

**VetSET / Making Connection trainings**

Community Health Improvement Plan (CHIP) Priority: Mental Health

SHDHD is implementing strategies for the CHIP priority on Mental Health by providing education, awareness, and promotion of mental health first aid and other trainings. In an effort to increase access to mental health assistance and services, SHDHD used VetSET / Making Connections project funds to provide 3 training opportunities to our partners: Military 101 (16 participants), Mental Health 1st Aid with Veteran Module (15 participants), and Trauma 101 & Recovery (14 participants).



**Project Homeless Connect—July 27, 2017**

Community Health Improvement Plan (CHIP) Priority: Access to Care

SHDHD's community health worker and public health nurse connected with 30 individuals during the PHC event, which focuses on linking individuals and families who are homeless, near homeless, and low income with a variety of community resources. SHDHD focused on immunization, promoting health care provider connections/medical home, cancer screenings, and Human Papillomavirus (HPV) prevention.



**Coordinated School Health**

SHDHD's Brooke Wolfe (L) presents Hastings School District Wellness Team members Terry Julian and Montessa Munoz with a plaque for completing the Coordinate School Health Institutes.



**Kool-Aid Days**

CHIP Priority: Obesity  
SHDHD's interactive learning activity about sugar content of foods and beverages.



Community Health Improvement Plan (CHIP) Priority: Obesity  
 Prevention Connection strategies: Physical activity promotion, Choose Healthy Here vending and grocery store initiatives, and medical clinic staff training on how to use electronic health records to help identify and care for patients at risk for diabetes and cardiovascular disease.



Choose Healthy Here Vending Signage at Brodstone Memorial Hospital



New display units at an ethnic store to promote healthy choices



Harvard community member participating in the Sugary Drink Challenge Education booth



Harvard: Signs promoting walking erected at the High School Track and around the community



Clinic Informatics Training

UNL Extension partner displaying and promoting a healthy food recipe



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

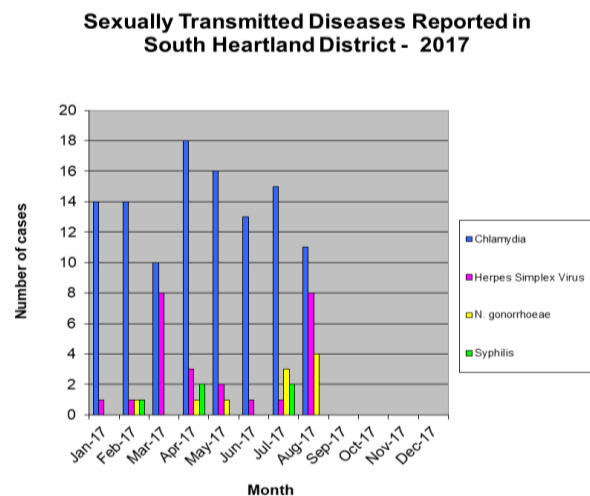
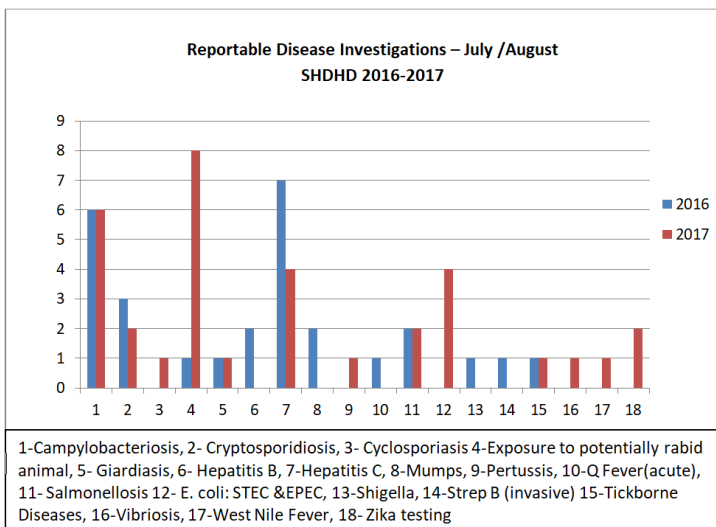
## 1. Monitor health status and understand health issues facing the community.

