

Strategic Plan

2013-2016

The Division of Public Health
Nebraska Department of Health and Human Services

April 30, 2013



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A special thank you to everyone for their assistance. A list of work group members is located in Appendix A. A list of the Senior Management Team members is located in Appendix B.

Message from the Director

To the dedicated people who worked diligently to collect, review and present information, formulate plans to reach goals and objectives and who will be doing much work to implement the plan, I thank you.

The Division of Public Health's Strategic Plan for 2013–2016 provides a roadmap to continue to help Nebraskans live healthier lives now and into the future. The plan, originally undertaken by my predecessor, Joann Schaefer, M.D., outlines a course of action that will help make our vision a reality by identifying our highest priority initiatives. The Division's vision statement provides the motivation for what we work and strive for every day: A Healthy and Safe Nebraska – Everyone, Everywhere, Every Day.

We have made great strides in improving the health of Nebraskans, but there's more work to do. To remain part of an effective public health system we need to continue to develop a culture of quality and performance improvement, continue the effective programs that are currently in place, and focus work on our priority strategies.

While this strategic plan does not attempt to outline all the strategies that will be implemented over the next few years, it does reflect our priorities in focusing our work. In carrying out the strategies in this plan, the Division remains committed to working with our partners and communities across the state to achieve our mission of helping Nebraskans live healthier lives.

With this plan, we build on our successes and look forward to the future.

Joseph M. Acierno, M.D., J.D.
Chief Medical Officer
Director, Division of Public Health
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Table of Contents

Background.....	5
The Strategic Planning Process.....	5
Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis	8
Strategic Priorities.....	8
Common Themes	9
Priority: Building and Sustaining a Culture of Wellness	11
Priority: Reducing Health Disparities	16
Priority: Being the Trusted Source of State Public Health Data	22
Priority: Creating a Communications Plan	28
The Implementation and Performance Monitoring Process.....	30
Link to the Nebraska Public Health Improvement Plan.....	30
Appendix A. Strategic Priority Work Group Members	31
Appendix B. Management Team Members	33
Appendix C. Results of Strengths, Weaknesses, Opportunities, and Threats Analysis.....	34

This strategic plan was developed by the Division of Public Health in the Nebraska Department of Health and Human Services. This plan is based on a deliberate decision-making process and provides a road map for the direction the Division is going in the next three to five years. The plan is designed to identify what the Division plans to achieve, how it will achieve it, and how it will monitor those achievements. It also serves as a template for all employees in the Division as well as stakeholders to make decisions that move the organization forward. It should be emphasized that many programs within the Division have developed program-specific strategic plans that complement and support the Division's plan.

Background

The strategic plan has been developed as part of a broader planning process. In October 2011, a comprehensive state health assessment process began. This assessment, which involved both internal and external stakeholders, was designed to identify the key health problems and resources that are available. This assessment was based on the Mobilizing for Action through Planning and Partnerships (MAPP) model. The MAPP model consists of four major assessments, including a health status assessment, a forces of change (trends, factors, and events) assessment, a statewide themes and strengths assessment, and a state public health system assessment.¹ The results of the assessment served as the foundation for developing the priorities in the Nebraska Public Health Improvement Plan (NPHIP) and the Division's strategic plan. The NPHIP was developed by a large group of both internal and external stakeholders called the Nebraska Public Health Improvement Plan Advisory Coalition. In February 2013, the Coalition approved the Nebraska Public Health Improvement Plan which includes objectives and strategies to achieve the following major strategic priorities:

- Reduce heart disease, stroke, and cancer morbidity, mortality, and associated risk factors
- Expand health promotion capacity to deliver public health prevention programs and policies across the lifespan
- Improve the integration of public health, behavioral health (mental health and substance abuse), environmental health, and primary health care services
- Expand capacity to collect, analyze, and report health data

The priorities in the Division's strategic plan are very consistent with the results of the needs assessment and the priorities from the Nebraska Public Health Improvement Plan.

The Strategic Planning Process

On August 30, 2012, members of the management team led by Joann Schaefer, MD, then Director of the Division of Public Health, held a strategic planning retreat (see Appendix B for a complete list of the participants). At this retreat, the mission, vision, and values for the Division were discussed. The participants at the meeting unanimously agreed on the following mission and vision:

¹ A more detailed description of these assessments and the results from them can be found at http://dhhs.ne.gov/publichealth/Pages/puh_oph.aspx

Mission: Helping People Live Healthier Lives

Vision: A Healthy and Safe Nebraska – Everyone, Everywhere, Every Day

They also agreed on the following slogan:

Nebraska – The Healthy Life

A potential list of values was also discussed. These values included:

- **Accountability:** Committing to work together for the greater good through personal responsibility (for the people of Nebraska, the legislature, the process, the outcomes, and each other).
- **Adaptability:** Innovating and thinking outside the traditional solutions.
- **Sustainability:** Assuring commitment to the process.
- **Inclusivity:** Encouraging a collaborative spirit by engaging a broader range of stakeholders.
- **Integrity:** Assuring honesty in our dealings with others. We can be counted on to be reliable, responsible, and consistent.
- **Stewardship:** Respecting the valuable resources placed in our trust. The public good is our watchword; caring and cared-for employees are our hallmark. We acknowledge and honor diversity among ourselves and those we serve.
- **Effectiveness:** Setting our goals based on documented need. We measure our performance in terms of quality, timeliness, and cost. We are innovative and do not accept mediocrity.
- **Consistency:** Holding always to the same operating principles or practices, allowing our customers and stakeholders a certain amount of predictability and stability.
- **Commitment:** Investing, personally and organizationally, in our work to achieve quality outcomes.
- **Diligence:** Persevering and caring in our work to incorporate a sense of urgency and follow through.
- **Quality:** Striving to achieve excellence by setting high standards, being prepared, using accurate data, being equitable, and using evidence-based strategies.
- **Transparency:** Operating in a manner that is easily understood with openness, a willingness to modify or correct, and inclusiveness.
- **Innovation:** Openness to new methods, ideas, and partnerships. Ours is a learning organization in which we are able to celebrate our successes and learn from mistakes.
- **Anticipation:** Taking an active role by foreseeing potential problems or solutions and preventing or performing them in advance.

In order to narrow the list and obtain feedback from Division staff, a survey containing this list was mailed to all of the employees. A total of 206 employees responded to the survey, which asked the participants to respond to the following question: “How well do these values represent the work and culture of the Division of Public Health?” The scale of the responses was 1—not at all to 5—extremely well. The results of the survey are presented in Figures 1 and 2. These figures indicate that the top six values are Integrity (3.85), Commitment (3.75), Quality (3.74), Stewardship (3.67), Accountability (3.65), and Diligence (3.62).

Figure 1. Results of the Nebraska Division of Public Health employee values survey.

