

**Nebraska FY 2017
Preventive Health and Health Services
Block Grant**

Work Plan

Original Work Plan for Fiscal Year 2017

Submitted by: Nebraska

DUNS: 808819957

Printed: 6/30/2017 8:50 AM

Governor: Pete Ricketts

State Health Officer: Thomas Williams, M.D.

Block Grant Coordinator:

Gwen Hurst

301 Centennial Mall S.

P.O. Box 95026

Lincoln NE 68509-5026

Phone: 402-471-3485

Fax: 402-471-6446

Email: gwen.hurst@nebraska.gov

CDC Work Plan ID: NE 2017 V0 R0

Created on: 2/9/2017

Submitted on: 06/30/2017

Contents	Page
Executive Summary	3
Statutory and Budget Information	8
Statutory Information	8
Budget Detail	9
Summary of Allocations	10
Program, Health Objectives	12
<u>Emergency Health Systems - Stroke Systems of Care</u>	12
HDS-3 Stroke Deaths	12
HDS-17 Awareness of and Response to Early Warning Symptoms of Stroke	14
<u>Health Disparities & Health Equity</u>	17
ECBP-11 Culturally Appropriate Community Health Programs	18
<u>Infectious Disease</u>	26
HIV-13 Awareness of HIV Serostatus	27
STD-1 Chlamydia	28
STD-6 Gonorrhea	30
<u>Injury Prevention</u>	34
IVP-2 Traumatic Brain Injury	35
IVP-9 Poisoning Deaths	37
IVP-16 Age-Appropriate Child Restraint Use	40
IVP-23 Deaths from Falls	42
IVP-40 Sexual Violence (Rape Prevention)	45
<u>Oral Health</u>	49
OH-8 Dental Services for Low-Income Children and Adolescents	50
OH-16 Oral and Craniofacial State-Based Health Surveillance System	52
<u>Public Health Infrastructure</u>	55
C-1 Overall Cancer Deaths	56
PHI-7 National Data for Healthy People 2020 Objectives	58
PHI-17 Accredited Public Health Agencies	62
<u>Worksite Wellness</u>	66
ECBP-8 Worksite Health Promotion Programs	66

Executive Summary

FINAL 2017 Work Plan

Request to lift restrictions. Nebraska respectfully requests that restrictions be lifted from our Notice of Award so that FY2017 funds can be released.

Executive Summary

On May 17, 2017, the Nebraska Preventive Health Advisory Committee reviewed and recommended programs for funding, contingent upon release of restrictions from Nebraska's Notice of Award dated March 9, 2017.

On May 17, 2017, the Public Hearing was convened.

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2017. 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 2017 Preventive Health and Health Services Block Grant is \$2,568,275. This amount is based on an allocation table distributed by CDC.

Funding for FY 2017 Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: \$36,752 of this total is a mandatory allocation to address sexual offenses. Nebraska passes through the total amount to the Nebraska Coalition to End Sexual and Domestic Violence (the Coalition), an organization that provides leadership, technical assistance and financial support to 20 local domestic violence/sexual assault programs across the state. The Coalition 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 prevention campaign, "Step Up Speak Out." The comprehensive campaign focuses on youth and young adults and also reaches parents, educators, youth-serving adults and the general population. The Coalition will also provide sexual abuse prevention education for its network of local programs.

The PHAC approved *additional funding, above and beyond the required set aside*. Additional funding totals \$25,036 and will support "Engaging Men in Preventing Violence Against Women," a program endorsed by the U.S. Department of Justice Office of Violence Against Women (OVW). The Coalition will bring a national expert to provide training at their annual meeting. That expert will also provide subject matter expertise to three local programs as they assess their readiness to engage men in preventing sexual and domestic violence, build their capacity and implement the program in their communities. The other programs and activities that will be funded by this PHHSBG include those described below.

Program: Emergency Health Systems – Stroke Systems of Care

National Health Objective: HDS-3 Stroke Deaths

Nebraska Health Objective: Provide Stroke System of Care training and education to EMS services, critical access hospitals and improve public education

PHHSBG Funding: \$75,500 will be utilized by the DHHS Emergency Health Systems Program to work with primary stroke centers to target hospitals and EMS services to receive stroke system of care training. The EHS Program will also work with the Cardiac Registry project to add a minimal stroke registry data collection set for pre-hospital and hospital providers. The best outcome for a person having a stroke is focused on early and rapid identification, diagnosis, and treatment of stroke in efforts to prevent death and revers neurological deficits such as paralysis and speech and language impairments. Timely treatment is critical, and PHHS funding for this project will support training for first responders and hospital staff, thereby reducing stroke deaths and negative outcomes of strokes.

Program: Emergency Health Systems

National Health Objective: HDS-17 Awareness of and Response to Early Warning Symptoms of Stroke

Nebraska Health Objective: Provide Stroke System of Care training and education to EMS Services,

critical access hospitals and improve public education/awareness

PHHSBG Funding: \$7,000 will be utilized by the Nebraska Emergency Health Systems (EHS) program to provide collaborate with the Nebraska Stroke Advisory Council (NSAC) and the Stroke Region to incorporate a triage, treatment and transport plan that will help reduce morbidity of stroke patients. Specifically, the EHS program will work with NSAC and the American Stroke Association (ASA) to coordinate public education/awareness materials that will be distributed through a variety of media outlets.

Program: Health Disparities & Health Equity

National Health Objective: ECBP-11 Culturally appropriate community health programs

Nebraska Health Objective: Increase health equity and reduce health disparities in Nebraska.

PHHSBG Funding: \$301,951 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 and vulnerable populations such as those with intellectual or developmental disabilities in Nebraska; provide cultural and health disparity presentations; provide education and public health service for American Indians; collect and analyze data through the BRFSS regarding social determinants of health; develop reports addressing disparities in social determinants of health, especially among racial and ethnic minorities and vulnerable populations; establish data sets to identify and report behavioral risk factors for refugees in Nebraska; and involve self-advocates in home and community based services (HCBS) waiver audits.

Program: Infectious Disease

National Health Objective: HIV-13 Awareness of HIV Serostatus

Nebraska Health Objective: Limit Human Immunodeficiency Virus (HIV) in Nebraska

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

Program: Infectious Disease

National Health Objective: STD-1 Chlamydia

Nebraska Health Objective: Reduce the prevalence of chlamydia trachomatis infections among Nebraska's adolescent and young adult females and males, aged 15 to 34 years

PHHSBG Funding: \$45,000 will be utilized by the DHHS Infectious Disease Program to contract laboratory services that provide tests for sexually transmitted diseases (STDs) at selected clinics. The services will provide increased access to Disease Intervention Specialists (DIS) and report results in order to facilitate follow-up with people who are infected, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission. Douglas County Health Department STD staff will offer tests and DIS services as well as risk reduction and prevention strategies.

Program: Infectious Disease

National Health Objective: STD-6 Gonorrhea

Nebraska Health Objective: Reduce the prevalence of gonorrhea infections among Nebraska's adolescent and young adult females and males, aged 15 to 34 years

PHHSBG Funding: \$35,000 will be utilized by the Infectious Disease Program to contract laboratory services that provide tests for STDs at selected clinics. The services will provide increased access to Disease Intervention Specialists (DIS) and report results in order to facilitate follow-up with people who are infected, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission. Douglas County Health Department STD staff will offer tests and DIS services as well as risk reduction and prevention strategies.

Program: Injury Prevention

National Health Objective: IVP-2 Traumatic Brain Injury

Nebraska Health Objective: Reduce the number of traumatic brain injuries requiring emergency

department visits and hospitalization

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

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

Program: Injury Prevention

National Health Objective: IVP-9 Poisoning Deaths

Nebraska Health Objective: Reduce poisoning deaths in Nebraska, especially those related to prescription drugs

PHHSBG Funding: \$22,130 will be utilized by the DHHS Injury Prevention Program to provide subawards to at least two partners to administer injury prevention programs aimed at reducing unintentional poisonings in children and adults, provide technical assistance to subrecipients about evidence-based interventions to reduce unintentional poisonings and, where applicable, conduct evaluation to determine reach and behavior change as a result of the funded programming.

Program: Injury Prevention

National Health Objective: IVP-16 Age-Appropriate Child Restraint Use

Nebraska Health Objective: Increase observed use of child restraints in Nebraska

PHHSBG Funding: \$74,507 will be utilized by the DHHS Injury Prevention Program to provide child passenger safety training and technical assistance and coordinate Safe Kids Nebraska Child Care Transportation Training. Among the activities are:

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

Program: Injury Prevention

National Health Objective: IVP-23 Deaths from Falls

Nebraska Health Objective: Reduce the age-adjusted death and injury rates from falls

PHHSBG Funding: \$150,487 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

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

Nebraska Health Objective: Provide subawards to at least three local health agencies to provide oral screenings, fluoride varnish treatments, education and referrals to dental homes.

