Nebraska FY 2018
Preventive Health and Health Services Block Grant

Work Plan

Original Work Plan for Fiscal Year 2018
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Governor: Pete Ricketts

State Health Officer: Thomas Williams, M.D.

Block Grant Coordinator:

Gwen Hurst
301 Centennial Mall S.
P.O. Box 95026
Lincoln NE 68509-5026
Phone: 402-471-3485
Fax: 402-471-6446
Email: gwen.hurst@nebraska.gov

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Contents

FINAL 2018 Work Plan

Executive Summary

On May 15 and June 12, 2018, the Nebraska Preventive Health Advisory Committee reviewed and recommended programs for funding.

On May 15, 2018, the Public Hearing was convened.

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2018. It is submitted by the Nebraska Department of Health and Human Services (DHHS) as the designated state agency for the allocation and administration of PHHSBG funds.

Funding Assumptions: The total award for the FY 2018 Preventive Health and Health Services Block Grant is $2,778,738. This amount is based on an allocation table distributed by CDC.

Funding for FY 2018 Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: $36,752 of this total is a mandatory allocation to address sexual offenses. Nebraska passes through the total amount to the Nebraska Coalition to End Sexual and Domestic Violence (the Coalition), an organization that provides leadership, technical assistance and financial support to 20 local domestic violence/sexual assault programs across the state. The Coalition will braid PHHS funding with Rape Prevention Education funding to move the Coalition and local programs toward more evidence-based programming. Specifically, FY 2018 funding will allow for assessment of the capacity of the Coalition to provide evidence-based sexual violence prevention strategies across the state. Assessment will go hand-in-hand with the reestablishment of a Sexual Violence Prevention Advisory Committee that will help develop a statewide strategic plan for addressing sexual offenses, with a focus on prevention.

The PHAC approved additional funding, *above and beyond the required set aside.* Additional funding totals $25,000 and will support the Coalition's No More Crimes of Sexual or Domestic Violence Conference, a combined effort of the Coalition and statewide law enforcement and criminal justice agencies. In addition to the one-day Nebraska conference, the Coalition will utilize funding to send up to eight local program advocates to the national Sexual Violence Prevention Summit. Advocates provide written reports regarding lessons learned and will be available to other local programs and the Coalition to provide presentations regarding promising programs and projects.

The other programs and activities that will be funded by this PHHSBG include those described below.

Program: Emergency Health Systems
National Health Objective: HDS-3 Stroke Deaths
Nebraska Health Objective: Provide Stroke System of Care training and education to dispatchers, EMS services, critical access hospitals and the public
PHHSBG Funding: $10,000 will be utilized by the DHHS Emergency Health Systems Program to work with primary stroke centers to target hospitals and EMS services to receive stroke system of care training. The best outcome for a person having a stroke depends on early and rapid identification, diagnosis, and treatment of stroke in efforts to prevent death and revers neurological deficits such as paralysis and speech and language impairments. Timely treatment is critical, and PHHS funding for this project will support training as well as public education regarding identification of signs and symptoms of a stroke and the proper timely response if a stroke is suspected. .

Program: Emergency Health Systems
National Health Objective: HDS-19 Timely Artery-Opening Therapy
Nebraska Health Objective: improve STEMI education to EMS services within the state and train critical access hospitals (CAH) on the importance of using field acquired 12-leads

PHHSBG Funding: $27,466 will be utilized by the DHHS Emergency Health Systems Program to work with EMS services and critical access hospitals across the state to provide education on obtaining, transmitting and using 12-leads and will provide STEMI education to trauma hospitals, providers, nurses and EMS services. A key component of this objective is data collection and use. The DHHS EHS will work with hospitals and EMS services on the collection of data for the CARES Registry with the goal of increasing positive patient outcomes.

Program: Emergency Health Systems
National Health Objective: IVP-1 Total Injury
Nebraska Health Objective: evaluate Nebraska Trauma Registry and the Trauma Quality Improvement Program (TQIP) data regarding trauma-related deaths and provide trauma education to hospitals, trauma nurse managers, trauma registry staff and EMS services
PHHSBG Funding: $57,534 will be utilized by the DHHS Emergency Health Systems Program to subscribe to the TQIP and performing a data analysis of all Level I and Level II Trauma Hospitals. Based on results from the analysis, DHHS EHS will provide needed trauma leadership development training, trauma registry training and trauma education to trauma hospitals, providers, trauma nurses and EMS services.

Program: Health Disparities & Health Equity
National Health Objective: ECBP-11 Culturally appropriate community health programs
Nebraska Health Objective: identify at least 20 of the most critical health disparities and health needs among racial ethnic minorities in Nebraska and work to equalize health outcomes and reduce health disparities through information and education
PHHSBG Funding: $284,8400 will be utilized by the Office of Health Disparities and Health Equity (OHDHE) to continue its vital work as the state's trusted source of health data and information. Activities will include:

- Providing cultural intelligence and health disparities presentations;
- Working with four Tribes to provide education and public health services;
- Collecting and analyzing BRFSS data and data regarding hepatitis B, minority population growth, leading cause of death and births among the state's minority populations;
- Developing minority reports addressing disparities in socioeconomic status, health status and minority population growth;
- Conducting a needs assessment for American Indians;
- Conducting a needs assessment among Nebraska's refugee populations;
- Assisting refugee communities with health education and information;
- Assisting with implementation of the State Health Improvement Plan (SHIP); and
- Implementing the annual Minority Health Conference

Program: Infectious Disease
National Health Objective: HIV-13 Awareness of HIV Serostatus
Nebraska Health Objective: limit Human Immunodeficiency Virus (HIV) in Nebraska
PHHSBG Funding: $30,962 will be utilized by the DHHS Infectious Disease Program to increase the percentage of high-risk persons tested for HIV/AIDS to at least 75% of total tests performed. HIV Program staff will work with partners in high-risk areas to provide anonymous and confidential HIV testing at no cost to the client in order to facilitate follow-up with people who are infected and provide increased access to Disease Intervention Specialists at selected clinics that serve the target population (MSM, IDU). The aim is to change risk behaviors and prevent additional transmission of infection.

Program: Infectious Disease
National Health Objective: IID-27 Awareness of Hepatitis C Infection Status in Minority Communities
Nebraska Health Objective: increase from baseline to 40% the proportion of Nebraskans who are aware they have a hepatitis C infection
PHHSBG Funding: $39,106 will be utilized by the DHHS Infectious Disease Program to increase awareness of hepatitis C (HCV) infection in populations at high risk for the infection. The program will screen at-risk groups for HCV, provide health education and counseling, provide HCV confirmatory

testing and provide linkage to medical care for persons whose confirmatory test results are positive.

Program: Infectious Disease
National Health Objective: STD-1 Chlamydia
Nebraska Health Objective: Reduce the prevalence of chlamydia trachomatis infections among Nebraska's adolescent and young adult females and males, aged 15 to 34 years
PHHSBG Funding: $40,000 will be utilized by the DHHS Infectious Disease Program to contract laboratory services that provide tests for sexually transmitted diseases (STDs) at selected clinics. The services will provide increased access to Disease Intervention Specialists (DIS) and report results in order to facilitate follow-up with people who are infected, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission. Douglas County Health Department STD staff will offer tests and DIS services as well as risk reduction and prevention strategies.

Program: Infectious Disease
National Health Objective: STD-6 Gonorrhea
Nebraska Health Objective: Reduce the prevalence of gonorrhea infections among Nebraska's adolescent and young adult females and males, aged 15 to 34 years
PHHSBG Funding: $40,000 will be utilized by the Infectious Disease Program to contract laboratory services that provide tests for STDs at selected clinics. The services will provide increased access to Disease Intervention Specialists (DIS) and report results in order to facilitate follow-up with people who are infected, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission. Douglas County Health Department STD staff will offer tests and DIS services as well as risk reduction and prevention strategies.

Program: Injury Prevention
National Health Objective: IVP-1 Total Injury
Nebraska Health Objective: Reduce the number of traumatic brain injuries requiring emergency department visits and hospitalization
PHHSBG Funding: $36,000 will be utilized by the DHHS Injury Prevention Program to provide education, awareness and technical support to the public, partners, school districts, hospitals and local health departments across the state. The program will also provide subawards to Safe Kids programs to address and reduce injury.

Program: Injury Prevention
National Health Objective: IVP-2 Traumatic Brain Injury
Nebraska Health Objective: Reduce the number of traumatic brain injuries requiring emergency department visits and hospitalization

PHHSBG Funding: $36,146 will be utilized by the DHHS Injury Prevention Program to reduce the number of traumatic brain injuries requiring emergency department visits and the number of traumatic brain injuries requiring hospitalization. The Injury Prevention Program will:

- Partner with the Brain Injury Alliance of Nebraska to maintain a statewide Concussion Coalition to provide and guide concussion education, awareness and prevention across the state; and
- Provide and administer subawards to up to four local Safe Kids coalitions to conduct injury prevention programming to reduce traumatic brain injuries in children and youth.

Program: Injury Prevention
National Health Objective: IVP-9 Poisoning Deaths
Nebraska Health Objective: Reduce poisoning deaths in Nebraska, especially those related to prescription drugs
PHHSBG Funding: $37,130 will be utilized by the DHHS Injury Prevention Program to provide subawards to at least one partner entity to administer injury prevention programs aimed at reducing unintentional poisonings in children and adults, provide technical assistance to subrecipients about evidence-based interventions to reduce unintentional poisonings and, where applicable, conduct evaluation to determine reach and behavior change as a result of the funded programming.

Program: Injury Prevention
National Health Objective: IVP-16 Age-Appropriate Child Restraint Use
Nebraska Health Objective: Increase observed use of child restraints in Nebraska
PHHSBG Funding: $74,507 will be utilized by the DHHS Injury Prevention Program to provide child passenger safety training and technical assistance and coordinate Safe Kids Nebraska Child Care Transportation Training. Among the activities are:

- Conducting National Traffic Safety Administration child passenger trainings;
- Conducting meetings with the Nebraska Child Passenger Safety Advisory Committee;
- Providing technical assistance to DHHS Children and Family Services Division trainers, child passenger safety technicians and child care providers regarding child passenger safety;
- Providing subawards to local technicians to conduct child passenger safety seat checks;
- Updating the Safe Kids Nebraska Child Care Transportation Training to reflect emerging best practices in safely transporting children; and
- Providing information, education and technical assistance in response to requests for best practice child passenger safety programming and effective evaluation methods.

Program: Injury Prevention
National Health Objective: IVP-23 Deaths from Falls
Nebraska Health Objective: Reduce the age-adjusted death and injury rates from falls
PHHSBG Funding: $117,351 will be utilized to provide education about older adult falls and to establish and sustain Tai Chi and Stepping On programs. Activities will include:

- Providing local public health departments and community partners with education about older adult falls and evidence-based practices to help reduce them;
- Providing training and resources to conduct Tai Chi and Stepping On classes;
- Participating in National Older Adult Falls Prevention Day;
- Conducting Tai Chi training for new instructors and continuing education for current instructors; and
- Promoting the use of STEADI as one means to help older adults maintain their independence.

Program: Injury Prevention
National Health Objective: V-1 Vision Screening for Children
Nebraska Health Objective: improve access to and increase vision screenings for children
PHHSBG Funding: $25,000 will be utilized to gather and analyze data related to vision screenings for children, to develop a standardized process for school based vision screenings, develop eye care referral workflow patterns and expand collaboration with eye care providers and primary care providers. The DHHS Injury Prevention program will provide technical assistance and evaluation for the project.

Program: Oral Health
National Health Objective: OH-8 Dental Services for Low-Income Children and Adolescents
Nebraska Health Objective: provide subawards to at least three local health agencies to provide oral screenings, fluoride varnish treatments, education and referrals to dental homes
PHHSBG Funding: $139,616 will be utilized to provide subawards to local health departments and FQHCs to provide oral screenings, fluoride varnish treatments, education and referral to a dental home to children and their families. Primary focus locations will be WIC and related programs that provide services for new mothers, their children and families; and Early Head Start and preschool classes for children aged 2-3 years and Head Start classes for children aged 4-5 years. Services will be provided by Registered Dental Hygienists with a Public Health Authorization.

Program: Oral Health
National Health Objective: OH-16 – Oral and Craniofacial State-Based Health Surveillance System
Nebraska Health Objective: develop and activate one oral health surveillance framework for Nebraska, conduct oral health survey and assess use of emergency departments for oral health care
PHHSBG Funding: $139,846 will be utilized to develop the oral health surveillance concept plan, including working with the Association of State and Territorial Dental Directors (ASTDD) and the Council of State and Territorial Epidemiologists (CSTE). The Oral Health and Dentistry program (OOHD) will also conduct its first ever oral health survey of older adults to obtain essential baseline data for this population.

Finally, at the request of the Preventive Health Advisory Committee, the OOHD will assess the use of emergency departments for treatment of dental conditions, with the goal of understanding the need for improved patient care coordination in the future.

Program: Public Health Infrastructure
National Health Objective: C-1 Overall Cancer Deaths
Nebraska Health Objective: Impact cancer mortality and incidence on a wide variety of topics
PHHSBG Funding: $100,000 will be utilized to provide subawards to local health departments, federally qualified health centers, tribal organizations, 501 c 3s and American College of Surgeons Commission on Accredited Cancer Centers. Organizations will be offered the opportunity to apply for funding to implement one of the listed evidence-based activities in the Nebraska Cancer Plan. DHHS will provide technical assistance/subject matter expertise and will provide some data support as part of this project.

Program: Public Health Infrastructure
National Health Objective: PHI-7 National data for Healthy People 2020 Objectives
Nebraska Health Objective: maintain at least one comprehensive state-level health data surveillance system, sustaining the capacity for collection and analysis of needed health data on all populations for use in development of health status indicators
PHHSBG Funding: $381,418 will be utilized by DHHS staff to maintain a comprehensive state-level health data surveillance system and sustain the capacity for collection and analysis of health data. The DHHS Epidemiology and Informatics Unit will gather, analyze and report data; develop and enhance Nebraska's public health informatics infrastructure; and provide technical support, mapping, geocoding and updates through the Nebraska Public Health Geographic Information System (GIS). All activities are meant to support the goal of DHHS remaining the trusted source of health data in Nebraska.

Program: Public Health Infrastructure
National Health Objective: PHI-17 Accredited public health agencies
Nebraska Health Objective: DHHS and up to 18 local health departments will develop and/or maintain health improvement plans and will prepare for or maintain accreditation from the Public Health Accreditation Board
PHHSBG Funding: $732,181 will be utilized to support coalition members and partners to implement key strategies from the SHIP; maintain the State's public health accreditation; provide support for local health departments as they prepare for and maintain accreditation; and provide training and educational resources on topics related to core public health competencies, based on perceived need.

Program: Worksite Wellness Program
National Health Objective: ECBP-8 Worksite health promotion programs
Nebraska Health Objective: Improve the overall health of Nebraska adults through their places of employment
PHHSBG Funding: $90,000 will be utilized by DHHS to provide sub-awards to two of three worksite wellness councils to conduct evidence-based health promotion activities for workers and to develop sustainability and communications plans.

Administrative Costs
Nebraska equates "Administrative Costs" with "indirect costs" which are charged against salary and fringe benefits of the staff supported by the PHHSBG funds in accordance with the State's current federally approved Indirect Cost Rate of 32.6%. Nebraska does not exceed the cap of 10% imposed on Administrative Costs. DHHS uses the funds to support efficient operation of the PHHSBG through provision of legal services, personnel services, information technology services, office space, utilities, printing, phone, building and equipment maintenance.

Workforce development activities may be supported with administrative costs, including training related to grants management and monitoring, subject matter expertise and attendance at the PHHS annual meeting for block grant coordinators. For FY18, $273,790 is allocated for Administrative Costs, or 10% of the basic award.

Nebraska DHHS Administrators, Project Leads and PHHSBG Coordinator are confident that the current and planned use of funds allocated to Nebraska align with the principles and standards for PHHS Block Grantees. PHHSBG funds support Nebraska's preventive health efforts by:

- Building capacity for state and local health agencies;
- Maintaining accreditation for the state health department and encouraging and providing technical assistance for local health department accreditation;
- Building capacity for epidemiology and informatics;
- Setting priorities through the use of data and strengthened program impact and evaluation of outcomes;
- Strengthening capacity to collect minority health data and utilize alternative public health workforce to move toward equity in health status in Nebraska;
- Emphasizing primary prevention of chronic disease, infectious disease and injury;
- Building community clinical linkages and addressing chronic disease self-management through cross-cutting programs;
- Targeting primary and secondary prevention to disparately affected populations, including support of clinical testing and expanding oral health initiatives;
- Ensuring that existing and planned interventions employ evidence-based best or promising practices;
- Building the capacity of worksite wellness councils to increase involvement of businesses of all sizes in protecting the health of their workers; and
- Increasingly emphasizing the monitoring of program progress to track impact/outcomes and financial accountability.

