Community Health Improvement Plan

Nebraska Panhandle, Scotts Bluff County Health Department, Panhandle Partnership, Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Kimball Health Services, Morrill County Community Hospital, Regional West Garden County, Regional West Medical Center, Sidney Regional Medical Center

January 2018-January 2020

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Access to Care:
• Increase the proportion of persons with a usual primary care provider (HP 2020: AHS-3)
• Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines (HP 2020: AHS-6)
• Increase the proportion of worksites that offer an employee health promotion program to their employees (HP 2020: ECBP-8)
• Increase the proportion of pregnant women who receive early and adequate prenatal care (HP 2020: MICH-10)
• Increase the proportion of women giving birth who attend a postpartum care visit with a health worker (HP 2020: MICH 19)
• Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth (HP 2020: OH-1)
	• Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Source: Community Preventive Services Task Force)
	• Reducing Structural Barriers for Clients (Source: The Community Guide)
	  ○ Colorectal Cancer
	  ○ Breast Cancer
	  ○ Cervical Cancer
	• Worksite: Assessment of Health Risks with Feedback (AHRF) to Change Employees' Health – AHRF Plus Health Education With or Without Other Interventions (Source: Community Preventive Services Task Force)
	• Home Visitation Programs (Source: Council on Child and Adolescent Health)
	• Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs (Source: Community Preventive Services Task Force)

Aging Population: • Increase public transit use by older adults • Increase use of resource navigation by older adults • Reduce the rate of emergency department (ED) visits due to falls among older adults (HP 2020: OA-11)	• Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force) • Fall Prevention Program (Source: National Council on Aging)

Behavioral Health:
Mental Well-Being
• Reduce substantiated child maltreatment (based off of HP 2020: IVP-37 & IVP-38)
• Reduce the suicide rate (HP 2020: MHMD-1)
• Increase depression screening by primary care providers (HP 2020: MHMD-11)
• Increase the proportion of schools with a school breakfast program (HP2020: AH-6)
Substance Abuse
• Decrease drug-overdose deaths (based off of HP 2020: MPS-2.4)
• Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women (HP 2020: MICH-11)
• Reduce the proportion of persons engaging in binge drinking of alcoholic beverages (HP 2020: SA-14)
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• Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol (HP 2020: SA-1)
	• Violence: Early Childhood Home Visitation To Prevent – Child Maltreatment (Source: Community Preventive Services Task Force)
	• Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders (Source: Community Preventive Services Task Force)
	• Circle of Security
	• Families and Schools Together (FAST)
	• Suicide Risk: Screening in Adolescents, Adults, and Older Adults (Source: United States Preventive Services Task Force)
	• Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force)[1]
	  ○ Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products
	  ○ Quitline Interventions
	  ○ Smoke-Free Policies
	  ○ Interventions to Increase the Unit Price for Tobacco Products
	• Alcohol – Excessive Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors (Source: Community Preventive Services Task Force)
	• Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Source: Community Preventive Services Task Force)
	• Regional Use of Nebraska Prescription Drug Monitoring Program (Source: Nebraska DHHS)

Chronic Disease:
Cancer
• Reduce the proportion of adults with any kind of cancer (based off of HP 2020: C-1)
	• Cancer Screening: Multicomponent Interventions (Source: Community Preventive Services Task Force)
	  ○ Colorectal Cancer
	  ○ Breast Cancer

• Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines (HP 2020: C-18) • Reduce the proportion of females with human papillomavirus (HPV) infection (HP 2020: STD-9) **Cardiovascular Disease** • Reduce the proportion of adults with hypertension (HP 2020: HD S 5.1) • Reduce stroke deaths (HP 2020: HD S-3) • Reduce coronary heart disease deaths (HP 2020: HD S-2) **Diabetes** • Reduce the annual number of new cases of diagnosed diabetes in the population (HP 2020: D-1) **Chronic Disease Risk Factors** • Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity (HP 2020: PA-2) • Increase the contribution of fruits to the diets of the population aged 2 years and older (HP 2020: NWS-14) • Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older (HP 2020: NWS-15)	○ Cervical Cancer • Vaccination Programs: Community-Based Interventions Implemented in Combination (Source: Community Preventive Services Task Force) • Radon Screening and Mitigation (Source: American Cancer Society) • Skin Cancer: Multicomponent Community-Wide Interventions (Source: Community Preventive Services Task Force) • Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force)[1,2] • Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control (Source: Community Preventive Services Task Force) • Cardiovascular Disease: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control - When Used Alone (Source: Community Preventive Services Task Force) • Diabetes: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk (Source: Community Preventive Services Task Force) • Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)[1] • Physical Activity: Creating or Improving Places for Physical Activity (Source: Community Preventive Services Task Force) • Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables (Source: CDC/NCCDPHP)
Early Childhood Care & Education: • Increase quality childcare and preschool availability (based off of Buffett Early Childhood Institute findings)	• Child Care Quality Measures (Source: Step Up to Quality) • Health Equity: Center-Based Early Childhood Education (Source: Community Preventive Services Task Force) • Social-Emotional Development of Children (Source: Rooted in Relationships)
Social Determinants of Health: **Poverty** • Reduce proportion of persons living in poverty (HP 2020: SDPH-3) • Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade (HP 2020: AH-5.1) **Housing** • Reduce proportion of households that spend more than 30% of income on housing (HP 2020: SDOH-4.1) **Transportation** • Increase use of alternative modes of transportation for work (HP 2020: EH-2) **Intolerance** • Increase the number of health systems that include a standardized set of questions that identify lesbian, gay, bisexual, and transgender people (Based off of HP 2020: LGBT-1)	• Health Equity: High School Completion Programs (Source: Community Preventive Services Task Force) • Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)[1] • Health Equity: Cultural Competency Training for Healthcare Providers (Source: Community Preventive Services Task Force) • Health Equity: Use of Linguistically and Culturally Appropriate Health Education Materials (Source: Community Preventive Services Task Force)

[1]Mutually reinforcing strategy

[2]See directly related objectives for tobacco use under Substance Abuse section.

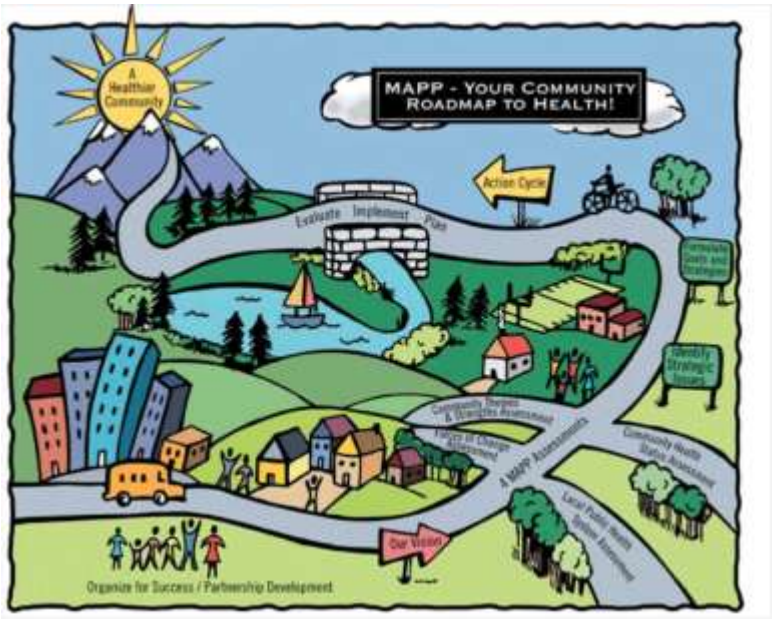
NOTE: HP 2020 stands for Healthy People 2020

Introduction

Overview of the Development Process

Overview of Mobilizing for Action through Planning and Partnerships (MAPP)

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the CHNA and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHNA and CHIP. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation.



The MAPP model has six key phases:

1. Organize for success/Partnership development
2. Visioning
3. Four MAPP assessments
    a. Community Themes and Strengths Assessment (CTSA)
    b. Local Public Health System Assessment
    c. Forces of Change Assessment
    d. Community Health Status Assessment
4. Identify strategic issues
5. Formulate goals and strategies
6. Take action (plan, implement, and evaluate)

This document encompasses phases five and six. Phases one through four can be found in the Community Health Assessment document at www.pphd.org.

Overview of Priority Areas

Priority areas were determined in a prioritization meeting in May, 2017. Stakeholders from across the region attended the meeting. Mind Mapping, a Technology of Participation (ToP) process was used to determine priority areas.

Priority areas determined were:

- **Access to Care**
- **Aging Population**
- **Behavioral Health**, including mental and emotional well-being and substance abuse.
- **Chronic Disease**, specifically cancer, cardiovascular disease, and diabetes.
- **Social Determinants of Health**, specifically transportation, housing, poverty, and intolerance.

At the same time as the Panhandle Community Health Assessment occurred, an Early Childhood Needs Assessment also took place in the Panhandle. Due to the findings of the early childhood needs assessment, we decided to also include **Early Childhood Care and Education** as a priority area in the CHIP.

Background data for each priority area can be found in the Panhandle Community Health Assessment, available on the PPHD website at www.pphd.org.

Selecting Objectives and Strategies

A broad list of objectives and strategies for each priority area (with the exception of Early Childhood Care and Education) were determined at a series of meetings surrounding each priority area in the fall of 2017. See Appendix A for the work products from these meetings. PPHD then narrowed down these lists to measurable and actionable items. Objectives and strategies were selected by taking the following into consideration:

- Availability of data to monitor progress
- Availability of resources
- Community readiness
- State and national priorities

Goal Setting

The Healthy People 2020 target-setting method of a 10% improvement was used to set goals for objectives.

Implementation

The CHIP will be implemented across the next three years, from January 2018 to December 2020. The CHIP will be implemented not only by PPHD but also in collaboration with the implementation partners listed in each priority area section of this document. Individuals from the organizations listed as implementation partners make up a work group for each priority area.

CHIP Priority Area Work Groups

A work group around each priority area was formed through surveys distributed to the broader local public health system and to anyone who attended any community health assessment meeting in 2017 (e.g., health summit, focus group, etc.). The surveys requested people to indicate if they were interested in working on any of the priority areas to:

- Commit to take action on the priority area,
- Meet quarterly,
- Report progress bi-annually, and
- Participate in annual evaluations of the CHIP.

Each work group will develop an annual work plan surrounding their respective priority area, which will be posted on the PPHD website separately from this document. Please visit www.pphd.org to find these work plans.

Evaluation

An annual report on this CHIP will evaluate progress made in implementing strategies in the CHIP and priority area work plans, and consider the feasibility and effectiveness of the strategies and/or changing priorities, resources, or community assets.

