Black Hawk County Health Department

FY 2015-2017 Strategic Plan

Exhibits A, B, C, D, E, F, G, H

Exhibit A

Black Hawk County Health Department
Adopted Operating Principles

As a team and as individuals:

- We will keep it informal, yet structured, and start on time/end on time unless otherwise agreed
- We will encourage maximum participation, being open/candid here in the session
- We will listen and not dominate
- We will remain constructive
- We will focus on and commit to the greater good
- We will "be present while we are here" (turning off cell phones)
- We will take silence to mean affirmation or informed consent
- We will trust the process
- We will be specific and use examples to avoid unintended misunderstandings

We will operate with consensus, as defined below

Definition of Consensus:

a) All team members have an opportunity to give input, exercised or not

b) Team members' ideas have been acknowledged by the group, and each person feels he or she has been "heard"

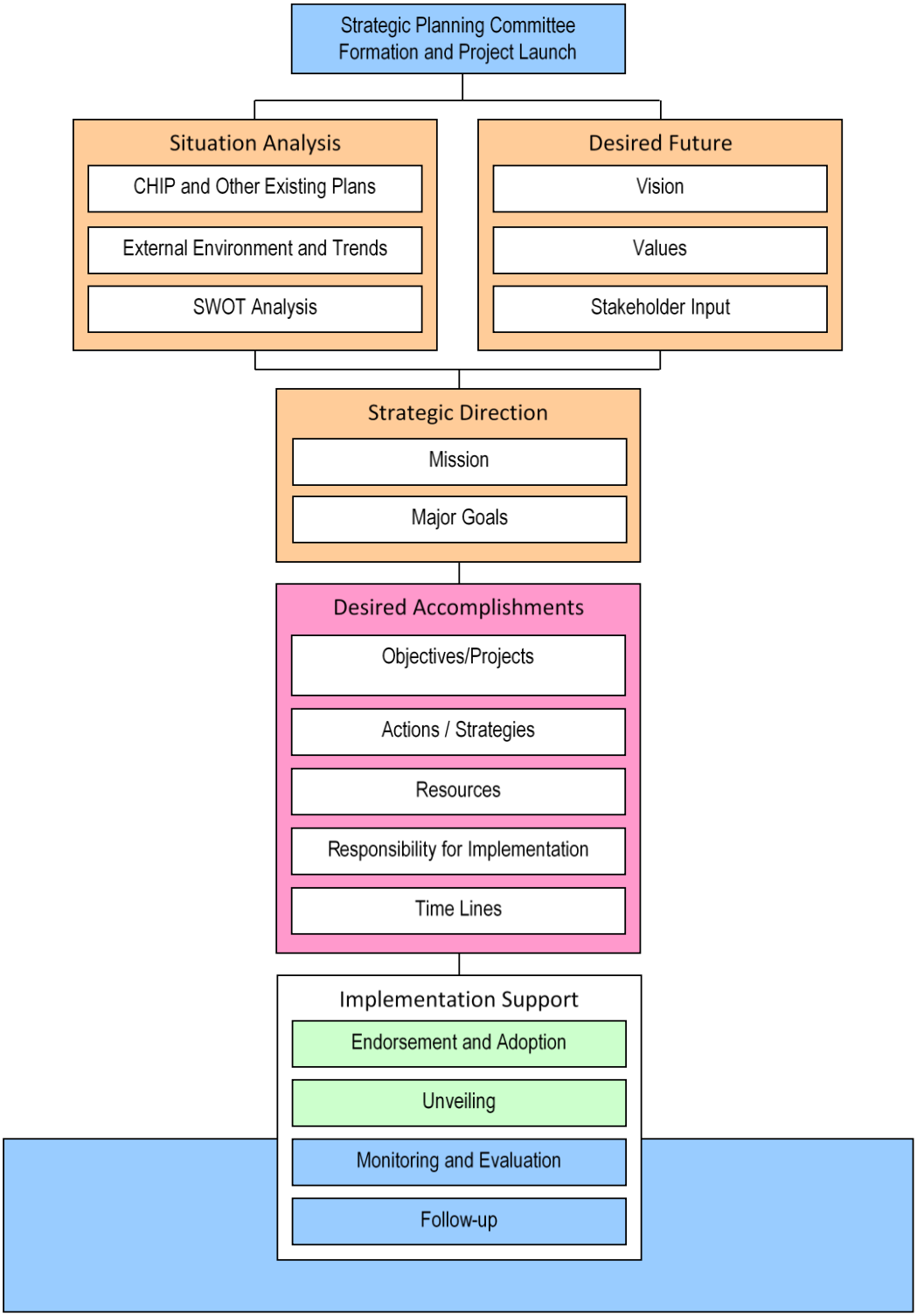
c) Team members indicate that they can live with the outcome of the process; they will not speak negatively or work against the outcome, since the process has been fair; team members agree to move forward

d) Team members accept that consensus is not necessarily unanimous agreement

Exhibit B

Black Hawk County Health Department

3-Year Strategic Planning Model



Black Hawk County Health Department

Environmental Scan

Several data sets will be reviewed to determine the value of existing information and establish a foundation for purposeful decision-making. This is a starting point, with an understanding that there are additional data to help us understand the needs of our local community. Through group process, the team will answer the question, "What are the trends, needs and opportunities for change in our community?"

Black Hawk County Demographic Detail Comparison Data:
This includes a core set of demographic and economic indicators from 2000 to projected 2018. Also available are comparisons of some categories including county, state and national data. The highlighted "trends" section on the right and a few highlighted areas in the left column, specific to race/ethnicity; housing and education also were noted. Race and ethnicity trends were discussed including a decline in the White population, with no change in the local African American population; and an increase in Hispanic and other newcomer populations, all mirroring national trends. Housing units available were reduced in 2010 with speculation this could be related to post-2008 flood mitigation and buy-outs; and higher educational attainment may be skewed due to persons achieving non-degree certificate level education.

County Health Ranking Data:
Although the trending of this national publication aimed at providing counties with local data specific to mortality, morbidity, and other health factors receives much attention, there exists variability and inconsistencies with the data. The major categories of data reflect a national movement to better understand the health status of communities in terms of behavioral, physical and social and physical infrastructure/community design.

Black Hawk County Health Status Data:
A core set of health status data was selected and trending summaries were reported for several years in the Black Hawk County Health Department Annual Report. All data were evaluated against a set of criteria - determination of the value, measurability, relevance, comparability, and ability to capture a multitude of health values, e.g. Low Birth Weight is a data point of both maternal and infant health. Ten data points were reviewed in relation to maternal/infant health; lead poisoning and child morbidity; children living in poverty; social behavior; access to oral and behavioral health services; disease surveillance; food safety; and prevention of disease.

Food System Assessment:
The food system assessment is pending completion and will yield baseline data regarding all sectors of the food system. The Board of Health completed a review of near-final data and established priorities to decrease childhood overweight/obesity, decrease adult overweight/obesity, and decrease correlation between poverty and food deserts.

2011 Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP): During 2011, six focus groups were organized around healthy behaviors, preventing injuries, environmental hazards, preventing public health emergencies, preventing disease and epidemics, and public health infrastructure. The process included each group completing a silent brainstorm, design of an Affinity Diagram, rank ordering and prioritization to identify needs and subsequently, goal statements. The Affinity Diagrams from each group identify the themes and groupings of rich qualitative data. A review of each diagram was completed to identify obvious inclusions in the strategic planning process.

Other Assessment and/or Frameworks Relevant to the Strategic Planning Process:

1. Frameworks for assessment, policy development and assurance of public health services
    a. Ten Essential Services of Public Health
    b. Twelve Domains of the Public Health Accreditation Board
2. Race Equity Impact Assessment Guide (in response to shifting racial demographics)
3. Health Impact Assessment as it relates to community design changes.

Additional Data to Understand:

- Resettlement of Burmese population
- Poverty level disparities, specifically, children living in poverty
- Changes to food inspection data, specifically "critical violation" vs. "priority item violation"
- Expand 1st Five Healthy Mental Development data collection
- Include food system assessment priority data s
- Public health professional competency, both internally and externally; as well as other issues identified in the public health infrastructure diagram of the 2011 CHNA process.

