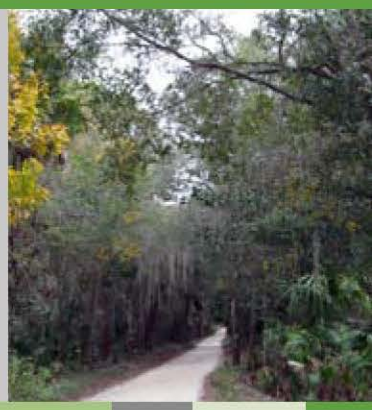
FLAGLER COUNTY
Community Health Improvement Plan





Prepared for:
FLAGLER COUNTY HEALTH DEPARTMENT

Prepared by:
HEALTH PLANNING COUNCIL OF NORTHEAST FLORIDA

July 2012

Flagler County Health Improvement Plan
2012

Sponsors: Flagler County Health Department
Florida Department of Health Planning Council of Northeast Florida

Produced by: Health Planning Council of Northeast Florida

Report and Executive Summary available at Northeast Florida Counts website - www.nefIcounts.org

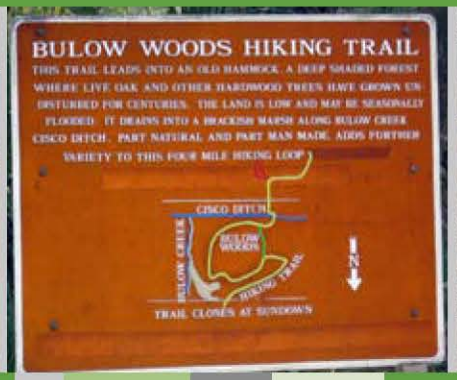
Acknowledgments: Many individuals and organizations contributed valuable information in the development of a quality community health action plan. Special thanks is extended to the following individuals who provided their expertise and guidance during this valuable collaborative initiative.

Subcommittee Members

Access to Care:	*Chronic Disease:*	*Behavioral Health:*
Sally A. Sherman	Wally DeAquino	Mia Gerber
Connie Rapolti	Mary Stetler	Toni Barrett
Pastor Charles Salano	Larry Jones	Linda Murphy

TABLE of CONTENTS

A Community Health Assessment—driven by community input—is a systematic approach to collecting, analyzing, and using complex data and information to identify priority areas for health improvement efforts.



INTRODUCTION

The Community Health Improvement Plan (CHIP) is a comprehensive tool that sets goals and recommended strategies for community health improvements based on assessment activities completed through the Mobilization for Action through Planning and Partnerships process (MAPP). The Flagler County Community Health Assessment report completed in 2012 resulted from the MAPP initiative. Embedded in the MAPP process are various assessment instruments that gauge community health and community beliefs within the current organizational frameworks that guide community decisions relative to public health. Flagler County Community Health Assessment report provides the basis for the CHIP with a goal of using the community-driven strategic planning process to improve community health.
The CHIP sets the public health priorities focused on:

- Create policies to improve community health
- Develop action steps to improve targeted areas of community health
- Implement long-term community health improvement strategies

Community partners including healthcare providers, government agencies, human service organizations, residents and business owners are vital contributors to the development of CHIP. For community members, the CHIP will help to identify the agencies and parties responsible for implementing policies and programs that influence the health issues. For agency leaders, the CHIP will help with internal strategic planning processes to ensure resources are utilized appropriately to meet the needs of the community served.

The CHIP serves as a "Call to Action" for Flagler County and provides an opportunity for private, nonprofit, and government agencies; academic, community, and faith-based organizations; and citizens and the business community to be involved in a unified effort to improve the health and quality of life for youths and adults throughout the Flagler County.

Three priority issues for Flagler County were identified during the MAPP process:

1. Access to Health Care
2. Chronic Disease
3. Behavioral Health (substance abuse and mental health)

In March 2012 committees, including key community leaders, were formed to address the three priority issues and complete a comprehensive CHIP. The committees looked at the CHIP as an opportunity to have a common vision and mission for community health. The following CHIP concentrates on priority goals with detailed objectives and creates a timeline and action steps for community agencies and organizations to achieve. Appendix A- D detail guidelines used to assist in their process.

VISION: That all residents of Flagler County enjoy excellent health through education, prevention and access to needed health care services.

MISSION: To ensure needed health care services through collaboration to improve the quality of life for Flagler residents.

Why community health assessment and improvement planning processes?

