Nebraska Public Health Improvement Plan: Coordinated Chronic Disease and Prevention Priority

2013 - 2017

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
Health Promotion Unit

Nebraska Public Health Improvement Plan: Coordinated Chronic Disease and Prevention Priority 2013-2017

INTRODUCTION

The Nebraska Public Health Improvement Plan (NPHIP): Coordinated Chronic Disease and Prevention Priority represents the ongoing commitment of the Nebraska Department of Health and Human Services (NE DHHS) to reduce the mortality and morbidity of chronic disease through a collaborative process with stakeholders throughout the state. It is intended to provide direction and support to our agency, other state-level agencies, local and district health departments, health care providers, funding agencies, policy- and decision-makers, communities, and consumers in creating a system that proactively addresses the prevention and control of chronic diseases. We hope that the framework presented in this document will, through the formation of new partnerships and the strengthening of existing ones, promote the development of a coordinated and comprehensive approach to reducing mortality and morbidity due to chronic disease in Nebraska.

THE BURDEN OF CHRONIC DISEASE IN NEBRASKA

Chronic Disease Mortality in Nebraska

In 2010, five of the top seven leading causes of death in Nebraska included cancer, heart disease, stroke, chronic lower respiratory disease, and diabetes, accounting for more than 60% of all deaths among the state's resident population (see Table 1). The most current mortality data also show marked racial disparities in the burden of chronic disease; African-Americans in Nebraska and nationally are more likely to die from cancer, heart disease, stroke, and diabetes than are whites, while Nebraska Native Americans are more than four times more likely to die from diabetes than are whites, and are also more likely to die from chronic lower respiratory disease, a finding not seen at the national level (see Table 2).

Table 1. Number of deaths and mortality rates for all causes of death and the 10 leading causes of death—Nebraska and the United States, 2010

	Nebraska		United States
Cause of death	***Deaths***	***Rate****	***Rate****
All causes	15,171	717.8 (706.2, 729.4)	747.0 (746.0, 747.9)
Cancer	3,438	167.4 (161.7, 173.0)	172.8 (172.3, 173.2)
Heart Disease	3,355	154.2 (148.9, 159.5)	179.1 (178.7, 179.6)
Chronic Lower Respiratory Disease	1,008	48.8 (45.7, 51.8)	42.2 (42.0, 42.4)
Cerebrovascular Disease (Stroke)	876	40.5 (37.7, 43.2)	39.1 (38.9, 39.3)
Accidents (Unintentional Injuries)	700	35.8 (33.1, 38.5)	38.0 (37.8, 38.2)
Alzheimer's Disease	565	24.9 (22.8, 26.9)	25.1 (24.9, 25.3)
Diabetes	452	21.7 (19.6, 23.7)	20.8 (20.7, 21.0)
Nephritis, nephrotic syndrome, & nephrosis	290	13.4 (11.8, 15.0)	15.3 (15.2, 15.4)
Influenza & pneumonia	266	11.9 (10.5, 13.4)	15.1 (15.0, 15.2)
Suicide	193	10.4 (8.9, 11.9)	12.1 (12.0, 12.2)

*Mortality rates are age-adjusted to the 2000 US population and are expressed per 100,000 population; numbers in parentheses are 95% confidence intervals

Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012.

Table 2. Ratio of African-American to White and Native American to White mortality rates for deaths due to selected chronic diseases—Nebraska and the United States, 2006-2010

	African-American: White		Native American: White	
Cause of death	***Nebraska***	***United States***	***Nebraska***	***United States***
Cancer	1.35	1.19	0.92	0.69
Heart Disease	1.32	1.29	0.85	0.73
Chronic Lower Respiratory Disease	0.86	0.65	1.36	0.72
Cerebrovascular Disease (Stroke)	1.58	1.45	*	0.76
Diabetes	2.89	2.05	4.59	1.88

NOTE: Mortality rates used to calculate ratios were age-adjusted to the 2000 US population
*Mortality rate ratio was not calculated due to small numbers (< 20 deaths)
Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012.

Prevalence of Chronic Disease in Nebraska

The prevalence of several chronic diseases among Nebraska adults can be estimated using data from the Nebraska Behavioral Risk Factor Surveillance System (BRFSS), a random-sample telephone survey of people age 18 years and older conducted by the Nebraska Department of Health and Human Services in conjunction with CDC. Recent Nebraska BRFSS data show the estimated statewide prevalence of heart disease, stroke, arthritis, asthma, and diabetes, and that Nebraska compares favorably with the rest of the nation for each of these measures (see Table 3). These data also show that, with the exception of asthma, these conditions become increasingly commonplace as people reach the age 65 and beyond, to the point where many people in this age group have to cope with two or more of them simultaneously.

