Nebraska FY 2015
Preventive Health and Health Services Block Grant

Work Plan

Original Work Plan for Fiscal Year 2015
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Governor: Pete Ricketts
State Health Officer: Courtney N. Phillips, MPA
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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Executive Summary

EXECUTIVE SUMMARY

On June 22, 2015, the Nebraska Preventive Health Advisory Committee reviewed and recommended programs for funding, contingent upon receipt of funding for FY 2015.

On June 10, 2015, the Public Hearing was convened.

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2015. 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 2015 Preventive Health and Health Services Block Grant is **$2,499,909**. This amount is based on an allocation table distributed by CDC.

Funding for FY 2015 Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: $80,000 total; **$36,752** of this total is a mandatory allocation to the **Nebraska Coalition to End Sexual and Domestic Violence (Nebraska Coalition)** which utilizes this funding to reduce the percent of total respondents on the Youth Risk Behavior Survey who report that they were forced to have sex when they did not want to from 8% to 7%. The Nebraska Coalition will continue its social marketing campaign, "Step Up Speak Out." The comprehensive campaign focuses on youth and young adults but also reaches parents, educators, youth-serving adults and the general population. The Nebraska Coalition will also provide sexual abuse prevention education for its network of 20 local domestic violence/sexual assault programs and will provide funding for local program advocates to attend a national conference focusing on prevention of sexual violence.

The various programs and activities that will be funded by this PHHSBG include the following.

Program: EMERGENCY MEDICAL SERVICES (EMS) PROGRAM
National Health Objective: AHS-I Rapid Prehospital Emergency Care (EMS)
Nebraska Health Objective: Increase the proportion of persons who have access to rapidly responding prehospital emergency medical services, both basic life support and advanced life support.
Funding: $30,000 will be utilized by the DHHS Emergency Medical Services/Trauma Services Program to help enhance the skills and effectiveness of state licensed EMS instructors. By improving instructor performance, EMS provider candidates will be better prepared and have greater potential for passing the licensing examination. In turn, EMS agencies will have more providers to respond to requests for services, increasing the proportion of persons who have access to rapidly responding pre-hospital emergency services.

Program: HEALTH DISPARITIES & HEALTH EQUITY PROGRAM
National Health Objective: ECBP-11 Culturally appropriate community health programs
Nebraska Health Objective: Identify and increase awareness, provide education and improve access to health services for racial and ethnic minorities, refugees and American Indians
PHHSBG Funding: $240,980 will be utilized by the Office of Health Disparities and Health Equity (OHDHE) to identify and increase awareness of health disparities among racial and ethnic minorities in Nebraska, provide education to expand community-based health promotion and provide training on cultural competency to improve access to health services for racial and ethnic minorities, refugees and American Indians in Nebraska. OHDHE will collect and analyze data, survey minority population growth and create and disseminate minority reports and report cards. Activities will include:

- Collecting and analyzing data from sources including birth, death and hospital discharge and minority surveillance data to identify health disparities among various racial and ethnic minority groups throughout Nebraska;

- Providing presentations, trainings and outreach events related to minority population growth, health disparities, health education and cultural intelligence to increase awareness of racial and ethnic minorities, refugees and American Indians in Nebraska;
- Developing reports and report cards addressing disparities in socioeconomic status, health status and minority population growth. This allows DHHS to monitor the health status of minorities of Nebraska and plan strategies for future interventions that target key disparities. These reports will be published in paper and disseminated at professional meetings, published on the Nebraska DHHS website, and the information will also be used in presentations to community members, partners, and stakeholders.

Program: INFECTIOUS DISEASE PROGRAM
National Health Objective: HIV-2 New HIV Infection
Nebraska Health Objective: Increase the percentage of high-risk persons tested for HIV/AIDS
PHHSBG Funding: $10,000 will be utilized by the DHHS HIV Program to increase the percentage of high-risk persons tested for HIV/AIDS to at least 70% of total tests performed. HIV Program staff 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 provide 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.

Program: INFECTIOUS DISEASE PROGRAM
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: $46,576 will be utilized by the DHHS STD 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: INFECTIOUS DISEASE PROGRAM
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.
$35,000 will be utilized by the STD 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 PROGRAM
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: $82,000 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:
- Contract with the Brain Injury Association of Nebraska to maintain a statewide Concussion Coalition to provide and guide concussion education, awareness and prevention across the state;
- Contract with Nebraska Educational Telecommunications (NET) to develop concussion education modules for health care providers; and
- Provide mini-grants (sub-awards) to up to four Safe Kids coalitions to conduct injury prevention

programming to reduce traumatic brain injuries in children and youth.

Program: INJURY PREVENTION PROGRAM
National Health Objective: IVP-16 Age-Appropriate Child Restraint Use
Nebraska Health Objective: Increase observed use of child restraints in Nebraska
PHHSBG Funding: $62,000 will be utilized by the DHHS Injury Prevention Program to provide child passenger safety training, provide 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 mini-grants 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 PROGRAM
National Health Objective: IVP-23 Deaths from Falls
Nebraska Health Objective: Reduce the age-adjusted death and injury rates from falls
PHHSBG Funding: $101,000 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; and
- Conducting Tai Chi training for new instructors and continuing education for current instructors.

Program: ORAL HEALTH PROGRAM
National Health Objective: OH-3 Untreated dental decay in adults
Nebraska Health Objective: Increasing oral health awareness and improving preventive oral care access among adults aged 65 and older.
PHHSBG Funding: $97,500 will be utilized to train care providers in the provision of oral care for persons residing in long-term care facilities, provide oral care education to adults and monitor and evaluate the program. Specific activities include:

- Renewing a contract with the University of Nebraska Medical Center College of Dentistry to train additional Registered Dental Hygienists with a Public Health Authorization;
- Integrating oral health awareness education into work with parents of young children who receive fluoride treatments and local health agencies; and
- Monitoring and evaluating progress of trainings and oral health awareness education.

Program: ORAL HEALTH PROGRAM
National Health Objective: OH-8-Dental services for low-income children and adolescents
Nebraska Health Objective: Provide fluoride varnish treatments, education and referrals to dental homes
PHHSBG Funding: $159,500 will be utilized to provide sub-awards through an RFA process to up to five local health departments, FQHCs and/or community contractors. Specific activities include:

- Providing education and preventive therapy and distributing oral health care supplies to clients who are of low-income in public health settings that are non-traditional for dental care (e.g., Early Head Start, Head Start, WIC);
- Utilizing Registered Dental Hygienists with a Public Health Authorization in the delivery of services; and

- Monitoring and evaluating the work of local community agencies.

Program: ORAL HEALTH PROGRAM
National Health Objective: OH-16 Oral and craniofacial state-based health surveillance system
Nebraska Health Objective: Develop an oral health surveillance system for Nebraska
PHHSBG Funding: $99,500 will be utilized to develop an oral health surveillance system for Nebraska. The DHHS Office of Oral Health & Dentistry (OOHD) will work with the DHHS Epidemiology & Informatics Unit to develop the surveillance system. Specific activities include:

- Reviewing current Nebraska data;
- Reviewing other states' surveillance systems for applicability to Nebraska;
- Developing a user-friendly conceptual surveillance system;
- Conducting an Open Mouth Survey of Nebraska's third graders;
- Establishing a memorandum of understanding with each partner (Association of State and Territorial Dental Directors, UNMC College of Dentistry and local community organizations); and
- Calibrating screeners.

Program: PUBLIC HEALTH INFRASTRUCTURE
National Health Objective: ECBP-10 Community-based primary prevention services
Nebraska Health Objective: Implement up to 10 community-based prevention projects
PHHSBG Funding: $345,000 will be utilized to issue RFAs and select sub-awardees to implement community-based prevention projects addressing chronic disease, oral health, trauma and injury prevention. DHHS staff will review applications, select awardees and monitor progress of projects. DHHS staff will also work with sub-awardees and/or contractors to expand the "Snack & Go" project, providing healthy snacks in convenience stores and providing healthy snacking education in nearby middle and high schools.

Program: PUBLIC HEALTH INFRASTRUCTURE
National Health Objective: EH-14 Radon mitigation systems in homes
Nebraska Health Objective: Increase the number of homes tested for radon in Nebraska
PHHSBG Funding: $30,000 will be utilized to identify and contract with an entity to implement a public awareness campaign, form a commission of stakeholders to help guide the campaign and assist in dissemination of information and monitor and evaluate the campaign.

Program: PUBLIC HEALTH INFRASTRUCTURE
National Health Objective: PHI-7 National data for Healthy People 2020 Objectives
Nebraska Health Objective: Maintain a comprehensive state-level health data surveillance system and sustain the capacity for collection and analysis of health data
PHHSBG Funding: $270,331 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. DHHS staff will identify all relevant health indicators for local health department reporting, update and execute analysis program and generate and disseminate reports. DHHS staff will review Healthy People 2020 objectives and latest trends, analyze Nebraska data for selected objectives and prepare a report for use by the state and local health departments and support accreditation efforts. DHHS will maintain the Nebraska Joint Public Health Data Center and will recruit and train an Informatician who will develop the Nebraska Public Health Informatics Strategic Plan and coordinate all public health informatics activities.

