ERIE COUNTY

HEALTH DEPARTMENT

COMMUNITY HEALTH CENTER

STRATEGIC PLAN

2026-2028

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EXECUTIVE SUMMARY

The Strategic plan was developed using guidance from the 2024 Community Health Assessment and Youth Health Assessment as well as the 2025 Community Health Improvement Plan to provide clear direction for the Erie County Health Department's efforts to promote and improve public health. This plan is built from ECHD's Community Health Assessment and Community Health Improvement Plan, ensuring alignment with evolving public health needs, organizational goals, and external influences.

The 2026-2028 Strategic Plan focuses on five priorities:

Part A: Mission Impact & External Reach

1. Promote and Elevate quality of life in our communities
By addressing underlying barriers to health through innovation and technology, the agency can create more effective, inclusive solutions that improve outcomes for all community members.

2. Rebrand Public Health's Mission within our communities
Cultivating and strengthening cross-sector partnership and community involvement fosters collective impact, leading to improved health outcomes and greater community resilience.

3. Funding and Expansion
Maintaining and expanding stable funding ensures the continuity of operations and enables the expansion of services to better serve the community.

Part B: Organizational Capacity & Efficiency

4. Assessment
By Collecting, analyzing and utilizing data from multiple sources - including the agency itself, community partners and community members - the agency can better understand community needs and make informed decisions that positively impact quality of life.

5. Workforce Development
Build and inspire a diverse team to take bold, effective action on sustainable public health priorities, driving long-term change and equity across communities.

As we move forward, implementation and accountability will remain a priority, with progress tracked quarterly through scheduled meetings.

This approach aligns with our Mission, Vision and Core Values, and also supports the accreditation standards and certifications held by the Erie County Health Department.

AGENCY OVERVIEW

The Erie County Board of Health is a separate body operating under the Ohio Revised Code and the Ohio Administrative Code in Erie County, Ohio. The eleven members are appointed by the three principal cities and the Erie County District Advisory Council. The purpose of the Erie County Board of Health is to define the organization's goals and objectives; evaluate the accomplishments of the programs; hire the chief executive officer (Health Commissioner); take a lead in the development of financial resources and represent the public interest in terms of good governance and disease prevention policies. The Board of Health represents each governmental jurisdiction within Erie County and is dedicated to improving quality of life, and advancing the health and well-being of our community.

The Erie County Community Health Center (ECCHC) is a Federally Qualified Health Center (FQHC) and a recognized Patient-Centered Medical Home (PCMH), dedicated to providing comprehensive, high-quality healthcare services. Our integrated care model includes medical, dental, and behavioral health services, tailored to meet the unique needs of individuals across the lifespan - from birth through senior years.

As a trusted healthcare provider in our region, ECCHC offers services at multiple locations across Eire, Huron, and Ottawa Counties, works to reduce barriers to care, and promote overall well-being in the communities we serve.

ECHD leverages real-time data systems and feedback channels to monitor trends and continuously refine services to meet emerging needs.

The Erie County Board of Health formally reviewed and approved the 2026-2028 Strategic Plan, aligning it with the agency's statutory responsibilities and community mandate. The Board will continue to receive quarterly progress reports and will participate in annual reviews of goal attainment, performance metrics, and resource allocation.

MISSION, VISION, CORE VALUES

MISSION

Our Mission is to promote and improve the health and safety of the communities and environment within Erie County while preventing disease through essential public health services.

VISION

We envision a thriving community where everyone has access to health services, resources and support.

CORE VALUES

Compassion
Community Innovation
Health Access
Health Promotion
Integrity
Respect

PRIORITY #1 - PROMOTE AND ELEVATE QUALITY OF LIFE IN OUR COMMUNITIES

ADDRESS ROOT CAUSES OF HEALTH DISPARITIES THROUGH INNOVATION AND TECHNOLOGY.

MISSION IMPACT & EXTERNAL REACH

MAXIMIZING OUR IMPACT THROUGH EXTERNAL PARTNERSHIPS AND COMMUNITY ENGAGEMENT.