Table 3. Prevalence of selected chronic diseases and conditions, by age—Nebraska and the United States, 2011.

	All adults (age 18+ years)		Age 65+ years only	
	Nebraska	***US****	***Nebraska***	***US****
Ever told had angina or coronary heart disease	3.9 (3.6, 4.2)	4.1	12.6 (11.6, 13.7)	12.5
Ever told had heart attack	4.3 (4.0, 4.6)	4.4	12.9 (11.9, 14.0)	12.9
Ever told had stroke	2.6 (2.4, 2.9)	2.9	7.7 (6.9, 8.5)	8.0
Ever told have arthritis	23.4 (22.7, 24.1)	24.4	52.2 (50.7, 53.7)	52.2
Currently have asthma	7.3 (6.9, 7.8)	9.1	6.9 (6.2, 7.6)	8.2
Ever told have diabetes	8.4 (7.9, 8.8)	9.5	18.9 (17.7, 20.1)	20.8

NOTE: All numbers are expressed as percentages; numbers in parentheses are 95% confidence intervals
*US prevalence data represent the median prevalence of the 50 states and the District of Columbia
Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data, 2011.

Cancer Incidence in Nebraska

During the past five years (2005-2009), the average annual incidence rate for all types of cancer combined in Nebraska was 475.9 cases per 100,000 residents, a figure not significantly different from the national rate of 472.2 (see Table 4). The most frequently diagnosed types of cancer in Nebraska were female breast, prostate, lung and bronchus, and colon and rectum (colorectal); these sites accounted for more than half (53.0%) of all invasive cancer diagnoses. The incidence rates for female breast and prostate cancer in Nebraska were about equal to the national rates for these cancers, while lung cancer was diagnosed significantly less often in Nebraska and colorectal cancer was diagnosed significantly more often in Nebraska when compared to national rates.

Nebraska data for 2005-2009 show that the incidence of all types of cancer and prostate, lung, and colorectal cancers are significantly greater among African-Americans than among whites, patterns also seen at the national level. Cancer incidence also increases with advancing age; Nebraska data for 2005-2009 show that cancer diagnoses among children, adolescents, and young adults are relatively rare, with fewer than 100 invasive cancers diagnosed annually among anyone under the age of 20. Nearly three of every five cases (57.6%) were diagnosed among people 65 years of age or older.

Table 4. Incidence of all cancers and cancers of selected primary sites—Nebraska and the United States, 2005-2009.

	Nebraska		United States
Primary site§	***Number***	***Rate****	***Rate****
All sites	45,025	475.9 (471.4, 480.3)	472.2 (471.9, 472.6)
Female breast	6,204	124.7 (121.5, 127.9)	121.9 (121.7, 122.2)
Colon & rectum (Colorectal)	5,188	53.8 (52.3, 55.3)	46.2 (46.1, 46.3)
Lung & bronchus	5,964	63.0 (61.4, 64.7)	67.7 (67.6, 67.8)
Prostate	6,504	150.9 (147.3, 154.7)	151.4 (151.1, 151.6)

*Rates are age-adjusted to the 2000 US population and are expressed as the average annual number of diagnoses per 100,000 population, except for female breast cancer (rates are per 100,000 female population) and prostate cancer (rates are per 100,000 male population); numbers in parentheses are 95% confidence intervals

§Data include invasive cases only

Source: Centers for Disease Control and Prevention (CDC), National Cancer Institute. National Program of Cancer Registries 1999-2009 Incidence on CDC WONDER Online Database, released 2011.

Prevalence of Chronic Disease-Related Health Risk Behaviors in Nebraska

Health risk behaviors are those behaviors that can either improve health or increase the risk for disease or disability. While many behaviors have some impact on health, those that have the greatest impact on the risk of the most common chronic diseases include tobacco use, sedentary living, and poor nutrition. While these behaviors are considered modifiable, it is important to remember that individual behavior is influenced at several levels, including the interpersonal (family and community), organizational (schools and workplace), and systemic (policy and infrastructure) levels. Without adequately addressing all of these external influences, behavior change is difficult and unsustainable.

Tobacco Use

Despite the known health risks associated with tobacco use, an estimated one in five (20.0%) Nebraska adults reported in 2011 that they currently smoked cigarettes (see Table 5). The prevalence of smoking in Nebraska was nearly even with the U.S. median prevalence rate of 21.2%. In addition to cigarette smoking, 5.6% of Nebraska adults reported in 2011 that they currently used smokeless tobacco products. Among Nebraska adolescents in grades 9-12 who participated in the Youth Risk Behavior Survey in 2011, 15.0% reported that they were cigarette smokers and 6.4% reported that they used smokeless tobacco.

