

Oklahoma State Board of Health Retreat

Chickasaw Retreat and Conference Center

Great Room

4205 Goddard Youth Camp Road

Sulphur, OK 73086

August 14-16, 2015

Retreat Objectives:

- Review, update and finalize the Department of Health Strategic Map: 2015-2020.
- Consider the formal approval of the Department of Health Strategic Map: 2015-2020.
- Conduct a Board Development Session to continue to enhance Board of Health's effectiveness.

Friday, August 14th

Story Boards

5:00 p.m.	Meet and Greet	
6:00 p.m.	Call to Order and Welcome	Dr. Ronald Woodson
	Retreat Mission and Objectives	Tim Fallon
	Healthy Communities Presentation	
	<i>Federal Reserve Bank of Kansas City</i>	Steven Shepelwich
	<i>Federal Reserve Bank of Dallas</i>	Elizabeth Sobel-Blum
	Adjournment	Dr. Ronald Woodson

Saturday, August 15th

8:00 a.m.	Continental Breakfast	
8:30 a.m.	Call to Order & Welcome	Dr. Ronald Woodson
9:00 a.m.	Strategic Planning Effectiveness Overview <i>Discussion and possible action</i>	Tim Fallon
9:30 a.m.	Overview of Strategic Map Work to Date	Dr. Cline
10:30 a.m.	Break	
10:45 a.m.	Strategic Map Work Session 1 <i>Discussion and possible action</i>	Tim Fallon
11:30 a.m.	Summary, Conclusions, Wrap Up	Tim Fallon
12:00 p.m.	Working Lunch	
1:00 p.m.	Strategic Map Work Session 2 <i>Discussion and possible action</i>	Dr. Ronald Woodson Tim Fallon
2:45 p.m.	Break	
3:00 p.m.	Finalize Strategic Map 2015-2020 <i>Discussion and possible approval</i>	Dr. Ronald Woodson Tim Fallon
3:45 p.m.	Summary, Wrap up, Closing	Dr. Ronald Woodson
4:00 p.m.	Adjournment	Dr. Ronald Woodson

Sunday, August 16th

8:00 a.m. Continental Breakfast

8:30 a.m. Call to Order

Dr. Ronald Woodson

Discuss and Finalize Strategic Map 2015-2020
(carried forward from August 15, 2015 if needed)
Discussion and possible approval

Tim Fallon

Board Development
Discussion and possible action

Tim Fallon

PROPOSED EXECUTIVE SESSION

Proposed Executive Session pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

Dr. Ronald Woodson

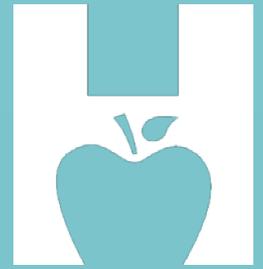
- OAS Investigation #2014-032
- OAS Investigation #2015-015
- OAS Investigation #2015-023

Possible action taken as a result of Executive Session

Adjournment

Dr. Ronald Woodson

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1. Healthy Communities Presentation
2. 2015-2020 Strategic Map Work To Date
3. 5 Year Performance Scorecard
4. Commonwealth Fund Oklahoma Scorecard
5. America's Health Ranking Summary
6. Oklahoma Health Improvement Plan Summary
7. Climate Survey/Public Health Workforce Survey
8. Top 5 Ranked State Strategic Maps
9. Oklahoma State Innovation Model
10. Articles of Interest

HEALTHY COMMUNITIES

Oklahoma State Board of Health
Meeting

August 14, 2015

Steven Shepelwich
Senior Advisor
Community Development
Federal Reserve Bank of
Kansas City



The Federal Reserve System



Ensure a strong economy through monetary policy and supervision of the banking and payment systems.

Community Development at the Fed

- Community Development supports the Federal Reserve System's mission by promoting:
 - Community development
 - Fair and impartial access to credit, and
 - Access to banking services by the underserved.
- Our Approach
 - Research
 - Relationship building
 - Resource development
- Stakeholders include financial institutions, community development organizations, community groups, small business support organizations and government leaders.

Focus Areas in Oklahoma

- **Community Development Investments**
Support efforts by lenders to reinvest in their communities
- **Financial Stability for the Underserved**
Support financial security for individuals and families
- **Small Business Development and Sustainability**
Support small business and micro-enterprise development
- **Workforce Development Initiatives**
Support efforts that promote workforce development
- **Healthy Neighborhoods**
Support housing solutions and sustainable neighborhoods

HEALTHY COMMUNITIES

Oklahoma State Board of Health
Meeting

August 14, 2015

Elizabeth Sobel Blum

Senior Advisor

Community Development

Federal Reserve Bank of Dallas

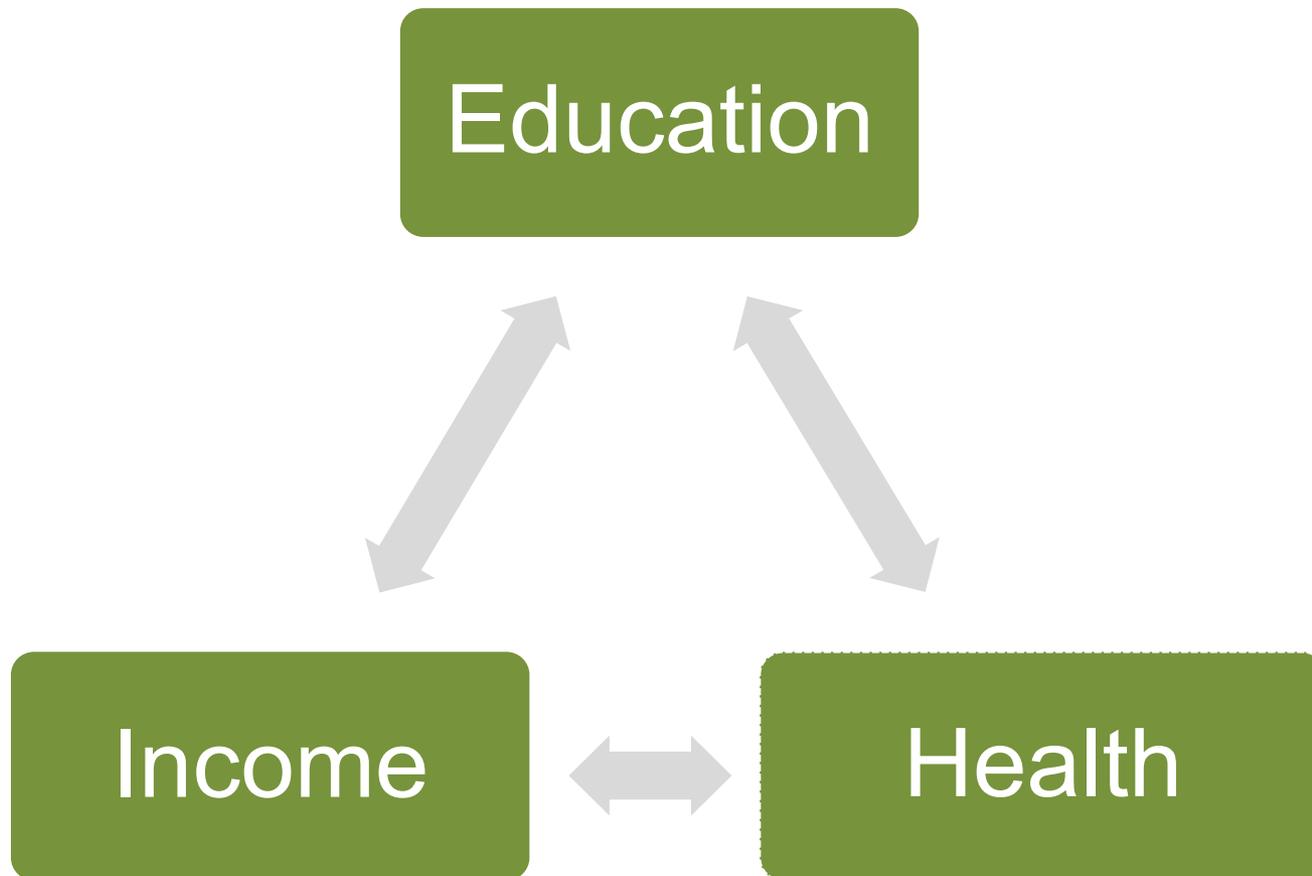


Health of our Nation, Health of our Economy

Disclaimer:

The views expressed here are the presenter's and not necessarily those of the Federal Reserve Bank of Dallas or the Federal Reserve System. Data and facts cited in this report are compiled from public and private sources deemed reliable at the time of presentation.

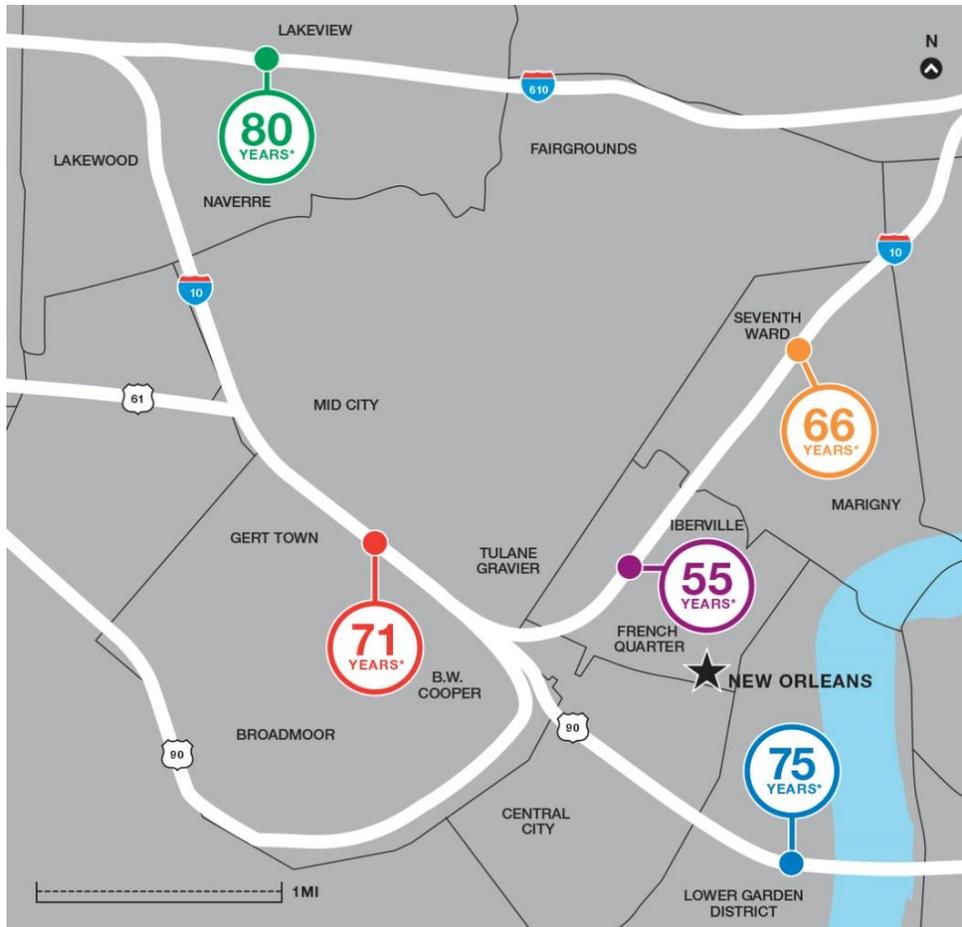
Health is an Asset



Community Reinvestment Act (CRA)

- Enacted to prevent redlining and encourage financial institutions to **help meet the credit needs of all** segments of their communities
- Each bank is evaluated on **how well it serves its “assessment area”**
- Community development activities **(loans, investments and services)**
 1. Affordable housing
 2. Community services targeting low- and moderate-income (LMI) individuals
 3. Economic development
 4. Revitalize or stabilize

ZIP Code Matters



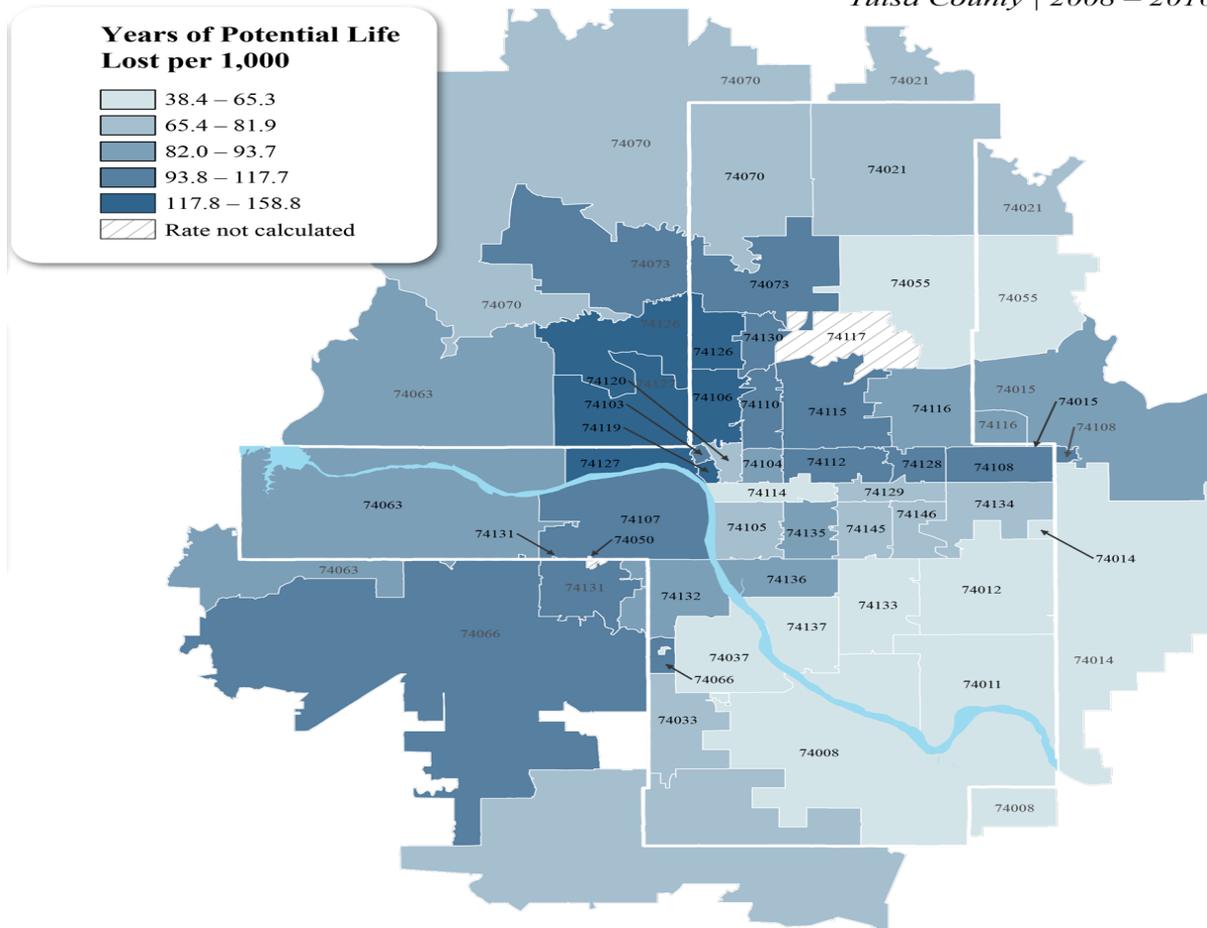
“Across America, babies born just a few miles apart have dramatic differences in life expectancy.

To improve health we need to improve people’s opportunities to make healthy choices— in the places where they live, learn, work and play.”

ZIP Code Matters

Years of Potential Life Lost

Tulsa County | 2008 – 2010

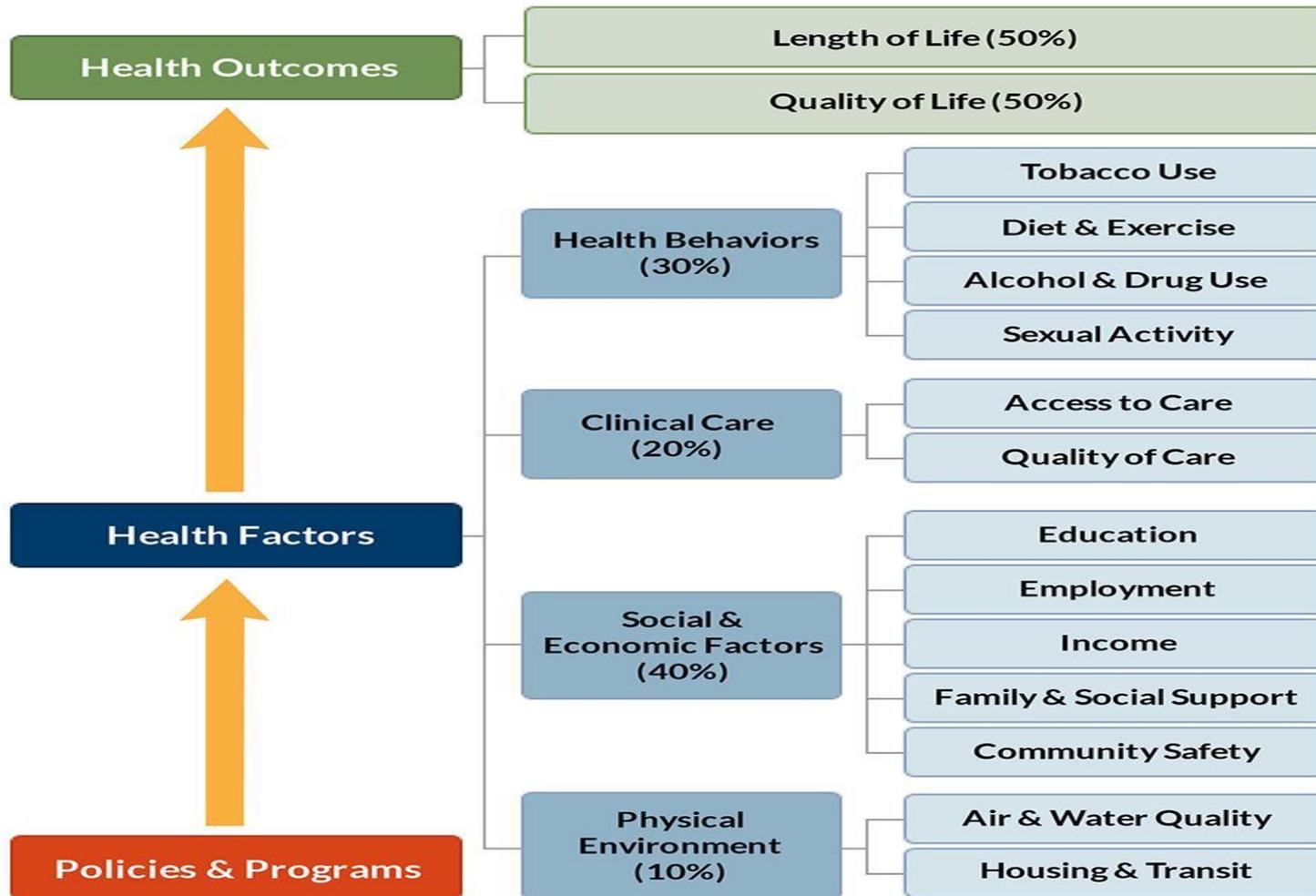


The ZIP Code Improvement Business

The Community and Economic Development Industries:

- Build high-quality, service-enriched **affordable housing**
- Support **small businesses and entrepreneurship**
- Finance **community facilities** (e.g., health clinics, child care centers, charter schools, grocery stores, shelters, community centers)
- Helping individuals build and repair their credit and access **quality financial products and services**

Health & CED Industries' Common Interests: SOCIAL DETERMINANTS OF HEALTH



County Health Rankings model © 2014 UWPHI

PRACTICAL APPLICATION: Public Health Accreditation Standards

The Essential Public Health Services and Core Functions

1. Monitor Health
2. Diagnose & Investigate
3. Inform, Educate, Empower
4. Mobilize Community Partnerships
5. Develop Policies
6. Enforce Laws
7. Link to/Provide Care
8. Assure Competent Workforce
9. Evaluate

PRACTICAL APPLICATION: Public Health Accreditation Standards

Standard 1.1: Participate in or Lead a Collaborative Process Resulting in a **Comprehensive Community Health Assessment**

Standard 1.3: Analyze Public Health Data to Identify Trends in...**Social and Economic Factors That Affect the Public's Health**

Standard 3.1: Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to **Support Prevention and Wellness**

Standard 4.1: **Engage with...the Community in Identifying and Addressing Health Problems through Collaborative Processes**

Standard 5.2: **Conduct a Comprehensive Planning Process** Resulting in a Tribal/State/Community Health Improvement Plan

Standard 6.1: **Review Existing Laws** and Work with Governing Entities and Elected/Appointed Officials to **Update as Needed**

Standard 8.1: Encourage the Development of a Sufficient Number of **Qualified Public Health Workers**

WHO TO ENGAGE: *Banking, Community & Economic Development Industries*



Identifying Opportunities

Healthy Communities Checklist

- Access to Healthy Food
- Access to Medical Care
- Aesthetics: Landscaping, Art, Culture
- Air, Soil and Water Quality
- Building Financial Capacity
- Built Environment
- Early Childhood Development
- Education
- Employment
- Entrepreneurship
- Personal/Public Safety
- Physical Activity
- Public Transportation
- Senior Needs: Accommodation, Care, Services
- Social Networks/
Social Environment
- Social Services

These components are integral to healthy, vibrant, resilient communities.

Appendix: List of Experts

Example: NeighborWorks

- **The NeighborWorks Network**
- **Training and Certification**
- **Foreclosure Resources**
- **National Programs, including:**
 - **NW Community Building & Organizing Programs**
 - **NW Financial Capability Program**
 - **NW in Rural America**
 - **Success Measures**
 - **Green Organization Program**

Healthy Communities Checklist:

- ☑ Air, Soil and Water Quality
- ☑ Building Financial Capacity
- ☑ Built Environment
- ☑ Employment
- ☑ Physical Activity
- ☑ Social Environment/
Community Engagement

HEALTHY COMMUNITIES

“Healthy Communities: A Framework for Meeting CRA Obligations” is available online at www.dallasfed.org/cd/healthy/index.cfm. Select the “CRA” tab for the full report, appendix and checklist.



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**Federal Reserve Bank of Dallas
Community Development**

DallasFedComDev.org

[@DallasFedComDev](https://twitter.com/DallasFedComDev)

Oklahoma City Branch Contact



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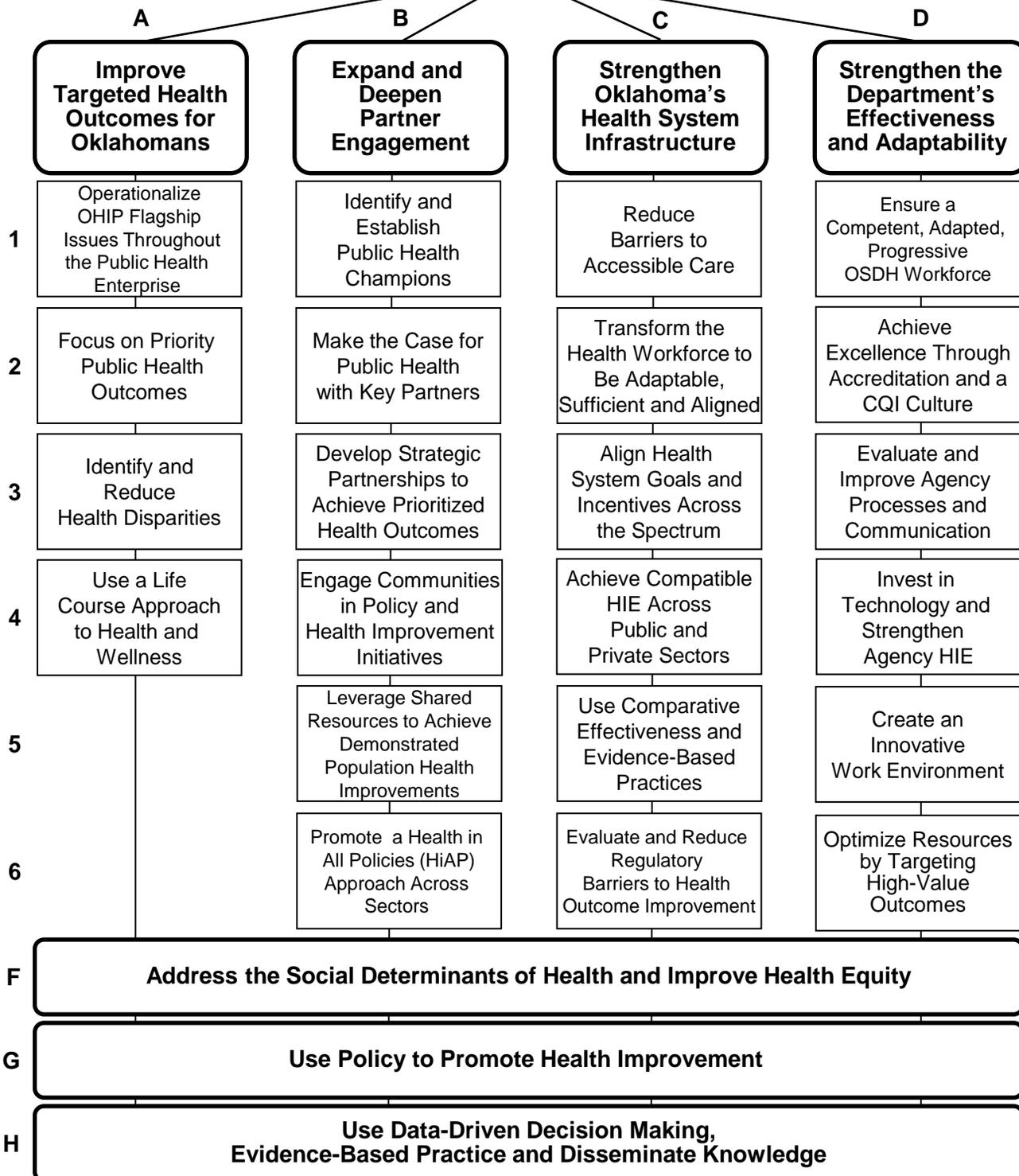
steven.shepelwich@kc.frb.org

**Federal Reserve Bank of Kansas City
Community Development**

KansasCityFed.org/community

Oklahoma State Department of Health Strategic Map: 2015-2020

Draft
07/08/15



Strategic Planning Timeline

Strategic Planning Timeline Overview

·OSDH prepares strategic planning timeline for Board consideration	March - April 2015
·Board of Retreat Planning Committee	April 16, 2015
·Tim Fallon and Stakeholder Focus Group	May 11, 2015
·Tim Fallon and Board Retreat Planning Committee	May 11, 2015
·Tim Fallon and OSDH staff Facilitated Strategic Planning Session	May 14, 2015
·Board of Health Survey Strategic Map Input Period	May 28, 2015
·OSDH Employee Comment Period on Draft Strategic Map	June 9, 2015
·Refinement of Draft Strategic Map per Employee Comments	June 30, 2015
·Board of Health Retreat / Finalize Strategic Planning	August 14-16, 2015
·Implementation	August 2015

Oklahoma State Department of Health

Strategic Planning Meeting Summary

Prepared by:



TSI CONSULTING PARTNERS, INC.

May 14, 2015

Oklahoma State Department of Health

Strategic Planning Session

Meeting Summary: May 14, 2015

INTRODUCTION

The May 14, 2015 session focused on providing a foundation for the Department's next generation strategic map. The session was an important step in the strategic planning process – leading up to Board of Health's retreat in August where they will finalize and approve the strategic plan.

Tim Fallon of TSI Consulting Partners provided an overview of strategic effectiveness (an organization's ability to set the right goals and consistently achieve them) and outlined the session agenda.

- Secure input on:
 - Existing strategic map priorities that should continue
 - The Department's weaknesses/areas of needed improvement
 - Critical issues the Department will face during the next three to five years
 - New priorities for the Department's strategic map
- Review the mission, vision and values of the Department.
- Develop the strategic map to guide the Department for the next five years.

INPUT FOR THE STRATEGIC MAPPING PROCESS

Participants met in small groups to develop input to guide the development of the Oklahoma State Department of Health's new strategic map. Each group addressed the following four areas.

- Continuing Priorities
- Department Weaknesses/Areas of Needed Improvement
- Critical Issues Next Three to Five Years
- New Strategic Map Priorities

A summary of the small group reports follows.

Continuing Priorities

GROUP 1: HENRY HARTSELL, LEE MARTIN, NEIL HANN, BRENDA POTTS, MIRIAM MCGOUGH

- Engage communities.
- Develop collaborative partnerships.
- Social determinants
- PHAB accreditation
- Imperatives/mandates
- OHIP flagship issues
- Education/strategic plan for health systems change

- Health Information Exchange
- Workforce recruitment
- Reduce health inequities.
- Educational resource on public health
- Keep health policy and advocacy, but...
- Comparative effectiveness research

GROUP 2: JON LOWRY, TIM CATHEY, STEVE RONCK, PAM ARCHER, JOE FAIRBANKS, STEPHANIE U'REN

- Improve targeted health outcomes.
 - Secondary target (new box)
 - Triple Threat (new box)
 - Shift from pay-for-service to value-based reimbursement.

GROUP 3: EDD RHOADES, LORI LINSTAD, LINDA THOMAS, TINA JOHNSON, JULIE COX-KAIN, JANICE HINER

- OHIP flagship issues
 - Core public health functions
 - Reduce health inequities.
 - Keep public health workforce but broaden it.
 - Social determinants of health
 - Foster relationships with public and private partners.
 - Broaden and strengthen engagement with communities.
 - Quality improvement/accreditation
 - Evaluate the public health infrastructure.
 - Policy champions
 - Health Information Exchange
 - Maximize resources/business plan.
 - Comparative effectiveness and evaluate science
- Big question: strategic vs. operational

GROUP 4: BETH MARTIN, MARIA ALEXANDER, MARK NEWMAN, TONI FRIoux, BECKI MOORE, JAMES ALLEN

- Improve targeted outcomes.
- Strengthen public health systems.
- Leverage resources (possibly as a cross-cutting priority).
- Public health policy (drop to cross-cutting)

Department Weaknesses/Areas of Needed Improvement

GROUP 1

- Limitations on county health department employees to partner locally
- Limited view of data sharing
- PHAB readiness
 - Capacity
 - Staff awareness

- Comprehensive QI systems integrated into operations
- Documentation
- Lack of competitive salaries
- Communication
 - Internal and external
 - Communications protocols
- Alignment of OHIP, the Strategic Map, the Performance Management Plan and national priorities
- Assumption that the health department is a panacea
- Identifying patterns and trends in data and educating the public/stakeholders

GROUP 2

- Communication – don't know what the other divisions are doing
- Break down the silos.
- Data
 - Not enough free flow
 - Data gaps
- Budget tracking capabilities
 - Software
 - Procurement process
 - Contract and setup lag time
- Hiring
 - Lag time
 - Under-resourced – not enough people, etc.
 - Need more state funding – matching funds
 - Educate communities, municipalities and the legislature.
- Dependent on Office of Management and Enterprise Services
- Technology within the health department
 - Skype
 - Showing websites
 - Delays in getting computers on desks

GROUP 3

- Utilization/operationalization of social determinants of health
- Communication
 - Internal
 - External
 - Targeted and effective
- Information technology
 - Software development
 - Data systems
- Data that effectively demonstrates the value and return on invests in public health
- Funding evidence-based practice and local implementation
- Health inequities/disparities
- Partnerships (P3)
 - Business

- Investment
- Department of Health champions

GROUP 4

- Data exchange, collection, etc.
 - Consistent reporting
 - Support
 - Sharing
- Financial
 - Procurement
 - Accounts payable
 - Staffing
 - Process
- Workforce development
 - Retention: succession, training, recruitment and adaptability
 - Retooling
- Technology
 - Progressive
 - Flexible
 - Infrastructure
- Access to care
 - Staffing
 - Resources improvement
 - Care coordination/navigation

Critical Issues Next Three to Five Years

GROUP 1

- Competent workforce
- Requirements
- Management and leadership development
- Access to primary care
- Shifting demographics
 - A growing, older adult population
 - More older adults in 2015 than children under 5
- The Affordable Care Act – what's next?
- A new presidential administration in 2017
- Eliminating unneeded mandates/requirements
- A new governor in 2019
- Technology
- What should rural health care look like?
- Being caretakers for legacy systems and infrastructure; which ones should go away?

GROUP 2

- Changing system
- Preemption

- Retiring workforce/loss of institutional knowledge
- Aging demographics
- Rural areas
 - Medically underserved populations
 - Outdated health care delivery system in community health departments
 - Loss of nurse practitioners
- Hospitals closing – distances for care
- System consolidation
 - Good and bad
 - Health department needs to fill gaps.
- Where do we deploy limited resources?
- How do we leverage existing resources?
- Insurance keeping pace with the prevention model
- Coordination with private payers
- Work with the tribes to leverage:
 - Tribal resources
 - Tribal data
- Perception of public health in a leadership role
- Political climate

GROUP 3

- Health transformation
 - Health care
 - Public health as an enterprise
- Information Technology
 - Development
 - A mandate for using data in different ways
- Transform the workforce.
- Funding
 - New models
 - Return on investment/public health value
- Addressing the social determinants of health
- Adverse childhood experiences (ACEs)
- Healthy aging

GROUP 4

- Changing technology – keeping up with data needs
- Workforce
 - New roles
 - Aging workforce
 - Recruitment
 - Loss of institutional knowledge
 - Competitive salaries
- Public health transformation
- Diminishing resources

New Strategic Map Priorities

GROUP 1

- Support public health infrastructure change – move past evaluating.
- Workforce development
- Policy development
 - Focus on the community rather than the state.
 - Be more inclusive.
- Aligning work across program areas, such as:
 - Healthy aging
 - Chronic disease
 - Immunization
 - Injury
 - Wellness
 - Regulation
- Health across the life course
- County health department's adaptation to the community
- Health outcomes for regulatory programs
- Being adaptive to population-based needs

GROUP 2

- Secondary targets
- Triple Threat
 - Efficiency
 - Population health outcomes
 - Improve quality/reducing cost
- Value-based reimbursement
- Health in all policies
- Data systems
- Staff leadership development
- Workforce retention
 - Need for increased salaries
 - Younger generation changes jobs more frequently.
 - More money-motivated
- Prioritize hiring grant positions.

GROUP 3

- Rural health (scalability of programs/initiatives)
- Childhood health – not just obesity
- Workforce beyond recruitment
 - Development
 - Support

GROUP 4

- Health informatics
- Health care payment transformation

- Integration with behavioral health

SETTING FUTURE DIRECTION

Overview of Key Elements of Future Direction

Tim Fallon provided a brief overview of the key elements of an organization's future direction.



Vision, Mission and Values

Participants began to set the future direction of the Oklahoma State Department of Health by reviewing its vision, mission and values.

VISION FOR THE OKLAHOMA STATE DEPARTMENT OF HEALTH

Creating a state of health

MISSION OF THE OKLAHOMA STATE DEPARTMENT OF HEALTH

To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy

VALUES OF THE OKLAHOMA STATE DEPARTMENT OF HEALTH

Leadership – To provide vision and purpose in public health through knowledge, inspiration and dedication and serve as the leading authority on prevention, preparedness and health policy

Integrity – To steadfastly fulfill our obligations, maintain public trust, and exemplify excellence and ethical conduct in our work, services, processes, and operations

Community – To respect the importance, diversity, and contribution of individuals and community partners

Service – To demonstrate a commitment to public health through compassionate actions and stewardship of time, resources, and talents

Accountability – To competently improve the public’s health on the basis of sound scientific evidence and responsible research

Strategic Map for the Oklahoma State Department of Health

Based on the input and extensive discussion that followed, the group developed a draft strategic map to act as a foundation for the Board’s consideration during the August 14-16, 2015 retreat. The Strategic map developed by the Board will guide the Department’s efforts during the next five years.

Discussion of the strategic map included the following points.

Central Challenge

- The central challenge, “Achieve demonstrated improvements in population health:”
 - Focuses on improving population health for:
 - All Oklahomans
 - Specific segments of Oklahoma’s population where health disparities exist
 - Emphasizes achieving improvements that demonstrate the value of public health, including its return on investment of resources

Strategic Priorities

- Strategic Priority A, “Improve targeted health outcomes for Oklahomans:”
 - Emphasizes focusing on prioritized health needs where proven interventions will provide significant benefit
 - Stresses using clear health outcomes and the consistent measurement of results to make demonstrated improvements in population health
- Strategic Priority B, “Expand and deepen partner engagement:”
 - Focuses on the increasing need for the Department to work effectively with a wide range of public and private partners across sectors
 - Emphasizes building strong community partnerships
 - Stresses using partner engagement to achieve demonstrated improvements in population health
- Strategic Priority C, “Strengthen Oklahoma’s health system infrastructure:”
 - Focuses on a comprehensive approach to Oklahoma’s health system infrastructure
 - Includes public health, the health care delivery system and a broad range of public and private partners across sectors
 - Also includes the future health workforce and enabling infrastructure such as Health Information Exchange
- Strategic Priority D, (***subsequently merged with Strategic Priority E***) “Optimize resources by targeting high-value outcomes:”
 - Emphasizes the Department’s continuing efforts to focus limited resources on those areas with the best potential to improve targeted health outcomes for Oklahomans
 - Stresses the need for each Department program and unit to make thoughtful resource allocation decisions in order to target those outcomes that produce the most benefit for Oklahomans

- Strategic Priority E, (*subsequently merged with Strategic Priority D*) “Strengthen the Department’s effectiveness and adaptability:”
 - Focuses on continuing efforts to improve the Department, preparing it to adapt to a rapidly changing environment
 - Prioritizes those organizational improvements that have the best potential for improving population health.

Cross-Cutting Strategic Priorities

- At the bottom of the strategic map there are three cross-cutting strategic priorities. In strategic map logic, cross-cutting strategic priorities:
 - Are placed at the bottom of the strategic map to show that they are foundational to the strategy
 - Span the map from left to right to demonstrate that efforts to achieve the cross-cutting priorities will be embedded in the efforts to implement all the other strategic priorities on the map
 - No plan to implement the other strategic priorities will be considered complete unless it includes emphasis on the cross-cutting priorities.
- Cross-cutting Strategic Priority F, “Address the social determinates of health and increase health equity:”
 - Focuses on a strategic approach to addressing the factors – such as poverty, education, transportation and the built environment – that impact the health of Oklahomans
 - Emphasizes the critical importance of increasing health equity – particularly for vulnerable and underserved populations in Oklahoma
 - Stresses the importance of multi-sector public and private partnerships to address these fundamental issues
- Cross-cutting Strategic Priority G, “Promote Health Improvement in All Policies:”
 - Focuses on the critical role of policy in improving population health
 - Emphasizes a broad-based understanding and approach to policy that includes legislation and regulation as well as organizational policy and social norms
 - Stresses the critical importance of ensuring health is a significant consideration in development and implementation of all policy
- Cross-cutting Strategic Priority H, “Use data-driven decision making and knowledge dissemination:”
 - Focuses on the importance of making effective use of data to guide the Department’s decision making
 - Emphasizes making effective use of data to demonstrate the value and return on investment of specific improvements in the health outcomes of Oklahomans
 - Stresses fostering data-driven decision making and knowledge dissemination among constituents and partners across sectors in order to optimize collaborative approaches to improving population health

Objectives Supporting Each Priority

Strategic Priority A, “Improve targeted health outcomes for Oklahomans,” is supported by **objectives** that:

- Focus on operationalizing the flagship issues identified by the Oklahoma Health Improvement Plan:
 - Tobacco use prevention
 - Children’s health improvement
 - Obesity reduction
 - Behavioral health
- Emphasize core public health priorities, using a scorecard to track progress on improvements.
- Prioritize reducing health disparities for specific segments of Oklahoma’s population, particularly those that are vulnerable and underserved.
- Emphasize a life course approach to healthy aging that recognizes the impact of adverse childhood experiences throughout a person’s lifetime.

Strategic Priority B, “Expand and deepen partner engagement,” is supported by **objectives** that:

- Stress the importance of making a compelling case for the value and contribution of public health among key partners.
- Emphasize establishing public health champions to help the Department communicate the need for and value of public health.
- Foster strategic partnerships across the public and private sectors and the engagement of communities to improve population health.
- Stress leveraging the shared resources of the Department and its partners to achieve targeted improvement in health outcomes for Oklahomans.

Strategic Priority C, “Strengthen Oklahoma’s health system infrastructure,” is supported by **objectives** that:

- Focus on a broad approach to health system infrastructure that includes public and private partners across all sectors.
- Emphasize transforming the public health workforce to meet current and future needs.
- Support Health Information Exchange as an enabling technology to align public and private sector partners.
- Stress reducing barriers to access to care and aligning health system goals and incentives.
- Use comparative effectiveness and evidence-based practices to improve population health.

Strategic Priority D, *(subsequently merged with Strategic Priority E)* “Optimize resources by targeting high-value outcomes,” is supported by **objectives** that:

- Focus the Department’s resources on targeted health outcomes for Oklahomans, including the Oklahoma Health Improvement Plan’s flagship issues.
- Encourage Department leaders at the program and unit levels to align their limited resources with those outcomes that produce the most benefit for Oklahomans.
- Expand the Department’s reach and influence by motivating and engaging stakeholders in addressing prioritized needs.

- Use health impact assessments to optimize the outcomes of private sector and community initiatives.

Strategic Priority E, ***(subsequently merged with Strategic Priority E)*** “Strengthen the Department’s effectiveness and adaptability,” is supported by objectives that:

- Complement Strategic Priority C, “Strengthen Oklahoma’s health system infrastructure,” by emphasizing Department-specific efforts that are necessary to ensure its effectiveness and adaptability.
- Focus on the Department’s efforts to ensure it has the right workforce to meet the current and future needs of Oklahomans.
- Emphasize developing an innovative work environment focused achieving excellence through a CQI culture and accreditation.
- Stress using technology, Health Information Exchange and the right work processes to achieve demonstrated improvements in population health.

Further Work to Refine the Map

At the conclusion of the meeting, some concern was expressed about the use of the word “high-value” in Strategic Priority D, “Optimize resources by targeting high-value outcomes.” While some further editing may be necessary, participants agreed on the following points.

- The Department needs to continue optimizing its resources by allocating them in support of key priorities – such as the OHIP flagship issues.
- Priority D is also intended to guide staff throughout the Department – urging them to focus their limited resources on the outcomes that will produce the most benefit for Oklahomans.
- Priority D is not intended to send a message that devalues Department staff or creates concern about the importance of their work.
- ***Priorities D & E were subsequently merged.***

NEXT STEPS

At the conclusion of the meeting, participants identified the following next steps.

TSI’s Next Steps

Tim Fallon will provide the following documents to Julie Cox-Kain for distribution to session participants.

- The strategic map
- The meeting summary for the strategic planning session
- A “presentation version” of the strategic map
- A protocol for the communications session

Finalizing the Strategic Map

Finalizing the strategic map will include the following steps.

- Communicating the draft strategic map to staff in the Department and securing their feedback on it
- Making any necessary revisions to the strategic map based on feedback from Department staff

- Using the Board Retreat in August to:
 - Secure Board and stakeholder input on the strategic map.
 - Make final revisions to the map based on the Board's direction.
 - Secure Board approval of the final strategic map.

Implementation of the Strategic Map

After the Board approves the strategic map, it will be used to guide the Oklahoma Department of Health for the next five years. This will include:

- Developing and implementing the Department's business plan based on the strategic map
- Conducting periodic review and adjust sessions to:
 - Review of progress with implementation of the strategic map and its key priorities, including:
 - Accomplishments
 - Issues/problems/gaps
 - Lessons learned
 - Recommendations for improving the strategic map and efforts to implement it
 - Reviewing the strategic map and the business plan, making any needed adjustments

Completing an annual strategy update to:

- Review progress on implementation.
- Update the strategic map based on:
 - What's working and what isn't
 - What was learned from implementation
 - How the environment has changed
- Set implementation priorities for the next 12 months.
- Use the business plan to align the Department's human and financial resources with its strategic map.

Oklahoma State Department of Health

Stakeholder Focus Group: May 11, 2015

PARTICIPANTS

- Bob Jamison, Oklahoma City County Health Department
- Reggie Ivey, Tulsa Health Department
- Tracey Strader, Tobacco Settlement Endowment Trust
- Carrie Slatton-Hodges, Oklahoma Department of Mental Health and Substance Abuse
- Jessica Hawkins, Oklahoma Department of Mental Health and Substance Abuse
- Gary Raskob, University of Oklahoma College of Public Health
- Nico Gomez, Oklahoma Health Care Authority
- Monica Basu, Kaiser Foundation
- Craig Jones, Oklahoma Hospital Association
- Richard Marshall, Housing Authority
- Melissa White, Department of Education
- Brent Wilborn, Primary Care Association
- Ted Haynes, Blue Cross Blue Shield

STRENGTHS OF THE OKLAHOMA STATE DEPARTMENT OF HEALTH

- Mission orientation
- Enhanced approach to health improvement
 - Focus on health outcomes
 - Use of evidence-based strategies
 - Emphasis on the social determinates of health
 - Use of data in making decisions
 - Defining health broadly to include behavioral health and wellness
 - Linking acute care and public health
- Leadership of Dr. Cline and Julie Cox-Kain
 - Strong collaboration and coordination
 - The ability to make connections across the state
 - Leadership with the local health departments
 - Cooperative relationship with the Tulsa Department of Health and the Oklahoma City County Health Department
- The structure of the Commissioner's role links leadership of the Department of Health with a role in the Cabinet.
- The ability to engage the Governor in issues related to public health
- The Department staff's passion for public health
- Strong public health expertise
- The Department's surveillance systems
- Establishing the Office of Tribal Liaison
- Partnerships with organizations across all sectors – public and private
- Fairness and inclusiveness

THE DEPARTMENT'S WEAKNESSES/AREAS OF NEEDED IMPROVEMENT

- Increasing data access and data sharing
 - The state has control of the data.
 - The Department seems unwilling to innovate; it doesn't want to get out of the box.
 - The lack of data sharing makes it very difficult for our agency.
 - We're completely dependent on the Department for data.
 - Lack of data sharing delayed the approach to addressing teen pregnancy.
 - We need county-level data. The Robert Wood Johnson Foundation has county health rankings, but we're not using them.
 - In regard to infant mortality, we've known for years that blacks have twice the infant mortality rate of whites. Rather than emphasizing statewide initiatives, we need the data to target specific areas where we can make improvements.
 - With the data they have, they are pretty good. It's a resource issue; and, to some extent, it's a technology issue.
- Health Information Exchange
 - The health department doesn't want to put its information on the HIE.
 - It wants to develop its own Health Information Exchange.
 - The Department is reluctant to give up control.
 - It could be outsourced and done tomorrow.
 - There will be multiple exchanges, but it's important that they talk to one another.
- We need to find mechanisms to decrease the number of uninsured people.
 - The lack of access to federal funding for insurance is frustrating.
 - Leadership should speak with one voice on that issue.
 - The Department needs to take a leadership stance.
 - It should accept and support the Oklahoma Hospital Association plan.
- Although the linkage of the Commissioner's Department of Health and Cabinet roles is helpful in some ways, it is also limiting from a political perspective.
 - There are statutory limitations on state employees being involved in advocacy.
 - The Commissioner is not always able to take unpopular stands that are best for the people of Oklahoma.
 - There is legislation being considered that would give the Governor the authority to appoint the Commissioner of Health.
 - That would be a very bad move leading to:
 - Increasing the political aspects of the Commissioner's role
 - Shortening the tenure of Commissioners
- Although Department leadership is strong, that's not true down through the organization.
 - There's a lack of training and skill depth down through the organization.
 - Increased training and development is needed at the middle management level.
 - Some are more bureaucratic than others; it depends on the person.
 - They need the mindset and tools to see more than one way to do things.
- Staff turnover/instability
 - It's hard to know who's in what position.
 - We don't know who makes decisions and who reports to whom.

- The limitation of resources and the lack of resource flexibility make prioritization difficult. It limits the ability to allocate resources to what's most important.
- Children First works well in Tulsa and Oklahoma City.
 - In the rural areas, there are open positions that go unfilled.
 - Those positions either need to be filled or the resources should be shifted to other locations.

CRITICAL ISSUES THE DEPARTMENT WILL FACE – NEXT THREE TO FIVE YEARS

- The shortage of financial resources as a result of state budget cuts
 - There's a "disconnect" on legislative mandates.
 - Rules and regulations still need to be implemented even though there are significant budget cuts.
 - The legislature doesn't consider that when it allocates resources.
 - The Department is forced to carry out the same mandates with fewer resources.
 - The lack of resources can create a survival mentality.
 - There needs to be a conversation with the legislature about how to meet the same expectations with fewer resources.
- There is a legislative ideology that is leading to reducing and minimizing government.
 - That anti-government mentality will characterize the next three to five years.
 - The assumption is that there's excess and waste in government.
 - The mentality will be to cut assuming there's bureaucracy and waste.
- Focusing on ensuring the Department has the human capital it needs
 - Workforce development
 - Succession planning
 - Particular emphasis is required at the leadership level.
- Determining how the State will provide appropriate laboratory support
- Health care providers are undergoing tremendous changes, including the shift to value-based payments.
 - We need to determine innovative ways to make everyone healthier.
 - This includes focusing more resources on the social determinants of health.
 - As resources decline, we need to do this to increase leverage.
 - This includes looking at things like economic development, graduation rates, and so on.
- Health literacy is a significant issue, particularly with those that are newly insured or have never had insurance.
- ACO networks and other innovative models need to include public health.
- The My Heart program had strong results by focusing on a single zip code.
 - The community health center trained community health workers to go into beauty shops, barber shops and other public places to do screening for blood pressure and cholesterol.
 - For two years, we created strong linkage with the treatment side and wellness classes.
 - That zip code is no longer the worst.
 - We need to look at innovative approaches. Unfortunately, there's no reimbursement code for community health workers.

- Recent legislation on access to medication has negative implications for some people. They have to visit a pain clinic once a month or they lose access to their medications.

PRIORITIES THE DEPARTMENT SHOULD CONSIDER IN DEVELOPING ITS STRATEGY

- Increase access to care.
- The large number of uninsured has impact on:
 - Health disparities
 - High blood pressure and high cholesterol
 - Increased rates of addiction and other behavioral health issues
 - Lack of preventative care – which results in health incidents that require hospitalization
 - All partners need to look at that together across the state.
- Support the Oklahoma Hospital Association initiative.
- If a federally qualified health center runs out of funding, the Department should continue to provide uninsured care. That used to be the case, but it no longer is.
- Continue to focus on the OHIP flagship issues.
 - Tobacco use prevention
 - Children’s health improvement
 - Obesity reduction
 - Behavioral health
- In regard to the four OHIP flagship issues, we know resources will be cut.
 - As resources are cut, how do we focus on what’s most important?
 - What does the evidence say?
 - We need to be able to focus on evidence-based policies.
- We need to get to the next generation to change health habits and behaviors.
 - We need to reduce the incidence of obesity and Type 2 Diabetes.
 - It’s good to see that the Department of Education is here.
- Stress integration of care across public health and private providers.
- Increase partnerships. The Department needs to leverage opportunities to work with the private sector.
- Increase the diversity of the Department.
 - Leadership beneath the Commissioner is not as diverse as it needs to be.
 - Diverse leadership is important to provide community role models.
 - The composition of the Department needs to look more like the composition of the state.

WAYS THE DEPARTMENT CAN SUPPORT YOUR ORGANIZATION

- Provide effective access to data.
- Provide good public policy on health issues.
- The emphasis of the Kaiser Foundation is on young children.
 - We would like to ensure there are home visitation programs to provide help to low income parents/families.
 - Every parents needs to be touched; they need role models.
 - ParentPRO is not well staffed.
- The Department of Education needs to lean on the Department of Health.

- We no longer have staff in areas of health.
- When Title IV was discontinued, that staff went away.
- As a result, we need the Department of Health to provide us with appropriate data and expertise.
- Then, the Department of Education can become a conduit to disseminate that information.
- 41% of Blue Cross Blue Shield members are in rural Oklahoma.
 - We need community health workers and other approaches to improving their health.
 - Long term, it's important to determine what the right health presence in rural communities is.
 - It requires a paradigm shift, and we need to think outside the box.
 - The Department has established dialogue within the communities, and it needs to build on that.
- I'd like to see the Department of Health share hires with the School of Public Health. This would link teaching and evidence into practice.
- The Department can help ensure health care is affordable for someone who works but only makes \$10 an hour.
- The Department can build trust by:
 - Ensuring the staff "looks like me"
 - Providing information in a format that I can access and understand
- Ensure the Board of Health represents the Department's stakeholders.
- Simplify the contracting process.
 - It's as though each contract we have with the Department is with a different agency.
 - Each contract has different requirements for budgeting, auditing and contracting.
 - Even though it goes through the same procurement office, the requirements are different.
- We need a political action committee for health.

OTHER COMMENTS

- The Department of Health has good communication and collaboration with:
 - Medicaid
 - Tobacco Settlement Endowment Trust
 - We have strong focus on a common goal.
- The OHIP Plan is staffed by the Department.
 - At present, it's a collection of ideas.
 - We need to understand what's most essential.
 - We need to know who's doing what by when.
- As the Department does its strategic plan, it needs to be integrated across the agency – not siloed in programs or sub-units.

OSDH Strategic Map Survey

Total Respondents - 421

Summary of Employee Survey Comments

Note – Several survey respondents commented on the fact that measures for the goals in the strategic map are not provided and that more detail is needed as to what specific objectives are to be met. This will be addressed as the program areas develop their STAT plans. By design, the strategic map is intended to serve as a summary / high level document and is understood to have more detail behind it via STAT, service area and county health department plans as documented in StepUp.

Q1 – What do you see as the strengths of the proposed strategic direction?

- Easy to read map / easy to understand and communicate
- In line with the direction public health is moving
- More specific and focused
- Partnerships / community engagement
- Addresses core public health priorities
- Lifecourse approach
- Data-supported decision making
- Focus on health disparities / health equity
- Multi-faceted approach
- Comprehensive
- Evolving workforce
- Evidence based and use of QI
- Brings everyone together
- Engages both central office and counties
- Strengthen the Department's Effectiveness and Adaptability

Q2 – What issues or concerns do you have about the proposed strategic direction?

- Concern that staff will not see themselves or their roles in achieving the strategic map goals
- Difficulty interpreting what is meant by terms such as “evolving workforce”
- Concern about how the plan connects at the local level
- Input needed from local, front line staff in the development of the strategic map
- Concern about employees understanding the strategic map
- Too many acronyms / too much jargon
- Cross cutting areas (F,G and H) need objectives
- Objectives overlap with each other, duplicative, too many objectives
- How do we communicate and disseminate this information down to front line staff and county staff?
- The strategic map is often interpreted by survey respondents as a strategic plan, and thus there are questions about sequencing (goals vs. objectives vs. activities) and measurability
- Concern about adequate resources (funding, personnel and technology) to implement the map and agency funding sustainability
- Strategic map is sometimes interpreted according to the job function of the survey respondents and not well understood
- Need to improve health internally with our own staff
- Concern about how the map connects to and involves county staff
- Overly broad
- Health protection (mandates) not addressed (or not readily visible to staff)
- Securing staff buy-in

- How to implement
- Much of the population change is out of our control / influence
- Need for increased/improved communications
- Need to focus on employee morale and wellbeing
- Broaden from Focus on Life Course to Healthy Aging to Wellness Across the Lifespan
- Not enough focus on prevention or protective factors
- Policy development and implementation is not clearly identified

Q3 – What suggestions do you have to ensure successful implementation?

- Connect people to the plan
- Health Across the Lifespan instead of Healthy Aging
- Hold a launch event
- Communicate with front line / county staff regularly
- Keep staff informed, trained and involved in strategic plan
- Share the plan with counties in person
- Value the workforce and the clients through engagement
- Community involvement
- Staff need to model healthy lifestyles
- Senior leadership each sponsor one major priority area of the map
- Feedback from clients on this map
- Managers regularly update staff on strategic map progress
- IRENE site for making suggestions going forward

- Ensure necessary data is available
- Ensure appropriate resources are available to implement the plan
- Narrow the focus
- Ensure appropriate pay/compensation

Q4 – Any other comments that will be helpful in strategic plan development?

- What does an “aligned workforce” refer to?
- Terms and concepts on the map are not clear (example, HIE)
- Communication
- “Adequate” does not describe excellence
- Seen as an add-on rather than how we carry out existing efforts
- Innovation not valued currently
- Scorecard for core performance does not highlight disparities
- Emphasize support from the private sector and from the legislature / Governor
- Simplify the plan
- Assure that agency policy is in line with the strategic plan
- Not clear how individual staff connect to the map
- Have meetings with staff to discuss the plan and solicit input that way
- Focus on lifespan which cuts across programs and can reduce turf
- Staff need to model healthy lifestyles
- Salaries need to be competitive
- Implementation is key
- Align plan with community partners

- Need electronic medical records/technology is important
- Reward innovation
- Push the plan out to citizens so they can see how it impacts them
- Language on the map needs to be understandable
- QI should be a cross cutting objective
- Much of the public's health is outside of our control
- Clinical services are important even though not population-based
- The environment is different for rural health departments / central office does not understand
- Move social determinants from the bottom to the top
- Those implementing the plan need to be at the table
- Give regular updates to all staff of our progress as the plan is implemented

**Oklahoma State Department of Health (OSDH)
2010–2015 Core Measure Performance Scorecard**

The following OSDH Performance Scorecard includes selected performance measures established in the 2010-2015 OSDH Strategic Plan. The scorecard offers a snapshot of data and information across the Department and is one tool used to monitor and improve performance.

It should be noted that data for each measure is drawn from the best, most current available data source and measures the degree of change for the time period indicated in the scorecard.

Routine review by the agency is conducted whereby data is compared against the original target and that may result in modified, removed, or newly adopted measures throughout the implementation period (2010-2015). This process is necessary to ensure realistic, relevant and achievable targets are established. The scorecard includes measures established at the beginning and throughout the implementation period in which five years of program implementation did not occur.

Color was assigned based on the rate of improvement as follows:

-  Target Met or Exceeded
-  Within 5% or Less of Target
-  Greater Than 5% From Target

The scorecard is concluded with a brief explanation of why particular performance measures did not meet the target as evidenced by assignment of yellow or red to the measure. Following the scorecard and explanation, is the 2010-2015 strategic map as a reference to demonstrate the placement of each performance measure within the map.

Oklahoma State Department of Health (OSDH) 2010–2015 Core Measure Performance Scorecard

The measures in this Scorecard were established in the 2010-2015 OSDH Strategic Plan.

Baseline and actual data were drawn from the most current data sources available for each measure during the implementation period.

Strategic Map Reference	Measure	Baseline Data	Target	Actual	Current Trend
A2	Inspection - % of state mandated non-complaint inspections meet frequency requirements *	100%	100%	100%	↑
A2	Inspection - % of state mandated complaint inspections meet time deadlines *	91%	100%	95%	↑
A2	Infectious Disease - % of immediately notifiable reports in which investigation is initiated by ADS within 15 minutes	96%	95%	100%	↑
A2	Infectious Disease - Incidence of tuberculosis, pertussis, hepatitis A, and indigenously-acquired measles cases per 100,000 *	7.2	6.74	5.6	↓
A2	Preparedness - Improve State Score on National Health Security Preparedness Index by 0.5% *	7.3	7.5	7.6	↑
A1	Children - # of infant deaths per 1,000 live births	7.6	6.7	6.8	↓
A1	Children - % of first trimester prenatal care **	65%	69.9%	68.5%	↑
A2	Injury - # of motor vehicle injuries in infants less than one year of age	105	93	88	↓
A2/D2	Prevention - # of preventable hospitalizations per 1,000 Medicare enrollees *	81	76.95	76.9	↓
A2	Immunization - % of immunized (19-35 months - 4:3:1:3:3:1:4) *	61%	72.4%	64.8%	↑
A1	Obesity - % of adults who are obese **	31.1%	31.5%	32.7%	↑
A1	Tobacco - % of adults who smoke **	26.1%	21%	21%	↓
A2	Cardiovascular - # of cardiovascular deaths per 100,000	151.9	135	148.1	↓
C3	Accreditation - # of PHAB accredited OSDH Health Departments in OK	2	5	2	→
C5	Public Health Partnerships - # of certified healthy community	43	96	77	↑
C5	Public Health Partnerships - # of certified healthy schools	155	565	595	↑
C2	Workforce - % of turnover agency wide *	12.9%	10%	13.2%	↑
C4	Immunization Interoperability - # of interoperable immunization systems *	0	1 (2018)	0	→
B1/B2	Policy - # of community organizations supporting OHIP legislation	0	13	13	↑

* Core measure adopted or modified during implementation period.

** Surveillance methodology changed during implementation period. Results can only be compared to 2011 forward.



Demonstrates placement of measure within attached 2010-2015 map



Target Met or Exceeded



Within 5% or Less of Target



Greater Than 5% From Target



Trend is positive



Trend is positive



Trend is negative



No Change

Scorecard Explanation for Unmet Performance Measures 2010-2015

Inspection Frequency Mandates: All complaints representing the highest potential harm, or immediate jeopardy, were timely investigated within two days. Of 331 other high-priority complaints, 324 (98%) were timely investigated within 10 days. The average time from complaint receipt to investigation for all 331 high priority complaints was 6 days. The remaining 36 (4%) investigations not timely performed were for medium and low priority complaints that did not represent actual harm to residents and should have been investigated within 25-30 days. The average time to investigate the medium and low priority complaints was 21 days. Overall compliance for 27,622 state and federal inspections (complaint and non-complaint) was 99.8%.

Prenatal Care: Slow but steady improvement over the last three years (approximately 5.4% relative positive increase) has been made from 2010 - 2013 in first trimester prenatal care in Oklahoma. Entry into prenatal care depends both on the health care system as well as women's individual characteristics. Additional emphasis has been placed on best practices in relation to women being healthy before, entering into, and during pregnancy for optimal outcomes for mother and baby. Multi-factorial interventions have been initiated including maternity clinics providing prenatal care, family planning clinics promoting early entry into prenatal care for clients with a positive pregnancy test, extensive evidence-based home visiting programs, initiation of the Women's Health Assessment tool promoting reproductive health planning, online enrollment assistance for Medicaid programs, targeted outreach and community resource linkage efforts in county and city-county health departments, the Oklahoma Perinatal Quality Improvement Collaborative, the Text4Baby social marketing tool, and the Preparing for a Lifetime and national CoIIN programs and initiatives.

Immunization: The 2010 goal (increase the 4:3:1:3:3:1 vaccine series immunization rates of children 19-35 months to 77.5% by 2015) was amended in 2013 with the addition of four doses of Prevnar (pneumococcal 7-valent conjugate) to the series (4:3:1:3:3:1:4). Factors that continue to challenge efforts include the escalating cost of vaccines and affordability for providers; delayed and/or reduced reimbursement rates from private insurance plans; diminished federal resources and changes in federal vaccine regulations; increased vaccine hesitancy by parents augmented by Oklahoma State Law which recognizes vaccine exemptions related to medical, religious or personal reasons. It should also be noted Oklahoma rates are lower than the national average. Lack of accessibility to required vaccines is becoming increasingly difficult for those children who are privately insured. Activities to improve childhood coverage rates are focused on increasing vaccine availability in county health departments for insured families; evidenced based practices such as recall/reminder, decreasing missed opportunities, and increasing partner involvement with the Caring Foundation and the Caring Van. Quality improvement initiatives have been launched such as the Child Care QI Project to increase compliance and the Assessment QI Project using the Assessment, Feedback, Incentives and eXchange (AFIX) Model.

Obesity: While a large, statistically significant increase in adult obesity was prevented between 2011 and 2014, a decrease in obese individuals has not been achieved. The slowing of the rate of growth in obesity is important as Oklahoma was projected to be the most obese state in the nation by 2013. Currently ranked 44th, this slowing in the trend line has potentially prevented thousands of Oklahomans from obesity and associated disease. Obesity is a complex and relatively new, emerging public health issue. Because of this, there is limited definitive evidence that point to particular statewide policy and environmental strategies for reducing obesity. Oklahoma implements promising practices in a voluntary and local manner that leads to slower change. In addition, obesity is a slow reversing condition. Once the environment is changed and the individual adopts healthy behavior, weight loss does not immediately happen.

Cardiovascular: While cardiovascular deaths have decreased they have not occurred at the pace anticipated when the benchmark was established. Oklahoma has a relatively high rate of cardiovascular disease due multiple factors including high rates of smoking and obesity, lack of physical activity and healthcare infrastructure gaps. In addition to primary prevention programs implemented through the Center for the Advancement of Wellness, the OSDH has recently implemented programs at the community and practice level for the early identification and management of disease that contributes to increased cardiovascular mortality. The programs have been pilot tested and indicated positive results but will take some time to realize improvement at a population level.

Accreditation: Three county health departments are nearing completion of the pre-requisites for accreditation and will initiate the accreditation process with PHAB by October 2015. When completed, this will bring the total number of accredited bodies within OSDH to five. Factors that have challenged the established timeline include staff turnover at the local level as well as leadership changes with some of the county health departments.

Partnerships: While the Certified Healthy Oklahoma program has rapidly expanded, this growth has been slower with communities than expected. One reason may be that a primary criterion for certification of communities is passage of a smoke-free ordinance on municipal property. While communities are passing these ordinances across the state it can be a relatively slow process in certain areas.

Workforce: While the OSDH continues to enjoy a turnover rate that is lower than the State of Oklahoma (13.2% OSDH vs. 17.27% statewide) it is high enough to negatively impact continuous and efficient business operations. The turnover rate did increase between the baseline year and target year; however, supplemental data suggests improvements were realized in certain areas. With the exception of retirement, the reasons for separation identified in Exit Surveys and Interviews for Fiscal Years 2012, 2013, and 2014 (promotional opportunities, wages, work environment and family) are no longer among the top three reasons for leaving the department. Current Exit Survey data suggests that *retirement, obtaining a job in a different field, and other reasons* are the primary reasons for leaving the OSDH. This is supported by 2014 Climate Survey data that indicated an increase in positive responses related to promotional opportunities and pay when compared to 2012 Climate Survey data. All collected data will be used to formulate agency action plans related to decreasing turnover rates in the future.

Oklahoma State Department of Health Strategic Map: SFY 2011-2015

Achieve Targeted Improvements in the Health Status of Oklahomans

A

Improve Targeted Health Outcomes

1
Achieve Improvements In Oklahoma Health Improvement Plan (OHIP) Flagship Issues*

2
Focus on Core Public Health Priorities**

3
Reduce Health Inequities

B

Lead Public Health Policy & Advocacy Development

1
Target Campaigns on Community Needs, Return on Investment, & Scientific Evidence

2
Identify & Establish Public Health Champions

3
Serve as Educational Resource on the Value of All Public Health Issues

C

Strengthen Public Health Systems

1
Evaluate Infrastructure to Support Public Health Systems

2
Employ Strategies for Public Health Workforce Recruitment

3
Achieve Accreditation & Create a Quality Improvement Culture

4
Achieve Compatible Health Information Exchange Across Public/Private Sectors

5
Foster Collaborative Relationships With Public & Private Partnerships

D

Leverage Resources for Health Outcome Improvement

1
Facilitate Access to Primary Care

2
Focus on Prevention

3
Use Comparative Effectiveness Research & Evaluate Science

4
Monitor Funding Opportunities

5
Educate & Strategically Plan for Health Systems Change

E
Engage Communities to Leverage Effectiveness
Utilize Social Determinants of Health & Whole Person Wellness Approaches
Responsibly Align Resources to Maximize Health Outcomes

Commonwealth Fund Scorecard State Health System Performance, 2014 Oklahoma Scorecard

The *State Scorecard* offers a framework through which policymakers and other stakeholders can gauge efforts to ensure affordable access to high-quality, efficient, and equitable care. With a goal of focusing on opportunities to improve, the analysis assesses performance relative to what is achievable, based on benchmarks drawn from the range of state health system performance.

The *State Scorecard* is designed to examine variation across the states on 32 indicators of health system performance related to access, quality, avoidable hospital use and costs, equity, and healthy lives. It reveals an unfortunate truth: where you live has a direct impact on your access to, and quality of, health care. By identifying the correlations between health care access and quality, and by illustrating areas in which states have room to improve, the Fund hopes to catalyze discussions at the state and federal levels on what steps are needed to improve health system performance and contain costs across the nation.

The *State Scorecard* estimates the cost savings and improved health outcomes that could be achieved if middle- and low-performing states implemented policies and strategies similar to those executed by the highest performers.

To access the Commonwealth Fund's Report Aiming Higher: Results from a Scorecard on State Health System Performance, 2014

visit: <http://www.commonwealthfund.org/publications/fund-reports/2014/apr/2014-state-scorecard>.

Oklahoma

Commonwealth Fund Scorecard on State Health System Performance, 2014

RANKING SUMMARY	2014	2009
	Scorecard	Revised ^a
OVERALL	49	50
Access & Affordability	37	48
Prevention & Treatment	45	45
Avoidable Hospital Use & Cost	45	46
Equity ^b	41	51
Healthy Lives	46	44

CHANGE IN RATES	2014	
	Count	Percent
Indicators with trends	33	100%
State rate improved ^c	12	36%
State rate worsened ^c	8	24%
No change in state rate ^d	13	39%

DISTRIBUTION OF RATES	2014	
	Count	Percent
Total indicators	42	100%
Top 5 states	0	0%
Top quartile	2	5%
2nd quartile	6	14%
3rd quartile	9	21%
Bottom quartile	25	60%
Bottom 5 states	9	21%

EQUITY	RANKING		CHANGE IN EQUITY GAP			
	2014	2009	Indicators with trends	No change in gap	Gap narrowed/ vulnerable group improved	Gap widened/ vulnerable group worsened
	Scorecard	Revised ^a				
Equity Dimension	41	51	16	4	9	3
Low-Income	48	50	7	2	4	1
Race/Ethnicity	32	49	9	2	5	2

ESTIMATED IMPACT		
If Oklahoma improved its performance to the level of the best-performing state for this indicator, then:		
Insured adults	447,120	more individuals (under age 65) would be covered by health insurance, and would be more likely to receive health care when needed
Adults with a usual source of care	369,111	more adults (age 18 and older) would have a usual source of care to help ensure that care is coordinated and accessible when needed
Adult preventive care	168,951	more adults (age 50 and older) would receive recommended preventive care, such as colon cancer screenings, mammograms, Pap smears, and flu shots
Children with a medical home	120,654	more children (ages 0–17) would have a medical home to help ensure that care is coordinated and accessible when needed
High-risk drug	27,138	fewer Medicare beneficiaries would receive an unsafe medication
Mortality amenable to health care	1,950	fewer premature deaths (before age 75) would occur from causes that are potentially treatable or preventable with timely and appropriate care
Hospital readmissions	2,972	fewer hospital readmissions would occur among Medicare beneficiaries (age 65 and older)
Potentially avoidable ED visits	26,501	fewer emergency department visits for nonemergent or primary care-treatable conditions would occur among Medicare beneficiaries
Tooth loss from decay or disease	206,738	fewer adults, ages 18–64, would have lost six or more teeth because of tooth decay, infection, or gum disease

NOTES
a Rates from the 2009 edition have been revised to match methodology used in the 2014 edition.
b The equity dimension was ranked based on gaps between the most vulnerable group and the U.S. national average for selected indicators.
c Denotes a change of at least 0.5 standard deviations.
d Denotes a change of less than 0.5 standard deviations.
EQUITY: The equity profile displays gaps in performance for vulnerable populations for selected indicators. An equity gap is defined as the difference between the U.S. national average for a particular indicator and the rate for the state's most vulnerable group by income and race/ethnicity. For all equity indicators, lower rates are better; therefore, a positive or negative gap value indicates that the state's most vulnerable group is better or worse than the U.S. average for a particular indicator.
ESTIMATED IMPACT: The table shows the estimated impact if this state's performance improved to the rate of the best-performing state for eight <i>Scorecard</i> indicators. (Refer to this state's individual performance profile to see actual rates.) These examples illustrate only a few important opportunities for improvement. Because some indicators affect the same individuals, these numbers should not be added.

Dimension and Indicator	Year	All-State			Rank	Year	All-State		Change in Rate ¹	Meaningful Change Over Time ²
		State Rate	Median	Best State			State Rate	Median		
ACCESS & AFFORDABILITY										
2014 Scorecard					2009 Revised Scorecard^a					
Adults ages 19–64 uninsured	2011-12	25	20	5	42	2007-08	22	17	-3	Worsened
Children ages 0–18 uninsured	2011-12	8	8	3	20	2007-08	10	9	2	Improved
Adults who went without care because of cost in past year	2012	18	15	9	34	2007	18	12	0	No Change
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2011-12	15	16	10	20	--	--	--	--	--
At-risk adults without a routine doctor visit in past two years	2012	20	14	6	46	2007	23	14	3	Improved
Adults without a dental visit in past year	2012	18	15	10	41	2006	19	14	1	No Change
PREVENTION & TREATMENT										
2014 Scorecard					2009 Revised Scorecard^a					
Adults with a usual source of care	2012	76	78	89	34	2007	79	82	-3	Worsened
Adults ages 50 and older who received recommended screening and preventive care	2012	38	43	52	42	2006	36	44	2	Improved
Children with a medical home	2011/12	56	57	69	30	2007	56	61	0	No Change
Children with a medical and dental preventive care visit in the past year	2011/12	62	69	81	40	--	--	--	--	--
Children with emotional, behavioral, or developmental problems who received needed mental health care in the past year	2011/12	61	63	86	28	2007	54	63	7	Improved
Children ages 19–35 months who received all recommended doses of seven key vaccines	2012	61	69	80	48	2009	52	43	9	Improved
Medicare beneficiaries who received at least one drug that should be avoided in the elderly	2011	27	19	12	47	2007	39	28	12	Improved
Medicare beneficiaries with dementia, hip/pelvic fracture, or chronic renal failure who received a prescription drug that is contraindicated for that condition	2011	27	21	14	48	2007	25	19	-2	Worsened
Medicare fee-for-service patients whose health provider always listens, explains, shows respect, and spends enough time with them	2013	76	76	80	21	2007	70	75	6	Improved
Risk-adjusted 30-day mortality among Medicare beneficiaries hospitalized for heart attack, heart failure, or pneumonia	07/2008 - 06/2011	12.6	12.8	11.9	15	07/2005 - 06/2008	12.7	12.6	0.1	No Change
Hospitalized patients given information about what to do during their recovery at home	2011	82	84	89	34	2007	81	80	1	No Change
Hospitalized patients who reported hospital staff always managed pain well, responded when needed help to get to bathroom or pressed call button, and explained medicines and side effects	2011	68	66	71	10	2007	65	63	3	Improved
Home health patients who get better at walking or moving around	04/2012 - 03/2013	59	59	63	21	--	--	--	--	--
Home health patients whose wounds improved or healed after an operation	04/2012 - 03/2013	91	89	95	9	--	--	--	--	--
High-risk nursing home residents with pressure sores	07/2012 - 03/2013	8	6	3	46	--	--	--	--	--
Long-stay nursing home residents with an antipsychotic medication	04/2012-03/2013	25	21.5	12	40	--	--	--	--	--

Dimension and Indicator	Year	All-State			Rank	Year	All-State		Change in Rate ¹	Meaningful Change Over Time ²
		State Rate	Median	Best State			State Rate	Median		
AVOIDABLE HOSPITAL USE & COST										
		2014 Scorecard				2009 Revised Scorecard^a				
Hospital admissions for pediatric asthma, per 100,000 children	2010	149	114	26	34	2004	*	137	--	*
Hospital admissions among Medicare beneficiaries for ambulatory care-sensitive conditions, ages 65-74, per 1,000 beneficiaries (3)	2012	38	27	13	45	2008	47	34	9	Improved
Hospital admissions among Medicare beneficiaries for ambulatory care-sensitive conditions, age 75 and older, per 1,000 beneficiaries (3)	2012	80	68	41	42	2008	101	80	21	Improved
Medicare 30-day hospital readmissions, rate per 1,000 beneficiaries	2012	49	45	26	30	2008	59	51.5	10	Improved
Short-stay nursing home residents readmitted within 30 days of hospital discharge to nursing home	2010	24	20	12	46	2006	23	20	-1	No Change
Long-stay nursing home residents hospitalized within a six-month period	2010	24	19	7	39	2006	26	19	2	No Change
Home health patients also enrolled in Medicare with a hospital admission	2012	17	17	14	25	--	--	--	--	--
Potentially avoidable emergency department visits among Medicare beneficiaries, per 1,000 beneficiaries	2011	196	183.5	129	41	--	--	--	--	--
Total single premium per enrolled employee at private-sector establishments that offer health insurance	2012	\$5,642	\$5,501	\$4,180	36	2008	\$4,736	\$4,505	-\$906	Worsened
Total Medicare (Parts A & B) reimbursements per enrollee	2012	\$9,190	\$8,526	\$5,406	39	2008	\$8,912	\$7,942	-\$278	No Change
HEALTHY LIVES										
		2014 Scorecard				2009 Revised Scorecard^a				
Mortality amenable to health care, deaths per 100,000 population	2009-10	112	82	57	46	2004-05	115	90.5	3	No Change
Years of potential life lost before age 75	2010	8,864	6,567	4,900	47	2005	9,181	7,252	317	No Change
Breast cancer deaths per 100,000 female population	2010	24.9	22.2	14.8	49	2005	25.2	23.9	0.3	No Change
Colorectal cancer deaths per 100,000 population	2010	16.5	16.2	12.0	28	2005	19.5	18.1	3.0	Improved
Suicide deaths per 100,000 population	2010	16.5	13.5	6.9	40	2005	14.8	11.8	-1.7	Worsened
Infant mortality, deaths per 1,000 live births	2009	7.9	6.4	4.6	44	2004	7.9	6.8	0.0	No Change
Adults ages 18-64 who report fair/poor health or activity limitations because of physical, mental, or emotional problems	2012	31	27	19	43	2007	29	24	-2	Worsened
Adults who smoke	2012	23	19	10	40	2007	26	19	3	Improved
Adults ages 18-64 who are obese (BMI >= 30)	2012	33	28	21	44	2007	30	27	-3	Worsened
Children ages 10-17 who are overweight or obese (BMI >= 85th percentile)	2011/12	34	30.5	22	37	2007	30	31	-4	Worsened
Percent of adults ages 18-64 who have lost six or more teeth because of tooth decay, infection, or gum disease	2012	14	10	5	43	2006	15	10	1	No Change

Notes:

* Data not available for this state.

-- Historical data not available or not comparable over time.

(1) The change in rate is expressed such that a positive value indicates performance has improved and a negative value indicates performance has worsened.

(2) Meaningful change (improvement or worsening) refers to a change between the baseline and current time periods of at least 0.5 standard deviations.

(3) Hospital admissions among Medicare beneficiaries for ambulatory care-sensitive conditions are displayed here separately for two age ranges, but counted as a single indicator in tallies of improvement.

Source: Commonwealth Fund Scorecard on State Health System Performance, 2014.

