

## **How will implementation of this plan benefit your agency/organization?**

- Moves agency forward from current to future → going forward
- We need increased capacity to analyze, prioritize, use data. Need workforce development.
- Need to evaluate the efforts in the plan.
- For Health Statistics Section, the recommendation about health indicators will require us to expand our data systems.
- Public health is responsible for messaging and marketing to others. How to counter commissioners and others in that marketing may be okay and services valued by those receiving them. Get good sound bites; our current elevator speech is too broad and/or undefined.

### **Academic/Education Sector Benefits**

- Will be able to help with community assessment templates and workforce development, evaluation skills, research
- Multi-level analyses (Europe example), similar to life course model)
- Quality improvement programs
- Academic review boards – curriculum setting
- Other educational curriculums (engineering, technical assistance, etc.)
- Drive interest in public health education and careers
- Plan helps students get real world experiences (Life skill learning/Internships) and hopefully encourage them to stay in the Colorado system\*
- Curriculum can be created to mirror and support planning efforts
- Create multidisciplinary course around public health planning, nursing, etc.
- Good partnership opportunities, link students/faculty to statewide communities
- Increase evidence based practice in local county health departments
- CSPH can use this process to inform planning and envisioning
- Link coursework/classes with Community Health Assessments and other areas
- More opportunities to link to other schools, university and to create more preceptor role with nurses and others.
- Increase linkages to rural health that may be missed in urban settings and for students to learn what it would be like to work in more rural parts of Colorado and other parts of U.S.
- How to cross pollinate nursing, School of Nursing, opportunity for various schools to be taught, feel up to date and informed.
- Need for more health education and training needs
- Current mismatch, with what locals give all, schools give nothing. Equal workload.
- More resource rich settings get more from universities than those that don't. Have a coordinated process vs. locals being inundated by student after student.
- Partners to apply for grant applications and builds local public health agencies \*
- Develops the public health workforce, thus building local public health capacity and having more trained professions.

**Governmental public health benefits**

- Implementation is key to process. Local governments may not be able to understand or implement the Act. Be sure the entire group is aware and can help.
- Be sure to watch the implementation from a legal vs. public health aspect
- Pushing a more defined structure for local health
- Collaboration
- Opportunity to make case for resources
- Mandate for planning and assessment
- Having treasurers be responsible for separate public health revenues/funds
- Use core public health functions as a framework (10 Essentials)
- Regulatory Framework (State Board of Health)
- Local Board of Health and policymakers involvement/education \*
  - Having a plan helps communicate with BOCC BOH and decision makers
- Communications/participation/linkages
- Continuity yet flexibility
- Best practices/standards (ties to academic & private/non-profit)
- Grants/Funding can be tied to the plan
- Help current and future staff see how they fit into the broader context of public health
- Equal opportunity to services
- Measures of success to help direct programming
- Also help direct training
- Help market and educate what Public Health is and create better awareness
- Engage community partners traditional and non-traditional to help maximize resources and build support
- Small communities can access resources through the School of Public Health (MPH students)
- Potential for better recruitment and retention
- Increased focus on demonstrated accountability because we will have tangible outcomes (in data, changes in health behaviors, etc.)
- The plan will help us determine what is most appropriately done by the state vs by local agencies. Defining roles and responsibilities will improve capacity and quality.
- Bring environmental health and public health together.
- Standard tools for community health assessment will really help.
- State should gain access to data from other state agencies—Medicaid, human services, justice, etc.
- Any informatics developments need to be developed in concert with the end users. New systems need to be developed that work and are simple enough to be used at the local level.

**Private/ non-profit benefits**

- Partnerships and linkages—when we are having conversations about better healthcare, the linkages are more clear between private/non-profit with public health
- Engages communities through MAPP/assessment around healthcare/public health issues

## **Bridge Day Summary: Ownership Discussion 1:00 – 2:30 pm, September 30, 2009**

- Explore partnerships with industries for workforce development, training, etc.
- Create linkages with state level policymakers and processes
- Increase partnerships with private/non-profit world
- Define role of private/non-profit partnerships with implementation
- Wellness & prevention programs already prolific – what’s working?
- 9Health Fairs, Influenza reporting with providers, chronic care collaborative, Red Cross, etc. etc.
- Uniformity helps industry have a consistent operating system
- Better data to identify needs and priorities
- Important for them to see how public health saves them money.
- Linked to changing health outcomes, hospitalizations, teen pregnancies, how can we demonstrate via data, research what public health does and how they benefit.
- Underinsured will benefit.
- Increase understanding to politicians to prevention that helps people stay out of clinics, thus saving money.
- Outside folks to do educational offering to federal level agencies/individuals.
- Now, private/non profit may not be benefiting as clients seek more care outside of public health.
- Should we be competing with private sector care providers on delivering services? How will the system best work? Dialogue needs to happen to maximum comprehensive public health system.
- Need to find ways to be sure our plan integrates and supports health care reform efforts underway.

