The South Heartland District

Community Health Improvement Plan

2025-2030

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
September 24, 2025

Michele Bever, PhD, MPH; South Heartland Executive Director

Samantha Nejezchleb; SHDHD Board of Health President

Adams, Clay, Nuckolls and Webster Counties in Nebraska

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

South Heartland Mission

The South Heartland District Health Department is dedicated to preserving and improving the health of the 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"

ACCREDITED HEALTH DEPARTMENT • PUBLIC HEALTH ACCREDITATION BOARD • PHAB Advancing public health performance

Table of Contents

SHDHD Vision and Mission and SHDHD National Accreditation

Acknowledgement and Core Team 1

South Heartland District Health Department (SHDHD) Board of Health Members 2

Letter of Introduction, SHDHD Executive Director 3

Introduction 4

Foundational Public Health Core Functions and 10 Essential Services 5-6

Social Drivers (Determinants) of Health, SDOH 7

Health Improvement Planning Process 8-12

- Public Health Systems Diagram 8
- Assessment and Priority Setting Process: Brief Summary 9
  - SHDHD Community CHIP Timeline Funnel 9
  - Laying the Foundation, Fall 2023 9-10
  - Telling the Community Story, 2024 10
  - Community Health Equity Survey 10
  - Priority Setting and Strategy Identification 11
  - Strategy Meeting Pictures 12

Community Health Improvement Plan Implementation

- Health Impact Pyramid 13
- CHIP Launch and Implementation 14

Summary of Community Health Priorities, 2025-2030 15

- Mental Wellbeing 16-24
  - Objective 1 17
  - Objective 2 22
- Chronic Disease Conditions 25-31
  - Objective 1 26
  - Objective 2 29
- Senior Health 32-39
  - Objective 1 33
  - Objective 2 38

Acknowledgement

The staff at South Heartland District Health Department would like to recognize the many community partners and public members that contributed to the development of this plan. Your input and commitment were instrumental to a productive, successful process and completion of the Community Health Improvement Plan (CHIP), 2025-2030.

We also are indebted to the MAPP Core Team members, who provided guidance, advice and county-level assistance throughout this process. The assessments and community planning processes were supported by SHDHD general funds as well as funds from the Nebraska Department of Health and Human Services Office of Community Health and Performance Management, Brodstone Memorial Hospital, Mary Lanning Healthcare and the United Way of South Central Nebraska.

Finally, we would like to recognize the efforts of SHDHD's core internal planning and support team for the CHA/CHIP process: Devi Dwarabandam, Heidi Davis, Kylene Hayes, Chris Junker, Jean Korth, Jessica Warner, Carrie Watson.

South Heartland Core Team

Brodstone Health Care: Treg Vyzourek, Maddie Peterson, Heather Erickson

Clay County Health Department: Donna Jensen, Sara Mertens

Mary Lanning Healthcare: Becky Sullivan, Eric Barber

South Heartland District Health Department:

- Staff: Michele Bever, Janis Johnson, Brooke Wolfe
- Board of Health: Sandra Nejezchleb, Nanette Shackelford

United Way of South Central Nebraska: Jodi Graves, Brady Rhodes

Webster County Hospital: Lamont Cook, Kelly Karr, Kathy Murphy-Buschkoetter

South Heartland District Health Department

Board of Health

(July 2025)

Adams County:	Charles Neumann, Board of Commissioners
	Michelle Oldham
	Barbara Harrington
Clay County:	Dick Shaw, Board of Supervisors
	Sandra Nejezchleb
	Nanette Shackelford
Nuckolls County:	Jerry Grove, Board of Commissioners
	Megan McMean
	Roger Williams
Webster County:	Jeff Pohlmeier-Mans, Board of Commissioners
	Kathy Murphy Buschkoetter
	Torey Kohmetscher

Professional Representatives:	Medical:	Kathy Amyot, MD
	Dental:	Michael Kleppinger, DDS
	Veterinary:	Erin Jobman, DVM

Officers	President:	Samantha Nejezchleb
	Vice President:	Michelle Oldham
	Secretary/Treasurer:	Charles Neumann

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

August 2025

Dear South Heartland Community Partners and Residents,

We wish to thank all of you for your many contributions to the process of community health assessment, priority-setting, and health improvement planning. You might have completed a community health survey, participated in a focus group, submitted data or health information collected by your organization, served as an expert for one of the health topics, reviewed fact sheets about various health issues and concerns, or helped us to rank the health concerns and choose priorities. You may have helped us identify root causes for the health concerns and you may have participated in groups that defined strategies to address the health priorities we chose. All of these joint efforts have resulted in this new Community Health Improvement Plan that will guide our collective work over the next 6 years.

Whether you were involved in any of the above activities or not, we invite you to join us in carrying out this plan! The following pages will be our road map. There are multiple strategies outlined for each of the three priorities (Mental Wellbeing, Chronic Disease Conditions, and Senior Health). Each strategy lists steps to move us toward a goal. There are also suggested measures to help us monitor our progress on each strategy, demonstrating how well we are doing and what difference we are making.

Please join us in striving toward our vision of "Healthy People in Healthy Communities".

Sincerely,

Michele M. Bever

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

Introduction

Perhaps you ask, 'What is Public Health'? Public Health is what we all, as a society, do collectively to improve our health. Your public health department supports and contributes to these efforts by carrying out statutory responsibilities, those mandates required of us as a governmental public health department. These include core functions of assessment, assurance, and policy development, as well as a variety of essential public health services. Public Health guiding frameworks include the *Foundational Public Health Services and the 10 Essential Services.*

One role of a public health department is to help our communities identify health issues and set health improvement goals. *Where* we live, learn, work, worship and play affects each of us and can determine our health and life expectancy. South Heartland District Health Department (SHDHD) is accredited by the Public Health Accreditation Board (PHAB), which requires the health department to conduct a comprehensive Community Health Assessment (CHA) every five years. However, Internal Revenue Service (IRS) regulations require tax-exempt hospitals to conduct a CHA every three years. SHDHD collaborates and facilitates with our three district hospitals by adding a "mini" CHA at year 3 to monitor progress and need for revisions. The purpose of the health assessment process is to describe the current health status of the community, identify and prioritize health issues, better understand the range of factors that can impact health, and identify assets and resources that can be mobilized to improve the health of the community.

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the CHA and Community Health Improvement Plan (CHIP) development process in the South Heartland district since 2007. In 2023, the National Association of County and City Health Officials (NACCHO) created a new version of the MAPP. MAPP 2.0 emphasizes the importance of community engagement, data-driven assessments, and addressing health disparities in a more streamlined process. The new resources and tools for engagement were designed to be more accessible to the partners who participate in the process.

Public health is all of us! It's how we work together to *Protect*, *Connect* and help our residents and communities to *Thrive*. Public health is about assuring availability of health care for all. But it's so much more than that! It's the steps we take to make sure our neighborhoods and environment are free from pollution. It's making sure our food and water are safe to eat and drink. It's about the relationships we foster in our communities. We're all interconnected. When we all come together to support public health, all of us — individuals, families, communities and