This report will include review and revision, as necessary, of the health improvement plan strategies based on results of the assessment. Revisions may be in the:

- Improvement strategies,
- Planned activities,
- Time-frames,
- Targets, and
- Assigned responsibilities

Revisions may be based on:

- Achieved activities,
- Implemented strategies,
- Changing health status indicators,
- Newly developing or identified health issues, and
- Changing level of resources.

Priority Area 1: Access to Care

Objectives

Objective 1.1: Increase the proportion of persons with a usual primary care provider (HP 2020: AHS-3)

Baseline:	24.2% (2015)
Target (2020):	26.6%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report that they do not have a personal doctor or health care provider

Objective 1.2: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines (HP 2020: AHS-6)

Baseline:	13.8%
Target (2020):	12.4%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report that they needed to see a doctor but could not because of cost in the past 12 months.

Objective 1.3: Increase the proportion of worksites that offer an employee health promotion program to their employees (HP 2020: ECBP-8)

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Objective 1.4: Increase the proportion of pregnant women who receive early and adequate prenatal care (HP 2020: MICH-10)

Baseline:	75.1% (2013-2015 three year moving average)
Target (2020):	82.6%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Vital Records
Indicator	Percentage of infants born to a woman receiving prenatal care beginning in the first trimester.

Objective 1.5: Increase the proportion of women giving birth who attend a postpartum care visit with a health worker (HP 2020: MICH 19)

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Objective 1.6: Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth (HP 2020: OH-1)

> *There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.*

Strategies

Evidence-based strategies were selected to address this objective. Specific activities can be found in the CHIP Annual Work Plan:

- Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Source: Community Preventive Services Task Force)
- Reducing Structural Barriers for Clients (Colorectal Cancer, Breast Cancer, Cervical Cancer) (Source: Community Preventive Services Task Force)
- Worksite: Assessment of Health Risks with Feedback (AHRF) to Change Employees' Health – AHRF Plus Health Education With or Without Other Interventions (Source: Community Preventive Services Task Force)
- Home Visitation Programs (Source: Council on Child and Adolescent Health)
- Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs (Source: Community Preventive Services Task Force)

Implementation Partners

Sidney Regional Medical Center
Regional West Health Services
Panhandle Public Health District
Panhandle Trails Intercity Public Transit
Community Action Partnership of Western Nebraska
Region 1 Behavioral Health Authority
Disability Rights Nebraska
Helping Hands Independent Living Center
Dr. Gage Stermensky LLC
Health Thyme, LLC
Panhandle Health Group
Rural Nebraska Healthcare Network
Gordon Memorial Health Services
Box Butte General Hospital
Panhandle Area Development District
Chadron Community Hospital
Kimball Health Services
Regional West Garden County
Educational Service Unit 13
Morrill County Community Hospital
Western Community Health Resources

Priority Area 2: Aging Population

Objectives

Objective 2.1: Increase public transit use by older adults

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Objective 2.2: Increase use of resource navigation by older adults

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Objective 2.3: Reduce the rate of emergency department (ED) visits due to falls among older adults (HP 2020: OA-11)

There are no regional data points that specifically measure this objective. Data for this objective will be developed throughout the cycle of this CHIP, for now the below data point will be used.

Baseline:	13.3% (2015)
Target (2020):	12.0%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 45 and older who report that they were injured due to a fall in the past year.

Strategies

- Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)
- Fall Prevention Program (Source: National Council on Aging)

Implementation Partners

Regional West Health Services
Disability Rights Nebraska
Helping Hands Independent Living Center
The DOVES Program
Western Community Health Resources
Health Thyme, LLC
Scottsbluff Community Health
Deuel County Community Organizer
Aging Office of Western Nebraska
Community Action Partnership of Western Nebraska
Rural Nebraska Healthcare Network
Gordon Memorial Health Services
Box Butte General Hospital
Panhandle Area Development District
Sidney Regional Medical Center
Chadron Community Hospital
Regional West Garden County
Kimball Health Services
Education Service Unit 13
Morrill County Community Hospital
Senior Services, Inc.

Priority Area 3: Behavioral Health

Priority Area 3A: Mental & Emotional Well-Being

Objectives

Objective 3A.1: Reduce substantiated child maltreatment in counties in which the rate is higher than the rate for the state of Nebraska (based off of HP 2020: IVP-37 & IVP-38)

Baseline:	Scotts Bluff County – 10.5 per 1,000 children (2015)
Target (2020):	Scotts Bluff County – 9.45 per 1,000 children
Target-Setting Method:	10% improvement
Data Source:	Kids Count in Nebraska Report
Indicator	Number of substantiated victims of child maltreatment.

Objective 3A.2: Reduce the suicide death rate (HP 2020: MHMD-1)

Baseline:	17.5 per 100,000 population (2013-2015 combined)
Target (2020):	15.8 per 100,000 population
Target-Setting Method:	10% improvement
Data Source:	Nebraska Vital Records
Indicator	Suicide death rate per 100,000 population (age-adjusted)

Objective 3A.3: Increase depression screening by primary care providers (HP 2020: MHMD-11)

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Objective 3A.4: Increase the proportion of schools with a school breakfast program (HP2020: AH-6)

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Strategies

- Violence: Early Childhood Home Visitation To Prevent – Child Maltreatment (Source: Community Preventive Services Task Force)
- Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders (Source: Community Preventive Services Task Force)
- Suicide Risk: Screening in Adolescents, Adults, and Older Adults (Source: United States Preventive Services Task Force)
- Circle of Security
- Families and Schools Together (FAST)

Priority Area 3B: Substance Abuse

Objectives

Objective 3B.1: Decrease drug-overdose deaths (based off of HP 2020: IVP-37 & IVP-38)

Baseline:	10.9 per 100,000 population (2013-2015 combined)
Target (2020):	9.8 per 100,000 population
Target-Setting Method:	10% improvement
Data Source:	Nebraska Vital Records
Indicator	Drug overdose death rate per 100,000 population (age-adjusted)

Objective 3B.2: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women (HP 2020: MICH-11)

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Objective 3B.3: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages (HP 2020: SA-14)

Baseline:	Adults – 14.0% (2015) 8th Grade – 1.6% (2016) 10th Grade – 8.9% (2016) 12th Grade – 17.3% (2016)
Target (2020):	Adults – 12.6% 8th Grade – 1.4% 10th Grade – 8.0% 12th Grade – 15.6%
Target-Setting Method:	10% improvement
Data Source:	Adults - Nebraska Behavioral Health Risk Factor Surveillance System Youth – Nebraska Risk and Protective Factor Student Survey
Indicator	Adults – Percentage of adults 18 and older who report having five or more alcohol drinks for men/four or more for women on at least one occasion in the past 30 days. Youth – Percentage who reported having five or more drinks of alcohol in a row, within a couple of hours.

Objective 3B.4: Reduce tobacco use by adults (HP 2020: TU-1)

Baseline:	19.0% (2015)
Target (2020):	17.1%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System (BRFSS)
Indicator	Percentage of adults 18 and older who report that they currently smoke cigarettes either every day or on some days.

Objective 3B.5: Reduce tobacco use by adolescents (HP 2020: TU-2)

Baseline:	8th Grade – 4.3% (2014) 10th Grade – 13.6% (2014) 12th Grade – 14.6% (2014)
Target (2020):	8th Grade – 3.9% 10th Grade – 12.2% 12th Grade – 13.1%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Risk and Protective Factors Student Survey
Indicator	Past 30 day cigarette use

Objective 3B.6: Reduce the initiation of tobacco use among children, adolescents, and young adults (HP 2020: TU-3)

Baseline:	8th Grade – 12.8% (2014) 10th Grade – 30.6% (2014) 12th Grade – 36.5% (2014)
Target (2020):	8th Grade – 11.5% 10th Grade – 27.5% 12th Grade – 32.9%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Lifetime cigarette use

Objective 3B.7: Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol (HP 2020: SA-1)

Baseline:	12.5% (2016)
Target (2020):	11.2%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Risk and Protective Factor Student Survey
Indicator	Rode in vehicle driven by someone who had been drinking alcohol in past 30 days.

Strategies

- Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force)
    - Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products
    - Quitline Interventions
    - Smoke-Free Policies
    - Interventions to Increase the Unit Price for Tobacco Products
- Alcohol – Excessive Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors (Source: Community Preventive Services Task Force)

- Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Source: Community Preventive Services Task Force)
- Regional Use of Nebraska Prescription Drug Monitoring Program (Source: Nebraska DHHS)

Implementation Partners

Sidney Regional Medical Center
Regional West Health Services
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Chadron Public Schools
Box Butte Family Focus
Health Thyme, LLC
Panhandle Health Group
Options in Psychology LLC
Deuel County Community Organizer
Community Action Partnership of Western Nebraska
Rural Nebraska Healthcare Network
Gordon Memorial Health Services
Box Butte General Hospital
Panhandle Area Development District
Chadron Community Hospital
Regional West Garden County
Kimball Health Services
Box Butte General Hospital
Morrill County Community Hospital

Priority Area 4: Chronic Disease

Priority Area 4A: Cancer

Objectives

Objective 4A.1: Reduce the proportion of adults with any kind of cancer (based off of HP 2020: C-1)

Baseline:	15.4% (2015
Target (2020):	13.9%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report they were ever told they have any kind of cancer.

Objective 4A.2: Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines (HP 2020: C-18)

Baseline:	Colon Cancer - 58.3% (2015) Breast Cancer - 59.8% (2015) Cervical Cancer - 76.5% (2015)
Target (2020):	Colon Cancer – 64.0% Breast Cancer - 65.7% Cervical Cancer – 84.0%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Risk Factor Surveillance system
Indicator	Colon Cancer - Percentage of adults 50-75 years old who reported having had a fecal occult blood test (FOBT) during the past year, or a sigmoidoscopy during the past 5 years and an FOBT during the past 3 years, or a colonoscopy during the past 10 years. Breast Cancer - Percentage of females 50-74 years old who report they are up-to-date on breast cancer screening. Cervical Cancer - Percentage of females 21-65 years old who report they are up-to-date on cervical cancer screening.

