

Office of Health Policy and Planning

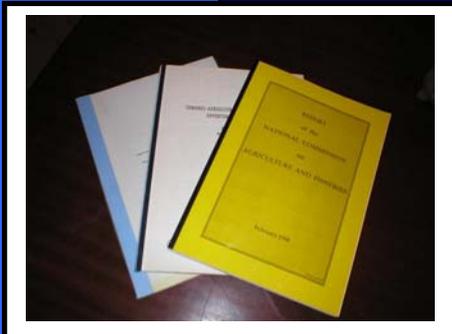


---

# Strategic Plan

---

2005



# **Virginia Office of Health Policy and Planning Strategy and Business Plan August, 2004**

## **Introduction**

The Strategy and Business Plan for the Virginia Office of Health Policy and Planning (OHPP or the Office) was developed during the late spring and early summer of 2004. The project is being completed as part of a Federal Office of Rural Health Policy (ORHP) funded initiative with three other State Offices of Rural Health (SORH) in Arkansas, Florida, and Kansas. As the overall project is completed during the upcoming two months, this Plan may be modified based on additional input from other participating State Offices.

The Virginia Office of Health Policy and Planning is organized within the Department of Health. There are several component parts of the Office's "business," including responsibilities for Rural Health, Primary Care, including recruitment support, Minority Health, Telehealth, the State's HRSA planning grant for addressing the needs of the uninsured, and policy development/issues support for the Secretary of the Department and the Governor's office. Thus, the Office's planning has embraced more than just rural health. However, given the nature of ORHP's project sponsorship, this planning process has a rural tinge.

This Plan addresses some strategy and operational issues related to other units within the Department of Health. However, it primarily concentrates on the Office's functions and associated grant related expectations.

To date, the OHPP has sought input from individuals within the Office and other closely associated individuals within the Department, as well as from non-government affiliated individuals and organizations familiar with the Office's role in the State. These non-Office participants included the following: The Virginia Rural Health Association and Rural Health Research Center, the Virginia Primary Care Association, and a representative Critical Access Hospital.

Planning discussions and analysis was facilitated by an independent consultant familiar with State Offices of Rural Health throughout the country and with Federal Office of Rural Health programs and grants, including the State Office of Rural Health, FLEX, and SHIP programs.

It is particularly important to note that the Office cannot address all of the identified issues simultaneously with the same intensity. Although some immediate actions can be taken and some of the philosophical underpinnings of the Office clarified and strengthened in the short-term, many of the issues, opportunities, and actions steps outlined in this Plan need to be addressed in phases over an eighteen month to two year timetable.

## **Basic Roles and Functions of the Office**

There are several basic role expectations for State Offices of Rural Health that receive federal funding. Although the Office's role is much broader than just rural health, it is helpful to review the expected functions of State Offices for they are fairly well aligned with the broad rural and no-rural focal points identified for OHPP during the planning retreat. Role expectations include the following: (Examples are provided, but are not meant to be specific mandates or all inclusive.)

- Technical Assistance (a core function that may include data support, research, project planning support, grant-getting support, phone or onsite consultations)
- Information Clearinghouse (a core function that may include disseminating information concerning rural health issues and grants through website development, newsletters, and educational conferences) For OHPP the role can be broader than just rural.
- Coordination of (Rural) Health Activities Statewide (a core function that may include planning, including major planning such as rural health plans or in the case of OHPP the Minority Health Plan, systems development, e.g., network development, partnership/relationship development, including participation with various groups in meetings/committees, advocacy roles within and outside of state government, development of regional or statewide work groups, i.e. telehealth networks or quality forums, as well as additional educational activities aimed at coordinating services)
- Support for Recruitment and Retention Initiatives (a supplemental function basically focusing on primary care physicians and done in conjunction with Primary Care Offices, which are not joined with SORH in all states) This function may also be broader in support of other health professionals.
- Participation in Collaborative Relationships That Foster State-Federal Partnerships (supplemental function)
- Demonstration of Leadership That Impacts State and Federal Policy Initiatives (Note: this last point is not defined in legislation or regulation, but has evolved as an unstated "desirable" role in most states. This point fits with OHPP's policy role.)

