

▶ 2013 Annual Report of the Nebraska Health Care Funding Act (LB 692)

Health Department: ▶PUBLIC HEALTH SOLUTIONS

All local public health departments receiving funds under the Act are required to report on the activities carried out during the fiscal year July 1, 2012 – June 30, 2013.

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 and Rural Health by **October 1, 2013**. Please e-mail to Pat DeLancey (patti.delancey@nebraska.gov).

2013 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?

Data is made available to our partners and community in several ways. First, we make know that we are a repository of data and share data in meetings such as our CHIP initiative and through the discussion of projects and planning. Second, we issues relevant reports using available data. An example would be the issuance of the Jefferson County Behavioral Risk Factor Survey (special sample of Jefferson County using the BRFSS survey) results in a special report, that was subsequently distributed to interested parties and its availability posted on our Web site. Last, we purchased the **Nebraska Network of Care Public Health Solutions**, which is an online data and information system for use by organizations, agencies, and/or individuals.

Surveillance data is monitored and reported monthly or via special reports depending on needs and circumstances for public information and protection

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

Major problems and trends identified in the past year include a growing number of potential rabies exposures exhibiting a lack of community understanding the need for rabies prevention activities. This includes a lack of public and professional awareness about safe practices around wildlife as well as good public health practices to prevent potential exposures. PHS plans to address this in the spring of the coming year in an organized initiative involving veterinarians, extension and the media.

There are also 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 inadequate exercise, low consumption of fruits and vegetables, high rates of unintentional injuries, low use of preventive services and disparities in access to care continue. There has been a significant increase in the number of uninsured diabetics being referred to the PHS.

- c. If you updated your community health assessment during the past year, describe the process and the major outcomes.

We engaged in a collaborative process with hospitals, and community organizations and agencies. We used the data we have accumulated since our last completed plan. Four priorities were addressed. These include 1. Strengthening families and family supports; 2, improving behavioral health through the development and implementation of prevention and treatment services that are assessable and effective within the District 3. Increasing access to comprehensive coordinated care, particularly that for dental and behavioral health problems and; 4, the need to increase the emphasis on preventive services as opposed to treatment.

Funding Source: Both LB 692 & LB 1060

2. Protect people from health problems and health hazards.

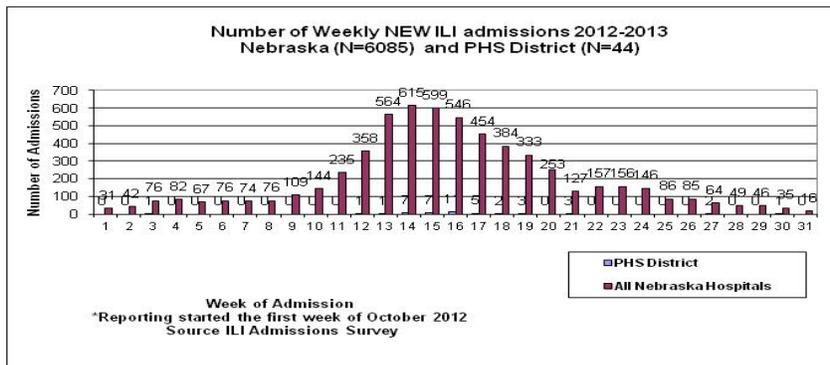
- a. What key activities did you complete in the past year to prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities?

PHS engaged in 3 core activities 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. These included public information, education and response and investigation. The amount of activity and the topics addressed were based upon resident calls, and anticipated threats and cyclical issues. These included public concerns regarding insect infestations and nuisance properties (5 complaints of bed bugs, 16 problem properties, and 3 of head lice). Other complaints more directly health related included 17 for Mold, 3 for asbestos concerns, 1 for smoking, and 12 for potential food borne illnesses. Staff also provided information and assistance regarding municipal and recreational water violations. Other more directed program efforts included West Nile surveillance and education, radon testing and recommendations and lead testing and lead risk reduction.

ILI surveillance and control

PHS conducts surveillance in conjunction with the NDHHS and the Centers for Disease Control. This information is used as part of the PHS community and facility mitigation efforts. ILI illnesses account for nearly half of the illness reports in schools and Head Start Programs.

Illness Reports	School Reports		Head Start	
	Number	Frequency	Number	Frequency
Asthma	21	0.3%	1	0.3%
ILI	3049	45.2%	142	42.6%
Strep	180	2.7%	0	0.0%
Rash w// Fever	13	0.2%	1	0.3%
Gastro	1369	20.3%	17	5.1%
Other	1185	17.5%	58	17.4%
Unknown	936	13.8%	114	34.3%
Total Illnesses	6753	100.0%	333	100.0%



Surveillance of ILI illnesses in hospitals and long term care facilities is also monitored. Outbreak reports are completed for long term care facilities and disease control assistance is provided to them. Over the past 6 years the PHS has conducted community

mitigation efforts to reduce the impact of seasonal flu outbreaks. There are three components of this effort. First is public information and education on measures to take to avoid the flu and/or minimize its spread. This effort takes the form of periodic news releases, radio stories, social media, etc. Education and recommendations were provided to select populations and facilities at greater risk for illness. This involves the provision of recommendations and guidance to long term care facilities, schools and day cares to reduce risk and implement control measures, if necessary.

PHS considers two groups of people are considered major vectors of ILI in communities. These are health care staff and schools children. All health care providers are advised to immunize their staff and the PHS conducted its annual School Kids Immunization Program(SKIP) Flu program for children and faculty of all area schools. Not only are school kids a major vector for the transmission of flu in the community, school age children are the least likely to be immunized against flu in clinics and in doctor’s offices. CDC

recommends in- school immunization programs as an evidence based method for increasing immunization levels of school age children.

A total of 1682 students were immunized. While the primary objective of the program was to immunize children, faculty immunizations were offered for simplicity. A total of 265 staff and faculty were immunized. This is a 14% increase over the prior year. This year PHSDHD had contracts in place to bill Blue Cross Blue Shield, Midlands Choice, Arbor Health, Coventry Cares, and Nebraska Medicaid. A total of \$35,297.68 has been collected at this time. The majority of payments were received through insurance and Medicaid with just a very small portion being private pay. The contributions of four counties (Fillmore, Jefferson, Saline, and Thayer) totaled \$7,300.00 or 15% of the program cost. The payments received from insurance and Medicaid has greatly decreased the funds needed to be contributed from the health fund. PHS staff worked to reduce the stress and expenses this year. This was accomplished by using the Administrative Assistant’s time instead of that for a Public Health Nurse, to schedule the clinics, prepare materials, and provide administrative support for the clinics.

County SKIP Flu Immunization Rates	Number	Rate
TOTAL FOR FILLMORE COUNTY	832	26.7%
TOTAL FOR GAGE COUNTY	3382	11.6%
TOTAL FOR JEFFERSON COUNTY	1602	18.7%
TOTAL FOR SALINE COUNTY	2614	20.4%
TOTAL FOR THAYER COUNTY	796	29.6%
District Total	9226	18.2%

Through this program immunization levels for school children within the PHS area are nearly three times that for school children in comparable districts.

Percentage of PHS kids aged 5-12 who received an influenza vaccine	28.7%
Percentage of kids from comparable district aged 5-12 received an influenza vaccine	10.6%
Percentage of PHS kids aged 13-18 who received an influenza vaccine	16.1%
Percentage of kids aged 13-18 from comparable district who received an influenza vaccine	6.7%

In addition to the SKIP Flu program, Hispanic clients were given flu vaccine during PHS routine immunization clinics. Hispanics are among those least likely to be immunized. Outreach was done to several local businesses to offer flu vaccinations to employees. Head Start clinics were contacted and clinics were held at 7 sites. In early March, a high school student living within the district contracted influenza-like illness and later died of overwhelming sepsis. PHS initiated the investigation and requested NDHHS support for the postmortem assessment. PHS provided guidance to and continuing support for local school officials and parents.

