Nebraska Panhandle Community Health Improvement Plan

Regional Work Plan

Updated April 13, 2018

Contents

Abbreviations and Acronyms

Abbreviations or acronyms you may encounter in this document are listed and defined below.

PPHD	Panhandle Public Health District
BBGH	Box Butte General Hospital
KHS	Kimball Health Services
MCCH	Morrill County Community Hospital
RWMC	Regional West Medical Center
GMH	Gordon Memorial Hospital
RWGC	Regional West Garden County
CCH	Chadron Community Hospital
SRMC	Sidney Regional Medical Center
PWWC	Panhandle Worksite Wellness Council
TFN	Tobacco Free Nebraska
HFA	Healthy Families America
FAST	Families and Schools Together
HP 2020	Healthy People 2020

Introduction

Overview of Mobilizing for Action through Planning and Partnerships

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHA and CHIP. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation.

The MAPP model has six key phases:

1. Organize for success/Partnership development
2. Visioning
3. Four MAPP assessments
    a. Community Themes and Strengths Assessment (CTSA)
    b. Local Public Health System Assessment
    c. Forces of Change Assessment
    d. Community Health Status Assessment
4. Identify strategic issues
5. Formulate goals and strategies
6. Take action (plan, implement, and evaluate)

This document contains detailed information on the "implementation" aspect of Phase 6. The full CHA and CHIP documents can be found at www.pphd.org. This is a living

document that may change as activities are implemented; the date on which the document was last updated will always be listed on the cover page.

Implementation of the CHIP will take place from January 2018 to December 2020, and will be guided by this work plan document. This document contains specific activities that will be used to address the objectives identified in the CHIP, including:

- Measurable and time-framed targets
- Policy changes needed to accomplish health objectives
- Individuals and organizations that have accepted responsibility for implementing strategies

Priority Area Overview

Each section of this document contains information on a specific priority area, including:

- Objectives,
- Implementation plan,
- Strategies, and
- Partners

Objectives include a summary of the objectives from the CHIP. Specific data, goals, and sources can be found in the full CHIP.

Implementation Plan includes steps the region will take to move the needle on the objectives. The implementation plan includes SMART goals, performance measures, and lead partners.

Strategies includes evidence-based strategies that will be utilized to meet the goals in the implementation plan.

Partners includes the list of individuals and/or organizations that have committed to form a work group around each priority area. The individuals and/or organizations in these work groups have committed to:

- To take action on the priority area,
- Meet quarterly,
- Report progress bi-annually, and
- Participate in annual evaluations of the CHIP.

If you are interested in joining a work group, please contact:

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Community Health Planner
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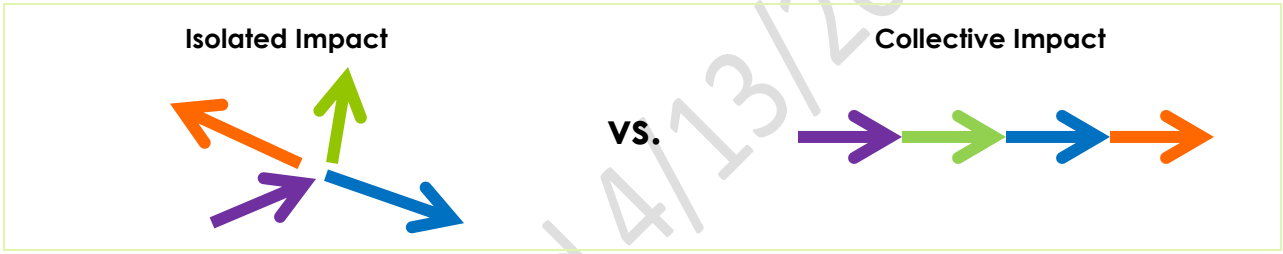
Collective Impact

Collective impact is "the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem".[1] For the CHIP, organizations from different sectors and geographic areas of the Panhandle have come together to make a difference in the health of Panhandle residents.