Equity Type and Indicator	Year	Vulnerable Group Rate	U.S. Average (all populations)	Gap ¹	Rank	Year	Vulnerable Group Rate	U.S. Average (all populations)	Gap ¹	Change in Vulnerable Group Rate ²	Change in Vulnerable Group Relative to US Average ³
RACE & ETHNICITY											
Uninsured ages 0–64	2011-12	31	18	-13	28	2007-08	31	17	-14	0	No Change
Adults who went without care because of cost in past year	2012	25	17	-8	12	2007	29	13	-16	4	Improved
At risk adults without a doctor visit	2012	31	14	-17	44	2007	28	14	-14	-3	Worsened
Adults without a usual source of care	2012	47	22	-25	43	2007	50	20	-30	3	Improved
Older adults without recommended preventive care	2012	66	58	-8	20	2006	71	56	-15	5	Improved
Children without a medical home	2011/12	57	46	-11	13	2007	64	42	-22	7	Improved
Children without a medical and dental preventive care visit in the past year	2011/12	42	32	-10	31	--	--	--	--	--	--
Mortality amenable to health care	2009-10	193	86	-107	35	2004-05	196	96	-100	3	No Change
Infant mortality, deaths per 1,000 live births	2008-09	13.9	6.5	-7.4	36	2003-04	13.2	6.8	-6.4	-0.7	Worsened
Adults with poor health-related quality of life	2012	32	27	-5	13	2007	34	24	-10	2	Improved
LOW-INCOME											
Uninsured ages 0–64	2011-12	30	18	-12	28	2007-08	33	17	-16	3	Improved
Adults who went without care because of cost in past year	2012	33	17	-16	41	2007	33	13	-20	0	No Change
At risk adults without a doctor visit	2012	26	14	-12	44	2007	31	14	-17	5	Improved
Adults without a usual source of care	2012	32	22	-10	45	2007	33	20	-13	1	Improved
Older adults without recommended preventive care	2012	74	58	-16	46	2006	72	56	-16	-2	No Change
Children without a medical home	2011/12	52	46	-6	16	2007	55	42	-13	3	Improved
Children without a medical and dental preventive care visit in the past year	2011/12	43	32	-11	38	--	--	--	--	--	--
Elderly patients who received a high-risk prescription drug	2010	41	25	-16	46	--	--	--	--	--	--
Adults with poor health-related quality of life	2012	48	27	-21	45	2007	42	24	-18	-6	Worsened

Notes:

* Data not available for this state.

-- Historical data not available or not comparable over time.

(1) Gaps measure the difference between the most vulnerable group in this state, by income or race/ethnicity, and the U.S. national average for each indicator.

(2) The change in vulnerable groups rate is expressed such that a positive value indicates performance has improved and a negative value indicates performance has worsened.

(3) Improvement indicates that the gap between this state's vulnerable population and the U.S. average has narrowed AND that the vulnerable group rate in this state has improved.

Worsening indicates that the gap between this state's vulnerable population and the U.S. average has widened AND that the vulnerable group rate in this state has worsened. No change

indicates that either the gap narrowed but the vulnerable group rate worsened, or the vulnerable group rate improved but the gap widened.

Source: Commonwealth Fund Scorecard on State Health System Performance, 2014.

**United Health Foundation, America's Health Rankings 2014
Oklahoma Profile**

America's Health Ranking is a comparative health index of states. It uses measures of behavior, community and environment, policy, clinical care, and health outcomes to describe the health and wellness of each state compared to all other states. The report is produced annually.

Enclosed is the state profile produced for the state of Oklahoma. It summarizes Oklahoma's overall ranking, strengths, challenges and highlights from the most recent edition of America's Health Rankings report.

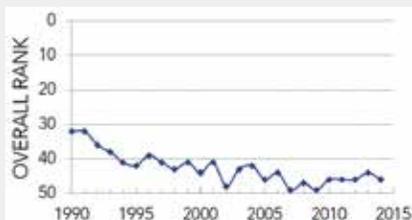
To access the most current edition of America's Health Rankings visit: <http://www.americashealthrankings.org/reports#sthash.BL1kHEAY.dpuf>

Oklahoma

OKLAHOMA

Overall Rank: 46

Change: ▼ 2
 Determinants Rank: 45
 Outcomes Rank: 47



Strengths:

- Low prevalence of binge drinking
- Low incidence of pertussis
- Low prevalence of low birthweight

Challenges:

- High prevalence of physical inactivity
- Low immunization coverage among children
- Limited availability of primary care physicians

Ranking:

Oklahoma is 46th this year; it was 44th in 2013. The ranking for senior health in Oklahoma was 47th in 2014.

Highlights:

- In the past year, children in poverty decreased by 35 percent from 27.4 percent to 17.8 percent of children.
- In the past 2 years, binge drinking decreased by 23 percent from 16.5 percent to 12.7 percent of adults.
- In the past 2 years, immunization coverage among adolescents increased by 21 percent from 49.7 percent to 59.9 percent of adolescents aged 13 to 17 years.
- Since 1990, violent crime increased by 12 percent from 419 to 469 offenses per 100,000 population. The US rate of violent crime dropped by 37 percent during the same period.
- Since 1990, cardiovascular deaths decreased by 23 percent from 415.3 to 322.0 deaths per 100,000 population.

State Health Department Website:
www.ok.gov/health

	2014 VALUE	RANK	NO 1 STATE
Behaviors			
Smoking (Percent of adult population)	23.7	45	10.3
Binge Drinking (Percent of adult population)	12.7	7	9.6
Drug Deaths (Deaths per 100,000 population)	19.8	45	3.0
Obesity (Percent of adult population)	32.5	44	21.3
Physical Inactivity (Percent of adult population)	31.1	47	16.2
High School Graduation (Percent of incoming ninth graders)	79.0	30	93.0

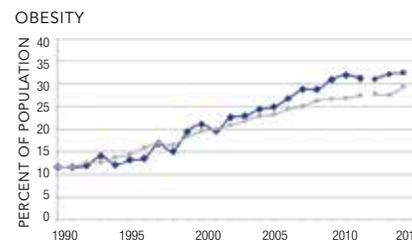
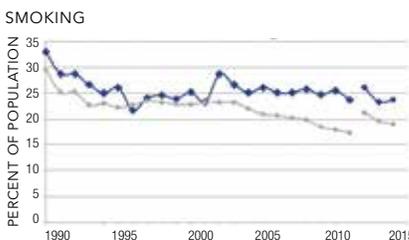
	2014 VALUE	RANK	NO 1 STATE
Community & Environment			
Violent Crime (Offenses per 100,000 population)	469	41	123
Occupational Fatalities (Deaths per 100,000 workers)	7.1	44	2.2
Infectious Disease (Combined score Chlamydia, Pertussis, <i>Salmonella</i> *)	-0.07	25	-0.9
<i>Chlamydia</i> (Cases per 100,000 population)	444.2	27	233.0
<i>Pertussis</i> (Cases per 100,000 population)	4.1	6	1.6
<i>Salmonella</i> (Cases per 100,000 population)	20.1	39	6.8
Children in Poverty (Percent of children)	17.8	26	9.2
Air Pollution (Micrograms of fine particles per cubic meter)	9.7	33	4.9

	2014 VALUE	RANK	NO 1 STATE
Policy			
Lack of Health Insurance (Percent of population)	18.0	44	3.8
Public Health Funding (Dollars per person)	\$79	24	\$219
Immunization—Children (Percent aged 19 to 35 months)	62.7	47	82.1
Immunization—Adolescents (Percent aged 13 to 17 years)	59.9	39	81.3

	2014 VALUE	RANK	NO 1 STATE
Clinical Care			
Low Birthweight (Percent of live births)	8.0	24	5.7
Primary Care Physicians (Number per 100,000 population)	84.8	48	324.6
Dentists (Number per 100,000 population)	50.2	37	107.6
Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	71.4	42	28.2
ALL DETERMINANTS	-0.44	45	0.71

	2014 VALUE	RANK	NO 1 STATE
OUTCOMES			
Diabetes (Percent of adult population)	11.0	39	6.5
Poor Mental Health Days (Days in previous 30 days)	4.3	44	2.5
Poor Physical Health Days (Days in previous 30 days)	4.4	42	2.8
Disparity in Health Status (Percent difference by education level**)	32.1	38	15.5
Infant Mortality (Deaths per 1,000 live births)	7.4	43	4.2
Cardiovascular Deaths (Deaths per 100,000 population)	322.0	48	184.7
Cancer Deaths (Deaths per 100,000 population)	214.1	45	145.7
Premature Deaths (Years lost per 100,000 population)	9,654	46	5,345
ALL OUTCOMES	-0.30	47	0.34
OVERALL	-0.74	46	0.91

*Negative score denotes less disease than US average, positive score indicates more than US average
 **Difference in the percentage of adults aged 25 and older with vs without a high school education who report their health is very good or excellent



STATE ◆ NATION ● The 2012–2014 data in the above graphs are not directly comparable to prior years. See Methodology for additional information.

ECONOMIC ENVIRONMENT	OK	US
Annual Unemployment Rate (2013)	5.4	7.4
Annual Underemployment Rate (2013)	10.2	13.8
Median Household Income (2013)	\$43,777	\$51,939

MEASURE	ADULT POPULATION AFFECTED
Smoking	679,000
Obesity	900,000
Physical Inactivity	904,000
Diabetes	321,000

2014 Edition OKLAHOMA



America's Health Rankings® is the longest running comparative health index of states. It uses measures of behavior, community and environment, policy, clinical care, and health outcomes to describe the health and wellness of each state compared to all other states. The Rankings are updated each year and provide a perspective on change in health over the last 25 years. The primary objective of America's Health Rankings® is to stimulate discussion and action among individuals, community leaders, elected officials, health professionals, educators, and employers to improve the health of each state and our nation.

The Rankings are sponsored by United Health Foundation in partnership with American Public Health Association and Partnership for Prevention.

Overall, Oklahoma ranks 46th. The state has varied from 32nd, it's healthiest rank, to 49th, it's poorest rank. It ranked 44th last year.

Strengths

- * Low prevalence of binge drinking
- * Low incidence of pertussis
- * Low prevalence of low birthweight

Challenges

- * High prevalence of physical inactivity
- * Low immunization coverage among children
- * Limited availability of primary care physicians

Highlights

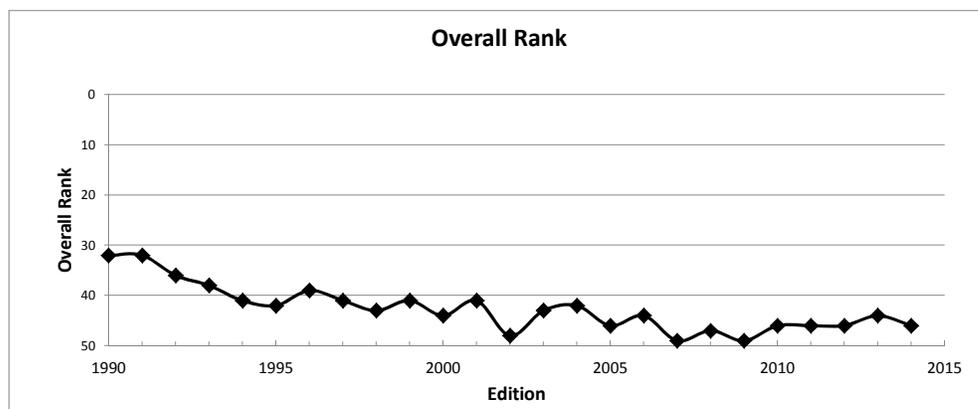
* In the past year, children in poverty decreased by 35 percent from 27.4 percent to 17.8 percent of children.

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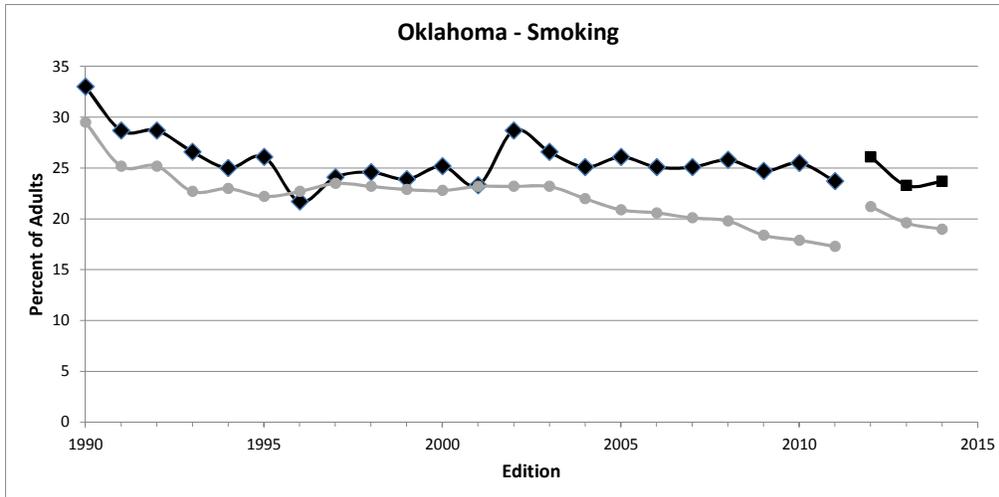
* Since 1990, cardiovascular deaths decreased by 23 percent from 415.3 to 322.0 deaths per 100,000 population.



	Value	Rank	No. 1 State
Determinants			
Behaviors			
Smoking (Percent of adult population)	23.7	45	10.3
Binge Drinking (Percent of adult population)	12.7	7	9.6
Drug Deaths (Deaths per 100,000 population)	19.8	45	3.0
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High School Graduation (Percent of incoming ninth graders)	79	30	93
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Primary Care Physicians (Number per 100,000 population)	84.8	48	324.6
Dentists (Number per 100,000 population)	50.2	37	107.6
Preventable Hospitalizations (Number per 1,000 Medicare beneficiaries)	71.4	42	28.2
All Determinants	-0.44	45	0.71
Outcomes			
Diabetes (Percent of adult population)	11.0	39	6.5
Poor Mental Health Days (Days in the previous 30 days)	4.3	44	2.5
Poor Physical Health Days (Days in the previous 30 days)	4.4	42	2.8
Disparity in Health Status (percent difference)	32.1	38	15.5
Infant Mortality (Deaths per 1,000 live births)	7.4	43	4.2
Cardiovascular Deaths (Deaths per 100,000 population)	322.0	48	184.7
Cancer Deaths (Deaths per 100,000 population)	214.1	45	145.7
Premature Death (Years lost per 100,000 population)	9,654	46	5,345
All Outcomes	-0.30	47	0.34
Overall	-0.74	46	0.91

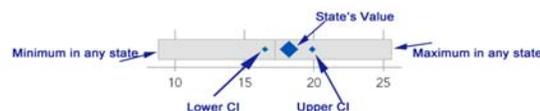
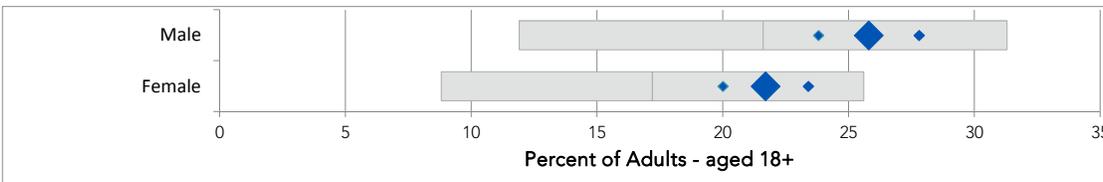
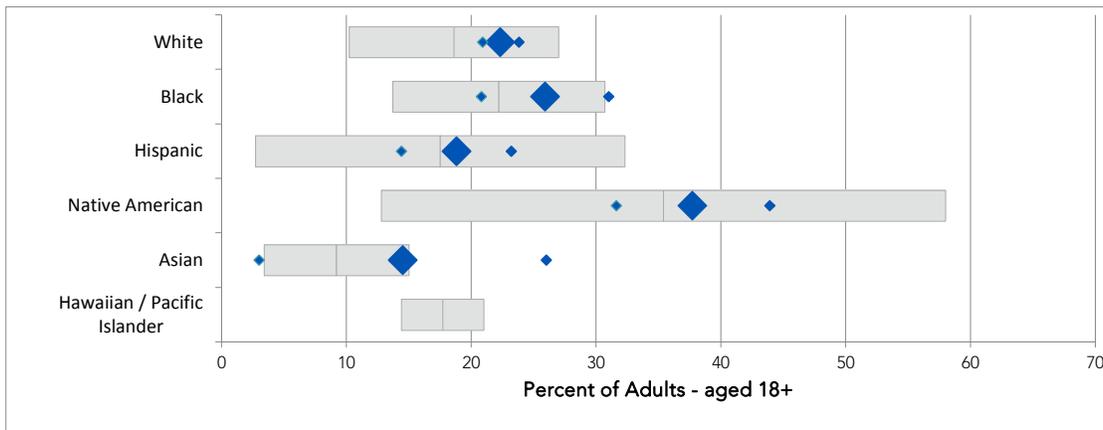
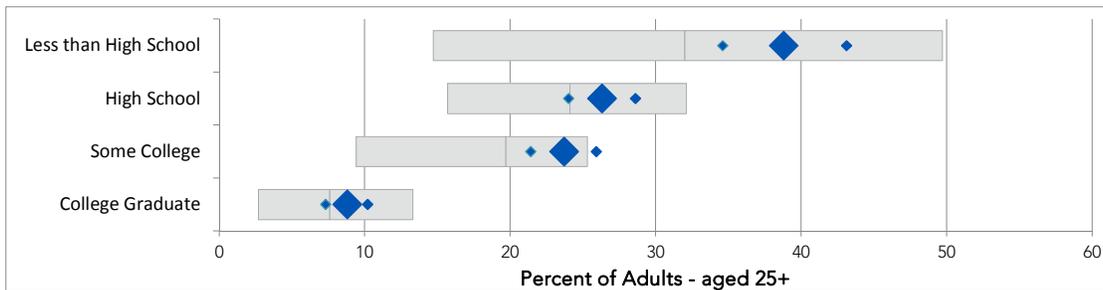
Smoking

Smoking is the prevalence of adults who smoke cigarettes regularly. It is defined as the percentage of adults who self-report smoking at least 100 cigarettes in their lifetime and who currently smoke.



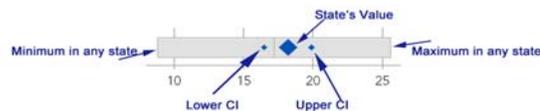
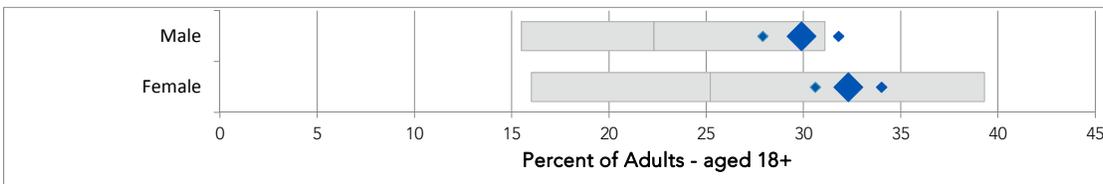
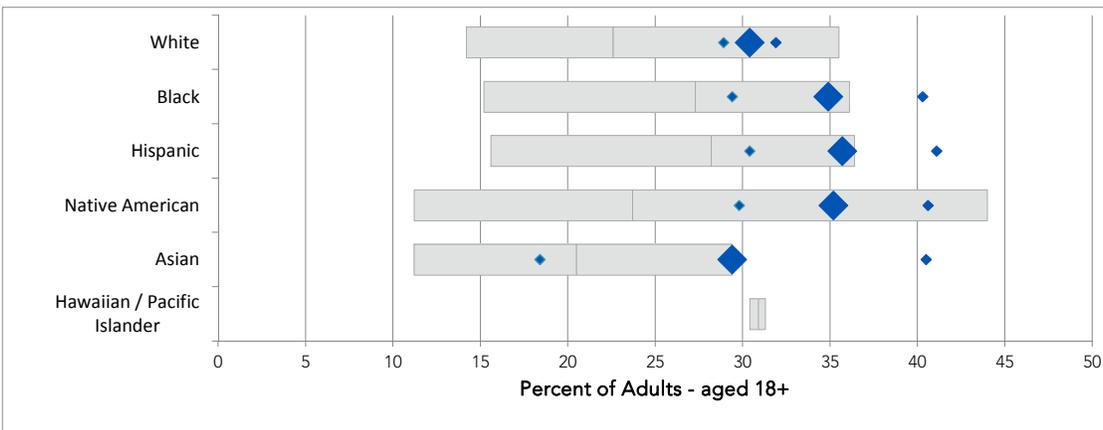
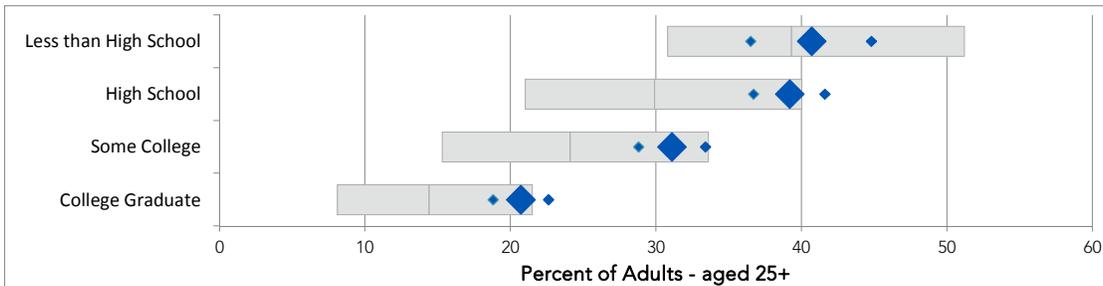
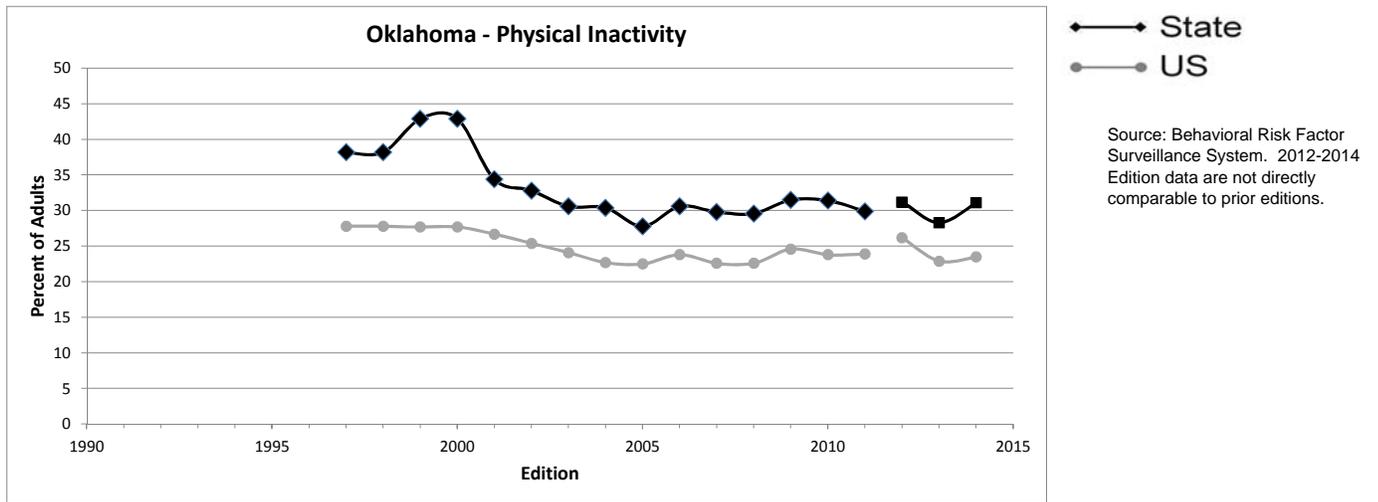
State
US

Source: Behavioral Risk Factor Surveillance System. 2012-2014 Edition data are not directly comparable to prior editions.



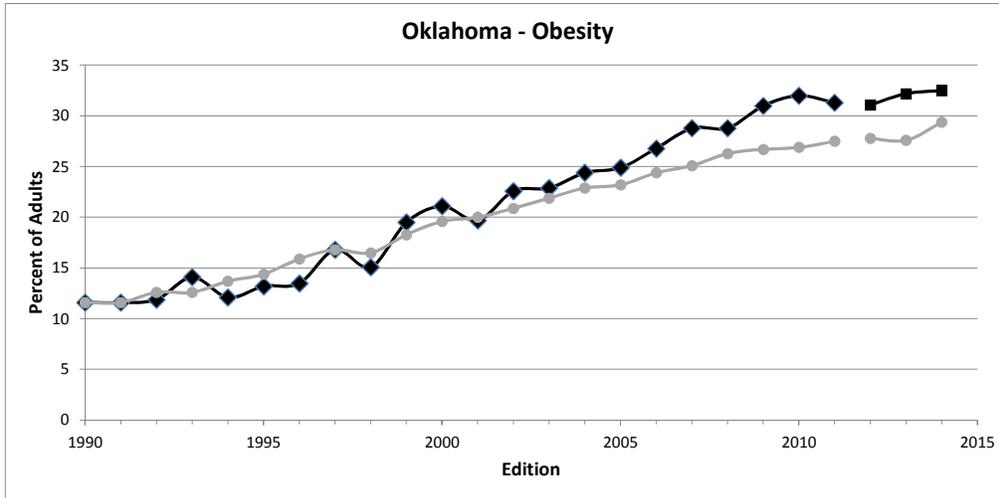
Physical Inactivity

Physical Inactivity is the percentage of adults who report doing no physical activity or exercise (such as running, calisthenics, golf, gardening, or walking) other than their regular job in the last 30 days.



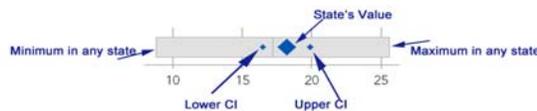
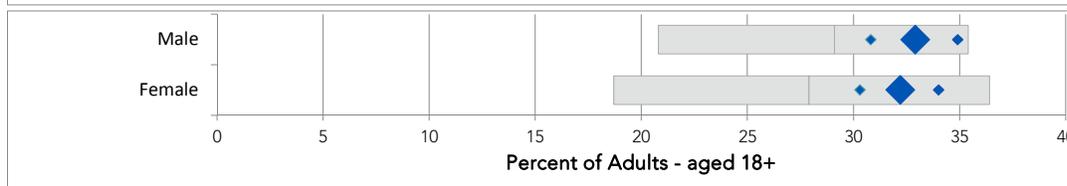
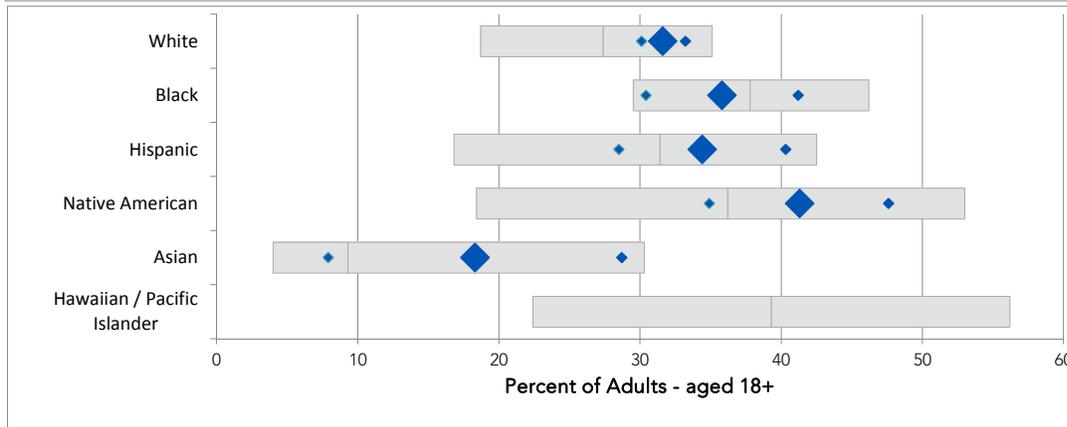
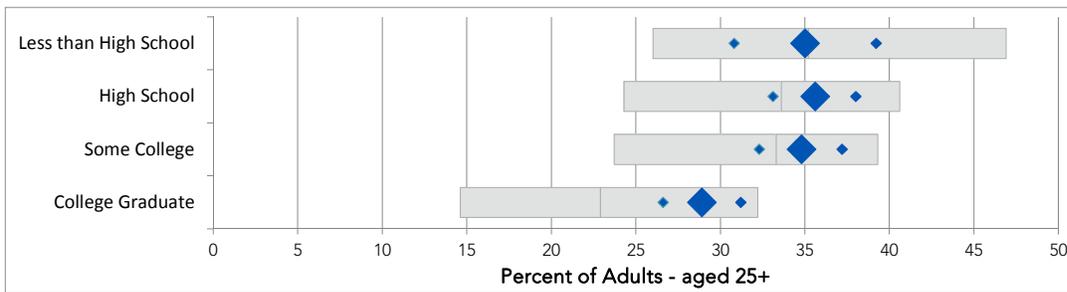
Obesity

Obesity is the percentage of adults who are estimated to be obese, defined as having a body mass index (BMI) of 30.0 or higher, according to self-reported height and weight. BMI is equal to weight in pounds divided by height in inches squared and then multiplied by 703.



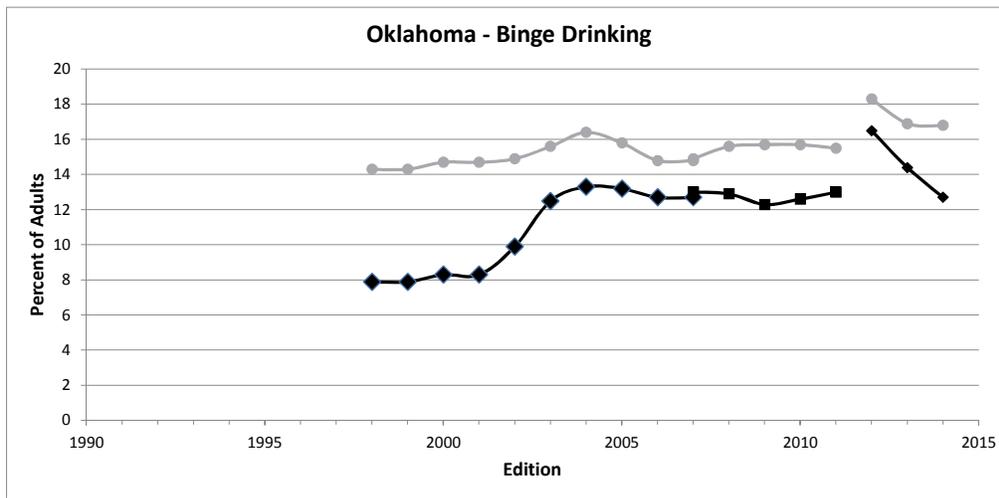
State
US

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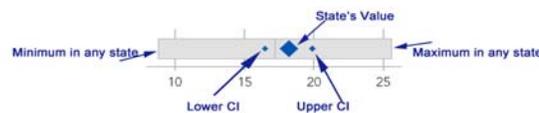
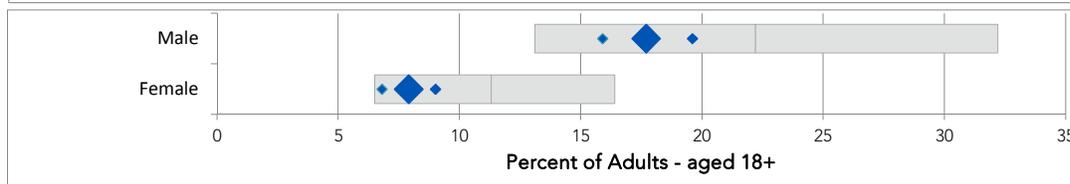
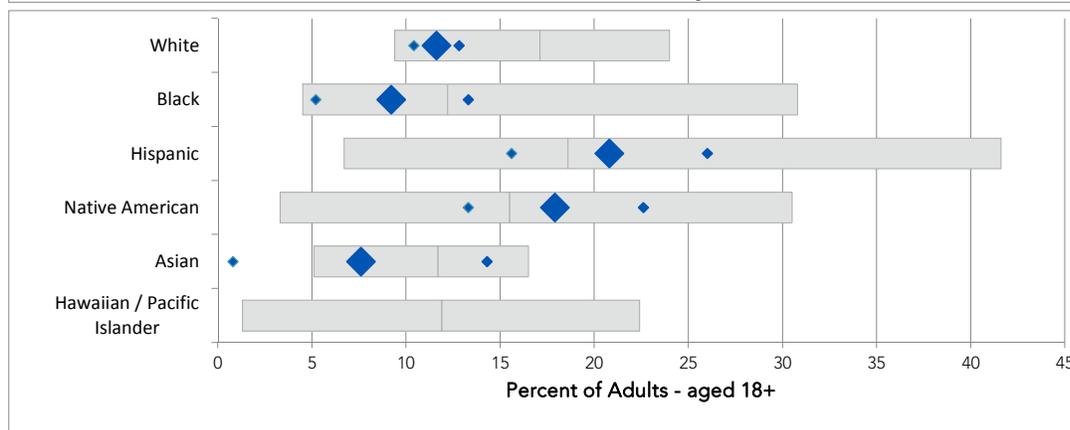
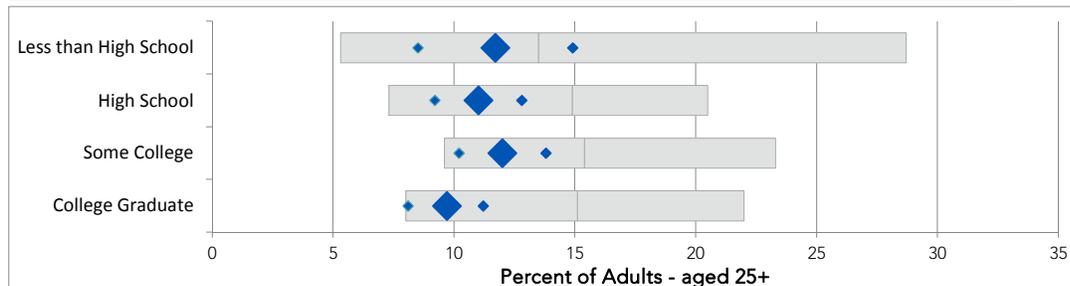
Binge Drinking

Percentage of adults who had 4 or more (women) or 5 or more (men) alcoholic beverages on a single occasion in the past 30 days.



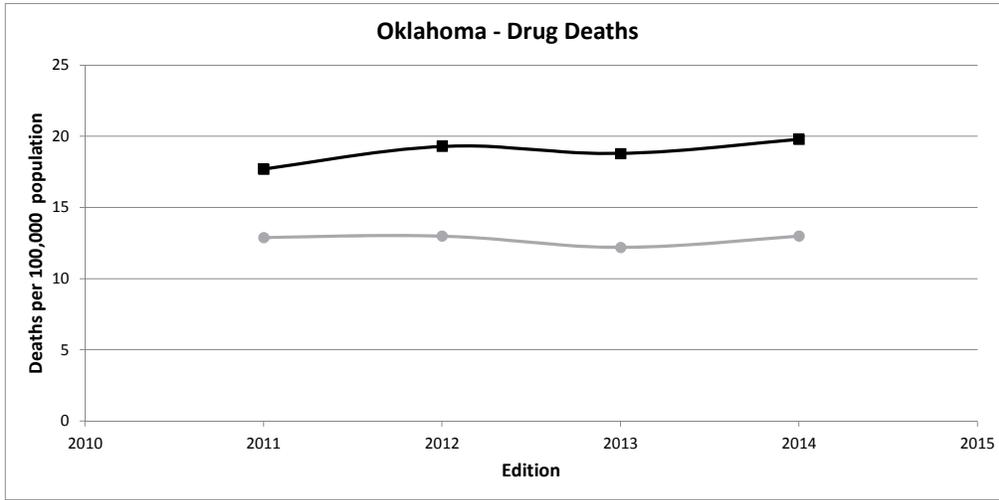
State
US

Source: Behavioral Risk Factor Surveillance System, 2012-2014
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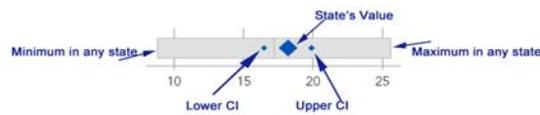
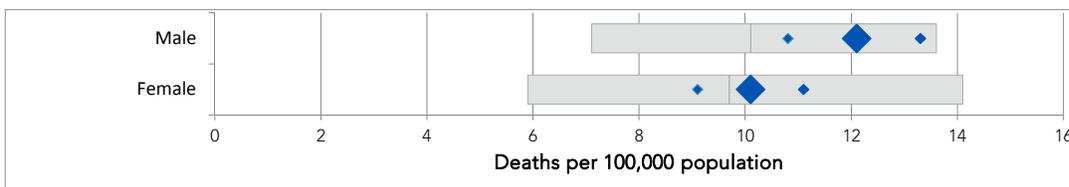
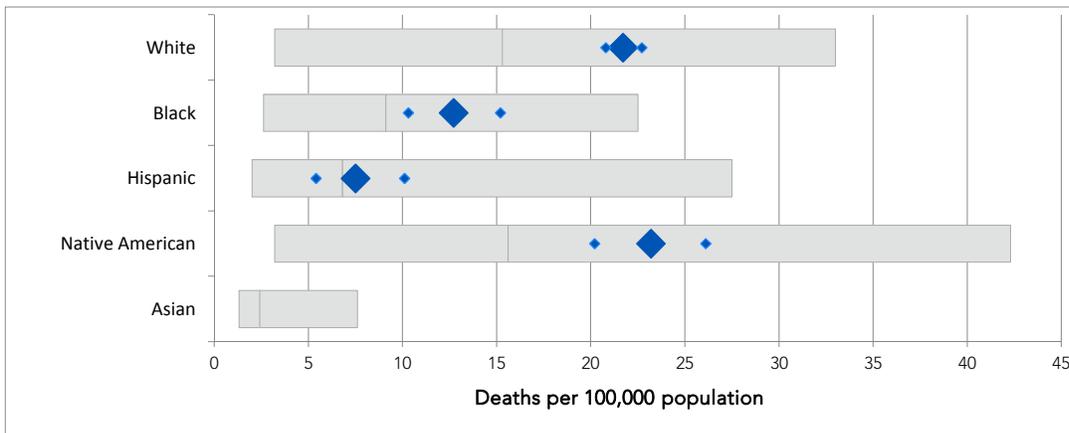
Drug Deaths

Number of deaths due to drug injury of any intent (unintentional, suicide, homicide, or undetermined) per 100,000 population. (3-year average)



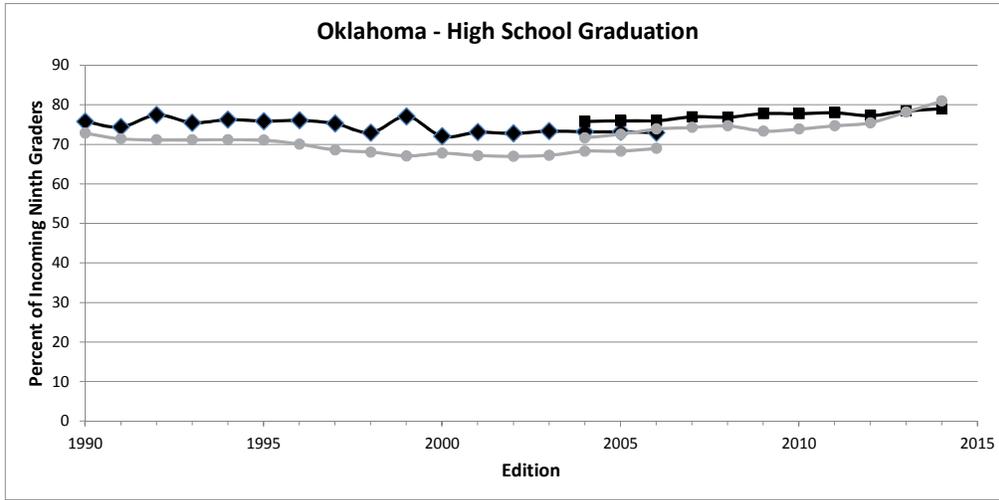
◆ State
● US

Source: National Vital Statistics System



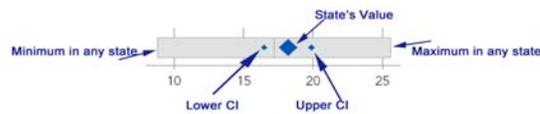
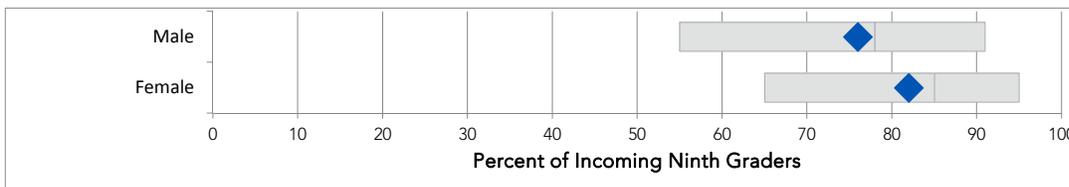
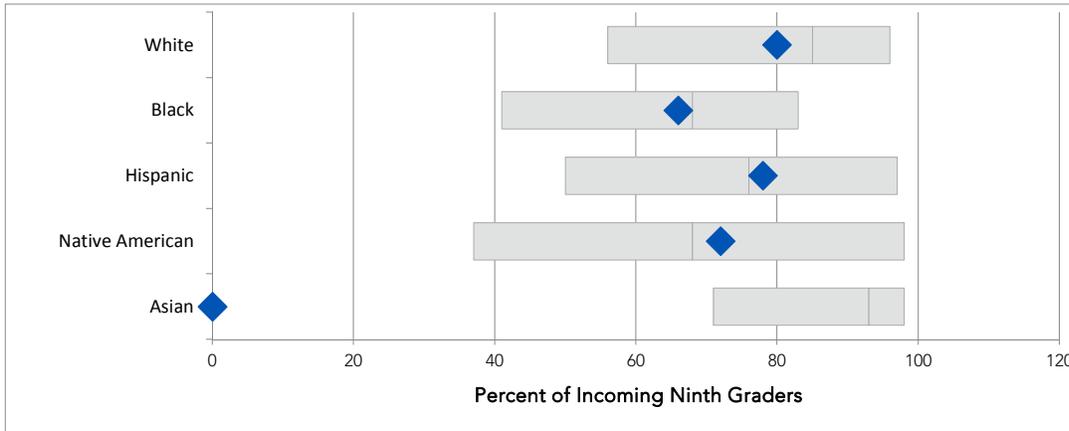
High School Graduation

Percentage of incoming ninth graders who graduate in 4 years from a high school with a regular degree.



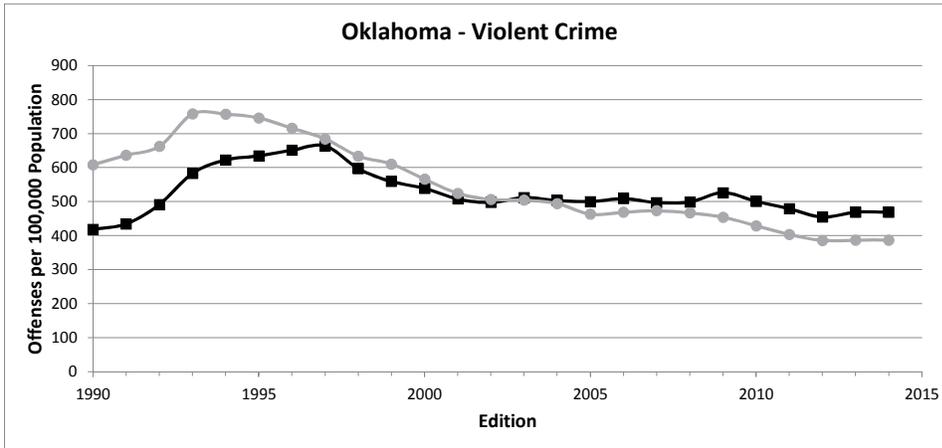
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US

Source: National Center for Education Statistics. 2004-2014 data not directly comparable to 1990 - 2006 data.



Violent Crime

Number of murders, rapes, robberies, and aggravated assaults per 100,000 population.

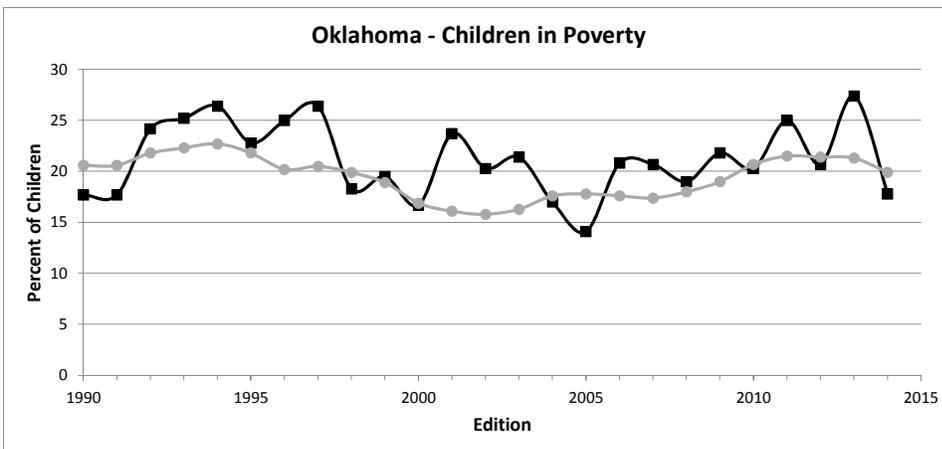


State
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Source: Federal Bureau of Investigation

Children in Poverty

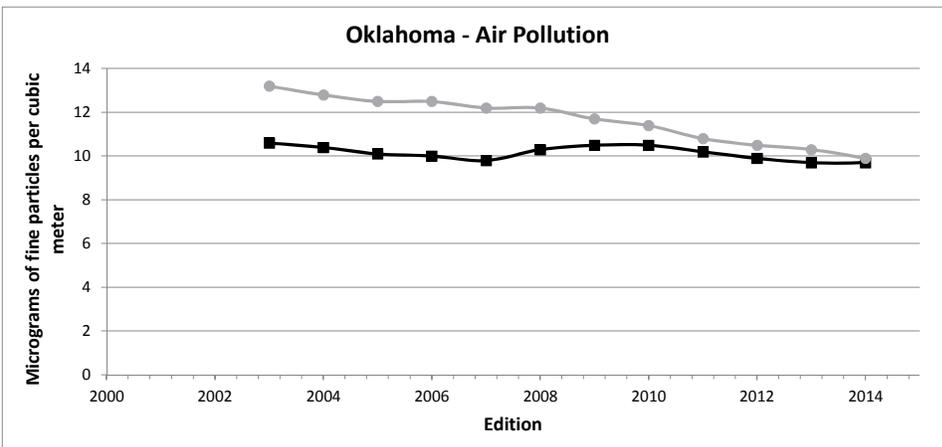
Percentage of persons younger than 18 years who live in households at or below the poverty threshold.



Source: Current Population Survey, 2014 Annual Social and Economic Supplement

Air Pollution

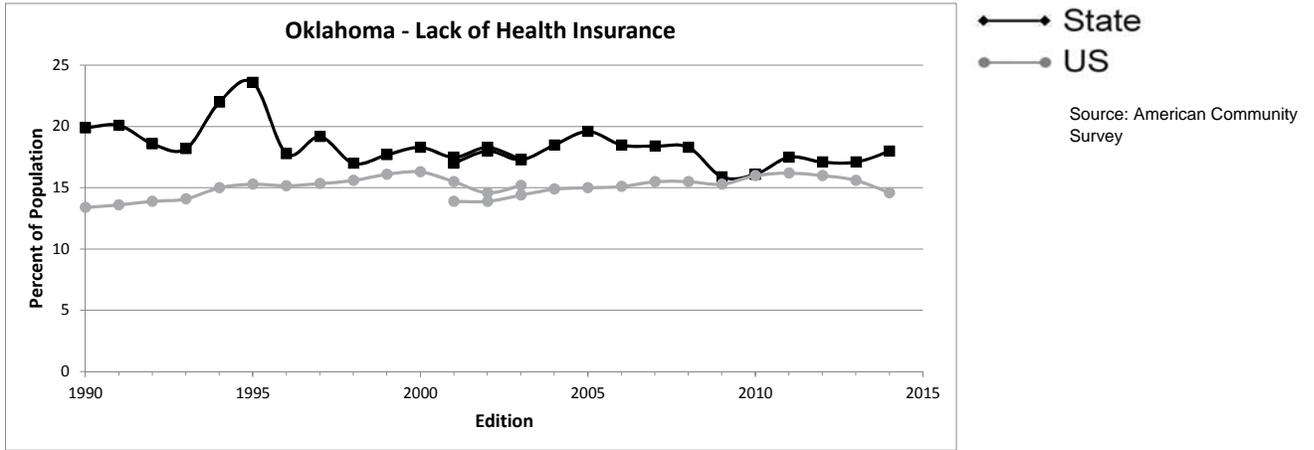
Average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5).



Source: Environmental Protection Agency

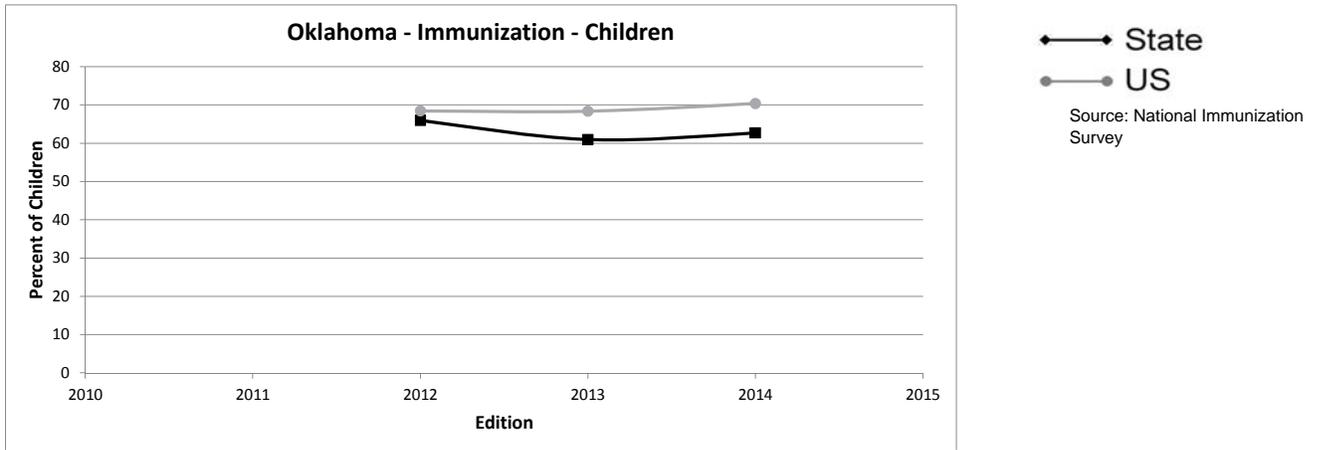
Lack of Health Insurance

Percentage of the population that does not have health insurance privately, through their employer, or the government. (Two year average)



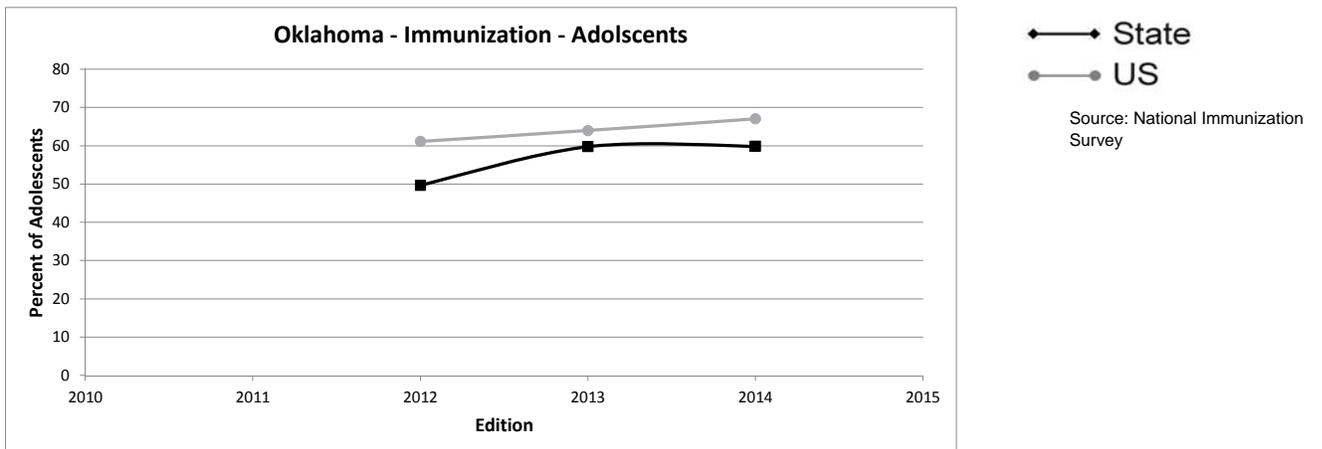
Immunization - Children

Percentage of children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines.



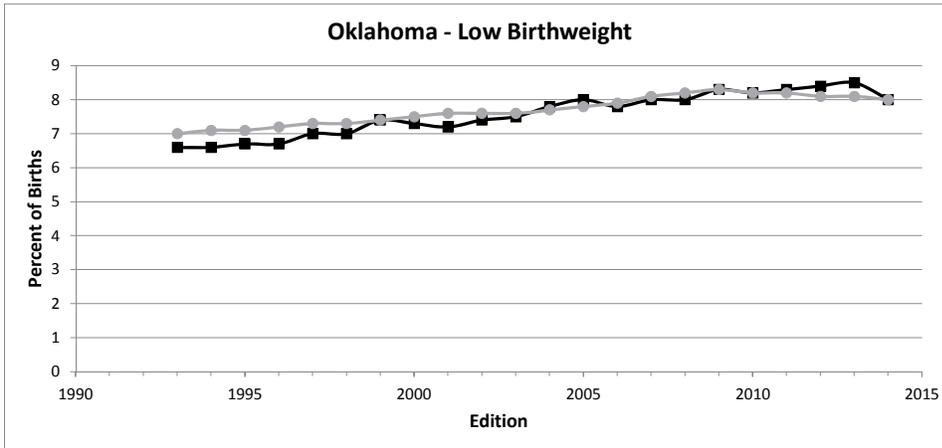
Immunization - Adolescents

Percentage of adolescents aged 13 to 17 years who have received 1 dose of Tdap since the age of 10 years, 1 dose of meningococcal conjugate vaccine, and 3 doses of HPV (females).



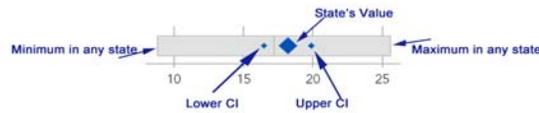
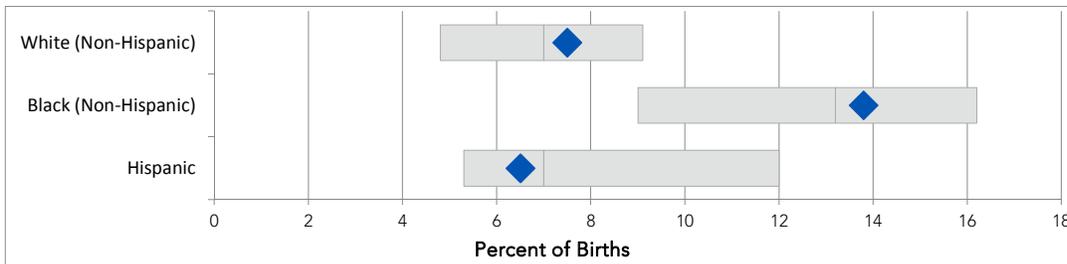
Low Birthweight

Percentage of infants weighing less than 2500 grams (5 pounds, 8 ounces) at birth.



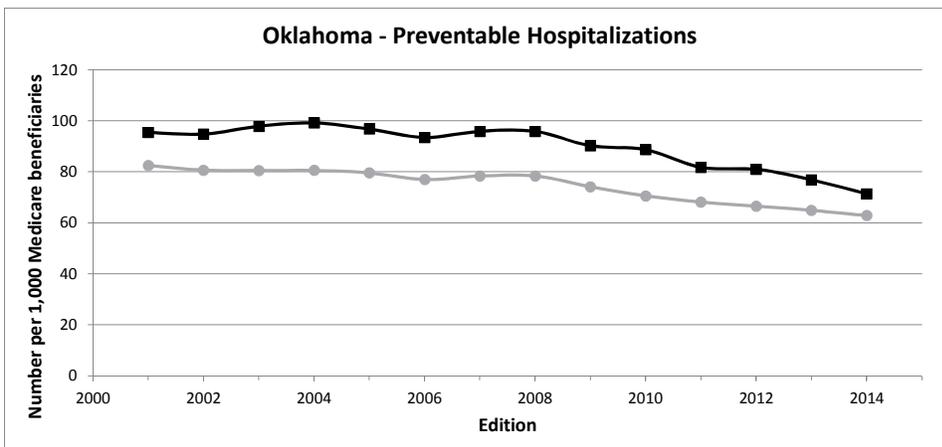
State
US

Source: National Vital Statistics System



Preventable Hospitalizations

Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care.

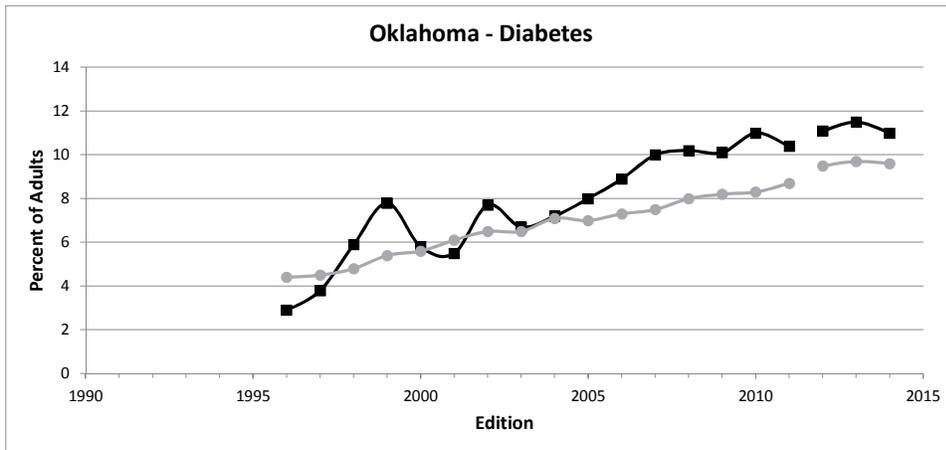


State
US

Source: Dartmouth Atlas

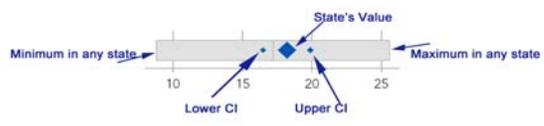
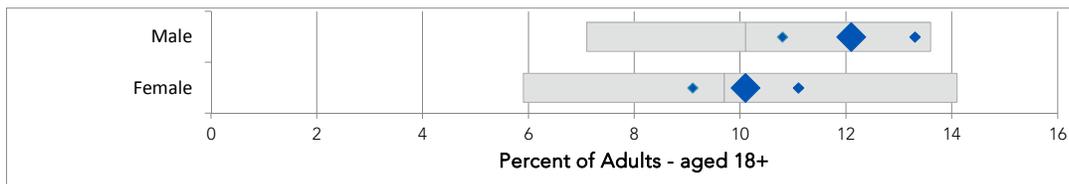
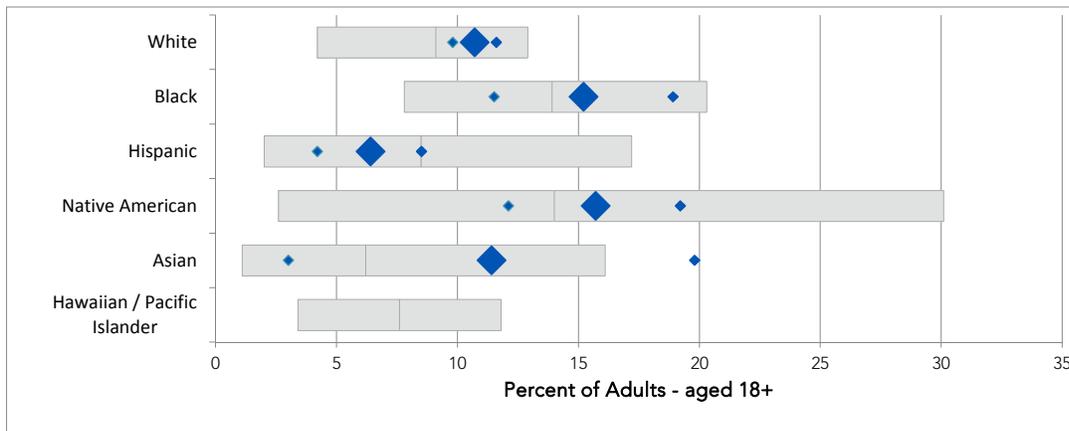
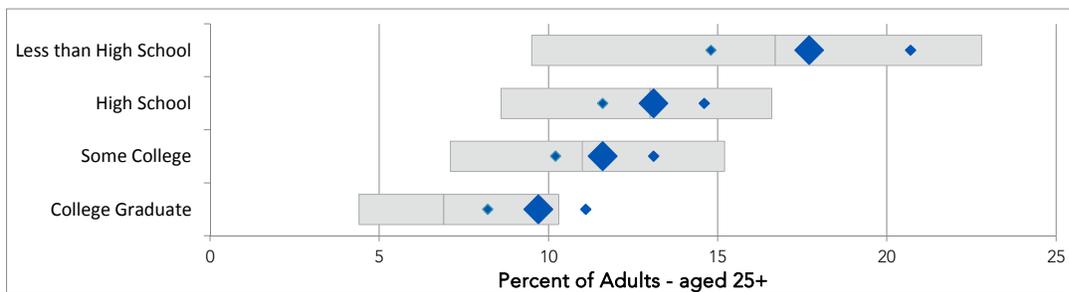
Diabetes

Percentage of adults who responded yes to the question "Have you ever been told by a doctor that you have diabetes?" (Excludes pre-diabetes and gestational diabetes).



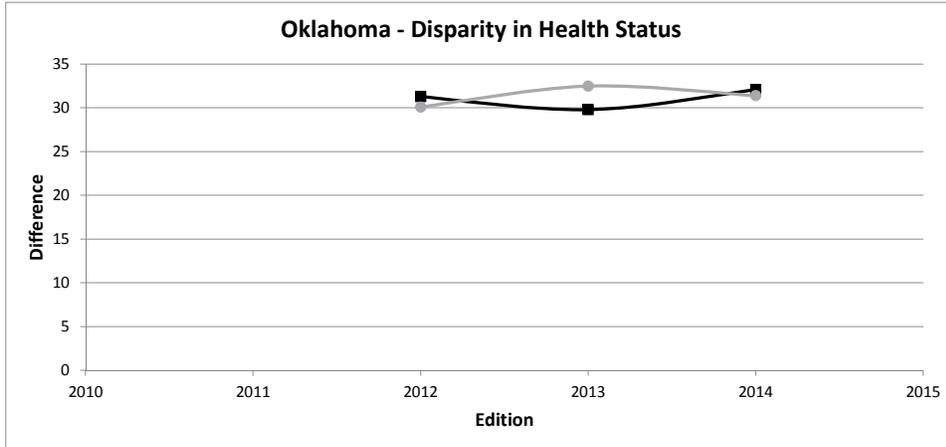
State
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Source: Behavioral Risk Factor Surveillance System, 2012-2014
Edition not directly comparable to prior editions.



Disparity in Health Status

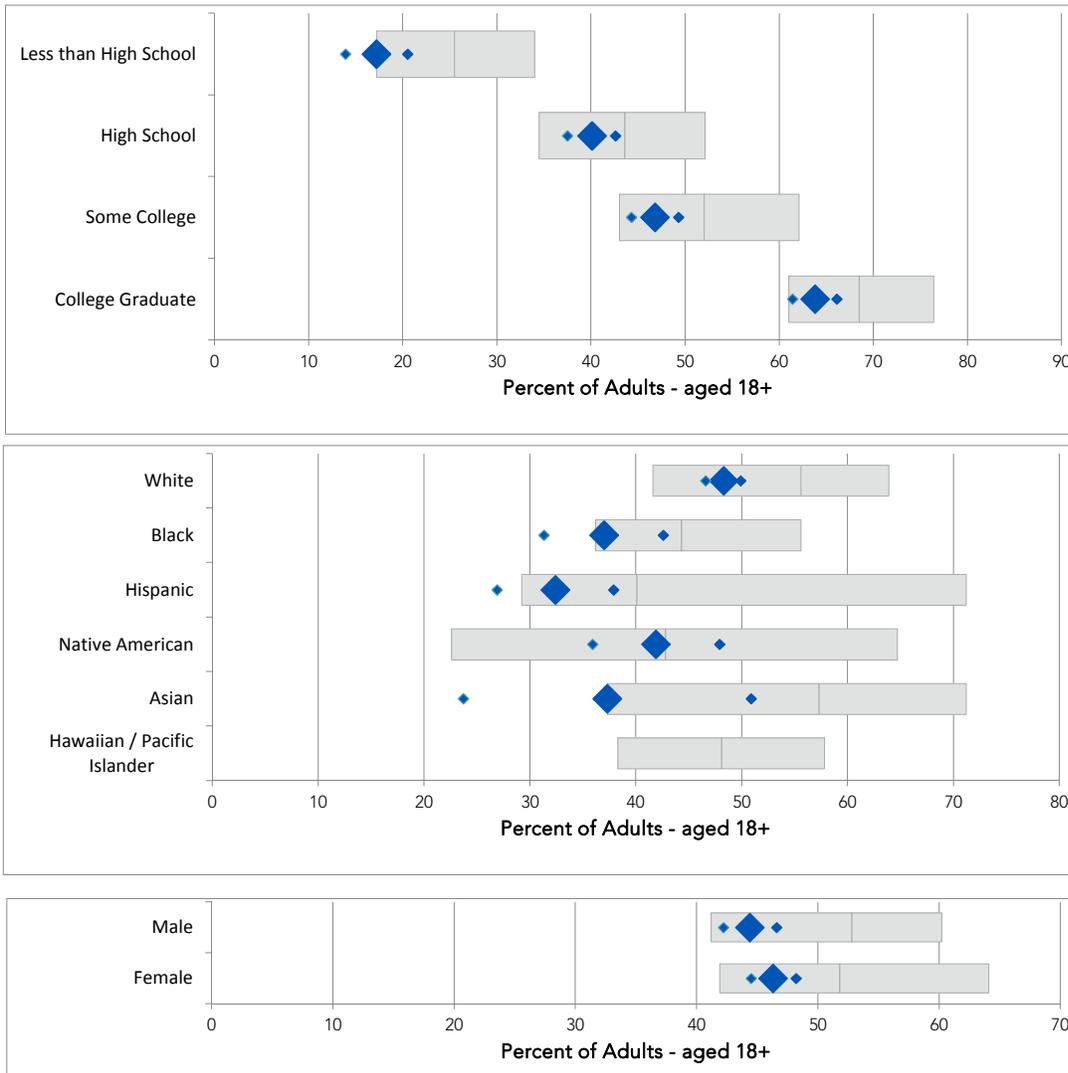
Difference in the percentage of adults aged 25 and older with vs without a high school education who report their health is very good or excellent



State
US

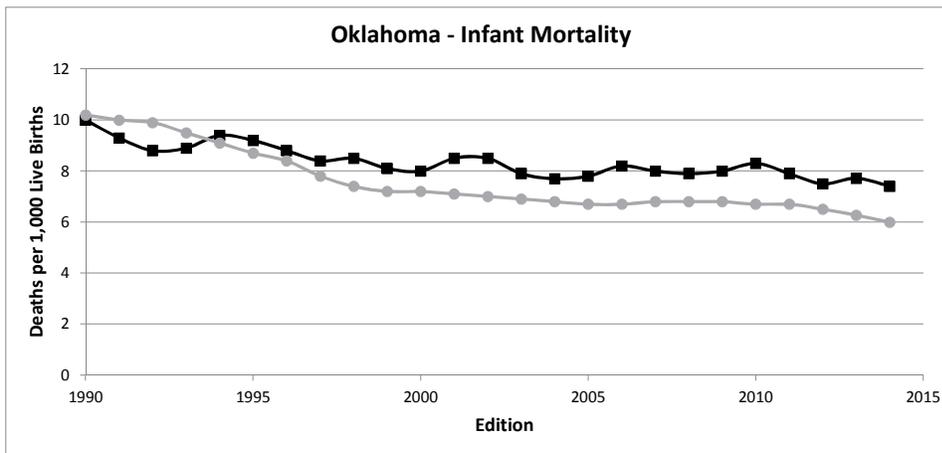
Source: Behavioral Risk Factor Surveillance System.

High Health Status



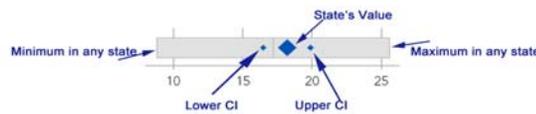
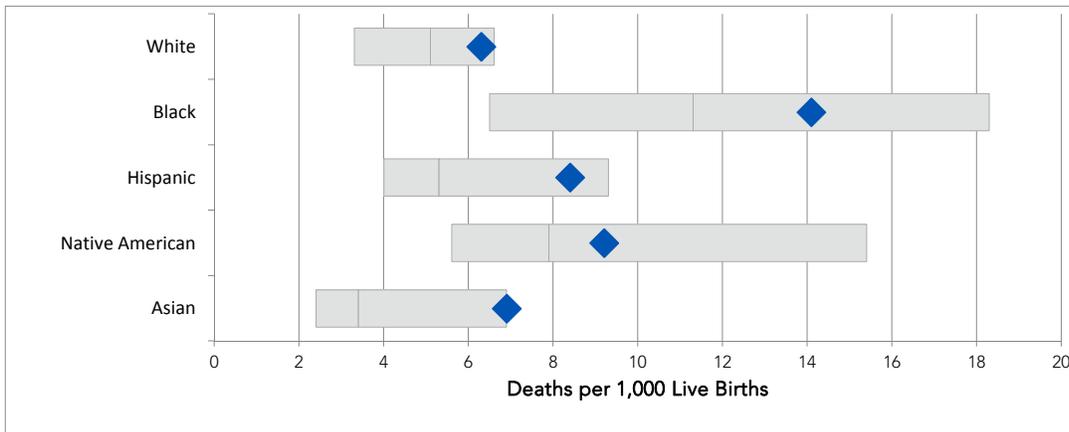
Infant Mortality

Number of infant deaths (before age 1) per 1,000 live births.



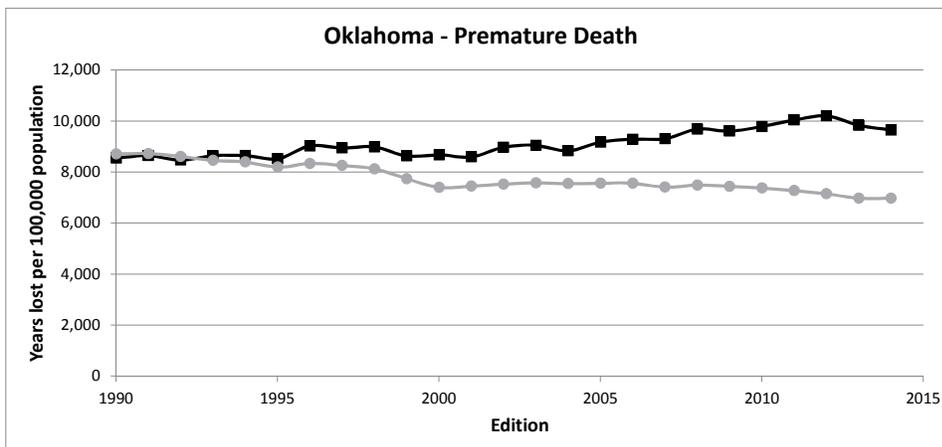
State
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Source: National Vital Statistics System



Premature Death

Number of years of potential life lost prior to age 75 per 100,000 population.

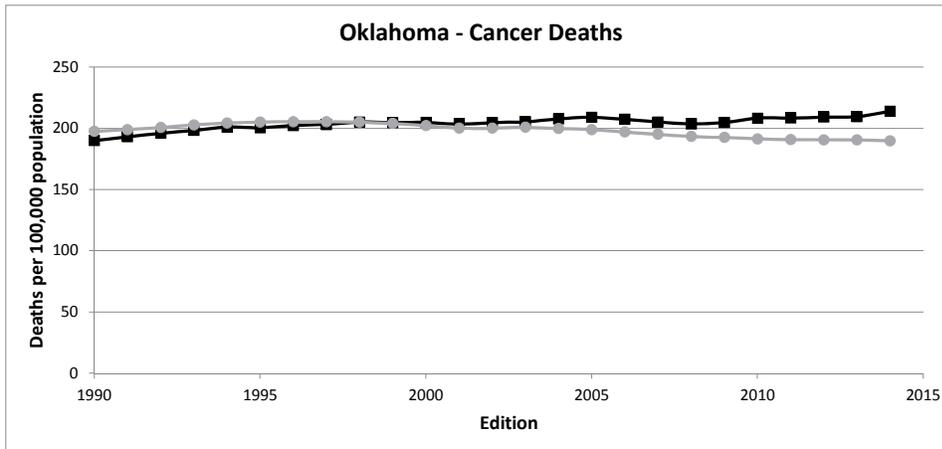


State
US

Source: National Vital Statistics System

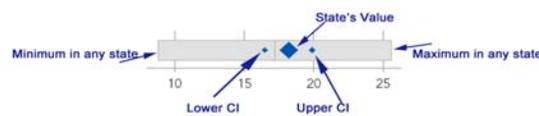
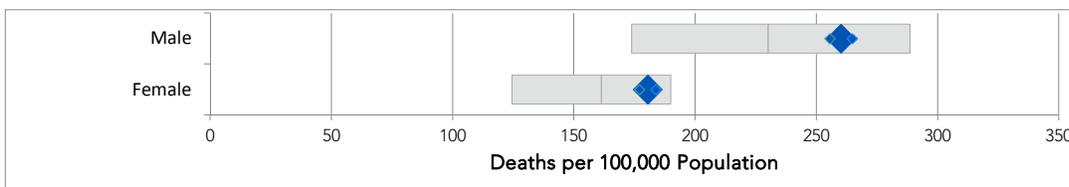
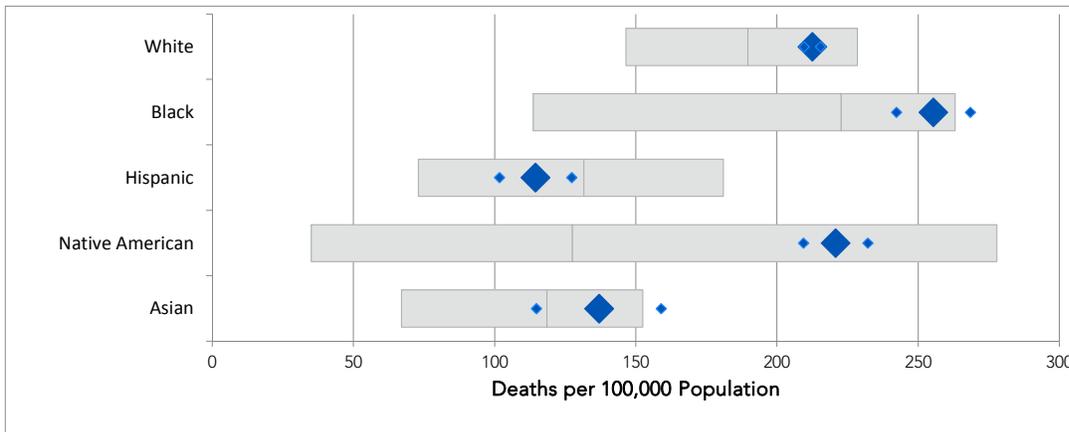
Cancer Deaths

Number of deaths due to all causes of cancer per 100,000 population.



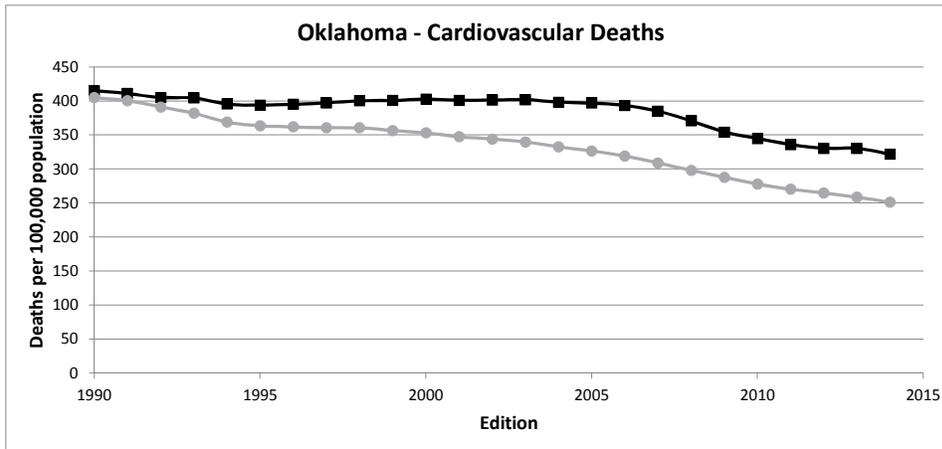
State
US

Source: National Vital Statistics System



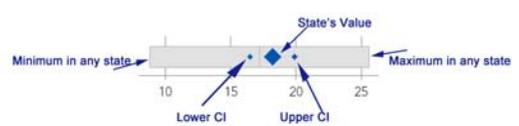
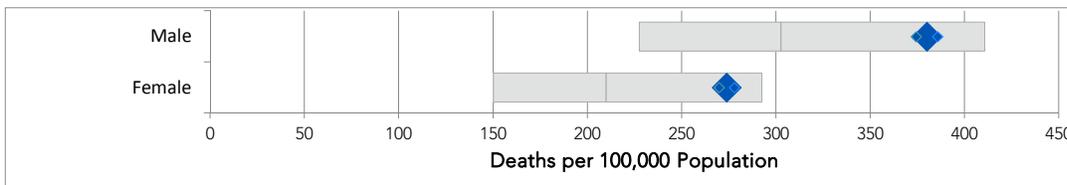
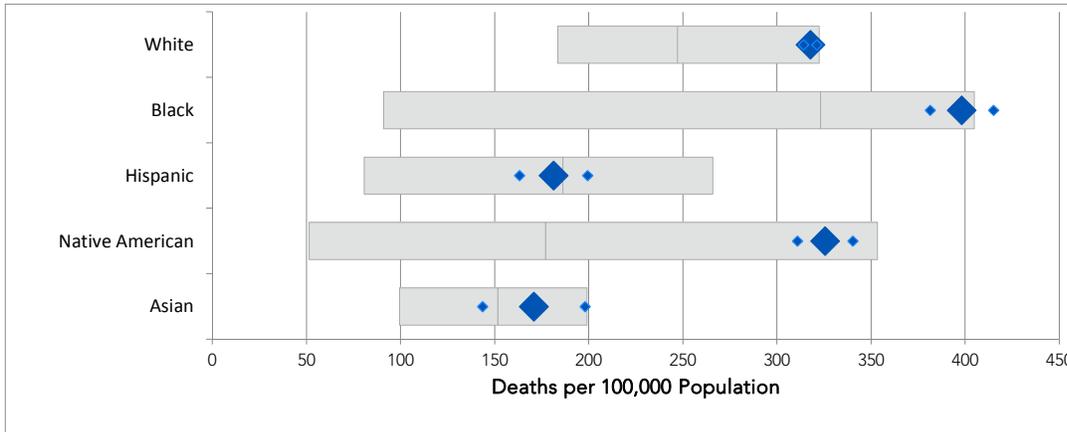
Cardiovascular Deaths

Number of deaths due to cardiovascular disease, including heart disease and stroke, per 100,000 population.