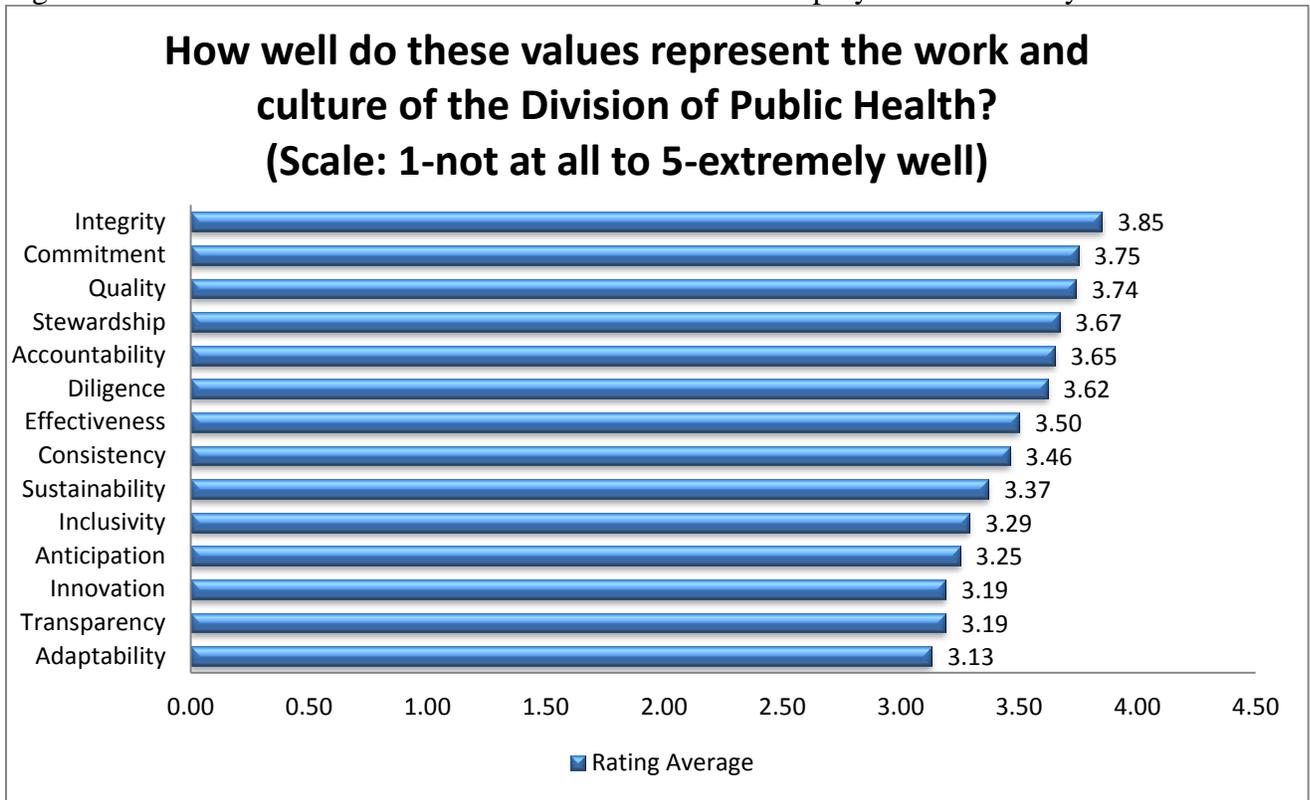
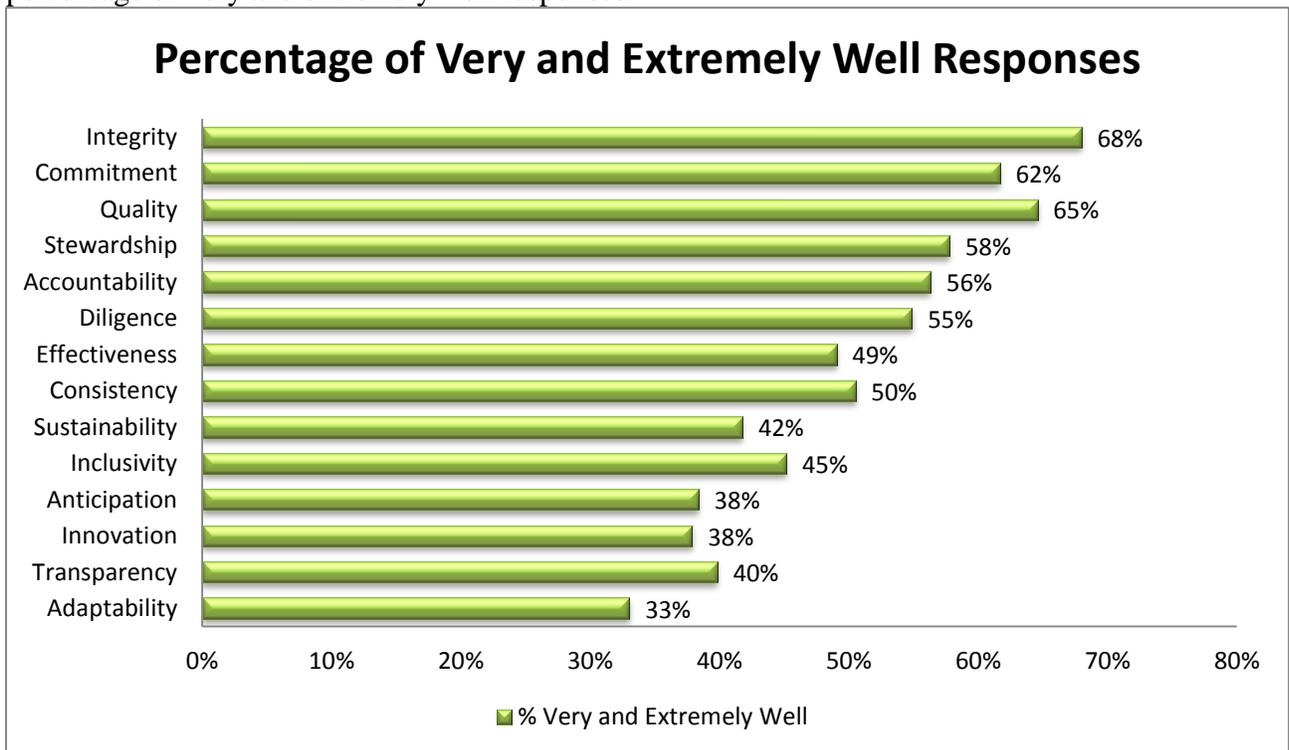


Figure 2. Results of the Nebraska Division of Public Health employee values survey by the percentage of very and extremely well responses.



Based on the results of the survey and discussion at the Senior Management Team meeting on February 12, 2013, the following values were selected: Integrity, Commitment, Quality, and Stewardship. These values are defined as follows:

Integrity—assuring honesty in our dealings with others. We can be counted on to be reliable, responsible, and consistent.

Commitment— investing, personally and organizationally, in our work to achieve quality outcomes.

Quality— striving to achieve excellence by setting high standards, being prepared, using accurate data, being equitable, and using evidence-based strategies. We continuously improve and measure our performance. We are effective and innovative, and do not accept mediocrity.

Stewardship—respecting the valuable resources placed in our trust. The public good is our goal; caring and cared-for employees are our promise. We acknowledge and honor diversity among ourselves and those we serve.

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

At the August management team retreat, three small groups were formed to discuss the internal strengths and weaknesses of the Division and the external threats and opportunities. The participants identified strengths and weaknesses under several common categories, including: resources, collaboration, leadership, and public perception.

