measures Linked to Strategic Priorities (2014)				
A	**B**	**C**	**D**	**TOTAL**
40 measures	21 measures	36 measures	38 measures	**113 measures**

Administration

Objective	**Goals**	**Strategic Priorities**	**Program**
1. 100% of the clinical staff will complete all assigned clinical competencies by the designated due date	4		Clinical QI
2. By December 31, 2014, at least two (2) changes in clinical practice, based in best practice research, will be implemented to improve client outcomes.	4		Clinical QI
3. By December 31, 2014, at least two (2) interventions will be implemented to decrease the incidence of clinical errors	4		Clinical QI
4. 80% of clients rating “counseling was beneficial” as “Agree” or “Strongly Agree”	3,4		EAP
5. By December 2014, an internal customer satisfaction survey will be developed for the SNT program	3,4		SNT
6. By December 2014, 95% of participants in Childcare Provider Communicable Disease Prevention classes will "Agree" or “Strongly Agree” that teaching was effective by CPH staff.	2,3		SNT
7. By December 2014, 2 SNT nurses will have completed the Healthy U: Chronic	1,3	C,D	SNT

	Disease Self-Management/ Diabetes Self-Management 5 day leader training and facilitate at least 2 six-week sessions within the community.			
8.	By December 2014, SNT will partner in one new community site in each of the five regions to provide health promotion and wellness.	2,3	D	SNT
9.	2,500 transactions per FTE per month	1,3,4		Vital Stats
10.	100% of birth and death certificates registered within seven days of receipt of a valid certificate from the hospital	1,3,4		Vital Stats

Center for Epidemiology, Preparedness and Response (CEPR)

Objective	Goals	Strategic Priorities	Program
1. OEP staff will conduct 3 educational presentations per quarter by December 31, 2014 regarding emergency preparedness related topics.	1,2,3,4	C	Emergency Preparedness
2. The Columbus and Metropolitan Medical Response System will increase its attendance of community partners by adding at least one new targeted partner to each meeting by December 31, 2014.	1,2,3,4	C	Emergency Preparedness
3. 100% of all new full-time employees will successfully complete ICS-100 (Incident Command System) training within three months of hire	1	C	Emergency Preparedness
4. 100% of all new full-time employees will successfully complete IS-700 (NIMS) training within three months of hire	1	C	Emergency Preparedness
5. By December 31st, 2014, publish and share neighborhood-based profiles	1,3	A,B,C,D	Epidemiology
6. By December 31st, 2014, publish and share key community health indicators	1	A,B,C,D	Epidemiology
7. By December 31st, 2014, publish and share annual summary and weekly surveillance reports of reportable diseases	1	C	Epidemiology
8. By December 31st, 2014, publish and share maternal and infant health indicator reports, 12 yearly	1	A	Epidemiology
9. By December 31st, 2014, publish and share maternal and infant health indicator reports, 4 yearly	1	A	Epidemiology
10. By December 31st, 2014, three CPH programs will implement a tool, technique or other advice from an epidemiologist for the purpose of program improvement	4		Epidemiology
11. Throughout 2014, Infectious Disease Investigator will respond within 1 business	1	A,C,D	Infectious Disease

day of receipt of the report of a reportable disease 90% of the time.			
12. Throughout 2014, 95% of Infectious Disease Investigation reports will have all key fields completed.	1,4	C	Infectious Disease
13. In order to remain current and competent 100% of staff who are part of the Office of Infectious Disease Investigation will participate in at least 75% of the IDEI & OR education sessions offered in 2014	1,4	C	Infectious Disease
14. 95% of outbreaks will be entered in National Outbreak Reporting System (NORS) within 30 days of initial notification to Ohio Department of Health	1,2,4	C	Outbreak Response
15. Infectious Disease Epidemiologic Investigation & Outbreak Response (IDEI & OR) educational sessions will be conducted 4 times per quarter throughout 2014.	1,4	C	Outbreak Response

