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# COMMUNITY HEALTH IMPROVEMENT PLAN

Serving the Counties of: Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock

2016-2019


NCDHD
North Central District
Health Department

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# ACKNOWLEDGEMENTS

The North Central District Health Department would like to recognize the following organizations for their participation in the planning sessions that led to the development of this report:

North Central District Health Department (NCDHD)
Antelope Memorial Hospital
Avera Creighton Hospital
Avera St. Anthony's Hospital
Brown County Hospital
Cherry County Hospital
CHI Health Plainview Hospital
Niobrara Valley Hospital
Osmond General Hospital
Rock County Hospital
West Holt Memorial Hospital
The Evergreen Assisted Living Facility
Cottonwood Villa Assisted Living Facility
Good Samaritan Society – Atkinson
Pregnancy Resource Center
Finish Line Chiropractic
Counseling & Enrichment Center / Building Blocks
Region 4 Behavioral Health System
Central Nebraska Community Action Partnership
Northeast Nebraska Community Action Partnership
Northwest Nebraska Community Action Partnership
NorthStar Services
NCDHD Board of Health
North Central Community Care Partnership
Area Substance Abuse Prevention Coalition
O'Neill Chamber of Commerce
Central Nebraska Economic Development
Holt County Economic Development
Knox County Economic Development
Neligh Economic Development
Pierce County Economic Development
University of Nebraska Lincoln Extension Office, Brown-Rock-Keya Paha County
Ewing Public School
Lynch Public School
O'Neill Public School Board
O'Neill Ministerial Association
West Holt Health Ministries
O'Neill Lions Club
O'Neill Rotary Club
Mitchell Equipment – O'Neill, NE
Family Service Child Care Food Program

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# EXECUTIVE SUMMARY

The health of our nation and its people is an especially important topic. Improving and maintaining good health for the entire nation starts with a dedicated public health system that works together at the local level to promote quality of life, health equity, supportive environments, and healthy behaviors across all life stages.

This community health improvement plan was developed through a collaborative process involving a wide variety of local community partners and stakeholders. It serves to describe the priority health issues identified through the community health assessment process, and outlines the work plan developed to address those issues.

Individuals and organizations involved in the effort thus far have committed to continue their participation as workgroup members to strategically implement work plan action items. A tracking system has been developed to document activities completed by all participating workgroup partners and periodic progress updates for each priority health issue.

As the public health system serving north-central Nebraska, we are excited to move forward into the implementation phase of our community health improvement efforts, with a focus on building and strengthening the local foundation that will ultimately serve to support good health for our entire nation.

# DETERMINING HEALTH PRIORITIES

## HOW DID WE GET HERE?

The Community Health Assessment and Community Health Improvement Plan were developed through a community-driven strategic planning process called Mobilizing for Action through Planning and Partnership (MAPP). The MAPP process commenced in July of 2015 and took approximately 15 months to complete. North Central District Health Department (NCDHD) guided the processes and incorporated members and representatives of many organizations throughout the health district.

The Community Health Assessment was completed by obtaining and reviewing health data for the community. The Community Health Improvement Plan details strategic issues noted throughout the assessment process and outlines goals and strategies to address identified health priority areas.

Data related to the health of the North Central District referenced throughout this document can be found on the NCDHD website: www.ncdhd.gov

## PURPOSE

We recognize that by including members from many organizations throughout the community, we can accomplish more than what could be done by any one organization alone. The purpose of the Community Health Improvement Plan is not to create a heavier workload for our partners, but rather, to align efforts of these various organizations to move forward in improving the health of the community in a strategic manner. Community partnership also serves to create a broader representation of community perspectives and engender ownership of the efforts aimed at addressing identified priority health issues.

What follows is the result of the community's collaborated effort and planning to address health concerns in a way that combines resources and energy to make a measurable impact on the health issues of the North Central District community. We understand there are many assets within the North Central District that will aid in the accomplishment of these goals.

## PROCESS

Results of the community health assessment were presented to planning partners at the community prioritization meeting. Significant health issues were highlighted and evaluated for priority status. Each priority of concern was written on a sheet of paper and put on the wall for stakeholders to vote on. During this prioritization process, the group created categories from issues based on themes and relationships between issues. The process resulted in several theme areas: aging issues, environmental health, mental health, substance abuse, chronic diseases, and others. Stakeholders then voted on the issues they felt were most important.

