Examination of Collaborative Efforts of Central District to Achieve Success of the Community Health Improvement Plan

Liene Topko
University of Nebraska Medical Center, liene.topko@gmail.com

Follow this and additional works at: https://digitalcommons.unmc.edu/coph_slce

Part of the Public Health Commons

Recommended Citation
Topko, Liene, "Examination of Collaborative Efforts of Central District to Achieve Success of the Community Health Improvement Plan" (2017). Service Learning/Capstone Experience. 8.
https://digitalcommons.unmc.edu/coph_slce/8

This Service Learning/Capstone Experience is brought to you for free and open access by the Master of Public Health at DigitalCommons@UNMC. It has been accepted for inclusion in Service Learning/Capstone Experience by an authorized administrator of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.
Examination of Collaborative Efforts of Central District to Achieve Success of the Community Health Improvement Plan

Liene Topko, MPHc

November 20th, 2017
Abstract

This was a quality improvement project that helped Central District Health Department (CDHD) work more closely with their community partners to identify the activities and programs that are currently in place to address priority health needs that were included in the 2016 Comprehensive Community Health Needs Assessment (CHNA). The purpose of this project is to identify the specific activities and programs that are being implemented by the health department and community partners in relation to the priority needs. These activities and programs were identified by conducting a survey of the major community partners. The findings from the survey helped to identify what activities and programs are currently underway, what progress has been made, and what, if any, technical assistance is needed to continue and improve these implementation efforts. Based on the results of the survey, the partner organizations are working in one or more of the six priority areas. Some organizations may be working in only one area, while others may be implementing activities and programs in three or four areas. In addition to learning about the current implementation initiatives, the survey also provided information about the extent to which these organizations measure their success. Specific success measures allow CDHD to use a unified reporting system, the Results-Based Accountability (RBA) Scorecard for performance management, to identify baseline as well as track overall progress and the overall impact of the intervention strategy(s) over the three to five-year implementation period. One of the lessons learned was that implementation is a complex process and may need to move more slowly to involve all of the organizational partners.
Introduction

The mission of Central District Health Department (CDHD) is, “To protect and improve the health and well-being of our community.” The health department is located in Grand Island, Nebraska and serves Hall, Hamilton, and Merrick Counties (CDHD, 2016). The population of the service area is approximately 78,600 (U.S. Census Bureau, 2016). The health department includes 39 employees, 31 full-time and 8 part-time, in four units: 1) Administration, 2) Environmental Health, 3) Community Health, and 4) Health Projects. They provide a variety of services to meet the health and wellbeing needs of their community.

CDHD conducted a Comprehensive Community Health Needs Assessment (CHNA) in 2016. This plan incorporated six priority needs, including behavioral/mental health; substance abuse; injury & violence; obesity; maternal, infant & child health; and access to health care. Because of the broad nature and complexity of these priority needs, multiple organizations need to be involved in the implementation efforts of the Community Health Improvement Plan (CHIP). The purpose of this research is to assist CDHD with the CHIP by gathering data on the program-implementation activities of their community partners. This information will be utilized to enhance collaborative efforts of the organizations and improve program progress measurement.

Throughout the implementation process, CDHD serves as the backbone organization by bringing representatives of the partner organizations together and facilitating discussion on how to improve the health of the community, the processes used, how to measure effectiveness of the programs they provide, and what has worked versus what has not. The intent is to begin by educating and training organizations in using the Results-Based
Accountability (RBA) framework, and associated Scorecard as the performance management system, not only to identify baseline of what is occurring in the community, but to also measure the impact of intervention programs and to share data more efficiently. All of these efforts are important steps in becoming an accredited health department.

Literature Review

To achieve a better understanding of this project, it was essential to conduct a literature review to understand the various components of this process and how they fit together. Another important factor is to determine what will work best in the future, how the implementation activities and programs can be tied into a cohesive unit and achieve CDHD’s priorities. To successfully improve the health of the community, many community organizations and members need to be involved – participatory research. In this way, richer information can be learned about community health, better insight gained into the community’s health definitions and previous efforts to improve health, as well as a greater knowledge of the high-priority intervention areas (Williams, Bray, Shapiro-Mendoza, Reisz, & Peranteau, 2009). The methods and approaches used by CDHD addressed these issues and the results were more detailed and specific.

Community Health Assessment

This project is based on the Comprehensive Community Health Needs Assessment (CHNA), also referred to as Community Health Assessment (CHA), conducted by CDHD. Per Turnock, a CHA is “a systematic examination of the health status indicators for a given
population that is used to identify key problems and assets in a community;” it encompasses state, tribal, local, and territorial health and is a combined effort of local government, business, health organizations, and community groups (Turnock, 2009; Rosenbaum, 2013; Curtis, 2002). The goal of a CHA is to develop strategies that will help address the needs and issues that were identified, while also providing organizations with comprehensive information on the current health status, needs, and issues of the community, which can help develop an improvement plan (Turnock, 2009; CDC, 2015). The Internal Revenue Service (IRS) mandates nonprofit hospitals to document compliance with the CHA requirements, which is a necessity under the Patient Protection and Affordable Care Act (ACA) of 2010 (Turnock, 2009). The ACA links a hospital’s tax-exempt status with the completion of a needs assessment and implementation strategy (Rosenbaum, 2013).

Conducting a successful CHA requires following various principles. These principles include having multisector collaboration supporting shared ownership of the phases of the community health improvement, transparency to increase community engagement and accountability, as well as constant and diverse community engagement (Rosenbaum, 2013). It is also important to have a large enough implementation area to allow for population-wide interventions and measurable results, the use of evidence-based intervention and innovative practices, evaluation of the continuous improvement process, and use of high quality data that is shared among public and private sources (Rosenbaum, 2013). To achieve community health improvement, the CHA process must be collaborative and transparent which will accelerate assessment, planning, intervention, and evaluation (Rosenbaum, 2013). Involving the community and being open about the process is vital to a successful CHA. Gaining buy-in and
interest from organizations, community members, and health care organizations more likely to lead to a smoother process and greater success in implementing strategies that will improve the community’s health and well-being.

Besides giving an insight on health status, needs, and issues, the CHA has a variety of other benefits. Conducting a CHA improves organizational and community coordination and collaboration which can help to implement various health programs; it also increases knowledge on what public health is and how everything is connected (CDC, 2015). Another key benefit is strengthening the state and local public health system partnerships, which are key to working together to meet the communities’ needs; this can be done through identifying strengths and weaknesses of the quality improvement efforts (CDC, 2015). Lastly, the CHA provides performance baselines which can be used in preparation for accreditation as well as benchmarks for public health practice improvements (CDC, 2015).

A study conducted in Kansas concluded that certain community characteristics are associated with the completion of a CHA; these include interagency cooperation, success of problem solving, and shared decision-making power (Curtis, 2002). The study found that lack of leadership, money, and time, as well as poor functioning coalitions play a role in the completion rate of a CHA (Curtis, 2002). This shows that agencies wanting to do a CHA need to work together with the community to determine what is feasible and identify the barriers prior to attempting a CHA.

Another study examined the rate of CHA participation among local health departments (LHDs). The overall result was that participation had greatly increased—from 2005 to 2008, increasing from 51% to 63%, and then decreasing to 58% in 2013; a similar trend was found for
those who conducted a CHA within the past 5 years, 60% in 2010 to 70% in 2013 (Laymon, Shah, Leep, Elligers, & Kumar, 2015). The researchers also determined that the structure of the CHA influenced the collaborative nature – LHD-led CHAs were associated with more and varying types of partnerships than those that were hospital-led (Laymon et al., 2015).

Community Health Improvement Plan

The information and data gathered during the CHA is then formed into a Community Health Improvement Plan (CHIP), which is a long-term, systematic effort to address the health problems determined (MDH, n.d.). The CHIP process, which looks outside of individual organizations serving a predetermined segment of the community, encompasses the entire community and looks at how the activities, programs, etc. contribute to community health improvement (NACCHO – Community, 2017). The CHIP provides guidance to health departments, their partners, and stakeholders on how to improve health, which is critical in developing the plan for policies and future actions to promote health (MDH, n.d.). Data collected from the CHA is used to track progress for implementation strategies and establish accountability measures for health improvement (NACCHO, n.d.). “Government agencies, including those related to health, human services, and education, use the CHIP in collaboration with community partners to set priorities and coordinate and target resources” (MDH, n.d.).