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

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

### Local

- Surveillance data, water violations, and other [health information is made available](#) on our website, through links on our website, on SHDHD's Network of Care website, through news releases and interviews to various forms of media, and upon request from partners or others.
- During the month of August, SHDHD received access and training on the [ESSENCE Syndromic Surveillance database](#). Syndromic surveillance is a biosurveillance methodology that integrates new information technologies, electronic health record data, and principles of epidemiology and biostatistics. The data are collected from hospitals and public health departments and transmitted to public health agencies in near-real time (at least every 24 hours). The data reported are categorized as a "syndrome" on the basis of a collection of symptoms or other variable.<sup>1</sup> The ESSENCE program was developed and licensed through Johns Hopkins University and is used by 27% of local health departments across the US.



- Our summer program assistant for mosquito surveillance is plotting the [number of mosquitoes by type](#) and by week from his trapping activities in Adams and Webster counties. The mosquitoes are sent to the state lab for sorting, typing and testing and we receive a tabular summary of the counts by species, location and week. The analysis of our local data will help us identify seasonal and annual trends.
- [Updates were made for Zika testing](#) in August due to changes in recommendations for testing at the CDC. Testing paid for by public health will be approved for females who conceive or are already pregnant if they arrive or immigrate to Nebraska from a high risk area. Pregnant females who travel to a high-risk area for an extended period of time and are pregnant or conceive after travel are now referred to commercial testing as of August 15<sup>th</sup>. We have been working hard to raise awareness about the health risks associated with travel to Zika affected areas. While SHDHD processes two Zika tests in July and August, we anticipate an increase in referrals for commercial Zika testing.
- In July, Brodstone Lab and Webster County Hospital Lab were provided [information about changes made to the list of reportable diseases](#). There have been several diseases added to the list including Zika and Chikungunya viruses with the official document being sent out by DHHS in May.
- [Mary Lanning ER department notified SHDHD surveillance](#) of several Hasting College Football team members being seen at the ER. South Heartland made contact with Hastings College Administration as well as team coaches to determine the risk of illness spreading to other players. Information about the illness was gathered from a coach and several players. A specimen was collected and sent off to NPHL for testing, but the GI panel had a negative result. Fortunately, the ill players recovered in a few days and no additional reports of ill team members occurred. We are very fortunate to have assistance from local hospitals as well as cooperation from Hasting College in this event. Great partners in our community keep illness from spreading.

## 2. Protect people from health problems and health hazards.

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

- *What key activities did we complete in the past 2 months to prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities*
- *What activities did we complete for emergency preparedness (e.g., planning, exercises, and response activities)?*
- **Emergency Preparedness.** Continued to have Memoranda of Agreement (MOA's) signed with all of law enforcement and Emergency Management in the district and completed review of all Points of Dispensing (POD's) and Subhub locations for responses that will need distribution and dispensing of vaccine or antibiotic. Adams Co Emergency Management, Hastings PD & Adams Co Sheriff are the only ones remaining.
- Finished **closed Points of Dispensing (closed POD) exercises with all of the long term care (LTC) facilities** in the health district. Very successful. Began After Action Report (AAR)/ Full Scale Exercise meetings with Nursing homes for Strategic National Stockpile (SNS) and closed POD distribution. Two more remaining. Developing Full Scale exercise for all of the LTC's for this fall. Met with Randy Fischer from Lincoln-Lancaster HD to be sure this FSE will meet the needs of CMS and FEMA definition of FSE. Matt Blum (who was in on the meeting with Randy Fischer) from Superior Good Samaritan Society and I have completed the initial work on the FSE and I will take it to the other LTC's for input before a final meeting with all LTC's at SHDHD Office. It is hoped these exercises will be completed by the end of October.
- **Implementation of the Hazard Risk Assessment Plan:** Received notification of a Presidential disaster declaration for the Omaha area due to storm damage, which opens up funds for SHDHD to apply for a grant for a generator to cover our building. SHDHD submitted a notice of intent to apply for the funding and met with an electrician who will give us an estimate of what needs to be done and what it will cost.

