

Public Health System Improvement Task Force Minutes
October 11, 2017
10:00am-12:15pm
Public Health and Safety Division's Cogswell Building
1400 Broadway, Helena, MT.
Room C205 & C207

Task Force Attendees:

- **Kristi Aklestad** (Toole County Health Department—Small County Member)
- **Kim Cuppy** (Fallon County Public Health Department—Frontier County Member)-Webinar
- **Hillary Hanson** (Flathead City-County Health Department—AMPHO)-Webinar
- **Todd Harwell** (DPHHS, PHSD Administrator)-Co-Chair
- **Heather Jurvakainen** (Park County Public Health Department—Medium County Member)-Webinar
- **Rosemary Cree Medicine** (Blackfeet Tribal Health Department—Tribal Health Department Member)
- **Melanie Reynolds** (Lewis and Clark City-County Public Health Department—Large County Member)
- **Kari Smith** (Department of Environmental Quality)

Other Attendees:

- **Natalie Claiborne** (Montana State University Office of Rural Health)-Webinar
- **Alisha Johnson** (MEHA)
- **James Mayberry** (System Improvement Office, PHSD)
- **Jessica Miller** (Plans Coordinator)
- **Kerry Pride** (System Improvement Office, PHSD)
- **Terry Ray** (System Improvement Office, PHSD)
- **Jane Smilie** (AMPHO)

Excused Task Force Members:

- **Jean Curtiss** (Montana Association of Counties)
- **Kristin Juliar** (Montana State University Office of Rural Health)
- **Kathy Moore** (Lewis and Clark City-County Public Health Department—MEHA)
- **Janet Runnion** (Rocky Boy's Health Board—Tribal Health Department Member)
- **Tony Ward** (School of Public and Community Health Sciences)
- **Lora Wier** (MPHA)-Co-Chair

Review of Previous Meeting Minutes

- No comments on previous minutes. Todd Harwell made a motion to approve the minutes, Kristi Aklestad seconded. Minutes were approved with no opposed.

Point of Contact for this document: Jessica Miller, Office of Public Health System Improvement, 406-444-5968 or JMiller5@mt.gov

Announcements and Updates

Jessica Miller gave an update on behalf of Blair Lund regarding the Maternal and Child Health Block Grant. The review panel meeting in Denver was successful and the final version of the 2018 Maternal and Child Health Block Grant application and 2016 report was submitted on September 22.

Kerry Pride gave an update on the upcoming lead local orientation, which will be held on November 2, 2017. We have four locals signed up currently. This orientation is available for all emerging leaders not just lead locals. The next local orientation will be available in May. There has been discussion surrounding the name of the orientation and how it is misleading. Terry Ray added a proposal to change the name of the orientation to new public health leader's orientation. Melanie Reynolds agreed with this name change.

Terry Ray gave an update on the national institutes the Public Health System Improvement Office belongs to; the Public Health Informatics Institute, the Council of Linkages, Healthy People 2020, PHAB state accreditations coordinators group. We will provide updates to the Task Force on these national programs annually.

Healthcare Foundation Grant Opportunities and Feedback

Kerry Pride discussed challenges surrounding Healthcare Foundation grants and their upcoming strategic planning session. The Healthcare Foundation is discouraged that there has not been a greater application response from the local and tribal health departments for their grants. Unfortunately, there is a conflict in dates with the lead local orientation and the healthy communities' conference. As a result, Aaron Wernham will be at the next lead local orientation to discuss the grants available from the healthcare foundation. The Healthcare Foundation's Strategic Planning session is November 8th and they would like to know if there are other big investments that they can make in the public health system, what are the priority areas as a state, and what would the preferred delivery mechanism be. Kristi Aklestad commented that workforce development and system improvement such as Community Health Improvement Planning would be great as investment opportunities. Melanie Reynolds suggested that it would be easiest for PHSD to send out an email to the lead locals requesting their opinions on what the priorities are. Todd Harwell added that they will also suggest to Aaron that Mental Health and Substance Use Disorders and treatment is a great investment for continued support. Todd Harwell commented that a Qualtrics survey would be a great tool to get feedback to the Healthcare Foundation.

National Association of County and City Health Officials (NACCHO) Workforce Development Competencies Process

Hillary Hanson serves on the NACCHO Workforce Development Committee and reviewed the work of the Committee. The Committee is focusing on determining the core competencies a lead local health official would need to become the Community Chief Health Strategist. This concept comes from the article "The High Achieving Governmental Health Department in 2020 as the Community Health Chief Strategist" which defines seven practices for local health departments. The Committee has created a group of draft competencies, that mostly come from the Council on Linkages. Once they are final the goal is to create a self-assessment for lead health officials, and identify (or develop) trainings to develop the identified competencies. Melanie Reynolds asked Hillary how we could connect with partners to ensure they understand that this is the role of the health department. Hillary brought this question to the group for discussion. She added that a starting point could be spreading awareness of the NACCHO article and utilizing this concept idea as we develop trainings. Todd Harwell added that this is something that should be brought up at the follow-up leadership training on

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November 1, 2017 and that we should move forward on adopting these strategies for the public health system as a whole. We should also do an assessment to determine what trainings we need to address these competencies. Kristi Aklestad stated that she would like to also discuss this at the next AMPHO meeting.

Preventive Health and Health Services Block Grant 2018 Budget Review and Public Hearing

Terry Ray reviewed the budget proposals for the FFY 2018 & 2019 Preventive Health and Health Services Block Grant. We can probably expect the money for these items around May or June 2018. However, we currently have funding from now until September 2018. There are a few changes for the grant amount that we are anticipating; we will currently budget for \$1,034,000. We added the Behavioral Risk Factor Surveillance System (BRFSS) to this budget to account for the decrease in State funds. This budget will enable Montanans to gather self-reported data on a number of different behaviors. The Built Environment and Emergency Medical Services Administration programs are similar to the previous budget proposals. Kristi Aklestad asked for specifics on what the money for the Emergency Medical Services Administration program goes towards. Terry Ray commented that this money would go towards the program as a whole, but also support trainings and for the travel for inspectors to inspect the ambulances throughout Montana. The biggest change to the block grant budget is the local and tribal public health system support program. We have \$160,000 in employees' salaries; this was not included in last year's grant. Originally, the salaries were paid for by the Montana Healthcare Foundation grant. Their grants now support technical assistance through grants rather than employee salaries. The Public Health and Safety Division Internal Operations and Public Health Workforce Development program is flexible and can offer funding to those who need it. Alisha Johnson asked what MEHA would need to do to request conference support. Todd Harwell commented that it depends on what exactly MEHA would need more. Would they need the training and conference or support for online microbiology class for getting more sanitarians into the workforce? Todd Harwell added that MEHA would need to write up a short proposal requesting these funds for the items they need. Terry Ray will send an example proposal to Alisha. Terry Ray proposed that we add a budget line for MEHA support; this funding will be taken out of the PHSD Internal Operations and PH Workforce Development program. Terry Ray opened the public hearing for the PHHS Block Grant FFY 2018 and 2019 Budget proposal. No public was present at the hearing, so the hearing was closed. Kristi Aklestad motioned to approve the budget with the amendment to add MEHA funding. Melanie Reynolds seconded the proposal with the mentioned amendment. Terry Ray opened the floor for discussion; there was no discussion. All members approved the budget with the stipulation that funding to support MEHA training and professional development activities would be considered in the budget. None were opposed.

Review of 2017 MPHA's Annual Conference

Kristi Aklestad gave an update on behalf of Lora Wier. MPHA had over 150 members in attendance at the 2017 annual conference. Next year will be the 100 year anniversary. Shawn Hinz from Riverstone was chosen to be the new President of MPHA. Stefanie Tassarò out of Bozeman was chosen to represent region 4. Timber Dempewolf and Emily Colomeda were chosen to represent regions 1 and 5 respectively.

