MESSAGE FROM PUBLIC HEALTH BOARD AND STAFF

Greetings on behalf of the PUBLIC HEALTH SOLUTIONS Board of Health and Staff. This is the annual report of what we have done to prevent disease, and promote and protect the health of the residents of Jefferson, Fillmore, Gage, Saline, and Thayer Counties.

Every three years the community identifies the priorities for health improvement. The community defines the needs and we do our best to enable community resources and agencies to work together to address the needs.

Each year The Board of Health gives direction to the Department regarding what work should be done to address these community priorities.

Through the annual report we tell the public what projects and programs we engaged in, what we accomplished, and with whom we worked.

Our work this year is notable in the amount of resources we were able to garner to address areas of need and the number of needs we were able to address. These include funds to increase children’s access to dental health services, increasing survival rates of those who were subject to cardiac events, assisting communities and health care facilities to reduce rates of chronic illness, and decreasing the gaps in those protected through immunizations. We are pleased to report our work to you and welcome any comments and suggestions.

We are committed to preventing disease and promoting and protecting the health of the community. We endeavor to be good stewards of public resources and responsive to community needs. We thank our many community partners and the State for their leadership and support.
The Board of Health is the administrative authority for the Department. They set policies and priorities based upon the expressed needs of the greater community (5 counties). The members are appointed by the Boards of each county and include a County Board member and public spirited citizen from each County as well as one Physician and Dentist.

**BOARD MEMBERS BY COUNTY**

**Fillmore County**
Larry Cerny, Fillmore County Board
Paul Utemark, *CEO Fillmore County Hospital*

**Gage County**
Dennis Byars, Gage County Board
Linda Ament, *Compliance Regulations Officer, Beatrice Community Hospital*

**Jefferson County**
Arthur Craig, Jefferson County Board
Jeremy Christiansen, *Principal Central Elementary School*

**Saline County Board**
Janet Henning, Saline County Board
Judy Henning, *Crete City Council*

**Thayer County**
Dave Bruning, Thayer County Board
Trudy Clark, *Superintendent of Schools Bruning - Davenport Unified School*

**District**
Walter Gardner, MD, *Physician*
Bruce Kennedy, DDS *Dentist*

**Officers**
*President Bruce Kennedy*
*Vice President Dennis Byars*
*Treasurer Larry Cerny*
*Secretary Dave Bruning*
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anet Bernabe</td>
<td>Reception and Application Assistance</td>
</tr>
<tr>
<td>Kim Buser</td>
<td>Surveillance Coordinator</td>
</tr>
<tr>
<td>Carmen Chinchilla</td>
<td>Dental Program Coordinator</td>
</tr>
<tr>
<td>Jane Ford-Witthoff</td>
<td>Health Director</td>
</tr>
<tr>
<td>Alejandro Gomez</td>
<td>Reception and Community Health Worker</td>
</tr>
<tr>
<td>Becky Hansen</td>
<td>Health Services Manager /Healthy Families America Manager</td>
</tr>
<tr>
<td>Jennifer Hansen</td>
<td>Community Development Assistant</td>
</tr>
<tr>
<td>Natalie Kingston</td>
<td>Community Development Coordinator</td>
</tr>
<tr>
<td>Dave Wieting/Jill Kuzelka</td>
<td>Veteran Community Advocate</td>
</tr>
<tr>
<td>Kate Lange</td>
<td>Saving Rural Hearts Coordinator</td>
</tr>
<tr>
<td>Sharon Leners</td>
<td>Healthy Pathways Coordinator</td>
</tr>
<tr>
<td>Kelly Oblinger</td>
<td>Family Resource Specialist</td>
</tr>
<tr>
<td>Kim Plouzek/David Wieting</td>
<td>Environmental/Emergency Response Coordinator</td>
</tr>
<tr>
<td>Debbie Pohlmann</td>
<td>Immunization Coordinator</td>
</tr>
<tr>
<td>Nicole Reynolds</td>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>Simera Reynolds</td>
<td>Health Services Coordinator</td>
</tr>
<tr>
<td>Deb Schardt</td>
<td>Public Health Dental Hygienist</td>
</tr>
<tr>
<td>Maria Schinstock</td>
<td>Diabetes Program</td>
</tr>
<tr>
<td>Nancy Schlamann</td>
<td>Reception and Development Assistant</td>
</tr>
<tr>
<td>Shirley Terry</td>
<td>Rooted in Relationships Program</td>
</tr>
<tr>
<td>Kerri Thornburg</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>Deb Wendelin</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>Sonya Williamson</td>
<td>Financial Aide</td>
</tr>
<tr>
<td>Lori Wagers</td>
<td>Family Home Visitor</td>
</tr>
<tr>
<td>Laura Wooters</td>
<td>Health Services Manager /Healthy Families America Manager</td>
</tr>
<tr>
<td>Adam Zobel</td>
<td>Health Education Specialist</td>
</tr>
</tbody>
</table>
PHS GOALS AND STRATEGIC PRIORITIES FY 2015

1. INCREASE ACCESS TO CARE: PRIMARY, DENTAL, AND MENTAL HEALTH
   - Match people to needed services through Healthy Pathways
   - Increase behavioral health screening
   - Decrease undiagnosed chronic illness through Health Hub:
     - Increase dental health screening, preventative services and referrals
     - Community education regarding importance and availability of services
     - Application assistance to help overcome financial barriers to health care services
     - Increase health assessments and referrals through Health Hub

2. INCREASE THE AVAILABILITY AND USE OF PREVENTIVE HEALTH SERVICES
   - Increase community assets that support healthy choices
   - Increase awareness about the availability of preventive services
   - Increase community promotion of preventive services and activities
   - Application assistance to increase access to preventive health care services
   - Increase screening and education through Health Hubs and worksite wellness
   - Assist with practice transformation
   - Decrease gaps in immunizations of HPV, pertussis, pneumonia and flu
   - Injury prevention: Safe Kids and Elder Fall Prevention

3. IMPROVE BEHAVIORAL HEALTH
   - Strengthen behavioral health of children through Rooted in Relationships
   - Support Community Prevention Coalitions in each county
   - Increase early intervention for children
   - Match people to needed behavioral health services through Healthy Pathways
   - Increase physical activity through walkable and bike-able communities
   - Connect veterans and families to needed services and support through VetSet
   - Community promotion of behavioral health

4. STRENGTHEN FAMILIES AND FAMILY SUPPORT SERVICES
   - Healthy Families America home visitation
   - Support for Prevention Coalitions in each county
   - Increase parenting skills through Circle of Security parenting program
   - Healthy Pathways to address children and family needs
   - Application assistance to reduce financial barriers
   - Vet Set program for veterans and their families
   - Increase community assets that support healthy families
COMMUNITY NEEDS AND PROGRAM OVERVIEW

Motivated by its mission to serve the members of its district and address concerns voiced by key stakeholders in its communities, Public Health Solutions identified “access to dental care for children” as a priority for improving the overall health of its district’s residents through a collaborative Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP). Higher than average community poverty rates, lack of access to transportation, high rates of undocumented children, lack of public value of dental care and low Medicaid reimbursement rates for dental care are all contributors to the problem. According to the last “open mouth survey” in Nebraska 2005, 36% of the children in third grade had untreated decay. Such a chronic lack of routine dental care has made an impact on the community’s dental health, with nearly 20% of adults having had no dental examinations from 2004 to 2010, and some counties in the district reporting over 15% of adults with poor dental health. The goal of the Life of Smiles program is to improve the number of children with access to dental care by providing children ages 0 and above with dental screenings, dental health education and preventive services, such as fluoride varnish, dental sealants, and referral for dental care. Throughout the 2014-2015 year, the Life of Smiles program served approximately six times more kids than when PHS first began providing dental health services to kids in 2012.

PROGRAM SUCCESS AND PUBLIC RESPONSE

Since the start of Life of Smiles program in late 2014, PHS has served approximately 2,157 children and adults at WIC clinics, schools and Head Start programs. By the end of grant year one, Life of Smiles will have served about 3,800 children and adults in the district. Life of Smiles program coordinator, Carmen Chinchilla, expresses excitement about the changes she has seen in the community, where young children and families are increasing their awareness of the need for routine dental screenings and preventive care and learning the importance of good dental health for improving overall health.

FUNDING

PHS received a sub grant award from the NE Dept. of Health and Human Services from the federal Title V/Maternal & Child Health Services (MCH) Block Grant Program. This is a two year grant from October 2014-September 2016.
51 MILLION SCHOOL HOURS LOST NATIONWIDE DUE TO POOR ORAL HEALTH

SERVICES PROVIDED IN HEAD STARTS FROM 2012 TO 2015 RESULTS

<table>
<thead>
<tr>
<th>Reduction in the number of children referred to dentists for dental caries</th>
<th>Reduction in the number of children in need of urgent dental care referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>42%</td>
<td>56%</td>
</tr>
</tbody>
</table>

WE WILL HAVE SERVED

2,157 CHILDREN AS OF JUNE 30, 2015

TOTAL BY COUNTY

- GAGE: 744
- SALINE: 369
- JEFFERSON: 371
- THAYER: 232
- FILLMORE: 441

Ready, Set, Go! event winner for the Dental Program.