### **Which of these recommendations align most closely with the work of your agency or organization?**

- Use organizations CEHA/ NEHA other organizations to build capacity.
- Industry and associations as a resources
- AHEC commits to working with diversity and pipeline work.
- Assessment and Planning - state would also do an assessment using a standardized model
- Local agencies can compare areas to state assessment
- Financing and Funding – Indirect rates currently variable; Need centralization and locals could maybe drop an FTE; Standardize/streamlining timing of reports and who receives report; Need common grant process; Eliminate the challenging silo financing in state;
- Need local input – shared decision making
- Provide structure and identify needs of the community to help prioritize programming and planning. Build a case to bring in funding to meet needs
- Create sustainability to fund programs instead of chasing available money
- The recommendations all fit with the work we are and should be doing\*
- We will do what we need to do get it done

## **What improvements to the public health system do you think are the most important?**

### *Priorities*

- Culture of data – choosing the right data and tracking it
- Communicable disease control
- Protecting the environment for optimum health
- Assurance of family health (MCH)
- Funding/alternative sources
- Capacity building
- Partnerships
  - Have messaging 1<sup>st</sup>
  - Know the audience
  - Don't overthink
  - What's In It For Me?
- Access to Care

### **Our group prioritized the recommendations in the following order:**

- #1 *Financing and Funding (14 votes)*
- #2 *Assessment and Planning (12 votes)*
- #3 *Services and Standards (9 votes)*
- #4 *Public Health Informatics (8 votes)*
- #5 *Roles and Relationships (2 votes)*
- #6 *Workforce Development (0 votes)*

### **Specific comments by area:**

#### **Services and Standards**

- Performance standards
- Collaboration/partnerships
- Regional approaches
- Organizational standards/accreditation
- Measure outcomes
- Based on 10 essential public health services driven by assessments and data
- Use standards & services used in other states...just adopt and adapt (i.e. WA standards, MI standards, other WFD plans)
- State out of direct services

#### **Financing and Funding**

- Prioritize program goals
- Alternative sources of funding
- Resource development
- Sustainable funding \*

## *Bridge Day Summary: Ownership Discussion 1:00 – 2:30 pm, September 30, 2009*

- Include partners Colorado Municipal League (lobbying power)
- Develop funding formula. Based on needs and not population.
- Immediate need of resources for local assessment and planning
- Reassessing existing funding (fees, taxes, etc.) Problems when they are set in Statute and set by County Commissioners
- Funding directly skipping the middle man (CDPHE)
- Transparency in funding
- Definition of roles (State & locals)
- State has to fund PH
- Funding is the starting point to all other strategic priorities
- CDPHE works to provide a resource in a closer jurisdiction
- CDPHE funding from FEDS so watching DC – are they watching locals?
- Change to 100% funding from partial to locals
- Process : how do I get the funding to do the process
- Demonstrate cost benefit (prevention)
- Access/knowledge to resources of locals (i.e. neighboring counties).across the state....NE – SW.

### **Assessment and Planning**

- Need to be counting the same things (apples to apples)
- Increased efficiency
- Identify gaps
- What are we tracking? What's necessary?
- Ongoing evaluation
- Gathering meaningful data
- Communication between assessment and planning and informatics
- Include occupational health indicators
- Ensure they have all stakeholders represented in advisory boards/task forces
- Must have a baseline—assessment comes first. We need to do these in order to demonstrate that we are making improvements. Then, we can show where we have improvements and market this out to the community.
- We need to have the data to measure our activities to demonstrate our success. Need to do a health status assessment for the state, identify health outcome priorities, target efforts, and measure change.
- More logical outcome measurements – health risk based outcomes
- Appropriate indicators
- standardized method to count beans...across programs/divisions → understanding some is required by feds...what is control of state can be changed
- public health needs to be done at point of delivery (local)
- sharing of knowledge of impacts/indicators across counties to do work beyond what “counting of beans”
- critical evaluation by CDPHE to provide feedback to locals on impact of programs/divisions

## *Bridge Day Summary: Ownership Discussion 1:00 – 2:30 pm, September 30, 2009*

- Need to improve identification of health disparities throughout state
- Do what works....stop bean counting -- we look at process out comes without looking at health outcomes (reports on what doing regardless of impact on pop) → correct evaluation methods based on actual need

### **Roles and Relationships**

- Better relationship between state and local.
- Communications
- Skills matrices
- MOU's/Intergovernmental agreements
- Continue to expand partnerships
- CALPHO and PHDoC roles
- Need to figure out state and local roles and responsibilities and need to work on relationships with other system partners.
- CDPHE to communicate with Local Board of Health – not just Public Health directors. This will better determine what Local Board of Health responsibilities are. Add new commissioner trainings! Tools to better serve Local Board of Health ....how to be effective Local Board of Health.
- CDPHE should rely on locals to keep tabs on locals...but often slow to respond
- State role for technical assistance/expertise \*
- CDPHE/other counties may be able to provide technical resource ...i.e. air quality
- County commissioners as Local Board of Health may not be the correct model....don't have time to properly address PH issues.

