NEBRASKA
Good Life. Great Mission.

Annual Report on Local Public Health in Nebraska

Nebraska Health Care Funding Act (LB692)

Public Health
Prevent. Promote. Protect.

This report highlights the accomplishments of local health departments over the past year to meet the three core functions of public health and the ten essential public health services.

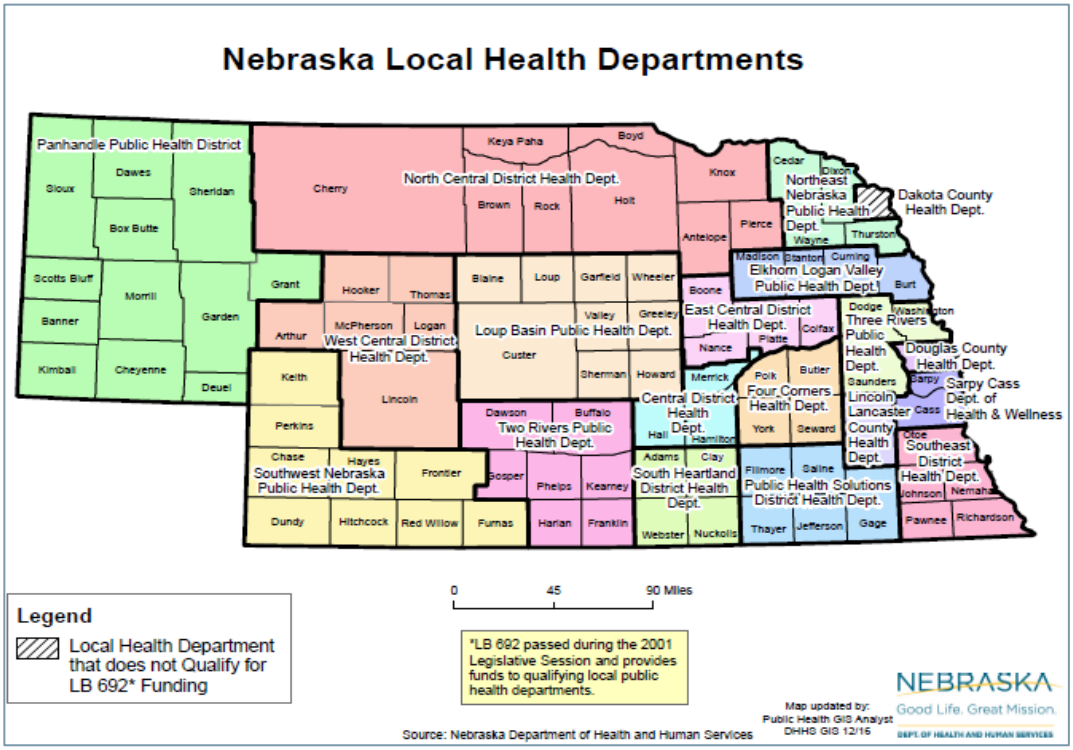
December 1, 2018

Presented to the Governor of the State of Nebraska
and the Health and Human Services Committee of the Legislature

Office of Community Health and Performance Management
Community and Rural Health Planning Unit
Nebraska Department of Health and Human Services, Division of Public Health

The Nebraska Health Care Funding Act (LB 692) was passed in 2001 by the Nebraska Legislature and provides funding to local public health departments through the County Public Health Aid Program (Neb.Rev.Stat. §71-1628.08) through the Department of Health and Human Services Division of Public Health (DHHS-DPH). The Act also requires eligible local health departments (LHDs), currently all but one, to prepare an annual report each fiscal year, currently covering the period of July 1, 2017 to June 30, 2018. These reports provide LHDs the opportunity to share a brief summary about what they do while providing the ten essential public health services to their communities.

Figure 1. Map of Nebraska Local Health Departments



Leveraging Other Funds

Funding from the Nebraska Health Care Funding Act contributes to the financial foundation of many of the local health departments but is not sufficient to ensure the availability of comprehensive local public health services for all communities. As such, all LHDs seek additional funding through other local, state or federal resources including private foundations. Several LHDs receive federally funded subawards from DHHS-DPH to address specific public health issues such as emergency preparedness, lead and radon testing, or child health programs.

Special Highlight: Public Health Accreditation

Across the nation, local, tribal and state health departments have been challenged to meet the standards of national public health accreditation, as defined by the Public Health Accreditation Board (www.phab.org). Accreditation focuses on the measurement of health department performance against a set of nationally recognized, practice-focused and evidence-based standards, and requires a continued focus on quality improvement. The accreditation process includes seven steps: 1) Pre-application, 2) Application, 3) Document

selection and submission, 4) Site visit, 5) Accreditation decision, 6) Reports and 7) Reaccreditation. The journey is daunting and requires a significant investment of time and resources.

DHHS-DPH provides funding support to nearly all LHDs and one Tribal Health Department to work toward meeting the pre-requisites prior to application, or to maintain an accredited status with continued improvement activities. While accreditation is voluntary, to date 235 health departments nationwide (32 state, 202 local, and 1 tribal) have achieved five-year accreditation. In Nebraska this includes the DHHS-DPH and five local health departments, with several others in pursuit. The LHDs who have already achieved accreditation include:

- ✓ East Central District Health Department
- ✓ Elkhorn Logan Valley Public Health Department
- ✓ Lincoln-Lancaster County Health Department
- ✓ Panhandle Public Health District
- ✓ West Central District Health Department

Many Nebraska health departments participate in a 'community of practice' sponsored by DHHS-DPH in partnership with the Public Health Association of Nebraska (PHAN) to receive training and technical assistance and share lessons learned. The commitment toward performance improvement is to be commended, and ultimately it is communities who benefit from the increased capacity of accredited local, state and tribal health departments.

Report Structure

As of June 30, 2018, a total of eighteen local public health departments covering ninety-two counties were eligible to receive funds under a portion of the Health Care Funding Act, Neb.Rev.Stat. §71-1626 through 71-1636. As required by statute, LHDs funded under the Act submit a report to DHHS by October 1 for inclusion in the full report submitted by DHHS on December 1. Each local health department authors their own content, which is included within, highlighting a few examples of their public health activities.

This year, the local health departments partnered with the Nebraska Association of Local Health Directors (NALHD) to design a new format for providing a glimpse of their work. It is important to note that these short reports only reflect some of their efforts and should not be considered a comprehensive review of each local health department or the public health network. We encourage readers to explore more information via the website links provided for each health department, as many also produce supplementary reports or a more complete annual report. The local health departments of Nebraska, in partnership with NALHD, have authored the remaining portion of this report.

For more information about local health departments, please contact them directly at their contact information provided in each respective report within. The Nebraska Association of Local Health Directors also serves as a valuable resource about local health departments, and may be contacted at: www.nalhd.org, or 402-904-7946.

For more information about this report or about public health in Nebraska, please contact the Nebraska Department of Health and Human Services Division of Public Health - Office of Community Health and Performance Management at 402-471-2353, or www.dhhs.ne.gov.

Conclusion

During the seventeenth year of funding, progress continues to be made to strengthen local public health departments throughout the state. All departments funded under the Act provide the three core functions of public health: assessment, policy development, and assurance. In addition, these health departments deliver the ten essential public health services to best serve the communities. They allocate funds based on health needs and priorities as determined through regular comprehensive community health planning processes. The departments have assumed a key leadership role in the coordination and planning of public health services, and have been successful in bringing together local organizations to plan for public health emergencies such as Influenza outbreaks and natural disasters. They also continue to fill in health service gaps with key services such as immunization programs, dental services, and home visiting programs. Additionally, the departments track and monitor infectious disease outbreaks, identify and follow up with individuals who have communicable diseases, and offer a wide variety of health promotion and disease prevention programs. Finally, continued efforts are made in the areas of evaluation and research as health departments evaluate programs and activities and collaborate with research centers to participate in various public health studies.

As a decentralized state, the collaboration and coordination of the state and local public health department network is vital to the infrastructure of public health. Nebraska is often commended for its collaborative nature and the strength of relationship the public health departments have collectively, which is supported by public health partners such as NALHD and PHAN. Individually and collectively we strive to improve the strength of the public health system to ensure efficient and effective public health services for Nebraska communities.

2017-2018

Annual Report
on Local Public Health in Nebraska

Nebraska Health Care Funding Act

Nebraska's local public health departments (LHDs) act as communities' Chief Health Strategists by assuring that local partners are working together to improve and protect the health and wellbeing of all Nebraskans. The Nebraska Health Care Funding Act (LB 692) was passed in 2001 by the Nebraska Legislature. This Act provides funding to LHDs through the County Public Health Aid Program (Neb.Rev.Stat. §71-1628.08). The Act also requires all of the eligible LHDs to prepare an annual report each fiscal year. These reports highlight examples of specific programs and activities toward meeting their statutory obligations.

The **Three Core Functions of Public Health**—as referenced in the Health Care Funding Act—are…

Assessment: Collect and analyze information about health problems in Nebraska communities.

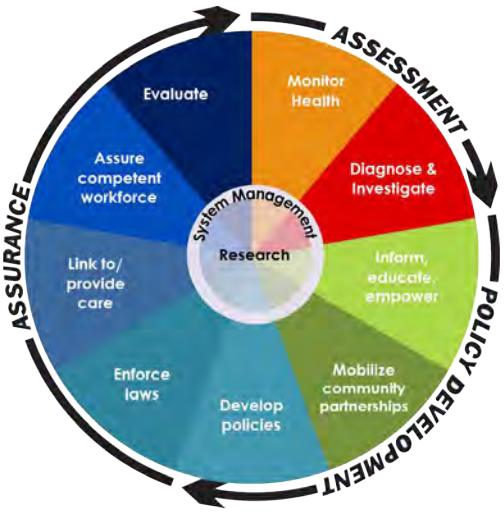
Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.

The activities and programs of LHDs are summarized under the associated **10 Essential Services of Public Health**. The 10 Essential Services provide a working definition of the public health system and a guiding framework for the responsibilities of local public health partners.

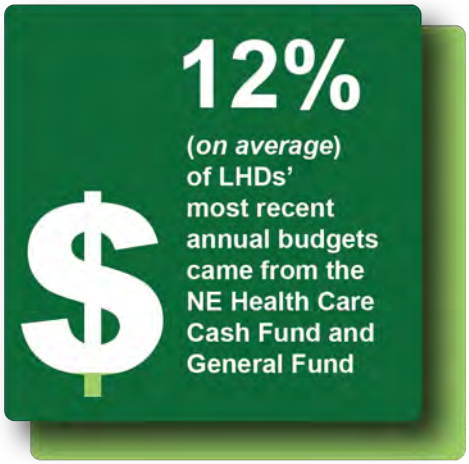
The 10 Essential Services include:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.



Leveraging Other Funds

The funds from the Nebraska Health Care Funding Act serve as the financial foundation for LHDs. However, LHDs' sustainability and ability to perform the Three Core Functions and 10 Essential Services of Public Health, and to the meet their statutory obligations, require ongoing success in securing additional funds. Some of these funds come to LHDs from federal pass-through awards through DHHS, and other State agencies, for a range of work including: emergency preparedness planning, oral health outreach, chronic disease prevention, West Nile Virus prevention and education, the Clean Indoor Air Act education, Preventive Health block grants, Maternal and Child Health block grants, and radon education and testing. Some LHDs also receive grants from private foundations, and/or by way of pass-through grants and contracts from professional associations such as the Nebraska Association of Local Health Directors (NALHD). In a few cases, LHDs have direct grants from the federal government. Some LHDs also collect fees for limited services.



Except in the case of Lincoln-Lancaster County Health Department and Southwest Nebraska District Health Department, the work described in the following reports reflects work supported through multiple funding sources.

In FY 2017-2018, the proportions of eligible LHDs' budgets derived from the Nebraska Health Care Cash Fund and the Nebraska General Fund ranged from 4% to 71% and are illustrated in each individual LHD's report. Statewide, approximately 12% of LHDs' budgets came from these State sources.

Organizational Coverage

As of June 30, 2018, a total of 18 LHDs covering 92 counties were eligible to receive funds under a portion of the Health Care Funding Act, Neb.Rev.Stat. §71-1626 through 71-1636. The list of eligible public health departments and their affiliated counties is shown in Table 1. Dakota County has a single county health department that does not meet the population requirements of the Health Care Funding Act. DHHS-DPH and other local public health partners continue to support the work of all LHDs, therefore Dakota County's work is included in this report.

Nebraska Local Public Health Departments (LHDs)

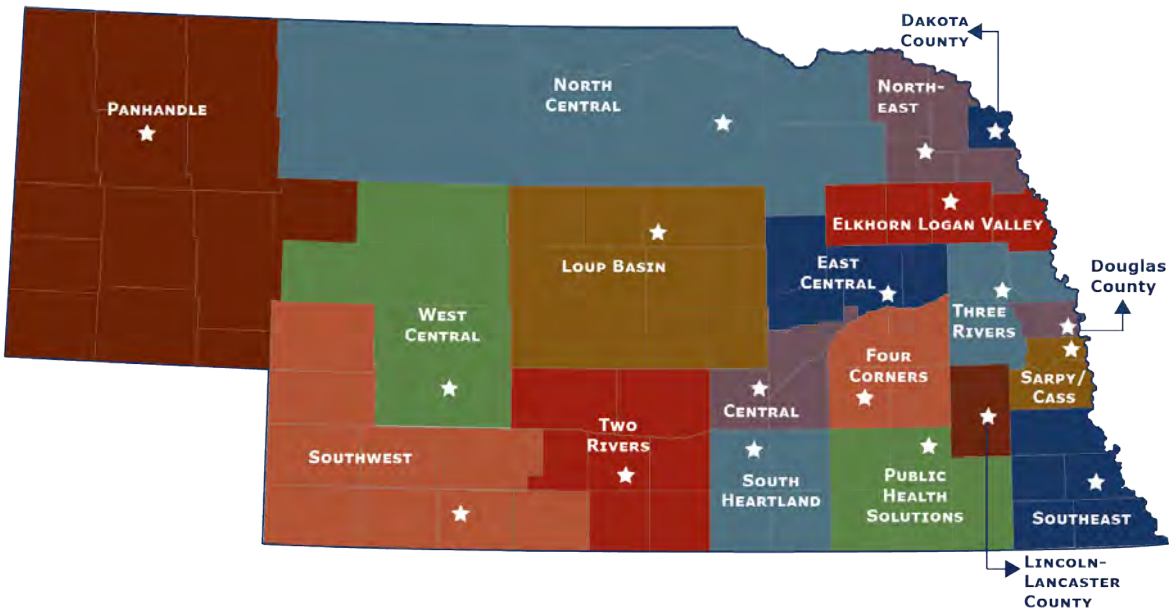


Table 1: Health Care Funding Act – Eligible Local Public Health Departments (LHDs)	
HEALTH DISTRICT	**COUNTIES**
Central District Health Department	Merrick, Hall, and Hamilton counties
Douglas County Health Department	Douglas County
East Central District Health Department	Boone, Nance, Platte, and Colfax counties
Elkhorn Logan Valley Public Health Department	Madison, Stanton, Cuming and Burt counties
Four Corners Health Department	Polk, Butler, York and Seward counties
Lincoln-Lancaster County Health Department	Lancaster County
Loup Basin Public Health Department	Blaine, Custer, Garfield, Greeley, Howard, Loup, Sherman, Valley, and Wheeler counties
North Central District Health Department	Cherry, Keya Paha, Boyd, Brown, Rock, Holt, Knox, Antelope, and Pierce counties
Northeast Nebraska Public Health Department	Cedar, Dixon, Wayne and Thurston counties
Panhandle Public Health District	Deuel, Dawes, Box Butte, Sheridan, Banner, Morrill, Garden, Kimball, Cheyenne, Grant, Sioux, and Scotts Bluff counties
Public Health Solutions	Fillmore, Saline, Thayer, Jefferson and Gage counties
Sarpy/Cass Health Department	Sarpy and Cass counties
South Heartland District Health Department	Adams, Clay, Nuckolls, Webster counties
Southeast District Health Department	Otoe, Johnson, Nemaha, Pawnee and Richardson counties
Southwest NE Public Health Department	Chase, Dundy, Frontier, Furnas, Hayes, Hitchcock, Perkins, Red Willow and Keith counties
Three Rivers Public Health Department	Dodge, Washington and Saunders counties
Two Rivers Public Health Department	Dawson, Buffalo, Gosper, Phelps, Kearney, Harlan, and Franklin counties
West Central District Health Department	McPherson, Logan, Lincoln, Hooker, Arthur and Thomas counties

Report Time Frame and Scope

As required by statute, LHDs funded under the Health Care Funding Act submit a report to DHHS by October 1, for inclusion in the full Annual Report submitted by DHHS on December 1. This Annual Report covers the period July 1, 2017 to June 30, 2018 and includes brief descriptions of selected activities, services, and programs provided by the LHDs related to the Three Core Functions and 10 Essential Service of Public Health.

All LHDs, as local Chief Health Strategists supported through the public health portion of the Nebraska Health Care Funding Act, are working across their service areas to improve and protect the health and wellbeing of local communities. Only a few examples of the extensive range and number of activities and programs provided by each LHD are covered within this report. Visit LHDs' individual websites (included in each report) to learn more about the full scope of their work.

Central District
Health Department

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Spotlight Success Story from 2018

Central District Health Department (CDHD) received a grant, Nebraska Teeth Forever (renamed Healthy Smiles by CDHD), from the State of Nebraska, Division of Public Health, Office of Oral Health and Dentistry in April 2017. The purpose of this grant is to develop local infrastructure and oral health workforce capacity to provide dental disease prevention services and activities in non-traditional settings targeting children ages 3-11 and elders in nursing home facilities. Services provided to elders included oral screenings and cleanings. In addition, when necessary, CDHD recommended follow-up care with a dental provider. Services to children included oral screenings, cleanings, fluoride treatments, and sealants. The services were provided to children at schools, daycares, and pre-school learning facilities. In addition to providing dental services in these establishments, CDHD also hosted dental days at our agency for youth. CDHD has seen a total of 517 children and 45 elders.

A requirement of the grant was to hire a Community Health Worker (CHW) and a Public Health Registered Dental Hygienist to provide the dental services. In addition to the services mentioned above, the dental hygienist and the CHW provided education to nursing home staff and to parents and caregivers of children.

A resident at a nursing home had dentures for many years. The dentures were not properly cared for and were incredibly stained. The hygienist spent over an hour scrubbing the dentures and returned them to the resident. The resident was so moved by this improvement that he started to cry. It was incredible to see the joy on his face.

Many children served through this grant were not covered by insurance or Medicaid and were unable to follow-up with the referrals to treatment because their families could not afford it. Some children had significant tooth decay, and one child had a significant infection. Eight children were identified as needing follow-up care. Because of the partnership between CDHD and Heartland Health Center (HHC), a Federally Qualified Health Center, the children were able to recieve services at HHC. HHC requested a fee of $70.00 per child. CHI Saint Francis, a long-time partner with CDHD, in Grand Island agreed to cover the fees. While at HHC, the children received physical and dental exams and dental x-rays. All children seen needed further care. HHC devised a payment and dental treatment plan for each child. A private, anonymous funder came forward with the monies to cover treatment for at least 20 uninsured children with significant dental needs.

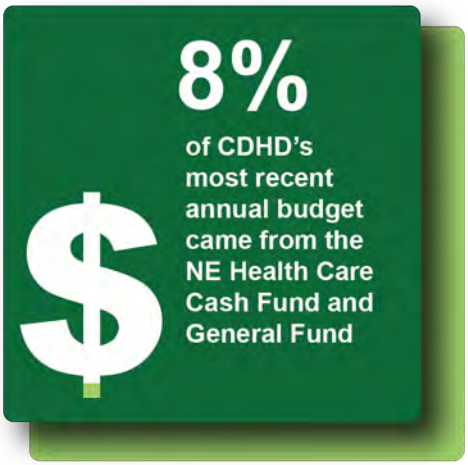
This report includes examples of efforts of Central District Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: Central District Health Department (CDHD) assesses data on oral health, especially school age children, to monitor needs and target resources. We have learned that there are a number of children in our district who will require surgery for severe dental issues that have not been addressed due to lack of finances and/or access to care. We have linked these children to the Federally Qualified Health Center and to a local pediatric dentist who has offered a reduced fee to serve these children. We have located a separate funding source to assist with payments through our Community Response Program. Our Community Health Workers (CHWs) who are bilingual, provide interpreter and translator services to reduce barriers of communication.

Assurance: CDHD utilizes a Dental Hygienist to assist the WIC program to provide education to participating parents, to conduct oral assessments, and to administer fluoride. CDHD provides onsite assessments, fluoride varnish and sealants to preschools, elementary schools, nursing homes and at our facility in Grand Island. We also make referrals to dental follow-up as needed.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: Data from the CDHD three-county region indicate that diabetes is a widespread concern and merits attention as a priority public health issue. The percentage of residents reporting that they had ever been told by a doctor that they had diabetes (excluding pregnancy) was 9.3% in 2014, an increase of 0.5% from 2011. Additionally, CDHD residents are more likely to be overweight or obese as compared with the state (70.6% compared to 66.7%) Obesity is a risk factor for diabetes and has increased by 1.6% from 2011.

Assurance: CDHD works with health care providers to use electronic health records (EHRs) to identify patients at risk for diabetes or with uncontrolled diabetes. CDHD works to refer such patients to appropriate community programs. CDHD is one of the only providers of the evidence-based, National Diabetes Prevention Program (NDPP) in our area. CDHD is committed to assuring sustainable access to these types of programs and is therefore also working to become a Medicare-recognized Diabetes Self-Management Program Provider.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: CDHD continually evaluates district immunization rates and trends to provide appropriate community education regarding immunization and to determine areas of need. For the past three years, CDHD has promoted HPV vaccinations through parent education. CDHD has also hosted provider trainings to increase HPV immunization rates for youth. Because not all providers enter data into the Nebraska Registry, increases are difficult to measure but CDHD's internally monitored rates have increased. The percentage of children immunized for HPV in the Central District is 60% compared to 40% state-wide.