Dental Day client after getting treatment.
HEALTHY FAMILIES AMERICA

PROGRAM SUMMARY
Healthy Families America is a nationally recognized program that connects expectant parents and parents of newborns with a voluntary and free program to promote healthy parent-child interactions and the overall wellbeing of children and families. The program is a partnership between PHS and the Nebraska Children’s Home with PHS serving as the contractor with the State of Nebraska and The Nebraska Children’s Home working as a subcontractor for PHS. The Nebraska Children’s Home Society employs and provides two of the Family Resource Specialists as part of their subcontract. HFA is an intense home visitation program with family resource specialists providing information on resources available, growth and development, medical and health needs, support with finding work and education, and assisting families with setting goals for their future needs.

OBJECTIVE
Through home visitation and support on parenting, HFA programs have been successful in developing better parent-child interactions and attachments which results in better parenting, increased education levels, better immunization rates and health care, increased problem solving skills, and achievement of family goals, to name a few.

COMMUNITY NEEDS
There are no income requirements for participation. It is vital for the program to have strong partnerships with health care providers, community service agencies and schools in order to receive referrals of pregnant women, newborns and mothers, as well as very young children. The younger the families, the more the parents and children will benefit from the program. While the program now serves only families in Jefferson and Gage Counties, we want to expand the program to the remaining counties in our District because the need and potential benefit is in every county.

PARTNERSHIPS

FUNDING
State of Nebraska – contract for an evidence bases home visitation program serving Gage and Jefferson counties.
PLANNING AND IMPLEMENTATION

Public Health Solutions convened a wide variety of stakeholders consisting of providers of home visitation, representatives of early childhood programs, community agencies, medical professionals, elected officials, researchers, funders, advocates and other community members.

Community Planning meetings were held on April 9, 2014 in Beatrice and on May 6, 2014 in Fairbury.

An Advisory Board was developed from the community meetings and two advisory board meetings were held on Sept. 30, 2014 along with our Open House on March 17, 2015.

DATA COLLECTED SINCE SEPTEMBER 1, 2014

- Referrals/Screen: 66
- Parent Surveys Completed: 45
- Home Visits: 580
- Total Number of Families Served: 45

TRAINING

- HFA Training: All staff were trained per requirements for fidelity to HFA model
- Online training through the HFA learning center
- Program training on confidentiality, home visiting principles, boundaries
- Child abuse statutes and reporting requirements
- Cultural sensitivity training
- Answer for Families Home Visiting training - Online modules through the State of Nebraska
- 3 family home visitors received their certified lactation counselor certification
- 4 family home visitors attended infant massage training and a new hire has already had the training
- CPR training for all staff
- Bridges over poverty training
- Minority Health Conference
- Compassion fatigue training
- Family Wise training for the data base and charting
- Family home visitor trained as a car safety technician
- Stewards for Children - Sexual Abuse Training
- Hope Crisis Center - Training on Domestic Abuse
- Circle of Security training
Community Needs and Program Overview

Improving behavioral health is a high priority for the district. Saline County was one of three counties in Nebraska selected by Nebraska Children & Families Foundation to receive funding through the Rooted in Relationships Initiative to improve the behavioral health of young children. This selection was based on need as well as potential for success because of the early successful initiatives to improve services for young children in Crete. High rates of poverty and low rates of high school graduation among adults were the basis for Saline County being selected based on need. Low rates of high school graduation provided the basis, as 17.31% of adults in Saline County do not have a high school diploma versus the Nebraska state average of only 10% of adults not having a high school diploma. In addition, 20.24% of children in Saline County are living in poverty versus the Nebraska state average of 15.45%. The Crete School led collaborative programs to benefit young children, such as Sixpence were early evidence of the community commitment and likelihood of future success. The initiative targets specific service systems and partners within the communities to assist in the development and implementation of long-range plans to support the social-emotional development of children, birth through age 8. PHS has been a collaborating partner with Crete Public Schools, Blue Valley Community Action, Blue Valley Behavioral Health and UNL Extension and was asked by the community group to provide fiscal management and coordination for the project.

The Initiative Has 4 Key Community Activities

- Convene local partners to develop a long-range plan to support the social-emotional development of young children
- Implement the Pyramid, an evidence-based framework developed by the Center on the Social and Emotional Foundations for Early Learning (is already being used in some early care programs in Nebraska)
- Identify at least one other system in their community involved with young children and their families (health, mental health, child welfare, etc.) and work with that system to build upon the successful work they’re already doing
- Evaluate with outcome-based assessments and standardized achievement tools.
PROGRAM SUCCESS AND PUBLIC RESPONSE

Community stakeholders identified three main objectives to monitor program success and evaluation. These were to implement the Pyramid Model in Saline County early childcare venues, implement Circle of Security Parenting Training for parents in Saline County, and identify current screening for social-emotional development in ages birth through age 8. The program has been so successful it has well exceeded its original goals. Circle of Security Parenting classes have expanded in availability to three additional counties within the District as well as outside of the District. In addition three new childcare providers have been added to the Pyramid Model Initiative.

The Rooted in Relationships program reports highly engaged community stakeholders and a positive and encouraging community response. A testimonial from a high-risk family stated the family has “really made some changes and are taking some new approaches to life” after going through the program’s Circle of Security parenting classes. Another family stated, “This is the best parenting class I have taken and I have taken a few over the years. It has made a huge difference in me and how I handle situations with my children.” Finally, childcare providers in Saline County report being able to incorporate aspects of the Pyramid Model, including parent newsletters, into the services they provide their families.
SAFE KIDS

PROGRAM SUMMARY
Safe Kids of Jefferson, Filmore, Gage, Saline and Thayer Counties was formed as a collaborative of the previously independent County Coalitions. It was felt that by working together, more resources could be garnered for the District and PHS could serve as a facilitator of the effort.

The Coalition selected three areas for attention. The first and largest is to assure that children are transported safely, second is that children not be left unattended in a car and the third is to protect children from fire injury and death.

OBJECTIVE
- Ensure that all families with young children have access to a working smoke alarm, as well as a family evacuation plan.
- Ensure that children are transported in properly fitted and correct car seats, or booster seats
- Ensure that children are not left unattended in cars.

Implementation: SAFE TRANSPORT OF CHILDREN
- Public education to raise awareness of the importance of the proper installation and use of child safety seats
- Conduct car seat checks. These were done in three counties involving 22 car seat technicians and 13 volunteers. During these events, 31 seats were found to be incorrectly installed, 8 children arrived without car seats and three arrived needing installation. The following were distributed: 2 infant seats, 10 convertible seats, 9 booster seats and 2 combination seats.

Implementation: AVOIDING HEAT INJURY AND DEATH
Thirteen social media releases were done to increase awareness of the importance of double checking that children are not left in the car. These were done in conjunction with national media releases about each car related heat death.
COMMUNITY NEEDS
Fire safety is an important component of keeping children safe. Currently, fire-related injuries are the second leading cause of inpatient hospitalization for children under the age of one. It is also the seventh leading cause for Emergency Department visits. *(NE Hospital Discharge, 2007-2011)*

In an effort to improve current statistics, PHS focuses its efforts on children aged 0-4 and their families.

PUBLIC RESPONSE
There was a promotional campaign over the Fourth of July, by PHS, to encourage the public to practice safe firework habits to prevent unintentional injuries. There was paid media, radio interviews and social media efforts to encourage safety with fireworks.

PHS was also invited to speak to the Crete High School ELL Parent Group about fire safety. This event had 45 participants. It was very well received and PHS was encouraged to come back again in the fall.

### PLANNING AND IMPLEMENTATION FOR PREVENTION OF FIRE INJURY AND DEATH

1. This grant was received in February. PHS collaborated with home visitors to distribute smoke detectors.

2. Home visitors will conduct pre and post home safety analysis of those that they visit (HFA approximately 50 and Six Pence approximately 20), track monthly visits, test, safety plans and collateral provided to support children 0-4 and their parents. PHS has already received verbal commitment from both HFA & Six Pence to carry out objectives to meet the goal.

