2017 Annual Report

Public Health Solutions

Wake up to your Health!
#homevisitingworks

It’s the Pathogen’s World we’re just living in it.
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Welcome to the Public Health Solutions 2017 Annual Report. On behalf of the Board of Health and staff at Public Health Solutions, I invite you to review this report and learn more about the exciting work that is being done in the communities we serve. Our mission is to prevent disease and injury, promote wellness, and protect the personal, community, and environmental health of all people in Fillmore, Gage, Jefferson, Saline, and Thayer counties. We take this mission very seriously and strive to make a real difference in the lives of the people living in our district.

The past year has brought much change, transition, and growth to our Department. In November, we said goodbye to our previous Health Director of eleven years, Jane Ford Witthoff. Jane’s tireless passion for public health and her commitment to residents of rural Nebraska has been an incredible asset to our organization and to the people of our district. We wish her well in retirement and pledge to continue the good work she has started.

Nothing about us, without us

will be our focus in 2018, as we begin a comprehensive community health needs assessment in each of our five counties. We want to hear from all sectors of the district as we determine what areas PHS should focus our time and resources on to best assist communities in achieving the highest level of health and wellness possible. We invite you to be a part of this important process so please watch our Facebook page and website for more information on how you can participate and make your voice heard. We are here to serve you and we want to hear your suggestions, concerns, and ideas. Together, we can make lasting changes that improve the communities where we live, work, and play.

Please enjoy our annual report. I am tremendously proud of the work being done by the talented group of individuals on our staff. We look forward to the coming year with renewed focus, vision, and commitment to the residents of Fillmore, Gage, Jefferson, Saline, and Thayer counties.

Kim Buser

Kim Buser, RN, BSN
Health Director
Strategic priorities

1. Increase access to care: primary, dental, and mental health
2. Increase the availability and use of preventative health services
3. Improve behavioral health
4. Strengthen families and family support systems

10 Essential Services

1. Data collection and analysis
2. Investigate and control disease and injury
3. Public Information and education
4. Leader in coordinating partnerships
5. Leadership, Policy, Development, and Administration
6. Inspections
7. Targeted Outreach and Linkages
8. Licensure and standards
9. Assessment
10. Research and innovation for the future
FILLMORE COUNTY
Larry Cerny – President
Paul Utemark – served January 2017-May 2017
Stephanie Knight- served December 2017 – present

GAGE COUNTY
John Hill
Linda Ament

JEFFERSON COUNTY
Mark Schoenrock
Jeremy Christiansen - Treasurer

SALINE COUNTY
Janet Henning
Judy Henning

THAYER COUNTY
Dave Bruning - Vice President
Trudy Clark

DISTRICT
Dr. Josue Gutierrez, MD-
District Representative, Physician
Dr. Bruce Kennedy, DDS-
District Representative, Dentist

Board of Health Members

Caitlin Britwum, BS
Administrative Coordinator
Rooted in Relationships Coordinator
January 2017- October 2017

Kelly Erickson
Family Support Specialist
Healthy Families Gage and Jefferson Counties

Kim Buser, RN, BSN
Health Director
November 2017-Present

M. Jane Ford-Witthoff, MBA
Health Director
Retired November 2017

Layla Cabrera
Minority Health Program Coordinator
AmeriCorps Program Coordinator

Megan Garcia
Admin. Coordinator
Rooted in Relationships Program Coordinator

Carmen Chinchilla-Gutierrez, MA
Southeast Nebraska AHEC Program Director
Dental Program Director

Jennifer Hansen, MPH, CHES
Community Health and Development Specialist

PHS Staff
**our mission:** To prevent disease and injury, promote wellness, and protect the personal, community, and environmental health of all people in Fillmore, Gage, Jefferson, Saline and Thayer counties in Southeast Nebraska.
Family & Individual Health Services

96.4% of children receive their medical care from the medical clinic

259 children, ages 3+ received a medical check-up with in the last 12 months

268 children, ages 1yr+ received a dental check-up with in the last 12 months

Information compiled from 2017 Community Health Survey
The “Life of Smiles” program worked this year to continue to serve the people of the Public Health Solutions district. Even without grant funding, we were still able to reach about 1,675 children and adults with preventive dental services, including screenings, fluoride varnish applications, and sealant applications. PHS will continue to focus on young children, ages 0-5, through services at the Head Start and Early Head Start programs in the district. We will also continue to provide preventive services through the Crete office’s on-site clinic.

The biggest challenge that the dental program addresses is the access to dental care. In the US, cavities has the highest rate of incidence among children, even above asthma. In our district, the incidence ranges from about 10%-25% of children, depending on the site. The effects can be expensive, lifelong, and even fatal. In our district, access to a dental health professional can be complicated. Some counties only have one dentist. Some dentists do not see very young children (under 3) in their practice, though the recommendation from the American Dental Association is that children be seen before the age of 1. To add to this issue is the fact that children who do not have dental insurance or reliable access to transportation to get to a dental professional who accepts their insurance, go without regular care.

The “Life of Smiles” program is completed with the collaboration of the Head Start and Early Head Start sites managed by Blue Valley Community Action, and the several schools visited. We also get assistance from the Central Community College dental hygiene program students who help us during their public health rotation.

It is exciting for young kids at Head Starts to learn about the best way to brush their teeth. They are always excited to have us come (as long as we don’t “give them shots”!). It is always rewarding to see kids grow up with healthy smiles when maybe they were first seen in Early Head Start with only 7 teeth, then watch them develop to having all 20.

• We continue to provide services with a focus on young children
• The biggest challenge is continuing the services without grant funding.
• We still managed to provide services to close to 1,675 people and help decrease cavities about 16% in the Head Start/Early Head Start sites.

