LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT

COMMUNITY HEALTH IMPROVEMENT PLAN

2022 WORKPLAN

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INTRODUCTION

Community Health Summit

On May 19, 2022, the Lincoln-Lancaster County Health Department (LLCHD) hosted the 2022 Community Health Summit to identify the most important health priorities and health barriers in Lancaster County, Nebraska. The Community Health Summit experience was based on quantitative and qualitative results of the community health assessment using a three-part methodology:

- Epidemiological data from public health surveillance systems
- Community Health Survey
- Community Conversations with equity groups

From analysis of epidemiological and qualitative data, four priority area health needs that impact the community were identified. Community health summit participants were then asked to rank the most important sub-categories of focus for each primary health area. The following final sub-categories emerged:

Priority Area	**Sub-Priorities of Focus**
Access to Care	Maternal Child Health, Preventative Care, Barriers to Care
Chronic Disease	Heart Disease, Unhealthy Lifestyles, Diabetes
Behavioral Health	Youth Health, Access to Behavioral Health Care, Suicide
Injury Prevention	Motor Vehicle Safety, Unintentional Falls, Intentional Violence

The Community Health Summit then structured breakout groups for each priority area with a focus on each respective sub-categories to gain an in-depth understanding of the health priorities identified through the assessment process. The qualitative data analysis found in the breakout group process is part of a multi-pronged process of data collection and analysis structured to complete the community health assessment. Community breakout groups are essential for making an informed decision regarding selected priorities for the 2022 Community Health Improvement Plan (CHIP).

Breakout Group Analysis and Methodology:

A total of 54 community health partners took part in the breakout group data collection process. Individuals were asked to choose three of four available session priority topic areas. All groups were moderated by LLCHD staff facilitators trained in Technology of Participation (ToP) methodology. The question posed for each priority sub-category of focus was “when considering the challenges surrounding [sub-priority], what must be changed or addressed to impact this health priority in the next 3 years?”

Participant responses were analyzed, and the data collection process resulted in 12 key themes that focus on how best to address the four priority areas and respective sub-categories. Key

themes were analyzed by five epidemiologists to validate conclusions drawn as part of the breakout group process. This report describes the trends and themes across four priority areas and their respective three sub-category areas of focus. The breakout groups individual responses, corresponding coded theme, example goals, example objectives, and example strategies were provided to priority work groups prior to the first meeting as part of the CHIP.

Quarterly CHIP Workplans:

A new ongoing Community Health Improvement Plan will allow workgroups to reassess objectives quarterly, and add or remove element as needed. While the broader goals will remain fairly set for the three-year time period of the CHIP, objectives will evolve and iterate, and Action Strategies will be reset for each quarter and much be achievable within that time frame.

Quarterly CHIP workplans will be developed and spearheaded by workgroup leads identified by the team, and supported by the Lincoln-Lancaster County staff assigned to the Priority Area.

Initial Workgroup Analysis and Methodology:

During the week of June 20th, 2022, the Lincoln-Lancaster County Health Department hosted four initial workgroups sessions with a total of 50 community partners. Workgroups established a Quarter One Workplan foreach of the Priority areas in the Community Health Improvement Plan. Priorities Partners selected one of 3 sub-priority workgroups, and used themes identified from the Community Health Summit to set initial objectives and action strategies.

Health Equity and Social Determinants:

The updated Community Health Assessment and Improvement Plan prioritizes engagement and assessment of populations at higher risk for each of the population health outcomes monitored by the department. The Minority Health Summit gathered key minority health organizations and leaders in the community to establish key health priorities for populations at increased risk of most population health outcomes. The results were overlayed with those of the Community Health Summit to form priorities and themes.

The result is that the Community Health Improvement Plan has representation and influence from not only equity group data and input, but also membership from the same partnerships and participants on the Priority workgroups themselves. The desire is to grow the list of active participants over the next three years of this CHIP.

Evident in the CHIP Objectives and Action Strategies are efforts to directly identify and address barriers that directly connect to poorer health outcomes in Lincoln and Lancaster County, and increase the health inequity among specific communities. Many of these priorities are policy-level changes and will require significant partnership and engagement from across the community.

ACCESS TO CARE

Maternal Child Health

Working Goal: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.

The top three themes were:

- Education, information, & literacy programs
- Availability of services
- Community connectedness & support groups

Preventative Care

Working Goal: Reduce the proportion of persons who are unable to obtain and/or unaware of needed preventative medical care meeting CLAS standards.

