



South Heartland District Health Department Annual Report 2018

SOUTH
HEARTLAND
DISTRICT



**HEALTH
DEPARTMENT**



2018 South Heartland Staff:



Jim Morgan: Public Health Risk Coordinator



Janis Johnson: Standards and Performance Manager / Public Health Nurse



Dorrann Hultman: RN, Public Health Nurse, Community Health Service Coordinator



Jessica Warner: Health Surveillance Coordinator



Brooke Wolfe: Public Health Promotions and Prevention Coordinator



Jean Korfh: Chronic Disease Prevention Program



Liz Chamberlain: Community Health Worker



Joe Strautert, Finance and Operations Manager



Amy Markert: Receptionist/ Clerk



Susan Ferrone, RN, BSN, MPA, PH Nurse, MAPP Coordinator



Financial Report

2017-2018 Fiscal Year

Where The Money Goes...

Expense by Program \$753,001

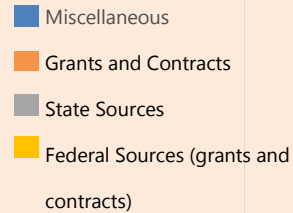


Expense by Source

Personnel	74%
Operating	20%
Supplies	3%
Travel	3%

Where The Money Comes From...

Revenue by Source \$734,744



A special thank you to all of the volunteers and student interns who provided vital support to South Heartland District Health Department during 2018.

2018 Board of Health: Adams County



Charles Neumann- Secretary/Treasurer



Judy Reimer



Donna Fejler-Daiss

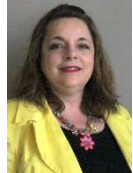
Clay County



Eric Samuelson



Sondra Nejezchleb



Nanette Shackelford- President

Nuckolls County



Doyle Christensen - Vice President



Peggy Meyer



Matt Blum

Webster County



Roger Bohrer



Ronald Kuenner



Mirya Hallock

Professional Representatives



Daniel Brailita, MD

Medical



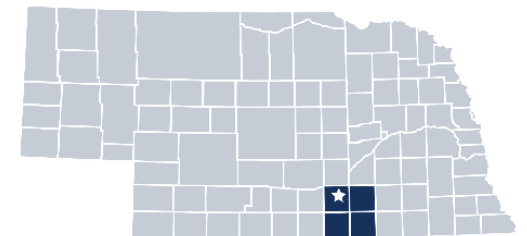
Michael Kleppinger, DDS

Dental



Lindsay Waechter- Mead, DVM

Veterinary



South Heartland's Vision: *Healthy People in Healthy Communities*

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



A message from the Health Director:

It is not unusual for us to meet people who haven't heard of the South Heartland District Health Department or who don't really know what we do. While public health workers do a great job carrying out statutory authorities and the ten essential services of public health, we often work behind the scenes. Everything we do supports progress toward our vision. We Prepare, Prevent, Promote, and Protect and we work with others in our communities to assure we have conditions in which people can be healthy. We are proud of our many partnerships that help make all of our work happen. We are continuing to develop our roles of community convener and chief health strategist for the four-county district to create an environment where people can be healthy.

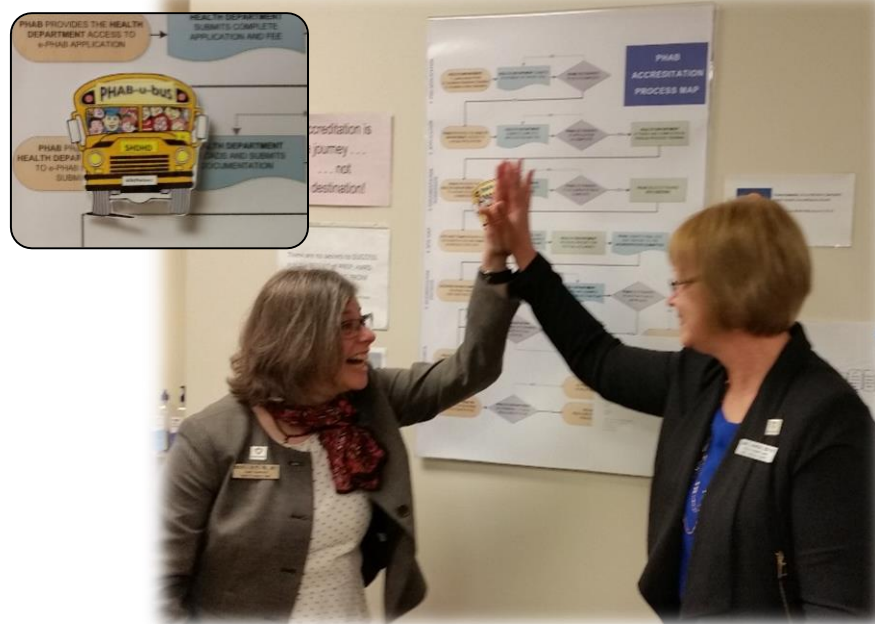
In 2018, we launched our 4th community health assessment and community health improvement planning process since the department formed in 2001. We invite you to join us as we continue our efforts to improve the health of our communities and strive toward our vision!

