**2016-2018 Implementation Plan (In progress)**

**Definitions:**

* **Priority Area:** Broad health issue being targeted, usually one of the community level indicators identified in the CHNA
* **Goal:** Broad statement of what will be achieved (e.g., vision)
* **Community Indicators:** Related data from CHNA
* **Timeframe:** Length of time for which the plan is targeting (in almost all cases will be FY17-FY19)
* **Scope:** Provides details on target geography and population
* **Strategy:** the overarching approach to help meet the goal (e.g., program, initiative, policy, grant, etc.)
* **Key Activities:** high-level actions to be taken as part of the strategy, not as detailed as an action plan
* **Hospital Role:** provides additional detail of the Hospital’s specific role in the work, especially important for community strategies (e.g, funder, grant management, provides educators/nurses, etc. )
* **Required Resources:** key resources that will be allocated to the strategy (e.g., grant money, staff, curriculum, etc.); does not have to include a budget but should if known.
* **Anticipated Impact:** what is the intended change as a result of the strategy (high-level, e.g.,
* **Measures:** measures of the activities that show progress toward the anticipated impact (# of classes, # of participants, amount of money provided, etc.); changes that are seen as a result of the activities (e.g., knowledge, attitude, behavior, health status); as specific as possible and reasonable.
* **Data Sources/Evaluation Plan:** Outlines what data will be collected, from, where, and when.

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| Priority Area # 1: Behavioral Health | | | |
| Goal | To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues. | | |
| Community Indicators | **CHNA 2013**   * 12.1% of adults 18+ reported frequent mental distress in the past 30 days. * The suicide death rate was 9.3 per 100,000 population (age-adjusted). | | |
| **CHNA 2016**   * 6.6% of adults 18+ reported frequent mental distress in the past 30 days. * The suicide death rate was 13.2 per 100,000 population (age adjusted). | | |
| **CHNA 2019** TBD | | |
| Timeframe | FY17-19 | | |
| Background | **Rationale for priority:** Behavioral health is consistently identified as a top health priority for the community. The suicide death rate has increased over time, access to behavioral health services and the cost of mental health services are reported barriers to accessing care for people with mental health problems in the community. | | |
| **Contributing Factors:** Cost, fragmentation of services, lack of availability of services, societal stigma toward mental illness. | | |
| **Research (if appropriate):** | | |
| **National Alignment:** Healthy People 2020 Goal is to improve mental health through prevention and by ensuring access to appropriate, quality mental health services. | | |
| **Additional Information:** | | |
| 1.1 Strategy & Scope: Expand behavioral health prevention that educates and engages parents of children and youth through the support of Parent University concept in Hall County, NE. | | | |
| Anticipated Impact | | **Hospital Role/ Required Resources** | **Partners** |
| * Improved positive parent/child relationships * Parents indicate a more positive relationship with children, etc. * Improve children’s knowledge and practice of good behaviors including dangers of alcohol, tobacco and drugs, etc. * Families stabilized through in-home Family Services. * Improvement in community child well-being indicators | | CHI Health System Role(s):   * Provide financial support * Strategic oversight (Behavioral Health Service Line) * Grant management   CHI Health St. Francis Role(s):   * Local Sponsor * Community Partnership   Required Resources:   * CHI Mission an Ministry grant funding * CHI Health Healthier Communities funding * Other H3C and GIPS funding * Hall County Community Collaborative (H3C)-Backbone Organization * Community partners | * Hall County Community Collaborative (H3C) * Grand Island Public Schools |
| Key Activities | | **Measures** | **Data Sources/Evaluation Plan** |