3. Through this grant, PHS will distribute approximately 42 new smoke alarm units to families (60% of the 70 seen).

   Twelve home visitors were trained and provided supplies to carry out the home visit with a pre/post test evaluation. PHS, through the Safe Kids Worldwide grant provided smoke detectors to home visitors. August will be the next training to support additional avenues for distribution. There were 8 smoke alarm units placed with families over a five month period, February – June. This program will run through November 30, 2015.
APPLICATION ASSISTANCE

PROGRAM SUMMARY
PHS works to enable residents to get a third party source of funds for care. We do not generally receive funds to provide this assistance, however, we did receive funds in conjunction with funding from the Federal Office of Rural Health. This enabled us to train some staff and to actively enroll clients. Enrolling in ACA allows an individual to select a primary care provider, participate in preventative health measures and reduce the number of ER admissions to our rural hospitals.

OBJECTIVE
• Help residents explore all options to finance their health care.
• Increase the number of individuals, across our health district, educated on health insurance options by general educators. Trained educators as needed, will explain health coverage options.
• Increase the number of clients that receive eligibility determinations through a trained Certified Applications Counselor (CAC) using the Market Place.
• Follow up with newly insured clients to ensure they understand their insurance and follow the road “From Coverage to Care”.

COMMUNITY NEEDS
• Insurance in order to better access care and decrease the use of emergency room visits.
• Increase the number of individuals that have a primary care provider.
• Educate consumers on the ACA & Marketplace enrollment.

SUCCESS STORIES
Reaching over 303 individuals about general education. Increasing awareness about the availability of insurance to those individuals struggling with medical bills, health issues, and families.

PARTNERSHIPS
Appleseed, hospitals, and other community service providers such as BVCA and AAA.

Simera Reynolds
Program Coordinator
Community Health Workers
Carmen Chinchilla
Alejandro Gomez
Emmanuel Sánchez
Certified Application Counselor
PUBLIC RESPONSE

There were several clients that came for ACA enrollment and left without enrolling due to the high cost and low income.

Another issue facing us in Nebraska, is that the state did not expand Medicaid. Also, Co-Opportunity (located in Iowa) went bankrupt and both the Iowa & Nebraska Department of Insurance had to take over and manage issues related to the insurance and coverage. The CAC did have to find a new insurance for a newly insured couple that picked Co-Opportunity as their provider.

![ACA training and implementation chart]
ELDER FALL PREVENTION

PROGRAM SUMMARY
Unintentional injuries are high within our District. We are working to increase the capacity of local organizations and agencies to provide services to reduce falls. The two larger programs are Tai Chi and Stepping On.

The Stepping On Program allows older adults to determine issues and approaches that are personally relevant to each participant. Stepping On is a 7-week multi-faceted group program with support and follow up.

The class topics cover:
• Moving safely
• Home hazards
• Vision & falls
• Medication management
• Getting out and about

PROGRAM TARGETS
• Individuals that have had a fall in the last year or have a fear of falling
• Participants that walk independently, use a walker or cane
• Live in their own home or independent living
• Individuals that want to learn safety measures that will allow them to remain independent

Participants will explore safety strategies and potential barriers to putting strategies in place. The program goal is to facilitate the individual taking control, exploring alternative measures, and encourage follow-through on safety strategies in everyday life.

OBJECTIVE
Injury prevention, due to falls, for adults 65 and older are the primary target. The intent is to keep older adults out of the hospital and in their own homes for a longer period of time.

PARTNERSHIPS
Senior Centers, DHHS Injury Prevention Program, Aging Partners Lincoln/Lancaster Counties

Brenda Motis, Fillmore County Hospital

FUNDING
Injury Prevention grant from the Department of Health & Human Services.
TAI CHI PROGRAM

Tai Chi: Moving for Better Balance is designed to improve the strength, balance, and physical functioning of individuals with diminished physical abilities, including older adults and those with Parkinson’s disease. The focus of the program is Tai Chi, a nontraditional form of exercise, which is used to help participants improve postural stability, control of body positioning, gait initiation and locomotion, movement symmetry, and coordination; increase the range of motion around ankle joints; and build strength in lower extremities. Tai Chi also can be used to enhance mental health, improve sleep quality, and reduce blood pressure.

The Tai Chi program is community based and implemented through instructor-led group sessions that are held two or three times per week for approximately six months, with the ultimate goals of improving participants’ functional balance, increasing their mobility, and reducing the incidence of falls. The program consists of a core eight-form routine with built-in exercise variations and a subroutine of eight integrated therapeutic activities, which, collectively, involve a set of simple, continuous, rhythmic, and functional Tai Chi–based actions. The sessions focus on stimulating participants’ musculoskeletal and sensory systems via self-initiated movements, such as body weight shifting, unilateral weight-bearing trunk rotation, ankle sways, and coordinated eye-head-hand movements. To meet the specific needs and performance capabilities of the participants, the program includes chair-supported progressions, from completely assisted to unassisted. Participants are also taught exercises that they can perform at home for additional, out-of-class practice. Before delivering the program, Tai Chi instructors must receive training and certification through a two-day instructional workshop.

PLANNING AND IMPLEMENTATION

This is the third year of the grant. Each year we provide training to new trainers, provide support or the provision of classes, advertise, promote and develop collateral materials. The first year we conducted this program we had 2 classes. This year we have 14 instructors conducting classes.

There will be two Stepping On classes conducted in Saline & Fillmore Counties in the fall of 2015, with the possibility of a third class held through a faith-based partner.

PUBLIC RESPONSE

There has been a strong response for the program in Fillmore and Saline Counties. The program will meet capacity and very little advertising was done. Stepping On is a sound program to complement the existing Tai Chi program.
COMMUNITY HEALTH HUBS

PROGRAM SUMMARY
The purpose of Community Health Hubs is to decrease morbidity and mortality through early detection and referral to treatment. The health hub model uses evidence-based strategies to promote clinical preventive services and make appropriate linkages to medical homes for the provision of high quality screening, follow up, and treatment services. An environmental scan was completed for the grant period of July 1, 2014 – June 30th, 2015 to assess the needs and gaps of knowledge, attitudes, and behaviors at the community level, and evidence-based strategies were developed based on the scan results.

OBJECTIVE
The evidence-based interventions were selected with the purpose of increasing screening rates for breast cancer, cervical cancer, prostate cancer, colon cancer, diabetes, and cardiovascular disease within our district. Public Health Solutions also set out with the goal to increase community linkages, to primary health care and community resources for preventative screening, follow up, and treatment, as well as chronic disease self-management. In promoting cancer screenings for colon cancer, our target population is men and women who are 50-75 years of age. Women over the age of 40 are recommended to have start having mammogram testing done to screen for breast cancer. Men over the age of 40 are recommended to begin discussions with their doctor on screenings for prostate cancer.

To carry out these strategies, we utilized “Lunch & Learns,” Individual Health Assessments, and Health Screenings.

Natalie Kingston
Community Development

Deb Wendelin
Health Education & Community Health Worker

Adam Zobel
Health Education Specialist

PARTNERSHIPS
Crete Chamber of Commerce, Beatrice Chamber of Commerce, Crete Rotary Club, Farmland Foods Inc., Saline County Employees, Bunge Inc., Fillmore County Hospital, Beatrice Community Hospital and Health Center, Southeast Community College Beatrice, Beatrice Community Resource Center, Deines Pharmacy, Clabaugh Pharmacy, Walmart-Crete, Shopko-Crete, Walmart-Beatrice, Shopko-Beatrice, Walmart-Fairbury, The Medicine Shoppe-Crete, Korbel Drug, Weaver Pharmacy, Warren Memorial Hospital, Lake Crest Pharmacy, and Priefert Pharmacy.

FUNDING
Nebraska Department of Health and Human Services (DHHS)
COMMUNITY NEEDS
In order to increase screening rates for colon cancer and reduce barriers around the actual test, PHS developed a “how to” video on completing a colon cancer screening test at home. This video was produced in English and Spanish and demonstrated how to complete an in-home FOBT (fecal occult blood test), which is an indicator of colon cancer. Both videos were completed for our March colon cancer campaign. They were put on our website and accessible online through YouTube.

Public Health Solutions was able to start a Worksite Wellness Initiative that started gaining momentum towards the end of the year. We were able to work with four organizations in Saline County, two organizations in Gage County, and one organization in Fillmore County to complete Lunch & Learn Presentations, Health Assessments, and Health Coaching.

SUCCESS STORIES
Through completing one-on-one health coaching, Deb Wendelin had 12 individuals complete a Zumba class in Crete, Nebraska. Zumba is a dance fitness and follow the leader class. Many of the individuals that completed the class were impressed with the exercise class and stated they would be interested in enrolling in the class more permanently.

NUMBERS SERVED FROM JULY 1, 2014 TO JUNE 30, 2015:
One of the important goals of the program is to distribute 300 Fecal Occult Blood Tests (FOBT) to people ages 50-75 within our district. These FOBT kits are a test that can be completed in an individual’s home and are an indicator for colon cancer. For the year July 1st, 2014 to June 30th 2015 we were able to distribute 289 FOBT kits with a 51% return rate. From our March colon cancer campaign we had 5 positive FOBT results. We were able to partner with pharmacies, businesses, and other organizations to distribute and collect FOBT kits.

