

Priority 3

Senior Health

Overview/Snapshot: SHDHD counties have a higher percentage of population 65 years and older compared to the state, especially in Nuckolls and Webster. Health of older adults (including memory loss diseases and care for older adults) was tied as the 3rd most important health issue (out of 13 health issues) among survey respondents. The following senior health themes emerged from community focus groups: limited availability of in-home care services and assisted living facilities; transportation barriers; and concerns about the high costs of in-home care services. A significantly higher percentage of SHD area adults in the 65+ age category reported being told they have one of the following chronic health conditions (compared to those in the 45-64 and 18-44 age categories): coronary artery disease, cancer, COPD, diabetes, high blood pressure. In addition, those in the 65+ age group experience more emergency department visits for falls compared to other age groups. The number of falls for this age group has increased since 2018.

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.1 Provide health insurance literacy and enrollment assistance.

Strategy SH 1.2 Improve access by filling prioritized transportation (by county & population needs) gaps.

Strategy SH 1.3 Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration.

Strategy SH 1.4 Expand Falls Prevention Programs and promote provider and community referrals, especially for high-risk individuals.

Objective SH 2: Improve socialization and physical/social support

Strategy SH 2.1 Implement community senior social centers (provide structure within every community for a viable, peer-driven engaged elder/senior social center).

Strategy SH 2.2 Implement a community-based Program to Encourage Active and Rewarding Lives (PEARLS) that encourages activity and socialization for older adults.

Measures/Data Sources*/Targets:

Percentage of adults over 45 years experiencing a fall in the past year	BRFSS	Downward trend
Percentage of adults 65+ ever told they had depression	BRFSS	Downward trend
Percentage of local survey respondents indicating that elder care support is a family support resource they need	2027 SHCHS	Downward trend (<16.5%)
Exploratory: Percentage of older adults experiencing social isolation		Downward trend

*BRFSS=Behavioral Risk Factor Surveillance System, SHCHS – South Heartland Community Health Survey

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.1 *If We*: Provide health insurance literacy and enrollment assistance...

<i>Then people will ...</i>	<i>Resulting in ...</i>	<i>And creating ...</i>
Immediate Results	Bigger Changes	End Goals
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Assess the number/location/capacities of current health insurance enrollment specialists in all 4 counties	Directory of insurance enrollment specialists trained in health insurance literacy (HIL)	Gaps in enrollment specialists filled (as identified in the assessment)
Health Insurance Literacy (HIL) training “curriculum”, decision tools, and supports for plain language communication of health insurance plan features are identified/created (with examples of interventions explaining health plan benefits, cost-sharing, etc.)	- Enrollment specialists trained in health insurance literacy (HIL) - Local Enrollment Specialist Community of Practice initiated to communicate best practices and support local collaborative efforts	Enrollment specialists and point of care navigation staff are utilizing tools and training to incorporate HIL into interventions with patients at points of health care navigation
Community organizations and stakeholders are educated on local resources for health insurance literacy	Educational events regarding health insurance literacy opportunities reach older adults in all 4 counties	More older adults with insurance self-efficacy (health insurance literacy measure)
<i>With these community partners and assets...</i>		
Hospitals, SHDHD, MAAA, United Way, Community Impact Network, primary care clinics, behavioral health providers, dental providers, Center for Consumer Information and Insurance Oversight (CCIIO); <i>Association of Health Insurance Literacy with Health Care Utilization: a Systematic Review (Yagi, BF, et al., J. Gen Intern Med 37(2):375-89; Ten Attributes of a Health Literate Organization; (HIL) Measure</i>		
<i>Potential Performance Measures:</i>		
<i>How much change did we produce? How well did we do it?</i>		<i>Is anyone better off?</i>
# of health insurance enrollment specialists per county # insurance enrollment specialist gaps identified - HIL Training Curriculum and Tool Kit # community organizations educated on HIL resources	- Improved health insurance literacy at point of health care navigation (% of pts...) # of enrollments specialists trained in health insurance literacy for medicine (goal at least 1 per county) % of trained enrollment specialists satisfied they have the skills to address health insurance literacy with patients % of patients with improved insurance self-efficacy (Health Insurance Literacy Measure)	- Increased usage of primary care and other preventive services - Reduced ER utilization for non-emergency - Increased medication adherence % patients up-to-date on preventive screenings and wellness exams

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.2 *If We*: Improve access by filling prioritized transportation (by county & population needs) gaps...