Physical Activity and Fruit and Vegetable Intake

More than one in four (26.3%) Nebraska adults reported in 2011 that they were physically inactive, i.e., they had not engaged in any leisure-time physical activity during the past month (see Table 5). In addition, less than one in five (19.0%) participated in enough aerobic physical activity and muscle strengthening activities to meet the current federal recommended guidelines. Barely one in five (20.9%) Nebraska adults reported in 2009 that they consumed the recommended five or more servings

of fruits and vegetables every day, a percentage even lower than the national median of 23.4% (see Table 5).

Table 5. Prevalence of selected chronic disease risk factors—Nebraska and the United States, 2011.

	Nebraska	United States*
Current smoker	20.0 (19.3, 20.7)	21.2
Physically inactive (no physical activity in past month)	26.3 (25.5, 27.1)	26.2
Consume 5+ fruits and vegetables every day	20.9 (19.6, 22.2)	23.4

NOTE: All numbers are expressed as percentages; numbers in parentheses are 95% confidence intervals
*US prevalence data represent the median prevalence of the 50 states and the District of Columbia
§Data were collected in 2009
Source: Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data, 2011.

Cost of Chronic Disease in Nebraska

Chronic diseases account for a considerable amount of health care costs. For heart disease alone, in 2011, it is estimated there were $677 million worth of inpatient hospital charges and $118 million for stroke care (Nebraska Hospital Discharge Data, 2011). According to the most recent estimates from CDC, the total cost of diabetes for the entire US was $174 billion ($116 billion for direct medical costs and $58 billion for indirect costs, i.e., the cost of lost productivity due to illness, disability, and premature mortality). Extrapolating these figures to Nebraska produces an estimate of the total cost of diabetes equal to $1.08 billion per year ($672 million for direct costs and $336 million for indirect costs).

BACKGROUND AND DEVELOPMENT OF THE NPHIP: COORDINATED CHRONIC DISEASE AND PREVENTION PRIORITY

As part of the Centers for Disease Control and Prevention (CDC) continuing effort to advance the prevention and control of chronic diseases, the agency launched an initiative designed to help states coordinate efforts to manage chronic diseases and address their multiple risk factors. As part of this initiative CDC developed four domains around which chronic disease prevention and control efforts should revolve. These domains are:

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 public health 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 use it 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.*

Domain 2 - Environmental approaches that promote health and support and reinforce healthful behaviors (statewide in schools, worksites, and communities).

- *Improvements in social and physical environments make healthy behaviors easier and more convenient for Americans. A healthier society delivers healthier students to our schools, healthier workers to our businesses and employers, and a healthier population to the health care system.*

These types of interventions support and reinforce healthy choices and healthy behaviors and make it easier for Americans to take charge of their health. They have broad reach, sustained health impact and are best buys for public health.

Domain 3: Health system interventions to improve the effective delivery and use of clinical and other preventive services in order to prevent disease, detect diseases early, and reduce or eliminate risk factors and mitigate or manage complications.

- *Health systems interventions improve the clinical environment to more effectively deliver quality preventive services and help Americans more effectively use and benefit from those services. The result: some chronic diseases and conditions will be avoided completely, and others will be detected early, or managed better to avert complications and progression and improve health outcomes. Health system and quality improvement changes such as electronic health records, systems to prompt clinicians and deliver feedback on performance, and requirements for reporting on outcomes such as control of high blood pressure and the proportion of the population up-to-date on chronic disease screenings can encourage providers and health plans to focus on preventive services. Effective outreach to consumers and reducing barriers to accessing these services is also key, as coverage alone will not ensure use of preventive services.*

Domain 4: Strategies to improve community-clinical linkages ensuring that communities support and clinics refer patients to programs that improve management of chronic conditions. Such interventions ensure those with or at high risk for chronic diseases have access to quality community resources to best manage their conditions or disease risk.

