The South Heartland District Community Health Improvement Plan
2019 - 2024

A Four-County Plan for Public Health Partners and Stakeholders to Improve the Health of South Heartland Residents

Approved by the South Heartland District Board of Health
July 10, 2019

Michele Bever, PhD, MPH; SHDHD Executive Director
Nanette Shackelford; SHDHD Board of Health President

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Adams, Clay, Nuckolls and Webster Counties in Nebraska

Acknowledgements

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SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

July 2019

Dear South Heartland Community Partners and Residents,

I am excited to present to you the South Heartland Community Health Improvement Plan, 2019-2024. This six-year plan will guide our collective work addressing five identified health concerns in our health district of Adams, Clay, Nuckolls and Webster counties. In early 2018, we initiated a community-participatory public health assessment and improvement planning process called Mobilizing for Action through Planning and Partnerships (MAPP). We engaged residents, community service organizations, health care providers, mental health professionals, government officials, education professionals, business and civic leaders, and many other partners who contribute to the public health system in our four counties. These partners helped us to gather and review information about the health of our communities. These partners also helped us to make decisions about which issues to address and how best to address them. This resulting health improvement plan supports our shared purpose of connecting people and resources for strong and healthy communities.

*The **South Heartland Community Health Improvement Plan 2019–2024** has five health priority areas: Access to Health Care, Mental Health, Substance Misuse, Obesity and Related Health Conditions, and Cancer. With our many partners who participated in the assessment and planning, and others who have committed to providing leadership during the implementation phase, we seek to improve the health and quality of life of South Heartland residents by focusing collectively on these five priorities. We hope you will join us in our collaborative work to improve the health of our communities and that you will find a place in this plan where you can contribute to these efforts.*

Sincerely,

Michele M. Bever, PhD, MPH
Executive Director
South Heartland District Health Department

South Heartland 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.

South Heartland Vision

"Healthy People in Healthy Communities"

Public Health Core Functions and Essential Services

(1) Core Public Health Function: Assessment

Essential Service 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?

Essential Service 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?

(2) Core Public Health Function: Policy Development

Essential Service 3: **Give people the information they need to make healthy choices.**
How well do we keep all people and segments of our district informed about health issues?

Essential Service 4: **Engage the community to identify and solve health problems.**
How well do we really get people and organizations engaged in health issues?

Essential Service 5: **Develop policies and plans that support individual and community health efforts.**
What policies promote health in our district? How effective are we in planning and in setting health policies?

(3) Core Public Health Function: Assurance

Essential Service 6: **Enforce laws and regulations that protect health and ensure safety.**
When we enforce health regulations are we up-to-date, technically competent, fair and effective?

Essential Service 7: **Help people receive health services.**
Are people receiving the medical care they need?

Essential Service 8: **Maintain a competent public health workforce.**
Do we have a competent public health staff? How can we be sure that our staff stays current? How are we assisting our community and professional partners to stay current on public health interventions?

Essential Service 9: **Evaluate and improve programs and interventions.**
Are we doing any good? Are we doing things right? Are we doing the right things?

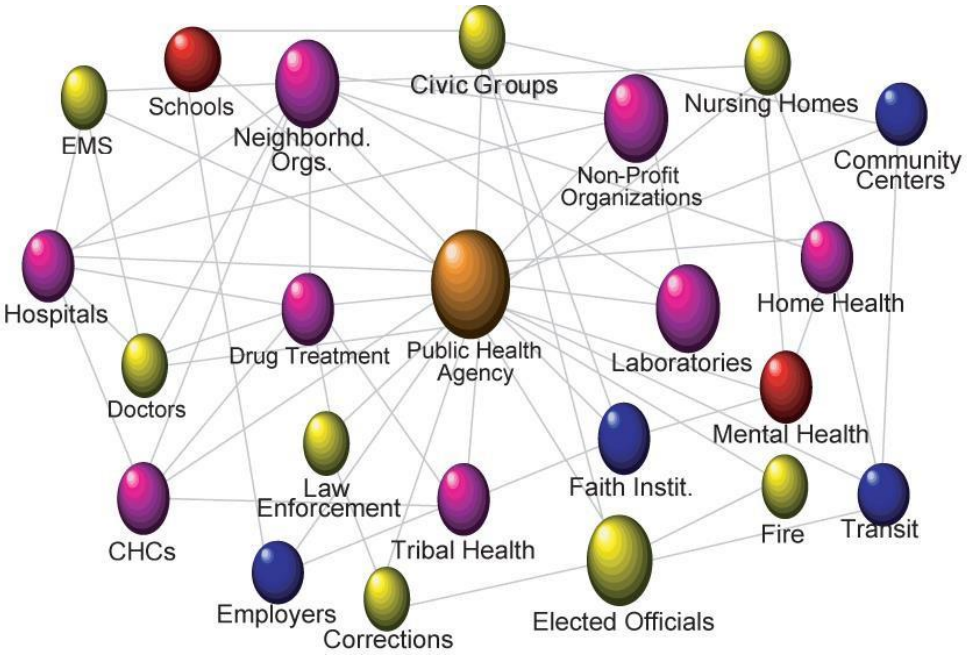
Essential Service 10: **Contribute to and apply the evidence base of public health.**
Are we discovering and using new ways to get the job done?

Assessment and Priority-Setting Process: A Brief Summary

South Heartland (SHDHD) conducted a regular comprehensive public health community health assessment (CHA) for and with residents of Adams, Clay, Nuckolls and Webster counties. The assessment and planning process is an important component of meeting the public health core functions and essential services, especially Essential Service 1: Monitor health status and understand health issues facing the community, Essential Service 4: Engage the community to identify and solve health problems, and Essential Service 5: Develop policies and plans that support individual and community health efforts.

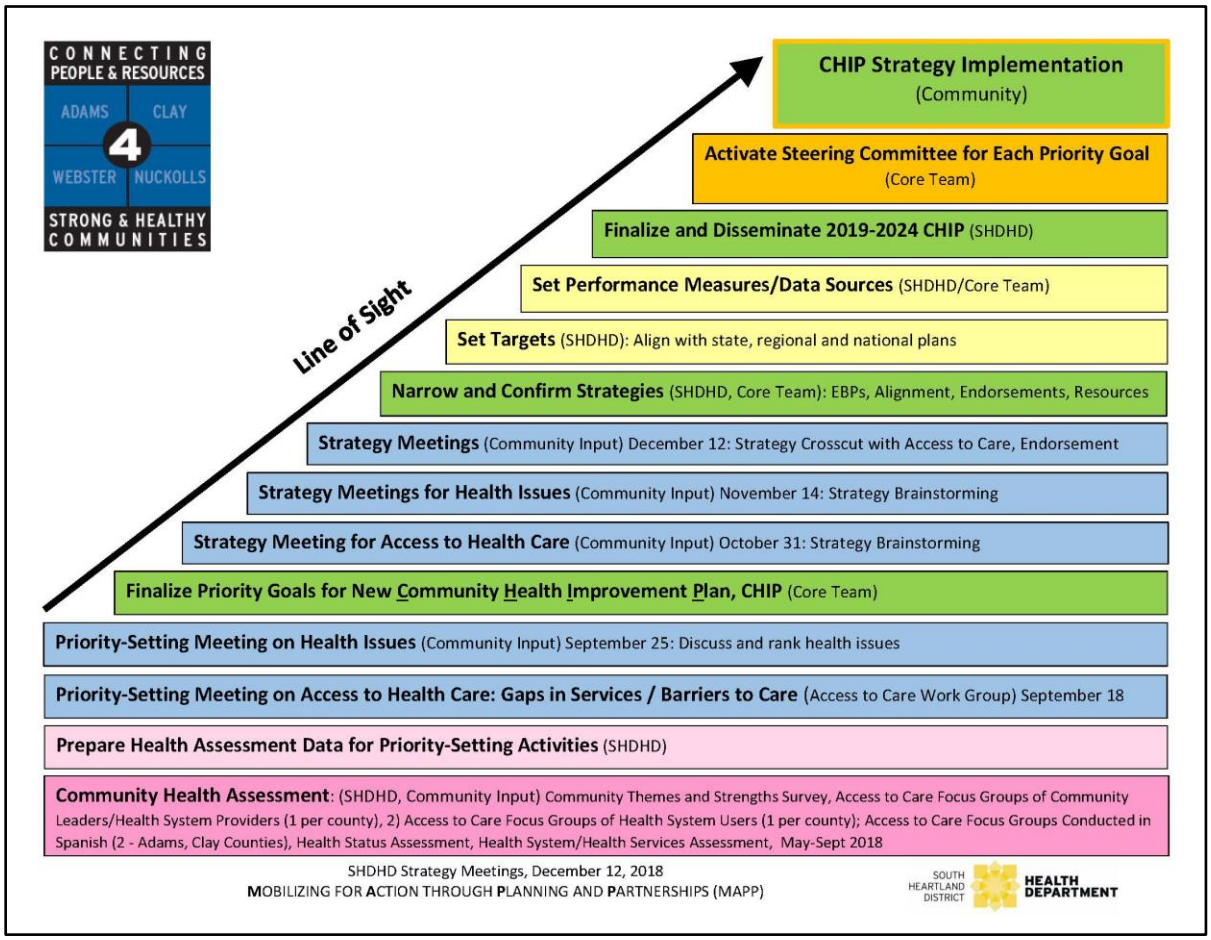
SHDHD used the Mobilizing for Action through Planning and Partnerships (MAPP) strategic approach that focuses efforts to improve health and quality of life through community-wide and community-driven strategic planning and leading to a community health improvement plan (CHIP). SHDHD's CHA/CHIP process is a continuous process of assessment, evaluation and planning, working with partners to carry out our plans and reevaluating our activities. We began the 2018 MAPP process by forming a core team to review/evaluate our past MAPP process, identify stakeholders, determine timelines and discuss resources to implement the process. Core team members represented all four counties, all three hospitals, the United Way of South Central Nebraska, mental healthcare stakeholders, and SHDHD staff and board of health – each entity or representative contributing time, staff, data and/or resources. Through the MAPP process, the South Heartland Health District continues to strengthen the local public health system. We define the local public health system as all of the entities that contribute to the delivery of public health services within our communities. This includes public and private entities, civic and faith-based organizations, individuals and informal associations, front-line and grassroots workers, and policy makers.

Figure 1. The local public health system consists of many entities that contribute in various positive ways to the health of the residents and the community as a whole. [CHC = Community Health Center]



We customized the 2018 process to meet our local needs, including 1) a health status assessment, 2) a community themes and strengths assessment (CTSA survey), and 3) a health system assessment (access to care and forces of change), which focused on identifying gaps in services, barriers to accessing care, and emerging healthcare needs. The health system assessment included data from the CTSA survey, a health system assets inventory, and focus groups conducted in each county for 1) health system users, and 2) health system providers/community leaders. The team also conducted two additional health system user focus groups in Spanish.

Figure 2. SHDHD 2018 Community Health Assessment and Improvement Planning Process – Line of Sight



Results from the assessments were presented to stakeholders in priority-setting meetings, one focused on the health system and one focused on health issues. Assessment results included specific information on ten health topics identified through CTSA as top concerns for the communities. Stakeholders also contributed to gap analysis on access to care (root causes, gaps in services and barriers in our local healthcare system) and how access to care impacted the various health issues.

For each health issue reviewed, the process included small and large group discussion, brief presentation and Q&A with experts, and a priority scoring activity. SHDHD staff weighted and analyzed the priority scoring by county and for South Heartland District overall. These results were reviewed and the top five priorities finalized by the core team for inclusion in the new Community Health Improvement Plan (see graphic of the 2019-2024 health priorities, below).

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

CONNECTING PEOPLE & RESOURCES
ADAMS CLAY 4 WEBSTER NUCKOLLS
STRONG & HEALTHY COMMUNITIES

Community Health Priorities 2019-2024

Access to Health Care

Goal 1: Access to Health Care

Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Goal 2: Mental Health

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

Goal 3: Substance Misuse

Reduce substance misuse/risky use to protect the health, safety and quality of life for all.

Goal 4: Obesity & Related Health Conditions

Reduce obesity and related health conditions through prevention and chronic disease management

Goal 5: Cancer

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

Health Improvement Planning Process

In October, November and December 2018, as a continuation of the MAPP process, SHDHD facilitated district-wide community conversations to identify key strategies for improving the priority areas identified through the 2018 community health assessment. A local trained facilitator (the community health assessment coordinator) and the SHDHD executive director led one meeting for Access to Care strategy setting and a series of two meetings for each health priority (Mental Health, Substance Misuse, Obesity and Related Health Conditions, and Cancer). Each meeting connected participants in all four counties via Go-To-Meeting technology, with SHDHD staff facilitating discussion, promoting active engagement at each site, and assuring input to the district-wide discussion.

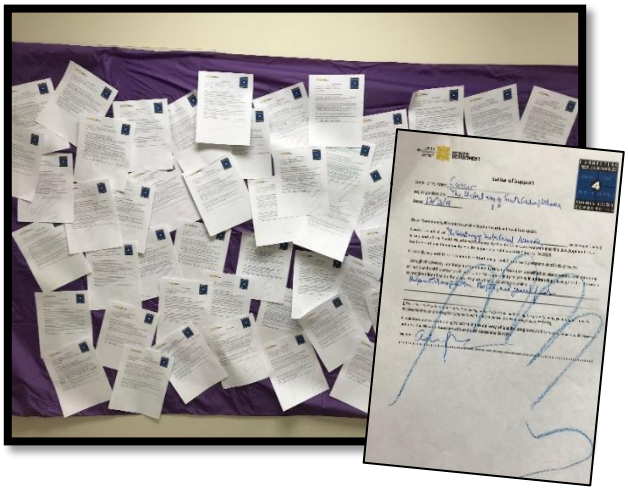
Strategy-setting meetings included a wide range of participants representing various sectors, including: hospitals, health care and behavioral health providers, Region 3 Behavioral Services, academic institutions, local schools, city/county government, fire and rescue, emergency management, law enforcement, judicial, long term care, child development, community not-for-profits, civic groups, local businesses, insurance, chamber of commerce, Area Health Education Centers (local and state), veterinary, and agriculture. Each priority "work group" consisted of 17 – 44 participants.