Montana Environmental Health Association (MEHA) Update

Alisha Johnson gave an update on the MEHA/MPHA joint conference and some changes they are making within MEHA. They had about 2/3 of their members attend and they have about 40% more members this year as compared to last year. They have a plan to increase membership satisfaction within the organization. MEHA has been working with Montana State University (MSU) to get an accredited Environmental Health Program. Currently the workforce is pretty low nationwide. The challenge surrounds

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keeping and maintaining a good workforce for sanitarians. They will be applying for accreditation next fall. Melanie Reynolds asked if this would be for an Environmental Health degree. Yes, this would be an undergraduate degree. Montana does have some higher requirements than other states, however, this helps prevent things like the issues Flint, Michigan had. Melanie Reynolds asked if they are able to do their sanitarian in training program along with the undergraduate degree. No, I do not believe this is possible at this point. In order to get the training program running concurrently with the degree, the Board of Sanitarians would have to approve it. The degree does however require a practicum or internship that would involve working and gaining experience with sanitarians. Currently the credential program requires a science background and on the job training with a licensed sanitarian. Todd Harwell requested that Alisha send Jessica Miller a summary of the program so that we can send this out to local health departments.

Terry Ray asked if there is anything that the Task Force can help MEHA with. Yes, we would like to request a list of available mentors to help train Environmental Health Interns. Funding for traveling Environmental Health students of MSU would also be useful and students who need scholarships for education. Todd Harwell asked if Food and Consumer Safety at PHSD could be an option for internships. Yes, that could be a possibility for interns. Alisha Johnson provided an overview of the minimum requirements needed to attain a sanitarian license. You have to have a certain amount of school credits in science and lab work, including a class in Microbiology, along with a year's worth of experience.

Association of Montana Public Health Officials (AMPHO) Update

Jane Smilie gave an update on the Mentorship program. The kickoff for this program began in August with 11 mentees paired with nine mentors. Wendy Boyer was brought in as an organizational consultant and discussed workplace style and how that impacts your leadership. The first mentorship program meeting occurred during the MPHA conference. There are four webinars coming up and they will be open to all lead locals and any interested staff. The first webinar is leading through change and into accountability led by Wendy Boyer on October 17. The January webinar is on public health law and policy, led by Joan Miles. The April webinar led by Erick Bryson of MACo will be on budget and finance. The June webinar led by Wendy Kowalski will be on Quality Improvement and Performance Management.

Kristi Aklestad gave an update on the AMPHO Membership Meeting. They discussed accomplishments from the past several years as well as what can be expected moving forward. The board will have four meetings throughout the year and will be creating more opportunities for AMPHO members to facilitate more conversation and face-to-face time. Kristi is now the President/Chair for AMPHO.

Jane Smilie discussed the leadership session held at Summer Institute in July of 2017. The foundation is helping us host a small group to process the information that was gathered from that session and MPHA. This group consists of 15 leaders from the various public health organizations. This will be held on November 1, 2017.

Melanie Reynolds asked Jane if AMPHO has any money that would help pay for travel associated with the mentorship program. Jane let the group know that there is funding for two trips per mentorship pair. This would cover trips for the mentor to visit the mentee and vice versa. The information for traveling is available on the AMPHO website as well as the information given at the start of the mentorship program.

Follow-Up Items

- PHSD will send out a Qualtrics survey to lead locals to assess what the greatest public health system needs are for funding opportunities from the Healthcare Foundation.

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- Terry Ray will send Alisha Johnson an example of a funding proposal so MEHA can receive support from the PHHS block grant.
- The next meeting will be on February 28th (webinar) from 2:00-3:00pm.

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Agenda
Public Health System Improvement Task Force
October 11, 2017
10:00am-12:15pm
Public Health and Safety Division
1400 Broadway St., Helena, MT. 59620

10:00am	Roll call of members	Jessica Miller
	Introductions	Jessica Miller
	Approval of previous meeting minutes and announcements	Jessica Miller
	Announcements from members and any additions to agenda	Chair

Old Business

Montana Public Health Association (MPHA) workforce development and support activities update and lessons learned	Kristi Aklestad
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New Business

National Association of County and City Health Official's workforce development competencies process	Hillary Hanson	
Preventive Health and Health Services (PHHS) Block Grant 2018 Budget Review	Terry Ray	
-PHHS Block Grant public hearing and vote	Terry Ray	
Review of 2017 MPHA's Annual Conference	Terry Ray, Kristi Aklestad	
Montana Environmental Health Association (MEHA) Update	MEHA member	
MPHA Update	MPHA member	
Other topics of discussion	Chair	
12:15pm	Adjourn	Chair

For more information, contact Jessica Miller at 406-444-5968 or JMiller5@mt.gov

Office of Public Health System Improvement, Public Health and Safety Division, MT DPHHS

The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist

Public Health Leadership Forum

This paper was prepared by RESOLVE as part of the Public Health Leadership Forum with funding from the Robert Wood Johnson Foundation. John Auerbach, Director of Northeastern University's Institute on Urban Health Research, also put substantial time and effort into authoring the document with our staff. The concepts put forth are based on several working group session (See Appendix B for members) and are not attributable to any one participant or his/her organization.

RESOLVE

May 2014

The High Achieving Governmental Health Department in 2020 as the Community Chief Health Strategist

Public Health Leadership Forum

Background

Local and state health departments need to adapt and evolve if governmental public health is to address emerging health demands, minimize current as well as looming pitfalls, and take advantage of new and promising opportunities. To succeed requires a view into the future. This paper provides that vision. And, importantly, it zeroes in on what a high *achieving* public health department of the future will be doing differently. It does so not with a comprehensive inventory of tasks but rather with a distillation of the most important new skills and activities essential to be high achieving and serve in the role of the *community chief health strategist*.

A working group of public health practitioners and policy experts was convened by RESOLVE as part of the [Public Health Leadership Forum](#) with funding from the Robert Wood Johnson Foundation (See Appendix B for a list of members). The working group purposely set a time frame of public health in 2020 – just six years into the future – in order to look far enough ahead to provide a compelling beacon, while staying close enough to the present to emphasize the urgency of taking immediate steps to start the process of change and build the leadership necessary to be successful.

Vision

The core mission of public health remains the same: the reduction of the leading causes of preventable death and disability, with a special emphasis on underserved populations and health disparities. This is our perpetual north star. But *how* we achieve that mission has to change, and change dramatically, because the world in which we find ourselves is very different than just a few years ago, and it will continue to rapidly change. Unless we recognize the new circumstances and adapt accordingly, public health will not just be ineffective, it runs the risk of becoming obsolete.

Just what are the conditions that have brought about the need for this overhaul and a call for new practices and skills? A short list includes:

- *The health care needs of the population are changing.* The prevalence of chronic disease has skyrocketed as life expectancy has increased and other causes of death have

decreased. Much attention has appropriately focused on obesity and asthma in the last several years, and health departments have scrambled to find the necessary resources to respond. In the coming years these diseases are likely to continue to remain priorities, but in addition, health departments will need to focus on other chronic diseases that are leading preventable causes of morbidity as well such as those associated with behavioral and oral health and sensory-related disabilities.