Several opportunities were also identified under performance improvement, enhanced partnerships, sharing information more effectively with the public and other partners, better documentation of our successes, and improving the skills of the workforce. Potential threats included funding uncertainties, workforce shortages, security of data, structural issues (i.e., small division within DHHS), and public perception about the value of government programs.

A complete list of the strengths, weaknesses, opportunities, and threats are listed in Appendix C. These factors were considered in the development of the objectives and strategies to achieve the strategic priorities.

Strategic Priorities

The information from the SWOT analysis, the state health assessment, and the priorities contained in the Nebraska Public Health Improvement Plan reinforced the current priorities of the Director of the Division of Public Health. These priorities are:

- Creating a culture of wellness
- Becoming a trusted source of state health data
- Addressing health disparities
- Creating a communications plan

In order to move forward on these strategic priority areas, four internal work groups were formed in the fall of 2012 (see Appendix A for a list of work group members). The purpose of the work groups was to further define the priority and the scope of the issue. Once these issues were considered, they began to develop a work plan that included measurable objectives, key strategies and activities, the lead role, a timeline, key partners, and expected outcomes. Each work group had a lead staff and representatives from several areas within the Division. Facilitation and draft work plans were developed by staff from the Office of Community and Rural Health. The work groups met at least three times and completed their work in early February 2013. All of the work plans are included below.

The final plan was approved in April 2013. Once it was approved, it was made available to Division employees and meetings were scheduled to review the strategies and activities contained in the work plans.

Common Themes

During the discussions of the work groups, several common themes emerged. These common themes focused on a variety of activities, including:

- Focusing on internal and external collaborative communication
- Building additional internal and external collaborative partnerships
- Enhancing workforce skills and core competencies
- Identifying gaps in core competencies and developing training programs to reduce them
- Expanding data collection efforts
- Creating a data dashboard
- Expanding and modifying information on the DHHS website

Every work group recommended activities to improve internal and external communication and to forge more effective collaborative partnerships within the Division and with outside partners. In addition, all of the work groups suggested that new training programs were needed to enhance the understanding of key issues (e.g., reducing health disparities) or to reduce the gaps in core public health competencies.

In an era where financial and other resources are likely to become more restrictive, it is essential to make more effective use of current resources. More efficient and effective resource allocation can only occur through more collaborative communication, creating strong partnerships, enhancing the knowledge and skills of the current and future workforce, implementing evidence-based strategies, and evaluating promising practices.

Table 1. Common Themes among the Strategic Priorities

Common Themes	Priority Areas			
	Culture of Wellness	Trusted Source of Data	Reducing Health Disparities	Communications Plan
Improve internal collaborative communication	X	X	X	X
Improve external collaborative communication	X	X	X	X
Build effective internal partnerships	X	X	X	X
Build effective external partnerships	X	X	X	
Enhance workforce skills and core competencies	X	X		
Identify gaps in core competencies	X	X		
Develop training programs to reduce gaps	X	X	X	X
Build inventory of evidence-based interventions	X	X	X	
Identify data gaps and expand data collection efforts		X	X	
Create a dashboard		X	X	
Expand the DHHS website	X		X	X

Priority: Building and Sustaining a Culture of Wellness

Definition

The Division of Public Health will promote and support a healthy and safe environment in the home, school, workplace, and community for every Nebraskan by enhancing 1) coordination of our health promotion and prevention efforts and 2) the use of evidence-based and best practice approaches including policy, systems, and environmental change, leading to wellness as a way of life and community norm.

Background

The Division of Public Health includes many Units that are all working to build and sustain a culture of wellness. This plan helps to outline the activities that will expand this priority across the Division and state.

One of the main keys to success in creating a culture of wellness and preventing the unhealthy behaviors that are associated with heart disease, cancer, and the other leading causes of death is the ability of the public health system and partners to deliver effective health promotion programs and policies across the lifespan. This ability involves helping individuals, groups, and communities understand the influences of health, become motivated to strive for optimal health, and change lifestyle, policies, and systems to move toward a state of optimal health.^{2,3} Because the factors that influence health behaviors are complex and often interrelated, building a culture of wellness must focus on building strong organizational capacity, improving the skills and competencies of the public health workforce, reallocating and targeting resources on evidence-based interventions, enhancing leadership skills, and forming new collaborative partnerships.

Major Strategy Areas

- Internal Collaboration
- Skill Building
- External Collaboration including other DHHS Divisions

² O'Donnell M.P. (2009). Definition of health promotion 2.0: embracing passion, enhancing motivation, recognizing dynamic balance, and creating opportunities. *American Journal of Health Promotion*, 24 (1): iv.

³ Association of Maternal and Child Health Programs. (July 2012). *Forging a comprehensive initiative to improve birth outcomes and reduce infant mortality: Policy and program options for state planning*. Washington, DC.

Internal Collaboration (Priority for implementation, 11/2013)

Objective 1: By December 31, 2016, create a culture of wellness by improving information and resource sharing throughout the Division.

Background: Staff in the Division of Public Health are frequently focused on achieving specific outcomes included in categorical federal grant programs. Recently, there has been some success in coordination and collaboration across programs, but additional synergy can be generated with a greater focus on creating a culture of wellness.				
Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Establish an expectation that Units/Programs attend each other’s staff meetings to share information about prevention and wellness initiatives and discuss collaboration efforts	Director, Deputy Directors, Unit Administrators	April 2013	Program Managers	Documentation of staff meetings attended and outcomes
Using the Division’s grant “Intent to Apply” form, indicate that collaboration has occurred with other Units/Programs regarding wellness projects when applicable	Judy Martin	May 2013		Updated Division grant “Intent to Apply” form
Provide trainings to staff on collaboration techniques to improve resource coordination and avoid duplication	Colleen Svoboda, Kathy Goddard, Jamie Hahn	Annually through December 2016	Program staff from all Units	Trainings documented; attendee list
Organize informational meetings for staff to learn about a variety of topics that promote a culture of wellness and program planning	Julie Reno, Elizabeth Esseks	December 2013		Documentation of meetings; at least 4 meetings (commitment to participate)
Modify the DHHS web search process to enhance access to desired information (keyword searches)	Liz Green, Kari Majors, Jason Kerkman, Andrea Riley, Diane Lowe	December 2013	Communications and Legislative Services	Updated website
Establish a set of evidence-based strategies that should be used in developing RFPs/RFAs issued to community organizations	Judy Martin, Health Promotion Unit Work Group to be formed	July 2013	Program staff from all Units	List of evidence-based strategies; State plans; RFPs released; Update annually and post on DHHS and program websites
Share local health department assessment results (MAPP) among Division staff to collaborate and consolidate funding to minimize the number of requests for applications (RFAs) issued to community organizations	Colleen Svoboda, Greg Moser Office of Community and Rural Health	July 2013		Assessment results shared in a summary report; Presentations to staff

Skill Building (Priority for implementation, 11/2013)

Objective 2: By December 31, 2016, identify and encourage program practices, effective evaluation methods, and successful grant writing to enhance our capacity to promote a culture of wellness.