GOAL 1: ASSESS AND MONITOR THE COMMUNITY'S HEALTH AND WELL-BEING ACROSS THE CONTINUUM OF CARE, INCLUDING PHYSICAL, BEHAVIORAL, ENVIRONMENTAL, AND SOCIAL HEALTH NEEDS, TO ENSURE RESPONSIVE AND COORDINATED SERVICES.

Objective 1.1: By December 31, 2028, improve the seamlessness and effectiveness of client care across primary care, dental, behavioral health, and public health services by establishing a unified model, identifying and closing service gaps, and streamlining client pathways.

Action Steps:

- Conduct a comprehensive inventory of all existing services and infrastructure across primary care, dental, behavioral health, and public health
- Identify and document specific service gaps (e.g., lack of specific specialty, insufficient capacity) and areas of duplication across departments
- Design and finalize unified intake protocols, assessment tools, and client-centric referral pathways that ensure smooth transitions across all service lines
- Use qualitative and quantitative data from Community Health Assessment(s) and Community Health Improvement Plan(s) to guide ECHD's strategic plan

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Protocols and referral pathways formalized and disseminated			100
80% of targeted staff complete cross-training			80
Launch pilot program(s) with initial positive feedback collected			2
Percentage of referrals linked to application intake			100

Several divisions within ECHD/ECCHC deliver services that directly address the needs identified in both the Community Health Assessment (CHA) and the Youth Health Assessment (YHA). This objective responds to identified needs to ease chronic disease, increase behavioral health access, improve oral health access, and end service navigation confusion.

- **Chronic Disease Burden**
  - 33.3% of adults report being told they have high blood pressure.
  - 13.5% of adults report having diabetes.
  - 72.6% of adults are overweight or obese.
- **Behavioral Health Access**
  - 15.4% of adults report experiencing poor mental health for 14+ days in the past month.
  - 12.6% of adults reported ever being diagnosed with depression.
  - Community survey respondents cited long wait times and insurance barriers as major obstacles to mental health care.
- **Oral Health Disparities**
  - 21.3% of adults report not having seen a dentist in the past year.
  - Among low-income adults, dental care access was cited as one of the top unmet needs.
- **Service Navigation Confusion**
  - Focus groups revealed a lack of awareness of available services and confusion over how to access integrated care or coordinated referrals.

PRIORITY #1- PROMOTE AND ELEVATE QUALITY OF LIFE IN OUR COMMUNITIES

ADDRESS ROOT CAUSES OF HEALTH DISPARITIES THROUGH INNOVATION AND TECHNOLOGY.

MISSION IMPACT & EXTERNAL REACH

MAXIMIZING OUR IMPACT THROUGH EXTERNAL PARTNERSHIPS AND COMMUNITY ENGAGEMENT.

GOAL 2: INVESTIGATE, DIAGNOSE AND ADDRESS HEALTH PROBLEMS AND HAZARDS AFFECTING POPULATION

Objective 2.1: By December 31, 2028, determine the feasibility of creating a real-time surveillance system for senior health and wellness, cancer cluster data, and chronic disease to integrate with primary, oral, mental, and behavioral health data sources, to improve the timeliness and accuracy of public health investigations and communications.

Objective 2.2: By December 31, 2028, update and operationalize the Public Health Emergency Preparedness and Response Plan to strengthen coordination and readiness for environmental, infectious, and emerging threats across Erie County.

Objective 2.3:
By June 30, 2028, review existing public health emergency preparedness and response plan(s) to update, including identification of plan gaps and community need.

Action Steps:

- Establish data sharing protocols between divisions
- Identify external partners (cancer registries, state data resources) needed for additional data
- Determine feasibility of sharing syndromic data via owned media resources
- Develop data dashboard(s) related to identified community needs
- Develop chronic disease education, including disease management materials, for public use
- Participate in regional full-scale exercise(s) as set by the State of Ohio
- Identify both qualitative and quantitative outcome measures for all Quality Improvement projects

Epidemiology and Surveillance monitors the health status of Erie County by investigating and containing emerging health issues. These are essential to understanding the health status of a population and planning effective prevention and response programs.

