Public Health

Prevention Funding Report

2014

During the State's FY14 fiscal year, the local health departments received a $50, 000 one-time grant as a result of a request for $200,000 with LB119 in 2013; it was reduced to $50,000 in LB195, the State's main budget bill in 2013. Funds were used to implement prevention programs in their health districts. The programs implemented were based on the health priorities identified by the community. Targeted programs to improve health and promote wellness in Nebraska using evidence based and promising practices were implemented. By focusing funding on prevention, the efforts were to prevent disease and health complications by improving health and promoting wellness.

Efforts funded included local programs in communities designed to: Increase physical activity; Decrease obesity; Prevent complications from diabetes, cardiovascular disease, and other chronic diseases; Improve access to medical homes and dental homes to offer prevention and wellness services; Increase worksite wellness initiatives to prevent disease and disability; and /or Assure preventive services for children and adults.

Central District Health Department (CDHD)

The Central District Health Department service area of Hall, Hamilton and Merrick Counties in Nebraska has identified obesity as a significant public health concern. Placing a focus on improved nutrition and physical activity through a change in our environment has been a priority. The prevention funds have been used to increase the districts capacity to combat this issue through the use of Health Educators. Health Educators have been working with area worksites, churches, day cares and schools to educate and inform them about ways to enact policy to support healthy living. These are areas where people live, work and pray; place where people spend their time. They have conducted environmental assessments on worksites and daycares to get a picture of current supports in place. They assess the readiness of an organization to move towards change. When ready, Health Educators begin training and provide support to implement policy that affects the population they see every day. Examples include the reduction of sugary drinks, creation of wellness committees, reduction in access to high-calories foods and increase in access to water.

Each county within the district has developed a community advisory group to support the efforts on a community-wide basis. Stakeholders with an interest or background in healthy living come together to find ways to improve community conditions related to obesity. These groups are led by CDHD Health Educators. Prevention funds, through the Health Educators, have been used to promote health living to the community through a wide range of media. This includes regular articles in the local paper, Face book, local radio and the organization's website. Altogether, awareness is being raised, the community is becoming energized and policies are being put in place for the future.

Douglas County Health Department (DCHD)

The $50,000 appropriation to the Douglas County Health Department was used to help address teen pregnancy through Douglas County's Personal Responsi-bility Education Program (PREP).

The idea behind PREP is to decrease teen pregnancy and STD rates by increasing the protective factor present in at-risk youth living in Douglas County. To accomplish that, DCHD increased the number of evidence-based youth development programs (Wyman's Teen Outreach Programs sites) in Douglas County.

Douglas County Health Department (DCHD) (Cont.)

The Douglas County Health Department served as the lead agency and assumed fiduciary responsibilities. Three components were created with the grant management core in the Douglas County Health Department.

An implementation core with the DCHD serving as lead master trainer and facilitator was set up to work with implementation partners Lewis and Clark Middle School After-School Program (Nothing But Net), and Norris Middle School After-School Program (Completely Kids) for a total of two clubs.

The governance core element was handled by the Douglas County High School Citizen Youth Advisory Health Council, a group comprised of representatives from the health department and Douglas County youth.

The plan was to replicate Wyman's Teen Outreach Program (TOP)-evidence based youth development program under Nebraska DHHS licensure, the replication partner. To make the program a success, a target population of 20-to-45 youth aged 12-to-19 was needed.

The rationale behind this project was for DCHD to establish two new TOP clubs and acquire a master trainer to stabilize the program. Future expansion of program would be centered on a master trainer housed within the health department who could train facilitators to accommodate community demand. In addition, some funds would be used to provide for an evaluation of these new sites covered by the public health prevention funds to assess programmatic outcomes. The Wyman's TOP program was selected as the optimal program to expose at-risk youth to assets (protective factors) that would increase the probability of them to become successful and productive adults.

As a result of this initiative, 26 lessons were completed on topics ranging from "Introduction to Values," "Introduction to Relationships," and "Introduction to making choices and consequences," Self-Esteem Rip-off," "Examining Teenage Parenthood," and "Ways to Say No."

More than 175 hours of service was provided to the community via community service learning by the members of Youth Advisory Health Council. Examples of their work include Health Ministry Center Volunteering (a local food pantry); homemade dog treats and blankets/towels drive for Nebraska Humane Society, May Day baskets for Families in Action, Reading to Kindergarten/1st Graders at Field Club Elementary School, Dental Kits for the Sienna Francis House homeless shelter, and a local HIV/AIDS Awareness Campaign.

Teen Outreach Program Training of Facilitators included 10 individuals who were registered and trained to administer the Wyman Teen Outreach Program-evidence based youth development program.

The long term outcomes from Prep are expected to include a lower risk of school suspension, a lower risk of course failure, a lower risk of pregnancy, and lower risk of dropping out of school.

Work that has been accomplished through PREP that was related to the 10 Essential Public Health Services included: 1) Giving people information they need to make healthy choices; 2) Helping people receive health services; 3) Contributing to and applying to the evidence base of public health.

