

What was your first reaction to the plan?

- Broad and that is positive *
- Need lots of input before finalizing decisions
- Appreciate the timeline to produce a comprehensive local plan especially smaller counties
- OPP has been inclusive
- Some concern that at critical input meeting things were already decided
- Health outcomes not here, but plan – need to get into new mode quickly (move from process to action – need to get there quickly)
- Include lessons learned in 1985 document as springboard
- Counties to ensure they have ability/tools to meet needs
- Need for access to degree (graduate) in rural area
- Outside consultant to do capacity assessment – in county
- Consider changing layout. Vague—first 22 pages, some things were clear. Draft core services should be at the front.
- People want to know where they fit into the plan by profession. Examples of how people fit in and connect up with core services.
- May need TA/training to show agency staff how the plan gets implemented.
- “People” are looking for the list of core services and don’t understand the system change components of the plan. Aren’t the first 26 pages just background?
- Regionalization can extend beyond just public health (health and human services.) Initial regionalization efforts may be functional vs formal.
- Need a better word for regionalization.
- Plan involves a shift in the way we think about our work.
- Glad environmental health is separate from public health in Core Services

Strengths/Opportunities in the Plan

General

- Improved communication, information sharing, and ability to collaborate
- opportunity to strengthen language around health equity and disparities
- In regards to long term planning and Continuity, with staff/commissioner turnover every four years, figure out ways to have a long term succession to bring incoming and new commissioner on board with this plan and involvement in the process
- Opportunity to promote transparency
- Reveal what a good agency would look like
- Opportunity to demonstrate accountability
- Positions us to address outcomes in our work and confirm our need for Public Health and its place in the health care system. This can contribute to more options in funding.
- Common expectation and vision
- Common contact person for components of the plan (possibly who is included in diagram wheel)
- Be sure when developing objectives for workforce develop, to outline more specifically how the entities like the School of public health will interact in this process
- Voices have been heard
- Plan is intended to raising level of public health services and not create level of fear

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- Occupational Health could be involved and integrated
- Locals can remain autonomous but opportunity to collectively address issues and share resources
- Grounded in the 10 essential public health services
- Consistency: Leading to better community partnerships reducing duplication and better data.
- Orientation for new public health directors and updates for local boards of health is very useful
- We're off the dime and moving forward
- Have come a long way since the summit.
- Taking the time to plan the plan.
- Like the workforce development section. This is an important strategy.
 - It values public health as a specialty that needs formal training; places value in our skill set and our discipline.

Partnerships

- There is a platform for integrating Environmental Health and Public Health, but not much of a discussion about the connection and formal integration/partnership between Environmental Health, Public Health and Human Services and others within the public health systems in communities.
- Relationship of state plan related to national standards/accreditation
- Plan bringing state and local public health with others into the process of working together
- The document developed unity and continuity between agencies
- Missing partners County attorneys, Admin directors, Finance directors. Explore opportunities to engage others involved in health and safety (injury prevention, EMS, Safety groups, land use planners)
- Plan encourages Increased engagement with partners including commissioners
- should strengthen relationships between public health and environmental health
- strengthen relationships in other areas i.e. Public health/social services, mental health
- collaborative practices between disciplines

Educating and Marketing Public Health

- Engaging community members enables communication of value of public health and what we do.
- Need a marketing plan.—to public, elected officials, other system partners.
- Assessment will help with marketing—need consistent, comparable statistics to demonstrate the need for public health.