Routine disease surveillance

This is conducted by the PHS staff 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. 133 contacts were made by PHS in the investigation of these reports.

Disease/Illness	Number of Cases investigated
Campylobacteriosis	6
Cryptosporidiosis	2
Hepatitis B (chronic)	2
Hepatitis C (chronic or resolved)	4
Pertussis	2
Varicella Zoster	1
Varicella	1
Influenza	3
Group B Streptococcus	1
Salmonella	2
Shiga toxin-producing E-Coli	1
Hansen’s Disease	1
Tularemia	1
Rabies	3
Animal Exposure	6
Tuberculosis	4

Pertussis:

Information on the need for adult Pertussis boosters was provided to the public. The PHS Board of Health also authorized giving pertussis boosters to low income adults on a sliding fee scale. Shortly thereafter through CDC the State also offered free vaccine for adults in potential contact with babies. Adults with contact with babies were recruited from existing program enrollments. Subsequently legislation was also passed by the unicameral to increase the number of pertussis boosters given. 60 boosters were given in the past year.

Tuberculosis:

With the influx of immigrants, cases of TB are appearing more frequently. 4 cases were brought to the attention of staff this past year. A latent TB case in a recent toddler immigrant was investigated for follow up. Assistance was provided in getting medication for treatment of a latent TB infection. Treatment of the child was provided by his/her personal health care provider. A second case was a new immigrant with Class B1 TB who moved out of PHS district and received care elsewhere. Direct Observation Therapy (DOT) was completed for a third case and an intake was completed for the fourth case.

Lead:

Lead poisoning continues to be a concern in the District because of the high proportion of older housing stock and the lack of redevelopment. The PHS monitors lead level reports and follows up on all levels of 5 and above to ensure that the risk associated with lead exposure is reduced for children. During the calendar year PHS staff followed up on 91 reports of elevated blood lead levels ≥ 5 ppm. Lead levels are reported to the PHS through the NEDDS program as well as through calls from health care providers. Information on the harmful effects of lead and how to prevent lead poisoning was mailed to the parents of 14 children with elevated lead levels living throughout the district. Home visits were done on cases of elevations above 5. Information was provided on the phone when requested. Reminder calls were made to 11 families when a recheck of lead levels was required. As needed the PHS staff initiated environmental and medical case management to reduce exposure. The environmental case management focuses on the child's environment and what can be done to reduce environmental contamination. Given that the department does not have required certifications, consultations are limited to the investigation of lead sources, education of the parents and interim control measures to reduce contamination. Last staff assures that parents or guardians understand the continued blood lead monitoring needs. 68 case management contacts were made through the investigation and response to these reports.

Immunizations:

Given that no care providers immunize insured children within Jefferson County, the PHS stepped in at the request of BVCAP and the Jefferson Community Health Center to provide this service. In a joint initiative, PHS, the Jefferson Community Health Center (JCHC) and Blue Valley Community Action Partnership (BVCAP) provide childhood vaccinations to children in Jefferson County. PHS makes all the appointments for the JCHC clinic—for both insurance and VFC. Records are pulled for the PHS appointments to assure that duplicate shots are not given to a child and that the immunization records are complete. PHS continues to provide VFC and other child hood immunization to those in Saline County. In all 3,356 immunizations were given to 2,290 residents this past year. Of these, 1941 were children under the age of 18. Publicly funded immunizations accounted for 872 and private immunizations, 2484. 29 rabies immunizations were given.

Skin Cancer: Safety in the Sun:

This grant project was to reduce risk for skin cancer by reducing skin burns, through shade structures, education, and use of a skin scope . Through an NC2 grant we targeted swimming pools, children’s outdoor play areas and community event areas for the purchase and installation of permanent shade structures. The PHS contacted 13 local municipal pools regarding sun structures, signage, and management in relation to sun exposure. Through Cool Pool funding assistance was provided to Fairmont Pool to install a major shade structure. In addition, shade structures were provided for communities with farmers’ markets and other community events. To participate communities had to show interest and willingness to install and use the structures. In addition UV wrist band promotions were done through department phone handling and through department fair and event coverage. The UV Wriest Bands were highly popular as a way to monitor when it was time to apply more sunscreen. Last a Skin Scope was purchased and used at events targeting young people to educate them about the detrimental effects of too much sun exposure.

West Nile Virus

In additional to surveillance for the virus through dead bird analysis and mosquito collection the PHS engaged in its prevention initiative designed to reduce public exposure to mosquitoes. Using County and City Clerks as distribution points because of their prominence within each county, educational material plus 500 DEET wipes and 1600 dunks were distributed to the public including those at special risk (construction and road work crews as well as day camps and special children’s events. Media releases were issued as well as radio spots.

Salmonella:

During the spring, a Salmonella outbreak in Nebraska was traced back to the purchase of baby geese purchased at farm supply stores. The source was identified as a single hatchery in Missouri. Partnering with the Nebraska Department of Health and Human Services, PHS contacted farm supply stores in Beatrice, Crete, and Fairbury by phone to:

- Assure that the stores had posted warnings to the public regarding Salmonella infections associated with handling/raising chickens and geese.
- Assure a hand-washing station or alcohol gel was available for persons who handled fowl.
- Assure written information from DHHS related to Salmonella infections was available to purchasers of fowl.
- Answer any questions employees have regarding Salmonella infection and fowl.

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

Increasing preparedness among those least prepared

According to the results of our County BRFS survey the immigrant population is the least prepared for emergencies. PHS worked with the Crete Police Department and Crete Public Schools to conduct emergency preparedness classes for the ESL (English Second Language Learners) to encourage the development of family preparedness plans. Each of the 30

participants who completed a family preparedness plan received an emergency preparedness kit.

Bruning Davenport School and Thayer County Emergency Management Full Scale Exercise– The PHS worked with the Bruning Davenport School to engage in a full scale exercise for tornadoes preparedness and response. PHS staff facilitated the design and implementation of a full scale exercise and the development and review of the school preparedness plans.

Multi-county courthouse bomb threats – on Friday November 2nd PHS discovered that a bomb threat had been made to the Saline County Courthouse. The Wilber School was in lock-down and the courthouse had been evacuated and was being searched. PHS worked with the County Emergency Manager to notify area hospital ER's in Crete and Friend and identify the hospitals surge capacity and level of available care. In working on this response in Saline County it was discovered that multiple Counties had been contacted with similar threats, including Gage, and Jefferson. PHS contacted Gage and Jefferson County Emergency Managers to provide similar assistance, but was not needed.

Jefferson Community Health Center Chemical release – PHS was contacted by Jefferson County Emergency Management to assist with an emergency response that involved the evacuation of the hospital, long-term care and assisted living facilities. In the laundry area there was a chemical release that was unknown, and not contained. The Hospital Incident Command along joined with Fairbury Fire Chief and Jefferson County Emergency Management to form Unified Command in order to maintain command and control of the scene. PHS was requested to provide support to the evacuation site and also notify area hospitals that JCHC was closed to transfers and dealing with this response. PHS staff received the request at approximately 2:17 on a Friday afternoon and was in Fairbury with a trailer of equipment and supplies at 4:03 pm. Equipment and supplies included 90 cots, traffic control equipment, head lamps, lighting, coolers, extension cords, computers, PPE and additional disease mitigation support supplies. PHS remained on scene with Incident Command and at the evacuation site until the hazard was mitigated and the all-clear was given (late Friday evening). PHS also participated in the After Action Review the following week.