There are five key elements of collective impact that are crucial to implementation of the CHIP:[2]

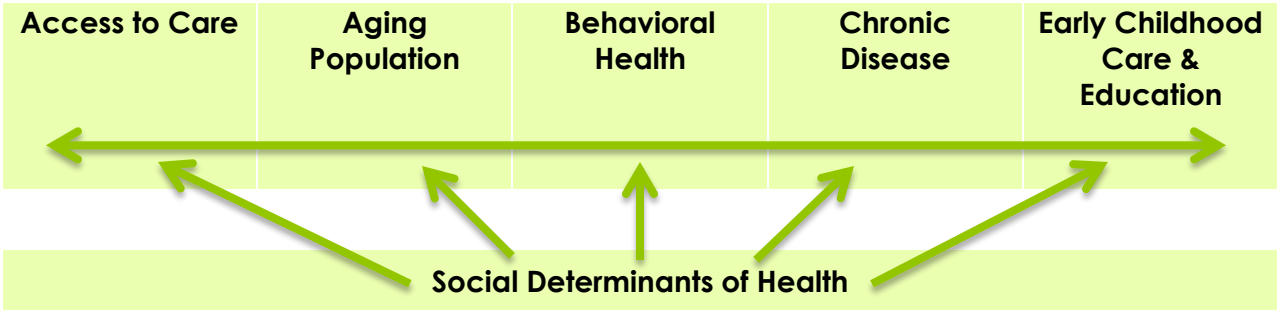
1. Common agenda
2. Measuring results consistently
3. Mutually reinforcing activities
4. Continuous communication
5. Backbone organizations

Collective impact is in contrary to "isolated impact". In isolated impact, "each organization is judged on its own potential to achieve impact, independent of the numerous other organizations that may also influence the issue."[2]



Mutually Reinforcing Activities

Many activities in this work plan are mutually reinforcing in that they address root causes of multiple priority areas. For example, tobacco use is a risk factor for chronic disease, thus activities intended to decrease tobacco use are pertinent to the chronic disease priority area; however, tobacco use is also an aspect of behavioral health and substance abuse. Although activities related to tobacco use impact both areas, they are listed in only one area in this document in order to avoid repetitiveness.



[1] Kania, J., & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review*. Retrieved from: https://ssir.org/articles/entry/collective_impact

[2] The Collective Impact Framework. Retrieved from: http://www.collaborationforimpact.com/collective-impact/

Priority 1: Access to Care

Objectives

- Increase the proportion of persons with a usual primary care provider (HP 2020: AHS-3)
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines (HP 2020: AHS-6)
- Increase the proportion of worksites that offer an employee health promotion program to their employees (HP 2020: ECBP-8)
- Increase the proportion of pregnant women who receive early and adequate prenatal care (HP 2020: MICH-10)
- Increase the proportion of women giving birth who attend a postpartum care visit with a health worker (HP 2020: MICH 19)
- Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth (HP 2020: OH-1)

Implementation Plan

SMART Goals	Performance Measures	Lead Partners
Increase appointment availability by decreasing structural barriers by 5% annually.	• # of walk-in clinics offered • # of hospitals/clinics offering walk in appointment slots on regular basis • # of hospitals/clinics offering extended hours • # of hospitals/clinics offering services in non-clinic settings	BBGH KHS RWMC
Increase use of automated appointment reminders in Panhandle hospitals and clinics by 5% annually	• # of patients that receive automated appointment reminders	BBGH KHS RWMC
Increase access to screenings through health fairs or other community screening opportunities by 5% annually.	• # of health fairs • # of people who receive screening or other preventive services through public settings • # of worksites that offer health screenings	MCCH PWWC GMH RWGC
Reduce transportation as a barrier to medical care by 5% annually.	• Assess local transportation systems for baseline data • # of patients that indicate transportation is a barrier to medical care	BBGH RWMC
Increase the number of health systems that are PWWC members by 2, by 2020.	• # of PWWC members	PWWC KHS RWGC
Increase number of children in grades K-4 that fall into Class 0 for school-based oral health screenings by 5% annually.	• #/% of K-4 children rated Class 0 at school-based oral health screenings	PPHD Dental Health Program
Maintain or increase number	• # of dentists participated	PPHD Dental Days Program

