Regional Institute
for Health and Environmental Leadership

Advanced Leadership
Training Program

Leadership Project Executive Summaries
Class of 2005
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Environmental Public Health Professional’s Advocacy Toolkit
Kristin Benn

Background/Importance
In the Center for Disease Control's (CDC) document *A National Strategy to Revitalize Environmental Public Health Services*, the CDC's National Center of Environmental Health recognized and acknowledged the need to develop strategies and materials to educating public policymakers and others on environmental public health issues and services. However, anecdotal evidence suggests that environmental health professionals are uncomfortable approaching policy and decision makers, and that major improvements in contemporary environmental public health can only be achieved through improved communication and marketing.

In order to insure that environmental health services and the environmental health workforce in local and state jurisdictions are adequately understood and supported by policy makers on the local, state, and national levels, environmental health professionals must be equipped with tools (such as talking points, photographs, charts and graphs, and poignant case reports) in order to advocate on behalf of the profession. However, a comprehensive toolkit containing the type of resources environmental health professionals can use to advocate on their own behalf does not currently exist.

Vision
My vision is to develop a Web-based toolkit which contains downloadable and linkable resources for environmental health professionals to use when speaking with policy makers at the local, state, or national level.

Goals
- To provide environment health professionals additional guidance when dealing with policy makers.
- To communicate the importance of supporting environmental health services and the environmental health workforce.
- To increase the understanding of and support for environmental health services.

Timeline
- Conceptualize the toolkit with Environmental Health Workforce Development Consortium. (December 2004)
- Gather potential resources to include in the toolkit. (January 2005)
- Share potential resources with the Consortium and determine criteria for inclusion. (February 2005)
- Solicit CDC funding to support development of the toolkit, continue gathering and developing materials. (March 2005)
- Plan testing of the toolkit with environmental health professionals and local policy makers (providing that funding has been secured). (April 2005)
- Finalize the toolkit contents and get CDC approval. (May 2005)
Finalize the toolkit presentation and plans for the testing meeting; conduct testing meeting. (June 2005)
Analyze testing results and make necessary changes to the toolkit. (July 2005)
Release toolkit. (August 2005)

Resources
This project requires committed funding for the actual development of the toolkit, as well as the continued support of the organizations represented on the Environmental Health Workforce Development Consortium, whose members include:

- American Public Health Association
- Association of Environmental Health Academic Programs
- Association of State and Territorial Health Officials
- Environmental Council of the States
- National Association of County and City Health Officials
- National Association of Local Boards of Health
- National Conference of Local Environmental Health Administrators
- National Environmental Health Association

Communication System
The Consortium will meet monthly via conference calls and will share resources through e-mail. The debut of the final product will take place at an in-person meeting of the Consortium at the National Environmental Health Association's Annual Conference.

Results of Project
The Consortium was convened by way of conference calls in January and February 2005. During the calls, a vision for the contents and the use of the toolkit was developed. Consortium participants gathered information bites specific to their constituents for potential inclusion in the toolkit.

In late February 2005, a proposal was submitted to the CDC requesting funding for the development of the toolkit. Additionally, an in-person meeting with CDC personnel was held to garner support of the development idea.

Due to my resignation from my position at the National Environmental Health Association the project was not completed. I am now employed in the health sector and am exploring leadership challenges in a new arena.

Leadership Lessons Learned
Throughout the process of my project, I learned valuable lessons about the importance of articulating a shared vision. At times, the Consortium was not as strong as it needed to be because we all had slightly different constituents for whom our vision needed to be tailored. Once I was able to develop a plan for a customizable toolkit, the group enjoyed the ability to see how the end goal was applicable to them and ultimately they were more vested in the development process.

Long-distance leading presented challenges as well because it is difficult to gauge what communications are lost when group members are unable to meet face to face. This Consortium was able to meet only via conference calls and often we had people who were
absent. I found it helpful to recap the major points of our last call at the beginning of each of our calls. It was also helpful to ask volunteers to facilitate our calls—this seemed to increase participation.

References

Inter-professional Curriculum at the University of Colorado
Hospital Outpatient Pharmacy to Improve Patient Safety
Hilda Bi

Background and Importance of the Project

Patient safety is defined as a type of process or structure the application of which reduces the probability of adverse events resulting from exposure to the healthcare system across a range of diseases or procedures. Despite increasing technological and medical knowledge, medical errors have become a major threat to patient safety. Researchers now believe that most medical errors can be reduced through the coordinated efforts of multiple members of the healthcare team. Reports by the Institute of Medicine (IOM) have brought patient safety concerns to the forefront in many healthcare facilities.

In January 2004, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) revised national safety goals that focus on a recommended series of actions to prevent medical mistakes, some of which include:

- Making sure medicines are being given to the right patient before they are administered (e.g., using a room number to identify a patient is not sufficient).
- Reading back medical orders given via the telephone in order to reduce the likelihood of miscommunication or misunderstanding.
- Standardizing abbreviations or symbols used in providing care.
- Removing from patient care units certain concentrated medications that, if administered accidentally, can be deadly.
- Marking the site where surgery is to be performed (e.g., the left foot) and involving the patient in the pre-operative process, which reduces the risk that surgery will be performed accidentally on the wrong site.
- Testing clinical alarm systems and ensuring they can be heard at a distance and above the din of background noise.
- Ensuring that all IV infusion pumps have free-flow protection to reduce the risk of a patient inadvertently receiving a medication overdose.

Vision

My vision is to coordinate an interdisciplinary effort with other healthcare professionals and work toward identifying and exploring possible opportunities for improving patient safety.

Specific Goal

The goal of this project is to identify patient safety issues at the University of Colorado Hospital’s outpatient pharmacy clinical rotation site and develop an intervention plan in response to the issues identified at this site.

Project Timeline

Stage 1- December 2004

- Establish a common vision and goal with the preceptor at the University of Colorado outpatient pharmacy site.
Stage 2- January 2005
- Collect existing patient safety data available through the Patient Safety Net (PSN) outpatient database.
- Identify and categorize patient safety issues according to severity and prevalence.
- Conduct background literature review on issues identified.

Stage 3-February 2005
- Work with Pharmacy D student(s) on rotation at this practice site in order to integrate patient safety issues identified during extern-ship experience.
- Interview other healthcare professionals on their understanding of the issues identified and how they can be involved in reducing the occurrence of these safety issues.

Stage 4-March-May 2005
- Have analysis and recommendations prepared for improving patient safety issues identified at this practice site.
- Identify resources required to successfully complete the project.
- Work with the outpatient pharmacy manager and preceptor at the University of Colorado Hospital, who have agreed to work with me on this project.
- Use/integrate the outpatient pharmacy safety information that has previously been identified at the hospital.
- Work with the preceptor's students on rotation (the preceptor has agreed to this) in order to conduct literature review.
- Interview other healthcare professionals on issues identified.
- Meet with the Patient Safety Coordinator at the University Hospital to discuss the project and to request patient safety information stored in the Patient Safety Net database.
- Conduct interviews by phone or in person.

Progress to date (May 5, 2005)
Patient safety data was collected from the Patient Safety Net database at the University of Colorado Hospital. This database is an online system that offers the ease of one-step reporting plus unprecedented data collection capabilities. Collection of data was focused on outpatient safety issues categorized as:

- Wrong dose (over dosage/under dosage)
- Wrong drug
- Wrong patient
- Wrong time
- Wrong technique
- Wrong duration

Analysis of data focused closely on two of the above categories—wrong drug and wrong patient—because these categories had the most events reported. Results of the data analysis were presented to the University of Colorado Outpatient Pharmacy Manager with recommendations that could possibly reduce the medication errors identified.
Next Step

The next step in this process is to present the results of this patient safety analysis to the entire outpatient pharmacy staff. The aim is to give every team member a chance to contribute ideas and to make recommendations on possible solutions to the problems that were identified to cause errors. Involvement of other healthcare professionals is still anticipated.
Project Background
   Currently, the Wyoming Department of Environmental Quality (DEQ) places a high value on the technical competence of the staff. This is evidenced by the effort placed on hiring the best qualified applicants, the willingness to pay for training to maintain a high technical expertise, and the evaluation of technical performance of the staff. There is very little emphasis placed on the development of leaders within the department. This leadership project will result in the same level of value placed on leadership skills.

Vision
   We envision a Wyoming DEQ where leadership is practiced at all levels within the agency, making the DEQ one of the most effective state environmental agencies in the country.

Goals
   - The agency will develop and institute an ongoing, formal training program for employees at all levels to teach leadership skills.
   - The agency will adopt a formal goal within its strategic plan of ensuring that leadership skills are valued and are important to agency management.
   - The agency will develop and institute a system to monitor the quality of leadership training offered to employees, and to provide feedback to employees on how well their leadership skills are being used.
   - The agency’s customers will see continuous improvements in the timeliness of agency actions and in responsiveness to customer contacts.
   - The agency will receive national recognition for its leadership abilities.

Project Timeline
   Goal No. 1
   - The agency will develop and institute an ongoing, formal training program for employees at all levels in order to teach leadership skills.
     - Identify the different areas where training will be required. (To be completed by April 29, 2005.)
     - Identify the training programs needed to support the different area of training. (To be completed by April 29, 2005.)
     - Develop a department policy statement that explains the leadership program and outlines the different required and optional training programs. (To be completed by May 15, 2005.)

   Goal No. 2
   - The agency will adopt a formal goal within its strategic plan of ensuring that leadership skills are valued and are important to agency management.
     - Provide a draft to the DEQ leadership team for their review. (To be completed by April 29, 2005.)
- Incorporate the leadership element into the department’s new strategic plan. (To be completed by May 15, 2005.)

**Goal No. 3**
- The agency will develop and institute a system to monitor the quality of leadership training offered to employees and to provide feedback to employees on how well their leadership skills are being used.
  - Develop one to three evaluation criteria to be presented to the DEQ leadership team by June 1, 2005.
  - Incorporate the evaluation criteria into the state’s new evaluation system, which is anticipated during third quarter 2005.

**Goal No. 4**
- The agency’s customers will see continuous improvements in timeliness of agency actions and in responsiveness to customer contacts.
  - The Department’s outreach group will develop a customer questionnaire and poll customers on a yearly basis beginning July 1, 2005.

**Goal No. 5**
- The agency will receive national recognition for its leadership abilities.
  - In fiscal year 2007, the department will submit an application for an award to at least one national organization for formal recognition of its leadership program.

**Resources Required to Successfully Complete the Project**
The department currently spends approximately $160,000.00 on training per year. While there are some leadership classes included in this amount, most of the training is technical in nature. It is anticipated that an additional $50,000.00 to $75,000.00 would be required to institute the leadership training program.

**Risks and Analysis of Those Risks**
There are several risks involved. The first is resistance from the staff in investing additional time for training. Upper management is supportive of the project and this should assist in the selling of the project to others. Another risk is if individuals do not apply what they have learned. The addition of evaluating leadership skills into the personnel evaluation system should encourage the practice of the skills. The last risk is lack of funding. Currently, the state is experiencing large budget surpluses and should continue to do so for the short term. However, this may not be true in future years, and there may be a danger of cutting training if budget shortages become a reality. It is our hope that enough momentum and positive results will have been established to have the program "institutionalized" within the department. This would allow for some form of the project will continue even through hard times.

**Communication Among Those Involved in the Project**
There are several lines of communication. One is between the division administrators and the director in establishing support for the components of the project. The second is presenting the plan to the staff, to sell them on the need and importance of the project and the
benefits to them. Finally, there is communication between the supervisors and their direct reports as the results of the training are evaluated.
Background and Importance

Petroleum refineries are among the most environmentally complex and highly regulated facilities in the United States. Over the past few years, the U.S. Environmental Protection Agency (EPA) has classified the petroleum refining industry as a priority for enforcement due to the EPA’s view that the industry has significant compliance deficiencies. Under its former owner, the Suncor Denver Refinery participated in discussions with the EPA and the state of Colorado and agreed to reduce emissions. Suncor’s goal is to meet or exceed stakeholder expectations. While the Suncor Refinery has a proactive environmental compliance stance, recent environmental performance does not meet refinery management and staff expectations. Internal discussions have identified the need to provide better information and higher awareness to all personnel at the refinery in order to make the desired improvements in environmental performance.

Vision

The Suncor Denver Refinery will achieve the desired changes in its environmental performance so that stakeholders view the refinery as an environmental leader in the state of Colorado.

Specific Goal

To implement an online environmental awareness tool at the Suncor Denver Refinery that is accessible to all employees. This tool, available twenty-four hours a day, will provide compliance and performance information in an understandable format, as well as a means to communicate environmental issues and obligations to all employees.

Project Timeline

Stage 1
- Meet one-on-one with environmental staff and refinery leadership to obtain feedback on communication tool elements.

Stage 2
- Prepare prototype of communication tool.

Stage 3
- Review prototype with key audiences.

Stage 4
- Incorporate feedback as appropriate and roll out the new environmental communication tool.

Stage 5
- Maintain the communication tool and keep it current.

(This timeline is indefinite because the project should be maintained as an ongoing initiative, not a one-time event.)

As of May 2005, the project is behind schedule due to ongoing time demands. Stage 1 is complete; Stages 2 and 3 are partially complete. Some communications have been issued...
to the facility, but the anticipated tool has not yet been fully developed. However, I remain committed to implementing this process, just not on the initial timeline. My supervisor, RIHEL 2004, also remains committed to helping me see this project through to completion.

Resources Required to Successfully Complete the Project

The resources for this project are all internal within the Suncor Denver Refinery. The primary resource commitments are:

- The project facilitator.
- Other members of the Suncor environmental staff.
- Local management for their input on the content of the tool and support for using this tool going forward. I may ask for management support to provide some rewards for employee contests to find and submit information from the new system to encourage initial use.
- Information Technology (IT) department support—I envision this communication tool as Web-based and will need IT support to install and establish links to this site. Access to Suncor's Internet site will be required; this should not be an issue.

Risks and Analyses of the Risks

Project Risk: On risk is insufficient time on the part of the project facilitator to implement the project.

Analysis: My supervisor supports the concept of this project and supports my efforts in making this happen. I will need the support of my co-workers to allow me time to focus on this effort, and I will need them to give their time and to provide information from their areas of expertise.

Project Risk: Getting the users of the communication tool to take the time to review the information provided and to incorporate the information into how they do their jobs.

Analysis: This may be the most difficult step because adding something more to everyone’s list of things to do is not always viewed positively. I believe this challenge can be met by (1) our employees’ desire to do the right thing, and (2) by rolling this out in a fun way with contests, etc., (this has been done successfully for other activities) in order to encourage our employees to become acquainted with this new source of information.

Communication System for the Project

The early stages of the project will involve one-on-one or small group discussion with individuals that I can access fairly readily. I do not believe that there will be any issues in making this part of the communication process move forward. Ultimately, the entire project is all about communication. What defines project success is establishing an effective electronic communication system that provides environmental information to all personnel at the refinery.
Reinventing and Reimagining Work in Health and Environment Agencies
David Coffey

Project Background
I am currently working in a large agency which is among other state agencies. Because of this professional situation, not only do I perceive that there is a need to reimagine and reinvent our work life and work places, but also that this need is becoming more obvious and pressing over time. Despite the level of dedication given to the work that is done, the problems inherent in the way the New Mexico Department of Health is constructed and managed are present everyday. Silos, power struggles, top down controls, and layers of control to assure accountability all create conditions of personal and group stress and inefficiencies in conducting the work at hand.

These internally generated difficulties stem in large part from an understanding of organizations that was derived from seventeenth century physics that valued the machine, its operations and parts, as the principle metaphor for how the world works and how humans should work. This view held that humans and the Universe could be viewed as a kind of a clock-works, with parts that could be separated, analyzed, and replaced or repaired. But, the usefulness of this idea is limited when, for example, healthcare focuses on the sick part and not on the whole.

New scientific theories born in the twentieth century confirm that chaos theory, quantum mechanics, systems theory, information sharing, and adaptability are a more accurate reflection of how the world works. I believe this should be reflected in our organizational life as well. These new scientific theories affirm the fact that at a certain level of development, things from molecules to galaxies to health and environmental agencies become self-organizing. Since this is so, the need for avoidance-of-change-unless-planned-and-approved and layers of bureaucracy to make sure everything is in its place and operating according to plan (that is, like a machine) are not so important. Humans and our organizations do not run like machines; rather, they can take on a life of their own. They must be viewed as a whole, with parts that function in an interconnected, evolving manner—not as a static machine of separate unrelated parts.

The reason for considering these abstract ideas is not just because they are interesting or even sensible. The fact is that despite our conscientious work, public agencies are not solving many of the fundamental problems that need to be solved. These problems are complex—like raising a child or ending poverty is complex, and solving such problems requires an organizational model that is more adaptive, more flexible than agencies operating within a seventeenth century model with its focus on stability, parts, and control. Agencies can solve complicated problems—problems that require more of the command, control, and accountability model, like getting someone on the Moon or creating a regulatory framework for hazardous waste—but these strengths become weaknesses when solutions require continual learning and adaptability such as the problems that give rise to the generation of hazardous waste or poverty.