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

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

- *Provide examples of key information related to physical, behavioral, environmental, social, economic, and other issues affecting health that we provided to the public.*
- *Provide examples of health promotion programs that we implemented to address identified health problems.*
- Staff covered monthly **satellite office hours** in Superior, Clay Center, and Red Cloud.
- Utilized **community sign boards** (located in Edgar, Lawrence, Red Cloud, Bladen, Roseland, and Kenesaw) to get information out. Topics covered in July/August: West Nile Virus, Safety, School Immunizations.
- **News releases, public health columns, ads and interviews:** News releases and columns: Health district urges precautions for heat, Webster County Mosquitoes test positive for West Nile, Vaccination - equal Protection for all ages, and Fight the Bite: Avoid West Nile and other Mosquito-borne illnesses.
- **SHDHD Facebook:** In July, the number of people reached was 1,952. For August the number of people reached was 2,710 people. The topics for Facebook and twitter in July were fire work safety, sun safety and West Nile Awareness throughout the month, August centered on Immunization topics.
- **Worksite Wellness:** The worksite wellness network meeting for July was focused on Blood Pressure Awareness, designed to help the five businesses in attendance to learn how they can promote self-monitoring blood pressure among their employees and how they can support the Hastings YMCA new Blood Pressure Program. In June the 5 businesses learned about stress awareness and how they can watch for signs and symptoms that their employees are over stressed as well as how to deal with stress.
- **Senior Center Presentations:** West Nile Virus and Health Care Access, Adult Immunization
- **Stepping On classes** (fall prevention) Stepping On participants completed the 7week classes and there will be a 3 month follow-up class on October 13<sup>th</sup> and, during the intervening 3 months, SHDHD's program coordinator can provide home safety inspections for interested participants.
- **Beginning Tai Chi Classes** Started a new Tai Chi class at Good Samaritan Village in the Community Building on August 1<sup>st</sup>. Have new Tai Chi classes starting at the Golden Friendship Center on August 29<sup>th</sup>, in Nelson at the Community Building on September 7<sup>th</sup>, Clay Center at the school gym on September 14<sup>th</sup>, in Fairfield at the Auditorium on September 12<sup>th</sup>, in Superior at the Catholic Church on September 12<sup>th</sup>.
- **Smart Moves (Diabetes Prevention Program (DPP))** –SHDHD supported training of 1 new lifestyle coach, a staff member from Mary Lanning, to help support additional classes in the Hastings area.

- **Health Coaching:** 3 trained SHDHD Every Woman Matters Program staff are working to provide health coaching, healthy supports and lifestyle change program opportunities to women across the district who are age 40-75. There were 8 health coaching clients in August.
- **Kool Aid Days:** Our themes this year were sugar consumption in beverages and West Nile Virus prevention. There were approximately ~2,000 people who viewed our materials or stopped by. About 50 kids won water bottles for participating in a sugar match up game. We also passed out shoe laces and 500 DEET wipes.
- **Information about accessing care:** During July and August SHDHD helped link community members to Every Woman Matters services, access to local medical/dental providers offering financial assistance programs, promotion of having a medical home, vaccine information including HPV, local immunization clinics, access to NESIIS immunization records and Smart Moves Diabetes Prevention Program informational sessions at the following venues:-**Project Homeless Connect** – 30 homeless, near homeless or low income community members; **National Night Out** – 21 community members; **Salvation Army Backpack Program** – 34 parents/guardians of school age children

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

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

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

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

➤ **Access to Health Care:**

- **Prevention Connection** – SHDHD met with six district clinics (Superior, Webster County, Mary Lanning, Hastings Family Medical, Internal Medicine and Quality Clinic of Sutton) to identify strategies that align with chronic disease prevention work to be completed in the last year of the prevention connection funding. The strategies will improve the quality of care the patients receive.