PHHSBG Funding: \$171,083 will be utilized to provide subawards to local health departments and FQHCs to provide oral screenings, fluoride varnish treatments, education and referral to a dental home to 2,500 children and their families. Primary focus locations will be WIC and related programs that provide services for new mothers, their children and families; and Early Head Start and preschool classes for children aged 2-3 years and Head Start classes for children aged 4-5 years. Services will be provided by

Registered Dental Hygienists with a Public Health Authorization.

Program: Oral Health

National Health Objective: OH-16 – Oral and Craniofacial State-Based Health Surveillance System

Nebraska Health Objective: Work with the DHHS Epidemiology and Informatics Unit to develop one oral health surveillance framework for the State of Nebraska

PHHSBG Funding: \$57,333 will be utilized to develop the oral health surveillance concept plan, including working with the Association of State and Territorial Dental Directors (ASTDD) and the Council of State and Territorial Epidemiologists (CSTE). Funding will also support preparations to conduct a future Nebraska Oral Health Survey of Older Adults, partnering with ASTDD, the State Unit on Aging, Registered Dental Hygienists with a Public Health Authorization and local community organizations.

Program: Public Health Infrastructure

National Health Objective: C-1 Overall Cancer Deaths

Nebraska Health Objective: Impact cancer mortality and incidence on a wide variety of topics

PHHSBG Funding: \$100,000 will be utilized to provide subawards to local health departments, federally qualified health centers, tribal organizations, 501 c 3s and American College of Surgeons Commission on Accredited Cancer Centers. Organizations will be offered the opportunity to apply for up to \$10,000 to implement one of the listed evidence-based activities in the Nebraska Cancer Plan. DHHS will provide technical assistance/subject matter expertise and will provide some data support as part of this project.

Program: Public Health Infrastructure

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

Nebraska Health Objective: Maintain a comprehensive state-level health data surveillance system and sustain the capacity for collection and analysis of health data for use in development of health status indicators

PHHSBG Funding: \$318,480 will be utilized by DHHS staff to maintain a comprehensive state-level health data surveillance system and sustain the capacity for collection and analysis of health data. The DHHS Epidemiology and Informatics Unit will gather, analyze and report data; develop and enhance Nebraska's public health informatics infrastructure; and provide technical support, mapping, geocoding and updates through the Nebraska Public Health Geographic Information System (GIS). All activities are meant to support the goal of moving DHHS toward being the trusted source of health data in Nebraska.

Program: Public Health Infrastructure

National Health Objective: PHI-17 Accredited public health agencies

Nebraska Health Objective: DHHS and up to 18 local health departments will develop and/or maintain health improvement plans and will prepare for or maintain accreditation from the Public Health Accreditation Board

PHHSBG Funding: \$732,181 will be utilized to support coalition members and partners to implement key strategies from the SHIP; maintain the State's public health accreditation; provide support for local health departments as they prepare for and maintain accreditation; and provide training and educational resources on topics related to core public health competencies, based on perceived need. Training in mental health first aid will be offered to LHDs and state health department staff.

Program: Worksite Wellness Program

National Health Objective: ECBP-8 Worksite health promotion programs

Nebraska Health Objective: Improve the overall health of Nebraska adults through their places of employment

PHHSBG Funding: \$80,000 will be utilized by DHHS to provide sub-awards to two of three worksite wellness councils to conduct evidence-based health promotion activities for workers and to develop sustainability and communications plans.

Administrative Costs

Nebraska equates "Administrative Costs" with "indirect costs" which are charged against salary and fringe benefits of the staff supported by the PHHSBG funds in accordance with the State's current federally approved Indirect Cost Rate (32.6%). Nebraska does not exceed the cap of 10% imposed on

Administrative Cost. DHHS uses the funds to support efficient operation of the PHHSBG through provision of legal services, personnel services, information technology services, office space, utilities, printing, phone, building and equipment maintenance. Workforce development activities may be supported with administrative costs, including training related to grants management and monitoring, subject matter expertise and attendance at the PHHS annual meeting for block grant coordinators. For FY17, \$252,744 is allocated for Administrative Costs, or 10% of the basic award.

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

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

Statutory Information

Advisory Committee Member Representation:

Advocacy group, American Indian/Alaska Native tribe, College and/or university, Community-based organization, Community resident, County and/or local health department, Drug and/or alcohol organization, Foundation, Hospital or health system, Mental health organization, Minority-related organization, Schools of public-health, State health department, State or local government, Transportation organization

Dates:**Public Hearing Date(s):**

5/17/2017

Advisory Committee Date(s):

2/15/2017

5/17/2017

Current Forms signed and attached to work plan:

Certifications: Yes

Certifications and Assurances: Yes

Budget Detail for NE 2017 V0 R0	
Total Award (1+6)	\$2,568,276
A. Current Year Annual Basic	
1. Annual Basic Amount	\$2,527,441
2. Annual Basic Admin Cost	(\$252,744)
3. Direct Assistance	\$0
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$2,274,697
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)	\$2,311,449
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)	\$4,855,927

Summary of Funds Available for Allocation	
A. PHHSBG \$'s Current Year:	
Annual Basic	\$2,274,697
Sex Offense Set Aside	\$36,752
Available Current Year PHHSBG Dollars	\$2,311,449
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	\$4,855,927

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL Year PHHSBG \$'s
Emergency Health Systems - Stroke Systems of Care	HDS-3 Stroke Deaths	\$75,500	\$60,000	\$135,500
	HDS-17 Awareness of and Response to Early Warning Symptoms of Stroke	\$7,000	\$0	\$7,000
Sub-Total		\$82,500	\$60,000	\$142,500
Health Disparities & Health Equity Program	ECBP-11 Culturally Appropriate Community Health Programs	\$301,951	\$386,171	\$688,122
Sub-Total		\$301,951	\$386,171	\$688,122
Infectious Disease Program	HIV-13 Awareness of HIV Serostatus	\$30,962	\$10,000	\$40,962
	STD-1 Chlamydia	\$45,000	\$46,576	\$91,576
	STD-6 Gonorrhea	\$35,000	\$35,000	\$70,000
Sub-Total		\$110,962	\$91,576	\$202,538
Injury Prevention Program	IVP-2 Traumatic Brain Injury	\$36,146	\$92,000	\$128,146
	IVP-9 Poisoning Deaths	\$22,130	\$0	\$22,130
	IVP-16 Age-Appropriate Child Restraint Use	\$74,507	\$73,122	\$147,629
	IVP-23 Deaths from Falls	\$150,487	\$101,000	\$251,487
	IVP-40 Sexual Violence (Rape Prevention)	\$73,689	\$40,835	\$114,524
Sub-Total		\$356,959	\$306,957	\$663,916
Oral Health Program	OH-8 Dental Services for Low-Income Children and Adolescents	\$171,083	\$267,166	\$438,249
	OH-16 Oral and Craniofacial State-Based Health Surveillance System	\$57,333	\$81,083	\$138,416
Sub-Total		\$228,416	\$348,249	\$576,665
Public Health Infrastructure Program	C-1 Overall Cancer Deaths	\$100,000	\$80,000	\$180,000
	PHI-7 National Data for Healthy People 2020 Objectives	\$318,480	\$365,733	\$684,213
	PHI-17 Accredited Public Health Agencies	\$732,181	\$635,574	\$1,367,755
Sub-Total		\$1,150,661	\$1,081,307	\$2,231,968
Worksite Wellness Program	ECBP-8 Worksite Health Promotion Programs	\$80,000	\$270,218	\$350,218
Sub-Total		\$80,000	\$270,218	\$350,218
Grand Total		\$2,311,449	\$2,544,478	\$4,855,927

State Program Title: Emergency Health Systems - Stroke Systems of Care

State Program Strategy:

Stroke is the fourth leading cause of death in Nebraska according to the CDC and accounts for 42.4 deaths per 100,000 populations. The number two leading cause of death in the state is heart disease. The American Stroke Association predicts a 24% increase in the prevalence of stroke between 2010 and 2030. The total costs related to stroke in Nebraska has increased from \$54,000,000 to \$108,000,000 between 2001 and 2010 with the average cost of a stroke hospitalization being \$31,000 to \$38,600. This does not include the cost of any rehab, the long-term home care due to deficits or the cost of skilled nursing facility care if the patient is not able to go home.