Objective 4A.3: Reduce the proportion of females with human papillomavirus (HPV) infection (HP 2020: STD-9)

Baseline:	9.4 new cervical cancer cases per 100,000 population (2009-2013 combined)
Target (2020):	8.5 per 100,000 population
Target-Setting Method:	10% improvement
Data Source:	Nebraska Vital Records
Indicator	Cervical Cancer Incidence

Strategies

- Cancer Screening: Multicomponent Interventions (Source: Community Preventive Services Task Force)
    - Colorectal Cancer
    - Breast Cancer
    - Cervical Cancer
- Vaccination Programs: Community-Based Interventions Implemented in Combination (Source: The Community Guide)
- Radon Screening and Mitigation (Source: American Cancer Society)
- Skin Cancer: Multicomponent Community-Wide Interventions (Source: Community Preventive Services Task Force)
- Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force) (See Section 3B section for detailed activities and objectives)

Priority Area 4B: Cardiovascular Disease

Objectives

Objective 4B.1: Reduce the proportion of adults with hypertension (HP 2020: HD S 5.1)

Baseline:	35.8% (2015)
Target (2020):	32.2%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report that they were ever told by a doctor, nurse, or other health professional that they have high blood pressure.

Objective 4B.2: Reduce stroke deaths (HP 2020: HD S-3)

Baseline:	36.3 per 100,000 population (2013-2015 three year moving average)
Target (2020):	32.3 per 100,000 population
Target-Setting Method:	10% improvement
Data Source:	Nebraska Vital Records
Indicator	Stroke death rate per 100,000 population (age-adjusted)

Objective 4B.3: Reduce coronary heart disease deaths (HP 2020: HD S-2)

Baseline:	152.9 per 100,000 population (2013-2015 three year moving average)
Target (2020):	137.6 per 100,000 population
Target-Setting Method:	10% improvement
Data Source:	Nebraska Vital Records
Indicator	Heart disease death rate per 100,000 population (age-adjusted)

Strategies

- Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control (Source: Community Preventive Services Task Force)
- Cardiovascular Disease: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control - When Used Alone (Source: Community Preventive Services Task Force)

Priority Area 4C: Diabetes

Objectives

Objective 4C.1: Reduce the annual number of new cases of diagnosed diabetes in the population (HP 2020 D-1)

Baseline:	10.8% (2015)
Target (2020):	9.8%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report they were ever told they have diabetes (excluding pregnancy).

Strategies

- Diabetes: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk (Source: Community Preventive Services Task Force)

Priority Area 4D: Chronic Disease Risk Factors

Objectives

Objective 4D.1: Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity (HP 2020 PA-2)

Baseline:	18.7% (2015)
Target (2020):	20.5%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report that they met both the aerobic and muscle strengthening recommendations

Objective 4D.2: Increase the contribution of fruits to the diets of the population aged 2 years and older (HP 2020: NWS-14)

Baseline:	39.8% (2015)
Target (2020):	35.9%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System

Indicator	Percentage of adults 18 and older who report that they consume fruits less than one time per day.

Objective 4D.3: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older (HP 2020: NWS-15)

Baseline:	23.8% (2015)
Target (2020):	21.4%
Target-Setting Method:	10% improvement
Data Source:	Nebraska Behavioral Health Risk Factor Surveillance System
Indicator	Percentage of adults 18 and older who report that they consume vegetables less than one time per day.

Strategies

- Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)
- Physical Activity: Creating or Improving Places for Physical Activity (Source: Community Preventive Services Task Force)
- Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables (Source: CDC/NCCDPHP)
- Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force) (See Section 3B section for detailed activities and objectives)

Implementation Partners

Sidney Regional Medical Center
Regional West Health Services
Disability Rights Nebraska
Western Community Health Resources
Community Action Partnership of Western Nebraska
Bayard Public schools
Health Thyme, LLC
Panhandle Health Group
Scottsbluff Community Health
Rural Nebraska Healthcare Network
Gordon Memorial Health Services
Box Butte General Hospital
Panhandle Area Development District
Chadron Community Hospital
Regional West Garden County
Kimball Health Services
Educational Service Unit 13
Morrill County Community Hospital
Nebraska Extension
Garden County Schools

Priority 5: Early Childhood Care & Education

Objectives

Objective 5.1: Increase quality childcare and preschool availability (based off of Buffett Early Childhood Institute findings)

> *There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.*

Strategies

- Child Care Quality Measures (Source: Step Up to Quality)
- Health Equity: Center-Based Early Childhood Education (Source: Community Preventive Services Task Force)
- Social-Emotional Development of Children (Source: Rooted in Relationships)

Implementation Partners

Buffet Early Childhood Institute

Systems of Care 0-8

Panhandle Schools

Priority Area 6: Social Determinants of Health

Priority Area 6A: Poverty

Objectives

Objective 6A.1: Reduce proportion of persons living in poverty (HP 2020: SDPH-3)

Baseline:	14.7%
Target (2020):	13.2%
Target-Setting Method:	10% improvement
Data Source:	U.S. Census Bureau, American Community Survey
Indicator	Percent of population with income in past 12-months below the poverty level.

Objective 6A.2: Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade (HP 2020: AH-5.1)

There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.

Strategies

- Health Equity: High School Completion Programs (Source: Community Preventive Services Task Force)

Priority Area 6B: Housing

Objectives

Objective 6B.1: Reduce proportion of households that spend more than 35% of income on housing (Based off of HP 2020: SDOH-4.1)

Baseline:	Housing units with a mortgage – 18.1% Housing units without a mortgage – 9.8% Occupied units paying rent – 33.6%
Target (2020):	Housing units with a mortgage – 16.3% Housing units without a mortgage – 8.8% Occupied units paying rent – 30.2%
Target-Setting Method:	10% improvement
Data Source:	U.S. Census Bureau
Indicator	Selected monthly owner costs as a percentage of household income, 35% or more.

Strategies

Evidence-based strategies for this priority area continue to be reviewed by the Social Determinants of Health Priority Area Work Group and will be selected and put into action as the CHIP cycle goes on.

Priority Area 6C: Transportation

Objectives

Objective 6C.1: Increase use of alternative modes of transportation for work (HP 2020: EH-2)

> *There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.*

Strategies

- Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)

Priority Area 6D: Intolerance

Objectives

Objective 6D.1: Increase the number of health systems that include a standardized set of questions that identify lesbian, gay, bisexual, and transgender people (Based off of HP 2020: LGBT-1)

> *There are no regional data points that measure this objective. Data for this objective will be developed throughout the cycle of this CHIP.*

Strategies

- Health Equity: Cultural Competency Training for Healthcare Providers (Source: Community Preventive Services Task Force)
- Health Equity: Use of Linguistically and Culturally Appropriate Health Education Materials (Source: Community Preventive Services Task Force)

Implementation Partners

Regional West Health Services
Disability Rights Nebraska
Regional West Health Services
The DOVES Program
Sidney Regional Medical Center
Dr. Gage Stermensky LLC
Region 1 Behavioral Health Authority
Educational Service Unit 13
Community Action Partnership of Western Nebraska
Panhandle Trails Intercity Public Transit
Morrill County Community Hospital
Western Community Health Resources
Western Nebraska Community College
Panhandle Partnership
Northwest Community Action Partnership
Monument Prevention Coalition
Panhandle Health Group
Rural Nebraska Healthcare Network
Gordon Memorial Health Services
Box Butte General Hospital
Panhandle Area Development District
Chadron Community Hospital
Regional West Garden County
Kimball Health Services
Cirrus House

Appendix A

Access to Care Work Product

Summary

Participants of the Community Health Improvement Plan Access to Care Workgroup met at the Prairie Winds Community Center in Bridgeport, NE, on October 26, 2017 from 9:00 am – noon. The meeting was facilitated by Sara Hoover from Panhandle Public Health District.

The meeting started with participants identifying partners and the local resources working on Access to Care. Kelsey Irvine, Community Health Planner with Panhandle Public Health District, provided data from the Community Health Assessment pertaining to Access to Care. This included health care coverage and those that did not seek care due to cost, health literacy data, the provider shortage maps for Nebraska, including family practice, general dentistry, and psychiatry and mental health, cancer screening rates for colon cancer, breast cancer, and cervical cancer, vaccinations, dental care for adults. She also reviewed the results of the focus groups and surveys pertaining to Access to Care and health disparity data by race, education and income level.

After the presentation, participants identified barriers for specific populations, gaps in services, and emerging issues in Access. They then reviewed a list of Healthy People 2020 objectives and interventions and strategies. A list of each was compiled that was either related to current work of the partners or that aligned with current resources and capacity, or where significant work could be made to address the issues around Access to Care.

The following pages are the results of the meeting.

Meeting Participants

Tiffany Peterson, Perkins County Health Services
Jeff Tracy, Community Action Partnership of Western Nebraska
Jessica Davies, Panhandle Public Health District
Tabi Prochazka, Panhandle Public Health District
Kelsey Irvine, Panhandle Public Health District
Cheri Farris, Panhandle Public Health District
Sarah Nicholson, Regional West Health Services
Jonnie Kusek, Panhandle Trails
Kim Engel, Panhandle Public Health District
Sara Hoover, Panhandle Public Health District

Partners and Local Resources

Participants identified a list of partners and resources currently available or working to address issues around Access to Care.

- Community Action Partnership of Western Nebraska (CAPWN)
  - Bilingual services
  - Sliding fee scale
- Hospitals and clinics
  - Some have walk-in service days
  - Extended hours?
- Parish nurses
  - Lakota Lutheran, Chadron, Mitchell
- Lakota Lutheran Services
- Transportation
  - Panhandle Trails, Liberty Mobility Now, Other ride hailing services
  - County Transit – Handibus
- School-based nurses
- Dental hygiene school
  - Screenings and sealants
  - CAPWN clinic for Hwy 20 area
  - Dental Health Program
- Local pharmacies
- National Diabetes Prevention Program (NDPP) System and structure
  - Screenings and assessments
- Fecal Occult Blood Test (FOBT Kits) for colon cancer
- Local health fairs
- Clinics developing team-based care
  - CAPWN, Chadron Clinic, Regional West Physician's Clinic
- Worksite Wellness programs
  - Resources to families for screenings, Employee Assistance Program
- Head Start
  - Children and outreach to homes
- Healthy Families America home visitation program
- Faith-based community
- Local/traveling food pantries
- Women Infant and Children (WIC)
- Western Community Health Resources (WCHR)
  - WIC
  - Family reproductive health
- Immunization programs
- Childcare access and universal preschool
- EMS System
- "Welcome to Medicare"
- Volunteer programs
  - Meals on Wheels, etc
- Senior Health Insurance Information Program (SHIIP)
- Social service workers and offices
- Care coordination
- Managed Care Organizations (MCOs)
  - Coordinate and educate them about nonadherent patients
- Aging Office of Western Nebraska (AOWN)

Barriers, Gaps, and Emerging Issues

Participants were broken into 3 groups and each group was asked to focus on one area – Barriers for Specific Populations, Gaps or Deficiencies, and Emerging Issues.

