Appendix A: Organizational Chart

Village of Oak Park
Public Health Department

Organizational Chart

Board of Health
Farmer's Market Commission
Advisory Bodies

Public Health Director

Administrative Assistant

Grant Coordinator (.5)

West Nile Virus Intern (.25)

Public Health Nurse (1)

Sanitarian (2)

Animal Control Officer

Farmer's Market Manager (Contractor)

Assistant (Contractor) (5)

Appendix B: Meeting Minutes

All Stakeholder's Meeting Summary-May 18, 2017

Attendees: Candice Martin, Marta Alvarado, Kelli Bosak, Felicia Owens, Mary Egan, Diane Farina-White, Terry Herbstritt, Bertha Magana, Mike Carmody, Lynn Hopkins, Linda Francis, Jeanne Griffin, Gail Shelton, Laura Olzewski, Carla Sloan, Carey Carlock, Mike Padavic, Elizabeth Stewart, Ed Condon, Carol Gall, Alexis Witkowski, Mike Charley, John Meister, Vanessa Matheny, Rachel Wood, Avis Rudner, Carla Beatrici, Michael Zakalik, Debra Howard-Frye, Gavin Morgan, Carolyn Newberry-Schwartz, Rob Simmons, Marianne Birko, Lucy Flores, Florence Miller, Lori Opiela, Nikki Paplaczyk, Carol Kelly, Maureen McCarthy, Anita Pindiur, Colette Lueck, Christopher Fox, Jim Haptonstahl, Cara Pavlicek, Denise Wienand, Sue Warwik, Shaun Lane, Sue Quinn, Vicki Scaman, Elizabeth Chadri, Kimberly Knake, Rory Conran, Lynda Schueler, Anna Padron-Sikora, Amy Hill, Noreen Powers, Tammie Grossman.

LHF presented an overview of the demographic and health-related data about Oak Park and River Forest presented in the Needs Assessment.

Initial Problems Presented and voted on:
Community Health

- Access to adequate health (and dental) care
- Obesity prevalence (adult and pediatric)
- Diabetes prevalence and mortality
- Cardiovascular disease mortality
- Asthma prevalence
- Access to cancer screenings
- Colorectal cancer mortality
- Low birth weight incidence
- Influenza prevention and mortality
- Linguistically isolated population

Behavioral Health

- Youth alcohol and substance abuse
- Access to mental and behavioral health for all ages
- Access to mental and behavioral health for minority populations

Developmental Disability

- Access to services for persons with DD over the age of 22
- Aging caretakers of persons with DD

Through a system of voting, the following problems were prioritized:

Physical Health
Obesity prevalence (adult and pediatric)
Cardiovascular disease and mortality
Diabetes prevalence and mortality
Chronic Disease
Fragile elderly, some with mental health needs

Mental Health
Youth alcohol and substance abuse
Access to mental and behavioral health for minority populations
Access to mental and behavioral health for all ages
Under addressed Mental and Behavioral Health Conditions
    Factors; insufficient capacity, underutilization, not culturally or linguistically competent
Limited parenting skills/need for parenting support
Overuse of opiates among adults??

Developmental Disability
Aging caregivers of persons with DD
Access to services for persons with DD over the age of 22

Physical Health Meeting #1 Summary- June 6, 2017

Attendees: Rachel Wood, Betsy Rogers, Theresa Havalad, Cynthia Fisch, Florence Miller, Jenny Kraak, Laura Olzewski, Tony Barrett, Cathaleen Roach, John Meister, Laura Palmer, Elizabeth Stewart, Amy O'Rourke, Carol Gall, Avis Rudner, Celeste Duignan, Denise Wienand, Louise Corzine, Maureen McCarthy, Anna Sikora, Lisa DeVivo, Marta Alvarado, Rahel Woldemichael, Mike Charley, Pamela Mahn, Maria Cardenas, Carla Sloan.

Purpose and Desired Outcomes: Confirm physical health priorities and identify risk factors and direct and indirect contributing factors for each priority.

Activities: Facilitators from LHF reviewed the planning process to this point and defined terms. Participants confirmed the physical health problems prioritized at the May meeting and identified risk factors. Breakout groups then worked on developing direct and indirect contributing factors under each risk factor as part of the root cause analysis. Contributing factors with asterisks indicate priority.

Outcomes:

Problem #1: Obesity Prevalence

- **Risk Factor #1A:** Physical Inactivity and sedentary lifestyle
    - Direct Contributing Factor: Access
        - Indirect Contributing Factors
            - Transportation
            - Cost
            - Physical barriers/accessibility (e.g. weather)
            - Awareness*
    - Direct Contributing Factor: Facilities/built environment
        - Indirect Contributing Factors:
            - Awareness*
            - Bike trails/walking paths
            - Time/convenience*
            - Health education
            - Delayed benefits/not instant gratification
            - Targeted classes/programs (older adults)*
            - Misconceptions about ability to exercise
    - Direct Contributing Factor: Prioritization/lack motivation (lifestyle)
        - Indirect Contributing Factors:
            - Awareness*
            - Community support
            - Safety for outdoor exercises*
            - Societal norms (busy)
            - Time management
            - Not motivated until a wake up call
            - Sedentary occupations

        - Reliance on medicine to solve health issues
        - Sleep
- **Risk Factor #1B:** Unhealthy Diet
    - Direct Contributing Factor: Decreased accessibility to food
        - Indirect Contributing Factors:
            - School lunches
            - Food cost*
            - Transportation
            - Lack of food vendors healthy options
    - Direct Contributing Factor: Changes in dietary habits
        - Indirect Contributing Factors:
            - Life changes
            - Mental health issues: stress/depression, trauma
            - Physical changes
            - Medication
            - Taste
    - Direct Contributing Factors: Limited education or lack of generalized education
        - Indirect Contributing Factors:
            - Generational/cultural
            - Social isolation
            - Lack of resources
            - Exposure to healthy foods

Problem #2: Chronic Disease

- **Risk Factor #2A:** Uncontrolled co-morbidities
    - Direct Contributing Factor: Lack of use of/access to primary care
        - Indirect Contributing Factors:
            - Health Literacy issues around insurance*
            - Primary care not a priority (too many other concerns)
            - Need for extended hours at MD offices
            - Lack of knowledge regarding the importance of disease management
    - Direct Contributing Factor: Lack of supportive preventative services
        - Indirect Contributing Factors:
            - Lack of community based health education services
            - Lack of access to free and simple health screenings
            - Lack of resource information upon hospital discharge
            - Lack of list of community resources (even by hospital staff)
    - Direct Contributing Factor: Social Isolation (inability to access resources)
        - Indirect Contributing Factors:
            - High percentage of those with no family/no resources
            - Lack of access to safe public/disability transportation
            - Lack of help with confusing medication and regime
            - Inability to navigate complex healthcare system alone

- **Risk Factor #2B:** Use of an exposure to tobacco products (including exposure to second-hand and third-hand smoke)
    - Direct Contributing Factor: Socioeconomic status, gender, age, educational level
        - Indirect Contributing Factors:
            - Onset age of 1st tobacco use
            - Socioeconomic status
            - Exposure to behaviors (e.g. parent/social network)
    - Direct Contributing Factor: Mental Health
        - Indirect Contributing Factors:
            - Stress
            - Substance use and ending substance abuse
    - Direct Contributing Factor: Access
        - Indirect Contributing Factors:
            - Access to tobacco products*
            - Density of tobacco retailers
            - Enforcement of tobacco policies/laws
            - Youth programming
            - Tobacco advertising (youth-focused)
            - Access to cessation resources*
            - Smoke-free policies

Behavioral Health Meeting #1 Summary-June 7, 2017

Attendees: Molly Reynolds, Maureen McCarthy, Pamela Mahn, Shawn Lome, Christopher Fox, Stephen Jackson, Matthew Quinn, Megan Salisbury, John Meister, Kim Knake, Vicki Scaman, Gail Shelton, Brenda Riarden, Warren Hend, Rachel Wood, Candice Martin, Jennifer Little, Ruth Reko, Amy Starin, Mike Carmody, Anita Pindiur, Florence Miller, Mike Charley, Kelly O'Connor, Lisa DeVivo, Carla Sloan

Purpose and Desired Outcomes: Confirm behavioral health priorities and identify risk factors and direct and indirect contributing factors for each priority.

Activities: Facilitators from LHF reviewed the planning process to this point and defined terms. Participants confirmed the behavioral health problems prioritized at the May meeting and identified risk factors. Breakout groups then worked on developing direct and indirect contributing factors under each risk factor as part of the root cause analysis. Contributing factors with asterisks indicate priority.

Outcomes:

Problem #1: Youth Alcohol and Substance Abuse

- **Risk Factor #1A:** Mental Illness
  - Direct Contributing Factor: Homelessness
    - Indirect Contributing Factors
      - Mix drugs with alcohol
      - Self-medicating
      - Affordable housing
      - Family issues/lack of support
      - Lack of outreach* (alcohol and substance use education)
      - Inadequate Info
  - Direct Contributing Factor: Lack of Access to mental health services
    - Indirect Contributing Factors:
      - Lack of location
      - Lack of assessment
      - Stigma (including where you get services)*
      - Services in schools
      - More case workers
  - Direct Contributing Factor: Toxic Stress, Trauma, society pressures, bullying, pressure for success/meeting expectations.
    - Indirect Contributing Factors:
      - Lack of support* (Lack of parent/family skills/resources)
      - Lack of assessment
      - Peer pressure
      - Cultural Competency training
- **Risk Factor #1B:** Social Norms
  - Direct Contributing Factor: Permissive parent/adult attitudes/behaviors
    - Indirect Contributing Factors:
      - Parent providing*
      - Obtaining without permission

- Social Hosting*
- Parent past use (we drank as teens and turned out fine)*
- Rite of passage
- Lack of understanding of effect on brain development
- Legalization of marijuana (lowered perceived risk)*

- Direct Contributing Factor: Peer influence/acceptance
  - Indirect Contributing Factors:
    - Lack of confidence
    - Peer pressure
    - Wanting acceptance
    - Living up to reputation
    - Legalization of marijuana*
    - Lack of understanding or effect on brain development
- Direct Contributing Factor: Community Culture of Use
  - Indirect Contributing Factors
    - Use at events by adults*
    - Number of bars, pubs, etc.
    - Sending message that its ok to use, youth feel parents think it's ok to use*
    - Not carding

Problem #2: Under-Addressed Mental and Behavioral Health Needs

- **Risk Factor #2A:** Lack of available behavioral health services
  - Direct Contributing Factor: Gaps in the array of services
    - Indirect Contributing Factor:
      - Lack of evidence based services
      - Training for professionals
      - Mentoring
      - Case management/care coordination/outreach
      - Home based services
      - Culturally/ethnically adequate
      - Groups-i.e. anger management and social skills
      - Funding* -Insurance/deductibles/co-pays
      - Capacity*
  - Direct Contributing Factor: Lack of specialty mental health professionals
    - Indirect Contributing Factor:
      - Age specific
      - Racially/culturally/ethnically adequate
      - Infant/Child
      - Psychiatry (child)
      - Funding/deductibles/co-pays, etc.

- **Risk Factor#2B:** Under-utilization of existing behavioral health services
  - Direct Contributing Factor: Lack of knowledge of mental health (signs and symptoms)
    - Indirect Contributing Factors:

      - Signs and symptoms
      - No primary care doctor screenings*
      - Teacher/school education, systems,
      - Parent knowledge/support skills
      - Community Awareness
  - Direct Contributing Factor: Stigma
    - Indirect Contributing Factors
      - History of mental health (how it was dealt with in the past)
      - Self stigma/fear*
      - Media/Social Media
      - Cultural
  - Direct Contributing Factor: Access and Navigating
    - Indirect Contributing Factors
      - Integration of mental health in community settings (schools, senior centers, library, etc.)
      - Cost and Insurance*
      - No wrong door
      - Tech barriers for seniors* (phone, computers, etc.)

