Columbus Public Health

STRATEGIC & OPERATIONAL PLAN
May 2012

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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

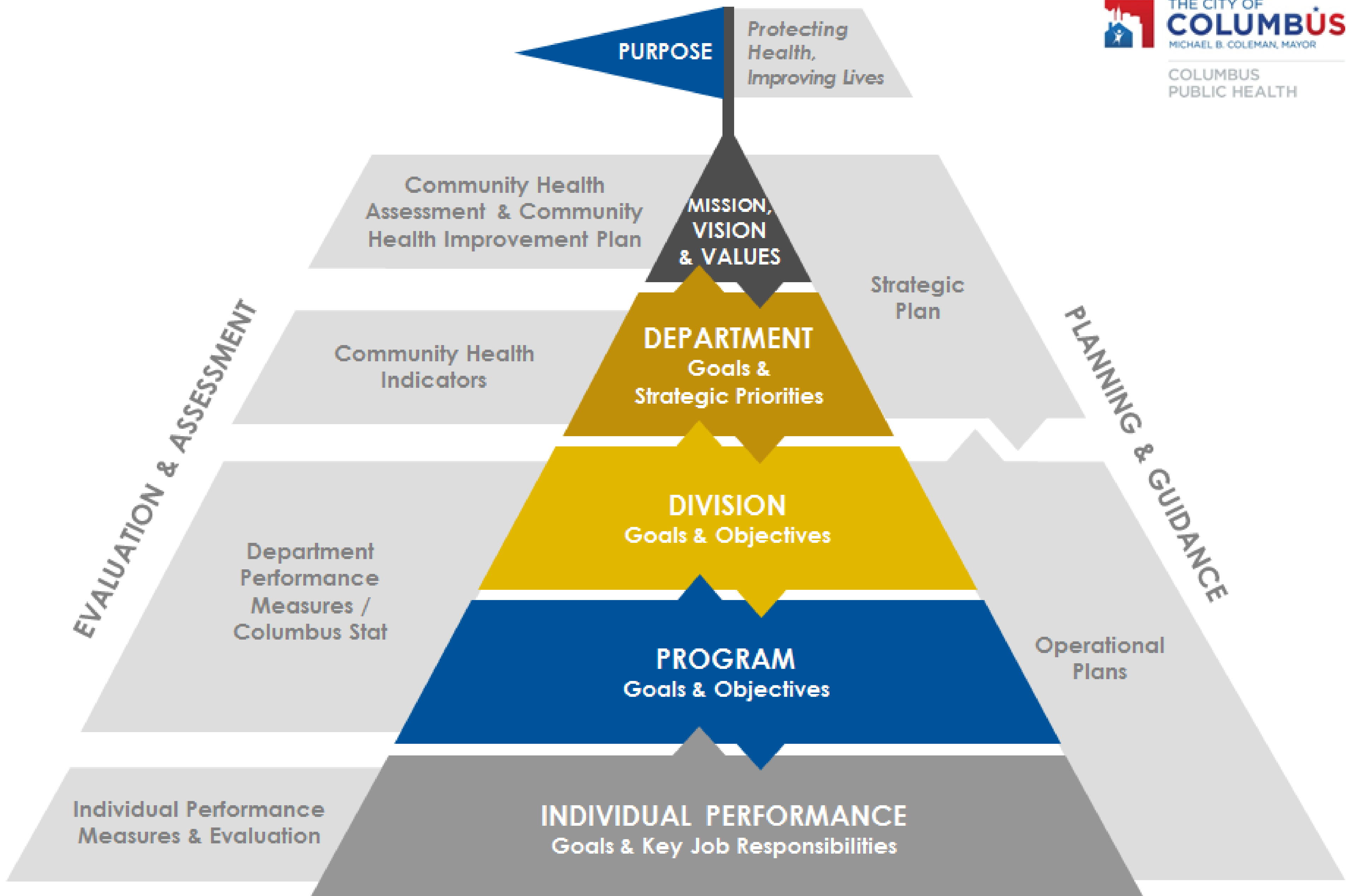
It is important to note, there is no attempt in this document to detail all of the programs or services that exist in the Department. The Strategic Plan is intended to provide a focus for the staff and the Board over the next three years. The Strategic Priority Measures and the Operational Plan are intended 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

THE CITY OF COLUMBUS
MICHAEL B. COLEMAN, MAYOR
COLUMBUS PUBLIC HEALTH

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.**

2012-13 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

OVERVIEW OF COLUMBUS PUBLIC HEALTH

2012

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 Health Equity Section: Health Equity Healthy Neighborhoods Minority Health Neighborhood Services Chronic Disease Prevention Section: 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