Natalie Kingston, Deb Wendelin, and Adam Zobel completed 14 Lunch & Learn Presentations at Crete Chamber of Commerce, Beatrice Chamber of Commerce, Crete Rotary Club, Farmland Foods Inc., Saline County Employees, Bunge Inc., Fillmore County Hospital, Beatrice Community Hospital and Health Center, Southeast Community College Beatrice, and Beatrice Community Resource Center. From these “Lunch & Learns approximately 150 people were referred for health or screening related services.

Over 50 people have received 1-on-1 health and lifestyle coaching. In all health coaching sessions employees made at least 1 goal towards living a healthier lifestyle (such as:
• exercise for 30 minutes 3-4 days a week
• eat 2-3 cups of vegetables daily 3-4 days a week
• reduce pop consumption, etc)
ENVIRONMENtal SCAN RESULTS

Based on the findings below the evidence-based interventions selected were related to cancer, diabetes, cardiovascular disease group and one-on-one education. To carry out these strategies we utilized “Lunch & Learns,” Individual Health Assessments, and Health Screenings. Lunch & Learns are a 30 minute presentation on cancer prevention and health lifestyle habits. Individual Health Assessments are risk assessments, blood pressure checks, and health coaching for interested individuals. These were completed with people attending Lunch & Learns and through the Minority Health Program and Healthy Pathways Program. Individual Health Screenings were also made available to those individuals that wanted to see progress or success within the program.

CANCER SCREENING RATES

**BREAST CANCER**

STATE SCREENING RATE: 64.97%

JEFFERSON COUNTY: 52.94%

**CERVICAL CANCER**

STATE SCREENING RATE: 76.2%

FILLMORE: 74.3%

JEFFERSON: 74.6%

SALINE: 75.9%

**COLON CANCER**

STATE SCREENING RATE: 56.8%

FILLMORE: 49.7%

GAGE: 50.7%

JEFFERSON: 50.7%

SALINE: 52.2%

THAYER: 49.6%

The rates of colon cancer screening in females across Nebraska increased from (63.6%) in 2012 to (64.4%) in 2013 while decreasing within PHS district (61.1%) in 2012 to (55.3%) in 2013.

SMOKING RATE

STATE: 19.07%

GAGE: 23.9%

The percentage of cigarette smokers has decreased across Nebraska from 2012 to 2013, but increased in PHS district from (23.5%) to (29.4%).

DIABETES

STATE: 7.82%

GAGE: 8.6%

DISTRICT 7.97%

THAYER: 8.4%

An increase in diabetes can be seen from 2011 to 2013 for males and females within PHS District.

OBESITY

STATE: 7.82%

GAGE: 33.9%

JEFFERSON: 32.3%

SALINE: 31.9%

There has been an increase in the percentage of the population being considered obese (BMI=30+) and overweight (BMI=25+)

HYPERTENSION

STATE: 48.94%

FILLMORE: 52.16%

GAGE: 52.19%

THAYER: 52.19%

HIGH BLOOD CHOLESTEROL

STATE: 38.28%

GAGE: 42.06%

SALINE: 43.26%

PHS District is consistent with the state in an increase in blood pressure incidence for males and females from 2011 to 2013.
COMMUNITY NEEDS AND PROGRAM OVERVIEW

The six critical access hospitals in the district and PHS jointly identified that a growing number of people were going to emergency rooms to seek primary care. This resulted in a decrease in quality and continuity of care and an increase in monetary loss for hospitals providing uncompensated care. The primary reasons for this growing problem were a lack of patient awareness of the proper use of health care resources, a lack of financial access to a physician or ongoing access to a personal or family physician (a medical home). Growing problems associated with economic hardships, lack of transportation, inadequate or no health insurance and unsteady employment were limiting access to health care. Nearly 4 out of 5 uninsured households live at or below 200% of the federal poverty level, and only 63% have an employed head of household. To address these problems the six hospitals and PHS developed a collaborative program (Healthy Pathways) with the help of a HRSA grant to establish lower cost alternatives for care, and help patients engage in self-care to reduce the need for costly emergency room visits. Overtime the goal expanded to include reducing readmissions, helping to develop a strong rural health system that engages the population in healthy living, and increasing access to preventive and health promoting services. The Healthy Pathways program is a comprehensive program that takes into account the wellbeing of the whole person and whole family. This includes financial, emotional, mental, spiritual, and physical health. This recognizes that food, housing, transportation, family stability and access to prescriptions are also key factors contributing to the health of families and individuals. By taking this holistic approach and providing assistance in the areas shown below, Healthy Pathways is able to provide individuals with resources and tools to better manage medical conditions and improve health.
By a partnership with the physicians and clinics the Healthy Pathways staff have been able to increase the patient compliance and active participation in their own care. This helps the physicians and clinics extend their impact by eliminating obstacles that may interfere with the patients following the physician’s care plan. For example the patient may not take blood pressure medicine because of an inability to afford the medications, the patients may not understand their care plan, or they simply need to understand the importance of the clinic’s direction, or may not know how to integrate physical activity into their lives. Through the program, patients are provided one-on-one support and education to become key participants in their own care. This includes assuring that patients take needed medications as prescribed and have access to free or reduced-cost medications, that patients engage in self testing to keep illnesses in check, follow prescribed diets and exercise programs, and otherwise follow the physician recommendations. The net impact of the Healthy Pathways program is to improve health, reduce readmissions and the use of the emergency room, contribute to the team approach to care, helping care providers become more effective and increasing the health and wellbeing of the population.

In total, 345 new referrals were made to the program this past fiscal year. With the addition of 386 existing clients, 731 clients received services through the program. While the needs of those successfully contacted varied greatly, they did have some commonalities. 72% were uninsured, 23% were recently unemployed or underemployed, and 38% of the unemployed clients were disabled. Many had gone without health care, had chronic illnesses, behavioral health issues, had housing problems, and could not get health services due to unpaid accounts at their clinics. A large portion of those referred (303 clients) were given some form of application assistance for Medicaid, SNAP, disability determinations, and ACA. Referrals for housing assistance and other support services were made to other agencies as possible. Of those referred, many had commonalities. 13% had a behavioral health diagnosis, 23% of the clients were diabetic, 5% had asthma, 13% had hypertension, and 15% needed medication assistance. Through this program we were able to secure $139,500 in medications for patients who otherwise would not have had access to needed medication during the fiscal year. Those with a need for medications or simple information and referral were assessed, assisted with their immediate needs, and entered into short term case management. Staff then worked with the patient and health care provider to get needed medication and make needed referrals. The focus for patients who were recently released from a hospital or who were newly diagnosed was education and assuring that each patient was prepared to care for himself. In each case of staff service, staff advised the physician of record about what had been accomplished for the patient/family, as well as the observed condition of the patient. Clients with more complex problems such as chronic illness and no medical home or those with acute needs were opened to longer term case management.

Quantitative data which validated the success of case management came in the form of HgA1c measurement. Diabetic clients receiving case management and home visitation saw an average reduction of 2 points in their HgA1c over a 12 month period. In addition, by comparing initial SF-12 scores on client’s enrolled into case management with subsequent SF-12s, we found an increase of 44% in client’s perceived improvements in mental and physical functioning and overall health-related quality of life. Of clients referred to the program without a primary care provider, we were successful in establishing a medical home for 55%. Regarding those for whom a medical home was not established,
some clients declined our offer to help, preferring to seek services on their own, others were non-compliant in keeping appointments that had been set up for them. There were also clients who were unable to establish care based on an inability to pay a local provider. Some clients who had available transportation, we referred to an FQHC in Lincoln, Grand Island, or Omaha.
TRANSFORMATION OF HEALTH CARE

PROGRAM SUMMARY
Through the 1422 grant, PHS will be working with six selected clinics to help them achieve meaningful use and work towards team-based care, improve their efficiency and teamwork in the identification and evidence-based treatment of hypertension and diabetes, as part of Component 2. PHS is contracting with Health Information Technology and Team Based Care experts to provide assistance to medical clinics to improve their care of clients with prediabetes and hypertension. Part of the work in Component 2 of the grant, focuses on helping clinics advance their meaningful use of Electronic Health Records. Another aspect of Component 2 is to provide assistance from a practice transformation expert to improve clinic workflows. Other strategies in Component 2 are to integrate the use of community health workers within these selected clinics, work with pharmacists on hypertension self-management strategies for their clientele, and facilitate the development of an improved referral system between health care providers and community services for clients.

OBJECTIVE
Support health system interventions and community-clinical linkages that focus on the general population and people with uncontrolled high blood pressure and/or at high risk for type 2 diabetes.