Following the community prioritization process, stakeholders were divided into groups to identify goals, strategies, and resources that can be put forth to address the issue at hand. During this meeting, each group was tasked with a specific health priority to address. These groups met several times to discuss objectives, strategies, activities, and organizations that can be utilized to meet specific goals.

Work groups for each priority health issue will meet regularly to implement action plans and ensure progress is being made to obtain goals. NCDHD will assist in convening these meetings and measuring progress with each work plan.

# PRIORITY 1: PHYSICAL WELLNESS

## STRATEGIC ISSUE 1A: HOW DO WE OPTIMIZE PHYSICAL WELLNESS WITHIN THE HEALTH DISTRICT?

### CURRENT SITUATION

NUTRITION

Within the health district, BRFSS indicators of 2013 report many nutritional statistics: sugar-sweetened beverages are consumed by 27% of adults (1 or more in the last 30 days); 47% of adults reported either watching or reducing their sodium intake; 42% consumed fruits less than once a day; and 22% consumed vegetables less than once a day. Forty-one percent of community health survey respondents noted "poor eating habits" as their top risky behavior. The proportion of respondents concerned about their eating habits decreased with age. Forty-nine percent of low income residents of Boyd County (the highest county-specific proportion) did not live near a grocery store, thus limiting access to healthy foods.

Food insecurity was reported in the BRFSS data, present in 10% of the health district, which was less than the 18% for Nebraska in 2012. However, these numbers increased in 2013 to 17% for the health district and 19% for Nebraska.

PHYSICAL ACTIVITY

According to the Centers for Disease Control and Prevention guidelines, proper daily exercise for adults (ages 18 to 64) include weight training on two or more days per week incorporating all major muscle groups and walking 150 minutes per week, or jogging 75 minutes per week and weight training on two or more days a week incorporating all major muscle groups. Overall, the health district area is more physically inactive than the state of Nebraska (31% and 24%, respectively). The most physically inactive county is Keya Paha County and the least is Antelope County (36% and 27%, respectively). In 2014, the percentage of those in the health district area with no leisure time activity was 26%, which had decreased from 32% in 2011. The proportion of those who met the aerobic physical activity requirements varied from 45% in 2011 to 51% in 2013. Similarly, the muscle strength recommendation in 2013 was met by 21% of the health district population (lower than 28% of Nebraskans). The four least physically active counties were: Brown (32% inactive), Holt (29% inactive), Keya Paha (36% inactive) and Pierce (31% inactive); all approximately equivalent to the 33% target set by Healthy People 2020. Overall, in the community health survey, "lack of exercise" ranked 4$^{th}$ as a community health problem. Trends in the community health survey showed "lack of exercise" identified as a health problem decreased with age and increased with income and with education. "Lack of exercise" also tied for third in the ranking of risky behaviors of the community.

WEIGHT MANAGMENT

Obesity is a chronic disease that impacts one-third of U.S. adults. The definition of being obese is a BMI of 30kg/m$^2$ or greater. In 2014 BFRSS, 72% of North Central District adults were either overweight or obese, significantly greater than the 67% reported at the state level. Further, 32% of these were obese, which was approximately the same as Nebraska's 30%.

DIABETES

In Nebraska, the percent of adults with diabetes has been steadily increasing, from 4% in 1990 to 9% in 2014. The health district rate was 10% in 2014, while 4% reported being told they had pre-diabetes, which is down from 7% in 2013.

The counties with the highest proportion diagnosed with diabetes were Rock County and Pierce County (8.6% and 8.5%, respectively). Of the Medicare enrollees in the district area with diabetes, 82% have had an annual exam, which is important in preventing further complications due to diabetes.

### ASSETS AND RESOURCES:

Healthcare providers, hospitals, employers, local public health department, schools, community organizations, economic development, Chamber of Commerce, fitness facilities, long-term care facility activity directors, senior centers, extension offices, and community action agencies.