Barriers for Specific Populations	Gaps or Deficiencies
• Language • Medicines needed for chronic pain patients • Accessible transportation – distance and logistics of day/visit • Income • Co-pays and deductibles – insurance costs • Insurance coverage • Time – extended clinic/service hours for hourly workers • Childcare • Specialist availability • Lack of Medicaid providers, especially in oral health, due to low reimbursements • Same-day appointments • "Cowboy Up" mentality – ignoring issues until they are extreme, no prevention efforts • Scheduling at Indian Health Services (HIS) • Cost of medicines • Access to pharmacy – delivery options	• Money (middle class) • Transportation – rural • Education • Priorities • Navigation – cultural competence • Community Health Workers (CHWs) • Continuum of Care coordination • Charity care usage • High deductible insurance plans • No Medicaid expansion in Nebraska • Lack of global/consolidated billing – confusing for patients • Gaps between intervention and prevention • Provider shortage areas (family practice, general dentistry, psychiatry and mental health) • Oral health providers and coverage – very few Medicaid providers
Emerging Issues	

• Volatility and uncertainty with insurance coverage
• Uncertainty with federal funding (sustained)
• Disconnect between political climate and public health policy work at all levels (fed, state, local)
• Undercurrent anti-vaccination (anti-vax) movement
• Integrated care – ie., mental health and physical health
• Team based care
• Pharmacy and clinical partnerships
• Transition to value based care
• Increase in technology use in care – more complete coverage
• Increase in mid-level providers
	• University of Northern Colorado partnership with local schools for school psychologists program
	• UNMC including public health coursework in all medical programs
	• Recruitment/retention
	  ○ Health, dental, mental/behavioral
	• Grow Your Own/RHOP/Public Health Early Admissions Student Track (PHEAST)
	• Providers flying in from afar
	• Population shifts
	• Increase in chronic illness at younger ages
	• Transportation needs being addressed
	• Use of more metrics to measure success
	  ○ NDPP – blood pressure, waist measurement
	  ○ PWWC – blood pressure, cholesterol, glucose

Evidence-based Strategies and Chosen Strategies

- The group reviewed an extensive list of objectives and interventions and strategies available from Health People 2020. Topic areas included: Access to Health Services, Disability and Health, Health Communication and Health Information Technology, Maternal, Infant, and Child Health, Mental Health and Mental Disorders, Older Adults, and Oral Health. Access strategies related to nutrition, physical activity, and chronic illness (cardiovascular disease, cancer, and diabetes) were chosen during the Chronic Disease meeting and were not included to not duplicate efforts in each workgroup.

Chosen Objectives

Access to Health Services
• AHS-3 Increase the proportion of persons with a usual primary care provider • AHS-4 (Developmental) Increase the number of practicing primary care providers. • AHS-6 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
Disability and Health
• DH-4 Reduce the proportion of adults with disabilities aged 18 years and older who experience delays in receiving primary and periodic preventive care due to specific barriers • DH-8 Reduce the proportion of adults with disabilities aged 18 and older who experience physical or program barriers that limit or prevent them from using available local health and wellness programs • DH-20 Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings
Education and Community Based Programs
• ECBP-1 (Developmental) Increase the proportion of preschool Early Head Start and Head Start programs that provide health education to prevent health problems in the following areas: unintentional injury; violence; tobacco use and addiction; alcohol or other drug use; unhealthy dietary patterns; and inadequate physical activity, dental health, and safety • ECBP-2Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity • ECBP-4 Increase the proportion of elementary, middle, and senior high schools that provide school health education to promote personal health and wellness in the following areas: hand washing or hand hygiene; oral health; growth and development; sun safety and skin cancer prevention; benefits of rest and sleep; ways to prevent vision and hearing loss; and the importance of health screenings and checkups • ECBP-5 Increase the proportion of elementary, middle, and senior high schools that have a full-time registered school nurse-to-student ratio of at least 1:750 • ECBP-6 Increase the proportion of the population that completes high school education • ECBP-8 (Developmental) Increase the proportion of worksites that offer an employee health promotion program to their employees • ECBP-11 (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs

Health Communication and Health Information Technology
• HC/HIT-1 Improve the health literacy of the population • HC/HIT-2 Increase the proportion of persons who report that their health care providers have satisfactory communication skills • HC/HIT-12 Increase the proportion of crisis and emergency risk messages intended to protect the public's health that demonstrate the use of best practices • HC/HIT-13 Increase social marketing in health promotion and disease prevention
Maternal Infant and Child Health
• MICH-10 Increase the proportion of pregnant women who receive early and adequate prenatal care • MICH-11 Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women • MICH-19 (Developmental) Increase the proportion of women giving birth who attend a postpartum care visit with a health worker • MICH-29 Increase the proportion of young children with autism spectrum disorder (ASD) and other developmental delays who are screened, evaluated, and enrolled in special services in a timely manner • MICH-30 Increase the proportion of children, including those with special health care needs, who have access to a medical home
Mental Health and Mental Disorders
• MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral • MHMD-6 Increase the proportion of children with mental health problems who receive treatment • MHMD-9 Increase the proportion of adults with mental health disorders who receive treatment • MHMD-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders • MHMD-11 Increase depression screening by primary care providers
Older Adults
• OA-1 Increase the proportion of older adults who use the Welcome to Medicare benefit • OA-6 Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities
Oral Health
• OH-1 Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth • OH-2 Reduce the proportion of children and adolescents with untreated dental decay • OH-3 Reduce the proportion of adults with untreated dental decay • OH-7 Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year • OH-8 Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year • OH-11 Increase the proportion of patients who receive oral health services at Federally Qualified Health Centers (FQHCs) each year • OH-12 Increase the proportion of children and adolescents who have received dental sealants on their molar teeth

Chosen Strategies

Access to Health Services
• Community Health Workers – diabetes, cardiovascular disease, mental health **Diabetes Prevention: Interventions Engaging Community Health Workers** **Cardiovascular Disease: Interventions Engaging Community Health Workers** • School based dental sealants/fluoride **Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs** • Team Based Care – Blood Pressure Control **Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control** • Mental Health Collaboration for management of depressive disorders **Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders** • Access to oral health for underserved **Improving Access to Oral Health Care for Vulnerable and Underserved Populations** • Health Professions – especially dental **Health Professions** • Health Equity – school based health centers **Health Equity: School-Based Health Centers** • Vaccines – school/childcare based **Vaccination Programs: Schools and Organized Child Care Centers** • Reduce out of pocket costs – breast care **Cancer Screening: Reducing Client Out-of-Pocket Costs – Breast Cancer** • Tobacco – out of pocket cessation costs **Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments**
Disability and Health
• Vaccinations – home visits **Vaccination Programs: Home Visits to Increase Vaccination Rates** • Flu vaccines – worksites **Worksite: Seasonal Influenza Vaccinations Using Interventions with On-Site, Free, Actively Promoted Vaccinations – Healthcare Workers**
Education and Community Based Programs
• No interventions/strategies available in this area
Health Communication and Health Information Technology
• Clinical Decision Support Systems (CDSS) – done? • **Cardiovascular Disease: Clinical Decision-Support Systems (CDSS)** • Health communication/social marketing **Health Communication and Social Marketing: Health Communication Campaigns That Include Mass Media and Health-Related Product Distribution. (Community Guide Recommendation)** • National Action Plan – Health Literacy **National Action Plan to Improve Health Literacy**
Maternal Infant and Child Health
• Tobacco use – reduce 2nd hand exposure **Tobacco Use and Secondhand Smoke Exposure: Mass-Reach Health Communication Interventions** • Tobacco unit price **Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products** • Breastfeeding interventions **Breastfeeding: Interventions in Pregnant Women and New Mothers**

• Lead screening – 1-5 years **Lead: Screening in Children Ages 1 to 5 Years at Average Risk** • Child seats **Motor Vehicle Injury – Child Safety Seats: Community-Wide Information and Enhanced Enforcement Campaigns** • Prevent lead exposure **Preventing Lead Exposure in Young Children: A Housing-Based Approach to Primary Prevention of Lead Poisoning** • 10 steps to successful breastfeeding **Evidence for the 10 Steps to Successful Breastfeeding**
Mental Health and Mental Disorders
• Depression screening – kids **Depression: Screening in Children Age 11 Years and Younger** • Depressing screening – adolescents **Depression in Children and Adolescents: Screening** • Depression screening – adults **Depression in Adults: Screening** • Suicide screening – teens/adults **Suicide Risk: Screening in Adolescents, Adults, and Older Adults** • Address childhood psychological harm from violence –research additional strategies
Older Adults
• Fall prevention **Falls Prevention: Multifactorial Risk Assessment in Older Adults** • Screening – colorectal cancer **Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation**
Oral Health
• Dental caries screening – birth-5 years old **Dental Caries in Children From Birth Through Age 5 Years: Screening** **Dental Caries: Screening in Children Age 5 Years and Younger** • School based sealants **Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs** • Number of dentists serving Medicaid patients *No strategy listed specifically, but noted this is a great need for the area to improve access

Next Steps

PPHD staff will review available local measures for the identified objectives. If data is not available to track locally, those objectives will be removed. Staff will also review the identified strategies to see where work is happening locally, or to identify opportunities for new partnerships and collaboration to implement identified strategies and interventions.

The workproduct will be sent back out to the group. A meeting will be scheduled in the first quarter of 2018 to continue work.

Aging Population Work Product

Summary

Participants of the Community Health Improvement Plan Aging Population Workgroup met at the Prairie Winds Community Center in Bridgeport, NE, on October 6, 2017 from 9:00 am – noon. The meeting was facilitated by Sara Hoover from Panhandle Public Health District. Presentations about the health and economic data pertinent to this topic were provided by Kelsey Irvine with Panhandle Public Health District and Daniel Bennett with Panhandle Area Development District, respectively. Steve Trickler with the Aging Office of Western Nebraska provided information on the work and role of AOWN, including some of the limitations they are experiencing in providing services.

The following pages are the results of the meeting.

Meeting Participants

Roger Wess, Panhandle Partnership Board Member
Robin Stuart, Morrill County Community Hospital
Kelsey Irvine, Panhandle Public Health District
Cheri Farris, Panhandle Public Health District
Courtney Ostrander, Gordon Memorial Hospital
Tabi Prochazka, Panhandle Public Health District
Sherri Blome, Western Community Health Resources, Respite
Jonnie Kusek, Panhandle Trails
Steve Trickler, Aging Office of Western Nebraska
Dan Newhoff, Box Butte General Hospital
Jessica Davies, Panhandle Public Health District
Sara Hoover, Panhandle Public Health District
Terri Allen, Scotts Bluff County Health Department
Daniel Bennett, Panhandle Area Development District

Local Resources, Retention Needs, and Gaps and Barriers

Although the dynamics of an aging population are something that have been discussed in the last several CHA cycles, aging population has never been chosen as a priority area, but was seen more as an underlying current.