Clinical Health Division

Objective	Goals	Strategic Priorities	Program
1. 100% of WIC-eligible children under the age of 5-years who are seen in the CPH walk-in immunization clinic are referred to WIC within 5-business days of the clinic visit	1,2	A,B,C,D	Immunizations
2. At least 90% of children between the ages of 0-35 months who are seen in the CPH immunization clinic are up-to-date on their immunizations upon leaving the clinic	1,2,3	A,C,D	Immunizations
3. The percentage of children between the ages of 0-35 months receiving all the vaccines available to them at the time of their visit in the CPH immunization clinic meets or exceeds 95%	1,2,3	A,B,C,D	Immunizations
4. The percentage of Immunization Clinic clients between the ages of 36-72 months receiving all required vaccines prior to entering kindergarten meets or exceeds 95%.	1,2,3	A,C,D	Immunizations
5. Percentage of STI lab panels processed within 1-hour of receipt meets or exceeds 95%.	1,4	C,D	Laboratory
6. Documentation in the EHR reflects that lab results from a venipuncture blood collection are recorded within 7-days of being resulted at least 98% of the time.	4	A,C,D	Laboratory
7. 100% of proficiency testing meets CLIA requirements.	4	C,D	Laboratory
8. 100% of the Hep B positive pregnant females in Franklin County that are reported to CPH are contacted by Project L.O.V.E. with information about the Perinatal	1,2,3	A,C,D	Project LOVE

	Hepatitis B Program			
9.	By 12/31/14, the number of children's clinics scheduled and conducted in designated zip codes will be increased by 5%.	1,2,3	A,C,D	Project LOVE
10.	By 12/31/14, the number of Hepatitis A and Hepatitis B vaccines given by Project L.O.V.E. staff will meet or exceed 1600/year.	1,2,3	A,C,D	Project LOVE
11.	Documentation in the electronic health record (EHR) reflects that 100% of clients are treated for STIs using the 2010 CDC treatment guidelines	1,2	A,C,D	Sexual Health
12.	Percentage of clients needing any STI service that are turned away is <10%.	1,2	A,C,D	Sexual Health
13.	90% of documentation in the EHR reflects that attempts were made to contact clients within 10 business days of CPH receiving positive STI results.	1,2,3,4	A,C,D	Sexual Health
14.	85% of clients with syphilis are started in treatment within 14-days of CPH being notified of their diagnosis	1,2	C,D	STD Prevention
15.	75% of HIV/AIDS clients that are served through Linkage-to-Care are successfully linked to medical care	1,2,3	C,D	STD Prevention
16.	Increase the positivity rate for HIV to at least 0.5%.	1,2,3	C,D	STD Prevention
17.	95% of identified newly diagnosed active TB clients will complete therapy as recommended within 12 months.	1,2,3	A,C,D	Tuberculosis
18.	93% of persons who are identified as close contacts of individuals with active TB will complete a clinical evaluation.	1,2,3	A,C,D	Tuberculosis
19.	79% of persons who are identified as infected close contacts of individuals with active TB will complete LTBI therapy	1,2,3	A,C,D	Tuberculosis
20.	The number of female clients who choose to use LARCs is increased to > 30 per quarter.	1,3	A,D	Women's Health
21.	Percentage of WHFP female clients who initiate breastfeeding meets or exceeds 60%.	1,2,3,4	A,D	Women's Health
22.	95% of Title V & Title X clients presenting for a urine pregnancy test in the WHFP clinic, will receive prenatal vitamins with folic acid			Women's Health