For each priority, stakeholders and community participants identified community partners working in the priority area, reviewed current local strategies addressing the priority area, and brainstormed additional evidence-based strategies for consideration. For new strategies, participants identified the implementation setting (e.g., schools, clinics, community) and intended recipients (e.g., students, patients).

SHDHD staff summarized these discussions and input by identifying overarching themes in the strategies (i.e., health system strategies, community-based or empowerment strategies, policy/system/environment strategies, and strategies focused on resources and information), then summarizing the broad types of strategies (e.g., screening/testing, referral, workforce training) in each theme. Staff also summarized the specific strategies or programs in each broad strategy (e.g., Whole School, Whole Community, Whole Child (WSCC) Model for improving student health, federally qualified health center satellite clinic for improving access to primary care, behavioral health and oral health services), along with the implementation setting and intended recipients for each proposed strategy.

At the second strategy meeting for each health priority, participants worked in small groups to review the summary of draft strategies from the first strategy meeting, providing feedback, clarifying strategies and suggesting additional strategies. Next, facilitators asked each participant to individually review the list of strategies and "endorse" the strategies they thought should be implemented in our communities, considering how the strategy addressed the priority and the identified expertise already existing in the community.

Facilitators invited participants to complete a letter of support for the CHA/CHIP process that outlined how their organization's goals or mission aligned with the priority area and ways their organization might contribute to implementation of the strategies. Participants could trace their hand on the letter – symbolizing that many hands working together can make a difference. Participants were also invited to indicate their interest in being considered for service on an Implementation Steering Committee and/or identify other key stakeholders to be considered for the Steering Committees.



Following the strategy meetings, SHDHD staff narrowed the field of strategies that would be included in the plan by reviewing all of the community stakeholder-identified strategies and participant endorsements, assessing the strategies to confirm matches with evidence-based or promising practices, and evaluating appropriate state and national plans for strategy alignment. Next, SHDHD staff developed specific goals, objectives, measures and key performance indicators for each strategy. SHDHD added the baseline data and six-year targets, data sources, and lead organizations for each strategy, then asked the new steering committee leads for each priority to review and provide input on the fully developed strategies for their priority. These vetted strategies and objectives for each priority are summarized on pages 12-13, with full priority information on pages 14-60, along with a list of data and resources for implementation (starting on page 61).

Community Health Improvement Plan Implementation

In 2019 and beyond, each Priority Area, determined by the Community Health Assessment process, will have a 10-15 member CHIP Implementation Steering Committee. An individual may participate in more than one Steering Committee. Members of the committees represent different sectors of the community, diverse stakeholders and key leaders/experts in the priority area.

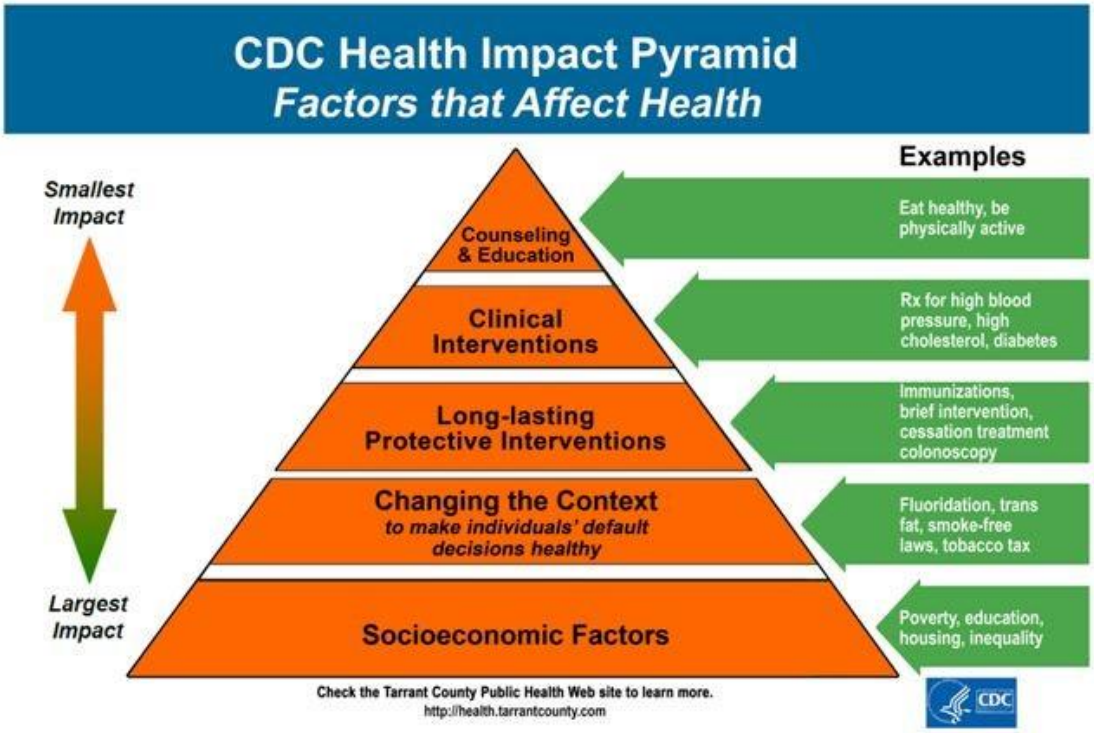
The Purpose of the Implementation Steering Committees is to:

- Provide oversight of the Community Health Improvement Plan by meeting bi-annually to review progress on community-based efforts related to specific strategies, for their respective priority area(s).
- Coordinate the transfer of data between organizations involved in community-based efforts related to specific strategies.
- Review Data collected, including outcomes data and key performance indicator data.
- Make recommendations for quality improvement and strategy adjustments.

One South Heartland District Health Department staff member will participate in each of the Implementation Steering Committees. South Heartland District Health Department will provide the meeting space for each Steering Committee to convene two times per year, as well as coordinate technology connections between participating counties. SHDHD will compile an annual CHIP report based on data collected and steering committee recommendations.

Community Health Improvement and the Health Impact Pyramid

Figure 3. The Health Impact Pyramid[1]



The five-tier pyramid is a conceptual framework for public health action.[2] Efforts to address socioeconomic determinants are at the base and can affect the health of the greatest number of people and make a big impact on issues that contribute to disparities. Examples of these determinants include poverty and education. Next are public health interventions that change the context for health (e.g., clean water, safe roads, elimination of lead exposures, and eliminating artificial *trans* fat in food). Next higher in the pyramid are one-time or infrequent protective interventions with long-term benefits (e.g., immunizations, colonoscopy, smoking cessation programs). Direct clinical interventions (e.g., blood pressure and cholesterol control medications) can be limited in their overall population impact due to lack of access and lack of adherence, among other factors. At the top of the pyramid are counseling and education efforts, which are designed to help individuals rather than an entire population. These approaches tend to be least effective and have limited public health impact due to their dependence on long-term individual behavior change, especially if there is no context or environment where healthy choices are the default actions. However, when applied consistently and repeatedly, educational interventions may be effective.

"Comprehensive public health programs should generally attempt to implement measures at each level of intervention to maximize synergy and likelihood of long-term success."
- Thomas R. Frieden, MD, MPH, Director, Centers for Disease Control and Prevention

[1] Social Determinants of Health, National Advisory Committee on Rural Health and Human Service Policy Brief, January 2017.
[2] Frieden, TR., 2010. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health. Vol.100 (No. 4): 590 – 595.

South Heartland Community Health Improvement Plan
Priority Goals, Strategies and Objectives
2019-2024

In the following pages, we present the five priority goals with results of the community strategy-planning process for each, including a process snapshot, line-of-sight performance measures and targets, the strategies and the six-year objectives. Key performance measures, data sources, evidence base, strategy implementation "settings" and lead organizations are included for each objective, along with considerations, examples, potential partners and other guidance for implementation.

Summary of all objectives by priority:

- **Priority Goal 1. Access to Care, 6-Year Objectives:**
    - **1a**: Expand access to primary care, oral health and behavioral health services by securing a satellite Federally Qualified Health Center (FQHC) in Hastings
    - **1b**: Improve access to substance misuse/behavioral health acute care services by assessing medically-assisted detox and related services
    - **1c**: Improve access to care by expanding transportation options
    - **1d**: Improve access through empowering people with knowledge to obtain and utilize insurance options
    - **1e**: Improve access through professional or lay workers trained in patient navigation, coaching and advocacy
    - **1f**: Improve access to care through adoption of evidence-based practices that strengthen communication and understanding of health information
    - **1g**: Improve access by increasing awareness and understanding of factors that contribute to disparities
    - **1h**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services
- **Priority Goal 2. Mental Health, 6-Year Objectives:**
    - **2a**: Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral
    - **2b**: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education
    - **2c**: Improve MH/SM services through advocacy initiatives and policy change
    - **2d**: Expand mental health services through adoption of evidence-based technology
    - **2e**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services

- **Priority Goal 3. Substance Misuse, 6-Year Objectives:**

    - **3a**: Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral
    - **3b**: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education
    - **3c**: Improve MH/SM services through advocacy initiatives and policy change
    - **3d**: Explore expansion of teen drug court program into Clay, Nuckolls and Webster Counties
    - **3e**: Reduce inappropriate access to prescription drugs through proper disposal of unused, expired medications and best practice prescribing protocols
    - **3f**: Expand and improve the Resource Guide to integrate and promote local substance misuse resources

- **Priority Goal 4. Obesity and Related Health Conditions, 6-Year Objectives:**

    - **4a**: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity or weight at their child or adolescent patient visits
    - **4b**: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity, weight or chronic disease management at their adult patient visits
    - **4c**: Increase the number of provider offices who utilize/promote electronic methods for patient-provider bidirectional communication about chronic disease prevention and management
    - **4d**: Increase the number of provider offices who utilize/promote electronic health records (EHR) for improving patient outcomes around chronic disease prevention and management
    - **4e**: Increase the proportion of children/adolescents and adults who meet current federal physical activity guidelines for aerobic physical activity and muscle strengthening physical activity
    - **4f**: Increase the proportion of children/adolescents and adults who meet current CDC nutrition recommendations for food and beverage consumption
    - **4g**: Increase the number of physical/environmental changes throughout the communities to make it easy to be physically active
    - **4h**: Improve the environment and culture that promote/support healthy food and beverage choices
    - **4i**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services

- **Priority Goal 5. Cancer, 6-Year Objectives:**

    - **5a**: Increase the proportion of patients assessed by providers and who are aware and counseled on their cancer risk factors
    - **5b**: Implement consistent messaging on cancer risk factors and empower individuals to make healthy choices
    - **5c**: Increase the number of individuals up to date on recommended cancer screenings
    - **5d**: Increase the access to cancer screening, diagnosis and treatment
    - **5e**: Conduct an investigation on types and prevalence of other cancers and associated risk factors in our communities
    - **5f**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services

Priority Goal: Access to Health Care

Goal 1: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Process Snapshot:

Assuring access to quality health care is an essential public health service. Through the 2018 community health assessment, South Heartland made a deliberate effort to evaluate gaps in services and barriers to accessing care. To address access to care concerns, the CHIP strategies, objectives and key performance indicators will address the barriers and gaps identified by health system users, community leaders and providers. Top identified barriers included cost, affordability, insurance/reimbursement, transportation and education/awareness. Top identified gaps included mental health practitioners, substance abuse prevention and treatment services, school-based health services, specialty services, emergency services and chronic disease management. These barriers and gaps are addressed through strategies that expand services, address transportation needs and insurance coverage, provide system navigation and support, promote evidence-based practices, address disparities, and connect people and organizations to resources and information.

Line of Sight Performance Measures and Targets

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.
Source- *BRFSS, 2016* (adults, >18 years)

- Increase the proportion of persons with a personal doctor or health care provider.
  Baseline: 83.5% (State 80.9%)
  Target: 84.0%
- Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.
  Baseline: 67.0% (State 64.1%)
  Target: 71.0%
- Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.
  Baseline: 13.9% (State 14.7%)
  Target: 13.0%
- Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.
  Baseline: 11.4% (State 12.1%)
  Target: 10.7%
- Increase the proportion of persons who report visiting a dentist for any reason in the past year.
  Baseline: 64.7% (State 68.7%)
  Target: 68.5%

Priority Area 1: Access to Health Care			
Strategy 1a: Access to health care through expanded services			
6 Year objective: Expand access to primary care, oral health and behavioral health services by securing a satellite Federally Qualified Health Center (FQHC) in Hastings			
What will be measured: • Services are available through a satellite FQHC in Hastings.	**Baseline/Target:** • 0 / 1 Satellite clinic	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Uninsured, Underinsured, and Vulnerable Populations	**Setting:** • FQHC	**Lead Organizations:** • Heartland Health Center • SHDHD • Mary Lanning Healthcare
Evidence Based: CHRR – FQHC, access regardless of ability to pay; Medical Homes		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Community partners provide data and resources to support the application process. • Initiate education to stakeholders for history and current progress toward a satellite FQHC in Hastings.	**Intermediate Term KPIs:** • Application submitted to HRSA for satellite access point. • Complete education to stakeholders for history and current progress toward a satellite FQHC in Hastings.	**Long Term KPIs:** • If funding secured, assure FQHC is operational within 120 days.	
Partners: Heartland Health Center (Grand Island), SHDHD, Mary Lanning Healthcare, Primary Care Providers, Lanning Center for Behavioral Services and other Behavioral Health Providers, South Central Behavioral Services (SCBS), Dental providers			

Priority Area 1: Access to Health Care			
Strategy 1b: Access to health care through expanded services			
6 Year objective: Improve access to substance misuse/behavioral health acute care services by assessing medically-assisted detox and related services			
What will be measured: • Completed assessment report with recommendations	**Baseline/Target:** N/A	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** N/A	**Setting:** • Healthcare System • Community	**Lead Organizations:** N/A
Evidence Based: CHRR – mobile applications for MH		**Lead workgroup:** Access to Care Steering Committee	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Establish a task force to assess availability of resources and services for acute substance use/behavioral health needs in Adams, Clay, Nuckolls and Webster counties.	• Report with recommendations based upon the assessment.	• Initiate action on task force recommendations.

