Bi-monthly Report on the Ten Essential Services of Public Health

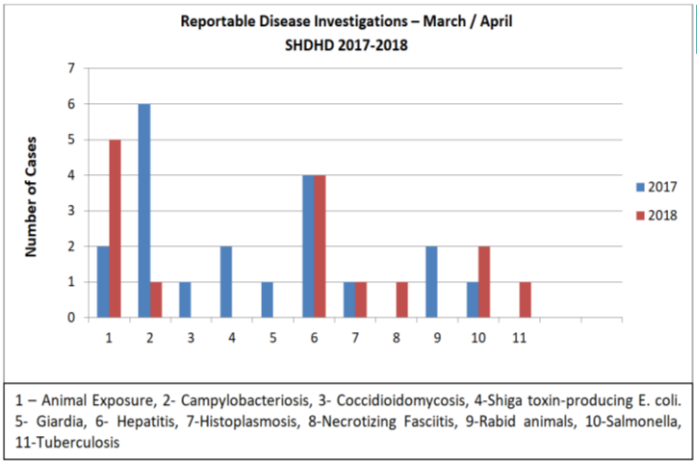
1. Monitor health status and understand health issues facing the community.

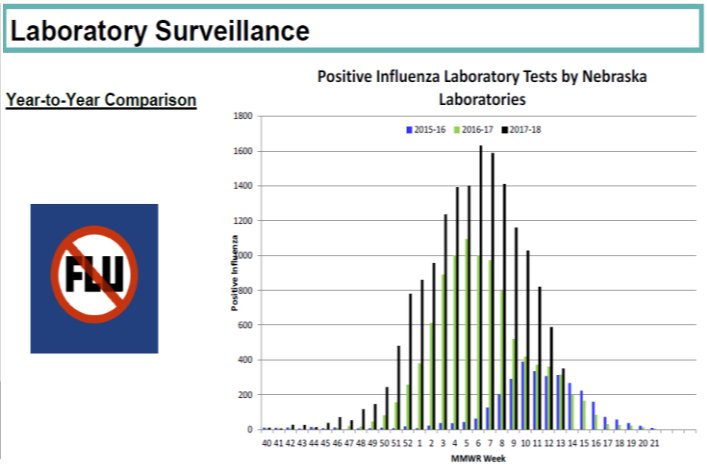
(What's going on in our district? Do we know how healthy we are?) *How do we collect and maintain data about conditions of public health importance and about the health status of the population, and how do we make it available to our partners and our community?*

- *What major problems or trends have we identified in the past 2 months?*

Local

- Surveillance data, water violations, and other health information is made available on our website, through links on our website, on SHDHD's Network of Care website, through news releases and interviews to various forms of media, and upon request from partners or others.
- SHDHD is in the planning stage for the 2018 Community Health Assessment (CHA) process. We are following the MAPP (Mobilizing for Action through Planning and Partnerships) process again. Part-time staff member Susan Ferrone is coordinating the process. The Core Team is currently reviewing the assessments and is planning additional focus on mental health and health system to identify community needs/gaps.
- School Surveillance has provided valuable information about flu activity in our community this season. Additionally, there have been reports of Fifth's Disease and Hand Foot and Mouth disease circulating during this reporting period. Reporting will end in the first week of May.
- Community Health Improvement progress tracker was created and shared with community partners and made public on our website and in our office.
- County Health Rankings Report (A Robert Woods Johnson Program) was published in March, 2018. This report was shared with several partners including City/County Combined Services, Clay County LEPC and Cancer Coalition, and was promoted through news release and radio interview.
- Two influenza outbreaks have been reported to SHDHD this year in long-term care facilities. Recommendations were provided to both facilities and required documentation sent to DHHS. Both outbreaks were small, with less than 25 individuals affected.
- A Chickenpox outbreak occurred during this period which involved four unvaccinated individuals in the same household. Although there were several additional unvaccinated individuals in the household, precautions were put in place to reduce the spread to other individuals. Information about this outbreak was reported to the CDC.
- SHDHD is currently working with DHHS and the CDC on a multi-state outbreak of Salmonella. There is a cluster from Nebraska with an isolate matching PFGE pattern. While information has been collected for SHDHD cases, this outbreak is ongoing.
- Influenza continues to circulate across Nebraska and parts of the US. Due to the high number of positive labs at the current time, Hospital ILI reporting has been extended through week 21 (see below for year-to-year comparison).