| * Implement the Circle of Security- Parent (COSP) program and identify potential educators in the community to be trained (up to 2 individuals). * Offer up to 4 COSP classes in year one. * Offer up to 5 COSP classes in year 2 and 3. * Train and secure additional Discovery Kids staff to implement program in additional schools for the 2nd -5th grade children 5-6 series per year. * Expand Discovery Kids in the Elementary Schools of 5-6 series per year. * Begin developing a sustainability plan for post grant. * Finalize sustainability plan and prepare to implement. | | * % of COSP parents that indicate a more positive relationship with children. * % of Discover Kids showing increasing knowledge of steps to reach goals, who make good choices, and know about dangers of alcohol, tobacco, and drugs, etc. * # of Circle of Security – Parent (COSP) classes offered * # of parents completing the COSP class. * # of new Discovery Kid classes offered. * # of additional children participating in Discovery Kids. * # of parents participating and completing the in-home Family Services. * Sustainability Plan established. | * COSP Parent survey-post/at the end of the program * Pre-post program survey * Annually |
| Results *(pending)* | | | |
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| Priority Area # 2: Injury & Violence Prevention | | | | |
| Goal | Reduce unintentional injuries and violence in Hall County. NE | | | |
| Community Indicators | **CHNA 2013**   * The KIDS Count reported 952 annual juvenile arrests in Hall County. * Unintentional injury death rate was 33.3 per 100,000 population (age-adjusted). * Motor vehicle crash death rate of 16.8 for per 100,000 (age-adjusted). * Number of Falls for adults 65+ was \_\_\_ in 2013 | | | |
| **CHNA 2016**   * The KIDS County report 632 annual juvenile arrest in Hall County. * Unintentional injury death rate was 47.7 per 100,000 population (age-adjusted). * Motor vehicle crash death rate of 23.7 for per 100,000 (age-adjusted). * Number of Falls for adults 65+ was \_\_\_\_in 2015 | | | |
| **CHNA 2019** | | | |
| Timeframe |  | | | |
| Background | **Rationale for priority:** The juvenile arrest rate of 632 for Hall County ranks the third highest in the state in 2013. Poverty remain significant issues for Hall County. Unintentional injury death rate per 100,000 population has increased to 47.2, with falls being the leading cause of hospital injury data. | | | |
| **Contributing Factors:** The social environment has a notable influence on the risk for injury and violence through:  Individual social experiences (social norms, education, victimization history),  Social relationships (parental monitoring and supervision of youth, peer group associations, family interactions),  Community environment (cohesion in schools, neighborhoods, and communities) and  Societal-level factors (cultural beliefs, attitudes, incentives and disincentives, laws and regulations) | | | |
| **Research (if appropriate):** | | | |
| **National Alignment:** Healthy People target goal is to prevent unintentional injuries and violence, and reduce their consequences. | | | |
| **Additional Information:** | | | |
| 2.1 Strategy & Scope: Implement SANKOFA and Families and Schools Together (FAST) program at the middle schools in Hall County, NE. | | | | |
| Anticipated Impact | | **Hospital Role/ Required Resources** | | **Partners** |
| * Decrease youth arrest rate and gang recruitment. * Increased graduation. * Reduced crime/school violence. | | CHI Health System Role(s):  CHI Health Saint Francis Role(s):   * Leadership * Technical assistance * Provide staff for H3C steering committee and on the Executive Board * Grant management   Required Resources:   * CHI Mission and Ministry funding * NE Office of Juvenile Justice funding * Community partners time * Facilitator services * Project coordinator * Interpreters | | * Hall County community Collaborative * Gang Violence Prevention Coalition * Grand Island Police Department, * Grand Island Public Schools |
| Key Activities | | **Measures** | | **Data Sources/Evaluation Plan** |
| * Continue SANKOFA Program at the three middle schools. * Identify and recruit at least 180 students for the SANKOFA program. * Develop continuity between the Families and Schools Together (FAST) program and the SANKOFA program and improve link to students to the SANKOFA program. * Expand SANKOFA facilitators and adapt curriculum to enhance and further SANKOFA learning experience. * Monitor SANKOFA graduates to ensure sustained benefits/ skills over time. | | * # of SANKOFA graduates * # of SANKOFA enrolled in Beyond SANKOFA * 75% of participants will complete the SANKOFA program. * 85% of SANKOFA graduates will say they improved personal assets. * 80% of SANKOFA graduates will improve attendance at middle school level l. * 70% of SANKOFA graduates will improve grades at middle school level. * 80% of SANKOFA graduates will avoid criminal and school-related trouble. * 50% of SANKOFA graduates will improve attendance at the high school level. * 50% of SANKOFA graduates will improve grades at the high school level * 70% of SANKOFA graduates will avoid criminal and school-related trouble at the high school level. | | * Grand Island Public School records * Grand Island Police records * Pre and Post Surveys |