Like the CHA, collaboration, teamwork, transparency, and community engagement are key to a successful CHIP and the goal of improving the communities’ health. The CHIP process has eight key elements: preparation and planning, engaging the community to gauge needs, developing a goal/vision; conducting a CHA, prioritization of health issues from CHA results, development of
CHIP, implementation followed by evaluation and monitoring of CHIP outcomes (NACCHO, n.d.).

These two processes – CHA and CHIP – are the foundations for improving and promoting healthier communities (Abarca, Grigg, Steele, Osgood, & Keating, 2009). The Institute of Medicine’s (IOM) definition of CHA & CHIP was expanded in a Florida study to “the practice of collecting, analyzing, and using data to educate and mobilize communities, develop priorities, gather resources, and plan action to improve public health” (Abarca et al., 2009). The purpose of this study was to assess the capacity of county health departments (CHDs) in conducting a CHA and planning to identify training and technical assistance needs (Abarca et al., 2009). The study found that the perception of high or very high importance of conducting a CHA and CHIP had decreased from 76% to 58% in a year (Abarca et al., 2009). This finding is troublesome, because of the need to improve the health status of the state and nation; more emphasis needs to be placed on the need to conduct these assessments. Many CHDs reported having started the process, but only 28% had identified strategic priorities and 15% had implemented these strategies (Abarca et al., 2009).

Mobilizing for Action through Planning and Partnerships

The data collected during the CHA by CDHD was done through the process of Mobilizing for Action through Planning and Partnerships (MAPP) (CDHD, 2016). The MAPP process is an approach to community health improvement that helps communities improve health and quality, which is done collectively throughout the community using strategic planning (NACCHO – MAPP, 2017). It was developed “to provide structured guidance resulting in an effective
strategic planning process that is relevant to public health agencies and the communities they serve” (Lenihan, 2005). Throughout this process, communities are seeking to achieve optimal health “by identifying and using their resources wisely, considering their unique circumstances and needs, and forming effective partnerships for strategic action” (NACCHO – MAPP, 2017).

Henry Ford once said, “Coming together is the beginning. Keeping together is progress. Working together is success;” this is exactly what the MAPP process is designed to do (NACCHO – MAPP, 2017). For successful implementation of MAPP, seven principles must be followed: systems thinking, dialogue, shared vision, data, partnerships and collaboration, strategic thinking, and celebration of successes (NACCHO – MAPP, 2017). The success of this process is based upon building on the history of planning and the introduction of new approaches that connect public health agencies to the challenges of the world and the partners they need to meet the challenges (Lenihan, 2005).

The MAPP process has numerous benefits for the health department, as well as the community. By using this process, the health department can create a healthy community with better quality of life, which is the optimal goal of the process (NACCHO – MAPP, 2017). Public health is still not very visible or talked about, beyond public health practitioners; however, this process provides an opportunity to increase the visibility among community members through increased awareness and knowledge (NACCHO – MAPP, 2017). Increased awareness of public health increases interest and expands the network of partners to create a stronger public health infrastructure, which, in turn, leads to better coordination and management of services and resources (NACCHO – MAPP, 2017). Lastly, the MAPP process encourages better community engagement and ownership of programs (NACCHO – MAPP, 2017). Unfortunately,
the process is not always successful. One of the reasons is a lack of understanding of the process and an overemphasis on one particular aspect, such as cost, receives more attention than the whole process (Lenihan, 2005).

The Chicago Department of Public Health (CDPH) used the MAPP process to develop their strategic plan which included creating partnerships to address community needs, resource assessment, and program development (Salem, Hooberman, & Ramirez, 2005). The process provided a framework for CDPH to guide the planning processes as well as inform the role of local public health agencies in supporting the work; they determined that any single process was sufficient, and it is most beneficial and effective to include the community to determine their needs and priorities (Salem et al., 2005). The key conclusion from the study was that, while it may take time and convincing, multidisciplinary teams and partnerships are a necessity for success because they provide a strong framework and guidance (Salem et al., 2005). In this Chicago community, successful implementation of the process required leadership, commitment to a new way of doing business, a prepared public health workforce, coalition coordinator participation, and community readiness (Salem et al., 2005).

Public Health Accreditation Board

Health departments, such as CDHD, now have the opportunity to become accredited. The accreditation process involves comparing a health department’s performance “against a set of nationally recognized, practice-focused and evidence-based standards” (PHAB – What, 2013). According to NACCHO, for a health department to be eligible to apply for accreditation, it must have completed a CHA, CHIP, and an agency strategic plan (NACCHO – Community,
The Public Health Accreditation Board (PHAB) is a non-profit organization and the accrediting body for public health departments (PHAB – Acronyms, 2013). It strives to advance continued improvement of tribal, state, local, and territorial health departments and works to protect the health of the public through advancing the quality and performance of health departments across the United States (PHAB – Acronyms, 2013). Being an accredited health department helps to determine their strengths and weaknesses, promote transparency, improve the management process, and be more competitive for funding (CDC, 2017). This designation also helps stimulate quality improvement and performance management, improves accountability to the community, stakeholders, and policy makers, as well as improves communication with governing bodies and the board of health (CDC, 2017).

To become accredited, health departments must understand the standards they must meet and provide evidence that the standards have been met. According to PHAB, “The focus of the PHAB standards is ‘what’ the health department provides in services and activities, irrespective of ‘how’ they are provided or through what organizational structure” (PHAB – Standards, 2013). These standards, which were approved by PHAB’s Accreditation Improvement Committee, fall into twelve categories that reflect the Ten Essential Services plus administration and management, and governance (PHAB – Standards, 2013).

**Performance Measures**

When assessments are conducted and followed by the implementation of new programs, it is important to be able to measure the success of these programs. If a program is not improving health or if people are not participating, it is vital to make adjustments,
otherwise it is a waste of time and resources. Performance measures can be difficult to determine, depending on the program because it may be a self-assessment, which are not always accurate—due to bias, while other times it may be a pre-/post-test or observation. When evaluating public health, measurements are based on the 10 Essential Services of Public Health (Beaulieu, Scutchfield, & Kelly, 2003). Per Beaulieu et al., “Good performance measures should distinguish between well-functioning and poorly functioning public health systems. Therefore, establishing that the instruments are valid measures of performance is crucial to public health system improvement;” no matter the kind of study or measurement, ideally, it should be compared against a ‘gold standard’ to establish its validity, although a ‘gold standard’ may not always exist (Beaulieu et al., 2003). To overcome this problem, benchmarks can be used. A randomized control trial, conducted by Kiefe et al., concluded that benchmark feedback allowed for better improvement in performance (Kiefe et al., 2001).

**Quality Improvement**

The Centers for Disease Control and Prevention’s (CDC) National Public Health Performance Standards Program (NPHPSP) has been in charge of laying groundwork for public health quality improvement (QI) activities (Corso, Lenaway, Beitsch, Landrum, & Deutsch, 2010). NPHPSP is in charge of improving the quality of public health practice and the performance of public health systems (Corso et al., 2010). PHAB and NPHPSP work toward similar goals in supporting QI and establishing standards based on the Ten Essential Services framework (Corso et al., 2010). Measurement for public health practice has been shifting from a categorical program toward the community and organization, therefore it is the responsibility
of public health agencies to know which partners and organizations to include in the decision-making processes (Handler, Issel, & Turnock, 2001; Beaulieu et al., 2003). Although many industries use QI techniques to improve service delivery and performance, these methods have been rarely used in public health, and the field of public health has not developed a set of shared principles nor a common definition for QI (Riley et al., 2010).

