Solano Public Health
Strategic Plan

Updated December 20, 2017

SOLANO PUBLIC HEALTH

Healthy People – Healthy Community

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Strategies for Solano Public Health

After reviewing possible scenarios and forces of change that Solano Public Health may need to address or respond to in the future, participants identified strategies that Solano Public Health could utilize to preemptively address future health issues and ensure success toward our vision, *Healthy People – Healthy Community*, regardless of which scenarios actually come to pass.

Among some of the real and potential scenarios and forces identified are:

- Changes to Affordable Care Act
- Health Equity
- Immigrant Issues
- Opioid Crisis
- Bay Area Expansion
- Workforce Readiness
- Value-Based Care / Outcome Driven
- Aging Population
- Federal & State Budgets

Both the vision, Healthy People - Healthy Communities and the identified strategies are guided by a set of values which serve as the guardrails for decision-making. Solano Public Health leadership surfaced the following key values, which align with the core values previously identified:

- Evidence-based
- Equity
- Proactive
- Cross-system
- Upstream
- Prevention-focused
- Centrist (politically moderate)
- Innovation-friendly
- Integration
- Data –drive

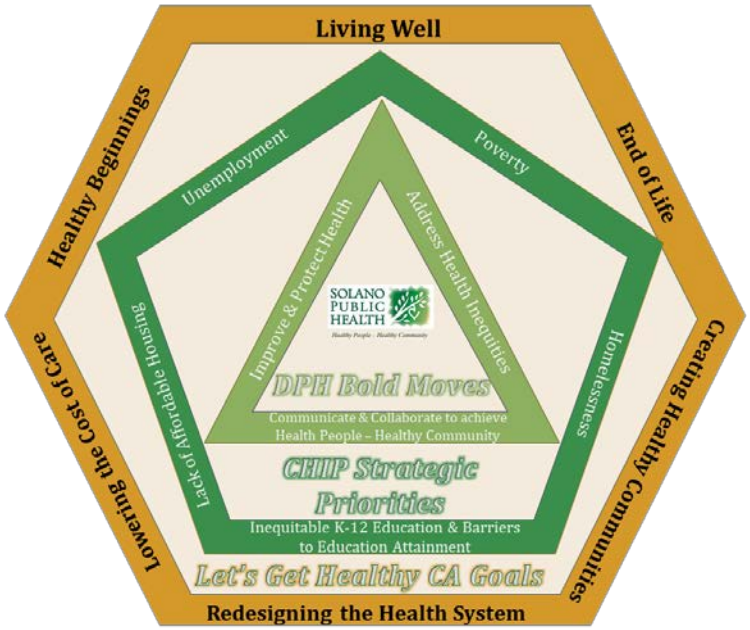
Strategies for Solano Public Health

Solano Public Health will, within the wide scope of their responsibilities,

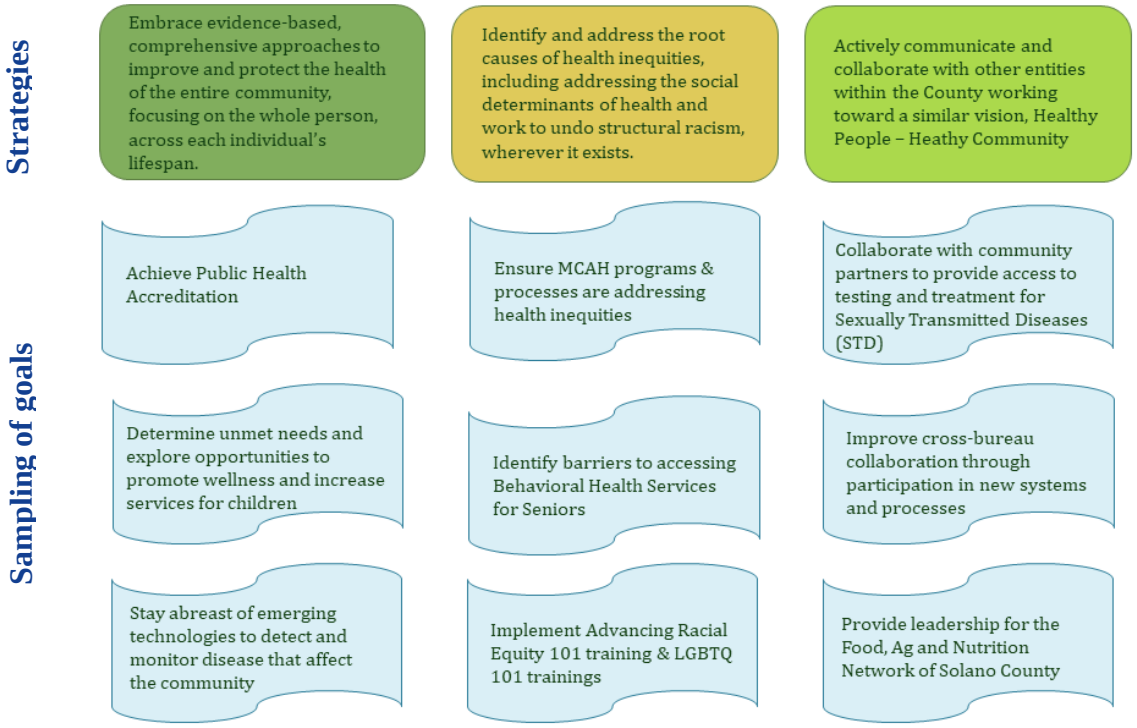
- Embrace evidence-based, comprehensive approaches to improve and protect the health of the entire community, focusing on the whole person, across each individual's lifespan.
- Identify and address the root causes of health inequities, including addressing the social determinants of health and work to undo structural racism, wherever it exists
- Actively communicate and collaborate with other entities within the County working toward a similar vision, Healthy People – Heathy Community

