LCDHD Strategic Plan

2018 - 2023

> "A strategic plan sets forth what an organization plans to achieve, how it will achieve it, and how it will know if it has achieved it" – Public Health Accreditation Board

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LCDHD
Lake Cumberland District Health Department
A Healthy Today for a Brighter Tomorrow

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Strategic Efforts Summary Letter

The mission of the Lake Cumberland District Health Department is to "…prevent illness and injury, promote good health practices, and to assure a safe environment." In short, we desire for our community's health to improve. The enclosed *Strategic Plan* provides a "thumbnail overview" of many of our major initiatives that help us achieve our mission. Below is a summary of additional "plans" developed and utilized within our agency. We list them here to demonstrate how our plans are inter-related and that we use the concepts of strategic thinking and performance management at all levels of planning within our agency.

Performance Management System

As much as possible, we have integrated the concepts of performance management into each of our plans so that they might be living documents that guide our agency's strategic efforts. The introduction to each of our plans, provided below, indicates how we set our performance standards, what performance measures we utilize to assess our progress, how and where our performance is documented and reported, and what steps we take for quality improvement should any aspect of our plans be fall short of our performance expectations.

Quality Improvement Plan

Besides Quality Improvement Projects, in an effort to be as efficient and effective as possible operationally, we utilize several Quality Assurance processes such as Patient and Employee Satisfaction Surveys, Utilization Review of Medical Records and quarterly division meetings.

Furthermore, as we endeavor not only to assure operational quality, we also look for areas of potential agency and community improvement. Therefore, we engage periodically in research (such as, the "Centering in Pregnancy" Research Project with the University of Kentucky) or pilot projects (such as, same day scheduling).

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In terms of Quality Improvement, quality improvement activities emerge from a systematic and organized framework. LCDHD maintains a quality improvement plan outlining the quality improvement process utilized. This framework, adopted by LCDHD leadership, will be understood, accepted and utilized throughout the organization, as a result of continuous education and involvement of staff at all levels.

The Quality Improvement Committee (QIC) will be responsible for developing quality improvement strategies based on available data and recommendations from staff and board members. The QIC will also commission and supervise continuous quality improvement, including the design of new services and the improvement of existing services based on measures and assessment through the collection and analysis of data.

The performance management system utilized in this department is:

Performance Standard:
From time to time, processes within our agency need to be enhanced in order to achieve desired outcomes. Suggestions for areas of quality improvement are solicited from our staff (i.e. employee suggestions at staff meetings), the Executive Team (via brainstorming when program evaluation reflects poor performance), and from our board members (via suggestion box on the board meeting agenda). The tools (PDCA, Flow Charting, etc.) utilized to achieve these improvements are identified in our Quality Improvement Plan.

Performance Measures:
Consistent with our QI Plan, an AIM statement is developed to clarify what, how, for whom and by when improvement will occur.

Performance Reporting:
Minutes from QI Team Meetings and a Quality Improvement Action Plan are utilized to track the QI project as it unfolds. A storyboard is created when the project is complete to summarize the findings. These are then shared with all staff and board members in our monthly newsletter and placed on our website.

Quality Improvement:
QI Projects that demonstrate improved processes that result in desired outcomes will be adopted by the Executive Team.

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Community Health Improvement Plan

As our Quality Improvement Plan assures organizational efficiency and effectiveness, we leverage such to focus on community health improvement. Our agency evaluates existing health data and, via the Mobilizing for Action through Planning and Partnerships (MAPP) process, garners community input (Community Health Assessment [CHA]) and cooperation (Community Health Improvement Plan [CHIP]) to address public health issues in a collaborative manner. The activities which guide the CHIP's completion will be identified on the health coalition's yearly report.

The performance management system utilized in this department is:

> ***Performance Standard:***
> *CHIPs are developed utilizing the results of the CHAs. The CHIP's are action plans local health coalitions utilize for creating healthier communities. These action plans target specific health behaviors that will impact health outcomes. These action plans utilize the core functions of public health and/or ten essential services as deemed necessary. Available state, federal, and local funds are planned and budgeted accordingly and ultimately approved by the District Board of Health and the Department for Public Health. The goal is improving the health status of our communities.*
>
> ***Performance Measures:***
> *Bi-annual progress notes will track activities of the health coalitions and the strategies adopted from the CHIP. They will also note unexpected outcomes, both positive and negative.*
>
> ***Performance Reporting:***
> *Bi-annual reports will be completed in December and June. The CHIP reports will be composed by the Health Educators who facilitate the health coalitions. The Health Education Director will share the CHIP reports to the Executive Team. These reports will be available on the LCDHD website.*

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Quality Improvement:
The Health Education Director and Health Educators will review the CHIPs (goals/objectives/strategies) on a yearly basis. Health Educators will discuss bi-annual progress notes within our staff meetings for unexpected outcomes. Financial assistance will be reviewed on a yearly basis, which is guided by Kentucky Department for Public Health allocations to assist with cost for the CHIPs. Health coalitions will devise strategies to improve and follow up at the meetings.

