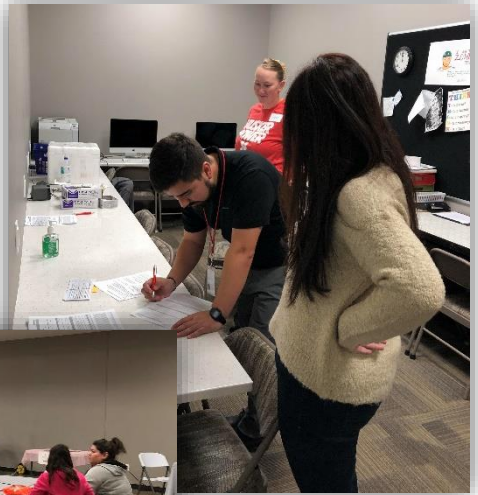


**Women's Health Event –
Breast Health/Screening presentation
Flu Shot opportunity for the uninsured**



**Hastings College Influenza Vaccination Promotion:
Team educating peers about influenza and promoting vaccination**

Community Health Needs Assessment Priority Settings Meetings: Health Issues and Access to Care Meetings at Clay, Nuckolls, Webster and Adams Counties





Hastings Middle School Walking Signage Project



Kids Fitness Day 2018



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

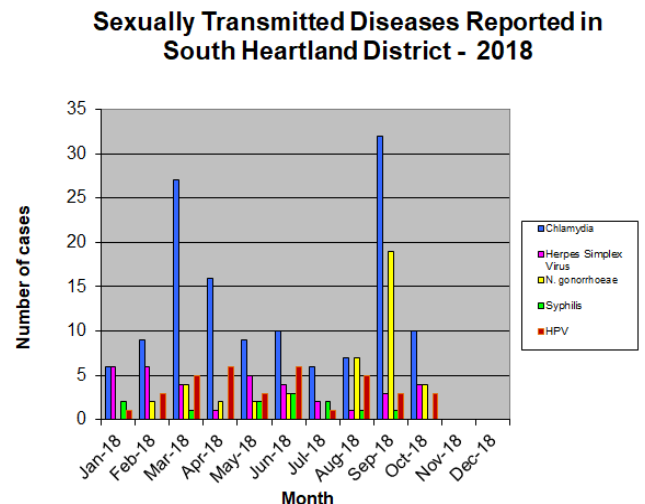
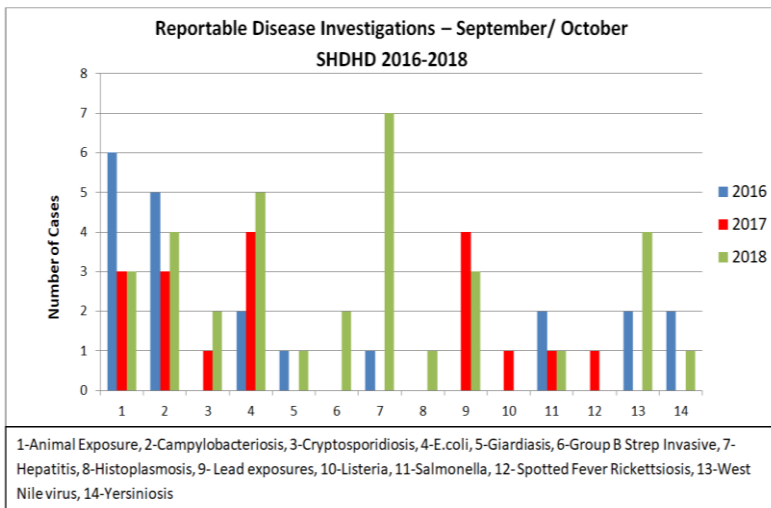
1. Monitor health status and understand health issues facing the community.

(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 Community Health meetings were held for on September 18th (Access to Care) and 25th (Health Issue priority setting). In preparation for these events, surveillance and other staff compiled materials including survey summaries, fact sheets and meeting evaluations for both meetings. We are in the process of preparing additional materials for strategic planning meetings for all selected health priority areas.
- Food Recalls: During the months of September and October, a few additional food items have been recalled due to possible listeria, salmonella or E.coli contamination. Recall items are monitored to identify what foods may have been distributed to our health district.
- School Surveillance: Schools have been providing information on illnesses at their school starting on September 5th. Hand Foot and Mouth disease has been circulating in our communities. There have also been reports of pink eye and head lice.
- SHDHD coordinated with DHHS to complete case report forms that were sent to the CDC. Six reports were completed and sent to DHHS and on to the CDC during September and October.



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:

- Strategic National Stockpile (SNS) Sub-hub Planning: Continued meetings with Garry Steele, Steve Eddy, Emergency Response Coordinators from Two Rivers, Loup Basin, and Central District. Russ Wren from the state has also had input in the exercise. It is scheduled for November 28th with approximately 35 people expected to be in attendance. Dorrann and Jim conducted a successful experiment on Cold Chain Management (to assure safe vaccine storage) for transport of vaccines.

