Fall Prevention: *Stepping On Classes*
Above: Mary Lanning acute care physical therapist Eric Davis, PT, DPT, shows *Stepping On* participants at Adams County Senior Services how to properly get up from a fall. Ryan Bourdo, SPT, teaches participants how to properly navigate steps with a cane. Earlier in the class they showed participants recommended balance exercises to do daily and strength exercises to do 3x/week.

TJ Harvey, Owner/Manager Brown’s Shoe Fit Co., demonstrated different shoes and what to look for in a proper shoe to help prevent falling. Funding to SHDHD from NE DHHS Injury Prevention Program for evidence-based Fall Prevention Center: Guest expert for *Stepping On* class Kristi Stephenson, OD, from Geiger & Dietz Ophthalmology talked about different eye conditions and falling. Deanna Jesse, MS, ED, CVRCB, from the NE Commission for the Blind and Visually Impaired told about the services they offer.

Closed Point of Dispensing (POD) Tabletop Exercises with Long Term Care Centers
Completed six in June including (pictured L to R): Haven Home (Kenesaw), Sutton Community Home, Good Samaritan Society—Superior, and Good Samaritan Society-Hastings. The long term care centers (LTCs) are signing memoranda of agreement to serve as closed PODs that could help dispense antibiotic or vaccine to LTC residents, employees, and employee families in emergency events, pandemics, or other outbreaks.
YMCA Blood Pressure Self-Monitoring Program

On June 20, the YMCA-Hastings (a partner in chronic disease prevention) held a Kick-off event for a new evidence-based initiative to help people monitor and regulate their blood pressure. Approximately 25 Individuals participating in the event were offered healthy snacks, education about blood pressure and healthy eating, a blood pressure check (above) & registration into the 4 month program (below, SHDHD’s Liz Chamberlain helps with program registration).

SHDHD staff (top right) educated and demonstrated to participants about eating healthy and promoted the evidence-based Smart Moves diabetes prevention program. Pharmacist Brent Gollner (right) visited with participants about managing blood pressure.

Clinic Workshop:
Hypertension Protocol Implementation

Left: participants learn as Wanda Kelley from Praesidio presents a video on the value of evidence-based protocols. Center and right: participants divide into small groups to look at components of available toolkits.
SHDHD is increasing access to healthy foods by facilitating changes in vending machine inventory and educating customers about their vending options. Examples of vending machine signage at Brodstone Hospital (left) and a Choose Healthy Here vending taste testing event at Centennial Plastics (right, below).

**Choose Healthy Here! at Ethnic Grocery Stores**

SHDHD is increasing access to healthy foods by facilitating changes in inventory, display, and promotion at groceries that serve populations at higher risk for poor health outcomes. At Market Delicioso, in Hastings, store owners are adding fresh fruits and vegetables and whole grains for their customers.
More Social Supports for Chronic Disease Prevention
Supports for making healthy food choices and being active: Table tent at Brodstone’s cafeteria, Recipe Makeover Workshop, and Mall Walking Club in Hastings.

Recipe Makeover Workshop
Looking to lighten-up your recipes? With just a few subtle changes, recipe makeovers can result in a healthier food without changing the taste!

June 12, 2017
12:00 - 1:00 p.m. or 1:00 - 2:00 p.m.
Brodstone Memorial Hospital
West Conference Room
RSVP to Amber Kusman or any wellness team member. Staff will need to clock out during the presentation.

Taught by Cami Weis, MS, RD
Extension Educator

Risk Communication Exercise. Emergency Response Coordinator Jim Morgan led staff in a tabletop exercise for risk communications and Public Health Coordination Center incident command roles/responsibilities.

CATCH Kids Training: SHDHD hosted our 4th training on CATCH Kids Club After School program, with participants from Hastings Public Schools and the City of Hastings Library. Our partner UNL Extension provided instruction by their CATCH Kids Master Trainer. CATCH is based on the CDC Whole School, Whole Community, Whole Child model in which health education, school environment, and family/community involvement work together to support youth in a healthy lifestyle.
1. Monitor health status and understand health issues facing the community.
(What’s going on in our district? Do we know how healthy we are?) How do we collect and maintain data about conditions of public health importance and about the health status of the population, and how do we make it available to our partners and our community?
- What major problems or trends have we identified in the past 2 months?