The top three themes were:

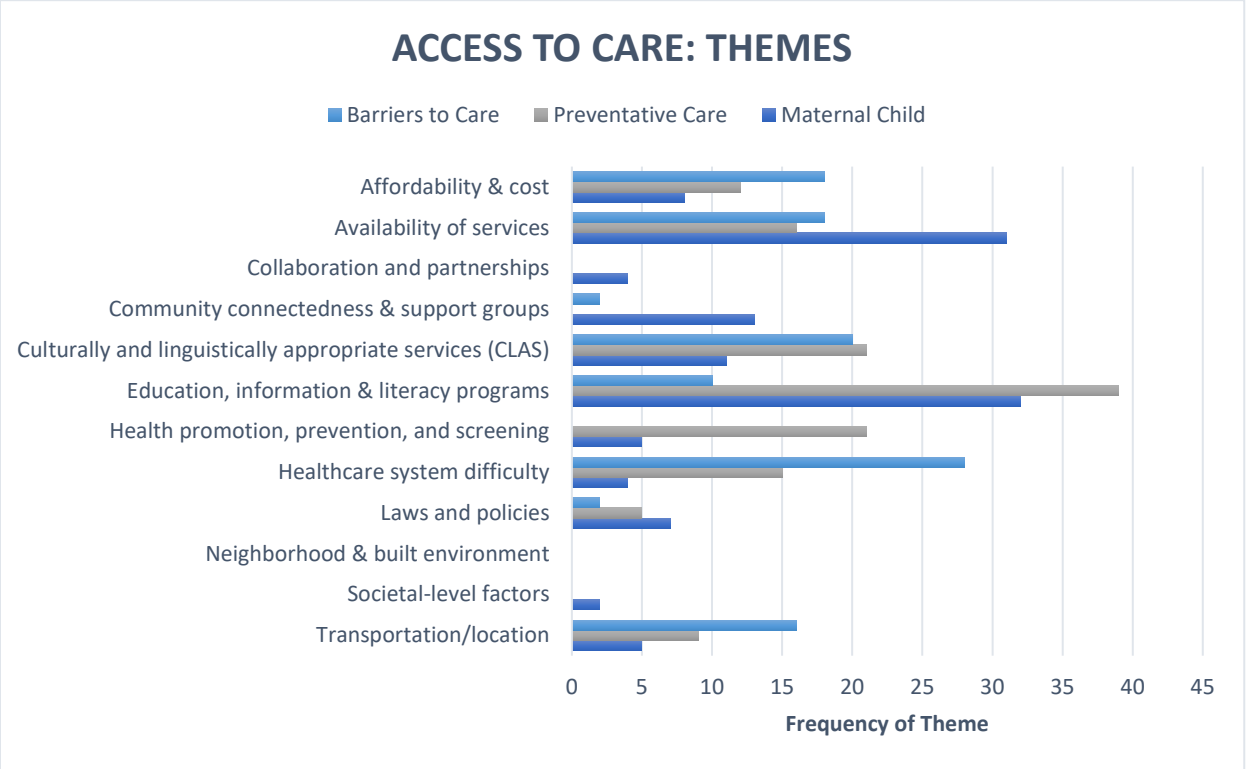
- Education, information, & literacy programs
- Health promotion, prevention, and screening
- Culturally and linguistically appropriate services (CLAS)

Barriers to Care

Working Goal: Reduce barriers to care (cost, availability, transportation, literacy, and language).

The top three themes were:

- Healthcare system difficulty
- Culturally and linguistically appropriate services (CLAS)
- Affordability & cost, Availability of services (tied)



ACCESS TO CARE

MATERNAL AND CHILD HEALTH WORKGROUP

Goal: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations.

THEME: Education, information, and literacy programs

OBJECTIVE 1A: By June 1, 2025, increase breastfeeding rates by 5% in the proportion of infants who initiate breastfeeding. (Data Source: Birth data)

OBJECTIVE 1B: By June 1, 2025, increase breastfeeding rates by 5% in the proportion of infants who are breastfed through 6 months of age. (Data Source: PRAMS, CyncHealth, WIC)

OBJECTIVE 1C: By June 1, 2025, increase breastfeeding rates by 5% in the proportion of infants who are breastfed at 1 year. (Data Source: PRAMS, CyncHealth, WIC)

ACTION STRATEGIES:

1.1: By October 1, 2022, workgroup members will have meet with the following groups to identify current efforts toward increasing breastfeeding rates in Lancaster County: Lincoln Breastfeeding Coalition, Lancaster County WIC programs, Nebraska Breastfeeding Coalition, Malone Center, Bryan & CHI Health Systems through Baby Friendly Hospital Practices.

1.2: By October 1, 2022, workgroup members will assess receptiveness, through the Cultural Centers (see UHV outreach effort above) toward the Babe Café concept in efforts to increase breastfeeding rates.

THEME: Community connectedness & support groups

OBJECTIVE 1: By June 1, 2025, through the Universal Home Visitation (UHV) program, 85% of new moms (living in Lancaster County) will be offered a home visit following the birth of their child with 70% accepting a home visit.

2.1: By October 1, 2022, workgroup members will meet with representatives from the Cultural Centers to provide information/education on the UHV Model (Family Connect), determine how this will impact their community members and identify barriers/concerns to address.

2.2: By October 1, 2022, LLHD, with community partner support, will begin to initiate the planning process for the Family Connects UHV model (road map is already developed for planning purposes.