Problem #3: Overuse of Opioids

- **Risk Factor #3A:** Availability of opioids
  - Direct Contributing Factor: Availability of prescription opiates
    - Indirect Contributing Factors:
      - Lack of talk
      - Lack of awareness of consequences*
      - Mismanagement of pain
  - Direct Contributing Factor: "Heroin Highway"
    - Indirect Contributing Factors:
      - Inexpensive
      - Proximity
      - Lack of access to treatment*
      - Lack of referral to treatment*
  - Direct Contributing factors: Social Norms
    - Indirect Contributing Factors:
      - Socially acceptable to share prescriptions*
      - It's legal-less stigma
      - Keeping pills in home
      - Lack of knowledge re disposal

Developmental Disabilities Meeting Summary- June 15, 2017

Attendees: James Conyers, Rachel Wood, LaTonya Roberson, Nikki Paplaczyk, Maureen McCarthy, Tony Barrett, Bianca Ingwersen, Bill Wallace, Laura Gonzalez, Jennifer Doyle, Amber Grzeda, Terry Herbstritt, Colleen Madej, Lisa DeVivo, Florence Miller, Shannon Ellison, Diane Farina-White, Mike Charley, Carla Sloan, Mike Carmody

Purpose and Desired Outcomes: Confirm developmental disability health priorities and identify risk factors and direct and indirect contributing factors for each priority. Identify barriers and resources, objectives, corrective actions, and evaluation plan.

Part 1 Activities:

Facilitators from LHF reviewed the planning process to this point and defined terms. Participants confirmed the developmental disability health problems prioritized at the May meeting and identified risk factors. Breakout groups then worked on developing direct and indirect contributing factors under each risk factor as part of the root cause analysis. Contributing factors with asterisks indicate priority.

Part 1 Outcomes:

Problem #1:* *Needs of people with developmental disabilities are under-addressed.

- **Risk Factor #1A:** Limitations of caregivers of people with DD
    - Direct Contributing Factor: Aging
        - Indirect Contributing Factors
            - Lack of support
            - Lack of finances
            - Change in family dynamics
            - Knowledge of resources
            - Qualify for funding
            - Future planning/legal
            - Lack of services
            - Training for caregivers, staffing crisis
    - Direct Contributing Factor: Illness
        - Indirect Contributing Factors:
            - Lack of emergency respite
            - Lack of/inconsistent training of first responders
    - Direct Contributing Factor: Fatigue
        - Indirect Contributing Factors:
            - Lack respite
            - Navigating public benefits
            - Parental involvement/collaboration/trust
            - Lack of case management for adults

- **Risk Factor #1B:** Access to Services for persons with DD ages 22 and up
    - Direct Contributing Factor: Funding
        - Indirect Contributing Factors:

- PUNS
- Employment
- Transportation
- Client openings/staff openings
- Higher needs care

- Direct Contributing Factor: Advocacy and Guidance
  - Indirect Contributing Factors:
    - Up to family
    - Lack of support
    - Denial by family support system
    - Lack the long view
    - Appropriate advocacy
    - Higher needs care
- Direct Contributing Factor: Integration of services
  - Indirect Contributing Factors
    - Collaborative efforts-system
    - Community awareness
    - Cross training of staff

Final prioritized contributing factors:

- Risk Factor: Limitations of caregivers of persons with DD.
  - *Contributing Factor: Lack of family support/training/education*
- Risk Factor: Access to services for people with DD over the age of 22
  - *Contributing Factor: Integration of services (collaboration, cross-training, awareness)*
  - *Contributing Factor: Lack of funding/funding flexibility for higher needs care.*

Part 2 Activities

During a break, participants added to a list of assets and barriers in the community.

Part 2 Outcomes:

Assets:

- Village of Oak Park
- River Forest Township/Mental Health Committee
- River Forest Township
- Community Mental Health Board
- Collaboration for early childhood
- Developmental Disabilities Consortium of OP-RF
- Rotary Club
- WSSRA
- Oak Leyden
- Park District of Oak Park
- Parks and recreation facilities
- Strong leadership at select providers
- 2 universities (under tapped, perhaps)
- Supportive Police Departments
- Strong leadership at the local HS (connect pre-22 to post-22)
- Abundance of local businesses with social awareness
- Active families
- Active non-profit community
- Oak Park-River Forest Community Foundation

- Hephzibah
- Opportunity Knocks
- Sequin
- CSS
- Aspire
- Open minded supportive community
- Oak Park Township
- The Arc
- UCP Seguin
- PACTT

Barriers:

- Cost, scholarship availability
- State funding cuts/inadequate state funding
- Lack of a state budget
- Alignment between programs and needs
- Residential placement opportunities
- Volume of NPOs in the area
- Availability of staff
- General cost of living
- Paratransit
- Developmental level
- Affordability of staff
- Opportunities for community living
- Limited coordination/collaboration between agencies
- Effectiveness of transition planning at HS
- Complicated nature of I/DD benefits (i.e. PUNS, Medicaid, Medicare, HCBS, CILA, SSI, SSDI)
- Stigma
- Correlation between benefits/funding and ability to hold a job with a living wage
- State of Illinois' DT Workshop & day program guidelines

Part 3 Activities

Facilitators from LHF then worked with the group to solicit ideas for an outcome objective, and explained the impact objectives, process objectives, and corrective actions. Breakout groups then completed the objectives grid for each prioritized contributing factor.

Part 3 Outcomes:

Problem 1: Needs of people with developmental disabilities are under-addressed	**Outcome Objective**: By 2030, 95% of Oak Park and River Forest residents with developmental disabilities will have their needs met through seamless, coordinated services between organizations.
Risk Factor 1a: Limitations of caregivers of persons with DD.	**Impact Objective**: By December 2022, 75% of Oak Park River Forest families will be educated on accessing available services.
Contributing Factors: Lack of family support/training/education	**Process Objective:** By December 2020, OP and RF will develop a model to educate families and caregivers-addressing the needs of developmentally disabled individuals.
Corrective Actions: • Host regularly scheduled informational meetings/seminars • Build support group for aging caregivers • Review/revise and put on the website community resource guides • Group respite services • Case management resource to work with families (ensuring they are aware of services and funding opportunities available to them)	

• **Collaborators:** • School districts • Community mental health board • Senior services • DD agencies • Sib shops • Transition planning about adult services • PUNS agency? • Already have a community resource guide • River Forest Township/Mental Health Committee	**Evaluation Plan:** • Baseline of how much training is happening • Measure number of families on respite in terms of caregiver support • Exit interviews and services for transition planning • School can call families up to a year after leaving to see if they have everything they need - can get data on who is and isn't accessing services • Could measure roll out of community resource guide onto other website
Problem 2: Needs of people with developmental disabilities are under-addressed	**Outcome Objective**: By 2030, 95% of Oak Park and River Forest residents with developmental disabilities will have their needs met through seamless, coordinated services between organizations.
Risk Factor 1b: Access to services for people with DD over the age of 22	**Impact Objective**: 90% of all families/adults have access to the services they need no matter what their functioning level.
Contributing Factors: Integration of services (collaboration, cross-training, awareness)	**Process Objective**: Create a tool that will assess the needs of OP and RF that higher level of care than they are currently getting and populate it by March 31, 2018
Corrective Actions: • Evaluate Network of Care-user friendliness and effectiveness to link families and referral sources to appropriate services by Dec 31, 2018. Who: Committee of consortium and parents. • Bring MH/DD providers together-alternating organizations host to educate and discuss specific cases. By Dec 31 2017 have at least 1 meeting and develop annual schedule. • Funding flexibility for case consultation across agencies for specific clients. • Create a focus on collaboration to develop greater knowledge among programs/agencies of each other's services	
Collaborators: • Community Mental Health Board-Be flexible in funding to support different types of things, bring people together • Early Childhood Collaboration - to teach preschool teachers about screening/signs • UCP Seguin • CSS • Opportunity Knocks • Oak-Leyden • River Forest Township/Mental Health Committee, Suburban Access	**Evaluation Plan:** • 90% their needs will be addressed • Of people who screen positive for needing higher level of care via the tool • PUNS list is a good way to measure how many people need services • Number of cross-referrals that agencies make • Number of people that sign up for the police department's bracelet program.

<table>
<tr><td>Problem 3: Needs of people with developmental disabilities are under-addressed</td><td>Outcome Objective: By 2030, 95% of Oak Park and River Forest residents with developmental disabilities will have their needs met through seamless, coordinated services between organizations.</td></tr>
<tr><td>Risk Factor 1c: Access to services for people with DD over the age of 22</td><td>Impact Objective: Continuum of services from early childhood through adulthood.</td></tr>
<tr><td>Contributing Factors: Lack of funding/funding flexibility for higher needs care, including more complex cases and co-morbidities.</td><td>Process Objective: By Dec 31, 2018 conduct assessment of available funds to OP and RF orgs
By 12/31/18 survey DD population over age 22 to understand needs
Build discrepancy reserve (endowment) to support cost of higher needs care.</td></tr>
<tr><td colspan="2">Corrective Actions:
• Coordinate funding across agencies to use funds more efficiently/effectively
• Advocate, lobby, go after more funding
• Assessment of available funding
• Assessment of needs of over 22 DD population</td></tr>
<tr><td>Collaborators:
• Community mental health board
• Agencies that work with people with Development Disabilities
• River Forest Township/Mental Health Committee, Suburban Access</td><td>Evaluation Plan:
• Assess needs
• Assess capacity (funding and providers)
• Assess gaps (cannot supplement Medicaid)
• Develop specialized services at the impact objective level</td></tr>
</table>

Behavioral Health Meeting #2-Summary- June 27, 2017

Attendees: Maureen McCarthy, Sue Warwik, Rachel Wood, Florence Miller, Sandra Montes, Mike Charley, Anita Pindiur, Gail Shelton, Lisa DeVivo, Midge Ruhl, Rob Simmons, Carla Beatrici, Michael Zakalik, Anthony Ambrose, John Meister, Laura Palmer, Christopher Fox, Tom Ebsen, Karen Boozell, Megan Salisbury, Carey Carlock, Pamela Mahn, Matt Quinn, Cara Pavlicek, Vicki Scaman, Kelly O'Connor, Anna Padron Sikora, Gavin Morgan, Candice Martin, Carla Sloan, Avis Rudner

Purpose and Desired Outcomes: Identify barriers and resources, objectives, corrective actions, potential collaborators, and evaluation plan.

Activities:

Facilitators from LHF worked with the group to solicit ideas for an outcome objectives for each problem, and explained the impact objectives, process objectives, and corrective actions. Breakout groups then completed the objectives grid for each prioritized contributing factor.

