



Fall Prevention: Fairfield Stepping On Class, Week #1

Above: Jolene Griess, PT, MPT, DPT from Clay County Physical Therapy—Sutton shows participants of the Stepping On class the Front-knee strengthening exercise (one of the four exercises that older adults should be doing 3 x a week to help improve strength).

Below: Rachel Devlin Stepping On Health Educator along with Jolene Griess shows participants the Stand-to-Sit balance exercise (one of the four exercise that older adults should be doing daily to help improve their balance).



December Worksite Wellness: Staff/Board Networking and Recognitions



NACO Annual Meeting, December 14, 2017

Janna West Kowalski (community coach, County Health Rankings & Roadmaps), Kevin Cluskey (Southeast District Health Department director), Michele Bever, Susan Bockrath (NALHD executive director)

Full Scale Exercises testing Closed 'Points of Dispensing' at Long Term Care Facilities



Harvard: After Action "Hot Wash" to identify what went well and areas for improvement.



Emergency Operations Center in Blue Hill



Dietary Department evaluation at Good Samaritan Society, Hastings.



Emergency Operations Center at Good Samaritan, Hastings.



Pre-Exercise meeting in Red Cloud.



Nursing Department in action at Kenesaw.



Participants and evaluators at Good Samaritan, Superior.



Evaluation of Dietary Department in Sutton

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

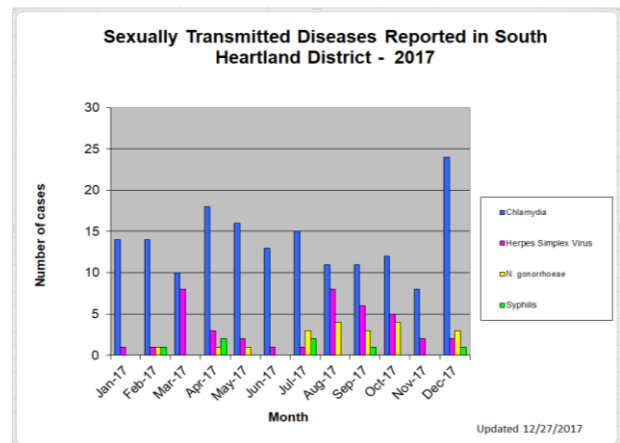
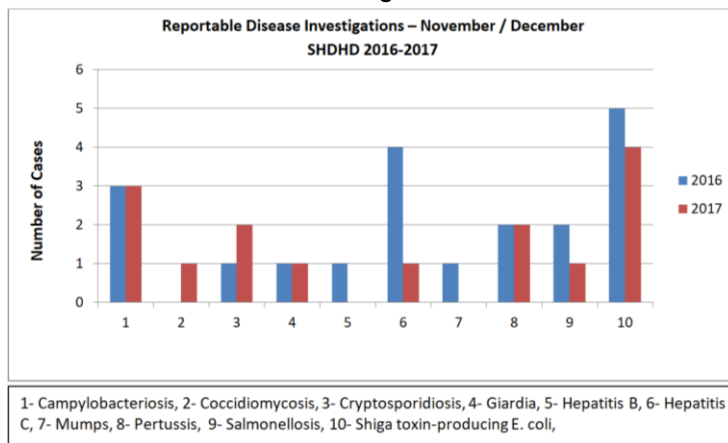
1. Monitor health status and understand health issues facing the community.

(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.
- Fall semester [school surveillance](#) is complete with less illness when compared to previous years. There have been reports of chickenpox, Fifth's Disease, norovirus like illness, strep throat and influenza this semester.
- [Hospitals continue to report influenza activity](#) with various viruses circulating. No PCR confirmed flu has been reported by any of our three hospitals as of 12/19/2017. Early predictions indicate that the vaccine may not be an effective match for circulating strains this season.