The approaches used by the OHPP to meet these expectations are extensively documented in the Office's annual application to HRSA for grant funding, in the FLEX Program grant, and in the Small Hospital Improvement Program. The associated detail is not repeated here. It is not the purpose of this plan to explore or restate all aspects of the OHPP functions, but rather to incorporate previous SORH program development with the specific findings and recommendations outlined below.

### **Some Other Program Components**

In addition to programs through the ORHP, the OHPP is also the Primary Care Office (PCO) for the State and the recipient of the State's Primary Care Grant from HRSA. It is also the State's Minority Health Office. Additional detail on how the Office fulfills its functions is found in associated grants and planning documents. These roles also help to define additional expectations.

### Other Role Expectations Identified

In the Planning discussions, the Office also identified or clarified other roles including the following:

- Advocacy for the reduction in disparities across special populations (minority, the poor, those with limited English proficiency, and rural)
- Advocacy for Access (availability, geographic access, and financial access)
- Advocacy for community involvement (with clarification that the Office's role is to support health community strategies, not lead them)
- Clarification that the Office is primarily in the "business" of state-wide, regional, and community-oriented systems development and not focused on specific disease mitigation strategies
- Clarification that the Office's primary constituents are other organizations, not individual Virginians, except that to the extent that other organizations impact access and health status in conjunction with OHPP initiatives.

The following sections highlight some of the OHPP's strengths and weaknesses/challenges. *These points are not all inclusive and are open to modification.* Also note that several of the "strengths" have shadow sides and several of the weakness/challenges have associated opportunities.

### **Some Office Strengths**

- Within the past two years, the OHPP has developed much greater stability after a period of multiple reorganizations and changes in leadership.
- The OHPP has an increasingly progressive track record and has demonstrated both flexibility and creativity in addressing pressures and opportunities.
- The Office staff represents a diverse cross-section of individual expertise and interests and represents good collective depth. (However, note weaknesses.)
- The OHPP is increasingly well perceived by those who have used its services, its partners, and those in State government who are aware of its role.

- The Office has a considerable scope of activity (a diversified portfolio) that is much more substantive than most State Offices of Rural Health. The role of the Office in policy research and support for the Commissioner and Secretary has increased and become favorable received.
- The Office has established a leadership role in minority health through its Office of Minority Healthy function and the development of a Minority Health Plan.
- The Office is very positively positioned for further leadership in the development of telehealth/telemedicine systems, through leadership and staffing of a diverse statewide working group, the Virginia Telehealth Network and participation in the Southern Governors Telehealth Task Force
- There has been increasing success in obtaining grant funds for the Office and the State. The Office's success in obtaining and managing a major HRSA planning grant for addressing the needs of the underinsured and in "producing" the Governor's Conference on the Uninsured is particularly notable.
- For the last fiscal year, the OHPP was responsible for identifying and/or management of grants worth \$1,856,000, obtained from Federal or other non-State budget fund sources. Using widely accepted economic multipliers, this non-State revenue generates approximately \$4,083,000 on statewide economic impact. This amount does not include Federal, Office of Rural Health Policy associated, Network, Outreach or other grants; or additional Medicare reimbursement associated with CAH development. Beyond their positive clinical impacts, these other sources contribute several million additional dollars to the economic welfare of Virginia.
- The OHPP has increasingly good working relationships with several organizations. There has been particular success in nurturing relationships with the Virginia Rural Health Association, the Virginia Rural Health Research Center, the Virginia Primary Care Association, and all four academic medical centers.
- The Office is working with the VRHA to promote awareness of the importance of health care and health communities in supporting community economic development. The resources of the Rural Health Works program are being explored.
- The OHPP is making progress in developing performance measures. The Office primarily addresses its Quality Improvement (QI) strategies in conjunction with the State's quality improvement organization (QIO.)
- The Office has a positive history of collaboration with the Medical College of Virginia, the University of Virginia, and increasingly with the new Osteopathic Medical School.
- The Office has assumed a leadership role within the Commonwealth on the issue of the uninsured. It should continue to develop this role because lack of health insurance