According to Riley et al., “Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health” (Riley et al., 2010). The Plan-Do-Check-Act cycle is also known as PDSA, check is replaced with study. This cycle is vital to successful plan structuring and implementation. Initially the data is gathered to learn about the needs and wants via the CHA, the program is developed and implemented, LHDs or other entities running it periodically check on the progress by studying outcomes, and act if there is a need by making adjustments. Other key techniques are the priority-setting matrix and the fishbone technique, which looks at cause and effect (Corso et al., 2010). Successful implementation of interventions and programs requires multidisciplinary teams that are committed to the cause—among these teams, strong leaders must emerge to lead the group to success (Kahn & Fuchs, 2007). Concepts required for implementation are customization of the intervention dependent upon the communities’ needs, developing a system for data collection and reporting, as well as integrating several methods for changing behaviors (Kahn & Fuchs, 2007). A 2010 study found it was challenging to transition from performance assessment into performance improvement while using the NPHPSP instrument; it was determined that assessment-related outcomes were more commonly achieved, such as engaging system
partners, building awareness of interconnectedness of public health activities, and creating stronger collaborations (Corso et al., 2010). QI continues to be a struggle because of the difficulty in conceptualizing it for the public health system due to the diversity of organizations and focus areas within the field (Corso et al., 2010). For QI to be successful within health departments, integration needs to be a top-down and bottom-up approach; to penetrate the culture, “leaders and management must commit to ensuring that staff consider QI to be ‘business casual;’” changes are possible when “small, incremental improvements are linked with large, meaningful changes at the organizational level” (Riley et al., 2010).

Health departments are seen as the ‘first line of defense’ in protecting the health and safety of the community; this obligation is best met by applying public health science and highly reliable techniques of QI (Riley et al., 2010). To successfully achieve this goal, developing quality and performance improvements as cornerstones of the accreditation process is important because it brings together health departments with local and state entities by establishing a framework for excellence (Bender & Halverson, 2010). Combined efforts would eliminate inefficiency, error, and redundancy allowing health departments to improve processes and reduce costs that are associated with poor quality (Riley et al., 2010). Bender et al. concluded, “Measurement and accountability, reward and recognition, alignment of goals and measures, and empowerment of employees and their communities are all hallmarks of a solid approach to QI in healthcare” (Bender & Halverson, 2010).

**Partnership**
In 1997, the Robert Wood Johnson Foundation (RWJF) in collaboration with the W. K. Kellogg Foundation initiated a program called Turning Point, whose purpose was strengthening public health infrastructure among states, local communities, and the public health agencies to be able to respond to future challenges in health (Hassmiller, 2002). Early on in the project, many lessons were already learned, including the need for new thinking when trying to improve health, the importance of leadership, and alignment of incentives with partners of power (Hassmiller, 2002). An important realization was that government entities are not always the best facilitators, communication of successes must have been happening from the beginning, and probably one of the most important is that partnerships create a greater impact than individual efforts (Hassmiller, 2002). Without proper partnerships, it can be very difficult to make changes or even come up with possible plans for change.

It was mentioned previously how important partnerships are, and how using community partners and organizations in interventions and projects can be beneficial. Israel et al. states that partners contribute “unique strengths and shared responsibilities” in enhancing the understanding of phenomenon as well as social and cultural dynamics of the community; they also integrate knowledge with actions to improve the health of the community (Israel, Schulz, Parker, & Becker, 1998). Over the last several decades, interest in partnership approaches has grown significantly in the field of public health (Israel et al., 1998). According to the U.S. Department of the Interior (DOI), successful partnerships have four key components: focus on an important need, adopt a shared vision, understand each partner’s mission and organizational culture, and negotiate a formal agreement that outlines the specifics (DOI, n.d.).
The components are as significant in public health and health care as they are in business relationships.

*Results-Based Accountability*

One of the goals of the health department is to introduce the Results-Based Accountability (RBA) Framework and associated performance management Scorecard to their community partners. RBA is “a disciplined way of thinking and acting to improve entrenched and complex social problems ... RBA is also used by organizations to improve the effectiveness of their programs” (Clear Impact, 2016). Measuring the success of programs can be difficult, and sharing data with the community and community partners is even more so. Therefore, having a unified way of looking at programs and measuring their impact would make data sharing much more effective. The use of RBA deepens the way organizations make decisions, and it moves beyond discussing problems and finding ways to solve them (Clear Impact, 2016). What is so different about RBA is that it begins with the end in mind, essentially working backwards (Clear Impact, 2016). The three components, or performance measures, of RBA are: how much did we do? how well did we do it? and is anyone better off? (Clear Impact, 2016).

The main purpose for using this framework and performance management Scorecard is that it moves quickly from talking about a problem to action and that it is simple and a very common sense process (Clear Impact, 2016). One of the most important factors is also that it builds collaboration and consensus (Clear Impact, 2016). In public health, and health care as a whole, it can be difficult to make a decision without someone thinking that they are being left out, or
things should be done a different way. The utilization of this tool would address these concerns and build stronger relationships which can lead to healthier communities.

**Socioecological Model**

The work of health departments fits well with the Socioecological Model (Figure 1) because the purpose is to improve the health of the community, and they do so by addressing all the needs of an individual through direct service or referral.

![Figure 1: Socioecological Model (Turnock, 2016)](image)

The Socioecological Model addresses individual, interpersonal & family, neighborhood & community, and policy, systems & society factors (Beyer, Wallis, & Hamberger, 2015). Individual factors include age, gender, race, and other biological factors (Turnock, 2016). The interpersonal level includes societal expectations, family relationships, and community networks (Beyer et al., 2015; Turnock, 2016). This level may include health care, having someone around when help is needed, or having someone there to say, “I think you need some help,” and pushing for a change. This level also would be the family and friend support during
lifestyle changes or medical (physical, emotional and spiritual) recovery. Living and working conditions fall under neighborhood and community while overall policies, culture, environment, and more are within the policy, systems, and society level (Turnock, 2016). Living and working conditions play a large role in health and often the health department may be involved. One of the messages sent by health care organizations is to go out and exercise; if a neighborhood is not safe then individuals cannot do that. City housing and walkability fall into the last level of policy. Often health departments and other health care organizations will take a stance and advocate for policy changes as a means to improve their work capability as well as for the betterment of the community’s health.

Methods

The questions that were addressed in this research were: Based on the priority areas established in the 2016 CHNA, what programs and activities are the partner organizations within Central District working on, and how are they measuring success? To do this, a mixed methods design study was utilized because it reduces the limitations and biases present in one single method (Creswell, 2003). Another reason for utilizing a mixed methods approach is that one method can be used to inform the use of the other, for example, one question answers what priority areas are being addressed, while the next gives specific examples of the programs (Creswell, 2003).

A SurveyMonkey survey (Appendix 1) was developed by the Central District Health Department (CDHD) health director, the performance management coordinator, and student, and then distributed to community partners. The data collection method was considered cross-
sectional because it looked at a particular point in time to assess the current aptitudes, opinions, beliefs, values, behaviors, or characteristics of the population surveyed (Cottrell & McKenzie, 2010). An online survey platform was chosen because of the advantages to the surveyor and those being surveyed (Windsor, Clark, Boyd, & Goodman, 2004). For example, the participants could fill it out at their leisure, the data could be collected in a short period of time and was low cost, but most importantly, every participant was exposed to the same questions which allowed a better comparison of results. (Windsor et al., 2004). Prior to releasing the survey, the survey was field-tested to ensure appropriateness and quality (Bowden, Fox-Rushby, Nyandieka, & Wanjau, 2002). This was important because first of all, the link was the checked, second the clarity of questions assessed, and last but not least, the participants could provide feedback on the questions that were asked, and made suggestions for how to make the question clearer (Bowden et al., 2002).

It was important to use both quantitative and qualitative data because determining what priority areas are being worked on is not sufficient. It was also important to identify the implementation programs, whether the organizations were measuring their success and how they were doing this (qualitative). As for the quantitative data, interest in participating in the CHIP, work in priority areas, and gaps were researched.

Once the survey was complete, it was sent to 60 individuals, including representatives of organizations and hospitals that previously participated in the CHNA, as well as members of the health department. For larger organizations, more than one individual needed to be asked to get a more accurate and encompassing response. A couple reminders were sent to increase the response rate, as well as individual telephone calls were made. Once the responses were
obtained (n=25), some more research was done on the programs that were in place to gain a better understanding of these initiatives.

