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%

Priority Area 4: Obesity and Related Conditions			
Strategy 4a: Primary prevention in the clinic setting			
<u>6 Year objective</u>: 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			
What will be measured: • The number of primary care physicians who regularly assess body mass index (BMI) for age and sex in their child or adolescent patients • The proportion of visits made by all child or adolescent patients that include counseling about nutrition or diet or physical activity	**Baseline/Target:** TBD	**Data Source:** • Primary data collected from local provider offices	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • Child or adolescent patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Healthcare (Primary Care Providers)
Evidence Based: Healthy People 2020 - NWS 5.2 & 6.3; PA 11.2		**Accountability:** Obesity Steering Committee	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Determine the number of providers with knowledge, attitudes and beliefs supporting obesity interventions.	• Increase the number of providers with knowledge, attitudes and beliefs that support obesity intervention. • Increase the number of providers with policies/protocols for child or adolescent obesity interventions.	• Number of child or adolescent patients who have access to providers with policies/protocols for obesity intervention.

Priority Area 4: Obesity and Related Conditions			
Strategy 4b: Primary and secondary prevention in the clinic setting			
6 Year objective: 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			
What will be measured: • The number of primary care physicians who regularly assess body mass index (BMI) for age and sex in their adult patients • The proportion of physician visits made by all adult patients that include counseling about nutrition, physical activity, weight and/or chronic disease management.	**Baseline/Target:** TBD	**Data Source:** • Primary data collected from provider offices locally	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention	**Population:** • Adult patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Healthcare (Primary Care Providers)
Evidence Based: USPSTF, Healthy People 2020 – NWS 5.1 and 6.1, 6.2, 6.3; D16; PA 11.1		**Accountability:** Obesity Steering Committee	
Short Term Key Performance Indicators (KPIs): • Determine the number of providers with knowledge, attitudes and beliefs supporting obesity interventions. • Determine the number of providers who refer to community based programs for chronic disease prevention or management. • Determine the number of providers utilizing chronic care management.	**Intermediate Term KPIs:** • Increase the number of providers with knowledge, attitudes and beliefs that support obesity intervention. • Increase the number of providers who refer to community based programs for chronic disease prevention or management. • Increase the number of providers utilizing chronic care management.	**Long Term KPIs:** • Number of adult patients who have access to providers with policies/protocols for obesity intervention. • Number of patients enrolled in community based programs for chronic disease prevention or management. • Number of patients enrolled in chronic care management. (and/or the number of patients completing 1 year).	
Examples of evidence based Lifestyle Change Programs to build/expand/promote: Smart Moves-National Diabetes Prevention Program, Living Well, Health Coaching/Chronic Disease Management, YMCA Blood Pressure Self Monitored Program, obesity interventions (cooking classes/culinary art program partnership), etc.			

Priority Area 4: Obesity and Related Conditions			
Strategy 4c: Primary and secondary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the number of provider offices who utilize/promote electronic methods for patient-provider bidirectional communication about chronic disease prevention and management			
What will be measured: • Number of patients who utilize electronic methods for provider communication about chronic disease prevention and management	**Baseline/Target:** TBD	**Data Source:** • Primary Data Collected from Provider offices locally	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention	**Population:** • Adults patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Clinics • Brodstone/Superior Family Med. • Webster County Clinic
Evidence Based: The community guide- what works, health communication and health information technology (CPSTF) – reduce/maintain weight loss, PA-11.1		**Accountability:** Access to Care and Obesity Steering Committees	
Short Term Key Performance Indicators (KPIs): • The number of practices that utilize any method of electronic communications with their patients.	**Intermediate Term KPIs:** • Increase the number of practices that utilize any method of electronic communications with their patients.	**Long Term KPIs:** • The number of practices that utilize any method of electronic communications with their patients. • The number of patients who have access to any method of electronic communications with their provider.	
Examples: Medication adherence, outpatient follow-up, and adherence to self-management goals. "mHealth" interventions use mobile-phones, smartphones, or other hand-held devices to deliver content. Interventions must include one or more of the following: text-messages that provide information/encouragement for treatment adherence; text-message reminders for medications, appointments, or treatment goals; web-based content that can be viewed on mobile devices; or applications (apps) developed or selected for the intervention with goal-setting, reminder functions, or both. Interventions also may include an interactive component, mobile communication or direct contact with a healthcare provider, or web-based content to supplement text-message interventions **Considerations:** Relationship of low health literacy to portal barriers and use			