# AGING POPULATION AND RELATED ISSUES

## STRATEGIC ISSUE 1B: HOW DO WE ADDRESS QUALITY OF LIFE ISSUES AFFECTING OUR AGING POPULATION?

### CURRENT SITUATION

#### SUBSTANDARD HOUSING

Substandard housing is identified as homes where the quality of living and housing can be considered substandard due to lack of complete plumbing facilities, lack of complete kitchen facilities, 1.01 or more occupants per room, monthly owner costs as a percentage of household income greater than 30%, and gross rent as a percentage of household income greater than 30%. Approximately 21% of the North Central District's occupied housing units (rented or owned) meet at least one of these aforementioned criteria. These numbers range from 17% in Rock County to 25% in Keya Paha County.

#### DISABILITY

Disability status is defined as the civilian non-institutionalized population with a disability. This is a relevant metric for the Community Health Needs Assessment, because providers consider disabled individuals a vulnerable population that require targeted services and outreach. Within the service area, 28% of households have at least one disabled individual residing there, which is equivalent to about 14% of the service area's total population. The age breakdown is as follows: 3% under 18 years of age, 10% are 18-64 years of age, and 37% are 65 years or older. The county with the highest percent of the population with a disability is Keya Paha with 20% and the lowest is Pierce with 14%

#### INFLUENZA VACCINATION

Influenza vaccinations were administered to nearly 42% of the health district population, less than the near 44% of the state that received the vaccine in 2014. The vaccination rates for influenza have had minute changes from 2011 to 2014, the peak being in 2014 and the lowest being in 2012 with 38.5% receiving the vaccine. Of those individuals residing in the North Central District over the age of 65, 63.5% received the vaccination, nearly the same as the 64.8% of the state. However, in past years the health district has remained below the state proportions for those over the age of 65 receiving the influenza vaccination.

### ASSETS AND RESOURCES:

Healthcare providers, hospitals, pharmacies, local public health department, faith/community organizations, economic development, nursing homes and long-term care facilities, senior centers, extension offices, and community action agencies.

# PRIORITY 2: MENTAL WELLNESS

## STRATEGIC ISSUE 2: HOW DO WE OPTIMIZE MENTAL WELLNESS WITHIN THE HEALTH DISTRICT?

### CURRENT SITUATION

Mental health issues can range from displaying issues to resisting seeking care due to associated stigma. The 2014 Behavioral Risk Factor Survey (BRFSS) reported that approximately 12% of the survey respondents had been told they have depression, which has decreased from 15% in 2011. This is significantly lower than the state proportion of those reported to have depression, which is approximately 18%. Frequent mental distress in the past 30 days was reported by 5% of respondents of the service area survey. In 2012, 7% of respondents reported taking medication for a mental health condition, and 1% experienced symptoms of a serious mental illness within the last 30 years.

All counties within the district are state-designated shortage areas for psychiatry and mental health.

### ASSETS AND RESOURCES:

Healthcare providers, mental health/behavioral health agencies, hospitals, pharmacies, local public health department, schools, faith/community organizations, law enforcement, and community action agencies.

# PRIORITY 3: SUBSTANCE ABUSE

## STRATEGIC ISSUE 3: HOW DO WE MANAGE AND MINIMIZE SUBSTANCE ABUSE IN OUR COMMUNITY?

### CURRENT SITUATION

ALCOHOL

According to BRFSS responses, the North Central District population who were current consumers (past 30 days) was approximately 54%, which was less than the state's 59%. There were a higher proportion of males that consumed alcohol than females (61-65% and 48-49%, respectively).

About 17% of adults within the North Central District engaged in binge drinking in the past 30 days, which has decreased since 2013 from 19%. Binge drinking in 2014 varied by gender from 26% of males to 9% of females. Proportions of the health district that had reported heavy drinking in the last 30 days ranged between 4.5-7%. Approximately 23% of health district inhabitants drank excessively in the last 30 days, compared to 20% for Nebraska. The counties with the highest estimated adults drinking excessively were Knox (27%) and Antelope (24%). The counties with the lowest estimated adults drinking excessively were Rock (16%) and Cherry (17%).

YOUTH

In 2013, the Youth Risk Behavior Survey (YRBS) reported 14.6% of statewide respondents engaged in binge drinking in the past 30 days. In 2012, the Nebraska Risk and Protective Factor Survey (NRPFSS) reported 20% of 12th graders in the health district had engaged in binge drinking in the past 30 days, which is 2% less than that of the state.