- *Community-clinical linkages help ensure that people with or at high risk of chronic diseases have access to community resources and support to prevent, delay or manage chronic conditions once they occur. These supports include interventions such as clinician referral, community delivery and third-party payment for effective programs that increase the likelihood that people with heart disease, diabetes or prediabetes, and arthritis will be able to "follow the doctor's orders" and take charge of their health – improving their quality of life, averting or delaying onset or progression of disease, avoiding complications (including during pregnancy), and reducing the need for additional health care.*

A requirement of the CDC initiative was the development of a Coordinated Chronic Disease and Prevention State Plan. Around the same time the CDC initiative was launched, NE DHHS began the process of developing a Nebraska Public Health Improvement Plan (NPHIP) and the NE DHHS Division of Public Health Strategic Plan. NE DHHS determined that to maximize staffing and resources and to ensure complete alignment of public health priorities both internal and external to NE DHHS that the Coordinated Chronic Disease and Prevention State Plan would align with NPHIP and the NE DHHS Division of Public Health Strategic Plan, therefore resulting in the NPHIP: Coordinated Chronic Disease and Prevention Priority.

Nebraska Public Health Improvement Plan

The NPHIP has been a collaborative effort to identify, analyze, and address health problems in the state; assess applicable data; develop measureable health objectives; invent tory statewide health assets and resources; develop and implement coordinated strategies; identify accountable entities; and cultivate state public health system "ownership" of the entire process.

The NPHIP was developed by a large group of both internal and external stakeholders called the Nebraska Public Health Improvement Plan Advisory Coalition (Appendix I). The SHIP process began with

a statewide health assessment, including the following assessments: themes and strengths; forces of change; health status; and system capacity. After reviewing the results of the four assessments, the NPHIP Advisory Coalition identified four priorities for public health in Nebraska to address over the next five years. These are:

- Reduce heart disease, stroke, and cancer morbidity, mortality, and associated risk factors
- Expand health promotion capacity to deliver public health prevention programs and policies across the lifespan
- Improve the integration of public health, behavioral health, environmental health, and health care services
- Expand the capacity to collect, analyze, and report health data

Subcommittees of the NPHIP Advisory Coalition developed a detailed work plan that contains the objectives, the activities to achieve these objectives, and the expected outcomes. The NPHIP work plan is intended to be a blueprint for improving the public health system in Nebraska. The plan assumes that one of the necessary ingredients for improving the health status of our population is to focus more on evidence-based prevention strategies and enhance the collaborative efforts between the private and public sectors.

NE DHHS Division of Public Health Strategic Plan

This strategic plan was developed by the Division of Public Health in the Nebraska NE DHHS (see Appendix II for a list of participants). This plan provides a road map for the direction the Division is going in the next three to five years. The plan is designed to identify What the Division plans to achieve, how it will achieve it, and how it will monitor those achievements. It also serves as a template for all employees in the Division as well as stakeholders to make decisions that move the organization forward. The priorities in the Division's strategic plan are very consistent with the results of the needs assessment and the priorities from the NPHIP.

HEALTH EQUITY

Health Equity is a key priority for NE DHHS and our stakeholders engaged in the implementation of the NPHIP. Addressing health disparities is reflected in all of the NPHIP priorities. Chronic disease and prevention efforts are also reflected in the NE DHHS Office of Health Disparities and Health Equity 2013-2017 Strategic Plan. The following objectives and activities related to chronic disease and prevention have been identified for the first year:

- **Promote chronic disease prevention, maternal child health promotion, reduction of obesity, and improve physical activity and nutrition among Nebraska's racial and ethnic minority populations**
    - Promote chronic disease prevention evidence-based programs through a variety of funding sources and opportunities.
    - Work collaboratively with the DHHS Chronic Disease and Prevention Programs to provide information to communities and organizations that work with minorities, and to work on program priority/focus areas.
    - Collaborate with the Every Woman Matters program to increase awareness and screening rates for breast, cervical, colon cancer and cardiovascular screening for racial and ethnic minority populations.
    - Conduct 30 presentations on chronic disease prevention, maternal child health issues and obesity and physical activity & nutrition throughout Nebraska through Community Health Educators and Lay Health Ambassadors.

MONITORING AND EVALUATION

The NE DHHS Office of Community and Rural Health in the Division of Public Health will be responsible for coordinating implementation activities of the NPHIP and the Division's Strategic Plan. However, it is anticipated and expected that many other entities within the Division and organizations outside the Division will assume the lead role in the implementation of these strategies and assist in the monitoring and evaluation.

The Office of Community and Rural Health will also be responsible for developing the evaluation plan, including performance measures that can be used to monitor and track the progress of the plan. The evaluation plan will follow the CDC framework for evaluation. The evaluation plan and performance measures will be identified in early 2014.

The NPHIP Advisory Coalition will continue to play a critical role in the monitoring and evaluation process. The Coalition will continue to meet on a regular basis to approve the performance measures and to monitor the progress based on these measures. It will also discuss the challenges or barriers to implementation and provide recommendations for change. For example, it may be necessary to discontinue the implementation of an ineffective strategy or modify an existing strategy to take advantage of new technologies or innovative evidence-based programs and policies. In the current highly dynamic environment, it is critical to be flexible and take advantage of new opportunities.

