Community Health Improvement Plan Annual Report 2023

South Heartland District Health Department

March, 2024

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2019-2021 PRIORITY HEALTH AREAS OF HOSPITALS IN THE SOUTH HEARTLAND DISTRICT.

Mary Lanning Healthcare, Hastings	www.marylanning.org
Brodstone Memorial Hospital, Superior	www.bodstonehospital.org

March, 2023

Purpose

This is the 2023 annual report for the 2019-2024 South Heartland District Health Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a "long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process."

A CHIP is designed to:

- Set community health priorities
- Coordinate and target resources needed to impact community health priorities
- Develop policies
- Define actions to target efforts that promote health
- Define the vision for the health of the community
- Address the strengths, weaknesses, challenges, and opportunities that exist in the community related to improving the health status of the community

This document serves as a progress review on the strategies that were developed in the 2019-2024 CHIP and activities that have been implemented. This document also refers to the Community Health Needs Assessment, CHA, 2018 and interim CHA, 2021. Both documents can be found on the SHDHD website:

www.southheartlandhealth.ne.gov

The CHIP is a community driven and collectively owned health improvement plan. South Heartland District Health Department provides administrative support, data tracking and collecting, and preparation of the annual report.

Five priority steering committees meet twice a year to review data, progress and needs for strategy revisions, removal or additions. These committees' leaders and members are from the district's communities, with one or two SHDHD staff assigned for support.

For more information on the CHIP or the annual CHIP report, please contact:

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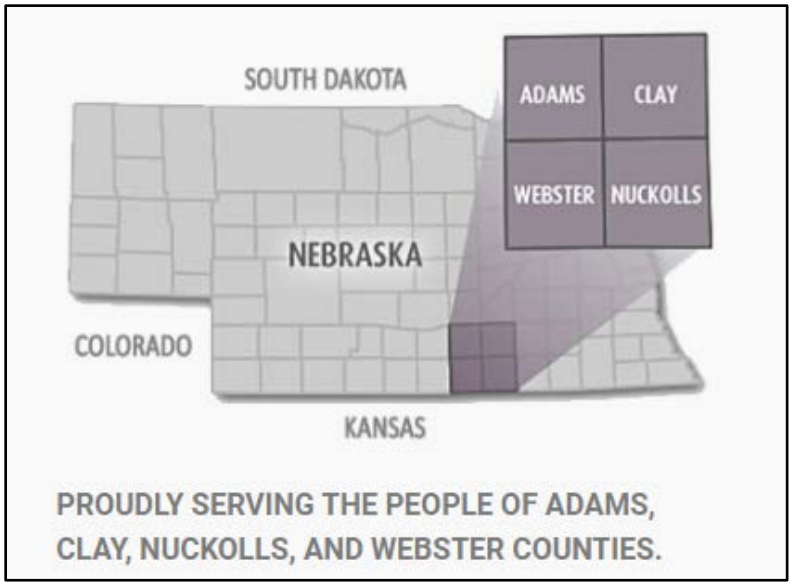
South Heartland District Health Department Overview



Population: 44,815

Area: 2,286 square miles

Mission: **T**he South Heartland District Health Department is dedicated to preserving and improving the health of residents of Adams, Clay, Nuckolls and Webster counties. We work with local partners to develop and implement a Community Health Improvement Plan and to provide other public health services mandated by Nebraska state statutes.

Vision: Healthy people in healthy communities

Guiding Principles:

We are committed to the principles of public health and strive to be a credible, collaborative and stable resource in our communities.

We seek to perform our duties in a courteous, efficient and effective manner within the limits of sound fiscal responsibility.

We work together to create a positive environment, listening carefully and treating everyone with honesty, sensitivity, and respect.

2023 Summary

- The 5 priority steering committees met in April and October via zoom.
- The process set up for the implementation of the 2019-2024 CHIP continues to be supported by community and partner leads and members.
- Each committee is supported by SHDHD backbone staff who organize meeting data, agendas, minutes and logistics and also track progress in the CHIP performance dashboard and annual CHIP report.
- The 2024 CHA work has begun for the 2025-2030 CHIP, making this the last year of the current CHIP (2 more meetings for each committee). During the October, 2023 meeting, each committee chose 1 or 2 KPIs or other task(s) to focus on to work toward completion in 2024. (See the text box at the top of each priority stoplight progress list.)