Assurance: CDHD works closely with area schools to provide immunization education to parents. We also work with school nurses to identify children who are not up-to-date on their mandatory and/or recommended immunizations. They then schedule convenient appointments. CDHD houses the Grand Island Public Schools' Welcome Center where children who speak English as a second language and who are new to the school are assessed for language skills. While they are onsite, CDHD is able to evaluate immunization records and provide any necessary referrals.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: Radon exposure is the leading cause of lung cancer for non-smokers in the U.S. and is a serious health risk throughout Nebraska. CDHD monitors radon levels and trends across the three-county district.

Assurance: CDHD educates the public on risks associated with radon, especially in Hamilton County, which has the highest predicted average indoor radon screening levels (greater than 4pCi/L). CDHD also provides free radon kits to residents to test in-home radon levels. Test kits are sent to DHHS and results are distributed to participating home owners along with suggested mitigation, as indicated by results.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: CDHD monitors data related to injuries, including trends in motor vehicle crashes.

Policy Development: Recognizing the relatively high rates of motor vehicle-related injuries and deaths in our area, CDHD promotes mandatory seatbelt use, especially during holidays.

Assurance: CDHD partners with law enforcement to participate in the Back to School Bash where we promote seatbelt use, among other healthy behaviors.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: As the local WIC provider, CDHD is able to identify the percent of WIC mothers who are breastfeeding at two months, six months, and one year and use that data to more effectively target education and outreach efforts.

Assurance: CDHD's WIC Breastfeeding Day is held annually at Conestoga Mall to celebrate and educate women on breastfeeding and its benefits. CDHD works with WIC vendors to assure that they understand the WIC program and to recruit new WIC vendors as appropriate.

Additional public health activities that Central District Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

CDHD is a permanent member on the Hall County Community Collaborative (H3C). The H3C is a 501c3 non-profit organization whose vision is "healthy families and children." The role of the H3C is to provide support for systems and services that impact health in our community. Key members on the H3C include DHHS, Schools, CASA, CHI-SFMC, Heartland Health Center, Region 3 Behavioral Health, United Way, Boys Town, City of Grand Island and many others. The H3C has grown in members and budget to nearly $1 million over the last few years. The H3C operates using the Collective Impact framework, maintaining a neutral backbone. It focuses on transparent communication, use of data to measure progress, shared goals, and common agenda.

One example of success in this organization is Community Response where individuals in need of services or resources are identified in the community and then referred to Community Response where needs can be addressed either directly or through referral.

An example of this is as follows: The school nurse reports to the local office of DHHS that a child comes to school regularly in unwashed clothes. She is concerned about the home situation. A DHHS visitor makes the home visit and finds loving parents who are down-on-their-luck. The washing machine is broken and there is no money to fix it. DHHS refers the family to Community Response with their approval. The family is given a voucher for a new washer. The child begins coming to school in clean clothes. He is more social and has greater self-confidence. Community Response has decreased the family stress and strengthened the family's belief in the community and in each other.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

Knowing and being an essential part of our community is key to effecting change for better health and well-being. Through CDHD's Community Health Assessment (CHA) activities, we collect, synthesize, and present a picture of our district in words and numbers that are meaningful and useful to our community. In addition to gathering the readily available quantitative data, CDHD generates qualitative data through focus groups and discussions that add to the depth of our understanding of community needs. A beneficial side effect of conducting focus groups and community meetings is the building and strengthening of relationships and partnerships. Through these partnerships, CDHD works together to formulate plans aimed at addressing those issues most important to our three-county district.

PRIORITIES

Obesity (Lifestyle behaviors)

Behavioral Health

Diabetes

CDHD's Community Health Improvement Plan (CHIP) is still evolving. CDHD has provided data reports to our three area hospitals specific to their catchment areas and is working with them to integrate their identified priorities and action plans into a comprehensive, regional plan designed to foster partnership and efficient use of resources while reducing duplication and waste. Along with these partnerships, CDHD also works closely with our community collaboratives, schools, social service providers, and Heartland Health Center (our Federally Qualified Health Center [FQHC]). Additionally, CDHD looks to state and national resources for technical expertise and resources. The CDHD CHIP will continue to develop as we work with our partners on formalizing the plan into a working document.

Dakota County
Health Department

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Spotlight Success Story from 2018

Dakota County Health Department coordinates care across many facets and impacts our community in important ways. One recent example of this involved our Community Health Worker (CHW). She was approached by a client who was unfamiliar with the healthcare system and new to the country. This client was worried about a lump that she had detected and wanted to get connected with a healthcare provider but had limited financial resources to cover a visit. Our CHW worked to find resources across many of our local agencies, coming up empty handed on many, as this client was not eligible for many safety-net services. However, the CHW was able to eventually locate a local program that was appropriate for the situation and helped the client apply for assistance. Our LHD coordinated the interpretation and translation and helped the client complete paperwork. Once approved, our team helped arrange for a mammogram for this client. A lump was located, and the biopsy found it to be an aggressive breast cancer. Our CHW then worked with the local cancer center on behalf of the client who had limited resources to afford and manage the care that she desperately needed. Eventually, the CHW found a provider who agreed to do the surgery pro-bono. The CHW helped the client arrange a payment plan for the remainder of her care.

This report includes examples of efforts of Dakota County Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

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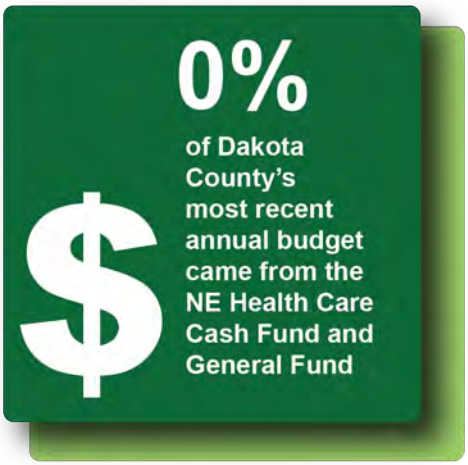


ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Our local health department (LHD) works with our English, Spanish and Somali patients to coordinate information and engage local healthcare providers who care for these patients. We assist with paperwork, interpretation and translation needs. We educate patients on the importance of talking with their providers about their health needs.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

We educate our community on self-management skills to prevent and control obesity, cardiovascular disease and diabetes. According to County Health Rankings, 36% of Dakota County adults are considered obese and 29% are physically inactive. Many of our staff are instructors for the Diabetes Prevention Program and the Living Well Chronic Disease Self-Management program. We offer these multi-week courses as needed, in a variety of languages (including English, Spanish and Somali).

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

The vision of Dakota County Health Department is to create and promote a healthier community. Increasing overall vaccination rates is important to achieving this vision. Our department provides three immunization clinics per week, for adults and children. We offer a variety of hours, to make this service convenient for all our community members. We actively work with our local schools to offer immunizations to students and faculty. We also work with our community agencies to increase awareness of our program and encourage vaccinations.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Radon exposure is the leading cause of lung cancer for non-smokers in the U.S. and is a serious health risk throughout Nebraska and in Dakota County. Therefore, our department actively promotes environmental public health by engaging our Library, City Hall and Extension office in the distribution and education of radon prevention and testing materials. We also use newspapers, social media and various community events to promote both radon and lead prevention within our county. Our Emergency Response Coordinator works with local agencies on community-wide efforts to be prepared for disease outbreaks, natural disasters and other emergencies. We regularly meet with partners from Long Term Care, Fire, Emergency Medical Services, Police, and Emergency Management to assure public health preparedness by engaging in table-top exercises and establishing good plans in the event of the worst.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Dakota County is not directly involved in Injury Prevention programming.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Dakota County is not directly involved in Maternal, Child and Family health programming.

Additional public health activities that Dakota County Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

Our department takes great pride in being able to provide great public health programs to our community on limited funding. We are fiscally responsible and concentrate our efforts so that they will provide the most impact across our community. The work of Dakota County Health Department is critical to impacting the high incidence of chronic disease in our areas and promoting overall health within our community. We are proud to serve Dakota County.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

Our Community Health Assessment (CHA) process engages many sectors of our community—including local businesses, other health agencies, the schools, and community members—so that the CHA priorities are reflective of the priorities of our entire service area. Once the assessment process is complete, we work with partners to develop a Community Health Improvement Plan (CHIP) that addresses our shared priority areas. Leveraging partner agencies expertise and ability to address given priorities is the most effective means to create shared ownership and make progress toward Dakota County's CHIP goals.

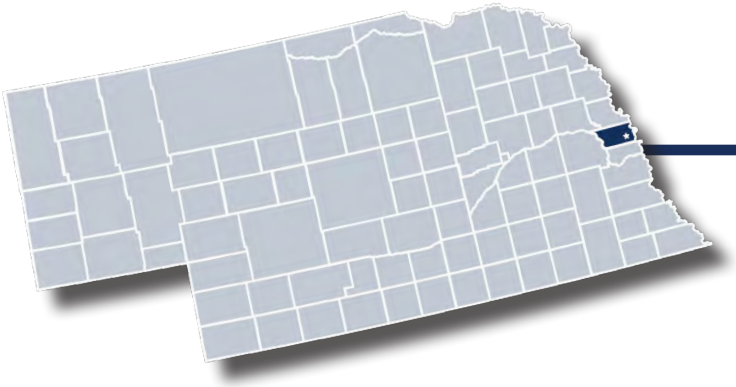
PRIORITIES

Diabetes Prevention

Weight Management

Cancer Support

For more information about *Dakota County Health Department* please visit:
www.dakotacountyne.org



Douglas County
Health Department

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Spotlight Success Story from 2018

In 2004, the Douglas County Board of Health declared that sexually transmitted diseases (STDs) were at epidemic levels in Douglas County. After more than a decade of intense work in the community to address the epidemic, Douglas County Health Department (DCHD), in collaboration with the Adolescent Health Project (AHP), reported a decrease in chlamydia rates for the last year, from 662.2 per 100,000 population in 2016 to 658.5 per 100,000 population in 2017. "This is a time to recognize our success," Health Director Dr. Adi Pour said. "This means we have been doing the right thing, but our work is far from over. We will continue to educate, test, and provide outreach to as many people as we can." An increase in sexual health knowledge and improved health outcomes are the result of providing unrestricted access to STD testing and treatment as well as free condoms to reduce STDs, according to the Adolescent Health Project funded by the Women's Fund of Omaha. The DCHD and other clinical AHP partners make STD testing accessible by offering free testing to young adults at clinic locations. There were over 5,700 visits to the DCHD Clinic in 2017 and over 2,800 visits in the first six months of 2018. DCHD also makes STD screening more accessible by providing testing at outreach locations that are convenient for young adults, including public libraries, special events, and community centers. There is an average of 40 outreach testing sites offered by DCHD throughout the county each month, in addition to normal testing hours at the DCHD Clinic. DCHD outreach staff also provided STD education to 23,041 people in 2017.

One of the most successful programs has been free condom distribution. In the past 15 months, more than one million condoms have been distributed through the Adolescent Health Project. Free condoms are available at all AHP STD testing locations and at more than 150 other locations throughout the Omaha metropolitan area. "This slight decrease is a bright light for our continued work in the community. We are optimistic that with access to education and safer sex resources, more people will be able to take control of their sexual health," Dr. Pour said. "We know the only way to maintain this trend is to continue with our hard work and create sustainable, community-wide changes."

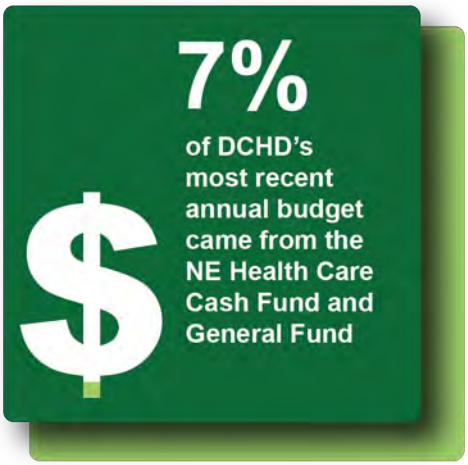
This report includes examples of efforts of Douglas County Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

DCHD developed an MOU between DCHD and health care providers to link HIV positive patients to PrEP (Pre-exposure Prophylaxis for HIV Prevention) and ongoing STD screening services and gathered input from community members to address perceptions of PrEP utilization. Additionally, DCHD is currently building capacity for an integrated care STD clinic. A Behavioral Health Consultant (BHC) has been hired. She is working to establish screening tools for STD clients specific to depression screening, substance use and safety in the home. The BHC will provide SBIRT (Screening, Brief Intervention, Referral, Treatment) services along with referrals and follow-up based on needs identified during the STD clinic visit.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

DCHD, in partnership with community partners, is working to ensure that public and voucher housing is healthy by 2025. Efforts have focused on adopting one consistent assessment tool (Wyatt) by all home inspectors (public and voucher housing) and building capacity for smoke free housing regulations for landlords/rental properties. DCHD, working with health systems, has assisted in developing capacity for a Team Based Care approach with a focus on the management of hypertension. This has included staff training, policy development, and learning how to use electronic health record (EHR) data to drive systems changes within the clinic environment.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

After more than a decade of work addressing the STD epidemic, the 2017 decrease in the chlamydia rate is an indication that the efforts are paying off. DCHD, with help from community partners such as the Omaha Women's Fund, has been innovative in expanding access to testing, education, and condoms in community settings and in assuring all reported infections are treated. The highest number of influenza infections in over ten years was reported to DCHD in the 2017-18 season, with 6,023 lab reports and 26 outbreaks investigated. DCHD vigorously investigates and monitors the circulating viruses and educates the community and partners.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Over 20,000 blood lead screening tests were conducted in Douglas County by health care providers in 2017, compared to 17,000 in the previous year. Lead poisoning prevention staff used aggressive outreach, education, and financial support to expand existing capacity, and presented their work at national meetings and scientific journals. DCHD worked closely with Nebraska Biocontainment Unit partners in addressing and responding to high-consequence disease in the community, participated in several full-scale Ebola exercises, and revised the Rules and Regulations of Douglas County for the Control of Communicable Diseases and Poisonings based on Ebola quarantine and isolation experiences.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Through the facilitation of a Douglas County CHIP Objective, DCHD is working with partners to develop capacity for the Omaha community to become a Trauma Informed Care (TIC) community. This involves baseline training (TIC 101) for education, health, child welfare, and first responder sectors, as well as policy development for entities to focus on trauma-informed service delivery. DCHD is also working with multiple health systems and Project Extra Mile to build capacity for Integrated Care and using the Screening, Brief Intervention, Referral and Treatment (SBIRT) to address concerns with substance use and mental health issues within primary care settings.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

DCHD, in conjunction with health systems and community partners, has established a Metro Area Breastfeeding Coalition. The Coalition has a mission, vision, and eight focus areas, specific to policy, systems and environmental changes, to build supports for breastfeeding mothers and to increase breastfeeding rates according to the Healthy People 2020 goals. In an effort to reduce the infant mortality rate, DCHD, in conjunction with community partners, meets on a routine basis to review cases of infant death to determine contributing factors which then drive the Baby Blossoms Collaborative community-wide strategic plan to address infant mortality.

Additional public health activities that Douglas County Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

Based on the vision for Douglas County to become an Accountable Health Community and on feedback from community partners, DCHD is leading a large community-based work group to build a Community Health Worker (CHW) model for Douglas County. The work group adopted a common definition, and core competencies; and developed a "CHW 101" training, a CHW Supervisor training, and a job description for employers. The work group continues to flesh out the challenges surrounding reimbursement, certification, support for the CHW workforce, and the evaluation methods needed to measure the impact of CHWs in the community. DCHD collaborated with state and federal partners to investigate five national foodborne outbreaks by participating in coordinating conference calls, re-interviewing patients with outbreak-specific focused interviews, conducting data analysis, and communicating results and preventive messages. DCHD Public Health Nurses performed 1,442 home visits to persons with tuberculosis (TB) for Directly Observed Therapy and performed 264 tests for TB in 2017. The environmental health division Retail Food Section was successfully audited in August 2017 for FDA Voluntary Retail Food Standards 1 & 7, and developed policies and procedures for FDA Voluntary Retail Food Standard # 3, 4, and 5. The DCHD Health Data and Vital Statistics Section responded to multiple internal and external requests for data, mapping and analysis.

The environmental health division provided health education to food manufacturers/retailers and collaborated with stakeholders on local and national foodborne outbreaks. Environmental Health Air Quality Laboratory Section assessed local air quality for federal standards (National Ambient Air Quality Standards: NAAQS). The Sanitation Section staff assured safe swimming pool construction and operations, on-site septic system installation and operation, landfill operation, and investigated numerous environmental hazard complaints (odors, waste disposal, infestations, etc.) and collaborated with stakeholders on arboviral vector monitoring.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

The Community Health Assessment (CHA) is a collaborative effort, across four counties (Douglas, Sarpy, Cass and Pottawattamie) that involves local health departments, health systems and community partners. The most recent Metro Area CHA is currently in process and DCHD is leading efforts to add three additional assessments using the Mobilizing Action through Planning and Partnerships (MAPP) process. These assessments include the Forces of Change, Local Public Health Systems, and Community Strengths and Themes assessments which include participation with multiple community partners. We anticipate the release of these assessments, including the CHA, in the fall of 2018 to determine the prioritization of Community Health Improvement Plan (CHIP) objectives.

PRIORITIES

Access to Care

Obesity

Violence and Safety

Behavioral Health

The Douglas County CHIP process, facilitated by DCHD, is overseen by two committees. The CHIP Steering Committee, represented by all health systems, including the two federally qualified health centers, Live Well Omaha, and DCHD, meets three times a year and serves in an advisory capacity to the CHIP Planning Committee. Two new community members have been invited to join the CHIP Steering Committee (Omaha Community Foundation and United Way of the Midlands) to support and ensure coordination of services across the community. The CHIP Planning Committee, represented by the Steering Committee, workgroup members and the community at-large, meets quarterly to provide updates on the objectives within each priority area of the CHIP. These quarterly meetings are an opportunity to share successes as well as barriers and to identify opportunities that may be mutually reinforced across focus areas. Workgroups, represented by multiple community partners, meet throughout the year to work on specific strategies to accomplish each CHIP Objective.

East Central
District Health Department

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Spotlight Success Story from 2018

The image shows Community Response staff, coaches, and referral sources from 20 different agencies receiving training in February 2018. This success story highlights a family assisted by this important health department program. "L" was referred to Community Response by Schuyler Elementary School staff at the end of March 2018. L's family had fled from California because her family was receiving threats. It reached the point where they were involved in a car crash that involved one of the people who threatened them. They are unsure of, or unwilling to share, the reason why they were targeted, but the threat to their family was such that they packed as much as they could carry with them and left for the airport without looking back. L's family stayed with her sister-in-law in a one bedroom home for her family of five, including her husband and three children. L was grateful that she was no longer in danger but felt burdened that her family was taking room in the small, already-crowded home. L and her husband found a two-bedroom basement apartment they were able to move into, but L was very hesitant to move in because there was a cockroach and mouse infestation that the landlord refused to acknowledge. The desperate need for a home of their own pushed them to work out a payment plan with the landlord and move in despite their hesitancy. The family stayed there for roughly a month until they were forced to move out due to non-payment and then had to move back in with L's sister-in-law.

About the time they moved back, L was referred to East Central District Health Department's (ECDHD) Community Response (CR) initiative. L looked for work and for a place to live while her husband was at work each day. L was very willing to meet with Bellyni at their arranged times and put effort into the program because L wanted better for herself and her family. Bellyni helped L find many services like NEWORKS for unemployment and helped her get ready for GED classes, as well as helped L's husband to make sure his application for citizenship was completed properly. L's family found a spacious, clean rental in Columbus and was able to cover the first month of rent themselves, but utilized flex funding to help pay the deposit.

Since April when they moved into their new home, Bellyni has helped the family create a realistic budget that ensures they are able to pay their rent and other expenses, and L has begun the journey toward her GED. L has expressed her gratitude for the support that the Community Response initiative has been able to give her when her family was struggling and is happy to say they were able to graduate from CR, stable and with the supports they need in place.

This report includes examples of efforts of East Central District Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

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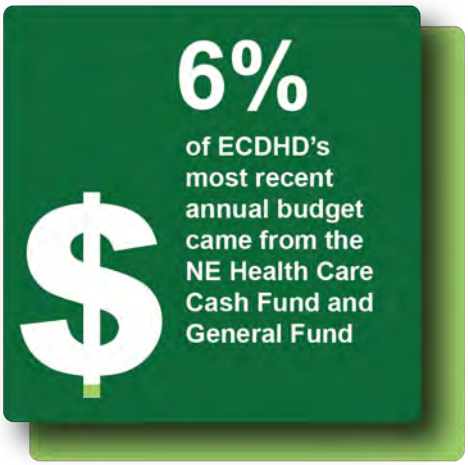

ACCESS TO AND LINKAGE TO CLINICAL CARE

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Assessment: Suicide and mental health concerns have been a top priority identified in East Central District Health Department's (ECDHD) most recent Community Health Needs Assessment (CHNA). The most recent data from 2016 shows 12% of area 12th graders have attempted suicide in the past year.

