Central District Health Department Annual Report 2008-2009

MISSION:
Our mission is to educate, protect, assist and collaborate through comprehensive public health programs based on best practices. This is achieved by qualified staff empowered by personal and professional growth opportunities. We embrace a philosophy of integrity, commitment, and continuous quality improvement while providing progressive, economically sound programs that target our community's needs.

Many Faces, Many Programs, One Goal: *"A Healthy Community in Which to Live, Work, and Play"*

By Laurie Andrews, Board President

At Central District Health Department (CDHD), we have a variety of programs and services. Our programs are diverse in their makeup and function. Each member of the CDHD staff applies his or her own unique skills, education and experiences to the work at hand. And while our programs and staff are distinctly different from one another, we all share a common goal.

That goal is a "healthy community in which to live, work and play!"

Below, please find an update on the Federally Qualified Community Health Center Project, a regional project which has engaged many partners over the past two years. Following that article, we present the Central District's H1N1 Story recounting how we have addressed the influenza pandemic.

The last section is "The Faces of Public Health", which features the stories of several CDHD staff members along with the programs in which they work. As you will see, many of our staff wear a variety of hats. We think that when you finish reading, you will agree that Central District Health Department is

"Central to Your Health!"

The Making of a Federally Qualified Community Health Center

South Central Nebraska Community Health Center Steering Committee

Access to care is an ongoing issue in Central Nebraska. When the opportunity arose this past year for CDHD to be part of a team in a formal assessment of access to care, we gladly accepted the challenge. We found ourselves headed down the path of determining the need for a Federally Qualified Community Health Center (FQCHC) in Central Nebraska. Our first task was to be certain that access to care was indeed a problem. As a small group, we discussed the meaning of the term "access to care." After some discussion, it was defined as, "the ability to seek and receive appropriate health care services from a qualified provider."

Who were the players in this process? The planning grant for the FQCHC was a collaborative effort of the Iowa Nebraska Primary Care Association (INPCA), the South Heartland District Health Department (SHDHD) and the Central District Health Department (CDHD). The geographic region covered by the planning grant included the seven counties of Hall, Hamilton, and Merrick (CDHD district), and Adams, Clay, Nuckolls, and Webster (SHDHD). The INPCA served as the grant coordinator. A Steering Committee of approximately forty community representatives provided guidance

Continued on Page 2

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The Making of a Federally Qualified Community Health Center *Continued*

for the project's progress. Hospital administrators, public and private health clinic providers, behavioral health administrators, community leaders, minority representatives, and local health department board members all served on this steering committee.

The first step in the process was to complete an assessment of the geographic area. We looked at existing data related to indicators of health and health care coverage. We held focus groups of health care providers and community leaders in each county to learn more about the access to care issue. Additional information was gathered from focus groups of minority residents. In late November and early December, we conducted surveys in parking lots at Wal-Mart stores around the holiday shopping season. We utilized bilingual surveyors who collected information from both English and Spanish speakers. Additional surveys were collected at area immunization clinics, WIC site and Senior Centers. All of this information was compiled into a useable document that was shared with the Steering Committee. Basically, we learned that there were indeed folks who had no medical home, were uninsured, and were not getting preventive care and routine screenings, let alone medical attention for minor to moderate health issues. These folks often ended up in local hospital emergency rooms because they either had no other place to go for treatment, or because they had waited so long to seek care that their health issues had become medical emergencies. We were beginning to see that there was a need, but we decided to dig a little deeper.

In the CDHD district, health department officials met with healthcare providers as a group to discuss their thoughts on the need for a FQCHC, and to answer questions regarding the process. These discussions resolved some lingering concerns related to who might use the FQCHC. As a result, we believed that the majority of area providers were on board with the concept of a Central Nebraska FQCHC. Information related to these discussions was relayed to the Steering Committee.

The Steering committee considered all of the information gathered thus far in the process and concluded there was indeed both a need and desire for a FQCHC in Central Nebraska. The next step was a series of site visits to existing FQCHC's. A subgroup of the Steering Committee toured three FQCHC's in Iowa and Nebraska and observed similarities and differences in operations, services and clientele, and again reported findings to the larger Steering Committee.

Now the question was, "Where will the FQCHC be located?" At this point, the Steering Committee engaged in some healthy dialogue. Both Grand Island and Hastings committee members believed that the city they represented could support the FQCHC, with the notion that the other community would later serve as a second FQCHC site. However, the Steering Committee agreed that Grand Island was the logical first site based on population, with a long range plan to later coordinate the placement of a second site in Hastings. With the assistance of the NE DHHS Office of Rural Health, a grant writer was hired. The Central Nebraska Area Health Education Center (CN AHEC) was contracted to serve as the local coordinating agency.