Local
- Surveillance data, water violations, and other health information is made available on our website, through links on our website, on SHDHD’s Network of Care website, through news releases and interviews to various forms of media, and upon request from partners or others.
- An acute Nitrate Violation was reported in May for a City of Hastings well in Adams County and posted to our website the same day.
- Reportable Diseases list – Title 173, LHD service area maps and rabies algorithms sent to Mary Lanning ER.
- Zika testing at SHDHD has decreased in 2017 and cases have decreased across the US this year as well. This year there have been 143 symptomatic cases as of June 28, 2017. Last year, there were symptomatic 5,102 cases reported for the US in 2016. US territories report 513 symptomatic cases in 2017 and 36,079 cases for 2016.

2. Protect people from health problems and health hazards.
(Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?)
- What key activities did we complete in the past 2 months to prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities
- What activities did we complete for emergency preparedness (e.g., planning, exercises, and response activities)?
  - A Lead Assessment Home Screening was completed with the assistance of DHHS on June 30th, 2017. Residential screenings identify sources of lead allowing homeowners to mitigate the source and protect children as well as other family members from lead exposure.
  - Worked with NPHL and DHHS for response to unidentified rash. Lab testing was approved and submitted to NPHL to rule out measles. The individual was quarantined during the infectious period as a precaution.
  - Rabies packets were sent out to all vets in our health district. Materials included algorithms for rabies exposure management, contact information, and brochures about rabies. Equine vaccination brochures were also provided for horse owners for West Nile virus prevention.
  - Worked with TRIMRS and other Health Care Coalitions statewide on a state-wide surge capacity Functional Exercise.
  - Getting Memoranda of Agreement (MOA’s) signed with all of law enforcement and Emergency Management in the district and completed review of all Points of Dispensing (POD’s) and Subhub locations for responses that will need distribution and dispensing of vaccine or antibiotic.
  - Began closed Points of Dispensing (closed POD) exercises with all of the long term care LTC facilities in the health district. Very successful. Six completed. One left to go. Currently getting Memoranda of
Understanding (MOUs) signed with all the LTC's for closed POD.'s. Developing Full Scale exercise for all of the LTC's for this fall.

- SHDHD participated in a staff **risk communication tabletop exercise**, conducted by emergency response coordinator Jim Morgan. Staff discussed notifications, timelines, messaging methods and message content, as well as Public Health Coordination Center incident command roles and responsibilities.

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

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

- Provide examples of key information related to physical, behavioral, environmental, social, economic, and other issues affecting health that we provided to the public.
- Provide examples of health promotion programs that we implemented to address identified health problems.