State
US

Source: National Vital Statistics System



Oklahoma Health Improvement Plan (OHIP): Healthy Oklahoma 2020 Executive Summary

The *Oklahoma Health Improvement Plan* Executive Summary highlights numerous key priorities and outcomes that will support health improvement throughout the state. As a result of Senate Joint Resolution 41 of the Oklahoma Legislature in 2008, the Oklahoma State Board of Health produced a report that outlines a plan for the “general improvement of the physical, social and mental well-being of all people in Oklahoma through a high-functioning public health system.” A multi-stakeholder OHIP planning team provided direction toward implementation of the plan. The second edition of the OHIP was published in March of 2015 and hard copy plans were provided to members of the State Board of Health prior to the unveiling of the plan.

For the complete OHIP, including a full list of partners, visit: <http://ohip2020.com>

OKLAHOMA HEALTH IMPROVEMENT PLAN

20/20: BRINGING OKLAHOMA'S HEALTH INTO FOCUS

The Oklahoma Health Improvement Plan (OHIP) was developed by health leaders, representatives of business, labor, tribes, academia, non-profit health organizations, state and local governments, professional organizations and private citizens.

OHIP Framework



Making the Connection: Social Determinants, Personal Behaviors and Health Outcomes



FLAGSHIP ISSUES

TOBACCO USE



45th

23.7%

on smoking among adults

OBESITY



44th

32.5%

on obesity among adults

CHILDREN'S HEALTH



43rd

6.8 PER 1,000

on infants who do not survive to their first birthday

BEHAVIORAL HEALTH



44th

4.3 DAYS

on number of poor mental health days in the past 30 days reported by adults

CORE MEASURES

Reduce adolescent smoking prevalence from 15.1% in 2013 to 10% in 2020 for high school-aged youth and from 4.8% in 2013 to 2% in 2020 for middle school-aged youth (2018 data).

Reduce adult smoking prevalence from 23.7% in 2013 to 18% in 2020 (2019 data).

CORE MEASURES

Reduce adolescent obesity prevalence from 11.8% in 2013 to 10.6% in 2020 (2019 data).

Reduce adult obesity prevalence from 32.5% in 2013 to 29.5% in 2020 (2019 data).

CORE MEASURES

Reduce infant mortality from 6.8 per 1,000 live births in 2013 to 6.4 per 1,000 live births by 2020 (2018 data).

Reduce Maternal Mortality from 29.1 per 100,000 live births to 26.2 per 100,000 live births by 2020 (2018 data).

Reduce Infant, Child and Adolescent Injury Mortality from 15.2 per 100,000 in 2013 to 13.9 per 100,000 by 2020 (2018 data).

CORE MEASURES

Reduce the prevalence of untreated mental illness from an 86% treatment gap to 76% in 2020 (2018 data).

Reduce the prevalence of addiction disorders from 8.8% to 7.8% by 2020 (2018 data).

Reduce suicide deaths from 22.8 per 100,000 in 2013 to 19.4 per 100,000 by 2020 (2017 data).

HEALTH SYSTEMS

In order for Oklahoma to achieve demonstrated improvement in health outcomes, systems that support health must be high quality, accessible and value-based. These systems should create an environment in which the healthy choice is the easy choice for Oklahomans. OHIP 2020 addresses health systems through two major focus areas – Health Transformation and Health Education.

HEALTH TRANSFORMATION

Efforts are focused on creating a high-functioning health system that improves population health, health quality and access to care while bending the healthcare cost curve.

HEALTH EDUCATION

Efforts are focused on empowering people to take action by increasing knowledge and skills, while also focusing on systems, environments and policies that affect health.

CALL TO ACTION

All Oklahomans are asked to do their part and participate in creating a culture of health through the following actions:

Adopt recommended healthy lifestyle changes and encourage your friends and family.

Get connected with a local Turning Point or other community partnership to plan and implement local community health improvement efforts.

Encourage local businesses, schools, communities, and congregations to apply for and achieve Certified Healthy Oklahoma recognition.

Visit www.health.ok.gov for a complete listing of Turning Point Coalitions in Oklahoma.

Go to OHIP2020.com to learn more about the Oklahoma Health Improvement Plan.

2014 Oklahoma State Department of Health Climate Survey

The 2014 organizational climate survey for the Oklahoma State Department of Health (OSDH) was conducted by the University of Oklahoma Health Sciences Center, Department of Biostatistics and Epidemiology. The OSDH had approximately a 60% response rate with 1,494 surveys completed. Included are the Climate Survey Summary Methods and Response Distributions by Dimension, Year, Trend, and Service Area.

Public Health Workforce Interests and Needs Survey (PH/WINS)

The PH WINS is a survey conducted by the Association of State and Territorial Health Officials (ASTHO) and the deBeaumont Foundation. The survey was conducted in 37 state public health departments, including the Oklahoma State Department of Health (OSDH), during 2014. The OSDH had approximately a 50% response rate with 1,116 surveys completed. Surveys were completed anonymously and electronically submitted to ASTHO/deBeaumont. The goal of the survey was to collect perspectives from across all programs, levels and geographic areas on workforce development needs. There are three major aims of the survey:

- To inform future investments in workforce development
- To establish a baseline of key workforce development metrics
- To explore workforce attitudes, morale, and climate

The information that follows is selected information from the PHWINS report. The full report can be accessed at the following link:

<http://www.debeaumont.org/programs/public-health-workforce-interest-and-needs-survey-ph-wins/>

Employee Engagement Survey

The Employee Engagement Survey was conducted by Durand Crosby, Chief Operating Officer for the Department of Mental Health and Substance Abuse Service, as part of a research project. The survey compared the OSDH with other state agencies and non-profit organizations and measured employee engagement and related variables including: Public service motivation, Perceived organizational image, Organizational commitment, Organization identification, Meaningfulness of work, and Job satisfaction. It should be noted that some agency surveys were edited by each agency such that not all agencies had the same variables. The survey report compares items that measured the same variables between different agencies.

Climate Survey
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I. 2014 OSDH Climate Survey Summary Methods

The OSDH climate survey consisted of 67 questions in the form of statements using a five-point Likert response scale. These questions were divided into four dimensions, the employee's 1) view of their job, 2) view of their program area, 3) view of the organization/central management, and 4) view of processes, improvements, and training. They were also divided into ten retention factors: 1) effective onboarding, 2) quality supervision, 3) effective communication, 4) opportunities for training and career development, 5) safe, secure, supportive, and engaging work environment, 6) effective system for the management of human resources, 7) rewards and recognition, 8) quality improvement, 9) overall job satisfaction, and 10) other. Ten demographic questions were included, identifying the agency service area, job group, County Health Department District, and work location of the employee. There were also five additional questions regarding public health emergencies, the employee assistance program, emergency preparedness and response, work-related concerns, and work-related suggestions for improvement (i.e. yes/no, importance scale, and open-ended response). A copy of the survey is provided in **Appendix C**.

The survey was distributed electronically and respondents accessed the survey through an email web link. The survey was distributed to 2,487 employees with a total of 1,494 employees submitting survey responses for a response rate of 60%. When considering the subset of 1417 employees who reported their work location as Central Office or County Health Department (5% of respondents did not provide their location information), and utilizing denominator information from Human Resource records as of 11/26/14, the response rate is 65% (555/856) among Central Office employees and 65% (862/1328) among County Health Department staff, compared to an overall response rate of 1417/2184 (65%) among those classified as Central Office or County Health Department staff. Note that the location-specific estimates should be interpreted cautiously given that the denominator based on Human Resources information (n=2184) is somewhat lower than the denominator used for survey distribution (n=2487). This discrepancy is due in part to former employees exiting the Human Resources records once they transfer to a different state agency and the lag between the date of survey administration in July 2014 and the November 26, 2014 date on which the Human Resources records were queried. As a comparison, in 2012, the survey was distributed to 2,333 employees with a total of 1,740 employees completing the survey for a response rate of 74.6%. The response rate could not be calculated separately among County Health Department versus Central Office locations for 2012 because accurate employee numbers at the time of survey administration are not known given that employees are removed from the Human Resource system once they transfer to another state agency.

The initial survey invitation was sent to employees on Monday, July 21, 2014. Reminders were sent to employees on July 28, August 4 and August 7, 2014 and the survey link was closed on Friday, August 8, 2014. Data was then retrieved from the server and analyzed for the agency as a whole and after stratifying by agency service areas (Survey Item A), classification group (Survey Item C), job group (Survey Item D), broad category of job group (Survey Item E), office staff group (Central Office Staff vs. County Staff), and County Health Department District (coded as Districts 1-15). County Health Department Districts were coded, for analysis purposes, as **summarized in the following table**. In the 2014 survey, several counties, including Alfalfa County, Cimarron County, Dewey County, Ellis County,

Nowata County, Roger Mills County, and Washita County, were not included in the County Health Department District stratified analyses because these counties do not have county health department locations; however, responses from these counties were included in the overall data summaries.

Code	County Health Department	Administrator	District Code
010	Cherokee County Health Department	Alexander	1
016	Craig County Health Department	Alexander	1
019	Delaware County Health Department	Alexander	1
045	Mayes County Health Department	Alexander	1
052	Ottawa County Health Department	Alexander	1
059	Rogers County Health Department	Alexander	1
020	Garfield County Health Department	Dionne	2
023	Grant County Health Department	Dionne	2
043	Major County Health Department	Dionne	2
002	Atoka County Health Department	Echelle	3
013	Coal County Health Department	Echelle	3
035	Latimer County Health Department	Echelle	3
055	Pittsburg County Health Department	Echelle	3
056	Pontotoc County Health Department	Echelle	3
006	Bryan County Health Department	Fowler	4
011	Choctaw County Health Department	Fowler	4
041	McCurtain County Health Department	Fowler	4
058	Pushmataha County Health Department	Fowler	4
021	Garvin County Health Department	Milton	5
022	Grady County Health Department	Milton	5
046	Murray County Health Department	Milton	5
062	Stephens County Health Department	Milton	5
032	Kay County Health Department	O'Connor, A	6
048	Noble County Health Department	O'Connor, A	6
053	Pawnee County Health Department	O'Connor, A	6
054	Payne County Health Department	O'Connor, A	6
007	Caddo County Health Department	O'Connor, B	7
014	Comanche County Health Department	O'Connor, B	7
015	Cotton County Health Department	O'Connor, B	7
034	Kiowa County Health Department	O'Connor, B	7
047	Muskogee County Health Department	Pierson	8
050	Okmulgee County Health Department	Pierson	8
051	Osage County Health Department	Pierson	8
066	Wagoner County Health Department	Pierson	8
067	Washington County Health Department	Pierson	8

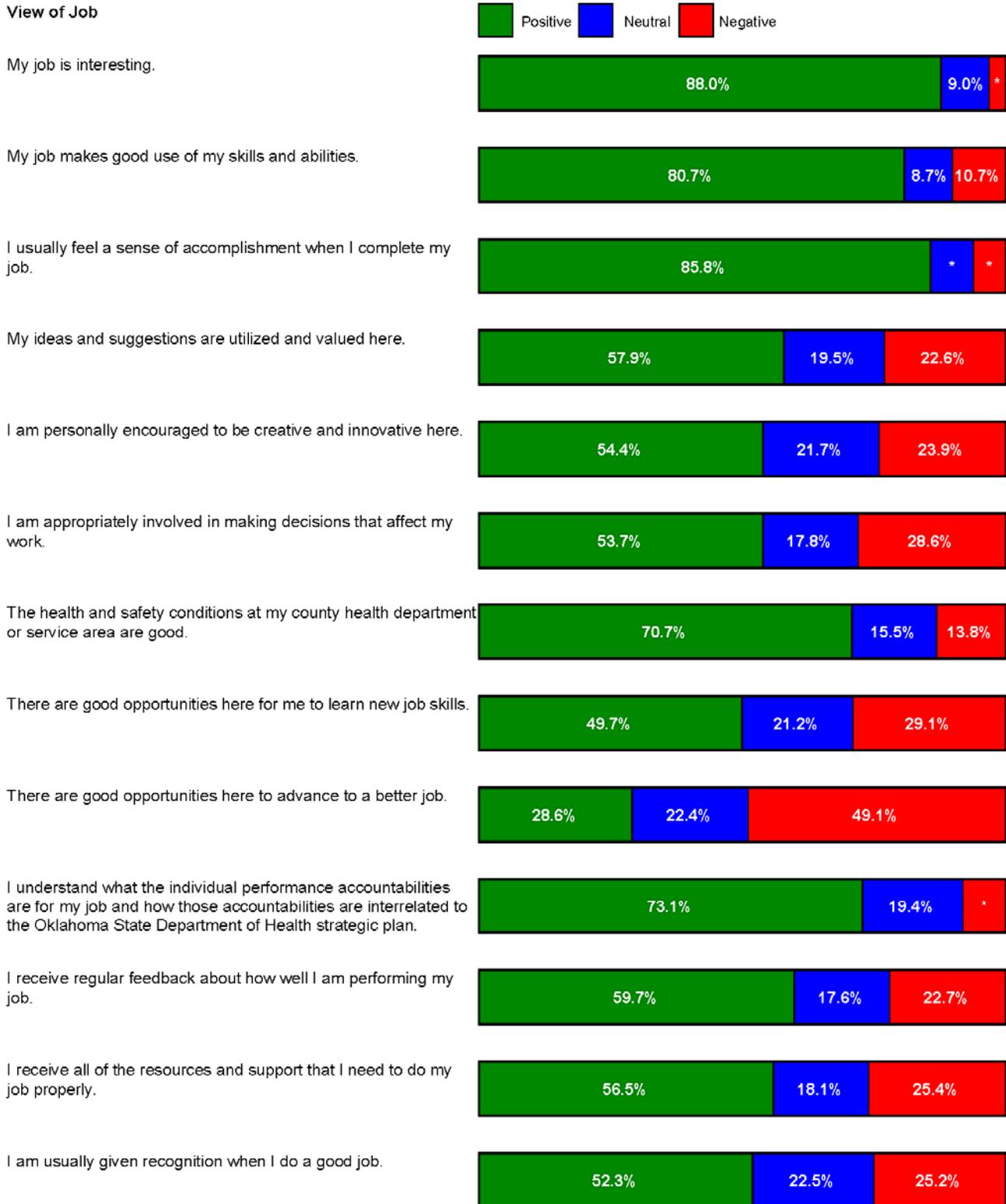
Code	County Health Department	Administrator	District Code
028	Hughes County Health Department	Potts	9
049	Okfuskee County Health Department	Potts	9
057	Pottawatomie County Health Department	Potts	9
060	Seminole County Health Department	Potts	9
001	Adair County Health Department	Rader	10
027	Haskell County Health Department	Rader	10
036	LeFlore County Health Department	Rader	10
042	McIntosh County Health Department	Rader	10
061	Sequoyah County Health Department	Rader	10
012	Cleveland County Health Department	Reed	11
040	McClain County Health Department	Reed	11
003	Beaver County Health Department	Salisbury	12
026	Harper County Health Department	Salisbury	12
063	Texas County Health Department	Salisbury	12
068	Woods County Health Department	Salisbury	12
069	Woodward County Health Department	Salisbury	12
005	Blaine County Health Department	Smith	13
008	Canadian County Health Department	Smith	13
017	Creek County Health Department	Smith	13
018	Custer County Health Department	Smith	13
033	Kingfisher County Health Department	Smith	13
037	Lincoln County Health Department	Smith	13
038	Logan County Health Department	Smith	13
009	Carter County Health Department	Spohn	14
030	Jefferson County Health Department	Spohn	14
031	Johnston County Health Department	Spohn	14
039	Love County Health Department	Spohn	14
044	Marshall County Health Department	Spohn	14
004	Beckham County Health Department	Weaver	15
024	Greer County Health Department	Weaver	15
025	Harmon County Health Department	Weaver	15
029	Jackson County Health Department	Weaver	15
064	Tillman County Health Department	Weaver	15

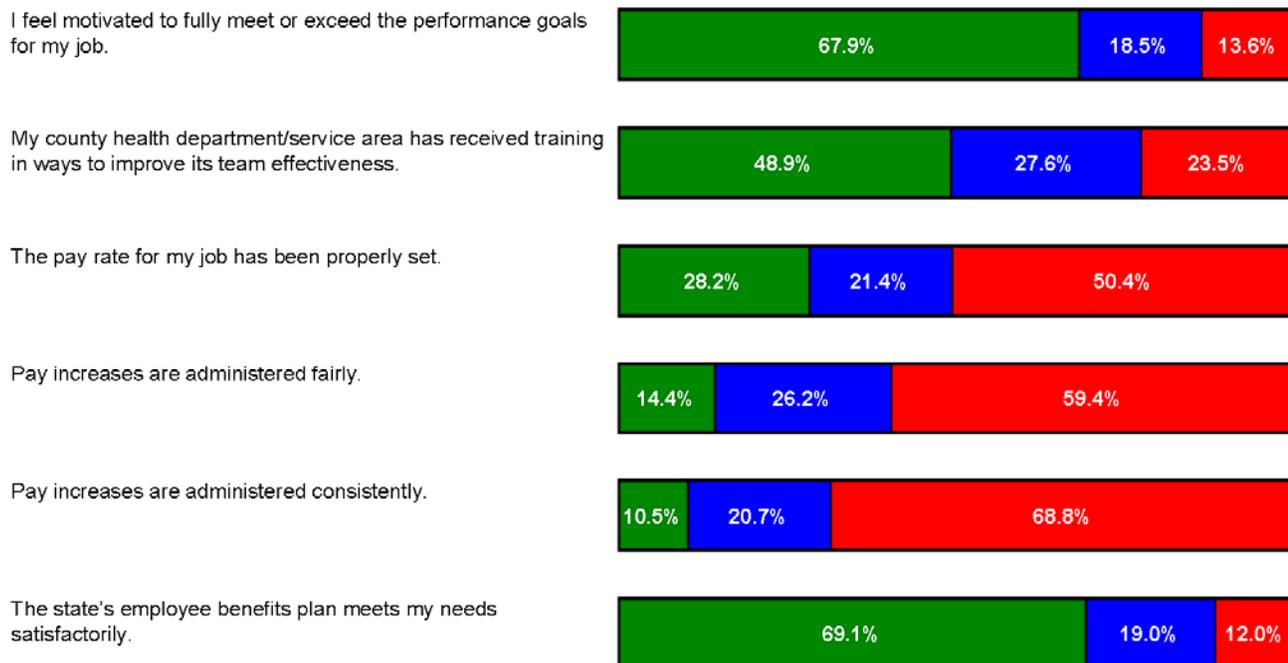
The statistical data in this report is presented in the form of a percentage distribution. Because all survey items were stated in the positive, a response of “Strongly Agree” and “Agree” are considered a positive response. “Neither Agree nor Disagree” is considered a neutral response, and “Inclined to Disagree” and “Strongly Disagree” are considered negative responses. This summary includes a comparison of the positive responses among all participants in the 2014, 2012, 2010, 2001, and where possible, the 1997 survey. The results section includes a footnote to indicate changes in survey question items among the years. Horizontal bar charts of the overall response distributions (positive, neutral, and negative) were created for the survey items. The bar charts are grouped by dimension and by retention factor. Positive responses were also compared among subgroups. These subgroup analyses included comparisons by agency service areas (Survey Item A), classification group (Survey Item C), job group (Survey Item D), broad category of job group

(Survey Item E), office staff group (Central Office Staff vs. County Staff, Survey Item B), and County Health Department District (Districts 1-15).

II. Overall 2014 Response Distribution by Dimension

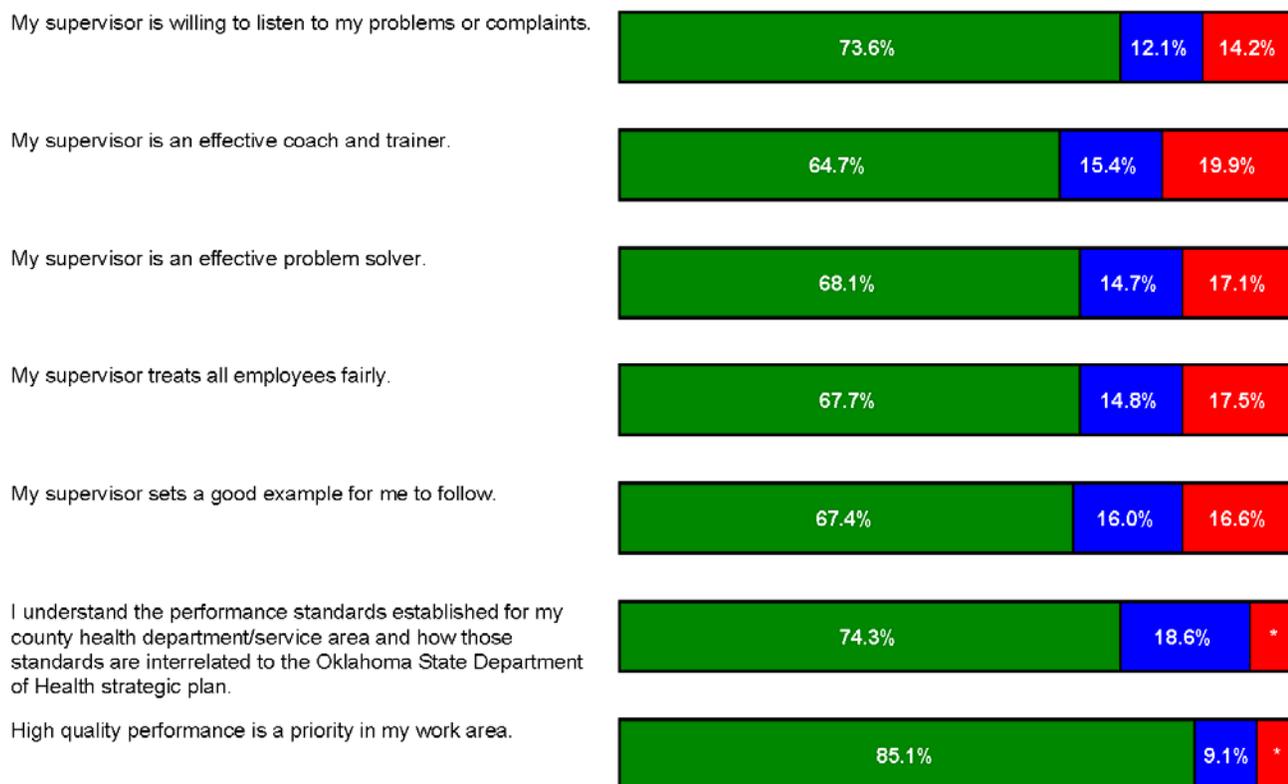
II. Overall 2014 Response Distribution by Dimension

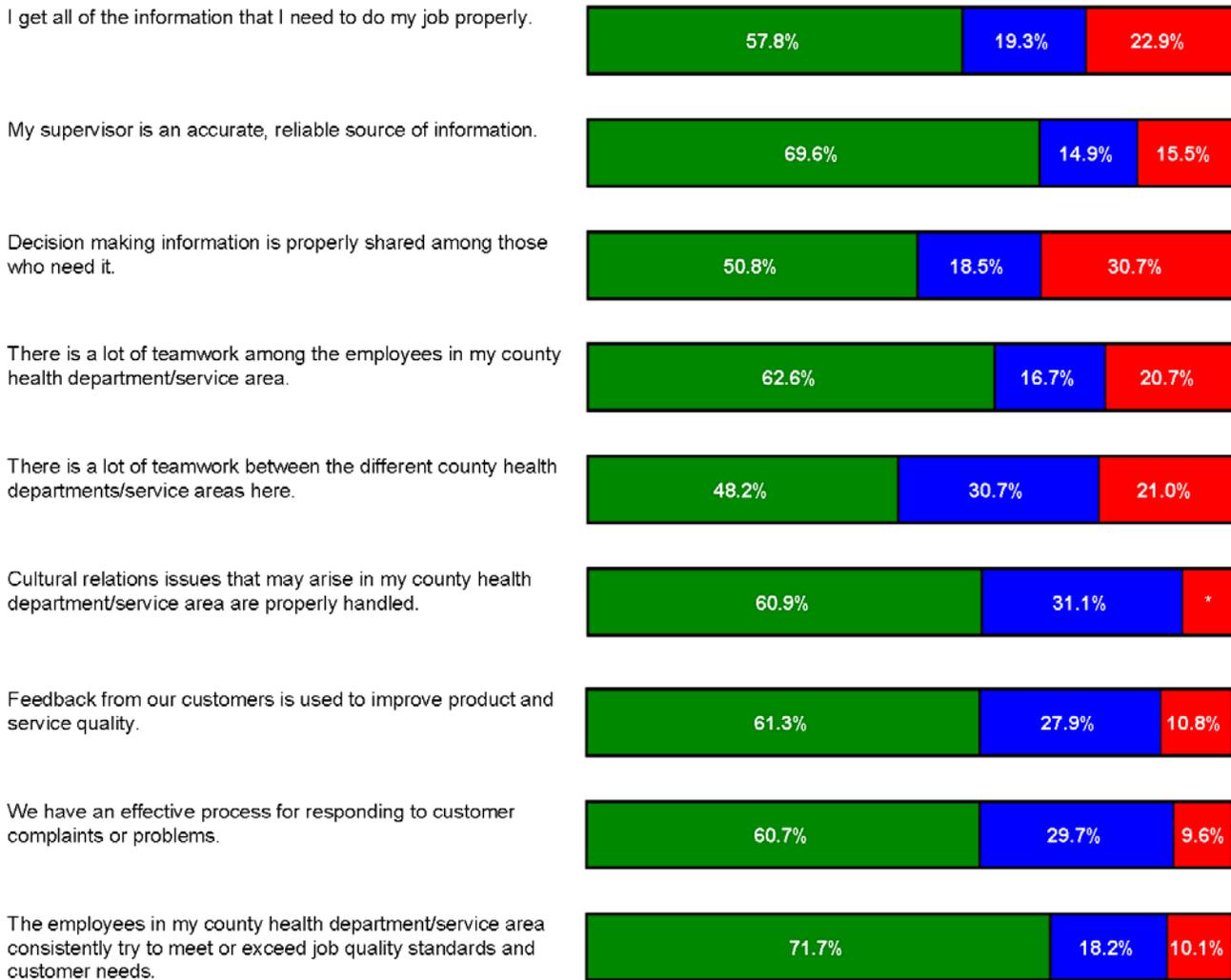




* % not displayed for less than 9% Note: Percents may not sum

View of Program Area

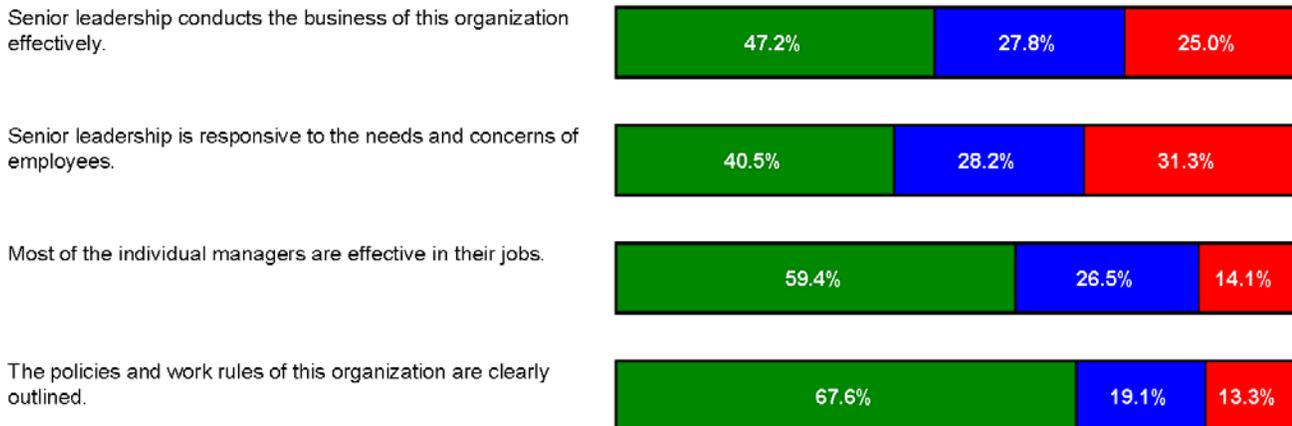


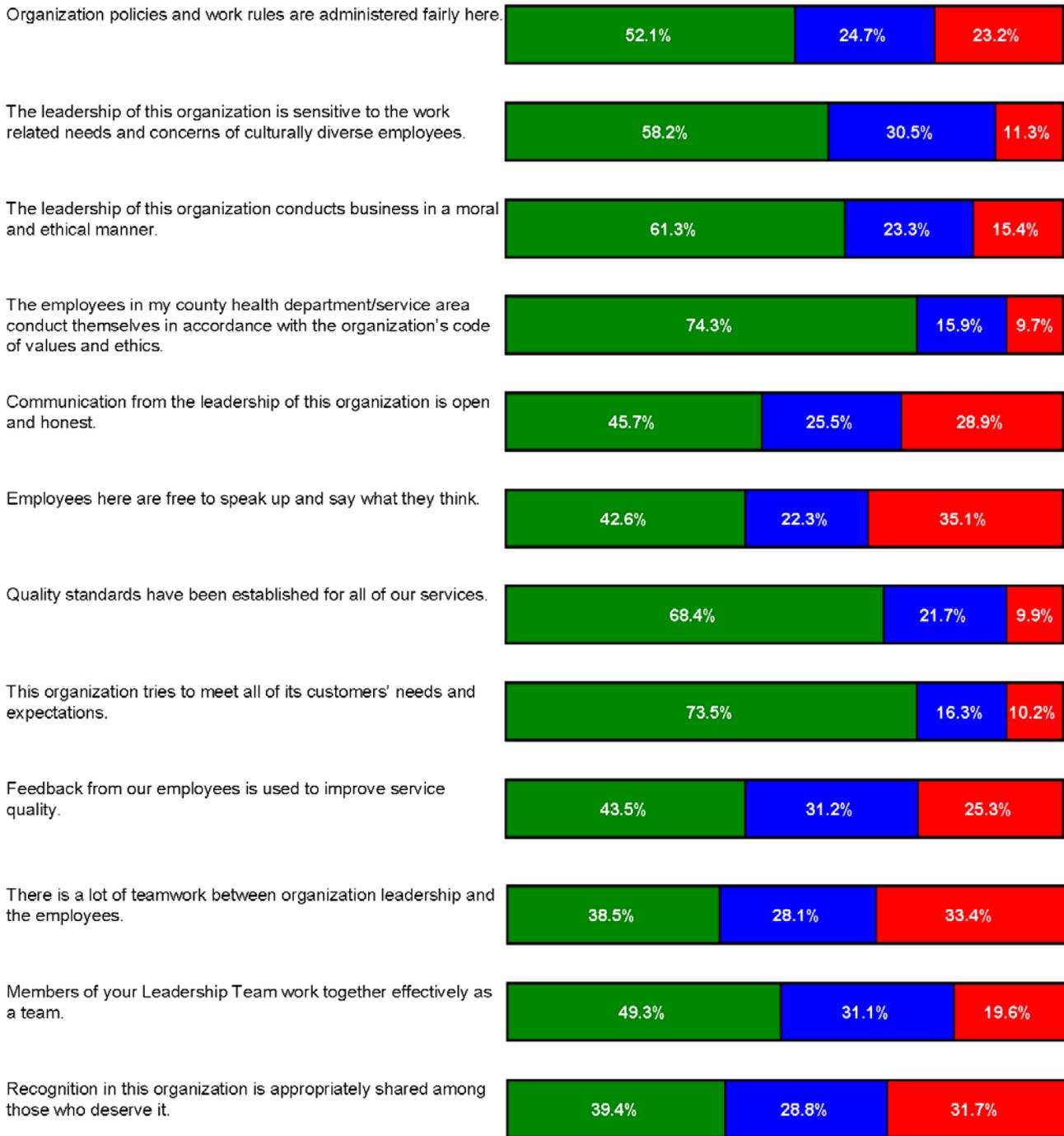


* % not displayed for less than 9%

Note: Percents may not sum

View of Organization/Central Management





* % not displayed for less than 9%

Note: Percents may not sum

View of Processes, Improvements, and Training



My county health department or service area continually strives to improve the way it conducts business.



I feel comfortable discussing possible ways to improve efficiency, effectiveness, and productivity with my supervisor.



My work location utilizes quality improvement techniques and tools for identifying and implementing work processes or service improvements.



I am aware of the agency's employee recognition and appreciation program and the process for submitting a nomination.



The agency's recognition program is an excellent way to recognize employee contributions and performance.



The Oklahoma State Department of Health onboarding process is informative, thorough, and effective.



The agency's New Employee Orientation is well developed and effective.



The agency's in-service training is well developed and effective.



There is open communication and transparency up, down, and across the organization.



The Oklahoma State Department of Health provides a supportive environment for maintaining work/life balance and addressing work/life stressors.



There are human resources procedures and practices in place that ensure fair treatment of all employees.



There are human resources procedures and practices in place that ensure equitable treatment of all employees.



I am aware of the Office of Accountability Systems.



I do not fear retaliation if I bring issues to the Office of Accountability Systems.



I am aware of the Oklahoma State Department of Health grievance process.



I do not fear retaliation if I were to utilize the Oklahoma State Department of Health grievance process.



* % not displayed for less than 9%

Note: Percents may not sum

III. Response Distribution by Year – Tables

III. Response Distribution by Year – Tables

Percentages of positive responses that changed by more than 5% (absolute difference) relative to 2012 are highlighted in green (5% increase) or are highlighted in red (5% decrease).

View of Job	2014 Survey Results						2014 Comparison of Positive Responses				
	Strongly Agree	Inclined to Agree	Neither Agree Nor Disagree	Inclined to Disagree	Strongly Disagree	Positive Responses	2014	2012	2010	2001	1997
My job is interesting.	777	518	133	26	18	1295	88.0%	88.0%	91.6%	88.1%	
My job makes good use of my skills and abilities.	660	528	128	116	41	1188	80.7%	78.7%	79.3%	81.0%	64.0%
I usually feel a sense of accomplishment when I complete my job.	707	559	116	65	28	1266	85.8%	84.9%	85.3%	84.5%	
My ideas and suggestions are utilized and valued here.	366	488	287	206	128	854	57.9%	55.6%	54.0%	49.4%	41.0%
I am personally encouraged to be creative and innovative here.	372	432	320	215	138	804	54.4%	54.7%	52.3%	51.7%	
I am appropriately involved in making decisions that affect my work.	333	456	261	247	173	789	53.7%	50.9%	50.3%	49.6%	48.0%
The health and safety conditions at my county health department or service area are good.	541	496	228	137	65	1037	70.7%	72.0%	70.0%	66.8%	64.5%
There are good opportunities here for me to learn new job skills.	322	411	312	253	176	733	49.7%	43.3%	47.6%	51.7%	47.0%
There are good opportunities here to advance to a better job.	153	266	328	336	384	419	28.6%	21.1%	19.0%	22.7%	
I understand what the individual performance accountabilities are for my job and how those accountabilities are interrelated to the Oklahoma State Department of Health strategic plan.	488	590	286	62	48	1078	73.1%	74.0%	84.1%	84.4%	80.0%
I receive regular feedback about how well I am performing my job.	351	529	259	212	122	880	59.7%	59.9%	57.3%	56.1%	41.0%
I receive all of the resources and support that I need to do my job properly.	299	532	267	252	122	831	56.5%	55.1%	52.3%	48.6%	52.0%
I am usually given recognition when I do a good job.	313	455	331	205	165	768	52.3%	53.6%	51.5%	44.3%	41.0%
I feel motivated to fully meet or exceed the performance goals for my job.	473	527	272	108	93	1000	67.9%	65.0%	66.9%	60.2%	
My county health department/service area has received training in ways to improve its team effectiveness.	277	439	404	213	131	716	48.9%	43.1%	48.1%	50.3%	
The pay rate for my job has been properly set.	134	282	315	346	396	416	28.2%	13.2%	20.8%	23.1%	
Pay increases are administered fairly.*	72	139	385	307	565	211	14.4%	5.0%	7.7%	12.4%	
Pay increases are administered consistently.*	54	99	303	324	681	153	10.5%				
The state's employee benefits plan meets my needs satisfactorily.	388	621	277	105	70	1009	69.1%	63.4%	69.2%	53.9%	

*In previous surveys, this question was worded as “Pay increases are administered fairly and consistently.”

III. Response Distribution by Year – Tables

View of Program Area	2014 Survey Results						2014 Comparison of Positive Responses				
	Strongly Agree	Inclined to Agree	Neither Agree Nor Disagree	Inclined to Disagree	Strongly Disagree	Positive Responses	2014	2012	2010	2001	1997
My supervisor is willing to listen to my problems or complaints.	651	430	178	96	113	1081	73.6%	75.4%	77.8%	73.9%	
My supervisor is an effective coach and trainer.	514	438	227	147	145	952	64.7%	65.5%	62.5%	58.8%	
My supervisor is an effective problem solver.	541	458	216	125	126	999	68.1%	68.8%	65.6%	60.0%	
My supervisor treats all employees fairly.	553	443	217	107	151	996	67.7%	67.1%	64.9%	60.3%	53.0%
My supervisor sets a good example for me to follow.	570	415	234	109	133	985	67.4%	68.6%	66.2%	59.8%	52.0%
I understand the performance standards established for my county health department/service area and how those standards are interrelated to the Oklahoma State Department of Health strategic plan.	479	606	272	69	35	1085	74.3%	68.7%	82.8%	75.8%	68.0%
High quality performance is a priority in my work area.	724	528	134	57	29	1252	85.1%	82.0%	85.2%	72.1%	
I get all of the information that I need to do my job properly.	346	504	284	228	108	850	57.8%	58.2%	62.7%	47.0%	52.0%
My supervisor is an accurate, reliable source of information.	569	453	218	108	120	1022	69.6%	71.2%	70.6%	65.5%	
Decision making information is properly shared among those who need it.	332	414	272	272	179	746	50.8%	50.0%	48.8%	34.9%	31.0%
There is a lot of teamwork among the employees in my county health department/service area.	457	461	245	159	144	918	62.6%	62.7%	66.4%	69.3%	68.0%
There is a lot of teamwork between the different county health departments/service areas here.	216	490	450	205	103	706	48.2%	43.5%	46.6%	45.9%	40.0%
Cultural relations issues that may arise in my county health department/service area are properly handled.	334	556	454	72	45	890	60.9%	61.4%	64.2%	50.7%	33.0%
Feedback from our customers is used to improve product and service quality.	325	573	409	103	56	898	61.3%	58.9%	59.5%	47.8%	54.0%
We have an effective process for responding to customer complaints or problems.	325	563	435	96	45	888	60.7%	60.6%	61.3%	43.3%	45.0%
The employees in my county health department/service area consistently try to meet or exceed job quality standards and customer needs.	450	600	266	108	40	1050	71.7%	70.6%	75.4%	71.4%	

III. Response Distribution by Year – Tables

View of Organization/Central Management	2014 Survey Results						2014 Comparison of Positive Responses				
	Strongly Agree	Inclined to Agree	Neither Agree Nor Disagree	Inclined to Disagree	Strongly Disagree	Positive Responses	2014	2012	2010	2001	1997
Senior leadership conducts the business of this organization effectively.*	262	428	407	201	165	690	47.2%	50.6%	49.4%	31.8%	34.0%
Senior leadership is responsive to the needs and concerns of employees.**	233	359	412	242	215	592	40.5%	46.6%	42.7%	29.1%	31.0%
Most of the individual managers are effective in their jobs.	298	571	388	139	68	869	59.4%	59.6%	56.1%	29.7%	48.0%
The policies and work rules of this organization are clearly outlined.	378	612	280	121	73	990	67.6%	69.5%	68.4%	84.3%	
Organization policies and work rules are administered fairly here.	307	454	360	184	155	761	52.1%	53.5%	51.5%	47.4%	35.0%
The leadership of this organization is sensitive to the work related needs and concerns of culturally diverse employees.	313	543	448	89	77	856	58.2%	55.6%	58.6%	53.3%	
The leadership of this organization conducts business in a moral and ethical manner.	372	528	342	126	100	900	61.3%	64.3%	64.7%	56.1%	
The employees in my county health department/service area conduct themselves in accordance with the organization's code of values and ethics.	459	632	234	93	50	1091	74.3%	75.9%	79.3%	73.4%	
Communication from the leadership of this organization is open and honest.	273	399	375	234	191	672	45.7%	48.5%	46.7%	45.5%	
Employees here are free to speak up and say what they think.	227	399	327	262	254	626	42.6%	44.4%	43.6%	43.7%	48.0%
Quality standards have been established for all of our services.	369	631	318	97	48	1000	68.4%	65.0%	63.8%	48.8%	
This organization tries to meet all of its customers' needs and expectations.	440	639	239	107	43	1079	73.5%	72.1%	72.5%	62.1%	51.0%
Feedback from our employees is used to improve service quality.	242	396	458	201	171	638	43.5%	43.5%	41.0%	47.4%	36.0%
There is a lot of teamwork between organization leadership and the employees.	231	332	412	262	227	563	38.5%	39.0%	35.7%	40.0%	35.0%
Members of your Leadership Team work together effectively as a team.	274	442	451	162	122	716	49.3%	42.8%	39.7%	37.3%	32.0%
Recognition in this organization is appropriately shared among those who deserve it.	216	355	418	244	216	571	39.4%	38.3%	38.1%	18.4%	

*In previous surveys, this question was worded as “Management conducts the business of this organization effectively.”

**In previous surveys, this question was worded as “Management is responsive to the needs and concerns of employees.”

III. Response Distribution by Year – Tables

View of Process, Improvements, and Training	2014 Survey Results						2014 Comparison of Positive Responses				
	Strongly Agree	Inclined to Agree	Neither Agree Nor Disagree	Inclined to Disagree	Strongly Disagree	Positive Responses	2014	2012	2010	2001	1997
My county health department or service area continually strives to improve the way it conducts business.	488	591	253	104	32	1079	73.5%	69.5%			
I feel comfortable discussing possible ways to improve efficiency, effectiveness, and productivity with my supervisor.	508	480	221	145	116	988	67.2%	68.6%			
My work location utilizes quality improvement techniques and tools for identifying and implementing work processes or service improvements.	379	516	364	139	66	895	61.1%	58.8%			
I am aware of the agency's employee recognition and appreciation program and the process for submitting a nomination.	437	596	268	112	55	1033	70.4%	70.9%			
The agency's recognition program is an excellent way to recognize employee contributions and performance.	300	436	472	165	94	736	50.2%	48.4%			
The Oklahoma State Department of Health onboarding process is informative, thorough, and effective.	186	368	618	172	120	554	37.8%	34.0%			
The agency's New Employee Orientation is well developed and effective.	194	431	620	142	78	625	42.7%	39.2%			
The agency's in-service training is well developed and effective.	194	492	520	172	79	686	47.1%	43.4%			
There is open communication and transparency up, down, and across the organization.	145	266	409	309	334	411	28.1%	26.7%			
The Oklahoma State Department of Health provides a supportive environment for maintaining work/life balance and addressing work/life stressors.	238	453	380	211	178	691	47.3%	46.8%			
There are human resources procedures and practices in place that ensure fair treatment of all employees.*	296	522	366	156	125	818	55.8%	51.3%			
There are human resources procedures and practices in place that ensure equitable treatment of all employees.*	296	518	382	148	121	814	55.6%				
I am aware of the Office of Accountability Systems.	431	652	241	98	41	1083	74.0%	70.3%			
I do not fear retaliation if I bring issues to the Office of Accountability Systems.	265	340	444	192	221	605	41.4%	39.6%			
I am aware of the Oklahoma State Department of Health grievance process.	413	705	210	92	40	1118	76.6%	74.4%			
I do not fear retaliation if I were to utilize the Oklahoma State Department of Health grievance process.	258	323	413	212	249	581	39.9%	39.4%			

*In previous surveys, this question was worded as "There are human resources procedures and practices in place that ensure fair and equitable treatment of all employees."

III. Response Distribution by Year – Tables

In my position at the Oklahoma State Department of Health, I think I should be expected to assist with a public health emergency event or incident.	2014 Survey		2012 Survey		2010 Survey	
	Yes	1247	85.5%	1,384	82.0%	1,129
No	211	14.5%	305	18.0%	262	18.7%

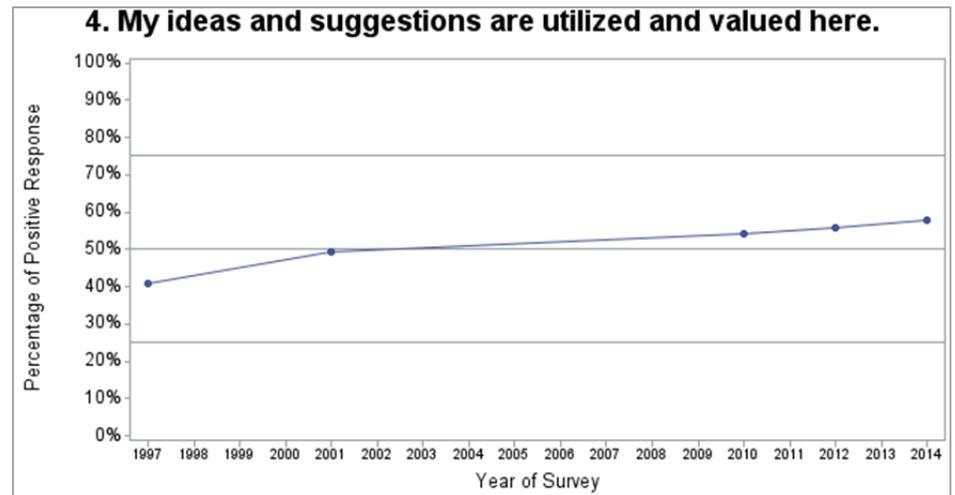
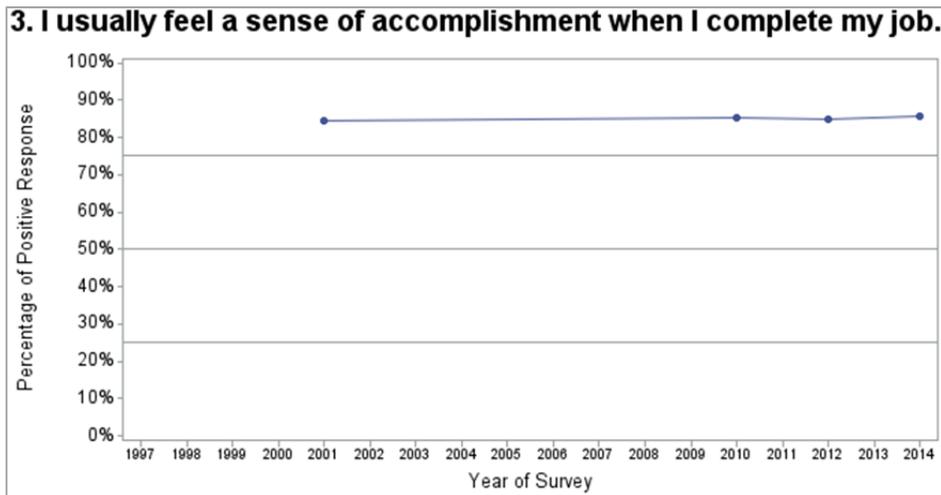
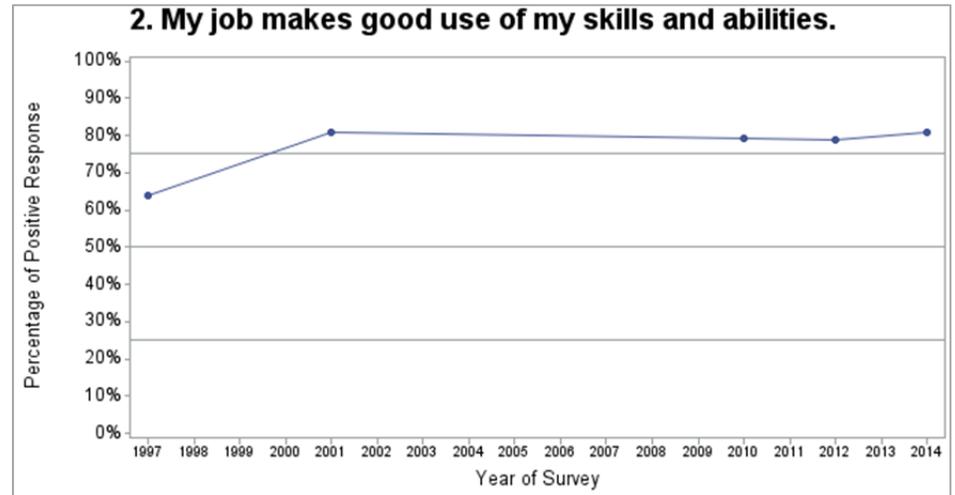
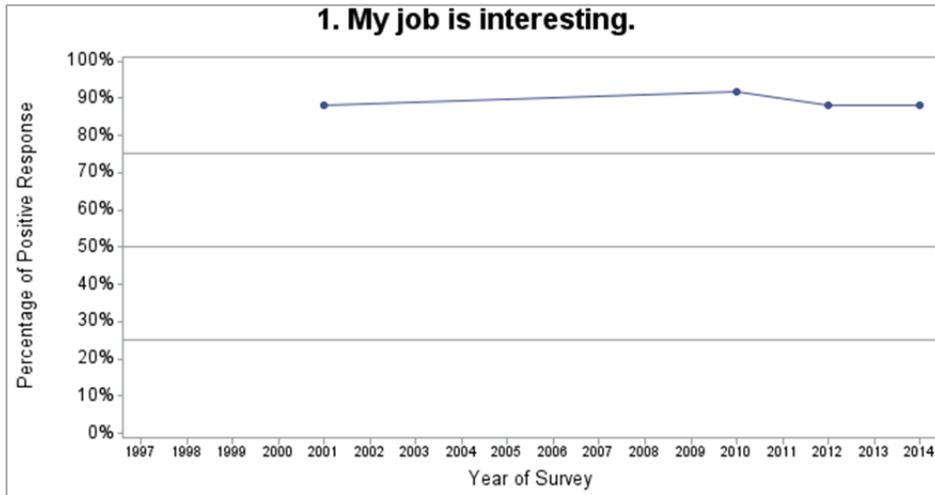
I am aware that Oklahoma State Department of Health has an employee assistance program (EAP), and I am confident that I could access this program should I find it necessary to do so.	2014 Survey		2012 Survey		2010 Survey	
	Yes	1295	88.8%	1,507	90.0%	1,189
No	163	11.2%	176	10.0%	208	14.8%

I feel emergency preparedness and response is ...	2014 Survey		2012 Survey		2010 Survey	
	Not a role of public health as a public health function of this agency	17	1.2%	21	1.2%	7
Not very important as a public health function of this agency	24	1.6%	31	1.8%	28	2.0%
Somewhat important as a public health function of this agency	214	14.6%	349	20.0%	310	22.1%
Very important as a public health function of this agency	1209	82.6%	1,321	77.0%	1056	75.4%

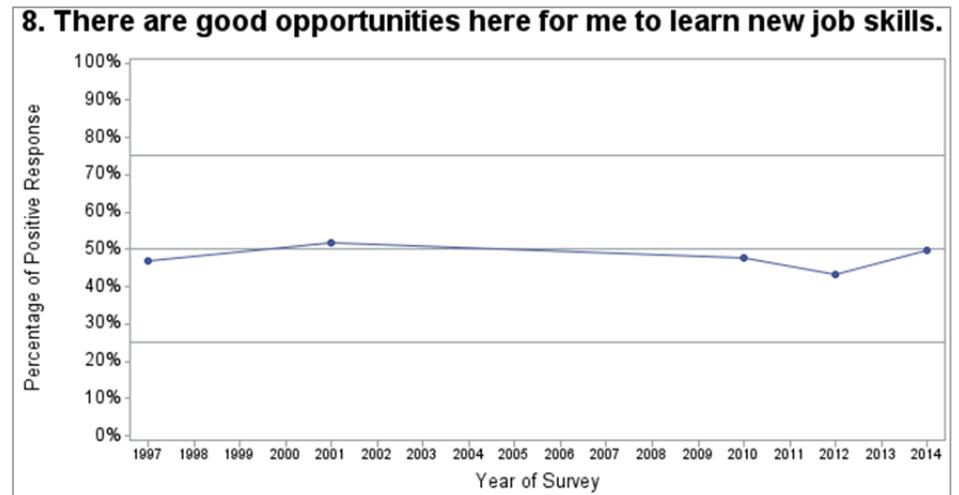
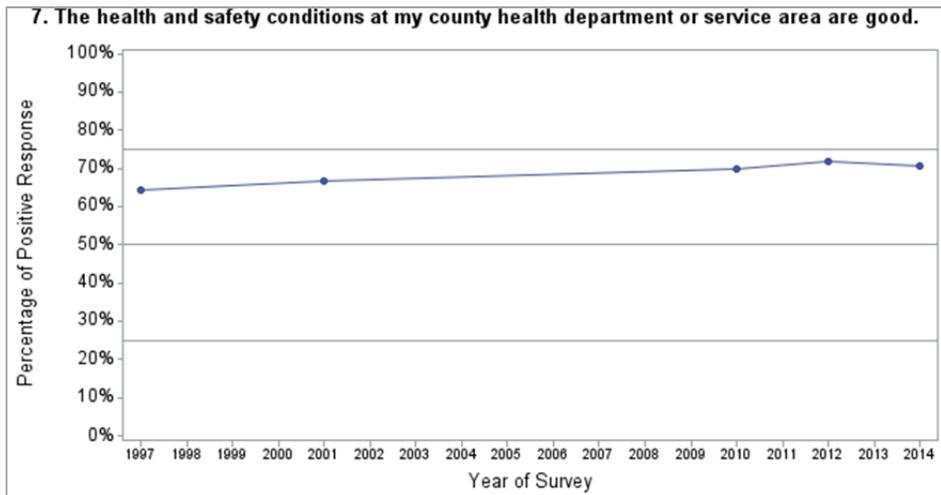
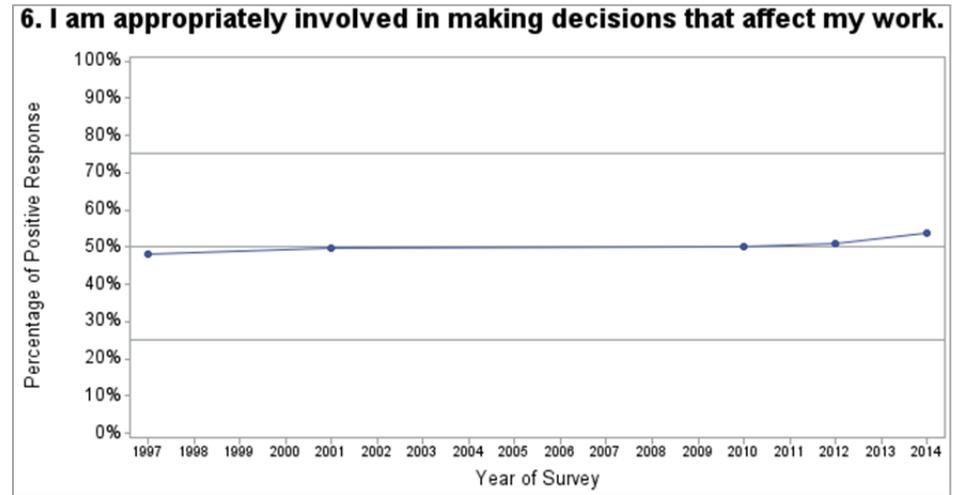
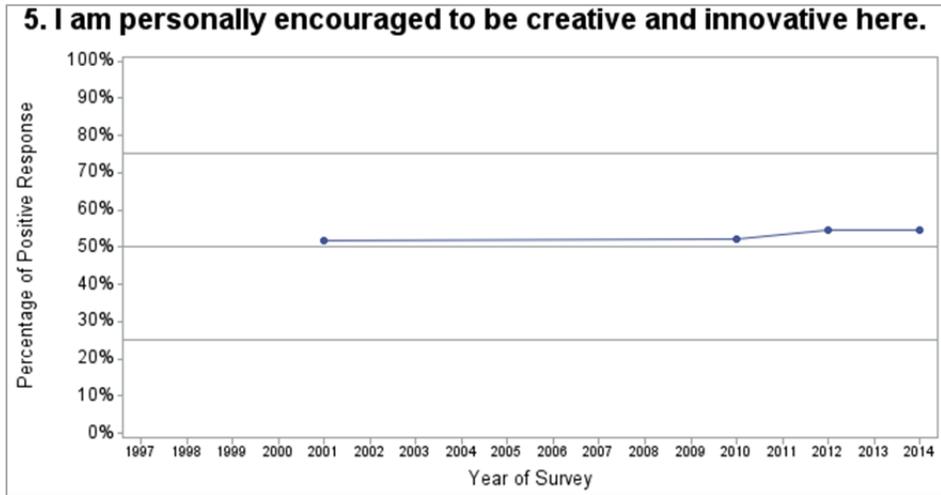
I have worked for the Oklahoma State Department of Health for:	2014 Survey		2012 Survey	
	Less than 1 year	208	14.1%	189
1 to 2 years	234	15.9%	165	9.6%
3 to 5 years	188	12.8%	225	13.0%
6 to 10 years	256	17.4%	383	22.0%
More than 10 years	586	39.8%	763	44.0%

IV. Response Distribution by Year – Trend Line Figures

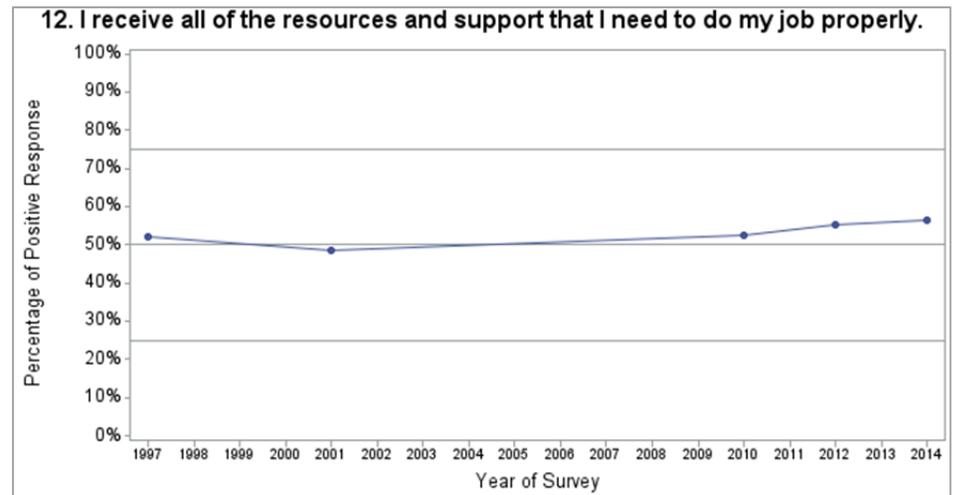
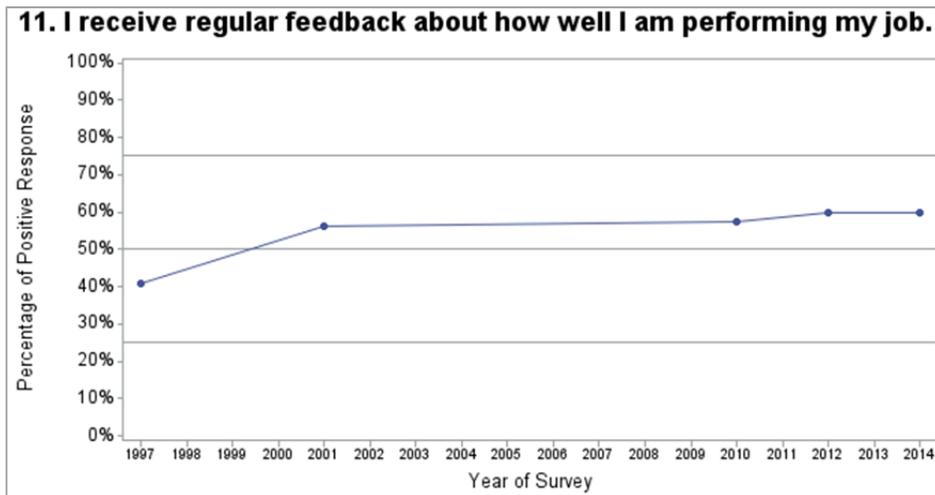
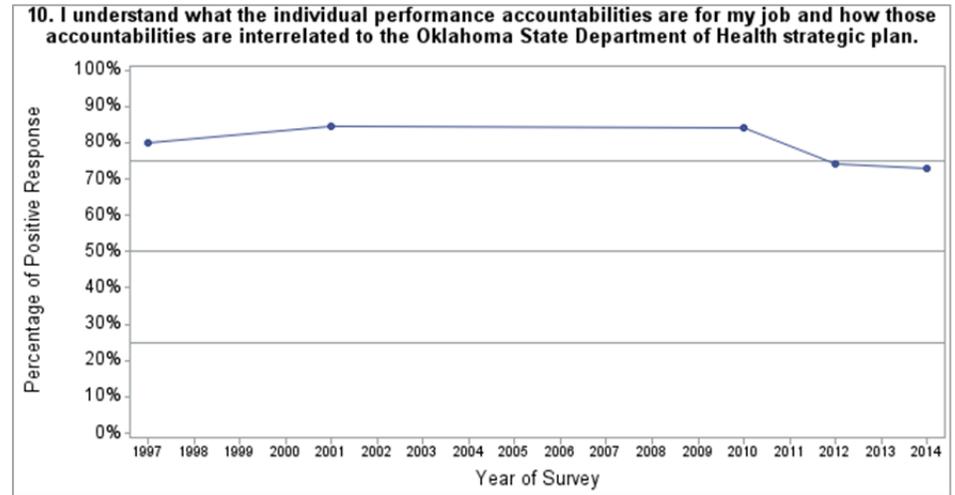
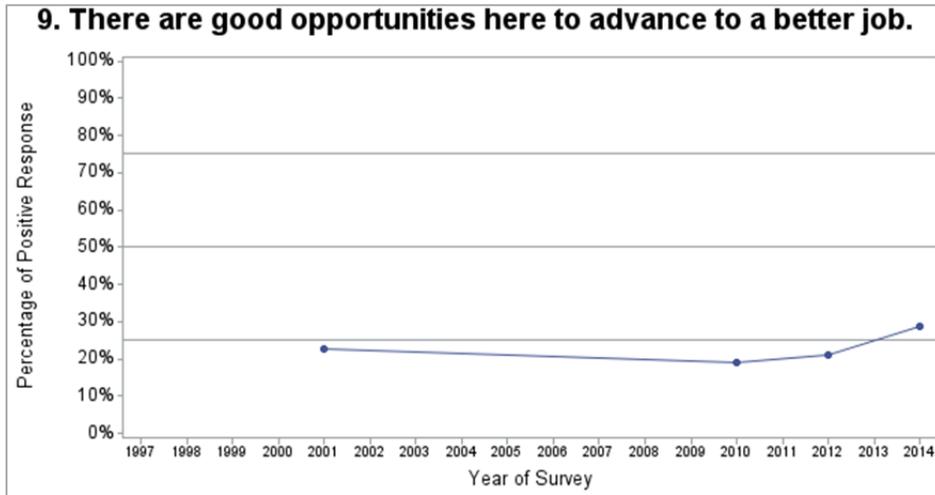
IV. Response Distribution by Year – Trend Line Figures



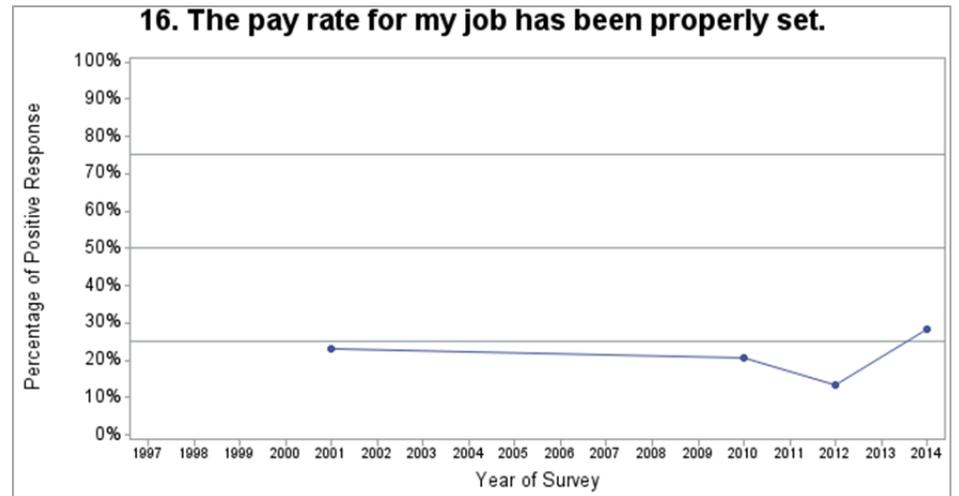
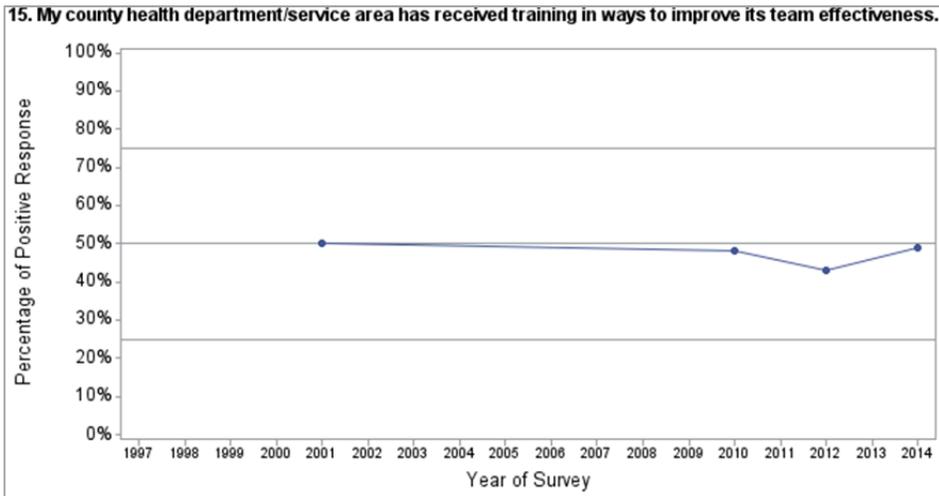
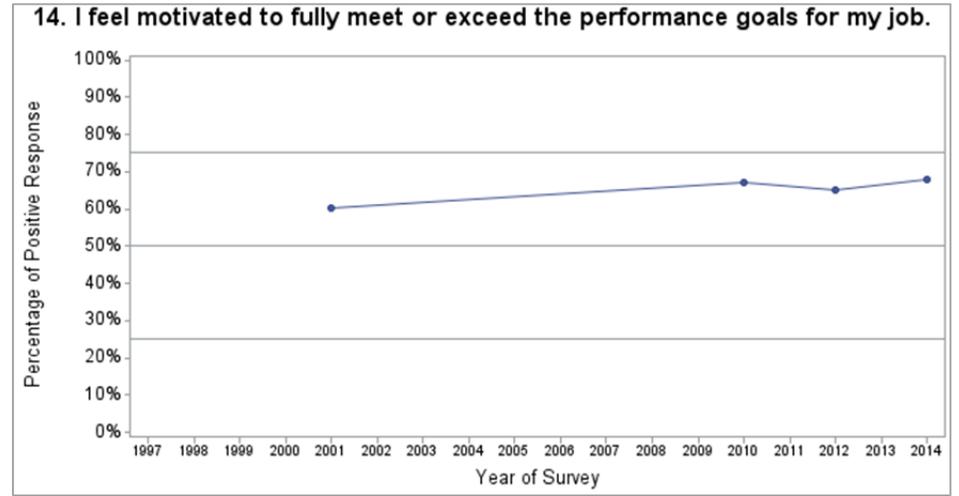
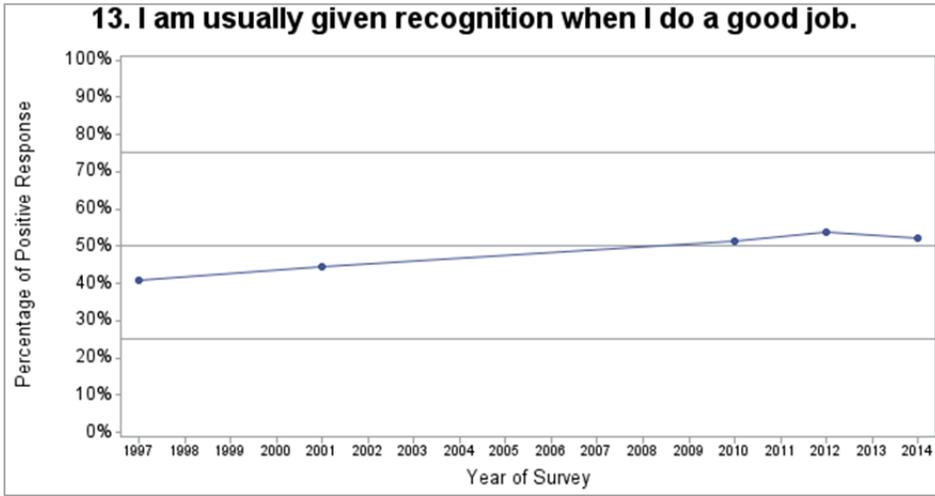
IV. Response Distribution by Year – Trend Line Figures



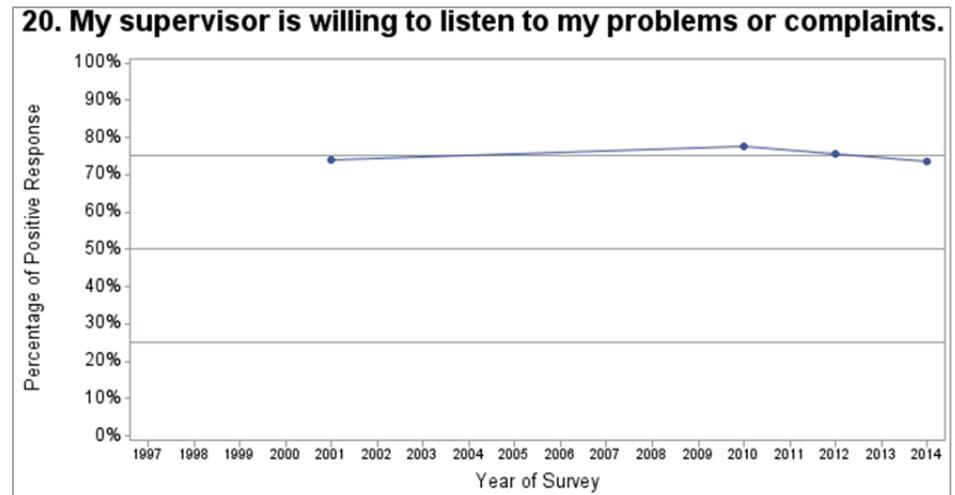
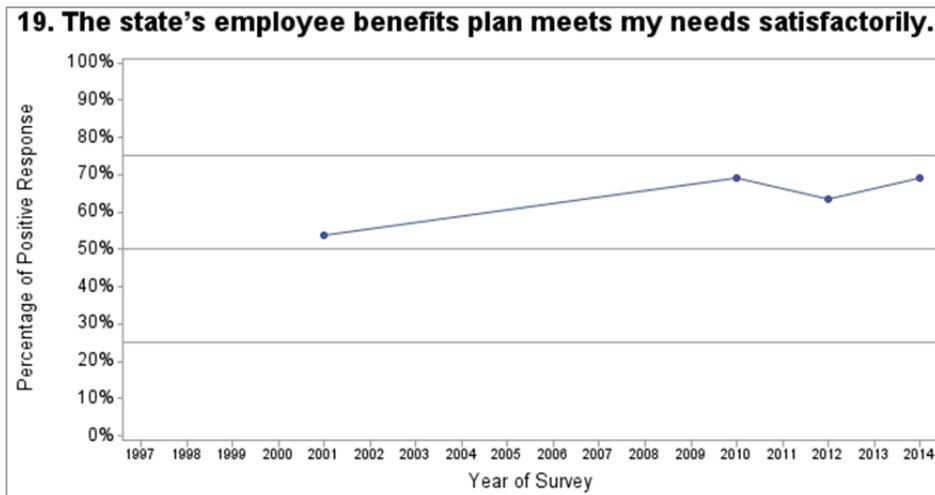
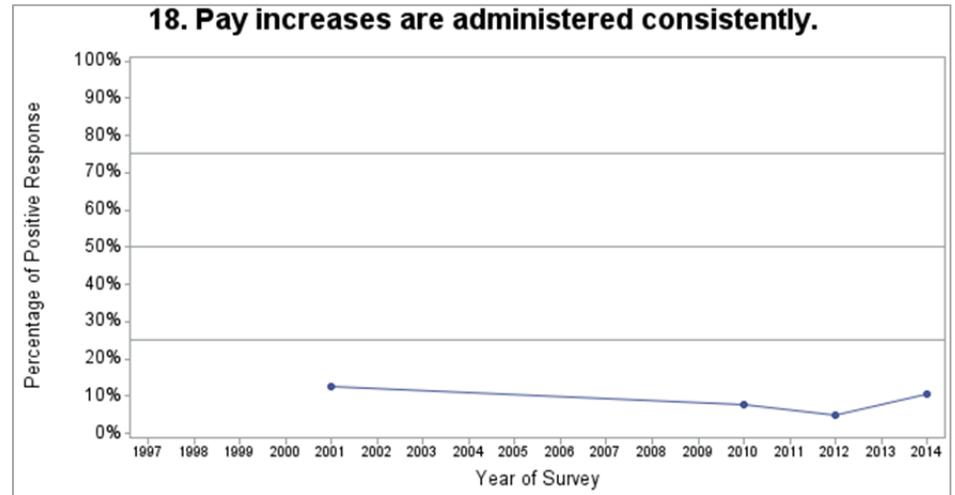
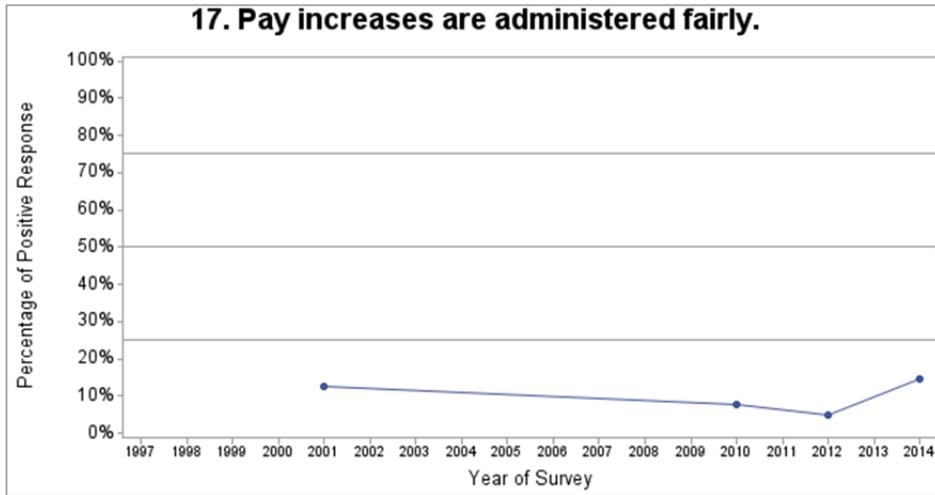
IV. Response Distribution by Year – Trend Line Figures