The best outcome for a person having a stroke is focused on the early and rapid identification, diagnosis, and treatment of stroke in efforts to prevent death and reverse neurological deficits such as paralysis and speech and language impairments. This requires a timely treatment. In order for this to happen, numerous things must fall into place. Education is critical, and education includes public, hospital, and Emergency Medical Services. To ensure a seamless transition of care from pre-hospital, critical access hospitals, stroke centers, and rehabilitation these agencies will need training on how to interact and utilize the others assessments. This request will focus on public education as well as training for the 64 critical access hospitals and 421 Emergency Medical Service agencies. Emergency Medical Services will be trained to identify a stroke in the field and notify hospitals. Hospitals will be trained to use this stroke alert to have appropriate staff at the ER upon EMS arrival and use the assessment that was done in the field to send the patient straight to CT. Valuable time is wasted when EMS and hospital staff do not work together and the patient misses the 3.5 to 4-hour window that a stroke must be treated within. States that have implemented this type of coordination are seeing much lower door to needle times and as high as 40% to 50% better patient outcomes.

State Program Setting:

Community based organization, Medical or clinical site, University or college

FTEs (Full Time Equivalent):

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

Position Name: Carol Jorgensen

Position Title: Emergency Medical Specialist II Supervisor

State-Level: 23% Local: 0% Other: 0% Total: 23%

Total Number of Positions Funded: 1

Total FTEs Funded: 0.23

National Health Objective: HO HDS-3 Stroke Deaths

State Health Objective(s):

Between 10/2017 and 09/2018, DHHS will provide Stroke System of Care training and education to EMS Services, critical access hospitals and improve public education. DHHS will work in collaboration with Nebraska Stroke Advisory Council (NSAC) and the Stroke Region to incorporate a triage, treatment and transport plan that will help reduce the morbidity of stroke patients.

Baseline:

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

Data Source:

Nebraska eNARSIS database and hospital discharge data.

State Health Problem:

Health Burden:

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

Target Population:

Number: 1,881,503

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 1,881,503

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: US Census Bureau, 2014 population estimate

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

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

Total Current Year Funds Allocated to Health Objective: \$75,500

Total Prior Year Funds Allocated to Health Objective: \$60,000

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:

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:

Provide Stroke System of Care Training

Between 10/2017 and 09/2018, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems in collaboration with NSAC will provide stroke system of care training to **a minimum of 25** hospitals and the all the EMS services that transport to the respective critical access hospital.

Annual Activities:

1. Target Hospitals and EMS services within Stroke Regions

Between 10/2017 and 09/2018, Nebraska Emergency Health Systems will work with primary stroke centers to target hospitals and EMS services in their respective areas to receive stroke system of care training.

2. Collaborate with NSAC to Provide Training

Between 10/2017 and 09/2018, Nebraska Emergency Health Systems Program will work in conjunction with NSAC to provide training to hospitals and EMS services on stroke system of care training and data collection.

3. Provide Training

Between 10/2017 and 09/2018, Nebraska EHS Program will provide training for the EMS and hospitals.

4. Develop Stroke Registry

Between 10/2017 and 09/2018, Nebraska EHS Program will work with the Cardiac Registry project to add a minimal stroke registry data collection set for pre-hospital and hospital providers.

National Health Objective: HO HDS-17 Awareness of and Response to Early Warning Symptoms of Stroke

State Health Objective(s):

Between 10/2017 and 09/2018, DHHS will provide Stroke System of Care training and education to EMS Services, critical access hospitals and improve public education. DHHS will work in collaboration with NSAC and the Stroke Region to incorporate a triage, treatment and transport plan that will help reduce the morbidity of stroke patients.

Baseline:

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

Data Source:

Nebraska eNARSIS database and hospital discharge data.

State Health Problem:

Health Burden:

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

Target Population:

Number: 1,881,503

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 1,881,503

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: US Census Bureau, 2014 population estimate

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

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

Total Current Year Funds Allocated to Health Objective: \$7,000

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:

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:**Public Education Campaign**

Between 10/2017 and 09/2018, Nebraska Department of Health & Human Services (DHHS) Emergency Health Systems in collaboration with Nebraska Stroke Advisory Council and American Stroke Association will develop 2 public education campaigns to identify the signs and symptoms of a stroke and the proper timely response if a stroke is suspected.

Annual Activities:**1. Collaborate with NSAC and ASA for Stroke Public Education**

Between 10/2017 and 09/2018, Nebraska Emergency Health Systems will work with NSAC and ASA to coordinate public education materials to be distributed through a variety of media outlets.

2. Distribute Public Education Materials

Between 10/2017 and 09/2018, Nebraska Emergency Health Systems Program will NSAC and ASA to distribute through media outlets the educational materials.

State Program Title: Health Disparities & Health Equity Program

State Program Strategy:

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

Health Priorities:

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

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

Primary Strategic Partners: Minority Health Initiative grantees, the Statewide Minority Health Council, local health departments, health care providers, community- and faith-based organizations, American Indian tribes, Public Health Association of Nebraska, DHHS Division of Developmental Disabilities, Beatrice State Developmental Center and the University of Nebraska at Lincoln (UNL).

Evaluation Methodology: The Minority Health program evaluation plan will be guided by the impacts and outcomes outlined in the Strategic Framework for OMH: Improving Racial and Ethnic Minority Health and Eliminating Racial and Ethnic Health Disparities (OMH Strategic Framework). The Minority Health program evaluation activities will employ both process and outcome evaluation methods.

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

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

Performance measures/indicators:

- # of refugee surveys completed
- # of refugee BRFSS data set created
- # of refugee BRFSS report completed
- # of Karen refugee community resource brochure created
- # of health related brochure translated in Karen
- # of health related brochure printed for Karen community
- # of health equity stakeholder meetings completed
- # of CLAS trainings and P3 trainings completed
- # of minority population growth presentations completed

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

State Program Setting:

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

FTEs (Full Time Equivalent):

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

Position Name: Brittney Kapustina

Position Title: Program Analyst (Temp)

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Name: Asserewou Etekpou

Position Title: Statistical Analyst (temp)

State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Name: To be determined

Position Title: Community Health Educator

State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 3

Total FTEs Funded: 2.50

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

State Health Objective(s):

Between 10/2015 and 09/2019, Identify at least 20 of the most critical health disparities and health needs among racial ethnic minorities in Nebraska. Based on identified disparities and needs, work to equalize health outcomes and reduce health disparities through information and education of public health and other stakeholders who serve these populations. Compose a State Health Equity Plan as a method of working towards reducing health disparities.

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

Baseline:

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

Nebraska Behavioral Risk Factor Surveillance System (BRFSS) (2011-2014)

- Hispanics, American Indians, and African Americans had 24.6-28.8% 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 (39.6%) was approximately 2.3 times that of non-Hispanic Whites (17.1%).
- The proportion of American Indian current smokers was approximately two times greater (40.5%) than the proportion of non-Hispanic White smokers (19.4%).
- The proportion of Hispanics who did not have health insurance was 3.6 times greater than the proportion of non-Hispanic Whites.
- Compared to non-Hispanic Whites, American Indians had 1.5 times the proportion of people who were obese (BMI >30).
- Both American Indians (17.2%) and African Americans (13.8%) reported higher percentages of diabetes compared to non-Hispanic Whites (7.6%).
- The proportion of Hispanics who did not participate in physical activities outside of work was 1.5 times greater than non-Hispanic Whites.

Nebraska DHHS Vital Statistics (2010-2014)

- African Americans experienced a stroke mortality rate that was 1.5 times that of non-Hispanic Whites.
- African Americans had an infant mortality rate that was nearly 2 times larger than the rate for non-Hispanic Whites.
- American Indians had the highest alcohol-related mortality (89.1 per 100,000); this was nearly 3 times greater than the rate for non-Hispanic Whites.
- Of all racial and ethnic minority groups, American Indians (3.3 times higher) and African Americans (2.5 times higher) experienced the highest levels of diabetes mortality when compared to non-Hispanic Whites.
- The death rate due to homicide among African Americans was 13 times higher than the rate for non-Hispanic Whites; for American Indians, the rate was 5 times higher.
- Among all race/ethnicity groups, American Indians had the highest drug-related death rate (13.5 per 100,000). This was 1.8 times greater than the rate for non-Hispanic Whites.
- 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 (2010-2014)

- The proportions of American Indians and African Americans living in poverty were 4.5 times and 3.4 times greater, respectively, than the proportion of non-Hispanic Whites.
- American Indians (12.9%) and African Americans (9.7%) experienced similarly high proportions of unemployment when compared to non-Hispanic Whites (3.1%).
- The Hispanic population was the group with the highest prevalence of those without high school education (47.8%), compared to the non-Hispanic White population (5.7%).
- The proportion of American Indians receiving food stamps was 5.6 times greater than non-Hispanic Whites. For African Americans, the proportion was 4.5 times greater.
- Few American Indians and Hispanics were enrolled in college or graduate programs, compared to other race/ethnic groups.
- High proportions of Asians and Hispanics did not speak English very well.

Data Source:

2010-2014 Nebraska Vital Statistics, 2011-2014 BRFSS, 2010-2014 U.S. Census Bureau ACS.