- Staff covered monthly **satellite office hours** in Superior, Clay Center, and Red Cloud.
- Utilized **community sign boards** (located in Edgar, Lawrence, Red Cloud, Bladen, Roseland, and Kenesaw) to get information out. Topics covered in May/June: Women’s Health Month, Sun Safety, Men’s Health Month, West Nile Virus.
- **News releases, public health columns, ads and interviews:** News releases and columns: Men’s Health Month and Women-Take Steps to Better Health. Webster County at bottom in health rating, an interview conducted by NBC/Neb staff regarding Protecting yourself from West Nile and other viruses, Health district urges precautions for heat.
- The following **radon education materials** were provided to CCC Construction Technology class:
  - Radon: A guide to reducing your risk of radon exposure in your home (Brochure)
  - Average Radon Concentrations by County (Map)
  - Highest Radon Results by County (Map)
  - South Heartland District Health Department Radon by County (Local Data Table)
  - International Residential Code: Appendix F
  - Legislative Bill 9 (LB 9) – A bill for an act relating to radon; to adopt the Radon Resistant New Construction Act; and to create a task force.
- Radon packets and presentations were also provided to city government officials at the Board of Supervisor’s meeting in all four counties and the City Council meeting in Juniata.
- **SHDHD Facebook:** In May, the number of people reached was 1528. For June the number of people reached was 2600 people. The topics for Facebook and twitter in May were Melanoma Monday, Don’t Fry Day, and Women’s Health topics throughout the month, June topics centered on Men’s Health topics.
- **Worksite Wellness:** The worksite wellness network meeting for May was focused on the Walk-It toolkit, designed to help businesses learn how they can promote walking in their worksites. 5 businesses attended and each had an action item they are planning to complete by August. June was focused on Nutrition, with 5 businesses attending. All attendees identified one nutrition improvement to implement at their worksites.
- **Senior Center Presentations:** West Nile Virus and Food Safety.
- **Stepping On classes** (fall prevention) started in Adams County w/ 19 participants. Classes include guest experts: Mary Lanning PT taught about daily exercises to improve balance, 3x/wk exercises to improve strength; MLH PTs showed how to navigate steps with a cane and walker and how to get up from a fall; Mary Lanning Lifeline presented home hazards and Geiger & Dietz Ophthalmology along w/ the NE Commission for the Blind and Visually Impaired presented on vision and falls; Brown’s Shoe Fit Co. talked about the proper shoe wear; Bert’s Pharmacy staff will be talking about medications and falls; MLH PT will be back for a presentation on Getting Out and About. Week 7 is a Review and Plan Ahead activity. There will be a 3 month follow-up class in Oct. and, during the intervening 3 months, SHDHD’s program coordinator can provide home safety inspections for interested participants.
- **Beginning Tai Chi Classes** 9 out of 12 Tai Chi Instructors along with the Tai Chi Mentor attended Refresher Training on June 20\(^\text{th}\) @ the Fairfield Auditorium. Beginning Tai Chi classes will start again this fall in the SHDHD district.
- **Smart Moves (Diabetes Prevention Program (DPP)** –SHDHD supported training of 1 new lifestyle coach, a staff member from Mary Lanning, to help support additional classes in the Hastings area.
- **Health Coaching:** 3 trained staff are working through the Every Woman Matters Program to provide health coaching, healthy supports and lifestyle change program opportunities to women across the district who are age 40-75. More than 134 health coaching contacts have been made since July 1, 2017.
4. Engage the community to identify and solve health problems.
   *(How well do we really get people and organizations engaged in health issues?)*
   - **Describe the process for developing SHDHDs community health improvement plan (CHIP) and/or implementing your work plan.**
   - **Provide examples where we engaged the public health system and community to address health problems collaboratively. What were the evidence-based strategies that were implemented?**

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

- **Access to Health Care:**
  - Prevention Connection –
  - Health Literacy Initiative (internal):
  - Health Literacy Initiative (community):

