Office of Minority Health and Public Health Policy

Strategic Plan

Our mission is to advance health equity by identifying health inequities, assessing their root causes, and addressing them by promoting social justice, influencing policy, establishing partnerships, providing resources, and educating the public.

Office of Minority Health
& Public Health Policy
Advancing Health Equity For All Virginians

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OMHPHP's mission is to advance health equity by identifying health inequities, assessing their root causes, and addressing them by promoting social justice, influencing policy, establishing partnerships, providing resources, and educating the public. OMHPHP serves as Virginia's state office of minority health, rural health, and primary care. The Office focuses on advancing health equity by designating medically underserved areas, improving access to quality health care, supporting the development of comprehensive models of health care, addressing barriers to rural health, focusing on health promotion, and facilitating strategies to target the social determinants of health and advance social justice.

Office of Minority Health & Public Health Policy

Advancing Health Equity For All Virginians

(http://www.vdh.virginia.gov/healthpolicy/index.htm)

Our Mission:

The mission of the Virginia Department of Health (VDH) Office of Minority Health & Public Health Policy (OMHPHP) is to identify health inequities, assess their root causes and address them by promoting social justice, influencing policy, establishing partnerships, providing resources and educating the public.

- **Division of Health Equity**

  The Division of Health Equity promotes a focus on social determinants of health and social justice, in addition to more traditional health promotion, as key strategies to eliminate health inequities that exist by socioeconomic status, race/ethnicity, geography, gender, immigration status, and other social classifications.
  - ***State Office of Minority Health***
    - Minority Health Advisory Committee
  - ***Culturally and Linguistically Appropriate Health Care Services Initiative***
    - Web-based Resource Guide (http:/CLASActVirginia.org)
    - Culturally Appropriate Public Health Training Series
    - Medical Interpreter Training Grants Program
  - ***Health Equity Initiatives***
    - Partner in National Effort to Promote the PBS Documentary "Unnatural Causes: Is Inequality Making Us Sick?"
    - Web-based Resource
    - Annual Health Equity Report
    - Community Partnerships to Promote Health Equity

- **Division of Primary Care and Rural Health**

  The Division of Primary Care and Rural Health promotes health equity throughout the Commonwealth by improving access to quality care, supporting the development of models of care and addressing barriers related to rurality.
  - ***Primary Care***
    - State Primary Care Office
    - Healthcare Workforce
      - *Commissioner's Healthcare Workforce Recognition Awards*
      - *Health Workforce Advisory Committee*
      - *Incentive Programs*
        - *Loan Repayment Programs*
          - Health Resource Services Administration, Bureau of Health Professions – State Loan Repayment Program (SLRP)
          - National Health Service Corps Loan Repayment Program
          - Virginia Physicians Loan Repayment Program
        - *Scholarship Programs*
          - Mary Marshall Nursing Scholarship Program for RNs and LPNs.
          - Nurse Educator Scholarship Program
          - Virginia's Nurse Practitioner Nurse Midwife Scholarship Program
        - *Waiver Programs*

        - J-1 Visa Waiver Program
        - National Interest Waiver Program

    - *Primary Practice Opportunities of Virginia (http://www.PPOVA.org)*
    - *Virginia Recruitment & Retention Collaborative Team Initiative*
  - Shortage Designations
    - *Health Professional Shortage Areas (HPSAs)*
    - *Medically Underserved Areas (MUAs) and Populations (MUPs)*
    - *Virginia Medically Underserved Areas (VMUAs)*
  - Telehealth
    - *Virginia Telehealth Network*

- ***Rural Health***
  - State Office of Rural Health
  - Medicare Rural Hospital Flexibility Program (FLEX)/Critical Access Hospital (CAH)Program
    - *FLEX CAH-HIT Network (CAHHITN) Program*
    - *State Rural Health Plan*
  - Small Rural Hospital Improvement Program (SHIP)

- **Policy Analyses and Research**
  - ***Healthy Virginians 2010***
  - ***InsureMoreVirginians.org***
  - ***VDH Institutional Review Board***

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Office of Minority Health and Public Health Policy

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Program Action - Logic Model

Situation

Virginians suffer from poor health outcomes due to inequities in both access to care and the distribution of resources

Priorities

Identifying and addressing inequities that result in higher incidence of ambulatory sensitive care conditions, poor birth outcomes, years of potential life lost and obesity.

Inputs	Outputs: Activities	Outputs: Participation	Outcomes - Impact: Short Term	Outcomes - Impact: Medium Term	Outcomes - Impact: Long Term
What we invest	**What we do**	**Who we reach**	**Short term results**	**Medium Term results**	**Ultimate impacts**
			Learning	Action	Conditions
Personnel	Collect & disseminate information	Health care providers and organizations	Identify HPTAs based on inequities in both access to care and the distribution of resources	Implement policy changes that promote health equity in HPTAs and statewide	Decrease health inequities in HPTAs and statewide
Time	Coordinate resources & activities	Policy makers, including State and Local Government officials		Engage VDH and community stakeholders and partners in promoting health equity in HPTAs and statewide	Improve health outcomes in HPTAs and among disadvantaged and underserved populations statewide
Money	Provide technical assistance	Underserved Virginians and marginalized communities	Identify policies that create health inequities/contribute to health equity	Establish a pro-active surveillance system for tracking health inequities.	
Technology	Provide technical assistance	VDH and community partners	Identify the linkages between health inequities and poor health outcomes		
Internal and external partners	Encourage policy and regulatory changes		Increase stakeholder awareness, knowledge and support of the above		
	Strengthen partnerships				
	Empower community stakeholders				
	Empower community stakeholders				

Assumptions

External Factors

Division of Primary Care and Rural Health

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Program Action - Logic Model

Situation

Virginians suffer from poor health outcomes due to inequities in access to quality primary, mental and dental health care.

Priorities

Identifying and addressing distance, provider distribution, service fragmentation and cost barriers to health care access.

Inputs

What we invest

- Personnel
- Time
- Money
- Technology
- Internal and external partners

Outputs

Activities	Participation
What we do	**Who we reach**
Collect & disseminate information	Health care providers and organizations
Coordinate resources & activities	Policy makers, including State and Local Government officials
Provide technical assistance	Underserved Virginians
Encourage recruitment and retention	
Strengthen partnerships	

Outcomes - Impact

Short Term	Medium Term	Long Term
Short term results	**Medium Term results**	**Ultimate impacts**
Learning	Action	Conditions
Identify HPTAs based on distance, provider distribution, service fragmentation and cost barriers to care	Restructure workforce incentives to support provision of services to HPTAs	Reduce the number of areas identified as underserved due to distance, provider distribution, service fragmentation and cost barriers
Identify policies that reinforce distance, provider distribution, service fragmentation and cost barriers to care	Engage internal and external partners in the provision of services to HPTAs	Reduce the rate of hospitalizations for ambulatory care sensitive conditions in HPTAs
Identify the linkages between barriers to care and ambulatory care sensitive conditions	Implement policy changes that enhance access to care in HPTAs and statewide	
	Develop and implement new models of care in HPTAs	
Increase stakeholder awareness, knowledge and support of the above	Establish a pro-active surveillance system for tracking barriers to health care access	

Assumptions

External Factors

Division of Primary Care and Rural Health Program Evaluation Worksheet

Statement of Need (Problem): Virginians suffer from poor health outcomes due to inequities in access to quality primary, mental and dental health care.

Description of Need (Problem): According to a study published by Reschovsky and Staiti (2005) in Health Affairs, "access to care defies simple measurement; it encompasses both patients' care-seeking decisions and system responses once the patient has initiated contact." The authors of this study framed their comparisons of rural versus urban access to care issues using a typology that consisted of three factors. The first factor is the set of issues related to "convenience of use." This included things like wait times to get appointments, distance to care and wait times in doctors' offices. Less convenient access essentially makes care more costly to use. The second factor is the set of barriers related to "provider supply". A shortage of providers makes it more difficult to obtain services because physicians are less likely to accept new patients and can charge higher fees, or because physicians themselves will have difficulties getting the services their patients need. The third factors is the set of concers related to "patient resource constraints". This includes contributors to patients' demand for services and is has to do with income, insurance coverage and other financial barriers that discourage seeking care and hinder their providers' ability to obtain services for them. The Division of Primary Care and Rural Health is committed to identifying and addressing inequities within Virginia within each of the three types of barriers to accessing care.