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Plan readiness/updates completed and disseminated			
Intra-agency data sharing protocols established			
Participate in 2 regional/state full scale exercises per year			2
Number of PHEP plans reviewed and updated (annually)			4
Chronic disease education materials developed for heart disease, diabetes, cancer (prostate, breast, lung)			4

PRIORITY #1- PROMOTE AND ELEVATE QUALITY OF LIFE IN OUR COMMUNITIES

ADDRESS ROOT CAUSES OF HEALTH DISPARITIES THROUGH INNOVATION AND TECHNOLOGY.

MISSION IMPACT & EXTERNAL REACH

MAXIMIZING OUR IMPACT THROUGH EXTERNAL PARTNERSHIPS AND COMMUNITY ENGAGEMENT.

GOAL 3: IMPROVE COMMUNITY HEALTH LITERACY AND PATIENT EXPERIENCE THROUGH INNOVATIVE, COMMUNITY BASED OUTREACH TO IMPROVE HEALTH ACCESS

Objective 3.1: By December 31, 2028, design two seasonal campaigns annually to increase awareness of priority health topics among existing clients and the broader community. This objective is repeatable based on emerging needs.

Objective 3.2: By December 31, 2028, execute two seasonal campaigns annually to increase awareness of priority health topics among existing clients and the broader community. This objective is repeatable based on emerging needs.

Objective 3.3: By December 31, 2028, implement a mandatory, agency-wide customer service education program for all front-facing staff, with a goal of increasing participation in client satisfaction surveys by 15%.

The following objectives address trust barriers, low awareness of services, and public health literacy gaps identified in the CHA:

- Only 37% of survey respondents said they "strongly agree" that they know what the Health Department does.
- 47% of respondents report being unaware of public health events or services in their area.
- 22% of respondents noted lack of trust in health-related messaging from public agencies as a barrier to care-seeking.
- Focus group themes included:
  - "We don't see them."
  - "I'm not sure what they do."
  - "Unless I get sick or need a shot, I don't think about them."

Action Steps:

- Content development for disparate populations (non-English speakers, hard of hearing, cognitive delays, vision impediments, etc.)
- Content channel selection (yard signs, social and traditional media, CARE campaigns via 1Call, CARE Message)
- Implement seasonal campaigns for existing Health Center clients
- Implement seasonal campaigns for all owned media
- Identify customer service training curriculum
- Deliver training

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Identify customer service curriculum			
Percentage of staff completing customer service curriculum			100
Percentage of clients completing post-visit survey			25
Number of health problem specific campaigns, materials developed			12
Percentage of campaigns/materials available in an inclusive format			100
Number of campaigns launched (annually) via 1Call, CARE Message			4

PRIORITY #2 - REBRAND PUBLIC HEALTH'S MISSION WITHIN OUR COMMUNITIES

FOSTER DYNAMIC, CROSS-SECTOR COLLABORATIONS AND DEEP COMMUNITY ENGAGEMENTS TO COLLECTIVELY ADVANCE HEALTH OUTCOMES

MISSION IMPACT & EXTERNAL REACH

MAXIMIZING OUR IMPACT THROUGH EXTERNAL PARTNERSHIPS AND COMMUNITY ENGAGEMENT.

GOAL 1: STRENGTHEN, SUPPORT, AND MOBILIZE COMMUNITIES AND PARTNERSHIPS TO IMPROVE HEALTH

Objective 1.1: By December 31, 2028, shift from transactional outreach to transformational engagement by developing Public Health Outreach Clinics (PHOC) and placing staff in visible, meaningful contact with residents and leaders across Erie County communities.

Objective 1.2: By December 31, 2028, position Erie County Health Department as a proactive, visible, credible entity through deliberate, consistent presence, storytelling, and service delivery.