Priority Area 4: Obesity and Related Conditions			
Strategy 4d: Primary and secondary prevention in the clinic setting			
<u>6 Year objective</u>: Increase the number of provider offices who utilize/promote electronic health records (EHR) for improving patient outcomes around chronic disease prevention and management			
What will be measured: • The number of patients who have access to health systems utilizing EHR functions for chronic disease prevention and management	**Baseline/Target:** TBD	**Data Source:** • Primary Data Collected from Provider offices locally	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention • Secondary Prevention	**Population:** • Adults patients	**Setting:** • Provider Offices	**Lead Organizations:** • ML Clinics • Brodstone/Superior Family Med. • Webster County Clinic
Evidence Based: Community Guide – Health IT: CVD digital intervention self-monitor BP, Diabetes Apps for self-management, text med adherence PA-10		**Accountability:** Access to Care and Obesity Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• The number of practices that utilize EHR functions for their patients around chronic disease prevention and management.	• Increase the number of practices that utilize EHR functions for their patients around chronic disease prevention and management. • Increase number of practices with policies/protocols/ processes in place that utilize EHR functions for their patients around chronic disease prevention and management.	• The number of practices that utilize EHR functions for their patients around chronic disease prevention and management. • The number of practices with policies/protocols/ processes in place that utilize EHR functions for their patients around chronic disease prevention and management.

Examples: Diabetes Protocol, Pre-diabetes Protocol, Hypertension Protocol, Team review of dashboard data, BMI/Weight/Nutrition/Physical Activity Protocols, Cardio Vascular/Stroke Protocol
Considerations: Relationship of low health literacy to portal barriers and use

<table>
<tr><td colspan="4">Priority Area 4: Obesity and Related Conditions</td></tr>
<tr><td colspan="4">Strategy 4e: Evidence based health/wellness programs to increase physical activity in schools & communities</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the proportion of children/adolescents and adults who meet current federal physical activity guidelines for aerobic physical activity and muscle strengthening physical activity</td></tr>
<tr><td>What will be measured:
% of 9th-12th graders who are physically active at least 5 days/week for at least 60 minutes
% of 9th-12th graders who are met the muscle strengthening recommendation of at least 3 days/week
% of adults that met aerobic physical activity recommendations
% of adults that met muscle strengthening recommendations</td><td>Baseline/Target:
51.8% / 57%
53.4% / 59%
46.1% / 51%
20.9% / 23%</td><td>Data Source:
YRBSS
BFRSS
Target Setting Method:
10% improvement Health People 2020 Goals</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Primary Prevention</td><td>Population:
2-18 years old
Families
Adults</td><td>Setting:
Schools/Daycares
Communities
Faith Based
Worksites</td><td>Lead Implementation Organizations:
YMCA
YWCA
Schools/Daycares
Faith Based
HeadStart
UNL Extension
United Way</td></tr>
<tr><td colspan="2">Evidence Based: HP2020 – PA 1-7, Community Guide – Worksite Programs, built environment interventions, PA Community-Wide Interventions, Health IT (activity monitors); CHRR – community based social supports for PA, places for PA, school based physical education enhancements, worksite obesity prevention interventions</td><td colspan="2">Accountability: Obesity Steering Committees</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Number of schools or organizations that have policies supporting physical activity.
The number of 2-18 year olds served by organizations that</td><td>Intermediate Term KPIs:
Increase the number of schools or organizations that have policies supporting physical activity.
Increase the number of 2-18 year olds served by</td><td colspan="2">Long Term KPIs:
% of the total district population of 2-18 year olds who have access to schools or organizations that support physical activity through policy or programs.
The number of 2-18 year olds served by organizations that have policies supporting physical activity.</td></tr>
</table>