- On October 3rd, a [Table Top Exercise](#) was conducted in preparation for the Full Scale on November 28th. Nine people were present at SHDHD, including staff, EM's, Garry and Steve from NWS. We were connected with the other three health departments involved through "ZOOM". The scenario took a Pandemic problem from its onset until the ordering of the Strategic National Stockpile, which included vaccine for the flu. The full scale will start with the arrival of the SNS through distribution to cold storage sites (Hospitals, Long Term Care facilities, clinics, etc.)
- J Morgan attended [LEPC's \(Local Emergency Planning Committee\)](#) in Adams and Clay County. J Johnson is also a member of the Clay County LEPC. Items discussed were the tanker accident in Clay Center where the people cleaning it were overcome by fumes, and a Tabletop Exercise in Adams County testing response to tornado damage through the middle part of town.
- [West Nile Surveillance](#): A press release was sent to media contacts to alert the public about positive mosquito pools and reports of human cases in our district. This season, SHDHD has had four human cases and two positive blood donors.

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 and Red Cloud in September and October. Red Cloud doesn't have a center that has as many activities since it has moved, so I am starting to go to the Guide Rock center instead. Topics covered for congregate meals included flu shots, cold weather, and radon.
- [Community sign boards](#): were utilized to get information out (located in Edgar, Nelson, Lawrence, Red Cloud, Bladen, Roseland, and Kenesaw). Topics were Fall Prevention, Preparedness, Breast Cancer, and CHIP information.
- [Radon testing and mitigation](#): Continue to receive calls and share information on radon testing and mitigation, including one contractor.
- [News releases, public health columns, ads and interviews](#): Topics covered in September and October - Healthy Everyday; Fall Prevention; Captured by You Photos - YMCA staff and Edgar Fire and Rescue Accepting Awards during the South Heartland District Health Department Annual Luncheon; Step Up to Falls Ad; Health Priority Meeting Announcements; Adams and Webster Co. Mosquitoes Test Positive for West Nile; West Nile Season Not Over Yet; Enterovirus D68; Kids Fitness and Nutrition Day: Fourth Graders Get Fit; Protect Yourself, Protect your Family: Everyone Needs a Flu Shot; Prevention Can Stop Rising Cancer Rates; Health Department Seeks More Input - Community Health Plan Gets Update.
- [SHDHD Facebook](#): In September, the number of people reached was 1,200. For October, the number of people reached was people 2,589. The topics for Facebook and twitter in September were Emergency Preparedness, Community Health Assessment Promotions and Falls Prevention. October's topics included promotion of immunizations and Breast Cancer Awareness, as well as health priority setting materials.
- [Worksite Wellness](#): SHDHD's worksite wellness program is restructuring with meetings held only once a quarter. September SHDHD and ML hosted "The Importance of Stretching" lunch and learn with 2 out of 5 worksites in attendance.
- [Childhood Obesity](#): SHDHD has been active connecting with schools about wellness activities, attending Hastings Public District Wellness Team meetings, putting together a co-presentation (with Hastings Public) to present at Ne SHAPE conference, and beginning to work with schools to complete the School Health Index Assessment.
- [Tai Chi Classes](#): [Beginning Tai Chi classes](#) started during August / September in Hastings at the Golden Friendship Center and YMCA, Superior at the Catholic Church, and Nelson at the Community Center with 25 participants. [Year round Advanced Tai Chi classes](#) are offered in Hastings at the Golden Friendship Center and YMCA, and Red Cloud at the Community Center, for individuals that have completed the beginning 12-week class. Currently there are 35 participants participating in the advanced Tai Chi classes. September 22nd was [Falls Prevention Awareness Day](#) - "Step It Up to Stop Falls" cards were delivered in Adams, Clay, Nuckolls, and Webster Counties to Primary Care clinics, Pharmacies, Hospital ER or Convenience Care, Physical Therapy clinics, Vision Clinics, Senior Center/MAAA, Browns Shoe Fit, and the YWCA (99 display racks were delivered).

- **Smart Moves (Diabetes Prevention Program (DPP)):** SHDHD's Smart Moves classes continue to occur- Superior, SHDHD, and MLH's Smart Move classes are well into their maintenance phase of the program. Partners are beginning to look at when and where they would like to start a class in 2019.
- **YMCA's SMBP Program:** South Heartland's community health workers continue to have an active role serving as Healthy Heart Ambassadors for the program and holding office hours each Monday from 12:30 - 3:30 to assist participants in learning the correct way to measure their blood pressure. This collaboration with the YMCA in delivering their Self-Monitored Blood Pressure program allows us to engage and continue working with women identified for health coaching through the NeDHHS WISEWOMAN Program (Well-Integrated Screening and Evaluation for Women across the Nation).
- **Hastings Public Schools Wellness Fair:** education and information on breast cancer screening, cervical cancer and HPV, tobacco quit line, immunization clinic, adult immunization recommendations, Smart moves and SMBP (self-monitored blood pressure) to approx. 200 HPS staff.
- **Opportunity House (South Central Behavioral Services day rehabilitation site):** education was provided for the following three topics by SHDHD staff during Sept./Oct.: Public Health – What does the South Heartland District Health Department Do, Adult Immunization/Influenza Vaccination, and Cancer Screening and Prevention.
- **Wind Generator - Health Effects:** Gathered evidence-based information and model regulations from the environmental health staff at Lincoln-Lancaster Health Department to share with members of public concerned about health effects of wind turbines and proposed wind farm(s) in Nuckolls County.