Carmen Chinchilla-Gutiérrez, Southeast NE AHEC Program Director & Dental Program Coordinator, Deb Schardt, Public Health RDH; Brittany Rogge, Public Health RDH; Martha Merrill, Public Health RDH; Nancy Schlamann, Program Support
The goal of Healthy Families Gage and Jefferson (HFGJ) is to enroll families who are expecting a baby or parenting a newborn less than 3 to 4 months of age. Our families may have current or previous challenges with substance abuse, behavioral health issues, or domestic violence or just feel the need for a little extra support. Many of the families may be facing challenges such as low income, single parenthood, a childhood history of abuse/neglect, or other difficult childhood experiences.

Through decades of rigorous studies, HFGJ has shown that their accredited program sites improve the lives of children and parents:
- More capable, less stressful parenting
- Healthy, secure children
- Resilient, self-sufficient families

Community partnership is critical to success for families and our program. We are grateful for the support and collaboration we receive from local partners, including hospitals, medical providers, behavioral health providers, local public schools, social service programs, community service programs, and churches.

But even with support, success can be difficult. There is a constant challenge with accessing needed services due to financial, transportation, insurance, workforce, or health provider barriers. We work hard and use creative thinking to help families reach and maintain the care they need, whether the need is transportation services, connection with community resources, or coaching them in how to advocate for themselves, among others.

Families also sometimes have concerns whether they can use our services without compromising personal or family privacy. We reassure them that we follow HIPAA guidelines for confidentiality, just as their doctor’s office does.

Lack of confidence that the program has value/benefit for unique family needs. From the first encounter we work hard to develop a trusting relationship with parents and their children. As their trust grows, so does their understanding of the HFA parenting strategies, as well as the worth of Healthy Families Gage and Jefferson for their family.

All parents want the best for their children, but they don’t always know how to do it. Every now and then, parents need a little help learning how to deal with the challenges that come with parenthood. Through weekly hour-long home visits, the family support specialists work with parents to give them the tools and resources they need to create healthy, nurturing environments for their children.
We have seen numerous success stories from our work with children and their parents. Our program has helped promote healthy child development for dozens of families since 2014. With our help, these parents have been given the support needed to gain confidence and be the best parents they can be.

One such story is that of Lynsie*

I was living with my boyfriend in his truck when we got arrested for possession of narcotics. I spent 64 days in jail and then I found out I was pregnant. I was so scared. My boyfriend didn't want to be a dad, so we broke up. My foster mom took me in after I got out of jail on the promise that I'd stay clean. My probation officer told me about a program called Healthy Families America.

My family support specialist started meeting with me every week to help me get ready for my baby. My baby girl was born in February and my family support specialist comes to visit us every week. She helps me learn how to be the best mom to Kylie.

I haven't always made the greatest decisions in my life, but now that I have Kylie, I want to do my best and be my best. It makes me feel awesome when we have the screening visits and I learn that her development is right where it should be. Healthy Families America has lots of fun activities that help Kylie's brain grow and I have so much more confidence in myself as a mother.

I love my daughter so much and look forward to my HFGJ visit every week. Being a single mom isn't easy, but I'll do whatever it takes to make a better life for my daughter. I'm on the right path and I'm even signed up for GED classes to start next month!

*Name has been changed to respect confidentiality.
We know that children with strong social-emotional skills become better able to self-regulate as adults, resulting in a more stable and secure self. Communities were selected to participate in the Rooted in Relationships (RIR) Initiative based on a variety of factors which address the need for increased awareness concerning the realm of early childhood social-emotional wellbeing through community partnerships and early childhood provider education.

RIR partners with communities to implement evidence-based practices that enhance the social-emotional development of children birth to age 8. This includes implementing the Pyramid Model, an evidence-based framework that promotes the social, emotional, and behavioral competence of young children in selected home-based childcare and childcare centers.

We work with a core group of childcare providers throughout a three-year period to implement the Pyramid Model Framework, providing them with trainings and monthly coaching to support these practices.

Healthy, positive relationships during a child's first years play a critical role in their future success in life.

Impacting the Community

- Provided Pyramid Model coaching and training to early childcare providers in Saline and Jefferson Counties.
- Offered Circle of Security-Parenting classes throughout the year in counties within the Public Health Solution's district.
- Offered a Parent Pyramid Module class to parents of young children in Jefferson County.
- Worked with community members and organizations to provide community-wide support of early childhood social-emotional development awareness.
Community System’s Work
Pulling it all together

Community stakeholders are involved in the RIR initiative at the time of conception and work throughout the program to develop long-range plans, or Systems Work, that influence the early childhood systems of care community-wide, and support the healthy social-emotional development of children. These stakeholders are comprised of community members in several sectors including representatives from healthcare, education, law enforcement, economic development, community action agencies, non-profits, and public health collaboration.

As part of the Parent Empowerment Systems Work, a six-week Parent Pyramid Module class was offered to parents in Jefferson County. Additionally, RIR offered multiple Circle of Security-Parenting (COS-P) classes to participants throughout our district. COS-P is an evidence-based, 8-week parenting program designed to help parents build a strong relationship with their children and learn how to better respond to their children’s needs.

“The class was amazing. The trainer did an outstanding job teaching and building relationships with all the parents. I learned new things every week!”

Other partnerships:
Crete Public Schools, Saline Medical Specialties, Sixpence, Crete Police Department, Fairbury Public Schools, BVCA, Jefferson Community Health and Life

Megan Garcia, Rooted in Relationships Program Coordinator; Caitlin Britwum, previous Rooted Coordinator and contract support; Sue Bainter, Early Childhood Coach; Barbara Bedlan, Early Childhood Coach; Janice Lee, Early Childhood Coach; Carrie Gottschalk, Early Childhood Coach; Katie Zabel, Early Childhood Coach; Cara Small, Jefferson County Coordinator; Stephanni Renn, Circle of Security Coordinator; Rachel Degenhardt, Community Awareness Coordinator
Immunizations promote the health of our entire population, prevent disease, and increase the well-being of the public. The benefits of immunizations far outweigh the risks, with the exception of individual characteristics vaccine allergy or conditions that are adverse to a particular vaccine. This affects a very small percentage of the population and screening for those characteristics helps to identify and avoid those risks.