➤ **Obesity:**

- **Nutrition Advisory Board (NAB)** - The NAB met in July with 5 in attendance. The group was very helpful in guiding SHDHD to potential partners for Choose Healthy Here implementation, vending connections and promotion ideas. Outcomes from the meeting include: identifying possible new partnerships, two community members sharing what is happening in their communities, success of the vending kick-off and the barriers experienced, and grant report update on the Mid-West Dairy grant for the grocery stores (an eligible partner organization applied for the grant on behalf of our local grocery stores).
- **Prevention Connection: Choose Healthy Here** – Healthy food options in convenience and grocery stores. SHDHD continues to work in three Hispanic stores in Hastings implementing the *Choose Healthy Here* (CHH) program. The three stores continue to implement their action plan. They all hosted a taste testing in July and August with 30 and 40 customer interactions respectively. During the taste testing blood pressures are taken, Smart Moves information is presented and general nutrition education is available.
- **Prevention Connection: Superior's follow up to their Walking Summit.** Superior's design team promoting walkability met in July to discuss future funding opportunities. The team has identified they would like to apply for trail funding come next August. The team is also working on signage they are hoping to place in downtown business to promote walking.
- **Prevention Connection Healthy Vending Initiative** SHDHD continues to work with partnered sites to improve vending. The YMCA and Brodstone are working to get language in their vending contracts to ensure healthy options are always available, however, no partnered sites have successfully got the language approved by their boards/administration.
- **Prevention Connection: Healthy Hastings follow up on action summit.** Healthy Hastings continues to meet to fulfill the action plan. At July's meeting (6 in attendance) committees reported progress and shared their frustration with Hastings City on implementation of Complete Streets Policy. They group was also looking at doing city promotion of 1<sup>st</sup> street bike path, but due to a short timeline the promotion/education will be delayed to spring 2018. August's meeting (7 in attendance) committees reported and the committee is planning a family fun day in January and a bike/walk to work/school week come the spring.
- **SHDHD WoW (Worksite Wellness):** July was focused on managing stress through laughter. There was a laughter challenge and a lunch and learn which was well attended by staff. August was also focused on

stress reduction through sleep tracking. There was a tracking challenge and a lunch and learn over the solar eclipse.

- **School Wellness:** As school kicks off the three schools that attended the institutes (Hastings Public District Office, Alcott and Longfellow) are celebrating their success last spring by receiving plaques as a Coordinated School Health School. Two of the three schools have had their “award ceremony.” SHDHD also continues to be involved in the school’s wellness teams for all schools willing. In August the Hastings District school wellness met and SHDHD help them establish their district wide evaluation plan.
- **Prevention Connection:** Superior Pharmacy continues to work with patients with hypertension on education and self-monitoring. Keith’s pharmacy is working to identify patients on hypertensive medication which will then lead to the identification of patients who are hypertensive and not well managed to allow for the pharmacy to do some patient education with them and promotion of the YMCA self- monitoring blood pressure program. The Red Cloud pharmacy and SHDHD are currently in the planning stages for activities they would like to work with SHDHD on in the last year of the prevention connection funding.