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:** SHDHD programs/activities, along with partners, continue to implement the strategies in the 2013-18 CHIP. The 2019-2024 CHIP is in process, developed from the Community Health Needs Assessment. The first CHIP strategy meeting for Access to Care is 10.31.18.
- **Access to Health Care:** Staff continues 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. SH staff presented updates on Every Woman Matters, Nebraska Colon Cancer Screening Program, Smart Moves diabetes prevention program and the Y's self-measured blood pressure (SMBP) programs with nurses at Community Health Center in September.
- **Prevention Connection:** The three district clinics (Webster County Clinic, Community Health Center-Mary Lanning, and Quality Healthcare Clinic of Sutton) all completed their benchmark activities identified through the 1422 chronic disease prevention grant. As a final opportunity to improve efforts towards chronic disease prevention and control, SHDHD and Mary Lanning Healthcare signed a MOU for chronic care management (CCM) education for clinic providers and Hastings Family Care staff. Fifty staff members and providers completed the initial roll-out education on CCM. The training included a description of CCM, how CCM works, which patients qualify for CCM, what the Comprehensive Care Plan entails, and payment for CCM. In addition, the MOU agreement included one-on-one training for the Community Health Center manager on EHR reporting. The sessions provided the manager with a better understanding of report types, allowing her to continue using her knowledge for ongoing and future process improvement projects and management of patients with chronic diseases. Quality Healthcare Clinic of Sutton also signed a MOU allowing a staff member the opportunity to complete additional training in population health, care coordination, chronic disease care, care plans, and care management overview. A goal tracker to use in chronic care management was developed. Webster County clinic manager completed training modules from their EHR learning depot and one-on-one training with an informatics nurse specialist from a nearby facility using the same EHR system in an effort to strengthen report building skills.
- **Team-based care:** Although the 1422 chronic disease prevention grant has ended, both ML Community Health Center and Quality Healthcare plan to continue with daily huddles. When short of staff, Quality Healthcare has adopted a shorter huddle with the focus on the patients visits that day, and when fully staffed the huddle is longer where information such as portal adoption and other positive or needs improvement items can be shared.
- **Obesity:**

- **Nutrition Advisory Board (NAB):** With the conclusion of the Prevention Connection grant, the Nutrition Advisory Board will only be meeting quarterly. In October the board met with 4 of the 8 active members in attendance. The group shared what they were doing and helped one organization (new to her role at the organization) learn what was going on in the communities and some tips on successful nutrition activities they have experienced.
- **Prevention Connection: Choose Healthy Here (CHH):** During the last month of the Prevention Connection grant, SHDHD met with their CHH convenient store partners to ensure all activities were wrapped up. UNL extension will continue to stop in twice a month to answer questions, add small signage and take down any incorrect marketing.
- **Prevention Connection, Superior's follow up to their Walking Summit:** Superior Design team continues to work towards the capacity to apply for funding to support a trail in their park. The team met with the park board to discuss plans & gather input on a proposed trail and brought the trail plans to a community-planning meeting (hosted by the City of Superior). They received great feedback, but no "final" trail plan.
- **Prevention Connection: Healthy Hastings follow up on action summit:** Healthy Hastings continues to meet to fulfill the action plan. The team met in September and discussed the option to expand their downtown farmer's market, as well as reviewing a yearend report for the first year downtown farmer's market. The Complete Streets Advisory Council representative reported the city continues to move forward with their chosen contractor to do the walkability/bike ability planning project around town. SHDHD and partners hosted a close out meeting with Hastings Middle School team on implemented/purchase of new signage for their safe routes to school project.
- **Prevention Connection: Smart Moves, Diabetes Prevention Class (DPP):** SHDHD continues to work with partners in implementing this evidence-based yearlong 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 of Red Cloud. A session zero was presented on September 18th to Jenny Wickham, APRN (new practitioner at Webster County Community Clinic).
- **SHDHD WoW (Worksite Wellness):** During September, SHDHD staff focused on being more physically active during the workday and thinking about what they are thankful for each day - a time of reflection. The WOW team hosted two challenges - step counting challenge and a gratitude challenge. During a lunch and learn, staff had the opportunity to learn about overall wellbeing and how to better utilize their strengths in the work place. The WOW team also hosted an all staff breakfast where there was a short networking activity - 9 of the 11 staff attended.
- **Prevention Connection:** SHDHD hosted their quarterly pharmacy collaboration meeting in October; three of the six active pharmacist were in attendance. Chris Watts, guest speaker from Kearney, spoke on how pharmacist can play a role in chronic disease management and prevention. The pharmacists also had the opportunity to network on a variety of topics.
- **Kids Fitness and Nutrition Day:** SHDHD and partners hosted the 13th annual Kids Fitness and Nutrition Day (KFND) with 348 students in attendance from 11 of the 18 schools throughout the district. The day was a huge success - students improved their knowledge of what are healthy habits (pre and post survey) and the staff that completed the satisfaction survey were satisfied with the event.
- **Cancer**
 - **Cancer Coalition:** South Heartland Cancer Coalition met for its regularly scheduled meeting in October. During the months of August and September this group of committed partners expanded as we came together to plan and hold the 4th annual Be Well, Feel Good, Get Checked women's health event. Together with volunteer Creighton nursing students and community volunteers (many bilingual) we provided community cancer education and prevention activities and promoted screening. Breast cancer was the educational highlight along with accessing affordable healthcare, cervical cancer screening, HPV cancer prevention, sun safety, exercise, nutrition, lifestyle change and blood pressure management promoted at the event.
 - **Mary Lanning Healthcare Cancer Committee:** Cancer Committee meets quarterly with the next meeting scheduled for November. Together as partners, we collaborate on community cancer education and screening projects which helps ML meet their COC Accreditation requirements and helps both ML and SHDHD meet community health improvement goals.
 - **Lung Cancer:** Radon detection kits remain available at SHDHD, satellite offices and UNL Extension.