Demographic Detail Comparison
Black Hawk County

Demographic Detail Comparison					Population Trend	
Geography: Black Hawk					2000	128,011
					2010	131,090
Demographics:	**2000**	**2010**	**2013B**	**2018**	Change 2000 to 2010	2.4%
					2013B	132,267
Employees			73,004		2018	134,230
Establishments*			4,803		Change 2013B to 2018	1.5%
Total Population	128,011	131,090	132,267	134,230		
Total Households	49,686	52,470	53,093	54,477	**Household Trend**	
Female Population	66,553	67,382	67,913	68,848	2000	49,686
% Female	52.0%	51.40	51.35	51.3%	2010	52,470
Male Population	61,458	63,708	64,354	65,382	Change 2000 to 2010	5.6%
% Male	48.0%	48.60	48.65	48.7%	2013B	53,093
Population Density (per Sq. Mi.)		231.70	236.17		2018	54,477
					Change 2013B to 2018	2.6%
Age:						
Age 0 - 4	6.1%	6.5%	6.3%	6.4%	**Average Household Size Trend**	
Age 5 - 14	12.8%	11.7%	11.6%	11.5%	2000	2.5
Age 15 - 19	8.7%	7.7%	7.8%	7.2%	2010	2.4
Age 20 - 24	11.2%	11.4%	12.0%	11.3%	Change 2000 to 2010	-2.5%
Age 25 - 34	11.9%	13.3%	13.3%	14.1%	2013B	2.4
Age 35 - 44	13.3%	10.7%	10.5%	10.3%	2018	2.4
Age 45 - 54	13.6%	12.7%	12.3%	11.2%	Change 2013B to 2018	-0.7%
Age 55 - 64	8.4%	12.1%	12.4%	12.7%		
Age 65 - 74	6.8%	6.9%	7.0%	8.1%	**Median Age Trend**	
Age 75 - 84	5.2%	4.7%	4.7%	4.8%	2000	34.4
Age 85 +	2.0%	2.3%	2.3%	2.4%	2010	34.5
Median Age	34.4	34.5	34.2	34.6	2013B	34.2
					2018	34.6
Housing Units						
Total Housing Units	51,762	58,524	56,831	58,524	**Housing Units Trend**	
Occupied Housing Units	96.0%	93.1%	93.4%	93.1%		
Vacant Housing Units	4.0%	6.9%	6.6%	6.9%	**Total Housing Units**	
					Change 2000 to 2010	8.0%
Housing Units by Tenure					Change 2013B to 2018	3.0%
Occupied Housing Units			53,093		**Owner Occupied Housing Units**	
Owner Occupied Housing Units	34,266	35,649	36,375	37,308	Change 2000 to 2010	4.1%
Owner Occupied free and clear	66.2%	22.9%	24.2%	24.3%	Change 2013B to 2018	2.6%
Owner Occupied with a mortgage or loan		45.0%	44.3%	44.2%	**Renter Occupied Housing Units**	
Renter Occupied Housing Units	29.8%	32.1%	31.5%	31.5%	Change 2000 to 2010	9.0%
					Change 2013B to 2018	2.7%
					Vacant Housing Units	
					Change 2000 to 2010	64.7%
					Change 2013B to 2018	8.3%

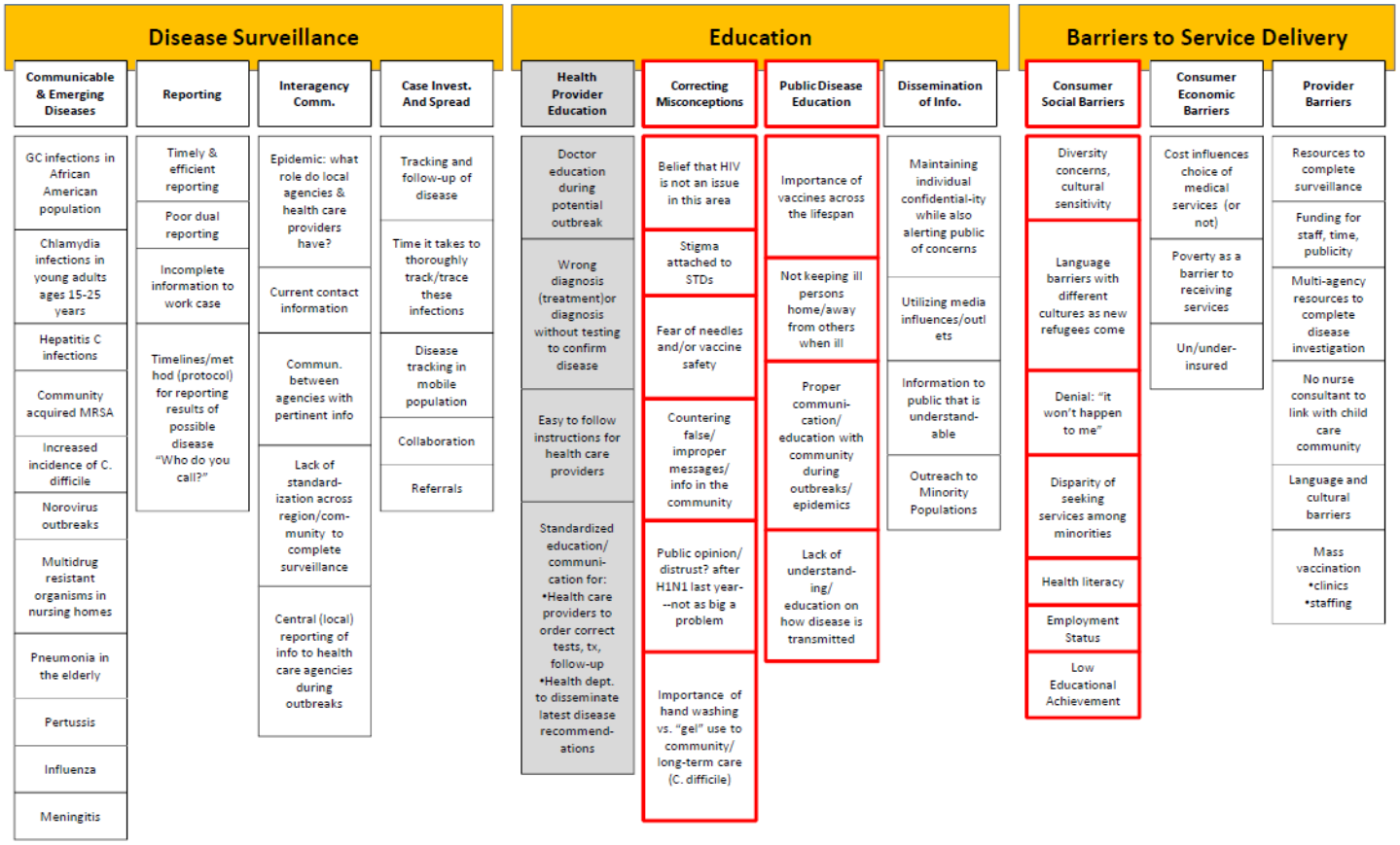
Demographic Detail Comparison
Black Hawk County

Race and Ethnicity	2000	2010	2013B	2018
American Indian, Eskimo, Aleut	0.2%	0.2%	0.3%	0.3%
Asian	1.0%	1.3%	1.6%	1.7%
Black	8.0%	8.9%	8.5%	8.7%
Hawaiian/Pacific Islander	0.0%	0.2%	0.2%	0.2%
White	88.4%	85.6%	85.5%	84.8%
Other	0.9%	1.6%	1.6%	1.6%
Multi-Race	1.5%	2.3%	2.5%	2.7%
Hispanic Ethnicity	1.8%	3.7%	4.0%	4.5%
Not of Hispanic Ethnicity	98.2%	96.3%	96.0%	95.5%
Race of Hispanics				
Hispanics		4,907	5,329	5,979
American Indian		1.8%	2.2%	2.2%
Asian		0.4%	0.6%	0.5%
Black		3.0%	2.9%	2.9%
Hawaiian/Pacific Islander		0.5%	0.6%	0.7%
White		45.8%	47.1%	48.4%
Other		39.1%	36.6%	34.5%
Multi-Race		9.3%	10.0%	10.8%
Race of Non Hispanics				
Non Hispanics		126,183	126,938	128,251
American Indian		0.2%	0.2%	0.2%
Asian		1.3%	1.6%	1.8%
Black		9.1%	8.7%	8.9%
Hawaiian/Pacific Islander		0.1%	0.2%	0.2%
White		87.1%	87.1%	86.5%
Other		0.1%	0.1%	0.1%
Multi-Race		2.0%	2.1%	2.3%
Marital Status:				
Age 15 + Population	103,766	107,259	108,568	110,205
Divorced	8.9%	9.5%	8.9%	8.9%
Never Married	31.1%	36.9%	36.6%	36.9%
Now Married	49.8%	47.6%	48.5%	48.2%
Now Married - Separated	3.4%	1.0%	1.3%	1.3%
Widowed	6.8%	6.0%	6.0%	6.0%