- *The demographics of the country are changing.* The increased prevalence of the chronic conditions mentioned above will continue as the elderly and very elderly (over 85 years of age) population grows. Public health departments will face the challenge of developing strategies to help elders maintain their independence and quality of life. The continuing growth of the Latino population and other populations of color could intensify the already existing health disparities even as access to care increases for many. To date, our public health successes have not often been evenly effective by class and race. As a consequence and particularly in poorly resourced areas the preventable disease burden of the future will require new approaches perhaps drawn from the global health arena.
- *Access to clinical care will change in a post Affordable Care Act (ACA) environment.* Although there will be differences from community to community, access to clinical care will likely grow everywhere due to an increase in public and private health insurance coverage. As a result some services traditionally provided by public health departments will be covered by health insurance. This change will mean that the role of public health departments as the safety net provider will be diminished and in some instances eliminated entirely. At the same time there will likely be an enhanced role of such departments in assuring that the care provided by others is accessible as well as high quality, prevention-oriented and affordable.
- *An information and data revolution is underway as the world changes to an internet-based, consumer-driven communications environment.* Public health's role as the primary collector of population health information will be reduced as new, diverse and real-time databases emerge. However, the public health role as interpreter and distributor of information will become more pronounced. Governmental public health will have the responsibility for surveying and aggregating the many sources and ensuring accessibility of the essential information in understandable formats.
- *As attention to the factors contributing to chronic diseases increases, the non-health sectors will often be the key to optimizing the health of the public.* Public health's role will involve working collaboratively with these diverse sectors – be they city planners, transportation officials or employers – to create conditions that are likely to promote the health and well-being of the public.

In combination, these new required practices might be characterized as creating a sweeping new role, one we are calling the “*chief health strategist*” of a community. This new role builds upon the past and present functions of health departments and is a critical evolution necessary to be a high achieving health department in the near future.

Public health departments functioning as chief health strategists should retain, refine and defend the programs that are currently successful, such as environmental health, infectious disease control, all hazards preparedness and response, and other skills, strategies and programs essential for protecting and improving the health of communities. But as the chief health strategist, public health departments’ roles will differ in significant ways.

Departmental representatives will be more likely to design policies than provide direct services; will be more likely to convene coalitions than work alone; and be more likely to access and have real-time data than await the next annual survey. Additionally, chief health strategists will lead their community’s health promotion efforts in partnership with health care clinicians and leaders in widely diverse sectors, from social services to education to transportation to public safety and community development. The emphasis will be on catalyzing and taking actions that improve community well being, and such high achieving health departments will play a vital role in promoting the *reorientation of the health care system towards prevention and wellness*. Health departments will also be deeply engaged in addressing the causes underlying tomorrow’s health imperatives.

While it won’t be easy for health departments, even those with the most resources, to achieve this vision of becoming chief health strategists in their communities, it is imperative. Even the smallest of health departments can take partial steps, and some departments are already changing to meet the new demands, and can provide examples for others to follow.

The vision of high achieving health departments serving as community chief health strategists may seem ambitious, particularly for those health departments that are small or under-resourced, and we recognize that many agencies will not be able to adapt quickly. Change across our nation’s diverse health departments will occur at different times and at different paces, but beginning the process is necessary for departments of all sizes whether or not they have lost resources. The demands of the future are unavoidable. Governmental public health must be ready to meet them.

Key Practices of the Chief Health Strategists of the Future

High-achieving local and state governmental health departments of 2020 serving as the community's chief health strategists will share several key practices, seven the working group identified as the newest or most unique are highlighted below. Following the description of the practices, we suggest a beginning menu of steps that health departments large and small can take in order to begin to work toward at least the first practice in the next few years.¹

PRACTICE #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.

Starting in the first few decades of the 20th century, public health departments focused great attention and received considerable funding to fight infectious disease. This orientation of funding reflected the dominance of such diseases as tuberculosis, food-borne illness, and influenza as causes of death in the early part of the century. While improved water and sewage-system regulations, widespread public education, and medical interventions helped address those illnesses, the HIV and then the H1N1 epidemics made clear the continuing health threat posed by infectious diseases, which remain serious health concerns in the U.S. These health threats will require adequate resources to maintain the progress that has already been made, as well as address new infectious disease challenges.

But health departments lack the equivalent capacity to prevent and respond to today's leading causes of illness and death: heart disease, cancer, lower respiratory illness, stroke, and unintentional injuries and overdoses. Unlike infectious diseases, many of these involve chronic conditions that require years if not decades of expensive care and control. Today's public health budgets are not properly aligned or sufficiently funded to tackle these now leading causes of illness, injury, and premature death. Current funding and programs are in fact more reflective of the health concerns of the past than of the present, let alone the future.

Here is where health departments of the future need to shift their focus and the funding streams must follow. Chief health strategists of the future will be able not only to *anticipate* those factors contributing to death and disease in a community, but be able to identify and secure the essential resources necessary to focus attention on chronic disease prevention. The health department strategists of the future will need to focus on the ongoing as well as emerging leading health concerns with the same intensity and strategic skills they once directed toward eliminating tuberculosis.

The most effective preventive solutions for these chronic conditions are often similar across disease categories. The widespread benefits associated with modified and improved conditions at community work places or schools, such as infrastructure for fresh fruits and vegetables and

¹ We look forward to gathering additional action steps for the other practices as this paper is disseminated more broadly.

locating near parks and other open spaces, to support the concurrent behavioral changes of improved diet and exercise, for example, can help individuals and communities that share multiple and interacting risks and health conditions. But prevention efforts that would substantially reduce deaths by addressing tobacco use and obesity are currently underfunded—dangerously so.

And while more needs to be done to address tobacco, obesity, heart disease, cancer and stroke, there are other challenges that will be increasingly appearing on our radar screen. For example, the lack of progress that has been made in reducing the prevalence of disabilities related to behavioral health, musculoskeletal disorders, and sensory loss, will become ever-growing problems if unaddressed as the make up of our communities change and as life expectancy increases. To effectively and efficiently improve community health, public health departments as chief health strategists must keep up to date not only with *what* is threatening people's health, but also *who* is most at risk – discussed in Practice #2 below.

To summarize: the high-achieving health department of 2020 serving as the chief health strategists must understand and address the primary causes of illness, injury, and premature death. These departments will ensure that their efforts are aligned with the needs of the growing prevalence of disabilities; that they have developed expertise in the prevention and/or treatment of chronic conditions; that they are continually looking to and preparing for the newly emerging health trends; and that they are seeking, securing and channeling resources to be successful.

PRACTICE #2: Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.

Demographic trends are shifting the make-up of our communities, rendering some of our focus and community health strategies outdated. If not updated, these changes will potentially compound some of our current weaknesses. By 2020, baby boomers will be over 65, and the percentage of the population that is elderly will be larger than ever before. This shift will intensify the need to focus on the health of the elderly, the importance of preserving their quality of life and the prevalence of such conditions as dementia, as well as paying more attention to their preventable health concerns, such as the injuries resulting from falls.

The country will also be more racially and ethnically diverse, as the non-white population edges toward outnumbering the white population for the first time. And unless we tap new strategies to more effectively confront and reduce health disparities, not only will these disparities increase, they will jeopardize the overall health and well-being of our communities even more extensively. To date our public health advances have often been less successful at reducing class and racial disparities. The preventable burden of the future will differentially require new,

health equity approaches including those that specifically improve health in poorly resourced areas.

These and other changes will compel the health departments of 2020 as the chief health strategists to focus on the health needs and concerns of the fastest-growing populations. Health departments that have historically focused on maternal and child health activities – understandable as high level of death and disability were occurring in infants and pregnant women in communities of the past. However, now – in communities of today and because of successes we have had with maternal and child health issues - health departments will need to broaden their vision to include the elderly as they become a larger proportion of the community and the injuries and illnesses they experience become a more significant variable of overall community health. Health departments also will need to pay greater and greater attention to people of color and Latinos, Asian-Americans, and other immigrants. Demographic shifts may also be accompanied by socioeconomic changes such as a growing income gap and concurrent inequalities in health outcomes. The state and local health departments as chief health strategists should be the trusted source regarding emerging demographic and health trends.

The high achieving health department and health strategist must address the needs related to emerging demographic patterns, and the health inequities experienced by specific sub-populations. Chief health strategists need to answers these questions for each community:

- What are (and will in the future be) the greatest health threats, and who is (and will be) most at risk?
- What will it take to reduce these threats and reach the greatest number of high risk populations with whatever resources are available?

A starting point is to have access to accurate, timely, and understandable data. And that leads to the next essential practice.

PRACTICE #3: Chief health strategists will identify, analyze and distribute information from new, big, and real time data sources.