<p>Background: In any profession, there is a need to offer and provide continuing education opportunities. In order to continue to build resources to create a culture of wellness, Division staff members need to continue to build their skills especially in evaluation methods and grant writing. The activities outlined in this work plan will help the Division set standard competencies for health promotion staff, improve skills in evaluation and grant writing, and identify training needs.</p>				
Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
<p>Determine core competencies for all staff involved in health promotion related activities</p> <ul style="list-style-type: none"> Develop survey tool to assess and identify training needs including awareness of electronic health records and meaningful use, evaluation, grant writing, and evidence-based strategies Distribute survey Analyze survey results to identify gaps in competencies and recommend training needs Present recommendations to Unit Administrators, Chief Administrators, and Division Director Develop and implement a training program based on the approved recommendations 	<p>Paula Eureka (lead)</p> <p>Jeff Soukup, Cathy Dillon, Diane Lowe, Jennifer Severe-Oforah, Elizabeth Esseks</p> <p>(recruit others as necessary)</p>	<p>May 2013</p> <p>July 2013</p> <p>September 2013 November 2013</p> <p>December 2013</p> <p>December 2014</p>		<ul style="list-style-type: none"> Group formed and survey tool developed or selected Survey completed Summary of results and recommendations Approved recommendations Training plan
<p>Develop a plan to encourage Division staff to participate in healthy workplace wellness/prevention practices (e.g., walking breaks, CPR instruction, and healthy food policy)</p>	<p>Brian Coyle, Jason Kerkman</p>	<p>December 2013</p>	<p>DAS/Wellness Options; Program staff from each Unit</p>	<p>Wellness practices documented by Unit</p>

Collaboration with other DHHS Divisions and External Partners

Objective 3: By December 31, 2016, improve Division of Public Health collaboration with and between external partners and stakeholders to facilitate the promotion of a culture of wellness. (Progress can be measured by the Wilder Collaboration Survey or a similar tool)

Background: Because of grant funding, staff and external partners are often focused on achieving specific outcomes for only one or two risk factors. However, a broader, more comprehensive approach is needed to create and sustain a culture of wellness that is based on a broad array of evidence-based strategies.				
Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Create a work group of internal staff and external stakeholders to identify environmental health activities that could be completed at the local level and prepare a report that includes recommendations and the potential resources needed	Sue Semerena, Dave Palm	December 2013	LHDs; Other DHHS programs	Report completed with draft of recommendations
Work with internal staff and external stakeholders to identify programs and activities to promote a culture of wellness <ul style="list-style-type: none"> • Begin with Licensure Unit <ul style="list-style-type: none"> ○ Collaborate on wellness presentations to provider associations (e.g., long term care providers) ○ Research evidence-based strategies similar to NAP SACC⁴ program in child care settings for replication in nursing homes and assisted living facilities 	Jamie Hahn, Peg Ogea-Ginsburg, Connie Wagner, Holly Dingman	December 2013	Other DPH programs	Report of identified programs and activities
Provide information to key internal and external partners about resources available and encourage more consistent messages <ul style="list-style-type: none"> • Create and share specific policies, guidelines, messages and activities that stakeholders could implement to promote a culture of wellness • Create a summary document that describes existing Division programs and activities related to a culture of wellness (e.g., worksites, schools, community, and health care). [Note approaches to reduce health disparities as applicable] • Create and disseminate annual reports that summarize successful “culture of wellness” efforts, including the four cornerstones of change (i.e., worksites, schools, community, and health care) 	Judy Martin facilitator Barbara Pearson, Monica Pribil, Jillian Savage, Elizabeth Esseks, Carol Tucker, Tracey Bonneau, Greg Moser, Josie Rodriguez	December 2013	DPH program staff; Communications and Legislative Services	<ul style="list-style-type: none"> • Completed materials; dissemination • Completed inventory • Talking points; news releases

⁴ Nutrition and Physical Activity Self-Assessment for Child Care

<p>Form a work group with representatives from DPH and the Division of Children and Family Services to identify opportunities to work together to promote a culture of wellness</p> <ul style="list-style-type: none"> • Present recommendations to Unit Administrators, Chief Administrators, and Division Directors (Public Health and Children and Family Services) to assist programs in the development of policies, guidelines, recommendations, and activities to promote a culture of wellness • Develop and implement a work plan to complete identified opportunities 	<p>Representative from Children and Family Services, Julie Reno, Shirley Deethardt, Kristin Yeoman</p>	<p>May 2013</p> <p>December 2013</p> <p>2014</p>		<ul style="list-style-type: none"> • Group formed and opportunities identified • Summary of approved recommendations • Work plan
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Priority: Reducing Health Disparities

Definition

The Division of Public Health will reduce health disparities and strive to improve the health of all Nebraskans by focusing on outcomes for the following demographic factors (or groups):

- Race and ethnicity
- Gender
- Disability status or special health care needs
- Geographic location (e.g., rural/urban)

The Division will do this by enhancing 1) our capacity for data collection and analysis, 2) our knowledge and skills to work with these demographic groups, and 3) the coordination of programs and activities, leading to addressing health disparities as a way of doing business and Division-wide norm.

Background

The Division of Public Health has several programs that focus on addressing health disparities some of which include: the Office of Health Disparities and Health Equity, the Nebraska Planning Council on Development Disabilities, Lifespan Health Services, and the Office of Community and Rural Health. While these programs have a specific focus on reducing health disparities, all of the programs within the Division are concerned with the elimination of health disparities. This strategic plan outlines how the entire Division of Public Health can address these issues.

Health equity can be defined as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.”⁵ Reducing health disparities can only be achieved if public health professionals use a comprehensive approach that includes identifying and addressing the root causes of health inequity. The National Association of County and City Health Officials (NACCHO) has outlined “Guidelines for Achieving Health Equity in Public Health Practice” based on the essential services of public health.⁶ Many of the strategies included in the work plan align with these guidelines. For example, NACCHO recommends enhancing a health department’s ability to obtain and maintain data that reveal inequities in the distribution of disease, and supporting, implementing, and evaluating strategies that tackle the root causes of health inequities in partnership with public and private organizations.

Major Strategy Areas

- Data
- Health Disparities Broker

⁵ U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action Draft as of February 17, 2010. Chapter 1: Introduction.

⁶ National Association of County and City Health Officials. (April 2009). *Guidelines for Achieving Health Equity in Public Health Practice*. Retrieved on February 13, 2013 from: <http://www.naccho.org/topics/justice/>.

Data (Priority for implementation, 11/2013)

Improve data collection and consistency on demographic factors (e.g., race/ethnicity, gender, age, disability status, and geographic location) throughout the division to use a data-informed quality improvement approach to address health disparities.

Objective 1: By December 31, 2016, increase the inclusion of standard demographic factors (e.g., race/ethnicity, disability status, geographic location) within primary data collection systems within the Division.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Establish a work group to develop Division-wide demographic definitions related to health disparities and gain buy-in	Co-leaders: Jianping Daniels and Debbi Barnes-Josiah Work Group: Administrator, Office of Health Statistics; Jeff Armitage; Anthony Zhang	June 2013	Other DHHS Divisions	Written work product; disseminate across Division
Complete an inventory of data collected in the Division and other organizations <ul style="list-style-type: none"> Update existing inventory with expanded fields including demographic factors (include definitions currently used for demographics; state/federal) Connect with other potential sources of data (e.g., behavioral health regions) 	Administrator of the Office of Health Statistics Work Group led by Jianping and Debbi	June 2013	Joint Public Health Data Center	Updated inventory of databases/sets
Identify gaps/deficiencies in the collection of health disparity data and create a plan for addressing gaps	Work group led by Jianping and Debbi	December 2013		Plan for addressing gaps
Implement a plan to address gaps		December 2014		

Objective 2: By December 31, 2014, establish health disparities performance measures based on the leading causes of death and morbidity for racial and ethnic minorities and high risk geographic location.