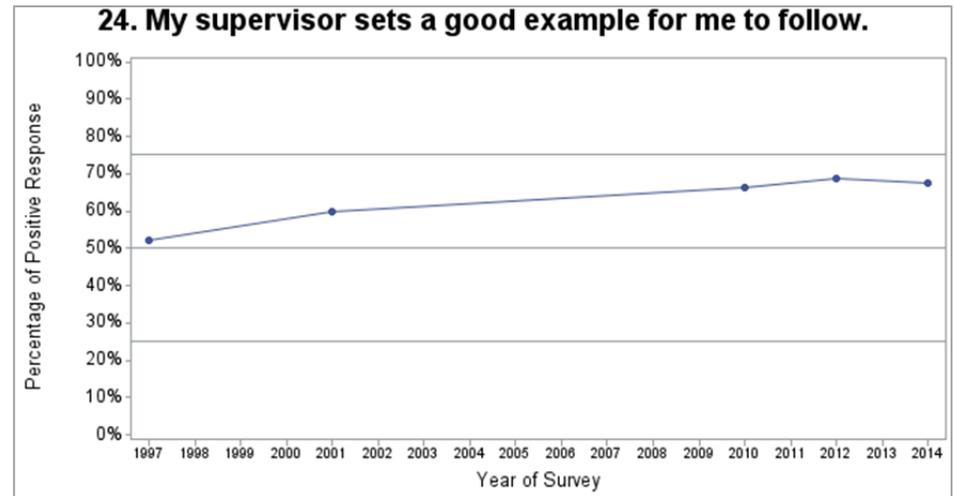
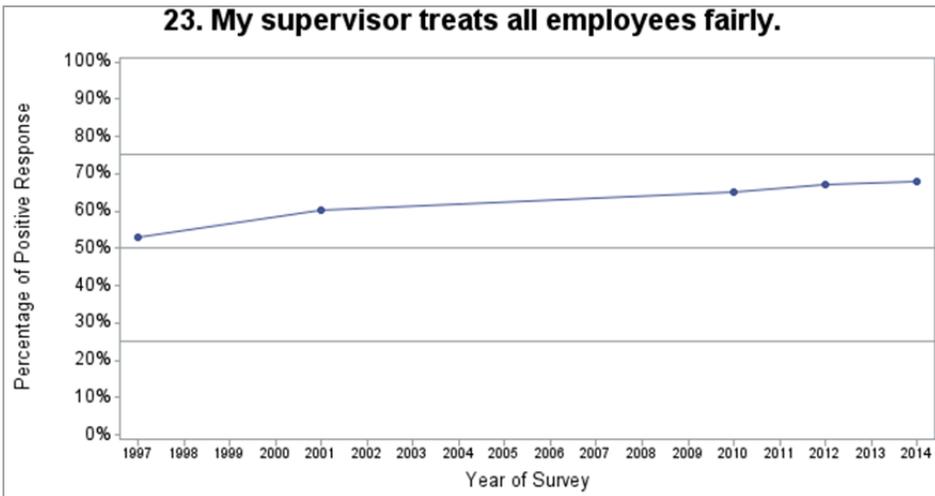
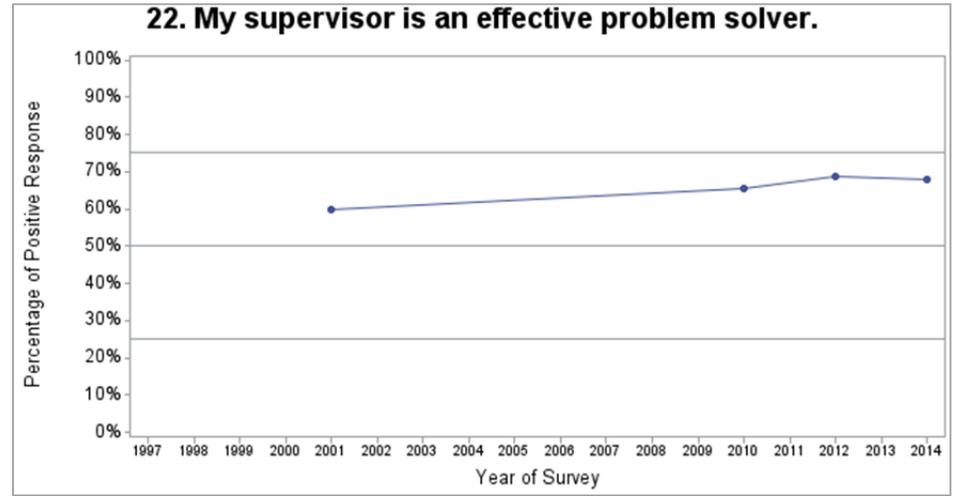
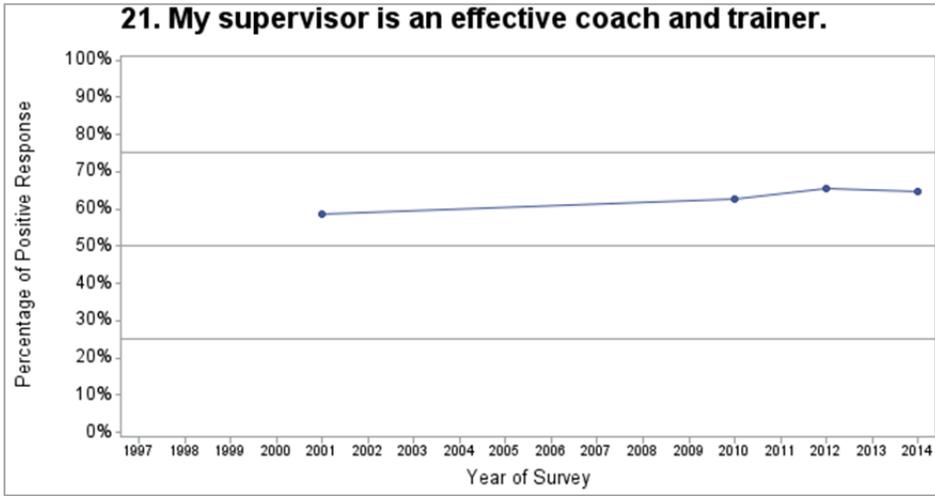
IV. Response Distribution by Year – Trend Line Figures



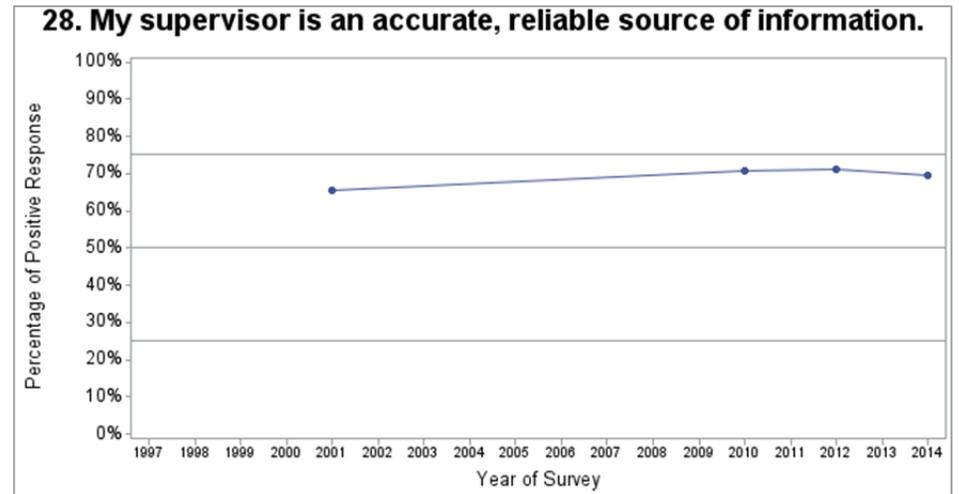
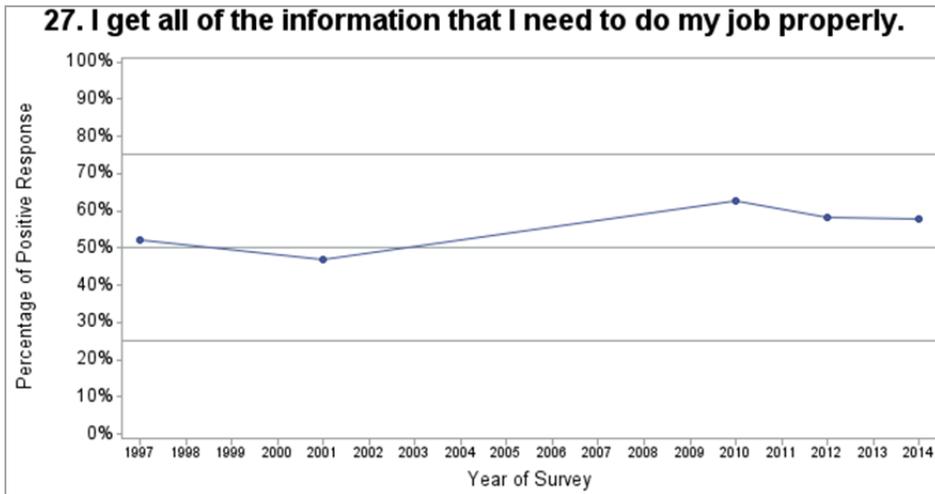
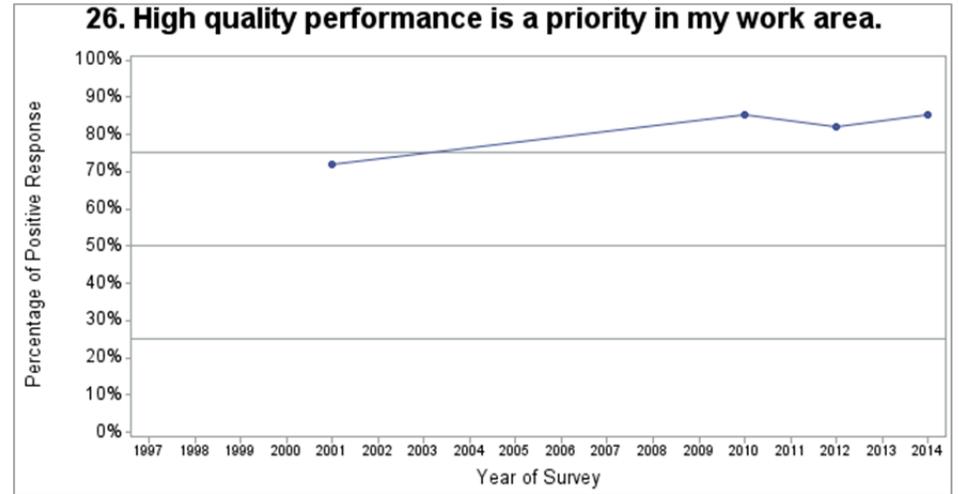
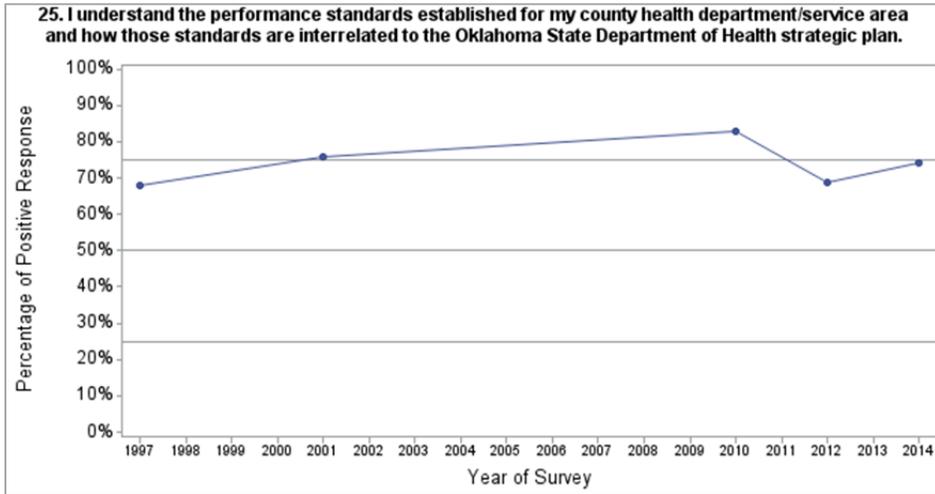
IV. Response Distribution by Year – Trend Line Figures



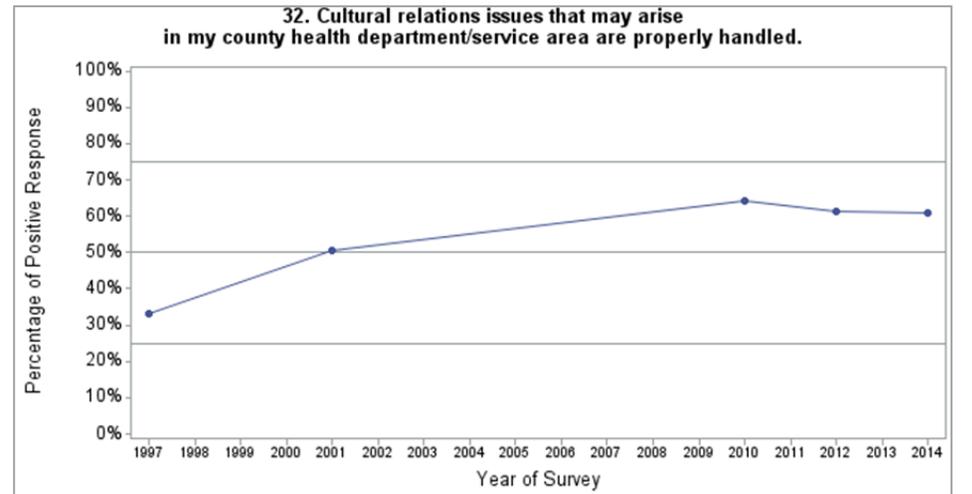
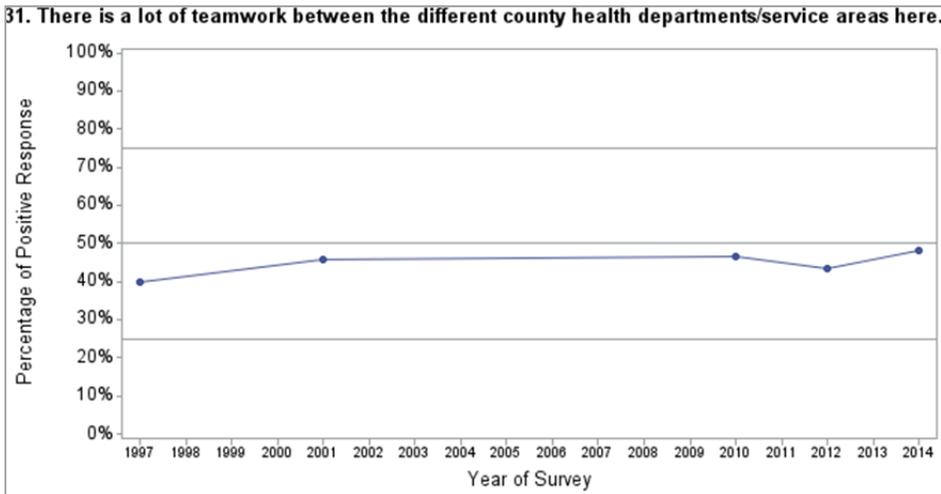
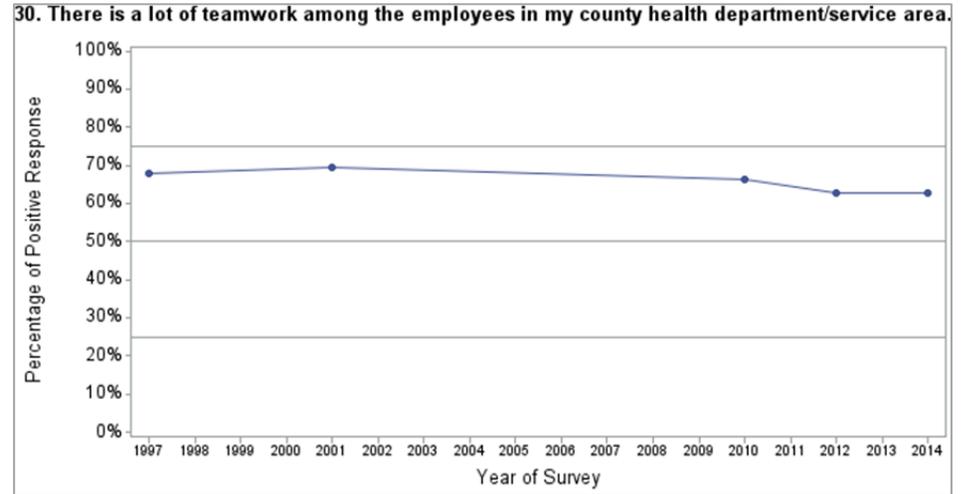
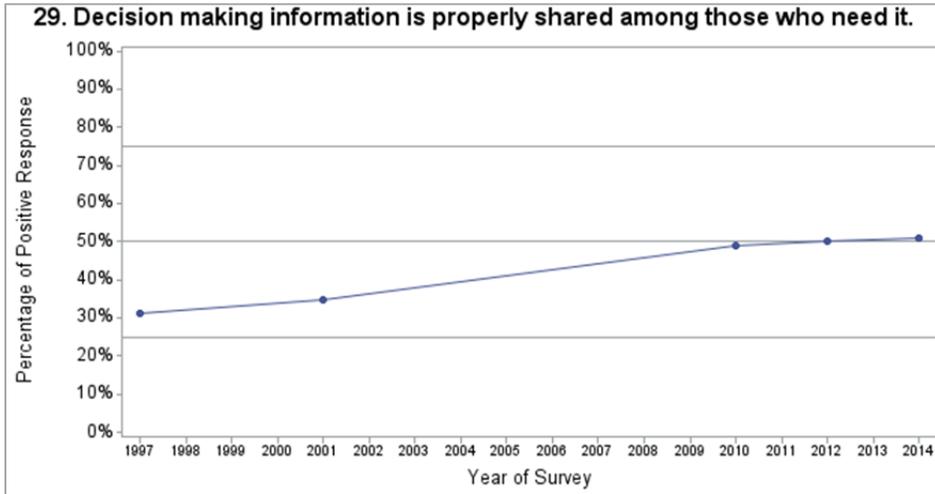
IV. Response Distribution by Year - Trend Line Figures



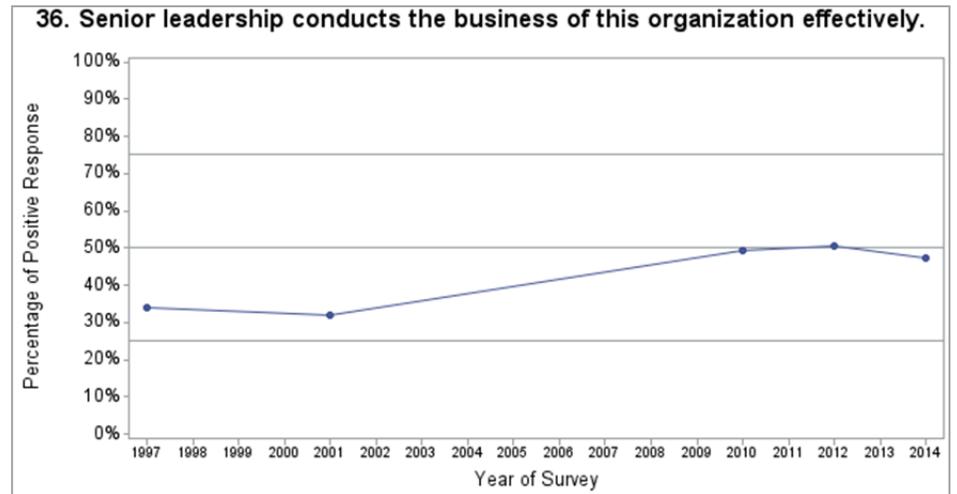
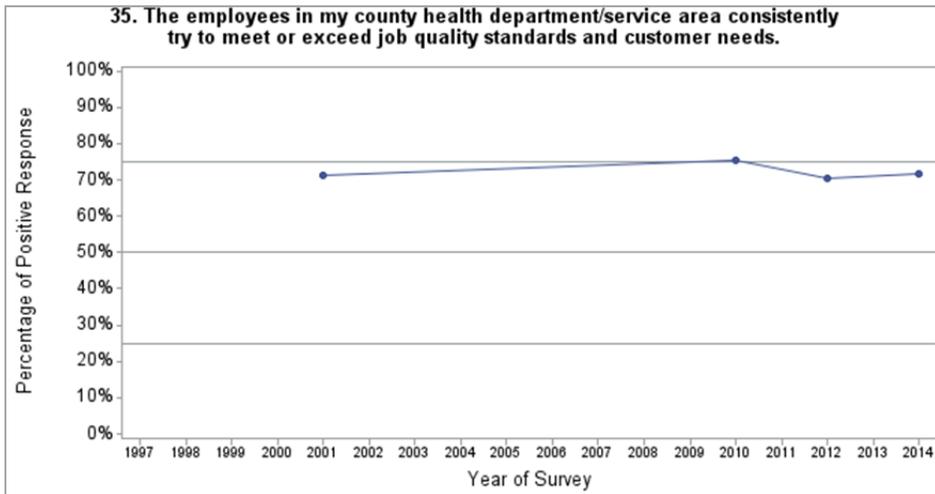
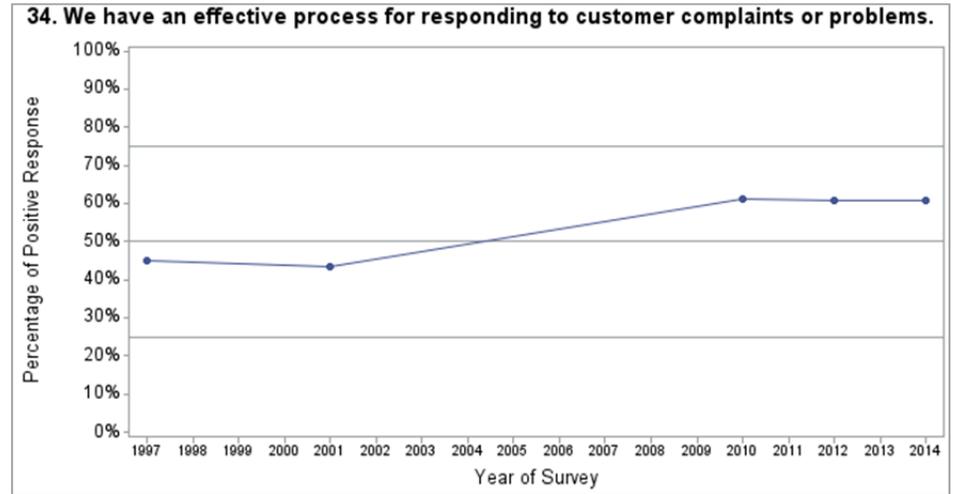
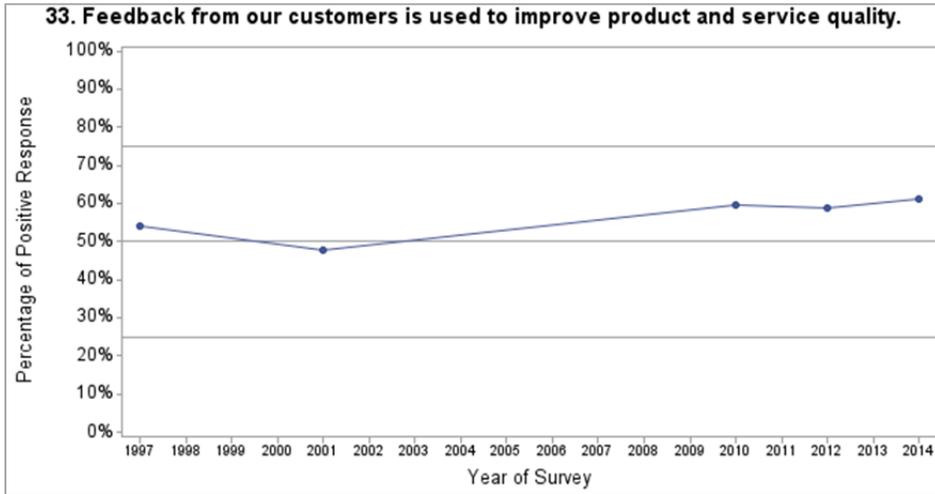
IV. Response Distribution by Year – Trend Line Figures



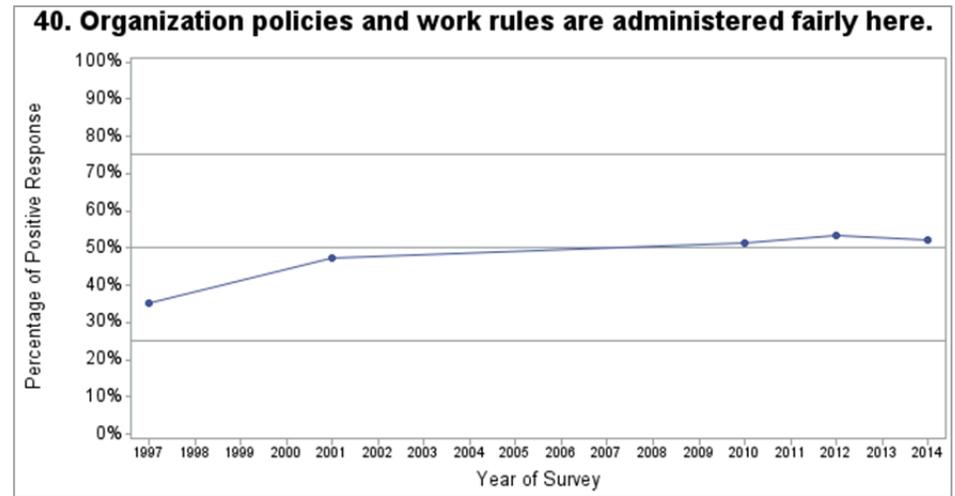
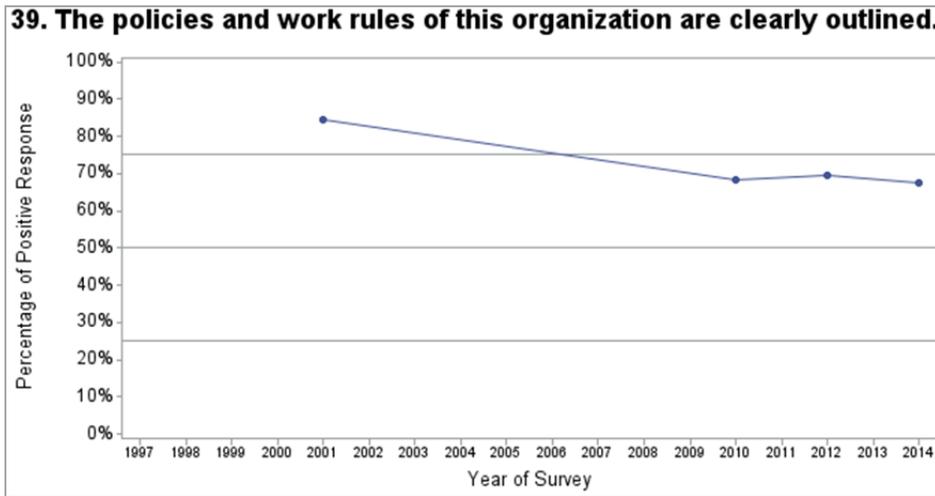
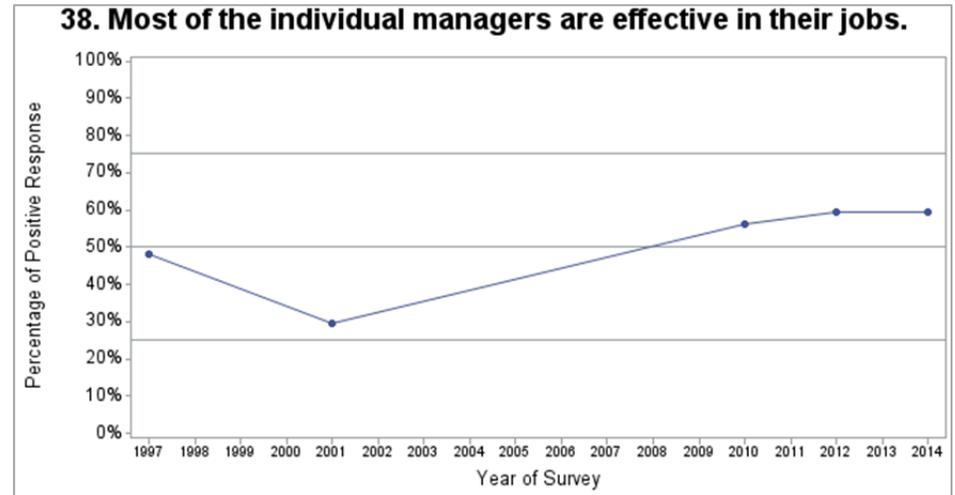
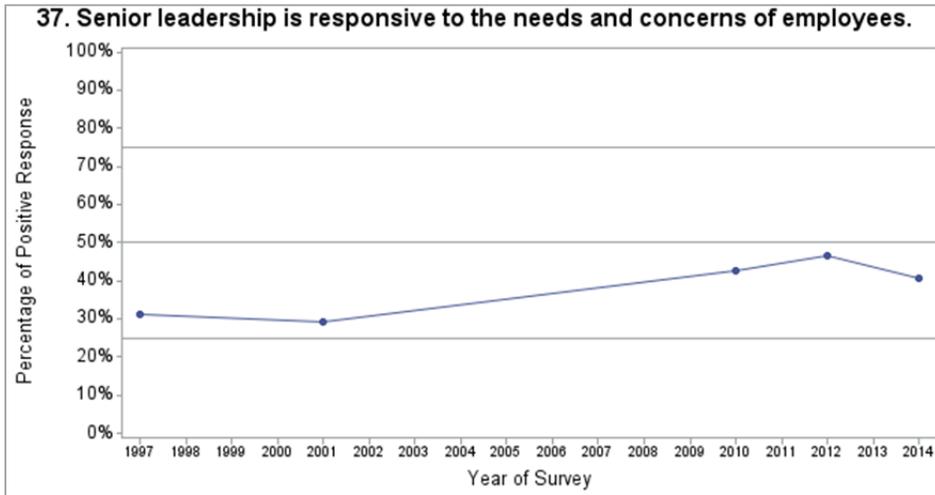
IV. Response Distribution by Year – Trend Line Figures



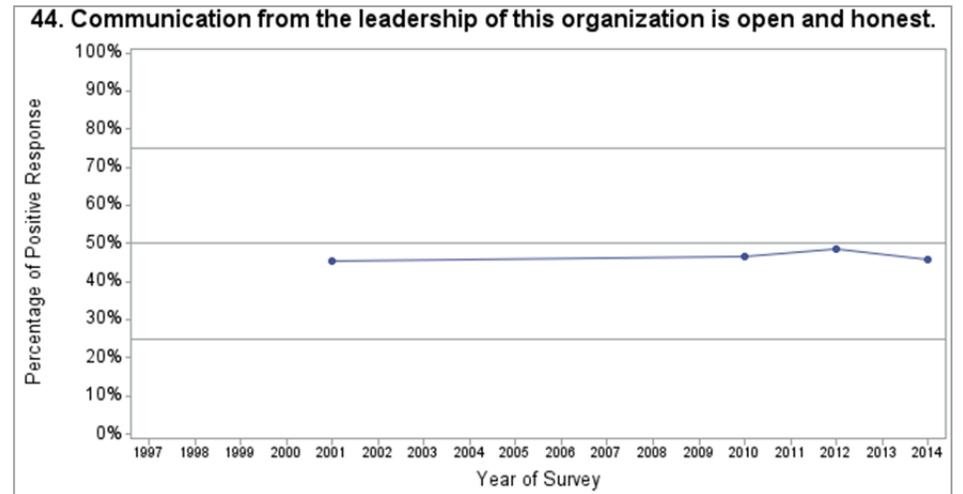
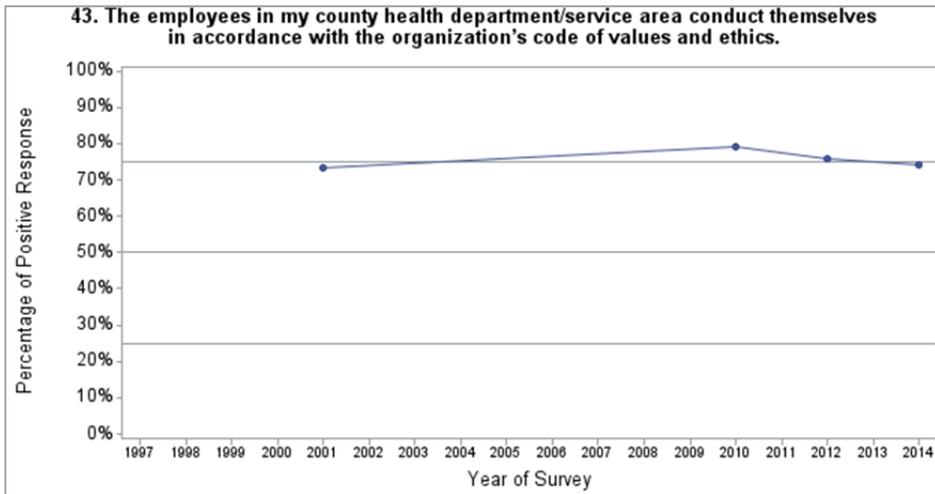
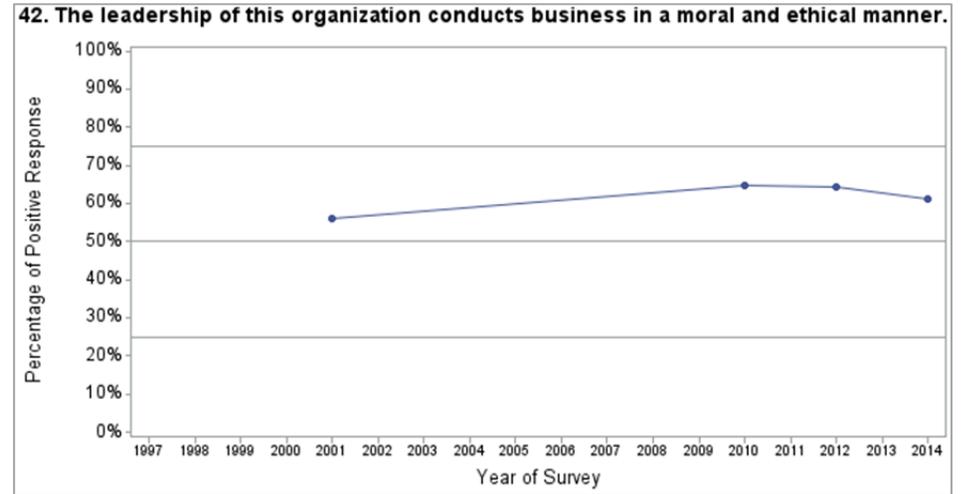
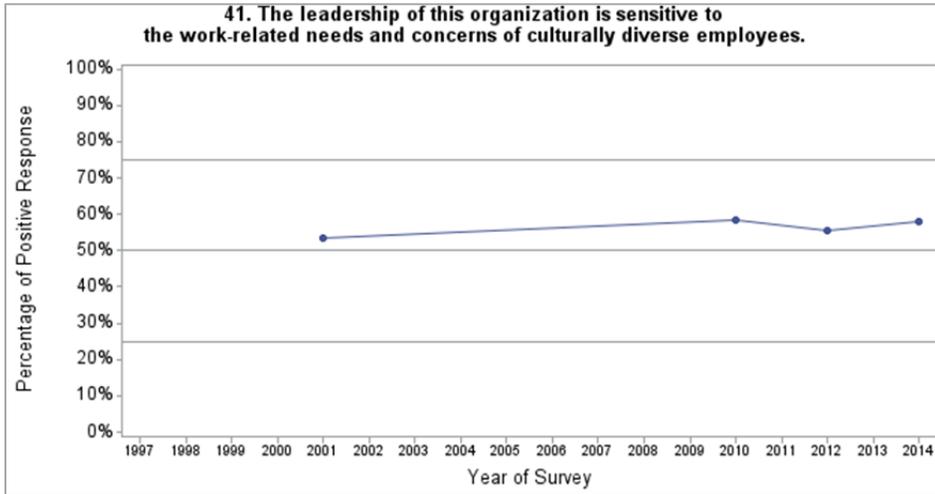
IV. Response Distribution by Year – Trend Line Figures



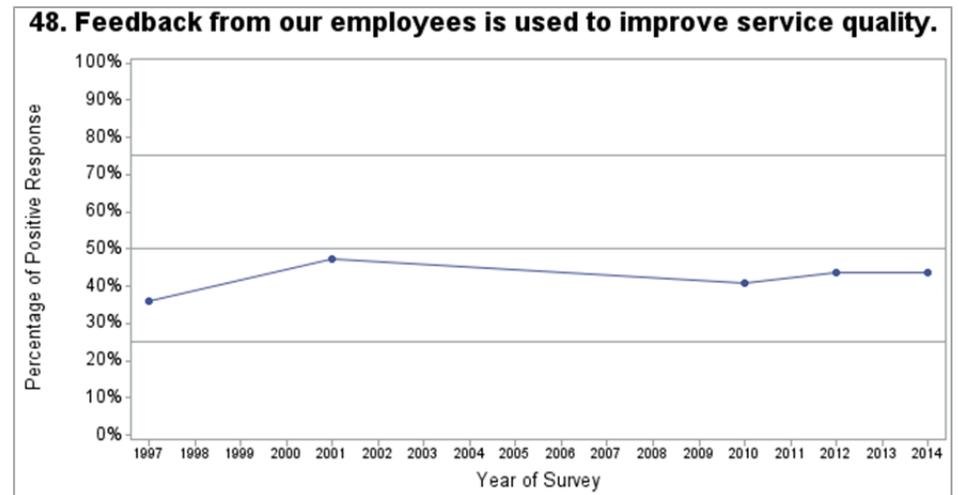
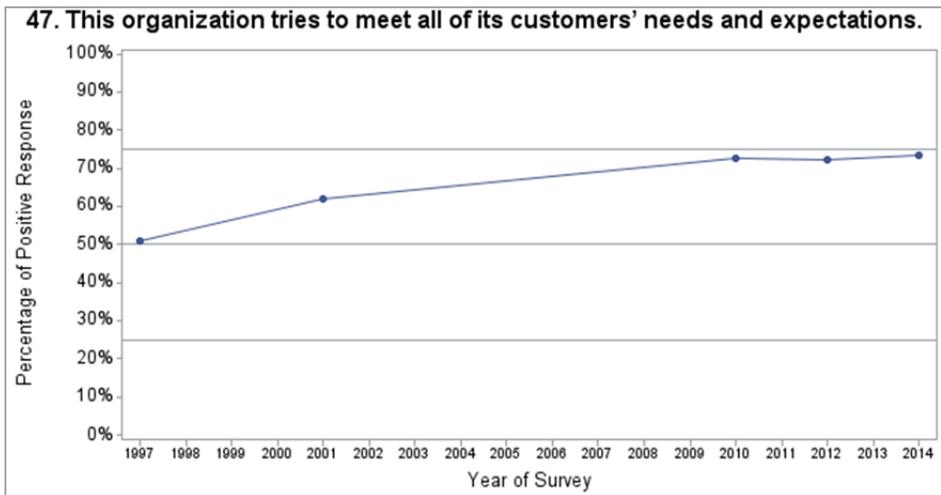
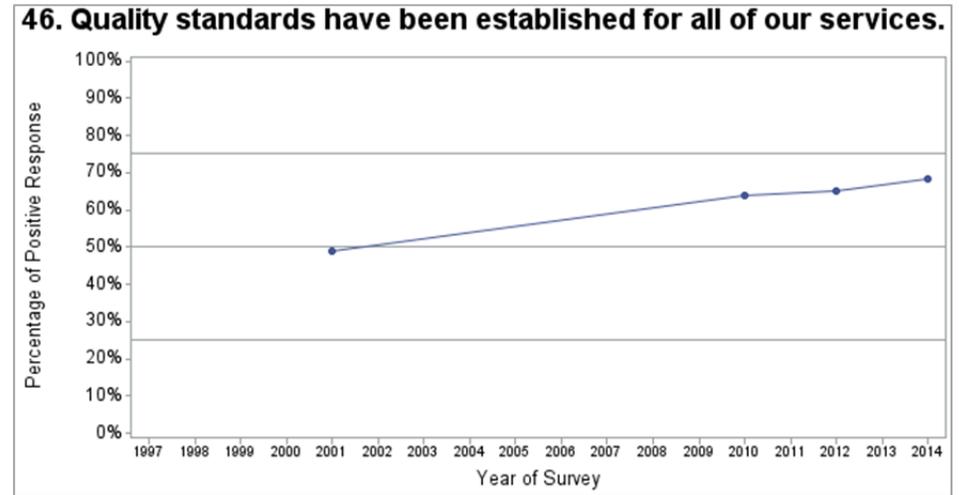
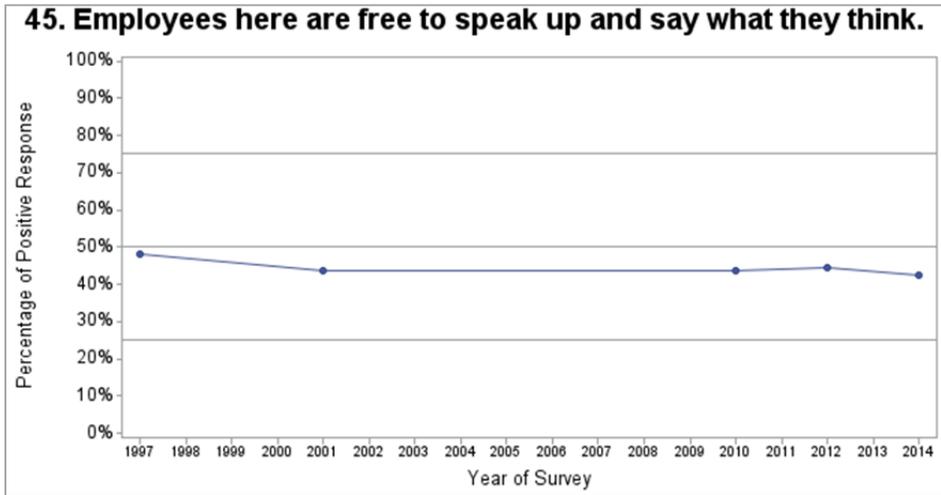
IV. Response Distribution by Year – Trend Line Figures



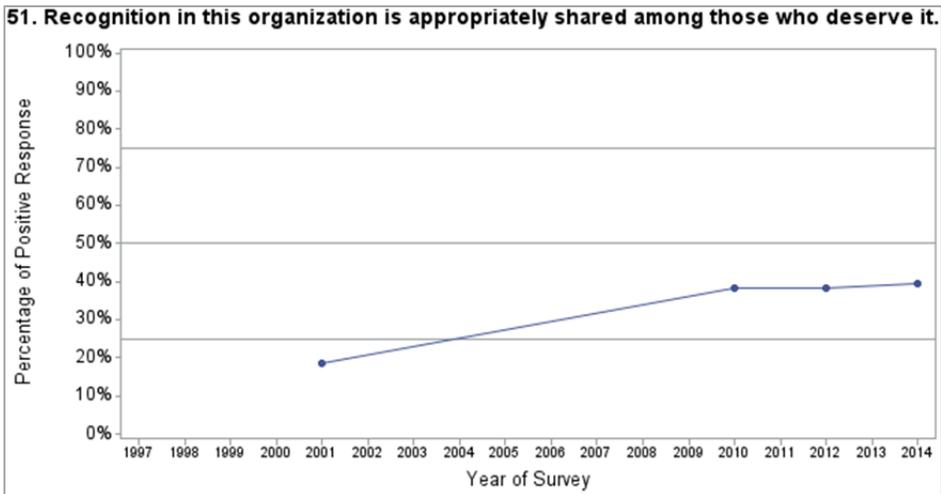
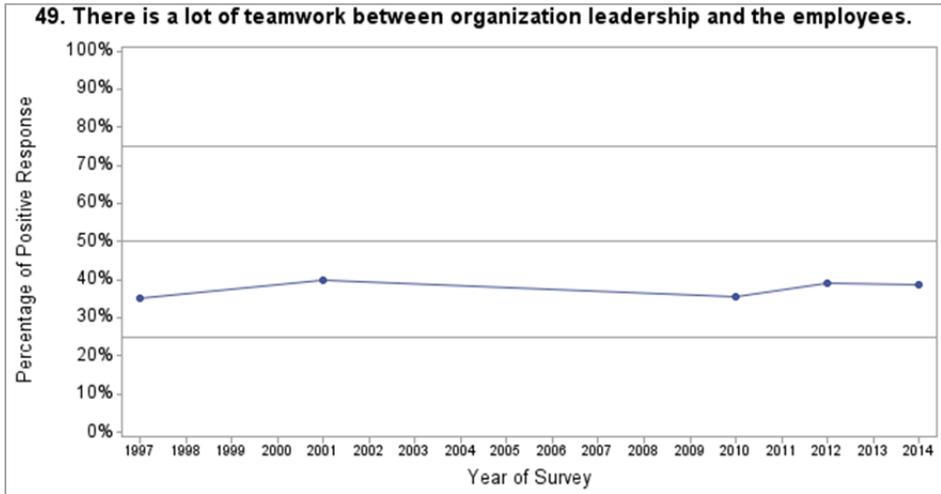
IV. Response Distribution by Year – Trend Line Figures



IV. Response Distribution by Year - Trend Line Figures



IV. Response Distribution by Year – Trend Line Figures



V. 2014 Response Distribution by Agency Service Area

V. 2014 Response Distribution by Agency Service Area

The following table includes the percentage of positive responses (strongly agree or inclined to agree) within each subgroup.

View of Job	Commissioner's Group (n=29)		Senior Deputy Commissioner's Group (n=35)		Chief Operating Officer's Group (n=88)		Community & Family Health Services (n=855)		Prevention & Preparedness Services (n=193)		Protective Health Services (n=239)	
	n	%	n	%	n	%	n	%	n	%	n	%
My job is interesting.	25	86.2%	32	94.1%	69	80.2%	766	90.0%	161	83.9%	204	86.8%
My job makes good use of my skills and abilities.	23	79.3%	27	79.4%	62	70.5%	710	83.4%	145	75.9%	191	81.3%
I usually feel a sense of accomplishment when I complete my job.	25	86.2%	31	91.2%	65	73.9%	754	88.4%	156	81.7%	204	86.8%
My ideas and suggestions are utilized and valued here.	16	55.2%	29	85.3%	44	50.0%	502	59.0%	114	59.4%	123	52.1%
I am personally encouraged to be creative and innovative here.	13	44.8%	23	67.6%	42	47.7%	494	57.9%	101	52.6%	109	46.2%
I am appropriately involved in making decisions that affect my work.	15	51.7%	24	70.6%	43	48.9%	460	54.2%	100	52.1%	127	54.3%
The health and safety conditions at my county health department or service area are good.	15	53.6%	19	54.3%	39	44.8%	684	80.6%	107	56.3%	144	61.5%
There are good opportunities here for me to learn new job skills.	13	44.8%	23	65.7%	40	45.5%	436	51.3%	93	48.4%	111	47.0%
There are good opportunities here to advance to a better job.	7	24.1%	15	42.9%	31	35.2%	238	28.2%	51	26.7%	68	29.1%
I understand what the individual performance accountabilities are for my job and how those accountabilities are interrelated to the Oklahoma State Department of Health strategic plan.	19	65.5%	22	62.9%	57	64.8%	644	75.7%	138	71.9%	172	73.2%
I receive regular feedback about how well I am performing my job.	17	58.6%	20	58.8%	43	48.9%	529	62.2%	109	57.1%	139	58.7%
I receive all of the resources and support that I need to do my job properly.	17	58.6%	21	61.8%	36	40.9%	509	59.9%	100	52.1%	126	53.6%
I am usually given recognition when I do a good job.	14	48.3%	28	80.0%	39	44.8%	459	54.3%	92	48.2%	116	48.9%
I feel motivated to fully meet or exceed the performance goals for my job.	21	72.4%	26	74.3%	48	55.2%	598	70.4%	130	67.7%	151	64.0%
My county health department/service area has received training in ways to improve its team effectiveness.	13	46.4%	17	50.0%	37	42.5%	447	52.8%	77	40.3%	109	46.6%
The pay rate for my job has been properly set.	10	34.5%	18	51.4%	22	25.0%	231	27.2%	73	38.0%	51	21.6%
Pay increases are administered fairly.	6	20.7%	5	14.3%	14	16.3%	127	15.0%	25	13.0%	29	12.3%
Pay increases are administered consistently.	6	20.7%	6	17.1%	12	13.8%	95	11.3%	15	7.9%	15	6.4%
The state's employee benefits plan meets my needs satisfactorily.	20	69.0%	25	71.4%	62	72.1%	594	70.5%	136	70.8%	147	63.1%

V. 2014 Response Distribution by Agency Service Area

View of Program Area	Commissioner's Group (n=29)		Senior Deputy Commissioner's Group (n=35)		Chief Operating Officer's Group (n=88)		Community & Family Health Services (n=855)		Prevention & Preparedness Services (n=193)		Protective Health Services (n=239)	
	n	%	n	%	n	%	n	%	n	%	n	%
My supervisor is willing to listen to my problems or complaints.	21	75.0%	29	82.9%	61	69.3%	637	75.2%	137	71.7%	165	70.2%
My supervisor is an effective coach and trainer.	18	62.1%	24	70.6%	51	58.0%	576	67.8%	111	57.8%	149	63.1%
My supervisor is an effective problem solver.	16	55.2%	31	91.2%	52	59.1%	594	70.2%	123	64.7%	159	67.4%
My supervisor treats all employees fairly.	16	55.2%	30	85.7%	60	68.2%	599	70.6%	116	60.7%	149	63.1%
My supervisor sets a good example for me to follow.	17	58.6%	32	91.4%	56	63.6%	598	70.9%	112	59.3%	145	61.7%
I understand the performance standards established for my county health department/service area and how those standards are interrelated to the Oklahoma State Department of Health strategic plan.	19	67.9%	19	55.9%	49	57.0%	660	78.0%	141	73.8%	168	71.5%
High quality performance is a priority in my work area.	25	86.2%	31	91.2%	67	76.1%	741	87.2%	151	78.6%	199	84.7%
I get all of the information that I need to do my job properly.	20	69.0%	21	61.8%	43	48.9%	499	58.8%	110	57.6%	137	58.1%
My supervisor is an accurate, reliable source of information.	16	55.2%	28	82.4%	59	67.0%	614	72.3%	123	65.1%	157	66.5%
Decision making information is properly shared among those who need it.	12	41.4%	20	58.8%	41	46.6%	466	54.8%	80	42.3%	109	46.2%
There is a lot of teamwork among the employees in my county health department/service area.	20	74.1%	22	64.7%	40	45.5%	561	66.2%	103	53.9%	145	61.7%
There is a lot of teamwork between the different county health departments/service areas here.	10	35.7%	15	44.1%	21	24.4%	450	53.2%	79	41.4%	107	45.3%
Cultural relations issues that may arise in my county health department/service area are properly handled.	12	44.4%	17	50.0%	33	38.8%	582	68.8%	96	50.5%	125	53.2%
Feedback from our customers is used to improve product and service quality.	17	58.6%	27	79.4%	42	48.3%	565	66.7%	95	49.7%	132	56.4%
We have an effective process for responding to customer complaints or problems.	15	51.7%	18	52.9%	36	41.4%	558	65.8%	89	46.8%	151	64.5%
The employees in my county health department/service area consistently try to meet or exceed job quality standards and customer needs.	19	67.9%	25	73.5%	51	60.0%	632	74.4%	132	69.5%	159	68.2%

V. 2014 Response Distribution by Agency Service Area

View of Organization/Central Management	Commissioner's Group (n=29)		Senior Deputy Commissioner's Group (n=35)		Chief Operating Officer's Group (n=88)		Community & Family Health Services (n=855)		Prevention & Preparedness Services (n=193)		Protective Health Services (n=239)	
	n	%	n	%	n	%	n	%	n	%	n	%
Senior leadership conducts the business of this organization effectively.	10	34.5%	16	47.1%	25	29.1%	433	51.2%	72	37.9%	118	50.4%
Senior leadership is responsive to the needs and concerns of employees.	8	28.6%	10	29.4%	19	22.6%	378	44.7%	61	31.9%	102	43.6%
Most of the individual managers are effective in their jobs.	14	48.3%	19	57.6%	36	41.4%	541	63.9%	94	49.2%	146	62.4%
The policies and work rules of this organization are clearly outlined.	16	55.2%	25	73.5%	47	54.7%	591	69.9%	124	64.9%	161	68.5%
Organization policies and work rules are administered fairly here.	11	37.9%	20	58.8%	34	39.5%	476	56.5%	81	42.6%	121	51.7%
The leadership of this organization is sensitive to the work related needs and concerns of culturally diverse employees.	11	37.9%	22	64.7%	40	46.0%	542	64.0%	96	50.3%	124	52.5%
The leadership of this organization conducts business in a moral and ethical manner.	13	44.8%	22	64.7%	44	50.6%	571	67.3%	98	51.9%	132	55.9%
The employees in my county health department/service area conduct themselves in accordance with the organization's code of values and ethics.	19	67.9%	29	85.3%	54	61.4%	666	78.4%	123	64.7%	168	70.9%
Communication from the leadership of this organization is open and honest.	11	37.9%	15	44.1%	29	33.3%	421	49.6%	70	36.8%	110	46.2%
Employees here are free to speak up and say what they think.	10	34.5%	15	44.1%	27	31.0%	397	46.9%	63	33.0%	99	41.8%
Quality standards have been established for all of our services.	12	41.4%	17	50.0%	45	51.7%	635	75.1%	123	65.1%	145	61.4%
This organization tries to meet all of its customers' needs and expectations.	19	65.5%	23	67.6%	46	52.3%	668	78.9%	130	68.8%	170	71.7%
Feedback from our employees is used to improve service quality.	10	34.5%	16	47.1%	25	28.7%	409	48.3%	65	34.2%	93	39.4%
There is a lot of teamwork between organization leadership and the employees.	10	34.5%	15	44.1%	13	14.8%	363	43.0%	49	25.8%	99	42.3%
Members of your Leadership Team work together effectively as a team.	11	39.3%	16	48.5%	26	31.0%	462	55.1%	72	37.9%	111	47.4%
Recognition in this organization is appropriately shared among those who deserve it.	10	34.5%	14	45.2%	22	25.6%	365	43.7%	57	30.2%	87	37.0%

V. 2014 Response Distribution by Agency Service Area

View of Process, Improvements, and Training	Commissioner's Group (n=29)		Senior Deputy Commissioner's Group (n=35)		Chief Operating Officer's Group (n=88)		Community & Family Health Services (n=855)		Prevention & Preparedness Services (n=193)		Protective Health Services (n=239)	
	n	%	n	%	n	%	n	%	n	%	n	%
My county health department or service area continually strives to improve the way it conducts business.	18	64.3%	26	76.5%	55	62.5%	663	78.1%	125	66.1%	161	68.2%
I feel comfortable discussing possible ways to improve efficiency, effectiveness, and productivity with my supervisor.	18	62.1%	30	88.2%	57	64.8%	598	70.4%	123	65.1%	133	56.4%
My work location utilizes quality improvement techniques and tools for identifying and implementing work processes or service improvements.	13	48.1%	24	70.6%	41	46.6%	560	66.1%	104	54.7%	126	53.8%
I am aware of the agency's employee recognition and appreciation program and the process for submitting a nomination.	22	75.9%	26	76.5%	64	72.7%	568	67.0%	148	77.9%	173	73.6%
The agency's recognition program is an excellent way to recognize employee contributions and performance.	13	44.8%	15	44.1%	31	35.6%	438	51.7%	95	50.0%	126	53.4%
The Oklahoma State Department of Health onboarding process is informative, thorough, and effective.	10	34.5%	14	41.2%	23	26.4%	349	41.2%	60	31.7%	85	36.3%
The agency's New Employee Orientation is well developed and effective.	15	53.6%	16	47.1%	40	45.5%	372	43.9%	74	39.4%	93	39.4%
The agency's in-service training is well developed and effective.	18	62.1%	19	55.9%	35	39.8%	419	49.6%	77	41.4%	109	46.8%
There is open communication and transparency up, down, and across the organization.	5	17.9%	11	32.4%	15	17.6%	264	31.2%	38	20.1%	67	28.4%
The Oklahoma State Department of Health provides a supportive environment for maintaining work/life balance and addressing work/life stressors.	10	34.5%	15	44.1%	28	33.3%	435	51.5%	86	45.7%	103	43.8%
There are human resources procedures and practices in place that ensure fair treatment of all employees.	12	41.4%	18	54.5%	42	48.8%	522	61.7%	92	48.7%	114	47.9%
There are human resources procedures and practices in place that ensure equitable treatment of all employees.	12	41.4%	17	50.0%	40	46.5%	523	61.8%	92	48.7%	112	47.3%
I am aware of the Office of Accountability Systems.	19	65.5%	25	73.5%	64	73.6%	650	76.7%	136	72.3%	158	66.9%
I do not fear retaliation if I bring issues to the Office of Accountability Systems.	12	41.4%	16	47.1%	40	46.5%	377	44.7%	57	30.3%	89	37.6%
I am aware of the Oklahoma State Department of Health grievance process.	18	62.1%	26	76.5%	61	71.8%	669	79.2%	142	74.7%	171	72.8%
I do not fear retaliation if I were to utilize the Oklahoma State Department of Health grievance process.	11	37.9%	16	47.1%	37	44.6%	365	43.6%	52	27.5%	86	36.3%

Public Health Workforce Interests and Needs Survey (PH/WINS)

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How to Use This Report

This report is broken down by the major sections of the PH WINS. Further analysis of each section is broken down by geographical area, supervisory status, years with the agency, role classification, and program area.

Geographic regions are shown in Table 1 and on the map below. Tables in this report represent the data by state, by the rest of the region (excluding your state), by all other regions (excluding your state and region), and provides national estimates which are labeled as "total."

New England and Atlantic Territories	CT, MA, ME, NJ, NY, NH, RI, VT
Mid Atlantic and Great Lakes	DE, IL, IN, MD, MI, MN, OH, PA, VA, WI, WV
South	AR, AL, FL, GA, KY, LA, MS, NC, NM, OK, SC, TN, TX
Mountain/Midwest	CO, IA, KS, MO, MT, ND, NE, SD, UT, WY
West	AK, AZ, CA, HI, ID, NV, OR, WA
States in italics text did not participate in PH WINS.	

Role Classifications and the Foundational Public Health Services Model

To maintain privacy of survey respondents we collapsed program areas and role classifications. The tables below explain how these variables were categorized.

Job Classifications	
Collapsed job classification	Job classification response options
Administration	Business Support - Accountant/Fiscal, Clerical Personnel (Administrative Assistant, Secretary), Custodian, Grant and Contracts Specialist, Health Officer, Human Resources Personnel, Information Technology Specialist, Other Facilities/Operations worker, Public Health Agency Director, Public Information Specialist
Clinical and Lab	Behavioral Health Professional, Community Health Worker, Home Health Worker, Laboratory Aide/Assistant, Laboratory Developmental Scientist, Laboratory Scientist (Manager, Supervisor), Laboratory Scientist/Medical Technologist, Laboratory Technician, Licensed Practical/Vocational Nurse, Medical Examiner, Nutritionist, Other Oral Health Professional, Other Physician, Other Registered Nurse- Clinical Services, Other Veterinarian, Physician Assistant, Public Health Dentist, Public Health/Preventative Medicine Physician, Registered Nurse - Community Health Nurse, Registered Nurse - Unspecified
Public Health Science	Animal Control Worker, Behavioral Health Professional, Department/Bureau Director, Deputy Director, Engineer, Environmentalist, Epidemiologist, Health Educator, Other Management and Leadership, Other Professional and Scientific, Program Director, Public Health Manager/Program Manager, Public Health Veterinarian, Public Health Informatics Specialist, Sanitarian/Inspector, Technician, Statistician, Student - Professional and Scientific
Social Services and All Other	Social Services Counselor, Social Worker, Other

Interpreting Tables and Charts

Reading the Tables

Each table presented in this report will indicate whether the Oklahoma results are statistically significantly different from the national average. Each estimate you'll see will have two parts - the point estimate and a confidence interval. For example, 78% of respondents in Oklahoma (95% CI 76%-80%) agree/strongly agree with a particular statement. The point estimate is first part of the example (78%), while the confidence interval is the second (76%-80%). A 95% confidence interval means that if we were to repeatedly take independent samples of staff from your health department, 95% of the time the true value we are estimating will fall within that range - in this example 76%-80%. It is a measure of uncertainty that occurs because we don't have responses from 100% of your staff in PH WINS.

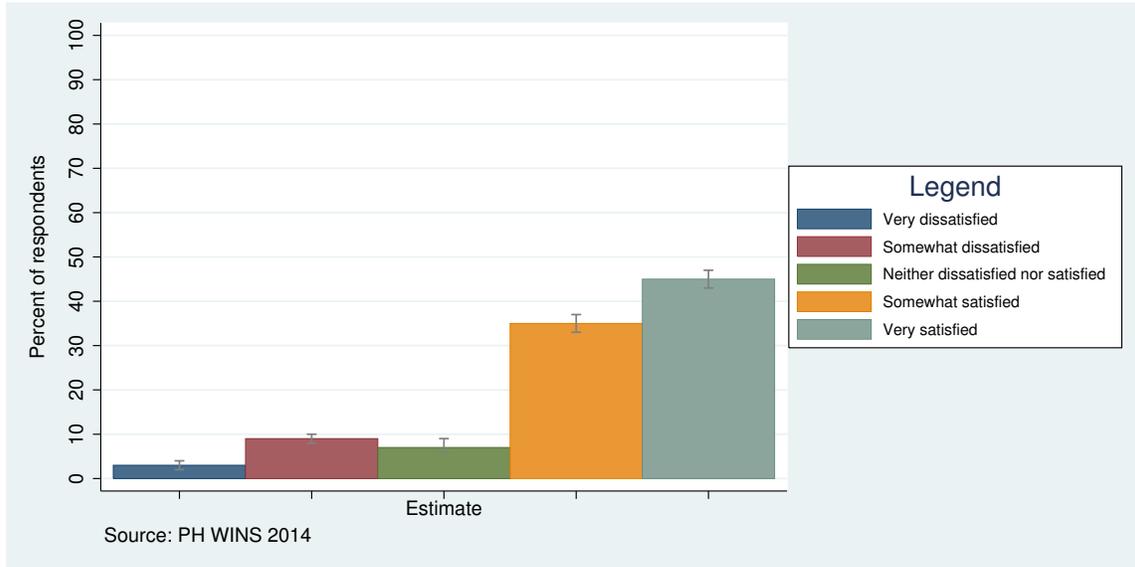
Reading The Charts

When examining the charts be sure to notice the legend and axis titles. A short text description is below every chart for your reference. The lines in the middle of each bar with the chart represent the confidence interval for that estimate.

Statistical Significance

To figure out if the Oklahoma estimate for a particular item is different from the national average, check if your agency column's 95% Confidence Interval overlaps with the "Total" column's 95% Confidence Interval. For example, let's say the Oklahoma estimate is 60% agree/strongly agree (95% CI 55%-65%) and the national average is 50% agree/strongly agree (95% CI 48%-52%). Because the two confidence intervals don't overlap, the difference is statistically significant. If, on the other hand, your estimate had been the same but the national average was 57% (95% CI 55%-59%), the confidence intervals (55%-65% and 55%-59%) would overlap. Even though your point estimate is different from the national average, that difference is not statistically significant. We would advise you to treat two estimates where the difference is not statistically significant as essentially equal for your policy or planning purposes. There may be some instances where confidence estimates go below 0 percent or above 100 percent; please interpret those as 0 percent and 100 percent, respectively. This occurs in circumstances where the number of responses is relatively low (for instance, job satisfaction among managers). As explained below, there are also circumstances where the number of responses are too low to create any estimates.

Overall Job Satisfaction



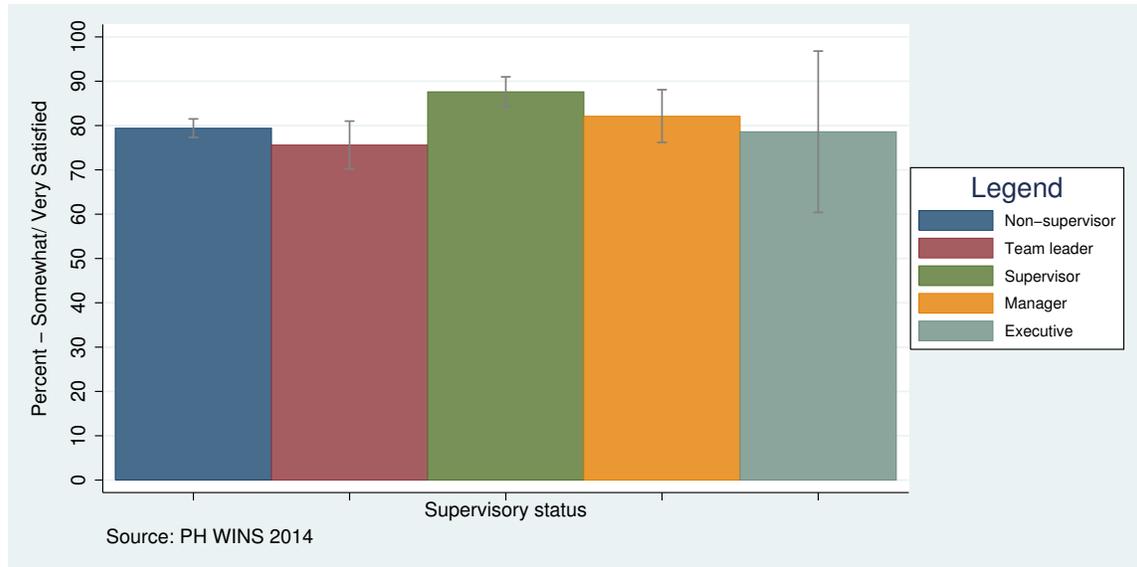
This chart represents the proportion of overall job satisfaction.

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Very dissatisfied	3%	[2%-	4%]	4%	[3%-	4%]	3%	[3%-	4%]	3%	[3%-	4%]
Somewhat dissatisfied	9%	[8%-	10%]	9%	[8%-	10%]	10%	[9%-	10%]	9%	[9%-	10%]
Neither dissatisfied nor satisfied	7%	[6%-	9%]	7%	[7%-	8%]	8%	[8%-	9%]	8%	[7%-	8%]
Somewhat satisfied	35%	[33%-	37%]	38%	[37%-	39%]	39%	[38%-	40%]	38%	[38%-	39%]
Very satisfied	45%	[43%-	47%]	42%	[41%-	43%]	40%	[39%-	41%]	41%	[40%-	42%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Job Satisfaction by Supervisory Status



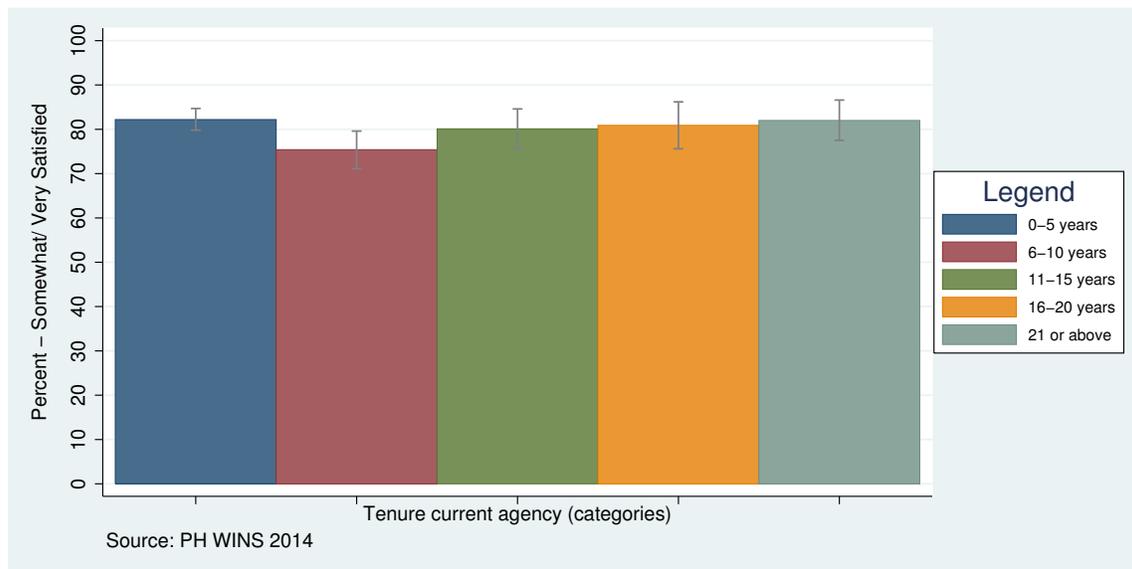
This chart represents the proportion of staff by supervisory status who are “Very satisfied/Somewhat satisfied” with their job.

Supervisory status	State, Regional, and National Estimates														
	OK Estimate			Rest of region						All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI			
Non-supervisor	79%	[77%-	81%]	78%	[77%-	80%]	77%	[75%-	78%]	77%	[77%-	78%]			
Team leader	76%	[70%-	81%]	80%	[78%-	83%]	77%	[75%-	79%]	78%	[77%-	80%]			
Supervisor	88%	[84%-	91%]	86%	[84%-	88%]	82%	[80%-	84%]	84%	[82%-	85%]			
Manager	82%	[76%-	88%]	84%	[81%-	86%]	85%	[83%-	87%]	84%	[83%-	86%]			
Executive	79%	[60%-	97%]	87%	[82%-	91%]	91%	[88%-	95%]	89%	[86%-	91%]			
Total	81%	[79%-	82%]	81%	[80%-	82%]	79%	[78%-	80%]	79%	[79%-	80%]			

Source: PH WINS 2014

This estimate is NOT statistically significantly different compared to the national average

Job Satisfaction By Tenure In Current Health Department (Years)



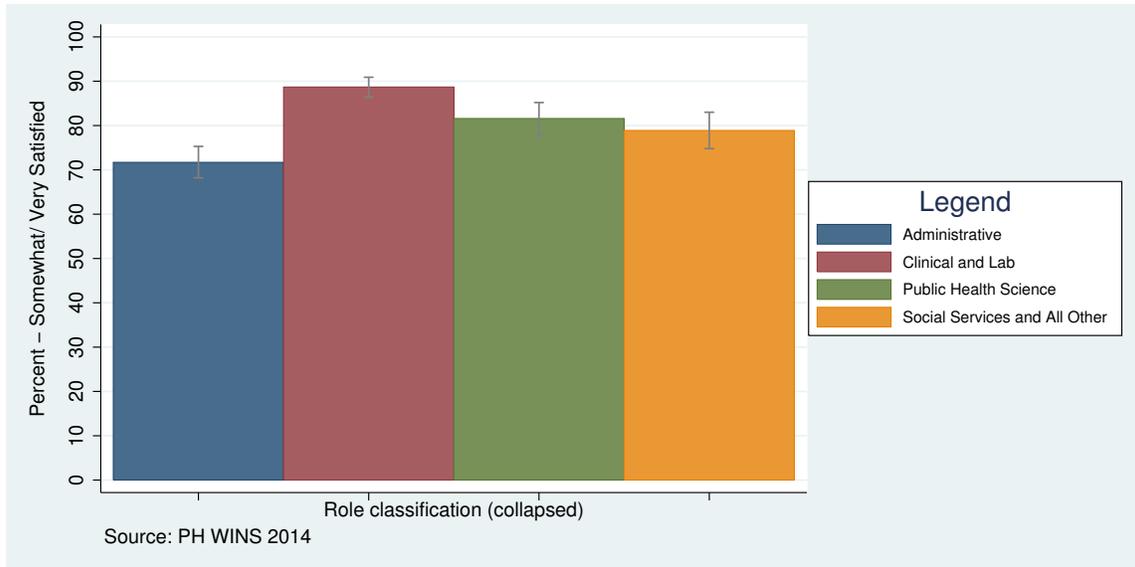
This chart represents the proportion of staff by tenure in current health department (years) who are “Very satisfied/Somewhat satisfied” with their job.

Tenure current agency (categories)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
0-5 years	82%	[80%-	85%]	81%	[80%-	83%]	80%	[79%-	81%]	81%	[80%-	82%]
6-10 years	75%	[71%-	80%]	78%	[76%-	80%]	78%	[76%-	79%]	78%	[76%-	79%]
11-15 years	80%	[76%-	85%]	78%	[76%-	81%]	77%	[75%-	78%]	77%	[76%-	79%]
16-20 years	81%	[76%-	86%]	80%	[78%-	83%]	77%	[74%-	80%]	79%	[77%-	81%]
21 or above	82%	[78%-	87%]	84%	[82%-	86%]	80%	[78%-	82%]	82%	[80%-	83%]
Total	81%	[79%-	82%]	81%	[80%-	82%]	79%	[78%-	80%]	79%	[79%-	80%]

Source: PH WINS 2014

This estimate is NOT statistically significantly different compared to the national average

Job Satisfaction By Role Classification



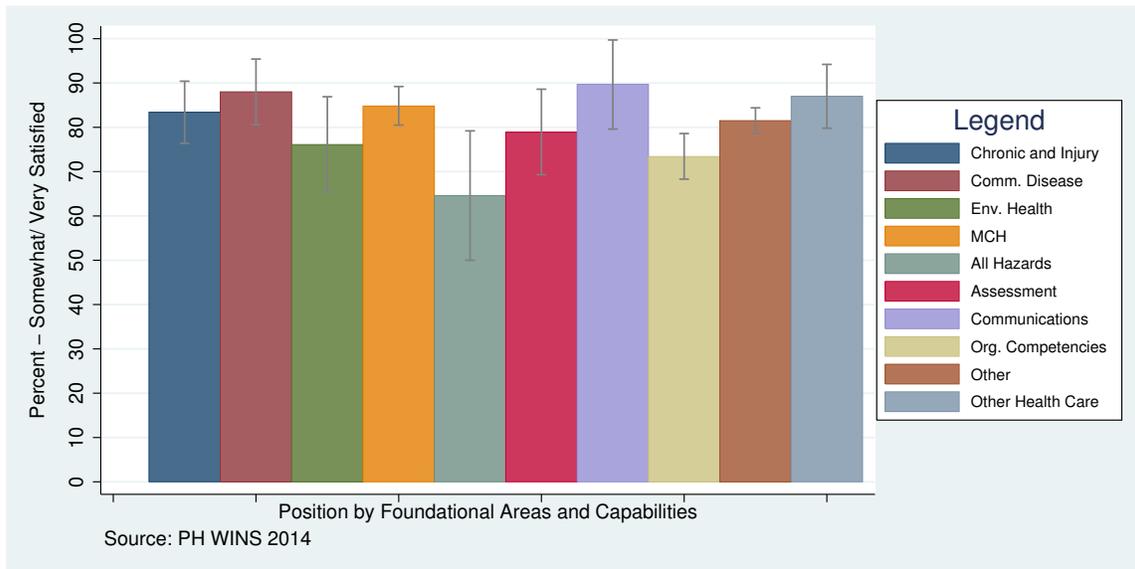
This chart represents the proportion of staff by role classification who are “Very satisfied/Somewhat satisfied” with their job.

Role classification (collapsed)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Administrative	72%	[68%-	75%]	78%	[76%-	80%]	77%	[76%-	79%]	77%	[76%-	79%]
Clinical and Lab	89%	[86%-	91%]	83%	[81%-	85%]	79%	[78%-	81%]	81%	[80%-	82%]
Public Health Science	82%	[78%-	85%]	82%	[81%-	84%]	80%	[78%-	82%]	81%	[80%-	82%]
Social Services and All Other	79%	[75%-	83%]	79%	[77%-	82%]	76%	[74%-	78%]	77%	[76%-	79%]
Total	81%	[79%-	82%]	81%	[80%-	82%]	79%	[78%-	80%]	79%	[79%-	80%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Job Satisfaction By Foundational Areas/Capabilities



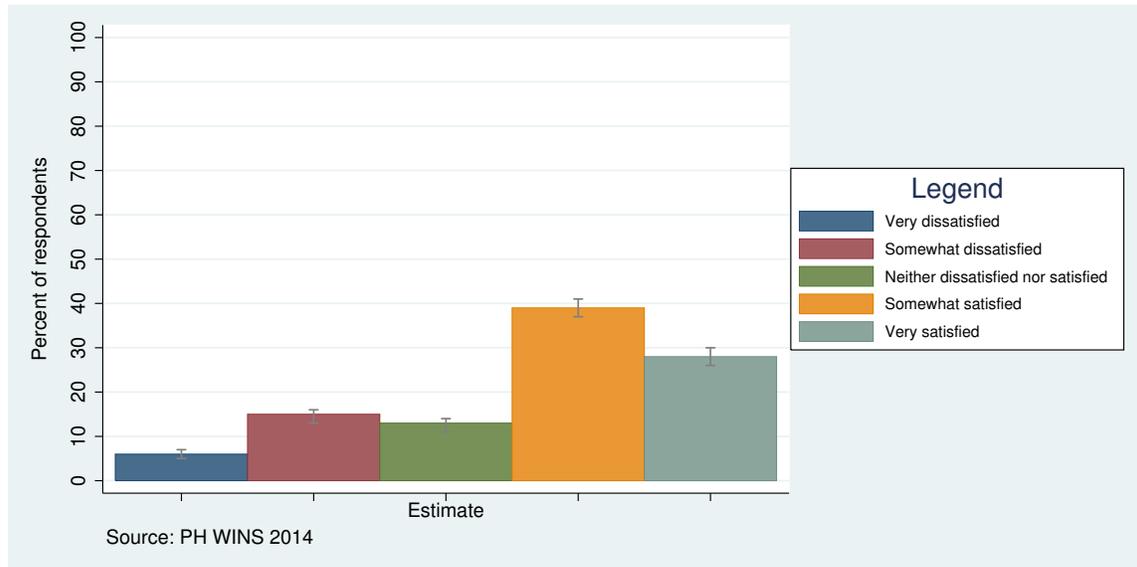
This chart represents the proportion of staff by foundational areas/capabilities who are “Very satisfied/Somewhat satisfied” with their job.

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	83%	[76%-	90%]	86%	[82%-	90%]	77%	[74%-	81%]	81%	[78%-	83%]
Comm. Disease	88%	[81%-	95%]	83%	[80%-	86%]	79%	[76%-	81%]	80%	[78%-	82%]
Env. Health	76%	[65%-	87%]	75%	[71%-	79%]	76%	[74%-	79%]	76%	[74%-	78%]
MCH	85%	[80%-	89%]	76%	[73%-	80%]	77%	[74%-	80%]	77%	[75%-	79%]
All Hazards	65%	[50%-	79%]	80%	[75%-	85%]	76%	[70%-	83%]	78%	[74%-	82%]
Assessment	79%	[69%-	89%]	80%	[76%-	84%]	82%	[79%-	84%]	81%	[79%-	83%]
Communications	90%	[80%-	100%]	86%	[78%-	93%]	86%	[77%-	95%]	86%	[81%-	92%]
Org. Competencies	73%	[68%-	79%]	83%	[80%-	85%]	79%	[77%-	81%]	80%	[79%-	82%]
Other	81%	[79%-	84%]	81%	[79%-	83%]	77%	[75%-	79%]	79%	[77%-	80%]
Other Health Care	87%	[80%-	94%]	80%	[76%-	85%]	83%	[79%-	87%]	82%	[79%-	85%]
Total	81%	[79%-	82%]	81%	[80%-	82%]	79%	[78%-	80%]	79%	[78%-	80%]

Source: PH WINS 2014

This estimate is NOT statistically significantly different compared to the national average

Overall Organization Satisfaction



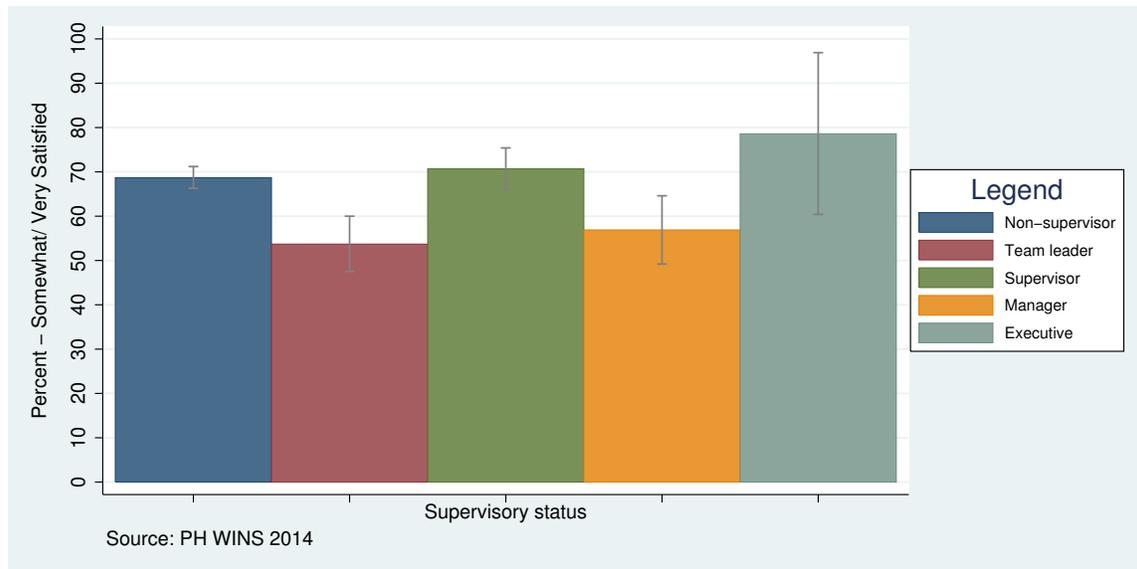
This chart represents the proportion of overall organization satisfaction.

