Community Health Improvement Plan

2024 - 2028

WEST CENTRAL
DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

www.wcdhd.org

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Community Health Improvement Plan 2024-2028

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Executive Summary

This **2024-2028 Community Health Improvement Plan (CHIP)** was collaboratively developed by a group of community partners after reviewing data from the **2023 Community Health Assessment (CHA)**. Assessing and improving the health and well-being of our community is a core function of local health departments. The CHA offers a point in time review of health data indicators, community demographics and findings from a community survey to help us answer: **How are we doing right now?**

We are honored to help tell the story of the counties within the West Central District Health Department (WCDHD**)** district: **Lincoln, Logan, McPherson, Thomas, Hooker and Arthur.**

The **CHIP** is a participatory process that utilizes data-driven decision making and consensus to select priorities and enact collaborative strategies that positively impact health outcomes.

While our CHA identified several health issues of concern, this **CHIP** reflects a commitment to a few priorities: **Mental Health, Substance Use, Health Literacy and Preventive Care.**

We express gratitude to those who participated in this process, and to everyone who works to make our community healthier for everyone to live, work and play!

We look forward to opportunities to leverage shared strengths and collaborate for collective impact. Learn more about our work and how to partner at: wcdhd.org

WEST CENTRAL
DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

Letter from the Director

We are pleased to present the Community Health Assessment and Community Health Improvement Plan, produced in partnership with many great community organizations.

As we look to the future, we are eager to continue collaborating and create meaningful progress towards the betterment of community well-being. It is through our collective wisdom that we can affect positive change.

Our mission is rooted in the belief that every individual within our district should have the opportunity to thrive at work, at home and at play. And it is with great enthusiasm and a deep sense of purpose that we affirm our commitment to the overall health and well-being of our communities.

We extend heartfelt thanks to each of you for your partnership, support and dedication to creating a more vibrant future for all. We look forward to the journey together!

Shannon Vanderheiden

Executive Director,
West Central District
Health Department

2024-2028 COMMUNITY HEALTH IMPROVEMENT PLAN

PRIORITIES

WEST CENTRAL DISTRICT HEALTH DEPARTMENT
Lincoln, Logan, McPherson, Thomas, Hooker, & Arthur Counties