Policy Development: The Child Well Being (CWB) coalition provides mental health vouchers to youth community members who may otherwise not be able to pay for them. Youth are identified as potentially needing services through school or diversion staff that may notice a need for services.

Assurance: Many behavioral health care providers in ECDHD's four-county jurisdiction have entered agreements with our agency to provide care at an agreed-upon cost when presented these vouchers.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: During this reporting period, ECDHD collected and assessed student Body Mass Index (BMI) data on 5,319 K-12 students throughout the four-county area. ECDHD contracts with the University of Nebraska at Kearney BMI website to enter, access and analyze these data.

Assurance: With this aggregate student BMI data, ECDHD assesses the number and percent of students per grade that are underweight, of normal weight, overweight or obese and then shares the data with the CHIP coalitions working in each county. These coalitions work together to promote programs and activities in their communities to increase physical activity and improve nutrition. Because of their higher risk for diabetes when compared to our population at large, ECDHD's minority health program also provides targeted services for adult minorities in Platte and Colfax counties.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

East Central District Health Department (ECDHD) offers programs that monitor, prevent and address communicable diseases, including those that are prevented through immunizations.

Assessment: Through several electronic data surveillance systems, ECDHD monitored and investigated disease-related data. Included in these systems are the state's immunization database (Nebraska State Immunization Information System or NESIIS) and the reportable disease system (Nebraska Electronic Disease Surveillance System or NEDSS) which provide ECDHD with information on cases of infectious and non-infectious diseases in the four-county area.

Policy Development: ECDHD worked closely with its partner agency, Good Neighbor Community Health Center, to revise its policies and protocols around tuberculosis testing and treatment this past year to ensure the safety of both the patient and the providers.

Assurance: ECDHD conducts weekly school surveillance activity for illness reporting regarding influenza-like illness in ECDHD's schools. Staff work with schools to assure they have the resources they need to prevent further spread of disease and educate students and families and to give guidance when there are high levels of illness present.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: ECDHD gathered data on the number of homes tested for radon and the percent of homes with radon levels above or below the safe level as determined by the Environmental Protection Agency (EPA). Over half of homes tested in the district were above the recommended level. ECDHD's surveillance program monitors high lead levels in children. When a child has a confirmed blood lead level greater than 10 micrograms/liter, the state health department is notified for a home visit to be completed.

Policy Development: This information is also used to develop policies and work with the cities and counties to educate them about the risks lead poses to children and families.

Assurance: ECDHD works with the state to conduct home visits, provide education, and assure the family continues to follow up with their provider to continue testing until the child's level drops below 5. This is a team effort to assure coordination of services to improve the health and well-being of children in the ECDHD region.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

East Central District Health Department's (ECDHD) commitment to injury prevention is evident in our robust programs in substance abuse prevention and screening and our leadership role with the substance abuse coalition.

Assessment: We assess data (including that from the Youth Risk Behavior Surveillance System) on youth substance abuse prevention including but not limited to alcohol, tobacco use, marijuana, etc. We review, track and discuss this data with our substance abuse community coalition, Back to BASICs.

Policy Development: Based on data trends, our agency works to assure the availability of interventions such as compliance checks and other strategies. The coordinator of our substance abuse programs also works with businesses to adopt tobacco-free policies that include e-cigarettes. The Alcohol Literacy Challenge is an evidence-based strategy that the coalition implemented this past year with over 500 students. The program educates and empowers youth to delay or reduce their alcohol use.

Assurance: Compliance checks are another evidence-based strategy conducted by our agency and the coalition in collaboration with law enforcement.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: East Central District Health Department's work to link community members to services to improve Maternal Child Health (MCH) includes its Early Development Network (EDN). EDN serves families who have a child within the birth to 3 year age range that is not developing typically.

Assurance: EDN Service Coordinators assist families in accessing their local school district for therapy service as well as connecting them to state and local resources to meet their family's needs. From July 2017 through June 2018, EDN served 108 families on average per month and made over 700 visits to the homes of families in efforts to educate them and assist them to linking to other services available. Another example of ECDHD's MCH work includes the WIC program. WIC provides nutrition education to parents/guardians of children under age 5 as well as vouchers for healthy, pre-identified food/juices. WIC promotes breastfeeding and encourages clients to consider nursing their infant. Over 1,100 individuals were served on the WIC program in this reporting period.

Additional public health activities that East Central District Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

During this period, ECDHD's Infectious Disease Surveillance staff investigated 224 reportable diseases in the four counties. These cases included 20 Chronic Hepatitis C and seven Hepatitis B infections, newly diagnosed, with one acute case of Hepatitis B. (Blood-borne conditions represent 12% of all communicable conditions); 78 food-borne or animal-contact related conditions (35% of all communicable conditions), such as: Campylobacter, Salmonella, Shigella, Giardia, Escherichia coli, Cryptosporidiosis, and Cyclosporiasis. Among the 12 cases (5% of all communicable conditions) of vaccine preventable diseases reported, were five Varicella (Chicken Pox) cases in one family that refuses preventative vaccines, isolated Mumps cases and severe Streptococcal pneumoniae infections in elderly, or patients with underlying conditions. Two vector-borne diseases were included Spotted Fever Rickettsiosis (transmitted by a tick bite), and a neuro-invasive West Nile Virus disease (transmitted by a mosquito bite). Fifty-four animal bites or rabies exposure investigations were performed, and two persons required treatment because two of the animals were unsuitable for testing. Thirty-four investigations for lead poisoning in children were initiated, requiring home visits for environmental inspections in two of them, located in different counties. Extra, temporary, funding provided by DHHS this year has allowed for enhanced lead surveillance and coordination of services for the families affected. Some other cases included: 11 invasive bacterial diseases such as Streptococcus Group A and B, and Haemophilus influenza; four investigations of systemic fungus invasion: Histoplasmosis; and one sporadic Legionellosis disease. The only disease cluster investigated, belongs to the Chicken Pox group.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

In March 2017, ECDHD began its fifth iteration of the Mobilizing for Action through Planning and Partnerships (MAPP) cycle for assessment of the community's health status. By the end of August, 500 paper Community Health Surveys were distributed in all four counties, the first ever electronic Community Health Survey was made available, focus groups were conducted, and county assets and resources were identified. The Local Public Health System Assessment and Forces of Change Assessment were completed in October 2017.

The Community Health Needs Assessment (CHNA) was completed in March 2018 and released to the public.

PRIORITIES

Access to Care

Mental Health

Substance Abuse

Obesity

Each of the four counties held individual workshops where health department leadership presented the data from the CHNA and Community Health Improvement Plan (CHIP) priorities were identified for each county. County coalitions formed consisting of key stakeholders that are passionate and knowledgeable about given topic areas. Each counties' CHIPs were then combined into the overall ECDHD agency CHIP. ECDHD staff are involved in and support the coalitions in all four counties to assess, plan, and deliver public health services. ECDHD convenes each county group at least every six months to share progress and collect evaluation data to include in its annual report. The CHA and CHIP provide the overall strategic roadmap to improved community health in our region.

Elkhorn Logan Valley
Public Health Department

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Spotlight Success Story from 2018

Elkhorn Logan Valley Public Health Department (ELVPHD) held its first mammography event in Norfolk at the Midtown Health Center on June 21, 2018. ELVPHD was able to screen 18 women but had contact with 30 women; 22 of whom were signed up for a mammogram while the other 8 were put on a waiting list to be screened or were referred to another location for mammography services. Out of the 18 women screened, 4 were Hispanic while the remaining 14 were Caucasian. Of the women screened, 16 fell into the age range of 40-75, while two others were 39, but had a family history of breast cancer and were advised to be screened earlier.

ELVPHD had help in spreading the word about the event from Midtown Health Center (MHC) in Norfolk. MHC sent all their female clients, who had no record of a mammogram within the past year and in the age range for mammography screenings, a postcard invitation to schedule a mammogram. MHC helped with promotion online, as well.

With the success of this event, ELVPHD has plans to continue hosting mammography events. This event helped ELVPHD to navigate women to complete a mammogram and to also provide health coaching to those women that needed those services. ELVPHD was able to develop a working relationship with a new community partner (Medical Imaging Consultants) as well as to continue its relationship with Midtown Health Center.

This report includes examples of efforts of Elkhorn Logan Valley Public Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA) .

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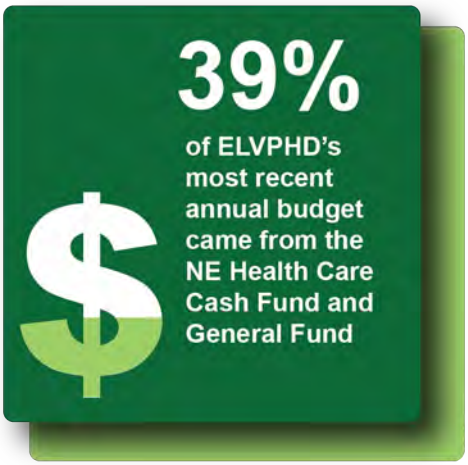
Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: ELVPHD works with the public health dental hygienists to record areas of concern during oral health screenings. ELVPHD then works with Head Start Family Service Workers and the families they serve to help ensure that problems identified during service visits are followed-up on to correct decay and/or prevent larger problems from developing. Subsequent visits track whether problems were taken care of.

Policy Development: ELVPHD hosted a training for multiple medical clinics and hospital representatives on chronic care management and transitional care management techniques and approaches. Of those that attended the training, 100% participated in a telephone needs assessment, and two were subsequently chosen to pilot our community-based coordination initiative.

Assurance: ELVPHD expanded dental services during the past year to include sealants provided at school venues and screenings and cleanings at long-term care facilities (LTCFs). New partners for oral health services included six schools and two LTCFs (314 additional people were provided dental services because of these new partnerships).

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: As a component of the school nursing contracts that ELVPHD holds, public health nurses assess asthma, diabetes, and life-threatening allergies among students. State law requires that students have an Emergency Action Plan on file. During the 2017- 2018 school year, 70% of applicable students achieved the goal (up from 51% during the 2016-2017 school year).

Policy Development: ELVPHD was awarded a model practice award by the National Association of County and City Health Officials (NACCHO) in July of 2017 for our own Operation Heart to Heart program. This program uses a worksite wellness model and achieved successes in 12 of its 14 goal sets around biometric measures, self-reported behavior and knowledge changes and community-education activities over a four-year period.

Assurance: ELVPHD works with community partners such as Head Start centers, schools and clinics for referrals into Eating Smart and Being Active (an obesity prevention program). Weight and BMI tracking of participants show that 86% have lost weight and 27% have reduced their BMI by at least one point.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: During the reporting period, ELVPHD investigated 164 reportable infections. One more intensive area of involvement included partnership with Nebraska DHHS on the surveillance and investigation of a salmonella outbreak within our four-county jurisdiction that was linked to a local food establishment. Within one week of the identification of the outbreak, it was considered “contained” and was declared to be “over” two weeks later.

Policy Development: Following the aforementioned salmonella outbreak, ELVPHD staff worked with local hospitals, labs, and medical clinics to discuss and update their policies regarding specimen testing, handling and submission. These updates will allow for more-timely processing and seamless coordination in future outbreak situations.

Assurance: ELVPHD provided ongoing immunization clinics (serving both private and Vaccines for Children [VFC] clients) and on-site flu shot clinics. At flu shot clinics, ELVPHD provided 1,195 immunizations compared with 1,062 the prior year (12.5% increase). ELVPHD served three times as many VFC clients during this past year over the prior year.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: Data regarding radon levels detected by kits distributed by ELVPHD is tracked and released via ELVPHD's website, press releases and other promotional channels as a means to encourage home owners to test their homes. During the previous reporting period, ELVPHD achieved an average of 68.9% return rate on test kits disseminated.

Policy Development: ELVPHD initiated a statewide agreement for all Nebraska Public Health Departments to provide mutual aid to each other in the event of a public health emergency. This alleviated the task of each individual department initiating individual agreements with each other. This step of efficiency accomplished the same result and took the place of hundreds of agreements that existed prior to the statewide initiative. The master MOA is overseen and signed by all Nebraska Health Directors. The Nebraska Association of Local Health Directors (NALHD) oversaw logistics necessary to finalize the statewide agreement.

Assurance: ELVPHD assists DHHS in coordinating environmental inspections, referrals, and linkages to services for children with elevated blood lead levels. During the reporting period, ELVPHD followed up with families of 24 children with a blood lead value greater than 5 ug/dL.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: ELVPHD has two fall-prevention programs (Stepping On and Tai Chi). Participants are assessed prior to the start of and at the end of each class series on fall-related criteria. Outcomes included: 52% increased their confidence level regarding preventing falls, 59% made at least one fall-prevention environmental change and 60% improved their TUG (Timed Up and Go) fall risk measure, which measures ability to balance, sit to stand and walking.

Policy Development: ELVPHD's Director worked to educate elected officials and other members of the general public regarding the public health evidence for retaining Nebraska's motor cycle helmet law. This included dissemination of survey results that were collected by AAA and the Nebraska Safety Council. The helmet law saves lives and protects against preventable tragedies in our state.

Assurance: ELVPHD currently has three funding streams that provide funds for: 1) The Nebraska State Patrol to conduct compliance checks at alcohol retail establishments (In 2017, a 98% alcohol compliance check rate was achieved across the service area); and 2) Instructors to teach Responsible Beverage Server Training (RBST) to alcohol retailers and servers (58 people received RBST Training, with 99% passing the class).

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

ELVPHD is not directly involved in Maternal, Child and Family health programming.

Additional public health activities that Elkhorn Logan Valley Public Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

ELVPHD works with the vast majority of schools in the service area on one or more of the following projects: substance abuse prevention, dental services, immunization services and suicide prevention. School partnerships allow ELVPHD to provide services and/or information to the students in an efficient manner.

ELVPHD has developed a robust internship program where we invite and accept undergraduate and masters-level student interns to gain experience in the public health field. An array of interns have conducted projects at ELVPHD throughout the year--including interns from UNMC College of Public Health, Wayne State College, Northeast Community College, and others from out of state.

By July 31, 2018, HUD housing facilities were to implement new regulations related to smoke-free public housing. In preparation for this implementation date, ELVPHD contacted HUD housing facilities in May and June and provided materials and smoke-free signage to the housing entities. Twenty calls were made to HUD facilities and 14 accepted smoke-free signage.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

ELVPHD, along with the hospital partners in our district (Oakland Mercy Hospital, St. Francis Memorial Hospital and Faith Regional Health Services), conducts a community health and safety assessment and Community Health Improvement Plan (CHIP) every three years. Community partners are invited to participate in the process as a way of achieving community input and buy-in. Because reaching the goals in the identified priority areas stretches beyond the local health department and become the responsibility of the entire public health system, ELVPHD takes care to ensure that this community engagement occurs throughout all steps of the process. The plan is intended to serve as a road map for the local public health system. ELVPHD uses the assessment and the CHIP internally—to inform our decisions regarding allocation of funds and level of effort in achieving these goals for ELVPHD staff. We also use the process as a conduit to build and maintain collaborations and partnerships with other community players—all working towards the common goals.

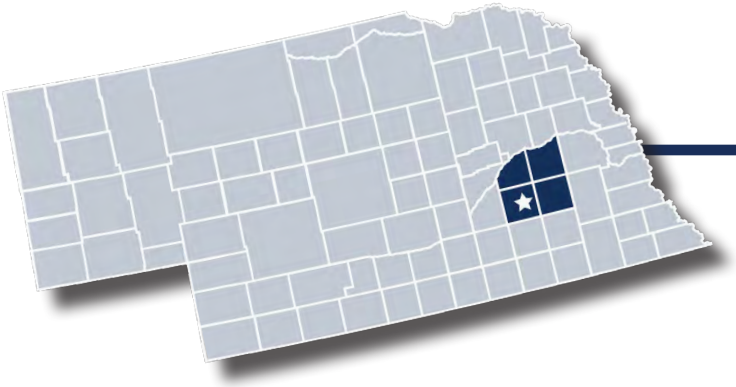
PRIORITIES

Obesity

Access to Care

Cancer Prevention and Screening

Standard Motor Vehicular Safety



Four Corners
Health Department

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Spotlight Success Story from 2018

A priority established in the Four Corners Community Health Improvement Plan (CHIP) is to Improve Local Public Health System Collaboration. Our goal, as a system, is to make a collective impact in all CHIP priority areas. We are making progress by way of ever-increasing new linkages to the partners in our four-county service area. Here are a just a few examples:

- We have formed a Worksite Wellness Collaborative between the York General Hospital, York Medical Clinic and Four Corners to offer an expanded menu of wellness opportunities, screenings, guidance, and services to local employers. In this way we are able to collectively impact health at local businesses, facilities and schools.
- Four Corners is impacting the prevalence of diabetes in our area through partnerships with fitness facilities, hospitals, diabetes educators, foot clinics, urgent care, optometrists, and pharmacies. This has allowed us to form Diabetes Referral Networks so that diabetics are not lost within the system and are better able to control their diabetes. Other partnerships allow us to ensure that the National Diabetes Prevention Program (NDPP) is offered.
- Our collective impact partnerships have created other opportunities. For example, Four Corners receives referrals from medical providers to provide children's car seats to those in need. Other times, we join forces to fit children with bicycle helmets, or to train instructors to offer Tai Chi to older adults for better balance.

These and other activities under our Local Public Health System Collaboration are key to Four Corners' work to improve community health. We are increasingly being joined in these efforts by medical systems who wish to impact population health. Through these common objectives, we are finding a shared voice and benefit from each other's efforts.

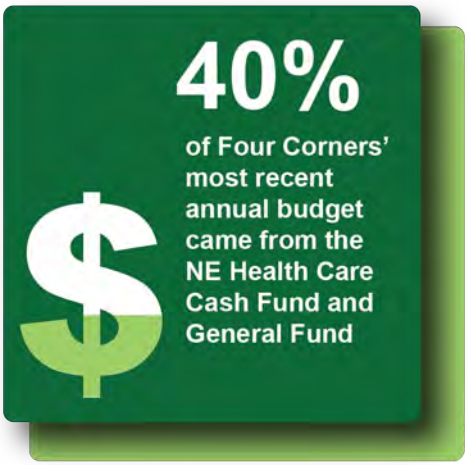
This report includes examples of efforts of Four Corners Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: Four Corners staff and a Public Health Dental Hygienist completed oral health screenings for 375 children and 84 older adults. When potential problems were identified, we connected patients to local dentists.

Policy Development: Four Corners offers local programs and trainings to decrease the stigma surrounding mental health issues, recognize behavioral health concerns and support survivors of suicide.

Assurance: Four Corners was key in a grassroots effort to form a York County Human Trafficking Task Force. York partners came together to understand and address the human trafficking problem in our area. Four Corners is assisting to mobilize and organize this dedicated team.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: Health assessments, culture audits and screenings for chronic diseases are performed as part of Four Corners' Worksite Wellness initiatives with local employers. We also offer these assessments and screenings at many community events.

Policy Development: Four Corners assisted worksites and community venues in developing and implementing policies to support healthy lifestyles. Examples of these policies include tobacco free areas, healthy foods in vending machines, walkable/bikeable communities, and support for breastfeeding—to name a few.

Assurance: Four Corners spearheaded the development of local Diabetes Referral Networks. A variety of groups offering services to people with diabetes came together to address the need to better connect diabetics to existing resources in the community and deal with gaps in needed services.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: Four Corners investigated over 150 reportable diseases and conditions last year and took action as needed to stop further threat to our communities.

Policy Development: Four Corners provided education and recommendations to schools and facilities when many students/staff were absent with influenza and norovirus, to prevent the further spread of those diseases. Four Corners partners with law enforcement and veterinarians to assure agency protocols align with Nebraska's rabies regulations.

Assurance: When notified of a communicable disease threat, Four Corners takes action to stop the spread of disease, whether that be through treatment by the medical provider, educating the patient to stay home, eliminating the source of illness, or other measures.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: Many homes in Four Corners' counties have high levels of radon gas which, when inhaled, is the second leading cause of lung cancer. Last year, we distributed 464 radon test kits. Over 70% of those tests revealed high radon levels in homes and other structures. We follow up with families in these cases to offer education and options for remediation.

Policy Development: Four Corners is part of a local collaboration of Federal, State and Local entities addressing groundwater contamination plumes under the city of York. Four Corners offers local perspectives and input on community education and zoning.

Assurance: Four Corners promotes the coordination of local emergency response plans. In partnership with other emergency, medical, and community sectors, we completed assessments, developed plans, and supported training activities.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: Four Corners conducted interviews in partnership with local prevention coalitions to assess community perceptions around youth, alcohol, and drugs. The information collected is used to determine environmental strategies that evidence suggests will reduce unhealthy behavior.

Policy Development: Four Corners assists worksites, schools, and families in developing policies around wearing seat belts, using child car seats, ATV safety, bike helmets, and not using alcohol or drugs or texting while driving.

Assurance: Trained leaders and Four Corners staff hold Stepping On classes. Stepping On is an evidence-based program that offers older adults ways to reduce falls through recognizing risks, incorporating home safety, strength and balance exercises, medication review, vision exams and safe footwear.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: When possible concerns are identified, local providers refer new mothers to our Public Health Nurse under our Healthy Baby program. Our nurse will visit the home and perform an assessment, checking for safety issues and linking the family to community resources.

Policy Development: We guided the formation of the Four Corners District Breastfeeding Coalition to promote education, resources and support for new moms.

Assurance: Four Corners shares lead testing information and regulations with medical providers. When young children's blood lead levels are high, Four Corners educates families and recommends further testing when needed.

