



When?
 Sunday May 20th 2018
 1:00 p.m. – 3:00 p.m.
 With Spanish subtitles and interpreters.
 3:30 p.m. – 5:30 p.m.

Where?
 Hastings Public Library, room AB

What?
 Learn about how to protect your loved ones from HPV.
 We welcome adults, and children over the age of 12.

SUNDAY MAY 20TH 2018
 FREE PUBLIC SCREENING OF THE FILM, *SOMEONE YOU LOVE*

South Heartland District Health Department is sponsoring a free public screening of *Someone You Love*, a film about the human papilloma virus epidemic. Local medical providers will be present to answer questions following the film.

This project is supported by Cooperative Agreement Number H02504056270, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.



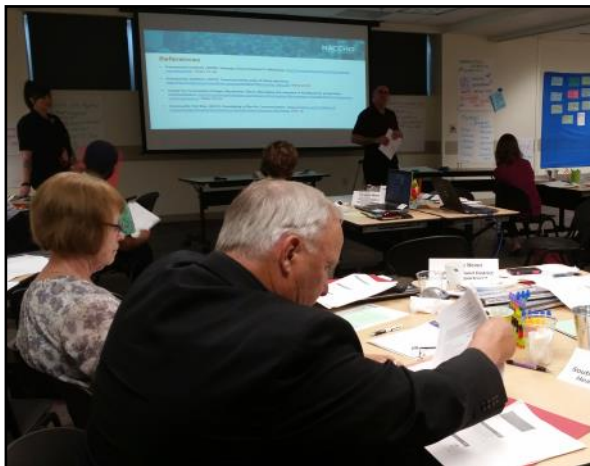
SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT
 506 N. Minnesota, Suite 2
 Hastings, Ne 68901
 (402) 462-6211
 1-877-238-7595
 southheartlandhealth.org



Above: Dr. Thomas Zusag, from the Morrison Cancer Center, answered questions following a screening of the film "Someone You Love: The HPV Epidemic" at the Hastings Public Library on May 20.

Left: HPV Cancer Prevention and Awareness Event Flyer.

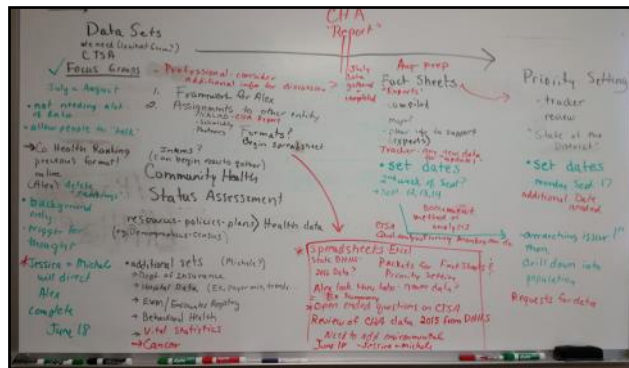
Right: Dorrann Hultman and Lorena Najera presented to Hastings Family Care nurses and medical assistants providing updated information on helping women access Nebraska's Every Woman Matters program and men and women access the Nebraska Colon Cancer Screening Program. The opportunity also allowed us to engage them and schedule their team for a viewing of the film, *Someone You Love*, about the human papilloma virus (HPV) epidemic.



Janis Johnson, Jim Morgan and Michele Bever (not shown) attended a NACCHO workshop on developing communication plans focused on health equity, hosted in by NE DHHS.



Above: Creighton nursing students visited SHDHD and spent nearly 3 hours learning about public health. SHDHD staff Dorrann Hultman, Susan Ferrone, Michele Bever, Janis Johnson, Jessica Warner, Liz Chamberlain, Lorena Najera, Jim Morgan, Brooke Wolfe, and Jean Korth all discussed public health, and shared about their roles and their programs.



Right: Susan Ferrone and Janis Johnson plan the activities and schedule for the 2018 Community Health Assessment (CHA).

Left: White board in Conference Room 2 is filled with planning notes for the 2018 CHA and the priority-setting meetings.





SHDHD Prevention Connection

Left and Right: SHDHD hosted Walking Audits as part of Active Hastings Week. Five Hastings schools participated in these activities. As part of these audits, students went on a short walk around their school to assess the safety of the sidewalks and the environment, talk about what made them feel safe and unsafe, and learn about how to safely and correctly walk the streets of Hastings. Following the walk, the students were asked to fill out a short evaluation of their walk and a post-survey to assess their knowledge of safe walking (below).



Prevention Connection

Below: Promoting self-monitoring of blood pressure at Fill 'N Chill convenience store in Hastings during a 'Choose Healthy Here' taste-testing demonstration.



Prevention Connection

Below: Torey Kranau (middle), PharmD/MPH student, presented her MPH practicum project results to SHDHD's pharmacy collaboration quarterly meeting in May. Torey developed and implemented a 4-week blood pressure program for pharmacies in Sutton (Clay County), Superior (Nuckolls County) and Red Cloud (Webster County). Also shown are pharmacist Tom Choquette (Bert's Pharmacy, Hastings) and project supervisor Brooke Wolfe.



Bi-monthly Report on the Ten Essential Services of Public Health

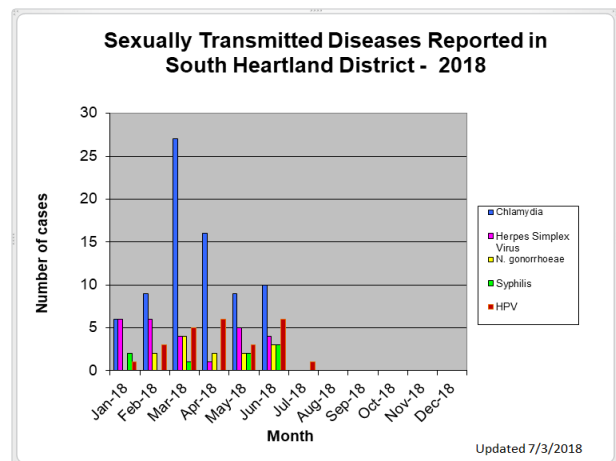
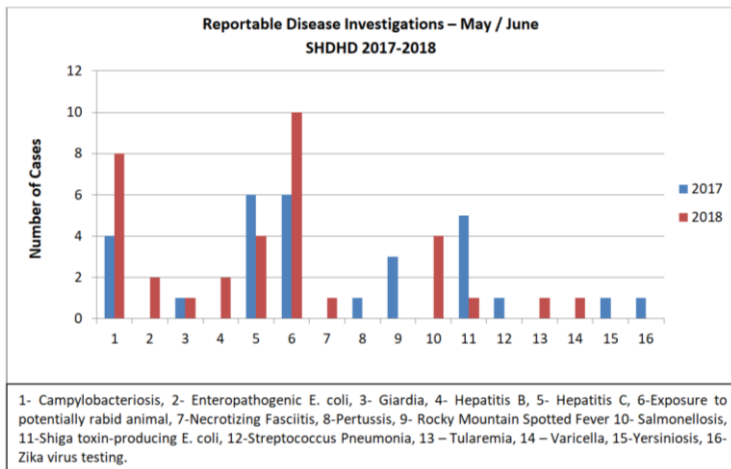
1. Monitor health status and understand health issues facing the community.