Considerations: Patient population (adult, pediatric), regulations, costs, resources, staffing/workforce, location, training needs. Utilize/expand current MLH-based Mental Health/Substance Use Task Force
Partners: Hospital ERs, law enforcement/EMS, justice system, mental health providers/Lanning Center (outpatient behavioral health services), MLH (inpatient behavioral health services), South Central Behavioral Services, Mid-Plains Center (Grand Island, serving 23 counties), SHDHD, Region 3 Behavioral Services, DHHS Division of Behavioral Health

Priority Area 1: Access to Health Care			
Strategy 1c: Access to health care through transportation			
6 Year objective: Improve access to care by expanding transportation options			
What will be measured: • Availability of and gaps in reliable transportation (public and private)	**Baseline/Target:** TBD	**Data Source:** • CTSA • Local map/listing	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Residents requiring transportation assistance (physical, financial)	**Setting:** • Community	**Lead Organizations:** • United Way
Evidence Based: CHRR Rural Transportation Services		**Lead workgroup:** Access to Care Steering Committee	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Completed environmental scan of available transportation services in all four counties (hours of operation, schedule requirements, costs).	• Proposal for increasing transportation services with recommendations.	• Number of recommendations implemented to reduce gaps and increase availability.

Considerations: volunteer liability/safety of volunteer and patient, hours of operation, schedule requirements, number of vehicles/drivers, cost, voucher options, reimbursement (insurance, Medicaid, ACEs, other benefactors)

Priority Area 1: Access to Health Care			
Strategy 1d: Access to health care through insurance coverage			
6 Year objective: Improve access through empowering people with knowledge to obtain and utilize insurance options			
What will be measured: • The percentage of insured adults, ages 18-64	**Baseline/Target:** 84.9% / 90%	**Data Source:** • BRFSS (2017) **Target Setting Method:** 1% per year improvement	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Adults, ages 18-64+ • Uninsured, self-employed, fixed income	**Setting:** • Community/Service CBO • Provider office/hospital • Worksites	**Lead Organizations:** • MAAA • United Way • BMH • MLH
Evidence Based: HP2020/SDOH AHS-1.1; CHRR Health insurance enrollment outreach & support; MH benefits legislation; Ten Attributes of a Health Literate Organization #10		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Identify lead agency or workgroup to implement strategy. • Inventory of insurance education resources.	**Intermediate Term KPIs:** • Proposal for increasing insurance education resources or promoting current resources. • Develop tool for measuring effectiveness of interventions.	**Long Term KPIs:** • The number of recommendations implemented to assist people in obtaining and utilizing insurance. • Report on effectiveness of interventions.	
Considerations: focus on understanding and utilizing insurance (private/commercial, Medicare/Medicaid, expanded Medicaid, Medi-share/Healthshare, Tricare/Veterans, clinic memberships, fee for service, sliding-scale), worksite HR **Partners:** AARP, Medicaid Managed Care, MAAA, local insurance agents, insurance navigators (community/clinic/hospital)			

Priority Area 1: Access to Health Care			
Strategy 1e: Access to health care through system of navigation and support			
6 Year objective: Improve access through professional or lay workers trained in patient navigation, coaching and advocacy			
What will be measured: • Professional or lay workers trained in patient navigation, coaching and advocacy	**Baseline/Target:** TBD	**Data Source:** • SHDHD survey/inventory from CHW project	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Individuals at risk for poor health outcomes; vulnerable; those experiencing barriers	**Setting:** • Community • Healthcare	**Lead Organizations:** • SHDHD
Evidence Based: USPSTF, Community Guide – Chronic disease, behavioral health; CHRR – CHW engagement to expand access, Patient Navigators		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Create taskforce to lead an environmental scan of assistive workforce current status and emerging needs. • Inventory of community / organizational needs for trained professional and lay workers who navigate, coach, and/or advocate (assistive workforce). • Summary of current workforce serving in these roles.	**Intermediate Term KPIs**: • Gap analysis of training programs, curriculums, career pathways, competencies, and certifications for professional and lay workers who navigate, coach, and/or advocate (assistive workforce). • Recommendations for system/policy changes needed to identify, train, support and utilize this assistive workforce. • Develop ROI promotion for development of community-based and health system-based assistive workforce (see considerations, below).	**Long Term KPIs:**: • The number of recommendations implemented to identify, train, support and utilize this assistive workforce. • Implement ROI Promotion for development of community-based and health system-based assistive workforce.	
Examples: Community Health Workers - CHW (Promotora, Lay health ambassadors, Lay health workers), navigators, social workers, health coaches, chronic care managers, case managers, home visitation, and EMS expanded roles **Partners:** AHEC, CCC, Pathways Program, Hastings College, Providers, Employers, Community Based Organizations, PHAN Community Health Worker Section **Considerations:** Scopes of practice, core competencies, certifications, liability, curriculums, cost/return on investment, internships, community needs/system drivers, career development/career pathways, workforce development; ROI promotion (organizational productivity, efficiency, revenue; jobs/economic development; quality of care/access to care, and patient outcomes), CCC Project HELP (support education completion/guidance to healthcare jobs)			

Priority Area 1: Access to Health Care			
Strategy 1f: Access to health care through evidence-based practices			
6 Year objective: Improve access to care through adoption of evidence-based practices that strengthen communication and understanding of health information			
What will be measured: • Adoption of evidence based practices	**Baseline/Target:** TBD	**Data Source:** TBD • Options: Local survey, Self-report	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Patient population	**Setting:** • Healthcare (target audience: clinic staff and providers)	**Lead Organizations:** • BMH • MLH • SHDHD
Evidence Based: CHRR (Health Literacy, Telehealth, telehealth services, text message interventions, medical homes); USPSTF - HIT; HP2020 AHS-3		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Identify lead agency or workgroup to prepare a list with supporting rationale of evidence-based practices and protocols that strengthen communication, sharing and understanding of health information.	**Intermediate Term KPIs:** • Determine champions or expertise to educate and assist implementation of evidence based healthcare practices. • Create a toolkit of evidence based practices and protocols to include associated experts and champions (local/regional/state), and/or tools and training for implementation.	**Long Term KPIs:** • Marketing and promoting use of evidence based practices and protocols that strengthen communication, sharing and understanding of health information in healthcare settings. • Number of practices that adopt new policies as a result of the toolkit information.	
Examples: EHR use (dashboards and reports), portals, patient reminders, community based referrals, text message based health interventions, health literate practices, mobile phone apps, digital monitoring, telehealth, preventative care provided at each visit, patient follow up, bi-directional communication, patient understanding and uptake of technology, behavioral counseling/one-on-one education, medical homes **Considerations:** communications and information-sharing: within clinics and between providers (including beyond PCP), between CBOs and providers, between providers/clinic and patients; goal: strengthen compliance, empower patient for healthy choices/decision-making, improve health outcomes, patient and provider education on use and benefits, relationship of low health literacy to portal barriers and use			

Priority Area 1: Access to Health Care			
Strategy 1g: Access to health care through addressing disparities.			
6 Year objective: Improve access by increasing awareness and understanding of factors that contribute to disparities			
What will be measured: • Organizations / individuals implementing a policy change to address disparities	**Baseline/Target:** TBD	**Data Source:** • Local training database	**Timeframe:** by 2024
Continuum of Care: • Access	**Population:** • Vulnerable populations	**Setting:** • Community	**Lead Organizations:** • United Way
Evidence Based: CHRR - Cultural competence training and culturally adapted healthcare		**Lead workgroup:** Access to Care Steering Committee	
Short Term Key Performance Indicators (KPIs): • Training Plan: training/education and target audiences identified. • Disparities Toolkit – examples of training, action planning and evidence-based policies and protocols that reduce disparities for identified populations.	**Intermediate Term KPIs:** • Training Plan initiated • Policy Toolkit/Resources launched and marketed.	**Long Term KPIs:** • Number of organizations implementing a policy change to reduce disparities in an identified population.	
Considerations: Vulnerable populations/those experiencing disparities to include: those living in poverty; military service men/women, veterans, and their families; rural/Ag geographically isolated / self-insured; race/ethnicity/language; school settings, older adults **Awareness Trainings:** Bridges Out of Poverty; Military Cultural Competency; Culturally and Linguistically Appropriate Services (CLAS); Trauma-Informed Care; ACEs and 40 Developmental Assets; AgriMedicine; Ask the Question Campaign (for Veterans, military service men/women, & their families), Older adult needs/services, Social Determinants of Health (e.g., food insecurity, housing insecurity and resulting family stressors)			

Priority Area 1: Access to Health Care			
Strategy 1h: Connecting people/organizations through access to resources.			
6 Year objective: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** • General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs**:	**Long Term KPIs:**
• Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	• Promotion/education on the improved Resource Guide.	• Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.

Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource

Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce

"Bike Rack" Strategies

Access to Health Care "Bike Rack" Strategies are strategies identified through the CHA/CHIP process that have merit and may be included in future as additions or revisions of the Community Health Improvement Plan. These strategies also could be included in the strategic plans of individual organizations, as they are aligned with the CHIP Access to Health Care priority.

Access to Health Care through:

1. Schools
   - School-based Health Centers (EB: CHRR) [note – could be outreach of a federally-qualified health center]
   - Telemedicine [as an alternative/augmentation to school-based health centers for schools, school nurses and families]
2. Telemedicine/telehealth (EB: CHRR, deliver services remotely for patients with limited access to care)
3. Uptake and understanding of technology, e.g. intergenerational partnering, mentorship (EB: unknown)
4. System/Process that promotes consistent and collaborative health communications (SHDHD Strategic Plan) (EB: HP2020 HC/HIT-2)
5. Partnerships between CBOs, ACOs, etc. to improve patient outcomes (include in toolkit?)
6. Filling Gaps in Service: volunteer EMS (rural setting) – recruiting, retention, training

Abbreviations:
ACOs = Accountable Care Organizations
CBOs = Community-based Organizations
CHA = Community Health Assessment
CHIP = Community Health Improvement Plan
CHRR = County Health Rankings and Road Maps
EB = Evidence-based
EMS = Emergency Medical Services
HP2020 = Healthy People 2020

Priority Goal: Mental Health

Goal 2: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Process Snapshot:

In the Community Themes and Strengths survey, residents identified mental health as the second most troubling health issue in South Heartland communities. The health status assessment data supported this concern. For example, 28% of 9th-12th grade students in South Heartland indicated they were depressed in the past 12 months, 18.7% considered suicide and 13.2% attempted suicide. The Nebraska suicide rate for 10-24 year olds exceeds the national rates. Among South Heartland adults with mental illness, only 47% report receiving treatment and only 43% of adolescents reporting depression received treatment. Strategies, objectives and key performance indicators were developed to address this priority, utilizing broad strategic approaches that focus efforts on the health system, community-based prevention, resources, and policy/environmental changes. The specific strategies are applying evidence-based primary and secondary prevention in the provider and community settings, addressing mental health services through advocacy and policy efforts, expanding and promoting evidenced-based technology that supports access to quality mental health services, and by connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

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.
Source- *BRFSS, 2016* (adults, >18 years) / *YRBSS (Grades 9-12) SHDHD-2016, State-2017*

Youth

- Reduce the proportion of youth reporting feeling sad or hopeless almost every day for two weeks or more in a row causing abandonment of usual activities.
  Baseline: 27.9% (State 27.0%)
  Target: 26.2%
- Reduce reported suicide attempts by high school students during the past year.
  Baseline: 13.2% (State 8.0%)
  Target: 12.4%

Adults

- Reduce the proportion of adults who reported ever being diagnosed with depression
  Baseline: 20.5% (State 17.8%)
  Target: 19.3%
- Reduce the proportion of adults reporting frequent mental distress in the last 30 days
  Baseline: 9.2% (State 9.5%)
  Target: 8.7%

<table>
<tr><td colspan="4">Priority Area: Mental Health and Substance Misuse (MH/SM)</td></tr>
<tr><td colspan="4">Strategy 2a: Primary and secondary prevention in the provider and community settings</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral</td></tr>
<tr><td>What will be measured:
The number of individuals that are served by a system that utilizes EB practices for screening/assessment
The percent of individuals served by a system that are screened/assessed</td><td>Baseline/Target: TBD</td><td>Data Source:
TBD (provider survey)</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Primary Prevention
Secondary Prevention / Treatment</td><td>Population:
0-K
K-18
Adult / Pregnant
Older Adults</td><td>Setting:
Community (including schools)
Providers</td><td>Lead Organizations:
Hastings Public Schools (AWARE project)
Rural Network Partners</td></tr>
<tr><td colspan="2">Evidence Based: USPSTF - screening depression/ suicide; HP2020 – screen 12 & over (MHMD 4.1, 11.2 & 2); CHRR – MH primary care integration</td><td colspan="2">Accountability: Mental Health and Substance Misuse Steering Committees</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Environmental scan to identify screening practices (ages, frequency); tools in use; focus of tools; barriers to implementing screening/assessments; referral processes; referral resources.
Conduct gap analysis – populations not reached, orgs not screening that could, types of assessments that are/are not being utilized.</td><td>Intermediate Term KPIs:
Plan for increasing the number of organizations in all four counties that utilize evidence-based screening and/or assessment for facilitating referral (Plan includes recommendations for referral processes and resources needed to facilitate assessment/screening follow up).</td><td colspan="2">Long Term KPIs:
Number of (plan) actions implemented/completed.
Percent of stakeholders satisfied that appropriate referral resources are available to them.</td></tr>
<tr><td colspan="4">EB screening/assessment Tools: Ask the Question, ASQ-SE, ACEs, SBIRT, TPOT, PHQ-2, PHQ-9, SAEBRS, Gallup Hope and Engagement, Sixpence Child Care Partnership Program (CCP), Drug Testing, CES-D
Focus areas: depression/anxiety, social emotional, ATOD, tobacco/vaping, chemical dependency</td></tr>
</table>

Referral resources: smoking cessation, Love and Logic curriculum, Multi-Tier System of Support (MTSS), recovery programs (AA 12 Step, Smart Recovery), Medication Assisted Therapy, individual/group counseling services, PEARLS, Horizon Recovery, Striving Towards Attendance Realizing Success (STARS), Girls on the Run, Teammates, Mentoring Works, medical detox (and/or a peer intervention in lieu of med detox), treatment facility, emergency room, law enforcement, addiction clinics, Prime for Life
Considerations: Federally-qualified Health Center, detox facilities
Environmental scan targets - schools, colleges, MH and PC providers, and appropriate community-based organizations, emergency departments.