I recently completed doctoral studies (Doctor of Ministry) in which these ideas were the focus. I am, therefore, on a mission to blend the best of the seventeenth and twentieth centuries!
Vision

My vision, in collaboration with a partner, is to develop a series of focused and sustained discussions with colleagues that would help to build awareness of the deep structural problems embedded in our public service organizations—problems that interfere with the often-noble mission of the organizations—and, then, together we can imagine ways to begin changing the organizations and ourselves. It only takes a few to create a tipping point for such change.

Project Goals

- Raise awareness of some of the fundamental limiting beliefs that tend to support the continuance of organizational behaviors that are often ineffective in achieving organizational goals and are disrespectful of people.
- Promote an awareness of organizational values that reflect contemporary science and universal human values such as authenticity, fairness, and creativity.
- Promote actions that will assist project participants in managing their work life and relationships in a manner that empowers and fosters organizational-culture change.

Timeline

*By end of January 2005*
- Develop and announce the project goals and begin soliciting participants.
- Develop a plan for the first introductory meeting, set a time and place.
- Develop an evaluation tool for the first meeting.

*By end of February 2005*
- Conduct introductory meeting and first meeting.
- Develop an outline of meeting topics and group methods for group's approval at the first official meeting.
- Develop meeting time and place; schedule and secure agreements for participation at each of the meetings.
- Develop agreement as to the number of meetings for the project (6-8 at least).
- Develop agreement with participants about a method for evaluating the project in terms of usefulness, pleasure, change in attitudes (for empowerment), changes in work life that have been initiated and the like.

*By end of May (or final RIEHL meeting)*
- Provide a status report consisting of meeting themes, evaluations of meetings to date, numbers of participants (including their job titles), and reports of any changes to date.

*Note:* At this time I cannot predict the meeting schedule. My hope is to meet twice a month; but, this will depend on the collective will of the participants.

Risks Involved

Risks include failure to obtain supervisor approval and/or opposition from Departmental authorities (although these seem unlikely). To deal with this risk it will be necessary to hold meetings outside of the work place and on our own time.
Other risks include an insufficient number of suitable participants (environmental health and public health professionals in the New Mexico Department of Health) or inconsistent participation. To deal with this risk my partner and I will actively recruit by both e-mail and personal recruitment. We will over-enroll to assure that at each meeting we have a sufficient group size to make discussions lively. (Eight to twelve participants at each meeting would be ideal. We will, therefore, recruit up to sixteen participants.)

If we fail to garner a sufficient number of participants, we will, with permission, send an invitation via e-mail for people to receive articles and information related to the topic and develop a discussion through the e-mail system. This could eventually lead to the development of a sufficient number of participants for the discussions. (My sense, at this time, is that we will have no difficulty in recruiting sufficient participants.)

Resources Required

I will need permission to take work time to convene the group and hold the meetings. Other resources include access to meeting space, printing, and e-mail facilities.

Results

Meetings of one-and-a-half hours each began on January 20, 2005. There have been four additional meetings since. Seventeen people have signed on; twelve have attended at least one meeting. Suggested discussion topics and process announced for the first meeting were as follows:

- We will draw from our own experience and wisdom, and we will also read and discuss written material in order to tap into the experience and wisdom of others.
- We will play the Word Café way of creating conversations that matter.
- We will explore using other formats for conversation and dialogue as well.
- We will explore the following topics, at a minimum:
  - Authentic leadership/authentic self
  - Staying empowered
  - Issues of personal control vs. personal influence
  - How communication really happens
  - Mental models about organizations
  - Ways to make changes
  - Ways to promote more peace and fairness at work

Actual discussions have focused on ways to deal with exhaustion, the difference between an organization focused on accountability versus adaptability, the difference between complex and complicated problems, and the different methods needed to solve them. There were discussions about ways to bring more joy, happiness, beauty, and celebration into the workplace. To that end, we have agreed to meet outside the agency every third meeting to share food in an informal atmosphere. We have also embedded within the organizational structure an understanding of the seventeenth century machine model.

Effects of the conversations (which are really just getting started as we define terms and map out the territory) are anecdotal: "I wasn’t going to come today, but I realized I need this," and so on. The co-convener raised an issue in a plenary session of the New Mexico
Public Health Association meeting in April about the need to change the Department of Health from one that can deal with complicated issues only, to one that can deal better with complex issues like poverty, and the roots of violence.

**Implementation**

I hope that the group will coalesce in the next few months and continue indefinitely, and that other groups will begin this process. We look for 15-18 regular participants and would expect 8-10 at any given meeting. Participation will stabilize as the group gels.

**Leadership Lessons Learned**

I am learning the power of small actions to leverage deep change when the small actions come from a heart-felt place, from humor, and from commitment. Confidence grows by doing. Partnering well is rewarding.
Routine Communicable Disease Training
Alicia Cronquist

Background and Importance
Communicable disease (CD) control is a core public health activity. In Colorado, local public health agencies have primary responsibility for CD control activities, with guidance from the state health department and direct assistance when requested. Communicable disease control is a complex activity that requires knowledge of a wide variety of conditions, control measures, etc. While several of the larger health departments do provide CD training to their staff, currently there is not a system for routine, ongoing education about CD case investigation and disease control. A survey of local public health agencies, conducted in early 2004 found that the majority of local health departments and public health nursing services in Colorado indicated a desire for further training on follow-up and investigation of individual cases of zoonotic, food-borne, vaccine-preventable, and invasive bacterial diseases, as well as training on general interview techniques.

Vision
Local public health agency staff in Colorado will have adequate knowledge and skills to conduct routine CD interviews and CD control, and will be able to identify resources available to help them perform disease control activities.

Goal
To develop a plan for routine CD training for public health nurses, environmental health specialists, and epidemiologists who have CD duties in Colorado. My goal is to develop this plan by integrating existing resources in the Disease Control and Environmental Epidemiology Division, the Office of Local Liaison, and local public health agencies.

Project Timeline
Stage 1
- Identify available resources (human and material); examine and enumerate current and past communicable disease training sessions that have been used in Colorado; explore existing training used by other public health entities in other states, on the Web, etc. (December 2004)

Stage 2
- Establish who my partners will be, and form a working group of those who will develop the initial curriculum. (January 2005)

Stage 3
- Hold meetings with stakeholders (those who will be using the training) to determine key subject areas to include in the training. (February-March 2005)

Stage 4
- Develop initial curriculum. (March-July 2005)

Stage 5
- Pilot the program in a few sites. (August-September 2005)
Stage 6

- Refine based on feedback from pilots and launch training. (October 2005-Ongoing)

My goal during RIHEL training is to develop a plan for the training and to begin working on the content. The best time to launch training for our department is the fall. In addition, a CD manual is in progress now and training will best be done when the manual is complete so that it can be used as a reference.

Resources Required to Successfully Complete the Project

- Commitments from local public health agencies that they will send people to this training.
- Staff time for meetings and development.
- Continued funding for the Colorado Department of Public Health and Environment (CDPHE) to provide statewide CD services and training (i.e., continued funding of epidemiology program staff).
- Travel money and time for CDPHE epidemiologists to conduct training sessions.
- Funding to support conference calls for stakeholder meetings and other meetings.
- Possibly electronic resources (space on department's Web site) to post various educational materials.

Progress to Date (May 1, 2005)

So far, I have identified existing CD training materials and interviewed people about what worked and what didn’t work with each approach. I’ve met with key leadership figures at the Colorado Department of Public Health and Environment who must support my project in order for it to be successful, and I have had numerous discussions with various stakeholders about content areas that should be covered and the format of the training (location, timing, etc.). I have met with one key stakeholder group and received their support and an offer of assistance in developing the curriculum. I have established several of the partners with whom I will work, but I have not yet completed the team. My next step will be to convene two large meetings that will be open to all local public health agencies. The goals of these meetings will be to generate enthusiasm for the project, discuss key subject areas that participants wish to have included in the training, and identify additional partners who will participate in curriculum development.

My timeline was overly optimistic. However, I am making slow progress and am becoming more enthusiastic about the project as time goes by and will pursue it this summer and fall.
Coaching Supervisors to Coach in New Mexico Public Health
Constance Dixon

Background and Importance of the Project
Coaching is an ongoing partnership or a sustained alliance between a manager and an employee designed to enhance learning, growth, and organizational effectiveness. It is a one-to-one relationship in which the focus is on developing the individual, challenging and supporting her to become more effective, and allowing her to reach her own highest levels of competence and ability. Coaching is about unlocking a person's potential in order to reach new levels of performance. It's about helping people learn, rather than teaching them.

It is important to note that coaches don't develop people per se; rather, they guide individuals to develop themselves. Coaches serve as a catalyst for development. One of the basic philosophical underpinnings of coaching is that individuals are creative, resourceful, and whole. They don't need fixing. In fact, more often than not, they have the answers to the challenges they face within them. A good coach can help individuals evoke those answers and become aware of possibilities, working alongside them to set goals and craft action plans. Coaching is a collaborative effort that expands a person's capacity to take effective action.

The Gallup research refers to disengaged employees as ROAD (Retired on Active Duty) Warriors. There are many of them. In small companies (fewer than 50 people), only 33 percent of employees reported that they felt fully engaged. The number drops to 22 percent in medium-sized companies. In large companies (more than 5,000 employees), only 19 percent of employees felt fully engaged. (From, Coaching for Managers, by Laura A. Belsten, Ph.D.)

As public health in New Mexico has seen a decrease in resources, including personnel, there can be no ROAD Warriors. All of the staff needs to be used to the fullest.

Vision
The supervisory group in District 1 of the New Mexico Public Health Division builds a culture of coaching, not only up and down the chain of command but also laterally between staff.

Specific Goal
To train a small cadre of supervisors on the coach manager role and have them, in turn, coach the staff in their direct chain of command, using Laura Belsten's manual, Coaching for Managers.

Project Timeline
November 2004
- Present the concept to the supervisor group. Identify volunteers.
December 2004
- Supervisor and employee complete the pre-survey.
January 2005
- Provide supervisor coaching training, 3 three-hour sessions.
January February 2005
- Supervisor and employee set up agreement. Plan on meeting at least monthly in February, March, and April using the prep form.

April 2005
- Supervisor and employee take post-survey and evaluation.
- Supervisors meet as a group to evaluate progress and come up with next steps.

May 2005
- Present project to the supervisors group and work on expanding the number of supervisors coaching their employees.

Resources Required to Successfully Complete the Project
- Volunteers
- Survey on Coaching
- Coaching Manuals

Risks and Analysis of Those Risks
*Project risks:* There is a risk that the supervisors in the district do not see coaching as a useful tool in working with employees.

*Personal risks:* As a member of the District Management Team, this will seem as a mandate for some instead of volunteering at this time. I'm looking for volunteers that are committed to trying to make this work in our setting.

Communication System Agreed Upon by the Persons Involved in the Project
- I will communicate with the supervisor's—at their group meeting, on a quarterly basis. Reminders will be sent to volunteers monthly. Requests for feedback will be made monthly.

Project Update
- I am using a coaching survey tool to evaluate changes in perception. At this point I have completed the training for ten supervisors and managers. All supervisors and the staff that they are mentoring have completed the coaching survey once and are completing it again. This will help to evaluate whether the staff feel that coaching is improving the supervisor/employee relationship. Supervisors have been meeting with staff a minimum of once a month and using the coaching dialogue.
Identify the Strengths and Articulate the Health Needs of the Age 40 and Over Community at EPA Region 8
Pamela Dougherty

Background and Importance of the Project
In October of 2004, EPA Region 8 identified the need to address issues around the topic of aging by creating a regional point of contact for aging issues. The current wave of folks moving into the older adult generation has potential implications for our regional office; for example, generation gap issues, education, financial security, health and insurance coverage, and care-giving, to name a few. The impact of these issues on a person’s daily work life can be overwhelming.

During October, following our Leadership Training in Aspen, I was personally impacted by health issues around the same topic. Both of my parents have been very ill the last two and half months, and while they have good insurance, gaps still exist. While the Internet is a great tool, it is not the end-all for seniors trying to gather information. I have spent countless hours on the Internet searching for information on issues such as senior care, care-giver support, Medicare, transportation, home healthcare. The issues surrounding aging and health just keep growing and growing. It has become apparent to me that in order to insure confidence in my decisions I must have information at my fingertips. Currently, there is not a single-point/resource clearing house for information on health issues and aging.

Vision
I envision a compendium on the Region 8 Intranet Web Site containing fact sheets, news releases, and linkable resources that deal with health issues and our aging workforce.

Goals
- Understand more accurately and predict the services and resources required to serve an increasingly aging community in the workplace.
- Establish a Health and Aging Issues Web Site for EPA Region 8 which would serve as a one-stop shopping source for information.

Timeline
- Recruit a team to draft an assessment tool to identifying the strengths and articulate the needs of the 40 and over age community at EPA Region 8. (Jan. 2005)
- Administer assessment. (Feb. 2005)
- Analyze data. (March 2005)
- Present results. (March 2005)
- Gather potential resources for compendium. (May 2005)
- Web site up and running. (Aug 2005)

Resources
This project will require resource commitment by me, the Aging Coordinator for the Regional Office, the Equal Employment Opportunity Office Director, EPA staff
participation in the assessment, support from the Denver Regional Council of Governments, and Computer Services support.

**Risks and Analysis of the Risks**

For some people this type of information isn't useful or necessary until they are in the middle of a crisis—then they need it. Getting staff to complete the assessment tool and then utilize the Web site may be a challenge. As the team drafts the assessment tool, we will have to be creative in our thinking of how to roll it out to folks.

Ongoing maintenance of the Web site with the limited resources we have could be a potential risk. We will need to insure management buy-in as we proceed.

**Communication System for the Project**

This is where the "inspiring a shared vision" (my focus for this project) really comes into play. My communication strategy will be directed at communicating my hopes and dreams (since this is very personal to me) as well as a sense of purpose for this project, which will be meaningful to those who have yet to experience this same issue. I have already begun working with our Regional Aging Issues Coordinator. Informal meetings in the early stages of the project will be important.
The Northern New Mexico Diabetes Consortium
Cassandra Duran

Project Description
The Northern New Mexico Diabetes Consortium will replicate an existing and highly successful Diabetes Collaborative Program currently in use by clinics in the western region of the Health Centers of Northern New Mexico (HCNNM) service area and the Mora Valley Health Care Services.

The program has substantially lowered average blood sugars as measured by A1c values. Over three years, the replication will spread the program to seven new clinics and nine hundred patients who are not currently receiving the enhanced services. In addition to addressing diabetes, this project will create an infrastructure that can be used to address other chronic diseases as a part of future projects.

Goals for the Consortium
- Improve blood sugar control for nine hundred diabetes patients over three years through expanded education and preventative care.
- Improve management of other chronic diseases by establishing the infrastructure for a Chronic Disease Management Program.

Needs Addressed
New Mexico has the seventh highest rate of death due to diabetes in the nation, with the prevalence of diabetes among Native Americans and Hispanics being a contributing factor. Mortality rates for diabetes are 523 percent higher for Native Americans and 144 percent higher for Hispanics compared to whites. Since 80 percent of the residents in the project service area are Hispanic, diabetes is a critical health issue in this area.

Proposed Services Will Include
- Clinical services for diabetes patients.
- Educational services provided by Certified Diabetes Educators (CDEs) and promotoras (culturally sensitive health advocates) encouraging diabetes patients to use a self-management tool.
- Public education programs and diabetes screening at health fairs, schools, etc.

Completion Milestones
The work plan in the following section will provide projected completion dates for specific activities. The following milestones deal with major goals and strategies to be used as part of a summative evaluation process.

Year One
- Hire a Disease Management Director to oversee project. (Month 2)
- Hire additional staff needed to expand the project to the entire seven-county area. (Month 4)
- Register at least 200 new diabetes patients in the electronic registry. (Month 12)
Year Two
- Continue ongoing training for project staff. (Ongoing)
- During the year, add 300 new (500 total) in the electronic registry. (Month 24)

Year Three
- Continue ongoing training for project staff. (Ongoing)
- During the year, add 400 new (900 total) in the electronic registry. (Month 36)

Risks and Analysis of Those Timelines
Four primary obstacles are predicted in implementing the work plan cited in the previous section:

- Overcoming cultural barriers with patients
- Developing effective working agreements between agencies
- Financial/poverty barriers
- Distance/transportation barriers

Cultural Barriers: A primary component of this project involves overcoming cultural barriers in treating diabetes patients. One of the reasons diabetes was chosen as the first disease to be addressed by the Chronic Disease Management Program was the importance of self-management for patients dealing with the disease.

Working Agreements: The planning process for this project has done much to build bridges among the Health Centers of Northern New Mexico (HCNNM), the New Mexico Department of Health, and the Mora Valley Community Health Services. These three agencies are the primary health providers for low-income residents in the region. In fact, there is a long history of cooperation and mutual assistance between these agencies. For example, the HCNNM and the Department of Health have an integrated services model in Roy, a small rural town an hour north of Las Vegas. In this town, both nursing and clerical staff share the responsibility for services.