This project, as well as the work of the health department, reflects the Socioecological Model (Figure 1). The work aligns with the Socioecological Model because these programs are addressing the needs of the community on all levels – individual, relationship, community, and societal. Successful individual programs should address one or more of these levels of the model, and overall the programs in a community should be addressing all levels to achieve the goal of a healthy community.

After obtaining the survey results, the intention was to bring representatives from the organizations together and discuss a common way of measuring the success of the many programs that are already in place. The common measuring tool would be the Results-Based Accountability (RBA) Scorecard. The RBA framework, which encourages organizations to focus on the result from the onset. Throughout the process, future adjustments would be noted to ensure a better and more effective process for the next round of the Community Health Improvement Plan (CHIP). These adjustments include changes to the survey, increasing the participant list, and finding ways to involve more people from the beginning.

Results

The survey was sent out to 60 individuals representing 25 organizations; however, the final sample size was 25 participants from 16 organizations (a 64.0% organizational response rate) (Figure 2). After initially sending the survey, several individuals did not fill out the survey and they either did not return e-mails or indicated that they were only involved during the
Community Health Needs Assessment (CHNA) process. The participants were chosen based on previous participation, and those who are current contacts at partnering organizations. The survey had a 41.7% individual response rate.

Quantitative Data

The main survey question posed was: What priority areas are organizations working on? The priority areas were those included in the 2016 CHNA: behavioral/mental health; substance abuse; injury & violence; obesity; maternal, infant & child health; and access to health care. The results of the survey indicated that at least to some degree implementation activities are underway in each of the six priority areas. To present the data more accurately, the analysis was limited to organizational responses. This adjustment was made because some of the larger organizations had more than one person fill out the survey, which provided a broader and more
encompassing view of the work being done. The survey showed that 62.5% of organizations are working on behavioral/mental health, while only 37.5% are working on substance abuse (Figure 3). Each data slice examines the percent response for each priority from the 16 responding organizations. While a few organizations are working on only a single priority, several organizations are implementing activities and programs that involve multiple priorities.

![Figure 3: Which Priority Areas are being worked on?](image)

Another component of the survey was future participation in the Community Health Improvement Plan (CHIP). Seventy-five percent of the survey participants said ‘yes’ or ‘need more information’ while 25% said ‘no’ (Figure 4). This response was also looked at on an organizational level because it is possible that an individual said ‘no’ because they were the wrong person to ask within the organization. Organizational level responses were also used because more than one participant had both answers selected. Overall, the CHIP is intended to be a team effort so it is important to involve as many people as possible and find out why people do not want to participate in the planning process.
In addition to determining the overall interest in participation, it was important to find out which organizations wanted to collaborate and in what areas. This information could be used to develop collaborative partnerships if they were not already in place. The greatest interest in collaboration was in the behavioral/mental health and access to health care priority areas. In these areas, 50% of the organizations were interested in working collaboratively; only 25% of the organizations were interested in the injury and violence area. Unfortunately, 25% of organizations indicated that they were not interested in meeting with others (Figure 5). Once again, this issue needs to be addressed because working in silos will not solve the community’s problems and could lead to duplication of efforts.
Qualitative Data

The second important component of this survey was to determine the programs that were already in place in each of the six priority areas. The general conclusion was that many excellent activities and programs are already underway throughout the service area of CDHD (Appendices 2-6). Some programs under behavioral/mental health include: completion of a Juvenile Justice Community assessment, workshops for individuals working in behavioral health, various youth programs dependent upon age, VetSET, and others. Substance abuse programs include: supporting prevention and early intervention, the DARE program in schools, distribution of resources, and more. Within injury & violence, the programs included fall prevention, education through public safety, and working with the legal system. Obesity programs had one of the more extensive lists, and included efforts to make the healthy choice the easy and affordable choice, increasing walkability throughout Grand Island, health challenges, and a national Diabetes Prevention Program (DPP). Some programs within
maternal, infant & child included the WIC program, breastfeeding support groups, and overall efforts to educate the community. Last but not least, efforts in addressing access to care included providing health screenings in community settings, extension of clinic hours, and telehealth services.

The data on performance measures was quite mixed and unclear. Part of the problem may have been the wording of the question, and lack of clarity in what was being asked. The most common ways to measure performance included pre-post surveys, evaluations, and participation rates. A full list of performance measures is presented in Appendix 7. It is difficult to break down performance measures into six categories, however if the framework is used from the beginning, then certain expectations would be set, and it would be easier to track the achievements.

**Discussion/Recommendations**

One of the surprising findings of this project was the relatively low response rate to the survey (41.7% individual and 64.0% organizational) even though they were all involved in the CHNA. Although 40% is seen as a good response rate, it could have been better. It is difficult to know if the wrong questions were asked or the wrong individuals responded to the survey. Some of the individuals who did not complete the survey indicated they were only there in a supporting role or as the facilitator, yet others did not respond to the emails because they were retired or had changed organizations. These responses also raised questions about who was left out but should be at the table, such as religious/spiritual groups, and other organizations that were involved in other projects. Another potential partner could be neighborhood associations,
even if it were on a different level. These individuals could be given a different survey to
determine their needs, and then a representative from their board, if one exists, could
collaborate with the health department to receive information and education about how to
become involved in implementation efforts.

Another finding from the study is the importance of receiving responses from more than
one individual at larger organizations. For example, when reading the responses from CDHD,
some programs were not, or only briefly, mentioned. This type of response shows that
sometimes individuals may be so focused on their own work, and not realize how much work is
being done throughout the organization. Even if they know the work, they may not know the
logistics of the programs and their progress measures.

It was disappointing that some people did not want to be involved in the next
Community Health Improvement Plan (CHIP). The CHIP is meant to be a community effort to
improve the health of the community. Obstacles that deter people and organizations from
participating need to be evaluated and addressed. To address this concern, one of the survey
questions was who should be the main contact for the organization in the future. A tool that
could be utilized to improve response rate and increase involvement in the CHIP is to follow the
process used by the RWJF Culture of Health Prize winners Garrett County (Maryland) to build a
culture of caring (Garrett County, 2017). One of their efforts is the intergenerational initiative
where the health department is working with children and adults simultaneously (RWJF, 2017).
They are aware that not everyone has the ability or means to attend educational events, so
they have a mobile classroom, inside of a school bus, where they go to ten communities doing
school readiness efforts, educating about nutrition, healthy food, and much more (RWJF, 2017).
These are only a few examples of how Garret County’s local health department involves their community to achieve better health outcomes.

CDHD and CHI St. Francis Medical Center sponsored a community health assessment strategic meeting for Hall County. While discussing the lack of response and who else could be involved, this report was brought up. The final report from this strategic meeting should be used as a source to identify other community organizations as well as individuals that could and should be involved in the CHIP process. During this meeting, priority areas were discussed based on data from Hall County. Each priority area had a table of “propel us forward,” “hold us back,” and “who is doing what.” There were various organizations or community programs listed that currently are not a part of this CHIP, so including them in the CHIP process would give a much better and broader view of the programs as well as clearer definitions of potential gaps. In the next CHIP process, more people need to be involved to ensure that it is not the few telling the many what to do and how to do it.

One of the positive findings is that work is being done in all six priority areas. An initial surprise was that such a low percentage, 37.5%, of organizations were working on substance abuse, especially when it is such a large problem in Nebraska. However, some organizations may consider it a behavioral/mental health problem, rather than a separate issue. Another surprise was that only 50% of organizations are implementing activities and programs related to obesity. Because obesity is such a major problem in the country and Nebraska, it was assumed that more organizations would be working on this issue. However, this finding may reflect the relatively few organizations and individuals who responded to the survey. Another idea suggested by the preceptor was the lack of funding for prevention activities.
Lastly, the survey itself needs to be modified because unexpected responses were given to some of the questions. For example, some individuals who did not choose the substance abuse priority but selected behavioral health may not have understood that they could have chosen both. The survey could also be improved by providing clearer and more elaborate definitions regarding the different progress measures of the programs. While it is great that programs are reaching hundreds or thousands of people, the intent of the question was to find out how they are measuring their progress (e.g., having a sign-in sheet or RSVPs). Each question needs to be structured in a manner that has a clear expectation and outcome in mind, similar to the Results-Based Accountability (RBA) Scorecard itself. If it is unclear what is being asked and why it is being asked, then the answers will likely be unclear as well.