The fundamental purpose of public health is defined by three core functions: assessment, policy development and assurance. Community Health Assessments (CHAs) provide information for problem and asset identification and policy formulation, implementation, and evaluation. CHAs also help measure how well a public health system is fulfilling its assurance function.

-NACCHO

To improve the health of all Floridians, our communities must commit to action that goes beyond "health care."

Florida State Health Improvement Plan 2012-2015

ACCESS TO CARE

Healthcare coverage for adults in Flagler County has been slowly declining from 2002 (85.2%) to 2010 (83%). The biggest impact has been on the age group between 45-65 years old, which is 28.7% of the total population. Enrollment in Medicaid has been increasing since 2006, however has been consistently lower than the state average. In November 2000, the Department of Health and Human Services designated the low-income population in Flagler County to be a Medically Underserved Population. Another area of concern for access to care is transportation to primary care and specialty care providers throughout the county. The Flagler County Public Transportation system has had a significant increase in the demand for services from 1,700 clients in 2005 to over 4,300 reported in 2009.

In 2010 Flagler County residents participated in focus groups as part of the MAPP process to assess community themes and strengthens in their county. The major issues identified related to access to care were the following:

- The poor economy has taken its toll by increasing unemployment and decreasing access to health insurance.
- More affordable primary care and pharmaceutical services are needed.
- More providers are needed in the areas of dentistry, mental health and specialty care to those who cannot currently afford such services.
- Transportation to health care providers is a barrier.

In 2011 a community survey was conducted in which 723 citizens responded and answered questions related to areas of overall personal health and health and wellness concerns about the community. Over 30% of the residents who responded stated that they could not afford health insurance; almost 50% reported the major barrier to services was not being able to afford to pay, and almost 20% reported transportation issues.

A third assessment was completed also completed as a result of the MAPP process for Flagler County which indicates forces that may impact quality of life and community health systems. The top three forces reported with the highest potential of impact were lack of transportation, economic downturn (high unemployment) and an increase in un/underinsured.

In September, 2011 Flagler County business leaders and key stakeholders also participated in focus groups and interviews to prioritize health concerns from their perspective. These leaders weighed in on strategic initiatives to help improve each area of concern and develop action plans. The key findings from the group of community leaders highlighted access to affordable care, chronic disease, and behavioral health as primary concerns. There was almost a unanimous agreement that lack of access to care is the highest priority.

Evidence

suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs.

-County Health Rankings & Roadmaps

STRATEGIC ISSUE #1 ACCESS TO HEALTH CARE

GOAL 1: PROVIDE ALL RESIDENTS IN FLAGLER WITH QUALITY AND COMPREHENSIVE HEALTH CARE			
OBJECTIVE 1.1: Increase percentage of adults in Flagler County who have a regular source of health care.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
1.1.a.: Understand how uninsured and underinsured adults use the healthcare systems in Flagler County	Conduct survey in targeted areas to gather data	• Free Clinic • FCHD • Hospital	Oct 2012-July 2013
1.1.b.: Increase the capacity of Flagler County to provide healthcare to uninsured and underinsured adults	Explore options to establish a "Flagler Cares" network/ pool of specialists willing to share the burden of providing free/reduced cost care for the uninsured	• FCHD • Free clinic • St. Vincent's (mobile) • Flagler County Medical Society • Hospital	Oct 2012-Dec. 2015
1.1.c.: Develop nontraditional programs to meet the health care needs of the uninsured and underinsured adults	Continue to build partnership with St. Vincent's Mobile Outreach	• St. Vincent's (mobile) • Pastor Solano's initiative	Oct 2012-Oct.2013
1.1.d:Increase community awareness of available health and humans services	Continue and expand current messaging programs and campaigns Develop additional marketing and messaging strategy for community outreach that responds to and is aligned with National Prevention Model Provide, faith-based organizations, schools, libraries and city operated facilitates with appropriate messaging about health care and services	• Hospital (new website) • Social services partners • Churches • Media • Healthy Flagler.com	Oct 2012-July 2013 Oct 2012-July 2013