Outcomes:

Problem 1: Under-Addressed Behavioral Health Needs	**Outcome Objective: 95% of Oak Park and River Forest residents with behavioral health needs will have their needs met by 2030.**
Risk Factor 1a: Under-utilization of existing behavioral health services	**Impact Objective**: • Increase provider screenings by 25% by 2020 in non-traditional settings such as schools, primary care, and emergency departments. • Increase provider collaboration (inter-agency referrals) by 2020, as reported by utilization from Network of Care site
Contributing Factors: • Difficulty navigating the behavioral health system (especially for seniors) • Lack of screening in point-of-entry settings (primary care, ER staff, etc.)	**Process Objective:** • Research gap analysis to determine barriers to screenings • Find appropriate tools (common, community-wide, OP/RF) or standardized package • Develop application for funds to pay for real time capacity of area mental health providers
Strategies: • Parent education • Provider trainings-identify barriers • Determine point-of-entry • Community Awareness-Holistic wellness (not stigmatized) • Additional utilization of Network or Care	
Collaborators: • Primary care • Schools • Hospitals • Existing mental health agencies • Faith-based organizations	**Evaluation Plan:** • Use CMHB data-number of successful linkages to care • Use Network of care for agencies to populate real time numbers for capacity and service provision

• Agencies focused on vulnerable populations (e.g. homeless, etc.) • Township Senior Services • First Responders (police, fire, paramedics)	
Risk Factor 1b: Lack of available behavioral health services	**Impact Objective**: • Increase funding to existing agencies • Increase psycho-educational groups • More focused funding to existing agencies • Partnerships
Contributing Factors: • Funding gaps (types of services and providers) and cost of services • Inadequate diversity of providers and cultural competency training • Capacity/provider shortage	**Process Objective**: • MD collaborations with mental health professionals • Cultural competency trainings for staff within each agency, use train the trainer model. Could use Social workers/care coordinators as trainers • Partner with universities to address capacity/provider shortages.
Corrective Actions: • Loan repayment: $ for year of service, partnership with National Healthcare Service Corps (NHSC) • Incentives for licensure, leadership, job diversity via partnerships • More trainees, students, interns	
Collaborators: • Physicians, Nurses, Advance Practice Providers • Agencies • Social Workers • Care Coordinators • Organizations that train on cultural competency • PCC Wellness training on sexual orientation • Universities	**Evaluation Plan:** • Track number of people trained in cultural competency-aim to increase • Measure if things change at an agency level after these trainings

Problem 2: Youth Alcohol and Substance Abuse	**Outcome Objective: Reduce underage drinking and substance use to consistently below state average by 2030.**
Risk Factor 2a: Social Norms	**Impact Objective:** By 2030: • Increase perception of harm • Reduce perception of peer use • Reduce perception of "coolness" according to IYS data 2016
Contributing Factors:	**Process Objective:** • Meet campaign goals (from IYS)

<table>
<tr><td>• Parent support and education (attitudes, behaviors, coping mechanisms, etc.)
• Lower perceived risk of marijuana for a variety of reasons</td><td>• Number of different messages for communication
• # of people reached via campaigns
• Hold 5 Parent Cafes by…
• Day in Our Village</td></tr>
<tr><td colspan="2">Strategies:
• Communication campaigns (adults, parents, youth) i.e. Parent educational forums, timely events (prom, graduation, etc.)
• Community policy and education</td></tr>
<tr><td>Collaborators:
• Schools
• Parents
• NAMI (for education)
• Success of all youth community foundation
• Churches and faith communities,
• IMPACT Coalition
• YMCA
• Liquor Boards
• I-Search (RF)
• Police/Villages
• Townships
• Other leaders (Kiwanis, Rotary, etc.)
• Positive Youth Workgroup (prevention grant for underage alcohol use)</td><td>Evaluation Plan:
• Number of people attending education sessions, parent cafes, etc.
• Number of people reached through campaigns
• Number of NAMI presentations
• All evidence-based curriculum
• Pre and post tests</td></tr>
<tr><td>Risk Factor 2b: Lack of mental wellness</td><td>Impact Objective:
By 2020:
• Increase education of mental health symptoms and risk factors
• Increase awareness and knowledge of services and resources
• Identify underserved populations</td></tr>
<tr><td>Contributing Factors:
• Stigma
• Lack of outreach and awareness of support services to specific youth populations</td><td>Process Objective:
• Create culturally competent programs, number of classes and individuals served
• Increase number of community partners across sectors
• Conduct market research to identify appropriate paths of communication and reach underserved populations
• Focus groups</td></tr>
<tr><td colspan="2">Strategies:
• Prevention education, including parental involvement
• Social Norms campaign
• Resource fairs, parent forums
• Education related to effective parenting</td></tr>
</table>

<table>
<tr><td>Collaborators:
Schools
Parents
NAMI
Faith-based communities
Oak Park Community Mental Health Board
River Forest Township/Mental health committee
Mental health agencies</td><td>Evaluation Plan:</td></tr>
</table>

<table>
<tr><th>Problem 3: Illicit Opioid Abuse</th><th>Outcome Objective: Maintain or reduce OP and RF resident opioid use levels by 2030 (using 2016 baseline data)</th></tr>
<tr><td>Risk Factor:
Availability of illicit opioids</td><td>Impact Objective:
By 2022 establish reporting systems for illicit opioid availability within OP and RF.</td></tr>
<tr><td>Contributing Factors:
Awareness (of consequences, of not sharing prescriptions, treatment options)</td><td>Process Objective:
By 2020, develop coordinated communication campaign on opioids overuse with all OP/RF agencies to address contributing factors</td></tr>
<tr><td colspan="2">Strategies:
Identify and collect data on opioid overdose
Data sharing agreement with hospitals/state
Education about safe disposal
Advocate for adopting CDC guidelines for opioid prescriptions
Coordinated referral/treatment</td></tr>
<tr><td>Collaborators:
Hospitals
Village and township
Police and Fire Dept.
Treatment providers
First responders
Hospital ER
High schools and school districts
Positive Youth Workgroup (if comprehensive Substance prevention grant awarded)
IMPACT
Faith-based communities</td><td>Evaluation Plan:
IDPH-syndromic surveillance data from hospitals
Emergency overdose data from Fire Dept.-providing monthly reports
Uniform Crime Data reporting, for minors there are limitations-mostly aggregate data.
Work with someone who understands data for surveillance data-capstone projects with UIC, Dominican Social work.
Focus on overdoses by residents</td></tr>
</table>

Identify Assets and Barriers

During a break, participants added to a list of assets and barriers in the community.

Outcomes:

Assets:

- Local schools/universities
- Library
- Way Back Inn
- NAMI
- Riveredge Hospital
- Pillars
- West Cook YMCA
- Thrive
- SmartLove
- Doctors/Hospitals
- Parent Groups
- Suicide Prevention Education Task Force
- Community of Churches
- CIT Training
- Oak Park Community Mental Health Board
- Thresholds
- Park Districts
- Police/Fire
- Community Policing
- School Resource Officers
- Network of Care
- Oak Park-River Forest Community Foundation
- Presence Health
- Rosecrance
- New Moms
- PCC Community Wellness (primary care, BH, and Psych)
- Housing Forward
- Mental Health First Aid Trainer
- River Forest Township/ Mental Health Committee

Barriers:

- Permissive Community Norms
- Education
- Lack of Community Mental Health Center (facility)
- Avoiding blame
- Lack of technology to access information
- Avoidance/defensiveness
- Lack of awareness of resources
- Closures and decrease in community mental health and psychiatrists
- Services for all, regardless of race, ethnicity, poverty, religion, intact family, etc.
- Access from affluence
- Transportation-accessibility
- Understanding current provider availability
- Lack of prevention/early intervention in middle/high schools
- Stigma
- Competing agendas
- Lack of psychiatrists willing to treat those with Medicaid
- Access to meds

Physical Health Meeting #2 Summary-June 28, 2017

Attendees: Rachel Wood, Theresa Havalad, Mike Charley, Carla Sloan, Maureen McCarthy, Ed Condon, Cathleen Roach, Pamela Mahn, Florence Miller, Kiran Joshi, Bertha Magana, Amy O'Rourke, Denise Wienand, Elizabeth Chadri, Anna Padron Sikora, Mike Carmody

Purpose and Desired Outcomes: Identify barriers and resources, objectives, corrective actions, potential collaborators, and evaluation plan.

Activities:

Facilitators from LHF worked with the group to solicit ideas for an outcome objectives for each problem, and explained the impact objectives, process objectives, and corrective actions. Breakout groups then completed the objectives grid for each prioritized contributing factor.

Outcomes:

Problem 1: Obesity Prevalence	**Outcome Objective: By 2030, the Oak Park and River Forest child and adult obesity rates will be below Healthy People 2030 goals.**
Risk Factor 1a: Physical Inactivity and sedentary lifestyle	**Impact Objective*:** • X # of participants participate in summer fit tracking program (similar to library summer reading program) • Identify those that are homebound, and modify exercises for them
Contributing Factors: • Awareness of importance of physical activity • Convenience/ease of physical activity (classes, outdoor safety, etc.)	**Process Objective*:** • Outreach classes geared toward seniors/offices/ moms (agencies could take turns) • Exercise based with leave-behinds for folks to continue on their own • Passport program
Strategies: • Develop a method of sharing opportunities • Walking/biking groups • Exercise program similar to Summer reading program	
Collaborators: • Hephzibah • YMCA • New Moms Club • Chamber (employee wellness)-yearly health fair • OP Township Senior Services • Assisted Care Facilities • Park Districts • River Forest Community Center	**Evaluation Plan:** • Number of classes offered • Participation rates • Evaluate classes based on age and other categories • Could get private health club data? • Evaluate path and resources for River Forest engagement

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- Early Childhood Collaboration
- Township Senior Services

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<tr><td>***Risk Factor 1b:*** Unhealthy diets</td><td>

Impact Objective:
- By 2021 increase the number of servings of fruits and vegetables as measured by: Community survey, IYS, and the Nutrition Risk Assessment (seniors)

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Contributing Factors:
- Increased accessibility of nutritious foods (cost, availability)
- Changes in dietary habits (due to mental health, physical changes, medications, etc.)

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Process Objective:
By 2019 expand outreach by 25% by:
- Improving/implementing data collection for OP and RF schools,
- Increase collaboration with partner organizations for education/programming for vulnerable populations

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Strategies:
- Fruit of the week tasting
- Community garden
- Workplace wellness policies and practices
- Linkage and coordination between community-based organizations
- River Forest Farmers Market
- Early childhood education-get parents involved as well
- Possible adoption/implementation of CDC's Whole School/Whole Community/Whole Child model
- Subsidize vending machines for health options

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Collaborators:
- Early Childhood Education
- Farmer's Markets
- Senior Services
- Schools
- River Forest schools-data collection
- Villages
- Township Senior Services

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Evaluation Plan:
- River Forest-obesity data collection
- Evaluate path and resources for River Forest engagement

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<tr><td>**Problem 2: Chronic Disease**</td><td>**Outcome Objective: By 2030, mortality rates for diabetes, cardiovascular disease, breast cancer, cervical cancer, colorectal cancer, and pediatric asthma hospitalizations will be reduced to below Health People 2030 goals.**</td></tr>
<tr><td>***Risk Factor 2a***: Exposure to tobacco products (including 2nd and 3rd hand smoke)</td><td>

Impact Objective: By 2030:
- By December 2022, decrease youth and adult tobacco use by 10% as measured by IYS, BRFSS data, and informed by a community survey.
- By December 2022, decrease the use of e-cigarettes among youth and adults by 10% as measured by IYS.