Environmental Health Division

Objective	Goals	Strategic Priorities	Program
1. Ensure that at least 6000 larvaciding inspections are performed at catch basins during mosquito season (June through October of 2014)	1		Disease Protection
2. 80% of mammal bites taken to completion within 14 days	1		Disease Protection
3. 90% of EBL investigations initiated annually within state-recommended period	1		Disease Protection
4. 100% mandated outdoor swimming pool inspections completed annually	1		Disease Protection
5. 100% of all required quality control activities will be completed for field activities	4		Disease Protection
6. 100% of state-mandated risk-level inspections completed annually	1		Food Safety
7. 100% of state-level mandated mobile inspections completed annually	1		Food Safety
8. Inspect at least 50% of the licensed vending locations of each owner as state-mandated annually	1		Food Safety
9. 100% of mandated school facility inspections completed annually	1		Food Safety
10. 100% of all required quality control activities will be completed for field activities	1,4		Food Safety

Family Health Division

Objective	Goals	Strategic Priorities	Program
1. By 12/31/14, 45% of clients will receive 4 services within 30 days of being admitted.	1,2,3	A	Alcohol and Other Drugs (AOD)
2. By 12/31/14, 45% of clients will successfully complete the AOD treatment program.	1,2,3	A,C	AOD
3. By 12/31/14, 100% of pregnant clients who complete treatment services will deliver drug-free babies.	1,2,3	A,C	AOD
4. By 12/31/2014, 70% of participants who complete SAGE, SOS and the LRP services will report an intention to follow low risk guidelines for substance abuse and/or HIV/STD infections	1,2,3	C,D	AOD
5. 600 dental visits per 1.0 FTE dentist per quarter	4	D	Dental Clinic
6. 275 dental hygienist visits per 1.0 FTE dental hygienist per quarter	4	D	Dental Clinic
7. 60% of all patients will complete their treatment plan within 12 months of	4	D	Dental Clinic

comprehensive exam			
8. 40% of all second and sixth graders will have parental consent to be screened at the time of visit	1,2,4	D	Dental Sealants
9. 92% of students screened who are eligible for sealants actually received them at time of visit.	4		Dental Sealants
10. 87% of sealants that have retained one year after placement	4		Dental Sealants
11. 90% of all Franklin County child fatality cases, where charges have not been filed, will be reviewed within one year by the Child Fatality Review Team.	1,2	A	CFR/FIMR
12. Establish a case review team for reviewing fetal and infant deaths (<12 months of age) by July 1, 2014.	1,2	A	CFR/FIMR
13. Starting July 1, 2014, 3 cases of Franklin County fetal and infant deaths (<12 months of age) where charges have not been filed will be reviewed per month.	1,2	A	CFR/FIMR
14. By December 31, 2014, the review board will make at least 1 recommendation to reduce fetal and infant deaths based on the reviews	1,2	A	CFR/FIMR
15. Starting July 1, 2014, at least one community education event that promotes infant safe sleep will be conducted in one of the targeted high risk zip codes.	1,2,3	A	CFR/FIMR
16. The car seat program will increase the amount of classes held in 2014 by 10% (9 classes/yr).	3	A	Injury Prevention
17. Staff will increase the number of community based car seat events (outside of 240 Parsons) in 2014 by 10% (5 external events/yr)	2,3	A	Injury Prevention
18. 2 Fatality (crash) review board meetings will be held each quarter in 2014.	1,2		Injury Prevention
19. 97% of clients will rate MCH Home Visiting services as good or excellent on the customer satisfaction survey	1,3	A,D	Newborn Home Visiting
20. 98% of all families will have the safe sleep assessment completed by staff during the first postpartum visit.	1,2,3,4	A,D	Newborn Home Visiting
21. 98% of mothers with infants aged 0-6 months will have the Edinburgh depression tool completed at least once	1,2,3,4	A,D	Newborn Home Visiting
22. 80% of mothers seen through the MCH Home Visiting programs will deliver a baby with a healthy birth weight	??	??	Newborn Home Visiting
23. Average cost per client served in 2014 is at or below the statewide average.	3,4		WIC
24. 90 % of WIC clients rating time spent in clinic as "just right"	4		WIC
25. 80% of WIC clients stated that a health professional set a goal with them during	3,4		WIC

their visit.			
26. 60% of women in Franklin County WIC program will initiate breastfeeding	3	A,B	WIC
27. 98% of caseload ceiling reached	3,4		WIC