In addition to planning for the future of the division, Solano Public Health is also coordinating efforts for the Solano County Community Health Improvement Plan (CHIP). The intent of the strategic plan will not only clearly communicate the direction of the division, but will also clarify the role Solano Public Health intends to take in the CHIP activities and how to focus limited resources.

The 5 strategic issues identified by the community for the CHIP are Poverty, Homelessness, Unemployment, Inequitable K-12 Education & Barriers to Education Attainment, and Lack of Affordable Housing. Solano Public Health strategies and goals align and support these strategic issues as well as the goals and strategic issues of statewide public health efforts. The specifics of this alignment can be seen in Appendix A.



The graphic below highlights some of the goals for each of the strategies. A full list of the goals for each bold move is included later in the full report in Table 1.



Letter from the Health Officer

Dear Colleagues & Community Members,

I am pleased to present the Solano Public Health Strategic Plan. With this plan in place, we have established Vision, Values and Strategies Solano Public Health will use as a guide to pursue excellence across all activities.

We are particularly proud of the plan's alignment with the Community Health Improvement Plan (CHIP) and the statewide efforts of Let's Get Healthy California and the level of engagement in planning of internal and external stakeholders, including the Healthy Solano Collaborative. The plan integrates the voices of the community gathered as part of the CHIP planning efforts, which were done simultaneously. Solano Public Health staff from each bureau were included in forming the plan's goals and action steps.

The plan does not highlight all of the work of the division. The full scope work of public health covers the entire community, across the lifespan and the many and varied factors that impact the health of the population living in or visiting Solano County. The plan, by design, is a high-level document to guide Solano Public Health with a few bold and strategic directions. It will be used to make decisions, allocate resources, monitor our progress and support the efforts of our community, our collaborative partners and the State of California.

By adhering to the values laid forth, intervening in critical issues, committing to continuous quality improvement and adapting to the ever-changing environment, we will move the needles to improve the health and quality of life for our communities and visitors.

We want to thank all of the individuals participating in the strategic planning efforts and the CHIP processes without whom we would not have the diversity of thought and creativity to solve the problems we face as a community. Additionally, we would like to acknowledge the support of the Board of Supervisors, Mayors, City Council Members, and Health & Social Services leadership. Our efforts are enhanced by everyone's commitment to our vision, *Healthy People – Health Communities.*

Sincerely,

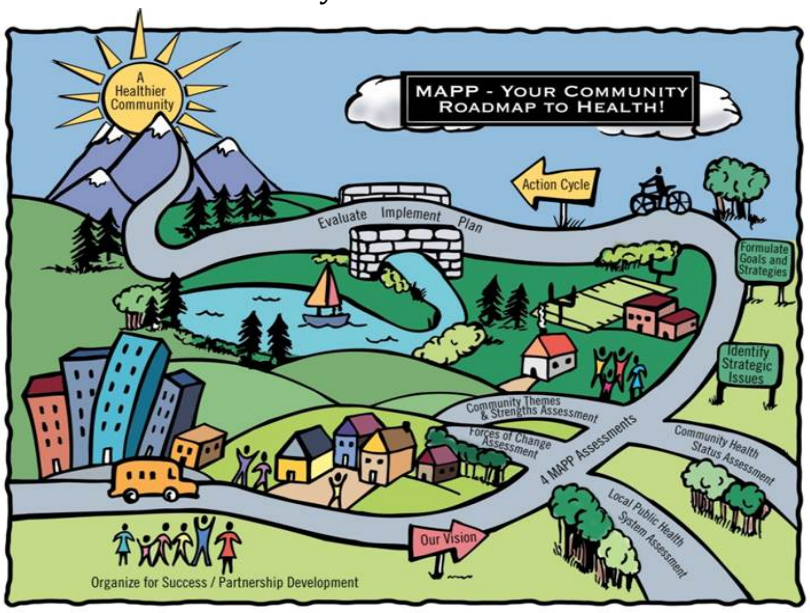
Dr. Bela T. Matyas
Solano County Health Officer
Health & Social Services Deputy Director