NPHIP: COORDINATED CHRONIC DISEASE AND PREVENTION PRIORITY FOCUS AREAS

The NPHIP: Coordinated Chronic Disease and Prevention Priority plan has five goals including:

- Increase competencies and capacity to deliver coordinated public health chronic disease and prevention programming.
- Increase effective use of data and information to assess, plan, deliver, and evaluate strategies to improve health.
- Build strong communities to ensure Nebraskans of all ages and abilities can live free of chronic diseases.
- Increase the number of Nebraskans that receive optimal preventive health services to prevent and reduce chronic disease.
- Increase Nebraska communities that provide quality community resources that improve management of chronic conditions and clinics refer patients to those resources.

Objectives from the NPHIP and the NE DHHS Division of Public Health Strategic Plan were organized into these five goals. The goals were developed to align with the four domains of public health for chronic disease prevention with the addition of a goal for the improvement of public health competencies and capacities.

NEBRASKA PUBLIC HEALTH IMPROVEMENT PLAN: COORDINATED CHRONIC DISEASE AND PREVENTION PRIORITY WORK PLAN 2013-2017

Long Term Goal: Prevent and reduce the burden of chronic disease for all Nebraskans.

Goal 1: Increase competencies and capacity to deliver coordinated public health chronic disease and prevention programming.

Objective 1.1: By December 2017, NDHHS staff and public health partners will develop an organizational framework and an implementation plan for building health promotion capacity throughout Nebraska.

Baseline: Currently, there is not existing organizational framework. **Data Source for Monitoring:** NPHIP Performance Management System				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Assess the effectiveness of collaborative health promotion throughout Nebraska	Administrator (DPH, Health Promotion Unit) and a LHD representative (form a task force)	June 2014	Division of Public Health (DPH), local health departments (LHDs), College of Public Health (CoPH), Public Health Association of Nebraska (PHAN), Nebraska Association of Local Health Directors (NALHD), local coalitions and organizations (such as Live Well Nebraska, Live Well Omaha, Community Action Agencies, etc.), Nebraska Association of Local Boards of Health (NALBOH)	Task Force created and meeting (minutes); Complete Wilder Collaboration Factors Survey annually; Completed assessment
Identify and link appropriate partners to implement strategies effectively and to carry out mutual goals for maximum impact in the four domains	Task Force	January 2015		Increased collaboration, reduced duplication of services and resources
Develop and implement a 3-year implementation plan based on assessment results that outlines the organizational framework	Task Force	March 2015		Completed plan; dissemination

Objective 1.2: By December 2017, NDHHS staff and public health partners will identify and implement health promotion workforce competencies and leadership skills.

Baseline: No current set of competencies **Data Source for Monitoring:** NPHIP Performance Management System				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Review existing model competencies for health promotion (e.g., NACDD, Directors of Health Promotion, Healthy People 2020, CHES, PHAB, NACCHO) and determine those that are most applicable	Task Force	October 2013	DPH, LHDs, CoPH, PHAN, NALHD, local coalitions and organizations	Competencies identified and disseminated
Develop health promotion workforce competencies	DPH; LHDs; CoPH; PHAN; NALHD	December 2014		Competencies selected and approved; disseminated
Assess the adequacy of current training opportunities to meet these competencies and workforce skills and identify a training plan for health promotion workers in NDHHS.	DPH	December 2014		Assessment completed; report Training plan established; evaluation of trainings provided; satisfaction surveys

Objective 1.3: By December 2017, increase the capacity of community organizations, including local public health departments and coalitions, to implement evidence-based strategies in community settings.

Baseline: Capacity is currently unknown. Baseline will be determined upon the completion of the workforce development assessment being completed late in 2013. **Data Source for Monitoring:** NPHIP Performance Management System; Workforce Development Assessment				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Assess the current capacity of community organizations to implement evidence-based strategies • Provide an inventory of strategies that are being implemented or have been proposed (e.g., "approved but not funded" grant applications) • Identify technical assistance, resource, capacity, and readiness needs • Document success stories	Great Plains Public Health Training Center (GPPHTC)	June 2013 December 2013	DPH, LHDs, local coalitions	Assessment report

Objective 1.4: By December 31, 2017, develop guidelines that encourage and support a greater focus on health disparities in chronic disease and prevention program activities throughout Nebraska.