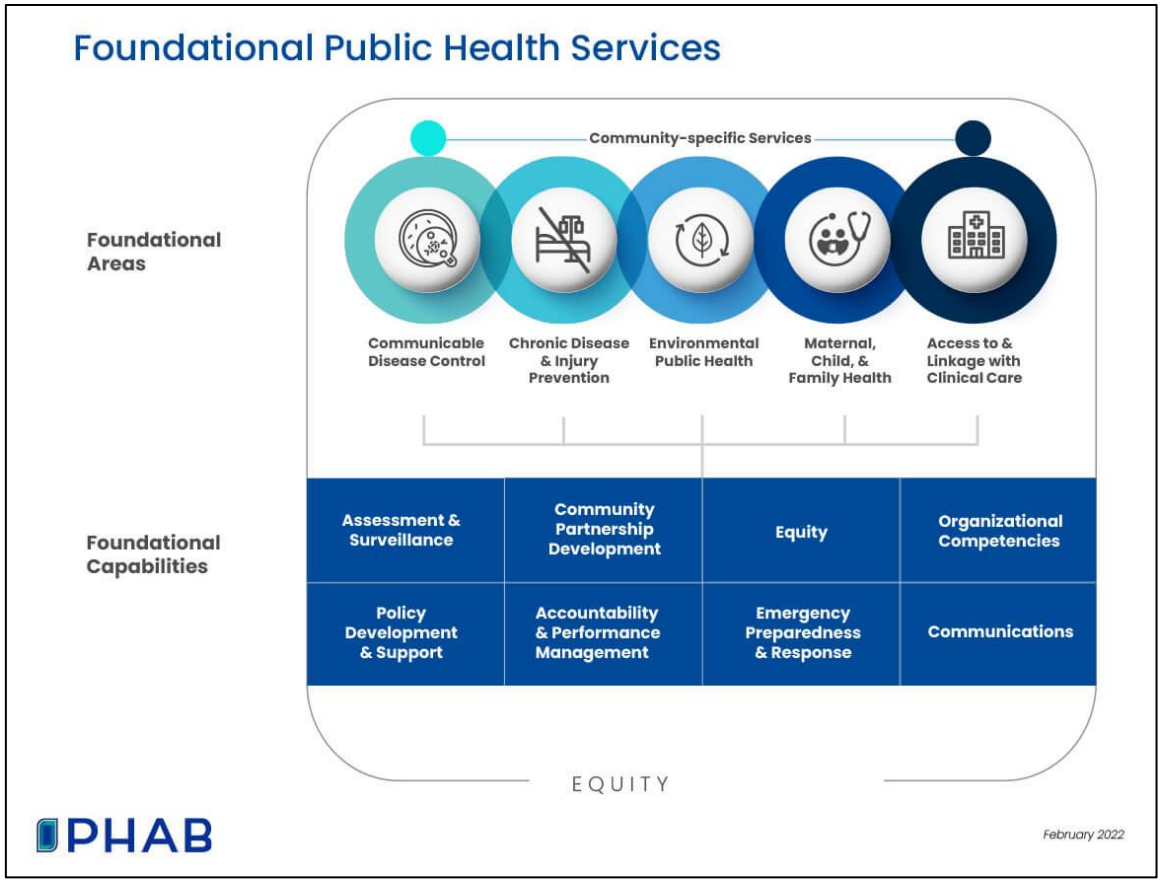
the public health system — can achieve the goals of public health and bring us closer to our vision of Healthy People in Healthy Communities!

Foundational Public Health Services

The Foundational Public Health Services (FPHS) framework defines a minimum set of capabilities and areas that must be available in every community. This outlines the unique responsibilities of governmental public health and reflects the minimum level of services that should be available to all communities.

The Foundational Capabilities provide the infrastructure needed to protect and provide fair and just opportunities for all. Everyone should have a fair and just opportunity to achieve good health and well-being.

The Public Health services are basic public health, topic-specific programs and services aimed at improving the health of the community affected by certain diseases or public health threats. These include, but are not limited to, chronic disease and injury prevention; communicable disease control; environmental public health; maternal, child, and family health; and access to and linkage with clinical care.



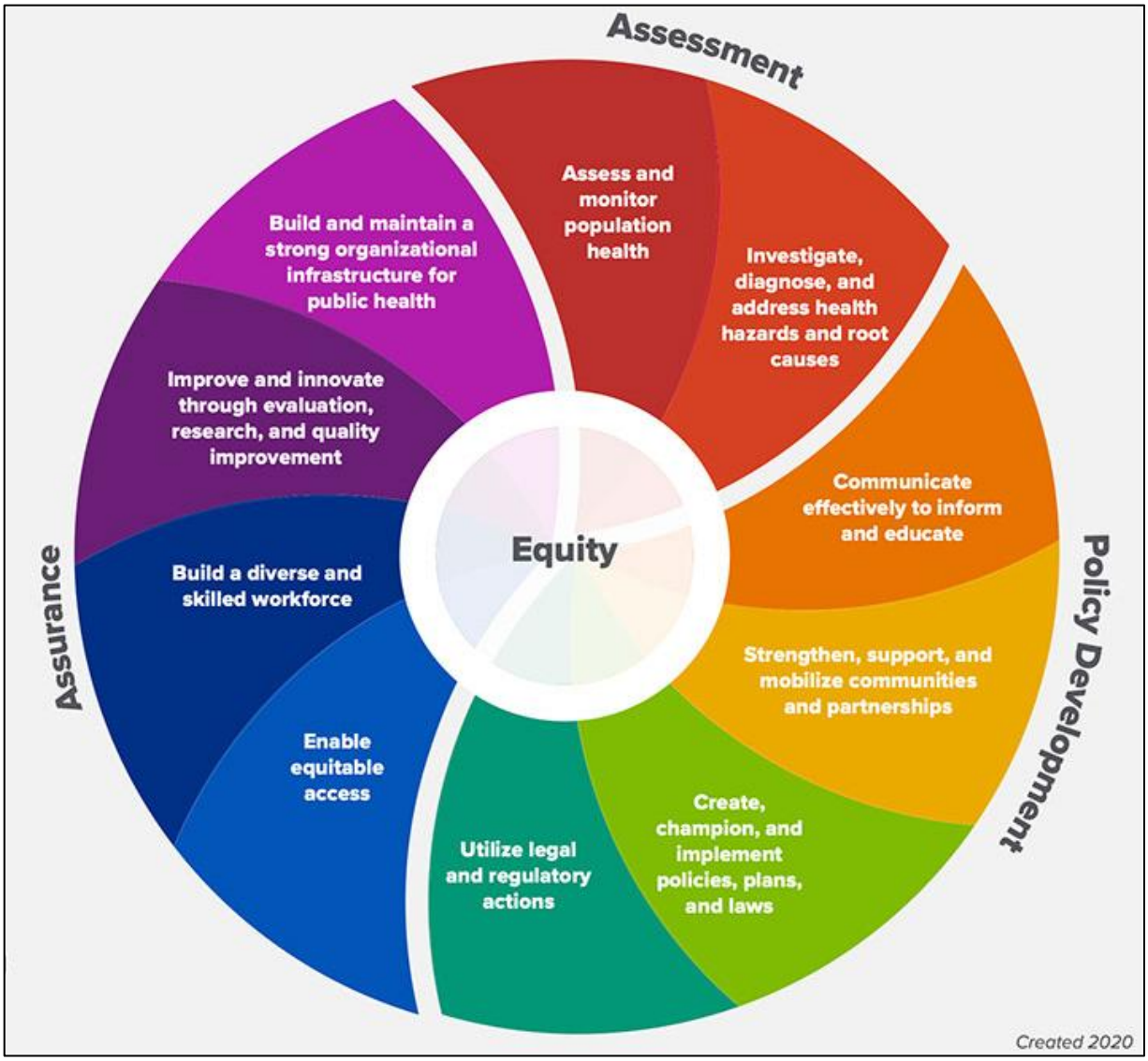
Phnci.org/transformation/fphs

10 Essential Public Health Services

The strength of a public health system rests on its capacity to effectively deliver the 10 Essential Public Health Services. The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities.

To achieve optimal health for all, the Essential Public Health Services actively promote policies, systems and services that enable good health and seek to remove obstacles and systemic and structural barriers that have resulted in health inequalities.

Everyone should have a fair and just opportunity to achieve good health and well-being.



https://www.apha.org/what-is-public-health/10-essential-public-health-services

SDOH: Social Determinants (Drivers) of Health

Social determinants (or drivers) of health have a greater influence on health than either genetic factors or access to healthcare services. The impact of a SDOH is pervasive and deeply embedded in our society, creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These inequities put people at higher risk of poor health. *Source: CDC Social Determinants of Health (SDOH)*

The term "drivers" is often favored because it implies that these factors can be influenced and changed through policy and community efforts, rather than being “fixed determinants".

South Heartland Community focus groups identified the following social drivers of health themes impacting choices for CHIP priorities and strategies:

- Housing costs and challenges
- Food insecurity
- Transportation barriers
- Educational barriers
- Need for social and community supports
- Employment and economic issues, such as low-paying jobs and need for job support, particularly for immigrant communities