- **Obesity:**
  - Nutrition Advisory Board (NAB) - The NAB met in May with 6 in attendance. The group was very helpful in guiding SHDHD to potential partners for Choose Healthy Here implementation, vending connections and promotion ideas. Outcomes from the meeting include: identifying possible new partnerships, two community members sharing what is happening in their communities, success of the vending kick-off and the barriers experienced, and notification of a recipients of Mid-West Dairy grant for the grocery stores (an eligible partner organization applied for the grant on behalf of our local grocery stores).
  - Prevention Connection: Choose Healthy Here – Healthy food options in convenience and grocery stores. SHDHD continues to work in three Hispanic stores in Hastings implementing the Choose Healthy Here (CHH) program. Two of the three businesses worked with SHDHD to become SNAP-certified but were not approved due to lack of protein options. They all completed their action plan and have some great goals. SHDHD helped with implementation of signage and shelving units. In partnership with local UNL extension, hosted the first taste testing on June 30th with 30 interactions. In addition to trying the food being demoed customers also had the opportunity to get their blood pressure checked and enrolled in the YMCA Self-Monitoring Blood Pressure program.
  - Prevention Connection: Superior’s follow up to their Walking Summit. Superior’s design team promoting walkability didn’t meet in May or June, but did receive a planning grant to help facilitate community conversations on how to improve city streets to improve walkability. When conversations begin again Superior Design team will be actively engaged.
  - Prevention Connection Healthy Vending Initiative SHDHD hosted four taste test events with four partnered sites, Brodstone (55 interactions), Hastings YMCA (40 interactions) Ne Cold Storage (30 interactions) and Centennial Plastic (40 interactions). All signage materials are up to help employees/community members understand the standards and what the new ‘pushers’ indicate.
  - Prevention Connection: Healthy Hastings follow up on action summit. Healthy Hastings continues to meet to fulfill the action plan. At May’s meeting (13 in attendance) committees reported progress and safe kids reported their successful “Walking Safety to Middle School” campaign. The group discussed how to advocate more to promote the Complete Streets concepts at the City level with administration on board. In June (10 in attendance) committees reported, the marketing materials for the park walking activity were shared and what kind of way finding signage would be helpful on and around the Hastings trail as discussed. The ½ cent sales tax was also explained to the committee and plans on how to advocate as a committee were made.
  - SHDHD WoW (Worksite Wellness): May focused on getting out and enjoying the warmer days through a walking challenge and June we focused on sharpening our mental game through brain challenges. 90% of SHDHD staff participated in these challenges. Three lunch and learns provided with topics covering wellbeing to aging healthfully. All staff who participate in the wellness program at SHDHD received 9 stars for the first ½ of the year- first time since SHDHD has started the point system.
  - School Wellness: SHDHD has partnered with the Nebraska Department of Education to host and deliver Coordinated School Health Institutes for 2 schools in the district (Alcott Elementary and Longfellow Elementary) as well as HPS district office staff. The fourth institute was held in May. All participants walked away with action items to complete by August with some signed up to participate in CATCH kids training. In May local UNL extension CATCH Kids Master trainer trained 5 community and school staff on
CATCH Kids Curriculum. SHDHD now has two more entities that will be implementing CATCH Kids evidence-based program.

- **Prevention Connection**: Superior pharmacy identified list of patients not consistent in hypertensive medication pick up and are initiating a program to improve medication compliance through verbal and written education and checking for initial change in compliance after 60-90 days.

- **Cancer**:
  - **SH Cancer Coalition**: South Heartland Cancer Coalition met June. Collaboration occurs as we share time and resources while working toward the common goal of raising awareness of the need for cancer screenings, education to inform of symptoms and advantages of early detection and promoting evidence based screenings. Recent areas of focus: Colorectal Cancer screening follow-up to encourage FOBT kit completion, return and case management, providing sun safety bags with printed education, sunscreen and lip balm to champion providers in each county, bags are to be used along with provider counseling for patients age 10-24 at school physicals or other visits, working to coordinate sun safety education into middle school health classes, follow-up of referrals from skin screenings at VSHF, and planning ways to increase HPV vaccination rates.
  - **Mary Lanning Healthcare Cancer Committee**: SHDHD participates in quarterly meetings. Mary Lanning /Morrison Cancer Center are key partners in advancing community education and screening activities and are key partners in the SH Cancer Coalition.
  - **Lung Cancer**: Nebraska Quit Line cards were included in all FOBT colon cancer kits this campaign. Education and resources are commonly shared through our health coaching contacts. Staff identified residents who have mitigated their homes and will be interviewing them for additional radon testing and mitigation promotion. Radon detection kits continue to be available through the HD and satellite offices. Invited presentation on radon to 25 individuals at Werner Construction.
  - **Colon Cancer**: FOBT colon cancer screening kits are available to all district residents age 50-75 throughout the year with primary promotion during the March Colorectal Cancer Campaign. Partners across all 4 counties assist in distributing these kits. Partners include: South Central Partnership, SH Cancer Coalition, Clay County Health Department, Webster County Hospital, Brodstone Hospital and area pharmacies. 411 FOBT kits have been distributed to date since the March campaign. Current return rate is 62% which is up from 46% in 2016. 7 clients have tested positive and are receiving case management.
  - **Cervical Cancer**: Human Papillomavirus (HPV) vaccine educational materials are shared at monthly VFC clinics. CHWs continue to work with clients to access health care and EWM resources.
  - **Breast Cancer**: Using the Encounter Registry we continue to identify women in need of breast, cervical and colorectal cancer screening as well as resources to lifestyle change. Needs are assessed including health coverage and other barriers that might stand in the way of a woman completing cancer and cardiovascular screenings. Those without insurance who meet the Every Woman Matters program requirements are assisted with completing the Healthy Lifestyle Questionnaire to enroll in the program. Those not meeting requirements are connected with the clinics offering assistance or Komen funds.
  - **Prostate Cancer**: 2 Hastings College students working with our Sun Safety project in 2016 have been helping with some additional projects this spring/summer. Sophia Pankratz worked with HHS staff to bring a sun safety education power point and interactive Jeopardy game to the Freshman mentoring program. She and Jake Fowler helped assemble bags of sun safety education, sunscreen and lip balm and have delivered those bags to clinics with champion health care providers we engaged with the 2016 project. June 7th, Jake Fowler went to Liberty Cove and provided education to 63 8-12 year olds on sun safe behaviors. From pre/post questions all children increased their knowledge about sun safety. Jake was accompanied by summer employee, Albert Pedroza, who is also a HC student.