Annual Plan and Budget

Responding to health statistics and community concerns, our Annual Plan and Budget is our annual "step along the way" to achieving our mission of improved community health outcomes. This includes each division's annual goals (i.e. our Health Policy and Promotion Division's Plan is referred to as the "Community Plan" and focuses on health policy development and promotion; engaging in the MAPP process; and, community health education).

The performance management system utilized in this department is:

Performance Standards:
CHAs (and other parts of the MAPP process) along with available health statistics help us to identify public health needs in our communities. Available state, federal, and local funds are then planned and budgeted accordingly and ultimately approved by the District Board of Health and the Department for Public Health with the goal of improving the health status of our communities.

Performance Measurement:
Each month, revenues and expenditures are evaluated by the Director of Administrative Services to determine whether plans are progressing as budgeted.

Performance Reporting:
Financial status is reported to Executive Team monthly, who make adjustments by program as necessary. Quarterly, financial status is reported to the District Board of Health. Year-end close-out data is also

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reported to the Board and published on the Department of Local Government (DLG) and the LCDHD website annually.

Quality Improvement:
Financial status is reported to Executive Team/Program Managers monthly. Director of Administrative Services communicates with Program Managers the revenues and expenditures of each program compared to budget. Program Managers and Director of Administrative Services evaluate reason for variance and Director of Administrative Services and Program Managers will form a correction if appropriate.

Preparedness Plans

In the event of a public health emergency or a bioterrorism attack, our various preparedness plans guide our response efforts and our continuity of agency operations.

The performance management system utilized in this department is:

Performance Standards:
Preparedness plans for the agency are exercised and reviewed regularly. Plans are submitted to Kentucky Department for Public Health (KDPH) for their input and approval and are also submitted for approval by the Board of Health.

Performance Measurement:
Plans are written with the expectation of being carried out with success for the agency's response and operations. If plans are exercised or utilized and found to need revision or corrections, those are conducted and all plans are resubmitted for approval to local and state partners.

Performance Reporting:
After action reports (AARs) are completed for each event and exercise to report the strengths and areas of improvement for each plan. Hot washes and debriefings are held with staff to capture their immediate input about the response and operations. The AARs are shared with and disseminated to partner agencies and the state.

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Quality Improvement:
Improvement plans are written as part of the AAR process that assign corrective actions to the appropriate department and ensure follow-up on actions that need improvement.

Workforce Development Plan

The Workforce Development plan assures that we recruit, train and retain a competent workforce.

The performance management system utilized in this department is:

Performance Standards:
LCDHD builds and maintains a public health workforce through recruitment of qualified individuals, continual training for staff, retention of staff through promotion of benefits and a positive work environment and evaluation of employee performance and satisfaction. Employee professional development ties in with the current strategic plan and is an ongoing process to ensure employees are staying current in licensure requirements, programmatic needs, as well as core competencies and emergency preparedness competencies.

Performance Measurement:
Workforce development is conducted and maintained in accordance with the Administrative Regulations for Local Health Departments. Training is monitored on an ongoing basis via TRAIN training plans and a checklist was developed from the training grid generated by division directors, taking into account which core competencies are vital within their division, to assist supervisors and Human Resources to monitor completion of required trainings. In addition, state databases are available for tracking various programmatic trainings. Employee recognition (via the employee of the month/year process) and opportunities for advancement promote good retention. Regularly scheduled performance evaluations are conducted using merit system forms at designated intervals in addition to employee satisfaction surveys.

Performance Reporting:
Human Resources updates are reported to the Executive Team monthly and to the Board of Health on a quarterly basis.

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Quality Improvement:
Program Mangers review staffing needs annually as part of budget preparation and Executive Team / Program Managers meet bimonthly to discuss staffing needs, training, retention and performance. The training requirements of each division are reviewed annually and adjusted as needed by division directors.

In order for our agency to have the best opportunity to achieve our mission, all of our plans must correlate with one another. Each plan designated above ties either directly or indirectly with the other plans and serves to guide us as we move toward improved health outcomes for our communities.

In good health,

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Need for a Plan

The purpose of this strategic plan is to define the direction of LCDHD over the next five years. There are many reasons why we choose to engage in a strategic planning process. For example:

- **National Public Health Accreditation:** LCDHD was accredited through the Public Health Accreditation Board's (PHAB) voluntary national accreditation program in March 2017.
- **Effective Use of Available Resources:** The current economic situation has led to significant reductions in public health funding over the past several years. This type of environment requires us to evaluate what services and programs are provided by the health department, while also ensuring that we are making strides to do our work in a more efficient and effective manner to meet customer and client expectations.
- **Importance of Continuous Learning and Improvement:** Constantly monitoring progress and making necessary adjustments in program and service delivery are critical actions for ensuring we are achieving intended public health outcomes. Establishing an organizational culture of continuous learning and quality improvement guided by research and identified needs of stakeholders is imperative.

Planning Process

In March 2018, the strategic planning committee (see *Appendix A* for a complete listing of strategic planning committee participants) met to begin the process of reviewing and revising the LCDHD Strategic Plan that was in place from 2013-2018. But, upon examination of the plan and much discussion it was decided that the plan just needed to be completely rewritten due to the rapidly changing infrastructure and capacity of the health department and the emerging trends in the community. This strategic planning process was initiated from the beginning utilizing the *NACCHO Developing a Local Health Department Strategic Plan: A How-To Guide* to lead us through that process again. A series of meetings followed that resulted in the development of the LCDHD Strategic Plan 2018-2023 (see *Appendix B* for a list of strategic planning session dates and the purpose of each).