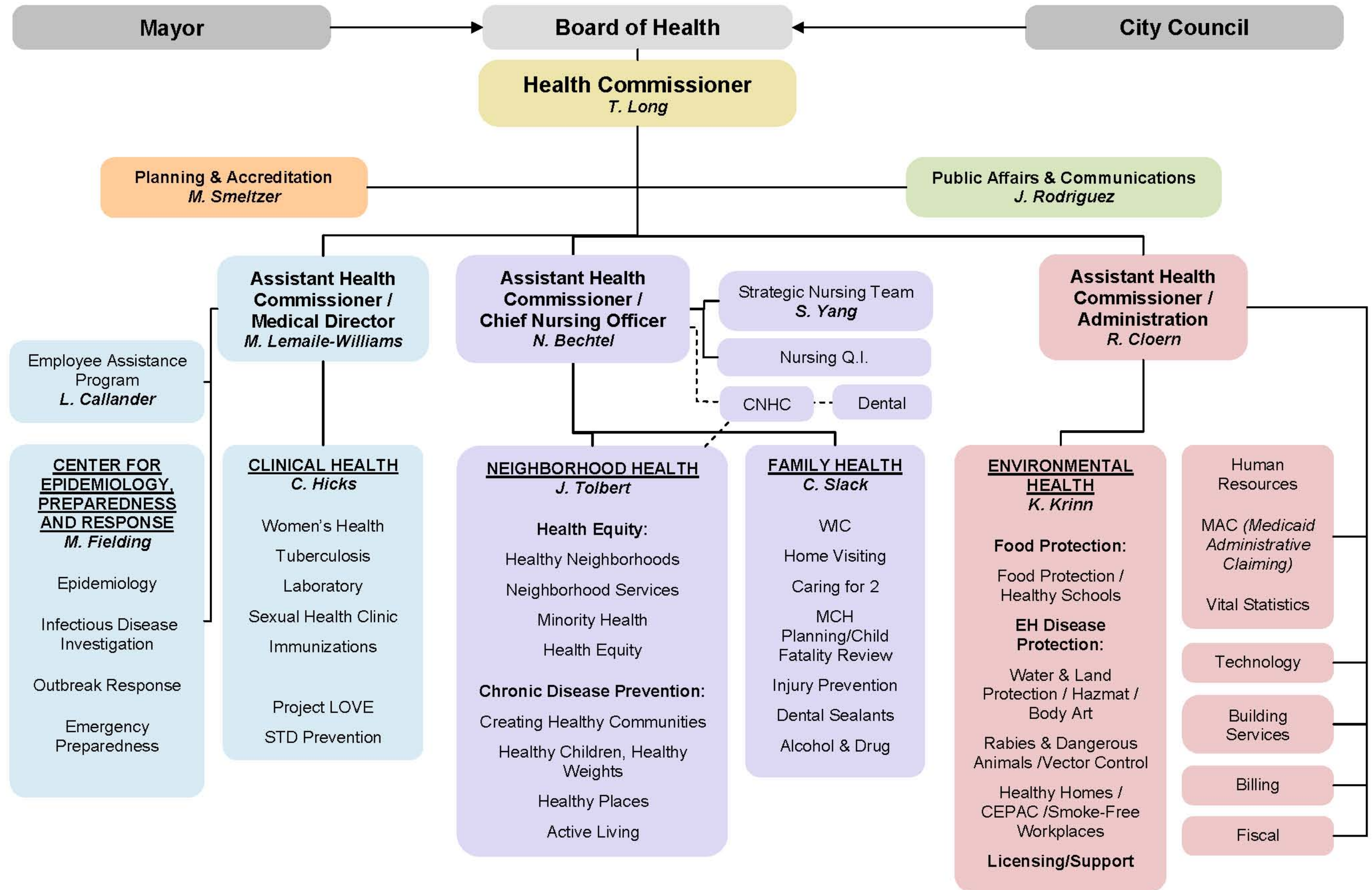
Billing
Fiscal
Human Resources
MAC *(Medicaid Administrative Claiming)*
Technology
Vital Statistics

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

City of Columbus

Columbus Public Health Organizational Chart – *3/8/2012*



STRATEGIC PRIORITY MEASURES

2012-2013

CPH Strategic Priority Measures 2012-2013

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

2012-2013

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.

Goal #1	Identify and respond to public health threats and priorities

Center for Epidemiology, Preparedness and Response (CEPR)

Objective	Timeframe	Program
1. Throughout 2012, respond within 30 minutes to all serious public health threats establishing a command and control process for response and recovery throughout 2012-2013	Throughout 2012	Emergency Preparedness
2. By December 2012, facilitate 3 CMMRS meetings with emergency preparedness/response stakeholders to identify health and medical gaps and to establish processes to address them	By December 31, 2012	Emergency Preparedness
3. Key community health indicators will be updated and shared with all stakeholders by October 31, 2012	By October 31, 2012	Epidemiology
4. Throughout 2012, Infectious Disease Investigator will be available 24 hours/day to receive and initiate a response to a Class A reportable diseases	Throughout 2012	Infectious Disease
5. Throughout 2012, Infectious Disease Investigator will respond within 1 business day of receipt of the report of a communicable disease	Throughout 2012	Infectious Disease
6. All staff who are part of the Office of Infectious Disease investigation will participate in at least 75% of the IDEI&OR education sessions in 2012	Throughout 2012	Infectious Disease
7. Outbreak investigations will be initiated within 1 business day of first notification throughout 2012	Throughout 2012	Outbreak Response
8. Outbreaks will be entered in National Outbreak Reporting System (NORS) within 30 days of notification to Ohio Department of Health throughout 2012	Throughout 2012	Outbreak Response
9. Infectious Disease Epidemiologic Investigation & Outbreak Response	Throughout	Outbreak Response