has been cited by numerous studies as the greatest barrier to health care access. The office should be reorganized to accommodate and reflect this key responsibility.

### **Challenges and Opportunities**

The following set of observations should not be seen as insurmountable weaknesses and challenges. Rather, it should be seen as the “opportunity list.” Several points are underlined as focal points for more specific discussion.

- While the diversity of the OHPP’s efforts is on one hand a strength the Office’s staff is pulled in multiple directions, time is spread very thin on many initiatives, and some opportunities go undeveloped or underdeveloped. The Office has the potential to do more, but is constrained by depth of personnel and some less than optimal working relationships. Several current positions are unfilled. Travel time to rural areas exacerbates difficulties in getting out to many meetings and actively participating in local discussions. Given staffing limitations, the pressure to just keep up with the basics of the Office is intense. In addition, time pressures hamper “creative stretch” to identify ways to expand and improve performance.
- Within the Office and the Department, there is an absence of an integrated planning process and no strategic planning conducted as a group. Even within the Office, multiple responsibilities and actions among several individuals are not well integrated. The relationships among various OHPP strategies and other Department strategies are also disjointed.
- Within the Office there is too much “parallel play.” There is insufficient shared purposeful intent to align initiatives. To use a rural analogy, there is too much “siloeing.” Collaborative processes do suffer in the face of time constraints, of which the Office has many. However, the potential synergism that could be achieved might not only yield better results for OHPP, but also ultimately better focused efforts and saved time.
- Office generally embraces the theme of promoting “Access.” However, this theme should be more consistently referenced to provide more of a unifying touchstone across the Office’s separate programs. The theme of access, to the extent it is apparent is not as well connected with “cost” and “quality” as it should be. Although the Minority Health Plan notes several goals and strategies for implementation (e.g., the reduction in health disparities, the development of partnerships with others, the promotion of community health planning, and the fostering of broad-based coalitions) it is difficult to find these same unified “connectors” in all Office activities.
- The Office has several functions where the fit with other Office functions is not clear, specifically, staffing the Board of Health, remnants of some evaluation programs, and staffing and providing a chair for the Institutional Review Board. There are likely to be others that have not been identified during this study. (The Office might wish to divest itself of some of these responsibilities in order to improve its focus, unless it can be clearly demonstrated where the function advantages the Office.)