Funding Priority: Under or Unfunded, Data Trend, State Plan (2017)

Statutory and Budget Information

Statutory Information

Advisory Committee Member Representation:

- Advocacy group
- Community-based organization
- County and/or local health department
- Drug and/or alcohol organization
- Foundation
- Hospital or health system
- Mental health organization
- Minority-related organization
- Schools of public-health
- Senior/adult serving organization
- State health department
- State or local government
- Transportation organization

Dates:

Public Hearing Date(s):	Advisory Committee Date(s):
5/15/2018	3/7/2018
	5/15/2018
	6/12/2018

Current Forms signed and attached to work plan:

Certifications: Yes
Certifications and Assurances: Yes

Budget Detail

Budget Detail for NE 2018 V0 R0	
Total Award (1+6)	$2,778,738
A. Current Year Annual Basic	
1. Annual Basic Amount	$2,737,903
2. Annual Basic Admin Cost	($273,790)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$2,464,113
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$40,835
7. Sex Offense Admin Cost	($4,083)
(8.) Sub-Total Sex Offense Set Aside	$36,752
(9.) Total Current Year Available Amount (5+8)	$2,500,865
C. Prior Year Dollars	
10. Annual Basic	$2,527,441
11. Sex Offense Set Aside (HO 15-35)	$40,835
(12.) Total Prior Year	$2,568,276
13. Total Available for Allocation (5+8+12)	$5,069,141

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$2,464,113
Sex Offense Set Aside	$36,752
Available Current Year PHHSBG Dollars	$2,500,865
B. PHHSBG $'s Prior Year:	
Annual Basic	$2,527,441
Sex Offense Set Aside	$40,835
Available Prior Year PHHSBG Dollars	$2,568,276
C. Total Funds Available for Allocation	$5,069,141

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
Emergency Health Systems - Time Sensitive Emergencies	HDS-3 Stroke Deaths	$10,000	$95,500	$105,500
	HDS-19 Timely Artery-Opening Therapy	$27,466	$0	$27,466
	IVP-1 Total Injury	$57,534	$0	$57,534
Sub-Total		**$95,000**	**$95,500**	**$190,500**
Health Disparities & Health Equity Program	ECBP-11 Culturally Appropriate Community Health Programs	$284,850	$343,953	$628,803
Sub-Total		**$284,850**	**$343,953**	**$628,803**
Infectious Disease Program	HIV-13 Awareness of HIV Serostatus	$30,962	$10,000	$40,962
	IID-27 Awareness of Hepatitis C Infection Status in Minority Communities	$39,106	$0	$39,106
	STD-1 Chlamydia	$40,000	$46,576	$86,576
	STD-6 Gonorrhea	$40,000	$35,000	$75,000
Sub-Total		**$150,068**	**$91,576**	**$241,644**
Injury Prevention Program	IVP-1 Total Injury	$36,000	$92,000	$128,000
	IVP-2 Traumatic Brain Injury	$36,146	$92,000	$128,146
	IVP-9 Poisoning Deaths	$37,130	$7,130	$44,260
	IVP-16 Age-Appropriate Child Restraint Use	$74,507	$73,122	$147,629
	IVP-23 Deaths from Falls	$117,351	$101,000	$218,351
	IVP-40 Sexual Violence (Rape Prevention)	$61,752	$102,587	$164,339

	V-1 Vision Screening for Children	$25,000	$0	$25,000
Sub-Total		**$387,886**	**$467,839**	**$855,725**
Oral Health Program	OH-8 Dental Services for Low-Income Children and Adolescents	$139,616	$171,083	$310,699
	OH-16 Oral and Craniofacial State-Based Health Surveillance System	$139,846	$57,333	$197,179
Sub-Total		**$279,462**	**$228,416**	**$507,878**
Public Health Infrastructure Program	C-1 Overall Cancer Deaths	$100,000	$80,000	$180,000
	PHI-7 National Data for Healthy People 2020 Objectives	$381,418	$425,418	$806,836
	PHI-17 Accredited Public Health Agencies	$732,181	$755,574	$1,487,755
Sub-Total		**$1,213,599**	**$1,260,992**	**$2,474,591**
Worksite Wellness Program	ECBP-8 Worksite Health Promotion Programs	$90,000	$80,000	$170,000
Sub-Total		**$90,000**	**$80,000**	**$170,000**
Grand Total		**$2,500,865**	**$2,568,276**	**$5,069,141**

Program, Health Objectives

State Program Title:

Emergency Health Systems - Time Sensitive Emergencies

State Program Strategy:

Program Goal: The PHHS Block Grant-funded Emergency Health Systems Program is dedicated to strengthening patient care and promoting the well-being of the citizens of Nebraska and to those who work in and visit the State of Nebraska through cooperative partnerships, education and training, establishing systems of care and technical assistance.

Health Priorities: According to the CDC, three of the five top five leading causes of death are related to time sensitive emergencies. The three that meet the requirements of a time sensitive emergency and that Nebraska will address are

- Heart Disease (leading cause)
- Accidents (4th leading cause)
- Stroke (5th leading cause)

The American Stroke Association predicts a 24% increase in the prevalence of stroke between 2010 and 2030. The total costs related to stroke in Nebraska has increased from $54,000,000 to $108,000,000 between 2001 and 2010, with the average cost of a stroke hospitalization being $31,000 to $38,600. The American Heart Association's current research approximates that by 2035 the costs related to Heart Disease will double to $1.1 trillion from $555 billion.

Trauma (injuries) are the fourth leading cause of death and are second to cancer for years of potential life lost according to Nebraska Department of Health and Human Service report "Injury in Nebraska 2009-2013." Heart disease, accidents and stroke require a trained and responsive system of care that includes Dispatch, Emergency Medical Services, Critical Access Hospitals and definitive care hospitals.

The best outcome for a person who is experiencing a cardiac event, traumatic event or stroke is early and rapid identification, diagnosis and treatment in efforts to prevent death and disability. Rapid identification results in timely treatment. To facilitate timely treatment, numerous actions must fall into place. Education is critical for the public, dispatch, hospitals, and Emergency Medical Services. To ensure timely and seamless transition of care from dispatch, pre-hospital, critical access hospitals, specialty centers and rehabilitation, agencies need training regarding how to interact and utilize each other's assessments.

PHHS funding will focus on education and training for the system of care. The Office of Emergency Health Systems will partner to provide education for dispatch, EMS and Critical Access Hospitals to identify, notify and build on the prior level of cares assessment. Assessment will help reduce valuable time wasted when EMS and hospital staff do not work together in the common interest of the patient. Patients will see better outcomes and reduced disabilities. Part of the education process is the ability to evaluate a system and access data. Training will be provided to EMS providers regarding how to properly document a patient care report.

Primary Strategic Partners: Dispatch, Emergency Medical Services, Critical Access Hospitals, definitive care hospitals, specialty centers, public, critical access hospitals and rehabilitation.

Evaluation Methodology: Nebraska eNARSIS data will be used to collect information about Trauma, Stroke and STEMI alerts activated and services bypassing Critical Access Hospitals to definitive care or ALS Intercept. Data will also be used to track the number of participants. This data will be compared to show differences prior to the grant period and during/after the grant to evaluate if the education is affecting patient care. EHS will track the type of education being provided. Trauma and stroke registry

data as well as Cardiac Arrest Registry to Enhance Survival (CARES) registry data will be analyzed to show current trends and identify target areas for education and improvement.
EHS plans to begin using Nebraska eNARSIS to compare run reports to state protocol to ensure patients are receiving the proper treatment.

State Program Setting:
Community based organization, Medical or clinical site, University or college

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Sherri Wren
Position Title: Trauma Program Manager
State-Level: 30% Local: 0% Other: 0% Total: 30%

Total Number of Positions Funded: 1
Total FTEs Funded: 0.30

National Health Objective:

HO HDS-3 Stroke Deaths

State Health Objective(s):
Between 10/2018 and 09/2019, DHHS will provide Stroke System of Care training and education to dispatchers, EMS Services, critical access hospitals and the public. DHHS will work in collaboration with Nebraska Stroke Advisory Council (NSAC) and the Primary and Comprehensive Hospital stroke regions to incorporate a triage, treatment and transport plan that will help reduce the morbidity of stroke patients.

Baseline:
The objective baseline will be an analysis of EMS and hospital stroke activations prior to receiving the training and after implementation of the Stroke System of Care Training.

Data Source:
Nebraska eNARSIS database and hospital discharge data.

State Health Problem:

Health Burden:
Nebraska had 876 stroke related deaths in 2010. The rate is 40.5 higher than the national average of 39.1. This also accounts for $118 million in hospital charges. These charges do not account for the continued health care needs, rehabilitative services, or skilled nursing needs for stroke patients. The incidence of stroke is expected to increase 24% from 2010 to 2030, bringing with it the increased costs.

Target Population:
Number: 1,881,503
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,881,503
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census Bureau, 2014 population estimate

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: American Stroke Association Stroke Guidelines

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $10,000
Total Prior Year Funds Allocated to Health Objective: $95,500
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Stroke Deaths Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Provide Stroke System of Care Training
Between 10/2018 and 09/2019, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems in collaboration with NSAC will provide stroke system of care training to **a minimum of 25** hospitals and the all the EMS services that transport to the respective critical access hospital.

Annual Activities:
1. Target Hospitals and EMS services within Stroke Regions
Between 10/2018 and 09/2019, Nebraska Emergency Health Systems will work with primary stroke centers to target hospitals and EMS services in their respective areas to receive stroke system of care training.

2. Collaborate with NSAC to Provide Training
Between 10/2018 and 09/2019, Nebraska Emergency Health Systems Program will work in conjunction with NSAC to provide training to hospitals and EMS services on stroke system of care training and data collection.

3. Provide Training
Between 10/2018 and 09/2019, Nebraska EHS Program will provide training for the EMS and hospitals.

Objective 2:
Public Education Campaign
Between 10/2018 and 09/2019, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems (EHS) in collaboration with Nebraska Stroke Advisory Council and American Stroke

Association will develop **2** public education campaigns to identify the signs and symptoms of a stroke and the proper timely response if a stroke is suspected.

Annual Activities:

1. Collaborate with NSAC and ASA for Stroke Public Education

Between 10/2018 and 09/2019, EHS will work with NSAC and ASA to coordinate public education materials to be distributed through a variety of media outlets.

2. Distribute Public Education Materials

Between 10/2018 and 09/2019, EHS Program will work with NSAC and ASA to distribute through media outlets the educational materials.

National Health Objective:

HO HDS-19 Timely Artery-Opening Therapy

State Health Objective(s):

Between 10/2018 and 09/2019, DHHS will improve STEMI education to EMS Services within the state and train CAH on the importance of using field acquired 12-Leads. To enhance STEMI Care, DHHS will maintain its subscription to CARES for the collection and use of STEMI and outcome data.

Baseline:

The objective baseline will be an analysis of EMS STEMI activations and documentation of the transmission of 12-Leads prior to receiving the training and after training on the acquisition of field 12-leads and bypass protocols. DHHS will run baseline reports in CARES and compare after hospitals and EMS Services have received continuing education.

Data Source:

Nebraska eNARSIS database, CARES Registry

State Health Problem:

Health Burden:

Nebraska has Heart disease is the number one cause of death in Nebraska with over 17,663 hospital admissions in 2010. Heart disease also cost over $709 million in 2010. . This project will help reduce the delays in receiving care for ST Elevation Myocardial Infarction, which will reduce recovery time as well as long-term disability.

Target Population:

Number: 1,881,503
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:

Number: 1,881,503
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other

Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census Bureau, 2014 population estimate

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: American Heart Association Mission LifeLine STEMI Response.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $27,466
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Timely Artery-Opening Therapy Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Data Collection and Use
Between 10/2018 and 09/2019, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems (EHS) will collect **5** elements of cardiac arrest data from hospitals and respective EMS services for the CARES Registry.

Annual Activities:
1. Target EMS services to obtain, transmit and use 12-Leads
Between 10/2018 and 09/2019, Nebraska Emergency Health Systems will work with EMS services to provide education on obtaining, transmitting and using 12-leads.

2. Target Critical Access Hospitals on the receiving and use of pre-hospital 12-leads
Between 10/2018 and 09/2019, Nebraska EHS Program will provide training to Critical Access Hospitals on the receipt of pre-hospital 12-leads and how to make patient care decisions such as bypass or pre-arrange Advanced Life Support transport based on the 12-lead.

Objective 2:
Provide STEMI System of Care Training
Between 10/2018 and 09/2019, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems will provide STEMI education to **10** trauma hospitals, providers, nurses and EMS services.

Annual Activities:
1. Data Collection and Use
Between 10/2018 and 09/2019, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems (EHS) will work with hospitals and EMS services on the collection of data for the CARES Registry, which will help determine if positive patients outcomes are being increased.

2. Collaborate with hospitals and EMS Agencies for data collection and reporting
Between 10/2018 and 09/2019, EHS will work with hospitals and EMS Services to collect and utilize CARES Registry information to promote positive patient outcomes.

National Health Objective:

HO IVP-1 Total Injury

State Health Objective(s):

Between 10/2018 and 09/2019, DHHS will evaluate Nebraska Trauma Registry and the Trauma Quality Improvement Program (TQIP) data regarding trauma-related deaths and provide trauma education to hospitals, Trauma Nurse Managers, Trauma Registry Staff and EMS Services to help reduce injury deaths utilizing proper trauma system of care training and documentation.

Baseline:
The objective baseline will be an analysis of Nebraska Trauma Registry data to determine the current trauma trends. This data will then be used to educate the Nebraska Trauma System of Care.

Data Source:
Nebraska Trauma Registry and Trauma Quality Improvement Program databases.

State Health Problem:

Health Burden:
Nebraska has started to see a steady rate in the number of injury deaths since 2013, increasing from 51.5 deaths per 100,000 of population to 56.5 deaths per 100,000 of population. PHHS funding will give DHHS the ability analyze why there is an increase in the number of deaths and provide the Trauma System of Care with the education needed to help decrease and improve patient care.

Target Population:
Number: 1,881,503
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,881,503
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census Bureau, 2014 population estimate

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Trauma Quality Improvement Program is a shared best practice with the goal of Trauma System quality improvement.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $57,534
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Total Injury Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Analyze Trauma Data
Between 10/2018 and 09/2019, Nebraska Emergency Health Systems will participate in the Trauma Quality Improvement Program will analyze **4** Level I and Level II Trauma Hospitals.

Annual Activities:
1. Participate in the Trauma Quality Improvement Program (TQIP)
Between 10/2018 and 09/2019, Nebraska Emergency Health Systems will participate in the Trauma Quality Improvement Program by subscribing to the program and performing data analysis of all Level I and Level II Trauma Hospitals.

2. Analyze Data from Nebraska Trauma Registry and TQIP
Between 10/2018 and 09/2019, Nebraska EHS Program and stakeholders will analyze data from the Trauma Registry and TQIP data systems to determine what the educational needs are for Nebraska Trauma Hospitals, providers, nurses and EMS providers.

Objective 2:
Trauma Education
Between 10/2018 and 09/2019, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems (EHS) will provide trauma education to **6** Nebraska Trauma Hospitals, providers, nurses or EMS providers.

Annual Activities:
1. Provide education to Trauma Hospitals, Providers, Trauma Nurses and EMS Agencies
Between 10/2018 and 09/2019, EHS will work with the Trauma System of Care to provide trauma leadership development training, trauma registry training and trauma education to trauma hospitals, providers, Trauma Nurses and EMS Services.

State Program Title:

Health Disparities & Health Equity Program

State Program Strategy:

Program Goal: The PHHS Block Grant-funded Health Disparities and Health Equity Program is dedicated to reducing disparities in health status among racial and ethnic minorities and vulnerable populations residing in Nebraska.

Health Priorities:
- Identify disparities among racial and ethnic minorities;
- Increase awareness of health disparities;
- Establish and maintain behavioral risk surveillance system for sub-groups of minority populations and refugees;
- Improve access to culturally competent and linguistically appropriate health services for racial and ethnic minorities and vulnerable populations;
- Improve data collection strategies for racial, ethnic and other vulnerable populations; and
- Expand community-based health promotion and disease prevention outreach efforts to the aforementioned populations.

Specifically, the PHHS Block Grant-funded activities help assure that community health interventions and health promotion services are culturally tailored and linguistically appropriate in order to reduce health disparities.

Primary Strategic Partners: Minority Health Initiative grantees, the Statewide Minority Health Council, local health departments, health care providers, community- and faith-based organizations, American Indian tribes, Public Health Association of Nebraska, and the University of Nebraska at Lincoln (UNL).
Evaluation Methodology: The Minority Health program evaluation plan will be guided by the impacts and outcomes outlined in the Strategic Framework for OMH: Improving Racial and Ethnic Minority Health and Eliminating Racial and Ethnic Health Disparities (OMH Strategic Framework). The Minority Health program evaluation activities will employ both process and outcome evaluation methods.

Process evaluation will be conducted, as appropriate, prior to an activity's initiation in order to ensure that the activity can be successfully implemented as planned. The Office of Health Disparities and Health Equity (OHDHE) will track all the activities monthly, including number of presentations, number of participants, location of participants, demographic info of participants, invitation and attendance records, the status and dissemination of reports.

Outcome evaluations create an overall picture of program success, and they are used to document short-term results. Pre- and post-test methods will be used to measure participant changes in knowledge, attitudes, beliefs, or behaviors as a result of health disparities presentations, chronic disease presentations and cultural intelligence and social determinants trainings. Participant satisfaction surveys will be used for community-based outreach activities for minorities.

Performance measures/indicators:

SHIP plan completed
Of SHIP training completed
of Tribe education events completed
# of refugee BRFSS data sets created
# of refugee BRFSS reports completed
# of Karen refugee community resource brochures created
# of health related brochures translated in Karen
# of health related brochures printed for Karen community

# of health equity stakeholder meetings completed
# of CLAS trainings and P3 trainings completed
# of minority population growth presentations completed
# of disparity presentations completed
% of participants who indicated knowledge increased about minority population growth and health disparities among minorities
% of participants who indicated knowledge increased about CLAS & social determinants
% of stakeholders who indicated satisfaction with Health Equity Plan meetings
% of participants who indicated satisfaction with minority population growth and health disparity presentations and % of participants who indicated satisfaction with CLAS standard, social determinants and P3 trainings
# of key social economics disparity identified
# of key chronic disease disparities identified and # of key risk factors identified

State Program Setting:
Community based organization, Local health department, State health department, Tribal nation or area, Other: Refugee community

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective:

HO ECBP-11 Culturally Appropriate Community Health Programs

State Health Objective(s):

Between 10/2017 and 09/2019, Identify at least 20 of the most critical health disparities and health needs among racial ethnic minorities in Nebraska. Based on identified disparities and needs, work to equalize health outcomes and reduce health disparities through information and education of public health and other stakeholders who serve these populations. Compose a State Health Equity Plan as a method of working towards reducing health disparities.