Michele Bever, PhD, MPH

Community Health Improvement Plan, 2012 – 2018

Priority Goals

1. Obesity
2. Mental Health
3. Substance Abuse
4. Cancer
5. Access to Health Care Services



MOVE THAT BUS! National Accreditation

During 2018, SHDHD continued our journey towards national public health accreditation through the Public Health Accreditation Board (PHAB) process. Staff prepared for the accreditation site visit in April, including a review of documents uploaded the previous year. In August, we received word that SHDHD's next step is an action plan to expand capabilities in performance management and quality improvement. SHDHD's action plan was approved by PHAB. As the journey continues, SHDHD looks to be fully accredited in 2019.

The PHAB-u-bus was created by SHDHD to "drive" our progress along the PHAB Process Map (see picture). Occupants in the bus include staff, Board of Health and community partners, as accreditation will improve the health department processes and collaboration with partners to better address health priorities in our communities.

Community Health Improvement Tracker 2012-2018

As we prepare to launch our new Community Health Improvement Plan (CHIP) goals and priorities for 2019 - 2024, SHDHD would like to share the progress and the great work all our community partners have done on the 2013-2018 CHIP. These data below show how we are making a difference by working together

Please note, this tracker represents the most current data available

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	Over 41 partners worked in their communities to decrease obesity rates and improve overall health across the lifespan. Education, programming and interventions to increase opportunities for physical activity and access to healthy foods are taking place in settings like schools, worksites, clinics and senior centers. Two evidence-based lifestyle change programs, Smart Moves Diabetes Prevention Program and the YMCA Blood Pressure Self Monitoring program, were expanded in 2018.
↓	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	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	
Cancer (% and rate per 100,000)					
○	Increase percentage of women aged 50-74 years who are up-to-date on breast cancer screening	70	71.7	74.2	Over 44 partners worked to decrease cancer death rates, educate their communities, increase access to screenings and improve cancer supports. Preventive screening and early detection were a primary focus through community and provider outreach and education. Through community awareness and local fundraising, communities across the district have helped support cancer patients financially and have expanded local services.
○	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	
↓	Reduce incidence rates due to female breast cancer	128.9	131.6	121.2	
↓	Reduce mortality rates due to female breast cancer	19	22.8	18	
+	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	

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	17.4	
↓	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	Over 47 partners worked to improve mental health stigma, access to services and provide mental health training to target populations. Partners implemented service expansions, integrated care and telehealth services.
+	Mental health was not good on 14 or more of the past 30 days*	11	9.2	10.3	
○	Reduce reported suicide attempts by high school students during the past year.	9.6	13.2	9	
	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	Over 29 partners worked in their communities to decrease substance abuse. Pharmacies collaborated with law enforcement and community-based organizations to educate, advocate and promote take back of expired or unused medications. Community-based and health care organizations hosted community educational forums, and led social norms campaigns and peer-to-peer programs in 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	Over 45 partners worked in their communities to increase access to care. Community partners offered evidence-based programs that aimed to improve health outcomes and health care systems expanded services, improved electronic health record utilization, and increased collaboration efforts and referrals.
+	Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.	63	67	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	

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



CHIP 2019-2024

CHIP = Community Health Improvement Plan

In early 2018, SHDHD began a new round of Mobilizing for Action through Planning and Partnerships (MAPP) to lead our district in the development of a new six-year community health improvement plan (CHIP). SHDHD's community assessment and health priority-setting processes involve our stakeholders and community members at every step. Residents from all four counties gave input about the strengths and opportunities in their communities. Our community partners contributed data to help us understand the health and risky behaviors of our residents. Community leaders and health providers helped us understand the health assets and services gaps in our communities, and community members shared their barriers to accessing preventive health services.