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<tr><td>Contributing Factors:
Mental Health (stress, substance use and ending substance use)
Access (limit access to tobacco, increase access to cessation resources)</td><td>Process Objective:
By 2019, organizations will be trained to provide easily accessible cessation programs with implementation in both Oak Park and River Forest
By 2019 communication strategies will be developed to address tobacco use and smoke-free policies</td></tr>
<tr><td colspan="2">Strategies:
Advocate for smoke-free multi-family housing
Active enforcement of tobacco sales laws/ordinances
Advocate for stronger state-level legislation regarding purchase age, smoke free environments, and local authority to tax tobacco products
Point-of-Sale strategies (flavored tobacco restrictions, restrictions on price discounting, etc.)
Develop partnerships with retailers to explore voluntary sales restrictions to young adults
Expand cessation programs through funding and access</td></tr>
<tr><td>Collaborators:
Illinois Tobacco Free Communities (IDPH)
Illinois Coalition Against Tobacco (ICAT) partners (RHA, ACS, AHA, ALA, AAP)
Multi-family properties
Researchers
Schools
Villages
Townships</td><td>Evaluation Plan:
Illinois Youth Survey Data
Village of Oak Park Multi-family Housing Smoke-Free Data
School Discharge Data
Evaluate path and resources for River Forest engagement</td></tr>
<tr><td>Risk Factor 2b: Un-controlled co-morbidities</td><td>Impact Objective:
By 2021 increase screening for breast, cervical and colorectal cancer by 5%
By 2021, increase diabetes screening by 5%
By 2021, decrease number of kids sent home from school and emergency calls related to asthma by 5%</td></tr>
<tr><td>Contributing Factors:
Lack of knowledge regarding system navigation (health literacy, insurance and community resources)
Lack of knowledge of impo0rtance of primary care and disease self-management</td><td>Process Objective:
By December 2018, develop online resource directory related to chronic disease/primary care/ cancer screening and prevention education.
By December 2019 hold 8 education programs regarding the management of chronic disease
By Fall 2019, develop and implement asthma education program for school faculty and staff in elementary, junior high and high school (goal-reach 90% of faculty/staff)</td></tr>
<tr><td colspan="2">Strategies:
Online resource directory
education programs
asthma education program for faculty and staff, reach 90% of faculty and staff</td></tr>
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• Staff and faculty required to be trained in asthma evaluate with pre and post tests	
Collaborators: • Hospitals • Primary care • Community organizations • EMS • Orgs that hold events or fairs would have someone there that talks about prevention • Park district	**Evaluation Plan:** • Collaborators will determine a way to measure progress for screenings for Oak Park and River Forest • Evaluate CDC prevalence data for diabetes, using existing 2013 data as a baseline. • Pre and post tests for asthma education program • Evaluate path and resources for River Forest engagement

Identify Assets and Barriers

Assets

- Park District fitness classes
- Oak Park Public Health Department
- Rush Oak Park Hospital
- West Suburban Hospital
- YMCA
- Strong Schools
- Tobacco 21 policy
- Township Senior Services
- Faith-based organizations and churches
- Concordia
- Dominican
- Village policies/ordinances
- Respiratory Health Association
- River Forest Community Center

Barriers:

- Turnover
- Inequitable conditions for residents
- DHS application and processing process
- Available data sources for benchmarking
- Community Resources/Collaboration

Appendix C: Community Health Committee Stakeholders List

The following individuals participated in the All Stakeholder and/or Committee meetings:

- Alexis Witkowski, OP and RF Infant Welfare Society aka "Children's Clinic"
- Amber Grzeda, UCP Seguin
- Amy Hill, OPRFHS D200
- Amy O'Rourke, Respiratory Health Association
- Anita Pindiur, The Way Back Inn
- Anna Padron Sikora, Pillars
- Village of Oak Park Police Department
- Avis Rudner, River Forest Township
- Bertha Magana, Oak-Leyden Developmental Services
- Betsy Rogers, Housing Forward
- Bianca Ingwersen, Oak Park Township
- Bill Wallace, Thrive Counseling Center
- Candice Martin, TASC
- Cara Pavlicek, Village of Oak Park
- Carey Carlock, River Edge Hospital
- Carla Beatrici, Smart Love
- Carla Sloan, River Forest Township
- Carol Gall, Sarah's Inn
- Carol Kelley, School District 97
- Carolyn Newberry-Schwartz, Collaboration for Early Childhood
- Cathleen Roach, River Forest Township
- Celeste Duignan, Oak Park Township
- Christopher Fox, Thrive Counseling Center
- Colette Lueck, JCMHP
- Colleen Madej , PACTT Learning Center
- Cynthia Fisch, Rush Oak Park Hospital
- Debra Howard-Frye, Thresholds
- Denise Wienand, Rush Oak Park Hospital
- Diane Farina-White, Community Support Services
- Kimberly Knake, NAMI
- Kiran Joshi, Cook County Dept of Public Health
- LaTonya Roberson, UCP Seguin
- Laura Gonzalez, UCP Seguin
- Laura Olszewski, West Cook YMCA
- Laura Palmer, Thrive Counseling Center
- Linda Francis, Success of All Youth (Foundation)
- Lisa DeVivo, Oak Park Community Mental Health Board
- Lori Opiela, UCP Seguin
- Louise Corzine, Arbor West Neighbors
- Lucy Flores, PCC Wellness Center
- Lynda Schueler, Housing Forward
- Lynn Hopkins, PCC Wellness Center
- Maria Cardenas, Chicago Health Medical Group
- Marianne Birko, West Suburban Special Recreation Association
- Marta Alvarado, Westlake Hospital
- Mary Egan, Rosecrance
- Matt Quinn, Rosecrance
- Maureen McCarthy, Oak Park Park District
- Megan Salisbury, Oak Park Township Senior Services
- Michael Zakalik, Smart Love
- Midge Ruhl, Oak Park Community Mental Health Board
- Mike Carmody, Opportunity Knocks
- Mike Charley, Oak Park Public Health Department
- Mike Padavic, School District 97
- Nikki Paplaczyk, MENTA
- Noreen Powers, Trinity High School
- Pamela Mahn, Oak Park Township Senior Services
- Rachel Wood, Oak-Leyden Developmental Services

- Ed Condon, School District 90 (River Forest) and OP and RF Rotary
- Elizabeth Chadri, Oak Park-River Forest Community Foundation
- Elizabeth Stewart, Pillars
- Felicia Owens, Smart Love
- Florence Miller, Oak Park Board of Health
- Gail Shelton, Parenthesis Family Center
- Gavin Morgan, Oak Park Township
- James Conyers, Oak-Leyden Developmental Services
- Jeanne Griffin, West Suburban Medical Center
- Jennifer Doyle, Riverdale
- Jenny Kraak, West Cook YMCA
- Jim Haptonstahl, UCP Seguin
- John Meister, Thrive Counseling Center
- Karen Boozell, District 90 Director of Special Education
- Kelli Bosak, PCC Wellness Center
- Kelly O'Connor, IMPACT
- Rahel Woldemichael, Village of Oak Park
- Rob Simmons, Oak Park Public Library
- Rory Conran, MENTA
- Sandra Montes, PCC Wellness Center
- Shannon Ellison, Collaboration for Early Childhood
- Shaun Lane, Hephzibah
- Sue Quinn, River Forest Public Library
- Sue Warwik, Presence Health
- Tammie Grossman, Village of Oak Park
- Terry Herbstritt, PACTT
- Theresa Havalad, Rush Oak Park Hospital
- Tom Ebsen, Village of Oak Park Fire Dept
- Tony Barrett, Oak-Leyden Developmental Services
- Vanessa Matheny, Oak Park Community Mental Health Board
- Vicki Scaman, Oak Park Township

Appendix D: Initial List of Problems from Data

Initial List of 15 Identified Health Problems

Community Health

- Access to adequate health (and dental) care
- Obesity prevalence (adult and pediatric)
- Diabetes prevalence and mortality
- Cardiovascular disease mortality
- Asthma prevalence
- Access to cancer screenings
- Colorectal cancer mortality
- Low birth weight incidence
- Influenza prevention and mortality
- Linguistically isolated population

Behavioral Health

- Youth alcohol and substance abuse
- Access to mental and behavioral health for all ages
- Access to mental and behavioral health for minority populations

Developmental Disability

- Access to services for persons with DD over the age of 22
- Aging caretakers of persons with DD

Appendix E: Organizational Capacity Assessment: Analysis of Organizational Strengths

ANALYSIS OF ORGANIZATIONAL STRENGTHS WORKSHEET

Indicators	Defnitition of Stregth & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
I. Indicators for Authority to Operate		
A. Legal Authority		
1. The Health Department has clear authority to act as a law enforcement office for public health problems.	Authority identified in VOP municipal code (20-1-6), by state statutes for local certified health departments.	
2. The Health Department has authority to develop and introduce local regulations when needed.	Authority identified in VOP municipal code (20-1-6), by state statutes for local certified health departments.	
5. The health department exercises authorities delegated to it by the state or federal government.	Authority by state statutes; Identified also in LHP grant rules. Grant Agreements	
B. Intergovernmental Relations		
2. At least biennially, the health department reviews and discusses its formal relationship with the state health authority to identify problems, propose solutions and look for areas for further improvement.	The Health Department maintains approximately 8 State of Illinois grants that are reviewed annually.	
4. Units of government within the jurisdiction of the health department are represented on a committee, subcommittee or other body advisory to the local health department.	On the positive note, we have a BOH. The BOH will occassionally invite other government and other public health organizations to participate in BOH meetings. The Health Department has also been invited to participate in YMCA strategic planning and to work on the Townships Strategic planning team for reducing youth alcohol consumption. In addition, the Health Department invites all community stakeholders into their IPLAN process as stakeholders. The stakeholders do serve in an advisory capacity to the Health Department.	
5. The health department is regularly consulted by the local elected officials about aspects of local policy related to health issues.	The HD has been consulted in the past on beekeeping; H1H1 policy; the impact of handguns; West Nile prevention. Staff sit on the PRT and BIC.	
7. The director or a representative communicates appropriately and regularly with the Village Board who represent the Village the health department serves.	The director meets with the Village Board when necessary.	
8. The health department is regularly consulted by the local schools when setting health policy.	The HD has been consulted on H1N1; communicable disease; substance abuse prevention; pregnancy prevention; and food protection.	

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
9. The health department has a formal and productive working relationship with the state health authority.	We are a delegate agency for CD, Food, Childhood Lead, Body Art, etc. The HD receive s grant funding for LHP, ITFC, FCM, TPP, WNV; Body Art; Tanning. Regularly consults on STD; Lead' air quality; vector control	
C. Legal Counsel		
1. The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies and procedures; relevant laws and ordinances; contracts; and other legal matters.	Legal staff assist with agreements and contracts; changes in Village code including bees, Animal Control; Environmental health fees; isolation and quarantine; adjudication; citations; fines' FOIA requests; consultations on local ordinance violations	
2. The health department maintains a current file or library of all relevant federal, state and local statutes and regulations.	The HD has access to the VOP code; LHP grant rules; Administrative rules for LHDs; State Food Code; CD Rules and Regs; Lead Poisoning Act & Code; Body Art Codes; Animal Control and Animal Welfare Act, Day Care Licensing Standards.	
3. At least biennially, the director and the management staff of the health department review with legal counsel the specific authorities of the department to operate public health programs and to enforce public health laws, ordinances and regulations; as well as the specific responsibilities in these entail	Ordinances should be reviewed and if applicable updated.	
b. The director and management staff of the health department continuously maintain documentation of the scope of the department's powers to adopt its own regulations and the specific responsibilities these entail.	This is primarily a Law Department function.	
II. Indicators for Community Relations		
A. Constituency Development		
1. The health department has a system that actively involves individuals and groups affected by its planning of services, its methods of service delivery and its service results.	IPLAN, BOH, more collaboration between IPLAN meetings	
2. At least every five years, the health department actively involves all key individuals and organizations within its jurisdiction that might be engaged in public health related activities to determine their goals and perceptions of their roles, authorities and needs including:	IPLAN process, every 5 years	
a. Units of local government with authority within the jurisdiction of the health department, including the governmental unit from which the department derives its basic authority.	Invited are the Board of Trustees; Commission members; Village Manager's Office; OP Township; Schools; Parks.	