Program: PUBLIC HEALTH INFRASTRUCTURE
National Health Objective: PHI-17 Accredited public health agencies
Nebraska Health Objective: Achieve accreditation for the State Public Health Department
PHHSBG Funding: $424,700 will be utilized to support activities related to achieving accreditation for the State Public Health Department. DHHS will submit an application to the Public Health Accreditation Board and submit all documentation required for consideration for accreditation and will engage in activities in support of best practices accompanying accreditation. DHHS will focus on four key areas:

1. Implementing State Health Improvement Plan (SHIP) activities and providing support to coalition members and partners in implementing key strategies;
2. Issuing RFAs and providing oversight for sub-awardees addressing state health objectives, impact objectives and activities;
3. Providing funds and subject matter expertise for local health departments to implement evidence-based strategies related to implementation of their health improvement plans and preparation for accreditation;

Providing training and educational resources related to core public health competencies and mentoring to increase capacity to implement evidence-based programs and prepare for accreditation.

Program: WORKSITE WELLNESS PROGRAM
National Health Objective: ECBP-8 Worksite health promotion programs
Nebraska Health Objective: Provide support to worksite wellness councils
PHHSBG Funding: $110,500 will be utilized by DHHS to provide sub-awards to two of three worksite wellness councils to build capacity to conduct evidence-based health promotion activities for workers and to document improvement in the health status of workers. The two sub-awardees are the Nebraska Safety Council (operating the WorkWell Council) and the Wellness Council of the Midlands (WELCOM). Activities related to this objective include:

- Conducting the Nebraska Worksite Wellness Survey through a contract with the University of Nebraska-Lincoln Bureau of Sociological Research;
- Building worksite wellness capacity by providing training and technical assistance. DHHS will work with wellness councils, and those councils will in turn work with worksites providing information, resources and assistance regarding evidence-based practices for worksite wellness.

ADMINISTRATIVE COSTS
Nebraska equates "Administrative Costs" with "Indirect Costs." For FY15, up to $225,322 (less than the 10% allowable) will be utilized for salary and fringe benefits of staff supported by the PHHSBG funds in accordance with the State's current federally approved Indirect Cost Rate of 46.2%. DHHS uses the funds to support efficient operation of the PHHS Block Grant; provision of legal, accounting, personnel and information technology services; office space; utilities; printing; phone; and building and equipment maintenance.

Nebraska DHHS Administrators, Program Managers 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;
- Obtaining accreditation for the state health department and encouraging and providing technical assistance for local health department accreditation;
- Building capacity for both 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 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

Statutory Information

Advisory Committee Member Representation:

Advocacy group, American Indian/Alaska Native tribe, College and/or university, Community-based organization, Community health center, Community resident, Faith-based organization, Medical society or organization, Minority-related organization, Senior/adult serving organization, State health department, State or local government, Transportation organization

Dates:

Public Hearing Date(s):	**Advisory Committee Date(s):**
6/22/2015	6/10/2015
	6/22/2015

Current Forms signed and attached to work plan:

Certifications: Yes
Certifications and Assurances: Yes

Budget Detail for NE 2015 V0 R1	
Total Award (1+6)	$2,499,909
A. Current Year Annual Basic	
1. Annual Basic Amount	$2,459,074
2. Annual Basic Admin Cost	($225,322)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$2,233,752
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)	$2,270,504
C. Prior Year Dollars	
10. Annual Basic	$2,503,643
11. Sex Offense Set Aside (HO 15-35)	$40,835
(12.) Total Prior Year	$2,544,478
13. Total Available for Allocation (5+8+12)	$4,814,982

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$2,233,752
Sex Offense Set Aside	$36,752
Available Current Year PHHSBG Dollars	$2,270,504
B. PHHSBG $'s Prior Year:	
Annual Basic	$2,503,643
Sex Offense Set Aside	$40,835
Available Prior Year PHHSBG Dollars	$2,544,478
C. Total Funds Available for Allocation	$4,814,982

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 MEDICAL SERVICES PROGRAM	AHS-8 Rapid Prehospital Emergency Care (EMS)	$30,000	$0	$30,000
Sub-Total		**$30,000**	**$0**	**$30,000**
HEALTH DISPARITIES & HEALTH EQUITY PROGRAM	ECBP-11 Culturally Appropriate Community Health Programs	$240,980	$0	$240,980
Sub-Total		**$240,980**	**$0**	**$240,980**
INFECTIOUS DISEASE PROGRAM	HIV-2 New HIV Infection	$10,000	$0	$10,000
	STD-1 Chlamydia	$46,576	$0	$46,576
	STD-6 Gonorrhea	$35,000	$0	$35,000
Sub-Total		**$91,576**	**$0**	**$91,576**
INJURY PREVENTION PROGRAM	IVP-2 Traumatic Brain Injury	$82,000	$0	$82,000
	IVP-16 Age-Appropriate Child Restraint Use	$62,000	$0	$62,000
	IVP-23 Deaths from Falls	$101,000	$0	$101,000
	IVP-40 Sexual Violence (Rape Prevention)	$75,917	$2,544,478	$2,620,395
Sub-Total		**$320,917**	**$2,544,478**	**$2,865,395**
ORAL HEALTH PROGRAM	OH-3 Untreated Dental Decay in Adults	$97,500	$0	$97,500
	OH-8 Dental Services for Low-Income Children and Adolescents	$159,500	$0	$159,500
	OH-16 Oral and Craniofacial State-Based Health Surveillance System	$99,500	$0	$99,500
Sub-Total		**$356,500**	**$0**	**$356,500**
PUBLIC HEALTH INFRASTRUCTURE PROGRAM	ECBP-10 Community-Based Primary Prevention Services	$345,000	$0	$345,000
	EH-14 Radon Mitigation Systems	$30,000	$0	$30,000

	in Homes			
	PHI-7 National Data for Healthy People 2020 Objectives	$320,331	$0	$320,331
	PHI-17 Accredited Public Health Agencies	$424,700	$0	$424,700
Sub-Total		**$1,120,031**	**$0**	**$1,120,031**
WORKSITE WELLNESS PROGRAM	ECBP-8 Worksite Health Promotion Programs	$110,500	$0	$110,500
Sub-Total		**$110,500**	**$0**	**$110,500**
Grand Total		**$2,270,504**	**$2,544,478**	**$4,814,982**

State Program Title: EMERGENCY MEDICAL SERVICES PROGRAM

State Program Strategy:

Program Goal:
The PHHS Block Grant-funded **Emergency Medical Services (EMS)/Trauma Program** is dedicated to improving the capacity of local pre-hospital emergency medical services to provide emergency care to the sick and injured in Nebraska. The goal of this project is to help enhance the skills and effectiveness of state licensed EMS Instructors. By improving instructor performance, EMS provider candidates will be better prepared and have greater potential for passing the licensing examination. In turn, EMS agencies will have more providers to respond to requests for services. Personnel expenses are often the largest expenditure made by EMS providers, and turnover among volunteer EMS providers is equally expensive in human terms. An effective leader or educator can leverage the significant dollars and time spent on people into astounding results; however, to realize these results, investment must be made in the leaders themselves. Investment in leaders/educators will result in maintaining or growing the number of licensed EMS providers and ultimately to increasing the proportion of persons who have access to rapidly responding prehospital emergency medical services.

Health Priority:
In the 18 months between December 2013 and June 2015, the number of Nebraska licensed EMS providers dropped by 13% from 8,436 to 7,367. In the same period, the number of licensed EMS agencies dropped by 3% from 426 to 414. Not only did the number of providers and services decrease, but the number of licensed EMS instructors fell from 311 to 266, a 14% drop. In the calendar year 2014, the state's population is estimated to have increased by 1%.

Many of the EMS agencies that are still licensed have very small personnel rosters. Of the 414 agencies, 170 (41%) of them have 10 or fewer licensed members. A total of 35 (8%) have five or fewer, with a handful having only two licensed providers.

A supermajority (75%) of the EMS providers in the State of Nebraska are at the EMT licensure level. The EMT pass rate on the National Registry of Emergency Medical Technician's (NREMT) cognitive examination for 1/1/2013-12/31/2014 has stalled at around 78% cumulative (70% first attempt), while the cumulative results of the Emergency Medical Responder (EMR), Advanced Emergency Medical Technician (AEMT), and Paramedic levels have all risen to 88% or better. Persons passing the NREMT exam for a licensure level are generally eligible to become licensed, active EMS providers.

Primary Strategic Partners:
State licensed EMS-instructors, the Nebraska Instructor's (EMS) Society, state approved EMS training agencies.

Evaluation:
Create a written report which reflects the following:

- Number of licensed EMS-Instructors attending.
- Number of approved EMS training agencies represented.
- A summary of the topics and content presented.
- A comparison of candidate pass rates on the state's licensure examination.

The major markers of success will include comparing the cumulative NREMT pass rate of the EMT level following the activities funded by this grant. Additionally, we will compare the number of active/licensed EMS providers to the ones previously stated.

State Program Setting:

Community based organization, Medical or clinical site, University or college, Other: Emegency Medical Services and training agencies

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 AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):

Between 10/2014 and 09/2015, increase the proportion of persons who have access to rapidly responding prehospital emergency medical services, both basic life support and advanced life support.

Baseline:
As of June 24, 2015
Nebraska licensed EMS providers – 7,367.
Nebraska licensed EMS agencies – 414.
Nebraska licensed EMS agencies with 10 or fewer licensed providers - 170
Nebraska licensed EMS agencies with five or fewer licensed providers - 35
Nebraska's cumulative pass rate on the National Registry of Emergency Medical Technician's (NREMT) examination, January 1, 2013 through December 31, 2014: 79% (National rate is 80%).
Nebraska's cumulative pass rate on the NREMT examination at ALL licensure levels, January 1, 2013 through December 31, 2014: 84% (National rate is 80%).
Ratio of EMS providers to citizens: 1:255.