Overview of Planning Process

The process for developing the strategic plan was integrated with the comprehensive process for developing the CHIP. In 2014, Solano Public Health initiated the MAPP process, which stands for Mobilizing for Action through Planning & Partnerships. MAPP is an evidence-based process that numerous, jurisdictions across the country have used to assess and address the health needs of their communities. In May 2016 we finished the assessment phase of the MAPP process, which required the completion of four in-depth community assessments.

1. **COMMUNITY HEALTH STATUS ASSESSMENT (CHSA)**

CHSA answers questions such as: "How healthy are our residents?" and "What does the health status of our community look like?"



2. **COMMUNITY THEMES & STRENGTHS ASSESSMENT (CTSA)**

CTSA results in a strong understanding of community issues and concerns, perceptions about quality of life, and a map of community assets.

3. **LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT (LPHSA)**

LPHSA focuses on all of the organizations and entities that contribute to the public's health.

4. **FORCES OF CHANGE (FoC)**

FoC focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate.

Following the completion of the four assessments, the numerous issues identified needed to be prioritized. Solano Public Health & the Healthy Solano Collaborative worked with stakeholders to identify the strategic issues with the highest priority.

Using the information gathered in the MAPP process, Solano Public Health Leadership and line staff worked together to begin the process for developing the strategic plan. The steps included:

- Reviewing the FoC results and adding any new or different information relevant to Solano Public Health
- Creating a shared definition of the vision, Healthy People – Healthy Community
- Anticipating the future through a matrixed scenario planning activity
- Identifying the values that serve as guardrails for decision-making and resource allocation

- Drafting the strategic direction for Solano Public Health

Following the strategic direction meeting, three workshops were held to assist each Solano Public Health Bureau with the development of goals and objectives to support the strategies and the success measures or outcomes. Teams from each bureau participated in these workshops and the resulting drafts were then reviewed with larger bureau teams. The following sections outline the current vision, mission, core values and the resulting goals for the strategic plan. How the goals align with other local and statewide efforts can be found in Appendix A.

Vision, Mission, Core Values

The existing vision, mission, and core values were determined to still be relevant and no edits were made.

Our Vision: Healthy People—Healthy Community

Our Mission: To optimize the health of the community through individual and population-based services which promote health and safety through prevention and treatment of disease and injury.

Core values:

- Prevention is the key to community health.
- Families are healthy when quality of life, healthy development, and healthy behaviors are promoted across all life stages.
- All Individuals have the right to be treated with fairness, respect, and dignity in a culturally and linguistically appropriate way.
- Health equity is achieved, disparities eliminated, and the health of all groups is improved by influencing the social, economic, environmental and political factors that influence positive health outcomes.
- Increased access to quality client-centered medical care, public health services, and information will enhance the health and well-being of all people served.
- Partnerships and collaboration with community members and organizations are critical to achieving community health.
- The ethical practice of public health involves a commitment to excellence and continuous improvement in services and education, delivered with integrity and accountability.

Current Environment

The graphic below highlights both the forces impacting or with potential to impact Solano County. These came from the FoC assessment and from updates made during the strategic direction meeting.

Strategies & Goals

The following table outlines the strategies and the goals of the Strategic Plan.

