BETHLEHEM HEALTH BUREAU

Strategic Plan 2020 - 2022: Building a Healthy City for All

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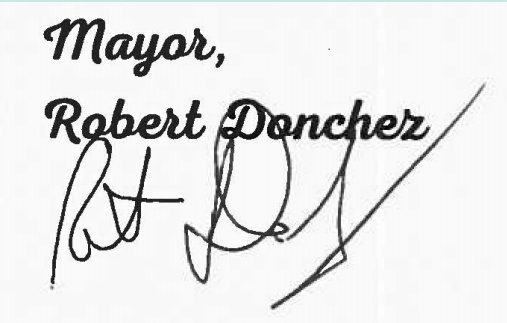
Mayor's Letter

Dear City of Bethlehem Residents and Visitors,

I am honored to present to you this ambitious three-year strategic plan for your public health department. Our city can and will continue to tackle the major public health challenges of our time. To do so, this plan builds on its long history of being an innovative and compassionate public health leader. The priorities set out in this plan are crucial to our success in creating a thriving, healthy and innovative Bethlehem. This report outlines how the Bethlehem Health Bureau will continue to be our city's leading voice in driving forward the residents and community's health needs through six areas of focus that emerged from a community health needs assessment and focus groups with the community. The health department's efforts will center around advancing equity, addressing the social determinants of health, developing the public health workforce, improving health in all policies, building resilient communities, and establishing a more sustainable business model for our public health workforce. This strategic plan outlines a framework for how decisions regarding health programs and services will be made over the next three years. City leadership is dedicated to ensuring a high quality of life, equitable services and programs and safe neighborhoods that our residents' value and have come to expect. My vision for the City of Bethlehem is to be a City that provides an exceptional quality of life for residents to work, live, play and worship.

Together we will create a healthy community,

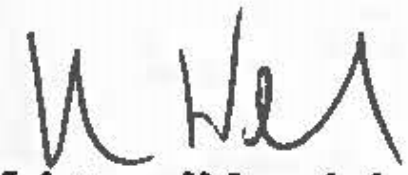


HEALTH DIRECTOR'S LETTER

Dear Reader,

Health equity means that everyone has the opportunities and resources needed for optimal health. The Bethlehem Health Bureau is working to fundamentally change how we think about and approach our work to systematically address the unjust policies, practices, and attitudes that consistently produce negative health outcomes for communities across our City. I am excited to present the 2020-2022 Strategic Plan that anchors health equity as a priority for the Bureau, and focuses on advancing equity, addressing the social determinants of health, developing the public health workforce, improving health in all policies, building resilient communities, and establishing a more sustainable business model for our public health workforce. By working together, we will ensure that everyone in the City of Bethlehem has the opportunities and resources in our community that support optimal health and well-being

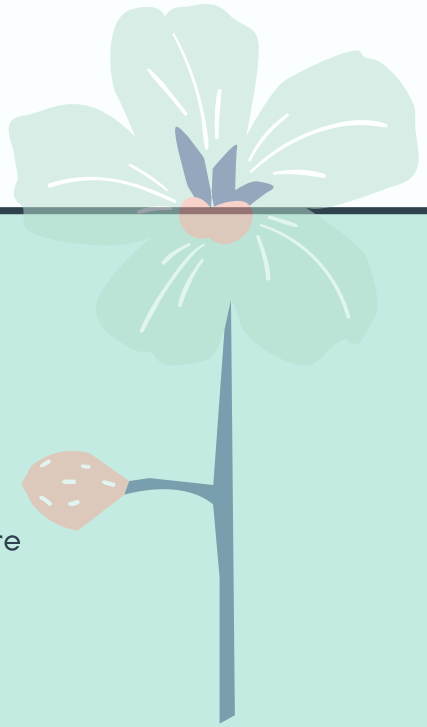
In Good Health,



Kristen Wenrich, MPH, CPH
Health Director

Bethlehem Health Bureau Overview

The Bethlehem Health Bureau, officially founded in 1980, ensures the health of the Bethlehem City residents and visitors by utilizing the three core functions of public health: monitor health status to identify community health problems, diagnose and investigate health problems and hazards in the community and evaluate effectiveness, accessibility and quality of personal and population-based health services.



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.

Vision

We envision a healthy Bethlehem for all residents through a city of inclusive places, connected communities and equitable opportunities for health and wellness.

Principles

HOLISTIC HEALTH

We care for the whole person, recognizing that physical, mental, spiritual, environmental and social needs all contribute to one's overall health.