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Very dissatisfied	6%	[5%-	7%]	7%	[6%-	8%]	6%	[6%-	7%]	7%	[6%-	7%]
Somewhat dissatisfied	15%	[13%-	16%]	14%	[13%-	14%]	15%	[14%-	16%]	14%	[14%-	15%]
Neither dissatisfied nor satisfied	13%	[11%-	14%]	13%	[12%-	14%]	14%	[13%-	15%]	14%	[13%-	14%]
Somewhat satisfied	39%	[37%-	41%]	39%	[38%-	40%]	41%	[40%-	42%]	40%	[39%-	41%]
Very satisfied	28%	[26%-	30%]	27%	[26%-	28%]	25%	[24%-	25%]	26%	[25%-	26%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Organization Satisfaction By Supervisory Status



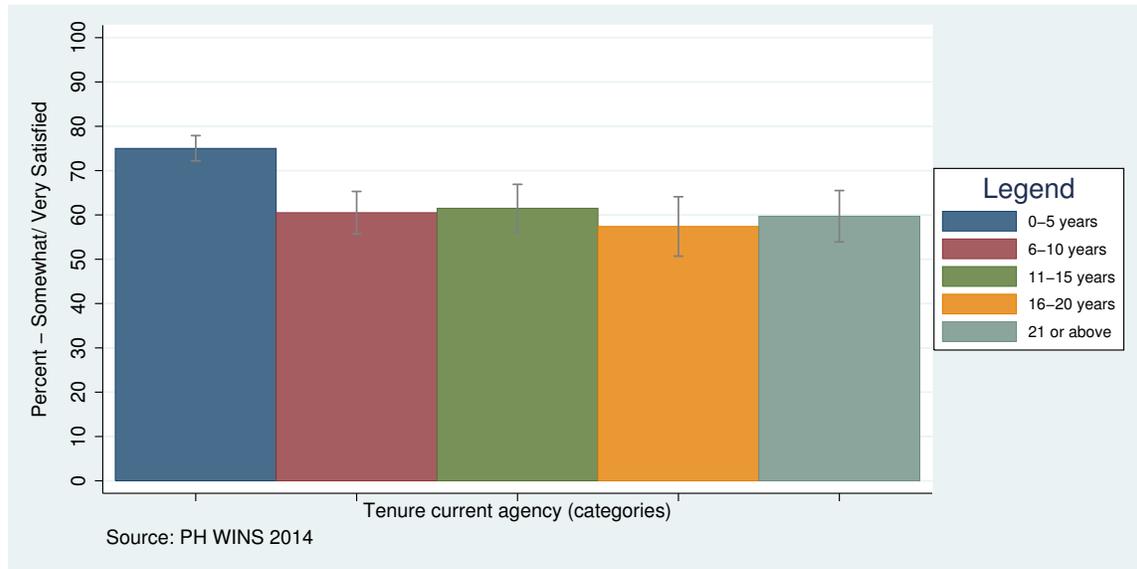
This chart represents the proportion of staff by supervisory status who are “Very satisfied/Somewhat satisfied” with their organization.

Supervisory status	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Non-supervisor	69%	[66%-	71%]	65%	[64%-	67%]	66%	[64%-	67%]	66%	[65%-	67%]
Team leader	54%	[47%-	60%]	65%	[61%-	68%]	60%	[57%-	62%]	61%	[59%-	63%]
Supervisor	71%	[66%-	75%]	70%	[67%-	72%]	65%	[62%-	67%]	67%	[65%-	68%]
Manager	57%	[49%-	65%]	66%	[62%-	70%]	69%	[66%-	72%]	67%	[65%-	70%]
Executive	79%	[60%-	97%]	78%	[72%-	84%]	82%	[76%-	87%]	80%	[76%-	84%]
Total	67%	[65%-	69%]	66%	[65%-	67%]	65%	[64%-	66%]	66%	[65%-	66%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Organization Satisfaction By Tenure In Current Health Department (Years)



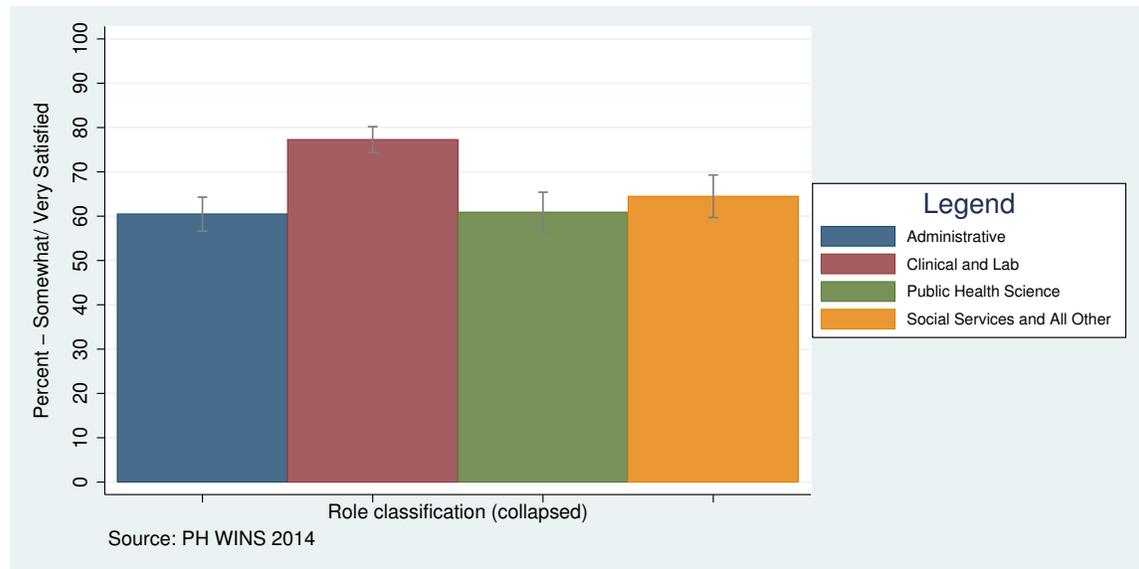
This chart represents the proportion of staff by tenure in current health department (years) who are “Very satisfied/Somewhat satisfied” with their organization.

Tenure current agency (categories)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
0-5 years	75%	[72%-	78%]	72%	[70%-	74%]	73%	[71%-	74%]	72%	[71%-	73%]
6-10 years	60%	[56%-	65%]	61%	[59%-	64%]	62%	[60%-	64%]	62%	[60%-	63%]
11-15 years	62%	[56%-	67%]	65%	[62%-	68%]	60%	[58%-	62%]	62%	[60%-	63%]
16-20 years	57%	[51%-	64%]	62%	[58%-	65%]	62%	[59%-	65%]	62%	[59%-	64%]
21 or above	60%	[54%-	65%]	64%	[62%-	67%]	61%	[59%-	63%]	62%	[61%-	64%]
Total	67%	[65%-	69%]	66%	[65%-	67%]	65%	[64%-	66%]	66%	[65%-	66%]

Source: PH WINS 2014

This estimate is NOT statistically significantly different compared to the national average

Organization Satisfaction By Role Classification



This chart represents the proportion of staff by role classification who are “Very satisfied/Somewhat satisfied” with their organization.

Role classification (collapsed)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Administrative	60%	[57%-	64%]	67%	[65%-	69%]	68%	[66%-	70%]	67%	[66%-	68%]
Clinical and Lab	77%	[74%-	80%]	67%	[65%-	70%]	63%	[61%-	65%]	65%	[64%-	67%]
Public Health Science	61%	[56%-	65%]	64%	[62%-	66%]	65%	[63%-	67%]	65%	[63%-	66%]
Social Services and All Other	64%	[60%-	69%]	68%	[65%-	71%]	65%	[63%-	67%]	66%	[64%-	68%]
Total	67%	[65%-	69%]	66%	[65%-	67%]	65%	[64%-	66%]	66%	[65%-	66%]

Source: PH WINS 2014

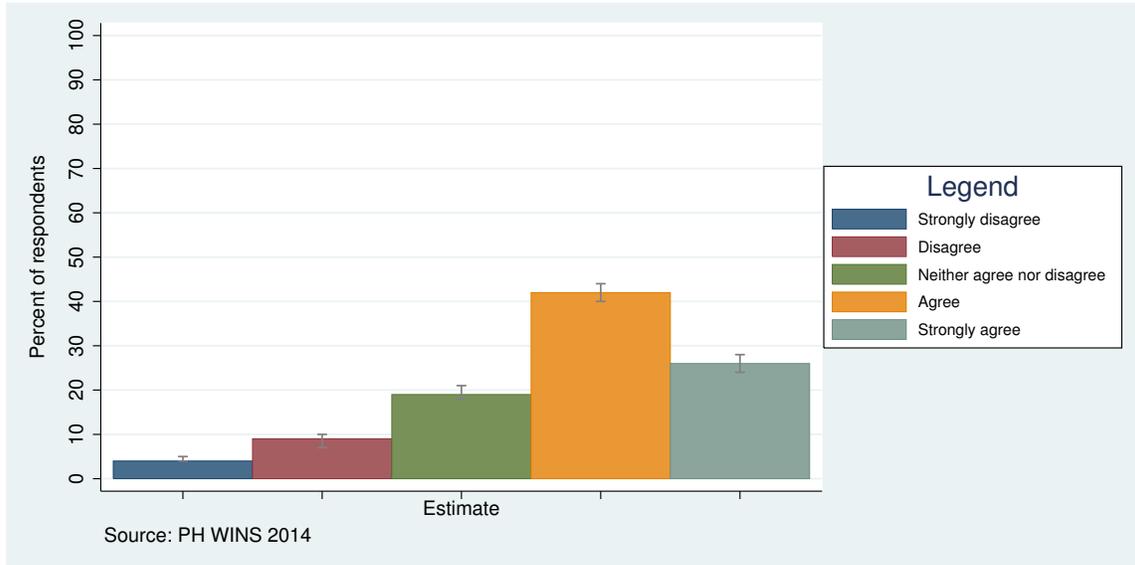
This estimate IS statistically significantly different compared to the national average

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	72%	[63%-	80%]	68%	[62%-	74%]	65%	[61%-	69%]	66%	[63%-	69%]
Comm. Disease	65%	[54%-	76%]	68%	[64%-	72%]	63%	[60%-	66%]	65%	[62%-	67%]
Env. Health	70%	[58%-	81%]	59%	[55%-	63%]	63%	[61%-	66%]	62%	[60%-	64%]
MCH	76%	[71%-	82%]	60%	[56%-	64%]	63%	[59%-	66%]	62%	[60%-	65%]
All Hazards	60%	[45%-	75%]	56%	[50%-	63%]	68%	[62%-	75%]	62%	[58%-	67%]
Assessment	56%	[44%-	67%]	68%	[63%-	72%]	69%	[65%-	72%]	68%	[65%-	71%]
Communications	76%	[62%-	89%]	70%	[60%-	81%]	76%	[66%-	87%]	74%	[67%-	81%]
Org. Competencies	59%	[53%-	64%]	73%	[70%-	76%]	67%	[65%-	70%]	69%	[67%-	71%]
Other	67%	[64%-	70%]	67%	[65%-	69%]	63%	[61%-	65%]	64%	[63%-	66%]
Other Health Care	69%	[59%-	78%]	67%	[61%-	72%]	68%	[63%-	73%]	67%	[64%-	71%]
Total	67%	[65%-	69%]	66%	[65%-	67%]	65%	[64%-	66%]	65%	[64%-	66%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Organization Is A Good Place To Work



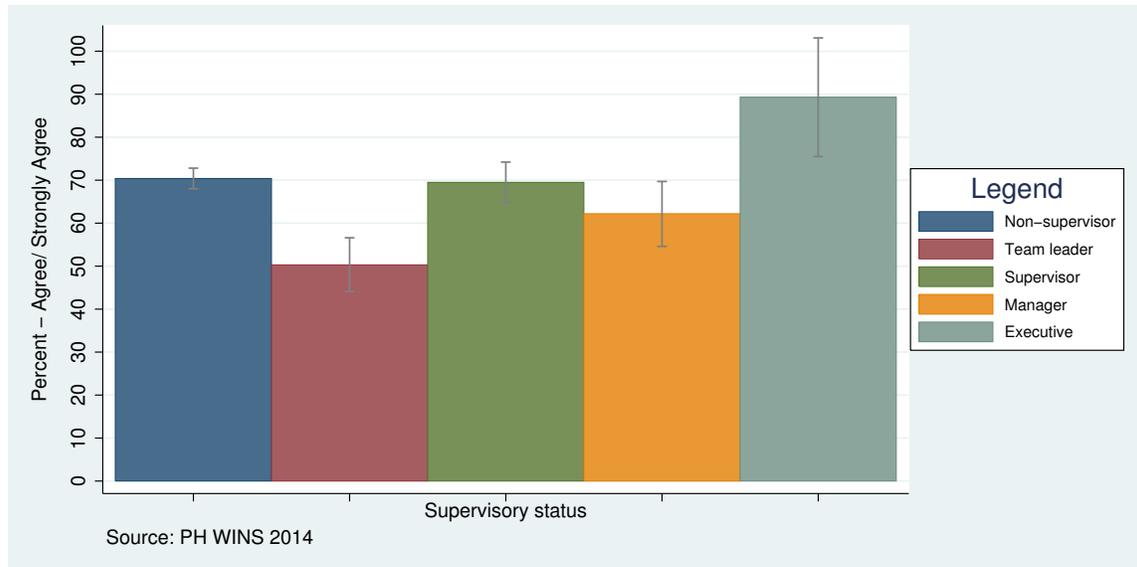
This chart represents the proportion of overall agreement with the statement: I recommend my organization as a good place to work.

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Strongly disagree	4%	[4%-	5%]	5%	[4%-	5%]	4%	[4%-	5%]	5%	[4%-	5%]
Disagree	9%	[7%-	10%]	8%	[7%-	9%]	9%	[8%-	10%]	9%	[8%-	9%]
Neither agree nor disagree	19%	[18%-	21%]	22%	[21%-	23%]	23%	[22%-	24%]	22%	[22%-	23%]
Agree	42%	[40%-	44%]	43%	[42%-	45%]	43%	[42%-	44%]	43%	[42%-	44%]
Strongly agree	26%	[24%-	28%]	21%	[21%-	22%]	21%	[20%-	22%]	21%	[21%-	22%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

I Recommend My Organization As A Good Place To Work By Supervisory Status



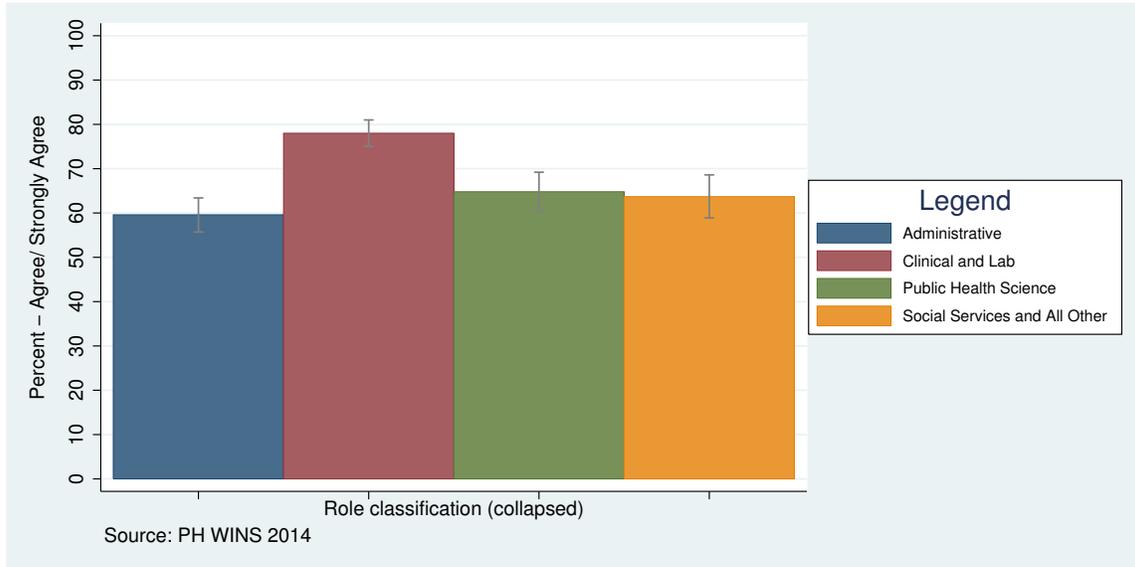
This chart represents the proportion of staff by supervisory status who “Strongly agree/agree” with the statement: I recommend my organization as a good place to work.

Supervisory status	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Non-supervisor	70%	[68%-	73%]	63%	[62%-	65%]	63%	[62%-	65%]	64%	[63%-	65%]
Team leader	50%	[44%-	57%]	61%	[58%-	65%]	59%	[56%-	61%]	59%	[58%-	61%]
Supervisor	69%	[65%-	74%]	70%	[67%-	73%]	67%	[64%-	69%]	68%	[66%-	70%]
Manager	62%	[55%-	70%]	68%	[64%-	71%]	69%	[66%-	71%]	68%	[66%-	70%]
Executive	89%	[76%-	103%]	77%	[71%-	82%]	81%	[76%-	86%]	79%	[75%-	83%]
Total	68%	[66%-	70%]	65%	[64%-	66%]	64%	[63%-	65%]	64%	[64%-	65%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

I Recommend My Organization As A Good Place To Work By Role Classification



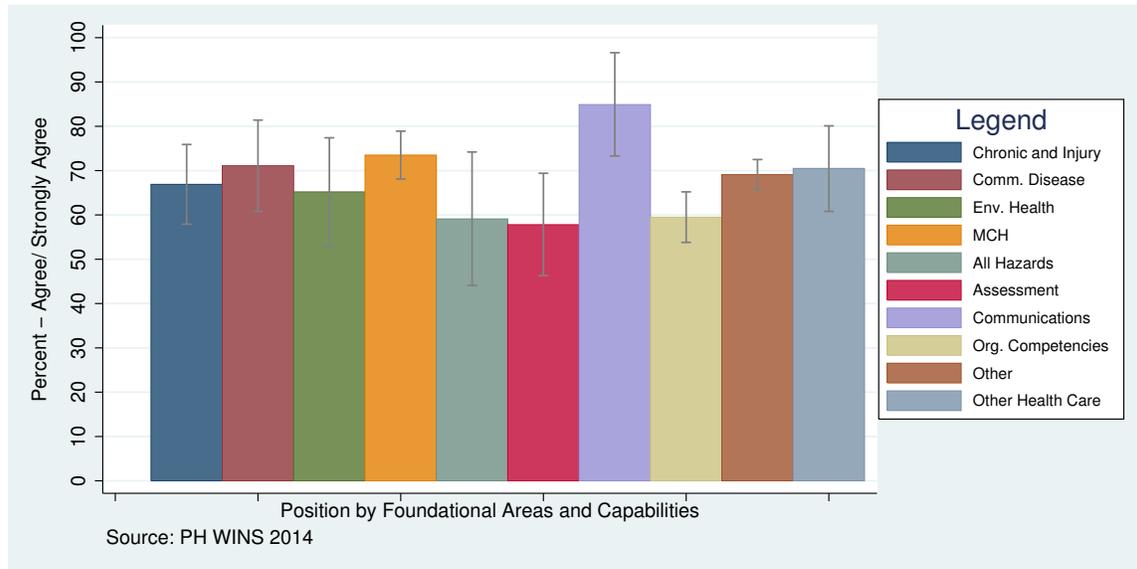
This chart represents the proportion of staff by role classification who “Strongly agree/agree” with the statement: **I recommend my organization as a good place to work.**

Role classification (collapsed)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Administrative	60%	[56%-	63%]	65%	[63%-	67%]	66%	[64%-	68%]	65%	[64%-	66%]
Clinical and Lab	78%	[75%-	81%]	69%	[67%-	71%]	62%	[60%-	64%]	66%	[64%-	67%]
Public Health Science	65%	[60%-	69%]	63%	[61%-	65%]	65%	[63%-	67%]	64%	[63%-	66%]
Social Services and All Other	64%	[59%-	69%]	63%	[60%-	66%]	61%	[59%-	64%]	62%	[60%-	64%]
Total	68%	[66%-	70%]	65%	[64%-	66%]	64%	[63%-	65%]	65%	[64%-	65%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

I Recommend My Organization As A Good Place To Work By Foundational Areas/Capabilities



This chart represents the proportion of staff by foundational areas/capabilities who “Strongly agree/agree” with the statement: I recommend my organization as a good place to work.

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	67%	[58%-	76%]	65%	[59%-	72%]	66%	[62%-	70%]	66%	[63%-	69%]
Comm. Disease	71%	[61%-	81%]	67%	[63%-	71%]	64%	[60%-	67%]	65%	[63%-	68%]
Env. Health	65%	[53%-	77%]	59%	[55%-	63%]	65%	[62%-	68%]	63%	[61%-	65%]
MCH	73%	[68%-	79%]	58%	[54%-	62%]	64%	[61%-	67%]	62%	[59%-	64%]
All Hazards Assessment	59%	[44%-	74%]	59%	[52%-	66%]	60%	[53%-	68%]	60%	[55%-	64%]
Communications	85%	[73%-	97%]	74%	[64%-	83%]	76%	[66%-	87%]	76%	[70%-	83%]
Org. Competencies	59%	[54%-	65%]	69%	[66%-	72%]	66%	[63%-	69%]	67%	[65%-	69%]
Other	69%	[66%-	72%]	67%	[65%-	69%]	61%	[59%-	62%]	63%	[62%-	65%]
Other Health Care	70%	[61%-	80%]	64%	[59%-	70%]	64%	[59%-	69%]	65%	[61%-	68%]
Total	68%	[66%-	70%]	65%	[64%-	66%]	64%	[63%-	65%]	64%	[63%-	65%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	84%	[77%-	91%]	88%	[83%-	92%]	82%	[79%-	86%]	84%	[82%-	87%]
Comm. Disease	88%	[81%-	95%]	88%	[86%-	91%]	87%	[85%-	89%]	87%	[86%-	89%]
Env. Health	84%	[75%-	94%]	84%	[81%-	87%]	82%	[80%-	84%]	82%	[81%-	84%]
MCH	87%	[83%-	91%]	85%	[82%-	88%]	85%	[82%-	88%]	85%	[83%-	87%]
All Hazards	87%	[77%-	97%]	85%	[80%-	90%]	84%	[80%-	89%]	85%	[82%-	88%]
Assessment	82%	[73%-	91%]	86%	[82%-	89%]	86%	[84%-	89%]	86%	[84%-	88%]
Communications	95%	[89%-	102%]	83%	[74%-	92%]	88%	[80%-	95%]	87%	[82%-	92%]
Org. Competencies	79%	[75%-	84%]	88%	[86%-	90%]	85%	[83%-	87%]	86%	[85%-	87%]
Other	83%	[80%-	85%]	87%	[86%-	89%]	83%	[81%-	85%]	85%	[83%-	86%]
Other Health Care	86%	[79%-	93%]	92%	[89%-	95%]	84%	[79%-	88%]	88%	[85%-	90%]
Total	84%	[82%-	85%]	87%	[86%-	87%]	84%	[83%-	85%]	85%	[85%-	86%]

Source: PH WINS 2014

This estimate is NOT statistically significantly different compared to the national average

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	94%	[89%-	98%]	94%	[91%-	98%]	91%	[89%-	93%]	92%	[91%-	94%]
Comm. Disease	84%	[75%-	92%]	94%	[92%-	96%]	91%	[90%-	93%]	92%	[91%-	94%]
Env. Health	94%	[88%-	100%]	89%	[86%-	91%]	88%	[86%-	90%]	89%	[87%-	90%]
MCH	96%	[94%-	98%]	95%	[94%-	97%]	91%	[90%-	93%]	93%	[92%-	95%]
All Hazards	91%	[83%-	100%]	94%	[91%-	97%]	95%	[93%-	97%]	95%	[93%-	96%]
Assessment	79%	[70%-	89%]	92%	[89%-	95%]	93%	[92%-	95%]	92%	[91%-	94%]
Communications	95%	[89%-	102%]	89%	[82%-	96%]	87%	[78%-	97%]	89%	[84%-	95%]
Org. Competencies	93%	[90%-	96%]	96%	[95%-	97%]	94%	[93%-	96%]	95%	[94%-	96%]
Other	92%	[90%-	94%]	95%	[94%-	96%]	92%	[91%-	94%]	93%	[92%-	94%]
Other Health Care	96%	[91%-	100%]	95%	[93%-	98%]	89%	[85%-	92%]	92%	[90%-	95%]
Total	92%	[91%-	93%]	94%	[94%-	95%]	92%	[92%-	93%]	93%	[92%-	93%]

Source: PH WINS 2014

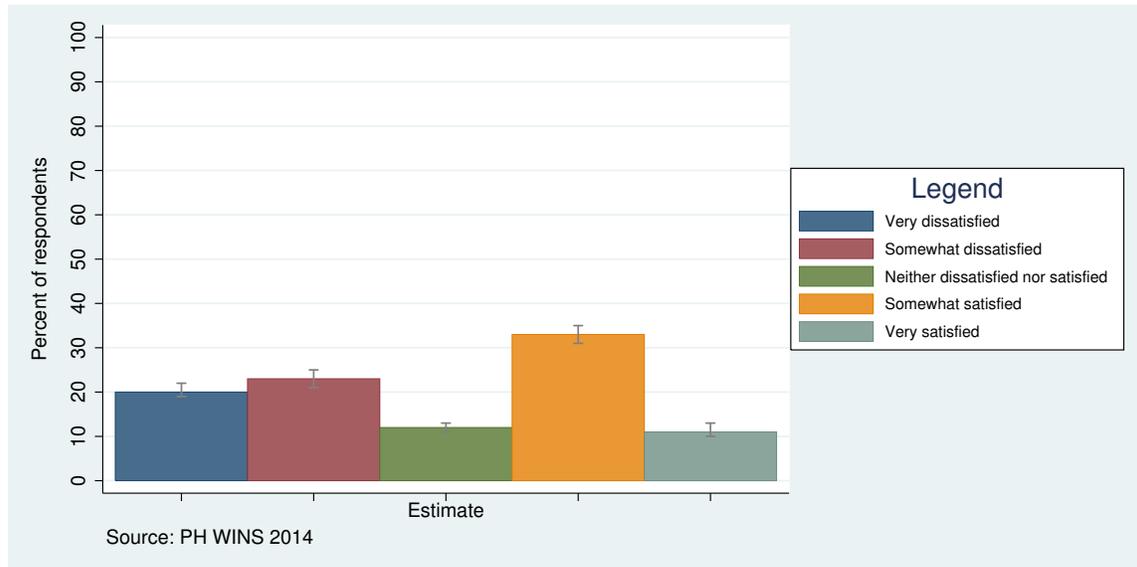
This estimate IS statistically significantly different compared to the national average

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	49%	[40%-	59%]	44%	[37%-	50%]	40%	[36%-	45%]	42%	[39%-	45%]
Comm. Disease	47%	[35%-	58%]	39%	[34%-	43%]	39%	[36%-	43%]	39%	[37%-	42%]
Env. Health	21%	[11%-	31%]	34%	[30%-	38%]	35%	[32%-	38%]	34%	[32%-	37%]
MCH	47%	[41%-	53%]	36%	[32%-	40%]	40%	[36%-	43%]	39%	[36%-	41%]
All Hazards Assessment	33%	[19%-	47%]	37%	[31%-	43%]	38%	[31%-	45%]	37%	[32%-	42%]
Communications	66%	[51%-	81%]	47%	[36%-	59%]	42%	[29%-	54%]	47%	[39%-	55%]
Org. Competencies	30%	[24%-	35%]	40%	[37%-	43%]	40%	[38%-	43%]	40%	[38%-	42%]
Other	43%	[39%-	46%]	38%	[36%-	40%]	36%	[34%-	38%]	37%	[35%-	38%]
Other Health Care	40%	[29%-	50%]	37%	[31%-	42%]	43%	[38%-	49%]	40%	[36%-	43%]
Total	40%	[38%-	42%]	38%	[37%-	40%]	39%	[38%-	40%]	38%	[37%-	39%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Overall Pay Satisfaction



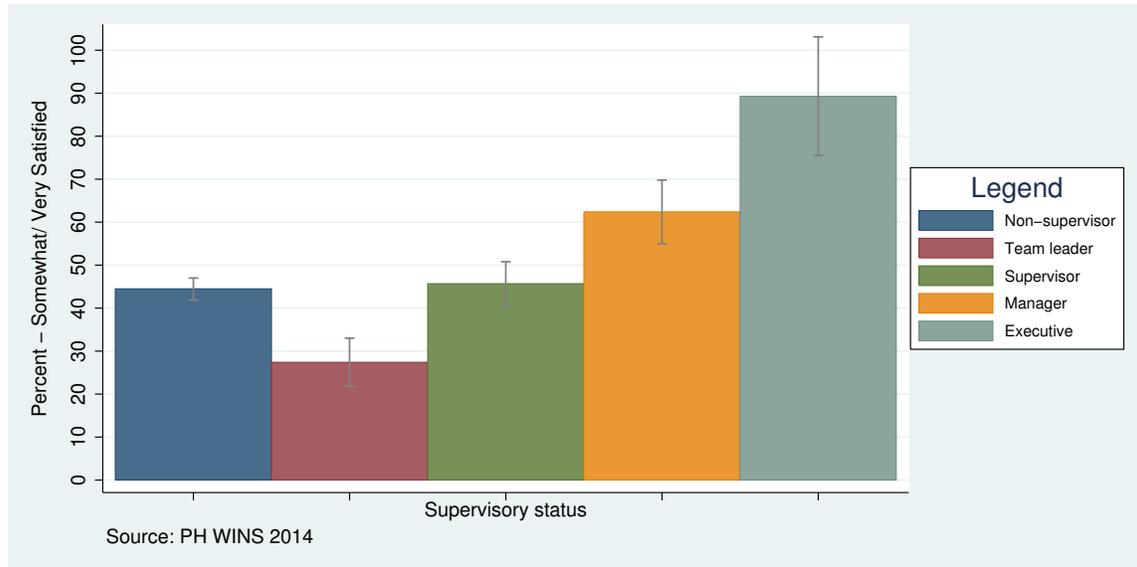
This chart represents the proportion of overall pay satisfaction.

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Very dissatisfied	20%	[19%-	22%]	23%	[22%-	24%]	14%	[13%-	14%]	17%	[17%-	18%]
Somewhat dissatisfied	23%	[21%-	25%]	28%	[27%-	29%]	22%	[21%-	23%]	24%	[23%-	25%]
Neither dissatisfied nor satisfied	12%	[11%-	13%]	12%	[11%-	13%]	13%	[12%-	14%]	13%	[12%-	13%]
Somewhat satisfied	33%	[31%-	35%]	30%	[29%-	31%]	37%	[36%-	38%]	34%	[34%-	35%]
Very satisfied	11%	[10%-	13%]	8%	[7%-	8%]	14%	[14%-	15%]	12%	[11%-	12%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Pay Satisfaction By Supervisory Status



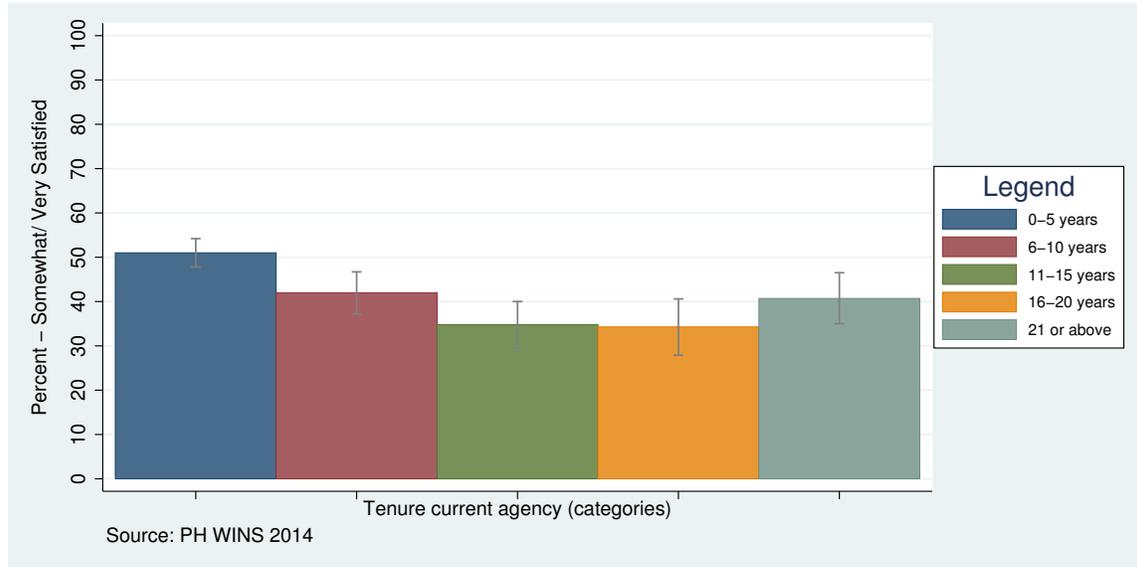
This chart represents the proportion of staff by supervisory level who are “Very satisfied/Somewhat satisfied ”with their pay.

Supervisory status	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Non-supervisor	44%	[42%-	47%]	35%	[33%-	36%]	50%	[49%-	51%]	44%	[43%-	45%]
Team leader	27%	[22%-	33%]	34%	[31%-	37%]	48%	[46%-	51%]	43%	[41%-	45%]
Supervisor	46%	[41%-	51%]	42%	[39%-	45%]	56%	[54%-	58%]	50%	[48%-	52%]
Manager	62%	[55%-	70%]	47%	[43%-	50%]	61%	[58%-	64%]	55%	[53%-	57%]
Executive	89%	[76%-	103%]	60%	[54%-	66%]	69%	[63%-	75%]	65%	[60%-	69%]
Total	45%	[42%-	47%]	38%	[36%-	39%]	52%	[51%-	53%]	46%	[46%-	47%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Pay Satisfaction By Tenure In The Current Health Department (Years)



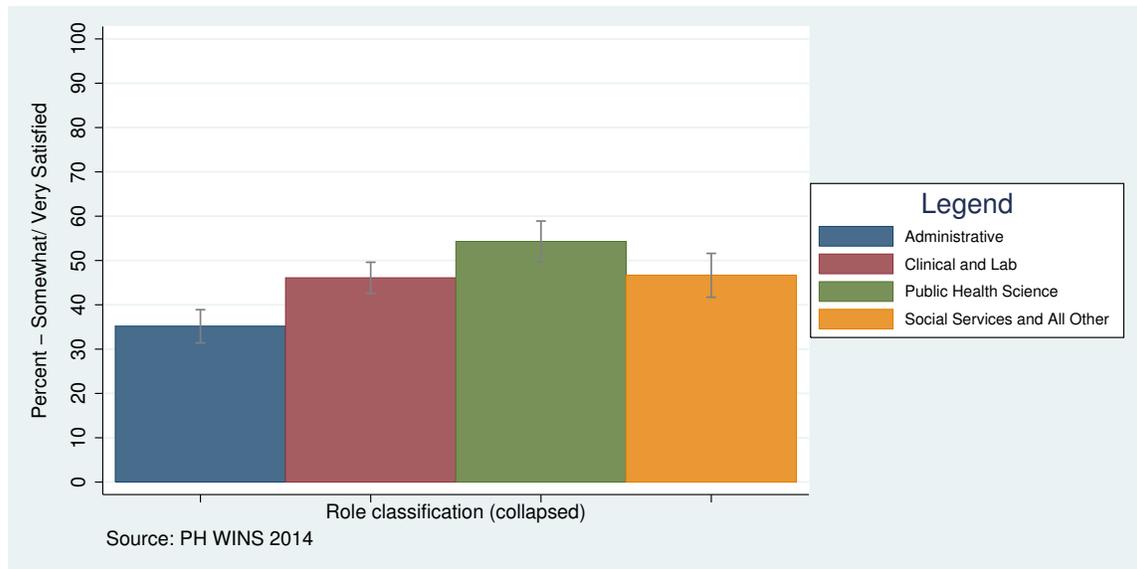
This chart represents the proportion of staff by tenure in current health department (years) who are “Very satisfied/Somewhat satisfied ”with their pay.

Tenure current agency (categories)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
0-5 years	51%	[48%-	54%]	38%	[36%-	40%]	50%	[49%-	52%]	46%	[45%-	47%]
6-10 years	42%	[37%-	47%]	34%	[31%-	36%]	49%	[47%-	51%]	43%	[42%-	45%]
11-15 years	35%	[29%-	40%]	36%	[33%-	39%]	56%	[53%-	58%]	48%	[46%-	50%]
16-20 years	34%	[28%-	41%]	36%	[33%-	40%]	55%	[52%-	59%]	47%	[44%-	49%]
21 or above	41%	[35%-	47%]	43%	[40%-	46%]	56%	[54%-	58%]	50%	[49%-	52%]
Total	45%	[42%-	47%]	38%	[36%-	39%]	52%	[51%-	53%]	46%	[46%-	47%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Pay Satisfaction By Role Classification



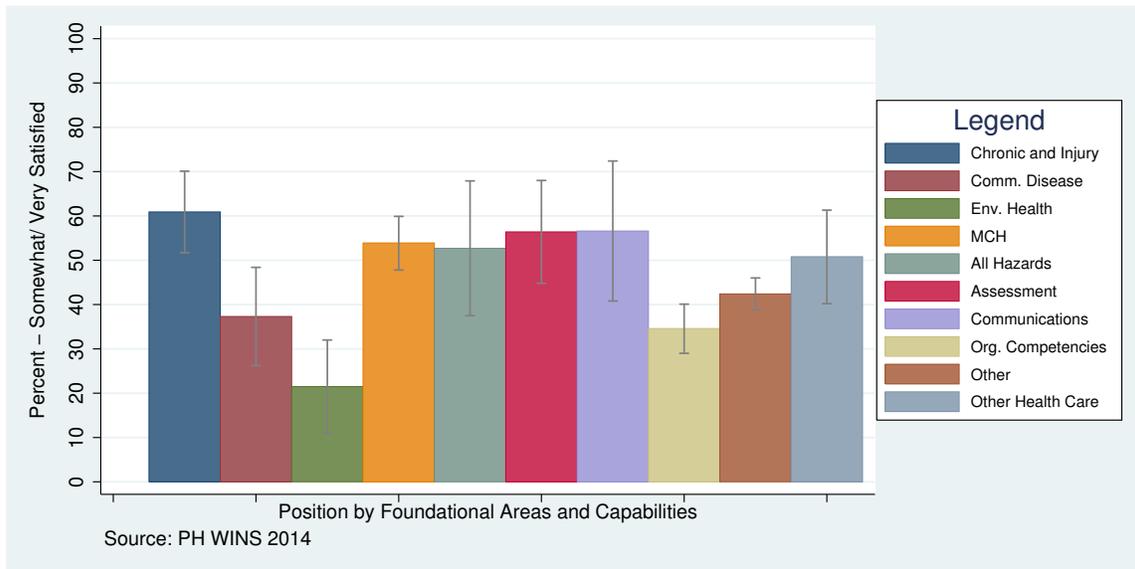
This chart represents the proportion of staff by role classification who are “Very satisfied/Somewhat satisfied ”with their pay.

Role classification (collapsed)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Administrative	35%	[31%-	39%]	35%	[33%-	37%]	51%	[50%-	53%]	44%	[42%-	45%]
Clinical and Lab	46%	[43%-	50%]	40%	[37%-	42%]	49%	[47%-	51%]	45%	[44%-	47%]
Public Health Sci- ence	54%	[50%-	59%]	39%	[37%-	42%]	54%	[53%-	56%]	49%	[48%-	51%]
Social Services and All Other	47%	[42%-	52%]	36%	[33%-	39%]	50%	[48%-	53%]	45%	[44%-	47%]
Total	45%	[42%-	47%]	38%	[36%-	39%]	52%	[51%-	53%]	46%	[45%-	47%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Pay Satisfaction By Foundational Areas/Capabilities



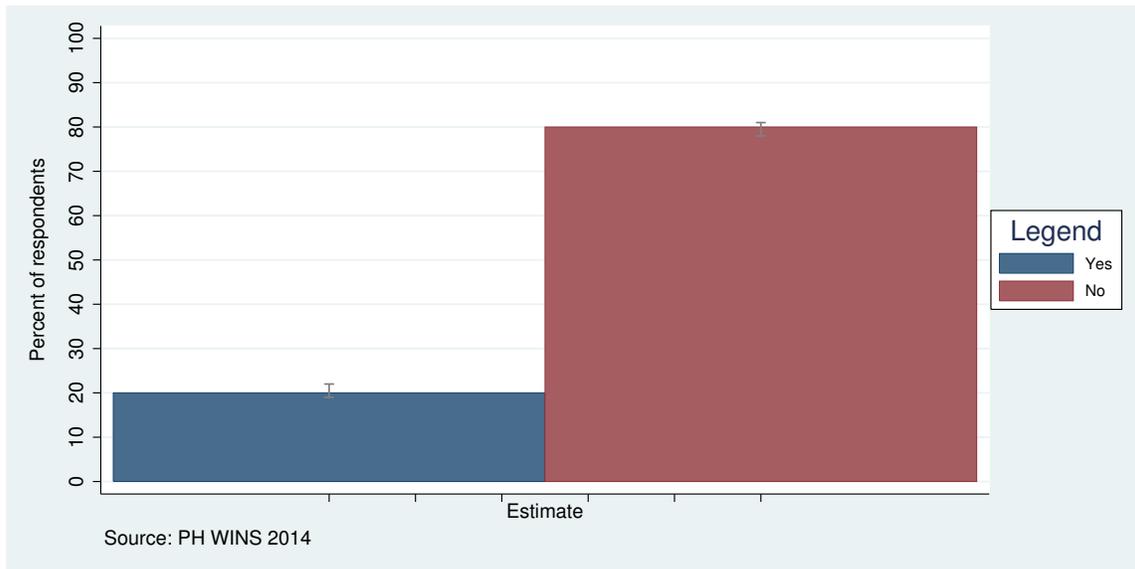
This chart represents the proportion of staff by foundational areas/capabilities who are “Very satisfied/Somewhat satisfied” with their pay.

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	61%	[52%-	70%]	28%	[22%-	34%]	57%	[53%-	62%]	48%	[45%-	52%]
Comm. Disease	37%	[26%-	48%]	39%	[35%-	43%]	53%	[50%-	57%]	48%	[45%-	50%]
Env. Health	21%	[11%-	32%]	30%	[27%-	34%]	55%	[52%-	58%]	46%	[44%-	49%]
MCH	54%	[48%-	60%]	37%	[33%-	41%]	58%	[55%-	61%]	49%	[46%-	51%]
All Hazards	53%	[38%-	68%]	34%	[28%-	40%]	52%	[45%-	59%]	44%	[39%-	48%]
Assessment	56%	[45%-	68%]	32%	[28%-	37%]	54%	[50%-	58%]	46%	[43%-	49%]
Communications	57%	[41%-	72%]	46%	[34%-	57%]	67%	[55%-	78%]	57%	[49%-	65%]
Org. Competencies	35%	[29%-	40%]	43%	[40%-	46%]	52%	[49%-	55%]	47%	[45%-	49%]
Other	42%	[39%-	46%]	39%	[37%-	41%]	48%	[46%-	50%]	44%	[43%-	46%]
Other Health Care	51%	[40%-	61%]	37%	[32%-	42%]	61%	[55%-	66%]	49%	[45%-	53%]
Total	45%	[42%-	47%]	38%	[36%-	39%]	52%	[51%-	53%]	46%	[46%-	47%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Staff Plans to Leave Position Within One Year



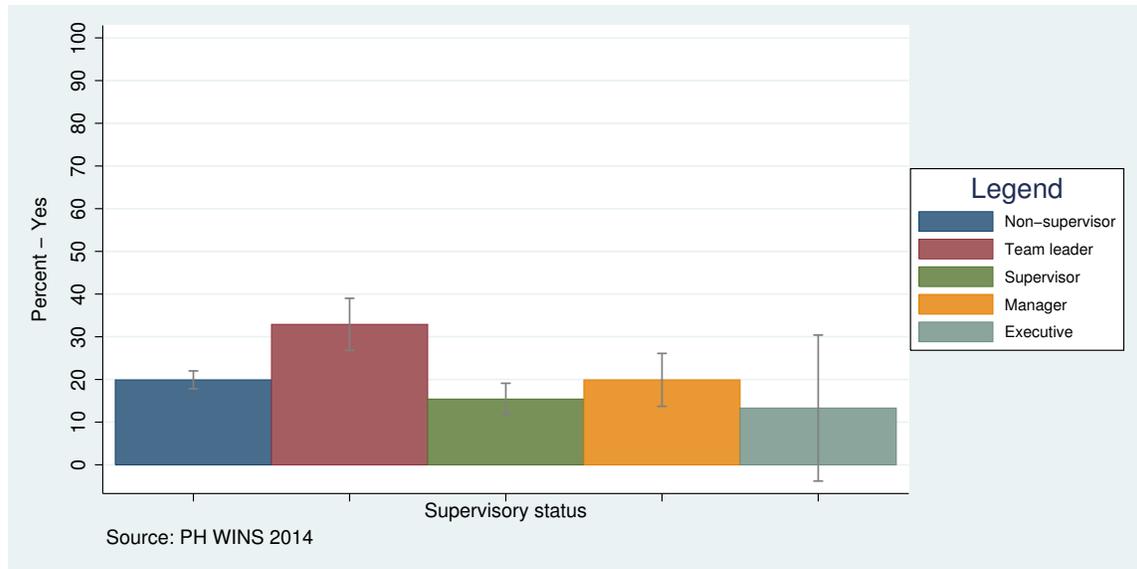
This chart represents the proportion of staff considering leaving the agency in the next year.

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Yes	20%	[19%-	22%]	25%	[24%-	26%]	25%	[24%-	26%]	25%	[24%-	25%]
No	80%	[78%-	81%]	75%	[74%-	76%]	75%	[74%-	76%]	75%	[75%-	76%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Considering Leaving The Organization In The Next Year By Supervisory Status



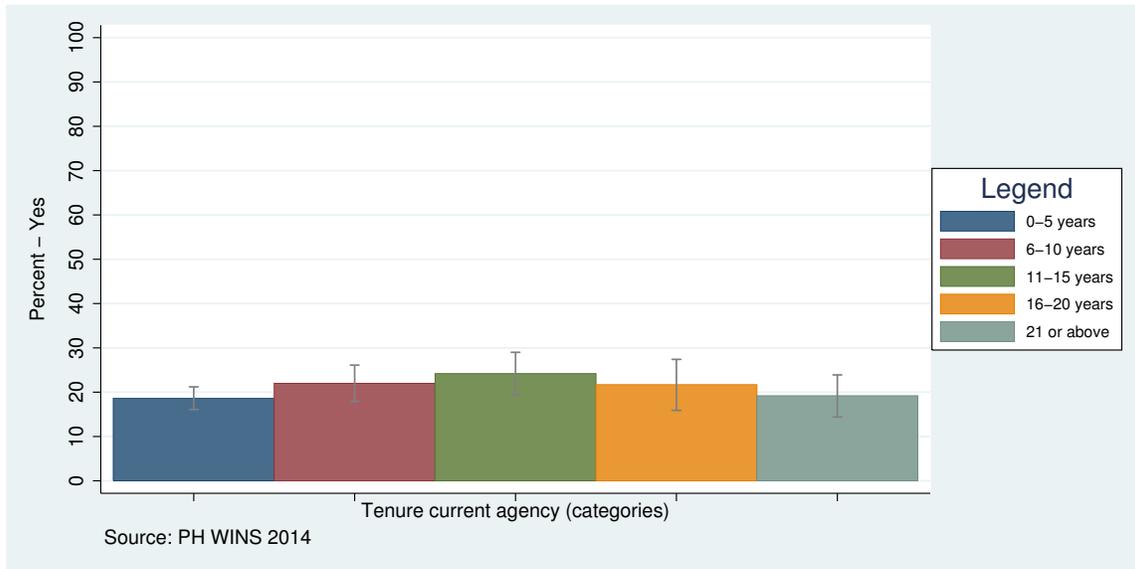
This chart represents the proportion of staff by supervisory status considering leaving the agency in the next year.

Supervisory status	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Non-supervisor	20%	[18%-	22%]	26%	[24%-	27%]	25%	[24%-	26%]	25%	[24%-	26%]
Team leader	33%	[27%-	39%]	29%	[26%-	32%]	29%	[26%-	31%]	29%	[27%-	31%]
Supervisor	15%	[12%-	19%]	21%	[19%-	24%]	21%	[19%-	23%]	21%	[19%-	22%]
Manager	20%	[14%-	26%]	22%	[18%-	25%]	24%	[21%-	27%]	23%	[21%-	25%]
Executive	13%	[-	30%]	22%	[16%-	28%]	17%	[12%-	22%]	19%	[16%-	23%]
Total	20%	[19%-	22%]	25%	[24%-	26%]	25%	[24%-	26%]	25%	[24%-	25%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Considering Leaving The Organization In The Next Year By Tenure In Current Health Department (Years)



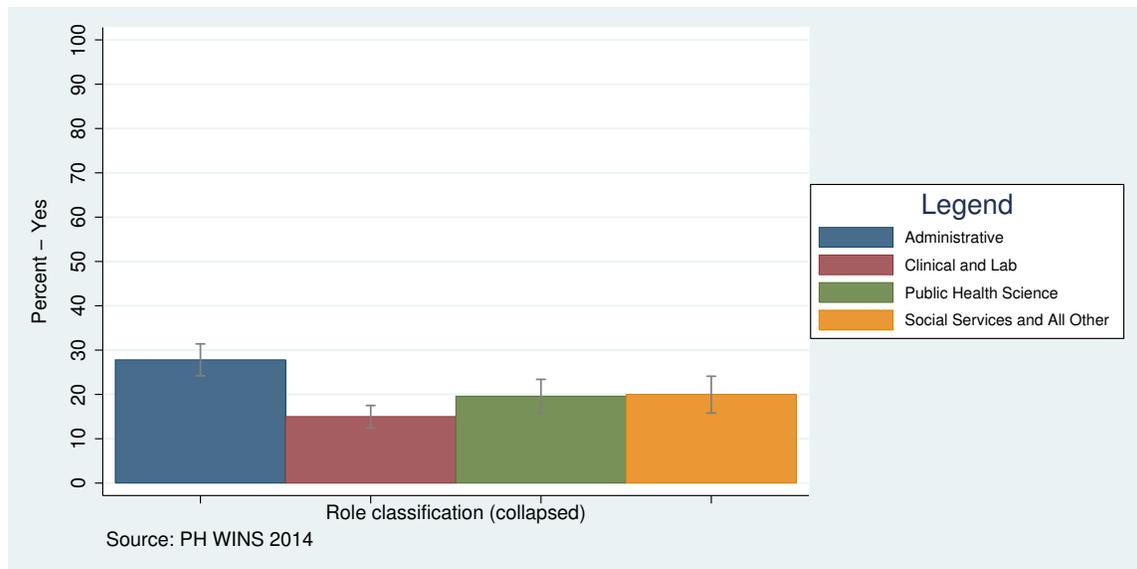
This chart represents the proportion of staff by tenure in current health department (years) considering leaving the agency in the next year.

Tenure current agency (categories)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
0-5 years	19%	[16%-	21%]	28%	[26%-	30%]	27%	[25%-	28%]	27%	[25%-	28%]
6-10 years	22%	[18%-	26%]	28%	[25%-	30%]	26%	[24%-	27%]	26%	[25%-	28%]
11-15 years	24%	[19%-	29%]	21%	[18%-	24%]	21%	[19%-	23%]	21%	[20%-	23%]
16-20 years	22%	[16%-	27%]	21%	[18%-	24%]	22%	[20%-	25%]	22%	[20%-	24%]
21 or above	19%	[14%-	24%]	23%	[21%-	26%]	27%	[25%-	29%]	25%	[24%-	27%]
Total	20%	[19%-	22%]	25%	[24%-	26%]	25%	[24%-	26%]	25%	[24%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Considering Leaving The Organization In The Next Year By Role Classification



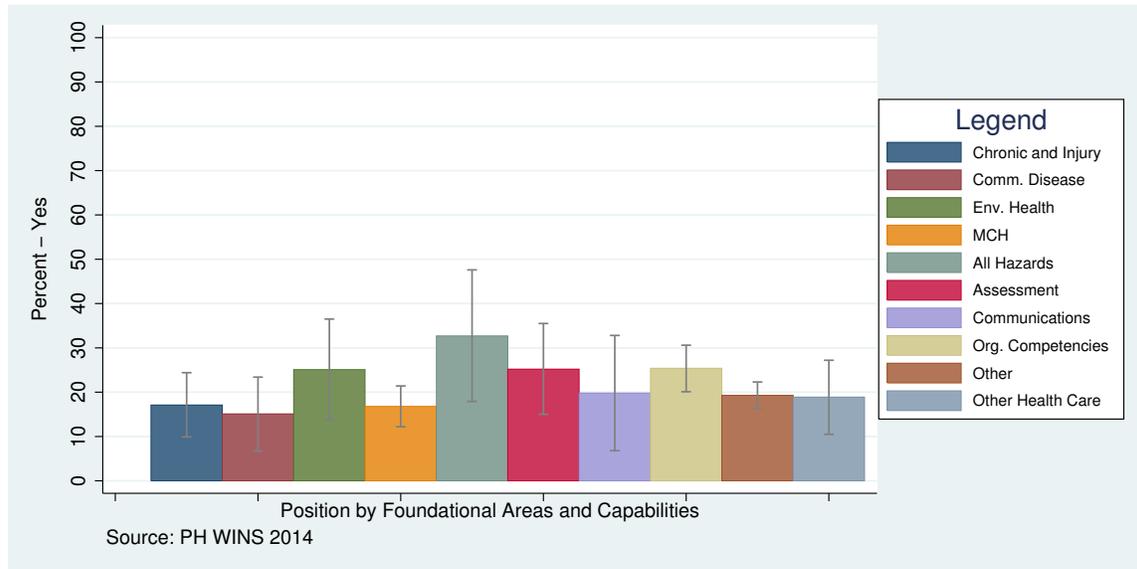
This chart represents the proportion of staff by role classification considering leaving the agency in the next year.

Role classification (collapsed)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Administrative	28%	[24%-	31%]	24%	[22%-	26%]	27%	[26%-	29%]	26%	[25%-	27%]
Clinical and Lab	15%	[12%-	18%]	22%	[20%-	24%]	22%	[20%-	24%]	21%	[20%-	23%]
Public Health Sci- ence	20%	[16%-	23%]	27%	[25%-	29%]	25%	[24%-	27%]	26%	[24%-	27%]
Social Services and All Other	20%	[16%-	24%]	27%	[25%-	30%]	26%	[24%-	28%]	26%	[24%-	27%]
Total	20%	[19%-	22%]	25%	[24%-	26%]	25%	[24%-	26%]	25%	[24%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Considering Leaving The Organization In The Next Year By Foundational Areas/Capabilities



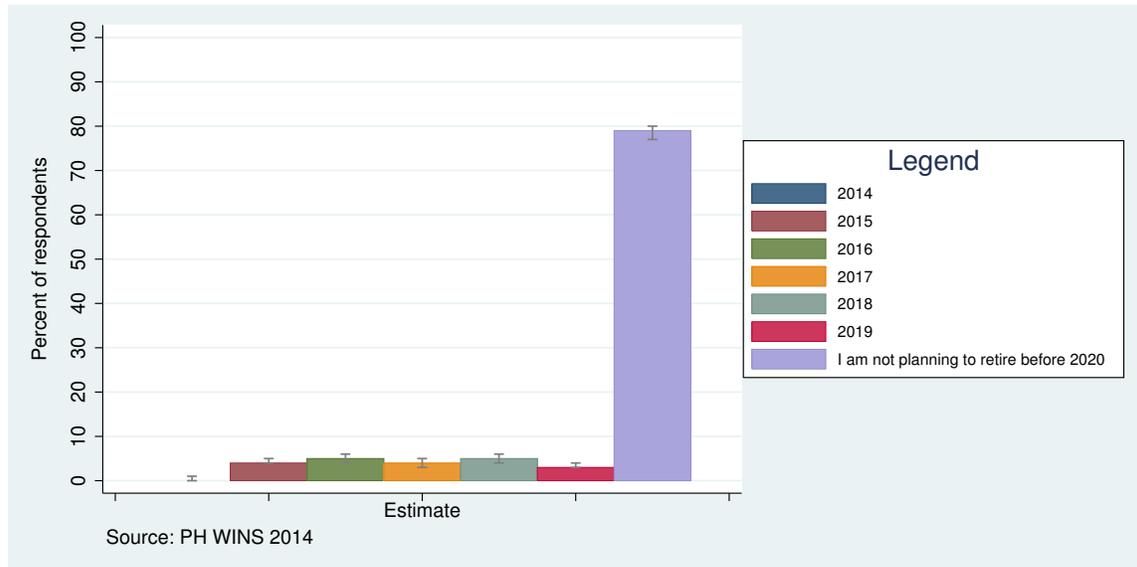
This chart represents the proportion of staff by foundational areas/capabilities considering leaving the agency in the next year.

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	17%	[10%-	24%]	26%	[21%-	32%]	29%	[25%-	33%]	27%	[24%-	30%]
Comm. Disease	15%	[7%-	23%]	26%	[22%-	30%]	26%	[23%-	29%]	26%	[24%-	28%]
Env. Health	25%	[14%-	36%]	26%	[23%-	30%]	21%	[18%-	23%]	23%	[21%-	25%]
MCH	17%	[12%-	21%]	28%	[24%-	32%]	30%	[27%-	34%]	29%	[26%-	31%]
All Hazards	33%	[18%-	48%]	28%	[22%-	34%]	28%	[21%-	35%]	28%	[24%-	33%]
Assessment	25%	[15%-	35%]	30%	[26%-	35%]	25%	[22%-	28%]	27%	[24%-	29%]
Communications	20%	[7%-	33%]	27%	[17%-	38%]	19%	[10%-	29%]	23%	[16%-	29%]
Org. Competencies	25%	[20%-	31%]	22%	[19%-	25%]	26%	[24%-	29%]	24%	[23%-	26%]
Other	19%	[16%-	22%]	24%	[22%-	26%]	25%	[23%-	27%]	24%	[23%-	26%]
Other Health Care	19%	[11%-	27%]	22%	[17%-	27%]	24%	[20%-	29%]	23%	[20%-	26%]
Total	20%	[19%-	22%]	25%	[24%-	26%]	25%	[24%-	26%]	25%	[24%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Staff Plans to Retire



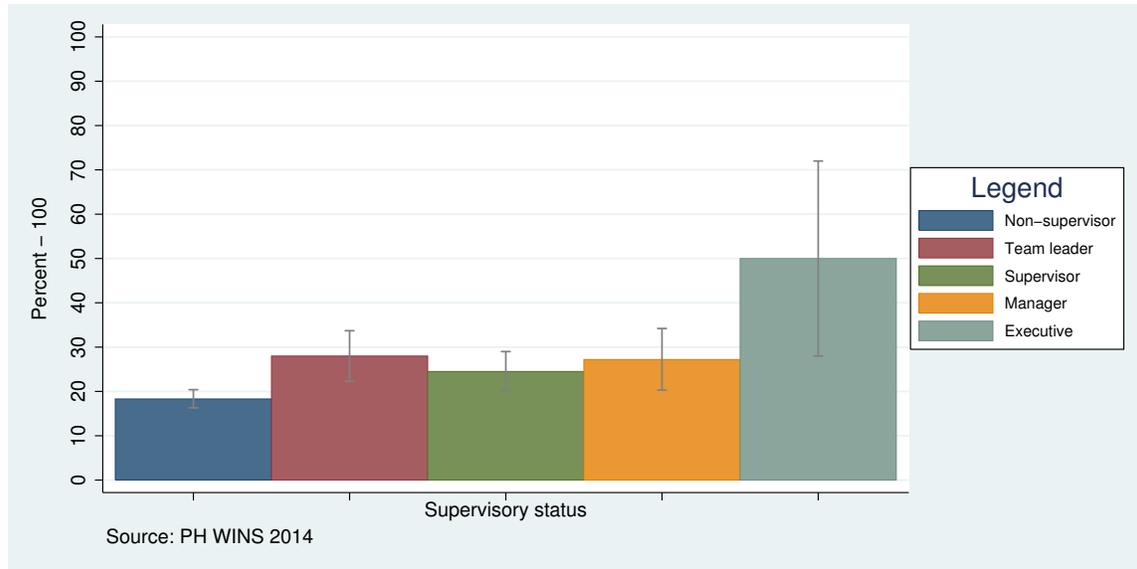
This chart represents the proportion of agency staff planning to retire before the year 2020.

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
2014	0%	[0%-	1%]	1%	[1%-	1%]	1%	[1%-	1%]	1%	[1%-	1%]
2015	4%	[4%-	5%]	4%	[4%-	5%]	5%	[4%-	5%]	5%	[4%-	5%]
2016	5%	[4%-	6%]	5%	[4%-	6%]	5%	[5%-	6%]	5%	[5%-	6%]
2017	4%	[3%-	5%]	5%	[5%-	6%]	6%	[5%-	6%]	5%	[5%-	6%]
2018	5%	[4%-	6%]	5%	[4%-	5%]	4%	[4%-	5%]	4%	[4%-	5%]
2019	3%	[3%-	4%]	5%	[4%-	5%]	5%	[5%-	6%]	5%	[5%-	5%]
I am not planning to retire before 2020	79%	[77%-	80%]	75%	[74%-	76%]	74%	[73%-	75%]	75%	[74%-	75%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Planning To Retire By Supervisory Status



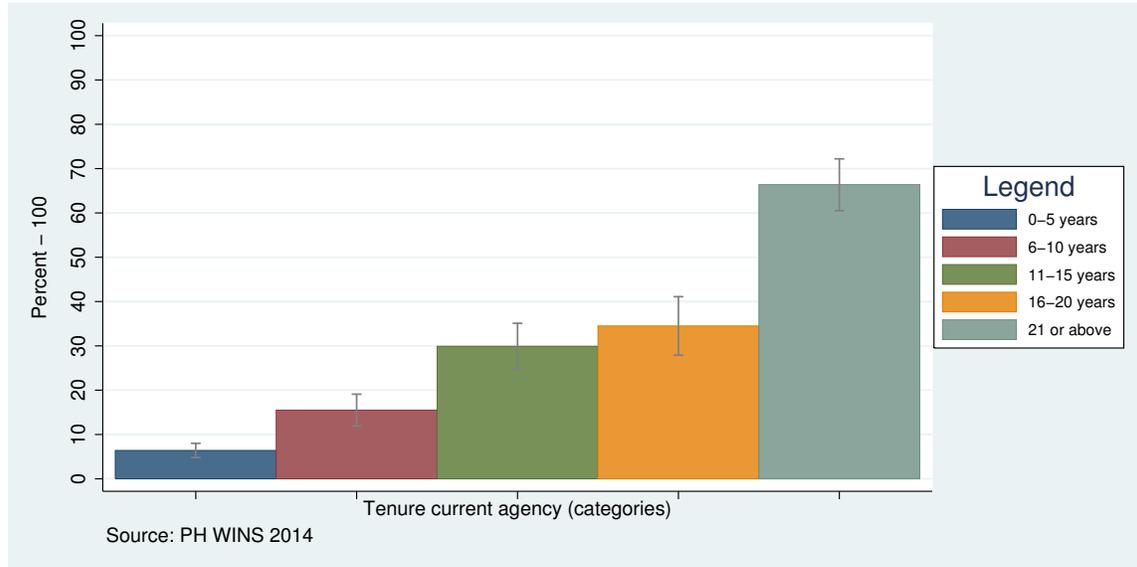
This chart represents the proportion of agency staff by supervisory status planning to retire before the year 2020.

Supervisory status	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Non-supervisor	18%	[16%-	20%]	23%	[22%-	25%]	23%	[22%-	25%]	23%	[22%-	24%]
Team leader	28%	[22%-	34%]	23%	[21%-	26%]	26%	[24%-	28%]	25%	[23%-	27%]
Supervisor	25%	[20%-	29%]	26%	[23%-	29%]	30%	[28%-	32%]	28%	[27%-	30%]
Manager	27%	[20%-	34%]	32%	[29%-	35%]	37%	[34%-	39%]	34%	[32%-	36%]
Executive	50%	[28%-	72%]	30%	[24%-	35%]	32%	[26%-	38%]	31%	[27%-	35%]
Total	21%	[20%-	23%]	25%	[24%-	26%]	26%	[25%-	27%]	25%	[25%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Planning To Retire by Tenure In Current Health Department (Years)



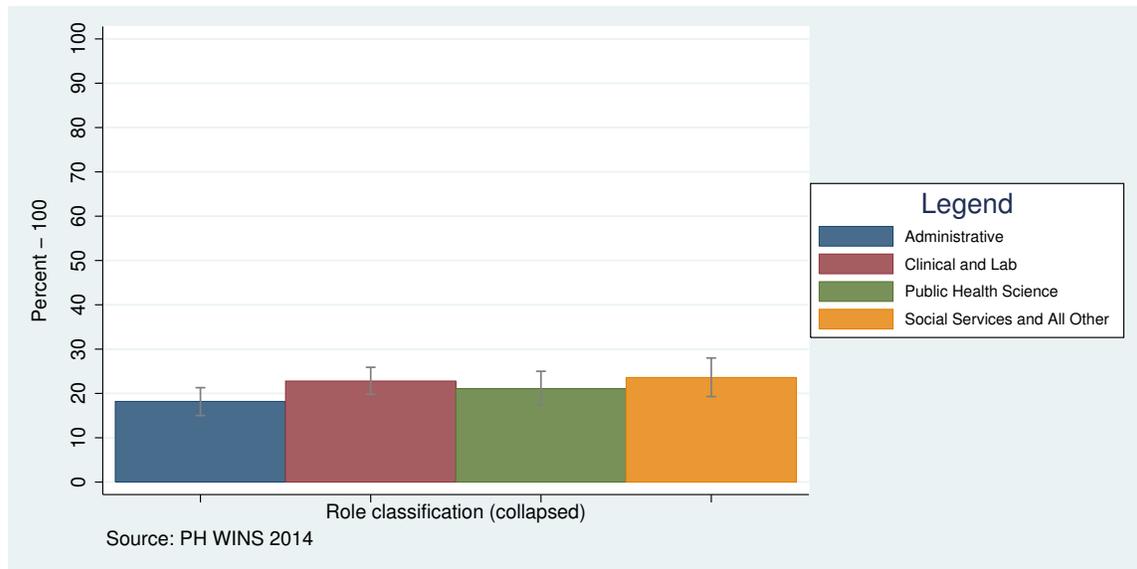
This chart represents the proportion of agency staff by tenure in current health department (years) planning to retire before the year 2020.

Tenure current agency (categories)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
0-5 years	6%	[5%-	8%]	10%	[8%-	11%]	10%	[9%-	11%]	10%	[9%-	11%]
6-10 years	16%	[12%-	19%]	18%	[16%-	20%]	20%	[19%-	22%]	19%	[18%-	21%]
11-15 years	30%	[25%-	35%]	24%	[21%-	27%]	28%	[26%-	30%]	27%	[25%-	28%]
16-20 years	35%	[28%-	41%]	31%	[28%-	34%]	33%	[30%-	36%]	32%	[30%-	35%]
21 or above	66%	[61%-	72%]	60%	[57%-	63%]	60%	[57%-	62%]	60%	[58%-	62%]
Total	21%	[20%-	23%]	25%	[24%-	26%]	26%	[25%-	27%]	26%	[25%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Planning To Retire by Role Classification



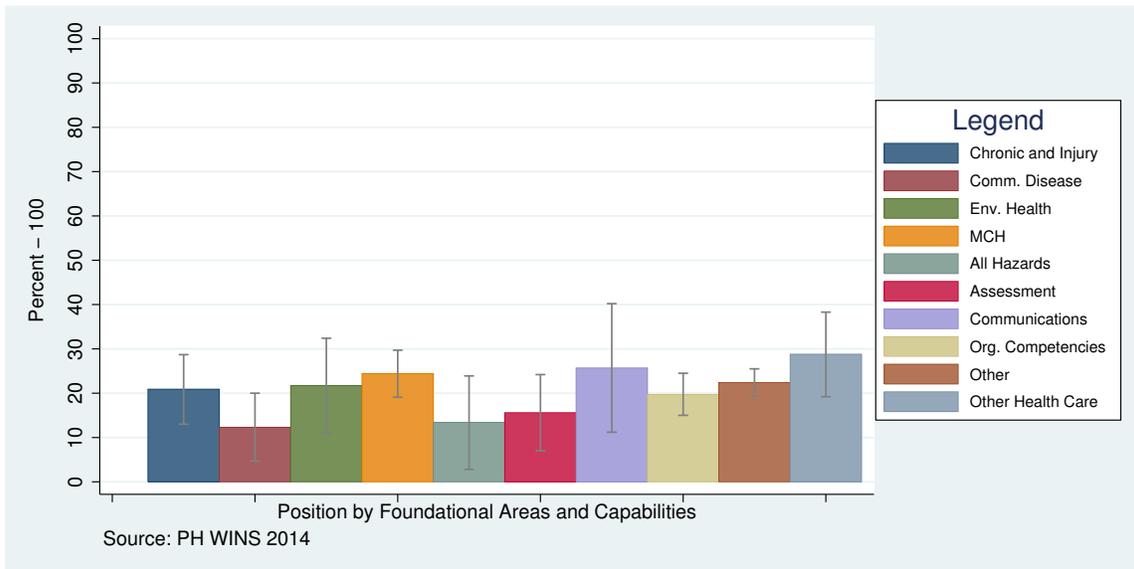
This chart represents the proportion of agency staff by role classification planning to retire before the year 2020.

Role classification (collapsed)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Administrative	18%	[15%-	21%]	25%	[23%-	26%]	25%	[24%-	27%]	25%	[24%-	26%]
Clinical and Lab	23%	[20%-	26%]	26%	[24%-	28%]	29%	[28%-	31%]	28%	[26%-	29%]
Public Health Science	21%	[17%-	25%]	25%	[24%-	27%]	26%	[24%-	28%]	26%	[24%-	27%]
Social Services and All Other	24%	[19%-	28%]	23%	[20%-	25%]	23%	[21%-	24%]	23%	[21%-	24%]
Total	21%	[20%-	23%]	25%	[24%-	26%]	26%	[25%-	27%]	25%	[25%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Percent Of Staff Planning To Retire By Foundational Areas/Capabilities



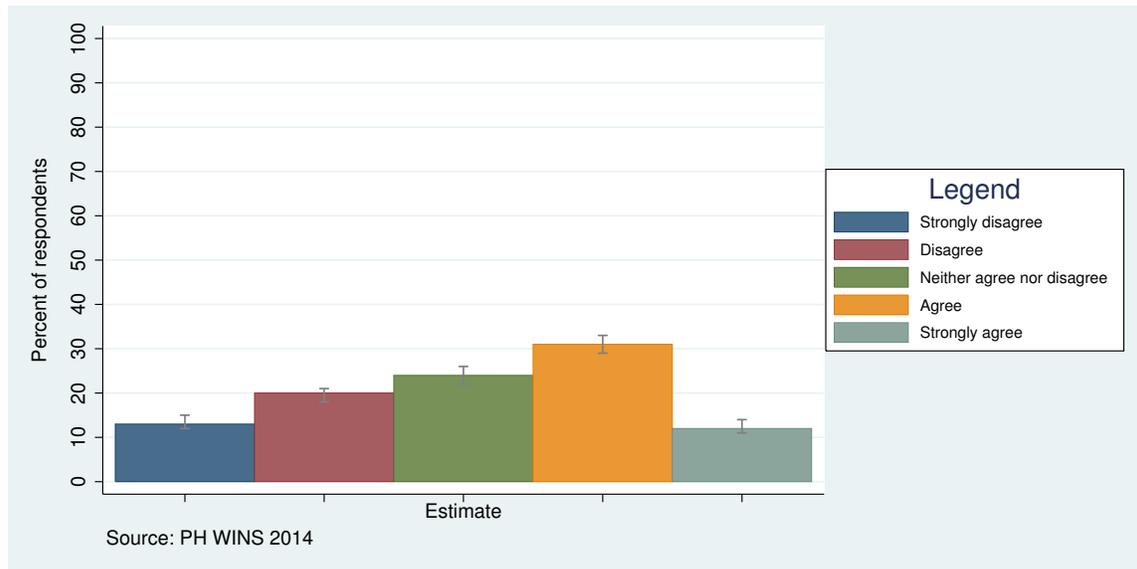
This chart represents the proportion of agency staff by foundational areas/capabilities planning to retire before the year 2020.