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

CONNECTING PEOPLE & RESOURCES
ADAMS CLAY 4 WEBSTER NUCKOLLS
STRONG & HEALTHY COMMUNITIES

Community Health Priorities 2019-2024

Access to Health Care

Goal 1: Access to Health Care

Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Goal 2: Mental Health

Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Goal 3: Substance Misuse

Reduce substance misuse/risky use to protect the health, safety and quality of life for all.

Goal 4: Obesity & Related Health Conditions

Reduce obesity and related health conditions through prevention and chronic disease management

Goal 5: Cancer

Reduce the number of new cancer cases as well as illness, disability and death caused by cancer

South Heartland Community Health Improvement Plan
Priority Goals, Strategies and Objectives
2019-2024

In the following pages, we present the five priority goals with results of the community strategy-planning process for each, including a process snapshot, line-of-sight performance measures and targets, the strategies and the six-year objectives. Key performance measures, data sources, evidence base, strategy implementation "settings" and lead organizations are included for each objective, along with considerations, examples, potential partners and other guidance for implementation.

Summary of all objectives by priority:

- **Priority Goal 1. Access to Care, 6-Year Objectives:**
    - **1a**: Expand access to primary care, oral health and behavioral health services by securing a satellite Federally Qualified Health Center (FQHC) in Hastings
    - **1b**: Improve access to substance misuse/behavioral health acute care services by assessing medically-assisted detox and related services
    - **1c**: Improve access to care by expanding transportation options
    - **1d**: Improve access through empowering people with knowledge to obtain and utilize insurance options
    - **1e**: Improve access through professional or lay workers trained in patient navigation, coaching and advocacy
    - **1f**: Improve access to care through adoption of evidence-based practices that strengthen communication and understanding of health information
    - **1g**: Improve access by increasing awareness and understanding of factors that contribute to disparities
    - **1h**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services
- **Priority Goal 2. Mental Health, 6-Year Objectives:**
    - **2a**: Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral
    - **2b**: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education
    - **2c**: Improve MH/SM services through advocacy initiatives and policy change
    - **2d**: Expand mental health services through adoption of evidence-based technology
    - **2e**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services

- **Priority Goal 3. Substance Misuse, 6-Year Objectives:**

    - **3a**: Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral
    - **3b**: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education
    - **3c**: Improve MH/SM services through advocacy initiatives and policy change
    - **3d**: Explore expansion of teen drug court program into Clay, Nuckolls and Webster Counties
    - **3e**: Reduce inappropriate access to prescription drugs through proper disposal of unused, expired medications and best practice prescribing protocols
    - **3f**: Expand and improve the Resource Guide to integrate and promote local substance misuse resources

- **Priority Goal 4. Obesity and Related Health Conditions, 6-Year Objectives:**

    - **4a**: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity or weight at their child or adolescent patient visits
    - **4b**: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity, weight or chronic disease management at their adult patient visits
    - **4c**: Increase the number of provider offices who utilize/promote electronic methods for patient-provider bidirectional communication about chronic disease prevention and management
    - **4d**: Increase the number of provider offices who utilize/promote electronic health records (EHR) for improving patient outcomes around chronic disease prevention and management
    - **4e**: Increase the proportion of children/adolescents and adults who meet current federal physical activity guidelines for aerobic physical activity and muscle strengthening physical activity
    - **4f**: Increase the proportion of children/adolescents and adults who meet current CDC nutrition recommendations for food and beverage consumption
    - **4g**: Increase the number of physical/environmental changes throughout the communities to make it easy to be physically active
    - **4h**: Improve the environment and culture that promote/support healthy food and beverage choices
    - **4i**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services