SMART Goals	Performance Measures	Lead Partners
of dentists involved with Dental Days, annually.		
Increase or maintain the number of children and caregivers who receive referral to resources through HFA, annually.	• # of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts • # of children with positive screens for developmental delays who receive one or more service contacts	PPHD Healthy Families Program
Increase or maintain percentage of HFA clients receiving medical appointments on schedule, annually.	• % of children who received the last recommended well child visit • % of mothers who received a postpartum visit within 8 weeks of delivery	PPHD Healthy Families Program
Increase opportunities for no-cost colorectal cancer screening by 5% annually.	• # of people informed about no-cost FOBT kits from PPHD • # of FOBT kits distributed • % return rate	GMH RWGC BBGH KHS RWMC PPHD

Strategies

- Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Source: Community Preventive Services Task Force)
- Reducing Structural Barriers for Clients (Source: The Community Guide)
    - Colorectal Cancer
    - Breast Cancer
    - Cervical Cancer
- Worksite: Assessment of Health Risks with Feedback (AHRF) to Change Employees' Health – AHRF Plus Health Education With or Without Other Interventions (Source: Community Preventive Services Task Force)
- Home Visitation Programs (Source: Council on Child and Adolescent Health)
- Dental Caries (Cavities): School-Based Dental Sealant Delivery Programs (Source: Community Preventive Services Task Force)

Partners

- Sidney Regional Medical Center
- Regional West Health Services
- Panhandle Public Health District
- Panhandle Trails Intercity Public Transit
- Community Action Partnership of Western Nebraska
- Region 1 Behavioral Health Authority
- Disability Rights Nebraska
- Helping Hands Independent Living Center
- Dr. Gage Stermensky LLC

- Health Thyme, LLC Panhandle Health Group
- Rural Nebraska Healthcare Network
- Gordon Memorial Health Services
- Box Butte General Hospital
- Panhandle Area Development District
- Chadron Community Hospital
- Kimball Health Services
- Regional West Garden County
- Educational Service Unit 13
- Morrill County Community Hospital
- Western Community Health Resources

Priority 2: Aging Population

Objectives

- Increase public transit use by older adults
- Increase use of resource navigation by older adults
- Reduce the rate of emergency department (ED) visits due to falls among older adults (HP 2020: OA-11)

Implementation Plan

SMART Goals	Performance Measures	Lead Partners
Implement two community-based fall prevention programs by December 2020.	• # of fall prevention programs offered • # of Tai Chi classes offered • # of Tai Chi instructors	GMH RWMC
Increase number of elderly people accessing community resources by 5% annually.	• # of clicks on elderly-specific resources listed in Panhandle Resource Guide • # of hospitals/clinics with staff that can connect elderly with needed resources • # of calls to Alzheimer's Association Care Line • # elderly caregivers utilizing respite • # of people utilizing in home delivery meals	RWGC Panhandle Partnership MCCH Alzheimer's Association Nebraska Respite Network Office of Aging
Increase number of elderly signed up for Panhandle Alert by 5%, by 2020.	• # of elderly residents signed up on Panhandle Alert	PPHD
Increase number of elderly people utilizing public transportation.	• # of elderly people utilizing public transportation	Panhandle Intercity Transit
Decrease social isolation of elderly people.	• # of meals served in congregate settings	Office of Aging

Strategies

- Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)
- Fall Prevention Program (Source: National Council on Aging)

Partners

- Regional West Health Services
- Disability Rights Nebraska
- Helping Hands Independent Living Center
- The DOVES Program
- Western Community Health Resources
- Health Thyme, LLC
- Scottsbluff Community Health

- Deuel County Community Organizer
- Aging Office of Western Nebraska
- Community Action Partnership of Western Nebraska
- Rural Nebraska Healthcare Network
- Gordon Memorial Health Services
- Box Butte General Hospital
- Panhandle Area Development District
- Sidney Regional Medical Center
- Chadron Community Hospital
- Regional West Garden County
- Kimball Health Services
- Education Service Unit 13
- Morrill County Community Hospital
- Senior Services, Inc.