In the future, the committee will meet at least annually to review the plan and make revisions as needed. Changes to the plan will be documented on the *Strategic Plan Revision Tracking Sheet*, including a summary of changes and will reflect the meeting minutes where the modifications to the plan were made. When amendments to the plan are necessary, a final draft of the modified plan will be presented to the governing Board of Health for review and approval.

Every five years, a SWOT analysis that includes all employees and board members will occur and the plan will be rewritten based on identified strengths, weaknesses, opportunities, or threats identified. Refer to *Appendix C* for a compilation of the 2017-2018 results.

Vision, Mission, and Guiding Principles

Vision:

The Lake Cumberland District Health Department will be a progressive leader providing innovative solutions to achieve optimal health status for our communities.

Mission:

The Lake Cumberland District Health Department prevents illness and injury, promotes good health practices, and assures a safe environment to protect and improve the health of our communities.

Guiding Principles:

- **integrity**
- **respect**
- **empathy**
- **excellence**
- **responsibility**
- **efficient**
- **trustworthy**
- **compassion**
- **accountability**
- **inspire/empower**
- **leadership**

Strategic Priorities

LCDHD first identified four *Priority Areas* to focus on during this plan cycle based upon the needs of the community, agency and the results of the SWOT analysis. These strategic priorities were identified as:

Priority Area: 1. Improve Quality of Life
Priority Area: 2. Enhance Community Access, Engagement and Collaboration
Priority Area: 3. Foster Employee Engagement, Development and Performance
Priority Area: 4. Efficacy of Business Practices through Innovation, Process Improvement and Maximizing Efficiencies

Goals and objectives with measurable and time-framed targets:

Broad goals were identified in each priority area, followed by the development of measurable, time framed objectives. Specific measures for each objective can be found underneath the strategies for that objective (refer to the following chart). In addition, measurable strategies that will be taken to achieve the objectives have also been listed.

Key support function required for efficiency and effectiveness:

All LCDHD plans must take into account our capacity for information management, workforce development and financial sustainability of all programs and services as part of the initial planning process. In addition, all plans will be reviewed at least annually and modified as needed based on support functions and funding available at that time.

Identification of external trends, events, or factors that may impact community health or the health department:

It is important to assess the agency's (information technology) IT, workforce, financial, etc. capacities before beginning any strategic effort to assure all needed resources are sufficiently available to see the process through. Therefore, all LCDHD strategic efforts/plans must consider these capacities as part of the initial planning process. In addition, all plans will be reviewed at least annually and modified as needed based on how available resources evolve.

Assessment of health department strengths and weaknesses:

A SWOT analysis that included all employees and board members was completed before the strategic plan was developed to guide our efforts. The final summary is located in *Appendix C* for quick review of results.

Link to the health improvement plan and quality improvement plan:

Links to other LCDHD plans, such as the Quality Improvement Plan, the Workforce Development Plan and the Community Health Improvement Plans is apparent when reading through the goals and objectives as all plans were taken into consideration as the strategic plan was being developed. Just a few examples:

Goal 1.1 focuses on the community health coalition partners, community health assessments and community health improvement plans

Goal 2.1 focuses on the Local Public Health System and Mobilizing for Action through Planning and Partnerships

Goal 3.3 links to the Workforce Development Plan by focusing on competent workforce

Goal 4.1 refers to the Annual Plan and budget by adjusting to the new financial realities

Goal 4.3 ties directly to utilizing the QI plan and tools to make improvements

Monitoring, Evaluation and Reporting

A database was developed that houses all of the strategic plan priority areas, goals, objectives, strategies and measures. It also includes the baseline data and target measures with time frames noted. Quarterly, the assigned staff (also noted in the database) will report on the progress of each strategy and objective measure to date, with the ability to make comments on progress if needed. This will be reviewed at bimonthly executive team meetings along with the reports from the performance management database that is used in conjunction with the strategic plan tracker.

Progress on the strategic plan will be communicated to all staff via the monthly executive team meeting minutes and reports. Annual updates to the strategic plan and the meeting minutes will be posted on the website so they will be available to all staff, stakeholders and board members.

Lake Cumberland District Health Department: Strategic Plan Dashboard for Fiscal Year Ending: 2020

Priority Area: 1. Improve Quality of Life	Measure Baseline	Measure Target	Start Date	Target Date
Goal: 1.1. Provide more evidence based programs in the community				
Objective: 1.1.1. Within the Lake Cumberland District, community health coalition partners, including the Lake Cumberland District Health Department (LCDHD), will adopt and implement at least three evidence-based strategies to address priority areas as identified in the Community Health Assessments/Community Health Improvement Plans (CHAs/CHIPs) by June 30, 2023.				
Strategy: 1.1.1.1. Provide community health coalition partners with information regarding research-based initiatives that they might choose from to address community identified priorities	No	Yes	7/1/2018	6/30/2023
Strategy: 1.1.1.2. Document which programs were adopted and when by community health coalition partners in CHIPs and performance management tracking tool.	No	Y[illegible]	7[illegible]18	6/30/2023