At this writing, the process continues to move forward. The yet-to-be-built FQCHC now has an official name: Heartland Health Center, Inc. A Transitional Board for the Heartland Health Center, Inc. has been actively meeting, and progress is being made according to an established timeline. Our goal is to submit an application at the next possible funding opportunity. A successful grant application means federal dollars coming to our community on an annual basis to supplement the FQCHC's services and programs.

The process has been rewarding, if not somewhat groundbreaking in its initial impact. Members of communities who may not normally work shoulder to shoulder on collaborative health-related projects put aside differences and personal agendas for the good of the entire 7-county area. New working relationships that will benefit the entire region have been formed. In the near future as progress continues, all residents of Central Nebraska will be able to seek and receive appropriate health care services from qualified providers.

An Unusual and Challenging Flu Season

We don't usually think flu in the spring. In a typical cycle of influenza (flu), we place an order for vaccine in late winter, and then essentially forget about it until September when we start planning clinics. But this past year was anything but typical. In the spring of 2009, we were greeted by the threat of a pandemic (world-wide outbreak of a new disease or virus) of influenza. The culprit was the novel H1N1 influenza virus, which was spreading quickly worldwide and affecting our young people disproportionately. This threat presented us with challenges as well as opportunities. Our first step was to form an internal H1N1 committee made up of staff, each with a variety of expertise.

Continued on page 3

An Unusual and Challenging Flu Season *Continued*

Each staff member was assigned an area such as school liaison or media contact. Our weekly meetings involved updates on the progression of H1N1 and local activities by committee members.

By April 2009, CDHD staff was communicating on a regular basis with representatives of schools, physician offices, and hospitals to address the looming pandemic. We were also in contact with businesses and the community in general to help them prepare for the H1N1 pandemic. We started making plans for vaccinating folks when vaccine became available.

Ideally, our initial efforts would be aimed at preventing H1N1 from entering our community altogether, but that soon proved impossible. Therefore our focus was on controlling the number and severity of cases of H1N1. Through a public health education campaign, we provided folks with information designed to help them protect themselves and their families from coming into contact with the virus. We gave them information and encouraged them to prepare home disaster kits that included enough food and water to get them through at least three days of being homebound.

It proved true that our children were particularly susceptible to the virus. We met with school officials and developed plans for vaccinating students. We met with representatives of physician offices and hospitals to inform them of the vaccine situation, and we discussed how we could provide them with vaccine once shipments started rolling into the district. We moved the dates of our seasonal (usual) influenza vaccination program forward. Getting an early start on seasonal influenza vaccinations meant more time and energy to deal with H1N1 vaccinations later when that vaccine became available.

We produced materials in several languages for specific groups (parents, childcare providers, school officials) most likely to be affected by the virus. These pamphlets were designed to help folks recognize symptoms of H1N1 and to take appropriate measures should a child in their care become ill.

We were informed that vaccine would trickle in at first and then become more plentiful later in the season. We estimated the number of high-risk folks as identified by the Centers for Disease Control (CDC) who lived in our area. We made plans for school-based clinics and for public clinics to vaccinate these high-risk groups first. We planned and prepared to be certain we had the staff and supplies necessary for our clinics. Knowing that all H1N1 vaccine coming to our area would come directly to us, we worked out a distribution system to get vaccine into the hands of area health providers so that they could reach priority groups quickly.

In early October, we were informed that vaccine was on the way. One of our established goals was to move the vaccine as quickly as possible once it arrived. Basically, we wanted to get the vaccine out of our refrigerator and into people's bodies as soon as possible. Our months of planning started to pay off for us. As vaccine came in, we redistributed approximately half to area hospitals and medical clinics for their use in high-risk individuals. We reserved H1N1 intranasal FluMist for school-age children, and once we received enough nasal mist vaccine for a school on our list, we held a clinic at that school. We also began holding clinics at our Grand Island and Central City offices for those in high-risk groups. In the first two weeks of H1N1 vaccine availability, we had given 1550 doses to those in the high-risk groups. Each week, we gave vaccine till there was no more to give and then we planned for the next vaccine delivery. Later, when vaccine

availability allowed, we opened clinics to everyone wishing to be vaccinated. We arranged to go on-site to area businesses as requested to vaccinate against H1N1.