East Central District Health Department (ECDHD)

The $50,000 prevention funds were a huge asset to the agency as it provided us the ability to carry out one of the objectives found in each of the Platte, Boone and Colfax County CHIP workgroups: gathering baseline body mass index (BMI) data on school students in the district. We gathered student BMI data by offering student health screenings to schools that do not have nurses. Student health screenings consist of a hearing, dental and vision check along with the collection of the student's name, height, weight, age, gender and date of birth. During this year, we obtained BMI data on 3,035 students in 11 schools (one of these schools did have their own nursing staff and shared their data with ECDHD). The prevention funds also provided a way for us to contract with the University of Nebraska Kearney's Body Mass Index computer system and insert our district's BMI data into their BMI system that calculates BMI and provides aggregate data per school or school district. Using the UNK system, we were able to determine that of the students screened 3% were underweight, 59% were of normal weight, 18% were overweight and 20% were obese.

This funding relates to Essential Service 1, monitoring health status and understand health issues facing the community. As we continue to gather student BMI data, we believe that ultimately, we will use the aggregate data to impact upon Essential Service 4 Engage the community to identify and solve health problems as we share the aggregate data with the Platte, Colfax and Boone Obesity Prevention Coalitions and with school officials as well as with the public as we include this data in the 2015 CHA. We hope that as we release this aggregate data that Essential Service 5 Develop public health policies and plans may be impacted within school systems.

Elkhorn Logan Valley Public Health Department (ELVPHD)

The prevention funding has been aligned with ELVPHD's community health improvement plan Priority #1 – Obesity. Following are the outcomes and upcoming activities/events.

Outcomes:

1. A baseline survey was sent to all licensed child care providers (140 licensed child care providers were sent surveys and 19 were returned = 14% return rate) to determine practices regarding physical activity, nutrition and breastfeeding. A notable result from the baseline survey was: Results showed that 86% of children age 1 and older do not get the recommended 90 minutes of physical activity per day.

2. One staff person became a NAP SACC certified trainer so that workshops could be held with child care providers in the area on this physical activity/nutrition/breastfeeding curriculum whose focus is on policy/procedure adoption by child care facilities.

3. Three child care workshops were scheduled for the Fall of 2014 in which training and policy/procedure development was the target goal. Policy/procedure outcomes will be known once those workshops have taken place. 43 individuals from 8 different centers/in-home day cares registered. Pre/post assessments were included at the work shop (in addition to the emphasis on policy development) to measure participant knowledge/gain of the subject matter.

Elkhorn Logan Valley Public Health Department (ELVPHD) (Cont.)

4. During the Fall/Winter 2014 – ELVPHD will be updating all of the walking maps and signage previously distributed to all communities in our service area to include QR codes for smart phone users to take advantage of this shift in technology to gain further interest in the maps and signage by community members.

5. A Human Resource Law workshop was hosted by for employers in the Norfolk area to learn about the laws/regulations regarding breastfeeding in the workplace. This training was marketed to over 150 businesses in the Norfolk area and 6 employers took part in the workshop ranging from small businesses to one of the largest employers in Norfolk. The coordinator will follow-up with these businesses to determine if policy changes have occurred in the fall of 2014. Supplemental materials on breastfeeding were requested by 3 of the 6 businesses that attended (50%). A resource directory was created and distributed to the 6 business attendees. Additionally, the President of the local chapter of the Society for Human Resource Management attended and is interested in having the HR Law presentation presented to the local chapter of SHRM at one of their meetings in 2015.

6. The Coordinator has publicized breastfeeding related trainings and information via Facebook to promote broader distribution of the information and ELVPHD has incorporated training information on ELVPHD'S webpage as well. Trainings were also publicized via newspaper press release, via mailings direct to the intended audience and via in-person notifications.

7. Healthy vending policies have been established at 2 businesses which ELVPHD previously had worksite wellness relationships with. An additional worksite wellness business adopted an informal healthy snack procedure within their business.

Four Corners Health Department (FCHD)

Healthy Babies (Essential Service #3)
This is a home visitation program for pregnant women and new moms.
An example of the work done is:

The Public Health Nurse (PHN) visited a new baby and her parents, 17 year old dad and 19 year old mom with physical challenges. The referral was received from St. Elizabeth hospital, who wanted to increase support for this family. Through the PHN home visits, education on safety, parenting, and infant care has been provided. During one of the visits, it was discovered that only one floor of the home had smoke detectors and it wasn't the floor where the family slept. The PHN had brought a supply of safety items to the home that are given to all new parents, which includes a smoke detector. The PHN had encouraged them to use one of the safety items before the next home visit, mentioning that the putting a smoke detector in the hallway outside their bedrooms would be an important priority. While the visit continued, the dad went into the sack of items, pulled out the smoke detector box, pulled out the instructions, and began reading how to install it.

The goal of the program is to identify "at risk" situations and provide referral and guidance to the family. This would lead to preventing danger to the child, including the long term effects of abuse, neglect or seriously unhealthy homes.

Healthy Communities – Worksite Wellness (Essential Service #4)
Take Heart Live Smart (THLS) Butler County

Take Heart Live Smart (THLS), the Four Corners worksite wellness program for area businesses, began a new way to support smaller worksites. Starting with Butler County, Four Corners is working with small businesses who normally have limited resources for providing worksite wellness services. Four Corners is partnering with Bank of the Valley, Dale's Food Pride, Butler Public Power District, KV Supply, HR Block, and Butler County Chamber of Commerce. Each business has at least one representative on the THLS Wellness Committee. The group is focused not only on the health of the employees at each participating business, but also the health of each member on the Wellness Committee.