Health disparities must be eliminated before the health of the nation and Nebraska can be improved. These disparities are often associated with social (cultural barriers), economic (poverty), or environmental disadvantages (substandard housing) (Healthy People 2020 Objective, Chapter 1, The Role of Public Health). The Health Care Home Model (HCHM) has the potential to improve the health of the population by improving access to care (e.g., after hours care and electronic communication), and reducing health disparities (Healthy People 2020 Objective, Priority 4, Improving Population Health).

Baseline:

The following baseline data include socioeconomic data, vital statistics, and behavioral risk factor surveillance system data.

Nebraska Behavioral Risk Factor Surveillance System (BRFSS) (2011-2015)
- Hispanics (29.5%), American Indians (26.2%), and African Americans (23.6%) were more likely to perceive their health status as fair or poor, compared to non-Hispanic Whites (11.4%).
- The proportion of Hispanics who did not have a personal physician (39.8%) was approximately 2.3 times greater than that of non-Hispanic Whites (17.1%).
- Almost half of the Hispanic population (46.4%) and over one-fourth of the African American population

(29.7%) reported having no health care coverage, compared to only 12.6% of non-Hispanic Whites.
- The proportion of American Indians who were current smokers (37.9%) was almost twice that of non-Hispanic Whites (19.0%).
- American Indians (43.3%) were more likely to be obese, compared to non-Hispanic Whites (29.1%)
- Both American Indians (15.8%) and African Americans (13.7%) reported higher rates of diabetes compared to non-Hispanic Whites (7.6%).
- The proportion of Hispanics (33.8%) who did not participate in physical activities outside of work was 1.5 times greater than that of non-Hispanic Whites (21.7%).

Nebraska DHHS Vital Statistics (2011-2015)
- African Americans (46.3 per 100,000) reported higher rates of stroke mortality than did non-Hispanic Whites (34.8 per 100,000).
- African Americans (13.4 per 1,000 live births) reported an infant mortality rate over twice that of non-Hispanic Whites (5.8 per 1,000 live births).
- American Indians reported the highest alcohol-related mortality rate (86.9 per 100,000), which was nearly three times greater than that of non-Hispanic Whites (31 per 100,000).
- African Americans (50.5 per 100,000) and American Indians (53.4 per 100,000) reported the highest rates of diabetes mortality among all racial and ethnic minority populations, compared to non-Hispanic Whites (21.2 per 100,000).
- The death rate due to homicide among African Americans (28.8 per 100,000) was 13 times greater than that of non-Hispanic Whites (2.2 per 100,000).
- The drug-induced death rate among American Indians (16.5 per 100,000) was over twice that of non-Hispanic Whites (7.7 per 100,000).
- The death rate due to chronic lung disease was 1.3 times greater among American Indians (61.7 per 100,000), compared to non-Hispanic Whites (46.5 per 100,000).

American Community Survey (2011-2015)
- The proportions of American Indians (40.5%) and African Americans (30.9%) living in poverty were much higher than that of non-Hispanic Whites (10.9%).
- American Indians (17.5%) were over four times more likely to be unemployed, compared to non-Hispanic Whites (4.1%). African Americans (11.2%) were 2.7 times more likely to be unemployed, compared to non-Hispanic Whites.
- The Hispanic population (46.6%) was over five times more likely than the non-Hispanic White population (7.9%) to report not having a high school education.
- American Indians (9.8%) were the least likely population to report having a college education, compared to non-Hispanic Whites at 29.9%.

Data Source:

2011-2015 Nebraska Vital Statistics, 2011-2015 BRFSS, 2011-2015 U.S. Census Bureau American Community Survey.

State Health Problem:

Health Burden:
As compared to the White population of Nebraska:

Hispanics
- Teen birth rates (ages 15-19) were 2.6 times higher among Hispanics than among non-Hispanic Whites.
- The proportion of individuals who did not exercise outside of work was 1.6 times greater among Hispanics (33.8%) than among non-Hispanic Whites (21.7%).
- The proportion of mothers receiving inadequate prenatal care among Hispanics (25.7%) was two times higher than that of non-Hispanic White mothers (12.0%).

African Americans

- Low birth weight rates among African Americans (12.3%) were almost twice as high as among non-Hispanic Whites (6.2%).
- African Americans reported the highest cancer mortality rates among all populations (200.6 per 100,000), compared to non-Hispanic Whites (160.6 per 100,000).
- African Americans reported the highest death rate due to heart disease at 177.9 per 100,000, compared to 147.4 per 100,000 among non-Hispanic Whites.
- African Americans (29.4%) were 1.4 times more likely to not exercise outside of work, compared to non-Hispanic Whites (21.7%).

American Indian and Alaska Natives

- The death rate due to diabetes among American Indians (53.4 per 100,000) was over twice that of non-Hispanic Whites (21.2 per 100,000).
- The death rate due to homicide among American Indians (10.1 per 100,000) was 4.6 times higher than that among non-Hispanic Whites (2.2 per 100,000).
- Teen birth rates (ages 15-19) among American Indians were 3.1 times higher than among non-Hispanic Whites.

Source: Nebraska Vital Statistics (2011-2015); 2011-2015 BRFSS.

Target Population:
Number: 326,588
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 326,588
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census 2010

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)

Other: National Standards on Culturally and Linguistically Appropriate Services CLAS (US Department of Health and Human Services, Office of Minority Health.)

Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency (US Department of Health and Human Services, Office of Minority Health)

BRFSS: The guidelines for doing BRFSS surveys was developed by the CDC - Behavioral Surveillance Branch, called the Behavioral Risk Factor Surveillance System Operational and User's Guide.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $284,850
Total Prior Year Funds Allocated to Health Objective: $343,953
Funds Allocated to Disparate Populations: $160,000
Funds to Local Entities: $110,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Culturally Appropriate Community Health Programs Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Cultural Intelligence and Health Disparity Presentations
Between 10/2018 and 09/2019, OHDHE will provide presentations, trainings and outreach events regarding minority population growth, health disparities, social determinants of health, health education and cultural intelligence to **20** key stakeholders/community members/organizations to increase awareness of racial and ethnic minorities, refugees, and American Indians in Nebraska.

Annual Activities:
1. Minority Population Growth and Health Disparity Presentations
Between 10/2018 and 09/2019, OHDHE will conduct 5 health disparities presentations to stakeholders in Nebraska to increase awareness of the Nebraska minority population growth, key disparities among minorities and the factors that influence disparities and health outcomes.

2. Provide Cultural Intelligence and Social Determinants Trainings
Between 10/2018 and 09/2019, OHDHE will complete 8 social determinants of health and cultural intelligence trainings to stakeholders in Nebraska to improve access to health services for racial and ethnic minorities, refugees, and American Indians in Nebraska.

3. Provide Culturally and Linguistically Appropriate Services (CLAS) Trainings
Between 10/2018 and 09/2019, OHDHE will complete 3 trainings on Culturally and Linguistically Appropriate Services (CLAS) to stakeholders in Nebraska to advance health equity, improve quality, and help eliminate health care disparities.

4. Conduct Community-Based Outreach for Minorities
Between 10/2018 and 09/2019, OHDHE will participate in 4 community-based outreach events for racial and ethnic minorities, refugees and American Indians in Nebraska.

Objective 2:
Educational and Public Health Service for American Indians
Between 10/2018 and 09/2019, OHDHE will provide 20 public health education and prevention activities/presentations to improve the health of Americans Indians in Nebraska to **4** federally recognized tribes and organizations who have a substantial American Indian clientele.

Annual Activities:
1. Work with the Ponca Tribe to Provide Education and Public Health Services
Between 10/2018 and 09/2019, OHDHE will contract and work with Ponca Tribe of Nebraska to provide 5

public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

2. Work with Omaha Tribe to Provide Education and Public Health Services
Between 10/2018 and 09/2019, OHDHE will contract and work with Omaha Tribe of Nebraska to provide 5 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

3. Work with Winnebago Tribe to Provide Education and Public Health Services
Between 10/2018 and 09/2019, OHDHE will contract and work with Winnebago Tribe of Nebraska to provide 5 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

4. Work with Santee Sioux Tribe to Provide Education and Public Health Services
Between 10/2018 and 09/2019, OHDHE will contract and work with Santee Sioux Tribe of Nebraska to provide 5 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

Objective 3:
Minority Data Collection and Analysis
Between 10/2018 and 09/2019, the OHDHE will analyze **3** data sets and collect minority Behavioral Risk Factor data. Socioeconomic, vital statistics, and hospital discharge data will be used to identify health disparities among various racial and ethnic minority groups throughout Nebraska.

Annual Activities:
1. Analyze Data on Hepatitis B among Nebraska Minority Populations
Between 10/2018 and 09/2019, OHDHE will work with DHHS epidemiology staff to analyze and summarize data on Hepatitis B among minority groups. The analysis and summary will focus on the Asian population in Nebraska.

2. Track Minority Population Growth and Summarize Key Socioeconomic Factors for Nebraska Minorities
Between 10/2018 and 09/2019, OHDHE will identify and summarize key socioeconomic factors for all the racial ethnic minority groups in Nebraska based on US Census Bureau the latest American Community Survey (ACS) data. This data allows OHDHE staff and partners to identify important socioeconomic factors that influence the health of Nebraskans to reduce health disparities. OHDHE will also track Nebraska minority population growth using Census Population Estimates program data. This is valuable information for minority health initiative grantees, local health departments, and evidence-based chronic disease prevention programs.

3. Summarize the Latest Leading Cause of Death and Births Data
Between 10/2018 and 09/2019, OHDHE will identify the top 10 leading causes of death (i.e., cancer, heart disease, and stroke) and the related disparities between minority groups and non-Hispanic Whites based on the latest data. OHDHE will also identify the disparities between minority groups and non-Hispanic Whites related to maternal and child health (i.e., infant mortality, low birth weight). This data allows DHHS to monitor the health status of minorities and plan strategies for future interventions that target key disparities.

4. Minority Behavioral Risk Factor Surveillance Data Collection
Between 10/2018 and 09/2019, OHDHE will continue to survey minority populations using the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) in partnership with the University of Nebraska-Lincoln. Every year, eight race-related questions are added to the survey to ensure additional information from minority populations is available.

Objective 4:

Minority Reports and Report Cards

Between 10/2018 and 09/2019, OHDHE will develop **3** reports addressing disparities in socioeconomic status, health status and minority population growth.

Annual Activities:

1. Publish Nebraska Disparity Report (2018)

Between 10/2018 and 09/2019, OHDHE will publish the Nebraska Health Disparities Report, which contains the latest data to elucidate major disparities and identify targets for the State Health Equity Plan. The report will provide trend data for three five-year periods (2001-2005, 2006-2010, 2011-2015). This updated report will provide a comprehensive look at many health-related issues and concerns and the disparate outcomes experienced by some of Nebraska's historically medically underserved minority residents. Regular updates ensure the report continues to be a useful resource for policymakers, service providers, and those interested in minority health issues.

2. Complete the Socioeconomic of Health for Nebraska Minorities report card and Minority Growth report

Between 10/2018 and 09/2019, OHDHE will complete the Socioeconomic of Health for Nebraska Minorities report card based on US Census Bureau, the latest American Community Survey (ACS) data.

3. Publish Risk Factors for Nebraska LEP Population Report

Between 10/2018 and 09/2019, based on the questions OHDHE added to the 2011-2015 Nebraska BRFSS, key risk factors will be identified in a report for Nebraska's LEP populations. The report will be published in paper and disseminated at professional meetings; published on the Nebraska DHHS website; and information will be used in presentations to community members, partners, and stakeholders.

4. Publish the Risk Factors for Nebraska Immigrant (Foreign-Born) Report

Between 10/2018 and 09/2019, based on the questions OHDHE added to the 2011-2015 Nebraska BRFSS, key risk factors will be identified in a report for Nebraska's foreign born populations. The report will be published in paper and disseminated at professional meetings; published on the Nebraska DHHS website; and information will be used in presentations to community members, partners, and stakeholders.

Objective 5:

Needs Assessment for American Indians

Between 10/2018 and 09/2019, DHDHE will conduct **2** needs assessments for American Indian tribes in Nebraska. The needs assessment will use core questions from the Nebraska Behavioral Risk Factor Surveillance System (BRFSS), as well as questions from the tribes.

Annual Activities:

1. Conduct Assessment for American Indians

Between 10/2018 and 09/2019, OHDHE will conduct a needs assessment with Ponca Tribe. The needs assessment will identify key trends and behavioral risk factors in the Ponca community.

2. Conduct a needs assessment for Santee Sioux Tribe

Between 10/2018 and 09/2019, OHDHE will conduct a needs assessment with Santee Sioux Tribe. The needs assessment will identify key trends and behavioral risk factors in the Santee Sioux community.

Objective 6:

Refugee Needs Assessment Project Phase 2

Between 10/2018 and 09/2019, OHDHE will establish **3** Nebraska Refugee BRFSS data sets to identify and report Behavioral Risk Factors for refugees in Nebraska, Karen refugees in Nebraska, and the refugees served by the Asian Center in Nebraska. OHDHE will conduct 1 taskforce meeting to share the status of the statewide 2017 Refugee BRFSS survey.

Annual Activities:

1. Refugee Needs Assessment Workforce Meetings

Between 10/2018 and 09/2019, along with partners and refugee community members, OHDHE will conduct 1 taskforce meeting to share the status of the statewide Refugee BRFSS survey.

2. Complete Behavioral Risk Factors Report for Nebraska Refugees

Between 10/2018 and 09/2019, OHDHE will complete a statewide report on behavioral risk factors for refugees. Data specific to the five largest refugee population in Nebraska will be analyzed in order to identify key trends and behavioral factors in the community

3. Complete Behavioral Risk Factors Report for Karen Refugees in Nebraska

Between 10/2018 and 09/2019, OHDHE will work with the Karen Society of Nebraska to identify and report behavioral risk factors for Karen refugees in Nebraska. Data specific to Karen refugees will be analyzed in order to identify the key trends and behavioral risk factors in the Karen community. These findings will be compiled into a report.

4. Complete Behavioral Risk Factors for the Refugees in Lancaster County

Between 10/2018 and 09/2019, OHDHE will work with the Asian Center to identify and report behavioral risk factors for the refugees in Lancaster County based on the Nebraska Statewide Refugee Survey completed in 2017.

Objective 7:

Social Determinants of Health Project Focus on Refugees

Between 10/2018 and 09/2019, OHDHE will publish **5** information videos, translate at least 2 brochures, and print and distribute at least 150 documents.

Annual Activities:

1. Assist the Karen Refugee Community with Creation of Informative Videos

Between 10/2018 and 09/2019, OHDHE will partner with the Karen Society of Nebraska to make 5 information videos for the Karen community. These videos will focus on cultural issues and helping Karen individuals to more easily navigate their communities.

2. Translate Health Related Brochures into Karen

Between 10/2018 and 09/2019, OHDHE will assist in translating at least 2 health related brochures or documents into the Karen language to address the language barrier faced by many in the community.

3. Print and Distribute Health Related Documents within the Karen Community

Between 10/2018 and 09/2019, OHDHE will work with the Karen Society of Nebraska to select at least 2 health related brochures and print at least 150 copies to distribute throughout the Karen community. These documents will provide educational information aimed at increasing the community's access to healthcare and improving economic stability.

4. Complete 2 Trainings (Lunch and Learns) to the Karen Refugee Community

Between 10/2018 and 09/2019, the Karen refugee community will complete at least 2 trainings (Lunch and Learns) on what is included in the brochures that were translated and/or created and how to use the selected brochures.

Objective 8:

State Health Improvement Plan Implementation and Minority Health Conference

Between 10/2018 and 09/2019, OHDHE will conduct **2** baseline assessments regarding health equity efforts and demographic data collection capacity levels among organizations in Nebraska for SHIP Health Equity committee, provide recommendations based on the needs identified, and determine training needs and strategies to meet the organization needs.

Annual Activities:

1. Complete 2 baseline assessments with organizations in Nebraska

Between 10/2018 and 09/2019, OHDHE in collaboration with the State Health Improvement Plan Health Equity priority group, will conduct 2 baseline assessments. One baseline assessment will be to determine if organizations in Nebraska are addressing health equity. The second baseline assessment will assess the capacity or organizations on demographic data collection efforts and their readiness for change.

2. Begin writing a demographic data collection recommendation report

Between 10/2018 and 09/2019, OHDHE, in collaboration with the State Health Improvement Plan Health Equity Priority Data Committee data committee, will begin writing a demographic data collection recommendations report on how to collect meaningful data.

3. Develop a healthy equity framework and language document

Between 10/2018 and 09/2019, OHDHE, in collaboration with the State Health Improvement Plan Health Equity Priority Organizational Capacity group, develop a standardized framework and language document to assist organizations in using consistent health equity terminology.