Table 1

Solano Public Health Strategies & Goals

Strategy #1: • • Embrace evidence-based, comprehensive approaches to improve and protect the health of the entire community, focusing on the whole person, across each individual's lifespan.	**Strategy #2:** • • Identify and address the root causes of health inequities, including addressing the social determinants of health and work to undo structural racism, wherever it exists	**Strategy #3**: • • Actively communicate and collaborate with other entities within the County working toward a similar vision, Healthy People – Heathy Community
Achieve Public Health Accreditation	Implement Racial Equity toolkit in Public Health	Increase utilization of PH/Solano Care websites
Continuous Quality Improvement (CQI) activities are integrated into Public Health programs	Implement Advancing Racial Equity 101 training & LGBTQ 101 trainings	Build improved relationships with Board & Care operators within the County
Create and implement an assessment tool which assesses and educates clients on aging in place and end of life decisions	Establish indicators to paint a picture of health inequities (eg county snapshots)	Develop an education campaign to increase awareness of services and role of Adult Protective Services (APS)
Increase exposure to the ReThink Your Drink (RYD) campaign about risks associated with sugar sweetened beverages and choosing healthy beverage options	Identify barriers to accessing Behavioral Health Services for Seniors	Educate IHSS providers to work with their clients to prevent falls
Increase the purchase of fruits and vegetables by WIC participants.	Increase the number of exclusive breastfeeding initiation rates for African American women	Provide leadership for the Breastfeeding Coalition of Solano County
Secure sustainable funding for MCAH programs	Increase the number of hospitals that are baby friendly	Provide leadership for the Food, Ag and Nutrition Network of Solano County
Determine unmet needs and explore opportunities to promote wellness and increase services for children	Ensure MCAH programs & processes are addressing health inequities	Improve cross-bureau collaboration through participation in new systems and processes
Ensure that every mom has access to perinatal and postpartum mental health care services	ID and address the needs of children with adverse childhood experiences (ACES) in Solano County	Provide linkage to healthcare for all identified HIV patients for the purpose of preventing progression to AIDS
Contribute PH perspective to county-wide planning for a reduction of homelessness and increase affordable housing. Ensure a focus on chronic disease prevention for people who are not currently housed.	Evaluate current & new methods of outreach and messages regarding STDs to ensure they are culturally specific and that are targeted at both the individual and community level	Maximize collaboration and strengthen relationships within and between programs in the MCAH Bureau, and between MCAH and other H&SS programs
Increase awareness and utilization (uptake) of Prep and Pre Exposure Prophylaxis (PEP) by both patients and providers	Pursue communicable disease testing for the prison population	Monitor data for patterns of outbreaks and recommend preventative measures to environmental health
Target interventions based on data trends with intent to minimize or prevent disease occurrence		Collaborate with community partners to provide access to testing and treatment for Sexually Transmitted Diseases (STD)
Stay abreast of emerging technologies to detect and monitor disease that affect the community		Extend laboratory electronic connectivity with clients and partners to ensure timely electronic reporting and data management

Implementation Plan

This table incorporates the action steps, success measures and responsible person(s) for each goal in the implementation plan

Table 2

	Strategy #1: • • Embrace evidence-based, comprehensive approaches to improve and protect the health of the entire community, focusing on the whole person, across each individual's lifespan.	**Strategy #2:** • • Identify and address the root causes of health inequities, including addressing the social determinants of health and work to undo structural racism, wherever it exists	**Strategy #3**: • • Actively communicate and collaborate with other entities within the County working toward a similar vision, Healthy People – Heathy Community
Goals	Achieve Public Health Accreditation	Implement Racial Equity (RE) toolkit in Public Health	Increase utilization of PH/Solano Care websites
Actions	• Create logo for Healthy Solano • Complete CHIP Implementation • Complete Strategic Plan • Complete domain registration	• RE toolkit training • Select projects • Communicate strategy • Final toolkits scheduled & presented	• Coordinate with IT to get SMART register • Acquire the SMART register • Create policy & procedure for new register
Success Measures	• Earn "Accredited" status & logo	• Report out on 1 toolkit project per Bureau per year	• Number of hits to website increase
Responsible Person(s)	PH Accreditation Coordinator	PH Accreditation Coordinator	Sr. Health Education Specialist
Timeline	1-2 Years	1-3 years	1-3 years
Goals	Continuous Quality Improvement (CQI) activities are integrated into Public Health programs	Implement Advancing Racial Equity 101 training & LGBTQ 101 trainings	Build improved relationships with Board & Care operators within the County
Actions	• CQI trainings for Bureaus/Programs • Project selection • Communication strategy • Final reports scheduled & presented	• Establish contract for LBGTQ vendor • Develop trainers for SR101 Implement trainings	• Identify Board & Care homes in Solano • Identify the cost of Board & Care beds • Determine Board & Care operators' willingness to negotiate costs with County • Partner with local hospitals, SCBH, PHP, Solano County to develop safety net funding
Success Measures	• CQI project is reported out at least once by Bureaus	• 75% of Public Health staff are trained	• Presentation done June 2018 to SCBH Exec Committee, with data on recent "high" cost clients
Responsible Person(s)	PH Accreditation Coordinator	PH Admin Bureau	PG Supervisor
Timeline	1-3 years	1-2 years	2 years