Financial/Poverty Barriers: One in four residents of San Miguel and Mora Counties live below the poverty level. Unemployment in San Miguel County is at 10.2 percent and at 15.4 percent in Mora County. These people do not have health insurance. National health programs estimate that individuals and families must have an income of at least 200 percent of the Census Bureau's designated poverty level to be able to afford health insurance. Using this figure, uninsured residents in that two-county area include at least one-third of the total population. Public assistance health programs such as those provided by partners in the Northern New Mexico Diabetes Consortium are essential for the uninsured population.

This subsidized diabetes education and preventative care program not only benefits low-income diabetes patients but also the local taxpayer. At present, too many diabetes patients fail to seek care until they require treatment at a local emergency room. This translates into decreased quality-of-life for the patient and a substantial health cost for taxing entities that cover the cost of such treatment.

By identifying, diagnosing, and treating low-income diabetes patients through a relatively low-cost educational and preventative care program, this project addresses barriers faced by low-income patients. The use of *promotoras* for this project will encourage diabetes
patients to enroll in public health programs and seek the type of ongoing preventative care that can both improve quality-of-life and decrease health costs.

Distance/Transportation Barriers: Travel from one end of the northern New Mexico service area to the other takes up to an hour and that is on a good day when the driver isn't dealing with snow and ice on mountain highways. The 2000 Maternal and Child Health Plan states: Travel to a clinic or to the doctor's office often poses a problem for many residents. There is not enough public transportation available in the San Miguel County area. This finding was confirmed in public meetings held as a part of project planning. Several senior citizens, when asked about what would help them get more exercise as a part of diabetes treatment, stated that transportation to classes and exercise facilities was difficult for them.

Public transportation is simply not cost effective in a rural area where some counties have less than one person per square mile. This is an ongoing challenge for healthcare providers, and there is no immediate solution in site. Consortium partners strive to maintain clinics in highly rural communities, thereby decreasing the distance rural residents must travel for care. Although details have not been solidified in project planning, it is likely that part of the promotora's tasks will include home visits, especially to those who face particular difficulty in traveling to clinics.

Project Update

The Consortium met and we received an update from HCNNM informing us that the funding grant was not approved. We are still gearing up for completion of the project because the curriculum for the CDE does not require any monies from any of the agencies—it only requires commitment from the agencies for salaries and time. One change brought to yesterday’s meeting was that the HCNNM is now volunteering a registered nurse from their facility in order to complete the training along with the public health nurse.

During the course of the timeline of the meetings listed, I was also able to get the Las Vegas Medical Center to participate by donating the services of a registered nurse. This facility has approximately 1,000 or more community mental health clients who more than meet the risk factors listed in this project. Thus, three RNs will attend the training together during the up-coming year.

I will continue to closely monitor this project during the next year and reapply for funding to hire the Disease Prevention Coordinator as I planned before receiving the news that the project was not funded. This project could be used to improve the health of northern New Mexico clients with at risk behavior which leads to chronic disease.
Interactive Public Health Atlas for Colorado
Mark Egbert

Background
A properly designed, interactive public health atlas could be an effective education and visualization tool for both public health professionals and the public. Such an atlas would present public health topics geographically or demographically; for example, by county, zip code, census tract, or neighborhood.

This project will test the feasibility of developing a public health atlas for Colorado. Public health professionals will be contacted and introduced to the idea. A simple prototype atlas will then be developed, and this prototype will be used to further explore and illustrate the concept.

Goals
I have two overall goals for this project. First, I hope to refine the concept of a public health atlas as it applies to Colorado. Second, I hope to illustrate the importance of presenting a more detailed overall picture of public health in Colorado.

The Prototype May be Modeled after the Following Web Site
http://www.mla.org/census_main

Resources Required
The data that will be needed for the prototype is generally available, or it is being assembled to meet deliverables for other projects.

Since this project does not require a great deal of applications development work, additional resources will probably not be required. However, if additional money does become available for the development of the atlas prototype, it may be possible to develop a more usable final product.

Timeline
Phase 1
- Public health professionals will be interviewed from January through March of 2005. The concept of a public health atlas for Colorado will be introduced by demonstrating existing Web-based atlases, and by illustrating the ways that an atlas could help address a specific health issue. Feedback obtained during this process will be incorporated into the development of a prototype.

Phase 2
- Beginning April 2005, work will be started on the public health atlas prototype. I anticipated that the prototype will take at least one month to develop. Once the prototype has been developed, the people interviewed in Phase 1 will be recontacted, and their feedback will again be solicited.

Risks and Analysis of Those Risks
- This project will bring to the forefront a number of issues pertaining to the use and distribution of spatially enabled public health information. The data will
be handled appropriately, but it is possible that presenting the data in this manner may make some people uneasy.

- The concept must be kept simple. If the prototype is too complex, the overall message will be unclear.
- The atlas prototype must be very well organized and very well presented. If the prototype does not present the idea well, opportunities for future work may be lost.

**Communication**

The concept of a public health atlas for Colorado will be presented through a series of informal contacts. Ideally, opportunities for more formal presentations will also occur.

Hopefully, follow-up communications that occur after the prototype has been developed will lead to opportunities for the continued development of the Colorado public health atlas.

**Relevant Web Sites**

- [http://www.dartmouthatlas.org/](http://www.dartmouthatlas.org/)
- [http://www.drcog.org/](http://www.drcog.org/)
- [http://www.cdphe.state.co.us/stats.asp](http://www.cdphe.state.co.us/stats.asp)
- [http://www.cdphe.state.co.us/cohid/overviewPub.html](http://www.cdphe.state.co.us/cohid/overviewPub.html)
- [http://www.cdc.gov/epiinfo/maps.htm](http://www.cdc.gov/epiinfo/maps.htm)
- [http://www.coloradotrust.org](http://www.coloradotrust.org)
- [http://circ.rupri.org/](http://circ.rupri.org/)

Indian Ocean disaster:

- [http://www.geodata.gov/gos](http://www.geodata.gov/gos)
Colorado Physicians of Color
Oswaldo Grenardo, Andrea Oliver, and Suman Morarka

Background and Short Description of Project
Colorado has a long record of talented under-represented minority (URM) physicians. These individuals have broken through color barriers, changed law, and pioneered social interventions to better serve the healthcare needs of Coloradans, especially those that are underserved. The national and local focus on health disparities between racial and ethnic populations has also intensified the glaring need for URM physicians to effectively and collaboratively address this issue. While these physicians have made significant contributions, they have lacked an organization dedicated to these same issues to augment their efforts.

The project undertaken was to develop a professional organization called Colorado Physicians of Color (CPOC). CPOC is a proposed 501(c)(3) not-for-profit organization whose mission is to serve as an instrument for URM physicians to address the needs and concerns of the Colorado URM physician community as well as the patients they serve.

Goals for this Organization
- Build the community and leadership training of Colorado's URM physicians through education, networking, and social activities.
- Promulgate guidelines and develop other devices for promoting cultural competence and diversity between the health professionals.
- Serve as a resource for Colorado concerning health and social issues related to racial and ethnic minority communities in Colorado.
- Engage in recruitment and retention of URM medical students, residents, and physicians in Colorado.
- Provide opportunities to mentor URM medical students, residents, and physicians in Colorado.
- Obtain 5 percent participation among Colorado Medical Society (CMS) members in order to be granted a seat on the CMS Board of Directors.

Note: This will be a Web-based organization with a physical office location near the Colorado Medical Society office. It is anticipated that partner organizations would contribute either funding or volunteer staff assistance to initially support the organization.

The Results of the Project to Date
Prior to holding the CPOC inaugural meeting, partnerships were formed with the Colorado Medical Society, the University of Colorado Health Sciences Center (UCHSC), the Commission on Family Medicine/Colorado Association of Family Medicine Residencies, Caring for Colorado Foundation, the Colorado Minority Health Forum, the Office of Health Disparities at the Colorado Department of Public Health and Environment, the office of Civil Rights/U.S. Department of Health and Human Services, Kaiser Permanente, the Denver-metro Black Church Initiative, Graduate Medical Education programs throughout Colorado, the UCHSC American Indian and Alaska Native Program, and the International Medical Graduates and Colorado Asian Health Education and Promotion (CAHEP).
Several examples of the support obtained from our partners include, (1) an ad that was paid for and placed in a prominent physicians’ newsletter, (2) funding was secured for dinner, (3) education was received on infra-structure building, (4) guidance was received about forming a health professional organization, and (5) information regarding the meeting was widely distributed. The primary benefit of the partnerships, however, was to secure support from various organizations that are committed to developing long-term working relations with the CPOC in order to assist the organization in meeting its goals and functions and the objectives of their respective organizations.

The inaugural meeting for CPOC was held on April 8, 2005, at the Ben Nighthorse Campbell Center for Native American Research, University of Colorado Health Sciences Center, Fitzsimons Medical Campus. The meeting was attended by approximately fifty individuals that were physicians, medical residents/students, and persons from the healthcare field. During the meeting, participants were placed in small groups to discuss survey questions and then their responses were shared with the larger group. During the facilitated discussion, strategic planning was discussed and recommendations were given as to next steps to be taken by CPOC in order to ensure its sustainability.

A debriefing was held following the inaugural meeting and it was agreed that it is imperative to tap into the excitement generated in order to keep up the momentum.

Looking Forward

The Board members will meet quarterly and will decide on issues facing the URM physicians and students. The members will be communicating through e-mail and telephone.

We believe this project has great promise and feel it is critical in these beginning stages of development to continue to recruit members and provide a value-added-product to sustain momentum. We will be looking for short term sources of grant money to build our database and Web site, create a board of directors, and file for 501(c)(3) designation.

Update

We are in the process of setting up a Web site for information and a directory for the CPOC. This will serve as a resource site for anyone interested in URM physician issues. Some of this work is possible due to a grant from Caring for Colorado Foundation. This grant started in August 2006, and will be for a period of one year. A section for Diversified Physicians has been established at the Colorado Medical Society. We are excited about meeting for educational and informational exchange purposes every other month. Ozzie Grenardo and Suman Morarka are the Co-Directors of CPOC and Andy Oliver is on the Board of Directors.
Public Health Experience Connection
Heath Harmon

Background
During the past several years, public health funding has been drastically decreased. This has had many adverse affects on the local public health workforce, such as decreases in staff, and, in an effort to try and compensate, the assumption of new responsibilities on top of already overwhelming workloads.
At the same time, there has been an increase in the number of accredited public health programs throughout the nation. Many of these curriculums require students to complete internships or practicums in order to fulfill experience criteria necessary for graduation. In addition to public health students, there are many other health-related fields, such as medicine, nursing, and veterinary medicine, where public health experience would be helpful to their training.

Vision
I envision the creation of a network that helps to connect the resource (students) to the need (public health departments). This connection will allow for the students to develop their real world experiences in public health by working on specific projects, internships, etc., for public health agencies throughout Colorado.

Specific Goal
Develop a Web portal that allows public health agencies to post descriptions of projects in order to recruit qualified students to perform activities that benefit the public health mission while providing valuable work experiences.

Project Timeline
Stage 1

Stage 2
- Identify and develop partnerships that share this vision. (January 31, 2005)

Stage 3
- Hold collaborative meeting that pulls all partners together. (February 2005)

Stage 4
- Research the development of an application that will provide this connection with limited ongoing maintenance. The application should allow public health agencies to post positions while providing students and universities access to the site. The site should be easily navigable and support the overall mission of public health. (February 2005)

Stage 5
- Develop a specific timeline for the development of the Web page and application. (March 2005)

Stage 6
- Develop a marketing strategy that will reach the students, universities, and public health agencies. (February-April, 2005)
Stage 7
- Deployment of the Web page. (August 31, 2005)

Stage 8
- Maintain, assess, improve, and continue marketing. (Ongoing)

Resources Required
Partnerships and investors will be vital to the success of this vision. This will include public health agencies, universities, and student organizations, as well as other public health organizations, such as the Colorado Public Health Association (CPHA) and the Colorado Environmental Health Association. In addition, funding may be necessary to employee programmers and developers to create the Web page and application. Significant time will be needed to fully develop a resource that is useful and professional.

Risk Assessment
There is no risk to members of the public. However, there will be a risk to the integrity of all partners involved in the development and deployment process. Each partnering agency or organization will be forced to review their own policies to assure that no internal policies are being broken. For this to be useful, a method of maintenance and ownership will need to be devised to ensure its continuation.

Communication
There will be one project manager that will oversee all of the routine daily activities necessary to keep the project on a timeline. Communication will occur through all possible methods, including face-to-face meetings, telephone/conference calls, and e-mail, and will include other methods as identified in the marketing strategy. The effectiveness of the communication systems will continuously be assessed to ensure that best practices are being implemented at all times.

Results
Progress has been made in several areas, yet there remains much work to see this project through to its original vision.

The idea of a network connecting applicants to positions is not a new idea. Several searches were performed online to determine what networks could potentially serve as a template for this Web portal, including several employment sites. Among the many that were reviewed, a site housed within Emory University’s Rollins School of Public Health seemed to provide a user friendly interface that allows public health agencies to post positions, and it allows students to review opportunities based on their interests.

Partnerships are extremely important in order to get this project off the ground. In the past five months, discussions have been held with many public health professionals, including the president of the CPHA, many Boulder County Public Health (BCPH) staff, and student organizations at the University of Colorado.

Initially, the thought of partnering with a large public health association, such as CPHA, was promising. Housing a public health experience connection portal on their Web site seemed like a good choice given the common objectives of promoting public health in Colorado and improving resource availability to local agencies. However, obstacles regarding the development and maintenance proved too much to overcome in the short term.
The potential for partnering with CPHA is still a possibility, but only after a Web portal can be tested on a smaller scale to ensure that it can be easily sustainable and effectively meet the goal of this project. Thus, the short-term focus has changed to that of developing a portal that can be housed on BCPH's Web site.

In addition to the collaborative work thus far, an equally important component of this project is to show just how effective interns and volunteers can be at helping a public health program meet its mission. This quickly turned into an opportunity to lead by example (i.e., model the way). With the assistance of handful of staff at BCPH and the Colorado Department of Public Health and Environment, several internship opportunities were created to assist with critical communicable disease control efforts in Boulder County this summer, including a zoonotic disease surveillance program and West Nile virus prevention and outreach. It is my hope that by demonstrating the positive impact of interns that I will motivate other programs to utilize students when possible, ultimately increasing the opportunities that BCPH creates to meet their public health mission.

Next Steps

A business proposal will be developed and presented to Boulder County’s Information Technology Department to gain a better understanding of what resources will be necessary to create this Web portal. Additionally, work must continue on networking and collaborating with Colorado universities and other public health professionals to refine the concept of this portal, ensuring that it meet the needs of students and public health agencies.
**Family Preparedness Outreach**  
Diana Harris, Julie Thibodeau, and Lyle Moore Jr.

**Background**  
The United States of America was forever changed with the terrorism events of the World Trade Center, the Pentagon, and the bioterrorism event of anthrax along the east coast. Every year hurricanes strike the coast and wildfires rage through our nation's forests. Even in our state of Colorado, disasters occur: the blizzard of 1982, the anthrax scare in Fort Collins, the Missionary Ridge Fire, the Haymen Fire, and the snowstorm that brought four feet of snow in the spring of 2003. While it is hard to predict when emergencies might happen, it is easy to be prepared should they occur.

**Vision**  
Raise awareness in Colorado families about the importance of being prepared for emergency events, whether they are natural or man-made, and help ensure a more informed community.

**Goal**  
To educate families through an outreach campaign in a familiar environment regarding activities that facilitate discussions and development of a family readiness plan and emergency kit.

**Timeline**
- Brainstorm outreach ideas, concepts, and target populations. (12/2004)
- Review and gather existing materials and data on family preparedness. (2/2005)
- Obtain funding source(s). (Ongoing)
- Identify possible mediums and/or locations for outreach campaign. (3/2005)
  - Contacted McDonalds, Chick-fil-A, Wendy’s, and the Denver Zoo.
  - Met with Denver Zoo Director of Special Events, Patrick Phalen, on 4/6/2005.
  - Solidified date with Denver Zoo for 8/13 and 8/14 (Dr. Zoolittle Days).
- Develop/compile/modify educational materials for dissemination. (7/2005)
- Campaign kickoff. (8/13/2005)

**Resources Required**
- Staff time from Diana, Julie, and Lyle.
- Educational materials from the Federal Emergency Management Agency, the Red Cross, the Office of Emergency Management, and health departments.
- Possible graphic designer to develop pamphlets/coloring books, etc.
- Use of “Jeffco Fight Bac” game wheel.
- Prizes for games.
Funding sources:
- The Colorado Department of Public Health and Environment - $2,500.
- The San Juan Basin County Health Department – tbd.

Risks and Analysis
There is a potential for a lack of interest from the facilities and/or families. As of December 10, 2004, we are still waiting for facility buy-in. One facility has requested a one-page project summary to determine interest.

There is a potential lack of funding. During a meeting in December of 2004, discussions were held surrounding possible funding sources. There may be a lack of interest by our employers to support this project. There may be a need to secure external grant funding.