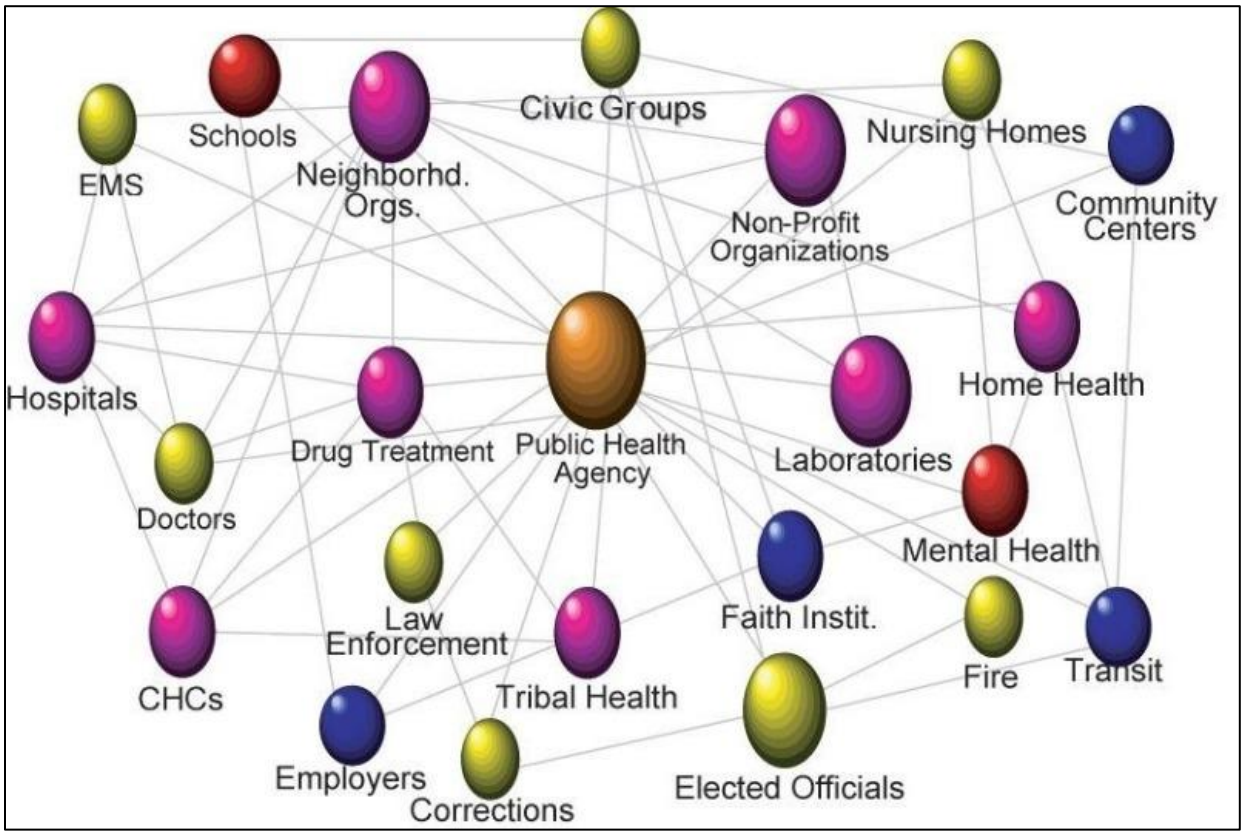
Social Vulnerability refers to the demographic and socioeconomic factors (such as poverty, lack of access to transportation, and crowded housing) that adversely affect communities that encounter hazards and other community-level stressors. These stressors can include natural or human-caused disasters (such as tornadoes or chemical spills) or disease outbreaks (such as COVID-19). Social Vulnerability Index (SVI) Scores range from 0 (least vulnerable) to 1 (most vulnerable), with scores determined based on comparison to other Nebraska counties. The SVI scores for South Heartland Counties ranged from 0.1 (Nuckolls County) to 0.9 (Adams County).

SDOH are the conditions in the environments where people are born, live, learn, work, play, and age, and that affect a wide range of health, functioning, and quality-of-life outcomes. These factors, such as economic stability, education access, health care access, and the built environment, are nonmedical and influence health in ways that are often beyond individual control.

Health Improvement Planning Process

Local Public Health System Diagram

The Foundational Public Health Services and the 10 Essential Services provide the framework for the local public health system. The local public health system consists of many entities that contribute in various positive ways to the health of residents and the community as a whole. These local public health system entities are a network of partners with differing roles, relationships, and interactions. This includes governmental services, elected leaders, schools and colleges, hospitals, healthcare providers, behavioral health providers, emergency services, faith-based, civic and human services organizations, businesses and worksites, non-profits, volunteers, and many others who contribute in large and small ways to the public's health.



Assessment and Priority-Setting Process: A Brief Summary for 2023-2025

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. This effort continues SHDHD's commitment to the core public-health functions—especially *Essential Service 4* (community engagement) and *Essential Service 5* (policy and planning)—by translating fresh assessment findings into actionable strategies that advance our vision of **"Healthy People in Healthy Communities."**

Laying the Foundation (Fall 2023)

- Internal Health-Equity Survey & Staff Workshops: SHDHD staff used an internal survey to embed equity considerations in every stage of the CHA/CHIP cycle and mapped out timelines, roles, and resources.
- Core-Team Formation: A leadership group—representing all three local hospitals, United Way of South-Central Nebraska, Clay County Health Department, and SHDHD staff/Board—was convened to steer the process and contribute data, outreach, and subject-matter expertise.

- Community Input: The community contributed in multiple ways, including 1) community-wide health assessment survey (May-June 2024), focus groups (July-August, including one in Spanish), priority setting meetings (September 2024), and strategy meetings (November 2024 and January 2025).

- Community Health Equity Survey: The Assessment for Advancing Community Transformation was a critical component of the SHDHD's Community Health Assessment (CHA) to align community resources, foster equity-driven partnerships, and drive meaningful health improvements:
  - ✓ Evaluated the capacity of community organizations and stakeholders to address health inequities across the four district counties.
  - ✓ Results provided valuable insights into strengths, challenges, and opportunities for collaborative progress in advancing health equity.
  - ✓ Assessment aim: 1. Gauge Community Collaboration, 2. Identify Equity Gaps, and 3. Establish Baselines for Progress.
  - ✓ Identified 6 key themes essential for health equity advancement: collaboration, communication, advance equity, plan for action, measure to improve, and sustainability.

Telling the Community Story (2024): Guided by the core team and supported by Partners for Insightful Evaluation (PIE), SHDHD wove together multiple data streams: a district-wide Community Health Survey (566 responses), a Community Partners Health Equity Assessment, five county-level focus groups (including one conducted in Spanish), and extensive secondary data from other agencies. These activities spanned February through September 2024 and ensured that the lived experiences of all residents and underserved residents informed every analytic step.

Priority-Setting (September 2024) & Strategy Identification (November 2024, January 2025)

County-level stakeholder sessions were linked virtually to promote cross-county dialogue. The primary facilitator was located in Adams County, and groups facilitated by SHDHD staff joined by Zoom from Nuckolls, Clay and Webster Counties. Attendance averaged 70-80 people across the 4 counties for each meeting. This included healthcare and mental health professionals (hospitals and clinics, schools, elder care leads and staff), data, technology and business representatives, county commissioners, SHDHD

Priority-Setting Meeting, Adams County, September2024

Board of Health members, and many nonprofit partners. These meetings were hosted by Hastings Public Library / ESU-9 (Adams Co.), Clay County Health Department / Clay Center City Office / Clay Center Christian Church (Clay Co.), Brodstone Healthcare (Nuckolls Co.) and Webster County Community Hospital (Webster Co.).

The deliberations at the Priority-Setting Meeting culminated in consensus on three district-wide priorities for 2025-2030:

1. **Mental Wellbeing**
2. **Chronic Disease Conditions**
3. **Senior Health**

At the Strategy Meeting in November, stakeholders identified problem statements for each Priority and also the root causes of these concerns. At the January meeting, teams of participants set desired goals, identified evidence-based practices, then utilized *Theory of Change* framework to fill in the steps needed to get to the long-term goals by answering: "If we do X, then people will… [immediate results], resulting in… [bigger changes], and creating… [end goals]. The teams also identified community partners and assets that could help implement the strategies, along with proposed performance measures to help the community track: "How much did we do?", "How well did we do it?", and "What difference did we make?"

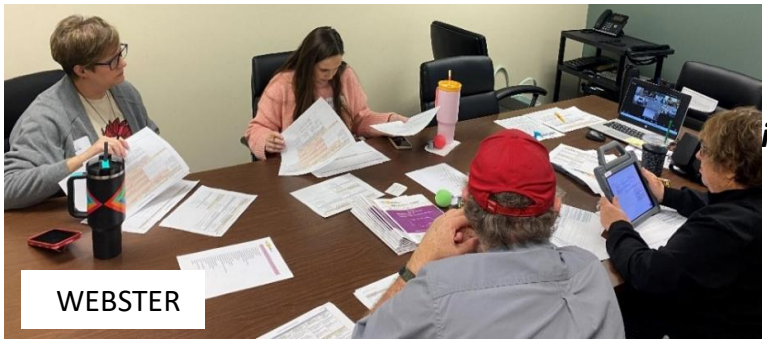
South Heartland staff then fine-tuned and melded similar ideas that came from different teams and put the resulting strategies into the desired CHIP plan format. The final strategies touch multiple levels of the health impact pyramid from socioeconomic factors (bottom of the pyramid) to counseling and education (top of the pyramid).

Community Health Improvement Planning on January 31 to identify strategies to address root causes of issues related to the three health priorities: Mental Wellbeing, Chronic Disease Conditions, and Senior Health.