(IDEI&OR) education sessions will be offered at least once monthly throughout 2012	2012	

Clinical Health Division

Objective	Timeframe	Program
10. Maintain a 10% or lower rate of missed opportunities or invalid vaccine doses given to clients 0-35 months seen at immunization clinics by December 31, 2012	By December 31, 2012	Immunizations / Project LOVE
11. Throughout 2012, maintain a reminder/recall system for immunization clinic clients under age 24 months to achieve a return rate of 85% or higher	Throughout 2012	Immunizations / Project LOVE
12. Provide protection against Hepatitis A and B by educating and vaccinating at least 600 residents against vaccine preventable hepatitis at partner locations where highest risk individuals seek services by December 31, 2012	By December 31, 2012	Immunizations / Project LOVE
13. Throughout 2012, provide monthly immunization clinics to children under age 24 months in communities shown to have immunization coverage disparities	Throughout 2012	Immunizations / Project LOVE
14. Offer hepatitis C screening to at least 450 individuals at partner locations where highest risk individuals seek services by December 31, 2012	By December 31, 2012	Immunizations / Project LOVE
15. Accomplish paperless/electronic lab result reporting by September 2012	By September 2012	Laboratory
16. Process routine slides and STAT testing for the SHC within 1 hour of receipt 95% of the time by December 2012	By December 31, 2012	Laboratory
17. Increase the detection rate of rectal gonorrhea and rectal Chlamydia by switching from routine rectal cultures to rectal NAAT testing by September 2012. In the validation study, the prevalence increased by an average of 10-15%	By September 2012	Laboratory
18. Begin centralizing 100% of reference laboratory workflow through	By	Laboratory

Columbus Public Health Laboratory by December 2012	December 31, 2012	
19. Evaluate the laboratory's current scope of services to determine if the current mission is being met or of other options need to be considered and/or evaluated by December 2012	By December 31, 2012	Laboratory
20. Ensure 100% accurate documentation of all sexual health clinical records by December 31, 2012	By December 31, 2012	Sexual Health
21. Ensure 100% accuracy of clinical treatment records by December 31, 2012	By December 31, 2012	Sexual Health
22. Maintain productivity standards as set forth by the Sexual Health Clinic guidelines, 90% of the time (1.3-3 clients per hour based on Event Type) by December 31, 2012	By December 31, 2012	Sexual Health
23. By June 2013, develop and implement a program designed to improve the reproductive sexual health education and services available for youth (less than 18 years of age) in Columbus	By June 2013	Sexually Transmitted Diseases (STD) Prevention
24. Throughout 2012, 75% of early syphilis (P, S, EL) contacts are prophylactically treated within 30 calendar days from the date of interview of index case	Throughout 2012	STD Prevention
25. Achieve a partner index of at least 2.0 for newly identified HIV-positive cases interviewed	Throughout 2012	STD Prevention
26. 80% of newly diagnosed persons receive risk-reduction counseling	Throughout 2012	STD Prevention
27. 90% of newly identified, confirmed HIV-positive clients are referred to medical care	Throughout 2012	STD Prevention
28. At least 93% of newly diagnosed TB patients whose therapy time is indicated to be twelve (12) months or less, will complete therapy during the time period	2012-2013	Tuberculosis
29. Increase the proportion of contacts to smear positive cases that are evaluated to 90% by 2013	By January 1, 2013	Tuberculosis
30. Increase the proportion of contacts to smear positive cases with newly	By January	Tuberculosis

diagnosed LTBI who start treatment to 82% by 2013	1, 2013	
31. Increase the percentage of contacts to smear positive cases that complete treatment for LTBI once initiated to 75% by 2013	By January 1, 2013	Tuberculosis
32. Throughout 2012, at least 55% of B1B2 Division of Quarantine referrals will have their medical evaluation initiated within 30 days of arrival	Throughout 2012	Tuberculosis
33. Throughout 2012, increase the percentage of perinatal clients who complete their postpartum visit from 43% to 90%	Throughout 2012	Women's Health
34. Throughout 2012, 90% of prenatal clients have been screened during each trimester for mental health risk factors	Throughout 2012	Women's Health
35. Throughout 2012, 100% of appropriate patients are screened for cervical cancer utilizing a liquid based Pap test	Throughout 2012	Women's Health
36. Throughout 2012, 100% of patients of childbearing age will have a documented reproductive life plan established in the chart	Throughout 2012	Women's Health
37. Throughout 2012, 100% of patients requesting contraception are provided counseling and education on all types of voluntary contraception, including abstinence and natural family planning, and assisted in selecting the best individualized method of contraception	Throughout 2012	Women's Health