Measure: 1.1.1.1 At least three evidence based programs adopted/implemented by community health coalition partners as documented in the CHIPs.	0.00	3.00	7/1/2018	6/30/2023
Goal: 1.2. Promote healthy lifestyles				
Objective: 1.2.1. Decrease tobacco related death and disease rates 2% by June 30, 2023.				
Strategy: 1.2.1.1. Educate and advocate for the adoption of smoke-free ordinances within the LCDHD district, currently 2 jurisdictions	2.00	3.00	7/1/2018	6/30/2023
Strategy: 1.2.1.2. Educate and advocate for the adoption of tobacco-free schools, currently 9 schools are tobacco-free	9.00	12.00	7/1/2018	6/30/2023
Measure: 1.2.1.1 Decrease lung cancer incidence as listed in the health report card from 102 (2015 data) to 101 (1% decrease)	102.00	101.00	7/1/2018	6/30/2023
Measure: 1.2.1.2 Decrease death rates as listed in the health report card from 73.8 (2015 data) to 72.8 (1% decrease)	73.80	72.80	7/1/2018	6/30/2023
Measure: 1.2.1.3 Decrease adult smoking rates from 24% to 23%, source County Health Rankings, 2018.	24.00%	23.00%	7/1/2018	6/30/2023
Measure: 1.2.1.4 Decrease youth smoking rates (in the past 30-day use) from 14.3 to 13.3%, source: Kentucky Incentives for Prevention (KIP) data.	14.30%	13.30%	7/1/2018	6/30/2023
Goal: 1.3. Prevent/respond to existing and emerging public health threats				
Objective: 1.3.1. Provide education and information related to emerging or existing public health threats to community partners and LCDHD staff a minimum of two times per year, or as needed when events warrant. .				

Strategy: 1.3.1.1. Provide education through traditional and social media	Yes	Yes	7/1/2018	6/30/2023
Strategy: 1.3.1.2. Disseminate information provided by Kentucky Department for Public Health (KDPH) to community partners.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 1.3.1.3. Analyze community health data to identify emerging public health threats.	Yes	Yes	7/1/2018	6/30/2023
Measure: 1.3.1.1 Number of communications related to public health threats LCDHD has initiated with staff and partners, at least 2 times a year.	0	2	7/1/2018	6/30/2023
Objective: 1.3.2. Improve LCDHD's response to public health threats by participating in a minimum of one tabletop or functional exercise per year, beginning in FY 2019				
Strategy: 1.3.2.1. Develop multiyear training and exercise plan (MYTEP) to reflect exercise/drill opportunities annually.	No	Yes	7/1/2018	6/30/2023
Strategy: 1.3.2.2. Partner with regional healthcare preparedness coalition to schedule/provide public health exercise opportunities annually.	No	Yes	7/1/2018	6/30/2023
Strategy: 1.3.2.3. Track required trainings of Epi Rapid Response Team (ERRT) staff in public health response annually.	No	Yes	7/1/2019	6/30/2023
Measure: 1.3.2.1 LCDHD will participate in at least one tabletop or functional exercise per year.	0.00	1.00	7/1/2018	6/30/2023
Objective: 1.3.3. Reduce morbidity and mortality rates related to substance use disorder by 2% across the Lake Cumberland District by January 1, 2023				
Strategy: 1.3.3.1. Implement Syringe Exchange Programs (SEPs) in 2 additional counties, currently have SEPs in 5 counties.	4.00	[illegible]	[illegible]	6/30/2023

Strategy: 1.3.3.2. Provide community education and awareness (presentation/mass media campaign) on opiate use disorder quarterly.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 1.3.3.3. Provide naloxone to community and first responders at community events.	Yes	Yes	7/1/2018	6/30/2023
Measure: 1.3.3.1 Decrease substance use disorder hospital admissions (as an indicator of morbidity) as listed in the Kentucky Injury Prevention and Research Center profiles from 3.64 to 3.5 per 1,000.	3.64	3.50	7/1/2018	6/30/2023
Measure: 1.3.3.2 Decrease substance use related overdose deaths as listed in the Kentucky Injury Prevention and Reseach Center profiles from 29.45 to 29 per 100,000.	29.45	29.00	7/1/2018	6/30/2023
Seperator				
Priority Area: 2. Enhance Community Access, Engagement & Collaboration	**Measure Baseline**	**Measure Target**	**Start Date**	**Target Date**
Goal: 2.1. Increase awareness of public health services				
Objective: 2.1.1. Increase the public's engagement via media campaigns / communications as measured by the annual increase of social media and website utilization				
Strategy: 2.1.1.1. Update our Health Report Card webpages' information as statistics become available and notify the public through social media posts.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 2.1.1.2. Update Data Analysis Committee webpage after each meeting and notify the public of our activities through social media posts.	Yes	Y[illegible]	[illegible]18	6/30/2023

