

Community Health Improvement Plan Annual Report 2018

South Heartland District Health Department



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2012-2017 PRIORITY HEALTH AREAS OF HOSPITALS IN THE SOUTH HEARTLAND DISTRICT.

Mary Lanning Healthcare, Hastings	https://www.marylanning.org/
Brodstone Memorial Hospital, Superior	www.brodstonehospital.org/

Purpose

This is the annual report of the 2012-2017 Nebraska South Heartland District Health Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a “long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process.”

A CHIP is designed to:

- Set community health priorities
- Coordinate and target resources needed to impact community health priorities
- Develop policies
- Define actions to target efforts that promote health
- Define the vision for the health of the community
- Address the strengths, weaknesses, challenges, and opportunities that exist in the community related to improving the health status of the community

This document serves as a progress review on the strategies that were developed in the 2011-2017 CHIP and activities that have been implemented. This document also refers to the Community Health Needs Assessment, CHA. Both documents can be found on the SHDHD website:

www.southheartlandhealth.org

The CHIP is a community driven and collectively owned health improvement plan. South Heartland District Health Department provides administrative support, data tracking and collecting, and preparation of the annual report. For more information on the CHIP or the annual CHIP report, please contact:

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December, 2018

Definitions

This section contains the definitions of acronyms or other public health specific words included in this report.

ATC: Access to Care

BMI: Body Mass Index

CHA: Community Health Needs Assessment

CHIP: Community Health Improvement Plan

BRFSS: Behavioral Risk Factor Surveillance System

EWM: Every Woman Matters

DHHS: Department of Health and Human Services (or NeDHHS)

FOBT: Fecal Occult Blood Test

NDPP: National Diabetes Prevention Program

NRPFSS: Nebraska Risk and Protective Factor Student Survey

SHDHD: South Heartland District Health Department

Tai Chi: Fall prevention program

VetSET: Program for outreach to Veterans and their families of those recently discharged Veterans in rural or underserved areas.

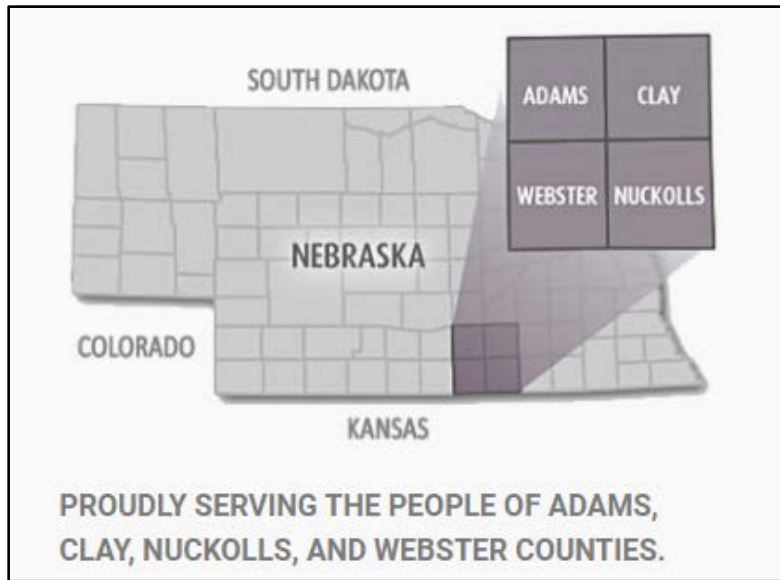
YRBS: Youth Risk Behavior Survey

YTS: Youth Tobacco Survey (YTS)

1422 Grant: Chronic Disease Prevention – Healthy Food Choices, Worksite Wellness, Walkability/ Safe Streets, Coordinated School Health, Scrubby Bear, Pool Cool/Sun Safety, Bi-directional Referral of Patients with Hypertension/Diabetes with District clinics.

Linkages between Local Public Health Departments and Primary Care Clinics in Nebraska to Improve Population Health Outcomes

South Heartland District Health Department Overview



Population:

Area: 2,286 square miles

Mission: Mission: The South Heartland District Health Department is dedicated to preserving and improving the health of residents of Adams, Clay, Nuckolls and Webster counties. We work with local partners to develop and implement a Community Health Improvement Plan and to provide other public health services mandated by Nebraska state statutes.

Vision: Healthy people in healthy communities

Guiding Principles:

We are committed to the principles of public health and strive to be a credible, collaborative and stable resource in our communities.

We seek to perform our duties in a courteous, efficient and effective manner within the limits of sound fiscal responsibility.

We work together to create a positive environment, listening carefully and treating everyone with honesty, sensitivity, and respect.

“Unique Characteristics of SHDHD”

South Heartland District Health Department (SHDHD) serves one frontier and three rural counties in South Central Nebraska. SHDHD was the first health department formed under LB 692, a 2001 bill that created public health infrastructure using Nebraska’s Master Tobacco Settlement Funds. Many district challenges exist, but strong collaboration with community partners assists us with strategies to protect and promote the health of the district’s residents.

The four counties are served by three hospitals, but also utilize hospitals from surrounding counties and their satellite clinics in the district. Rural geographic isolation hinders access to care, and emergency health responders volunteer, except for in the largest town. The Hastings Regional Center, created in 1887 as the State Asylum for the Incurably Insane, was phased out to community-based services during the past decade’s state mental health reform. Although there is a deep immigrant/pioneer history tied to the land, agriculture, water and railroads, the current immigrant influx brings multicultural richness and challenges (diversity resistance, language barriers).

Our district has the potential for seasonal weather problems (tornados, drought, flooding, storms). Rural outdoor air quality is high, but agricultural chemicals and dust can cause problems seasonally. Radon potential in indoor air is high. District ground water quality is impacted by agricultural nitrates, and chemicals from storage bunkers from the largest WWII Naval Munitions Plant (EPA superfund site).

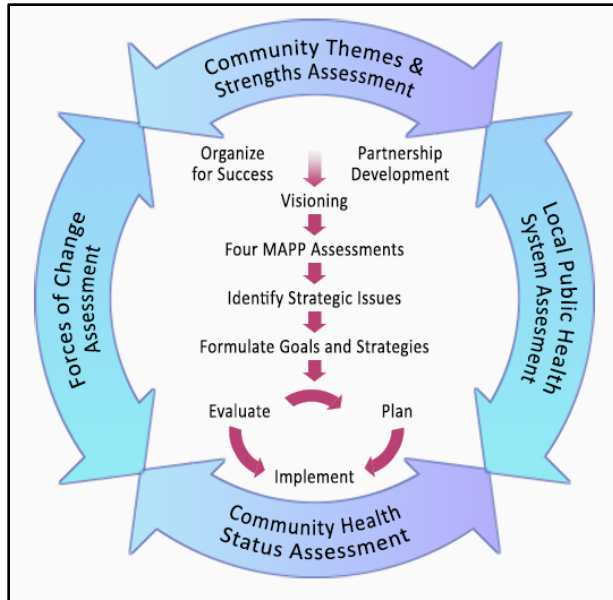
Large numbers of livestock are in owner-operated and commercial feedlots, and at the U.S. Meat Animal Research Center (MARC), where scientists increase livestock production and consumer benefit.

International travel (personal and work-related) and large numbers of livestock increase potential for disease transmission. The central bird migration flyway and diverse wildlife are also conducive to infectious and vector-borne diseases. SHDHD’s Board of Health includes a veterinarian (not a statutory requirement) to advise on agricultural and wildlife concerns.

*Created with input from Board and Staff
for SHDHD’s Accreditation Application
May 18, 2016*



Community Health Needs Assessment, CHA



Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them.

In this model, the phases of the process are diagramed in the center. The entire process is informed by data and the four assessments that produce these data are shown in the arrows around the outside. The phases of the MAPP process are: Organizing/Partnership Development, Visioning, Assessment, Identifying Strategic Issues, Formulating Goals and Strategies, and the Action

Cycle for the resulting Community Health Improvement Plan (CHIP).

Community Health Needs Assessment – South Heartland’s Process

Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic approach to community health improvement. South Heartland District Health Department (SHDHD) used this tool to facilitate the 4-county health district in efforts to improve health and quality of life through community-wide and community-driven strategic planning. This process helped the district identify and plan use of resources, taking into account the unique circumstances and needs of the district and the individual component counties. It also promoted new and solidified existing partnerships in our communities and across the district.

The SHDHD MAPP/CHIP process began with identification of core planning team members, whose responsibilities were to review the MAPP process, complete a readiness assessment, discuss and define “community” for each hospital, review stakeholder categories, identify stakeholders, determine timelines and discuss resources to implement the process. All three hospitals in the district committed to participate with SHDHD in MAPP and signed Memoranda of Understanding outlining their contributions; including resources. Hospital administrators identified staff members to participate in the core team. This team was also responsible for overseeing the implementation and management of the process. The core team included eight members: hospital administrators and/or appointed staff from Brodstone Memorial Hospital, Mary Lanning Healthcare and Webster County Community Hospital; Clay County Health Department director; SHDHD Board of Health president; and SHDHD director. The first planning meeting was held September 2, 2011.

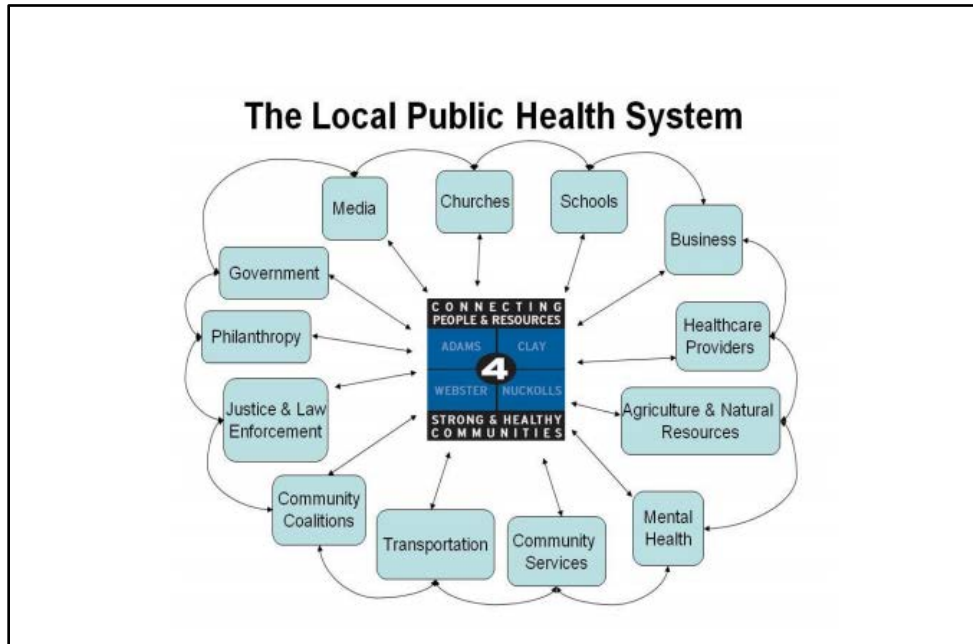
The Core Team developed an overall timeline for the process which was carried out as follows:

- November 2011 – Local Public Health System Assessment (CDC Field Test Site)
- February 2012 – Forces of Change Assessment (focus groups – one per county)
- February – May 2012 – Community Themes and Strengths Assessment (Intercept Survey)
- May 2012 – August 2012 – Health Status Assessment

December, 2018

- September 2012 – Identify Strategic Issues (Priority-Setting)
- October - December 2012 – Formulate Goals & Strategies
- December 2012 – March 2013 – Develop Community Health Improvement Plan

The MAPP assessment process leads to the development of a community-wide health improvement plan (CHIP), which can only be adopted and realistically implemented if the community has contributed to the plan development. SHDHD worked to ensure participation by a broad cross section of the district, inviting representatives from many sectors of our communities. In addition, MAPP also supports organizational action plan development by each of the participating entities, including the key hospital partners, for their service areas. Through the MAPP process, the South Heartland District continued to strengthen the local public health system. We defined the local public health system as all of the entities that contribute to the delivery of public health services within our communities. This included public and private entities, civic and faith based organizations, individuals, and informal associations, front-line and grassroots workers and policy makers.



The Assessment Phase consisted of implementing all four of the MAPP Assessments and was carried out, with assistance from a contracted facilitator, during the period of October 1, 2011 – August 30, 2012. Following the Assessment Phase, the community (via stakeholder work groups) identified strategic issues and formulated goals and strategies for addressing each issue. Community stakeholders collaborated in a facilitated development of a Community (district-wide) Health Improvement Plan (CHIP). In 2013 and beyond, work groups for each priority will move the plan components into the Action Phase (CHIP implementation).

Community Health Improvement Plan

Priority Goals

Goal 1: Obesity

Reduce obesity and associated chronic disease risk through consumption of healthful diets, daily physical activity and achievement and maintenance of healthy body weights

Goal 2: Cancer

Reduce the number of new cancer cases as well as illness, disability and death caused by cancer

Goal 3: Mental Health

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Goal 4: Substance Abuse

Reduce substance abuse to protect the health, safety, and quality of life for all, especially young people

Goal 5: Access to Health Care

Improve access to comprehensive, quality health care services



Priority Goal: Obesity

Goal 1: Reduce obesity and associated chronic disease risk through consumption of healthful diets, daily physical activity, and achievement and maintenance of healthy body weights

Targets/Performance Measures

Short-term: Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

- Increase the percentage of adult consuming five or more servings of fruits and vegetables daily
Baseline: 22.9% (State 21.1) BRFSS, 2009-2010
Target: 24.3%
- Increase the percentage of youth who report eating fruits ≥ 2 times/day and vegetables ≥ 3 times/day during the past 7 days
Baseline: 23.4% fruits (State 27%), 8.5% vegetables (State 12%) (YRBS, - SHDHD 2012, State, 2011)
Target: 24.8% fruits, 9% vegetables
- Decrease the proportion of high school students who report consuming soda one or more times per day during the past 7 days.
Baseline: 21.1% (State, 26%) (YRBS, - SHDHD 2012, State, 2011)
Target: 19.8%
- Increase the percentage of adults/youth meeting the 2008 Physical Activity Guidelines for Americans
Baseline: 49.1% (State, 49.0%) of adults reported 30 min of aerobic activity 5 days of the week (BRFSS: SHDHD, 2011 State, 2011)/ 58.7% (State, 54%) of youth reported 60 minutes of physical activity 5 days or more per week (YRBS, - SHDHD 2012, State, 2011)
Target: 52% adults reporting 30 min, 5 days per week / 62.2% of youth reporting 60 min. of PA 5 days or more per week.
- Increase the number of mothers who meet the recommendations for breastfeeding (exclusive for 6 months)
Baseline: (no data available for general population about duration)
Target: collect duration data for the general population

Long-term:

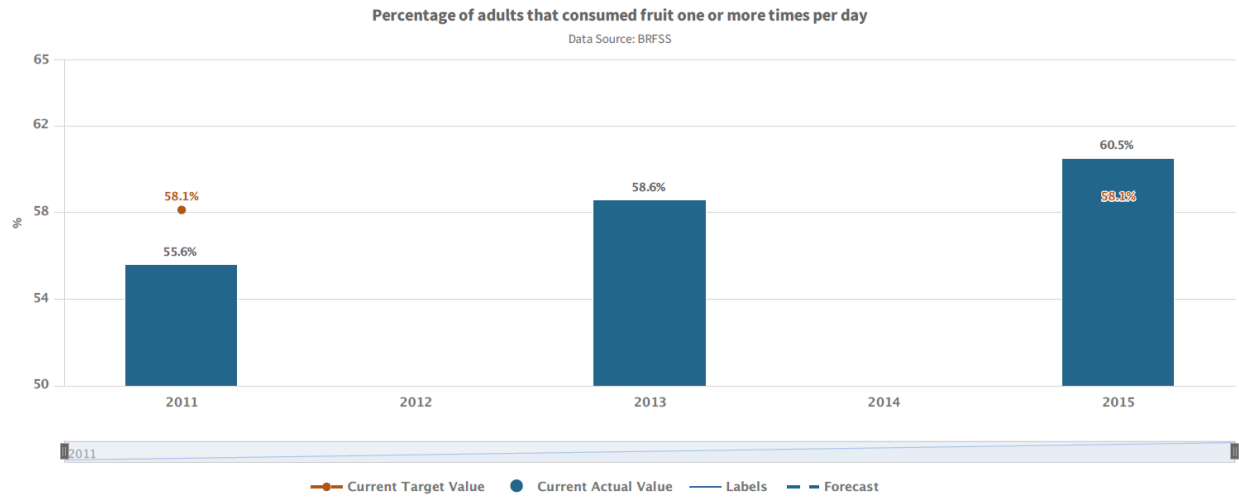
- Decrease the percentage of adults 18+ years who are overweight or obese (BMI ≥ 25.0)
Baseline: 68.7% (State, 65%) (BRFSS, 2012)
Target: 64.6%
- Decrease the percentage of adults who are obese (BMI ≥ 30.0)
Baseline: 30.6% (State, 28.6%) (BRFSS, 2012)
Target: 28.8%
- Decrease the percentage of children under 18 years who are overweight (BMI ≥ 25) or at risk of becoming overweight ($21 < \text{BMI} < 25$)
Baseline: Overweight or Obese 32.1% (State, 26.5%) (YRBS, 2012)
Targets: Overweight or Obese 30%

Obesity:

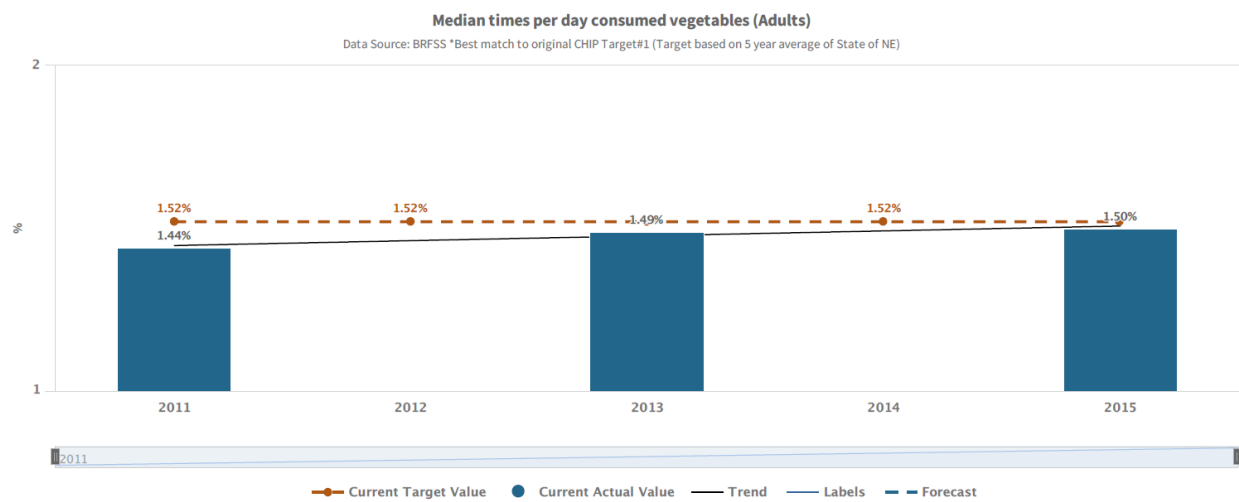
60.5% of adults report consuming fruit 1 or more times per day. Fruit consumption, as reported by South Heartland adults, has improved from the baseline of 54.6 in 2012. Youth fruit consumption is below that of adults. Only 30.5% of youth reported consuming fruit 1 or more times per day in 2016. Our target for youth of consuming two or more servings of fruits per day is down from 23.4 in 2012 to 18.0 in 2016. Through the school system, students have access to at least one serving of fruit per meal. These data indicate that there is a need to continue to encourage fruit consumption and provide a variety of fruits to youth.