Indicators	Defnitition of Stregth & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
b. The general public of the community, at least through some form of community health committee or representation on an advisory board	Board of Health	
c. Interest groups, such as environmental protection and conservation groups, local business organizations, the local medical and dental societies, religious organizations, an other key organizations in the community.	Invited religious community to partcipate in IPLAN. Regularly interact with churches with Emergency Preparedness.	
d. Representatives from hospitals, community centers, the Visiting Nurse Association, and other health and human service agencies.	IPLAN process, every 5 years	
e. Educational Institutions, such as university schools of public health, medicine and nursing; colleges private schools, and local school districts.	IPLAN process, every 5 years	
3. The health department cooperates and collaborates with other community agencies that have similar or overlapping missions.	Collaborated on most recent IPLAN with Mental Health Board of Oak Park Township & River Forest Mental Health Committee. Collaborating with CCDPH and IPHI on WNV, CD; NIPHC on Emergency response and CD Control; PCC on health services; CEDA WIC with FCM; Township Senior Services', Thrive Mental Health Center, Collaboration for Early Childhood.	
4. The health department cooperates and collaborates with other agencies that deliver similar programs in the same service area.	Collaborated on most recent IPLAN with Mental Health Board of Oak Park Township & River Forest Mental Health Committee. Collaborating with CCDPH and IPHI on WNV, CD; NIPHC on Emergency response and CD Control; PCC on health services; CEDA WIC with FCM; Township Senior Services', Thrive Mental Health Center, Collaboration for Early Childhood.	
5. The health department has formed a citizens' or community committee or has established another formal method of involving the people it serves in the identification of community health problems and the development of a community health plan.	IPLAN Stakeholder Committee	
6. The health department has established mechanisms to guide and ensure active and cooperative relationships with community and professional groups	Emailed 'health alerts' to MD community, Infection Control; Schools and social service agencies.	
7. Health department staff are aware of relevant programs, policies and priorities of the federal Department of Health and Human Services (HHS), Environmental Protection Agency (EPA) and other federal agencies.	The health department regularly reviews federal codes and rules as they pertain to the Village of Oak Park.	
8. The health department has a physician health officer, medical adviser or consultant to assist in maintaining relationships with the private medical community.	Dr. Luning, PCC Wellness Center, Medical Director.	
B. Constituency Education		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
1. The health department has a documented plan for informing the public above the current health status of the community	Programmatic: WNV; Foodborne Illness communication plans. Also, the Health Department web page; FYI, print and online; Press releases, as needed; I-PLAN and annual reports posted on the website.	
2. The local media looks to the health department as a source of information about the health of the community.	Regularly contacted by the Wednesday Journal and Oak Leaves.	
3. The health department regularly provides background information and news information to the media.	Information posted on website	
5. Professional staff members of the health department participate in or serve on councils, boards or committees of public-health-related organizations at the state of local level.	IEHA, Interact with IDPH, IDHS, Cook County monthly meetings.	
6. The health department has current mailing list (no older than 1 year) of the directors, chairs and other officials of all citizen groups, service organizations, health care professional organizations, business groups and other community groups in its jurisdiction.	Mailing lists are managed and updated by the Emergency Response Manager	
7. The health department has a means of regular public communication, such as regular newsletter of column in a community newspaper.	Through Village vehicles including the FYI, website, Breaking News, E-News	
8. The health department makes its own information systems and databases available to interested community groups for their health-related activities.	I-PLAN and annual reports are on-line. HD has responded to citizens requests for information, directly.	
9. The health department has an established program for community volunteers and student interns in department programs.	Health Department hires Environmental Health Intern annually. In past has hosted nursing students. Students regularly attend BOH meetings.	
10. The health department widely disseminates reports regarding public health issues to the community.	The Health Department disseminates information WNV, Rabies/Dog Bites, emergency preparedness.	
C. Documentation		
1. The health department maintains files documenting relations and communications with other organizations related to public health.	Blast emails to MDs; recalls; all are archived.	
2. The health department maintains current information on the needs of health-related organizations.	IPLAN process encourages participation from all health-related organizations and encourages them to share their needs for IPLAN priority setting.	
3. In all cases in which a potential duplication of significant public health activities might exist between the health department and another local organization the director has established a written agreement with the executive officer or board of that organization clarifying functional relationships and identifying areas of collaboration.	We have an agreement with the Collaboration for Early Childhood with the Family Case Management Program (case referrals). The health department doesn't duplicate servcies with other agencies.	
III. Indicators for Community Health Assessment		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
A. Mission & Role		
1. The health department has a clear and concrete mission statement that all staff are capable of stating and explaining in relation to duties.	Statement is written and has been posted.	
2. The health department has established a process for community health assessment and the development of a community health plan.	IPLAN process	
3. At least every five years, the health department conducts a public review and discussion of its mission and role, its public health goals, its accomplishments, past activities, and plans in relation to community health.	IPLAN process, annual budget document, planning for grants	
4. At least every two years, the health department formally requests all units of government within its jurisdiction to comment on the department's programs, plan and budget.	Units of local government perceived as other Village Departments and Grantors	
6. The health department maintains a current description (no older than two years) of the public health services, programs, and authorities of the Village.	Budget document	
B. Data Collection and Analysis		
1. The health department maintains a database of existing health resources and community health status.	IPLAN, other databases, information on website	
2. The health department receives reports of communicable disease in the community on a daily basis.	I-NEDDS, directly from W. Suburban and OP Hospital and physicians, HIV/Syphilis through confidential US Mail.	
3. The health department has qualified professionals to review and analyze reported morbidity and mortality data.	CD Nurse, Health Director, Paul Luning, M.D. consultant for the Village	
4. Morbidity and mortality data are reviewed and analyzed for appropriate action on a regular schedule.	Every 5 years through the IPLAN process	
6. The health department conducts appropriate statistical analysis of birth and death records and reports these results to the policy board, staff and community on a regular basis.	IPLAN is only time we would look at this information.	
7. The health department conducts or support periodic risk factor surveys to identify community risk factors, their prevalence and interrelationships.	IPLAN Community Survey	
C. Resource Assessment		
1. The health department has joint powers agreements with other units of government in neighboring jurisdictions or within its own jurisdiction of the shared funding and operation of enforcement and service delivery programs where economies of scale and efficiency are possible.	State Delegate and grant agreements, Indirectly Fire and Police (Emergency Preparedness) with other municipalities.	
2. The health department maintains a current roster of qualified health professionals employed by units of government within its jurisdiction for reference in the development of technical study groups, activities, related to professional development, ant other personnel-related purposes.	The Health Department has a list of current qualified personnel. IPLAN.	

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
3. The health department participates in joint efforts to pool training needs with neighboring health agencies.	Partnership with Collaboration for Early Childhood. Routinely provide referrals to other health-related organizations in Oak Park.	
4. The health department has agreements with health related organizations operating programs within hits jurisdiction for sharing staff expertise.	State delegate and grant agreements	
5. The health department annually compiles or updates a listing of health-related information systems and database maintained by community organizations that operate within its jurisdiction.	Really only our databases apply	
6. The health department has an established program for the development of in-kind contributions from private industry, private not-for-profit organizations, churches and other community organizations.	Emergency Response Manager has agreements for us of space from local organizations.	
D. Planning and Development		
1. The health department has staff with education and experience in planning and evaluation.	Health Director & Support Staff	
2. The health department uses health data, including vital records, in its community health planning process.	IPLAN process every 5 years and as needed	
3. The health department has standard, ongoing process to examine internal and external trends, to make forecasts and to systematically develop long term plans for its future.	The Village budget process and the I-PLAN process.	
4. The health department has a published strategic plan that includes the current year.	The Village budget process and the I-PLAN process.	
E. Evaluation and Assurance		
1. The health department monitors program impact indicators on a regular basis.	The Health Department collects data from all programs and evaluates program data at least monthly.	
2. The health department has community health objectives that are timed, limited and measurable.	IPLAN Process includes measurable strategies and goals.	
3. The health department reviews and revises community health programs on the basis of the community health plan.	The Health Department will take the lead on priority areas where Village resources make the Health Department the lead agency. On other issues such as mental health and developmental disabilities the Health Department collaborates with outside organizations.	
IV. Indicators for Public Policy Development		
A. Community Health Assessment and Planning		
1. The health department director assures and facilitates the completion of a community health assessment process.	The IPLAN every 5 years	
2. The health department and the community identify and set priorities for addressing health problems based on the results of the community health assessment.	The IPLAN every 5 years	