(What's going on in our district? Do we know how healthy we are?) How do we collect and maintain data about conditions of public health importance and about the health status of the population, and how do we make it available to our partners and our community?

- *What major problems or trends have we identified in the past 2 months?*

Local

- Surveillance data, water violations, and other [health information is made available](#) on our website, through links on our website, on SHDHD's Network of Care website, through news releases and interviews to various forms of media, and upon request from partners or others.
- SHDHD is in the planning stage for the 2018 [Community Health Assessment \(CHA\)](#) process. We are following the MAPP (Mobilizing for Action through Planning and Partnerships) process again. Part-time staff member Susan Ferrone is coordinating the process. The Core Team is currently reviewing the assessments and is planning additional focus on mental health and health system to identify community needs/gaps.
- [Community Health Improvement progress tracker](#): was created and shared with community partners and made public on our website and in our office.
- [School Surveillance](#): Absence due to illness reports for Spring Semester were sent out to 35 schools.
- [Community Themes and Strengths Survey](#): has been shared with partner organizations with a total of 791 responses to date. Our goal is to get 1,000 responses with a minimum of 100 from each county by July 15.
- [Chickenpox](#): A child attending a local daycare reported having chickenpox. The director consulted with South Heartland for guidance and reporting. The child was excluded for an appropriate time and no additional cases resulted in this exposure.
- SHDHD is currently working with DHHS and the CDC on a [multi-state outbreak of Salmonella](#). There is a cluster from Nebraska with an isolate matching PFGE pattern. The source of salmonella was identified in May linking these two cases to sprouts.



2. Protect people from health problems and health hazards.

(Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?)

- *What key activities did we complete in the past 2 months to prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities*
- *What activities did we complete for emergency preparedness (e.g., planning, exercises, and response activities)?*

Emergency Preparedness & Response:

- Nebraska DHHS Lead Program teamed up with our surveillance coordinator to conduct a [lead investigation](#) in the home of a child with elevated blood lead levels. We were successful in identifying several sources of lead in the home in Adams Co.

- **Strategic National Stockpile (SNS) Sub-hub Planning:** Began meetings with Garry Steele, SHDHD's new sub-hub site manager, on appointing of new personnel and developing a tabletop exercise, and possibly a full-scale exercise, for the SNS sub-hub site.
- Met with South Central Partnership and case managers to work on **how to contact at-risk populations** in case of a need to distribute information to them of an emergent nature.
- Met with Emergency Managers and Senior Services regarding **contact and movement of at-risk populations** in cases where emergency information needs to get out and they need transportation to a clinic.
- **West Nile Surveillance:** Started mosquito trapping in May in Red Cloud and Hastings and will continue through September.
- J. Morgan was **lead evaluator for an exercise for Mary Lanning Memorial Hospital**. The event was the evacuation of the entire hospital. Focus was on evacuation of patients and use of the ICS system.
- SHDHD acquired (using public health emergency preparedness funds) a **solar powered generator** for use at disaster sites and other events. It can be charged through AC/DC as well.

3. Give people information they need to make healthy choices.

(How well do we keep all people and segments of our district informed about health issues?)

- *Provide examples of key information related to physical, behavioral, environmental, social, economic, and other issues affecting health that we provided to the public.*
- *Provide examples of health promotion programs that we implemented to address identified health problems.*
- **Satellite office:** Staff covered monthly hours in Superior, Clay Center, and Red Cloud in May and June. Topics covered in congregate meals were WNV and weather safety.
- **Community sign boards:** were utilized to get information out. (located in Edgar, Nelson, Lawrence, Red Cloud, Bladen, Roseland, and Kenesaw) Topics were WNV, Sun Safety, Public Health in Action, Access to Care.
- **Radon testing and mitigation** Continue to receive calls and share information on radon testing and mitigation, which is unusual for this time of the year. However, while kit sales are the same or higher than last year, radon kit completion rates are significantly lower this year.
- **News releases, public health columns, ads and interviews:** Topics covered in May and June: Know your district health department, HPV film: Someone you love newspaper ads, KHAS radio interview and radio ads, Smart Moves in Superior, Plan to avoid West Nile Virus this season, and your public health department does all this. SHDHD ran PSA's on KFRS, the Superior radio station, on KHAS and KLIQ in Hastings, and Power 99 in Kearney about bad weather awareness for approximately 3 weeks in June, and radio PSA promotions for the HPV film screening event in May.
- **Senior Presentation:** SHDHD hosted Senior presentations in Kenesaw and Roseland to about 30 seniors - teaching a population that often experiences or knows someone who has high blood pressure, how to better manage their condition through sodium reductions in their diet. WNV prevention was also presented in Superior to ~25 individuals attending a congregate meal.
- **SHDHD Facebook:** In May, the number of people reached was 2,150. For June the number of people reached was people 2,225. The topics for Facebook and twitter in May were on how SHDHD can help you, mental health/VetSET, HPV movie/event promotion and sharing other partners post about a variety of topics. June's topics included promotion of the community health needs assessment, mental health/veterans mental health and health literacy.
- **Worksite Wellness:** SHDHD's worksite wellness program is restructuring with meetings held only once a quarter. During May the topic covered was financial wellness with 10 employees 5 worksites in attendance. SHDHD also continues to work with local worksite wellness groups to improve their internal processes and programs to promote wellness.
- **Scrubby Bear:** SHDHD did a Scrubby Bear presentation for the YMCA's Cooking Club class kick off. In attendance were 12 pre-school - 2nd grade youth who learned how to "wash their hands the Scrubby Bear way".
- **Childhood Obesity:** SHDHD staff attended a statewide conversation about how agencies, state wide and local, can support the schools in implementation of the national wellness policy standards. The group came up with action steps that a statewide committee could take on to support the schools.
- **Tai Chi Classes:** Beginning Tai Chi classes are ending for the spring and will be starting back up in the fall August / September. Year around advanced classes are offered in Hasting and Red Cloud for individuals that have complete the beginning 12 week class.

- **Smart Moves (Diabetes Prevention Program (DPP)):** SHDHD's Smart Moves classes continue to occur- Superior, SHDHD and MLH's Smart Move classes are nearing the half way mark of the core 16 week classes and the Village Pharmacy in Red Cloud finished their week 10 class with 3 participants.
- **YMCA's SMBP Program:** South Heartland's CHWs have an active role serving as Healthy Heart Ambassadors for the program and holding office hours each Monday from 12:30 - 3:30. This collaboration with the YMCA in delivering this program allows us to engage and continue working with women identified for health coaching or otherwise called "WiseWoman".