➤ **Cancer:**

- **SH Cancer Coalition:** South Heartland Cancer Coalition met July and August. Collaboration occurs as we share time and resources while working toward the common goal of raising awareness of the need for cancer screenings, education to inform of symptoms and advantages of early detection and promoting evidence based screenings. Recent areas of focus are sun safety and Human Papillomavirus (HPV).
- **Mary Lanning Healthcare Cancer Committee:** This committee which includes SHDHD met in August. Mary Lanning /Morrison Cancer Center are key partners in advancing community education and screening activities and are key partners in the SH Cancer Coalition.
- **Lung Cancer:** Nebraska Quit Line cards were included in all FOBT colon cancer kits this campaign. Education and resources are commonly shared through our health coaching contacts. Staff identified residents who have mitigated their homes and will be interviewing them for additional radon testing and mitigation promotion. Radon detection kits continue to be available through the HD and satellite offices.
- **Colon Cancer:** FOBT colon cancer screening kits are available to all district residents age 50-75 throughout the year with primary promotion during the March Colorectal Cancer Campaign. Partners across all 4 counties assist in distributing these kits. Partners include: South Central Partnership, SH Cancer Coalition, Clay County Health Department, Webster County Hospital, Brodstone Hospital and area pharmacies. 412 FOBT kits have been distributed to date since the March campaign. Current return rate is 64% which is up from 46% in 2016. 7 clients have tested positive and are receiving case management. After presenting on the topic of adult immunization at the Elm Street Senior Center in Red Cloud, a resident who is a colon cancer survivor shared his story.
- **Cervical Cancer:** Human Papillomavirus (HPV) vaccine educational materials are shared at monthly VFC clinics. E-mails were sent to all area school nurses with our new immunization clinic brochure and a sample letter provided by ACS for school nurses to use as a template when sending immunization letters home to parents. Community Health Workers continue to work with clients to access health care and Every Woman Matters resources. Clients are navigated to screening and diagnostics or treatment when needed.
- **Breast Cancer:** Using the Encounter Registry we continue to identify women in need of breast, cervical and colorectal cancer screening as well as resources to lifestyle change. Needs are assessed including health coverage and other barriers that might stand in the way of a woman completing cancer and cardiovascular screenings. Those without insurance who meet the Every Woman Matters program requirements are assisted with completing the Healthy Lifestyle Questionnaire to enroll in the program. Those not meeting requirements are connected with the clinics offering assistance or Komen funds. Community health workers, CHWs, help navigate women to screenings and to diagnostic services. In July and August, staff assisted 15 women with access to health care: completing healthy lifestyle questionnaires, linking them to health resources, or navigating them to cancer screenings. Planning meetings are underway with area partners for holding a women’s health event again this fall.
- **Prostate Cancer:**
- **Skin Cancer:** Sun Safety bags with printed education, sunscreen and lip balm were shared with previously identified champion providers in each county and with 2 new NPs at the Community Health Center. The bags are to be used along with provider counseling about skin cancer prevention for patients age 10-24 at school physicals or other visits.

- **Substance Abuse:** SHDHD shared information with Area Substance and Alcohol Abuse Prevention about Life of an Athlete training being held in Chadron, NE. Made contact with area law enforcement to recruit support and request registration for participation in the next [DEA national Medication Take Back Day in October](#).
- **Mental Health:**
  - [VetSET/Making Connections](#): SHDHD provided 3 training opportunities to community partners during the months of July & August: Mental Health 1<sup>st</sup> Aid w/ Veteran Module, a tailored module built upon the effectiveness of the standard Mental Health First Aid curriculum by focusing on the unique experiences and needs of the military, veteran and family populations to 15 partners and 5 staff. Trauma 101 & Recovery - how to engage people with histories of trauma that acknowledges the role that trauma has played in their lives, to 14 partners and 9 staff, and Military 101 to better serve the veterans and their families in your community, to 13 partners and 3 staff.
- **Other Collaborations (1422):** Hastings YMCA has kicked off their [Blood Pressure Management program](#). SHDHD is working with the clinic partners who attend the bidirectional task force meetings to identify a provider champion and a way the provider and YMCA can directly communicate and refer patients to their program. SHDHD has partnered on this launch and has staff trained as Health Ambassadors for this program. EWM staff are working to connect hypertensive EWM health coaching clients and clients we connect with at other venues to the YMCA's Self-monitored Blood Pressure program.