Additional public health activities that Four Corners Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

The National Diabetes Prevention Program (NDPP) is a lifestyle change program to prevent or delay type-2 diabetes. NDPP participation can also lower the risk of a heart attack or stroke, improve overall health, and help people feel more energetic. Four Corners is pleased that three partnering Diabetes Prevention Program Sites have achieved National Recognition Status by the Centers for Disease Control and Prevention (CDC). This is a great accomplishment. These sites have demonstrated fidelity to the NDPP program for two years. Since 2014, Four Corners has facilitated NDPP technical assistance through on-site meetings, bi-monthly support calls, and CDC-required data submission. Congratulations to York Medical Clinic, Memorial Health Care Systems, and the Butler County Health Care Center NDPP groups for this recognition.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

Four Corners shares Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) data with the local community and partners to give these groups the chance to provide the "voice" of the community to our priority setting and decision making. The CHA tells us how residents and area partners are faring with their health, and how they view community health. We use this information to create our CHIP, where we and our partners collectively articulate our priority issues as we move forward with decisions about programs, activities and policies. Area hospitals rely on the CHA data and CHIP priorities when developing their Community Health Needs Assessment goals and plans.

PRIORITIES

Healthy Lifestyles

Behavioral and Mental Health/ Substance Abuse

Local Public Health System Collaboration

Motor Vehicle Crashes and Deaths

Lincoln-Lancaster County
Health Department

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Spotlight Success Story from 2018

On January 1, 2017, the Lincoln Municipal Code (LMC 8.14) for Child Care Programs was updated to require child care center staff to report potential communicable diseases and illnesses to the Lincoln-Lancaster County Health Department (LLCHD) within 24 hours. Communicable diseases, especially gastrointestinal diseases, spread rapidly in child care settings. Through NE Health Care Funding Act (HCFA), LLCHD has a Child Care Health Consultant. She works with child care centers throughout Lincoln and Lancaster County to review, develop and implement health and safety policies and procedures.

Disease outbreaks in child care settings in past years grew and spread across the community and were difficult to contain. The training and consultation provided by LLCHD engaged providers as partners. The combined efforts of consultant and providers proved effective in slowing the spread of disease.

The new ordinance will allow LLCHD to respond more quickly to a possible outbreak if providers understand and comply with the 24-hour disease reporting requirement. During this past year, the Child Care Health Consultant has developed and implemented training and materials to help child care providers meet the new reporting requirements. Child Care Health staff started a quality development planning process for the implementation of child care centers' illness reporting.

Through the Quality Development process, our goal is to develop a reporting system that assists in the prevention of the spread of communicable diseases into the community. In addition, we would like to demonstrate that the reporting is valuable and useful to the child care centers' business.

LLCHD staff used customer discovery interviews with 17 centers that have reported disease events, five that have not and more focused interviews with three staff from different centers. Using the information from the interviews to test initial assumptions that "child care centers have a problem knowing what to report related to illness/symptoms" and "child care centers do not understand that illness reporting (tracking) is connected to the spread of illnesses." This led to a focused problem statement: "Child care centers are not cohesively tracking, managing and reporting diarrhea and vomiting."

Based on the work to date, the Child Care Consultant is working with centers to test a quick and simple illness tracking process. Each participating child care center classroom tracked the incidents of diarrhea and vomiting of all the children in their care. Using the results of the trial and feedback from providers, we are currently building a tracking and reporting solution for our community.

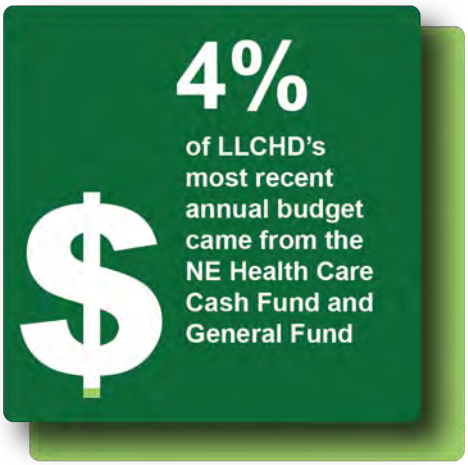
This report includes examples of efforts of Lincoln-Lancaster County Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect only the work *directly* supported by monies from the Nebraska Health Care Funding Act (HCFA). Other work, supported by other sources are not included here.

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

The Health Care Funding Act (HCFA) helps to fund screening of all school age children who have not seen a dentist in the past year. LLCHD staff work with the school and parents to assure that children with priority needs get an appointment with a dentist. Over time, the goal is to assure that children receive care at least annually. The program goal to reduce the percent of children who have not seen a dentist in the past year to 25% or less was met in FY 2018 (18%). This initiative helps to assure that serious oral health problems in children are identified and addressed.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

LLCHD works with multiple City departments and community partners to increase physical activity among adults and children especially in the areas of biking and walking. An indicator to assess physical activity is the percent of adults accomplishing 150 minutes of physical activity per week. A measure of success is the revision of the indicator from 50% to 60% of adults meeting the 150 minutes per week. Contributing to this success are Complete Streets policies, Bike Share programs, protected bike lanes, worksite wellness, walking/biking to school efforts, community coalitions, and media campaigns.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

The HCFA helps to fund LLCHD's epidemiologists who routinely assess communicable disease in the community through reportable diseases, sentinel medical office surveillance and school absentee surveillance. The epidemiologists also participate in the Epi Team which is initiated within 24 hours of a disease outbreak report. They investigate the outbreak, create survey questionnaires, interview affected individuals and analyze the responses to determine cause of the disease, pattern of spread of disease and identify steps to stop the outbreak. The Epi Team also includes staff from the Food Safety and/or Child Care Programs if the outbreak is tied to a child care facility or restaurant.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Staff funded by HCFA funds coordinate the Hazardous Materials Emergency Response to spills or exposure to the public from toxic chemicals. In addition, staff works with other environmental health staff to provide technical assistance to the public for safe disposal of hazardous waste through the Special Waste program for businesses and the Household Hazardous Waste program. Staff funded by HCFA funds help to staff the City's Complete Streets Committee. The Committee coordinates efforts to assure that public and private streets include some combination of infrastructure to accommodate all modes of transportation, including private vehicles, public transportation, walking and bicycling.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Staff funded by HCFA funds assist in the coordination and scheduling of more than 20 community car seat check events annually, with 500 plus seats checked in the past year and 303 of these seats provided at no cost to low-income families. Fifty certified car seat technicians volunteer to check seats and provide education to families. Car seat events are held at car dealerships, sponsoring agencies such as AAA, Lincoln Fire & Rescue Station #14, culture centers, and Bluestem Health, the Federally Qualified Health Center (FQHC).

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

The HCFA supports a LLCHD epidemiologist and a programmer who have created and linked reports that take information from the electronic medical record and create dashboards for the evidence-based home visitation program. This generates the data report sent monthly to the state. The dashboards provide home visitors with daily updates on caseloads and status of clients, track assessments and interventions by required time frames and monitor timeliness required to meet benchmarks. The dashboards also track the benchmarks and outcomes in near real time which helps supervisors and home visitors to reach their goals.

Additional public health activities that Lincoln-Lancaster County Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

The HCFA funds help to support LLCHD's information infrastructure. The department has a planned approach to the development, acquisition and deployment of technology that supports the department's mission and workforce. The November 2015 Information Management Strategic Plan was created with input about needs from across the department. It describes the goals, guiding principles, key elements and strategies LLCHD uses to build / acquire IT tools and solutions that support public health functions. Currently, LLCHD is engaged in the 2018 Strategic Planning process which includes as a primary goal: Leveraging Technology to Improve Public Health. The continuing investment in technology infrastructure has allowed LLCHD to work more efficiently, monitor and report effectiveness and support critical work by all department staff.

Over the past two years, LLCHD have:

- Replaced the system used to track licenses, patrolling, investigation and enforcement activities for Animal Control.
- Obtained and configured a service to make policies and procedures available for all staff, both in the office and remotely.
- Expanded capacity to provide on-line training and track staff participation. This reaches more staff at lower cost.
- Re-designed the internal website to provide easy access for all staff to a multitude of resources and tools. It includes a one-stop-shop for staff to access plans and reports, submit a problem to the help desk, find interpretation services, and monitor and track work processes using dashboards. This website reduces errors and time needed reporting for payroll. It also tracks quality improvement and links to policies and procedures and to city websites and directories.

LLCHD has several in-house applications that support day-to-day operations: Time Reporting System, Quality Improvement Electronic Tracking System, Performance Improvement System and dashboards designed for individual programs. These initiatives enable the department to be more accountable, more efficient, more transparent and more successful.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

LLCHD facilitates the process of the Lincoln-Lancaster County Community Health Assessment (CHA) with input from more than 140 community partners. These partners then assess the data and other factors to determine the priorities for the Community Health Improvement Plan (CHIP). The Lincoln-Lancaster County CHIP has four priority areas: Chronic Disease Prevention, Injury Prevention, Access to Care, and Behavioral Health. Partners select one or more priority areas of the CHIP in which they will continue to be involved. They play an active role in development, implementation, and evaluation of the measurable goals and objectives for each of the priorities. Each priority area is co-led by a community partner and a LLCHD representative with multiple partners taking responsibility for the implementation and on-going monitoring of the goals and objectives. Periodic reviews by the participants of each of the priority areas ensures that progress (or lack of) on the goals and objectives is assessed and documented. These reviews are also an opportunity to revise objectives if needed based on the progress made or the changing needs of the community. In addition to community partners utilizing the CHIP priorities and strategies within their own agencies to impact the public's health, the Community Health Endowment (CHE) uses the CHIP priorities to frame the primary funding priorities for CHE. Through CHE's grant process, more than $1.5 million is put back into the community annually to address the CHIP priorities. The on-going partner utilization of the CHIP priorities in coordination with LLCHD and the grant funding strategy of CHE ensure effective coordination of services in our service area.

PRIORITIES

Chronic Disease Prevention

Injury Prevention

Behavioral Health

Access to Care

Loup Basin
Public Health Department

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Spotlight Success Story from 2018

A successful partnership with a large agriculture production company in central Nebraska reaches a minority population with preventative health screening services. Loup Basin Public Health Department's (LBPHD) Well @ Work program connects employees at businesses and schools with preventative care through onsite health screening events. LBPHD is a rural health department serving a nine-county area with a population that is 98.3% Caucasian. Despite the relatively small overall numbers, LBPHD's minority populations, such as Hispanics, can experience disproportionate health needs such as limited access to care, language and transportation barriers and lack of insurance coverage. In an effort to reach out to this and other vulnerable populations living within our district, LBPHD partnered with one of our large agricultural businesses, Thomas Livestock. Thomas Livestock is a fourth-generation family farm located in Broken Bow, Nebraska. According to their online bio, they are a farrow-to-finish hog operation with 16,500 sows, finishing around 580,000 market hogs per year. The operation takes place on many properties located in central Nebraska. Thomas Livestock employs 231 workers, 85% of whom are Hispanic. Many of their workers are limited-English speaking in predominantly English-speaking communities. Thomas Livestock recognized they needed assistance to encourage and provide realistic access to vital health information for their employees. Thus, our partnership began.

LBPHD provided a two-day health screening event and reached 87 employees at the corporate office south of Broken Bow. An interpreter from Thomas Livestock facilitated communication to ensure a smooth and comfortable experience for all participants. Providing the screenings at their workplace, coupled with having a familiar interpreter, played a vital role in the success of the event. The employees received a general wellness screening including height, weight, body mass index, waist circumference, blood pressure, lipid panel and glucose. The lipid panel included total cholesterol, LDL, HDL and triglycerides levels. Each participant received a folder containing all their personal results and education on blood pressure, diabetes, weight and cholesterol.

Personalized recommendations were indicated and referrals to their primary medical providers were made. Of the 87 screened, 33% had a referral for further evaluation of results. LBPHD has worked with Thomas Livestock over the months following the screenings to ensure that employees understand recommended lifestyle modifications and action plans, such as doctor referrals.

Loup Basin staff strives to identify additional vulnerable populations within our service area to provide health information and education to decrease the impact of chronic illnesses. Forming strong partnerships with an area business that employs a large number of minorities has proven to be a successful way to break down barriers to health care such as language, access and health literacy.

This report includes examples of efforts of Loup Basin Public Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

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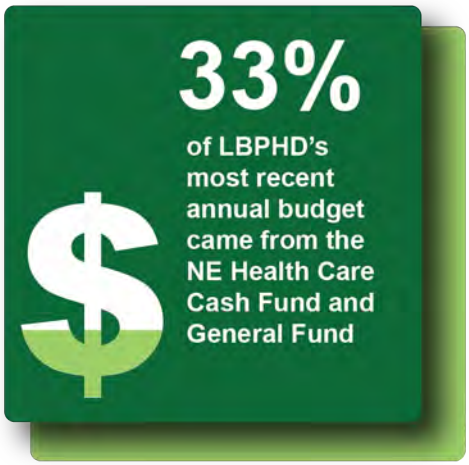


ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Loup Basin Smiles is an oral health prevention program that provides fluoride varnish at Head Start programs, preschools, and elementary schools in LBPHD's district. LBPHD uses public health certified dental hygienists to perform oral screenings and apply fluoride varnish treatments to children's teeth. Loup Basin Smiles reaches over 2,000 students during the school year.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

The Well @ Work program offers onsite health screenings to businesses and schools in the LBPHD service area. LBPHD collects important health screening data and provides personalized education to improve health outcomes through modifications in nutrition and physical activity. The goal of Well @ Work is to provide community members with important information about the status of their health and steps to improve it. LBPHD's Community Health Hub program is specifically increasing preventative cancer screenings with an emphasis on breast, cervical and colon cancers. This program also works towards decreasing hypertension, obesity and diabetes in adults. Through the chronic disease prevention programs, LBPHD is improving access to preventative screening services and enhancing community linkages through education and other resources in our service area.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Loup Basin Public Health Department (LBPHD) conducts surveillance, investigation, and follow-up of reportable communicable diseases as part of its core responsibilities as the local health department (LHD) in our nine-county jurisdiction. Nebraska utilizes an electronic reporting system called the National Electronic Disease Surveillance System (NEDSS), allowing LHDs to receive communicable disease reports from a variety of health care entities. LBPHD strives to reduce or eliminate cases of vaccine preventable diseases through our immunizations program. This program promotes and provides immunizations to adults and children. In addition to administering vaccines in the office, immunization services are offered every other month in Broken Bow, the county seat of Custer County. LBPHD staff members also work with school nurses across our jurisdiction to assure compliance with Nebraska Student Immunization Law.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Whether caused by natural, accidental, or intentional means, public health threats are always present and can lead to the onset of public health emergencies. Since 2001, the Loup Basin Public Health Department (LBPHD) has been protecting the community's health by collaborating with local, state, and national partners to prevent, respond to, and rapidly recover from these ever-changing public health threats. LBPHD works with multi-sector partners to annually update plans, participate in training, and maintain relationships and procedures—all while adhering to national standards. This assures the highest level of preparedness for Loup Basin's health district. Program components are executed by all staff members of LBPHD and spear-headed by our Emergency Response Coordinator.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

LPBHD staff provide community education by way of a variety of presentations and trainings. Audiences include local school staff and students, community groups, and clients receiving public health services at our office in Burwell. Topics range from environmental concerns, chronic disease prevention, healthy nutrition, physical activity, food safety, preventing and addressing infections, disease prevention, car seat safety, tobacco prevention and cessation, blood borne pathogens, first aid, and other general health topics. LBPHD has a public health nurse who is certified as a car seat technician and is available by appointment to instruct caregivers on installation, provide education, and inspect car seats.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

LBPHD protects the families in our health district by providing a wide array of services such as immunizations, health screenings, communicable disease investigations, and car seat safety education and checks. Currently, LBPHD does not provide any specific maternal or child and family health programs. These needs are met by NE DHHS or other resources in our area. LBPHD refers all candidates for these programs to these resources.

Additional public health activities that Loup Basin Public Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

Loup Basin offers influenza vaccinations at our Burwell office and the following outreach clinic locations: businesses, Red Cross blood drives, schools, senior centers and nursing homes. Loup Basin participates in the Vaccines for Children (VFC) and Adult Immunization Program (AIP). These programs are federally-funded and state-operated vaccine supply programs. Through the programs, ACIP (Advisory Committee on Immunization Practices) recommended vaccines can be given to eligible persons for a requested donation.

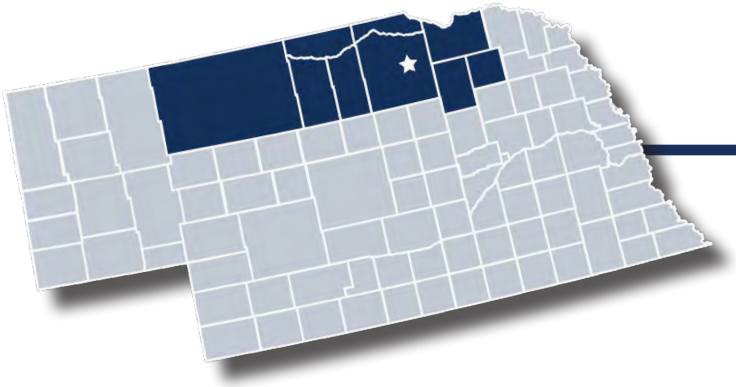
Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

PRIORITIES

Heart Disease

Pediatric Oral Health

Every three years, Loup Basin Public Health Department (LBPHD) convenes a community-informed public health assessment and facilitates development of a Community Health Improvement Plan (CHIP). People across our health district work collaboratively to review data, share concerns and strengths of our communities, and identify priority areas that we can work on together to improve the health status for the people living in the Loup Basin health district. LBPHD's three-year public health assessment and planning process is an important component of meeting the public health core functions and essential services. We use the nationally-recognized Mobilizing for Action through Planning and Partnership (MAPP) process to determine the CHIP priority areas. Thereafter, working groups convene to identify strategic issues and formulate goals and strategies for addressing each issue. The working groups consist of hospital staff, LBPHD employees, and health coalitions in the area that represent key members of the community.



North Central
District Health Department

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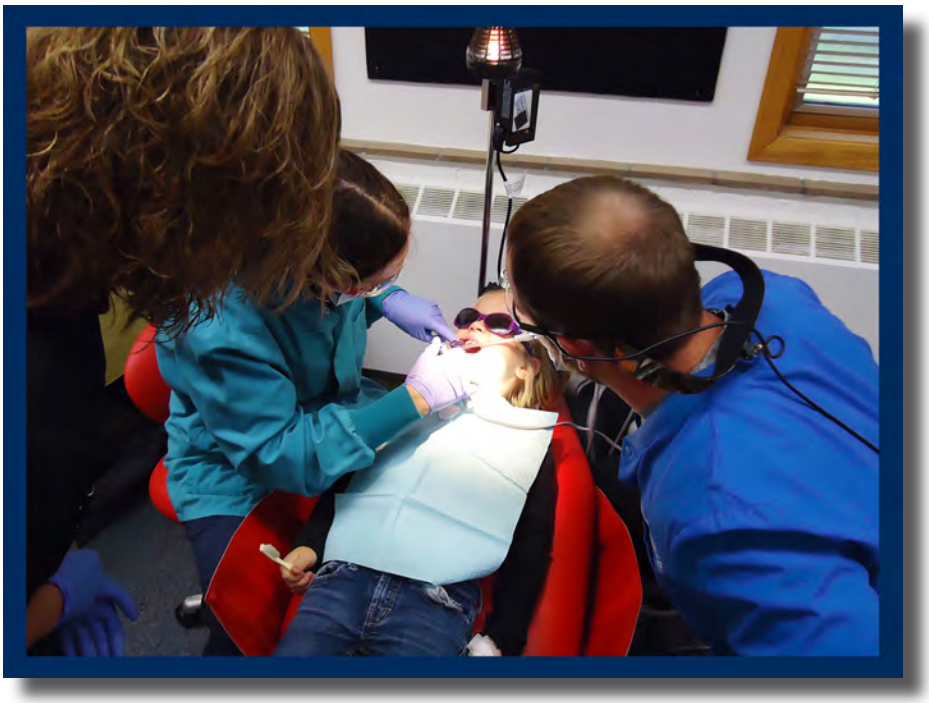
Spotlight Success Story from 2018



Miles of Smiles has helped many children with their dental care, but one story stands out. At one of NCDHD's rural schools, our dental hygienist was providing a screening for a young girl and found that the girl had decay in almost every tooth. A review of her previous screening record showed that she had decay present at the time of that screening, too. Nothing had been fixed, it had in fact gotten worse. After speaking with the school nurse and several school personnel who knew her family background, it became apparent that there were many barriers to her follow-up care with a dentist. Her single mother worked out of town for very little money. The children in the household were not on Medicaid. They lived 30 minutes from the closest dental office and 50 minutes from the closest dental office that offered a sliding fee. The mother worked long hours and would have had to take at least a half day off work to get the girl to the dentist. The Miles of Smiles program worked closely with the school nurse and the nearest federally qualified health center (FQHC) in Norfolk to get this girl the dental care she needed. After several dental visits, this girl had her teeth fixed and a smile on her face! The girl's teacher reports that she is a completely different child now, happy and talkative and engaged more during class time. This is just one of many Miles of Smiles success stories.

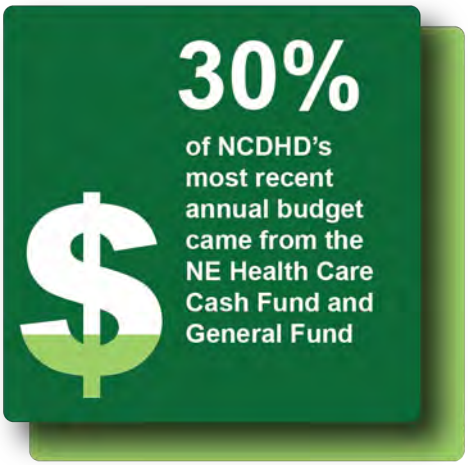
This report includes examples of efforts of North Central District Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: NCDHD collects statewide data as well as local data to assist our decision-making process for improvement of our school-based oral health program.