- **Priority Goal 5. Cancer, 6-Year Objectives:**

    - **5a**: Increase the proportion of patients assessed by providers and who are aware and counseled on their cancer risk factors
    - **5b**: Implement consistent messaging on cancer risk factors and empower individuals to make healthy choices
    - **5c**: Increase the number of individuals up to date on recommended cancer screenings
    - **5d**: Increase the access to cancer screening, diagnosis and treatment
    - **5e**: Conduct an investigation on types and prevalence of other cancers and associated risk factors in our communities
    - **5f**: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services

Priority Goal: Access to Health Care

Goal 1: Improve access to comprehensive, quality health care services by addressing identified gaps in services and barriers to accessing care.

Process Snapshot:

Assuring access to quality health care is an essential public health service. Through the 2018 community health assessment, South Heartland made a deliberate effort to evaluate gaps in services and barriers to accessing care. To address access to care concerns, the CHIP strategies, objectives and key performance indicators will address the barriers and gaps identified by health system users, community leaders and providers. Top identified barriers included cost, affordability, insurance/reimbursement, transportation and education/awareness. Top identified gaps included mental health practitioners, substance abuse prevention and treatment services, school-based health services, specialty services, emergency services and chronic disease management. These barriers and gaps are addressed through strategies that expand services, address transportation needs and insurance coverage, provide system navigation and support, promote evidence-based practices, address disparities, and connect people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.
Source- *BRFSS, 2016* (adults, >18 years)

- Increase the proportion of persons with a personal doctor or health care provider.
  Baseline: 83.5% (State 80.9%)
  Target: 84.0%
- Increase the proportion of persons who report visiting the doctor for a routine exam in the past year.
  Baseline: 67.0% (State 64.1%)
  Target: 71.0%
- Decrease the proportion of persons aged 18 – 64 years without healthcare coverage.
  Baseline: 13.9% (State 14.7%)
  Target: 13.0%
- Decrease the proportion of persons reporting cost as a barrier to visiting a doctor in the past year.
  Baseline: 11.4% (State 12.1%)
  Target: 10.7%
- Increase the proportion of persons who report visiting a dentist for any reason in the past year.
  Baseline: 64.7% (State 68.7%)
  Target: 68.5%

Update as of 1/16/2023

Color Code: Complete- Green
In progress- Yellow
Not started- Red

CHIP Implementation Progress: Access to Care (ATC)

2024 Focus:
Improve access to care by expanding transportation options.
Improve access by increasing awareness and understanding of factors that contribute to disparities.

2023 Access to Care Health Steering Committee Outcomes	0 strategy was deleted
	0 strategy was added
	0 strategies modified
	8 key performance activities completed
	13 key performance activities completed in progress
	3 key performance activities with no progress

Status	Strategy	6 Year objective	Update
	Increase ATC through Expanded Services	**1A:** Expand access to primary care, oral health and behavioral health services by securing a satellite Federally Qualified Health Center (FQHC) in Hastings.	The Heartland Health Center FQHC in Grand Island has approved a satellite clinic in Hastings. Space is secured to complete the set-up of the satellite clinic and will be looking at implementing dental and mental health first.
		1B: Improve access to substance misuse/behavioral health acute care services by assessing medically-assisted detox and related services.	The SH Rural BH Network assessed current SM/BH resources and gaps. South Central provided an executive summary of CCBHC assessment, confirming barriers to care and staffing shortages and needs. Since October, Revive, Inc., began exploring the feasibility of a detox center in Hastings.
	ATC through Transportation	**1C:** Improve access to care by expanding transportation options.	City of Hastings is working on a Strategic Plan – opportunity to bring up transportation. EMS/ United Way and Midlands Area Agency on Aging working collaboratively to address transportation concerns in Hastings in the interim.
	ATC through Insurance Coverage	**1D**: Improve access through empowering people with knowledge to obtain and utilize insurance options.	Local partners host Medicaid enrollment event. SHDHD and MAAA have trained application assisters.
	ATC through system of navigation and support	**1E:** Improve access through professional or lay workers trained in patient navigation, coaching and advocacy.	Navigators, Community Health Workers (CHWs) and Community Impact Network (CIN) are in place. CHW system development in progress- working with CCC on pathways program for CHWs, SHDHD has 4 community health workers, MAAA staff is completing UNMC CHW training.