Strategy: 2.1.1.3. Promote on social media various other public health features such as: staff photos on "blue jean and colored shirt'" health awareness days, various public health news related events, "52 Weeks of Health" health promotion, staff engaging in various program related activities within their communities, various other health promotion activities, etc.	Yes	Yes	7/1/2018	6/30/2023
Measure: 2.1.1.1 Number of Facebook followers	8899	10500	7/1/2018	6/30/2023
Measure: 2.1.1.2 Number of YouTube followers	44.00	100.00	7/1/2018	6/30/2023
Measure: 2.1.1.3 Number of Twitter followers	566.00	600.00	7/1/2018	6/30/2023
Measure: 2.1.1.4 Number of Instagram followers	179.00	300.00	7/1/2018	6/30/2023
Measure: 2.1.1.5 Monthly traffic to website.	9348	10000	7/1/2018	6/30/2023
Goal: 2.2. Strengthen the Local Public Health System through partnership and planning across the Lake Cumberland District				
Objective: 2.2.1. Sustain, rejuvenate and amplify ten health coalitions (local public health system partners) to collect and analyze data in the creation and implementation of ten community health improvement plans by June 30, 2023.				
Strategy: 2.2.1.1. Implement the Mobilizing for Action through Planning and Partnerships (MAPP) tool.	No	Yes	7/1/2018	6/30/2023
Strategy: 2.2.1.2. Identify and engage partners across Local Public Health System (LPHS) and invite key partners to attend.	Yes			6/30/2023

Measure: 2.2.1.1 75% of coalition members regularly attend meetings as recorded in the coalition attendance tracking tool.	50.00%	75.00%	7/1/2018	6/30/2023
Measure: 2.2.1.2 25% of newly invited key partners will attend the meetings as recorded in the coalition attendance tracking tool	0.00%	25.00%	7/1/2018	6/30/2023
Objective: 2.2.2. Increase the number of presentations to stakeholders, policy makers and civic groups on up-to-date health information and community health improvement plans by June 30, 2019.				
Strategy: 2.2.2.1. Attending stakeholder, policymaker and civic group meetings to share data/community health improvement plan.	Yes	Yes	7/1/2018	6/30/2023
Measure: 2.2.2.1 Conduct three presentations per county as documented in the community health plan.	0	30	7/1/2018	6/30/2023
Objective: 2.2.3. Provide at least one opportunity for community members to offer feedback regarding our community health improvement plan by June 30, 2019.				
Strategy: 2.2.3.1. Provide a web-based feedback form	No	Yes	7/1/2018	6/30/2023
Strategy: 2.2.3.2. Promote web-based feedback form via social media	No	Yes	7/1/2018	6/30/2023
Measure: 2.2.3.1 Conduct 3 surveys regarding feedback on CHIPs by June 30, 2023.	0	3	7/1/2018	6/30/2023
Goal: 2.3. Increase awareness of public health services and implement new approaches when appropriate based on data analysis.				
Objective: 2.3.1. Increase public awareness of illicit drug related health impacts by June 30, 2023 via the health report card and annual social media promotions				

Strategy: 2.3.1.1. Share morbidity and mortality data with the public via our health report card and social media promotions annually.	No	Yes	7/1/2018	6/30/2023
Measure: 2.3.1.1 Add drug overdose mortality data to health report card.	No	Yes	7/1/2018	6/30/2020
Measure: 2.3.1.2 Promote health report card annually via social media.	No	Yes	7/1/2018	6/30/2023
Objective: 2.3.2. Analyze available illicit drug-use hospital and ER visit data via the data analysis committee and recommend educational awareness and interventions annually				
Strategy: 2.3.2.1. Review data at the bi-annual data analysis committee meetings.	0.00	2.00	7/1/2018	6/30/2023
Measure: 2.3.2.1 To review the material and analyze the data at each Data Analysis Committee Meetings.	Yes	Yes	7/1/2019	6/30/2023
Objective: 2.3.3. Increase number of Harm Reduction Syringe Exchange Programs (SEPs) from 4 to 6 by June 30, 2023.				
Strategy: 2.3.3.1. Educate the public via public forums and media releases.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 2.3.3.2. Educate law enforcement agencies via face-to-face meetings.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 2.3.3.3. Educate fiscal courts and city councils.	Yes	Yes	7/1/2018	6/30/2023
Measure: 2.3.3.1 Increase number of Syringe Exchange Programs from 4 to 6 by June 30, 2023.	4	6	7/1/2018	6/30/2023

Goal: 2.4. Increase childhood immunization rates by promoting use of the immunization registry and providing technical assistance for such as needed.				
Objective: 2.4.1. Promote more extensive use of Kentucky Immunization Registry (KYIR) with providers in the LCDHD service area by June 30, 2023.				
Strategy: 2.4.1.1. Utilizing the information provided by KYIR showing 175 pharmacies are using the KYIR, educate the remaining pharmacies and physician offices on value of immunization registry through correspondence or face-to-face meetings.	No	Yes	7/1/2018	6/30/2023
Measure: 2.4.1.1 Send out educational materials to pharmacies and physcians promoting the use of the Immunization Registry by 6/30/20.	No	Yes	7/1/2019	6/30/2020
Seperator				
Priority Area: 3. Foster Employee Engagement, Development and Performance	**Measure Baseline**	**Measure Target**	**Start Date**	**Target Date**
Goal: 3.1. Increase staff awareness and collaboration across all programs				
Objective: 3.1.1. Increase general awareness of staff regarding programs by highlighting 12 programs per year beginning Fiscal Year (FY) 2019				
Strategy: 3.1.1.1. Highlight a program monthly via email, website and/or newsletter updates.	0.00	12.00	7/1/2018	6/30/2020
Strategy: 3.1.1.2. Annually, all county staff are required to attend the Quality Assurance (QA) safety/shut-off training so this will provide an opportunity for any program to review program purpose, activities, and/or share needs with staff.	No	[illegible]	[illegible]	6/30/2023