State Health Problem:

Health Burden:

As compared to the White population of Nebraska:

Hispanics

- Teen birth rates (ages 15-19) are 3.1 times higher in Hispanic/Latinos than non-Hispanic Whites

- The percentage of individuals who did not exercise outside of work was 1.5 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 are about 1.8 times higher than that of non-Hispanic Whites.
- Highest rate of cancer (208.7.0/100,000 population vs. 162.3/100,000 White population).
- Highest mortality from heart disease (188.2 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 3.3 times as high as non-Hispanic Whites.
- American Indians were 1.2 times more likely to die from accidental or unintentional injury.
- The death rate due to homicide was 5 times greater for American Indians than for non-Hispanic White
- Teen birth rates (ages 15-19) are 3.5 times higher in American Indians than non-Hispanic Whites.

•

Source: Nebraska Vital Statistics (2010-2014); 2011-2014 BRFSS.

Target Population:

Number: 326,588

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Number: 326,588

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: U.S. Census 2010

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

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

Guide to Community Preventive Services (Task Force on Community Preventive Services)

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

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

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

Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No.

13166: Improving Access to Services for Persons with Limited English Proficiency (US Department of Health and Human Services, Office of Minority Health)

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

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

Total Current Year Funds Allocated to Health Objective: \$301,951

Total Prior Year Funds Allocated to Health Objective: \$386,171

Funds Allocated to Disparate Populations: \$160,000

Funds to Local Entities: \$110,000

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:

Cultural Intelligence and Health Disparity Presentations

Between 10/2017 and 09/2018, OHDHE will provide presentations, trainings and outreach events regarding minority population growth, health disparities, social determinants of health, health education and cultural intelligence to 17 key stakeholders/community members/organizations to increase awareness of racial and ethnic minorities, refugees, and American Indians in Nebraska.

Annual Activities:

1. Minority Population Growth and Health Disparity Presentations

Between 10/2017 and 09/2018, OHDHE will conduct 4 health disparities presentations to stakeholders in Nebraska to increase awareness of the Nebraska minority population growth, key disparities among minorities and the factors that influence disparities and health outcomes.

2. Provide Cultural Intelligence and Social Determinants Trainings

Between 10/2017 and 09/2018, OHDHE will complete 6 social determinants of health and cultural intelligence trainings to stakeholders in Nebraska to improve access to health services for racial and ethnic minorities, refugees, and American Indians in Nebraska.

3. Provide Culturally and Linguistically Appropriate Services (CLAS) Trainings

Between 10/2017 and 09/2018, OHDHE will complete 2 trainings on Culturally and Linguistically Appropriate Services (CLAS) to stakeholders in Nebraska to advance health equity, improve quality, and help eliminate health care disparities.

4. Conduct Community-Based Outreach for Minorities

Between 10/2017 and 09/2018, OHDHE will participate in 3 community-based outreach events for racial and ethnic minorities, refugees and American Indians in Nebraska.

Objective 2:

Educational and Public Health Service for American Indians

Between 10/2017 and 09/2018, OHDHE will provide public health education and prevention activities/presentations to improve the health of Americans Indians in Nebraska to 6 federally recognized tribes and organizations who have a substantial American Indian clientele.

Annual Activities:

1. Work with the Ponca Tribe to Provide Education and Public Health Services

Between 10/2017 and 09/2018, OHDHE will contract and work with Ponca Tribe of Nebraska to provide 5

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

2. Work with Omaha Tribe to Provide Education and Public Health Services

Between 10/2017 and 09/2018, OHDHE will contract and work with Omaha Tribe of Nebraska to provide 5 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

3. Work with Winnebago Tribe to Provide Education and Public Health Services

Between 10/2017 and 09/2018, OHDHE will contract and work with Winnebago Tribe of Nebraska to provide 5 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

4. Work with Santee Sioux Tribe to Provide Education and Public Health Services

Between 10/2017 and 09/2018, OHDHE will contract and work with Santee Sioux Tribe of Nebraska to provide 5 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

5. Work with Chadron Native American Center to Provide Education and Public Health Services

Between 10/2017 and 09/2018, OHDHE will contract and work with Chadron Native American Center to provide 4 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

6. Work with Nebraska Minority Resource Center to Provide Education and Public Health Services

Between 10/2017 and 09/2018, OHDHE will contract and work with the Nebraska Minority Resource Center to provide 4 public health education and prevention activities/presentations to improve the health of American Indians in Nebraska.

Objective 3:

Minority Data Collection and Analysis

Between 10/2017 and 09/2018, the OHDHE will analyze **3** data sets and collect minority Behavioral Risk Factor data. Socioeconomic, vital statistics, and hospital discharge data will be used to identify health disparities among various racial and ethnic minority groups throughout Nebraska.

Annual Activities:

1. Minority Hospital Discharge Data Project Phase 5

Between 10/2017 and 09/2018, OHDHE will use the new hospital discharge data set from the previous fiscal year, and work with DHHS and the University of Nebraska Medical Center (UNMC) Joint Data Center to prepare a Nebraska Minority Hospital Discharge report card. The report card will include the leading causes of hospital discharge data for all minority groups (African American, American Indian, Asian, and Hispanic), Hospital discharge disparities for selected diseases for all the minority groups, and bill payment information.

2. Identify and Summarize Key Socioeconomic Factors for Nebraska Minorities

Between 10/2017 and 09/2018, OHDHE will identify and summarize key socioeconomic factors for all the racial ethnic minority groups in Nebraska based on US Census Bureau 2011-2015 American Community Survey (ACS) data. This data allows OHDHE staff and partners to identify important socioeconomic factors that influence the health of Nebraskans to reduce health disparities. This is valuable information for minority health initiative grantees, local health departments, and evidence-based chronic disease prevention programs.

3. Summarize Data from 2011-2016 Leading Cause of Death and 2011-2016 Births

Between 10/2017 and 09/2018, OHDHE will identify the top 10 leading causes of death (i.e., cancer, heart disease, and stroke) and the related disparities between minority groups and non-Hispanic Whites. OHDHE will also identify the disparities between minority groups and non-Hispanic Whites related to maternal and child health (i.e., infant mortality, low birth weight). This data allows DHHS to

monitor the health status of minorities and plan strategies for future interventions that target key disparities.

4. Minority Behavioral Risk Factor Surveillance Data Collection

Between 10/2017 and 09/2018, OHDHE will continue to survey minority populations using the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) in partnership with the University of Nebraska-Lincoln. Every year, eight race-related questions are added to the survey to ensure additional information from minority populations is available.

Objective 4:

Minority Reports and Report Cards

Between 10/2017 and 09/2018, OHDHE will develop **3** reports addressing disparities in socioeconomic status, health status and minority population growth.

Annual Activities:

1. Finalize Nebraska Disparity Report (2018)

Between 10/2017 and 09/2018, OHDHE will update the Nebraska Health Disparities Report with the latest data to elucidate major disparities and identify targets for the State Health Equity Plan. The report will provide trend data for three five-year periods (2001-2005, 2006-2010, 2011-2015). This updated report will provide a comprehensive look at many health-related issues and concerns and the disparate outcomes experienced by some of Nebraska's historically medically underserved minority residents. Regular updates ensure the report remains up-to-date and continues to be a useful resource for policymakers, service providers, and those interested in minority health issues.

2. Publish and Distribute American Indian Health Status Report

Between 10/2017 and 09/2018, OHDHE will publish and distribute the Nebraska American Indian Health Status Report. This report will present health status facts on the American Indian population in Nebraska and will show the contrast between the American Indian population and the non-Hispanic/Latino White majority population. This report allows DHHS to monitor the health status of Nebraska American Indians and plan strategies for future intervention.

3. Complete Risk Factors for Nebraska LEP Population Report

Between 10/2017 and 09/2018, based on the questions OHDHE added to the 2011-2015 Nebraska BRFSS, key risk factors will be identified in a report for Nebraska's foreign born populations. The report will be published in paper and disseminated at professional meetings; published on the Nebraska DHHS website; and information will be used in presentations to community members, partners, and stakeholders.

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

Between 10/2017 and 09/2018, based on the questions OHDHE added to the 2011-2015 Nebraska BRFSS, key risk factors will be identified in a report for Nebraska's foreign born populations. The report will be published in paper and disseminated at professional meetings; published on the Nebraska DHHS website; and information will be used in presentations to community members, partners, and stakeholders.

Objective 5:

Refugee Needs Assessment Project Phase 2

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

Annual Activities:

1. Refugee Needs Assessment Workforce Meetings

Between 10/2017 and 09/2018, along with partners and refugee community members, OHDHE will conduct 1 taskforce meeting to share the status of the statewide Refugee BRFSS survey in 2017.

