2014 Annual Report of the Nebraska Health Care Funding Act (LB 692)

Health Department: Public Health Solutions District Health Department

All local public health departments receiving funds under the Act are required to report on the activities related to the core public health functions carried out during the fiscal year July 1, 2013 – June 30, 2014.

Please respond to the questions and provide specific examples and outcomes wherever possible. You may not be able to respond to every question but be complete as possible.

This report is due to the Office of Community Health & Performance Management by October 1, 2014. Please e-mail to Pat DeLancey (patti.delancey@nebraska.gov).
2014 Annual Report of the Nebraska Health Care Funding Act (LB 692)

1. **Monitor health status and understand health issues facing the community.**

   a. How do you make data available to your partners and your community?

   Public Health Solutions (PHS) provides data for the community members and partners. PHS disseminates data through a variety avenues; agencies that we partner with (LEO’s, Hospitals, schools, BVCA), community coalitions, website and links to specific data from the state and other high value sources (CDC). We continue to utilize Nebraska Network of Care Public Health Solutions, an online data and information system for use by organizations, agencies, and/or individuals.

   Surveillance data is monitored and/or reported monthly depending on the needs and circumstances for public information and protection.

   b. What major problems or trends have you identified in the past year?

   The department continues to observe growing problems for which data is not readily available. These include the perceived declining strength of families, lack of effective parenting, continuing economic decline and problems with health care access and basic life necessities.

   The second area is the apparent growing number of behavioral health problems. These are observed in the reports of community agencies regarding people without access to behavioral health services, growing numbers of children medicated based on parental reports of symptoms, and continuing concerns with domestic and child abuse. There are few if any screening and brief intervention programs reported within the District.

   Also there continue to be problems with binge drinking events within the district. The documented problems of high rates of unintentional injuries, low use of preventive services and disparities in access to care continue.

   **Problems Identified**

   1) The number of uninsured or underinsured individuals/families that seek support from the district health department, 2) The number of individuals that are at risk with respect to diabetes, 3) access to care for behavioral health, 4) The number of alcohol-related fatal, A and B injuries in Saline and Gage Counties continues to be an alarming trend.
c. If you updated your community health assessment during the past year, describe the process and the major outcomes.

PHS continued our successful collaborative process with the hospitals, community organizations, agencies and school districts. We gathered data from our last completed plan and remained focused on four priority areas, they include: strengthening families and family supports, improving behavioral health through the development and implementation of support services that are evidenced based and accessible, strong focus on increasing access to comprehensive and coordinated oral health care for children, and behavioral health. PHS works with coalitions and law enforcement agencies to reduce the number of motor vehicle deaths and injuries due to alcohol involvement, underage drinking and binge drinking.

PHS continues to strive to implement preventative measures and services, with regards to health outcomes, in order to reduce those in need of treatment.

Funding Source: Both LB 692 & LB 1060

2. Protect people from health problems and health hazards.

a. What key activities did you complete in the past year to prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities?

Routine Disease Surveillance

PHS conducts surveillance in cooperation with NDHHS hospitals and health care providers. Disease reports are received through the Nebraska Electronics Disease Data System (NEDDS) and through direct reports. The following illness reports were investigated to determine whether what, if any, disease control measures were necessary for public health protection. The department coordinates surveillance and response efforts with the state through monthly Health Alert Network calls. There were 76 cases identified and they are as follows:
Case Counts for July 1, 2013 to June 30, 2014

<table>
<thead>
<tr>
<th>Disease</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aseptic Meningitis</td>
<td>1 case</td>
</tr>
<tr>
<td>Campylobacteriosis</td>
<td>15 cases</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>3 cases</td>
</tr>
<tr>
<td>Cyclosporiasis</td>
<td>1 case</td>
</tr>
<tr>
<td>Giardiasis</td>
<td>5 cases</td>
</tr>
<tr>
<td>Hepatitis B, chronic</td>
<td>2 cases</td>
</tr>
<tr>
<td>Hepatitis C, chronic or resolved</td>
<td>12 cases</td>
</tr>
<tr>
<td>Lyme Disease, confirmed and probable</td>
<td>1 case-travel to endemic region</td>
</tr>
<tr>
<td>Pertussis, (include confirmed, probable, and suspect)</td>
<td>4 cases</td>
</tr>
<tr>
<td>Rabies, animal</td>
<td>1 case</td>
</tr>
<tr>
<td>Rocky Mountain Spotted Fever (Spotted Fever Rickettsiosis), confirmed and probable</td>
<td>3 cases</td>
</tr>
<tr>
<td>Salmonellosis</td>
<td>10 cases</td>
</tr>
<tr>
<td>Shiga Toxin-producing E. coli, included probable and confirmed</td>
<td>1 case</td>
</tr>
<tr>
<td>Invasive Pneumococcal Disease</td>
<td>2 cases</td>
</tr>
<tr>
<td>Tuberculosis (Pulmonary)</td>
<td>1 case; received directly observed therapy (DOT)</td>
</tr>
<tr>
<td>Varicella</td>
<td>1 case</td>
</tr>
<tr>
<td>WNV Encephalitis/Meningitis, includes probable and confirmed</td>
<td>5 cases</td>
</tr>
<tr>
<td>WNV Fever, includes probable and confirmed</td>
<td>8 cases</td>
</tr>
</tbody>
</table>

Seasonal Influenza Immunization

Over the last 7 years, PHS has conducted community mitigation efforts to reduce the impact of seasonal flu outbreaks. PHS continues to see rates that exceed the school immunization rates, for school children, in comparable local health districts (3 times higher than other districts). There are multiple prongs to this effort. They are:

- **Public information and education** regarding the measure the public can take to avoid the flu and/or minimize the spread. PHS utilizes a communication platform that includes press releases, radio (earned and paid), social media promotion, promotional information for school venues. The information provided supports recommendations to effectively reduce and/or prevent flu outbreaks in schools, day cares, long term care facilities to reduce risk and implement control measures, as needed.
• PHS focused heavily on the success of the School Kids Immunization Program (SKIP) Flu program for children and school faculty of all area schools in the five county service area. School children are a major vector for the transmission of the flu in the community, school age children are the least likely to be immunized against the flu in clinics and/or doctor’s offices. CDC recommends in-school immunization programs as an evidenced based method for increasing the immunization levels of school age children and reducing the incidence of flu in the general community. Last year, flu vaccinations increased by 70% in 2013/14.