Funding and Resources

- need for resources in rural areas: workforces, \$\$\$, school of public health
- Sharing resources
- Develop key messaging to “target” groups like elected officials on how this will cost.
- Streamlining of contracts – format should make more sense (front page should be clear); simpler reporting
- This work helps us to educate the community about all the work we do, not just their preconceived notions of public health.
- Political leverage and financial leverage
- pulling together resources to fill in gaps for the community

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

Local

- Can the plan help foster commitment on the part of local elected officials to public health.
- Staff can be engaged in local Public Health plan development/implementation.
- local control to say “don’t have money and can’t”
- Adequate representation from rural
- help rural communities pull resources together and standards
- accountability factors
- Provided the opportunity to improve local health and nursing services relationships

Data and Assessments

- HUGE strength in that we focused on data, use of data, related to outcomes, etc.!!
- Include data component into goals (i.e. goal #2)
- Weighing data with community input
- Consistency for the public in terms of service outcomes.
- Developing common templates and meaningful info/data. Assessment piece is important
- Maybe we haven’t articulated well in this plan the impact of Public Health – to show significant and importance and tie to what we actually do – talking to ourselves. (think broad national security, etc...)
- Best practices
- Grants may have already generated data for assessments
- Standardize expectations for assessment for planning (community assessments), because it has been so inconsistent in the past.

Local Boards of Health

- Missed having County Commissioners involved. Leary about that.
- Recommend having the group figure out ways to sit down and involve County Commissioners.
- How to approach elected officials. Public health folks to engage, one on one or collectively to assure involvement.
- Add more language in Section 4 about elected officials being involved.
- Some locals don’t perceive that it is a local level up process, in part cause commissioners not there rather it looks like it’s coming from the top/state down. “Their plan, not ours”
- Heavy recommendation to local elected officials involved, including State Board of Health. Bring all together in room with PUBLIC HEALTH folks at the local level, hearing other commissioners talk. They are detached, not big buy in from local Board of Health.
- CCI: lack of involvement by CC in public health planning process.

Core Services

- Pleased with the core services—looks like what came out of the Summit, but is better.
- Plan may be able to help elevate public health within small counties.
- Plan leads us to examine what services should be provided by whom—
- Initially, staff were concerned that the core services might be too rigid and could impact their jobs and work. After seeing the plan and the flexibility and reinforcement for the validity of their work, they felt more comfortable.
- We need to be careful how we explain the plan and services and how they are financed

Challenges in the Plan

General

- Environmental health Core Service—doesn't address potential of conflict of interest between BOCC and BOH (ethics agreement is need)
- Accomplishments are not accurate
- Plan needs to be accessible. Clear language, table of contents, not boring, understandable. Needs to be a teaching tool. *
- It's hard to even agree to this vague plan, so how will we be able to agree on standards, etc.
- How does the plan provide impetus to do business differently? Need leadership at levels and the courage to change.
 - Need to title the recommendations to help locate yourself in the plan
- Not all of the input weren't added by OPP *
- Whole Plan: There are things not defined. (P 14 examples; Example: "Educate workforce"—not measurable. Focus group the plan with different audiences (BOCC's, etc.) for clarity.
- Stronger environmental health and public health connection... the concept of public health incorporates the medically oriented and the environmental services. We need to start thinking of them together under the one umbrella of environmental health
- The plan isn't really much better than what we have now.
- Long and tedious process
- Gaging political will be important—do we have a power and authority to do the work?

Funding and Resources

- Inequity in funding based on population versus need (Block Grants, per capita funding) Seek other models for funding distribution (Dept. of Education)
- Funding is yet to be determined and a concern that we will be required to do things that we don't have appropriate funding to accomplish
- Funding can be difficult due to Tabor, recession issues, balancing the budget, and legislative decisions
- We are not a strong enough voice collectively and individually with legislators to ensure the success and funding for public health.
- Page 10: Recommendation 1: Funding Formula for local agencies needs to be based on more than numbers of people.
- Roles and Relationships or Funding Formula: State and locals should partner on large federal grants to identify both state and local needs before funding is distributed so locals don't just get "leftovers" or funding on a regional level when local is needed. (EPR; MCH; WIC); Where are duplications? Who needs how much staff, etc.?
- Resources going into the plan is extensive
- Determining the financial components will be difficult.
- We need to add the funding and support for public health lab services – add under health monitoring health status – core service #1
- Rural Health and resources: fear that we cannot do all this with the money we have or that we will lose control locally