Family Health Division

Objective	Timeframe	Program
38. Increase by 5-10% the number of "protective factors" used (as defined by the Center of Substance Abuse Prevention [CSAP]) for preventing alcohol & drug misuse among the youth served in the AOD clinical target population, measurable via a modified "Communities That Care" Youth Assessment	By December 31, 2012	Alcohol and Other Drugs (AOD)
39. Establish a specialty group for opiate dependent and/or abusing clients within 45 days of program entry that includes intensive case management: this will be done in conjunction with the client's medical provider in order to develop a plan for cessation of opiates and other medications with a high risk for dependence (anxiolytics, sleep medicating or stimulants).	By December 31, 2012	AOD
40. Establish a baseline number of opiate abusers successfully transferring to	By	AOD

an abstinence-based treatment modality; this is a pre-cursor to a December 2013 goal of increasing the number by 5%-10% of opiate abusers successfully transferring to an abstinence-based treatment modality	December 31, 2012	
41. Establish a baseline of pregnant women who are alcohol/drug users by December of 2012; this is a pre-cursor to a December 2013 goal of increasing the percentage by 5% of pregnant women who are alcohol/drug users who deliver drug-free babies	By December 31, 2012	AOD
42. Establish a baseline of pregnant women alcohol/drug users who are connected to the Caring for 2 CPH Program; this is a pre-cursor to a December 2013 goal of increasing the percentage of pregnant women who are alcohol/drug users to the Caring for 2 Program	By December 31, 2012	AOD
43. By December 31, 2012, increase the number of women who are enrolled in Caring for 2 who receive prenatal care in the first trimester from 68% to 72%	By December 31, 2012	Caring for 2
44. By December 31, 2012, convene the Caring for 2 Advisory Committee at least 6 times and establish co-chairs for leadership, along with new goals for the annual 2012 Community Health and Wellness Conference	By December 31, 2012	Caring for 2
45. Screen a minimum of 5,175 second and sixth graders in Columbus City Schools (CCS) for dental sealants by Dec. 31, 2012	By December 31, 2012	Dental Sealants
46. Provide sealants to a minimum of 4,347 students with follow-up screening in third grade by Dec. 31, 2012	By December 31, 2012	Dental Sealants
47. Provide sealants to a minimum of 1,506 third and seventh graders in CCS for follow-up screenings by Dec. 31, 2012	By December 31, 2012	Dental Sealants
48. By December 31, 2012, reduce by 3% the incidence of injuries and deaths among children 0-17 years of age from motor vehicle crashes and pedestrian crashes in Franklin County	By December 31, 2012	Injury Prevention
49. By December 31, 2012, reduce the child car seat misuse rate by 10%, based on data collected at car seat check-up events	By December	Injury Prevention

	31, 2012	
50. Decrease sleep-related infant deaths by 5% (Baseline = 29 sleep-related infant deaths in 2010) by December 31, 2012	By December 31, 2012	Maternal Child Health Planning (MCH)
51. By December 31, 2012, provide expert review to the Office of Public Affairs and Communication of materials/information (print, electronic and broadcast) developed by CPH in 2012 to assure conformity to the Safe Sleep Guidelines developed by First Candle in order to decrease sleep-related infant death	By December 31, 2012	MCH Planning
52. Establish a Policy and Procedure for Family Health Division home visiting staff to standardize the education components and ensure consistent messages regarding infant safe sleep environments among clients (room sharing, not bed-sharing) by December 31, 2012	By December 31, 2012	Home Visiting
53. Engage community partners (enhance partnerships) to implement at least 1 recommendation from the Child Fatality Review Board to prevent future child deaths by December 31, 2012	By December 31, 2012	Child Fatality Review
54. Review 95-100% of all Franklin County child fatalities within 2 years of the death by December 31, 2012	By December 31, 2012	Child Fatality Review
55. By December 31, 2012, increase the percentage of women on Franklin County WIC that initiate breastfeeding from 58% to 60%, as measured by the WIC Project Breastfeeding Initiation report	By December 31, 2012	Women, Infants and Children (WIC)
56. By December 31, 2012, establish a Breastfeeding Committee consisting of representatives from the CPH Family Health Division and representatives from other departments to develop breastfeeding friendly practices within our organization and for the community	By December 31, 2012	WIC
57. By December 31, 2012, meet or exceed target show rates for Franklin County WIC centers as measured by the September caseload closeout numbers	By December 31, 2012	WIC
58. By December 31, 2012, redesign the caseload tracking process to incorporate trending in growth and reduction, and conduct training for WIC staff on how to read these trends and interpret them	By December 31, 2012	WIC