Key Strategies & Activities	Lead Role	Timeline	Partners	Expected Outcomes
Establish work group in collaboration with the data strategic plan priority group and review existing data and sample performance measures (e.g., Healthy People 2020)	Leader: Jeff Armitage	May 2013		Summary of existing performance measures and data calculations
Set performance measures	Work Group: Anthony Zhang, Debbi Barnes-Josiah, Melissa Leypoldt, Blanca Ramirez-Salazar, Tom Rauner, Jihyun Ma	July 2013		List of performance measures and data
Display measures on Division dashboard (i.e., DHHS website)		December 2013		Dashboard display
Develop and implement a plan to monitor and update annually		June 2014		Create talking points
		December 2014		

Health Disparities Liaison (Priority for implementation, 11/2013)

Goal: Improve training, communication, and coordination to increase and promote access, awareness, understanding, and practices that address health disparities and health equity and support and strengthen our workforce.

Objective 3: By December 31, 2013, develop guidelines that encourage and support a greater focus on health disparities (i.e., inequalities in health outcomes) in program activities throughout the Division.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Develop and distribute guidelines for addressing health disparities to be used by staff when writing grants, issuing RFPs/RFAs, and planning program activities	Co-leaders: Josie Rodriguez and Mary Gordon Work Group: Diane Lowe, Peg Ogea-Ginsburg, Greg Moser, Rayma Delaney, and Kathy Karsting	July 30, 2013		Guidelines written and approved; disseminated
Modify the DPH “Intent to Apply” grant form to indicate that the health disparities guidelines were used when preparing grant applications or did not apply	Co-leaders: Sue Medinger and Judy Martin Deputy Directors	August 30, 2013		Form updated
Work with Unit Administrators to integrate the health disparities guidelines into program planning and activities	Leader: Sue Medinger Work Group: Mary Gordon and Josie Rodriguez	Ongoing after July 30, 2013		
Develop a resource directory of evidence-based/best-practices to address health disparities	Co-leaders: Mary Gordon and Josie Rodriguez Work Group: Diane Lowe, Greg Moser, Jennifer Severe-Oforah, Kathy Goddard	December 31, 2013; updated annually		Directory developed and distributed

Objective 4: By December 31, 2013, provide 10 trainings and/or presentations to enhance staff and partners' understanding of health disparities and how to work with diverse populations.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Market and promote trainings available on health disparities to Division staff and partners	Josie Rodriguez and Mary Gordon	May 2013		Promotion documented
Offer trainings that include the following topics: <ul style="list-style-type: none"> • Health Disparities • Cultural Intelligence • Social Determinants of Health • Co-presentations on health disparities mortality & morbidity (obesity, diabetes, cancer, cardiovascular disease, infant mortality, etc.) • Adverse Childhood Experiences (ACEs) 	Work Group: Bruce Rowe, Tina Goodwin, Diane Lowe, Kristin Yeoman, Charlene Gondring Other experts as required	December 2013		Trainings and activities provided; tracking participants by program; pre/posttest; evaluation
Work with Unit Administrators to encourage staff to attend training on work time	Sue Medinger	December 2013 and ongoing		
Work with Division staff to develop supplemental materials to the cultural intelligence training (e.g., data challenges, developmental disabilities, geographic location, and other topics)	Josie Rodriguez and Diane Lowe Mary Gordon and others as appropriate	December 2013		Supplemental materials developed and implemented

Objective 5: By December 31, 2013, increase communication and information sharing opportunities among Division staff regarding health disparities and health equity.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
<p>Improve linkages on our website for health disparities information</p> <ul style="list-style-type: none"> • Keyword searches • Insert links to health disparities information from other Division pages 	Liz Green, Kari Majors, Jason Kerkman, Andrea Riley, Diane Lowe	September 2013	Communications and Legislative Services	
Senior management encourages administrators to utilize staff meetings to share information regarding opportunities to coordinate and collaborate regarding health disparities and health equity	Sue Medinger will work with Deputy Directors	Ongoing		Meeting minutes
Identify opportunities to expand communication and coordination on health disparities to all appropriate Divisions in DHHS	Mary Gordon and Josie Rodriguez	September 2013		Summary report
Work with the DHHS Communications & Legislative Services to publicize health disparities reports	Josie Rodriguez and Anthony Zhang	Ongoing		

Priority: Being the Trusted Source of State Public Health Data

Definition

Being the trusted source of public health data means that the Division of Public is the first place that people look for Nebraska health data. The data are high quality (e.g., accurate and as complete as possible), easy to access (e.g., the Division's website), reported in a timely and useful manner, and integrated into public health practice (e.g., by Division staff and external practitioners).

Background

Although the Public Health Support Unit is responsible for health data collection and distribution, epidemiologists and data analysts are spread throughout the Division's seven units to help collect, analyze, and report public health data. In addition, program staff are responsible for using the data to identify important health challenges and develop evidence-based intervention strategies to meet these challenges.

A 1988 report by the Institute of Medicine (IOM) on *The Future of Public Health* identified assessment as one of the three core functions of public health. This report defined assessment as the regular and systematic collection, assembly, analysis, and dissemination of health information.⁷ Assessment was considered a core function of public health agencies because measuring the health of the population is a key element in improving health outcomes. The collection, analysis, and dissemination of data allow public health practitioners to identify patterns and trends in public health events (diseases, conditions, or injuries) and health determinants (behavioral and biological risk factors, exposures, and medical care).

Effective assessment activities have been greatly expanded in the past few years. For example, new data have been collected through various surveys (e.g., Behavioral Risk Factor Surveillance System surveys by local health department region) and the development of new information technology (e.g., electronic medical records). As a result of new federal meaningful use requirements, health care providers are sharing information electronically through an immunization registry and submitting more timely laboratory reports for infectious diseases. The development of electronic medical records in physician clinics will provide a new source of data that will allow public health practitioners to examine the risk factors associated with the leading causes of death. These data can then be used by public health officials to target population groups and design programs and policies that should be more effective in addressing health risks.

Major Strategy Areas

- Meaningful Use
- Statutes
- Resource Development
- Collection, Use, and Sharing of Data

⁷ National Research Council (1988). *The Future of Public Health*. Washington, DC: The National Academies Press.

Meaningful Use (Priority for implementation, 11/2013)

Goal: Build a high quality and accessible public health data system that produces useful and timely data.