Next, our partners and stakeholders helped choose health priorities to focus on over the next six years. They participated in facilitated planning sessions with us to determine how, as a health district, we will address our top health priorities. It was through these planning sessions that our CHIP strategies were generated and partner organizations identified strategies they will participate in or lead. The CHIP serves as a guide for SHDHD and for our community partners.

Some partners, including two non-profit hospitals (Brodstone Memorial and Mary Lanning Healthcare) in our district also are required to complete periodic community needs assessments. Collaboration on this process reduces duplication and leads to coordinated, aligned plans across organizations and shared community goals for seeking resources and coordinating services. Many partners use the resulting needs assessment data and CHIP to guide their own strategic planning. For example, previously the Hastings Family YMCA partnered with SHDHD to seek funding and implement a national YMCA pilot program on blood pressure self-management. This partnership aligned with SHDHD's chronic disease initiative and the 2012-2018 community health priority of reducing obesity and associated chronic diseases.

CHIP 2019-2024 priority areas, determined by our communities:

Priority area 1: Access to Health Care Services

Priority area 2: Mental Health

Priority area 3: Substance Misuse

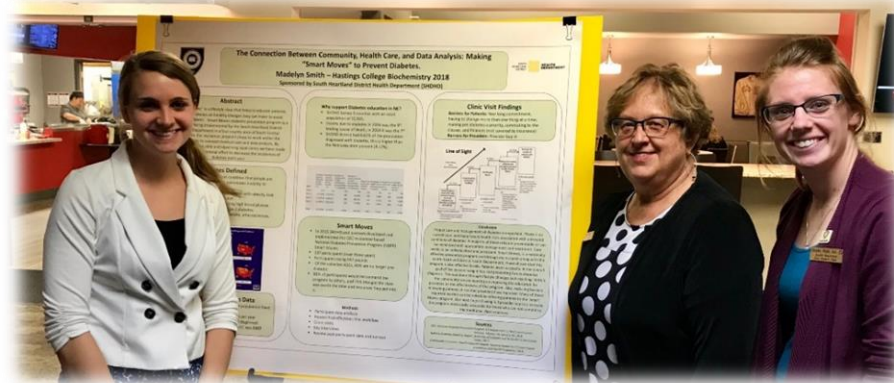
Priority area 4: Obesity and Related Conditions

Priority area 5: Cancer





A monthly consultation with a Heart Health Ambassador as part of the YMCA's Blood Pressure Self-Monitoring Program



Hastings College Student Intern Madelyn Smith presenting her poster at the Hastings College Academic Showcase – The Connection Between Community Healthcare & Data Analysis: Making “Smart Moves” to Prevent Diabetes

SHDHD in Action!

Making it safe for kids: Students helping SHDHD staff assess walking routes around schools



Providing monthly public health information during a KHAS Radio Sunrise 60 interview



Staff and Volunteers for the “Be Well, Feel Good, Get Checked” Women’s Health Event



Students learn about nutrition at the annual Kids Fitness and Nutrition Day



Falls Prevention: A Tai Chi Moving for Better Balance class in Superior, Nebraska

Access to Health Care:

SHDHD staff are working to address access to health care needs within the community by:

- Providing monthly immunization clinics through the Vaccines For Children and Adult Immunization Programs.
- Connecting individuals with affordable health care and enrolling them in programs supporting cancer and cardiovascular screening through the Every Woman Matters (EWM) program.
- Collaborating with local agencies to address barriers to breast cancer screening for uninsured low income women who do not qualify for the EWM program
- Offering interpretation, transportation and support through a culturally appropriate liaison to EWM clients.
- Making available and promoting low cost community lifestyle change programs.