<i>Then people will ...</i>	<i>Resulting in ...</i>	<i>And creating ...</i>
Immediate Results	Bigger Changes	End Goals
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Transportation assessment results are obtained (or previous are reviewed) to understand and prioritize needs/gaps/barriers by county	Resources (human, funding, etc.) are identified to support bi-directional transportation needs (people and/or goods delivery)	Transportation services are affordable and reliable in all 4 counties
Transportation solutions created to address the prioritized gaps in each county (including on-demand transportation services?)	A transportation plan is piloted/launched in each county	Seniors have reliable, affordable transportation to access the health system and other resources for independent living
Community and partners (health providers, local businesses, etc.) are aware of and support prioritized transportation-based needs and gaps	Local community partners (including retailers, in-home care providers, etc.) utilize transit resources to address elder needs (health and social determinants of health)	Age-friendly communities; Increased local economic success
<i>With these community partners and assets...</i>		
Agency on Aging; Midland Public Transit; R.Y.D.E. Transit; Senior Centers; Hospitals/Clinics; Rural Passenger Transportation Assistance Program; United Way; Nebraska Hospital Association – Age-Friendly Community initiatives; local businesses		
<i>Potential Performance Measures:</i>		
<i>How much change did we produce? How well did we do it?</i>		<i>Is anyone better off?</i>
• Transportation assessment review completed • # increase total rides given • % decrease in wait times for rides	• #/% increase in transportation options (in all 4 counties) • % decrease in no-show appointments (monitored by health system?) • #/% increase in access to appointments (monitored by health system?)	• #/% Transportation system users (seniors, health system/providers, retailers, etc.) in all 4 counties satisfied with the services/options • #/% of participants with increased disease management through access to appointments (monitored by health system?)

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.3 *If We*: Build/Support/Implement a community-based referral & navigation system to support screening (including SDOH), wrap around care, peer support and provider collaboration...

<i>Then people will ...</i>	<i>Resulting in ...</i>	<i>And creating ...</i>
Immediate Results	Bigger Changes	End Goals
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
SDOH and other intake or screening tools identified and tool use promoted with Navigators, Case Managers, Providers	SDOH and other intake or screening tools utilized to identify needs (universal – no wrong door)	Patient, Community Member needs are identified for referral
FindHelp promoted with community organizations and resources, encouraging training and participation in the single web referral platform	Expand information in FindHelp: comprehensive community resources are connected to a single web platform referral tool, functioning and accessible in all 4 counties Identify resource gaps in our counties and develop/implement a plan to fill resource gaps	Robust referral system that is sustainable and utilized universally throughout all 4 counties.
Navigators, CHWs, case managers, providers, discharge staff, and others (HR Leads, EMS, Insurance SMEs, etc.), are aware of/trained/know how to use the referral tool	Navigators, case managers, providers, etc., utilize FindHelp to refer clients/patients to resources.	• Improved collaboration, connection, & wrap-around care • Expanded community/health system navigation and utilization • Decreased unnecessary ER services • Decreased hospitalization and LTCF placement • Increased client/patient satisfaction and access to resources
FindHelp promoted to community members and peer support system	Increased awareness of where to go (one-stop shop) to find resources/services Increased privacy/reduced stigma	Increased community awareness of area professional- and community-based services

<i>With these community partners and assets...</i>		
SHDHD, government, non-governmental organizations, faith-based, any entities that provide services to this population, health department, healthcare systems (hospitals, clinics), transportation services, pharmacy, in-home caregivers, assisted living/home health, senior centers, contractors (home modification), grocery stores		
<i>Potential Performance Measures:</i>		
<i>How much change did we produce? How well did we do it?</i>		<i>Is anyone better off?</i>
• Inventory of screening/intake tools • # of trainings, # participants trained in FindHelp platform • Inventory of community resources by type/county • # of trainings, # participants trained in referral • # outreach/promotion activities	• #/% of agencies using an intake/screening tools to identify needs • #/% of new community resources in the inventory • #/% of identified resources gaps for seniors filled • # of FindHelp referrals; % increase in referrals over time • trends in visits to FindHelp website (and to individual orgs websites?) • #/% of participants over age 60 served with FindHelp	• #/% clients/patients over age 60 with positive screening results who are referred (data by referring entity?) • % of users and referral agents satisfied with FindHelp resources and referral process • Possible to measure referral completions? (Close the Loop) • #/% of clients over age 60 referred through FindHelp satisfied with referral (referred, and received what they needed? patient stories?)

Objective SH 1: Improve access to resources to maintain successful independent living

Strategy SH 1.4 *If We...* Expand Falls Prevention Programs and promote provider and community referrals, especially for high-risk individuals...