4. Engage the community to identify and solve health problems.

(How well do we really get people and organizations engaged in health issues?)

- *Describe the process for developing SHDHDs community health improvement plan (CHIP) and/or implementing your work plan.*
- *Provide examples where we engaged the public health system and community to address health problems collaboratively. What were the evidence-based strategies that were implemented?*

Community Health Improvement Plan (CHIP) Implementation – Staff continue to implement the CHIP strategies with our partners:

- **Access to Health Care:** Staff have begun collaborative efforts with local agencies to address the identified need for navigating low income, undocumented women, who do not qualify for Every Woman Matters, to breast and cervical cancer screening. This collaborative process is supported through Health Hub funding.
- **Prevention Connection:** Progress continues between SHDHD and three district clinics (Webster County Clinic, Community Health Clinic/ Mary Lanning and Quality Healthcare Clinic of Sutton) as they work towards benchmarks identified through the 1422 chronic disease prevention grant. Clinics are ensuring or trouble shooting implemented strategies to improve Blood Pressure dashboard/registry in their clinics and through portal use. Community Health Clinic is having all staff the take patient blood pressure review by completing a three module series – Detection and Management High Blood Pressure offered by MCD Public Health. Patients are continuing to be encouraged to monitor their blood pressure and provide their numbers back to the clinic. Quality Healthcare Clinic used its portal system to push a message out to all clinic patients with elevated blood pressure or a diagnosis of hypertension to monitor blood pressure at home or other convenient locations in an effort to improve their treatment outcomes. The message also provided information on how to send results back to the clinic through the portal and provided an explanation of how the staff records the blood pressure and reports the results to their provider.
- **Team-based care:** activities, such as daily huddles, provide focused communication and coordination of efforts for complex patients. Clinic staff are able to discuss the patient's needs and prepare for adequate support personnel, all in an effort to deliver safe and reliable patient care Quality Healthcare Clinic recognized a need for additional staffing (.4 FTE) and the addition made a positive impact on patient care, better use of staff time and talents, increased number of Medicare Wellness visits.
- **Obesity:**
 - **Nutrition Advisory Board (NAB):** The NAB met in May with 6 in attendance, the group continues to share successes that are occurring throughout the district as well as barriers to accessing healthy foods. The participants were able to collaborate and learn from each other. The UNL shared their Action plan status, which SHDHD and Fill 'N Chill are involved in, with NAB as well as their upcoming training opportunities. SHDHD also attended UNL Extension's community nutrition update, where their partners are at the table and they are giving their quarter updates. The 6 partners at the table also shared what they were doing.
 - **Prevention Connection: Choose Healthy Here:** Increasing healthy food options in convenience and grocery stores implementing the Choose Healthy Here (CHH) program. SHDHD is working with Fill 'N Chill to implement their action plan. The store owner has dedicated one open faced cooler to healthy food items and is working on getting healthier items such as low fat milk and lower calorie/lower fat granola bars in stock. SHDHD placed signage around the store to help bring awareness to the healthier materials, released a press release to the media and hosted 2-taste tests. In May and June, SHDHD and UNL Extension hosted (2) taste testing with about 40 total customers stopping at the table and trying the samples. SHDHD and UNL Extension hosted a training for the Brodstone Dietary staff who have been working over the past year to implement 2015 assessment recommendations. All 6 dietary staff members were present for the training on "Easy Snack and Go Changes."
 - **Prevention Connection, Superior's follow up to their Walking Summit:** Superior Design team gathered for the city council to ask for approval and support to move forward with the funding for the trails. The city supported them in being a funding host agency, but ask the committee to continue looking for resources to

support the grant match required. The committee is currently in the process of looking for funds and writing the application.

- **Prevention Connection Healthy Vending Initiative:** SHDHD continues to work with partnered sites to improve vending. All sites continue to wait as the vender works to get healthier options in stock, and then they will start hosting taste testing. The vendor committed to getting the healthier options in the vending machine as soon as possible, but has not followed through.
- **Prevention Connection: Healthy Hastings follow up on action summit:** Healthy Hastings continues to meet to fulfill the action plan. At the May meeting (5 in attendance) and June meeting (7 in attendance) committees reported progress. The Complete Streets Advisory Council representative reported they are moving forward with their chosen contractor to do the walkability/bike ability planning project around town. The team is hosting and working with The Hastings Downtown Association in implementation of a downtown farmers market. We hosted our first downtown farmers market June 21st with 11 vendors and will continue to offer it each week through August. There is live music and cooking demonstrations occurring during the market hours. Active Hastings Week occurred during the week of May 6-12th. The week consisted of 5 Hastings schools completing walking audits with their students, walking to work/school, free group bike rides and much more. The events were not well attended but the committee felt there was an increase in community awareness around walking and biking. SHDHD and Nebraska Bicycle Alliance leader- Julie Harris completed a walking audit/observation at Hastings Middle school. The purpose of the observation was to assess areas for improvement around the school for pick up and drop off. There were three suggestions for improvement and the safe routes to school committee at the middle school is actively working on all three of them.
- **Prevention Connection: Smart Moves, Diabetes Prevention Class (DPP):** SHDHD continues to work with partners in implementing this evidence-based year-long program. SHDHD has worked with community partners and has established the capacity to serve 3 of the 4 counties with Smart Moves. Partners include Brodstone Memorial Hospital, Mary Lanning Healthcare and Village Pharmacy. During the month of May SHDHD hosted our quarterly coaches meeting and of the 13 active coaches, 7 were in attendance.
- **SHDHD WoW (Worksite Wellness):** During May and June, SHDHD staff focused on being more physically active during the workday. The WOW team hosted two challenges- a walking to or while at work and participating in a staff lead Tai-Chi demonstration. Staff had the opportunity to learn about mental health and the effect on the work place and the human sex trafficking epidemic in and around Nebraska.
- **Prevention Connection:** Village Pharmacy in Red Cloud continues to work with Webster County Clinic and Main Street Clinic to receive Smart Moves referrals and communicate with providers about blood pressures that are recorded in the pharmacy. SHDHD continues to stay connected with the Blue Hill Mary Lanning Clinic to implement a referral relationship. SHDHD also continues to work with the three-pilot sites to implement Torey Kranau, PharmD/MPH, self-monitoring blood pressure program, without Torey's assistance. From the pharmacy collaboration quarterly meeting in May, SHDHD had two of five active pharmacists present at the meeting. The group talked about Torey's project outcomes and how it could be implemented as well as identifying other outreach programs where pharmacists could play a valuable role.
- **Cancer Coalition:** South Heartland Cancer Coalition met in May and June. This group of committed partners continues to work together advancing community cancer education and prevention activities and promotion of screening. HPV and HPV related cancer have been the recent priority topic. SH and MCC nurses are providing follow-up case management of positive FOBT screening tests and skin referrals initiated at VSHF.
- **Mary Lanning Healthcare Cancer Committee:** Cancer Committee meets quarterly with no scheduled meeting in May/June. Together as partners we collaborate on community cancer education and screening projects which helps ML meet their COC Accreditation requirements.
- **Lung Cancer:** Radon detection kits remain available at SHDHD, satellite offices and UNL Extension.
- **Colon Cancer:** FOBT colon cancer screening kits are available to all district residents age 50-75 throughout the year. During this past fiscal year 07/01/17 – 6/30/18 394 kits have been distributed across the district. 244 (62%) have been completed and submitted to the lab with 4 (1%) of clients having a positive result. Case management by public health nurse is underway with each of these clients.