		1F: Improve access to care through adoption of evidence-based practices that strengthen communication and understanding of health information.	Work is in progress. Mary Lanning has expanded portal use with patients. SHDHD is working to understand how well we communicated with non-English (Spanish) speaking residents during the pandemic and how we can improve risk communication with minority communities. SHDHD shared a toolkit for health literacy with local health care providers.
		IG: Improve access to care by increasing awareness and understanding of factors that contribute to disparities	Bridging Forward (reducing poverty by 30% by 2030) is launched, cohort of 8 individuals (with 36 kids) meeting for coaching, budgeting, meals; start meeting every week, then every other week; have "allies" for each. SHDHD continues to support minority health advisory group- meeting every other month and hosting 6 educational events annually.
	Connecting people/organizations through access to resources.	**1H:** Expand and improve the Resource Guide to integrate and promote local resources for accessing health care and health services-understanding of health information.	UniteUs platform expanding in pilot projects in our area; United Way's 211 is also expanding in resources and specifically for certain needs (e.g., elderly). All five CHIP priorities will be included.

Priority Goal: Mental Health

Goal 2: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services

Process Snapshot:

In the Community Themes and Strengths survey, residents identified mental health as the second most troubling health issue in South Heartland communities. The health status assessment data supported this concern. For example, 28% of 9th-12th grade students in South Heartland indicated they were depressed in the past 12 months, 18.7% considered suicide and 13.2% attempted suicide. The Nebraska suicide rate for 10-24 year olds exceeds the national rates. Among South Heartland adults with mental illness, only 47% report receiving treatment and only 43% of adolescents reporting depression received treatment. Strategies, objectives and key performance indicators were developed to address this priority, utilizing broad strategic approaches that focus efforts on the health system, community-based prevention, resources, and policy/environmental changes. The specific strategies are applying evidence-based primary and secondary prevention in the provider and community settings, addressing mental health services through advocacy and policy efforts, expanding and promoting evidenced-based technology that supports access to quality mental health services, and by connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.
Source- *BRFSS, 2016* (adults, >18 years) / *YRBSS (Grades 9-12) SHDHD-2016, State-2017*

Youth

- Reduce the proportion of youth reporting feeling sad or hopeless almost every day for two weeks or more in a row causing abandonment of usual activities.
  Baseline: 27.9% (State 27.0%)
  Target: 26.2%
- Reduce reported suicide attempts by high school students during the past year.
  Baseline: 13.2% (State 8.0%)
  Target: 12.4%

Adults

- Reduce the proportion of adults who reported ever being diagnosed with depression
  Baseline: 20.5% (State 17.8%)
  Target: 19.3%
- Reduce the proportion of adults reporting frequent mental distress in the last 30 days
  Baseline: 9.2% (State 9.5%)
  Target: 8.7%

Update as of 1/16/2023

Color Code: Complete- Green
In progress- Yellow
Not started- Red

CHIP Implementation Progress: Mental Health Strategies

2024 Focus:
Rebasing in patient rates, and rates overall.
Screening tools/assessment and promotion.
Lay community skills to help fill the gaps with provider shortages.

2023 Mental Health Steering Committee Outcomes	0 strategy was deleted
	0 strategies modified
	5 key performance activities completed
	14 key performance activities completed in progress
	2 key performance activities completed no progress