In 2014 NRPFSS, reported about 10% of 12th graders said they had driven a car after drinking alcohol and 17% reported riding with someone who was under the influence of alcohol (17% for 10th graders). Also in 2014, 98% of 12th graders said it was wrong to drive after drinking and 81% saw driving after drinking alcohol as a "great risk."

TOBACCO

Within the North Central District, an estimated 14% of adults reported smoking cigarettes either some days or every day. BRFSS data showed 16% of the district reported smoking cigarettes, which is less than the 18% of the state. This proportion of current smokers of the district area has been fairly constant from 2011-2014.

Approximately 7% of the health district uses smokeless tobacco, less than the state's 8.6%. The number of current adult smokers that have attempted to quit was 57% in 2014, 62% in 2013, 50% in 2012 and 46% in 2011. The BRFSS also reported that 84% of respondents don't allow smoking in their home. The NRPFSS of 2014 reported that 16% of 12th graders were currently using smokeless tobacco and 12% were current smokers. In 2011, 44% of 10th grade students said it would be easy to get cigarettes, which increased to 63% in 2012.

YOUTH SUBSTANCE ABUSE

Marijuana use has declined between 2003 and 2014. For 12th grade students, lifetime use fluctuates from 15% in 2007 to 19% in 2012 and to 15% in 2014. Current use of marijuana for 12th graders fluctuated from 5.6% in 2010 to 8.2% in 2012 then to 6.3% in 2014.

COMMUNITY'S PERCEPTION

The community perceives alcohol abuse as a greater problem than drug abuse for both adults and youth. Eighty percent said underage drinking is a problem within their community. Alcohol abuse among adults was perceived as a problem for the community by 65% of the respondents. Approximately 60% said drug abuse is a problem among youth in the community, while 35% disagreed. From the 2016 community health survey, 32% selected drug abuse as a top-three risky behavior, thus ranking drug abuse as the 5th most commonly selected risky behavior.

PRESCRIPTION DRUG ABUSE

In the 2014 BRFSS data, 25% of respondents had been prescribed pain medication in the past year and 36% of these individuals had leftover medications in the household. Youth from focus groups mentioned the presence of Adderall and Hydrocodone at schools. Law enforcement confirmed that they have been witnessing the abuse of prescription drugs due to "using multiple doctors; people selling their own drugs; stealing; or using fake prescriptions." This is prevalent from age ranges of teens to 40 years of age, according to law enforcement. Their experience is also that marijuana use is increasing across all age ranges, but primarily among teens. There have also been cases of parents using around children, or even contributing to the child's access to marijuana.

## ASSETS AND RESOURCES:

Healthcare providers, mental health/behavioral health agencies, hospitals, pharmacies, local public health department, schools, faith/community organizations, law enforcement, and community action agencies.

## PARTNERS AND COMMUNITY MEMBERS WHO HAVE AGREED TO SUPPORT CHIP ACTION:

North Central District Health Department (NCDHD)
NCDHD Board of Health
Antelope Memorial Hospital
Avera Creighton Hospital
Avera St. Anthony's Hospital
Brown County Hospital
Cherry County Hospital
CHI Health Plainview Hospital
Niobrara Valley Hospital
Osmond General Hospital
Rock County Hospital
West Holt Memorial Hospital
The Evergreen Assisted Living Facility
Cottonwood Villa Assisted Living Facility
Good Samaritan Society – Atkinson
Pregnancy Resource Center
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Knox County Economic Development
Neligh Economic Development
Pierce County Economic Development
University of Nebraska Lincoln Extension Office, Antelope/Knox County
University of Nebraska Lincoln Extension Office, Brown-Rock-Keya Paha County
O'Neill Public School Board
O'Neill Ministerial Association
West Holt Health Ministries
O'Neill Lions Club
O'Neill Rotary Club

# WORK PLAN

The remaining pages in this document outline the work plan for each issue identified by community partners as priority health areas through this planning process.

The work plan contains goals, objectives, strategies, activities, measures, timelines, and partners for each priority health area.

Over the course of the next three years, workgroup members will commit resources and efforts to activities as outlined in the work plan. This section is meant to be a flexible, responsive component of the community health improvement plan. As such, it will periodically be reviewed and updated to ensure the elements reflect workgroup progress and needs of our community.