<table>
<thead>
<tr>
<th></th>
<th>Fillmore County</th>
<th>Gage County</th>
<th>Jefferson County</th>
<th>Saline County</th>
<th>Thayer County</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-10</td>
<td>232</td>
<td>552</td>
<td>333</td>
<td>657</td>
<td>349</td>
<td>2123</td>
</tr>
<tr>
<td>2010-11</td>
<td>249</td>
<td>508</td>
<td>387</td>
<td>582</td>
<td>328</td>
<td>2054</td>
</tr>
<tr>
<td>2011-12</td>
<td>254</td>
<td>538</td>
<td>386</td>
<td>578</td>
<td>294</td>
<td>2050</td>
</tr>
<tr>
<td>2012-13</td>
<td>248</td>
<td>450</td>
<td>371</td>
<td>571</td>
<td>307</td>
<td>1947</td>
</tr>
<tr>
<td>2013-14</td>
<td>321</td>
<td>747</td>
<td>488</td>
<td>766</td>
<td>437</td>
<td>2759</td>
</tr>
</tbody>
</table>

*SKIP Flu Program across all 5 counties, over 5 years.*

*SKIP Flu Program by percentages, all counties, over 5 years.*
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.

A total of 2,759 people were immunized. This included 2,333 students and 426 staff who took advantage of our on-site school clinic. PHSDHD worked hard on a new media campaign that helped increase the overall rate of participation. Our highest county at a 42.8% participation rate and the lowest was at 18.0%, which is still higher than the national average.

The cost of the vaccine was again a major problem for the Department. Our request for VFC vaccine from the State was turned down again. While there is no written Federal or State policy prohibiting the use of VFC vaccine in the schools, the State, by practice, does not distribute it for this use.

Our health department has worked hard to make this a viable program by going through the process of obtaining a Medicaid Provider number. Once this number was received, we were than able to contract to bill insurance and Medicaid. We also receive contributions from each of the counties in our district. This is a small amount, 1/3 the cost of vaccine used in their county, but the contribution is greatly
appreciated. There are three Medicaid managed care agencies in our area and they each provided mini-grants that helped pay for the increased media campaign. The increase of revenue due to the billing, county contributions, and mini-grants has made this a successful program. The goal is to continue the education and promotion on the importance of the flu immunization.

School Illness Surveillance

The PHSDHD conducts weekly syndromic surveillance for all schools within the five county district. This data is collected on Wednesday, assembled, and submitted to the state every Thursday. Reports are sent back out to the schools showing overall absentee numbers, those absent due to influenza-like illness (ILI), and percentage of students absent. PHSDHD not only monitored the absences from illness in all the schools within the district, it investigated any elevations in illness and provided consultation and assistance to the schools to minimize the spread of illness. For the 2013-2014 school year, the mean absenteeism rate for all reporting schools within the five county district was 2.1% over the 35 week reporting period from August 28th through May 7th, with a high of 3.5% on Jan. 22nd and a low of 1.36% on May 7th.
The PHSDHD conducts weekly surveillance for all schools within the 5 county district. This data is collected on Wednesday, assembled and submitted to the state every Thursday. Reports are sent back out to the schools with graphs showing overall number of absenteeism, those absent due to ILI, and percentage of students absent. PHSDHD not only monitored the absences from illness in all the schools within the District, it investigated any elevations in illness and provided consultation and assistance to the schools to minimize the spread of illness. Examples of problems included MRSA, scabies, influenza, gastrointestinal illnesses and whooping cough.

<table>
<thead>
<tr>
<th>2013-14 Total School Illness Reported by Category</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>17</td>
<td>0.3%</td>
</tr>
<tr>
<td>ILI</td>
<td>2154</td>
<td>34.3%</td>
</tr>
<tr>
<td>Strep</td>
<td>184</td>
<td>2.9%</td>
</tr>
<tr>
<td>Rash w// Fever</td>
<td>14</td>
<td>0.2%</td>
</tr>
<tr>
<td>Gastro</td>
<td>1381</td>
<td>22.0%</td>
</tr>
<tr>
<td>Other</td>
<td>1454</td>
<td>23.1%</td>
</tr>
<tr>
<td>UnKnown</td>
<td>1084</td>
<td>17.2%</td>
</tr>
<tr>
<td>Total Illnesses</td>
<td>6288</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Hospital and Outpatient Influenza like Illness (ILI) Surveillance

All six hospitals within the health district worked with the department to track the number and severity of influenza-like illness admissions, staff illness, and shortages due to ILI. In addition to this, the Department worked with each facility to assure that all measures were taken to mitigate spread of the illness among residents, staff, and visitors. Assistance was provided as necessary to ensure that the facility maintained adequate inventory of masks, gloves, sanitizers, and other supplies.

Long Term Care Facility Surveillance

The long term care facilities cooperated in the surveillance program, providing information on residents and staff that were ill with influenza-like illness. The PHSDHD provided support and worked with each facility to help assure that necessary measures were taken to contain any illness and offered assistance and/or implemented measures to control illness as needed.
Head Start/Early Head Start

The PHSDHD not only monitored the absences from illness, it investigated any elevations in illness and provided consultation and assistance to minimize the spread of illness.

Immunization

PHS regularly provides immunizations to any community members that need services to protect their health status. Records are pulled for the PHS Immunization Nurse and appointments are set to assure that duplicate shots are not given to a child and that immunization records are complete. All immunizations given at PHS is recorded in Nebraska State Immunization Information System (NESIIS). PHS continues to provide VFC and other childhood immunizations to those in Saline County. There were a total of 4,750 immunizations given to 3,360 residents during the annual reporting period. There were 3,037 children under the age of 18 immunized. Additionally, there was a need to provide 7 rabies immunizations in 2013/14.

Immunization Clinic

Public Health Solutions holds an immunization clinic every Monday from 3:00 p.m. to 6:00 p.m. We also provided support to the Blue Valley Community Action at their immunization clinic in Fairbury. PHS served the insured at the BVCA location while they were going through the process of getting contracts with all the insurance companies. This began in October of 2012 and continued until BVCA had their billing system in place in April of 2014. PHS already had a billing system
in place and was glad to be partnering with BVCA so that insured clients could continue to be served at these clinics.

**Minority Health Initiative (MHI) Immunizations**

PHS staff conducts MHI screenings and events. When conducting the screening staff will define if immunizations, and flu vaccinations, are needed to protect the individual and the community. Frequently, the immunizations are given at the department and recorded by our public health RN.

**Pertussis**

PHS staff has continued to educate and immunize for adult Pertussis. PHS has the support of the Board of Health and authorized the continued practice of giving Pertussis boosters to low income and/or uninsured adults. There were a total of 38 boosters given by PHS during the 2013/2014 reporting period.

**Environmental**

Public Health Solutions receives requests for support and consultation from community members on a variety of environmental health related topics. The following is a breakdown of requests for assistance PHS received during the 2013-2014 fiscal year:

- **Water** – well testing/4, septic system/1, municipal water violations/13,
  - **IAQ** – smoking/3, mold/8, asbestos/3, radon/4,
- **Waste** – recycling/2, hazardous material/1,
- **Pest Infestation** cockroaches/1, bed bugs/9, flea/2, **Food** – licensing/2, illness/2, waste disposal/1, animal slaughter/1, food bank regulations/1,
- **Enforcement** smoking ban/2, meth/4 (new) & 4 (ongoing),
- **Healthy Housing** – dilapidated property/14, elevated blood lead level & lead based paint/5,
- **Disease Investigation** – Salmonella/10, STEC/1, meningitis prophylaxis/1, rabies/5, tick borne illness/1, WNV dead bird.