Data Source:
Nebraska DHHS Licensure Database, National Registry of Emergency Medical Technician's exam results.

State Health Problem:

Health Burden:
In the 18 months between December 2013 and June 2015, the number of Nebraska licensed EMS providers dropped by 13% from 8,436 to 7,367. In the same period, the number of licensed EMS agencies dropped by 3% from 426 to 414. Not only did the number of providers and services decrease, but the number of licensed EMS instructors fell from 311 to 266, a 14% drop. In the calendar year 2014, the state's population is estimated to have increased by 1%.

Many of the EMS agencies that are still licensed have very small personnel rosters. Of the 414 agencies, 170 (41%) of them have 10 or fewer licensed members. A total of 35 (8%) have five or fewer, with a handful having only two licensed providers. Annually, there are approximately 150,000 requests for EMS in Nebraska. This number is expected to grow exponentially over the next several years as more of the "baby-boomer" generation reaches retirement age and beyond.

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: 1. National Association of State EMS Officials. (2010 December) "EMS Instructor Qualifications: A Template to Assist States with Implementing the EMS Education Agenda for the Future: A Systems Approach."
http://www.nasemso.org/EMSEducationImplementationPlanning/documents/EMSInstructorQualificationsFinal.pdf

2. Margolis, Gregg S., Jonathan R. Studnek, Antonio R. Fernandez, Joseph Mistovich. Strategies of High Performing EMT-Basic Educational Programs. Prehosp Emergency Care. 2008;12:206–211.

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

Total Current Year Funds Allocated to Health Objective: $30,000
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: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

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:
EMS Educator Development
Between 10/2014 and 09/2015, Nebraska Department of Health & Human Services (DHHS) EMS/Trauma Program will increase the number of state sponsored instructor development activities from 1 to **3**.

Annual Activities:

1. Design and host EMS Educator's Academy
Between 10/2014 and 09/2015, with the assistance of state approved EMS training agencies, the EMS & Trauma Program will design and host an EMS Educator's Academy to help develop strong EMS educators. The academy will feature topics that are relevant to the modern day EMS educator. It will introduce best practices in EMS education, such as peer learning/mentoring in psychomotor skills instruction, switching from teacher-centered to learner-centered environments and the use of problem based learning. By improving the effectiveness of the instructor, the state will see improved performance on the licensing examination by the learner. In turn, this will lead to an increase in the number licensed EMS providers to serve the citizens of the State of Nebraska and an increase in the availability of and rapidness in the response of pre-hospital emergency care.

2. Support instructor development activities
Between 10/2014 and 09/2015, the EMS & Trauma Program will provide financial support to help offset the cost of additional EMS-Instructor development conferences that are hosted by the Nebraska Instructor's Society in conjunction with the Nebraska EMS Association's conferences. As with the EMS Educator's Academy, the conferences will help introduce best practices in EMS education, such as psychomotor skills instruction, educational ethics, using educational objectives to drive instruction and the development of classroom assessments. By improving the effectiveness of the instructor, the state will see improved performance on the licensing examination by the learner. In turn, this will lead to an increased number licensed EMS providers to serve the citizens of the State of Nebraska and an increase in the availability of and rapidness of response of pre-hospital emergency care.

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 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;
- 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, Native American tribes, Public Health Association of Nebraska, and the University of Nebraska at Lincoln (UNL).

Evaluation Methodology: The Health Disparities & Health Equity (HDHE) 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 HDHE Program evaluation activities will primarily use two types of evaluation: process and outcome. 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. DHHS staff 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 of reports and the dissemination of reports.

Outcome evaluations create an overall picture of program-success and they will document short-term results. Pre-post test methods will be used to measure participant changes in knowledge, attitudes, beliefs, or behaviors from 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.

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.

Position Name: Danna Bacon
Position Title: Community Health Educator
State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 1
Total FTEs Funded: 0.50

National Health Objective: HO ECBP-11 Culturally Appropriate Community Health Programs

State Health Objective(s):

Between 10/2014 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.

Baseline:

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

Nebraska Behavioral Risk Factor Surveillance System (BRFSS) (2011-2013)

- Hispanics, American Indians, and African Americans had 24-28% of their populations who perceived their health status to be fair or poor, compared to non-Hispanic Whites at about 12%.
- The proportion of Hispanics who do not have a personal physician (39.14%) was approximately twice that of non-Hispanic Whites (17.10%).
- The proportion of American Indian current smokers was approximately two times larger (39.8%) than the proportion of non-Hispanic White smokers (20.1%).
- In terms of stroke prevalence, African Americans and American Indians reported proportions that were at least twice that of non-Hispanic Whites.
- Compared to non-Hispanic Whites, American Indians had the largest ratio of those with diabetes at 2.3 times higher, while African Americans experienced 1.7 times more of their population with diabetes.
- Both American Indians (39.3%) and African Americans (44.4%) reported higher percentages of hypertension compared to non-Hispanic Whites (27.1%).
- American Indians and African Americans had roughly 1.3 times the prevalence of obesity (BMI 30+) than non-Hispanic Whites.
- Similar proportions of Hispanic and African American individuals reported being unable to see a physician due to cost (~25%); this proportion was more than twice that of non-Hispanic Whites (11.36%).

Nebraska DHHS Vital Statistics (2009-2013)

- African Americans experience a stroke mortality rate that is 1.5 times that of non-Hispanic Whites.
- American Indians (5.4 times higher) and African Americans (4.9 times higher) experience much higher HIV/AIDS mortality rates when compared to non-Hispanic Whites.
- In terms of congestive heart failure mortality, African Americans experienced a rate 1.7 times that of non-Hispanic Whites, while all other races had rates lower than that of non-Hispanic Whites.
- Of all racial minority groups, American Indians (3.6 times higher) and African Americans (2.4 times higher) experienced the highest levels of diabetes mortality when compared to non-Hispanic Whites.
- The death rate due to homicide among African Americans is 13 times higher than the rate for non-Hispanic Whites; for American Indians, the rate was nearly 5 times higher.
- Among all race/ethnicity groups, American Indians had the highest death rate due to non-motor vehicle accidents (26.0 per 100,000).
- The death rate due to chronic lung disease is 1.4 times greater in American Indians when compared to non-Hispanic Whites.

American Community Survey (2008-2012)

- The proportions of American Indians and African Americans living in poverty were 4.1 times and 3.5 times greater, respectively, than the proportion of non-Hispanic Whites.

- American Indians (11.4%) and African Americans (10.5%) experienced similarly high proportions of unemployment when compared to non-Hispanic Whites (3.2%).
- The Hispanic population was the group with the highest prevalence of those without high school education (48.1%), compared to the non-Hispanic White population (6.1%).
- The proportion of American Indians receiving food stamps was 6.4 times greater than non-Hispanic Whites. For African Americans, the proportion was 5 times greater.
- Few American Indians and Hispanics were enrolled in college or graduate programs, compared to other race/ethnic groups.
- Higher proportions of American Indians and African Americans reported disabilities than non-Hispanic Whites.

Data Source:
2009-2013 Nebraska Vital Statistics, 2009-2013 Birth certificate, 2011-2013 BRFSS, 2008-2012 U.S. Census Bureau ACS.

State Health Problem:

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

Hispanics

- Teen birth rates (ages 18-19) are 2.1 times higher in Hispanic/Latinos than non-Hispanic Whites
  - The percentage of individuals who did not exercise outside of work was 1.6 times greater for Hispanics compared to non-Hispanic Whites
  - The percentage of mothers receiving inadequate prenatal care was 2.1 times higher in Hispanics than non-Hispanic Whites

African Americans

- Low birth weight rates about two times higher than that of non-Hispanic Whites.
- Highest rate of cancer (224.0/100,000 population vs. 163.7/100,000 White population).
  - Highest mortality from heart disease (199.4 deaths/100,000 population) and are 1.3 times as likely to die of heart disease.
  - The percentage of individuals who did not exercise outside of work was 1.4 times greater for African Americans compared to non-Hispanic Whites

American Indian and Alaska Natives

- Death rate due to diabetes is 2.4 times as high as non-Hispanic Whites.
- Males were 1.2 times more likely to die from accidental or unintentional injury.
- The death rate due to pneumonia is 1.9 times greater for American Indians than for non-Hispanic Whites
- Teen birth rates (ages 18-19) are 2.7 times higher in American Indians than non-Hispanic Whites.

Source: Nebraska Vital Statistics (2009-2013); 2011-2013 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
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
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)

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: $240,980
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $100,000
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

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:
Minority data collection and analysis
Between 10/2014 and 09/2015, the Office of Health Disparities and Health Equity (OHDHE) will analyze **3** data sets and collect minority Behavioral Risk Factor data. Birth, death, and hospital discharge data will be used to identify health disparities among various racial and ethnic minority groups throughout Nebraska.

Annual Activities:
1. Minority hospital discharge data project phase 3
Between 10/2014 and 09/2015, per the created hospital discharge data with minority information in the previous fiscal year, OHDHE will join together with DHHS and University of Nebraska Medical Center

(UNMC) joint data center to finish a Nebraska Minority Discharge preliminary report which includes the leading causes of hospital discharge for all minority groups.

2. Summarize 2010-2014 leading cause of death data
Between 10/2014 and 09/2015, OHDHE will identify the top 10 leading causes of death (i.e., cancer, heart disease, stroke) and the related disparities between minority groups and non-Hispanic Whites.

3. Summarize 2010-2014 birth data
Between 10/2014 and 09/2015, OHDHE will identify the disparities between minority groups and non-Hispanic Whites related to maternal child health (i.e., infant mortality, low birth weight).