| Results *(pending)* | | | | |
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| 2.2 Strategy & Scope: Provide Child Safety education to prevent injury in children of Hall County, NE. | | | | |
| Anticipated Impact | | **Hospital Role/ Required Resources** | **Partners** | |
| * Reduce unintentional child injury due to motor vehicle crashes | | CHI Health St. Francis Role(s):   * Lead program * Provide staff * Collect data * Provide car seats   Required Resources:   * Staff * Car seats | * Kohl’s, * Children’s Day Festival * Conestoga Mall | |
| Key Activities | | **Measures** | **Data Sources/Evaluation Plan** | |
| * Provide 8 educational Child Safety events each year on car seat safety and installation. * Provide 400 hospital postnatal LDRP/NICU car seat educational visits, and car seat Inspection appointments. * Develop pre/post survey. | | * % of participants who increase knowledge of proper car seat installation. * # of car seats inspected * # of consultations * # of community events scheduled * # of children reached | * Emergency department registration data * Surveys | |
| Results *(pending)* | | | | |
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| 2.3 Strategy & Scope: Provide fall prevention programs targeted at residents aged 60 and over. | | | | |
| Anticipated Impact | | **Hospital Role/ Required Resources** | **Partners** | |
| * Improve balance and of our adults 65+ and older. * Decrease incidence of falls for adults 65+ years. | | CHI Health St. Francis Role(s):   * Funding * Staff   Required Resources:   * Funding * Staff * Supplies/materials * Partnerships | * Saint Mary’s Catholic Church, * Area on aging * Community Nursing Homes * Area on aging, Grand Generation * St. Leos Church * YMCA * Merrick Foundation | |
| Key Activities | | **Measures** | **Data Sources/Evaluation Plan** | |
| * Train 10 new instructors for Tai Chi classes * Find key locations to implement Tai chi programs. * Offer three 12-week Tai Chi--Moving for Better Balance classes to improve functional status and decrease falls for adults 65 years and older. * Secure financing to expand the program to other counties. | | * % increase in functional status of our 65+ and older * % improvement balance * # of staff trained * # of classes offered * # of individuals participated | * Class attendance sheets * interview responses * Pre/Post participant survey * Pre/Post clinical assessments * Hospital ER data- unintentional injury for Falls | |
| Results *(pending)* | | | | |
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| Priority Area # 3: Access to Care | | | |
| Goal | To improve access to health care services, especially for those in underserved communities. | | |
| Community Indicators | **CHNA 2013**   * 12.6% of adults 18 years or older reported that they needed to see a doctor but could not due to cost. * 19.2% of adults 18-64 years old have no health coverage | | |
| **CHNA 2016**   * 14.1% of adults 18 years or older that needed to see a doctor but could not due to cost. * 18.2% of adults 18-64 years old have no health coverage. | | |
| **CHNA 2019** | | |
| Timeframe | TBD | | |
| Background | **Rationale for priority:** Access to care is consistently identified as a top health priority for the community. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.  Community stakeholders discussed barriers to accessing health care include transportation, lack of insurance, low rate of primary care providers accepting new Medicaid patients. | | |
| **Contributing Factors:** With the passing of the ACA,Nebraska did not expand Medicaid, therefore, there remains a coverage gap for Hall County residents with incomes between 100% and less than 138% of the Federal Poverty Level who are not eligible for the Medicaid program as it currently exists in Nebraska and also not provided a subsidy for health insurance premiums through the Healthcare Marketplace. Additional contributing factors include: transportation, hours and locations of health services, language. | | |
| **Research (if appropriate):** | | |
| **National Alignment:** Health People Target is to improve access to comprehensive, quality health care services. | | |
| **Additional Information:** | | |