Race and Ethnicity Trend	
American Indian, Eskimo, Aleut	
Change 2000 to 2010	30.3%
Change 2013B to 2018	7.3%
Asian or Pacific Islander	
Change 2000 to 2010	45.6%
Change 2013B to 2018	13.3%
Asian	
Change 2013B to 2018	13.5%
Hawaiian/Pacific Islander	
Change 2013B to 2018	11.6%
Black	
Change 2000 to 2010	14.4%
Change 2013B to 2018	3.9%
White	
Change 2000 to 2010	-0.9%
Change 2013B to 2018	0.7%
Other	
Change 2000 to 2010	71.8%
Change 2013B to 2018	5.4%
Two or More Races	
Change 2000 to 2010	56.2%
Change 2013B to 2018	9.6%
Hispanic Ethnicity	
Change 2000 to 2010	108.0%
Change 2013B to 2018	12.2%
Not of Hispanic Ethnicity	
Change 2000 to 2010	0.4%
Change 2013B to 2018	1.0%

Demographic Detail Comparison
Black Hawk County

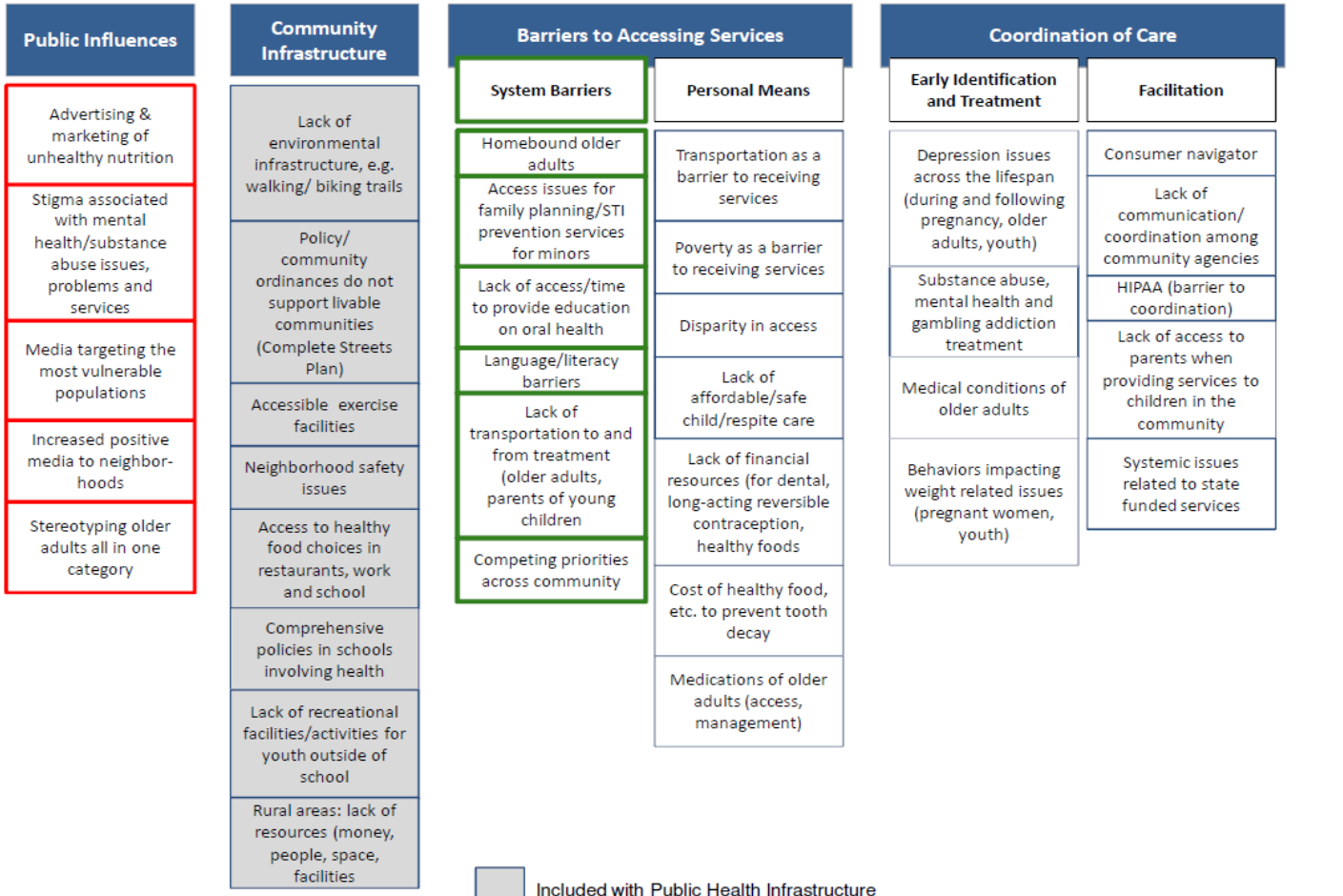
Demographic Detail				
Educational Attainment:	**2000**	**2010**	**2013B**	**2018**
Total Population Age 25+	78,401	82,166	82,487	85,441
Grade K - 8	4.4%	3.0%	3.0%	3.0%
Grade 9 - 12	8.5%	7.2%	7.2%	7.2%
High School Graduate	35.1%	33.3%	32.9%	32.3%
Associates Degree	7.3%	8.8%	9.0%	9.0%
Bachelor's Degree	14.3%	17.0%	17.3%	17.6%
Graduate Degree	8.7%	8.3%	8.5%	8.7%
Some College, No Degree	21.1%	20.4%	20.4%	20.3%
Household Income:				
Income $ 0 - $9,999	9.8%	8.6%	8.5%	6.5%
Income $ 10,000 - $14,999	7.3%	7.1%	7.0%	6.5%
Income $ 15,000 - $24,999	14.5%	12.8%	12.6%	11.4%
Income $ 25,000 - $34,999	15.3%	13.3%	12.7%	11.5%
Income $ 35,000 - $49,999	17.8%	15.0%	14.4%	13.3%
Income $ 50,000 - $74,999	19.9%	19.9%	20.2%	21.1%
Income $ 75,000 - $99,999	8.5%	10.9%	11.1%	12.5%
Income $100,000 - $124,999	3.1%	6.1%	6.4%	8.0%
Income $125,000 - $149,999	1.5%	2.9%	3.2%	4.2%
Income $150,000 +	2.5%	3.6%	4.1%	5.1%
Average Household Income	$47,727	$57,281	$58,872	$65,858
Median Household Income	$37,317	$42,765	$43,976	$50,965
Per Capita Income	$18,525	$23,477	$24,164	$27,252
Vehicles Available				
0 Vehicles Available	7.7%	7.3%	7.3%	7.3%
1 Vehicle Available	31.8%	33.8%	34.0%	34.1%
2+ Vehicles Available	39.2%	58.8%	58.7%	58.7%
Average Vehicles Per	1.80	1.90	1.90	1.90
Total Vehicles Available	91,833	99,746	100,811	103,384