Joining the Worksite Wellness and the Patient Navigation programs, the two public health nurses have offered on-site health screenings in focused on cancer prevention, heart health, and diabetes prevention. The diabetes screening helped to identify individuals who were high risk for diabetes and were referred to their physician.

Four Corners has committed significant staff hours to work with alcohol/drug use prevention programming. We are partners in the Butler, Polk, Seward and York county prevention coalitions. These groups are working to prevent underage drinking, reduce binge drinking in young adults, ages 18-25, and reduce the incidents of drinking and driving. The cost of youth drinking, especially in relation to driving, is a huge burden to the taxpayer now and in the future.

Lincoln-Lancaster County Health Department (LLCHD)

The work accomplished related to prevention funding relates to Essential Public Health Service #7; "Help people receive health services".

Target Population:

Poor and uninsured adults with a diagnosis of diabetes.

Intervention:

Provide diabetes case management.

Key Outcomes (October 2013-June 2014):

- Patients Case Managed: 67 patients
- Access to free or low cost glucometer strips: 14 patients (20%)
- Lancaster County GA application assistance: 12 patients (17%)
- Medical home connection: 9 patients (13%)
- NE Medicaid application assistance: 9 patients (13%)
- Transportation assistance: 9 patients (13%)
- Access to lancets, needles, syringes: 7 patients (10%)
- Diabetes Specialty Clinic at Clinic With a Heart***: 7 patients (10%)
- Access to insulin or oral hyperglycemic medication: 5 patients (7%)
- Medication reconciliation assistance by Creighton Pharmacy faculty & students: 4 patients (6%)
- Access to dietetic intern for 1 on 1 nutrition counseling: 2 patients (3%)
- Access to foot clinic: 1 patient (1%)
- Access to vision care: 1 patient (1%)
- Access to diabetes management class: 1 patient (1%)

Evaluation Findings/911 Impact:

Two (2) out of the 67 case managed patients called 911 for diabetes related concerns (2.9%) in the time period studied (September 1, 2011 to September 15, 2014). This is lower than the percentage of all people who have received free/reduced cost glucometer strips through our program, who called 911 for diabetes related concerns (8.4% or 46 out of 547 unique people).

***Diabetes Specialty Clinic: Held every 4th Monday of the month at Clinic With a Heart. All patients were poorly managed diabetics without a medical home. 100% of patients in this project, to date, have been assessed by our APRN and a Certified Diabetes Educator and were connected to a medical home (all at People's Health Center) within 2 months by the diabetes case manager or a public health nurse. While those assisted were waiting to establish as new patients at People's Health Center, they were medically stabilized on free medications (insulin or Metformin), given a glucometer and free glucometer strips, provided glucometer, insulin, nutrition and lifestyle management education, and were assessed for transportation needs.

Loup Basin Public Health Department (LBPHD)

At the present time, there are 8 active dentists in the district consisting of nine counties with a geographical area of just over 7,000 square miles. In 2005, the LBPHD implemented an oral health prevention program to help reduce the number of dental caries and provide immediate referrals to children in need who otherwise may not be identified.

This past school year, 2013-2014, Loup Basin Public Health Department visited every elementary school and most pre-schools and head starts in our district for a total of 40 sites. We screened 2,163 children, applied fluoride varnish to 1,024, and referred 259 children for an immediate visit to their dentist. We also supplied every child with a new toothbrush. The percentage of immediate referrals continues to decline since the inception of this program.

We feel that good oral health is a pre-cursor to good mental and physical health. This program has contributed to improved oral health indicators and continues to demonstrate continued progress since inception. Unfortunately, to effectively administer this program, expenses have always surpassed revenues and sustainability of the program continues to be a concern. In the past year, this program had a net cost of approximately $25,000 a year to implement. The prevention funds were used to bridge the gap between revenues and expenditures to enable the health department to sustain operations indefinitely.

North Central District Health Department NCDHD)

NCDHD Miles of Smiles

In 2011, North Central District Health Department (NCDHD) started laying out a business plan for an oral health program in our district, as a large need was evident based on our prior two community health needs assessments. We proceeded, with the assistance of the University Of North Carolina College Of Public Health, to establish a sustainable business plan. In 2012 an oral health screening and fluoride varnish program for preschool and elementary students living in the health department district was started.

We started with very little funding or equity for this program. We solicited the support of our dental offices and worked towards contracting with dental hygienists, many of whom volunteer some of their time and/or commute time and expenses. In the fall of 2012 we were in nine (9) schools and increased to seventeen (17) in the spring of 2013. With the assistance of our Legislative funds we have increased to having all but one school participate in our program; jumping up to thirty-seven (37) schools participating in the Fall of 2013 and maintaining all (37) schools during the Spring of 2014. Because of our success with this program, this also lead us to a working relationship with the Nebraska College of Dentistry, providing a Sealant program in Boyd County where we provided 564 sealants to 137 youth, over two-hundred percent more than what the College of Dentistry was anticipating or has done before in a school. This program was so successful that the College of Dentistry is working with us to provide another sealant program, in Bassett, this fall, 2014. From there our strategic plan will be to accomplish this on our own in one community once per year. Something we never dreamed of two years ago.