Priority Area: Mental Health and Substance Misuse (MH/SM)			
Strategy 2b: Primary and secondary prevention in the provider and community settings			
6 Year objective: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education			
What will be measured: • Number of individuals completing education/training	**Baseline/Target:** N/A	**Data Source:** • Training sign in sheets	**Timeframe:** by 2024
Continuum of Care: • Primary	**Population:** • Professional Workforce • Lay/Community	**Setting:** • Provider • Community	**Lead Organizations:** • ASAAP • SHDHD • ML MH
Evidence Based: USPSTF, Community Guide What Works – collaborative care management, case mgrs. CHRR – patient navigators, CHW		**Accountability:** Mental Health and Substance Misuse Steering Committee	
Short Term Key Performance Indicators (KPIs): • Completed MH/SM Training and Awareness Education Plan.	**Intermediate Term KPIs:** • MH/SM Training and Awareness Education Plan initiated.	**Long Term KPIs:** • Number of individuals completing training. • Number and types of training available.	
EB Training: Mental Health First Aid (MHFA), Question-Persuade-Refer (QPR) suicide prevention, Trauma-Informed Care/Adverse Childhood Experiences (ACES)/40 Developmental Assets, SBIRT, Medication-Assisted Treatment (MAT) **Awareness Education:** substance use disorders, signs and consequences of substance misuse and how to confront/intervene, military cultural competency, Drugs/Addiction 101 (ASAAP) **Resources:** VetSET/Making Connections funding to SHDHD, Hastings Public Schools AWARE Grant, Region 3 Behavioral Services, BHECN, Six Pence Grant, United Way **Target Audience Considerations:** parents, students, families/home, schools, community at large, EMS, worksites, caregivers, faith-based, healthcare settings (providers, intake staff, nurses, ER staff), veterans and military families, probation officers, judges **Other Considerations:** Coordination with training plan in Access to Care Strategy 1g (Access to Care through addressing disparities)			

Priority Area: Mental Health and Substance Misuse			
Strategy 2c: Mental health and substance use services through advocacy and policy			
6 Year objective: Improve MH/SM services through advocacy initiatives and policy change			
What will be measured: • Local coordinated behavioral health advocacy process	**Baseline/Target:** • No process / 1 process	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Policy/Systems	**Population:** N/A	**Setting:** • System • Community	**Lead Organizations:** • MLH • SCBS
Evidence Based: CHRR/USPSTF/Healthy People 2020 – MH benefits legislation, collaborative care		**Accountability:** Mental Health and Substance Misuse Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Organize a volunteer Behavioral Health Advocacy Group for the South Heartland District, SH-BHAG. • Determine guidelines for setting policy priorities, and ground rules for advocacy, including relationships with professional organizations and their lobbyists. • Create a list-serve for the Advocacy Group.	• SH-BHAG determines an annual "platform" of identified priorities for advocacy that support behavioral health – friendly policies and legislation. • Hold meetings at least annually with area state senators and other policymakers to discuss and promote behavioral health priorities. • Provide talking points for consistent messages around priorities.	• Functional and sustainable advocacy process.

Topic Considerations: Funding, reimbursement, insurance, insurance premium incentives (worksites), e-cig/ tobacco policies, school/worksite wellness policies, training requirements (hours required for license), gun access
Future expansion: tracking policy interventions or advocacy initiatives
Partners/Resources: Nebraska Association of Behavioral Health Organizations (NABHO), Region 3, NACO, Nebraska Hospital Association (NHA), local BH professionals, local government, local law enforcement

Priority Area: Mental Health			
Strategy 2d: Mental Health services through evidenced based technology			
6 Year objective: Expand mental health services through adoption of evidence-based technology			
What will be measured: • Adoption of evidence-based technology for mental health services	**Baseline/Target:** TBD	**Data Source:** • Initial survey • Follow up Survey Report	**Timeframe:** by 2024
Continuum of Care: • Access **Level of Action**: System	**Population:** • Rural population • Patients – all ages	**Setting:** • Healthcare • Community-based	**Lead Organizations:** • ML Clinics • Brodstone/Superior Family Medical Center • Webster County Clinic
Evidence Based: USPSTF, Community Guide What Works, CHRR – telemedicine, text services, apps, mobile health for MH medical homes, collaborative care		**Accountability:** Mental Health Steering Committee	

Short Term Key Performance Indicators (KPIs):
• Establish workgroup for Mental Health Technology Expansion.
• Completed survey of providers (health and mental health) to determine:
  ○ Preference/need for expanded telehealth for mental health services.
  ○ Barriers to telehealth for mental health services.
  ○ Barriers to patient portal use for communication between provider and patient regarding patient health information and sharing mental health educational resources.
	Intermediate Term KPIs:
	• Report with recommendations based upon the survey regarding expansion of evidence-based technology for mental health services.
		Long Term KPIs:
		• Number of recommendations implemented to expand evidence-based technology for mental health services.
		• Number of organizations utilizing telehealth and/or patient portals for mental health services.	

Considerations: Telehealth: mental health solutions for schools, ERs, community-based organizations; staff needed on site, secure/HIPAA connections, address privacy/stigma, **Patient Portals:** patient and provider education on use and benefits, relationship of low health literacy to portal barriers and use			

Priority Area: Mental Health			
Strategy 2e: Connecting people/organizations through access to resources.			
<u>6 Year objective:</u> Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide.	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	• Promotion/education on the improved Resource Guide.	• Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.

Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource

Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce

Priority Goal: Substance Misuse

Goal 3: Reduce substance misuse / risky use to protect the health, safety and quality of life for all.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified substance misuse as the third most troubling health issue in South Heartland communities. The South Heartland health status assessment showed that in the past 30 days 18% of adults used cigarettes and 15% reported binging drinking. For high school students, 11% reported using cigarettes, 15% used electronic vaper devices, 24% used alcohol, 11% used marijuana and 11% had misused or abused prescription drugs in the past 30 days. The societal costs of substance abuse in disease, premature death, lost productivity, theft and violence, including unwanted and unplanned sex, as well as the cost of interdiction, law enforcement, prosecution, incarceration, and probation are greater than the value of the sales of these addictive substances, costing over $135 billion (Substance Abuse: facing the Costs; Issue Brief Number 1 August 2001). Strategies, objectives and key performance indicators were developed to address this priority, utilizing strategies focused on the health system, community-based prevention initiatives, resources, and policy/environmental changes. Strategies will address substance misuse through primary and secondary prevention in the provider and community settings, advocating for substance use prevention and treatment services through policy and system changes, expanding diversion services, reducing inappropriate access to prescription drugs in community and provider settings, and by connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Based on standards set by Healthy People 2020, targets were set to achieve a 6% improvement over the next 6 years.

Source- *YRBSS (Grades 9-12) SHDHD-2016, State-2017, BRFSS, 2016* (adults, >18 years)

Youth:

- Decrease alcohol use, past 30 days among high school students.
  Baseline: 23.9% (24.4% State)
  Target: 22.5%
- Reduce marijuana use, past 30 days among high school students.
  Baseline: 11.3% (13.4% State)
  Target: 10.6%
- Decrease misuse or abuse, (lifetime) of prescription drugs among high school students.
  Baseline: 11.1% (14.3% State)
  Target: 10.4%
- Reduce cigarettes use, past 30 days among high school students.
  Baseline: 11.3% (10.7% State)
  Target: 10.6%
- Reduce electronic vapor product (e-cigarettes) use, past 30 days among high school students.
  Baseline: 15.4% (9.4% State)

Target: 14.5%

Adult:

- Reduce binge drinking among adults (18+), past 30 days.
  Baseline: 14.8% (20.0% State)
  Target: 13.9%
- Increase the percentage of current smokers who reportedly attempted to quit smoking in the past year.
  Baseline: 59.8% (54.6% State)
  Target: 56.3%
- Reduce current cigarette smoking among adults.
  Baseline: 18.0% (17.0% State)
  Target: 16.9%
- Reduce opioid prescription medication abuse, (adults reporting ever used outside of prescription guidelines).
  Baseline: TBD – new question BRFSS 2018
  Target: TBD

Priority Area: Mental Health and Substance Misuse (MH/SM)			
Strategy 3a: Primary and secondary prevention in the provider and community settings			
6 Year objective: Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral			
What will be measured: • The number of individuals that are served by a system that utilizes EB practices for screening/assessment • The percent of individuals served by a system that are screened/assessed	**Baseline/Target:** TBD	**Data Source:** • TBD (provider survey)	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention / Treatment	**Population:** • 0-K • K-18 • Adult / Pregnant • Older Adults	**Setting:** • Community (including schools) • Providers	**Lead Organizations:** • Hastings Public Schools (AWARE project) • Rural Network Partners
Evidence Based: CPSTF – screening/depression 12 & over/unhealthy alcohol use; HP2020 (MHMD 4.1, 11.2 & 2), electronic screening & brief intervention		**Accountability:** Mental Health and Substance Misuse Steering Committees	
Short Term Key Performance Indicators (KPIs): • Environmental scan to identify screening practices (ages, frequency); tools in use; focus of tools; barriers to implementing screening/assessments; referral processes; referral resources. • Conduct gap analysis – populations not reached, orgs not screening that could, types of assessments that are/are not being utilized.	**Intermediate Term KPIs:** • Plan for increasing the number of organizations in all four counties that utilize evidence-based screening and/or assessment for facilitating referral - Plan includes recommendations for referral processes and resources needed to facilitate assessment/screening follow up.	**Long Term KPIs:** • Number of plan actions implemented/completed. • Percent of stakeholders satisfied that appropriate referral resources are available to them.	
EB screening/assessment Tools: Ask the Question, ASQ-SE, ACEs, SBIRT, TPOT, PHQ-2, PHQ-9, SAEBRS, Gallup Hope and Engagement, Sixpence Child Care Partnership Program, Drug Testing, CES-D Focus areas: depression/anxiety, social emotional, ATOD, tobacco/vaping, chemical dependency **Referral resources:** smoking cessation, Love and Logic curriculum, Multi-Tier System of Support (MTSS), recovery programs (AA 12 Step, Smart Recovery), Medication Assisted Therapy, individual/group counseling services,			

PEARLS, Horizon Recovery, Striving Towards Attendance Realizing Success (STARS), Girls on the Run, Teammates, Mentoring Works, medical detox (and/or a peer intervention in lieu of med detox), treatment facility, emergency room, law enforcement, addiction clinics, Prime for Life, Challenging College Alcohol Abuse, Sport Map, Too Good for Drugs

Considerations: Federally-qualified Health Center, detox facilities.

Environmental scan targets: schools, colleges, mental health and primary care providers, and appropriate community-based organizations, emergency departments

Priority Area: Mental Health and Substance Misuse (MH/SM)			
Strategy 3b: Primary and secondary prevention in the provider and community settings			
6 Year objective: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education			
What will be measured: • Number of individuals completing education/training	**Baseline/Target:** TBD	**Data Source:** • Training sign in sheets	**Timeframe:** by 2024
Continuum of Care: • Primary	**Population:** • Professional Workforce • Lay/Community	**Setting:** • Provider • Community	**Lead Organizations:** • ASAAP • SHDHD • ML MH
Evidence Based: USPSTF, Community Guide What Works – collaborative care management, case mgrs.; CHRR - Cultural competence training and culturally adapted healthcare, patient navigators, CHW		**Accountability:** Mental Health and Substance Misuse Steering Committees	
Short Term Key Performance Indicators (KPIs): • Completed MH/SM Training and Awareness Education Plan.	**Intermediate Term KPIs:** • MH/SM Training and Awareness Education Plan initiated.	**Long Term KPIs:** • Number of individuals completing training. • Number and types of training offered.	
EB Training: Mental Health First Aid (MHFA), Question-Persuade-Refer (QPR) suicide prevention, Trauma-Informed Care/Adverse Childhood Experiences (ACES)/40 Developmental Assets, SBIRT, Medication-Assisted Treatment (MAT) **Awareness Education:** substance use disorders, signs and consequences of substance misuse and how to confront/intervene, military cultural competency, Drugs/Addiction 101 (ASAAP) **Resources:** VetSET/Making Connections funding to SHDHD, Hastings Public Schools AWARE Grant, Region 3 Behavioral Services, BHECN, Six Pence Grant? United Way? **Target Audience Considerations:** parents, students, families/home, schools, community at large, EMS, worksites, caregivers, faith-based, healthcare settings (providers, intake staff, nurses, ER staff), veterans and military families, probation officers, judges **Other Considerations:** Coordination with training plan in Access to Care Strategy 1g (Access to Care through addressing disparities)			

Priority Area: Mental Health and Substance Misuse (MH/SM)			
Strategy 3c: Mental health and substance use services through advocacy and policy			
6 Year objective: Improve MH/SM services through advocacy initiatives and policy change			
What will be measured: • Local coordinated behavioral health advocacy process	**Baseline/Target:** • No process / 1 process	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Policy/Systems	**Population:** N/A	**Setting:** • System • Community	**Lead Organizations:** • MLH • SCBS
Evidence Based: CHRR/USPSTF/Healthy People 2020 – MH benefits legislation, collaborative care		**Accountability:** Mental Health and Substance Misuse Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Organize a volunteer Behavioral Health Advocacy Group for the South Heartland District. (SH-BHAG) • Determine guidelines for setting policy priorities, and ground rules for advocacy, including relationships with professional organizations and their lobbyists. • Create a list-serve for the Advocacy Group.	• SH-BHAG determines an annual "platform" of identified priorities for advocacy that support behavioral health – friendly policies and legislation. • Hold meetings at least annually with area state senators and other policymakers to discuss and promote behavioral health priorities. • Provide talking points for consistent messages around priorities.	• Functional and sustainable advocacy process.