Status	Strategy	6 Year objective	Update
	Primary and secondary prevention in the provider and community settings	**2A:** Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral.	Brodstone and Mary Lanning have screeners, with referrals built into E.H.R, data for hospitals and clinics associated w/ hospitals. Nebraska Department of Education is offering comprehensive mental health grant to schools, most schools have LMHP engaged in this process.
		2B: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education.	Local taskforce met throughout the year, working collaboratively to address training gaps, learning from each other and networking to ensure training gaps are addressed.
	Mental health and substance use services through advocacy and policy	**2C:** Improve MH/SM services through advocacy initiatives and policy change.	Coordinator has been identified to lead the advocacy group, and shared several bills with CHIP committee- how to advocate and status of bills.
	Mental Health services through evidenced based technology	**2D**: Expand mental health services through adoption of evidence-based technology.	Provider assessment was completed to identify current telehealth utilization and desired state.
	Connecting people/organizations through access to resources.	**2E:** Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services.	UniteUs platform expanding in pilot projects in our area; United Way's 211 is also expanding in resources and specifically for certain needs (e.g., elderly). All five CHIP priorities will be included.

Priority Goal: Substance Misuse

Goal 3: Reduce substance misuse / risky use to protect the health, safety and quality of life for all.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified substance misuse as the third most troubling health issue in South Heartland communities. The South Heartland health status assessment showed that in the past 30 days 18% of adults used cigarettes and 15% reported binging drinking. For high school students, 11% reported using cigarettes, 15% used electronic vaper devices, 24% used alcohol, 11% used marijuana and 11% had misused or abused prescription drugs in the past 30 days. The societal costs of substance abuse in disease, premature death, lost productivity, theft and violence, including unwanted and unplanned sex, as well as the cost of interdiction, law enforcement, prosecution, incarceration, and probation are greater than the value of the sales of these addictive substances, costing over $135 billion (Substance Abuse: facing the Costs; Issue Brief Number 1 August 2001). Strategies, objectives and key performance indicators were developed to address this priority, utilizing strategies focused on the health system, community-based prevention initiatives, resources, and policy/environmental changes. Strategies will address substance misuse through primary and secondary prevention in the provider and community settings, advocating for substance use prevention and treatment services through policy and system changes, expanding diversion services, reducing inappropriate access to prescription drugs in community and provider settings, and by connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Based on standards set by Healthy People 2020, targets were set to achieve a 6% improvement over the next 6 years.

Source- *YRBSS (Grades 9-12) SHDHD-2016, State-2017, BRFSS, 2016* (adults, >18 years)

Youth:

- Decrease alcohol use, past 30 days among high school students.
  Baseline: 23.9% (24.4% State)
  Target: 22.5%
- Reduce marijuana use, past 30 days among high school students.
  Baseline: 11.3% (13.4% State)
  Target: 10.6%
- Decrease misuse or abuse, (lifetime) of prescription drugs among high school students.
  Baseline: 11.1% (14.3% State)
  Target: 10.4%
- Reduce cigarettes use, past 30 days among high school students.
  Baseline: 11.3% (10.7% State)
  Target: 10.6%
- Reduce electronic vapor product (e-cigarettes) use, past 30 days among high school students.
  Baseline: 15.4% (9.4% State)

Target: 14.5%

Adult:

- Reduce binge drinking among adults (18+), past 30 days.
  Baseline: 14.8% (20.0% State)
  Target: 13.9%
- Increase the percentage of current smokers who reportedly attempted to quit smoking in the past year.
  Baseline: 59.8% (54.6% State)
  Target: 56.3%
- Reduce current cigarette smoking among adults.
  Baseline: 18.0% (17.0% State)
  Target: 16.9%
- Reduce opioid prescription medication abuse, (adults reporting ever used outside of prescription guidelines).
  Baseline: TBD – new question BRFSS 2018
  Target: TBD

Update as of 1/16/2023

Color Code: Complete- Green
In progress- Yellow
Not started- Red

CHIP Implementation Progress: Substance Misuse Prevention Strategies

2023 Substance Misuse Steering Committee Outcomes	0 strategy was deleted
	0 strategies modified
	7 key performance activities completed
	17 key performance activities completed in progress
	2 key performance activities completed no progress

2024 Focus:
Increase client connections to MH/SM services through evidence-based screening/assessment across the lifespan to facilitate referral