2. Protect people from health problems and health hazards.

(Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?)

- *What key activities did we complete in the past 2 months to prevent, minimize, and contain adverse health events and conditions resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental hazards; injuries; and health disparities*
- *What activities did we complete for emergency preparedness (e.g., planning, exercises, and response activities)?*

Emergency Preparedness & Response:

- SHDHD represented at Local Emergency Planning Committee (LEPC) meetings in both Clay County Adams County with approximate 12 attendees present.
- Trained Clay County Emergency Manager how to use fit-testing machine.
- Took part in Regional THIRA meeting to develop Jurisdictional Risk Analysis. Included TTX involving a plane crash on 281 Hall/Adams county line.
- Held meetings with Regional ERC's to develop work plan for 2018-2019 PHEP sub-award. Completed review and revision of Special At Risk Vulnerable Population policy determining who they are and how to reach them. Met with MAAA county directors to discuss their role in accessing their population.
- On April 26th, Jim Morgan was an assessor for Mary Lanning for a state-wide table top exercise for Health Care Coalitions to test hospital evacuation and regional surge capacity.

Environmental Response:

- Nebraska DHHS Lead Program teamed up with our surveillance coordinator to conduct a home lead investigation. We were successful in identifying several sources of lead in the home.

3. Give people information they need to make healthy choices.

(How well do we keep all people and segments of our district informed about health issues?)

- *Provide examples of key information related to physical, behavioral, environmental, social, economic, and other issues affecting health that we provided to the public.*
- *Provide examples of health promotion programs that we implemented to address identified health problems.*

- Staff covered monthly satellite office hours in Superior, Clay Center, and Red Cloud in March and April.
- Utilized community sign boards (located in Edgar, Nelson, Lawrence, Red Cloud, Bladen, Roseland, and Kenesaw) to get information out. Topics covered were Colorectal Cancer, Tanning safety, Public Health Week, and Teenage drinking.
- Continue to receive calls and share information on Radon testing and mitigation. There are two new mitigation businesses (one in Hastings and one in Minden).
- News releases, public health columns, ads and interviews: Radon ad; Vital Signs Health Fair; Operations Manager position; Colon Cancer Screening kit; Health snack pilot project begins today; Colon Cancer: Preventable, Beatable, and Treatable; Training to help with traumatized youth; Health Department holds training on adverse childhood experiences; Director says more is needed to erase mental health stigma; Challenge to South Heartland District Health Department: Be healthier; 2018 Nuckolls County Health Fair; Annual health fair Saturda in Superior High school gym.
- SHDHD Facebook: In March, the number of people reached was 1,950. For April the number of people reached was 774 (as of 4.16.2018) people. The topics for Facebook and twitter in March were Colon Cancer Awareness, mental health/VetSET, and promotion of local health fairs. April's topics included promotion of Public Health awareness week, How SHDHD can help "you" and Mental Health/Veterans Mental health.
- Worksite Wellness: SHDHD's worksite wellness program is restructuring with meetings held only once a quarter. During March and April there was no meeting, however, SHDHD continues to work with local worksite wellness groups to improve their internal processes and programs
- Scrubby Bear: No Scrubby Bear presentations were done in this quarter
- Childhood Obesity: SHDHD presented at the Head Start Annual Supper and Award night on childhood obesity local rates and linkage to good nutrition. The presentation was given to about 150 Head Start employees and families and focused on the CDC MyPlate recommendations for a healthy meal.
- Stepping On classes: Hastings 7 week Stepping On classes had 5 participants complete the class. Their beginning Time Up and Go was an average of 14.2 seconds and finished with an average of 11.2 seconds in just 7 weeks. On participant went form 24.4 seconds to 15.9 seconds. SHDHD will be offering another class in Hastings this fall.