Public health has always been an information-based discipline. That's its stock in trade. But the old ways of collecting and analyzing information are no longer sufficient. The nature of information technology, information sources, and public expectations of accessibility are changing, and public health needs to rapidly adapt and evolve in response.

Other new and often big data sources can help correct that. Future health departments as strategists should be able to retrieve certain up-to-date clinical data from Electronic Health Records. Among the other sources used will be “big data,” data sets so large and complex that

traditional processing and management approaches don't apply. Health departments are unlikely to have data systems within their control that are large enough to capture all the necessary behaviors, attributes, and community determinants of health.

Instead, by 2020 health departments as chief health strategists may submit regular requests for data from Medicaid, Medicare, from all payer claims, or even outside of the health arena, from city planners, schools, and public safety officials. The strategist will need to look beyond the usual health-related data sources to patient-initiated feedback from social media and to extract data from search engines.

Once these data are collected, assessed, and aggregated, the public health departments as chief health strategist will not just make these data available but analyze them and translate the health implications of identified trends and hot spots, as well as share this information with the public, providers, partnering agencies, and policy makers to inform community-wide decision making and actions collaboratively in order to improve overall health and well being. The chief health strategist's responsibility is to the community it serves, and communities will want and should have meaningful interpretations of what information means for them and their health. The goal, in addition to informing the broad community, will be to offer a more comprehensive picture of health that will deepen their and their partners' understanding of the complex factors affecting the health of a community.

But by 2020, the obligation of health departments as strategists will go beyond accessing and analyzing data to providing information. Health departments will make information accessible for users to customize questions whenever they are needed for whatever purpose they are needed. Data collection and analysis must move closer and closer to real time. It will be unrealistic and unacceptable, in 2020, to wait one year or longer to have the latest reported information on, for example, infant mortality and diabetes rates, as is currently the case.

The health department as the chief health strategist will be prepared to answer what is happening in the current year and not what was happening one, two, or even three years ago. How will the health department as strategist get that information? One way is for clinicians, hospitals, and health departments to look to up-to-the-minute reporting of dangerous infectious disease outbreaks and the response to them. In recent years there have also been numerous examples of the value of rapid responses to clusters of health care associated infections. Access to such information might not require the regulatory-imposed reporting systems of infectious disease thanks to the evolving opportunities to access such data through meaningful usage agreements. In a growing number of communities there are local health information exchanges that can become intermediaries, collecting the data in a format that is usable by a health department without requiring unrealistically sophisticated IT capacity.

The range, freshness, and subtlety of new data sources can make the health department as strategist of the future far more responsive and effective than in the past. With such data health departments can, and good strategists will, focus interventions to more effectively serve populations with disparities. They will be able to evaluate ongoing interventions with more precision and accuracy. And with access to new kinds of data, the high achieving health department as strategist can respond quickly and inventively to chronic disease diagnoses, not just infectious disease outbreaks. If clinicians identify clusters of newly diagnosed asthma cases in one neighborhood, for instance, the public health department can determine which neighborhood environmental factors can be altered in order to reduce future incidence. This means that health departments as chief health strategists of the high achieving departments will need new kinds of skills. Mobilizing the department's existing resources to respond most effectively to the new health priorities will require familiarity with multiple data sources, the ability to advocate for access to those data sources, and then the ability to extract and interpret new data and share the most meaningful findings with the health department's partners and the public. Analysis, energy, and imagination will be essential characteristics; so will clear communication and the ability to make the complex seem simple.

Clear, accurate, and well-analyzed data will be especially important as health departments as strategists expand their partnerships to include multiple governmental agencies and community-based organizations that may be less familiar with health indicators and disease causation – as the next section will make clear. And above all, health departments as strategists will strive for increased accessibility of information to the community by such means as tapping friendly interfaces to accessible information and increasing sophistication in the use of social media.

In these efforts, high achieving health departments will rely heavily on one particular segment of the larger community – health care providers and facilities. The chief health strategist will understand, reach out to and collaborate with key partners in the health care community. These key allies and alliances promote good health, of course. But they may also be crucial in answering the all-important question of how high achieving health departments as chief health strategists of the future will fund community mobilization and policy-oriented campaigns – namely by redirecting funding from services for which they no longer need to pay. This leads to the next practice.

PRACTICE #4: Build a more integrated, effective health system through collaboration between clinical care and public health.

With some notable exceptions, the American public health and the clinical care systems have long been separate and distinct. One is focused on population groups and the other on individual patients; one is largely funded by the government, the other mostly by insurers.

Today, the two systems sometimes interact - for example, through infectious disease reporting during an outbreak like measles or pertussis, or when a community health center or a hospital needs a license. Numerous health departments directly provide or fund a limited number of clinical services such as immunizations or treatment for sexually transmitted infections. A few departments even run their own federally qualified community health centers. But these are the exceptions, not the rule.

Collaboration with Clinical Partners

In Massachusetts, a Prevention and Wellness Trust was created in 2012 by the state legislature, which awarded \$60 million to the Department of Public Health to oversee a process of establishing community-clinical partnerships to promote health and reduce costs. With this resource, the health department has funded 9 collaborative initiatives made up of municipalities, community-based organizations, healthcare providers, health plans, regional planning agencies, and worksites. The activities funded include enhancing community-clinical relationships, lowering community members' barriers to optimal health, identifying health-related community resources, tracking referrals to and the use of community resources in clinical records, and using quality improvement to strengthen community-clinical process and linkage.)

family planning services.

By 2020, health departments as chief health strategists will have conducted careful analyses of the available and accessible clinical services in their communities and determined if their departments should continue to provide them, at what level, and for whom. The high-achieving health department will reduce, eliminate, or significantly adapt its provision of direct services, implement billing practices where services are still needed, and may shift to primary care providers some activities such as tuberculosis care and disease intervention so they are more integrated.

This separation of public health and health care has not served us well in our overall goal to create a system that improves health. That can and must finally change. The high achieving health department as chief health strategist in 2020 will form close and interactive relationships with the clinical providers and health insurers in its municipality. The chief health strategist will know who to connect with and how best to make these connections, as well as work within the financing network to make respective efforts viable.

There are several reasons why this change will occur. The ACA is increasing health care access to millions of additional Americans and decreasing (although not eliminating) the need for the public health system to provide safety-net services such as immunizations, STD treatment, and

As more people have access to care through expanded health insurance benefits, governmental public health can increasingly serve an expanded health assurance function – linking those in need with potential providers rather than offering the services themselves. And they can play an increased role in monitoring and reporting on community access, cost, and quality of treatment care.

Departments may identify certain new services they can provide to complement those offered by clinical providers. One example: bundled packages of home visits by educators and risk reduction specialists to women with high-risk pregnancies or to families with a child who has moderate to severe asthma. Such services can be new generators of revenue, offered to insurers and clinicians in exchange for reimbursement. A second example involves using community health workers or other strategies to help patients address the social determinants of health, linking with opportunities for improved housing, employment training, or family unification.

Another dynamic changing the landscape is the continuing rise of health care costs and associated interest by the health care community in turning to partnerships to leverage their ability to improve health. The widening range of state and national payment reform initiatives will bring with it new possibilities for linkage between public health and clinical medicine. The movement away from the predominant fee-for-service to a global, value-based system of reimbursement should open the door for greater partnership and to the allocation of new revenue to support public health efforts. New global payment systems can potentially add population-based outcome measures to the list of quality measures that must be met to maximize reimbursement. For example, if clinicians have a financial incentive for their patients to stop smoking, they may seek the involvement of the local or state health department. And in turn, departments can share in the revenue incentives.

Such possibilities also build upon the momentum created by the ACA's provision that hospitals must develop community health assessment reports or face penalties from the IRS. Many hospitals have sought the guidance of and/or collaborated with their public health departments to meet that requirement. The health departments of the future will strive to solidify those connections, and to ensure that those connections result in the investment of hospital resources in population health initiatives. In addition, health departments may seek out or solicit new strategies for innovative investment in community prevention, for example through the use of wellness trusts and social impact bonds.