2. Clean, Recode and Analyze Refugee Behavioral Risk Factor Surveillance Survey Data

Between 10/2017 and 09/2018, the data collected during the Refugee Behavioral Risk Factor Surveillance Survey will be entered, recoded and analyzed in order to identify the key findings of the survey and key risk factors for various populations.

3. Identify and Report Behavioral Risk Factors for Karen Refugees in Nebraska

Between 10/2017 and 09/2018, OHDHE will work with the Karen Society of Nebraska to identify and report behavioral risk factors for Karen refugees in Nebraska. Data specific to Karen refugees will be analyzed in order to identify the key trends and behavioral risk factors in the Karen community. These findings will be compiled into a report.

4. Identify and Report Behavioral Risk Factors for the Refugees Served by the Asian Center

Between 10/2017 and 09/2018, OHDHE will work with the Asian Center to identify and report behavioral risk factors for the refugees that the Asian Center serves. Data specific to refugees served by the Asian Center will be analyzed in order to identify key trends and behavioral factors in the community. These findings will be compiled in a report for the Asian Center.

Objective 6:

Self-Advocate Involvement in HCBS Waiver Audits

Between 10/2017 and 09/2018, OHDHE will conduct **50** audits of the Home and Community Based Services (HCBS) audits incorporating self-advocate participation, in partnership with the Division of Developmental Disabilities.

Annual Activities:

1. Establish a Team of Self-Advocates

Between 10/2017 and 09/2018, OHDHE will partner with the Division of Developmental Disabilities Quality Assurance Coordinator and provider and advocacy organizations to establish a team of self-advocates to assist with in-home HCBS audits.

2. Train the Identified Self-Advocates and Specialists

Between 10/2017 and 09/2018, OHDHE will partner with the Quality Assurance Coordinator to train the identified self-advocates and Quality Control Specialists to assist with HCBS participant audits.

3. Complete Waiver Participant Audits

Between 10/2017 and 09/2018, OHDHE will partner with DDD Quality Control Specialists and self-advocates to complete at least 50 HCBS waiver participant audits.

Objective 7:

Social Determinants of Health Project

Between 10/2017 and 09/2018, OHDHE will develop **2** resources to address social determinants of health in the Karen community. OHDHE will create a resource brochure, translate at least 2 brochures, and print and distribute at least 300 documents. OHDHE will also provide 2 trainings (Lunch and Learns) to the Karen refugee community.

Annual Activities:

1. Create and Distribute a Karen Refugee Community Resource Brochure

Between 10/2017 and 09/2018, OHDHE will create a brochure for the Karen community that will list useful resources to help individuals more easily navigate resources in their communities.

2. Translate Health Related Brochures into Karen

Between 10/2017 and 09/2018, OHDHE will assist in translating at least 2 health related brochures or documents into the Karen language to address the language barrier faced by many in the community.

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

Between 10/2017 and 09/2018, OHDHE will work with the Karen Society of Nebraska to select at least 2 health related brochures and print at least 300 copies to distribute throughout the Karen community. These documents will provide educational information aimed at increasing the community's access to healthcare and improving economic stability.

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

Between 10/2017 and 09/2018, the Karen refugee community will complete at least 2 trainings (Lunch and Learns) on what is included in the brochures that were translated and/or created and how to use the selected brochures.

State Program Title: Infectious Disease Program

State Program Strategy:

Program Goal: The PHS 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 7,970 cases in 2015.
- Gonorrhea is the second most common STD in Nebraska, accounting for 1,704 cases in 2015.

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-13 Awareness of HIV Serostatus**State Health Objective(s):**

Between 10/2017 and 09/2018, increase the percentage of high-risk persons tested for HIV/AIDS to at least 75% of total tests performed.

Baseline:

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

Data Source:

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

State Health Problem:**Health Burden:**

- **HIV/AIDS Incidence:** During 2013, 834 new cases of HIV/AIDS were diagnosed, reflecting an incidence rate of 4.5 cases per 100,000 population.
- **Prevalence:** At the end of 2013, 2,468 Nebraska residents were known to be people living with HIV/AIDS (PLWHA).
- **Overall AIDS Trends:** From 2005 to 2013, a total of 589 incident AIDS cases were diagnosed among Nebraska residents. Since reporting of AIDS cases began in 1983, the number of cases per year rapidly increased, reaching a peak of 99 cases in 1992. The number of AIDS cases remained stable from 1992 through 1995. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply. The sharp decline is primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) and improve survival among those with AIDS. Since 1998, the number of reported AIDS cases in Nebraska has averaged 65.4 cases per year.

Target Population:

Number: 6,500

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, White

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 6,500

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, White

Age: 20 - 24 years, 25 - 34 years, 35 - 49 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: EvaluationWeb and Enhanced HIV/AIDS Reporting System

(eHARS)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

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

Total Current Year Funds Allocated to Health Objective: \$30,962

Total Prior Year Funds Allocated to Health Objective: \$10,000

Funds Allocated to Disparate Populations: \$30,962

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

Less than 10% - Minimal source of funding

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 10/2017 and 09/2018, the HIV Program, through contracting laboratory services and purchase of rapid test kits, will conduct **800** tests. The HIV Program will provide anonymous and confidential HIV testing at no cost to the client in order to facilitate follow-up with people who are infected and providing increased access to Disease Intervention Specialists at selected clinics that serve the target population (MSM, IDU). The aim is to assure change in risk behaviors and prevention of additional transmission of infection.

Annual Activities:

1. HIV Samples Tested

Between 10/2017 and 09/2018, contract for laboratory testing on samples, including those serving the target population (MSM and IDU). Number of tests to be completed:

4 HIV Confirmatory tests at \$94 per test

800 Rapid Tests at \$12 per test.

National Health Objective: HO STD-1 Chlamydia

State Health Objective(s):

Between 10/2015 and 09/2019,

A. Reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending Family Planning clinics to no more than 6.0 percent positive.

B. Reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending STD clinics to no more than 14.0 percent positive.

C. Reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescent and young

adult males, aged 15 to 34 years, attending STD clinics to no more than 17 percent positive.

Baseline:

Target and baseline: Nebraska

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

Data Source:

Data source STD Program (STD*MIS/ELIRT)

State Health Problem:

Health Burden:

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

The number of Chlamydia cases and rate -- among the target population estimated as 503,422 persons:

- 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
- 2015 -- 6,695 cases - rate 1,307 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: \$45,000
Total Prior Year Funds Allocated to Health Objective: \$46,576
Funds Allocated to Disparate Populations: \$45,000
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:

Chlamydia/Gonorrhea Testing

Between 10/2016 and 09/2017, 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 10/2016 and 09/2017, provide testing on samples from 131 provider sites, including those serving the target population (adolescents and young adults, aged 15 to 34). Numbers of tests to be completed:

- Chlamydia/Gonorrhea Gen Probe Amplified Tests = 3000.
- Chlamydia/Gonorrhea Gen Probe Urine Tests = 520.

National Health Objective: HO STD-6 Gonorrhea

State Health Objective(s):

Between 10/2015 and 09/2019,

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

Baseline:

Target and baseline: Nebraska

Objective	Reduction in <i>Gonorrhea</i> infections	2010 Baseline-201 case rate Percent	2018 Target-190 case rate
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
- 2015 -- 1,499 cases - rate 293 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: \$35,000
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:
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:

Chlamydia/Gonorrhea Testing

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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

State Program Strategy:

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

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

- Injuries are the fifth leading causes of death for Nebraskans.
- For Nebraskans aged 1 through 44 years, unintentional injuries are the leading cause of death.
- In Nebraska, more years of potential life are lost due to injury than any other cause of death.
- Falls are the leading cause of injury hospital discharge for all ages combined in Nebraska. 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 falls and 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 Alliance 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, Child Passenger Technicians, Tai Chi and Stepping On instructors and other entities receiving contracts and subawards. Staff will access and analyze Death Data and Hospital Discharge Data for results and trends, provide data results to partner programs and monitor program participant survey results.

Intentional Injury:

Sex Offense Set-Aside: DHHS will collect and analyze data from Youth Risk Behavior Survey and reports from 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 PHS 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 10/2016 and 09/2020,

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

Baseline:

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

Data Source:

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

State Health Problem:**Health Burden:**

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

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

In 2012, the highest number of TBI related deaths 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 2013 and Oct. 1, 2014 – Sept. 30, 2015

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: \$36,146

Total Prior Year Funds Allocated to Health Objective: \$92,000

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$10,000

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

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 10/2017 and 09/2018, DHHS Injury Prevention Program and the Brain Injury Alliance 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 10/2017 and 09/2018, DHHS will partner with the Brain Injury Alliance of Nebraska to regularly

convene the Concussion Coalition to provide and guide concussion education, awareness and prevention across the state. Focus areas of the Concussion Coalition may include Return to Learn, 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.