4. Nebraska Annual Minority Health Conference

Between 10/2018 and 09/2019, OHDHE will hold a Minority health Conference in 2019. Health equity presentations and trainings will be provided at the Minority Health Conference to support the improvement of organizational capacity among public health and other stakeholders in Nebraska

State Program Title:

Infectious Disease Program

State Program Strategy:

State Program Strategy:
Program Goal: The PHHS Block Grant-funded Infectious Disease Program (IDP) is dedicated to limiting infection with Hepatitis C Virus (HCV), two sexually transmitted diseases (STDs)—chlamydia and gonorrhea, as well as human immunodeficiency virus (HIV) in Nebraska. IDP provides free testing of samples at selected sites for residents of Nebraska who are at risk of infection with HCV, HIV and STDs. Subsidizing the cost of laboratory testing makes testing accessible to all, increases awareness of disease status and ultimately helps prevent the spread of infection.
Sites are identified where higher risk populations are more likely to be served. Higher risk is defined by the STD Program as adolescents and young adults aged 15 to 34 and black females. Higher risk is defined for the HIV/AIDS Program as men who have sex with other men (MSM), heterosexual contact with a person known to be at risk for HIV infection, and injection drug use (IDU). For the Hepatitis Program, recommendations for birth cohort testing is defined as persons born in the years 1945-1965, and high risk is defined as persons who: currently or have ever injected drugs; received a transfusion of blood, blood components, or organ transplant prior to 1992; have HIV infection; have history of tattoo from an unregulated setting; history of incarceration; and/or born to an HCV infected mother.
The Infectious Disease Program helps to accomplish the goals of three statewide disease control programs:

- DHHS Sexually Transmitted Disease Program aims to control and prevent the transmission of STDs and reduce the disease burden and cost of treating infections. By identifying cases among high risk populations at public clinics, the overall rate of infection will be reduced.
- DHHS HIV Prevention Program aims to lower HIV infection, illness and death rates and create an environment of leadership, partnership and advocacy that fosters HIV prevention and the provision of services. By identifying cases among high risk populations, providing counseling and testing sites and related services, the overall rate of infection will be reduced.
- DHHS Viral Hepatitis Program aims to increase the proportion of persons aware of their hepatitis C infection and reduce new hepatitis C infections. By screening and identifying cases among baby boomers and high risk populations and providing health counseling and referrals, the overall rate of infection will be reduced.
-

Health Priorities:
HCV
- In 2017, 1,113 (rate 58.0) newly reported hepatitis C infections were identified in Nebraska.

STDs:
- Chlamydia is the most common STD in Nebraska, accounting for 7,970 cases in 2015.
- Gonorrhea is the second most common STD in Nebraska, accounting for 1,704 cases in 2015.
-

Primary Strategic Partnerships:

HCV: Local health departments, Federally Qualified Health Centers, public and community based centers/organizations. Contractor: Nebraska Public Health Laboratory (NPHL).
STDs: STD clinics, family planning facilities, correctional centers, student health centers, Indian Health Services, substance abuse centers and other medical facilities seeing persons with high-risk behaviors. Contractor: Nebraska Public Health Laboratory at the University Nebraska Medical Center (UNMC).
HIV/AIDS: Local health departments, Title X Family Planning Clinics, public health centers, correctional facilities, community-based organizations which provide HIV counseling and testing services across the state of Nebraska. Contractors: Nebraska Public Health Laboratory at UNMC, Heritage Laboratories in Kansas, Center for Disease Detection in Texas.

Evaluation Methodology:
Progress is tracked through the following means:

HCV: Monitoring and evaluation of current practices with testing sites for compliance/effectiveness of implementation of risk based and birth cohort testing. This includes tracking of screening per formal reporting process, confirmatory testing (utilizing NPHL ELIRT system and Nebraska NEDSS system), and referrals.

STDs: Monitoring performance of laboratory contractor through reports and billing, calculation of rates using U.S. Census figures for comparison, calculation of cost benefit using CDC formula.

HIV/AIDS: Monitoring performance of laboratory contractors through lab testing documents and billing, and clinic patient service forms, generating data using Counseling and Testing (CTS) and Program Evaluation and Monitoring System (PEMS).

State Program Setting:
Community based organization, Community health center, Faith based organization, Local health department, Medical or clinical site, Rape crisis center, Tribal nation or area, University or college, Work site, Other: Corrections facilities, libraries, community events

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective:

HO HIV-13 Awareness of HIV Serostatus

State Health Objective(s):
Between 10/2018 and 09/2019, increase the percentage of high-risk persons tested for HIV/AIDS to at least 75% of total tests performed.

Baseline:
Of the 9,766 tests performed in 2012, 71% involved high-risk persons.

Data Source:
Nebraska's HIV Prevention Counseling, Testing and Referral Program.

State Health Problem:

Health Burden:
- **HIV/AIDS Incidence:** During 2013, 834 new cases of HIV/AIDS were diagnosed, reflecting an incidence rate of 4.5 cases per 100,000 population.
- **Prevalence:** At the end of 2013, 2,468 Nebraska residents were known to be people living with HIV/AIDS (PLWHA).
- **Overall AIDS Trends:** From 2005 to 2013, a total of 589 incident AIDS cases were diagnosed among Nebraska residents. Since reporting of AIDS cases began in 1983, the number of cases per year rapidly increased, reaching a peak of 99 cases in 1992. The number of AIDS cases remained stable from 1992 through 1995. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply. The sharp decline is primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure,

but can delay progression to AIDS among persons with HIV (non-AIDS) and improve survival among those with AIDS. Since 1998, the number of reported AIDS cases in Nebraska has averaged 65.4 cases per year.

Target Population:
Number: 6,500
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,500
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: EvaluationWeb and Enhanced HIV/AIDS Reporting System (eHARS)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Confirmation testing for HIV follows the process outlined by the Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings, published by CDC, MMWR, September 22, 2006/55 (RR14); 1-17.

HIV counseling, testing and referral services follow the Revised Guidelines for HIV Counseling, Testing and Referral: Technical Expert Panel Review of CDC HIV Counseling, Testing and Referral Guidelines, published by the CDD MMWR, November 9, 3001/50 (RR19); 1-58.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $30,962
Total Prior Year Funds Allocated to Health Objective: $10,000
Funds Allocated to Disparate Populations: $30,962
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
Less than 10% - Minimal source of funding

Awareness of HIV Serostatus Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
HIV lab testing
Between 10/2018 and 09/2019, the HIV Program, through contracting laboratory services and purchase of rapid test kits, will conduct **800** tests. The HIV Program will provide anonymous and confidential HIV testing at no cost to the client in order to facilitate follow-up with people who are infected and providing increased access to Disease Intervention Specialists at selected clinics that serve the target population

(MSM, IDU). The aim is to assure change in risk behaviors and prevention of additional transmission of infection.

Annual Activities:
1. HIV Samples Tested
Between 10/2018 and 09/2019, contract for laboratory testing on samples, including those serving the target population (MSM and IDU). Number of tests to be completed:
4 HIV Confirmatory tests at $94 per test
800 Rapid Tests at $12 per test.

National Health Objective:

HO IID-27 Awareness of Hepatitis C Infection Status in Minority Communities

State Health Objective(s):
Between 10/2018 and 09/2019, increase from baseline to 40% the proportion of Nebraskans who are aware they have a hepatitis C infection.

Baseline:

At this time, there is no surveillance system in Nebraska to determine the statewide baseline for this objective. The Epidemiology and Surveillance Unit of the Division of Public Health lists HCV surveillance as a priority for the next three to five years.
For the U.S., 53.0 percent of National Health and Nutrition Examination Survey respondents who tested positive for chronic hepatitis C reported that they were aware of their hepatitis C infection prior to the laboratory confirmation in 2003-08. No state specific data available from NHANES.

The DHHS Viral Hepatitis Program implemented a hepatitis C testing initiative pilot project. Data obtained from two testing sites (tests completed from March 1, 2017 - October 31, 2017), show estimates of: 32.7 % of those at risk (birth cohort, IDU, history of incarceration and unregulated tattoos) were tested at site one: 9.3% of those at risk (birth cohort only) were tested at site two.

Data Source:
National Health and Nutrition Examination Survey (NHANES), CDC/NCHS, DHHS Viral Hepatitis Program

State Health Problem:

Health Burden:
Using CDC's national estimates, approximately 1.3 to 1.9% of Nebraska's population or 24,650 to 36,028 are infected with the Hepatitis C virus. Chronic hepatitis C infection is a serious disease that can result in long-term health problems, including liver damage, liver failure, liver cancer or death. Many people with chronic hepatitis C do not have any symptoms of disease until liver problems develop. Increased access to testing will increase the number of people who are aware they are infected with hepatitis C and who will seek care and treatment for the disease

Incidence: In 2017, 1,113 (rate 58.0) newly reported hepatitis C infections were identified in Nebraska. Of those 1,113, 60% were born between 1945 and 1965. The CDC reports that 1 in 30 baby boomers – the generation born from 1945 through 1965 – has been infected with hepatitis C, and most don't know it.

Target Population:
Number: 744,334
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 194,334
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Specific Counties
Target and Disparate Data Sources: National Electronic Disease Surveillance System (NEDSS), American Community Survey, US Census Bureau, Centers for Disease Control and Prevention

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: American Association for the Study of Liver Diseases (AASLD)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $39,106
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Awareness of Hepatitis C Infection Status in Minority Communities Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Increase awareness of HCV infection status in populations at high risk for HCV
Between 10/2018 and 09/2019, DHHS will establish **7** partnerships to increase access to HCV testing in urban and rural settings in areas at high risk for HCV infection.

Annual Activities:
1. Establish/maintain partnership agreements for HCV testing
Between 10/2018 and 09/2019, HCV testing will be completed through partnership agreements with seven sites that provide services to populations at high risk for HCV infection.

2. Targeted screening
Between 10/2018 and 09/2019, perform 1,300 targeted screening tests for HCV antibodies following CDC, AASLD, and USPSTF guidelines., Guidelines include risk based and birth cohort screenings.

3. HCV Health Education and Counseling
Between 10/2018 and 09/2019, utilizing educational and counseling messages based on CDC and

AASLD, partnership sites will provide health education and counseling as appropriate for all receiving screening and those who require further testing and follow up medical evaluation.

4. Provide HCV Confirmatory Testing
Between 10/2018 and 09/2019, through a contractual agreement with Nebraska Public Health Laboratory, HCV confirmatory tests (96 HCV RNA tests) will be offered to those whose HCV antibody screening results in reactive. Training will be provided to partnership sites on how to collect and transport specimens and how to order and receive results of testing on NPHL's ELIRT.

5. Provide Linkage to Medical Care
Between 10/2018 and 09/2019, partners will provide appropriate linkage to medical care for those whose confirmatory test results are positive. DHHS will maintain and provide to partners a list of clinics/medical providers who accept HCV patients. The list will include clinics/providers who will provide care for those who are underinsured or uninsured

National Health Objective:

HO STD-1 Chlamydia

State Health Objective(s):

Between 10/2015 and 09/2019,
A. Reduce the prevalence of *chlamydia trachomatis* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending Family Planning clinics to no more than 6.0 percent positive.
B. Reduce the prevalence of *chlamydia trachomatis* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending STD clinics to no more than 14.0 percent positive.
C. Reduce the prevalence of *chlamydia trachomatis* infections among Nebraska's adolescent and young adult males, aged 15 to 34 years, attending STD clinics to no more than 17 percent positive.

Baseline:

Baseline and target numbers appear below:

Objective	Reduction in *Chlamydia trachomatis* infections	**2010 Baseline**	**2018 Target**
		Percent	
25-1A.	Females aged 15 to 34 years attending family planning clinics	6.0	6.0
25-1B.	Females aged 15 to 34 years attending STD clinics	15	14
25-1C.	Males aged 15 to 34 years attending STD clinics	18	17

Data Source:
Data source STD Program (STD*MIS/ELIRT)

State Health Problem:

Health Burden:
Preventing sexually transmitted diseases in clients living in disparity and in marginalized geographic locations of North Omaha, Nebraska, is difficult with only one community health center serving a densely populated metropolitan area. Reaching at-risk adolescents in North Omaha, educating them of risky

behaviors, availability of testing, treatment and partner notification, as well as prevention education is essential to reduce the spread of sexually transmitted diseases. In addition, there is a need to increase non-traditional STD testing throughout high morbidity areas within North Omaha. Opening of new outreach sites at local Omaha libraries, concerts, health fairs, and student gatherings show promise; however, there is a lack of support for focused data driven efforts in North Omaha, leaving this population underserved.

The number of Chlamydia cases for the target population and percentages of total annual positivity:

2013 -- 6,326 cases or 85% of total annual positivity
2014 -- 6,421 cases or 84.75% of total annual positivity
2015 -- 6,567 cases or 84% of total annual positivity
2016 -- 6,898 cases or 84% of total annual positivity
*2017 – 7,156 cases or 84% of total annual positivity

*These are preliminary numbers.

Target Population:
Number: 503,422
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 25,616
Ethnicity: Non-Hispanic
Race: African American or Black
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census and STD*MIS

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Other: Gen Probe package insert, CLIA, and CAP guidelines of good laboratory practice.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $40,000
Total Prior Year Funds Allocated to Health Objective: $46,576
Funds Allocated to Disparate Populations: $40,000
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Chlamydia Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Chlamydia/Gonorrhea Testing
Between 10/2018 and 09/2019, STD Program will contract laboratory services that will provide tests for STDs at selected clinics to **4,000** individuals, including adolescents and young adults, aged 15 to 34 years. The services will provide increased access to Disease Intervention Specialists (DIS); and report results in order to facilitate follow-up with people who are infected, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission. Douglas County Health Department STD staff will offer tests and DIS services as well as risk reduction and prevention strategies.

Annual Activities:
1. Chlamydia Samples Tested
Between 10/2018 and 09/2019, provide testing on samples from 131 provider sites, including those serving the target population (adolescents and young adults, aged 15 to 34). Numbers of tests to be completed:
- Chlamydia/Gonorrhea Gen Probe Amplified Tests = 3000.
- Chlamydia/Gonorrhea Gen Probe Urine Tests = 520.

National Health Objective:

HO STD-6 Gonorrhea

State Health Objective(s):

Between 10/2015 and 09/2019,
A. Reduce the prevalence of *Gonorrhea* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending Family Planning clinics to no more than 0.4 percent positive.
B. Reduce the prevalence of *Gonorrhea* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending STD clinics to no more than 5.6 percent positive.
C. Reduce the prevalence of *Gonorrhea* infections among Nebraska's adolescent and young adult males, aged 15 to 34 years, attending STD clinics to no more than 7.5 percent positive.

Baseline:

Baseline: Baseline and target numbers appear below.

Objective	Reduction in Gonorrhea infections	2015 Baseline Percent	2019 Target
25-2a.	Females aged 15 to 29 years attending family planning clinics	0.5	0.4
25-2b.	Females aged 15 to 29 years attending STD clinics	5.6	5.6
25-2c.	Males aged 15 to 29 years attending STD clinics	7.5	7.5

Data Source:
Data Source STD Program (STD*MIS/ELIRT)

State Health Problem:

Health Burden:
Preventing sexually transmitted diseases in clients living in disparity and in marginalized geographic locations of North Omaha, Nebraska, is difficult with only one community health center serving a densely populated metropolitan area. Reaching at-risk adolescents in North Omaha, educating them of risky behaviors, availability of testing, treatment and partner notification, as well as prevention education is essential to reduce the spread of sexually transmitted diseases. In addition, there is a need to increase non-traditional STD testing throughout high morbidity areas within North Omaha. Opening of new outreach sites at local Omaha libraries, concerts, health fairs, and student gatherings show promise; however, there is a lack of support for focused data driven efforts in North Omaha, leaving this population underserved.

These numbers represent the number of Gonorrhea cases for the target population and percentage of total annual positivity:

2013 -- 1,028 cases or 74% of total annual positivity
2014 -- 1,069 cases or 72% of total annual positivity
2015 -- 1,184 cases or 71% of total annual positivity
2016 -- 1,483 cases or 68% of total annual positivity
*2017 – 1,781 cases or 68% of total annual positivity
*These numbers are preliminary.

Target Population:
Number: 503,422
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 25,616
Ethnicity: Non-Hispanic
Race: African American or Black
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female
Geography: Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Other: Gen Probe package insert, CLIA, and CAP guidelines of good laboratory practice.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $40,000
Total Prior Year Funds Allocated to Health Objective: $35,000
Funds Allocated to Disparate Populations: $40,000
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Gonorrhea Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Chlamydia/Gonorrhea Testing

Between 10/2018 and 09/2019, STD Program will contract laboratory services and will provide tests for STDs at selected clinics to **4,000** individuals, including adolescents and young adults, aged 15 to 34 years. The services will provide increased access to Disease Intervention Specialists (DIS); and report results in order to facilitate follow-up with people who are infected, the aim of which is to assure change in risk behaviors and prevention of additional transmission of infection. Douglas County Health Department STD staff will offer tests and DIS services as well as risk reduction and prevention strategies.

Annual Activities:

1. Gonorrhea Samples Tested

Between 10/2018 and 09/2019, DHHS will contract with laboratory to provide testing on samples from 131 provider sites, including those serving the target population (adolescents and young adults, aged 15 to 34). Numbers of tests to be completed:

- Chlamydia/Gonorrhea Gen Probe Amplified Tests = 2,000
- Chlamydia/Gonorrhea Gen Probe Tests = 2,000

State Program Title:

Injury Prevention Program

State Program Strategy:

Program Goal: The PHHS Block Grant-funded Injury Prevention Program is dedicated to the prevention of unintentional and intentional injuries, injury-related hospitalizations, long-term disability and deaths.

Health Priorities: The Injury Prevention Program focuses on prevention of traumatic brain injury in youth, consistent child restraint use among children up to 10 years, reduction of falls among older adults. The basis for establishment of these focus areas is listed below:

- Injuries are the fifth leading causes of death for Nebraskans.
- For Nebraskans aged 1 through 44 years, unintentional injuries are the leading cause of death.
- In Nebraska, more years of potential life are lost due to injury than any other cause of death.
- Falls are the leading cause of injury hospital discharge for all ages combined in Nebraska.
- Statewide, the leading causes of age-adjusted injury death are traumatic brain injury fatalities followed by motor vehicle traffic fatalities.
- Eight percent of respondents to the Youth Risk Behavior Survey reported that someone forced them to have sex when they did not want to.

Primary Strategic Partnerships:

Unintentional Injury:

External: Safe Kids Coalitions, Child Passenger Safety Technicians and Instructors, Local Public Health Departments, Nebraska Office of Highway Safety, Nebraska Safety Council, local hospitals, Nebraska State Patrol, Brain Injury Alliance of Nebraska, Nebraska Athletic Trainer's Association, Nebraska Pharmacists Association, parents and the general public.