Conclusion

The survey results showed that a wide range of activities and programs are being implemented, but organizations appear to be struggling with measuring performance. Each of the six priority areas included in the Community Health Needs Assessment (CHNA) are being addressed, although the number of organizational interventions varies by priority area. The majority of the respondents would like to be involved or would like more information on the Community Health Improvement Plan (CHIP). However, 25% of the survey respondents indicated that they do not want to be involved in the development of the next CHIP and further study is needed to identify why they do not want to be involved. Moving forward, Central District Health Department will educate other organizations about the Results-Based Accountability (RBA) framework and associated performance management Scorecard. The goal
is to have a common reporting system, which will allow for better documentation of program success and reporting of the results. By starting with the end in mind, organizations may also have an easier time achieving their goals because they will be more clearly defined.

**Ethics**

Due to the nature of the project, the Institutional Review Board (IRB) determined an application of approval was not necessary. The student submitted an inquiry to the IRB that described the project, tasks to be completed, and the quality improvement nature. After reviewing the inquiry, the IRB gave their permission to move forward with the project, upon agreement that if the project changed, the student would inquire again. This project does not require contact with individual patients, nor is it an experiment. The entities being contacted are partners of Central District Health Department (CDHD), therefore there was no conflict of interest.
Glossary

ACA – Patient Protection and Affordable Care Act

CDC – Centers for Disease Control and Prevention

CDHD – Central District Health Department

CDPH – Chicago Department of Public Health

CHA – Community Health Assessment

CHD – county health department

CHIP – Community Health Improvement Plan

CHNA – Community Health Needs Assessment

DOI – Department of the Interior

IOM – Institute of Medicine

IRB – Institutional Review Board

LHD – local health department

MAPP – Mobilizing for Action through Planning and Partnership

MDH – Minnesota Department of Health

NACCHO – National Association of County & City Health

NPHPSP – National Public Health Performance Standards Program

PDSA – plan-do-study-act

PHAB – Public Health Accreditation Board

QI – quality improvement

RBA – Results-Based Accountability

RWJF – Robert Wood Johnson Foundation
Appendices

1. Survey

2. Lists of programs – Central District Health Department

3. Lists of programs – Bryan Health – Merrick Medical Center

4. Lists of programs – Hall County Community Collaborative

5. Lists of programs – CHI – St. Francis

6. Lists of programs – Everyone else

7. List of progress measures
Acknowledgements

I would like to thank Ms. Stephanie Bunner, MSN, RN and Ms. Teresa Anderson, MSN APRN-CNS, BC for the opportunity to conduct my Service Learning and Capstone Experience at Central District Health Department. It was an absolute pleasure working with you and I learned a lot. I would like to also thank all the wonderful staff that I had the opportunity of working with and learn about.

Another huge thank you to Dr. David Palm, PhD, and Dr. Brandon Grimm, PhD, MPH for being on my committee. I greatly appreciate all the assistance in forming this experience and guidance along the way. You are very both very devout to the work you do and therefore very knowledgeable. It was a pleasure working with you and learning along the way.
References

Articles


**Books**


**Documents**
CDHD. (2016). *Central District comprehensive community health needs assessment*. Retrieved from Central District Health Department:

http://www.cdhd.ne.gov/PDFs/FinalCCHNA.pdf

Websites


MDH. (n.d.). *Community Health Improvement Plan (CHIP)*. Retrieved from Minnesota Department of Health: http://www.health.state.mn.us/divs/opi/pm/lphap/chip/

Officials: http://archived.naccho.org/topics/infrastructure/CHAIP/


Officials: http://archived.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm


Rosenbaum, S. (2013). *Principles to consider for the implementation of a community health needs assessment process*. George Washington University, School of Public Health and


Last year, your organization participated in the Comprehensive Community Assessment. Using the Mobilizing for Action through Planning and Partnership (MAPP) framework, where we focused on identifying the needs of residents in the Central District.

The better part of this year will be spent formulating the Community Health Improvement Plan (CHIP). The CHIP is a 3-5-year plan for improving the health of Central Nebraska through the efforts of all partners.

We believe our first step is to determine “who is doing what” in our community to promote better health. Therefore, we invite you to complete the Community Health Improvement Plan Survey for your organization. Your organization can complete the survey as many times as needed by multiple persons within your organization to assure all of your information is entered.

Thank you for the valuable work you do in our community!

1. What is your first name?*

2. What is your position within your organization?*

3. What organization do you represent?*

   Other (please specify)

---

## Appendix 1: Survey

<table>
<thead>
<tr>
<th>Community Health Improvement Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hello!</td>
</tr>
</tbody>
</table>

Last year, your organization participated in the Comprehensive Community Assessment. Using the Mobilizing for Action through Planning and Partnership (MAPP) framework, where we focused on identifying the needs of residents in the Central District.

The better part of this year will be spent formulating the Community Health Improvement Plan (CHIP). The CHIP is a 3-5-year plan for improving the health of Central Nebraska through the efforts of all partners.

We believe our first step is to determine “who is doing what” in our community to promote better health. Therefore, we invite you to complete the Community Health Improvement Plan Survey for your organization. Your organization can complete the survey as many times as needed by multiple persons within your organization to assure all of your information is entered.

Thank you for the valuable work you do in our community!

1. What is your first name?*

2. What is your position within your organization?*

3. What organization do you represent?*

   Other (please specify)
Recently your organization participated in facilitated meetings and focus groups as part of the Community Health Assessment (CHA) process. During this process, we as a group identified six (6) community priority areas. Please check the priority area/s your organization/agency is currently addressing.

* Behavioral/Mental Health
* Substance Abuse
* Injury & Violence
* Obesity
* Maternal, Infant & Child Health
* Access to Health Care

Please list any additional areas that your organization/agency has prioritized and choose from the priority area with which your work is most closely related. (choose all that apply)

* Behavioral Health / Mental Health
* Substance Abuse
* Injury & Violence
* Obesity
* Maternal, Infant & Child Health
* Access to Health Care
* None

Additional areas that your organization/agency has prioritized:

For the next 6 questions, please describe the activities you are currently doing. If you are not working in a certain priority, please write 'none'.


* 6. If you are working on Behavioral/Mental Health, please provide a brief explanation of what is being done (programs, services, education).

* 7. If you are working on Substance Abuse, please provide a brief explanation of what is being done (programs, services, education).

* 8. If you are working on Injury & Violence, please provide a brief explanation of what is being done (programs, services, education).

* 9. If you are working on Obesity, please provide a brief explanation of what is being done (programs, services, education).
* 10. If you are working on **Maternal, Infant & Child Health**, please provide a brief explanation of what is being done (programs, services, education).


* 11. If you are working on **Access to Care**, please provide a brief explanation of what is being done (programs, services, education).


* 12. Please list any additional areas that your organization/agency have prioritized and identify the priority area with which your work is most closely associated, if any.
* 13. How do you measure progress? Please describe:

Process measures:
Number reached/served:
Behavior change:
Intention to change:
Knowledge change:
Improved health:
Other - please explain:

* 14. If your organization/agency is interested in meeting with others to address priority issues, please indicate which priority area(s) you are interested in.

- Behavioral Health / Mental Health
- Substance Abuse
- Injury & Violence
- Obesity
- Maternal, Infant & Child Health
- Access to Care
- I am not interested.

* 15. Are you interested in being part of a community-based (Hall, Hamilton, Merrick) health improvement plan, sharing and providing workplans and data to the public, and to other organizations?

- Yes
- No
- I need more information

* 16. Who should be listed as the main contact for your organization as we move forward with the Community Health Improvement Plan?