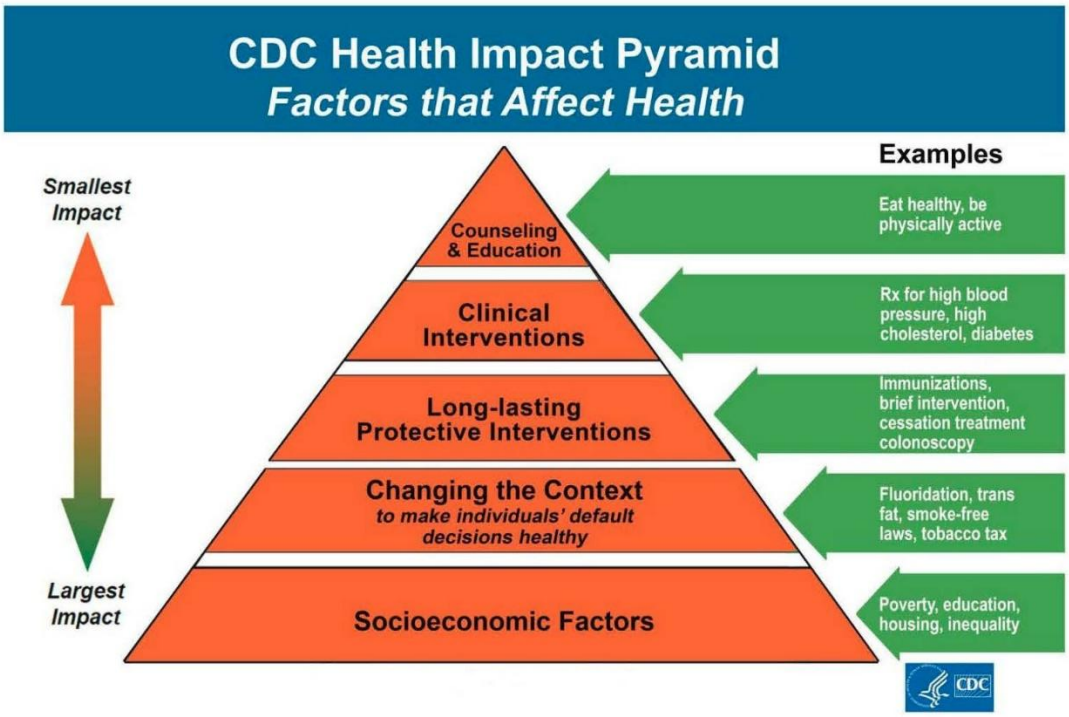

ADAMS


NUCKOLLS


CLAY


WEBSTER

The Health Impact Pyramid is a graphical representation of tiers of influence that may result from public health interventions. At the base of the pyramid, indicating interventions with the greatest potential impact, are efforts to address social determinants of health. In ascending order are interventions that change the context to make individuals' default decisions healthy, clinical interventions that require limited contact but confer long-term protection, ongoing direct clinical care, and health education and counseling. Interventions focusing on lower levels of the pyramid tend to be more effective because they reach broader segments of society and require less individual effort. Implementing interventions at each of the levels can achieve the maximum possible sustained public health benefit.



Adapted from Thomas R. Frieden. A Framework for Public Health Action: The Health Impact Pyramid. American Journal of Public Health: April 2010, Vol. 100, No. 4, pp. 590-595. doi: 10.2105/AJPH.2009.185652

This version of the Health Impact Pyramid from: Connecticut Health Improvement Coalition
file:///S:/Quality%20Performance%20&%20Accreditation/Community%20Health%20Improvement%20Plan%202025-2030/Draft%20CHIP%20Template/2018-04-16-appendix-l-cdc-health-impact-pyramid.pdf

CHIP Launch and Implementation

The “launch” of the Community Health Improvement Plan (CHIP) will include invitations to all participating partners involved in the previous processes that determined ‘Priority Goals, Objectives, Root Causes and Strategies’ (approximately 80 individuals/organizations). At the launch event, SHDHD will (1) review the community-chosen priorities and (2) introduce the finalized strategies that were merged and funneled down from the contributions of teams of community members in January, and (3) describe the structure for implementation. Individuals and organizations will have an opportunity to choose which strategy/ies they would like to support for implementation (commitment activity).

Team leads (volunteers or recruits) will be responsible for facilitating their team’s decisions about strategy timelines, confirming performance measures, communicating data needs and assuring reporting responsibilities. SHDHD will provide back bone support, touching base about progress, data and report out processes, guiding quality improvement opportunities, and planning annual full CHIP progress celebrations.

By sustaining a transparent, data-driven, and community-owned process, SHDHD and its partners are poised to make measurable strides in Mental Wellbeing, Chronic Disease Conditions, and Senior Health across South Heartland during 2025-2030.

Launching our plan for “Healthy People in Healthy Communities”!

South Heartland Community Health Improvement Plan 2025-2030

Summary of Priority Goals, Objectives, Root Causes and Strategies

Priority	Objective	Root Cause	Strategy
Mental Wellbeing	**Improve Access to Mental Health Care**	Cultural Differences/ Stigma	**Coordinate communication efforts to reduce public stigma.**
		Health System Access/Barriers	**Improve access by filling prioritized (by county & by population needs) mental health provider gaps.**
			Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.
			Explore pathways for providing access to behavioral health risk assessments and screenings for all South Heartland residents.
	Decrease prevalence of factors contributing to poor mental health outcomes	Community System Support	**Promote evidence-based/community based trainings for lay community skills and interventions (Mental Health First Aid, QPR, healthy social media use).**
		Individual Behaviors	**Implement "Connecting People" (evidence-based community engagement) to enhance community members' social networks and connections to improve their quality of life.**
Chronic Disease Conditions	**Improve understanding / access to screening & prevention resources**	Knowledge/ Awareness	**Implement a coordinated community campaign for screening opportunities through various partners.**
		Health System Access/Barriers	**Explore pathways for providing access to chronic disease risk assessments and screenings for all South Heartland residents.**
		Individual Behaviors	**Assure community prevention supports, including community-based lifestyle modification programs (e.g., DPP, BPSM/Hypertension Management) to address chronic disease risk factors and promote individual healthy choices.**
	Improve access to and navigation of the health system (options, services, costs, insurance)	Health System Access/ Barriers, Knowledge/ Awareness, Individual Behaviors	**Create and promote roadmaps for patients/providers for effectively navigating the healthcare and behavioral health system using evidence-based strategies.**
		Health System Access/ Barriers	**Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.**
Senior Health	**Improve access to resources to maintain successful independent living**	Cost/Income/Poverty	**Health Insurance literacy and enrollment assistance.**
		Health System Access/Barriers	**Improve access by filling prioritized (by county & by population needs) transportation gaps.**
		Community System/ Supports	**Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.**
			Expand Falls Prevention Programs and promote provider and community referrals, especially for high-risk individuals.
	Increase socialization and physical/social support	Cultural Differences/ Stigma	**Implement community senior social centers. (Provide structure within every community for a viable, peer-driven engaged senior social center.)**
		Individual Behaviors	**Implement a community-based Program to Encourage Active, Rewarding Lives (PEARLS) to encourage activity and socialization.**

Priority 1 Mental Wellbeing

Overview/Snapshot: Mental Wellbeing (which includes feelings of sadness, worry, and stress) was tied as the 2nd most important health issue among survey respondents. Results from focus groups of community members highlighted the pressing need for improved access to mental health services, with particular emphasis on the shortage of providers, long wait times, and challenges for Medicaid patients. Nearly half of respondents to our community health survey reported they sometimes, often, or always felt lonely, isolated, depressed, hopeless, stressed, or overwhelmed in the past year. The suicide rate among adults in Adams County was higher than the state and U.S. rates. Financial stress, stigma, language barriers, and the lack of community-based mental health support further exacerbate the mental health challenges. All four SHDHD counties are designated as Mental Health Professional Shortage Areas.

Objective MW 1: Improve access to mental health care

Strategy MW 1.1 Coordinate communication efforts to reduce public stigma.

Strategy MW 1.2 Improve access by filling prioritized (by county & by population needs) mental health provider gaps.

Strategy MW 1.3 Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.

Strategy MW 1.4 Explore pathways for providing access to behavioral health risk assessments and screenings for all South Heartland residents.

Objective MW 2: Decrease prevalence of factors contributing to poor mental health outcomes

Strategy MW 2.1 Promote evidence-based/community-based trainings for lay community skills and interventions (Mental Health First Aid, QPR, healthy social media use).

Strategy MW 2.2 Implement "Connecting People" (evidence-based community engagement) to enhance community members' social networks and connections to improve their quality of life.