MENTAL HEALTH

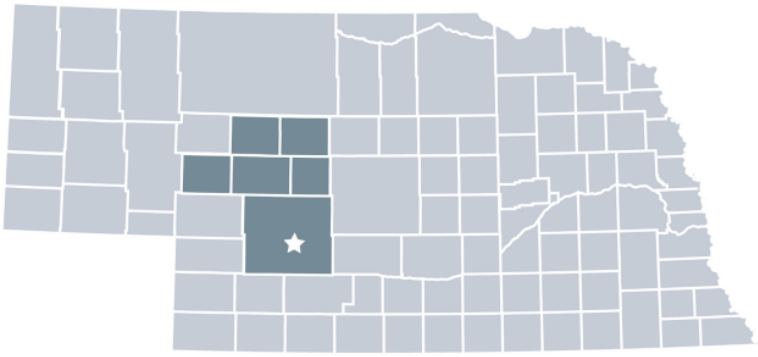
SUBSTANCE USE

HEALTH LITERACY

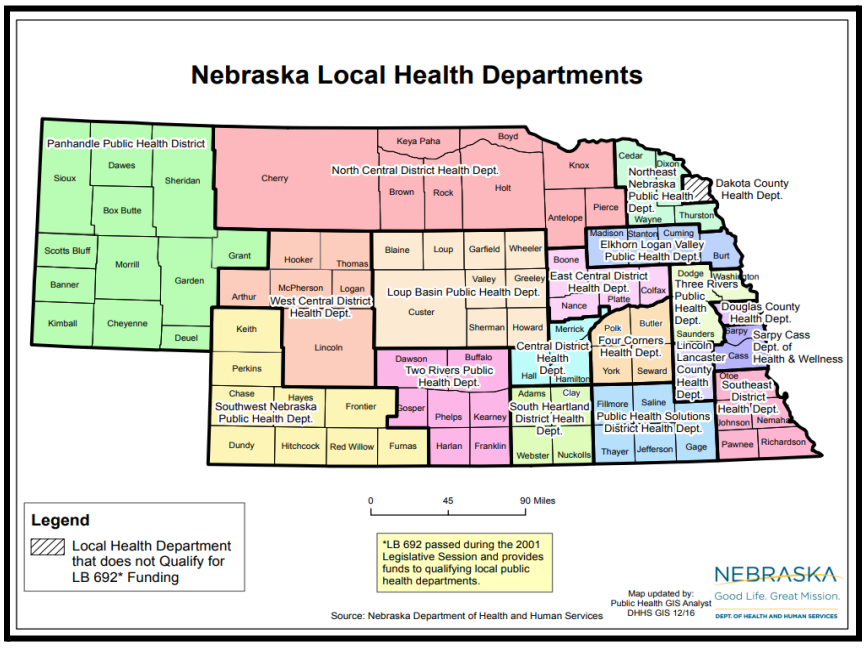
PREVENTIVE CARE

Introduction

West Central District Health Department (WCDHD) is a local public health department in mid-western Nebraska, serving six counties: Lincoln, Logan, McPherson, Thomas, Hooker and Arthur. This district serves approximately 37,605 people as per the 2020 U.S Census population estimate.

Our Mission	
To educate, promote, and improve the overall health of our communities and each resident; allowing all who live, work, and play within to thrive.	

Our Board of Health (Appendix A) includes one county commissioner from each of the six counties of our district as well as several community representatives referred to as spirited persons. The Board also includes at least one physician and one dentist, for a total of twelve (12) members.



WCDHD is one of 18 local health departments (LHDs) covering 93 counties of Nebraska formed under the Nebraska Health Care Funding Act (LB 692) passed in 2001 by the Nebraska Legislature. Click HERE to view a condensed summary of Nebraska Revised Statutes related to LHDs.

Nebraska local public health departments are charged with providing the 10 Essential Public Health Services to all communities. Conducting assessments routinely and facilitating improvement planning are foundational public health activities.

As the chief public health strategist for our district, we share a leadership role in implementing public health efforts with our local hospital and community organizations. We are proud to have a multitude of great partners that contribute to the well-being of our communities.

About Community Health Improvement Planning

A **Community Health Improvement Plan (CHIP)** is a vital tool for public health departments and other community serving organizations to prioritize action toward a few key health priorities. State, Tribal and local health departments routinely conduct health improvement planning to update a shared vision for wellness and identify alignments and collaborative opportunities.

The CHIP reflects the determined action in response to the review of updated community data from our 2023 Community Health Assessment (CHA). That report (found at wcdhd.org) includes demographic and health data from a variety of sources, including a community survey, to better understand well-being, health inequities, and potential barriers to health and well-being.

While the CHA elevated several health issues of which we encourage community action, this CHIP details the process utilized to find consensus among a group of community partners toward a few select community health priorities.

Many local health departments collaborate with local non-profit hospitals who are also charged with conducting health needs assessments and improvement planning as a way to host a shared vision for wellness and identify alignments and improvement opportunities. WCDHD and Great Plains Health partnered in 2019 on this work, before the Covid-19 pandemic disrupted that progress. As timing allowed, both organizations updated their CHA's independently, and it is anticipated that collaborative initiatives will continue for the betterment of our communities.