Priority 3: Behavioral Health

Objectives

Mental & Emotional Well-Being

- Reduce substantiated child maltreatment in counties in which the rate is higher than the rate for the state of Nebraska (based off of HP 2020: IVP-37 & IVP-38)
- Reduce the suicide rate (HP 2020: MHMD-1)
- Increase depression screening by primary care providers (HP 2020: MHMD-11)
- Increase the proportion of schools with a school breakfast program (HP 2020: AH-6)

Substance Abuse

- Decrease drug-overdose deaths (based off of HP 2020: MPS-2.4)
- Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women (HP 2020: MICH-11)
- Reduce the proportion of persons engaging in binge drinking of alcoholic beverages (HP 2020: SA-14)
- Reduce tobacco use by adults (HP 2020: TU-1)
- Reduce tobacco use by adolescents (HP 2020: TU-2)
- Reduce the initiation of tobacco use among children, adolescents, and young adults (HP 2020: TU-3)
- Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol (HP 2020: SA-1)

Implementation Plan

SMART Goals	Performance Measures	Lead Partners
Mental & Emotional Well-Being		
Increase use of depression and anxiety screening tools in hospitals by 5% annually.	• Proportion of primary care physician office visits where adults 19 years and older are screened for depression • Proportion of primary care physician office visits where youth aged 12-18 are screened for depression	BBGH KHS MCCH RWMC CAPWN
Increase primary care provider referral to mental health specialists by 5% annually.	• # of referrals to mental health specialists	RWGC CAPWN

SMART Goals	Performance Measures	Lead Partners
Increase knowledge of suicide identification and awareness by 5% annually.	• # of providers proficient in QPR • # of providers educated on suicide warning signs • # of Out of the Darkness events	KHS BBGH RWMC Out of the Darkness
Enhance parent-child connections through involvement in community programs (CoS, Love and Logic, etc.) by increasing attendance by 5% annually.	• # of people completing CoS • # of people completing Love and Logic • # of families participating in FAST • # of families participating in HFA	BBGH CCH Healthy Families FAST CoS Love and Logic
Increase number of Panhandle businesses that offer evidence-based strategies to address employee mental health and well-being	• # of worksites with EAP • # of worksites that offer flexible scheduling • # of worksites that offer stress management support • # of worksites with supportive management practices	BBGH KHS RWMC PWWC
Decrease substantiated child maltreatment by 5%, annually.	• % of children with at least 1 investigated case of maltreatment • Rate of injury-related visits to ED among HFA children	Healthy Families
Substance Abuse		
Increase tobacco free resources and policies by 5% annually.	• # of tobacco cessation programs • # of tobacco-free policies for businesses • # of tobacco-free policies for schools • # of smoke-free policies for recreational areas • # of people that utilize Quitline • Compliance rate	BBGH CCH KHS PWWC TFN in the Panhandle CAPWN Training Academy State Patrol Region 1
Increase number of people educated by safe alcohol events by 5% annually.	• # of community education activities • # of RBST training attendees • # of TIPS training attendees • Compliance rate	CCH RWMC PPC Training Academy State Patrol

SMART Goals	Performance Measures	Lead Partners
		Region 1
Increase appropriate opioid use by 5% annually.	• # of drug-take back events • # of providers trained on safe opioid prescribing guidelines • # of community education events on dangers of opioids • # of EMS units educated on Naloxone use • # of prescribers using PDMP appropriately	KHS RWMC PPHD CAPWN Region 1 BHA
Increase or maintain percentage of HFA primary caregivers referred to tobacco cessation counseling, annually.	• % of primary caregivers who reported using tobacco at enrollment and were referred to tobacco cessation counseling	Healthy Families
Increase availability of means restriction devices in Panhandle by 5% in 2018.	• # prescription medication lock boxes available to public • # of local law enforcement buildings with permanent drug disposal boxes	PPHD