Objective 2:

TBI prevention sub-awards

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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;
- Providing technical assistance to awardees about evidence based interventions to reduce traumatic brain injuries
- 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-9 Poisoning Deaths

State Health Objective(s):

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

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

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

Baseline:

From 2009 to 2013, the age-adjusted death rate due to unintentional poisoning was 6 per 100,000 Nebraskans.

From 2009 to 2013, the age-adjusted hospitalization rate due to unintentional poisoning was 18.8 per 100,000 Nebraskans.

From 2009 to 2013, the age-adjusted emergency department (ED) visit rate due to unintentional poisoning was 96.6 per 100,000 Nebraskans.

Data Source:

Source: NE hospital discharge data, 2009-2013

State Health Problem:

Health Burden: Deaths

Unintentional poisoning was the third leading cause of unintentional injury death in Nebraska between 2009 and 2013. Among deaths due to unintentional poisoning, 85% were due to poisonings by medications.

Deaths due to unintentional poisoning were most common among Nebraska adults aged 45-54 years (12 per 100,000 persons). Overall, death rates due to unintentional poisoning were approximately equal for males and females (6.0 per 100,000 males vs. 5.8 per 100,000 females).

Hospitalization

From 2009 to 2013, the age-adjusted hospitalization rate due to unintentional poisoning was 18.8 per 100,000 Nebraskans. Hospitalization rates due to unintentional poisoning were highest among adults aged 75-84 years old (32 per 100,000 persons) and 85 years and older (33 per 100,000 persons). For adults aged 35 years and older, hospitalization rates due to unintentional poisoning were higher among females than among males. This difference was particularly evident for adults aged 45-54 years (33 per 100,000 females vs. 23 per 100,000 males).

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

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

Emergency department (ED) visits

From 2009 to 2013, the age-adjusted emergency department (ED) visit rate due to unintentional poisoning was 96.6 per 100,000 Nebraskans. ED visit rates due to unintentional poisoning were highest for children ages 1-4 years (449 per 100,000 persons). Within this age category, ED visit rates due to unintentional poisoning were higher for boys than for girls (473 per 100,000 boys vs. 423 per 100,000 girls).

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

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

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

Source: NE hospital discharge data, 2009-2013

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: 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: 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: 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: 2010 Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: \$22,130
Total Prior Year Funds Allocated to Health Objective: \$0
Funds Allocated to Disparate Populations: \$0
Funds to Local Entities: \$15,000
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:

Poisoning prevention sub-awards

Between 10/2017 and 09/2018, Nebraska DHHS Injury Prevention Program will provide sub-awards to local partners to engage in poisoning prevention activities to **at least 2** partners.

Annual Activities:

1. Administer poison prevention sub-awards

Between 10/2017 and 09/2018, •Develop an application and process to determine which local organizations will receive funding;
•Provide funding to local programs to administer injury prevention programs aimed at reducing unintentional poisonings in children and adults.
•Provide technical assistance to subrecipients about evidence based interventions to reduce unintentional poisonings.
•Where applicable, conduct evaluation to determine reach and behavior change as a result of the funded programming.

National Health Objective: HO IVP-16 Age-Appropriate Child Restraint Use

State Health Objective(s):

Between 10/2016 and 09/2020, **maintain observed use of child restraints in Nebraska at 98 percent.**

Baseline:

Since inception of the child restraint usage survey, observed usage has risen from 56 percent (1999) to 98.4 percent (2016).

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 5-34 years, the leading cause of death is motor vehicle or traffic crashes (CDC WISQARS, 2004-2014). Nebraska's child safety seat law only requires children up to age 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 2015, Safe Kids Nebraska funded 15 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: \$74,507

Total Prior Year Funds Allocated to Health Objective: \$73,122

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 10/2017 and 09/2018, DHHS Injury Prevention Program, partners and contractors will maintain **98** percent observed use of child restraints.

Annual Activities:

1. Child Passenger Safety Certification Training

Between 10/2017 and 09/2018, DHHS staff will partner with the Nebraska Office of Highway Safety (NOHS) to conduct four National Highway Traffic Safety Administration Certification child passenger safety technician trainings (contingent upon outside funding). Staff will establish the training schedule, promote the classes and identify needed resources in conjunction with the Nebraska Child Passenger Safety Advisory Committee and NOHS.

2. Provide technical assistance

Between 10/2017 and 09/2018, DHHS staff will provide technical support to over 350 child passenger safety technicians through various means, including newsletters, e-mail lists, mailings, technical updates and grant funding.

3. Provide mini-grants

Between 10/2017 and 09/2018, DHHS will provide a minimum of 10 mini-grants to local child passenger safety technicians to conduct community car seat check events.

4. Provide Child Care Transportation Training Technical Assistance

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, DHHS Injury Prevention Program and partners will provide education and information to **100** Child Passenger Safety Technicians, local public health departments, child care providers, Safe Kids coalitions and the general public.

Annual Activities:

1. Provide public information

Between 10/2017 and 09/2018, the DHHS Injury Prevention Program and partners will provide information to the public about child safety seat use and restraint laws through various means, including participating in Child Passenger Safety Week and responding to requests from the public, school districts, hospitals or public health departments.

National Health Objective: HO IVP-23 Deaths from Falls

State Health Objective(s):

Between 10/2014 and 09/2019, reduce the age-adjusted death and injury rates from falls to:

- Less than 9.4 deaths per 100,000 Nebraskans.
- Less than 220.6 hospitalizations per 100,000 Nebraskans.
- Less than 2,009 emergency department (ED) visits per 100,000 Nebraskans.

Baseline:

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

In Nebraska (Oct. 1, 2014 – Sept. 30, 2015):

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

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

Data Source:

Nebraska death certificates
Nebraska hospital discharge data

State Health Problem:

Health Burden:

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

Target Population:

Number: 1,114,029

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: \$150,487
Total Prior Year Funds Allocated to Health Objective: \$101,000
Funds Allocated to Disparate Populations: \$30,000
Funds to Local Entities: \$36,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

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 10/2017 and 09/2018, DHHS Injury Prevention Program, partners and contractors will conduct **2** meetings of the Older Adult Falls Prevention Coalition.

Annual Activities:

1. Older Adult Falls Coalition meetings

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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 10/2017 and 09/2018, DHHS Injury Prevention and Control Program staff will maintain **3** sites to implement the evidence-based fall prevention program Stepping On.

Annual Activities:

1. Train the trainers

Between 10/2017 and 09/2018, through partners, DHHS will recruit and train Stepping On trainers. Contracts will be established with the trainers.

2. Stepping On Implementation

Between 10/2017 and 09/2018, 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.

3. Stepping On Program Technical Assistance

Between 10/2017 and 09/2018, DHHS staff will provide technical support to the sites implementing the Stepping On program.

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

State Health Objective(s):

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

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

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

Baseline:

8.6 percent of the 1,885 YRBS respondents reported that someone forced them to have sex when they did not want to. (2013)

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

Data Source:

Youth Risk Behavior Survey (2013)

Youth Risk Behavior Survey (2009), unweighted

State Health Problem:

Health Burden:

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

The NISVS also reveals that approximately one-third (29.9%) of female victims of rape experience their first rape between 11 and 17 years of 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 and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S Census Data, 2010 Ages 12 to 18; Rural includes all counties, except Douglas, Sarpy and Lancaster

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

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

Total Current Year Funds Allocated to Health Objective: \$73,689

Total Prior Year Funds Allocated to Health Objective: \$40,835

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

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:

Engaging Men to Prevent Sexual Violence

Between 10/2017 and 09/2018, the Nebraska Coalition to End Sexual and Domestic Violence will implement 1 pilot test of the Engaging Men to Prevent Sexual Violence program in up to three local programs.

Annual Activities:

1. Provide training for local programs

Between 10/2017 and 09/2018, The Coalition will provide information and training at its statewide

conference regarding the Engaging Men to Prevent Sexual Violence program. Advocates from the state's 20 local programs will learn ways to include men in their community outreach efforts.

2. Provide subject matter expertise

Between 10/2017 and 09/2018, The Coalition will contract with a subject matter expert to work with up to three local programs to test pilot utilizing the Engaging Men to Prevent Sexual Violence in their communities. Subject matter expertise will include assessing capacity, developing a strategic plan, and training specific to their community and capacity.

Objective 2:

Sexual Violence Prevention Summit

Between 10/2017 and 09/2018, the Coalition to End Sexual and Domestic Violence will provide sexual violence prevention training to **up to eight** sexual/domestic violence advocates.

Annual Activities:

1. Sexual Violence Prevention Summit

Between 10/2017 and 09/2018, The Coalition will provide financial support for up to eight local sexual/domestic violence advocates to attend the national Sexual Violence Prevention Summit. Advocates will apply for support, attend workshops related to sexual violence, evaluate their experience, and provide written reports of what they learned. The written reports will be disseminated among the state's 20 local domestic violence/sexual assault programs. Advocates may be asked to present at Coalition trainings or meetings.