COMMUNITY NEEDS
We are targeting residents within our five county district who are at risk for obesity, diabetes, heart disease, hypertension, and stroke.

SUCCESS STORIES
Partnering first with the Beatrice Community Hospital, we are providing individuals resources to community programs and integrating the role of CHW to improve the health outcomes. This directly builds upon the work of Health Pathways. Healthy Pathways has already demonstrated its usefulness to the hospital in helping to keep diabetics in control and maintaining blood pressures.

PARTNERSHIPS
Contractor for Health Information Technology Work: Wide River
Contractor for Team-Based Care/Practice Transformations: Remedy Health Care Consulting

Clinics selected to receive the work of the 1422 grant for the first two years of the project: Community Medical Center (Beatrice), Wymore Medical Clinic, Beatrice Internal Medicine, Beatrice Medical Center, Gage County Medical Clinic, and Fillmore County Medical Clinic.

In addition, there will be collaboration with selected pharmacies in Gage and Fillmore County.

FUNDING
1422 Grant provided by the CDC through the Nebraska DHHS.
MINORITY HEALTH

PROGRAM SUMMARY
Mi Vida Mi Salud, (My Life, My Health), aimed to increase the understanding, prevention, and management of diabetes among Saline County residents, specifically racial and ethnic minorities, refugees, and immigrants.

COMMUNITY NEEDS
African Americans, Hispanic/Latino Americans, American Indians, Asian Americans, and Pacific Islander Americans are at particularly high risk for type 2 diabetes. Also, gestational diabetes occurs more frequently in African Americans, Hispanic/Latino Americans, and American Indians than in other groups. In addition, poverty, lack of access to health care, cultural attitudes and behaviors are barriers to preventive and diabetes management care for some minority Americans. (from the Centers for Disease Control cdc.gov)

Between July 1, 2014 – May 31, 2015, a total of 138 participants were screened, all of which were unduplicated. The self-reported demographic make-up of those unduplicated participants:

- 96% identified as Hispanic
- 2% identified as Asian/Pacific Islander
- 1% identified as Puerto Rican
- 1% identified as Black/African American

FUNDING/ PARTNERSHIPS
Funding for the Minority Health Initiative is provided through a grant from DHHS, Office of Minority Health.

Our partners include: Crete Public Schools, Blue Valley Community Action, Inc., local healthcare providers and clinics.

276 RACIAL AND ETHNIC MINORITIES IN SALINE COUNTY WERE SCREENED FOR DIABETES RISK AND RECEIVED OUTREACH AND EDUCATION TO PREVENT OR MANAGE DIABETES.
Juan’s Story

Juan had experienced multiple strokes and was struggling with poor health and sickness. Another client recommended that Juan come to PHS and meet with a Community Health Worker. When Juan came to the health department for first time, he was not looking very well. Part of his body was visibly affected from the stroke, he was struggling with memory issues and he had difficulty walking. Right away he was screened for diabetes, cholesterol and blood pressure. His blood pressure, blood glucose level and Hemoglobin A1c were all extremely high and put him at risk for further strokes and severe medical complications. After reviewing his results, a PHS Public Health Nurse contacted his clinic to schedule an appointment to be seen by his doctor. A few months later, Juan was diagnosed with type 2 diabetes. The Community Health Worker immediately began working with Juan on the following:

1. Daily Physical Activity
2. Learning to Love and Take Care of Himself
3. The Importance of Taking His Medication
4. Eating the Right Foods, on Schedule
5. The Importance of Seeing the Doctor Every Three Months
6. Checking His Blood Sugar Level

The PHS Community Health Worker has now worked with Juan for over a year and a half. It has been rewarding to watch his progress and see the wonderful partnership that has grown between this client and the Community Health Worker. Juan is able to drive now and he is very happy and much more independent. He is working on his exercise techniques and has joined the PHS walking group. Juan and his Community Health Worker continue to work together to help him take back control of his health and improve his chances of living a long, happy life.
DIABETES PREVENTION PROGRAM

Over the 2014-2015 fiscal year, PHS helped communities in the District build capacity in diabetes prevention by hosting a training in which 14 lifestyle coaches were trained to implement the National Diabetes Prevention Program (DPP). The program, Smart Moves DPP, is a year-long healthy lifestyle program that helps participants make real lifestyle changes, including fitting physical activity into their daily lives, eating healthier, and improving problem-solving and coping skills, to help them prevent type 2 diabetes. Participants meet with a trained lifestyle coach in a small group setting once a week for 16 weeks and then once monthly for 6 months. The program is evidence-based and proven to help people with pre diabetes make achievable and realistic lifestyle changes and reduce their risk of developing type 2 diabetes.

The Smart Moves Initiative also encompasses programs aimed at increasing physical activity through encouraging and empowering communities to become more walking and biking friendly and improving access to healthy nutrition. PHS has been working with the city of Hebron to provide community members with a safer and more welcoming environment for participating in walking and biking activities. Hebron has identified key community members who are passionate about increasing physical activity and are hosting a community-wide Walk Hebron Summit in November 2015 to ensure the community’s voice is heard in this exciting opportunity. To this point, key stakeholders in the community have identified inadequate sidewalks and road crossings and an incomplete trail system as barriers to walking and biking in Hebron. They have also identified many exciting possibilities for overcoming these barriers, which will be discussed and decided upon at the Walk Hebron Summit.

To increase availability of and access to healthy foods in the community, PHS has partnered with the Gretchen Swanson Center for Nutrition to conduct a Nutrition Environment Measures Survey (NEMS) in grocery stores and convenience stores throughout the five counties in the PHS district to measures consumer access to food options essential to a healthy diet. This data collection and analysis revealed some startling information. According to the NEMS data, 18 out of the 42 surveyed convenience stores carried no healthy food or beverage options. With this information, we are now working to identify and assist key convenience stores interested in increasing their selection of healthy food options.
COMMUNITY TRANSFORMATIONS IN PHYSICAL ACTIVITY AND HEALTHY EATING

PROGRAM SUMMARY

In the face of rising rates of obesity and growing prevalence of diabetes and other related chronic illnesses, public health efforts are being directed to reduction of risk factors for chronic illness at the national, State and local levels. Through CDC “1422” grant funds, PHS has been able to expand efforts to help communities reduce the risk factors for chronic illness and to increase the means of reducing the onset of chronic illness. This includes increasing options for exercise, improving access to fruits and vegetables and increasing screening to find untreated illness.

In addition, PHS has been working with key community members and leaders to help transform the community environment to support and sustain health behavior change. Data collection and analysis to identify areas of need was an integral and essential function throughout the year’s objectives. As a result, key transformations taking place include creating communities where walking and biking are safe and encouraged, providing lifestyle change programs with built-in support systems, and working with partners to increase healthy food and drink options in vending machines, convenience stores, and grocery stores throughout the community.
DEVELOPING WALKABLE AND BIKEABLE COMMUNITIES

The Smart Moves Initiative also encompasses programs aimed at increasing physical activity through encouraging and empowering communities to become more walking and biking friendly and improving access to healthy nutrition. PHS has been working with the city of Hebron to provide community members with a safer and more welcoming environment for participating in walking and biking activities. Hebron has identified key community members who are passionate about increasing physical activity and are hosting a community-wide Walk Hebron Summit in November 2015 to ensure the community’s voice is heard in this exciting opportunity. To this point, key stakeholders in the community have identified inadequate sidewalks and road crossings and an incomplete trail system as barriers to walking and biking in Hebron. They have also identified many exciting possibilities for overcoming these barriers, which will be discussed and decided upon at the Walk Hebron Summit.

PHS also is working with Beatrice and Blue Cross Blue Shield to establish BIKE depots and programs to encourage biking as a strong transportation option.

BOLTAGE

Schools in both Crete and Beatrice have hosted the Boltage program through which walking and biking of children is measured through computer chipped badges and rewarded. In Crete alone, 65% of the participating student body is made up of ethnic and racial minorities and these students are directly impacted by the Boltage program.
**BOLTAGE NUMBERS**

- **$1,600**
  - Blue Cross Blue Shield grant funds covered Year 2 program expenses and online operation of the Boltage Unit at Crete Elementary.

- **$250**
  - Mini grant was awarded to Crete Elementary school principal, Erin Gonzalez to help with Boltage program costs at Crete Elementary.

- **$700**
  - The Crete Schools Foundation provided an additional grant to covering remaining program costs for the 2014-15 school year.

- **200+**
  - Students logged trips on the Boltage Unit during the 2014-15 school year at Crete Elementary.

- **50**
  - Students logged trips on the Boltage Unit during the 2014-15 school year at Lincoln Elementary.

- **6**
  - Bikes purchased for the Crete Community with Safe Kids Mini-Grant funding.

- **1,005**
  - Copies of bike safety information sent out through Backpack Mail to all 4 elementary schools.

- **12**
  - Kids reached at bike event in partnership with Grandma’s Daycare.