Objective 1: By December 2016, the Division of Public Health will obtain and utilize electronic health record data collected through meaningful use standards with consideration to privacy concerns.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Maintain an internal work team to prepare the Division for collecting and managing public health data required for meaningful use (i.e., immunization data, laboratory data, syndromic surveillance data, and cancer registry data)	Michelle Hood	Ongoing		Work team meets at least four times per year
Develop and update a work plan that identifies goals and objectives of the meaningful use data process (e.g., obtaining, securing, analyzing, and sharing data)	Michelle Hood and Work Group	June 2013		Work plan developed and updated
Analyze all relevant meaningful use data and communicate findings on immunizations, laboratory results, syndromic surveillance data, and cancer registry data		December 2013		Findings communicated (e.g., presentations)
Provide educational opportunities for Division staff to learn about meaningful use and electronic health records at least two times per year		March 2014		Two educational sessions completed
Provide educational opportunities for data and program staff so they can use the data to answer program specific questions		March 2014		Two educational sessions completed
Use de-identified data to identify best public health practices		December 2015		Three best practices identified

Public Health Data Statutes (Priority for implementation, 11/2013)

Objective 2: By December 2016, the Division of Public Health will review and suggest improvements (through the DHHS statute review process) to statutes related to public health data.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Create a work group to modify the draft Public Health Information Act to streamline and improve consistency in data collection efforts, data use, and dissemination activities	Co-Leaders: Michelle Hood and Sara Morgan Work Group: Dave Palm, Bryan Rettig, Darrell Klein, Roger Brink, Julie Luedtke	May 2013		Work group created
Review best practices from other states that have changed their data statutes		August 2013		Best practices reviewed
Clarify which Division data need to be included in this statute		December 2013		Data sources identified
Review other statutes for needed improvements (e.g., patient identifiers to link data)		July 2015		Statutes that need to be changed are identified
Submit changes through the appropriate process at DHHS		September 2015		Legislative proposal submitted

Resource Development (Priority for implementation, 11/2013)

Objective 3: By December 2016, enhance the competencies and collaborative efforts of the Division of Public Health data workforce.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Identify public health data competencies for epidemiology, biostatistics, and data informatics staff	Leader: Ming Qu Work Group: Jeff Armitage, Bryan Buss, Jianping Daniels, Mark Miller, Jennifer Severe-Oforah, Sara Morgan, Bryan Rettig, Anthony Zhang, Tom Safranek	September 2013	LHDs, Great Plains Public Health Training Center (Brandon Grimm)	Competencies identified
Develop a data workforce training plan to achieve these competencies		March 2014		Training plan developed
Revise epidemiology and other data workforce job descriptions (state personnel) to reflect these competencies		December 2015		Job descriptions revised
Collaborate with educational institutions to assure that we have job-ready graduates through internships and other opportunities		July 2014		Collaborative activities completed
Develop a plan to recruit and retain a competent workforce (e.g., provide practicum opportunities for students, link graduates to job opportunities at DPH, develop a mentoring program for new employees)		March 2014		Recruitment and retention plan completed
Provide opportunities for Division staff to work with students and offer practical experience		March 2014		Opportunities identified and created
Create a formal internal data work group to create a venue for sharing ideas and improving communication among data staff <ul style="list-style-type: none"> This group could eventually include local health department and other data staff across the state 		August 2013		Internal work group formed

Collection, Use, and Sharing of Data (Priority for implementation, 11/2013)

Objective 4: By December 2016, improve the collection of high quality (i.e., accurate and relevant) public health data.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Establish a work group to identify and promote options for collecting and making more comprehensive data available for racial/ethnic minority populations, including Tribes	Leader: Anthony Zhang	December 2013		Work group established and outcomes identified
Begin to provide education and training to external data providers (e.g., hospitals and clinics) on the importance of collecting and using racial/ethnic data identifiers for public health practice	Work Group:	December 2014		Education and training sessions completed
Conduct an evaluation of each surveillance system (i.e., ongoing systematic collection of data) to enhance data quality and efficiency (e.g., BRFSS, cancer registry)	Leader: Jeff Armitage	September 2016		Evaluations of all major data systems completed
Ensure that quality improvement and quality assurance processes are incorporated into the operation of all data collection systems, surveys, and smaller data projects	Work Group:	December 2015		Quality improvement and quality assurance processes developed

Objective 5: By December 2016, increase the analysis and timely reporting of quality public health data.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Continue to expand the reporting of health data through a state data dashboard including data showing the results of regulatory oversight	Jeff Armitage	September 2013		Dashboard created
Continue to work with local health departments to ensure consistency in reporting and expand the reporting and use of local health department level data	Jeff Armitage	Ongoing		Consistency and expansion of reporting demonstrated
Expand and reorganize data available on the DHHS website	Ming Qu	March 2014		Website reorganized
Prepare a template that programs can use to present data in fact sheets and establish guidelines and a technical review process prior to release	Administrator, Office of Health Statistics	June 2014		Template and guidelines established
Establish a standardized process for the DPH to respond to internal and external data requests that includes consideration of Division resources		December 2013		Process developed

Objective 6: By December 2016, improve the use of health data by Division staff, local health department staff, academic researchers, and other partners.

Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Update annually the list and description of the core public health datasets in Nebraska and post on the DHHS website	Ming Qu	July 2013		Description and posting completed
Increase the number of collaborative studies between public health practitioners and academic researchers <ul style="list-style-type: none"> Develop a process to ensure that the Division is credited appropriately 	Ming Qu and Dave Palm Joint Public Health Data Center, Practice-based Research Network	June 2015		Studies completed
Educate staff on the process for determining when an IRB review is necessary and how the review will take place <ul style="list-style-type: none"> When appropriate, ensure that staff are provided “human subjects protection” training 	Colleen Svoboda, Debbi Barnes-Josiah, Roger Brink	December 2013		Staff education completed
Expand the integration of data sets (e.g., cancer registry with the Every Woman Matters Program) to promote more sophisticated and meaningful analysis	Administrator, Office of Health Statistics; Ming Qu, Joint Public Health Data Center	September 2015		A minimum of four integration studies completed

Priority: Creating a Communications Plan

Background

Health departments need to provide information to the public on a number of topics including the department's mission, programs, resources, and successes, as well as the occurrence of health crises and outbreaks. Written procedures and protocols help ensure a consistent approach in the management of communications on public health issues, but the Division of Public Health does not currently have a formal written communications plan. However, there is already a formal plan in place for emergency and risk communication. According to the Public Health Accreditation Board (PHAB) standards and measures, "processes and procedures should address both accessing information from outside sources and communicating to people outside of the department."

To meet national standards, health departments must have procedures that:

- Describe the process for disseminating information accurately, timely, and appropriately for different audiences.
- Describe the process for informing and coordinating with community partners to disseminate consistent and unified public health messages.
- Outline current contact lists of media and key stakeholders.
- Designate staff as public information officer and define responsibilities.
- Define the responsibilities for staff that interact with the news media and public.
- Outline risk communication plans.

Goal: Develop a communications plan for the Division of Public Health (Priority for implementation, 11/2013)

Objective 1: By December 2013, the Division of Public Health will have a written communications plan.

Background: The Division of Public Health does not currently have a formal written communications plan. The plan needs to meet our Division's needs as well as the requirements outlined in the Public Health Accreditation Board (PHAB) standards and measures.				
Key Strategies and Activities	Lead Role	Timeline	Partners	Expected Outcomes
Create an internal advisory group	Communications	December 2012		Work group formed; meeting minutes
Review communication plans from other state health departments	Communications	January 2013		Outline created
Prepare the Division communication plan	Communications	December 2013		Written plan that meets PHAB standards approved by Division Director
Provide trainings for Division staff to learn about implementation of the plan	Communications	2014		List of participants; evaluations

The Implementation and Performance Monitoring Process

In the implementation phase, members of the Senior Management Team will oversee the implementation activities and initiatives. For some priorities, work groups will be established to provide input into the implementation efforts. The Office of Community and Rural Health and the work groups will work together to develop the measures that will be used to monitor the progress of each priority issue. Updates and progress on the plan will be reported periodically at the Division staff meeting and a newsletter will be prepared at least quarterly to update all Division staff on the implementation activities.