- **Colon Cancer:** DHHS has contracted with a new lab for processing FOBT colon cancer screening kits so during the transition time, July – August, kits were not available for distribution. Currently work is underway to have funding and a distribution plan in place so that kits can be available to all district residents age 50-75 now and throughout the year.
- **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:** In September, a screening of the film *Someone You Love – the HPV Epidemic* followed by 4 HPV survivor stories was held for the College age audience. Albert Pedroza and Alex Stogdill, two HC students working with the department, promoted the event to Hastings College peer group leaders and to all college students during new student orientation. Flyers were also shared with college age contacts at Central Community College for promotion of the event. The event was attended by 4 college students and one adult (leader of the Hastings High Sunny D's peer education group). Event was likely not well attended due to conflicting commitments for students, some of which were mandatory to attend at the beginning of the school year. There is interest in holding another event at a later date, as well as an event of the Sunny D's group.
- **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 (2 in Sept./Oct.). In Sept./Oct. staff documented 6 navigation contacts to 3 women for breast and cervical cancer screenings and diagnostic services. 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.
- **Prostate Cancer:** September was prostate cancer awareness month. Facebook messaging was used to educate and to inform about having screening discussions with providers.
- **Skin Cancer:** Sun safety education and access to information about a local skin clinic using the Direct Pay Care model were shared at the women's health event.
- **Substance Abuse:** We are continuing to promote drug take back programs through our pharmacies. Hastings Police Department is unable to register us for the fall DEA National Drug Take Back this year, so we will not be holding one this fall.
- **Mental Health: VetSET/Making Connections** - Mental Health First Aid trainings were completed during two different training events – one at Brodstone Hospital September 30th with 22 participants attending and the second at SHDHD September 14th with 23 participants attending.
- **Other Collaborations (1422 Chronic Disease Prevention):** 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 (Hastings Health Ministry):** The group met in Sept. and Oct. SHDHD staff shares community program updates at each meeting.
- **Vital Signs Health Fair Board:** 2 SH staff are members of this board which held its first yearly meeting in Oct.
- **Other Collaborations (Ag Safety Day):** Taught First Aid / CPR to 139 Students + staff / adults. Topics covered during the day: First Aid Kits, CPR/AED, Heimlich maneuver, Wound Care, Universal Precautions and proper glove removal, Burns, Poison Control and Medication Take back, Allergic Reactions, Bites and Stings, Cold & Heat Emergencies.

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:**
- **Tai Chi / Stepping On Falls Prevention Suabaward:** fully executed agreement for October 1, 2019 – September 30, 2019 for \$13,000.
 - **2019 Immunization Funding:** submitted proposal for SHDHD immunization program funding for the period Jan 2019 – June 2019 for \$10,300.
 - **Lead Poisoning Surveillance:** submitted a work plan and budget for Lead Poisoning Surveillance and Prevention subaward with DHHS for \$6,900.
 - **Health Hub / Every Woman Matters:** waiting for subaward from DHHS. We were able to continue some activities during October, which they assure us will be reimbursed, but other activities are on hold until we have a signed agreement.
 - **Radon Awareness and Risk Reduction:** submitted a work plan and budget for subaward with DHHS Environmental Health for \$3,000. Requires \$3,000 match.
 - **Nebraska Department of Education's proposal to the CDC for Coordinated School Health:** was funded. SHDHD is one of 4 health departments named to participate in this 5-year grant project and will be working with Harvard Public Schools and Hastings Public Schools, based on qualifying factors identified by NDE. Approximately \$20,000/year to SHDHD, but a large portion of that will pass through to the schools.
 - **CS-CASH Proposal:** Our proposal to the Central States Center for Agricultural Safety and Health (CS-CASH) for \$20,000 to promote agricultural health and safety was not funded, although our proposal scored well. We were notified that there were a record number of applications and they encouraged us to apply again next year.
- **Medicaid Expansion:** Two staff attended the Nebraska Secretary of State's 3rd Congressional District hearing on Measure 427 to hear testimony about Medicaid expansion.
- **HRSA Rural Health Network Development Planning:** under the leadership of South Heartland District Health Department, five partners are developing a proposal to work together to create a behavioral healthcare network, complete a behavioral health assessment and develop a plan to address identified needs including workforce training issues.
- **Chronic Care Management Clinical Integration:** Three staff members attended a clinical integration workshop (facilitated by Tim McNeill) in hopes to facilitate conversations with area clinics to collaborate on chronic care management health coaching. We have met with one entity to discuss piloting this collaboration with their providers. We are also developing a business plan for this type of collaborative agreement.
- **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. The evaluated PM process is being utilized in the 2019-2024 CHA-CHIP-SP Process (Community Health Assessment - Community Health Improvement Plan - Strategic Plan). The performance management system measure is included in SH's PHAB Action Plan, "to integrate performance management throughout SHDHD and continue training to develop staff and BOH understanding of performance management system". The Action Plan objectives and actions include staff and BOH training.
- **Workforce Development Plan:** The Workforce Development Plan will be reviewed/updated/revise to include those opportunities for improvement identified at the site visit and included in the PHAB Action Plan.