Indicators	Defnitition of Stregth & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
3. The health department and the community develop a community health plan based on the results of the community health assessment and priority-setting processes.	The IPLAN every 5 years	
4. The health department director and the community involve the policy board in the review and revision, if necessary, of the proposed community health plan.	Board of Health reviews and approves IPLAN. BOH Chair participates in the stakeholder meetings portion of the IPLAN process.	
5. The policy board adopts the community health plan	Board of Health reviews and approves IPLAN. BOH Chair participates in the stakeholder meetings portion of the IPLAN process.	
6. The policy board acts as an advocate on behalf of the health department for allocation of resources needed to implement the community health plan.	Board of Health reviews and approves IPLAN. BOH Chair participates in the stakeholder meetings portion of the IPLAN process.	
7. The policy board monitors the implementation of the community health plan.	The Health Department works collaboratively with the Policy Board. The Director must identify Health Department resource needs and clearly communicate those needs using the IPLAN as a tool. The BOH approves the IPLAN.	
B. Community Health Policy		
1. The policy board obtains information from an established citizens' advisory group and from the health department regarding public policy issues affecting the public.	The Board of Health advises on the Board of Trustees on bees; WNV issues; handgun laws, emergency preparedness.	
2. The policy board identifies any additional public polity issues affecting public health and analyzes those issues.	Village Board of Trustees and the Board of Health analyze public policy issues affecting public health.	
3. The policy board establishes priorities and formulates strategies for action on high priority health policy issues.	Village Board of Trustees and the Board of Health analyze public policy issues affecting public health.	
4. The health department facilitates the formulation of public health policy in the community.	The IPLAN conducted every five years formulates health policy, as well as day-to-day/month-to-month needs of the Village as identified by Staff, the Village Board and the Board of Health.	
5. The policy board and the health department director monitor and evaluate the impact of public policy on specific health concerns	The IPLAN conducted every five years formulates health policy, as well as day-to-day/month-to-month needs of the Village as identified by Staff, the Village Board and the Board of Health.	
6. The policy board advocates changes in public policy to correct the public health problems in the community.	The IPLAN conducted every five years formulates health policy, as well as day-to-day/month-to-month needs of the Village as identified by Staff, the Village Board and the Board of Health.	
C. Public Health Policy and Public Health Issues		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
1. The local governmental unit collaborates with the policy board and the health department director in developing public polity which may impact public health.	The IPLAN conducted every five years formulates health policy, as well as day-to-day/month-to-month needs of the Village as identified by Staff, the Village Board and the Board of Health.	
2. The elected officials at the local level actively solicit the opinions of the professional staff and/or health department director on scientific issues in policy development.	The IPLAN conducted every five years formulates health policy, as well as day-to-day/month-to-month needs of the Village as identified by Staff, the Village Board and the Board of Health.	
V. Indicators for Assurance of Public Health Services		
A. Public Policy Implementation		
1. The policy board uses its authority to assure necessary services to reach agreed upon goals for its constituents.	Village Board reviews and approves Health Department budget annually.	
2. The policy board assists the health department in utilizing all resources in the community to assure the desired services for all its citizens.	The BOH routinely invites outside organizations to BOH meetings. Village Board approves Health budget and set's policy.	
4. The health department assures and implements legislative mandates and statutory responsibilities.	Services are provided directly or through agreements with vendors/grantors; follow the certified local health department grant rules.	
5. The health department maintains a level of service without interruption to avoid crises affecting the health of the community.	Staff are on-call and available to respond to emergencies 24 hours/day.	
B. Personal Health Services		
2. The health department seeks to assure that all citizens receive the level of personal health services referred to in B1 above, regardless of their ability to pay.	The HD assists residents with enrollment in Healthcare; All Kids; Family Case Management; WIC. Refers to PCC; Children's Clinic; refer parents and children to Collaboration for Early Childhood.	
4. The health department provides the services necessary to assure a clean, safe and secure environment in the community.	Food protection, CD Surveillance. Childhood Lead - We do these programs well.	
C. Involvement of Community in the Public Health Delivery System		
3. The policy board and the health department director assure health protection and health promotion services utilizing community-based organizations.	The HD assists residents with enrollment in Healthcare; All Kids; Family Case Management; WIC. Refers to PCC; Children's Clinic; refer parents and children to Collaboration for Early Childhood.	
VI. Indicators for Financial Management		
A. Budget Development and Authorization		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
1. A department budget is adopted annually by the policy board.	The Village has an annual budget process. The Health Department works closely with a centralized Finance Department when preparing and submitting the annual budget which includes General Fund, Grant and Farmers' Market expenditures and revenue	
2. A budget accurately reflects the priorities established in the organizational action plan.	The Village has an annual budget process. The Health Department works closely with a centralized Finance Department when preparing and submitting the annual budget which includes General Fund, Grant and Farmers' Market expenditures and revenue	
3. Budget justifications reflect health department programs and health problems within its jurisdictions.	The Health Department provides for the core programs for a certified health department. Additional grant funded programs are also provided. The Village Manager and Village Board review and approve all Health Department budget expenditures	
4. Professional or community groups help the health department present and justify its budget.	Through the IPLAN process, partnerships with outside organizations such as PCC, IDPH, Cook County, IDHS	
5. Health department management staff are involved in developing the proposed budget.	The Village has an annual budget process. The Health Department works closely with a centralized Finance Department when preparing and submitting the annual budget which includes General Fund, Grant and Farmers' Market expenditures and revenue	
6. The health department receives locally assessed tax funds from the unit of government to which it is responsible.	The Village has an annual budget process. The Health Department works closely with a centralized Finance Department when preparing and submitting the annual budget which includes General Fund, Grant and Farmers' Market expenditures and revenue	
7. The health department has the authority to recommend and charge fees for the services it provides.	The Village has an annual budget process. The Health Department works closely with a centralized Finance Department when preparing and submitting the annual budget which includes General Fund, Grant and Farmers' Market expenditures and revenue	
8. The health department has an adequate contingency fund for dealing with public health emergencies.	The Village supports the Health Department through tax dollars. The Health Department has grants with State agencies that may be used in times of emergencies (PHEP, CRI-Ebola)	
B. Financial Planning and Financial Resource Development		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
1. The health department has a predictable source of funds to allow the development and implementation of a long range plan (minimum 5 years).	General Fund monies for core PH programs. Food protection, rats, animal control, farmers' market	
2. The health department has a financial management capacity that provides for securing funding for, or the orderly phasing out of, discretionary programs, for which funds are not available.		
4. The health department maintains or has access to a foundation directory and other information about sources of public and private funding for public health activities.	State grant program databases	
5. The health department has a current description of state and federal funding sources available to it and to organizations within its jurisdiction.	The health department can access lists of grants through government websites.	
7. The health department has staff skilled in writing successful grant applications.	The Health Director, Emergency Preparedness Coordinator and Grant Coordinator.	
C. Financial Reporting and Financial Management		
1. Expenditures follow the budget and financial plan of the health department.	The Health Department has access to BS&A and keeps a shadow system to track expenditures and revenues for both the general fund and grants.	
2. A description of the health department financial management system is a part of orientation for new policy board members.	The Village Board is responsible for all budgeting review and approval.	
3. Financial reports are understood by polity board members and administrative and supervisory staff.	Staff receive regular financial reports and have a good relationship with the Finance Department	
4. The financial position of the health department is routinely reviewed by the policy board and the administrative and supervisory staff.	A Finance Committee of the Village Board regularly reviews the financial position of all departments	
5. An administrative officer or finance director is designated by the policy board to oversee all finances of the health department, including meeting all legal financial documents, adherence to department fiscal policies, and reporting to the policy board regular on financial matters.	The Finance Director oversees all finances	
6. The policy board and staff understand their legal accountability and liability, as well as their general responsibility to the public for wise financial management.	The Village is required to issue annually a report of its financial position and activity presented in conformance with generally-accepted accounting principles (GAAP) and audited in accordance with generally accepted auditing standards by an independent firm of certified public accountants (CPA).	
D. Audit		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
1. The health department has an independent, outside, annual financial and performance audit which conforms with the requirements stipulated by the general accounting principles.	The Village is required to issue annually a report of its financial position and activity presented in conformance with generally-accepted accounting principles (GAAP) and audited in accordance with generally accepted auditing standards by an independent firm of certified public accountants (CPA).	
2. The annual audit is reviewed and clearly understood by the policy board and key department staff.	The audits are reviewed by the Village Board of Trustees, the Finance Director and is available for review by the Director and Grants Coordinator.	
E. Documentation		
1. A written standard budget development and review procedure is authorized by the policy board, and is available to staff and the public.	The health department must follow clear rules and procedures with developing and submitting a budget.	
2. Appropriate journals, ledgers, registers and financial reports are kept, using generally accepted accounting procedures.	The Finance and Health Department utilize generally Accepted accounting procedures.	
3. Copies of the health department annual financial audit area available to policy board members, department staff and the public.	The audits are reviewed by the Village Board of Trustees, the Finance Director and is available for review by the Director and Grants Coordinator.	
4. A written procedure for participating in state and federal grants, and public and private foundation funding awards, is authorized by the policy board and available to department staff and the public.	The Health Department follows the written procedures from grantors' Notice of Funding Opportunities and application directions. Grant application and execution is authorized by the Village Board of Trustees.	
VII. Indicators for Personnel Management		
A. Policy Development and Authorization		
1. A written job description, including minimum qualifications, exists for each position in the health department.	Human Resources has job descriptions on file.	
2. Written personnel policies and procedures are developed or revised with staff input.	The Village has written personnel policies.	
3. Personnel recruitment, selection and appointment procedures are documented	The Human Resources Department maintains records.	
5. if labor unions represent department staff, there is an established working relationship and labor contract between the health department policy board and each respective labor union.	SEIU union agreement with Village. Four health department staff are SEIU members.	
6. Both the policy board and senior management of the health department have input into any labor union contract negotiations.	The Board of Trustees and senior management are able to provide input into contract negotiations.	

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
7. There is a documented procedure, authorized by the policy board and developed with input from senior management of the health department and staff where appropriate, for employee grievances, reprimands, suspensions and dismissals.	Disciplinary procedures are documented in the SEIU Agreement and the VOP Personnel handbook	
8. There is a documented, structured salary administration plan that is authorized by the policy board and that is designed to attract and retain competent staff.	There is a plan in place that is managed by Human Resources and the Finance Departments.	
B. Personnel Administration and Reporting		
1. The health department director is responsible for internal administration of the department.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
3. Written staff performance appraisals area conducted by supervisors with employees at established intervals.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
4. The performance appraisal system is monitored by the health department director.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
5. Union contract provisions are administered in a well-coordinated manner with documented provisions for non-union employees.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
6. Health department announcements and program information are distributed to all employees via a standard mechanism.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
7. There are regularly scheduled meeting by work group, work site, division and department.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
9. the health department director selects qualified individuals as staff for the department.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
10. The health department provides appropriate credentialed for all personnel records.	The Health Department follows the policy and procedures of the Village's Human Resources in selecting and evaluating staff and in managing personnel records.	
C. Staffing Plan and Development		
1. Staffing patterns and levels match policy board authorized programs and services and current levels of demand for services.	Staffing id determined by the Director based upon programmatic needs.	
2. The health department has a written plan or policy regarding staff recruitment, selection, development and retention.	Human Resources.	

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
3. All employees have structured, routine, group opportunities to discuss program methods and procedures, current levels of demand for services, and quality of work issues with their respective supervisors.	The Director meets with staff regularly.	
4. The health department staff have access to training provided by the state health authority in areas relevant to local health departments.	Health department staff participate in state training regularly.	
5. The health department has access to staff development resources of a school of public health or of other relevant educational institutions.	Health will contact local universities when positions open up. Health markets open positions to universities.	
6. The health department has clearly expressed its staff development needs to school of public health or to other educational institutions.	Health will contact local universities when positions open up. Health markets open positions to universities.	
7. The health department uses volunteers to support programs where possible, and manages its volunteer program through clearly defined policies and procedures.	Medical Reserve Corp, CERT Team, Board of Health	
8. There are adequate provisions for liability insurance protection for the department board members, staff and volunteers.	Law Department, VMO maintain provisions for insurance	
9. The health department has documented staff development program, monitored by the department director, which includes employee-supervisor annual plan development and cost projections with routine review and update.	We can work on this more. Strategic planning with staff.	
11. The health department encourages and supports staff participation in professional organizations.	Staff participate in the Illinois Environmental Health Association, Illinois Public Health Association, Northern Illinois Public Health Consortium, National Association of City and County Health Professionals, National Environmental Health Association	
12. The health department staffing plan includes provisions for "backup staff" to enable critical scheduled operations to continue without interruption when temporary vacancies occur.	The Health Department has staffing plans.	
13. The health department has the ability to fill new and vacant positions in a timely manner.	HR Function working with health department	
10. The health department personnel administration system and personnel policies and procedures are reviewed with each new policy board member and department staff member.	SEIU agreement, Personnel Policies, IT PoliciesHR, VMO, IT and Health	
D. Personnel Policy and Procedure Audit		
1. A periodic personnel administration audit is performed by a department team to determine if authorized personnel policies and procedures are being followed.	Annual Appraisals, Grant deliverables, Review of monthly/annual employee stats	
E. Documentation		
1. There is a standard, written description of the health department personnel management system which is available to policy board members, department staff and the public.	Personnel Manual, SEIU Agreement	

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
2. All personnel transactions are documented.	Human Resources working with Health Department	
3. An up-to-date coordinated, structured and confidential file is maintained for every employee and volunteer.	Human Resources function	
4. All job descriptions, policies and procedures are consolidated and available to policy board members, department staff and the public.	Human Resources function	
5. All recruitment, selection, appointment and applicant grievance procedures are available in writing to policy board members, department staff and the public.	Human Resources function	
6. The salary administration plan is written and available to policy board members, department staff and the public.	Human Resources function	
VIII. Indicators for Program Management		
A. Organizational Structure		
1. Operating programs are authorized by the policy board.	The Village Board of Trustees reviews the Health Department Budget annually.	
3. There is a current organizational chart which shows all functional elements of the organization and their relationship to each other.	We have a current organizational chart within the Village budget.	
4. Staff meetings are held at reasonable frequencies, include appropriate staff, and are called and structured by appropriate individuals.	Department staff meetings are held at least monthly.	
5. The health department maintains emergency contact staff (on site or on call) to respond to local public health emergencies.	The Village and Health Department maintain emergency contact for all staff. Staff are available 24 hours per day 7 days per week.	
B. Evaluation		
1. The health department collects and regularly analyzes information describing program administration and funding, program activities, workload, client characteristics and services cots needed to evaluate the process of program activities.	Each Division prepares monthly statistical data and a summary is prepared for the Board of Health and the Village Manager's Office, monthly.	
2. The health department collects and regularly analyzes information that is needed to evaluate the impact and outcome of program activities on risk factors and health status.	Done on a regular basis utilizing objective and qualitative data.	
3. Program objectives are time limited and measurable.	Programs have been eliminated and/or expanded based on IPLAN and routine monitoring of the Health Department programs.	
4. Operating programs are reviewed or reviewed on a regular periodic scheduled.	Programs have been eliminated and/or expanded based on IPLAN and routine monitoring of the Health Department programs.	
C. General Information Systems		

Indicators	Defnitition of Strength & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
1. The health department has a management information system that allows the analysis of administrative, demographic, epidemiologic and utilization data to provide information for planning, administration and evaluation.	The health department has numerous datasets both internal and external to manage data. The health department uses web-based systems managed by state agencies including childhood lead, FCM, Provide project, INEDDS, etc.	
2. The health department has a plan for the introduction and/or expansion of computer based systems.	The Health Department works collaboratively with the IT Department.	
3. The health department has a technical library of books and other publications relevant to its public health activities for immediate reference by its staff, and a method for keeping materials current.	The Health Department maintains public health publications, however the health department has utilized the web to access current publications available to the health department.	
4. The health department subscribes to an on-line computer-based data system that provides direct access to health-related data or that has direct access to public health and population data compiled by state agencies.	The state of Illinois publishes PH Data on their websites. Health-related data is also available on the CDC website and Healthily People 2020, among others.	
5. The health department subscribes to an on-line computer-based data system that provides direct access to health-related data or that has direct access to public health and population data compiled by state agencies.	I-Plan Data System, Stellar, INEDDS, etc.	
6. The health department maintains current information on federal data bases and information systems relevant to its programs.	We don't maintain any information on Federal Databases	
D. Shared Resources		
2. The health department participates in shared service or purchase agreements where volume purchasing can reduce costs, such as for printing, supplies, and other materials.	Flu vaccine, don't have many opportunities for this.	
IX. Indicators for Policy Board Procedures		
1. Health department policy board members attend policy board and committee meetings.	There are monthly Board of Health meetings. BOH members attend Village Trustee meetings as necessary.	
2. New policy board members routinely receive orientation through an established and documented orientation program of the health department.	Clerk's office and Citizens Involvement Commission provide orientation.	
3. Policy board meetings are scheduled on a regular basis, with sufficient frequency to ensure board control and direction of the health department.	Village Board. BOH is an Advisory board only.	
4. Policy board materials, including agenda and study documents, are mailed to members no less than three days in advance of board meetings.	Documents are emailed to BOH members, VMO, Clerk's Office. Documents posted at Village Hall and on Village website.	
5. Policy board meetings deal primarily with policy determination, review of plans, making board authorizations and evaluating the work of the health department.	Village Board.	