A potential personal risk could be the lack of support by employers for staff time. There may be a need to volunteer free time in order to disseminate educational materials.

Communication System
All activities within timelines require monthly update meetings among team members. The use of e-mail and phone conferencing is the choice of communication system. Meetings with external partners will be held on an as-needed basis and systems used will be determined at that time.

Results
Based on the research for facilities to support the project, we decided to utilize the Denver Zoo as our familiar environment in order to facilitate discussions and raise awareness on family emergency preparedness. We have obtained a space free of charge at the Dr. Zoolittle Days on August 13 and 14, 2005. The focus of Dr. Zoolittle Days is childhood health, safety, and literacy. The Denver Zoo will host the event along with two national sponsors, Radio Disney and CBS Channel 4. The projected attendance for the two-day event is 14,000 to 20,000.

Funding has been obtained through the Colorado Department of Public Health and Environment Emergency Preparedness and Response Section for $2,500. Funding support from Jefferson County and San Juan Basin County Health Departments is still in negotiations. All three agencies have supported staff time due to the relevance of the project with the Centers for Disease Control and Prevention preparedness grant deliverables.

We are currently preparing materials for our resource table. The following ideas are currently under development:
- Red Cross Disaster Preparedness coloring book
- Colorado specific emergency preparedness guide
- Magnets with hotline numbers
- Prizes for games
- Colorado Division of Emergency Management 72 Hour Family Emergency Kit pamphlet
- Other pamphlets/books/games as discovered
Limited English Proficiency (LEP) Educational Forum
for Health Professionals
Cara Silva Huff

Background
In 2004, it was estimated that forty-six million people in the United States did not speak English as their primary language, and more than twenty-one million spoke English less than "very well." Providing adequate health information when communicating with patients who have limited English proficiency (LEP) is a challenging issue faced by providers across health professions. Health professionals are in need of communicating effectively with their clientele in order to provide adequate and needed health information. These health professionals include physicians, nurses, public/environmental health professionals, medical assistants, front-desk workers, and health interpreters.

Vision
I envision an improvement in the administration of health information to populations with LEP.

Specific Goal
To create an educational forum or group in which health professionals may learn and share resources and information about working with LEP populations.

Project Timeline
Stage 1
- Gathering buy-in with local health professionals and/or organizations that have a similar passion and vision.

Stage 2
- Perform a needs assessment with local health professionals (providers).

Stage 3
- Coordinate and empower these providers to act, through an initial meeting.

Stage 4
- Create an educational platform for sharing and learning about providing health information and care to individuals and communities with LEP.

Stage 5
- Establish a home and a maintenance system for the platform.

Resources Required
- Staff time.
- Electronic resources: a survey tool for the creation and implementation of a needs assessment, Internet, e-mail access, etc.
- Possible funding to administer needs assessment, marketing, and/or training sessions.
- Educational materials, pamphlets, flyers, and posters.
- Community collaborative partners input and participation.
Risk Assessment

- Potential for non-interest from target audience (health professionals).
- Potential for lack of buy-in from prospective collaborative partners/individuals.
- Lack of financial, staff, and/or support resources from agencies (CDPHE, private, etc.).
- Future sustainability of the final product.

Results

The first stage of this project has included the gathering of partners for collaborative participation in the project. There are currently four main groups who have agreed to participate in the project in a variety of capacities:

- Community individuals who share a similar interest in the subject and who will assist in the leadership, development, and assessment.
- The Colorado Department of Public Health and Environment.
- The LEP Steering Committee, who has agreed to provide the group with guidance and the possibility of partnership with their department activities.
- The Colorado Minority Health Forum, who has agreed to take the prospective LEP Educational Forum (LEPEF) under the umbrella of their organization, allowing use of their organization’s resources and name, as well as taking this project under their Leadership Committee as a priority.

The second phase of this project includes the development and implementation of a needs assessment survey to our target group throughout Colorado. The development of an electronic survey (through Zoomerang) is in the final stages. I hope to have this survey in the distribution mode by the time we meet at our final meeting in Estes Park, Colorado. The strategy is to distribute the survey to a variety of health professionals (providers) and to create a "snowball" sample by asking providers to answer the survey and distribute it to others they know who might be willing to answer a short twelve-question survey. The objectives of this survey include:

- To gather input from a variety of health professional perspectives (physicians, nurses, social workers, public and environmental health professionals, medical assistants, interpreters, etc.).
- To gather demographic information and to assess needs from these providers.
- To assess their specific interest in participating in an LEPEF.
- To identify what a forum might look like (where, how, what, cost, etc.).
- To discover if they might want to be involved further.

If you are a Colorado resident, please consider answering this Zoomerang questionnaire yourself at [http://www.zoomerang.com/survey.zgi?p=WEB224AU8H7LEJ](http://www.zoomerang.com/survey.zgi?p=WEB224AU8H7LEJ)
Healthy Connections in Head Start Communities
Jim Ledbetter, Gloria Richardson, and Nancy Strauss

Background, Importance of the Project, and Goals

Primary healthcare begins with developing a relationship with a primary care provider (PCP). Children who receive care through a consistent PCP are more likely to receive coordinated care in a compassionate manner. Those children are more likely to be up-to-date in immunizations and less likely to utilize expensive emergency room services for non-urgent care. Yet, access to primary healthcare services for Head Start families continues to be a barrier because many families do not qualify for public health insurance, such as Medicaid or the Children's Health Plan Plus, and cannot afford private insurance. Other families are having increasing difficulty finding healthcare providers that will see them if they are covered through a public health insurance program. Many low-income families are baffled by the complex healthcare system that they must navigate to obtain quality healthcare for their children.

Local Head Start programs are run through community not-for-profit agencies via a competitive federal grant process. Denver Great Kids Head Start began in 1997 when the City and County of Denver was awarded a Head Start grant. The City and County of Denver oversees a collaborative of direct service providers and contractors in providing early childhood care and education programs. In Aurora, the Head Start grant is managed by Cerebral Palsy of Colorado and is incorporated into their child care program called Creative Options and includes one site for Early Head Start (EHS) for children 0 through 2 years, as well as several Head Start sites for children 3-5 years.

Kaiser Permanente has a long history and tradition of community service, and, as a not-for-profit organization, has a duty and social responsibility to help the communities in which they live and work. "Connections" is Colorado's reduced rate healthcare plan that is available to a limited number of low-income persons in the Denver/Boulder metropolitan service area as they move toward economic self-sufficiency. By offering subsidized memberships through an appropriated charitable fund, Kaiser Permanente reaches out to communities and makes connections with individuals who need assistance.

Vision

To increase access to primary healthcare services for Head Start children and families through the following objectives:

- Increase the number of children who access primary healthcare services.
- Increase the number of children who access dental health services.
- Increase the number of families who have health insurance.

Resources Required to Complete the Project

The core project team consisted of Gloria Richardson, Nancy Strauss and Jim Ledbetter. Partners include: Denver Great Kids Head Start, Creative Options of Aurora (Head Start) and their parent organization Cerebral Palsy of Colorado, Kaiser Permanente (specifically their Prevention Department), Clinica de la Familia, Rocky Mountain Youth
Clinic, the Colorado Dental Society, the Children’s Dental Health Project, the Region 8 Dental Consultant, Colorado Consumer Health Initiative, and Denver Health.

**Project Timeline**

<table>
<thead>
<tr>
<th>Healthy Connections (RIHEL Project)</th>
<th>Lead</th>
<th>Begin Date</th>
<th>Due Date</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet to design project</td>
<td>RIHEL Trio</td>
<td>9-Nov-04</td>
<td>15-Dec-04</td>
<td>27-Dec-05</td>
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<tr>
<td>Review data</td>
<td>RIHEL Trio</td>
<td>9-Nov-04</td>
<td>31-Jan-05</td>
<td>31-Jan-05</td>
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<tr>
<td>Recruit collaborators</td>
<td>RIHEL Trio</td>
<td>9-Nov-04</td>
<td>1-Mar-05</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Assistance to enroll in any eligible insurance program</td>
<td>NS</td>
<td>16-Nov-04</td>
<td>31-Jan-05</td>
<td>28-Feb-05</td>
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<tr>
<td>Meet with Head Start staff around Kaiser enrollment</td>
<td>RIHEL Trio</td>
<td>16-Nov-04</td>
<td>10-Dec-04</td>
<td>7-Dec-04</td>
</tr>
<tr>
<td>Recruit and meet with dental providers</td>
<td>GR</td>
<td>15-Dec-04</td>
<td>1-Mar-05</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Recruit and meet with PCP</td>
<td>JL</td>
<td>15-Dec-04</td>
<td>1-Mar-05</td>
<td>31-Dec-04</td>
</tr>
<tr>
<td>Meet with faculty consultants</td>
<td>RIHEL Trio</td>
<td>15-Dec-04</td>
<td>11-May-05</td>
<td>6-Jan-05</td>
</tr>
<tr>
<td>Develop system to provide service</td>
<td>RIHEL Trio</td>
<td>2-Jan-05</td>
<td>1-Mar-05</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Develop outcome evaluators on improved access to care</td>
<td>RIHEL Trio</td>
<td>2-Jan-05</td>
<td>28-Feb-05</td>
<td>14-Mar-05</td>
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<tr>
<td>Develop education materials on accessing care</td>
<td>RIHEL Trio</td>
<td>2-Jan-05</td>
<td>1-Mar-05</td>
<td>02-May-05</td>
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<tr>
<td>Train HS staff to work with families on accessing care</td>
<td>NS</td>
<td>31-Jan-05</td>
<td>1-Jan-05</td>
<td>27-Apr-05</td>
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<tr>
<td>Begin implementing follow up services for Dentistry</td>
<td>GR</td>
<td>1-Mar-05</td>
<td>1-May-05</td>
<td>01-Nov-04</td>
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<tr>
<td>Begin implementing on site services for PCP</td>
<td>JL</td>
<td>1-Mar-05</td>
<td>1-May-05</td>
<td>Not Feasible</td>
</tr>
<tr>
<td>Evaluate results and write report</td>
<td>RIHEL Trio</td>
<td>1-May-05</td>
<td>11-May-05</td>
<td>11-May-05</td>
</tr>
</tbody>
</table>
Results

Our project team was able to increase access to primary healthcare services for Head Start children and families, and will reach many others via our health literacy fact sheet, training for Head Start providers, and collaboration with the Colorado Community Health Network.

- **Objective 1**: Increase the number of children who access primary healthcare services. About fourteen children previously ineligible for public programs were enrolled in the Kaiser Permanente Connections program. Many other children have and will continue to receive information about how to access primary healthcare services.

- **Objective 2**: Increase the number of children who access dental health services. Dental screening increased to 100 percent (up from 96 percent). Head Start children received dental screening by the nurses and dental care providers.

- **Objective 3**: Increase the number of families who have health insurance. Nineteen families (thirty-six individuals) were enrolled in the Kaiser Permanente Connections Program—ten families from Aurora Head Start and nine Denver Great Kids families. Many other families in both programs have received and will continue to receive information about how to access primary care.

Lessons Learned

- Transition an idea into action—others had similar needs, develop the idea and collaborate!
  - Shared values—we helped empower employees and clients to navigate the system and to develop resources for communities (agencies, providers, consumers, and advocates).
  - Use consumers to get input—we learned:
    - To lay the foundation of the "why."
    - That the need for affordable healthcare coverage for the working poor needs to be clearly confirmed (i.e., early childhood education staff).
    - To make it usable/practicable (i.e., language, literacy level, portability!).
  - Communicate to collaborators that sometimes the most simple needs go unaddressed. Share information and ideas and make the work product available to collaborators. Everyone has ownership. Disseminated by individuals, agencies, systems, structures, and networks.
  - That the healthcare delivery system is in need of a complete overhaul. Each one of us has a role in how to make that happen.
The Colorado Coalition  
of Sexually Transmitted Disease (STD) Prevention  
Terry Lee

Background  
In 1999, The Colorado Department of Public Health and Environment created the Colorado Coalition of STD Prevention (CCSP) to address STD prevention efforts in the state. The CCSP membership consists of state health department officials, youth serving agencies, correctional facilities, and various community based organizations. The mission of the CCSP is to develop a coordinated network of prevention activities to reduce disparities of sexually transmitted diseases, particularly among communities of color, through leadership, advocacy, and collaboration.

Since its inception, the CCSP has undergone several changes in leadership and philosophy, which has caused a decrease in meeting attendance.

As one of two new co-chairs for the CCSP, I hope to help change the direction of the CCSP. Historically, the CCSP has made global goals which were difficult if not impossible to achieve. The lack of progress towards these goals has created a perception of ineffectiveness.

Vision  
To restore the credibility of the CCSP and to make the coalition a major network of STD prevention activities around the Denver-metropolitan area and the state of Colorado.

Goals  
The CCSP identified three short term goals:
- Create a resource inventory guide.
- Develop a quarterly CCSP newsletter and event calendar.
- Develop a CCSP Web site.

Timeline/Progress to Date (May 2005)  
- The co-chairs, steering committee, and facilitators conducted a strategic planning meeting. During this meeting, we discussed the areas the CCSP needed to focus on for the next year, and established three goals we felt were obtainable within the year. We all agreed that some short term successes were necessary to revitalize the coalition. (December 2004)
- The first quarterly meeting took place at a community-based organization on the Fitzsimons campus. While the attendance was less than hoped for, community members who did attend were committed and excited with the new goals and direction of the coalition. (February 2005)
- The first CCSP newsletter was drafted and will be distributed to the member list shortly before the next quarterly meeting. The CCSP Web site is developed and should be up and available to the public within the next few weeks. (April 2005)
- The resource directory has been more difficult to develop than initially thought. Few community members responded to the e-mail or letter that was
sent in February. The e-mail and letter included a brief questionnaire asking for agency information. We decided that a personal touch would be more effective, therefore, the co-chairs and facilitators agreed to make telephone calls to community agencies to gather information for the resource directory. We hope that the resource directory will be started by the next quarterly meeting. (May 2005)

**Accomplishments**

By achieving two of the three initial goals for the year, I believe the CCSP has shown some small steps of progression. The newsletter and event calendar will be used to share information of up-coming events that focus on STD prevention activities. Often many organizations are not aware of each others' activities and therefore can not offer support or collaboration to ensure success for those events. In addition, by having a Web site which lists STD prevention activities, the CCSP creates credibility and viability within the community and among organizations that address STDs.

In the past, meetings were not convenient for the Coalition members and often took hours to complete. This year the Coalition has tried to implement teleconferencing and e-mailing. The time of the quarterly meetings has changed to be less time intensive and more accommodating to Coalition members.

**Challenges**

The CCSP does not have a governing body and lacks the authority and power to make decisions that can influence the progress of the Coalition. The Coalition is open to anyone who is interested in STDs. At times, there are conflicts among coalition members who are not involved in the area of STDs and the co-chairs and facilitators. Some Coalition members have motives and agendas that are not directly tied to the overall mission of the CCSP.

The CCSP does not receive direct funding to implement any STD prevention activities, making it difficult to impact the communities with the highest prevalence of STD infections. It is hard to foster collaboration with few resources. The CCSP will need more community lay members in order to become widely known and accepted by the community at large. To date, progress toward gaining involvement and support from these community members has been slow but this continues to be a future goal for the Coalition.
National Environmental Policy Act (NEPA) Training at the Installation Level

Jeff Linn

Background
The purpose of the National Environmental Policy Act (NEPA) is to require proponents of federally funded projects to consider the environmental impacts that the projects may have and to consider alternatives that would minimize any impacts. These impacts would include changes to air and water quality, wetlands, wildlife, watersheds, cultural resources, contaminated sites, and socio-economics. Any impacts addressed in the NEPA document that require mitigation are the responsibility of the project proponent. Too often, proponents of a project at Fort Carson may not know of their responsibility or the purpose for going through the NEPA process. There are also times when a proponent decides that they can ignore the NEPA process. A study was conducted at Fort Carson to ascertain the root causes for this failure to comply with the NEPA process. One of the primary causes for breakdown is the lack of understanding of the often complex NEPA process.

Vision and Goal
My vision is to have one hundred percent of Fort Carson’s projects in compliance with the NEPA.
To accomplish this vision, the active participation of all project proponents is necessary. The purpose of this RIHEL project is to create a NEPA training program to reach all Fort Carson project proponents that explains their role and responsibilities. Customized training materials will be developed to meet the specific needs of each organization. These training materials will be available to share with other installations.

Project Timeline
Stage 1
- Prepare training materials, give training at the Fort Carson-wide level and evaluate. (Give training workshop in mid-November 2004 and evaluate in December 2004. Give training workshop in May 2005.)

Stage 2
- Develop training workshop targeted to organizations within Fort Carson and begin presenting the courses and evaluate. (March 2005)

Stage 3
- Conduct ongoing monitoring and feedback. (After giving each workshop.)