Internal: DHHS programs including Epidemiology and Informatics Unit (CODES Crash Outcome Data Evaluation System); Nutrition and Physical Activity for Health; Community and Rural Health Planning Unit, EMS/Trauma System; Lifespan Health Services Unit; Maternal and Child Health; Public Health/Child Care Licensing, Child and Family Services.

Intentional Injury:

DHHS contracts with the Nebraska Coalition to End Sexual and Domestic Violence (Nebraska Coalition) in addressing use of the Sex Offense Set-Aside funds. The Nebraska Coalition provides technical assistance to a network of 20 domestic violence and sexual assault programs across the state.

Evaluation Methodology:

Unintentional Injury: Process and outcome evaluation will be used to evaluate progress. DHHS will collect and monitor reports from Safe Kids Coalitions, Child Passenger Technicians, Tai Chi and Stepping On instructors and other entities receiving contracts and subawards. Staff will access and analyze Death Data and Hospital Discharge Data for results and trends, provide data results to partner programs and monitor program participant survey results.

Intentional Injury:

Sex Offense Set-Aside: DHHS will collect and analyze data from Youth Risk Behavior Survey and reports from the Nebraska Coalition on evaluation of activities and attitude and behavior changes.
Source: DHHS Vital Statistics, DHHS Hospital Discharge Data, Nebraska Coalition to End Sexual and Domestic Violence.

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Home, Local health department, Medical or clinical site, Parks or playgrounds, Rape crisis center, Schools or school district, Senior residence or center, State health department, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Jason Kerkman
Position Title: Community Health Educator Senior
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective:

HO IVP-1 Total Injury

State Health Objective(s):

Between 10/2018 and 09/2020,

- Reduce the crude rate of injuries requiring emergency department visits to less than 6,650.8 per 100,000 Nebraskans.

- Reduce the age-adjusted rate of injuries needing hospitalization to less than 428.1 per 100,000 Nebraskans.
- Reduce the age-adjusted rate of injury-related deaths to less than 55.2 per 100,000 Nebraskans.

Baseline:

- From Oct. 1, 2014 – Sept. 30, 2015, 6,650.8 per 100,000 Nebraskans required emergency room care for injury.
- From Oct. 1, 2014 – Sept. 30, 2015, 428.1 per 100,000 Nebraskans required hospitalization for injury.
- From Oct. 1, 2014 – Sept. 30, 2015, 55.2 per 100,000 Nebraskans suffered fatal injuries.

Data Source:

Data Source: Nebraska Hospital Discharge Data, Oct. 1, 2014 – Sept. 30, 2015

State Health Problem:

Health Burden:

Falls are the leading age-adjusted causes of unintentional injury in Nebraska. Nebraska's Injury Community Planning Group, made up of community partners who focus solely or in part on injury prevention, developed a strategic plan to address the leading causes of injury in Nebraska.
In 2015, 1,109 Nebraskans died as a result of an injury, and such deaths were more than double among males than females. In addition, from Oct. 1, 2014 – Sept. 30, 2015 there were 8,876 hospitalizations and 125,963 emergency department (ED) visits for injuries.
In 2015, the age-adjusted rate of injuries was highest among adults older than 84 years and children ages 1-4.

Nebraska Hospital Discharge Oct. 1, 2014 – Sept. 30, 2015

Target Population:
Number: 18,961,900
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 18,961,900
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Target and Disparate Data Sources: DHHS Vital Statistics, US Census data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
Promising Practices Network (RAND Corporation)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $36,000
Total Prior Year Funds Allocated to Health Objective: $92,000
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $10,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Total Injury Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Injury awareness and prevention
Between 10/2018 and 09/2019, DHHS Injury Prevention Program will provide education, awareness and injury prevention technical support across the state to **at least 4** grantees and other entities seeking injury prevention technical assistance.

Annual Activities:

1. Provide public information

Between 10/2018 and 09/2019, The DHHS Injury Prevention Program and partners will provide injury prevention information to the public by various means, including newsletters, social media, traditional media and by responding to requests from the public, partners, school districts, hospitals or local health departments.

Objective 2:

Injury prevention subawards

Between 10/2018 and 09/2019, DHHS Injury Prevention and Control Program will provide sub-awards to **4** local Safe Kids programs or other organizations involved in injury prevention programming.

Annual Activities:

1. Administer injury prevention subawards

Between 10/2018 and 09/2019,

- Develop an application and process to determine which local Safe Kids programs will receive funding;
- Provide funding to local Safe Kids programs to administer injury prevention programs aimed at reducing traumatic brain injuries in adolescents and youth;
- Provide technical assistance to awardees about evidence based interventions to reduce traumatic brain injuries;
- Where applicable, conduct evaluation to determine reach and behavior change as a result of the Safe Kids injury prevention programs that are funded.

National Health Objective:

HO IVP-2 Traumatic Brain Injury

State Health Objective(s):

Between 10/2016 and 09/2020,

- Reduce the number of traumatic brain injuries requiring emergency department visits to less than 828 per 100,000 Nebraska children among children aged 1 to 14 years
- Reduce the number of traumatic brain injuries needing hospitalization to less than 24 per 100,000 Nebraska children among children aged 1 to 14 years.

Baseline:

- From Oct. 1, 2014 – Sept. 30, 2015, 828 of 100,000 Nebraska children (ages 1 to 14 years) required emergency room care for traumatic brain injury.
  From Oct. 1, 2014 – Sept. 30, 2015, 24 of 100,000 Nebraska children (ages 1 to 14 years) were hospitalized due to traumatic brain injury.

Data Source:

Data Source: Nebraska Hospital Discharge Data, Oct. 1, 2014 – Sept. 30, 2015

State Health Problem:

Health Burden:

The leading causes of traumatic brain injury (TBI) in Nebraska are motor vehicle crashes and falls. Nebraska's Injury Community Planning Group, made up of community partners who focus solely or in part on injury prevention, developed a strategic plan to address the leading causes of injury in Nebraska. One of the specific areas they chose for targeted efforts is TBI, especially reducing TBI in children and youth. DHHS partners with the Brain Injury Alliance of Nebraska and the Nebraska Office of

Highway Safety, among others, to address the leading causes of TBI.

In 2015, 409 Nebraskans died as a result of a traumatic brain injury, and such deaths were more common among males than females. In addition, from Oct. 1, 2014 – Sept. 30, 2015 there were 1,521 hospitalizations and 10,841 emergency department (ED) visits for TBI. Average TBI emergency medical costs are $3,738.83 (median) per emergency room visit and $27,928.86 (median) per hospitalization.

In 2015, the highest number of TBI related dates was among persons aged 15-24 years.*
Persons ages 0-14 years made the most TBI-related emergency department visits.**

*TBI was reported as a cause of death on the death certificate alone or in combination with other injuries or conditions.
**TBI alone or in combination with other injuries or conditions.

Nebraska Hospital Discharge 2013 and Oct. 1, 2014 – Sept. 30, 2015

Target Population:
Number: 526,284
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 526,284
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: DHHS Vital Statistics, US Census data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)
Promising Practices Network (RAND Corporation)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $36,146
Total Prior Year Funds Allocated to Health Objective: $92,000
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $10,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Traumatic Brain Injury Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Concussion/TBI awareness and prevention
Between 10/2018 and 09/2019, DHHS Injury Prevention Program and the Brain Injury Alliance of Nebraska will maintain **1** statewide concussion coalition to provide and guide TBI/concussion education, awareness and prevention across the state.

Annual Activities:
1. Nebraska Concussion Coalition
Between 10/2018 and 09/2019, DHHS will partner with the Brain Injury Alliance of Nebraska to regularly convene the Concussion Coalition to provide and guide concussion education, awareness and prevention across the state. Focus areas of the Concussion Coalition may include Return to Learn and healthcare provider education. Other partners will include local/district health departments, local Safe Kids programs, Nebraska State Athletic Trainers' Association, Nebraska School Activities Association, YMCA, the Nebraska Medical Association and other community partners such as hospitals.

National Health Objective:

HO IVP-9 Poisoning Deaths

State Health Objective(s):

Between 10/2017 and 09/2020, Reduce the age-adjusted death rate due to unintentional poisoning to less than 6 per 100,000 Nebraskans.

Reduce the number of unintentional poisonings requiring emergency department visits to less than 18.8 per 100,000 Nebraskans.

Reduce the number of unintentional poisonings needing hospitalization to less than 96.6 per 100,000 Nebraskans.

Baseline:
- From 2009 to 2013, the age-adjusted death rate due to unintentional poisoning was 6 per 100,000 Nebraskans.
- From Oct. 1, 2014 – Sept. 30, 2015, the age-adjusted death rate due to unintentional poisonings was 6.4 per 100,000 Nebraskans.
- From 2009 to 2013, the age-adjusted hospitalization rate due to unintentional poisoning was 18.8 per 100,000 Nebraskans.
- From Oct. 1, 2014 – Sept. 30, 2015, the age-adjusted hospitalization rate due to poisonings was 64.8 per 100,000 Nebraskans.
- From 2009 to 2013, the age-adjusted emergency department (ED) visit rate due to unintentional poisoning was 96.6 per 100,000 Nebraskans.
- From Oct. 1, 2014 – Sept. 30, 2015, the age-adjusted ED visit rate due to poisonings was 175.8 per 100,000 Nebraskans.

Data Source:
Source: NE hospital discharge data, 2009-2015

State Health Problem:

Health Burden:
Deaths
From Oct. 1, 2014 – Sept. 30, 2015, the age-adjusted death rate due to poisonings was 8.5 per 100,000 Nebraskans. During the same time period, the unintentional poisoning rate was 6.4 per 100,000 Nebraskans. Among deaths due to poisoning, 78% were due to poisonings by drugs.
From Oct. 1, 2014 – Sept. 30, 2015, deaths due to poisonings were most common among Nebraska adults aged 45-54 years (17.9 per 100,000 persons). Overall, death rates due to poisonings were higher among males than among females (10.6 per 100,000 males vs. 6.5 per 100,000 females).

Hospitalization
From 2009 to 2013, the age-adjusted hospitalization rate due to poisoning was 18.8 per 100,000 Nebraskans; From Oct. 1, 2014 – Sept. 30, 2015, the age-adjusted hospitalization rate due to poisonings was 64.8 per 100,000 Nebraskans.
Hospitalization rates due to poisoning were highest among adults aged 45-54 years old (93.4 per 100,000 persons) and 35-44 years (86.2 per 100,000 persons). For adults aged 35 years and older, hospitalization rates due to poisoning were higher among females than among males. This difference was particularly evident for adults aged 45-54 years (15.4 per 100,000 females vs. 9.8 per 100,000 males).

The median hospital charge for unintentional poisonings was $11,263 for hospitalizations. Approximately 51% of hospitalization charges to treat unintentional poisonings were paid for by Medicare and Medicaid.[CR1]

Among hospitalizations due to unintentional poisoning, approximately 90% were due to poisoning by medications. The remaining 10% were due to poisoning by gases and vapors (4%), alcohol (3%), cleaning and polishing agents (0.7%), and other means (2.3%). [CR2]

Emergency department (ED) visits
From 2009 to 2013, the age-adjusted emergency department (ED) visit rate due to unintentional poisoning was 96.6 per 100,000 Nebraskans; from Oct. 1, 2014 – Sept. 30, 2015, the age-adjusted ED visit rate due to poisonings was 175.8 per 100,000 Nebraskans.
ED visit rates due to poisoning were highest for children ages 1-4 years (443.4 per 100,000 persons). Within this age category, ED visit rates due to poisoning were higher for boys than for girls (530.4 per 100,000 boys vs. 352.3 per 100,000 girls).

The median hospital charge for unintentional poisonings was $816 for emergency department (ED) visits. Approximately 32% of ED visit charges to treat unintentional poisonings were paid for by Medicare and Medicaid.

Among emergency department (ED) visits due to unintentional poisoning, approximately 57% were due to poisoning by medications. The remaining 43% were due to poisoning by gases and vapors (10.9%), alcohol (1.4%), cleaning and polishing agents (3.7%), and other means (26.9%).

Agents involved in unintentional poisonings include: medications, alcohols, gases and vapors, cosmetics and personal care products, cleaning products, pesticides and plants.

Source: NE hospital discharge data, 2009-2015; CDC WISQARS

Target Population:
Number: 1,869,531
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,869,531
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Target and Disparate Data Sources: DHHS Vital Statistics, US Census data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: CDC Guidelines, Safe Kids Worldwide and National Poison Center

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $37,130
Total Prior Year Funds Allocated to Health Objective: $7,130
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $30,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

Poisoning Deaths Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Poisoning prevention subawards
Between 10/2018 and 09/2019, Nebraska DHHS Injury Prevention Program will provide sub-awards to engage in poisoning prevention activities to **at least 1** partner entity.

Annual Activities:
1. Administer poison prevention subawards
Between 10/2018 and 09/2019, •Develop an application and process to determine which local organizations will receive funding;
•Provide funding to local programs to administer injury prevention programs aimed at reducing unintentional poisonings in children and adults;
•Provide technical assistance to subrecipients about evidence based interventions to reduce unintentional poisonings;
•Where applicable, conduct evaluation to determine reach and behavior change as a result of the funded programming.

National Health Objective:

HO IVP-16 Age-Appropriate Child Restraint Use

State Health Objective(s):
Between 10/2016 and 09/2020, maintain observed use of child restraints in Nebraska at 98 percent.

Baseline:
Since inception of the child restraint usage survey, observed usage has risen from 56 percent (1999) to 98.4 percent (2016). Observed usage was 97% in 2017.

Data Source:

Nebraska Department of Transportation Highway Safety Office
- Child Restraint Surveys are conducted each year between August and September.
- Child safety seat use is surveyed annually through observations conducted in rural and urban counties in Nebraska.

State Health Problem:

Health Burden:
In Nebraska, for children 5-14 years, the leading cause of death is motor vehicle or traffic crashes (CDC WISQARS, 2004-2014). Nebraska's child safety seat law only requires children up to age eight to use child safety seats (including booster seats) while riding in vehicles. Best practice guidelines provided by the National Highway Traffic Safety Administration recommend children use booster seats until the child reaches a height of 57 inches or to about the age of 10. Since Nebraska's law does not follow best practice guidelines, it is important to educate parents and care givers about proper child safety seat use and the importance of using booster seats for older children.

During 2016 on Nebraska roadways:
- Five children were killed, and 314 children ages 0-4 were injured
- Two children ages 5-9 were killed, while 493 were injured.
- Three children between the age of 10-14 were killed, and 685 were injured

In 2016, Safe Kids Nebraska funded 14 car seat safety checks. These events found a 53 percent misuse rate. According to Safe Kids Worldwide Safe Kids Worldwide website, 2013:
- Children seated in a booster seat in the back seat of the car are 45 percent less likely to be injured in a crash than children using a seat belt alone.
- Children 2 to 5 years of age using safety belts prematurely are four times more likely to suffer a serious head injury in a crash than those restrained in child safety seats or booster seats.
- When installed and used correctly, child safety seats and safety belts can prevent injuries and save lives. Child safety seats can reduce fatal injury by up to 71 percent for infants and 54 percent for toddlers (ages 1 to 4).
- The overall critical misuse for child restraints is about 73 percent. Infant seats have the highest percent of critical misuse, followed by rear facing convertible seats.

Target Population:
Number: 526,284
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 526,284
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: DHHS Vital Statistics, US Census data, Nebraska DOT Highway Safety Office

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
Promising Practices Network (RAND Corporation)

Other: Governor's Highway Safety Association's Occupant Protection for Children: Best Practices Manual, Model Program Elements Section to address childhood occupant protection: 2007

Safe Kids World Wide: Motor Vehicle occupant injury fact sheet (2004).

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $74,507
Total Prior Year Funds Allocated to Health Objective: $73,122
Funds Allocated to Disparate Populations: $20,000
Funds to Local Entities: $7,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

Age-Appropriate Child Restraint Use Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Child Passenger Safety Programs
Between 10/2018 and 09/2019, DHHS Injury Prevention Program, partners and contractors will maintain **98** percent observed use of child restraints.

Annual Activities:
1. Child Passenger Safety Certification Training
Between 10/2018 and 09/2019, DHHS staff will partner with the Nebraska Highway Safety Office to conduct four National Highway Traffic Safety Administration Certification child passenger safety technician trainings (contingent upon outside funding). Staff will establish the training schedule, promote the classes and identify needed resources in conjunction with the Nebraska Child Passenger Safety Advisory Committee and Highway Safety Office.

2. Provide technical assistance

Between 10/2018 and 09/2019, DHHS staff will provide technical support to over 350 child passenger safety technicians through various means, including newsletters, e-mail lists, mailings, technical updates and grant funding.

3. Provide mini-grants
Between 10/2018 and 09/2019, DHHS will provide a minimum of 10 mini-grants to local child passenger safety technicians to conduct community car seat check events.

4. Provide Child Care Transportation Training Technical Assistance
Between 10/2018 and 09/2019, DHHS will provide technical assistance to child passenger safety technicians and child care providers related to the Safe Kids Nebraska Child Care Transportation Training.

Objective 2:
Education and information
Between 10/2018 and 09/2019, DHHS Injury Prevention Program and partners will provide education and information to **100** Child Passenger Safety Technicians, local public health departments, child care providers, Safe Kids coalitions and the general public.

Annual Activities:
1. Provide public information
Between 10/2018 and 09/2019, the DHHS Injury Prevention Program and partners will provide information to the public about child safety seat use and restraint laws through various means, including participating in Child Passenger Safety Week and responding to requests from the public, school districts, hospitals or public health departments.

National Health Objective:

HO IVP-23 Deaths from Falls

State Health Objective(s):

Between 10/2014 and 09/2019, reduce the age-adjusted death and injury rates from falls to:
- Less than 9.4 deaths per 100,000 Nebraskans;
- Less than 220.6 hospitalizations per 100,000 Nebraskans;
- Less than 2,009 emergency department (ED) visits per 100,000 Nebraskans.