4. Minority surveillance data collection
Between 10/2014 and 09/2015, OHDHE will survey minority populations using the Nebraska Behavioral Risk Factor Surveillance System (BRFSS), adding eight race and reaction to race questions to the survey conducted by the University of Nebraska-Lincoln (UNL).

Objective 2:
Minority population growth and health disparities presentations and outreach
Between 10/2014 and 09/2015, OHDHE will provide presentations, trainings and outreach events regarding minority population growth, health disparities, health education and cultural intelligence to **31 entities** 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 10/2014 and 09/2015, OHDHE will complete 5 minority health population growth and 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 health education regarding chronic disease
Between 10/2014 and 09/2015, OHDHE will complete 6 presentations on chronic disease modules to minority populations, refugees and American Indians in Nebraska.

3. Provide cultural intelligence and social determinants trainings
Between 10/2014 and 09/2015, OHDHE will complete 10 trainings on cultural intelligence and social determinants to stakeholders in Nebraska to improve access to health services for racial and ethnic minorities, refugees and American Indians in Nebraska.

4. Conduct community-based outreach for minorities
Between 10/2014 and 09/2015, OHDHE will attend 10 community-based outreach events for racial and ethnic minorities, refugees and American Indians in Nebraska.

Objective 3:
Minority reports and report cards
Between 10/2014 and 09/2015, OHDHE will develop **9** reports and report cards addressing disparities in socioeconomic status, health status and minority population growth.

Annual Activities:
1. Complete Nebraska Minority Socioeconomic Status Reports
Between 10/2014 and 09/2015, OHDHE will identify and summarize key socioeconomic factors for all the Racial Ethnic minority groups in Nebraska based on US Census Bureau 2008-2012 American Community

Survey (ACS) data and will complete the report of this data. Compiling status reports allows OHDHE staff and OHDHE's partners to identify, with numerical data, important socioeconomic factors that influence the health of Nebraskans that should be targeted to reduce health disparities. This is valuable information for minority health initiative grantees, local health departments, and evidence-based chronic disease prevention programs. This also allows DHHS to monitor the health status of minorities of Nebraska and plan strategies for future interventions that target key disparities. These reports will be published in paper and disseminated at professional meetings, published on the Nebraska DHHS website, and the information will also be used in presentations to community members, partners, and stakeholders.

2. Complete minority socioeconomic status reports for Nebraska's 3 Congressional Districts
Between 10/2014 and 09/2015, OHDHE will identify and summarize key socioeconomic factors for all the Racial Ethnic minority groups in Nebraska Congress District One (new boundary), Congress District two (new boundary), and Congress District Three (new boundary), based on US Census Bureau 2008-2012 American Community Survey (ACS) data and will complete the three reports of these data. Doing so will allow OHDHE staff to identify socioeconomic factors that influence the health of individuals specific to each Congressional District, and identify ways to target these factors to reduce disparities. These reports are valuable to minority council meetings and minority health grantees as they help identify key areas that should be the focus of their health initiatives. These reports will be published in paper and disseminated at professional meetings, published on the Nebraska DHHS website, and the information will also be used in presentations to community partners and stakeholders, especially in presentations concerning social determinants of health. They will also be given to each Congressional District office and OHDHE satellite offices (Omaha, York, Grand Island, and Scottsbluff).

3. Complete Chronic Disease Fact Sheets
Between 10/2014 and 09/2015, complete 4 Chronic Disease fact sheets for Diabetes, Obesity, Heart Disease and Cancer. Report cards will include basic knowledge (symptoms, cause of disease, and risk factor of disease) and recommendations for all the diseases. The fact sheets also include some behavioral risk factor and vital statistics data. These fact sheets will serve as sources of helpful information for both lay audiences and health professionals. With basic knowledge surrounding chronic disease in addition to epidemiologic data, these fact sheets could help reduce the burden of chronic disease by educating Nebraskans. The fact sheets will also provide data to Minority Health Initiative grantees and support chronic disease prevention presentations and programs. They will be made available in hard copy at professional events, at DHHS offices, partner organizations and upon request. They will also be published online.

4. Update the Nebraska Disparity Report Card
Between 10/2014 and 09/2015, the OHDHE will create a report card containing the latest 2009-2013 data regarding minority health risk factors and outcomes in relation to those of non-Hispanic Whites. Each health indicator will be graded according to the disparity ratio derived from dividing the rate or percentage for each group by the non-Hispanic White population. The grades in this report card can indicate how well a population group is doing compared to non-Hispanic Whites. The report card is especially helpful in monitoring the health of minority populations of Nebraska and identifying top areas where efforts and resources should be allocated in an effort to reduce the disparities. The report card will be included in reports published by the OHDHE both online and on paper. They will also be used at professional events and conferences and made available upon request. The information will also be used in presentations given by OHDHE and other DHHS staff.

State Program Title: INFECTIOUS DISEASE PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded **Infectious Disease Program** is dedicated to limiting infection with two Sexually Transmitted Diseases (STDs), Chlamydia and Gonorrhea, as well as Human Immunodeficiency Virus (HIV) in Nebraska. This program provides free testing of samples at selected sites for residents of Nebraska who are at risk of infection with 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.

Certain 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).

The Infectious Disease Program helps to accomplish the goals of two 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 these 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.

Health Priorities:

STDs:

- Chlamydia is the most common STD in Nebraska, accounting for 5,553 cases in 2009.
- Gonorrhea is the second most common STD in Nebraska, accounting for 1,384 cases in 2009.

HIV/AIDS: During 2013, a total of 84 persons were newly diagnosed with HIV or Acquired Immunodeficiency Syndrome (AIDS) in Nebraska, and 2,468 persons were living with HIV/AIDS.

Primary Strategic Partnerships:

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:
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, haunted houses, concerts

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-2 New HIV Infection

State Health Objective(s):

Between 10/2014 and 09/2015, increase the percentage of high-risk persons tested for HIV/AIDS to at least 70% of total tests performed.

Baseline:
Of the 5,924 tests performed in 2000, 62% 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, 834new 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: $10,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $10,000
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:
Less than 10% - Minimal source of funding

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 10/2014 and 09/2015, the HIV Program, through contracting laboratory services and pre-purchase of rapid test kits will conduct **520** 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 10/2014 and 09/2015, contract for laboratory testing on samples, including those serving the target population (MSM and IDU). Number of tests to be completed:
40 HIV Confirmatory tests at $94 per test
520 Rapid Tests at $12 per test.

National Health Objective: HO STD-1 Chlamydia

State Health Objective(s):

Between 10/2014 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 17.4 percent positive.

Baseline:

Target and baseline: Nebraska

Objective	Reduction in *Chlamydia trachomatis* infections	2010 Baseline	2015 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	15.0	14.0
25-1C.	Males aged 15 to 34 years attending STD clinics	18.0	17.4

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 and rate -- among the target population estimated as 503,422 persons:

2011 -- 6,222 cases - rate 1,236 cases per 100,000 population
2012 -- 6,695 cases - rate 1,330 case per 100,000 population
2013 -- 6,917 cases - rate 1,374 cases per 100,000 population
2014 -- 5,560 cases - rate 1,104 cases per 100,000 population

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: $46,576
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $46,576
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:
50-74% - Significant source of funding

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 10/2014 and 09/2015, 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 10/2014 and 09/2015, 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 10/2014 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:

Target and baseline: Nebraska

Objective	Reduction in *Gonorrhea* infections	2010 Baseline-201 case rate	2015 Target-190 case rate
		Percent	
25-2a.	Females aged 15 to 34 years attending family planning clinics	0.5	0.4
25-2b.	Females aged 15 to 34 years attending STD clinics	5.6	5.6
25-2c.	Males aged 15 to 34 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.

The number of Gonorrhea cases and rate - among the target population estimated as 503,422 persons:
2011 -- 1,225 cases - rate 243 cases per 100,000 population

2012 -- 1,367 cases - rate 272 cases per 100,000 population
2013 -- 1,190 cases - rate 237 cases per 100,000 population
2014 -- 1,069 cases - rate 212 cases per 100,000 population

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: $35,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $35,000
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:
50-74% - Significant source of funding

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 10/2014 and 09/2015, 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 10/2014 and 09/2015, 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: Focus 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. Falls are also the second leading cause of unintentional injury death in Nebraska.
- Statewide, the leading cause of injury death is motor vehicle crashes, followed by suicide.
- 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 Association of Nebraska, Nebraska Athletic Trainer's 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 and Chapters, Child Passenger Technicians, Tai Chi and Stepping On instructors and other entities receiving contracts and sub-awards. 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 Nebraska Coalition on evaluation of social media campaign, including website hits and materials distributed.

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-2 Traumatic Brain Injury

State Health Objective(s):

Between 10/2014 and 09/2019,

- **Reduce the number of traumatic brain injuries requiring emergency department visits to less than 730 per 100,000 Nebraska children among children aged 1 to 14 years.**
- **Reduce the number of traumatic brain injuries needing hospitalizations to less than 19 per 100,000 Nebraska children among children aged 1 to 14 years.**

Baseline:

- In 2013, 730 of 100,000 Nebraska children (ages 1 to 14 years) required emergency room care for traumatic brain injury.
- In 2013, 19 of 100,000 Nebraska children (ages 1 to 14 years) were hospitalized due to traumatic brain injury.

Data Source:
Nebraska Hospital Discharge Data, 2013

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. Among the specific areas they chose for targeted efforts is TBI, especially reducing TBI in children and youth. DHHS partners with the Brain Injury Association of Nebraska and the Nebraska Office of Highway Safety, among others, to address the leading causes of TBI.