COLLABORATIVE LEADERSHIP

We collaborate with public, private, and community partners to inspire and motivate collective actions that improve health and well-being.

CULTURAL COMPETENCE

We believe that culturally and linguistically competent settings increase the quality of health services and outcomes.

Principles cont.'

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

We embrace the opportunity to initiate ideas and programs without being prompted.

RESPECT

We approach all people with significance, understanding, compassion, and dignity.

Bethlehem Health Trends and Community Needs

The Bethlehem Health Bureau gathered and analyzed health data and diverse community perspectives to identify the strategic priorities that will best advance equitable healthcare access and health outcomes for all Bethlehem residents over the next three years.

About the City of Bethlehem

Bethlehem is a city in Northampton and Lehigh Counties in the Lehigh Valley region of eastern Pennsylvania. According to the census, the city has a population of 74,982, making it the seventh largest city in Pennsylvania. Bethlehem is nicknamed, "the Christmas City" and is home to over 150 major events and festivals throughout the year.

DEMOGRAPHICS

Bethlehem's racial breakdown is as follows: 78.7% white, 7% African American, 2.9% Asian and 5.8% other. Bethlehem's Hispanic population continues to grow, accounting for 28.5% of the City's population. Bethlehem also has an aging population, with 27.5% of its residents aged 55 and older.

ECONOMY

With a median household income of $51,888, Bethlehem residents earn less than the county, state, and national averages. Approximately, 15.8% of the population is below the federal poverty level and 18.1% of households participate in SNAP. The unemployment rate for Bethlehem is comparable to county, state, and national averages at 4%.

EDUCATION

Bethlehem has an 87.4% high school graduation rate. Approximately, 27.8% of the City of Bethlehem's population has a bachelor's degree or higher.

SOCIAL AND MENTAL HEALTH

A total of 37.5% of Bethlehem survey respondents reported having at least one poor mental health day in the past month. Additionally, a total of 11.7% of Bethlehem residents stated that they had received a mental health diagnosis.

The rate of opioid deaths in Bethlehem from 2015-2017 was 19.7 per 100,000.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social determinants of health include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care. Addressing social determinants of health is important for improving health and reducing longstanding disparities in health and health care.

CAUSES OF DEATH

Bethlehem still struggles with deaths due to chronic diseases. Bethlehem is above the county, state, and national rates for deaths due to heart disease, cancer, non-transport accidents, stroke and diabetes. Deaths rates from these aforementioned diseases all increased from the 2016 community health needs assessment.

MATERNAL AND CHILD HEALTH

In 2016, a total of 1.6% of births were to mothers under the age of 18. A total of 8% of births were classified as low birthweight, 9% were pre-term and 24.4% of pregnant women did not have prenatal care in the first trimester. When looking at these maternal and child health indicators by race and ethnicity, disparities exist.

FACTORS THAT INFLUENCE HEALTH

Factors that influence the health of the residents and visitors of the City of Bethlehem are the physical environment, lifestyle, health care, social environment, education, and economics.

ENVIRONMENTAL HEALTH

Approximately, 81.5% of Bethlehem homes are pre-1979. A total of 76.2% of Bethlehem's population lives within a 10 minute walk of green space and 51% lives more than ½ mile from the nearest grocery store.

HEALTH BEHAVIORS

Bethlehem residents reported increased numbers of high blood pressure and high cholesterol compared to the last community health needs assessment. A total of 39.8% of residents surveyed indicated that they had high blood pressure and 26.7% reported high cholesterol.

Cigarette smoking rates continued to decrease locally. A total of 9.8% of survey respondents reported smoking cigarettes. Additionally, a total of 21.3% of residents reported binge drinking, which was slightly higher than the county and state.

A total of 11% of residents reported eating at least 5 servings of fruits and vegetables daily. These results are comparable to the last community health needs assessment. Almost a quarter of Bethlehem's residents reported no days of exercise per week. Bethlehem is still above the county and state average for obesity, with 39.2% of residents falling in the obese, severely obese and morbidly obese category.

DISEASE AND INJURY

Bethlehem has a higher prevalence of diabetes and asthma than the county, state and national averages; however, the percentage of residents reporting these diseases decreased since the last community health needs assessment. A total of 12% of Bethlehem residents reported being diagnosed with asthma and 14.2% reported being diagnosed with diabetes.

