HEALTHY BETHLEHEM

Fiscal Years 2017-2019 Strategic Plan

September 2016

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Executive Summary

The Bethlehem Health Bureau is committed to providing high quality public health services that protect and promote the health of the residents we serve. The Bethlehem Health Bureau serves every City of Bethlehem resident and offers preventive care such as vaccines; conducts restaurant food inspections to ensure the safety of the food; provides smoking cessation programs to assist individuals with quitting smoking; conducts investigations in order to stop the spread of communicable diseases; facilitates fall prevention programs with the elderly; and prepares residents for emergency situations, among many other programs.

Healthy Bethlehem was developed to guide the planning, priorities, and decision making for the Bethlehem Health Bureau over the next three years. The Strategic Planning Committee took a comprehensive approach to creating an agency-wide strategic plan aimed at improving health outcomes, creating a more efficient organization, and providing effective public health programming.

Development of this strategic plan was based on the National Association of City and County Health Officers' (NACCHO) planning model for local health departments. Healthy Bethlehem outlines the strategic initiatives along with the objectives, tactics, and measures to achieve those goals. This strategic plan, developed in alignment with data obtained from the community health needs assessment, local health status indicators, local demographic trends, and legislative priorities, will guide the Health Bureau's efforts over the next three years.

The Bethlehem Health Bureau looks forward to working with our community partners, key stakeholders and residents in an effort to fulfill our mission and create a healthier Bethlehem.

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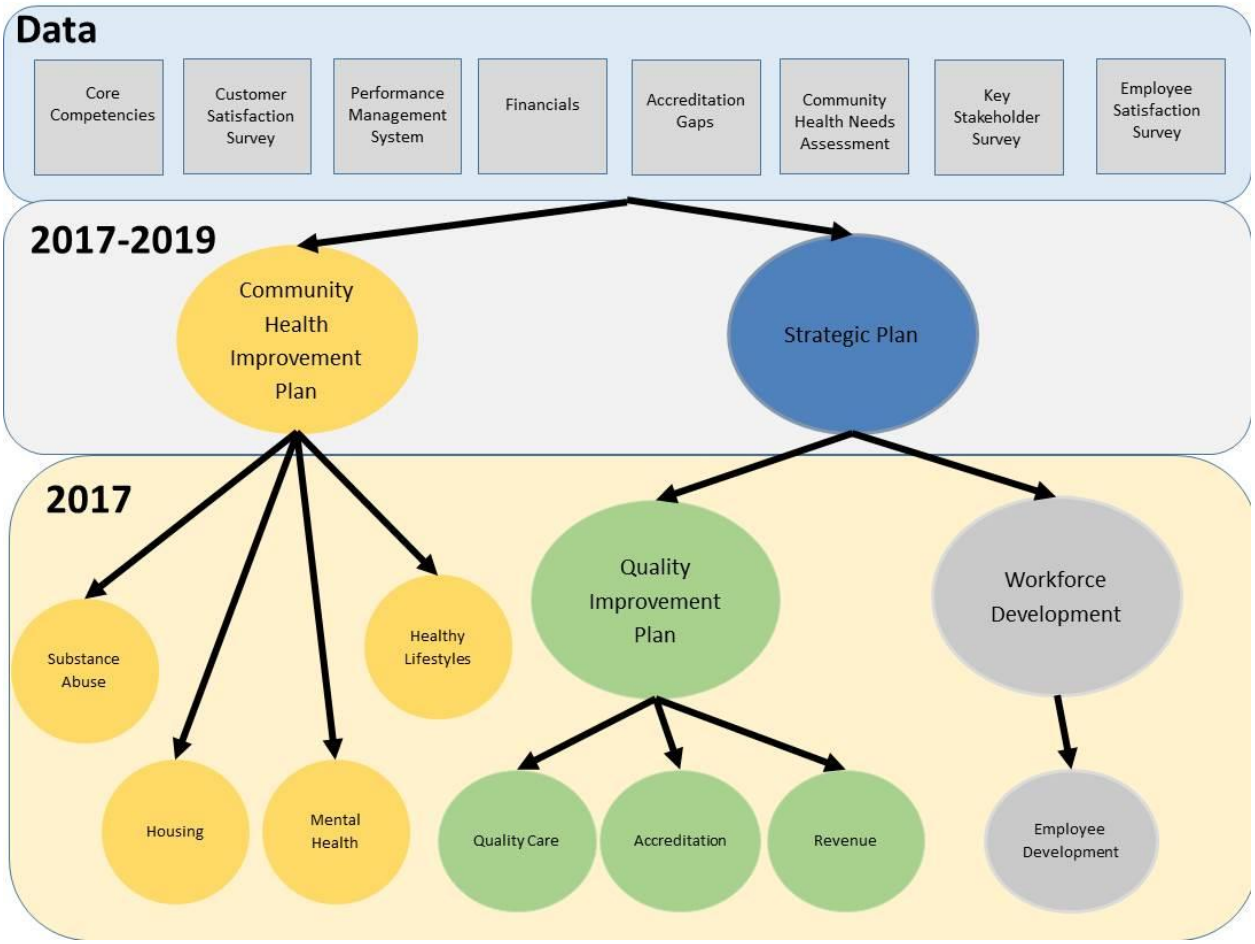
2017-19 Strategic Plan