Baseline:

Falls are the most common non-fatal injury in Nebraska.

In Nebraska (Oct. 1, 2014 – Sept. 30, 2015):
- Falls in all age groups accounted for more than 4,850 hospitalizations (an age-adjusted rate of 218.2 per 100,000 population) and over 40,600 emergency department visits (an age-adjusted rate of 2,060 per 100,000).
- In 2015, falls were the second leading cause of unintentional injury death for all age groups, with unintentional falls resulting in 217 deaths (an age-adjusted rate of 9.4 per 100,000 population).
- In 2015, falls were the leading cause of injury death for adults in Nebraska aged 75 years and older.

The death rate due to unintentional falls for all age groups has remained stable for the past ten years.

Data Source:
Nebraska death certificates
Nebraska hospital discharge data

State Health Problem:

Health Burden:
From 2009 to 2013, unintentional falls were the leading cause of hospitalizations and emergency department (ED) visits due to injury among Nebraskans, and the third leading cause of injury death. From 2009 to 2013 there were 924 deaths, 24,264 hospitalizations and 195,000 ED visits due to unintentional falls. Unintentional fatal falls were most common among adults aged 85 years and older. Among hospitalizations, the majority of cases were among those 65 and older. For non-fatal injuries resulting in an ED visit, medical care was needed most often for those 75 and older and among those 1-4 years old. In Nebraska from 2009 to 2013, for hospitalization the median charge to treat injuries due to unintentional falls was $27,290. Approximately 76% of hospitalization charges to treat unintentional fall injuries were paid for by Medicare and Medicaid. For ED visits, the median charge for care was $1,028, with nearly half (43%) of ED visit charges to treat unintentional fall injuries paid for by Medicare and Medicaid.

Target Population:
Number: 1,174,010
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,174,010
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: NE Vital Statistics, Hospital Discharge Data 2013-2015, US Census data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
Model Practices Database (National Association of County and City Health Officials)
Promising Practices Network (RAND Corporation)

Other: CDC- Preventing Falls: What Works

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $117,351
Total Prior Year Funds Allocated to Health Objective: $101,000
Funds Allocated to Disparate Populations: $30,000
Funds to Local Entities: $36,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

Deaths from Falls Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Falls Prevention Programming
Between 10/2018 and 09/2019, DHHS Injury Prevention Program will maintain **5** local partnerships, providing resources and technical assistance to continue implementing Tai Chi and Stepping On.

Annual Activities:
1. Falls prevention subawards
Between 10/2018 and 09/2019, DHHS will provide subawards to local partners to implement the Tai Chi Moving for Better Balance and Stepping On programs.

2. Tai Chi/Stepping On training
Between 10/2018 and 09/2019, DHHS will facilitate Tai Chi and Stepping On training for new instructors.

3. Instructor Development
Between 10/2018 and 09/2019, DHHS will enhance Tai Chi and Stepping On instructor development through the use of technical assistance and/or site visits provided by a Tai Chi consultant and the Stepping On Master Trainers.

Objective 2:
Older adult falls
Between 10/2018 and 09/2019, DHHS Injury Prevention Program will maintain **1** Older Adult Falls Prevention Coalition.

Annual Activities:
1. Older Adult Falls Coalition meetings
Between 10/2018 and 09/2019, DHHS will provide education on the scope of the problem of older adult falls in Nebraska and evidence-based prevention strategies to public health partners and other community partners through Falls Coalition activities.

2. Older Adult Falls Prevention Day
Between 10/2018 and 09/2019, DHHS will provide education on older adult falls prevention by participating in the National Older Adult Falls Prevention Day. Activities will include local community events, distribution of materials and media releases.

Objective 3:
STEADI Programming
Between 10/2018 and 09/2019, DHHS Injury Prevention Program will establish **2** local sites to pilot STEADI.

Annual Activities:
1. STEADI subawards
Between 10/2018 and 09/2019, DHHS will provide subawards to local partners to pilot STEADI.

National Health Objective:

HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 10/2016 and 09/2019, Between 10/2016 and 09/2019, the percent of total respondents on the Youth Risk Behavior Survey (YRBS) who report that they were forced to have sex when they did not want to will decrease from 8% to 7%.

The Nebraska Coalition to End Sexual and Domestic Violence (Nebraska Coalition) uses the YRBS as its primary data source for this objective. The YRBS is a random sample survey that targets public high school students, grades 9 – 12, in Nebraska. It is the only state level source of information on sexual violence among Nebraska high school students. The Nebraska Department of Education and DHHS administer the survey in the fall of even calendar years and release the findings the following year. The 2013 YRBS had an overall response rate of 70%; thus, the CDC was able to weight the data to be representative of all public high school students in Nebraska.

The Nebraska Coalition will also use the National Intimate Partner and Sexual Violence Survey (NISVS) to inform its efforts towards this objective. The Centers for Disease Control and Prevention (CDC) National Center for Injury Prevention and Control launched the NISVS in 2010 with the support of the National Institute of Justice and the Department of Defense. The survey is an ongoing, nationally representative telephone survey that collects information about sexual and intimate partner violence and stalking among women and men aged 18 or older in the United States. While respondents are older than the 11–17 target age ranges for this particular objective, the survey asks respondents about their experiences with violence throughout their lifetime, including childhood. The CDC breaks down the data by state.

Baseline:

8.4 percent of the 1,414 YRBS respondents reported that someone forced them to have sex when they did not want to. (2017)

Of the 2,885 respondents grades 9-12, 9.9% (N = 286) of the total indicated that they were forced to have sex when they did not want to (2009).

Data Source:
Youth Risk Behavior Survey (2013)
Youth Risk Behavior Survey (2009), unweighted

State Health Problem:

Health Burden:
According to the NISVS, nearly 1 in 5 women and 1 in 71 men in the United States have been raped in their lifetimes (CDC, 2011). About 1 in 2 women and 1 in 5 men have experienced some other form of sexual violence sometime in their lives. The lifetime prevalence of sexual violence for men and women in Nebraska mirrors these proportions, although the exact prevalence of rape and sexual violence is slightly higher among Nebraskans. Ultimately, approximately 129,000 women in Nebraska have been raped, and 325,000 otherwise sexually victimized, sometime in their lives.[1] An additional 174,000 Nebraska males have experienced sexual violence other than rape in their lifetimes.[2]

The NISVS also reveals that approximately one-third (29.9%) of female victims of rape experience their first rape between 11 and 17 years or age, with 37.4% experiencing their first rape between the ages of 18 and 24 years (CDC, 2011). Over one-quarter (27.8%) of men experienced their first rape at or before the age of 10. (Due to the small number of men who reported being raped, the CDC was unable to

calculate an estimate for any other age categories for male victims.)

Data from the YRBS further support these findings. The YRBS indicates that 13% of female students in grades 9–12 and 4% of male students in grades 9 – 12 reported being forced to have sex (Nebraska Department of Education and Nebraska Department of Health and Human Services, 2017). (Please note that the YRBS measures only physical force to have sex, while the NSVIS includes other nonconsensual acts such as drug facilitated rapes.)

The impact sexual violence can have on victims' mental health is complex and unique to each individual; however, research suggests that sexual violence carries a potentially significant impact on victims. For example, studies show that sexual violence can increase the risk for victims to experience post-traumatic stress disorder, depression, anxiety and suicide. People who experience sexual violence are more likely to use and abuse substances than those who have not experienced sexual violence.
[1] These categories are not mutually exclusive and as a result there may be some duplicate counts. Some women may have reported both rape and sexual violence other than rape, which would place them in both categories.

[2] Estimates on the prevalence of rape among Nebraska men could not be made due to the small number of men who reported rape. Such small numbers result in unreliable estimates.

Some unique barriers to sexual violence prevention efforts in Nebraska exist in schools. Not all schools, particularly rural schools, have in-house school nurses, counselors, or resource officers to help facilitate sexual violence prevention. Classroom sizes are increasing, whereas time and resources are decreasing, making it even more difficult to incorporate sexual violence prevention into schools. Administrators indicate semester schedules are perpetually full. This leads to additional time and energy placed into "selling" the need for sexual violence prevention to administrators and teachers in the schools. Certainly these barriers are not unique to Nebraska; however, said barriers are magnified in rural communities in which sexual violence is not often discussed and resources are spread thin across large geographic areas. In these areas, targeting schools in prevention efforts is important, as schools are among the few places in which young people in rural communities can aggregate and discuss sexual violence and prevention.

Target Population:
Number: 175,005
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 85,329
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S Census Data, 2010 Ages 12 to 18; Rural includes all counties, except Douglas, Sarpy and Lancaster

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Foubert JD, Tabachnick J & Schewe PA. (2010). The prevention of sexual violence: A practitioner's sourcebook. Kaufman, K (Ed.). Holyoke, MA: NEARI Press.

Tabachnick, J. (2008). Engaging bystanders in sexual violence prevention. Enola, PA: National Sexual Violence Resource Center.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $61,752
Total Prior Year Funds Allocated to Health Objective: $102,587
Funds Allocated to Disparate Populations: $61,752
Funds to Local Entities: $61,752
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

Sexual Violence (Rape Prevention) Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Capacity assessment
Between 10/2018 and 09/2019, a consultant contracted by the Nebraska Coalition will conduct **1** assessment of the capacity of the Nebraska Coalition to lead primary sexual violence prevention initiatives in Nebraska.

Annual Activities:
1. Consultant Contract
Between 10/2018 and 09/2019, the Nebraska Coalition will identify and contract with a consultant with expertise in sexual violence prevention, assessment and evaluation to assess the Coalition's capacity to lead programs in providing comprehensive sexual violence prevention strategies across the state.

2. Assessment of the Coalition's prevention program
Between 10/2018 and 09/2019, the Nebraska Coalition will work with a consultant to assess its existing prevention program according to evidence-based and best practices. Examples of potential work include:
- Mapping the Nebraska Coalition's prevention programming to make sure it is comprehensive and effective; and
- Mapping program outcomes onto the social ecological model and identifying ways in which the Nebraska Coalition can reach the community and societal levels with their work.

3. Identify areas for improvement and expansion.
Between 10/2018 and 09/2019, the Nebraska Coalition will work with a consultant to identify ways in which prevention programming can be more effectively implemented at the state level and organizational resources used wisely.

Objective 2:
Sexual Violence Prevention Summit
Between 10/2018 and 09/2019, the Coalition to End Sexual and Domestic Violence will provide sexual violence prevention training to **up to eight** sexual/domestic violence advocates.

Annual Activities:
1. Sexual Violence Prevention Summit
Between 10/2018 and 09/2019, the Nebraska Coalition will provide financial support for up to eight local

sexual/domestic violence advocates to attend the national Sexual Violence Prevention Summit. Advocates will apply for support, attend workshops related to sexual violence, evaluate their experience and provide written and/or oral reports/presentations of what they learned. The reports will be disseminated among the state's 20 local domestic violence/sexual assault programs. Advocates may be asked to present at Coalition trainings or meetings.

Objective 3:
Sexual violence prevention training for local programs
Between 10/2018 and 09/2019, the Nebraska Coalition to End Sexual and Domestic Violence will provide sexual violence prevention training to **up to 18** local domestic violence/sexual assault programs.

Annual Activities:
1. Provide training for local programs
Between 10/2018 and 09/2019, the Nebraska Coalition will provide information and training at a one-day summit. Advocates from the state's local domestic violence/sexual assault programs will receive education and information on primary sexual violence prevention.

2. Host a two-day statewide conference
Between 10/2018 and 09/2019, the Nebraska Coalition will host a two-day state conference for advocates from the local domestic violence/sexual assault programs and other community partners on sexual and domestic violence. The Nebraska Coalition will secure a national expert to speak about primary sexual violence prevention in one keynote and two breakout sessions throughout the conference.

3. Sexual Violence Prevention Summit
Between 10/2018 and 09/2019, the Nebraska Coalition will provide financial support for up to eight local sexual/domestic violence advocates to attend the National Sexual Assault Conference. Advocates will apply for support, attend workshops related to sexual violence, evaluate their experience and provide written and/or oral reports of what they learned. The written reports will be disseminated among the state's 20 local domestic violence/sexual assault programs. Advocates may be asked to present at Nebraska Coalition trainings or meetings.

National Health Objective:

HO V-1 Vision Screening for Children

State Health Objective(s):

Between 10/2018 and 09/2020, Improve access to and increase the number of vision screenings for children.

Baseline:

Nebraska Administrative Code (NAC) 173, Chapter 7 requires distance vision acuity (myopia) and near vision acuity (hyperopia) screenings for all students in grades Pre-K, K, 1, 2, 3, 4, 7, and 10. The results of these screenings are not shared or analyzed beyond the school that is conducting the screenings. For the 2017-2018 school year, DHHS initiated a pilot effort asking schools to voluntarily submit results of screenings to the DHHS School Health Program as part of their yearly School Health Screening Data Collection project. Approximately 55 of Nebraska's 250 schools submitted their screening results.
The Child Vision Collaborative of Nebraska also conducted vision screenings

- 2017-2018 Vision Events (screening and private clinics)
- Three private clinics (Omaha Primary EyeCare, ViewPoint Vision, and Truhlsen Eye Institute)
- Six PreK clinics with Dr. Sarah Weirda

School Vision Program Impact				
	2015-2016	2016-2017	2017-2018	Total
# of schools	8	9	21	38
Total Screened	4984	4602	10789	20375
Total Referred	1677	1580	4420	7677
% referral	34%	34%	41%	38%
Total Exams	740	672	402	1814
Total Glasses	570	511	269	1350
Total Referrals for further care	45	42	16	103

Data Source:

Children's Vision Collaborative (201-2018), DHHS School Health Program - School Health Screening Data Collection, 2018

State Health Problem:

Health Burden:
While some efforts have been made in recent years to collect vision data, there is currently no standardized method for collecting data, and there is no one currently designated to clean and analyze data. In 2017-2018, DHHS convened a group of stakeholders to begin focusing more closely on the vision and eye health of Nebraskans. That group determined that priorities for DHHS should be data collection and analysis and helping to determine a statewide standardized process to conduct the screenings. Following that, an eye care referral workflow pattern for underserved children who screen positive for the need to receive a comprehensive eye exam would benefit children in the state.

Target Population:
Number: 526,264
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 526,264
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Target and Disparate Data Sources: DHHS Vital Statistics, US Census data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $25,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

Vision Screening for Children Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Eye/Vision Health Subaward
Between 10/2018 and 09/2019, DHHS Injury Prevention and Control Program will provide a subaward to address eye/vision health to **1** local partner involved in eye/vision health programming.

Annual Activities:
1. Administer eye/vision health subaward
Between 10/2018 and 09/2019,
1. Develop an application and process to determine which partner will receive funding. The application will center on activities such as:

- Conducting school-based vision screenings via standardized process and developing processes to be shared with other statewide groups;
- Developing eye care referral workflow patterns for underserved children who have screened positive for the need for a comprehensive eye exam;
- Developing surveillance system for school health screenings utilizing statewide school eye health reporting;
- Expanding collaboration with eye care providers and primary care providers.

2. Provide funding to conduct the work plan activities of the subaward.
3. Provide technical assistance to subrecipient on the topic of eye/vision health.
4. Where applicable, conduct evaluation to determine reach and effectiveness of the funded eye/vision health sub award activities.

State Program Title:

Oral Health Program

State Program Strategy:

Program Goal: The PHHS Block Grant-funded Oral Health Program is dedicated to improving and protecting the oral health status of Nebraskans across the lifespan. The Office of Oral Health and Dentistry (OOHD) will actively promote oral health awareness and dental disease prevention through access to care.

Health Priorities: The program will focus on addressing dental disparities within the current health care system, with special emphasis on rural residents, young children and the elderly. Nebraska convenes an Oral Health Advisory Panel (OHAP) that reviews statistics and trends and recommends priorities for the OOHD. The OOHD has completed the 2016 Nebraska Oral Health Assessment Report. The report was approved by DHHS in February 2017. The State Assessment Report and OHAP guide and support OOHD's program priorities.

Primary Strategic Partners:

- External: Local county and district health departments, Federally Qualified Health Centers (FQHCs), Head Start and Early Head Start Programs, WIC, University of Nebraska Medical Center Colleges of Dentistry and Public Health, Creighton University School of Dentistry, and others.
- Internal: DHHS programs including Epidemiology and Informatics Unit, Tobacco Free Nebraska Program, Office of Health Disparities and Health Equity and Community and Rural Health Planning, School Health, Performance Management, Refugee Health, and other internal programs.

Evaluation Methodology:

The Oral Health Program will work with the Oral Health Epidemiologist and the DHHS Division of Public Health Epidemiology & Informatics Unit to write an oral health surveillance plan and to activate a dental health surveillance system. A scan of available data sources was completed during 2017 that identified dozens of existing databases that are used to inform program decisions and document efficacy of interventions. OOHD will utilize BRFSS, HP2020, Nebraska Oral Health Survey information along with the most helpful evaluation methods and sources and work with the Epidemiology & Informatics Unit to gather consistent data for short- and long-range analysis.

State Program Setting:

Child care center, Community based organization, Community health center, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Jessica O. Ball
Position Title: Health Program Manager I/Dental Health Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Dr. Charles F. Craft
Position Title: Dental Health Director
State-Level: 31% Local: 0% Other: 0% Total: 31%

Total Number of Positions Funded: 2
Total FTEs Funded: 1.31

National Health Objective:

HO OH-8 Dental Services for Low-Income Children and Adolescents

State Health Objective(s):
Between 10/2018 and 09/2019, OOHD will provide subawards to at least three local health agencies to provide oral screenings, fluoride varnish treatments, education and referrals to dental homes. The target population will be children and their families through Head Start, Early Head Start, WIC and other identified community programs where families with low income can be reached.

Baseline:
All seven of Nebraska's FQHCs and 12 LHDs are providing preventive services to children from families with low income.