High-achieving health departments as chief health strategists will fight for a seat at the table where payment reform and insurance expansion are being determined in their states and localities, alongside the usual participants of Medicaid, private insurers, and providers. To achieve this goal by 2020, chief health strategists must develop new knowledge and skills in

such areas as benefit package design, identification and analysis of health metrics, and analyses of return on investment.

Finally, the movement to near-universal use of electronic medical records (EMRs) governed by the ACA's required "meaningful use" provisions will offer access to new and timely data, as discussed in Practice #3. And EMRs may assist in the tracking of patient referrals and the usage of community-level services supported by public health such as smoking cessation services, chronic disease self-management training, and home visits by community health workers.

In summary, the high achieving health department as chief health strategist, then, will take advantage of the numerous opportunities to join the efforts of public health, clinical providers and insurers. Health care and payment reform will allow for innovative collaboration such as linking smoking cessation treatment with community level cessation groups and expanding smoke-free regulations. Departments will face challenges in the process, as they reduce their own direct services and refer newly insured residents to primary care medical homes and as they strive to acquire a new understanding and appreciation of insurance practices.

Additionally, as health departments work more closely with clinical partners, they may also learn useful lessons about quality improvement measures and transparent goal setting and monitoring – aspects of the health care business model that can be integrated into the high achieving health department's in 2020 and beyond. They can then look inward and identify some of the organizational system changes in their own departments that will help them function more efficiently and effectively. The following practice highlights why it will be important for departments to be on the lookout for those lessons, as well as Practice #6 which pushes further the need for improved business systems.

PRACTICE #5: Collaborate with a broad array of allies – including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.

A century ago, as public health advocates grappled with deadly infectious diseases, they looked to other disciplines for assistance. They knew they would need the involvement of other kinds of authorities if they were going to solve the problems associated with, for example, water-borne and air-borne infections, which spread rapidly in the living conditions of the poor. It was changes in housing codes and municipal investments in sewer systems, plumbing infrastructure, swamp drainage, and aerial insecticide spraying that saved more lives, faster, than public information campaigns or even medical breakthroughs could.

The conditions today and in the future are clearly different. As mentioned in Practice #1, it takes more focused teamwork within the public health community, with new and different skills and strategies, as well as cooperation and coordination with the health care community, when grappling with chronic conditions instead of infectious disease. But there are some

additional lessons in the past successes worth learning from and adapting to the present. And among them is the importance of working beyond a limited circle of partnerships – even a more expanded team among health and human service organizations. There is once again the need for cross-disciplinary collaboration and close partnerships with non-health-oriented organizations.

Environmental irritants in the home, the workplace, and the community contribute to ever-rising asthma rates, to choose one current and pressing example of an illness that requires collaborations among diverse non-health – oriented agencies and community leaders as well as those in the public health and health care sectors. In order to reduce these asthma triggers, health departments need to align their particular skill sets, as well as form partnerships with the medical community, landlords and housing code inspectors, employers and unions, polluting businesses and environmental regulators – to name just a few.

But developing the needed partnerships with other sectors takes time, training, and specialized personnel, and those partnerships will happen only if they are made to be priorities. Much of our work with these sectors will need to be through adaptive leadership and influencing without direct authority. These partnerships will require developing experience and skills among non-governmental organizations and other community leaders with how to effectively navigate regulatory and legal processes at the local and state levels and to influence policy. But they will also require understanding and respecting the priorities, goals, and objectives of other public and private, governmental and non-governmental agencies and organizations.

Building Community Coalitions

The Robert Wood Johnson Foundation's County Health Rankings initiative has prompted the creation of a number of broad-based community coalitions to tackle local health problems. One such effort was in Scioto County, Ohio, which was ranked last among all 88 Ohio counties in 2012. That ranking motivated community leaders to convene meetings of stakeholders to set the agenda for helping improve the county's health. Local health departments played a key role in providing data, identifying needs and gaps, and highlighting other efforts that were already underway. The initial coalition members decided to broaden the group so it would include people from contiguous counties in urban Kentucky that were facing similar issues. While the meetings were initially primarily of health professionals, they soon included teachers, superintendents of schools, clergy, law enforcement officials, and large employers. An early project involved improving childhood immunizations by linking schools and electronic medical records.)

It is not just diseases that require cross-disciplinary partnerships. It is the socio-economic conditions that foster them and make them worse. As health departments confront and address health disparities caused by economic inequality, racism, and discrimination, they need to take a broader approach. Factors as diverse as housing segregation, high school dropout rates, gang violence, and unemployment contribute to elevated risk for illness, injury, and premature death in low-income and minority communities. Working on these issues can, it is true, push most health departments out of their comfort zones. Nonetheless, the high achieving health departments as chief health strategists of the future will speak out compellingly on the connection between these issues and specific health outcomes, and then work collaboratively to change those factors to improve health outcomes.

The health department of the future will also encourage and support the leadership of community members in the efforts to promote healthy conditions. By training, informing, and nurturing leadership in neighborhoods with elevated health problems, the chief health strategists can develop a valuable and long-term resource for health promotion and, in essence, expand the public health base.

The Surgeon General's National Prevention Strategy of 2011 touts the importance of a health department's active engagement with community members and organizations. Community efforts, the report says, help people "take an active role in improving their health, support their families and friends in making healthy choices, and lead community change."¹

Health departments should thus explore the possibility that federal resources can support local and state health departments in convening broad-based collaborative efforts at the community level. But with or without federal funding, such convening is necessary.

In summary, by 2020 chief health strategists will identify, pursue and establish effective partnerships with those in positions to make a difference in the community's health. In addition to partnerships with others in the health system, as well as other governmental agencies, chief health strategists will participate in and support community-based coalitions that examine health data, set goals, and develop plans to improve health. They will enlist civic and other community leaders such as key local businesses and the Chamber of Commerce as well as leaders at the grass roots level to help carry out those plans. In community-based collaborative efforts, health departments will share the latest findings on evidence-based action steps and, if possible, give community coalitions grants and other resources.

Partnerships can be catalyzed and fostered through the provision of access to information and unique skills that others see as adding value to their respective endeavors, as well as joining in meaningful collaborations. Additionally, potential and ongoing partners and patrons alike are drawn to professional practice and conduct, and business practices are key elements in demonstrating value.

PRACTICE #6: Replace outdated organizational practices with state-of-the-art business, accountability, and financing systems.

Not surprisingly, the training most public health professionals received in school and on the job is insufficient to handle the challenges of the future and as the health enterprise changes. Mining big data? Tapping social media for epidemiological information? Embedding population health metrics within value-based insurance contracting? Participating in designing bidding packages for major transportation projects? These aren't in the job description or the skill sets of the employees in most public health departments. But they need to be... and soon.

To assume the mantle of chief health strategist, health departments need to retool and retrain and seek new employees with updated required skills. The high achieving health department of 2020 will have the personnel, know-how, and technological tools to handle the variety of required tasks. By 2020, the health departments as chief health strategist will have assessed the necessary skills - particularly the newer ones required – and compared them with the skills of the current workforce. Where they don't match, the health department will develop a plan to either rewrite job descriptions or hire people with the needed skills as positions become available. Or, it will investigate and pursue re-training opportunities for the current workforce, prioritizing the skills that are most essential.

Public health programs operate inefficiently for a number of reasons. One is that they are simply following the practices that have previously been put in place. But these outdated modes need to be replaced with current business practices. These include being efficient, effective, transparent, and accountable – in other words, being good stewards of public resources. Among the necessary practices will be establishing visible goals (perhaps with the use of an online dashboard), measuring and analyzing the progress in meeting them, and striving for continuous improvement using a thorough analysis of the lessons learned in the process. Such practices are now common in the private sector. Health departments would do well to study and learn from the best of such models.