<i>Then people will ...</i>	<i>Resulting in ...</i>	<i>And creating ...</i>
Immediate Results	Bigger Changes	End Goals
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Community healthcare professionals and organizations will be aware of the program and its benefits	Increase in awareness of programs offered	The program is a reputable, effective program in South Heartland Communities
There will be a program structure & referral process in place; including community-based program coaches recruited/trained	Increase in older adults that are being referred to the program by providers and organizations that serve the priority (fall risk/fall history) populations	Participants have Reduced risk of falls, hospitalizations
Health professionals and organizations will be educated on the programs and willing to refer to it	Increase interest in falls prevention programs, increase registered participants	Maintained or increased sense of independence, financial stability
Priority populations will be identified: (e.g., veterans, 60+ members of the community, rural older adult community members living independently/assisted with falls risk and or previous falls)	Serve as an extension to the participants' healthcare needs.	Increase in socialization – gives the elderly population events to look forward to and to invest in their own health
<i>With these community partners and assets...</i>		
Senior center leaders, Midland Area Agency on Aging, health departments, churches, assisted living, independent living organizations, YMCA, Catholic Social Services, Meals on Wheels, healthcare professionals (e.g. eyecare, pharmacists, orthopedics), donor partners within the community, senior centers		
<i>Potential Performance Measures:</i>		
<i>How much change did we produce? How well did we do it?</i>		<i>Is anyone better off?</i>
# stakeholders & providers educated about the program % coaches completing training % satisfied with the training % of providers agree to refer % partners representing priority populations agreeing to promote/refer to the program	# of classes/cohorts #/% of providers referring #/% referrals that enroll #/% of participants completing the program #/% of participants satisfied with the program #/% of participants from priority populations	#/% of participants with fall risk/fall history (screening tool) - Overall improved health of seniors

Objective SH 2: Improve socialization and physical/social support

Strategy SH 2.1 *If We:* Implement community senior social centers (Provide structure within every community, a viable, peer-driven engaged elder/senior social center)...

<i>Then people will ...</i>	<i>Resulting in ...</i>	<i>And creating ...</i>
Immediate Results	Bigger Changes	End Goals
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Current senior centers and local stakeholders provide input about offerings, gaps, needs, barriers to programming/services for seniors	Community members, health professionals, and organizations will be informed about the various programs/services available through senior centers in each county.	• Senior/elder population is engaged; gains a sense of community and purpose of being • Increased socialization in senior population
Solutions identified to fill needs and expand opportunities for physical/social support for seniors	Resources (human, infrastructure, funding, etc.) are identified to support existing or expanded opportunities	• A sustainable program amongst community partners and health professionals • Health care professionals making referrals within their communities
<i>With these community partners and assets...</i>		
Village boards, senior center leaders, Midland Area Agency on Aging, health departments, churches, assisted living, YMCA, Catholic Social Services, Meals on Wheels, donor partners within the community		
<i>Potential Performance Measures:</i>		
<i>How much change did we produce? How well did we do it?</i>		<i>Is anyone better off?</i>
• # community senior centers and # of seniors participating in programs • # of programs initiated • and baseline overall health?	• Number of participants who successfully completed programs • Survey response rate for feedback related to specific programs or ideas of what the senior/elder population would like to see offered	• Increase active members, re-issue baseline survey for comparison, boost interest in upcoming programs, adjust for changes in living situations.

Objective SH 2: Improve socialization and physical/social support

Strategy SH 2.2 *If We*: Implement a community-based Program to Encourage Active and Rewarding Lives (PEARLS) that encourages activity and socialization for older adults...

<i>Then people will ...</i>	<i>Resulting in ...</i>	<i>And creating ...</i>
Immediate Results	Bigger Changes	End Goals
2025-2030 (Specific activity timelines to be determined by strategy workgroups with SHDHD)		
Community stakeholders and organizations will be aware of the program and its benefits	A program is piloted/launched in each county	The program is a trusted, effective program in South Heartland Communities
There will be a program structure & referral process in place; including community-based program Coaches recruited/trained;	Older adults are being referred to the program by providers and organizations that serve the priority populations	Participants have reduced/managed depression
Health professionals will be educated on the program and willing to refer to it	Demand for the program; Participants are satisfied with the program and share their stories	Participants have reduced social isolation & loneliness
Priority populations will be identified: (e.g., older veterans, rural older adult community members living independently with depression)		Participants have reduced hospitalizations and nursing home stays
<i>With these community partners and assets...</i>		
Health department/s, Agency on Aging / Senior Centers, Behavioral health professional/s or other experts in older adult mental health, chronic conditions and medications, Health care providers and community organizations to identify and refer participants, Community organizations to provide staff to be trained to deliver the classes/program/coaching, Community Impact Network (CIN)		
<i>Potential Performance Measures:</i>		
<i>How much change did we produce? How well did we do it?</i>		<i>Is anyone better off?</i>
# community stakeholders & providers educated about the program % coaches completing training % satisfied with the training % of providers agreeing to refer % partners representing priority populations agreeing to promote/refer to the program	# of classes/cohorts #/% of providers referring #/% referrals that enroll #/% of participants completing the program #/% of participants satisfied with the program #/% of participants from priority populations	#/% of participants with reduced/ managed depression (screening tool) #/% of participants with reduced social isolation & loneliness (screening tool) - TBD - Overall improved health of seniors