GOAL 2: ALIGN CROSS-SECTOR COLLABORATIONS TO ENSURE FLAGLER COUNTY RESIDENTS HAVE FULL ACCESS TO EXISTING RESOURCES AND ASSETS			
OBJECTIVE 2.1: Support objectives of the Flagler County Department of Economic Opportunity to help reduce unemployment.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
2.1.a.: Align access to health dialogue with economic development initiatives	Participate on DEO committee	• Flagler County Office of Economic Development • Flagler County Health Department • Chamber of Commerce	Oct 2012-Dec 2015
GOAL 3: INCREASE TRANSPORTAION OPTIONS TO IMPROVE ACCESS TO CARE			
OBJECTIVE 3.1: Enhance transit options and access for transportation			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
3.1.a.: Increase hours of operation for Westside Flyer	Assess current FCDT schedules Survey users	• FCDT • Community Services Department • Council of Aging	Oct 2012-Dec 2012
3.1.b.: Increase coordination with mobile health providers	Explore partnership opportunities with St. Johns County Explore opportunities with St. Vincent's mobile health Identify funding source to support mobile health	• FCDT • Community Services Department • Council of Aging • St. Johns County Health Department • St. Vincent's mobile	Oct 2012-Jan 2013 Oct 2012-Jan 2013 Jan 2013-July 2013
3.1.c: Create more flexible hours for public transit to meet the needs of working families	Provide transit providers with office hours schedules and location of health providers hours of operation	• FCDT • FCHD	Oct 2012-Jan 2013
3.1.d: Work Flagler County Public Transportation (FCPT) and other transportation providers to facilitate a more efficient system of scheduling on-demand service	Seek funding and partnership opportunities Work with Transit Needs Assessment Study group to include access to care in the discussion related to: • Delivery of transit services • Branding • Marketing to help connect to the community	• Urban Transportation Research	Oct 2012-Jan 2013 Jan 2013-Dec 2013

3.1.e: Create a transit special pass or discount card for low income priority groups to use services for doctor and dentist visits to the Community Health Center	Explore best practices used by transit providers in other regions for replication		Oct 2012-July 2013
OBJECTIVE 3.2 Provide residents with information on transit options available within Flagler County to facilitate access to health and human services.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
3.2. A: Increase outreach to residents to educate them on available services	Develop target messaging campaign Use social media for outreach	• Flagler County Health Department • Social and Human Service Providers	Oct 2012-July 2013 July 2013-Dec 2015

CHRONIC DISEASE

In 2009 the top three major causes of death in Flagler County were cancer, heart disease, and chronic lower respiratory disease. In 2010 Flagler County participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey which collects data related to behavioral factors that can contribute to such chronic diseases. Three notable behavioral risk factors associated with chronic diseases in Flagler County are hypertension, tobacco use, and overweight/obesity.

Since 2002 the percentage of adults in Flagler County who have been diagnosed with hypertension has risen from 31.4% to 43.1% and continues to be higher than the state average. Important to control hypertension is a healthy diet, exercising, and taking medication as prescribed; currently only 80% of diagnosed residents report taking their medication. When county residents were surveyed in 2011 as part of the MAPP being overweight and poor eating habits were ranked third and fourth among "unhealthy behaviors of most concern."

Tobacco use and exposure to second hand smoke can be a contributing factor in cancer, heart disease, and respiratory issues. In 2010 one in five (21.5%) adults in Flagler County reported smoking. This is more than 4% higher than the state average. Between 2007-2009 10.7% of mothers reported smoking during pregnancy. (Florida Department of Health, Bureau of Vital Statistics). This average is also almost 4% higher than the State of Florida average. Smoking during pregnancy has been shown to increase the risk of preterm infants, low birth weight, still births, and sudden infant death syndrome (SIDS).

A third area of concern is the percentage of the population that is overweight or obese. An adult that has one of these two conditions can be more likely to have a chronic health issue such as diabetes, heart problems, and certain types of cancers, hypertension and more. The 2010 BRFSS survey data shows almost 40% of Flagler County is overweight and another almost 30% of the population is obese. In 2012 the combined percentage of adults in Flagler County who are not of a healthy weight was 68.3%. The 2010 MAPP focus groups which focused on community themes also noted the need for more health and nutrition education was needed and more preventative services were seen as valuable and necessary.

Chronic diseases are the most common and costly of all health problems, but they are also the most preventable. Four common, health-damaging, but modifiable behaviors—tobacco use, insufficient physical activity, poor eating habits, and excessive alcohol use—are responsible for much of the illness, disability, and premature death related to chronic diseases.