Our Immunizations Department has sought to increase the percentage of individuals of all ages who complete their immunization schedules and complete them on time. Through education, respect, gentle touch, and a little humor we have steadily increased the number of immunizations given over the past four years, as well as seen an increase in the percentage of immunization schedule completion.

Not only do we provide required vaccines, we also offer many other vaccines such as Human Papilloma Virus (HPV) and a fairly recent immunization available to the public, Meningitis B. HPV is prevalent in 75-80% of adults, both men and women, in the United States. Meningitis B causes at least 32% of all Meningitis cases. Both of these vaccines are not required but strongly recommended to immunize for these diseases.
“Vaccine preventable disease has declined by over 99% with the introduction of vaccines*”

*Nebraska Department of Health and Human Services

We provided over 3,000 immunizations in 2017, at no cost to our clients.

The most exciting fact is that the percentage of our population getting immunizations has increased, as has our percentage of individuals completing their immunization schedules at the appropriate time frame.

OUR PARTNERS

We have worked with SCC Beatrice to provide immunizations to their students and staff.

We have partnered with 19 businesses in our 5 county district and taken immunization clinics to their employees to create a healthier, more productive workforce and improve the employee’s health.

We partner with schools to provide immunizations and education. We have partnered with medical clinics to provide immunizations.

Debbie Pohlmann  RN BSN
Public Health RN
Immunization Coordinator

Support Staff: Kim Buser RN, Program Manager; Kate Lange RN, Immunizations RN; Elia Ornelas, Front Desk Receptionist, Appointments and Data Entry; Jennifer Banos, part-time program support; Megan Garcia, program support
The School Kids Immunization Program-Flu (SKIP Flu) began in 2007 for two main reasons. First, there was a desire to avoid deaths by complications of flu among school age children. Second, the CDC advised that children were a primary vector of flu transmission within a community and school children were the least likely to be immunized in traditional settings. PHSDHD created the SKIP Flu program with the goal of promoting community wellness by increasing the number of immunized students; and to increase acceptance of annual flu immunizations.

This year, again, the major concern was the unavailability of any flu mist due to the changes in the CDC recommendations. All schools, except one, elected to continue to participate in the SKIP Flu program, as in years past. We will continue to communicate with school personnel to ensure their comfort level with giving the injection versus the flu mist.

Student packets are delivered to the school at least two weeks prior to the Clinic. These packets include a parent letter, consent form, and VIS Statement. The letter that went out in the packet did explain that it would be shots only this year. We continued the policy again this year to schedule a PHS nurse to be at every clinic to oversee the process and supervise the contract nurses. Sonya worked to schedule staffing at the clinics trying to make it where no staff member was out of the office more than two days during any week.

There was a total of 17 days during the month of October that PHS had SKIP Flu clinics scheduled with several days having more than one school being served on the same day. The Fillmore County Hospital was unable to help this year as they had a previously scheduled training. SCC provided several nursing students at the Beatrice and Tri County SKIP Clinics. PHS hopes to continue to work more closely with SCC in an effort to utilize nursing students for other programs. PHS did change the process for booster process again this year. Prior to last year, we would go back to each school again to offer the boosters. There are very few students who need a booster and many elect not to get the booster. PHS decided to only inform those students that need a booster and provided our information if they needed help getting a booster.

FUNDING
Each of the counties were approached to see if they would continue to support the funding as in past years. PHSDHD has requested funding to help purchase the flu vaccine for their county. Insurance and Medicaid claims are entered for reimbursement of all immunizations. Valeria does all of the billing for the immunization clinics but Sonya did help with the flu immunization claims. This does take a little longer than the billing for our regular immunization clinics. PHS does ask for a copy of the insurance card to be submitted with the consent form. There are usually a few at each school that will be missing this information. We then follow up with phone calls to get this information.

We received $1,000 from the managed care agencies in 2014-15 and 2015-16 but due to the change in agencies we did not receive any additional funding in 2016-17. We were able to get one of the agencies to provide $250.00 for this 2017-18 year. Hopefully we can again get all of the managed care agencies to support the SKIP program in the future.

Sonya Williamson
Support Staff: Elia Ornelas, Megan Garcia, AAS
Debra Wendelin, CHW
Sharon Leners, RN, BSN
Debbie Pohlmann, RN, BSN
Kate Lange, RN, BSN
Education on car safety seat installation is in great need. Lack of income to purchase a correct-fitting seat, language barriers, insufficient transportation resources...all present challenges for parents. When a car safety seat check up event is scheduled in advance, people either forget or choose not to make this a priority.

Many parents prioritize safety in the home as a low concern in relation to meal preparation, bath time, and general household chores after a full day of work...they are too busy. Children need to learn fire and burn safety. So where does this happen? Teachers, counselors, day care providers...locations where their children spend the most time...need to incorporate this education into their daily activities.

Trying to locate businesses to host car safety seat check events has been challenging. Check sites need adequate shelter for outdoor checks in inclement weather and be easily accessible to the public. Safe Kids FGJST Counties Coalition provides free advertising and Safe Kids Worldwide, through our Coalition, provides liability coverage for the duration of the event. Business owners are sometimes hesitant about still being liable for any accidents.