Strategies

- Violence: Early Childhood Home Visitation To Prevent – Child Maltreatment (Source: Community Preventive Services Task Force)
- Mental Health and Mental Illness: Collaborative Care for the Management of Depressive Disorders (Source: Community Preventive Services Task Force)
- Suicide Risk: Screening in Adolescents, Adults, and Older Adults (Source: United States Preventive Services Task Force)
- Circle of Security
- Families and Schools Together (FAST)
- Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force)
- Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products
- Quitline Interventions
- Smoke-Free Policies
- Interventions to Increase the Unit Price for Tobacco Products
- Alcohol – Excessive Consumption: Enhanced Enforcement of Laws Prohibiting Sales to Minors (Source: Community Preventive Services Task Force)

- Health Communication and Social Marketing: Campaigns That Include Mass Media and Health-Related Product Distribution (Source: Community Preventive Services Task Force)
- Regional Use of Nebraska Prescription Drug Monitoring Program (Source: Nebraska DHHS)

Partners

- Sidney Regional Medical Center
- Regional West Health Services
- Region 1 Behavioral Health Authority
- Disability Rights Nebraska
- Dr. Gage Stermensky LLC
- Western Community Health Resources
- Educational Service Unit 13
- Chadron Public Schools
- Box Butte Family Focus
- Health Thyme, LLC
- Panhandle Health Group
- Options in Psychology LLC
- Deuel County Community Organizer
- Community Action Partnership of Western Nebraska
- Rural Nebraska Healthcare Network
- Gordon Memorial Health Services
- Box Butte General Hospital
- Panhandle Area Development District
- Chadron Community Hospital
- Regional West Garden County
- Kimball Health Services
- Box Butte General Hospital
- Morrill County Community Hospital

Priority 4: Chronic Disease

Objectives

Cancer

- Reduce the proportion of adults with any kind of cancer (based off of HP 2020: C-1)
- Increase the proportion of adults who were counseled about cancer screening consistent with current guidelines (HP 2020: C-18)
- Reduce the proportion of females with human papillomavirus (HPV) infection (HP 2020: STD-9)

Cardiovascular Disease

- Reduce the proportion of adults with hypertension (HP 2020: HD S 5.1)
- Reduce stroke deaths (HP 2020: HD S-3)
- Reduce coronary heart disease deaths (HP 2020: HD S-2)

Diabetes

- Reduce the annual number of new cases of diagnosed diabetes in the population (HP 2020: D-1)

Chronic Disease Risk & Protective Factors

- Increase the proportion of adults who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity (HP 2020: PA-2)
- Increase the contribution of fruits to the diets of the population aged 2 years and older (HP 2020: NWS-14)
- Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older (HP 2020: NWS-15)

Implementation Plan

SMART Goals	Performance Measures	Lead Partners
Cancer		
Increase knowledge of preventive cancer screenings by 5% annually.	• # of community education events for colorectal cancer • # of community education events for breast cancer • # of community education events for cervical cancer	BBGH GMH KHS RWMC
Increase individuals receiving reminder of preventive cancer screenings by 5% annually.	• # of portal reminders for colorectal cancer screening • # of portal reminders for mammograms • # of portal reminders for cervical cancer screening	BBGH KHS RWMC
Increase knowledge of HPV vaccination by 5% annually.	• # of community education events for HPV vaccination	BBGH RWMC
Increase number of individuals completing full course of HPV	• #/% of people receiving HPV series that receive	BBGH RWMC