Neighborhood Health Division

Objective	Goals	Strategic Priorities	Program
1. By June 2014 provide at least 25 gardens with equipment and supplies through the Columbus Foundation/ Institute for Active	2	B	Active Living
2. By October 31, 2014 at least 75% of riders participating in Kids Cycle Columbus will complete the bicycling skills and safety curriculum and earn a bicycle	2	B	Active Living
3. By 12/31/2014, at least 6 community-based organizations including faith-based and nonprofit organizations will implement at least one physical activity policy and/or environmental change as evidenced by written policy and/or observational assessment.	2,3	A,B	Creating Healthy Communities
4. By 12/31/2014, at least 6 community-based organizations including faith-based and nonprofit organizations will implement at least one healthy food policy and/or environmental change as evidenced by written policy, menus and/or observational assessment.	2,3	A,B	Creating Healthy Communities
5. By 12/31/2014, at least 3 multi-unit housing properties will implement a 100% smoke free policy as evidenced by written policy.	2,3	A,B	Creating Healthy Communities
6. By 12/31/2014, staff will train 25 childcare centers and/or Columbus City Schools pre-Kindergarten classrooms on the 10-hour Healthy Children Healthy Weights curriculum*.	1,2,3	A,B	Healthy Children, Healthy Weights
7. By 12/31/2014, staff will provide Technical Assistance** to 25 childcare centers and/or CCS Pre-Kindergarten classrooms regarding modifying menus to reflect the Ohio Healthy Program/Healthy Children Healthy Weights menu standards (i.e. increasing fruit and vegetable offerings and decreasing fried food offerings)* and/or towards adopting policies that support a healthy environment.	1,2,3	B	Healthy Children, Healthy Weights
8. By 12/31/2014, staff will provide technical assistance to at least 3 Community Based Organizations regarding hosting a healthy event or creating a healthy environment for residents, reaching families of children who may or may not be	1,2,3	A,B	Healthy Children, Healthy Weights

enrolled in traditional child care settings			
9. By 12/31/2014, staff will develop an online toolkit**** to support partners in implementing the designated 2014 key message campaign (An Hour a Day to Play) selected by the HCHW-facilitated 50+ member strong Growing Healthy Kids Columbus coalition.	1,2,3	A,B	Healthy Children, Healthy Weights
10. By 12/31/2014, staff will make at least one programmatic decision based on information found in the key message campaign tracking sheets and/or key message pre and post survey results from the 2013 campaign (Water First for Thirst) selected by the HCHW-facilitated 50+ member strong Growing Healthy Kids Columbus Coalition.	1,2,3,4	A,B	Healthy Children, Healthy Weights
11. By December 31, 2014, the # of people/ walk location at the Walk With A Doc: Columbus Neighborhood Walking Clubs will increase by 10% of the baseline.	2,3	B	Healthy Places
12. By December 31, 2014, the Healthy Places Program will conduct 4 or more walk studies/ year in partnership with Neighborhood Pride Columbus and the Columbus City Safe Routes to School District-Wide School Travel Plan.	2,3	B	Healthy Places
13. By December 31, 2014, 40% of the rezoning recommendations made by the Healthy Places Program to property owners, developers (or their legal rep), Development Commissioners, and/or City Council members will be accepted.	2,3	B	Healthy Places
14. By 12/31/14, the number of residents participating on the Near East Health Advisory Committee will increase by 2 residents per year	2,3	A,B,C,D	Healthy Neighborhoods
15. By 12/31/14, the number of residents participating on the Westside Health Advisory Committee will increase by 8 residents per year	2,3	A,B,C,D	Healthy Neighborhoods
16. By 12/31/14, the number of residents participating on the South Side Health Advisory Committee will increase by 8 residents per year	2,3	A,B,C,D	Healthy Neighborhoods
17. By 12/31/14, the number of residents participating on the North Side Health Advisory Committee will increase by 3 residents per year	2,3	A,B,C,D	Healthy Neighborhoods
18. By 12/31/14 complete 4 interpreter wait-time studies (one per quarter) to provide baseline data for quality improvement.	2,3,4	A,B,C,D	Minority Health
19. By 12/31/14 the Office of Minority Health will provide presentations/workshops/forums on minority health issues and services to at least 900 community members.	2,4	D	Minority Health
20. By 12/31/14 collect baseline data from at least 3 community clinic partners about	4		Neighborhood