- The Offices internal workings are compromised by an inconsistent administrative staffing capacity. Secretarial and administrative assistant functions are often perceived to be lacking and/or inconsistently aligned with needs.
- There is no State Health Plan, Rural Health Plan, or even internal Office plans that can guide decision making and resource allocation or grant seeking.
- It is difficult to develop grants, advocate for staff, re-channel funds to different applications, or to hold grantees accountable for performance in the absence of support for a clearly defined plan. This factor ripples through several of the following observations. (Note, there is a draft “plan” for the Agency; however, this document has yet to be circulated.)
- The Office’s success in obtaining grant funds has a definite downside. Success has fostered the expectation that the Office will be available to write (and administer) grants for the Department, even when the “grant getting” activity may present a significant negative distraction from the existing work demands of the Office. The Office sometimes finds that it is “required” to “move to the noise,” rather than acting more productively with consistent focus. The Office is also expected to administer some grants (the most significant current example being the HRSA planning grant) without the concurrent authority to adequately staff the initiative. This expectation further stretches the Office staff to the point of unproductive stress and exacerbates any other weaknesses (e.g., the challenge of developing more collaborative plans and interactions.)
- Internal evaluation processes for the uses of grant funds are underdeveloped. It also seems that there is more emphasis on getting the grants in some cases than on optimally managing the funds received.
- Federal Funding programs through State Offices of Rural Health have by their nature promoted greater emphasis on working with hospitals than with other organizations. The Medicare FLEX program in fact promotes Critical Access Hospitals as the core of the communities’ systems of care. However, to build stronger rural health strategies there is a need to look beyond “hospitals” to the fostering of involvement of other key stakeholders, e.g., CHCs, RHCs, homecare providers, dentists, and nursing homes.
- Within the FLEX program there is minimal apparent long term goals and associated strategy, e.g., what the State hope to “build” with its multi-year federal funding. There is minimal attention to the development of local or regional networks.
- Current relationships with the Virginia Hospital and Healthcare Association are insufficiently developed. It might be speculated that the VHHA does not fully grasp the evolution of the Office and may be working on “old” assumptions regarding its instability, lack of focus, and questionable “value.” There is a need to reassess

strategies such as network development, and quality strategies that could have the potential to further develop ties with the Hospital Association

- There is some sense that the Office may advocate primarily for other organizations, (e.g., the RHA and the PCA) and not developed much advocacy for communities. (This is a limited opinion, but it presents an interesting question.)
- Although there currently is a very positive relationship with the Virginia Primary Care Association and several individual Federally Qualified Community Health Centers (FQHCs or CHCs) these relationships can be further developed. The Office has been very supportive of the VPCA and generally integrates the VPCA Strategic Plan (with respect to fostering area designations and FQHC development) into the Office's Plans. However, while approaches are reasonably consistent, there are more facets to the Office's primary care strategies and more attention should be given to crafting a boarder primary care vision or plan for the State than is embodied in just the PCA Plan. (See the discussion of Basic Health Services on page 11.
- Simultaneously, more could be done to develop relationships with the Rural Health Clinics (RHC) in the State. It appears that there is no "home" for the RHCs to share mutual interest or to collaborate on addressing shared needs. However, some of the clinics are also members of the VPCA.
- There does not seem to be any concerted strategies for promoting collaborative approaches for linking CHCs, RHCs, CAHs, other small hospitals, and local health departments in consideration of overall primary care development strategies or in identifying, sharing, and fostering "best practices" for quality enhancement e.g., diabetes and cardiac care. In addition, there is no clear linkage with minority health strategies. From a rural standpoint, primary care might better be defined as those physicians and associated providers that are appropriate for the care they can be provided in rural communities and thought of as a "basic" care. There is a need for a primary care "plan" other than the HRSA primary care grant application and the acceptance of the PCA plan.
- There does not appear to be much commitment to or leadership regarding community level health planning. (This is a State, not just an OHPP issue.) Here we can define communities as individual communities or small, multi-community, or multi-county clusters. There are several regional health planning agencies; however, their success in advocating for sound community health planning is inconsistent. Particularly in the more rural areas of the state, there do not appear to be any philosophical goals or operational structures for encouraging community planning processes. OHPP should not lead such efforts, but should support community planning efforts when available resources allow.

The State is currently in the process of clarifying which offices or other organizations have responsibilities for various levels of health planning or "community engagement." But, it is clear that this responsibility does not rest with the OHPP. At

the retreat, the Office staff was a strong advocate for community planning. However, the Office is not staffed to work with individual communities on planning initiatives and does not have the state-defined responsibility for this task. However, the Office can support local initiatives through technical assistance and targeted grant funding, as well as by stimulating discussions regarding health planning within state government and with other organizations.