Obesity continues to be a concern in our four county area. Improvement is seen in the rate at which overweight individuals are becoming obese. While the percentage continues to increase, it is at a slower rate when compared to the change in the obese population. The percent change for Individuals with a BMI of ≥ 30 has increased more drastically than that of the overweight population with a BMI of ≥ 25 . With this division, it appears that some overweight individuals have made behavior changes over the past six years which accounts for the current data being slightly over the baseline. We hope to see a decrease in both of these categories in the upcoming six years.

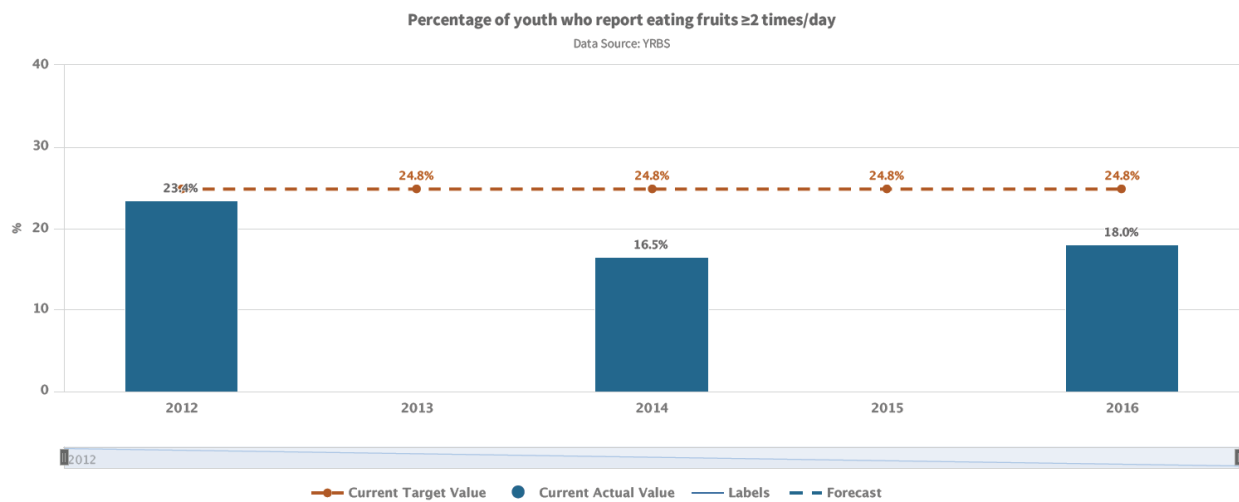
Obesity Trends for Performance Measures and Targets



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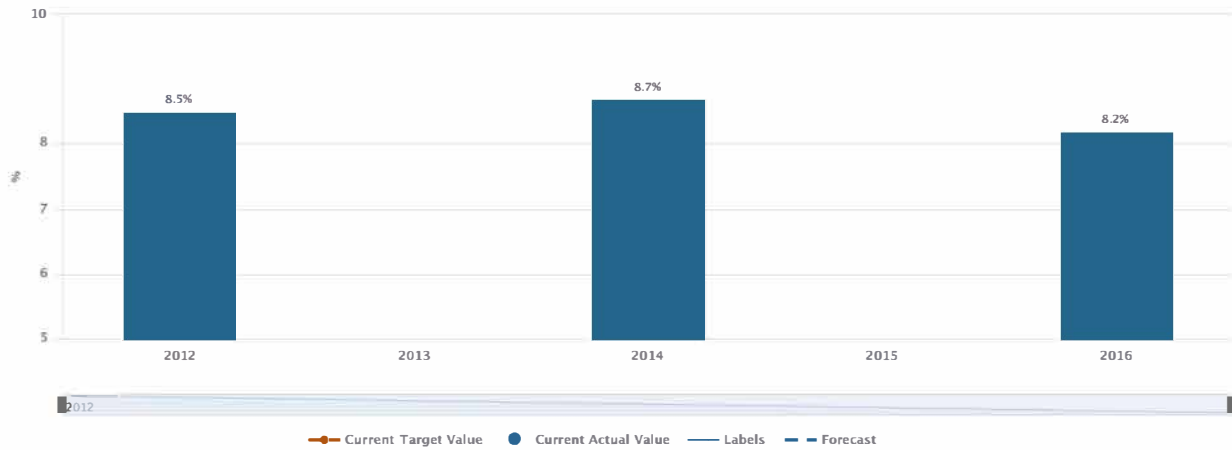
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Vegetable consumption among high school students 3 or more times per day

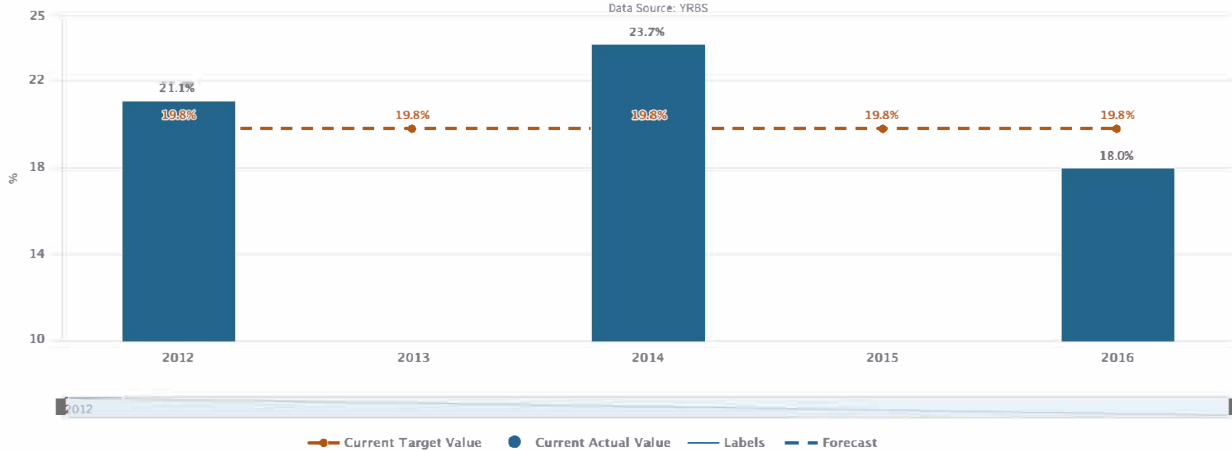
Data Source: BRFSS



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Soda consumption among high school students, one or more times per day

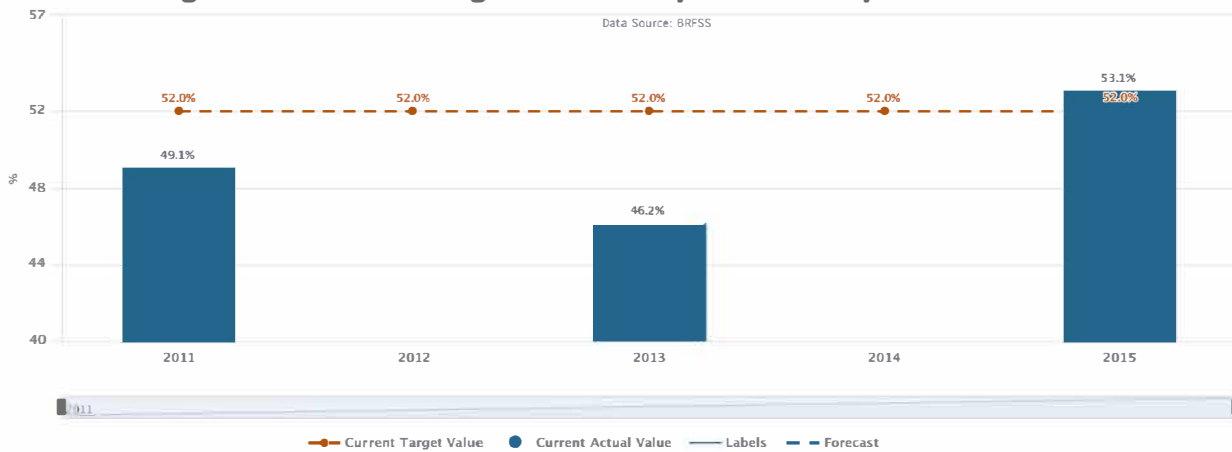
Data Source: YRBS



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Percentage of adults meeting the 2008 Physical Activity Guidelines for Americans

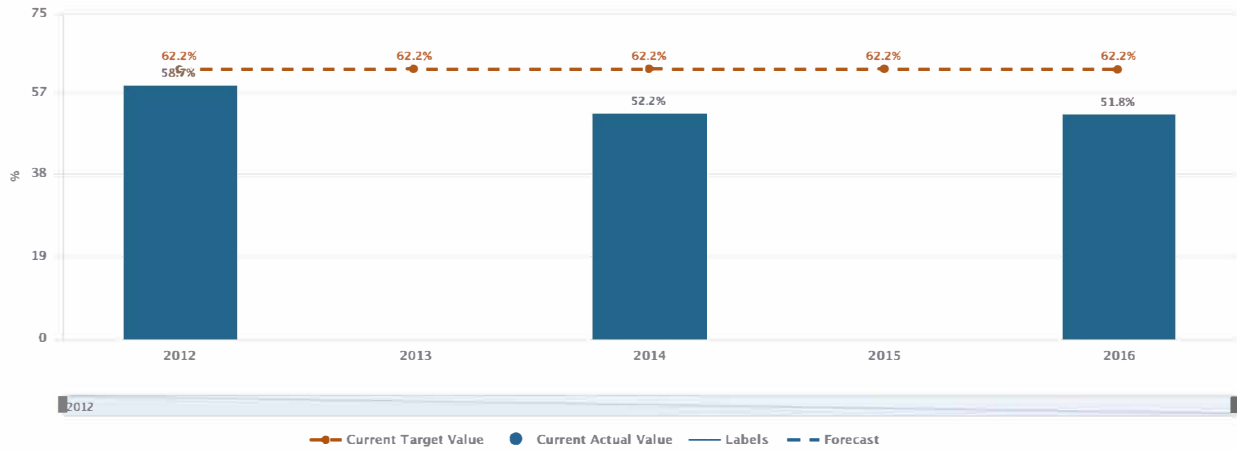
Data Source: BRFSS



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Percentage of youth meeting the 2008 Recommendations for Physical Activity at least 5 days per week

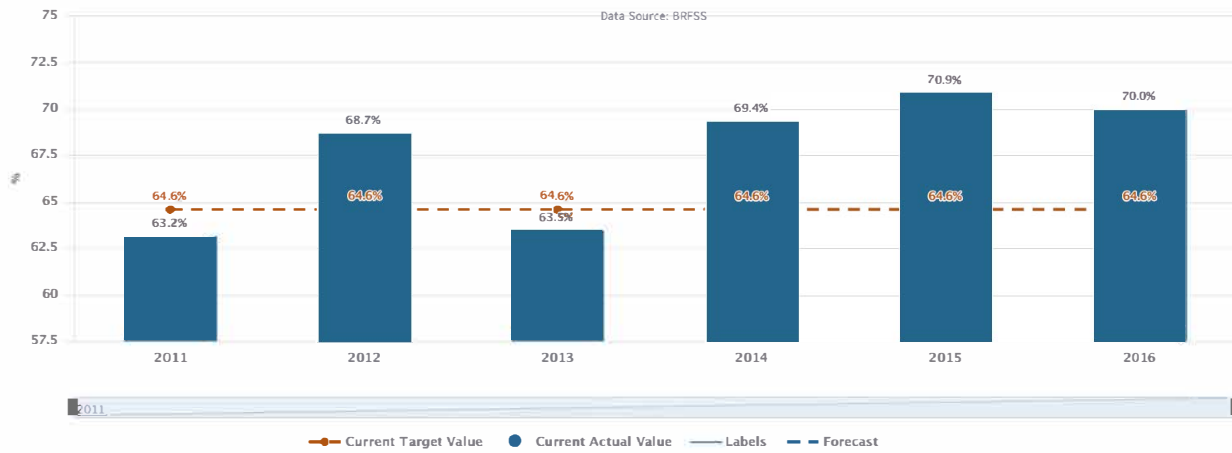
Data Source: YRBS



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Percentage of adults 18+ years who are overweight or obese (BMI=25+)

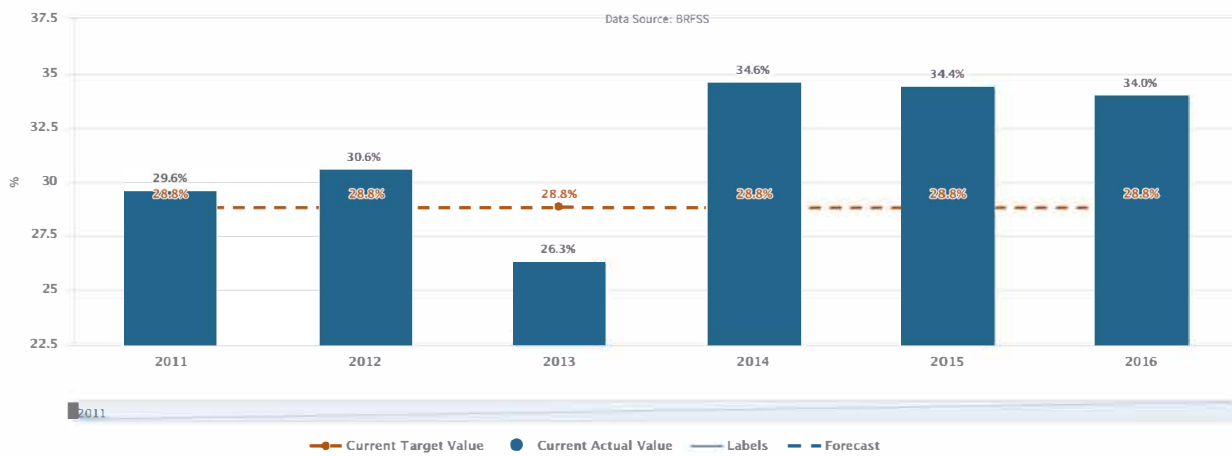
Data Source: BRFSS



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Percentage of adults who are obese (BMI=30+)

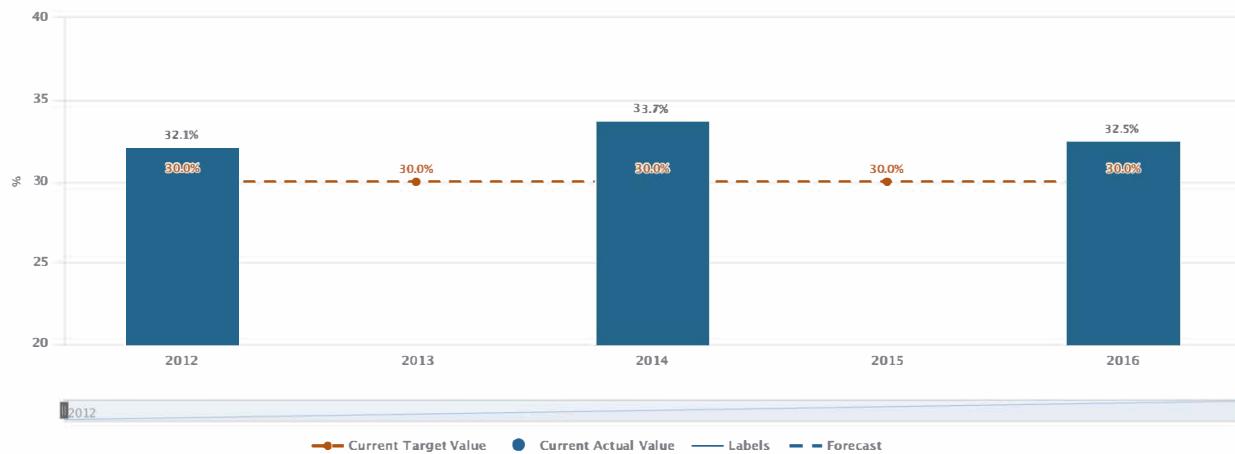
Data Source: BRFSS



ClearImpact.com

Percentage of children under 18 years who are overweight (BMI =25+) or at risk of becoming overweight (BMI >21)

Data Source: YRBS



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Obesity Prevention Strategies

O-1. Community Partnerships: Increase the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP).

Setting: Community

- A. Expand Obesity Prevention Coalition to include representation from a range of health providers, organizations providing services for underserved populations, parent support organization, businesses (e.g., Chambers of Commerce, grocers, restaurants), insurance brokers, athletic trainers, colleges, schools and school boards, PTOs, educational service unit, child care facilities, Veteran's Services, faith- and community-based organizations, health/wellness organizations, city and county government decision-makers, food banks/pantries, and others needed to support the strategies in this plan

O-2. Community Context: Increase opportunities for active living and healthful diets in our local communities.

Setting: Community

- A. Promote community planning that includes a focus on health
- Support development of comprehensive community plans that promote active living and safe environments including coordination between planning, transportation, health and parks departments to enhance the build environment (e.g., trail systems, parks, green space and sidewalks in new housing developments, safe non-vehicular routes to community points of interest)
 - Advocate for policies and actions that create safer environments to be active (e.g., improved sidewalks/bike lanes, Safe Routes to School, Complete Streets policies)
 - Identify resources to support community planning (e.g., Safe Routes to School, NE Department of Roads)
- B. Support the creation, improvement and promotion of community-based facilities and events that provide opportunities for physical activity and healthful diets (community centers, parks, fitness centers, farmer's markets, community gardens, grocery stores)
- Identify, promote and secure resources (e.g., community foundations, Farm Service Agency, hospitals)
 - Identify and promote partnerships and model policies (e.g., school/community agreements for facility and equipment use)

O-3. School Context: Increase opportunities for active living and healthful diets in our local schools and childcare centers.

Setting: Schools, childcare facilities

- A. Identify and implement school-based programs and policies that promote physical activity and healthful diets.
- B. Research school and childcare center practices related to nutritional offerings and physical activities not linked to organized sports (e.g., food reward policies, vending machine offerings, time allotted to physical activity by grade) and promote best practices and implementation of model policies.
- C. In partnership with school staff, monitor physical activity and nutrition indicators in children in educational settings, then use these data to educate students and parents and to support policy adoption

O-4. Worksite Context: Increase opportunities for physical activity and nutrition at worksites.

Setting: Worksites

- A. Promote adoption of successful models for worksite-based wellness
- Determine baseline and expand number of worksites doing health risk assessments and using these to promote policy, system and environment changes
 - Determine baseline and increase number of worksites with model worksite wellness polices (including breastfeeding model policies)

- B. Engage small businesses and self-employed populations into discussions about wellness initiatives (e.g., healthy meeting guidelines)

O-5. Empowered People: Empower the general public, referral agents, and communities to connect with and recruit needed resources and share reliable health information.