Position by Foundational Areas and Capabilities	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Chronic and Injury	21%	[13%-	29%]	19%	[14%-	24%]	22%	[18%-	26%]	21%	[18%-	24%]
Comm. Disease	12%	[5%-	20%]	20%	[17%-	24%]	23%	[20%-	26%]	22%	[20%-	24%]
Env. Health	22%	[11%-	32%]	23%	[19%-	26%]	25%	[22%-	27%]	24%	[22%-	26%]
MCH	24%	[19%-	30%]	29%	[26%-	33%]	30%	[27%-	33%]	29%	[27%-	32%]
All Hazards	13%	[3%-	24%]	25%	[19%-	31%]	22%	[16%-	27%]	23%	[19%-	27%]
Assessment	16%	[7%-	24%]	21%	[17%-	25%]	20%	[17%-	24%]	21%	[18%-	23%]
Communications	26%	[11%-	40%]	21%	[12%-	31%]	21%	[11%-	31%]	22%	[15%-	28%]
Org. Competencies	20%	[15%-	24%]	29%	[26%-	32%]	29%	[27%-	32%]	29%	[27%-	31%]
Other	22%	[19%-	25%]	25%	[23%-	27%]	26%	[25%-	28%]	26%	[25%-	27%]
Other Health Care	29%	[19%-	38%]	26%	[21%-	32%]	26%	[21%-	31%]	26%	[23%-	30%]
Total	21%	[20%-	23%]	25%	[24%-	26%]	26%	[25%-	27%]	25%	[25%-	26%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Communication Between Senior Leadership And Employees Is Good In My Organization



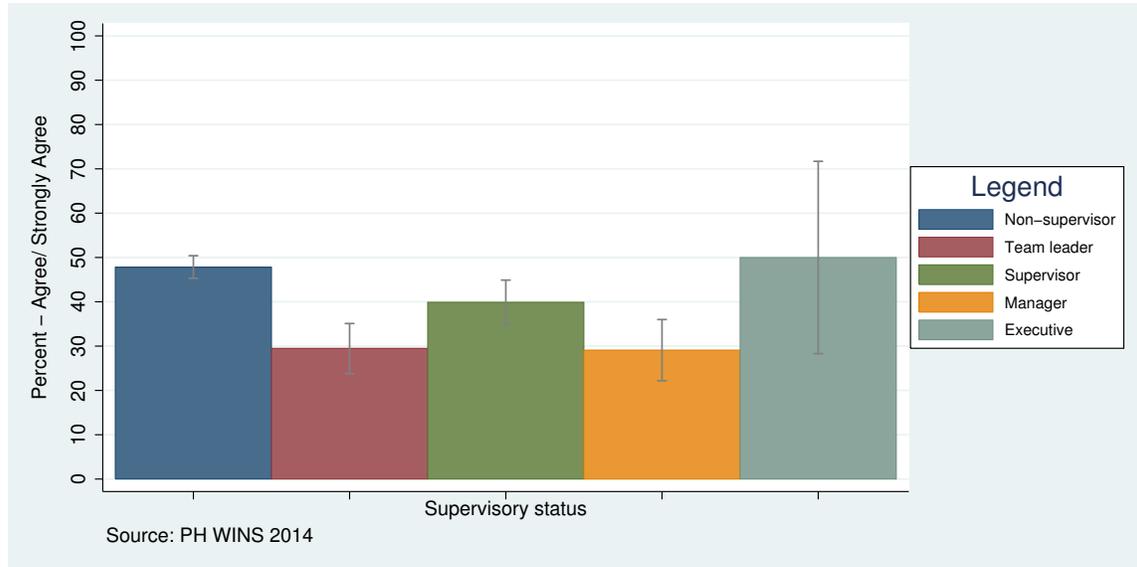
This chart represents the proportion of overall agreement with the statement: **Communication between senior leadership and employees is good in my organization.**

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Strongly disagree	13%	[12%-	15%]	12%	[11%-	13%]	12%	[11%-	13%]	12%	[11%-	13%]
Disagree	20%	[18%-	21%]	19%	[18%-	20%]	21%	[20%-	22%]	20%	[20%-	21%]
Neither agree nor disagree	24%	[22%-	26%]	22%	[21%-	23%]	23%	[22%-	24%]	23%	[22%-	23%]
Agree	31%	[29%-	33%]	34%	[33%-	36%]	32%	[31%-	33%]	33%	[32%-	34%]
Strongly agree	12%	[11%-	14%]	13%	[12%-	13%]	11%	[11%-	12%]	12%	[11%-	12%]
Total	100%			100%			100%			100%		

Source: PH WINS 2014

This estimate is NOT statistically significantly different compared to the national average

Communication Between Senior Leadership And Employees Is Good In My Organization By Supervisory Status



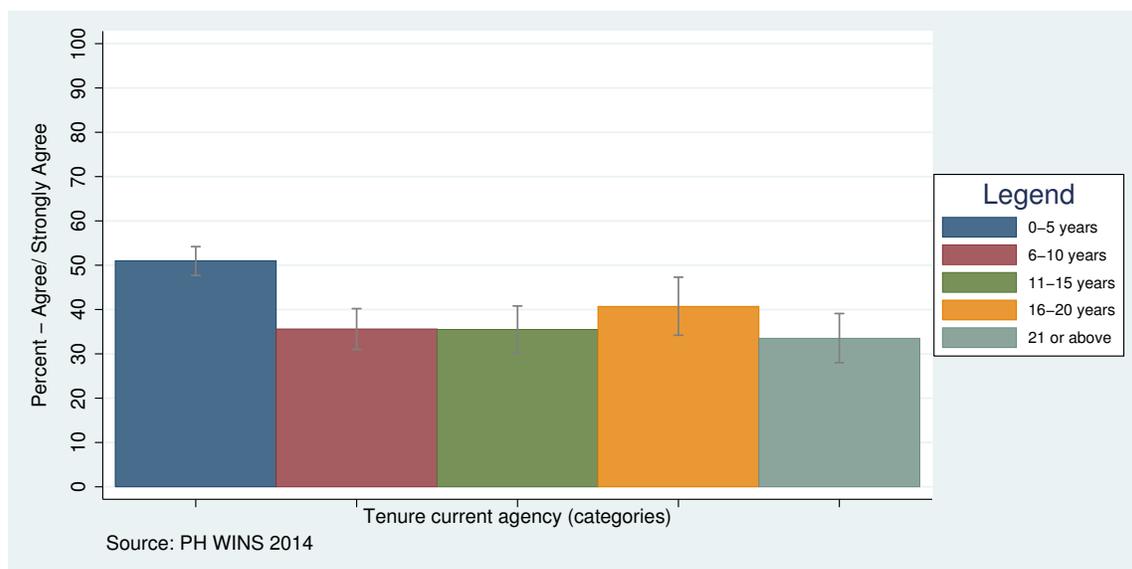
This chart represents the proportion of staff by supervisory status who “Strongly agree/agree” with the statement: **Communication between senior leadership and employees is good in my organization.**

Supervisory status	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Non-supervisor	48%	[45%-	50%]	47%	[45%-	48%]	44%	[43%-	46%]	45%	[44%-	46%]
Team leader	29%	[24%-	35%]	42%	[39%-	45%]	35%	[33%-	38%]	37%	[36%-	39%]
Supervisor	40%	[35%-	45%]	49%	[46%-	52%]	43%	[41%-	45%]	45%	[43%-	47%]
Manager	29%	[22%-	36%]	49%	[46%-	53%]	47%	[44%-	50%]	47%	[45%-	50%]
Executive	50%	[28%-	72%]	69%	[63%-	75%]	71%	[66%-	77%]	70%	[65%-	74%]
Total	43%	[41%-	45%]	47%	[46%-	48%]	44%	[43%-	45%]	45%	[44%-	45%]

Source: PH WINS 2014

This estimate IS statistically significantly different compared to the national average

Communication Between Senior Leadership And Employees Is Good In My Organization By Tenure In Current Health Department (Years)



This chart represents the proportion of staff by tenure in current health department (years) who “Strongly agree/agree” with the statement: **Communication between senior leadership and employees is good in my organization.**

Tenure current agency (categories)	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
0-5 years	51%	[48%-	54%	[52%-	50%	[48%-	51%	[50%-	54%	[48%-	52%	53%
6-10 years	36%	[31%-	41%	[38%-	39%	[37%-	40%	[38%-	41%	[37%-	41%	41%
11-15 years	36%	[30%-	44%	[41%-	37%	[35%-	39%	[38%-	41%	[35%-	39%	41%
16-20 years	41%	[34%-	42%	[39%-	38%	[35%-	40%	[38%-	42%	[35%-	41%	42%
21 or above	34%	[28%-	46%	[44%-	42%	[39%-	43%	[42%-	45%	[39%-	44%	45%
Total	43%	[41%-	47%	[46%-	44%	[43%-	44%	[44%-	45%	[43%-	45%	45%

Source: PH WINS 2014
This estimate is NOT statistically significantly different compared to the national average

Continuing Education

	State, Regional, and National Estimates											
	OK Estimate			Rest of region			All other regions			Total		
	%	95%	CI	%	95%	CI	%	95%	CI	%	95%	CI
Require continuing education	55%	[53%-	57%]	46%	[45%-	47%]	31%	[30%-	32%]	38%	[37%-	38%]
Include education and training objectives in performance reviews	78%	[76%-	80%]	58%	[57%-	60%]	60%	[59%-	61%]	60%	[60%-	61%]
Allow use of working hours to participate in training	94%	[93%-	95%]	89%	[88%-	90%]	91%	[90%-	91%]	90%	[90%-	91%]
Pay travel/registration fees for trainings	88%	[87%-	89%]	74%	[73%-	76%]	75%	[75%-	76%]	76%	[75%-	76%]
Provide on-site training	88%	[87%-	90%]	79%	[78%-	80%]	78%	[77%-	79%]	79%	[78%-	79%]
Have staff position(s) responsible for internal training	71%	[69%-	73%]	61%	[59%-	62%]	60%	[59%-	61%]	61%	[60%-	61%]
Provide recognition of achievement	67%	[65%-	69%]	49%	[48%-	51%]	56%	[55%-	58%]	54%	[54%-	55%]

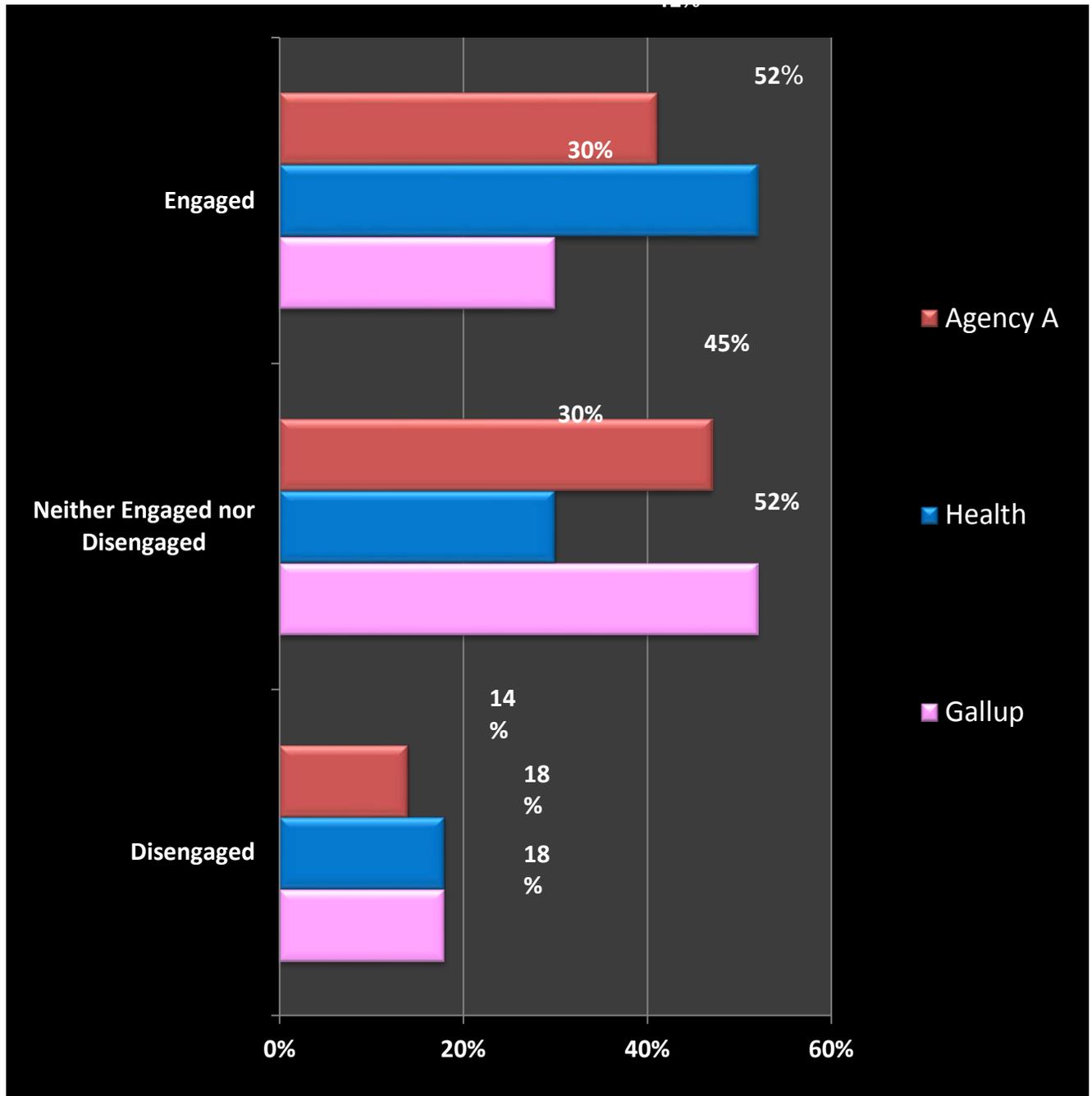
Employee Engagement Survey

Section III

RESULTS - ENGAGEMENT

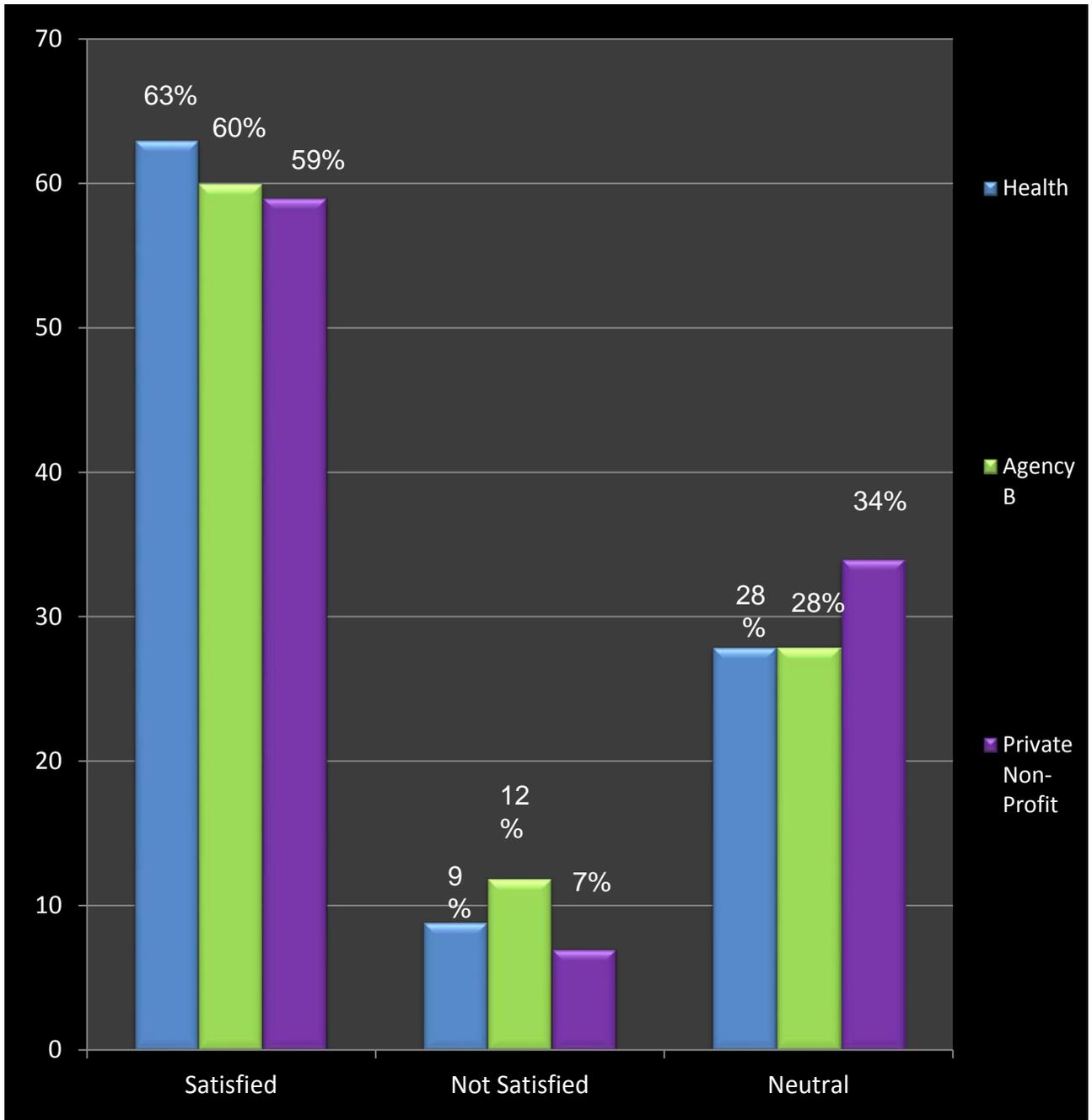
OSDH Engagement Compared to Agency A & Gallup Survey (2012)

Employee engagement is described as the degree to which an individual is attentive and absorbed in the performance of his or her job (Bakker, 2011).



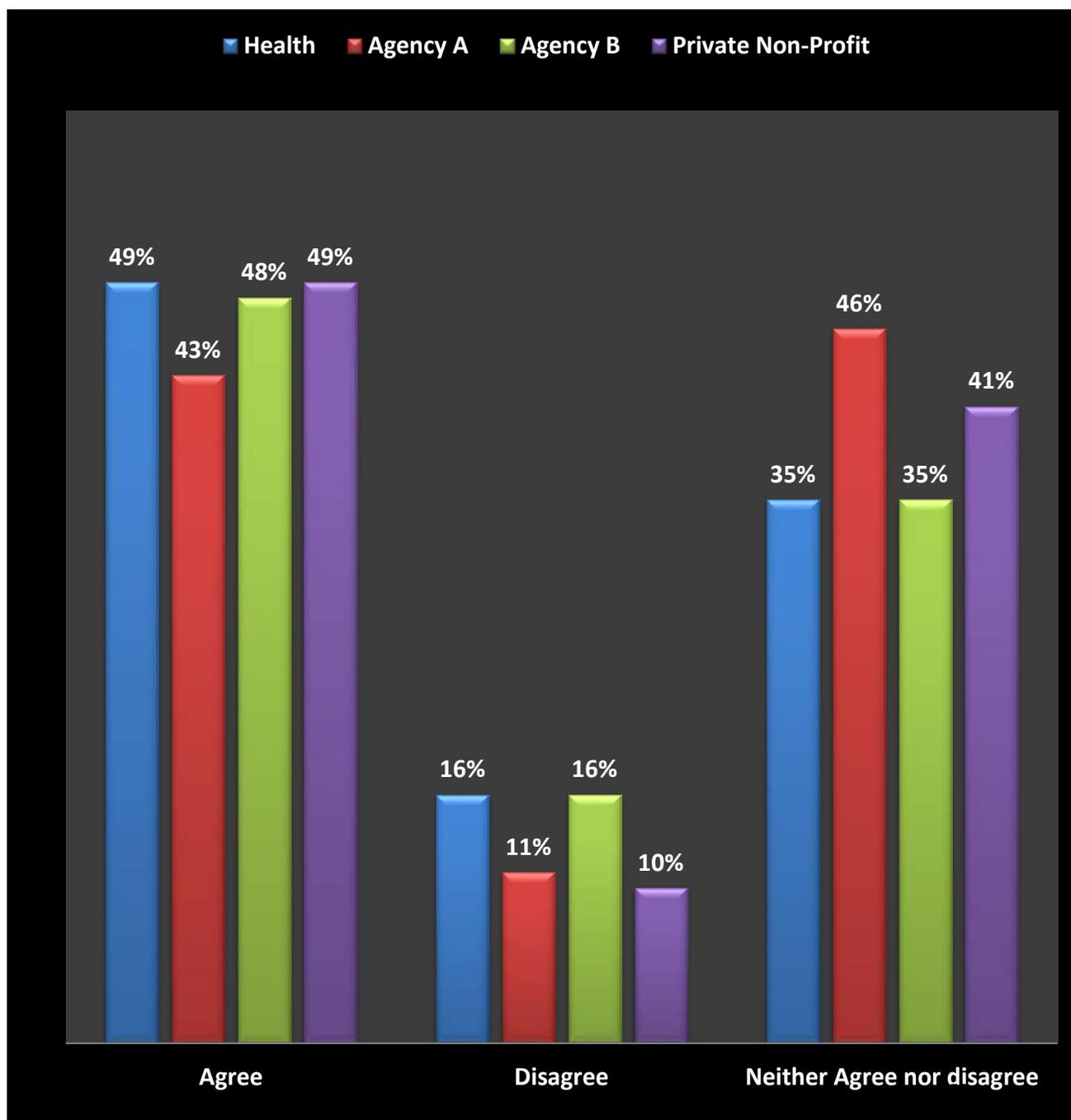
RESULTS – JOB SATISFACTION

Job Satisfaction is defined as the extent to which a persons hope, desires and expectations about the employment he/she is engaged in are fulfilled.



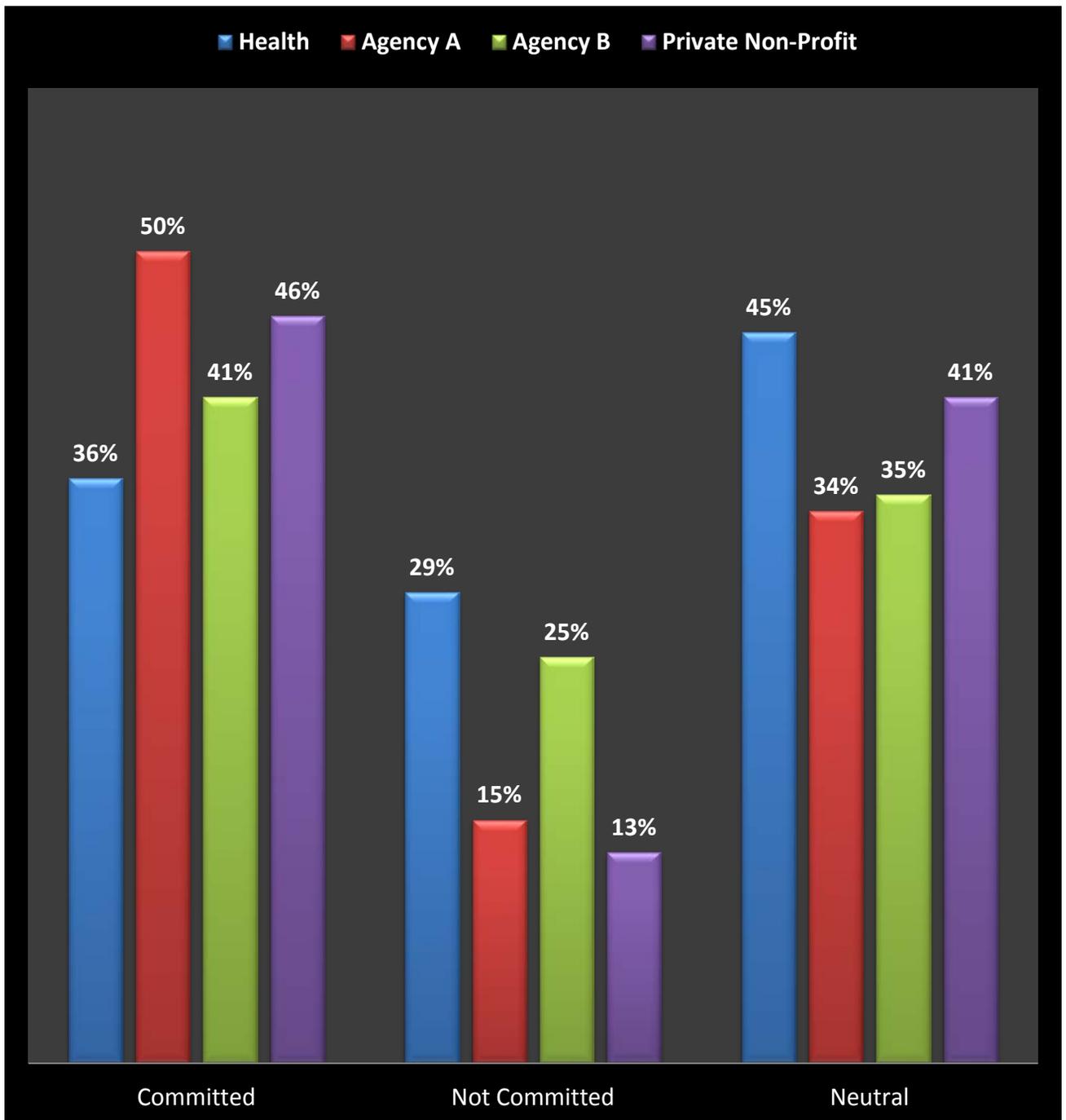
RESULTS – ORGANIZATIONAL IDENTIFICATION

Organizational identification is the extent to which a person identifies themselves with the organization: a possessing or sharing of organizational values.



RESULTS - ORGANIZATIONAL COMMITMENT

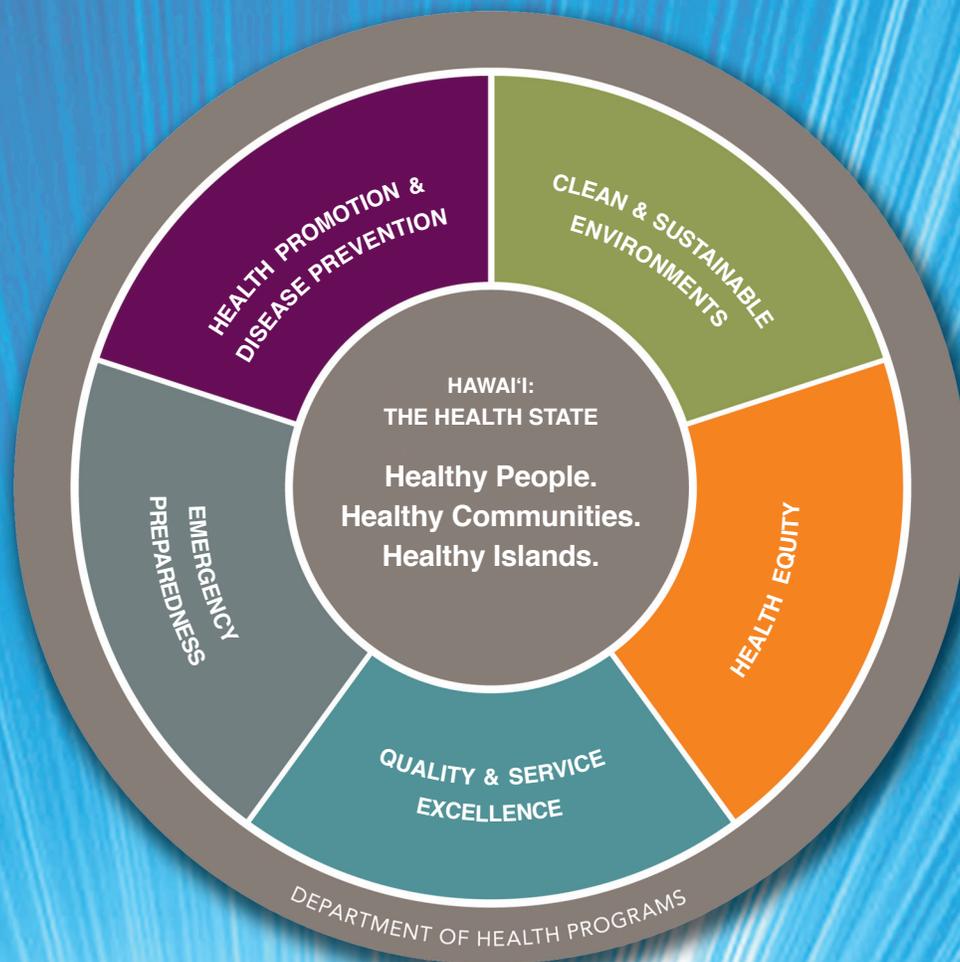
Organizational commitment is a persons psychological attachment to the organization.



Top 5 Ranked State Strategic Maps

1. Hawai'i Department of Health
2. Vermont Department of Health
3. Massachusetts Department of Public Health
4. Connecticut Department of Public Health
5. Utah Department of Health

The Hawai'i Department of Health Strategic Plan, FY 2011–2014



“ Foundations for Healthy Generations ”



Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health

Neil Abercrombie
Governor

Hawai'i The Health State

Governor Abercrombie's New Day Agenda

**Sustainable
Economy**

**Investing in
People**

**Transforming
Government**

Clean & Sustainable
Environments

Health Equity

Quality & Service
Excellence

Health Promotion &
Disease Prevention

Emergency
Preparedness

"The Five Foundations for Healthy Generations"

Eliminate disparities and improve the health of all groups throughout the State of Hawai'i.

Create social and physical environments that promote and support good health for all.

Develop internal systems to assure timely consumer responsiveness and satisfaction.

Attain lifelong quality health free from preventable disease, disability injury, and premature death.

Mitigate, respond to, and recover from natural external or man made threats impacting individual and community well-being.

Towards National Public Health Accreditation

A Proposal to Improve Public Health

Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health

Hawai'i and the nation have seen health care costs increase dramatically over time. The United States spends more on healthcare than any other country, mostly to treat preventable and non-communicable chronic diseases such as cardio-vascular disease, hypertension, diabetes, and obesity. Despite this enormous expenditure, we continue to see unprecedented rates of chronic diseases in children and adults. For the first time in over 200 years today's children may expect a shorter life span than their parents.

Geographic, economic, and educational barriers and other social inequities exacerbate poor health outcomes. Current societal norms and practices encourage lifestyle and behavioral choices the result in such preventable conditions as cardio-vascular disease, hypertension, diabetes, and obesity.

Financial, housing, and interpersonal stress often influence unhealthy habits like smoking, alcohol and substance abuse, and passive forms of entertainment. Our environment, both natural and built, affects our choices for physical activity and impacts diseases such as asthma and cancer. Unless significant societal changes are made chronic diseases will become an unsustainable burden for future generations.

Therefore, the Department of Health proposes the Foundations for Healthy Generations Initiative, a coordinated effort to address social determinants of health, or the conditions in which people are born, grow, live, work, and age. We will drive the public health system to achieve fundamental, cost-effective, and sustainable improvements in health status that will improve outcomes and reduce long term cost. We will empower personal responsibility and promote informed choices on the part of health care consumers.

Foundations for Healthy Generations harnesses the Department's expertise in behavioral health, environmental health, and public health to advance proven and promising practices such as promotion of healthy life choices, family and care-giver support, strengthening the safety net, and assisting individual and family decision-making. These are tools that allow families not only to prevent disease, but promote resiliency and survival in times of personal or social uncertainty.

The Initiative reaches beyond the Department of Health to harness the expertise of other State agencies and the private sector to influence key drivers of social determinants of health such as tax policy, built and natural environments, economic development, education and human services, housing and transportation, and natural resources. Health must be an integral part of all Hawai'i state policies.

Foundations for Healthy Generations assures that our island home promotes lifelong health and wellness in a sustainable and clean environment today and for future generations.

Foundations for Healthy Generations protects the people and environment of Hawai'i from unforeseen threats to health whether natural, biological, or manmade through a focus on emergency preparedness, response, and recovery.

Foundations for Healthy Generations connects with people across the lifespan, starting with preconception and perinatal health, through childhood and adolescence, and on to adulthood and the senior years with approaches appropriate to the unique and rich diversity of populations in Hawai'i.

Lastly, Foundations for Healthy Generations emphasizes administrative and service excellence to maximize tax payer return on investment, customer satisfaction, and public health impact.



*From left to right:
Keith Yamamoto, Deputy Director, Administration
David Sakamoto, Deputy Director, Health Resources
Loretta Fuddy, Director of Health
Gary Gill, Deputy Director, Environmental Health
Lynn Fallin, Deputy Director, Behavioral Health*

The Five Foundations for Healthy Generations

In keeping with the mission of the Department of Health to preserve and protect the health and environment of the people of Hawai'i the **Foundations for Healthy Generations** will:

- Establish *health improvement priorities* for the State of Hawai'i
- Establish *policies and best practices* for engagement of various segments of our state
- Provide *measurable goals and objectives* as a guidepost for action
- Establish evaluation and data needs to *identify risk and measure success*

FOUNDATION 1: HEALTH EQUITY

Goal: Eliminate disparities and improve the health of all groups throughout Hawai'i

Objective 1-1: Improve access, affordability, and quality of care

- Expand telehealth services statewide
- Ensure integration of behavioral health with primary care
- Develop and strengthen partnerships to improve access for uninsured and underinsured individuals, rural communities, and others with limited access to health resources

Objective 1-2: Increase culturally- and community-oriented interventions

- Integrate community and family engagement in program development
- Establish the Office of Health Equity
- Improve health literacy for all demographic groups

Objective 1-3: Collaborate on longitudinal, unified, and interactive data systems to document health status and risk factors

- Improve data collection systems to increase the accuracy and consistency of data on race, ethnicity, and other determinants of health
- Increase dissemination of information from publicly available surveillance systems which track cultural, linguistic, environmental, and socioeconomic factors related to poor health outcomes
- Expand the health outcomes dashboard

Objective 1-4: Reduce stigma associated with health conditions

- Increase public awareness and interest in mental health issues
- Expand the person-centered care model
- Expand prevention and treatment programs focused on high-risk populations



FOUNDATION 2: HEALTH PROMOTION & DISEASE PREVENTION

Goal: Attain lifelong quality health free from preventable disease, avoidable disability, and premature death

Objective 2-1: Improve quality of life and healthy development across all stages of life

- Support the healthy development of children and adolescents
- Support geriatric and long-term health care needs
- Increase access to preventive services throughout the life cycle, including mental health

Objective 2-2: Increase promotion of healthy choices and behaviors

- Promote key messages throughout programs and policies
- Promote good nutrition and physical health
- Promote positive social and emotional health

Objective 2-3: Increase adoption of evidence-based interventions to improve health

- Collaborate with stakeholders to address root causes of premature disease and death
- Influence system-wide changes in partnership with other agencies to address health-related issues of housing, education, safe communities, and health-promoting environments
- Implement meaningful use of client and community health data

FOUNDATION 3: EMERGENCY RESPONSE & PREPAREDNESS

Goal: Mitigate, respond to, and recover from natural external or man made threats impacting individual and community well-being

Objective 3-1: Increase the State's readiness to mitigate external threats

- Increase DOH staff and partner agencies' knowledge of mitigating health and environmental threats
- Develop data sharing systems to report timely, accurate, clear, and useful information to monitor threats and make decisions
- Ensure residents and visitors are prepared for infectious, environmental, and terroristic threats

Objective 3-2: Increase the State's readiness to respond to external threats

- Increase DOH staff capacity to respond to health and environmental emergencies
- Expand collaboration with other response agencies
- Maintain necessary response supplies

Objective 3-3: Increase the State's capacity to recover from external threats

- Expand partnerships with other recovery agencies
- Ensure adequate funding and staff support to maintain oil and chemical emergency response and clean up

FOUNDATION 4: CLEAN & SUSTAINABLE ENVIRONMENTS

Goal: Create social and physical environments that promote and support good health for all

Objective 4-1: Improve environmental protection

- Enforce state and national standards for clean air, land, coastal and inland water, drinking water, and wastewater systems
- Collaborate with stakeholders to protect the environment
- Support DOH staff capacity to protect the environment

Objective 4-2: Improve consumer health

- Strengthen environmental health protection policies
- Protect the public from harmful substances

Objective 4-3: Improve industry's ability to protect the environment

- Increase industry knowledge of environmental protection regulations and practices through educating businesses
- Continue to enforce environmental regulations



FOUNDATION 5: QUALITY & SERVICE EXCELLENCE

Goal: Develop internal systems to assure timely consumer responsiveness and satisfaction

Objective 5-1: Increase the implementation of management science best practices

- Improve business processes and outcomes
- Increase transparency
- Cultivate an organizational learning philosophy
- Follow national recommendations and best practices
- Improve policy change control and compliance

Objective 5-2: Improve coordination of funding and prioritization across programs

- Maximize federal and private grant funding
- Maximize Medicaid and private revenues
- Maximize state funding

Objective 5-3: Improve customer satisfaction with DOH programs and services

- Increase coordination of multiple program service delivery
- Ensure the quality of foreign language interpretation and translation services for DOH programs
- Expand user-friendly web-based applications

Objective 5-4: Ensure timely, accurate, useful, and clear public health information and risk communication

- Expand integration of health information systems
- Ensure proper data and information for decision making
- Leverage social media to engage community discussion and promote health messaging

For more information on DOH programs, work plan details, and strategic plan updates, please visit:

<http://hawaii.gov/doh/strategicplan>

OUR MISSION

The mission of the Department of Health is to protect and improve the health and environment for all people in Hawai'i.

OUR VISION

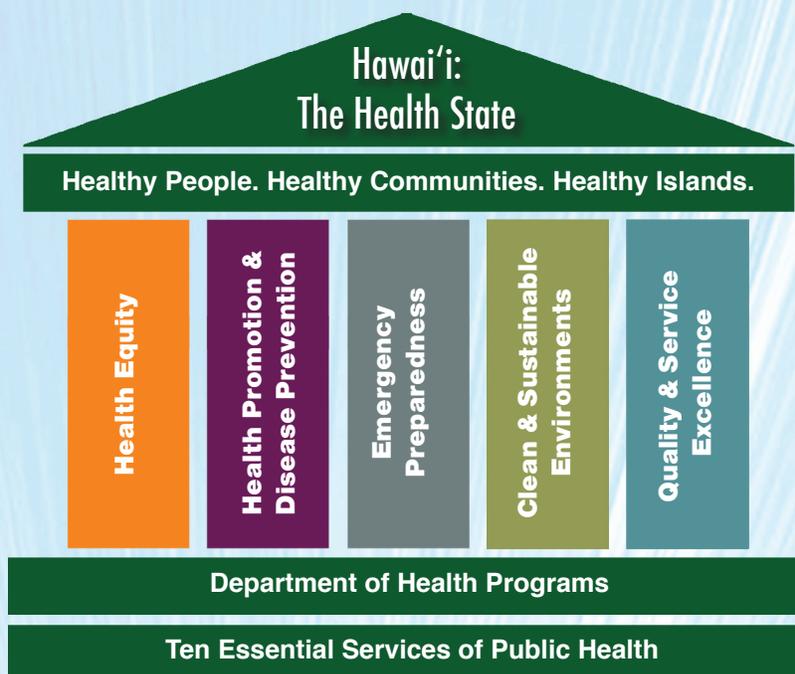
Healthy People. Healthy Communities. Healthy Islands.

WE VALUE:

- Diversity in our communities, stakeholders, and employees
- Excellence and quality improvement to maintain public trust and confidence
- Timely response to the unique needs of individuals, families, and communities
- Science-based decision-making and evidence-based practices
- Collaboration with strategic partners to improve public health
- Professionalism and dedication of our public health workforce

OUR STRATEGIC INTENTS:

- Be passionate champions for public health
- Shape Hawai'i's health and environmental agenda
- Do the greatest good for the greatest number of people
- Promote environmental and social justice
- Advocate for the needs of the under-represented and vulnerable populations
- Improve the business practices of state government to assure quality and sustainability
- Achieve national accreditation





We focus on improving internal systems and processes in the Vermont Department of Health's Strategic Plan. By successfully implementing the Plan's objectives, we will better support efforts to improve the health status of Vermonters, as outlined in Healthy Vermonters 2020 and the State Health Improvement Plan.

Many dedicated public health professionals from across the department provided input for the development of the Strategic Plan. Their assessment of strengths and improvement opportunities (Appendix A), coupled with lessons learned during our department's preparations for becoming an accredited public health department, led to the strategic directions and objectives reflected in this Plan.

To facilitate successful implementation, processes described in the department's Quality Improvement Plan will be used. These include development of annual work plans, monitoring of progress made through use of a Strategic Plan Scorecard, and oversight of progress made by the department's Performance Management Committee.

Annual progress reports will document results.



July 2014

Strategic Plan Summary

Mission

To protect and promote the best health for all Vermonters.

Vision

Healthy Vermonters living in healthy communities.

Goals



Our values

Performance-based	We learn from our previous efforts and use performance measures and data to focus future activities
Equitable	We promote practices that minimize health disparities
Accountable	We are responsive and transparent in our actions and our communication
Professional	We encourage staff to pursue professional growth
Collaborative	We partner with others to work on shared goals
Innovative	We encourage creativity while staying aligned with the evidence base

Goal 1: Effective and integrated public health programs

Strategic Direction 1: Engage public health partners in efforts to improve State Health Improvement Plan (SHIP) priority outcomes.

- 1.1.1 Beginning in 2014, health improvement activities of public health partners will be incorporated into the annual SHIP progress report.
- 1.1.2 By 2015, an overview of SHIP priorities will be incorporated into all public presentations aimed at informing others about the Health Department.
- 1.1.3 By 2017, at least two evidenced-based strategies that will impact multiple SHIP priorities will be implemented statewide.

Strategic Direction 2: Integrate academic partners, clinical care and public health to enhance population prevention efforts.

- 1.2.1 By 2016, the role of public health in relation to health reform, including regional Accountable Care Organizations, patient centered medical homes, and Accountable Care Communities will be defined.
- 1.2.2 By 2017, a formal affiliation agreement with at least one institution of higher learning will be executed.

Strategic Direction 3: Expand use of performance management framework.

- 1.3.1 Beginning in 2015, the department will complete at least 10 Agency Improvement Model (AIM) projects annually.
- 1.3.2 By 2015, 95% of the department's Healthy Vermonters 2020 scorecards will include program performance measures, current data and stories behind the curve.
- 1.3.3 By 2016, 95% of the department's Healthy Vermonters 2020 scorecards will include the most recent population indicator data, stories behind the curve and documentation of at least three department recommended evidence-based strategies.

Goal 2: Communities with the capacity to respond to public health needs

Strategic Direction 1: Increase capacity of communities to support disease prevention and health promotion.

- 2.1.1 Beginning in 2014, district offices will be regular participants on at least 85% of hospital led Community Health Needs Assessment and Community Health Improvement Plan stakeholder groups.
- 2.1.2 By 2016, at least one community agency per district will participate annually in department trainings aimed at improving SHIP priority outcomes.
- 2.1.3 By 2017, department programs will make mini-grant funds available to district offices to support prevention team implementation of SHIP priorities.
- 2.1.4 By 2017, all division strategic plans will include at least one objective about communication between central office and district offices.

Strategic Direction 2: Empower stakeholders to contribute to the public health agenda.

- 2.2.1 By 2016, the Strategic Prevention Framework will be utilized across divisions as a model for community engagement.
- 2.2.2 Upon completion of the department's website redesign, an electronic mechanism for consumers to submit feedback to the department will be easily accessible.
- 2.2.3 Beginning in 2015, programs providing direct service will conduct customer satisfaction surveys at least every three years.
- 2.2.4 Beginning in 2016, the department will conduct an assessment every five years to gather input from public health partners to learn about strengths, improvement opportunities and priorities for the department.
- 2.2.5 By 2017, the department will utilize this public health partner input to guide decisions regarding funding policies related to community infrastructure for implementing disease prevention and health promotion initiatives.

Goal 3: Internal systems that provide consistent and responsive support

Strategic Direction 1: Develop and share resources to encourage consistent documentation and adherence to internal processes.

- 3.1.1 By 2016, a health department records management plan will be finalized.
- 3.1.2 By 2017, 90% of each division's core protocols, guidelines and procedures will be current.

Strategic Direction 2: Streamline the process to collect, manage, analyze, present and share data.

- 3.2.1 By 2016, a plan that describes processes for collection, management, analysis, presentation and sharing of data will be finalized.

- 3.2.2 By 2018, 90% of data reports and briefs will demonstrate adherence to the written plan.
- 3.2.3 By 2016, a department-wide data request tracking procedure will be implemented.
- 3.2.4 By 2017, a web-based system to evaluate public health efforts of funded communities will be implemented.
- 3.2.5 By 2016, a list of department data sets that could be posted on the department's website for analysis by outside entities will be identified.
- 3.2.6 By 2018, at least 50% of identified department data sets will be publicly available on the department's website.

Strategic Direction 3: Develop coordinated, sustainable evaluation capacity across the department.

- 3.3.1 By 2016, a department-wide program evaluation plan will be finalized.
- 3.3.2 By 2016, all department grant applications will include an evaluation plan, with 10% of grant funds committed to evaluation.
- 3.3.3 By 2017, applicable Healthy Vermonters 2020 priorities will be included in programmatic evaluation plans.

Strategic Direction 4: Facilitate cross-division sharing of effective internal processes.

- 3.4.1 By 2016, the process for requesting information technology services will be documented.
- 3.4.2 By 2017, 90% of prioritized key business practices will be documented.

Strategic Direction 5: Financial systems will inform program decisions, support organizational change, and maintain excellence in internal controls and operations.

- 3.5.1 In 2015, electronic payment options to department customers will begin to be offered.
- 3.5.2 Use of performance budgeting in the department's annual budget request will be expanded.
- 3.5.3 By 2016, improved quarterly financial reports with timely, accurate and useful information to support program decision-making will be provided to division directors.

Goal 4: A competent and valued workforce that is supported in promoting and protecting the public's health

Strategic Direction 1: Assess staff competency across the department.

- 4.1.1 By 2015, revised public health core competencies will be identified and adopted department-wide.
- 4.1.2 Beginning in 2015, and then every three years following, a self-assessment will be performed to analyze strengths and measure gaps in competencies of employees both at the division level and across all divisions of the department.

Strategic Direction 2: Expand the variety of workforce development opportunities for staff, including online education, internal and external trainings.

- 4.2.1 Beginning in 2014, formal training opportunities for staff will be developed utilizing expertise of department staff.
- 4.2.2 By 2016, all divisions will implement use of individual development plans.
- 4.2.3 By 2016, implement mentorship opportunities and ongoing discussion groups on various public health competencies.

Strategic Direction 3: Implement an ongoing communication plan for workforce development opportunities.

- 4.3.1 Beginning in 2014, the AHS Training Registration Management System (TRMS) will be consistently used by all divisions to enter and track training opportunities.
- 4.3.2 By 2015, all trainings entered into TRMS will be linked to core competencies.
- 4.3.3 By 2015, a master training calendar will be created.

Goal 5: A public health system that is understood and valued by Vermonters

Strategic Direction 1: Define the Health Department's brand – how our work is identified and viewed by Vermonters, and the qualities we are associated with.

- 5.1.1 By 2015, guidance for community partners on appropriate use of the Health Department's brand will be documented.
- 5.1.2 By 2016, the Health Department's brand will be updated, based on research with division staff and stakeholders.

Strategic Direction 2: Expand capacity of staff to effectively communicate public health messages with various populations.

- 5.2.1 By 2016, tools and resources to help staff communicate effectively will be developed.
- 5.2.2 By 2016, communication training opportunities will be developed and made available to Health Department staff.

Strategic Direction 3: Support development of effective communication and marketing strategies.

- 5.3.1 Beginning in 2014, the number of personal stories and testimonials shared to communicate public health efforts will increase annually.
- 5.3.2 Beginning in 2015, all programs developing communication and marketing strategies will do so based on national or local research.

Goal 6: Health equity for all Vermonters

Strategic Direction 1: Reduce health disparities in communities that experience a disproportionate burden of disease.

- 6.1.1 By 2015, 90% of new grant applications and renewals presented at the department's Grant Review Committee will include a plan to address health disparities, when applicable.
- 6.1.2 By 2016, a plan that includes strategies and guidance to reduce barriers to health equity will be finalized.
- 6.1.3 By 2017, 75% of reports and briefs published by the department will incorporate analysis of data to evaluate the impact of programming on health disparities.

Strategic Direction 2: Recruit and retain qualified candidates from diverse backgrounds.

- 6.2.1 By 2015, hiring practices that are designed to recruit and retain qualified candidates from diverse backgrounds will be integrated into department processes.
- 6.2.2 By 2016, all department staff will complete on-line cultural competency training within 60 days of hire.

Strategic Direction 3: Translate documents for people with limited English proficiency.

- 6.3.1 By 2015, the department's website will contain information on how to access translated materials and interpreter services.
 - 6.3.2 By 2017, 90% of the materials needing translation, as identified by the department's translation committee, will be translated.
-

Appendix A

Department strengths and opportunities for improvement

In preparation for development of our strategic plan, staff from across the department participated in an assessment of strengths, weaknesses, opportunities and threats (SWOT analysis). The themes that emerged through this process are reflected in the strategic directions and objectives listed on the previous pages of this plan.

The following is a summary of identified themes:

Strengths

- Staff is dedicated, motivated and knowledgeable.
- Our department is a leader in the use of evidence base and data.
- District Office staff provide strong linkages to communities.
- Our department earned national public health accreditation status in 2014.

Opportunities for improvement

- Develop stronger linkages with academic settings and wellness components of health reform.
- Increase internal efficiencies through documentation of processes and protocols.
- Utilize revised public health core competencies to support professional development of staff.
- Improve understanding of public health by Vermonters through use of evidence-based communication practices.



Massachusetts Department of Public Health Strategic Plan 2014-2016



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<http://www.mass.gov/eohhs/gov/departments/dph/>

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Purpose of the Plan

This 2014-2016 Strategic Plan provides direction for prioritizing, aligning and maximizing the impact of programs and services provided by the Massachusetts Department of Public Health (MA DPH). This strategic plan incorporates the findings and recommendations of the State Health Assessment (SHA) and State Health Improvement Plan (SHIP) as mandated by the Public Health Accreditation Board (PHAB), and builds on the success of the 2012-2014 Strategic Plan whose goals were to:

1. Support the success of health care reform by ensuring that public health is involved in promoting wellness and access to high quality care while reducing increases in health care costs.
2. Reduce health disparities by promoting health equity.
3. Promote wellness and reduce chronic disease.
4. Strengthen local and state public health systems to prevent disease and promote health.
5. Reduce youth violence.

This strategic plan is intended to be a living document that will be integrated with the Department's Performance Management and Quality Improvement processes, support and promote cross-bureau collaboration and synergy, and result in more effective and efficient public health systems and processes to improve health across the Commonwealth.

Vision, Mission and Values

The Vision of the Massachusetts Department of Public Health is:
Optimal Health and Well-Being for all people in Massachusetts, supported by a strong Public Health Infrastructure and Healthcare Delivery.

The Mission of the Massachusetts Department of Public Health is to:
Prevent illness, injury, and premature death;
Assure access to high quality public health and health care services;
Promote wellness and health equity for all people in the Commonwealth.

The Values/Guiding Principles of the Massachusetts Department of Public Health are:

1. Health is not merely the absence of disease or infirmity.
2. Health equity and multi-sector partnerships are prerequisites for achieving the objectives of health care reform and securing and sustaining population health.
3. Massachusetts is uniquely positioned to demonstrate the practicality and value of an integrated public health and health care system.
4. "Upstream solutions" (e.g., systems analysis and environmental changes at the community and regional levels) are required to achieve Health Reform objectives.
5. Continuous Quality Improvement is a path to public health performance excellence.
6. Evidence-based practices and promising innovations that provide the best opportunities for cost effective results should be integrated into Continuous Quality Improvement (CQI) activities.

Strengths and Opportunities

Our Strategic Plan capitalizes on the expertise of DPH staff, very strong partnerships, and our dedicated commitment to health equity and ensuring data-informed decision-making. An analysis of strengths and weaknesses and external opportunities and threats (SWOT) was conducted using a combination of key informant interviews and focus groups.

“Having the ability to integrate clinical, epidemiologic, and laboratory data of public health importance from multiple sources and rapidly share these data across state and local public health agents has greatly accelerated our response to priority infections and enabled us to rapidly evaluate our performance.”

*Alfred DeMaria, MD, State Epidemiologist
MA Department of Public Health*

Expert and Committed Leaders with New Strategic Focus: collaborative and knowledgeable professionals devoted to protecting and improving the health of the public and **eliminating health disparities**, including behavioral health. This expertise and responsiveness must continue to create public health innovations, a new focus on **data-informed performance management and quality improvement**, and **alignment of DPH initiatives** focused on achieving the DPH mission.



DPH has outstanding academic partners including Harvard, Tufts, Boston University, Boston College, UMass and Brandeis – which keep them on the cutting edge.”

*Charles Deutsch, Sc.D.
Harvard Catalyst, Harvard Medical School*

“DPH has important partnerships with many Community-based organizations and other government agencies such as the Center for Health Care Information and Analysis, the Department of Elementary and Secondary education, Public Safety and Housing and Community Development.”

*Jay Youmans,
Director of Government Affairs
MA Department of Public Health*

External partnerships and support at the local, state, and national levels enable us to successfully address public health threats that, in isolation, we could not. DPH must continue to **serve as a convener of diverse partners, conduct surveillance and evaluation, and provide expertise in evidence-based practices in prevention and intervention**. The Governor, Secretary of the Executive Office of Health and Human Services, the Massachusetts legislature, and advocates across the Commonwealth support our vital work.

Health Equity Focus: Although Massachusetts is one of the healthiest states in the nation, disparities persist. This is particularly true for certain populations. DPH is primed to **improve health equity by building on its significant achievements in improving overall health care access and quality, addressing the social determinants of health through the State Health Improvement Plan.**

“DPH leaders are forward-thinking, caring, thoughtful, innovative people.”

*Rebekah Gewirtz, CEO
MA Public Health Association*

“Around the country, MA DPH is recognized as an “incubator” of population health management strategies to support Health Reform. The Prevention and Wellness Trust Fund with its e-referral system is a groundbreaking mechanism to achieve THE TRIPLE AIM: Better health, better health care, and lower costs.”

*Madeleine Biondolillo, MD
Associate Commissioner
MA Department of Public Health*

Population Health Management and Prevention Expertise Informs Program Development and Regulation:

Is demonstrated by **evidence-based public health practices** as well as **leadership and innovation in public health** efforts including **thoughtful application of regulatory oversight**. DPH leads Initiatives such as **Prescription Monitoring to reduce opiate abuse, Prevention Wellness Trust Fund for population health management, Health Planning** to ensure appropriate utilization of costly health resources, and ongoing analysis and development of guidance and regulations related to Behavioral Health Integration, Long Term Care for the elderly and disabled, and other services for underserved populations.



Challenges

DPH executes a broad scope of work and must be prepared to shift focus and resources to address natural disasters or infectious disease outbreaks. Our population is increasingly diverse, challenging us to engage the right partners, develop effective outreach and data collection strategies, and ensure the delivery of culturally competent interventions. Our most pressing infrastructure challenges involve:

Our ability to collect, analyze, and use data requires adaptations to support Health Reform including better use of current statistical techniques and surveillance resources which allow us to track health behaviors, risk factors, and health conditions. Outdated Information Technology no longer meets our needs for collecting, analyzing and sharing data which are critical to timely decision-making. In order to guide programs in setting performance targets for quality improvement, DPH must streamline the Institutional Review Board approval process and promote the use of data through the DPH Data Warehouse.

The state's public health laboratories are no longer adequate for meeting the demand for advanced technology now used to prevent infection in Massachusetts. Insufficient space and a physical plant in need of renovations, outdated Information Technology, and staffing issues (over 40% facing retirement within five years) are causing challenges in meeting our mission related to foodborne infections, communicable diseases, and bioterrorism.

“Massachusetts is uniquely positioned with highly qualified staff, top accredited labs, and a rich culture of health policy to continue to provide public health protection. However, significant threats face the Lab’s future: a transitioning staff, and aging space built for a very different time that does not meet critical needs for public health and safety.”

*Michael A. Pentella, PhD, D(ABMM)
Director, Bureau of Laboratory Sciences
MA Department of Public Health*

“One of the most important things DPH must do is enhance its ability to serve as a central repository for data and translate data for external stakeholders to set goals and track improvements.”

*David Seltz Executive Director
Health Policy Commission*

“By optimizing the use of data and ensuring the skills of staff are updated to current public health requirements, DPH can deliver timely and meaningful reports to the public and the legislature.”

*Thomas Land,
Director Office of Data Management
and Outcomes Assessment
MA Department of Public Health*



“Most people who are not in government have no idea public health exists unless there is a crisis. The Public does not get health messages on a regular basis. Very few citizens know the depth and breadth of their portfolio.”

*Ann Hartstein, Secretary
MA Department of Elder Affairs*

“I think they are doing a lot of fantastic work that people don't know about.”

*Marcia Fowler,
Commissioner
MA Department of Mental Health*

Our ability to communicate effectively within and outside of DPH requires modernization of our methods. Externally, the public, by and large, is unaware of what we do and how we protect their health and safety. One way to address this gap is to deliver timely reports on critical public health issues. Historically, DPH was a leader in health communications such as those that led to significant reductions in tobacco use. Currently, we will need to effectively use resources such as social media to deliver our messages. Internally, efforts must be made to breakdown silos within DPH. Effective communications between program planners and evaluators is crucial for performance management. This will allow staff to understand the breadth of work conducted within the Department and the opportunities for collaboration and maximizing resources to uphold our mission.

The public health workforce has been cut significantly in the past several years, particularly at the local level. Roughly 25% of the public health workforce may retire in the next 5-10 years and there are too few opportunities to train and mentor public health leaders. Our ability to ensure an adequate and skilled workforce to ensure public health is a major challenge. Local health infrastructure varies across the Commonwealth's 351 communities, with many struggling to meet their public health responsibilities. The losses in local public health capacity threaten our ability to enforce regulations and necessitate actions to maximize resources at the local level.

“With the significant cuts sustained by local public health, we should revisit the idea of regionalization. Having 351 communities trying to staff their public health functions isn't feasible.”

*Michael Wong, MD
Public Health Council
MA Department of
Public Health*

“State and local public health are essential partners in the protection of the health of the Commonwealth's residents. The erosion of local health capacity, largely due to fiscal pressures, threatens the seamlessness of our public health response, and requires ongoing attention as a public policy concern.”

*Kevin Cranston,
Director, Bureau of Infectious Disease
MA Department of Public Health*



Framework for Strategic Planning

Capitalizing on an organization’s strengths, seeing the opportunities available to it, and meeting the challenges ahead of it require a framework within which to plan. The Massachusetts State Health Improvement Plan (SHIP) set forth goals in 8 Domains. This strategic plan has organized the 8 SHIP Domains into 3 areas of focus: Healthy Living, Healthy Environments, and Public Health Systems.

State Health Improvement Plan DOMAINS							
Active Living, Healthy Eating, Tobacco Free Living	Chronic Disease Prevention and Control	Substance Abuse Prevention, Intervention, Treatment, and Recovery	Infectious Disease Prevention and Control	Environmental Risk Factors and Health	Injury, Suicide, and Violence Prevention	Maternal, Child and Family Health Promotion	Health Systems Infrastructure



DPH STRATEGIC PLAN - DOMAINS		
HEALTHY LIVING	HEALTHY ENVIRONMENTS	PUBLIC HEALTH SYSTEMS
Active Living, Healthy Eating, Tobacco Free Living Chronic Disease Prevention and Control Substance Abuse Prevention, Intervention, Treatment, and Recovery Infectious Disease Prevention and Control	Environmental Risk Factors and Health Injury, Suicide, and Violence Prevention Maternal, Child and Family Health Promotion Infectious Disease Prevention and Control	Health Systems Infrastructure

DPH STRATEGIC PLAN - STANDARDS and MEASURES		
<p>Improve prevention and management of chronic disease.</p> <ul style="list-style-type: none"> Hypertension Asthma Obesity <p>Reduce morbidity related to vaccine preventable infections.</p> <ul style="list-style-type: none"> Immunization <p>Prevent development of alcohol and substance use disorders.</p> <ul style="list-style-type: none"> Youth alcohol use Screening and intervention for substance use Prescription Monitoring <p>Reduce gender based and youth violence.</p> <ul style="list-style-type: none"> Sexual and domestic violence 	<p>Reduce morbidity related to foodborne infections.</p> <ul style="list-style-type: none"> Local health inspections Salmonella and other infections <p>Reduce Unintentional Injury.</p> <ul style="list-style-type: none"> Opioid deaths Falls Youth Violence Leadpoisoning <p>Improve maternal health and infant outcomes.</p> <ul style="list-style-type: none"> Low birth weight Breastfeeding Dental screening <p>Increased capacity to address environmental health issues.</p> <ul style="list-style-type: none"> Poor housing conditions Climate change/adaptation Environmental tracking 	<p>Assure health equity and health reform goal through robust systems and resources for monitoring, protecting, and promoting the health and well-being of the entire population.</p> <ul style="list-style-type: none"> Public Health Data Warehouse development State Laboratory infrastructure Emergency Preparedness and Response Internal and external communications Public health workforce development Performance Management and Quality Improvement Regulatory enforcement capacity IRB Process Improvement

Standards and Measures

The Strategic Planning Framework was used in a half-day prioritizing and planning session that resulted in the identification of standards, measures and strategies to be included in the annual work plan/action plan. The Selection Criteria used for identifying standards, measures and strategies included:

- Aligns with DPH mission
- Promotes cross-bureau collaboration
- Provides DPH with a leadership role; Informs the new administration
- Provides opportunity to maximize/leverage resources

The following is a summary of the three Strategic Plan domains and their associated standards and measures.

An icon  has been used to highlight critical health equity areas. The numbering used in the strategic plan mirrors the corresponding numbering for standards and measures from the Massachusetts State Health Improvement Plan (SHIP).

Healthy Living

The CDC has designated a reduction in obesity and improvements in nutrition and physical activity as “Winnable Battles” in efforts to improve the health of Americans and reduce the prevalence and severity of chronic diseases. In addition to these winnable battles, it is important to reinforce healthy choices and early interventions when it comes to chronic disease management, inadequate vaccine coverage, youth violence and substance use and abuse.



Standard 1C: Support all MA residents in leading tobacco-free lives.

Measure 1.6: Reduce the relative percentage of adults who report exposure to second hand smoke of more than one hour per week by 10%.

- 1.6.5 Increase the number of public and private smoke-free multi-unit housing properties.

Standard 2B: Improve prevention, management and control of chronic disease and associated risk factors.

Measure 2.3: Increase the percentage of adults with hypertension who have their hypertension under control by 2.5%.



- 2.3.8 Promote policies and best practices to strengthen linkages among clinical settings and community programs and resources to help reduce hypertension (e.g., e-referrals and community health workers).
- 2.3.13 Ensure utilization of bi-directional e-Referral in Preventive and Wellness Trust Fund (PWTF) communities.

Measure 2.5: Reduce the at-risk rate of pediatric asthma hospitalizations by 1.5% and the disparity among Black Non-Hispanics by an additional 1%.

- 2.5.5 Implement evidence-based, comprehensive, culturally adaptable programs that include patient self-management, environmental assessment, and remediation (home, school, and workplace).

Measure 2.6: Decrease relative percentage of obesity among Massachusetts adults and youth by 5%.

- 2.6.5 Work with communities, businesses, and local/state agencies to expand active living options (e.g., school site planning, improved transit, bike lanes, bike paths, pedestrian paths, and sidewalks).
- 2.6.8 Work with stakeholders to fully implement local Complete Streets Policies

Standard 3A: Reduce morbidity related to vaccine preventable infections.

Measure 3.1: Reduce the incidence of selected vaccine preventable diseases/increase immunization rates for selected vaccine preventable diseases.



- 3.1.1 Use new and existing data systems to measure vaccine coverage among populations to examine disparities and target vaccine strategies; ensure access for local health departments.
- 3.1.2 Provide public education on the safety and benefits of vaccines.
- 3.1.6 Increase roll-out and routine use of the Massachusetts Immunization Information System (MIIS) to over 1,000 health care provider sites and inclusion of over 3,000,000 patient records.
- 3.1.7 Promote compliance with CDC guidelines for influenza prevention programs in healthcare facilities, which include vaccination.



Standard 4A: Prevent the development of alcohol and substance use disorders.

Measure 4.1: Reduce the relative percentage of youth who report having tried alcohol for the first time before age 13 by 5%.

- 4.1.3 Increase social media and traditional media outreach through statewide public awareness and- parent-oriented campaigns that are built on evidence-based prevention that are culturally and linguistically adapted.
- 4.1.6 Ensure that DPH/BSAS funded substance abuse prevention coalitions include community partners representing populations disproportionately impacted by substance abuse to prevent/reduce underage drinking.

Measure 4.2: Increase the annual number of healthcare providers trained by DPH/BSAS to incorporate screening and intervention for unhealthy substance use by 5%.

- 4.2.1 Consult with and coach practices to incorporate Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocols into health care setting and practices, including primary care, hospitals, and school-based health practices in all middle and high schools.

Standard 5D: Reduce gender based and youth violence.

Measure 5.8: Reduce fatal violence among youth age 15-24 with particular focus on disparate populations.



- 5.8.4 Support positive youth development programming in schools and the community to reduce violence and promote healthy relationships for middle and high school-aged youth.

Healthy Environments

Preventing key environmental factors that contribute to poor health can have a significant impact on improving overall health outcomes in the Commonwealth.

Systems Strategy 1.6: Cross-Cutting for Healthy Environments - Publicize access to culturally and linguistically appropriate services as they become available through phased implementation of system development.

Standard 3G: Reduce morbidity related to foodborne infections.

Measure 3.7: Limit the yearly increase in reported campylobacter cases to less than 1% and maintain reported cases of salmonella at fewer than 1,200 per year.

- 3.7.1: Maintain the activities of the Working Group on Foodborne Illness Control which includes epidemiologists, laboratorians and environmental specialists.
- 3.7.2: Increase public awareness of foodborne illness infection by providing current information on the MDPH website on all foodborne illnesses.
- 3.7.3: Update and distribute educational materials regarding hand washing and the appropriate handling of high risk foods.

Measure 7.5: Reduce the number of foodborne illness outbreaks by increasing the number of mandatory local health inspections to retail food establishments.

- 7.5.3: Work with local health officials and industry to ensure appropriate training of food service employees.
- 7.5.17: Work with local health officials statewide to enhance training opportunities for food inspectors.
- NEW: Advocate for increase in absolute number of food inspectors.

Standard 5A: Reduce Unintentional Injury

Measure 5.2: Prevent an increase in the rate of unintentional fall deaths among residents ages 65+ years.

- 5.2.5 Promote implementation of evidence-based, multi-faceted, culturally appropriate programs for community-dwelling older adults that integrate falls risk reduction strategies (physical activity; exercise; balance training; medication review and management; vision, hearing and foot care) and home/environment modification.



Measure 5.8: Reduce fatal violence among youth age 15-24 with particular focus on disparate populations.

- 5.8.1 Promote peer education models to develop skills for preventing violence at home, at work and in the community.
- 5.8.6 Promote violence prevention strategies that address disparities based on race, economic status, sexual orientation, gender or gender identity.

- 5.8.8 Amend existing hospital regulations to require universal education and suicidality and violence screening.
- 5.8.10 Partner with EOHHS Safe and Successful Youth Initiative to provide wrap-around services for high impact youth who are at proven risk for firearm or edge/sharp weapon violence.
- 5.8.12 Promote trauma-informed service provision among providers working in the youth violence prevention field in MA.

Measure 7.1: Increase blood level screening rates in high-risk communities (as defined by low socioeconomic status, percent of old housing stock, and other factors) by 10% (relative).

- 7.1.1 Use existing coalitions and collaborations to develop programs to target all children under six years of age. Use blood lead poisoning surveillance data to identify the highest risk populations in urban areas, such as minority populations in larger cities, in schools, and in out-of-school time programs to promote environmental justice.
 - 7.1.2 Reach out to Head Start program and others using CDC guidance on reference values to convey renewed interest in education and screening.
 - 7.1.3 Explore partnerships (e.g., Healthy Homes, Fair Housing, Get the Lead Out) to expand the number of properties inspected and revise the protocols to include integration of lead and asthma.
 - 7.1.6 Work with clinicians or other health care providers to improve screening and education about lead hazards to children, notably in high risk communities.
- Systems Strategy 1.5: Promote the use of mathematical modeling techniques to increase the speed that data is released to stakeholders and the public.
- Systems Strategy 3.6: Coordinate training and technical assistance, including integrated web-based and data services, to support municipalities, community health coalitions, professional provider associations, community health workers, and other partnerships involving the state health department.

Standard 6B: Improve maternal health and infant outcomes.

Measure 6.2: Reduce the relative percentage of infants with low birth weight births by 5% and premature births by 5%.

- 6.2.1 Prepare and disseminate Birth Data Packets and other reports.
- 6.2.2 Participate in national Infant Mortality Collaborative for Improvement and Innovation Network (CollIN) and take a lead in Massachusetts to assess infant mortality and to inform the development of effective infant mortality reduction strategies.

Measure 6.3: Increase the proportion of infants who are breastfed.

- 6.3.1 Establish data sources and baseline data to measure exclusive breastfeeding at discharge and other metrics.
- 6.3.5 Collaborate with Massachusetts Breastfeeding Coalition (MBC) to enhance collaboration with Massachusetts Birth Hospitals to support hospital policies that promote breastfeeding.



Measure 6.4: Increase the proportion of pregnant women who receive teeth cleaning before and during pregnancy by 5%.

6.4.2 Review claims data for evidence of non-utilizers of oral health prevention services.

6.4.3 Provide SEAL programs in schools and meet nurse leaders to promote program regarding dental carries and prevention.

Standard 7D: Increase the capacity of local and state health officials to address environmental health issues through enhanced training.

Measure 7.4: Reduce the number of avoidable complaints of poor housing conditions by increasing the number of local inspectors trained by 10%.

7.4.2 Expand training opportunities to increase the number of local public health officials who can conduct inspections.

7.4.7 Revise housing regulations to provide clear and uniform direction to local housing inspections.



Photo by northshorereviews.com

Measure 7.6: Enhance local and state capacity for climate change/adaptation by increasing the number of local health officials trained by 10% annually.

7.6.1 Promote use of health surveillance data (e.g., through Environmental Public Health Tracking portal) to identify smaller geographic areas within communities especially vulnerable to climate effects.

7.6.9 Provide training of local health officials and other municipal officials on adaptation strategies for their community.

Measure 7.7: Enhance local capacity to respond to environmental health inquiries by use of the Environmental Public Health Tracking (EPHT) network by 10%.

7.6.1 Promote use of health surveillance data (e.g., through Environmental Public Health Tracking portal) to identify smaller geographic areas within communities especially vulnerable to climate effects.

Public Health Systems

In order to provide the necessary information to guide programs in setting performance targets and to assist them as they engage in a quality improvement process, DPH must streamline the internal approval process, ensure that programmatic staff and evaluators work together at all stages of work, upgrade the skills of epidemiologists and evaluators, and promote the use of data through the DPH Data Warehouse. By optimizing the use of data and upgrading the skills of staff, DPH can deliver timely and meaningful reports to the public and the legislature. This will ensure that important decisions about individual and public health can be based on the best possible information.

Systems Standard: Assure health equity and health reform goal attainment through robust systems and resources for monitoring, protecting, and promoting the health and well-being of the entire Massachusetts population.

NEW Measure: By June 30, 2017, provide training programs so that at least 75% of DPH epidemiologists and evaluators will be trained on statistical modeling techniques.

NEW Measure: By June 30 2017, reduce median time until final approval or rejection of IRB/24A applications to 30 days.

Systems Measure 4: Establish six regional health and medical coordinating coalitions that will support and enhance the ability of the Commonwealth to prepare for, respond to, recover from, and mitigate the impact of public health and medical threats, emergencies and disasters, including acts of terrorism.

- S.4.3 Support the development of capabilities-based local, regional, and state all-hazards plans that address potential hazards, vulnerabilities, and risks to public health, medical, and mental/behavioral health services and systems identified through jurisdictional risk assessments.
- S.4.4 Ensure that local, regional, and state plans prioritize and address the rebuilding of public health, medical, and mental/behavioral health services and systems following a disaster to at least a level of functioning comparable to pre-disaster levels, and to improved levels where possible.

Systems Measure 5: Develop a Public Health Workforce Development Plan (e.g., PM/QI including regulatory oversight) to increase public health workforce capacity for Massachusetts, including quantity, quality, and diversity of workforce, by December 2015.

- S.5.1 Develop collaborations among Schools of Public Health, MDPH, health researchers, local health departments, and community based public health and health care organizations to promote public health as an occupation and to provide trainings and other resources that support and



develop public health employees, with an emphasis on the core competencies for public health.

- S.5.4 Strengthen training and workforce development opportunities for local public health employees.

Systems Measure 6: Increase Massachusetts' public health licensing and regulatory enforcement capacity (e.g., Health Planning, Determination of Need (DoN)) by December 2015.

- S.6.1 Assure adequate resources to support state regulatory enforcement operations.
- S.6.2 Document and disseminate policies, procedures, algorithms, and communication protocols for notifying appropriate parties when corrective action is taken against a licensed or certified public health professional.
- S.6.3 Develop and disseminate policies and procedures for identifying reliably when corrective/enforcement action should be taken regarding a certified or licensed health care facility.

NEW Measure: Improve State Laboratory Infrastructure to ensure capacity to effectively coordinate and respond to a public health emergency/crisis.

New Strategy: Build capacity to effectively coordinate and respond to a public health emergency such as Ebola.

Note: Strategies for new measures identified during the strategic planning process are under development.

Annual Action Plan/Work Plan

The detailed action plans/work plans for the Healthy Living and Healthy Environments Domains may be found in [a separate document].

Appendix A: Strategic Planning Process

Identification of Health Needs

In 2010 DPH published, *The Health of Massachusetts*, a comprehensive assessment of the health of the Commonwealth. This report compiled data from over fifty sources to describe the state's health status and areas of health improvement, as well as the factors that contribute to the health challenges. Many of the data sources were updated as part of the development of the State Health Improvement Plan, including key informant interviews with Tribal experts.

Creation of the State Health Improvement Plan (SHIP)

The findings from the health assessment were used to set priorities for health improvement. The *State Health Improvement Plan* aligns the activities of the health department and our partners with our health improvement domains, standards, and measures. The SHIP reflects a commitment of partners and stakeholders to collaborate in addressing shared issues in a systematic and accountable way.

Creation of the Strategic Plan

The Strategic Plan describes how the Department will achieve health improvement standards and measures and implement key strategies identified in the SHIP. Developing the strategic plan included affirming the vision and guiding principles presented in the SHIP; affirming the Department's mission; and gathering data on the Department's current and future capacity. An analysis of strengths and weaknesses and external opportunities and threats (SWOT) was conducted using a combination of key informant interviews and focus groups. The data gathering process included 3 focus groups with Department Senior Leaders, Bureau Directors, and Program Managers, 6 internal interviews with Department leadership, and 7 external interviews with key partners in other state agencies (DMH, DEA, DESE) and public health/health organizations (Health Policy Commission, MA Health Council, MPHA, Public Health Council). Themes from the focus groups and interviews were summarized and used by Department Senior Leadership and Bureau Directors as the basis for identifying strategic priorities for the Strategic Plan in alignment with SHIP priorities and measures.

A framework that was developed to map SHIP Domains to the Priority Domains of this plan was used in a half-day prioritizing and planning session that resulted in the identification of standards, measures and strategies to be included in the annual work plan/action plan. The Selection Criteria used for identifying standards, measures and strategies included:

- Aligns with DPH mission
- Promotes cross-bureau collaboration
- Provides DPH with a leadership role; Informs the new administration
- Provides opportunity to maximize/leverage resources

Appendix B: Participants

Key Informant Interviews

External:

Mike Wong, Public Health Council
Susan Servais, MA Health Council
David Seltz, MA Health Policy Commission
Rebekah, Gewirtz, MA Public Health Association
Commissioner Marcia Fowler, MA Dept of Mental Health
Kate Millett, MA Dept of Elementary and Secondary Education
Secretary Ann Hartstein, MA Dept of Elder Affairs

Internal:

Cheryl Bartlett, RN, Commissioner
Eileen Sullivan, Chief of Staff
Jay Youmans, Legislative Director
Thomas Land, Office of Data Management and Outcome Assessment
Thomas O'Brien, Office of General Counsel
Madeleine Biondolillo, Associate Commissioner

Focus Group Participants

Three internal focus groups were held with Department Senior Leaders, Bureau Directors, and Program Managers. A total of 28 people participated; these same people also participated in the planning sessions.

Planning Session Participants

Senior Team

Cheryl Bartlett, Commissioner
Eileen Sullivan, Chief of Staff
Madeleine Biondolillo, Associate Commissioner
Tom O'Brien, General Counsel
David Kibbe, Director of Communications
Jay Youmans, Legislative Director
Ed Dyke, Development Director
Hillary Jacobs, Senior Policy Advisor

Bureau and Office Directors

Carlene Pavlos, Bureau of Community Health and Prevention
Deborah Allwes, Bureau of Health Care Safety & Quality
Georgia Simpson May, Office of Health Equity
Kevin Cranston, Bureau of Infectious Disease
Lydie.Ultimo, Bureau of Substance Abuse Services
Mary Clark, Office of Preparedness and Emergency Management
Mike Pentella, Bureau of Laboratory Services
Ron Benham, Bureau of Family Health and Nutrition
Sandra Akers, Bureau of Hospital Services
Suzanne Condon, Associate Commissioner, Director Environmental Health
Tom Land, Office of Data Management

Program Directors/Line Staff

Kathy Messenger, Family Health and Nutrition
Jana Ferguson, Office of Local and Regional Health
Lea Susan Ojamma, Community Health and Prevention
Carol Cormier, Human Resources
Tish Davis, Data Management
Hermik Babakhanlou-Chase, Substance Abuse Services
Jan Sullivan, Environmental Health
Leonard Lee, Community Health and Prevention
Jennifer Cochran, Infectious Disease

Appendix C: Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

Strengths	Weaknesses
<ul style="list-style-type: none"> • Strategic, collaborative and flexible leadership • Staff expertise/competencies • Committed staff with diverse Expert & committed staff with diverse training/experience • “Team” spirit at all levels of the organization • Strong external partnerships (health care, CBOs, state agencies, LPH) who see DPH as responsive, positive and proactive • Other states see DPH as forward thinking, innovative and cutting edge • Track record of successes & a public health leader (tobacco, violence, teen pregnancy, HIV/AIDS) • DPH has the expertise in prevention & population health to be a leader in health reform • Organization* • Data* • Communications* • Fundamentally a science-based/evidence-based organization • Innovative <p><i>* Also identified as weaknesses (most of the strengths above could also be classified as weaknesses).</i></p>	<ul style="list-style-type: none"> • Staffing and resources vs. workload • Hiring/managing staff • Labor Relations creates challenges: hiring/firing, changing job descriptions of existing staff, bumping of staff into openings • Unqualified staff receive recommendations from managers to bump them into other positions • Workforce issues • Organization* • Data,* IT and IRB • Communications* • Recreation of the wheel • Not always clear who the decision-maker is • Although DPH mission typically prevents a biased response, self-preservation also impact our responses • Lack of depth in management structure • DPH's message is too complicated (must simplify) • Public and many staff do not understand the breadth of what DPH does and its role <p><i>*Also identified as strengths</i></p>
Opportunities	Threats
<ul style="list-style-type: none"> • DPH has the expertise in prevention & population health to be a leader in health reform • Health reform: focus on health care quality and access and health equity • Move toward universal health insurance • Progressive political climate • Progress on/support for substance abuse work • Understanding of social determinants of health • Understanding of intersection of health and behavioral health • Growing focus on performance management • Prevention and Wellness Trust Fund • State agencies and other partners willing to collaborate • Strong academic partnerships • Support from EOHHS Secretary, legislature and advocates • Data informs the work • Can be the unbiased adult in the room • Neutral convener • Converting DPH mission into improvement for health • Embed QI/PM into the work to advance DPH's mission • Ask how current/future work is advancing DPH's mission (mission-centered work) • Education should be added to the mission • Must adopt to environment under new administrations • Publishing evaluation of DPH's work (reports, publications) • Re-organize DPH's Data so that the Commissioner can evaluate DPH's role • DPH's core business lines should be based on mission and resources 	<ul style="list-style-type: none"> • New administration with potential new priorities • Dependence on state budget process to rebuild from cuts • Changing priorities at CDC • Federal and state laws/unfunded mandates • Growing need for data make our case for support • New infectious disease outbreaks • Diminished capacity of local public health • Schools cutting health services and physical education • Public health graduates not educated on health reform • Public is confused about DPH's role • Media is focused on failures • Some (other state agencies, public, legislature) see DPH as well-resourced, making it vulnerable to cuts • Potential cleavages within/across DPH rather than team spirit • Brutal media market/need different posture than duck and cover • Universal health care - it will be harder to measure some things

- | | |
|--|--|
| <ul style="list-style-type: none">• Universal health care• Marketing plan for communicating with stakeholder segments | |
|--|--|



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Connecticut Department of Public Health

Strategic Map Update
2015-2018

Addendum 1 to Agency Strategic Plan
2013-2018



The Connecticut Department of Public Health
Strategic Map Update
2015-2018
January 1, 2015 – December 31, 2018

The Connecticut Department of Public Health developed its first Strategic Map in 2011. This first Map was finalized on April 11, 2012 (see Appendix A) and was in effect from 2011-2014.

Subsequently in February, 2013 and as part of an update to this original strategic planning effort, a formal agency Strategic Plan 2013-2018 was published that reaffirmed the vision and mission, identified organizational values for the agency, and built consensus around priorities with an additional focus on worksite wellness and the importance of partnerships.

In October 2014, DPH updated the original strategic map in effect through 2014. The Strategic Map is the foundation for the formal agency Strategic Plan and implementation of agency strategic planning efforts. This updated map will become Addendum 1 to the Agency Strategic Plan 2013-2018. The Strategic Plan, including mission, vision, and values, will be formally revisited and updated in 2018.

An overview of DPH's continuous strategic planning process from 2011-2014 is provided in Appendix B on page 16, including number of meetings, duration of the planning process, participants, methods used for review, and steps in the planning process.

The Strategic Map Update in effect for 2015-2018 is depicted on page 3. DPH will revisit the map annually and may update each year or report on progress annually as appropriate. A high level summary of revisions and updates to the map is included on page 2 with additional detail on the pages that follow, organized by Strategic Priority.

Overview of Updates to the Strategic Map

The updated Strategic Map modifies the original Central Challenge (Improve Health Outcomes for All in Connecticut through Leadership, Expertise and Focus) to:

Improve Population Health in Connecticut through Leadership, Expertise, Partnerships and Focus

Population Health replaces Health Outcomes to differentiate between health care and public health (emphasis on population health, rather than individual health outcomes), and *Partnership* is added because collaboration is key to all DPH activities.

The Strategic Priorities remained the same except for Strategic Priority A (Ensure Programmatic Excellence) that was changed to better reflect and support the new Central Challenge and frame the related objectives. Strategic Priority D was also slightly modified to add focus to worksite wellness and its importance to the agency's workforce. The Strategic Priorities are:

- A – Strengthen Approaches and Capacity to Improve Population Health**
- B – Promote the Value and Contributions of Public Health**
- C – Build Strategic Partnerships to Improve the Public Health System**
- D – Foster and Maintain a Competent, Healthy, Empowered Workforce**
- E – Build a Sustainable, Customer-Oriented Organization**

Cross Cutting Priorities were confirmed and a new cross cutting objective was added (Secure Sustainable, Diversified Funding). This was moved from an objective in E-1 to a crosscutting strategic priority because it is a need that cuts across all priorities and objectives. The Cross Cutting Priorities are as follows:

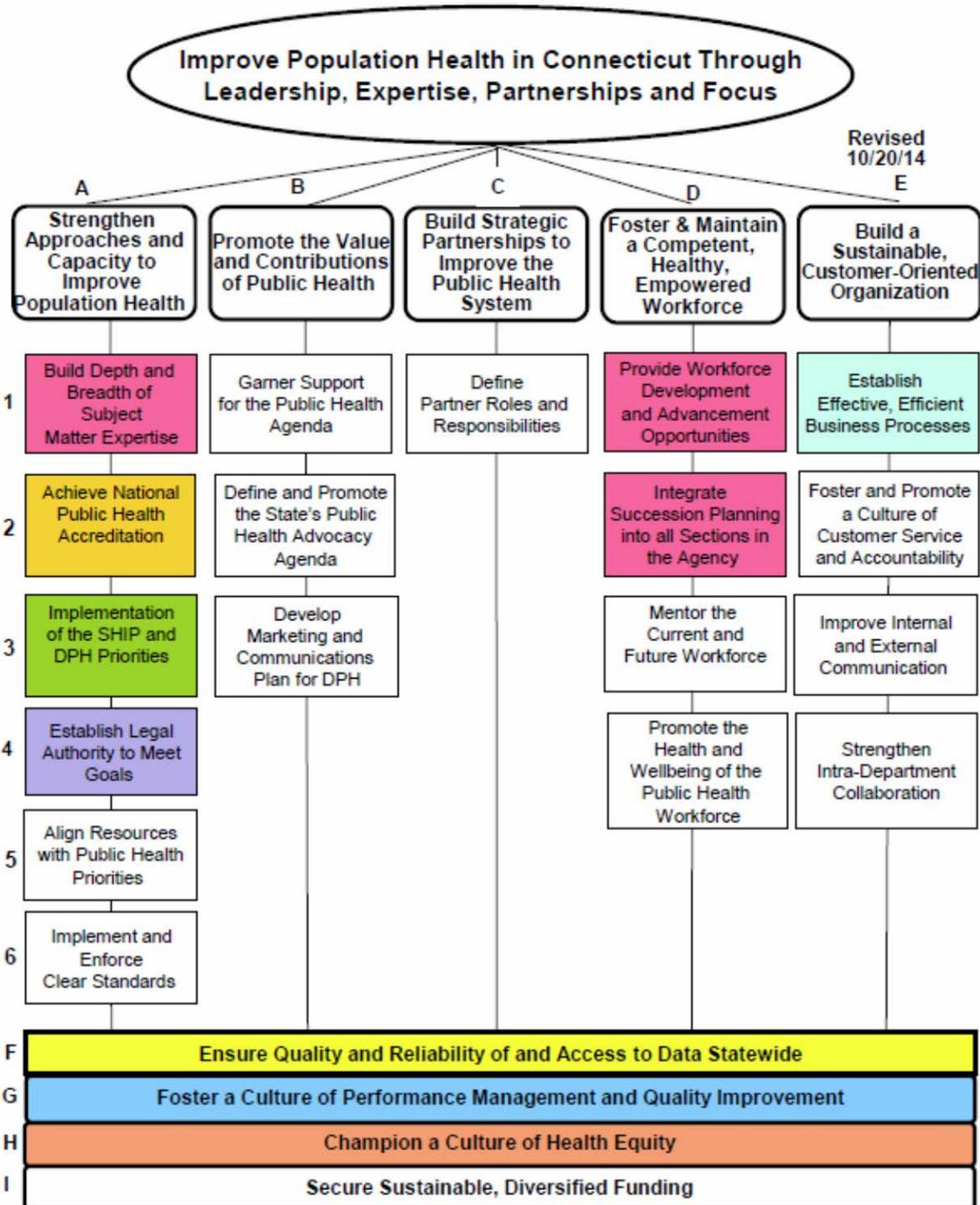
- F – Ensure Quality and Reliability of and Access to Data Statewide**
- G – Foster a Culture of Performance Management & Quality Improvement**
- H – Champion a Culture of Health Equity**
- I – Secure Sustainable, Diversified Funding**

The four Cross Cutting Priorities are depicted at the bottom of the Strategic Map indicating that they are foundational for all efforts to implement the Strategic Map, that they are embedded in actions to implement all other strategic priorities, and that no plans to implement the other strategic priorities will be considered complete unless they include an emphasis on performance management and health equity, and consideration and ongoing work to ensure funding, as well as quality, reliability, and access to data in order to make data-driven decisions.