-Centers for Disease Control and Prevention

STRATEGIC ISSUE #2 CHRONIC DISEASE

GOAL 1: REDUCE TOBACCO RELATED DISEASE IN FLAGLER COUNTY			
OBJECTIVE 1.1: By 2015 reduce the percentage of pregnant women who report smoking by 5% (from 10.7 in 2009)			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
1.1.a: Collaborate with health care organizations to promote awareness of smoking cessation programs	Identify media outlets Identify funding sources for promotion Create social media sites Create dates/times more accessible to community	• FCHD • School Board • Social and Human Service Providers	Oct 2012-Dec 2012 Jan 2013-July 2013 Oct 2012-July 2013
1.1b.: Develop a collaborative Tobacco Free Partnership	Identify community partners Identify funding (grants) for support	• FCHD • School Board • Social and Human Service Providers	Oct 2012-Dec 2012 Dec 2012-Dec 2013
1.1c: Create public webinars for smoking cessation and educational information	Identify host sites for information dissemination Promote awareness of materials	• FCHD • School Board • Social and Human Service Providers	Oct 2012-Dec 2012 Jan 2013-Dec 2015
OBJECTIVE 1.2: By 2015 reduce the percentage of high school students who report using cigarettes in the past 30 days			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
1.2.a.: Create a Students Working Against Tobacco (SWAT) program in local middle and high schools	Recruit local organization to support club Attend school board meetings to get on agenda for topic of discussion and approval Recruit teachers within school as sponsors Advertise club meetings/agendas	• FCHD • School Board • Social and Human Service Providers • FCHD	Oct 2012-July 2013 Oct 2012-July 2013 Oct 2012-July 2013 Aug 2013-May 2014

1.2.b.: Develop anti-smoking media campaign for teens	Partner with SWAT clubs or other agencies/organizations to recruit youth to design campaign Find funding sources to support campaign development Secure media outlets for promotion	• School Board • Social and Human Service Providers	Aug 2013-May 2014 Aug 2013-Jan 2014 Jan 2014-Mar 2014
GOAL 2: REDUCE THE IMPACT OF HEALTH RELATED ISSUES THAT CORRELATE WITH BEING OVERWEIGHT, HIGH BLOOD PRESSURE AND DIABETES.			
OBJECTIVE 2.1: Increase the percentage of adults who are receiving education for their condition (Diabetic Self Management Education) by 5% by 2015.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
2.1.a.: Develop a patient diabetes management protocol to improve patient disease management	Identify all health care systems treating patients with diabetes Create/purchase monitoring system to alter health care providers on levels and whether or not patient has been given self check education	• FCHD • Rural Health Network	Oct 2012-Jan 2013 Jan 2013-Dec 2014
2.1.b.: Increase patient education on importance of and proper procedures for self checks	Create community accessible social media trainings on areas related to medication management, healthy eating, and life style choices Create patient education system within health care systems that is mandatory for identified patients	• FCHD • Rural Health Network	Oct 2012-Dec 2013 Oct 2012-Dec 2013

OBJECTIVE 2.2: Decrease by 5% the number of adults who are overweight (from 40% to 35%) and who are obese (from 30% to 25%) by 2015.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
2.2.a.: Increase community awareness of importance of healthy eating habits and exercise	Create community accessible social media trainings on areas related to medication management, healthy eating, and life style choices Host community health and wellness fair to inform and educate community Promote free BMI testing for children and adults to raise awareness Promote farmer's markets for fresh fruits and vegetables (if one is in the area, if not put one together)	• FCHD • Rural Health Network	Oct 2012-Oct 2013 Jan 2013-July 2013 Oct 2012-Dec 2015
2.2.b.: Increase access for community members to walking trails and/or walking groups	Promote/highlights areas of the community with high walkability scores Sponsor and promote walking groups within neighborhoods or through employers Host events at local parks or recreation facilities that involve time and space for walking	• Flagler County Parks and Recreation • FCHD • School District • CRA • City of Bunnell	Oct 2012-July 2013 Mar 2013-Dec 2015 Oct 2012-Dec 2015
OBJECTIVE 2.3: Decrease by 5% the number of residents with high blood pressure (hypertension) from 43.1% to 38% by 2015.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
2.3.a.: Create a physical activity strategy for patients including a recommended/manageable goal	Organize 5k run/walk activities for the community several times per year Sponsor and promote walking groups within neighborhoods or through employers	• Flagler County Park and Recreation • FCHD • School District • CRA • City of Bunnell	Jan 2014-Dec 2015 Mar 2013-Dec 2015

SUBSTANCE ABUSE and MENTAL HEALTH

During the 2011 Community Survey conducted through the MAPP process Flagler County residents thought the top health problem was addiction (alcohol and drugs) (33%) and the top "unhealthy behavior of most concern" was drug abuse (61%) followed by alcohol abuse (40%). Statistically however, Flagler county residents report drinking less in 2010 than the previous eight years.