FP Program Goal: Identifying and addressing distance, provider distribution, service fragmentation and cost barriers to health care.

Objective (long-term): I. Reduce the rate of hospitalizations for ambulatory care sensitive conditions in HPTAs.

Sub-Objectives	Activities	Person(s) Responsible	Begin/End Date	Outcomes	Measures	Met Sub-Objective Yes/No
1. Identify the linkages between barriers to care and ambulatory care sensitive conditions	1.1 Analyze Virginia data related to rates of hospitalization due to ambulatory care sensitive conditions and identify areas with higher than expected rates of such conditions.	Ken Studer		1.1 HPTAs based on ambulatory care sensitive conditions will be identified.	1.1 Rates of hospitalization due to ambulatory care sensitive conditions by census tract (or meaningful geographic unit for Virginia)	A statistical model for understanding the relationship between rates of hospitalization due to ambulatory care sensitive conditions and distance, provider distribution, service fragmentation and cost barrers to care and a pro-active surveillance system for tracking barriers to health care

	1.2 Identify measures, aquire Virginia data needed, and analyze data related to barriers to distance to care, provider distribution, service fragmentation and cost.	Ken Studer with input from all Division Staff		1.2 HPTAs based on distance, provider distribution, service fragmentation and cost barriers to care in Virginia will be identified.	1.2 To be determined but will include Percentage of Census Tracts in Virginia that could be considered medically underserved based on having over 20% of their population below Federal Poverty Level (FPL) that have been designated as either a Medically Underserved Area (MUA) and/or a Health Professional Shortage Area (HPSA) and result in some type of index of severity.	access will exist if this sub-objective is met.
	1.3 Develop models for understanding the correlation and/or causation between distance, provider distribution, service fragmentation and cost with ambulatory care sensitive conditions.	Ken Studer with input from all Division Staff		1.3. Strategies for intervention in the HPTAs will be developed.	1.3 To be determined	New/improved models of care will exist in HPTAs and the number and severity of areas

2. Align DPC&RH programs and activities to address barriers to care in HPTAs	Restructure workforce incentives to support provision of services to HPTAs	Aileen Harris		2.1 Workforce incentives will be targed to identified HPTAs	2.1 Percent of obligated health care providers (NHSC, SLRP and J-1 Visa) serving in HPTAs	identified as underserved/HPTAs due to distance, provider distribution, service fragmentation and cost barriers will decrease if this sub-objective is met.
	Align grant objectives (SORH, PCO, FLEX, etc...) to support addressing barriers to care in HPTAs.	Kathy Wibberly with input from all Division Staff		2.2 Grant proposals will be aligned with recommended strategies for interventions in HPTAs	2.2 Percentage of grant objectives and activities aligned with strategies for interventions in HPTAs	
	Identify policies that reinforce distance, provider distribution, service fragmentation and cost barriers to care	Kathy Wibberly with input from all Division Staff		2.3 A policy agenda will be developed to reduce policy related (regulatory, legal, etc...) barriers.	2.3 The number of policy changes that are identified and successfully implemented to enhance access to care in HPTAs and statewide.	
	Provide technical assistance, training and education as a way to engage internal and external partners in the provision of services to HPTAs	Kathy Wibberly and all sub-program Managers		2.4 Resources will be better targeted to areas of highest need.	2.4 Number of partnerships, collaborations and activities for the purpose of advancing understanding of	

					strategies for interventions in HPTAs with measures to include website utilization, data, # of individuals, organizations and communities receiving technical assistance per year, # of participants/stake holders engaged in planning, partnership and other collaborative efforts and total amount of resources allocated to HPTAs by internal and external partners.	

Medically Underserved Area Designation Program in Virginia—Logic Model

INPUTS	OUTPUTS		OUTCOMES - IMPACT		
What we invest	ACTIVITIES	PARTICIPANTS	SHORT TERM	MEDIUM TERM	LONG TERM
1. Personnel **2. Data & Information Technology** **3. Resources and Technical Assistance** **4. Partnerships** **6. Funding**	1.1 Maintain staff expertise regarding changes in underserved designation rules, regulations and methodologies 1.2 Establish staff mentoring and continuous improvement program to strengthen staff skills in spatial analysis and epidemiology 2.1 Obtain and develop databases for evaluating the potential designation of Medical Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA) 2.2 Develop a proactive surveillance system and a method for identifying the most needy areas within jurisdictions to be considered for designation as underserved areas 2.3 Provide appropriate data for the federal Application Submission and Processing System (ASAPS) 2.4 Develop competence in spatial analysis and GIS 2.5 Manage databases to make them "user friendly" for wider audiences. 3.1 Fulfill the requirements of the OMHPHP, Primary Care Office (PCO), HRSA cooperative agreement regarding designations of underserved areas 3.2 Support the State Office of Rural Health (SORH) Grant Program in evaluating rural underserved areas 3.3 Provide data to evaluate high priority target areas to facilitate public health interventions 3.4 Provide information regarding the utilization of underserved designations 4.1 Develop partnerships with local community stakeholders in the designation of underserved areas 4.2 Develop appropriate targeted data to support community interventions 4.3 Provide data required to assess levels of underservice and support partner's local needs assessment processes 4.4 Prepare presentations regarding the utilization of "small area analysis," "high priority target areas," and the relevance of geospatial data analysis for public health policy, and community involvement in the change process. 6.1 Seek funding from private foundations to support the geospatial analysis program of the OMHPHP and VDH 6.2 Partner with other VDH divisions to leverage data and research relevant to the designation process and the development of public health policy	▪ Develop partnerships with other *state agencies, LHD and other VDH divisions* that have an interest in public health policy and in improving access to primary care, dental and mental health care services ▪ Develop partnerships with health *professional advocacy groups* who have a vested interest in underserved area designations to support increased reimbursements and other incentive programs ▪ Develop partnerships with those *organizations with an interest in supporting communities* identified through "high priority target area" analysis (i.e, Community Health Centers, free clinics) and who are seeking grant funds to address their issues ▪ Maintain close working relationship with *federal funding agencies* monitoring our designation process	▪ Assess primary care, dental and mental health professional (and other specialties when requested) needs and demands throughout the Commonwealth ▪ Develop methodology for the assessment of "high priority target areas" ▪ Develop methodology to support innovative "models of care" where traditional health care services cannot be sustained ▪ Develop partnerships within VDH to support geospatial analysis at the sub-jurisdictional level ▪ Seek foundation funding to expand small area geospatial analysis to support the designation and health equities agenda within OMHPHP and VDH	▪ Develop a proactive surveillance system to assure that the entire Commonwealth is annually scanned for potential designation and to identify areas where adverse health outcomes are occurring ▪ Develop a strategy for assuring current provider data and the best population estimates are continuously available for small area analysis and to support the designation process ▪ Embed the designation process, and small area and high priority target area analysis within a agency-wide strategy for allocation of public health resources	▪ Equitable designation of underserved areas to support federal, state and other funding resource allocations in support of previously underserved and marginalized populations ▪ Utilization of geospatial epidemiology and small area analysis to support a community-based, targeted approach to public health policy ▪ Develop area specific models of care based on data analysis of community needs and the demand for health professional services within targeted areas

Medically Underserved Designation Program Evaluation Worksheet

Statement of Need (Problem): **Identify areas where accessing primary care, dental and mental health services has been significantly compromised and the area would benefit from federal Medically Underserved Area/Population (MUA/P) or Health Professional Shortage Area (HPSA) designations.**

Description of Need (Problem): **The lack of physicians, dentists and other health care resources can compromise health care interventions and can lead to poor health status for inner-city, rural and other marginalized populations. Because adverse social determinants of health often intersect with the absence of health professionals, these social conditions need to be taken into account in specifying the "highest priority targets" for designation and for public health intervention purposes.**

Designation Program Goal: **Improve access to health care through appropriately designating underserved areas and facilitate state, federal and private agency funding and incentive programs to address health care issues for marginal populations.**

Objective (long-term): **Develop a proactive surveillance system to identify underserved areas and rank the Commonwealth's neediest areas (High Priority Target Areas) to assure that, where possible, they are given priority to be designated as MUA and HPSA.**