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- Resource challenges—will need stretch current money. Will I have to give up some of my money to another county?
- Information and resource sharing – need to find a way to network better and utilize the available resources better
- Funding across state with programs and including economic climate across state and nation; No dedicated funding for changing logo etc.
- We need to establish a mechanism of reporting about who's getting grants and money for various projects, so that we can be aware of natural partners.
- Identify the things that are not readily available everywhere because it does not need to be duplicated if there is the information and resources available somewhere else. Need to capture some of the things that are unique or basic environmental needs that other people may need and put them on a network. But who manages it? Needs to be centralized like CDPHE or CALPHO or school. How do you pay for it? Look at the ideal and what is going on and figure out if you need to upgrade State systems to support the Public Health Act.

Data and Assessments

- Assessment need time, money and state support
- Identify other tools other than Mobilizing for Action through Planning and Partnerships (MAPP) for the community health assessment template
- Need money to do analysis of assessments
- Not a strong focus on Data but should be in goal section
- Lack of environmental indicators
- Availability of local data – timely data, legitimate data samples (costly) and proper usage of data. Cost of data accumulation. Hard to get data you need or not knowing if the data is available and knowing how to analyze. Regional battle.
- MAPP, 6 Sigma, and lean thinking to use with staff about planning and how these public health revitalization activities impact their work and their lives.
- Need to develop a path to transition from numbers-based program reporting to outcome based program reporting.
- state requirements vs. what the community needs (data)

Workforce

- Need to mention other schools and programs other than the Colorado School of Public Health *
- Qualifications for county directors – workforce development section vague for all sections*
- rural can't afford medical certificates
- We need systems, where we can learn, share and connect that we can all feed into as opposed to creating our own systems
- There's emphasis on MPH. Need be more inclusive of public health nurses and other disciplines *
- Workforce part needs to reinforce existing certification programs and continuing education through incentives or penalties (REHS, CHES, etc.)
- Look to national models for developing competencies
- lack of services or opportunities provided through school of public health or school of nursing, and mental health
- waivers need to be phased out (for directors)
- state says "they" local must do one thing whereas the community says another

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- Colorado School of Public Health seems to have a monopoly on the training; linkages within own communities not mentioned.

Small vs Large agency

- Adequate representation from rural counties *
- Smaller health departments have more limitations. Is it possible that standards variable based on size of health department. Are larger health departments asked to do more or less, or are able to do more or less than smaller?
- How do you make the plan real for every person in every agency? Need a marketing plan. Need to find a quick success.
- Disproportionate improvement asked of locals related to state especially challenging rural area; consider infrastructure building
- What is the skill set required in Public Health Agency in relationship to services agency is required to deliver
- Doesn't address infrastructure (facilities, bricks/mortar)
- Planning process on top of other day to day work is quite challenging especially in small agencies
- Hopes that counties will have more accountability

Local Boards of Health

- Local Boards of Health may not be fully aware now – as we are doing this work. There needs to be more training at the local level. SALBOH training and board development possibilities. Is there an orientation process that they will go through to move forward with us on this process? Timing issue because as local boards of health move forward and get trained, the process will have already moved forward.
- Consistency in training for local boards of health with updates and resources after orientation; develop, implement and maintain
- Communicating to BOCC: Need a way to clearly articulate to County Commissioners, the public, new Public Health staff; Need a specific strategy to help directors communicate plan to BOCC.
- Page 15, recommendation #5: SALBOH-Why would local BOH's/BOCC care? With CCI?