Shelter in winter storm

PHS worked with county emergency managers to support shelter needs in response to a winter storm moving across Nebraska. Cots, blankets, pillows, lighting, etc were offered to all 5 county EM's, Fillmore County utilized cots, and pillows in support of a shelter set up in the old hospital for stranded travelers.

Use of SNAP (Specific Needs Awareness Registry)

PHS staff utilized the SNAP (Specific Needs Awareness Registry) twice during the year to make phone calls to registrants to assure their preparedness. Before a predicted severe winter weather forecast, approximately 175 registered individuals with special health needs were called to confirm that the person knew of the impending weather, had made

plans to not travel, and had enough food, medication and other equipment to get them through until next week. County emergency management was notified that we were taking this action. In working through this we were able to discover problems with querying the web based database and initiate corrections. In the spring, once again due to a predicted severe weather pattern PHS utilized the SNAP registry and phoned individuals registered with SNAP to discuss the forecasted weather throughout the week and their preparedness level. 2 PHS administrative support staff made 135 phone calls in just 4 hours, during those calls, the predicted storms, including potential for tornado and flooding was discussed with the registrant. If possible contact information was updated as well.

Medical Reserve Corp

Staff recruited 49 individuals from the southeast volunteer database that had identified interest in the PHS Medical Reserve Corp. Each was phoned to update contact information. A mailing including a personal note, MRC unit application and self addressed stamped envelope was mailed to all 49 individuals. Once applications are returned a background check was completed. In addition to this recruitment activity staff researched the NE DHHS licensing and credentialing website and purchased data lists for individuals licensed for various health occupations through the State of Nebraska. The variety of health licenses included physicians, registered nurses, psychology, respiratory therapist, funeral directors, veterinarians, etc. The list will be beneficial in the recruitment and marketing of the PHS MRC unit as well as the Departments master contacts list. PHS is also working with the NE DHHS ESAR-VHP (Emergency System for Advanced Registry of Volunteer Health Professionals) to exchange information on individuals from the 5 county district registered with ESAR-VHP. With the pending recruitment of individuals, staff initiated efforts with Crete News-Graphic designer in the creation of the PHS MRC pamphlet and retooling of the application to be utilized for outreach efforts. In addition to the recruitment of volunteers PHS is finalizing efforts for conducting background checks on applicants. PHS staff researched efforts through local law enforcement, Nebraska State Patrol, NEMA, DHHS and private industry. The background checks will cost and absorb a portion of the PHS budget, but is an essential operating expense. PHS will continue to flag this as a statewide issue and look for potential resolution to save on already tight budgets.

Homestead LEPC

This is a collaborative emergency preparedness efforts continue with the 4 county LEPC group. PHS continued to facilitate the HMEP project. During July GIS Workshop completed the data sets for the mapping project. Staff spent a great deal of time in the development of the Homestead LEPC Table Top exercise. Staff worked with the facilitator, Pat Borer, Lincoln Fire and Rescue, Chief Brian Daake, Beatrice Fire and Rescue, Industry reps from Agrium and Loveland Byproducts in the development of the scenario, the exercise objectives, situation manual, and exercise questions. The exercise was conducted on September 6th as part of the quarterly meeting with representatives from industry, fire, rescue, law enforcement, medical, emergency management, elected official and public health represented. The exercise is part of a HMEP program, funded specifically through NEMA and unique to the Homestead LEPC. The exercise as with previous work was

focused on the potential organizational structure of a response and that structures ability to assist with the pressures and response needs of an incident management team.

Funding Source: BT ,LB 692 & LB 1060, and grant funds

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.

Safe Routes Initiatives to Increase Walking and Biking to School

PHS led the promotion of Walk to School Days in the fall and spring throughout the District to continue education and encouragement efforts and continue focus on the importance of walking/biking.

In the fall of 2012, PHS facilitated International Walk to School Day at Crete Elementary with 3 school staff volunteers and 12 student Teammate volunteers; Volunteers identified 150 actual student walkers and 5 bikers that morning; 400 students arrived at school early to walk the green space a total of 555 participants ;

Walk to School day events also occurred in Bruning, Davenport, Beatrice, Diller-Odell and Thayer Central reaching over 800 students across the District, totaling 1,350 participants.

PHS again led Walk to School day efforts throughout the District in April of 2013. Encouragement incentives were provided to 6 communities involving 10 schools participating in Spring Walk to School Day; Participation totaled 2,253 students.

Initiated Spring Walk to School Day as part of our ongoing commitment to encourage walking/biking throughout the District; Backpack mail developed for all 5 Beatrice schools, Diller Odell and Wilber, in addition to Crete and Thayer Central and reached 2,253 participants ; Crete Elementary Walk to School Day drew a total of 471 participants – 77 walker/bikers (despite elements!) and 394 walkers in the gym; totaling 2,724 participants throughout the District

Distributed 300 sport bottles, 200 neon bags for Color Run in partners with the No Child Left On Their Behind Program at Thayer Central spring event

Child Safety

Crete Safety Seat Check Up Event held in partnership with the Crete Fire Department and Safe Kids; Over 200 seat check promotional flyers were distributed at the Crete Police Station; Crete Area Medical Center; Head Starts; WIC and BVCA; 1,000 flyers were distributed through backpack mail at Crete and Wilber Elementary schools and two local churches; 4 seat checks were conducted

Spearheaded contact with Saline County schools for information on juniors and seniors for prevention letter in partnership with Gage County MAPS, Saline County Sheriff and our County Attorney; Revised Department letterhead for the Saline County mailing and included 600 thumb bands with the letter.

Environmental radio spots

This past year PHS provided 7 radio interviews through 99.5 KUTT FM. The interviews give PHS the opportunity to reach out the 5 county district and listeners from additional parts of the state on important health topics like West Nile Virus, asthma and environmental triggers, bed bugs, lead poisoning, summer safety, and senior lifestyle topics. This effort also improves on the communities knowledge and understanding of public health and the resource local public health is to community health. January was National Radon Awareness month; staff conducted a radio interview, coordinated radio spots and web banners to increase awareness and availability of free test kits via PHS.

Anonymous walk in services

Services are provided by phone and walk-in to clients who need a brief intervention—whether that be a referral to another agency, information about the department, requests for radon tests, battery recycles, etc. A total of 1150 anonymous services were entered into the database for the year. Information and Referral services include interpreting letters from clients, referring clients to WIC services, assistance in completing a DHHS assistance applications, faxing documents to DHHS, scheduling of transportation to appointments, information about well woman care (breast and cervical exams), etc. The breakdown of anonymous services is as follows:

Service:	# of encounters:
Information & Referral	157
Immunizations	174
Environmental	68 (includes 18 radon kits distributed)
Material Requests	195
Department Information	144
Fax	67
Phone	30
EWM apps distributed through Anonymous Service	86
FOBT kits distributed through anonymous service	235

Healthy Heroes

PHS mailed material to 134 day cares for use in encouraging child hand washing. Staff visited 4 preschools, 4 head start programs, 1 business and 1 ay car to conduct in person presentations about the importance of hand washing to mitigate disease outbreaks. Distribution of the “Healthy Heroes” hand washing activity books for children in English

and Spanish as well as hand washing posters was done through the mailings and through the in person presentations. In all 240 children and 15 adults attended the presentations.

Health Fairs and Presentations

PHS provided screenings and education at the 5 county health fairs, the Czech festival, health fairs and through community presentations. A sun and heat shelter was provided at each county air and at the Czech festival to attract people who would stay awhile, making screening and education easier :

Community presentation attendees	156
Health Fair Attendees	367
County Fairs	Tallies of visits were not done because of the number involved

Birth to Three Program:

The Birth to Three Program is a partnership with Crete Public Schools through which the PHS provides nursing case management services. Crete Public Schools receives Sixpence funding. Sixpence expands the Early Childhood Education Grant Program which currently prioritizes services for at-risk three and four year-olds most at risk of school failure.