Strategy: 3.1.1.3. All program directors made aware of annual Quality Assurance (QA) meeting opportunity and allotted time if requested.	No	Yes	7/1/2018	6/30/2019
Measure: 3.1.1.1 Survey staff via Survey Monkey annually to measure the increase in general program awareness.	1.00%	85.00%	7/1/2018	6/30/2023
Objective: 3.1.2. Improve collaboration across divisions by discussing program needs, as identified at executive staff meeting, with relevant staff				
Strategy: 3.1.2.1. As program needs arise, appropriate groups would meet to discuss strategies / opportunities to educate staff on program needs / requirements.	No	Yes	7/1/2018	6/30/2023
Strategy: 3.1.2.2. Directors of new programs will present in person or via electronic meeting in annual QA meeting (that all staff are required to attend) and inform staff about the new program.	No	Yes	7/1/2018	6/30/2023
Measure: 3.1.2.1 Survey Division Directors annually to measure their perceived improvement in cross-program collaboration.	1.00%	85.00%	7/1/2018	6/30/2023
Goal: 3.2. Develop and adopt procedures to protect sensitive personnel information and improve departmental efficiencies.				
Objective: 3.2.1. By June 30, 2023, we will develop a modality to electronically send, receive, and store essential personnel records.				
Strategy: 3.2.1.1. Develop a secure process allowing all employees to electronically sign documents.	15.00%	100.00%	7/1/2018	6/30/2020
Strategy: 3.2.1.2. Work with IT to develop a secure process and method to electronically send, receive, and store personnel forms/records.	No	Yes	7/1/2018	6/30/2023
Measure: 3.2.1.1 All performance evaluations will be submitted by due date.	90.00%	[illegible]	[illegible]	6/30/2023

Objective: 3.2.2. By 2023, all job descriptions for applicable employees will be reviewed at least every three years and updated as needed.				
Strategy: 3.2.2.1. Update modality for ensuring job descriptions are updated at least every three years to reflect expectations for current tasks.	No	Yes	7/1/2018	6/30/2023
Measure: 3.2.2.1 95% or more job descriptions will have been reviewed and (if needed) updated to reflect current tasks expectations within the past three years.	50.00%	95.00%	7/1/2018	6/30/2023
Goal: 3.3. Recruit and assure a competent workforce by providing training opportunities that develop core public health competencies				
Objective: 3.3.1. Review and revise the professional development section of the WFDP to include ad-hoc staff development opportunities to ensure staff are appropriately trained to deal with emerging health issues by July 31, 2023.				
Strategy: 3.3.1.1. During annual employee performance evaluations, supervisors will utilize the "professional development assessment" results to discuss and identify staff professional development needs/wants and make recommendations on individual development.	No	Yes	7/1/2018	6/30/2023
Strategy: 3.3.1.2. Supervisors will facilitate opportunities for necessary trainings as appropriate and report annually, via the "professional development assessment", outcomes from the previous year.	No	Yes	7/1/2018	6/30/2023
Measure: 3.3.1.1 As the "professional development assessments" are submitted to HR, HR Director will review to insure supervisors are consistently utilizing the "professional development assessment".	25.00%	100.00%	7/1/2018	6/30/2020
Objective: 3.3.2. By June 30, 2023, revise recruitment process to entice qualified and quality applicants.				
Strategy: 3.3.2.1. Work with GoHire to implement improved recruitment strategies.	No	[illegible]	[illegible]	6/30/2020

Strategy: 3.3.2.2. Update recruitment wording on our website and social media to entice more qualified applicants.	No	Yes	7/1/2018	6/30/2020
Strategy: 3.3.2.3. Update job interview questions to help us better identify quality candidates.	No	Yes	7/1/2018	6/30/2023
Measure: 3.3.2.1 Each job vacancy that is advertised outside the agency will have at least three qualified applicants.	1.00	3.00	7/1/2018	6/30/2023
Seperator				
Priority Area: 4. Efficacy of Business Practices through Innovation, Process Improvement and Maximizing Efficiencies	**Measure Baseline**	**Measure Target**	**Start Date**	**Target Date**
Goal: 4.1. Adjust the Agency to New Financial Realities				
Objective: 4.1.1. If advantageous, consider relinquishing various under-funded clinic programs to other community partners and adjust staff compliment accordingly by June 30, 2023.				
Strategy: 4.1.1.1. Should it become necessary to pursue this objective (off-loading various under-funded programs), secure Governing Board Approval to pursue this strategy.	Yes	Yes	7/1/2018	6/30/2020
Strategy: 4.1.1.2. Identify other community partners that can provide our clinic services.	Yes	Yes	7/1/2018	6/30/2020
Strategy: 4.1.1.3. Continue work with DPH Commissioner's Public Health Redesign workgroup to determine which programs are most feasible to relinquish, should it become necessary to pursue this objective.	Yes	Yes	7/1/2018	6/30/2020