**OUR COMMUNITY PARTNERS**

- Public Health Solutions District
- Health Department
- Jefferson Community Health and Life
- Beatrice Community Hospital and Health Center
- Fillmore County Hospital
- Fairbury Police Department
- Blue Valley Community Action
- Thayer Community Health Services
- Friend Community Healthcare System
- Fillmore County Extension Office
- Healthy Families America
- Crete Fire Department
- Runza Restaurants
- Nebraska Department of Health and Human Services
- Safe Kids Worldwide
- Safe Kids Nebraska
- Bright Futures Childcare
- Barefoot Buddies Daycare
- Twin Rivers Dodge, Jeep, Chrysler
- Merry Manor School of Childhood
- Safe Kids South Central
- Safe Kids Lincoln-Lancaster County
DISTRICT-WIDE COMMUNITY HEALTH SURVEY RESULTS
Including data from Fillmore, Gage, Jefferson, Saline, & Thayer Counties

Survey collected from November 8, 2016 – December 20, 2016

Completed through collaboration between Public Health Solutions, Fillmore County Hospital, Beatrice Community Hospital & Health Center, Jefferson Community Health & Life, Crete Area Medical Center, Friend Community Healthcare System, and Thayer County Health Services

93.2% have health insurance

TOP 3 Behaviors Impacting Health & Well-being

1. DRUGS
2. ALCOHOL
3. POOR DIET

63% of smokers want to quit
64.5% of people have a wellness program at their place of employment

48.4% of responders get at least 30 minutes of exercise 5+ days a week

10.9% of responders never read their food labels

38% of responders spend 1-2 hours a day looking at electronic screens outside of school or work

5 Biggest Driving Distractions
1. Talking on cell phone
2. Texting
3. Reading
4. Hair/Makeup
5. Eating/Drinking

Heart disease still remains the number one cause of death.

483 responders have completed CPR training within the last two years

142 households have a member who has served in the military

48.4% of responders have at least 30 minutes of exercise 5+ days a week
Access to healthcare in our district remains a major issue for the uninsured and underinsured populations. Due to multiple barriers to care, individuals with chronic conditions ultimately end up visiting the emergency room for either preventive care or for acute episodes that could have been avoided with the access and use of primary care. This common practice ends up costing hospitals and communities, and is not very efficient. After multiple meetings, an alliance was formed between Public Health Solutions and several community partners in order to pilot a program that would ultimately involve more community stakeholders with a vested interest in creating a healthier community for all. Thus the “Healthy Community Alliance was formed in February of 2017 in an attempt to address the obvious needs in our community. Our objective is to: provide health care services for uninsured/underinsured community members with chronic illness in an effort to decrease barriers to care, promote the use of primary and preventive care, and maintain a healthier community overall. Using an evidence-based approach, the Healthy Community Alliance (HCA) began to see patients using a volunteer doctor, a registered nurse and two community health workers. The structure of care is simple:

**PRESCREEN**
PHS evaluates possible program candidates through risk assessments, tests, and need.

**CARE & REFERRAL**
At PHS clients receive care from a PCP, testing, prescriptions, regular follow-ups, and referrals as needed.

**CASE MANAGEMENT**
PHS helps patients access resources and maintain compliance with provider.

Carmen Chinchilla-Gutiérrez, Southeast NE AHEC Program Director & Dental Program Coordinator; Kate Lange, RN, BSN; Layla Cabrera, CHW
The Healthy Community Alliance was formed by a partnership between Saline Medical Specialties and Public Health Solutions. The alliance has grown to include: Bessler Family Eye Care of Crete, Crete Physical Therapy, Shopko Pharmacy in Crete, Nebraska Health Imaging, and diabetic educators from Gage and Jefferson counties have made themselves available to help with the project. As the program continues to grow, we also involved People’s Health Center in order to coordinate care at a local level for patients that use both services.

However, there are a few big challenges that the HCA is trying to address:

- Uninsured/underinsured community members and those without reliable transportation to get to the nearest Federally Qualified Health Center (FQHC)
- Lack of funding for this program. The seed funding was initially provided by generous PHS Board of Health members, but more will be required in order to continue serving the people of the community

Despite these challenges, one of the most exciting parts of this program is the partnerships we have built with community stakeholders. Patient health has improved and helped cut costs to community resources, such as emergency rooms. And, as more people are willing to volunteer their services, the community is becoming responsible for each other in a way that benefits us all.

**PATIENT DIAGNOSES**

- Anxiety/Depression
- Hypertension
- Hyperlipidemia
- Diabetes
- GERD
- Obesity
- Hypothyroidism
- Rotator cuff disorder
- Pre-diabetes
- Alcoholism
- Insomnia
- COPD
- Bipolar
- PTSD
- Osteoarthritis
- Metabolic Syndrome
- Other (Gestational Diabetes, Asthma, Sleep Apnea, etc.)

**SHARING THE HEALTH**

- Patients have been receiving regular primary care and lab work as needed.
- Patients have been able to afford their medications.
- Patients have received annual depression screenings.
- Only one patient has ended up in the emergency room and it was due to a dental issue.
- Diabetic vision screenings have been provided at no cost to diabetic patients.
- Patients have been able to access physical therapy sessions at no cost.
- Patients have been held accountable to commit to lifestyle changes that will yield healthier lives and better health results.
Falls are the main reason why older people lose their independence. Stopping Elderly Accidents, Deaths & Injuries (STEADI): The Centers for Disease and Prevention (CDC) work to make fall prevention a routine part of clinical care. STEADI uses established clinical guidelines and effective strategies to help primary care providers address their older patients’ fall risk and identify modifiable risk factors.

- Each week, there are over 233 emergency department visits among residents ages 65 and older, over 70 hospitalizations and 4 deaths due to fall injuries in Nebraska.
- Residents ages 65 and older account for 85% of all fall deaths and 75% of nonfatal fall hospitalizations in Nebraska.
- Falls are a leading cause of traumatic brain injury (TBI) in Nebraska residents ages 65 and older, accounting for 60% of TBI deaths and 83% of TBI hospitalizations. 78% of fall deaths and hospitalizations among older adults were associated with a TBI.
- Projected lifetime costs associated with fall injuries in 2014 among Nebraska residents ages 65 and older are estimated to be $335 million.