PHS has signed letter of agreement with Crete Public Schools to provide nurse case management and consultation when needed. The program averages 15 families at any one time. PHS engaged in 252 contacts in conducting the Birth to 3 Program. We also provide presentations to program participants that includes information about well child exams, RSV, colds, influenza. Influenza vaccine and dental exams are provided to the participants at no charge.

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

Childhood Obesity

No Child Left On Their Behind at Thayer Central was a program implemented during the 2012-13 school year to increase walking/biking to school, during school and after school and enhance the amount of physical activity among K-5th Thayer Central students per day. Thayer Central 6th – 8th grades were targeted separately with the iwalk ibike program to distinguish middle school from elementary while still encouraging physical activity.

Crete Elementary BOLTAGE is an environmental strategy implemented at Crete Elementary school to increase the number of students who walk/bike to school, during school and after school to enhance the amount of physical activity per day among students. A solar powered Zap unit installed on school grounds, records trip data through an RFID (radio frequency identification tag) tag. Students receive an RFID tag when they sign up for the program.

Participants receive encouragement incentives each month based on the number of trips they log. Approximately 229 students had logged trips to date by early spring of 2013.

Tai Chi

Unintentional injuries are a major concern within the PHS district. Elder falls make up a significant portion of these injuries and account for the largest proportion of expenditures. Tai Chi is an evidenced based program that has the greatest impact in reducing elder falls including first falls with the least resource requirements. With a small grant from the state injury prevention program PHS was successful in building upon its past effort in getting 11 new instructors trained as part of its program, Tai Chi Moving for Better Balance Classes. Classes were established in nine facilities within our five-county service area. Participation in Tai Chi improves balance, prevent falls, and increases muscular strength, flexibility and fitness. The Tai Chi program includes 2 classes each week for 12 weeks. Participants in Tai Chi classes are reported to have fewer fall-related injuries and their risk of first-time falls decrease by 55%. The impact of the classes on participants is measured using tests to measure, flexibility, speed and stability. The classes completed in the year were located at the DeWitt Senior Center, Beatrice Senior Center and the Kensington Assisted Living Facility. A total of 47 elders benefitted from the program.

Farmer's Market Coalition

The Farmers' Market Coalition of Southeast Nebraska addressed healthy eating and healthy choices through local farmers' markets. Knowing where your food comes from allows consumers to make informed decisions about their food choices. The PHS received a prevention grant from the state to implement a project identified through the PHS Community Health Improvement Plan. PHS staff formed a coalition of Farmer's Market managers to develop and implement plans to promote the use of farmers' markets by the public. Increasing the consumption of fruits and vegetables, is an important strategy for reducing obesity and health risks. The use of the markets has increased according to the perceptions of managers and two new markets were added and have now joined the coalition. PHS provided funds and leadership for the promotional effort. This included 300 useable seed packet promotions, 22 stand up signs, 40 other signs, 126 posters, four hundred flyers, a billboard for the full season, and 2000 local food guides to encourage citizen use of the markets. By the end of the season, membership in the coalition had grown to nine.

- 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.

EWM and FOBT Applications

According to the PHS CHIP needs assessment, screening rates and use of preventive services are low within the district. As a result the department conducts a number of programs to increase screening rates. Breast cancer and colon cancer have gotten a great deal of attention because of the funding available through the state to try to increase

screening rates. Through EWM and the FOBT applications low income people can get screening free of charge. This has the effect of increasing screening rates. Through the department's main office and outreach, 86 EWM application and 235 FOBT kits were distributed to qualified residents. 140 past FOBT program participants were sent rescreen reminders. Also an FOBT coupons were offered to the public to get kits at 18 locations throughout the district. Other promotional events were held at a variety of events. For example, PHS promoted enrollment in the EWM and FOBT kit programs at the Jefferson County Home & Garden Show on March 23rd. A display board was created and PHS provided special incentives for attendees to complete either a EWM application or FOBT kit application. The incentives provided by PHS were for fresh produce at a local supermarket. It is estimated that over 250 visited the PHS booth/display. Staff also followed up on referrals of people who had not completed screening. Staff completed 212 contacts to increase screening and to ensure that enrolled women scheduled and received a mammogram.

Increasing fruit and vegetable consumption among EWM enrollees.

Public Health Solutions District Health Department, along with the office of Every Woman Matters, Department of Health and Human Services, designed and distributed \$2.00 produce vouchers to 450 Every Woman Matters clients to introduce them to healthy produce and healthy eating at markets within the Farmers' Market Coalition of Southeast Nebraska. These coupons could only be used for the purchase of fresh fruits and vegetables. This not only allowed clients purchasing power, but provided them with a future distribution location to buy fresh and locally.

Funding Source: LB 692 and NDHHS grant funds

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.

The CHIP was initiated with a review of existing plans and data sources. These materials were distributed to community partners including the six critical access hospitals for their use in planning. The department assisted other partners including 4 critical access hospitals in the completion of their community health improvement plans. These plans as well as research results and reports were used to draft a basis for discussion of priorities. Representatives of the community, groups, and organizations were brought together to identify priorities for attention within the district. Subsequent meetings were then held to discuss options and alternatives for addressing these issues. Last, meetings and deliberation occurred to complete the department strategic plan. The plans serve as a basis for annual work plans and projects.

- b. During implementation of your work plan or other community-driven plans:
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- 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?

A variety of evidence based strategies were considered and will be considered as work proceeds on the priorities. We consulted the Community Preventive Services Task Force report as well as other sites for information about evidence based and/or promising practices. Most communication was through meetings and phone calls but we also used other technical devices and services.

The majority of the department's work involves community engagement. In fact this is an area identified in the Beta Accreditation Test Site visit in which the department excelled. The PHS has a strong belief in the importance of community decision making and community development.

Safe Routes

The Zap has been installed at a number of schools across the country with impressive results to date.

Farmers Market

Our farmers' market project was formulated from a August 2006 Ford Foundation Project for Public Spaces and a Public Markets as a Vehicle for Social Integration and Upward Mobility report prepared for the Ford Foundation in September of 2003.

Safe Kids

Transitioning PHS to spearhead the Safe Kids Coalition incorporating all 5 counties. Submitted and received a grant for Wendelin and Kingston to attend the National Safe Kids Conference in Washington, DC

Nebraska Breast Cancer Control Partnership Network

PHS was invited to be part of the Nebraska Breast Cancer Control Partnership Network. They have three Priority Screening Task Force Projects that include:

- Promote regional partnerships of organizations involved in breast health care to identify local mammography rates and barriers to screening (financial, transportation, cultural, etc.) resulting in community-based strategizing and evidence-based action.
 - Promote collaborative relationships to support referrals to financial assistance programs that reduce the cost burden of breast health screening and facilitate networking to share successful program models.
 - Promote the use of a genetic counseling assessment tool to help high risk women access services.
-

Cancer Coalition Health Navigation/Health Hub:

PHSDHD established a Cancer Coalition in 2010. The membership is made up of 34 individuals and agencies across the district. Communication with the Coalition is primarily by email right now due to lack of funding to have routine meetings. However, the Coalition members reviewed the State ad materials for the statewide media campaign plan. The work of the cancer coalition has been expended as project funding has come available. The initial focus of the coalition was on distribution of FOBT kits and the general promotion of breast cancer awareness and the importance of screening. The Health Navigation/Health Hub grant was received by PHS as one of 4 given to select departments on a demonstration basis. The departments including PHS were selected because of their low screening rates for cancer and relatively high death rates from cancer.