From 2009 to 2013, 1,761 Nebraskans died as a result of a traumatic brain injury, and such deaths were more common among males than females. In addition, there were 7,660 hospitalizations and 48,288 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 2012, the highest number of TBI related dates were among persons ages 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 Data, 2013

Target Population:
Number: 514,327
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: 514,327
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: $82,000
Total Prior Year Funds Allocated to Health Objective: $0
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

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 10/2014 and 09/2015, DHHS Injury Prevention Program and the Brain Injury Association of Nebraska will maintain **1** statewide concussion coalition to provide and guide concussion education, awareness and prevention across the state.

Annual Activities:
1. Nebraska Concussion Coalition
Between 10/2014 and 09/2015, DHHS will partner with the Brain Injury Association of Nebraska to establish a 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, community sports 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.

2. Health Care Provider Concussion Education
Between 10/2014 and 09/2015, DHHS will work with expert partners to develop concussion education modules for health care providers. Modules will be produced by Nebraska Educational Telecommunications (NET) through a contract and made available online on the DHHS website, as well as appropriate partner websites.

Objective 2:
TBI prevention sub-awards
Between 10/2014 and 09/2015, DHHS Injury Prevention and Control Program will provide sub-awards to **4** local Safe Kids coalitions to conduct injury prevention programming to reduce traumatic brain injuries in children and youth.

Annual Activities:
1. Administer TBI prevention sub-awards
Between 10/2014 and 09/2015, DHHS will administer sub-awards. Administration will include any or all of the following activities:

- Developing an application and process to determine which local Safe Kids programs will receive funding;
- Providing funding to local Safe Kids programs to administer injury prevention programs aimed at reducing traumatic brain injuries in adolescents and youth (i.e., bicycle and/or home safety injury prevention programming;
- Providing technical assistance to awardees about evidence based interventions in the areas of home and bicycle safety;
- Where applicable, conducting 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-16 Age-Appropriate Child Restraint Use

State Health Objective(s):
Between 10/2014 and 09/2019, **increase observed use of child restraints in Nebraska to 98 percent.**

Baseline:
Since inception of the child restraint usage survey, observed usage has risen from 56 percent (1999) to 96.9 percent (2014).

Data Source:

Nebraska Office of Highway Safety – Nebraska Department of Roads (DOR)

- 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 ages 1-19 years, the leading cause of death is motor vehicle or traffic crashes (CDC WISQARS, 2001-2010). Nebraska's child safety seat law only requires children up to age six 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.

In 2012, Safe Kids Nebraska funded 14 car seat safety checks. These events found a 72 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: 514,327
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: 514,327
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)
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: $62,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $20,000
Funds to Local Entities: $6,500
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

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 10/2014 and 09/2015, DHHS Injury Prevention Program, partners and contractors will increase the rate of observed use of child restraints from 96.9 percent to **98 percent**.

Annual Activities:
1. Child Passenger Safety Certification Training
Between 10/2014 and 09/2015, DHHS staff will conduct four National Highway Traffic Safety Administration Certification child passenger trainings (contingent upon outside funding). Staff will establish the training schedule and identify needed resources in conjunction with the Nebraska Child Passenger Safety Advisory Committee.

2. Provide technical assistance
Between 10/2014 and 09/2015, 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. Update Safe Kids Nebraska Child Care Transportation Training
Between 10/2014 and 09/2015, DHHS staff will update the Safe Kids Nebraska Child Care Transportation training curriculum, trainers and current child care providers to ensure current best practices in child passenger safety.

4. Provide mini-grants
Between 10/2014 and 09/2015, DHHS will provide a minimum of 10 mini-grants to local child passenger safety technicians to conduct community car seat check events.

5. Provide Child Care Transportation Training Technical Assistance

Between 10/2014 and 09/2015, 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 10/2014 and 09/2015, DHHS Injury Prevention Program and partners will provide education and information to **150** 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 10/2014 and 09/2015, 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 8.2 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 (2013):
- Falls in all age groups accounted for more than 4,700 hospitalizations (an age-adjusted rate of 220.6 per 100,000 population) and over 38,000 emergency department visits (an age-adjusted rate of 2,009 per 100,000).
- Falls were the second leading cause of unintentional injury death for all age groups, with unintentional falls resulting in 185 deaths (an age-adjusted rate of 8.2 per 100,000 population).
- Falls were the leading cause of injury death for adults in Nebraska aged 65 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: 1,114,029
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: 1,114,029
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 2013, Hospital Discharge Data 2013, 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: $101,000
Total Prior Year Funds Allocated to Health Objective: $0
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

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:

Older adult falls
Between 10/2014 and 09/2015, DHHS Injury Prevention Program, partners and contractors will conduct **4** meetings of the Older Adult Falls Prevention Coalition.

Annual Activities:
1. Older Adult Falls Coalition meetings
Between 10/2014 and 09/2015, 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 10/2014 and 09/2015, DHHS will provide education on older adult falls prevention by participating in the National Older Adult Falls Prevention Day (activities include local community events, distribution of materials, and media releases).

3. Tai Chi training
Between 10/2014 and 09/2015, DHHS will facilitate Tai Chi training for new instructors and Tai Chi update training for current Tai Chi instructors.

4. Tai Chi instructor development
Between 10/2014 and 09/2015, DHHS will enhance Tai Chi instructor development through the use of technical assistance and site visits provided by a Tai Chi consultant.

Objective 2:
Stepping On
Between 10/2014 and 09/2015, DHHS Injury Prevention and Control Program staff will establish **3** sites to implement the evidence-based fall prevention program Stepping On.

Annual Activities:
1. Train the trainers
Between 10/2014 and 09/2015, DHHS will recruit and train Stepping On trainers. Contracts will be established with the trainers.

2. Stepping On sites
Between 10/2014 and 09/2015, DHHS will develop an application for sites/partners to implement Stepping On locally. Staff will review applications, select sites and engage sub-award agreements with selected sites.

National Health Objective: HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 10/2014 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 year 2011 marks the eleventh administration of the YRBS. 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 2011 YRBS had an overall response rate of 66%; thus, for the

first time since 2005, 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:

Eight percent of the 3,832 YRBS respondents reported that someone forced them to have sex when they did not want to. (2011)

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 (2011), unweighted
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 11% of female students in grades 9–12 and 5% 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, 2011). (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
Primarily Low Income: No
Location: Specific Counties
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: $75,917
Total Prior Year Funds Allocated to Health Objective: $2,544,478
Funds Allocated to Disparate Populations: $20,000
Funds to Local Entities: $36,752

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

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 training to educators
Between 10/2014 and 09/2015, The Nebraska Coalition to End Sexual and Domestic Violence will conduct **4** primary prevention summits.

Annual Activities:
1. Host 4 one-day primary prevention summits.
Between 10/2014 and 09/2015, The Nebraska Coalition will host four one-day summits on prevention for Nebraska's network of local domestic violence/sexual assault programs on various topics related to the prevention of sexual assault and service access for victims of sexual assault. National and/or state experts will be utilized to conduct the summits. Staff of local and state sexual assault programs will enhance their skills for providing services for rape victims/survivors and will utilize training to enhance their efforts in sexual assault prevention.

2. National Sexual Assault Conference
Between 10/2014 and 09/2015, the Nebraska Coalition to End Sexual and Domestic Violence will identify and provide funding for eight local prevention educators to attend the National Sexual Assault Conference. Educators will attend sessions on prevention and on victim services at the conference and provide a report of lessons learned. Funding for this objective are in addition to the Sex Offense Set Aside funds.

Objective 2:
Social media sexual abuse prevention
Between 10/2014 and 09/2015, Nebraska Coalition to End Sexual and Domestic Violence staff will maintain **1** sexual assault primary prevention social marketing campaign.

Annual Activities:
1. Step Up Speak Out website
Between 10/2014 and 09/2015, the Nebraska Coalition will maintain the Step Up Speak Out (SUSO) website. Based on the premise that youth utilize social networking and digital media, the website provides education for youth, parents, teachers, and community members about bystander engagement (stepping up and speaking out when sexual assault occurs), healthy relationships (clues to identify when a relationship is abusive), supporting a friend who is experiencing violence and creating a safety plan for someone who has experienced sexual violence.

2. Step Up Speak Out social media outreach
Between 10/2014 and 09/2015, the Nebraska Coalition will maintain Facebook, Twitter, and YouTube sites to build communication about healthy relationships, bystander engagement and resource and service access for victims. Effectiveness of this component is measured by number of site visits and followers.

3. Produce and distribute public education material
Between 10/2014 and 09/2015, the Nebraska Coalition will provide SUSO posters, brochures and other campaign material to local programs and communities. The Nebraska Coalition will create one new brochure

on bystander engagement (how to become an upstander rather than a bystander), two new pocket cards with bystander engagement and healthy relationship tips and other information and promotional material. These materials will include information about prevention, access to services and how social media may be used to bully victims of sexual violence versus supporting and believing victims of violence. Effectiveness of the social media outreach will ultimately be measured by a reduction in the number of youth who report being forced to have sex.

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 young children and the elderly. Nebraska convenes an Oral Health Advisory Panel OHAP) that meets quarterly. The OHAP reviews statistics and trends and recommends priorities for the OOHD. The OHAP has reviewed a draft State Oral Health Plan that is in the approval process with DHHS. The OHAP and draft State Oral Health Plan guide and support OOHD's emphases.