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.

- 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 completed DOT during the month of September.

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.*
- In Sept./Oct. the Vaccine for Children clinic staff delivered 125 vaccines to 68 patients at two monthly clinics. Of those 68 patients, 35 (51%) had no insurance, 18 (26%) had Medicaid, 15 (22%) were underinsured and 0 were American Indian. 14 of the 68 patients (21%) were new to the clinic. Total donation collected from clients for Sept./Oct. = \$672.00 (avg. \$5.79 per immunization or \$13.22 per patient).
- We continue to implement strategies to help increase complete immunization rates of all clinic patients. NE DHHS Immunization has now provided us the ability to run AFIX (Assessment, Feedback, Incentives & eXchange) reports through NESIIS for our immunization program at times of our own choosing vs. the twice a year report that they previously did. This will allow us to monitor our rates and adjust workplan activities accordingly.
- SHDHD uses quarterly reminder/recall, an Evidence-Based Strategy for improving vaccination rates. The NESIIS program generates a list of clients not up-to-date with vaccinations in the age categories that we select. In October we selected all age groups. 137 clients not up-to-date were on our list. After review, 21 clients were found to no longer be associated with our clinic. 80 English reminder/recall letters were sent out and 36 Spanish reminder/recall phone calls are being made. To date, 8 of the Spanish clients are already scheduled for our next clinic and 12 scheduled as a result of the reminder call.
- In Sept./Oct. the Adult Immunization Program delivered Tdap to 1 adult age 19 and over. This client was uninsured.
- SHDHD staff is working with a group of 3 Hastings College (HC) student volunteers and the HC school nurse on activities to educate college students about influenza and to promote flu vaccination to students and staff.
- Access to adult flu vaccine through collaboration with Walgreens and their voucher program provided vaccine access to 41 uninsured women at the women's health event. SHDHD arranged for WG to hold an adult flu shot clinic at the department in Oct. 28 uninsured men and women and 2 insured individuals (one a SHDHD staff member) were served at this clinic.
- 91% of SHDHD staff report that they have received or plan to receive flu vaccination in the near future.
- Community Health Worker (Bilingual):
Every Woman Matters (EWM)/Encounter Registry:
 - Health coaching for 4 total clients (Spanish speaking)
 - 12 adult clients assisted in office, 12 adult referrals to other organizations/ providers
 - SMBP, self-monitor blood pressure program: 1 Spanish speaking enrolled in the YMCA SMBP program.
- Community Health Worker (English Only):
Every Woman Matters and Health Coaching: September: No clients receiving a 1st health coaching session, but for 1 client, 3 attempts to connect failed, so client was discontinued from health coaching and sent a letter; 2/2 received 2nd health coaching session; 3/3 received their 3rd health coaching session and finished EWM survey.
October: No health coaching – waiting for authorization to continue health coaching from the state.

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: Training will be determined to advance understanding of performance management and expand PM implementation (“to integrate performance management throughout the HD and continue training to develop staff and BOH understanding of performance management system” PHAB Action Plan).

- **The Workforce Development Plan:** The QI-PM Team continues to work on succession planning/knowledge transfer development for critical positions. Review and implementation of the new Succession Plan is in progress.
- **CLAS and Literacy Improvement and Innovation Project (Title V):** The CLAS and Literacy Innovations Project continues and includes statewide and cross-sector partners sharing a common interest in advancing equity in the Nebraska population.
- **NALHD Health Literacy Mini-grant Implementation:** October is Health Literacy Month and, as part of the action plan, J. Korth provided staff annual training on Health Literacy and health literacy tools at the October 22nd staff meeting.
- SHDHD staff, B. Wolfe, is part of a **virtual facilitation training** hosted by TOPs training, using Adobe Connect, to continue learning about the online program and the ability to facilitate conversations with partners via distance.
- **“Psychology of Change” IHI webinar series:** B. Wolfe, is participating in an online 8 session webinar. This series is designed to help organizations foster change in a healthy collaborative way that will make a positive impact on the organization. Brooke is sharing a summary of the training with the QI-PM team members, and training of other staff and BOH will be determined by the team.
- **Nebraska Environmental Health Association:** J Warner received updates on environmental health and infectious diseases at the annual NEHA conference in October.
- **Chronic Disease Summit:** Four staff members attended the DHHS led chronic disease summit to learn about new opportunities and strategies to prevent and manage chronic diseases across Nebraska.
- **Nebraska Public Health System Forum:** 4 staff attended this workshop with education on data governance, performance management/quality improvement, and public health ethics, and discussed state and local health improvement planning.
- **Rural Health Conference:** Two staff members attended the annual rural health conference to learn about the barriers, the successes and the partnering opportunities there are in rural health.
- Hastings College senior Geena Piper is doing a **credit-based internship** with SHDHD and is working with Jessica Warner in health surveillance.
- J Morgan attended the **state ERC conference**. A major part was how to recognize vulnerable populations and how to contact them in emergencies.
- M Bever is participating in a **Community of Practice for human resources** hosted by Nebraska Association of Local Health Directors. The current focus is on worksite safety policies and job descriptions.