Success Story:

Access to Care by Community Collaboration

Thirty five percent of adults in SHDHD area struggle with hypertension (high blood pressure – high BP) which, if left undetected or not properly managed, can contribute to an increased risk of stroke and heart disease. Prior to 2017, residents of Hastings and the surrounding rural areas did not have access to BP management programs or access to education about their condition without visiting their health care providers. To help address this issue, SHDHD encouraged the Hastings Family YMCA to apply to be a host site for the National YMCA Blood Pressure Self-Monitoring Program, an evidence-based program geared toward hypertension education and management.

The YMCA and SHDHD collaborated to connect with providers and convey the benefits of the program for their patients. The team established an efficient communication system with the primary care providers (PCPs), sharing patient progress and increasing the PCP's willingness to refer additional patients.

SHDHD community health workers continue to serve as healthy heart ambassadors delivering nutrition classes and taking blood pressure measurements for participants. They are also actively referring clients into the program. As a result of these efforts, collaboration between the community organizations and providers has increased, and one participant shared with her provider that the program was "very valuable" to her because she learned how to take her own BP the correct way.



Cancer:

Using the Encounter Registry, SHDHD identifies women in need of breast, cervical and colorectal cancer screenings, as well as resources for lifestyle change. Needs are assessed including health coverage and other barriers that might stand in the way of a women completing cancer and cardiovascular screenings. Those without insurance who meet the Every Women Matters program requirements were assisted with enrollment into the program. SHDHD enrolled 19 new women into the program. 138 women were navigated to breast and cervical screening and/or diagnostics. In addition, SHDHD promotes colon cancer screening with distribution of fecal occult blood testing (FOBT) kits, lung cancer prevention through radon testing, cervical cancer prevention through HPV vaccination, and prostate and skin cancer prevention through community education.

Success Story:

Top Performer in Health Hub Program

South Heartland's outreach to minority and low income women was so successful that we were identified as the top performing health department in the 2017-2018 NE Health Hub / Every Woman Matters (EWM) program. When asked "So, how do you "sell it" to get community members interested?" program coordinator Dorrann Hultman says: "We don't. It's all about making a personal connection first and building on that. Whether we meet people in the community or they are coming through our door, we greet them. We want them to know that we are invested in them and will explore ways that we can help them. We invite them to our office and ask them a few questions that will help us identify how we can serve them best. Navigation to breast, cervical and/or colorectal cancer screenings often begins at this time. We'll also talk about their cardiovascular disease history and share information about community based programs and health coaching. For our team, it is all about building a relationship with each client. Our community health workers are the key to our success with clients. We take advantage of opportunities to talk with organizations and groups about public health and what we do at South Heartland District Health Department so people become familiar with us and our services."



47%
of Smart Moves
participants reached
weight loss goals and

96%
reached attendance
goals

144
Individuals
participated
in a Mental
Health
Training

62% of
Hypertensive patients
had controlled blood
pressure after a new
clinic protocol was
implemented – up
from 49%

Mental Health:

SHDHD facilitated or coordinated 3 different types of trainings throughout the district to increase capacity and community knowledge about mental health needs: QPR (Question, Persuade, Refer) Suicide Prevention, Mental Health First Aid, and Military Cultural Competency. A total of 6 trainings reached 93 total participants and at least 35 organizations. SHDHD also provided youth mental health-related training opportunities: Adverse Childhood Experiences (ACES) and the 40 Developmental Assets.

Success Story:

SHDHD placed focus on mental health and mental health education during the 2018 Annual Luncheon and Public Health Awards. Sheri Dawson, Director for the DHHS Division of Behavioral Health gave the keynote address, followed in the afternoon with training on Adverse Childhood Experiences (ACES) and 40 Developmental Assets with Kay Glidden and Trish Crandall. There were 74 community partners who attended the lunch and 51 who attended the training.

Obesity:

SHDHD's four-year Chronic Disease Prevention Grant through NeDHHS has ended. The project focused on: (1) community strategies to promote health and reinforce healthy behaviors and (2) health system strategies to improve the quality of health care delivery to their patient populations with the highest hypertension and prediabetes disparities. SHDHD collaborated with six area worksites to provide wellness resources and evidence-based practices for healthier employees. We also teamed up with two area school districts to engage in school wellness assessments (School Health Index) as part of Nebraska Department of Education's 5-year project - Whole School, Whole Child, Whole Community (WCSS) - to improve health and wellness of youth.