Measures/Data Sources*/Targets:

Number of SHDHD counties that are designated mental health shortage areas	HRSA	<4 Counties
Percentage of adults ever told they had depression	BRFSS	Downward trend
Percentage of adults reporting that their mental health was not good for 14 or more of the past 30 days	BRFSS	Downward trend
Percentage of HS students reporting depression in the last 12 months	NRPFSS	Downward trend

*HRSA=Health Resources and Services Administration; BRFSS=Behavioral Risk Factor Surveillance System, NRPFSS=Nebraska Risk and Protective Factor Surveillance System

Objective MW 1: Improve access to mental health care

Strategy MW 1.1 ***If We:*** Coordinate communication efforts to reduce public stigma…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Develop/Offer cultural competency training for PCP/BH healthcare professionals	Effective patient-provider communication	Reduced stigma in healthcare and behavioral health settings
Integrate measures for mental well-being along with other routine and standard primary care protocols and promote mental wellbeing as a component of chronic disease prevention/management	• Mental health care is more accessible and less intimidating	Individuals seek help when needed
Community agencies/partners collaborate on public awareness campaigns and education focusing on correcting inaccurate stereotypes about people living with mental disorders	• Availability of factual, disconfirming information about prevalence, the possibilities for recovery, etc. • More partners acknowledge and communicate about mental health	• Public understanding of mental health conditions and empathy towards affected individuals • More community members talking about mental health and recognizing concerns.
Interpersonal contact and peer support opportunities between the general public and members of a stigmatized group	Individuals who have personally experienced mental health issues provide support services to others	Reduction in self-stigma, improved self-esteem and feelings of empowerment among MH service users
With these community partners and assets…		
Extension UNL, ministerial associations, first responders, rural mental health, nursing homes, assisted living, mothers groups, CCC, parks departments Promising Practices: *Mental Health Stigma and Communication and Their Intersections with Education (https://pmc.ncbi.nlm.nih.gov/articles/PMC6660176/pdf/nihms-1507172.pdf); Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review (DOI: 10.7759/cureus.39549)*		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of culture competency trainings offered to providers • #/% of clinics with Integrated measures for mental well-being • # of public awareness campaigns	• % of patients reporting effective provider communication • # of individuals providing peer support services • # of interpersonal contact or peer support opportunities	• Trends in percent of patients referred for MH services who follow through. • % of MH service users with improved self-esteem.

Objective MW 1: Improve access to mental health care

Strategy MW 1.2 ***If We***: Improve access by filling prioritized (by county & by population needs) mental health provider gaps…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Bi-annual assessments of provider knowledge, referral and specialty gaps by county and by population need	Continuing education for providers to know how to utilize resources	Providers confident in screening and referral for behavioral health needs
Healthcare/Behavioral Health/Community Collaborative Groups initiated in each county	Collaborative groups identify priority gap/s for their county and steps to address	• Priority gap/s filled • Increased access to a variety of services
Create Communication Campaigns to increase awareness of available services	People are aware the services are available	• More people obtain services • Increase in mental wellbeing for our community members
With these community partners and assets…		
Clinics/providers, BH clinics/providers, schools, churches, government offices, senior centers, libraries, Lanning Center, South Central Behavioral Services, CCBHC, Region 3, SHDHD, NE DBH		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of Bi-annual assessments (goal =3) • # of counties with a collaborative initiated/active • # of communications campaigns	• # of continuing education opportunities offered • # of providers completing continuing education • % of providers satisfied with educational opportunities • % of county collaborative groups with steps to address identified priority gap/s • Trends in referrals from PC and BH providers • (List different screening types and how many are available.) Survey to measure increased awareness • #/% of providers utilizing resources to make referrals	• % of providers confident in screening and referral options • % decrease in ER-to-inpatient admissions for MH diagnosis • #/% Reduced depression scores • % decrease in adolescents attempted suicides • #/% decrease in completed suicides. • % of Counties with reduced gaps in mental health provider gaps (measured by assessments)

Objective MW 1: Improve access to mental health care

Strategy MW 1.3 ***If We:*** Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
SDOH and other intake or screening tools identified and tool use promoted with Navigators, Case Managers, Providers	SDOH and other intake or screening tools utilized to identify needs (universal – no wrong door)	Patient, Community Member needs are identified for referral
FindHelp promoted with community organizations and resources, encouraging training and participation in the single web referral platform	Expand information in FindHelp: comprehensive community resources are connected to a single web platform referral tool, functioning and accessible in all 4 counties Identify resource gaps in our counties and develop/implement a plan to fill resource gaps	Robust referral system that is sustainable and utilized universally throughout all 4 counties
Navigators, CHWs, case managers, providers, discharge staff, and others (HR Leads, EMS, Insurance SMEs, etc.), are aware of/trained/know how to use the referral tool	Navigators, case managers, providers, etc., utilize FindHelp to refer clients/patients to resources	• Improved collaboration, connection, & wrap-around care • Expanded community/mental health / health system navigation and utilization • Decreased mental health emergencies and unnecessary ER services • Increased client/patient satisfaction and access to resources
FindHelp promoted to community members and peer support system	Increased awareness of where to go (one-stop shop) to find resources/services Increased privacy/reduced stigma	Increased community awareness of area professional- and community-based services

With these community partners and assets…		
SHDHD, Schools, Clinics & providers, Clay Co Health Dept, Behavioral Clinics & providers, Churches, Government offices, Your Life Your Voice, 988, Hastings Give Day promotion for $, CIN bilingual navigator, Interpretation services, Mary Lanning, People with lived experiences, Heartland Health Center, Public Schools/ESU9, United Way, Find Help/211, Bridging Forward		
Potential Performance Measures:		
How much change did we produce?	How well did we do it?	Is anyone better off?
• Inventory of screening/intake tools (including behavioral health screeners) • # of trainings, # participants trained in FindHelp platform • Inventory of community resources by type/county • # of trainings, # participants trained in referral • # outreach/promotion activities	• #/% of agencies using intake/screening tools to identify needs • #/% of new community resources in the inventory • #/% of identified resources gaps filled for behavioral health prevention and intervention • # of FindHelp referrals; % increase in referrals over time trends in visits to FindHelp website (and to individual orgs websites) • #/% increase in utilization of services for 988 calls	• #/% clients/patients with positive behavioral health/ SDOH screening results • % of users and referral agents satisfied with FindHelp • Possible to measure referral completions? (Close the Loop) • #/% of clients referred through FindHelp satisfied with referral (referred, and received what they needed Capture/ celebrate patient stories) • Trends in use of emergency mental health care

Objective MW 1: Improve access to mental health care

Strategy MW 1.4 ***If We***: Explore pathways for providing access to behavioral health risk assessments and screenings for all South Heartland residents…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Community awareness of importance/benefit of universal mental health screenings	Aware of screening tools/options (example: online) and trained in their use	More people are getting screened
Stake holder awareness (schools, daycares, providers, home visiting program)	Providers and other stake holders are implementing behavioral health screening tools. Example: online assessments, PHQ, etc.	Persons are referred for care or resources
Identify gaps in those receiving screening (Priority population)	Providers and other stake holders adopt policy, protocol, work flows for screening Eg: EHR triggers, or team-based implementation	Fewer adults report poor mental health days
Identify primary organizations that work with population. (Include pregnant and post partum)	Training in SBIRT for stakeholders	
With these community partners and assets…		
Lanning Center, MAAA, Health and Behavioral Health Providers, CHWs, Community Impact Network, Find Help, LTC, Home Health, Region 3, South Central Behavioral Services, ESU 9, Behavioral Health Private Practice		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of community stakeholders aware of benefits • % of community stakeholders satisfied with training education	• # of trainings • % satisfied with the trainings • % stakeholders who adopt policy, protocol, work flows for screening (# of clinics with EHR that trigger MH screening, # of clinics utilizing a team-based approach to screening) • % Stakeholders are aware of how and where to refer.	• % of patient priority population screened for depression or substance use. • % of adults reporting poor mental health days

Objective MW 2: Decrease prevalence of factors contributing to poor mental health outcomes

Strategy MW 2.1 ***If We***: Promote evidence-based/community-based trainings for lay community skills and interventions (Mental Health First Aid, QPR, healthy social media use)…

<table>
<tr><th>Then people will …</th><th>Resulting in …</th><th>And creating …</th></tr>
<tr><th>Immediate Results</th><th>Bigger Changes</th><th>End Goals</th></tr>
<tr><td colspan="3">2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)</td></tr>
<tr><td>Diverse target audiences identified</td><td>Target audience mental wellness training needs assessed</td><td rowspan="2">Wider community prepared to identify and respond to mental wellness needs/gaps</td></tr>
<tr><td>Instructors identified; training plan created</td><td>Evidence-based trainings offered (Mental Health First Aid, QPR, healthy social media use, trauma-informed care, ACEs, Developmental Assets)</td></tr>
<tr><td colspan="3">With these community partners and assets…</td></tr>
<tr><td colspan="3">Region 3; Opioid Response Network (ORN); local trainers; Lanning Center; hospitals; BH providers, Primary Care Providers; SHDHD; schools/ESU-9; churches; Erin Walsh/Spark & Stitch Institute</td></tr>
<tr><td colspan="3">Potential Performance Measures:</td></tr>
<tr><td colspan="2">How much change did we produce? How well did we do it?</td><td>Is anyone better off?</td></tr>
<tr><td>• # Trainings offered
• # individuals trained</td><td>• % of target audiences offered/receiving training
• % participants completing trainings</td><td>• % of trained participants confident in applying skills</td></tr>
</table>