- **10**
  - Students taught bike safety by two League Certified Instructors for six weeks.

- **15**
  - Helmets provided to kids in need at Thayer Central schools.

- **6**
  - Helmets provided to Crete Elementary for the migrant Saturdays program during June of 2015.

- **6**
  - Kids reached at BIKE Event in Partnership with Grandma’s Daycare.

- **12**
  - Copies of bike safety information sent out through Backpack Mail to all 4 elementary schools.

- **10**
  - Students taught bike safety by two League Certified Instructors for six weeks.

- **15**
  - Helmets provided to kids in need at Thayer Central schools.

- **6**
  - Helmets provided to Crete Elementary for the migrant Saturdays program during June of 2015.

- **6**
  - Kids reached at BIKE Event in Partnership with Grandma’s Daycare.

- **12**
  - Copies of bike safety information sent out through Backpack Mail to all 4 elementary schools.

- **10**
  - Students taught bike safety by two League Certified Instructors for six weeks.

- **15**
  - Helmets provided to kids in need at Thayer Central schools.

- **6**
  - Helmets provided to Crete Elementary for the migrant Saturdays program during June of 2015.

- **6**
  - Kids reached at BIKE Event in Partnership with Grandma’s Daycare.

- **12**
  - Copies of bike safety information sent out through Backpack Mail to all 4 elementary schools.

- **10**
  - Students taught bike safety by two League Certified Instructors for six weeks.

- **15**
  - Helmets provided to kids in need at Thayer Central schools.

- **6**
  - Helmets provided to Crete Elementary for the migrant Saturdays program during June of 2015.
HEALTHY FOOD- MORE FRUITS AND VEGETABLES

To increase availability of and access to healthy foods in the community, PHS has partnered with the Gretchen Swanson Center for Nutrition to conduct a Nutrition Environment Measures Survey (NEMS) in grocery stores and convenience stores throughout the five counties in the PHS district to measure consumer access to food options essential to a healthy diet. This data collection and analysis revealed some startling information. According to the NEMS data, 18 out of the 42 surveyed convenience stores carried no healthy food or beverage options. With this information, we are now working to identify and assist key convenience stores interested in increasing their selection of healthy food options.

FARMERS’ MARKET COALITION OF SOUTHEAST NEBRASKA

PHS is encouraging the consumption of fruits and vegetables through food markets and through Farmers ‘Markets. While some local food retailers are able to carry fresh, local, or organic products, not all of them have the ability to carry a variety of local foods or ensure a fair price to the farmer in return. The Farmers’ Market Coalition of SE Nebraska is a group of consumers and farmers concerned with the sustainability of the small family farm and are working to expand the local food economy in all five counties PHS serves. This initiative is helping to bring fresh, local, and nutritious foods into homes across our District, and local farmers’ markets are a major component to improving healthy food access and sustainability in our District. Information about each of the 10 farmers’ markets operating within the District has been compiled into the 2015 Guide to Local Foods put out by PHS and members of the 2015 Farmers’ Market Coalition of Southeast Nebraska. The guide, printed in both English and Spanish, provides information about seasonal fruits and vegetables that can be found at farmers’ markets in the District. PHS also assists farmers’ market managers with advertising, signage and promotion of markets, and provides support to the coalition members through linkages with Nebraska’s State resources and extension offices. In a new effort this year, PHS sent a team out to conduct surveys collecting data to provide market managers with valuable information for improving their markets. Data from these surveys are currently being analyzed at the Gretchen Swanson Center for Nutrition; and we look forward to the opportunity to share survey results with the Coalition’s market managers later in 2015.
VETERAN SERVICES

COMMUNITY NEEDS AND PROGRAM OVERVIEW
Public Health Solutions is part of the Nebraska Association of Local Health Directors and received a grant from the Veterans Administration to help veterans and their families reintegrate into communities in rural areas. Due to multiple deployments, complex injuries and the limitation of the Veterans Service System in rural areas, many veterans are not receiving the services they need. The VetSET program supports Veterans and their families as they work to adapt back into the communities they left to serve in our nation’s Armed Forces.

Regardless of where or how they serve, Veterans and their families return with diverse and unique needs that must be addressed for them to maintain good physical and mental health. Of the 143,000 Veterans living in Nebraska communities in 2014, over 4,300 of them reside within the Public Health Solution’s district. In a survey of the district’s Veterans, the VetSET program at PHS was able to identify common concerns, including financial education, marriage and/or family counseling to provide family structural support upon returning from deployment, and resource identification and referral in order to more easily access community after care services. These measures ensure our district’s Veterans are not falling through cracks in accessing health care services.

The VetSET program has three main objectives focused on strengthening the community’s network of resources available to Veterans, service members, and their families; helping them to connect with and access those resources, and on increasing Military Cultural Competence across rural Nebraska.

PARTNERSHIPS
Nebraska Association of Local Health Directors (NALHD)
Southeast Community College, Beatrice
Law enforcement, EMT, Fire/Rescue
County Commissioners
American Legion and VFW & Auxiliary’s
County Veterans Service Officers
Blue Valley Community Action

FUNDING
Veterans Grant through Nebraska Association of Local Health Directors

Dave Wieting
VetSET Coordinator
Jill Kuzelka
VetSET Coordinator
OBJECTIVE
As our veterans return home, Public Health Solutions is working in the community to:

- Develop strategies and give insight into networking and partnering in order to fill service gaps
- Assist veterans and their families, as they transition into their jobs, schools and communities
- Address common challenges and provide ideas about creating partnerships in the community to assist with topics to include: employment, education, well-being of service members, Veterans and Families.

PROGRAM SUCCESS AND PUBLIC RESPONSE
The PHS veteran advocate has had several successful outcomes after taking a call from a veteran in need. The advocate was able to encourage a Korean Veteran to get hearing aids after his family had tried for years, and now the grandfather can actually hear what his grandchildren are saying to him. That means the world to the whole family. Another success, was working with a Vietnam Veteran who was in dire need of services. The advocate worked with him at all times of the day and night, including well past mid-night, to ensure he was getting the care he needed at that time. A Veteran’s Administration case worker was so impressed by the work the advocate did he stated, “You may have saved his life.” What a good feeling for our staff, our organization and our community.

SERVICES PROVIDED JANUARY – JUNE, 2015

49 Veterans & Family Members
2 Gold Star Wives
2 Community Colleges
5 County Veteran Services Officers
3 Military Units

“After implementing this program, my biggest reward was a hug from a Gold Star Wife.” - Dave Wieting, Veteran Advocate
PROGRAM SUMMARY
Several years ago, PHS conducted an assessment of environmental health needs within the five county area. The primary concerns identified were children’s health, dilapidated properties, exposure to toxins, outdoor recreation, public awareness, community investment, waste management, and water quality/quantity.

The lack of funding opportunities has made it difficult to respond to the problems with a systematic program. Consequently, we have had to resort to the implementation of small grants, monitoring data and response to problems on a compliant basis.

OBJECTIVE
To develop capacity within the 5 county area to control and/or remediate environmental hazards.

We have had several small grants. These include Radon Education and Testing, Battery Collection and Recycling, and West Nile Surveillance and Education.

BATTERY RECYCLING
Battery recycling is provided because of the toxicity of batteries when discarded, the fire hazard they represent if improperly stored, and the threat to children posed by button batteries. We provide recycling boxes to the extension office and other key sites within the district. Those accepting batteries boxes must properly package discarded batteries and ship them back to the recycling center. The major cost to PHS is the special recycling box and associated recycling system. PHS is attempting to obtain a grant for this effort to reduce local costs.
NEBRASKA HAS VERY HIGH LEVELS OF RADON IN HOMES. RADON IS A CANCER-CAUSING NATURAL RADIOACTIVE GAS THAT YOU CAN'T SEE, SMELL OR TASTE AND CAUSES ABOUT 21,000 CASES OF LUNG CANCER IN THE U.S. EACH YEAR. APPROXIMATELY ONE OUT OF EVERY TWO RADON TESTS DONE IN THE STATE OF NEBRASKA SHOWS HIGH LEVELS. HOMES WITH AN ANNUAL AVERAGE RADON LEVEL AT OR ABOVE 4.0 PICOCURIES PER LITER (pCi/L) SHOULD IMPLEMENT MITIGATION MEASURES TO LOWER RADON LEVELS.