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Strategic Plan

Scope: City of Bethlehem, Bethlehem area school district, Northampton County areas as funded
Target customers: City of Bethlehem residents, Children and Families of BASD, Visitors, Homeless, Agencies, City Businesses, Property Owners, Employees, Volunteers
Key stakeholders: City Administration, Board of Health, Health Bureau team, Pennsylvania Department of Health, grant funders, local hospitals, local community based organizations, Bethlehem Area School District, local colleges, and universities
Time Frame: FY2017 – FY2019
Leader: Kristen Wenrich
Team Members: Kristen Wenrich, Sherri Penchishen, Jessica Lucas, Sue Madeja

Vision

Healthy Choices Healthy People Healthy Places Healthy Bethlehem

Mission

To provide high quality public health services that protect and promote optimal health and well-being to assure Bethlehem is a safe and healthy community.

Values

Integrity: We act with a consistency of character, deal fairly, honestly, and transparently to the public and one another, and are accountable for our actions
Initiative: Embrace the opportunity to initiate ideas and programs without being prompted.
Respect: We approach all people with significance, understanding, compassion, and dignity
Leadership: Collaborate to inspire & motivate the community to improve health and well- being

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Important Data

(Include Customer/Community, Organization, Process, Culture, Learning)

Customer/Community:

- Customer
  - Focus Group Summary
  - 2014-15 Bethlehem Health Bureau Customer Satisfaction Survey
  - Customer Satisfaction 2014
  - Customer Satisfaction 2015
  - Environmental Health
- Equity; Do delivered services match the high need areas?
  - Outcome gaps to target or benchmark
  - Vital Statistics from Danielle
- Community
  - St. Luke's CHA Report
  - Bethlehem Campus FG final summary version (CHNA)
  - HCC Focus Group Report

Organization:

- Budget and Funding potential
- Grant win rate
- Budget areas' impact and performance: comparisons vs benchmarks for effectiveness and efficiency
- Revenue potential and performance (unrecovered revenue)

Process:

- Performance measures
  - Gaps to target
  - Gaps to benchmarks, Other health bureaus, Commercial businesses
- Accreditation gaps
- Cost per service delivered compared to benchmark

Culture:

- Employee Engagement survey
- NACCHO Self-Assessment Tool (SAT), team elements 1-2
- Turnover rate
- Absenteeism
- Focus groups
- Demographic changes
- Equity
- Core Competencies

Learning:

- Prior Strategic Planning and Annual Improvement Planning lessons learned

Environment/External:

- Political/legislation (federal, state, local)
- Partner strategies

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Technology:

- Systems changes (IT) internal
- Systems changes (IT) external
- Customer/Supplier/Partner interface changes, e.g., billing
- Alternative ways to deliver a service

SWOT

STRENGTHS: Internal strengths from the data and from the point of view of your customers. Consider your organization's characteristics.

WEAKNESSES: Consider data and feedback that noted your weaknesses.