Objectives	Activities	Person(s) Responsible	Begin/End Date	Outcomes	Measures	Met Sub-Objective Yes/No
1. Develop the knowledge and database capabilities to identify targeted areas where adverse health outcomes, social conditions and provider shortages intersect to the detriment of the health and healthcare of the population at risk	1.1 Develop/obtain the appropriate databases to support a proactive surveillance system for "high priority target areas" and HPSA and MUA designations Develop a methodology for ranking the severity of conditions that would qualify an area for specific policy interventions and designations Monitor changes in federal definitions of underservice and determine how they could be applied to support Virginia's needs 1.4 Maintain dialogue with public health policy stakeholders to facilitate implementation of policy relevant decisions regarding identification of areas and designation priorities			1.1 Integration of the designation process with larger spatial and epidemiological issues 1.2. Increased focus on high priority target areas and root causes of adverse health outcomes 1.3 Establishment of "working relationships" with key stakeholders in the designation process. 1.4 Satisfy the federal requirements of the PCO and SORH grants regarding medical underserved designations	1.1 Number of areas reviewed for possible designation as HPSA and MUA 1.2 Number of areas that qualify for dedesignation (successes!) 1.3 Number of Policies that were impacted by designations 1.4 Fiscal impact (increased reimbursements, grants, etc) of designations	1.1 Annually review all expiring (older than 3 years) primary care, dental and mental HPSA and MUA 1.2 Apply proactive surveillance system statewide at all levels of potential designation, from the jurisdictional to sub-jurisdictional level and designate where possible 1.3 Survey annually all sub-jurisdictional high priority target areas for possible changes in ability to designate

Program Development **Program Action – Logic Model**
Planning – Implementation – Evaluation

Virginia's State Office of Rural Health Logic Model

This logic model is prepared under the guidance of and in accordance with the Virginia Department of Health (VDH) Office of Minority Health and Public Health Policy (OMHPHP). The overarching goal is to identify health inequities, assess their root causes and address them by promoting social justice, influencing policy, establishing partnerships, providing resources and educating the public.

The OMHPHP houses the Division of Health Equity (DHE) and the Division of Primary Care and Rural Health (DPCRH). Under the priorities of the DPCRH, which are the identification and addressing of distance, provider distribution, service fragmentation and costs barriers to health care access, the Virginia State Office of Rural Health (VA-SORH) seeks to address the barriers of rurality that hinder access to quality health and health care services.

Situation –Due primarily to challenges that result from geographic location, rural Virginians are faced with increased barriers that hinder access to quality and affordable health and health care services. These barriers oftentimes result from distance and transportation, distribution of health care providers, availability and affordability of quality health care services, and fragmentation within the rural health care infrastructure. Other contributing factors that hinder access include high poverty rates, high unemployment and underemployment, lack of health insurance coverage and demographic shifts.

Priorities – To address barriers of rurality that hinder access to quality primary, mental and dental health care services through the (1) development of effective programs that strengthen the rural health care infrastructure, (2) implementation of programs that improve quality and performance of rural health hospitals, (3) coordination of statewide planning efforts, (4) increased community health care education, (5) increased utilization of health information technology, and (6) the development of effective rural health care network systems.

Assumptions - Assumptions are the beliefs, theories and underlying principles that form the foundation of our programs. Such assumptions, both validated and theoretical, include:

- Rural areas are uniquely different and have distinct challenges than non-rural and other rural areas in Virginia
- Rural communities and partners desire to collaborate to achieve the common goal
- Funding, time, resources and staff are adequately available (both internally and externally) to meet the goals and objectives
- Partners desire to collaborate and are willing to leverage resources
- Rural communities and partners acknowledge the proposed situation as an accurate depiction of the current rural health care system
- There are other components of the rural health care spectrum that ought to be included in the overall rural health continuum
- Present rural health conditions are in need of improvements
- Outputs, outcomes and impacts are realistic and achievable

External Factors – External factors are influencing contributors that the VDH, OMHPHP and its staff members and consultants have little and/or no control over.

- Government
- Politics
- Economy
- Environment
- Natural Disasters
- Life's inevitability (i.e. death)
- Demographic shifts/patterns
- Rural job market structures
- Availability of funding and time
- Internal staff turnover
- Consistency of funding/program goals and mandates

Rural Health Logic Model

Statement of Need (Problem): Virginians suffer from poor health outcomes due to inequities in access to quality primary, mental and dental health care.

Description of Need (Problem): Due primarily to challenges that result from geographic location, rural Virginians are faced with increased barriers that hinder access to quality and affordable health and health care services. These barriers oftentimes result from distance and transportation, distribution of health care providers, availability and affordability of quality health care services, and fragmentation within the rural health care infrastructure. Other contributing factors that hinder access include high poverty rates, high unemployment and underemployment, lack of health insurance coverage and demographic shifts.

FP Program Goal: To address barriers of rurality that hinder access to quality primary, mental and dental health care services through the (1) development of effective programs that strengthen the rural health care infrastructure, (2) implementation of programs that improve quality and performance of rural health hospitals, (3) coordination of statewide planning efforts, (4) increased community health care education, (5) increased utilization of health information technology, and (6) the development of effective rural health care network systems.

Objective (long-term): **(1)** To fully integrate the continuum of health (i.e. primary care, mental, dental, behavioral, etc.) in rural areas; (2) to significantly reduce the fragmentation of health services related to rurality; (3) to provide a clear depiction of Virginia's rural areas; and to fully implement the recommendations from the Virginia State Rural Health Plan.

Sub-Objectives	Activities	Person(s) Responsible	Begin/End Date	Outcomes	Measures	Met Sub-Objective Yes/No
1. Conduct an extensive analysis of rural health and health care services.	1.1 Assess needs, inequities and characteristics (i.e. demographics, economic trends, environmental factors, assets) as they relate to rurality. 1.2 Analyze data collection needs relating to rurality. 1.3 Assess health care quality and performance improvement, redefinition of primary care and the integration of EMS, network development and HIT.	Rural Health Manager	Begin: October, 2008 End: October, 2010	1.1 Completion of the FLEX program evaluation. 1.2 Completion of EMS studies in seven CAH areas. 1.3 Completion of a study examination of quality and performance improvement condition of current health care services in CAH and SHIP facilities. 1.4 Complete development and implementation of a statewide rural health database portal. 1.5 Completion of multiple special studies/analyses of rural health (i.e. mental and behavioral health, primary care, oral, and workforce)	1.1 Increase CAH participation 1.2 Increase SHIP participation 1.3 Increase number of dedicated rural health partners 1.4 Increase the level of participation of rural health partners 1.5 Increase the rural health awareness of partners	Successful outcomes for the activities will indicate success of sub-objective.

2. Use data, analyses and studies to effectively align grant and non-grant funding to support (1) models of care, (2) high target priority areas in rural communities, and (3) critical projects, program and activities that will positively impact the health of rural citizens and available health care services in rural areas.	2.1 Develop and implement models of care/pilot projects to address health needs, inequities related to rurality. 2.2 Analyze and use data to report on health and characteristics (i.e. demographics, economic trends, environmental factors, assets) as they relate to rurality. 2.3 Integrate the DPCRH model into rural health programs. 2.4 Update VA-SRHP to include current needs.	Rural Health Manager	Begin: October, 2010 End: October, 2011	2.1 Development and execution of applicable models of care programs (i.e. integration of primary care and mental/behavioral health) 2.2 Full integration of rural health into the overall direction of HTPA, DPCRH and OMHPHP, and vice versa. 2.3 Successful deployment of years 1-3 VA-SRHP recommendations.	2.1 Increase the number of EMS providers and affiliated network hospitals served by the VA-SORH. 2.2 Increase the amount and type of technical assistance provided to CAHs, CAH-eligibles, EMS providers, and affiliated network hospitals by served by the VA-SORH. 2.3 Increase the presence and number of learning or educational networking opportunities related to rural health and health care services in rural areas. 2.4 Increase the presence (and frequency) of a rural health advisory process (e.g., Flex advisory committee, periodic meetings with CEOs) used to gather input from CAHs and to understand their needs. 2.5 Increase the presence and number of activities that result from relationships between the VA-SORH and other state agencies and external stakeholders (e.g., hospital associations,	Successful outcomes for the activities will indicate success of sub-objective.

					medical societies, rural health associations, QIOs, licensing agencies, or state EMS offices). 2.6 Increase the proportion of CAH and SHIP facilities involved in a management program using benchmarked data to improve their organizational, clinical, financial, or administrative performance.	