By the end of January 2010, we had vaccinated approximately 25% of the Central Nebraska population. We gave over 4000 H1N1 influenza vaccinations to school-age and preschool children through our school-based clinics. Then based on the recommendation that all children younger than age 10 should receive a second dose, we returned to schools to repeat vaccinations for approximately 2000 preschool and elementary children. We estimate that of those needing a second dose, just slightly less than 80% received it at a school-based clinic.

Continued on Page 4

An Unusual Flu Season *Continued*

As we reflect on our experiences with H1N1 Pandemic this past year, we agree that we as a community have been successful in limiting the virus spread.

We have identified four reasons: Planning, Priorities, Partnerships, and Patience.

Planning: "Pandemics actually do happen! "

We utilized our years of preparing for a pandemic as our initial base for action. Then we developed an H1N1 plan that was fluid and adaptable, adjusting it as circumstances changed. We, in effect, practiced what we preach every day about being prepared. And it paid off for us.

Priorities: "Setting priorities is the Priority. "

Early on, we determined that H1N1 pandemic was our priority. In addressing the pandemic, we emphasized the importance of communication, capacity, and continuity of operations. . When high priority groups were identified by the CDC, we made it our priority to establish the number of folks in each priority groups and planned how best to vaccinate them first.

Partnerships: "Coming together is a beginning. Keeping together is progress. Working together is success."

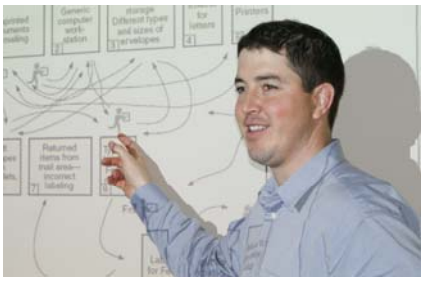
Schools, media, health providers, elected officials, Nebraska Health and Human Services and other entities served as partners in controlling H1N1 in our community. Clearly, without the ongoing investment by these partners, our success would have been limited at best.

Patience: "Patience is Waiting."

We found that we could control some things and not others. Patiently waiting for vaccine might have presented a challenge, but it gave us adequate time to plan and prepare and we utilized that time well.

The Faces of Public Health

Jeremy Eschliman



Jeremy has been with CDHD for nine years. A graduate of Wayne State College with a Bachelor's degree in Chemistry and Biology, Jeremy has always had an interest in the medical field. While in college, Jeremy worked at a food processing plant where he developed great respect for food safety. After college, he spent a short time working in a laboratory with an emphasis on quality control measures. Then he applied for a position in environmental health at the Grand Island Hall County Health Department (now CDHD), and began his employment in 2000 as an Environmental Specialist. He became a Registered Environmental Health Specialist a short time later. Over the years, Jeremy has seen the inside of many food establishments. "One of the things I enjoyed most about my work in food safety was the opportunity to educate food handlers on safety guidelines. In that position, I was able to make a positive impact on the health of the community on a daily basis. "

Jeremy recently accepted the position of Community Health Analyst at CDHD. "In this new position, I can apply my experience and knowledge of our community in assessing the community's health status, and also in developing quality management department-wide. I hope to have an even greater impact on the health of this community by assuring that our programs meet quality standards and are achieving their goals."

Last year, CDHD's Food Inspectors completed over 1000 inspections of food establishments, including restaurants, bakeries, school cafeterias, bars, convenience stores, food warehouses, mobile food units, and grocery stores in Hall County. Over 100 follow-up inspections were made to food establishments where critical food violations (contamination, chemicals, temperature, food dating, employee health and hygiene)were identified to assure that appropriate corrections were made to assure food safety. Additionally, inspectors provided education and guidance to retailers and consumers on food recalls related to foodborne illness outbreaks.

Inspectors responded to truck wrecks on the area highways and interstate where food products are involved to assure that damaged foods are properly disposed.

FACT: While the American food supply is among the safest in the world, the Federal government estimates that there are more than **76 million cases** of foodborne illness annually, resulting in **325,000 hospitalizations** and **5,000 deaths** - meaning that roughly 13 men, women and children die every day because of foodborne illness. (http://www.fda.gov/Food/ResourcesForYou/Consumers/ucm103263.htm).