Name
Position
Email Address
Phone Number
17. Who should be listed as an additional contact for your organization as we move forward with the Community Health Improvement Plan?

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

18. Who should be listed as an additional contact for your organization as we move forward with the Community Health Improvement Plan?

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
</tbody>
</table>

**Next Steps**

Focus groups will be held Summer 2017
CHIP completed Fall 2017
Appendix 2: Central District Health Department Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral/Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1</td>
</tr>
<tr>
<td>Injury &amp; Violence</td>
<td>2</td>
</tr>
<tr>
<td>Obesity</td>
<td>6</td>
</tr>
<tr>
<td>Maternal, Infant &amp; Child Health</td>
<td>6</td>
</tr>
<tr>
<td>Access to Health Care</td>
<td>5</td>
</tr>
</tbody>
</table>

**Behavioral/Mental Health**
- We will be working on behavioral health through our Minority Health Initiative grant. We will provide a behavioral health individual assessment and then connect to appropriate programming.
- VetSET aims to connect veterans and their families with the care and support that they need. We are going to be offering a mental health first aid class in the very near future.

**Substance Abuse**
- VetSET

**Injury & Violence**
- Wellness Program which encourages health and wellness by increasing activity, which results hopefully in less problems with injury.
- VetSET aims to connect veterans and their families with the care and support that they need in the case of mental health crisis and PTSD which can lead to suicide and attempted suicide. We are going to be offering a mental health first aid class in the very near future.

**Obesity**
- The 1422 grant focuses on creating an environment conducive to healthy choices in food and physical activities. We work with the city on hike/bike trail development and promotion. We work with businesses to place healthy choices in vending machines. We work with work sites on adopting healthy policies.
- CDC Diabetes Prevention Program
- WIC education
- Walkability
- Minority Health Initiative (National Diabetes Prevention Program) & Living Well (Managing Diabetes) - both which support weight loss and increase in activity.
- We also refer to medical homes if obesity is an issue that has been identified and needs to be addressed.
- We take blood pressures, and make referrals as necessary.
- We attend numerous health fairs, at which time we promote healthy eating, wise nutrition, benefits of increasing physical activity, and our diabetes programs.
- Every Woman Matters - we provide National Diabetes Prevention Program;
- Health Coaching to clients who requested it through their physician and who sent the enrollment form to Nebraska Department of Health and Human Services;
- blood pressure readings;
- referrals to programs such as YWCA, or other exercise, and/or weight loss programs.
- Through the WIC Program we have developed a Performance Measure surrounding the obesity/overweight status of 3 and 4 year old children. We will increase staff training in how to help support parents understanding of the health effects of childhood obesity, how to increase activity and increase healthy food.
- Through the breastfeeding support program, obesity is being addressed as research has shown lower rates of obesity in breastfed babies.
- In the Diabetes Prevention courses, healthy eating and maintaining a healthy weight is being taught and supported
- 1422 grant,
• worksite wellness,
• WIC Program

**Maternal, Infant & Child Health**

- Our WIC program provides education and vouchers for healthy food and beverage choices.
- WIC
- I do not work with this program; however, our agency does. We have the Women, Infant, and Children (WIC) program available in our agency to our community.
- The WIC program works with the MCH population. We have 3000 clients participating in WIC. Healthy eating, increased activity, assessing for overweight and obesity status is completed on each participant.
- Also the Breastfeeding Support Program builds peer counseling into helping women reach their breastfeeding goals.
- VetSET can help families of deployed service members connect with support networks
- WIC Program

**Access to Health Care**

- Every Woman Matters: colorectal and breast cancer screenings
- MHI grant: outreach and referral to services
- We are ensuring, through our Minority Health Initiative (MHI) and Every Woman Matters program that everyone has a medical home, and if they do not have a medical home, we refer them to a medical home.
- For the MHI program, we are providing case management/follow up to people who we meet with who have an identified need, so we can help them work through any barriers they may have that would result in better health for them, as well as ensuring they are following through with any recommendations made by the health care provider.
- In addition to this, we ensure that there is "No Wrong Door" so that when any person enters our doors and has a need, we know where to refer them. This is a large part of the VetSET Nebraska/Making Connections program that we work with, as well, which is a support and referral source for Veterans and their family members.
- Clients who present to us for immunizations or for WIC services are assessed for other medical needs and referred appropriately to Community Health Workers or other entities who can help them navigate the health care system.
- Pregnant women are assisted with how and where to access prenatal care.
- VetSET aims to connect veterans and their families with the care and support that they need.
- Community Health Workers,
- 1422 (to a small extent),
- TB program
Appendix 3: Bryan Health – Merrick Medical Center Programs

<table>
<thead>
<tr>
<th>Behavioral/Mental Health</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
<td></td>
</tr>
<tr>
<td>Injury &amp; Violence</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>2</td>
</tr>
<tr>
<td>Maternal, Infant &amp; Child Health</td>
<td></td>
</tr>
<tr>
<td>Access to Health Care</td>
<td>3</td>
</tr>
</tbody>
</table>

**Behavioral/Mental Health**
- Telemedicine psychiatric participation and on-site counselors and psychologist sessions.
- Mental Health Clinic on-site
- We offer telehealth services which will improve access to care.

**Injury & Violence**
- Education through public safety

**Obesity**
- Diabetic and wellness education including diet guidelines for complete healthy lifestyle
- Shape your health education program
- We kicked off a #happyexercisingmc campaign which promotes exercise in our community.
- We are developing a program to work with area businesses.
- And we most recently are working with a group out of Columbus to provide fresh fruits and veggies to our facility on a regular basis (that our staff can then buy).

**Maternal, Infant & Child Health**
- We do provide health care to this group of people - and we are working to expand those offerings.

**Access to Health Care**
- Extended clinic hours
- Education
- Services-expansion of clinic hours
- Through telehealth services

**Additional priority areas:**
- Diabetic education
- Wellness Prevention
- We have a team that is working on discharge planning to ensure patients who leave the hospital have access to all of the necessary services they need once they go home
Appendix 4: Hall County Community Collaborative Programs

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral/Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>1</td>
</tr>
<tr>
<td>Injury &amp; Violence</td>
<td>1</td>
</tr>
<tr>
<td>Maternal, Infant &amp; Child Health</td>
<td>2</td>
</tr>
<tr>
<td>Access to Health Care</td>
<td>1</td>
</tr>
</tbody>
</table>

**Behavioral/Mental Health**
- Complete Juvenile Justice Community assessment, behavioral/mental health was identified as a primary priority.
- Support and attend Behavioral Health sub-committee meetings within H3C and also CHI St. Francis.
- Incorporate behavioral health discussions within 11 - 24-year-old H3C sub-committee including juvenile justice issues.
- Early childhood social-emotional development - Circle of Security-Parenting will begin in October 2017 and addresses parental trauma and strengthening their relationships with their children; Rooted in Relationships/Pyramid Model is provided for classroom teachers and directors in 3 child care centers and 1 in-home child care in Hall County.
- Community Response for children and families to avoid entering higher systems of care - families can be referred for coaching or for other needs related to behavioral/mental health.
- The H3C is in the process of developing a Nebraska System of Care (NeSOC) implementation plan to provide behavioral health resources for families with children that have an un-diagnosed behavioral health need but lack resources or connections to get the help they need to avoid moving into diagnosis and the mental health system.
- Connected Youth Initiative to assist youth, ages 14 up to age 25, who are unconnected from traditional supports due to experience with foster care or juvenile justice, homeless or near homeless, and/or another life event or circumstance that has interrupted their ability to become self-sufficient and transition to independence. Youth are connected to coaching, which may include referrals for behavioral/mental health.
- The H3C has a Behavioral Health Subcommittee that is working across the system to fill gaps and needs for families and children.