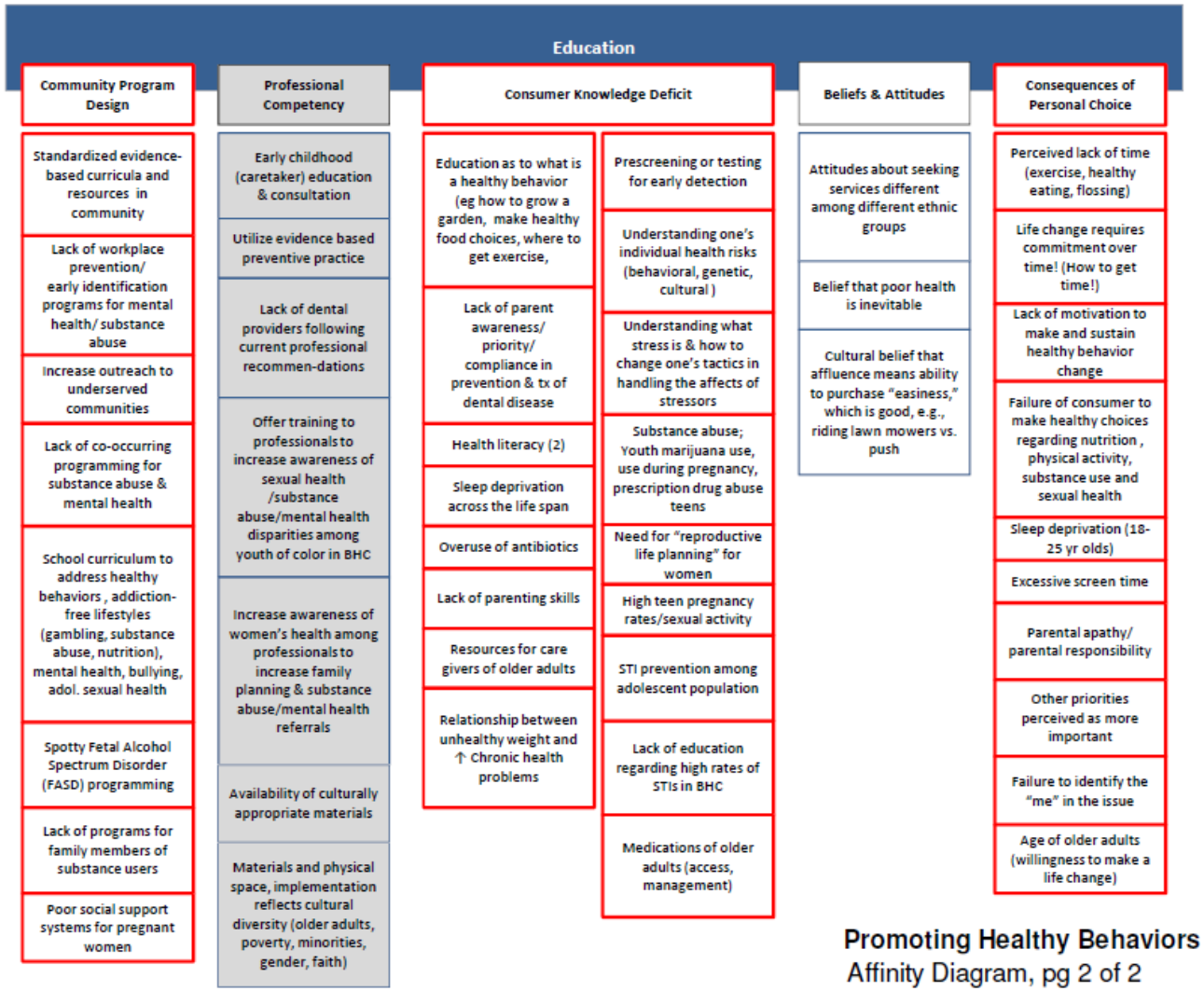
Preventing Epidemics & the Spread of Disease
Affinity Diagram 11-15-2010

Included with Public Health Infrastructure

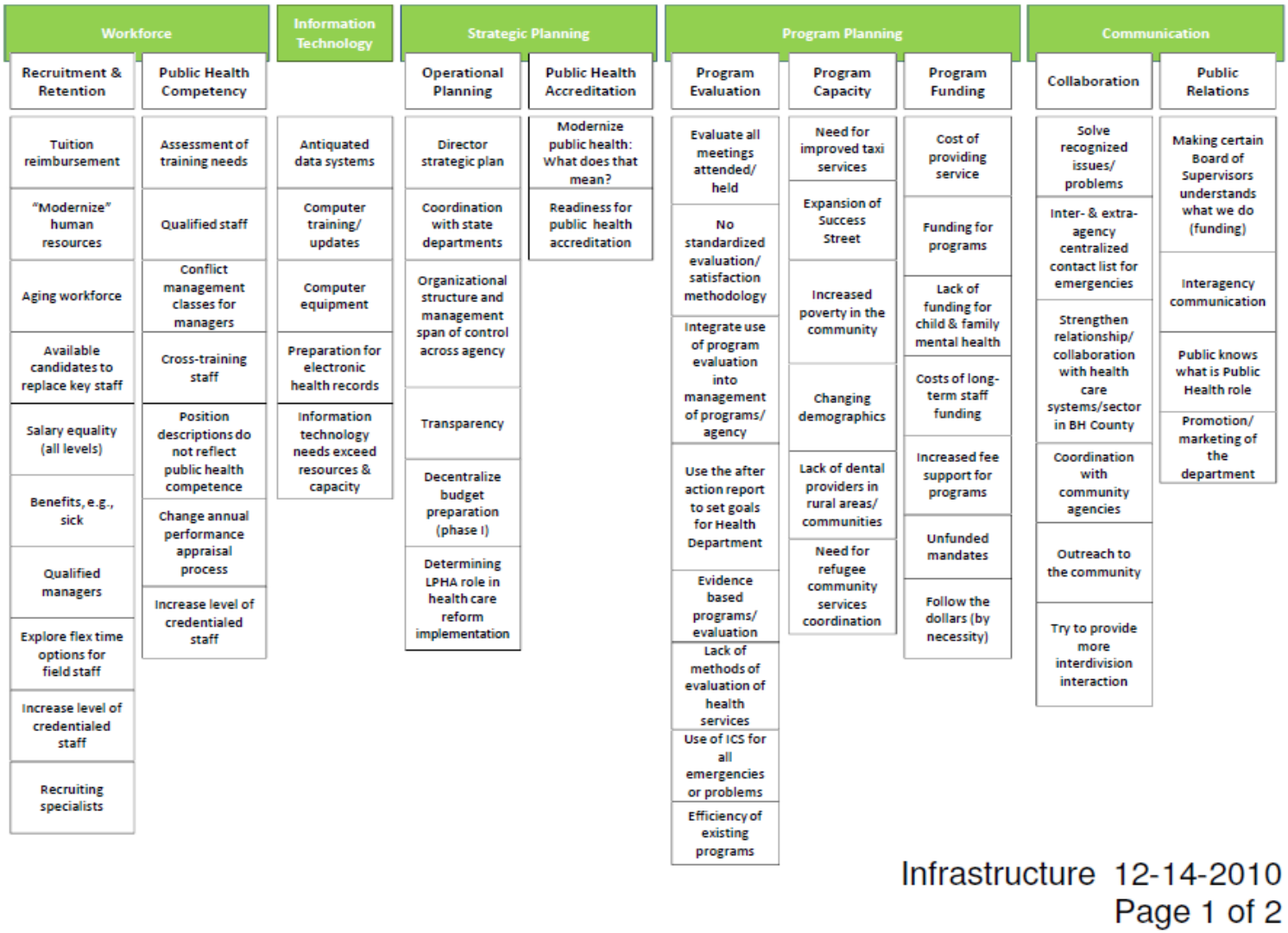
Need to provide clear, culturally appropriate, timely and effective education, information and consultation about prevention, management and control of communicable diseases to the public and health care community