**Rabies Investigation**

A rabies exposure investigation that PHS initiated involved collaboration with the DHHS and Sarpy Cass District Health Department. An individual from within the PHS district stopped at the department for information on rabies exposure. She had discovered a bat in her home dead on the steps leading to the 2nd floor. The individual went on to explain that she had been hearing
animal noises in her attic for several months and has even complained to the landlord. She also shared that in early summer she had unexplained bites on her hand, but didn’t think too much about them. In addition to her bites, a couple of weeks before finding the dead bat she explained she had hosted house guests for the weekend and that some guests complained of having bites that they couldn’t identify where they came from. PHS staff discussed the necessary steps to investigate the potential risk. It was necessary to interview all of the house guests, which was a list of 15, 2 out of state and 2 in the PHS district. The remaining 11 lived in Sarpy Cass District Health Department. Staff reached out to Sarpy-Cass District Health Department for their support, created a list of appropriate questions, and worked with the individual to identify names and contact information for the house guests. Staff then started making contact to gather additional information. Based on the interviews only two individuals stated that they had bites, the bites were not necessarily different from other vectors like mosquitoes, chiggers, or spiders. No one interviewed claimed to have heard or saw a bat. Based on the interview data it was not PHS’ or DHHS’s recommendation that rabies vaccination was necessary at this time. We did provide the individual with a letter stating the timeline including the discovery of a bat in the home and left rabies vaccination at the discretion of those individuals and their healthcare provider. PHS also worked with local law enforcement to secure and deliver the bat to a local vet who prepared it for submission, test results were inconclusive due to inability to analyze due to the condition of the sample. Rabies investigations and consultation is a very good example of the force on local public health departments regarding the staffing capacity but also the ability to shift and reprioritize, and collaboration with local and state partners.

b. What activities did you complete for emergency preparedness (e.g., planning, exercises, response activities) in the past year?

Infection Prevention/Control
PHS was notified of an infectious disease probability regarding a patient transported via EMS following a car accident. The hospital contacted PHS to relay information regarding an elevated bacterial count for meningitis. This information required PHS to conduct an investigation regarding the EMS
treatment & transportation activities regarding exposure. In consultation with PHS’s infectious disease practitioner it was determined that individuals involved with suctioning, intubation were most at risk from potential exposure. In the investigation it was determined that two volunteer EMS departments responded and worked jointly, with law enforcement from the Gage County Sheriff’s department. Multiple interviews were conducted to assess risk and specific individuals in need of prophylaxis. PHS sent a letter summarizing the investigation and the recommendations to appropriate healthcare providers, DHHS and other community partners.

Preparedness in School Setting
PHS worked with Crete Public Schools Special Programs – ESL classes and Crete Police Department’s Chief Hensel to host and facilitate an All-Hazard Preparedness presentation to class participants. The presentation was given to 55 English language learners, a number of them recent immigrants to Crete. In addition to the presentation the individuals worked on a preparedness plan template that includes family conversations about the plan and once they complete the plan are given an emergency preparedness kit.

PHS met with Emergency Managers from 3 of the 5 counties in October to discuss a number of efforts. The group is working on the development of an orientation meeting for the Homestead LEPC that will take place in December and will be used as a recruitment effort for membership. Invitees will include industry representatives that are currently not involved, long-term care and assisted living administration, school administration, and elected officials. The Homestead LEPC is focused on emergency preparedness for hazardous material events. From highways, railways, pipelines, and storage locations hazardous chemical events have the potential to impact every community, school, long term care, assisted living facility throughout the 5 county health district. In addition to working on the orientation meeting the group looked at the 15 targeted public health emergency capabilities, the 8 healthcare emergency capabilities and discussed weaknesses and strengths. Three capabilities were chosen to be of particular focus for PHS over the next contract year. Finally the workgroup completed a Hazard Vulnerability Assessment, and based on the scoring discovered that natural and technological emergency events were most likely to have the most impact on the health of the district and the department.

PHS continues to coordinate a workgroup of Homestead LEPC members to develop an orientation workshop for the December quarterly meeting. The agenda included introduction to the Emergency Preparedness and
Community Right to Know Act, SARA Title III & Tier II reporting requirements, Homestead LEPC GIS mapping project, and an assessment of organizations preparedness plans, training, and exercise capacity.

**PHS development of the Medical Reserve Corp.**

At the end of June 2014, the PHS MRC had 40 volunteers, from a variety of healthcare, emergency preparedness, and community backgrounds. During this time PHS facilitated 2 orientation meetings to introduce the operating procedures, including background checks and minimum training requirements to volunteers. The orientations in January were the first opportunity to meet the volunteers face to face, provide the units policies and procedures, assess training needs, and share potential volunteer options. PHS also received word in December that our application to NACCHO for a Capacity Building Award was selected. PHS worked with national and state MRC coordinators to conduct a technical assessment of the previous year.

**Red Cross Partnership**

PHS initiated preparedness efforts with the local Red Cross chapter that provides service to the 5 PHS counties. The local Red Cross chapter has gone through administrative changes and ongoing collaborative efforts are essential. Planning efforts focus on shelters collaboration between Red Cross, who is responsible in all 5 counties for opening community shelters, environmental assessment and control, and health assessments (medical and behavioral). PHS was provided with an updated list from the national database of shelter locations throughout the 5 counties. The list includes name, location, contact information, evacuation capacity, post impact capacity, usable footage, generator availability, total seating, was the property built after 1993 or significantly remodeled since 1992. From the listing we are able to initiate some environmental assessment but will continue to work with Red Cross on capturing additional information. We are also continuing to work on health assessment needs and delivery capabilities, family resource centers and multi-agency resource centers (MARC) if requested through the Emergency Operations Center (EOC). Local public health provides operation support (health and environmental) for shelters and assistance through a MARC-Multiagency Resource Center depending on the needs of the community. This will be an ongoing collaboration.
Wildfires/Environmental Health Concerns
On March 26th, 2014, PHS learned that multiple wildfires were burning in Jefferson and Thayer counties. PHS reached out to both county emergency managers to provide support. Public Health provided risk communication to the general public and vulnerable populations regarding the wildfires and the impact the fires and wind have on air quality. Our risk communication went out via KUTT 99.5 radio, the PHS Facebook page, and the Fairbury Journal Facebook page. Impacted air quality can cause respiratory problems for those in impacted communities, and can worsen the health of those suffering from heart and lung diseases, including asthma. In addition to the community wide risk communication effort, PHS contacted individuals registered with the LINK (formerly SNAP) emergency preparedness program. We informed the registrants of the wildfires and impact to air quality; encouraged those to stay indoors with doors and windows closed for better air quality, and to seek medical care if symptoms were unmanageable.