Planning and Implementation

- Community Health Assessment should be primary driver, not the plan.
- Need a gant chart or clear timeline, expectations, may need facilitation in smaller health departments may need help facilitating the process since many lack staff who oversees the overall local plan. *
- Partner with other jurisdiction to meet core services if resources are lacking. Will more funds come in to help under resourced areas to meet all parts of plan?
- Be sure language addresses how the state health department will be "graded". Reciprocal evaluation of state and local plans. *
- Identify those that may not see themselves as "public health" workers to help them see that they are part of public health. *
 - *Add more formally to the plan (it's not stated until p.21).*
 - *Include nonprofits in the planning process at local and state level.*

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- Very important to have a rich, diverse, and inclusive group of people (policy, boards of health, county commissioner, businesses and private entities) who are appointed and involved in all of the task forces for funding, planning, core services, etc. *
 - What is the process for assembling these groups (looks like CALPHO and CDPHE doing everything)
- Need to increase the presence of the state role in the plan. Need to add them to key issues of Roles, Responsibilities, Resources and Authority, assuring state follows standards for direct services they provide at county level like TB. (Too Focused on Local Responsibilities: Page 5 (as an example):Too much of a local focus. Capacity—State needs to do this too; Accreditation; Page 7: Outcome evaluations—not specific to locals; State should have to do outcome measures too; Page 9: Recommendation #4: State is involved in Health Planning too; Standards: Some direct services provided at the state level; State should have to meet same standards.)
- List regional coordination as a model of service delivery and explain it.
- Local agencies need to be actively involved with CDPHE in generating the State level plan
- Questions that local level may not have the capacity to create next 5 year plans, especially when staff is running at bare levels and have many objectives to accomplish already
- Concern that the representation with CDPHE to create the State plan will involve directors, rather than include a few people who are not at the administrative/director level. To include those staff perspectives and could contribute to buy in from local “in the trenches” staff once things roll out
- Equally, we need to have policy, boards of health, county commissioner representation in these task forces to ensure their buy-in.
- Challenges in communicate these activities to all of our “baseline” staff, but not overwhelming them. *
- This process is happening due to legislation and it’s going quickly/short time frame.
- What we set up will impact us in the future
- Still see silo issues with services at the state level
- Nothing was seen as too hard or not going to work – However, (pg. 12, under action steps) wording that address how we will strengthen partnerships, identifying best practices, etc. This area needs to include the emphasis on how we will actively pursue capacity and staff help from groups like RIHEL, Co School of Public Health, other universities or colleges, Center for nursing excellence, CPHA, PHNAC, CEHA, and private entities, etc. who are outside of the normal governmental public health system in order to accomplish these great task. Without this being done and incorporated, we will potentially fail in our goals.
- Environmental health is put in a different category than public health
- Guidance is needed to define or clarify the role between public health and other departments that manage environmental services.
- Need to be sure the local priorities with statewide data and priorities are synching together
- The relationship between and public health and environmental health needs to be specified in the Section 4—roles and relationships
- Informatics-Begin with the end in mind. What type of data do we need to walk backwards.; Need one IT solution for interoperability between state programs for locals. There are too many systems; Flexibility needed for small counties who are expected to use multiple systems for small number of events. Can’t they send to state in a common format (fax, word doc, email).
 - Need to talk about technology, especially with partners

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- Huge area of importance and concern, about “brokering” services with other local and state partners, especially related to assurance part of plan. Will state fill gaps that can’t be fulfilled by partners or at local level?
- Page 13: Nursing accomplishments, only two orientations have been held. Wording not clear.