Baseline: No existing guidelines **Data Source for Monitoring:** NPHIP Performance Management System				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Develop and distribute guidelines for addressing health disparities that can be used by staff when writing grants, issuing RFPs/RFAs, and planning program activities	Josie Rodriguez and Mary Gordon	July 2014	Diane Lowe, Peg Ogea-Ginsburg, Greg Moser, Rayma Delaney, and Kathy Karsting	Guidelines written and approved; disseminated
Work with Unit Administrators within NDHHS to integrate the health disparities guidelines into program planning and activities	Sue Medinger	Ongoing after July 2014	Mary Gordon and Josie Rodriquez	Increased health disparities being addressed in program activities
Develop a resource directory of evidence-based/best-practices to address health disparities.	Mary Gordon and Josie Rodriguez	December 2014	Diane Lowe, Greg Moser, Jennifer Severe-Oforah, Kathy Goddard	Directory developed and distributed

Goal 2: Increase effective use of data and information to assess, plan, deliver, and evaluate strategies to improve population health.

Objective 2.1: By December 2017, NDHHS staff and public health partners will identify and incorporate into practice workforce competencies and leadership skills for the epidemiology and data workforce.

Baseline: No existing competencies **Data Source for Monitoring:** NPHIP Performance Management System				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Establish a work group with representatives from the CoPH, LHDs, the DPH, and other stakeholder groups to review existing model competencies for epidemiology, biostatistics, and data informatics (e.g., CSTE, CoPH) and determine those that are most applicable	CoPH	October 2013	Division of Public Health (DPH), local health departments (LHDs), College of Public Health (CoPH), Public Health	Work Group created; meeting minutes; competencies identified and disseminated

Identify the most pressing workforce competency gaps and develop a training program to eliminate these gaps	CoPH; Work Group	February 2014	Association of Nebraska (PHAN), Nebraska Association of Local Health Directors (NALHD), local coalitions; nonprofit organizations	Review existing assessment results/reports; collection of additional data if needed; training opportunities documented; number of participants; evaluation of trainings provided
Formalize an internal NDHHS chronic disease and prevention data work group to create a venue for sharing ideas and improving communication among data staff	Health Promotion Unit Data Staff	December 2013	Chronic Disease and Prevention Program Managers	Work group created; meeting minutes

Objective 2.2: By December 2017, increase the proportion of health care systems with EHRs reporting blood pressure and A1c outcomes to NDHHS or partners by 50%.

Baseline: 20 **Data Source for Monitoring:** Documentation of EHR reports				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Develop a work team to coordinate the collection and management of EHR data	Chronic Disease Epidemiologist	January 2014	CIMRO of NE; American Heart Association, FQHCs, Minority Health Initiative grantees, BCBS of NE, NeHII	Work plan formed; meeting minutes
Identify methods for obtaining, securing, analyzing, and sharing EHR data	Chronic Disease Epidemiologist	June 2014		Methods developed
Host 5 health information technology (HIT) workshops throughout NE to increase healthcare providers ability to attain patient data from electronic health records	Chronic Disease Epidemiologist	June 2015		Workshops conducted; workshop evaluation;

Objective 2.3: By December 2017, provide at least four trainings on evaluating health promotion programs and policies.

Baseline: No trainings are currently offered **Data Source for Monitoring:** NPHIP Performance Management System; Documentation of training including agendas and training evaluations				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Determine the evaluation needs of local and state public health agency staff	CoPH, Great Plains Public Health Training Center	November 2013	LHDs, DPH, local coalitions and organizations	Needs assessment completed; report
Identify and offer training programs to meet these needs	CoPH	June 2014 and ongoing		Trainings completed; training evaluations
Provide guidelines and technical assistance to local health departments on evaluation methods and measures while they are developing grant applications	DPH	Ongoing	LHDs, CoPH, and other academic institutions	Number of technical assistance encounters

Goal 3: Build strong communities to ensure Nebraskans of all ages and abilities can live free of chronic diseases.

Objective 3.1: By December 2017, increase by 5% the availability of employee wellness programs that address nutrition access and policies; physical activity access and policies; breastfeeding support; and tobacco cessation services in workplace.