Objective MW 2: Decrease prevalence of factors contributing to poor mental health outcomes

Strategy MW 2.2 ***If We***: Implement "Connecting People" (evidence-based community engagement) to enhance community members' social networks and connections to improve their quality of life…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Curate relevant community participation opportunities	"What's your why?" portal – Assessment/Exploration Tool – created; a survey that focuses on "what do you love or want to do more of?" (e.g., sing, drama, cooking, being outside, art, volunteering, animals, knitting)	Individuals access the assessment on line or through advocates; can choose to share their info/survey results with an advocate
Identification of diverse messengers; trained and engaged community partners (advocates, could include MH/PCP) who help improve access	Community partners committed to easing and broadening access to community participation activities	Community entities adopt a more collaborative mindset (community well-being mindset)
Plan/Implement a public awareness campaign to promote "What's your why?"	Individuals participate in new opportunities, are exposed to new ideas, meet new people	Individuals build competencies, build/strengthen their social networks and circles of support and build attachment to the local community
With these community partners and assets…		
Encourage, United Way, YMCA, Prairie Loft, social service organizations, libraries, Parks & Rec, volunteer groups, breweries (community spaces), faith groups, FindHelp, CIN, PFLAG, Ag Community, Hispanic community, primary care providers (PCPs), behavioral health providers (BHPs); the "Connecting People" model - https://connectingpeople.net/home/implementation-toolkit/		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*

Trends in survey responses: • #/% times per wk participating in a social activity • #/% people who participate in Community support system • #/% with sense of connection to community • % with >X? days depressed/poor mental health days in past 30 days	• #/% community entities w/ language access • # of community partners committed to easing/broadening access • # of people who complete survey • # of mental health referrals • # community partners trained or engaged in improving access • # of people engaged in volunteerism (trends) • Budget trends for Community Support Services (CSS)	• Anxiety/Depression score rates • Child abuse/neglect rates • Geotargeted social media "feel" • Social isolation/loneliness rates • Post-survey "how did it go"? • Engagement with MH Services

Priority 2 Chronic Disease Conditions

Overview/Snapshot: Long-lasting health conditions (such as diabetes, heart issues, cancer, breathing problems) was tied as the 2nd most important health issue (out of 13 health issues) among survey respondents. Several chronic health themes emerged from focus groups of community members: concerns about prevalence of cancer, diabetes, and obesity; lack of access to specialists for chronic disease management; medication costs, especially for diabetics; a need for more preventive care and community screenings/education; limited access to healthy foods, grocery stores; and limited access to fitness facilities and inadequate infrastructure for physical activity. The percentage of adults reporting they have coronary heart disease was significantly higher for SHDHD counties compared to the state. The percentage of adults reporting that they have diagnosed diabetes (excluding gestational diabetes) has been trending upward, as has the percentage reporting they have high blood pressure. Incidence for cancers (all sites) is high in Clay and Webster Counties, and pediatric cancers are above the national average in Adams, Clay and Nuckolls Counties.

Objective CD 1: Improve understanding/access to screening and prevention resources

Strategy CD 1.1 Implement a coordinated community campaign for screening opportunities through various partners.

Strategy CD 1.2 Explore pathways for providing access to chronic disease risk assessments and screenings for all South Heartland residents.

Strategy CD 1.3 Assure community prevention supports, including community-based lifestyle modification programs (e.g., DPP, BPSM/Hypertension Management), to address chronic disease risk factors and promote individual healthy choices.

Objective CD 2: Improve access to and navigation of the health system (options, services, costs, insurance)

Strategy CD 2.1 Create and promote roadmaps for patients/providers for effectively navigating the healthcare and behavioral health systems (costs, quality, insurances, options, preferences) using evidence-based strategies.

Strategy CD 2.2 Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.

Measures/Data Sources*/Targets:

Percentage of adults reporting they have high blood pressure, diabetes, coronary artery disease, stroke, or cancer of any form	BRFSS	Downward trends

*BRFSS=Behavioral Risk Factor Surveillance System

Objective CD 1: Improve understanding/access to screening and prevention resources

Strategy CD 1.1 ***If We***: Implement a coordinated community campaign for screening opportunities through various partners…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
A core committee and hierarchy of communication development and disbursement are established	A program (community campaign) is launched providing consistent and effective messaging	Increased knowledge and awareness of prevention and screenings opportunities
There will be an education campaign strategy about importance / benefit of chronic disease risk assessment and screenings in place for partners to follow	Enthusiasm is generated among partners around sharing of messaging	Increased number of screenings
Healthcare & community partners have a higher awareness of prevention and screening opportunities and pass those on to their stakeholders	Healthcare entities are disseminating information through EMRs	
With these community partners and assets…		
Hospitals, clinics, health departments, pharmacists, EMS, chiropractors, PTs, worksite and faith-based wellness teams, and other community organizations working to increase access and understanding of screening and prevention resources, American Academy of Pediatrics		
Potential Performance Measures:		
How much change did we produce?	*How well did we do it?*	*Is anyone better off?*
• Core Committee plan regarding hierarchy of message development/ dissemination • 1 Annual Campaign Strategy (6 total) about importance / benefit of chronic disease risk assessment and screenings • # of survey responses / response rate (%) healthcare & community partners - awareness of screening opportunities	• #/% of partners participating in dissemination of information (validation of participation by partners entities) • #/types of communications methods partners are utilizing • #/% of impressions around campaign communications	• # pts screened in community settings and pt survey at screening to determine how they learned about the screening opportunity (tie back to partners and communications methods) • Incidence of screening completion (healthcare facilities, through EMR data)

Objective CD 1: Improve understanding/access to screening and prevention resources

Strategy CD 1.2 ***If We***: Explore pathways for providing access to chronic disease risk assessments and screenings for all South Heartland residents…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Identify gaps in those receiving screenings to determine priority populations	Annual plan/s developed (or revised) with stakeholders to address chronic disease risk assessment & screening gaps for priority populations (barrier reduction)	Priority populations are aware of risk factors for chronic diseases. Priority populations engage in regular screening for chronic diseases
Identify organizations that work with at-risk / priority populations	Stakeholders that work with at risk populations commit to supporting/implementing the plan.	Stakeholders adopt chronic disease screening policies/practices to support clients/employees (Policy)
Stakeholders who work with at risk populations are aware of roles to improve screening access	Plan/s launched	
With these community partners and assets…		
Healthcare entities, CIN network organizations, schools and daycares, worksites, community coalitions, other service partners		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # Gaps and which priority populations identified • List of organizations identified that work with at risk populations • % of stakeholders contacted about roles to improve screening access for priority populations	• # of annual plans completed • % of stakeholders commit to implement the plan/s to increase access to screenings. • % of plans with at least one activity in progress	• % of priority population at risk who complete screening for chronic disease (E.H.R. data?) • #/% of stakeholder organizations offering risk assessments/screenings • #/% of stakeholder organizations sustaining access to risk assessments/screenings through policy adoption

Objective CD 1: Improve understanding/access to screening and prevention resources

Strategy CD 1.3 ***If We***: Assure community-based lifestyle modification programs (e.g., DPP, BPSM/Hypertension Management) and community supports to address chronic disease risk factors and promote individual healthy choices…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Engage coalitions and community partners to evaluate existing community supports for chronic disease prevention (contribute to gap analysis of community supports)	Annual review of community supports to identify successes and implementation barriers	Community supports meet needs of the participants and other stakeholders
Identify evidence-based lifestyle support programs to implement *(to fill prioritized gaps, based on available resources – may need to seek)*	Participants enrolled and are completing lifestyle modification programs.	Program participants achieve measurable lifestyle changes (reduced risk)
Coalitions/ Providers/ Community Partners commit to offering community supports	Community-based supports/lifestyle modification programs are in place	The programs and supports are utilized by community members
Promote available lifestyle modification programs/community supports to providers and community	Providers aware of community-based programs and actively refer.	
With these community partners and assets…		
Diabetes on Track Coalition, Mary Lanning Cancer Committee, Community Impact Network, health care providers, hospitals, MAAA, pharmacies, PTs, dieticians,		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• Completed gap analysis • List of prioritized lifestyle modification programs to implement • # of community partners committed to offer programs • # of providers/community partners approached with information on available programs	• # of participants enrolled, % completing the program, % satisfied with programs • #/% of participants referred by providers • #/% of providers satisfied with the programs	• % participant and stakeholders satisfied with community supports • % of program participants with measurable reduced chronic disease risk