The Objectives depicted in boxes under each Strategic Priority describe the key actions that will be taken to carry out these strategies. The Objectives are listed in order of importance as assigned by the agency through a voting process and additional discussion. It should be noted that the Public Health Strategic Team was judicious in selecting priority objectives in deliberate effort to be strategic in its focus rather than comprehensive.

Objectives/boxes in color are those for which activity is anticipated in the current year. White Objectives/boxes represent areas of importance but ones that will not receive additional emphasis in the current year via the establishment of a committee or new initiatives. Objectives for the Cross Cutting Priorities will be identified by work groups or programs as assigned. Each Strategic Priority is briefly described in the following pages.

**Connecticut Department of Public Health
Strategic Map: 2015-2018**



A
Strengthen Approaches and Capacity to Improve Population Health

Strategic Priority A: Strengthen Approaches and Capacity to Improve Population Health

This strategic priority was changed from “Ensure Programmatic Excellence”. The change to “Strengthen Approaches and Capacity to Improve Health” was made because it better supports the central challenge, and because completion of major activities that support programmatic excellence were completed.

1
Build Depth and Breadth of Subject Matter Expertise

Omitted Objectives: The following objectives were omitted from the map because they were completed in SFY 2014.

Conduct a statewide health assessment (was A1)

Develop a statewide health improvement plan (was A2)

2
Achieve National Public Health Accreditation

Maintained Objectives

A4: Establish Legal Authority to Meet Goals. This was set as Priority Objective. This objective is carried out by various programs in the agency, not one committee. These programs such as Government Relations, Legal, and others, will be asked to report activity to the Public Health Strategic Team (PHST) in order to determine a work plan and monitor progress.

3
Implementation of the SHIP and DPH Priorities

A5: Align Resources with Public Health Priorities

A6: Implement and Enforce Clear Standards

4
Establish Legal Authority to Meet Goals

New Objectives:

A2: Achieve national public health accreditation. This was set as a Priority Objective. This work will be led by Public Health Systems Improvement working with teams assigned to each of the 12 Domains.

5
Align Resources with Public Health Priorities

A3: Implement the State Health Improvement Plan. This was set as a Priority Objective to provide a formal link to health improvement and subsequently added “and DPH Priorities” to reflect alignment of DPH priorities for the SHIP with our agency’s strategic priorities. This work will be led by Public Health Systems Improvement.

6
Implement and Enforce Clear Standards

Adapted Objectives:

A-1: Changed from “Build subject matter expertise” to “Build depth and breadth of subject matter expertise.” Depth and breadth were added to acknowledge that we already have extensive subject matter expertise in all program areas but would benefit from having more than one expert in any given area. This was set as a priority objective and color coded to align with tracks of work relative to the strategic priority D focusing on a competent, healthy and empowered workforce . This work will be carried out by the existing Workforce Development Plan Committee created to develop the agency’s Workforce Development Plan. The committee meets monthly and is an extension of the original Workforce Training Needs Assessment and Workforce Development and Advancement Committees established under the first strategic mapping process.

Other Adjustments: Two other objectives were originally included under Strategic Priority A but after discussion and voting were reassigned as follows:

Continually update the State Health Assessment. This objective was moved under cross-cutting priority *Ensure Quality and Reliability of and Access to Data Statewide* given similar subject matter and association.

Implement Health in All Policies. This objective was removed due to no votes and will be considered during next update.

This Strategic Priority contains four tracks of work as indicated by the different color coding. A work plan will be developed for each track of work either by an existing committee or through reporting to the PHST as identified above.

B

Promote the Value and Contributions of Public Health

Garner Support for the Public Health Agenda

Define and Promote the State's Public Health Advocacy Agenda

Develop Marketing and Communications Plan for DPH

Strategic Priority B: Promote the Value and Contributions of Public Health

This strategic priority recognizes that public understanding of public health and dedicated state resources to promote population health is critical health improvement, and that efforts to increase understanding and value of DPH, its programs, and public health in general is needed to successfully improve the health of our residents. Initial focus of the strategic mapping workgroup included messaging, media outreach and visibility. Accomplishments include, public health forums, initiation of the Lead Public Health Initiative, (creating demand for public health through education, outreach and dialogue, and opportunity to create a vision for an equitable and robust public health system in Connecticut); increased social media presence (Facebook, twitter, videos, e-polling, media site and google hangouts), and other communication enhancements such as launch of the agency intranet page, a communications guidance document, and assignment of a dedicated webmaster.

Maintained Objectives

B1: Garner support for the public health agenda

B2: Define and promote the state's public health advocacy agenda

New Objective:

B3: Develop marketing and communications plan for DPH. This would help to promote consistent messaging developed and disseminated.

Other Adjustments

- *Demonstrate impact and return on investment (was B4).* This Objective did not receive any votes and was removed.
- *Promote DPH Leadership as the Voice for Public Health (was B2)* was changed to Promote DPH as the Voice for Public Health. Leadership was removed because all staff can be leaders and all staff members speak for public health. This Objective did not receive any votes and was removed.

C

Build Strategic Partnerships to Improve the Public Health System

Define Partner Roles and Responsibilities

Strategic Priority C: Build Strategic Partnerships to Improve the Public Health System

This strategic priority recognizes that our partners are central to our work and improving population health, and the term “Partnerships” was included in the central challenge. Much work has been done to identify and build strategic partnerships. Accomplishments include development of a comprehensive listing of agency public health partners used to build a statewide coalition for health improvement planning, partnerships for health equity, and outreach to state agencies and other organizations that play key roles in health promotion and prevention.

Building strategic partnerships takes place throughout the agency on an ongoing basis. Many collaborative planning efforts are ongoing in areas such as chronic disease, maternal and child health, environmental health to name a few, and new partnerships and outreach efforts such as Lead Public Health, are ongoing. Although there is no centralized coordination for listing our partnerships, it was acknowledged that building new and diverse partnerships will continue through various planning and implementation activities that will also help define roles and responsibilities. For this reason and resource constraints, there will not be a new track of work devoted to this however, this strategic priority will be reviewed next year in context of evolving needs to improve population health and agency resources.

Maintained Objectives

C3: Define partner roles and responsibilities. This is work is ongoing as the agency continues work in improving population health.

Other Adjustments

- *Identify key partners (was C1).* This Objective did not receive any votes and was later removed. Many participants also felt key partners have largely been identified over the past couple of years through planning and other initiatives undertaken by the agency.
- *Establish and implement goals and objectives (was C2).* This Objective did not receive any votes and was removed.

D
**Foster & Maintain
 a Competent,
 Healthy,
 Empowered
 Workforce**

**Provide Workforce
 Development
 and Advancement
 Opportunities**

**Integrate
 Succession Planning
 into all Sections in
 the Agency**

**Mentor the
 Current and
 Future Workforce**

**Promote the
 Health and
 Wellbeing of the
 Public Health
 Workforce**

Strategic Priority D – Foster and Maintain a Competent, Healthy, Empowered Workforce

This strategic priority recognizes that our workforce is our greatest asset and that training, empowerment, and worksite wellness opportunities are key to the agency’s success in being a high performing organization capable of achieving our mission and this central challenge. The term “Healthy” was added to this strategic priority to reflect the importance of providing a safe and healthy work environment.

Omitted Objectives: The following objectives were omitted from the map because they were completed in SFY 2014 unless otherwise specified.

- Conduct a workforce needs assessment (was D1)
- Establish and implement leadership training (was D5)
- Encourage creativity and decision-making (was D6). This was removed because many participants felt it was a value, not an objective. Valuing new ideas, empowered decision making, and learning from mistakes was noted as critical in culture and organizational change.

New Objective:

D4: Promote the health and well-being of the public health workforce. A healthy workforce is essential to carrying out the agency’s mission and it is expected that work will continue by the DPH Wellness, Health and Safety Committees in this area. Several accomplishments include Walking Wednesdays, heart healthy snacks in vending machines, email tips, cafeteria banners and tent cards, tobacco cessation awareness, Weight Watchers awareness, Quiet Room, Tai Chi, Mediation, race awareness, bike to work, Resolved 100% of OSHA citations, cleanup and building improvements.

Maintained Objectives

D1: Provide workforce development and advancement opportunities. This was set as a priority objective and color coded with other workforce development tracks of work. This work will be carried out by the Workforce Development Committee through the creation of the agency workforce development plan with goals and objectives, and training and curricula schedule.

D3: Mentor the Current and Future Workforce

Adapted Objectives:

D2: This objective was changed from “Develop a Succession Plan” to “Integrate succession planning into all sections in the agency.” This reflects the need for agency-wide succession planning, instead of a single succession plan, to ensure continuity and preclude loss of institutional knowledge in all program areas as our workforce ages and key staff retires. This objective is set as a priority objective and color coded with other workforce development tracks of work. This work will be carried out by the Workforce Development Committee.

D5: Changed from “Establish and Implement Leadership Training” to “Promote and monitor effectiveness of leadership training.” Leadership training was established and implemented, so this is the follow-up objective. Later removed for no votes and because it is currently done by Public Health Systems Improvement as part of regular program implementation and evaluation.

E

Strategic Priority E – Build a Sustainable, Customer-Oriented Organization

Build a Sustainable, Customer-Oriented Organization

This strategic priority reflects the importance of meeting our customer’s (internal and external) expectations and responding to their needs. The initial workgroup discussed internal collaboration, stewardship and sharing vs. ownership. An internal customer service survey was conducted and the results shared with the agency.

Establish Effective, Efficient Business Processes

Omitted Objectives:

Improve Data and Information Sharing, Access and Tools (was E4). This was identified as a critical objective and that it would be best addressed as part of *Cross-Cutting Strategic Priority F: Ensure Reliability of and Access to Data Statewide*.

Foster and Promote a Culture of Customer Service and Accountability

Maintained Objectives

Improve Internal and External Communication

E1: Establish Effective, Efficient Business Processes was set as a priority Objective and a track of work. Primary coordination resides with the Administration Branch that will provide discussion of work plan and updates at PHST meetings.

E2: Foster and Promote a Culture of Customer Service and Accountability. Work included results of a customer service survey and identification of customer satisfaction systems around the country and recognizing good work through rewards and incentives.

Strengthen Intra-Department Collaboration

E3: Improve Internal and External Communication.

E4: Strengthen Intra-Department Collaboration

E3 and E4 above are being addressed by: regular Town Hall meetings, cross cutting teams, intranet, and volunteer opportunities outside usual staff duties to name a few, has increased internal agency initiatives and activities. Proactive communications such as press releases and public forums have enhanced external communication.

Adapted Objectives:

Secure sustainable, diversified funding (was E1). This Objective was moved to become *Cross Cutting Strategic Priority I* because sustainable funding sources are needed to support all strategic priorities and goals.

Cross Cutting Strategic Priority F

Ensure Quality and Reliability of and Access to Data Statewide

This cross cutting priority was adapted by adding the word “quality”.

Accomplishments from this group included confidentiality training for data users, a data inventory, and establishment of a computer room including investment in software. The dedicated room is being reassessed given the reported lack of use, and need for office or conferencing space. Additionally, some progress has been made on making data (e.g., CHIME, Medicaid) searchable and more available using a data portal.

A data quality committee meets regularly to discuss data quality issues. This work will be discussed with the Public Health Strategic Team to help identify and resolve data access issues and the need to continuously update and refine the state health assessment and state health improvement plan (particularly indicators, targets and specific data analyses). Other items to address in this area include ways for data epidemiologists and program personnel to connect and work with each other to identify and refine important indicators, and describe data trends and implications. This is important for continued implementation of the Healthy Connecticut 2020 Performance Dashboard. The Dashboard displays how Connecticut is faring in meeting both population health and programmatic objectives.

Cross Cutting Strategic Priority G

Foster a Culture of Performance Management and Quality Improvement

This cross cutting priority was maintained. It is essential to have a performance management system in place so that the agency can measure, monitor, report on, and continuously improve performance. The committee made important progress in this area by helping to develop and put in place a quality framework that includes: a QI Council that meets monthly; completion of a performance management assessment used to inform development of leadership training and quality culture; a Quality Plan that identifies a performance management framework for the agency; training in QI tools and methods and LEAN, and the development and implementation of a Performance Dashboard.

The QI Committee convened by Public Health Systems Improvement will develop a work plan to further this work and report to the PHST on progress. The work plan will include update and refinement of the agency's QI Plan.

Cross Cutting Strategic Priority H

Champion a Culture of Health Equity

Health Equity is an important concept that is critical to improving population health. DPH has incorporated health equity as part of its Mission statement, its organizational values, and one of its goals in its strategic plan. The agency is working to operationalize health equity in its programs, partnerships and policies and health improvement efforts. A cross cutting workgroup identified key terms, established a data surveillance committee to adopt standards for race and ethnicity, developed a staff training toolkit, developed a partnership list and began promoting CLAS Standards to DPH staff (i.e., Culturally & Linguistically Appropriate Standards).

This year, the Office of Health Equity was officially created within DPH and will lead future efforts to champion a culture of health equity. The Office of Health Equity will be the lead on this effort and report work in this area to the PHST focusing on diverse partnerships and promotion of CLAS standards.

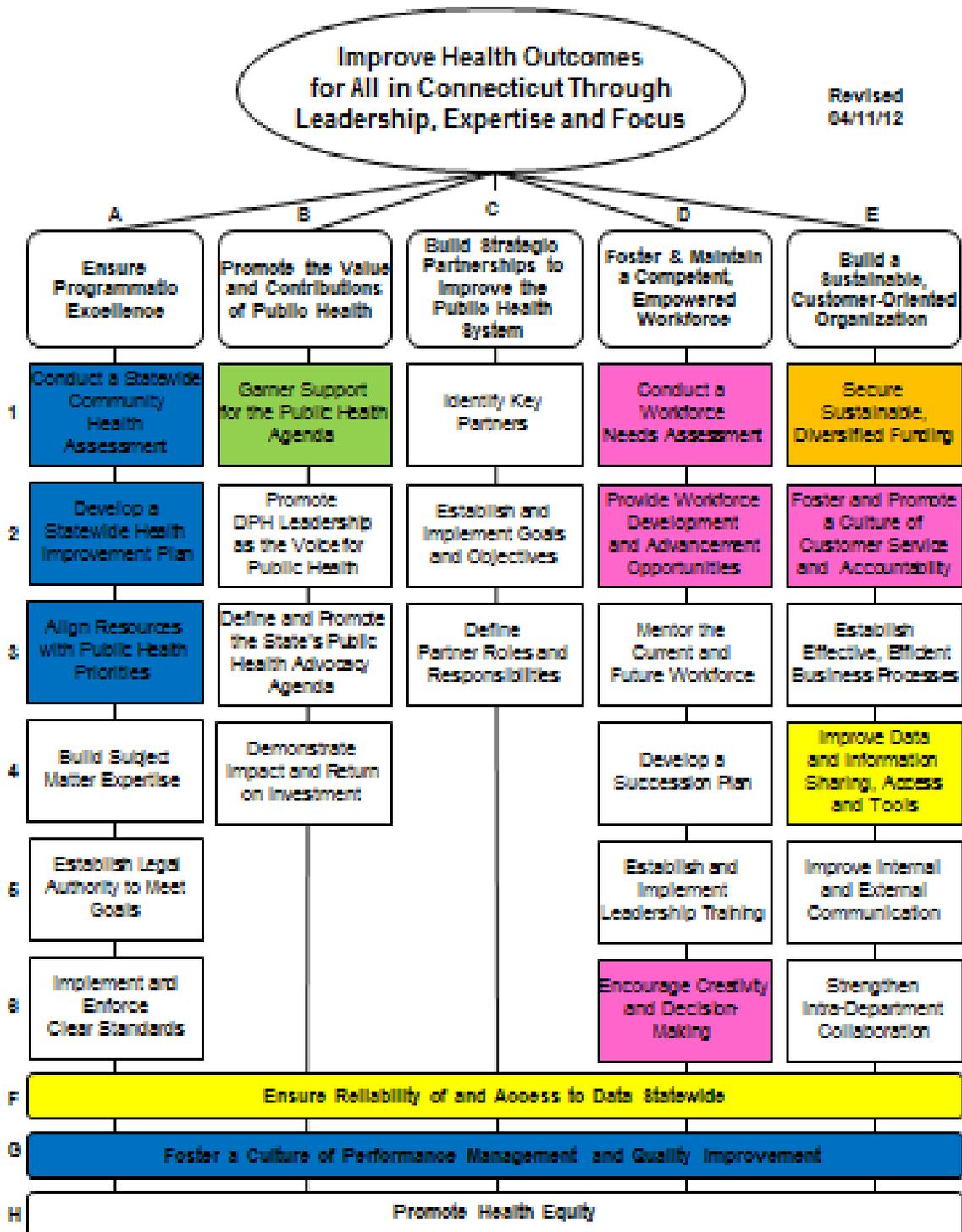
Cross Cutting Strategic Priority I

Secure Sustainable, Diversified Funding

This strategic objective was moved to a cross cutting priority given the importance to population health improvement activities, and also the uncertainty of federal and state funding levels. There are many avenues by which the agency seeks funding – through state appropriations, federal grants, philanthropies, and there are other innovative ways to sustain population health improvement activities such as key partnerships and promoting the value of public health. While agency leadership and programs all play roles and work on this in various ways, it was decided not to convene a special committee to specifically work on this given that 1) agency leadership and programs all play roles and work on this in various ways, and 2) the complexity is beyond the scope of programmatic areas and staff. This will be reassessed next year for feasibility of being able to reasonably address this through committee work.

Appendix A: Strategic Map Finalized 4/11/12

Connecticut Department of Public Health
Strategic Map: 2011-2014



Appendix B: Overview of DPH's Strategic Planning Process 2011 – 2014

Strategic Mapping Process and Implementation, 2011-2013- DPH leadership convened a strategic planning process on September 21 and 22, 2011 that included a group of 29 agency staff and community partners (identified below) with facilitation and technical assistance provided by TSI, Inc. Community partner participation included local health agencies, the Commission on Health Equity, and the CT Public Health Association. The goal of the 2-day meeting was to develop a “good enough” strategic plan. TSI, Inc. led participants through assessing the current situation, setting the future direction, and creating a strategic map that depicts how to move from the current state to the future. To assess the current situation, participants met in small groups to identify the strengths, weaknesses, and the critical issues facing the agency in the next 3-5 years. Next the group reconvened to discuss setting the future direction including development of the agency’s mission, and vision. The group then discussed and developed the agency’s central challenge and strategic priorities. Small groups were used again to identify objectives that support each strategic priority. The group then set implementation priorities by 1) identifying the allocation of the agency’s time and energy that should be devoted to each column of the map, and 2) participating in a straw vote to identify which objectives were the most important to emphasize over the next year. Six tracks of work, a group of related objectives that use the same resources and are of priority, were discussed and agreed upon. Lastly, small groups began developing implementation plans for each track of work including result, deadline and accountability. A detailed meeting summary was prepared by TSI and is available on the agency shared drive: <u:/sharedoc/strategic plan 2013-2018/strategic mapping 2011>. The final strategic map is in Appendix A on page 15..

On January 3, 2012 another half-day session was held at DPH facilitated by TSI, Inc. for all agency staff that volunteered (approximately 100 staff) to serve on committees for each track of work. The purpose of the meeting was to kick-off implementation. TSI took the group through strategic effectiveness concepts and a suggested process for implementation planning. A “review and adjust” process was established. The session is taped and available at <u:/sharedoc/strategic plan 2013-2018/strategic mapping 2011>.

On March 12 and 13, 2012 TSI provided a technical assistance and coaching session by reviewing strategic effectiveness principles and the strategic map, and modeling development of an implementation plan. Then they met with each track of work/committee individually to assist with developing key results. A meeting summary is available at <u:/sharedoc/strategic plan 2013-2018/strategic mapping 2011>.

Co-Chairs were identified for each committee which began to meet monthly or periodically to implement the plan. Communication of the strategic map and status of the work was provided through agency emails, report outs at semiannual town hall meetings in which staff could attend in person, listen by conference call or view a taped version made available on the agency’s shared drive. Posters of the map were made and distributed across the agency. Each Section Chief was also asked to discuss the map and process with their staff.

Strategic Mapping Participants September 21-22, 2011

Olga Armah, Associate Research Analyst, Office of Health Care Access	Marianne Horn, Section Chief Public Health Hearing Office
Judith Bailey, Health Program Assistant 2, Practitioner Licensing and Investigations Section, Health Care Systems Branch	Vanessa Kapral, Section Chief Information Technology Section
Rosa Biaggi, Chief Family Health Section	Katharine Kranz-Lewis, Co-chair, Advocacy Committee, CT Public Health Association; Faculty Expert, University of Hartford (Will attend 9/22 Session only)
Janet Brancifort, Manager Family Health Section	Leonard Lee Deputy Commissioner
Ellen Blaschinski, Chief Regulatory Services	Kim Martone, Director Office of Health Care Access
Tim Callahan, Director Norwalk Department of Health	Patrick McCormack, Local Health Director Uncas Health District
Michael Carey, Human Resources Administrator Administration Branch	Jewel Mullen Commissioner
Renee Coleman-Mitchell, Chief Community Health and Prevention Section	Michael Purcaro, Chief Administration Branch
Jose Cortez, Tech Analyst 2, Information Technology Section	Jane Purtill, Registrar Vital Records
Lisa Davis Deputy Commissioner	Lori Schulte TSI Inc
John Fontana, Director Public Health Laboratory	Tracy Scraba, Counsel, Aetna Law & Regulatory Affair; President, CT Public Health Association (9/21 Session only)
Mary Fuller, Director Fiscal Services	Raja Staggers Hakim, Executive Director Commission on Health Equity
Wendy Furniss, Chief Health Care Systems Branch	Kevin Sullivan, Health Program Associate Family Health Section
Jackie Gaston, Office Assistant Fiscal Services	Kristin Sullivan, Manager Public Health Systems Improvement
Meg Hooper, Chief Planning Branch	Stacey Zawel TSI Inc.

Formal Agency Strategic Plan Development, June 2012 – February 2013 –A first review and update was undertaken starting in June 2012 with the goal of validating previous work, filling in gaps (e.g., agency core values) and developing a formal organizational strategic plan. Since much of the work was done through strategic mapping, a survey was sent to a group of managers and strategic mapping co-chairs in July 2012 to assess the degree to which there was consensus on the mission, vision, strengths/opportunities, and weaknesses/challenges that were identified on a “good enough” basis as part of the initial strategic mapping meeting held last September, identify the agency’s core values, and further prioritize activities. The survey results formed the basis of discussion at a full day retreat held on August 1, 2012 where the mission and vision and were reaffirmed, agency values were agreed upon, and

consensus on priorities was achieved. Contractor JSI, Inc. provided facilitation for the activities and assisted DPH in developing a formal organizational strategic plan that was finalized, posted on the internet and shared with agency partners and the public. The plan reaffirmed the strategic priorities identified with the addition of worksite wellness and a renewed emphasis on the importance of partners/partnerships in achieving the agency’s vision and mission. The [strategic plan](#) was published in February, 2013 and is a five year plan that will be in effect from 2013-2018. The plan is available on the agency’s website and shared drive.

Committees continued to meet to work on priorities and work plans at varying paces through 2014 although some committees finished earlier. All work plans are available on u:/sharedoc/strategic plan 2013-2018/. The agency has continued with communication via town hall meetings. A new Healthy DPH committee took on worksite wellness activities. Additionally, staff in the Commissioner’s Office met with managers and supervisors by section to discuss the contents of the strategic plan and their role in implementing and contributing to the priorities. Brochures were developed and distributed, and a vision, mission and values poster board in both English and Spanish versions, was produced for the customer access points on the ground and first floor.

Strategic Plan Development 2012-2013 (Survey and Retreat Participants)

Chris Andresen, Section Chief TB, HIV, STD & Viral Hepatitis	Wendy Furniss, Chief Health Care Quality and Safety Branch
Olga Armah, Associate Research Analyst, Office of Health Care Access	Jackie Gaston, Office Assistant Fiscal Services
Suzanne Blancaflor, Section Chief Environmental Health	Bill Gerrish, Director Office of Communications
Ellen Blaschinski, Chief Regulatory Services	Leslie Giovanelli, Environmental Sanitarian 2 Environmental Health Section
Marc Camardo, Epidemiologist 2 Family Health Section	Mary Ann Harward, Chief Administration Branch
Michael Carey, Human Resources Administrator Administration Branch	Margaret Hynes, Director Health Equity Research, Evaluation, and Policy
Matt Cartter, Section Chief Infectious Diseases Section	Kim Martone, Director Office of Health Care Access
Renee Coleman-Mitchell, Section Chief Community Health and Prevention	Lori Mathieu, Section Chief Drinking Water Section
Mehul Dalal, Director of Chronic Diseases Community Health and Prevention Section	Jewel Mullen Commissioner
Lisa Davis Deputy Commissioner	Terry Rabatsky-Ehr, Epidemiologist 4 Infectious Diseases Section
Penny Davis, Principal Human Resources Specialist Administration Branch	Shawn Rutchik, Staff Attorney 2 Public Health Hearing Office
John Fontana, Director Public Health Laboratory	Christopher Stan, Health Program Associate Office of Communication
Kenny Foscue, Epidemiologist 4 Environmental Health Section	Kristin Sullivan, Manager Public Health Systems Improvement

Strategic Map Update, August 2014-October 2014 –In August, 2014 the agency began a review and update of the agency’s original strategic map that provides the basis for the agency’s formal agency strategic plan. This time the agency conducted the process through a Public Health Strategic Team (PHST) launched that year as part of the agency’s quality improvement plan and framework. The PHST, a 25-member committee representing most programs and levels of the department, was tasked with advising on all agency strategic initiatives including for example, the state health assessment/state health improvement plan, strategic planning, quality plan, and workforce development plan. It serves to guide and sustain critical planning initiatives that support all areas and activities of the agency.

Five meetings were held in which committee co-chairs provided information on the status of their work and achievements since implementation began in January, 2012. On September 18, 2014 a full day session was held with the PHST to update the map and was facilitated by Joan Ascheim. A similar process was undertaken – reaffirm vision, mission, and values; adapt as necessary the central challenge, strategic priorities, and objectives; and prioritize by straw vote. The PHST reconvened on October 16, 2014 to reflect on the new map and finalize recommendations. The process and outcome of these meetings is documented and contained in the main body of this document. The final map and recommendations for implementation were discussed and approved at a Branch Chief’s meeting on October 21, 2014. The PHST will assist with implementation by reviewing and advising on progress of committees. Committee work plans will be updated and posted on u:/sharedoc/strategic plan 2013-2018/.The updated map was also discussed with staff at the fall town hall meeting. This map update is an addendum to the plan that will be officially updated in 2018. It is available on the agency’s shared drive identified above.

Public Health Strategic Planning Team 2014-2015

Diane Aye, Chief Population Health Statistics and Surveillance	Katharine Kranz-Lewis Deputy Commissioner
Joan Ascheim, Performance Improvement Manager Public Health Systems Improvement	Kevin Krusz, WIC Food Resource Administrator Community Health and Prevention Section
Rosa Biaggi, Chief Family Health Section	Sheila Mayo Brown Tumor Registry
Janet Brancifort Deputy Commissioner	Kim Martone, Director Office of Health Care Access
Ronald Capozzi, IT Analyst Information Technology Section Administration Branch	Richard Melchreit, Health Care Associated Infections Program Coordinator Infectious Disease Section
Renee Coleman-Mitchell, Chief Community Health and Prevention Section	Amy Mirizzi, Early Hearing Detection & Intervention (EHDI) Program Family Health Section
Carmen Cotto, Associate Health Care Analyst Office of Health Care Access	Jewel Mullen Commissioner
Aby Cotto, Secretary Affirmative Action Office	Charles Nathan, Principal Health Care Analyst Public Health Systems Improvement
Wendy Furniss, Chief Health Care Quality and Safety Branch	Alison Rau, Paralegal Specialist Public Health Hearing Office

Mary Ann Harward, Chief Administration Branch	Carol Stone, Supervising Epidemiologist BRFSS Project Director/Principal Investigator Population Health Statistics and Surveillance
Margaret Hynes, Director Office of Health Equity	Kristin Sullivan, Manager Public Health Systems Improvement
Dermot Jones, Certification Officer Regulatory Services Branch	Alex Tabatabai Drinking Water Section Regulatory Services Branch
Fay Larson, Nurse Consultant Newborn Screening Program Public Health Laboratory	



UTAH DEPARTMENT OF
HEALTH



STRATEGIC PLAN 2013-2016



OUR VALUES

These values serve as a guide to our actions and our decision-making. We will hold ourselves accountable to these values as we work to achieve our mission and vision.

Collaboration	We engage each other, our partners, and the people of Utah in decision-making, planning, and integrated effort.
Effective	We are efficient and timely in making decisions and taking actions. We do the right things well in order to produce the greatest health benefit and the greatest return on the public investment.
Evidence-based	We use science and current, accurate data to guide our priorities and enhance the value of our actions.
Innovation	We foster creativity to meet challenges and continually identify opportunities for improvement.
Integrity	We are honest and straightforward with each other, our partners, and the people of Utah. We embrace high standards of ethical conduct, responsiveness, and quality performance.
Respect	We honor and appreciate each other, our partners, and the people of Utah.
Service	We strive to provide health programs that benefit the people of Utah and are consistent with their values and diversity. We seek to exceed internal and external customer expectations.
Transparency	We operate with open communication and processes.
Trustworthy	We are ethical, competent, and effective stewards of the public interest, public confidence, and public funds.



OUR STRATEGIC GOALS

Healthiest People...

The people of Utah will be the healthiest in the country.

Health in Health Reform...

Utah health reform will focus on cost-effectively improving the health of all the people of Utah.

Transform Medicaid...

Utah Medicaid will be a respected innovator in employing health care delivery and payment reforms that improve the health of Medicaid clients and keep expenditure growth at a sustainable level.

A Great Organization...

The Utah Department of Health will be recognized as a leader in government and public health for its excellent performance. The organization will attract, retain, and value the best employees to serve the health needs of the State.

HEALTHIEST PEOPLE

Strategy:

Engage public health partners, stakeholders, and the people of Utah to improve our shared understanding of what makes us healthy and to identify statewide priorities for health improvement.

- Identify a set health measures to evaluate the health of Utahns compared with residents of other states.
- Engage partners and stakeholders to prioritize actions to improve health in Utah.
- Produce regular reports on progress toward this goal.

Strategy:

Promote environments (physical, policy, cultural) that facilitate healthy behaviors, focusing especially on active living and healthy eating, to address the obesity epidemic and associated health outcomes.

- Increase capacity to implement health policy and environmental change.
- Profile of the *Health of Utah's Community Environments*.



Strategy:

Focus on the health of women, infants, and young children to assure that Utah children have a healthy start to life.

- Increase awareness of factors causing premature birth and infant mortality, and promote healthy lifestyles that contribute to optimal pregnancy outcomes.
- Improve health before conception.
- Improve use of early prenatal care and quality neonatal care.

HEALTH IN HEALTH REFORM

Strategy:

Infuse prevention and a focus on improving health into the public policy discussion of health reform in Utah.

- Establish processes to consider the health impact in policies affecting the people of Utah.
- Develop a prevention and health reform toolbox for business leaders, policy makers, and health care professionals.



Strategy:

Assure that the delivery of prevention services is a central theme of health reform efforts.

- Develop an educational campaign to improve knowledge and use of prevention and wellness services offered through health insurance policies.
- Improve the use of evidence-based clinical prevention services, including among Medicaid recipients.
- Address disparities in access and use of prevention services.

Strategy:

Use high-quality data to guide individual health decisions and the development of health care and public health policy.

- Improve use of data, including the All Payer Claims Database, to guide health policy and priorities.
- Improve health data security.
- Use data from clinical data systems to monitor health status, behaviors, and care.



TRANSFORM MEDICAID

Strategy:

Implement the Utah Medicaid Accountable Care Organization (ACO) model.

- Implement accountable care model along the Wasatch Front (completed).
- Improve measurement of quality of care in accountable care models.
- Growth rate in per member/per month ACO costs should be equal to or lower than the growth rate of state revenue.

Strategy:

Promote health management for Medicaid clients.

- Improve use of breast cancer screening and tobacco cessation services for Medicaid enrollees.
- Improve disease management of diabetes, asthma, and other chronic conditions for Medicaid enrollees.



Strategy:

Establish new, and expand existing, quality standards to improve health outcomes for Medicaid clients.

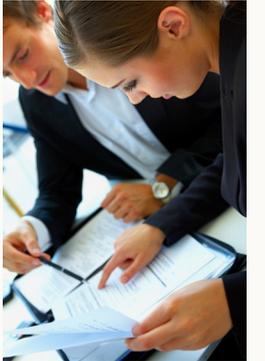
- Utilize All Payer Claims Database to evaluate quality and value of care for Medicaid enrollees.
- Assure state-of-the-art measures are used to evaluate care provided to Medicaid enrollees both inside and outside of the ACOs.

A GREAT ORGANIZATION

Strategy:

Improve organizational performance, both to provide greater value to the people of Utah, and to create a great place for people to work.

- Establish agency and program capacity for performance improvement.
- Improve productivity in programs targeted for the Governor's SUCCESS initiative.
- Implement performance measurement across the Department.



Strategy:

Demonstrate the highest level of performance, accountability, and value delivery for the State of Utah.

- Improve the efficiency and transparency of business processes by using the SharePoint environment.
- Communicate regularly with stakeholders on Department performance improvement efforts.

Strategy:

Ensure a supportive work environment—value our employees, invest in employee development, and encourage and support organizational learning.

- Build staff competencies and facilitate learning across the Department.
- Improve communication processes across the Department.
- Develop an effective employee recognition program.
- Support a healthy workforce and a healthful work environment.



Strategy:

Improve trust and collaboration with partners, including Local Health Departments, other State agencies, and community partners.

- Ensure an effective statewide health-improvement planning process.
- Pursue public health accreditation.
- Improve partner and stakeholder relations.

Oklahoma State Department of Health



Oklahoma State Innovation Model (OSIM) Update

Material Provided to
OSIM Statewide Stakeholder Meeting/Webinar
June 11, 2015

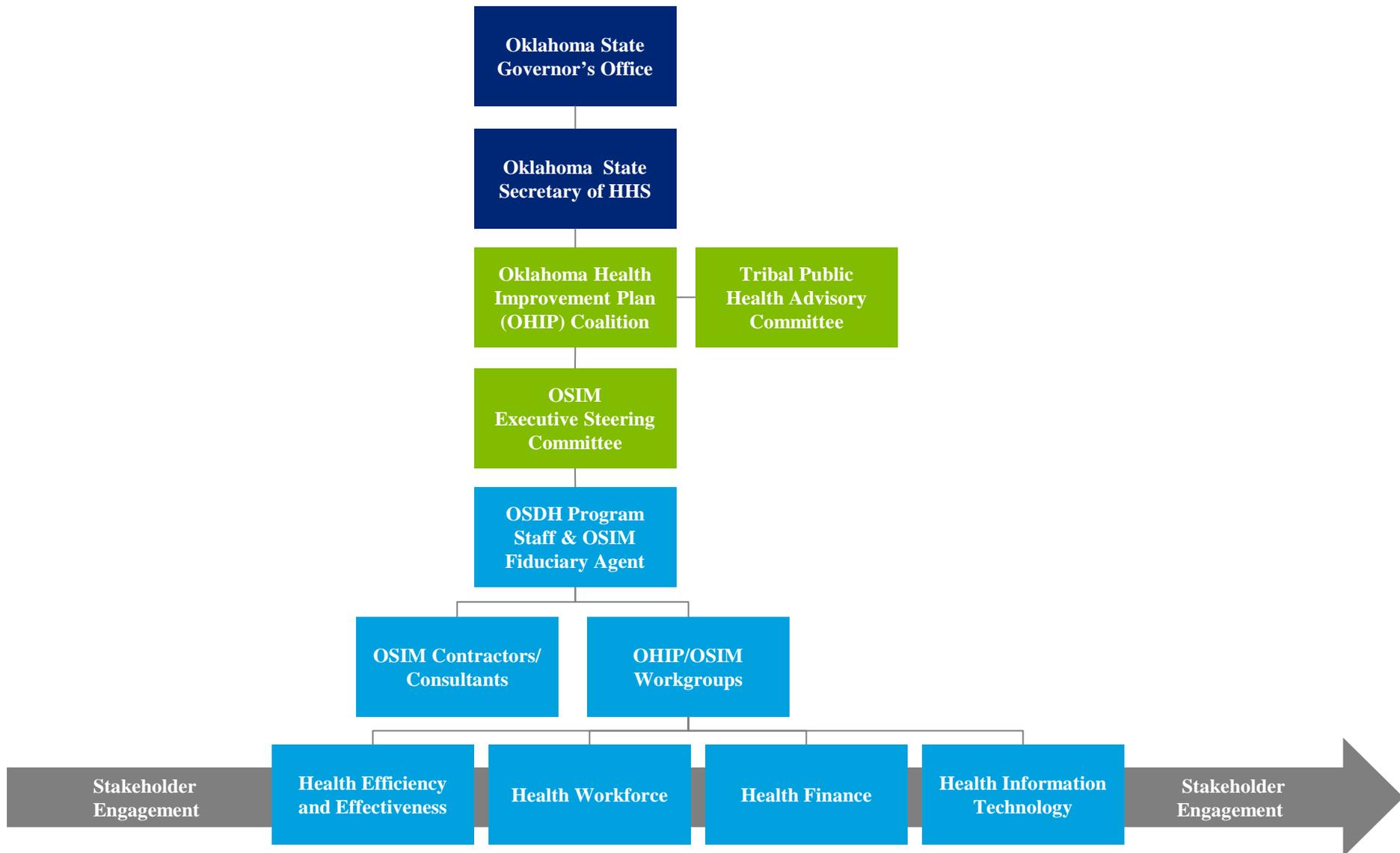


SIM Update

- **This PowerPoint presentation is meant to provide an update on the State Innovation Model Design Grant**
- **This is a subset of material that was provided in a public webinar on June 11, 2015. The full slide set can be viewed at the following link:**
<http://www.ok.gov/health2/documents/OSIM%20Statewide%20Stakeholder%20Meeting%202006%202011%202015.pdf>
- **There were 110 total participants dialed into the webinar on June 11, 2015. This number may not reflect the total number of people viewing the webinar in real time nor those that have viewed this material since posting on the OSDH website.**



OSIM Leadership and Organization



OSIM State Health System Innovation Plan – High Level Steps

	Align Population Health Priorities	Determine Necessary Data	Select New Payment and Delivery Models	Build Infrastructure to Support System
Necessary Decisions	<ul style="list-style-type: none"> • Consensus on quality measures • Consensus on population measures 	<ul style="list-style-type: none"> • Identify where data elements of measures are held • Identify necessary infrastructure to measure • Identify reporting and accessibility requirements 	<ul style="list-style-type: none"> • Create payment and delivery system to achieve population health goals • Identify new and existing infrastructure necessary for system transformation 	<ul style="list-style-type: none"> • HIT system upgrades • Value based program education • Necessary workforce
Continuous Activities	<ul style="list-style-type: none"> • <i>Identify Funding Opportunities</i> • <i>Stakeholder Engagement and Input</i> 			
Component of SHSIP	<ul style="list-style-type: none"> • Population Health Plan • Driver Diagrams 	<ul style="list-style-type: none"> • Health Information Technology Plan 	<ul style="list-style-type: none"> • Value Based Health Care Delivery and Payment Methodology Transformation Plan 	<ul style="list-style-type: none"> • Operational and Sustainability Plan
Contracted Work	<ul style="list-style-type: none"> • Evaluation Plan • Market Effects of Transformation • Population Health Plan 	<ul style="list-style-type: none"> • HIE Scan • EHR Survey 	<ul style="list-style-type: none"> • VBA Roadmap • Inventory of Current Efforts • High Cost Delivery Services • Forecast of Model 	<ul style="list-style-type: none"> • Workforce Assessment • Care Delivery Models

Mission: To create an agile and responsive health system in Oklahoma that rewards quality care and value to achieve the triple aim and promote the health and well-being of all Oklahomans

OSIM Successes to Date

In the first four months of the project, the OSIM Project Team has achieved the following:

Area	Successes
Project Leadership	<ul style="list-style-type: none">• Finalized all 5 contracts to support each area of the OSIM deliverables<ul style="list-style-type: none">○ Technical Assistance and Stakeholder Engagement (Deloitte Consulting)○ Health Efficiency and Effectiveness (University of Oklahoma ETEAM)○ Health Workforce (Oklahoma State University Center for Rural Health)○ Health Finance (Milliman)○ Health Information Technology (Milliman, Oklahoma Foundation for Medical Quality)
Workgroups	<ul style="list-style-type: none">• Each Workgroup Held at least one meeting• Established subcommittees (two workgroups)
Deliverables	<ul style="list-style-type: none">• Submitted the following deliverables for review by CMS and/or OSDH Program Staff:<ul style="list-style-type: none">○ CMS: Operational Plan, Stakeholder Engagement Plan, SHSIP Roadmap, Quarter 1 Report, Population Health Improvement Plan, Population Health Driver Diagrams○ OSDH: Health Data Catalog, Baseline Health Workforce Landscape – Provider Organizations



Stakeholder Strategy

The OSIM Project Team is targeting a **diverse assortment of stakeholders** and using a multi-pronged approach to ensure broad stakeholder engagement.

TARGETED GROUPS

- Commercial Payers
- Providers/Health Care Associations
- Public Health Associations/Coalitions
- Consumer Representatives
- Employers/Business Associations
- State and Local Agencies
- Tribal Nations/Associations
- Academic Institutions
- Advisory Groups
- Vendors

ENGAGEMENT APPROACH

- OHIP/OSIM Workgroups
- OSIM Website Public Comment Box
- Stakeholder One-on-One Meetings
- Stakeholder Group Meetings
- Stakeholder Statewide Meetings
- Conference/Forum Presentations
- Rural Engagement
- Tribal Nation Engagement

Stakeholder Organizations

The OSIM Project Team is collaborating with **more than 60 stakeholder organizations** across the state. This includes stakeholders involved in the OHIP/OSIM workgroups as well as stakeholders from one-on-one meetings, group meetings, conferences/forums, etc.

Stakeholder Categorization	Total Organizations
Commercial Payer	4
Provider/Health Care Association	18
Public Health Association/Coalition	8
Consumer Representative	1
Employer/Business Association	5
Tribal Nation/Association	8
State/Local Agency	11
Academic Institution	6
Advisory Group	2
Vendor	5
Grand Total	68



OSIM Website Public Comment Box

Visit www.osim.health.ok.gov to receive updates and leave comments for the OSIM Project.

Each Workgroup has area under the Workgroup Deliverables where stakeholders can leave comments on the various components of the State Health System Innovation Plan (SHSIP).

Workgroup Deliverables

Program Evaluation Report

1. Population Health Needs Assessment:

Objectives: *Identify and describe statewide health problems, gaps and strengths in services, and interventions to improve the health of Oklahoma.*

2. In-State Program Evaluation Plan with Quality Metrics:

Objectives: *Design an evaluation plan that incorporates quality measurements, addresses health disparities, and provides a means by which to evaluate them to align them with a value-based health care delivery system.*

**Leave a Comment: Health Efficiency & Effectiveness
Workgroup Deliverables**



OSIM Website Public Comment Box

By clicking on the “Leave a Comment” link, you will be taken to Public Comment form where you can provide feedback for various components the SHSIP.

OSIM Stakeholder Public Comments - Health Efficiency & Effectiveness

OSIM Stakeholder Public Comment - Health Efficiency & Effectiveness Workgroup

* Indicates Required Field

*

Health Efficiency & Effectiveness Workgroup

The Oklahoma State Innovation Model project (OSIM) is currently accepting comments from the public.

Please select the deliverable you would like to submit a comment on: (check any that apply)

- Population Health Needs Assessment
- In-State Program Evaluation Plan with Quality Metrics
- Other

* Health Efficiency & Effectiveness Workgroup Comments:

*Name:

*Organization:

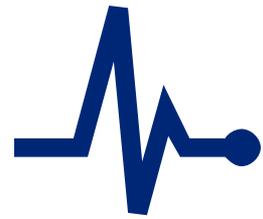
*E-mail Address:

If you would like to receive a confirmation email upon submission of this form, please enter your email here.



OHIP/OSIM Workgroups

Health Efficiency & Effectiveness



*Workgroup members may participate virtually or in person

Objective	Organization/Leadership	Upcoming Deliverables	Upcoming Meetings
<p>Provide services related to the design and implementation of a comprehensive and rigorous evaluation plan that will analyze the performance of the value-based model(s) selected for testing by the OSIM leadership and stakeholders</p>	<p><u>Vice Chair:</u></p> <ul style="list-style-type: none"> • Rebecca Pasternik-Ikard, JD, RN, MS, Deputy State Medicaid Director <p><u>Subcommittees:</u></p> <ul style="list-style-type: none"> • Evaluation Performance and Reporting • Emergency Department and Utilization (in development) <p><u>Contractor:</u></p> <ul style="list-style-type: none"> • University of Oklahoma ETEAM 	<ul style="list-style-type: none"> • Inventory of Current State Efforts (Mon. 7/20) • Oklahoma Care Delivery Models (Wed. 7/15) • High Cost Delivery Services (Mon. 8/24) • In-State Evaluation Plan with Quality Metrics Draft (Thurs. 10/1) • In-State Evaluation Plan with Quality Metrics Final (Fri. 10/30) 	<ul style="list-style-type: none"> • July 23 • August 27 • September 17 • October 15 • November 12

For more information on workgroup meeting dates and locations, visit the following webpage: [Click Here](#)



Health Workforce



*Workgroup members may participate virtually or in person

Objective	Organization/Leadership	Upcoming Deliverables	Upcoming Meetings
<p>Conduct an assessment of the health workforce data in Oklahoma reflecting a comprehensive description of issues and influences affecting this workforce sector in the state</p>	<p><u>Vice Chair:</u></p> <ul style="list-style-type: none"> Deidre D. Myers, MA, Deputy Secretary of Workforce Development <p><u>Subcommittee:</u></p> <ul style="list-style-type: none"> Data (in development) <p><u>Contractor:</u></p> <ul style="list-style-type: none"> Oklahoma State University Center for Rural Health 	<ul style="list-style-type: none"> Health Workforce Assessment Reports: <ul style="list-style-type: none"> Providers (Wed. 7/1) Gap Analysis (Wed. 7/1) Environmental Scan – Policy Levers (Fri. 8/31) Emerging Trends (Tues. 9/1) Policy Prospectus (Thurs. 10/1) Health Workforce Assessment Final Report (Fri. 10/30) 	<ul style="list-style-type: none"> July 15 October 15

For more information on workgroup meeting dates and locations, visit the following webpage: [Click Here](#)

Health Finance



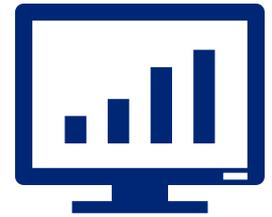
*Workgroup members may participate virtually or in person

Objective	Organization/Leadership	Upcoming Deliverables	Upcoming Meetings
<p>Provide actuarial and financial expertise and simulation on model proposals and health economics. Develop comparative instruments to explain payment and care delivery models. Perform a review of market effects of health reform initiatives in other states</p>	<p><u>Vice Chair:</u></p> <ul style="list-style-type: none"> Joseph Cunningham, MD, Chief Medical Officer, VP, Blue Cross Blue Shield of Oklahoma <p><u>Contractor:</u></p> <ul style="list-style-type: none"> Milliman 	<ul style="list-style-type: none"> Market Effects on Health Care Transformation (Wed. 7/15) Oklahoma Care Delivery Model Analysis (Wed. 7/15) High-Cost Delivery Services (Mon. 8/24) Financial Forecast of New Payment Delivery Models (Mon. 10/26) 	<ul style="list-style-type: none"> July 17 July 24 October 28 November 3

For more information on workgroup meeting dates and locations, visit the following webpage: [Click Here](#)



Health Information Technology



*Workgroup members may participate virtually or in person

Objective	Organization/Leadership	Upcoming Deliverables	Upcoming Meetings
<p>Perform a gap analysis and advise on strengthening and expanding the use of Health Information Technology (HIT) and Health Information Exchanges (HIE) to support population health, health care delivery, and new value-based payment models</p>	<p><u>Vice Chair:</u></p> <ul style="list-style-type: none"> • Bo Reese, State Chief Information Officer, Office of Management and Enterprise Services • David Kendrick, MD, MPH, Chair of Medical Informatics, University of Oklahoma College of Medicine <p><u>Contractors:</u></p> <ul style="list-style-type: none"> • Milliman • Oklahoma Foundation for Medical Quality 	<ul style="list-style-type: none"> • EHR Survey/Adoption Analysis (Wed. 7/1) • HIE Environmental Scan (Fri. 7/24) • Value Based Analytics Roadmap (Tues. 8/25) • Health Information Technology Plan: Internal Review (Fri. 10/30) • Health Information Technology Plan: CMS Review (Fri. 11/30) 	<ul style="list-style-type: none"> • July 15 • July 29 • August 27

For more information on workgroup meeting dates and locations, visit the following webpage: [Click Here](#)



Articles of Interest

HEALTHY COMMUNITIES: *A Framework for Meeting CRA Obligations*

<http://www.dallasfed.org/assets/documents/cd/healthy/CRAframework.pdf>

The Health in All Policies (HiAP) Approach and the Law: Preliminary

http://www.aslme.org/media/downloadable/files/links/1/2/12.Gakh_SUPP.pdf

Time to Act: Investing in the Health of Our Children and Communities

<http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf409002>

Shaping Health in Early Childhood Panel I

<https://www.youtube.com/watch?v=uKxIHyrVSIg&list=PLqF-bKPCi6CrX0SIxY5DtzGS45R51VJ34&index=7>

HEALTHY COMMUNITIES: *A Framework for Meeting CRA Obligations*



“There is a symbiotic relationship between the health and resilience of a country’s economy, and the health and resilience of a country’s people. This publication is important because it provides strategic direction to financial institutions on how to invest in healthy communities, and how to communicate the value of these investments to stakeholders.”

—Richard W. Fisher
President and CEO,
Federal Reserve Bank of Dallas



March 2014

HEALTHY COMMUNITIES: *A Framework for Meeting CRA Obligations*

By **Elizabeth Sobel Blum, MA, MBA**
Federal Reserve Bank of Dallas

INTRODUCTION

Community Reinvestment Act (CRA) and compliance officers at financial institutions are responsible for making complex decisions about how to invest in community development to meet their CRA obligations. The purpose of this publication is to provide:

1. a roadmap of best practices in community development,
2. a healthy communities framework that highlights the types of investments that are valuable both to financial institutions and their target communities,
3. a list of CRA reference guides to help ensure that planned CRA activities meet regulatory requirements, and
4. a template for how financial institutions can tell their CRA story.

This framework is not prescriptive, as there is no “right” answer, but helps financial institutions make strategic decisions and give comprehensive reasons for their community development activities. This information is vital when CRA and compliance officers share their community development story with internal management, customers, community partners, target communities and bank examiners.

This framework is the “Healthy Communities Framework” because it highlights resources that help make healthy the norm. It involves creating an environment in which there is an abundance of healthy choices. Healthy communities—those in which individuals and neighborhoods thrive and are resilient—matter, as the health of the nation¹ affects the health of the economy, and the health of the economy affects the health of the nation. Low Income Investment Fund president and CEO Nancy Andrews and Harvard Business School senior lecturer Nicolas Retsinas explain this interdependence:

“Today, a child’s ZIP code is one of the most powerful predictors of her future life—health, education, longevity. As [former] Federal Reserve Chairman Ben Bernanke has warned, ‘income inequality is a very bad development. It’s creating two societies.’ . . . If the United States intends to remain the most prosperous economy in the world, we can no longer afford to see 20 percent of our children ill-housed and poorly educated. We can no longer afford an achievement gap estimated at \$1–\$2 trillion annually and between 9 percent and 13 percent of lost gross domestic product, or what McKinsey & Company has called the ‘equivalent of a permanent national recession.’”²

The Healthy Communities Framework is relevant to financial institutions because it helps them avoid the trap of cherry-picking community development activities. It helps bring clarity to what direction a financial institution can take and how its community development activities are valuable both to it and its host communities. Clarity is key as financial institutions, their customers, partners and target communities navigate through the complexities of poverty and the systems that create, facilitate and sustain it.

PART ONE: IDENTIFYING BEST PRACTICES

A new generation of community development models is emerging. Their common purpose is to make successes easier to replicate and expand; their best practices are listed below.

*Best Practices in Community Development*³

1. Use innovative methods to leverage private capital.
2. Blend people- and place-based strategies to realize a broader vision.
3. Provide equal opportunity to quality education so that everyone can reach their highest potential.
4. Measure outcomes to identify what works.
5. Invest resources in what works.

Most of these community development models also strive to promote small businesses and increase access to living wage jobs.

It is recognized that inequalities start early in life, necessitating quality early childhood development resources, namely parental attachment, guidance and supervision, and quality schools and neighborhoods. These investments are fundamental to the health of individuals, communities and the economy. It is far more effective and financially wise to invest in quality early childhood development resources than invest in efforts that try to remediate the effects of poor early childhood development, such as crime, low workforce productivity, teenage pregnancy and unhealthy behaviors. It is important to equitably distribute the costs and benefits of community development investments so as to prevent lower-income communities from being excluded from newly created opportunities.

In addition, when the goal of community development efforts is to transform neighborhoods for the better, it is recommended that efforts focus on a well-defined geography, simultaneously addressing housing, education, private investments and social services, and leveraging the neighborhood's unique assets.⁴

Creating an Environment That Makes Healthy the Norm

Making healthy the norm is the responsibility of not only organizations and groups but individuals as well. And it is easier for individuals to make healthy choices when healthy foods are affordable and convenient, when there are plenty of safe and convenient ways to be physically active and socially engaged, and when the environment—air, soil, water, homes, schools, office buildings, street design,⁵ parks, playgrounds and other public spaces—promotes health.

The importance of having these choices is evidenced in the world's "Blue Zones."

About a decade ago, Blue Zones founder and CEO Dan Buettner worked with National Geographic and longevity experts to find "pockets of people around the world with the highest life expectancy, or with the highest proportions of people who reach age 100."⁶ The pockets they found were in California (Seventh Day Adventists in Loma Linda), Costa Rica, Greece, Japan and Sardinia. Collaborating with additional researchers, they identified the healthy environments and behaviors these communities—Blue Zones—have in common.⁷

Common Environments and Behaviors of Blue Zones

1. Live in environments “that constantly nudge them into moving without thinking about it.”
2. Have a sense of purpose.
3. Have routines that reduce stress.
4. Eat only until 80 percent full, eat the smallest meal in the late afternoon or early evening and don’t eat thereafter.
5. Eat a diet centered on beans, and eat three to four ounces of meat only five times a month.
6. Drink one to two glasses of alcohol a day with friends and/or with food. (Note: Seventh Day Adventists in Loma Linda are the exception.)
7. Belong to a faith-based community.
8. Prioritize all generations of family by keeping aging parents and grandparents at home or nearby, committing to a life partner and investing time and love in their children.
9. Be in social circles that support healthy behaviors because “smoking, obesity, happiness and even loneliness are contagious.”

While there is one Blue Zone in the United States, the Robert Wood Johnson Foundation highlights that this community is the exception to the rule in America.

“America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on earth. Yet on some of the most important indicators, like how long we live, we’re not even in the top 25, behind countries like Bosnia and Jordan. It’s time for America to lead again on health” and that means taking several steps, including “stop thinking of health as something we get at the doctor’s office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it. Scientists have found that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. It’s time we expand the way we think about health to include how to keep it, not just how to get it back.”⁸

PART TWO: IDENTIFYING OPPORTUNITIES

Financial institutions and their target communities can tap into the numerous opportunities that already exist in “healthy communities.” Below are some examples of how to identify these opportunities.

I. Becoming Familiar With Healthy Communities Experts

All communities can use the new generation of community development models, embrace the best practices listed above and tailor their efforts to meet their unique needs. Knowing how to invest in opportunities to make healthy the norm starts with knowing:

1. The components integral to healthy communities, which are listed in the **Healthy Communities Checklist** (on page 6), and
2. The leading experts, programs, initiatives, organizations and communities that are working in this space.

Financial institutions can ask these experts if they are working in the financial institution’s assessment area. To become well-versed in the experts’ work, it is recommended that financial institutions read this publication’s [appendix](#), which has summaries of dozens of healthy communities experts’ activities, and also review experts’ websites to develop a comprehensive understanding of their mission or purpose, areas of focus, strategies, partners and/or membership. Detailed information can be found in their publications (newsletters, reports, blogs, etc.), conference agendas and explanations about their policy work (if applicable).

If these experts are not working in a financial institution’s assessment area, it is recommended that financial institutions ask them if they know of any healthy communities initiatives—or about a specific type of healthy communities initiative (e.g., building financial capacity, early childhood development and other activities on the **Healthy Communities Checklist** on page 6)—in their assessment area.

A wide variety of other organizations may know about healthy communities initiatives or a specific type of healthy communities initiative. These organizations include national and local foundations and think tanks, colleges and universities, hospitals, public health departments, cities’ community development and economic development departments, health associations (e.g., American Heart Association), industry associations (e.g., Association for Enterprise Opportunity) and the community affairs/development departments of Federal Reserve District Banks.⁹

II. Community Health Needs Assessments (CHNAs)¹⁰

CHNAs are used by “organizations seeking to better understand the needs and assets of their communities, and to collaborate to make measurable improvements in community health and well-being.”¹¹

Financial institutions can contact county public health departments and/or local nonprofit hospitals to request a free copy of their CHNA report.

If this information is insufficient, financial institutions can use the Community Commons’ CHNA Toolkit, which “informs investments and activities related to the Community Reinvestment Act; more explicitly connects the work of banks, trusts, Community Development Finance Institutions (CDFIs) and other related entities—to the work of hospital community benefit and health and social well-being initiatives; [and] provides a means for alignment and outcomes tracking of investments made across different fields and sectors.”¹²

III. Health Initiatives Focusing on Prevention

There are a number of initiatives that focus on prevention; it is common to hear about initiatives or coalitions with, for example, “obesity,” “asthma” or “diabetes” in their names.

Financial institutions can contact county public health departments, hospitals and health associations, such as the American Diabetes Association, to help them identify community initiatives that focus on public health issues. Financial institutions may be interested in participating if these initiatives focus on preventing these health issues, such as through improving access to safe and affordable housing, healthy foods, pedestrian walkways and/or bike trails.

IV. STAR Communities¹³

There are communities across the country that are certified, reporting or participating STAR Communities. STAR stands for “Sustainability Tools for Assessing & Rating” and STAR Communities’ five-star rating system helps local governments measure their communities’ health and locate health disparities. It scores communities on seven factors: Built Environment; Climate & Energy; Economy & Jobs;

Education, Arts & Community; Equity & Empowerment; Health & Safety; and Natural Systems.

Financial institutions can contact STAR Communities to ask if any communities in their CRA assessment areas are certified, reporting or participating STAR Communities. If so, they can plug into the network of local organizations that are working toward a five-star rating.

V. Healthy Communities Institute¹⁴

The Healthy Communities Institute created the Healthy Communities Network to assist communities in improving community health. It provides data and tracks communities' progress in improving health, assists in prioritizing opportunities and spotlights accomplishments.

Financial institutions can contact the institute to determine if anyone in their assessment area is using the Healthy Communities Network. If so, they can get involved in the community coalition using the network.

HEALTHY COMMUNITIES CHECKLIST¹⁵

The Healthy Communities Checklist lists the components integral to healthy, vibrant, resilient communities. It can help financial institutions identify the types of healthy communities activities that they can participate in. Accompanying this publication is an [appendix](#) that lists dozens of prominent healthy communities leaders across the U.S. It provides a summary of each entity's purpose and activities in their own words (from their websites) and then a checklist of the healthy communities components that they focus on. The Federal Reserve Bank of Dallas does not endorse these entities.

- Access to Healthy Food
- Access to Medical Care
- Aesthetics: Clean and Well-Maintained Environment; Landscaping; Art; Culture
- Air, Soil and Water Quality
- Building Financial Capacity: Financial Literacy Training; Quality Financial Services and/or Products that Build/Maintain Assets
- Built Environment (Complete Streets, Housing, Schools and Workplaces, Parks and Playgrounds, Pedestrian Walkways and Bike Trails, Brownfields and Open Spaces)
- Early Childhood Development: Education, Care
- Education
- Employment, Creating and Retaining Jobs, Job Training
- Entrepreneurship
- Personal/Public Safety
- Physical Activity
- Public Transportation, including Transit-Oriented Development
- Senior Needs: Accommodation, Care, Services
- Social Networks/Social Environment; Democracy-Building, Community Engagement
- Social Services

PART THREE: CRA REFERENCE GUIDES

Understanding how their community development activities meet CRA requirements is vital information for CRA and compliance officers when they are communicating with internal management, customers, community partners, target communities and bank examiners.

To help ensure that the community development activities that they are considering or planning meet CRA requirements in a safe and sound manner, financial institutions should refer to the information in the CRA documents listed below and, for more detailed data, the CRA webpage of the Federal Financial Institutions Examination Council. They should also contact their CRA examiners to obtain specific feedback on the strengths and weaknesses of their community development activities and opportunities for improvement.¹⁶

Community Reinvestment Act (CRA) Reference Guides

“Community Development Decision Flow Chart,” e-Perspectives, Volume 7, Issue 4, 2007,
www.dallasfed.org/microsites/cd/epersp/2007/4_3.cfm

“CRA Toolkit,” e-Perspectives, Volume 7, Issue 4, 2007,
www.dallasfed.org/microsites/cd/epersp/2007/4_2.cfm

A Banker’s Quick Reference Guide to CRA, Federal Reserve Bank of Dallas, Sept. 1, 2005,
www.dallasfed.org/assets/documents/cd/pubs/quickref.pdf

CRA Loan Data Collection Grid, Federal Reserve Bank of Dallas, September 2006,
www.dallasfed.org/assets/documents/cd/pubs/craloan.pdf

Interagency Questions and Answers (Q&A) Regarding Community Reinvestment, March 11, 2010,
www.ffiec.gov/cra/qnadoc.htm

Information Useful in Developing a Performance Context 

PART FOUR: A TEMPLATE FOR FINANCIAL INSTITUTIONS TO TELL THEIR CRA STORY

Sometimes what is lost in the conversation of which community development activities to become involved in is the fundamental question of *why*—why should a particular financial institution engage in a particular community development activity? Written below is a template intended to help CRA and compliance officers construct a story that explains their community development activities to internal management, customers, community partners, target communities and bank examiners. How much of the following information to share will differ based on the audience. It would be helpful to bank examiners, however, if this information were included in the financial institution’s CRA performance context report.¹⁷

*Your Financial Institution's Community Development Story**

Section A: BACKGROUND

I. Your mission and/or purpose

II. Your geographic market(s)

III. Define the CRA. Below is sample text.

"Under the Community Reinvestment Act (CRA), it is our responsibility to identify community development opportunities in low- and moderate-income communities and engage in community development activities in a safe and sound manner. These activities must benefit both our financial institution and these communities."

"The CRA defines community development as that which 'Encompasses affordable housing (including multifamily rental housing) for [low- and moderate-income] LMI individuals; community services targeted to LMI individuals; activities that promote economic development by financing businesses or farms that meet the size eligibility standards of the Small Business Administration's Development Company or Small Business Investment Company programs or have gross annual revenues of \$1 million or less; or activities that revitalize or stabilize LMI geographies, designated disaster areas or distressed or underserved nonmetropolitan middle-income geographies designated by the [Federal Reserve] Board of Governors, [Federal Deposit Insurance Corporation] FDIC and [Office of the Comptroller of the Currency] OCC.'"¹⁸

IV. "Below are examples of how our financial institution has met our CRA obligations."

Below is sample text.

- "We provide financial guidance to organization(s) that serve low- and moderate-income communities. Specifically, we serve as the treasurer on the board of the local early childhood education center and community health center. The majority of students at the childhood education center are low- and moderate-income (*give the specific percent*) and the majority of clients at the community health center are low- and moderate-income (*give the specific percent*)."
- "We work with entities that provide financial products and/or services to low- and moderate-income microbusinesses and small businesses. Specifically, we:
 - work with (*list the entities, such as U.S. SourceLink, Small Business Development Centers, ACCION Texas, a local community development financial institution, etc.*) to provide training on business plan development, financial statement preparation and cash flow management. Some of our clients have become quite successful. (*Share success stories.*)
 - sit on the board (*and/or loan committee*) of (*list the entities*) to share our financial expertise." (*Share specific examples of how you provide financial guidance.*)
- "We provide financial support (*list dollar amount in specific time period*) to entities that provide financial products and/or services to low- and moderate-income microbusinesses and small businesses. These entities are . . . (*list the organizations, such as U.S. SourceLink, Small Business Development Centers, ACCION Texas, a local community development financial institution, etc.*)"

*How to cite this publication in your community development story: "Healthy Communities: A Framework for Meeting CRA Obligations," by Elizabeth Sobel Blum, Federal Reserve Bank of Dallas, March 2014.

- “Local community leaders have identified a need for small dollar loans—particularly in low- and moderate-income neighborhoods. In response, we offer creditworthy individuals small-dollar loan products in a safe and sound manner. These loans are valuable to our customers because . . .” *(Note: The FDIC developed “A Safe, Affordable and Feasible Template for Small-Dollar Loans.” For details, see www.fdic.gov/smalldollarloans/.)*¹⁹
- “We help our low- and moderate-income customers build financial capacity skills through our financial literacy trainings. We also provide this service to local high school students.” *(Share specific training data, such as the number of customers and students who received training, how the income level of these customers and students was determined and your assessment of how successful the training was.) (Note: The Federal Reserve Bank of Dallas has a personal financial education resource that presents an overview of personal wealth-building strategies for consumers, community leaders, teachers and students. For details, see www.dallasfed.org/cd/wealth/index.cfm.)*
- “We help our low- and moderate-income customers who have thin or no credit files to build credit. Building a credit score is important because it is often used to determine loan terms such as APR (*annual percentage rate*) and the down payment amount, and rates charged for insurance products such as motor vehicle insurance. Here are examples of how we help them build credit. . . .”
- “We established retail operations in a low- and moderate-income community that did not have a bank but had a strong need for one. *(Explain which community leaders identified the need and how you decided that it made business sense to locate new operations there.)* This bank branch offers the same products and services as our branches in middle- and upper-income areas. This bank’s hours of operation, however, are longer to accommodate customers who lack the flexibility to come during our traditional hours. *(List your traditional and expanded hours of operation.)* Because of our presence, community members have fair and impartial access to credit, have a safe place for their savings and, through our financial capacity classes, are learning how to build, save and invest for their financial future. . . .”
- “We partner with a community development corporation (*list name of CDC*) that builds housing that fits the budget of working households that are low- and moderate-income. Members of these households would otherwise have few options for safe and affordable housing. . . .”
- “We partner with a community development corporation (*list name of CDC*) that builds housing that fits the budget of working households that live or work in a distressed/underserved/designated disaster area.²⁰ These individuals would otherwise have few options for safe and affordable housing for themselves and their families. . . .”
- “We invest in community development loan funds that . . .”
- “We use Low Income Housing Tax Credits to . . . *(describe how the credits were used)*. Our partners were . . . *(list public, private and nonprofit organizations)*.”
- “We use New Markets Tax Credits to . . . *(describe how the credits were used)*. Our partners were . . . *(list public, private and nonprofit organizations)*.”

Section B: OUR CURRENT AREA(S) OF FOCUS

I. Background: The Healthy Communities Framework

“We are now using the healthy communities framework to help guide our community development strategy.”

“Healthy communities—those in which individuals and neighborhoods thrive and are resilient—matter, as the health of the nation affects the health of the economy, and the health of the economy affects the health of the nation.”

“Making healthy the norm involves creating an environment in which there is an abundance of healthy choices. Making healthy the norm is the responsibility not only of organizations and groups but individuals as well. And it is easier for individuals to make healthy choices when healthy foods are affordable and convenient, when there are plenty of safe and convenient ways to be physically active and socially engaged, and when the environment—air, soil, water, homes, schools, office buildings, street design,²¹ parks, playgrounds and other public spaces—promotes health.”

II. Our Community Development Focus

“In low- and moderate-income communities, there are noticeably fewer opportunities to make healthy choices than in higher-income communities. At *(name your financial institution)*, we are becoming actively engaged in helping make healthy the norm, particularly in LMI communities in our CRA assessment area. This area consists of ... *(define the geographic area)*.”²²

“We conducted research to learn the major opportunities and challenges in helping make healthy the norm. Following is an overview of how we conducted this research.” *(Give specific examples. Information should be included from Part Two: Identifying Opportunities of this publication.)*

“We have decided to focus on the following community development activities ... *(list your activities)*.”

“This is how our community development activities meet CRA requirements ... *(refer to specific CRA reference materials)*.”

Section C: OUR PROJECTED IMPACT

Note: The following information may not be important to include in your performance context but will be important to know as you share your community development story with internal management, customers, community partners, target communities and bank examiners.

“We decided to focus on these community development activities because:” *(Below are examples.)*

- “The return-on-investment is expected to be strong for both our financial institution and the communities in which we invest. Outlined below are estimates of the financial returns.”
 - **Financial ROI to your financial institution:** *(Explain who calculated this, how it was calculated, and the estimated time frame.)*
 - **Financial ROI to your community partners:** *(Explain who calculated this, how it was calculated, and the estimated time frame.)*
- “It will generate a savings that is estimated to be ... *(Explain who calculated this, how it was calculated and the estimated time frame.)*”
- “The impact is expected to be positive for both our financial institution and the communities in which we invest. Written below are estimates of the financial, social and health impacts.”

- **Financial impact to your financial institution:** *(Explain who calculated this, how it was calculated and the estimated time frame.)*
 - **Financial impact to your community partners:** *(Explain who calculated this, how it was calculated and the estimated time frame.)*
 - **Social impact to your financial institution:** *(For example, “Our community development activities entail developing and maintaining strong community partnerships, which are vital to building mutual trust and respect between us and the community. . . .”)*²³
 - **Social impact to your community partners:** *(For example, “This is what our community partners are saying about our community development activities. . . .”)*
 - **Health impact to the community:** *(Explain who calculated this, how it was calculated and the estimated time frame.)*²⁴
- “The financial impact to our institution is neutral/negative in the short term but the positive regulatory impact (*good CRA rating*) and intangible goodwill are projected to generate a positive financial impact in the long term. Specifically, the people we help today may grow into our customers tomorrow. Here’s how: . . . *(explain your strategy/plan).*”
 - Describe the community collaborative that you’re involved in that is promoting healthy communities. For example, “In our assessment area we are involved in a collaborative/partnership/initiative called Its purpose is to The collaborative meets our community development obligations by focusing on” *(List at least one of the four community development purposes: 1. affordable housing, 2. community services that target LMI individuals, 3. economic development, 4. revitalization or stabilization. Next, explain the model that the collaborative is using to identify the community’s priority areas and assess its impact. Examples are below.)*
 - “The model that we are using to identify our priority areas and assess our impact is the Protocol for Assessing Community Excellence in Environmental Health (PACE-EH), an iterative process that was developed by the Centers for Disease Control and Prevention’s (CDC) National Center for Environmental Health and the National Association for County and City Health Officials (NACCHO).²⁵ Following is a list of our accomplishments and plans in the near term.”
 - “The model that we are using to identify our priority areas and assess our impact is the collective impact model.²⁶ *(List the backbone support organizations.)* We play a leadership role by serving on the advisory committee and providing financial guidance. *(Give specific examples of the type of financial guidance you are providing).* Following is a list of our accomplishments and plans in the near term.”
 - “The model that we are using to identify our priority areas and assess our impact is the Prevention Institute’s THRIVE: Toolkit for Health and Resilience in Vulnerable Environments.²⁷ Following is a list of our accomplishments and plans in the near term.”

Section D: OUR LEADERSHIP ROLE

I. Putting Our Leadership Role in Context

“A new generation of community development models is emerging and their common purpose is to make successes easier to replicate and expand. Their prominent features are outlined below.”

*Best Practices in Community Development*²⁸

1. Use innovative methods to leverage private capital.
2. Blend people- and place-based strategies to realize a broader vision.
3. Provide equal opportunity to quality education so that everyone can reach their highest potential.
4. Measure outcomes to identify what works.
5. Invest resources in what works.

“Most of these community development models also strive to promote small businesses and increase access to living wage jobs.”

“It is recognized that inequalities start early in life, necessitating quality early childhood development resources, namely parental attachment, guidance and supervision, and quality schools and neighborhoods. These investments are fundamental to the health of individuals, communities and the economy. It is far more effective and financially wise to invest in quality early childhood development resources than invest in efforts that try to remediate the effects of poor early childhood development, such as crime, low workforce productivity, teenage pregnancy and unhealthy behaviors. It is important to equitably distribute the costs and benefits of community development investments so as to prevent lower-income communities from being excluded from newly created opportunities.”

“In addition, when the goal of community development efforts is to transform neighborhoods for the better, it is recommended that efforts focus on a well-defined geography, simultaneously addressing housing, education, private investments and social services, and leveraging the neighborhood’s unique assets.”²⁹

II. Our Specific Leadership Role

“We are playing a leadership role in our assessment area by supporting the community development best practices listed above/introducing our community partners to the community development best practices listed above and advocating them. Here’s how ... (*List specific examples.*)”

ACKNOWLEDGMENTS

This publication builds upon the tremendous work and insights of leaders working in the “healthy communities” space—where the community development, economic development, public health and health care industries collaborate to create healthier opportunities for all. I would like to extend my thanks to the Federal Reserve Bank of San Francisco, Low Income Investment Fund and contributing authors to their book *Investing in What Works for America’s Communities: Essays on People, Place & Purpose*. The best practices outlined in this paper come directly from their book. I would like to thank Dan Buettner, author of *Blue Zones*, for sharing his and his colleagues’ insights on the ingredients for human longevity. The Blue Zones information in this publication comes from his books and website. I would like to thank the Robert Wood Johnson Foundation for providing a wealth of health information in layman’s terms—it makes health concepts and data more accessible and meaningful to those whose expertise is not in public health and/or health care. Last but not least, I would like to extend my thanks to Richard J. Jackson, whose mentorship is invaluable. With Stacy Sinclair he wrote *Designing Healthy Communities*. My publication highlights many of their book’s examples of communities working to make healthy the norm. In addition, my Healthy Communities Checklist builds upon their “community audit walk” ideas and “checklist of potential [community] issues.” It is my hope that “Healthy Communities: A Framework for Meeting CRA Obligations” generates productive conversations on how everyone—private businesses, academia, health care providers, governments, philanthropies, citizens, etc.—can advance the health and resilience of their communities.

About the Author

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The views expressed are those of the author and should not be attributed to the Federal Reserve Bank of Dallas or the Federal Reserve System.

To access the **Appendix: Experts in Healthy Communities** and other resources, visit www.dallasfed.org/cd/healthy/ and select the **CRA** tab.

Notes

¹ Here, the definition of “nation” is “a country’s people and their communities.”

² “Inflection Point: New Vision, New Strategy, New Organization,” by Nancy O. Andrews and Nicolas Retsinas in *Investing in What Works for America’s Communities: Essays on People, Place & Purpose*, Nancy O. Andrews and David J. Erickson, eds., San Francisco: Federal Reserve Bank of San Francisco and Low Income Investment Fund, 2012, pp. 407–08.

³ This information is from *Investing in What Works for America’s Communities: Essays on People, Place & Purpose*, Nancy O. Andrews and David J. Erickson, eds., San Francisco: Federal Reserve Bank of San Francisco and Low Income Investment Fund, 2012, p. 75. For details, see www.whatworksforamerica.org/.

⁴ “It Takes a Neighborhood: Purpose Built Communities and Neighborhood Transformation Investing,” by Shirley Franklin and David Edwards in *Investing in What Works for America’s Communities: Essays on People, Place & Purpose*, Nancy O. Andrews and David J. Erickson, eds., San Francisco: Federal Reserve Bank of San Francisco and Low Income Investment Fund, 2012, pp. 180–81.

⁵ See detailed information about Complete Streets at www.smartgrowthamerica.org/complete-streets/complete-streets-fundamentals.

⁶ For details about the Blue Zones Project, see www.bluezones.com/live-longer/power-9/.

⁷ See note 6.

⁸ “A New Way to Talk About the Social Determinants of Health,” Robert Wood Johnson Foundation, Jan. 1, 2010, www.rwjf.org/en/research-publications/find-rwjf-research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html.

⁹ A map of the 12 Federal Reserve District Banks is available at www.federalreserve.gov/otherfrb.htm. Each Reserve Bank’s website contains information about its community affairs/development department.

¹⁰ For more information about Community Health Needs Assessments, see “Collaboration, Community, and Research: Conducting a Community Health Needs Assessment for Accreditation and IRS Reporting,” by Dawnetta Smith and Jennifer Edwards, June 2013, www.dallasfed.org/assets/documents/cd/healthy/wp_edwards.pdf.

¹¹ The Community Health Needs Assessment definition is provided by Community Commons at <http://assessment.communitycommons.org/CHNA/>.

¹² “Community Health Needs Assessment: About CHNA Toolkit,” Community Commons, <http://assessment.communitycommons.org/CHNA/About.aspx>.