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 and the cafeteria improvements at Brodstone Hospital. During the months of September, evaluators collected outcomes for the final assessment of Brodstone’s menu changes and staff food choices to assess personal employee behavior change and employee option choice.
- **Prevention Connection:** SHDHD finalized 3 spotlight stories from the work accomplished with the prevention connection grant for SHDHD. The spotlight stories included data, the project implementation and the results of the project. These highlight the successes at Brodstone Hospital’s Cafeteria, the Smart Moves program across the district and Quality Clinic’s staff huddle and policy implementation work.
- **Prevention Connection:** SHDHD attended 2 DHHS lead calls on evaluation - 1 over general grant progress from the last four years and 2 over progress that Ne, and each local health department, made on the walkability efforts with each of its communities.
- **QI projects:** client interaction tracking (Access database), standardization of SHDHD documents, and finance and operations standardization of the grant compliance files continue. Two staff developed an Action Plan outlining a new QI project for records retention.

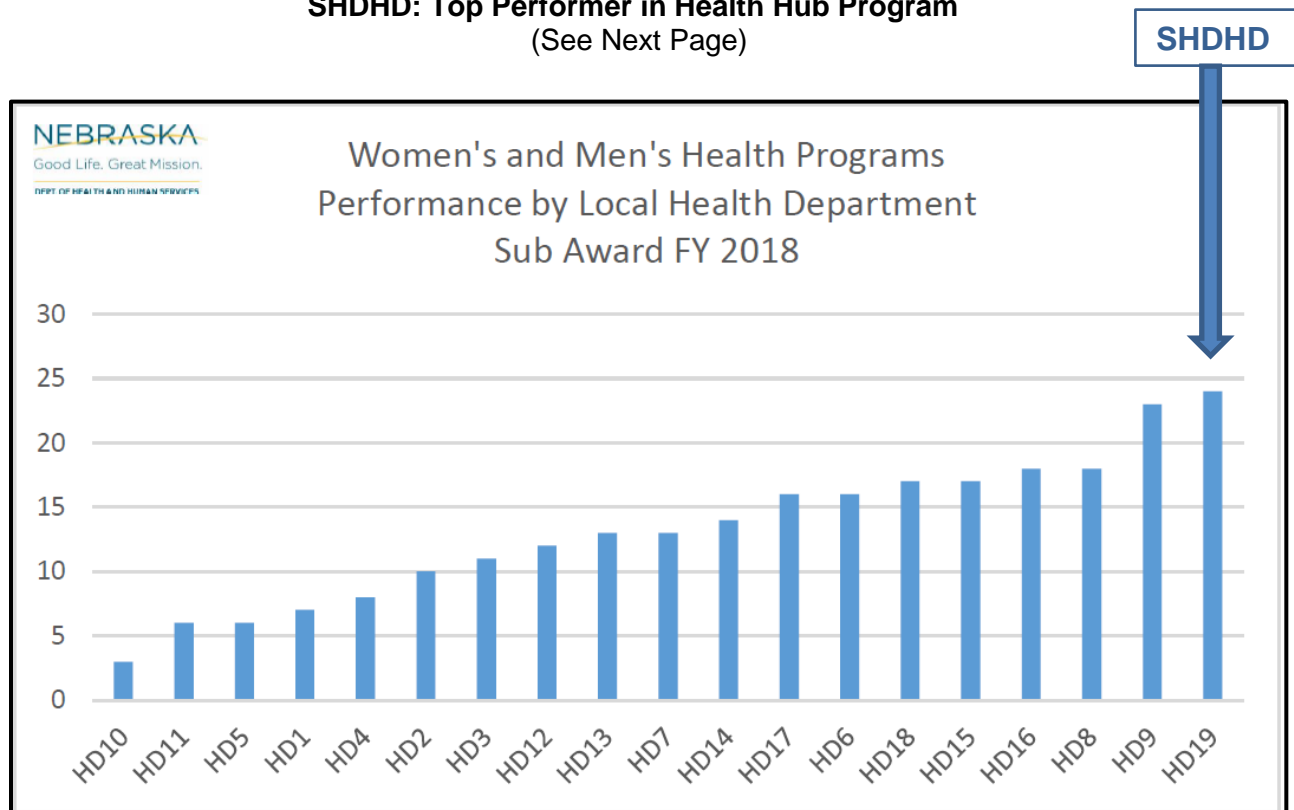
10. Contribute to and apply the evidence base of public health. *(Are we discovering and using new ways to get the job done?)*