- **Cervical Cancer:** Human Papillomavirus (HPV) vaccine educational materials are shared at monthly VFC clinics. Community Health Workers continue to work with clients to access health care and Every Woman Matters resources. Clients are navigated to screening and diagnostics or treatment when needed.
- **HPV Cancer Prevention:** 4 recent events were held promoting HPV Cancer Prevention, Awareness and Vaccine Promotion. The events included 2 community events (1 English, 1 Spanish), 1 staff event and 1 event for Hastings Public Library staff. These and future HPV projects focus on increasing community education, changing perceptions and promoting cancer prevention through HPV vaccination. A July 22nd event is scheduled for Hastings Family Care nurses and medical assistants. A fall event for HC peer groups is also being planned.
- **Breast Cancer:** Using the Encounter Registry we continue to identify women in need of breast, cervical and colorectal cancer screening as well as resources to lifestyle change. Needs are assessed including health coverage and other barriers that might stand in the way of a woman completing cancer and cardiovascular screenings. Those without insurance who meet the Every Woman Matters program requirements are assisted with completing the Healthy Lifestyle Questionnaire to enroll in the program (8 in May/June). Those not meeting requirements are connected with the clinics offering assistance. Despite assistance from Mary Lanning's clinic for clinical and mammogram services, the radiology fee of approx. \$200 is a barrier preventing many women from moving forward with screening. A collaborative impact project with local partners was initiated to address this need but barriers to implementation have occurred. Work to overcome barriers will continue. In May/June staff documented 90 navigation contacts to 53 women for breast and cervical cancer screenings and diagnostic services. This significant increase was due to the State EWM Program inclusion of women who did not qualify for the EWM program (women who were previously navigated and may/may not have followed through with screening).
- **Prostate Cancer:** No current activity
- **Skin Cancer:** Lincoln School of Hastings and UNL Extension 4H summer programs both asked SHDHD to do a Sun Safety Presentation for their students. At Lincoln School, SHDHD taught about 75, 3-5th graders how to be Sun Safe. UNL Extension 4H hosted their annual summer program at Liberty Cove. SHDHD taught about 40 9-11 year olds how to be sun safe.
- **Substance Abuse:** Our partner ASAAP is working with the NE State Patrol for compliance checks on alcohol and tobacco sales. SHDHD received access to tobacco point of sale data for our district and the state. Some of our local data were gathered through assessments that SHDHD (Liz Chamberlain) conducted last fall 2017. We are able to query out info such as facility density and facility proximity to schools and parks, etc.
- **Mental Health: VetSET/Making Connections:** Free Family Fun Day for Military Service men, women, veterans and their family members living in Adams, Clay, Nuckolls, or Webster Counties will be held at Timberlake Ranch camp in Marquette, NE on August 18th, from 9am to 4pm. Need to register by April 10 either by calling 402-462-6211 / 1-877-238-7595 or On-line @ <http://southheartlandhealth.org>.
- **Other Collaborations (1422):** Hastings YMCA continues to implement their **Blood Pressure (BP) Management program**. SHDHD continues working with clinic partners at Hastings Family Care and Community Health Center in establishing clinic protocols for hypertension that include promotion of self-monitoring of blood pressure (SMBP). Clinic managers are still working on educating the providers on EHR utilization to make referrals and the importance of the program. SHDHD also continues to network with local food pantries to get healthier options in their food pantry. The Backpack/Superior School food pantry has a choice pantry currently, but would like some assistance on teaching and providing youth with the necessary tools to make healthier snacks and meals at home.
- **Other Collaborations (Vital Signs Health Fair Board):** 2 staff represent SHDHD on the VSHF board. Board meets monthly from October – April planning, implementing and evaluating activities for this annual event. No current activity.
- **Other Collaborations (Hastings Health Ministry):** Community Health Services Coordinator/Public Health Nurse attended the May monthly meetings of the Hastings Health Ministry promoting the HPV events and other community opportunities through the department. (The group does not meet June-August).
- **Rabies and West Nile virus materials:** were sent out to 8 veterinary clinics in our district. Rabies testing is now done in Lincoln, and the packets included link instructions and information about requesting state funds to pay for exposure to potentially rabid animals. Equine vaccination materials were recently updated, and new brochures were sent out the clinics to educate horse owners on the importance of vaccination against West Nile virus.

5. Develop public health policies and plans.

(What policies promote health in our district? How effective are we in planning and in setting health policies?)

- *What policies have we proposed and implemented that improve population health and/or reduce disparities?*
- *Describe how our department engaged in agency-specific strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.*
- *What plans are we developing and implementing to improve our department's quality and effectiveness (plans for quality improvement, workforce development, branding, communication, and performance management)?*

➤ Grant Proposals (Plans)/Awards/New Funding:

- NALHD Health Literacy Mini-Grant: Nebraska Association of Local Health Directors, \$6000 grant awarded for meeting deliverables including training, policy development and a HD action plan for implementing health literacy. This is their second phase for awarding "Health Literacy Champion" to LHDs.
- Accreditation Subaward, 2018-19: was submitted for \$15,000 to advance accreditation implementation.
- Immunization Grant: Intent to Award (7/1/18 – 12/31/18) \$10,300
- Health Hub/Every Woman Matters: Fixed cost subaward for 2017-2018 ended June 30 and DHHS Office of Men's and Women's Health amended the subawards to carry the work until October, when they expect to receive additional federal funds for a new funding cycle. SHDHD was awarded an amendment of \$25,000 dollars for the period of July 1, 2018 – September 30, 2018.
- Kid's Fitness & Nutrition Day – SHDHD was awarded \$3,000 from the University of Nebraska Kearney to implement the KFND event in fall of 2018.
- Emergency Preparedness Subaward – Expected award of \$85,251.78 for preparedness activities, July 1, 2018 – June 30, 2019. SHDHD has not received the subaward to date.
- Arbovirus Surveillance Subaward – Subaward for \$3,069 for the period May 1, 2018 – July 31, 2018. Subaward was signed by SHDHD on 5/24/18, but have not received copy of fully executed award.
- Community Health Assessment /Community Health Improvement Planning funding: Signed agreements with Brodstone Memorial Hospital for \$5,000 in 4 payments and with Mary Lanning for \$15,000 in 4 payments, SHDHD is responsible for leading the planning and implementation of the CHA/CHIP process.
- Mental Health First Aid/QPR Training Contract: Nebraska Association of Local Health Directors, \$3,700 to increase LHD capacity to address behavioral health needs across the State by getting staff trained in Question, Persuade, Refer (QPR)—a suicide prevention training, assuring QPR events are held in the community, and assuring Mental Health First Aid events are held in the community.
- Proposal to NEMA for back up generator: Jim Morgan received notification that emergency funds were being released in Nebraska and that SHDHD is eligible to apply for a backup generator (identified as a need in a hazard risk assessment conducted in 2016). Jim is working with NEMA to gather the required information and complete the proposal. If awarded, SHDHD will be responsible for a 25% match.