¹³ STAR Communities, www.starcommunities.org

¹⁴ Healthy Communities Institute, www.healthycommunitiesinstitute.com

¹⁵ This list builds upon the work of Richard J. Jackson and Stacy Sinclair in *Designing Healthy Communities*, Hoboken, N.J.: Jossey-Bass, 2012.

¹⁶ There are state and federal requirements concerning public welfare investments, which include community development investments. To ensure compliance with these rules, it is recommended that financial institutions contact their state and federal banking regulators.

¹⁷ For more information about the performance context, see “Information Useful in Developing a Performance Context.”

¹⁸ A Banker’s Quick Reference Guide to CRA, Federal Reserve Bank of Dallas, Sept. 1, 2005, www.dallasfed.org/assets/documents/cd/pubs/quickref.pdf. For the complete definition of community development, see “PART 228—COMMUNITY REINVESTMENT (REGULATION BB)” at www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=635f26c4af3e2fe4327fd25ef4cb5638&tpl=/ecfrbrowse/Title12/12cfr228_main_02.tpl.

¹⁹ Bankers are required to refrain from committing unfair, deceptive or abusive acts or practices (UDAAP). The Consumer Financial Protection Bureau provides guidance on how to perform a UDAAP risk assessment. For details, see <http://files.consumerfinance.gov/f/supervision-manual/PartIIICFPBsupervisionmanual.pdf>.

²⁰ For the list of distressed or underserved nonmetropolitan middle-income geographies, see www.ffiec.gov/cra/distressed.htm. For the list of federal designated disaster areas, see www.fema.gov/disasters.

²¹ See detailed information about Complete Streets at www.smartgrowthamerica.org/complete-streets/complete-streets-fundamentals.

²² For a detailed definition of the assessment area, see page 1 of “A Banker’s Quick Reference Guide to CRA, Federal Reserve Bank of Dallas, Sept. 1, 2005,” www.dallasfed.org/assets/documents/cd/pubs/quickref.pdf.

²³ A Dallas, Texas-based firm that does social impact assessments is Social Impact Architects, <http://socialimpactarchitects.com/>.

²⁴ To learn more about health impact assessments, see the Health Impact Project: Advancing Smarter Policies for Healthier Communities, www.healthimpactproject.org/project.

²⁵ In *Designing Healthy Communities*, pp. 203–04, authors Richard J. Jackson and Stacy Sinclair explain in nontechnical terms how the community of West Wabasso, Fla., (population: 500–1,000) used PACE-EH. For detailed information, see the CDC’s website at www.cdc.gov/nceh/ehs/ceha/PACE_EH.htm.

²⁶ For more information about the collective impact model, see “Collective Impact” by John Kania and Mark Kramer, *Stanford Social Innovation Review*, Winter 2011, pp. 36–41, www.ssireview.org/images/articles/2011_WL_Feature_Kania.pdf.

²⁷ For more information about THRIVE, see “THRIVE: Community Tool for Health & Resilience in Vulnerable Environments,” www.preventioninstitute.org/component/jlibrary/article/id-96/127.html.

²⁸ See note 3.

²⁹ See note 4.



The Health in All Policies (HiAP) Approach and the Law: Preliminary Lessons from California and Chicago

Claudia Polsky, Kendall Stagg, Maxim Gakh, and Christine T. Bozlak

Introduction

“Health in All Policies” (HiAP) is the latest manifestation of an ecological approach to public health enhancement — one that recognizes connections between health and other sectors, and that socioeconomic determinants of health are significant. HiAP is related to other holistic, prevention-oriented approaches to collective health, such as the use of Health Impact Assessments to evaluate the health externalities of pending government decisions. Yet HiAP is unique. It goes beyond evaluation of specific projects and policies, and embodies a distinct approach to cross-sectoral public health work.

HiAP is institutionally flexible, and is more about organizational culture than a fixed framework. Despite local variation, however, HiAP efforts typically: (1) create an ongoing *collaborative forum for work across government agencies* to improve public health; (2) advance *specific government projects, programs, laws, or policies* that enhance public health while furthering participating agencies’ core missions; and (3) *embed health-promoting practices* in participating agencies.

Experiments in progress in California and Chicago demonstrate these principles. They also suggest how project-specific victories can lead to recognition of

health concerns, and institutionalization of health-promoting activities, throughout government.

What Is a “Health Issue”?

The very creation of sector-specific health codes and health agencies, while important, arguably promotes a siloed approach to public health. Yet the public health community has widely accepted a social-ecological model, which views public health as largely a product of environmental settings that interventions must address.¹ Consequently, the first step of HiAP work should (re)frame key issues as “health” issues. For instance, access to full-day kindergarten — an “education” issue — can be reframed as a “health” issue by demonstrating the link between educational opportunity and positive health outcomes into adulthood. Similarly, building additional bicycle lanes and ensuring walkability are not just transportation or zoning matters; they are directly relevant to reducing obesity and injury.

Two HiAP Experiments

The City of Chicago and the State of California are engaged in concurrent experiments in adopting a HiAP approach, although their processes started differently.

Chicago

In Chicago, HiAP efforts formally launched in 2011, when Mayor Rahm Emanuel and the Health Commissioner, Bechara Choucair, M.D., unveiled Healthy Chicago.² This blueprint for public health improvement identified 12 priorities and 193 strategies. Mayor Emanuel simultaneously helped launch the Healthy Chicago Interagency Council to leverage all city agencies’ missions to improve public health, work col-

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lectively on policy change, allow for project-specific partnerships, and stress the public health impacts of each agency's work. Chicago had previous, nationally-recognized experience in launching an interagency health-related committee via an Inter-Departmental Task Force on Childhood Obesity.³

In 2013, the Chicago Plan Commission approved A Recipe for Healthy Places, a comprehensive food system plan resulting from inter-agency collaboration and a partnership with the Consortium to Lower

helped legitimize the HiAP process and assure its longevity.

Although most agencies' participation in HiAP is unfunded, critical to the Task Force's success has been funded staff (housed at the Department of Public Health) that convenes meetings, facilitates cross-agency interactions, generates written products, and maintains documents, protocols, and institutional memory. Having paid, HiAP-dedicated staff also ensures process accountability: HiAP is their main job, not an add-on.

Although Chicago and California HiAP efforts have been roughly concurrent, Chicago already has on-the-ground results: streets brimming with bike-share stations, and school children on track for fewer cavities, vision problems, and STDs. Many of California's statewide efforts have dramatic reach, but will take longer to create visible change: state public school siting rules, for example, potentially impact transportation choices for six million K-12 pupils.

Obesity in Chicago Children. It engaged more than 400 participants from the community and the public, private, and non-profit sectors.⁴ This plan was funded by the Centers for Disease Control and Prevention's Communities Putting Prevention to Work initiative. Implementation will include ensuring land is safe for growing food, connecting more Chicagoans with food assistance programs, and expanding healthy food options.⁵

California

California's HiAP effort launched in 2010 via an executive order that created a cross-agency HiAP Task Force charged with collaborating to improve the health of Californians.⁶ Several months of Task Force meetings, stakeholder workshops, and outreach to nongovernmental public health experts yielded five priority areas, such as "healthy food" and "active transportation." The Task Force identified six broad strategies, including creating state guidance documents, to "promote healthy public policy."⁷

Creating the right institutional structures has helped infuse HiAP into the cultures of participating agencies, and ensured that HiAP endures changes in political leadership. The HiAP Task Force has since inception formally reported to the Governor's Strategic Growth Council, a high-visibility body focused on climate change that enjoys bipartisan support. The Task Force's stature was further enhanced by recent legislation that made it a standing body of the Department of Public Health.⁸ These features have

Early Signs of Success

Examples of HiAP accomplishments to date in Chicago and California demonstrate the power of the HiAP approach.

Chicago has engaged in comprehensive health re-framing with the Chicago Public Schools (CPS) through the Healthy CPS initiative, which "aims to remove health-related barriers to learning such that all CPS students may succeed in college, career and life."⁹ Healthy CPS also seeks to improve academic achievement through school-based daily physical education, provision of nutritious foods, and medical screenings and interventions. In a novel institutional arrangement that increases accountability for health, CPS now has a chief health officer — a physician who simultaneously serves as a member of CPS senior leadership and directly reports to the commissioner of the Chicago Department of Public Health. Healthy CPS's early successes include greatly expanded preventative oral health care services (more than 100,000 students served in 2013-14) and vision-care services (nearly 40,000 student eye exams performed to date), and reduced sexually transmitted diseases (STDs).¹⁰

In California, state agencies have recognized the dramatic increase in children commuting to school by car rather than walking or bicycling.¹¹ This phenomenon stems in part from increased distances between schools and homes, in turn traceable to the state's acreage minimums for new schools. These requirements hinder building schools in densely populated areas. Using a HiAP approach, the Califor-

nia Department of Education is now revising school siting guidelines to eliminate mandatory minimum acreages.

Task Force agencies have also collaborated in multiple ways through food-systems work. They pooled part-time positions across three agencies to create a “Farm to Fork” office that promotes consuming healthy local produce, for example, and implemented farm-to-office, community-supported agriculture programs in state buildings to boost state workers’ consumption of fresh organic produce. Additionally, collaboration among the Departments of Corrections and Rehabilitation, General Services, and Public Health — through a HiAP “Food Procurement Work Group” — yielded new guidelines for food purchasing expected to reduce fat and sodium content of meals served to over 120,000 California state prisoners.

Although Chicago and California HiAP efforts have been roughly concurrent, Chicago already has on-the-ground results: streets brimming with bike-share stations, and school children on track for fewer cavities, vision problems, and STDs. Many of California’s statewide efforts have dramatic reach, but will take longer to create visible change: state public school siting rules, for example, potentially impact transportation choices for six million K-12 pupils.

The Role of Law and Lawyers

Beyond the role of law in creating HiAP structures, law can support the HiAP process as agencies strive to promote health, collaborate for mutual benefit, and engage health-oriented stakeholders. And despite their frequent reputation as the actors who say “No,” lawyers can facilitate the transition to healthy public policy by identifying legal levers for changing agency business-as-usual.

Lawyers can: (1) find or draft model “healthy” zoning, vending, and procurement laws; (2) evaluate institutional solutions to health-related problems that have legal-system manifestations, such as specialty courts addressing mental health or substance abuse issues; (3) support policy innovation by advising on ways to minimize legal liabilities of health-promoting activities; (4) draft memoranda of understanding, executive orders, regulations, or legislation that institutionalize HiAP; and (5) determine how agencies can encourage healthy public policy. For example, lawyers can help schools execute facility joint-use agreements with local communities, or develop a well-planned crossing guard program that minimizes tort liability. Likewise, lawyers can help navigate jurisdictionally tricky terrain, such as determining how local food facility and inspection regulations may apply to serving school garden produce in school cafeterias.

Recommendations for Localities and States

Although there is no one right way to conduct a HiAP effort, the Chicago and California experiences suggest that the following can assist cross-agency work to enhance health:

1. Obtain high-level political support. Active and public championing of HiAP at high levels promotes legitimacy and durability.
2. Ensure governmental collaboration across sectors, but prioritize activities. Identifying high-priority areas for immediate collaborative action is a good way to begin a HiAP process, even if fewer than all agencies are convened under a HiAP banner.
3. Collaborate with non-governmental partners. Early and ongoing engagement of nonprofits and philanthropies infuses HiAP efforts with evidence-based policy recommendations, generates broad political support, and encourages adequate funding.
4. Engage members of the priority populations. The importance of engaging the true stakeholders in a HiAP process is a fundamental principle in health promotion.¹²
5. Study HiAP models from comparable settings. Consider which strategies (such as sharing staff, data, or professional development opportunities) will be most effective for eliminating silos in your context.
6. Use HiAP to address health-relevant tensions between agencies’ missions. For example, one agency may favor urban infill development, while another aims to avoid building homes in high-pollution areas. The HiAP process can help surface and resolve such tensions.
7. Solicit regular feedback on the process from agency participants, and adjust as necessary. The best approach is often to minimize plenary meetings and work through issue-based subgroups and/or agency-to-agency collaboration.
8. Set realistic expectations for visible results. Combine short-term, small-scale projects that generate observable results (e.g., installing more bicycle racks) and long-term projects with more far-reaching impact (e.g., changing a 25-year transportation plan).

9. Consider how law, lawyers, and the academy can support HiAP. For example, law student interns can provide legal research. Advocates may turn HiAP recommendations into bills.

10. Start somewhere. Modest but sustained efforts to foster cross-sector relationships can shift norms, become self-reinforcing, and over time create major successes.

Conclusion

The primary goal of HiAP practitioners should be to create a new norm of cross-agency collaboration around health. Reframing key issues as “health” issues is an essential first step in any HiAP process. The experiments in Chicago and California, although still in early stages, provide both reason for optimism that old agencies can learn new, health-promoting ways, and lessons for other jurisdictions. Law and lawyers can be pivotal in facilitating HiAP, and their potential role is only just emerging.

Acknowledgement

The views of expressed are those of the authors, and not official positions of any government agency or institution.

References

1. P. Braveman et al., “The Social Determinants of Health: Coming of Age,” *Annual Review of Public Health* 32 (2011): 381-398 ; T. R. Frieden, “A Framework for Public Health Action: The Health Impact Pyramid,” *American Journal of Public Health* 100, no. 4 (2014): 590-595.
2. City of Chicago, *Healthy Chicago, A Public Health Agenda for a Healthy City*, August 2011, available at <<http://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/PublicHealthAgenda2011.pdf>> (last visited January 12, 2015).
3. C. B. Bozlak et al., “An Inter-Governmental Approach to Childhood Obesity,” in R. M. Caron and J. Merrick, eds., *Public Health: Improving Health Via Inter-Professional Collaborations* (New York: Nova Science, 2014): at 73-48.
4. City of Chicago, *A Recipe for Healthy Places: Addressing the Intersection of Food and Obesity in Chicago*, January 24, 2013, available at <http://www.cityofchicago.org/city/en/depts/dcd/supp_info/a_recipe_for_healthyplaces.html> (last visited January 12, 2015).
5. *Id.*
6. Cal. Exec. Order No. S-10-04 (Feb. 23, 2010).
7. Health in all Policies Task Force, *Report to the Strategic Growth Council*, December 3, 2010, available at <https://www.apha.org/-/media/files/pdf/fact%20sheets/hiap_final_report_12_2010.ashx> (last visited January 12, 2015).
8. Cal. Health & Safety Code § 131019.5 (2012).
9. Chicago Public Schools Office of Student Health and Wellness, “Healthy CPS,” available at <<http://cps.edu/Programs/HealthyCPS/Pages/HealthyCPS.aspx>> (last visited January 12, 2015).
10. K. Stagg, “Health in All Policies,” presented at the Public Health Law Conference: Intersection of Law, Policy and Prevention, Atlanta, Georgia, October 17, 2014.
11. U.S. Department of Transportation, *2009 National Household Travel Survey*, Version 2.1 (February 2011).
12. World Health Organization, *The Ottawa Charter for Health Promotion* (November 21, 1986).

RWJF Commission
to Build a Healthier America



Time to Act: Investing in the Health of Our Children and Communities

Recommendations From the Robert Wood Johnson Foundation
Commission to Build a Healthier America

Executive Summary



Robert Wood Johnson Foundation

Charge to the Commission

In 2008, the Robert Wood Johnson Foundation (RWJF) convened the *Commission to Build a Healthier America* to help us find better ways to improve the health of our nation. In their search for solutions, the Commissioners found that there is much more to health than health care and that where we live, learn, work, and play profoundly influence our health. The Commissioners, a national, nonpartisan group of leaders from both the public and private sectors, issued 10 sweeping recommendations aimed at improving the health of all Americans. Their recommendations called for breaking down conventional policy-making silos and creating opportunities for better health in our neighborhoods, homes, schools, and workplaces.

The Commission's work sparked a national conversation that has led to a marked increase in collaboration among a wide variety of partners aimed at addressing the many determinants of health. Eager to build upon this progress, we asked the Commissioners to come together again. I want to thank the Commissioners for their willingness to do so, and for their wise counsel and strong guidance to help advance our transformation to a healthier nation.

RWJF believes that carrying out the recommendations in this report will be essential to building a culture of health—a culture that enables all in our diverse society to lead healthier lives, now and for generations to come. Moving forward, we call on others to join us. Advancing from recommendations to action will require all of us—including business, education, government, and health and health care—to join together with energy, passion, and commitment.



Risa Lavizzo-Mourey, MD, MBA
President and CEO
Robert Wood Johnson Foundation

January 2014

Statement From the Commissioners

We come to this Commission with different backgrounds, experiences, and points of view. Despite our differences, we agree that when it comes to health, the United States must do better. What we are doing is not working. We must find ways to keep more of us healthy and reduce the health care costs that are strangling our economy. It is unconscionable that we spend more than any other country on health care, yet rank at or near the bottom compared with other industrialized nations on more than 100 measures of health.

Since the Commission issued its sweeping recommendations in 2009, we've seen encouraging progress. Positive changes to federal nutrition programs, including updated standards for school meals and the Healthy Food Financing Initiative's success in bringing grocery stores and healthy food options to "food deserts," are squarely in line with what the Commission recommended. Health impact assessments are being used by decision-makers to identify the health impacts of policy decisions and development projects, and more states now have strong smoke-free laws.

This year, the Commission tackled immensely complex matters that underlie profound differences in the health of Americans: experiences in early childhood; opportunities that communities provide for people to make healthy choices; and the mission and incentives of health professionals and health care institutions. We explored these topics against the backdrop of the nation's

recovery from the longest and worst recession since the Great Depression; growing gaps between those at the top of the income ladder and the rest of us; demographic shifts, such as an aging population and the rapidly growing number of young people of color; and further evidence that validates why we must help those who are being left behind and who struggle to be healthy.

We examined programs and systems that were created decades ago and concluded that the complex web of factors that shapes the health of Americans today demands new solutions. We were also forced to confront the reality that the current economy makes new spending difficult, meaning that shared goals, collaboration, and efficiency are more essential than ever.

Throughout our deliberations, we were encouraged by promising examples of cross-sector collaboration and pockets of success across the country. Communities are showing they are willing to pull up their bootstraps and create locally funded, innovative solutions even in these challenging times. Many of these examples are highlighted in the report.

We would not have joined this effort if we weren't hopeful for the future, based on our confidence in the American people's shared values that health is what makes all else possible.

While we don't have all the answers, we can't wait. We know enough to act. And we must act now.

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Introduction

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As Americans, we like to think that we are healthier than people who live in other countries.

That is a myth. In fact, it is a myth for Americans at all income levels, but especially so for those living in vulnerable communities.

Our nation is unhealthy, and it is costing us all through poorer quality of life and lost productivity. Health in America is worse than in other developed nations on more than 100 measures. Thirty countries have lower infant mortality rates and people in 26 countries can expect to live longer than we do.¹ While it is true that the United States spends more on health care than any other country—more than \$2.7 trillion in 2011—part of the reason we spend so much on health care is that so many Americans are in such poor health.²

The key to better health does not lie primarily in more effective health care, although that is both important and desirable. To become healthier and reduce the growth of public and private spending on medical care, we must create a seismic shift in how we approach health and the actions we take. As a country, we need to expand our focus to address how to stay healthy in the first place. This will take a revolution in the mindset of individuals, community planners and leaders, and health professionals. It will take new perspectives, actors, and policies, and will require seamless integration and coordination of a range of sectors

and their work. This shift in thinking is critical for both the health and economic well-being of our country.

As we consider ways to improve our nation's overall health, we must consider options that will improve opportunities for all, with special emphasis on lifting up low-income children and those who are in danger of being left behind. A stronger, healthier America hinges on our ability to build a sustainable foundation for generations to come.

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Losing Ground in Health: Life Expectancy

figure 1 In 1980, the United States ranked 15th among affluent countries in life expectancy (LE) at birth. By 2009, it had slipped to 27th place.

1980	Rank	2009
LE = 76.7 Iceland	1	Japan LE = 83.0
Japan	2	Switzerland
Netherlands	3	Italy
Norway	4	Spain
Sweden	5	Australia
Switzerland	6	Iceland
Spain	7	Israel
Canada	8	Sweden
Greece	9	France*
Australia	10	Norway
Denmark	11	Canada**
France	12	New Zealand
Italy	13	Luxembourg
Israel	14	Netherlands
LE = 73.7 United States	15	Austria
Finland	16	Korea
Belgium	17	United Kingdom
New Zealand	18	Germany
United Kingdom	19	Greece
Germany	20	Belgium
Ireland	21	Finland
Luxembourg	22	Ireland
Austria	23	Portugal
Portugal	24	Denmark
Slovenia	25	Slovenia
Slovak Republic	26	Chile
Czech Republic	27	United States LE = 78.5
Poland	28	Czech Republic
Chile	29	Poland
Estonia	30	Mexico
Hungary	31	Estonia
Mexico	32	Slovak Republic
Korea	33	Hungary
Turkey	34	Turkey

Sources: 1980 data for Chile and Slovenia are from UNDESA. *2010 Revision of World Population Prospects*. United Nations Development Programme; 2011. www.un.org/en/development/desa/publications/world-population-prospects-the-2010-revision.html. Accessed December 23, 2013. All other data are from OECD. OECD Stat, (database); 2012. http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT. Accessed May 21, 2013.

*Estimate

**Latest year available for Canada is 2008

Note: Small differences in rank order may not be meaningful because a number of countries are tied at the same value; tied countries are ranked alphabetically.

Recommendations From the Robert Wood Johnson Foundation Commission to Build a Healthier America

We are a Commission whose members bring diverse backgrounds and experience, but one common focus: finding ways to achieve better health for all Americans. We have spent many months exploring the evidence on how to help people live longer, healthier lives. We have come to agreement on three major strategies for improving America's health that reach beyond medical care. We must make great strides in all three of these areas if we hope to dramatically improve the health of all Americans:

1

Make investing in America's youngest children a high priority. This will require a significant shift in spending priorities and major new initiatives to ensure that families and communities build a strong foundation in the early years for a lifetime of good health.

- Create stronger quality standards for early childhood development programs, link funding to program quality, and guarantee access by funding enrollment for all low-income children under age 5 in programs meeting these standards by 2025.
- Help parents who struggle to provide healthy, nurturing experiences for their children.
- Invest in research and innovation. Evaluation research will ensure that all early childhood programs are based on the best available evidence. Innovation will catalyze the design and testing of new intervention strategies to achieve substantially greater impacts than current best practices.

Research clearly tells us that children have a greater chance of achieving good health throughout life if they are raised in families that provide a well-regulated and responsive home environment, benefit from early supports that build resilience by mitigating the effects of significant adversity (such as chronic poverty, violence and neglect), and participate in high-quality early childhood programs. While much emphasis has been placed on the foundational importance of the early years for later success in school and the workplace, we are convinced that an environment of supportive relationships is also the key to lifelong physical and mental health.

2

Fundamentally change how we revitalize neighborhoods, fully integrating health into community development.

- Support and speed the integration of finance, health, and community development to revitalize neighborhoods and improve health.
- Establish incentives and performance measures to spur collaborative approaches to building healthy communities.
- Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation.

Historically, community development has focused on planning and building housing, schools, health clinics, and community facilities, but rarely on how the built environment can improve health and lives. People can make healthier choices if they live in neighborhoods that are safe, free from violence, and designed to promote health. Ensuring opportunities for residents to make healthy choices should be a key component of all community and neighborhood development initiatives. Where we live, learn, work, and play really does matter to our health. Creating healthy communities will require a broad range of players—urban planning, education, housing, transportation, public health, health care, nutrition and others—to work together routinely and understand each other’s goals and skills.

3

The nation must take a much more health-focused approach to health care financing and delivery. Broaden the mindset, mission, and incentives for health professionals and health care institutions beyond treating illness to helping people lead healthy lives.

- Adopt new health “vital signs” to assess nonmedical indicators for health.
- Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.
- Incorporate nonmedical health measures into community health needs assessments.

Health professionals have extraordinary expertise in treating disease and injury, but in most cases their training emphasizes “patient” care, not assessing all the factors that affect people’s lives and contribute to their overall health. That training also does not focus on integrating public health, prevention, and health care delivery or reward them for striving to address the foundations of lifelong health—factors such as education, access to healthy food, or safe housing—that shape how long or how well people live. A healthier America requires health professionals and institutions to broaden their mindset for improving health to include working with others outside of the traditional medical community. Collaboration with professionals in other sectors will enable an efficient use of shared resources to improve the opportunities for health that communities offer their residents. This shift will also require developing and using new measures of health, as well as designing and implementing reimbursement systems that reward providers for working together and taking other steps to be more effective in enhancing health, not just caring for the sick. To change the actions of health professionals and institutions, it is critical to change their incentives and training to foster improved health beyond the medical exam room.

We Must Act Now

Unless we act now, our nation will continue to fall farther behind, putting our health, economic prosperity, and national security at even greater risk.

- Nationally, nearly one in three children is overweight or obese.³
- As many as three in four Americans ages 17 to 24 are ineligible to serve in the U.S. military, primarily because they are inadequately educated, have criminal records, or are physically unfit.⁴
- Poor health results in the U.S. economy losing \$576 billion a year, with 39 percent, or \$227 billion, of those losses due to lost productivity from employees who are ill.⁵
- Medicare would save billions of dollars on preventable hospitalizations and re-admissions if every state performed as well as the top-performing states in key measures of health.⁶
- More than one-fifth of all U.S. children live in poor families, and nearly half of Black children live in particularly unhealthy areas of concentrated poverty.⁷
- Nearly a fifth of all Americans live in unhealthy neighborhoods that are marked by limited job opportunities, low-quality housing, pollution, limited access to healthy food, and few opportunities for physical activity.⁸

It is time to address these dismal facts. Recent decades have seen major advances in our understanding of how education, income, housing, neighborhoods, and exposure to significant adversity or excessive stress affect health. Our health-related behaviors are shaped by conditions in our homes, schools, workplaces, and communities. Every one of us must take responsibility for making healthy choices about what we eat, how physically active we are, and whether we avoid risky habits like smoking. But when it comes to making healthy decisions, many Americans face barriers that are too high to overcome on their own—even with great motivation.

We must take a clear look at who we are. The country is changing. We are undergoing an unprecedented shift in demographics related to age, race, and ethnicity. By 2043, the majority of U.S. residents will be people of color, who are disproportionately low-income and living in disadvantaged communities. In the U.S., low-income people and people of color generally experience the worst health for reasons that are preventable and that require actions beyond health care alone.

The bulk of this demographic shift is taking place within the population under age 18. At the same time, there are now more Americans age 65 and older than at any other time in U.S. history. The population of those age 65 and older jumped 15.1 percent between 2000 and 2010, compared with a 9.7 percent increase during that same period for the entire U.S. population.⁹ We are seeing a growing demographic divergence between the young and the old, with dramatic growth in the predominantly white older generation (age 65 and older), and a far more diverse younger population.¹⁰

Our recommendations are designed to improve the health of all Americans and to minimize barriers for Americans whose needs are more urgent. This is especially critical in the early childhood years, when children's lifelong behavioral and coping skills are heavily influenced by the environments in which they live. Low-income children must have the same opportunities to be healthy as all children in America, no matter where they live. Leaving them behind would put our nation's well-being and prosperity at great peril.

This report identifies roles that various sectors beyond health care—including business, government, community organizations, philanthropy, financial investors, faith leaders, and community planners—can play. All have a role.

We cannot build a healthier, more prosperous America without addressing the basic building blocks of health promotion and disease prevention. And we cannot continue to indulge in current levels of spending on medical care, especially for treating disease or conditions that could have been prevented. It is time to invest more wisely—in all areas that affect health. This is an investment in our future and generations to come.

Research must continue, but we know enough to act now.



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A child's experiences and environmental influences can affect his or her health well into adulthood.

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Photo: Jordan Gantz

Today's Economic Climate

The period between December 2007 and June 2009 was one of profound crisis for the economy, with the U.S. experiencing its longest and, by most measures, worst economic recession since the Great Depression. In 2007, the property market collapsed, triggering a near meltdown in the financial sector, and the deep recession thereafter saw the median American family lose 40 percent of its wealth.

In 2013, the nation's Gross Domestic Product (GDP) grew around 2.5 percent, and analysts considered recovery from the recession to still be weak. States have struggled to address extraordinarily large budget shortfalls, which have totaled more than \$540 billion combined from 2009 through 2012.¹¹ These shortfalls have been closed through a combination of spending cuts, withdrawals from reserves, revenue increases, and use of federal stimulus dollars.

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Federal budget cuts known as “sequestration” that took effect on March 1, 2013, were projected to impact state and local economies even further. The cuts are expected to reduce projected spending by \$1.2 trillion over the next nine years, split evenly between defense and non-defense spending. Sequestration sliced Head Start and Early Head Start budgets by nearly 5.3 percent, resulting in a services cut for more than 57,265 children and pay decreases or layoffs for more than 18,000 staff across the country, according to the U.S. Department of Health and Human Services.¹²

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Concerned about the country's economic viability, some political leaders have called for strong private-sector growth and entitlement reform. Rising health care-related entitlement costs at the federal and state levels are the fastest-growing components of public budgets. This puts pressure on “discretionary” programs like Head Start at the federal level and on early childhood education programs at the state level.

Those working to create policy change at the federal, state, and local levels must recognize that programs will need to work smarter, with fewer resources and smaller budgets. This will require innovation and collaboration between the public and private sectors, including businesses and philanthropy. Science can show where our dollars have the greatest potential to impact overall health. The country cannot continue spending at the expense of investing in our youngest children and in communities, which makes sense for a healthy future.

Shifting Demographics

America is in the midst of a seismic demographic shift. By 2043, the majority of U.S. residents will be people of color.¹³ Perhaps even more striking is the growing demographic divergence between the young and old, with dramatic growth in the predominantly White older generation (age 65 and older), and a far more diverse younger population. These changes carry tremendous import for policy as the country grapples with how to tackle significant economic strains while attempting to foster a healthy America for generations to come.

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Forty-six percent of today's youth are people of color. The fastest percentage growth is among multiracial Americans, followed by Asians and Hispanics. Non-Hispanic Whites make up 63 percent of the population; Hispanics, 17 percent; Blacks, 12.3 percent; Asians, 5 percent; and multiracial Americans, 2.4 percent. Minorities make up 46.5 percent of the under-18 population, according to the U.S. Census Bureau. By the end of this decade, the majority of youth will be people of color, and, by 2030, the majority of workers under age 25 will be people of color.¹⁴

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Contrast this with the fact that there are now more Americans age 65 and older than at any other time in U.S. history. The population 65 and older jumped 15.1 percent between 2000 and 2010, compared with a 9.7 increase during that same time period for the entire U.S. population. An overwhelming majority of today's seniors are White; just 20 percent are people of color.¹⁵

The America of the future will comprise a diverse young population alongside a largely White older generation. This will certainly affect the country's spending priorities and the creation of policies or programs designed to strengthen the nation as it grows. The challenge will be to create a workable balance that enables the country to be competitive now while preparing our young people to achieve health and success in the future.

We must make investments that will allow the country to maximize the potential of all its residents and create a foundation of health for generations to come. This includes investing in early childhood development, revitalizing communities, and ensuring that all children—especially low-income children—have the opportunities they need to thrive.

Recommendations

Efforts to improve health have often focused on changing how health care is delivered or reimbursed. But changes to health care alone will not lead to better health for most Americans. As a Commission, we have learned that there is far more to health than health care. Other factors such as education, income, job opportunities, communities, and environment are vitally important and have a bigger impact on the health of our population. We must address what influences health in the first place.

To improve the health of all Americans we must:

- **Invest in the foundations of lifelong physical and mental well-being in our youngest children;**
- **Create communities that foster health-promoting behaviors; and**
- **Broaden health care to promote health outside of the medical system.**

Recommendation 1:

Make investing in America’s youngest children a high priority. This will require a significant shift in spending priorities and major new initiatives to ensure that families and communities build a strong foundation in the early years for a lifetime of good health.

A child’s experiences and environmental influences can affect his or her health well into adulthood. Toxic stress caused by repeated or prolonged exposure to adversity can lead to physiological disruptions that increase the prevalence of disease decades later, even in the absence of later health-threatening lifestyles. These biological disruptions include elevated stress hormones that can impair brain circuitry, increased inflammation that can accelerate atherosclerosis and lead to heart disease, and increased insulin resistance that increases the risk of diabetes.

Sources of toxic stress include chronic poverty and various combinations of repeated abuse, chronic neglect, neighborhood violence, maternal depression, or a primary caregiver with a substance abuse problem. These factors may be present regardless of whether a child is poor or faces persistent economic insecurity.

There are many ways to protect children from these adverse effects, including fostering stable, nurturing relationships with the important adults in their lives; providing parents and other caregivers the supports they need to help children develop a wide range of capabilities; creating safe, supportive environments; and providing access to high-quality early childhood experiences and development programs.

We see growing demand—not only from families, educators, and public health officials, but also from champions in the realms of faith, science, economics and finance, business, and national security—to invest in healthy child development as an investment in America’s future.

The role of providing support for children and families cuts across sectors, including early childhood education, social services, public health, preventive health care, and family economic stability. But too often, their work is siloed. Cross-sector collaboration that adopts an integrated view of a child’s needs based on a unified science of development is critical to building a foundation for lifelong health. This collaboration should stretch widely, from maternal health to early learning to public health and community supports to child welfare to planning and zoning.

As a country, we invest significant dollars in K-12 education, health care, and support programs of various kinds. But when it comes to our youngest children, our nation’s budget does not match our values or the evidence. The U.S. ranks 25th out of 29 industrialized countries in public investments in early childhood education.¹⁶ We must change our spending priorities to ensure that America’s youngest children, from birth to age 5, get the best foundation for a healthy and productive life.

Current science is clear: If children experience toxic stress as a result of significant adversity during the period from birth to the time they enter school, when their brains and bodies are undergoing rapid development, their chances of a successful and healthy future are diminished. This lost opportunity has lifelong effects. We must make support for vulnerable young children a national priority.

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*Some communities are already giving high priority to spending on children—including **Denver** and **San Antonio**, where tax revenues are being earmarked to fund early childhood programs. **Minnesota** recently approved funding for early learning scholarships. And in Salt Lake City, **Goldman Sachs, United Way of Salt Lake**, and the **J.B. and M.K. Pritzker Family Foundation** have formed a partnership to create the first-ever social impact bond designed to expand access to early childhood education through the early Childhood Innovation Accelerator. **Oklahoma** has offered universal access to pre-kindergarten since 1998 and has one of the highest enrollment rates in the country, with 74 percent of all 4-year-olds attending a pre-K program. While the state does not provide specific funding for 3-year-olds, some Oklahoma school districts offer classroom programs for these younger students through a combination of funding sources, including Title I, Head Start, special education, and general district funds.*

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Create stronger quality standards for early childhood development programs, link funding to program quality, and guarantee access by funding enrollment for all low-income children under age 5 in programs meeting these standards by 2025.

Early childhood programs can serve as building blocks for a lifetime of good health, yet access to high-quality programs is inconsistent. Only a small fraction of low-income children are in high-quality programs. They aren't always available, and, when they are, either space is limited or parents are unable to afford them.

State and federal agencies, such as the U.S. Department of Health and Human Services and the Department of Education, should create, strengthen, and enforce quality standards that look beyond the provision of rich learning experiences and include interventions designed to improve health and protect the developing brain from significant adversity that can lead to illness.

While several Head Start performance standards are related to health, state-based early childhood programs seldom assess this dimension, and almost all currently focus on access to health services rather than protection against adversity.

The vast majority of early childhood programs are designed primarily to improve children's readiness for school and later educational success. Although educational attainment is associated with better health later in life, early childhood programs could have a more direct impact on reducing later disease by building the resources and capacities of parents and other caregivers to promote resilience in young children by strengthening their ability to cope with adversity.

New quality standards should address the dangers of toxic stress factors by aiming to reduce its sources and strengthen the adult-child relationships that mitigate its adverse consequences. Prevention efforts are generally aimed at adults and adolescents, but they may actually be most effective in the earliest years.

High-quality programs are essential but not sufficient if all children do not have access to them. In 2011, the U.S. Department of Health and Human Services implemented tougher rules for low-performing Head Start grantees, requiring those who fail to meet specific benchmarks to re compete for continued federal funding. This is one good example of a federal program that is working to address the variable quality of existing programs. A strengthened, improved Head Start should be embraced as a model for others.

We must invest in early childhood programming as seriously as we do in education for children beginning at age 5. This will require reprioritizing programs, and redirecting existing funds from programs that are underperforming or of a lower priority. For example, funding for Head Start or other programs that fail to meet performance standards should be redirected to other early childhood development initiatives that clearly demonstrate their ability to provide high-quality services. No one funding stream can respond to this need. All funding sources—federal, state, community, philanthropy, and private sector—should be tapped.

In a time of economic constraints, all programs and initiatives should be examined for efficiency and strength of outcomes to ensure that we are investing as wisely as possible to meet children's current needs. This includes entitlement programs that can be difficult to sustain and can crowd out spending on other discretionary programming. For example, at the state level, pension programs should be examined for

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Early childhood programs can serve as building blocks for a lifetime of good health, yet access to high-quality programs is inconsistent.

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Photo: Tyrone Turner

opportunities for greater efficiency and accountability, and for other reforms to help assure that funds are available to support early childhood education.

When the amount of dollars available is finite, the country is forced to prioritize its spending. It is imperative that the country, for both fiscal and moral reasons, put our youngest children first and invest in initiatives that we know will lead to a healthier, stronger America tomorrow. We must invest in our future and we urge prioritizing early childhood programs in difficult decisions about how we spend our money now.

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***Educare** is a network of state-of-the-art, full-day, year-round schools across the country that provide at-risk children from birth to age 5 with comprehensive programs and instructional support that build skills and lay the foundation for successful learning. The goal is to prepare children who are growing up in poverty to enter kindergarten on a par with children from middle-income families. Each Educare network offers unique features tailored to meet the needs of young children and their families in the local community. For example, four Educare schools include or are directly adjacent to on-site health clinics. Additionally, two Educare schools are linked to elementary schools with on-site health clinics. Many provide dental screening, additional nutrition efforts (e.g., “Educook” at Educare Omaha), and efforts to counter obesity.*

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Help parents who struggle to provide healthy, nurturing experiences for their children.

While high-quality early childhood programs help children develop, even children who have access to them spend the majority of their time at home. These settings need to be as supportive and growth-promoting as possible. Some parents may lack the knowledge, capabilities, or resources to provide well-regulated and responsive home environments. Others may not be able to maintain economically stable and secure households. Economic stability is a major factor that can affect early childhood development. Some children live in homes where the stresses of daily life, work, and child rearing make a well-functioning home environment difficult to achieve.

These stresses can be high in single-parent families, where there may be fewer resources. However, they may occur even in families that are not as constrained by resources. Children who are exposed to chronic adversity and unsafe environments—such as personal abuse or violence at home or in their neighborhoods—experience constraints on all domains of their development (including cognitive, physical, social, and emotional opportunities) and are more likely to experience health problems later in life.

Communities should have informal supports and programs that can strengthen families and help them break the cycle of disadvantage that is often passed across generations. For example, child welfare agencies could address the adult impairments in physical and mental health that they encounter through external referral or integrated child-parent services.

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*Boston’s **Crittenton Women’s Union** helps create pathways to economic independence for low-income women and their families by providing comprehensive services, including transitional and supportive housing; job-readiness training; and mentoring services in self-sufficiency. In Los Angeles, **Preschool Without Walls** employs a two-generation approach, engaging parents to serve as their children’s first and lifelong educators by teaching them how to improve their children’s school readiness.*

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Invest in research and innovation. Evaluation research will ensure that all early childhood programs are based on the best available evidence. Innovation will catalyze the design and testing of new intervention strategies to achieve substantially greater impacts than current best practices.

Advances in neuroscience on the biological consequences of significant adversity are radically changing our understanding of how early childhood influences affect lifelong health. Research tells us that children are active learners as soon as they are born, yet public education often does not start until kindergarten. A child’s future depends on both education and health, yet approaches to both are siloed.

Family Structure

The number of two-parent households in the United States has been declining for the past several decades, profoundly affecting the middle class, and our nation's children and their ability to thrive.¹⁷ Over the past 50 years, the income inequality between dual-income and single-income families has grown dramatically. Median incomes among families led by single dads and single moms have stayed the same or declined, falling behind those of married couples. Marital status may account for as much as 40 percent of the growth in income inequality nationally.¹⁸

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*One in five American children is raised in a household headed by a single mother, with another 7 percent raised by a single father. This phenomenon is more common among American-born Hispanics, American Indians and Blacks: More than 50 percent of Hispanic babies and 72 percent of Black babies are born to unwed mothers.*¹⁹

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The decline in marriage is taking place almost exclusively among the poor. Research shows that children raised by single parents are more likely to drop out of high school, be unemployed as teenagers, and less likely to enroll in college.²⁰ Children in single-parent families are more than three times as likely to be poor as children raised in two-parent households. In 2011, 42 percent of children in single-parent families were poor,

compared with 13 percent of children in two-parent families.²¹ Both education and income are linked to better health and longevity.

The dramatic increase in rates of single-parent households has paralleled increases over time in unemployment, underemployment, and low wages among men with low educational attainment. Achieving higher rates of two-parent, married families may require improving educational and employment opportunities for young men as well as women.

Research indicates that improving economic opportunities for males promotes marriage. Experience in the military backs this up. Compared with civilians, men in active-duty military service have higher rates of marriage versus cohabitation, greater likelihood of first marriage, and more stable marriages. These patterns hold for both Black and White men, but are stronger for Blacks than for Whites. This has been associated with opportunities in the military for stable employment, economic mobility, housing, daycare centers, and school-age activity centers.²²

Children in single-family households need not be consigned to a poor start in life, and can indeed thrive. Strong social and family supports, such as high-quality early childhood programs, job and parental skill training programs, and healthy communities that foster healthy choices, can greatly improve a child's opportunities for success.

It is vital that we incorporate 21st-century scientific knowledge into the development of all supports designed to improve early childhood development. Government and private funders, including philanthropy and business, have an important role to play in ensuring that the best science informs both the scaling of high-quality programming and the development of new ideas. Advances in scientific research have dramatically changed our understanding of how children’s brains develop and how toxic stress can also affect other maturing organs and metabolic regulatory systems in a way that can influence short-term, biological responses and long-term health outcomes later in life. Yet little of this knowledge has been applied in practice. In order to correct this shortcoming, it is critical that we expand our definition of evidence to include scientific concepts that can inform new program models. Success in this endeavor will require an innovation-friendly environment that catalyzes fresh thinking, supports risk-taking, and recognizes the value of learning from interventions that don’t work.

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*The Adverse Childhood Experiences (ACE) study, a collaboration between researchers at the **U.S. Centers for Disease Control and Prevention** and **Kaiser Permanente**, was among the first to establish strong links between adverse early childhood experiences and lifelong mental and physical health conditions, including depression, addiction, heart disease and diabetes. The study, which has involved over 17,000 participants, assesses exposure to 10 categories of early childhood trauma or toxic stress. The higher the score, the greater the exposure, and the greater the risk of negative consequence. In May 2013, the **Institute for Safe Families** and the **Robert Wood Johnson Foundation** hosted the first national summit of professionals who are using the biology of stress and research on adverse childhood experiences to encourage social workers, police, educators, doctors, nurses, and others to apply this knowledge in their work.*

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Photo: Tyrone Turner

Recommendation 2:

Fundamentally change how we revitalize neighborhoods, fully integrating health into community development.

There is significant opportunity to dramatically improve the health of our nation by improving the neighborhoods where we live, learn, work, and play. While the Commission believes that efforts should be made to improve the health of all communities, we must prioritize communities where low-income Americans lack opportunities to make healthy choices.

Nearly one-fifth of all Americans live in low-income neighborhoods that offer few opportunities for healthy living. In these neighborhoods, job opportunities are scarce; access to adequate housing and nutritious food is poor; and pollution and crimes are prevalent. These factors have a tremendous impact on health.²³

There is a broad ecosystem of organizations that serve the same “customer,” “client,” or “patient” living in the same neighborhood, but seldom work together to meet that person’s different needs. This includes the public health and community development fields, as well as those organizations that focus on directly improving the health of community residents by connecting them to community supports such as job training, counseling, or child care services. Community leaders can play a vital role in identifying common ground among different organizations and helping catalyze changes that are tailored to meet the needs of the community.

For the past 50 years, the community development sector—made up of nonprofit neighborhood improvement agencies; real estate developers; financial institutions; foundations; and government—has worked to transform impoverished neighborhoods into economically viable communities by planning and building roads; child-care centers; schools; grocery stores; community health clinics; and affordable housing.

But creating healthier communities and lives requires considering the health impacts of all aspects of community development and revitalization, and ensuring that a broad range of sectors work together toward shared goals. This will result in less duplication of effort and smarter use of resources. It will require leadership and action from people who work in public health and health care; education; transportation; community planning; business; and other areas. Public health professionals can provide the “health lens” for community decision-makers. The increased use of health impact assessments provides an example of how this can work.

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Concerned about the effect of high energy costs on children’s health in the wake of Hurricane Katrina, Boston-based pediatricians and researchers conducted a health impact assessment (HIA) to explore the tradeoffs that low-income families face in paying utility bills, the safety risks of using unsafe heating sources, and how health is affected when families are forced to move to lower-quality housing because of high utility bills. The HIA helped policy-makers understand the connection between energy costs, children’s health, and potential Medicaid cost increases. As a result, the state increased funding for the Low Income Energy Assistance Program, and advocates in Rhode Island used the report to advocate for similar changes there.

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Support and speed the integration of finance, health, and community development to revitalize neighborhoods and improve health.

A broad range of organizations work to improve low-income communities. Yet too often, these organizations work separately from each other. To strengthen their efforts and make better use of scarce financial resources, they must work together.

The community development sector should work closely with the public health sector, which offers a nationwide network of health departments and public health workers—along with evaluation and research tools—to help improve coordination among cross-sector efforts.

Ways to support and speed integration include:

- Requiring cross-sector collaboration as a condition of funding.
- Establishing and supporting a nationwide communications network that connects professionals across fields, facilitating collaboration to achieve healthy communities.
- Supporting a platform or clearinghouse where examples, models, evidence-based tools, and metrics can be found and shared.
- Creating a national partnership to support and catalyze work at the intersection of community development and population health.
- Building capacity to offer cross-sector training to increase mutual understanding of each field’s approaches, business models, strengths and weaknesses, and uses of financing and policy.
- Developing skills needed for successful collaboration, including ways to engage the community in planning; coalesce around aims; negotiate across vested interests; and tackle policy and financial barriers.
- Broadly promoting successes of cost-effective models for cross-sector collaboration.

Meaningful, needle-moving outcomes will not be achieved without these kinds of efforts. While some effective cross-sector collaboration is beginning to occur, much more is needed.

To encourage greater collaboration, other leaders—from federal, state, and local departments of housing, transportation, health, and education; private and public financial institutions; philanthropies; and business, agriculture, and community development professionals—should launch similar efforts and support ongoing collaborative mechanisms.

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*The **National Prevention Council**—comprising 20 federal departments and agencies committed to supporting healthy and safe community environments, and clinical and community preventive services—is working to eliminate health disparities. At the local and regional levels, the **Partnership for Sustainable Communities**—cutting across the U.S. Department of Housing and Urban Development, the U.S. Department of Transportation and the Environmental Protection Agency—funds neighborhood development in more environmentally and economically sustainable ways.*

*In **Seattle**, public health and housing leaders are working together to reduce allergens in low-income homes to better control asthma. In **Richmond, Va.**, **Bon Secours Health System** has partnered with the **Local Initiatives Support Corporation** to revitalize the **Church Hill** neighborhood, supporting development of a trash service, coffee shop, a bakery, a hair salon, and a janitorial service. And the **Federal Reserve**, along with the **Robert Wood Johnson Foundation** and others, have held a series of conferences to encourage collaboration between the health and community development sectors.*

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Establish incentives and performance measures to spur collaborative approaches to building healthy communities.

Maintaining current federal funding streams that support community improvements and improved health is vital, but new policy and financing incentives also are needed to break down the silos between health and community improvements.

To encourage more effective collaboration, we must promote balance when an investment of money or resources by one sector generates savings for another. For example, investments in transportation or housing can improve health and generate cost savings to the health care system. One sector invests, but another benefits. Working together provides an opportunity for negotiating how both can benefit. In this case, a portion of the health care savings could be re-invested in additional health-promoting neighborhood improvements to create a virtuous cycle of cost savings and health improvement.

Changes in public- and private-sector financial and policy incentives are needed to reward collaboration and to incorporate health improvement strategies into community improvements. Incentives should be tied to demonstrable improvements in areas that affect health, such as improved housing or access to healthy food. Incentives should also be designed to spur private investment and innovation from many sources, including social entrepreneurs and socially motivated investors.

Incentives and cross-sector work will also require new measures that document benefits and are strong enough to affect significant outcomes. They go hand in hand with offering incentives.

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*The **Healthy Futures Fund** developed by **Morgan Stanley**, the **Kresge Foundation**, and the **Local Initiatives Support Corporation** is encouraging community development organizations and community health care providers to collaborate using Low Income Housing Tax Credit equity and an innovative New Markets Tax Credit structure to drive economic development that helps improve health outcomes. The project will support development of 500 housing units with integrated health services and eight new federally qualified health centers through a \$100 million initial investment.*
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Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation.

Public and private funders should invest in integrated approaches that show promise or have demonstrated results in creating healthier communities. This will require developing new funding streams, reducing barriers to maintaining and integrating existing funding streams, and promulgating a shared vision of what constitutes success.

It is important to invest in what works, but it is equally critical to fund continued innovation so that a healthy community development field can evolve. For example, public and private funders could establish an innovation fund for community improvement that could be modeled on the Center for Medicare & Medicaid Innovation, which supports the development and testing of innovative health care financing and service delivery models.

While seeking to scale up or replicate promising models, we must recognize that there is no “one-size-fits-all” approach. Communities must determine their own challenges and opportunities and borrow from the best examples, such as Promise Neighborhoods, a U.S. Department of Education program that seeks to improve educational outcomes for students in distressed urban and rural neighborhoods, and Purpose Built Communities, a nonprofit that rebuilds struggling neighborhoods.

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*Instead of attacking poverty, urban blight, and failing schools piecemeal, a group of community activists and philanthropists in Atlanta took on all of these issues at once, becoming the model for **Purpose Built Communities**. All of the distressed public housing units were demolished and replaced with new apartments, half of which are at the market rate. The neighborhood, which once had 1,400 extremely low-income residents, is now home to 1,400 mixed-income residents. As a result of these efforts, the employment rate of low-income adults increased from 13 percent to 70 percent. The neighborhood’s Drew Charter School moved from last to first place among 69 Atlanta public schools and violent crime dropped by 90 percent. The model has been replicated in eight additional communities so far.*

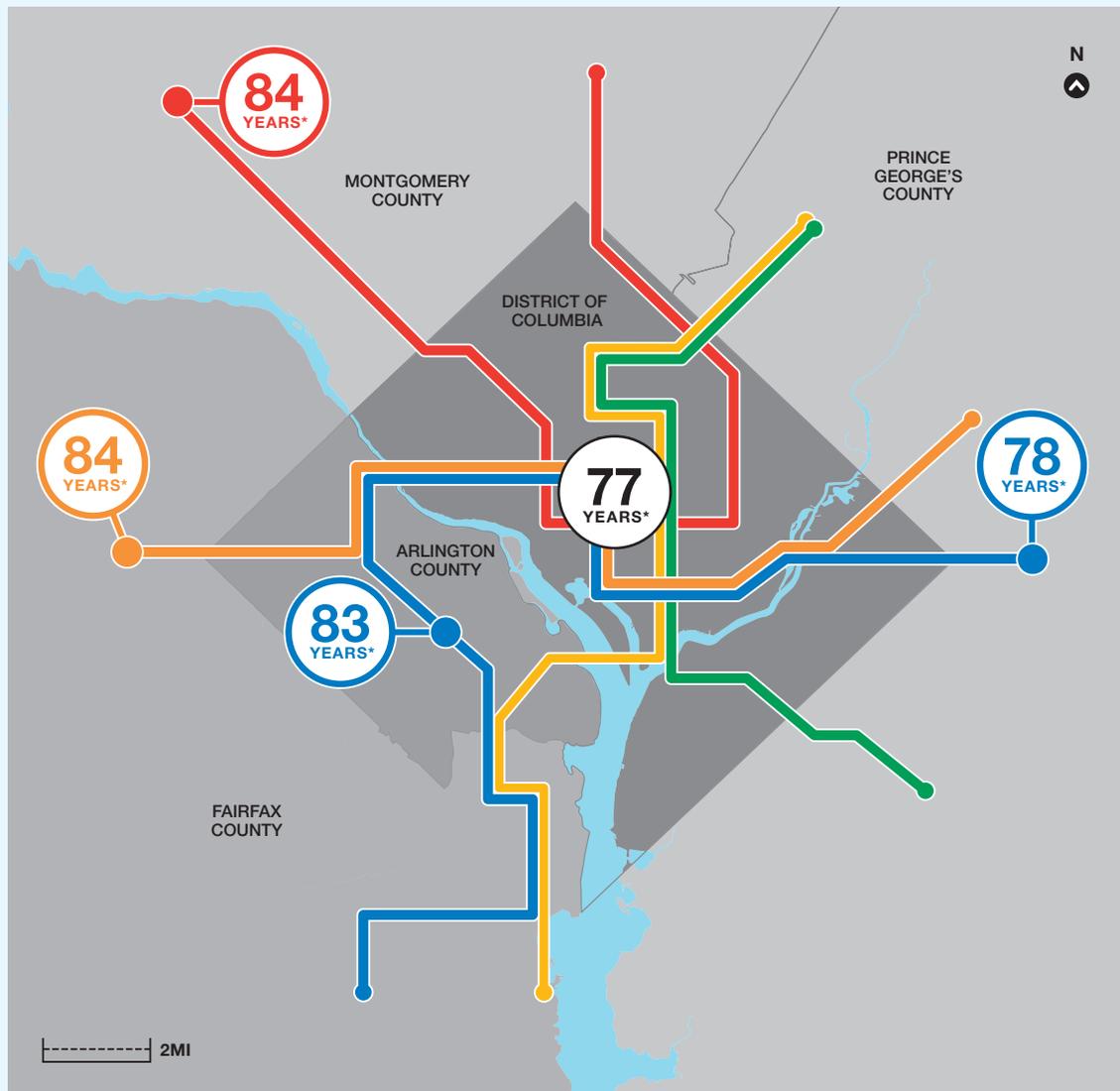
*Another promising model is the \$18 million **ReFresh** “healthy food hub” that **Goldman Sachs**, **JPMorgan Chase**, and **L+M Development Partners** funded in New Orleans with the **Low Income Investment Fund**. Aiming to eliminate food deserts, the effort created a small-format Whole Foods Market offering lower prices, kitchens and facilities for local healthy food enterprises and culinary educational institutions, office space for a local charter school organization, and 10,200 square feet of retail space.*

*For more than 20 years, **Living Cities, Inc.**, has worked to improve the lives of low-income people and the cities where they live by bringing together 22 of the world’s largest foundations and financial institutions to invest in health and community development. The collaborative comprises 20 partners—including the **Citi Foundation**, **Morgan Stanley**, the **Kresge Foundation**, the **Robert Wood Johnson Foundation**, and **Prudential Financial, Inc.**—who have collectively invested nearly \$1 billion in dozens of communities across the country to build homes, schools, clinics, and other community facilities.*
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WASHINGTON, D.C.:

Short Distances to Large Disparities in Health

figure 2 Babies born to mothers in Maryland's Montgomery County and Virginia's Arlington and Fairfax Counties can expect to live six to seven years longer than babies born to mothers in Washington, D.C.—just a few subway stops away.



Source: Prepared by Woolf et al., Center on Human Needs, Virginia Commonwealth University using Centers for Disease Control and Prevention, National Center for Health Statistics, CDC WONDER Online Database, released January 2013. Data are compiled from Compressed Mortality File 1999–2010 Series 20 No. 2P, 2013, <http://wonder.cdc.gov/cmfi-icd10.html>.

*Life expectancy at birth

Recommendation 3:

The nation must take a much more health-focused approach to health care financing and delivery. Broaden the mindset, mission, and incentives for health professionals and health care institutions beyond treating illness to helping people lead healthy lives.

As health care becomes more personalized and prevention-oriented, our nation requires a new approach to health that emphasizes overall well-being and assesses *all* factors in a person's life, even when a person is seeking treatment for *one* specific symptom or illness. Financial incentives are being used to move away from traditional fee-for-service payment to focus on increasing quality while reducing costs. In addition, current health care law changes contain elements that enable initiatives to focus on prevention and keeping people well in the first place. Health professionals, institutions, and payers are recognizing the need to address nonmedical causes of poor health in the places where we live, learn, work, and play.

Health care alone cannot ensure good health. Nonmedical factors play a significant role as well. Health professionals must take an active role in helping their patients become and stay healthy outside of a clinic, hospital, or health care practice by recognizing their nonmedical needs and prescribing referrals that can help patients connect to social or economic resources. For example, a patient may not take insulin as prescribed because he or she has no transportation to get to a pharmacy, or no way to refrigerate it. Other patients may be unable to follow recommendations to eat more fruits and vegetables because they can't get to a supermarket or afford the food.

Under a broader approach that emphasizes overall well-being, a health professional could offer a referral to a transportation service or vouchers to a nearby farmers' market to obtain healthy food.

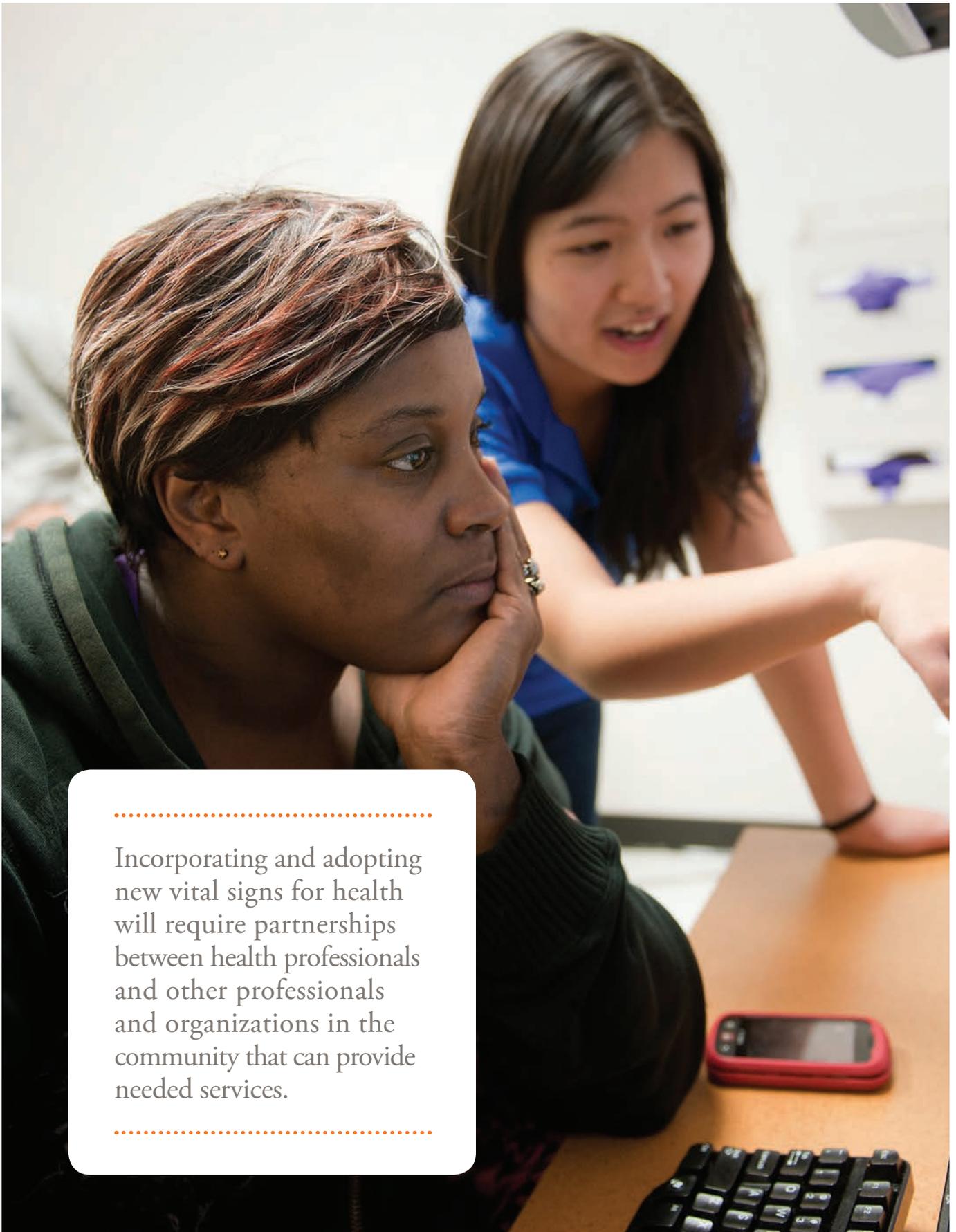
Connecting patients to supports in the community will require closer links between health care institutions and professionals with public health, social services, and other resources.

This will help form a much-needed bridge between health and health care. For example, health professionals should assess whether patients have access to healthy food; safe and healthy housing; educational opportunities; and job skills training or jobs, and prescribe services in the community that can help address identified needs. This will require training health professionals to identify and address the realities of patients' lives that directly impact health outcomes and costs, and to understand the importance of connecting patients to the community resources they need to be healthy.

Adopt new health “vital signs” to assess nonmedical indicators for health.

Clinical vital signs include heart rate, blood pressure, temperature, weight, and height. But other, nonmedical vital signs—such as employment, education, health literacy, or safe housing—can also significantly impact health. Health professionals and health care institutions must incorporate these new vital signs into their routines to broaden their understanding of factors affecting their patients' health.

Incorporating and adopting new vital signs for health will require partnerships between health professionals and other professionals and organizations in the community that can provide needed services. For example, if a health professional issues a prescription for a healthier diet, that practitioner should be able to direct the patient to a program or service that can fill that prescription. Coordination will be essential for linking patients to services that cannot be provided in the medical office.



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Incorporating and adopting new vital signs for health will require partnerships between health professionals and other professionals and organizations in the community that can provide needed services.

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Photo: Matthew Moyer

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Health Leads, a national health care organization, enables physicians and other health professionals to systematically screen patients for food, heat, and other basic resources that patients need to be healthy and “prescribe” these resources for patients. Patients then take the prescriptions to a Health Leads desk in the clinic, where a corps of well-trained and well-supervised college student advocates “fill” the prescriptions, working side by side with patients to access existing community resources. Health Leads advocates also provide real-time updates to the clinical team on whether a patient received a needed resource, resulting in better-informed clinical decisions. Health Leads operates in 23 clinics—pediatric and prenatal, newborn nurseries, adult primary care, and community health centers—across six geographic areas, all with significant Medicaid patient populations.

The **Medical-Legal Partnership** operates in 38 states to remove barriers that impede health for low-income populations by integrating pro bono legal professionals into care teams to intervene with landlords, social service agencies and others to address health-harming conditions ranging from lack of utilities to bedbugs to mold in rental properties to accessing needed school support services for children.

Medicare’s Care Transitions program—developed by Denver geriatrician and MacArthur Foundation “genius grant” winner Eric Coleman—helps prevent hospital re-admissions by addressing the medical and mental health needs of recently discharged patients with a focus on the determinants of health that often trigger unnecessary re-admissions.

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Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.

The Affordable Care Act will accelerate the use of new physician payment mechanisms and incentives, including paying more to providers who deliver better outcomes at a lower cost. Some public and private insurers are already moving in this direction. Government and private insurers should further expand payment reform innovation to include incentives and measures that relate to identifying and addressing nonmedical factors that affect patient health. Such incentives should also reward health professionals, hospitals, and other health care institutions for screening patients for social needs related to health and working with community partners to link patients with resources appropriate to their needs in the community.

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Some insurers have already broadened their work to address nonmedical factors. For example, the **Oregon Medicaid** program has implemented coordinated care organizations, which are similar to accountable care organizations, to facilitate collaboration between health care and social services providers, with the goal of improving community health. In Minnesota, the **Hennepin Health Accountable Care Organization**—created as part of an early Medicaid expansion—is linking Medicaid health services and county-provided social services, such as housing and employment counseling in its **Prescription for Health** program. The federal **Center for Medicare & Medicaid Innovation** has issued a request for proposals for innovative payment systems at the regional or community level that may spur new, more cost-effective ways of paying for and improving population health.

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As a part of engaging public health experts and individuals representing the broad interests of the community, as the law requires, hospitals should engage community leaders and planners, government partners, social services professionals, and others in identifying better ways to address nonmedical factors that can have either adverse or positive impacts on health.

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Incorporate nonmedical health measures into community health needs assessments.

Under current law, all nonprofit hospitals must conduct a community health needs assessment every three years and develop an implementation strategy to address identified needs. The U.S. Centers for Disease Control and Prevention (CDC) recommends that assessments include collecting and using information on social determinants of health.

As a part of engaging public health experts and individuals representing the broad interests of the community, as the law requires, hospitals should engage community leaders and planners, government partners, social services professionals, and others in identifying better ways to address nonmedical factors that can have either adverse or positive impacts on health. The Community Guide by the CDC provides a menu of recommended community interventions.

Examples include establishing measures, such as access to high-quality early childhood programs; recreation centers; job training; or mental health services. The needs assessment also could include community characteristics, such as levels of pollution; job opportunities; or safe public spaces that promote physical activity.

Assessment alone is not sufficient. Hospitals should be strategic and invest in specific community improvements identified through the needs assessment. Especially important are investments to improve access to high-quality early childhood and family support programs and initiatives to foster healthy community development, building a bridge between individual health and community health.

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***Boston Children’s Hospital** launched “Healthy Children. Healthy Communities” as a first step toward improving community health. Boston Children’s Hospital partners with the community to merge the medical model of care (patient care, research, and teaching) with a public health model of care (prevention, education, and advocacy), in order to offer needed programs and services. **Nationwide Children’s Hospital in Columbus, Ohio,** launched “Healthy Neighborhoods, Healthy Families” to remove barriers to the health and well-being of families by targeting affordable housing, health and wellness, education, safe and accessible neighborhoods, and workforce and economic development. **Children’s Hospital Medical Center in Cincinnati** has partnered with community groups to address asthma, accidental injuries, and poor nutrition in the community. And **Seattle Children’s Hospital** partnered with community residents and community organizations to develop the “Livable Streets Initiative.”*

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A Call for Leadership and Collaboration



“Achieving better health requires action by both individuals and by society. If society supports and enables healthier choices—and individuals make them—we can achieve large improvements in our nation’s health. Too often, we focus on how medical care can make us healthier, but health care alone isn’t sufficient. We need to cultivate a national culture infused with health and wellness—among individuals and families and in communities, schools and workplaces.”

—RWJF Commission to Build a Healthier America, 2009

Opportunities to Advance a Culture of Health

Creating a culture of health where children have the opportunity to grow up healthy and communities offer opportunities for all to make healthy choices requires involvement from all of us—individuals, thought leaders, business leaders and community developers, education leaders and policy-makers. All have a role to play in ensuring that health is not only a core value, but that health is strengthened by working together, with a common vision.

As a Commission, we outline three critical areas in which leadership and collaboration are needed and offer specific action steps that partners—many of them outside of health care—can take to move the country toward a culture of health.

Recognizing that every community has different assets and challenges, each community must forge its own way forward. Throughout this report, we provide examples of opportunities for leadership and change from around the country, which include:

- Healthy Communities cross-sector work launched by the Federal Reserve Bank of San Francisco between community development and health.
- The U.S. Green Building Council’s movement to show how green building can advance health and well-being through better use of healthy materials, access to healthy food

and clean fresh air and water, and design that encourages physical activity.

- The Low Income Investment Fund’s change in mission and investment strategy to better incorporate health into its work.

This report identifies opportunities for action, highlighting examples of where change is needed and how cross-sector collaboration can make it happen. It identifies opportunities that can be pursued at the local, state, and national levels, across all sectors. Cross-sector collaboration is a strong, swift, and efficient strategy to employ toward improving health.

It is also important to note that individuals from different generations have roles to play in advocating and working for changes to improve health. Recognizing the necessity of good health for future generations, older Americans can

take the lead in demanding that policy-makers invest in health. Young people can also play a powerful role—using new advocacy and communications tools—to help others understand how integral health is not only now but for future generations. While each of us has a personal responsibility to make choices that support good health for ourselves and our families, we as individuals can also catalyze others to do the same and spur larger groups to remove barriers to good health. Every family wants to do right by its children, but some families need greater support to make this happen.

The following section identifies opportunities for improving health, by sector:

Private Sector

- **Businesses and employers** can invest in making their communities healthier places to live and work, recognizing the long-term economic benefits.
- **Financial institutions** can incorporate health improvements into their investment strategies, recognizing the long-term return from investing in early childhood education and creating communities that promote health.
- **Health professionals and institutions** can adopt new vital signs for health and connect patients with services and resources.
- **Health payers** can restructure financial incentives to reward health promotion, not just disease management.

Public Sector

- **State and local government** can make early childhood development a high priority and offer financial and policy incentives for investments in communities that create healthy choices.
- **Federal and state government** can maintain funding streams; continue to lead the way in cross-sector collaboration; streamline reporting requirements; and provide financial incentives for innovation, as well as guard against automatic health care spending, while shifting focus to other areas that greatly impact health.
- **Public health agencies, organizations, and state health departments** can share best practices and partner with other groups to integrate health into efforts outside of health care.
- **Public health care payers** can use financial incentives to reward health promotion.

Nonprofit Sector

- **Advocacy organizations at all levels—local, state, and national**—can demand quality early childhood programs and opportunities, and mobilize cross-sector collaboration to share resources in support of common goals.
- **Community leaders** are particularly critical in advocating for local residents. They often operate from a place of trust and can spur people to action. They uniquely understand local needs, challenges, and potential solutions.
- **Philanthropic institutions** can identify and support innovative models of cross-sector collaboration that integrate health, community building and design, joining with new partners in supporting demonstrations, and recognizing the need for risk-taking in new ventures.
- **Faith leaders** can serve as respected voices in their communities, teaching community members about the value of health.
- **Nonprofit hospitals** can use community benefit assessments to identify ways to improve the overall health of the community.
- **Community development practitioners** can consider health improvement as one goal of their work, seeking out new partners and ensuring that every investment in a low-income community promotes health.
- **Education and early childhood development program leaders** can integrate the latest science into their trainings and curricula, help raise awareness of what constitutes “high-quality” early childhood development, and demand high performance.

Academia

- **Research institutions and universities** can train leaders in developing healthy communities, help create new data and metrics for cross-sector collaboration, and serve as clearinghouses for data. They can also train health professionals to recognize and address the social factors that affect health as part of overall patient care.

Resources

Adverse Childhood Experiences Study
www.cdc.gov/ace/ind

**American Academy of Pediatrics:
A Public Health Approach to Toxic Stress**
www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Pages/Public-Health-Approach.aspx

Basics for Health
<http://basicsforhealth.ca/>

Bon Secours Health System
www.eastendvision.org/home.html?

Boston Children's Hospital
www.childrenshospital.org

**Bright From the Start: Georgia
Department of Early Care and Learning**
<http://decal.ga.gov/>

**The California Endowment:
Building Healthy Communities**
www.calendow.org/healthycommunities

Calvert Foundation
www.calvertfoundation.org

Child First
www.childfirst.com

**Center on the Developing Child at
Harvard University: National Scientific
Council on the Developing Child**
<http://developingchild.harvard.edu/activities/council/>

County Health Rankings and Roadmaps
www.countyhealthrankings.org

Crittenton Women's Union
www.liveworkthrive.org

Denver Preschool Program
www.dpp.org

Educare Schools
www.educarenschools.org/home/index.php

Head Start Performance Standards
<http://eclkc.ohs.acf.hhs.gov/hslc/standards/Head%20Start%20Requirements/1304/1304.20%20Child%20Health%20and%20developmental%20services..htm>

Healthy Futures Fund
<http://kresge.org/news/100-million-investment-fund-integrate-health-care-affordable-housing-low-income-communities>

**Health in All Policies: Seizing
Opportunities, Implementing Policies**
www.hiap2013.com

Health Leads
<https://healthleadsusa.org/>

**Hennepin Health Accountable Care
Organization**
www.hennepin.us/healthcare

ISAIAH
<http://isaiahmn.org/>

Jobs for the Future
www.jff.org

Joint Center Place Matters
www.jointcenter.org/hpi/pages/place-matters

Kaiser Permanente
<https://healthy.kaiserpermanente.org/html/kaiser/index.shtml>

Kresge Foundation
<http://kresge.org/programs/community-development>

Living Cities
www.livingcities.org

Local Initiatives Support Corporation
www.lisc.org

Low Income Investment Fund
www.liifund.org

Magnolia Place
www.magnoliaplacela.org

Medical-Legal Partnership
www.medical-legalpartnership.org

Medicare Care Transitions
<http://innovation.cms.gov>

Mercy Housing
www.mercyhousing.org

**Minnesota Early Learning Foundation:
Saint Paul Early Childhood
Scholarship Program**
www.melf.nonprofitoffice.com/index.asp?Type=B_BASIC&SEC=%7B8868E9AD-3850-4506-9D5A-6E230A5C6A73%7D

**National Association for the Education
of Young Children: A Call for Excellence
in Early Childhood Education**
www.naeyc.org/policy/excellence

**National Institute for Early Education
Research: Abbott Preschool Program
Longitudinal Effects Study**
<http://nieer.org/publications/latest-research/abbott-preschool-program-longitudinal-effects-study-fifth-grade-follow>

**National Institute for Early Education
Research: The State of Preschool
2011—Oklahoma**
<http://nieer.org/sites/nieer/files/Oklahoma.pdf>

National Prevention Council
www.surgeongeneral.gov/initiatives/prevention/about/index.html

**Nationwide Children's Hospital:
Healthy Neighborhoods, Healthy Families**
www.nationwidechildrens.org/healthy-neighborhoods-healthy-families

Neighborhood Centers, Inc.
www.neighborhood-centers.org/en-us/default.aspx

**Partnership for a Healthier America:
Play Streets**
<http://ahealthieramerica.org/play-streets/>

Partnership for Sustainable Communities
http://thedataweb.rm.census.gov/TheDataWeb_HotReport2/EPA2/EPA_HomePage2.html

Pennsylvania Pre-K Counts
www.pakeys.org/pages/get.aspx?page=Programs_PreKCounts

Purpose Built Communities
<http://purposebuiltcommunities.org/>

**Save the Children: Early Steps
to School Success**
www.savethechildren.org/sitec.8rKLIXMGlp4E/b.8193011

Seattle Children's
<http://construction.seattlechildrens.org/2011/03/livable-streets-initiative-gathers-momentum/>

StriveTogether
www.strivetgether.org

**United Way of Salt Lake: Innovation
Accelerator**
www.uw.org/news-events/news/pritzker-goldman-sachs.html

U.S. Green Building Council
www.usgbc.org

YouthBuild USA
<https://youthbuild.org/>

References

1. Braveman P and Egerter S. Overcoming Obstacles to Health in 2013 and Beyond. Princeton, NJ: Robert Wood Johnson Foundation, 2013.
2. Centers for Medicare & Medicaid Services, www.cms.gov/Research-StatisticsData-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. Accessed November 11, 2013.
3. Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of obesity and trends in body mass index among U.S. children and adolescents, 1999-2010. *Journal of the American Medical Association*. 2012;307(5):483-490.
4. *Ready, Willing, and Unable to Serve*, Mission Readiness. www.missionreadiness.org/2009/ready_willing/. Accessed November 15, 2013.
5. *Poor Health Costs U.S. Economy \$576 Billion According to the Integrated Benefits Institute*. PR Newswire; September 12, 2012. www.prnewswire.com/news-releases/poor-health-costs-us-economy-576-billion-according-to-the-integrated-benefits-institute-169460116.html. Accessed October 30, 2013.
6. Radley D, et al. *Rising to the Challenge: Results from a Scorecard on Local Health System Performance*, 2012. The Commonwealth Fund. March 14, 2012. www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx. Accessed October 30, 2013.
7. *KIDSCOUNT Data Snapshot on High Poverty Communities*. Baltimore: Annie E. Casey Foundation; 2012. www.aecf.org/~media/Pubs/Initiatives/KIDS%20COUNT/D/DataSnapshotonHighPovertyCommunities/KIDSCOUNTDataSnapshotHighPovertyCommunities.pdf. Accessed October 30, 2013.
8. *Where We Live Matters for Our Health: Neighborhoods and Health*. Princeton: Robert Wood Johnson Foundation; September 2008. Accessed October 30, 2013.
9. Frey, W. *America's Diverse Future: Initial Glimpses at the U.S. Child Population From the 2010 Census*. Washington: Brookings; April 2011. www.brookings.edu/~media/research/files/papers/2011/4/06%20census%20diversity%20frey/0406_census_diversity_frey.pdf. Accessed November 19, 2013.
10. *U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation Half a Century From Now*. U.S. Census Bureau; December 12, 2012. www.census.gov/newsroom/releases/archives/population/cb12-243.html. Accessed November 19, 2013.
11. Oliff, P. *States Continue to Feel Recession's Impact*. Center on Budget and Policy Priorities, June 27, 2012. www.cbpp.org/cms/index.cfm?fa=view&id=711. Accessed November 1, 2013.
12. www.hhs.gov/secretary/about/blogs/head-start-numbers.html. Accessed November 1, 2013.
13. Frey, supra.
14. Frey, supra.
15. Frey, supra.
16. U.S. Department of Education, www.ed.gov/early-learning.
17. McLanahan S, Sandefur G. *Growing Up With a Single Parent: What Hurts, What Helps*. Cambridge, Mass; Harvard University Press; 1994.
18. Livingston G. *The Rise of Single Fathers*. Pew Research; July 2013. www.pewsocialtrends.org/2013/07/02/the-rise-of-single-fathers/. Accessed December 23, 2013.
The Marriage Gap: The Impact of Economic and Technological Change on Marriage Rates. The Hamilton Project; 2012. www.hamiltonproject.org/papers/the_marriage_gap_the_impact_of_economic_and_technological_change_on_ma/. Accessed December 23, 2013.
19. KIDSCOUNT, supra.
20. Testa M, Astone N, Krogh M, et al. Employment and marriage among inner-city fathers. In: Wilson, William J., ed. *The Ghetto Underclass*. Newberry Park, CA: Sage; 1993. pp. 96-108.
Wilson W, Neckerman K. Poverty and family structure: The widening gap between evidence and public policy issues. In: Danziger, SH.; Weinberg, DH., eds. *Fighting Poverty*. Cambridge, MA: Harvard University Press; 1986. pp. 232-259.
21. *Status, Food Stamp Receipt, and Public Assistance for Children Under 18 Years by Selected Characteristics: 2012*, www.census.gov/hhes/families/data/cps2012.html
22. Teachman, J; 2007. Race, military service, and marital timing: evidence from the NISY-79. *Demography*. 44:389-404.
Teachman, JD and L Tedrow. 2008. Divorce, race, and military service: more than equal pay and equal opportunity. *Journal of Marriage and Family*. 70:1030-1044.
Teachman, J. 2009. Military service, race, and the transition to marriage and cohabitation. *Journal of Family Issues*. 30:1433
23. *Where We Live Matters for Our Health*, supra.

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For more information, please visit www.rwjf.org/commission.

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