Objective 3:

Social media sexual abuse prevention

Between 10/2016 and 09/2017, the 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 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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 10/2016 and 09/2017, the Nebraska Coalition will provide SUSO posters, brochures and other campaign material to local programs and communities. The Nebraska Coalition will distribute one new recently created 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

State Program Strategy:

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

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

Primary Strategic Partners:

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

Evaluation Methodology:

The Oral Health Program will work with the 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 2015 that identified dozens of existing databases that are used to inform program decisions and document efficacy of interventions. OOHD will utilize BRFSS, HP2020, Nebraska OH Survey information along with the most helpful evaluation methods and sources and work with the Epidemiology & Informatics Unit to gather consistent data for short- and long-range analysis.

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 2015 that identified dozens of existing databases that are used to inform program decisions and document efficacy of interventions. OOHD will utilize BRFSS, HP2020, Nebraska OH Survey information along with the most helpful evaluation methods and sources and work with the Epidemiology & Informatics Unit to gather consistent data for short- and long-range analysis.

State Program Setting:

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

FTEs (Full Time Equivalent):

Full Time Equivalent 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: 65% Local: 0% Other: 0% Total: 65%

Position Name: Dr. Charles F. Craft

Position Title: Dental Health Director

State-Level: 31% Local: 0% Other: 0% Total: 31%

Total Number of Positions Funded: 2
Total FTEs Funded: 0.96

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

State Health Objective(s):

Between 10/2017 and 09/2018, OOHD will provide subawards to at least three local health agencies to provide oral screenings, fluoride varnish treatments, education and referrals to dental homes. The target 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:

Only a few existing FQHCs and a few local health departments provide preventive services to children from families with low income.

Data Source:

DHHS Office of Oral Health and Dentistry

State Health Problem:

Health Burden:

- Dental decay is the most prevalent chronic childhood illness in the United States. [i]
 - Tooth decay causes pain and can affect how children eat, speak, play, learn and grow. [ii]
 - Each year in the United States students miss over 850,000 school days due to dental related illnesses. [iii]
 - A 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/Sept2007FINALFIVarnishpaper.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/FIVarnishfactsheet.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: \$171,083

Total Prior Year Funds Allocated to Health Objective: \$267,166

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$69,346

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 10/2017 and 09/2018, at least three Local Health Departments (LHDs), FQHCs, and community contractors will provide fluoride varnish treatments, education, and referral to a dental home to **2500** children and their families.

Annual Activities:

1. Fluoride varnish, education and referral to dental home

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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, Dental Health Director, and others within the DHHS Division of Public Health to evaluate the outcomes of the program.

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

State Health Objective(s):

Between 10/2017 and 09/2018, OOHD will work with DHHS's Epidemiology and Informatics Unit to develop one oral health surveillance framework 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 2015. 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, partner organizations, and to the general public the surveillance data and information in a timely manner, and that communication should enable decision-makers at all

levels to readily understand the implications of the information;

- Strive to put surveillance data to action to improve the oral health of residents in the state.

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

Target Population:

Number: 50

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: 50

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: \$57,333

Total Prior Year Funds Allocated to Health Objective: \$81,083

Funds Allocated to Disparate Populations: \$57,333

Funds to Local Entities: \$0

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

50-74% - Significant source of funding

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 framework for Nebraska

Between 10/2017 and 09/2018, 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 concept plan

Between 10/2017 and 09/2018, OOHD and the Epidemiology & Informatics Unit will develop the oral health surveillance concept plan. Activities that may be included in developing the concept plan 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 2017-2018 Nebraska Oral Health Survey of Older Adults

Between 10/2017 and 09/2018, OOHD will prepare to conduct a future Nebraska Oral Health Survey of Older Adults. Nebraska has not conducted an oral health survey for this population. Among the activities that may be included in the preparation phase are: identifying and establishing a memorandum of understanding or contracts with each of the partners (ASTDD, State Unit on Aging, Public Health Registered Dental Hygienists, and local community organizations) who will assist in completing the Nebraska Oral Health Survey of Older Adults.

State Program Title: Public Health Infrastructure

State Program Strategy:

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

Health Priorities: DHHS selected as priority activities:

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

Primary Strategic Partnerships:

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

Evaluation Methodology:

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

State Program Setting:

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

FTEs (Full Time Equivalents):

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

Position Name: Gwen Hurst

Position Title: DHHS Program Manager II
State-Level: 85% Local: 0% Other: 0% Total: 85%
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: 25% Local: 0% Other: 0% Total: 25%
Position Name: Patti DeLancey
Position Title: Administrative Assistant I
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: To Be Determined
Position Title: DHHS Epidemiology Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Jeff Soukup
Position Title: DHHS Program Performance Measurement Consultant
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: To be determined
Position Title: Financial Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 7
Total FTEs Funded: 5.35

National Health Objective: HO C-1 Overall Cancer Deaths

State Health Objective(s):

Between 10/2017 and 09/2018, To impact cancer mortality and incidence on a wide variety of topics, DHHS will issue an RFA in October of 2017 and fund no less than 4 but no more than 6 awards to Local Health Departments, Federally Qualified Health Centers, 501 c 3 Organizations, Tribal Organizations or American College of Surgeons Commission on Cancer Accredited Cancer Centers to implement listed activities in the revised Nebraska Cancer Plan. Awarded projects will be one year in scope.

Baseline:

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

Data Source:

Nebraska Cancer Registry

State Health Problem:

Health Burden:

According to the draft Annual Cancer Incidence and Morality Report, there were 9,338 Nebraskans diagnosed with cancer in 2013. The most common cancers diagnosed in men were prostate, lung and colorectal. While the most common cancers diagnosed in women were breast, lung and colorectal. Taken together, these cancers accounted for nearly half of all the cancer cases in 2013.

More than half of all cancer cases in 2013 were diagnosed in people over the age of 65. African Americans, Native Americans, Asian-Americans/Pacific Islanders and Hispanics were much more likely than whites to be diagnosed with many types of cancer.

Overall 3,485 Nebraska Residents died from cancer. This is the fifth year that cancer has overtaken heart disease as the leading cause of death in Nebraskans.

Target Population:

Number: 300,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander

Age: 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Disparate Population:

Number: 150,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander

Age: 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: Nebraska Cancer Registry

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

Guide to Community Preventive Services (Task Force on Community Preventive Services)

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

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

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

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$60,000

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:**Cancer Related Evidence Based Projects**

Between 10/2017 and 09/2018, Nebraska Comprehensive Cancer Control (NE CCCP) staff will increase the number of cancer related evidence based projects from 4 to 6.

Annual Activities:**1. Issue RFA**

Between 10/2017 and 09/2018, NE CCCP will issue a competitive RFA to local health departments, federally qualified health centers, tribal organizations, 501 c 3s, and American College of Surgeons Commission on Cancer Accredited Cancer Centers. Organizations will be offered the opportunity to apply for up to \$10,000 to implement one of the listed evidence based activities in the Nebraska Cancer Plan.

2. Provide technical assistance

Between 10/2017 and 09/2018, NE CCCP will provide technical assistance to awardees to ensure quality projects.

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 & Data Section, Epidemiology and Informatics Unit

State Health Problem:

Health Burden:

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

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

DHHS has a goal to be the leading source of reliable data and health information in Nebraska, strengthening programs that address the state's most challenging health issues. 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. As DHHS maintains its accreditation status, the data surveillance and epidemiology functions are partially supported by the PHHSBG assist in that preparation.

Target Population:

Number: 7,000

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

Disparate Population:

Number: 40

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

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

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

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

Total Current Year Funds Allocated to Health Objective: \$318,480

Total Prior Year Funds Allocated to Health Objective: \$365,733

Funds Allocated to Disparate Populations: \$210,000

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:

Data and surveillance

Between 10/2017 and 09/2018, DHHS Epidemiology and Informatics Unit will provide health data to **5,000** users of data.

Annual Activities:

1. Data gathering, analysis and reporting

Between 10/2017 and 09/2018, DHHS will identify all relevant health indicators for local health department reporting, update and execute analysis programs and disseminate Public Health Indicators electronically (e.g., the 2016 Vital Statistics Report). At least 5,000 users log on to the NE DHHS public website every year. 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 10/2017 and 09/2018, DHHS will update Nebraska HP 2020 objective data on the Division's online dashboard.

3. Enhance data quality, utilization and integration

Between 10/2017 and 09/2018, the DHHS Epidemiology and Informatics Unit, working with the University of Nebraska Medical Center's College of Public Health, will continue to enhance data quality, utilization and integration and will improve data utilization to support public health practices. Activities may include determining data integration strategies; linking data (i.e., hospital discharge data (HDD) with death certificate data, HDD with the Cancer Registry, HDD with Parkinson's Disease); geocoding HDD, cancer and vital records to support public health surveillance and social determinants of health; supporting internal public health programs and external partnerships; conducting pilot project similar to CDC's 500 Cities Project.