Assurance: NCDHD is improving our oral health program, with continued education at the school employee level and with the parents. NCDHD has secured some additional funds, in particular, a five-year partnership with the Nebraska Community Foundation.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: NCDHD collects chronic disease-related data in places of business. NCDHD gathers data as we enter our Community Health Assessment (CHA) process to guide our efforts developing our Community Health Improvement Plan (CHIP).

Policy: NCDHD is working to increase wellness screenings in local businesses to assist in the reduction of obesity and other chronic diseases. NCDHD also assists these businesses in establishing worksite wellness policies.

Assurance: NCDHD is coordinating more with community resources to increase appropriate worksite programs and to assist with increasing personal wellness. NCDHD is coordinating more with local clinics to increase our efficiency in screening for colorectal cancer—a deadly, but curable, cancer that Nebraskans disproportionately fail to be screened for.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: NCDHD collected oral health data to determine needs of our current school program. These data led to funding partnerships with the Nebraska Office of Oral Health and, later, with the Nebraska Community Foundation. NCDHD is working to increase the effectiveness of our immunizations program by tracking data more consistently and applying our limited resources where most needed.

Policy: NCDHD is working with local private businesses and community partners to develop Responsible Beverage Server Training guidelines in bars and restaurants. NCDHD assists businesses in establishing worksite wellness policies.

Assurance: NCDHD is coordinating more with community resources to increase appropriate vaccination rates. NCDHD is coordinating more with clinics to increase our efficiency in following up on incidence of communicable disease in our area.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: NCDHD analyzes data for emergency preparedness efforts.

Assurance: NCDHD provides radon test kits for the public, participates in lead education and provides education for emergency preparedness efforts.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment, Policy, and Assurance: NCDHD is working with schools by providing programs to prevent distracted driving. We are also working with businesses to provide Responsible Beverage Server Training and assisting our schools in developing a positive peer relations and social responsibility program through John Underwood's "Pure Performance" Program. All these activities include the work of policy development and assurance as NCDHD progresses.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

NCDHD is not directly involved in Maternal, Child and Family health programming.

Additional public health activities that North Central District Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

NCDHD is focusing on working more in wellness screenings and care coordination to reduce the incidence and impact of chronic disease. NCDHD has a robust immunization program for children and adults.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

North Central District Health Department (NCDHD) uses the nationally-recognized Mobilizing for Action through Planning and Partnership (MAPP) process as part of our Community Health Assessment (CHA) and subsequent development of our Community Health Improvement Plan (CHIP). NCDHD works with the hospitals and other community partners in our nine-county jurisdiction to complete the CHA. NCDHD plans to work with the Nebraska Association of Local Health Directors (NALHD) and the UNMC College of Public Health to complete data collection and reports, community focus groups, and reporting back to community partners. This work will lead to the development of our next, regional CHIP. These plans serve as a resource for many community partners, including our hospitals who incorporate it into their own plans to meet their statutory/community needs.

PRIORITIES

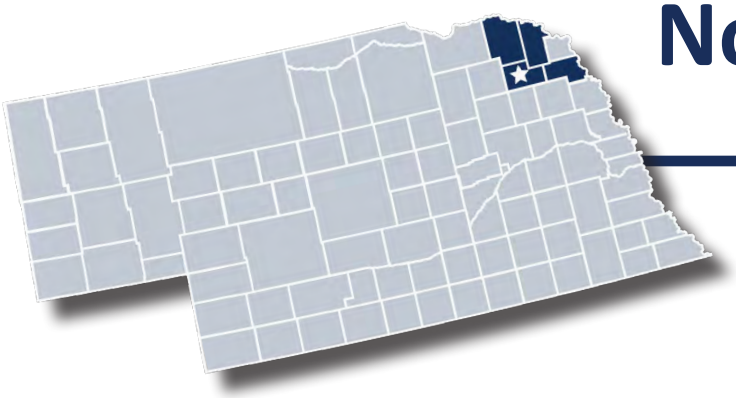
Chronic Disease and Obesity

Aging

Wellness

For more information about *North Central District Health Department* please visit:
www.ncdhd.ne.gov

NCDHD North Central District Health Department



Northeast Nebraska
Public Health Department

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Spotlight Success Story from 2018

Northeast Nebraska Public Health Department (NNPHD) has provided its fair share of disaster responses over the past decade, from H1N1 flu and tuberculosis (TB) outbreaks, to tornadoes and avian flu; that could be why NNPHD and partners see the importance of continual improvement of response plans and methods. This past year, NNPHD response personnel participated in nine mock disasters along with response partners to keep preparedness planning moving forward.

This past spring NNPHD personnel prepared and facilitated three exercises to test our preparedness in Incident Command Training and Mass Medication Distribution. All local health departments in Nebraska are charged with providing a coordinated response to bioterrorism and/or disease outbreak disasters. Local health departments like NNPHD work with many response partners including emergency management, law enforcement, fire and rescue and hospitals. All these agencies have trained using the National Incident Management System which streamlines disaster response. NNPHD conducted an exercise with all 11 of our Board of Health (BOH) members in May 2018. BOH members were presented with a scenario of a large tornado destroying the county courthouse. Within the mock disaster response, the NNPHD was requested to complete mass dispensing operations and open clinics to administer tetanus vaccine to responders, survivors and volunteers. BOH members were questioned and trained about what role they would serve in the NNPHD emergency response plan. An evaluation was conducted at the close of the exercise to determine the strengths and challenges of the plan; this will help to continue to improve our response plans. The evaluations showed a 26% increase in disaster response knowledge related to the emergency response plan after completion of the exercise.

NNPHD also facilitated two additional exercises in May 2018. These exercises were designed to test the ability of hospitals, clinics, nursing homes, assisted living centers, hospice and businesses within the health district to respond to a mass medication dispensing event.

Should an infectious disease outbreak occur, and medication is necessary to prohibit the spread of the disease, the federal and state government along with local health departments like NNPHD will provide the necessary medication and distribute it to partners and residents. NNPHD has identified 28 facilities in our four-county district which will be able to provide these medications directly to their employees and residents at the job site. NNPHD sent 28 invitations to the exercises and a total of 34 attended. This response indicates a high level of engagement from other response partners in our jurisdiction. Strengths and challenges were identified after the exercise and we are currently working to further improve our emergency plans.

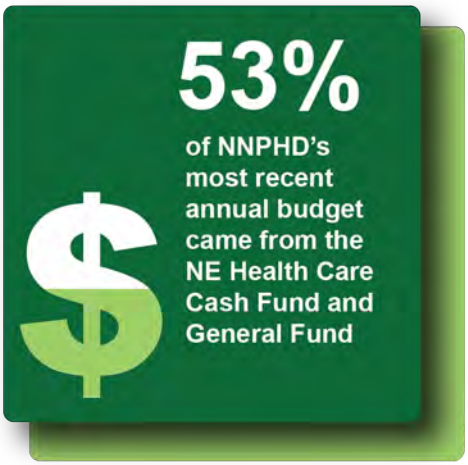
This report includes examples of efforts of Northeast Nebraska Public Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

NNPHD staff participate in several access-to-care activities in the district all supported at some level by the Health Care Funding Act (HCFA). NNPHD participates on the Northeast Nebraska Behavioral Health Network working to address the behavioral health provider shortage in our area. Staff also participate in the Wayne County Family Coalition and coordinate its Community Response services which have provided linkages and support to 51 families between January and June 2018. The NNPHD Oral Health Program, Creating New Smiles, provided fluoride varnish and/or oral health screenings to 180 children at six partner sites from January to June 2018; 30% of the children were referred or connected to a dentist for identified problems.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

NNPHD provided 283 health screenings to 262 people. Through two small chronic disease grants in addition to support from HCFA funding, 36 people were provided with health classes to help them set personal goals and make lifestyle changes that fit into their daily lives. One success story is shared on our website (www.nnphd.org): Sandra, with the support of an NNPHD Community Health Worker (CHW) Health Coach, went from a size XL to an M. Most importantly, Sandra told NNPHD that this experience gave her the power to change her life and she will pass what she has learned about healthy living onto her children.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

In fiscal year 2017-18, NNPHD received 494 lab reports of infectious and other reportable diseases for people in the four-county health district. A local hospital identified a cluster of E. coli cases and notified NNPHD. NNPHD and DHHS identified the source, and policies were put in place with the organizer of the public function to prevent future disease. NNPHD receives requests from clinics and hospitals for the most up-to-date scientific evidence for disease control. Through this collaboration between NNPHD, DHHS and the medical community, we are building safer and healthier communities in our area. NNPHD is also currently building a district-wide EPI (Epidemiology) infectious disease collaborative.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

NNPHD works together with partners to address environmental health issues, specifically unhealthy housing. NNPHD receives a small DHHS subaward to address radon and lead issues, supplemented by HCFA. NNPHD distributed 147 radon test kits, 112 were submitted for testing (75% test rate). Seventy-two of the 112 tests (64%) returned with elevated results. NNPHD provided education with each test kit about mitigation and connection to area contractors certified in mitigation. NNPHD distributes a “mold packet.” This resource includes information when a person should remediate mold in their household. It also includes Nebraska’s Landlord and Tenant Handbook. NNPHD participates on a special healthy housing committee of the Wayne County Family Coalition.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Although NNPHD did not have supplemental funding for these activities in this fiscal year; Occupational injuries, senior fall prevention, substance abuse, and binge drinking were not ignored thanks to HCFA dollars. NNPHD has developed and distributes a “Stay On Your Feet” falls prevention toolkit for seniors. NNPHD has taken an active role in the Thurston County Partnership for Success Collaborative, funded through Region 4 Behavioral Health, to promote substance use prevention and healthy living for teens. The collaborative is planning to support 13 people to receive training for the Human Performance Project, an evidence-based approach to healthy lifestyle choices for teens. Plans are under way to roll out this work across Thurston County.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

NNPHD works with the area Community Action Agency to provide interpreters at their WIC and immunization clinics and for their home visitation program. NNPHD staff participate on the Head Start Health Advisory Committee, the Healthy Families America Advisory Committee and the area Title X Information and Education Committee. The Health Director was an appointed member of the Nebraska Early Childhood Interagency Coordinating Council serving as Vice-Chairperson at the end of her term which ended in 2018.

Additional public health activities that Northeast Nebraska Public Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

NNPHD provides a variety of assessment, policy development and assurance functions to the public health system of Northeast Nebraska. To do this, it is imperative that NNPHD be an active partner in the community. In addition to those partnerships and activities already mentioned, NNPHD is also involved in: presenting to classes at Wayne State College (WSC), UNMC College of Nursing in Norfolk, and various community groups such as Rotary, hosting the UNMC College of Public Health summer public health immersion students, partnering with WSC for World Heart Day events, PET (Planning, Exercise and Training) Region meetings and the area COAD (Community Organizations Active in a Disaster), partnering with both local Native American Tribes and the two acute care hospitals on Emergency Preparedness, Infectious Disease Surveillance and Investigation.

The HCFA funding provides both foundational and matching support to NNPHD's six full-time and seven (very) part-time staff to coordinate 12 programs and a variety of services that are offered through additional funding sources. In addition to those services already mentioned, NNPHD offers a program for Veterans and their families, coordinating with county Veterans Service Officers (VSO) to connect Veterans and families to needed services. Thank-you cards are written as part of community meetings/events. These are given to the VSOs for distribution to Veterans, thanking them for their service to our country. The NNPHD Blue Ribbon Outreach project works to reach the agricultural community to provide them with evidence-based health and safety resources as well as asking for their input about health and safety in their communities. UNMC College of Nursing in Norfolk is partnering with NNPHD to conduct a men's rural health research project that focuses on weight loss and is funded by the National Institute of Health. NNPHD also partnered this last year with Lions Club to provide vision screenings to students at Wayne schools. The HCFA funding provides foundational support from which NNPHD has been able to launch an impressive array of needed services that rely on additional, though often less-sustainable, funding.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

PRIORITIES

Access to Care

Maternal and Child Health

Prevention (Chronic Disease & Infectious Disease)

Aging Adults

Developing the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP) has been attempted in the past but is extremely challenging due to funding limitations. While Northeast Nebraska Public Health Department (NNPHD) continually assesses health in the four-county health district through the ongoing collection of data, it does not have a staff person who can dedicate his or her time to compiling a CHA or developing a subsequent CHIP.

Funding received from the Nebraska Health Care Funding Act (HCFA) is used to support organizational functions and offset the expenses of several grants and contracts that do not come fully funded; these activities are basic public health services that are needed in the health district and would not be provided without the funding from the HCFA. Although NNPHD contributes to partners' data collection processes, there has not been a district-wide collaborative attempt at the CHA and CHIP since 2012. That 2012 process could not maintain momentum due to the inability to have dedicated staff to continue the process. NNPHD was recently awarded a HRSA, Rural Health Network Development grant, which will provide the monetary support to build local momentum for development of a CHA and CHIP along with several partners in the district during Fiscal Year 2018-19.

Both acute-care hospitals in the district are partners in the HRSA process. One of the two Tribal Health Departments and the regional Community Action Agency have also committed their participation. Six schools have signed memorandums of agreement to participate. The goal is that this grant will set the stage for developing a network process for complementary CHIPs for all partners to maximize efforts and resources both now and in the future. Successful completion of this HRSA process will position NNPHD and partners for future collaborative efforts.

Panhandle
Public Health District

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Spotlight Success Story from 2018

The mom pushing the double stroller with a youngster riding alongside a busy street; the elderly man walking to the post office in the street due to trash cans impeding the sidewalk; the lady commuting to work on her bike as a means of necessity; the middle-aged woman in an electric wheelchair shopping in the downtown stores; or the visually impaired high school student crossing one of the busiest community intersections; are all real-life examples of walkability challenges the Tri-City Active Living Advisory Committee (ALAC) in Scottsbluff, Gering and Terrytown has heard. A resolution adopted by all three city councils, and spearheaded by Panhandle Public Health District (PPHD), created Tri-City ALAC. The group provides a monthly forum for community collaboration and input to Public Works, Parks and Recreation Departments, Law Enforcement, other staff, and elected officials about "active living" community development and design principles. This diverse group brainstormed built environment strategies to make streets safer and more conducive for all users to actively get around their community.

Recent walk audits provided input to assist the Scottsbluff Public Works Department to refine the newly installed Accessible Pedestrian Signals. Disability Rights Nebraska and the Nebraska Commission for the Blind and Visually Impaired—both active members of the coalition—coordinated a committee of residents to perform the walk audits.

These audits are part of the Tri-City's efforts to improve sidewalks and intersections, calm traffic, and expand the network of bike routes and walking trails. The ALAC is a resource and liaison among all groups seeking to provide input and have representation. Their goals include:

- Safe Active Transportation on All Travel Ways
- Creating Collaborative Community Ownership
- Complete Streets: Planning for a Safer, More Connected, Healthier Community

The Tri-City ALAC serves as a model for sustainability in communities looking to implement strategies from the Surgeon General's Call to Action to Promote Walking & Walkable Communities.

This report includes examples of efforts of Panhandle Public Health District to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

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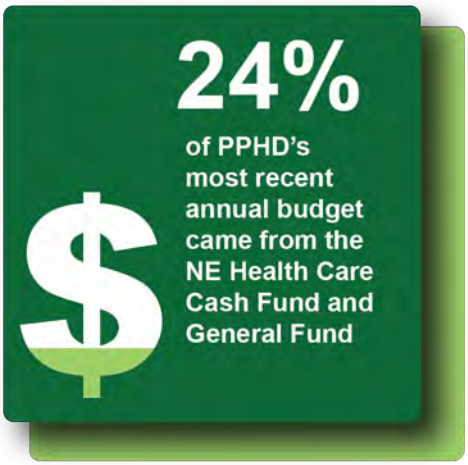


ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: PPHD's school-based Dental Health Program provides a dental screening by our Public Health Dental Hygienist to determine the student's current dental status. We also assess if the child has dental insurance, how often the child goes to the dentist, and if the child has a dental home.

Policy Development: We educate parents through informational and referral letters. Our education for school staff, parents and children promotes prevention of oral disease.

Assurance: We develop and coordinate our dental health program with local dental providers, school nurses and school administration.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: PPHD's Panhandle Worksite Wellness Council provides an annual assessment to member companies to monitor overall progress on organizational policies, systems, and environmental supports for health. An individualized scorecard is created for the member company and reviewed with their wellness committee to encourage further adoption of low-cost, high-impact strategies, including policies.

Policy Development: Examples of policies that businesses have adopted include: tobacco free campus to include e-cigarettes and vaping; breastfeeding policies to include room designation; and healthy vending standards. PPHD provides education to supervisors, management and employees on the importance of a supportive worksite environment.

Assurance: Worksite Wellness is a key strategy in the Panhandle Community Health Improvement Plan (CHIP).

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: Increased mosquito pools were identified in the Bayard area in the late summer and early fall following a June tornado that impacted the town. An increase in West Nile Virus (WNV) was identified by PPHD through reporting systems with infectious disease nurses at local hospitals and clinics.

Policy Development: Media releases went out on WNV prevention and mosquito bite prevention. Bayard schools were key partners in the distribution of educational materials to the public.

Assurance: PPHD worked to assist the city of Bayard to increase spraying efforts with targeted community events planned in the evenings. Dunks and repellent were provided by PPHD.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: Hazard vulnerability assessments have identified gaps to rapidly alert and notify employees, responders and citizens in the event of a public health emergency .

Policy Development: Public health, emergency management, and hospitals began implementing procedures and implemented the mass notification system, Panhandle Alert. Five of the eight hospitals are using Panhandle Alert to notify their staff and rapidly communicate information.

Assurance: Panhandle Alert is in two of three area Emergency Management Regions. All partners are registering the public with this emergency notification system. The system also helps identify at-risk populations with unique health care needs. This information will help public health and emergency managers to respond effectively in an emergency.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: PPHD's opioid response assessment included access to drug take-back, use of the prescription drug monitoring program, and naloxone availability for first responders.

Policy Development: We partnered with sheriffs, police chiefs, EMS captains, pharmacists, and clinicians to review their current policies and adopt new policies for prescribing, drug take-back and carrying naloxone.

Assurance: We used a multi-tiered approach working with partners to set up systems and policies. Sustainable outcomes we are aiming for include: 1) every day is drug take-back day at local law agencies and most pharmacies and 2) processes are developed and adopted for EMS and law enforcement to carry and use naloxone.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: PPHD's Healthy Families program assesses families with infants and small children for program eligibility, safe sleep, hazards in the home, depression, intimate partner violence, and substance abuse. Home visitors also administer developmental assessments until children are 36 months of age.

Policy Development: Healthy Families enrolls families prenatally, or within three months of birth. Enrolled families are educated on prenatal and early childhood development through our home visitation curricula, Growing Great Kids and Circle of Security. PPHD's policies mirror the 12 Best Practice standards of the Healthy Families model.

Assurance: Our program collaborates with the Panhandle Partnership's 0-8 System of Care, including Sixpence, Early Development Network and Early Head Start.

Additional public health activities that Panhandle Public Health District performs to assure that the health and wellbeing of Nebraskans are protected and improved.

PPHD seeks to prevent diabetes and hypertension through evidence-based interventions like National Diabetes Prevention Program (NDPP), health coaching, and partnership with retail pharmacists. A primary goal of this work is to enhance the bi-directional referral of patients with prediabetes and hypertension to and from interventions and health systems. We have worked with area hospitals, certified rural health clinics, and independent clinics to create sustainable workflows for referral to NDPP and health coaching through adoption of referral processes and policies. We have developed two comprehensive guidance documents: Healthy Living Supports Guidance Document and Hypertension Management Toolkit for Health Care Provides, which include sample policies, procedures, fax referral forms, assessments, and more for providers to use as they are ready to implement policies and processes.

When looking to health care extenders for support, we find pharmacists are crucial partners. We work with retail pharmacists to set up processes to: refer hypertensive patients for health coaching, educate them on how to take blood pressure correctly with home blood pressure monitor, refer to their provider as needed for abnormal blood pressures, and provide other patient education and wallet blood pressure cards. Retail pharmacists also refer patients to NDPP as needed.

We have strengthened referral back to providers in each of these programs. Providers receive feedback on patients at specific moments throughout each intervention. This allows providers to touch base with patients to encourage or congratulate as needed. We have been able to enhance the bi-directional feedback process by leveraging our regional and hospital-level Community Health Improvement Plans (CHIPs) and the already established NDPP network in the Panhandle. Our robust network of partners with consistent policies and processes ensures a sustainable approach to providing the patient with the best resources available to reduce chronic disease.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

The Panhandle Public Health District (PPHD) completes a Community Health Assessment (CHA) every three years using Mobilizing for Action through Planning and Partnerships (MAPP). This collaborative process is completed through partnership between public health, eight area hospitals, economic development, Panhandle Partnership, and community organizations. This assessment was most recently completed in 2017, leading to the 2018-2020 Panhandle Community Health Improvement Plan (CHIP). Additionally, PPHD provides technical assistance to each of the eight area hospitals to use CHA findings to determine priority areas and develop a community health improvement plan for each hospital service area. The final priorities for the Panhandle at a regional level were Access to Care, Behavioral Health, Aging Population, Chronic Disease, Early Childhood Care & Education, and the Social Determinants of Health. The hospitals' priorities align with these.