North Central District Health Department NCDHD) (Cont.)

Consistent averages of 90% of those students who receive an oral health screening are also receiving a fluoride varnish application.
An average of 39% of those students receiving a fluoride varnish application is Medicaid Clients. The vast majority of the remaining students is under-dental-insured or has no dental coverage.
We have recorded a dramatic DECREASE in needed referrals for some type of necessary or urgent dental care, decreasing from30% in fall of 2012 to 19% after the completion of spring 2014. This trend data indicates the program is working as youth are referred to dental providers and are receiving more timely intervention.

We are currently well ahead of schedule in our business plan of this program, much due to the assistance of Nebraska Legislative funds.

We have sought technical assistance from Loup Basin Public Health Department and have made some additions to program logistics that fit the need in our health district. I share the same viewpoint as that of LBPHD; good oral health is a pre-cursor to good mental and physical health. This program has contributed to improved oral health indicators and continues to demonstrate continued progress since inception just a short time ago.

Working of Wellness
Again, by going off our department community health needs assessment, NCDHD is also launching a wellness screening program. The program starts with an online health risk assessment which is followed by a blood pressure screening, body mass index measurements and blood work (complete cholesterol profile and fasting blood sugar).

The Cholestech LDX Starter Kit will be utilized to obtain the blood work portion of the screening program. NCDHD is planning to provide technical assistance to facilities to enhance work site wellness programs that they have in place or are creating. Through our WELCOA membership, NCDHD will purchase educational books for participating work sites. The books to be purchased are “Walking 4 Wellness” and “Fitness That Works”. Both of these books are a valuable resource for companies to assist their employees in becoming healthier and more active which will decrease their risks for chronic disease such as hypertension, diabetes and high cholesterol.

We have done presentations to businesses and are starting to book wellness screenings.

Northeast Nebraska Public Health Department (NNPHD)

NNPHD is using the $50,000 appropriation to plan and implement an immunization program that will expand the capacity of NNPHD to respond to a variety of public health situations, both emergency and non-emergency. There were three events that inspired this decision: 1) H1N1 in 2009 and 2010; 2) Pertussis outbreak in a school district located within the health district; and 3) The disaster events that occurred in Wayne County on 10/4/14, Wayne, Thurston and Dixon Counties on 6/16/14 and Cedar and Dixon Counties on 6/17/14. Each event provided more and more evidence that NNPHD needs the capacity to provide basic immunizations independent of healthcare partners. An additional R.N. is hired to carry out these activities with the prevention funds.

Panhandle Public Health Department (PPHD)

PPHD is using the $50,000 prevention appropriations over two years to enhance our worksite wellness efforts. The additional funds have allowed us to increase the amount of staff time dedicated to the effort, as well as enhance the community and environmental supports that make the healthy choice the easy choice. The answer to this question is tied in with the following success story. We were chosen to be highlighted in the Annual Status Report that the Surgeon General gives to Congress and the White House on the progress of the National Prevention Strategy. Panhandle Public Health District's work through the Panhandle Worksite Wellness Council is highlighted on page 60. We continue to use worksite wellness as a conduit for creating a healthy Panhandle.

The 10 Essential services that are related to worksite wellness are:
Inform, educate, and empower people about health issues
Mobilize community partnerships to identify and solve health problems
Develop policies and plans that support individual and community health efforts
Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

National Prevention Council, *Annual Status Report,* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2014. Available at http://www.surgeongeneral.gov/initiatives/prevention/about/annual_status_reports.html
Since its inception in 2011, the Panhandle Worksite Wellness Council has provided significant benefit to area organizations helping develop area supports to further enhance employee health. The council serves as the perfect conduit for delivery of many health promotion initiatives like colon cancer screening kits, radon test kits, and the ongoing promotions of active living, healthy eating, and reducing tobacco exposure in an effort to reduce the incidence of chronic diseases like diabetes, heart disease, and cancer. Worksite wellness is a proven strategy cited in the CDC's Community Guide.

Panhandle Worksite Wellness Council continues to work with upwards of 40 businesses reaching one in five employed people in the Panhandle region. We have continued to create and enhance council offerings ultimately impacting population-based health through organizational policies, systems, and environments by providing ongoing training and educational opportunities, resources, and technical assistance.

Panhandle Public Health Department (PPHD) (Cont.)

We have provided direct technical assistance in the past year to ten council worksites to build policies and/or environmental supports in the areas of tobacco-free, nutrition, physical activity, or breastfeeding. We were quite excited with the results:

Worksite	*Policy &/or Environmental support*
City of Chadron	Breastfeeding policy & supports
FALCO	Breastfeeding policy & supports
Gordon Memorial Hospital	Healthy meeting guidelines, healthy cafeteria options
Sidney Regional Medical Center	Healthy meeting guidelines, healthy cafeteria options
Northwest Community Action Partnership	Healthy meeting guidelines
City of Sidney	Break room assessment, added refrigerators & water coolers where necessary
Chadron Community Hospital	Tobacco free campus policy
Cirrus House	Healthy meeting guidelines, dietary standards including food portions, sugar-sweetened beverage reduction
Western Nebraska Community College	Walking path designation & promotional signage
City of Gering	Tobacco-free campus policy

Our Fall Panhandle Safety & Wellness Conference in collaboration with the Nebraska Safety Council and Western Nebraska Community College brought together over 150 business representatives from around the region. In addition to hearing top-notch presenters in the wellness and safety areas, four organizations were highlighted for "sowing the seeds for wellness" with the Governor's Wellness Award.