Setting: Community

- A. Use evidence-based small media/group education to reach target populations with accurate and consistent messaging that raises awareness and promotes physical activity and healthful diets through community partners and events.
- Provide educational, activity and screening opportunities to target populations: health fairs, nutrition classes and instruction on where food comes from, fitness and nutrition events for children and youth, for seniors, for parents and for underserved populations
 - Engage local grocery stores in activities that promote healthy diets (partnerships between hospitals and grocers: store tours, cooking demos, dieticians on-site, cost information for healthy foods, Go Local to promote local produce, etc.)
 - Explore role of health providers in empowering patients (to include wellness screening as part of physical exams, to provide wellness coaching, and to “prescribe” healthful diets and physical activity, and to offer informational videos in waiting rooms.
 - Encourage food banks/pantries to request healthful food donations, offer vouchers for fresh fruits and veggies, and provide healthful recipes



Priority Goal: Cancer

Goal 2: Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

Targets/Performance Measures

Screening: “Appropriate” screening methods are based on most recent recommendations by the U.S. Preventive Services Task Force (U.S.P.S.T.F.). Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

- Increase percentage of women aged 50-74 years who are up-to-date on breast cancer screening (mammogram within the last 2 years, U.S.P.S.T.F. , 2009)
Baseline: 70.0% (State 69.9%) BRFSS, 2012
Target: 74.2%
- Increase percentage of women aged 21-65 years who are up-to-date on cervical cancer screening rates (women without hysterectomy who had pap test within the last 3 years, U.S.P.S.T.F. , 2012)
Baseline: 80.4% (State 83.1%) BRFSS, 2012
Target: 85.2%
- Increase percentage of adults aged 50-75 years who are up-to-date on colorectal cancer screening (annual fecal occult blood test (FOBT), OR sigmoidoscopy every 5 years + FOBT every 3 years, OR colonoscopy every 10 years, U.S.P.S.T.F. , 2008)
Baseline: 57.1% (State 63.6) BRFSS, 2012
Target: 60.5%
- Developmental: Increase the proportion of men 40 years and older who have discussed with their health care provider the advantages and disadvantages of the prostate-specific antigen (PSA) test to screen for prostate cancer (U.S.P.S.T.F. guidelines of May 2012)
Baseline: Local baseline unknown; 2010 National Baseline = 14.4% (NHIS, CDC/NCHS)
- Developmental: Increase the proportion of youth and adults who follow protective measures that reduce the risk of skin cancer

Incidence/Mortality: Rates based on 100,000 population (Nebraska Vital Statistics, source years: Incidence 2003-07; Mortality 2004-08)

- Reduce incidence / mortality rates due to Female Breast Cancer
Baseline: 128.9 (state 123.2) / 19.0 (state 22.0)
Target: 121.2 / 18.0
- Reduce incidence / mortality rates due to Cervical Cancer
Baseline: 9.9 (State 7.2) / 0.0 (State 1.8)
Target: 9.6 (incidence)
- Reduce the incidence / mortality rates due to Colorectal Cancer
Baseline: 64.7 (state 56.2) / 15.5 (state 18.5)
Target: 60.9 / 14.6
- Reduce incidence / mortality rates due to Prostate Cancer
Baseline: 161.3 (state 158.9) / 25.1 (24.5)
Target: 151.6 / 23.6
- Reduce incidence / mortality rates due to Skin Cancer
Baseline: 18.5 (state 17.1) / 4.6 (State 3.0)
Targets: 17.4 / 4.3

- Reduce incidence / mortality rates due to Lung Cancer
Baseline: 66.2 (state 65.6) / 48.2 (state 47.2)
Target: 62.3 / 45.3

Cancer –

Two types of cancer are noted for significant incidence and mortality. Skin cancer incidence continues to increase from the baseline rate of 18.5 in 2012 to 29.0 in 2016. Mortality due to skin cancer continues to increase from the baseline of 4.6 to 5.6 in 2016.

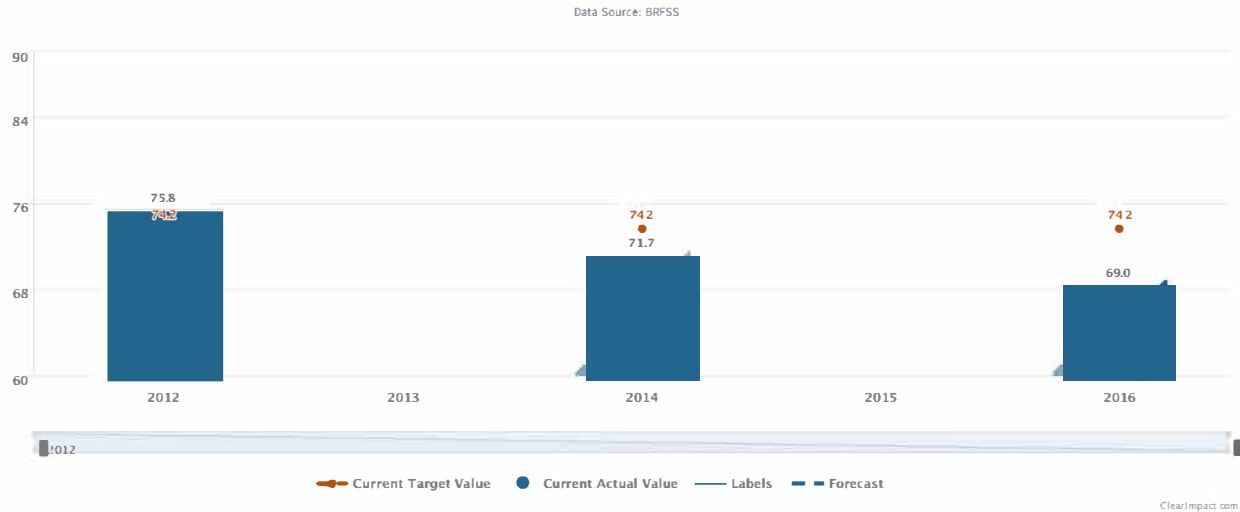
Breast cancer incidence and mortality has increased just slightly from the baseline data provided in 2012. The mortality rate due to breast cancer was 19.0 in 2012 and the current rate is 22.8. While breast cancer and mortality has decreased in the past two decades, it continues to be a concern.

Prostate cancer incidence has shown a huge improvement from the baseline rate of 161.3 to 112.6 in 2016. This rate is drastically better than our incidence target of 151.6.

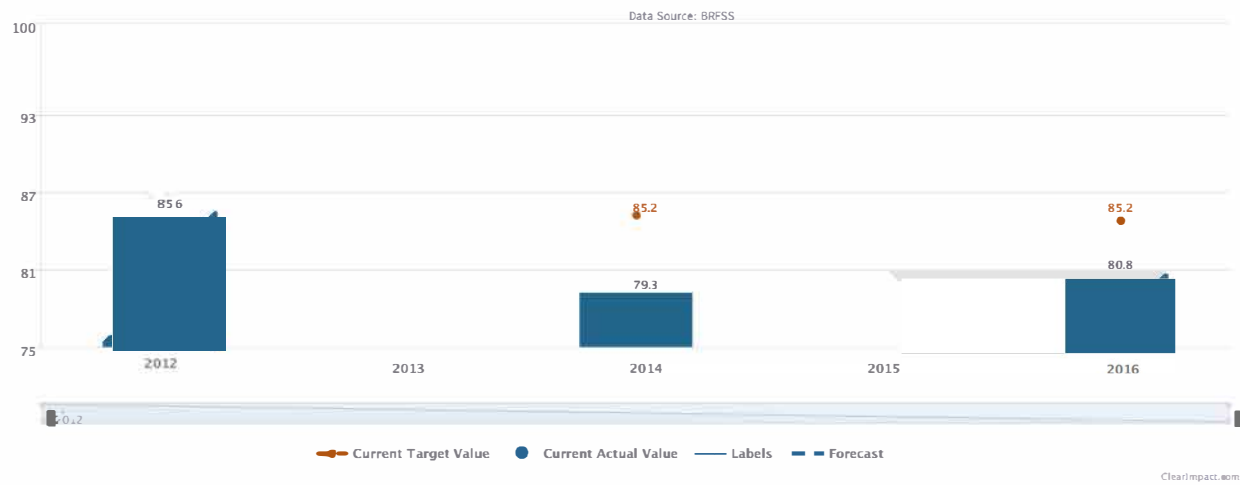
Colorectal cancer screening has improved significantly from 59.9 to 72.1. Incidence rates for colon cancer have decreased from 64.7 to 42.6. Colon cancer mortality rate is virtually identical since 2012. South Heartland continues to raise awareness, provide screening materials to individuals over 50, and promote Task Force recommendations to stay up-to-date on colorectal cancer screening.

Cancer Trends for Performance Measures and Targets

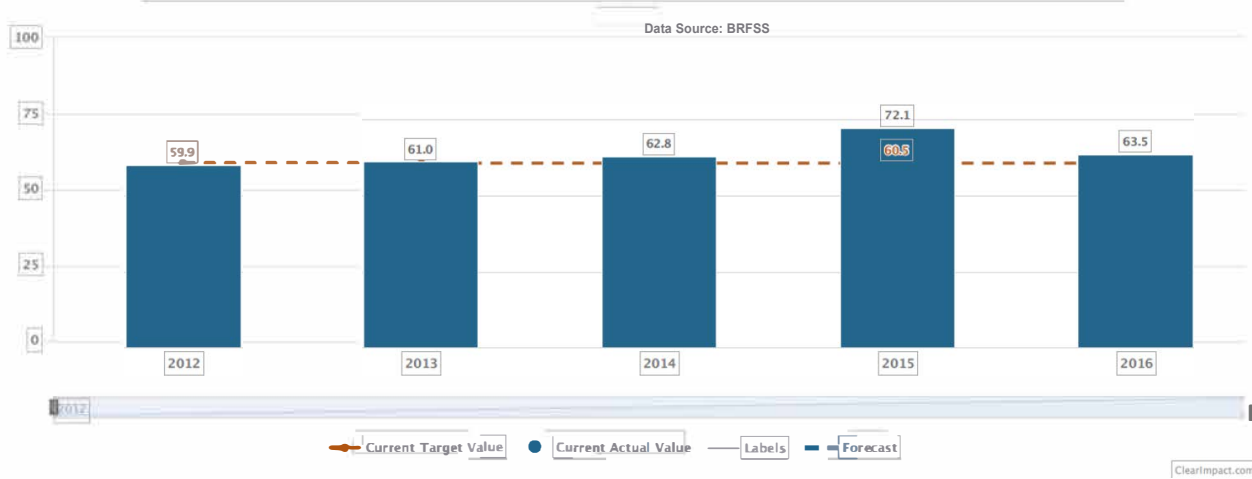
Percentage of women aged 50-74 years who are up-to-date on breast cancer screening



Percentage of women aged 21-65 who are up-to-date on cervical cancer screening rates

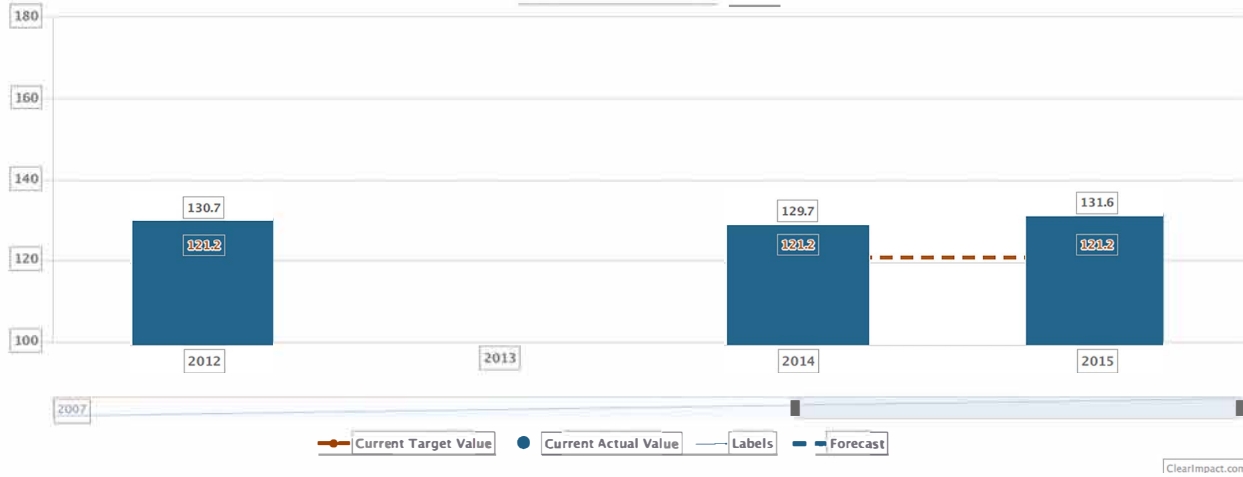


Percentage of adults aged 50-75 years who are up-to-date on colorectal cancer screening



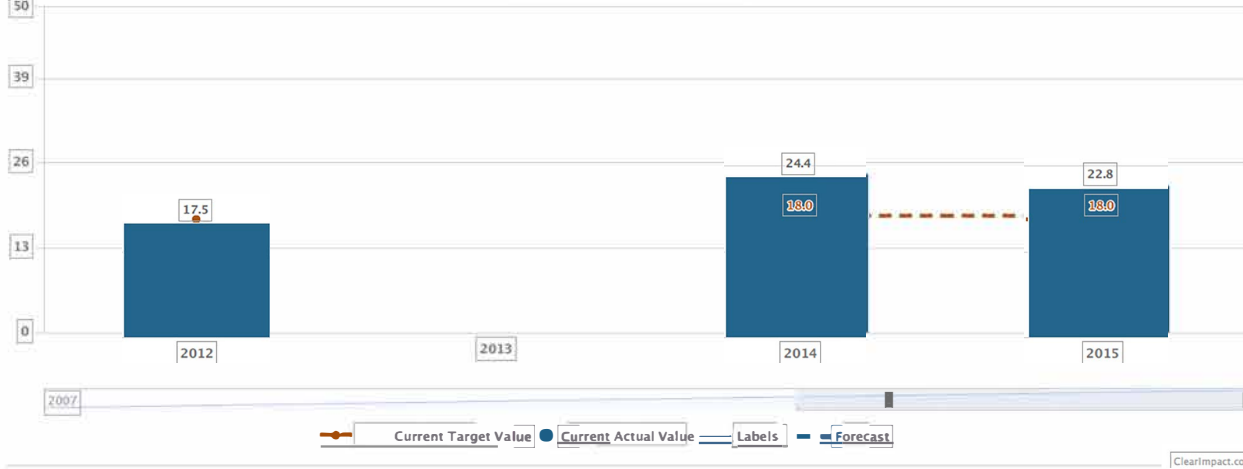
Reduce incidence of female breast cancer

Data Source: Nebraska Cancer Registry



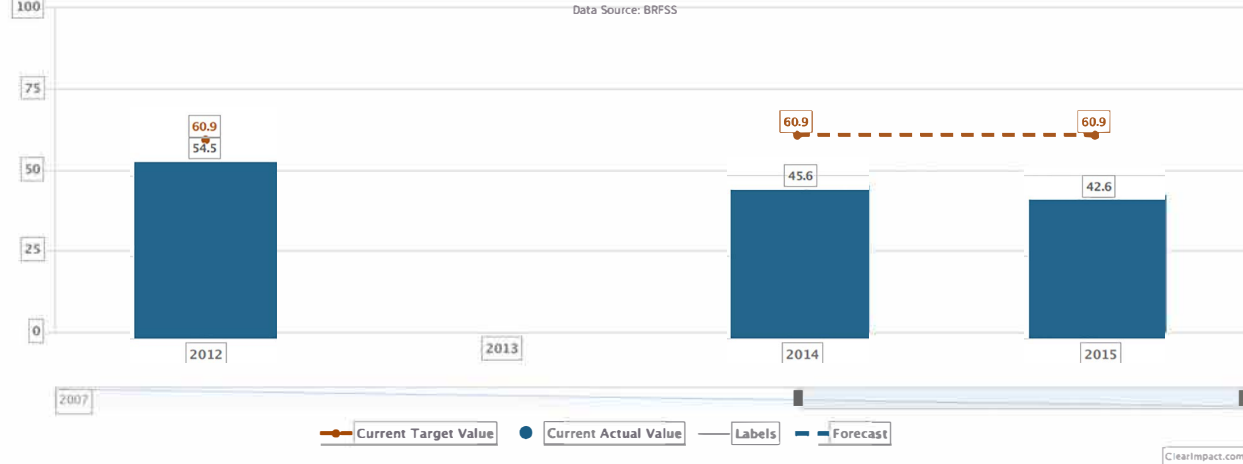
Reduce mortality due to female breast cancer

Data Source: Nebraska Cancer Data



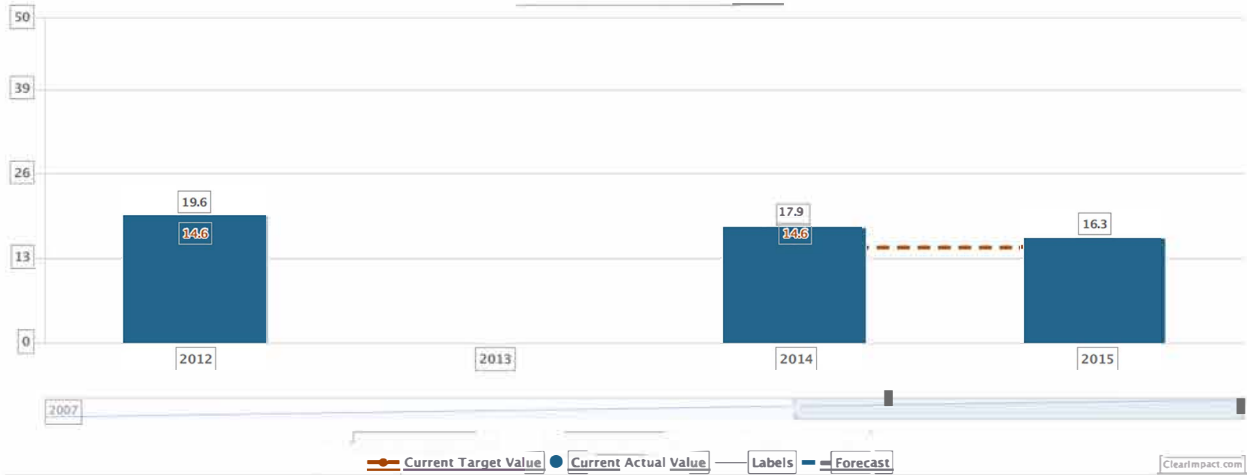
Reduce incidence of colorectal cancer

Data Source: BRFSS



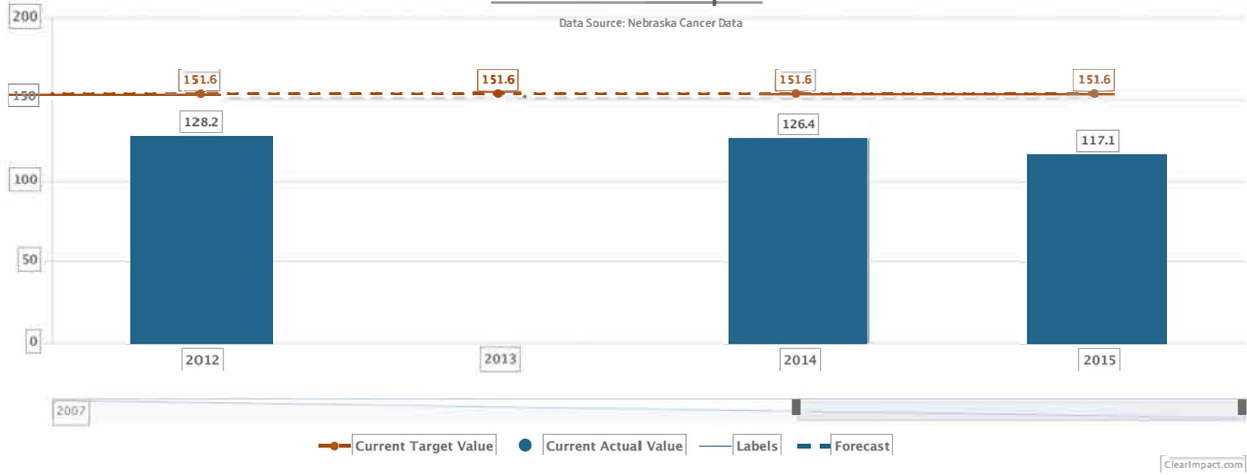
Reduce mortality due to colorectal cancer