➤ Performance Management System framework, PMS: Implementation continues with the Community Health Improvement Plan (CHIP) dashboard, data analysis and the final CHIP (2013-2019) report which will complete the performance management (PM) system cycle. We are evaluating the PM process to use going forward in the 2019-2024 CHA-CHIP-SP Process (Community Health Assessment - Community Health Improvement Plan - Strategic Plan).

➤ Prevention connection: Blood Pressure Management: with partner consultant Praesidio, SHDHD continues to work with 3 clinics to implement a blood pressure protocol (policy) within their clinic workflow to flag patients that may be hypertensive, not well managed, or are pre-hypertensive, and to promote systems changes to improve prevention and management of hypertension. Webster County clinic created a clinical workflow for high blood pressure, including counseling about self-monitoring with the clinic's chronic disease coordinator.

➤ Workforce Development Plan, WD: succession planning/knowledge transfer and implementation/tracking of the WD work plan activities for 2017-18 are ongoing. Orientation resources, checklists and files are continuing to be revised/improved. A new workforce development work plan will be developed for the next fiscal year.

6. Enforce public health laws and regulations.

(When we enforce health regulations are we up-to-date, technically competent, fair and effective?)

- *Describe our efforts to educate members of our community on public health laws, policies, regulations, and ordinances and how to comply with them.*
- *What laws and regulations have we helped enforce to protect the public's health?*

➤ Nebraska Clean Indoor Air Act: No smoking violations reported this period.

➤ SHDHD receives food recall alerts from the Nebraska Department of Agriculture. We also maintain a link on our website to the FDA Food Safety webpage. Several posts were made to Facebook about recent food recalls.

- Daniel Brailita, MD, Central Nebraska Infectious Disease Clinic, had requested [Direct Observed Therapy \(DOT\)](#) for one of his patients to assure compliance with treatment. SHDHD is continuing to provide this service under a DHHS program as part of the initiative to prevent the spread of infectious disease.

7. Help people receive health services.

(Are people receiving the medical care they need?)

- *Describe the gaps that our department has identified in personal health services.*
- *Describe the strategies and services that we have supported and implemented to increase access to health care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.*
- [Immunization Program](#): NE DHHS Immunization Program Compliance visit was conducted for SHDHD's Immunization Program in May.
- Immunize Nebraska 2018 Conference was attended remotely by clinic coordinator and both back-up vaccinators
- In May/June the [Vaccine for Children](#) clinic staff delivered 57 vaccines to 30 patients at two monthly clinics. Of those 30 patients, 15 (50%) had no insurance, 8 (27%) had Medicaid, 7 (23%) were underinsured and 0 were American Indian. 6 of the 30 patients (20%) were new to the clinic. Total donation collected from clients for May/June = \$350.00 (avg. \$5.13 per immunization or \$10.28 per patient).
- We continue to implement [strategies to help increase complete immunization rates](#) of all clinic patients. NE DHHS Immunization runs AFIX (Assessment, Feedback, Incentives & eXchange) reports for our immunization program twice a year providing rates for 2 year olds with complete immunizations and 11-18 year olds with complete HPV vaccination series. This report allows helps us set goals and outline priority age groups. This report has not been made available to us yet in 2018.
- SHDHD uses quarterly reminder/recall, an [Evidence-Based Strategy for improving vaccination rates](#). 33 reminder/recall letters (11 Spanish, 22 English) were sent out in May to our 5-18 y.o. clients.
- In May/June the [Adult Immunization Program](#) delivered Tdap to 4 uninsured adults age 19 and over. All 4 adults were new patients encountered at Hastings' Project Homeless Connect.
- [The Emergency Vaccine Management Plan](#): was implemented during a power outage in the early morning hours of 6/2/18. Vaccine was safely transported to ML Pharmacy for temporary storage. Clinic Coordinator has worked with Public Health Risk Coordinator to provide examples of quantity and cost of vaccines stored at the department and reports of power outage events impacting vaccines as needed for completing the application for a back-up generator.
- [Project Homeless Connect](#): SH staff helped 32 homeless and near homeless attendees as well as 3 volunteers at the event to access information on establishing medical and dental homes, enrolling in the EWM program, adult Tdap immunization, NESIIS immunization records for adults and children, monthly VFC clinics, community lifestyle support programs, HPV cancer prevention and vaccine promotion education, sun safety and environmental lead education.
- [Community Health Worker \(Bilingual\)](#):
[Every Woman Matters \(EWM\)/Encounter Registry](#):
 - Health coaching for 22 total clients (Spanish speaking) - 9 are also participating in the self-monitor blood pressure program (SMBP)
 - 16 adult clients assisted in office, 32 adult referrals to other organizations/ providers
 - 6 FOBT kits distributed
- [Community Health Worker \(English Only\)](#):
[Every Woman Matters and Health Coaching](#) May: 5/7 received 1st health coaching session and 1 client 3 attempts discontinue (DC) Health Coaching marked to send letter. 4/7 received 2nd health coaching session. 6 / 6 received their 3rd health coaching session and finished EWM survey. June: 3/4 received 1st health coaching session and 1 client 3 attempts discontinue (DC) Health Coaching marked to send letter. 4/4 received 2nd health coaching session. 3/3 received their 3rd health coaching session and finished EWM survey.

8. Maintain a competent public health and personal health care workforce.

(Do we have a competent public health staff? How can we be sure that our staff stays current?)