Tai Chi: Moving for Better Balance
12 week Tai Chi program

- Improve balance
- Increase leg strength
- Reduce fear of falling
- Improve mobility
- Improve flexibility
- Improve psychological

STEPPING ON: Building confidence, reducing falls
7 week Stepping On Program

- Simple and fun balance and strength training
- The role vision plays in keeping your balance
- How medications can contribute to falls
- Ways to keep from falling when out in your community
- What to look for in safe footwear
- How to eliminate falls hazards from your home

Our Community Partners:
Blue River Area Agency on Aging, Cortland Community Center, Aging Partners, Saline County Aging Series, Fillmore County Aging Services, Fairmont Senior Center, Geneva Senior Center, Jefferson Community Health & Life, Fillmore County Hospital.
The purpose of the Community Health Hub is to decrease morbidity and mortality through early detection and referral to treatment. The health hub model uses evidence-based strategies to promote clinical preventive services and make appropriate linkages to medical homes for the provision of screenings, follow up and treatment services.

The evidence-based interventions were selected with the purpose of increasing screening rates for breast cancer, cervical cancer, colon cancer, and diabetes within our district. Public Health Solution’s goal is to increase community linkages to primary health care and community resources for preventive screening, follow up and treatment, as well as chronic disease self-management.

Public Health Solutions chose evidenced based strategies to promote cancer screenings:

- **Breast cancer**: target population is women age 40-74. Women are recommended to have Mammogram testing done to screen for breast cancer.
- **Cervical Cancer**: target population is women age 40-74. Women are recommended to have a Pap (Papanicolaou) testing to screen for cervical cancer.
- **Colon cancer**: target population is men and women who are age 50-75 years of age. To increase screening rates, PHS disperses an at home screening test called FOBT (fecal occult blood test), which is an indicator of colon cancer.
- **Blood Pressure Screening**: target population is men and women who are age 18 or older. Those with high blood pressure readings are able to have health coaching and will be connected to interventions and health care providers.

Public Health Solutions was able to conduct comprehensive screenings and education at local organizations to target employees and community groups. Linkages to community resources are given to increase preventive measures.

Health Coaching & Navigation is also an important goal of Public Health Solutions. Health coaching is a process that facilitates healthy, sustainable behavior changes by challenging individuals to reveal his/her highest wellness potential. In all health coaching sessions, individuals made at least 1 goal towards living a healthier lifestyle.

Media campaigns for HPV (human papillomavirus infection) immunization and FOBT kits through traditional and social media were conducted to increase awareness.
The Minority Health Initiative was created to reduce health disparities among the minority population, the Community Health Worker (CHW) has worked with clients to overcome difficult hurdles. Some of these hurdles include language barriers, low income, health literacy, and access to healthcare.

Public Health Solutions is taking action to reduce health disparities among racial and ethnic minorities by providing health screenings for 200 new clients. Throughout the grant period, the CHW develops and implements chronic disease self-management plans and uses the evidence-based Diabetes Prevention Program to encourage pre-diabetic clients to make healthy lifestyle changes.

Developing a referral and resource network has been a crucial part of the Minority Health Initiative. Saline Medical Specialties (SMS) and Crete Area Medical Center (CAMC) providers have referred pre-diabetic and diabetic clients to Public Health Solutions. This network has helped PHS reach more clients with prediabetes, as well as diabetic clients who need case management and assistance in overcoming difficult barriers. We also rely on community partnerships with businesses in Saline County. The CHW has the opportunity to provide health screenings through partnerships with the WIC Clinic, Smithfield Foods, and Sixpence.

Diabetes self-management success story: 
At the beginning of 2017, Robert* was diagnosed with diabetes and was then referred to the community health worker at Public Health Solutions by Saline Medical Specialties. Robert came in weighing 268.5 pounds with a fasting glucose of 146. He had a body mass index of 43, which is considered extreme obesity. Robert met weekly with the community health worker to check blood glucose levels and chart vital signs. Throughout 2017, Robert worked to improve overall health by making lifestyle changes to his diet. At the end of 2017, Robert weighed 226.5 pounds, dropping his body mass index to 36. His fasting blood glucose was 98, a normal blood glucose.

Pre-diabetes success story: 
Towards the end of 2017, Joseph* came in to Public Health Solutions as a prediabetic with an A1C of 6.3. He was referred by Crete Area Medical Center. Joseph weighed 166.5 lbs. with a fasting blood glucose of 138 and had a BMI of 29. Joseph met weekly with the CHW and began tracking blood glucose levels and writing daily in the food log provided to him by the CHW. After a month and a half of these healthy lifestyle changes, Joseph lost 15.5 lbs., dropping his BMI to 26. Joseph’s fasting glucose is now 103. Joseph continues making lifestyle changes to his exercise and diet to eliminate the risk of becoming diabetic.

Layla Cabrera, Minority Health Program Coordinator; Kate Lange, Case Management Nurse
Through Public Health Solutions (PHS) provision of training and support for local facilitators, the Smart Moves National Diabetes Prevention Program (NDPP) has helped over 145 people achieve weight loss goals during 2017. The Smart Moves program teaches participants how to improve their diet, fit physical activity into their daily lives, and manage stress. The program is an evidence-based program shown to lower the risk of type 2 diabetes in participants with prediabetes.

PHS is working with providers to implement best practice physician referral systems to increase program participation and sustainability.

Objectives for this program include:
- Increasing number of trained facilitators and program availability
- Increasing number of participants
- Increasing retention of participants who enroll in the program
- Ensuring fidelity to CDC-approved curriculum

Some of the positive outcomes we have witnessed, as a result are:
- 145 people enrolled in all district Smart Moves programs during 2017
- 15 trained facilitators available to implement Smart Moves classes
- Participants experienced weight loss and reversal of prediabetes
- Smart Moves implemented in worksites as a full or partially covered health benefit
Many community members purchase snacks from vending machines, cafeterias, and convenience stores, but there are very few healthy options to choose from. When healthier options are available, people are reluctant to spend their money on items they have never tried, fearing they will have wasted money if they do not like the taste.