- We received one [nitrate violation](#) during this period which has been posted on our website to make public aware.
- [Dog Bite Prevention](#): Hastings College student intern Kim Spartz gathered and analyzed data on dog bites from Hastings Police Department and researched local and model ordinances and their enforcement. She presented a summary of data and led a focus group discussion with 3 Hastings Police officers and wrapped up her capstone project with a presentation to SHDHD staff.

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](#). Conducted seven full scale exercises in seven different nursing homes. A total of approximately 110 people participated from the nursing homes, SHDHD, Emergency Management, SHDHD, EMS, schools, hospitals, law enforcement, and government officials. There were a total of 6 evaluators with 3 needed at each exercise. They did an excellent job. Garry Steele, Bob Rose, Mirya Hallock, Dustin Handley from Two Rivers HD, Ashley Jeffres from Loup Basing HD, and Andrew Hill from Central District were the evaluators. Highlights include: Nursing homes and schools thinking they needed to have key staff learn NIMS. The Emergency Operation Center, EOC, was a great learning experience and participation was very good.
- Finished and submitted the ORR ([Operational Readiness Review](#)) which gives a general outlook on our ability to meet Medical Countermeasures (e.g., Strategic National Stockpile – SNS- supplies in a Pandemic, etc.), volunteers, and logistically meeting those needs.

- A [Hazard Vulnerability Assessment](#) was completed for the district, which includes input from hospitals, Emergency Management and some nursing homes. We use their input to see where we are as a district and what hazards are more likely to affect us.
- Working on a [Capabilities Planning Guide](#) (CPG) for the district. It outlines how we are working to meet the Emergency Preparedness needs, the positives, and where we need to strengthen our work.
- 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.
- Utilized [community sign boards](#) (located in Edgar, Lawrence, Red Cloud, Bladen, Roseland, and Kenesaw) to get information out. Topics covered in November and December were cancer, flu shots, and holiday stress.
- [News releases, public health columns, ads and interviews](#): Make ‘Smart Moves’ to reduce your risk of diabetes; Health Department: Try asking “Are you ok?”; South Heartland Diabetes Prevention Program Receives CDC Recognition; You’re invited! Smart Moves ad.
- [SHDHD Facebook](#): In November, the number of people reached was 2,250. For December the number of people reached was 1,410 people. The topics for Facebook and twitter in November were Diabetes Prevention and promotion of Smart Moves and “get your flu shot”. December topics included promotion of Smart Moves, Mental Health and Veterans Mental health and “get your flu shot.”
- [Worksite Wellness](#): The worksite wellness network meeting in Hastings for November was focused on mental health awareness in addition to providing worksite with community resources; there were 5 of the 6 worksites present. In December the network shared their personal worksite wellness successes from 2017 and their goals for 2018, there 4 of the 6 worksites present. Superior also had a worksite wellness meeting planned for November but due to the worksites busy schedule they were unable to attend an in-person meeting. SHDHD shared cancer resources with the worksites.
- [Senior Center Presentations](#): Topic: sugary drink consumptions - 20 seniors present
- [Scrubby Bear](#): SHDHD hosted 2 scrubby bear presentations to 2 different preschools with about 40 - 3, 4 and 5 year olds learning how to wash their hands the “scrubby bear” way.
- [West Nile virus](#): We are submitting final documentation for our 2017 WNV grant. This year, we sent out three press releases, a radio program and over 21 posts on Facebook. We provided prevention materials at three county fairs and Kool Aid days with over 3,000 contacts.
- [Stepping On classes](#): Stepping On classes started in Fairfield on November 2nd with 4 participants. They finished their 7 session on December 21 and then have a 3 month booster session on March 7, 2018. Classes will start in Hastings on January 11, 2018 at Adams County Senior Services.
- [Beginning Tai Chi Classes](#): Beginning classes are wrapping up in the district in December. Twelve week beginning classes will start back up in January or February 2018.
- [Smart Moves \(Diabetes Prevention Program \(DPP\)\)](#): Classes are coming to an end in Hastings and Superior in January 2018. The Hastings class is currently at 5% weight loss and the Superior classes are at 4.2% weight loss. Will have new classes starting in Superior on January 17, 2018 and Red Cloud and Hastings in February 2018.