59. By December 31, 2012, increase public awareness and promotion of the WIC program through monthly updates sent to the CPH Communications Department for posting on the CPH Facebook page and on the CPH information monitors	By December 31, 2012	WIC
60. By December 31, 2012, conduct 600 in-home visits which will provide: • Nursing physical health assessments for mothers and newborns; • Education on normal pediatric growth and development, care of the newborn and linkage to community resources; • Screenings for postpartum depression; and • Assessment of and instruction regarding safe sleep environments.	By December 31, 2012	Newborn Home Visiting (NHV)
61. By December 31st, 2012, provide phone consultation services to 700 mothers of newborns to answer questions and triage true medical needs of the infants	By December 31, 2012	NHV

Environmental Health Division

Objective	Timeframe	Program
62. All tattoo and body piercing facilities will receive a minimum of 2 inspections by December 31, 2012	By December 31, 2012	Body Art
63. Conduct 100% of all mandated Food Service Operation and Retail Food Establishment facility inspections on or before 2/28/13	By 2/28/13	Food Protection
64. Respond to all non-illness complaints against Food Service Operation and Retail Food Establishment facilities within 3 days	By 12/31/12	Food Protection
65. Participate in the Outbreak Response Team to respond to environmental health related illness complaints and outbreaks within 24 hours of receiving complaint information from the primary nurse investigator	By 12/31/12	Food Protection
66. Provide at least 36 Level One Food Safety classes during 2012	By 12/31/12	Food Protection
67. Provide at least 12 Level Two Food Safety Classes during 2012	By 12/31/12	Food Protection
68. Before 9/1/12, create and assign new program element codes to all school program records	By 9/1/12	Healthy Schools
69. Before 9/1/12, assign all school program records to Food Protection sanitarians by work area	By 9/1/12	Healthy Schools

70. Conduct 100% of all mandated school facility inspections between 8/1/2012 and 6/1/2013	By 6/1/13	Healthy Schools
71. By 9/1/12, train all Food Protection staff to perform Healthy Schools facility inspections	By 9/1/12	Healthy Schools
72. 100% of renewal applications for Food Service Operation and Retail Food Establishment licenses will be mailed on or before January 30, 2013	By 1/30/13	Licensing and Support
73. 100% of renewal applications for Disease Prevention licensed programs will be mailed on or before the month preceding the expiration of the current license	Through 2012	Licensing and Support
74. 100% of the renewal applications for 2013 Food Service Operation and Retail Food Establishment licenses will be processed after 2/1/13.	By 12/31/13	Licensing and Support
75. All seasonal swimming pools will have their first inspection and equipment inventory by July 12, 2012	By 7/12/12	Water and Land Protection
76. Provide at least 3 pool safety workshops by December 31, 2012	By December 31, 2012	Water and Land Protection
77. Provide at least 4 Certified Pool Operator (CPO*) Training Classes during 2012 and 2013	By December 31, 2012 and 2013	Water and Land Protection

Other

Objective	Timeframe	Program
78. Throughout 2012, ensure that uninsured patients are the priority population to receive dental treatment at CPH clinic by treating the number of patients as per the agreement between CPH and CNHC	Throughout 2012	Dental
79. Throughout 2012, meet or exceed HRSA guidelines for dental provider activity	Throughout 2012	Dental
80. EAP will achieve 80% client satisfaction in the following areas: Counseling was beneficial; Overall job performance improved; and Trainings/Workshops attended by December 31, 2012	By December 31, 2012	Employee Assistance Program (EAP)
81. EAP will participate in a minimum of 4 total outreach activities per month	By	Employee Assistance

within Public Safety-Divisions of Fire and Police by December 31, 2012	December 31, 2012	Program (EAP)
82. Influenza immunizations will be offered at every Columbus City School and Columbus Catholic School in 2012/13	Throughout 2012 & 2013	Strategic Nursing Team
83. Influenza vaccine participation will be increased by 2% in charter and private schools in 2012/13	Throughout 2012 & 2013	Strategic Nursing Team
84. Health screenings at neighborhood venues will be increased by 5% in 2012	Throughout 2012 & 2013	Strategic Nursing Team
85. Develop and document the role of Columbus Neighborhood Health Centers (CNHC) in CPH / community emergency response plans by July 2013	By July 2013	Columbus Neighborhood Health Centers (CNHC)
86. Improve childhood and adult immunization rates at CNHC by at least 10% by December 31, 2012 in partnership with CPH.	By December 31, 2012	Columbus Neighborhood Health Centers (CNHC)