We also work closely with Nebraska's two other wellness councils, WorkWell, Inc. based in Lincoln and WELLCOM based in Omaha to hold a collaborative conference, Collective Impact in Worksite Wellness-Annual Meeting of Nebraska's Wellness Councils. We are excited to leverage the collaborative working relationships between Nebraska's wellness councils to bring more opportunities to Nebraska businesses.

The National Diabetes Prevention Program has been an excellent opportunity to Panhandle businesses to improve employee health and wellness.
Additionally, we have offered an evidence-based eight-week interactive series of webinars offered by UNL Extension Educators, Creating Balance with Food & Fitness; over 100 area organizations participated in National Walk @ Lunch Day; and nearly 25 businesses representatives were trained by Nebraska Department of Health and Human Services Physical Activity Coordinator, Brian Coyle, on walkability not just benefitting employees but economically impacting businesses as well.

We were honored and humbled to be featured in the recent Surgeon General's National Prevention Strategy Annual Report and are working with UNMC College of Public Health, Dr. Patrik Johannsen, to develop a course learning module on the effective delivery of rural public health service through worksite wellness.

Panhandle Public Health Department (PPHD) (Cont.)

Tobacco and Smoke free campuses policies are being adopted through a concerted effort between Tobacco Free in the Panhandle and Panhandle Worksite Wellness Council, (both coordinated through Panhandle Public Health District). Along with that, worksites continue to adopt policies prohibiting smoking 15 feet from the entrance of their office. Tobacco Free in the Panhandle continues to work with multi-unit housing management to pass smoke free policies throughout all of the counties, 50% of the known multi-unit housing facilities are smoke-free. Tobacco Free in the Panhandle also works with schools on strengthening their tobacco free policies and fair boards and city councils to adopt smoke/tobacco-free outdoor policies.

National Diabetes Prevention Program (NDPP) in the panhandle is going strong. In March the NDPP in the Panhandle was accepted as a Promising Practice for the National Association of County and City Health Officials (NACCHO) Model Practices Program. NDPP was implemented to prevent obesity and type II diabetes (aligns with priorities in the Panhandle Community Health Improvement Plan).

NDPP is seeing success in partnering with Panhandle Worksite Wellness Council, a department of PPHD, businesses to offer the classes to their employees through their worksite wellness programs. There have been 18 contracts with local businesses to offer the classes to their employees. In the 6 business classes ending this fall there have been 961 pounds lost. Seventy-five percent of the community group participants met their 5% weight loss goal as of 16 weeks and 54 percent of business participants.

Public Health Solutions District Health Department (PHSDHD)

Reduce Diabetic Complications and the Cost of Care
The PHS district population is characterized by a high rate of obesity, a low level of exercise, and low rates of engagement in preventive and screening services. These factors contribute to our growing rate of diabetes and the delayed diagnosis and treatment that result in an increased rate of diabetic complications, early disability and death. The bottom line impact is an increase in the cost of health care and a decrease in the quality and productivity of lives. With other funding, we initiated a program two years ago to increase awareness of diabetic risk factors and to delay the onset of diabetes through education and exercise. However, in addressing the needs of pre-diabetics we found we had an even bigger problem with the number of uncontrolled diabetics we found.

Knowing our program and the community lacked the resources and capacity to handle a large number of uncontrolled diabetics, the appropriation from the legislature provided an opportunity for us to address the growing number of uncontrolled diabetics. Our goal was to improve the care of diabetics, thereby reducing diabetic complications and reducing the cost of care.

As we studied the problem we identified the obstacles to disease control. These were a lack of consistent care from a medical provider, inability to pay for clinic visits, inability to purchase medications and testing supplies. The diabetics were also inclined to underestimate the dangers of uncontrolled diabetes and did not see the need for care as urgent. The legislative appropriation enabled us to hire a Certified Diabetic Educator to complement the work of our Community Health Worker.

Public Health Solutions District Health Department (PHSDHD) (Cont.)

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

Insured Diabetics

The major challenges for the diabetics beyond a stable medical home are the inability to afford medications and testing supplies. As often happens for those with chronic illnesses, they acclimate to the discomfort of their illness and minimize the potential danger associated with a lack of treatment. After screening and counseling, the CDE often finds that in addition to no Medical Home they lack testing supplies and money for medication. The CDE has a clear picture of the patient's situation and works with them first to establish or reestablish a medical home. Clear and complete communication with the Primary Care Provider (PCP) enables the CDE and PCP to problem solve to help the patient achieve control of the diabetes and achieve compliance with the PCP plan of care. This may involve adjusting to lower cost medications, enrolling a client in medication assistance, helping the patient apply for medical assistance or other third party coverage, getting the patient budgeting assistance and/or helping them acquire least cost testing supplies.

In this regard we often assist patients in accessing blood glucose meters and test strips at a lower cost. We purchase test strips at 10.00/can and patients pay what they can afford. The balance is covered through donations. $550 in donations were collected and used for this purpose over the past several months. Up to the present time we had been able to provide low cost and/or free meters for testing. We expect this to change soon.