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](#):

- **Prevention Connection:** SHDHD continues work in 3 district clinics (Webster County, Community Health Clinic/Mary Lanning, and Quality Clinic of Sutton) as part of the 1422 chronic disease prevention grant. Each clinic is actively working with their electronic health records (EHR), but finding challenges in the ability to drill down to specific data such as past A1c levels, or easily transfer self-reported blood pressure values submitted through the patient's portal to discrete data in the patient's record. Quality Clinic in Sutton has good support from AthenaHealth in regarding to their electronic health records. Community Health/Mary Lanning recently changed to EPIC for their EHR. They continue to learn the functions of the system and have the direct support of an IT staff member.

➤ **Obesity:**

- **Nutrition Advisory Board (NAB):** The NAB met in November with 5 in attendance- with one of the members new to the group, who is activity implementing the Healthy Vending initiative. The group was helpful in connecting other members to already existing programs so they could promote those programs among their population verses duplicating services.
- **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. The three stores have successfully implemented their action plan and are now in the maintenance phase of the program. SHDHD checks in monthly and provides TA as needed. SHDHD also completed the pre environmental store assessment and the store assessment for Chill N Fill on east 2nd Street. They have agreed to work with SHDHD for the next 9 months to increase their healthy food selection as SHDHD promotes and engages the community to purchase these healthier items.
- **Prevention Connection: Superior's follow up to their Walking Summit:** Superior's design team for promoting walkability didn't meet in Nov/Dec, but continue to plan for the trails grant they plan to apply for come July by connecting with a grant writer and the City of Superior.
- **Prevention Connection Healthy Vending Initiative:** SHDHD continues to work with partnered sites to improve vending. Central Community College of Hastings met and planned their taste testing for January and Nebraska Aluminum Casting completed their pre- environmental assessment and their supervisor level support survey.
- **Prevention Connection: Healthy Hastings follow up on action summit:** Healthy Hastings continues to meet to fulfill the action plan. At the November meeting (5 in attendance) committees reported progress and shared the Complete Streets Advisory Council is working on a plan for a trail on the south side of Hastings, a plan for new development that includes sidewalks and the committee continues to pursue the idea of a strategic plan design to ensure implementation. The group also continued to plan their bike/walk to work and school week that will occur in May 2018.
- **Prevention Connection: Smart Moves, Diabetes Prevention Class (DPP)** SHDHD continues to work with partners in implementing this evidence based yearlong program. SHDHD became a CDC-Recognized site for the National Diabetes Prevention Program!
- **SHDHD WoW (Worksite Wellness):** November was focused on giving back to the community by bringing in canned goods for the local food pantry. The staff collectively brought in over 112 items of food for the food pantry. There was no lunch and learn for November or December. In December staff completed a wellness bingo where staff were asked to do a variety of activities for better wellbeing each day of the month. All staff and board members were also invited to join SHDHD in a holiday networking/lunch in - 100% of staff attended lunch. In addition, Michele handed out awards to all staff to recognize accomplishments in 2017.
- **Prevention Connection:** Red Cloud Pharmacy 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. The pharmacist also had the chance to network with other Smart Moves coaches in the area by participating in the 2nd annual National Conference on Prevention of Diabetes. Sutton Pharmacy is also working with their local clinic, Quality Health Care, to establish a direct messaging system that will allow for the pharmacist to communicate directly with the clinic and is compatible with their electronic health record so the message will go directly into the patient record.
- **Prevention Connection Community Health Worker Clinic Integration:** SHDHD began working with two clinics (Hastings Family Care and Community Health Center) who believe they have a staff member that functions as a community health worker. The goal of this project is to integrate their staff member more regularly into the patient's care and connecting them to community resources.