- Other offices and agencies and the Joint Commission on Healthcare have programs, studies, and processes that affect access and health policy. The Office often has an opportunity to participate in these processes but may not always be thought of as a “visible” participant in some discussions even where a “voice” of the Office, particularly the “rural voice”, might have meaningful effect. However, even if asked, there are practical constraints and the OHPP does not have the resources to sufficiently staff participation in all of these forums.
- Although the OHPP has many strengths and accomplishments it has taken a very limited approach to self-promotion and has yet to fully develop visibility within and outside of State government. In addition, some of the Office’s external partners have a limited view of the Office and only see a slice of the role the Office plays.
- There are indications that in earlier years the precursor of the current Office was seen as the evaluation consultant to other departments. This role is now greatly dissipated. The Office will not attempt to grow back into this role.
- During the next few years, the quality of care provided by hospitals, physicians, CHCs, and RHCs will be under increasing scrutiny, whether by public payers (e.g., Medicare and Medicaid,) private payers (managed care entities,) or by employers (e.g., the Leap frog initiatives.) Utilization standards, evidence based medicine, and the linkage of “standards” with reimbursement will be fundamental issues that will face and perhaps transform rural providers. Although the Office is involved with several quality initiatives, there is no “plan” as to how the Office will shape, participate in, or support the broader quality debate that will challenge its constituents, particularly rural providers and organizations.
- The use of web-based technology is underdeveloped for the purposes of information dissemination, promoting the Office as a resource or for promoting key strategies (e.g., healthy communities, minority health initiatives.)

### **Addressing Identified Challenges and On-going Commitments**

The following points could serve as basic strategies and guidelines for the Office’s programs and decisions. Again note the caveat that the “Office cannot address all of the identified issues simultaneously with the same intensity.”

- The Office must attempt to stay focused on what it can reasonable do well, and if it grows, it should grow with planned intent.

The current scope of the Office's activities also touches many other areas of state government as well as provider and consumer interests. For example, a broad responsibility for addressing access to services must consider access to mental health services. However, the Office does not have definitive responsibility for this topic. Thus, it can have concern and strive to work with other agencies to interface the Office's role with theirs (e.g., with minority health planning, provider recruitment, rural health planning, and the HRSA planning grant) but the Office must limit its involvement.

- This plan embodies a specific caution that the Office shows signs of being near its work “saturation point.” Some of the following recommendations may enable the Office to do more or at least “better” within its existing resources, but additional staffing will also be required to expand capacity.
- The Office must be cautious not to create demands that it cannot fill or take on tasks for which it does not have responsibility or adequate resources. Future development must be managed within practical limits and the Office must make judicious choices regarding the scope of its initiatives. It cannot take on all issues. Developing the ability to say “no” to requests for the Office's involvement and setting priorities within available resources is critical.
- In order to accomplish many of its objectives and to achieve its potential, the Office requires a sufficient staff, a stable workforce, a staff who are knowledgeable about pertinent issues and a staff that works better together. Credibility, as a small Office, demands an investment in experienced staff and an ability to convey teamwork and synergy to constituents. Dependable ability to respond to requests for Office support and involvement (e.g., advisory role with various organizations) is essential. To address challenges identified in this area the following suggested steps have been identified:
  - 1) Hold regular staff meetings (at least every two weeks, if not every week for several months) with expected attendance and with time for discussion of issues and programs and especially for the discussion of shared philosophical guidelines (e.g., approaches to partnerships and coalition building, grant seeking, program evaluation.)
  - 2) Develop an email based, short report (one to two pages max) that would be provided by each professional staff member to all others in the Office every two weeks, perhaps before every staff meeting. This report could provide a brief summary of major works-in-progress, brewing issues, and any anticipated upcoming demands. (This would be most effective if linked to internal Office plans on various topics as discussed below.)
  - 3) Circulate major works, e.g., the Minority Health Plan and the FLEX grant application, in draft form for comments and put discussion of the work on the

agenda of a staff meeting before it is issued. (This will require completing the work in time to allow for broader internal discussion and critiquing.)