Emergency Preparedness Planning & Development
PHS worked with Nebraska Public Policy Center and County Emergency Managers on an effort to have regular meetings and eventually include all preparedness partners to improve on planning and the overall emergency system. The Public Policy Center helped develop the first meeting agenda and facilitated the meeting. The goal of the meeting are to review, and assess the cohesion between the county LEOP’s and the PHS ERP, identify & discuss preparedness issues, and develop a plan for continued collaboration that will include additional preparedness partners.

Funding Source: Both LB 692 & LB 1060

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

a. Provide two to three examples of key information related to physical, behavioral, environmental, social, economic, and other issues affecting health that was provided to the public.

PHS initiated multiple media series this past fiscal year.

1) Top Ten Summer Safety concerns:
• Playground safety
• Pool safety
• Picnic food safety
• Parade safety
• And sun exposure

2) Public update on the active disease surveillance work including, Cyclosporium, MERS, H7N9, West Nile Virus, and a new gastroenteritis virus.

3) PHS also addressed increased concerns around Pertussis (Whopping Cough) and the increased activity that has been occurring in neighboring health districts. PHS encouraged individuals to get booster vaccinations with their health care providers or contact PHS.

4) PHS also developed media releases/interviews on environmental health issues regarding radon exposure, distribution of free radon testing kits, and the importance of preventing exposure to West Nile Virus.

Health & Wellness and Academic Success

Research shows that health and wellness directly relates to academic performance. Healthier students are better equipped for learning. As a result, schools across the state have incorporated a healthy balance of the mind and body into their educational curriculum to help close the achievement gap. From proper nutrition to physical fitness, socio-emotional growth of students and the well-being of teachers, school-based health and wellness programs empower our schools for academic achievement and enhance our students' ability to learn.

• Public Health Solutions was a featured partner of Thayer Central Schools as part of NET’s State of Education in Nebraska series, this 30-minute NE♥PS film explores what school programs around the state do to incorporate health and wellness into an academic environment in which students flourish. This film highlighted how a school, in our district, prepare our students to be focused and fit for the classroom and for life.
- **No Child Left On Their Behind at Thayer Central** –

![Image of students](image)

This program focuses on increasing the amount of physical activity in a child’s day and ideally impact rates of childhood obesity over time. PHS partnered with Thayer Central Schools to implement a walking school bus program with the help of community volunteers and school staff. Consolidation of schools is occurring more frequently nowadays in our rural areas. Students are bused a considerable amount of miles to school, reducing the ability for kids to walk/bike to school. The walking school bus is a viable option for these students once they reach the drop off point in Hebron. The program is quite popular according to Kurk Wiedel, Elementary School Principal with over 152 signed up which is 74% of our students.

![Image of no child left behind sign](image)

- Over 295 students recorded trips walking/biking to school as part of the BOLTAGE Program at Crete Elementary during the 2013-14 school year.
BOLTAGE program data was compiled and shared with upper school administration and local community stakeholders.

b. Provide two to three examples of health promotion programs that were implemented to address identified health problems.

**Fall Prevention**

“Tai Chi-Moving for Better Balance” classes were conducted in Public Health Solutions service area of Fillmore, Gage, Jefferson, Saline and Thayer counties. Tai Chi has been proven to improve mobility, strength, and balance, leading to a decreased risk of falling and has been shown to reduce the risk of falling among older adults by 55%. Falls are the leading cause of hospitalizations and emergency department visits due to injury among Nebraskans, and the state’s third leading cause of injury death. The overwhelming majority of these injuries occur among adults over the age of 65. “Tai Chi-Moving for Better Balance” Brochures and flyers were disseminated at local businesses, senior centers, city government offices, and assisted living facilities. Social media was utilized by providing information to the public on Public Health Solutions website (www.phsneb.org). Local newspapers carried press releases with information on fall prevention and contact information to find out about a class in their area.

*Tai Chi class participants doing “Part the Wild Horses Main” at Beatrice Senior Center.*
Healthy Eating/Every Women Matters

The Farmers’ Market Coalition of Southeast Nebraska was established to increase local access to fresh fruits and vegetables while helping local markets throughout our five counties thrive. Approximately 8 markets are active on the Coalition. The Coalition was selected to initiate a coupon redemption pilot program targeting 500+ Every Woman Matters clients in the PHS District during the 2013 season:

Total number of vouchers redeemed: **3,810**

Percentage of Redemption: **42%** (3,810 divided by 9,000 (450 EWM Clients x 20 $2 vouchers = 9,000))

Total amount of voucher deposits: **$7,620**

The Every Women Maters, WISEWOMEN Program was extremely pleased to see that this program had a 42% redemption rate and that overall, there were 36 different types of fruits and vegetables purchased by EWM clients. A successful pilot program.

c. Provide two or three examples of activities you completed to provide targeted, culturally appropriate information to help individuals understand what decisions they can make to be healthy.

Colon Cancer

FOBT kit registration forms were translated to Spanish to alleviate communication barriers and obtain necessary medical information for tracking and allow for follow-up. The kits, along with registration forms, were distributed at 16 locations across all five counties during the months of March and April 2014.

BOLTAGE Program

Health Literacy software was used to produce monthly backpack communication for parents with school age children at Crete Elementary (65 % minority student ratio). The goal was to increase parent awareness and knowledge of the BOLTAGE Program to encourage walking/biking to school, during school and after school.
Skip Flu Program

The consent forms, provided by PHS to the Crete Public Schools, were provided in both Spanish and English (CDC versions). PHS is culturally sensitive to the need of parents to have educational materials, in both Spanish and English, to ensure a broader scope of participation in the program and reduce the incidence of illness.

Funding Source: Both LB 692 & LB 1060

4. Engage the community to identify and solve health problems.

a. Describe the process for developing your community health improvement plan (CHIP) and/or implementing your work plan.

PHS Comprehensive Community Health Plan (CHIP)

PHS continued with the current comprehensive planning initiatives. The process involved the generation, collection and analysis of the most up-to-date data. Data was collected through a number of sources:

- The County CDC Behavioral Risk Surveys conducted for each of the five counties, 2007-2011.
- The 2011 Nebraska Community Themes and Strengths Assessment Survey Results for Public Health Solutions, conducted NDHHS.
- The Community Health Improvement Plan, PHS Qualitative Research Study, 2013.
- Data available through the National Data Clearinghouse was assembled and analyzed.
- Hospital Emergency room and Inpatient data for our district residents, purchased and analyzed, 2010.
- County meetings were held in conjunction with hospitals

Throughout the process community members, groups, and organizations were brought together to identify priorities for our district residents, there were follow-up meetings to define and discuss the actions needed to addressed problems identified.

Priority projects identified consist of, but not limited to:

- Strengthen families/ Support systems
• Access to comprehensive
• Behavioral health prevention and treatment services
• Strong emphasis on continued Prevention/Education/Intervention

b. During implementation of your work plan or other community-driven plans:
   • What were the evidence-based strategies that were implemented?
   • What were the key communication activities that were implemented?
   • Who were some of the key partners that were involved in the implementation of the work plan? What were some of their key contributions?
   • What is the impact on the health of community members?