The purpose of the Health Hub Contract was to increase breast cancer screening rates and thereby reduce the death rate. 130 new women were to be enrolled into the EWM program, health navigation provided inclusive of community education, linkage to medical homes completed, and abnormal results case managed. 300 FOBT kits were to be distributed to men and women 50-75 years of age; community linkages to primary health care and community resources for preventive screening increased, follow-up and treatment provided, as well as chronic disease self-management. This contract was initiated November 1, 2012. During this time period, the deliverables timeline was completed. In addition, the FOBT screening plan and the FOBT Promotion and Statewide Media Campaign Plans were completed. PHSDHD attended the state coordination meeting.

Staff generated a list of clients in the Med-It system that need colon cancer rescreening. The report listed 144 individuals in our district who have received colon cancer screening within the past 2 years and they were due for their annual screening. Reminder educational packets were mailed to those clients along with a coupon to receive a free FOBT kit. Display boards were utilized at health fairs and events. Staff designed a “Get your FREE Colon Cancer Test Kit” coupon which will be used as a marketing piece to educate the public on where they can get a free FOBT kit. Staff also designed a “No Butts about It...Colonoscopy Saves Lives” coupon that will be used in local newspapers to let the public know what pharmacy or business in their specific area is participating in the distributing free FOBT kits. 42 case management contacts were made as part of the work outlined in this contract.

Relay for Life

Gift baskets were assembled to donate to our district’s Relay for Life events. The baskets were designed using various “pink” items, including Avon breast cancer awareness women’s watches. These were purchased through our local Avon representative. Other items included bike helmets, balls, pedometers, bike locks, ball pumps, water bottles, t-shirts, and back packs. The gift baskets were valued at approx. \$100/each. Each gift basket included a message about the EWM program and the importance of breast cancer screenings. PHSDHD was a corporate sponsor of the Gage County Relay for Life event. In

cooperation with our Board of Health, it was decided that PHS would be a corporate sponsor of one of the county events each year and have a larger presence, but yet donate a gift basket for each county.



An all “blue” gift basket was developed for a local silent auction. The fund raising efforts were being done for a young man who was newly diagnosed with Type IV colon cancer.

Colon Cancer Awareness Month

During colon cancer awareness month, district wide phone calls to all participating pharmacies was completed. The pharmacies helped distribute the FOBT kits.



Funding Source: LB1060, 692 and NDHHS grants

5. Develop public health policies and plans.

- a. What policies have you proposed and implemented that improve population health and/or reduce disparities?

Crete Traffic and Safety Changes

Secured 12 portable pedestrian signs for Crete Elementary to enhance awareness of walkers in/around the vicinity of the school. Successfully installed Zap unit at Crete

Elementary and introduced BOLTAGE Program at an all school assembly to 400 2nd – 4th grade elementary students

Initiated round three of backpack mail in the fall of 2012 at CE to promote the BOLTAGE Program, again in January and March of 2013; Produced 29 stacks of 25 for backpack mail at CE, totaling 3,625 info. fliers distributed; 229 participants to date who have logged trips via the Zap unit.

Beatrice No Child Left on their Behind

Staff has been working with the City of Beatrice and the Beatrice Public Schools regarding changes in and around the Lincoln Elementary School to enhance safety for students walking and biking to school. As a result the City Council signed a city policy in June 2013 to create no parking areas in and around the school to address these issues.

- 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.

Beatrice as a Bike-able Community

The staff worked in partnership with the City of Beatrice and the Gage County MAPPs Coalition to establish the community as a bike able community. Staff wrote a Blue Cross Blue Shield Wellness grant to be used alongside the Safe Routes funding to establish bike depots and LAB certified instructors to educate kinds of effective and safe biking.

Thayer Central Walking School Bus.

Established a formalized walking school bus program in Thayer Central. This will be an ongoing effort.

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

We completed two quality improvement programs. One to increase SKIP Flu immunization levels and the second to establish an improve staff orientation protocol .

Funding Source: LB 692 and small grants

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.

Use of Public Health Law Network

PHS contacted the national Public Health Law Network for an interpretation of the Nebraska Landlord Tenant Act and the International Property Maintenance Code as it pertains to roles and responsibilities of property owners and tenants with regards to bed bug chemical treatments. Bed bug management and lack of good management by landlords is a continuing problem in the Crete area. Property owners are being charged for chemical treatments and appear to be intimidated if they bring a problem to the attention of the landlord or city official. This may be associated with the perceived powerlessness of what might be undocumented tenants. The PHS continues to be drawn into these issues because of tenants requests for health protection. The Department continues to receive complaints regarding housing, bug infestations, mold, and other housing concerns. Reports to the Crete Housing and Building Inspector are not resolved. On average, PHS receives a new complaint monthly regarding landlord/tenant rights and responsibilities yet PHS does not have the available staffing resources to properly address these concerns.

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

Nebraska's Clean Indoor Air Act.

Over the course of the year PHS investigated and consulted on 2 smoking complaints per Nebraska's Clean Indoor Air Act.

Meth Lab Clean Up

PHS also concluded the decontamination and clearance testing of 1 meth lab, continued to monitor 5 identified meth labs with no current action, and PHS worked with DHHS staff to conduct sampling of a meth property for program assessment/justification. Meth lab responses involve documenting the areas of potential contamination, securing the building from entry and working with the building owners to get building properly decontaminated and tested.

Funding Source: LB 692, 1060 and other reimbursement

7. Help people receive health services.

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

The gaps in personal health services include:

Noncompliant patients

Inappropriate use of the ER
Uncompensated care
Use of the ER for primary care for those who are uninsured or not welcome in local clinics
Low rates of screening and preventive services
Lack of the use of a medical home model
Lack of affordable medicines and care supplies
High rates of obesity
Low rates of exercise and vegetable and fruit consumption.
Lack of access to care by Medicaid covered patients
Inadequate number of dental service providers
Poor dental health and limited preventive services
Inadequate behavioral health services
High rates of diabetes
Asthma
Growing older population
High rate of unintentional injuries(motor vehicles and elder falls)
Lack of family supports
Lack of coordination of care

- a. 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.

Healthy Pathways

In addition to preventive service ventures case management is a major initiative to improve the health and wellbeing of area residents. The Healthy Pathways Program is intended to improve health, improve care, and help reduce health care costs through a collaborative enhanced case management program in partnership with the 6 critical access hospitals. The focus is to reduce inappropriate ER use by increasing self care and patient compliance, to increase early detection of illnesses and use of preventive services engage the into treatment, help care providers assume the medical home model of care, improve coordination of care and the use of community services, and identify needs for system change to improve care and reduce costs.

A Telehealth presentation was held on November 30th with over 20 in attendance. The presentation included speakers from Public Health Solutions, E.D. Connections (the program that Healthy Pathways was modeled after), and Lancaster County Medical Society (included information on medication assistance and specialty care). There was a lot of questions and good discussion. Upon completion of the presentation, the hospitals agreed that they were ready for individual visits from Public Health Solutions to discuss implementation at their hospitals, so those visits are now being scheduled. Meetings were held with four Critical Access Hospitals in the District. Contacts for the program have been

identified at all sites. The meeting agenda consisted of reviewing the goals of the grant, distributing the newly developed provider brochure and referral forms, and having discussions about how the hospital can give referrals, communication process for follow-up after the referral is received, and answering any further questions or concerns. The sites were all receptive. Follow-up will be done with the ER's to answer questions and to distribute the client flyer. One county is eager to include mental health services into the referrals, so a pilot project will be developed with them. The draft Operating Manual was shared with the partners at the meeting for review. Planning calls with HRSA staff and assigned TA staff were completed.