Status	Strategy	6 Year objective	Update
	Primary and secondary prevention in the provider and community settings	**3A:** Increase client connections to MH/SM Services through EB screening/assessment across the lifespan to facilitate referral.	2 Pilot projects were completed in small rural clinics, successes and barriers were shared with the committee. ML ER – depression/suicide primarily 12yrs+ (Columbia, for self-harm), but also tobacco/alcohol use screening to help with determining best treatment. ML ER is getting equipment to screen for synthetic opioids.
		3B: Increase professional workforce and lay/community skills in MH/SM interventions through evidence-based training and general awareness education.	Local taskforce met throughout the year, working collaboratively to address training gaps, learning from each other and networking to ensure training gaps are addressed. SHDHD, ACSO providing Naloxone education/awareness and placement.
	Mental health and substance use services through advocacy and policy	**3C:** Improve MH/SM services through advocacy initiatives and policy change.	Coordinator has been identified to lead the advocacy group, and shared several bills with CHIP committee- how to advocate and status of bills.
	Tertiary prevention through diversion services	**3D**: Explore expansion of teen drug court program into Clay, Nuckolls and Webster Counties.	CASA continues to facilitate a comprehensive Teen Diversion program (all 4 counties), with all components of Teen Court, except the peer-to-peer piece. Continuing to have local conversations to incorporate peer to peer learning. Discussed the need for mental health/drug treatment navigators to help families make the connections and follow through as needed

	Primary prevention through reduction of inappropriate access to prescription drugs in community and provider settings	**3E**: Reduce inappropriate access to prescription drugs through proper disposal of unused, expired medications and best practice prescribing protocols.	April '23 Drug Take Back was successful across the 4 counties. Discussed expansion of takeback and how to involve villages and other SOs not currently involved. ML continues quarterly Opioid Stewardship Team meetings, distributed updated brochures to clinics, and provided continuing education to Medical Staff on NE's PDMP. Gap Analysis: Completed. Plan formulation and implementation is in progress with two area hospitals driving the local work. PDMP training for small clinics is being developed.
	Connecting people/organizations through access to resources.	**3F:** Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services.	UniteUs platform expanding in pilot projects in our area; United Way's 211 is also expanding in resources and specifically for certain needs (e.g., elderly). All five CHIP priorities will be included. Additionally, developed a Substance Misuse resource card.

Priority Goal: Obesity

Goal 4: Reduce obesity and related health conditions through prevention and chronic disease management.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified obesity as the top most troubling health issue in South Heartland communities. Nationally, $1.42 trillion can be attributed to the total costs associated with obesity (Milken Institutes, Weighing America Down, The Health and Economic Impact of Obesity, November 2016). SHDHD's health status assessment demonstrated that 32.5% of youth grades 9-12 are overweight or obese (BMI ≥ 21, YRBS, 2016), while 70% of adults 18 years+ are overweight or obese (BMI ≥ 25, BRFSS, 2016). In addition, community members are concerned about obesity-associated chronic diseases such as heart disease, which is the leading cause of death in South Heartland adults, and diabetes. Stakeholder discussion during strategy meetings highlighted a shared desire to intervene using primary prevention, especially focused on young children. Strategies, objectives and key performance indicators were developed to address this priority by focusing on the health system, community-based prevention, access to resources and information, and policy and environmental changes. Identified strategies include primary and secondary prevention in clinic settings, evidence-based health/wellness programs to increase physical activity and healthy food and beverage consumption in schools and communities, primary prevention (environmental changes) in community settings to support active living and healthy food and beverage consumption, and connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020.
Source- *BRFSS, 2016* (adults, >18 years) / *YRBSS (Grades 9-12) SHDHD-2016, State-2017*

- Reduce overweight / obesity among high school students
  Baseline: Overweight / Obese youth: 32.5% (State, 31.2%)
  Targets: Overweight or Obese 30.55%
- Decrease overweight or obesity among adults, 18 years+ (BMI > 25.0)
  Baseline: 70.0% (State, 68.5%)
  Target: 65.8%
- Decrease diabetes in adults
  Baseline: 10.6% (State, 8.8%)
  Target: 9.0%
- Decrease high blood pressure (hypertension) in adults
  Baseline: 34.6% (State, 29.9%)
  Target: 32.5%
- Decrease heart disease in adults
  Baseline: 5.8% (State, 3.8%)
  Target: 5.4%