Action Steps:

- Develop Public Health Outreach Clinic (PHOC) schedule and locations within Erie County
- Develop community engagement framework to define the roles and responsibilities for PHOCs and Registered Environmental Health Specialists
- Reintroduce environmental and field staff as public facing agents
- Evaluate embedded public health touchpoints
- Leverage story-telling and lived experience
- Train staff as public health ambassadors
- Elevate presence at community cultural and civic events

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Number of community events with ECHD/ECCHC presence			25
Community Engagement strategy developed			
First 4 township/village/city partner(s) identified and PHOC embedded			4
ECHD Community Calendar updated to include PHOC dates, staff member assignment(s)			
Percentage of staff completing Public Health Ambassador Training			90
Number of campaigns that include lived experience			4

GOAL 2: PROMOTE HEALTH AND DRIVE ENGAGEMENT THROUGH TARGETED AND TAILORED SEASONAL COMMUNICATIONS

Objective 2.1:
By September 30, 2028, design and execute at least four distinct seasonal public health marketing campaigns, leveraging diverse communication channels to reach key community segments and increase awareness of relevant health initiatives by 15%.

PRIORITY #2 - REBRAND PUBLIC HEALTH'S MISSION WITHIN OUR COMMUNITIES

FOSTER DYNAMIC, CROSS-SECTOR COLLABORATIONS AND DEEP COMMUNITY ENGAGEMENTS TO COLLECTIVELY ADVANCE HEALTH OUTCOMES

MISSION IMPACT & EXTERNAL REACH

MAXIMIZING OUR IMPACT THROUGH EXTERNAL PARTNERSHIPS AND COMMUNITY ENGAGEMENT.

Action Steps:

- Identify owned media channels for campaign dissemination
- Develop campaign materials in multiple formats (e.g. large print, plain language, audio versions, etc.) to ensure content is accessible for all community members
- Identify community partners serving diverse community members to tailor and disseminate outreach materials
- Develop seasonal marketing plan, based on age groups, and content
- Develop seasonal marketing calendar
- Execute, monitor campaigns
- Evaluate campaign based on identified metrics (impressions, follower count, view-through, etc.)

These objectives address trust barriers, low awareness of services, and public health literacy gaps identified in the CHA:

- 32% of respondents say they rely primarily on non-official sources (e.g., social media, friends) for health information.
- 61% said they are only "somewhat confident" in information coming from the health department.
- 28% of respondents could not name any services provided by public health.
- Youth participants cited public health as "invisible" or "only about COVID now."

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Number of seasonal campaigns developed, documentation of campaign materials			4
Community partners identified for campaign tailoring/dissemination			
Seasonal campaign calendar developed			
Community partners identified for campaign tailoring/dissemination			
Number of campaigns available in multiple formats			8
Total estimated impressions based on social media platform, digital platform metrics			10,000 Impressions
Percentage of staff completing inclusive communication training			100%

GOAL 3: ENHANCE COMMUNITY PARTICIPATION AND CIVIC ENGAGEMENT IN PUBLIC HEALTH PLANNING

Objective 3.1: By December 31, 2028, assess and engage with at least three public policy opportunities that directly influence local health and well-being such as housing, school safety, food systems, or land use, and provide nonpartisan support in the form of policy briefs or technical assistance

PRIORITY #2 - REBRAND PUBLIC HEALTH'S MISSION WITHIN OUR COMMUNITIES

FOSTER DYNAMIC, CROSS-SECTOR COLLABORATIONS AND DEEP COMMUNITY ENGAGEMENTS TO COLLECTIVELY ADVANCE HEALTH OUTCOMES

MISSION IMPACT & EXTERNAL REACH

MAXIMIZING OUR IMPACT THROUGH EXTERNAL PARTNERSHIPS AND COMMUNITY ENGAGEMENT.

Objective 3.2: By December 31, 2028, implement quarterly roundtable meetings with community stakeholders with representation from disparate populations, various geographic areas, age groups, and service users to provide feedback on public health communication, outreach, and program planning.