Core Services and Standards

- Core services: seems like there was a way out. Be more specific.
- Defining Public Health’s role within the health care system will help our policy makers, other healthcare providers, the community, and we understand what our true purpose is. The challenge is actually communicating this
- We must focus on prevention and many of the other core functions of Public Health, rather than be so bogged down in direct care services.
- Need Manpower Standards: (expand this bullet 30, bullet 1 on Admin and Governance): and including surge capacity; H1N1 funding has to shift at local level for funding.
- Essential and Core Services: Unclear how the Essential Services and the Core Services are related (especially for the non- Public Health people). Adding a matrix would help illustrate
- Consider Scope of local services and the political, financial and other consequences of choices.
- Need to be sure it lays out vision of services being delivered and funding provided based on need and manpower standards.
- Need for uniformity at the base or core level, quality assurance and quality control.
- Public Health Ready → Health assessment and local accreditation. Have the same staff work on this.
- Administration and Governance; the 11th Essential Service (PHAB). This is the umbrella, and it feels buried.
- if programs are not specifically mentioned commissioners are cutting them MCH, MCP; not mentioned
- may stifle innovative programs
- commissioners will choose to cut services/programs that are not required to be provided.

How will the plan strengthen the public health system in Colorado?

- Lots of support for the plan in its ability to strengthen public health
- New organizational structures have come out of this (e.g. regional coordination)
- Identifies priorities so we are all working in the same direction.
- Should be able to easily describe public health system in Colorado.
- This process “tees us up” for accreditation toward improved outcomes.
- Hopeful that it will help financing of public health.
- Accountability of commissioners *
- May stifle innovation – balance between being specific enough and not being too constricting (don’t limit the potential)
- Will change what the workforce looks like with more emphasis on the MPH and eliminate some of the medical components. Who in the community fill those gaps for us? While environmental component wants to direct the focus from being just on the human health and make sure public health encompasses environmental as well under the umbrella.

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- COMMUNITY BASED community assessment – here is what is important to use. We don't have that level of access so we need that safety net. Prioritize within the community of what is most important.
- Create training plans. Connection between pg 16-17, workforce #1 and 2.
- Opportunity to “do the greatest good for the greatest number of people.” Challenges us to do business differently.
- Encourages partnerships*
- Creates awareness.
- Gets everybody on the same page—here is what a public health agency looks like.
- Sets a professional expectation—what is our commitment to the public health profession. Building levels of competencies and skills*
- Bridging public health and environmental health—will keep environmental health and public health together. Focus environmental health regulation on the health outcomes, rather than just regulation for regulation's sake.
- Consistent outcomes across the state: clean air everywhere*
- Identify successes—market them—improve our image.
- Informatics strengthens data collection
- Counties can define what they will do in their jurisdiction
- Helps focus work and projects – not just following the money *
- Helps to evolve and grow in public health – issues of our time
- public health & environmental health communicate – bringing down silos
- Strategic about long term funding – population health integrated with health care
- Strengthens of public health system – environmental health and public health coming together with other sectors of government *
- can change the public health workforce
- Dialogue and consensus building is good. Hope to find common ground across jurisdictions. Local issues, county lines so arbitrary. Long term impact requires common ground to achieve state and local needs.
- Increases credibility with MDs and hospitals. Brings us together on common goal and unites, vs. fragments us.
- If we have solid plan, relationships do not become the drivers, the plan does, whether we have a charismatic leader and can move forward to advance public health in Colorado.
- Political subdivisions, inadequate financing has placed state and local in opposition. This plan will bring us together in a cohesive way.
- A wide variety of perceptions are held by the public on what public health is. Core services and definitions will help and be a good thing: “ This is what public health does; these are the services.” It will give people something to hold onto; help communicate public health and have more people speak up to county commissioners.
- Implementing recommendation in plan, will provide more resources and accessibility
- Plan to answer questions by evaluation
- Strategic Prevention Framework model through Division of Behavioral Health Prevention Board
- Broaden partners including non traditional partners
- It would be helpful to develop guidance/recommendations for staffing by discipline for local jurisdictions.

Bridge Day Summary: Input Discussion 10:30 am – 12:00 pm, September 30, 2009

- Need to tap into prospective public health workers before the human resource process and link them with opportunities in public health; engaging students in the planning process; engaging the School to ensure needed credentials and competencies;
- Recruiting strategies: Need to tap the Prevention Leadership Council because of their linkage across state agencies and their past thinking and work around workforce.