Objective CD 2: Improve access to and navigation of the health system

Strategy CD 2.1 ***If We***: Create and promote roadmaps for patients/providers for effectively navigating the healthcare and behavioral health systems (costs, quality, insurances, options, preferences) using evidence-based strategies…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Encourage evidence-based strategies to include in the health system navigation roadmaps for patients	Develop/Utilize/Promote a roadmap to empower patients for self-advocacy	Patient self-advocacy (e.g., understand rights & responsibilities, ask informed questions, seek reliable information, advocate for self; utilize available resources)
Partner organizations and employers are educated on evidence-based strategies for patient navigation of the health care system	Partner organizations and employers in the community support and empower patients to utilize available resources for navigating the health care system	Patients empowered for self-advocacy
Encourage evidence-based strategy options for providers and navigators as patient advocates	Health/Public health professionals are educated/encouraged to be advocates for patients Health system navigation roadmaps are utilized by health and public health professionals (Policy)	Improved Provider-Patient Collaboration *(e.g., Understand the patient's needs and goals, Educate the patient on their options, Empower the patient to make informed decisions, Collaborate with the healthcare team, Connect the patient with resources and support, Evaluate the patient's outcomes and satisfaction)* Better care, better health outcomes

With these community partners and assets…

- Hospitals (wellness, diabetes ed, social services, pt portal, navigators, chronic care, patient financial services); clinics; pharmacies, worksites, Senior Centers, MAAA, SHDHD, United Way, CIN partners, patients (and their families/caregivers), patient lived experiences.
- Health System Navigation Evidence-Based Practices Summary (JJ, MMB)

Potential Performance Measures:

How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of community stakeholders (community partners, employers & health/public health professionals) educated about patient advocacy and/or patient self-advocacy	• #/% providers utilizing patient advocacy strategies • #/% of pts with portals • # providers using portals for forms & data communication • #/% of providers utilizing reminder recalls for screenings	• Patients share their stories • Increased patient satisfaction scores • % of pts up-to-date on age-eligible recommended chronic disease screenings

Objective CD 1: Improve understanding/access to screening and prevention resources

Strategy CD 2.2 ***If We***: Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
SDOH and other intake or screening tools identified and tool use promoted with Navigators, Case Managers, Providers	SDOH and other intake or screening tools utilized to identify needs (universal – no wrong door)	Patient, Community Member needs are identified for referral
FindHelp promoted with community organizations and resources, encouraging training and participation in the single web referral platform	• Expand information in FindHelp: comprehensive community orgs/resources are connected to a single web platform referral tool, functioning and accessible in all 4 counties • Identify resource gaps in our counties; develop and implement a plan to fill resource gaps	Robust referral system that is sustainable and utilized universally throughout all 4 counties
Navigators, CHWs, case managers, providers, discharge staff, and others (HR Leads, EMS, Insurance SMEs, etc.), are aware of/trained/know how to use the referral tool	Navigators, case managers, providers, etc., utilize FindHelp to refer clients/patients to resources	• Improved collaboration, connection, & wrap-around care • Expanded community/health system navigation and utilization • Decreased unnecessary ER services • Increased client/patient satisfaction and access to resources
FindHelp promoted to community members and peer support system	Increased awareness of where to go (one-stop shop) to find resources/services Increased privacy/reduced stigma	Increased community awareness of area professional- and community-based services
With these community partners and assets…		
United Way, FQHC, MLHC, SHDHD, churches, schools, Community Impact Network, FindHelp		

Potential Performance Measures:		
How much change did we produce? How well did we do it?		Is anyone better off?
• Inventory of screening/intake tools (including CD screeners) • # of trainings, # participants trained in FindHelp platform • Inventory of community resources by type/county • # of trainings, # participants trained in referral • # outreach/promotion activities	• #/% of agencies using an intake/screening tools to identify needs to address chronic disease • #/% of new community resources in the inventory • #/% of identified resources gaps filled for chronic disease prevention and intervention • # of FindHelp referrals; % increase in referrals over time • trends in visits to FindHelp website (and to individual orgs websites)	• #/% clients/patients with positive chronic disease/SDOH screening results • % of users and referral agents satisfied with FindHelp • Possible to measure referral completions? (Close the Loop) • #/% of clients referred through FindHelp satisfied with referral (referred, and received what they needed; patient stories)

Priority 3 Senior Health

Overview/Snapshot: SHDHD counties have a higher percentage of population 65 years and older compared to the state, especially in Nuckolls and Webster. Health of older adults (including memory loss diseases and care for older adults) was tied as the 3rd most important health issue (out of 13 health issues) among survey respondents. The following senior health themes emerged from community focus groups: limited availability of in-home care services and assisted living facilities; transportation barriers; and concerns about the high costs of in-home care services. A significantly higher percentage of SHD area adults in the 65+ age category reported being told they have one of the following chronic health conditions (compared to those in the 45-64 and 18-44 age categories): coronary artery disease, cancer, COPD, diabetes, high blood pressure. In addition, those in the 65+ age group experience more emergency department visits for falls compared to other age groups. The number of falls for this age group has increased since 2018.

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.1 Provide health insurance literacy and enrollment assistance.

Strategy SH 1.2 Improve access by filling prioritized transportation (by county & population needs) gaps.

Strategy SH 1.3 Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.

Strategy SH 1.4 Expand Falls Prevention Programs and promote provider and community referrals, especially for high-risk individuals.

Objective SH 2: Improve socialization and physical/social support

Strategy SH 2.1 Implement community senior social centers (provide structure within every community for a viable, peer-driven engaged elder/senior social center).

Strategy SH 2.2 Implement a community-based Program to Encourage Active and Rewarding Lives (PEARLS) that encourages activity and socialization for older adults.

Measures/Data Sources*/Targets:

Percentage of adults over 45 years experiencing a fall in the past year	BRFSS	Downward trend
Percentage of adults 65+ ever told they had depression	BRFSS	Downward trend
Percentage of local survey respondents indicating that elder care support is a family support resource they need	2027 SHCHS	Downward trend (<16.5%)
Exploratory: Percentage of older adults experiencing social isolation		Downward trend

*BRFSS=Behavioral Risk Factor Surveillance System, SHCHS – South Heartland Community Health Survey

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.1 ***If We***: Provide health insurance literacy and enrollment assistance…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Assess the number/location/capacities of current health insurance enrollment specialists in all 4 counties	Directory of insurance enrollment specialists trained in health insurance literacy (HIL)	Gaps in enrollment specialists filled (as identified in the assessment)
Health Insurance Literacy (HIL) training "curriculum", decision tools, and supports for plain language communication of health insurance plan features are identified/created (with examples of interventions explaining health plan benefits, cost-sharing, etc.)	• Enrollment specialists trained in health insurance literacy (HIL) • Local Enrollment Specialist Community of Practice initiated to communicate best practices and support local collaborative efforts	Enrollment specialists and point of care navigation staff are utilizing tools and training to incorporate HIL into interventions with patients at points of health care navigation
Community organizations and stakeholders are educated on local resources for health insurance literacy	Educational events regarding health insurance literacy opportunities reach older adults in all 4 counties	More older adults with insurance self-efficacy (health insurance literacy measure)
With these community partners and assets…		
Hospitals, SHDHD, MAAA, United Way, Community Impact Network, primary care clinics, behavioral health providers, dental providers, Center for Consumer Information and Insurance Oversight (CCIIO); *Association of Health Insurance Literacy with Health Care Utilization: a Systematic Review (Yagi, BF, et al., J. Gen Intern Med 37(2):375-89; Ten Attributes of a Health Literate Organization;* (HIL) Measure		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # of health insurance enrollment specialists per county • # insurance enrollment specialist gaps identified • HIL Training Curriculum and Tool Kit • # community organizations educated on HIL resources	• Improved health insurance literacy at point of health care navigation (% of pts…) • # of enrollments specialists trained in health insurance literacy for medicine (goal at least 1 per county) • % of trained enrollment specialists satisfied they have the skills to address health insurance literacy with patients • % of patients with improved insurance self-efficacy (Health Insurance Literacy Measure)	• Increased usage of primary care and other preventive services • Reduced ER utilization for non-emergency • Increased medication adherence • % patients up-to-date on preventive screenings and wellness exams