Stage 4
- Present a paper at a NEPA conference to present results and offer training course material to other installations to enhance NEPA awareness at their installations. (August 2005)

Resources Required to Successfully Complete the Project
Requirements will be minimal. No additional staff is required. The facility with projection equipment for the Fort Carson-wide meetings is readily available. Portable projection equipment and laptop may be required when giving the training courses to the
organizations. Many already are equipped, but some may not be. Travel, lodging, and meal expenses will be required when giving the presentation at the NEPA conference in August. Mailing costs and CDs may be required for installations interested in using the training at their installation.

Risks and Analysis of Those Risks

Project Risk: One risk is a potential lack of interest from those that need this information the most.

Analysis: We have found that giving training at the Fort Carson-wide level does not generate much interest at the project level. By taking the training to the organization and tailoring it to the type of projects they perform, we hope that interest will be greater. This, combined with the active support of upper management at Fort Carson, should generate greater participation.

Communication System Among Persons Involved in the Project

All stages require the interaction of the Fort Carson NEPA Team. The team will meet at least once a month and more often when necessary. The NEPA staff and management will coordinate organization level contacts to arrange on-site NEPA training courses. The NEPA team will evaluate the course effectiveness and training material at the next regularly scheduled meeting. The last stage will require the coordination and support of higher levels in the Army.

Results to Date

The NEPA team, consisting of five members, worked together in developing the training materials for an Installation-wide NEPA training workshop in mid-November 2004. The slides and notebooks were prepared with the project proponent in mind. We attempted to address what they needed to know regarding the NEPA and to anticipate any questions they may have. Only two participants of several that indicated an interest showed up for this workshop. We were going to cancel the workshop but the participants were in key decision making positions and insisted on it being given. An "After Action" assessment of the workshop emphasized the need to tailor the presentations to the several organizations on Fort Carson and take the workshop out to them. An informal poll of the organizations found that they were receptive to this approach.

The NEPA team identified the organizations that we would need to target. We identified five. One organization we identified needed to be broken out further, since one of their functions is unique to all the others. The real property section within the engineering organization has special requirements.

Since the November workshop (and our assessment of the workshop), our NEPA team went from five members to two. The NEPA workload did not diminish with this loss of personnel, in fact it increased. Therefore, focus was shifted to meeting the Installation’s needs of preparing and processing the NEPA documents and to recruiting replacement staff. We continue to provide support to the proponents when asked.

We are currently developing the training materials for our engineering organization, since they are our largest NEPA customers. We will be acquiring a new staff member in May, which will help to free up more of our time so that we can prepare to give this course this summer. We were planning to present this approach at an annual NEPA meeting this
summer, since other installations have the same challenge as we do. We have even received the support of higher levels of the Army. We may not be able to accomplish all of our goals this year because of staffing shortages, but information can be sent out to interested installations.

**Lessons Learned**

- Be flexible.
- Adjust fire when it is apparent that you are not on target.
- Do not be quick to accept failure—sometimes a project takes time to mature.
- People will help, but you will have to ask them.
- Beware of people who say they want to be on the team but in reality their interest is to be divisive.
Background and Importance

Bacterial Vaginosis (BV) is a common vaginal infection that has been associated with increased risk for preterm delivery. Preterm delivery is problematic in that babies born preterm (less than 37 weeks) tend to be low-birth weight (less than 2500 grams). Preterm and low-birth weight babies are at significantly greater risk than term and normal-weight babies for developing long-term disabilities, such as cerebral palsy, autism, mental retardation, and vision and hearing impairments. In 2002, 12 percent of Wyoming babies were born preterm. The 2004 Wyoming Women’s Reproductive Health Study enrolled 1,150 Wyoming women between the ages of 15 and 45. Over 26 percent of pregnant women and 32 percent of non-pregnant women tested positive for BV. Anecdotal evidence implies that many providers in Wyoming are not aware of how prevalent BV is, the potential consequences of BV infection, and how easily BV can be treated. Further, only 6 percent of women in the WWRHS reported a previous diagnosis of BV. Bacterial Vaginosis is an issue for all women of reproductive age, but it is of particular importance in Wyoming since more than half of Wyoming births are unplanned.

Vision

For BV infections to be detected and treated early in women of reproductive age, potentially preventing preterm deliveries.

Goals

- To increase knowledge and understanding of the epidemiology and consequences of BV in women of reproductive age for Wyoming providers of reproductive health services.
- To increase early identification and treatment of identified cases of BV in Wyoming.

Timeline

- Determine if approval from the Institutional Review Board (IRB) is required. (12/04)
- Develop pre- and post-test surveys for mail and Internet. (12/04)
- Develop educational materials. (12/04)
- Receive approval from the Maternal and Child Health program managers and the Community and Family Health Division (CFHD) administration for surveys and materials. (01/05)
- Prepare and submit the IRB application and material—if required. (12/04)
- Prepare mailing list. (01/05)
- Present to the IRB and obtain approval—if required. (01/05)
- Send mailing #1 of pre-test. (02/05)
- Print educational materials. (02/05)
- Send mailing #2 of pre-test to non-respondents. (02/05)
- Mail educational materials. (05/06)
- Analyze results of pre-test. (05/06)
- Send mailing #1 of post-test. (10/06)
- Analyze results of post-test. (01/07)
- Finalize results and prepare report. (02/07)

**Resources**

This project requires the approval and commitment of the CFHD to take time from other projects and to provide funding for printing and mailing costs (approximately $350). Funding was also provided by the Office of Women's Health in Denver for the educational portion of the project.

**Risks**

- Time required for development of materials and analyses of surveys will take time away from other CFHD activities; however, the benefits of the results should outweigh the costs.
- Increased education among providers may create demand for state-level laboratory services, which are currently unavailable.

**Communication System**

The CFHD's Epidemiology Unit will meet to assign tasks and will collaborate with the Perinatal Health Manager and staff. Additional communication will take place at the Maternal & Child Health management meetings.

**Results to Date**

- IRB permission was received.
- The pre-test questionnaire was mailed to all public health nursing clinics, family planning clinics, private family practice doctors, and ob/gyns. Providers had the choice of completing a paper copy or an online copy of the survey.
- The response rate for the first mailing was only about 30 percent (n=78). Many of the surveys were returned with incorrect addresses.
- Data from the survey shows that most providers are aware of at least one symptom (fishy odor), but very few are able to define the diagnostic criteria. Additionally, many healthcare providers are unaware of the recommended treatment of BV in pregnant women; however, most are interested in receiving additional information for themselves and for clients.
- An updated list of reproductive health providers was obtained for the second phase of the project from the Wyoming Board of Medicine, family planning, and public health nursing clinics.
- The educational materials were printed and ordered.
- The educational letter and materials were sent out in partnership with the WDH Preventative Health and Safety Division's Group B Strep educational campaign. Providers were given the option to order additional brochures and fact sheets on BV.
Additional brochures and fact sheets were sent out to providers who requested them.
The post-test survey was sent out to 506 reproductive health providers.
A few surveys are still coming in, but we have 67 completed with a response rate of 13 percent.

Future Steps
- Analyze post-test surveys
- Create and distribute report
Background and Importance of Project

The Colorado Department of Public Health and Environment's (CDPHE) STD/HIV section began a significant reconfiguration process in 1999 that lead to a first attempt at strategic planning in 2002. The first attempt did not produce a process that fully met the needs of the section. Therefore, program managers revisited a strategic planning approach again in 2004, the objective was to improve the benefits accrued to our partners by changing the way we define and deliver services while improving the management and culture of the HIV/STD section itself. In the initial phases of the process, the program managers and other members of the strategic planning team refined our overall vision for the section, developed ten operating principles to express our desired ways of doing business, defined five goals that would become the focus of the next phase of the strategic planning process, and identified milestones and timelines for each goal. At this time I introduced my RIHEL project. My intent was to coordinate the five teams that would be providing the recommendations of effective management models to be used by our section and to help them achieve their desired goals and milestones. It was at this point—by opening up the process to all interested section staff members so that they could make an active and meaningful contribution to our section’s planning process—that the strategic planning process began to bridge from strategic planning to strategic management. These phase two goal teams completed their work and submitted their recommendations to the strategic planning team by mid-January. The strategic planning team met throughout January in order to affirm the goal teams’ recommendations and to develop plans for a third phase—developing concrete implementation guidelines and objectives.

In the third phase, we utilized three strategy development teams, which allowed the process to open up again to all interested section staff members so that they could make an active and meaningful contribution to our section’s implementation development process. This third phase was quite condensed, lasting only a couple of weeks. The trick was to encourage staff members to remain committed and to be bold by envisioning new ways of doing business. I chaired one of the main teams that undertook this visioning process. (My project was completed on April 27, 2004, with the completion of the recommendation report of Best Practices Phase One Team. However, the process of completing the transition from strategic planning to strategic management is not fully completed for our section.)

Vision

To provide coordination and leadership while the CDPHE STD/HIV Section transitions from its recent strategic planning process (a time-limited process that can often deliver static plans) into the ongoing process of strategic management, which capitalizes on opportunities, allows for fluid adjustments during changing environments, and enables staff members to make an active and meaningful contribution to our section’s planning process.
Timeline

**Phase One**
- Strategic planning: initial discussion and groundwork.  
  (November 2003 - October 13, 2004)

**Phase Two**
- Strategic planning: goal team recommendation development.  
  (October 2004 - January 9, 2005)
- Strategic planning: team reviews phase two work and outcomes.  
  (January 10 & 12, 2005)

**Phase Three**
- Strategic management transition, vision, and recommendation development.  
  (January 9 - January 28, 2005)
- Staff meeting to roll out results to section staff and develop teams to manage implementation of the planning work done in phases one through three.  
  (March 8, 2005)
- Teams meet to develop concrete implementation guidelines and objectives, including the Best Practices Phase One Team, which I chaired.  
  (April 2005)
- Phase Three Teams submit final recommendations.  
  (May 2, 2005)

**Phase Four**
- Prioritize program activities, identify cross program collaboration initiatives and expectations, specify community partnerships, develop implementation plans and time frames, and develop work assignment and accountability systems.  
  (May 2 - 20, 2005)
- Strategic management: implementation and assessment.  
  (June 1, 2005 – Ongoing)

**Resources Required to Successfully Complete the Project**
Since this is largely a project about planning, its main resources are the time and energies of the HIV/STD Section program managers and staff members. Since this process is taking place with the oversight of our section chief, the staff time and contribution have been allocated to the process.

**Risks and Analysis of Those Risks**
The true potential of the strategic planning/management process will not be realized unless a broad range of staff members can become actively involved in the process and contribute in meaningful ways to the development of recommendation and strategies. This will require significant acceptance of the process by the staff and belief that the shared vision(s) can be developed and implemented. Section staff will need to first accept and embrace the process of change, colleagues and program managers will need to encourage other staff members to participate in the change process, program managers will need to be flexible with scheduling and workload so that staff can participate, and all staff members will need to step outside of the box in order to envision a better way of doing business and adapt new methods to reach our goals.

**Results**
Phase three was completed, as planned, by May 2, 2005.
Leadership Lessons Learned

- Model the way. (Challenging when the process has to be mediated by group dynamics.)
- Inspire a shared vision. (There may be as many perspectives of the vision as there are participants, providing clear instructions for group tasks is not enough when giving power away, continually clarify progress toward that vision, and listen carefully for non-verbal messages from the team.)
- Enable others to act. (Even though opportunities can be presented, not everyone has the will, desire, or dedication to act.)
- Celebrate small success. (Helps reinforce team’s will, desire, or dedication.)
Biotech Education for Colorado Opinion Leaders
Timothy Martin

Issue
Bioscience is a relatively mysterious field for rank-and-file policymakers. There is not a general understanding of the differences between traditional pharmaceuticals and biotechnology. Policymakers need a framework within which to analyze public policy issues (e.g., reimbursement, follow-on biologics, importation, tax and regulatory policy) that may affect patient access and future innovation in the biosciences. It is vital that policymakers understand the value of the new therapies and the consequences for patients if access and further innovation is threatened.

Project
Develop and implement a plan to educate key Colorado elected officials and opinion leaders regarding biosciences (human therapeutics).

Vision
This project envisions a future in which this is true: Key elected officials and opinion leaders possess a framework within which to analyze public policy issues that may affect biotechnology and future innovation in biosciences. They understand differences between traditional pharmaceuticals and biotechnology products. They understand the value and promise of innovations in biosciences, as well as the consequences for patients if access is restricted or incentives for innovation are diminished.

Tasks and Timeline
- Identify allies. (October 2004)
- Identify (or target) and engage key elected officials and opinion leaders. (November 2004)
- Develop (or refine existing) talking points, power points, hand-outs, and Biotech 101 curriculum. (November 2004)
- Identify educational opportunities (such as tours, hands-on exercises, meetings with doctors and patients, committee meetings, etc.). (November 2004 through May 2005)
- Prepare feedback mechanisms and modify tactics based on what’s working, and what's not. (November, December 2004)
- Assess impact of site visits on site operations. (Ongoing)

Execution
Key opinion leaders have been supportive. I have had face-to-face meetings with key legislators, key executive staff, Mayor Hickenlooper, and others. I have conducted four in-person bio tours.

Team Internal
- Colorado legislative consultants
- Science education specialists
- Communications
- Medical staff

**Team External**
- Area bioscience associations
- Governor’s bioscience specialist
- Legislative staff (healthcare)
- Patients and patient advocacy groups (Cancer, Arthritis, Kidney)

*Note*: People support what they help create. Engage external components of the team in the creative process in order to develop sustainability.

**Team communication**
- Because team members are not co-located, much of the communication will take place by phone or e-mail.
- Periodic face-to-face meetings will take place, including pre-meetings and wrap-ups associated with specific educational events.
- Notes, including action items, will be issued following meetings and events to ensure common understanding of goals, responsibilities, action items, etc.
- Tim Martin will have responsibility for convening meetings and coordinating communications with "external" team members.
Designing Drive-thru Clinics:  
A Concept for Increasing Access to Health Care  
Carol McDonald  

**Background and Importance of the Project**  
Since becoming a new Colorado county in November 2001, Broomfield has strived to offer customer service in a new and innovated manner. Part of the Health and Human Services (HHS) Mission Statement reads: We value the health and safety of our citizens and are dedicated to serve Broomfield with integrity, creativity, dignity, and respect. I believe that we need creativity to be utilized in order to address some of the issues surrounding access to health care. In 2004, HHS received a grant to provide flu vaccine to citizens using a mass clinic-type setting. As part of the deliverable of that grant, one of the clinic designs was a drive-thru setting. This design will be used as the foundation for this report as well as possible future projects.

*Note:* This particular grant project period was September 1, 2004-December 31, 2004.

**Vision**  
The City and County of Broomfield's HHS will provide services in an efficient and innovative manner that will promote accessibility for all clients and will not be problematic for staff.

**Specific Goals**  
- Assessments will be made to determine if drive-thru services could be used as an option in lieu of traditional clinic settings and other health and human service programs.
- Key staff and community members will be included in design plans and decision making process.

**Project Timeline**  
- Initial ideas and planning by key staff members. (7/2004)  
- Commitment from City and County Management, Police, Public Works, Emergency Management Unit, key staff, and community members (specifically Health and Human Services Advisory Council members) in assisting with the project. (8/15/2004)  
- Schedule initial planning meeting with representatives from City and County departments. (9/7/2004)  
- Potential sites for drive-thru clinic will be visited and assessed. (9/10/2004)  
- Site confirmed and design plans for that site initiated. (9/24/2004)  
- Continued planning and implementation process. Forms (consent, job descriptions, rosters, evaluations, etc.) for clinic use developed and formatted. Final ordering of necessary supplies, initial advertising, establishment of hot
line, and publicity of event coordinated by PIOs from Public Health, Human Services, and City and County. (9/27/2004)

- Finalization of staff and volunteer rosters and clinic set-up. (Ongoing)
- Promotion of event through media, newspaper, clinic setting, person to person, etc. (10/11/2004)
- Final preparations for event scheduled 10/30/2004.

Note: This event was cancelled due to the nationwide shortage of influenza vaccine. However, plans are being made to schedule a similar event in the fall that will promote Back-to-School Immunizations. So, in essence, a new timeline with similar objectives will start in March 2005. By May of 2005, commitments from key staff, community members, and other agencies (including North Metro Fire District) will be made.

Resources Required to Successfully Complete the Project

Staff and volunteer commitment will be required to successfully complete any scheduled event. It has been determined from the above exercise (which required 70+ persons) that approximately 10-15 persons will be needed to staff this scaled down version of the drive-thru clinic. Personnel will include medical and administrative staff, traffic control, public works, and other volunteers.

Risks and Analysis of Those Risks

Project Risks: Lack of response and commitment from staff and persons outside of HHS, such as volunteers, city and county staff, other agencies, etc. Clients may prefer the more conventional form of the clinic setting. Assessment of immunization and medical histories may be somewhat difficult in this type of clinical setting.

Personal Risks: Experiencing some disappointment that people do not always share the same vision of doing projects in a new and innovative manner. I am committed to new ways of doing things and making special projects happen.

Communication System

Much of the preliminary work has already been done for this project. Relationships with persons outside of HHS have been established, and many key persons already have some knowledge of how this event could occur. Public Health staff and, a few other HHS staff, have committed to be available for ongoing meetings regarding updates and decision making processes.