- Tai Chi Classes: Beginning Tai Chi classes are ending for the spring and will be starting back up in the fall August / September. Year around Advanced classes are offered in Hasting and Red Cloud for individuals that have complete the beginning 12 week class.
- Smart Moves (Diabetes Prevention Program (DPP): SHDHD's Smart Moves classes continue to occur- Superior and ML's Smart Move classes are nearing the half way mark of the core 16 week classes and SHDHD's class is at week 7. Village Pharmacy in Red Cloud began their 1st Smart Moves class with 3 enrollees.
- SHDHD hosted a community forum on Radon presented by Mark Versch, Environmental Health Analyst at Nebraska DHHS. His presentation provided updates about mitigation, real estate transactions, next steps after testing and current data and information about the health effects of radon exposure.
- YMCA's SMBP Program: South Heartland's CHW have an active role serving as Healthy Heart Ambassadors for the program and holding office hours each Monday from 12:30 - 3:30. This collaboration with the YMCA in delivering this program allows us to engage and continue working with women identified for health coaching or otherwise called "WiseWoman".

4. Engage the community to identify and solve health problems.

(How well do we really get people and organizations engaged in health issues?)

- *Describe the process for developing SHDHDs community health improvement plan (CHIP) and/or implementing your work plan.*
- *Provide examples where we engaged the public health system and community to address health problems collaboratively. What were the evidence-based strategies that were implemented?*

Community Health Improvement Plan (CHIP) Implementation – Staff continue to implement the CHIP strategies with our partners:

- Access to Health Care: Staff have begun collaborative efforts with local agencies to address the identified need for navigating low income, undocumented women, who do not qualify for Every Woman Matters, to breast and cervical cancer screening. This collaborative process is supported through Health Hub funding.
- Prevention Connection: Progress continues between SHDHD and three district clinics (Webster County Clinic, Community Health Clinic/ Mary Lanning and Quality Clinic of Sutton) as they work towards benchmarks identified through the 1422 chronic disease prevention grant. Clinics are reviewing dashboards and implemented protocols to improve patient outcomes related to hypertension. Patients are continuing to be encouraged to monitor their blood pressure and provide their numbers back to the clinic. Community Health clinic, along with Hastings Family care, are promoting the YMCA's evidence-based Self-monitoring Blood Pressure program by wearing t-shirts provided by the YMCA once a week. SHDHD staff, along with Creighton University College of Nursing Students provided height and weight screening at the Vital Signs Health Fair in Hastings, along with a pre-diabetes assessment tool. Information was available on the pre-diabetes program, SMART Moves, and the success of the program to date. Webster County Clinic is working with their protocol for patients that present with high blood pressure, as well as establishing a "stop card" for patients, as they self-monitor their blood pressure, to know when to contact their provider. The clinic manager has been running clinic reports through the Electronic Health Record and became aware of the number of patients with elevated or high blood pressure that are not controlled and questioned if the data reflects "pride in community health" as identified in their mission.
- Team-based care activities, such as daily huddles, provide focused communication and coordination of efforts for complex patients. Clinic staff are able to discuss the patient's needs and prepare for adequate support personnel, all in an effort to deliver safe and reliable patient care. Quality Health Clinic in Sutton has implemented a visual prompt for providers if the patient has elevated or high blood pressure reading that is not controlled, or a BMI that may indicated a risk for pre-diabetes. A red heart is affixed outside the exam room door for the blood pressure concern and the green apple for pre-diabetes. The prompt has served as a nice transition into the conversation as the provider enters the room.
- Obesity:
  - Nutrition Advisory Board (NAB): The NAB met in March with 7 in attendance, the group continues to share sessions that are occurring throughout the district as well as barriers to accessing healthy foods. The participants were able to collaborate and learn from each other. The UNL shared their Action plan status, which SHDHD and Fill N Chill are involved in, with the board as well as their upcoming training opportunities.
  - Prevention Connection: Choose Healthy Here: Increasing healthy food options in convenience and grocery stores - SHDHD continues to work in three Hispanic stores in Hastings implementing the *Choose Healthy Here* (CHH) program working on the maintenance phase of the program. SHDHD continues to work with Fill 'N Chill to implement their action plan. The store owner has dedicated one open faced cooler to healthy

food items and is working on getting healthier items such as low fat milk and lower calorie/lower fat granola bars in stock. SHDHD placed signage around the store in help bring awareness to the healthier materials, released a press release to the media and hosted 2 taste test. In March the first taste test had 5 customer engagements and the April had 12 customer engagements. UNL Extension has partnered with SHDHD to host these taste test.