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

The screening, assessment and case management of diabetics in conjunction with a health care provider is an effective and lower cost model for rural health care providers to provide a medical home for uncontrolled lower income patients. When the community based CDE services are provided under one umbrella for area health care providers desiring to operate as a medical home, there is an economy of scale and a higher quality of care provided. As an example, one client was visiting the Emergency Room for diabetic crises every 10 to 14 days. The frequency of these visits significantly decreased after our intervention with him. Given the national average cost for an ER visit for diabetes

Public Health Solutions District Health Department (PHSDHD) (Cont.)

is about $700.00, there was an estimated savings of $15,000/yr. for this patient alone. This does not include Inpatient admissions which often occur as a result of an ER visit or the prevention of complications. According to articles associated with the assessment of intervention programs, it is estimated that adult diabetics without CDE program intervention go to the ER at a rate of 1visit per hundred per year. After a CDE program intervention, to rate is reduced by one half. With the 47 diabetics we identified one would estimate that before intervention they would have produced 47 ER visits per year costing an estimated $32,000/yr. With intervention $16,000 in cost would be avoided each year. The estimates of impact of our program are likely too low considering the intensity of illness of those we enrolled. In addition, ours is a small program and the more diabetics in the program the more money could be saved. Also, the estimate for the potential cost avoidance as a result of our intervention did not include the potential cost avoidance from a reduction of inpatient days (interventions reduce inpatient days by 1/3). In addition we did not factor in the avoidance of complications.

Increase Dental Access for Children

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

Sarpy Cass Department of Health and Wellness (SCDHW)

With the prevention funds, the Department implemented the Senior CARE program. The program consists of three areas of focus: in-home visitation, community talks, and foot care clinics. The program relates to the following Essential Services of Public Health: Protect people from health problems and health hazards; Give people information they need to make healthy choices; Help people receive health services; Evaluate and improve programs and interventions; and Contribute to and apply the evidence base of public health.

The Sarpy/Cass Department of Health and Wellness implemented our Senior CARE (Community, Advocacy, Resources and Education) program for senior adults. The program was developed to help bridge identified gaps in the senior care continuum by connecting seniors and caregivers with community resources, providing health education, and ensuring supportive needs are met to help seniors remain safely in their home, thereby improving the overall health and well-being of seniors in Sarpy and Cass counties. During this fiscal year, a total of 947 seniors were served by the Senior CARE program, including 263 participants in the wellness clinics, 638 attendees at community talks, and 26 in-home visits.

Key outcomes of the program during this fiscal year include:
Individual Interactions:

- 26 home visits
- 19 phone consultations
- Estimated cost savings to clients of $10,335
- Spiritual/Emotional issues addressed: depression, emotional distress, grief/loss, relationships, spiritual distress, and stress.
- Health behaviors addressed: diet/nutrition, general health, knowledge deficit, living alone, medications, mobility, non-compliance, physical activity, safety, senses impaired, weight loss/gain.
- Medical diagnosis/concerns: cancer, cardiac, CHF, HTN, pain, diabetes, thyroid disorder, mental health, stress, hearing loss, respiratory, and smoking.
- Interventions provided: active listening, arrangement of meals, coordination of support, empowerment, chronic disease management, presence, promoting understanding, providing information, transportation, and health promotion.
- Referrals provided: case management, community resource, congregational resource, healthcare professional, home care, hospice, and physician.

Group Interactions:

- 931 total participants
- 263 clients attended clinics
- Estimated cost savings to clients of $14,710
- Interventions included: blood pressure screening, foot care and toe nail trimming, weight screening, medication review, diabetes screening, and health education (including diabetes, safe driving, nutrition, elder abuse prevention, hoarding behaviors, pharmacy and medication safety, fall risk reduction, respite training, CPR/AED training, end of life care, hospice workshop, advance directives, and exercise**.**

South Heartland District Health Department (SHDHD)

South Heartland's Community Health Improvement Plan has 5 priorities: Obesity, Cancer, Substance Abuse, Mental Health, and Access to Health Care. We focused the use of prevention funds on Goal 1: Obesity - To Reduce obesity and associated chronic disease risk through consumption of healthful diets, daily physical activity and achievement and maintenance of healthy body weights. The intervention is related to Essential Service #1: Monitor health status and understand the health issues facing the community, Service #5: Develop policies and plans that support individual and community health efforts, Essential Service #3: Give people the information they need to make healthy choices, and Essential Service #10: Contribute to and apply the evidence base of public health.

SHDHD is using prevention funds to implement Coordinated School Health (CSH) activities – including training and capacity building with schools, assisting schools in assessment and priority setting using the School Health Index, and culminating in policy change and policy implementation. Coordinated School Health includes eight components that are based on synthesized research, theory and best practices in healthy eating and physical activity promotion in school health, public health and education. These components include: health education, physical education, health services, nutrition services, counseling and psychological services, healthy school environment, health promotion for staff, and family/community involvement. These 8 components are supportive of strategies in all five of South Heartland's CHIP goals.