# PRIORITY 1: PHYSICAL WELLNESS/AGING POPULATION AND RELATED ISSUES

## GOAL: IMPROVE COMMUNITY PHYSICAL HEALTH AND WELLNESS ACROSS THE LIFESPAN.

| OBJECTIVE 1 | OUTCOME MEASURES |
|---|---|
| Reduce the proportion of district residents who are obese or overweight from 72% to 70% by 2019. | % of district residents who are obese or overweight |

| OBJECTIVE 2 | OUTCOME MEASURES |
|---|---|
| Reduce the proportion of district residents who are physically inactive from 31% to 29% by 2019. | % of district residents who are physically inactive |

| STRATEGY | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| 1. Develop resource directory of programs and services available throughout the district | Create targeted questionnaire | Questionnaire document | September 1 – October 31, 2016 | NCDHD |
| | Distribute questionnaire to workgroup committee members | Number of workgroup members who receive questionnaire document | October 31, 2016 | NCDHD |
| | Complete questionnaire | Number of completed questionnaire documents | October 31 – November 30, 2016 | All workgroup members |
| | Distribute questionnaire to community partners | Number of completed questionnaire documents | November 1 – November 7, 2016 | All workgroup members |
| | Follow up with community partners to ensure return of completed questionnaire | Number of community partners contacted | November 21 – December 2, 2016 | All workgroup members |
| | Compile results of completed questionnaires and develop resource document | Resource document | December, 2016 | NCDHD |
| | Review resource document; identify gaps in programs and services; determine additional strategies and activities for implementation | Additional work plan strategies and activities | January 1 – March 31, 2017 | All workgroup members |
| 2. Develop and strengthen community partnerships to increase awareness of services/programs throughout the district | Identify existing programs, services, and resources we can support as a workgroup | Meeting minutes and CHIP work plan tracking tool | 2017 – 2019 | All workgroup members |
| | Contact existing and potential new | CHIP work plan tracking tool | 2017 – 2019 | All workgroup members |

| | | | | |
|---|---|---|---|---|
| | organizations who would be most feasible to partner with and discuss needs/approach | | | |
| 3. Explore the feasibility of an online resource document that is available for all community members of the district. | Development and documentation of resources available<br><br>Research/ find/ develop tool/method to facilitate<br><br>Management f resource document | Resources documented<br><br>Documented method of management of resource document | 2017-2019<br><br>2017-2019 | All workgroup members<br><br>All workgroup members |
| 4. Support existing community programs and services | Assist with increasing community awareness of existing programs and services by utilizing the resource document to refer district residents to appropriate resources<br><br>*Action item: develop plan for periodic updates* | Media messages as documented on the CHIP work plan tracking tool | 2017 – 2019 | All workgroup members |
| 5. Ensure a strategic focus on populations at greater risk | Incorporate health literacy and cultural competency into program planning efforts | TBD | 2017 – 2019 | All workgroup members |
| 6. Potential future strategy: Implement organizational and programmatic nutrition standards and policies. | | | | |
| 7. Potential future strategy: Help people recognize and make healthy food and beverage choices. | | | | |
| 8. Potential future strategy: Enhance food safety. | | | | |
| 9. Potential future strategy: Facilitate access to safe, accessible, and affordable places for physical activity | | | | |
| 10. Potential future strategy: Support workplace policies and programs that increase physical activity | | | | |

## RECOMMENDED POLICY CHANGES

Encourage policies establishing standard practice of coordinating efforts among district partners
Incorporate health literacy and cultural competency into work group efforts
Encourage partner organizations to implement health literacy and cultural competency policies

## STATE ALIGNMENT

**NE SHIP 2013-2016 Priorities 1 and 2**: Reduce heart disease and stroke mortality, morbidity, and associated risk factors; Reduce cancer morbidity, mortality, and associated risk factors **Objective 1 Key Strategies and Activities:** Develop protocols for all health care providers to share screening results with patients to encourage more effective communication regarding healthy living (e.g., BMI, blood pressure, and cholesterol) that follows clinical guidelines; Develop a coordinated statewide education campaign for health screenings; **Objective 3:** Increase the capacity of community organizations, including local public health departments and coalitions, to implement evidence-based strategies in community settings; **Objective 4:** Increase the number of worksites that are implementing and evaluating the effectiveness of comprehensive worksite wellness programs to improve employee health; **Objective 5:** Increase the number of schools that implement a Coordinated School Health approach to improve the health of students by focusing on healthy eating, physical activity, obesity, and tobacco prevention