State Flex Program Logic Model: Rural Health in Virginia – Addressing

INPUTS	OUTPUTS		OUTCOMES		
	ACTIVITIES	PARTICIPANTS	SHORT TERM	MEDIUM TERM	LONG TERM
Staff: ▪ SORH Staff ▪ Consultants ▪ Students **Technology:** ▪ Telehealth ▪ Health Information Technology **Funding:** ▪ Small Rural Hospital Improvement Program (SHIP) ▪ Medicare Rural Hospital Flexibility (FLEX) Grant Program ▪ State Office of Rural Health (SORH)	▪ **Develop Projects to Focus on** ○ Quality and performance improvement ○ Integration of Emergency Medical Services (EMS) ○ Implementation of rural health network systems ○ Supporting existing Critical Access Hospitals (CAH) and CAH-eligible hospitals ○ Models of Care ○ High Priority Target Areas ▪ **Conferences/Planning Sessions** ○ Annual Statewide Strategic Planning Session ○ Annual Virginia Rural Health Association Conference ○ Annual Small Rural Hospital Conference/Leadership Training Sessions ▪ **Resources** ○ Financial resources for pilot/special projects ○ Educational resources ○ Financial indicators ○ Best practices and research	▪ **Health Care Providers** (including primary and acute care, behavioral and mental health; EMS; dental; Obstetrics and Gynecology; and community health care services) ▪ **Policymakers** (including State, federal and local government officials, departments and agencies, private and non-profit organizations) ▪ **Community Organizations and**	▪ Assess needs, inequities and characteristics (i.e. demographics, economic trends, environmental factors, assets) as they relate to rurality. Identify collaboration opportunities to meet identified needs. ▪ Analyze data collection needs relating to rurality. ▪ Assess health care quality and performance improvement, redefinition of primary care and the integration of EMS, network development and HIT. *Timeframe: 12-24 months*	▪ Develop and implement models of care/pilot projects to address health needs, inequities related to rurality. ▪ Analyze and use data to report on health and characteristics (i.e. demographics, economic trends, environmental factors, assets) as they relate to rurality. ▪ Integrate the DPCRH model into rural health programs. ▪ Update VA-SRHP to include current needs. *Timeframe: 24-36 months*	▪ Full integration of the continuum of health (i.e. primary care, mental, dental, behavioral, etc.) ▪ Reduce the fragmentation of health services related to rurality. ▪ Clear depiction of Virginia's rural areas. ▪ Full implementation of VA-SRHP. *Timeframe: 5-7 years*

INPUTS	OUTPUTS		OUTCOMES
Grant Program ▪ FLEX Critical Access Hospital Health Information Technology Network (CAHHITN) Grant Program **Resources and Technical Assistance:** ▪ Virginia's State Rural Health Plan ▪ Rural Health and Telehealth Policy and Planning **Partnerships** **Technical Assistance Services**	○ Internet-based data portals ○ Internet-based rural-specific websites and linkages ▪ **Partnerships/Collaborations** ○ Critical Access Hospitals (CAH) and CAH-eligibles ○ Small Rural Hospital Improvement Program (SHIP) Participants ○ VA's SRHP partners ○ Communities ○ Government ○ Private ▪ **Technical Assistance** ○ On-site ○ Electronic/Internet-based ○ Newsletters ▪ **Statewide Planning - Research, analyze and make recommendations on the components and contributing factors to a quality rural health care infrastructure** ○ Access to care (integration of primary and acute care, behavioral and mental health; EMS; dental, telehealth, Obstetrics and Gynecology (OBGYN) and community health care services) ○ Health care workforce ○ Quality and performance improvement ○ Data/rural definition ○ Long-term Care/Aging ○ Health information technology (HIT) ○ Education ○ Transportation ○ Rural Economic Development ▪ **Evaluation**	**Leaders** ▪ **Rural Partners** ▪ **Rural Virginians** ▪ **Virginia Department of Health Internal Partners**	

Health Care Workforce Logic Model

		Inputs	Outputs		Outcomes - Impact		
			Activities	Participation	Short Term	Medium Term	Long Term
Situation	**Priorities**	**What we invest**	**What we do**	**Who we reach**	**What the short term results are**	**What the medium term results are**	**What the ultimate impact(s) is**
Communities are suffering from inequities in health care due to inadequate access and distribution of primary medical, dental and mental care services.	Increasing access to quality medical care by reducing the number of areas identified as underserved due to distance and provider distribution barriers.	Personnel (staff, professional students, recipients) Time Funding (state & federal) Technology VDH & external Partners/ Stakeholders Data Marketing Materials	Administer Incentive Programs Provide recruitment, placement & retention services & technical assistance Coordinate resources & activities Collect and disseminate data & information Collaborate with partners and stakeholders Encourage Policy & Regulatory Changes	Health care providers and organizations Health profession students & residents Medical academic centers and other professional programs Policy makers VDH Community partners	Increase the number of residents and graduating students to commit to Virginia Each severely underserved community to establish a funding plan. Stabilize support from key stakeholders that influence policy.	Increase the percentage of health care practitioners that remain in Virginia. Re-align the distribution of health care providers in underserved areas Alter the funding mechanisms (federal & state) to reward practice sites for reaching full capacity of practitioners. Increase & sustain funding sources to support full capacity.	To eliminate the shortage of practitioners in medically underserved areas. Decrease barriers to access to quality medical care in Virginia.

Evaluation of Health Care Workforce

Program Goal: Increasing access to quality medical care by reducing the number of areas identified as underserved due to distance and provider distribution barriers.						
Objective	**Activity**	**Person(s) Responsible**	**Begin/End Date**	**Outcomes**	**Measures**	**Met Objective Yes/No**
Administer Incentive Programs to attract & recruit practitioners to medically underserved areas. • Nursing Scholarships (4) • Loan Repayment (2) • J-1 Visa Waiver	1. Development of Recruitment Campaign & Communications Plan (i.e. recruitment video, website, exhibits and recruitment packets) 2. Develop an effective database for tracking and forecasting for each program 3. Develop an efficient & effective application process 4. Utilize current program recipients as Ambassadors	Health Care Workforce Staff	July 1, 2008 to June 30, 2009	1. Each partnering organization (hospitals, CHCs, etc) to adopt & incorporate key elements of the recruitment plan. 2. A comprehensive database that contains essential demographic information for each practitioner. 3. A user-friendly application that ensures data integrity and accuracy across all incentive programs. 4. Three ambassadors per AHEC region actively recruiting on behalf of the incentive programs	1. Direct contact from each partnering or target organization (i.e. CAHs) for recruitment materials . (visibility of recruitment materials within facilities). 2. Quarterly status reports indicating active and completed service obligation; those still serving in HPTAs; and the retention of those serving in HPTAs. 3. A robust functionality with databases that includes business rules that prevents improper data entry. 4. At least two periodic Ambassadors communications.	

Objective	Activity	Person(s) Responsible	Begin/End Date	Outcomes	Measures	Met Objective Yes/No
Provide recruitment & placement services for practitioners & employers • PPOVA • NHSC	1. Promote free online recruitment service to graduating practitioners and employers (PPOVA). 2. Support eligible employer's interest in NHSC.	Health Care Workforce Staff	July 1, 2008 to June 30, 2009	1. Increase registration to PPOVA by both potential employees and employers by at least 15% (from last year's numbers). 2. Increase awareness of NHSC opportunity among eligible practice sites by at least 20% (from last year's numbers).	1. Number of hits on PPOVA site. 1a. Number of actual registration to PPOVA. 2. Number of follow-up inquiries from eligible practice sites. 2a. Number of practice sites submitting an NHSC application .	
Collect and disseminate data & information	Work to collect health workforce data in Virginia and share with appropriate partners and stakeholders			Obtain a complete set of regional and local data sets indicating the status of workforce capabilities.	The availability of health workforce data & formats suitable for regional, local and statewide reports.	
Coordinate resources & activities	Work with targeted partner organizations in the recruitment & retention of the health care workforce. (i.e. R&R Collaborative Team, SRHP-Workforce Council, AHEC, VPPI, CAHs, etc.)			Reduce recruitment expenditures with an increase in recruitment coverage by coordinating efforts with partner organizations.	Reduce recruitment budget. Increase distribution of recruitment materials via collaborative associations.	

Division of Health Equity

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Program Action - Logic Model

Situation

Virginians suffer from poor health outcomes due to the inequitable distribution of resources that impact health

Priorities

Identifying and addressing poverty/fiscal and housing stress, race, linguistic isolation and educational attainment as social determinants of health (SDOH).