### **Workforce Development**

- Partnership with professional organizations
- This could be one area that would help locals by being supported by outside partners, CSPH.
- Seen as partnership, state health and schools can help with this area. List of resources and get people to trainings. Concerns that academic opportunities may lie in Denver. Needs for online and other technology is key, over two mountain passes. One day training is three days away from office. Linked to IT needs.
- State/academic role.
- Make it easy
- Academic institutions
- Credentialing
- Assuring competency
- Continuity
- Mentoring
- Leadership cultivation
- School of Public Health to provide training and to promote recruiting and retention
- Access to and affordable education (Online and remote learning opportunities; scholarships)
- Continuing education for professionals

## *Bridge Day Summary: Ownership Discussion 1:00 – 2:30 pm, September 30, 2009*

- Recruitment and retention (competitive salary, upward mobility, talent management, professional development)
- Succession planning is critical. We need to develop our workforce and prepare for the massive retirements that are coming. \*

### **Public Health Informatics**

- Needs to be looked at as a state level function\*
- IT, locals do not have control over IT functions, its part of county IT departments vs. the public health agency.
- Look at partnerships in developing IT/database systems and having a cohesive statewide approach.
- Barriers with basic computer support, blocked from surveys, laptops, etc.
- Data is so important. Rural areas have a really hard time getting local data or it gets combined into a regional model that doesn't help the local level.
- Conversation came back to the partnerships needed to fill gaps in infrastructure. Availability and access to services to meet needs. An infrastructure assessment need.
- IT departments, others, need to know public health needs.
- Get down to local level
- Leading and lagging indicators
- Usable/user friendly
- Produce information
- Secure accessible data (meaningful)
- Uniform data management and data entry
- Remote connection to overcome travel barriers (Skype, webcasts, etc.)

### **Overall**

- Small local agencies need face-to-face outreach.
- Local health officers need to take responsibility for the plan—communicate it out to staff \*
- Information needs to make it down the food chain. Not sure how to do that—email overload.
- Communication amongst the structure including partners (traditional and non)
- Research needs to be integrated in the plan
- Some resonate better with state vs. local. All are equally important.
- It's OK to not do everything all at once. The process is evolutionary.
- Make plan relevant to all levels of staff.
- Add a definition of health, not just public health, and how it ties into to the plan
- Backwards process – local plans should drive state plan
- Process is too vague – is there a different way to get input besides committee
- Stretched workforce – doing many things
- How does the plan relate to health disparities/poverty? Include social determinants of health

## *Bridge Day Summary: Ownership Discussion 1:00 – 2:30 pm, September 30, 2009*

- Communication – environmental health and nursing and epidemiology at every level (in programs), state & local, decentralization of CDPHE – regional state health department offices with expertise. Database – should all be on the same → communication
- Committees important but lets use other resources (i.e. emails etc) - deadlines
- time frames – hard to get buy-in
- Program evaluation – to set priorities – who speaks loudest gets \$\$\$
- Trust is difficult because it's vague...plan....need to know where we're going. Need specifics to have dialogue
- Plan doesn't really seem to be any different from what we are already doing—it just writes it all down and organizes it.
- Need more state leadership here.

### **Other ideas**

- In plan, prevention seems light
- Marketing/messaging public health is necessary yet unclear
- Who is getting sick from what and dying from what????
- Having core services defined later is backwards
- Assurance that systematic biases aren't built into system especially related to core services recommendations
- Remember that systems are broader than government
- State health department needs to look at health indicators, SES, to help with assessing health disparities
- Include recommendations about expanding partnerships
- Need better construct or combined effort for local and state to work together ie joint local and state task force It is "OUR" problem; would work across many issues not just specific ones
- Shared decision making process ie CALPHO
- Decisions are the responsibility of all parties if shared decision making which is cultural shift
- Plan needs to be cooperative approach and not technical assistance approach in order to take advantage of LHA's and other partners knowledge/experience
- Regional data doesn't always work locally for counties
- Less process more voting on lists? Yes and no
- End date for committees and task forces to decrease on time heaviness