South Heartland partnered with the NE Department of Education to offer Coordinated School Health training for area schools. Four area schools or school districts committed at least 3 members of their School Health Advisory Councils to participate in 4 institutes (7 days total) held in October, December, January and March. Participating schools include:

Superior School District (K-12) - Nuckolls County

Adams Central School District (K-12) - Adams County

Lincoln Elementary School (K-6, Hastings Public Schools) – Adams County

Hastings Catholic School System (K-12) – Adams County

Total Reach: ~1725 students and >300 staff

Outcomes (at 12 months):

- 4 School Health Advisory Councils Activated - regular meetings, added members to include representation from community and other sectors.
- 4 schools/school districts completed School Health Index assessment tool – determined gaps and set health priorities
- 4 schools/school districts committed teams to participate in Coordinated School Health Institutes and completed all 4 institute trainings.
- Policy or environment changes adopted:
- Increase Physical Activity in the classroom - Set # of minutes per week that each grade level will be allotted and Increase # of minutes for recess each day
- Middle School students will have the opportunity for physical activity during their lunch period. The gym or outside facilities will be open to use during lunch when possible.
- Physical activity will not be used as punishment nor will physical activity be withheld as punishment
- No competitive foods or beverages sold during school hours
- Classroom celebrations will meet the USDA snack standards
- Foods will not be used as rewards

South Heartland District Health Department (SHDHD) (Cont.)

- Implementation of Breastfeeding Policy for staff
- Adding E-cigarettes to the tobacco policy
- Policy Implementation:
- Staff Wellness program with health assessments and screenings through Wellness Works.
- Teacher in-service days will be used to teach a variety of health topics that may include speakers from NE DHHS and outside agencies that will provide education on incorporating physical activity and nutrition into the classroom, staff wellness, etc.
- Mile Club - held Fall and Spring after school
- Walk & Bike to School 2x/year along with Walk to School Challenge in the late Spring
- Physical Activity and Nutrition Afterschool Program held in the Winter months
- Participation in Federal Fresh Fruits and Veggie Program w/nutrition education weekly
- Individual volunteers have been trained and certified in Body Pump that will be offered to students and staff before and after school.
- Healthy Snack Cart
- Staff training in CPR and first aid.
- Middle school noon activity for increasing daily physical activity**.**

Using the evidence-based Coordinated School Health model, school health advisory councils are reviewing their wellness policies, assessing their school's "environment" through a health lens, identifying priorities and developing action plans for improvement. Teams from four South Heartland area schools received training in a series of Coordinated School Health Institutes. Coordinated School Health is one strategy identified in South Heartland's Community Health Improvement Plan that is addressing obesity, substance abuse, mental health and access to health care through policy implementation in the school setting. In the first year alone, the Coordinated School Health initiative is impacting 1,725 students and more than 300 school staff in South Heartland area schools.

Southeast District Health Department (SEDHD)

The prevention funding assisted SEDHD in being able to carry out our Growing Great Kids Program in all counties. MCH funding requires a match and by using this funding, we were able to expand our visitation program to Johnson and Pawnee counties while providing match for the federal grant. 663 home visits were provided by SEDHD to pregnant and parenting women and their families

SEDHD also used the money to supplement the Immunization program in our District.

Southwest Nebraska Public Health Department (SWNPHD)

SWNPHD utilized prevention funding to increase access to care for residents living in communities with no healthcare providers or limited services. We serve Chase, Dundy, Frontier, Furnas, Hayes, Hitchcock, Perkins and Red Willow counties in rural Nebraska. This appropriation was used to provide outreach clinics to four rural areas. Services included immunizations for adults and children. Immunizations included free and discounted vaccinations.

Other services included lead screening, childcare provider screenings, and preventive laboratory services. All forms were translated in Spanish and a Spanish interpreter was hired.

These funds were the catalyst to kick off these programs. We could not have accomplished this goal without the $50,000. Preventive laboratory services were started in April 2014.

This intense project affects many of the ten essential public health services. To begin it has mobilized community partnerships to identify and solve health programs for residents. Physicians have been the top referral source for the lab services as they understand the challenges of the test costs for their patients. These lab services place SWNPHD as the link to needed personal health services and assures the provision of healthcare.

Through the training of our nurses, we feel that you can be assured of our competent public health and personal health care force.

Results from the preventive lab services, lead screening and childcare provider screenings are utilized to diagnose and investigate health problems. We are enforcing laws and regulations that protect health and ensure safety through the childcare provider screenings and lead screenings.

Through numerous media releases, radio interviews and one-on-one education, SWNPHD is working to inform, educate and empower people about health issues related to the preventive lab tests, lead screening and childcare provider screenings.

Through the evaluation process SWNPHD determined with the input of several organizations that preventive lab tests would improve the quality of personal and population-based health services.

Three Rivers Public Health Department (TRPHD)

Three Rivers used the $50,000 appropriation to pilot the "Healthy Kids Healthy Bodies" program, a health education program targeted towards kindergarteners in the school based setting. Our health educator used the evidence based curriculum, HealthTeacher.com, to present information related to nutrition and physical activity. This health promotion and education program was chosen because our CHIP placed a strong emphasis on addressing healthy lifestyle behaviors and our community supported targeting school aged children for intervention.

HealthTeacher.com is an online resource of research based health education tools including lessons, interactive presentations and additional resources to integrate health into classrooms. HealthTeacher.com lessons are developed by experts and measurement is focused on health literacy and behaviors. Family newsletters and at-home challenges, like "Drink water instead of soda for a whole day!", keep teachers and parents on the same team, and encourage parents to be healthy examples for their kids.