- **Cancer Coalition:** South Heartland Cancer Coalition cancelled its monthly meeting in November due to time limitations with the Mary Lanning partners during their medical record transition period and in December due to the holidays and vacation schedules. Meetings will resume in January with the primary focus in 2018 directed toward reducing colon, breast and skin cancer rates across the district through education, awareness, screening, referrals and follow-through to diagnosis and treatment.
- **Mary Lanning Healthcare Cancer Committee:** Cancer Committee met in November with SH staff 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.
- **Colon Cancer:** FOBT colon cancer screening kits are available to all district residents age 50-75 throughout the year. We are beginning to plan for the primary promotion during March 2018 Colorectal Cancer Campaign.
- **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.
- **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 (6 in Nov-Dec). Those not meeting requirements are connected with the clinics offering assistance, with Komen funds, or with donated services (e.g., donated mammogram at the Women's Health Event; 1 woman in Nov-Dec). Community health workers, CHWs, help navigate women to screenings and to diagnostic services. In October/November staff made navigation calls to 5 women for breast and cervical cancer screenings.
 - **Prostate Cancer:** No update.
 - **Skin Cancer:** No update.
- **Substance Abuse:** SHDHD staff attended/supported Area Substance and Alcohol Abuse Prevention (ASAAP)'s Quarterly Breakfast forum on **Opioid Addiction**. Presenters were Dr. Ken Zoucha, MD, and Dr. Max Owens, PharmD. 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:** SHDHD is currently doing 2 monthly media post on Facebook and Twitter for Veterans, Services members and their Family members.
- **Other Collaborations (1422):** Hastings YMCA continues to implement their **Blood Pressure (BP) Management program**. SHDHD is worked with the clinic partners at Hastings Family Care and Community Health Center to educate all patients on the YMCA program and the importance of monitoring their BP. For those that are hypertensive and do not control it well, they counsel those patients more intensely about the benefit of joining the YMCA program. Hastings Family Care has handed out over 300 brochures and counseled/referred five patients, Community Health Center has handed out 100 brochures and counseled/referred four patients. This collaboration has increased awareness in the patients at these two clinics as well as provider knowledge about the community program.
- **Other Collaborations (County Boards):** Nebraska Association of Local Health Directors (NALHD) contributed to a session on County Health Rankings and Roadmaps presented to the County Commissioners at the December NACO annual conference. Directors of Southeast District and South Heartland District presented along with Janna West Kowalski – Community Coach, County Health Rankings & Roadmaps.

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:**

- Subawards with DHHS were received, signed and executed **Accreditation** subaward (\$15,000) and **Immunization** (6 month, \$10,000).
- **Performance Management System framework, PMS:** SHDHD's PMS annual review with staff was completed. This included "bringing the pieces together" – HD and program quality improvement activities, updating the CHIP dashboard, examining program data - performance measures - progress, and evaluating customer services and satisfaction. This all is to answer the questions: What did we do? How well did we do it? Did we make a difference? (Results Based Accountability, RBA)
- **Prevention connection: Blood Pressure Management:** with partner consultant Praesidio, SHDHD continues to work with the 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.
- **Workforce Development Plan:** continue to work on core competencies (job descriptions), financial/budgeting skills training for staff, succession planning/knowledge transfer and implementation/tracking of work plan activities for 2017-18. Orientation resources, checklists and files updated for access and use.
- **Policies-Plans-Resources:** Hard copies are made where needed, electronic files updated, implementation tracking formulated and an annual review calendar developed.
- **Heartland Health Center Board Strategic Planning:** The Board and leadership of the federally qualified health center in Grand Island participated in a day long strategic planning activity to identify priorities for the next several years. M. Bever will be part of a task force to assess demand and need to determine space/growth needs at the GI location, in Hastings and elsewhere. We will do a needs assessment in year 1 (results of which can also contribute to SHDHD's upcoming 2018 CHA - community health assessment).