**Substance Abuse**
- Attend Tobacco Free Hall County and Grand Island Substance Abuse Prevention coalition meetings.
- Share student and young adults’ risk factor results at H3C coalition meetings.
- Support prevention, early intervention and intervention services within Hall County through H3C coalition meetings and the community stakeholders.
- Utilize local community prevention, evaluation, and treatment services for individuals needing these services.
- Use and share risk factor survey results to demonstrate needed services for the county.
- The Hall County Community Collaborative (H3C) does not provide direct substance abuse services but works within the substance abuse system in the H3C Birth to 11 Subcommittee, the H3C 12 -24 Subcommittee, and the H3C Behavioral Health Subcommittee to support agencies, identify gaps in, and work to reduce barriers to services. Both behavioral health and substance abuse have been identified as issues that are overarching problems for children, families, and older youth within all of the subcommittees and work groups of the collaboration.

**Injury & Violence**
- Provide community providers opportunities to share program information and education opportunities to other H3C members. Collective Impact
• The H3C worked closely with CHI-Saint Francis to implement SANKOFA which addresses gang recruitment, violence prevention, and gang resistance for youth at risk of being recruited to or participating in activities that put them at risk of entering juvenile justice or foster care systems.

Maternal, Infant & Child Health
• We are a member of the Hall County Community Collaborative whose focus is on promoting healthy families: positive parent-child interaction training for parents, providing one-time financial assistance to families in crisis as a means of reducing child neglect/abuse, reaching out to assist families where there is a need but where there is no psych diagnosis, providing support for youth who are aging out of foster care.
• Early childhood social-emotional development - Circle of Security-Parenting will begin in October 2017 and addresses parental trauma and strengthening their relationships with their children; Rooted in Relationships/Pyramid Model is provided for classroom teachers and directors in 3 child care centers and 1 in-home child care in Hall County.
• Community Response for children and families to avoid entering higher systems of care - families can be referred for coaching or for other needs related to behavioral/mental health.

Access to Health Care
• H3C Central Navigation Program through Heartland CASA. Recruitment and identifying of community service providers, making referrals to providers for support services. Identifying service array and gaps in services.
• Each of the initiatives already mentioned prioritize Access to Care as an important component in reducing barriers of children, families, and older youth for receiving the medical, mental, behavioral, and/or dental care that they need. Our approach tends to focus more on the transportation issues faced by rural Nebraska residents to even get to a location where care can be provided. However, through Community Response, Connected Youth Initiative, and the NeSOC, funds are available to reduce out-of-pocket costs to families that may prohibit them from accessing care.
• We are also aware of the stigma of accessing mental/behavioral health care, especially among many cultures that live in the H3C service area. The NeSOC plan has a component to provide more public education and to target populations that may be less likely to access needed care. This aligns well with CDHD priorities for improving access through Community Health Workers.

Additional priority areas:
• Juvenile Justice
• School Based programs
• after school programs
• System/Service navigation
• Un(connected) Youth Initiative
• Early childhood social-emotional development
• Community Response for children and families in Hall, Howard, Sherman, Greeley, and Valley Counties to avoid entering higher systems of care
• Connected Youth Initiative to assist youth, ages 14 up to age 25, living in in Hall, Howard, Hamilton, Merrick, Buffalo, Adams, Clay, Harlan, Franklin, Webster, Nuckolls, Phelps, and Dawson Counties, who are unconnected from traditional supports due to experience with foster care or juvenile justice, homeless or near homeless, and/or another life event or circumstance that has interrupted their ability to become self-sufficient and transition to independence.
• Collective Impact and community building through collaboration and shared resources
• Strengthening parent-child relationships in elementary school through Families and Schools Together (FAST) in select Grand Island Public School elementary schools.
Appendix 5: CHI – St. Francis Programs

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral/Mental Health</td>
<td>2</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>2</td>
</tr>
<tr>
<td>Injury &amp; Violence</td>
<td>2</td>
</tr>
<tr>
<td>Obesity</td>
<td>1</td>
</tr>
<tr>
<td>Maternal, Infant &amp; Child Health</td>
<td>1</td>
</tr>
<tr>
<td>Access to Health Care</td>
<td>1</td>
</tr>
</tbody>
</table>

**Behavioral/Mental Health**
- CHI Ministry Mission’s Grant- 3-year project to improve behavioral/mental health in the state of Nebraska
- Administration and oversight of CHI Mission and Ministry grant funding for Circle of Security and Discovery Kids

**Substance Abuse**
- Cancer Center: smoking cessation
- St. Francis Alcohol and Drug treatment center

**Injury & Violence**
- Tai Chi classes, helmet, car seat, fall prevention
- Administration and oversight of CHI Mission and Ministry grant funding for Sankofa violence prevention

**Maternal, Infant & Child Health**
- Administration, implementation and oversight of Child Safety, an outreach education program at CHI Health St. Francis

**Access to Health Care**
- Support of the Third City Community Clinic through the community health worker grant
Appendix 6: Other’s Programs

| Behavioral/Mental Health       | 6 |
| Substance Abuse                | 3 |
| Injury & Violence              | 5 |
| Obesity                       | 5 |
| Maternal, Infant & Child Health| 5 |
| Access to Health Care          | 3 |

**Behavioral/Mental Health**
- Assist with Grants for Circle of Security program, Discovery Kids program
- We have been working with the Munroe Myer Institute (MMI) through UNMC to put a post-doc fellow within our clinic to work on the integration of behavioral health in primary care. We currently have a referral agreement with Mid-Plains. While the MMI project is in in the works and has been pushed until the fall, we are currently exploring the process of contracting with a LIMHP or another psychologist to have 1-2 days a week onsite.
- We complete CES-D’s, which is a mental health screener for parents and make appropriate referrals.
- We complete ASQ/SE’s for children and make appropriate referrals.
- Workshops/Training opportunities for adults working in behavioral health, providing CEUs
- Kid’s Power! Program for children ages 7-11 who are directly affected by addiction in the family
- Discovery Kids for children in grades 2-5 (mental health promotion, substance use prevention, bully prevention)
- CATCH Kids Club for children in grades 3-7 (healthy nutrition, tobacco prevention)
- All Stars for youth in grades 6-7 (mental health promotion, substance use prevention, goal setting, decision making)
- Teen Power! Program for youth ages 13-17 who are directly affected by addiction in the family
- Youth Leadership Development
- Intervention (family education and actual interventions)
- 40 Developmental Assets (parent/adult education related to building assets in youth)
- Alcohol/Drug Education for youth and adults (MIP/MIC, DUI/DWI, possession of marijuana/tobacco)
- Lending Library houses more than 800 titles of books, CDs, DVDs that can be checked out free of charge on a whole range of topics related to behavioral/mental health, substance use, abuse, addiction and recovery
- Bookstore -- houses hundreds of titles of books, CDs, DVDs that can be purchased related to behavioral/mental health, substance use, abuse, addiction and recovery
- Provide free print information related to behavioral/mental health, substance use, abuse, addiction and recovery
- Provide referrals to other helping resources
- School nurses work closely with the counselors, social workers, Nurse Practitioner in Student Wellness in identifying students who need to get diagnosed as well as we administer meds that the student have prescribed.
- Implemented a screening tool in the clinic PHQ 9 to better identify patients with depression and other mental health issues.
- Participating in a grant with Bryan to offer Tele-psych services to our community.
- Have added a new service provider for tele-health to offer behavioral/mental health.
- Participating is a new grant with Bryan Health to access additional behavioral health services.