The Faces of Public Health

Mike Darbro

One may not associate emergency preparedness with public health programs and services, but Mike Darbro would advocate for preparedness to be a part of every person's life every day of every year. Mike, an Emergency Medical Technician who holds Bachelor's Degrees in Journalism, English Literature and American History has been at CDHD for the past five years as Emergency Response Coordinator. "When I saw this position advertised, I thought it fit my skills and experience, but even more, I saw it as an opportunity to help people. I know this sounds trite but it is true." Mike's responsibilities range from educating families and individuals on self sufficiency, to helping businesses and senior living facilities develop continuity of operations plans, to working with emergency personnel in the district to quickly and effectively provide medications and vaccines to the district in the event of a full scale disaster. Currently Mike serves as Chair of the Tri Cities Medical Response System (TRIMRS), a hospital-based organization designed to enhance the capacity of area hospitals respond to emergencies. Mike also chairs the Central Nebraska Medical Reserve Corps, a federally funded organization made up of volunteer healthcare professionals who respond to emergency situations across the country. In July 2009, Mike was selected by the Grand Island Independent as Extraordinary Person of the Week.

"The thing about my job that I find most gratifying is being part of the public health team, participating in a variety of programs and activities."

An example of Mike's willingness to expand his role include his work on the implementation project for Grand Island and the State going smoke-free, providing Fluoride information to the public, and assisting with the coordination of the volunteer plan for Mission of Mercy Dental Clinic. , Mike also spends time orienting health profession students visiting CDHD to the world of public health. His attitude is reflective of many CDHD staff members who actively volunteer to participate in teamwork as needed. "There are times around here, when I am the only person available to answer the phones, so I do that too."

FACT: Emergency preparedness is for everyone all the time. Every home should have a disaster kit with enough food and water to last three days; flashlight and radio, plus extra batteries; and a first aid kit. In Nebraska, severe weather is a year-round threat. Every business and home should have a disaster plan and every person should be familiar with it. Staying informed is key to staying safe!

TORNADO SAFETY

Home Inspection Checklist

The following suggestions will reduce the risk for injury during or after a tornado. No amount of preparation will eliminate every risk.

Possible Hazards

Inspect your home for possible hazards, including the following:

Are walls securely bolted to the foundation?

Are wall studs attached to the roof rafters with metal hurricane clips, not nails?

Utilities

Do you know where and how to shut off utilities at the main switches or valves?

Home Contents

Are chairs or beds near windows, mirrors, or large pictures?

Are heavy items stored on shelves more than 30" high?

Are there large, unsecured items that might topple over or fall?

Are poisons, solvents, or toxic materials stored safely?

The Faces of Public Health

Trina Vap

Trina is a relatively new staff member at CDHD. Trina joined the staff in 2008 as a Health Educator. With a Bachelor's Degree in Dietetics from University of Nebraska Lincoln, Trina has a strong interest in public health. "In the two years I've been here, I have learned so much." Among other duties, Trina is responsibilities for disease surveillance. "Part of my job is to investigate what we call notifiable diseases. These are diseases where public health reporting is required by state law. I look for trends in disease outbreaks- things like food borne illness, West Nile Virus and Influenza. This past year with H1N1 virus, our disease surveillance in schools showed a marked increase in school illnesses even before we had laboratory confirmation. The fact that we were able to catch H1N1 activity very early supports the value of what I do."

Another function of the Health Educator position is to work with Nebraska Health and Human Services in the Tuberculosis Program. Trina coordinates a process called "Direct Observation Therapy" (DOT) for clients diagnosed with tuberculosis. The bacterium that cause tuberculosis is very hearty and individuals often have a complicated medication schedule, taking maybe six different medications daily for as long as a year." Taking pills gets old for nearly anyone. Our job is to help these folks complete the treatment as prescribed.

If they don't, the disease can come back stronger, and others may become infected."

Arrangements are made with clients so that CDHD staff can observe them taking medications. "It's been proven that if we watch the medication being taken, clients are more likely to finish the treatment plan."

Trina also coordinates the "Be Your Kid's Supermodel" campaign. This program targets parents of young children with positive health messages. Studies show that if parents do things to stay healthy, children are likely to model that behavior. As a Health Educator, Trina is often called upon to provide current information on a variety of health issues. "Every day is different, exciting and challenging!"

FACT: The "Be Your Kid's Supermodel" Campaign is based on making parents more aware of the importance of role modeling health behavior for their children. Using a variety of media including television, radio, and billboards, consistent messages on positive role modeling are delivered. Recently, pre and post program surveys results were compared. Positive changes reported in children's daily physical activity, the number of parents who engaged in physical activity with a child, and the amount of time a child was allowed screen time (computer, game television time). Just over 25% of parents reported having seen the Supermodel television spots.