- **Substance Abuse**:
- **Mental Health**:
  - **VetSET – Dates have been schedule for our partners that are interested in attending Mental Health 1st Aid July 18 from 8am – 5 pm and Trauma 101 and recovery July 25 9am – Noon, both trainings will be held @ SHDHD and our free to our partners.**
- **VetSET Making Connections** project initiated – overall local work plan activities for Year1: 1) Partner with local area agencies to identify and connect with local veteran families. Partner agencies will include Midland Area Agency on Aging, Military Service Organizations, K-12 school systems and colleges in SHDHD and faith based community, 2) Participate in the Social media campaign workshop and roll out across the various media platforms with consistent coverage and penetration, 3) Identify and reach out to local military unit leaders in our district. Once identified, maintain consistent (monthly) contact with local military leadership and community partners by promoting outreach events, relevant information, training opportunities and social media highlights, 4) Use our local task force to brainstorm and plan a future fun and relaxing family activity to get Veterans and their Family members outside together. (i.e. possible idea may include buddy/family checks, etc).

- **Other Collaborations** (1422): Hastings YMCA has kicked off their **BP management program**. They have been going 1 week and have 10-12 participants with 1 provider office and a pharmacy actively referring patients to the program. SHDHD has partnered on this launch and has staff trained as Health Ambassadors for this program.

5. Develop public health policies and plans. *(What policies promote health in our district? How effective are we in planning and in setting health policies?)*

- What policies have we proposed and implemented that improve population health and/or reduce disparities?
- Describe how our department engaged in agency-specific strategic planning to develop a vision, mission, and guiding principles that reflect the community’s public health needs, and to prioritize services and programs.
- What plans are we developing and implementing to improve our department’s quality and effectiveness (plans for quality improvement, workforce development, branding, communication, and performance management)?

- **Grant Proposals (Plans)/Awards/New Funding:**
  - As of June 30, no subawards signed yet for PHEP funds or Health Hub/ Every Woman Matters. Health Hub start date was pushed back to August 1st (State has not received a Notice of Award from feds, so DHHS cannot issue a subaward.
  - Signed a contract with NALHD for **VetSET Making Connections project** – focused on mental health and wellness of men and boys, especially veteran and military servicemen and their families. $5,950.
  - **West Nile Virus/Arbovirus surveillance** subaward initiated - the scope for this year is expanded to other arboviruses for outreach, and for mosquito surveillance if Zika-positive humans are reported.

- **The Performance Management System framework** implementation continues through performance measurement evaluation and ongoing quality improvement activities. Current QI projects include Coding: Procurement, Coding: Supply Inventory, Staff Engagement Survey, Staff CLAS Survey and VFC Swim Lanes (Clinic Flow).