Inputs	Outputs: Activities	Outputs: Participation	Outcomes - Impact: Short Term	Outcomes - Impact: Medium Term	Outcomes - Impact: Long Term
What we invest	**What we do**	**Who we reach**	**Short term results**	**Medium Term results**	**Ultimate impacts**
			Learning	Action	Conditions
Personnel	Collect & disseminate information	Health care providers and organizations	Identify HPTAs based on poverty/fiscal and housing stress, race, linguistic isolation and educational attainment	Engage VDH and empower marginalized communities within HPTAs through CBPR Implement policy changes that promote health equity in HPTAs	Reduce the number and incidence of poor birth outcomes (infant mortality, low birthweight babies) in HPTAs
Time	Coordinate resources & activities	Policy makers, including State and Local Government officials			
Money	Provide technical assistance	Underserved Virginians and marginalized communities	Identify policies that impact the SDOH	Establish a pro-active surveillance system for tracking SDOH	Decrease years of potential life lost in HPTAs
Technology	Encourage policy and regulatory changes	Community partners	Identify the linkages between the SDOH and poor birth outcomes, years of potential life lost and obesity.		Reduce the incidence of obesity in HPTAs
Partners	Strengthen partnerships		Increase stakeholder awareness and knowledge of the above.	Increase the number of stakeholders who can articulate the basic principles of social justice and SDOH	
	Empower community stakeholders				

Assumptions

External Factors

Office of Minority Health and Public Health Policy

CULTURALLY APPROPRIATE HEALTH SERVICES INITIATIVES

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Program Action - Logic Model

Situation	Priorities
To assist health care providers meet the needs changing demographics, lack of cultural competence among providers, lack of cultural competence among organizationso f changing demographics through resources relating to cultural competence, overcoming language	To address health inequities and barriers in receiving culturally and linguistically appropriate health care services through developing resources and tools that are accessible to all Virginians

Inputs	Outputs: Activities	Outputs: Participation	Outcomes - Impact: Short Term	Outcomes - Impact: Medium Term	Outcomes - Impact: Long Term
What we invest	**What we do**	**Who we reach**	**Short term results**	**Medium Term results**	**Ultimate impacts**
Personnel CLAS Act Coord. DHE Staff				Provide training	
Time	Coordinate resources & activities	Policy makers, including State and Local Government officials	Conduct language needs assessment survey agencywide.	Identify needs, resources and tools.	Increase resources and tools to ensure availability of culturally and linguistically appropriate health care services in Virginia.
				Continue language needs assessments and modify on an as needed basis.	clas services provided to clients and/or providers have increased services.
Money General Funds SORH PCO	Provide technical assistance	Underserved Virginians and marginalized communities	Review the current CLAS Act programs.		
Technology VDH websites Internet	Encourage policy and regulatory changes			Build partnerships internally and externally to increase resources to achieve goals.	
Partnerships VDH Districts/Offices; Fed.&State agencies; Academic Institutions; Advocacy Groups & Professional Organizations	Strengthen partnerships	VDH internal and external partners	Explore and identify internal and external partnerships.		

Assumptions

External Factors

CLAS Act						
Goal 2: Ensure culturally and linguistically appropriate heath care for Virginians						
Objective: Increase availability of culturally & linguistically appropriate health care in Virginia						
Sub-Objective	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Increase district capacity to provide CLAS.	1.1 Assess language needs of the local health districts (LHD)	1.1 CLAS Act Coordinator.	1.1 Bi annually.	1.1 Identify Districts level of language needs.	1.1. Language Assessment completed by ____.2009.	1.1 Annual
	1.2 Extend the statewide telephonic interpretation and translation contract - Renew the current contract - Continue generating the monthly Telephone Interpretation Usage report	1.2 Director, Health Equity Division/CLAS Act Coordinator	1.2 Ongoing, beginning September 2009 when new contract begins	1.2 Increased efficiency in linguistically and culturally appropriate public health services to the clients	1.2 Review all complaints received each month & take necessary steps to reduce the number by 75%. - Reports generated each year	1.2 Monthly
	1.3 Conduct Language Needs Assessment survey every 2 years	1.3 CLAS Act Coordinator	1.3 Spring 2009	1.3 Increased efficiency in delivering services to the Limited English Proficiency (LEP) clients	1.3 Annual report completed	1.3 Annual
	1.4 Each health district develops a written plan about language access services to the LEP clients	1.4 CLAS Act Coordinator	1.4 June 2009 1.4.1 "Notice of Rights' posters distribution July 2008	1.4 Completion of the district plans 1.4.1 Clients receive clear guidance about accessing language services	1.4 Thirty-five (35) districts' plans completed	1.4 Quarterly

CLAS Act						
Goal 2: Ensure culturally and linguistically appropriate heath care for Virginians						
Objective: Increase availability of culturally & linguistically appropriate health care in Virginia						
Sub-Objective	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
	1.5 Develop a funding proposal for health district capacity building grants and submit to the General Assembly	1.5 Director, OMHPHP/Division Directors	1.5 June 2009	1.5 Continue the current programs & create new OMHPHP programs on an as needed basis	1.5 Completion of the proposal	1.5 Annual
2. Coordinate Cultural Series Training for internal and external stakeholders.	2.1 Identify training topics via survey –. 2.2 Quarterly training with organizational steps include: Selection of Topics, Presenters, Locations, Technical requirements and timeline.	2.1 CLAS Act Coordinator	2.1 – Annual 2.2 Ongoing from November 2008 through October 2009	2.1 Training need identified. 2.2 Attendees will experience increased knowledge of cultural series content.	2.1- Training Survey completed. 2.2 Track 100 % of completed evaluations, 75 % of attendees report increased cultural knowledge. 2.3- Fifty percent of organizations identify policy and procedural changes as result of presentation.	2.1 Annual report October 2008
3. Increase participation of internal and external stakeholders in the medical interpretation training grant program.	3.1 Promote availability of training to all stakeholders.	3.1 CLAS Act Coordinator.	3.1 Ongoing	3.1 Increased pool of medical interpreters.	3.1 Increase training participation rate by 10%. 3.2 Track 100% interpreter volunteer community hours with 60% reporting organizational usage.	3.1 Quarterly 3.2 Quarterly

CLAS Act						
Goal 2: Ensure culturally and linguistically appropriate heath care for Virginians						
Objective: Increase availability of culturally & linguistically appropriate health care in Virginia						
Sub-Objective	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
4. Establish a Statewide CLAS Act network.	4.1 Contact State agencies to develop partnership.	4.1 Director, Health Equity Division & CLAS Act Coordinator.	4.1 Begin September, 2008/Ongoing	4.1 Greater efficiency in coordination CLAS services statewide	4.1 Working group with other State agencies established	4.1 Quarterly
6. Support legislation for the Medicaid reimbursements for interpreter services.	6.1 Develop partnership and explore strategies with DMAS.	6.1 Director, Health Equity Division\CLAS Act Coordinator	6.1 Begin: September 2008	6.1 New Strategies developed for interpreter reimbursement	6.1 Change in laws allowing for payment of interpreter services.	6.1 Annually
7. Improve communication with external & internal stakeholders	7.1 Conduct research to identify appropriate resource materials. 7.2 Develop and deliver presentations on topics such as health literacy, cultural competency, etc. 7.3 Train immigrants to navigate the health system 7.3.1Presentations to the immigrant population in partnership with advocacy organizations.	7.1 CLAS Act Coordinator	7.1 Begin: August 2008 7.2 Ongoing 7.3.1Ongoing	7.1 Increase health literacy for external & internal stakeholders 7.2 Stakeholders will experience increased knowledge	7.1 Identify 10 new materials to be added as resources 7.2. Conduct 5 presentations annually and evaluate with pre-post-tests.	7.1 Monthly 7.2 Quarterly 7.3 Annually

CLAS Act						
Goal 2: Ensure culturally and linguistically appropriate heath care for Virginians						
Objective: Increase availability of culturally & linguistically appropriate health care in Virginia						
Sub-Objective	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
	7.3.2 Develop toolkit and post on CLAS Act website 7.4 Maintain the CLAS Act website 7.4.1 Update and delete information regularly on as needed basis.		7.3.2 March 2009 7.4.1 Ongoing	7.3.2 Toolkit completed 7.4.1 1National and local level information is added	7.3.2 Stakeholders demonstrate ability to access and use toolkit 7.3.2.1 Toolkit users report procedural changes as a result of using the toolkit 7.4.1 Twelve (12) Web Trends reports generated each year	7.3.2 Quarterly 7.4.1 Monthly
8. Maintain Emergency Public Relations Communications	8.1 Continue the working arrangements between the OMHPHP & Office of Communication	8.1 CLAS Act Coordinator	8.1 Meet twice a year	8.1 Prompt communication to the LEP populations in case of an emergency	8.1 Timely translation of materials during an emergency 100% of the time. 9.2 Conduct a drill semi-annually	8.1 Semi-annually.