OPPORTUNITIES: Useful opportunities can come from such things as: Changes in technology, economics, government policies, social patterns, population profiles, and local trends.

THREATS: What obstacles do you face? What services are no longer adding value? Which are under competitive pressure? Are new competitors emerging?

STRENGTH	DATA SOURCE
1. Training to do my job	Culture
2. Easy to get along, value & like colleagues	Culture
3. Opportunities to learn	Culture
4. Agree with overall mission	Culture
5. Cultural Competency Skills	Core Competencies
6. Financial Planning & Management Skills	Core Competencies
7. QI related goals in perform. Appraisal (SAT 1.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
8. All employees have access to skilled practitioners (SAT 1.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
9. All employees have the opportunity to identify & nominate improvements (SAT 1.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
10. Expectations of team performance (SAT 2.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
11. Teams meet regularly (SAT 2.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
12. Effective methods for communicating (SAT 2.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
13. Knowledge, skills, & longevity of staff; state-wide & LV leader to drive state program (preparedness)	Culture
14. Funding (Immun)	Organization
15. Knowledge, skills, passion, longevity of staff (EH, Hwy, HH, Tobacco, Healthy women, clinic, tb, Comm dis)	Culture

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16. Collaboration with partner (Hwy)	Culture
17. Internal referrals with Tobacco	Process
18. Collaboration with St. Luke's (HW)	Culture
19. Availability of appointments (clinic)	Culture
20. Consolidation clinic	Process
21. Low case load (TB)	Culture
22. Pilot for & influence state (TB)	Culture

WEAKNESSES	DATA SOURCE
1. Underutilized in my job	Culture
2. Work expected is unreasonable & correlates with each other	Culture
3. Manager <-> employee communication	Culture
4. Educating our clients	Core Competencies
5. Communication Skills	Core Competencies
6. Public Health Sciences Skills	Core Competencies
7. Employees use performance measures & targets for problem solving & improvement (SAT 1.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
8. Organization assesses employee KSAs to identify gaps (SAT 1.2)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
9. Inv. of training materials /methods available for us (SAT 1.2)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
10. Team members demonstrate respect for each other regardless of position (SAT 2.1)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
11. Employees seek out opportunities to participate in QI related learning communities (SAT 2.2)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
12. Employees apply knowledge acquired from learning communities (SAT 2.2)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
13. Central location for housing LL, improvements, ideas (SAT 2.2)	Improvement Roadmap Diagnostic – Self Assessment Test (SAT)
14. All employees taking/showing initiative	Culture
15. Not always included in city issues (Preparedness)	Customer
16. Staff turnover (MCH)	Culture
17. Internal referrals from other programs (MCH)	Process
18. Ability to reach clients & their partners (Comm Dis)	Process
19. Ability to bill all insurances (Immun)	Process
20. Ability to look for opps to be more innovative & replicate success from other HDs (Immun)	Process
21. Doing bare minimum of what have to do (food est.) (EH)	Culture
22. Nuisance abatement different skill set & activities and may move out of bureau (EH)	Process
23. Way the grant is written (not L/T outcome driven,	Process

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time to re-do grant data) (Hwy)	
24. Ability to identify EBL, change - cannot make direct changes - education only (HH)	Process
25. Low tobacco quit rate	Customer
26. Tobacco grant is labor intensive	Organization
27. Healthy Women funds do not cover costs	Organization
28. Limited outreach time (HW)	Organization
29. Not seeing younger population (clinic)	Organization
30. No internal process to take on new health issues Or process when funding goes away	Process
31. Lack of data for Environmental sometimes causes them to "not be at the table"	Organization
32. Healthy Lifestyles (QFD)	Customer
33. Mental health: navigating the system/process	Environment / External
34. IT innovation relies on PH resources to recognize, implement, & function	Environment / External
35. Performance Mgmt. system measures: not selected well, not defined, not enough in process measures in EH	Process
36. Domain 4: Engage community in identifying health problems	Process
37. Domain 5: Develop PH policies	Process
38. Domain 6: Enforce PH laws	Process