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.
- **Dog bite prevention:** Hastings College student intern Kim Spartz gathered information on local laws/ordinances related in any way to dog bite prevention, as well as rabies vaccination rates, and dog licensing rates. She presented this information, along with dog bite data trends from Hastings Police Department, and led a focus group discussion with 3 Hastings Police officers to learn perceptions of local ordinances and their enforcement, as well as recommendations for prevention approaches.

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.*
- In November/December the **Vaccine for Children** clinic staff delivered 137 vaccines to 67 patients (a 61% increase since September/October) at two monthly clinics. Of those 67 patients, 52 (78%) had no insurance, 13 had Medicaid and 2 were underinsured and 0 were American Indian. 15 of the 67 patients (22%) were new to the clinic. Total donation collected from clients for November/December = \$226.00 (avg. \$1.65 per immunization or \$3.37 per patient).
- Follow-up AFIX (Assessment, Feedback, Incentives & eXchange) report run 10/23/17 by DHHS Immunization for **our immunization program shows improvement** from the strategies we implemented to help increase complete immunization rates of 2 year olds and HPV rates of 11-18 year olds. It also highlights areas still needing improvement which happens to be 2 year olds vaccinated for Varicella.
- We've completed a written reminder/recall procedure for the Immunization program which will help guide this process in the future.

- In November/December the [Adult Immunization Program](#) delivering Tdap to uninsured or underinsured adults 19 and over, administered 4 Tdap vaccines to 4 patients who were all uninsured. All 4 adults were new patients.
- Through partnership with Walgreens Pharmacy, [flu shots were offered](#), with vouchers for free flu vaccine but the 50 available vouchers this year were used quickly and uninsured clients are now being referred to Central District Health Department in Grand Island for federally funded vaccine or to Clay County Health Department for reduced cost vaccine.
- Community Health Worker (Bilingual):
[Every Woman Matters \(EWM\)/Encounter Registry](#): 11 adult clients assisted in office, 33 adult medical referrals to other organizations/providers, 7 adults immunizations referrals, 3 child immunization referrals, 2 Health Coaching support calls to eligible Spanish speaking participants. 16 Health coaching [Self Monitor Blood Pressure Program, SMBP](#), 6 Health coaching physical activity, nutrition, 3 FOBT kits, 6 EWM completed Healthy Lifestyle Questionnaire, HLQ. There are 13 health coaching clients pending completion of their biometrics and paper work.
[Immunization Clinic \(VFC\)](#): 7 adult immunizations referrals, 3 child immunization referrals, assisted with interpretation for 10 clients.
[Inspirado Diabetes Management Project \(Minority Health, with Mary Lanning\)](#): Interpretation for 4 adult participants at vision exams, 2 (Nov), 2 (Dec).
- Community Health Worker (English Only): [Every Woman Matters and Health Coaching](#). Signed up one person that was a walk-in that needed assistance for EWM and she was approved. EWM Health Coaching for November: 3/3 received 1st health coaching session. 4/4 received 2nd health coaching session. 2/2 withdrawal because of 3 attempts by Health Coach and 1/1 withdrawal because phone number listed doesn't belong to client, Health Coaching for December: 1/1 received 1st health coaching session. 3/3 received 2nd health coaching session. 2/4 received 3rd health coaching session and completed their EWM Follow-up Survey. Signed up 1 EWM client for the YMCA Self-Monitored Blood Pressure program.