Performance Measures	Baseline	Target
First trimester prenatal care	80.9% of mother started prenatal care in first trimester (Birth 2020)	85% by 2025 2020-80.9% 2019-80.1% 2018-74.9%

Low birthweights	7.1% of births were low birth weight (Birth 2020)	6.5% by 2025 2020-7.1% 2019-7.5% 2018-7.3%
Percent of infants who initiated breastfeeding at birth	91.2% of mother-initiated breastfeeding to infant at birth (Birth 2020)	**96% by 2025** 2020-91.2% 2019-93.7% 2018-94.2%
Percent of infants breastfed at 6 months of age	54% any breastfeeding (LLCHD WIC July 2021-June 2022) 13% exclusive breastfeeding (LLCHD WIC July 2021-June 2022)	60% any breastfeeding (LLCHD WIC July 2024-June 2025)
Percent of infants breastfed at 1 year of age	17% (LLCHD WIC July 2021-June 2022)	20% (LLCHD WIC July 2024-June 2025)
Infant mortality rate	3.7 death per 1000 live birth (Death 2020)	2.5% by 2025 2020-3.7 per 1000 live birth 2019-3.8 per 1000 live birth 2018-3.3 per 1000 live birth
Number and percent of live births with mother completing a postpartum mental health screening including depression screening with positive rates, including PHQ-2/PHQ-4 in WIC with a PHQ-9 for a positive screening)	Data needed	Data needed
Barriers/concerns identified by Cultural Centers specific to UHV implementation	Planning	Reported
Family Connect Academy Timeline Benchmarks Met	Met	Met

PREVENTIVE CARE WORKGROUP

Goal: Reduce the proportion of persons who are unable to obtain and/or unaware of needed preventative medical care meeting CLAS standards.

THEME: Culturally and linguistically appropriate services (CLAS)

OBJECTIVE: Increase the number of Annual primary care visits by individuals not already participating by 10% by 2025.

1.1 Collect and analyze available data and develop action plan.
1.2 Increase health literacy of the community to include understanding of preventative care as part of the big picture of their long-term health, not only for their benefit but the benefit of their children and grandchildren.
1.3 Identify and engage trusted community partners to relay relevant and credible prevention health information by topic to the highest affected community members.

Below are data needs for this area.

- BRFSS results of Q 3.4 showing Lancaster County residents' routine checkup results, cross-tabulated with associated available demographics, particularly insurance status.
- Medicaid data reflecting the number and demographic information reflecting how many Lancaster County citizens receiving Medicaid have had an annual routine check-up in the last year, and how many have not.

MEMBERS: Romeo Guerra, Leader Lisa Decoteau, Christina Hitz

Performance Measures	Baseline	Target
Percent of 18+ years who visited doctor for a routine check-up during the previous 12 month	71.3% of adults reported to visit a doctor for a routine checkup during the previous 12 months (2020 BRFSS)	78% in 2025 2020-71.3% 2019-71.8% 2018-72.2%

BARRIERS TO CARE WORKGROUP

Goal: Reduce barriers to care (cost, availability, transportation, literacy, and language).

THEME: Healthcare system difficulty

OBJECTIVE: Connect 300 community members to care by 2025 by creating a coalition that utilizes a "homeless coalition model."

1.1 Meet with representatives from the healthcare industry with an interest in improving access to care.

1.2 Develop Community Coalition model of healthcare navigators akin to Homeless Coalition for testing

1.3: Meet with Strong Neighborhood subgroup through Prosper Lincoln to pitch concept and grow coalition

ASSIGNMENTS

- August 2022 – Nola Presents to Strong Neighborhood
- October 2022 – Stakeholder meetings
- January 2023 – first convening of Health Access Coalition

MEMBERS: Mike Bingeman, Nola Derby Bennett, Nancy Petitto, Brad Meyer, Teresa Harms (LEAD)

Performance Measures	Baseline	Target
# of people unable to access care due to barriers (decrease by 5% over 3 years?/serve 300 people over 3 years)	TBD	TBD
Percent of adults 18+ years who were unable to access care due to cost	9.7% of adults reported that the needed to see a doctor but could not due to cost	8.73% by 2025 2020-9.7% 2019-12.7% 2018-11.6%

BEHAVIORAL HEALTH

Youth Health

Working Goal: Increase availability and accessibility of mental health services in youth populations.

The top three themes were:

- Health promotion, prevention, and screening
- Education, information, & literacy programs
- Community connectedness & support groups

Access to Behavioral Health Care

Working Goal: Improve access to the continuum of mental health care among adults and children.