## 5. Develop public health policies and plans.

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

- *What policies have we proposed and implemented that improve population health and/or reduce disparities?*
- *Describe how our department engaged in agency-specific strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.*
- *What plans are we developing and implementing to improve our department's quality and effectiveness (plans for quality improvement, workforce development, branding, communication, and performance management)?*
- **Grant Proposals (Plans)/Awards/New Funding:**
  - As of August 28, no subawards signed yet for PHEP funds or Health Hub/ Every Woman Matters. Health Hub start date was pushed back to August 1<sup>st</sup> (State had not received a Notice of Award from feds, so DHHS cannot issue a subaward).
- The [Performance Management System framework](#) implementation continues through performance measurement evaluation and ongoing quality improvement activities. Current QI projects include, Coding: Supply Inventory, VFC Clinic Flow, with the final clinic survey completed in August. The Coding: Procurement project is completed and summarized in a story board.
- [Prevention connection: Blood Pressure Management](#) - with partner consultant Praesidio, SHDHD continues to work with the 2 clinics to implement a blood pressure protocol within their clinic workflow to flag patients that may be hypertensive, not well managed or pre-hypertensive.
- [Prevention Connection](#): SHDHD and UNL extension teamed up to provide Brodstone Dietary staff on how to make small changes in the cafeteria to increase the health of the food being served.
- [Workforce Development Plan](#) – completed core competency assessment prioritization and created and action plan for the next year based on high-yield Core Competency priorities.

## 6. Enforce public health laws and regulations.

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

- *Describe our efforts to educate members of our community on public health laws, policies, regulations, and ordinances and how to comply with them.*
- *What laws and regulations have we helped enforce to protect the public's health?*
- [Nebraska Clean Indoor Air Act](#): No smoking violations reported this period.
- SHDHD receives [food recall alerts](#) from the Nebraska Department of Agriculture. We also maintain a link on our website to the FDA Food Safety webpage.
- [Senator Kuehn visited the July Board of Health meeting](#), where he discussed LB 471 (Change prescription drug monitoring provisions and create the Veterinary Prescription Monitoring Program Task Force), LB 223 (Change provisions relating to prescription drug monitoring) and LB 481 (to provide guidance for clinicians and

dispensers as biosimilar products pass through the FDA approval process and amend the Nebraska Drug Product Selection Act to allow pharmacists to substitute interchangeable biosimilar products in place of branded drugs).

- The [Nebraska public health laws and authorities](#) are now accessible from our website homepage.
- We shared summary data on Salmonella cases for our district at the request of a City Council member who received concerns from citizens about the national outbreaks of Salmonella that were traced to backyard flocks. Hastings City Council passed an [amendment to the city code on Nov. 10, 2014, that allows chickens inside Hastings city limits](#). In 2016, there were 8 cases of Salmonella, none of which were traced to backyard flocks. In 2017, there have been 3 cases of Salmonella reported to date, none of which are related to the national outbreaks, and none of which have been traced to backyard flocks.

## 7. Help people receive health services.

*(Are people receiving the medical care they need?)*

- *Describe the gaps that our department has identified in personal health services.*
- *Describe the strategies and services that we have supported and implemented to increase access to health care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.*
- In July/August the [Vaccine for Children](#) clinic staff delivered 64 vaccines to 28 patients at two monthly clinics. Of those 28 patients, 20 had no insurance, 3 had Medicaid and 5 were underinsured. 2 of the 28 patients were new to the clinic. Total donation collected from clients for July/August = \$247.00 (avg. \$3.87 per immunization or \$9.07 per patient). Quarterly recall/reminder letters were mailed to 53 patients associated with our clinic who are not up to date with all recommended vaccines. After receiving the AFIX (Assessment, Feedback, Incentives & eXchange) report for our immunization program we selected 2 strategies to help increase immunization rates. The first was to include printed parent information about HPV and HPV vaccination along with the reminder/recall letter. This was implemented in July with 23 of the 53 patients needing HPV vaccination and receiving the printed education in addition to the reminder/recall letter.
- In July/August the [Adult Immunization Program](#) delivering Tdap to uninsured or underinsured adults 19 and over, administered 6 Tdap vaccines to 6 patients who were all uninsured. All adults were new patients with 1 being seen in the clinic and 5 seen at Project Homeless Connect.
- [Community Health Worker](#)  
[Every Woman Matters \(EWM\)/Encounter Registry](#): 5 adult clients assisted in office, 9 adult client seen at home visits, 46 adult medical referrals to other organizations/providers, 1 child immunization referral, 2 referrals for Smart Moves, 3 Health Coaching support calls to eligible Spanish speaking participants. [Diabetes Prevention Program \(DPP\)](#): Lifestyle Coach for group of 8 Spanish speakers.  
[Minority Health Diabetes Management](#): July - assisted with the group at the YMCA.