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).
- [The Workforce Development Plan](#): Provided training in program subaward budgeting and de minimus indirect cost calculations to all staff. SHDHD continues to work on core competencies (job descriptions), succession planning/knowledge transfer and implementation/tracking of 2017-18 work plan activities. Orientation resources, checklists and files updated for access and use.
- [Employment Law](#): Michele Bever attended a half-day training on "Employment Law Overview: How to avoid the things most likely to get you sued" presented by R. J. Stevenson of Baird Holm, LLP. (Provided by NALHD)
- [Prevention Connection](#): B Wolfe attended the 2nd annual National Conference on Prevention of Diabetes conference and the National Diabetes Prevention CDC standard update.
- [Training partner health departments](#): Amy Dinslage from Two Rivers District HD visited SHDHD to ask questions about surveillance programs, network, and find out about Domains 1 and 2 in our process of accreditation.
- Policies and efforts to prevent and respond to [Childhood Lead Exposure](#): J Warner attended a webinar on policy and prevention surrounding advocacy for children with elevated lead levels.
- [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. She is also part of a point team to develop short project proposals for the entire group. Project to be completed in December, 2018. Michele Bever presented on SHDHD's Health Literacy project with clinics and cancer center at the group's Dec. meeting.
- [Achieving Health Equity, IHI Virtual Expedition](#): All staff were able to view or can access archived (6) sessions Oct.-Dec., as schedules permit. The cost for this training is covered through DHHS.

- **New employee and New Board Member:** New Board member Donna Faigler Daiss (Adams County community – spirited appointee) completed Board orientation. She and new staff member, Jean Korth, were trained in National Incident Management System (training provided by Jim Morgan).

9. Evaluate and improve programs 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.
- **The Quality Improvement – Performance Management Team:** 2017 QI Projects are successfully continuing and documentation is being completed. The 2018 QI calendar and log are in progress.
- **CHIP** priority areas have been reviewed and data uploaded to our scorecard. Discussions for obtaining partner input and information/stories that support the data are in progress to complete an annual CHIP report.

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. Stepping On class began in Clay County on November 2nd with 4 participants and the 2nd class for Hastings will start on January 11, 2018 at Adams County Senior Services in Hastings. Stepping On classes are once a week for seven weeks for 1 ½ to 2 hours and then a booster session in 3 months.
 - 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 Site visitors have been assigned and the site visit scheduled for April 18-19. Completion of accreditation will align SHDHD with these evidence-based measures.
 - Executive Director Michele Bever along with Executive Director Kevin Cluskey of Southeast District Health Department presented on behalf of the Nebraska Association of Local Health Directors (NALHD) to the County Commissioners at the December NACO annual conference, following an intro by Janna West Kowalski, Community Coach, County Health Rankings & Roadmaps. The focus of the local health director portion of the presentation was to share how we use data to inform our selection of evidence-based interventions and to give examples of evidence-based programs used to address identified needs in counties across Nebraska.
 - As NALHD president, executive director Bever participated in the Prevention Institute's Making Connections 3rd Annual Community of Practice Convening in Oakland, CA, to learn about evidence-based and best practices addressing mental health (to be applied to Nebraska's VetSET/Making Connections project). Used evidence-based interventions gained at the meetings for SHDHD's December education and awareness on stress and mental health.
- **Research:**
 - No Report.

Stories: How we made a difference....

Team-based Care Engagement in Increasing Blood Pressure Management

Over the past two months we provided two of our local healthcare partners with educational brochures for their patients on understanding hypertension and what the blood pressure numbers mean, in addition to information on the evidence-based hypertension program being offered through the local YMCA.

One of our partners shared that they had a hypertensive patient that has failed to respond to the suggestions from the provider to manage their hypertension. The patient, upon reading the brochures being distributed, took it upon him/herself to contact the YMCA and enroll in the program!

- *Submitted by Jean Korth
Chronic Disease Prevention Program Assistant*

Stepping On – Falls Prevention

South Heartland’s first Clay County 7-week Stepping On class, offered in Fairfield, was completed in December. When the class started in November, one of the participant’s Time Up and Go score was 14.5 seconds and, at the end of the 7 weeks, her score dropped to 8.6 seconds! *(An older adult who takes more than 14 seconds to complete the TUG is at higher risk for falling).*

- *Submitted by Liz Chamberlain
Tai Chi Program Coordinator*