4) Develop projects that require and build team participation, rather than just assuming that this is going to happen naturally.

5) Fill open staff positions

6) Develop an orientation program for any new staff members

- The “business plan” for the Office and the allocation of the Office’s resources (time, intellect, and financial capital) should be based on some form of “health plan” that is data driven, evidence and need based, and around which there is reasonable consensus of affected parties. In the best case, a State Health Plan with a strong rural component would be helpful in guiding the Office’s actions. This concept might be adopted as a goal or theme for the Office. However, it is going to have to be a long-term goal.

In the meantime, the Office can take initiatives that would align its thinking and strategies and build internal teamwork through steps that it can manage.

1) Based on interviews conducted during the planning process, there is reasonable support for the idea that the State should develop a more complete and publicly supported Rural Health Plan. This approach should have support at the Secretarial level. The Office is working on the development of a plan in conjunction with the Virginia Rural Health Association. The scope of this plan need to be further defined. The concept is currently quite limited. In addition, the Office needs to be sure that the “plan” reflects the Office’s vision and strategies.

2) The Office can pull together meaningful internal processes and plans that would effectively develop more shared vision, internal consensus-driven strategies, and focus without having to engage in much broader public discussions than are now occurring or incur excessive time investments. The great challenge is to weave the threads of *current Office initiatives and current visions together and to build greater understand within the entire Office and to keep focused on reasonable achievable results.*

Specifically, silo-reducing, cross-responsibility, focused, work groups could be created under a team leader to “frame-up” or fit together the Office’s current, anticipated, and desirable activities around sets or packages of activities as follows: (Notes: The Plans do not have to be long; there should be emphasis on clarity. Each team would be responsible for seeking out interconnections with others in the Office. Each of the packages is an example that should be modified through further discussion. The Office might “run” two concurrent initiatives with well defined targets dates, e.g., maximum of one to two months for completion. All “Office plans” should be shared and discussed at Office staff meetings.)



### Package One

- FLEX program initiatives (CAH, EMS, Network development, etc.) including a reassessment of current strategies and identification of long-term goals or short-term responses depending on Federal funding.
- SORH grant-defined initiatives and SORH defined functions
- Rural Health Plan development strategy
- Current relationships and partnerships development opportunities with Rural Health Association, Rural Research Center, academic institutions, and other organizations, i.e., the Hospital and Medical Associations
- Assessment of health status and health expenditures as rural economic development issues, including RHW strategies
- Identification of desirable interfaces with public health, EMS, trauma, and bio-terrorism plans
- Other strategies for developing regional and multi-community/county strategies or planning processes
- Rural workforce development strategies
- Interface with other office activities

### Package Two (Basic Health Services Access Strategies)

- Primary Care Grant-defined strategies
- MUA/HPSA area designation activities
- Other Basic Health Services strategies such as those that might address general surgery, obstetrics, mental health, and dental
- Options for expanded approaches for working with with RHCs and CHCs (e.g., multi-service, CHC site strategies.)
- Relationships with the Primary Care Association and other organizations.
- Recruitment and retention strategies including direct services, National Health Service Corps, interface with academic institutions, and loan and scholarship programs
- Linkage with Minority Health Plan strategies
- Interface with other agencies with responsibilities for specific targeted clinical service (diabetes, mental health, dental, immunizations, health promotion, etc.
- Interface with the Virginia Health Foundation and the free clinic system

### Package Three

- Administrative support services (administrative services, contract management, etc.)  
(An initial working group was identified at the planning retreat on June 29.)

### Package Four (Minority Health)

- Minority Health Plan (revised to reflect full integration with other Office activities, e.g., language barrier reduction and rural issues, such as migrant service strategies.)

#### Package Five

- HRSA Planning Grant Strategies

#### Package Six

- Telehealth/Telehealth Strategies

#### Package Seven

- Information dissemination and education strategies (web site development, conferences, etc.)