OPPORTUNITIES	DATA SOURCE
1. Funding depending on formula (preparedness)	Organization
2. PT to FT Emer. Mgmt. position (preparedness)	Environment
3. Billing & state gov't funding for home visiting (MCH)	Organization
4. Clinic #s are low (Comm Dis)	Organization
5. Evaluate need for off-site clinics (Comm Dis)	Environment
6. Clinic schedule efficiency (balance walk-ins & scheduled) (Comm Dis)	Customer
7. See more insured clients (Comm Dis)	Organization
8. Expand program (Immun)	Organization
9. State-wide & LV leader to drive state program & funding, pilot programs (Hwy)	Environment
10. Funding-Highway	Organization
11. Changes in laws (Hwy)	Environment
12. More homes eligible (~80% of homes; current 50 of 12,000) (HH)	Environment
13. Bill for services (Tobacco)	Organization

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14. Better process for length of time client is seen (Tobacco)	Customer
15. Growing # of women under age but symptomatic (HW)	Customer
16. Clinic billing for services	Organization
17. Integration of other services (clinic)	Process
18. Reducing staff time (TB)	Process
19. Obesity Prevention funding	Environment
20. Injury Prevention funding	Environment
21. Opioid Use funding	Environment
22. Divestiture of "Animal" programmatic area	Environment
23. Combinations of clinics for efficiency (family planning + STD)	Environment
24. Counseling through WebEx	Technology
25. Receptiveness of social media in population; #s of people that heard about us	Technology
26. Lost revenue can be recovered (across city)	Environment
27. Federal funding – opioids, mental health, zika, early education, primary care	Environment
28. Found out about IT capabilities that can be used internally	Technology
29. Organization structure across departments may change (housing, animal control, Emer. Mgmt., Parks, & Compliant investigation)	Environment
30. Funding for IT systems at federal level & mental health	Environment
31. Funding for aging in place (leads to growth in program)	Environment
32. Systems underutilized (HER, Egov, GIS)	Technology
33. Substance Abuse (QFD)	Customer
34. Housing, poverty (QFD)	Customer

THREATS	DATA SOURCE
1. Funding (preparedness)	Organization
2. Continued changing CDC guidance-difficult to measure success - resulting in plan changes, community re-education (preparedness)	Environment
3. mass incidents (preparedness)	Environment
4. Int'l travel (preparedness)	Environment
5. Fed gov't funding changes (MCH)	Environment
6. Loss of state immun. Coalition leader (de-funded) (Immun)	Environment

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7. Politics (EH)	Environment
8. Growth of food establishments (EH)	Environment
9. Continued foreclosures of homes (EH)	Environment
10. Funding, changes in laws (Hwy)	Environment
11. Funding –Healthy Homes	Environment
12. Rise of commun. Health (hospital) doing our services, politics (HH)	Environment
13. Tobacco billing for services provides less revenue than funding	Environment
14. Change in # women seen due to ACA availability (HW)	Environment
15. Funding (HW)	Environment
16. Reliance on fed gov't policy/funding (Clinic)	Environment
17. Int'l travel (in & out) (TB)	Environment
18. Growth of Opioid use	Environment
19. BHB becomes City point of contact/liaison for unfunded “Homeless” programmatic area	Environment
20. Differences between fed & state perspectives on IT & support e.g. Zika	Technology
21. Community hospital visiting home programs emerging	Environment
22. Partnership collaboration becoming more difficult (No HCC, program encroachment)	Technology
23. City becoming a destination (venue for more events, more labor)	Environment

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SWOT Summary

STRENGTHS

Relationships (Priority 1)
- Easy to get along, value & like colleagues (team)
- Collaboration with partner (Hwy)
- Collaboration with St. Luke's (HW)

Training (Priority 1)
- Training to do my job (team)
- Opportunities to learn (team)
- All employees have access to skilled practitioners (SAT 1.1)

Knowledge of staff (Priority 1)
- Cultural Competency Skills (C. Competency)
- Financial Planning & Management Skills (C. Competency)
- Knowledge, skills, & longevity of staff
- State-wide & LV leader to drive state program (preparedness)
- Knowledge, skills, passion, longevity of staff (EH, Hwy, HH, Tobacco, HW, clinic, tb, Comm dis)

Effective methods of communication, SAT 2.1 (Priority 1)