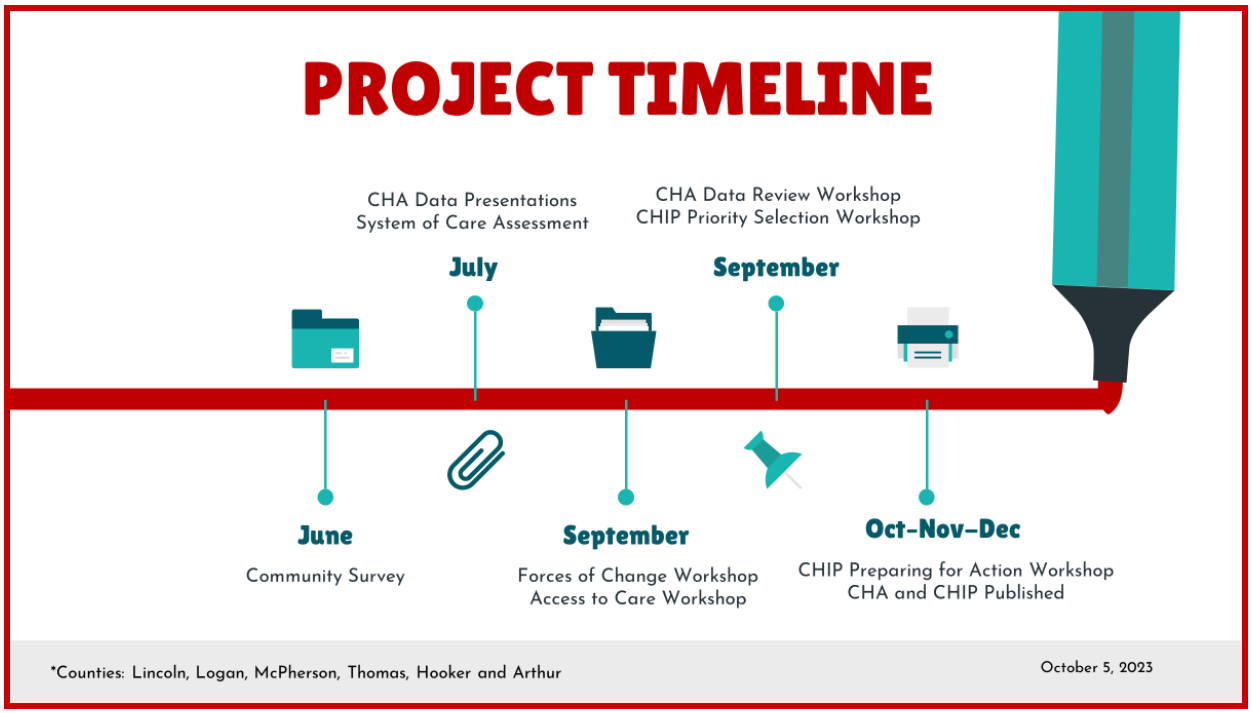
Methodology

While several models exist for community planning, the approach outlined by the Mobilizing for Action through Planning and Partnership (MAPP), developed by the National Association of County and City Health Officials (NACCHO) guided our approach. Our process was also informed by national public health accreditation standards with intentional effort to explore disparities as to elevate equity. In similar fashion to the three phases of the MAPP framework, our methodology (for both the CHA and the CHIP) included:

Phase 1: Build the Foundation (see 2023 CHA)	• Form a Design Team • Invite Community Health Partners • Draft a shared Vision for Well-Being
Phase 2: Tell the Community Story (see 2023 CHA)	• Assess Community Context: Forces of Change • Assess Community Context: Assets & Systems of Care • Assess Community Context: Community Survey • Review Community Status: Equity and Access to Care • Review Community Status: Health Data Profile

Phase 3: Continuously Improve the Community	• Affirm Priorities • Develop a Community Health Improvement Plan

Starting in spring 2023, our Design Team (see Appendix G) developed the process and determined what data variables to collect, prioritizing a second community survey to elevate community participation. This team also reviewed a community health needs assessment recently updated by our local hospital partner, Great Plains Health.



Next, we invited an array of **Community Health Partners** (Appendix B), having distributed invitations to a wide network of community organizations, stakeholders and health and human service partners.

This group met virtually over five total workshops to guide the process from data collection to the identification of key issues (the first three events) and eventually selecting a few priorities for the Community Health Improvement Plan (CHIP) in the last two events. Notes from each of these workshops can be found in the Appendices, in the CHA report, or are available upon request.

Workshop Purpose	Workshop Date	Appendix
Community Context: Forces of Change	August 17, 2023	(see CHA)
Community Status: Equity and Access to Care Barriers	August 31, 2023	(see CHA)
Community Health Assessment: Survey & Data Review	September 21, 2023	(see CHA)
Community Health Improvement Plan: Affirm Priorities	September 28, 2023	D
Community Health Improvement Plan: Propose Goals	October 5, 2023	E

A quick summary of the first three CHA workshops include:

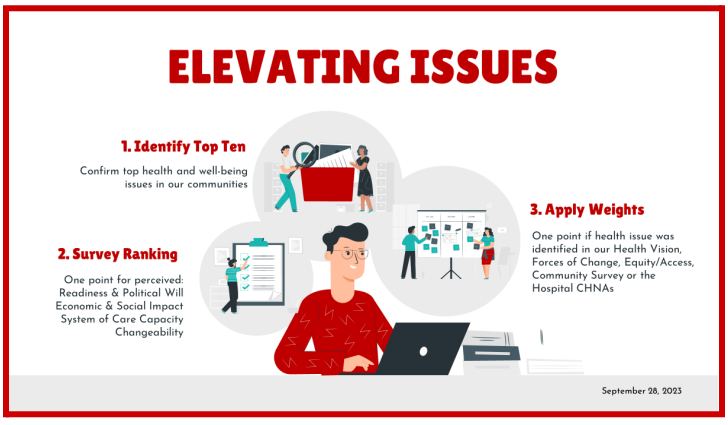
- ➔ The **first workshop** (Community Context) collected the community group's values and guiding principles that ground our community service, considered trends that are disappearing or emerging, and what shifts merit our attention post pandemic. Two important concerns were identified: social isolation and language barriers. This group went on to create a shared vision for well-being, identified community strengths and assets, and considered threats and opportunities that informed considerations for improvement planning.
- ➔ The **second workshop** (Community Status) focused on assessing disparities, inequities, social determinants of health and perceived barriers to accessing care. The group reviewed definitions and models related to health equity, reviewed data, and discussed what might be contributing to inequities and how biases might impact health disparities.
- ➔ The **third workshop** (Community Health Data) reviewed community demographics, health indicators and related data, as well as the summary from a Community Health Survey facilitated in 2021 and 2023. While data is a critical tool of community assessment and improvement planning, the perspective of lived experience is invaluable.