Topic Considerations: Funding, reimbursement, insurance, insurance premium incentives (worksites), e-cig/ tobacco policies, school and worksite wellness policies, training requirements (hours required for license), gun access
Future expansion: tracking policy interventions or advocacy initiatives
Partners/Resources: Nebraska Association of Behavioral Health Organizations (NABHO), Region 3, NACO, Nebraska Hospital Association, local behavioral health professionals, local government, local law enforcement

<table>
<tr><td colspan="4">Priority Area: Substance Misuse</td></tr>
<tr><td colspan="4">Strategy 3d: Tertiary prevention through diversion services</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Explore expansion of teen drug court program into Clay, Nuckolls and Webster Counties</td></tr>
<tr><td>What will be measured:
Completed assessment and feasibility reports with recommendations</td><td>Baseline/Target:
0 / 1 Report with Recommendations</td><td>Data Source: N/A</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Tertiary Prevention
Level of Action: Policy, System</td><td>Population:
Youth, age 14–19</td><td>Setting:
Community/Judicial</td><td>Lead Organizations:
Adams County Attorney
CASA</td></tr>
<tr><td colspan="2">Evidence Based: Currently Adams County only - reduced juvenile court case load; CHRR – Drug Courts (also included for community safety)</td><td colspan="2">Accountability: Substance Misuse Steering Committee</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Teen Court Expansion Task Force identified (to include CASA, county attorney offices, and schools).
Assessment of needs for Teen Court in each county from the perspectives of county attorney, CASA and schools.</td><td>Intermediate Term KPIs:
Feasibility study for counties that demonstrate need (costs, funding, personnel).
Report with recommendations based upon the assessment and feasibility study.</td><td colspan="2">Long Term KPIs:
Initiate action on task force recommendations.</td></tr>
<tr><td colspan="4">Partners: CASA, County attorney offices, law enforcement, service providers, schools, courts</td></tr>
</table>

Priority Area: Substance Misuse			
Strategy 3e: Primary prevention through reduction of inappropriate access to prescription drugs in community and provider settings			
6 Year objective: Reduce inappropriate access to prescription drugs through proper disposal of unused, expired medications and best practice prescribing protocols			
What will be measured: • Prescription drug take back opportunities • Adoption of model pain management policies in healthcare settings	**Baseline/Target:** • Baseline: Number of opportunities by county for prescription drug disposal A: 6 pharmacy, 3 annual C: 1 pharmacy, 1 sheriff N: 2 pharmacy, ~1 annual W: 3 pharmacy, 1 sheriff Target: Fill at least one gap/county • Number of healthcare settings with non-prescription pain management policies (TBD/unknown)	**Data Source:** • SHDHD local data • Local Clinic/hospital survey	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • SHDHD District	**Setting:** • Community/Home • Healthcare (ERs, provider offices, hospitals)	**Lead Organizations:** • Brodstone Memorial Hospital & Mary Lanning Healthcare (non-prescription pain mgmt) • Keith's Pharmacy (pharmacy take back) • SHDHD, HPD, WCSO, ASAAP (community take back) • ASAAP / SHDHD – Communication Plan
Evidence Based: FDA, USDOJ – Diversion Control Division, CDC Guidelines adherence to EB prescribing practices/inform local policy changes; CHRR – proper drug disposal programs		**Lead workgroup:** Substance Misuse Steering Committee	
Short Term Key Performance Indicators (KPIs): • Inventory of current policies/practices for pain	**Intermediate Term KPIs:** • Model policies identified for non-prescription pain management.	**Long Term KPIs:** • Fill at least one gap per county in drug take back opportunities. • Number/percent of healthcare providers that have adopted	

management in healthcare settings. • Identified gaps (locations/timing) for ongoing / widespread drug takeback programs in pharmacies and community. • Communication Plan for collaborative messages on appropriate drug disposal and pain management.	• Model policies promoted in healthcare settings • Plan for expanding drug take back opportunities. • Communication plan implemented and monitored.	model policies for non-prescription pain management.
Partners: community pharmacies, local law enforcement, hospitals, provider offices, ASAAP, SCBS, Region 3, DHHS Division of Behavioral Health, community prevention partners **Considerations:** Drug drop-off kiosks, storage and disposal costs, 2018 NE laws for opioid prescription restrictions for youth and addiction training for providers, pharmacy takeback program limitations, DisposeRx		

Priority Area: Substance Misuse			
Strategy 3f: Connecting people/organizations through access to resources			
6 Year objective: Expand and improve the Resource Guide to integrate and promote local substance misuse resources			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** TBD	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** N/A	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR - CHRR – (promote) shared decision making in patient centered care and medical homes		**Accountability:** Access to Care Steering Committee	

Short Term Key Performance Indicators (KPIs): • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	**Intermediate Term KPIs:** • Promotion/education on the improved Resource Guide.	**Long Term KPIs:** • Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report

Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource

Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce

Priority Goal: Obesity

Goal 4: Reduce obesity and related health conditions through prevention and chronic disease management.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified obesity as the top most troubling health issue in South Heartland communities. Nationally, $1.42 trillion can be attributed to the total costs associated with obesity (Milken Institutes, Weighing America Down, The Health and Economic Impact of Obesity, November 2016). SHDHD's health status assessment demonstrated that 32.5% of youth grades 9-12 are overweight or obese (BMI ≥ 21, YRBS, 2016), while 70% of adults 18 years+ are overweight or obese (BMI ≥ 25, BRFSS, 2016). In addition, community members are concerned about obesity-associated chronic diseases such as heart disease, which is the leading cause of death in South Heartland adults, and diabetes. Stakeholder discussion during strategy meetings highlighted a shared desire to intervene using primary prevention, especially focused on young children. Strategies, objectives and key performance indicators were developed to address this priority by focusing on the health system, community-based prevention, access to resources and information, and policy and environmental changes. Identified strategies include primary and secondary prevention in clinic settings, evidence-based health/wellness programs to increase physical activity and healthy food and beverage consumption in schools and communities, primary prevention (environmental changes) in community settings to support active living and healthy food and beverage consumption, and connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

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.
Source- *BRFSS, 2016* (adults, >18 years) / *YRBSS (Grades 9-12) SHDHD-2016, State-2017*

- Reduce overweight / obesity among high school students
  Baseline: Overweight / Obese youth: 32.5% (State, 31.2%)
  Targets: Overweight or Obese 30.55%
- Decrease overweight or obesity among adults, 18 years+ (BMI > 25.0)
  Baseline: 70.0% (State, 68.5%)
  Target: 65.8%
- Decrease diabetes in adults
  Baseline: 10.6% (State, 8.8%)
  Target: 9.0%
- Decrease high blood pressure (hypertension) in adults
  Baseline: 34.6% (State, 29.9%)
  Target: 32.5%
- Decrease heart disease in adults
  Baseline: 5.8% (State, 3.8%)
  Target: 5.4%

Priority Area 4: Obesity and Related Conditions			
Strategy 4a: Primary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity or weight at their child or adolescent patient visits			
What will be measured: • The number of primary care physicians who regularly assess body mass index (BMI) for age and sex in their child or adolescent patients • The proportion of visits made by all child or adolescent patients that include counseling about nutrition or diet or physical activity	**Baseline/Target:** TBD	**Data Source:** • Primary data collected from local provider offices	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • Child or adolescent patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Healthcare (Primary Care Providers)
Evidence Based: Healthy People 2020 - NWS 5.2 & 6.3; PA 11.2		**Accountability:** Obesity Steering Committee	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Determine the number of providers with knowledge, attitudes and beliefs supporting obesity interventions.	• Increase the number of providers with knowledge, attitudes and beliefs that support obesity intervention. • Increase the number of providers with policies/protocols for child or adolescent obesity interventions.	• Number of child or adolescent patients who have access to providers with policies/protocols for obesity intervention.

Priority Area 4: Obesity and Related Conditions			
Strategy 4b: Primary and secondary prevention in the clinic setting			
6 Year objective: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity, weight or chronic disease management at their adult patient visits			
What will be measured: • The number of primary care physicians who regularly assess body mass index (BMI) for age and sex in their adult patients • The proportion of physician visits made by all adult patients that include counseling about nutrition, physical activity, weight and/or chronic disease management.	**Baseline/Target:** TBD	**Data Source:** • Primary data collected from provider offices locally	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention	**Population:** • Adult patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Healthcare (Primary Care Providers)
Evidence Based: USPSTF, Healthy People 2020 – NWS 5.1 and 6.1, 6.2, 6.3; D16; PA 11.1		**Accountability:** Obesity Steering Committee	
Short Term Key Performance Indicators (KPIs): • Determine the number of providers with knowledge, attitudes and beliefs supporting obesity interventions. • Determine the number of providers who refer to community based programs for chronic disease prevention or management. • Determine the number of providers utilizing chronic care management.	**Intermediate Term KPIs:** • Increase the number of providers with knowledge, attitudes and beliefs that support obesity intervention. • Increase the number of providers who refer to community based programs for chronic disease prevention or management. • Increase the number of providers utilizing chronic care management.	**Long Term KPIs:** • Number of adult patients who have access to providers with policies/protocols for obesity intervention. • Number of patients enrolled in community based programs for chronic disease prevention or management. • Number of patients enrolled in chronic care management. (and/or the number of patients completing 1 year).	
Examples of evidence based Lifestyle Change Programs to build/expand/promote: Smart Moves-National Diabetes Prevention Program, Living Well, Health Coaching/Chronic Disease Management, YMCA Blood Pressure Self Monitored Program, obesity interventions (cooking classes/culinary art program partnership), etc.			

Priority Area 4: Obesity and Related Conditions			
Strategy 4c: Primary and secondary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the number of provider offices who utilize/promote electronic methods for patient-provider bidirectional communication about chronic disease prevention and management			
What will be measured: • Number of patients who utilize electronic methods for provider communication about chronic disease prevention and management	**Baseline/Target:** TBD	**Data Source:** • Primary Data Collected from Provider offices locally	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention	**Population:** • Adults patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Clinics • Brodstone/Superior Family Med. • Webster County Clinic
Evidence Based: The community guide- what works, health communication and health information technology (CPSTF) – reduce/maintain weight loss, PA-11.1		**Accountability:** Access to Care and Obesity Steering Committees	
Short Term Key Performance Indicators (KPIs): • The number of practices that utilize any method of electronic communications with their patients.	**Intermediate Term KPIs:** • Increase the number of practices that utilize any method of electronic communications with their patients.	**Long Term KPIs:** • The number of practices that utilize any method of electronic communications with their patients. • The number of patients who have access to any method of electronic communications with their provider.	
Examples: Medication adherence, outpatient follow-up, and adherence to self-management goals. "mHealth" interventions use mobile-phones, smartphones, or other hand-held devices to deliver content. Interventions must include one or more of the following: text-messages that provide information/encouragement for treatment adherence; text-message reminders for medications, appointments, or treatment goals; web-based content that can be viewed on mobile devices; or applications (apps) developed or selected for the intervention with goal-setting, reminder functions, or both. Interventions also may include an interactive component, mobile communication or direct contact with a healthcare provider, or web-based content to supplement text-message interventions **Considerations:** Relationship of low health literacy to portal barriers and use			

Priority Area 4: Obesity and Related Conditions			
Strategy 4d: Primary and secondary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the number of provider offices who utilize/promote electronic health records (EHR) for improving patient outcomes around chronic disease prevention and management			
What will be measured: • The number of patients who have access to health systems utilizing EHR functions for chronic disease prevention and management	**Baseline/Target:** TBD	**Data Source:** • Primary Data Collected from Provider offices locally	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention	**Population:** • Adults patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Clinics • Brodstone/Superior Family Med. • Webster County Clinic
Evidence Based: Community Guide – Health IT: CVD digital intervention self-monitor BP, Diabetes Apps for self-management, text med adherence PA-10		**Accountability:** Access to Care and Obesity Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• The number of practices that utilize EHR functions for their patients around chronic disease prevention and management.	• Increase the number of practices that utilize EHR functions for their patients around chronic disease prevention and management. • Increase number of practices with policies/protocols/ processes in place that utilize EHR functions for their patients around chronic disease prevention and management.	• The number of practices that utilize EHR functions for their patients around chronic disease prevention and management. • The number of practices with policies/protocols/ processes in place that utilize EHR functions for their patients around chronic disease prevention and management.