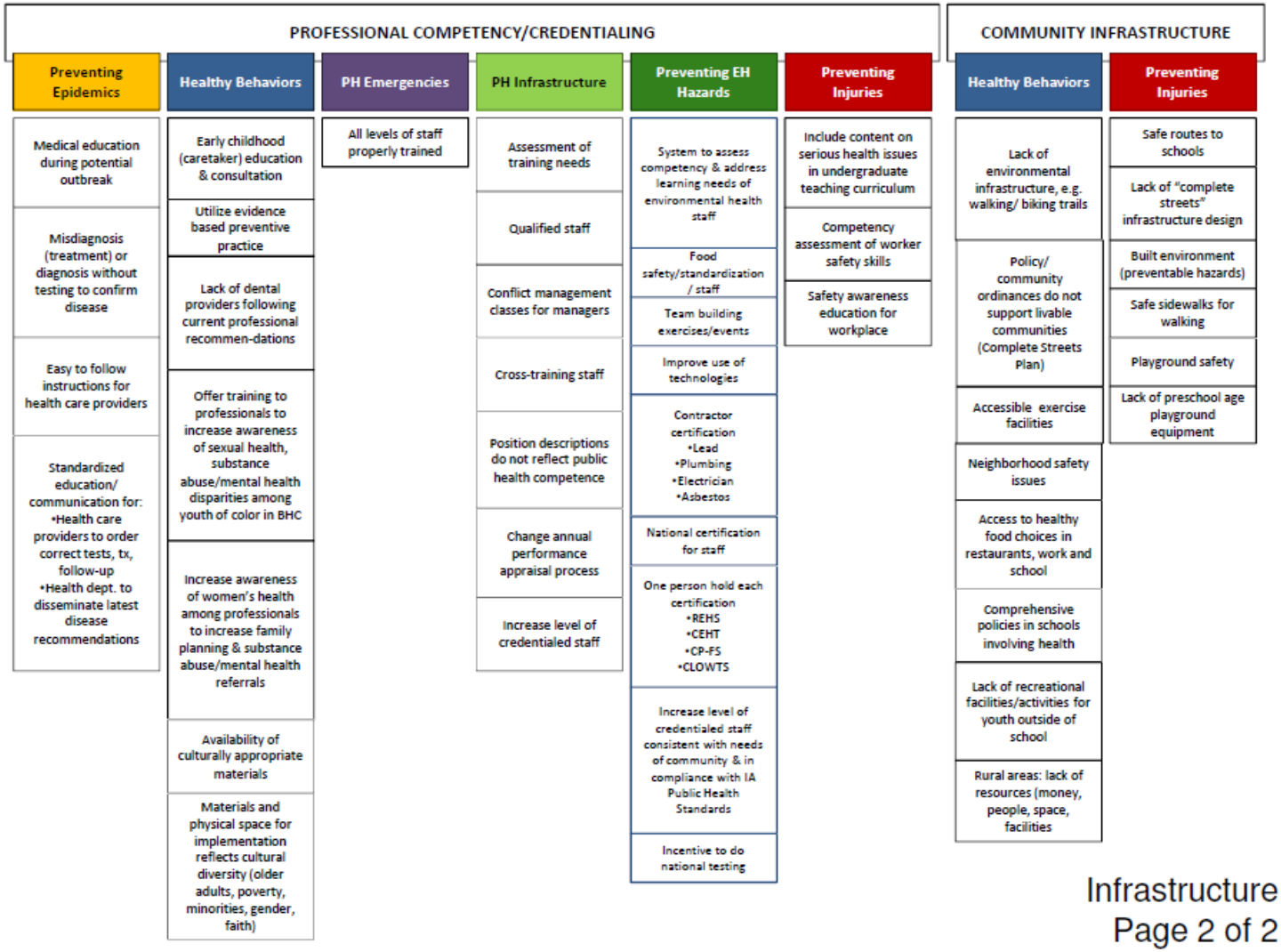


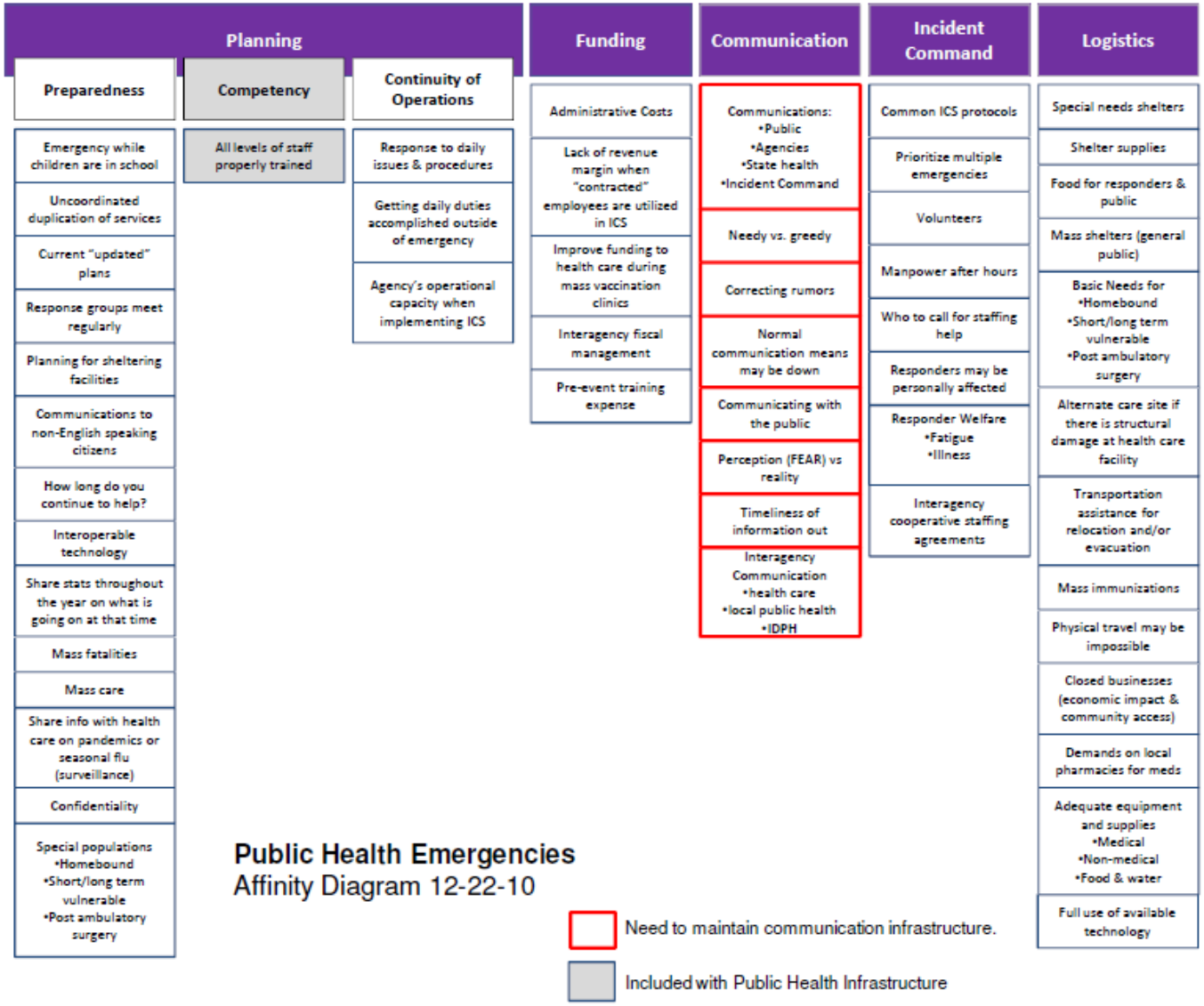
Promoting Healthy Behaviors Group
Affinity Diagram, pg 1 of 2
12-21-2010