RADON EDUCATION WAS PROVIDED VIA THE MEDIA, HOME AND GARDEN SHOWS AND ONE-ON-ONE CONSULTATION. A TOTAL OF 214 RADON KITS WERE DISTRIBUTED TO AREA RESIDENTS THROUGH THE 5 EXTENSION OFFICES. RESULTS WERE RETURNED ON 109 KITS AND CONSULTATION PROVIDED TO ALL WITH ELEVATED LEVELS. THE AVERAGE OF RESULTS FOR THE DISTRICT IS 9.55. BY COUNTY THE RESULTS ARE:

- FILLMORE COUNTY: AVERAGE 8.69
- GAGE COUNTY: AVERAGE 10.77
- JEFFERSON COUNTY: AVERAGE 8.45
- SALINE COUNTY: AVERAGE 7.1
- THAYER COUNTY: AVERAGE 12.75

PHS DOES NOT BELIEVE THIS PROGRAM IS ADEQUATE AND LEGISLATION ACTION WILL BE NEEDED IN THE FUTURE.

WEST NILE VIRUS

PROGRAM SUMMARY

The overall goal is to maintain a healthy population by increasing awareness and prevention of West Nile virus.

The West Nile Virus (WNV) surveillance and prevention program provides surveillance, education and outreach to district communities and residents by:

- Investigation of suspected human cases of WNV
- Engaging in surveillance of WNV by weekly sampling and testing of mosquito pools, collecting dead birds for necropsy to determine whether they are infected with WNV and monitoring illness reports for potential cases in humans
- Raising awareness about WNV and other mosquito and tick borne pathogens primarily through traditional and social media
- Distribution of materials such as dunks, bug repellents and instructions about how to avoid the proliferation of mosquitoes.
- Educating the public about how to avoid insects and exposure to WNV

West Nile virus disease cases have been reported from all 48 lower states. The only states that have not reported cases are Alaska and Hawaii. Seasonal outbreaks often occur in local areas that can vary from year to year. The weather, numbers of birds that maintain the virus, numbers of mosquitoes that spread the virus, and human behavior are all factors that can influence when and where outbreaks occur. Outbreaks have been occurring every summer since 1999, when WNV was first detected in the United States.
SUCCESS STORY
PHS distributes materials through county and municipal clerks, extension office and through special events. The materials are readily received and the public is responsive.

PLANNING AND IMPLEMENTATION
In advance of summer PHS works with the State in establishing mosquito collection sites and the distribution of material to educate and prepare the public. We use outlets that the public uses. County and Municipal Clerk and the Extension offices.

PUBLIC RESPONSE
The public response is good and they are cooperative. We are assisted by Villages, County Emergency Managers, local veterinarians and media.

FROM JULY 1, 2014 TO JUNE 30, 2015 THE WNV PROGRAM DISTRIBUTED

1,000
INDIVIDUAL DEET INSECTICIDE WIPES

500
CHILDREN’S BUG BANDS

1,000
MOSQUITO LARVICIDAL DUNKS
These were distributed at county fairs, community events, camps, sporting events, county offices, and county UNL Extension offices.

3
PRESS RELEASES REGARDING WNV PREVENTION AND DETECTION WITHIN THE DISTRICT
EMERGENCY RESPONSE

PROGRAM SUMMARY
We hired a new Emergency Response Coordinator this year and are emphasizing the development of relationships. We endeavor to educate the public about the importance of preparedness. We work closely with the County Emergency Managers and the health care facilities.

This past year extensive flooding in the district was a major issue. Four of five counties had emergency declarations requiring our active involvement. In all, $33,000 in department resources were expended in response. These resources were expended in surveillance, public information, consultations, immunizations, public education and the distribution of materials to combat mosquitoes.

OBJECTIVE
To help prepare the district and its resources to respond to all hazard emergencies. This requires not only department preparation but the establishment of effective relationships among responders across the district.

COMMUNITY NEEDS
Response to disasters of all kinds requires training and coordination among all responders to best protect the public. Coordination is essential among the counties as well as with the State and federal resources. Disasters can range from disease outbreaks to natural disasters to terrorism.

PARTNERSHIPS
County Emergency Managers, NEMA, NDHHS, and Villages

FUNDING
Funding is through Bioterrorism funds which are Federal funds passed through the State
SAVING RURAL HEARTS

PROGRAM SUMMARY
People die from cardiac events if they do not get assistance within four minutes. Even in the best of circumstances it is difficult to provide aid within four minutes. In rural areas, distances and limited resources makes it even more difficult to save lives in an emergency. PHS received a three year federal HRSA grant to increase survival rates from cardiac events.

Our goal is to reduce deaths from cardiac events by increasing the number of bystanders who intervene and provide CPR, AED, and 911 contacts when such an event occurs. It has been demonstrated repeatedly this kind of intervention greatly increases the survival rate for those with heart attacks.

OBJECTIVE
To meet this goal, PHS will distribute another 63 AED devices and train at least 30% of the population in CPR. The department is collaborating with county emergency managers, health care personnel, emergency responders and the public to accomplish these objectives.

PARTNERSHIPS
Partnerships were formed with the five county Emergency Managers, schools, churches, private businesses, EMS Squads and Fire Departments, County Extension, and CPR instructors.

FUNDING
The Saving Rural Hearts program is federally funded. It is part of the Rural Access to Emergency Devices Grant program.
COMMUNITY NEEDS
The focus of AED placements is on isolated communities, venues frequented by large numbers of people, and populations at risk. These included very small communities, schools, minority enclaves, etc. The overall focus is on creating awareness of the importance of CPR for all age groups. We want to make the use of CPR the norm.

Two special targets for CPR training are 911 dispatchers and the families of heart patients. The target population for this program is vast. Any person who is physically able to perform CPR and use an AED is part of the target group. In order to meet program goals over the next 3 years, 16,000 PHS district residents will need to learn to:

PROGRAM GOALS OVER THE NEXT 3 YEARS
- BYSTANDERS RECOGNIZE THAT HELP IS NEEDED
- BYSTANDERS CALL 911 AND START CPR IMMEDIATELY
- DISPATCHERS WILL BE TRAINED TO PROVIDE TELEPHONE ASSISTED CPR
- COMMUNITIES WILL MAINTAIN AND USE AEDS

PUBLIC RESPONSE
An advisory group is helping to place AEDs, assure current AEDs work and help train the public.
Debbie Pohlmann, RN, BSN
Immunization Coordinator

Michelle Blake, LPN
Laura Wooters
Immunizations Manager

Kim Buser, RN, BSN
Kate Lange, RN, BSN
Anet Bernabe
Data Entry, Scheduling

Alejandro Gomez
Data Entry, Scheduling
Nancy Schlamann
Data Entry, Scheduling

Daniela Ischiu
Data Entry, Scheduling

PROGRAM SUMMARY
Immunizations are a cornerstone for the prevention of communicable diseases. We promote routine immunizations of adults and children and also provide special immunization clinics as a way to combat outbreaks of illness, when needed and to reduce the number of immunization gaps in the population. While many health care facilities provide routine immunizations, PHS supplements their efforts by directing programs to those who are hard to reach or who have no means to pay for immunizations. An example of special clinics we conduct include the SKIP FLU clinics, tetanus immunization clinics during a flood or tornado, and pertussis clinics for adults and children to prevent the spread of whooping cough outbreak. We provide standing public clinics in Saline County because of the large proportion of people who are uninsured and/or undocumented. We also conduct public clinics at the request of immunizers or as needed, to reach those who are under served due to a lack of insurance or geographic area. We conduct a regularly scheduled public clinic in Fillmore County at the request of the hospital. Otherwise, we conduct special clinics to prevent community outbreaks and clinics targeted to the under served. Our newest target is composed of children and young adults not yet immunized for HPV. We actively educate the public about the importance of immunizations and the locations where immunizations are offered through health care providers and others.

OBJECTIVE
We help assure herd immunity to illnesses. We direct our efforts to fill gaps in the immune status of the population and to quell threats to the public.

FUNDING
We are funded by a state immunization grant to address gaps in the insured in three counties, fees and the departments health fund. Vaccine is provided by CDC through the state for those uninsured or on Medicaid

IMMUNIZATIONS FROM JULY 1, 2014 TO JUNE 30, 2015

<table>
<thead>
<tr>
<th>Publicly Funded</th>
<th>Privately Funded</th>
<th>Publicly Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines For Children</td>
<td>Vaccines For Children</td>
<td>Vaccines For Adults</td>
</tr>
<tr>
<td>1500</td>
<td>3494</td>
<td>278</td>
</tr>
</tbody>
</table>

= 5272

TOTAL IMMUNIZATIONS
COMMUNITY NEEDS
Adults without insurance are the least likely to be fully immunized. This includes many undocumented immigrants. Consequently undocumented adults are a target for Flu and TDAP immunizations. Despite the availability of HPV immunizations, a large portion of young adults and teens remain unimmunized and subject to cervical and other cancers.

PUBLIC RESPONSE
We have many who come to our clinic who do not understand what immunizations are for. They are sometimes reluctant to receive these immunizations due to misinformation from their peers or the internet/media. We provide informational handouts, answer their questions and provide education on the vaccine and what it does. The majority of the time they gain an understanding of prevention with immunizations and elect to be immunized and immunize their children.