Office of Minority Health and Public Health Policy

Health Equity Community Based Activities

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Program Action - Logic Model

Situation

Virginians suffer from poor health outcomes du to the inequitable distribution c the resource that impact health

Priorities

Identifying and addressing poverty/fiscal and housing stress, food security, race, access, linquistic isolation, educatuional attainment, and the total ecological environment as social determinants of health (SDOH)

Inputs

What we invest
Personnel
Time
Money
Technology
Training Materials
Research Base
VDH and External Partners

Outputs

Activities: What we do	Participation: Who we reach
Collect & disseminate information	Health care providers and organizations
Coordinate resources and activities	Policy makers, including state and local government officials
Provide technical assistance	Underserved Virginians and marginalized communities
Strengthen partnerships	VDH and community stakeholders
Develop on-line social strategies	Funders
Empower community stakeholders	

Outcomes - Impact

Short Term: Short term results	Medium Term: Medium Term results	Long Term: Ultimate impacts
Learning	Action	Conditions
Targeted populations will have increased awareness of health equity and SDOH	Engage underserved and marganalized communities by assisting with implementation of Community-Based Participatory Approach methods	All Virginians experience the best possible health outcomes
Policy makers will have increased knowledge of the importance of their policies relative to SDOH and health outcomes	Facilitate the implementation of policy changes that promote health equity	The social ecological landscape throughout the Commonwealth of Virginia offers equal access and equitable distribution of health-related resources for all Virginians
Underserved populations will learn that they can have a voice in determining their health outcomes	Increase the number of stakeholders that utilize the basic principles of social justice and SDOH in decision making.	Community stakeholders will monitor the SDOH in their communities and take actions to maintain health equity for all Virginians
Community stakeholders will identify the links between SDOH and health outcomes	Maintain web-based newsletter and on-line social communities.	Community-Based Participatory Approach initiatives are sustained by communities throughout the Commonwealth
Funders will have increased understanding of SDOH and the importance of funding community-based initiatives		

Assumptions

1. Communities will form collaborative partnerships around issues of concern
2. Finding and including community gatekeepers will open the door for successful Community-Based Participatory Approach initiatives
3. Communities have social capital that functions as the spring board for CBPA initiatives

External Factors

1. Policy
2. Money
3. Politics
4. Issues communities perceive as more important than SDOH

Health Equity Awareness and Education						
Goal # 3: Increased health equity awareness and education						
Objective 1: Design/develop initiatives and activities that broaden internal and external understanding and perspectives about the causes and impacts of health inequities in the Commonwealth						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Implement health equity education programs and awareness initiatives	1.1 Publish Health Equity Report	1.1 Health Equity Division Director/Office Director/Division Directors/Communications Specialist/Outreach Coordinator	1.1 Sept 2008	1.1 Pertinent information and data delivered to target audiences	1.1 Report completed, published, and distributed. 1.1.1 Number of new partnerships and/or projects created compiled and tracked.	Quarterly
	1.2 Publish on-line newsletter, *Health Equity Matters* 1.2.1 Send mass e-mail publication notice to stakeholders	1.2. Communications Specialist/Office Director/Division Directors/Outreach Coordinator	1.2 On-going	1.2 Stakeholders access and utilize newsletter and information	1.2 Four publications (quarterly) completed each year 1.2.1 Track web site hits 1.2.2 Track follow-ups to inquiries 1.2.3 Increase number of partnerships and/or projects created	Quarterly
	1.3 Conduct *Heritage Month* Series on health	1.3 Health Equity Specialist/ Health Equity	1.3 On-going	1.3 VDH Health Districts participate in *Heritage Month*	1.3 Health equity education for 75 districts	Quarterly

Health Equity Awareness and Education						
Goal # 3: Increased health equity awareness and education						
Objective 1: Design/develop initiatives and activities that broaden internal and external understanding and perspectives about the causes and impacts of health inequities in the Commonwealth						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
	equity and offer to local health districts throughout the Commonwealth of Virginia	Division Director		*Series* events	1.3.2 Five programs per year with 15 attendees in each program	
	1.4 Develop on-line social outreach strategies, including HE Communities, Blogs, My Space, HE community chats, and monitor activity	1.4 Communications Specialist/Office Director/ Division Directors & Staff/Outreach Coordinator	1.4 October 2008	1.4 Increase capacity to reach stakeholders	1.4 HE community established and monitored	Quarterly
	1.5 Facilitate town meetings/community forums in partnership with targeted organizations	1.5 Health Equity Division Director & Staff/ Office Director/Outreach Coordinator	1.5 On-going	1.5 Increased knowledge and understanding of HE	1.5 Conduct minimum of 3 annual meetings 1.5.2 Follow up of 75% of inquiries 1.5.3 Monitor number of new partnerships and/or projects created as result of the meetings	Quarterly
	1.6 Plan statewide Health Equity Conference	1.6 Health Equity Division Director & Staff/Office	1.6 2009 per availability of funds	1.6 Increase knowledge of health equity and health	1.6 Conference feasibility evaluated	Semi-annually

Health Equity Awareness and Education						
Goal # 3: Increased health equity awareness and education						
Objective 1: Design/develop initiatives and activities that broaden internal and external understanding and perspectives about the causes and impacts of health inequities in the Commonwealth						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
		Director/Division Directors & Staff/Outreach Coordinator/Etc.		equity initiatives in the Commonwealth 1.6.1 Develop partnerships with stakeholders of influence 1.6.2 Set groundwork for statewide health equity initiative		
2. Serve as an information and resource clearinghouse for health equity initiatives	2.1 Develop and update collateral items (printed materials, promotional items, etc.) as necessary to support on-going health equity initiatives and activities	2.1 Communications Specialist/Division Directors & Staff/Outreach Coordinator	Ongoing	2.1 Initiative/ activity appropriate materials available for dissemination	2.1 Internal and external stakeholders use DHE as a resource clearinghouse	Quarterly
	2.2 Maintain and continuously update web-based health equity information and resource center	2.2 Communications Specialist/Office Director/Division Directors & Staff/Outreach Coordinator	2.2 On-going	2.2 Serve as "one-stop" on-line health equity resource for internal and external stakeholders	2.2 Number of monthly inquiries reveal significant usage of site per web trend report data	Quarterly
	2.3 Establish health equity speakers	2.3 Health Equity Division Director &	2.3 2009	2.3 Build stakeholder capacity	2.3 Speakers bureau and mapping	Annually

Health Equity Awareness and Education						
Goal # 3: Increased health equity awareness and education						
Objective 1: Design/develop initiatives and activities that broaden internal and external understanding and perspectives about the causes and impacts of health inequities in the Commonwealth						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
	bureau and mapping services	Staff/Office Director/Division Director & Staff/Outreach Coordinator		to promote health equity	service available in 2009	
3. Develop media strategies to inform the general public about health equity issues	3.1 Develop story ideas to pitch to broadcast/print media; contact key editorial boards for meetings to discuss HE issues; work with VDH PIO's to get stories placed	3.1 Office Director/Health Equity Division Director/Outreach Coordinator	3.1 On-going	3.1 Increased media coverage of health equity issues across the Commonwealth	3.1 Four media exposures/placements annually	Annually