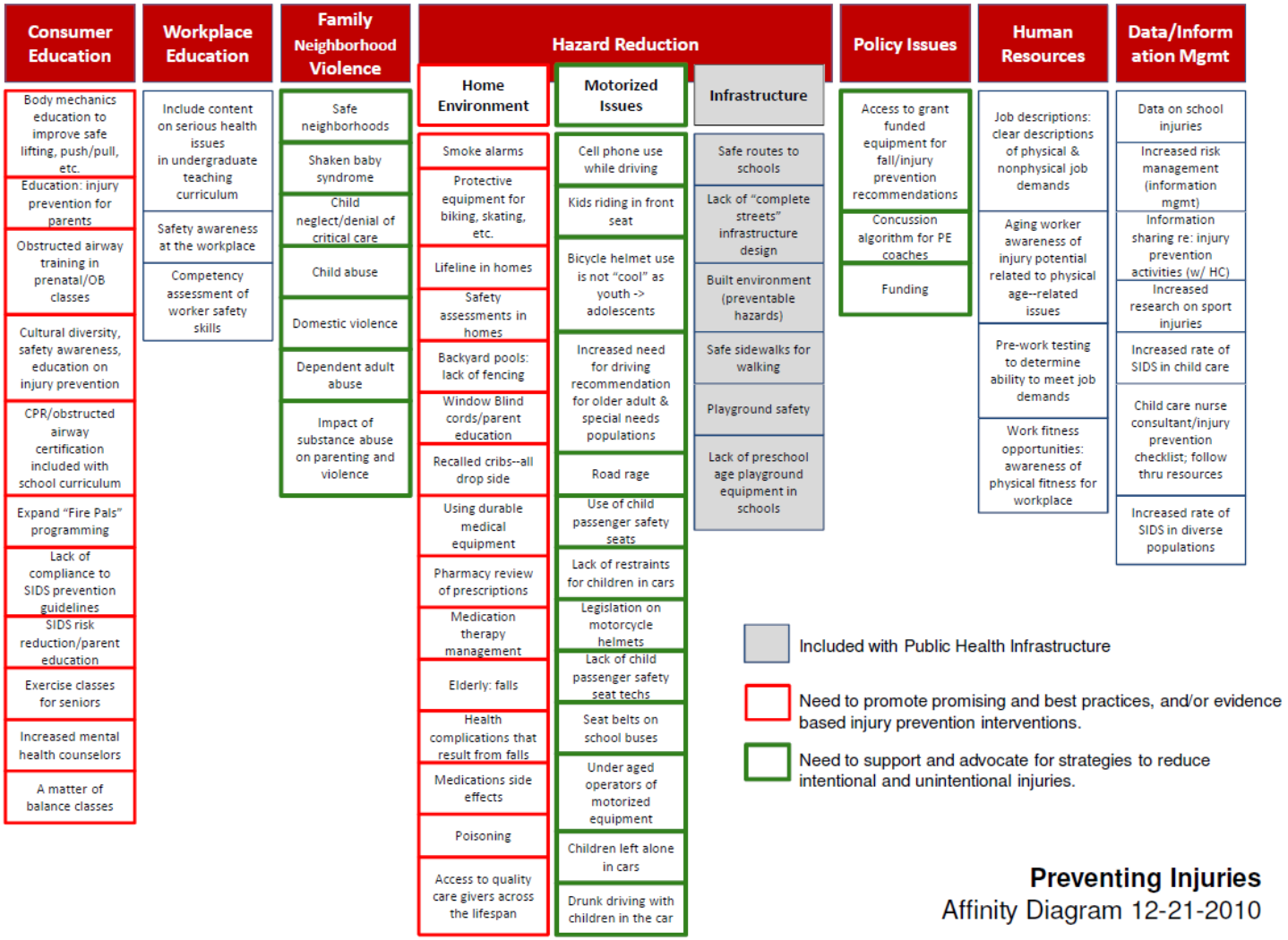


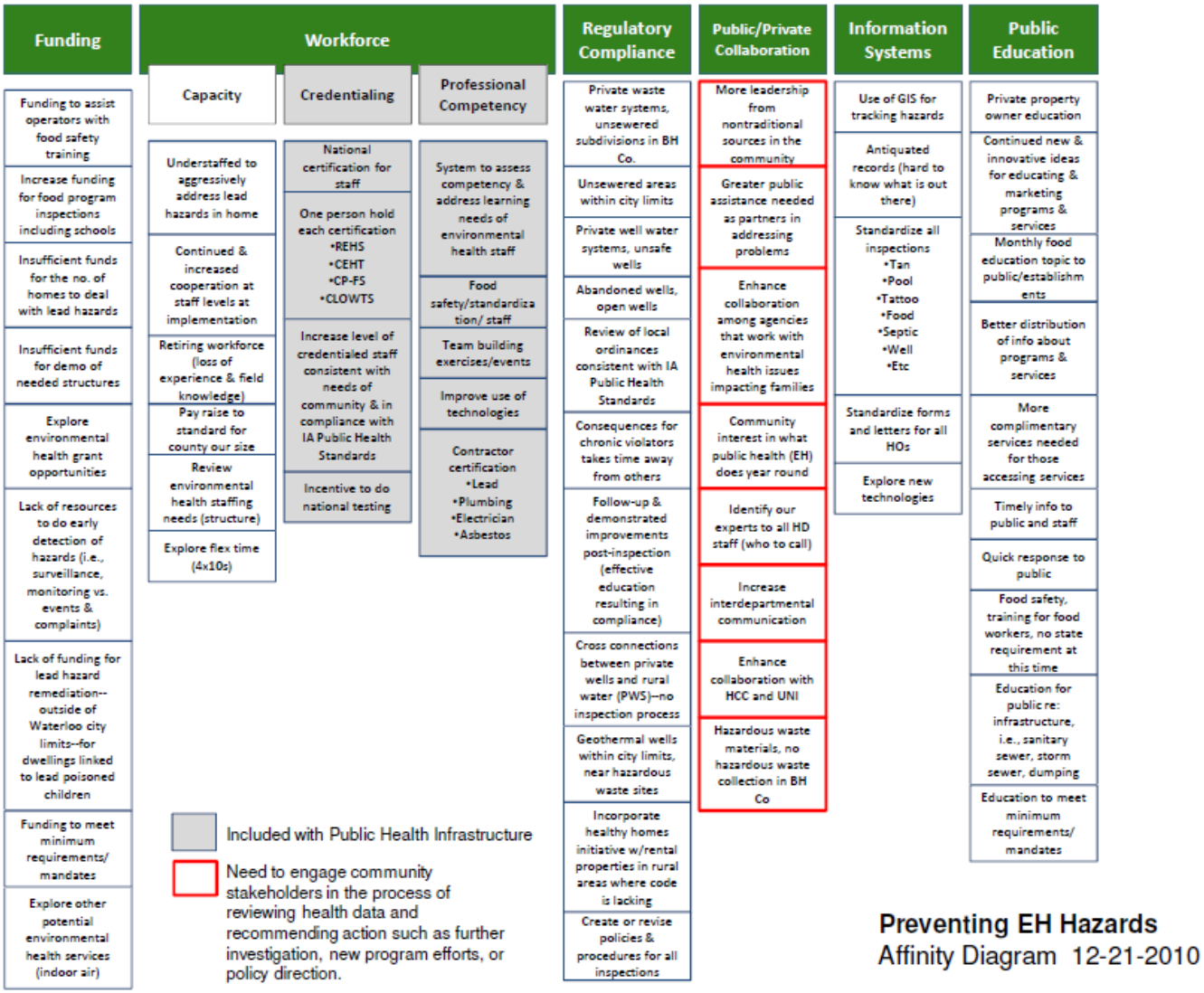
Promoting Healthy Behaviors Group
Affinity Diagram, pg 2 of 2


Workforce
Recruitment & Retention
Tuition reimbursement
"Modernize" human resources
Aging workforce
Available candidates to replace key staff
Salary equality (all levels)
Benefits, e.g., sick
Qualified managers
Explore flex time options for field staff
Increase level of credentialed staff
Recruiting specialists
Public Health Competency
Assessment of training needs
Qualified staff
Conflict management classes for managers
Cross-training staff
Position descriptions do not reflect public health competence
Change annual performance appraisal process
Increase level of credentialed staff
Information Technology
Antiquated data systems
Computer training/ updates
Computer equipment
Preparation for electronic health records
Information technology needs exceed resources & capacity
Strategic Planning
Operational Planning
Director strategic plan
Coordination with state departments
Organizational structure and management span of control across agency
Transparency
Decentralize budget preparation (phase I)
Determining LPHA role in health care reform implementation
Public Health Accreditation
Modernize public health: What does that mean?
Readiness for public health accreditation
Program Planning
Program Evaluation
Evaluate all meetings attended/ held
No standardized evaluation/ satisfaction methodology
Integrate use of program evaluation into management of programs/ agency
Use the after action report to set goals for Health Department
Evidence based programs/ evaluation
Lack of methods of evaluation of health services
Use of ICS for all emergencies or problems
Efficiency of existing programs
Program Capacity
Need for improved taxi services
Expansion of Success Street
Increased poverty in the community
Changing demographics
Lack of dental providers in rural areas/ communities
Need for refugee community services coordination
Program Funding
Cost of providing service
Funding for programs
Lack of funding for child & family mental health
Costs of long-term staff funding
Increased fee support for programs
Unfunded mandates
Follow the dollars (by necessity)
Communication
Collaboration
Solve recognized issues/ problems
Inter- & extra-agency centralized contact list for emergencies
Strengthen relationship/ collaboration with health care systems/sector in BH County
Coordination with community agencies
Outreach to the community
Try to provide more interdivision interaction
Public Relations
Making certain Board of Supervisors understands what we do (funding)
Interagency communication
Public knows what is Public Health role
Promotion/ marketing of the department
Infrastructure 12-14-2010
Page 1 of 2