Indicators	Defnitition of Stregth & Related Factors	Action Priority
	Briefly state any strengths suggested by the scoring of the indicators & describe the sources of each strength. Listing of resources.	I=Top II=Middle III=Lowest
6. There are written board and administrative policies consistent with the Mission Statement.	Village Board had goals, objectives and mission. Community Involvement Commission policies for all Boards and Commissions.	
7. The health department publishes the schedule of regular policy board meetings in local news media.	BOH on website, posted at Village Hall	
8. Minutes of board and committee meetings are written and circulated to board members and the health department staff and are available to the public.	Documents are emailed to BOH members, VMO, Clerk's Office. Documents posted at Village Hall and on Village website.	

Appendix F: Organizational Capacity Assessment: Analysis of Weaknesses/Problems

ANALYSIS OF ORGANIZATIONAL PROBLEMS/WEAKNESSES WORKSHEET

Indicators	Definition of Strength & Related Factors	Action Priority
	Briefly state any weaknesses suggested by the scoring of the indicators & briefly describe the sources of each weakness/problem, list barriers to the solution of each problem	I=Top II=Middle III=Lowest

II. Indicators for Community Relations		
A. Constituency Development		
9. The health department has established relationships with a university school of public health, medicine or nursing or with other educational institutions within or near its jurisdiction for staff development, internships, consultation, and other capacity-building purposes.	Have relationships for EH, we can build collaboration with the PH Nursing schools.	III
B. Constituency Education		
4. At least once a year, the director or a representative of the director meets with representatives of health related community organizations to define inter-organizational roles and responsibilities.	The Health Director meets regularly with some organizations, but not all.	II
III. Indicators for Community Health Assessment		
A. Mission & Role		
5. The health department has an uses a prepared presentation for informing the community and community groups of its role and authority in relation to the communities health.	Must update this presentation after new IPLAN process is complete.	II
V. Indicators for Assurance of Public Health Services		
A. Public Policy Implementation		
3. The health department assures or provides direct services for priority health needs identified in the community health assessment.	The health department provides direct services with Food Protection, CD, rats, public health nuisances and animal control. There are priorities identified within the IPLAN where the health department does not provide direct service through the Health Department, but will work with external partnering organizations to assure services are provided in some form or fashion.	II
VI. Indicators for Financial Management		

B. Financial Planning and Financial Resource Development		
3. The health department has a diverse funding base to lessen disruption of services caused by withdrawal of these funds.	Funds rely heavily on the local tax base. Currently, the Department receives approximately $275,000 in budget reimbursed by grant funding from Cook County, IDHS & IDPH. The Department continually seeks additional sources of outside revenue.	I

Appendix G: Organizational Capacity Assessment: Organizational Action Plan Worksheets

Organizational Action Plan Worksheet

Develop an action plan for each of the top priority problem areas (weaknesses) identified on the Analysis of Organizational Problems Worksheet. Initially, address the top priorities weaknesses only.

Problem Area: Contituency Development **APEXPH Indicator Reference No: II-A-9**

The health department has established relationships with a university school of public health, medicine or nursing or with other educational institutions within or near its jurisdiction for staff development, internships, consultation, and other capacity-building purposes.

Goals and Objectives *Define the goals and objectives for the problem area indicated above.*	**Responsibilities and Methods** *For each goal or objective indicate: 1) What individual or work team is rsponsible and 2) what methods wil be used and 3) when it will be accomplished.*
Goal: Creat a stronger relationship with local universities and public health education programs by December 31, 2018.	1) Health Director, public health nurse and if applicable health educator position to contact all local universities to stregthen relationships by December 31, 2018.
Objective: A new process will be established so that the health department regularly interacts with public health professionals at local univerisities.	2) Health Director to meet with staff to create a reasonable plan with existing staffing limitations. Schedule first meeting by July 1, 2018.

Evaluation Date: July 25, 2017

Organizational Action Plan Worksheet

Develop an action plan for each of the top priority problem areas (weaknesses) identified on the Analysis of Organizational Problems Worksheet. Initially, address the top priorities weaknesses only.

Problem Area: Constituency Education **APEXPH Indicator Reference No: II-B-4**

At least once a year, the director or a representative of the director meets with representatives of health related community organizations to define inter-organizational roles and responsibilities.

Goals and Objectives *Define the goals and objectives for the problem area indicated above.*	**Responsibilities and Methods** *For each goal or objective indicate: 1) What individual or work team is rsponsible and 2) what methods wil be used and 3) when it will be accomplished.*
Goal: Create a stronger working relationship with Oak Park public health organizations by December 31, 2018	1) Health Director and if applicable health educator position to reach out to all public health partners in Oak Park and inform each organization of interest in their work by December 31, 2018.
Objective: 1) Health Director to meet with health department staff to identify all public health partners by December 31, 2018. Objective: 2) Health Director to create a working group of local public health professional organizations and/or identify existing meetings to participate in.	2) Health director or appointed liaison to attend organizations' meetings by December 31, 2018.

Evaluation Date: July 25, 2017

Organizational Action Plan Worksheet

Develop an action plan for each of the top priority problem areas (weaknesses) identified on the Analysis of Organizational Problems Worksheet. Initially, address the top priorities weaknesses only.

Problem Area: **Mission &Role** **APEXPH Indicator Reference No:** **III-A-5**

The health department has an uses a prepared presentation for informing the community and community groups of its role and authority in relation to the communities health.

Goals and Objectives *Define the goals and objectives for the problem area indicated above.*	**Responsibilities and Methods** *For each goal or objective indicate: 1) What individual or work team is rsponsible and 2) what methods wil be used and 3) when it will be accomplished.*
Goal: Create a health role presentation for future use with community meetings by December 31, 2018. Objective: 1) Create a public health presentation and identify stakeholders in community for presentation.	1) Public Health Director to work with Health staff to draft and finalize a presentation that will not only communicate health department role, but cater to identified audience by December 31, 2018.

Evaluation Date: July 25, 2017

Organizational Action Plan Worksheet

Develop an action plan for each of the top priority problem areas (weaknesses) identified on the Analysis of Organizational Problems Worksheet. Initially, address the top priorities weaknesses only.

Problem Area: Public Policy Implementation **APEXPH Indicator Reference No: V-A-3**

The health department assures or provides direct services for priority health needs identified in the community health assessment.

Goals and Objectives *Define the goals and objectives for the problem area indicated above.*	**Responsibilities and Methods** *For each goal or objective indicate: 1) What individual or work team is rsponsible and 2) what methods wil be used and 3) when it will be accomplished.*
Goal: The Health Department will take a more active role in ensuring IPLAN priorities, strategies and objectives are completed through collaboration with partnering agencies by 2020.	1) Health Director to work with staff and outside Oak Park organizations to meet IPLAN goals and objective by 2022.
Objective: Identify stakeholders that have resources and expertise to assure priority needs of IPLAN priority health needs are addressed in the community. Objectives to be met by December 31, 2018.	2) Director or appointed staff to contact stakeholders identified in IPLAN and arrange meetings to meet IPLAN priority objectives by December 31, 2018.

Evaluation Date: July 25, 2017

Organizational Action Plan Worksheet

Develop an action plan for each of the top priority problem areas (weaknesses) identified on the Analysis of Organizational Problems Worksheet. Initially, address the top priorities weaknesses only.

Problem Area: Financial Planning & Financial Resource Development

APEXPH Indicator Reference No: VI-B-3

The health department has a diverse funding base to lessen disruption of services caused by withdrawal of these funds.

Goals and Objectives *Define the goals and objectives for the problem area indicated above.*	**Responsibilities and Methods** *For each goal or objective indicate: 1) What individual or work team is rsponsible and 2) what methods wil be used and 3) when it will be accomplished.*
Goal: Continue to seek out grant funding opportunities. Continuous. Objective: Identify new grant opportunities to support existing core programs and ensure that current grant deliverables are met so that grant funding continues for existing grants.	1) Director, Grant Coordinator and other Health staff to continually seek out grant funding opportunities to support existing core programs. Continuous

Evaluation Date: July 25, 2017

Appendix H: Community Mental Health Board of Oak Park: Strategic Plan

Goal 1: Address under-utilization of existing behavioral health services in order to meet the behavioral health needs of Oak Park residents

Objective 1.1: Increase provider collaboration (inter-agency referrals) by 2020, as reported by utilization from Network of Care site.

ACTION STEPS:

- By December of 2018, secure funding and identify a system to show real-time capacity of existing mental health providers
- By December of 2019, develop a system to show real-time capacity of existing mental health providers.
- Conduct parent education, senior education, and other education to raise community awareness and destigmatize behavioral health services.
- Collaborate more effectively with local hospitals, agencies and associations (e.g. Alzheimer's Association) to bring their prevention and support programs to targeted populations.
- Provide education and outreach to caregiver support groups and systems
- Partner more effectively with local hospitals, agencies and associations to bring their existing programs and services to targeted populations.
- Collaborate with 1st responders to promote ID program for those with behavioral health needs and dementia

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2021

POTENTIAL AGENCIES RESPONSIBLE:

- Community Mental Health Board to take the lead
- River Forest Township
- Network of Care
- Referrers:
  - Medical partners such as West Lake, West Suburban, Rush Oak Park, Loyola, Lake Street Physicians, etc.
  - Schools: D97 and D200
  - Residents
- Sources to which to refer: all funded agencies and referral sources (which would be responsible for getting the data to the system)

MEASURES:

- Develop at least two new mental health community partners (including that for dementia) by December 2018.
- Develop real-time NOC capacity to identify where people can be referred for services and have operational by December of 2019.
- Pilot and do coordinated community education/awareness by December 2020.
- By December 2020, establish baseline data on successful linkages to care.
- By December 2021, demonstrate decrease in wait times and/or increase in linkages to care over baseline.

Objective 1.2: Increase provider screenings by 25% by 2020 in non traditional settings such as schools, primary care, emergency departments, and interactions with first responders.

ACTION STEPS:
- Identify point-of-entry settings to target
- Conduct a gap analysis to identify barriers to screening
- Find appropriate screening tools and develop a standardized approach to screening in these settings
- Offering provider trainings on this approach
- Increase mental health training for first responders, including that for dementia and suicide prevention
- Increase transportation options for target groups such as seniors seeking screening, prevention and treatment

TIMELINE:
Start date: October 1, 2017
Establish baseline data and identify point-of-entry settings to target by April 2018
Begin providing mental health training for first responders by December 2019
Completion date: December 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:
- Managed care agencies
- Village of Oak Park + River Forest Township+ Oak Park Township
- Police and other first responders
- West Lake and West Suburban hospitals
- Schools: D97 and D200
- Other primary care partners such as Rush Oak Park, Loyola, Lake Street Physicians
- Senior Services
- YMCA
- Walgreens clinics and other urgent care/minute clinic settings
  Public awareness groups to be held by non-traditional partners like Park District, Thrive, PCC Wellness, etc.