Health Families America, evidenced based program, planning & implementation. The planning process for the evidence-based home visitation program in Gage and Jefferson County took place over a three month period and engaged over 140 community leaders and service providers. Based on an analysis of existing data, community strengths and needs, and the existing early childhood system including home visitation, the community planning group determined moving forward with implementation of a new evidence-based home visitation program was the best course of action.

The community planning group reviewed the needs and priorities of Gage and Jefferson Counties and compared them to Level 1 priorities and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) approved model program outcomes. This analysis led to the group choosing Healthy Families America (HFA) as the program model. This decision was based on several factors including:

• Aligns with the community’s priority area of child development and school readiness
• Addresses maternal and child health
• Addresses employment and educational attainment
• Impacts child maltreatment
• Addresses family violence
Participants in the community planning process also saw the need for a standing Early Childhood and Home Visitation Advisory Committee that will provide consultation to Public Health Solutions in their implementation of the evidence-based home visitation program and act as a resource and hub for all providers within the Early Childhood System. Key partners in this collaborative effort included staff from the Nebraska Department of Health and Human Services, Beatrice Community Hospital and Health Center, Jefferson Community Health Center, county extension offices, Hope Crisis Center, Educational Service Units 5 and 6, churches, Region V, private medical practitioners, Blue Valley Community Action Head Start and Early Head Start, public libraries, local colleges and universities, county attorneys, child welfare advocacy organizations, schools, law enforcement, county commissioners, Pregnancy Resource Center, and Mother to Mother Ministry.

The commitment of the community to ensuring children and families have the education, support and resources they need to thrive is evident and is the first step to sustainable improvements in the Early Childhood System.

**Implementation:**
As a result of this planning group work, office space for the program was rented in Beatrice at the One Stop Community Center on the Southeast Community College campus in May, 2014. It is an easy walk to another area of the One Stop Center for home visitation families to access a variety of other community resources. Two home visitors were hired by PHSDHD and two by Nebraska Children’s Home Society. The office space was renovated, outfitted with appropriate fixtures, and supplies, and ready to be occupied by home visitation workers and supervisor, Becky Hanson, RN, BSN by the start of the next fiscal year (July, 2014) with extensive training scheduled to occur over a 4 week period in July and August of 2014. Implementation of the Healthy Families America program will begin in earnest, accepting client families into the program in August of 2014.

**Funding Source:** LB 692

5. **Develop public health policies and plans.**
a. What policies have you proposed and implemented that improve population health and/or reduce disparities?

**Bed Bug Infestation Control**

PHS worked on bed bug guidelines, management steps, and letter to community members on the management of bed bug infestations. Bed bug infestations continue to be a problem for individuals and communities, particularly in multi-unit rental properties in Crete. To address this concern a letter addressing the necessary mitigation steps was sent to city officials, and property owners in the Crete area. This information was also be sent to stakeholders throughout our health district. PHS staff works with the landlords, tenants, and city officials to reduce the infestations and control the outbreak of bed bugs.

b. Describe how your department has engaged in agency-specific strategic planning to develop a vision, mission, and guiding principles that reflect the community’s public health needs, and to prioritize services and programs.

**SAFE KIDS, Injury Prevention (birth-14)**

PHS staff identified stakeholders to be trained to carry out the mission and vision of SAFEKIDS. There were 8 individuals that received state specific training and then certified to carry out injury prevention initiatives specific to SAFEKIDS, addressing bicycle and pedestrian safety. Upon completion of training, PHS then held a “Bike Bash” with Grandma’s Daycare, 12 children participated learning safety rules for biking and were given certificates to recognize their completion of training.

**Distracted Driving, Injury Prevention (14-18)**

PHS expanded efforts to reduce the number of unintentional injuries among teens. PHS worked with the schools, parents and teens to educate on the risky behaviors and reduce the number of unintentional injuries in the community. PHS was able to conduct an online needs survey among teens, school personnel and parents. The needs survey provided a window for PHS to provide education and awareness.

PHS focused efforts in three main areas: assessing community need, increasing, increasing community capacity, providing education and
awareness around this expanding topic. The focus counties for the initial project are Gage and Saline.

Facilitated SIDNE training for 4 out of 5 of our counties with 8 community partners in attendance. This training helped toward developing capacity for distracted driving programming within the PHS District.

c. Describe your efforts to develop and implement a quality improvement plan for your department.

**PHS Immunization Clinic Procedures**

PHS sought to improve service from first contact through payment/or last contact in order to assure consistent practices throughout the duration of service. A procedure was drafted and approved regarding each step that should be followed when providing immunizations at the Monday Clinic or with walk-ins. This document did streamline service and continuity of the immunization program.

**Improve SKIP Flu Immunization Rates**

PHS continues to strive for increased participation of the SKIP Flu program in all five counties. PHS works with all the schools, at every level, and has been successful in bringing onboard corporate sponsors to help promote the program to the public. A written report is then provided to the board, community partners and the sponsors that assisted in promotion.

**Funding Source:** Both LB 692 & LB 1060

6. **Enforce public health laws and regulations.**

   a. Describe your efforts to educate members of your community on public health laws, policies, regulations, and ordinances and how to comply with them.
External Policies

PHS is a member of the Saline County Coalition. The coalition members discussed, including law enforcement, the need to implement a rule regarding alcohol on the floats at the Czech Days in Wilber. The new rule was discussed and plans were made to enforce “No alcohol on the parade floats.” This rule came about through the Saline County Prevention Coalition work and collaboration. There was a strong concern that the young people attending Czech Days were getting the wrong message.

- *This year a new rule will be implemented for the parades as no alcoholic beverages will be allowed on parade entries. The City of Wilber and the Nebraska Czechs of Wilber would like the parades to be safe and to set a good example to the community’s youth.*

Internal policies

PHS successfully implemented a staff wellness policy this past year to support and encourage physical activity among its Department employees. Permanent employees of the Department receive up to a stipend if they log 10 or more days of physical activity per month over a course of a year.

b. What laws and regulations have you helped enforce to protect the public’s health?

Community Coalition Prevention Efforts

PHS is active in all five community prevention coalitions and strives to see that those under 21 are not served, texting and driving laws are enforced, and seatbelt laws are enforced.

Child Passenger Safety

PHS strives to ensure every community members understand the need for child passenger safety. PHS was dedicated to the establishment of a permanent fitting station in Crete for monthly car seat checks and seat distribution. To ensure every community member has sound knowledge PHS has an interpreter on hand for Spanish speaking clients.
Clean Indoor Air Act

1) PHS received an Indoor Air Quality enforcement complaint concerning a tobacco shop in Fairbury. PHS investigated and confirmed that the tobacco shop allowed smoking inside the store. PHS visited with the manager who disagreed with the regulation interpretation. An education packet was given. In addition, PHS visited with local law enforcement to clarify confusion regarding the exemption status. Information was shared with DHHS on the inspection.