PROFESSIONAL COMPETENCY/CREDENTIALING
COMMUNITY INFRASTRUCTURE
Preventing Epidemics
Healthy Behaviors
PH Emergencies
PH Infrastructure
Preventing EH Hazards
Preventing Injuries
Healthy Behaviors
Preventing Injuries
Medical education during potential outbreak
Misdiagnosis (treatment) or diagnosis without testing to confirm disease
Easy to follow instructions for health care providers
Standardized education/ communication for: •Health care providers to order correct tests, tx, follow-up •Health dept. to disseminate latest disease recommendations
Early childhood (caretaker) education & consultation
Utilize evidence based preventive practice
Lack of dental providers following current professional recommen-dations
Offer training to professionals to increase awareness of sexual health, substance abuse/mental health disparities among youth of color in BHC
Increase awareness of women's health among professionals to increase family planning & substance abuse/mental health referrals
Availability of culturally appropriate materials
Materials and physical space for implementation reflects cultural diversity (older adults, poverty, minorities, gender, faith)
All levels of staff properly trained
Assessment of training needs
Qualified staff
Conflict management classes for managers
Cross-training staff
Position descriptions do not reflect public health competence
Change annual performance appraisal process
Increase level of credentialed staff
System to assess competency & address learning needs of environmental health staff
Food safety/standardization / staff
Team building exercises/events
Improve use of technologies
Contractor certification •Lead •Plumbing •Electrician •Asbestos
National certification for staff
One person hold each certification •REHS •CEHT •CP-FS •CLOWTS
Increase level of credentialed staff consistent with needs of community & in compliance with IA Public Health Standards
Incentive to do national testing
Include content on serious health issues in undergraduate teaching curriculum
Competency assessment of worker safety skills
Safety awareness education for workplace
Lack of environmental infrastructure, e.g. walking/ biking trails
Policy/ community ordinances do not support livable communities (Complete Streets Plan)
Accessible exercise facilities
Neighborhood safety issues
Access to healthy food choices in restaurants, work and school
Comprehensive policies in schools involving health
Lack of recreational facilities/activities for youth outside of school
Rural areas: lack of resources (money, people, space, facilities
Safe routes to schools
Lack of "complete streets" infrastructure design
Built environment (preventable hazards)
Safe sidewalks for walking
Playground safety
Lack of preschool age playground equipment
Infrastructure
Page 2 of 2


Planning
Preparedness
Competency
Continuity of Operations
Funding
Communication
Incident Command
Logistics
Emergency while children are in school
Uncoordinated duplication of services
Current "updated" plans
Response groups meet regularly
Planning for sheltering facilities
Communications to non-English speaking citizens
How long do you continue to help?
Interoperable technology
Share stats throughout the year on what is going on at that time
Mass fatalities
Mass care
Share info with health care on pandemics or seasonal flu (surveillance)
Confidentiality
Special populations
•Homebound
•Short/long term vulnerable
•Post ambulatory surgery
All levels of staff properly trained
Response to daily issues & procedures
Getting daily duties accomplished outside of emergency
Agency's operational capacity when implementing ICS
Administrative Costs
Lack of revenue margin when "contracted" employees are utilized in ICS
Improve funding to health care during mass vaccination clinics
Interagency fiscal management
Pre-event training expense
Communications:
•Public
•Agencies
•State health
•Incident Command
Needy vs. greedy
Correcting rumors
Normal communication means may be down
Communicating with the public
Perception (FEAR) vs reality
Timeliness of information out
Interagency Communication
•health care
•local public health
•IDPH
Common ICS protocols
Prioritize multiple emergencies
Volunteers
Manpower after hours
Who to call for staffing help
Responders may be personally affected
Responder Welfare
•Fatigue
•Illness
Interagency cooperative staffing agreements
Special needs shelters
Shelter supplies
Food for responders & public
Mass shelters (general public)
Basic Needs for
•Homebound
•Short/long term vulnerable
•Post ambulatory surgery
Alternate care site if there is structural damage at health care facility
Transportation assistance for relocation and/or evacuation
Mass immunizations
Physical travel may be impossible
Closed businesses (economic impact & community access)
Demands on local pharmacies for meds
Adequate equipment and supplies
•Medical
•Non-medical
•Food & water
Full use of available technology
Public Health Emergencies
Affinity Diagram 12-22-10
Need to maintain communication infrastructure.
Included with Public Health Infrastructure


Consumer Education
Body mechanics education to improve safe lifting, push/pull, etc.
Education: injury prevention for parents
Obstructed airway training in prenatal/OB classes
Cultural diversity, safety awareness, education on injury prevention
CPR/obstructed airway certification included with school curriculum
Expand "Fire Pals" programming
Lack of compliance to SIDS prevention guidelines
SIDS risk reduction/parent education
Exercise classes for seniors
Increased mental health counselors
A matter of balance classes
Workplace Education
Include content on serious health issues in undergraduate teaching curriculum
Safety awareness at the workplace
Competency assessment of worker safety skills
Family Neighborhood Violence
Safe neighborhoods
Shaken baby syndrome
Child neglect/denial of critical care
Child abuse
Domestic violence
Dependent adult abuse
Impact of substance abuse on parenting and violence
Hazard Reduction
Home Environment
Smoke alarms
Protective equipment for biking, skating, etc.
Lifeline in homes
Safety assessments in homes
Backyard pools: lack of fencing
Window Blind cords/parent education
Recalled cribs--all drop side
Using durable medical equipment
Pharmacy review of prescriptions
Medication therapy management
Elderly: falls
Health complications that result from falls
Medications side effects
Poisoning
Access to quality care givers across the lifespan
Motorized Issues
Cell phone use while driving
Kids riding in front seat
Bicycle helmet use is not "cool" as youth -> adolescents
Increased need for driving recommendation for older adult & special needs populations
Road rage
Use of child passenger safety seats
Lack of restraints for children in cars
Legislation on motorcycle helmets
Lack of child passenger safety seat techs
Seat belts on school buses
Under aged operators of motorized equipment
Children left alone in cars
Drunk driving with children in the car
Infrastructure
Safe routes to schools
Lack of "complete streets" infrastructure design
Built environment (preventable hazards)
Safe sidewalks for walking
Playground safety
Lack of preschool age playground equipment in schools
Policy Issues
Access to grant funded equipment for fall/injury prevention recommendations
Concussion algorithm for PE coaches
Funding
Human Resources
Job descriptions: clear descriptions of physical & nonphysical job demands
Aging worker awareness of injury potential related to physical age--related issues
Pre-work testing to determine ability to meet job demands
Work fitness opportunities: awareness of physical fitness for workplace
Data/Information Mgmt
Data on school injuries
Increased risk management (information mgmt)
Information sharing re: injury prevention activities (w/ HC)
Increased research on sport injuries
Increased rate of SIDS in child care
Child care nurse consultant/injury prevention checklist; follow thru resources
Increased rate of SIDS in diverse populations
Included with Public Health Infrastructure
Need to promote promising and best practices, and/or evidence based injury prevention interventions.
Need to support and advocate for strategies to reduce intentional and unintentional injuries.
Preventing Injuries
Affinity Diagram 12-21-2010


Funding
Workforce
Capacity
Credentialing
Professional Competency
Regulatory Compliance
Public/Private Collaboration
Information Systems
Public Education
Funding to assist operators with food safety training
Increase funding for food program inspections including schools
Insufficient funds for the no. of homes to deal with lead hazards
Insufficient funds for demo of needed structures
Explore environmental health grant opportunities
Lack of resources to do early detection of hazards (i.e., surveillance, monitoring vs. events & complaints)
Lack of funding for lead hazard remediation--outside of Waterloo city limits--for dwellings linked to lead poisoned children
Funding to meet minimum requirements/ mandates
Explore other potential environmental health services (indoor air)
Understaffed to aggressively address lead hazards in home
Continued & increased cooperation at staff levels at implementation
Retiring workforce (loss of experience & field knowledge)
Pay raise to standard for county our size
Review environmental health staffing needs (structure)
Explore flex time (4x10s)
National certification for staff
One person hold each certification •REHS •CEHT •CP-FS •CLOWTS
Increase level of credentialed staff consistent with needs of community & in compliance with IA Public Health Standards
Incentive to do national testing
System to assess competency & address learning needs of environmental health staff
Food safety/standardization/ staff
Team building exercises/events
Improve use of technologies
Contractor certification •Lead •Plumbing •Electrician •Asbestos
Private waste water systems, unsewered subdivisions in BH Co.
Unsewered areas within city limits
Private well water systems, unsafe wells
Abandoned wells, open wells
Review of local ordinances consistent with IA Public Health Standards
Consequences for chronic violators takes time away from others
Follow-up & demonstrated improvements post-inspection (effective education resulting in compliance)
Cross connections between private wells and rural water (PWS)--no inspection process
Geothermal wells within city limits, near hazardous waste sites
Incorporate healthy homes initiative w/rental properties in rural areas where code is lacking
Create or revise policies & procedures for all inspections
More leadership from nontraditional sources in the community
Greater public assistance needed as partners in addressing problems
Enhance collaboration among agencies that work with environmental health issues impacting families
Community interest in what public health (EH) does year round
Identify our experts to all HD staff (who to call)
Increase interdepartmental communication
Enhance collaboration with HCC and UNI
Hazardous waste materials, no hazardous waste collection in BH Co
Use of GIS for tracking hazards
Antiquated records (hard to know what is out there)
Standardize all inspections •Tan •Pool •Tattoo •Food •Septic •Well •Etc
Standardize forms and letters for all HOs
Explore new technologies
Private property owner education
Continued new & innovative ideas for educating & marketing programs & services
Monthly food education topic to public/establishments
Better distribution of info about programs & services
More complimentary services needed for those accessing services
Timely info to public and staff
Quick response to public
Food safety, training for food workers, no state requirement at this time
Education for public re: infrastructure, i.e., sanitary sewer, storm sewer, dumping
Education to meet minimum requirements/ mandates
Included with Public Health Infrastructure
Need to engage community stakeholders in the process of reviewing health data and recommending action such as further investigation, new program efforts, or policy direction.
Preventing EH Hazards
Affinity Diagram 12-21-2010