SMART Goals	Performance Measures	Lead Partners
vaccination by 5% annually.	reminder calls	
Increase radon prevention initiatives by 5%, annually.	• # of radon test kits distributed • % analysis rate • # radon communications	PPHD Environmental Health Program
Maintain or increase safe sun practices, annually.	• # of pools providing shade structures • # of pools to which sunscreen and signage are distributed • # of pools with sun safety policy	PPHD Pool Cool Program
Heart Disease		
Increase health systems with a hypertension policy in place by 1 annually.	• # of health systems with hypertension policy in place	RWMC
Increase use of self-measured blood pressure monitoring in health systems by 5% annually.	• # of health care professionals trained on how to educate patients on SMBP • # of health care professionals trained to calibrate blood pressure monitors	BBGH CCH RWMC
Increase publicly available blood pressure monitors by 5% annually.	• # of publicly available blood pressure monitors	BBGH CCH Community Pharmacists
Increase awareness of stroke symptoms by 5% annually.	• # of health care providers who know warning sign of stroke and when to seek medical attention • # of community education events on stroke	MCCH RWMC
Diabetes		
Maintain or increase number of NDPP classes offered annually.	• # of NDPP classes offered annually • # of counties in which NDPP is offered	BBGH RWMC KHS CCH RWMC NDPP
Increase health systems with policy in place for referral of prediabetics/high risk patients to NDPP by 1 annually.	• # of health systems with NDPP referral policy	BBGH CCH NDPP in the Panhandle KHS MCCH RWGC RWMC
Maintain or increase number of businesses that offer NDPP classes during paid staff time, annually.	• # of businesses that offer NDPP classes during paid staff time	PWWC NDPP in the Panhandle CCH RWMC

SMART Goals	Performance Measures	Lead Partners
Increase health systems that offer DSME by 2 by December 2020.	• # of health systems with DSME	CCH RWMC
Chronic Disease Risk & Protective Factors		
Increase PWWC member worksites that offer health evaluations to employees by 1 annually.	• # of PWWC member worksites that offer HRA	BBGH PWWC CCH KHS
Increase communities with walkable community plans by 1 annually.	• # of communities with a walkable community plan	BBGH GMH KHS RWGC PWWC
Increase walkable campuses by 1 annually.	• # of businesses with walkable campuses	BBGH GMH RWGC PWWC
Increase number of healthy food or beverage policies in PWWC member worksites by 1 annually.	• # of healthy food or beverage policies in PWWC member worksites	BBGH PWWC KHS RWGC
Increase number of healthy food policies in schools by 1 by 2020.	• # of healthy food policies in schools	BBGH
Strengthen healthier food access and sales in retail venues and community venues through increases availability (i.e., Fruit & vegetables and more low/no sodium options), improved pricing, placement, and promotion.	• # of community venues with healthy food options o C-Stores o Grocery Stores o Food Pantries	KHS PPHD
Maintain or increase businesses that have space available of public use for physical activity annually.	• # of businesses with space publicly available to be used for physical activity	KHS PWWC
Increase number health systems following best practice screening protocol for blood lead levels by 5% annually.	• # of health systems educated on best practice protocol • # of providers completing lead testing CEU offered locally in Panhandle	PPHD

Strategies

- Cancer Screening: Multicomponent Interventions (Source: Community Preventive Services Task Force)
    - Colorectal Cancer
    - Breast Cancer
    - Cervical Cancer
- Vaccination Programs: Community-Based Interventions Implemented in Combination (Source: The Community Guide)
- Radon Screening and Mitigation (Source: American Cancer Society)
- Skin Cancer: Multicomponent Community-Wide Interventions (Source: Community Preventive Services Task Force)
- Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force) (See Section 3B section for detailed activities and objectives)
- Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control (Source: Community Preventive Services Task Force)
- Cardiovascular Disease: Self-Measured Blood Pressure Monitoring Interventions for Improved Blood Pressure Control - When Used Alone (Source: Community Preventive Services Task Force)
- Diabetes: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk (Source: Community Preventive Services Task Force)
- Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)
- Physical Activity: Creating or Improving Places for Physical Activity (Source: Community Preventive Services Task Force)
- Strategies to Prevent Obesity and Other Chronic Diseases: The CDC Guide to Strategies to Increase the Consumption of Fruits and Vegetables (Source: CDC/NCCDPHP)
- Tobacco Use and Secondhand Smoke Exposure (Source: Community Preventive Services Task Force) (See Section 3B section for detailed activities and objectives)