In Bethlehem, chlamydia increased almost 3% and gonorrhea increased by 28% since the last community health needs assessment. Syphilis rates are also higher than the county, state and national rates.

Alignment Between the Strategic Plan and Community Health Improvement Plan

The priorities in this strategic plan will be the focus of the Bethlehem Health Bureau's activities. However, the current and emerging health needs of our community far exceed the Bureau's capacity and resources.

The Community Health Improvement Plan is intended to engage and inspire collective action from a broad set of public, corporate, philanthropic and community partners committed to making Bethlehem a healthier place to live, work, learn and play.

Strategic Goals

Advancing Equitable Access to High Quality Health Services

Objective 1 (a)

Implement 100% of the Community Health Improvement Plan recommendations for equitable healthcare access.

Key Performance Indicator:

Percent of recommendations implemented.

Major Action Steps:

1. Participate in partner agency committees.
2. Lead initiatives that are not being done by another agency.

Advancing Equitable Access to High Quality Health Services

Objective 1 (b)

Reduce stigma related to substance abuse recovery and treatment by 5% from baseline.

Key Performance Indicator:

Percent of community members who perceive substance abuse negatively.

Major Action Steps:

1. Lead a stigma advocacy campaign based on survey results.
2. Lead substance abuse assisting/recovery initiatives to reduce stigma surrounding substance abuse.

Advancing Equitable Access to High Quality Health Services

Objective 1 (c)

Implement all of the citizen's recommendations that are applicable (fiscally, programmatically and structurally) in our community work through the engagement of diverse citizen perspectives, experiences and voices.

Key Performance Indicator:

Number of applicable recommendations presented and implemented.

Major Action Steps:

1. Recruit participants to serve on the Community Advisory Board.
2. Define roles and responsibilities.
3. Establish a Community Advisory Board that meets quarterly to provide recommendations to the Bureau.

Advancing Equitable Access to High Quality Health Services

Objective 1 (d)

Advance racial justice and health equity in 100% of Bureau policies, trainings and services.

Key Performance Indicator:

Number of racial justice and health equity policies, trainings and services adopted by the Bureau.

Major Action Steps:

1. Establish an understanding of race equity and inclusion principles for all staff.
2. Engage affected populations and stakeholders in decision making networks through the Community Advisory Board.
3. Collect and analyze disaggregated data.
4. Document existing inequities and create a plan to mitigate the inequities.
5. Conduct a race and equity impact assessment for all policies and decision making.
6. Infuse health equity into committees/taskforces that health staff lead and/or participate on.

Addressing the Social Determinants of Health and Improving Health-Related Infrastructure

Objective 2 (a)

Prevent housing and economic insecurity for 5% of the vulnerable populations that we serve.

Key Performance Indicator:

Percent of residents showing signs of financial/housing instability who remained in their homes.

Major Action Steps:

1. Create a committee or a subcommittee of an already existing group, to identify trigger/intervention points of residents who are showing signs of financial/housing instability.
2. Create a process of how identified residents can access assistance to prevent further financial/housing instability.
3. Identify resource lists of community assistance, such as 2-1-1.

Addressing the Social Determinants of Health and Improving Health-Related Infrastructure

Objective 2 (b)

Increase safe housing stock by 10% in identified distressed areas.

Key Performance Indicator:

Number of homes in distressed areas made safe.

Major Action Steps:

1. Use Bethlehem's blight study to identify areas to improve the housing stock.
2. Establish a medical legal partnership for home visiting clients to use when needed.
3. Outreach to landlords/property owners in distressed neighborhoods in regards to making home environment safe for occupants.
4. Enroll homes in Lead Hazard Control/ Healthy Homes Program.
5. Complete home remediation on enrolled units.

Addressing the Social Determinants of Health and Improving Health-Related Infrastructure

Objective 2 (c)

Expand two of the identified distressed areas to include neighborhood level interventions aimed at improving the safety and health of the environment.

Key Performance Indicator:

Number of distressed areas that received neighborhood level interventions.

Major Action Steps:

1. Choose distressed areas for neighborhood interventions.
2. Conduct an assessment of the needs of the neighborhood both from the city and the residents.
3. Create an action plan with short term and long term tasks.
4. Create a committee, or a subcommittee of another group, to execute the action plan.
5. Collaborate with city departments to provide action plan services.

Addressing the Social Determinants of Health and Improving Health-Related Infrastructure

Objective 2 (d)

Improve mobility by 5%, for all residents.