the Neighborhood Social Work program			Services

Planning & Accreditation Division

Objective	Goals	Strategic Priorities	Program
1. By 12/31/14, create and implement a tracking tool for updating and replacing documents for next submission to PHAB.	4		Accreditation
2. By 9/30/14, create and implement a plan based to assist with the yearly accreditation report to PHAB.	4		Accreditation
3. By April 30, 2014, the annual evaluation of QI initiatives will be submitted to SAT by the Chair of the QT.	4		Performance Improvement
4. By December 31, 2014, 12 of 16 of the required CPH Programs will have a new customer satisfaction survey developed with the assistance of the QT.	4		Performance Improvement
5. By Dec. 31, 2014, the 2014 Quality Improvement Plan will be approved by the Quality Team and submitted to SAT for final approval.	4		Performance Improvement
6. Report status of customer satisfaction surveys quarterly to SAT and the quality team within 60 days after end of survey reporting period.	4		Performance Improvement
7. Report status of programmatic performance measures quarterly to SAT and the quality team within 60 days after end of PM reporting period.	4		Performance Improvement
8. Revise the CPH Community Health Improvement Plan by 12/31/14 to incorporate at least 50% of the identified areas of improvement identified in the site visit report from the PHAB reviewers.	2,3,4	A,B,C,D	Planning
9. Conduct internal inventories of CPH programming to inform 3 priorities within the CHIP by Dec 31, 2014.	2,3,4	A,B,C,D	Planning

ASSESSMENT OR BACKGROUND DOCUMENTATION USED TO DEVELOP THE STRATEGIC PLAN

2011-2012

CPH – External Forces (Opportunities/Threats)

EXTERNAL FORCES (Opportunities/Threats):	
• **Affordable Care Act and how it will impact the work of CPH**	• Affordable Health Care Act -- can legislative requirements offer an opportunity for us to strengthen, add or re-focus our programming • Health care reform will increase access to care, can we be a provider?, can we help providers with meeting guidelines to provide care?
• **Funding/resources – decreasing/new opportunities**	• Decrease in funding in federal and state grants with increased outcomes measures and monitoring. Economic challenges that are on-going due to unemployment • Funding cuts, less empathy for desinfranchised communities. Put resources where you can impact larger numbers
• **Specific health challenges: infant mortality/breastfeeding, TB, obesity, opiate drug use, climate change**	• Helping to prevent the death rate for opiate and prescription overdose that is spiralling. • Emphasis on healthy living • More involvement with Mental Health and Addiction • Work with families to obtain prenatal care and birth control. • Breast feeding • Tobacco – youth • lack of basic health care because of lack of insurance due to unemployment.
• **Columbus's diverse population – immigrant and refugee populations – also specific populations, including seniors, teens**	• Emphasis on childhood obesity • Some kind of adolescent programming • Providing more opportunities for senior health care Offering programs and services for LGBT community since Columbus has a high gay population • increasing immigrant and non white populations • Needs related to diverse populations – languages, cultures - Additiional interpreters in the dominant languages
• **More focus on "public health" (for everyone) vs. providing health services to underserved populations**	•
• **Political environment – changing attitudes in general public re: health care, health equity, government funded services**	• Reductions in funding, contentious & at times anti-government political climate •
• **Wellness initiatives**	• healthy/fresh/local diets • 200Columbus and Healthy Columbus - support
• **More partnerships, more public health leadership**	• Opportunity to partner with Kirwan Institute, Opportunities to apply for funding from CDC, RWJF, etc • We have strong partnerships in place with external partners that we can grow and build upon. We could use those established partnerships to create new community partnerships in the next 5 years. • wellness initiatives at companies and corporations that will impact the employees' health and well-being.
• **Staff – more knowledge across organization of programs and services, also staff development and succession planning**	• Employee satisfaction. Understanding what "today's" workforce is really interested in. Continued engagement with the "quality of working life". • Loss of institutional knowledge with retirements • Employee satisfaction. Understanding what "today's" workforce is really interested in. Continued engagement with the "quality of working life". • Please consider child care for employees, especially those that work some evening hours.