In addition, training was completed on the new Patient Assistance Programs Rx software (PAPRx). Over 700 pharmaceutical companies voluntarily donate medications to indigent patients through Patient Assistance Programs (PAP). However, the paperwork and application process can be complicated and each company has a different application process, which makes it difficult for clients to complete the process. The software we purchased (PAPRx) will enable staff to help clients complete the forms required by the pharmaceutical companies when requesting prescription medications for at-need clients. It helps to automate and simplify the process, which in turn helps the client get their prescribed medications. Medicaid Assistance resource manuals are being developed for staff that will include information on other local and national prescription resources.

84 Healthy Pathways cases opened in the time period of July 1, 2012 – June 30, 2013. Individuals are open to services an average of 8.5 months.

The top presenting issues were:

Application assistance	81
Acute medical condition	34
Asthma	3
Behavioral Health	11
Chronic health condition	18
COPD	2
Diabetes	43
Dental care	8
Prescription assistance	28
No medical home	26
Uninsured/Underinsured	79

Services provided included:

1281 case management contacts
380 contacts for application assistance

Funding: LB 692 and HRSA

Every Woman Matters:

A list of women who need to schedule an annual physical exam and/or mammogram is received every month. This is a contract that PHS has with CATCH to provide this service in our district. That contract will end and this will be absorbed into the Health Navigation contract. This program is a great opportunity to encourage women to become self-advocates for their health. All contacts to women are entered into the Penelope database. This year, over 155 women were contacted with a total of 270 contacts. Women are contacted who are overdue for cancer prevention screenings, those who are newly eligible and they haven't used their coupon yet. Some of the feedback received regarding the program include: One participant had just turned 65 so information was provided on the transition from EWM to the Medicare program. She had a lot of questions on her Medicare benefits and was worried that losing her EWM eligibility (which happens when you turn 65 and qualify for Medicare) would affect her ability to get yearly mammograms. She was given information and resources on Medicare and we assisted her in obtaining the information she needed. She was very thankful. One woman contacted has not made an appointment for a mammogram because the last time she had seen her healthcare provider for a mammogram, she was billed 100% of the cost and was told that EWM would not pay her bill. This was incorrect information so she was given correct information, resources, and assistance in helping to resolve the billing issue. After several calls to clarify information, we were able to help resolve the issue and had made an appointment with her healthcare provider. We hear many stories from women who have lost their private health insurances due to job loss themselves or their spouse as well as struggles with private insurance companies and billing offices in clinics/hospitals. We had a display table at several events, including the Jefferson County Home & Garden Show.

We were thanked by a woman who stated that she has no health insurance and the EWM program provides her only access to preventive health care. She recently had abnormal mammogram results and is scheduled for a follow-up mammogram. She was very thankful she was able to schedule a mammogram through the EWM program and is confident that if anything is found in the follow-up, she will be able to receive treatment through the program.

Assisted a woman that was eligible for EWM but didn't understand how to utilize the program to make an appointment. She had concerns regarding a lump that she had found during self examination but was worried and hesitant to make the initial appointment. After discussion and education, she made an appointment for her first mammogram.

PHS purchased a new breast model to be used during BSE/Breast health presentations. The model allows women to feel the difference in normal breast tissue, fibrocystic tissue and what an actual 'lump' may feel like during a self-exam. This model will be used during presentations throughout the counties. This is a picture of the model:



The EWM PowerPoint presentation is being updated to include information on colon cancer preventative screening and Fecal Occult Blood Test (FOBT) use. We continue to solicit partners and meeting spaces throughout the five counties to provide educational sessions on breast cancer screening and the EWM program. The goal is to provide at least one educational session in each county. Sessions in Saline County will be provided in English and Spanish.

Medicaid PHONE Program

This program has been in operation since 2007. Delays in getting an NDHHS contract interfered with project operation. The purpose of the program was to increase preventive care including EPSDTs, assess and address health related and dental, optometric and behavioral health needs, and ensure clients were connected to health homes in partnership with managed care companies. Referrals of Medicaid clients came from a variety of sources including ERs, health care providers, community agencies, and NDHHS. The PHS:

- Completed health assessments and preventive education to 342 new enrollees.
- Followed up on 335 ER referrals
- Follow up on 26 people with no medical, dental, and/or behavioral health home.
- Followed up on 25 people with failed health care appointments.
- There were 20 diabetes assessments and 93 family health assessments.
- Outreach was completed to 64 newly Medicaid eligible children.
- 1307 case management contacts

ER Follow- ups

64 (Healthy Pathways)ER follow-ups were completed. ER follow-up calls were completed to clients by the PHN's. Clients were provided education related to appropriate ER use and necessary referrals were made. Education was completed about appropriate ER use, how to contact their PCP after hours, flu shots and availability, etc. If the client did not have a medical home, assistance was given and appropriate referrals made. Education on oral health and when to go to the dentist was completed with families that had young children.

Funding : HRSA Contract and LB692

Source of Case Referrals by percentage

ER	42%
Clinics	40%
Other agencies and self	19%

Proportion of clients by payment source

Medicaid Medicare	26%
Uninsured	44%
Private insurance	10%
Unknown	20%

Diabetes Education:

We have received many diabetic referrals. 25% of clients enrolled in the Healthy Pathways program have a diagnosis of diabetes. PHN attended the Nebraska AADE Conference, held in Kearney, NE. This conference was very informative and the PHN networked with other professionals that PHS will be able to use as resources and who will be able to provide free or low-cost educational materials in English and Spanish. PHS applied and received money from NDDS Minority Health Initiative Money for the program called My Life, My Health, which will focus on Saline County and will include identifying at risk individuals, education, and promoting better self-management.

We were able to secure inexpensive (\$10/container) diabetic testing strips by working with Wagey Drug in Lincoln. We are able to obtain new glucometers from this same source at no charge. These are supplied to individuals as needed.

Dental Day:

PHS sent 23 children to the UNMC Children’s Dental Day on February 1st. This annual event provides an opportunity for free dental care to children who are uninsured, underinsured or simply have no access to dental services. This year, our commitment to getting children to this event included providing transportation through Saline County Area Transit (SCAT). Scott Bartels and the SCAT drivers were extremely helpful and accommodating to allow as many children and their parents as possible ride a SCAT van to the Dental College in Lincoln. Dr. Kennedy in Crete and Dr. Cossaart in Hebron were fabulous to work with and assisted with dental pre-screening visits.

In total, the following dental/health services were provided at no charge to the children from our district:

Dental/Health Service	Number Completed
Pre-screening Visits provided by local dentists	7
X-Rays	27
Complete dental exams	16
Prophylaxis (dental cleanings)	13
Sealants applied	51
Fluoride Treatments	11
Extractions	20
Restorations (fillings)	13
Chrome crowns	2
Non-surgical root canal	1
Health assessments (includes vital signs, BMI calculation, & health education)	23

Seven children from our district were referred to private dentists for further dental care needed, a few needing quite extensive care. The PHS public health nurses follow up with

these kids and their families to ensure that they follow through on referrals and also assist them with finding a dental home for continued care. The day included educational games and activities as well as lunch for the kids and their families. Over 200 children attend this event each year and busses transport children from all over the state. UNMC senior dental, dental hygienist and radiology students provide dental care and UNMC College of Nursing students provide complete health assessments on each child.



Increase preventive dental services for children

Even though the state grant for preventive dental services lapsed, the PHS continued this initiative without funding because of its importance for children's health. This program uses a Public Health Dental Hygienist to do education, cleaning, apply fluoride varnishes, and make referrals to care for children attending Head Start/Early Head Start and preschools in the District. A total of 370 children participated in this program. There were 460 fluoride varnish applications, and 127 referrals for dental treatment. Of these 18 were severe cases.

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 competencies were measured through a UNMC School of Public Health Survey. This followed the PHAB accreditation standards. These results are used for staff development.

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

Staff is involved in department trainings for the entire staff where experts are brought in to conduct the sessions. In addition, staff is selected based on competencies to attend outside conferences and workshops.