More details can be found in the **2023 CHA** about the community data and these workshops. After reviewing all primary and secondary data, the group voted to elevate several emerging health issues: **Mental Health and Substance Use, Health Literacy and Culturally Competent Care, Chronic Disease and Preventive Care, Oral Health and the Aging Population.**

Prioritization Process

The last two workshops in the series pivoted focus to narrowing down to a few key health priorities and identifying opportunities for improvement, of which would become the CHIP.

After the third workshop, an electronic survey was sent to all participants to score each of the aforementioned emerging health issues in four categories: Readiness & Political Will, Economic & Social Impact, System of Care Capacity, and Changeability.



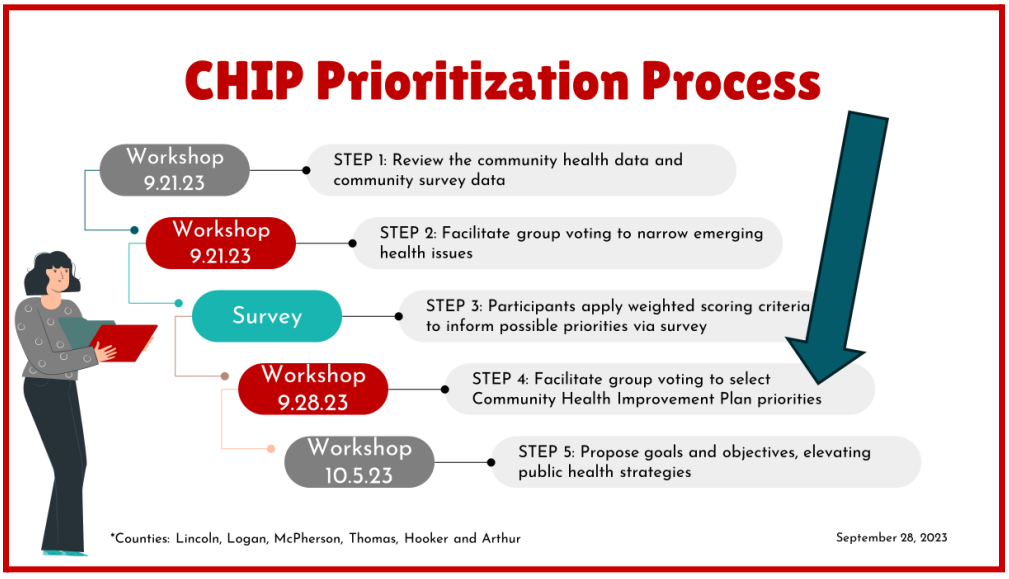
This survey (Appendix C) asked respondents to offer subjective perspectives, of which applied weights to further define our capacity to impact and inform the priority selection. For ease of applying weighted scoring, this format was used: Low = 1, Medium = 2, High 3.

Readiness & Political Will	*Is our community ready to address this? Is there 'political will' among organizations and partners to take on a collective impact approach toward this health topic?*
Economic & Social Impact	*Is there a high 'cost' to society now and/or will it escalate if this issue remains unaddressed? Is the burden of such a great impact to society that it demands immediate attention?*
Capacity of our System of Care	*Does our 'system of care' -our network of community organizations, partners, healthcare agencies, and the health department- have the capacity to make improvements as a collective toward this issue?*
Changeability	*Can this issue be improved with collective and coordinated strategies and interventions? Can we expect to make progress on this health problem?*

A second step applied weights to each of the health issues by assigning one point for each of the following criteria:

- ☐ Identified in the Shared Vision for Well-Being
- ☐ Identified in the Forces of Change
- ☐ Identified in the Equity and Access Barriers
- ☐ Identified in the Community Health Survey
- ☐ Related to an existing Great Plains Health Community Health Needs Assessment priority

At the **fourth workshop**, prior to seeing the total ranking results, the group reviewed a summary of the CHA findings: Shared Vision for Well-Being, Forces of Change, Threats and Opportunities, Top Health Equity Opportunities, Top Access to Care Opportunities and System of Care Opportunities. Participants discussed the perceived ‘red flags and green lights’ and were reminded of the 2023 Great Plains Health priorities.