Clinic availability (Priority 1)
- Availability of appointments (clinic)
- Consolidation clinic
- Low case load (TB)

Internal referrals (Priority 2)
- Internal referrals with Tobacco

QI in everyone's role (Priority 2)
- QI related goals in perform. Appraisal (SAT 1.1)
- All employees have the opportunity to identify & nominate improvements (SAT 1.1)

Leaders/Influencers in our program area (Priority 4)
- Pilot for & influence state (TB)

Moved to a condition:
- Teams meet regularly (SAT 2.1) – all internal & external teams
- Agree with overall mission (team)
- Expectations of team performance (SAT 2.1)

WEAKNESSES

Performance Mgmt. system measures (Priority 1)
- Not selected well, not defined, not enough in process measures in EH (Process)
- Employees use performance measures & targets for problem solving & improvement (SAT 1.1)

Billing (Priority 1)
- Ability to bill all insurances (Immun)

Accreditation (Priority 1)
- Domain 4: Engage community in identifying health problems (Process)
- Domain 5: Develop PH policies (Process)
- Domain 6: Enforce PH laws (Process)

Communication (Priority 1)
- Skills (C. Competency)

Healthy Lifestyles (QFD) (Priority 1)
- Heart disease, stroke, diabetes are below target
- Ability to identify EBL, change - cannot make direct changes - education only (HH)
- Low tobacco quit rate
- Tobacco grant is labor intensive
- Limited outreach time (HW)
- Not seeing younger population (clinic)
- Ability to reach clients & their partners (Comm Dis)

Mental health: navigating the system/process (Ext) (Priority 1)

People (Priority 1)
- Underutilized in my job (team)
- Work expected is unreasonable & correlates with each other (team)
- Manager <-> employee communication (team)
- Educating our clients (C. Competency)
- Organization assesses employee KSAs to identify gaps (SAT 1.2)
- Team members demonstrate respect for each other regardless of position (SAT 2.1)
- Employees seek out opportunities to participate in QI related learning communities (SAT 2.2)
- Employees apply knowledge acquired from learning communities (SAT 2.2)
- All employees taking/showing initiative
- Doing bare minimum of what have to do (food est.) (EH)
- Ability to look for opps to be more innovative & replicate success from other HDs (Immun)

Not always included in city issues (Preparedness) (Priority 3)

Training Documentation/Mgmt (Priority 3)
- Inv. of training materials /methods available for us (SAT 1.2)
- Central location for housing LL, improvements, ideas (SAT 2.2)

Staff turnover (MCH) (Priority 4)

Public Health Sciences Skills (C. Competency) (Priority 4)

Grant Writing (not L/T outcome driven, time to re-do grant data) (Hwy) (Priority 4)

Other
- Nuisance abatement different skill set & activities and may move out of bureau (EH)
- Lack of data for Environmental sometimes causes them to "not be at the table"

Moved to a Condition
- IT innovation relies on PH resources to recognize, implement, & function (Ext) (Priority 3)
- **For work processes that are improved – write Process Efficiency** (Priority 1)
- Healthy Women funds do not cover costs
- No internal process to take on new health issues Or process when funding goes away
- Internal referrals from other programs (MCH)

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THREATS

Housing (High Priority)

- Continued foreclosures of homes (EH)
- Community hospital visiting home programs emerging (Ext)

Funding (High Priority)

- Preparedness
- Funding, changes in laws (Hwy)
- Funding –Healthy Homes
- Funding (HW)
- Reliance on fed gov't policy/funding (Clinic)
- Fed gov't funding changes (MCH)
- Partnership collaboration becoming more difficult (No HCC, program encroachment) (Tech)
- BHB becomes City point of contact/liaison for unfunded "Homeless" programmatic area (Ext)
- Rise of commun. Health (hospital) doing our services, politics (HH)

Substance Abuse (High Priority)

- Growth of Opioid use (Ext)

Billing (High Priority)

- Tobacco billing for services provides less revenue than funding

Other (Low Priority)