Key Performance Indicator:

Percent of residents who do not have a mobility issue that impacts their quality of life.

Major Action Steps:

1. Improve connectivity across multiple modes including vehicular, transit, bicycle, and pedestrian in collaboration with community partners.
2. Enable safe, convenient and comfortable travel and access for users of all ages, races, ethnicities, economic status, and limited physical ability regardless of their mode of transportation in collaboration with commumity partners.
3. Explore using innovation and technology when appropriate
4. Create and implement context-sensitive design standards.

Addressing the Social Determinants of Health and Improving Health-Related Infrastructure

Objective 2 (e)

Create 3 safe spaces for physical activity and recreation.

Key Performance Indicator:

Number of physical activity spaces created from unused green spaces.

Major Action Steps:

1. Partnership with the City's Recreation Department, schools and community organizations to identify unused space to be transformed to promote physical activity.
2. Create activity design plans to encourage physical activity.

Addressing the Social Determinants of Health and Improving Health-Related Infrastructure

Objective 2 (f)

Integrate the social determinants of health assessment into clinic and home visitation programs.

Key Performance Indicator:

Percent integration of social determinants of health assessment into clinic and home visitation programs.

Major Action Steps:

1. Complete social determinants of health assessment tool.
2. Create an implementation plan.
3. Implement plan.

Developing the Public Health Workforce

Objective 3 (a)

Strengthen a culture of quality improvement among 100% of Bureau staff.

Key Performance Indicator:

Percent of Quality Improvement Action Plan recommendations implemented.

Major Action Steps:

1. Train new staff on quality improvement.
2. Dedicate one workforce development training to quality improvement.
3. Assign each staff to conduct one quality improvement initiative per year.
4. Staff to incorporate one quality improvement initiative in performance goals.

Developing the Public Health Workforce

Objective 3 (b)

Become an evidence-based organization.

Key Performance Indicator:

Percent evidence-based practice is integrated into the culture of the organization.

Major Action Steps:

1. Begin process of education, communication and engagement of staff.
2. Assess organization to determine priority area of change and to assess evidence-based practice progress.
3. Develop a workplan on the process and tools to use that support moving towards an evidence-based organization.
4. Prioritize work when new evidence-based program/ policies are added and discontinue ineffective ones.
5. Use data to drive decisions about effective policies and programs.
6. Assure evidence-based practice support through the organization's mission, vision, strategic plan, policies, procedures, technology and budget.

Developing the Public Health Workforce

Objective 3 (c)

Partner with research institutions to collaborate on a minimum of 4 initiatives to include but not limited to: conducting research, publishing articles, presenting at state and national conferences, etc. highlighting health bureau initiatives in public health.

Key Performance Indicator:

Number of initiatives completed in collaboration with research institutions.

Major Action Steps:

1. Determine type of program that warrants collaboration with research institutions.
2. Identify and reach out to most appropriate research institutes.
3. Determine research venue.

Developing the Public Health Workforce

Objective 3 (d)

Diversify people, persons and/or groups who provide oversight to the governing of the health bureau or provide program/services so that the total composition of these people, persons and/or groups match the racial, gender and ethnic equality composition of the City of Bethlehem's population within 5% in each category.

Key Performance Indicator:

Percent diversity of people, persons and/or groups who provide oversight to the governing of the health bureau or provide program/services.

Major Action Steps:

1. Cross-program diversity team, established as part of the workforce development committee, to make recommendations for Advisory Board and staff diversity training, recruitment policies and culturally responsive work environment.

Developing the Public Health Workforce

Objective 3 (e)

Establish an organizational level Trauma-Informed Care approach to those seeking and providing services by completing all 5 principles of Trauma-Informed Care.

Key Performance Indicator:

Number of the five Trauma-Informed Care guiding principles completed.

Major Action Steps:

1. Create a workplan to address all 5 Trauma-Informed Care guiding principles.
2. Utilize the Trauma-Informed Care worksite assessment to make improvements to the worksite based on the 5 trauma-informed care guiding principles.
3. Determine employee risk factors for vicarious trauma/compassion fatigue through conducting the Professional Quality of Life Scale (ProQOL-R-5) to measure satisfaction of workers who provide help to others and make a self-care plan.

Elevating Health in Multi-Sector Policies and Decisions

Objective 4 (a)

Integrate Health in All Policies (HiAP) across all governmental structures.

Key Performance Indicator:

Number of policies, programs or strategies created/executed in partnership with other governmental structures.