Examples: Diabetes Protocol, Pre-diabetes Protocol, Hypertension Protocol, Team review of dashboard data, BMI/Weight/Nutrition/Physical Activity Protocols, Cardio Vascular/Stroke Protocol
Considerations: Relationship of low health literacy to portal barriers and use

<table>
<tr><td colspan="4">Priority Area 4: Obesity and Related Conditions</td></tr>
<tr><td colspan="4">Strategy 4e: Evidence based health/wellness programs to increase physical activity in schools & communities</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the proportion of children/adolescents and adults who meet current federal physical activity guidelines for aerobic physical activity and muscle strengthening physical activity</td></tr>
<tr><td>What will be measured:
% of 9th-12th graders who are physically active at least 5 days/week for at least 60 minutes
% of 9th-12th graders who are met the muscle strengthening recommendation of at least 3 days/week
% of adults that met aerobic physical activity recommendations
% of adults that met muscle strengthening recommendations</td><td>Baseline/Target:
51.8% / 57%
53.4% / 59%
46.1% / 51%
20.9% / 23%</td><td>Data Source:
YRBSS
BFRSS
Target Setting Method:
10% improvement Health People 2020 Goals</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Primary Prevention</td><td>Population:
2-18 years old
Families
Adults</td><td>Setting:
Schools/Daycares
Communities
Faith Based
Worksites</td><td>Lead Implementation Organizations:
YMCA
YWCA
Schools/Daycares
Faith Based
HeadStart
UNL Extension
United Way</td></tr>
<tr><td colspan="2">Evidence Based: HP2020 – PA 1-7, Community Guide – Worksite Programs, built environment interventions, PA Community-Wide Interventions, Health IT (activity monitors); CHRR – community based social supports for PA, places for PA, school based physical education enhancements, worksite obesity prevention interventions</td><td colspan="2">Accountability: Obesity Steering Committees</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Number of schools or organizations that have policies supporting physical activity.
The number of 2-18 year olds served by organizations that</td><td>Intermediate Term KPIs:
Increase the number of schools or organizations that have policies supporting physical activity.
Increase the number of 2-18 year olds served by</td><td colspan="2">Long Term KPIs:
% of the total district population of 2-18 year olds who have access to schools or organizations that support physical activity through policy or programs.
The number of 2-18 year olds served by organizations that have policies supporting physical activity.</td></tr>
</table>

have policies/programs supporting physical activity guidelines. • The number of adults served by organizations that have policies/programs supporting physical activity guidelines.	organizations that have policies/programs supporting physical activity guidelines. • Increase the number of adults served by organizations that have policies/programs supporting physical activity guidelines.	• The number of adults served by organizations that have policies supporting physical activity.
Examples: walking meetings, PA breaks, before/after school PA programs, walking/stairs promotions; social supports, worksite wellness programs, worksite insurance incentives, etc. **Considerations:** Expand the data collection to include children preschool-8th grade For adults start with worksites, youth start with schools		

Priority Area 4: Obesity and Related Conditions			
Strategy 4f: Evidence based health/wellness programs to increase healthy food and beverage consumption in schools and communities			
6 Year objective: Increase the proportion of children/adolescents and adults who meet current CDC nutrition recommendations for food and beverage consumption			
What will be measured: • Median times per day an adult consumed vegetables • Median times per day an adult consumed fruits • % of students 9-12th grades who consumed green salad at least one time week • % of students 9-12th grades who did not drink soda or pop during the past 7 days (**not** including diet soda or diet pop)	**Baseline:** YRBS 2017 BRFSS • 1.67 per day / 1.77 per day • 1.02 per day / 1.08 per day • 61% / 65% • 26.2% / 28%	**Data Source:** • YRBSS • BFRSS **Target Setting Method:** • 1% per year	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • 0-18 years old • Families • Adults	**Setting:** • Schools/Daycares • Communities • Faith Based • Worksites	**Lead Organizations:** • YMCA • YWCA • Schools/Daycares • Faith Based • Head Start • UNL Extension • United Way
Evidence Based: HP2020 - NWS-2-4, 7, 12-17 Community Guide – Meal, fruit/vegetable snack interventions to increase healthier foods/beverages in schools (and sold or offered as rewards in schools); worksite programs. CHRR – School nutrition standards, school food & beverage restrictions		**Accountability:** Obesity Steering Committees	
Short Term Key Performance Indicators (KPIs): • Number of schools or organizations that have policies supporting healthy food and beverage consumption.	**Intermediate Term KPIs:** • Increase the number of schools or organizations that have policies supporting healthy food and beverage consumption. • Increase the number of 0-18 year olds served by	**Long Term KPIs:** • % of the total district population of 0-18 year olds who have access to schools or organizations that support healthy food and beverage consumption. • Increase the number of 0-18 year olds served by organizations that	

• The number of 0-18 year olds served by organizations that have policies/program supporting healthy food and beverage consumption.	organizations that have policies/program supporting healthy food and beverage consumption.	have policies/programs supporting healthy food and beverage consumption.
Examples of Education: before/after school nutrition programs (CATCH kids), cooking classes-adult or youth (4H); wellness policies, grocery stores with healthy free food/food choices, healthy meeting policies, worksite wellness programs (insurance incentives, healthy vending initiative), etc.		

<table>
<tr><td colspan="4">Priority Area 4: Obesity and Other Related Conditions</td></tr>
<tr><td colspan="4">Strategy 4g: Primary Prevention in the Community Setting</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the number of physical/environmental changes throughout the communities to make it easy to be physically active</td></tr>
<tr><td>What will be measured:
Number of communities that have access to physical activity opportunities due to physical/environmental changes</td><td>Baseline/Target:
0 changes /24 changes</td><td>Data Source:
Local Environmental Scan
Target Setting Method: From 1422 Chronic Disease Prevention program 16 changes were made from 2015-2018</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Primary Prevention / rehab</td><td>Population:
General population</td><td>Setting:
Communities
Organizations
Worksites</td><td>Lead Organizations:
Healthy Hastings
Superior Design Team
Sutton Design Team
School Wellness Teams</td></tr>
<tr><td colspan="2">Evidence Based: HP 2020 – PA 15; Community Guide - built environment interventions</td><td colspan="2">Lead workgroup: Obesity Steering Committees</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Plan that will promote physical/environmental changes to improve access to physical activity in all four counties.</td><td>Intermediate Term KPIs:
Targeted community/stakeholder education on impact of the built environment on physical activity.
Model policies resource list.</td><td colspan="2">Long Term KPIs:
Number of physical/environmental changes for physical activity.</td></tr>
<tr><td colspan="4">Examples: complete streets policies, wayfinding signage, bike/walking paths, parks/green space, community centers, joint use agreements, community pools, social supports (walking groups), etc.</td></tr>
</table>

Priority Area 4: Obesity and Other Related Conditions			
Strategy 4h: Primary Prevention in the Community Setting			
<u>6 Year objective</u>: Improve the environment and culture that promote/support healthy food and beverage choices			
What will be measured: • Number of communities that have access to healthy food and beverages choices due to new policy or environmental changes	**Baseline/Target:** TBD	**Data Source:** • Local Environmental Scan	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • General Population	**Setting:** • Communities • Organizations • Worksites	**Lead Organizations:** • SHDHD Nutrition Advisory Board
Evidence Based: Healthy People 2020 (NWS-4, SDOH/NWS-13)		**Lead workgroup:** Obesity Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Plan for increasing the number of organizations in all four counties that have environmental or policies that support healthy food and beverage choices.	• Targeted community/stakeholder education on impact of food policies and food environment on healthy food and beverage choices. • Model policies resource list.	• Number of environmental and policy changes supporting healthy food and beverages choices.

Examples: Policies at school/cafeterias promoting healthy eating, worksites improving their vending, grocery stores offering free fresh fruit/healthy food choices, expand Community Gardens and Farmer's Markets/Double Up Food Bucks Program, low income choices (food pantry options and culture - vouchers for fruits and vegetables, healthy recipes), etc.

Priority Area 4: Obesity and Other Related Conditions			
Strategy 4i: Connecting people/organizations through access to resources			
<u>6 Year objective</u>: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** • General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	• Promotion/education on the improved Resource Guide.	• Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.

Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource

Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce

Priority Goal: Cancer

Goal 5: Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified cancer as the fourth most troubling health issue in South Heartland communities. Cancers are the second leading cause of death in the health district (five-year period, 2012-2016). Estimates suggest that less than 30% of a person's lifetime risk of getting cancer results from uncontrollable factors (e.g., family history, gender). The remaining 70% risk can be modified by lifestyle change, including diet (Harvard Medical School, Sept, 2016). Strategies, objectives and key performance indicators were developed to address this priority, utilizing strategies focused on health system and community-based settings, access to resources and information, and policy and environmental changes. Cancer prevention strategies include primary and secondary prevention in provider settings, secondary prevention in the community setting, prevention through referral and barrier reduction, research on local cancer risks, and connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

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. Incidence/Mortality**:** Rates based on 100,000 population. Source - *Nebraska Cancer Registry, 2011-2015*

- Reduce incidence / mortality rates due to Female Breast Cancer
  Baseline: 131.6 (State 124.1) / 22.8 (State 19.9)
  Target: 123.7 / 21.4
- Reduce the incidence / mortality rates due to Colorectal Cancer
  Baseline: 42.6 (State 43.0) / 16.3 (State 15.7)
  Target: 40.0 / 15.33
- Reduce incidence / mortality rates due to Prostate Cancer
  Baseline: 117.1 (State 114.4) / 18.8 (State 20.2)
  Target: 110.1 / 16.9
- Reduce incidence / mortality rates due to Skin Cancer
  Baseline: 29.0 (State 22.1) / 5.6 (State 3.0)
  Targets: 27.3 / 5.3
- Reduce incidence / mortality rates due to Lung Cancer
  Baseline: 63.3 (State 58.7) / 43.9 (State 41.8)
  Target: 59.5 / 41.3

Priority Area 5: Cancer			
Strategy 5a: Primary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the proportion of patients assessed by providers and who are aware and counseled on their cancer risk factors			
What will be measured: • The number of patients who received an annual comprehensive cancer risk assessment and counseling during patient visits • The proportion of patients assessed and counseled annually	**Baseline/Target:** TBD	**Data Source:** • Primary Data Collected from local Provider offices (consider collected by provider, by practice, by district)	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • All patients	**Setting:** • Provider Offices	**Lead Organizations:** • Brodstone
Evidence Based: USPSTF - screening, Community Guide What Works – Screening/Provider Assessment and Feedback/One-on-one education; State Cancer Plan		**Accountability:** Cancer Steering Committee	
Short Term Key Performance Indicators (KPIs): • Determine the number of providers with knowledge, attitudes and beliefs supporting assessment and counseling on cancer risk factors. • Determine the current assessment practices done in provider offices. • Design or adopt a comprehensive cancer risk assessment tool.	**Intermediate Term KPIs:** • Increase the number of providers with knowledge, attitudes and beliefs supporting assessment and counseling on cancer risk factors. • Providers adopt through policy/protocol a comprehensive cancer risk assessment tool.	**Long Term KPIs:** • Number of patients who have access to providers with policies/protocols for counseling on cancer risk factors. • The number of providers utilizing comprehensive cancer assessment, tool at patient visits.	
Cancer Related Factors, Examples: radon exposure, second hand smoke, smoking, lung cancer screening, sun safe behaviors, farm chemicals, ACEs, nutrition, physical activity or weight, alcohol, HPV vaccination status			

Priority Area 5 : Cancer			
Strategy 5b: Primary prevention in the community setting			
6 Year objective: Implement consistent messaging on cancer risk factors and empower individuals to make healthy choices			
What will be measured: • Knowledge, attitudes and beliefs about cancer risk factors and healthy choices	**Baseline/Target:** • Measured with pre-assessment	**Data Source:** • Pre/post knowledge assessments	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • All individuals, especially vulnerable and high risk (consider cancer type, age, race, lifestyles, financial/ insurance status, exposure risk)	**Setting:** • Worksites • Schools/School Aged • Pools/Tanning Beds • Multi-unit housing • Rural/Agriculture related	**Lead Organizations:** • Morrison Cancer Center
Evidence Based: USPSTF/Community Guide What Works – small media targeting clients, group education, client reminders, assessment/provider feedback		**Accountability:** Cancer Steering Committee	
Short Term Key Performance Indicators (KPIs): • Implementation of coordinated awareness initiatives to increase knowledge, attitudes and beliefs about cancer risk factors and healthy choices.	**Intermediate Term KPIs:** • Increase the number of partners participating in coordinated awareness initiatives. • Increase the numbers coordinated awareness initiatives to increase knowledge, attitudes and beliefs about cancer risk factors and healthy choices.	**Long Term KPIs:** • Number of awareness initiatives within our communities.	
Examples: Radon awareness (SHDHD), sun safety (MCC and SHDHD), HPV awareness (SHDHD), physical activity and nutrition, smoking, alcohol, emerging risks			