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Goals	Create and implement an assessment tool which assesses and educates clients on aging in place and end of life decisions	Establish indicators to paint a picture of health inequities (eg county snapshots)	Develop an education campaign to increase awareness of services and role of Adult Protective Services (APS)
Actions	• Evaluate assessment tools already in existence • Determine what Solano County's tool looks like • Pilot test the tool • Follow-up with a representative sample who completed the form	• Survey other county health jurisdictions about what they have used • ID gaps • ID data elements • ID data resources	• Identify marketing plans used elsewhere for APS • Create a marketing plan • Determine who is the audience (Police, hospitals, churches, senior centers, etc.) • Identify what APS cannot do
Success Measures	• Tool is available for all staff with clients who need the assessment	• Reporting results in tables, charts & maps to the County	• A marketing plan that includes the message and target audiences and dissemination plan for the campaign. Attend community outreach events: Vallejo Health & Technology Fair, Family Justice Annual Fair
Responsible Person(s)	NSD - PHN Manager / Adult Health cooperative	Epidemiology Team	Jacque
Timeline	3 years	1-3 years	2 years
Goals	Increase exposure to the ReThink Your Drink (RYD) campaign about risks associated with sugar sweetened beverages and choosing healthy beverage options	Identify barriers to accessing Behavioral Health Services for Seniors	Educate IHSS providers to work with their clients to prevent falls
Actions	• Develop process for partners to report information on when RYD activities are conducted • Conduct RYD classes and events. • Revise RYD class for partners. • Develop process for partners to borrow RYD class and event materials and supplies. • Develop and implement an annual RYD campaign that includes media and events that includes ongoing media and events • Include RYD messages in WIC.	• Pull data from existing sources to demonstrate the inequities in accessing behavioral health services • Identify the barriers to access mental health services by exploring existing tools and then creating one for PH staff to use to assess the barriers to access BH services • Develop a plan to provide mobile counseling services to seniors • Identify & maintain a list of the available services for behavioral health care for seniors	

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Success Measures	• Increased number of RYD events	• Barriers are identified • Criteria of who would receive mobile services and a plan for implementing • Comprehensive list of services to seniors for behavioral health is available	• Decreased falls & ED visits
Responsible Person(s)	Nutrition Services Administration	Jamal	Teri Ruggiero
Timeline	5 years	2 years	3 years
Goals	Increase the purchase of fruits and vegetables by WIC participants.	Increase the number of exclusive breastfeeding initiation rates for African American women	Provide leadership for the Breastfeeding Coalition of Solano County

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Actions	• Divide Farmer's Market Nutrition Program checks between the 3 main WIC sites in 2018 and distribute at the farmers' market. • Develop campaign to implement in WIC 2 months prior to the start of the FMNP season to increase awareness of FMNP program with WIC participants (bulletin boards, WIF inserts, newsletters, class messages, Health Messenger). • Coordinate with NEOP to do taste testing or food demonstrations events in WIC clinics and to feature Harvest of the Month. • Give NEOP cookbook to all participants that receive FMNP booklet at farmers' markets. • Follow-up with WIC participants that receive FMNP checks if they used and if not encourage to do so. • Include resources for families that are participating in the summer lunch program distribution at Courage Drive about how to access fruits and vegetables and information on how to prepare. • Give out cookbooks in WIC from NEOP or purchase that feature recipes that use fruits and vegetables. • Add to the GA40 class information about fruits and vegetables when possible that could include: online recipe sites to find easy, tasty recipes; seasonal fruits and vegetables and how to make.	• Partner with the MEW program's projects include Community Baby Showers and Peer Counseling training. • Train and provide ongoing support to Black Infant Health (BIH) program on breastfeeding promotion and support. • Put together resources that include accurate and culturally appropriate materials on breastfeeding to give to programs that serve AA pregnant and breastfeeding woman. • Attend and support the African American (AA) Early Access to Prenatal Care group. • Ensure WIC staff are referring AA pregnant women to BIH and the Breastfeeding Peer Counseling Program.	• Identify barriers for women to breastfeed and select projects to address these barriers. • Facilitate project-oriented meetings to support work on strategic plan. • Complete projects
Success Measures	• Increase the purchase of fruits and vegetables by WIC participants.	• Increased number of African American women who are initiating breastfeeding	• Active participation and completed projects
Responsible Person(s)	Nutrition Services Administration	NS Administration	RBL
Timeline	5 years	5 years	5 years

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Goals	Secure sustainable funding for Maternal Child Adolescent Health (MCAH) programs	Increase the number of hospitals that are baby friendly	Provide leadership for the Food, Ag and Nutrition Network of Solano County
Actions	• Monitor the fiscal environment and promote robust communication regarding what is known about existing funding sources • Schedule regular opportunities for cross-program sharing of budget-related emerging issues and state funding updates (standing meeting agenda item) • Develop an infographic and/or timeline depicting MCAH Bureau funding cycle/changes. • Seek Out & Respond to Funding Opportunities • Form an MCAH Funding Development Team to develop infrastructure and designate responsibilities and ensure funding readiness when funding application opportunities arise. • Regularly share the value of MCAH programs • Explore opportunities to share with existing partners (e.g. other Divisions, Community Advisory Board (CAB) and subcommittees; County BOS	• Participate in Sutter's Baby Friendly Collaborative to provide technical assistance. • Support hospitals that are currently Baby Friendly to keep their designation.	• Develop a strategic plan • Facilitate project-oriented meetings to support work on strategic plan. • Complete projects
Success Measures	• MCAH Leadership Team meeting agendas/sign-in sheets and MCAH Manager meeting agendas/sign-in sheets • Completed infographic/ timeline of funding sources, expiration dates, renewal dates, etc. • An MCAH Funding Development Team is established and team will identify more specific measures. • Documentation of sharing on agendas and in meeting minutes.	• Count of hospitals with "baby friendly" designation or that following model hospital policies	• Active participation and completed projects