Data Source:
DHHS Office of Oral Health and Dentistry

State Health Problem:

Health Burden:
- Dental decay is the most prevalent chronic childhood illness in the United States. [i]
- Tooth decay causes pain and can affect how children eat, speak, play, learn and grow.[ii]
- Each year in the United States students miss over 850,000 school days due to dental related illnesses. [iii]
- A 2015-2016 survey of Nebraska third graders showed that 64% had a history of tooth decay, which is higher than the national average.[iv]
- A 2015-2016 survey of Nebraska third graders found, that of schools that have 75% of children enrolled in the free and reduced lunch program, 75% of the children had a history of dental decay and 30% had a history of untreated dental decay. [iv]
- Children living in rural areas of Nebraska are more likely to have oral health problems. [v]
- Over 50% of the state is considered a general dentistry shortage area, and 20 out of 93 counties in Nebraska do not have a full-time dentist. [vi]
- Children in Nebraska without private insurance are more likely to have poor oral health. [vii]
- Nebraska children whose primary language is not English are over 10 times more likely to have poor oral health.[viii]
- The Association of State and Territorial Dental Directors Evidence-based Approach brief found fluoride varnish to be effective in reducing decay on both primary and permanent teeth by up to 25% in high-risk children.[ix] [x]
- The American Academy of Pediatric Dentistry has stated that “80% of all the dental problems in children are found in those 25% from lower income groups that often are on public assistance programs.” [xi]

[i] Centers for Disease Control and Prevention. Oral Health. Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers at a Glance 2011; 7/29/2011. http://stacks.cdc.gov/view/cdc/11862
[ii] CDC Division of Oral Health (2012). *Children’s Oral Health*. Retrieved from http://www.cdc.gov/oralhealth/topics/child.htm
[iii] National Institutes of Health. Oral Health in America: a report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services; 2000
[iv] Nebraska Department of Health and Human Services (2017). *2015-2016 Oral Health Survey of Young Children*. Lincoln, NE.
[v] National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org.
[vi] Nebraska Department of Health and Human Service, Rural health Advisory Commission. State-Designated Shortage Area General Dentistry; Corrected January 2015.
[vii] National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health

Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org.
[viii] National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org.
[ix] Association of State and Territorial Dental Directors. Fluoride Varnish: an Evidence-Based Approach Research brief; September 2007. http://www.astdd.org/docs/Sept2007FINALFlvarnishpaper.pdf
[x] Barzel R, Holt K with Association of State and Territorial Dental Directors, Fluorides Committee. 2010. *Fluoride Varnish: An Effective Tool for Preventing Dental Caries*. 2010. Washington, DC: National Maternal and Child Oral Health Resource Center.
http://www.mchoralhealth.org/PDFs/FlVarnishfactsheet.pdf
[xi] American Academy of Pediatric dentistry. Policy and Guidelines. Retrieved Date: 03/11/2015.
http://www.aapd.org/search/?Keywords=status+of+children's+oral+health

Target Population:
Number: 13,200
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 13,200
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Oral Health Access for Young Children Program Final Report 2011-2012, DHHS, United States Census Bureau 2012

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Model Practices Database (National Association of County and City Health Officials)

Other: Association of State and Territorial Dental Directors (ASTDD) Best Practice Approach Prevention and Control of early Childhood Tooth Decay, http://www.astdd.org/prevention-and-control-of-early-childhood-tooth-decay/, February 2013

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $139,616
Total Prior Year Funds Allocated to Health Objective: $171,083
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $70,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

Dental Services for Low-Income Children & Adolescents Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Oral Health Access to Young Children
Between 10/2018 and 09/2019, at least three Local Health Departments (LHDs), FQHCs, and community contractors will provide fluoride varnish treatments, education and referral to a dental home to **1500** children and their families.

Annual Activities:
1. Fluoride varnish, education and referral to dental home
Between 10/2018 and 09/2019, LHDs, FQHCs, and community contractors will provide education combined with preventive therapy (fluoride varnish treatments) and will distribute toothbrushes and fluoride toothpaste to clients in various public health settings that are non-traditional for dental care. The primary focus locations are: 1) WIC and related programs that provide services for new mothers, their children and families, and 2) Early Head Start and preschool classes for children aged 2-3 years, and Head Start classes for children aged 4-5 years. Services will be taken to the patients and will be provided by Registered Dental Hygienists with a Public Health Authorization.

2. Monitoring and evaluation
Between 10/2018 and 09/2019, the Dental Health Coordinator will monitor and evaluate the progress of the local community agencies through quarterly reports, conference calls and site visits. The OOHD will ensure clinical quality control for clinical screenings and application of fluoride varnish. The Dental Health Coordinator will work with the Oral Health Epidemiologist, Dental Health Director, and others within the DHHS Division of Public Health to evaluate the outcomes of the program.

National Health Objective:

HO OH-16 Oral and Craniofacial State-Based Health Surveillance System

State Health Objective(s):
Between 10/2018 and 09/2019, OOHD will work with the Oral Health Epidemiologist and DHHS's Epidemiology and Informatics Unit to write an oral health surveillance plan and implement the dental surveillance system for the State of Nebraska. The oral health surveillance system will be part of the overall DHHS data governance process.

Baseline:
At this time, there is no active oral health surveillance system for the State of Nebraska. A scan of available data sources was completed during 2017. It identified dozens of existing databases that can be used to inform program decisions and document progress.

Data Source:
DHHS Office of Oral Health and Dentistry

State Health Problem:

Health Burden:
The State of Nebraska does not have an active oral health surveillance system. According to the Association for State and Territorial Dental Directors (ASTDD), which highly recommends such a system, best practice for a *State-based Oral Health Surveillance System* should:

- Have a clear purpose and objectives;
- Contain a core set of measures/indicators that describes the status of important oral conditions or behaviors to serve as benchmarks for assessing progress in achieving good oral health (5);
- Analyze trends when several years of data are available;
- Communicate to decision-makers, partner organizations, and to the general public the surveillance data and information in a timely manner, and that communication should enable decision-makers at all levels to readily understand the implications of the information;
- Strive to put surveillance data to action to improve the oral health of residents in the state.

The lack of an oral health surveillance system was identified in the document *Access to Oral Health Care in Nebraska* as one of the barriers the state has related to Oral Health Care. The article states, "...oral health surveillance data is needed to see where the state stands at present, to determine state deficiencies and to work toward improving Nebraska's oral health status; however, Nebraska currently does not have an oral health surveillance system, which leads to less data available to evaluate the effectiveness of oral health improvement programs and no clarity on where the state stands on some Healthy People 2020 objectives."

Target Population:
Number: 25
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 25
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Association of State and Territorial Dental Directors (ASTDD), Access to Oral Health Care in Nebraska, UMNC Center for Health Policy; 2013

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Chandak A, McFarland KK, Nayar P, Deras M, Stimpson JP. Access to Oral Health Care in Nebraska. Omaha, NE: UMNC Center for Health Policy; 2013.

Association of State and Territorial Dental Directors (ASTDD), Best Practices Approach - State-Based Oral Health Surveillance System, http://www.astdd.org/state-based-oral-health-surveillance-system/, May 17, 2011.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $139,846
Total Prior Year Funds Allocated to Health Objective: $57,333
Funds Allocated to Disparate Populations: $139,846
Funds to Local Entities: $0

Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

Oral and Craniofacial State-Based Health Surveillance System Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Develop an oral health surveillance plan for Nebraska
Between 10/2018 and 09/2019, OOHD and the Epidemiology & Informatics Unit will develop **1** surveillance plan that will enable DHHS to track oral health status and service needs among various populations in Nebraska.

Annual Activities:
1. Activate an oral health surveillance written plan
Between 10/2018 and 09/2019, OOHD and the Epidemiology & Informatics Unit will develop the oral health surveillance written plan. Activities may include working with the Association of State and Territorial Dental Directors and the Council of State and Territorial Epidemiologists; reviewing current Nebraska data; reviewing other states' surveillance systems.

2. Conduct 2018-2019 Nebraska Oral Health Survey of Older Adults
Between 10/2018 and 09/2019, OOHD will conduct a 2018-2019 Nebraska Oral Health Survey of Older Adults. Nebraska has not conducted an oral health survey for this population. Activities will include: identifying and establishing a memorandum of understanding or contracts with each of the partners (ASTDD, State Unit on Aging, Public Health Registered Dental Hygienists and local community organizations) who will assist in completing the Nebraska Oral Health Survey of Older Adults.

3. Assess Nebraska hospital emergency department use for dental conditions
Between 10/2018 and 09/2019, OOHD will track the hospital-based emergency department (ED) visits for dental conditions in Nebraska. Recently, the State has seen an increase in the costly use of hospital EDs for non-traumatic and preventable dental conditions that are more appropriate for treatment in dental offices. Dental ED visits will be characterized by sex, age, race, patient location, insurance, income level, comorbid conditions, etc. The OOHD will create GIS maps showing the number of dental ED visits in correlation to the distribution of dentists and hygienists for each county. Informatics graphics will be utilized to explain the overall impact of this situation in Nebraska. The OOHD will also examine the occurrence of re-admissions to EDs for dental conditions to understand the need for improved patient care coordination in the future.

State Program Title:

Public Health Infrastructure Program

State Program Strategy:

Program Goal: The PHHS Block Grant-funded Public Health Infrastructure Program is dedicated to supporting and strengthening Nebraska's capacity to protect the health of everyone living in Nebraska, primarily through organized governmental agencies, specifically the state health department and local/regional/tribal health departments. *(The program name was selected to reflect the public health planning, management and surveillance functions carried out.)*

Health Priorities: DHHS selected as priority activities:

- Assuring availability of health data and public health informatics expertise necessary to planning and evaluating health programs and increasing the effectiveness of health department staff.
- Maintaining information and data resources at the state level in order to respond to requests for information from the local level, enable public health entities to conduct community needs assessments and provide a basis for formulating health policies and appropriate intervention strategies.
- Facilitating strategic planning at the state and local level, instituting performance standards and maintaining a well-trained public health workforce, critical to the success of all of the activities carried out by DHHS.
- Building capacity at the local level to provide all three Core Functions of Public Health and carry out all Ten Essential Services of Public Health.
- Partnering with local health departments, FQHCs and tribes to implement evidence-based projects addressing Health People 2020 Objectives.

Primary Strategic Partnerships:

- Health data: External -- Local health departments, university researchers, university educators of health professionals, community-based organizations. Internal -- DHHS Offices and Units within the Division of Public Health.
- Epidemiology and informatics: UNMC, medical facilities, Nebraska Health Information Exchange
- Community health development: Local Public Health Departments (County and District), Public Health Association of Nebraska (PHAN), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), Association of State and Territorial Health Officials (ASTHO), Nebraska Public Health Law Committee, Nebraska Turning Point Committee, UNMC College of Public Health.

Evaluation Methodology:

- Health Data: Report completion dates, data request response dates, data quality assurance procedures, and feedback from users of data.
- Community Health Development: Observation of operations of local public health departments, reports from Local Public Health (LHD) Departments (including copies of their Health Improvement Plans, Performance Standards Assessment Results, Annual LHD Reports), reports from contractors, observation of presentations by LHD staff.
- Evidence-based community prevention projects: Review of written reports from subaward projects, site visit and grant monitoring reports and personal and telephone contact.

State Program Setting:

Business, corporation or industry, Community based organization, Community health center, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, State health department, Tribal nation or area, University or college, Work site

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Gwen Hurst
Position Title: DHHS Program Manager II
State-Level: 75% Local: 0% Other: 0% Total: 75%
Position Name: Norm Nelson
Position Title: Statistical Analyst III
State-Level: 35% Local: 0% Other: 0% Total: 35%
Position Name: Jeff Armitage
Position Title: Lead Program Analyst
State-Level: 25% Local: 0% Other: 0% Total: 25%
Position Name: Patti DeLancey
Position Title: Administrative Assistant I
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: To Be Determined
Position Title: DHHS Epidemiology Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Raheem Sanders
Position Title: DHHS Program Performance Measurement Consultant
State-Level: 50% Local: 25% Other: 0% Total: 75%
Position Name: Ryan Daly
Position Title: Financial Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: TBD
Position Title: DHHS SHIP & Strategic Planning Coordinator
State-Level: 25% Local: 0% Other: 0% Total: 25%
Position Name: TBD
Position Title: Fiscal Coordinator
State-Level: 12% Local: 0% Other: 0% Total: 12%

Total Number of Positions Funded: 9
Total FTEs Funded: 5.47

National Health Objective:

HO C-1 Overall Cancer Deaths

State Health Objective(s):
Between 10/2018 and 09/2019, To impact cancer mortality and incidence on a wide variety of topics, DHHS will issue an RFA in October of 2018 and fund no fewer than 4 but no more than 5 awards to Local Health Departments, Federally Qualified Health Centers, 501 c 3 Organizations, Tribal Organizations or American College of Surgeons Commission on Cancer Accredited Cancer Centers to implement listed activities in the revised Nebraska Cancer Plan. Awarded projects will be one year in scope.

Baseline:
Currently the Nebraska Comprehensive Cancer Control Program partners with the Preventive Health and Health Services Block Grant to fund four evidence based cancer prevention projects.

Data Source:
Nebraska Cancer Registry and program records

State Health Problem:

Health Burden:
In 2014, there were 9,514 diagnoses of cancer among Nebraska residents. This number is slightly higher than the number of cancers that were diagnosed in 2013 (9,476).

In 2014, prostate, lung, and colorectal cancers were the most frequently diagnosed cases among Nebraska men, while breast, lung, and colorectal cancers were the most frequently diagnosed cases among Nebraska women. Taken together, these cancers accounted for about half of all cancer cases diagnosed among Nebraska residents in 2014.

During the past five years (2010-2014), more than half (55%) of all cancers in Nebraska occurred among people 65 years of age and older. Fewer than 1% were diagnosed among children and adolescents. The average age at diagnosis was 65.3 years of age.

During the past decade (2005-2014), African-Americans in Nebraska were significantly more likely to be diagnosed with myeloma, colorectal, kidney, lung, pancreas, prostate, stomach and liver cancers than were whites. Liver cancer diagnoses were also significantly more frequent among Native Americans, Asian-American/Pacific Islanders and Hispanics compared to whites.

During the past five years (2010-2014), deaths from cancers of the stomach, liver, lung, ovary, and female breast occurred significantly less often among Nebraska residents when compared to the U.S. as a whole, while deaths from invasive brain tumors occurred significantly more often. Lung cancer was the leading cause of cancer mortality in Nebraska in 2014, accounting for 25.6% of all cancer deaths, followed by colorectal cancer. During the past two decades, prostate and female breast cancer mortality rates in Nebraska have both declined by about 40%, which is consistent with national trends.

Target Population:
Number: 300,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 150,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Nebraska Cancer Registry

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $100,000
Total Prior Year Funds Allocated to Health Objective: $80,000

Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $60,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

Overall Cancer Deaths Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Cancer related evidence based projects
Between 10/2018 and 09/2019, Nebraska Comprehensive Cancer Control (NE CCCP) staff will increase the number of cancer related evidence based projects from 3 to **up to 5**.

Annual Activities:
1. Issue RFA
Between 10/2018 and 09/2019, NE CCCP will issue a competitive RFA to local health departments, federally qualified health centers, tribal organizations, 501 c 3s, and American College of Surgeons Commission on Cancer Accredited Cancer Centers. Organizations will be offered the opportunity to apply for up to $25,000 to implement one of the listed evidence based activities in the Nebraska Cancer Plan.

2. Provide technical assistance and monitoring
Between 10/2018 and 09/2019, NE CCCP will provide technical assistance and subrecipient monitoring to ensure quality projects.

National Health Objective:

HO PHI-7 National Data for Healthy People 2020 Objectives

State Health Objective(s):
Between 10/2015 and 09/2019, maintain at least one comprehensive state-level health data surveillance system, sustaining the capacity for collection and analysis of needed health data on all populations for use in development of health status indicators.

Baseline:
Six major health databases are maintained, and reports are issued. Information is provided to at least ten types of end users (decision makers, health planners, health program staff, medical and health professionals, community coalitions and the public).

Data Source:
DHHS, Health Licensure & Data Section, Epidemiology and Informatics Unit

State Health Problem:

Health Burden:
The rationale for investing PHHSBG funds in data collection, analysis and distribution includes the following elements:

1. Surveillance, epidemiology and evaluation are prime public health functions of any state health agency.

DHHS has a goal to be the leading source of reliable data and health information in Nebraska, strengthening programs that address the state's most challenging health issues. PHHSBG funds are invested in data systems development and maintenance in order to realize the goal.

2. No other state agency, university or private entity has access to the full range of health data or the expertise to analyze and share the information with state and local programs that are addressing the critical health concerns in Nebraska.
DHHS must collect and analyze data in order to increase knowledge of reported health behaviors, track achievement of objectives, evaluate the success of interventions and complete reporting for the PHHS Block Grant. It is logical that a portion of Nebraska's PHHS Block Grant funds be used to support the data system.

"The third component of infrastructure development is information and data resources. Accurate and timely data must be available to conduct community and statewide needs assessments as well as provide a basis for formulating health policies and appropriate intervention strategies. Greater efforts are needed to link together databases and make data more accessible for people at the local level. Greater efforts should also be made to collect and analyze new data that will more clearly identify health needs."
[Source: *Turning Point: Nebraska's Plan to Strengthen and Transform Public Health in Our State, 1999]*

3. Every funded program is required to base decisions about interventions upon reliable health data, which is supplied by the Epidemiology and Informatics Unit of DHHS.