Data Source: Nebraska Cancer Data



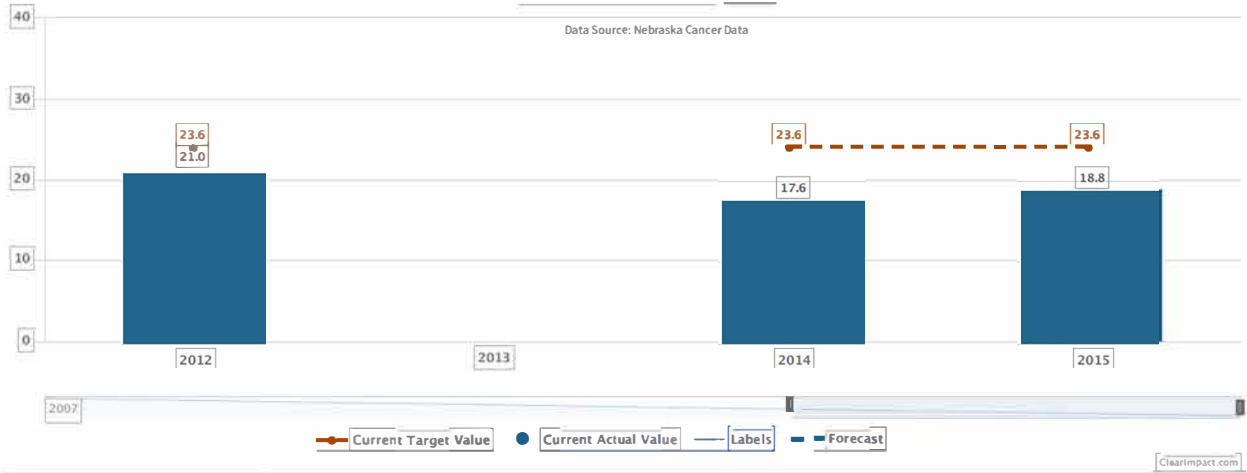
Reduce incidence of prostate cancer

Data Source: Nebraska Cancer Data

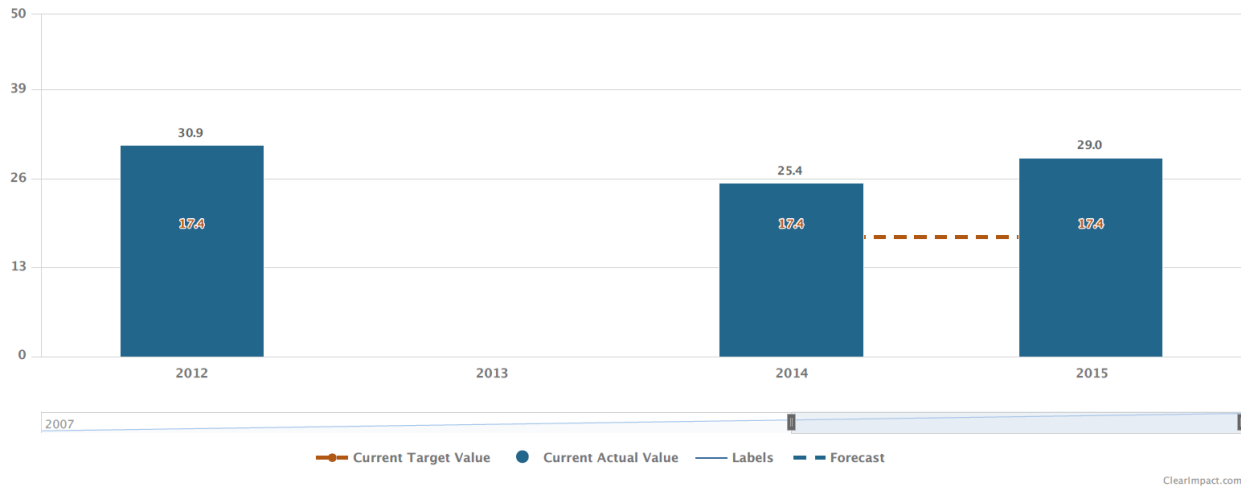


Reduce mortality due to prostate cancer

Data Source: Nebraska Cancer Data

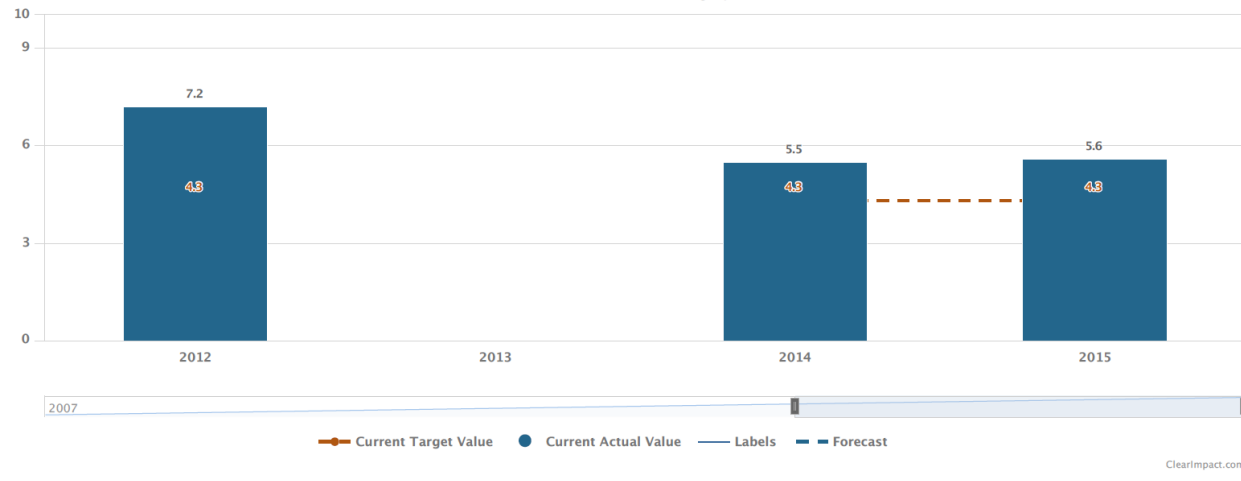


Reduce incidence of skin cancer



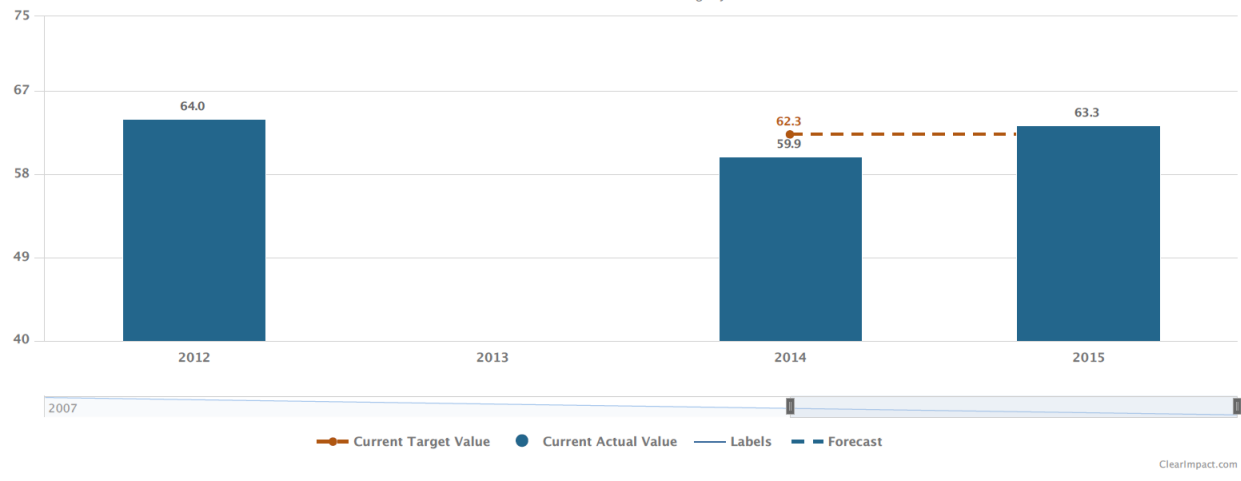
Reduce mortality due to skin cancer

Data Source: Nebraska Cancer Registry



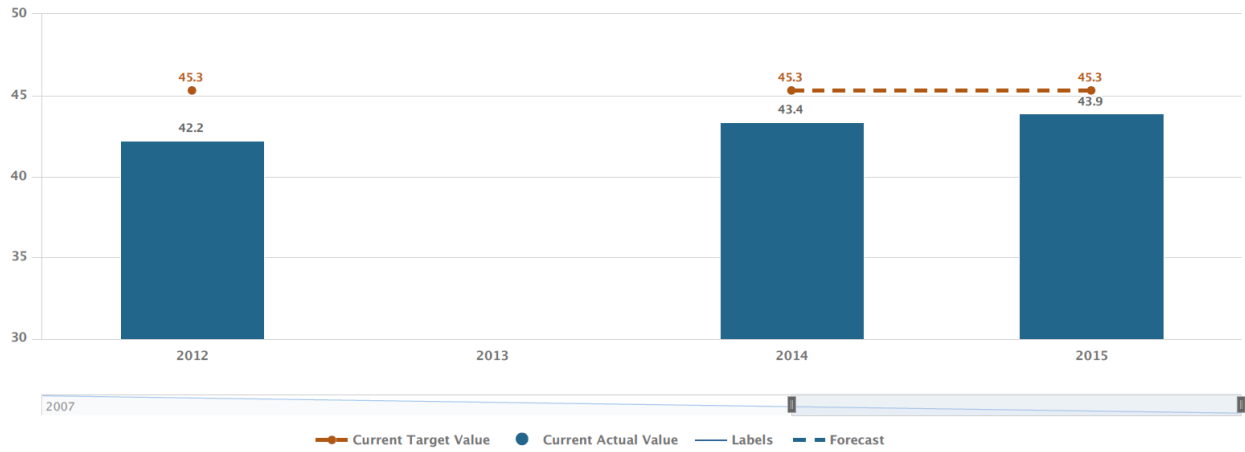
Reduce incidence of lung cancer

Data Source: Nebraska Cancer Registry



Reduce mortality due to lung cancer

Data Source: Nebraska Cancer Registry



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Cancer Prevention Strategies

C-1. Community Partnerships: Increase the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP)

Setting: Community

- A. Expand the local Colon Cancer Coalition to encompass all cancers and increase the number of local community members involved in the Cancer Coalition (cancer providers, survivors, representatives from organizations providing services for populations with low incomes, and representatives from organizations serving as community connections and communication channels for traditionally underserved populations)
- B. Increase # of organizations providing services and resources for populations with low incomes
- C. Increase # of organizations serving as community connections and communication channels for traditionally underserved populations.

C-2. Prevention & Screening: Increase the number of community members who actively participate in recommended prevention/screening activities

Setting: Community, health care, schools, worksites

- A. Use evidence-based small media/group education to reach target populations with accurate and consistent messaging about cancer prevention/screening through community partners and events
 - Radon awareness and low cost testing
 - Colorectal cancer education and FOBT kit distribution
 - Tobacco free activities
 - Breast cancer and breast cancer screening education - EWM project
 - Nutrition/physical activity initiatives
 - Identify/recruit local prevention champions for each cancer type (providers and/or survivors)
 - Deliver easy-to-understand explanations about cancer screenings and other preventive health benefits under the Affordable Care Act.
 - Support health literacy initiatives
- B. Develop local community health worker program/system as a link between providers of cancer prevention/screening services and target populations.
- C. Pursue funding or appropriate partnerships to provide recommended cancer screening services for those not covered by EWM, included those with high deductibles.

C-3. Survivorship: Increase the duration and quality of life for cancer survivors in our communities

Setting: Community, health care

- A. Assist seniors in accessing healthcare and related support services for cancer care (e.g., managed care plan assistance, partner development and referral, MAA programs).
- B. Partner to increase the number of local program offerings that provide support for survivors (e.g., A Time to Health, Reach to Recovery, ACS Transportation Program, YMCA's LiveStrong nutrition and physical activity, Living Well chronic disease management training, MLH survivorship care planning, ACS Library, etc.).

C-4. Empowered People: Enhance the ability of the general public and referral agents to connect with needed resources related to cancer prevention and health.

Setting: Community, health care, social media

- A. Partner in the development of a database system/search engine of local information for public and referring organizations and include links with regional, state and national cancer resources (e.g., VNA Financial Assistance Program, ACS, Komen Nebraska) and investigate Apps for access via mobile phones.
- B. Collaborate with the local library system to enhance available healthy living resources and serve as a channel for educational healthy living programming and cancer resources (e.g., Cancer Corners program through Nebraska Cancer Coalition) and use librarians as information brokers (e.g., Hastings Public Library, Republican Valley Library Association, school librarians, school computers, Bookmobile to nursing homes).



Priority Goal: Mental Health

Goal 3: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Targets/Performance Measures

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

Mental Health Outcome Targets:

- Reduce the proportion of persons who reported currently experiencing depression (based on a Severity of Depression score of 10 or more)
Strategy: Screening Across the Lifespan (behavioral health, substance abuse, suicide)
Baseline: 5.2% / State 8.7% BRFSS, 2008 (difference not significant)
Target: 4.9%
- Reduce the proportion of adults reporting Serious Psychological Distress (SPD) in the last 30 days
Strategy: Screening Across the Lifespan (behavioral health, substance abuse, suicide)
Baseline: 7.0% / State 2.4 BRFSS, 2008 (difference is significant)
Target: 6.6%
- Reduce reported suicide attempts by high school students during the past year.
Strategy: Screening Across the Lifespan (behavioral health, substance abuse, suicide)
Baseline: 9.6% (YRBS, 2012) / (State 8.0%) YRBS, 2011
Target: 9.0%

Access Targets:

- Increase the proportion of primary care facilities that provide mental health services onsite or by telehealth.
Strategy: Integrated Care (HRSA Integrated Care Project)
Baseline: 4 of 14 clinics
Target: 7 clinics
- Increase access to mental health assistance/services through local educational institutions and worksites.
Strategy: Recruit Additional Community Partners (School Admin/Boards, Employers);
Strategy: Education, Awareness, Promotion; **Strategy:** Mental Health First Aid
Baseline: 3 Trainers, 2 Trainings, 60 Trained, Target Groups Reached: Law Enforcement (35), Behavioral Health (25)
Target: Developmental
- Increase the number of mental health patients who participate in recovery support programs (i.e., NAMI peer support, Community Support, support groups, VA-sponsored programs, Vocational Rehab, etc.)
Strategy: Increase promotion of recovery support providers at community events such as Vital Signs, Hastings home page, Midland area for Aging etc.
Baseline: Identify partners who track data- contact for baseline
Target: improve by 6% over the next 3 years
- Increase collection and accessibility of local mental health data.
Strategy: Resource Network / Database
Baseline: Potential sources for local data: Magellan, Horizon Recovery, BRFSS, YRBS, County Attorney's Office, Region 3, South Central Behavioral Services, Network of Care for Behavioral Health
Target: Developmental

- Increase awareness of available mental health services by 10%
Strategy: Education, Awareness and Promotion; **Strategy:** Resource Network / Database
Baseline: 35.8% (source: Schmeckle, 2012)
Target: 40%
- Decrease stigma as a barrier to accessing services.
Strategy: Integrated Care (HRSA Project); **Strategy:** Education, Awareness, Promotion
Baseline: 62.9% (source: Schmeckle, 2012)
Target: 56.6%

Mental Health –

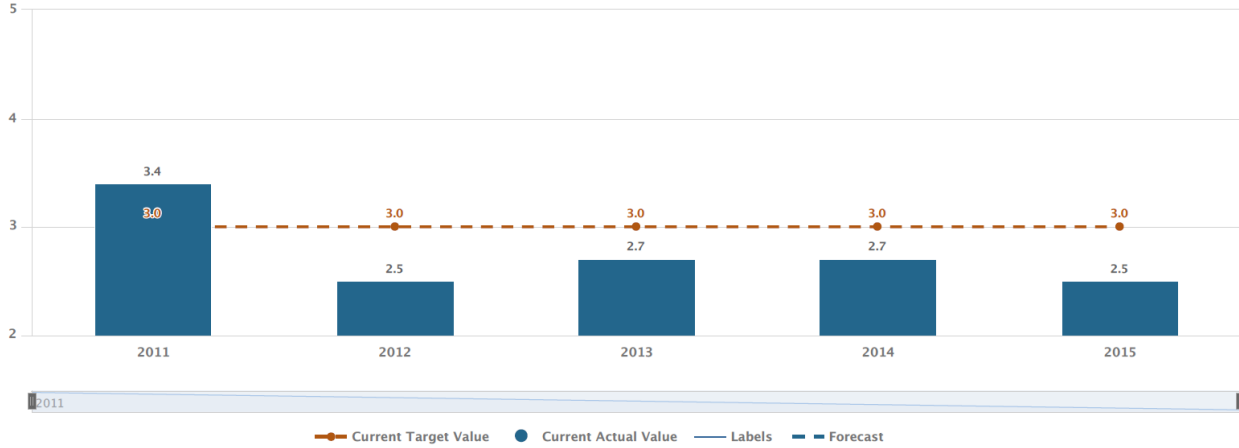
Overall, residents of South Heartland reported a slightly higher rate of mental illness limiting usual activities in the past 30 days compared to state data (2.3 days vs. 2.0 days in 2016). Suicide attempts among youth, as reported by district high school students (13.2%, 2016) continue to be above our desired target. Residents report an average number of days where mental health was not good in the past 30 days (3.1) similar to rates overall for Nebraska (3.2 for 2016).

Access to mental health services has improved over the past six years through integrated care and screenings by primary care physicians. Trends related to mental health issues are stable, but expected to improve in the coming years with increased access to services and efforts targeting suicide prevention.