HealthTeacher.com meets National Health Education Standards and Common Core standards for each grade level and can be used as a stand alone health education curriculum or supplement existing curriculum. HealthTeacher.com follows Guideline 5 of "Implement health education that provides students with the knowledge, attitudes, skills, and experience needed for lifelong healthy eating and physical activity" from the CDC's School Health Guidelines to Promote Healthy Eating and Physical Activity.

Our health educator presented educational, interactive sessions to participating classrooms. Activities for the classes involved giving each child their own MyPlate plate that showed how their meals should be composed to achieve a healthy balance. The classes also participated in a health snack day and contributed their favorite healthy recipe. The recipes were then collected and put into a "Healthy Kids Healthy Bodies" recipe book which were distributed to all children in participating classrooms.

This pilot program will be expanded in the next fiscal year through the Title V grant. Based on positive feedback from participating schools and the ability to grow the program with more funds, Three Rivers applied for and received Title V funding to implement a larger scale version of this program in five schools. There are two goals for the "Healthy Kids Healthy Bodies" project: Goal 1: To increase the prevalence of kindergarteners who are physically active. Goal 2: To increase the prevalence of kindergarteners who are eating healthy and are at a healthy weight.

To achieve these goals, the "Healthy Kids Healthy Bodies" program will use HealthTeacher.com and will also incorporate additional evidence based practices, such as completing a school health assessment and school health improvement plan. The school health improvement plan will lead to implementing other evidence based programs, such as a Walking School Bus, at the schools. As each participating school is in a different school district and are located in three different counties, it is expected that each school will be at different levels in having school policies and practices that reflect national best practice standards for nutrition and physical activity. "Healthy Kids Healthy Bodies" project staff will work with school personnel and parents at each school individually to identify the current school environment and create a unique work plan for each school to make progress towards a healthier school environment.

Two Rivers Public Health Department (TRPHD)

TRPHD is providing the Evidence Based "CATCH" program which targets children and obesity in our district utilizing Prevention funding to Gosper, Franklin and Harlan Counties and district schools that do not meet the minority population requirement such as Ravenna, and Minority Health Initiative funding in Buffalo, Dawson, Kearney and Phelps if the schools meet the minority population requirement. The TRPHD Wellness Coordinator and MHI Evaluator for the MHI grant adapted a pre/post evaluation from the master evaluation and converted it into an audience participation presentation (Turning Point). We are sharing this system and process with our statewide partners which will allow comparison of data and outcomes. TRPHD will be providing a training and technical assistance to partners in the state on the Turning Point System which will be utilized in the evaluation process of the CATCH Kids program. With the Turning Point program, staff will be able to track individual program participants as well as compile aggregate data. 33 children have participated in CATCH Kids funded with Prevention funding. The data from the pre and post tests revealed that their knowledge of healthy eating went from 41% to 72%; Foods that they eat and drink now that were healthy went from 35% to 54%; and keeping a steady pace during physical activity went from 47% to 81%. The student and parent evaluations were very positive as well. Comments from parents included "My kids don't argue as much when I make a healthy meal." and "She volunteers to go out and get active!" Healthy changes stated by the students included "I don't eat as much junk food." and "I eat more veggies and fruit than I used to." We anticipate requests for CATCH Kids to increase in the second year of our funding.

TRPHD is working with Dr. Matthew R. Bice of University of Nebraska at Kearney on the following project: IRB Number: 062514-2. Project Title: Innovation Perceptions & Motivation to Implement a Coordinated School Health Program in Rural Nebraska. The overall goal of the project is the evaluation and implementation of the CATCH Kids Afterschool program in rural Nebraska Communities. CATCH Kids Program Coordinator for Two Rivers Public Health Department oversees 10 schools implementing the program. Dr. Bice and TRPHD are working together to unify all the CATCH Projects around the state to improve program fidelity, provide training for instructors, integrating audience participation software for evaluation, and offering technical assistance.

We are also utilizing the funds to develop a worksite health screening program that will serve companies and groups in our area, especially those that are agriculturally related and do not have access to these services at this time.

West Central District Health Department (WCDHD)

The prevention funds were used to purchase a case management system which was designed specifically to meet the needs of our departments related to prevention programs and services both internally and externally. The system helps collect data on clients who are seeking services within our district. Referral management is a significant component of the system and allows WCDHD to network with other agencies to connect clients to services within our department and with outside agencies for their preventative needs.

Referrals have included clients seeking medical care, dental care, mental health, rent/utilities, substandard housing concerns and food pantries. The system will also track preventative measures related to Minority Health Initiative (MHI) by tracking blood pressure, height, weight, BMI, cholesterol level, and blood glucose. This information is compared to the baseline information that was collected when they joined the Minority Health Initiative.

Prevention funding also covered expenses related to the WCDHD Tooth Tour providing preventive dental services to school aged children within our district who may otherwise have gone without care. The system will be beneficial in the years to come for the dental team, as a data tracking system was built in to monitor the incidence of decay, and track that treatment is being competed.

Healthy Communities efforts benefited from the prevention funding providing schools with materials and supplies that addressed childhood obesity rates, including evidence based PE curriculum for Sutherland Elementary.