A second reason for the inefficiency of public health departments is the size and structure of some departments. Some are too small to capture the efficiencies that come with scale or to have the degree of specialization that is needed. So a key task of the chief health strategist will be to examine if such limitations can be overcome by sharing agreements across jurisdictions. This may necessitate and lead to formal affiliations and even mergers of health departments.

Health departments will need to make the business case for public health activities – that is, using health economics to highlight examples when public health interventions save money in the short, as well as the long, term. It will no longer be sufficient to simply claim that prevention saves money without the economic analysis to demonstrate that this is the case for

each specific activity. Such analyses will also be needed to demonstrate that health departments are wisely using their own resources and translating them into positive health and economic outcomes. One way to prove that they are will be to achieve accreditation from PHAB.

The health department as chief health strategist in 2020 will diversify the funding base for public health. In addition to relying on local, state, and federal grant funding, health departments will establish mechanisms to bill insurers and providers whenever possible. However, newly identified funding might or might not come to the health department itself, depending on an assessment by the department of where the funding can be of most use. Part of the role of the chief health strategist will be assuring that resources are directed to others. For example, departments of the future will collaborate with non-health related government agencies to encourage that they direct their own resources towards practices which will directly improve community conditions.

Accomplishing this expected practice is a tall order for any health department. To acquire this and the other goals for skills and practices mentioned previously, health departments need to help create and become part of a learning health system in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery of public health, and community health overall, and new knowledge captured as an integral by-product of the ongoing experience of becoming chief health strategists.

Health departments as chief health strategists also need guidance, support, and encouragement from what for many is their largest funder and most important technical assistance and policy partner... the federal government. The next section explores why the federal public health system is so important for the health departments of the future.

PRACTICE #7: Work with corresponding federal partners - ideally, a federal Chief Health Strategist - to effectively meet the needs of their communities.

Chief health strategists require the support (financial and policy) and architecture of the federal government. Without this support – and, moreover, leadership – from the federal government, it will be difficult for local and state health departments to adequately prepare for 2020 and become chief health strategists. Locals and states can and must be their own agents of change to become the health departments of the future.

But the necessary transformation is not something they can make entirely on their own. Certainly, they need financial support from the U.S. Department of Health and Human Services. The federal government, as a major (sometimes THE major) funder of state and local public

health, sets the tone and drives the structure and function of public health at the state and local level.

In order for local and state health departments to function cohesively, they need greater flexibility in funding than federal agencies currently provide coupled with the skills and tools to take advantage of that flexibility. Grant awards with narrowly segmented focuses – a short-term work plan for asthma, a separate one for tobacco, a third one for diabetes – lead to organizational silos and more limited external partnerships. If locals are to bring together all who can affect health, then federal health agencies need to make it easier to braid federal funding, and the federal health and non-health agencies need to design their programs to permit closer coordination of funding.

Such flexibility will encourage health departments to address community, workplace, and school conditions in ways that have a positive impact on many health problems. Prevention-related activities that encourage healthy eating and active living decrease a number of many health risks, including diabetes and heart disease. Efforts have been underway at the Centers for Disease Control and Prevention (CDC) to provide more coordinated funding in such areas as HIV and other sexually transmitted diseases and has piloted integrated chronic disease grants. Such approaches enhance the likelihood of improving health outcomes.

An additional example that will be of growing relevance to the health department of the future is the potential to use funding for what might be referred to as foundational public health services such as the needed steps to update Health Information Technology, develop broad-based partnerships, and collaborate with clinical systems.

To be clear, flexibility in the use of funding should not be confused with the lack of accountability. But the chief health strategist will be hampered in accomplishing specific necessary (and measurable) tasks if the funding continues to be awarded in an overly restrictive manner.

But the federal government's role in fostering change at the state and local level is not simply about funding. Transformation also requires a change in the way the federal agencies interact with the local and state officials. To begin with, a unified set of policies and practices, including but not limited to funding, would provide a consistent system within which to function.

One obvious challenge to such cohesive structure is that the current federal health enterprise is not a single "health department" with a unified set of policies and practices. Rather, it is a diffuse set of agencies charged with different aspects of health services that drive state and local public health activities through different funding streams and associated requirements, regulatory authorities, and legislative efforts.

The federal system needs to establish and embrace a goal and a plan to function as a “virtual” federal health department and be a chief health strategist at the national level. Federal inter-agency coordination that gives consistent and unified guidance, resources, and training to support local and state changes is invaluable. In fact, without such support, the necessary changes mentioned in each section of this report are more difficult to achieve. It may be too ambitious to propose that within the next six years (our 2020 time frame) there should be a federal equivalent to the chief health strategist at the local or state level. But, the closer the federal health system can come to operate with a single voice, uniform procedures, and a common set of priorities, the better.

There is opportunity and evidence that federal leaders recognize the changes needed for the future. The National Prevention Strategy paints an ambitious picture of what public health and prevention efforts need to be. And that picture looks startlingly and encouragingly familiar to a number of the themes identified above. For instance, it strongly reinforces Theme #4 regarding the importance of seeking broad-based meaningful partnerships, as indicated by its language that *“Aligning and coordinating prevention efforts across a wide range of partners is central to the success of the National Prevention Strategy. Engaging partners across disciplines, sectors, and institutions can change the way communities conceptualize and solve problems, enhance implementation of innovative strategies, and improve individual and community well-being.”*² A consistent message throughout the National Prevention Strategy is the importance of bringing all societal and governmental resources together to address the determinants of health and their direct health consequences.

The same observation applies to the six practices discussed above. For example, if locals and states are to harness health information technology and mine new data sources, they can’t be sidetracked by outdated national approaches to surveillance and other data collection. Or by conflicting reporting requirements that narrowly define what are the acceptable data for each federal agency and/or program. This means that the same vision of innovation and diversification in data sources needed at the local and state levels must occur at the federal level. Dozens of federal data collection efforts, surveys and registries need to be modernized. Cross-agency conferences and webinars should be held to identify promising practices. Partnerships with those managing useful big data sites should be brokered at the national level in ways that ease access to the data at the state and local levels. National and regional training for state and local health information technology staff should be frequent. And all federal agencies that fund public health should commit to abide by the outcome of such efforts, so that local and state health departments are not required to maintain the current, inefficient patchwork quilt of agency-specific data sources.

Similarly, if locals are going to succeed in bringing the community and clinical world together, then the federal government needs to incentivize both public health *and* the clinical world to

work together. Promising steps in that direction are beginning with the growing collaboration of CDC and the Center for Medicare and Medicaid Innovation, and the inter-agency support for Million Hearts and ABCS campaigns. But the funding, training, and prioritization of such efforts is limited.

One final point mentioned earlier but worth reiterating is the magnitude of the challenges faced by the health department of the future. It is unrealistic that a small and under-resourced department can achieve these. Therefore, an additional role for federal agencies might be to create incentives for health departments to consider municipal partnerships across local and state lines. Just as the ACA opens up whole new vistas for chief health strategists to collaborate across previously separated public-private lines, state and federal agencies should look to break down bureaucratic barriers.

In summary, the previous sections have called for the rethinking of the role of new local and state chief health strategists, suggesting a sweeping set of responsibilities that should be adapted to meet the actual conditions of the future. This final practice suggests not only that the state and local health departments as chief health strategists form a more effective partnership with the federal government agencies, but also necessitates that the federal government modify and adapt as well, as a virtual federal chief health strategist with the whole nation as its community, both to meet the new health needs and conditions, and to optimize, through unified goals, policies, and funding, the likelihood that local and state health departments will be modernized and well prepared. A few obvious starting points for such a federal health transformation would include the translation of the National Prevention Strategy into the terms and practices by which federal government and health agencies actually do business, and the creation of new, more unified working relationships across the federal departments and sectors.