- City becoming a destination (venue for more events, more labor) (Ext)
- Int'l travel (in & out) (TB)
- Int'l travel (preparedness)
- Loss of state immun. Coalition leader (de-funded) (Immun)
- Politics (EH)
- Growth of food establishments (EH)
- Differences between fed & state perspectives on IT & support e.g. Zika (Tech)
- Mass incidents (preparedness)
- Change in # women seen due to ACA availability (HW)
- Continued changing CDC guidance-difficult to measure success - resulting in plan changes, community re-education (preparedness)

OPPORTUNITIES

Housing (Priority 1)

- More homes eligible (~80% of homes; current 50 of 12,000) (HH)
- Housing (QFD)

Funding (Priority 1)

- Funding depending on formula (preparedness)
- Billing & state gov't funding for home visiting (MCH)
- Expand program (Immun)
- Funding-Highway
- Federal funding – opioids, mental health, zika, early education, primary care (Ext)
- Obesity Prevention funding (Ext)
- Injury Prevention funding (Ext)
- Opioid Use funding (Ext)
- Funding for aging in place (leads to growth in program) (Ext)

Substance Abuse Substance Abuse (QFD) (Priority 1)

Increase billed revenue (Priority 1)

- See more insured clients (Comm Dis)
- Bill for services (Tobacco)
- Clinic billing for services
- Lost revenue can be recovered (across city) (Ext)

Clinic efficiency/effective (Priority 1)

- Clinic #s are low (Comm Dis)
- Evaluate need for off-site clinics (Comm Dis)
- Clinic schedule efficiency (balance walk-ins & scheduled) (Comm Dis)
- Reducing staff time (TB)
- Combinations of clinics for efficiency (family planning + STD) (Ext)
- Better process for length of time client is seen (Tobacco)
- Integration of other services (clinic)

Promotion via. Social media (Priority 2)

- Counseling through WebEx (Tech)
- Receptiveness of social media in population; #s of people

IT functionality (Priority 3)

- Systems underutilized (HER, Egov, GIS)
- that heard about us (Tech)
- Found out about IT capabilities that can be used internally (Tech)
- Funding for IT systems at federal level & mental health (Ext)

City organization structure (Priority 3)

- PT to FT Emer. Mgmt. position (preparedness)
- Organization structure across departments may change (housing, animal control, Emer. Mgmt., Parks, & Compliant investigation) (Ext)
- Divestiture of "Animal" programmatic area (Ext)

Other

- State-wide & LV leader to drive state program & funding, pilot programs (Hwy)
- Growing # of women under age but symptomatic (HW)
- Changes in laws (Hwy)

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Communication Strategy					
Stakeholder	Frequency	Method	Who	Objective	Message or Theme
BHB	Monthly	Staff meeting, updates in breakroom, e-mails requesting input	KW/strat team	Keep informed and obtain input	Leadership team status, key findings/decisions, thoughts on priority areas
Customers/Residents	Once	Website, social media	KW	Inform	Knowledge of BHB's three year strategies
Board of Health	Monthly, as needed	Monthly board meetings or e-mail as needed	KW	Inform and obtain input	Inform members of progress through plan development, input and support into strategic priority areas
City Leadership (Mayor, DCED Director)	Weekly (Bureau Chiefs) Monthly (Mayor's staff meeting)	Provide updates at weekly bureau chiefs meeting and monthly at Mayor's staff meeting	KW	Inform and obtain input, make decisions where applicable	Inform city administration of progress through plan development, obtain input and support into strategic priority areas
City Council	Once	Send a copy of final plan	KW	inform	Inform City Council of key priority areas
Community Partners	Key milestones	E-mail	KW	Inform and obtain feedback	Inform and obtain feedback on key issues that may impact partners

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Strategic Plan Scorecard

Strategic Initiatives

Increase revenue from grants and billing in order to generate additional funds to address priority health issues and support critical health department operations.	Improve access to quality and affordable housing for City of Bethlehem residents.	Improve health outcomes among clients receiving BHB clinical services.	Become a high-performing, accredited health department that successfully meets core public health standards.
Decrease deaths associated with heroin and opioid use.	Improve access to care for those with mental health issues in Bethlehem.	Decrease the burden of chronic diseases among Bethlehem residents.	Operationalize the Health Bureau's values of initiative and leadership.