Health Equity & Social Justice Promotion						
Goal 1: All stakeholders involved in the promotion of health equity & social justice						
Objective: Engage marginalized stakeholders participation in the communities defined by HPTA in community based participatory approach to promote HE.						
Sub-Objective	**Activities**	**Lead/support**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Increase stakeholders' understanding of health equity & social justice framework	1.1 Plan & conduct health equity presentations 1.2 Design & implement introductory Train the Trainer programs, utilizing tools such as "Unnatural Causes" series segments	Office Director, DHE Director & all staff	Ongoing	1.1 Increase the awareness about health equity & social justice	1.1 – Conduct 12 presentations annually, including 1 in each health region, targeting 3 high priority target areas (HPTA) (Including 8- Train the Trainers and 4 generic presentations.) 1.2 – Annual stakeholders survey to determine health equity awareness 1.3- Fifty percent of organizations identify and implement a health equity strategic change as result of presentation.	1.1 Quarterly report (Includes presentations # people, topics, responses of audience, next action steps, timeline of activity of organizations, f/u plan.) 1.2 July 2009 1.3 – Quarterly report of follow-up.
2. Increase Community actions in addressing health equity.	2.1. Curriculum and Tool Kit development 2.2 Provide training and technical assistance.	Office Director, DHE Director, Consultant Office Director, DHE Director & all DHE staff	Summer 2008 Ongoing	2.1 Increase community engagement in health equity activities.	2.1– Track 100% of attendees and 25% will report next step actions addressing health equity. 2.2 Provide TA assistance to 10 entities monthly	

OFFICE OF MINORITY HEALTH AND PUBLIC HEALTH POLICY

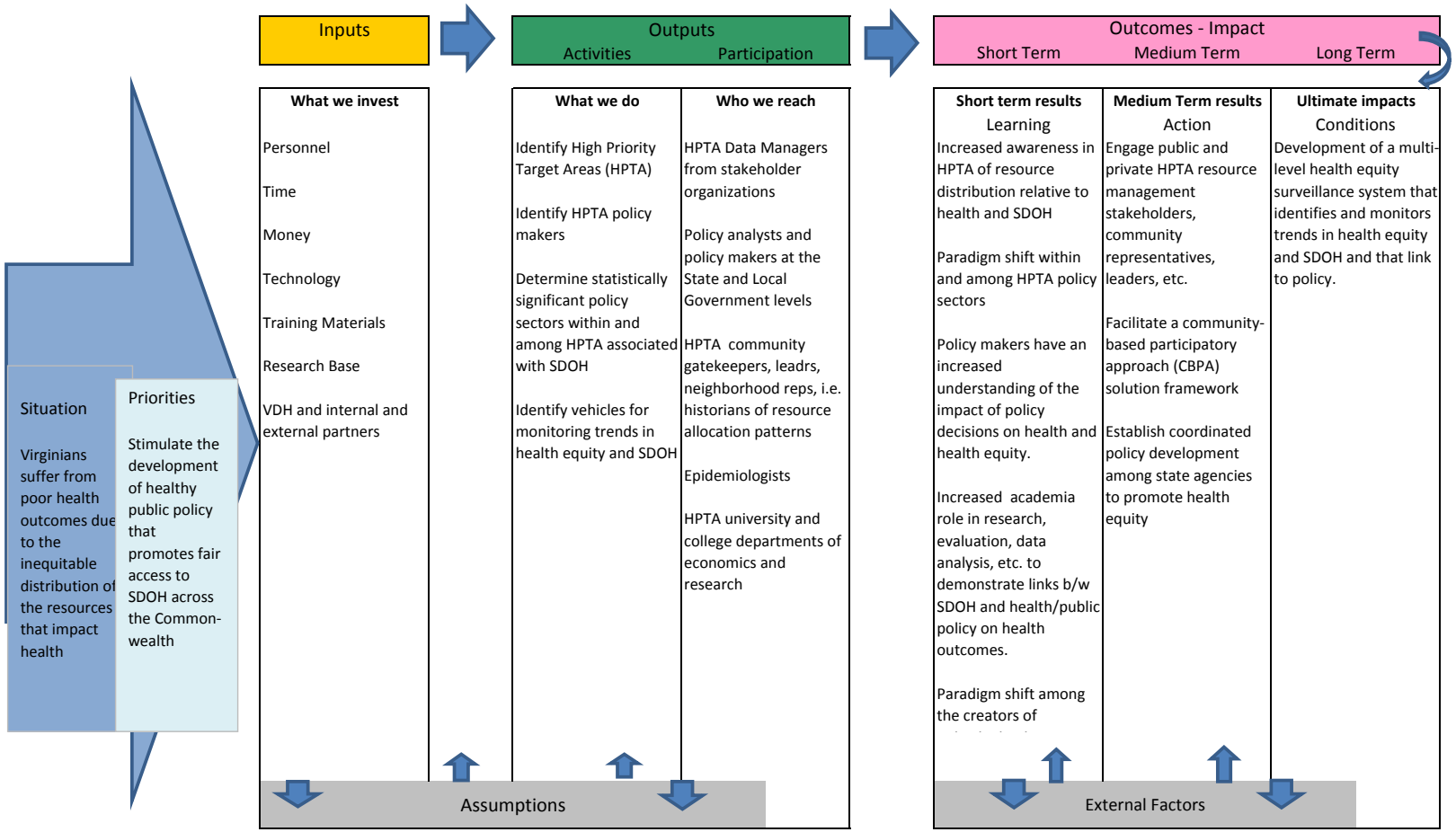
Health Equity Data Analysis

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Health Equity Data Analysis

Program Action - Logic Model



Healthy Public Policy-Data Analysis						
Goal # 4: Healthy public policy that promotes fair access to social determinants of health across the Commonwealth						
Objective 1 : Develop health equity surveillance system to identify and monitor trends in health equity and SDOH and link to policy						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Identify HPTAs based on presence of health inequities and adverse social determinants of health and indicators of medical under service	1.1 Acquire necessary databases for SES, environmental, business, etc. data 1.2 Ongoing analysis of health and SDOH data to determine statistically significant associations within HPTAs 1.3 Determine statistically significant associations between health and SDOH across multiple HPTAs	1.1 Data Mgr.	1.1 Ongoing and updated as new data becomes available and health and demographics change	1.1 All necessary databases obtained 1.2 At least one (1) HPTAs will be identified per month 1.3 SDOH that predict health inequities across multiple HPTAs will be identified	1.1 Databases and their contents catalogued 1.2 HPTAs listed and mapped on website and monthly update sent to Office and Division Directors	Quarterly
2. Determine policy sectors and individual policies related to statistically significant associations b/w health and SDOH within and among HPTAs	2.1 Review and analyze data from Sub-obj 1. 2.2 Engage in discussions with relevant internal and external partners	2.1 Data Mgr./ Office Director/ Division Directors/ Policy Analyst	Ongoing	2.1 Identify policies and sectors relevant to statistically significant associations between health outcomes and SDOHs within and among HPTAs 2.2 Develop partnerships with influential stakeholders	2.1 Report summarizing policies and sectors associated with health inequities	Annually

OFFICE OF MINORITY HEALTH AND PUBLIC HEALTH POLICY

PROGRAM DEVELOPMENT

Planning - Implementation - Evaluation

Health Impact Assessments

Program Action - Logic Model

Situation

Virginians suffer from poor health outcomes du to the inequitable distribution o the resources that impact health

Priorities

Stimulate the development of healthy public policy that promotes fair access to SDOH across the Common-wealth by utilizing the piloting of a Health Impact Assessment during the General Assembly to establish coordinated policy development among state agencies to promote health equity

Inputs

What we invest

Personnel

Interns

Time

Money

Technology

Training Materials

Research Base

Partners

Outputs

Activities

What we do

Identify participants from target communities

Work with community participants to develop methods for accomplishing HIA

Identify policies for HIAs

Identify health effects to be considered

Inform of intent to conduct HIA

Locate review panel of HIA experts

Identify case studies and other reference tools

Track and analyze bill development and implementation through GA

Introduce HIA related bills in 2009 or 2010 session of the GA

Engage stakeholders

Participation

Who we reach

State agency policy makers

Local government policy makers

Health care providers

Patron(s)

Public Health scientific and academic experts

Policy Analysts

Advocates

State and Local stakeholders

Outcomes - Impact

Short Term

Short term results

Learning

Stakeholders will experience increased awareness of how policies affect health outcomes

Policy makers experience increased skills in developing policies that promote health equity

Patron increases awareness and support of the HIA process

Identified experts support the HIA review process

Policy Analysts understand HIA surveillance benefits

Health equity and social justice policy advocates support the HIA process

Stakeholders increase awareness of and support for accomplishing HIAs

Medium Term

Medium Term results

Action

Strategies for policy change identified

HIA procedure manual exists

Agencies evaluate impact of internal policies/procedures on health and health equity

Coordinated policies developed within communities

Develop coordinated policies across multiple high priority target areas (HPTA)

Procedure Manuals are developed

Patrons assist with conducting HIA during the General Assembly

Analysts monitor HIAs

Advocates support HIA and healthy public policy implementation

Evaluators review HIAs

Long Term

Ultimate impacts

Conditions

The impact of SDOH on health and health equity is a priority for federal, state, and local stakeholders

HIAs are are part of the public policy process

A statewide policy surveillance system is in place in the Commonwealth to review all legislation.