## NATIONAL ALIGNMENT

**HP2020: Nutrition and Weight Status** Goal: Improve health, fitness, and quality of life through daily physical activity; Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights; **Health-Related Quality of Life & Well-Being** Goal: Improve health-related quality of life and well-being for all individuals; **Physical Activity** Goal: Improve health, fitness, and quality of life through daily physical activity
**National Prevention Strategy Priorities:** Healthy Eating, Active Living

| STATE ALIGNMENT | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| **NE SHIP 2013-2016 Priorities 1 and 2**: Reduce heart disease and stroke mortality, morbidity, and associated risk factors; Reduce cancer morbidity, mortality, and associated risk factors **Objective 3 Key Strategies and Activities:** Identify evidence-based health promotion programs or practices that target high priority population groups especially those experiencing health disparities | | | | |

## NATIONAL ALIGNMENT

**HP 2020: Arthritis, Osteoporosis, and Chronic Back Conditions; Environmental Health; Older Adults; Health-Related Quality of Life & Well-Being**
**National Prevention Strategy Priorities:** Healthy Eating, Active Living, Injury and Violence Free Living, Mental and Emotional Well-Being

# PRIORITY 2: MENTAL WELLNESS

## GOAL: MENTAL HEALTH WILL BE A UNIVERSALLY ACCEPTED PART OF HEALTHCARE IN OUR REGION

| OBJECTIVE 1 | OUTCOME MEASURES |
|---|---|
| Promote use of mental health screening tool to 100% of primary care providers and schools across the nine counties by July 1, 2017. | Percent of primary care providers and schools that receive a mental health screening tool. |

| STRATEGY | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| 1.1 Find/develop a tool to be utilized by primary care providers and schools | Research options of a tool | Research list is developed/found | May 1, 2017 | Mental health providers, Region 4 Behavioral Health Systems, Hospitals, Medical Clinics and ESU's |
| 1.2 Disseminate medically appropriate tool to primary care providers | | Number of primary care providers receiving the tool | July 1, 2017 | Mental health providers, Region 4 Behavioral Health Systems, Hospitals, Medical Clinics and ESU's |
| 1.3 Disseminate school appropriate tool to schools. | Research/Develop suggested criteria for referral | Criteria is developed/found | May 1, 2017 | SCIP, Mental Health providers, psychologists, ESU's |
| | Develop and disseminate warning signs information to school personnel | Number of schools receiving the tool | TBD | SCIP, Mental Health providers, psychologists, ESU's |
| | Offer technical assistance | Number of schools reached between May 1 and July 1, 2017 | July 1, 2017 | SCIP, Mental Health providers, psychologists, ESU's |

| OBJECTIVE 2 | OUTCOME MEASURES |
|---|---|
| Utilize existing partnerships among community organizations / agencies / individuals to connect mental health needs to mental health resources by August 2017. | Number of partner involved in connecting individuals with mental needs to mental health resources. |

| STRATEGY | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| 2.1 Add a focus on mental health to NCCCP and at least one other partnership | Develop letter to invite and engage | Letter is developed | March 31, 2017 | Partners in Public Health System |
| | Identify potential members and follow-up letter | Number of letters sent | March 31, 2017 and on-going | Partners in Public Health System |
| | Foster workgroup development and leadership through educational opportunities | Action plan developed<br>Number of opportunities available | August 31, 2017 and on-going | Partners in Public Health System |

| | | | | |
|---|---|---|---|---|
| | | Number of people reached | | |
| | Distribute information through schools | | | |

| OBJECTIVE 3 | OUTCOME MEASURES |
|---|---|
| Develop at least three strategies to address barriers and stigmas of mental health by 5/31/2018. | Number of strategies implemented |

| STRATEGY | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| 3.1 Implement a mental health awareness campaign, to include: presentation / partnerships / resource document; traditional media; and social media. | Develop a document to outline a campaign to include media, presentations and creation of a resource document | Campaign document is created | June 30, 2017 and on-going | Partners in Public Health System |