The top three themes were:

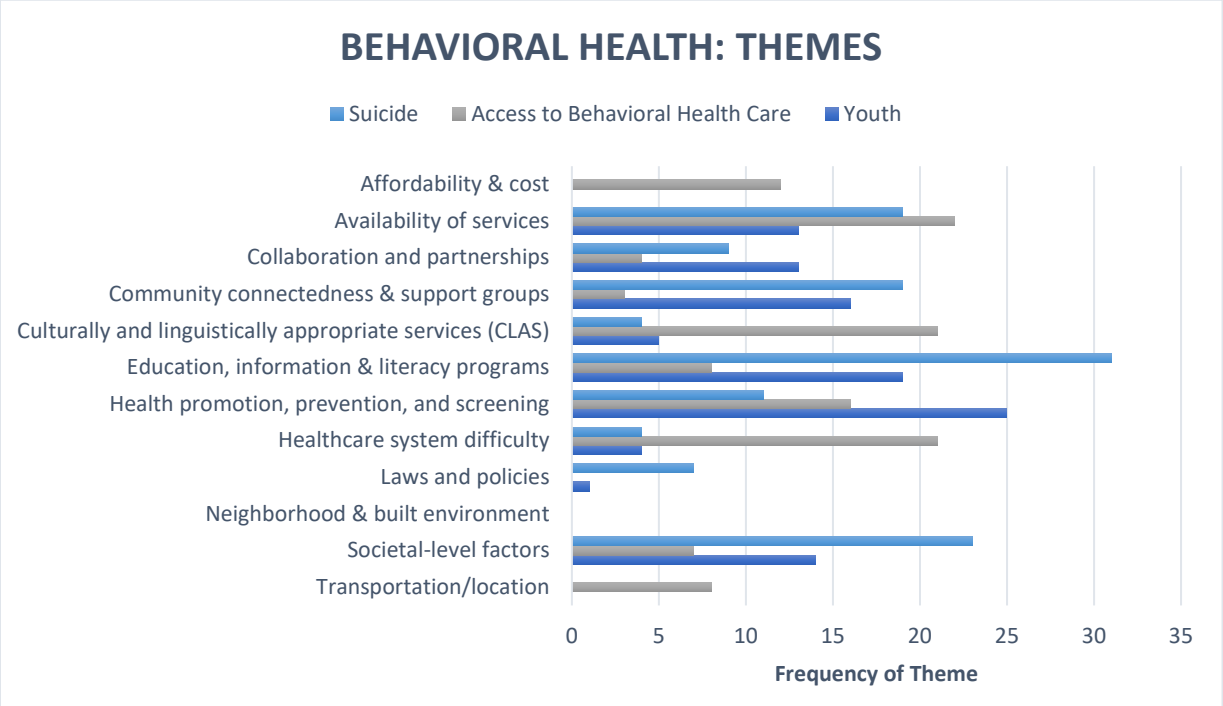
- Availability of services
- Culturally and linguistically appropriate services (CLAS)
- Healthcare system difficulty

Suicide

Working Goal: Reduce suicide in adults and children.

The top three themes were:

- Education, information, & literacy programs
- Societal-level factors
- Community connectedness & support groups; Availability of services (tied)



BEHAVIORAL HEALTH

YOUTH BEHAVIORAL HEALTH WORKGROUP

Goal: Increase availability and accessibility of mental health services in youth populations.

THEME: Health promotion, prevention, and screening

OBJECTIVE: Develop a list of resources for Behavioral Health focused on mentorship model (peer model – broad view) to share with community stakeholders by October 2022

1.1 Assess appropriateness and capacity of resources for stakeholder groups/organizations
1.2 Identify appropriate resources for families, youth, and caregivers

THEME: Education, information, & literacy programs

OBJECTIVE: Develop plan to disseminate resources to with follow-up evaluation rubric by December 2022

2.1 Create implementation process and plan resources for families
2.2 Include IT – technology plan as well as other modes

THEME: Community connectedness & support groups

OBJECTIVE: Develop a Youth Behavioral Health Initiative by October 2022

3.1 Identify list of providers and community stakeholders
3.2 Contact stakeholders – identify fragmentation or collaboration in community and what to use for education

MEMBERS: Wendy Rau (LEAD), Jason Varga, Barb Martinez, Michelle Coleman

Performance Measures	**Baseline**	**Target**
Providers identified	No	Yes
Community stakeholders	No	Yes
Stakeholders contacted	No	Yes
Plan developed	No	Yes

ACCESS TO BEHAVIORAL HEALTH CARE WORKGROUP

Goal: Improve access to the continuum of mental health care among adults and children.

THEME: Availability of services

OBJECTIVE: Increase number of people gaining access to behavioral health system of care

1.1 Collect, compile, and analyze the behavioral health access information already existing in the community.

1.2 Gather current behavioral health screening questions used by partners used for referral

MEMBERS: Shirley Terry, Chis Allende (Lead), Romeo Guerra, Lanetta Edison Soe, Maria Elena Villasante (Lead), Olga Caliendo, Sheila Dorsey Vinton

Performance Measures	Baseline	Target
Report of BH access information available	None	Developed
Report of existing BH screening practices	None	Developed

SUICIDE PREVENTION WORKGROUP

Goal: Reduce suicide in adults and children.