- Prevention Connection: Superior's follow up to their Walking Summit: Superior Design team gathered in March to finalize the maps that they will bring to the city council. There is one large route with different phases- the community will be voting on the phase they wish to implement first.
- Prevention Connection Healthy Vending Initiative: SHDHD continues to work with partnered sites to improve vending. Central Community College of Hastings and Nebraska Aluminum Casting (NAC) are waiting on the vender to get their healthier options in stock to host their taste testing. The vendor committed to getting the healthier options in the vending machine by April.
- Prevention Connection: Healthy Hastings follow up on action summit: Healthy Hastings continues to meet to fulfill the action plan. At the March meeting (7 in attendance) and April meeting (6 in attendance) committees reported progress and shared that the Complete Streets Advisory Council has released a request for bids to help them plan for a trail on the south side of Hastings, a plan for the new development that includes sidewalks and tree planting on the north side of Hastings. The team is also seeking out the idea for a down town Hastings farmers market and planning an Active Hastings Week. During the Active Hastings week that will occur May 6-12th the committee is planning walking audits with schools, a large community walk/bike to school/work day and community educational events.
- Prevention Connection: Smart Moves, Diabetes Prevention Class (DPP): SHDHD continues to work with partners in implementing this evidence-based year-long program. SHDHD has worked with community partners and has established the capacity to serve 3 of the 4 counties with Smart Moves. Partners include Brodstone Memorial Hospital, Mary Lanning Healthcare and Village Pharmacy. There were 6 new coaches training during March and April, as lifestyle coaches throughout the district to help SHDHD continue to grow capacity to offer the program.
- SHDHD WoW (Worksite Wellness): During March and April, SHDHD staff focused on developing and learning new ways to utilize and work with other staff members on the concept of Donald Clifton's Strength Finders. Staff attended a training on how to partner and utilize each other's strengths to an advantage. In addition, there was a focus on Vital Sign Health Fair booth interaction and a personal finance training. Staff are working their way around the track by completing challenges and attending lunch and learns to earn points.
- Prevention Connection: Village Pharmacy in Red Cloud continues to work with Webster County Clinic and Main Street Clinic to receive Smart Moves referrals and communicate with providers about blood pressures that are recorded in the pharmacy. Village Pharmacy and SHDHD met with Blue Hill Mary Lanning Clinic to begin a referral relationship in April. SHDHD is also reaching out to local worksites to help promote the Smart Moves program at Village Pharmacy. Torey Kranau, PharmD/MPH practicum student at SHDHD completed her community outreach project with 4 local pharmacies (Sutton, Superior, Red Cloud and Keith's Pharmacy of Hastings). Over the course of four weeks she hosted an education series at Sutton, Superior and Red Cloud pharmacies during March, meeting with hypertensive patients and giving them "tips" or lessons on how to better manage their blood pressure. In Hastings she worked to increase the number of referrals from the pharmacy to the YMCA self-monitoring BP program. For complete program outcomes see the success story below.
- Cancer Coalition: South Heartland Cancer Coalition met in March and April. This group of committed partners was instrumental in delivery of the colon and skin cancer education and screening provided to community members at the VSHF. Additionally the Morrison Cancer Center, an active partner has presented sun safety education to middle school students at Adams Central, St. Cecilia and the Hastings Middle School and to Hastings High students. They will be presenting to students in Harvard per a teacher request and may consider expanding to district schools next year.
- Mary Lanning Healthcare Cancer Committee: Cancer Committee met April 26th with SHDHD attending. Together as partners we collaborate on community cancer education and screening projects which helps ML meet their COC Accreditation requirements.