- *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:**

- **Prevention of Cardiovascular Disease and Diabetes:** September 30, as part of the Chronic Disease Prevention project (Prevention Connection), SHDHD completed the final year (4 year work plan) of evidence-based strategies.
 - 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 falls 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 a new class will be starting after the first of the year in 2019. Stepping On classes meet once a week for seven weeks for 1½ to 2 hours and then a booster session in 3 months; classes will be offered after the first of the year.
 - 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 received the PHAB Accreditation Board decision on August 27, 2018. The Action Plan is due on November 25th. The 16 identified measures are not a surprise, as they were identified by SH during the accreditation process and/or by the site visitors for their report, and will help SH advance and improve these areas. SH will have 1 year to implement our objectives and actions after PHAB approves our uploaded 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. We are now working on implementation of action plan goals. October is Health Literacy Month and, as part of the action plan, staff received a review of Health Literacy at the October 22nd staff meeting.
- **Research:** None to report this period.

Stories: How we made a difference....

SHDHD: Top Performer in Health Hub Program
(See Next Page)



Stories: How we made a difference....

SHDHD: Top Performer in Health Hub Program

South Heartland was the top performing health department in the 2017-2018 Health Hub/ Every Woman Matters (EWM) program. In discussing our Health Hub activities recently with another Hub who is struggling to engage clients, I was asked the following question: So, how do you “sell it” to get them interested?

I think she found my response interesting because I answered, we don't. It's all about making a personal connection first and building on that. Whether we meet them in the community or they are coming through our door we greet them, we introduce ourselves if they don't already know us and we visit with them. We want them to know that we are invested in them and will explore ways that we can help them. Some are coming to us because they have heard about our Immunization Program and need to schedule their children or grandchildren for an appointment. We invite them to our office if they have the time and ask if we can ask them a few questions (the Encounter Registry initial assessment) that will help us to see what other things we can offer them. From there we can identify financial and screening needs and help them with accessing care through the EWM program or assisting them with completing the hospital assistance forms so that we can then help them get scheduled with a provider. Navigation to breast, cervical and/or colorectal cancer screenings often begins at this time.

We'll also talk about their cardiovascular disease history and share information on Smart Moves Diabetes Prevention Program classes and the YMCA's Self-Monitoring Blood Pressure program. If they are not able to commit to one of these lifestyle change programs, then we offer three (3) health coaching connections. We address tobacco use and refer to the quit line. For our team, it is all about building a relationship with each client. Our community health workers are the key to our success with clients. I'd also like to add that we take opportunities to talk with organizations and groups about public health and what we do at South Heartland District Health Department so people become familiar with us and our services.

This is how we present and educate the public about the Every Woman Matters, Wise Woman, and Nebraska Cancer Program so that clients see the value and want to engage.

For the 2017-18 grant period:

- 114 women engaged for navigation to screening
- 394 FOBT kits distributed (colorectal cancer screening)
- 40 women engaged in Diabetes Prevention Program
- 40 women engaged in Self-Monitoring Blood Pressure Program)
- 58 women engaged with general health coaching
- 6 women engaged with health coaching Education/Referral

Dorrann Hultman, RN, is the community health services coordinator for SHDHD and project manager for South Heartland's Health Hub program.








South Heartland Bi-Monthly Board Report: Staff-Specific Program Updates, September-October 2018