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

Neighborhood Health Division

Objective	Timeframe	Program
87. By the end of December 2012, create / enhance a minimum of one policy that improves community garden land use or water conservation, simplifies the process, and increases the number of gardens by a minimum of 10% compared to 2011	By December 31, 2012	Active Living
88. By December 31, 2012, at least one (1) multi-unit housing landlord in each focus neighborhood (Linden, Hilltop and Franklinton) will have assessed the feasibility of establishing a 100% smoke-free policy in at least one building, as evidenced by written assessment results	By December 31, 2012	Creating Healthy Communities
89. By December 31, 2012, at least one (1) worksite in each focus neighborhood (Linden, Hilltop and Franklinton) will provide enhanced infrastructure to support employee biking to work, as evidenced by photographs and copies of employee promotional materials and/or written policies	By December 31, 2012	Creating Healthy Communities
90. By December 31, 2012, at least three (3) community gardens in each focus neighborhood (Linden, Hilltop and Franklinton) will establish a partnership with a local food pantry and establish a system for providing and tracking donated garden produce, as evidenced by donation log sheets	By December 31, 2012	Creating Healthy Communities
91. Completion of draft CPH Health Equity Plan by July 31, 2012	By July 31, 2012	Health Equity
92. Establish Health Equity Section, with manager, appropriate programs and staffing by July 31, 2012	By July 31, 2012	Health Equity
93. Finalize Health Equity plan with clear roles and responsibilities for section and programs by September 30, 2012	By September 30, 2012	Health Equity
94. By June 30, 2012, in partnership with Community Research Partners, The Columbus Foundation and The Kirwan Institute, CPH will co-sponsor a community summit on poverty and a dialogue of stakeholders regarding	By June 30, 2012	Health Equity

potential commitments and actions to reduce income disparity in the greater Columbus community.		
95. By 12/31/12, at least 10 non-profit organizations will receive technical assistance in creating policy, system and/or environmental change in their organizations	By December 31, 2012	Healthy Children, Healthy Weights
96. By 12/31/2012, at least one proposal for outside funding will be submitted to support at least one strategy in the City of Columbus' Early Childhood Obesity Prevention Plan	By December 31, 2012	Healthy Children, Healthy Weights
97. By 12/31/12, institutionalize Health Impact Assessment with at least one City Council Resolution committing that it will be used for at least one development process	By December 31, 2012	Healthy Places
98. By December 31, 2012, conduct 10 community forums to ensure community stakeholders understand the status of minority populations regarding the targeted health conditions and disparities	By December 31, 2012	Minority Health
99. Continue to develop and disseminate up-to-date information about health related resources for the Columbus community by increasing the number of agencies to our resource list by 15 new agencies/organizations by 12/31/12	By December 31, 2012	Neighborhood Services
100. Continue to respond to referrals from City staff – in particular from EMS and Code Enforcement – for Columbus citizens in need of additional community services by 12-31-12	By December 31, 2012	Neighborhood Services

Environmental Health

Objective	Timeframe	Program
101. Successfully propose amendments to the exotic animal law (SB 310) that would require that local jurisdictions to be on the advisory board and implement more stringent restrictions for exotic animals by July 31, 2012.	By July, 31, 2012	Health Commissioners Office Rabies and Dangerous Animals

Other

Objective	Timeframe	Program
102. By December 31,2012, in collaboration with CNHC, Physicians Care	By	Dental, Columbus

Connection and Columbus Dental Society, establish a free dental clinic using facilities at CPH	December 31,2012	Neighborhood Health Centers (CNHC)
103. By December 31, 2012, CNHC and CPH shall increase by 10% the number of clients served for emergency dental services through a more coordinated utilization of both organizations' equipment and personnel resources.	By December 31,2012	Columbus Neighborhood Health Centers (CNHC)
104. An MOA will be in place by October 2012 between CPH and CNHC that expedites referral and prompt medical care for CPH clients in need of a medical home, through a new CPH Nurse Practitioner/Social Work referral program.	By October 2012	Columbus Neighborhood Health Centers (CNHC)
105. CPH & CNHC shall collaborate throughout 2012 to increase access to health services for un/under-insured Columbus residents by: • Meeting quarterly to discuss and monitor the performance requirements as stated within the 2012 contract between CPH and CNHC (including an increase by 5% of CNHC's "New Patients" numbers); • Continued monitoring of the "financial stability" of CNHC, operational efficiency and maintenance of an appropriate ratio of insured to uninsured patients for the year; • Continued collaborative planning and development efforts as the new Southside Health Center is built, so that optimal healthcare services can be offered to local residents given space and other available resources in the community.	By December 31, 2012	Columbus Neighborhood Health Centers (CNHC)
106. Create and implement a focused campaign to recruit pregnant women for prenatal and on-going well woman care by Dec. 31, 2012, with assistance from CPH.	By December 31, 2012	Columbus Neighborhood Health Centers (CNHC) Public Affairs and Communications
107. Develop a policy agenda for the department that reflects the public health priorities of each division by December 31, 2012.	By December 31, 2012	Planning & Accreditation