- Lung Cancer: Radon detection kits continue to be available through SHDHD and satellite offices. SHDHD was awarded a 2018 Radon mini-grant to support activities ramping up for Radon Action month in January. Tobacco Quitline cards have been inserted into the colon cancer education booklets that are included with each screening kit.
- Colon Cancer: FOBT colon cancer screening kits are available to all district residents age 50-75 throughout the year. Since July 1, 2017, 383 kits have been distributed across the district. 161 (42%) have been completed and submitted to the lab with 2 (1%) clients having a positive result. Case management by public health nurse is underway with each of these clients.
- Cervical Cancer: Human Papillomavirus (HPV) vaccine educational materials are shared at monthly VFC clinics. Community Health Workers continue to work with clients to access health care and Every Woman Matters resources. Clients are navigated to screening and diagnostics or treatment when needed.
  An HPV project to increase community education, change perceptions and promote cancer prevention through HPV vaccination is underway. We will be hosting 2 showings at the Hastings Public Library of the "Someone You Love" the HPV Epidemic movie to English and Spanish audiences in May.
- Breast Cancer: Using the Encounter Registry we continue to identify women in need of breast, cervical and colorectal cancer screening as well as resources to lifestyle change. Needs are assessed including health coverage and other barriers that might stand in the way of a woman completing cancer and cardiovascular screenings. Those without insurance who meet the Every Woman Matters program requirements are assisted with completing the Healthy Lifestyle Questionnaire to enroll in the program (1 in March/April). Those not meeting requirements are connected with the clinics offering assistance. Despite assistance from Mary Lanning's clinic for clinical and mammogram services, the radiology fee of approx. $200 is a barrier preventing many women from moving forward with screening. It is because of this need that we have begun collaborative work with local agencies to find solutions. In March/April staff made 21 navigation contacts to 10 women for breast and cervical cancer screenings and diagnostic services.
- Prostate Cancer: ACS booklets "Testing For Prostate Cancer" was and continues to be made available at all area health fairs.
- Skin Cancer: See Cancer Coalition

➢ Substance Abuse: SHDHD staff contributed to a panel presentation on Opioid Addiction for League of Women Voters-Hastings featuring presenters Max Owens, Senator John Kuehn, and Dr. Bever. Community forums to educate and raise awareness help meet our Community Health Improvement Plan priority strategies for substance abuse prevention.

➢ Mental Health: VetSET/Making Connections: April 10th was our 1st Task Force meeting to plan QPR / Mental Health 1st Aid in the district (to help improve the mental health and well-being of our service members) and to plan a Military Fun Day for Veterans / Military Service men & women and their family that live in the SHDHD district. Fun Day will be held at Timberlake Ranch camp in Marquette, NE on August 18th, watch for more details.

➢ Other Collaborations (1422): Hastings YMCA continues to implement their Blood Pressure (BP) Management program. SHDHD continues working with clinic partners at Hastings Family Care and Community Health Center in establishing clinic protocols for hypertension that include promotion of self-monitoring of blood pressure (SMBP). Clinic managers are still working on educating the providers on EHR utilization to make referrals and the importance of the program.

➢ Other Collaborations (Vital Signs Health Fair Board): 2 staff represent SHDHD on the VSHF board. Board meets monthly from October – April planning, implementing and evaluating activities for this annual event.

➢ Other Collaborations (Hastings Health Ministry): Community Health Services Coordinator/Public Health Nurse attended the March and April monthly meetings of the Hastings Health Ministry reporting on lifestyle change programs and other community opportunities through the department.

5. Develop public health policies and plans.

(What policies promote health in our district? How effective are we in planning and in setting health policies?)

- *What policies have we proposed and implemented that improve population health and/or reduce disparities?*
- *Describe how our department engaged in agency-specific strategic planning to develop a vision, mission, and guiding principles that reflect the community's public health needs, and to prioritize services and programs.*
- *What plans are we developing and implementing to improve our department's quality and effectiveness (plans for quality improvement, workforce development, branding, communication, and performance management)?*

➢ Grant Proposals (Plans)/Awards/New Funding:

- Health Hub Collaborative Impact proposal: (within the Health Hub subaward) – SHDHD is partnering with Hastings Imaging Center to explore opportunities to increase access to breast cancer screening for women with no insurance.
- NALHD proposal to Robert Wood Johnson Foundation [just learned it was not funded]: "Farmstrong Nebraska: Growing Social Connections in Rural Communities" in response to the call for proposals issued by Global Ideas for U.S. Solutions – Developing Solutions for Social Isolation in the United States: Learning From the World.
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- Performance Management System framework, PMS: Implementation will continue with CHIP dashboard, CHIP report and evaluating partner collaboration and data, and the 2018-19 Community Health Needs Assessment planning in progress.
- Prevention connection: Blood Pressure Management: with partner consultant Praesidio, SHDHD continues to work with 3 clinics to implement a blood pressure protocol (policy) within their clinic workflow to flag patients that may be hypertensive, not well managed, or pre-hypertensive, and to promote systems changes to improve prevention and management of hypertension. In one partnered clinic, with the data that was submitted, there was an increase in controlled hypertensive patients by 13% over the past 3 years due to grant activity policies and process implementation.
- Workforce Development Plan: Core competencies in job descriptions, succession planning/knowledge transfer, and implementation/tracking of work plan activities for 2017-18 are ongoing (all current, although target completion dates were disrupted with accreditation document upload). The next work plan item is a Succession Plan. Orientation resources, checklists and files are being revised/improved, if needed, with implementation.