The results of the ranking produced the top six health issues, and the group held deeper discussion to uncover alignment and prospects for collaborative impact. This resulted in a vote for the top four priorities: **Mental Health, Substance Use, Health Literacy, and Preventive Care.**

Preparing for Action

Before concluding the fourth workshop, the group generalized an objective for progress as a mechanism to capture why each priority was selected and what we hoped to achieve together. Finally, at the **fifth and last workshop in this series**, participants again previewed relevant health priority data, brainstormed strengths to build upon, partners to engage, potential goals, and anything else necessary to determine the best course of action. This produced a summary of the opportunities, although it was recognized that additional data, root cause analysis, social determinant examination and engaging the voices of lived experience may also be necessary to discern strategies and prepare for implementation. Lastly, individuals identified priorities of interest and gathered into small groups to list a few activities for the first six months, with consideration for each organization's respective capacity and areas of expertise.

As the organizing body, WCDHD acknowledged that not all potential partners and stakeholders were able to participate. There are many great community initiatives occurring, and this group will need to identify how to best align with the existing system of care infrastructure and elevate capacity for impact.

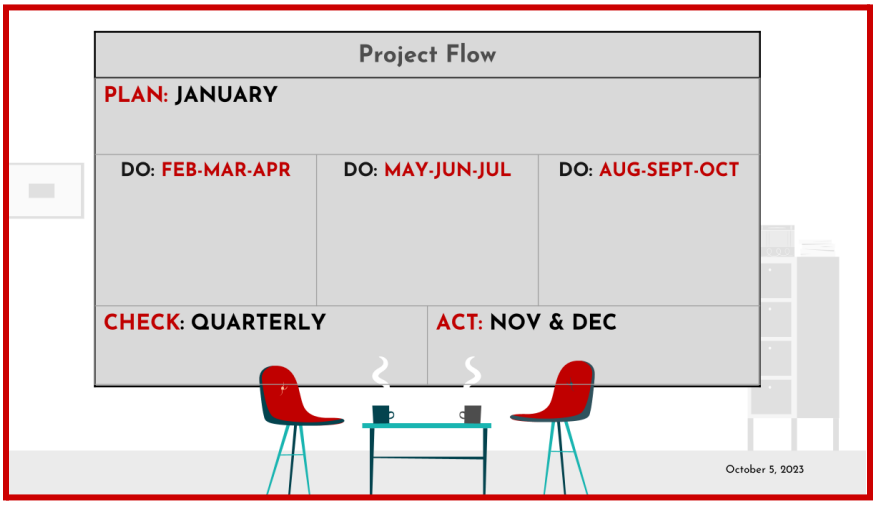
Our health department commits to promoting a participatory process that maximizes collaboration and alignment with other community initiatives where possible.

Related, WCDHD will reconvene with Great Plains Health to ensure collaborative opportunities for implementation and coordination to align future CHA and CHIPs.