Baseline: Being determined in year one through a statewide worksite wellness survey. **Data Source for Monitoring:** Worksite Wellness Survey				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Representatives from worksite wellness councils, businesses, local health departments, and NDHHS Division of Public Health will develop a statewide strategic approach to expand worksite wellness programs across the state, including nutrition guidelines, physical activity opportunities,	Worksite Wellness Councils, LHDs, DPH	November 2013	LHDs, Worksite Wellness Councils (WorkWell, WELCOM, Panhandle Worksite Wellness Council), Nebraska Safety Council and other Safety Councils, CoPH	Documentation of meetings and participants; meeting minutes; Written recommendations

breastfeeding support, and chronic disease self-management			and other academic institutions, local businesses and associations (e.g. Chamber of Commerce), Agribusiness	
Expand worksite wellness council coverage statewide and coordinate technical assistance and resources with a focus on nutrition guidelines, physical activity opportunities, breastfeeding support, and chronic disease self-management		December 2016		Number of counties with businesses supported by a worksite wellness council; number of technical assistance encounters
Complete the Worksite Wellness Toolkit		December 2013		Completed toolkit; dissemination
Promote participation statewide in Governor's Excellence in Wellness Award program	All partners	Ongoing		Number of awards given
Conduct more return on investment (ROI) studies of worksite wellness programs to demonstrate their effectiveness		December 2017		ROI reports

Objective 3.2: By December 2017, increase from 22 to a minimum of 40 school districts or education agencies that implement a Coordinated School Health approach to improve the health of students by focusing on healthy eating, physical activity, obesity, and tobacco use.

Baseline: 22 school districts or education agencies
Data Source for Monitoring: Signed agreements to participate in the Coordinated School Health training process (Nebraska Department of Education or Local Health Departments)

Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Re-establish a formal Coordinated School Health (CSH) Leadership Team • State Leadership: Nebraska Department of Education (NDE) and Division of Public Health (DPH) • Advisory Group: NDE, DPH, LHDs, ESUs, schools	NDE, DPH, LHDs	July 2013	NDE, LHDs, Educational Service Units (ESU), CoPH and other academic institutions, Nebraska Action for Healthy Kids, Alliance for a Healthier Generation, Nebraska Children and Families Foundation, UNL Extension, Behavioral Health Regions, School District representatives including school boards, Nebraska Medical Association,	List of team members
Identify current CSH efforts (e.g., the components of CSH that schools have implemented) • Conduct focus groups to determine future needs, resources, attitudes, etc.	Leadership Team	July 2013		Summary of current CSH efforts and future recommendations
Create a strategic plan (CSH Blueprint) for expanding CSH in Nebraska that includes:	Leadership Team	June 2014		Written strategic plan (CSH Blueprint)

• Recommendations on leadership roles, resources, technical assistance needs, etc.; • Building relationships with schools between LHDs, ESUs, DPH; and • Identifying sustainable local and state resources for implementation • Focus on professional development and implementation of a healthy nutrition environment, and quality PA/PE in schools			American Cancer Society, American Heart Association-Nebraska	
Implement recommendations in the strategic plan	Leadership Team	Beginning July 2014, ongoing		Expanded CSH implementation

Objective 3.3: By December 2017, public health partners will increase professional lactation support across Nebraska through the use of International Board Certified Lactation Consultants (IBCLCs) by 5%.

Baseline: 100 IBCLCs **Data Source for Monitoring:** IBLCE				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Identify the current number and reach of IBCLCs	NE Breastfeeding Coalition	October 2013	DPH, CoPH, Nebraska Medical Association, Nebraska Hospital Association, Nebraska Chapter of the American Academy of Pediatrics, Nebraska Academy of Family Physicians, local breastfeeding coalitions, Women, Infant, and Children Programs, Live Well Omaha, La Leche League, Gretchen Swanson Center for Nutrition	Written assessment results
Develop a plan for increasing lactation support across Nebraska (e.g., leadership resources, how many IBCLCs are needed, and where are the major gaps, and how can these gaps be reduced)	NE Breastfeeding Coalition	October 2013		Written vision/plan
Provide training opportunities to increase the number of IBCLCs and extend these services in areas with no or inadequate coverage • Provide continuing education credits	NE Breastfeeding Coalition	December 2014		Training numbers; evaluation results
Add a module to the Community Health Worker curriculum for lactation support	DPH	December 2013		Module added; training provided

Goal 4: Increase the number of Nebraskans that receive optimal preventive health services to prevent and reduce chronic disease.

Objective 4.2: By December 2017, increase from 1 to 8 the number of organizations that receive Joint Commission Primary Care Medical Home certification.