| 3.1 Strategy & Scope: Provide assistance and support of Third City Community Clinic to improve access to healthcare for uninsured and underinsured populations in Hall County. | | | |
| Anticipated Impact | | **Hospital Role/ Required Resources** | **Partners** |
| * Reduce unnecessary healthcare costs. * Reduce health disparities by assisting individuals to find a medical home. * Improve access and referrals to community resources resulting in better outcomes | | CHI Health St. Francis Role(s):   * Funding * Staff   Required Resources:   * Staff * Funding * Administration support * Supplies**-**operations and functions | * United Way |
| Key Activities | | **Measures** | **Data Sources/Evaluation Plan** |
| * Provide financial support for clinic operations and functions * Continue referral process for uninsured/underinsured populations from St. Francis to Third City Community Clinic. * Offer Community Health Workers (CHW) to assist individuals in navigating community resources, programs and services. | | * % reduced unnecessary ER visits. * % of individuals with a medical home. * % of individuals who receive follow- up services. * # of patients served at Third City Clinic * # of St. Francis referrals to Third City Community Clinic * # of referrals to community resources/programs | * Hospital data * CHNA |
| Results *(pending)* | | | |
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| 3.3 Strategy & Scope: Support preventive and early detection with health screenings for uninsured/underserved individuals in Hall County. | | | |
| Anticipated Impact | | **Hospital Role/ Required Resources** | **Partners** |
| * Increase screening rates for blood pressure, diabetes (glucose), cholesterol, breast cancer, HIV and dental with follow-up care navigation. * Increase knowledge of early prevention. | | CHI Health St. Francis Role(s):   * Staff * Funding * Support * Data collection   Required Resources:   * Community partnerships * Funding * Staff time * Educational and screening supplies | * Central District Health Department, * Third City Clinic * Heartland Health Center * Hy-Vee * Old Walnut * Neighborhood Nursing * Central Health Center * HHS * UNL * Hall County Extension Office. |
| Key Activities | | **Measures** | **Data Sources/Evaluation Plan** |
| * Provide 3 screening a year for blood pressure, diabetes (glucose), cholesterol, breast cancer, HIV and dental decay. * Develop pre/post evaluation to determine increase in knowledge. | | * % of individuals receiving follow up care * % who show an increased knowledge of early prevention * # of screenings events/# of referrals * # of total screenings/# of referrals * # of blood draw screenings/# of referrals * # of dental screenings/# of referrals * # of breast exams/# of referrals * # of HIV Screenings/# of referral | * Hospital data * Pre-post survey * Baseline and Bi-annually |
| Results *(pending)* | | | |
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| 3.4 Strategy & Scope: Provide convenient mental and physical health care in a school-based health care facility for middle and high schools students in Grand Island, NE. | | |
| Anticipated Impact | **Hospital Role/ Required Resources** | **Partners** |
| * Improve teens' access to mental health services * Improve teens' access to health care services | CHI Health St. Francis Role(s):   * Funding * Staff   Required Resources:   * Community partnerships * Funding * Staff time | * CHI Health Saint Francis * Third City Community Clinic * Grand Island Public Schools * Heartland Health Center * HHS * Richard Young Behavioral Center (RYBHC) |
| Key Activities | **Measures** | **Data Sources/Evaluation Plan** |
| * Hold a clinic at the high school 5 days a week to provide medical care. * Offer 2 behavioral health therapists at the high school 5 days a week for behavioral health counseling. * Offer psychotherapist through RYBYC using telehealth 2 times a month at the high school. * Recruited and contract with community therapist to provide 1 day behavioral health counseling to 3 middle schools (16 hours of on-site). * Develop a strategy to improve awareness of services. * Establish strategy or partnership to assist on increasing insurance coverage for all students. * Established sustainability of school health clinic through insurance reimbursement for primary care services provided by nurse practitioner/ in schools. | * % of students who are uninsured. * # of students served at the clinic for mental health care. * # of students served at the clinic for health care. * # of students receiving psychotherapy via telehealth | * Student Wellness Center (SWC) counseling records * Wellness Center records |