Healthy public policy is consistently developed

Assumptions

External Factors

Healthy Public Policy- Health Impact Assessment Workgroup						
Goal #5: Healthy public policy that promotes fair access to social determinants of health across the Commonwealth						
Objective 1: Pilot Health Impact Assessment during General Assembly session						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Conduct HIAs	1.1 Develop procedure for pilot HIAs 1.2 Identify subject matter areas and potential bills for HIA 1.3 Identify published HIAs as potential references 1.4 Have HIA reviewed by experts as time allows	1.1 Office Dir/ Data Mgr/ Div of HE Dir/ Student	1.1 August 2008 thru Dec. 2008	1.1 HIA procedure manual developed. To include potential bills from last GA; example HIAs that may serve as reference for HIAs conducted during 2009 1.2 Two HIAs completed during 2009 GA session	1.1 Manual completed 1.2 HIA reports	Quarterly
2. Increase awareness and support among policy makers for HIA	2.1 Inform patron of intent to conduct HIA 2.2 Educate patron regarding HIA 2.3 Present results of HIA at committee meeting	2.1 Office Dir/ Data Mgr/ Div of HE Dir/ Student	Ongoing	2.1 Patron report increased support for HIA 2.2 HIA results presented during committee meeting 2.3 Committee members report awareness and support for HIA concept	2.1 Pre/post survey of patron 2.2 Post survey of committee members	Annually
3. HIA result will influence decision-making process	3.1 Follow bills through GA	3.1 Student	Ongoing	3.1 GA members report that HIA influenced decision making 3.2 Bill disposition will be aligned with promotion of health equity and social justice for all citizens	3.1 Post survey of committee members	Quarterly

Healthy Public Policy- Health Impact Assessment Workgroup						
Goal #5: Healthy public policy that promotes fair access to social determinants of health across the Commonwealth						
Objective 1: Pilot Health Impact Assessment during General Assembly session						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
4. HIA will be institutionalized into GA process	4.1 Introduce legislation in 2009 or 2010 session to study HIA or require HIA in certain situations 4.2 Introduce legislation in 2009 or 2010 session to incorporate health impact statement into process for developing or changing regulations	4.1 Office Dir/ Data Mgr/ Div of HE Dir/ Student	4.1 Jan. 2009 thru May 2010	4.1 Code will be changed to require Health Impact Statement for new or amended regulations within the Virginia Administrative Code 4.2 HIA will be required for certain bills, budget amendments introduced in GA 4.3 OMHPHP or other entity will be funded to conduct HIAs during each GA session	4.1 Documentation of new code language or study resolution to require HIA and for health impact statement to be included in regulations. 4.2 New funding to support HIA, either within OMHPHP or other entity.	Annually

Healthy Public Policy- Health Impact Assessment Workgroup						
Goal # 5: Healthy public policy that promotes fair access to social determinants of health across the Commonwealth						
Objective 2: Establish coordinated policy development among state agencies to promote health equity						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Increase awareness among state agencies of health equity and SDOH framework	1.1 Orientation to framework using "Unnatural Causes" and other resources 1.2 Present data on health inequities and distribution of SDOH (see Obj. 1)	1.1 Office Director/ Div of HE Director/ Commissioner/ SHHR	1.1 August 2008	1.1 Increased knowledge regarding framework	1.1 Pre/post test	Annually
2. Increase understanding of how public policy influences health	2.1 Present case studies of health inequities and associated policies (see Obj. 1)	2.1 Office Director/ Div of HE Director/ Commissioner/ SHHR	2.1 August 2008	2.1 Increased understanding of how public policy influences health and health equity	2.1 Pre/post test 2.2 Facilitator's impressions regarding workgroup discussion content (does it demonstrate understanding of concepts)	Annually
3. To create systems changes within and among state agencies to facilitate the development of healthy public policy	3.1 Agencies identify internal policies/ procedures that encourage or deter the consideration of health and health equity when public policy is made 3.2 Agencies develop plans to	3.1 Office Director/ Div of HE Director/ Commissioner/ SHHR	3.1 Begin September 2008	3.1 Each state agency identifies 2-3 internal barriers and facilitators 3.2 Each participating agency identifies 2-3 strategies for internal policy change 3.3 Each agency	3.1 Survey agencies during process to identify the barriers and facilitators and strategies they identified. Follow up survey to identify what was implemented and the results	Quarterly

	address those policies/ procedures			implements 1-2 proposed strategies		
4. Coordinated policy development among state agencies to promote health equity	4.1 Identify target communities to pilot multi-agency policy development to promote health equity (see obj. 1) 4.2 Identify cross cutting policy issues for workgroup members to address 4.3 Develop coordinated policies within pilot communities 4.4 Develop coordinated policies addressing SDOH that are associated with health inequities across multiple HPTAs	4.1 Office Director/ Div of HE Director/ Commissioner/ SHHR	Ongoing	4.1 Cross sector policies identified and implemented within pilot communities 4.2 Agencies develop external policies that promote health equity across HPTAs	4.1 Summary report of policies identified and implemented	Annually
5. Proactive development of public policy that promotes health and health equity	5.1 Ongoing meeting and discussion among participating agencies 5.2 Workgroup will identify Code and Regulatory changes necessary to institutionalize development of healthy public policy (incl. HIA- see Obj. 3)	5.1 Office Director/ Div of HE Director/ Commissioner/ SHHR	Ongoing	5.1 2-3 Code or regulatory changes identified by Dec. 2008 5.2 Proposed changes introduced to G.A. in 2009 session 5.3 1 of proposed changes passes in G.A. 5.4 Funding stream established	5.1 Summary report of identified changes and the results 5.2 Committee docket 5.3 Bill signed by Governor	Quarterly

OFFICE OF MINORITY HEALTH AND PUBLIC HEALTH POLICY

PROGRAM DEVELOPMENT
Planning - Implementation - Evaluation

Health Equity Funding

Program Action - Logic Model

Situation

Virginians suffer from poor health outcomes due to the inequitable distribution of the resources that impact health

Priorities

Stimulate the development of healthy public policy that promotes fair access to SDOH across the Common-wealth by increasing funding for health equity initiatives

Inputs	Outputs: Activities	Outputs: Participation
What we invest	**What we do**	**Who we reach**
Personnel		
Time	Identify potential public/private funding sources	Public and private funders
Technology	Apply for grants	State Government
Research base	Propose increase in General Fund for future budget	Academic community
Grant writing skills	Present case studies and other reference tools	Collaborative Partners
Partners		

Assumptions

Outcomes - Impact: Short Term	Outcomes - Impact: Medium Term	Outcomes - Impact: Long Term
Short term results	**Medium Term results**	**Ultimate impacts**
Learning	Action	Conditions
Funders will understand the importance of funding health equity initiatives	State government will assign more general funds to health equity	Funding is available to promote health equity initiates

External Factors

Increased Funds For The Health Equity Initiatives						
Goal #6: Increase fund level to promote of health equity & social justice						
Objective 1: Secure additional funds from various sources to increase personnel and programs						
Sub-objectives	**Activities**	**Lead**	**Begin/End**	**Outcomes**	**Measures**	**Reporting**
1. Increase HE & CLAS grant funds	1.1 Research, identify grants and apply for them	1.1 DHE Director/HE Specialist/CLAS Act	1.1 Apply for 3 grants each year	1.1 Increased capacity to address health inequities.	1.1 Submission of three grants per year	1.1 Quarterly
2. Increase General Fund level	2.1 Work with the Commissioner's office to propose increase the GF in the future budget	2.1 Office Director/DHE Director	2.1 June 2009	2.1 Increased capacity to address health inequities.	2.1 Increase budget by 25%	
3. Identify new funding sources	3.1 Conduct research to identify new public & private fund sources and apply for them	3.1 Office Director/DHE Director/DHE staff	3.1 Weekly basis	3.1 Increased capacity to address health inequities.	3.1 Identify 10 potential sources per year.	Prepare monthly summary report