- c. Provide at least two examples of training experiences that were provided for staff.
-

The Emergency and Environmental Health Programs Manager participated in Training via NEMA for Advanced Concepts Planning, this two day course was designed to take participants through more advanced emergency response structure. Utilizing knowledge and training achieved in ICS 300 and 400 the manager learned and practiced emergency response and the “planning P”.

The department sponsored two internal education offerings, one was a series on cultural competence and the second was on team building.

Staff attended several sessions outside the department in accreditation, quality improvement, and planning.

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

The evaluation of capabilities has been redone by UNMC to ensure current staff needs are assessed. This is the prelude to the development of a new plan.

Funding Source: LB1060 and BT

9. Evaluate and improve programs and interventions.

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

Safe Routes to Schools

The No Child Left On Their Behind program distributed and collected pre and post parent surveys and Arrival and Departure tallies for data comparison and analysis by an Outside Evaluator.

The BOLTAGE Program collects data via the Zap unit through the RFID tag. Trip data can be assessed online through www.boltage.org daily, weekly, monthly, quarterly, etc. to determine student participation rates at various times throughout the school year.

The No Child Left On Their Behind at Thayer Central program distributed pre and post parent surveys and initiated classrooms Arrival & Departure tallies. This data was compiled by the National Center for Safe Routes to School. Public Health Solutions (PHS) distributed results to community partners, school administration and parents for input in addressing a barrier to walking/biking to school. A walking school bus program will be implemented during the 2013-14 school year as a result.

The Crete Elementary BOLTAGE program successfully installed a solar powered Zap unit on school grounds. The unit records trip data scanned from an RFID (radio frequency

identification tag). Each day a student walks/bikes to school, they simply pass under the Zap with their RFID tag. The trip data is accessed by community partners on a daily, weekly, monthly, quarterly and yearly basis. Encouragement incentives are awarded to participants based on number of trips they walk/bike each month over the course of the school year.

Farmers Markets

The Farmers' Market Coalition of Southeast Nebraska project produced voucher certificates that were encoded and tracked by the EWM Program. Vendor logs were used at the time of redemption to track fruit and vegetable purchases among EWM clients. A pre-survey tool was developed to determine buying habits, barriers, etc. among EWM clients in purchasing fresh fruits and vegetables. Social media measures implemented this past year are the Coalition website (www.fmcoalitionofseneb.org) Facebook and Twitter posts.

Tai Chi

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. The PHS evaluation includes TUG (Timed Up & Go) testing before and after each the 12-week class. 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. Post-test results are expected to show decreased TUG results which would be associated with increased stability and flexibility while building strength. All participants are also enrolled in a registry so that questions can be asked in subsequent months regarding activity levels, fall incidents, and efforts to continue the program activities.

Healthy Communities Farmers' Market Project

Increased access to fresh fruits and vegetables across the District through 8 local farmers' markets; Increased visits to local farmers' markets by Every Woman Matters clients through distribution of voucher program for fresh fruits and vegetables only; 3,810 vouchers redeemed for a 42% rate of redemption; Produced 2,000 local food guides featuring local markets and distributed throughout the District; Established website for Farmer's Market Coalition of Southeast Nebraska, Facebook and Twitter accounts to feature and promote local farmers' markets; Estimated 750 people viewed social media posts during the 2013 growing season

Healthy Pathways

The purpose of the Healthy Pathways Program is to improve health, improve care, and help reduce health care costs through a collaborative enhanced case management program. This includes: a) Increasing client self care; b) Increase use of preventative services; and c) Increase the use of a medical home for care. An operating manual is used to guide the delivery of this program. Two evidenced based assessment tools—the SF-12 and the PAM-13 are utilized. An outside evaluator will complete the evaluation. Questions considered in the measurement tools include as an example:

1. Upon admission to Healthy Pathways, clients who were asked the question:

“I know what each of my prescribed medications do”

64% agreed or strongly agreed

At progress assessment (approx. 3 months after being open to services)

77% agreed or strongly agreed

2. Upon admission to Healthy Pathways, clients who were asked the question:

“I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself”

57% agreed or strongly agreed

At progress assessment:

69% agreed or strongly agreed

3. Upon admission to Healthy Pathways, clients who were asked the question

“I have been able to maintain lifestyle changes, like eating right or exercising”

43% agreed or strongly agreed

At progress assessment:

46% agreed or strongly agreed

4. Upon admission to Healthy Pathways, clients who were asked the question

“I know how to prevent problems with my health”

71% agreed or strongly agreed

At progress assessment:

85% agreed or strongly agreed

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

QI was used to increase the effectiveness and reach of two projects:

SKIP Flu participation

The first was focused on increasing participation in the SKIP Flu program. The process for promotion and presentation of the program was documented and reasons for not getting immunizations identified from local reports as well as national research. Factors which could influence behavior were identified and proposed changes developed through a brain storming process. These were implemented and results documented. Some changes were incorporated into the program for the long term.

Public Key Informant Survey

The second was a study to determine awareness of the department and satisfaction with identified priorities. A contractor was engaged for a key informant series of interviews. Areas for department action were identified and incorporated into discussion of strategic plans for the coming year. Because of a loss of funds this project is incomplete.

Funding Source: LB 692 and 1060

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.

Minority Health Initiative Grant (Diabetes):

Because of the high rate of untreated diabetes among the Hispanic population within Saline County we submitted a grant proposal to the NDHHS Office of Health Disparities to:

1. Improve the understanding among minority adults in Saline County of the detrimental impact and severity of diabetes and what they as individuals can do to prevent its onset.
2. Increase the number of diagnosed minority adults in the diabetic registry that participate in the program who will be able to actively self-manage their disease.

The proposal was written for a bilingual Community Health Worker to provide the evidence based class, Road to Health class to those at risk. And a nurse will the evidence-based program, Journey for Control to those with diagnosed diabetes.

Tai Chi Project(Elder Fall Prevention) :

Because of the high rate of unintentional injuries associated with elder falls, we are in our third year of increasing community capacity to conduct Tai Chi classes. Tai Chi is the least expensive and most effective program in reducing falls including first falls among elders. Because of the size of the problem within the District and our limited resources, PHS has focused on increasing the number of trained instructors conducting classes on an ongoing basis. This past year has been our most successful yet in increasing instructors. We added an additional nine facilities which now offer the 12 week classes. We also plan to approach insurance companies and assisted living facilities to further increase the availability of classes. Until a these classes are generally available to elders we will not see evidence of reduced falls in population data.

SKIP Flu Program: School age children are least likely to be immunized against the flu at clinics or physician's offices, yet they and health care providers are key vectors in community flu outbreaks. In order to reduce community flu outbreaks and decrease mortality and complications, school based immunization programs have been demonstrated effective in increasing the level of flu immunizations among school children and reducing the intensity of community outbreaks. Since 2007, PHS has conducted the in school flu immunization program resulting in immunization levels three times that in

comparable districts within the state. However, the proportion of those immunized must be increased in order to achieve maximum community protection. Consequently in the coming years promotional efforts will be increased to push up levels of immunity among school children.

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

PHS UNMC Colleges of Nursing and Public Health

The PHS collaborated with the UNMC Colleges of Nursing and Public Health in the development of a proposal to the National Institutes of Health to decrease cardiovascular disease in underserved rural areas. The PHS assisted with the identification of partners, the conduct of focus groups and the collection of needed data and information. While the program is not yet funded, success is expected in the coming year.

Creighton University School of Social Work

The PHS also worked with a faculty member from the Creighton University School of Social Work to provide PHS County level Behavioral Risk Factor Survey System data for use by graduate students needing experience with the analysis of health data. This was the third year that this data was shared for student use.

The PHS regularly participates in all survey requests which advance knowledge about community health and public health services.