THEME: Availability of services

OBJECTIVE: By June 1, 2025, adult deaths due to suicide will decrease by 10%.

OBJECTIVE: By June 1, 2025, youth deaths due to suicide will decrease by 10%.

1.1A By September 1, 2022, the Suicide Prevention work group will schedule a meeting with HopeLNK and Region V to learn more about their suicide prevention initiatives (led by Kerry Kernen).
1.1B By September 1, 2022, the Suicide Prevention work group will develop the agenda for this meeting to identify and list current initiatives, in the Lancaster County community that the work group can support in the areas of education, information and literacy programs, societal-level factors and community connectedness (led by Kerry Kernen).
1.2 By October 1, 2022, the Suicide Prevention work group will identify and reach out to MyLink administrator (schedule meeting with agenda) about expanding community connectedness through additional resources listed in the health/mental health section (led by Sadie Thompson).
1.3: By November 1, 2022, the Suicide Prevention work group will, based on meeting Objective 1 above) identify gaps the work group can prioritize and focus on in the areas of education, information and literacy programs, societal-level factors, and community connectedness.
Below are some improvements to data that are necessary to improve evaluation capacity for interventions applied towards this area of behavioral health.

- Data needs were identified in the rates of mental health diagnosis (depression, anxiety, eating disorders, SPMI, etc.) in Lancaster County. Self-reporting as well as data form CyncHealth identified as possible resources. Demographics should be included, along with zip codes/regions for targeted interventions.
- Data needs on rates of ACE's scores in Lancaster County needed – all 10 questions and their connection to Social Determinants of Health (SDOH) and other health outcomes (mental health diagnosis, substance use & abuse disorders related to alcohol, tobacco and other drugs, chronic medical conditions such as diabetes, hypertension, CVD and more.)
- Data needs on rates of suicide ideation with demographics, zip codes/regions
- Data needs on self-reporting of support systems in place (with definition of "someone they can turn to for help" and yes/no for concrete/social support) with demographics & zip codes/regions

MEMBERS: Dave Miers, Sadie Thompson

Performance Measures	Baseline	Target
Youth suicide deaths (death certificates)	7.7 deaths per 100,000 youth (age between 10-19	0 Deaths per 100,000 population for youth age between 10-19 yr by 2025.

	Yrs). (2016-2020 death data)	2016-2020: 7.7 Deaths per 100,000
Adult suicide deaths (death certificates)	17.1 deaths per 100,000 adults (20+ yrs). (2016-2020 death data)	10 deaths per 100,000 population 20 yrs or older. 2016-2020: 17.1 Deaths per 100,000
Youth attempted suicide (YRBS)	9.5% youth reported to attempt suicide (2019 YRBS)	4.25% by 2025 2019-9.5% 2017-6.1% 2015-14.0%
Suicidal ideation among youth (YRBS)	17.6% youth seriously considered attempting suicide (2019 YRBS)	13.2% by 2025 2019-17.6% 2017-19.0% 2015-17.5%

CHRONIC DISEASE

Heart Disease

Working Goal: Decrease rates of cardiovascular disease in adults.

The top three themes were:

- Health promotion, prevention, and screening
- Education, information, & literacy programs
- Availability of services

Unhealthy Lifestyles

Working Goal: Increase rates of physical activity among adults and children.

The top three themes were:

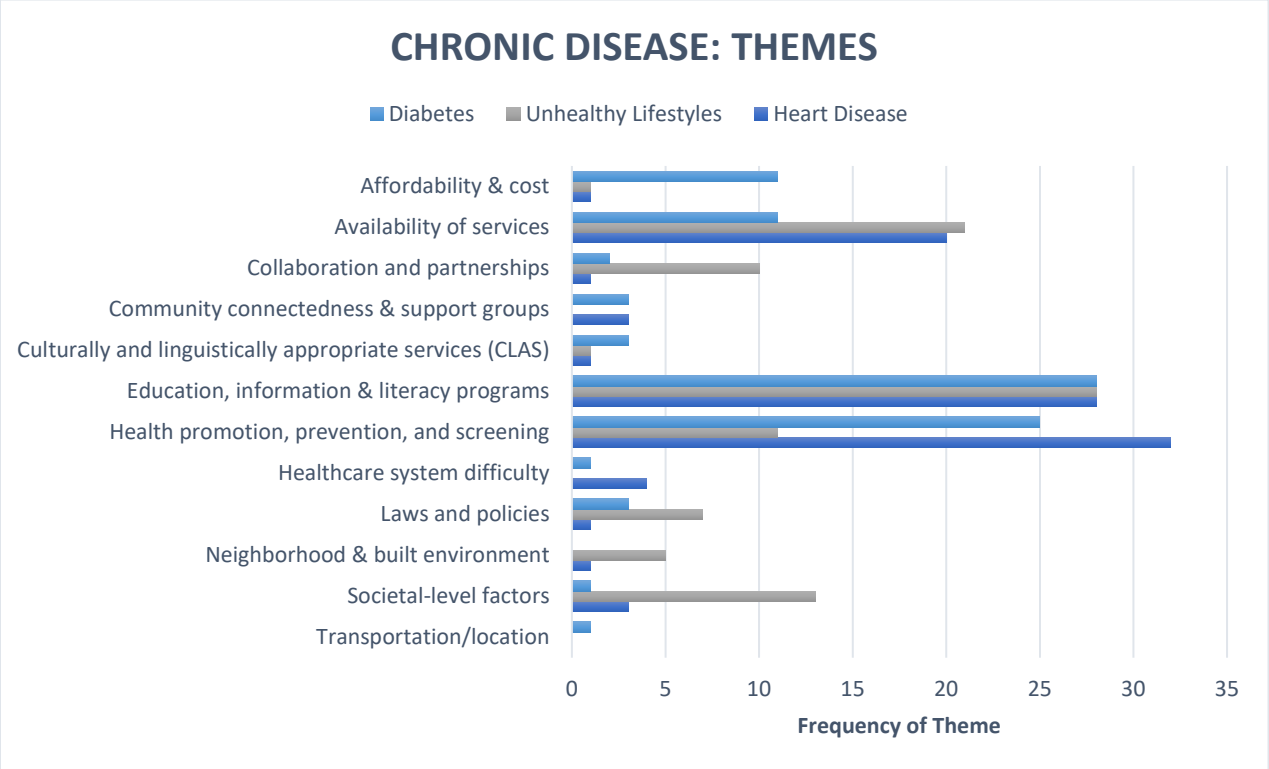
- Education, information, & literacy programs
- Availability of services
- Health promotion, prevention, and screening

Diabetes

Working Goal: Increase the availability and consumption of healthy foods.

The top three themes were:

- Education, information, & literacy programs
- Health promotion, prevention, and screening
- Availability of services



CHRONIC DISEASE

HEART DISEASE WORKGROUP

Goal: Decrease rates of cardiovascular disease in adults.

THEME: Health promotion, prevention, and screening

OBJECTIVE: Promote heart disease awareness, prevention, and screening with resources of organizations that provide services, screenings, and help with prevention.

1.1 Develop heart disease resource sheet (modeled after diabetes)
1.2 Distribute information in dental offices, Libraries, thrift stores, PCM, Matt Talbot, and grocery stores.

THEME: Education, information, & literacy programs

OBJECTIVE: Help people understand the importance of learning heart healthy lifestyle prior to the onset of heart disease

1.1 Identify Leaders/peers to help address language/cultural barriers
1.2 Identify cultures/languages needed
1.3 Reach out to cultural center health workers to collaborate
1.4 Build culturally appropriate access and resources to information through collaborations with Blue Stem, Health 360, Indian Medical Center, Family Health Services, Lincoln Educational Medical Partnerships and Medicaid.
1.5 Educate about healthy nutritional lifestyle choices through videos, flyers, attendance and events that teach about food in the Unites States.

MEMBERS: Jennifer Rathman, Lindsey Steele, Tiffany Quicke, Morgan Hermanek, Luke Stege, and Michelle Kiddoo. Leader: Luke Stege and Michelle Kiddoo, Samia Gamie, Lata Nawal

Performance Measures	Baseline	Target
BRFSS "Had cholesterol checked in the past 5 years, Adults 18 and older, by race/Ethnicity, Age Adjusted"	83.5% of adults reported checking their cholesterol in the past 5 years (2019 BRFSS)	91.85% by 2025 2019-83.5% 2017-85.8%
BRFSS, "Consumed fruits less than 1 time per day, Adults 18 and older, by Race/Ethnicity, Age-Adjusted," and "Consumed vegetables less than 1 time per day, Adults 18 and older, by Race/Ethnicity, Age-Adjusted."	20.9% of adults reported consuming vegetables less than one time daily (2019 BRFSS)	23 % by 2025 2019-20.9% 2017-18.6%

UNHEALTHY LIFESTYLES WORKGROUP

Goal: Increase rates of physical activity among adults and children.

THEME: Education, information, & literacy programs

OBJECTIVE: Define how physical activity positively impacts all aspects of an individual's well-being

1.1: Gather subject matter experts from various community partner organizations, i.e. spiritual, behavioral, health, etc., to provide working definition

MEMBERS: Andy Link, Matt Prokop, Mike Lefler, Carly Hunt, Kalen Petrie, Kelly Braswell-Burbach, Maureen Brase-Houchin, Kristen Agger, Tamara Robinson

Performance Measures	Baseline	Target
Adults meeting physical activity recommendations (BRFSS)	16.1% of adult reported no leisure-time physical activity in past 30 days. (2020 BRFSS)	17.75% by 2025 2020-16.1% 2019-20.3% 2018-18.2%
Youth meeting physical activity recommendations (YRBS)	60.3% of youth reported being physically active for a total of at least 60 minutes per day during the past 7 days. (2019 YRBS)	72.36% by 2025 2019-60.3% 2017-76.6% 2015-75.0%

DIABETES WORKGROUP

Goal: Increase the availability and consumption of healthy foods.