WHAT WE DO
- Monitor and order vaccine/medical supplies
- Research clients’ immunization history determine which immunizations will be given
- Prepare for clinics
- Prepare and administer immunizations
- Schedule appointments
- Prepare client paperwork
- Billing
- Skip Flu preparation
SKIP FLU

PROGRAM SUMMARY
We offer flu immunizations to all school students and faculty. These are scheduled in late May/early August for the following school year. This way PHS gets the clinics included in the school calendar for the next school year. We have every school in our five-county district participating, with the exception of two small parochial schools.

OBJECTIVE
The School Kids Immunization Program – Flu (SKIP Flu) began in 2007 for two reasons. First, there was a desire to avoid deaths by complications of flu among school age children. At the time, CDC had noted an apparent nationwide increase in the severity of childhood influenza cases. Second, CDC advised that children were a primary vector of flu transmission within a community and school children were least likely to be immunized in the traditional settings of a Physician’s Office or VFC Clinic. The availability of school based immunizations was and still is emerging as a best practice for community flu outbreak mitigation.

The number of schools participating has increased since it began and currently all schools except two small parochial schools participate in the program. The Department has endeavored to coordinate this initiative with other health care providers out of the belief that health care is best delivered and/or coordinated through community health care providers. Furthermore, this program is seen as an adjunct to existing immunization programs. So every effort is made to not disrupt local immunization programs and to avoid taking revenue away from planned events of health care providers.

The Department’s program objective is to promote community wellness and minimize the cases of flu by increasing the number of immunized students. It is also the goal to increase acceptance of annual influenza immunizations.
COMMUNITY NEEDS
This activity is offered to reduce the rate of flu. The student population generally has a tendency to have low flu immunization rates. We hope by going into the schools it is more convenient and our goal is to increase the amount of “herd” immunity.

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>STUDENTS</th>
<th>ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillmore</td>
<td>346</td>
<td>28</td>
</tr>
<tr>
<td>Gage</td>
<td>732</td>
<td>199</td>
</tr>
<tr>
<td>Jefferson</td>
<td>481</td>
<td>128</td>
</tr>
<tr>
<td>Saline</td>
<td>878</td>
<td>76</td>
</tr>
<tr>
<td>Thayer</td>
<td>351</td>
<td>84</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2788</td>
<td>515</td>
</tr>
</tbody>
</table>

= 3,303
TOTAL IMMUNIZATIONS
PUBLIC HEALTH SURVEILLANCE

PROGRAM SUMMARY

Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Such surveillance can:

- serve as an early warning system for impending public health emergencies;
- document the impact of an intervention, or track progress towards specified goals; and
- monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies.

Our surveillance team works with hospitals, clinics, nursing homes and schools in our district to recommend treatment guidelines for communicable diseases and contain outbreaks. Public Health Nurses follow up directly with patients and families to ensure a healthy outcome and to stop the spread of infectious disease.

OBJECTIVE

The history of the reporting and tracking of diseases that could pose a risk to public health in the United States dates back more than a century. In 1878, Congress authorized the U.S. Marine Hospital Service (the forerunner of today’s Public Health Service (PHS)) to collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was used to institute quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, a specific Congressional appropriation was made for collecting and publishing reports of these notifiable diseases. The authority for weekly reporting and publication was expanded by Congress in 1893 to include data from states and municipal authorities. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were reporting 29 infectious diseases to the Surgeon General.

Among the 10 nationally notifiable infectious diseases that are most commonly reportable today, several were unknown in June 1946. The 10 most frequent nationally reportable infectious conditions in 1994 (the most recent year for which final data are available) were, in descending order, gonorrhea, acquired immunodeficiency syndrome (AIDS), salmonellosis, shigellosis, hepatitis A, tuberculosis, primary and secondary syphilis,
Lyne disease, hepatitis B, and pertussis (5). Fifty years ago, AIDS and Lyme disease were unknown. “Infectious hepatitis” (subsequently identified as hepatitis A) had just been identified, and morbidity reports for this condition first appeared in 1947. In 1953, serum hepatitis (subsequently named hepatitis B) was recognized as a separate entity, although it was included in the general category of hepatitis until 1966, when infectious and serum hepatitis began to be reported separately. Other diseases reported on a weekly basis during 1946 included amebiasis, murine typhus fever, and tularemia; during the past 10 years, these three conditions were deleted from the nationally notifiable disease list and are no longer routinely reported to CDC.

Centers for Disease Control cdc.gov

COMMUNITY NEEDS
The disease surveillance program serves to improve the health of district patrons by monitoring, responding to and providing education on communicable disease.

SUCCESS STORIES
PHS has partnered with and provided support to healthcare facilities as they have prepared for or experienced disease outbreaks. This year, information was disseminated on the Ebola Virus as well as local outbreaks of norovirus.

A total of 121 communicable diseases were investigated and reported by PHS as part of the State surveillance system which is then reported to CDC. This number does not include investigations that resulted in “suspect” conclusions or animal exposures that did not require rabies prophylaxis. Breakdown by investigation type is as follows:

14 Animal Exposures (with prophylaxis recommended)
1 Aseptic meningitis
27 Campylobacteriosis
1 Cryptosporidiosis (confirmed or probable)
2 Giardiasis
2 Group B Streptococcus, invasive
4 Hepatitis B, chronic
14 Hepatitis C, chronic or resolved
3 Lead poisoning, adult
2 Legionellosis
13 Pertussis
1 Rabies, animal
17 Salmonellosis
5 Shiga toxin-producing E.coli (STEC)
1 Streptococcus pneumonia, invasive disease
1 Tuberculosis
1 Varicella (chickenpox)
2 West Nile Virus (confirmed or probable)
4 West Nile Fever (confirmed or probable)
1 Ehrlichiosis, chaffeensis
1 Histoplasmosis
3 Noroviruses
1 Rocky Mountain Spotted Fever
ILI (INFLUENZA-LIKE ILLNESS) SURVEILLANCE

PROGRAM SUMMARY
PHS conducts weekly surveillance of all schools, hospitals, long term care facilities, head starts and early head starts within the five-county district. Schools are asked to report absences for illness in five categories, which PHS watches closely to detect if there are illness outbreaks that need to be assessed and/or require intervention. The primary value of this program is for influenza tracking and relationship building with schools. PHS not only monitors absences from illness in all of the schools within the District, but it also investigates any elevations in illness and provides consultation and assistance to schools to minimize the spread of illness. PHS carefully monitors the reports from the long term care facilities because of their fragile population. Any reports require PHS attention to assist to assure outbreaks are contained. The reports from hospitals are more detailed and are monitored to track the virulence of the flu outbreak, its intensity and direction.
PUBLIC HEALTH SOLUTIONS
FUNDING SOURCES

- LB 1060 - $105,458.12
- LB 692 - $255,739.85
- Grant/Other - $1,655,512.96
- Total Budget - $1,987,710.93

PHS EXPENDITURES FY 2015

STATE

- $226,581.85 LB692
- $105,458.11 LB1060

FEDERAL - STRAIGHT TO PHS

- $175,772.56 HRSA - Healthy Pathways Competitive $25,000.49
- HRSA - ACA Supplemental
- $79,673.44 HRSA - RAED Competitive

FEDERAL - STATE PASS THROUGH

- $73,296.67 BT Contract
- $15,706.83 1422 Contract Competitive
- $53,449.25 Oral Health Grant Competitive
- $23,497.29 Health Hub Competitive
- $4,500.00 Radon Competitive
- $4,870.71 Immunization Grant Competitive
- $1,000.00 TB Cases
- $7,687.60 West Nile Virus Competitive
- $9,065.00 Fall Prevention Competitive

STATE - OTHER

- $3,766.03 Accreditation Competitive
- $503,332.45 Healthy Families America Competitive
- $28,223.08 Minority Health Grant Competitive

LOCAL

- $102,250.00 ECI - Rooted in Relationships Competitive
- $209,776.08 Fee For Service - Immunizations
- $9,842.00 Counties SKIP Flu
- $5,296.19 Other competitive grants
The activities and programs of the local public health departments are organized under the three core functions of public health: assessment, policy development, and assurance. The assessment function involves the collection and analysis of information to identify important health problems. Policy development focuses on building coalitions that can develop and advocate for local and state health policies to address the high priority health issues. The assurance function makes state and local health agencies as well as health professionals responsible for ensuring that programs and services are available to meet the identified priority needs of the population.

Additionally, the activities and programs of the local public health departments are summarized under the associated ten essential services of public health. The ten essential services of public health provide a working definition of the public health system and a guiding framework for the responsibilities of local public health partners. These functions and services are specifically referenced in the Neb.Rev.Stat. §§71-1628.04.

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based-health services.
10. Research for new insights and innovative solutions to health problems.