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 College of Dentistry and others.
- Internal: DHHS programs including Epidemiology and Informatics Unit, Together for Kids and Families, Tobacco Free Nebraska Program, Office of Health Disparities and Health Equity and Community and Rural Health Planning. Other internal programs include the programs that work with the CDC 1305 grant which include the Heart Disease and Stroke Program, Diabetes Program and the Nutrition and Activity for Health (NAFH) Program.

Evaluation Methodology:
The Oral Health Program will work with the DHHS Division of Public Health Epidemiology & Informatics Unit and the Epidemiologist on staff in the Health Promotion Unit to develop an evaluation process for the oral health programs. A scan of available data sources was completed during the summer of 2012 that identified dozens of existing databases that are used to inform program decisions and document efficacy of interventions. OOHD will identify the most helpful evaluation methods and sources and work with the Epidemiology 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%

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

National Health Objective: HO OH-3 Untreated Dental Decay in Adults

State Health Objective(s):

Between 10/2014 and 09/2019,
OOHD will design and implement at least one oral health program aimed at increasing oral health awareness and improving preventive oral care access among adults aged 65 and older.

Baseline:
Due to the lack of staffing, the OOHD was unable to carry out significant program activities for several years. As of March of 2013, OOHD has a Dental Health Director and a Dental Health Coordinator. With staff now in place, OOHD is working on strategies to establish priorities and initiate activities to reach target populations.

Data Source:
DHHS Office of Oral Health and Dentistry

State Health Problem:

Health Burden:
Three measures of adult oral health status from the 2012 Nebraska Behavior Risk Factor Surveillance System (BRFSS) showed:
• 32.4% of adults 18 and older did not visit a dentist or dental clinic for any reason during the past year.
• 39.8% of adults 18 and older reported having any permanent teeth extracted due to tooth decay or gum disease.
• 71.5% of adults 65 and older reported having any permanent teeth extracted due to tooth decay or gum disease.
• 13.4% of adults 65 and older reported having had all of their teeth extracted due to tooth decay or gum disease.

The drafted 2015 Nebraska State Oral Health Plan states, “The elderly face some of the greatest barriers to access care because many of them are not ambulatory and may require a cane, wheelchair or lift to safely move. Delivery of services can be problematic due to these transportation issues. Physical limitations can prevent personal oral hygiene without the use of special cleaning aids. Many also suffer from cognitive impairment, dementia or other mental illness, making communication difficult. Multiple medication usage can create dry mouth and contribute to increased dental carries."
Nebraska's DHHS Division of Public Health Licensure Unit reports there are 285 licensed Assisted Living Facilities with a total of 11,680 beds, and 228 licensed Nursing Homes/Long Term Care Facilities with a total of 16,760 beds in Nebraska. People residing in assisted living facilities and nursing homes/long-term care facilities are the focus of the oral health program for older adults.

Target Population:
Number: 258,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 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: 258,000

Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 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: Nebraska BRFSS 2012, United States Census Bureau 2012

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

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.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $97,500
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $38,000
Funds to Local Entities: $97,500
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

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:
Improving adult oral health status
Between 10/2014 and 09/2015, OOHD and partners will implement **15** prevention, education and/or oral health care awareness services for adults across the state.

Annual Activities:
1. Train care providers
Between 10/2014 and 09/2015, trained Registered Dental Hygienists (RDH) with a Public Health Authorization who have completed the Tool Kit for Care Providers training will train care providers in long-term care facilities to provide daily oral care for residents. Better daily care will result in better oral health and earlier detection of dental decay in older adults.

2. Adult oral health awareness
Between 10/2014 and 09/2015, DHHS will integrate oral health awareness education into three areas:
1) Registered Dental Hygienists with the Public Health Authorization will train care providers in long term care facilities;
2) Parents of young children who receive fluoride treatments will receive education regarding the importance of good oral health care not only for their children, but the entire family;
3) Local health agencies will distribute resources providing information and education about overall oral health care.

3. Monitoring and evaluation
Between 10/2014 and 09/2015, the Dental Health Coordinator will monitor and evaluate the progress of trainings for Registered Dental Hygienists with a Public Health Authorization and training of care providers through periodic written reports, phone calls and site visits. The Dental Health Coordinator will work with the Chronic Disease Epidemiologist and others identified within the DHHS Division of Public Health to evaluate the outcomes of the program.

National Health Objective: HO OH-8 Dental Services for Low-Income Children and Adolescents

State Health Objective(s):

Between 10/2014 and 09/2019, **OOHD will partner with at least four local health agencies to provide fluoride varnish treatments, education and referrals to dental homes. The target audience 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:
Existing FQHCs and a few local health departments already provide preventive services to children from families with low income; however, few of the 15 sub-awardees from a previous Health Resources and Services Administration-funded oral health program were able to sustain their activities.

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 2005 survey of Nebraska third graders showed that almost 60% had a history of tooth decay, which is higher than the national average.[iv]
- A 2005 survey of Nebraska third graders found, that of schools that have 75% of children enrolled in the free and reduced lunch program, 70% 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]
- Of 43 pediatric dentists in 2011, only seven were located outside of Omaha and Lincoln. Additionally, 20 out of the 93 counties in Nebraska do not have a dentist, and 50% of the state is considered a general dentistry shortage area. [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 (2005). *Open Mouth Survey of Third Graders, Nebraska 2005*. 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: $159,500
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $159,500
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

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 10/2014 and 09/2015, up to five 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 10/2014 and 09/2015, LHDs, FQHCs, and community contractors will provide education combined with preventive therapy (fluoride varnish treatments) and the distribution of 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 10/2014 and 09/2015, 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 is in place for clinical screenings and application of fluoride varnish. The Dental Health Coordinator will work with the Chronic Disease Epidemiologist 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 10/2014 and 09/2019, **OOHD will work with DHHS's Epidemiology and Informatics Unit to develop one oral health surveillance system for the State of Nebraska.**

Baseline:
At this time, there is no oral health surveillance system for the State of Nebraska. A scan of available data sources was completed during the summer of 2012. 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 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 and to the 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: 40
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: 40
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: $99,500
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $99,500
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

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 system for Nebraska

Between 10/2014 and 09/2015, OOHD and the Epidemiology & Informatics Unit will develop **1** surveillance concept plan that will enable DHHS to track oral health status and service needs among various populations in Nebraska.

Annual Activities:

1. Develop an oral health surveillance system

Between 10/2014 and 09/2015, OOHD and the Epidemiology & Informatics Unit will develop the oral health surveillance system. Activities that may be included in developing the system 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. Prepare for the 2015 Open Mouth Survey of Nebraska third graders

Between 10/2014 and 09/2015, OOHD will prepare to conduct an Open Mouth survey of Nebraska third graders which will provide data for analysis and comparison to the 2005 Open Mouth survey of third graders in Nebraska. Among the activities that may be included in the preparation phase are: identifying and establishing a memorandum of understanding with each of the partners (ASTDD, UNMC College of Dentistry, and local community organizations) who will assist in completing the Open Mouth Survey, calibrating screeners and reviewing the work that was done in 2005 to ensure consistency in data collection.

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 assessment 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.
- Capacity building at the local level to provide all three Core Functions of Public Health and carry out all Ten Essential Services of Public Health.
- Providing trauma-informed care training for Public Health staff, together with Behavioral Health and Children & Family Services staff, to better equip them to serve the public.

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, 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.
- Trauma-informed care: UNMC, DHHS Division of Behavioral Health, DHHS Division of Children & Family Services

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.
- PHHS Block Grant Coordinator: Review of written reports from sub award 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: 100% Local: 0% Other: 0% Total: 100%
Position Name: Norm Nelson
Position Title: Statistical Analyst III
State-Level: 25% Local: 0% Other: 0% Total: 25%
Position Name: Jeff Armitage
Position Title: Lead Program Analyst
State-Level: 29% Local: 0% Other: 0% Total: 29%
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: Jessica Dean
Position Title: Staff Assistant I
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 6
Total FTEs Funded: 4.54

National Health Objective: HO ECBP-10 Community-Based Primary Prevention Services

State Health Objective(s):

Between 10/2014 and 09/2019, **DHHS staff will issue RFAs and fund up to 10 community-based prevention projects addressing areas such as injury, violence, mental illness, tobacco use, chronic disease, oral health and trauma and implement "Snack & Go" in at least two additional retail establishments in underserved communities.**

Baseline:
DHHS has not offered external, competitive awards for several years, and the "Snack & Go" program is a new initiative. The competitive awards will be new to DHHS; the "Snack & Go" program began in FY14 and reached six local retailers.

Data Source:
Nebraska Department of Health and Human Services, Epidemiology and Informatics Unit

State Health Problem:

Health Burden:
Obesity and overweight: Obesity and overweight are significant public health problems linked to many causes of death.

- Overweight and obesity are measured by an individual's body mass index (BMI), which is calculated as weight in kilograms divided by height in meters squared. Overweight (BMI=25.0-29.9) and obese (BMI=30.0+) individuals are at increased risk for many health conditions, including hypertension, type 2 diabetes, coronary heart disease, stroke, and some cancers; however, even modest weight loss (e.g., 5-10% of total body weight) is likely to produce health benefits.

- Two-thirds of adult Nebraskans (64.9%) were overweight or obese in 2010. The proportion of adults who are at risk due to obesity has risen considerably in recent years, increasing by nearly 7 percent between 2001 and 2010, for both Nebraska and the nation. In 2010, 27.5% of persons aged 18 and older in the U.S. and in Nebraska reported heights and weights that placed them in the "obese" category.