Project to Date

Planning has continued to use this concept in July and August for a back-to-school campaign. Preliminary discussions with HHS, other city and county agencies, and North Metro staff have been initiated regarding this effort. Depending on vaccine supplies, drive-thru clinics still remain an option during influenza season.

Leadership Lessons Learned

(Taken from the 5 principals of the leadership practice)
Model the Way

Drive-thru clinic programs are not new concepts. However, with the exception of the Kaiser medical system, Colorado has conducted very few of these types of clinics. Broomfield Health and Human Service staff tend to push the envelope in taking on new projects and are not hesitant to step up to the plate in being role models.

Inspire a Shared Vision

As the author of a book titled *Good to Great* describes, creating a new program or service is like getting people on a bus to go on a trip. The leader’s goal is to motivate his followers to get on the bus by creating images of a compelling vision—a reason for going on the trip, an attractive destination, etc. Throughout the trip, when there are many twists and turns, flat tires, and bad roadside food, the leader’s job is to keep the group focused on the final destination. It takes trust and flexibility to let go of the details, such as how long the journey will take or by exactly what route, and to remain clear about the group’s ultimate mission of staying focused on the destination.

Some information I read from the "Management Moment" discusses how one of the essential elements of a successful partnership is leadership.

For this project, I had the partnership and support of a visionary person. Our leadership styles, although somewhat different, complemented each other. Individually and in tandem we were able to influence different groups to participate in this project. Because this project was initially not fully carried out, I have had to continue to maintain focus on what steps need to occur next in order to see it to completion.

Challenge the Process

Although the City and County of Broomfield’s vision states their intentions to work in a creative manner, it has indeed been a challenge to do this in the present work environment. The Broomfield "forefathers" have been functioning for many years in a systematic manner that has seemed to work for them. At times, different ideas and changes tend to make them uneasy. During the initial presentation of this project, Broomfield management staff had many questions and concerns. However, with the support of other City and County workers (police, facilities, public works, and others) and community members we were able to persuade management level staff to take a chance and change the business-as-usual routine.

Enable Others to Act

Before starting the project, the first step was to develop trusting relationships. We had to prove our knowledge of the subject and that we would follow through with our commitments. We listened and acknowledged those concerns, addressing them honestly and directly. We recognized and acknowledged individual's strengths, delegated responsibilities, and encouraged people to utilize their abilities.

Encourage the Heart

Specific goals and standards were set for this project. We wanted this project to succeed, and we wanted those who participated in it to feel they had contributed to a worthwhile cause. The project plans included rewards of public recognition, news releases, media coverage during the event, and special designations (such as baseball hats with the
City and County logo on them, which participants could keep). Even though we were unable to carry out this project, people who were recruited continue to show interest and desire to participate when it can be completed.
Stormwater Management Plan (SWMP)  
Revision and Training Development  
Diane Niemiec

Background and Importance of the Project
StorageTek has had a stormwater permit and management plan for years. Protection of stormwater is especially important at the site due to local agricultural use of surface waters flowing across the property and the proximity of a stream that feeds into the Rock Creek. Due to some recent facility upgrades and the desire to implement some best management practices, it is time to revise the plan. Upgrades and best management practices include the installation of a new secondary containment system for emergency generator fuel tanks, increased contractor oversight, and improvements to routine heating, ventilation, and air conditioning (HVAC) maintenance procedures and practices that will be incorporated into the plan revisions.

Vision
To protect the quality of stormwater runoff from the StorageTek facility by ensuring that our facility maintenance and contractor activities are not causing any harm to the environment.

Specific Goal
To review best management practices regarding HVAC maintenance procedures, incorporate those practices into our Stormwater Management Plan, and conduct training for facilities operations and contractors.

Project Timeline

**Stage 1**
- Review information available regarding best management practices (BMPs) for HVAC maintenance and construction procedures. (Review complete by December 31, 2004.)

**Stage 2**
- Review our current internal processes regarding HVAC maintenance and contractor management procedures. (Review complete by January 15, 2005.)

**Stage 3**
- Work with facility operations personnel to resolve discrepancies between best practices and actual, if they exist.
- Evaluate new BMP opportunities and decide on new practices as necessary. (Review complete by January 31, 2005.)

**Stage 4**
- Rewrite SWMP. (Rewrite complete by March 31, 2005.)

**Stage 5**
- Implement plan and practice changes. (Review complete by April 30, 2005.)

**Stage 6**
- Develop training course. (Review complete by May 10, 2005.)
Stage 7
- Deliver training course to facility operations personnel. (Review complete by May 30, 2005.)

Resources Required to Successfully Complete the Project
- Cooperation and assistance from facility maintenance personnel.
- Time is the largest resource needed:
  - Four different individuals' time to collaborate and discuss what is currently being done and what are the possible improvements to be made.
  - Time to develop the materials and deliver the training.
- Implement plan and revisions, this portion will require ongoing physical audits of work practices.
- Effective communication.
- Funding will be absorbed into departmental budget.

Risks and Analysis of Those Risks
Risk: The plan may require significant work practice changes by the facility operations group and contractors.
Analysis: Facility operations personnel will be directly involved with reviewing the BMP plans and plan revisions. This level of involvement should help to achieve sufficient support to the necessary changes. Facilities also have a good deal of contractor oversight responsibilities, which should help to ensure the contractors also adhere to our practices.

Communication System Among Persons Involved in the Project
Although the team members are from two different groups, we are located within the same building, so physical meeting locations will not pose a problem. Informal meetings will be conducted in person, with any meeting minutes or deliverables being forwarded by e-mail if applicable. Meetings will be conducted bi-weekly.

Project Update
The projected dates for developing and completing the training have slipped and it will probably not be done until the fall.

We are currently putting the final touches on the plan revisions and are implementing all of the changes as they are identified. The group is rather small, but is committed to doing the right thing. The facility operations personnel have been helpful in providing input and guidance regarding what practices will work for them as they do their various equipment maintenance and repairs. Since they are the ones who will be actually doing the preventive maintenance and contractor oversight, their buy-in is critical for implementation.
Kodak Colorado Community Diabetes Screening and Follow Up
Suzanne Parent

Description of Project
Recognizing the importance of early detection and treatment for diabetes, we decided to enhance our free, annual, simple screening. We accomplished this by doing comprehensive follow-up on the participants that had positive test results and by increasing the screening opportunities to twice a year. We developed an initial screening spreadsheet to track the basic data, then an assessment tool to document additional information. The screening dates were well advertised, and we had plenty of assistance and screening tools, as well as basic diabetes information to provide.

Vision
Kodak Colorado employees will have yearly access to free screening tests for diabetes, with follow-up by caring, concerned Medical staff.

Specific Goals
- To confirm they have shared the information with their physicians, had the diagnosis ruled out or confirmed, and received appropriate education.
- To promote early diagnosis and treatment, to prevent complications, and to enjoy a longer, healthier life.
- To develop and strengthen communication between KCD and community resources.

Project Timeline
Stage 1
- Organize the event. Create spreadsheet to record data. Gather team. Schedule testing event. Advertise and promote participation. (Complete by Nov. 30, 2004.)

Stage 2
- Conduct a testing event. Do follow-up with employees that tested positive. Do further follow-up as indicated. (Complete by February 25, 2004.)

Stage 3
- Document and measure results of project, write report, and post it. (April 1, 2005.)

Resources Required to Successfully Complete the Project
- Two nurses to do screening/testing with possibly one non-technical person for facilitation of prompt service.
- Participation of employees in testing, as well as in follow-up.
- Effective communication.
- Community resources and links to them.
- Funding will be through the company's wellness program budget.
Risks and Analysis of Those Risks

Project risks: A potential lack of participation by employees, employees not going in for follow-up with their personal doctors, and inadequate communication between participants, Kodak nurse, and community resources.

Analysis: We have been advertising the event and have promised prizes for participating, which is usually very successful. We will get HIPAA compliant medical information releases signed and will be diligent in maintaining contact, tracking needs, and documenting progress.

Personal risks: Personal disappointment on my part if the event does not draw good participation. I believe very much in the value of this and am excited at the prospect of getting early diagnosis and treatment for as many people as possible.

Communication System Among Persons Involved in the Project

Some of us work in the same office area, so we have had two planning meetings. We will use e-mail to facilitate contacting participants, as well as home phones. We will utilize FAX to share/receive information from doctors. We will need one or two meetings after the event to coordinate data collection and finalize the report.

Results of Project

We did a screening in November of 2004, and combined this with the data we had gathered at a screening done in March 2004. We noted the following information on the spreadsheet: the participant's name, risk score, and blood sugar. We then contacted those whose blood sugar results were over 115mg. They were asked if they had taken their results to their family MD. Most had, and had been either retested at the doctor’s office, or were told that the random test level result wasn’t high enough to be concerned with. Participation was good, with about 120 total being tested.

Fifteen out of 120 people were above 115mg. Three have refused to respond to our inquiries to participate further in the follow-up. Three have been officially diagnosed with diabetes. Of those three, one person did some follow-up with his MD, but is in a denial stage and really did not want to pursue much offered by way of education. We will continue to contact him periodically in order to assess his interest level and provide him with support as he is ready for it.

The other two confirmed diabetics are proceeding with all the appropriate education. We did find some gaps in their knowledge and were able to direct them to community resources. One was interested in working the "Colorado On The Move" step program, so we gave him a pedometer and the materials he needed to get started on that. We were satisfied that two of the three were making the progress they needed towards becoming knowledgeable about the disease, and had the tools to manage it successfully.

The varying levels of receptivity to information were interesting. It is of particular concern that there were three who tested high and we are unable to ascertain if they did any follow-up or if they are continuing to incubate their possible diabetes. This project is highly sustainable and, in fact, we have the next screening already scheduled for April 2005. We will continue to do the initial screening and comprehensive follow-up bi-annually. We feel gratified by the participation and that we were able to assist in early diagnosis and treatment in three positive cases.
Extreme Makeover to Lower Risks for Diabetes
Jo Ann Pegues

The purpose of this project was to work with individuals who were at risk for diabetes, either because of being overweight, having a family history, or some other predisposition to diabetes, in order to determine various approaches that would lower one’s risks for diabetes. This involved promoting lifestyle change interventions, to an extreme for some, to lower their risks.

Most people need support and encouragement from family or others to accomplish their goal. Support from healthcare providers is often limited or non-existent. This seems to be particularly the case for African Americans. Some people do not have a regular healthcare provider, or they only go when they are ill. Therefore, the opportunity to take advantage of preventive services is not an option. They may also be either uninsured or underinsured, which contributes to the difficulty to practice prevention.

Discussion
Initially, twenty-four persons indicated an interest in participating in this project; four of whom were men. Twenty-two were African American and two were Caucasian. They consented to be involved through May 2005. However, three of the men and six women dropped out. I am currently working with fifteen participants. They were all given an orientation at a group meeting where the majority attended. They were asked to journal throughout the study, to track their physical activity, and document their food intake. They also signed a consent form giving permission to either share their lipid results or to participate in having blood drawn for lipid and glucose measurements, as well as to be weighed and measured.

An analysis of food consumed was completed for those who kept dietary records, and individual counseling was provided. This proved to be successful for several because they were able to see what their food intake looked like in chart and graph form and how it relates to their overall health.

The participants were offered the opportunity to participate with Colorado Fitness and Wellness at their own expense to enhance physical activity through classes, boot camp, or personal trainers. Daily physical activity, especially walking, was encouraged. Logs to track steps were provided.

E-mail notes of encouragement were sent out regularly to the group and to some individually who seemed to be struggling.

In working with the subjects of my project, I have found that a major barrier is getting people to get started with the exercise. Two of my participants are extremely overweight/obese and do not feel comfortable in a gym with lots of other people. I was able to encourage them to walk with a partner. One had access to a hotel fitness center that did not have a lot of traffic and she felt comfortable going there to exercise; plus, the cost was affordable. Aerobic sessions for our group were offered on a few Saturday mornings in partnership with Colorado Fitness and Wellness at a nominal cost. This seemed to motivate some people and get them moving.
Moving forward

I am proposing to continue this project at the Metro Denver Black Church Initiative (MDBCI). One goal is to set up an intensive program over an eight-week period and involve personal trainer consultants for each individual. Another idea is to purchase some basic equipment that will be used and kept at the MDBCI.

During the eight weeks, I hope that the participants will become committed to doing the exercise and will see positive results that will encourage them to continue and make it a part of their ongoing health and well-being. An affordable cost will be determined so that people can continue beyond the eight-week period and pay for classes on an ongoing basis in the future. Nutrition counseling will also be provided. The model can then be replicated at the BCI and offered to people in the community in a safe and secure environment.

Lessons learned

I was gratified when one client said: "This has been the most inspirational program I have done in my lifetime. Although I knew my risk for eventually getting diabetes was high because of my family history, I had no idea that I was actually pre-diabetic with a glucose score of 106. In the last 6 months, I have learned to decrease my sugar and starch intake. I also learned how to increase my exercise, by first knowing what my baseline weight, especially my waist size. I have lowered my finger stick glucose to 77. Jo Ann has done a wonderful job to keep me encouraged and have someone to whom I was accountable. Thank you so much for such a timely, encouraging, knowledgeable way of decreasing my significantly high risk of diabetes."

Another important lesson that I learned was that the level of success achieved by people is based on their state of readiness to meet challenges. Many of the people who indicated they wanted to participate in this project were at a pre-contemplative stage. As I move forward with this project, I will pay more attention to the states of change within people and stay focused on how I can meet people where they are, always keeping in mind that it is their goals that need to be met, not mine.
Core Competency Development
for Health and Sanitation in Child Care Settings
Therese Pilonetti-Hall

Background
The Consumer Protection Division of the Colorado Department of Public Health and Environment promulgate regulations in order to protect the health of children enrolled in child care. However, because the Department of Human Services is the licensing agency for child care facilities in the state of Colorado, no licensing fees are available for enforcement or training relative to these regulations.

In May of 2005, newly adopted child care regulations will become effective. This is the first revision in over ten years. The revision process took over three years of stakeholder meetings and many, many drafts and hours of editing. The new regulations mean that both child care providers and regulators will be in desperate need of training. Yet, the lack of resources for education makes this need difficult to fulfill.

Project Goal
My goal is to meet the training needs of regulators and providers alike with minimal expenditure of resources and with minimal impact on the Consumer Protection Division.

Timeline
Phase I
- Provide classroom-based training for regulators that will explain the changes to the regulations, and provide long overdue education on health and sanitation issues in child care facilities.
  - Identify partners - March and April, 2005. (Completed in April)
  - Identify presenters for course - April, 2005. (Ongoing – 4 identified)
  - Identify location for course - April, 2005. (Ongoing)
  - Marketing for the course - May, 2005.
  - Classroom training - June, 2005.

Phase II
- Develop a computer-based training module covering this same material that will target both providers and regulators. This training module will allow for mass distribution of sustainable training materials at minimal expenditure of resources.
  - Identify partners - April and May, 2005. (Ongoing)
  - Acquire necessary software and hardware - June, 2005.
  - Development and editing - June and July, 2005.

Resources Required to Successfully Complete the Project
Phase I
- Facility for classroom based training.
- Marketing materials.
- Presenters for course.
- Projection equipment.

**Phase II**
- Software for developing an interactive computer-based training with a user-friendly interface.
- Course material conversion into self-paced module.
- CR-ROMs (or Web space).
- Mailing and distribution materials (if necessary).

**Risks and Analysis of Those Risks**
- Ineffective marketing or bad timing of classroom-based course resulting in poor turnout, despite identified need.
- Time necessary for development of materials will require time away from other duties. The benefit of an educated industry will outweigh the cost of providing education by improving compliance and building trust with providers.
- Unexpected delays in implementation may leave constituents ill-informed to comply with the new regulations.

**Communication System**
- Communication system is in place from the three-year regulation revision process. This system will be maintained.
- Marketing materials will be distributed to regulators through the Consumer Protection Division and the Colorado Environmental Health Association.
- Marketing materials will be distributed to providers through Colorado Department of Human Services and state and local child care organizations that actively participated in the regulation revision.

**Results of Project to Date**
The project is moving forward and gaining momentum. The need for the materials is still very much evident for both providers and regulators. A train-the-trainer approach will be used for the classroom training for regulators. This approach will allow and encourage the regulators to pass information along to colleagues and providers. The classroom training will also provide for valuable feedback, similar to a focus group, prior to the development of the computer-based training.

Numerous partners have been identified to help with the completion of the project. These partners include the Colorado Environmental Health Association, the Colorado Department of Human Services, Ball Aerospace, and Co-Train. Timely completion of this project would not be possible without their support.
A Resource Institute for Promotoras  
in Doña Ana County, New Mexico  
Thomas R. Ruiz

Background and Importance

Community health workers have been around for generations and have served many different purposes through their efforts while working in communities. There are numerous models defining what is a Community Health Advisor, a Community Health Worker, a Lay Health Advisor, a Promotora, a Health Promotion Outreach Worker, etc. Certain models are more applicable in rural areas than in urban; other models are accepted in some cultures more than in others; some models focus primarily on health, others on empowering individuals through grassroots organizing. Whatever the purpose, each is invaluable to the communities in which they serve, and each is a hard-working, dedicated individual who wants to improve the quality of life of the residents in their locale.