Update as of 1/16/2023

Color Code: Complete- Green
In progress- Yellow
Not started- Red

CHIP Implementation Progress: Obesity and Related Health Conditions Strategies

2023 Obesity Steering Committee Outcomes	0 strategy was deleted
	0 strategies modified
	1 key performance activities completed
	14 key performance activities completed in progress
	8 key performance activities completed no progress

2024 Focus:
Repeat survey to assess the number of provider offices who utilize electronic methods for patient-provider bi-directional communication about chronic disease prevention and management.

Status	Strategy	6 Year objective	Update
	Primary prevention in the clinic setting	**4A:** Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity or weight at their child or adolescent patient visits.	Obesity Steering Committee, no specific task force established, using the data collected in 2022, one clinic piloted a referral process using Unite Us for obesity related programs. Group discussed the need to reassess the clinic processes. The Hastings community developed a diabetes coalition with two areas of focus- clinic screening, education and referral and community supports. The Building Healthy Families pilot program, a family-based health education program, was not successful in Hastings- providers continued to refer, but no families enrolled.
		4B: Increase the number of providers who include at least one assessment, education, and/or counseling related to nutrition, physical activity, weight or chronic disease management at their adult patient visits.	
		4C: Increase the number of provider offices who utilize/promote electronic methods for patient-provider bidirectional communication about chronic disease prevention and management.	
		4D: Increase the number of provider offices who utilize/promote electronic health records (EHR) for improving patient outcomes around chronic disease prevention and management.	
	Evidence based health/wellness programs to increase	**4E**: Increase the proportion of children/adolescents and adults who meet current federal physical	Schools with a wellness policy that includes PA and nutrition guidelines, is 100%. Daycares and afterschool

	physical activity in schools & communities	activity guidelines for aerobic physical activity and muscle strengthening physical activity.	programs continue to improve their implementation of PA/nutrition guidelines. Continue to explore how to engage worksite policies for adult health/wellness programs.
		4F: Increase the proportion of children/adolescents and adults who meet current CDC nutrition recommendations for food and beverage consumption.	
	Primary Prevention in the Community Setting	**4G:** Increase the number of physical/environmental changes throughout the communities to make it easy to be physically active.	Steering committee members are reporting on initiatives/actions to improve PA opportunities in communities across the district. Assessment of area efforts to improve physical and environmental changes that promote physical activity and healthy food and beverages (i.e., what communities are planning and implementing), is being revised due to low response rates in 2022.
		4H: Improve the environment and culture that promote/support healthy food and beverage choices.	
	Connecting people/organizations through access to resources	**4I:** Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services.	UniteUs platform expanding in pilot projects in our area; United Way's 211 is also expanding in resources and specifically for certain needs (e.g., elderly). All five CHIP priorities will be included. Additionally, a health hub was developed for the Hastings community.

Priority Goal: Cancer

Goal 5: Reduce the number of new cancer cases as well as illness, disability, and death caused by cancer.

Process Snapshot:

In the Community Themes and Strengths survey, residents identified cancer as the fourth most troubling health issue in South Heartland communities. Cancers are the second leading cause of death in the health district (five-year period, 2012-2016). Estimates suggest that less than 30% of a person's lifetime risk of getting cancer results from uncontrollable factors (e.g., family history, gender). The remaining 70% risk can be modified by lifestyle change, including diet (Harvard Medical School, Sept, 2016). Strategies, objectives and key performance indicators were developed to address this priority, utilizing strategies focused on health system and community-based settings, access to resources and information, and policy and environmental changes. Cancer prevention strategies include primary and secondary prevention in provider settings, secondary prevention in the community setting, prevention through referral and barrier reduction, research on local cancer risks, and connecting people and organizations to resources and information.