PRIORITIES

Access to Care

Aging Population

Behavioral Health

Chronic Disease

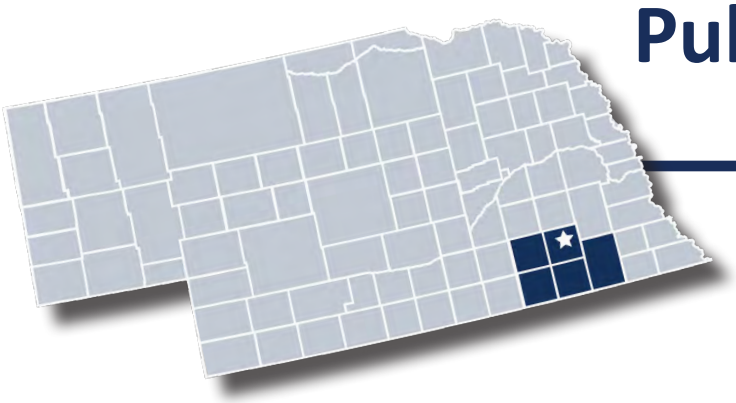
Early Childhood Care and Education

Social Determinants of Health

In order to drive this work, groups around each priority area were formed or existing work groups through the Panhandle Partnership were identified to promote progress of the plan. Work groups meet at least once per quarter to discuss progress and connect with partners. Lead partners submit data every six months, which is monitored through the Clear Impact performance management system. The MAPP Steering Committee—comprised of representatives from each regional hospital and various community organizations—also meets quarterly to further progress toward meeting CHIP goals at the regional and local level and find opportunities for partnership and collaboration. These work groups assist with coordination of various services in the Panhandle to assure we are working together to effectively serve the community. Each meeting provides an avenue for dialogue and discussion about services available in the community, upcoming opportunities, and how to better work together to meet the needs of the community.

For more information about *Panhandle Public Health District* please visit:
www.pphd.org

Panhandle
Public Health District



Public Health Solutions

District Health Department

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Spotlight Success Story from 2018

Physical activity has an important role in a community's health. Physical activity improves cardio-respiratory health, contributes to metabolic, musculoskeletal, and mental health, and reduces the risk of developing colon and breast cancer. Thayer County has high rates of physical inactivity (29%) compared to Nebraska's state average of 23% (County Health Rankings, 2018). To increase physical activity, Public Health Solutions (PHS), in partnership with Nebraska Department of Health and Human Services (DHHS) and S&G Endeavors, developed and implemented our local Nebraska Walkable Communities Initiative (WalkNE), which focused on helping communities create a locally-driven action plan with strategies focused on increasing walking, biking, and overall health. The Thayer County Walking Coalition (TCWC) was formed through implementation of the Nebraska Walkable Communities process. Once formed, the coalition immediately began implementing new concrete trails connecting strategic community locations and promoting use of the trails to the Hebron community. The group worked with PHS and a graphic designer to create a variety of trail maps showing existing trails, locations of future trail segments, and other information. Other promotional materials included magnets, brochures, and large poster boards. Maps and promotional materials were presented at local wellness and fundraising events and distributed throughout the community to increase awareness of the new trails in Hebron. A partnership was formed with the Hebron Chamber of Commerce to add the city's main trail access point as a destination point on directional signage placed throughout the community. This partnership also allowed for leveraging of funds to create and place two large wayfinding stations in the community's two major tourist and resident destinations, an RV and camp site and the city park where the World's Largest Covered Porch Swing is located. Through the efforts of the TCWC and implementation of its strategic plan, these activities have helped to inform residents and tourists that key community locations and attractions can now be accessed using the new trail system.

Completion of all five phases of the updated trails master plan created through the Walkable Community process has impacted the Hebron community in many ways. Trail users have included a mix of men and women of various ages. On July 4th, 2018, two sections of the new trail system were included on the route for the Freedom Fun Run, a new running event sponsored by the local hospital system. The 52 participants in the event walked and ran one-mile and three-mile courses. Additionally, well over 30 community residents participated on race day as volunteers to support the event. One community member stated, "The new trail is just good for the soul, body, and mind. I'm in better shape now than I have been in my whole life and I will be 60 years old next month!" PHS is proud to be part of vibrant, innovative community partnerships such as this. By working collaboratively with partner organizations and community leaders, a walking trail was built that will serve the community and impact health for years to come.

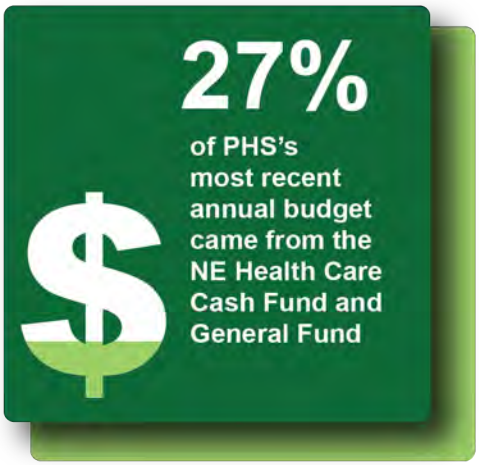
This report includes examples of efforts of Public Health Solutions District Health Department **to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).**

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/ mental health.

Assessment: Provide relevant data to the community regarding rates of poverty, uninsured individuals, social determinants of health, and barriers to accessing care.

Policy Development: Partnered with local health care providers and pharmacists to facilitate standardization of chronic disease care protocols such as self-monitored blood pressure (SMBP), leading to an increased likelihood of disease management by the patient.

Assurance: Provided technical assistance to local health care clinics to align electronic health records with the ability to more easily refer patients to needed services such as diabetes prevention and smoking cessation classes that are offered in their community.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: Continuously monitor data to determine disease prevalence in the district. This data is used for strategic planning, program development, and community health improvement planning. Provided community-based screening events to identify individuals with potentially undiagnosed hypertension and/or diabetes, referred individuals to providers or assisted with access to a provider.

Policy Development: Provided facilitator training for 18 volunteers and professionals in local community organizations to offer an evidence-based program (National Diabetes Prevention Program) in communities across the five-county district.

Assurance: Provide ongoing training and support in evidence-based practices to community partners in the areas of chronic disease prevention and control.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: Provide surveillance across the five-county district to detect potential outbreaks of infectious disease. Research and respond to rates of individuals fully immunized against vaccine preventable diseases.

Policy Development: Provide education and support to long term care facilities and schools in prevention of disease outbreaks and best practices in responding to outbreaks.

Assurance: Work with local health care providers and clinicians in planning for and mitigating disease outbreaks using evidence-based best practices.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: Providing radon testing kits to residents in the district and follow-up regarding testing results.

Policy Development: Partnering with local government to set standard procedures for resident complaints of insect infestations in rental properties.

Assurance: Working with local community government to develop regulations and access to resources that promote radon awareness and mitigation in childcare facilities.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: Facilitate and/or participate in local prevention coalitions in each county that track youth behaviors and lifestyle.

Policy Development: Facilitate multi-county Safe Kids Coalition, which offers programs such as car seat check-up events and bike safety rodeos. Partnered with a local elementary school to provide after-school children's educational activities on poison prevention and medication safety in the home.

Assurance: Partner with Nebraska State Patrol and local law enforcement agencies to provide activities/programs highlighting enforcement of safety laws. Provided training to community volunteers so that they can teach tai chi and other fall prevention programs to elders in the district.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: Provide screening and assessments to determine families at risk for child maltreatment or other adverse childhood experiences (ACEs) as part of an early childhood home visitation program.

Policy Development: Provide ongoing training and support to childcare providers on how to use the Pyramid Model for supporting social emotional competence in infants and young children. This tool provides a structure for providers to implement within their childcare program.

Assurance: Developed a collaborative partnership that now provides Parent-Child Interaction Therapy in a school-based setting. Achieved national accreditation for the Healthy Families Gage and Jefferson County home visitation program.

Additional public health activities that Public Health Solutions District Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

Public Health Solutions (PHS) engaged in several other notable activities this past year. PHS acquired our regions Area Health Education Center (AHEC). The AHEC covers a 17-county region of southeast Nebraska that includes the PHS counties. Consistent with our public health mission and many of our activities, the AHEC is charged with creating partnerships to provide training and education opportunities to students and health professionals, in an effort to strengthen the rural health care workforce. Our VetSet program focuses on providing support and resources to veterans and their families while working with systems in our state to improve the health and wellbeing of veterans and families. The SkipFlu program provided flu immunizations to over 3,000 children in local schools. This is part of our on-going effort to protect the entire population against communicable diseases. The Healthy Community Alliance clinic is a local partnership to serve patients with chronic disease conditions. A local physician volunteers time to the Partnership while PHS provides nursing support and a clinic space. Local providers such as pharmacists, laboratories, and eye care professionals provide care at a reduced rate to clinic patients. PHS also offers an on-site dental clinic that provides basic screening and prevention services from a dental hygienist. Emergency preparedness efforts include planning, training, and collaboration between health care organizations, the local health department, first responders, law enforcement, and other agencies to ensure that our communities are prepared for disasters.

Highlights from our community development work include facilitating community coalitions that are building walking trails, promoting policies that support healthy changes to vending and cafeteria choices in schools and businesses, supporting businesses in wellness activities, and providing healthy food demonstrations and support to local grocery retailers. PHS continues to support local farmers' markets and their coordinators so that fresh, locally-grown produce is available to area residents of all income levels. Our immunization program has seen progress in increasing the number of area children who are fully-immunized according to CDC guidelines. This year, we focused efforts on increasing rates of HPV (human papillomavirus) immunization as well. The PHS surveillance team monitors data from area schools and hospitals as well as the NEDSS (National Electronic Disease Surveillance System) to investigate food-borne illness reports and communicable diseases. This surveillance provides the best early-warning system for disease outbreak. Behavioral health continues to be a priority area for the PHS jurisdiction because rural communities struggle with limited access to mental health providers. PHS staff provided QPR (Question, Persuade, and Refer) training in communities across the district this past year. QPR is a tool that can be used by anyone when responding to someone in crisis and at risk for suicide. Our organization has QPR facilitators that provide the training in both English and Spanish.

PHS is focused on moving our work "upstream" to the level of policy and systems change. To this end, we are working with local community and organizational leaders to invest our resources in high-level change that will provide lasting improvements in the communities where we live, work, play, and learn. We are tremendously proud of the partnerships being formed and the work being accomplished in our public health district.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

PHS is currently completing a new Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The development of these plans brings partners to the table from all sectors of the community. Advocates and leaders from education, health care, law enforcement, community action, social service organizations, aging services, the faith community, city and county government, and more are all working toward one goal: To identify gaps in resources and assist communities in leveraging their resources most effectively. It is important that the entire community come together to plan for improvement. The PHS Board of Health uses the priority areas identified by the CHA process to strategically plan how PHS will allocate resources and focus staff effort. For example, if chronic disease prevention is a top priority for communities in the district, PHS will prioritize opportunities to facilitate collaboration between partners and community leaders to address this issue and allocate a larger amount of staff resources to this end. The practice of public health is based in evidence and data. By facilitating a CHA and the resulting Community Health Improvement Plan (CHIP) for our jurisdiction every five years, we can monitor areas of improvement or decline, work with communities to identify gaps in resources, and create innovative partnerships that will benefit whole community health and wellness. Understanding the evolution of our communities and their priority needs allows us to plan and implement our work most effectively and with greater impact.

PRIORITIES

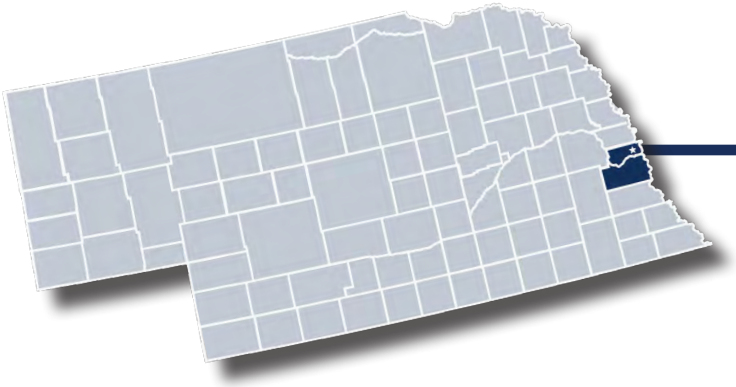
Prevention of Chronic Disease and Crises

Behavioral Health

Accessibility/ Availability of Health Services

Economic Impacts on Health (including population decline)

For more information about *Public Health Solutions District Health Department* please visit: www.phsneb.org



Sarpy/Cass
Health Department

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Spotlight Success Story from 2018

Tuberculosis or TB is a contagious infection that typically attacks the lungs. The disease investigation, management and coordination of treatment that is done by the local health department is a vital component to keeping the community safe. In most recent years the Sarpy/Cass Health Department (SCHD) would typically provide case management to one TB patient per year. However, fiscal year 2018 (July 1, 2017 – June 30, 2018) proved to be uncharacteristic with SCHD's public health nurses coordinating the treatment of seven TB cases. This success story details the importance of organization, collaboration and trust across multiple sectors and of public health, health care and the community that ensured the successful treatment of SCHD's TB patients.

When SCHD is notified of a confirmed TB case, public health nurses immediately put in place the standard protocol of isolation, sputum collection and contact investigation. Typically, the patient is also placed on a four-drug regimen prescribed by their provider. From the local health department's perspective, support and management of a positive TB case can last anywhere from six (typical case) to 30 months (multi-drug resistant case). During this time the health department is providing TB control by overseeing prophylaxis, treatment, surveillance, and contact tracking. In FY18 the SCHD worked in partnership with not only DHHS and the Nebraska Public Health Lab, but also numerous infectious disease doctors, the Center for Disease Control and Prevention (CDC) lab, National Jewish Center Laboratory, Heartland National TB Center, US Food and Drug Administration (FDA) and the Institutional Review Board at the Nebraska Medical Center for the management and care of the SCHD's seven TB patients. The diverse and robust care team of experts through research, sharing of findings and collaboration determined and ensured the safest treatment possible for each patient. In order for this level of collaboration to occur seamlessly, transparency and solid communication is paramount with each partner being clear on their roles, expectations, goals and clinical findings.

Establishing a trusting relationship with TB patients is vital to ensuring compliance and mitigating risk of transmission to the community at large. Ultimately, that responsibility fell on SCHD and was achieved during Directly Observed Therapy (DOT). During this fiscal year, 100 DOT appointments were completed either in person or virtually by SCHD's public health nurses. DOT visits do more than just ensure that the prescribed medication is being taken. It allows the public health nurse to monitor the patient for medication side effects, track mental health and well-being, answer questions regarding the patients care plan and build rapport and trust with the patient's support system.

The management of TB cases can be likened to a rippling effect. The single individual with a positive diagnosis is the first pebble in the water. Without the actions of the care team engaged throughout the patient's spheres of influences and into the greater community at large, the impact of that first ripple and the number of community members exposed to/impacted by TB can expand quickly. SCHD's collaboration and coordination of care ensures positive health outcomes for the initial patient and overall protection of the public's health.

This report includes examples of efforts of Sarpy/Cass Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

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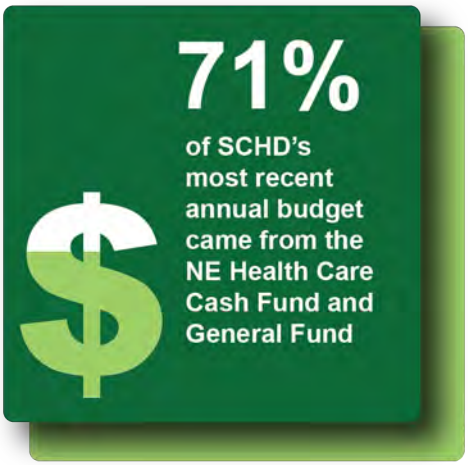
Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: The 2015 community health assessment (CHA) identified transportation as a barrier for Cass County residents to receive medical care. This issue was addressed through a partnership with Susan G. Komen which supports transportation to mammogram appointments for women aged 45 to 72.

Policy Development: Through a Collaborative Impact Project, staff educated and empowered Cass County medical providers to identify and connect women who had never been screened or were past due to breast and/or cervical cancer screenings.

Assurance: Staff provided one-on-one health education, mammogram or cervical screening scheduling and transportation assistance to women visiting the federally qualified health center in Cass County.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: Sarpy/Cass Health Department (SCHD) staff investigated transportation barriers for Cass County residents through surveys and one-on-one interviews with 40 residents, ages 45-72. Staff gained valuable insight into issues residents face in making and keeping medical appointments. The information garnered will help to inform future interventions.

Policy Development: SCHD staff provided colon and breast cancer education to over 350 individuals. As a component of the SCHD's Active Aging wellness clinics, nurses provided individualized health information to over 1,000 clients.

Assurance: SCHD nurses conducted 142 wellness clinics which provided diabetic foot care, blood pressure screening and referrals to over 1,000 individuals. These same services were also provided to 130 seniors as part of the Active Aging's home visitation program.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: All communicable disease investigations conducted by the Sarpy/Cass Health Department (SCHD) were documented in the Nebraska Disease Surveillance System. This year, 435 cases of reportable diseases were investigated by SCHD Public Health Nurses (PHRNs). Additionally, weekly school surveillance and monitoring was completed for 32,554 students.

Policy Development: PHRNs led sexually transmitted disease/infection (STD/STI) discussions with 35 high school students—discussing STD/STI modes of transmission, prevention, testing, and treatment.

Assurance: The SCHD provided case management and education for seven residents with tuberculosis (TB), all with varying levels of challenges that included multi-drug resistant, extra-pulmonary and pediatric considerations. PHRNs collected sputum samples, oversaw 100 Directly Observed Therapy (DOT) appointments, coordinated care with infectious disease specialists, and conducted contact investigations.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: SCHD provided education to 2,026 families of children with elevated blood lead levels (< 4.9 micrograms/deciliter). Additionally, staff provided education and necessary follow-up to four families with a child whose level was greater than five.

Policy Development: SCHD Environmental Health Coordinator attended five Nebraska Radon Task Force meetings. This task force was created to provide a set of comprehensive recommendations to the Nebraska Legislature regarding radon resistant new construction.

Assurance: Under the guidance of the DHHS Swimming Pool Program, SCHD staff inspected 39 swimming pools for compliance with Nebraska Regulation Title 178 Chapter 2.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: During each car seat installation the certified child passenger safety technician collects multiple pieces of information (i.e. is the seat within the use by date) that is entered into the Safe Kids Worldwide database. The Safe Kids Sarpy/Cass (SKSC) Coordinator generates jurisdiction level reports to ensure targeted education messages and supports are disseminated to residents.

Policy Development: SKSC program provided safety presentations to over 600 adults and children, with topics including child passenger safety, handwashing, fire prevention and planning, home safety, hydration, distracted driving, and bike safety.

Assurance: SCHD certified child passenger safety technicians installed 95 child passenger safety seats, and 21 seats were provided for no cost to families in need.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: Through the Sarpy/Cass Health Department's (SCHD) Maternal and Child Health (MCH) home visitation program, nurses assess the physical health (i.e. weight status) of clients to guide education and referrals to facilitate optimal health.

Policy Development: MCH program nurses distributed breastfeeding resources to over 20 community partners (i.e. medical clinics) to inform them of the benefits of breastfeeding and to help ensure consistent messaging across the community.

Assurance: MCH nurses utilized the evidence-based Growing Great Kids curriculum, which emphasizes child development, parenting skills and strengthened family support networks, for 172 home visits for pregnant women and children up to age 3.

Additional public health activities that Sarpy/Cass Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

The Sarpy/Cass Health Department's (SCHD) Health Hub program aims to implement evidence-based strategies (i.e. health coaching) and educational supports (i.e. blood pressure cuff) to increase screening rates for breast, cervical, and colon cancers, and positively impact the number of residents participating in healthy lifestyle behaviors. Clients who are enrolled in Every Woman Matters program are navigated to appropriate service and/or support by Department staff for optimal health. This year, 200 health coaching calls were made to women engaged in modifiable health programs. Additionally, 22 fecal occult blood test (FOBT) kits were distributed to the public as a mechanism to screen for polyps or colorectal cancer.

The SCHD's VetSET/Making Connections program hosted a Veteran's event at Mahoney State Park in August. Over 200 service members, veterans, and their families attended the event. The VetSET Coordinator also worked with the Cass County Veteran's Service Officer to assist veterans and their families in need of transportation, housing and utility assistance, and injury prevention training and information.

In an effort to address mental health and more specifically suicide prevention, SCHD partnered with the Nebraska Association of Local Health Directors, DHHS and Region VI to train two staff members on the QPR (Question, Persuade and Refer) program and to offer the Mental Health First Aid training to employees of a local school district. Additionally, the SCHD's Emergency Preparedness Coordinator arranged to provide a Psychological First Aid course for staff. The training, led by Region VI Behavioral Healthcare and the Medical Reserve Corps, is an evidence-informed approach that aims to reduce stress symptoms and assist in a healthy recovery following a traumatic event, natural disaster, public health emergency, or personal crisis.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

PRIORITIES

Access to Healthcare Services

Mental Health

Nutrition, Physical Activity and Weight Status

The Sarpy/Cass Health Department (SCHD) utilizes the Community Health Assessment (CHA) process to ensure that the health and behavioral needs of residents within the jurisdiction are met in the most effective and efficient manner. The Department participates in a collaborative planning process that results in a regional CHA. The CHA is sponsored by a coalition of local health departments, health systems, federally qualified health centers (FQHCs), and non-profit agencies. The assessment is a systematic, data-driven approach to determine the health status, behaviors and needs of residents in the Omaha metropolitan area (includes in Nebraska: Douglas, Sarpy, and Cass counties and in Iowa: Pottawattamie County). The CHA serves as a tool to a) improve residents' health status through increased life spans and elevate overall quality of life; b) to reduce the health disparities among residents; and c) to increase accessibility to preventive services for all community residents.