The Office of Border Health in Las Cruces, New Mexico, has funded and supported Border Area Community Health Programs (Promotoras) for approximately six years. Given the success and popularity of such programs, they have inevitably been replicated and have expanded in the border area. Many different groups of promotoras from various organizations have been formed and are serving the area. What is lacking now is a standardization of skills for the promotora. These skills range from a knowledge of various topics (i.e., environmental health issues) to developing effective leadership skills.

Vision

To develop uniform proficiencies for New Mexico border area promotoras in the areas of environmental health and leadership. This would ultimately benefit the communities in which they serve.

Goal

My goal is to create a Resource Institute for Promotoras in southern New Mexico for the purposes of providing knowledge on area-specific environmental health issues and leadership building.

Project Timeline

Stage 1
- Ascertain and review current promotora training modules in place throughout Doña Ana County. (Complete by January 2005.)

Stage 2
- Announce the idea of the institute to the various promotora groups and solicit ideas on what additional resources they would like to see included. (Begin in January and complete by March 2005.)

Stage 3
- Develop resource packets or "toolboxes" for each major environmental health issue in the county. Packets will include bilingual Power Point presentations on each issue as well as appropriate literature and resource guides. A separate
curriculum on leadership development and collaboration will also be created. (Complete by April 2005.)

**Stage 4**
- Open the institute and facilitate the training of the first class of participants. Conduct pre- and post-tests on their knowledge of regional environmental health issues as well as leadership concepts. (Complete by fall 2005.)

**Resources Required to Successfully Complete the Project**

The New Mexico Office of Border Health (OBH) will have to utilize its contacts within the communities of *promotoras* in order to effectively communicate its idea of the Resource Institute. Since the OBH has been at the forefront of *promotora* work in the region, we don’t expect to encounter any difficulty in spreading the word and selling the idea. A classroom type setting will be needed for the participants, complete with a library of appropriate environmental health resources. The OBH has this space available at its location within the Border Epidemiology and Environmental Health Center at New Mexico State University. Additional resources include securing experts in various environmental health related fields. These "faculty" can provide the latest information in their specific area of expertise. Finally, providing incentives is an ideal way for getting *promotoras* to participate in the institute.

**Risk and Analysis of Those Risks**

There is a chance that the area-wide *promotoras* will have a lack of interest or commitment to the institute. Some may also see this potential training as a burden to their already busy schedules. To prevent this, we must market the institute in a positive way by stressing that the information is pertinent to the communities in which they serve. We must also emphasize the fact that this will be a bilingual institute with bilingual resources since resources are often not utilized if they are only in English. Another potential risk is the territorial attitude that exists within many factions of *promotoras*. Coordinators of certain groups may feel threatened by the establishment of an institute where their *promotoras* are receiving training and education. Once again, the Office of Border Health will have to rely on its history of excellent work within the community and involve key personnel in dealing with coordinators who may feel threatened.

**Communication System Among Persons Involved in the Project**

Stages one and two will require key meetings with the coordinators of the various *promotora* programs throughout Doña Ana County. I may meet with each coordinator individually (or perhaps as a group) in order to gather their opinions on the content of the Resource Institute. During stage three, I will utilize my connections with various experts in environmental health in putting together the toolboxes for each topic. Finally, stage four will require effective marketing for potential participants. This will involve the mailing and e-mailing of newsletters advertising the institute and perhaps a promotion for an open house.
Boulder County Reproductive Health/Family Planning Initiative
Jody Shulins

Background and Importance of the Project

Unintended pregnancy remains a significant public health issue in the Boulder County community. The consequences of an unintended, mistimed, and/or ambivalent pregnancy range from late to no prenatal care, premature and/or low birth-weight infants, and poor self-care during the pregnancy (higher smoking, drinking, and substance use rates, as well as inadequate weight gain), to a host of psychosocial risks, such as maternal depression, domestic violence, and child poverty. Teen pregnancy, in particular, is of pressing concern. Research on teen parenting indicates a strong association between adolescent parenting and poverty, welfare, abuse/neglect, poor educational outcomes, and substance use. There are approximately 250 teen births in Boulder County annually; between 12-15 percent of these teens experience a subsequent birth within two years of their first delivery. Pregnancy prevention is, and remains, a complex and highly politicized social issue.

In his 1997 publication, No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy, Douglas Kirby concludes that teen pregnancy prevention programs to date have shown limited success in addressing this problem, primarily due to the myriad of social issues that are contributing factors to the phenomenon of teen pregnancy. In addition to these factors, the problem is further complicated by the increasing politicization of reproductive health, including legislation and policies that have significant impact on teen’s access to, and knowledge about, family planning services available to them. In the past several years, the county has been impacted by (1) a shift from Title X funds out of the Longmont Planned Parenthood into a less accessible family planning clinic, (2) parental consent laws for abortion services, (3) increased funding for abstinence-only education programs, and (4) restricted access to emergency contraception based on a pharmacist’s religious convictions.

The body of literature on this topic indicates that pregnancy prevention requires a multifaceted approach that is comprehensive, intensive, collaborative, and lasting. The solutions must not only address issues of access and knowledge, but also the more complex concerns such as a teen’s ambivalence regarding pregnancy and/or contraception, and theories of behavior change. These issues need to be addressed both on the direct-service and the community levels. In Boulder County, there are currently several coalitions that address pregnancy and infant/early childhood issues, but none that examine the family planning needs of the community.

Vision

I envision an ongoing working coalition that addresses the family planning issues of women in Boulder County. This group will recognize that reproductive health is, first and foremost, a public health issue, and, therefore, will place the health needs of women and adolescents above personal and/or political agendas. The group will incorporate stakeholders from all sectors of the community, including public health, mental health, direct service providers, the faith community, both school districts, teens, and parents.
Goal
To create a highly effective, community-wide coalition of stakeholders who will address the ongoing reproductive needs of families in Boulder County and implement positive change on the individual and community level.

Project Timeline

Stage 1
- Discuss concept and logistics with program manager and agency director to get clearance and buy-in. (Completion Date: January 7, 2005.)

Stage 2
- Compose invitation letter to potential stakeholders. (Completion Date: February 15, 2005.)

Stage 3
- Research successful coalition-building strategies. Research strategies to increase collaboration when bringing together rivaling parties on contentious issues. (Completion Date: April 15, 2005.)

Stage 4
- Convene pre-coalition planning meeting with key players to determine size and scope of initial kick-off meeting. (Completion Date: March 1, 2005.)

Stage 5
- Mail invitations with RSVP included in order to determine interest level within the community. (Completion Date: March 15, 2005.)

Stage 6
- Research and compose educational presentation for first meeting. Compose Power Point presentation. (Completion Date: March 30, 2005.)

Stage 7
- Hold first coalition meeting. Present concept and Power Point presentation, determine mission and expected outcome of coalition. Secure commitment of key players. (Completion Date: April 30, 2005.)

Stage 8
- Work of coalition begins. (Completion Date: Ongoing.)

Resources Required to Successfully Complete the Project
Most of the required resources for the project will be in the form of community involvement. The various agencies/programs invited to participate will need to have confidence in the worthiness of the cause as well as the proposed intervention in order to commit staff time. Incidental resources include meeting space and refreshments. As the group solidifies and identifies strategies for change, the group might require funding to carry out the proposed projects. The funding for these initiatives is outside of the scope of the project at this stage in time.

Risks and Analysis of Those Risks
The greatest risk would be that the coalition fails to attract the key players in the community who have the most ability to enact positive change. Although I believe the desire exists to tackle this issue in Boulder County, service providers are already overly-taxed in carrying out the day-to-day responsibilities of their jobs. Much work will need to be done up-
front to attract and maintain the commitment of stakeholders. The first meeting will be critical in creating a sense of enthusiasm and energy that will entice people to get involved. Another potential pitfall will likely arise when opposing factions hammer out potential interventions. Issues such as abstinence vs. comprehensive sexual education, access to birth control and abortion services, and social marketing campaigns for emergency contraception have the potential to create strong rifts, which could possibly paralyze any efforts. It is possible that opposing factions could become even more entrenched in their positions. Finding common ground (preventing unplanned pregnancies) and deferring to research findings and best practices will be one approach I will use to diffuse conflict. Working through differences will be time-consuming, but it also is critical for the success of the coalition. Strong facilitation and leadership will also be key.

**Communication System Among Persons Involved in the Project**

Initially, communication will be limited to other Boulder County Public Health (BCPH) staff, whom I intend to recruit to assist me in identifying key community players. Once the coalition is established, we will agree on the time commitment, the schedule of meetings, and the necessity of subcommittees to work on identified projects. E-mail will be critical in keeping coalition members informed of work accomplished outside of the group.

**Progress to Date**

I met with key internal BCPH stakeholders in March. Response to the coalition was mixed, with many doubting the feasibility of engaging the community in this effort. The group cited time constraints, lack of funding, and unavailability of medical providers as their primary concerns. In addition, there was a unanimous feeling that the coalition would not be effective in bringing together the polarized segments of the community, and people were not willing, at this point, to come to the table with the more vocal (and powerful) community groups that represented a more conservative viewpoint.

People felt that their participation in previous endeavors has been disruptive to the point of paralyzing all future efforts. Feedback from the meeting also made it clear to me that I needed to provide a stronger vision of the mission of the coalition prior to convening people. Originally, it had been my intent to initially keep the focus of the coalition very broad and allow the group to prioritize its mission. Stakeholders felt that people would not be drawn to a group that did not have a clearly defined project at the outset. Admittedly, I felt rather deflated and a bit lost after that meeting and briefly considered finding another project to work on. In thinking things over for a day or two, I recognized that my greatest fear when it comes to leadership is taking risks—and this was the perfect opportunity to begin to tackle this challenge. I regrouped, researched strategies on successful coalition-building, and came back with renewed energy. I created a survey that I sent out to potential community coalition members, testing the waters for their willingness to come on board. The response, thus far, has been positive. In fact, I have been able to uncover some private providers who are excited about the prospect of getting involved. I am now in the process of tabulating the results of this community assessment and will be convening the first meeting in the coming two months. In April, I met with an established sexual health coalition and made a pitch for their involvement as well. Finally, the BCPH is in the process of hiring a sexual health coordinator. I intend to involve this person in steering the committee, perhaps eventually turning over the reigns to them to assure a sustained effort. Although this project has taken
longer than I originally had anticipated, I believe it will eventually become a solid force in Boulder County.

References

Public Health Reference List for Physicians
Charles Smedly

Project Description/Vision
Many emergency room physicians, especially residents and other practitioners that are in the early stages of their training, do not know what public health resources are available in the Denver-metro area. In my conversations with emergency department (ED) doctors, many have expressed a desire to have a listing of public health clinics and programs that they can use for patient referrals. The listing would not be overly detailed but would contain general categories, the resource name, and a contact number. I envision that the resource would be available as a Personal Digital Assistant (PDA) file that can be easily shared between providers. Palm units allow users to beam files between units and this would facilitate the spread of the resource listing into the healthcare community.

Project Goals
- An easy-to-use reference for physicians to refer patients to appropriate public health resources.
- Increased access to public health resources for patients.

Timeline
- Identify public health resource information from ad-hoc compilations, local health departments, and the Colorado Department of Public Health.
- Review resource listings with other RIHEL fellows for resource ideas.
- Review with ED physicians for content and format.
- Identify appropriate file format for PDAs to use Palm operating system and possible CE operating system.
- Work with analyst to build file structure.
- Test application on PDA.
- Test beaming application to PDA.
- Distribute to ED physicians at Denver Health and CU Anschutz Pavilion for initial testing and user acceptance.
- Review physician feedback and modify as required.

Risks and Analysis of Those Risks
- Outdated resource information
  - Editing of lists can be easily performed by the PDA user.
  - I will evaluate the possibility of hosting a master file on a Web site if resources can be identified to maintain the data.
- System will be not be accepted by targeted community
  - I have interviewed emergency room providers and have been encouraged to continue the project by all. The demand and interest in such a resource appear to be strong, leading me to believe that it would be used and would self-propagate amongst the provider population.
Project Update

An initial meeting focused on the content of resource information that would be useful to an emergency room care provider. In today’s climate, many patients do not have insurance and the area of public health increasingly finds itself filling gaps in health care. This realization helped to drive the initial resource content to be used. Subsequent discussion centered on the best method of displaying the information on a Palm PDA. I also began to work with a systems analyst to determine the most appropriate technical method to use with PDA type devices. We evaluated Palm and CE-based devices and decided to limit the project to the Palm PDA platform. We chose to use an application that was already included on the Palm-based PDA devices so we could avoid licensing issues that would have resulted with more sophisticated applications. As programming would not be needed with this approach, a programmer was not required for the project.

The initial resource data set and display options were evaluated by one of the ED physicians. This took longer than anticipated and I now realize that I should have delegated more of the work to others. The initial test of the resource listings and the Palm interface was tested at the Anschutz Pavilion. Rollout of the project at Denver Health has not yet occurred. We found that we needed to train some Palm users on how to "beam" categories from their address books. We had not fully identified the types of "just-in-time" training that would be useful. We also found that commonly accepted acronyms used in public health did not necessarily have meaning in the medical community.

I found that the individuals that agreed to help on the project had good intentions, but often were overwhelmed with other tasks and it was difficult to schedule time with them and to get timely feedback from them. It is important to think out and clearly communicate expectations of time and work so all participants have a clear understanding and buy-in from the beginning. I also found it useful to celebrate small success and to be generous in appreciation.
Public Health for Journalists
Paula Steib

Background and Importance
Expensive outreach and branding programs have been done to try to raise the visibility of public health among broadcast and print journalists with little effect. A leading hurdle is the need to explain public health to an audience of reporters that turns over continually, especially in small markets. Public Information Officers are often at a disadvantage in explaining public health policies, emergencies, and decisions to reporters new to the beat because they must first explain the system, the funding mechanisms, divisions of responsibility, etc. The National Public Health Information Coalition (NPHIC) has identified this as a problem for their members.

Vision
To create a brief publication that simply outlines what public health is, how it works, and where the funding comes from, that can be adapted to fit the unique facets of each state program. The publication would be available online and in print for journalists and broadcasters.

Specific Goals
- Ask NPHIC members to identify the questions that they are most often asked by novice health journalists, and develop a core set of Q & As based on that information.
- Work with the leadership of the Association of Health Care Journalists (AHCJ) and several seasoned and respected medical writers to identify those facets of public health that are the most difficult for journalists to get their arms around when they are trying to meet deadline, as well as how and where to get the information they need.
- Conduct a literature search of public health definitions.
- Design a publication that can be easily read online or downloaded by journalists and others seeking information about public health.

Project Timeline
- Meet with the NPHIC leadership to describe the project and get their buy-in. (Completed 10/6/04)
- Contact new executive director of AHCJ to discuss the best way to solicit input. (Completed 9/30/04)
- Survey the NPHIC members for Q & As. (Completed February 2005)
- Conduct online literature search for public health definitions and other materials that might be useful in design of the publication. (Completed March 2005)
- Survey healthcare journalists. (March 14-31, 2005)
- Compile and analyze responses. (April 15, 2005)
- Develop publication layout and draft text and review with NPHIC members and selected journalists. (May-July 2005)
▪ Develop distribution plan. (July 2005)
▪ Make final edits to text and layout. (September)
▪ Publish and distribute publication. (October 2005)

**Resources Required to Successfully Complete the Project**

▪ Team of three to collect and analyze data and produce publication.
▪ Cooperation and support from the NPHIC and the AHCJ.
Immunization Program Redesign at Tri-County Health Department
Lynnsay Trefren

Project Background
The Tri-County Health Department (TCHD) is the largest local health department in the state, and we are responsible for about one fourth of the state’s population. For two years in a row, Colorado has ranked 50th in the National Immunization Survey (NIS), which looks at the immunization status of children ages 19-35 months. Our immunization services were designed almost ten years ago, and although changes and shifts in services have been made, we have not looked at our program design since that time. In addition, we have not asked our clients if we are meeting their needs.

Vision
The TCHD will provide immunization services in a way that best meets the needs of our citizens. The redesign will include TCHD staff members and will take their needs and abilities into account.

Resources Required
- Staff time to look at data for existing services, to develop and administer a customer satisfaction survey, and commitment to change services as needed.
- Information Technology time to load EpiInfo on staff computers.

Project Timeline
- Chose project team from existing immunization staff. (Completed 10/15/04)
- Meet with the team to develop the project vision and goals, and develop the survey. (1st meeting: 10/21/04, survey tool completed 11/15/04)
- Distribute survey to every immunization client during two weeks chosen by the project team. (Completed 12/6/04-12/17/04)
- Obtain zip code information and clinic utilization information for the past year. (Data collected and available 12/1/04)
- Obtain training on the use of EpiInfo for data analysis. (Completed January 2005)
- Data entered into EpiInfo. (Completed by 2/28/05 - delayed because of shifting of staff to two disease control outbreaks)
- Team met to review data and decide on implementation plan. (Meeting 3/14/05)
- Changes implemented by 4/15/05.