Mental Health Trends for Performance Measures and Targets

Average number of days mental health was not good in past 30 days

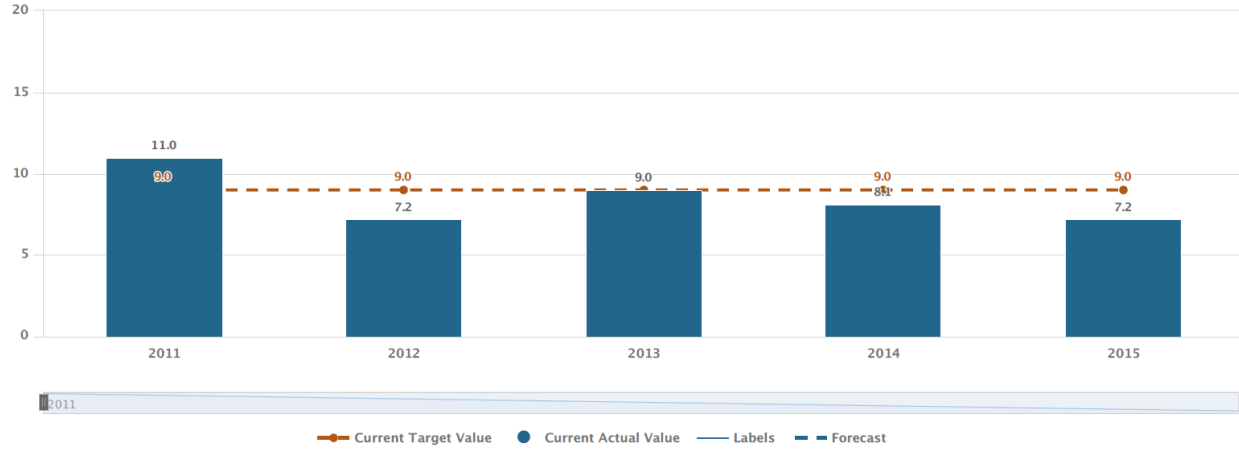
Data Source: BRFSS (Best match to CHIP question) * target based on 5 year average of State of NE



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Mental health was not good on 14 or more of the past 30 days

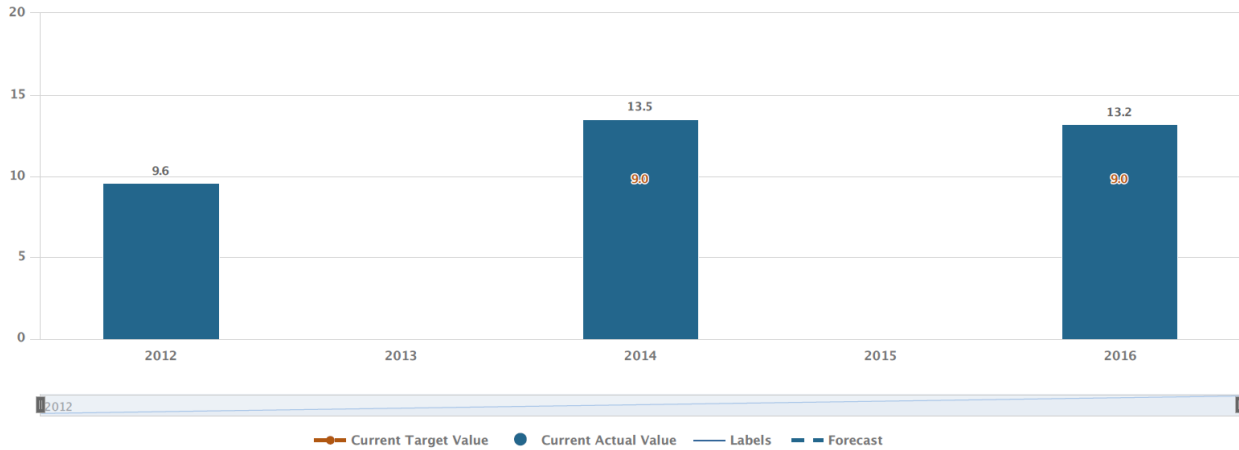
Data Source: BRFSS (Best match to original CHIP question) * see CHIP Outcome Target #2



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Reduce reported suicide attempts by high school students during the past year.

Data Source: YRBS



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Mental Health Strategies

MH-1. Screening Across the Lifespan

- A. Promote screening for behavioral health, depression, substance abuse, and suicide
- B. Increase venues where screening is available; provide Screening, Brief Intervention, Referral for Treatment (SBIRT) education/training to primary care providers and others
- C. Target at risk populations (youth, college age, pregnant and postpartum women, veterans, seniors) and general adult population
- D. Provide education, awareness, and promotion of screening across the lifespan

MH-2. Integrated Care

- A. Support HRSA-funded Integrated Care Project
 - Pilot Integrated Care model in rural clinic settings
 - Facilitate implementation of policies that reduce billing/payer barriers and elevate mental health services on par with primary care
 - Pursue and secure funding for integrated care implementation
- B. Provide education, awareness, and promotion of integrated care

MH-3. Resource Network/Database

- A. Partner in the development or identification of a database system or search engine for local information and include links with state and national online resources when applicable, i.e., NE DHHS. Tools: Community Resource Guide on SHDHD website, Network of Care for Behavioral Health, Network of Care for Public Health
- B. Prioritize areas of data collection and resources; organize into a database system or add to existing publically accessible database system
- C. Provide resource network training to partners, referral organizations, community based behavioral health and health care services
- D. Provide education, awareness and promotion of resource network and mental health data

MH-4. Mental Health First Aid

- A. Provide mental health education (include screening assessment and medication management as appropriate) and mental health first aid training to school and college counselors, home health, nursing home and assisted living staff
- B. Provide education, awareness, and promotion of mental health first aid

MH-5. Education, Awareness, Promotion (also a component of the other strategies)

- A. Support local activities that decrease stigma and increase awareness of mental health as a critical component of overall community wellness
 - Mental Health Awareness dinner (MLH), presentations at senior centers (MAAA as partners), Active Minds, ASAP Quarterly Breakfasts, Suicide Prevention Coalition / QPR Trainings, community presentations about mental health issues, including traumatic brain injury and substance abuse causes, symptoms, impact, value of screening, etc.
- B. Partner for public education and messaging in all variety of media describing local healthy living resources and how best to access them cost effectively
 - Mental health and substance abuse services
 - Appropriate use of hospital emergency rooms
 - Substance abuse, risk factors, disorder, community services

C. Promote mental health and screenings

- Include with healthy habits at health fairs, combined multi-agency events, and worksite wellness activities
- Build on Head Start ASQSE assessments to reach families and replicate models to other health/support programs serving young families (e.g., WIC)
- Develop/Implement family-focused mental health programs building on Healthy Beginnings, Good Beginnings and parenting education programs
- Youth sports camps and other extracurricular activities

D. Promote recovery support programs and prevention programs/services

- NAMI peer support, community support, support groups, VA-sponsored, Vocational Rehab, etc.
- Active Minds, Girls in Action, Tigers on the Run, Youth Mentorship programs (Teammates, Big Brothers/Big Sisters), crisis response systems, stress management



Priority Goal: Substance Abuse

Goal 4: Reduce substance abuse to protect the health, safety, and quality of life for all, especially young people

Targets/Performance Measures

Youth Targets: Based on standards set by Healthy People 2020, targets were set to achieve a 6% improvement over the next 6 years. Local data: YRBS, 2012

- Decrease the proportion of high school students who reported use of alcohol in the past 30 days.
Baseline: 24.2% (27% State)
Target: 22.75%
- Decrease the proportion of high school students who reported use of marijuana in the past 30 days.
Baseline: 12.3% (13% State)
Target: 11.5%
- Decrease the misuse or abuse of prescription drugs among high school students.
Baseline: 11.8% (12% State)
Target: 11.1%
- Reduce the proportion of adolescents who report riding in the past 30 days with a driver who had been drinking alcohol
Baseline: 22.7% (24% State)
Target: 21.3%
- Decrease the proportion of high school students who reported texting or email while driving.
Baseline: 38.7% (45% State)
Target: 36.4%

Adult Targets: Based on standards set by Healthy People 2020, targets were set to achieve a 6% improvement over the next 6 years. Local data: BRFSS, 2011.

- Reduce the proportion of adults (18+) who reportedly engaged in binge drinking in the last 30 days.
Baseline: 22.8% (22.7% State)
Target: 21.4%
- Increase the percentage of current smokers who reportedly attempted to quit smoking in the past year.
Baseline: 47.9% (55.6% State)
Target: 50.8%

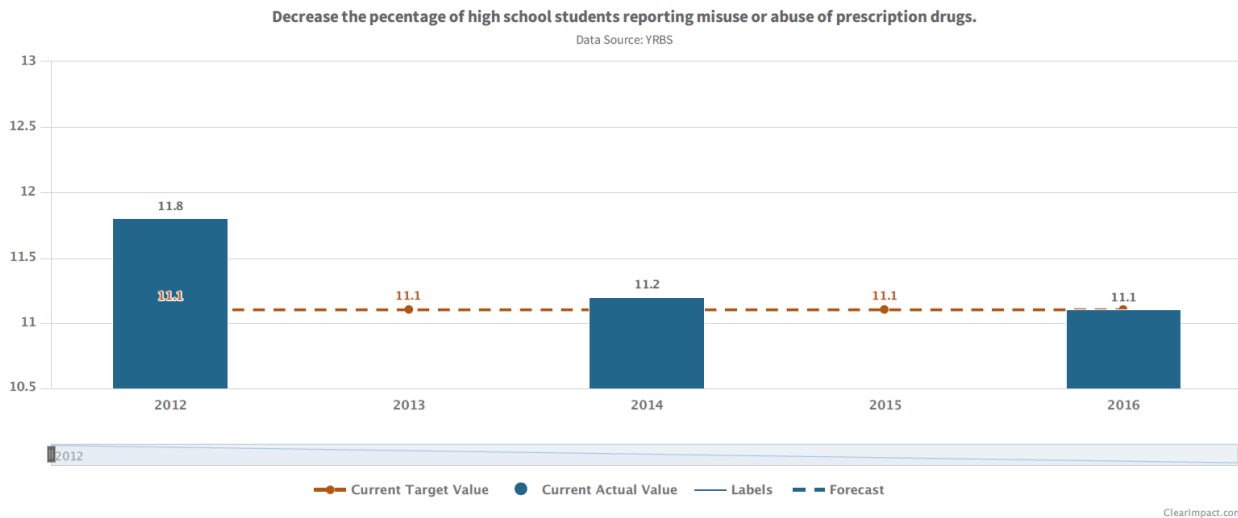
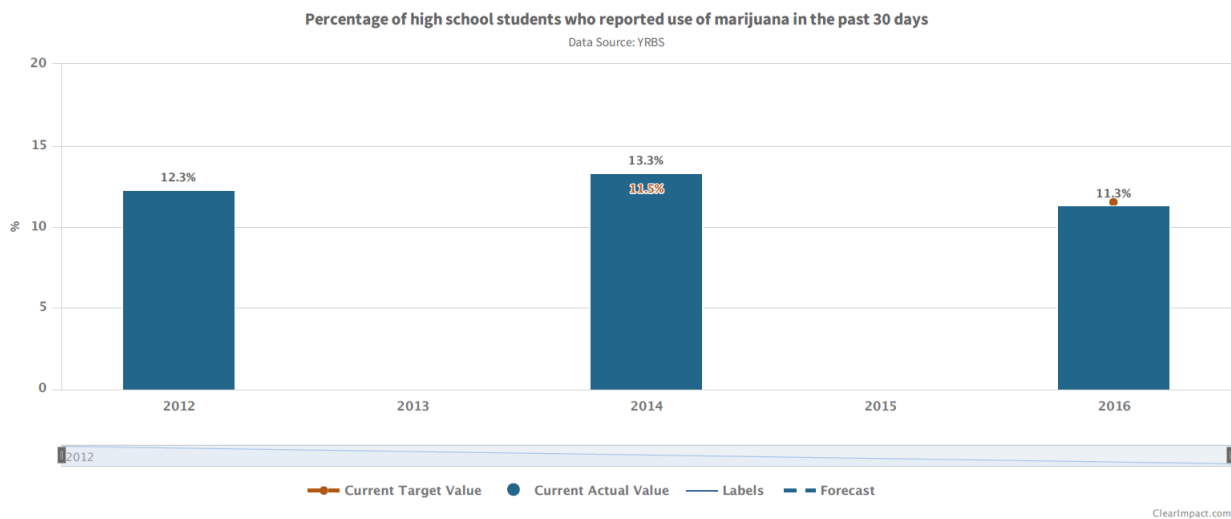
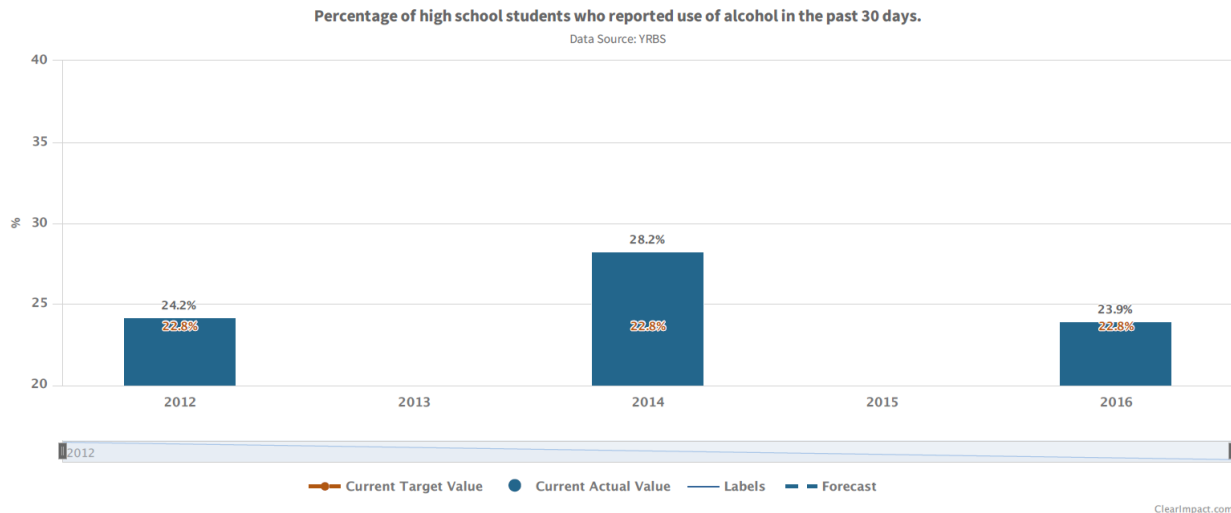
Substance Abuse -

A significant decrease in adult binge drinking is indicated over the past six years. Baseline data show 22.8% (2011) respondents binged the past 30 days with a drop to 14.8% in 2016. Alcohol use in the past 30 days among youth (23.9%, 2016) continues to fluctuate, but is currently lower than baseline data: 24.2% in 2012. Youth reporting being a passenger in a vehicle with an intoxicated driver has not changed significantly over the past six years.

Past 30 day misuse of prescription drugs and marijuana use among youth are trending downward (2016). Both are lower in 2016 than NE values of 14.3% for prescription drug misuse and 13.4% for marijuana use.

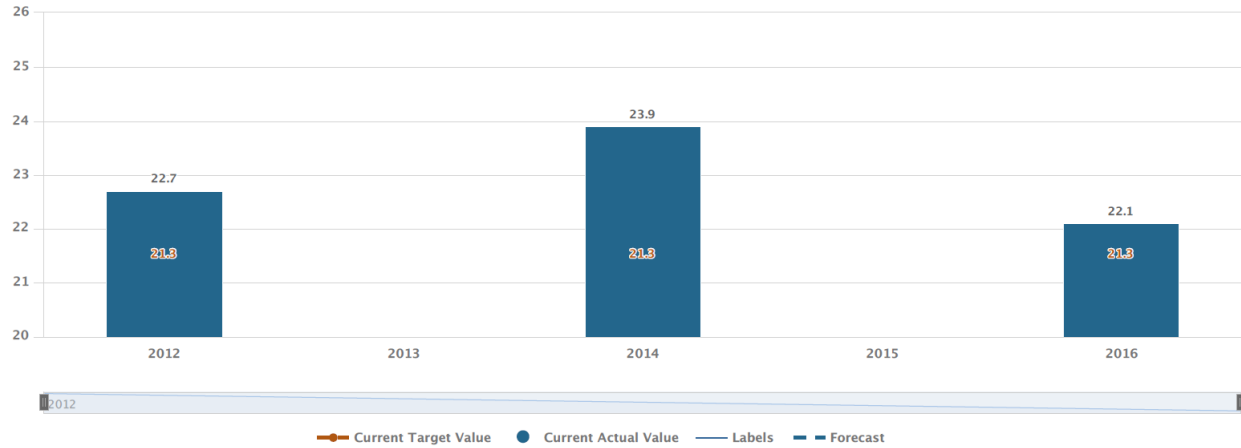
Texting and driving remains above the target of 36.4% for student drivers. Baseline data from 2012 indicated 43.3% of students reported texting or emailing while driving in the past 30 days, with 43.0% students reporting cellphone use in 2016.