Major Action Steps:

1. Promote health, equity and sustainability.
2. Use Health In All Policies State and Local Government Guide.
3. Support intersectoral collaboration.
4. Look at government mechanisms for opportunities to include HiAP and create partnership.

Elevating Health in Multi-Sector Policies and Decisions

Objective 4 (b)

Mobilize support from a minimum of 5 cross-sector agencies for implementation of the Community Health Improvement Plan (CHIP).

Key Performance Indicator:

Number of cross-sector and community partners participating in semi-annual CHIP action team meetings.

Major Action Steps:

1. Partner on initiatives with partner agencies to advance the CHIP in the community.

Elevating Health in Multi-Sector Policies and Decisions

Objective 4 (c)

Recommend at least 1 regulatory and public policy change that advances community health.

Key Performance Indicator:

Number of recommendations gathered from the PA Public Health Advocacy Group and other policy think tanks disseminated online and in-person meetings.

Major Action Steps:

1. Provide legislative briefings with staff monthly.
2. Recommend 1 policy change to city administration or PADOH.
3. Participate in PA Public Health Advocacy Group

Building Resilient Communities through Civic Engagement

Objective 5 (a)

Develop and disseminate at a minimum of 3 times per week, timely and relevant health and safety information to the public through a variety of communications strategies.

Key Performance Indicator:

Number of posts per program area.

Increase amount of information published on website.

Major Action Steps:

1. Create a social media plan of what and when material is posted.
2. Train social media staff on how and what “voice” to post in to be as consistent as possible.

Building Resilient Communities through Civic Engagement

Objective 5 (b)

Include target audience in the creation of 100% of health literacy and promotion materials.

Key Performance Indicator:

Increase number of materials developed that engage community members that are useful and responsive to the needs of specific populations.

Major Action Steps:

1. Distribute more developmentally appropriate public health information.
2. Follow the process that was created in testing materials with the target audience.
3. Utilize CANVA or other professional marketing tools to create media that is released to the community.

Building Resilient Communities through Civic Engagement

Objective 5 (c)

Increase the community, organizational and governmental emergency preparedness readiness status from baseline.

Key Performance Indicator:

Percent readiness status of community, organizations and government.

Major Action Steps:

1. Create a checklist based on what to implement for a disaster.
2. Update and link checklist based on lessons learned from each disaster.
3. Emergency Management committee to conduct community, organizational and governmental readiness status survey yearly.
4. Create a workplan to implement processes and procedures to improve community, organizational and governmental readiness status.

Establishing a More Sustainable Business Model for Public Health

Objective 6 (a)

Raise the Bureau's brand identity by 10% as a trusted and valuable leader at the intersection of public health, equity and sustainability.

Key Performance Indicator:

Increased number of positive news stories about the Bureau; Increased number of website visits; Increased number of social media followers.

Major Action Steps:

1. Conduct a community survey to determine where the community receives valuable and trusted public health information.
2. Create a plan to post information proactively instead of reactively.

Establishing a More Sustainable Business Model for Public Health

Objective 6 (b)

Increase funding and create more flexible spending model from the Pennsylvania Department of Health.

Key Performance Indicator:

Funding increased or made more flexible.

Major Action Steps:

1. Participate on county/municipal health director's call and formulate a cohesive plan to present to PA DOH.

Establishing a More Sustainable Business Model for Public Health

Objective 6 (c)

Maximize revenue from billing services increasing each year from baseline.

Key Performance Indicator:

Increased revenue; Percentage of denied claims

Major Action Steps:

1. Conduct quality improvement with billing
2. Create new processes to ensure accurate billing.
3. Create a check and balance process to assure what is billed is received.
4. Create process to bill for additional services.
5. Cross train staff to assist with billing.

Establishing a More Sustainable Business Model for Public Health

Objective 6 (d)

Build internal capacity to improve performance and increase from baseline, employee satisfaction.

Key Performance Indicator:

Employee satisfaction.

Major Action Steps:

1. Succession plans for key staff members created and/or updated annually.
2. Conduct employee satisfaction survey annually.

Together we will create a healthy community

Monitoring

In an effort to achieve the strategic objectives, work plans will be developed for certain strategic goal activities. Each work plan will be in place to operationalize and monitor the progress of specified activities. These work plans will be integrated with quality improvement plans to assure the work plans are meeting the strategic goal activity. Every program will report monthly, quarterly, bi-annually or yearly to review and assess the progress of the objectives and evaluate the results.