During 2017, Public Health Solutions (PHS) worked with network partners to engage vending machine companies and convenience stores to increase the amount and variety of healthy food options for local residents. Collaborative team efforts with our community partners, vendor representatives, and store and food pantry workers, helped us to identify solutions for increasing access to healthier foods in the communities they serve through:

**Vending Machines:** Increase access to healthier foods by increasing Nutrition Environment Measures Survey for Vending (NEMS-V) award level and including at least one “green” item

**Cafeterias:** Increase access to healthier foods by making improvements to cafeteria environments to increase amount and variety of healthy options and encourage consumers to select healthier options through improved placement, pricing, and promotion

**Convenience Stores:** Increase access to healthier foods by improving stores’ Nutrition Environment Measures Survey for Stores (NEMS-S) healthy food access score on a scale of 0 to 5.

PHS staff worked to ensure vending companies would not lose profits from the changes made to increase healthy options available in vending machines. To support the efforts made by all partnering organizations to increase healthy food access in the district, PHS hosted healthy food taste test events at convenience stores and near vending machines offering healthier items. Community members sampled healthier items and voted for those they would buy.
The most exciting, and perhaps most impactful, outcome of the Choose Healthy Here program came from the SpeeDee Mart convenience store in Friend, Ne. PHS worked with Gage County Extension dietician and staff of the SpeeDee Mart to increase fresh fruit and vegetable access for the 992 Friend residents. We love hearing SpeeDee Mart manager, Beth, is personally thanked by community members who appreciate purchasing fresh produce at the convenience store rather than driving long distances for one or two items in a pinch. PHS worked with SpeeDee Mart to increase their NEMS-S healthy food access score in the vegetable category, and provided the Friend Redevelopment Group with customer survey data showing local resident support of reopening a full-service grocery store and shed light on resident and community impact from the closing of the only grocery store in Friend.
Many Americans are sedentary at work and home, and do not meet the guidelines for physical activity to prevent chronic disease and early death. Through the physical activity strategies in the 1422 grant, Public Health Solutions assists local coalitions, worksites, and community venues with increasing safe and inviting places to be physically active and to increase promotion of physical activity to encourage residents and staff to “Step and Repeat.” Because of these efforts, new trails with signage and amenities were placed, walking programs and groups were started, and education was provided to get our district up and moving in 2017 and to improve overall health.

Chronic diseases like heart disease, cancer, and diabetes are responsible for 2 out of 3 adult deaths each year in the U.S. Physical activity has been shown to prevent chronic diseases and improve health, but 3 out of 10 adults are inactive and fewer than 1 in 4 Americans currently meet the recommended levels of physical activity to improve health.

The Thayer County Walking Coalition and JeffCo on the Move! Community groups were formed and branded through the 1422 walkability efforts. Community coalitions were developed consisting of a variety of partners, including city and county government officials, school administrators, hospital staff, community college administration, local businesses, law enforcement, local nonprofit organizations, chambers of commerce, public spirited individuals, students, and other volunteers. Coalition work to increase walkability and promotion for physical activity could not have been accomplished without collaboration from PHS community partners. Representatives from each of the mentioned organizations came together to provide a passionate, balanced, and cohesive voice for the communities they serve. Their work stood as the foundation for improving their communities’ trails and sidewalks, implementing and revitalizing city sidewalk grants available to homeowners for improving residential sidewalks, conducting walk audits to identify priority routes for safe and active transportation and additional trails, sidewalks, and wayfinding signage, frequently meeting to form a sustainable model for implementing new projects, and creating community-specific brands for carrying walkability work forward into the future. Coalition objectives include:

- Increasing the number of communities that develop and/or implement a transportation plan that includes walking.
- Increasing the number and type of community venues that promote physical activity through signage, worksite policies and shared/joint use agreements.
- Increasing the number of people who have access to community venues that promote physical activity through signage, worksite policies and shared/joint use agreements.
- Increasing the number of people who have access to communities that develop and/or implement a transportation plan that includes walking.

It can be difficult to maintain community interest and participation in coalitions. The strength of the physical activity strategies stems from the Walkable Communities process, which culminates in the community-drive summit and resulting action plan. The dialogue that takes place during the process along with local health department’s guidance through action steps ensures stakeholders’ personal investment will to bring them back to the table until the change they wish to see is carried out in their communities.
LASTING CHANGES

- 2 communities received ongoing technical assistance and support for implementing Walkable Communities action plans
  Outcomes: new sections of trails added, wayfinding projects implemented, new wayfinding projects developed (but not yet implemented—stay tuned!), matching sidewalk grants made available to residents, priority routes for physical activity identified, diverse community partnerships formed to foster sustainability for future projects
- 1 additional grant pursued by PHS staff and awarded to a district community for $7500 to purchase and place benches, trash cans, trees, and wayfinding signage on new trails to increase access for residents and tourists
- 1 new community on-boarded to Walkable Communities process to increase walkability/physical activity access
- 6 worksites implemented signage encouraging employees to be more physically active
- 1 community college implemented signage encouraging students and staff to take on campus walking breaks
- 1 social support program implemented to encourage individuals with chronic diseases to walk while provided education for making health behavior changes to better manage disease
- 1 educational campaign implemented for benefits of walking and safe walking habits
- 1 wayfinding project implemented to increase trail use

HEBRON GETS NEW TRAILS!

Jen Hansen, MPH, CHES
Community Health & Development Specialist
Support Staff: Deb Wendelin, CHW
Community Development Assistant
As we age so does the risk for heart disease and diabetes. With healthcare guidelines changing, it can be difficult for people to get the care they need. In addition, some individuals may not have access to blood pressure or diabetes screening.

The partnerships that have been created through the chronic disease grant have allowed the opportunity to increase awareness of evidenced-based clinical guidelines, incorporating pharmacist as health care extenders, and the importance of combining community transformation such as walking trails, signage, and access to healthier foods to create a healthier environment and improve population health outcomes. Many of the partners that have worked to implement chronic disease guidelines and workflows into the medical clinics have also taken the opportunity to work in community transformation with PHS.

Our objectives are to:

• Identify elevated blood pressure and create a workflow or policy around hypertension management including self-care efficacy.