2) PHS conducted an investigation on a smoking complaint with a business in Fairmont. The complaint was forwarded to PHS from the DHHS. PHS reached out to the manager who confirmed that they were out of compliance with smoking practices in the break area, and had taken steps to correct the deficiency. The community regulation education packet that included no-smoking signs, Q/A pamphlet and the regulation was provided to the business manager.

Meth Lab Clean Up

PHS trained staff was contacted regarding 4 meth labs and 1 existing property.

a) There were four meth labs identified and PHS worked with law enforcement to secure the buildings, conduct samplings and provide adequate information on the decontamination process. One property, in Gage County, was demolished according to a defined plan and approval from the city board. The other three were located in Jefferson County.

b) The one existing property was provided appropriate educational materials and documents, used the proper resources to decontaminate the property and used an approved company to conduct clearance testing.

Funding Source: Both LB 692 & LB 1060

7. Help people receive health services.

   a. Describe the gaps that your department has identified in personal health services.

Healthy Pathways

The mission of the Healthy Pathways consortium is to improve patient health outcomes, increase access to quality health care in the most appropriate setting; and reduce inappropriate use of hospital and health resources through working partnerships among health care providers and patients. Long term, the result will be
improved health status of our five county District, improved quality and accessibility of the health system and services, and improved financial health and viability of consortium hospitals.

Healthy Pathways is conducted through a collaborative, enhanced case management program. This case management for clients with complex medical issues is conducted by public health nurses in collaboration with health care providers, social workers, medical clinic staff, nurses, and other community agencies. The goal of case management includes: a) Increasing client self-care; b) Increased use of preventative services; and c) Increased use of a medical home for primary care.

The Healthy Pathways program focuses on patients who:

- Visit the emergency room for care instead of going to their primary care provider.
- Do not use preventative care and/or seek care at the last minute.
- Are non-compliant and do not follow their plan of care.
- Have uncontrolled chronic health conditions.
- Are experiencing complex situations, such as an acute medical condition, physical disabilities, emotional or psychological challenges, family problems, addictive behaviors, etc.
- Lack a source of payment for their care.
- Fail or routinely show up late for medical appointments, which may result in a health care provider dismissing the patient from their practice and loss of a medical home for the patient.

When a referral is received from a health care provider, the nurse case managers/health care navigators can:

- Coordinate the most appropriate plan of care based on an individual assessment, including medical, behavioral, and/or social needs.
- Provide follow-up phone and home visits and assist in completing any applications for available assistance, such as Medicaid, SSI/SSDI, etc.
- Help complete medication assistance applications.
- Assess barriers to care and assist with scheduling, transportation to appointments, and Spanish interpretation.
- Provide information and referrals to services that can help supplement their plan of care, such as housing resources, food resources, parenting resources, etc.
Healthy Pathways Statistics from July 1st, 2013 to June 30th 2014 include:

- Referrals received from consortium hospitals/clinics: 291
- Referrals made by case management nurses/health navigators to other community agencies or health care providers: 98
- Case management encounters: 1295
- Medication Assistance Applications: 343
- Home Visits:
- Assistance finding transportation to appointments: 38
- Medical Home established for client: 73
- Emergency Room follow up: 200

**Diabetic Education**

PHS began a diabetic education class for clients that were identified for pre-diabetes. During MH screenings it became apparent that many of the clients already have Type 2 Diabetes/Diabetes. A large amount of Minority Health patients screened do not have a medical home. Access to care became a very real concern and access to care remains a huge concern for the educators and clients. Education/directed care can be provided to clients, but there is an extended wait. The length of time to access care (approximately 3 months).

**Other Gaps Identified**

PHS continues to focus on gaps that consist of: inappropriate use of ER, ER as primary care for those uninsured/underinsured, High rate of obesity, Low rates of exercise & vegetable/fruit consumption, Poor dental health and concerns around limited providers, an aging population, and high rates of unintentional injuries (motor vehicle & elder falls)

b. Describe the strategies and services that you have supported and implemented to increase access to health care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.

**Diabetic Education**

MHI works to establish strong partnerships with Clinic with a Heart, the FQHC’s in Lincoln, Columbus and Grand Island, and develop access to needed medications through the PAPRX system.
Oral Health

UNMC’s yearly Dental Day provides an opportunity for uninsured and underinsured children to get free dental work. This year, Public Health Solutions was able to register 54 children from the five counties we serve. PHS is again committed to helping children access this free service by providing transportation for children from the Saline County area. With the help of the Saline County Area Transit (SCAT), 15 children and their five parents (20 total) were able to attend Dental Day.

The following services were provided to the children of our district:

TOTAL Registered: 54
Total Attended 40
Cancelled 2
No Show 12
Need further dental work 8

Increase activity with student population

*BOLTAGE Programs in Beatrice and Crete* - PHS was successful in the implementation of an environmental approach to increase walking/biking to school. PHS installed solar powered ZAP units on school campuses to track the number of kids walking/biking to school, during school and after school.

Funding Source: LB 692

8. Maintain a competent public health workforce.

   a. Describe your efforts to evaluate LHD staff members’ public health competencies. How have you addressed these deficiencies?
Staff development for Emergency Response
During the year PHS focused on staff development for emergency response. Staff reviewed what roles and responsibilities they would be expected to fulfill if they were requested to serve as the public health liaison for county Emergency Operations Coordination (EOC). The review focused on situational awareness/assessing, what questions to ask and answer, and what information would be necessary to report back for public health planning purposes. The department’s goal is to build this capability in staff with the understanding that some natural emergencies can affect all 5 counties in the service area, requiring emergency responses that include emergency support function 8, public health & medical at the same time. If this type of emergency were to occur this would be a significant stress on PHS staffing. In addition to EOC liaison training staff reviewed ICS (Incident Command System) forms. There are federal forms that are required to be used in emergency responses in order to document the work of the locals to secure state and federal reimbursement for local funds used to support the emergency response. In addition staff completed an exercise call down; this call down was a surprise to all staff and was conducted via text message. Twelve staff members were contacted, and told that an emergency occurred and asked how long it would take for them to report to the department. Out of the 12 staff, texts from 9 staff were received within the hour stating they could be at the department within 90 minutes, 1 staff person checked in face to face, we discovered that 1 staff persons cell number was wrong, and PHS did not hear back from 1 staff person who is part time. The call down was effective in using and identifying problems with use of cellular texting as a form of communication. PHS also finalized changes to the emergency response plan – base plan. The plan was distributed to staff and reviewed at a staff meeting

b. Describe the strategies you have used to develop, train, and retain a diverse staff.