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Responsible Person(s)	MCAH Fiscal Analyst, Program Managers, Health Education Specialist, MCAH Leadership Team, MCAH Funding Development Team, MCAH Leadership	BF Coordinator	NEOP Supervisor
Timeline	1-3 years	5 years	5 years
Goals	Determine unmet needs and explore opportunities to promote wellness and increase services for children	Ensure MCAH programs & processes are addressing health inequities	Improve cross-bureau collaboration through participation in new systems and processes
Actions	• Conduct MCAH Title V Needs Assessment to determine priority unmet needs for children • Promote ACES awareness through participation in Solano Kids Thrive Collective Impact and screening of "Resilience" film • Explore a joint project with Health Promotion and Education around unmet needs of children and to promote ACES concept • Participate in Child Death Review Team • Increase awareness of resources for adolescent mental health	• All staff will attend the Advancing Racial Equity 101 training and then MCAH will have subsequent program team meetings to discuss the training and implications • MCAH Bureau will maintain Health Equity, Social Determinants of Health, and Structural Racism as a standing agenda item for All-Staff meetings • All new and updated MCAH program policies will be reviewed with a health equity lens (utilizing an equity tool - to be identified) • MCAH programs will continue to support Solano HEALS and promote community/public participation • MCAH programs will develop program-specific platforms to foster an environment which allows clients and families a platform to discuss barriers to accessing services	• Meet regularly with PH cross collaboration team Share resources & coordinate community outreach and engagement efforts • Establish liaison with Public Health Leadership • Identify and implement a plan to improve the health of residents in The Crest through a strategic combination of services and PSE work • Implement Racial Equity toolkit
Success Measures	• # Screenings of "Resilience" • # meetings attended of Child Death Review • Summary written of children's health needs • Share or create a resource list for adolescent mental health	• Tracking who attended training and which programs held subsequent team meetings to discuss • Reviewing team meeting agendas • Number of program policies/processes developed or updated • Reviewing Solano HEALS meeting agendas and minutes • Platforms are identified for each MCAH program	• Decreased number of projects with uncoordinated overlap; • Encourage this as a standing item on Bureau Chief/Public Health Leadership agenda

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Responsible Person(s)	MCAH Director, Program Coordinator, MCAH & AFLP program staff	MCAH Program supervisors and managers, MCAH Program Director/Coordinator and Solano HEALS liaison	David & Wendy
Timeline	1-2 years	1-3 years	Ongoing
Goals	Ensure that every mom has access to perinatal and postpartum mental health care services	ID and address the needs of children with adverse childhood experiences (ACES) in Solano County	Provide linkage to healthcare for all identified HIV patients for the purpose of preventing progression to AIDS
Actions	• Update the Solano Public Health website to include a link to perinatal mental health resources that includes APPS, information/assessment to help women to recognize symptoms of perinatal mood disorders and a resource guide for moms and providers. • Develop a perinatal mental health resource pamphlet that includes evidence based perinatal depression intervention programs that is offered to every maternal woman at initial contact and/or enrollment in MCAH programs. • The perinatal mental health resource guide and pamphlet will be culturally, age and language appropriate. • Training and provision of the resource guide will be provided to providers i.e. medical, WIC, MCAH staff etc. • Train staff in Mothers & Babies program • Implement Moving Beyond Depression program	• Attend community networking opportunities related to ACES • Conduct community education activities • Collaborate and implement Positive Behavioral Interventions and Supports (PBIS) • Regularly contact California Tobacco Control Program funded statewide projects • Implement Racial Equity toolkit	• Benchmark data with other counties • Research possible health care providers • Make sure providers are aware and are providing linkage • Random sampling/continue to track progress • Continue to build relationships with HIV care providers