Line of Sight Performance Measures and Targets

Local targets were set to achieve a 6% improvement over the next 6 years, consistent with the target of 10% change over 10 years set by Healthy People 2020. Incidence/Mortality**:** Rates based on 100,000 population. Source - *Nebraska Cancer Registry, 2011-2015*

- Reduce incidence / mortality rates due to Female Breast Cancer
  Baseline: 131.6 (State 124.1) / 22.8 (State 19.9)
  Target: 123.7 / 21.4
- Reduce the incidence / mortality rates due to Colorectal Cancer
  Baseline: 42.6 (State 43.0) / 16.3 (State 15.7)
  Target: 40.0 / 15.33
- Reduce incidence / mortality rates due to Prostate Cancer
  Baseline: 117.1 (State 114.4) / 18.8 (State 20.2)
  Target: 110.1 / 16.9
- Reduce incidence / mortality rates due to Skin Cancer
  Baseline: 29.0 (State 22.1) / 5.6 (State 3.0)
  Targets: 27.3 / 5.3
- Reduce incidence / mortality rates due to Lung Cancer
  Baseline: 63.3 (State 58.7) / 43.9 (State 41.8)
  Target: 59.5 / 41.3

Update as of 1/16/2023

Color Code: Complete- Green
In progress- Yellow
Not started- Red

CHIP Implementation Progress: Cancer Strategies

2023 Cancer Steering Committee Outcomes	0 strategy was deleted
	0 strategies modified
	4 key performance activities completed
	8 key performance activities completed in progress
	0 key performance activities completed no progress

2024 Focus:

- Implement consistent messaging on cancer risk factors and empower individuals to make healthy choices.
- Increase the number of individuals up to date on recommended cancer screenings.
- Increase the access to cancer screening, diagnosis, and treatment.
- Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services.

Status	Strategy	6 Year objective	Update
	Primary prevention in the clinic setting	**5A:** Increase the proportion of patients assessed by providers and who are aware and counseled on their cancer risk factors.	Current cancer screening practices have been assessed in all area clinics, with improvements seen in 2 clinics. Continue to work with clinics on assessment processes. Working on checking in process to see how work has progressed. Seven out of 9 clinics surveyed, reported EHR to track cancer screening for breast, colorectal and cervical cancers.
		5B: Implement consistent messaging on cancer risk factors and empower individuals to make healthy choices.	Comprehensive plan has been developed. Education materials on cancer are provided to clinics on a bi-annual basis (2 times per year). American Cancer Society resource sheet including ages for recommended screening and recommended tests. (able to co-brand for distribution at health events)
	Secondary prevention in the community and clinical setting	**5C:** Increase the number of individuals up to date on recommended cancer screenings.	In progress: 4 cancer screening practices promoted to improve screening rates. Improvements seen in 2 clinics using reminder recall practices. Comprehensive screening assessment tool was piloted. Working on checking in process to see how work as progressed. Contact made with Melissa Leypoldt, DHHS, for data shared during the October NE CA Registry Advisory Committee Meeting.

	Prevention through referral and barrier reduction	**5D**: Increase the access to cancer screening, diagnosis and treatment.	All clinics interested in cancer education materials have been provided information. Guidance document of how and when to place materials in clinics is being developed. Developing/writing for funding to support preventive breast screening for underserved women. Promotion of Breast CA screening through EWM CIP project
	Research on Cancer Risks	**5E**: Conduct an investigation on types and prevalence of other cancers and associated risk factors in our communities.	Report was completed. Committee continues to review cancer data to determine the local needs/gaps. SHDHD contacted Dr. Jesse Bell (UNMC) to discuss potential collaboration on project to correlate exposures with cancer incidence.
	Connecting people/organizations through access to resources.	**5F:** Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services.	United Way has expanding/utilizing the 211 platform, updating the resources within the platform and doing all the promotion for Adams, Clay, Nuckolls and Webster. All five CHIP priorities will be included; obesity and cancer to be expanded. Additionally, began exploring UniteUs as a referral platform between health care, service organizations and nonprofits. Prepare for implementation of required SDOH for hospitals.