• Encourage pharmacies to be health care extenders. Offering free blood pressure clinics, walk in checks, off site screenings, or offering a kiosk at their location. CHW and pharmacist are trained on accurate blood pressure monitoring, referring to SMBP (self-measure blood pressure monitoring) and also screening and referring to the Smart Moves program (National Diabetes Prevention Program)

• Create physician awareness of prediabetes and best practice of physician referral to the Smart Moves lifestyle change program

Making a Change of Heart

• Three pharmacies have trained staff in accurate blood pressure monitoring, including following evidence based blood pressure polices. Pharmacies have a fax form to report elevated blood pressure and SMBP results to the customer’s primary care physician.

• Working with several clinics on implementation on evidence based best practice guidelines to improve health outcomes. This includes looking at identification of elevated blood pressure and prediabetes including a workflow or policy to treat/refer and follow up with hypertension/prediabetes management.

• One clinic has implemented and Electronic health record referral to the diabetes prevention program and another clinic is currently working with their electronic health program to implement an electronic referral process.
Each year in the U.S., over 360,000 people suffer out-of-hospital sudden cardiac arrest (SCA), and sadly only about 10% survive. When bystanders quickly recognize SCA, call 911, and start CPR, survival rates can be doubled or even tripled. Despite the loss of funding, PHS continues to teach these lifesaving skills to people throughout the district.

PHS wanted to increase out-of-hospital SCA survival rates within the district by training non-medical professionals to correctly respond to out-of-hospital sudden cardiac arrest. All target measures were met and included:

- Providing information and resources related to AED purchase and maintenance when requested.
- Providing CPR/AED demonstrations and classes to people in all 5 counties.
- Providing free use of department equipment including AHA training materials, CPR manikins, AED trainers, and training masks, to other instructors in the district when requested.

Number of AHA HeartSaver classes taught = 10
Number of AHA Basic Life Support classes taught = 2
Number of people who chose an AHA online course and completed skills testing with PHS = 8
Total number of people trained in CPR/AED by PHS = 108

Teaching to Save

Saving Rural Hearts program was able to provide CPR/AED classes/demonstrations for people living or working in all five counties. These included:

- Workers at large companies assigned to emergency response teams
- Adult students learning English
- PHS staff
- Volunteer firemen and EMTs
- Long-term care facility staff
- Teachers and para-professionals grades pre-k through 12 working in both public and private schools.
- Teachers and para-professionals working with special needs students or English Language learners
- Coaches
- Child Care Providers
- New parents, including foster and adoptive parents
The VetSET program is committed to supporting Service members, Veterans and Families. Public Health Solutions (PHS) has a veteran advocate to work with the veterans in the five counties PHS serves. The advocate coordinated meeting with every county veteran service officer to support program initiatives: serve, educate, transition.

Regardless of where or how they serve, Veterans return to their families with diverse and unique needs that must be addressed for them to maintain good physical and mental health.

As our veterans return home, Public Health Solutions is working in the community to:

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

Through the VetSET program, we have impacted several veterans and their family members. Of the 143,000 Veterans living within the Nebraska communities, over 4,300 of them reside within Public Health Solution’s district. We have connected with 176 Veterans & Family members, so there is still a lot of work to be done with Veteran & Families as well as education to public. Out of those 176, approximately 100 of them asked for assistance in finding resources and/or help getting appointments to those resources. Over 80 referrals were given to providers and organizations in their own communities. As a result of networking in the communities, there have been over 200 partnerships formed with rural businesses, organizations and service providers. Through surveys, VetSET program at PHS was able to identify common concerns, including health and mental health education, financial education and marriage and/or family counseling.

VetSET was also able to help military members navigate questions and concerns about the VA and the CHOICE program. The Veteran’s Choice program provides eligible Veterans the option to receive non-VA health care from approved providers in their communities. VetSET coordinated CHOICE Briefs in rural hospitals so the staff and administration understand the benefits of being a CHOICE provider. Town hall meetings were also conducted so the veterans are able to understand their eligibility for the CHOICE program.

Anytime we can help a Veteran connect with a resource to ensure a better quality of life is a success. I am also proud that, because of the work through VetSET, Military Cultural Competence has been increased in the counties that we serve.

One of the mothers of a veteran that was suffering from PTSD called to thank me for helping get her son back. No one stayed with him long enough to help him see everything thru.
Allowing possession or consumption of an alcoholic beverage or controlled substance by an underage person is a misdemeanor; $1,000 fine and 30 days in jail.

Do you know about the Social Host Law?

Training for Intervention Procedures (TiPS) is recommended for hotels, bars, restaurants, bars, nightclubs and community festivals.

60% of our children have been bullied in the past 12 months. Be aware of the types of bullying; Physically, Verbally, Socially, Electronically

STAND UP & SPEAK OUT

PREVENT sales to minors
DIFFERENTIATE between social drinkers & alcohol abusers
RECOGNIZE signs of intoxication
HELP STOP drunk driving
Population Protection

- 643 homes have a smoke detector
- 76.9% of homes have not been checked for radon in the last two years
- 428 homes have a fire extinguisher
- 60.4% of homes have an emergency plan
- 40.8% of people keep their firearms locked up
- 28 homes have called 911 at least once in the last 12 months

DISTRICT-WIDE COMMUNITY HEALTH SURVEY RESULTS
Including data from Fillmore, Gage, Jefferson, Saline, & Thayer Counties

Survey collected from November 8, 2016 - December 20, 2016
IT WASN’T RAINING WHEN NOAH BUILT THE ARK!

Living in rural Nebraska, we know that resources can be limited. Working with hospitals, community leaders, and Emergency Managers, we try to develop emergency plans that will help us identify and assist special populations. Families with limited English skills, the elderly, individuals with disabilities, and household with limited financial resources are groups that we pay close attention to and try to plan for when developing community-wide emergency plans.