Link to the Nebraska Public Health Improvement Plan

All of the strategic priorities contained in the strategic plan are either directly or indirectly linked to the priorities of the Nebraska Public Health Improvement Plan (NPHIP). For example, there is a direct connection between the strategic plan priority of “creating a culture of wellness” and the priority in the NPHIP “reduce heart disease, stroke, and cancer morbidity, mortality, and associated risk factors.” A direct connection also exists between the strategic plan priority “becoming a trusted source of state health data” and the NPHIP priority “expand capacity to collect, analyze, and report health data.” In addition, the strategic plan priorities “creating a communications plan” and “addressing health disparities” are reflected in all of the NPHIP priorities.

Appendix A. Strategic Priority Work Group Members

Building and Sustaining a Culture of Wellness

Brian Coyle, Nutrition and Activity for Health Program
Jeff Soukup, Tobacco Free Nebraska Program
Jamie Hahn, Heart Disease and Stroke Program
Sandy Klocke, HIV/AIDS and STD Prevention Program
Jason Kerkman, Injury Prevention and Control Program
Kathy Ward, Women's and Men's Health
Kathy Goddard, Diabetes Prevention and Control Program
Greg Moser, Community and Rural Health
Elizabeth Esseks, Environmental Health
Julie Reno, Reproductive Health
Diane Lowe, Health Disparities and Health Equity
Cathy Dillon, Women's and Men's Health
Dave Palm, Community and Rural Health
Peg Ogea-Ginsburg, Injury Prevention and Control Program
Linda Henningsen, Adolescent Health

Judy Martin, Work Group Leader, Health Promotion Unit
Colleen Svoboda, Facilitator, Community and Rural Health

Reducing Health Disparities

Diane Lowe, Health Disparities and Health Equity
Jason Kerkman, Injury Prevention and Control Program
Sue Medinger, Community Health Planning and Protection Unit
Debbi Barnes-Josiah, Lifespan Health
Melissa Leypoldt, Women's and Men's Health
Holly Dingman, Nutrition and Activity for Health Program
Julie Reno, Reproductive Health
Tom Rauner, Community and Rural Health
Bryan Miller, Environmental Health
Dave Palm, Community and Rural Health
Bruce Rowe, Nutrition and Activity for Health Program
Peg Ogea-Ginsburg, Injury Prevention and Control Program
Jamie Hahn, Heart Disease and Stroke Program
Cathy Dillon, Women's and Men's Health
Maria Hines, Health Disparities and Health Equity
Chris Newlon, Emergency Preparedness
Kathy Karsting, School Health
Mary Gordon, Developmental Disabilities Planning Council

Josie Rodriguez, Work Group Leader, Health Disparities and Health Equity
Colleen Svoboda, Note taker and Facilitator, Community and Rural Health

Being the Trusted Source of State Public Health Data

Bryan Buss, Epidemiology
Jianping Daniels, Women's and Men's Health
Mickie Johnson, Nutrition and Activity for Health Program
Debbi Barnes-Josiah, Lifespan Health
Mark Miller, Vital Statistics
Jennifer Severe-Oforah, Lifespan Health
Sara Morgan, Environmental Health
Ming Qu, Public Health Support Unit
Bryan Rettig, Public Health Support Unit
Anthony Zhang, Health Disparities and Health Equity
Michelle Hood, Epidemiology
Tom Safranek, Epidemiology

Jeff Armitage, Work Group Leader, Health Statistics
Colleen Svoboda, Facilitator, Community and Rural Health

Devising a Communication and Education Plan

Mary Gordon, Developmental Disabilities Planning Council
Trudy Hill, Radiological Health
Bill Wiley, Communications and Legislative Services
Marla Augustine, Communications and Legislative Services
Jason Kerkman, Injury Prevention and Control Program
Chante Chambers, Health Disparities and Health Equity
Andrea Wenke, Women's and Men's Health
Jackie Johnson, WIC
Colleen Svoboda, Community and Rural Health

Leah Bucco-White, Work Group Leader, Communications and Legislative Services

Appendix B. Management Team Members

Joseph M. Acierno, MD, JD

Chief Medical Officer
Director, Division of Public Health

Joann Schaefer, MD

Former Chief Medical Officer
Former Director, Division of Public Health

Jenifer Roberts-Johnson, JD

Deputy Director
Division of Public Health

Marla Augustine

Public Information Officer
Communications and Legislative Services

Roger Brink

Attorney
Legal Services

Leah Bucco-White

Public Information Officer
Communications and Legislative Services

Paula Eurek

Administrator
Lifespan Health Services Unit

Teresa Hampton

Attorney
Legal Services

Eric Henrichsen

Chief Information Officer
Information Systems and Technology

Darrell Klein

Attorney
Legal Services

Judy Martin

Administrator
Health Promotion Unit

Sue Medinger

Administrator
Community Health Planning and Protection
Unit

Helen Meeks

Administrator
Licensure Unit

Robert Semerena

Administrator
Investigations Unit

Sue Semerena

Administrator
Environmental Health Unit

Staff

Dave Palm

Administrator
Office of Community and Rural Health

Jeff Armitage

Epidemiology Surveillance Coordinator
Office of Community and Rural Health

Colleen Svoboda

Performance Improvement Manager
Office of Community and Rural Health

Roxanne Rediger

Administrative Assistant
Division of Public Health

Karen Berry

Administrative Assistant
Division of Public Health

Appendix C. Results of Strengths, Weaknesses, Opportunities, and Threats Analysis

STRENGTHS

Resources

- The Division has a breadth of resources (e.g., funding, technology, data) which we have the ability to responsibly pass through to other organizations when necessary.
- Division employees are able to leverage additional resources.

Partnerships and Collaboration

- Division employees are highly accessible.
- Division representatives regularly are invited to participate in external meetings and projects. External partners see us as their peers/partners.
- Internally, we have an open communication process.
- Division employees have a spirit of collaboration versus competitiveness. People support one another. We are cooperative. We have a positive sense of community and camaraderie.
- Division employees identify new partners and establish good working relationships. We collaborate well.
- We remember who our customers are. We include the “customer” in decision-making.
- We have a sense of urgency; we are more responsive to customers than other government agencies.

Leadership

- The Division has strong leadership who are out doing presentations and attending meetings and willing to reach out. There is a good working environment and good management.
- Our overall leadership approach is collaborative.
- Unit administrators have good collaboration and accountability.
- Division employees provide strong technical assistance and resources to subrecipients, partners, and stakeholders.