<table>
<tr><td colspan="4">Priority Area 5: Cancer</td></tr>
<tr><td colspan="4">Strategy 5c: Secondary prevention in the community and clinical setting</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the number of individuals up to date on recommended cancer screenings</td></tr>
<tr><td>What will be measured:
The percent up to date on cancer screenings:
Cervical- female age 21-65
Colorectal- male/female age 50 through 74
Breast- female age 50-74
Prostate- male age 40+ having doctor/nurse or other health professional discuss PSA test</td><td>Baseline/Target:
Cervical:
80.8% (2016 data) / 92%
Colorectal:
(ages 50 through 74 yrs)
Male: 71.8% / 80%
Female: 65.8% / 80%
Breast:
69% (2016 data) / 73%
Prostate:
no data available</td><td>Data Source:
BRFSS
Target Setting Method:
Cervical: NE DHHS State Cancer Goals
Colorectal: NE DHHS State Cancer Goals
Breast: 1% improvement/year</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Secondary Prevention</td><td>Population:
All age appropriate patients</td><td>Setting:
Provider Offices
Community</td><td>Lead Organizations:
SHDHD Cancer Coalition</td></tr>
<tr><td colspan="2">Evidence Based: USPSTF - screening, Community Guide What Works – Provider reminder & recall systems</td><td colspan="2">Accountability: Cancer Steering Committee</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Implementation of coordinated District wide awareness initiative to increase knowledge, attitudes and beliefs about cancer risk factors and screenings.
Determine current client reminder/recall practices.</td><td>Intermediate Term KPIs:
Increase the number of partners participating in coordinated awareness initiative.
Increase the number of clinics with reminder/recall protocols/policies.</td><td colspan="2">Long Term KPIs:
Standard practice and communication plan for coordinated District wide awareness initiative.
Increase utilization rates of reminder/recall practices.</td></tr>
<tr><td colspan="4">Community Screening venues: pharmacies, health fairs/screening events, health departments, worksites, mobile screening (mammography - mammovan)</td></tr>
</table>

<table>
<tr><td colspan="4">Priority Area 5: Cancer</td></tr>
<tr><td colspan="4">Strategy 5d: Prevention through referral and barrier reduction</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the access to cancer screening, diagnosis and treatment</td></tr>
<tr><td>What will be measured:
Screening Rates</td><td>Baseline/Target:
Cervical:
80.8% (2016 data) / 92%
Colorectal:
(ages 50 through 74 yrs)
Male: 71.8% / 80%
Female: 65.8% / 80%
Breast:
69% (2016 data) / 73%</td><td>Data Source:
BRFSS for screening rates
Primary data from Every Woman Matters and organizations or events participating in barrier reduction
NE Cancer Registry Data
Target Setting Method:
Cervical: NE DHHS State Cancer Goals
Colorectal: NE DHHS State Cancer Goals
Breast: 1% improvement/year</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Secondary Prevention
Tertiary Prevention</td><td>Population:
All age appropriate individuals/patients</td><td>Setting:
Provider Offices
Community</td><td>Lead Organizations:
SHDHD Cancer Coalition</td></tr>
<tr><td colspan="2">Evidence Based: CG, What Works – Screening, reducing barriers, USPSTF - screening</td><td colspan="2">Accountability: Cancer Steering Committee</td></tr>
<tr><td colspan="2">Short Term Key Performance Indicators (KPIs):
Identify clinics that incorporate health literacy and Culturally & Linguistically Appropriate Services (CLAS).
Identify clinics that assess patients for barriers to screening, diagnosis and/or treatment and connect them to resources.
Identify resources for barrier reduction (insurance knowledge, transportation, cost, scheduling/extended hours, SHDHD Health Hub program, Health Systems Navigators).</td><td>Intermediate Term KPIs:
Increase the number of health literate organizations, including CLAS (interpretation services).
Increase clinics connecting patients with barriers to appropriate resources.
Implement resources or activities for barrier reduction (insurance knowledge, transportation, cost, scheduling/extended hours, SHDHD Health Hub program, Health Systems Navigators).</td><td>Long Term KPIs:
Increased number of organizations participating in barrier reduction for screening/diagnosis/treatment.
Increase number of clinics identifying barriers and referring patients to appropriate resources.</td></tr>
</table>

Priority Area 5: Cancer			
Strategy 5e: Research on Cancer Risks			
<u>6 Year objective</u>: Conduct an investigation on types and prevalence of other cancers and associated risk factors in our communities			
What will be measured: • Completion of investigation	**Baseline/Target:** N/A	**Data Source:** N/A	**Timeframe:** by 2024
Continuum of Care: N/A	**Population:** • SHDHD general population	**Setting:** • Community/Environment	**Lead Organizations:** • SHDHD • College of Public Health • Morrison Cancer Center/Dr. Copur
Evidence Based: N/A		**Accountability**: Cancer Steering Committee	
Key Performance Indicators (KPI): • Completed report on types and prevalence of other cancers and associated risk factors in our communities. • Report disseminated to appropriate stakeholders.			
Examples: Lymphoma, pediatric cancers; risk factors: pesticides, insecticides, etc.			

Priority Area 5: Cancer			
Strategy 5f: Connecting people/organizations through access to resources.			
6 Year objective: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** • General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	
Short Term Key Performance Indicators (KPIs): • Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	**Intermediate Term KPIs**: • Promotion/education on the improved Resource Guide.	**Long Term KPIs:** • Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.	
Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce			

Resources for Implementation

South Heartland Community Health Improvement Plan, 2019-2024

Resources for each priority area include:

- evidence-based practices
- related national, state, and regional plans
- data sources

Additional data can be found in the South Heartland Community Health Assessment Report located at: https://southheartlandhealth.org/public-health-data/community-health-needs-assessment.html.

Access to Care:

Evidence Based Practices:

- CHRR: Policies & Programs that can Improve Health, filtered by Access to Care: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies?f%5B0%5D=field_program_health_factors%3A12068&items_per_page=50
- HP2020 Access to Health Services evidence-based resources: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/ebrs
- HP2020 Access to Health Services Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives
- HP202 Access to Health Services Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services
- The Community Guide- What Works: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Health-Communication-Health-Information-Technology.pdf
- CDC: Improving access to children's mental healthcare: https://www.cdc.gov/childrensmentalhealth/access.html
- Milbank Memorial Fund: *Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers,* March 15, 2017 | Elizabeth Tobin Tyler, JD, MA, Rachel L. Hulkower, JD, MSPH, and Jennifer W. Kaminski, PhD. https://www.milbank.org/publications/behavioral-health-integration-in-pediatric-primary-care-considerations-and-opportunities-for-policymakers-planners-and-providers/
- Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers: https://www.milbank.org/wp-content/uploads/2017/03/MMF_BHI_Executive-Summary-FINAL.pdf
- Behavioral Health Integration in Pediatric Primary Care: by Elizabeth Tobin Tyler, JD, MA, Rachel L. Hulkower, JD, MSPH, and Jennifer W. Kaminski, PhD A Milbank-Supported Considerations and Opportunities for Policymakers, Planners, and Providers- Report: https://www.milbank.org/wp-content/uploads/2017/03/MMF_BHI_REPORT_FINAL.pdf
- Milbank Memorial Fund: Behavioral Health Integration and Workforce Development: https://www.milbank.org/wp-content/uploads/2018/05/Milbank-Memorial-Fund-issue-brief-BHI-workforce-development-FINAL.pdf
- CDC Prevention Checklist- https://www.cdc.gov/prevention/index.html
- Providing Access to Mental Health Services for Children in Rural Areas: https://www.cdc.gov/ruralhealth/child-health/images/Mental-Health-Services-for-Children-Policy-Brief-H.pdf \
- Access to Health Care, CDC Vital Signs: https://www.cdc.gov/vitalsigns/healthcareaccess/index.html

National, State, Regional Plans:

- HP2020 Access to Health Services Objectives (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/objectives
- NE DHHS Division of Behavioral Health Strategic Plan: http://dhhs.ne.gov/Reports/Behavioral%20Health%20Strategic%20Plan%202017-2020.pdf
- Nebraska State Health Improvement Plan (SHIP): http://dhhs.ne.gov/publichealth/Documents/SHIP%20Plan%20-%202017-2021.pdf

Data:

- HP2020 Access to Health Services Snapshots: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/national-snapshot
- Health Insurance and Access to Care- CDC: https://www.cdc.gov/nchs/data/factsheets/factsheet_health_insurance_and_access_to_care.pdf
- Disability and Access to Health Care- CDC: https://www.cdc.gov/features/disabilities-health-care-access/index.html
- Health Care Systems and Substance use Disorders: https://addiction.surgeongeneral.gov/executive-summary/report/health-care-systems-and-substance-use-disorders
- Nebraska Minority Disparities Chart book: http://dhhs.ne.gov/Reports/Minority%20Disparities%20Chart%20Book%20-%202016.pdf
- Access to Health Care- Data are for the U.S.: https://www.cdc.gov/nchs/fastats/access-to-health-care.htm
- Coverage and Access Data- CDC: https://www.cdc.gov/nchs/health_policy/coverage_and_access.htm
- SHDHD Community Health Assessment Data Fact Sheets: www.southheartlandhealth.org

Mental Health:

Evidence Based Practices:

- Community Preventive Services Task Force Findings-Mental Health: https://www.thecommunityguide.org/task-force-findings?field_topic_tid_selective=7614&field_recommendation_tid_selective=All&field_published_date_value%5Bmin%5D%5Byear%5D=1998&field_published_date_value%5Bmax%5D%5Byear%5D=2018
- U.S Preventive Services: https://www.uspreventiveservicestaskforce.org/Search
- HP2020 Mental Health evidence-based resources: https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources?f%5B%5D=field_ebr_topic_area%3A3498&ci=0&se=0&pop=
- HP2020 Mental Health Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives
- HP2020 Mental Health Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders
- Screening for Depression in Adults: https://jamanetwork.com/journals/jama/fullarticle/2484345
- Primary Care Interventions to Prevent Child Maltreatment: U.S. Preventive Services Task Force Recommendation Statement: http://annals.org/aim/fullarticle/1696071/primary-care-interventions-prevent-child-maltreatment-u-s-preventive-services
- Screening for Depression in Children and Adolescents: https://www.ncbi.nlm.nih.gov/pubmed/26908686

- Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: U.S. Preventive Services Task Force: http://annals.org/aim/fullarticle/1558517/screening-intimate-partner-violence-abuse-elderly-vulnerable-adults-u-s
- Region 3: http://www.region3.net/Portals/0/Annual%20Reports/Region%203_AR2018.pdf https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources?f%5B%5D=field_ebr_topic_area%3A3498&ci=0&se=0&pop
- Healthy People: https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources?f%5B%5D=field_ebr_topic_area%3A3498&ci=0&se=0&pop

National, State, Regional Plans:

- HP2020 Mental Health Objectives (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives
- NE DHHS Division of Behavioral Health Strategic Plan: http://dhhs.ne.gov/Reports/Behavioral%20Health%20Strategic%20Plan%202017-2020.pdf
- Nebraska State Health Improvement Plan (SHIP): http://dhhs.ne.gov/publichealth/Documents/SHIP%20Plan%20-%202017-2021.pdf
- National Institute of Mental Health: https://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml
- World Health Organization Strategic Plan for Mental Health: http://afrolib.afro.who.int/doc_num.php?explnum_id=7570

Data:

- CDC Community Health Online Resources Center- Substance Misuse: https://nccd.cdc.gov/DCH_CHORC/#
- Health Care Systems and Substance use Disorders: https://addiction.surgeongeneral.gov/executive-summary/report/health-care-systems-and-substance-use-disorders
- Mental Health Information: https://www.nimh.nih.gov/health/index.shtml
- Mental Health Information from Mental Health America: http://www.mentalhealthamerica.net/mental-health-information
- Mental Health Data from CDC: https://www.cdc.gov/mentalhealth/data_publications/index.htm
- Nebraska Region 3 Behavioral Health Services, Annual Report: http://www.region3.net/Portals/0/Annual%20Reports/Region%203_AR2017.pdf
- SHDHD Community Health Assessment Data Fact Sheets: www.southheartlandhealth.org

Substance Misuse:

Evidence Based Practices:

- Community Preventive Services Task Force Findings- Tobacco: https://www.thecommunityguide.org/task-force-findings?field_topic_tid_selective=7620&field_recommendation_tid_selective=All&field_published_date_value%5Bmin%5D%5Byear%5D=1998&field_published_date_value%5Bmax%5D%5Byear%5D=2018
- National Cancer Institute-Tobacco Control Intervention Programs: https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102271&choice=default
- U.S Preventive Services: https://www.uspreventiveservicestaskforce.org/Search

- CHRR: Policies & Programs that can Improve Health, filtered by Alcohol and Drug Use: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies?f%5B0%5D=field_program_health_factors%3A12056
- HP2020 Substance Misuse evidence-based resources: https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources?f%5B%5D=field_ebr_topic_area%3A3500&f%5B%5D=field_ebr_topic_area%3A3510&ci=0&se=0&pop=
- HP2020 Substance Misuse Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/objectives
- HP2020 Substance Misuse Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse
- HP2020 Substance Misuse Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use/objectives
- HP2020 Substance Misuse Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use
- Treating Tobacco Use and Dependence- 2008 update: https://www.ncbi.nlm.nih.gov/books/NBK63952/
- Improving quality of care in substance abuse treatment using five key process improvement principles: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3495233/
- Community Guide: https://www.thecommunityguide.org/sites/default/files/assets/BAC-Nationwide.pdf
- CDC Rural Health: https://www.cdc.gov/ruralhealth/drug-overdose/policybrief.html
- Community Guide Tobacco: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-Tobacco.pdf
- Community Guide Alcohol: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-Alcohol.pdf
- Community Guide Motor Vehicles: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-MotorVehicle.pdf

National, State, Regional Plans:

- HP2020 Substance Misuse Objectives (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse/objectives
- HP2020 Tobacco Use Objectives (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use/objectives
- Nebraska State Health Improvement Plan (SHIP): http://dhhs.ne.gov/publichealth/Documents/SHIP%20Plan%20-%202017-2021.pdf
- Nebraska Substance Abuse Prevention Strategic Plan: http://dhhs.ne.gov/Documents/NE_Sub_Abuse_Prev_Strat_Plan.pdf
- NE DHHS Division of Behavioral Health Strategic Plan: http://dhhs.ne.gov/Reports/Behavioral%20Health%20Strategic%20Plan%202017-2020.pdf

Data:

- CDC Community Health Online Resources Center- Substance Misuse: https://nccd.cdc.gov/DCH_CHORC/#
- Substance Abuse and Mental Health Services Administration: https://www.samhsa.gov/data/
- Person Who Injects Drugs: https://www.cdc.gov/pwid/substance-treatment.html

- Smoking and Tobacco Use- CDC: https://www.cdc.gov/tobacco/basic_information/index.htm?s_cid=osh-stu-home-nav-003
- Smoking and Tobacco Use Facts- CDC: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm?s_cid=osh-stu-home-spotlight-001
- Behavior Health Useful Links: http://dhhs.ne.gov/behavioral_health/Pages/beh_mhsa.aspx
- Nebraska Region 3 Behavioral Health Services, Annual Report: http://www.region3.net/Portals/0/Annual%20Reports/Region%203_AR2017.pdf
- SHDHD Community Health Assessment Data Fact Sheets: www.southheartlandhealth.org

Obesity and Related Health Conditions:

Evidence Based Practices:

- Community Preventive Services Task Force Findings- Obesity: https://www.thecommunityguide.org/task-force-findings?field_topic_tid_selective=7617&field_recommendation_tid_selective=All&field_published_date_value%5Bmin%5D%5Byear%5D=1998&field_published_date_value%5Bmax%5D%5Byear%5D=2018
- National Cancer Institute-Obesity Intervention Programs: https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=1592287&choice=default
- U.S Preventive Services: https://www.uspreventiveservicestaskforce.org/Search
- CHRR: Policies & Programs that can Improve Health, filtered by Diet and Exercise: http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies?f%5B0%5D=field_program_health_factors%3A12058
- HP2020 Obesity evidence-based resources: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resources?f%5B%5D=field_ebr_topic_area%3A3516&f%5B%5D=field_ebr_topic_area%3A3502&f%5B%5D=field_ebr_topic_area%3A3504&pop=&ci=0&se=0
- HP2020 Obesity Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives
- HP2020 Obesity Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status
- HP2020 Obesity Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity
- HP2020 Obesity Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity/objectives
- HP2020 Obesity Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes
- HP2020 Obesity Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives
- CDC Obesity Evidence Based Strategies: https://www.cdc.gov/obesity/strategies/community.html
- Health People 2020: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/interactive-health-communication-applications-for-0
- Health People 2020 cardiovascular: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/cardiovascular-disease-mobile-health-mhealth
- Health People 2020 clinical decisions: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/cardiovascular-disease-clinical-decision-support
- Health People 2020 Physical Activity: https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity/objectives

- CDC Fruit and Vegetable: https://www.cdc.gov/media/releases/2017/p1116-fruit-vegetable-consumption.html
- Healthy People 2020 Nutrition: https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives
- Community Guide Obesity: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-Obesity.pdf

National, State, Regional Plans:

- HP2020 Nutrition (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status/objectives
- HP2020 Heart Disease and Stroke (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke/objectives
- HP2020 Diabetes (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/diabetes/objectives
- HP2020 Physical Activity (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity/objectives
- Nebraska Physical Activity and Nutrition Plan: http://dhhs.ne.gov/publichealth/Documents/StatePlanPresentation.pdf
- Nebraska State Health Improvement Plan (SHIP): http://dhhs.ne.gov/publichealth/Documents/SHIP%20Plan%20-%202017-2021.pdf

Data:

- CDC Overweight and Obesity Data and Statistics: https://www.cdc.gov/obesity/data/index.html
- CDC Community Health Online Resources Center- Obesity: https://nccd.cdc.gov/DCH_CHORC/#
- At-A-Glance: A Fact Sheet for Professionals: https://health.gov/paguidelines/factsheetprof.aspx
- Blue Hill Comprehensive Plan: https://static1.squarespace.com/static/59073fd915d5db2857ed5591/t/59235b3d5016e13293b005ad/1495489407112/Comprehensive+Plan.pdf
- Hastings Comprehensive Plan: https://www.cityofhastings.org/assets/site/coh/documents/doccentral/Comprehensive-Development-Plan1482166724.pdf
- Superior Comprehensive Plan: http://www.cityofsuperior.org/cityCodes/Comp%20Plan/2014SuperiorCompPlant.pdf
- Screening for Obesity in Children and Adolescents: https://jamanetwork.com/journals/jama/fullarticle/2632511
- Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults Without Cardiovascular Risk Factors: https://jamanetwork.com/journals/jama/fullarticle/2643315
- Behavioral Weight Loss Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults: https://jamanetwork.com/journals/jama/fullarticle/2702878
- Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement: http://annals.org/aim/fullarticle/2490528
- SHDHD Community Health Assessment Data Fact Sheets: www.southheartlandhealth.org

Cancer:

Evidence Based Practices:

- Community Preventive Services Task Force Findings- Cancer: https://www.thecommunityguide.org/task-force-findings?field_topic_tid_selective=7607&field_recommendation_tid_selective=All&field_published_date_value%5Bmin%5D%5Byear%5D=1998&field_published_date_value%5Bmax%5D%5Byear%5D=2018
- National Cancer Institute-Breast Cancer Intervention Programs: https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102263&choice=default
- National Cancer Institute-Cervical Cancer Intervention Programs: https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102264&choice=default
- National Cancer Institute-Colorectal Cancer Intervention Programs: https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=102265&choice=default
- National Cancer Institute-Prostate Cancer Intervention Programs: https://rtips.cancer.gov/rtips/topicPrograms.do?topicId=28360573&choice=default
- U.S Preventive Services: https://www.uspreventiveservicestaskforce.org/Search
- HP2020 Cancer evidence-based resources: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resources?f%5B%5D=field_ebr_topic_area%3A3513&ci=0&se=0&pop=
- HP2020 Cancer Objectives: https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
- HP2020 Cancer Goals: https://www.healthypeople.gov/2020/topics-objectives/topic/cancer
- CDC Cancer Policy and Practices: https://www.cdc.gov/cancer/promoting_prevention.htm
- Medications for Risk Reduction of Primary Breast Cancer in Women: U.S. Preventive Services Task Force Recommendation Statement: http://annals.org/aim/fullarticle/1740757/using-medications-decrease-risk-breast-cancer-women-recommendations-from-u
- Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement: https://www.ncbi.nlm.nih.gov/pubmed/26757170
- Screening for Cervical Cancer: https://jamanetwork.com/journals/jama/fullarticle/2697704
- Screening for Colorectal Cancer: https://jamanetwork.com/journals/jama/fullarticle/2529486
- Behavioral Counseling to Prevent Skin Cancer: https://jamanetwork.com/journals/jama/fullarticle/2675556
- Screening for Skin Cancer: https://jamanetwork.com/journals/jama/fullarticle/2536638
- The Breast Cancer Risk Assessment Tool- NIH: https://bcrisktool.cancer.gov/
- What Works Cervical Cancer: https://www.thecommunityguide.org/resources/one-pager-multicomponent-interventions-increase-cancer-screening-cervical-cancer
- What Works Breast Cancer: https://www.thecommunityguide.org/resources/one-pager-multicomponent-interventions-increase-cancer-screening-breast-cancer
- What Works Colon Cancer: https://www.thecommunityguide.org/resources/one-pager-multicomponent-interventions-increase-cancer-screening-colorectal-cancer

National, State, Regional Plans:

- HP2020 Cancer Objectives (baseline and target indicators): https://www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives
- National Cancer Institute Plan: https://www.cancer.gov/about-nci/budget/plan/progress
- Nebraska Cancer Plan: http://dhhs.ne.gov/publichealth/Documents/Nebraska%20Cancer%20Coalition%20Plan%202017%20-%202022.pdf

Data:

- State Cancer Profiles: https://statecancerprofiles.cancer.gov/quick-profiles/index.php?statename=nebraska
- Cancer Control Planet- Breast Cancer: https://cancercontrolplanet.cancer.gov/planet/breast_cancer.html
- Cancer Control Planet- Cervical Cancer: https://cancercontrolplanet.cancer.gov/planet/cervical_cancer.html
- Cancer Control Planet- Colorectal Cancer: https://cancercontrolplanet.cancer.gov/planet/colorectal_cancer.html
- Cancer Control Planet- Prostate: https://cancercontrolplanet.cancer.gov/planet/prostate_cancer.html
- CDC Community Health Online Resources Center- Cancer: https://nccd.cdc.gov/DCH_CHORC/#
- CDC Cancer Data and Statics: https://www.cdc.gov/cancer/dcpc/data/index.htm
- SHDHD Community Health Assessment Data Fact Sheets: www.southheartlandhealth.org
- Nebraska State Health Improvement Plan (SHIP): http://dhhs.ne.gov/publichealth/Documents/SHIP%20Plan%20-%202017-2021.pdf

Data:

- HP2020 Access to Health Services Snapshots: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services/national-snapshot
- Health Insurance and Access to Care- CDC: https://www.cdc.gov/nchs/data/factsheets/factsheet_health_insurance_and_access_to_care.pdf
- Disability and Access to Health Care- CDC: https://www.cdc.gov/features/disabilities-health-care-access/index.html
- Health Care Systems and Substance use Disorders: https://addiction.surgeongeneral.gov/executive-summary/report/health-care-systems-and-substance-use-disorders
- Nebraska Minority Disparities Chart book: http://dhhs.ne.gov/Reports/Minority%20Disparities%20Chart%20Book%20-%202016.pdf
- Access to Health Care- Data are for the U.S.: https://www.cdc.gov/nchs/fastats/access-to-health-care.htm
- Coverage and Access Data- CDC: https://www.cdc.gov/nchs/health_policy/coverage_and_access.htm
- SHDHD Community Health Assessment Data Fact Sheets: www.southheartlandhealth.org

Glossary of Abbreviations

Abbreviation	Definition
AA	Alcoholics Anonymous
AARP	American Association of Retired Persons
ACEs	Adverse Childhood Experiences
ACOs	Accountable Care Organizations -Centers for Medicare and Medicaid Services
ACS	American Cancer Society
AHEC	Area Health Education Centers
AHS	Access to Health Services
ASAAP	Area Substance and Alcohol Abuse Prevention
ASQ-SE	Ages and Stages Questionnaires - Social-Emotional
ATOD	Alcohol, Tobacco & Other Drug Education
AWARE project	Advancing Wellness and Resiliency in Education
BHECN	Behavioral Health Education Center of Nebraska
BMH	Brodstone Memorial Hospital
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CASA	Court Appointed Special Advocates
CATCH kids	Coordinated Approach to Child Health
CBO	Community Based Organization
CCC	Central Community College
CCC Project **HELP**	Health Education Laddering Program
CDC	Center for Disease Control
CES-D	Center for Epidemiologic Studies Depression Scale
CG	Cancer Genetics
CHA	Community Health Assessment
CHIP	Community Health Improvement Plan
CHRR	County Health Rankings and Roadmap
CHW	Community Health Worker
CLAS	Culturally and Linguistically Appropriate Services
CPSTF	Community Preventative Services Task Force
CTSA	Community Themes and Strengths Assessment
DHHS	Department of Health and Human Services
EB	Evidence Based
EHR	Electronic Health Record
EMS	Emergency Medical Services
ER	Emergency Room
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HP 2020 **HC/HIT**	Health Communication and Health Information Technology
HP 2020 **NWS**	Nutrition and Weight Status
HP 2020 **PA**	Physical Activity
HP2020	Healthy People 2020

HP2020 - **AHS**	Access to Health Services
HPD	Hastings Police Department
HPV	Human Papillomavirus
HR	Human Resources
KPI	Key Performance Indicator
MAAA	Midland Area Agency on Aging
MAPP	Mobilizing for Action through Planning and Partnership
MCC	Morrison Cancer Center (Mary Lanning Healthcare)
MH	Mental Health
MHMD	Mental Health and Mental Disorders
MLH	Mary Lanning Healthcare
MTSS	Multi-Tier System of Support
N/A	Not Applicable
NABHO	Nebraska Association of Behavioral Health Organizations
NACO	Nebraska Association of County Officials
NE	Nebraska
NHA	Nebraska Hospital Association
PA	Physical Activity
PC	Primary Care
PCP	Primary Care Physician
PEARLS	The Program to Encourage Active, Rewarding Lives
PHAN	Public Health Association of Nebraska
PHQ-2	Patient Health Questionnaire-2 (Mental Disorders Screening)
PHQ-9	Patient Health Questionnaire - 9 (Depression screening)
PSA	Prostate- specific antigen
ROI	Return on Investment
SAEBRS	Social, Academic, Emotional Behavior Risk Screener
SBIRT	Screening, Brief Interventions, Referral to Treatment
SCBS	South Central Behavioral Services
SDOH	Social Determinants of Health
SH	South Heartland
SH - BHAG	South Heartland Behavioral Health Advocacy Group
SHDHD	South Heartland District Health Department
SM	Substance Misuse
TBD	To Be Determined
TPOT	Teaching Pyramid Observation Tool (for preschoolers)
UNL	University of Nebraska Lincoln
USDOJ	United States Department of Justice
USPSTF	U.S. Preventative Services Task Force
VetSet	Veteran - Serve, Educate, Transition
WCSO	Webster County Sheriff's Office
WIC	Women, Infant, Child
WSCC	Whole School, Whole Community, Whole Child
YMCA	Young Men's Christian Association
YRBSS	Youth Risk Behavior Surveillance System
YWCA	The World Young Women's Christian Association

References

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2. *The South Heartland District Community Health Assessment 2018: A Four-County Needs Assessment using the Mobilizing for Action through Planning and Partnerships (MAPP) Process.* More information on the comprehensive assessment and priority setting process is contained in the companion document located on the South Heartland website: https://southheartlandhealth.org/public-health-data/community-health needs-assessment.html
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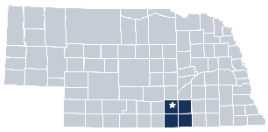

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