The process for the CHA follows an approach developed by the Association for Community Health Improvement. During this process, collaborating partner organizations reflect and strategize, identify and engage stakeholders, and define the community. The consulting firm selected to lead the assessment process then collects and analyzes data, prioritizes community health issues, documents outcomes and communicates the results. Partnering organizations then work collaboratively to plan and implement strategies and evaluate progress. Following the 2015 regional CHA, the SCHD partnered with local partner agencies to address CHA-identified issues including diabetes, breast cancer, food deserts, car seat usage, and tobacco use.

South Heartland
District Health Department

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Spotlight Success Story from 2018

Too many people (35% of adults) in South Heartland District Health Department (SHDHD) communities struggle with hypertension (high blood pressure – high BP) which, if left undetected or not properly managed, can contribute to an increased risk of stroke and heart disease. The age-adjusted death rate due to heart disease is higher in Adams County (198.3) than the rate for Nebraska (143.0). Prior to 2017, residents of Hastings, and the surrounding rural areas, did not have access to blood pressure management programs or access to education about their condition without visiting their health care provider. To help address this issue, SHDHD encouraged the Hastings Family YMCA to apply to be a host site for the National YMCA Blood Pressure Self-Monitoring (YMCA BPSM) Program, an evidence-based program geared toward hypertension education and management. The YMCA launched this program in June 2017 as the first site in Nebraska and one of only a few rural sites in the country.

To ensure success, the YMCA and SHDHD partnered to connect with providers and convey the benefits of the program for their patients. SHDHD helped identify a pharmacist, whose pharmacy was a program host site and a referral source. Patients at the pharmacy could visit the healthy heart ambassador (the YMCA program implementers) for blood pressure measurements and management tips while picking up their medications.

The pharmacy also referred patients into the program. The YMCA and SHDHD collaborated to establish an efficient communication system with the primary care providers (PCPs). The communication system is bi-directional: after a patient is referred by the PCP, the YMCA provides information back to the PCP, sharing patient progress and increasing the PCP's willingness to refer additional patients. Currently, there are two PCPs actively referring to the program.

Two SHDHD community health workers (one bilingual) received training to be healthy heart ambassadors for the YMCA program, which includes delivering nutrition classes and taking blood pressure measurements for participants. They are also actively referring clients into the program and were responsible for referring 61 clients since June 2017.

As a result of these efforts, collaboration between the community organizations and providers has increased, and patients, providers, and community partners are providing positive feedback regarding the program. One participant shared with her provider that the program was "very valuable" to her because she learned how to take her own BP the correct, accurate way. As of June 2018, more than 150 individuals had participated in this program at three different program sites.

This report includes examples of efforts of South Heartland District Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

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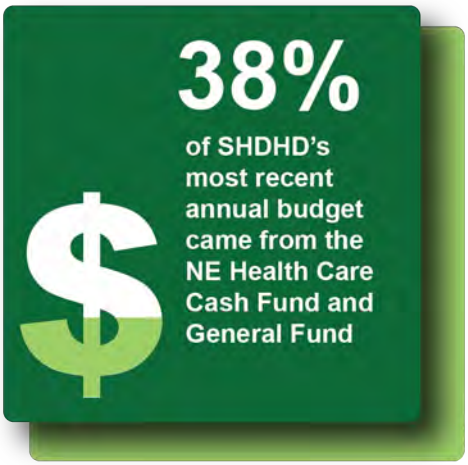


ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: With SHDHD support, five clinics improved their capacity to pull reliable "population health" reports from their electronic health records (EHRs). In one clinic, 38 of 78 (49%) hypertensive patients had blood pressure under control. Upon changing their patient protocols, 62% of their hypertensive patients had controlled blood pressure.

Policy Development: We helped three partner clinics implement a pre-diabetes protocol to identify patients at risk for diabetes, educate them on lifestyle change, and refer them to SHDHD's Smart Moves Diabetes Prevention lifestyle change program (20% of participants were referred by a provider).

Assurance: SHDHD provided a variety of mental health-related training opportunities to community members and partners in the district: Mental Health First Aid with Veteran Module, Trauma 101 & Recovery, Military Cultural Competency, Adverse Childhood Experiences (ACES) and the 40 Developmental Assets.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: Staff conducted a tobacco point-of-sale assessment of all 77 retail outlets in the district.

Policy Development: SHDHD partners with five area worksites, impacting over 500 employees, to implement policies that promote lifestyle change programs at work.

Assurance: We are helping reduce chronic disease through health coaching and promotion of cancer screening: 144 women received health coaching (86% completing), we helped 114 women access breast and cervical cancer screening (38% completing). We distributed 394 colon cancer screening kits (62% completing) and navigated the 1% with positive results to colonoscopy. We are out in our communities at clinics and other organizations promoting cancer prevention through Human Papilloma Virus (HPV) vaccination. Community forums featuring the movie "Someone you Love" are increasing awareness of HPV. We surveyed 74 area providers to learn about their HPV immunization practices, then shared resources with clinic staff and patients.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: Staff coordinated efforts to prevent additional cases of norovirus illness at a long-term care facility, gathering data on 27 ill residents and eight ill staff members, collecting specimens for analysis, and implementing control measures to prevent further spread.

Policy Development: SHDHD created policies regarding therapy for an active TB patient receiving Directly Observed Therapy and developed internal screening policies to protect staff.

Assurance: Access to immunization benefits both the individual and entire community. Funds from the DHHS Immunization Program, Adams County, and the city of Hastings help support immunization services to children and adults in our district. Through our community health workers' connections, outreach events, and work with partners, we are reaching minority and low income populations, providing access to vaccinations and helping connect them to a medical home that offers financial assistance: 80% of children served were uninsured or underinsured with no resources to cover the expense of vaccination, 23% of patients served were new to our clinic, 34% needed and received English/Spanish interpretation.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: We completed a Jurisdictional Risk Assessment with hospitals and emergency managers to determine which incidents/events are most likely to occur in our district and how to prepare for or prevent them. SHDHD promotes and sells short-term home test kits for radon. Approximately 75% of homes tested for radon in our district have levels greater than 4 picocuries/liter (the "Action" level).

Policy Development: Working with partners in the communities of Harvard, Hastings, and Superior, we are implementing community plans (walking routes/trails, "way-finding" signs) to promote walking for health.

Assurance: Staff followed DHHS guidelines to investigate and manage 34 cases of lead poisoning (elevated blood lead) in children, including follow up with parents of children with levels greater than 10 ug/dL to assure timely retesting, and assisting with home lead assessments to identify sources of lead.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: Staff evaluate risk of falls in older adults using the "Timed Up and Go" (TUG) assessment before and after every Tai Chi falls prevention class we offer. Nearly all (97%) participants finishing the 12-week class maintained or improved their scores.

Policy Development: In collaboration with local pharmacists, a physician, and Area Substance and Alcohol Abuse Prevention, SHDHD staff is providing data to the community on opioid and prescription medication misuse, promoting medication disposal at pharmacies, and hosting community drug take-back events.

Assurance: SHDHD implements the evidence-based 'Stepping On' program to offer older adults exercises, strategies and information to reduce falls. Program partners include local physical therapists, pharmacists, vision experts, community safety personnel, and footwear specialists.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Assessment: Maternal and child health data are included in SHDHD's regular comprehensive community needs assessments. Of interest, the percentage of low birthweight babies is 6.5% in SHDHD compared to 6.9% in NE overall (2005-2014).

Assurance: SHDHD is fortunate to have strong partners in our communities who are leaders in areas of maternal and child health, including Mid-Nebraska Community Action Partnership (WIC), Community Health Center-Mary Lanning (family planning), Good Beginnings-Brodstone and Healthy Beginnings-Mary Lanning (home visitation, newborn hearing screening, child car seat safety), Head Start Child and Family Development (home visitation, lead screening), CCC-Hastings dental hygiene program (oral health preventative services). SHDHD provides referrals and promotes partner services through our community resources guide.

Additional public health activities that South Heartland District Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

One important role of local public health is to prepare for and respond to local public health emergencies, including weather-, disease- and bioterrorism-related events. Nebraska DHHS Licensure had asked public health emergency response coordinators in Nebraska to assist nursing homes with their emergency plans, if requested. This past year, SHDHD partnered with seven nursing homes to complete tabletop and full-scale exercises that met the needs of each entity. South Heartland's emergency response coordinator offered to assist the nursing homes to complete a full-scale exercise that would help them meet their requirements for funding, and nursing homes agreed to allow SHDHD to test plans for Closed Points of Dispensing (PODs), Strategic National Stockpile (SNS) ordering and distribution, and working with community partners in an Emergency Operations Center (EOC).

Using an anthrax poisoning scenario, SHDHD completed a table top exercise with each nursing home facility to help them develop emergency plans before conducting a full-scale exercise at each location. The exercises engaged administrators, dietary staff, care staff and transport staff at the facilities, and provided an opportunity to practice recognizing an outbreak in residents, activating emergency plans, transferring patients to the hospital, communicating with the health department, using a leadership team to direct closed POD activities, and participating in the EOC. SHDHD was able to test response planning within an emergency operations center where representatives from emergency management, nursing homes, hospitals, schools, EMS, and law enforcement practiced their roles and responsibilities in activating plans, identifying local resources, ordering and distributing supplies from the SNS, notifying appropriate entities and practicing joint information center communication.

Interaction between SHDHD, nursing homes, and community partners in the EOC demonstrated a willingness to work together through exercises—coordinating with each other to protect the public's health.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

In early 2018, SHDHD began a new round of Mobilizing for Action through Planning and Partnerships (MAPP) to lead our district in the development of a new six-year community health improvement plan (CHIP). SHDHD's community assessment and health priority-setting processes involve our stakeholders and community members at every step. Residents from all four counties give input about the strengths and opportunities in their communities. Our community partners contribute data to help us understand the health and risky behaviors of our residents. Community leaders and health providers help us understand the health assets and services gaps in our communities, and community members share their barriers to accessing preventive health services.

PRIORITIES

Obesity

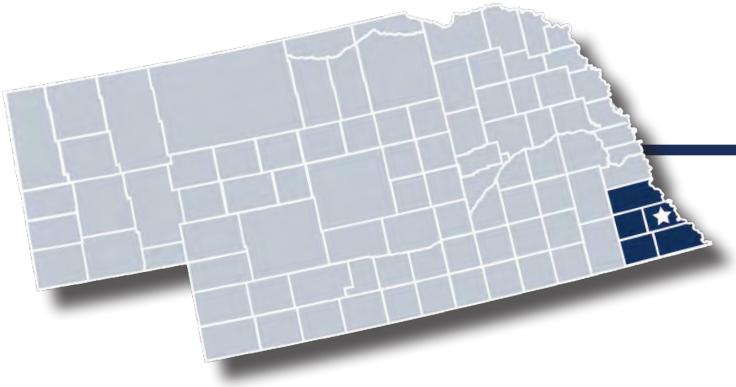
Cancer

Mental Health/ Substance Abuse

Access to Care

Next, our partners and stakeholders help choose health priorities to focus on over the next six years. They participate in facilitated planning sessions with us to determine how, as a health district, we will address our top health priorities. It is through these planning sessions that our CHIP is generated and partner organizations identify strategies they will lead or participate in. The CHIP serves as a guide for SHDHD and for our community partners.

Some partners, including two non-profit hospitals (Brodstone Memorial and Mary Lanning Healthcare) in our district, also are required to complete periodic community needs assessments. Collaboration on this process reduces duplication and leads to coordinated, aligned plans across organizations and shared community goals for seeking resources and coordinating services. Many partners use the resulting needs assessment data and CHIP to guide their own strategic planning, with "lines of sight" to the community's goals and objectives. For example, the Hastings Family YMCA partnered with SHDHD to seek funding and implement a national YMCA pilot program on blood pressure self-management. This partnership aligned with SHDHD's chronic disease initiative and the community health priority of reducing obesity and associated chronic diseases.



Southeast
District Health Department

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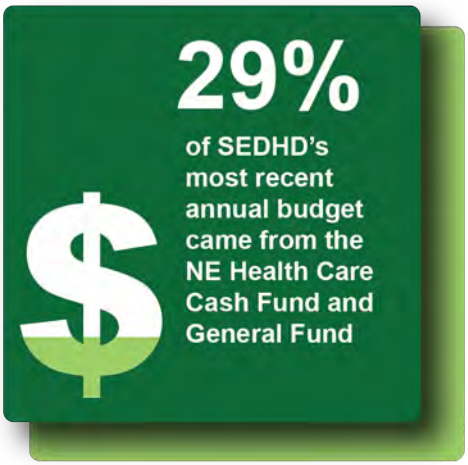
This report includes examples of efforts of Southeast District Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Southeast District Health Department (SEDHD) works to assure access and linkages to clinical care. Our Growing Great Kids program screens for and collects/monitors data on behavioral and mental health risks among children while also providing referrals when applicable. Through our involvement in the Health Hub we collect data and help to navigate clients with increased risk for breast, cervical, and other cancers to screenings and care. Our oral health program (Brighter Smiles) provides dental care for elementary-aged children who might otherwise lack preventive care and face barriers in accessing oral healthcare.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Through our community health assessment (CHA) process, SEDHD looks at community data to determine health priorities—among these priorities are preventing and addressing chronic diseases, cancer, behavioral health issues and substance abuse. Examples to address chronic diseases, such as obesity, cardiovascular disease, and diabetes, include: 1) the Health Hub program performs health assessments for clients and appropriate clients receive health coaching and/or referral to the Diabetes Prevention Program (DPP) and 2) through partnerships with University of Nebraska Medical Center (UNMC) and a regional hospital, we are offering our communities a cardiovascular disease risk reduction program and can provide referrals for further evaluation with health clinics.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

SEDHD offers programs that monitor, prevent and address communicable diseases, including those that are prevented through immunizations. We partner with schools to educate students and families on disease prevention and immunizations. We also provide referrals to immunization clinics for children and adults. Our disease surveillance and public health emergency preparedness programs collect and analyze data to monitor disease incidence across our five-county region. With support from a mini grant from NE-DHHS Comprehensive Cancer Control Program we worked to prevent cancers by increasing human papillomavirus (HPV) immunization rates.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

SEDHD recognizes that radon exposure is the leading cause of lung cancer for non-smokers in the U.S. and is a serious health risk throughout our five-county region. SEDHD collects and monitors radon levels across the region. We partner with other organizations to distribute educational materials and radon test kits. SEDHD then tracks test kit results and refers community members to radon mitigation services. Through our Epidemiology program we also follow up on and monitor reported instances of lead exposure.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

SEDHD's commitment to injury prevention is evident in our robust programs in this area including substance abuse screening through our Growing Great Kids program. Our opioid prevention programming in partnership with Region V Behavioral Health Systems includes assessing data on opioid use within our five counties and placing five medication drop-off boxes across the region. Our Safe Kids program includes a certified staff member who offers car seat checks. This program provides low income families with car seats.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

SEDHD work in Maternal Child Health includes collecting data to understand needs in this area. We offer Growing Great Kids developmental screenings and use secondary data sources (i.e. BRFSS) to collect and share maternal/child/family data. For those children and families who present with a developmental delay, SEDHD refers to the Early Development Network. SEDHD work in family planning includes supporting curriculum for family planning and providing referrals.

Additional public health activities that Southeast District Health Department performs to assure that the health and well-being of Nebraskans are protected and improved.

SEDHD has emphasized prevention as its primary focus in all activities. Programs such as disease surveillance, emergency preparedness, immunizations, and Health Hub have been at the forefront of SEDHD prevention efforts. Additionally, community-based programs have been implemented to further push prevention strategies. Such programs include an innovative cardiovascular risk reduction pilot program in partnership with the UNMC and one of the regional critical access hospitals within the five-county jurisdiction. Also, in partnership with UNMC and one of the region's public-school districts, SEDHD has started a wellness-based program which aims to increase physical activity among youth.

SEDHD continues to strengthen existing and implement new community-based coalitions to promote healthy communities. The Southeast Nebraska Breastfeeding Coalition has developed a strategic plan to emphasize efforts to support and normalize breastfeeding and to work with employers within the region to create breastfeeding-friendly work environments and provide support and education to breastfeeding mothers. SEDHD is currently partnering with Region V Behavioral Health Systems to develop a regional coalition to drive substance abuse prevention strategies, including youth programming, for our five counties. Additionally, SEDHD is in its second year of serving as fiscal agent for the Southeast Nebraska Healthcare Coalition, a 16-county regional coalition that coordinates disaster preparedness between healthcare facilities, public health, emergency management, and emergency medical services. SEDHD has also assumed a role as fiscal agent for the Nebraska Plains Healthcare Coalition, serving 15 counties in Southwest Nebraska.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

SEDHD collaborates with six regional critical access hospitals and other partner organizations in completing the community health assessment (CHA) and community health improvement plan (CHIP). The 2018-2019 CHA and CHIP will provide a county-specific and regional outlook of the health status of SEDHD communities. Additionally, the health priorities that are identified through the assessment and improvement plan will inform future healthcare service-based strategic initiatives and program development across the region.

PRIORITIES

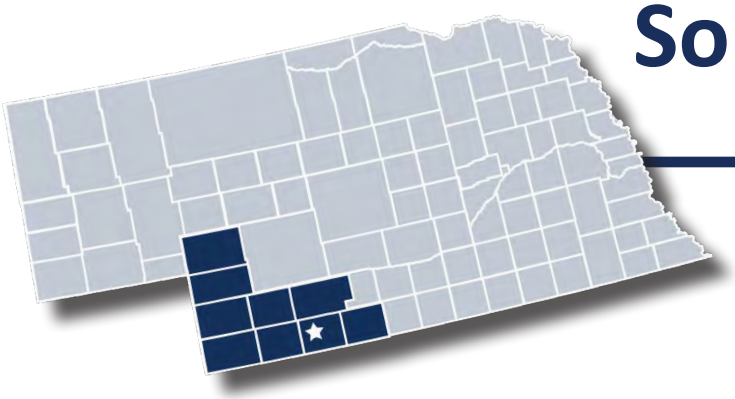
Chronic Disease

Cancer

Behavioral Health

Substance Abuse

For more information about *Southeast District Health Department* please visit:
www.sedhd.org



Southwest Nebraska

Public Health Department

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Southwest Nebraska
Public Health Department

PREVENT • PROMOTE • PROTECT

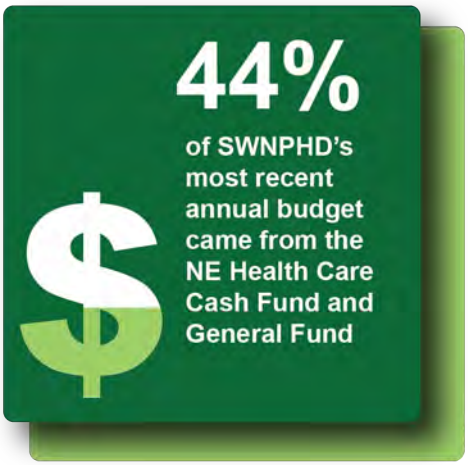
This report includes examples of efforts of Southwest Nebraska Public Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect only the work *directly* supported by monies from the Nebraska Health Care Funding Act (HCFA). Other work, supported by other sources are not included here.

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Tobacco program; radon awareness and testing program; Kids Fitness and Nutrition Day event for 4th grade students, annual Walk To Health program.

Assessment: Cancer, Cardiovascular, Tobacco

Policy Development: Cancer, Cardiovascular, Tobacco

Assurance: Cancer, Cardiovascular, Tobacco

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Prevent: Immunizations-provide 5 immunization clinics in areas with limited medical access.

Promote: Tobacco program; radon awareness and testing program; Kids Fitness and Nutrition Day event for 4th grade students, annual Walk To Health program.

Protect: Prevent spread of disease by monitoring and follow-up on reportable diseases; follow-up and referral on environmental health hazards i.e. mold.

Assessment: Communicable Disease Epidemiology (disease outbreak management/response), Immunizations, Tuberculosis, Surveillance (tracking and following up on reports and provider/school reports)

Policy Development: Communicable Disease Epidemiology (disease outbreak management/response), Immunizations, Surveillance (tracking and following up on reports and provider/school reports)

Assurance: Communicable Disease Epidemiology (disease outbreak management/response), Immunizations, Tuberculosis, Surveillance (tracking and following up on reports and provider/school reports)

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Radon poster contest; host radon education class for real estate CEU's; licensed measurement specialist on staff; promote radon testing through advertisements on local media outlets. Lead-monitor testing; follow-up on out of range results; education with providers and families.

Assessment: Radon, Lead

Policy Development: Radon, Lead

Assurance: Radon, Lead

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

FROG - Fitness Reaching Older Gens was developed by SWNPHD in 2006 and has spread to most of Nebraska as a senior fitness program with an emphasis on fall prevention.

Policy Development: Senior Fall Prevention

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Additional public health activities that Southwest Nebraska Public Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

Data obtained during this process is utilized for grant applications for services and/or programs in the nine-county area.

PRIORITIES

Cancer

Heart Disease

For more information about *Southwest Nebraska Public Health Department* please visit: www.swhealth.ne.gov

Southwest Nebraska Public Health Department

PREVENT • PROMOTE • PROTECT

Three Rivers
Public Health Department

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Spotlight Success Story from 2018

In early November 2017, Three Rivers Public Health Department (Three Rivers) investigated the death of a Dodge County resident due to tuberculosis (TB). As a part of this investigation, Three Rivers was responsible for case investigation, community education, and testing of close contacts. Three Rivers identified and tested 19 individuals for exposure to TB. Additionally, 29 individuals were tested by local and state partners. Of these initial tests, two were found to be positive, with one person starting treatment for latent (inactive) TB in late November. As of the end of this year, no exposed individuals have been diagnosed with active TB. Through the efforts of Three Rivers and their partners, further transmission of TB into the wider community was prevented.