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.2 ***If We***: Improve access by filling prioritized transportation (by county & population needs) gaps…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Transportation assessment results are obtained (or previous are reviewed) to understand and prioritize needs/gaps/barriers by county	Resources (human, funding, etc.) are identified to support bi-directional transportation needs (people and/or goods delivery)	Transportation services are affordable and reliable in all 4 counties
Transportation solutions created to address the prioritized gaps in each county (including on-demand transportation services?)	A transportation plan is piloted/launched in each county	Seniors have reliable, affordable transportation to access the health system and other resources for independent living
Community and partners (health providers, local businesses, etc.) are aware of and support prioritized transportation-based needs and gaps	Local community partners (including retailers, in-home care providers, etc.) utilize transit resources to address elder needs (health and social determinants of health)	Age-friendly communities; Increased local economic success
With these community partners and assets…		
Agency on Aging; Midland Public Transit; R.Y.D.E. Transit; Senior Centers; Hospitals/Clinics; Rural Passenger Transportation Assistance Program; United Way; Nebraska Hospital Association – Age-Friendly Community initiatives; local businesses		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• Transportation assessment review completed • # increase total rides given • % decrease in wait times for rides	• #/% increase in transportation options (in all 4 counties) • % decrease in no-show appointments (monitored by health system?) • #/% increase in access to appointments (monitored by health system?)	• #/% Transportation system users (seniors, health system/providers, retailers, etc.) in all 4 counties satisfied with the services/options • #/% of participants with increased disease management through access to appointments (monitored by health system?)

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.3 ***If We***: Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
SDOH and other intake or screening tools identified and tool use promoted with Navigators, Case Managers, Providers	SDOH and other intake or screening tools utilized to identify needs (universal – no wrong door)	Patient, Community Member needs are identified for referral
FindHelp promoted with community organizations and resources, encouraging training and participation in the single web referral platform	Expand information in FindHelp: comprehensive community resources are connected to a single web platform referral tool, functioning and accessible in all 4 counties Identify resource gaps in our counties and develop/implement a plan to fill resource gaps	Robust referral system that is sustainable and utilized universally throughout all 4 counties.
Navigators, CHWs, case managers, providers, discharge staff, and others (HR Leads, EMS, Insurance SMEs, etc.), are aware of/trained/know how to use the referral tool	Navigators, case managers, providers, etc., utilize FindHelp to refer clients/patients to resources.	• Improved collaboration, connection, & wrap-around care • Expanded community/health system navigation and utilization • Decreased unnecessary ER services • Decreased hospitalization and LTCF placement • Increased client/patient satisfaction and access to resources
FindHelp promoted to community members and peer support system	Increased awareness of where to go (one-stop shop) to find resources/services Increased privacy/reduced stigma	Increased community awareness of area professional- and community-based services

With these community partners and assets…		
SHDHD, government, non-governmental organizations, faith-based, any entities that provide services to this population, health department, healthcare systems (hospitals, clinics), transportation services, pharmacy, in-home caregivers, assisted living/home health, senior centers, contractors (home modification), grocery stores		
Potential Performance Measures:		
How much change did we produce?	How well did we do it?	Is anyone better off?
• Inventory of screening/intake tools • # of trainings, # participants trained in FindHelp platform • Inventory of community resources by type/county • # of trainings, # participants trained in referral • # outreach/promotion activities	• #/% of agencies using an intake/screening tools to identify needs • #/% of new community resources in the inventory • #/% of identified resources gaps for seniors filled • # of FindHelp referrals; % increase in referrals over time • trends in visits to FindHelp website (and to individual orgs websites?) • #/% of participants over age 60 served with FindHelp	• #/% clients/patients over age 60 with positive screening results who are referred (data by referring entity?) • % of users and referral agents satisfied with FindHelp resources and referral process • Possible to measure referral completions? (Close the Loop) • #/% of clients over age 60 referred through FindHelp satisfied with referral (referred, and received what they needed? patient stories?)

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.4 ***If We***…Expand Falls Prevention Programs and promote provider and community referrals, especially for high-risk individuals…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Community healthcare professionals and organizations will be aware of the program and its benefits	Increase in awareness of programs offered	The program is a reputable, effective program in South Heartland Communities
There will be a program structure & referral process in place; including community-based program coaches recruited/trained	Increase in older adults that are being referred to the program by providers and organizations that serve the priority (fall risk/ fall history) populations	Participants have Reduced risk of falls, hospitalizations
Health professionals and organizations will be educated on the programs and willing to refer to it	Increase interest in falls prevention programs, increase registered participants	Maintained or increased sense of independence, financial stability
Priority populations will be identified: (e.g., veterans, 60+ members of the community, rural older adult community members living independently/assisted with falls risk and or previous falls)	Serve as an extension to the participants' healthcare needs.	Increase in socialization – gives the elderly population events to look forward to and to invest in their own health
With these community partners and assets…		
Senior center leaders, Midland Area Agency on Aging, health departments, churches, assisted living, independent living organizations, YMCA, Catholic Social Services, Meals on Wheels, healthcare professionals (e.g. eyecare, pharmacists, orthopedics), donor partners within the community, senior centers		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # stakeholders & providers educated about the program • % coaches completing training • % satisfied with the training • % of providers agree to refer • % partners representing priority populations agreeing to promote/refer to the program	• # of classes/cohorts • #/% of providers referring • #/% referrals that enroll • #/% of participants completing the program • #/% of participants • satisfied with the program • #/% of participants from priority populations	• #/% of participants with fall risk/fall history (screening tool) • Overall improved health of seniors

Objective SH 2: Improve socialization and physical/social support

Strategy SH 2.1 ***If We***: Implement community senior social centers (Provide structure within every community, a viable, peer-driven engaged elder/senior social center)…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Current senior centers and local stakeholders provide input about offerings, gaps, needs, barriers to programming/services for seniors	Community members, health professionals, and organizations will be informed about the various programs/services available through senior centers in each county.	• Senior/elder population is engaged; gains a sense of community and purpose of being • Increased socialization in senior population
Solutions identified to fill needs and expand opportunities for physical/social support for seniors	Resources (human, infrastructure, funding, etc.) are identified to support existing or expanded opportunities	• A sustainable program amongst community partners and health professionals • Health care professionals making referrals within their communities
With these community partners and assets…		
Village boards, senior center leaders, Midland Area Agency on Aging, health departments, churches, assisted living, YMCA, Catholic Social Services, Meals on Wheels, donor partners within the community		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # community senior centers and # of seniors participating in programs • # of programs initiated • and baseline overall health?	• Number of participants who successfully completed programs • Survey response rate for feedback related to specific programs or ideas of what the senior/elder population would like to see offered	• Increase active members, re-issue baseline survey for comparison, boost interest in upcoming programs, adjust for changes in living situations.

Objective SH 2: Improve socialization and physical/social support

Strategy SH 2.2 ***If We***: Implement a community-based Program to Encourage Active and Rewarding Lives (PEARLS) that encourages activity and socialization for older adults…

Then people will …	*Resulting in …*	*And creating …*
Immediate Results	**Bigger Changes**	**End Goals**
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Community stakeholders and organizations will be aware of the program and its benefits	A program is piloted/launched in each county	The program is a trusted, effective program in South Heartland Communities
There will be a program structure & referral process in place; including community-based program Coaches recruited/trained;	Older adults are being referred to the program by providers and organizations that serve the priority populations	Participants have reduced/ managed depression
Health professionals will be educated on the program and willing to refer to it	Demand for the program; Participants are satisfied with the program and share their stories	Participants have reduced social isolation & loneliness
Priority populations will be identified: (e.g., older veterans, rural older adult community members living independently with depression)		Participants have reduced hospitalizations and nursing home stays
With these community partners and assets…		
Health department/s, Agency on Aging / Senior Centers, Behavioral health professional/s or other experts in older adult mental health, chronic conditions and medications, Health care providers and community organizations to identify and refer participants, Community organizations to provide staff to be trained to deliver the classes/program/coaching, Community Impact Network (CIN)		
Potential Performance Measures:		
How much change did we produce? How well did we do it?		*Is anyone better off?*
• # community stakeholders & providers educated about the program • % coaches completing training % satisfied with the training • % of providers agreeing to refer • % partners representing priority populations agreeing to promote/refer to the program	• # of classes/cohorts #/% of providers referring #/% referrals that enroll • #/% of participants completing the program • #/% of participants satisfied with the program • #/% of participants from priority populations	• #/% of participants with reduced/ managed depression (screening tool) • #/% of participants with reduced social isolation & loneliness (screening tool) • TBD - Overall improved health of seniors

South Heartland District Health Department

606 N. Minnesota Avenue, Hastings, NE 68901

Office: 402-462-6211 | Fax: 402-462-6219

southheartlandhealth.ne.gov