MEASURES:
- Establish baseline level of screenings in specific settings (e.g. hospitals, hospital-affiliated/employed primary care practices, school districts) by April 1, 2018.
- By December 2018, research gap analysis to determine barriers to screenings.
- By December 2019, find appropriate tools (common, community-wide, OP/RF) or standardized package.
- Provide mental health training (including that for dementia and suicide prevention) for 100% of 1st responders by December 2019.
- Collaborate with 1st responders to more effectively identify those with behavioral health needs and dementia, to increase safety and referrals, by December 2019.
- Develop at least one new transportation program for a target groups seeking screening, prevention and treatment, by December 2018.
- By December 2019, hold community wellness series with different agencies and non-traditional providers for community awareness/education. (e.g., stress, anxiety, depression, suicide)

Goal 2: Address lack of available behavioral health services in order to meet the behavioral health needs of Oak Park residents

Objective 2.1: By December 2020, increase focused funding to gap areas including coordination of care, universal screening, and parenting services.

ACTION STEPS:
- Conduct gap analysis of continuum of services to identify holes by July 1, 2018.
- Prioritize funding strategies to address gap areas by October 1, 2018.
- Fund according to focused funding priorities by April 1, 2019.
- Bring more behavioral health students, nurses, trainees, and providers into the community by developing partnerships with universities.
- Introduce loan repayment options like the National Healthcare Service Corps (NHSC).
- Develop other incentives for licensure, leadership, job diversity via partnerships.

TIMELINE:
Start date: January 1, 2018
Completion date: March 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:
- CMHB-OP to lead/spearhead
- Village of Oak Park + River Forest Township+ Oak Park Township
- Oak Park River Forest Community Foundation- Success of All Youth
- Funders Collaboration
- Hospitals
- Universities (Dominican, etc.)

MEASURES:
- Include gaps as funding priorities in FY 2020 application process.
- By December 2019, establish at least one partnership with universities to address capacity/provider shortages.

Objective 2.2: By 2020, increase inter-agency partnerships by 10% (Continuum of Care, share client records, etc.)

ACTION STEPS:

- Collect baseline on existing coordinated care partnerships in community (e.g. PCC Wellness and River Edge psychiatry partnering with behavioral health service partners; YEMBA and BUILD mentoring partnership, TASC Care Coordination and D97 partnership, etc.)
- Encourage providers to share client records, engage in care coordination/linkage
- Implement physician collaborations with mental health professionals.
- Use a train-the-trainer model (perhaps with social workers or care coordinators as trainers) to deliver cultural competency trainings for agency staff.
- Train agencies on what the continuum of care looks like (visual model of prevention, early intervention, etc.) with information on successful models/case studies in community, via consortium meetings.
- Establish at least one partnership with a managed care company by December 2018 (inter-governmental partnerships)

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:

- CMHB-OP to convene/lead
- Primary care, hospitals like West Suburban and West Lake, FQHCs like PCC wellness
- After care support services, support groups, wrap around care
- All behavioral health agencies
- All coalitions (homelessness, etc.)
- NAMI to lead psycho-educational groups
- Managed care companies (CMHB to establish a partnership w/ at least one MCO)

MEASURES:

- Starting in 2018, hold two trainings/year with physician and mental health professionals.
- Starting in 2018, hold three cultural competency trainings for staff within each agency, using train the trainer model, with at least 25 physicians participating in the trainings (provide CME credits).
- By December 2019, increase psycho-educational groups and presentations by 25%.
- By December 2020, ensure at least one consortium meeting covers successful continuum of care models.

Goal 3: Address social norms among parents and youth in order to reduce underage drinking and substance abuse.

Objective 3.1: Develop and deliver one coordinated communication campaign using school posters, website, and newspaper for 10th and 12th graders at OPRF High School by December 31, 2020.

ACTION STEPS:

- Implement communication campaigns directed towards adults, parents, youth.
- Implement evidence-based curriculum
- Implement binge drinking intervention

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:

- Substance use and mental health agencies
- School districts
- CMHB-OP
- River Forest Township
- Oak Park Township-SPF-PFS
- IMPACT
- MBHAC
- Non-traditional partners that reach youth to run PSAs etc.

MEASURES:

- By December 2018, increase percentage of 9th, 10th and 12th grade students (at OPRFHS) who perceive marijuana use to be risky (per IYS).
- By December 2020, decrease percentage of 12th grade students (at OPRFHS) who engaged in binge drinking (per IYS) by at least 10%.
- By December 2019, see positive change in outcomes according to Project Towards No Drug Abuse data.
- By December 2019, implement at least three programs which are culturally competent, serving at least 50 individuals under age 18.
- Conduct market research to identify appropriate paths of communication and reach youth and parents, including underserved populations (e.g., minority, LGBTIA, and homeless youth).

Objective 3.2: Develop parent education opportunities that include substance abuse of youth to be offered for parents of 8th-12th grade parents by December 31, 2020.

ACTION STEPS:

- Survey at least 400 parents of youth in Oak Park and River Forest regarding youth drinking, by December 2018.
- Host at least two parent focus groups to discuss teens and underage drinking, by December 2019.
- Identify all parent groups and/or existing organizations that may have an interest and/or current goal of reducing youth substance abuse, by December 2019.
- Implement evidence based parent cafes and other parent educational forums and timely events (around prom, graduation, etc.)
- Reach parents at existing parent nights by infusing youth drinking and substance use content into existing activities and workshops, using targeted opportunities during the school year (e.g. homecoming).
- Target education towards dangerous behavior (e.g. binge drinking, daily marijuana use, use by youth at high risk) based on existing public awareness campaigns (e.g. Australia).
- Develop and implement a binge drinking education program for parents.

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:

- OP Township's underage drinking grant (SAMHSA) to take lead in implementing action steps (SPF-PFS)
- IMPACT
- CMHB-OP to take lead on infusing youth alcohol and substance use content into existing parent nights *in partnership with D97 and D200*
- School districts
- Business partners
- Village of OP Public Health Department

MEASURES:

- By December 2018, increase parent disapproval of children (8th graders) using marijuana.
- Decrease binge drinking among 12th graders (per IYS) by at least 10% by December 2020.

Objective 3.3: By December 2020, increase access and strengthen the Continuum of care prevention, intervention treatment, and recovery support.

ACTION STEPS:
- Provide information at Day in Our Village and at least three other community-wide events (including media) per year.
- Hold at least 2 networking consortium meetings of DD and BH providers per year
- Support different coalitions (e.g. addiction recovery team, etc.) to strengthen the continuum of care
- Strengthen adjudication assessment and linkage protocols in collaboration with police, Rosecrance, and other partners.
- Establish who is part of full continuum of care for youth alcohol and substance use.
- Train agencies on what the continuum of care looks like (visual model of prevention, early intervention, etc.) with information on successful models/case studies in community, via consortium meetings.

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:
- Police, judges, Village of Oak Park
- Rosecrance
- CMHB-OP
- OP and RF Townships
- Youth Substance Use Coalitions
- All partner and affiliate substance use and mental health agencies
- Hospitals and primary care partners
- Other System of Care Coalitions, e.g., ART; MBHAC)

MEASURES:
- Increase screenings and linkages to appropriate services at adjudication from current baseline number
- Increase networking and informational events for continuum of care partners by indicators mentioned above

Goal 4: Address the availability of illicit opioids in order to reduce resident opioid use levels.

Objective 4.1: By 2022, establish reporting systems for illicit opioid availability within Oak Park and River Forest.

ACTION STEPS:
- Identify organizations already committed to dealing with the issue.
- Work with Heroin Task Force in Chicago.
- Identify and collect data on opioid overdose.
- Review successful evidence-based strategies from other communities and develop a pilot program.
- Work with D200 to develop a prevention program for high school seniors.
- Develop data sharing agreements with hospitals and the State of Illinois.
- Actively promote safe disposal of medications through increased outreach, education, and promotion.
- Advocate for adoption of CDC guidelines for opioid prescriptions.
- Coordinate referrals for treatment.

TIMELINE:
Start date: January 1, 2018
Completion date: December 31, 2022

POTENTIAL AGENCIES RESPONSIBLE:
- Village of Oak Park takes the lead
- River Forest Township, Oak Park Township
- Police departments
- Fire department
- Hospitals
- CMHB-OP to partner with schools on prevention programs, etc.

MEASURES:
- By 2020, implement a coordinated communication campaign on opioids overuse, with a focus on young adults, and prevention for teens and senior adults.
- By December 2018, increase volume of safe disposal medications by 20%.
- Track progress using IDPH syndromic surveillance data from hospitals, emergency overdose data from the Fire Department, and Uniform Crime Data.

Goal 5: Support caregivers of persons with developmental disabilities in order to ensure residents with developmental disabilities have their needs met.

Objective 5.1: By December 2022, 75% of Oak Park River Forest families will be educated on accessing available services.

ACTION STEPS:
- Host regularly scheduled informational meetings/seminars for families.
- Build support groups for aging caregivers.
- Review, revise, and disseminate the community resource guide onto other websites.
- Offer group respite services.
- Deploy case management resources to work with families, ensure they are aware of services and funding opportunities available to them.
- Conduct survey of parents through D97 and D200 about their support needs.

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2022.

POTENTIAL AGENCIES RESPONSIBLE:
- All DD consortium members (approx. 10-12 agencies)
- School districts
- CMHB-OP
- Village of Oak Park, Oak Park Township, River Forest Township
- Support groups for developmental conditions (Down Syndrome group, Autism group)

MEASURES:
- By December 2020, Oak Park and River Forest will develop a model to educate families and caregivers addressing the needs of developmentally disabled individuals.
- By December 2019, at least one family training will be held around family support services/resources (and continue beyond 2019).
- By December 2020, increase the availability of the right respite models (including CSS staffed respite, group respite, vouchers, etc.) to the right families.

Goal 6: Increase access to services for people with developmental disabilities over the age of 22 to ensure residents with developmental disabilities have their needs met.

Objective 6.1: By December 2020, increase by 20% the number of families that have all services needed, regardless of functioning level or age.

ACTION STEPS:

- Assess unmet needs among people with developmental disabilities over age 22, especially those with a need for a higher level of care and seniors with DD.
- Evaluate Network of Care-user friendliness and effectiveness to link families and referral sources to appropriate services.
- Bring mental health and developmental disability providers together (perhaps alternating which organizations host) to educate and discuss specific cases.
- Create a focus on collaboration so agencies develop greater knowledge of each other's services.
- Use follow-up calls from schools to families who have aged out of school system to evaluate transition success, unmet needs, and acquire data on who is and isn't accessing services.
- Build discrepancy reserve (endowment) to support cost of higher needs care.
- Train respite workers on higher needs care
- Resolve funding limits by:
  - Assessing available funding,
  - Advocating for and lobbying for increased funding,
  - Coordinating funding across agencies to use funds more efficiently/effectively, and
  - Increasing funding flexibility for case consultation across agencies for specific clients.

TIMELINE:
Start date: October 1, 2017
Completion date: December 31, 2020

POTENTIAL AGENCIES RESPONSIBLE:

- All DD agencies
- Schools
- CMHB-OP
- River Forest Township
- Oak Park Township
- Equip for Equality
- State or regional DD representatives
- Managed care companies
- DORS

MEASURES:

- By December 2017, have at least one meeting of a collaborative group of mental health and developmental disability providers and develop annual meeting schedule.

- Create a tool that will identify residents with developmental disabilities who require a higher level of care than they are currently getting and populate it by December 2018.
- By December 2018, conduct assessment of funds available to Oak Park and River Forest agencies.
- By December 2018, survey population with developmental disabilities over age 22 to understand their needs.