Karen Helms

A long term staff member, Karen Helms has been a secretary in the CDHD Women, Infant and Children (WIC) Program for 24 plus years. For Karen, the reason for being a part of public health is simple. "I feel like we make a positive impact on the parents and the children we serve. By helping them get nutritious foods, we help them eat better. Hopefully, by eating healthier foods, they will develop healthier habits all around." Karen is one of first contacts for people coming to WIC. She asks potential clients a series of questions to determine eligibility for the WIC program. Then she explains the program and the rights and responsibilities to each new client before she schedules them to see a health professional. "For me, being here for so many years, I am now seeing the third generation - moms in the old days are now the grand moms." One thing that Karen sees changing over time is the makeup of the WIC clientele. "The people we serve are now quite diverse, more so than say 15 years ago."

Karen recently extended her role to vendor management. "I am the contact for the stores who participate in the WIC Program to make sure things go the way they should. Basically, I do the training for store managers every three years. I also follow up on potential problems like inventory levels of new foods."

The Faces of Public Health

This year, the WIC Program implemented a new food package nationwide. This allows expanded choices in fruits and vegetables and more high fiber foods. For infants, baby fruits and vegetables are now a contract food. WIC staff has spent many hours working with vendors as well as with clients to assist them in understanding these changes. "Some days it gets really complicated - only certain brands and sizes are allowed. All of this is federally mandated. We get to deal with any issues on the local level." Karen remains enthusiastic and positive. "When you see an overweight child who, over time shows change for the better, Mom is happier, the child is happier, and I feel like I've accomplished something. It really is gratifying!"

NEBRASKA WIC INCOME GUIDELINES Effective July 1, 2009 through June 30, 2010			
1 person	$20,036	$1,670	$386
2 person	$26,955	$2,247	$519
3 person	$33,874	$2,823	$652
4 person	$40,793	$3,400	$785
5 person	$47,712	$3,976	$918
6 person	$54,631	$4,553	$1,051
7 person	$61,550	$5,130	$1,184
8 person	$68,469	$5,706	$1,317
For each additional family member, add:			
	+$6,919	+$555	+$134

FACT: The average monthly enrollment at the CDHD WIC Clinic is 2722. Criteria for WIC eligibility in Nebraska are as follows: 1) A resident in Nebraska; 2) pregnant, breastfeeding, postpartum, infants or children up to age 5; and, 3) 185% of poverty.

Rosa Coronado-Solis

"When I first arrived in Grand Island with my husband, we were essentially all alone. I had to explore where to go to access appropriate services. From that experience, I learned how to help others." Rosa has been in the United States for eleven years. She works full time at CDHD, splitting her time between WIC where she serves as a Clerk, and in Community Health where she serves as a Community Health Peer Educator.

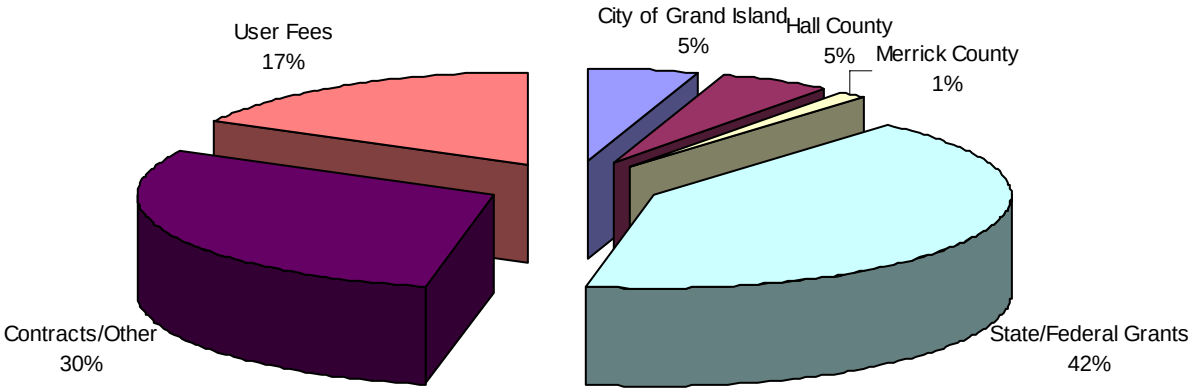
Rosa clearly outlines her reasons for wanting to work at CDHD. "The first reason is that when I was pregnant with my first child, I applied for WIC. I liked the service, and I liked the people. I thought to myself, one day I could work for WIC. The other reason is that I saw clearly how the WIC staff maintained confidentiality of the people served - you can really trust them. The third reason is that I really knew growing up in Mexico that working for a health department would be a good opportunity for me to learn, and at the same time help the community.