Action Steps:

- Map local/state policies impacting public health and community quality of life
- Develop issue briefs or resource guides for civic partners and stakeholders
- Participate in workgroups or hearings in a non-advocacy, technical support role
- Evaluate impact through stakeholder feedback and alignment with public health outcomes
- Identify residents/partners/stakeholders for quarterly roundtable meetings
- Host quarterly listening sessions to gather feedback and share updates
- Integrate input into seasonal campaign development, program adjustments, community reporting

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Number of policy focused meetings/forums attended			4
Number of briefs or guidance documents created			4
Number of community roundtables hosted			4
Community input documented and incorporated into community outreach and marketing efforts			
Diverse representation at community roundtables as shown through sign-in sheets, organizations represented			

These objectives respond to gaps in preventive care utilization across life stages and missed opportunities for timely interventions:

Prenatal & Infant

- 8.1% of births were low birth weight.
- 24.5% of pregnant women received no prenatal care in the first trimester.

Youth & Teens

- 34.8% of high school students reported feeling sad or hopeless every day for 2+ weeks.
- 17.3% reported considering suicide in the past year.
- 24.2% reported using vape products.

Adults

- 49.5% of adults did not receive an annual wellness visit in the past year.
- Only 38% of eligible adults are current on colorectal cancer screening.

Older Adults

- 31.6% of adults age 65+ reported falling in the past year.
- 15.2% of older adults live alone and lack regular contact with support services.

PRIORITY #3 - FUNDING AND EXPANSION

DIVERSIFY SUSTAINABLE FUNDING STREAMS TO ENSURE THE CONTINUITY OF ESSENTIAL PUBLIC HEALTH PROGRAMS AND STRATEGICALLY EXPAND SERVICES THAT ADDRESS IDENTIFIED COMMUNITY HEALTH PRIORITIES.

GOAL 1: DEVELOP AND IMPLEMENT A FINANCIALLY SUSTAINABLE, FULLY INTEGRATED PRIMARY CARE, BEHAVIORAL HEALTH, ORAL HEALTH, AND PUBLIC HEALTH MODEL THAT SERVES AS THE FOUNDATION FOR HEALTH ACCESS AND LONG-TERM AGENCY STABILITY.

Objective 1.1: By December 31. 2028, design and pilot a redesigned behavioral and mental health program that closes the identified service gaps by incorporating at least one new residential treatment and one new intensive outpatient service option, supported by a clear financial sustainability plan.

These objectives are crucial as evolving federal fiscal priorities increasingly influence traditional public health funding structures.

Objective 1.2: By December 31, 2028, stabilize and diversify agency funding, with a particular focus on integrating public health services into reimbursable models and demonstrating their financial insulation from budget fluctuations.

Action Steps:

- Conduct a detailed mapping of all current revenue streams (e.g., FQHC, grants, insurance billing, specific public health funding) and analyze their stability and proportional contribution to the total budget
- Analyze the feasibility and potential financial impact of introducing value-based payment models or bundled billing options for specific integrated service packages
- Identify public health services or functions that can be integrated into existing or new clinical workflows to become reimbursable under current regulations (e.g., specific preventative screenings, chronic disease management education)
- Develop and implement billing protocols and staff training necessary to capture and bill for these newly integrated public health services
- Complete workforce needs analysis for program expansion
- Launch expanded program(s)
- Develop sustainability plan(s) for program expansion

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Complete workforce personnel needs assessment			
Report on public health financial insulation completed and shared			
Formal licensing, certification, accreditation for new service line obtained			
Develop financial tracking system for embedded public health services			
Financial tracking system for embedded public health services fully operational			

PRIORITY #4 - ASSESSMENT

COLLECT, ANALYZE, AND USE DATA FROM INTERNAL AND EXTERNAL SOURCES TO DETERMINE POPULATION HEALTH AND WORKFORCE PRIORITIES

ORGANIZATIONAL CAPACITY & EFFICIENCY

BUILDING INTERNAL STRENGTH AND ROBUST SYSTEMS FOR EFFECTIVE OPERATIONS.

GOAL 1: ASSESS AND MONITOR POPULATION HEALTH STATUS, NEEDS, AND FACTORS INFLUENCING HEALTH.

Objective 1.1: By December 31, 2028, identify target representation from all municipalities within Erie County as well as under-represented community organizations to inform and enrich ongoing public health assessment processes through a combination of public forums, targeted focus groups, and accessible surveys.