Success Stories:

A Comprehensive Approach to Diabetes and Stroke Prevention

SHDHD worked with cafeterias, grocery stores, and food pantries to increase access to healthy food in worksites and in the community. Brodstone Memorial Hospital cafeteria implemented a regular salad bar lunch option for their employees, resulting in an increased participation in lunch (n=58 to n=78), and a consistent level of participation eleven months post-salad bar implementation (n=78 and n=76). Fill N Chill convenience store in Hastings has added a healthy food section.

Hastings Middle School has brighter, noticeable signs reminding drivers to watch for crossing youth. The City of Hastings and the Complete Streets committee is actively working to make Hastings streets more walkable.

Smart Moves, SHDHD's CDC-recognized diabetes prevention program is being offered in 3 out of 4 of South Heartland's counties.

Clinics are using their Electronic Health Records (EHR) system to better serve their patients. They adopted methods for accurately measuring blood pressure and implemented protocols to educate and encourage those with elevated or high blood pressure to self-monitor their blood pressure. Patients were also encouraged to document their home readings into their patient portal. One clinic introduced a unique way to queue conversations on a patient's high blood pressure (hypertension risk) or high BMI score (pre-diabetes risk) by attaching a heart- or apple-shaped symbol to the patient's exam room door.

Two clinics are referring eligible patients to community programs, like the YMCA Blood Pressure Self-monitoring program and community partners are sharing patient progress back to providers. A self-monitoring blood pressure pilot program was hosted through 3 pharmacy partners and engaged 21 hypertensive patients. Of those patients participating in the program, 100% increased their knowledge and confidence in recording an accurate blood pressure.

Substance Abuse:

SHDHD collaborated with partners to educate the community on a variety of topics around substance abuse. SHDHD staff contributed to 2 panel presentations on opioid addiction for community organizations.

In addition to education, SHDHD monitored substance use data. SHDHD received access to tobacco point of sale data for our district and the state. Some of the local data was gathered through assessments that SHDHD conducted during the fall of 2017. The data can be queried for information such as facility density and facility proximity to schools and parks, etc.

SHDHD continued to promote the drug take back programs through our pharmacies and hosting drug take back days. SHDHD hosted a drug take back table at the Vital Signs Health Fair in Hastings and a community event on National Drug Take Back Day (April 28th).



180
pounds of
expired or
unused
medication
collected



Falls Prevention:

SHDHD coordinated 13 Beginning Tai Chi classes offered throughout the district in Fairfield, Clay Center, Superior, Nelson, Red Cloud, Hastings - Good Samaritan Village, Golden Friendship Center and Hastings YMCA. 74 participants began one of the 12-week evidence-based fall prevention classes and 45 (61%) finished the class with 90% demonstrating quantitative gains and/or maintenance of their pre-score for Timed Up and Go test (TUG), which measures their ability to rise from a chair, walk a certain distance and return. A TUG score of more than 14 seconds means an individual has a higher risk for falling.

SHDHD is also implementing the evidence-based 'Stepping On' program to offer older adults exercises, strategies and information to reduce falls. Stepping On classes were offered in Fairfield and Hastings, with 16 total participants and a 50% completion rate. 100% of the participants demonstrated quantitative gains and/or maintained their pre score for TUG. The beginning TUG average for all participants was 13.0 seconds and the final TUG average was 10.2 seconds.

Success Story:

Class participants are experiencing substantial improvements in TUG scores thereby reducing their risk of falls. One 'Stepping On' participant's TUG score was initially 24.4 seconds, but recorded a score of 15.9 seconds just 7 weeks into the class. A Tai Chi participant decreased their TUG score by 6.6 seconds in just 12-weeks.



Vet Set/Making Connections:

SHDHD participates in a state initiative to better connect our service men and women to local and regional services through community outreach and one-on-one interactions.

During 2018, SHDHD hosted a Military Family Fun Day at Timber Lake Ranch Camp – Marquette, NE, with 107 in attendance, engaging 21 families. The event allowed for families to network and collaborating agencies to connect with their target populations.

Throughout 2018, SHDHD strived to engage service men and women through social media posting, utilizing state and national campaigns, printed materials and radio marketing. With one staff member, a wife of an active service man, and a community health worker, SHDHD worked to understand service men and women's needs creating a warm and welcoming environment that invites all service men/women to be connected.