Strategy: 4.1.1.4. Work as KHDA representative on Legislative Workgroup that is drafting the public health transformation bill.	Yes	Yes	7/1/2019	6/30/2020
Measure: 4.1.1.1 Clinic programs will improve self-sufficiency from requiring 60% of the agency’s total local tax funds to 30%.	60.00%	30.00%	7/1/2018	6/30/2020
Objective: 4.1.2. Implement/enhance three technologies to streamline existing practices/processes by June 30, 2023.				
Strategy: 4.1.2.1. Explore options to improve processes and services (for example: utilizing videoconferencing for Medical Nutrition Therapy, Directly Observed Therapy, training, coalition meeting, supervision, etc.)	No	Yes	7/1/2018	6/30/2023
Strategy: 4.1.2.2. Follow Kentucky Health Department Association's (KHDA) Best Practice Committee and the DPH Commissioner’s Public Health Redesign Workgroup findings and recommendations and adopt when appropriate.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 4.1.2.3. Enhance communication log utilization to include query abilities, link or upload supporting documenting to include the final product.	Yes	Yes	7/1/2018	6/30/2020
Measure: 4.1.2.1 Implement/enhance at least three streamlined processes annually by June 30, 2023 as reported in the executive team meeting.	3.00	3.00	7/1/2018	6/30/2023
Goal: 4.2. Seek Opportunities to Enhance Capacity				
Objective: 4.2.1. Continue utilizing alternative staffing arrangements (other than merit system) FY 2020.				
Measure: 4.2.1.2 18% of staff will be transitioned to these alternate models, if it is determined this is advantageous.	No	Yes	7/1/2018	6/30/2023

Objective: 4.2.2. Provide written agreements with community agencies to enhance and provide access to services beginning FY 2019 and ending in FY 2023.				
Strategy: 4.2.2.1. Establish at least 15 closed Point of Dispensing (POD) partnerships by FY 2021 as evidenced by written agreements	0.00	15.00	7/1/2018	6/30/2021
Strategy: 4.2.2.2. Make space available for utilization by other members of the public health system when excess facility capacity exists.	No	Yes	7/1/2018	6/30/2023
Strategy: 4.2.2.3. Create opportunities to partner with community agencies to provide public health services that may no longer be provided by the local health department.	Yes	Yes	7/1/2018	6/30/2023
Measure: 4.2.2.1 Increase number of written agreements with community agencies to enhance and provide access to services.	0.00	75.00	7/1/2018	6/30/2023
Objective: 4.2.3. Aggressively seek out and apply for grant opportunities to help finance existing programs and fund work on issues as identified in our CHIP, Strategic Plan and Data Analysis Committee on an ongoing basis.				
Strategy: 4.2.3.1. Review grant opportunities via popular grant promotion websites and apply for such, when appropriate.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 4.2.3.2. Work with KHDA to pilot test their being a 501(c)(3) partner with us on grants which require said designation.	No	Yes	7/1/2018	6/30/2020
Measure: 4.2.3.1 The submission of at least seven grant applications annually as recorded in the grant managements database.	0.00	7.00	7/1/2018	6/29/2023
Goal: 4.3. Effectively use QI Plan/Tools to improve processes, programs and interventions.				

Objective: 4.3.1. LCDHD will engage in at least three Quality Improvement (QI) Projects per year, beginning FY 2019. With two focused on programmatic/community improvement; and one focused on internal agency improvement.				
Strategy: 4.3.1.1. Discuss potential QI Projects during the Executive/Quality Improvement Committee Meetings.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 4.3.1.2. Evaluate employee suggestions to determine if they would be appropriate for a QI Project.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 4.3.1.3. Encourage Board Members to make suggestions for improvement via the monthly Board Survey included on their meeting agenda.	Yes	Yes	7/1/2018	6/30/2023
Strategy: 4.3.1.4. Use results from Community Health Assessments and Data Analysis Committee work to drive potential QI Projects (discuss during data analysis committee meetings).	Yes	Yes	7/1/2018	6/30/2023
Strategy: 4.3.1.5. Review our Public Health Accrediation Board (PHAB) Action Plan and Annual Reports response to evaluate potential QI Project opportunities.	Yes	Yes	7/1/2018	6/30/2020
Strategy: 4.3.1.6. Monitor performance management database and other tracking tools to identify trends to continually identify opportunities for improvement/QI project development.	Yes	Yes	7/1/2018	6/30/2023
Measure: 4.3.1.1 Initiate at least one population focused QI project.	0.00	1.00	7/1/2019	6/30/2023
Measure: 4.3.1.2 Initiate at least three QI projects annually.	0	3	7/1/2018	6/30/2023
Seperator				
Do Not Delete				