Action Steps and Conclusion

It is not that long between now and 2020. Even as health departments persevere under the stressful conditions of several years of budget cuts and the simultaneous increase in the number of issues they must address, they must evolve. For some health departments, their limited size and relatively narrow scope of activities may potentially require combining resources with others in their state or region. It may simply be unrealistic for health departments below a certain size to become the chief health strategist and manage the necessary division of labor and flexibility to adapt to the new circumstances.

However, some health departments are already embracing the new opportunities outlined in this paper – whether through strategic planning, preparing for the Public Health Accreditation Board process, and considering the departmental changes they must make. They will recognize in our concept of a chief health strategist the new roles they have begun to assume.

These seven proposed practices are a tall order and require action that starts today if it is not already underway. Given the urgency of this need, we offer the following menu of suggested action steps, which are designed to stimulate discussion, idea development and additional to-dos. Some of the suggestions are intended to be scalable to the circumstances faced by any department. They emphasize processes that can be undertaken to assess new and future conditions, compare current practices to future needs, begin to explore new data sources, start one or more new partnerships, mobilize leadership at the community level, and strengthen management systems. Health departments can undertake necessary exploratory work – even without new resources. As more and more health departments engage in these efforts, there will be success stories and lessons from which all can learn.

Appendix A: Becoming the High Achieving Public Health Department as the Chief Health Strategist by 2020 and Beyond

- 1. The first practice mentioned above involved understanding and addressing the primary causes of illness, injury, and premature death, while the second practice highlights the needs related to emerging demographic patterns, and the health inequities experienced by specific sub-populations.*

To achieve both objectives of a health department as a chief health strategist of any size could begin with a planning process both internally and in partnership with others to determine the likely needs of 2020 and consider how best to meet them. Some of the steps could include:

- a. Collecting the most comprehensive available data on health and demographics including that prepared by area hospitals to meet the new IRS regulations;*
 - b. Assessing data for increasing prevalence of illness and injury and for changing demographics in the coming decade. Focus on the major causes of illness, injury and premature death; what's changing and what's problematic now and unaddressed.*
 - c. Convening an advisory group with external members to review data and determine if there are likely future trends and needs of the most prevalent current and future conditions not captured by the data; consider open public meetings to solicit additional input.*
 - d. Reviewing internal distribution of staff and resources relative to the issues of growing concern; assess ability to redistribute existing resources to better reflect these issues.*
 - e. Discussing possible steps to address the future needs with the advisory group; prepare materials highlighting the dilemma*
- 2. Assess the diagnoses, trends, and underlying causes of the leading illnesses, injuries, and premature deaths within a municipality and analyze their significance in relation to the current distribution of public health funding.*
- 3. Assess the demographic trends for the municipality as well as the populations with the greatest health disparities, and analyze their significance in relation to the current distribution of public health funding for the area.*
- 4. Examine existing and emerging databases in the area that can offer information relevant to the health department's planning, programs, and policies. Select one or two promising databases such as open-source, social media, or big data systems and invest in exploring what it would take to gain access to and analyze the data they hold. Learn to analyze aggregated information to better understand the health determinants in your area.*

5. *Convene meetings of clinical providers and insurers to discuss potential linkages between population health and clinical care. Develop at least one pilot program to strengthen these connections.*
6. *Collaborate with new non-health-sector partners such as police officers and educators who have the potential to make an impact on the living conditions of some of the more vulnerable segments of the community.*
7. *Invent or adapt job descriptions for positions likely to be needed in the future. These include: information technology, with expertise in big data systems, social media, and analyzing claims data from insurers; building coalitions and organizing communities; building bridges with other sectors including health care providers, non-health governmental agencies, large employers, and community-based organizations.*
8. *Initiate an effort to strengthen internal management systems in ways that create transparent goals, and establish ways to measure progress in achieving them.*

**NATIONAL ASSOCIATION
OF COUNTY CITY HEALTH
OFFICIALS: WORKFORCE
COMMITTEE**

**Chief Health
Strategist
Competencies
October 11,
2017**

CHIEF HEALTH STRATEGIST

- **Practice 1:** Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.
- **Practice 2:** Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow.
- **Practice 3:** Chief health strategists will identify, analyze and distribute information from new, big and real data sources.
- **Practice 4:** Build a more integrated, effective health system through collaboration between clinical care and public health.

CHIEF HEALTH STRATEGIST (CONT)

- Practice 5: Collaborate with a broad array of allies- including those at the neighborhood-level and the non-health sectors – to build healthier and more vital communities.
- Practice 6: Replace outdated organizational practices with state-of –the-art business, accountability, and financing systems.
- Practice 7: Work with corresponding federal partners – ideally, a federal Chief Health Strategist – to effectively meet the needs of their communities.

NOW WHAT?

- What competencies do the lead public health officials need to have in order to lead their health department to become the Chief/Community Health Strategist?
- Methodology:
 - Crosswalked, reviewed and ranked the top three competencies needed to achieve the seven practices.
 - Core Competencies for Public Health Professionals
 - CDC Competencies for Population Health
 - National Consortium for Public Health Workforce Development (the deBeaumont Foundation)

CROSSWALK VOTING

A CHS	B CoL	C Pop H	D NA16
<p>PRACTICE #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.</p>	<p>Describes factors affecting the health of a community (e.g., equity, income, education, environment)</p>	<p>1. Preventive Interventions - Explain the major preventive interventions, including their challenges and impact on population health</p>	<p>Evidence informed decision-making</p>
	<p>Determines quantitative and qualitative data and information (e.g., vital statistics, electronic health records, transportation patterns, unemployment rates, community input, health equity impact assessments) needed for assessing the health of a</p>	<p>2. Descriptive Tools of Population Health - Summarize and compare descriptive tools commonly used to understand population health</p>	<p>Integrating findings into program/strategy</p>
	<p>Assesses assets and resources that can be used for improving the health of a community (e.g., Boys & Girls Clubs, public libraries, hospitals, faithbased organizations, academic institutions, federal grants, fellowship programs)</p>		<p>Environmental scan: what's currently going on in your community around health equity and social justice? What are others doing- locally, nationally, and internationally?</p>
	<p>Develops organizational goals and objectives</p>		
	<p>Selects policies, programs, and services for implementation</p>		
	<p>Ensures development of community health assessments using information about health status, factors influencing health, and assets and resources</p>		
	<p>Makes evidence-based decisions (e.g., determining research agendas, using recommendations from The Guide to Community Preventive Services in planning population health services)</p>		
	<p>Advocates for the use of evidence in decision making that affects the health of a community (e.g., helping policy makers understand community health needs, demonstrating the impact of programs)</p>		
<p>Determines the feasibility (e.g., fiscal, social, political, legal, geographic) and implications of policies, programs, and services</p>			

Practice #1		
Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death.	Advocates for the use of evidence in decision making that affects the health of a community	8
	Determines the feasibility and implications of policies, programs, and services	4
	Influences policies, programs, and services external to the organization that affect the health of the community	4
	Makes evidence-based decisions	3
	Evaluates policies, programs, and services	3
	What's currently going on in your community around health equity and social justice? What are others doing- locally, nationally, and internationally?	3
	Selects options for policies, programs, and services	2
	Ensures the use of evidence in developing, implementing, evaluating, and improving policies, programs, and services	2
	Describes factors affecting the health of a community	1
	Assesses assets and resources that can be used for improving the health of a community	1
	Ensures development of community health assessments using	1

WHAT EMERGED?