Risks and Analyses of Risks
Risk: Clients needs may include significant changes in current services.
Analysis: Current staff may be inadequate or unwilling to adjust current schedules to meet the stated needs of the clients. This requires a true commitment to the process of redesign and the vision. The team participating was chosen for those strengths and will be encouraged to be creative in addressing client needs.
Risk: Additional staff may be needed to create necessary changes.  
Analysis: Additional funding is not currently available. We may need to look at ways to partner with other community providers to meet client needs.  
Risk: Clients may be happy with the TCHD program as it is, and changes may not be needed.  
Analysis: I will feel as if my project was not productive if no changes are made. I am personally invested in making sure this process results in some improvements in our services.

Communication System
The project team members work together, and some of the decisions, including review of the survey before completing, can be done informally. One team member has agreed to map the data from the zip code query. One team member has agreed to do data entry into EpiInfo. Meetings will be held weekly once all the data is available in order to facilitate decision making and the development of a timeline for implementation.

Results
Most clinics are located in areas saturated with low income families. Two clinics that were consistently well utilized several years ago are no longer full, and, therefore, probably not the best use of staff time. Two areas have had growth that our clinic availability has not kept up with, and appointments are often more than three weeks out. People are generally happy with the services they receive from us.

Implementation
- Two clinics cancelled, two were added.
- A team member suggested that area specific flyers might better advertise the services we have available (had previously had one flyer with all clinic locations on it). This is being implemented office by office.
- All staff that work immunizations need to hear the results of the client satisfaction survey. (Plan to present at staff meeting in July as we prepare for our busiest immunization season.)

Leadership Lessons Learned
- That involving staff in the program review and redesign resulted in more and better ideas for our changes—staff developed the project vision together.
- That time spent on the project strengthened team relationships. Staff was able to learn EpiInfo and feel like they had gained a professional skill that they can use in the future.
- That team member enthusiasm was transferred to other TCHD staff as they shared the results.
EPA Region 8 Regional Science Activities Web Site
Patti Tyler

Background
The results of an Environmental Protection Agency (EPA) Region 8 employee needs survey, completed in the fall of 2004, indicated that there is tension, and sometimes a clash, between science and policy with respect to questions surrounding why certain policy decisions were made and whether, or how, the scientific information was considered within the context of that particular decision. The question is: At what stage was the scientific information considered? While evaluating the causal factors that contribute to this issue, it appears there is a need for making scientific research and development activities available to all EPA Region 8 staff. These scientific research and development activities are taking place within the EPA Region 8, the other 9 Regions, and the Office of Research and Development (ORD) and could include:

- General and specific information about internal and external funding mechanisms.
- Identifying the Region 8 Science Council charter, work plan, members, and past and current activities.
- Creating a link to the National Regional Science Council and other Regional Science Councils that exist across the agency.
- Specific scientific information and cited literature sources for subjects such as Endocrine Disrupting Chemicals or Pharmaceuticals and Personal Care Products.
- Information on the ORD's Regional Science Program and links to pertinent Office of Research and Development Web sites.
- Funding opportunities for collaboration on research activities between the Regions and the ORD, like the Regional Applied Research Effort (RARE), Regional Methods (RM) and the Regional Research Partnership Program (RRPP).
- Announcements for up-coming science meetings, workshops, seminars, and conferences.
- Access to the ORD's research planning process.
- A link to scientific experts throughout the ORD and maybe provide an opportunity to develop a scientific expertise database for Region 8.
- Access to the EPA's Peer Review and Science Inventory Database.

Vision and Goal
To create an EPA Region 8 Web site that provides information about and access to scientific research and development activities, scientific products, and highlights throughout the agency.

Project Timeline
- Review existing regional and ORD Web sites and their information by February 15, 2005. Talk with those staff responsible for creating this Web site.
to learn more about the specific information and time frame necessary to accomplish the goal.

- Create formal request for assistance from EPA's Information Technology Team in developing the Web site prototype by January 31, 2005.
- Assist in developing a prototype Web site by March 15, 2005.
- Request for review and feedback from three different teams within Region 8 and incorporate their suggestions for improvements by April 15, 2005.
- Draft Web site completed by end of April 2005.

Resources Required to Successfully Complete the Project

In my role as Region 8's Science Liaison to the Office of Research and Development, this activity fits into my job description; and in a time of decreasing resources, I need to select a project that will fit into my existing position and allow me the time in completing the project. This is a project I had thought about quite awhile ago and it can be realistically achieved with my relying predominately on my dedication and effort. I will need to request technical assistance from the Information Technology Team and have already done so informally and there appears to be no conflict with that request. I will not be requesting additional money to get the project completed and will be relying on information that already exists as well as other Web sites that have already been created and can be used as possible templates.

Initial Steps

Contact was made with the EPA Region 8’s Web-site manager and a meeting was held to discuss the vision and make a formal request for their assistance. This task was discussed with my supervisor and it was agreed that this Web site would be developed.

Results to Date

An initial prototype of the Regional Science Activities Web site was developed according to the standard format recommended by the EPA. After the prototype was completed, my work on the Web site was interrupted.

In February of 2005, I was asked to reinvigorate the existing Regional Science Council (RSC). I began that project by creating two formal opportunities for regional staff to provide feedback on the following issues:

- What activities they would like to see the RSC involved with?
- What purpose would a RSC serve for Region 8?
- What are the activities that the RSC would perform?
- What would the RSC look like in terms of membership (how should it be formed)?
- What needs to be in place, or what needs to happen, to make the RSC a viable group?

I collaborated with staff from the Human Resources office in obtaining their facilitation support for these opportunities for input sessions and discussions with identifying potential members for the RSC. With input from several Region 8 staff, I incorporated these
ideas and suggestions and drafted a new charter for the RSC. The first meeting of the re-invigorated RSC has been held, and representatives from each of the seven multi-programmatic offices have been named to be members of the RSC Steering Committee. I have briefed the Senior Leadership Team of this progress and a RSC meeting will be held every month. The overall goal for reinvigorating the RSC is to increase the emphasis of science in the decision making process and to lead to a better understanding within the EPA Region 8 of how scientific information was or will be incorporated into specific regional decisions.

After pursuing the re-creation of and drafting the charter for the RSC, I returned to work on the Web site. The Regional Science Activities Web Site is now ready for review by other staff and managers in order to obtain their input on the types of scientific information that would be useful to include.

Next Steps

Now that the EPA Region 8 Regional Science Council has been re-created and a steering committee has been formed, it is time to return to the final development of the Web site. Since the prototype is already developed, there is not much to complete before the initial Web site will be developed and then updated on a regular basis. My goal for getting these next steps completed is to identify this item as an agenda topic during an upcoming RSC meeting and recruit 2-3 volunteers to assist me in getting this task accomplished. I do not foresee any other obstacles getting in the way of me completing this effort, since it has a direct connection to the RSC.
### Mapping Background Radiation for Emergency Responders

**Deb Watts**

**Vision**

| Develop background radiation guidance materials which can be effectively used by first response agencies and medical providers. |

**Mission**

| Establish pre-existing safe background radiation levels; document those levels and assemble background radiation emergency preparedness guidance tools. |

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**Radiation**

- **Types of Background Radiation**
  - **Dose Rate**
    - Determine personal exposure level
    - Reported in: Rem, mRem/hr, & Rads
  - **Count Rate**
    - Determine surface contamination
    - Reported in: CPM or CPS
  - **Activity**
    - Determine specific source isotope
    - Reported in: Ci, Pci, DPM, & DPS

**Emergency Response Tool**

As an emergency response agency mitigates a radiological emergency, they will know:

- What the safe or normal radiation levels are
- How to easily determine safe staging areas
- How to determine levels of concern (LOC)
- -2 x background for dose rate
- -300 counts above background for count rate

Sources:
- Oak Ridge Institute for Science and Education, FEMA, REP 22, October 2002

**Previous Research**

- Radiation Studies from 1956 to 1972:
  - Ground survey and background radiation surveys in U.S.
  - Dr. Donald T. Oakley, Composite Study Natural Radiation Exposure in the United States
  - Uranium Ore Open Pit Operators at 12 sites 1954-1962

**Summary and Future**

- Compass Background Radiation information in a GIS user friendly format, this will assist in the reduction of response times in the event of a radiological emergency
- Future Goal:
  - Define Background Radiation levels in all major metropolitan cities
  - Provide training to first response agencies and hospital personnel, so that all parties are speaking the same language
One Small Step Toward Environmental Sustainability  
Joyce Williams

Background and Importance

A sustainable society meets the needs of the present without compromising the ability of future generations to meet their needs. Even Thomas Jefferson recognized the importance of living our lives with this idea in mind when, in 1789, he wrote: "Then I say the earth belongs to each generation during its course, fully and in its own right, no generation can contract debts greater than may be paid during the course of its own existence."

Since the time of Jefferson, the importance of environmental sustainability has been recognized because a healthy environment is essential for a healthy society. However, the evidence shows that today's society is degrading its environment and I believe we need to take steps now to reverse this trend. Nowadays, "the practice of sustainability is about creating new ways to live and prosper while ensuring an equitable, healthy future for all people and the planet" (The Natural Step). Society needs to learn to live within the limits of the environment and in doing so needs to look for alternative ways of growing while conserving the vitality and diversity of the Earth.

Vision

To improve the quality of environmental and public health for the citizens of Colorado by continuously bettering our efforts to ensure proper management of hazardous waste and by improving compliance rates through an effective pollution prevention, compliance assistance, compliance monitoring, and an enforcement program, thus ensuring the citizens of Colorado an equitable and healthy future.

Specific Goal

To change the emphasis of the Hazardous Waste Compliance/Enforcement Unit's 2005 Federal Fiscal Year Work Plan by re-allocating resources, yet still showing a meaningful presence in the field (FFY’05 October 1, 2004, through September 30, 2005).

Project Timeline

August 1, 2004
- Meet with unit members to discuss the vision and goals for FFY 2005.
- Discuss with the group the two arms used to help reach the goal of protecting human health and the environment compliance assistance and enforcement arms.

September 15, 2004
- Submit FFY 2005 work plan to Program Manager for review and approval.

September 30, 2004
- Submit FFY 2004 end-of-year report to Program Manager.

October 1, 2004
- First quarter FFY 2005.

November 15, 2004
- Submit FFY 2005 projected goals to EPA Region 8.
January 3, 2004
- Begin final phase of the small quantity generator hazardous waste compliance self-certification pilot project—a compliance assistance tool that can also be used as an enforcement tool.
- Begin compiling/plotting 2005 First Quarter Inspection/Enforcement Data.
- Prepare new Power Point presentations for the four 2005 Generator Guidance Work Shops to be given in Fort Collins, Denver, Pueblo, and Grand Junction compliance assistance arm.
- Prepare Power Point presentation to be given to Western State Regulators conference enforcement arm.

January 19, 2005
- Unit retreat to discuss goals, vision, and team work.

February 1, 2005
- Send questionnaires and guidance document to facilities in the self-certification pilot project.

April 1, 2005
- Begin compiling/plotting 2005 2nd Quarter Inspection/Enforcement Data.
- Prepare mid-year report showing enforcement measures which are used as environmental indicators of the programs effectiveness.
- Self-certification questionnaire review begin next step in the project.

July 1, 2005
- Begin compiling/plotting 2005 3rd Quarter Inspection/Enforcement Data.

September 15, 2005
- Submit plan for FFY 2006 to program manager.
- Expand the self-certification project to other small business sectors.

October 1, 2005
- Prepare end-of-year report.

Resources Required
The major resource that is needed is buy-in by staff and senior management.

Risks and Risk Analysis
I am proposing that we focus inspections on facilities that have a high probability of non-compliance issues. This will most likely cause a drop in the compliance rate, one of the environmental indicators used to determine effectiveness of our program. I believe that the lower compliance rate will be apparent for several years until the regulated community becomes more aware of the new focus. Also, time spent per facility will increase due to the more complicated nature of the inspections. This may result in a drop in the number of inspections per inspector per year. I do not expect this drop to significantly impact the final count of inspections per year.

I believe that, in time, these efforts will result in a sustainable and meaningful compliance rate. In several years the evaluation of other environmental indicators, such as healthier ecosystems, prevention of hazardous waste exposure and release, a decrease in hazardous waste generation, and an increase in hazardous waste diversion rate through recycling or reclamation will also become more reliable.
Communication System by the Persons Involved in the Project

Several team members do not agree with the need for more compliance assistance—this could become a contentious issue. Unit meetings are scheduled twice a month and a unit retreat is being planned for January 19, 2005. An open atmosphere for discussion will be encouraged at these meetings. There will be routine informal updates and formal quarterly reports submitted to the program manger.

Project Timelines and Results

The timelines were overly optimistic but the project has moved along and a few of the easier goals were met.

References

Refer to The Natural Step at http://www.naturalstep.org/com/nyStart/.
Pediatric Disaster Preparedness for Pre-Hospital Professionals

Carol Zorna

Project Description

With the emphasis on disaster preparedness over the last five years, many agencies have developed plans to assist either themselves or a certain population in the event of a mass casualty or terrorist event. In Wyoming, Emergency Medical Technicians are not often called for a pediatric patient; therefore, their experiences can be few and far between. Also, most of us see children as particularly innocent and vulnerable and, therefore, it is difficult to see them seriously ill or injured. One child can make emergency care providers very nervous; in the case of a disaster or terrorist attack there could be multiple victims and that is the reason there needs to be training provided—to prepare these professionals for the worst-case scenario. We could say that children are a "special-needs" population. Thus, we need to be aware of the special considerations of this group and have a plan in place to care for them, physically and emotionally. A training curriculum will provide ongoing education so that during a time of extreme stress or fear, children will be treated efficiently while addressing their psychological needs as well.

Vision

To create an educational program that can be sent to Wyoming ambulance services and first responder units to use in conjunction with hands-on training to help them to be better prepared to cope with pediatric emergencies resulting from a disastrous event.

Timeline

Ideally, the modules will be created by May, 2005, for presentation at the graduation of the RIHEL class of 2005. The creation of the CD and distribution will be dependant on funding which will be requested from Merit Thomas, Wyoming Dept. of Health's Bioterrorism Grant coordinator.

Resources

The resources are many. Several states and hospitals have created educational materials to address pediatric disasters. I have collected materials, and my job will be to put together a curriculum that is specific to the needs of Wyoming; it must take into consideration the volunteer nature of our Emergency Medical Technicians and the lack of hospitals and clinics in each community.

Results

I have put together a two-day training program for pre-hospital professionals that combines a refresher program in pediatric medical care with a triage exercise and discussion of the special considerations for children on the second day. We currently teach pediatric care using the American Academy of Pediatrics' curriculum: Pediatric Education for Pre-hospital Professionals (PEPP). We have used this curriculum for several years and have approximately seven coordinators statewide. Therefore, it makes sense that we use this program to fulfill the first part of the training. It is easily adapted to the different training levels of our EMS providers and can be taught in an eight-hour segment.
The second day deals with the unique psychosocial issues of children, particularly in disasters. This is a 60-minute lecture that covers the events that are of the greatest significance with respect to children and their families in a disaster. We discuss pre-existing risk factors such as drug or alcohol abuse, disabilities, etc. There are also cultural and religious considerations. The stages of disaster response: immediate, early, and late are clarified. The next component will be a lecture on planning for disaster and organization. We will bring in one of our FEMA-trained individuals to present this lecture. The audience will be reminded that disaster plans need constant review and revision. We will stress the importance of familiarity with the plan and with the other community agencies involved in disaster planning. The importance of documentation, identification, and triage systems already in use will be stressed. Everyone involved will need to become familiar with the phases of disaster.

The third lecture will cover practical issues, such as supplies that might be needed (for example, multiple car seats and toys) as well as the specific pediatric medical supplies. Also, special disaster-related items such as formula, clean clothes, light sticks, soap, disaster tags, and chlorine bleach will be listed for students to take home. The need for child protection for lost children, psychologically traumatized children, and injured children, such as might be provided in a daycare setting, will be covered.

The last part of the day will be a simulation drill involving a school that has just experienced a tornado or an earthquake. We will create the voices of crying children on tape and dim the lights using mannequins for the patients. The students will be asked to triage and write down treatment protocols for each patient. This process will take 30 minutes. Then the students will be broken into discussion groups and will address overall assessment, triage of victims, stabilization of the scene, transport priorities, and communication needs.

There is a written test on day one covering the material presented in the PEPP program. On day two, after the faculty leads the exercise discussion, an evaluation form will be handed out to each student to allow for feedback on each topic covered, including the simulation drill.

The first program will be presented August 25-26, 2005, at the annual Wyoming State Trauma Conference. After reviewing the evaluations, the programs will be revised if necessary.

Team

My co-workers within the State of Wyoming Emergency Medical Services and several trained coordinators located throughout Wyoming.