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

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

- *Describe our efforts to evaluate LHD staff members' public health competencies. How have we addressed these deficiencies?*
- *Describe the strategies we have used to develop, train, and retain a diverse staff.*
- *Provide examples of training experiences that were provided for staff.*
- *Describe the activities that we have completed to establish a workforce development plan.*
- [Performance management, Results Based Accountability](#) continues to be implemented weekly in performance measures of programs and services (quantitative, qualitative and outcomes). [The Workforce Development Plan](#) was completed for PHAB documentation. Core Competency priorities are starting to be incorporated into job descriptions and training.
- [Prevention Connection](#): B Wolfe attended a "Walk-Audit training" by Mark Fenton to help support local communities assess their walking environment. Brooke also attended a clinic transformation training to identify the who, what, when and how of clinic transformation.
- [Mental Health First Aid Training](#) – B. Wolfe, J. Johnson, D. Hultman, J. Warner, and L. Najera. Staff from community organizations/partners: Hastings Police Department (7), Community Clinic, Crossroads Mission (4), Salvation Army, E-Free Church.



- Military 101: A. Market, M. Bever, L. Chamberlain. Staff from community organizations/partners: Salvation Army, Alzheimers Association, Western Alternative Corrections (5), District 10 Probation, Adams Co VSO, DAV (NE), DAV (Hastings), CCC-Hastings, E-Free Church.
- Trauma Informed Care: J Warner, D. Hultmann, D. Ferguson, J. Morgan, A. Market, L. Chamberlain, L. Najera, B. Wolfe, M. Bever. Staff from community organizations/partners: Alzheimers Association, Community Clinic, Catholic Social Services, E-Free Church, Salvation Army, NE Department of Education, Crossroads Mission (4), SASA, Goodwill, NE TotalCare.
- CLAS and Literacy Improvement and Innovation Project – J. Johnson is participating in this state project to be completed in December, 2018.
- Results Based Accountability Webinars – J. Warner and J. Johnson have been reviewing these free webinars. The webinars will be archived and available for training. The RBA Scorecard may be utilized for performance measurement.
- Jim Morgan attended a state-wide ERC conference where work plans and Operation Readiness Review documents were discussed, both necessary for the current year's PHEP sub-award.
- Succession Planning – overview webinar attended by J. Johnson, M. Bever, J. Morgan, D. Ferguson.

## 9. Evaluate and improve programs and interventions.

*(Are we doing any good? Are we doing things right? Are we doing the right things?)*

- *Provide examples of our evaluation activities related to evidence-based public health programs.*
- *Provide examples of QI projects that we have completed or are in process.*
- Choose Healthy Here initiative evaluation: Continued with Gretchen Swanson Center for Nutrition (GSCN) and NeDHHS on evaluation of *Choose Healthy Here* materials in partner Grocery Stores. Completed the monthly report.
- Prevention Connection - All Chronic disease prevention staff participated in evaluation of the chronic disease prevention project led by NeDHHS.
- The Quality Improvement – Performance Management Team: The VFC team is working on improving clinic workflow. They conducted a survey of staff satisfaction, knowledge and barriers to steps in the “swim lanes” of clinic work flow. After implementing changes, a follow up survey is being conducted to assess for improvement in staff satisfaction. The coding/procurement project is completed with processes and successes demonstrated in a story board. The coding/supply inventory project continues with success noted in decreased time for the office manager to match supply costs to grants. The QI calendar and log are completed. The team prioritized core competencies to determine training needs.
- Three staff participated in the The Movember Foundation's evaluation of the Making Connections project, by hosting a site visit and describing how the project is being implemented in South Heartland, and barriers/successes of implementation.