Cancer: Cancer was Nebraska's leading cause of death in 2010, surpassing heart disease.

- Nebraska Cancer Registry records that between 2007 and 2011, cancers of the prostate, breast, lung, and colon and rectum accounted for 23,371 diagnoses among Nebraska residents, which is over half of all invasive cancers diagnosed in Nebraska during these years.
- The Nebraska Cancer Registry recorded lists risk factors for certain types of cancer: tobacco use and exposure to tobacco smoke; too much sun or UV light exposure; excess body weight (obesity), dietary factors, excessive alcohol consumption; genetic and hereditary factors; and environmental exposures (such as radon, ionizing radiation and asbestos)
- Cancer incidence and mortality have reduced slightly over the past ten years in Nebraska.

Heart Disease and Stroke: Heart disease and stroke were the second and third leading causes of death in Nebraska in 2010, with rates of 154.2 and 40.5 deaths per 100,000 populations respectively.

- Most CVD risk factors are modifiable through simple lifestyle choices. While extensive efforts have been made in recent decades to improve these risk factors, many of these efforts have not been successful. This lack of successful behavior change can be attributed in part to societal barriers discouraging healthy behavior.

Risk Factors for CVD

Preventable Risk Factors: Type-2 Diabetes; High Blood Cholesterol; High Blood Pressure; Lack of Physical Activity; Overweight and Obesity; Unhealthy Eating; Smoking;

Non-Preventable Risk Factors: Increasing Age; Male gender; Race/Ethnicity; Family History of Premature CVD

- Large disparities in heart disease mortality exist between different racial and ethnic groups in Nebraska, making race an important non-preventable risk factor for heart disease.

Injury Prevention

Injury is a serious public health problem because of its impact on the health of Nebraskans including premature death, disability, and the burden on our health care system.

The Injury Problem in Nebraska:

- Injuries (including intentional and unintentional) are the fourth leading cause of death for Nebraskans.
- Unintentional and intentional injuries are the second leading cause of years of life lost for Nebraskans.
- In Nebraska, falls are the leading cause of all injury hospitalizations and outpatient treatment. Falls are the second leading cause of unintentional injury deaths.
- Motor vehicle crashes are the leading cause of death for person's ages 5 through 34 years.
- Suicide was the leading cause of injury death for individuals age 35-64.
- Prescription drug overdose is a growing problem in Nebraska.

2013 Nebraska Youth Risk Behavior Survey Quick Facts:

- Over half of 9th-12th grade students reported talking on the phone while driving, while nearly half reported texting/e-mailing while driving.
- Nearly 1 in 5 students reported riding in a car with a driver who'd been drinking alcohol, while 1 in 15 reported driving after drinking alcohol at least once in the past 30 days.
- About 1 in 6 males and 1 in 14 females reported not always wearing a seatbelt.

Target Population:

Number: 4,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: BRFSS, YRBS, Snack and Go Evaluation Tool, DHHS Epidemiology and Informatics Unit: Chronic Disease Status Report

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: National Prevention Strategy June 2011
CDC Recommended Community Strategies and Measurement to Prevent Obesity
IOM Local Government Actions to Prevent Childhood Obesity

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

Total Current Year Funds Allocated to Health Objective: $345,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $150,000
Funds to Local Entities: $345,000
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

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:
Community Based Prevention Projects
Between 10/2014 and 09/2015, community-based organizations chosen through a competitive grant process will increase the number of population-based primary prevention services in areas including injury, violence, mental illness, tobacco use, unintended pregnancy, chronic disease and nutrition from 0 to **10**.

Annual Activities:
1. Issue RFA
Between 10/2014 and 09/2015, develop and issue an RFA to invite external entities, including local health departments, tribal health departments, and other non-profit agencies, to apply for funds to carry out

projects addressing one of two goals: 1) continue and expand current primary and secondary preventive services, incorporating evidence-based strategies and well-established models shown to be effective in similar settings, or 2) improve staff capacity or competency through participation in training and/or education in order to improve the effectiveness of future delivery of public health interventions, both primary and secondary.

2. Select sub-awardees
Between 10/2014 and 09/2015, DHHS staff will review and rate applications and choose sub-awardees.

3. Monitor progress of sub-awardees
Between 10/2014 and 09/2015, DHHS staff will provide technical assistance, conduct site visits, monitor progress and review reports (narrative and financial) of sub-awardees.

Objective 2:
Increase access to healthy foods and beverages
Between 10/2014 and 09/2015, DHHS Staff, sub-awardees and/or contractors will increase the number of small retail venues and target schools within selected communities that sell healthier food options in underserved areas from 6 to **8**.

Annual Activities:
1. Increase retailer participation
Between 10/2014 and 09/2015, DHHS staff and sub-awardees will increase the number of retailers participating in the "Snack & Go" program. The existing project is a community intervention designed for convenience stores located near a middle or high school to promote healthier snack options in highly visible locations within their store. Modeled after research-tested interventions, Snack & Go involves conducting a pre-assessment of the store inventory, product placement, and promotion. Participating stores are then provided a Standard Kit of promotional materials and must agree to selecting two sites within their store for Snack & Go products. A community coordinator works with the participating store manager to select the products for the two locations. A post-assessment is completed at six months to determine if the products continue to meet the nutrition brand guidelines and to capture intervention outcomes.

2. Increase school participation
Between 10/2014 and 09/2015, DHHS will increase school-based youth engagement in the Snack & Go initiative, increasing both the number of youth involved and the number of schools participating.

National Health Objective: HO EH-14 Radon Mitigation Systems in Homes

State Health Objective(s):
Between 10/2014 and 09/2015, DHHS will increase the number of homes tested for radon in Nebraska from 73,280 to 75,000.

Baseline:
According to the Office of Indoor Air Quality 73,280 homes in Nebraska were tested in 2013.

Data Source:
Nebraska Department of Health and Human Services, Division of Public Health, Department of Community and Environmental Health, Environmental Health Unit, Office of Indoor Air Quality.

State Health Problem:

Health Burden:

According to the Nebraska Radon Program, the state has a very high incidence of radon in homes; over half of radon tests returned are above the action level of 4.0 pCi/L. Radon is a cancer-causing natural radioactive that is odorless, clear and tasteless. Radon is the leading cause of lung cancer among non-smokers and claims about 20,000 lives annually nationwide.
Although lung cancer was only the third most frequently diagnosed cancer among Nebraskans in 2012, according to the Nebraska Cancer Registry it was the year's leading cause of cancer mortality. During 2008-2012 lung cancer averaged about 1,200 diagnoses and 900 deaths per year.

Target Population:
Number: 100,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: Other
Age: 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: 48,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White, Other
Age: 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: Specific Counties
Target and Disparate Data Sources: Nebraska DHHS Office of Indoor Air Quality

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Environmental Protection Agency's "Protecting People and Families from Radon: A Federal Action Plan for Saving Lives" recommends public awareness to combat "Limited public understanding of the gravity of the risk and the fact that the solution is proven and uses readily available technology."
http://www.epa.gov/radon/pdfs/Federal_Radon_Action_Plan.pdf

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

Total Current Year Funds Allocated to Health Objective: $30,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $30,000
Funds to Local Entities: $0
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

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:
Radon Testing Awareness

Between 10/2014 and 09/2015, the DHHS Comprehensive Cancer program manager will identify a contractor who will design and implement a public awareness campaign that will increase the number of returned radon test kits from 73,280 to **75,000**.

Annual Activities:

1. Identify contractor to design campaign
Between 10/2014 and 09/2015, the DHHS program manager will work with partners external to DHHS and internally to identify a contractor skilled in public health and social marketing campaigns.

2. Form advisory committee for campaign
Between 10/2014 and 09/2015, the DHHS program manager will form a small working committee of radon stakeholders, including Comprehensive Cancer Control staff, Office of Indoor Air Quality staff, American Cancer Society partners, and if possible realtor association and home builders, to guide the campaign and assist in dissemination of information.

3. Implement the campaign
Between 10/2014 and 09/2015, DHHS will implement the campaign, with the assistance of the contractor and advisory committee.

4. Administer and evaluate the campaign
Between 10/2014 and 09/2015, DHHS, with the assistance of the contractor funded by the CDC Combined Cancer Grant, will design and implement an evaluation plan to assess the effectiveness of the campaign. The program manager will act as project manager for the campaign, approving all final work plans after they have been reviewed by the committee. The program manager will approve payments and make mid -ourse corrections as necessary.

National Health Objective: HO PHI-7 National Data for Healthy People 2020 Objectives

State Health Objective(s):

Between 10/2014 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 & Date 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.
Governor Heineman charged DHHS with being the leading source of reliable data and health information in Nebraska, strengthening programs that address the state's most challenging health issues. In addition, one

of the top five priorities for DHHS Division of Public Health is to become the trusted source of state health data. PHHSBG funds are invested in data systems development and maintenance in order to realize those purposes.

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. DHHS is preparing for accreditation, and the data surveillance and epidemiology functions 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: $320,331
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $210,000
Funds to Local Entities: $60,331
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

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:
Build capacity of Nebraska's public health informatics
Between 10/2014 and 09/2015, DHHS Epidemiology and Informatics Unit lead staff will increase the number of DHHS public health informaticians from 0 to **1**.

Annual Activities:
1. Recruit, hire and train Informatician
Between 10/2014 and 09/2015, Working with DHHS Human Resources, the Epidemiology and Informatics Unit lead staff will recruit, hire and train an informatician to develop Nebraska's public health informatics strategic plan and coordinate public health informatics activities.