Staff Knowledge and Attitudes

- Division staff apply the core functions of public health, including public health prevention efforts and diagnosing and investigating health problems.
- We have a strong focus on outcomes.
- Many staff have a long history with the organization and see their job as a career. The Division has longevity and institutional knowledge among its staff.
- Division employees have good knowledge of resources within the state and are highly educated compared to other agencies.
- We have strong data and data staff.
- Division employees have strong knowledge of evidence-based strategies and planning processes.
- The Division has expertise in many disciplines (e.g., environmental health, epidemiology, regulation).

- Division employees are flexible with an ability to adjust to change; they have the ability to work within a restricted environment as well as the ability to problem solve. We are resourceful. We have an ability to “get it done,” in spite of the challenges of a large organization and other barriers. We are problem solvers and do not dwell on the negativity.
- Division employees have the ability to react to meaningful innovation. We have a willingness to try new ideas.
- Division employees have buy in to the mission. They are dedicated and committed.
- We don’t just see this as our “job”; we believe in what we’re doing.
- Division employees are successful at acquiring federal grants.
- We don’t say “we can’t do it,” we say “how?”
- We have home-grown capacity (i.e., build our own workforce) which helps us better understand our customers.
- We play by the rules (e.g., human resources, federal). Division staff is aware of statutes and regulations.
- Division employees anticipate what needs to be done to solve problems as well as potential side effects.
- Division employees recognize the diversity of needs in Nebraska and respond appropriately.
- We are professional.

Public Perception

- The Division has a good public image and is seen as helping and protecting the public, and not just the regulatory arm of the government.
- Legislature has a lot of respect for the Division and knows we can help their constituents.
- Programs and staff are seen as leaders in the field.
- Federal funders have confidence in our ability to manage grants and to be good stewards of the funds. We are good at monitoring our grants and have a strong sense of accountability.

Structure

- The Division has a statewide reach and others come to us in times of need.
- Division employees communicate and work well together.
- The Division achieves a lot with a little.
- The Division has good legal support.
- We are successful despite working in a rural, geographically large state.

WEAKNESSES

Collaboration

- In some instances, additional collaboration with external partners and across internal program areas would be helpful.
- Collaboration across divisions within DHHS could be increased.
- The Division has a large number of staff and many staff do not know each other or the work that others do.

- Silos lead to operation in isolation; Division staff does not know what others in the Division do.
- In general, staff need to be mindful of people's time.

Leadership

- Leadership often has road blocks to success but are held accountable when problems persist.
- Improving staff participation in processes like Division strategic planning could be improved so that they feel ownership in the process. There is still a level of distrust of the leadership by some staff.
- We need to recognize our staff better and more often.

Resources and Staff

- We have a general lack of resources and personnel.
- The Division is highly dependent on federal funding which impacts sustainability, whereas a balance of state and federal funds could improve sustainability.
- We have limited resources to analyze data; need to expand/capture more data; and improve our dissemination.
- There are delays in distributing funds.
- We have trouble staying on the cutting edge when there are training and travel restrictions, which also limits our relationships with federal and private funders. Travel restrictions impact our expertise and partnerships.
- There is limited ability to individualize information technology to programs. IT is under-resourced and restricted.
- Sometimes customers get passed around too much, instead of getting more directly connected to the "correct" person.

Workforce and Training

- The Division has areas with a lot of staff turnover (e.g., data area).
- The Division does not have a standardized approach to mentoring of new hires.
- We do not have a staff development plan.
- Tuition reimbursement is restricted.
- The Division does not have a succession planning process in place.
- Staff compensation is low in some classifications.
- We are on the brink of having high staff turnover due to retirements.
- Use of SOS staff for professional work is a challenge because they are not permanent and use the job as a training opportunity and then leave.
- There is a cultural shift for short term employment of roughly five years, where workers do not plan to spend the majority of their career in one position or with one company.
- Current staff is sometimes viewed similar to how their predecessors were viewed even if they are open to change.

Public Health Perception and Voice

- Public health does not have as big of a voice as other areas.
- We need to educate people about what we do. Customers don't know what public health is. People inaccurately perceive public health as "soft" and that we do not have controversies.
- If there is not a crisis then the public health voice is not as big and often goes unnoticed. Public health does a lot of proactive work that people do not see and are not aware of.
- We do not share our successes well enough.
- It would be helpful for the Division to consider a systematic evaluation from partners.
- We need to improve our communication including what we are doing and what we do well.
- Customers sometimes have unrealistic expectations and we need to better educate them about what we can do or offer.

Politics

- The perception is that the Division is too politically-driven.
- Shifting requirements sometimes lead to dropped balls day to day.

OPPORTUNITIES

Performance Improvement

- The Division can benefit from the performance improvement and accreditation process.

Enhance Partnerships

- The Division can continue to partner with key organizations. We can build upon existing strong relationships with local health departments.
- We can use the "Nebraska Nice" attitude to engage new partners in our efforts.
- We can increase wellness activities with businesses.

Sharing Information with the Public and Partners

- We can better inform the public and stakeholders about what public health is and what we do. We also need to use simple and understandable language when we share health information and data.
- The Division should improve the sharing of health data, including expanding data query systems and a data dashboard. In addition, we can improve the sharing of information and data across programs internally to improve consistency and awareness.
- The Division can enhance the use of the media to share important program information and health messages.
- We need to ensure that the information being shared is accurate and clearly shared so that we don't get pigeon holed.
- We need to expand the availability of information related to evidence-based public health prevention strategies.
- We need to help others understand how public health fits in with Accountable Care Organizations and Meaningful Use. We need to improve networking with health information exchanges.

- We can develop better relationships with the media to capitalize on opportunities for free air time. We need to get messages out quickly, but control the accuracy.

Better Document our Successes

- We need to do more with return on investment (ROI). This would allow us to better make our case and the information would be fact based.

Legislature

- Additional education for legislators related to public health issues would be positive.

Workforce

- We need to improve training opportunities for staff.
- Contractors can pick up staffing shortfalls when they occur (but can also be a threat).
- With the retiring workforce, there are new opportunities for new ideas.

THREATS

Funding

- There are funding uncertainties. Funding is being squeezed from the federal and state levels. It seems like there is a constant erosion of funds which leads to competition within the agency. We will begin to see programs cut.
- Travel restrictions for staff or partners in other DHHS divisions that collaborate with the Division of Public Health create problems for our Division.

Workforce

- There is a public perception of too many employees and need for small government (anti-government sentiment).
- Contract staff limits internal capacity and come from organizations with a different culture and different expectations.
- Morale issues arise with funding cuts and uncertainty.
- Public Health employees do not always fit into the common classifications that human resources has established.
- The aging workforce is a threat in terms of lost institutional knowledge and skill.
- New employees may have different career expectations.

Data

- We need to ensure protection of data and confidentiality.
- Data can be manipulated and turned against you.

Structure

- Agency priorities are often driven by immediate needs, which can result in limited attention to the Division of Public Health.
- Recent changes in health care and their potential impact are a threat.
- There is sometimes a reluctance to get rid of things that are no longer useful.
- Our policies are not keeping up with new technology (e.g., social media).
- New generation of workers stymied by pecking order.

Public Perception

- There is media criticism about DHHS and sometimes the media only picks up on a piece of a story and presents it out of context making DHHS look bad.
- Our Division is often associated negatively with media press from larger DHHS issues.
- We need to prepare stories about our value to gain legislative support; give them something tangible.
- There are unreasonable expectations of government without providing more funds to pay for activities.