Also, according to the 2011 Community Survey the second most difficult services to obtain in Flagler County are those for mental health, followed by those for substance abuse. For residents with transportation issues and/or insurance and health care coverage concerns, mental health and substance abuse treatment are often hard to come by. A majority of key community leaders when interviewed were very supportive of the community pursuing a community health center. A community health center was seen as an asset to have not only continuity of care for those with identified mental health or substance abuse concerns but also assists with insurance and transportation barriers.

Both the consistent themes of access to services and economic conditions play a role in this priority area. Key community leaders, when surveyed responded that the concern over drug/alcohol abuse may seem surprising, it is noted a top issue to be addressed and that the rise of prescription drug use could be as a result of emotional turmoil due to the economy. "Pill mills" and doctors overprescribing are two other areas of concern that warrant some attention when looking at addiction. Another area of opportunity related to addiction and mental health is that of early education and prevention.

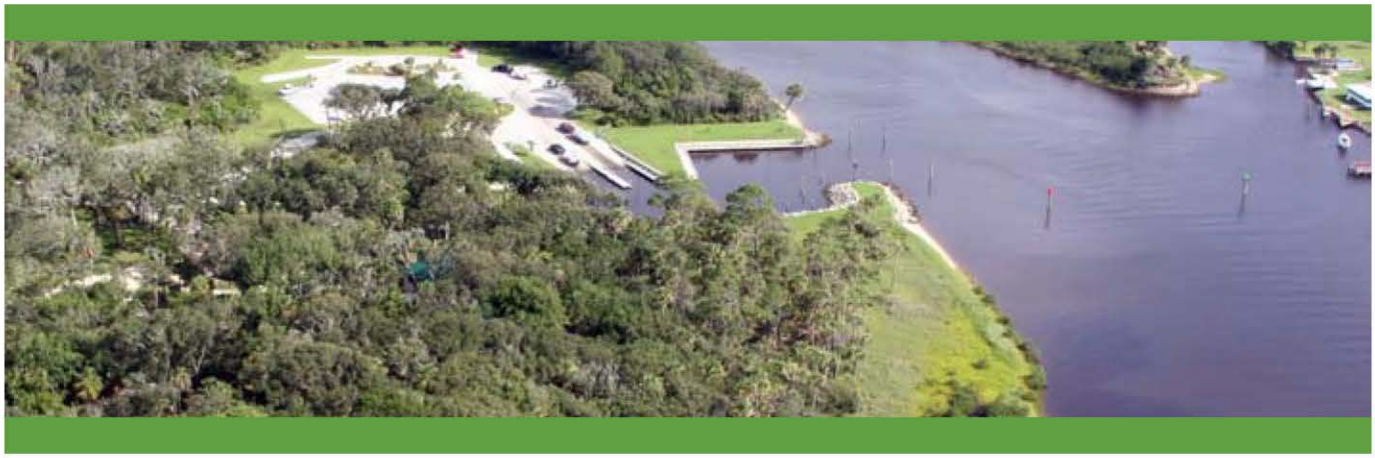
Mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

-World Health Organization. *Strengthening Mental Health Promotion.* Geneva, World Health Organization (Fact sheet no. 220), 2001.