<p style="text-align: center; margin: 0;">Jim Morgan</p>  <p style="text-align: center; margin: 0;">Public Health Risk Coordinator</p>	<p><u>Emergency Preparedness:</u> The full scale exercise draws closer as I prepare for it to be held on November 28th. The volunteers have been great in their willingness to participate. There are several from the state and surrounding LHD's who are planning on attending. This is a great way to showcase the willingness of people to get involved in our district as well as making the activation of the sub-hub successful.</p> <p><u>Environmental Health:</u> Mold still shows up in our telephone calls, but bed bug complaints have decreased. There has not been a smoking complaint in over 2 years as people are getting used to going outside to smoke now.</p>
<p style="text-align: center; margin: 0;">Dorrann Hultman</p>  <p style="text-align: center; margin: 0;">Community Health Services Coordinator</p>	<p><u>Every Woman Matters Health Hub (EWM) Cancer Prevention / Immunization Program:</u> I'd like to highlight the combined effort of our Health Hub staff, Morrison Cancer Center, Community Health Center, YWCA and YMCA in coordinating and holding the Be Well, Feel Good, Get Checked women's health event again this year. 45 women, primarily Spanish speaking, attended this event and were provided biometrics, printed educational resources, 1:1 education on various health topics and group education on breast cancer screening. 36 out of 45 were within the target age group of 40-74 years old. Looking at this age group, only 2 reported they have health insurance coverage. 22 report they have a provider, 25 report having a well woman exam in the past 3 years. For 4 women it has been more than 3 years since an exam and 2 women have never had an exam. 22 report being up to date with pap smears, yet only 16 are up to date with mammogram. Only 8 report having had any colorectal cancer screening.</p> <p>Through this event and the information we gather we can make future contacts with these women and work on breast, cervical or colorectal cancer navigation and referral into health coaching with lifestyle support programs.</p>
<p style="text-align: center; margin: 0;">Lorena Najera</p>  <p style="text-align: center; margin: 0;">Community Health Worker</p>	<p><u>Every Woman Matters (EWM)/Encounter Registry:</u> Health coaching for 4 total clients (Spanish speaking). 12 adult clients assisted in office, 12 adult referrals to other organizations/providers.</p> <p><u>SMBP, self-monitor blood pressure program:</u> 1 Spanish speaking enrolled in the YMCA Self-Monitoring Blood Pressure program.</p>
<p style="text-align: center; margin: 0;">Liz Chamberlain</p>  <p style="text-align: center; margin: 0;">Community Health Worker</p>	<p><u>Falls Prevention:</u> September 22nd was Falls Prevention Awareness Day. Promoted Falls Prevention activities through the Radio, TV, Local Papers, and SHDHD web site. Developed a ½ page double-sided cards "Step Up to Stop Falls – 6 Steps to Prevent a Fall". Delivered "Step Up to Stop Falls" cards to Primary Care Clinics, Pharmacies, Hospital ER, Physical Therapy, Vision Clinics, Senior Centers/MAAA, and Brown's Shoe Fit: Adams (54) Nuckolls (15), Webster (9) & Clay County (21). Total display racks delivered – 99.</p> <p>We received some extra money during August 2018, to be used on marketing for Falls Prevention Awareness. SHDHD had some resources budgeted for marketing for September, but we were able to do a lot more with the extra funding (Healthy Everyday segment / ads on TV and the ½ page double-sided cards). We are already receiving calls about when the next classes are going to be starting.</p>
<p style="text-align: center; margin: 0;">Brooke Wolfe</p>  <p style="text-align: center; margin: 0;">Public Health Promotions and Prevention Coord</p>	<p><u>1422 Prevention Connection:</u> Funding ended as of Sept 30, 2018. September was spent wrapping up all strategy component activities with partners to leave them in the best possible position to continue the work without SHDHD's support. In addition, the reporting of the 23 performance measures DHHS required was finalized and the success stories completed. October was spent completing the final reports and ramping up other activities such as school wellness, CHA/CHIP data collection, coordinating Kids Fitness Day and researching the best Health Coaching Clinical Integration Model for SHDHD.</p>



**South Heartland Bi-Monthly Board Report: Staff-Specific Program Updates,
September-October 2018**

<p>Jessica Warner</p>  <p>Health Surveillance Coordinator</p>	<p><u>Disease Surveillance:</u> SHDHD Coordinated Priority Setting meetings for our Community Health Improvement Plan. I worked with a small team to complete fact sheets and packets of information for these meeting. The Access to care packet (69 pages) involved survey summary information as well as disparity information for SHDHD residents. The Priority Setting packet included fact sheets for health priority areas (55 pages). Additionally, I created two surveys for evaluating these meetings. School Surveillance started in September and Hospital ILI started in October. I completed 32 investigations and sent 6 case reports to DHHS that were requested by the CDC.</p>
<p>Amy Market</p>  <p>Reception</p>	<p><u>Master Database:</u> I have continually been updating the master database contacts for the Emergency Response critical contacts, Michele’s emergency numbers, and overall use for staff. <u>VetSET/Making Connections:</u></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> Accreditation PHAB Action Plan, completing the objectives and actions to meet the opportunities for improvement for 16 measures. The Action Plan is due November 25. <u>CHA/CHIP:</u> Member of the MAPP Core Team, internal (SH) work on planning of focus group meetings, priority setting meetings, and strategy setting meetings, data meeting packets, facilitator for Clay County meetings and capturing process documentation. <u>Standards and Performance Manager:</u> Review-revision-implementation of policies, protocols, procedures and plans and identification of training to improve quality and performance management. Capturing CHA/CHIP processes to meet PHAB evidence-based standards.</p>
<p>Jean Korth</p>  <p>Chronic Disease Prevention Program Assistant</p>	<p><u>1422 Prevention Connection:</u> All 1422 partners completed their final benchmark activities. A push for assistance in EHR reporting was the focus of two clinics, along with support of efforts towards chronic care management. We are currently in the process of reviewing information on the process for outsourcing of chronic care management health coaching to Community Based Organizations. <u>Health Literacy:</u> October is Health Literacy Month and staff received an overview of Health Literacy at a staff Meeting.</p>
<p>Susan Ferrone</p>  <p>Lifestyle Coach for Diabetes Prevention & Community Assessment Coord.</p>	<p><u>Community Needs Assessment, Community Health Improvement Plan:</u> Core Team (4 County representation) continues to meet and dates/processes for Strategy Setting meetings have been determined, October 31st (Access to Care) and November 14 and December 12 (Health Issues). <u>Smart Moves Class:</u> Class now meets monthly.</p>