Substance Abuse Trends for Performance Measures and Targets



Decrease the percentage of adolescents who report riding in the past 30 days with a driver who had been drinking alcohol

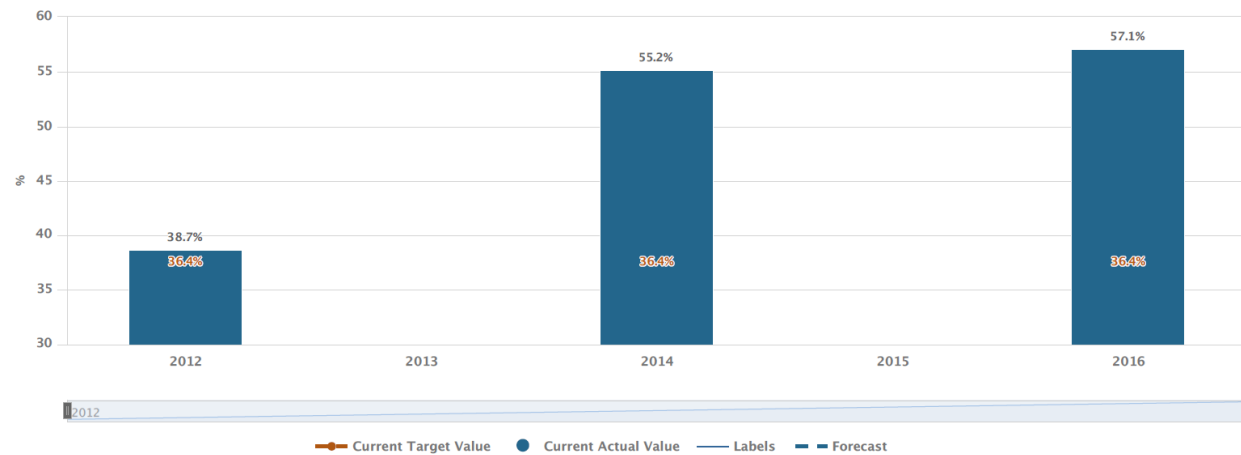
Data Source: YRBS



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Decrease the percentage of high school students who reported texting or email while driving during the past 30 days

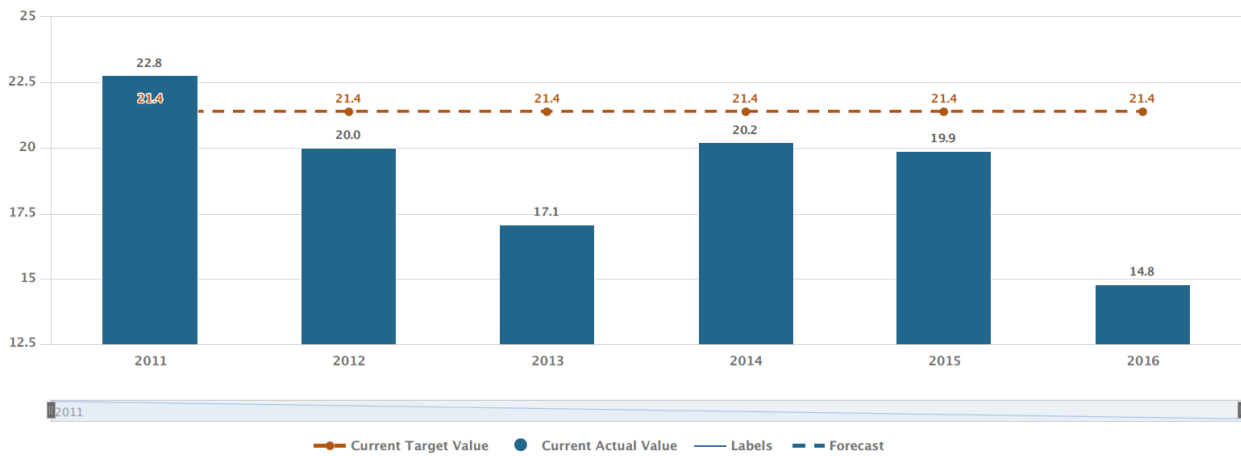
Data Source: YRBS



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Decrease the percentage of adults (18+) who reportedly engaged in binge drinking in the last 30 days

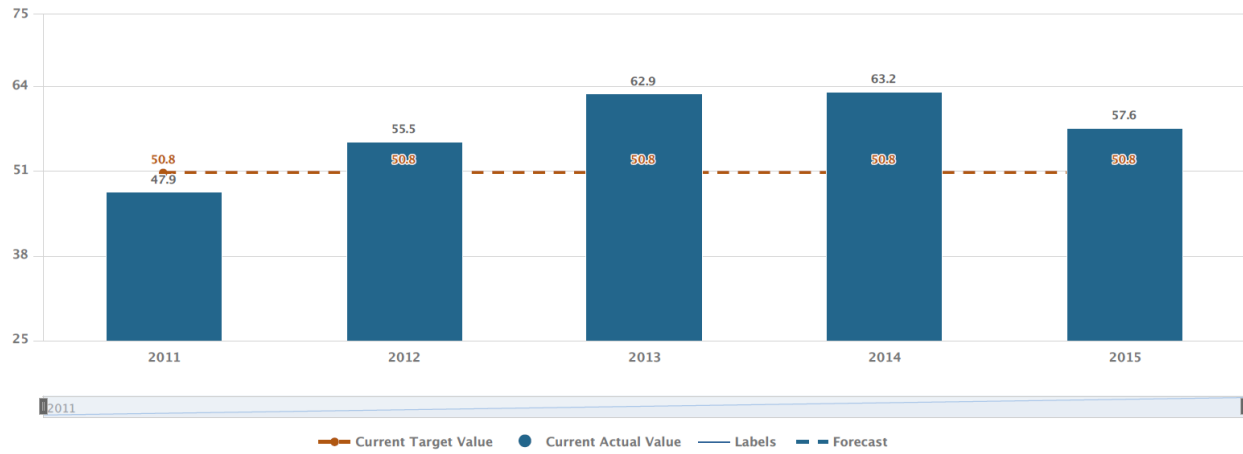
Data Source: BRFSS



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Percentage of current smokers who reportedly attempted to quit smoking in the past year

Data Source: BRFSS



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Substance Abuse Prevention Strategies

SA-1. Community Partnerships: Increase community-based public awareness/education activities about substance use that lead to informed policymaking.

Setting: Community

- A. Increase the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP)
 - Broaden ASAAP, County Substance Abuse Coalition, and Community & College Task Force memberships and partnerships to include judicial officers, businesses (including retailers), faith-based community members, youth mentoring programs, PTOs, Booster Clubs, school boards, worksites/employers, Latino population, and others needed to support the strategies in this plan
 - Support efforts of College/Community Task Force, County Substance Abuse Coalitions, and other community-based substance abuse prevention organizations
- B. Conduct community forums about critical issues (e.g., Life of an Athlete/Pure Performance, community impact of legalization of marijuana in CO, parent and adult behavior modeling, bullying, distracted driving)
- C. Use evidence-based small media/group education to reach target populations with accurate and consistent messaging that raises awareness on facts and perceptions on local substance use and prepares ground for policy change
- D. Engage community decision-makers to consider environmental changes and development of policies that promote prevention and healthy choices (e.g., healthy beverage choices for fundraisers and community events, tobacco/substance free parks, school-based codes of conduct for participation in activities)
- E. Expand pharmaceutical take back program
 - Recruit additional partners and venues for National Drug Take Back events (e.g., senior centers, nursing homes, local law enforcement, pharmacies, primary care clinics)
 - Work with partners to investigate opportunities for more frequent or on-going drug take back

SA-2. Empowered People: Increase evidence-based substance abuse prevention and early intervention activities for youth and college-age students and young adults.

Setting: Schools, Community

- A. Increase community partners involved in prevention and early intervention activities (e.g., Early Head Start, WIC, Healthy Beginnings/Good Beginnings) and support youth activities and mentoring programs that encourage prevention (TeamMates, Big Brothers/Big Sisters, The Zone, S.T.A.R.S., Girls in Action, Tigers on the Run, CASA, etc.)
- B. Expand evidence-based substance abuse programming in elementary and high schools (e.g., ASAAP prevention classes, Pure Performance, Coordinated School Health)
- C. Educate and engage parents (e.g., "I Pledge No" Campaign, Safe Homes, Peer Leadership program, coordinated school health, positive community norms campaigns)
- D. Initiate positive community norms campaign targeted to college communities and general public.

SA-3. Increase access to substance abuse screening, treatment and prevention services.

Setting: Providers, Community

- A. Investigate need and potential for expanded treatment services for juveniles.
- B. Increase community-based services in rural communities through training, funding and partnership opportunities (e.g., integrated behavioral health and primary care initiative), and technology supports (e.g., telehealth).
- C. Promote trauma-informed care in provider and service organizations.
- D. Provide Screening, Brief Intervention, Referral for Treatment (SBIRT) training to area hospital/primary care clinic staff and providers



Priority Goal: Access to Health Care

Goal 5: Improve access to comprehensive, quality health care services

Targets/Performance Measures

Short-term: Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.

Notes: *District data statistically different from State data. Reference: Data- BRFSS, 2012 (adults, >18 years)

- Increase the proportion of persons with a personal doctor or health care provider.
Baseline: 88.2% (State 82.8%)*
Target: 93.5%
- Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.
Baseline: 60.3% (State 58.0%) [note: BRFSS, 2009-2010]
Target: 63.6%
- Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.
Baseline: 19.3% (State 18.0%)
Target: 18.1%
- Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.
Baseline: 9.5% (State 12.8%)
Target: 8.4%
- Increase the proportion of persons who report visiting a dentist for any reason in the past year.
Baseline: 67.9% (State 67.6%)
Target: 72.0%

Long-term:

- Increase the number of medical home model clinics (patient-centered medical homes) within the district.
- Developmental
Baseline: 0
Target: 1
- Develop a Community Health Worker (CHW) program/system to increase the number of Community Health Workers serving as bridges between providers of health services and the community. -
Developmental
Baseline: No program available in the district
Target: Program/system in place which provides training and oversight in core competencies, educates on and promotes CHW utilization by providers of health care services and the community
- Increase the available access points across the district for those seeking behavioral health care. -
Developmental
Baseline: (Need to determine a baseline – use private provider list from Region 3 plus SCBS and ML Behavioral Health)
Target: Add access in at least one primary care clinic
- Adoption of EHR technology that meets meaningful use criteria, Health Information Exchange (NEHII), telehealth, and other technology upgrades that support and improve access to health care services.-
Developmental

- Increase the number of Health Literate Organizations - organizations that make it easier for people to navigate, understand, and use information and services to take care of their health. - *Developmental*
Baseline: Need to assess # of organizations meeting the 10 attributes of a health literate organization (Brach, et al., 2012)
Target: South Heartland District Health Department, all 3 hospitals, and at least 1 clinic in each county meet 80% of the attributes of a health literate organization.
- Create a web-based resource for reliable, local health information and resources related to healthy choices and disease prevention, diagnosis, treatment, and management. - *Developmental*
Baseline: Individual stakeholder websites and SHDHD *Network of Care* website for local health status data
Target: One-stop, searchable, comprehensive, linked network of resources and health information
- Support community education and recruitment efforts for health care professions. - *Developmental*

Access to Care –

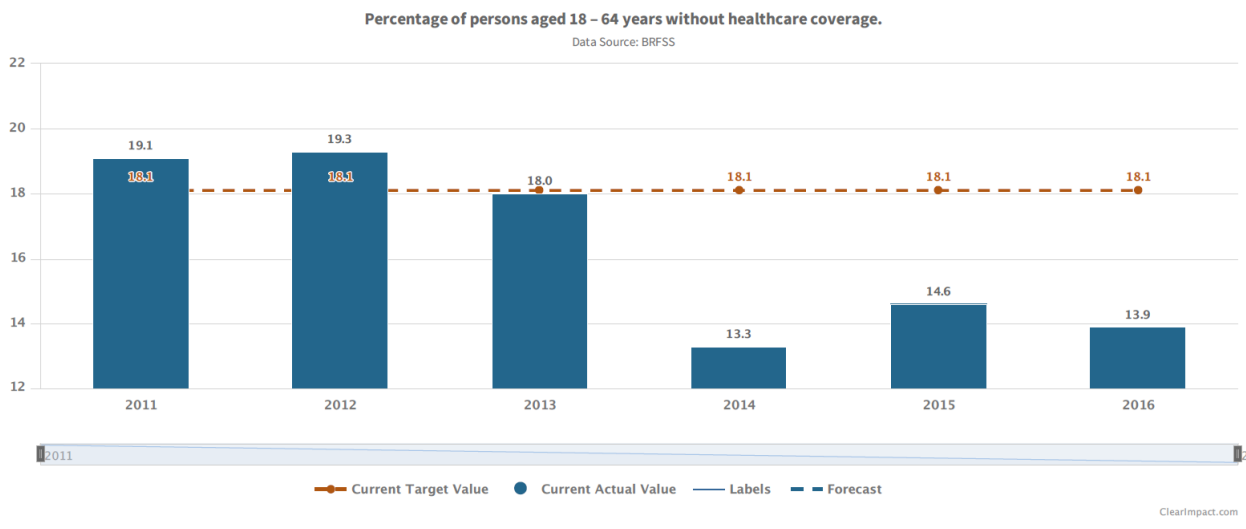
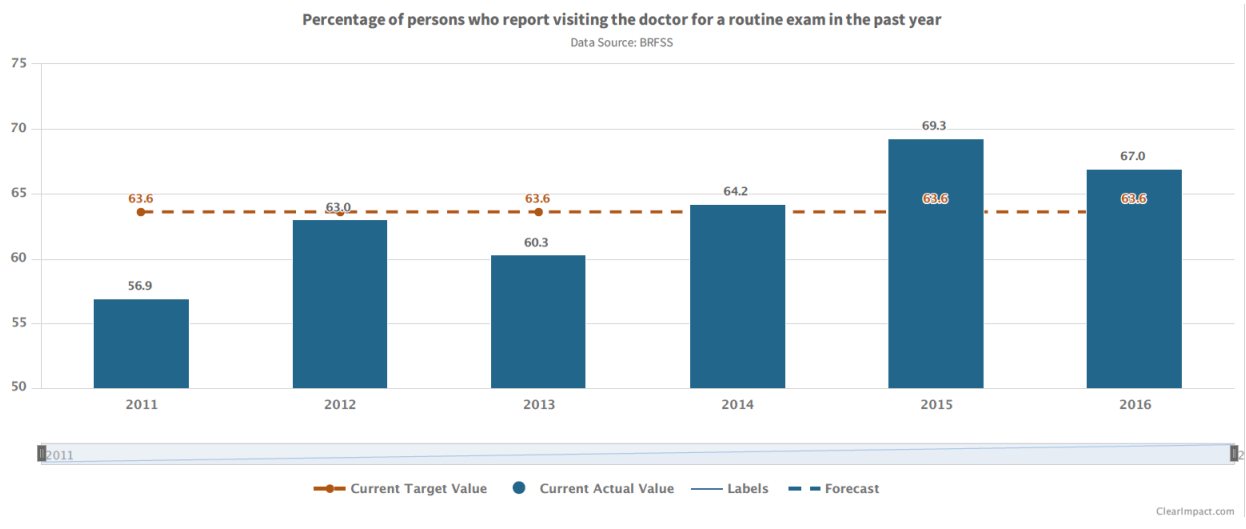
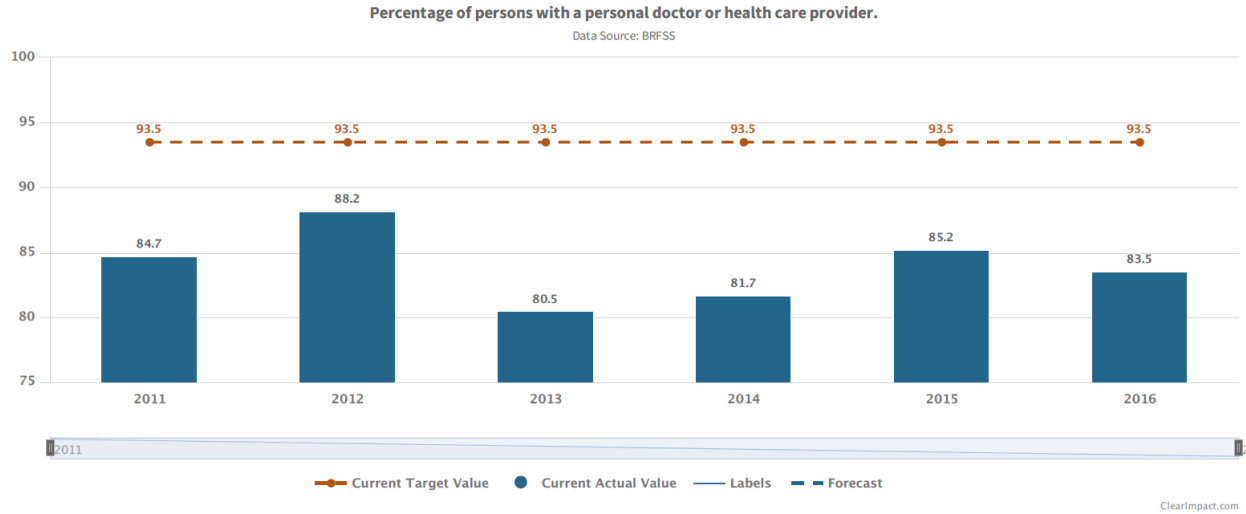
Overall, healthcare coverage has improved with a significant change from 19.3% (2012) of respondents reporting no coverage to 13.9% (2016) which is well below our target of 18.1%.

Percentage of persons reporting having visited a provider in the past year has increased from 56.9% (2011) to 67.0% (2016), exceeding the target of 63.3%.

Cost as a barrier to accessing medical care and individuals with a primary care provider has not changed significantly from baseline data over the past six years.

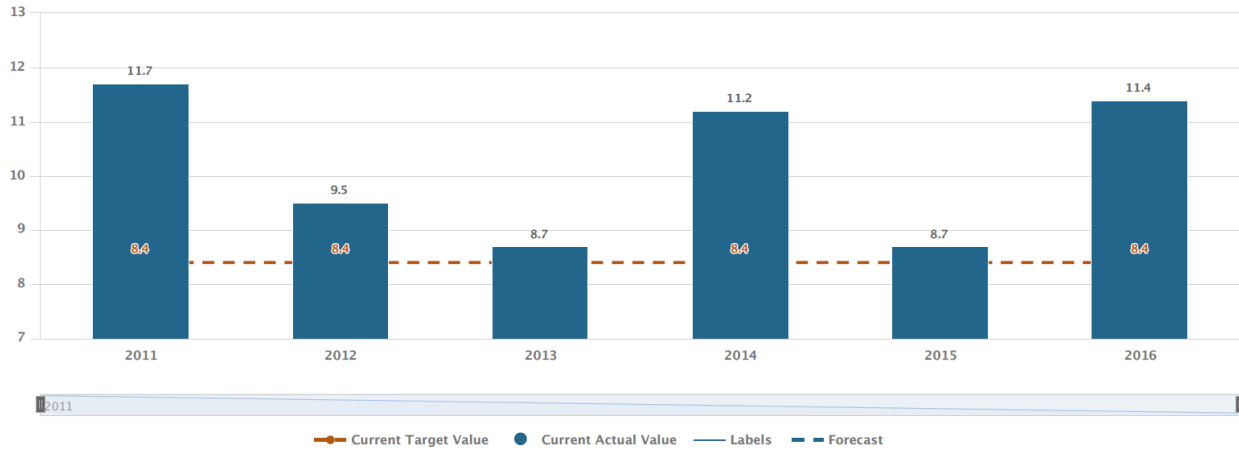
Residents who reported visiting the dentist in the past year remains below our target of 72%. Data fluctuated over the past six years from 64.9% in 2012 to 64.7% in 2016.

Access to Care Trends for Performance Measures and Targets



Percentage of persons reporting cost as a barrier to visiting a doctor in the past year

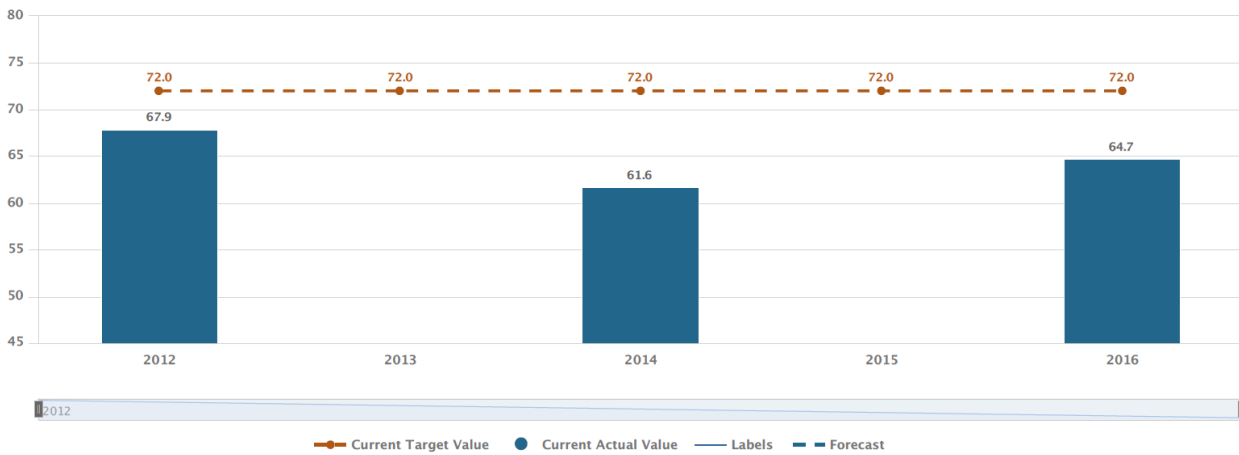
Data Source: BRFSS



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Percentage of persons who reported visiting a dentist for any reason in the past year

Data Source: BRFSS



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Access to Health Care Strategies

AC-1. Community Partnerships: Expand the number of community partners involved in the implementation of the Community Health Improvement Plan (CHIP).