Strengths, Weaknesses, Opportunities & Challenges

Strengths

1. Extremely experienced workforce (3)
2. Top to bottom decision-making that allows for input and involvement by all (2)
3. Broad funding base (2)
4. Well educated & trained/competent staff with a vision for future of Black Hawk County Health Department (3)
    a. Enthusiastic employees
    b. Good leadership (2)
5. Regional service delivery model
6. Very dedicated staff (2)
7. Good collaboration with the rest of the community (3)
8. Having a strong and supportive Board of Health
9. Demonstrated capacity to use data and drive decisions
10. Navigate consumers to available health services and resources
11. Electronic health records system
12. Large workforce
13. Passionate workforce – care about the work they are doing
14. Willingness to adapt to change

Weaknesses

1. Lacking specialty specific credentialing/competency (2)
2. Lack of management/training development opportunities (2)
3. Divisions are very defined, so silos and do not collaborate internally (2)
    a. Silo organizational functions
4. Large workforce – spread out at multiple locations (2)
5. Knowing what the priorities for the Health Department are
6. Wage scale to hire and retain quality employees (5)
    a. Not commiserate with state and federal averages
7. Never enough funding for what all needs to be done (2)
8. Aging management team and overall workforce (5)
9. Ability to communicate ideas effectively by staff (2)
10. Ineffective communication infrastructure
11. Information management/IT infrastructure (10)
    a. Inadequate
    b. User ability to use it
    c. Old equipment – poor function equipment
    d. IT support is lacking
12. Diminished human resources capacity to address workforce development

Opportunities

1. Build upon existing partnerships with other community agencies (5)
2. Continue as a leader/role model for other health departments statewide
3. Strong relationships with Iowa Department of Public Health
4. Advent of social media there are opportunities to communicate differently/more broadly
5. Continue to foster relationships with UNI and other academic institutions for internships which can and do foster good employees
6. Leader of professional development in the area of public health
7. Emerging emphasis on health care for the life span
8. Opportunity to tap into the Affordable Care Act to offer more mental health care services
9. Opportunity to improve the refugee health services – transportation, interpretation, medical referrals, etc.
10. Design community referral systems to navigate consumers to evidence-based health services

Challenges

1. Lack of clarity to the Affordable Care Act and other state and federal regulations (4)
2. Decreased cooperation with the Department of Human Services
3. With tight budgets it is a challenge to enhance wages (2)
    a. Retention of employees – encourage staff to stay long-term to move into management/leadership positions
4. Poverty in the community (3)
5. Uncertain local, state and federal funding (6)
6. How to get the message out to cultural groups – how to reach them and respect their cultures (4)
7. Health needs of newcomer populations
8. Human resource capacity (2)
9. Building a stronger relations with local healthcare system
10. Small community but with similar challenges to larger metros
11. Mental health issues of school-age children and how we get them services
12. Diverse and disparate community
13. Impact of violence on public health

Exhibit G

VISION, VALUES, MISSION

Black Hawk County Health Department Vision Statement

Black Hawk County Health Department is a leader and innovator in creating collaborative networks and approaches to health services and delivery. The Department is respected for its dedication and willingness to champion efforts; and adapt programs and services to improve the health of our community.

Black Hawk County Health Department Values Statements

Black Hawk County Health Department is committed to these guiding principles:

We are Accountable: We accept our individual and team responsibilities and meet the needs of our commitments. We expect to be evaluated by the successful execution of our commitments.

We are Effective: We utilize resources in ways that consistently produce desired results.

We are Responsible: We address the changing needs and trends that affect our diverse public. We are sensitive to the cultural and equity factors influencing health. We take responsibility for our performance in all of our decisions and actions.

We are Collaborative: Through effective partnerships and transparent communication, we practice collaboration internally and externally, vertically and horizontally, with public and the private sector, as a leader and as a team player.

We are Efficient: We maximize the benefits from our resources within a rapidly changing culture and economy to deliver services to the public economically without sacrificing quality.

We are Innovative: We foster an environment of continuous quality improvement where as we plan, do, study, and act upon evidence-based research, creative, open and resourceful changes to how we work.

We are Adaptable: We are flexible while remaining regulatory compliant and ethical.

Black Hawk County Health Department Mission Statement

The Black Hawk County Health Department is responsive and accountable. Through collaborative efforts, planning and policy development, we promote population health, prevent disease and protect the environment for all Black Hawk County residents and visitors.

IDENTIFIED STRATEGIC PRIORITIES

Sorted Into Theme Areas

Communication/Collaboration

- Improve communication and collaboration amongst departments horizontally and vertically to decrease silo effect
- Community collaboration
- Professional medical cooperation
- How we collaborate internally and organize our priorities
- Increase division collaboration
- Increase communication through the department
- Become a highly valued, collaborative partner with all area healthcare systems
- Implement communication infrastructure to promote transparency & equity both internally and externally, including emerging mediums
- Enhance collaboration with other partners to leverage effectiveness
- Work collaboratively providing health promotion services, education within the population of the service area
- Collaboration within the Health Department staff – internal & external
- How to communicate effectively both internally and externally
- Interdepartmental relations (communications)

Department Accreditation

- Work toward attaining public health accreditation
- Attain PHAB accreditation

Facilities

- Lack of physical space

Funding

- How we balance our responsibilities within the resources we have
- Decreased tax support in future years – Look at alternative revenue streams. Example billing for STI services/efficiencies
- Strive to maintain a fiscally sound agency through effective fund seeking

Organizational Management

- Apply same vision, mission, values internally as applied externally
- Patient advocacy
- Public health policy development that aligns with our mission statement
- Design a functional organizational structure to work more efficiently and effectively across the respective domains of public health
- Centralize review and revise policy, procedures and specialty specific standards across the agency

- Define the system of collaboration so the appropriate person(s) is representing the agency/Board of Health based on level of partnership and delegated authority and decision making required
- Evaluate the scope of current services based on historical performance, emerging trends, assed needs and capabilities
- Be in a position to respond effectively with Affordable Care Act implementation
- Transparency in all that we provide
- Addressing internal issues that can be dealt with to reduce strife in the workplace
- Goal setting for departmental standards

Outreach and Services

- Continuing to improve public health
- Public education
- Ongoing assessment of public health issues. (adapt) and public health conditions
- How we look at and attempt to solve community health needs
- Address health inequities within our community
- Planning for increased care coordination through the lifespan. How the Affordable Care Act is going to affect how we deliver services/population we serve.
- Promote a culture of quality improvement
- Enhance surveillance and assessment capacity
- Assist in the integration of Burmese refugee population
- Linking persons in need to mental health services
- Continue to innovate with new programming initiatives
- Continue to prevent, promote, protect to improve health statues of this community
- Advocate on behalf of community ever changing population
- Adapting to the community's changing health needs brought about by health care reform
- Address health equity issues related to poverty, race and culture
- The future of direct services

Technology

- Improve technology infrastructure
- How we utilize technology
- Increase IT/technology improvements – Having a plan for outdated equipment
- Develop departmental (internal) IT capabilities
- Information technology (IT) infrastructure
- The use of technology and how it can both simplify and expand our capacities
- Lagging technology standards

Workforce

- Attract and retain quality workforce to replace aging workforce to ensure good future for the department
- How we train and encourage our staff

- Attracting a keeping talent – reviewing/increasing wage structure
- Build an internal capacity/resources to train, prepare and develop future department management leadership
- Become a destination worksite for highly skilled professionals (not training ground for other departments)
- Overcome inequities to current compensation systems (internal & external inequities)
- Develop a human resources infrastructure
    - Public health competency model
    - Credentialing
    - Leadership development
    - Wage alignment
- Wages v. comps around the state of Iowa
- Maintain staff education, technology training needed to deliver services to population
- Maintaining a skilled, quality workforce
- The wage scale difference between Black Hawk County and similar organizations, for employees
- The education of our workforce to meet the highest standards in our fields – certifications, etc….
- Non-competitive bargaining and non-bargaining wages
- Professional certification