6. Enforce public health laws and regulations.

(When we enforce health regulations are we up-to-date, technically competent, fair and effective?)

- *Describe our efforts to educate members of our community on public health laws, policies, regulations, and ordinances and how to comply with them.*
- *What laws and regulations have we helped enforce to protect the public's health?*

- Nebraska Clean Indoor Air Act: No smoking violations reported this period.
- SHDHD receives food recall alerts from the Nebraska Department of Agriculture. We also maintain a link on our website to the FDA Food Safety webpage.
- Daniel Brailita, MD has requested Direct Observed Therapy (DOT) for one of his patients. SHDHD is providing this service under a DHHS program as part of the initiative to prevent the spread of infectious disease.

7. Help people receive health services.

(Are people receiving the medical care they need?)

- *Describe the gaps that our department has identified in personal health services.*
- *Describe the strategies and services that we have supported and implemented to increase access to health care and establish systems of personal health services, including preventive and health promotion services, in partnership with the community.*

- Annual VFC Program Provider Profile was completed for NE DHHS Immunization Program. Additionally connections were made with the 2 local providers serving as Vaccine For Children and Adult Immunization Program medical directors. Each provider renewed their commitment to serve in this role and authorized standing orders and the emergency plan for the SHDHD Hastings/Adams County Immunization Clinic.
- In March/April the Vaccine for Children clinic staff delivered 76 vaccines to 32 patients at two monthly clinics. Of those 32 patients, 23 (72%) had no insurance, 5 (16%) had Medicaid, 4 (13%) were underinsured and 0 were American Indian. 6 of the 32 patients (19%) were new to the clinic. Total donation collected from clients for March/April = $258.65 (avg. $3.37per immunization or $7.90 per patient).
- We continue to implement strategies to help increase complete immunization rates of 2 year olds and HPV rates of 11-18 year olds. NE DHHS Immunization runs AFIX (Assessment, Feedback, Incentives & eXchange) reports for our immunization program twice a year. We are waiting for our first report which typically comes after our program site visit which is scheduled in May. Each yearly report allows us to set new goals for identified priority areas.
- SHDHD uses quarterly reminder/recall, an Evidence-Based Strategy for improving vaccination rates. These will be sent out again in May.

- In March/April the Adult Immunization Program delivered Tdap to 5 uninsured adults age 19 and over. All 5 adults were new patients.
- Staff met with the team of 3 Hastings College student volunteers and the campus nurse following up on efforts to improve flu vaccination in students and staff. Team reviewed survey results and compared it to the results of the 2016 survey. Student and staff feedback provides us with information needed for planning future activities.
- Community Health Worker (Bilingual):
  Every Woman Matters (EWM)/Encounter Registry;
  - Health coaching for 22 total clients (Spanish speaking) - 9 are also participating in the self-monitor blood pressure program (SMBP)
  - 16 adult clients assisted in office, 32 adult referrals to other organizations/ providers
  - 6 FOBT kits distributed
- Community Health Worker (English Only):
  Every Woman Matters and Health Coaching: March: 3/4 received 1st health coaching session unable to connect with the other one. 1/1 received 2nd health coaching session. 1/2 received 3rd health coaching session but needs to complete their EWM follow-up Survey. April: still working on April Health Coaching list. Currently doing 4 health coaching for SMBP and have 6 health coaching clients signed up for Smart Moves in Hastings, 1 in Red Cloud, 19 in Superior and 10 at Mary Lanning.
- Translation Services: Translation services have been implemented three (3) times for practice by staff and implemented in actual service one (1) time for Spanish interpretation through the Martti system.