THEME: Education, information, & literacy programs

OBJECTIVE: Increase access to tools that improve health and wellness for populations of higher risk for diabetes as measured by reports from community providers responses to surveys, reports from food distribution sites and number of consumers accessing website by 2025.

1.1 Utilize stories about change/success stories

1.2 Create provider survey- add a question about if willing to share a success story

Performance Measures	Baseline	Target
Reports from community providers responses to surveys.		
Reports from food distribution sites.		
Number of consumers accessing website		
Percent of adults 18+ years who have ever been told by a healthcare professional that they have diabetes	7.5% of adult reported they have been told by a healthcare professional that they have diabetes (2020 BRFSS)	7% by 2025 2020-7.5% 2019-8.5% 2018-8.7%

INJURY PREVENTION

Motor Vehicle Safety

Working Goal: Reduce motor vehicle related injury and death for Lancaster County residents.

The top three themes were:

- Neighborhood and built environment
- Education, information, & literacy programs
- Transportation/location

Unintentional Falls

Working Goal: Reduce elder falls and promote aging in place.

The top three themes were:

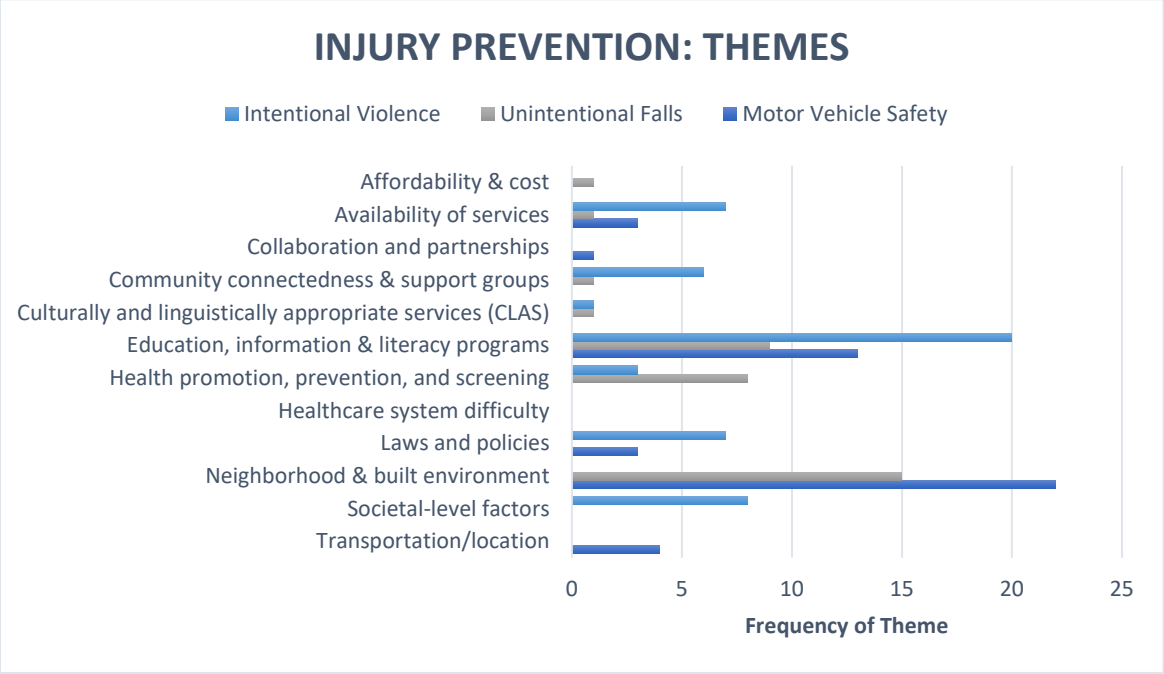
- Neighborhood and built environment
- Education, information, & literacy programs
- Health promotion, prevention, and screening

Intentional Violence

Working Goal: Promote violence prevention and address trauma (safe neighborhoods/community partnerships).

The top three themes were:

- Education, information, & literacy programs
- Societal-level factors
- Laws and policies; Availability of services (tied)



INJURY PREVENTION

MOTOR VEHICLE SAFETY WORKGROUP

Goal: Reduce motor vehicle related injury and death for Lancaster County residents.

THEME: Neighborhood and Built Environment

Objective: By 2025, reduce motor vehicle injury and death at the ten most dangerous intersection/neighborhoods/roadways in Lincoln and Lancaster County.

1.1: Gather LPD/LTU accident report data on top 10 injuries locations – "The Hit List"

2.2: Identify stakeholders to address leading traffic safety concerns in identified neighborhoods.

THEME: Education, information, and literacy programs

Objective: Identify appropriate educational outreach and information that is culturally relevant and at the appropriate reading level based on data for high-risk areas for crashes.