- **Advocacy**
- **Relationships**
- **Performance Management**
- **Policy, Programs and Services**
- **Data**
- **Strategic Thinking**

A WORK IN PROGRESS

A	B	C	D	E	F	G
	Advocacy	Relationships	Performance Management	Policy, Programs, and Services	Data	Strategic Thinking
PRACTICE #1: Adopt and adapt strategies to combat the evolving leading causes of illness, injury and premature death .	Advocates for the use of evidence in decision making that affects the health of a community			Determines the feasibility and implications of policies, programs, and services to address existing and	Uses data sources to determine how emerging health trends affect specific populations	Thinking – Demonstrate systems and strategic thinking in planning, implementing, and evaluating population health improvement
PRACTICE #2: Develop strategies for promoting health and well-being that work most effectively for communities of today and tomorrow .	Advocates for policies, programs, and resources that improve health, reduce disparities, increase health equity and address social justice in a community Supports and uplifts the efforts of community partners and other health advocates that resist various systems and structures of oppression that prevent marginalized people from having full access to resources that can improve their health outcomes.			Influences policies, programs, and services that contribute to health inequities in the community Track legislation on national, state, and local level for impact on LHD practice and health of the community	Uses data to identify emerging demographic patterns and the inequities experienced by certain community populations Assess the efficacy of current strategies by other LHDs and agencies that are reflective of current and emerging population. Contribute to a new evidence base and work towards more	Integrates current and projected trends (e.g., health, fiscal, social, political, environmental) into strategic planning Assess how sources of power/power differentials in communities lead to health inequities
PRACTICE #3: Chief health strategists will identify, analyze and distribute information from new, big, and real time data sources .	Promotes the use of new and innovative information technology in accessing, collecting, analyzing, using, maintaining, and disseminating				Determines quantitative and qualitative data needs and identifies and uses new data sources in assessing the health of a community	

NEXT STEPS

- Finish reviewing and compiling
- Develop materials to help leaders
 - Self-assessment
 - Listing of trainings that could assist them in developing identified competencies
 - New trainings?
- Develop competency list for management team

FFY 2018 & 2019 Preventive Health and Health Services Block Grant

Anticipated Award Amount = Approx. \$1,034,000

Program	Total	Description
Behavioral Risk Factor Surveillance System (BRFSS)	\$42,000	<p>This funding will be used for BRFSS data collection by the University of Missouri. The BRFSS is state-wide telephone survey of Montana adults consisting of approximately 120 questions. The BRFSS provides prevalence data for a wide-range of chronic conditions, health behaviors (e.g., smoking and alcohol use), and general well-being. The survey has two parts: 1) the core questions (approx. 90 questions) which are required by CDC; and 2) state-added questions (approx. 30 questions). Funding sources for the MT BRFSS comes from a CDC cooperative agreement which supports data collection of core survey and personnel (60% of operating budget) and survey fees for state-added questions (20% of operating budget). The CDC cooperative agreement is not enough to fully support data collection of the core survey. The block grant funding will support data collection of the core survey.</p>
Built Environment	\$100,000	<p>Support attendance of up to six (6) Building Active Communities Initiative (BACI) communities at the Action Institute, an annual statewide conference and training. The Action Institute provides attendees with expertise from national and local professionals on how to create and enhance community environments so that people of all ages, ability and income levels can safely walk, bike or take public transportation to places they need to go. The funding also supports conducting this training.</p> <p>In addition, this funding will be used to support Nutrition and Physical Activity (NAPA) program’s contract with Montana State University’s Office of Rural Health to employ a .75 FTE Built Environment Consultant. The consultant will provide training and technical assistance to communities on built environment strategies and will work with NAPA to plan and execute the annual Action Institute.</p> <p>\$75k MSU Contract. \$25k Action Institute and Community Assistance.</p>
Emergency Medical Services Administration	\$124,000	<p>Funding will support development and implementation of statewide, comprehensive Emergency Medical Services (EMS) and trauma care systems. This is accomplished through licensing of ambulance services, statewide coordination and training for pre-hospital emergency medical service providers, and data collection and analysis for quality improvement.</p>

Local and Tribal Public Health System Support	\$275,000	<p>Allocated to the Public Health System Support Unit to cover operational expenses and grant opportunities for local and Tribal health departments.</p> <p>\$160k Employee salary and benefits. \$15k Travel and technical assistance and/or training. \$100k Small grants to local and Tribal health departments for public health planning and systems improvement.</p>
Poison Control	\$196,000	<p>Funding will be used to contract with the Denver- based Rocky Mountain Poison and Drug Center (RMPDC). This contract provides: 1) poison information and management services to callers and 2) clinical toxicological services to Montana's health care professionals.</p> <p>\$196k to the RMPDC.</p>
Provide Community Health Data for Community Health Improvement Planning. IBIS - Data System	\$30,000	<p>The Internet Based Information System for Public Health (IBIS-PH), is the web-based data system used by the Public Health and Safety Division (PHSD) to meet the growing demand of sharing public health data with the public. The system was competitively procured and will allow the public to create their own user-defined queries based on the data sets provided by the Office of Epidemiology and Scientific Support.</p> <p>\$30k Programming support.</p>
Public Health and Safety Division Internal Operations and Public Health Workforce Development	\$200,000	<p>Public Health System Improvement Office funds to implement improvements to the Division's internal operations and to support the development of the state's public health workforce.</p> <p>\$40k Certificate of Public Health with University of Montana (UM). \$20k Electronic information management systems maintenance and development. \$3k Public Health System Improvement Office supplies and admin support. \$15k Montana Public Health Association (MPHA) conference support. (\$10k to stipends, \$5k to conference costs) \$5k Conference attendance for staff. \$3K Office supplies, training supplies, administrative support. \$57k Training and professional development events. \$8k Strategic planning meetings and technical support. \$20k Summer Institute \$15k MEHA Support (TBD) \$6k Practicum Placement and Support with MPHA and UM. \$8k Montana Public Health Mentorship program in partnership with AMPHO.</p>

Sexual Assault <i>(required funding)</i>	\$22,000	Funding is used to provide trainings and technical assistance that prioritize primary prevention strategies to reduce sexual assault on college campuses. \$22k Training support.
Grant administration and cost allocation	\$45,000	Division cost allocation and grant administration to include financial management, required conferences, meetings, and products. \$45k = 4.4% of award. Authorized amount is up to 10% of award.

Point of contact for this document is the PH System Improvement Office- Terry Ray at 444-9352 or TerenceRay@mt.gov

Public Health System Improvement Task Force Meeting Schedules

January 2018-December 2018

Core Task Force Activities:

- Preventive Health and Health Services Block Grant
- Maternal and Child Health Block Grant
- State Health Improvement Plan: Section F—Strengthen the Public Health and Health Care System

Date/Time	Agenda Item(s)	Meeting Details
February 28th, 2018 1:30-3:00pm	<ul style="list-style-type: none"> • PHS Block Grant update and proposed timeline for FY 18 funds • Public Health System Support Unit (PHSSU) Grant Proposal • Public Health Systems Assessment • Updates from national associations • Announcements from Associations 	Webinar: https://hhsmt.webex.com
April 25th, 2018 10:00am-3:00pm	<ul style="list-style-type: none"> • PHS Block Grant FY 18 Annual Report and FY 19 Application • MCH Block Grant annual application review • Announcements from Associations 	In-Person—Helena, MT. Public Health and Safety Division Room C205
June 27th, 2018 1:30-3:00pm	<ul style="list-style-type: none"> • PHS Block Grant FY 18 Application • Public Health System Support Unit (PHSSU) updates and discussion • Results of the lead local health official survey and foundational standards • Announcements from Associations 	Webinar: https://hhsmt.webex.com
August 22nd, 2018 1:30-3:00pm	<ul style="list-style-type: none"> • PHS Block Grant update • Announcements from Associations 	Webinar: https://hhsmt.webex.com
October 24th, 2018 10:00am-3:00pm	<ul style="list-style-type: none"> • PHS Block Grant FY 19 application review • PHSD Strategic Plan Annual Review • SHA/SHIP Review • Public Health System Support Unit (PHSSU) updates and discussion • Results of the workforce development survey • Announcements from Associations 	In-Person—Helena, MT. Public Health and Safety Division Room C205
December 5th, 2018 1:30-3:00pm	<ul style="list-style-type: none"> • Public Health System Support Unit (PHSSU) Grant Proposal • Announcements from Associations 	Webinar: https://hhsmt.webex.com