8. Maintain a competent public health and personal health care workforce.

(Do we have a competent public health staff? How can we be sure that our staff stays current?)

- *Describe our efforts to evaluate LHD staff members' public health competencies. How have we addressed these deficiencies?*
- *Describe the strategies we have used to develop, train, and retain a diverse staff.*
- *Provide examples of training experiences that were provided for staff.*
- *Describe the activities that we have completed to establish a workforce development plan.*

- Performance management, Results Based Accountability: RBA continues to be implemented weekly in performance measures of programs and services (quantitative, qualitative and outcomes). This informs staff of all program activities, successes, needs, and alignment with the Essential Services and PHAB domains.
- The Workforce Development Plan: March/April meetings were disrupted with the final accreditation document upload and hiring of the new Finance Operations position. Succession planning/knowledge transfer was completed for this position and will continue with other QI-PM Team positions. Organizational culture discussion with staff, 2018 QI projects, HD training, and beginning plans for the 2018-19 Community Health Needs Assessment and Improvement Plan will move forward. Two QI projects have been started – telephone call tracking and standardization of HD minutes.
- NETEC (National Ebola Training and Education Center) Emerging Infectious Diseases Workshop: J.Warner attended a two day workshop provided by the CDC on infectious Diseases. This training included Nebraska Public Health Lab procedures for specimen handling and shipping, transport and a tour of the Nebraska Biocontainment Unit at UNMC.
- CLAS and Literacy Improvement and Innovation Project (Title V): J. Johnson is participating in this state project (monthly meetings) and providing input for the local health department perspective. Project to be completed in December, 2018.
- For her practicum, CCC Human Services student, Olivia Prentice, researched immunization requirements for daycare employees in Nebraska and other states, then prepared a proposal with policy language to encourage daycares to adopt immunization requirements for pertussis, influenza, measles/mumps/rubella, hepatitis B, and varicella. She piloted the proposal presentation in two daycares and prepared recommendations for implementing it further.
- HC Senior, pre-veterinary student Kim Spartz, wrapped up her capstone project at SHDHD. On April 13th, Kim and Denise Ferguson with her dog Pepper, went to Hastings' Lincoln Elementary School and presented a dog bite prevention safety demonstration to the three 1st grade classes. They taught the students that any dog can bite, even their own and when they should leave their dogs alone. They demonstrated what to do in situations where a strange dog is loose and to never approach an unfamiliar dog, even if the dog is behind a fence. With the help of therapy dog, Pepper, they physically demonstrated how to approach a dog and ask the owner for permission before petting it. Then, they took Pepper around the classroom and let the students practice on how

to approach a dog. After the demonstration, they gave the students an activity packet to take home on dog safety and behavior.

- HC practicum student, Maddie Smith presented her capstone project at the Hastings College Academic Showcase, on April 24. Maddie analyzed some diabetes prevention program data and studied how clinic staff addressed diabetes in their workflows.
- Hired Joe Streufert as the new Finance & Operations Manager for SHDHD. Joe has a banking and accounts manager background and strengths (Clifton Strengthsfinder): Empathy, Consistency, Adaptability, Harmony, and Responsibility,
- M. Bever and J. Streufert participated in webinar training on "De minimus vs. Indirect Cost Rate vs. Direct Cost Allocation Workshop" hosted by the Nebraska Association of Local Health Departments.

9. Evaluate and improve and interventions. *(Are we doing any good? Are we doing things right? Are we doing the right things?)*. *Provide examples of our evaluation activities related to evidence-based public health programs.*

- *Provide examples of QI projects that we have completed or are in process.*

- Choose Healthy Here initiative evaluation: Continued with Gretchen Swanson Center for Nutrition (GSCN) and NeDHHS on evaluation of *Choose Healthy Here* materials in partner Grocery Stores, as well as Brodstone Hospital's cafeteria improvements. There was a collection of employee survey, with a 75% completion rate, during the month of March to help determine program and environmental change satisfaction.
- Prevention Connection: Pharmacy SMBP pilot project- SHDHD and MPH practicum student, Torey Kranau, collected data from clinics about their thoughts and implementations of BP data they received from Torey's program participants. As well as pharmacist data to help determine sustainability and satisfaction of the pilot program. In addition SHDH hosted 2 focused conversations with two entities to help us better understand how we can better reach our pre-diabetes population with Smart Moves.