Goal #3	Empower people and neighborhoods to improve their health

Neighborhood Health Division

Objective	Timeframe	Program
108. By December 2012, recruit a minimum of 5 local restaurants to participate in the Healthier Choices Initiative in partnership with OSU to promote healthier menu items with standardized number of calories, saturated fat, sodium and protein	By December 31,2012	Active Living
109. By December 2012, increase the number of Bike Columbus Festival participants by a minimum of 10%, add a minimum of one new sponsor, and recruit a minimum of 20 event volunteers	By December 31,2012	Active Living
110. By December 2012, update and improve the content of www.getactivecolumbumbus.gov, and create a Facebook page that engages participants and draws a minimum of 150 "Friends"	By December 31,2012	Active Living
111. Create a webpage on CPH Health Equity resources and initiatives by December 31, 2012	By December 31,2012	Health Equity Public Affairs and Communications
112. By 12/31/12, 75% of HCHW child care centers will have completed 6 month and annual evaluation and received additional technical assistance as needed to maintain Ohio's Program status	By December 31,2012	Healthy Children, Healthy Weights
113. By 12/31/12, provide technical assistance to the Community Health Advisory Committees to plan, implement and evaluate a minimum of four "Unnatural Causes" Town Hall meetings	By December 31,2012	Healthy Neighborhoods
114. By 12/31/12, apply for 5 public health-related grants on behalf of various CPH programs and the Community Health Advisory Committees	By December 31,2012	Healthy Neighborhoods
115. By 12/31/12, provide assistance to help support new public art development and creation of a new Art Walk in at least one socioeconomically vulnerable neighborhood	By December 31,2012	Healthy Places
116. By December 31, 2012, offer 12 trainings on the Effective and Empowered Health Care Consumer Program	By December	Minority Health

	31,2012	

Planning & Accreditation Division

Objective	Timeframe	Program
117. By December 2012, CPH, area hospitals and community collaborative health improvement projects will be merged into 1 initiative	By December 1,2012	Planning & Accreditation

Goal #4	Establish and maintain organizational capacity and resources to support continuous quality improvement

Neighborhood Health Division

Objective	Timeframe	Program
118. By 12/31/12, coordinate 50+ community wellness events along with creating a customer satisfaction survey for increased customer feedback	By December 31,2012	Healthy Neighborhoods
119. By 12/31/12, expand the use of Health Impact Assessment beyond the built environment use and focus by forming an internal CPH HIA Advisory Team and developing an HIA Checklist for each chronic disease team area	By December 31,2012	Healthy Places
120. Establish the CPH Resource Center and the CPH Community Health Navigator Program by 12/31/12	By December 31,2012	Neighborhood Services

Support Services Division

Objective	Timeframe	Program
121. Document and standardize clinical billing policies concerning timeliness of third party billing, assessment of patient sliding scale fees and financial hardship, and pursuit of patient balance, by December 2012	By December 2012	Billing
122. Coordinate new office space assignments for all divisions affected by the restructuring by December 2012	By December 2012	Building Services
123. Complete the design phase for the centralized registration area and the backup generator by December 2012	By December 1,2012	Building Services
124. Complete the north dorm renovation project by December 2012	By December 1,2012	Building Services
125. Complete the parking deck renovation project by December 2012	By	Building Services

	December 1,2012	
126. Update all Fiscal policies and procedures by December 2012	By December 1,2012	Fiscal
127. Complete a CPH succession plan by May 31, 2013	By May 31, 2013	Human Resources (HR)
128. Complete the workforce development and training curriculum plans by April 1, 2013	By April 1, 2013	Human Resources (HR)
129. Develop and implement a web-based application that will allow the public to apply and electronically pay for Environmental Health licenses and birth and death certificates by June 2013	By June 2013	Technology Services
130. Develop the capacity for staff to download routine VS documents (e.g., paternity affidavits) from the Internet by December 2012	By December 1,2012	Vital Statistics

Planning & Accreditation Division

Objective	Timeframe	Program
131. Develop a policy agenda for the department that reflects the public health priorities of each division by July 30, 2012	By July 30, 2012	Planning & Accreditation
132. By December 2012, CPH, area hospitals and community collaborative health improvement projects will be merged into 1 initiative	By December 1,2012	Planning & Accreditation
133. By May 2012, CPH Community Health Improvement Plan will be completed for accreditation submission	By May 1, 2012	Planning & Accreditation
134. Submit an accreditation application and required documentation to the Public Health Accreditation Board by May 31, 2012	By May 31, 2012	Planning & Accreditation
135. Complete pilot phase for six CQI projects by Dec. 31, 2012	By December 31,2012	Planning & Accreditation
136. By December 31, data collection and return process for customer satisfaction surveys will be < 1 month from the end of each quarter	By December	Planning & Accreditation

	31,2012	

Public Affairs & Communications

Objective	Timeframe	Program
137. Department communication with outside audiences (materials, web content, public speaking engagements, etc.) will reflect the organization's vision, mission and values at least 50% of the time, by December 31, 2012	By December 31,2012	Public Affairs & Communications
138. Department communication with outside audiences will reflect the CPH/City Brand 80% of the time by December 31, 2012	By December 31,2012	Public Affairs & Communications
139. Develop one staff training, with associated intranet materials, to ensure communication about CPH services use plain language guidelines by December 31, 2012	By December 31,2012	Public Affairs & Communications

Other

Objective	Timeframe	Program
140. By December 31, 2012, CPH will have a written and approved Nursing CQI Program Plan aimed at improving processes and capabilities of CPH staff to serve clients in the greater Columbus community	By December 31,2012	Clinical QI
141. By December 31, 2012, the new CPH Nursing QI/PI Program will have documented at least 2 successful QI initiatives with data	By December 31,2012	Clinical QI

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.