- *Describe our efforts to evaluate LHD staff members' public health competencies. How have we addressed these deficiencies?*
- *Describe the strategies we have used to develop, train, and retain a diverse staff.*
- *Provide examples of training experiences that were provided for staff.*

- *Describe the activities that we have completed to establish a workforce development plan.*
- **Performance management, Results Based Accountability:** RBA continues to be implemented weekly in performance measures of programs and services (quantitative, qualitative and outcomes). This informs staff of all program activities, successes, needs, and alignment with the Essential Services and PHAB domains.
- **The Workforce Development Plan:** Succession planning/knowledge transfer development for Finance Operations, Health Surveillance and Chronic Disease programs are in progress.
- **Communication Plan Workshop:** Jim Morgan, Janis Johnson and Michele Bever attended a workshop on Communication Plan Development and incorporating health equity. One learning topic was about Communication Strategy Core Elements, including how to carefully identify WHO: audience, WHY: desired outcome; What: message content; and How/Where: venue, method, and modality for communication. Staff also learned about framing elements for messages, such as: Value, Solutions, Numbers, Context, Visuals, Tone, Metaphors, Messenger, Order, Narrative, Examples, and Explanatory Chains.
- **Center for Preparedness Education:** hosted the 16th Annual Preparedness Education Conference. J Warner attended sessions including: 2017 Hurricane Season Disaster Responder's Panel, Sim Truck tour/Emerging Infectious Diseases, Hospital evacuation, Traumatology.
- **CLAS and Literacy Improvement and Innovation Project (Title V):** The CLAS and Literacy Innovations Project includes statewide and cross-sector partners sharing a common interest in advancing equity in the Nebraska population. Project Funds and other support are provided by the Nebraska Maternal Child Health Block Grant. Members of the Project Team are diverse in life experience, professional pursuits, geography, and other characteristics. J. Johnson is a member of the project.
- **SHDHD CLAS and Health Literacy:** SHDHD completed deliverables for the NALHD Health Literacy Mini-grant including a LHD Health Literacy Check-up, three trainings, and drafting an action plan and BOH resolution. This will equip the workforce with up to date information and tools to increase implementation of Health Literacy and Culturally and Linguistically Appropriate Services (CLAS).
- J. Streufert and M. Bever attended a training on **Office of Management and Budget (OMB) guidance** for grants management, cost principles, risk management and indirect costs with Kevin Myren, hosted by Nebraska Association of Local Health directors.
- **National Diabetes Prevention Program DPP:** B. Wolfe attended the national DPP conference to learn about national best practices, successes, barriers and next steps with program implementation and support.
- SHDHD staff B. Wolfe continues to be involved in a state led **Facilitation Training** to teach LHD staff how to lead community conversations to consensus and collaboration (training provided by DHHS through the 1422 chronic disease prevention project).
- **Walkability:** B. Wolfe attended a WorkWell walkability audit training.
- **Nursing, BSN Community Based Project:** Sara Glaser, Director of Clinic Operations for ML, may be working with our department on a project researching vaccination policy and practices for staff and residents at a local nursing home. She will be presenting education to help enhance their current practices and support policy development.
- J. Morgan attended a **state-wide TTX on evacuation and decontamination** of specialized children from a chemical exposure.
- Conducted **staff TTX** on ICS (incident command) duties and activation of the SHDHD sub-hub. Used exposure to anthrax as reason to activate sub-hub.
- Trained 1 new board member and 1 staff on **National Incident Management System (NIMS)**.
- 5 staff attended the **Nebraska Cancer Summit**.
- Clinic Coordinator and 2 back-up VFC clinic vaccinators attended the **Immunize NE Conference**.
- 12 SHDHD staff attended screenings of the film "Someone You Love: The HPV Epidemic", to learn about **cancers caused by human papilloma virus** and how to prevent them through vaccination.
- New Board Member orientation for Dr. Daniel Brailita, new physician representative to the Board of Health,

9. Evaluate and improve and interventions. (Are we doing any good? Are we doing things right? Are we doing the right things?). *Provide examples of our evaluation activities related to evidence-based public health programs.*

- *Provide examples of QI projects that we have completed or are in process.*
- **Choose Healthy Here initiative evaluation:** Continued with Gretchen Swanson Center for Nutrition (GSCN) and NeDHHS on evaluation of *Choose Healthy Here* materials in partner Grocery Stores, as well as Brodstone Hospital's cafeteria improvements. During the months of May and June, evaluators completed interviews and environmental assessments in the Brodstone Cafeteria to assess impact of changes and opportunities for improvement for future activities. A complete report will be provided to SHDHD and partners in July. SHDHD staff

also completed NEMS assessment on all partnered worksites implementing vending changes and grocery store partners.

- **Prevention Connection:** SHDHD is to provide DHHS with 3 spotlight stories from the work accomplished with the prevention connection grant. The spotlight stories include data, the project implementation and the results of the project and are highlighting the successes at Brodstone Hospital's Cafeteria, the Smart Moves program across the district and Quality Clinic's huddle and policy implementation work.
- **Two QI projects continue:** client interaction tracking (development of an Access database) and standardization of HD documents (agendas and minutes with a checklist for staff of required items to be included. Next steps: HD letterheads and power point slides).

10. Contribute to and apply the evidence base of public health.

(Are we discovering and using new ways to get the job done?)

- *Provide examples of evidence-based programs our department is implementing.*
- *Describe how we have collaborated with researchers to conduct any research studies (e.g., completed surveys, interviews, or focus groups).*
- **Evidence Based:**
 - As part of the Chronic Disease Prevention project (Prevention Connection), SHDHD is in the final year (4 year work plan) of evidence-based strategies for prevention of cardiovascular disease and diabetes.
 - SHDHD is partnering with worksite wellness committees and using evidence-based practices for improving physical activity and nutrition in worksites.
 - In the Every Woman Matters/Community Health Hub project, SHDHD uses evidence-based strategies to address health inequities and improve screening rates for cervical, breast and colon cancers.
 - Tai Chi – Moving for Better Balance and Stepping On: are evidence-based programs for fall prevention in older adults who have a fear of falling or that have fallen. In the South Heartland District, beginning and/or advanced Tai Chi classes are offered in all 4 counties. Tai Chi classes are set up to meet twice a week for 12 weeks for 1 hour and will be starting new class in the fall. Stepping On classes meet once a week for seven weeks for 1 ½ to 2 hours and then a booster session in 3 months; will be offering classes in the fall.
 - We are continuing to use the evidence-based Reminder Recall process for immunization clinic clients to improve immunization rates.
 - Public Health Accreditation Board (PHAB) Standards and Measures: Completion of accreditation will align SHDHD with these evidence-based measures, improving quality and performance. SHDHD has completed the document upload portion and moves forward to the accreditation status decision from the PHAB Committee during their August quarterly meeting. Their decision will be either “accredited HD” or need to complete an action plan.
 - NALHD Health Literacy Mini-grant: Evidence shows persons with limited health literacy skills are more likely to have chronic conditions and are less able to manage them effectively. Through the NALHD Health Literacy Mini-grant, SHDHD completed a Health Literacy Check-up, and created an action plan for future staff education and evaluation related to health literacy practices.
- **Research:**
 - SHDHD participated in a national survey in August-September 2017 led by the Prevention Research Center at Washington University in St. Louis. In June, we received a copy of the survey report: Evidence-Based Chronic Disease Control Local Health Departments: A National Survey. According to the notes that came with the report: “The survey results provided a national picture of local-level public health employees’ views on and use of evidence-based chronic disease prevention and control, skills for evidence-based decision-making (EBDM) and supports for its use. This survey is part of a larger study exploring strategies to enhance use of evidence-based chronic disease control among local health departments (LHDs) being conducted by the Prevention Research Center at Washington University in St. Louis.” Of note, more than 50% of local health departments reported not having adequate organizational supports for evidence-based decision making activities.
 - Environmental Scan on Integration of Public Health and Primary Care: M. Bever was one of three local health directors asked by Dr. David Palm to provide input on a survey being developed at the College of Public Health for one of the priorities of the State Public Health Improvement Plan: to integrate public health and primary care. A Public Health and Primary Care Integration Committee was formed and this committee