Appendix A:
Strategic Planning Committee Members 2018

Shawn Crabtree……………………...………………………...…...Executive Director

Christine Weyman…...…………………………………………….Medical Director

Carol Huckelby……...…………………………………Human Resources Manager

Ronald Cimala...…………………………..……Director of Administrative Services

Tracy Aaron……………………………...…...……Director of Health Education

Stuart Spillman……………………………...Director of Environmental Services

Laura Woodrum…………………………...…………………Director of Nursing

Amy Tomlinson………………………………Public Health Preparedness Manager

Janae Tucker…………………………...……………Quality Improvement Director

Appendix B: Strategic Plan Sessions

Date	Purpose
March 5, 2018	Preparation: • Readiness assessment • Plan to plan Assess the Current Situation: • Review of mission, vision, and guiding principles • Identifying values/beliefs • Stakeholder analysis
March 26, 2018	Preparation (continued): • Determine data needs Assess the Current Situation (continued): • Internal & external analysis Analyze SWOT results: • comparison of identified threats • to identified opportunities, identified weaknesses • to identified opportunities and identified • weaknesses to identified threats
May 2, 2018	Conclusive report for Strategic Plan 2013-2018 reviewed and approved Development of template for new strategic plan
May 11, 2018	Identified priority areas and goals for each. Began identifying strategies and measures for each goal.
May 14, 2018	Continued to work on objectives, strategies and measures for each goal
June 11, 2018	Analyze suggested Strategic Initiatives developed by group members and start adding them to the new strategic planning tracker that was created by the executive director
July 2, 2018	Continue to analyze suggested Strategic Initiatives developed by group members and start adding them to the new strategic planning tracker that was created by the executive director
July 12, 2018	Continue to analyze suggested Strategic Initiatives developed by group members and start adding them to the new strategic planning tracker that was created by the executive director.
August 20, 2018	Continue to analyze suggested Strategic Initiatives developed by group members and start adding them to the new strategic planning tracker that was created by the executive director
August 22, 2018	Finish compiling Strategic Initiatives and Objectives and finalize strategic plan tracker with baselines, target measures and person responsible for reporting on progress
August 27, 2018	Strategic Initiatives were reviewed to ensure they support the mission and vision of the organization Finish introduction and rest of plan put together for approval of executive team and BOH
August 16, 2019	Annual review/revisions. Annual report can also be accessed on the LCDHD Website (https://www.lcdhd.org/about/accreditation-strategic-planning/).

Appendix C: LCDHD SWOT Analysis Compilation (All staff & BOH results) 2017-2018

Strengths

Staff	BOH
*Programs in place/education – e.g. clinic, health education, syringe exchange programs, etc.	*Programs in place/education – e.g. tobacco cessation, health education, syringe exchange programs, screenings offered, etc.
*Established, Credible & Reputable in Community	
*Knowledgeable staff	*Knowledgeable, concerned & dedicated staff
*Established community & agency partners	
	*Education & community outreach
People who care	
Communication skills	
Organizational support	
Diverse population	
Needle exchange	Needle exchange
Outreach	
	Established, credible & reputable in community
	Established relationship with patients/clients
	Several counties working together on local health issues
	Presence in the schools

Weaknesses

Staff	BOH
*Funding	*Funding
*Lack of community participation	*Lack of community participation
*Difficulty motivating people	*Difficulty motivating people/patient compliance
	*Staff shortages
Staff shortages (turnover, fewer staff now, etc.)	
Lack of working together across divisions	
Staff personal beliefs prevent support	
Lack of control over regulations	
Lack of government support	
Public health	
Fear of change	
Internal communication	
Staff unaware of all programs	
	Education geared toward younger age groups
	Multi-cultural population
	Lack of advertisement of services
	Info on drug and/or alcohol use

Opportunities

Staff	BOH
*Seeking grant opportunities	
*Establish relationships with community and faith based partners	*Establish relationships with community partners (schools, jails, health entities, local law enforcement, faith based partners, etc)
*Seeking state and political support	
	*Providing more education/information to the community
	*Increasing community awareness & involvement
Media	
Word of mouth	
Unique programs	
Better community partners	
Population participation	
Drug education	Drug education / syringe exchange programs
Technology/apps	
Opportunity to refer to other programs	
Attend community events	Attend more community events
More professional development & training	More professional development & training

Threats

Staff	BOH
*State regulations	
*State and federal funding cuts	*State and federal funding cuts
*Uninterested/unmotivated population	*Uninterested/unmotivated population
	*Political resistance
Lack of grant funding	
Lack of community partners	
Negative employee / community partner attitudes	
Lack of services in rural areas	
Competing with community partners	
Problems with payees	
Challenging political climate	
Apathy from board members	
Illegal drugs readily available	Illegal drugs readily available & rapidly expanding
Conflicting values with faith community	
Moral decline of communities	
Program stigma	Stigma
	Lack of support from local government entities
	Competition from other health care providers
	Disinterest/apathy from public
	Educational levels of community
	Socioeconomic status of communities

Staff results are in black font & BOH results are in blue font with the most top answers in all categories in bold with an * next to them.

Strategic Plan Revision Tracking Sheet

Date	**Pages affected**	**Summary of changes**	**Responsible staff**
08/16/2019	Initiatives chart	Annual Review of the Strategic Plan and revisions where needed. Refer to meeting minutes and annual report for a comprehensive summary of changes.	Strategic Plan Committee