PHS is committed to the retention of staff, volunteers and board members. PHS holds an annual staff retreat to address employee communication, leadership development and the opportunity to grow as a LHD organization. A key component to the retreat is understanding our diverse counties, communities and individual staff needs, while meeting our program objectives.

c. Provide at least two examples of training experiences that were provided for staff.
Staff Trainings/Development

1) In December the Homestead Local Emergency Planning Committee held an orientation meeting. The orientation meeting was designed to be a recruitment of new members, educational and an opportunity to assess preparedness levels of community partners in industry, schools, long term and assisted living and elected officials. The orientation was developed and facilitated by Kim P., Mark Meints, John McKee, BJ Fictum and Bill McPherson. The orientation had over 50 people attend, including 5 PHS staff.

Tai Chi Training for Staff Development

PHS contacted Holly Warth, Tai Chi instructor contracted through DHHHS, to train two staff. PHS staff were certified as trainers and were able to conduct Tai Chi program across all five counties. Additionally, they went on to train a total of 8 instructors for the district.

d. Describe the activities that you have completed to establish a workforce development plan.

Organizational Development

PHS conducts annual needs assessment on the staff in order to maintain quality employees, define needs for training and/or continued education.

Funding Source: LB 692

9. Evaluate and improve programs and interventions.

a. Provide at least two examples of your evaluation activities related to evidence-based public health programs.

Injury Prevention/ Tai Chi Education

“Tai Chi-Moving for Better Balance” is an evidence-based program recommended by the Center for Disease Control (CDC) as an effective community-based intervention to prevent falls for older adults. Evaluation at the conclusion of the 12-week program includes TUG (Timed Up & Go) testing. This testing compares the time in seconds a student utilizes to stand from a sitting position, walk and cross a line 10 feet out, and return to sit in the chair. This test is performed prior to the first class
and again after the last class. Post-test results should be lower than pre-test results and evaluate the effectiveness of the program to help with stability and flexibility while building strength.

Road to Health (R2H) Education Classes

PHS contracted with a third-party evaluator to observe two Road to Health classes. The findings of that program are as follows:

4 sessions of R2H were completed – meeting objective

At least 85% of participants demonstrate increased knowledge of diabetes – class participation in discussion supported conclusion that students are learning new information about Diabetes.

Post participation surveys show documentation that 75% have taken part in at least one lifestyle change activity, again class discussion and participation supported conclusions that students are changing food choices.

Sign-in sheets were used to obtain demographic data and verify that 50 minority participants attended the entire series of formal education – met 40% of objective and on track to meet objective; 15 of 20 clients completed all sessions and 5 of 20 attended some but not all classes.

b. Provide two examples of QI projects that have been completed or are in process.

Immunizations PHS

Here is a breakdown of claims submitted. This is the number of shots with the administrative fee submitted for reimbursement, so it does not reflect number of clients served as most clients need more than one immunization. This also includes the flu immunizations, which increases the volume given during the month of October and November.

3,957 – Total Claims Submitted in FY13-14

2,338 – Blue Cross Blue Shield

434 – United Health Care

450 – Midlands Choice
2014 Annual Report of the Nebraska Health Care Funding Act (LB 692)

472 – Insurance, Other

263 – Medicaid/Managed Care

215 – Uninsured (Non-Medicaid) Immunizations Given

* This only includes 8 months of data as this information was not being collected and counted until November 2013

The immunization program has been going through changes with the main change from a VFC clinic to a true immunization clinic. The billing component was added in late 2012 so that all clients regardless of pay source could be served. We continue to try to improve our internal processes to make our clinic as efficient and effective as possible. This year a procedure was written so that all staff who worked with the immunization clinic follows the same process. This has helped serve as a way to check that a client is tracked from the time they call to make an appointment through the collection of claim payment.

Funding Source: Choose an item.

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

a. Provide at least two examples of evidence-based programs your department is implementing.

Colon Cancer Screening Initiative

<table>
<thead>
<tr>
<th>Population Health Practices</th>
<th>Fillmore</th>
<th>Gage</th>
<th>Jefferson</th>
<th>Saline</th>
<th>Thayer</th>
<th>PHS</th>
<th>NE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colon Cancer Deaths rates</td>
<td>54.0/ (26)</td>
<td>62.8/ (101)</td>
<td>48.6/ (31)</td>
<td>72.3/ (60)</td>
<td>51.6/ (27)</td>
<td>57.6/ (245)</td>
<td>53.8/</td>
</tr>
</tbody>
</table>
PHS staff initiated several avenues to distribute FOBT kits within community and though worksite settings. The initiative included: postcard reminders, media strategies, and attending work site wellness events. At the worksite wellness events there was an inflatable colon used for education and awareness. All five counties were addressed with specific emphasis on Gage and Saline Counties due to their rate being above the state average.

<table>
<thead>
<tr>
<th>Initial Test Adherence</th>
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<tbody>
<tr>
<td>Take-Home FOBT (214)</td>
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</tr>
<tr>
<td><strong>Result</strong></td>
<td>#</td>
</tr>
<tr>
<td>Received/Test performed</td>
<td>94</td>
</tr>
<tr>
<td>Pending</td>
<td>120</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Initial Test Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take-Home FOBT (214)</td>
</tr>
<tr>
<td><strong>Result</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Normal/Negative test</td>
</tr>
<tr>
<td>Abnormal/positive</td>
</tr>
</tbody>
</table>

b. Describe how you have collaborated with researchers to conduct any research studies (e.g., completed surveys, interviews, or focus groups).

**Colon Cancer Surveys**

Surveys were performed as part of PHS's contract with DHHS for the Colon Cancer Program. As part of the program, PHS surveyed people ages 50 and older regarding colon cancer and their knowledge and screening practices. PHS conducted these surveys at several different sites throughout the five-county area. Results are then published by DHHS for all health departments in the state.
Doane Focus Groups with Student Volunteers

PHS staff enlisted Doane students in a small group discussion. The group of 10 students, reviewed three department programs, SKIP flu, SNAP, and MRC providing feedback to the materials and commentary on how the program could better target the young adult age demographic. They then discussed the health impacts for their demographic group. The students provided a unique outlook, offered constructive comments, and engaged in their age groups health outcome discussions. PHS was also able to provide some of these students with a number of educational opportunities regarding health impacts and behavior risks for their particular demographic group.

Funding Source: LB 692

11. Please describe the activities that your department completed with the $50,000 appropriation from LB 195. Be specific and describe any key outcomes, achievements, or evaluation findings. Indicate which of the 10 Essential Services these relate to.

Reduce Diabetic Complications and the Cost of Care
The PHS district population is characterized by a high rate of obesity, a low level of exercise, and low rates of engagement in preventive and screening services. These factors contribute to our growing rate of diabetes and the delayed diagnosis and treatment that result in an increased rate of diabetic complications, early disability and death. The bottom line impact is an increase in the cost of health care and a decrease in the quality and productivity of lives. With other funding, we initiated a program two years ago to increase awareness of diabetic risk factors and to delay the onset of diabetes through education and exercise. However, in addressing the needs of pre-diabetics we found we had an even bigger problem with the number of uncontrolled diabetics we found.
Knowing our program and the community lacked the resources and capacity to handle a large number of uncontrolled diabetics, the appropriation from the legislature provided an opportunity for us to address the growing number of uncontrolled diabetics. Our goal was to improve the care of diabetics, thereby reducing diabetic complications and reducing the cost of care.
As we studied the problem we identified the obstacles to disease control. These were a lack of consistent care from a medical provider, inability to pay for clinic visits, inability to purchase medications and testing supplies. The diabetics were
also inclined to underestimate the dangers of uncontrolled diabetes and did not see the need for care as urgent. The legislative appropriation enabled us to hire a Certified Diabetic Educator to complement the work of our Community Health Worker.