CPH – Strengths and Weaknesses

	Strengths*	Weaknesses*
The People	• Strong leadership • Culturally Diverse • Commitment and passion for the work	• Too much work is done in silos – not enough opportunity and support for collaboration • Not paying attention to workforce development and leadership succession planning • Team member level of engagement varies significantly – not everyone believes they have a voice or can impact decisions that affect their work • Vision, mission – not clearly understood by everyone o Focus on health inequities – passing phase?
Reputation	• High level of expertise – recognized internally and externally, locally and nationally	• Stakeholders don't necessarily understand our work – what we do, what it takes, scope
Community	• Strong community partnerships	• Need to do a better job partnering with the community • Need to understand day-to-day realities of residents; need to engage residents in decision-making, foster trust and respect • Community capacity building • Working with/on non-health organizations/issues to address root causes
Services	• Broad-based, interdepartmental obesity program	
Processes	• Fast acting: outbreaks, public emergencies	• Hiring processes is cumbersome
Technology	• Has potential	• Not fully exploited • Phone system
Fiscal	• Fiscally sound	• Constant pressure of "more with less" • Always need more resources than are available; can end up competing internally • Lack of flexibility
		• Need more policy advocacy

* from 01/2012 Monthly Manager's meeting and staff and partner surveys from 2011

HEDGEHOG SUMMARY

OUR PASSIONS

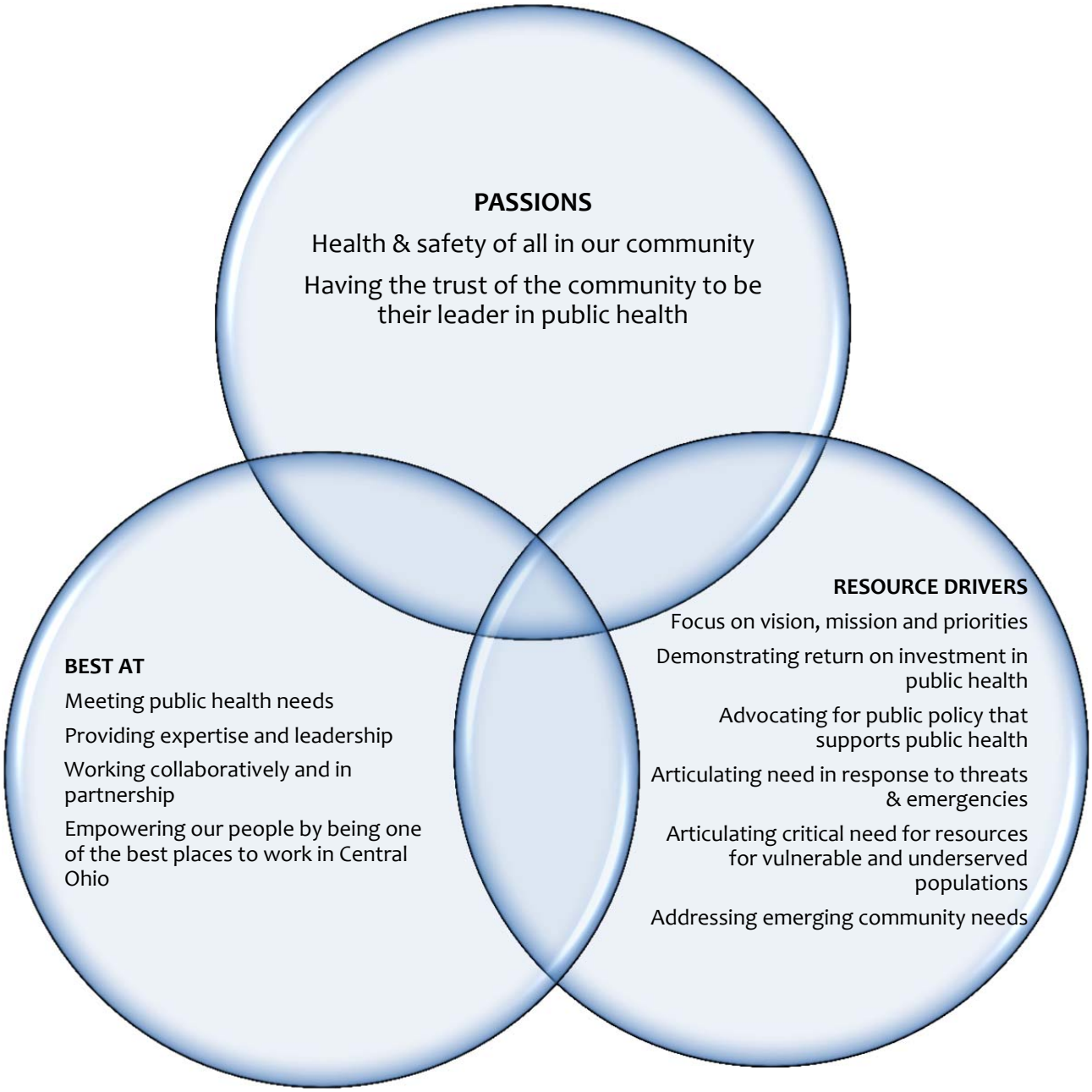
- Health and safety of all people in our community (including the underserved and our most vulnerable populations)
  - Protecting our community from public health threats
  - Preventing health conditions that put the public at risk
- Having the trust of community to take the lead on public health matters
  - Being responsive to community needs and concerns

STRENGTHS/ COMPETENCIES

- Meeting public health needs
  - prevention, protection, surveillance, threat response – with evidence-based, science-informed initiatives