Data shows that the increase in population over 65 will be marked in the next few decades and Panhandle will have to make significant changes to accommodate the population shift. Not only is the population aging, but a loss in younger cohorts to meet the services that will be needed will have a significant impact on the availability of services in the area.

Partners Involved in Current Work

- Multiple lifeline systems
- Nebraska Commission for the Blind and Deaf
- Nebraska Housing Authority
- Aging office of Western Nebraska – resource referral, direct services and support
- CAPWN – clinics, commodities, income-based
- Health and Human Services – Medicaid, SNAP, Energy Assistance
- Handyman and Handibus
- RSVP – organize skills for volunteering, Sheridan County Gives
- Home Instead – direct services and support
- Liberty Mobility Now – transportation to appointments
- Veteran's Association – nursing home/assisted living, medical care, direct support
- Assistive Technologies Program (ATP)
- Assisted living and nursing homes – Scottsbluff, Mitchell, Bayard, Bridgeport, Kimball, Gering, Alliance, Crawford, Chadron, Hay Springs, Sidney, Whiteclay, Hemingford, Oshkosh, Gordon
- Western Community Health Resources – CSFP, respite
- Local providers
- PT/OT
- Food Banks, soup kitchens, Mobile Food Pantry (community sponsors and volunteers)
- Fall prevention programs
- Places that loan wheelchairs, walkers, canes, etc (PILS no longer in operation)
- Senior Car Fit
- American Legion
- VFW
- Rec Centers – Silver Sneakers, Tai Chi
- Extension Offices
- Pharmacy delivery
- Regional West Community Health – immunizations
- Support groups – hospitals and churches
- Volunteers of America Western Nebraska
- Northwest Community Action Partnership – commodities
- Faith-based organizations
- Dental Health Program (PPHD)
- Panhandle Trails & ICB
- 55+ communities

Retaining/Attracting Younger Population

- Hospitals
- Local colleges
- Workforce development offices
- Vocational/technical schools*

- Job Corps*
- Schools
- Community vitality – parks & rec, built environment*
- Community centers/gyms*
- Childcare – affordable
- Health Professions Club, Medical Explorers – high school*
- Internships*
- CNA in high school*
- PT/OT rotation at hospital
- Business and Industry Day*
- Economic Development – when there are good jobs to come back to
- Flex scheduling
- Worksite Wellness
- Alumni tracking
- Teachers often come back

Gaps and Barriers

- Employment opportunities needing to be filled – larger, better trained *
- Smaller community vitality and population
- Gap for financial assistance just above Medicaid level*
- Behavioral Health
- Mobility – solution: driverless cars? *
- Technology – broadband
- In-home care
- Not being able to interact with technology*
- Dental, vision, hearing
- Engaged family members
- Planning for funds for longer lives
- Lack of planning on federal government level
- Insurance – affordable before Medicaid*
- Affordable medications – large co-pays and deductibles
- Health impacts on social interaction – hearing, vision, mobility*
- Facilitating inter-generational relationships; integrated communities
- Exercise, fall prevention*
- Paying for and building home safety improvements
- Lost Panhandle Independent Living Services (PILS)
- Built environment*
- The qualifications that must be met to get help*
- Local transportation*
- Built environment more conducive and accessible*
- Increase Medicaid/Medicare reimbursements
- Increased health needs that rural communities can't keep up with*
- Qualifications based on age, income*
- Remote location/access
- Transportation*
- Lack of transitional housing
- Lack of knowledge of services*
- Lack of skilled workforce*
- Underpaid workers*
- Insurance – literacy*
- Health literacy
- Providers that accept insurance/Medicaid*

Priority Areas

Chosen Priorities:

- How do we expand affordable transportation access? Cost, hours, routes
- Resource Navigation
- Environments and access points to support healthy aging and social connectedness

Additional information needs to be gathered on the following areas:

- The Donut hole –gap in accessing services and care due to financial requirements/eligibility
- Workforce recruitment and retention

Consideration and evaluation should be given to the following, although it is not something the local public health system has the capacity to address:

- Reimbursement rates are limiting access to care

A discussion was held after priorities were chosen that noted that nothing about the needs for Alzheimer's and dementia was captured in the information and because the care is so specialized, not many services are offered in the area.

Evidence-based Strategies and Performance Measures

With priority areas chosen, PPHD staff will review available evidence-based strategies and performance measures, such as The Community Guide and Healthy People 2020, respectively, to identify strategies to implement. These will be shared back out to the group prior to the next meeting date.

Behavioral Health Work Product

Summary

Participants of the Community Health Improvement Plan Behavioral Health Workgroup met at the Prairie Winds Community Center in Bridgeport, NE, on November 3, 2017 from 9:00 am – noon. The meeting was facilitated by Sara Hoover from Panhandle Public Health District.

The meeting started with participants identifying partners and the local resources working on Behavioral Health, and Successes or areas gaining traction. Kelsey Irvine, Community Health Planner with Panhandle Public Health District, provided data from the Community Health Assessment pertaining to Behavioral Health. This included:

- substance use rates for youth and adults, including cigarettes and smokeless tobacco, alcohol binge drinking and impaired driving, and opioid and overdose related deaths;
- self-reported depression rates among adults, frequent mental distress, suicide death rates, and the provider shortage map for psychiatry and mental health;
- health disparities specific to the LGBTQ population, substance use rates for cigarettes, smokeless tobacco, binge drinking and impaired driving by income level, race/ethnicity, and education; and child maltreatment by county;
- survey and focus group data pertinent to behavioral health, including access to care and lack of services, substance use and abuse, perception of quality of life for children in the Panhandle, and top health concerns and biggest risky behaviors.

After the presentation, participants identified gaps and barriers and emerging issues in Behavioral Health. They then reviewed a list of Healthy People 2020 objectives and interventions and strategies. A list of each was compiled that was either related to current work of the partners or that aligned with current resources and capacity, or where significant work could be made to address the issues around Behavioral Health.

The following pages are the results of the meeting.

Meeting Participants

Robin Stuart, Morrill County Community Hospital
Brenda McDonald, Region I Behavioral Health Authority
Sabrina Sosa, Community Action Partnership of Western Nebraska
Ryan Larson, Region I Behavioral Health Authority
Sarah Bernhart, Panhandle Public Health District
Faith Mills, Region I Behavioral Health Authority
Jessica Haebe, Region I Behavioral Health Authority
Melody Leisy, Panhandle Public Health District
Tabi Prochazka, Panhandle Public Health District
Kelsey Irvine, Panhandle Public Health District
Cheri Farris, Panhandle Public Health District
Sarah Nicholson, Regional West Health Services
Kim Engel, Panhandle Public Health District
Sara Hoover, Panhandle Public Health District

Partners, Local Resources, and Successes

Participants identified a list of partners and resources currently available or working to address issues around Access to Care.

- Region I Behavioral Heath Authority
- System of Care Grant – address youth mental health needs
    - Partners include: ESU, Native Futures, DHHS, Child and Family Services, Probation, Diversion, Western Community Health Resources (WCHR), Cirrus House, Snow Redfern Foundation, and the Connected Youth Initiative and System of Care for Youth 0-8
    - Embed behavioral health in other youth systems
    - Keep kids in their own homes
    - Get them services sooner
    - Increase attendance at schools
    - Crisis response, professional partners for crisis calls
    - IOP for youth through ESU
    - Day treatment school
- Local prevention system
    - Panhandle Prevention Coalition – suicide, tobacco, alcohol, substance use
    - 11 county prevention coalitions
- State Targeted Response (STR) – opioid work for prevention and treatment
- System of Care 0-8 (Panhandle Partnership)
    - ESU grant through Sixpence
    - Provide coaching to childcare providers about social and emotional well-being for children and how to build that healthy environment
- Home visitation programs
    - Healthy Families America – Morrill, Box Butte, and Scotts Bluff County,
    - Sixpence, Head Start
- University of Northern Colorado C Pilot Project - internships with mental health providers to work in our local schools
- Behavioral Health Education Center of Nebraska @ UNMC (BHECN) – grants and scholarships for drug and mental health counseling students
- Community Health Workers (CHWs)
- Circle of Security Parenting Classes - attachment focused parenting
    - Panhandle Partnership and Dr. Mark Hald
- Question Persuade Refer (QPR) and Mental Health First Aid – Region I Behavioral Health Authority
- Responsible Beverage Server Training (RBST) and Training for Intervention Procedures (TIPs)
    - Nebraska State Patrol and local trainers
- Human Performance Project (HPP) – school based approach to bring awareness of healthy living and leadership
- Mentoring programs at local schools
- TeamMates – Chadron, Bridgeport, Kimball, Alliance, Garden County, Sidney
- Region I – Office of Justice Grant – Stepping Up
    - Training for law enforcement to better handle mental health crisis on the streets
- LOSS (Local Outreach to Suicide Survivors) Team – 1st active team in Chadron
- Out of the Darkness Walks – suicide awareness and healing
- Prescription Drug Takeback Day
    - Local pharmacies, prevention coalitions, law enforcement
- Guidelines for opioid prescribing Regional West Medical Center/Physician's Clinic
    - Media campaign through PPHD/PPC
- Network of providers for youth – need to develop for adults
- Behavioral Health assistance funding – System of Care Grant
    - Private money from the Sherwood Foundation to Nebraska Children and Families Foundation (NCFF) to community collaboratives

- Tobacco free initiatives – parks, worksites, counties
- Connected Youth Initiative (CYI) – PALS, Central Plains
- Alternative Response – Children and Family Services – voluntary program
    - Get families the services they need without opening DHHS cases
- Panhandle Partnership – backbone organization
- Panhandle Health Group, CAPWN, WCHR – link between physical and mental health – screeners

Barriers, Gaps, and Emerging Issues

Participants were broken into 3 groups and each group was asked to focus on one area – Barriers for Specific Populations, Gaps or Deficiencies, and Emerging Issues.