STRATEGIC ISSUE #3 BEHAVIORAL HEALTH: SUSTANCE ABUSE AND MENTAL HEALTH

GOAL 1: INCREASE ACCESS TO BEHAVIORAL HEALTH SERVICE AND PREVENTION THROUGH THE INTEGRATION OF PRIMARY HEALTHCARE AND BEHAVIORAL HEALTHCARE TO SIGNIFICANTLY MEET BEHAVIORAL HEALTH NEEDS.			
OBJECTIVE 1.1: Integrate primary healthcare and behavioral healthcare through using a centralized medical home model with transportation opportunities.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
1.1.a: Offer assistance to clients who need to apply for disability and Medicaid	Identity locations where assistance can be offered Partner with Colleges and universities to assist clients	• St. Vincent's (mobile) • Pastor Silano's initiative	Oct 2012-Dec 2012 Jan 2013-Dec 2015
1.1b.: Identify effective preventative and relapse programs to refer clients	Establish a data base of programs and providers with a process for referral and follow up	• Flagler Housing Authority • Flagler County Health Department • Free Clinic • Stewart Marchman-ACT	Oct 2012-Jan 2014
1.1c: Explore options for co-locating behavioral health services with both existing and new primary care centers	Explore options for the provision of behavioral health at existing medical sites Continue efforts to fully integrate behavioral health services into the emerging Community Health Center model in Bunnell	• Stewart Marchman-ACT • Flagler CHD • Free Clinic	Oct 2012-July 2014 Oct 2012-Dec 2015
OBJECTIVE 1.2: Increase housing opportunities to provide individuals and family stability to support better behavioral health outcomes.			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
1.2.a.: Explore opportunities to retrofit or rehabilitate structures for housing		• Flagler Housing Authority	Oct 2012-Dec 2015
1.2.b.: Identify funding to create increased housing opportunities		• Flagler Housing Authority	Oct 2012-Oct 2013
1.2.c.: Review policy that prohibits individuals with a criminal record to obtain housing		• Flagler Housing Authority	Oct 2012-July 2013

OBJECTIVE 1.3 Assist in the facilitation of disability and Medicaid application processes for consumers			
STRATEGIES	**ACTION STEPS**	**PARTNERS / RESOURCES BEST PRACTICES**	**TIME FRAME**
1.3.a. Coordinate with DCF to identify appropriate/effective site(s) for computer kiosks	Include coordination with sites to identify key staff and/or volunteers who will assist the clients with their online applications at the kiosks	• DCF Field staff • Stewart Marchman-ACT • Flagler CHD • Flagler Housing Authority • School District	Oct 2012-Oct 2013
1.3.b. Coordinate with health and social services providers and area churches to identify volunteers and staff who can assist clients with applying through the kiosks	Coordinate this with Kiosk sites or with a mobile enrollment site if one is established	• DCF Field staff • Stewart Marchman-ACT • Flagler CHD • Flagler Housing Authority • School District	Oct 2012-Oct 2013



The outcome of the community health improvement planning process looks outside the performance of an individual organization to the way in which the activities of many organizations contribute to community health.

-NACCHO

CONCLUSION

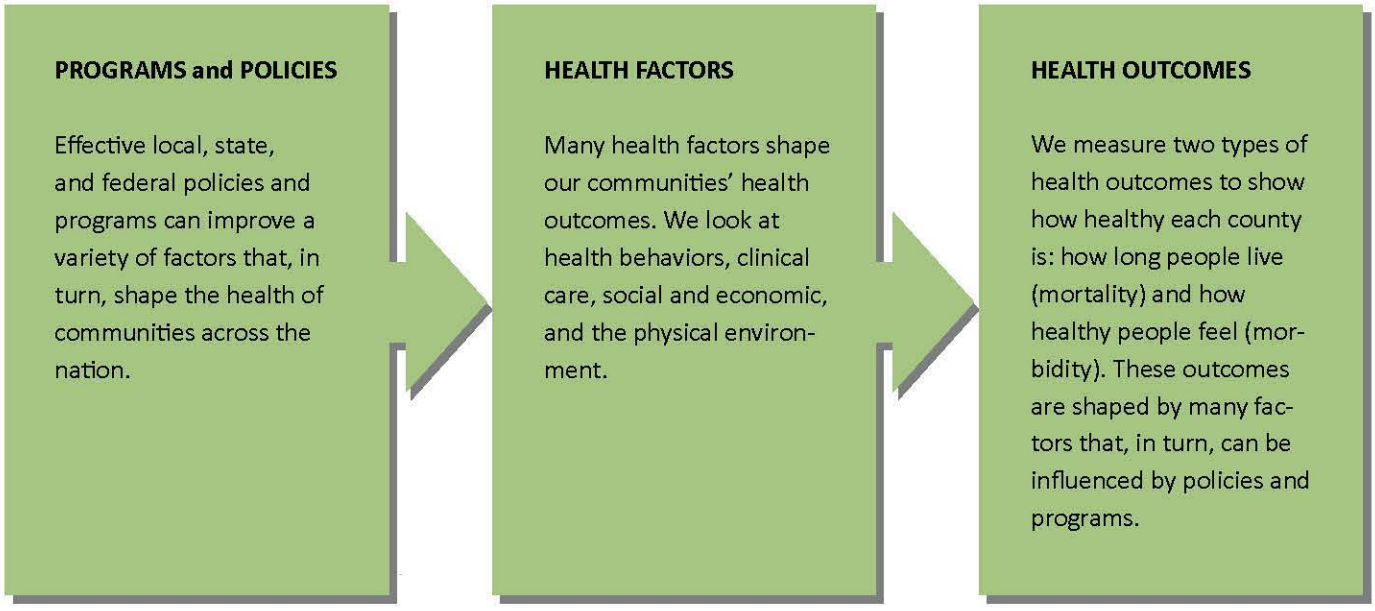
Flagler County has just under 100,000 residents. Approximately, 2,333 families are below the poverty standard. Over the past year community stakeholders have taken the time to gather data, conduct surveys and ask critical questions related to the health, wellness and future of the county. The primary focus would be on individuals and families that would benefit from a collaborative effort of healthcare and an integrated system of care. Community leaders took the time to assess the current status, procedures and current services and pose possible action steps to improve health care. It was obvious that primary areas of access to care, mental health and substance abuse and chronic disease were in significant need of attention.