Setting: Community

- A. Increase the number of local providers that are addressing access to care issues
- B. Increase the number of organizations providing services and resources for populations with low incomes
 - Outreach, educational programming and Q&A support groups (English/Spanish), health system navigation, sliding fee scales, Medicaid providers
 - Potential partners: homeless shelters, faith-based organizations, DHHS (ADC)
- C. Increase # of organizations serving as community connections and communication channels for traditionally underserved populations.
 - Potential partners: Latina Leadership group, MulticulturalHastings.org, Head Start, Project Homeless Connect
- D. Increase # of local businesses who contribute to the CHIP through worksite wellness, health policies, and health insurance options

AC-2. Preventive Services: Increase the ability of all residents to secure and utilize preventive services.

Setting: Community

- A. Establish measurement tools and methods to track establishment and use of “medical homes” by community residents (e.g., BFRSS question?)
- B. Support local efforts to develop community health facilities that follow the Medical Home model (personal physician, expanded access, whole person orientation, coordinated/integrated care across all elements of health care system and the patient’s community, etc.)
- C. Encourage local healthcare providers to offer extended hours for appointments or adjust hours to accommodate working families
- D. Increase access to care through worksites
 - Encourage more local businesses to provide flex-time or time off to accommodate health appointments
 - Increase # of local businesses that provide comprehensive education to their employees about the health services offered under company insurance plans. Include business/community partnerships.
- E. Increase # of organizations providing services, communications channels or community connections for populations with low incomes or who are otherwise traditionally underserved (to include undocumented residents)
 - Deliver easy to understand explanations to clients/members about health services they are entitled to receive under the Affordable Care Act
 - Assist clients/members in connecting with covered services. (MLH- sliding fee scale, care coordinators at homeless shelters, insurance navigators)
- F. Support access to care for smaller communities through development and maintenance of satellite clinics and/or provide transportation or telemedicine.
- G. Continue to work with partners across central Nebraska to support the development of a Federally Qualified Health Center in the region to include oral health, behavioral health, and primary care services

AC-3. Technology Enhancement: Increase the number of local providers using technology to improve access to care.

Setting: Healthcare

- A. Support provider efforts to adopt electronic health records systems
- B. Assist providers to adopt and use telehealth technology to link patients with specialists where appropriate
 - Identify funding and training

- Identify additional opportunities for Hospital outreach through telemedicine clinics (current initiatives: Endocrinology, Obesity, Mental Health, etc.)
- C. Upgrade technology in rural hospitals and clinics
- Explore funding resources (Helmsley Trust, etc.)

AC-4. Empowered People: Empower the general public, referral agents, and communities to connect with and recruit needed resources and reliable health information.

Setting: Community, Health Care Services

- A. Partner in the development of a database system/search engine of local information for public and referring organizations and include links with state and national online resources (e.g., NeDHHS)
- Explore partners/tools: Economic Development, SHDHD’s Community Resource Guide (on SHDHD website), Network of Care website for public health resources, Hastings Public Library, hospitals, United Way model
 - Collaborate with the local library system to enhance available healthy living resources and serve as a channel for educational healthy living programming
- B. Provide consistent public education messaging through program partners and in all varieties of media describing local healthy living resources (including dental health, mental health and substance abuse services) and how best to access them cost-effectively (include education about appropriate use of hospital emergency rooms, dental health and substance abuse)
- C. Implement a Health Literacy Initiative across the district
- D. Increase the base of trained/certified community health workers providing peer to peer education, navigation of healthcare services, and connection to community resources
- Participate in Statewide initiative to develop CHW program
 - Explore/define roles for nurse navigators, insurance navigators
- E. Assist target populations, including traditionally underserved and seniors, in accessing healthcare and related support services
- Support/Enhance/Develop community transportation programs that provide health and wellness transportation services
 - Provide information/referral on Affordable Care Act, managed care plans and insurance navigation (Potential partner: Mid-Nebraska Community Action)
- F. Develop and recruit health and allied health professionals and EMS to meet community needs
- Support local education programs to grow the base of CNAs and certified medical interpreters (explore AHEC scholarships; BMH Scholarships through local high schools and employee scholarship programs; partner w/ CCC)
 - Partner in economic development efforts to strengthen local health-related internship opportunities, and recruit needed healthcare providers to the community (including dental health, mental health and substance abuse treatment professionals)



Community Health Improvement Tracker – 2016

Progress Toward Target	Priority Area	Baseline Year	2015-2016 Data	Target	Special Thanks to our partners
Obesity (%)					
	Increase the percentage of adults exercising 30 minutes a day, five times per week.	49.1	53.1	52.0	YMCA, UNL Extension, Hastings College, Healthy Hastings, Mary Lanning Wellness, City of Hastings, Choose Healthy Here stores, Brodstone Hospital, Brodstone Healthcare, Harvard Multicultural Parent Association, HPS School Wellness Teams, Harvard Wellness Team, St. Cecilia Wellness Team, DHHS
	Increase the percentage of youth exercising 60 minutes a day, five times per week.	58.7	51.7	62.2	
	Consumed fruit more than 1 time per day*	54.6	60.5	58.1	
	Consumed vegetables more than 1 time per day*	72.9	75.8	77.2	
	Increase the percentage of youth who report eating fruits ≥2 times/day during the past 7 days	23.4	18.0	24.8	
	Increase the percentage of youth who report vegetables ≥ 3 times/day during the past 7 days	8.5	8.2	10.5	
	Decrease the percentage of adults 18+ years who are overweight or obese (BMI ≥ 25.0)	68.7	70.9	64.6	
	Decrease the percentage of adults who are obese (BMI ≥ 30.0)	30.6	34.4	28.8	
	Decrease the percentage of children under 18 years who are overweight (BMI ≥ 25) or at risk of becoming overweight (21 < BMI <25)	32.1	32.5	30.0	
Cancer (% and rate per 100,000)					
	Increase percentage of women aged 50-74 years who are up-to-date on breast cancer screening	70.0	71.7	74.2	Morrison Cancer Center, Brodstone Healthcare, Webster Co. Hospital, Vital Signs Health Fair, Mary Lanning Cancer Committee, SHDHD Cancer Coalition, American Cancer Society
	Increase percentage of women aged 21-65 years who are up-to-date on cervical cancer screening rates	80.4	79.3	85.2	
	Increase percentage of adults aged 50-75 years who are up-to-date on colorectal cancer screening (annual fecal occult blood test (FOBT), OR sigmoidoscopy every 5 years + FOBT every 3 years, OR colonoscopy)	59.9	72.1	60.0	
	Reduce incidence rates due to female breast cancer	128.9	131.6	121.2	
	Reduce mortality rates due to female breast cancer	19.0	22.8	18.0	
	Reduce incidence rates due to colorectal cancer	64.7	42.6	60.9	
	Reduce mortality rates due to colorectal cancer	15.5	15.7	14.6	
	Reduce incidence rates due to prostate cancer	161.3	117.1	151.6	
	Reduce mortality rates due to prostate cancer	25.1	18.8	23.6	

at or within 1% of target,
 within 5% of target,
 greater than 5% change from baseline away from target



Community Health Improvement Tracker – 2016

Progress Toward Target	Priority Area	Baseline Year	2015-2016 Data	Target	Special Thanks to our partners
Cancer (% and rate per 100,000), continued					Partners, Continued
	Reduce incidence rates due to skin cancer	18.5	29.0	17.4	Providers for Sun-Safe behavioral counseling, Community Pools, City of Hastings, DHHS Radon Program
	Reduce mortality rates due to skin cancer	4.6	5.6	4.3	
	Reduce incidence rates due to lung cancer	66.2	63.3	62.3	
	Reduce mortality rates due to lung cancer	48.2	43.9	45.3	
Mental Health (#)					
	Average number of days mental health was not good in past 30 days*	3.4	3.1	2.8	Region III, churches/colleges-suicide prevention; Dr. Kathy Anderson, Mary Lanning - integrated care
	Mental health was not good on 14 or more of the past 30 days*	11.0	9.2	10.3	
	Reduce reported suicide attempts by high school students during the past year.	9.6	13.2	9.0	
Substance Abuse (%)					
	Decrease the proportion of high school students who reported use of alcohol in the past 30 days.	24.2	23.9	22.7	Horizon Recovery, ASAAP, Region 3, Life of an Athlete, Dr. Ken Zoucha, Dr. Max Owen, Hastings Public Schools, Harvard Public Schools, Hastings Ste. Cecilia Schools
	Decrease the proportion of high school students who reported use of marijuana in the past 30 days.	12.3	11.3	11.5	
	Decrease the misuse or abuse of prescription drugs among high school students.	11.8	11.1	11.1	
	Reduce the proportion of adolescents who report riding in the past 30 days with a driver who had been drinking alcohol	22.7	22.1	21.3	
	Decrease the proportion of high school students who reported texting or email while driving	38.7	38.6	36.4	
Access to Care (%)					
	Increase the proportion of persons with a personal doctor or health care provider.	88.2	83.5	93.5	Mary Lanning Insurance enrollment, SC Partnership (Emergency Dentist), Project Homeless Connect, Salvation Army
	Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.	63.0	67.0	66.8	
	Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.	19.3	13.9	18.1	
	Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.	9.5	11.4	8.4	
	Increase the proportion of persons who report visiting a dentist for any reason in the past year.	67.9	61.6	72.0	

Sources: BRFSS 2015&2016, YRBS 2016, Nebraska Cancer Registry 2015.

at or within 1% of target,
 within 5% of target,
 greater than 5% change from baseline away from target



Community Health Improvement Tracker – 2017

Progress Toward Target	Priority Area	Baseline Year	2015-2016 Data	Target	Special Thanks to our partners
Obesity (%)					
	Increase the percentage of adults exercising 30 minutes a day, five times per week.	49.1	53.1	52.0	YMCA, UNL Extension, Hastings College, Healthy Hastings, Mary Lanning Wellness, City of Hastings, Choose Healthy Here stores, Brodstone Hospital, Brodstone Healthcare, Harvard Multicultural Parent Association, HPS School Wellness Teams, Harvard Wellness Team, St. Cecilia Wellness Team, DHHS
	Increase the percentage of youth exercising 60 minutes a day, five times per week.	58.7	51.7	62.2	
	Consumed fruit more than 1 time per day*	54.6	60.5	58.1	
	Consumed vegetables more than 1 time per day*	72.9	75.8	77.2	
	Increase the percentage of youth who report eating fruits ≥2 times/day during the past 7 days	23.4	18.0	24.8	
	Increase the percentage of youth who report vegetables ≥ 3 times/day during the past 7 days	8.5	8.2	10.5	
	Decrease the percentage of adults 18+ years who are overweight or obese (BMI ≥ 25.0)	68.7	70.9	64.6	
	Decrease the percentage of adults who are obese (BMI ≥ 30.0)	30.6	34.4	28.8	
	Decrease the percentage of children under 18 years who are overweight (BMI ≥ 25) or at risk of becoming overweight (21 < BMI <25)	32.1	32.5	30.0	
Cancer (% and rate per 100,000)					
	Increase percentage of women aged 50-74 years who are up-to-date on breast cancer screening	70.0	71.7	74.2	Morrison Cancer Center, Brodstone Healthcare, Webster Co. Hospital, Vital Signs Health Fair, Mary Lanning Cancer Committee, SHDHD Cancer Coalition, American Cancer Society
	Increase percentage of women aged 21-65 years who are up-to-date on cervical cancer screening rates	80.4	79.3	85.2	
	Increase percentage of adults aged 50-75 years who are up-to-date on colorectal cancer screening (annual fecal occult blood test (FOBT), OR sigmoidoscopy every 5 years + FOBT every 3 years, OR colonoscopy)	59.9	72.1	60.0	
	Reduce incidence rates due to female breast cancer	128.9	131.6	121.2	
	Reduce mortality rates due to female breast cancer	19.0	22.8	18.0	
	Reduce incidence rates due to colorectal cancer	64.7	42.6	60.9	
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	Reduce incidence rates due to prostate cancer	161.3	117.1	151.6	
	Reduce mortality rates due to prostate cancer	25.1	18.8	23.6	

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Community Health Improvement Tracker – 2017

Progress Toward Target	Priority Area	Baseline Year	2015-2016 Data	Target	Special Thanks to our partners
Cancer (% and rate per 100,000), continued					Partners, Continued
	Reduce incidence rates due to skin cancer	18.5	29.0	17.4	Providers for Sun-Safe behavioral counseling, Community Pools, City of Hastings, DHHS Radon Program
	Reduce mortality rates due to skin cancer	4.6	5.6	4.3	
	Reduce incidence rates due to lung cancer	66.2	63.3	62.3	
	Reduce mortality rates due to lung cancer	48.2	43.9	45.3	
Mental Health (#)					
	Average number of days mental health was not good in past 30 days*	3.4	3.1	2.8	Region III, churches/colleges-suicide prevention; Dr. Kathy Anderson, Mary Lanning - integrated care
	Mental health was not good on 14 or more of the past 30 days*	11.0	9.2	10.3	
	Reduce reported suicide attempts by high school students during the past year.	9.6	13.2	9.0	
Substance Abuse (%)					
	Decrease the proportion of high school students who reported use of alcohol in the past 30 days.	24.2	23.9	22.7	Horizon Recovery, ASAAP, Region 3, Life of an Athlete, Dr. Ken Zoucha, Dr. Max Owen, Hastings Public Schools, Harvard Public Schools, Hastings Ste. Cecilia Schools
	Decrease the proportion of high school students who reported use of marijuana in the past 30 days.	12.3	11.3	11.5	
	Decrease the misuse or abuse of prescription drugs among high school students.	11.8	11.1	11.1	
	Reduce the proportion of adolescents who report riding in the past 30 days with a driver who had been drinking alcohol	22.7	22.1	21.3	
	Decrease the proportion of high school students who reported texting or email while driving	38.7	38.6	36.4	
Access to Care (%)					
	Increase the proportion of persons with a personal doctor or health care provider.	88.2	83.5	93.5	Mary Lanning Insurance enrollment, SC Partnership (Emergency Dentist), Project Homeless Connect, Salvation Army
	Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.	63.0	67.0	66.8	
	Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.	19.3	13.9	18.1	
	Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.	9.5	11.4	8.4	
	Increase the proportion of persons who report visiting a dentist for any reason in the past year.	67.9	61.6	72.0	

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Goal: Reduce obesity and associated chronic disease risk through consumption of healthful diets, daily physical activity, and achievement and maintenance of healthy body weights

- Partners:** YMCA, Hastings Public Schools, Harvard Schools, Hastings Catholic Schools, Worksite Wellness Teams, Mary Lanning Corporate Wellness, Healthy Hastings, Webster County Hospital, Brodstone Memorial Hospital, Quality Healthcare Clinic, Mary Lanning Healthcare, Vital Signs Health Fair, UNL Extension, WIC, YWCA, District Clinics and providers, Community Health Workers, local gas stations and small grocery stores (Hispanic Stores), Complete Streets program, Hastings Chamber of Commerce, Community Centers, Clinic Providers, Pharmacies, Prairie Loft, [Superior Public Schools and L/N School](#), [Superior City office](#), [Elks](#), Churches, Red Cloud School, Willa Cather Foundation, City Council, [Lion's Club](#), [Ambulance squads](#), [Clay County Health Department](#), [Midlands Area of Aging](#), [Golf Course](#), [Senior Center](#), [non-profits](#), [Zone](#), [Chamber](#)
- Activities:** Provider/community health worker/pharmacist referrals to diabetes prevention and high blood pressure prevention programs, activities to promote healthy lifestyles, school promotion of healthy foods and morning walking programs, creation of wellness committees and wellness policies (encouraging healthy snacks, healthy celebrations, fruit and veggie bar in schools, walking breaks, etc.), lifestyle coaching, hosting Walk Out on Work events, youth and adult dance classes, Smart Moves Diabetes Prevention Programs, nutrition education at schools and events, community nutrition classes, year round youth sports, community health fairs, coaching about height and weight, providing healthy foods for infants, Choose Healthy Here at grocery stores and worksite vending machines/cafeterias, health insurance discount for fitness center use or other wellness activities, SHDHD has promoted various programs and healthy behaviors through media including social media and our website, Social supports for physical activity nutrition Coordinated School Health, CATCH Kids after school program, self-monitored blood pressure programs, and agricultural and outdoor education programs for children, [Victorian Stroll](#), [Firecracker Run](#), [Nelson Run on July 4th](#), [Presidential PE Award in Schools](#), [Lunchtime Walking @Superior Schools](#), [Beef Program @ Schools](#), [Bike/Ped Lane from Park to Park in Superior](#), [City Resolution for Complete Streets](#), [School Backpack Program](#), [Summer Backpack Program](#), [AM breakfast at School](#), [Healthy Living Program](#), [Walking School Bus](#), [Walking Program before school](#), [Walking Challenges @ hospital with community](#), ball programs with younger adults getting involved and prompting, city council moving towards adding trails to Red Cloud, installation of green house at the schools, Willa Cather Center recreation, beef donations to schools, church backpack program, [Clay County Wellness program](#), [Nurses screening at Sandy Creek](#), [3 Ambulances squads can do 12 lead EKGs](#), [statewide stroke prevention that allows us to by-pass closest hospital](#), [health fair education](#), [MAAA provides healthy meals and education](#), [Clay Center has a fitness center](#), [golf courses encourage walking verse carts](#), [restricted sugar at breakfast at HPS](#), [YMCA Blood Pressure Program](#), [Thursday Downtown farmers market](#), [½ cent sales tax for trial expansion](#), [Senior Center has free exercise program for 60+](#), [backpack program](#), [community non-profits have walks/run to promote services and health](#), [after school programs at the Zone and YMCA](#), [Chamber hosting Well-Being week](#)