have policies/programs supporting physical activity guidelines. • The number of adults served by organizations that have policies/programs supporting physical activity guidelines.	organizations that have policies/programs supporting physical activity guidelines. • Increase the number of adults served by organizations that have policies/programs supporting physical activity guidelines.	• The number of adults served by organizations that have policies supporting physical activity.
Examples: walking meetings, PA breaks, before/after school PA programs, walking/stairs promotions; social supports, worksite wellness programs, worksite insurance incentives, etc. **Considerations:** Expand the data collection to include children preschool-8th grade For adults start with worksites, youth start with schools		

Priority Area 4: Obesity and Related Conditions			
Strategy 4f: Evidence based health/wellness programs to increase healthy food and beverage consumption in schools and communities			
6 Year objective: Increase the proportion of children/adolescents and adults who meet current CDC nutrition recommendations for food and beverage consumption			
What will be measured: • Median times per day an adult consumed vegetables • Median times per day an adult consumed fruits • % of students 9-12th grades who consumed green salad at least one time week • % of students 9-12th grades who did not drink soda or pop during the past 7 days (**not** including diet soda or diet pop)	**Baseline:** YRBS 2017 BRFSS • 1.67 per day / 1.77 per day • 1.02 per day / 1.08 per day • 61% / 65% • 26.2% / 28%	**Data Source:** • YRBSS • BFRSS **Target Setting Method:** • 1% per year	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • 0-18 years old • Families • Adults	**Setting:** • Schools/Daycares • Communities • Faith Based • Worksites	**Lead Organizations:** • YMCA • YWCA • Schools/Daycares • Faith Based • Head Start • UNL Extension • United Way
Evidence Based: HP2020 - NWS-2-4, 7, 12-17 Community Guide – Meal, fruit/vegetable snack interventions to increase healthier foods/beverages in schools (and sold or offered as rewards in schools); worksite programs. CHRR – School nutrition standards, school food & beverage restrictions		**Accountability:** Obesity Steering Committees	
Short Term Key Performance Indicators (KPIs): • Number of schools or organizations that have policies supporting healthy food and beverage consumption.	**Intermediate Term KPIs:** • Increase the number of schools or organizations that have policies supporting healthy food and beverage consumption. • Increase the number of 0-18 year olds served by	**Long Term KPIs:** • % of the total district population of 0-18 year olds who have access to schools or organizations that support healthy food and beverage consumption. • Increase the number of 0-18 year olds served by organizations that	

• The number of 0-18 year olds served by organizations that have policies/program supporting healthy food and beverage consumption.	organizations that have policies/program supporting healthy food and beverage consumption.	have policies/programs supporting healthy food and beverage consumption.
Examples of Education: before/after school nutrition programs (CATCH kids), cooking classes-adult or youth (4H); wellness policies, grocery stores with healthy free food/food choices, healthy meeting policies, worksite wellness programs (insurance incentives, healthy vending initiative), etc.		