Connected with
575
Veterans/Service
men and
women/family
members

Emergency Preparedness

One important role of local public health is to prepare for and respond to local public health emergencies, including weather, disease, and bioterrorism related events. At the end of 2017, SHDHD collaborated with seven nursing homes to complete tabletop and full-scale exercises that met the needs of each entity. This allowed SHDHD to test plans for Closed Points of Dispensing (PODs), Strategic National Stockpile (SNS) ordering and distribution, and working with community partners in an Emergency Operations Center (EOC) in preparation for a full-scale exercise district wide.

In November of 2018, SHDHD planned and hosted a full-scale exercise with 30 volunteers from all four counties, SHDHD staff, and partner agencies, as well as news media. The exercise was a test of plans to request, receive and distribute vaccines during a pandemic influenza outbreak.

Success Story:

The SNS-requested vaccines were kept within the required temperature range during the 3 hour time period from pick up at the SNS Hub in Grand Island to distribution to partners within the district.



West Nile

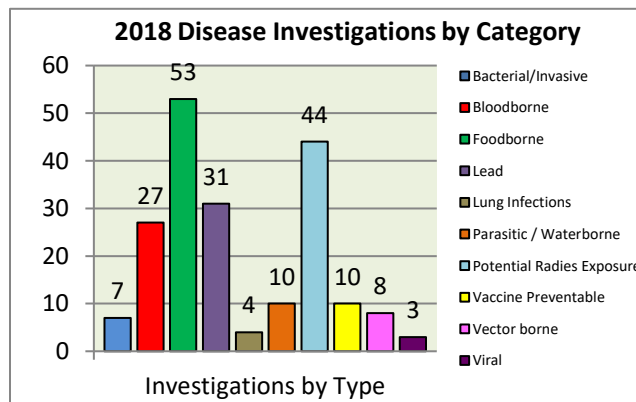
Nebraska experienced the 2nd worst year in history in 2018 with 242 cases and 11 deaths due to West Nile virus (WNV). South Heartland was fortunate to have fewer cases than average with only four. Mosquitoes trapped in Adams and Webster counties were positive for WNV in August 2018.



South Heartland continued to promote using insect repellent and encouraged residents to eliminate standing water. Through our website, Facebook, Twitter, press releases, health fairs, and other community events, we encouraged community members to **FIGHT THE BITE!!!**

Radon

Radon is a toxic radioactive gas that you cannot see, smell or taste. Natural decay of radium found in rocks and soils causes radon to be trapped in our homes. In 2018, 218 test kits were sold and 72.3% of South Heartland homes tested at or above the radon action level of 4.0 pCi/L. We hosted a community forum on radon featuring Mark Versch, an environmental health analyst at DHHS. We also promoted testing and provided education through radio and TV ads podcast, news releases, social media and community events. Jim Morgan, SHDHD's licensed radon testing specialist, assisted residents with questions on testing and mitigation.



Disease Surveillance

There are 106 different illnesses and conditions required by Nebraska statute to be reported to public health. SHDHD staff investigated 199 reports of 28 different types of illnesses in the district and tracked 317 reports of sexually transmitted diseases.



Disease investigation staff managed several outbreaks, including 2 influenza outbreaks in long term care facilities and 2 norovirus outbreaks. One long-term care facility reported 27 ill residents and 8 staff members experiencing illness. To assure expertise in our staff, surveillance coordinator Jessica Warner attended training on responding to highly infectious diseases (photo).

School Health Surveillance Program: 33 school buildings in our district reported illnesses weekly during the school year. These reports informed us about possible illness outbreaks at schools, including influenza. All three hospitals also provided reports of influenza-like illness (ILI) to us, which allowed us to monitor and inform the public of flu activity.

Nationally, over 300 food items were recalled by the FDA in 2018. Items that posed the greatest risk to South Heartland district residents were reposted on our Facebook page and shared during an interview with KSNB TV News.

SHDHD conducted 31 investigations for adults or children with elevated blood lead levels. We partnered with Ne DHHS to provide home lead assessments for children with blood lead levels above 10 µ/dl, which is the level that triggers investigation according to the State lead plan.



www.southheartlandhealth.org



Serving Adams, Clay, Nuckolls and Webster Counties

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Public Health
Prevent. Promote. Protect.