Partners

- Sidney Regional Medical Center
- Regional West Health Services
- Disability Rights Nebraska
- Western Community Health Resources
- Community Action Partnership of Western Nebraska
- Bayard Public schools
- Health Thyme, LLC
- Panhandle Health Group
- Scottsbluff Community Health
- Rural Nebraska Healthcare Network
- Gordon Memorial Health Services
- Box Butte General Hospital

- Panhandle Area Development District
- Chadron Community Hospital
- Regional West Garden County
- Kimball Health Services
- Educational Service Unit 13
- Morrill County Community Hospital
- Nebraska Extension
- Garden County Schools

Priority 5: Early Childhood Care & Education

Objectives

- Increase quality childcare and preschool availability (based off of Buffett Early Childhood Institute findings)

Implementation Plan

SMART Goals	Performance Measures	Lead Partners
Increase health systems that support local child care by 1 by 2020.	• # of health systems that support local child care	KHS
Increase number of licensed providers.	• # of providers completing required licensing training • # of providers with provisional license • # of providers with full license	Systems of Care 0-8
Increase number of programs that are enrolled in Step Up to Quality.	• # of programs enrolled • # of recruitment events	Systems of Care 0-8
Increase number of programs trained in Rooted in Relationships by 60, by July 2020.	• # of programs engaged with coaches in 2018 • # of Sixpence programs completing annual trainings • # of early childhood programs completing annual trainings • # of Rooted in Relationships coaches	Systems of Care 0-8

Strategies

- Child Care Quality Measures (Source: Step Up to Quality)
- Health Equity: Center-Based Early Childhood Education (Source: Community Preventive Services Task Force)
- Social-Emotional Development of Children (Source: Rooted in Relationships)

Partners

- Buffet Early Childhood Institute
- Systems of Care 0-8
- Panhandle Schools

Priority 6: Social Determinants of Health

Objectives

Poverty

- Reduce proportion of persons living in poverty (HP 2020: SDPH-3)
- Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade (HP 2020: AH-5.1)

Housing

- Reduce proportion of households that spend more than 30% of income on housing (HP 2020: SDOH-4.1)

Transportation

- Increase use of alternative modes of transportation for work (HP 2020: EH-2)

Intolerance

- Increase the number of health systems that include a standardized set of questions that identify lesbian, gay, bisexual, and transgender people (Based off of HP 2020: LGBT-1)

Implementation Plan

SMART Goals	Performance Measures	Lead Partners
Poverty		
Maintain or increase opportunities for engagement of youth by health systems annually.	• # of positions for youth within health systems • # of student extracurricular activities offered by hospitals	GMH MCCH KHS RWGC
Increase local job opportunities by 5% annually.	• # of community job fairs • # of health care position advertisements	GMH
Housing		
Increase housing opportunities by 5% annually.	• # housing development meetings with hospital representation • # of Section 8 housing opportunities	GMH KHS

Strategies

- Health Equity: High School Completion Programs (Source: Community Preventive Services Task Force)
- Physical Activity: Built Environment Approaches Combining Transportation System Interventions with Land Use and Environmental Design (Source: Community Preventive Services Task Force)
- Health Equity: Cultural Competency Training for Healthcare Providers (Source: Community Preventive Services Task Force)
- Health Equity: Use of Linguistically and Culturally Appropriate Health Education Materials (Source: Community Preventive Services Task Force)

Partners

- Regional West Health Services
- Disability Rights Nebraska
- Regional West Health Services
- The DOVES Program
- Sidney Regional Medical Center
- Dr. Gage Stermensky LLC
- Region 1 Behavioral Health Authority
- Educational Service Unit 13
- Community Action Partnership of Western Nebraska
- Panhandle Trails Intercity Public Transit
- Morrill County Community Hospital
- Western Community Health Resources Western Nebraska Community College
- Panhandle Partnership
- Northwest Community Action Partnership
- Monument Prevention Coalition
- Panhandle Health Group
- Rural Nebraska Healthcare Network
- Gordon Memorial Health Services
- Box Butte General Hospital
- Panhandle Area Development District
- Chadron Community Hospital
- Regional West Garden County
- Kimball Health Services
- Cirrus House