<table>
<tr><td colspan="4">Priority Area 4: Obesity and Other Related Conditions</td></tr>
<tr><td colspan="4">Strategy 4g: Primary Prevention in the Community Setting</td></tr>
<tr><td colspan="4"><u>6 Year objective</u>: Increase the number of physical/environmental changes throughout the communities to make it easy to be physically active</td></tr>
<tr><td>What will be measured:
Number of communities that have access to physical activity opportunities due to physical/environmental changes</td><td>Baseline/Target:
0 changes /24 changes</td><td>Data Source:
Local Environmental Scan
Target Setting Method: From 1422 Chronic Disease Prevention program 16 changes were made from 2015-2018</td><td>Timeframe:
by 2024</td></tr>
<tr><td>Continuum of Care:
Primary Prevention / rehab</td><td>Population:
General population</td><td>Setting:
Communities
Organizations
Worksites</td><td>Lead Organizations:
Healthy Hastings
Superior Design Team
Sutton Design Team
School Wellness Teams</td></tr>
<tr><td colspan="2">Evidence Based: HP 2020 – PA 15; Community Guide - built environment interventions</td><td colspan="2">Lead workgroup: Obesity Steering Committees</td></tr>
<tr><td>Short Term Key Performance Indicators (KPIs):
Plan that will promote physical/environmental changes to improve access to physical activity in all four counties.</td><td>Intermediate Term KPIs:
Targeted community/stakeholder education on impact of the built environment on physical activity.
Model policies resource list.</td><td colspan="2">Long Term KPIs:
Number of physical/environmental changes for physical activity.</td></tr>
<tr><td colspan="4">Examples: complete streets policies, wayfinding signage, bike/walking paths, parks/green space, community centers, joint use agreements, community pools, social supports (walking groups), etc.</td></tr>
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Priority Area 4: Obesity and Other Related Conditions			
Strategy 4h: Primary Prevention in the Community Setting			
<u>6 Year objective</u>: Improve the environment and culture that promote/support healthy food and beverage choices			
What will be measured: • Number of communities that have access to healthy food and beverages choices due to new policy or environmental changes	**Baseline/Target:** TBD	**Data Source:** • Local Environmental Scan	**Timeframe:** by 2024
Continuum of Care: • Primary Prevention	**Population:** • General Population	**Setting:** • Communities • Organizations • Worksites	**Lead Organizations:** • SHDHD Nutrition Advisory Board
Evidence Based: Healthy People 2020 (NWS-4, SDOH/NWS-13)		**Lead workgroup:** Obesity Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Plan for increasing the number of organizations in all four counties that have environmental or policies that support healthy food and beverage choices.	• Targeted community/stakeholder education on impact of food policies and food environment on healthy food and beverage choices. • Model policies resource list.	• Number of environmental and policy changes supporting healthy food and beverages choices.

Examples: Policies at school/cafeterias promoting healthy eating, worksites improving their vending, grocery stores offering free fresh fruit/healthy food choices, expand Community Gardens and Farmer's Markets/Double Up Food Bucks Program, low income choices (food pantry options and culture - vouchers for fruits and vegetables, healthy recipes), etc.

Priority Area 4: Obesity and Other Related Conditions			
Strategy 4i: Connecting people/organizations through access to resources			
<u>6 Year objective</u>: Expand and improve the Resource Guide to integrate and promote local resources for accessing health care/services			
What will be measured: • Percent of users satisfied with the Resource Guide	**Baseline/Target:** N/A	**Data Source:** • Survey	**Timeframe:** by 2024
Continuum of Care: N/A **Level of Action:** Systems	**Population:** • General population; referral organizations	**Setting:** N/A	**Lead Organizations:** • Hastings Public Library
Evidence Based: CHRR – promotion of shared decision making in patient centered care & medical homes		**Lead workgroup:** Access to Care Steering Committees	

Short Term Key Performance Indicators (KPIs):	**Intermediate Term KPIs:**	**Long Term KPIs:**
• Identify work group to implement strategy (to include at least one member from each Steering Committee). • Resource gaps are identified and filled. • A platform is determined to support interactive/accessible resource and referral guide.	• Promotion/education on the improved Resource Guide.	• Resource Guide that is more interactive and accessible (i.e., websites, Apps) to people and partners. • Resource Guide Evaluation/Satisfaction Survey Report.

Potential considerations: 211 system, Network of Care, Library system, SHDHD and Partner websites, App, Task Force (MCC, Social Workers, Catholic Social Services, Salvation Army, WIC, Churches, cities/counties, etc.), include application of Culturally and Linguistically Appropriate Services (CLAS) and health literacy practices, no wrong door! MyLNK app – use as example resource

Potential resources to include in the Guide: providers (Medicaid, holistic and alternative medicine), insurance education (expanded Medicaid, Medicaid/Medicare, Commercial Insurance), services in rural areas, provider – led resources, CHW/Navigators, Chambers of Commerce