4. Many sources of federal funding are being organized according to the Chronic Disease Domains. Programs within DHHS are striving to work collaboratively across programs and organizational structures.
Domain 1: Epidemiology and Surveillance: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.
Making the investment in epidemiology and surveillance provides states with the necessary expertise to collect data and information and to develop and deploy effective interventions, identify and address gaps in program delivery, and monitor and evaluate progress in achieving program goals. Data and information come with the responsibility to be utilized routinely to inform decision-makers and the public regarding the effectiveness of preventive interventions and the burden of chronic diseases and their associated risk factors, public health impact, and program effectiveness. The need to publicize widely the results of states' work in public health and demonstrate to the American people the return on their investment in prevention has never been greater.

Examples of Activities:

• Collect appropriate data to monitor risk factors and chronic conditions of interest through surveillance systems (such as the BRFSS, NPCR and other cancer screening data systems, Vital Statistics, and Medicare data sets), rapidly develop and disseminate data reports in easy-to-use and understand formats, describe multiple chronic conditions, and use data to drive state and local public health action.
• Conduct surveillance of behavioral risk factors, social determinants of health, and monitor environmental change policies related to healthful nutrition, physical activity, tobacco, community water fluoridation, and other areas.
• Collect cancer surveillance data to assess cancer burden and trends, identify high risk populations, and guide planning and evaluation of cancer control programs (e.g., prevention, screening and treatment efforts).
• Conduct youth and adult surveillance of tobacco-related knowledge, attitudes and behaviors (ATS/NATS, YTS/NYTS); translate and disseminate data and information for action.

5. As DHHS maintains its accreditation status, the data surveillance and epidemiology functions that are partially supported by the PHHSBG assist in that preparation.

Target Population:
Number: 7,000

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions

Disparate Population:
Number: 40
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: BRFSS: The guideline for completing BRFSS surveys was developed by CDC - Behavioral Surveillance Branch, called the Behavioral Risk Factor Surveillance System Operational and User's Guide.

Health Data: Toward a Health Statistics System for the 21st Century: Summary of a Workshop. http://www.nap.edu/openbook/0309075823/html, copyright, 2000 The National Academy of Sciences.

The Future of the Public's Health in the 21st Century (2002). http://www.nap.edu/openbook/030908704X/html/96.html, copyright 2002, 2001 The National Academy of Sciences.

CHD Unit: The Future of Public Health and The Future of the Public's Health in the 21st Century (Institute of Medicine of the National Academies)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $381,418
Total Prior Year Funds Allocated to Health Objective: $425,418
Funds Allocated to Disparate Populations: $210,000
Funds to Local Entities: $210,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

National Data for Healthy People 2020 Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Data and surveillance
Between 10/2018 and 09/2019, DHHS Epidemiology and Informatics Unit will provide health data to **5,000** users of data.

Annual Activities:
1. Data gathering, analysis and reporting
Between 10/2018 and 09/2019, DHHS will identify all relevant health indicators for local health department reporting, update and execute analysis programs and electronically disseminate Public Health Indicators (e.g., the 2016 Vital Statistics Report). At least 5,000 users log on to the NE DHHS Public Health website every year. The expected outcomes of this work include:
1. Enhanced and ongoing availability of numerators and denominators from DHHS and the Center for Public Affairs Research, University of Nebraska-Omaha, upon which local health departments rely;
2. Moving DHHS toward the goal of being the trusted source of health data; and
3. Supporting applications for public health accreditation at the state and local levels.

2. Nebraska HP2020 Basic Report
Between 10/2018 and 09/2019, The DHHS Office of Community Health and Performance Management will update Nebraska HP 2020 objective data on the Division's online dashboard. DHHS routinely provides updates to the dashboard charts and narratives with the most recent data available. There are approximately 25 HP 2020 indicators updated each year. The dashboards are available to the general public, hosted through an interactive performance dashboard system. Data is also shared with local health departments that utilize partner connect through the dashboard system.

3. Enhance data quality, utilization and integration
Between 10/2018 and 09/2019, The DHHS Epidemiology and Informatics Unit, working with the University of Nebraska Medical Center's College of Public Health, will continue to enhance data quality, utilization and integration and will improve data utilization to support public health practices. Activities may include determining data integration strategies; linking data (i.e., hospital discharge data (HDD) with death certificate data, HDD with the Cancer Registry data, HDD with Parkinson's Disease data); geocoding HDD, cancer and vital records to support public health surveillance and social determinants of health; supporting internal public health programs and external partnerships; conducting pilot project similar to CDC's 500 Cities Project.

4. Chronic Renal Disease data collection and analysis
Between 10/2018 and 09/2019, the DHHS Chronic Renal Disease Program will maintain client information and payment data and run necessary reports to better manage the program and serve clients. Additionally, the program's database will provide demographic information regarding Nebraskans with end-stage renal disease. Technical assistance contracts with the Nebraska Pharmacists Association and a nephrologist provide timely information and support to the program.

Objective 2:
Develop and enhance Nebraska's public health informatics infrastructure
Between 10/2018 and 09/2019, DHHS Epidemiology and Informatics Unit will update **1** Nebraska Public Health Informatics Strategic Plan based on public health informatics needs and development.

Annual Activities:
1. Establish Informatics classification with State Personnel
Between 10/2018 and 09/2019, the Epidemiology and Informatics Unit will continue working with the State's Department of Administrative Services to develop a job classification for public health informatics. If classified, staff will work to recruit, hire and onboard a qualified informatician. While classification request is processing, the Epidemiology and Informatics Unit will contract with one or more informaticians to provide necessary work support.

2. Establish and develop Nebraska Data Governance Committee
Between 10/2018 and 09/2019, DHHS Epidemiology and Informatics Unit in partnership with the Office of Community Health and Performance Management will continue to develop the nascent Nebraska Data Governance Committee. The committee's charge will be to conduct public health informatics needs assessment, develop a data and informatics strategic plan, conduct surveillance evaluations and collaborate with ASTHO's Public Health Informatics Workforce Committee. A project goal includes advancing data governance infrastructure up at least one level on the Gartner Business Intelligence Maturity Model.

3. Provide training
Between 10/2018 and 09/2019, DHHS Epidemiology and Informatics Unit will provide training for (internal) epidemiologists, data analysts and program managers and training for (external) entities utilizing public health data and GIS applications.

4. Modernize Nebraska's electronic laboratory reporting (ELR)
Between 10/2018 and 09/2019, Between 10/2018 and 09/2019, DHHS's Epidemiology and Informatics Unit will facilitate the modernization of Electronic Laboratory Reporting (ELR) to the State of Nebraska’s National Electronic Disease Surveillance System (NEDSS). Modernization will include, but not be limited

to the following:

- Collaborating with Epidemiology staff to improve their investigative processes and automate reporting to the CDC;
- Enhancing interoperability between registries, such as query and exchange of Immunization data from the Nebraska State Immunization Information System (NESIIS) to NEDSS;
- Augmenting the NEDSS database structure and content to bring it into alignment with International data standards through the use of LOINC, SNOMED and ICD10 Diagnostic codes;
- Improving stakeholder engagement and data quality through the automation of data quality assessment and creation of Laboratory Report cards;
- Providing expertise in the development of further registries in the Informatics development such as Electronic Case Reporting (eCR), improving big data utilization capacity such as syndromic data, and engaging NeHii (HIE) to enhance data exchange and sharing for public health practices.

Objective 3:

Nebraska Public Health Geographic Information System

Between 10/2018 and 09/2019, the DHHS Epidemiology and Informatics Unit will provide technical support, mapping, geocoding and updates to **1 state and 20** health departments and other users.

Annual Activities:

1. Provide GIS services

Between 10/2018 and 09/2019, the DHHS Epidemiology and Informatics Unit will provide GIS services for programs within Nebraska's Division of Public Health including but not limited to producing maps to demonstrate health status, disparities, health care services, outbreaks and risk factors.

2. Coordinate internal GIS activities

Between 10/2018 and 09/2019, the DHHS Epidemiology and Informatics Unit will coordinate internal GIS activities including surveillance and assessment.

3. Provide technical consultation and guidance

Between 10/2018 and 09/2019, the DHHS Epidemiology and Informatics Unit will provide technical consultation and guidance for internal and external GIS applications.

4. Actively participate in GIS steering committee

Between 10/2018 and 09/2019, the DHHS Epidemiology and Informatics Unit will actively participate in the statewide GIS steering committee meetings.

National Health Objective:

HO PHI-17 Accredited Public Health Agencies

State Health Objective(s):

Between 10/2018 and 09/2019, DHHS and up to 18 local health departments* will develop and/or maintain health improvement plans and will prepare for potential accreditation from the Public Health Accreditation Board.

*Nebraska has 20 Local/District Public Health Departments.

Baseline:

Currently five of Nebraska's twenty public health departments and the Nebraska Division of Public Health are accredited.

- The Nebraska Division of Public Health is currently implementing the 2017-2021 state health improvement plan. State health improvement plan workgroups have been meeting on an ongoing

basis to ensure implementation of the plan.
- 18 of Nebraska's 20 local health departments have completed or are in the process of completing a health improvement plan.

Data Source:
Nebraska Department of Health and Human Services, Division of Public Health

State Health Problem:

Health Burden:
Public health department accreditation is necessary to improve the quality and accountability of public health departments across the nation and ultimately the health status of Nebraskans. Currently the Nebraska Department of Health and Human Services (i.e., state health department) and five of the twenty local health departments are accredited. By working toward accreditation, Nebraska's public health infrastructure will become stronger and more consistent by meeting the PHAB standards and measures. All Nebraskans will receive quality and more uniform public health programs and services as health departments work toward and gain accreditation.

Target Population:
Number: 1
Infrastructure Groups: State and Local Health Departments

Disparate Population:
Number: 1
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $732,181
Total Prior Year Funds Allocated to Health Objective: $755,574
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $250,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

Accredited Public Health Agencies Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Implementation of State Health Improvement Plan (SHIP) Activities
Between 10/2018 and 09/2019, SHIP coalition members and partners will implement **3** key strategies from the State Health Improvement Plan.

Annual Activities:
1. Provide support to coalition members and partners
Between 10/2018 and 09/2019, DHHS staff will provide funding and support to coalition members and partners to implement key strategies from the SHIP. DHHS staff help coordinate coalition implementation work groups by planning quarterly meetings, reporting about activities, organizing and facilitating conference calls and providing other support.

Objective 2:

Maintain public health accreditation

Between 10/2018 and 09/2019, the DHHS Office of Community Health and Performance Management will increase the number of annual reports to the Public Health Accreditation Board for the Nebraska Division of Public Health from 2 to **3**.

Annual Activities:

1. Submit annual report to the Public Health Accreditation Board

Between 10/2018 and 09/2019, the Office of Community Health and Performance Management will submit its third annual report to the Public Health Accreditation Board which is a requirement to maintain accreditation status for the DHHS Division of Public Health.

2. Update plans and other key documents to maintain public health accreditation

Between 10/2018 and 09/2019, the Office of Community Health and Performance Management will update required documentation to maintain public health accreditation through the Public Health Accreditation Board. Documentation will provide evidence the Division meets all the standards and measures over the 12 PHAB domains in support of public health for Nebraskans.

3. Make at least one quality improvement in at least 6 of the 12 PHAB domains

Between 10/2018 and 09/2019, the Office of Community Health and Performance Management will facilitate an improvement in at least 6 of the 12 PHAB domains based on the results of our accreditation site visit report.

4. Track performance measures using a dashboard

Between 10/2018 and 09/2019, the Office of Community Health and Performance Management will track performance of State Health Improvement Plan, Strategic Plan and other key performance measures on the performance dashboard. The dashboards provide a visual representation for DHHS's Division of Public Health to track key performance indicators and determine/initiate quality improvements.

Objective 3:

Support for local health departments

Between 10/2018 and 09/2019, the Office of Community Health and Performance Management staff, contractors and local health department staff members will provide subject matter expertise, funding and training opportunities related to health improvement plan implementation and accreditation preparation to **18** local health departments and key partners.

Annual Activities:

1. Provide subject matter expertise

Between 10/2018 and 09/2019, DHHS staff will assess the needs of local health departments. Staff members will gather models and standards including evidence-based programs and accreditation information to share with local health departments. DHHS staff will also plan and arrange technical assistance and training opportunities. Technical support will be provided in the form of monitoring progress reports, one-on-one mentoring, conducting site visits and coordinating group updates and conference calls.

2. Financial assistance

Between 10/2018 and 09/2019, DHHS will provide funds for local health departments to prepare for public health accreditation. PHHSBG funds are used to leverage funds from state and other federally funded programs to provide financial assistance. Up to 18 awards will be made to local health departments.

3. Provide mock accreditation site visits and documentation training

Between 10/2018 and 09/2019, the Office of Community Health and Performance Management will provide mock site visits and documentation training to local health departments. Two local health departments will be in the process of preparing for PHAB site visits and staff will provide support towards these efforts.

Objective 4:

Training and educational resources

Between 10/2018 and 09/2019, DHHS staff and contractors will provide training on relevant topics related to core public health competencies to **19** health departments (one state and 18 local).

Annual Activities:

1. Facilitate training

Between 10/2018 and 09/2019, DHHS staff members will coordinate training opportunities for local health department staff by identifying resources (e.g., presenters, materials), arranging locations and presenters, marketing the training sessions and arranging registration and evaluation processes. Staff will also coordinate training opportunities for Division of Public Health staff based on the workforce development plan.

2. Mentoring

Between 10/2018 and 09/2019, DHHS staff will provide one-on-one mentoring to local health department staff members to increase their capacity to implement evidence-based programs and prepare for accreditation including planning, assessment and quality improvement.

State Program Title:

Worksite Wellness Program

State Program Strategy:

Program Goal: The PHHS Block Grant-funded Worksite Wellness Program is dedicated to improving the overall health of Nebraska adults through their places of employment.

Health Priorities: Building capacity among employers to provide data-driven, comprehensive worksite health promotion services statewide, primarily through Nebraska's worksite wellness councils and local health agencies.

Primary Strategic Partners: Local worksite wellness councils (WorkWell, Panhandle Worksite Wellness Council and WELCOM), local health departments and human services agencies, hospitals, state government, local health coalitions, public schools, universities and colleges, Nebraska DHHS Programs, Nebraska Sports Council, employers.

Evaluation Methodology: The project will be evaluated by tracking changes in health status data through Behavioral Risk Factor Surveillance Survey; LiveWell health assessment survey; reports from participating businesses on changes in health care and insurance costs; aggregate, de-identified biometric data obtained from employee health risk assessments; environmental and policy change information from the Nebraska Worksite Wellness Survey; and the Governor's Award database.

State Program Setting:
Business, corporation or industry, Community based organization, Local health department, Schools or school district, State health department, University or college, Work site

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective:

HO ECBP-8 Worksite Health Promotion Programs

State Health Objective(s):
Between 10/2018 and 09/2019, DHHS will provide subawards to two worksite wellness councils to conduct evidence-based health promotion activities for workers and to develop sustainability plans.

Baseline:
There are three well-developed worksite wellness councils operating in Nebraska. PHHSBG subawards will support continued development of two of the three councils: the Nebraska Safety Council (operates the WorkWell Council) and the Panhandle Public Health District (operates the Panhandle Worksite Wellness Council). DHHS staff will work with the councils to develop and implement sustainability plans.

Data Source:
Nebraska Department of Health and Human Services, WorkWell, Panhandle Council, WELCOM

State Health Problem:

Health Burden:
According to the 2013 Cancer Registry Incidence and Mortality Report there were 9,338 diagnoses of cancer in Nebraska. Prostate, lung, and colorectal cancers were the most common cancers among men, while breast, lung, and colorectal, were the most common in women. Together these cancers accounted for nearly half of all cancers in Nebraska in 2013.
Over the last five years more than half of all cancers were diagnosed in Nebraskans over the age of 65. And African Americans were also significantly more likely to be diagnosed with multiple kinds of cancer, as were Native Americans, Asian-Americans/Pacific Islanders, and Hispanics compared to Whites.

Overall 3,458 Nebraskans died from cancer in 2013. This is the fifth year that cancer has overtaken heart disease as the leading cause of death in Nebraska.

Target Population:
Number: 300,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 150,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander, White
Age: 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Nebraska Cancer Registry

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Task Force on Community Preventive Services states the "use of selected worksite policies and programs can reduce health risks and improve the quality of life for 141 million full and part-time workers in the United States." Nine exemplary companies were studied by the national task force. Two of the nine companies, Lincoln Industries and Duncan Aviation, are WorkWell member companies.

Well Workplace Seven Benchmarks for Success from Wellness Council of America (WELCOA), modified to meet local Nebraska needs.

Evidence based worksite health model.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $90,000
Total Prior Year Funds Allocated to Health Objective: $80,000
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $90,000
Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

Worksite Health Promotion Programs Objectives & Annual Activities

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Promote worksite wellness
Between 10/2018 and 09/2019, subrecipients and contractors will provide technical assistance designed to encourage active engagement in worksite health promotion activities to **150** worksites.

Annual Activities:
1. Training and technical assistance
Between 10/2018 and 09/2019, Two worksite wellness councils will provide technical assistance and training to at least 150 worksites.

The worksite wellness councils, partially supported by the PHHSBG, distribute newsletters and provide training seminars, peer learning/idea sharing, assistance with preparing to meet the qualifications for the Governor's Wellness Award and phone counseling.

2. Training and technical assistance for evidence-based interventions
Between 10/2018 and 09/2019, Wellness councils will provide technical assistance and training to employers specific to evidence-based interventions for active living, healthy eating and breastfeeding. Depending on Council needs, training may feature implementation of the CDC Worksite Physical Activity Toolkit, the Nebraska Walking Worksite Initiative, the Nebraska Healthy Beverage Guide, the WalkIts Toolkit for Walkable Worksites, healthy meetings and strategies for implementing workplace lactation programs.

3. Develop and implement sustainability plan
Between 10/2018 and 09/2019, Wellness councils will develop and begin implementing sustainability plans, exploring myriad funding resources in an effort to become self-sustaining.

4. Develop communications plan
Between 10/2018 and 09/2019, subrecipients and contractors will develop communications plans to encourage and enhance sustainability.