Of the 146 clients screened by PHS, 47 were identified as diabetics, 19 as pre-diabetics and 80 as not diabetic. The part time Certified Diabetic Educator (CDE) assessed each diabetic with respect to their behaviors, their sources of care and their use of medications and supplies. Of the 47 identified diabetics, 13% (6) could not be reached, 12% (5) refused enrollment, and 74% (36) had documented improvement. As example, we have seen HgA1cs decrease an average of 3.0 over a period of six months. A leading problem for the diabetics was the lack of an ongoing source of medical care. So assistance was provided to 68% (32) of the enrolled diabetics to establish or re-establish a Medical Home. Most had lost their Medical Home because of outstanding bills and/or not showing up for appointments because of a fear of bills and inability to pay for medication. Without a Medical Home they can drift into episodic care as they run out of medication. Episodic care by its very nature is inconsistent care which contributes to the continuing decline in diabetic control.

**Insured Diabetics**

The major challenges for the diabetics beyond a stable medical home are the inability to afford medications and testing supplies. As often happens for those with chronic illnesses, they acclimate to the discomfort of their illness and minimize the potential danger associated with a lack of treatment. After screening and counseling, the CDE often finds that in addition to no Medical Home they lack testing supplies and money for medication. The CDE has a clear picture of the patient’s situation and works with them first to establish or reestablish a medical home. Clear and complete communication with the Primary Care Provider (PCP) enables the CDE and PCP to problem solve to help the patient achieve control of the diabetes and achieve compliance with the PCP plan of care. This may involve adjusting to lower cost medications, enrolling a client in medication assistance, helping the patient apply for medical assistance or other third party coverage, getting the patient budgeting assistance and/or helping them acquire least cost testing supplies. In this regard we often assist patients in accessing blood glucose meters and test strips at a lower cost. We purchase test strips at 10.00/can and patients pay what they can afford. The balance is covered through donations. $550 in donations were collected and used for this purpose over the past several months. Up to the present time we had been able to provide low cost and/or free meters for testing. We expect this to change soon.

We help patients that are eligible, apply for reduced cost medications provided by manufacturers. We have saved over $100,000 in retail drug costs for people by
helping them get medication assistance over this past year. Each company has different requirements for eligibility but all do require that those helped be legal residents. This is problematic for those who are undocumented and plans are to address this through donations as we can. When we are able to use medication assistance for the uninsured it makes a tremendous difference in the ability of patients to stay compliant and keep their diabetes under control.

The screening, assessment and case management of diabetics in conjunction with a health care provider is an effective and lower cost model for rural health care providers to provide a medical home for uncontrolled lower income patients. When the community based CDE services are provided under one umbrella for area health care providers desiring to operate as a medical home, there is an economy of scale and a higher quality of care provided. As an example, one client was visiting the Emergency Room for diabetic crises every 10 to 14 days. The frequency of these visits significantly decreased after our intervention with him. Given the national average cost for an ER visit for diabetes is about $700.00, there was an estimated savings of $15,000/yr. for this patient alone. This does not include Inpatient admissions which often occur as a result of an ER visit or the prevention of complications. According to articles associated with the assessment of intervention programs, it is estimated that adult diabetics without CDE program intervention go to the ER at a rate of 1 visit per hundred per year. After a CDE program intervention, the rate is reduced by one half. With the 47 diabetics we identified one would estimate that before intervention they would have produced 47 ER visits per year costing an estimated $32,000/yr. With intervention $16,000 in cost would be avoided each year. The estimates of impact of our program are likely too low considering the intensity of illness of those we enrolled. In addition, ours is a small program and the more diabetics in the program the more money could be saved. Also, the estimate for the potential cost avoidance as a result of our intervention did not include the potential cost avoidance from a reduction of inpatient days (interventions reduce inpatient days by 1/3). In addition we did not factor in the avoidance of complications.

Increase Dental Access for Children
Increasing access to dental care and improving the dental health of children has also been a major priority for the District. The allocated to our department enabled us to increase the number of children in the program to include preschoolers not involved in Head Start/Early Head Start and to continue the program for two additional years. We have also been able to develop the capacity to bill which may help with sustainability. Because of the effectiveness of the program, the program has received monetary a $15,000 donation to the program for portable equipment. In addition an application for funding based on this program was funded for $150,000
for each of two years with a commitment of participation by ¾ of our school systems.

STORYTELLING

Highlight at least one significant accomplishment or success story for your department during July 1, 2013 – June 30, 2014. What was the impact of public health on individuals and families in your community? What did you accomplish? (What outcomes or impact did you achieve? Did the success promote efficiency or effectiveness? Does the success link to or support a broader strategic plan, health improvement plan, or specific essential service?)

Melissa a Mother of Six.

Melissa came into Public Health Solutions District Health Department one day as a direct result of her primary care provider referring her to us here at Public Health Solutions. It was learned the provider had become frustrated with Melissa and she was not making the changes he had hoped he could make regarding her diabetes.

He knew Melissa is a Type 1 Diabetic and she is just over 35 years of age with six children. She has health coverage through Medicaid, however sporadically. Her doctor was very concerned about her long-term prognosis if she did not deal with her Type 1 diabetes. He wanted her to get her diabetes under control or she would not live long enough to see them grow up. Needless to say that did scare Melissa, she had stated that she wanted to make changes in her life to better manage her situation but now she was willing to make those changes.

To compound the situation, Melissa is not even able to read or write. When she met with the Community Health Worker they instantly hit it off and a program was laid out. Since child care was provided during the educational classes, Melissa knew her children were being cared for in a safe environment and she was able to fully focus on learning the skills she needed to address her life as a diabetic. Melissa took the Road to Health class series and the Journey for Control classes. She has not missed any Live Fit classes. All in all, she is happier and has a positive attitude when she comes to PHS office for her weekly visits.

Melissa laughs with the staff and is eager to show off her children. She reports that she is a better mom and is very pleased that she has lost 40 pounds. Her doctor is very pleased with her and states that the Community Health Worker has opened up the door for change that he was never able to open after 10 years. The doctor is
very pleased that PHS staff has been able to make strides with his patient and after only a few months. At her last check, Melissa’s A1C results were within normal limits for the first time ever! She is happier, the kids have a healthy mom and the physician is pleased with Melissa’s results too. Truly a wonderful success story for everyone involved.