- **The Board Policy Committee** reviewed the following (June 22): governance documents chosen for Domain 12, Draft Policy for reviewing policies, addressing identified inconsistencies in HD plans, and viewing of core competency priorities (Workforce Development), Staff Engagement Survey results, and the changes to the website.

- **Prevention connection: Blood Pressure Management** - with partner consultant Praesidio, prepared and provided education to 5 district clinics on BP protocol value and implementation. The group reviewed 6 toolkits available to support efforts.

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

- Describe our efforts to educate members of our community on public health laws, policies, regulations, and ordinances and how to comply with them.
- What laws and regulations have we helped enforce to protect the public’s health?

- **Nebraska Clean Indoor Air Act**: No smoking violations reported this period.

- SHDHD receives **food recall alerts** from the Nebraska Department of Agriculture. We also maintain a link on our website to the FDA Food Safety webpage.
7. Help people receive health services.

(Are people receiving the medical care they need?)
- Describe the gaps that our department has identified in personal health services.
- Describe the strategies and services that we have supported and implemented to increase access to health care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.

➢ In May/June the Vaccine for Children clinic staff delivered 63 vaccines to 26 patients at two monthly clinics. Of those 26 patients, 19 had no insurance, 5 had Medicaid and 2 were underinsured. 9 of the 26 patients were new to the clinic. Total donation collected from clients for May/June = $255.25 (avg. $4.39 per immunization or $9.65 per patient). Quarterly recall reminder letters were mailed to 94 patients associated with our clinic who are not up to date with all recommended vaccines.

➢ In May/June the Adult Immunization Program delivering Tdap to uninsured or underinsured adults 19 and over, administered 11 Tdap vaccines to 11 patients who were all uninsured. All 11 adults were new to the clinic.

➢ Community Health Worker

Every Woman Matters (EWM)/Encounter Registry: 14 adult clients assisted in office, 41 adult client seen at home visits, 156 adult medical referrals to other organizations/providers, 1 child immunization referrals, 11 referrals for Smart Moves, 6 Health Coaching support calls to eligible Spanish speaking participants.


Minority Health Diabetes Management - May - Health Fair. Participants had blood work, blood pressure, and BMI done (85 people attended). June - Outdoor exercise activity at Hastings Lake (37 people attended). Followed up with 134 members over the two months to check up on their diet/exercise regimens/medication.

Prevention Connection – Facilitated group of 3 CHW (Alzheimers Association, 2 SHDHD) visit 3 Hastings clinics (ML Hastings Family Care and Community Health and Family Medical Center of Hastings) for networking. Also shared BP locations tool available on SHDHD web page and provided copies.

Prevention Connection - the YMCA hosted a kick-off event to their Self-Monitored BP program and enrolled 6 individuals. SHDHD participated with staff assisting with registration and a table with nutrition education and Smart Moves promotion.

Prevention Connection - we have a new Smart Moves coach from Mary Lanning who will be helping to educate the Hastings community. She has been oriented to our district history and plans and with supervisors and SHDHD is navigating what populations will be serving.

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

(Do we have a competent public health staff? How can we be sure that our staff stays current?)
- Describe our efforts to evaluate LHD staff members’ public health competencies. How have we addressed these deficiencies?
- Describe the strategies we have used to develop, train, and retain a diverse staff.
- Provide examples of training experiences that were provided for staff.
- Describe the activities that we have completed to establish a workforce development plan.

➢ Performance management. Results Based Accountability continues to be implemented weekly in performance measures of programs and services (quantitative, qualitative and outcomes). Ethics Procedures are completed, and were reviewed with staff. Health Literacy/CLAS Procedures and Resources and Core Competency priorities for workforce development/training were reviewed.

➢ Center for Preparedness Education offered their 15th Annual Preparedness Symposium. Sessions included: Flint, MI water crisis; a TTX on assisting a LTC facility during an unsafe water event, Autism during an Emergency, Cybersecurity and Foodborne illness. J.Morgan and J. Warner attended.