**Substance Abuse**
- Provide a treatment center
- Police department does a DARE project with the Schools in Aurora.
- Workshops/Training opportunities for adults working in behavioral health, providing CEUs
- Kid’s Power! Program for children ages 7-11 who are directly affected by addiction in the family
• Discovery Kids for children in grades 2-5 (mental health promotion, substance use prevention, bully prevention)
• CATCH Kids Club for children in grades 3-7 (healthy nutrition, tobacco prevention)
• All Stars for youth in grades 6-7 (mental health promotion, substance use prevention, goal setting, decision making)
• Teen Power! Program for youth ages 13-17 who are directly affected by addiction in the family
• Youth Leadership Development
• Intervention (family education and actual interventions)
• 40 Developmental Assets (parent/adult education related to building assets in youth)
• Alcohol/Drug Education for youth and adults (MIP/MIC, DUI/DWI, possession of marijuana/tobacco)
• Lending Library houses more than 800 titles of books, CDs, DVDs that can be checked out free of charge on a whole range of topics related to behavioral/mental health, substance use, abuse, addiction and recovery
• Bookstore — houses hundreds of titles of books, CDs, DVDs that can be purchased related to behavioral/mental health, substance use, abuse, addiction and recovery
• Provide free print information related to behavioral/mental health, substance use, abuse, addiction and recovery
• Provide referrals to other helping resources
• Help with identifying and getting diagnosed

Injury & Violence
• Fall prevention programs
• Work with the legal system
• We respond to 911 calls regarding violence.
• help with identification and getting diagnosed

Obesity
• Nebraska Extension’s Nutrition Education Program (NEP) helps families on a limited budget make healthier food choices and choose physically active lifestyles by acquiring the knowledge, skills, attitudes, and behavior changes necessary to improve their health. NEP does direct education with adults and youth. Additionally, NEP participates in Policies, Systems and Environmental (PSE) strategies that impact communities. These strategies include school wellness, community and school gardens, healthy food pantries, and child care center wellness.
• Litzenberg Foundation is teaching our community about healthy eating and making appropriate choices from quantity of food to an active lifestyle.
• The environmental sustainability office has provided a bike share station at our Grand Island campus for students and employees to use for transportation or for exercise.
• We are also promoting walking in the community.
• Our main goal of this is to reduce transportation emissions, but it has the added benefit of promoting a healthy lifestyle.
• We have nutritional education resources and handouts.
• CATCH Kids Club -- 8-week after school prevention program for children in grades 3-7 (healthy nutrition, tobacco prevention)
• Health fair Offering a program called Kids Move University to teach parents of toddlers how to make exercise into play.
• Developed a Wellness program for our employees that we are modeling to area businesses Sponsoring a walk out on work event for the community.
• Initiated a focus on Population health.
• Obesity is a key focus in prevention of many medical conditions.
• Through wellness visits, we are tracking BMI’s and the follow up education/plan for improvement. Reports are available per provider and as a group.
• Annual health fair focused on all aspects of health and education.
• Promoted many opportunities for increasing exercise.
• Sponsored a Health Challenge.
• Promoting better food choices through offering a healthy snack machine and free fresh fruit in the cafeteria that is available for employees and visitors.

Maternal, Infant & Child Health
• sponsor the EDN Service Coordination program.
• Litzenberg has presented information to the Child Development Center and the Elementary School children about eating healthy and staying active.
• We complete CES-D’s, which is a mental health screener for parents and make appropriate referrals.
• We complete ASQ/SE’s for children and make appropriate referrals.
• help to find source to diagnose pregnancy, help with pregnancy related illnesses
• Recruiting a female provider to meet the needs of the community.
• Education classes for pre-natal and child care. Classes also include sibling classes.
• Sponsor the Hamilton County Immunization clinic at Memorial Health Clinic. This scheduling promotes the immunizations and well child visits being a one stop event.
• Provide free follow up home visit for all new mothers.
• Trained 2 breast feeding specialists and formed a group call "Breast Feeding Friends" for support.

Access to Health Care
• Treating persons in Emergency room and referring on to TCCC and Heartland.
• Assisting people to find PCP’s and assisting with medication assistance programs.
• Community Health Care Workers at TCCC
• Vouchers for emergency medications and transportation
• Assist with community wide health screenings
• Student Wellness Center - physical and mental health provided
• As a FQHC, we are currently working to increase our capacity by hiring another APRN and also working on our workflows to increase the number of patients being seen per clinician. We are currently looking at our Outreach program and trying to incorporate Case Management and have Certified Application Counselor’s on staff.
• As our dental clinic has a 4-6 month waiting list, we have hired another dentist and she will start in August. This will help cut the wait list down.
• We are also working on patient scheduling templates.
• help kids/families find medical care at Third city Clinic, or Heartland Community Clinic or the Urgent Cares in town
• Expanded clinic hours to begin seeing patients at 7:00 Monday through Friday to offer before work and school options.
• Recruited 2 young female Physician Assistants to offer a different demographic option for young families for care.
• Expanded the hours of the satellite clinics - Clay Center to 5 days per week and Harvard to 3.

Additional priority areas:
• Outreach and Preventative Care
• Juvenile justice
• more public involvement of prevention
• women’s night out health fair
• diabetes walk-3 annual
Appendix 7: How do you measure progress?

Process measures
- self-reports, number attending programs, less ER visits, programs referred to, # of health screenings, student served - attendance at school,
- Participation in H3C coalition meetings, increase membership, increase service funding.
- HHC is highly regulated and provides Uniform Data Sets (UDS) measures to the Bureau of Primary Care which is under HRSA, and HHS
- tracking
- We track the time it takes to respond to 911 calls
- Number of users of the bike share system
- community assessments
- pre-post surveys, parent surveys, workshop evaluation surveys,
- Measured by our CEO & Quality
- tracking progress of grant activities,
- # of clinic patients with a PHQ 9 completed annually; Implemented focus and reporting related to population health in the clinic.
- Are the goals achievable and realistic
- Performance measures (RBA)
- 1422
- Continuous Quality Improvement processes among all initiatives

Number reached/served
- varies on the program
- H3C doesn’t provide direct services, collective Impact through community service providers.
- 2016 we served 3,282 patients with 6,722 visits. This is both medical and dental
- tracking
- around a 100 per year
- participation monitored
- Direct education numbers along with estimated PSE reach
- 56,000 emergency calls per year.
- 400
- 32 users of bike share system (since implementing new app in April 2017)
- 3000-5000
- Measured by our CEO & Quality
- number receiving each service
- # participating in the health fair and walk out on work event;
- Tracking number of wellness visits completed
- We keep track of each person served with the MHI program
- numbers of clients with risk codes reduced
- Surveys
- 1422
- Participants are tracked through databases and/or sign-in sheets
- Attendance tracked at events, classroom numbers

Behavior change
- Above (H3C doesn’t provide direct services, collective Impact through community service providers.)
- outcome measures
- number reporting
- Behavior checklist, 24 hour diet recall, Pre/post evaluation questions
- Education on dietary nutrition
• Number of trips per user
• pre-post surveys, parent surveys, workshop evaluation surveys,
• Measured by our CEO & Quality
• pre/post tests
• Change their health, eating habits, and exercise habits, along with making and attending all medical appointments.
• number of clients utilizing fruit and vegetable checks
• Protective Factor Surveys
• Outcome measurements defined in grant application - i.e. attendance records, number of detentions, arrests, tardies, etc.

**Intention to change**
• Increase community collaboration
• survey
• Unhealthy habits
• pre-post surveys, parent surveys, workshop evaluation surveys,
• Measured by our CEO & Quality
• pre/post tests
• Recruiting providers
• Through face to face contact with the customer, along with their engagement with staff.
• Protective Factor Surveys
• Pre/Post Self evaluation

**Knowledge change**
• Community training and education opportunities, sharing resources.
• pre and post survey
• attitude of individual we work with
• Behavior checklist, Pre/post evaluation questions
• Educate about nutrition
• pre-post surveys, parent surveys, workshop evaluation surveys,
• Measured by our CEO & Quality
• pre/post tests
• documented education of patients;
• Training staff on population health and quality improvement measures associated with
• have they lost weight, reduced BMI, lost inches around their waist, increased their exercise, taking medication as prescribed
• Protective Factor Surveys
• Before/after evaluations when possible

**Improved health**
• decreased visits to ER
• Collective Impact
• We look at clinical and dental indicators within our UDS data provided to our funders
• survey
• individual wellness goals achieved
• Pre/post BMI
• Lose unhealthy weight
• pre-post surveys, parent surveys, workshop evaluation surveys,
• Measured by our CEO & Quality
• DHHS and census data
• Monitoring a quality measure of depression improving in the last 12 months via the screening;
• Population Health quality measures
• Face to face contact to gain information, along with collecting biometrics
• program statistics
• Protective Factor Surveys

Other
• Look at the number of patients seen by providers
• relationship between students and Police
• Measured by our CEO & Quality
• Coaching Progress Forms