Barriers and Gaps

- Youth looks good on paper – but there are still a lot of gaps
    - Fewer youth services - access
    - Qualifying for services
    - Long wait for assistance/referral wait time
- Access to services
    - Shortages
    - Distance/transportation
    - If accessible, may be prohibited by lack of funding
- Stigma around resources and being labeled
- Barriers to social security card access and other legal documentation
- Workforce
    - Smaller pool to pull from
    - Higher youth, smaller numbers
    - Hard to attract needed professionals
- Affordable housing
    - Cannot qualify for Section 8 if drug related felony or misdemeanor
    - Landlords not health to standards
    - Economic focus on higher income workforce vs homeless – low income housing
- No homeless shelter – Perceived lack of need
- Public perception that there is no problem
- Visa renewal – huge distance (school visa child stays here and mom at home)
- Undocumented population
- School counselors – lack mental health practitioners
- School system not conducive to all students
    - Positive experience with new model at Scottsbluff Public Schools
- Youth lacking social and living skills – community via technology (cell phones)
- Parents are struggling to stay above water
- Lack of after-school programs – causes challenges
- Stress management techniques
- Access to healthy foods and physical activity
- Job availability
    - Challenges
    - Lose benefits
    - Lack of skill set
- State assistance – way of life

Emerging Issues

• Smartphone use
  ○ Increased depression rates, especially among teen girls (new research)
• Normalization of marijuana use
• Suicide rates are on the rise
  ○ Culture – negative attention/trend youth depression rates
  ○ Heightened awareness
  ○ Emo culture
• Opioid Crisis
• Behavioral Health stigma
• Peer support model
  ○ Community Health Worker/Continuity of Care
• Integrated care
• Public Health Emergency for Opioid crisis
• Unintended consequences of Value Based Care system
• Technology-assisted care
• Impact of multi-generational/sandwich care – due to substance abuse
  ○ Grandparents raising their grandchildren
• Shorter lifespan for white males ages 40-64
  ○ Stress, substance use, suicide
• Insurance coverage changes
  ○ Mental health parity coverage
• Youth in crisis – wait times
• Employee Assistance Plan (EAP)
• Law enforcement capability/capacity
• IEPs/Behavioral issues in schools and childcare
• Shortage of teachers/counselors

Evidence-based Strategies and Chosen Strategies

The group reviewed an extensive list of objectives and interventions and strategies available from Health People 2020. Topic areas included: Adolescent Health, Injury and Violence Prevention, Lesbian, Gay, Bisexual and Transgender Health, Mental Health and Mental Disorders, Substance Abuse, and Tobacco Use. Many strategies related to Access to Care were discussed at that workgroup's meeting and were not included to not duplicate efforts in each workgroup. The strategies chosen are either new or relate to current strategies already implemented by partners that can be enhanced or maintained.

It was noted that additional strategies need to be researched from SAMSHA, , other local workplans, incarceration work (Ryan Larson), and through the Systems of Care workplans. Additional data should be sought from YRPS, Betsy Vidlak, CAPStone, Child Protective Services, Healthy Families America, SHARP Survey, RPF Survey, Doves, and TeamMates.

Chosen Objectives

Access to Health Services
• No objectives identified as they were chosen in Access to Care workgroup
Adolescent Health
• AH-3 Increase the proportion of adolescents who are connected to a parent or other positive adult

caregiver • AH-4 Increase the proportion of adolescents who transition to self-sufficiency from foster care • AH-5 Increase educational achievement of adolescents and young adults • AH-6 Increase the proportion of schools with a school breakfast program
Injury and Violence Prevention
• IVP-34 Reduce physical fighting among adolescents • IVP-35 Reduce bullying among adolescents • IVP-37 Reduce child maltreatment deaths • IVP-38 Reduce nonfatal child maltreatment • IVP-39 (Developmental) Reduce violence by current or former intimate partners • IVP-40 (Developmental) Reduce sexual violence • IVP-42 Reduce children's exposure to violence
Lesbian, Gay, Bisexual, and Transgender Health
• LGBT-1 Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, bisexual, and transgender populations
Mental Health and Mental Disorders
• MHMD-1 Reduce the suicide rate • MHMD-2 Reduce suicide attempts by adolescents • MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral • MHMD-6 Increase the proportion of children with mental health problems who receive treatment • MHMD-11 Increase depression screening by primary care providers
Substance Abuse
• SA-1 Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol • SA-2 Increase the proportion of adolescents never using substances • SA-3 Increase the proportion of adolescents who disapprove of substance abuse • SA-4 Increase the proportion of adolescents who perceive great risk associated with substance abuse • SA-10 Increase the number of Level I and Level II trauma centers and primary care settings that implement evidence-based alcohol Screening and Brief Intervention (SBI) • SA-14 Reduce the proportion of persons engaging in binge drinking of alcoholic beverages • SA-19 Reduce the past-year nonmedical use of prescription drugs
Tobacco Use
• TU-1Reduce tobacco use by adults • TU-2Reduce tobacco use by adolescents • TU-3Reduce the initiation of tobacco use among children, adolescents, and young adults • TU-4Increase smoking cessation attempts by adult smokers • TU-11Reduce the proportion of nonsmokers exposed to secondhand smoke • TU-15Increase tobacco-free environments in schools, including all school facilities, property, vehicles, and school events • TU-17Increase the Federal and State tax on tobacco products • TU-19Reduce the illegal sales rate to minors through enforcement of laws prohibiting the sale of tobacco products to minors

Chosen Strategies

Access to Health Services
• Collaborative Care for Management of Depressive Disorders Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders • Health Professions Health Professions
Adolescent Health
• 40 Developmental Assets Not listed in the strategies provided, but currently being implemented in the Panhandle • Center-based early childhood education Health Equity: Center-Based Early Childhood Education • Quality childcare Not listed in the strategies provided, but is currently being addressed in the Panhandle
Injury and Violence Prevention
• Early childhood home visitation Violence: Early Childhood Home Visitation To Prevent – Child Maltreatment • Sobriety check points Motor Vehicle Injury – Alcohol-Impaired Driving: Publicized Sobriety Checkpoint Programs • Partner violence – screen women Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: Screening in Women of Childbearing Age • Person to person interventions – parenting skills Adolescent Health: Person-to-Person Interventions to Improve Caregivers' Parenting Skills
Lesbian, Gay, Bisexual, and Transgender Health
• No interventions/strategies available in this area
Mental Health and Mental Disorders
• Depression screening – all ages Depression: Screening in Children Age 11 Years and Younger Depression in Adults: Screening Depression in Children and Adolescents: Screening • Suicide screening – all ages Suicide Risk: Screening in Adolescents, Adults, and Older Adults • Collaborative care for management of depressive disorders Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders • Anxiety screening – all ages Look at strategies being implemented in local workplans and enhance where possible • Education about Adverse Childhood Experiences and Trauma Informed Care Look at strategies being implemented in local workplans and enhance where possible • Address childhood psychological harm from violence –research additional strategies
Substance Abuse
• Screening/brief interventions – alcohol/other substances; youth first then adults Alcohol Misuse: Screening and Behavioral Counseling Interventions in Adolescents Alcohol Misuse: Screening and Behavioral Counseling Interventions in Adults • Publicized sobriety check points Motor Vehicle Injury – Alcohol-Impaired Driving: Publicized Sobriety Checkpoint Programs • Limit hours of sale

Alcohol – Excessive Consumption: Maintaining Limits on Hours of Sale

- Enforce prohibited sale to minors
  Alcohol – Excessive Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors
- Worksite Risk Appraisal – alcohol use
  Worksite: Assessment of Health Risks with Feedback (AHRF) to Change Employees' Health – AHRF Plus Health Education With or Without Other Interventions
- Opioid
  Look at strategies being developed locally and enhance where possible
- Support Human Performance Project expansion
  Look at strategies being developed locally and enhance where possible
- CMCA – Communities Mobilizing for Change on Alcohol
  Look at strategies being developed locally and enhance where possible

Tobacco Use

- Comprehensive tobacco control programs
  Best Practices for Comprehensive Tobacco Control Programs – 2014
- Tobacco free and smoke free policies
  Tobacco Use and Secondhand Smoke Exposure: Smoke-Free Policies
- Quitline interventions
  Tobacco Use and Secondhand Smoke Exposure: Quitline Interventions
  Interventions for Smokeless Tobacco Use Cessation
- Increase tobacco unit price – local and state
  Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products
- Reduce out of pocket costs
  Tobacco Use and Secondhand Smoke Exposure: Reducing Out-of-Pocket Costs for Evidence-Based Cessation Treatments
- Pharmacotherapy
  Tobacco Smoking Cessation: Pharmacotherapy Interventions in Pregnant Women
  Tobacco Smoking Cessation: Behavioral and Pharmacotherapy Interventions in Nonpregnant Adults
- Mobilize to reduce minor access
  Tobacco Use and Secondhand Smoke Exposure: Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products
- Worksite risk appraisal – tobacco
  Worksite: Assessment of Health Risks with Feedback (AHRF) to Change Employees' Health – AHRF Plus Health Education With or Without Other Interventions
  Tobacco Use and Secondhand Smoke Exposure: Incentives and Competitions to Increase Smoking Cessation Among Workers – When Combined With Additional Interventions
- Increase compliance checks
  Look at strategies in local workplans and enhance where possible

Next Steps

PPHD staff will review available local measures for the identified objectives. If data is not available to track locally, those objectives will be removed. Staff will also review the identified strategies to see where work is happening locally, or to identify opportunities for new partnerships and collaboration to implement identified strategies and interventions.

The workproduct will be sent back out to the group. A meeting will be scheduled in the first quarter of 2018 to continue work.

Chronic Disease Work Product

Summary

Participants of the Community Health Improvement Plan Chronic Disease Workgroup met at the Prairie Winds Community Center in Bridgeport, NE, on September 29, 2017 from 9:00 am – noon. The meeting was facilitated by Sara Hoover from Panhandle Public Health District.

The group shared and discussed the successes of strategies from the previous CHIP priority areas (Healthy Living: Healthy Eating, Healthy Living: Physical Activity, Cancer Prevention: Primary Prevention, and Cancer Prevention: Early Detection) that relate to the new Chronic Disease Priority Area.

Participants then did mapping around the local resources, risk factors, prevention efforts, and populations affected by Cancer, Diabetes, and Cardiovascular Disease, identifying commonalities among the three areas. Jessica Davies then shared a lists of evidence-based strategies from the community guide pertaining to:

- Cancer Prevention and Control: Skin Cancer Prevention,
- Cancer Prevention and Control: Increasing cancer screenings, multicomponent interventions, breast cancer, cervical cancer, and colorectal cancer
- Promoting Health Equity
- Cardiovascular disease prevention and control
- Increasing physical activity
- Obesity Prevention

These recommended strategies were used to determine the strategies for the Implementation Plan.

The following pages are the results of the meeting.