Objective 1.2:
By December 31, 2028, implement evidence-informed interventions or programs directly aligned with the top three population health priorities identified by the Community Health Assessment and Community Health Improvement Plan.

Action Steps:

- Identify community members/groups who have been under-represented in previous Community Health Assessments
- Develop comprehensive plan including methods of communication, outreach strategies, engagement activities to engage group(s)
- Create and share engagement materials.
- Execute and document community engagement activities
- Complete community health assessment at identified intervals
- Analyze assessment data
- Collaborate with community members/groups to finalize priority health selection(s)
- Research and design interventions for prioritized need(s)
- Secure resources
- Launch pilot intervention(s) with baseline measures

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Community members/groups for assessment activities identified			
Community engagement plan developed			
Community Health Assessment Completed			
Completed Community Health Assessment shared with stakeholders for priority identification			
Number of key baseline metrics established and initial data collected for each launched intervention /program.			
Percentage of launched programs aligned with one of the top three population health priorities identified in the assessment.			

PRIORITY #5- WORKFORCE DEVELOPMENT

ATTRACT, CULTIVATE, AND RETAIN A RESILIENT, AND HIGHLY SKILLED PUBLIC HEALTH WORKFORCE, FOSTERING A CULTURE OF CONTINUOUS LEARNING AND INNOVATION TO ENSURE SUSTAINED LEADERSHIP IN ADDRESSING EVOLVING COMMUNITY HEALTH PRIORITIES.

ORGANIZATIONAL CAPACITY & EFFICIENCY

BUILDING INTERNAL STRENGTH AND ROBUST SYSTEMS FOR EFFECTIVE OPERATIONS.

GOAL 1: BUILD AND SUPPORT AND SKILLED PUBLIC HEALTH WORKFORCE

Objective 2.1:
By December 31, 2028, design and implement a new employee coaches program for all new hires, with a target of 100% participation, and establish formal succession plans for key leadership positions to improve overall staff retention.

Objective 2.2:
By December 31, 2028, ensure 100% compliance with regulatory requirements for professional credentials and licenses and provide real-time transparency and accountability for credentialing status across the agency.

Action Steps:

- Apply Personnel Needs Assessment to each program or service area
- Implement new employee coaches program
- Develop Succession Planning Policy
- Identify target recruitment areas to support the agency's expanded footprint within public health
- Conduct needs assessment of current licensing and credentialing processes to identify key gaps in accountability and transparency
- Determine if additional system(s) to configure or track licensing/credentialling are needed and implement as needed.
- Develop standardized policies and procedures for ongoing licensing and credentialing management

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
System audit performed to confirm accuracy/completeness of licensing process			
Zero instances of lapsed/non-compliant staff licenses/credentials identified through internal audits.			0
Measure retention as compared to annual evaluation summaries			
Public health workforce personnel needs assessment developed and initiated			
Position descriptions updated to comply with accreditation			100%

PRIORITY #5 - WORKFORCE DEVELOPMENT

ATTRACT, CULTIVATE, AND RETAIN A RESILIENT, AND HIGHLY SKILLED PUBLIC HEALTH WORKFORCE, FOSTERING A CULTURE OF CONTINUOUS LEARNING AND INNOVATION TO ENSURE SUSTAINED LEADERSHIP IN ADDRESSING EVOLVING COMMUNITY HEALTH PRIORITIES.

ORGANIZATIONAL CAPACITY & EFFICIENCY

BUILDING INTERNAL STRENGTH AND ROBUST SYSTEMS FOR EFFECTIVE OPERATIONS.

GOAL 2: MAINTAIN A SKILLED AND ADAPTABLE PUBLIC HEALTH WORKFORCE THROUGH ONGOING DEVELOPMENT, TRAINING, AND RETENTION STRATEGIES

Objective 2.1:
By December 31, 2028, all ECHD public health staff will demonstrate competency in core public health skills including Core Competencies for Public Health Professionals, Applied Public Health Informatics Competencies, Applied Epidemiological Competencies, Public Health Preparation and Response Capabilities, Public Health Nursing Scope and Standards of Practice through targeted training, assessment, and practical application in their respective program areas.