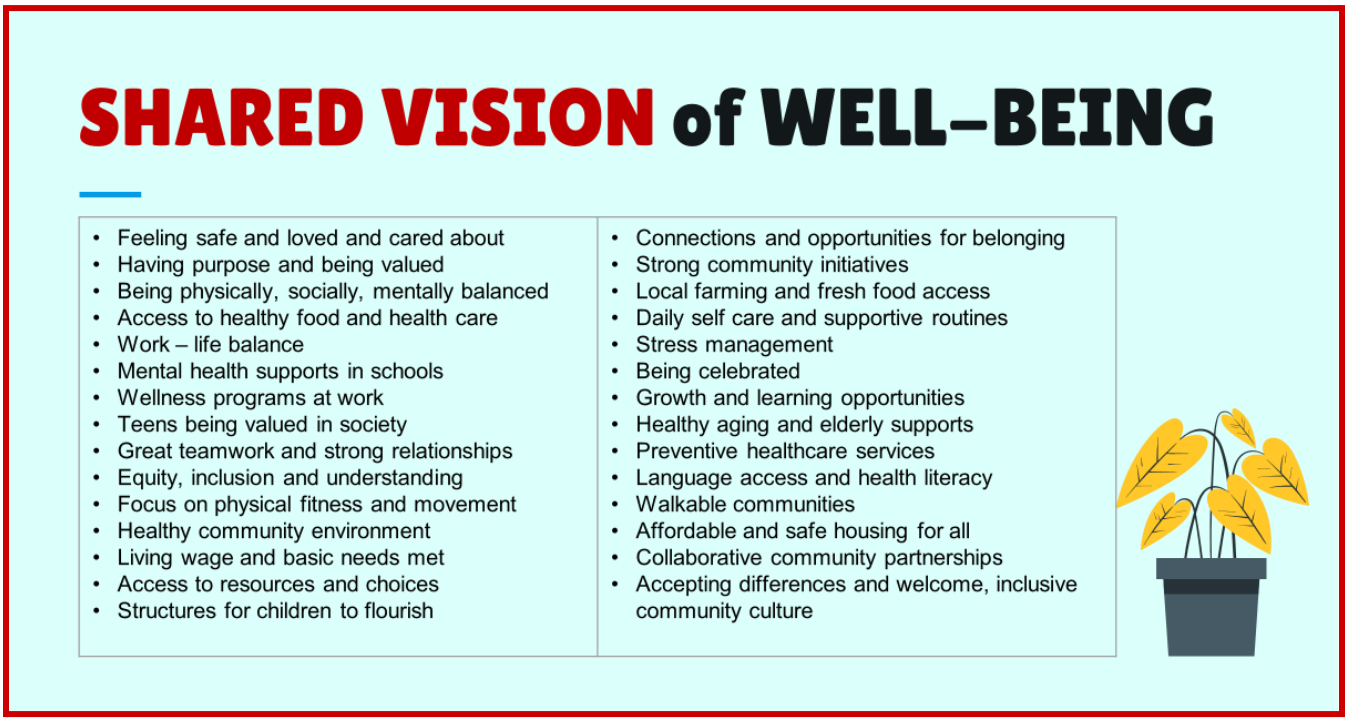
It is also noted that WCDHD may not be the lead on every priority or initiative, as the intention for a CHIP is for collective impact. The group reviewed the Collective Impact model and considered how that framework might be applicable.

As the community health partners closed out this workshop series, they defined what would help us feel successful. These ideas will be utilized to design our implementation and performance management practices.

WCDHD introduced a calendar year project flow based upon the Plan-Do-Check-Act, that offers a human centered experience to shared special projects. This enacts January as a planning launch, with three quarters of active projects and routine progress monitoring, and closes out the calendar year with November and December to assess lessons learned, document outcomes and review the proposed course of action for the upcoming year.



As such, this CHIP will launch in 2024 by convening partners and producing an action roadmap (Appendix F) that promotes Specific, Measurable, Actionable, Realistic, Timely, Inclusive and Equitable initiatives. This work plan will be routinely reviewed, and WCDHD will maintain updates and progress reporting to community partners, our Board of Health and to the public. Most importantly, it is our hope to help move our community a little closer to our shared vision of well-being.
Find out more about our work and ways to get involved at wcdhd.org.



Summary of Priorities

Each priority was selected by this group of community partners in reflection of the health data, community survey and shared experience with our system of care.

As a five year plan, year one (2024) serves as a planning period with participatory intent to empower community voices and better understand the need. As such, we propose capacity building objectives for year one, with the responsibility to identify health focused objectives and evidence informed strategies that maximize opportunity for positive impact through the remaining four year (2025-2028) implementation period.

It is also recognized that the review of health indicators as presented in the CHA does not always illuminate root causes, correlated social determinants or culturally appropriate interventions. Thus, year one planning will prioritize participatory design and collaborative practices, data driven decision making, and intent to advance equity among our system of care and community.

For each priority, a brief summary is offered below, including some relevant data and the community partner's proposed vision for well-being. Initial goals for the planning year are drafted, with expectations that an action roadmap (Appendix F) will be further developed and updated routinely.

PRIORITY VISION:
All people can exist with peace of mind.

MENTAL HEALTH

Summary of Current Environment:

In the last year data was available, the percent of adults who report having poor mental health on 14 or more of the last 30 days, has increased. Depression was also reported more frequently in this area than statewide. And, community members ranked mental health as one of top three health concerns, behind cancer and diabetes (34.5%, Community Survey).

Depression is defined as 'percentage of adults 18 and older who report that they have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder'.

- Females (23.6%) reported depression more frequently than Males (11.8%).
- Non-Hispanic White community members (19.1%) reported more depression than Minority respondents (16.4%).