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

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

- *Provide examples of evidence-based programs our department is implementing.*
- *Describe how we have collaborated with researchers to conduct any research studies (e.g., completed surveys, interviews, or focus groups).*
- Evidence Based:
  - SHDHD is continuing to implement the year 3 work plan consisting of evidence-based strategies for prevention of cardiovascular disease and diabetes as part of the 4-year Chronic Disease Prevention project (Prevention Connection).
  - SHDHD is partnering with worksites wellness committees and using evidence-based practices for improving physical activity and nutrition in worksites.
  - In the Every Woman Matters/Community Health Hub project, SHDHD uses evidence-based strategies to address health inequities and improve screening rates for cervical, breast and colon cancers.
  - Tai Chi – Moving for Better Balance and Stepping On are evidence-based programs for fall prevention in older adults. In South Heartland, beginning and/or advanced Tai Chi classes are being offered in all 4 counties. Stepping On 7 week classes finished in Adams County with 18 participants and Clay County will be having their 1<sup>st</sup> class sometime this fall.

- We are continuing to use a [Reminder Recall](#) process for immunization clinic clients to improve immunization rates.
- [Public Health Accreditation Board \(PHAB\) Standards and Measures](#) are evidence based. SHDHD submitted the required PHAB documentation (308+ documents) on August 8, 2017!
- SHDHD is using an evidence-based Sun Safety / Skin Cancer prevention strategy where health care providers provide [counseling about sun safe behaviors for skin cancer prevention](#) to patients age 10-24 during school physicals or other visits.

➤ **Research:**

- SHDHD participated in online survey as part of a research study from the Prevention Research Center at Washington University in St. Louis which is exploring strategies to support the use of evidence-based diabetes and chronic disease prevention and management among local health departments.
- [UNMC College of Public Health Master's student Katherine Kotas](#) – completed her capstone project on fall prevention and presented her work analyzing SHDHD Tai Chi program data and Mary Lanning ER older adult fall data at UNMC for her MPH final presentation and then also to SHDHD and Mary Lanning staff. Katherine's research paper is posted on the SHDHD website.

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**Stories: How we made a difference....**

This summer, under the coordination of community health worker Liz Chamberlain, South Heartland began implementing the evidence-based Stepping On program, a set of workshops proven to reduce the risk of falls in seniors by up to 50%. In just 7 weeks, participants can be stronger and steadier wherever they go, and keep doing the things they want to do, to stay active in their communities.

Several of the participants in our first 7 week series noted improvements in their abilities:

- “I was able to do some things I didn't think I could do before taking the class.”
- “My movement (getting in and out of chairs etc.) is easier.”
- “Taking the class, reminded me to pay attention when I'm walking.”

The next Stepping On classes will be scheduled in Clay County sometime this fall. Liz will share the details soon!

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**Reference**

Chughtai, Sarah MPP; DeVore, Katrina MPH; Kan, Lilly MPH; Streichert, Laura C. PhD, MPH. (2016). *Assessment of Local Health Department Utility of Syndromic Surveillance: Results of the 2015 Biosurveillance Needs Assessment Survey*. Retrieved from: [http://journals.lww.com/jphmp/Fulltext/2016/11001/Assessment\\_of\\_Local\\_Health\\_Department\\_Utility\\_of.13.aspx#P14](http://journals.lww.com/jphmp/Fulltext/2016/11001/Assessment_of_Local_Health_Department_Utility_of.13.aspx#P14)