Action Steps:

- Develop Competency Framework for each competency area
- Conduct a baseline competency assessment
- Develop structured training plan
  - Online training modules (CDC TRAIN, Public Health Informatics, etc)
  - In-Person workshops
  - Applied project-based learning
- Annual competency review with staff during performance review
- Annual applied skills integration to demonstrate competency (via work projects, program improvement projects, community initiatives, etc.)
- Agency Plan revisions/enhancement.
- Enhance leadership training program.

Metrics			
Indicator	**Y/N**	**Number / Percentage**	**Target**
Completion and formal approval of competency framework			
Percentage of staff completing baseline competency assessment			100
Average Competency Score (agency-wide)			85
Percentage of staff completing at least 1 Applied Health Informatics training			100
Percentage of identified emerging/current leaders who complete foundational leadership training program			90
Staff completing training in Epidemiology and Surveillance Competencies			100
Completion of annual competency re-assessment			100%
Increase in average competency scores			+10

PLAN DEVELOPMENT, PURPOSE & ALIGNMENT

Much like a road map, a Strategic plan outlines an agency's current position and charts the paths it can take to achieve its long-term goals. It services as a guide for decision-making and resource allocation, while also establishing criteria for measuring progress and evaluating outcomes. Although a Strategic Plan provides essential structure and direction, it must remain flexible and adaptable to meet the evolving needs of the agency and the community it serves.

An Action Plan was developed to track and monitor the progress toward the strategic goals and objectives. This plan is designed to be flexible, allowing for adjustments as the health department grows and evolves. All updates will be reflected in the plan's documentation.

Progress on the Strategic Plan is monitored through the Action Plan as part of the performance management process and is reported quarterly to the Performance Management and Strategic Committee, with leadership in attendance. Updates are communicated annually to all employees, community partners and members of the community. Example of tracking shown in figure.

The Board of Health reviewed and approved the 2026-2028 Strategic Plan and will receive structured quarterly updates. Their continued engagement ensures transparency, accountability, and strong alignment between public health services and county-wide priorities.

Updates on the Strategic Plan are communicated annually to all employees, community partners, and members of the community. The annual review includes an analysis of key trends, a summary of goals that have been achieved, and an evaluation of areas where improvements are needed. The evaluation process will assess the plan's effectiveness, support continuous health improvement, and indicate whether modifications are necessary to enhance its impact.

Erie County Health Department is committed to ensuring that all community members, regardless of age, location, income, or background, can access essential public health services. To that end, ECHD will analyze service usage data by geography and population groups to identify gaps in outreach, utilization, and outcomes.

To enhance its ability to respond to changing conditions and monitor population health, ECHD will expand its use of real-time data tools and interactive dashboards. This includes tracking usage patterns, service access by ZIP code or neighborhood, and outcome trends across different age and income groups.
These efforts will improve transparency, ensure more balanced service delivery, and support decision-making that meets the needs of the whole community. ECHD will also continue to collect qualitative feedback to understand lived experiences, especially where traditional metrics fall short.

The agency will use these insights to guide program planning, communication strategies, and resource allocation. By intentionally engaging groups that have historically faced barriers to care, ECHD will strengthen its ability to meet the full range of population needs while maintaining consistency with public expectations and federal/state program requirements.

SWOT ANALYSIS

SWOT identifies internal Strengths and Weaknesses, and external Opportunities and Threats to inform strategic planning.

STRENGTHS

- **Accommodating**
- **Versatility**
- **Accessibility**: several service locations .
- **Responsiveness:** regular data collection & analysis.

WEAKNESSES

- **Staffing:**
- **Culture of Mentorship and Peer Learning**
- **Community perception and awareness of services**
- **Reliance on State and Federal funding**

OPPORTUNITIES

- **Community Collaboration**
- **High-Touch/Peronalized Services**
- **Offer Education and Training**
- **Professional Workforce Development**

THREATS

- **Funding stability**
- **Federal Policies Affecting Public Health**
- **Competition**
- **Economy**

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