Funding Source: LB1060

STORYTELLING

Highlight at least one significant accomplishment or success story for your department during July 1, 2012 – June 30, 2013. 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?)

Public Health Solutions received questions and comments regarding the food vouchers for those enrolled in EWM. This is one: The Public Health Nurse was doing follow-up with a EWM client who not gotten appropriate follow up after her mastectomy. When she spoke with her on the phone she said “Honey, I want to thank you so much for those coupons. It has been a long time since I have been able to have fresh fruits and vegetables. Although I am weak from treatments, I live close

to the Beatrice Farmers' Market so I was able to walk there and use the coupons." ☺
How awesome is that?!

In regards to the No Child Left on Their behind Program, Elementary Principal Kurk Wiedel recently said, "I can't tell you enough how this program and your efforts have helped our school develop in the area of wellness. We are doing all of these great things now as a result of this program and I tell everyone I can about it."

Weekly medication set-up and twice weekly monitoring of medication administration completed with a client who otherwise may have become noncompliant with her physician ordered treatment. By communicating with the client's Primary Care Provider all was in order for medication monitoring. As a result the client was able to take her medications correctly, stay well, and stay out of the hospital.

Referral received from a PCP for an uninsured brittle diabetic client who needed to increase his frequency of blood sugar monitoring. The client was not able to afford the supplies needed to follow his PCP's recommendations. PHN assisted client with obtaining needed supplies and education. Client admitted to using the same lancet for over one year—a practice that is not recommended. Client is now following his PCP's recommendations, which helps the PCP and client better manage his disease.

Referral on newborn from a medical clinic. Mom did not have prenatal care. Infant placed on antibiotics after birth. The PHN made multiple home visits because of the concern about the baby's weight gain, jaundice, sleep positioning, and SIDS risk factors. Case management involved getting her some PHS purchased formula until she could get established with the local WIC office. PHN checked on other children to ensure they were getting preventive care. One of the siblings an 11 month old child only had 1 immunization recorded and 1 well child visit recorded. Arrangements were made to ensure the child received the needed immunizations and that family followed through on keeping MD visits due.

Walk-in client with Type 1 Diabetes requested assistance as client could no longer afford prescribed medications. Client had recently lost employment due to numerous hypoglycemic reactions while at work, and subsequently lost health insurance. Client did not have a PCP. Presented to the office with a foot sore, broken eye glasses, and 3 days of medication remaining. Client had not been testing his blood sugar due to inability to afford test strips. PHS supplied glucometer, test strips, and one month of insulin to client. Referrals for health care made to: Peoples City Mission in Lincoln and Peoples Health Center in Lincoln. Because , the earliest appointment for a new client for Peoples Health Center (our closest FQHC) was two months away, we arranged for client to be seen in the PHS's Health Care Connection clinic. Client decided to move back to Kansas with family, but before doing so, stopped by to express thanks to the PHN stating that she "was the only one who stayed with me and helped me."

Referral received from district PCP for a Type 2 Diabetic. PCP stated that "he does not feel he has been able to make any difference" for client, so was requesting assistance for a PHN

to work with client. Client is uninsured. Client reports to PHN that PCP told her that weight loss needs to occur in order to improve her health conditions and that if she does not lose weight, he will dismiss her as a patient. PHN is working with client to provide education and goal setting in several areas which include but not limited to the following: diabetes self-management education, weight loss, exercise and living a more physically active lifestyle, and nutrition. As of this date, client is making progress and the PCP is pleased.

Referral received for client who was a victim of domestic abuse. Client had no medical home and was having problems with PTSD , asthma, and anxiety attacks. PHS arranged a medical home with a sliding fee scale and was seen 2 times at the new medical home. PHS helped her with necessary prescriptions—a rescue inhaler and anxiety medication until client is able to be approved for medication assistance. PHS also called and got her an appt. with Behavioral Health home and client has been there 2 times so far also. Client is now working fulltime. Will lose housing soon as house is being sold. PHN gave information on several housing programs and contacts. PHN connected her with the SOAR program through BVCA to complete disability paperwork. Will keep client enrolled in Healthy Pathways to confirm attendance with behavioral health and medical appointments and connect to resources.

We assisted a woman that had recently moved back to Nebraska after leaving the state on the promise of a job that did not materialize. She returned to our district to live with family members. She returned to Nebraska with no job, no money and no insurance. After ending up in the ER with severe stomach pain, she was diagnosed with several GI conditions, including an ulcer, recurring nausea & vomiting and diverticulitis. We received a referral from the ER staff after the client told them she had no money or insurance. When I called to speak to her initially, she was very distraught and explained that although she was still vomiting and experiencing stomach pain, she simply could not afford the medications that the doctor had prescribed to help her feel better. The medications were going to cost her well over \$100 for just a one month supply. Although she had just begun a brand new job, she wouldn't get paid for a couple of weeks and had mounting bills and debt collections that she needed to take care of first. She was using a cell phone that was scheduled to be shut off the next day and she had already used most of her cell phone minutes to try and talk to someone about the medications. She was frustrated, sick, and out of options. We checked for any available patient assistance programs and found that her medications were not available on assistance programs. After many phone calls between the pharmacy and her physician's office, we were able to get her medications switched to similar drugs that were available in generic form and on the discount drug list at her pharmacy. It took patience and many phone calls to coordinate but she was extremely grateful when she received the call that her prescriptions were filled and ready to be picked up for only \$8. We will follow-up to make sure that she continues to get the medications she needs to manage her health issues.

Continue to work with a Type 2 Diabetic, who had been off of insulin for over 1 yr. and her Blood Sugars (BS's) were often running between 250-500. Client assisted with completing

MAP application. Assisted client with finding a medical home and working closely with PCP on management of diabetes. Client started on an oral medication until MAP application could be completed. PHN also provided nutrition education. Client has had a dramatic improvement in Blood Sugar results with the oral medication (costing only \$4) and so far has not needed to start insulin again. PCP is very appreciative of Healthy Pathways program and feels that through the lifestyle changes that the client has made with the education she has received along with the oral medication, she is doing well. Since PHN has visited with the client and provided education, client reports that her family members have benefited and all are making an effort to eat healthier.

Financial Report
LB 692 Local Public Health Departments
Per Capita and Infrastructure Funds Only

Health Department: Public Health Solutions

Total Funds Received: \$227,187.05

Total Funds Expended: \$249,758.14

Budget Period: July 1, 2012 - June 30, 2013

Expenditures for Per Capita and Infrastructure:

Line Items	Expenditures
Personnel	\$ 89,182.53
Benefits	\$ 21,877.77
Travel	\$ 18,626.34
Office Expenses/Printing	\$ 46,810.53
Communications/Advertising	\$ 16,340.25
Insurance	\$ 7,226.66
Mini-Grants	\$ -
Public Health Programs	\$ -
Equipment/Construction	\$ 3,066.06
Contractual	\$ 29,354.30
Other*	\$ 17,273.70
Totals	\$ 249,758.14

*Rent / Utilities

*Please explain the major items included and their dollar amount.

**Financial Report
LB 1060 Local Public Health Departments
General Funds Only**

Health Department: Public Health Solutions

Total Funds Received: \$105,458.12

Total Funds Expended: \$122,472.25

Budget Period: July 1, 2012 - June 30, 2013

Expenditures for General Funds:

Line Items	Expenditures
Personnel	\$ 29,474.86
Benefits	\$ 6,444.79
Travel	\$ 571.18
Office Expenses/Printing	\$ 958.77
Communications/Advertising	\$ 3,757.00
Insurance	\$ 114.00
Public Health Program	\$ 76,762.16
Equipment/Construction	\$ -
Contractual	\$ 4,389.49
Other*	\$ -
Totals	\$ 122,472.25

*Please explain the major items included and their dollar amount.