Objective 2:
Data and surveillance
Between 10/2014 and 09/2015, DHHS staff will provide health data to **5,000** users of data.

Annual Activities:
1. Data gathering, analysis and reporting
Between 10/2014 and 09/2015, DHHS will identify all relevant health indicators for local health department reporting, update and execute analysis program, populate a multi-sheet spreadsheet with current data for these indicators for use by local health departments, generate and disseminate reports electronically.

The expected outcomes of this work include: (1) enhanced and ongoing availability of data 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 10/2014 and 09/2015, DHHS will review US HP2020 objectives and latest trends, analyze Nebraska data for selected HP2020 objectives and prepare a report of objectives and current rates and trends.

3. Enhance data quality, utilization and integration
Between 10/2014 and 09/2015, DHHS and the University of Nebraska Medical Center's College of Public Health, through a collaborative Joint Data Center, will update the existing data inventory, conduct routine data linkages (such as Cancer Registry to death certificate and hospital discharge data) and continue development of the "Public Health Master Person Index."

4. Develop and integrate data tracking system
Between 10/2014 and 09/2015, DHHS Chronic Renal Disease Program staff will develop an automated data tracking system for participants in the Chronic Renal Disease Program. The data system will link with other data sources and provide vital statistics regarding Nebraskans with end-stage renal disease.

National Health Objective: HO PHI-17 Accredited Public Health Agencies

State Health Objective(s):
Between 10/2014 and 09/2019, **DHHS and up to 18 local health departments* will develop health improvement plans and will prepare for potential accreditation from the Public Health Accreditation Board.**

***Nebraska has 20 LB692 Local/District Public Health Departments.**

Baseline:
Currently none of Nebraska's 20 public health departments is accredited.

- A state health improvement plan was completed in 2013 for the Nebraska Division of Public Health.
- 18 of Nebraska's 20 local health departments have completed or are in the process of completing a health improvement plan.

*LB692 was the legislative bill under which the current system of district health departments was established; funding began in May 2001. For the first time, all 93 Nebraska counties are covered by local/district health departments

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 neither Nebraska's state health department nor any of the 20 local health departments is 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:

Other: The Centers for Disease Control and Prevention in partnership with several other national public health organizations is supporting the implementation of a national voluntary accreditation program for state, local, tribal, and territorial health departments (http://www.cdc.gov/stltpublichealth/accreditation/cdc_role.html). The Nebraska Division of Public Health and local health departments are following the best practice process outlined by the Public Health Accreditation Board (http://www.phaboard.org/accreditation-overview/).

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

Total Current Year Funds Allocated to Health Objective: $424,700
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $100,000
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:
50-74% - Significant source of funding

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:
Apply for public health accreditation
Between 10/2014 and 09/2015, the DHHS Office of Community and Rural Health will increase the number of applications submitted to the Public Health Accreditation Board for the Nebraska Division of Public Health from 0 to **1**.

Annual Activities:
1. Submit application to Public Health Accreditation Board
Between 10/2014 and 09/2015, the Office of Community and Rural Health will submit an application and fee

to the Public Health Accreditation Board which will initiate the accreditation process for the DHHS Division of Public Health.

2. Submit all required documentation to the Public Health Accreditation Board
Between 10/2014 and 09/2015, The Office of Community Health and Performance Management will upload all required documentation into E-PHAB and submit to the Public Health Accreditation Board. This documentation will provide evidence the Division meets all the standards and measures over the 12 PHAB domains including a State Health Improvement Plan, State Health Assessment, Strategic Plan, Workforce Development Plan, and Performance Management System. Documentation provides evidence of the activities Nebraska is doing in support of public health for residents.

Objective 2:
Implementation of State Health Improvement Plan (SHIP) Activities
Between 10/2014 and 09/2015, SHIP coalition members and partners will implement **5** key strategies from the State Health Improvement Plan.

Annual Activities:
1. Provide support to coalition members and partners
Between 10/2014 and 09/2015, DHHS staff will provide funding and support to coalition members and partners to implement key strategies from the SHIP (e.g., initial assessments and data analysis). Key strategies addressed include expansion of International Board Certified Lactation Consultants to support breastfeeding ($4,200); assessment of data needs and solutions for local health departments ($24,000); identification of opportunities for integrations of public health, primary care, and behavioral health ($13,500); expansion of community health workers across Nebraska through education and coordination ($8,000); expansion and coordination of Coordinated School Health efforts across Nebraska ($6,000). DHHS staff help coordinate coalition implementation work groups by planning quarterly meetings, reporting opportunities, conference calls, and other support. DHHS staff establishe and manage contracts to help coalition members complete these activities.

Objective 3:
Support for local health departments
Between 10/2014 and 09/2015, 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 10/2014 and 09/2015, DHHS staff will assess the needs of local health departments. Staff members will gather models and standards including evidence-based program and accreditation information to share with local health departments. DHHS staff will also plan and arrange technical assistance and training opportunities. Subject matter expertise 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 10/2014 and 09/2015, DHHS will provide funds for local health departments to implement evidence-based strategies outlined in the state and local health improvement plans. PHHSBG funds are used to leverage funds from state and other federally funded programs to provide financial assistance of this type to local health departments. Up to seven awards will be made to local health departments.

Objective 4:
Training and educational resources

Between 10/2014 and 09/2015, DHHS staff and contractors will provide training on relevant topics related to core public health competencies, based on perceived need to **19** health departments (one state and 18 local).

Annual Activities:

1. Training Sessions

Between 10/2014 and 09/2015, 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 the 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 10/2014 and 09/2015, 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 10/2014 and 09/2019,
DHHS will provide sub-awards to two worksite wellness councils in order for them to build capacity to conduct evidence-based health promotion activities for workers and document improvement in health status of workers.

Baseline:
There are three well-developed worksite wellness councils operating in Nebraska. PHHSBG sub-awards will be made to support continued development of two of the three councils: the Nebraska Safety Council (operates the WorkWell Council) and the Panhandle District Health Department (operates the Panhandle Worksite Wellness Council).

Data Source:

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

State Health Problem:

Health Burden:
Only a fraction of Nebraska worksites offer comprehensive health promotion programs for their employees, leaving many opportunities to reach working-aged adults with health promotion and prevention messages, as well as services such as health risk appraisal and counseling to lower risk to employee health.

Chronic diseases, along with associated risk factors (tobacco, obesity, nutrition, and physical activity, etc.) have a direct impact on Nebraska adults. In 2013, cancer was the leading cause of death, accounting for 3,458 deaths (22%). Heart disease was the second leading cause of death, accounting for 3,326 deaths (21%). Diabetes was the seventh leading cause of death. More than 103,500 Nebraskan adults are estimated to have been diagnosed with any one of these three diseases. Worksites are a terrific venue to deploy evidence-based strategies to impact the risk factors associated with these chronic conditions and to reduce early death and disability.
In 2013, DHHS conducted a survey among 1,352 businesses in Nebraska to determine the extent of initiation and development of worksite wellness programs. The survey was issued to small, medium and large scale businesses across all sectors. Results showed:

-- 20% of worksites had a health promotion or wellness committee and a coordinator
-- Among health issues which employers noted as having a negative impact on the worksite, stress was listed as the top issue, affecting more than half of the worksites. The two commonly reported issues were obesity and lack of physical activity/exercise/fitness.
-- Blood pressure checks were the most common type of screening and health assessment offered to employees in 2013, and 14% of worksites had permanent on-site access for an employee to check their blood pressure.
-- Slightly more than a quarter of worksites (27%) had adopted a smoke-free policy for their entire worksite campus while 71% had restricted smoking, allowing it only in designated places.
-- Fewer than 20% of worksites had policies or guidelines that encourage healthful food options to be served at staff meetings or company-sponsored events.
-- 39% of worksites provided a private, secure lactation room on-site that is not a bathroom and 18% of worksites had a written policy supporting breastfeeding.
-- 15% of worksites had one or more designated walking routes, but only 3% used signage to promote those routes.
-- 50% of worksite had a policy that prohibited talking on cellular phones while driving a vehicle on duty, an increase from 42% in 2010.

Target Population:
Number: 120,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 20 - 24 years, 25 - 34 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 20,000

Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Department of Economic Development, Worksite Wellness Councils, CDC's Chronic Disease Cost Calculator

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: $110,500
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $110,500
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

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:
Conduct 2015 Nebraska Worksite Wellness Survey
Between 10/2014 and 09/2015, DHHS and the University of Nebraska-Lincoln Bureau of Sociological Research (BOSR) will conduct **1** worksite wellness survey, engaging current and prospective businesses that participate in the state's worksite wellness councils.

Annual Activities:
1. Develop, implement and report findings from the 2015 Nebraska Worksite Wellness Survey
Between 10/2014 and 09/2015, DHHS will contract with the University of Nebraska-Lincoln (UNL), Bureau of Sociological Research (BOSR) to conduct the collection of policy and environmental data in Nebraska worksites on various health improvement and chronic disease topics. BOSR will develop the methodology, communicate with the sample businesses, send the survey, collect/clean/analyze the data and provide data to DHHS to write the final report.

Objective 2:

Worksite Wellness capacity building

Between 10/2014 and 09/2015, sub-awardees 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 10/2014 and 09/2015, two worksite wellness councils will provide technical assistance and training to at least 145 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 10/2014 and 09/2015, DHHS staff will provide training for two of the three Worksite Wellness Councils to implement and provide technical assistance for employers specific to evidence-based interventions for active living, healthy eating and breastfeeding. Training will 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. Training will build the capacity of Worksite Wellness Councils to offer subject matter expertise to their member worksites.