Three-Year Outcomes

Measure	Baseline	Target
Grant Revenue	$921,073 (2016)	$1,225,947
Billing Revenue	$17,800 (2016)	$30,758
Opioid Deaths	81 (2015) NC	61
Number of homes classified as blighted	TBD	
Connection to Care	TBD	
Customer Satisfaction	99%	99%
Employee Satisfaction	TBD	
Obesity Rates	31.6% (2014)	30%
Diabetes Rate	10.7% (2014)	10%
Heart Disease Rate	6.9% (2014)	6%

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Annual Improvement Plans

Housing	
Plans	Community Health Improvement Plan Strategic Plan
Goal	Improve access to quality and affordable housing for City of Bethlehem residents.
Objectives	(1) To assess 100% of the homes on the list of potential blighted properties using the blight rubric by June 30, 2017. (2) To identify a minimum of two "hot spot" areas in the City for interventions by December 31, 2017.
Actions	(1) Convene a working group with staff from the health bureau, housing rehab, and the Deputy Director from Community and Economic Development. (2) Create a blight rubric to assess substandard housing in Bethlehem. (3) Compile a list from water turn offs, code enforcement violations, foreclosed properties and vacant properties. (4) Conduct an assessment on properties from the above mentioned lists. (5) Analyze data and determine "hot spots" and outliers. (6) Reach out to other organizations that receive CDBG, HUD and other housing funding to coordinate efforts and maximize dollars.
Team	Kristen Wenrich, Jessica Lucas, Allyson Lysaght, Amy Burhkart, CACLV

Measures	Baseline	Target
Number of homes assessed	0	200
Number of hot spots identified	0	2

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Substance Abuse	
Plans	Community Health Improvement Plan Strategic Plan
Goal	Decrease deaths associated with heroin and opioid use.
Objectives	(1) Reduce the number of heroin and opioid overdoses in Bethlehem by 15% from baseline by December 31, 2017.
Actions	(1) Convene a task force with members including the county coroners, hospitals, drug and alcohol agencies and public health agencies to develop a plan to address heroin and opioid use in the community. (2) Identify critical sources of data that need to be collected. (3) Identify 2-3 strategies that both counties can work on collaboratively to address heroin and opioid use. (4) Submit an application for funding to support the plan (5) Implement the plan.
Team	Kristen Wenrich, Sherri Penchishen, Rajika Reed, Layne Turner, Beth Miller, Tiffany Rossanese, Zach Lysek, Scott Grim, Holly Edinger, David Zimmerman

Measures	Baseline	Target
Opioid Overdoses (COB)	108	92

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Increase Revenue	
Plans	QI Strategic Plan
Goal	Increase revenue from grants and billing in order to generate additional funds to address priority health issues and support critical health department operations.
Objectives	(1) Increase grant revenue by 10% by December 31, 2017 (2) Increase revenue from insurance billing by 20% by December 31, 2017.
Actions	(1) Identify priority funding areas and communicate to staff, administration, board of health and community partners. (2) Apply for funding in those priority areas. (3) Complete credentialing/contracting with remaining insurance companies.
Team	Kristen, Sue, Sherri, Jessica

Measures	Baseline	Target
Grant Revenue	$921,073	$1,013,180
Insurance Billing Revenue	$17,800	$21,360
% of successful grant applications	81%	90%

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Mental Health	
Plans	Community Health Improvement Plan Strategic Plan
Goal	To improve access to care for those with mental health issues in Bethlehem.
Objectives	(1) To connect 90% of individuals who screened positive for depression to services by December 31, 2017. (2) Increase depression screening among home visiting and clinic clients by completing depression screens for 100% of clients by December 31, 2017.
Actions	(1) Implement depression screening protocols in home visiting program and clinics. (2) Utilize the confidential template in EHR. (3) Provide training for staff on identifying MH in clients. (4) Identify referral sources, i.e. Community Voices, FQHC (5) Refer clients who score high to appropriate services.
Team	Sue, Donna, Jose, Zory, Benay, Steph

Measures	Baseline	Target
Percent of clinical depression screens complete	0	100%
Percent of home visiting depression screens complete	0	100%
Percent of clients connected to mental health services	0	90%