Regional Health Equity webinar 6/1/17 - M.Bever and J.Warner attended a webinar focused on defining disparities in our communities and working towards assisting dispirit populations.

HC student Corinne Huthoefer completed an internship at SHDHD during the spring assisting in health literacy for disease surveillance materials.

EWM Health Hub – in May/June, 1 staff attended 2 DHHS training webinars focused on health coaching activities, 4 staff attended the quarterly Hub leadership meeting, 1 staff and 1 SH Cancer Coalition member attended the Nebraska Cancer Coalition’s (NC2) NE Cancer Summit, 1 staff attended the following 3 NC 2 webinars: The Burden of Cancer in NE: Recent Incidence and Mortality, BRFSS Overview and Opportunities for Collecting and Reporting Cancer Related Data, Nebraska as the Healthiest & Most Equitable State (all 3 are available for viewing at www.necancer.org/webinars)

Nebraska Health Policy Short Course – E. Hardy, B. Wolfe and D. Hultman attended this 2 day training.

Immunization – 2 Immunization program staff attended the annual Immunize NE Conference to learn about current best practices.

Policy Development - 3 staff completed 2 day education on tools and practices for policy development at a Policy Academy training event.

Prevention Connection: Brooke and Elizabeth attended the Chronic Disease Summit hosted by NE DHHS to learn about evidence-based practices for chronic disease prevention. Brooke, Liz and Lorena completed the National YMCA Community Based Blood Pressure training to become Heart Health Ambassadors.

Prevention Connection: Brooke attended a “Walk- Audit training” by Mark Fenton to help support local communities assess their walking environment.

Three SHDHD staff attended an in-person “Social Media know how” with 4 other staff members attending via distance.

Hired 2 Hastings College students as program assistants in mosquito surveillance (Albert Pedroza) and chronic disease prevention (Alex Stogdill).

Serving as preceptor to UNMC College of Public Health Master’s student Katherine Kotas – who is doing her capstone project on fall prevention and analyzing Tai Chi program data and older adult fall data for SHDHD. She is also logging service learning hours with SHDHD this summer, assisting at Stepping On classes and the SHDHD booth at County Fairs.

9. Evaluate and improve programs and interventions.

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

- Provide examples of our evaluation activities related to evidence-based public health programs.
- Provide examples of QI projects that we have completed or are in process.

Choose Healthy Here initiative evaluation: Continued with Gretchen Swanson Center for Nutrition (GSCN) and NeDHHS on evaluation of Choose Healthy Here materials in partner Grocery Stores. Completed the mid-term NEMs grocery store assessment.

The Quality Improvement Team and the Accreditation Leadership Team (ALT): QI Team is now called the QI-PM Team to include performance management. The QI coding (formally procurement) project is completing the 9 month evaluation. Successes include improved process and decreased reliance on the line of credit. We are also implementing a second project for supply tracking to increase the correct match of inventory use to the corresponding grant. The VFC team is working on improving clinic workflow. They conducted a survey of staff satisfaction, knowledge and barriers to steps in the “swim lane” of clinic work flow. Based on the survey results, the team identified changes to improve efficiency and implemented these at the June Clinic.

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

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

- Provide examples of evidence-based programs our department is implementing.
- Describe how we have collaborated with researchers to conduct any research studies (e.g., completed surveys, interviews, or focus groups).

Evidence Based:

○ SHDHD is continuing to implement the year 3 work plan consisting of evidence-based strategies for prevention of cardiovascular disease and diabetes as part of the 4-year Chronic Disease Prevention project (Prevention Connection).