4. Chronic Renal Disease data collection and analysis

Between 10/2017 and 09/2018, The DHHS Chronic Renal Disease Program database maintains client information and payment data and runs necessary reports to better manage the Program and serve clients. Additionally, the database provides demographic information regarding Nebraskans with end-stage renal disease. Technical assistance contracts with the Nebraska Pharmacists Association and a nephrologist provide timely information and support to the Program.

Objective 2:

Develop and enhance Nebraska's public health informatics infrastructure

Between 10/2017 and 09/2018, DHHS Epidemiology and Informatics Unit will update **1** Nebraska Public Health Informatics Development Plan based on the public health informatics needs assessment.

Annual Activities:

1. Establish Informatics classification with State Personnel

Between 10/2017 and 09/2018, Working with DHHS Human Resources, the Epidemiology and Informatics Unit will continue working with the State's Department of Administrative Services to develop a job classification for public health informatics. If classified, staff will work to recruit, hire and onboard a qualified informatician to aid with following activities.

2. Establish and develop Nebraska Data Governance Committee

Between 10/2017 and 09/2018, DHHS Epidemiology and Informatics Unit will continue to develop the nascent Nebraska Data Governance Committee, whose charge will be, among other things, to conduct public health informatics needs assessment, develop a data and informatics strategic plan, conduct surveillance evaluations and collaborate with ASTHO's Public Health Informatics Workforce Committee.

3. Provide training

Between 10/2017 and 09/2018, DHHS Epidemiology and Informatics Unit will provide training for (internal) epidemiologists, data analysts and program managers and training for (external) entities utilizing public health data.

Objective 3:

Nebraska Public Health Geographic Information System

Between 10/2017 and 09/2018, the DHHS Epidemiology and Informatics Unit will provide technical support, mapping, geocoding and updates to **1 state and 20** health departments and other users.

Annual Activities:

1. Provide GIS services

Between 10/2017 and 09/2018, The DHHS Epidemiology and Informatics Unit will provide GIS services for programs within Nebraska's Division of Public Health including but not limited to producing maps to demonstrate health status, disparities, health care services, outbreaks and risk factors.

2. Coordinate internal GIS activities

Between 10/2017 and 09/2018, the DHHS Epidemiology and Informatics Unit will coordinate internal GIS activities including surveillance and assessment.

3. Provide technical consultation and guidance

Between 10/2017 and 09/2018, the DHHS Epidemiology and Informatics Unit will provide technical consultation and guidance for internal and external GIS applications.

4. Actively participate in GIS steering committee

Between 10/2017 and 09/2018, the DHHS Epidemiology and Informatics Unit will actively participate in the statewide GIS steering committee meetings.

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

State Health Objective(s):

Between 10/2017 and 09/2018, DHHS and up to 18 local health departments* will develop and/or maintain health improvement plans and will prepare for potential accreditation from the Public Health Accreditation Board.

*Nebraska has 20 Local/District Public Health Departments.

Baseline:

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

- The Nebraska Division of Public Health recently completed implementation of the 2012-2016 state health improvement plan. An updated state health improvement plan is currently being finalized and implementation of this plan will occur during 2017-2021
- 18 of Nebraska's 20 local health departments have completed or are in the process of completing a health improvement plan.

Data Source:

Nebraska Department of Health and Human Services, Division of Public Health

State Health Problem:

Health Burden:

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

Target Population:

Number: 1

Infrastructure Groups: State and Local Health Departments

Disparate Population:

Number: 1

Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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: \$732,181

Total Prior Year Funds Allocated to Health Objective: \$635,574

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$250,000

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:

Implementation of State Health Improvement Plan (SHIP) Activities

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, DHHS staff will provide funding and support to coalition members and partners to implement key strategies from the SHIP. DHHS staff help coordinate coalition implementation work groups by planning quarterly meetings, reporting opportunities, conference calls, and other support. DHHS staff will establish and manage contracts to help coalition members complete activities related to the SHIP.

Objective 2:

Maintain public health accreditation

Between 10/2017 and 09/2018, the DHHS Office of Community Health and Performance Management will increase the number of annual reports to the Public Health Accreditation Board for the Nebraska Division of Public Health from 1 to 2.

Annual Activities:

1. Submit annual report to the Public Health Accreditation Board

Between 10/2017 and 09/2018, The Office of Community Health and Performance Management will submit its second annual report to the Public Health Accreditation Board which is a requirement to maintain accreditation status for the DHHS Division of Public Health.

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

Between 10/2017 and 09/2018, In addition to the annual report, the Office of Community Health and Performance Management will update required documentation to maintain public health accreditation through the Public Health Accreditation Board. This documentation will provide evidence the Division meets all the standards and measures over the 12 PHAB domains. Documentation provides evidence of the activities Nebraska is doing in support of public health for residents.

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

Between 10/2017 and 09/2018, The Office of Community Health and Performance Management will facilitate an improvement in at least 6 of the 12 PHAB domains based on the results of our accreditation site visit report. An example of an improvement that will be made is to create a formal policy for ethical decision-making.

4. Track performance measures using a dashboard

Between 10/2017 and 09/2018, The Office of Community Health and Performance Management will track performance of State Health Improvement Plan, Strategic Plan, and other key performance measures on the performance dashboard. This allows DHHS, Division of Public Health to track key performance indicators and initiate quality improvements when necessary.

Objective 3:

Support for local health departments

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, DHHS staff will assess the needs of local health departments. Staff members will gather models and standards including evidence-based programs and accreditation information to share with local health departments. DHHS staff will also plan and arrange technical assistance and training opportunities. Technical support will be provided in the form of monitoring progress reports, one-on-one mentoring, conducting site visits and coordinating group updates and conference calls.

2. Financial Assistance

Between 10/2017 and 09/2018, DHHS will provide funds for local health departments to prepare for public health accreditation. PHHSBG funds are used to leverage funds from state and other federally funded programs to provide financial assistance of this type to local health departments. Up to 18 awards will be made to local health departments.

3. Provide mock accreditation site visits and documentation training

Between 10/2017 and 09/2018, The Office of Community Health and Performance Management will provide mock site visits and documentation training to local health departments as necessary. Two local

health departments will be in the process of uploading documentation for accreditation and staff will support those efforts.

Objective 4:

Training and educational resources

Between 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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 10/2017 and 09/2018, 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

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 Equivalent):

Full Time Equivalent 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 10/2017 and 09/2018, DHHS will provide subawards to two worksite wellness councils in order for them to conduct evidence-based health promotion activities for workers and to develop sustainability plans.

Baseline:

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

Data Source:

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

State Health Problem:

Health Burden:

According to the 2013 Cancer Registry Incidence and Mortality Report there were 9,338 diagnoses of cancer in Nebraska. Prostate, lung, and colorectal cancers were the most common cancers among men,

while breast, lung, and colorectal, were the most common in women. Together these cancers accounted for nearly half of all cancers in Nebraska in 2013.

Over the last five years more than half of all cancers were diagnosed in Nebraskans over the age of 65. And African Americans were also significantly more likely to be diagnosed with multiple kinds of cancer, as were Native Americans, Asian-Americans/Pacific Islanders, and Hispanics compared to Whites.

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

Target Population:

Number: 300,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander

Age: 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:

Number: 150,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Native Hawaiian or Other Pacific Islander, White

Age: 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Entire state

Target and Disparate Data Sources: Nebraska Cancer Registry

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)

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

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

Evidence based worksite health model.

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

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

Total Prior Year Funds Allocated to Health Objective: \$270,218

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$80,000

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:

Promote worksite wellness

Between 10/2017 and 09/2018, subawardees 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 10/2017 and 09/2018, Two worksite wellness councils will provide technical assistance and training to at least 150 worksites.

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

2. Training and technical assistance for evidence-based interventions

Between 10/2017 and 09/2018, Wellness councils will provide technical assistance and training to employers specific to evidence-based interventions for active living, healthy eating and breastfeeding. Depending on Council needs, training may feature implementation of the CDC Worksite Physical Activity Toolkit, the Nebraska Walking Worksite Initiative, the Nebraska Healthy Beverage Guide, the WalkIts Toolkit for Walkable Worksites, healthy meetings and strategies for implementing workplace lactation programs.

3. Develop and implement sustainability plan

Between 10/2017 and 09/2018, Wellness councils will develop and begin implementing sustainability plans, exploring myriad funding resources in an effort to become self-sustaining.

4. Develop communications plan

Between 10/2017 and 09/2018, subawardees and contractors will develop communications plans to encourage and enhance sustainability.