Learn more about this case at these links:
https://www.ketv.com/article/patient-with-tuberculosis-dies-after-treatment-in-fremont-and-omaha/13439485

https://fremonttribune.com/news/local/health-department-investigating-possible-exposure-following-tuberculosisdeath/article_e2694d94-6d62-5a7c-b349-f5d6665c2417.html

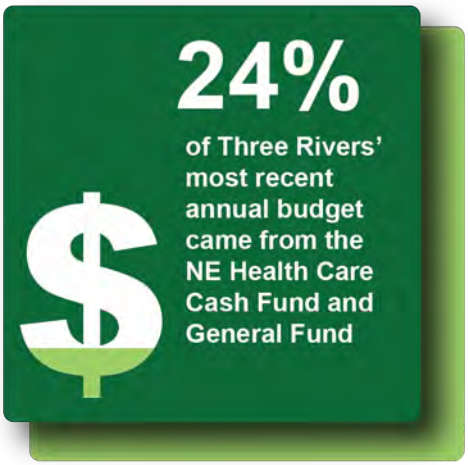
This report includes examples of efforts of Three Rivers Public Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Three Rivers Public Health Department has been highly involved with bringing a Federally Qualified Health Center (FQHC) to our public health jurisdiction. This was possible because of the Community Health Assessment (CHA) and the resulting Community Health Improvement Plan (CHIP) completed with multi-sector partners under Three Rivers' leadership. The CHA and CHIP demonstrated that access to care is a local need and priority. In addition to this success, Three Rivers has been seeking funding opportunities and developing relationships to work on behavioral and mental health services within local school districts.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Three Rivers Public Health Department is fortunate to house a Title X clinic where breast and cervical cancer screenings are provided. In addition, Three Rivers received a Susan G. Komen Great Plains grant that addresses the financial barriers many women experience as they try to complete necessary mammograms. As a result, women receive the breast cancer screenings that they otherwise would not have been able to afford. In terms of diabetes, a grant from the DHHS Office of Minority Health currently allows Three Rivers to host a free Spanish Diabetes Prevention Program. This is a year-long class. No other organization provides this service in the Three Rivers jurisdiction.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Three Rivers Public Health Department participated in several activities related to this area during the past year. In May of 2018, Three Rivers coordinated the response to a food-borne disease outbreak following a special event at a local hospital. In this instance, Three Rivers assisted with case surveillance, data collection, and community education. Also during May, Three Rivers facilitated the testing of a bat that had been in contact with three young girls. After the test came back positive for rabies, Three Rivers notified the family and helped coordinate initiation of rabies prophylaxis for each of the exposed children.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Three Rivers Public Health Department participated in several activities related to environmental health during the past year. In January 2018, Three Rivers provided radon test kits to residents across the three-county jurisdiction. As a result, 86 homes were tested for radon. Three Rivers also provided radon awareness education via social media and at a local home show event. Three Rivers addressed lead exposure by providing case management for children and adults with high lead levels. This included providing general education to affected families in 2017-2018 and participating in two home lead inspections for children with a lead level greater than 10 ug/dL.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Three Rivers Public Health Department leads a Safe Kids Coalition in which child passenger safety is a main area of focus. Through several grants, Three Rivers is able to provide car seats and education for families in need within the three-county public health district. Three Rivers also works to promote proper use of safety belts among children, teens, and adults since that is one of the safest choices one can make when riding in a vehicle. This education is done through car seat appointments, individual presentations, and social media posts.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

Three Rivers Public Health Department operates a Title X clinic offering reproductive services, testing for sexually transmitted diseases, and vaccinations at a low/reduced cost for community members. In addition, Three Rivers also employs a reproductive and sexual health educator who works closely with the clinic. The educator coordinates and conducts classes for community members at various agencies and public schools in the three-county service area. The educator engages local hospitals, providers, school educators, and other community agency administrators and staff. This outreach ensures knowledge of Three Rivers services and enables coordination to the benefit of patients and clients.

Additional public health activities that Three Rivers Public Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

Three Rivers Public Health Department does not have an environmental health division, but routinely assists community members with environmental issues such as mold, asbestos, and bed bugs. In one instance, Three Rivers assisted a family who had black mold in their apartment. Three Rivers called local and state contacts to determine available resources to help the family. Through this process, Three Rivers was able to connect the family with their local city office for further follow-up and inspection of their home.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

Under the direction of the Three Rivers Public Health Department, the 2016 Community Health Needs Assessment (CHA) was created for the three-county public health district (Dodge, Saunders, and Washington counties in Nebraska). This assessment was the basis for the 2016 Community Health Improvement Plan (CHIP). The CHA also served as a reference document for the non-profit hospitals in the district—to assist in strategic planning for their organizations. The CHA is intended to inform all interested parties about the health status of the population within the public health district and to provide community partners with a wide array of data that can be used to educate and mobilize resources to improve the health of the population.

PRIORITIES

Access to Health

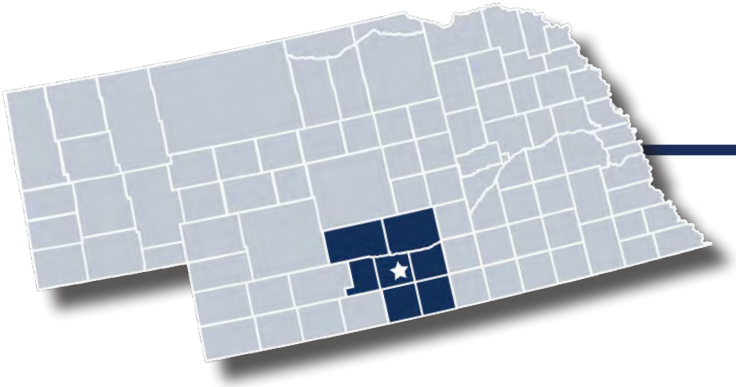
Mental Health Services

Preventative Health Education

Poverty & Workforce Education

For more information about *Three Rivers Public Health Department* please visit:
www.threeriverspublichealth.org

THREE RIVERS
PUBLIC HEALTH DEPARTMENT
Dodge, Saunders & Washington Counties



Two Rivers
Public Health Department

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Spotlight Success Story from 2018

Access to care is an established priority in the current Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) of Two Rivers Public Health Department (TRPHD). Oral health care is one area of focus. Oral health is related to many chronic diseases. TRPHD coordinated services to address the identified need for oral health services in our seven-county jurisdiction through the 2018 Life Smiles Care Project. This project focused on underserved populations and was held April 17-20, 2018 at The Opportunity Center / Dawson County Development building in Lexington, Nebraska.

According to the Centers for Disease Control and Prevention (CDC), "One in five people have untreated tooth decay which can lead to pain and infection and ultimately to problems speaking, eating, working, and playing. When tooth decay in very young children requires extensive treatment under general anesthesia in a hospital operating room, costs can increase by thousands of dollars. Timely delivery of fluorides and dental sealants to at-risk people reduces tooth decay and treatment costs." Unfortunately, oral health disparities persist in rural areas, often complicated by a systemic exclusion from oral health care based on socioeconomic status.

TRPHD has worked to address our area's oral health disparities through coordination of an annual treatment clinic utilizing local, volunteer providers. TRPHD has terrific providers across the spectrum, and dental care is no exception. In early 2018, TRPHD began the process of coordinating services to facilitate the Life Smiles Care Project—a week-long dental treatment clinic staffed by area volunteer providers who performed services for those in the most need. TRPHD dedicated many hours to this event to make it highly successful. Patients were recruited from WIC, schools, and preschools. Recruitment sites were identified as having potential patients with urgent needs, no insurance, and/or other barriers to oral health care. Preventative and restorative services provided by TRPHD included: prophylaxis, sealants, oral health education, radiographs, limited endodontics, extractions, silver diamine treatments, fluoride treatments, oral cancer screenings, dental screenings and exams, as well as distribution of home care supplies and educational materials. Prizes were also donated for children participating in the event. Those contributing to the Care Project were local dentists, dental assistants, Dawson Area Development, Central Community College, dental supply companies, and local businesses. Sister agencies, such as Central District Health Department and West Central District Health Department, loaned essential equipment for the event. The total value of in-kind services for this project was nearly $28,000. The return on these investments in the oral health of the communities served is exponential.

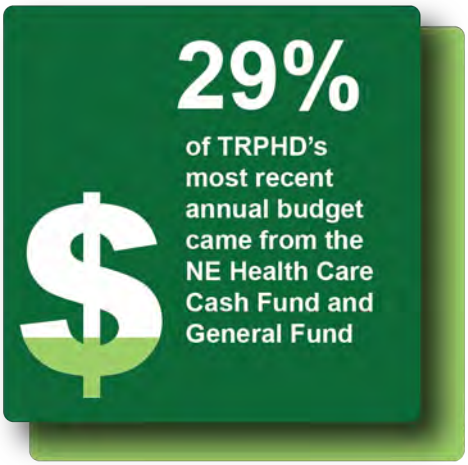
This report includes examples of efforts of Two Rivers Public Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA) .

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

Assessment: Oral Health/Dental Services, Behavioral and Mental Health

Policy Development: Oral Health/Dental Services, Behavioral and Mental Health

Assurance: Coordination of Services, Oral Health/Dental Services

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

Assessment: TRPHD has worked across multiple health systems to implement electronic health record (EHR) systems and stages of change.

Policy Development: TRPHD has continued to work with several clinics to support movement towards quality measures and policy-level improvements.

Assurance: TRPHD supports a referral network to area Diabetes Prevention Programs (DPP).

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

Assessment: TRPHD has recently completed the district Community Health Assessment (CHA) and Strategic Plan in addition to collaborating with a local health system—facilitating their system Community Health Needs Assessment (CHNA).

Policy Development: TRPHD's director has served on the Nebraska Radon Taskforce, recommending minimum standards for radon-resistant new residential construction across Nebraska. TRPHD is part of ongoing work to address chronic diseases—including work to increase community walkability, healthy food access, and to improve update/implementation of EHR systems to improve coordination and management of patient support and care.

Assurance: TRPHD depends on its partners across the seven-county district. TRPHD facilitates and participates regularly in collaboratives involving key community partners such as: community health workers (CHWs), infection preventists, and emergency preparedness professionals.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

Assessment: Radon, Lead, Emergency Response, Complete Streets

Policy Development: Radon, Lead, Emergency Response, Complete Streets

Assurance: Radon, Lead, Emergency Response, Hazardous Substances and Sites, Complete Streets

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

Assessment: Motor Vehicle, Occupational Injuries, Substance Abuse, Car Seat Safety, Binge Drinking, Distracted Driving

Policy Development: Car Seat Safety

Assurance: Senior Fall Prevention

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

TRPHD is not directly involved in Maternal, Child and Family health programming.

Additional public health activities that Two Rivers Public Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

TRPHD offers health education related to a variety of health topics, including those part of the week-long dental treatment clinic described in our Spotlight story. An additional program area we continue to work to implement is the Coordinated Approach to Child Health (CATCH), an evidence-based, comprehensive, school-based nutrition and physical activity program. When able to leverage resources, TRPHD has provided technical assistance and facilitated several sessions of CATCH at high-need schools in communities across the district.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

The Community Health Assessment (CHA) is an essential process to identify needs across the health district that help prioritize issues that will effect changes in health outcomes. While CHAs are a recent requirement for nonprofit health systems, they have long been used as a tool by local public health departments to identify and prioritize community health issues and create Community Health Improvement Plans (CHIPs). TRPHD is utilizing collaborative processes to implement our CHIP. The CHA/CHIP are often referenced and used by local health systems to develop forward-facing strategies and establish system priorities. TRPHD is an integral partner in local health systems' CHAs, continually working towards an aligned, regional CHA/CHIP process.

PRIORITIES

Access to Care

Lifestyle Choices and Personal Accountability

Districtwide Interagency Development

An additional benefit of the CHA/CHIP process is the focus and structure it provides for TRPHD's internal efforts around community health improvement and addressing the broad factors that influence health. Our spotlight story is just one example of how TRPHD has is strategically addressing the "access to care" priority in our CHIP. The Life Smiles Care Project is part of our larger Life Smiles Program which was designated a model practice by the National Association of County and City Health Officials (NACCHO). This program was started with grant funding, but is now sustainably funded and continues to expand to serve patients across the age-range—now providing services in area schools, WIC clinics, and long-term care facilities.

West Central
District Health Department

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Spotlight Success Story from 2018

West Central District Health Department (WCDHD) achieved national accreditation through the Public Health Accreditation Board (PHAB) on February 20, 2018. WCDHD is one of 223 health departments nationwide that have achieved this designation since PHAB accreditation launched in 2011. "Staff have worked tirelessly and with great pride to reach our shared goal of accreditation. WCDHD's efforts are a direct reflection of our commitment to bringing quality resources and services to all within our community", said Shannon Vanderheiden, Health Director of the WCDHD. Public health departments play a critical role in protecting and improving the health of people and communities. WCDHD provides a range of services aimed at promoting healthy behaviors; preventing diseases and injuries; ensuring access to safe food, water, clean air, and life-saving immunizations; and preparing for and responding to public health emergencies. To receive accreditation, a health department must undergo a rigorous, multi-faceted, peer-reviewed process to ensure it meets or exceeds a set of quality standards and measures. "The West Central District Health Department joins the growing ranks of accredited health departments in a strong commitment to their public health mission," said PHAB President and CEO Kaye Bender, PhD, RN, FAAN. "The peer-review process provides valuable feedback to inform health departments of their strengths and areas for improvement, so that they can better protect and promote the health of the people they serve in their communities. Residents of a community served by a nationally accredited health department can be assured that their health department has demonstrated the capacity to protect and promote the health of that community." As part of maintaining and improving quality of care and services, WCDHD engages community partners to inform and to receive feedback on progress and future needs and to celebrate successes along the way. Products of this engagement are incorporated in the Community Health Improvement Plan (CHIP) and in WCDHD's Strategic Action Plan.

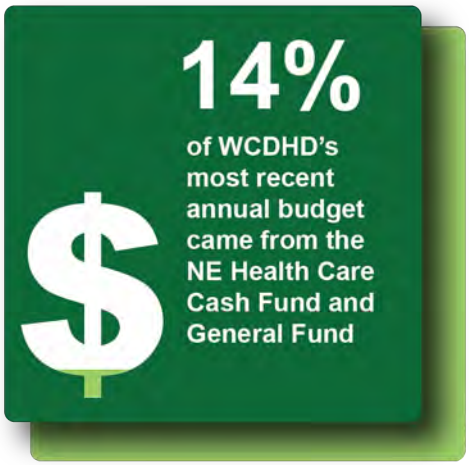
This report includes examples of efforts of West Central District Health Department to make the "Good Life" a healthy one in their jurisdiction. The following examples reflect work supported through multiple sources of funding, including monies from the Nebraska Health Care Funding Act (HCFA).

Local health departments act as communities' Chief Health Strategists by assuring that the health and wellbeing of Nebraskans are protected and improved. Local health departments do this by working in each of the ***Three Core Function Areas of Public Health***:

Assessment: Collect and analyze information about health problems in Nebraska communities.

Policy Development: Work with partners to apply data, educate the public, and develop programs and policies—all to address and prevent illness, disease and disability.

Assurance: Promote effective coordination and use of community resources to protect the health and wellbeing of Nebraskans.



ACCESS TO AND LINKAGE TO CLINICAL CARE

Access to and Linkage to Clinical Care includes (but is not limited to) coordination of services between medical providers and providers of health-related social needs, oral health/dental services, and behavioral/mental health.

WCDHD's 2016-2020 CHIP priorities included "Affordable and Equitable Access to Care and Services." One example of work toward this aim WCDHD's work with partners on understanding and improving the health and wellness of vulnerable youth in one local school system. Local school data reflects an 87.5% absenteeism illness rate, with 20% of those students having five or more absences. Approximately 40% of the students were enrolled in Medicaid or uninsured. In addition, 48% of students qualified for free and reduced lunch. Affordability is a likely barrier to health care for many students and, possibly, an underlying cause for absenteeism due to illness. WCDHD is convening partners to understand and develop solutions to these and other access issues district-wide. In the short term, WCHD provided dental services to at-risk students through our Tooth Tour program.

CHRONIC DISEASE CONTROL AND PREVENTION

Chronic Disease Control and Prevention includes (but is not limited to) asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco control, and worksite wellness.

WCDHD provided education about risks and screening recommendations for all types of cancers through classes, social media and paid service announcements. WCDHD received grant funding from Susan G. Komen Great Plains to provide education to and financial assistance for underinsured women to get cancer screenings. Additionally, WCDHD received funding for Minority Health Initiatives through the Nebraska Department of Health and Human Services (DHHS) and assisted over 600 clients with connection to chronic disease programs and services, including interpretation services and linkages to medical and dental appointments.

COMMUNICABLE DISEASE CONTROL AND PREVENTION

Communicable Disease Control and Prevention includes (but is not limited to) communicable disease epidemiology (disease outbreak management/response), tuberculosis (TB), immunizations, sexually transmitted infections, and surveillance (tracking and following up on reports and provider/school reports).

WCDHD provided technical assistance and status updates to 26 schools to assure surveillance of communicable diseases within our six-county jurisdiction. WCDHD reviewed its policies and practices to ensure alignment with state statute. WCDHD worked with area providers to meet state reporting requirements. WCDHD provided a drive-through flu clinic for the elderly and those with limited mobility to increase flu vaccinations. In addition, WCDHD provided education and repellant wipes to community members during the West Nile virus and flu seasons.

ENVIRONMENTAL HEALTH

Environmental Health includes (but is not limited to) radon, lead, emergency response, hazardous substances and sites, and Complete Streets initiatives.

WCDHD's radon program provided short-term radon test kits to residents who requested them. Individuals whose tests came back with levels greater than 4 pCi/L, were provided long-term radon test kits. WCDHD partnered with North Platte High School students to educate the community on the dangers of radon and the steps to reduce risk related to radon.

INJURY PREVENTION

Injury Prevention includes (but is not limited to) motor vehicle injuries, occupational injuries, senior fall prevention, substance abuse, car seat safety, binge drinking, and distracted driving.

WCDHD acts as the backbone agency for the Substance Abuse Prevention Coalition. The strategies, objectives, and interventions of the coalition's workplan address underage drinking in Lincoln County, student abuse of prescription drugs, student binge drinking, and marijuana use among teens. WCDHD provided technical assistance around best practices to address the problems identified in the workplan, shared substance abuse updates with leadership and other community members involved in the CHIP, promoted prescription drug collections via social media or employee involvement, and educated and promoted the "Be the Wall" campaign to decrease underaged drinking by distributing educational post-its on check-in forms.

MATERNAL AND CHILD HEALTH

Maternal and Child Health includes (but is not limited to) Women, Infant, and Children (WIC), family planning, newborn screening (hearing, screening for PCP, environmental hazards, etc.), evidence-based home visitation, Early Preventative Screening, Diagnosis, and Treatment (EPSDT).

WCDHD collaborates with the local WIC office to provide interpretation services and assistance with transportation.

Additional public health activities that West Central District Health Department performs to assure that the health and wellbeing of Nebraskans are protected and improved.

In an effort to reduce the proportion of children and adolescents who have dental caries, WCDHD's Tooth Tour was resurrected for the 2017-2018 school year. During the 2016-2017 school year, approximately 20% of students in the North Platte Public School Department (NPPSD) had more than five absences from school of which 87.5% were related to illness. Some of those illnesses were related to oral health. NPPSD and WCDHD partnered to offer dental care, including services such as teeth cleaning, fluoride application, and sealant placements, to vulnerable students. WCDHD provided dental care services to eight schools, serving over 100 students. Over 75 students had more complicated oral health issues that needed follow-up dental care, and four students were referred to a dental specialist.

WCDHD effectively coordinated community resources to provide dental care to vulnerable students in the NPPSD. This collaboration assisted in the control and prevention of disease.

Community Health Assessment (CHA)
Community Health Improvement Plan (CHIP)

In collaboration with community members and partners, WCDHD completed a Community Health Assessment (CHA) in 2015, which gathered and interpreted information from multiple and diverse sources to develop a deep understanding of the health of communities across our jurisdiction. WCHD utilized the Mobilizing for Action through Planning and Partnerships (MAPP) framework for this process. Our CHA report was distributed to partners and is available on the WCDHD website. This report was used by community partners to determine our local, health-related priorities: 1) Affordable and Equitable Access to Care and Services, 2) Healthy Lifestyles and Wellbeing, and 3) Community Collaboration. The CHA report continues provide direction to WCHD and our partners and to serve as a data resource.

PRIORITIES

Affordable and Equitable Access to Care and Services

Healthy Lifestyles and Well-being

Community Collaboration

The CHA informed the development of the WCDHD Community Health Improvement Plan (CHIP), a 5-year community-wide action plan. WCDHD and partners formed work groups around the identified health-related priorities and developed action plans to address these priorities. Work groups are implementing the action plans and meet as needed to monitor progress on goals and objectives. WCDHD engages the following partners in this process: schools, service/non-profit organizations, mental/behavioral health agencies/providers, healthcare providers, government organizations, local business, recreation organizations, and volunteers.

Outcomes, to date, from the current CHIP include 1) providing health programs for children—such as a Kids Klub 5K Run and the provision of oral health care in schools; 2) creating environmental supports for healthy lifestyles for both children and adults—such as improvement in recreation and the trails systems; and 3) improving community collaborations—such as the implementation of a community central navigation system (including health and behavioral health navigation to services) and a monthly community partners meeting.