○ SHDHD is partnering with worksite wellness committees and using evidence-based practices for improving physical activity and nutrition in worksites.
o In the Every Woman Matters/Community Health Hub project, SHDHD uses evidence-based strategies to address health inequities and improve screening rates for cervical, breast and colon cancers.

o Tai Chi – Moving for Better Balance and Stepping On are evidence-based programs for fall prevention in older adults. In South Heartland, beginning and/or advanced classes Tai Chi classes are being offered in all 4 counties and Stepping On classes are currently go on in Adams County with 19 participants and Clay County will be having their 1st class sometime this fall.

o We are continuing to use a Reminder Recall process for immunization clinic clients to improve immunization rates.

o Public Health Accreditation Board (PHAB) Standards and Measures are evidence based. SHDHD continues to become more aligned with these evidence based standards and measures as we progress through the accreditation process and apply them to our plans, policies and programs. This includes the review of current plans, and the development of other required plans, to align them with the PHAB standards and measures. Required documents must meet the PHAB guidelines for each measure. 184 of the 308 required documents have been reviewed and uploaded by Michele and Janis into ePHAB.

o Coordinated School Health Institutes: In partnership with Nebraska Department of Education, SHDHD is bringing in a fourth round of evidence-based Coordinated School Health Institutes to improve school wellness. The series of 4 institutes began in February and ended in May.

o CATCH Kids: In partnership with UNL Extension, CATCH Kids Master Trainer, SHDHD hosted fourth CATCH Kids training for local schools and organizations that interact with children to improve physical activity time through an evidence-based curriculum designed to work physical activity into a variety of subjects and teaching them about nutrition.

➢ Research:

o SHDHD participated in a research study led by Dave Palm, UNMC College of Public Health, to identify the linkages in programs and activities that are already being implemented between LHDs and primary care clinics in Nebraska. M. Bever was interviewed about ways that SHDHD works with primary care clinics and hospitals to improve community health. The resulting Research Findings Brief: Current Linkages between Local Public Health Departments and Primary Care Clinics in Nebraska to Improve Population Health Outcomes includes the following highlights:

  o There are several projects in Nebraska that link programs and activities between local health departments and primary care clinics.

  o Most of the projects implemented in the last three years focus on the prevention and control of chronic diseases and include health coaching such as the National Diabetes Prevention Program, screening programs for hypertension, promotion of cancer screening programs, and worksite wellness programs.

  o Although the majority of Local Health Departments (LHDs) are employing community health workers (CHWs) and using them as serving as health coaches, acting as interpreters, assisting clients in submitting Medicaid applications, and many other duties; relatively few of the CHWs have direct connections with primary care clinics.

  o There are many other programs and activities such as making home visits for low income families after a birth of a child, sharing educational messages, and assisting clinics in analyzing their electronic health records (EHR) data.

  o To expand the scope and reach of these linkages, some challenges must be overcome, including differences in training and culture (treatment of individual patients versus the whole population) and limited capacity and resources (workforce shortages, inadequate short term funding, and lack of sustainable long term funding).
Stories: How we made a difference….

Our community health worker, Lorena Najera, is also a National Diabetes Prevention Program (NDPP)-trained lifestyle coach. She and community health worker Mixa Reyes from Mary Lanning’s Community Clinic have been team teaching a Smart Moves Diabetes Prevention class in Spanish. One class participant, Mrs. Dayamis Negrin, was finding some success in losing weight through the class. Then her work schedule changed and she was unable to come to the classes. Lorena helped her stay with the program by scheduling separate coaching sessions with her to make sure she kept up with the class. With Lorena’s help, Mrs. Negrin has continued to lose weight - a total of 29 pounds so far!

Another participant, Mrs Elba Ventura, has arthritis and needed additional encouragement to be active. Lorena set up a morning walk schedule with her and texts her each morning to make sure that she is ready to go to the park. Lorena meets her there and walks with her – usually. Mrs. Ventura is sometimes reluctant, but says she feels better when she walks and she wouldn’t be able to do it without Lorena’s encouragement. This morning Mrs. Ventura was so happy because she had lost 2 pounds since last week. In the coming weeks, Lorena will be vacationing in Mexico and will continue to text Mrs. Ventura about their morning walks – and they will continue to walk “together” in the morning, although they will be nearly 1800 miles apart!

With SHDHD staff going the extra mile to meet people where they are, participants in Smart Moves classes are seeing positive changes to their health and are reducing their risks for diabetes. Now those are some smart moves!