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Success Measures	• Maternal women and providers have an increase awareness of perinatal mental health resources • # of "hits"/views to website • Review of data reports in MCAH database systems • Inclusion of perinatal mental health resources and information on brochure and website • Perinatal mental health brochure provided • Trained staff in maternal mental health, Mothers & Babies • *Moving Beyond Depression* launched	• ACES data for Solano County leads to ACES focus in chronic disease prevention efforts	• Evaluation of benchmark data is completed • List of health care providers is available • A resource list is available on the intranet • ARIES tracking is in place • Resource list is updated quarterly
Responsible Person(s)	Social Worker III (2), Mental Health Clinical Supervisor, Community Services Coordinator, Health Education Specialist	Wendy	HIV Surveillance Program Coordinator
Timeline	1-2 years	Ongoing	Ongoing
Goals	Contribute PH perspective to county-wide planning for a reduction of homelessness and increase affordable housing. Ensure a focus on chronic disease prevention for people who are not currently housed.	Evaluate current & new methods of outreach and messages regarding STDs to ensure they are culturally specific and that are targeted at both the individual and community level	Collaborate with community partners to provide access to testing and treatment for Sexually Transmitted Diseases (STD)
Actions	• Actively participate in 5-year plan to address homelessness • Review point in time assessment for information about where they are/live • Actively participate in the implementation of the plan • Assess the disease burden • Assist in prevention efforts geared towards the most common 3 diseases • Implementation of racial equity toolkit	• Evaluate the reach of social media platforms • Eliminate the strategies for platforms no longer meeting the target reach • Research new platforms • Update social media strategies	• Partner with Planned Parenthood to meet specific STD reduction goals • Continue partnership with school nurses • Explore opportunities for partnerships like "Pee in a Cup"
Success Measures	• Presence or participation in homeless strategy sessions and planning efforts • Report on a pilot for effectively reaching audience	• Obtain the targeted "reach" statistics from social media platforms • Culturally specific social media strategies are in place & social media strategy is updated	• Improved CalREDIE needs data • Reduction in STD rates among 14-19 y.o. • Monitor the number of condoms distributed through education programs

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Responsible Person(s)	Robin	Health Educators	Communicable Disease Investigators
Timeline	1-2 years	5 years	Ongoing
Goals	Increase awareness and utilization (uptake) of Prep and Pre Exposure Prophylaxis (PEP) by both patients and providers	Pursue communicable disease testing for the prison population	Monitor data for patterns of outbreaks and recommend preventative measures to environmental health
Actions	• Identify a method to measure the use of Prep & PEP • Track use of Prep & PEP • Educate providers • Educate public		• Review CMR for food-born disease occurrence • Investigate the occurrences • Frequencies above baseline are referred to Epis • Make recommendations to Environmental Health
Success Measures	• Increase in the number of "prep" users	• MOU or contract established between PH Lab and prisons for lab services	• Decrease in frequency of outbreaks & restaurant closures
Responsible Person(s)	Health Educators	PH Lab Director	Epidemiology Team
Timeline	5 years	3 years	Ongoing
Goals	Target interventions based on data trends with intent to minimize or prevent disease occurrence		Extend laboratory electronic connectivity with clients and partners to ensure timely electronic reporting and data management
Actions	• Determine areas to target • Continue to monitor data trends to determine where to implement interventions.		
Success Measures	• Decreased incidents of communicable disease in targeted locations • Continued testing & trending targeted geographic locations		• Number of clients and partners with access to Laboratory Information System & decrease in turnaround time for receipt of lab records
Responsible Person(s)	Epidemiology Team		PH Lab Director
Timeline	Ongoing		Ongoing

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Goals	Stay abreast of emerging technologies to detect and monitor disease that affect the community		Maximize collaboration and strengthen relationships within and between programs in the MCAH Bureau, and between MCAH and other H&SS programs
Actions			• Establish regularly scheduled meetings with representatives from H&SS programs and other County programs outside of H&SS as needed • Inform staff about meetings and who are designated liaisons/program representatives • Group will work on developing a process for orientation and collaboration between H&SS programs • Create opportunities to highlight programs (e.g. power point presentations, open house) to inform others about programs, eligibility criteria, etc. • Share applicable resources, tools, training opportunities, and strategies across programs
Success Measures	Number of new test methods implemented & decreased turnaround time for lab results when new tests indicate quicker results		• Results of who contacted and document their agreement and add document in S drive under folder titled "Strategic Plan Group 5". • Documentation of representatives assigned. • Agenda and sign-in sheets. • Notify all liaisons via e-mail. • Agenda, sign-in sheets and scheduling meeting. • Agenda and sign-in sheets
Responsible Person(s)	PH Lab Director		Public Health Leadership, MCAH Leadership, program staff
Timeline	Ongoing		1-4 years

Monitoring & Updates

Solano Public Health will monitor the trackable success measures for goals within the Strategic Plan via the Division's Performance Management System. Bureau representatives will update relevant goals on a monthly basis, and Public Health Leadership will review goal data on a quarterly basis.

When applicable, bureau representatives will annotate data with initiatives/interventions to align continuous quality improvement efforts with potential improvements/set-backs in the data.