10. Contribute to and apply the evidence base of public health.

(Are we discovering and using new ways to get the job done?)

- *Provide examples of evidence-based programs our department is implementing.*
- *Describe how we have collaborated with researchers to conduct any research studies (e.g., completed surveys, interviews, or focus groups).*

- Evidence Based:
  - As part of the Chronic Disease Prevention project (Prevention Connection), SHDHD is in the final year (4 year work plan) of evidence-based strategies for prevention of cardiovascular disease and diabetes.
  - SHDHD is partnering with worksite wellness committees and using evidence-based practices for improving physical activity and nutrition in worksites.
  - In the Every Woman Matters/Community Health Hub project, SHDHD uses evidence-based strategies to address health inequities and improve screening rates for cervical, breast and colon cancers.
  - Tai Chi – Moving for Better Balance and Stepping On: are evidence-based programs for fall prevention in older adults who have a fear of falling or that have fallen. In the South Heartland District, beginning and/or advanced Tai Chi classes are offered in all 4 counties. Tai Chi classes are set up to meet twice a week for 12 weeks for 1 hour and will be starting new class in the fall. Stepping On classes meet once a week for seven weeks for 1 ½ to 2 hours and then a booster session in 3 months will be offering classes in the fall.
  - We are continuing to use the evidence-based Reminder Recall process for immunization clinic clients to improve immunization rates.
  - Public Health Accreditation Board (PHAB) Standards and Measures: Completion of accreditation will align SHDHD with these evidence-based measures, improving quality and performance. The PHAB site visit was completed April 18 and 19 with (great and much appreciated) participation of staff, board members and partners! Three strengths and three opportunities were identified and shared by the site visitors at the exit conference. Six measures were reopened for additional documents (13 total) and were uploaded in the required time frame. SHDHD has completed the document upload portion and moves forward to the accreditation status decision from the PHAB Committee, most likely after their August quarterly meeting.
- Research: none to report this period.

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Stories: How we made a difference….

Community Support for Self-Monitoring Blood Pressures Access and Awareness

Self-Monitoring Blood Pressure (SMBP) pilot project at local pharmacies. The project was to provide one-on-one education (an evidence based intervention to improve BPs in hypertensive patients) with patients who elevated blood pressure in order to improve their lifestyle habits for better blood pressure (BP) outcomes and to encourage them to self- monitor. The program consists of 4 education sessions including: how and why to take a BP, importance of medication management, healthy diet and importance of physical activity. The participants completed a pre and post knowledge survey and the pharmacy completed a satisfaction survey. In addition to the one-on-one counseling, the student intern created a "toolkit" for pharmacies to supply them with tools, posters and educational handouts for patients with high blood pressure. In support of the program, the pharmacist provided blood pressure cuffs at no cost to all participants that completed the program that didn't already have a cuff at the beginning- they donated 3 cuffs to the participants.

The pilot project ended up with 21 enrolled with 19 participants completing the program, with the average age of 62 years old. 100% of the participants met their goals each week and 63 participant SMBP tracking logs were faxed to 5 clinics. There was one provider call due to very low patient BP reading and two providers were called for high patient BP readings, with both participants prescribed additional BP medication by their providers for better BP management. Out of the 19 participants, who completed the program, only two were initially "extremely confident" in knowing their BP and how to control it. By the end of the program, 15 participants were "extremely confident" in knowing their BP and how to control it.

One program participant shared with student intern about his experience he had with tracking the sodium in foods. He did a great job during the week and his blood pressure reflected his low sodium diet. However, during the weekend, he didn't monitor his food and his blood pressure was significantly higher and he didn't feel as well. That participant really began to understand the effect sodium had on his BP and health. Another participant shared with student intern how they were eating a prepackaged meal that marketed it as fresh and healthy, but when looking at the sodium content, the participant learned it had over the daily amount of sodium in just one serving. Pharmacists reported in the follow-up survey that they were satisfied with the program and felt it met their patient and community needs.

Submitted by Brooke Wolfe, SHDHD Chronic Disease Prevention & Health Promotion Coordinator