## RECOMMENDED POLICY CHANGES

Encourage policies establishing standard practice of coordinating efforts among district partners
Encourage providers and schools to implement use of mental health screening tool
Encourage integration of mental health focus and efforts among district partners
Incorporate health literacy and cultural competency into work group efforts
Encourage partner organizations to implement health literacy and cultural competency policies

## STATE ALIGNMENT

**NE SHIP 2013-2016 Priority 4**: Improve the integration of public health, behavioral health (mental health and substance abuse), environmental health, and primary health care services. **Objective 5:** Complete a study of the role of the state and local public health agencies in the prevention of mental health and substance abuse problems and the coordination of these services.
Key strategies and activities: Prepare a report that identifies these roles and responsibilities, essential collaborative partnerships, and recommendations that cover the life span and include high risk groups (e.g., individual with depression and/or adverse childhood experiences)

## NATIONAL ALIGNMENT

**HP 2020 Goal:** Improve mental health through prevention and by ensuring access to appropriate, quality mental health services.
Objective: Reduce the proportion of persons who experience major depressive episodes (MDEs)
Objective: Increase the proportion of children with mental health problems who receive treatment
Objective: Increase the proportion of adults with mental health disorders who receive treatment
Objective: Increase depression screening by primary care providers
**National Prevention Strategy Priorities:** Mental and Emotional Well-Being

# PRIORITY 3: SUBSTANCE ABUSE

## GOAL: ADOLESCENTS WILL BE AWARE OF ADVANTAGES OF BEING FREE OF ABUSIVE SUBSTANCES.

| OBJECTIVE 1 | OUTCOME MEASURES |
|---|---|
| Increase school participation in Student Health and Risk Prevention (SHARP) surveys by 10% by fall 2018. | Percent of increase of schools participating in the SHARP surveys |

| STRATEGY | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| 1.1 Increase the schools recognition of importance of completion of survey | Contact schools and provide information | Number of schools contacted | June 1, 2017 | ESU's, Region 4, schools, BOSR, NCDHD, Substance Abuse coalitions |

| OBJECTIVE 2 | OUTCOME MEASURES |
|---|---|
| Partner with at least three youth organizations that implement strategies to promote a substance-free culture by May 2018. | Number of partnerships with youth organizations |

| STRATEGY | ACTIVITY | PROCESS MEASURES | TIMELINE | PARTNERS |
|---|---|---|---|---|
| 2.1 Utilize Life of an Athlete (LOA) resources to create a substance-free environment. | Contact schools to educate and inform of the LOA program | Number of schools contacted | May 31, 2017 and on-going | Student athlete organizations, School administration and athletic staff, booster club and other parent organizations. |
| 2.2 Expand LOA resources beyond athletics. | Collaborate with schools to expand the LOA program | Number of schools that implement LOA for all students | May 31, 2017 | Student athlete organizations, School administration and athletic staff, booster club and other parent organizations. |

## RECOMMENDED POLICY CHANGES

Encourage policies establishing standard practice of coordinating efforts among district partners
School policy to participate in SHARP surveys
School policy to implement of Life of an Athlete program
Youth organization policy to implement substance abuse prevention efforts
Encourage policies establishing standard practice of coordinating efforts among district partners
Incorporate health literacy and cultural competency into work group efforts
Encourage partner organizations to implement health literacy and cultural competency policies

## STATE ALIGNMENT

**NE SHIP 2013-2016 Priority 4**: Improve the integration of public health, behavioral health (mental health

and substance abuse), environmental health, and primary health care services. **Objective 5:** Complete a study of the role of the state and local public health agencies in the prevention of mental health and substance abuse problems and the coordination of these services.
Key strategy: Prepare a report that identifies these roles and responsibilities, essential collaborative partnerships, and recommendations that cover the life span and include high risk groups (e.g., individual with depression and/or adverse childhood experiences)

## NATIONAL ALIGNMENT

**HP 2020 Goal:** Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.
Objective: Increase the proportion of adolescents never using substances
Objective: Increase the proportion of adolescents who disapprove of substance abuse
Objective: Increase the proportion of adolescents who perceive great risk associated with substance abuse
**National Prevention Strategy Priorities:** Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use