recommended updating an environmental scan that was conducted last year. The College of Public Health, with funding support from the DHHS Office of Community Health and Performance Management, is responsible for completing this initiative. According to Dr. Palm:

- The first step in the environmental scanning process is to survey all local health departments in Nebraska. Responses to the survey questions will help the Committee to evaluate what progress has been made in the past year, what barriers exist, and what support is needed to move integration efforts forward in the future.
- The second step in the process is to conduct short interviews with 6 to 8 local health department directors as a follow up to the survey. In addition, the community benefit spending for all nonprofit hospitals will be updated as will the lists of primary care clinics that have become patient-centered medical homes and/ or joined accountable care organizations.

Stories: How we made a difference....

See attached success story that is one of several required for the chronic disease prevention initiative.



Collaboration between Community and Clinic Benefits Hypertensive Patients

SUCCESS STORY

2018

Summary

Hypertension can have a significant impact on an individual's health and, if not properly managed, it can contribute to an increased risk of stroke and heart disease. Residents of Hastings, Nebraska, and the surrounding rural areas, did not have access to blood pressure management programs. Left uncontrolled or undetected, high blood pressure can endanger health and reduce quality of life.³ To help resolve the issue and aid health care providers in educating hypertensive patients, the local YMCA applied for and was selected to be a National YMCA Blood Pressure Self-Monitoring (Y BPSM) Program in 2017. Initially, the providers and patients were unaccustomed to involvement by community organizations in management of chronic health conditions. In order to reduce barriers, the YMCA and local health department partnered to connect with providers and convey the benefits of the program, identify a champion community pharmacist, and establish an effective communication system between health care providers and the YMCA. Due to all of these efforts, collaboration between the community organizations and providers has increased, and patients, providers and community partners are providing positive feedback regarding this system. As of February 2018, more than 120 individuals have participated in this program.

Challenge

Many people within the South Heartland District Health Department's (SHDHD) community struggle with hypertension; with a prevalence rate of 34.6% of the population, being told they have high blood pressure.¹ This common condition increases the risk for heart disease and stroke. Unsurprisingly, the age-adjusted death rate due to heart disease is higher in Adams County (198.3) than the rate for Nebraska (143.0).² Prior to 2017, many hypertensive patients did not have access to an evidence-based lifestyle change program or access to education about their condition without visiting their provider. Patients with unmanaged hypertension are more likely to experience health complications and increased utilization of the health systems services, such as emergency room.³

To address this issue, the Hastings Family YMCA applied to be a host site for the Y's BPSM program, an evidence-based program geared toward hypertension education and management. However, multiple barriers arose at the initiation of the program. Health care providers were not familiar with utilizing a community organization as a resource to help their patients manage their hypertension. Likewise, the patients in the community weren't used to having an organization like the YMCA assisting them with their health conditions through disease management programs. Additionally, the curriculum of the Y's BPSM program did not always fit the needs of the community.

¹Nebraska Behavioral Risk Factor Surveillance System (BRFSS). (2017). Nebraska Department of Health and Human Services.

²Nebraska Vital Statistics. (2018). *Nebraska 2016 Vital Statistics Report*. Nebraska Department of Health and Human Services. ICD-10 codes: I00-I09, I11, I13, I20-I51

³ American Heart Association. (2018) *Health Threats from High Blood Pressure*.

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/LearnHowHBPHarmsYourHealth/Health-Threats-From-High-Blood-Pressure_UCM_002051_Article.jsp#.WzFgqdKjIU

Solution

To make the program successful and familiarize health care providers with it, the Hastings YMCA and South Heartland District Health Department (SHDHD) collaborated in several outreach activities. The YMCA conducted several on-site visits at provider offices to give clinics information about the program and the benefits it would provide for them and their patients. Community organizations don't typically have occasions to speak directly with clinicians, but the YMCA was able to schedule meetings because the program was evidence-based and the providers had already been working with the health department to improve identification and management of chronic disease patients, especially focused on diabetes and hypertension.

To create a solid partnership between a community pharmacist and the BPSM program, the YMCA collaborated with SHDHD to find a champion community pharmacist. SHDHD had a pre-existing relationship with a local pharmacy, which was utilized as both a program host site and a referral network. The pharmacy was an effective environment, as patients could visit the healthy heart ambassador (the YMCA program implementers) to take blood pressure measurements and discuss hypertension management while picking up their medications. The pharmacy furthered the collaboration with the YMCA by referring their patients to the program.

The YMCA also worked with SHDHD to establish an efficient communication system with the primary care providers (PCPs), with the goal of making providers more comfortable with referring patients to the program. The communication system implemented was a bi-directional feedback loop where, after a patient was referred from the PCP, the YMCA provided patient progress information back to their PCP, showing evidence of patient progress and increasing the provider's willingness to refer additional patients. Another goal was to publicize the new program to the community so that they were aware of the YMCA BPSM program's benefits to those with hypertension. A kickoff event where the community could come and learn about the program was held in June, with local media attending. Prior to the event, a local news station did a story on the program. Brochures were placed in clinics, pharmacies and other locations around town to further reach those in the community.

Results

The YMCA BPSM program was initiated in June 2017 and detailed outcomes are not yet available. However, there is increased collaboration between the providers and community organizations. PCPs are working to establish a system to ensure all patients receive education on their hypertension and to refer those patients that would be a good fit for the Y's BPSM. Concurrently, the YMCA has established a method to provide patient progress back to the provider and is continually working to improve the process. The target measures for the project included enrolling 150 participants into YBPSM and getting 25 provider referrals into the program by the end of 2017. While the program ramp-up was a little slower than hoped, there have been more than 120 participants in the Y's BPSM as of February 2018 with 3 different program sites. Currently, there are two providers actively referring to the program, with the YMCA providing letters back to the provider about participants' successes.



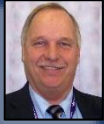




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Key community partners of this initiative include: Hastings Family Care, Hastings Family Medical, Community Health Center and Keith's Pharmacy.