Mental Distress is defined as 'percentage of adults 18 and older who report that their mental health was not good on 14 or more of the previous 30 days'.

- Females (14.3%) reported higher levels of frequent mental distress than Males (7.4%).
- Minority community members (14.2%) reported higher levels of frequent mental distress than Non-Hispanic White respondents (10.9%).

Cognitive Decline is defined as 'percentage of adults 45 and older who report that they have experienced significant confusion or memory loss that is happening more often or is getting worse during the past 12 months'.

- WCDHD residents (11.1%) reported more cognitive decline than Nebraska overall (9.5%).
- Males (11.7%) reported more cognitive decline than Females (10.6%).

Year 1 Objective:	**Establish a four year implementation plan with a public health objective, goals and strategies by November 30, 2024.**
Goal 1:	Create a mental health task force and assess community resources and identify opportunities for collaborative initiatives.
Goal 2:	Empower systems of care and community partnerships, and elevate voices of lived experience with participatory practices.
Goal 3:	Identify evidence informed public health strategies for implementation.

PRIORITY VISION: People are free from substance misuse and abuse.

SUBSTANCE USE

Summary of Current Environment:

In the Community Survey, 26% of respondents listed alcohol, drug and tobacco use as a top health concern, ranking in the top six. Among adults in this area, a lower percentage reported alcohol use in the past 30 days relative to the state, but still over 50% reported alcohol use.

Alcohol Use is defined as 'percentage of adults 18 and older who report having at least one alcoholic beverage during the past 30 days'.

- Males (61.3%) were more likely to consume alcohol than Females (47.4%).
- Non-Hispanic White community members more commonly reported alcohol consumption (57.8%) than Minority respondents (45.2%).

Binge Drinking is defined as 'adults 18 and older who report having 5 or more alcohol drinks for men or 4 or more alcoholic drinks for women on at least one occasion in the past 30 days'.

- Males (22.9%) were more likely to binge drink than Females (11.1%).
- Non-Hispanic White community members (19.8%) more commonly reported binge drinking than Minority respondents (14.3%).

Impaired Driving is defined as 'percentage of adults 18 and older who report driving after having had perhaps too much to drink during the past 30 days'.

- Males (2.9%) more frequently reported impaired driving than Females (0.9%).

Year 1 Objective:	**Establish a four year implementation plan with a public health objective, goals and strategies by November 30, 2024.**
Goal 1:	Create a substance use task force and assess community resources, spectrum of care and identify opportunities for collaborative initiatives.
Goal 2:	Empower systems of care and community partnerships, and elevate voices of lived experience with participatory practices.
Goal 3:	Identify evidence informed public health strategies for implementation.

PRIORITY VISION: Healthcare services are empowering for all people.

HEALTH LITERACY

Summary of Current Environment:

In the Community Survey when asked about the greatest barriers to care, 22.7% of respondents reported language barriers and cultural differences, which ranked second highest just behind co-pays and fees. Specific to healthcare communication, 31.9% of respondents reported that speaking a different language was a top issue.

In 2020, fewer individuals reported it was easy to get needed advice or information (65%) about health in WCDHD compared to the state (70%). Since 2016, just 56% have reported that it's easy to understand information from medical professionals.

Easy to Get Health Information is defined as 'adults 18 and older who report that it is very easy for them to get advice or information about health or medical topics if they need it.

- Males (71.9%) reported lower rates than Females (73.9%).
- Minority community members (65.2%) reported lower rates than Non-Hispanic White respondents (73.8%).

Easy to Understand Verbal Information is defined as 'adults 18 and older who report that it is very easy for them to understand the (verbal) information that doctors, nurses, and other health professionals tell them'.

- Males (53.0%) reported lower rates than Females (58.6%).
- Minority community members (50.5%) reported lower rates than Non-Hispanic White respondents (56.9%).

Easy to Understand Written Information is defined as 'adults 18 and older who report that it is very easy for them to understand written health information.

- Males (52.5%) reported lower rates than Females (60.7%).
- Minority community members (54.2%) reported lower rates than Non-Hispanic White respondents (58.5%).

Year 1 Objective:	**Establish a four year implementation plan with a public health objective, goals and strategies by November 30, 2024.**
Goal 1:	Create a literacy task force and assess community resources, identify best practices and opportunities for collaborative initiatives.
Goal 2:	Empower systems of care and community partnerships, and elevate voices of lived experience with participatory practices.
Goal 3:	Identify evidence informed public health strategies for implementation.