Baseline: 1 organization **Data Source for Monitoring:** Joint Commission website				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Provide education on primary care medical home and team-based care	NDHHS Heart Disease and Stroke Prevention Program (HDSP) and Diabetes Program (DP)	April 2014 and ongoing	HCAN, NE Medical Association, CIMRO of Nebraska	Trainings held and agendas and evaluations documented
Provide education on how clinics obtain and use patient experience data to inform improvement efforts to be more responsive to the needs and preferences of their clientele	NDHHS Heart Disease and Stroke Prevention Program (HDSP) and Diabetes Program (DP)	April 2014 and ongoing	HCAN, NE Medical Association, CIMRO of Nebraska, Wide River Tec	Trainings held and agendas and evaluations documented
Assist FQHCs in becoming eligible to apply for certification through direct consultation and technical assistance developed for the specific needs of each clinic	NDHHS HDSP and DP; HCAN	January 2016	FQHCs	FQHC apply for certification

Objective 4.2: By December 2017, increase by 10% Nebraskans who receive preventive health screenings for chronic diseases such as cancer, heart disease, and diabetes through the community health hub project.

Baseline: To be determined in year one **Data Source for Monitoring:** Reports from the Community Health Hub projects				
Key Strategies and Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Complete and evaluate Community Health Hub pilot project to determine if screenings and follow-up increased • Share evaluation results	Office of Women's and Men's Health	December 2013	Local health departments (LHDs), Office of Women's and Men's Health, Community and	Evaluation report; presentation of results at community of practice or meeting

Increase coordination of existing efforts by meeting quarterly with pilot project partners • Seek new partners	Division of Public Health (DPH), Health Center Association of Nebraska (HCAN)	Quarterly beginning January 1, 2013; ongoing	Rural Health, HDSP, DP, FQHCs; Nebraska Medical Association; BCBS; CIMRO; Wide River; American Cancer Society; College of Public Health (CoPH)	Documented meeting minutes and attendance lists; Memorandum of Understanding (MOU) for the partnership group
Develop a standard guidance template for the needs assessment and identify potential tools and methods. • Test template and tools with pilot health hubs	DPH collaborative team	September 2013 Year 2		Written framework Evaluation results summary
Establish a method for sharing best practices for community health hubs • Outline method and implement	DPH, HCAN, NALHD	December 2013		Written framework
Develop protocols for all healthcare providers to share screening results with patients to encourage more effective communication regarding healthy living (e.g., BMI, blood pressure, and cholesterol) that follows clinical guidelines • Provide training to pilot hub providers	DPH, HCAN	December 2013		Written protocols; Evaluation of pilot providers adherence to protocols
Develop a coordinated statewide education campaign for health screenings • Provide a toolkit to local agencies for implementation	DPH Collaborative Team, Nebraska Cancer Coalition (NC2)	December 2013	DPH, HCAN	Campaign developed
Begin to document best practices from health hub pilot projects on DPH website	NALHD, DPH, HCAN	December 2013		Web documentation

Goal 5: Increase Nebraska communities that provide quality community resources that improve management of chronic conditions and clinics refer patients to those resources.

Objective 5.1: By December 2017, increase the percentage of adults with diagnosed diabetes that have ever taken a course or class in how to manage their diabetes from 59% to 64%.

Baseline: 59% **Data Source for Monitoring:** BRFSS				
Key Activities	**Lead Role**	**Target Completion Date**	**Partners**	**Expected Outcomes**
Identify the organizations that provide self-management programs for diabetes, asthma, and arthritis	NDHHS Diabetes Prevention Program and Heart Disease and Stroke Prevention Program	September 2013	Diabetes Self-Management Educators, Living Well Leaders, Diabetes Prevention Program Coordinators	Number and location of each program
Develop survey to determine how participants are referred to programs and the referral source		October 2013	University of Nebraska Bureau of Sociological Research	Survey developed
Implement survey of organizations that provide self-management programs		December 2013		Survey implemented
Analyze survey results to identify: • Who should be referring but is not; • Who is referring • Referral methods used and not		March 2014		Survey results analyzed and summarized
Promote establishment of self-management programs in at least 10 counties that currently do not have a program		June 2016	LHDs, YMCAs, EWM, Medicaid, OHDHE, PHAN, State Unit on Aging, Area Agencies on Aging	Increased access of self-management programs
Provide technical assistance to at least 6 communities to develop a referral system for self-management programs		December 2016		Number of communities that develop a referral system

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APPENDIX I:
NEBRAKA STATE PUBLIC HEALTH IMPROVEMENT PLAN

The State Public Health Improvement Plan Advisory Coalition

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Priority 1: Reduce heart disease and stroke morbidity, mortality, and associated risk factors

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Priority 2: Reduce cancer morbidity, mortality, and associated risk factors

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Priority 3: Expand health promotion capacity to deliver public health prevention programs and policies across the life span

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APPENDIX II:
NDHHS OFFICE OF PUBLIC HEALTH STRATEGIC PLAN

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