Throughout the assessment process several themes were consistent as they related to the three priority areas. The areas of concern appeared to focus on transportation to services, financial difficulties related to care and resident knowledge of preventative measures and services. Areas of health including tobacco use, obesity, hypertension and substance use can all be substantially reduced with increased prevention efforts. The availability of information through media outlets, primary care providers and social sites will increase the ability of residents to educate themselves on key areas for sustained overall health. For residents, being able to obtain comprehensive services in one location would also substantially assist with patient care.

Between the end of 2012 and 2015 the proposed health improvement plan has established measurable objectives and action steps for key leaders and organizations to motivate and propel accomplishments throughout the county. In order for citizens to be healthy, the need access to care, the ability to afford it and the right information to manage and prevent health consequences is essential. Through the collaborative efforts of the transportation and housing authorities, primary care providers, the Department of Health and other service organizations, Flagler County can carry out a comprehensive set of strategies to set the system of care where it needs to be for residents that are most in need of services.

This plan should be an active document used to provide action and cohesion to create positive changes for the residents of Flagler County.

What We Know



Source: County Health Rankings.


BUNNELL


BUNNELL
CITY HALL

APPENDIX A

Phase I: Vision and Mission

Vision and Mission are to be inclusive of the entire Comprehensive Health Improvement Plan (CHIP).

A **vision** statement is a short (usually one sentence) message that conveys hope for the future. It should be broad enough to be inclusive of whole community and easy to communicate.

Examples:

Equal access to quality health care for all citizens.
Have a clean, safe and healthy environment.

A **mission** statement focuses more on the action of "how" a group's vision will be reached. It should be concise, outcome oriented and inclusive. A mission usually includes the words "through" or "by".

Examples:

To promote health and quality of life by preventing and controlling disease, injury, and disability (Centers for Disease Control and Prevention).

To ensure the citizens have access to a quality health care delivery system. The agency fulfills this mission by advising policy makers of health care issues; informing the public and the industry of statewide and national trends; and designing and directing health care system development. (Office of Health Care Access).

Priority Problems are taken directly from the Community Health Assessment. Each subcommittee is asked to list what factors in the community contribute to each issue.

Contributing factors are those things that may be responsible for or may have direct affect on the issue. Example: Poor diet is a contributing factor for obesity.

APPENDIX B

Phase II: Goals and Objectives

Goals: A clear statement of what you want to accomplish. In broad terms the desired outcome of an initiative. Goals cannot be quantified and are usually long-term. The goals should relate to the priority problem and the mission statement and do not contain numbers or timeframes.

Examples:

Eliminate deaths from tobacco-related cancers.
Promote awareness about cancer prevention.
Improve quality of life of cancer survivors and their families.

Objectives: Answer the "who", "what", "where", "when", and "how" questions. Objectives should be specific and measurable.

Outcome objectives measure what is to be achieved for a certain population (usually numerical).

Example:

Increase to 70% the proportion of women 40 years of age and older who have received a mammogram with the preceding 2 years.

Developmental objectives cannot be measured or tracked; they are descriptive in nature with no numeric value.

Example:

Increase the proportion of persons who have had a vision screening.