**South Heartland Bi-Monthly Board Report: Staff-Specific Program Updates,
May-June 2018**

<p>Jim Morgan</p>  <p>Public Health Risk Coordinator</p>	<p><u>Emergency Preparedness:</u> I helped TRIMRS complete an exercise at MLMH on hospital evacuation. I also developed a TTX for SHDHD staff on ICS duties and activation of the sub-hub. I am currently working with Garry Steele on development of a TTX and possible FSX for the sub-hub. We are working on getting new personnel to replace some who have left at the sub-hub. I have been working on ways to reach the vulnerable, at-risk population. This is a focus by CDC for the 2018-19 sub-award.</p> <p><u>Environmental Health:</u> There is more interest by people in radon, which is unusual for this time of the year. More questions seem to be about mitigation.</p>
<p>Dorrann Hultman</p>  <p>Community Health Services Coordinator</p>	<p><u>Every Woman Matters Health Hub (EWM) Cancer Prevention / Immunization Program:</u> Saturday, 6/2/18 at 2:27 AM the Sensaphone that monitors the vaccine storage equipment sent text and e-mail alerts for loss of power. No further messaging came to indicate that power was restored, so I came in to the department to investigate. The power was out and although the vaccine refrigerator and freezer were still within appropriate temperature ranges, the temps were beginning to change. Due to the unknown length of time the power would be out, I implemented the Emergency Vaccine Management Plan. Mary Lanning Pharmacy, our back-up vaccine storage location was contacted. All vaccine was transferred to the ML pharmacy. Arrangements were made for it to remain in storage at ML through the weekend. Vaccine was transferred back to the department on Monday, 6/4/18. Approximately \$14,000 worth of vaccine was kept safe and viable because of the Sensaphone alert, reliable internet (during times of power outage) needed to send out the messaging and staff action. This event further demonstrates our need for a back-up generator. (A project that Jim is working on).</p>
<p>Lorena Najera</p>  <p>Community Health Worker</p>	<p><u>Every Woman Matters (EWM)/Encounter Registry:</u></p> <p><u>Project Homeless Connect:</u> Assisted clients with information and education to access vaccination and Every Woman Matters Program.</p> <p><u>SMBP, self- monitor blood pressure program:</u> 13/16 Spanish speaking participants in Harvard are enrolled in the YMCA SMBP program. I meet with them twice a month for support, to take their blood pressure and monitor that they are taking their blood pressure correctly, and to provide heart healthy education.</p>
<p>Liz Chamberlain</p>  <p>Community Health Worker</p>	<p><u>VetSET / Making Connections:</u> Promoting Free Family Fun Day for Military Service men, women, veterans and their family members on August 18, from 9am – 4pm at Timberlake Ranch Camp (17 miles North of Aurora). Attended Hastings American Legion meeting and participated in Project Homeless Connect in the Veteran section. Visited fourteen communities to hang up flyers for Family Fun Day: Harvard, Sutton, Fairfield, Clay Center 100 fliers, Lawrence, Superior, Nelson, Edgar, Glenvil -110 fliers, Guide Rock, Red Cloud, Bladen, Blue Hill, Ayr - 100 fliers. Currently working on ads for all the local papers and a PSA for the radio. Also working on scheduling Mental Health 1st Aid, QPR (suicide prevention), and Military 101 in the SHDHD district.</p>
<p>Brooke Wolfe</p>  <p>Public Health Promotions and Prevention Coord</p>	<p><u>1422 Prevention Connection:</u> <u>Walkability:</u> SHDHD attended 2 trainings hosted by DHHS to better assess our local walkable environment. Attended 4 planning meetings for walkability coordination in either Hastings or Superior. Hosted one safe routes to school planning committee meeting to address the assessed three major barriers at the Hastings Middle School pick up and drop off times.</p> <p><u>Smart Moves-</u> Continue to coordinate three communities implementing the Smart Moves program and hosted quarterly Smart Moves coach meetings.</p>



**South Heartland Bi-Monthly Board Report: Staff-Specific Program Updates,
May-June 2018**

<p>Jessica Warner</p>  <p>Health Surveillance Coordinator</p>	<p><u>Disease Surveillance:</u> Reports were sent out to 35 schools for Spring Semester for absenteeism due to illness. A nationwide outbreak involving two individuals from South Heartland was determined to be related to consumption of sprouts. Completed information requested by the CDC for an additional salmonella case related to caring for a backyard flock. Veterinarian packets were sent out to all districts vets with updates in procedures on rabies testing. Attended the 16th Center for Prep Ed. symposium with updates about emerging infectious disease.</p>
<p>Amy Market</p>  <p>Reception</p>	<p><u>VetSET/Making Connections:</u> Promoting and planning the free Family Fun Day for Military members and their families that is to be held Aug. 18th from 9 am to 4 pm. <u>Immunizations Program:</u> Attended the HPV movie: "Someone you Love" and came away with a better perspective on the disease itself as well as the vaccine. <u>Emergency Preparedness:</u> I have been working on updating all of the needed contact information for the 60+ individual groups that are required for Jim's Emergency Preparedness grant and Michele's emergency contact book.</p>
<p>Janis Johnson</p>  <p>Standards and Performance Manager / Public Health Nurse</p>	<p><u>Immunizations (VFC, Vaccines For Children):</u> <u>Accreditation Coordinator:</u> <u>Standards and Performance Manager:</u> During the interim between the PHAB site visit and the PHAB Committee decision for accreditation, we are continuing to move forward in performance management. We are addressing "gaps" that we identified (during the accreditation process and through the site visitor's exit conference strengths and opportunities), continuing prior and identifying new quality improvement projects, strengthening oversight by the QI-PM team, implementing plans and tracking, and analyzing data to report on the 2013-19 Community Health Improvement cycle.</p>
<p>Jean Korth</p>  <p>Chronic Disease Prevention Program Assistant</p>	<p><u>1422 Prevention Connection:</u> Clinics are completing the third quarter of the grant year. Progress continues on the use of the EHR, especially portal use and enrollment of patients with hypertension to report SMBP. <u>Health Literacy:</u> All requirements have been fulfilled for a Health Literacy Mini-grant offered by NALHD, including participation in the CHAMPIONS Soft Launch Webinar, the Institute for Healthcare Advancement 17th Annual Health Literacy Conference and the planning workshop at the NE Cancer Summit.</p>
<p>Susan Ferrone</p>  <p>Lifestyle Coach for Diabetes Prevention & Community Assessment Coordinator</p>	<p><u>Community Needs Assessment:</u> Core Team (4 County representation) has met and determined dates and invitee lists for Community "User" and Community "Leader" Focus Groups. Community Themes and Strengths survey has been distributed (790 Surveys completed, which has surpassed number collected in 2012. - Goal is 1,000 surveys. Survey deadline is extended to July 15) <u>Smart Moves Class:</u></p>