Performance Management Tracker will be updated and available for review here:

S:\Common\PH Benchmark Data Tracker

Appendix A - Goal Alignment

Alignment of Goals with other Local and Statewide Efforts

	CHIP Strategic Priorities					Relevant Priorities from the California Department of Public Health Strategic Map - 2014-2017		Let's Get Healthy California Goals					
Solano Public Health Strategies & Goals	**Poverty**	**Homelessness**	**Lack of Affordable Housing**	**Inequitable K-12 Education & Barriers to Educational Attainment**	**Unemployment**	**Communicate & Promote the Value of Public Health**	**Strengthen Prevention & Control of Disease & Injury**	**Healthy Beginnings**	**Living Well**	**End of Life**	**Redesigning the Health System**	**Creating Healthy Communities**	**Lowering the Cost of Care**
Strategy #1: • • Embrace evidence-based, comprehensive approaches to improve and protect the health of the entire community, focusing on the whole person, across each individual's lifespan.	X	X	X	X	X	X	X	X	X	X	X	X	X
Achieve Public Health Accreditation	X	X	X	X	X	X	X				X	X	
Continuous Quality Improvement (CQI) activities are integrated into Public Health programs		X		X									
Create and implement an assessment tool which assesses and educates clients on aging in place and end of life decisions		X					X			X		X	X
Increase exposure to the ReThink Your Drink (RYD) campaign about risks associated with sugar sweetened beverages and choosing healthy beverage options				X		X	X	X	X			X	X
Increase the purchase of fruits and vegetables by WIC participants.	X					X	X	X	X			X	X

Secure sustainable funding for MCAH programs	X			X			X	X	X			X	
Determine unmet needs and explore opportunities to promote wellness and increase services for children				X			X	X				X	
Ensure that every mom has access to perinatal and postpartum mental health care services					X			X	X				
Contribute PH perspective to county-wide planning for a reduction of homelessness and increase affordable housing. Ensure a focus on chronic disease prevention for people who are not currently housed.	X	X	X		X		X		X			X	
Increase awareness and utilization (uptake) of Prep and Pre Exposure Prophylaxis (PEP) by both patients and providers							X		X			X	
Target interventions based on data trends with intent to minimize or prevent disease occurrence	X				X		X					X	
Stay abreast of emerging technologies to detect and monitor disease that affect the community					X		X						X
Strategy #2: • • Identify and address the root causes of health inequities, including addressing the social determinants of health and work to undo structural racism, wherever it exists	X	X	X	X	X	X		X	X	X	X	X	X
Implement Racial Equity toolkit in Public Health	X	X		X	X		X				X	X	
Implement Advancing Racial Equity 101 training & LGBTQ 101 trainings				X	X	X					X	X	
Establish indicators to paint a picture of health inequities (eg county snapshots)	X	X	X	X	X		X				X	X	
Identify barriers to accessing Behavioral Health Services for Seniors	X						X		X	X			X
Increase the number of exclusive breastfeeding initiation rates for African American women								X				X	
Increase the number of hospitals that are baby friendly								X				X	

Ensure MCAH programs & processes are addressing health inequities				X				X	X		X		
ID and address the needs of children with adverse childhood experiences (ACES) in Solano County				X		X	X	X				X	
Evaluate current & new methods of outreach and messages regarding STDs to ensure they are culturally specific and that are targeted at both the individual and community level	X				X		X		X			X	X
Pursue communicable disease testing for the prison population							X					X	X
Strategy #3: • • Actively communicate and collaborate with other entities within the County working toward a similar vision, Healthy People – Heathy Community	X	X	X	X	X	X	X	X	X	X		X	X
Increase utilization of PH/Solano Care websites	X			X	X	X					X	X	
Build improved relationships with Board & Care operators within the County		X	X								X		X
Develop an education campaign to increase awareness of services and role of Adult Protective Services (APS)						X	X					X	
Educate IHSS providers to work with their clients to prevent falls						X	X					X	X
Provide leadership for the Breastfeeding Coalition of Solano County				X				X				X	
Provide leadership for the Food, Ag and Nutrition Network of Solano County	X					X			X			X	
Improve cross-bureau collaboration through participation in new systems and processes	X	X	X	X	X		X				X	X	X
Provide linkage to healthcare for all identified HIV patients for the purpose of preventing progression to AIDS		X					X		X			X	X
Collaborate with community partners to provide access to testing and treatment for Sexually Transmitted Diseases (STD)	X	X			X		X					X	X

Monitor data for patterns of outbreaks and recommend preventative measure to environmental health		X	X									X	
Extend laboratory electronic connectivity with clients and partners to ensure timely electronic reporting and data management						X	X				X		
Maximize collaboration and strengthen relationships within and between programs in the MCAH Bureau, and between MCAH and other H&SS programs				X							X		X