#### Package Eight

- Policy Planning, issues support, grant writing, for other agencies
- Catch-all of other activities that do not fit elsewhere

- The Office can adopt a philosophy of supporting a “healthy community” approach to “developing healthy rural (and non-rural) communities that provide opportunities for residents via employment, education, recreation, safety, housing and health care opportunities.” (Note: this quote is found in the Florida SORH Plan.) This is a broad philosophy that can define the context in which Office may wish to act, even though it does not have definitive programmatic responsibilities in most of these areas.
- Stronger encouragement of collaborative strategies will in turn set some expectations for relationships with, support for, and performance of the FLEX networks, and CAHs, as well as for the Office’s support for CHCs, RHCs, and local health departments. It would also clarify some of the parameters for interactions with other organizations such as the Virginia Hospital and Healthcare Association.
- If community and regional level collaboration, partnerships, and shared strategy development were the driving themes, then the OHPP could work with others in the Division and the DOH to leverage State actions and available funding mechanisms to create effective results in local, regional, and State settings. More could be done to channel funding streams to flow together and to working with other parties to encourage them to provide complementary funding to targeted initiatives. The “leveraging” of resources should be thematic to the Office’s objectives, actions, and relationships.
- Due to limitations on staffing and other resources, it will be increasingly important for the OHPP to develop internal partnerships within the Virginia Department of Health as well as external partnerships.
- The Office should inventory its current partnership arrangements and their strengths and weaknesses in the context of its internal planning and assess the needs and opportunities for change if appropriate. It should further discuss the question “What do we want our partners to help us achieve?” not just “What can we do for our partners?”

- Specific attention should be given to reviewing the relationships between the Office and the Joint Commission on Health Care with respect to planning, evaluation, and policy functions.
- Coordinated “grant-seeking” strategies could complement both the Office’s own strategies as well as its partnerships. However, as has been recognized, grant seeking can be staff intense and that this approach needs be limited unless additional resources can be secured to support this strategy. The Office can also be effective in helping other agencies to pursue grant funding, without doing the grant writing or management itself.
- The Office should slow down, if not suspend, its current grant-seeking “imperative.” At a minimum, grant seeking should be place in the context of targeted, Office (or Department) initiatives consistent with the above suggested planning. As stated at the retreat, “If it does not advantage our plans, it is a disadvantage.”
- This resource strategy should be paralleled by a review of grants-management and “compliance” activities and greater efforts to evaluate the performance (outcomes) of grants.
- Some great successes can be achieved at the community, regional, or network level with focused projects, strong community involvement, and targeted funding. However, OHPP does not have sufficient resources to simultaneously work with every potential partner with the same intensity. Significant meaningful results may best be achieved by focusing on targeted goals and initiatives with demonstrable potential for success.
- The Office should engage in target funding consistent with its plans. If the OHPP can build visible successes, it can incrementally build more successful examples; this strategy will breed additional success.
- Where the Office has had inadequate staff depth or expertise, it has used outside contracting to meet some of its objectives. It is likely that it will have to expand and further develop its contracting capabilities. However, the Office needs to be clear that its contracts are targeted to specific needs (consistent with the Office’s vision and Plan) and that they are yielding demonstrable results of adequate value. The Office has identified the desirability of considering contracts that are not only targeted to specific tasks, but also partially aimed at capacity-building to enable other organizations to become stronger partners.
- The ability to structure supportive contractual relationships and to evaluate, re-define goals and expectations, and modify approaches to the contracts and relationships is essential and needs to be more fully discussed and developed.

- The Office can be a valuable resource within the Department in an advisory role, contributing its perspective, particularly in the case of rural, primary care, minority, and telehealth issues, to the efforts of others.
- Within the limitations of its resources, the Office should more systematically “market” its capabilities and its potential involvement with others. There are underdeveloped opportunities for the SORH to promote greater internal and external multi-party focus on select issues.