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Healthy Lifestyles	
Plans	Community Health Improvement Plan Strategic Plan
Goal	To decrease the burden of chronic diseases among Bethlehem residents.
Objectives	(1) To provide 2 educational opportunities for the community to learn how to change behaviors, knowledge and attitudes to improve health status by December 31, 2017. (2) To facilitate a minimum of 3 infrastructure changes which promotes opportunities for healthy living by December 31, 2017.
Actions	(1) Implement 2 CDC Diabetes Prevention Programs in conjunction with the YWCA. (2) Pilot the "farm raiser" fundraiser in one BASD elementary school. (3) Collaborate with St. Luke's University Health Network on playground improvements to decrease injuries. (4) Work with identified Healthy Corner Stores to complete all phases. (5) Complete application to become a bicycle friendly community.
Team	Sherri Penchishen, Dr. Carolan (St. Luke's), YWCA, Claudia, Allison Czap (Buy Fresh, Buy Local)

Measures	Baseline	Target
Number of educational programs conducted in the community	0	2
Facilitate a minimum of 3 infrastructure/ policy changes which promotes opportunities for healthy living.	0	3

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Quality Care	
Plans	QI Strategic Plan
Goal	Improve health outcomes among clients receiving BHB clinical services.
Objectives	(1) Increase internal referrals by 25% and link 50 % to services by December 31, 2017. (2) Increase the number of FP clinic clients by 25 and STD clients by 50 by December 31, 2017. (3) Increase in vaccination rates for flu, pnuemonia and Tdap by 50% by December 31, 2017. (4) 95% of family planning clients will complete a reproductive life plan by December 31, 2017.
Actions	(1) Identify ways to promote clinic services to the community. (2) Training for staff on immunizations, family planning and STD services. (3) Develop a tool to assess efficiency of clinic services. (4) Determine best locations, hours, and staffing for BHB Family Planning/STD Clinic. (5) Utilize EHR to improve quality of care by documenting the reproductive lifeplan and using the confidential template. (6) Provide education and referral if necessary to clients who smoke, clients with high blood pressure, clients who are overweight and obese.
Team	Sue, Donna, Benay, Steph, Jose, Zory, Mel

Measures	Baseline	Target
Number of internal referrals	32	40
Percentage of referrals linked to service	10	20
Percentage of reproductive lifeplans completed	0	95%
Number of family planning clients	137	162
Number of STD clients	591	641
Vaccination Rates	1573 (flu) 4 (pneumonia) 49 (Tdap)	50% increase

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Accreditation	
Plans	QI Strategic Plan
Goal	To become a high-performing, accredited health department that successfully meets core public health standards.
Objectives	(1) Receive national accreditation by March 31, 2017. (2) Increase percentage or performance indicators that are performing at or above target to 50% by December 31, 2017.
Actions	(1) Develop a plan to address the standards which received a designation of "not demonstrated" or "slightly demonstrated." (2) Develop a plan to integrate the new policies/processes into everyday work across all program areas. (3) Revise the performance management system to better align with measures in the strategic plan and community health improvement plan.
Team	Sherri Penchishen, Kristen Wenrich, Beth Somishka, Mildred Ozoa, Zory Garcia, Melitza Lopez

Measures	Baseline	Target
Accreditation Status	Pending	Approved
Percent of performance management indicators performing at or above targets	Pending Q1 baseline	50%

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Employee Development	
Plans	Workforce Development Plan Strategic Plan
Goal	To operationalize the Health Bureau's values of leadership and initiative.
Objectives	(1) Increase the percentage of employees who feel utilized to their potential from 70% to 90% by December 31, 2017. (2) A minimum of one KSA will be identified for each employee by June 30, 2017.
Actions	(1) Identify a tool to use to measure employee satisfaction (2) Identify knowledge, skills and abilities of employees and develop "go to" individuals. (3) Incorporate strategic plan initiatives into overall workforce development plan and trainings.
Team	Mildred, Jess, Mel, Donna, Carrie

Measures	Baseline	Target
Percentage of employees who feel utilized to their potential	70%	90%
Number of KSAs identified for each staff person	0	1 per person

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