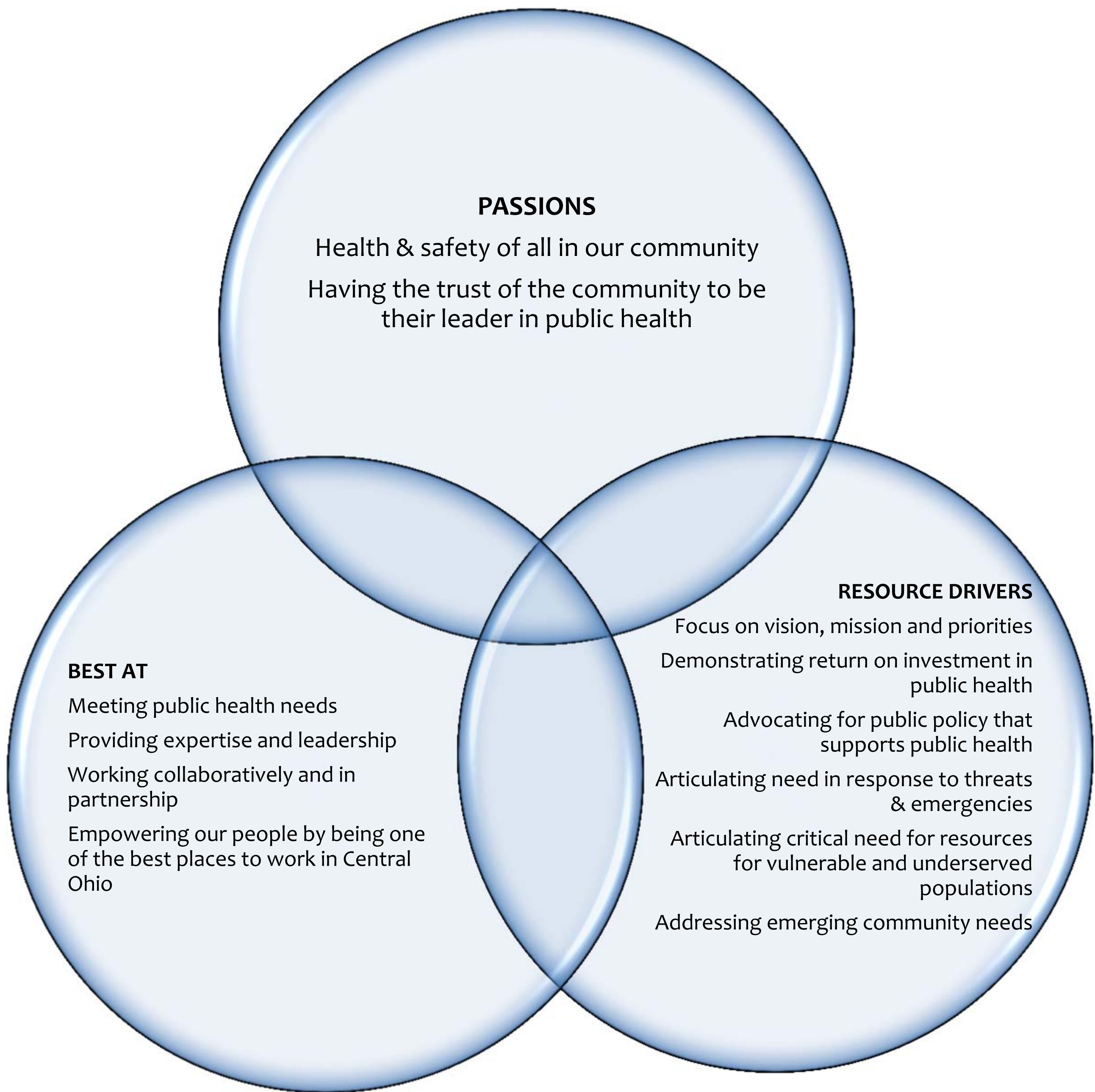
CPH – Strengths and Weaknesses

	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 ○ 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) o Protecting our community from public health threats o Preventing health conditions that put the public at risk • Having the trust of community to take the lead on public health matters o Being responsive to community needs and concerns
STRENGTHS/ COMPETENCIES	• Meeting public health needs o prevention, protection, surveillance, threat response – with evidence-based, science-informed initiatives • Providing expertise and leadership needed to ensure public health o being the voice of health for the community – willing to speak up and speak out • Working collaboratively and building partnerships – internally and externally – o 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