Goal: Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

- Partners: Morrison Cancer Center, Community Health Center, YWCA, YMCA, Brodstone, Superior Pharmacy, Shopko Pharm, Webster Co. Clinic, Village Pharmacy, Blue Hill Pharmacy, Clay Co. Health Dept., Russ's Pharmacy, community members, Hastings Health Ministry, South Heartland Cancer Coalition, Mary Lanning Cancer Committee, Hastings College, Hastings Public Library, Vital Signs Health Fair Board, Extension Offices (Clay, Nuckolls, Webster), community swimming pools, Sun Safe provider champions (Main Street Clinic, Superior Family Medical Clinic, Quality Healthcare Clinic, Family Medical Center, MLH Community Health Clinic,), American Cancer Society, Nebraska Comprehensive Cancer Control program, [Nuckolls County Fair Board](#), [Superior Country Club](#), [Superior Estates Winery](#), South Heartland District Health Department, VA, Midland Area Agency on Aging, Webster County Fair board, [Midlands Area Agency on Aging](#), [Hastings Utilities](#), [NDEQ \(Nebraska Department of Environmental Quality\)](#), [Hastings Respite](#), [Community Action Partnership](#)
- Activities: Vital Signs Health Fair, Women's Health Event, Colon cancer screening kit (FOBT) distribution, HPV community education and "Someone You Love" film screenings, Every Woman Matters program, Tobacco Point of Sale Assessment, promotion and sales of radon testing kits, Pool Cool Sun Safety program, sun safety education in schools and provider offices, [Cancer Stomp](#), [Donation to Susan Komen and Cancer Stomp Education piece to golf tournament](#), [Time to Heal Program](#), [Woman's Health Night](#), [T-shirt sales- donation to Pancreatic Cancer](#), [Gala/ Woman's Health Night- Survivor Highlight](#), [Colonoscopies](#), [FOBT kits/Skin Scope/Rolling Colon at Health Fair](#), selling of Radon Kits, Telemed specialty oncology clinics, Breast cancer awareness/colorectal cancer info at health fair, "tough enough to wear pink" at Webster County Fair, [Colon Cancer kit distribution](#), [mental health provider](#), [managed care](#), [transportation for seniors to access healthcare and senior centers](#), [Care of Caretakers program](#), [Community Action Partnership helping with economic problems that arise when cancer hits](#), [Community Sun Safety Presentations](#), [securing funds for oral chemotherapies](#), [Healthy kids day and learn to Swim](#)

Goal: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

- Partners:** Mary Lanning (ML) Behavioral Health Services / Lanning Center, CASA, SASA, Horizon Recovery, Crossroads, Veterans Hospital, Region 3, all licensed MH providers/ counselors within SHDHD jurisdiction, Dr. Kathy Anderson, Children and Adolescent Clinic, local providers, Hastings College, CCC, local schools. South Central Behavioral Services (SCBS), support groups, UNMC, UNL, ESU9, Positive Solutions, Ministerial Association, Webster County Clinic, Spring Creek Homes, Main Street Clinic, Assisted Living/Nursing homes, Blue Hill clinic, Ministries Society, UNL Consults and Richard Young Consults, VA, Quality Health Care Clinic-Fillmore County Counselor, Renee Duffek, Sutton Chamber office, EMS, Boys Town, United Way, Bristol Station, CCC, Hastings Public Library, Sunny Side Foundation, Churches, YWCA, Teen Court, VA, Adams County Probation program, ML Healthy Beginnings program, Schools
- Activities:** Depression screenings, full service mental health care at Mary Lanning; behavioral health services offered at various clinics and nursing home, integrated or collaborative behavioral health/primary care, Mental Health First Aid Training, Question Persuade Refer (QPR) Suicide Prevention Training, Trauma Informed Care trainings, SBIRT adoption, military cultural competency training, psychological first aid trainings, training and promotion on use of Adverse Childhood Experiences (ACEs) and 40 developmental assets, Federally Qualified Health Center (GI) for Behavior Health (BH) services, promotion of treatment for behavioral health issues and increased awareness/ understanding needs for behavioral health services for others, Grad Student seeing patients at Brodstone once a month and through telehealth, brief depression screening at annual physicals, hospitalized patients brief screening during admission, screening more in Jr/Sr w/High Council (school Physiologist), depression/anxiety/bipolar support group, mental health directory, mental health providers are part of specialty clinic, Clinics and Assisted Living/Nursing Homes have med management programs, Teammates, 4H groups and FFA, TVCDC activities, Bible School/Studies, Telemedicine, VA has resources, Telehealth services integrated Behavior Health and Primary Care at Quality Health Care, Chronic Care management Services, Mental Health assessment done at annual screenings, Vanderbilt Assessments teacher tools @ Sutton Schools for ADHD kids on meds, Sutton School provides counseling services, Renee different avenues of therapy, Sutton Chamber hosts educational meetings for community (e.g. effects of screen time for adults and children), Critical Incident Stress Meeting (CISM) for EMS, State trained individuals on peer and mental health response- recommendations can be requested through state patrol, Boys Town serving all of central Nebraska providing diagnosis and outpatient therapy, community paramedics working with EMS/Police and mental health practitioners to get mental health patients in crisis to appropriate care, United Way's low cost prescription program, CCC has student assistance program with 12 free counseling sessions per year and has a C.A.R.E team that is an immediate response team for a variety of issues (suicide, bullying, death), Hastings Public Library has health stories lessons that are health literate, substance abuse evaluations that are funded by United Way- but clients responsible for a portion of the cost, Senior services host free mental health training and sessions funded by Sunny Side, Juvenile Recovery Meetings, grief share program, YWCA's Empower Hour, 1st St. Paul's Stephen's Ministry, VA Suicide Prevention program, Ask the Question Campaign, Support Groups, Probation program with vouchers available to pay for services depending on type of probation and bring in providers to lead mandatory meetings, SCBS sliding scale fee, ML Healthy Beginnings program does a complete depression assessment on all clients and provides assistance if action is needed, ML staff provided with MH 1st aid quarterly, ML PHQ2 depression screening at yearly apt, PHQ2 all Psych admissions, ML Integrated behavior health providers in primary care clinics, ML

provides BH services to Brodstone 2x per month and telehealth to Webster County, SCBS- Outpatient from ML all ages get screened using TOP screening tool, SCBS day rehab, psych residential rehab, community support, SCBS evidence based programs: Parent-child interaction therapy, 24/7 crisis response, same day access for new admits, serve people who have no insurance or high deductibles, focus on co-occurring (mental health and substance abuse), have a trainer for trauma 101; Autism support group for parents, Preventative problem solving groups and school counselors are in every k-5 classroom weekly to teach social skills and friendship skills at Hastings Public School

Goal: Reduce substance abuse to protect the health, safety, and quality of life for all, especially young people

- Partners: ASAAP, Region 3, Mary Lanning Behavioral Services, Horizon Recovery & Counseling, South Central Behavioral Services (SCBS), Hastings College and CCC, Hastings Police Dept., Superior Police Dept., Adams/Webster/Clay Co Sheriff's offices, Hastings Area Chamber of Commerce, public schools and Hastings Catholic schools, Youth Task Force, pharmacies, city/county governments, media, [UNL Telehealth](#), [Erica Ferrell](#), [Teammates](#), [Telehealth](#), [Halfway House](#), [Crossroads](#), [Mary Lanning Living Center](#), [Teen Court](#), [The Bridge](#)
- Activities: Peer to Peer programs in schools, Red Ribbon Week, ASAAP Quarterly Community Breakfast forums, Medication Take Back events, Social Norms Campaigns, John Underwood's Life of an Athlete program, Opioid Epidemic forums, support of legislative activity and education on laws related to substance abuse, Policy Academy - South Heartland Area Drug & Alcohol Policy Team, Chemical Dependency evaluations, Teen Court, Youth education programs through the schools, Adult recovery programs for recovering addicts, alcohol and drug student assessments (electronic SBIRT, Screening, Brief Intervention, Referral, Treatment), emergency room policies and referrals, Girls on the Run (Lincoln Elementary), Nebraska Risk and Protective Factor Student Survey and Youth Risk & Behavior Survey for baseline data, [Teammates](#), [1 question on intake at annual physicals](#), [Quality Health Care LDAC practitioner using the PDMP system to catch multiple prescriptions from other provider](#), [Sutton drug dog is used in schools](#), [working with Region 3 Behavior health to provide Naloxone to first responders](#), [Bridge outpatient program](#), [Bristol Station recovering addict program for formerly incarcerated individuals](#), [New Dimensions](#), [12 Step Early Birds Meeting](#), [Provide education to physician offices and local ED's regarding treatment of substance abuse patients](#), [substance use evaluation](#), [outpatient therapy](#), [Intensive outpatient \(10 hr/wk\) using Matrix model](#), [work with patients that have no insurance or high deductibles](#), [MLC support for homes and near homeless youth in danger of substance misuse](#), [diversion program](#), [The Bridge's women with children program helping with group support and career](#), [Mary Lanning Healthy Beginnings program for expecting parents or parents already- provide home visits](#), [NEHI for potential abusers](#), [Hastings juvenile chemical dependency program at Hasting Regional Center](#), [long-term inpatient treatment for adolescent males](#), [Horizon's program with schools to provide services for substance using students](#)

Goal: Technology Enhancement: Increase the number of local providers using technology to improve access to care

- **Partners:** All district primary care clinics, hospitals and pharmacists (EHR), ambulance services, telehealth services, BHECN, Behavioral Health Education Center of Nebraska.
- **Activities:** E.H.R. Meaningful Use - patient portal use and clinic dashboard data monitoring, EPIC in ML clinics Aug 2016, 4 protocols implemented in three area clinics. Telehealth as a resource for access to some specialty clinics & mental health services. New platforms are also being used such as WebEX and Zoom and Go-to-Meeting in order to provide access to consultation and communication among healthcare entities. Rural clinics have upgraded technology during this CHIP cycle to a web based platform allowing for improved access. SHDHD has access to NeHII (2017) allowing for increased access to health records related to reportable diseases. EMS. Built new clinic with better technology, community wide internet program, communication with specialty clinics for mental health, recruitment of specialist providers so can provide onsite services, use of telehealth, NESSIS auto updates in EHR and vice versa, CommonWell, connect with clinics in Clay County (all) to increase collaboration and opportunities, use of Telehealth, EPIC being able to see patient's medical care throughout different levels of care, BHCEN-education for addiction to rural areas, interpreter services by phone and Ipad, cell phone reminders for appointments, apps for live doc appointments, SHDHD access to NeHII, SHDHD Facebook messaging, customer surveys after visit per email, call after hours at Blue Hill clinic, Repower- rural health study to help obesity, Insurance provider offering online consultation, project ECHO, caregiver support groups online, family caregiver training and respite provider training online, use of NCCN Distress tool within the EMR- reporting allows us to track if a patient's distress has decreased over time

Goal: Preventive Services: Increase the ability of all residents to secure and utilize preventive services

- **Partners:** Community Health Workers (CHW), Marketplace Assisters and Navigators, VetSET (State, VA, Tricare), Bi-directional Communication Task Force - Village Pharmacy (Red Cloud), Brodstone Memorial Hospital, Quality Healthcare Clinic (Sutton), Mary Lanning Healthcare clinics (2), Hastings YMCA, Adams County YWCA, Morrison Cancer Center, Mary Lanning Healthcare Insurance Navigators & charity care, MAAA, Walgreens, Clay County Health Department, Schools, Henderson/Aurora clinics, WIC, Headstart, Horizon Recovery and counseling center, schools Lanning Center, ESU9, SASA, Russ's, Safe Kids, Worksites, Parish nurses, UNL extension
- **Activities:** ML clinics designated PCMH July 2016; Twin Rivers Urgent Care; Extended hours - Family Medical Center has Sat. hours, ML Community Clinic - Mon nights, Lanning Center open til 6; SHDHD phone health coaching, Transportation Vouchers to community prevention programs; ML exploring emedicine; Patient Portals; Fall 2015 Dental care @ Heartland Health Center, Federally Qualified Health Center (FQHC); Vaccine for Children and Adult programs, Every Woman Matters - provider referrals through health coaching and navigation to screening with transportation and

interpretation support available; Diabetes Prevention Program offered in 3 communities; Be Well, Feel Good, Get Checked women's health events, expansion of worksite wellness and preventative coverage by some employers. Screening at Vital Signs health fair and all county health fairs. Expansion of service to rural clinics including mental health services. Availability of integrated mental health services at some local primary care clinic. Additional specialty services now available including Allergy/ Immunology, Endocrinology, Cardiac, acupuncture, and other specialty services. Fall Prevention: TAI CHI & Stepping On classes in all four counties. Flu Vaccine Vouchers, [Walk with the Doc Program](#), [Physical Therapy department open Saturday mornings for athletes with injuries](#), [Smart Moves Program \(diabetes prevention\)](#), [UNL Mental Health Telehealth](#), [Opened Edgar Clinic](#), [Expanded Nelson's hours](#), [patient portal](#), [pre-employment testing](#), [community wide walking activities](#), [recreation center/teacher led workouts](#), [mini lab health fair for worksites](#), [chronic care management](#), [recruit provider and specialties](#), [Chronic care management program](#), [patient portal access](#), [Blue Hill run/walk club](#), [Blue Hill clinic](#) and [Blue Hill Methodist Church health fairs](#) with preventative screenings [adult vaccination by request and in-home patient care at Clay County Health Department](#), [care coordination](#), [mental health practitioner](#), [sliding scale for cost reduction](#), [free blood pressure checks](#), [post cards for yearly appointments](#), [reduced cost blood draws](#), [Horizon Recovery and counseling center](#) has evening hours for juveniles and adults, [drug and alcohol education class on Saturday](#), [mental health services onsite at Brodstone](#), [telehealth services at Webster County](#), [Lanning Center open access for therapy- new patients can be seen 3x's a week for walk in appointments](#) and they currently have a Spanish speaking therapist, [HPS employs 2 school community liaisons to connect families with community resources](#), [ESU9 has a psychologist 1 day per week in Superior Public Schools](#), [SASA Crisis Center provides education and support groups- including batterer's intervention program and trauma informed care](#), [senior events other than health fairs providing information about services available to seniors- Day of Caring/Senior Test/Etc](#), [Horizon Recovery- alcohol/drug evaluations and alcohol/drug education class](#), [YMCA Blood pressure monitoring program](#), [YMCA and Cancer Center personal training program](#), [chart prepping offering state PAP plus Every Women Matters](#), [Medicaid providers in clinic to notify of available blood pressure program](#), [Sun Safety presentation for 357 middles and high school kids](#), [HPS Wellness policy and wellness teams at schools](#), [more businesses dabbling in wellness](#), [Safe Kids monthly car seat checks](#), [Russ's free fresh fruit](#), [counselor in Glenvil working with foster/adoptive kids](#) has extended hours, [Safety day for elementary children through Adams County Extension](#), [ML Home Health providers blood pressure screenings in surrounding communities- free to anyone](#)

Goal: Empowered People: Empower the general public, referral agents, and communities to connect with and recruit needed resources and reliable health information

- **Partners:** Cancer Coalition, ML cancer committee, medical providers, mental health providers, grocery stores, Nutrition Advisory Board (NAB), ASAAP, SASA, Mary Lanning-Morrison Cancer Center, Mary Lanning Insurance enrollment to marketplace, School Wellness teams, UNL Extension, ML Community Health Center and Hastings Family Care, Hastings College and CCC -Hastings, DHHS, Health Ministries, Pharmacist, [Medical Schools](#), [Midland Area Agency on Aging](#), [nursing homes](#), [schools](#), [Churches](#), [Facebook](#), [Recovery School](#), [Horizon Recovery](#)

- Activities:** Every Women Matters and State Pap Plus programs, YMCA Self-Monitoring Blood Pressure Program (SMBP) and Diabetes Prevention Program update letters to providers, Diabetes Prevention Program, SMBP pilot program in 3 area pharmacies with provider communication, SHDHD provides Network of Care, SHDHD website, Hastings Library renovation includes increased access to online health resources. Presentations at senior centers, to school groups, to worksites, clinics, the Hispanic community. Internships to recruit individuals to public health and healthcare. Project Homeless Connect and Salvation Army for resources to underserved. Education/enrollment to ACA. Education to teens and adults about health outcomes of substance abuse, resource for abusive relationships, nutrition and healthy living community classes, screening and education at county health fair. CHW program training, [Health literacy education](#), [insurance navigators](#), [partner with school for job shadowing and CNA training](#), [partner with medical schools to provide PA/Medical/PT/Pharmacy Students on job experience](#), [added pharmacist to staff](#), [increased PT staff](#), [better staff to patient communication- using teachback](#), starting in high school with education of health care services, local library in Blue Hill recruited Nurse Practitioner to give health talks for different age ranges, [transportation services by appointment](#), [veteran education](#), [nursing home transportation](#), [bilingual education in schools](#), [nursing homes](#), [provider clinics](#), [Every Women Matters program](#), [reduced cost for sports physicals](#), [Autism support group](#), [NAMI support group](#), [Horizon Recover life skill classes](#), [Retired and Senior Volunteer program](#), [volunteers provider transportation to elderly who are unable to drive](#), [mentoring programs](#), [after school programs](#), [Diversion parenting classes](#), [HPS offers parenting classes](#), [schools complete vision/hearing screenings](#), [South Central Town Hall Caregiver Coalition](#), [Medicare supplement review put on by MLH sterling connection](#), [Health Education videos in waiting rooms](#), [screening sheet on which people can record medical information to make appointments more efficient](#), [Horizon will refer clients to local self-need meetings](#)

Goal: Community Partnership: Expand the number of community partners involved in the implementation of the community health improvement plan (CHIP)

- Partners:** Mary Lanning Healthcare, Brodstone Memorial Hospital, Webster County Hospital, all district health clinics, Horizon Recovery, YMCA, ASAAP, SASA, CASA, YWCA, United Way, Senior Services, Hastings Utilities, UNL Extension, ESU 9, Emergency Managers of every county, all district nursing homes, County government, churches, Hastings College and Central Community College, Worksite Wellness sites, the VA, Sun Safe provider champions, Salvation Army, Tricare, Walgreens, Hastings Health Ministry, Clay County Health Department, [EMS](#), [Pharmacy](#), [Schools](#), [Headstart](#), [Hope Pregnancy](#), [Midland Area Agency on Aging](#), [Dentist](#), hearing and vision clinics, specialist, wound care, urologist, Blue hill Clinic, Blue Hill Library, [Sutton-Pt](#), [chiropractor](#), [pharmacy](#), [Veteran services](#), [Daycare](#), [School](#)

nurses, long term care, mental health provider, Horizon Recovery, Center of Rural Affairs, United Way, Churches, Good Sam, Schools, Daycares, Region 3

- Activities:** Making Connections-Vet Set, Sun Safety promotion, Every Women Matters Program, Immunization Clinic, Walgreen's Adult flu shot clinics, Vital Signs Health Fair, Heartland Health Center (Federally Qualified Health Center), Project Homeless Connect, Chronic Disease Prevention protocol implementation in clinics (3), Implementation of Diabetes Prevention Program (Smart Moves), blood pressure self-management program implementation and referral, SNAP education, dental services, health fairs, EMS, recruitment of specialty providers, West Gate Homes are low income housing that offers community resources and education onsite, Medicaid Providers, Spanish Translation, Horizon partners with probation to serve kids with substance use programs, United Way program for reducing prescription cost, Teammates program, Meal on Wheels, Horizon Recovery people living in recovery talking with youth groups, community mentoring programs, after school programs, Sunny Side Grant, schools- free vision, hearing, dental screenings, HPS school Community liaison connecting families with community resources, parenting classes, MLH Home health provides monthly foot clinic at Adams County senior center and Blue Hill, Lanning Center- BSU Partnership with Region 3 access sliding fee scale to eliminate or reduce cost, ML Community support workers- home visits for patient with high mental health needs