- Providing expertise and leadership needed to ensure public health
  - being the voice of health for the community – willing to speak up and speak out
- Working collaboratively and building partnerships – internally and externally –
  - creating a system of response that can deliver the highest quality services with transparency and accountability
- Creating a work environment and team culture that allows us to achieve our mission and vision and makes CPH one of the best places to work in Central Ohio (and one of the best places to work in public health anywhere).

RESOURCE DRIVERS
How do we maximize the resources we have available to do our work?

- Focus on vision, mission and priorities
  - ➢ Doing what we are supposed to do – effectively and with an efficient use of resources
- Making public health a priority
  - ➢ Limiting impact of changing economic conditions on funding
- Public health threats and emergencies
  - ➢ Must be prepared to clearly articulate resource needs in order to respond to threats and emergencies
- Policy advocacy
  - ➢ Must be effective in advocacy initiatives that positively impact the resources available for public health
- Health equity
  - ➢ Must be the voice for vulnerable and underserved populations so that resources are available to serve their needs.
- Being tuned in to emerging community needs
  - ➢ Must ensure that issues are addressed before they develop into crises.


PASSIONS
Health & safety of all in our community
Having the trust of the community to be their leader in public health
BEST AT
Meeting public health needs
Providing expertise and leadership
Working collaboratively and in partnership
Empowering our people by being one of the best places to work in Central Ohio
RESOURCE DRIVERS
Focus on vision, mission and priorities
Demonstrating return on investment in public health
Advocating for public policy that supports public health
Articulating need in response to threats & emergencies
Articulating critical need for resources for vulnerable and underserved populations
Addressing emerging community needs