Meeting Participants

Jessica Davies, Panhandle Public Health District
Tabi Prochazka, Panhandle Public Health District
Nona Kindsvater, Health Thyme
Kelsey Irvine, Panhandle Public Health District
Cheri Farris, Panhandle Public Helath District
Sandy Roes, Chadron Community Hospital/Western Community Health Resources
Dan Newhoff, Box Butte General Hospital
Cathy Peterson, Chadron Community Hospital
Faith Mills, Region I Behavioral Health Authority
Sara Hoover, Panhandle Public Health District

Accomplishments

The group discussed accomplishments of the last CHIP cycle priority areas in relation to the new priority Chronic Disease – cancer, diabetes, and cardiovascular disease. They noted strategies and successes that were working well and should be maintained or expanded in the next implementation cycle.

Healthy Living: Healthy Eating (related to cancer, diabetes, and cardiovascular disease)

- 3 hospitals transitioned vending to healthy options
- Dairy added to some school vending machines
- Assessed 110+ grocery and c-stores for healthy items
- Worksites passed breastfeeding friendly policies
- Hospitals increasing number of lactation consultants
- Farm-to-table in school settings and schools adding salad bars – Coordinated School Health Institute
- National Diabetes Prevention Program
- Nebraska fresh fruit and vegetables program in schools
- Increased accessibility of school breakfast programs
- Backpack programs meet access needs but are not very healthy – options for fresh foods available in Gering program
- Farmers markets increasing – especially in Scotts Bluff

Health Living: Active Living (related to cancer, diabetes, and cardiovascular disease)

- Sidney Active Living/Walkability
- Tri-City Active Living Advisory Committee – Scottsbluff, Gering, Terrytown
- Several businesses have walkable campus
- Dawes County & Fort Robinson walkable trails promotion
- Crawford is increasing access to walkable trails through town –access and maintenance
- Cities are conducting special studies to increase walking within city – Safe Routes to School – Chadron
- Walkability included in several Comp Plans
- Moving from 3-ft sidewalks to 5-ft
- National Diabetes Prevention Program
- Kids Fitness and Nutrition Day for 3rd graders
- Worksites promoting physical activity
- Downtown Scottsbluff improvements are increasing physical activity

Cancer Prevention: Primary Prevention (related to cancer)

- Businesses pass and promote tobacco-free campuses
- Best practices resources for tobacco cessation
- Promoting tobacco cessation through Healthy Families America, WIC, businesses – having supports available for when they quit
- 6 cities have completely tobacco-free policies for recreational facilities (pools, baseball fields)
- 1 county went tobacco free
- Work with local pools on Sun Safety/shade structures
- Maintaining +90% tobacco compliance rates since 2012
- Continue distribution of free radon test kits
- Chadron Community Hospital went tobacco-free (2014 or 2015)
- University of Colorado is partnering for an effort to test for radon levels via blood tests
- Promote tobacco free through NDPP, health fairs

Cancer Prevention Early Detection (related to cancer)
• Reminders for FOBT kits • One-on-one education through NDPP • Continued media • Work with U of Colorado – can and mammography – early detection (Wyo-Braska area) • EMRS set up to do check backs – but often centered around other topics such as diabetes; BBGH hired a chronic disease nurse; System limitations

Problem Mapping

Participants were broken into 3 groups and each group was asked to focus on one area – cancer, cardiovascular disease, and diabetes (type 2). They were asked to build a mind map around the risk factors, local resources, prevention efforts, and populations affected by their area. Once completed, groups shared their work with the other participants. They were then asked to identify items throughout all three maps based on the following criteria.

*What is preventing a person's ability to prevent or address chronic illness?
*Where is headway being made that we can capitalize on?
*What do we have the capacity to address?

Cancer

Risk Factors	Local Resources	Prevention Efforts	Population Affected

• Diet*
• Exposure
  ○ Sun
  ○ Smoke
  ○ Radon
  ○ Environmental
• Obesity**
• Access to care (screening)**
  ○ Location
  ○ Cost
  ○ Insurance*
• Alcohol consumption
• Familial/genetics*
• Social media inaccuracies**
• Lack of vaccines
• Occupation*
• Poverty*
• Tobacco use*
  ○ Cultural acceptance
	• Faith community
	• Community
	• Civic clubs
	  ○ Lions
	  ○ Rotary
	• Circle of Light
	• Health Care System*
	• PPHD – radon testing
	• PPHD – FOBT kits
	• Leukemia and lymphoma national chapter
	• American Cancer Society
		• FOBT
		• Sun safety
		• Health screenings
		• Radon detection
		• Health literacy*
		• Immunizations
		  ○ HPV
		  ○ Hep A/B
		• Health Risk Appraisals
		• Tobacco
		  ○ Compliance checks
		  ○ Cessation
		  ○ Education
		  ○ Policy*
			• Skin cancer – Caucasians
			• Familial
			• Lifespan
			• Breast cancer – African Americans
			• Poverty*
			• Reproductive Age
			  ○ Cervical
			  ○ HPV

Cardiovascular Disease

Risk Factors	Local Resources	Prevention Efforts	Population Affected
• High blood pressure	• Uninsured/ underinsured*	• Chronic Disease Prevention	• 40+ years old • Male

• Diabetes
• Chronic illness
• Environmental factors
• Non-compliance
• Medication
• Poor nutrition*
• Hereditary*
• Physical inactivity*
• Obesity*
• Smoking*
	• Food Supply
	  ○ Education
	  ○ Selection
	  ○ Low availability
	  ○ Cost
	• Stress management*
	  ○ Agricultural*
	  ○ Workers*
	  ▪ Shift*
	  ○ Single parents
	• Education**
	• Preventative
	• Management
	• Local tobacco cessation classes
	• Outlets to be active
	  ○ Cost
	  ○ Shift workers
	  ○ Built environment is not conducive
	  ○ Misinformed
	  ○ Transportation
	  ○ Parks
	• Chronic illness management
	  ○ Root cause rather than symptomatic
	• Access to care***
	  ○ Non-patient specific medication
	  ○ Rural
	  ○ Lack of specialists
	  ○ Uninsured
	  ○ Transportation
	• Transportation
	  ○ Connectivity
	  ○ Low socio-economic status*
	  ○ Panhandle Trails/ Liberty Mobility Now
		○ NDPP*
		○ Support groups
		○ Education
		▪ SNAP
		• Nutrition*
		○ Farm-to-table
		○ Grocery and convenience stores
		○ Farmer's markets
		○ Vending initiatives
		• Physical activity
		○ Kids programming
		○ Increased fitness centers
		○ Walkable communities*
		• Collaborative infrastructure of local resources
		○ State
		▪ Health and Human Services
		○ Federal
		▪ Centers for Disease Control and Prevention
		○ Local
		▪ Panhandle Worksite Wellness Council*
		▪ Panhandle Public Health District
		▪ Panhandle Partnership
		▪ Stress Prevention Modalities
		▪ Rural Nebraska Healthcare Network
			• Lower income
			• Lower education
			• No difference shown with ethnicities
			• Worksites
			• How to reach
			○ Panhandle Worksite Wellness Council
			○ Annual health screenings
			○ Targeted marketing and outreach

Diabetes

Risk Factors	Local Resources	Prevention Efforts	Population Affected
• Tobacco use* • Work instability* • Insurance* • Co-morbidity* • Access*** ○ Physical activity opportunities ○ Healthy food • Lack of diagnosis • Genetics*	• National Diabetes Prevention Program • Panhandle Worksite Wellness Council* Clinical/Community Partnerships ○ Provider buy-in* ○ Referral policies ○ Pre-differential diagnosis	• National Diabetes Prevention Program* • Public health and clinical partnerships • Political will • Regional West Medical Center Diabetes Care Center • Walkability* • Positive lifestyle	• Higher minority rates • Rural Caucasians • Higher rates for youth • Education level • Low income*

• Unhealthy diet*
  ○ Sweetened beverages
  ○ Portion sizes
• Sedentary lifestyle*
  ○ Lack or physical activity
• Lack of knowledge**
  ○ Lack of understanding
• Lack of motivation
  ○ Behavioral health*
  ○ Diagnosis
• Cultural norms
  ○ Social pressure
  ○ Acceptance of obesity trend*
	• Healthy eating & active living achievements*	efforts
		• Access
		  ○ Food
		  ○ Physical Activity*	

Evidence-based Strategies and Chosen Strategies

Jessica Davies, Assistant Health Director of Panhandle Public Health District, reviewed snapshots of the evidence-based strategies related to Diabetes, Obesity, Cardiovascular Disease……. These strategies helped inform the chosen strategies for the implementation cycle. Participants asked the group as a whole to consider the following points when implementing strategies:

- Ratio of Patient Centered Medical Homes (PCMH)
- Racial/Ethnic Minorities
- Transportation, nutrition, health education
- Connect to school wellness committees and government officials
- Maintain community involvement in all strategies.

Chosen strategies

Cancer	Cardiovascular Disease	Diabetes
• Mass and small media campaigns and the public health level • Client reminders for both everyday treatment and preventative screenings • Education given to patients • Alternative screening hours • Childcare and rec area work on skin cancer prevention • Tobacco free policies in worksites through Panhandle Worksite Wellness Council	• Team-based care • Education given to patients • Self-monitoring blood pressure • Education to health care extenders about how to take proper blood pressure • Support for physical activity – city comp plans and worksites through Panhandle Worksite Wellness Council	• Strengthen and support National Diabetes Prevention Program • Health coaching – work with clinics on referrals • Technology supported interventions around NDPP • Appropriate diagnosis and support for diabetes • Walking/physical activity/buddy systems through Panhandle Worksite Wellness Council • Vending/nutrition/cafeteria worksite policies around sodium through Panhandle Worksite Wellness Council • Grocery, c-store and school approaches

Social Determinants of Health Work Product

Summary

Participants of the Community Health Improvement Plan Social Determinants of Health Workgroup met at the Prairie Winds Community Center in Bridgeport, NE, on November 16, 2017 from 9:00 am – noon. The meeting was facilitated by Sara Hoover from Panhandle Public Health District.

The meeting started with participants identifying current efforts underway to address the Social Determinants of Health. Kelsey Irvine, Community Health Planner with Panhandle Public Health District, and Daniel Bennett, Planner with Panhandle Area Development District, provided data from the Community Health Assessment pertaining to the factors that impact the Social Determinants of Health, including the local priority areas of poverty, intolerance, housing, and transportation. This included:

- Examples of the social determinants of health within a community;
- The correlation between expected age at death vs household income; Panhandle unemployment, household income distribution, per capita income, persons below poverty level and children under 5 below poverty level, family type and families in poverty by type;
- Housing tenure by county and family type;
- Panhandle population percentages by race and county, population by race for children under 5, population pyramids for white (Caucasian) only and Hispanic or Latino populations;
- Information specific to the Panhandle's LGBTQ population, including healthcare utilization (source of ongoing care), tobacco use rates;
- Health care access, chronic disease, and risk/protective factor disparities by race; and
- Results of the Community Themes and Strengths survey and focus groups, identifying strengths and needs in each of the focus areas.