PRIORITY VISION: Everyone has access to affordable, culturally and linguistically competent preventive care services.

PREVENTIVE CARE

Summary of Current Environment:

In the Community Survey, respondents reported their top health concerns = 48.7% said Cancer, 38.8% said Diabetes, and 29.7% said Heart Disease.

Respondents also reported their top barriers to care:

- **Co-pays and fees = 28.6%**
- **No insurance = 21.2%**
- **Difficulty getting appointments = 19.7%**
- **Difficulty getting time off work = 14.8%**
- **Transportation or other difficulties getting to appointments = 4.9%**

There are many health data indicators relevant to preventive care about specific health issues, diseases and populations. The planning process will include review of data and determine what areas of need to target, which may include specific disease interventions and/or preventive care barriers. Some examples of health data indicators reviewed in the CHA include:

- Percentage of adults reporting a routine check up in the past year
- Percentage of births whose mother initiated prenatal care in the 1st trimester
- Percentage of adults who reported a dental visit for any reason in the past year
- Percentage of adults 50-74 who are up-to-date on their breast cancer screening
- Percentage of adults 50-75 who are up-to-date with their colon cancer screening
- Percentage of adults 40+ who had an eye exam in the past year

Year 1 Objective:	**Establish a four year implementation plan with a public health objective, goals and strategies by November 30, 2024.**
Goal 1:	Create a task force and assess community resources, current preventive care providers, available services and existing referral practices. Review data to understand barriers and root causes and identify areas of need of which to address.
Goal 2:	Empower systems of care and community partnerships, and elevate voices of lived experience with participatory practices.
Goal 3:	Identify evidence informed public health strategies for implementation which may include mitigation initiatives and education in the importance of preventive care.

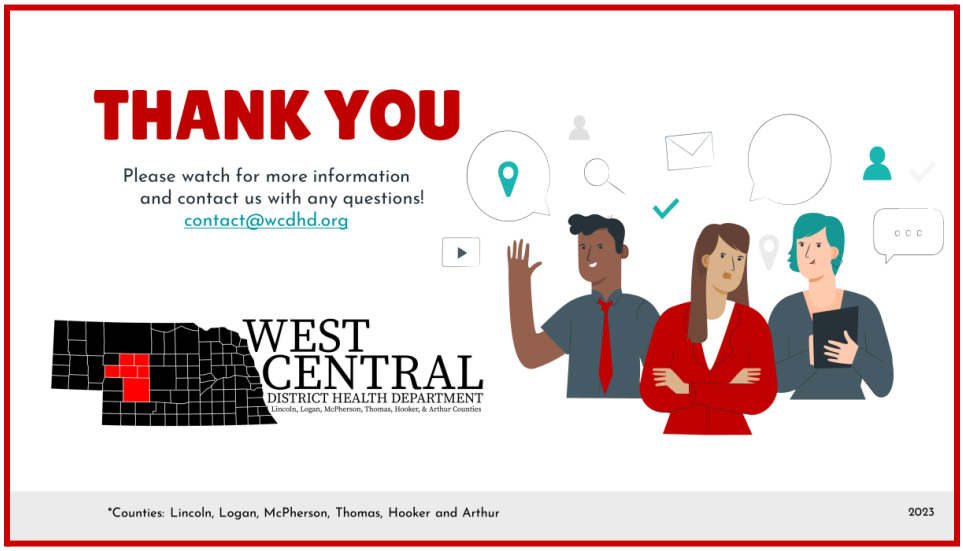
Closing Summary

This **2024-2028 Community Health Improvement Plan** resulted from a structured methodology and collaborative practice to review community data, listen to community voices, consider our system of care, and identify opportunities for impact.

After reviewing all primary and secondary data collected, the community health partners narrowed the focus to elevate four health issues. It is our hope to encourage community action toward these findings.

- ➔ **Mental Health**
- ➔ **Substance Use**
- ➔ **Health Literacy**
- ➔ **Preventive Care**

By enacting public health strategies to improve the health of individuals, families and neighborhoods, we pursue our shared vision for equitable health outcomes for all. We express gratitude for all who participated and contributed to this process, including our hospital and healthcare partners, behavioral health agencies, community organizations and most specifically - all the members of our communities that elevated their voice via the community survey. Thank you!



Design Team Consultant Information

Our Design Team for the Community Health Assessment and Community Health Improvement Plan process included collaboration with a Nebraska based consultant and facilitation support from an Oregon consultant.

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coflowco	 **Emily Weltman** emily@coflowco.com

APPENDIX

(Available upon request)