Process objectives describe tasks to be completed or implemented; are measurable but may not be quantifiable.

Example:

Implement guidelines for pre-hospital and hospital pediatric care. Good objectives should include a target population, timeframe, baseline values (if available) and a target value.

Examples:

By 2013 increase by 85% the number of women 50 years of age and older who have annual breast exams.
By 2012 establish a free statewide cancer screening program for people 50 years of age and older who do not have health insurance.

SAMPLE WORKSHEET

PRIORITY AREA:
CONTRIBUTING FACTORS: (Identified areas that may cause priority issues)
GOALS: (General statement of what you want to accomplish)
OBJECTIVES: (Measurable within a suggested timeframe)

APPENDIX C

Phase III: Resource and Capacity Assessment

Current Strategies: Is there a program, practice, or policy in place in the county that is currently addressing the identified goals relevant to each priority?

Does the strategy address the target population: Is the strategy likely to influence the population most at risk for the identified priorities targeted? Consider the age, gender and other characteristics of the target population as well as the context of the priority issue. Process evaluation or other implementation tracking data may provide insight into the populations that are affected by the strategy.

Is it evidenced-based/best practice: Has there been documented, scientific research or literature on the strategy that proves it is effective in what is doing for a particular goal and target population? (For example...a smoking cessation program is currently being taught in the middle schools in the county. Is it a reputable curriculum? Has it been recognized nationally as a best practice program? Does it yield positive results that can be measured and replicated?) Are positive outcomes happening as a result of this strategy?

Is it implemented with fidelity: Is the current strategy (policy, program or practice) being implemented the way it was intended by the developer? This there a system in place for how/who/what/when/where the implemented strategy is to occur and is it being followed to produce the best results? Are there any adaptations being done that would jeopardize the program or participants?

Does it reach the population adequately: Does the strategy reach enough of the intended population to be making a population level change? Are there additional things being done with the strategy to assist in reaching more of the population? (For example if a program is for 5th graders are all 5th graders, even home schooled or alternative students getting the program?)

Gap: Where in this strategy is there a gap in providing adequate service? Is there not enough capacity within the program? Is there an enforcement issue? Is there not enough funding, manpower, space, time, community by-in?

Capacity Needed: Is there needed capacity within the organization implementing the strategy? Is there needed community capacity for proper implementation? Is it a capacity issue with training, skill sets, or administrative needs?

SAMPLE WORKSHEET

PRIORITY AREA:

CONTRIBUTING FACTORS:

GOAL:

CURRENT STRATEGIES	DOES IT ADDRESS POPULATION TARGET	IS IT EVIDENCED-BASED/BEST PRACTICE	IS IT IMPLEMENT-ED WITH FIDELITY	DOES IT REACH POPULATION ADEQUATELY	GAP	CAPACITY NEEDED

APPENDIX D

Phase IV: Strategies

A **strategy** suggests a path to take and how to move along. It is what determines how to achieve the objectives through action. They should fit the resources that may already be in place and at the same time take into account existing barriers. Good strategies should be able to reach those most affected (target population) and involve as many community sectors as possible. Strategies often begin with the words "identify," "advocate," "support," and "educate."

Questions to consider when developing a strategy:

1. The levels to be targeted (i.e. individuals, special groups, organizations).
2. Is the strategy universal or targeted?
3. The personal and environmental factors to be addressed.
4. Those who can most benefit and contribute and how they can be reached or involved in the effort.
5. The kind of behavioral strategies to be used. (i.e. provide information, enhance services, modify barriers, change incentives, modify policies)
6. For each strategy consider what policy/practice/or program would need to be created or modified.

Examples of strategies for objective: By 2010, increase to 85% proportion of women 50 years of age and older who have annual clinical breast exams and mammograms.

1. Identify populations who underutilize mammography and clinical breast exams.
2. Advocate for increased public funding for breast cancer screening for the uninsured and underinsured.
3. Develop a media campaign (public service announcements, posters) to educate women about breast cancer risk factors and the benefits of early detection.
4. Train people in faith-based organizations to educate their congregations about the importance of breast cancer screening.

SAMPLE WORKSHEET

PRIORITY AREA:			
GOAL:			
OBJECTIVE (Measure):			
STRATEGIES	**ACTION STEPS**	**RESOURCES/PARTNERS/ BEST PRACTICES**	**TIME FRAME**

HEALTH PLANNING
COUNCIL
OF NORTHEAST FLORIDA