After the presentation, participants identified gaps and barriers and emerging issues in Behavioral Health. They then reviewed a list of Healthy People 2020 objectives and interventions and strategies. A list of each was compiled that was either related to current work of the partners or that aligned with current resources and capacity, or where significant work could be made to address the issues around Behavioral Health.

The following pages are the results of the meeting.

Meeting Participants

Brenda McDonald, Region I Behavioral Health Authority
Jonnie Kusek, Panhandle Trails
Daniel Bennett, Panhandle Area Development District
Tyler Irvine, Panhandle Partnership
Rachel Sissel, Volunteers of America Western Nebraska
Nici Johnson, ESU #13
Sandy Roes, Western Community Health Resources
Jennifer Sibal, Western Nebraska Community College
Jessica Davies, Panhandle Public Health District

Melody Leisy, Panhandle Public Health District
Tabi Prochazka, Panhandle Public Health District
Kelsey Irvine, Panhandle Public Health District
Cheri Farris, Panhandle Public Health District
Kim Engel, Panhandle Public Health District
Sara Hoover, Panhandle Public Health District

Current Efforts

Participants identified a list of current efforts and partners working to address issues around Social Determinants of Health.

- Walkability – pedestrian safety
- Healthy food retail options
- Local backpack programs to address food insecurity for children – multiple throughout the district, mostly school-based
- Family Reproductive Health – Western Community Health Resources, Community Action Partnership Western Nebraska
    - Prevent unplanned pregnancies, good coverage in northern Panhandle, mainly localized to Scotts Bluff County – gaps in other southern Panhandle communities
- Tobacco/alcohol retail compliance efforts
    - Assessment noted targeted sales/marketing in low income areas – very low unit purchase price
    - Possible statewide approach soon if tobacco tax doesn't pass the Legislature
    - Are owners aware about the pricing, or is it targeted and set by the tobacco companies?
    - Bolster cessation efforts and techniques
    - Continue to increase tobacco/smoke-free policies
- Pricing/crime rates associated with retail of alcopops
- Nutrition programs – WIC (pregnant/post-partum women, children birth-5), Commodity Supplemental Food Program for adults 60+, food pantries and mobile food trucks for all ages
- Worksites – support flexible work schedules to help families relieve stressors
- Outreach/access to WNCC for Hispanic population
- WNCC has an organization for LGBTQ population
- Alternate education programs – Choices, Reconnect, VAULTS, Scotts Bluff Schools is adding Air Force ROTC
- Increased support for early childhood
    - Home visitation
    - School-based preschools
    - Quality measures for childcare
    - Families and Schools Together (FAST)
- Scotts Bluff and other dual credit programs, tech programs, career academies
- Social enterprise connections can be made with schools – industrial arts opportunity via ESU in Feb 2018
- Graduation rates are up – good quality schools in the Panhandle, Job Corps
- Business side of childcare
    - Help providers be seen as a local business in the community, not just as a babysitter
    - Better pay, better jobs and better workers
    - Improves workforce conditions
- Down payment assistance programs for low-moderate income homebuyers to help with home ownership
- Small business loan programs
    - Community foundations
    - Micro loans
    - Panhandle Partnership loan/grant program
- Every Woman Matters – screenings and disease prevention for qualifying women

- Youth mentoring programs
- Recent Brownfield property work
- Hay Springs shop class students are building homes
- Most communities have economic development professionals or groups
- Saver's programs – Chadron Credit Union
- CAPWN financial wellness classes – open to Panhandle residents
- Sliding scale fees for services or scholarship programs available
- High Plains Community Development – more resources than just loan assistance
- Senior centers – meal programs
- Social Enterprise via Panhandle Partnership
    - Greater Good funds
    - Innovation and Investment funds
    - Opportunity Passport – for youth 14-24 that are homeless or have no parent
        - Asset matching programs – save and help purchase an asset
- Community Planning and Zoning Commissions
    - Land use – economic development, walkability, changes for business/industry near residential areas
- Local realtors working to engage all populations with financial institutions
    - Advocate for customers/clients
- Nebraska Appleseed Foundation – addressing diversity, equality, inclusion, education, social injustice
- CAPWN ACA navigators
- Network of good worksite safety programs – but more can be engaged through Panhandle Worksite Wellness Council
    - Especially those that have a number of high minority population employees
    - Connection to pain killer addiction from worksite related injuries
- Panhandle Equality – local LGBTQ advocacy and education group
- Lawyer opportunity program via Chadron State, Wayne State and University of NE Kearney
- Legal Aid
- Panhandle Trails
    - Other transportation efforts, partnerships, planning, improving access to care
    - Inter-city issues are still very prevalent
    - Developing new routes continually
    - Support all modes of transportation
- After-school care is hit and miss in communities
    - Issues for small communities where workers travel out, child's food needs
    - Summer programs
    - Extended day care to include before-school hours too
- Community centers – YMCA and others serve as an after-school resource, although not always officially
- Opportunities for funding from state to match local resources for workforce housing
- Region I Behavioral Health Authority – sliding scale fees
    - Heart program
    - Professional partners program
    - Youth Transition Services

Trends and Themes in the Community and Emerging Issues

Participants were broken into 2 groups and each group was asked to focus on one area – the trends and themes that currently exist in the community and the emerging issues around Social Determinants of Health.

Trends and Themes in the Community

• Rural economic decline
  ○ Consolidation of business production and population
  ○ Loss of family farms
• Priority of living a "good life" in Rural America and the Panhandle
• Baby Boom Echo
• Collaboration amongst communities and within
• Lack of understanding regarding poverty
  ○ The working poor
• Growing minority population
• Lack of representation reflective of population make-up in local government and on boards
• Decline of wages to meet the cost of living
• Employability skills for potential workforce that are unemployed
• Pride of and in self/reliance, education
• Empowered to tell our own story: no one is going to tell us what our outcome is
• Preparation for aging population

Emerging Issues

• Political unrest
  ○ Divisive
  ○ activism and community engagement
• Recognition that poverty is an issue
• Dialogue on racism, class, and marginalized populations
• Health care system is failing
  ○ Behavioral health needs
  ○ Dental health needs
• Shift to focus on prevention
  ○ Connection to community and healthcare
• System revamping and innovation
  ○ Early childhood, education, assistance, etc.
• Tax reform
  ○ Implications for education
• Workforce shift
  ○ De-emphasis of need for college
  ○ Increasing technical trades
• Predatory lending-fighting
• Panhandle Equality
  ○ Awareness in population
• Out-migration
• Low wages in areas
• Increase in telecommuting
  ○ Infrastructure – internet
• Substance abuse

Evidence-based Strategies and Chosen Strategies

The group reviewed an extensive list of objectives and interventions and strategies available from Health People 2020. Topic areas included: Social Determinants of Health, Lesbian, Gay, Bisexual and Transgender Health, and Environmental Health. Strategies related to Access to Care and Behavioral Health (mental/emotional and substance use) were discussed at the respective workgroup meetings and were not included to not duplicate efforts. The strategies chosen are either new or relate to current strategies already implemented by partners that can be enhanced or maintained.

Additional data sources that may help better shape objectives are noted where identified.

Chosen Objectives

Social Determinants of Health

Economic Stability

- SDOH-3 Proportion of persons living in poverty
- SDOH-4 Proportion of households that experience housing cost burden
- SDOH-4.1 Proportion of households that spend more than 30% of income on housing
  - Notes: look at the ACS Tables
- NWS-13 Reduce household food insecurity and in doing so reduce hunger

Education

- SDOH-2 Proportion of high school completers who were enrolled in college the October immediately after completing high school
  - Notes: is there data showing those who entered the workforce within the same time frame?
- DH-20 Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings
  - Notes: data is available, check with 3 planning region teams
- Quality childcare/preschool availability? Need additional research on data
- EMC-2.3 Increase the proportion of parents who read to their young child
  - Notes: check into availability of Dolly Parton book program

Health and Health Care

- AHS-1.1 Increase the proportion of persons with medical insurance
- AHS-5.1 Increase the proportion of persons of all ages who have a specific source of ongoing care
- AHS-6.1 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
- HC/HIT-1.1 Increase the proportion of persons who report their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition

Neighborhood and Built Environment

- Housing vacancy rates, quality, safety, renter issues
  - Notes: David Jones @ RIBHA?
- EH-19 Reduce the proportion of occupied housing units that have moderate or severe physical problems
- IVP-42 Reduce children's exposure to violence
  - Notes: Doves, Alternative Response, Home Visitation Programs

Social and Community Context

- AH-3.1 Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems
- SDOH-6 Proportion of persons eligible to participate in elections who register and who actually vote
- Incidence of hate crimes – check Southern Poverty Law Center data

Environmental Health

- EH-2 Increase use of alternative modes of transportation for work
  - EH-2.1 Increase trips to work made by bicycling
  - EH-2.2 Increase trips to work made by walking
  - EH-2.3 Increase trips to work made by mass transit
  - EH-2.4 Increase the proportion of persons who telecommute
    - Notes: look at employment/poverty, van pool system, alternate transit for healthcare

Lesbian, Gay, Bisexual, and Transgender Health

- LGBT-1 Increase the number of population-based data systems used to monitor Healthy People 2020 objectives that include in their core a standardized set of questions that identify lesbian, gay, bisexual, and transgender populations
  - Notes: May be part of intake assessment, not just a check box

Chosen Strategies

Social Determinants of Health

- Look at national resources for planning and discussing the Social Determinants of Health

  A New Way to Talk about the Social Determinants of Health (Robert Wood Johnson Foundation)

  A Roadmap for Healthier General Plans (ChangeLab Solutions)

  Health in All Policies: A Guide for State and Local Governments (The California Endowment, American Public Health Association, California Department of Public Health, and the Public Health Institute)

- Look at strategies currently in place addressing the noted objectives

Environmental Health

- Look at strategies currently in place addressing the noted objectives

Lesbian, Gay, Bisexual, and Transgender Health

- Assess systems including LGBTQ inclusive language and providing services in appropriate manner
- CLAS Standards

Next Steps

PPHD staff will review available local measures for the identified objectives. If data is not available to track locally, those objectives will be removed. Staff will also review the identified strategies to see where work is happening locally, or to identify opportunities for new partnerships and collaboration to implement identified strategies and interventions.

The workproduct will be sent back out to the group. A meeting will be scheduled in the first quarter of 2018 to continue work.