Our Emergency Response Coordinator works with partners in each of our five counties and is responsible for helping protect individuals and families in every community we serve. We work with these community organizations to share resources and do our best in planning for a disaster or event. Partners in this effort include healthcare organizations, schools, county emergency management agencies, community leaders, law enforcement, and fire/EMS units. We also work closely with NEMA (Nebraska Emergency Management Agency), the Center for Preparedness at the UNMC College of Public Health, and the CDC to use evidenced based practices in planning and emergency preparedness.

Our main objectives include:
- Working with community partners to plan and train for emergencies and natural disasters.
- Preparing for all disasters, from natural, (tornadoes, floods, winter storms), to chemical spills, bioterrorism, and pandemic illness.
- Protecting the health & wellness of the total population by responding to health needs, environmental concerns, and providing disease surveillance.

At a community event in Fairbury, we had a table with information on preparing a family emergency kit. We teach families that every household should be able to shelter in place for at least 72 hours in a disaster. A young school-aged child was looking at our display and asking us many good questions. As his parents approached our table, he looked at his dad and said, “You see....THIS is what I told you. We need to do this stuff!” We hope that all families will take the time to prepare a family emergency kit. Kids love to be involved in this activity! Contact us at PHS if you would like information on how to assemble your kit.

Highlights:
- Participated in and helped facilitate training exercises on pandemic outbreaks, active shooter, Zika (vector borne illness outbreaks), mass casualty events, agricultural disasters, and chemical spills.
- Provided enhanced training to public health staff to ensure that our department is ready to respond to community needs in the event of a disaster.
- Monitored regional and national events such as the Zika virus outbreak, avian flu outbreak, massive flooding in the south, to help mitigate the effects of those events on our local communities.
- Presented vital information on family emergency preparedness at various community events.
In 2017, Public Health Solutions became a part of AmeriCorps with a focus in community preparedness. Research shows vulnerable populations (those who are elderly, have limited or no English proficiency, experience geographic or cultural isolation, or who suffer from addiction) face barriers in community preparedness exercises and educational opportunities. The US Census Bureau 2016 estimates 24.7% of Saline County residents identify as Hispanic or Latino, higher than both the state and national average. The demographics of Saline County are continually shifting into a more diverse population and PHS AmeriCorps is taking action to educate vulnerable populations on topics including disaster preparedness.

PHS AmeriCorps will consist of 6 members to assist vulnerable populations in overcoming disaster preparedness barriers. We have recruited some bilingual AmeriCorps members that will focus on educating the growing Hispanic populations in our communities and addressing the language barrier.

- AmeriCorps members will provide brief one-hour informational sessions about disaster preparedness for at least 300 community members. These informational sessions will address safety and education about disasters such as floods, tornadoes, wildfires, earthquakes, hurricanes, blizzards, extreme temperatures, etc.

- AmeriCorps members will provide expanded, specific community trainings and programs for 50 community members. These trainings will be six-weeks in length, meeting once a week for 90 minutes per session. In order to be counted as having attended the session, community members will need to attend four out of the six classes.

PHS is the first organization in Nebraska to run a “disaster preparedness” focused AmeriCorps program!
The disease surveillance program touches every aspect of the community by monitoring for potential disease outbreaks and contributing to the safety and wellness of all individuals.

PHS partners with many community organizations to provide disease surveillance. This includes schools, hospitals, daycare providers, Nebraska Department of Health & Human Services, city/county officials, and emergency management agencies.

- Public Health Solutions monitors the district for communicable disease, foodborne illnesses, and potential outbreaks.
- Every day, PHS staff is looking at reports from schools, hospitals, and state and national partners to help identify potential disease outbreaks and help mitigate the impact on residents of our district.
- Vector borne viruses (those carried by animals such as mosquitoes) are monitored closely. PHS provides a great deal of education to the public on prevention of these viruses such as West Nile virus and Zika.

Provided updates on latest CDC recommendations for Zika virus testing and treatment to area healthcare providers as new information was received. Monitored suspected cases of Zika virus within the district and coordinated testing with the Nebraska Public Health Laboratory.

Investigated cases of potential foodborne illness (enteric disease) and communicable disease as reports were received from local healthcare providers and laboratories.

Conducted a comprehensive West Nile virus prevention effort including surveillance of human cases, dead birds, and mosquito trapping for testing. This included the distribution of mosquito bite prevention materials: Deet wipes, children’s activity books, and larvicide dunks.

Provided assistance to organizations/facilities on disease prevention and outbreak mitigation.
PUBLIC HEALTH SOLUTIONS
FUND REVENUES
YEAR END JUNE 2017

- Local (16.18%) $284,561.28
- Services (12.78%) $224,305.70
- Federal (2.3%) $41,755.63
- State (35.80%) $629,555.86
- Federal Through State (13.45%) $236,574.48
- General Fund (19.44%) $341,796.82

Total Revenue: $1,758,549.77
# PHS EXPENDITURES FY 2017

## GENERAL FUNDS
- LB 1060: $105,458.11
- LB 692: $236,338.71

## FEDERAL - STRAIGHT TO PHS
- HRSA - RAED: $41,755.63

## FEDERAL - STATE PASS THROUGH
- BT: $84,104.45
- Ebola: $2,265.57
- Immunization Grant: $33,971.12
- Dental Grant: $107,476.92
- West Nile Virus: $8,756.42

## STATE
- 1422: $230,296.42
- DHHS - Accreditation: $3,354.95
- Health Navigator: $73,711.83
- Home Visitation Contract: $305,657.69
- Tai Chi: $16,534.97

## LOCAL
- AHEC: $142.31
- AmeriCorps: $8,940.31
- NACCHO - Accreditation: $15,000.00
- ECI - Rooted Relations: $135,800.00
- Minority Health: $33,707.40
- NALHD - VA: $29,870.75
- NE Office Highway Safety: $19,605.13
- Dental Grant - BCBS: $12,000.00
- Other Grants: $29,495.38

## SERVICES
- Health Care Connections: $6,043.64
- Immunization Clinic: $67,723.88
- Dental Services: $28,988.00
- SKIP Flu Reimbursement: $121,550.18