Before coming to Grand Island, Rosa graduated from the University of Guadalajara, Mexico with degrees in Business Administration and Human Resources. She was also educated and certified as a Preschool Teacher, a profession she left behind in coming to the States.

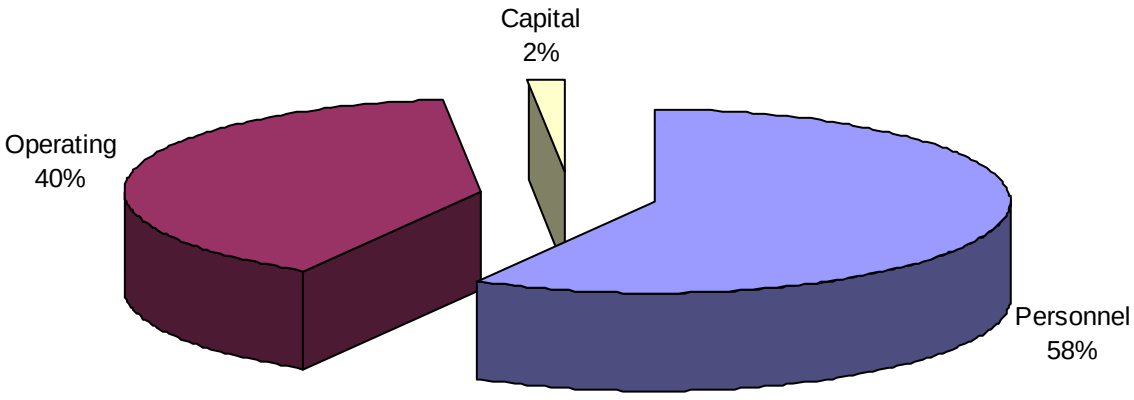
The Hall County Minority Health initiative is a collaborative effort of the Grand Island Multicultural Coalition, Saint Francis Medical Center, CDHD, Third City Community Clinic, Hope Harbor, Neighborhood Nursing Project, YWCA and YMCA. Rosa looks with optimism at her role as a Peer Educator, fulfilling CDHD's commitment to the project. "First of all, I get to meet people from different countries and to understand their culture and background. I have the opportunity to inform them of which health services they can and should receive. Sometimes they are new to this country and they don't know what is available here. I work with them on things like enrolling their children in Kids Connection, how to find a dentist, how to pay bills for food and rent when it seems they don't have enough money, where to get vaccinations, lots of questions like that. Because of my experiences in coming to Grand Island, I believe I know what is important to share with newcomers, so that they stay healthy and become familiar with our way of life."

FACT: A comparison between the 2000 U.S. Census data of Hispanic residents and the 2007-2008 Grand Island public school enrollment clearly indicates a growing number of Hispanic residents. Latino newcomers to the United States face similar health issues as do longtime residents. Obesity, diabetes and cardiovascular disease are present in even higher percentages in Latino vs. non-Latino residents. Additionally, Latino-Americans have a disproportionate burden of poverty and a lack of insurance.

Revenue By Source



Expenditure By Category



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Jeremy Eschliman.....Community Health Analyst
Nola Bailey.....Receptionist
Shirley Bouska.....Administrative Secretary

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Elnida Chandler.....Community Health Supervisor
Diane Bockmann.....Community Health Nurse
Delores Brabander.....Community Health Nurse
Jeanniene Burdett.....Community Health Nurse
Stacey Burns.....Breastfeeding Peer Counselor
Rosa Coronado-Solis.....Health Clerk
Cielo Delarosa.....Health Clerk
Sherry Dockweiler.....Community Health Nurse
Linda Erickson.....Community Health Nurse
Karen Helms.....Administrative Secretary
Alma Low De Fuentes.....Breastfeeding Peer Counselor
Vicki McDermott.....Community Health Nurse
Jane Miller.....Community Health Nurse
Susan Monaghan.....Community Health Nurse
Rachel Sazama.....Nutritionist
Lynette Weller.....Nutritionist
Ursula Wilson.....Administrative Secretary

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Tina Byerly.....Administrative Secretary
Rosa Coronado-Solis.....Peer Health Educator
Michael Darbro.....Emergency Response Coordinator
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