Performance Measures	**Baseline**	**Target**
Obtaining raw accident report data from LTU & LPD to drill down on locations	Planning	Completed

UNINTENTIONAL FALLS WORKGROUP

Goal: Reduce elder falls and promote aging in place.

THEME: Neighborhood and Built Environment

Objective: By 2025, Reduce falls among adults in medically underserved areas through providing a minimum of 300 fall risk assessments.

1.1: Partner with Clinic with a Heart, Bluestem Health, Bryan Health, and CHI Saint Elizabeth to conduct initial fall incident screening to identify intervention participants.

1.2: Partner with appropriate referral partners to conduct assessments

THEME: Education, information, and literacy programs

Objective: By 2025, reduce falls among older adults in medically underserved areas through partnering with local health and medical providers to conduct a minimum of four community fall prevention education courses.

2.1: Identify community partners to facilitate education/training

2.2: Identify location(s) for education in respective medically underserved areas

THEME: Health promotion, prevention, and screening

Objective: By 2025, reduce falls among older adults in medically underserved areas and the general population through a multi-media fall prevention campaign.

3.1: Conduct traditional/social media fall prevention campaigns

3.2: Assure medical providers and home visitors are educating on fall prevention

Performance Measures	Baseline	Target
What percent of assessed underserved population requires intervention	Measures to be identified	TBD
Document percent of participants in these areas that receive education/training	Planning	Completed
Annual review of LFR and EMS ground-level falls and lift-assist dates	Planning	Completed
Falls among adults (18+ years)	52.7 Falls per 10,000 population resulted in hospitalization for adults 18 years or older. (2017 IP HDD) 263.7 Falls per 10,000 population resulted in ER visit for adult 18 years or older. (2017 OP HDD)	47 Falls per 10,000 population by 2025 in population 18 years or older. 2017-52.7 per 10,000 (IP) 2016-50.7 per 10,000 (IP) 2017-263.7 per 10,000 (OP) 2016-274.9 per 10,000 (OP)

	316.5 Falls per 10,000 population resulted in hospital visit for adults 18 years or older. (2017 HDD)	2017-316.5 per 10,000 (Overall) 2016-325.7 per 10,000 (Overall)
Falls among older adults (65+ years)	219.6 Falls per 10,000 population resulted in hospitalization for adults 65 years or older. (2017 IP HDD) 638.3 Falls per 10,000 population resulted in ER visit for adult 65 years or older. (2017 OP HDD) 857.9 Falls per 10,000 population resulted in hospital visit for adults 65 years or older. (2017 HDD)	197 Fall per 10,000 population by 2025 in population 65 years or older. 2017-219.6 per 10,000 (IP) 2016-213.5 per 10,000 (IP) 2017-638.3 per 10,000 (OP) 2016-670.7 per 10,000 (OP) 2017-857.9 per 10,000 (Overall) 2016-884.3 per 10,000 (Overall)

INTENTIONAL VIOLENCE WORKGROUP

Goal: Reduce intentional violence related injury and death for Lancaster County residents.

THEME: Education, information, and literacy programs

Objective: By 2025, reduce emergency room visits because of domestic violence by 10%

1.1: Gather data of emergency room visits from previous years

1.2: Start with high-risk areas to create educational campaigns through neighborhood strength areas (faith, businesses, barber shops, etc.)

1.3: Educate responders, caseworkers, etc., to provide appropriate resources

Performance Measures	Baseline	Target
Obtain data of emergency room visits from previous years and over the next 3 years	Pending data	Pending data

Workgroup Enrollment

First Name	Last Name	Organization	Primary Work Group Preference
Kayla	Abel	Family Service Lincoln	Access to Care
Brad	Meyer	Bluestem Health	Access to Care
Kelly	Braswell-Burbach	Lancaster County Medical Society	Access to Care
Nola	Derby-Bennett	Lincoln Public Schools	Access to Care
Teresa	Harms Coder	Clinic with a Heart	Access to Care
Nancy	Petitto	Civic Nebraska	Access to Care
Kay	Wenzl	Aging Partners	Access to Care
Michael	Bingeman	CHI Health	Access to Care
Ted	Fraser	Partnership for a Healthy Lincoln	Access to Care
Romeo	Guerra	El Centro de las Americas	Access to Care
Thuy	Ho	Asian Community and Cultural	Access to Care
Emily	Kluver	Community Health Endowment of Lincoln	Access to Care
Heather	Loughman	Community Action	Access to Care
Bob	Rauner	Partnership for a Healthy Lincoln/OneHealth Nebraska/LPS Board	Access to Care
Ashton	Wyrick	Bryan Health	Access to Care
Barb	Martinez	Lincoln-Lancaster County Health Dept.	Behavioral Health
Olga	Caicedo	El Centro de las Americas	Behavioral Health
Kerry	Kernen	Lincoln-Lancaster County Health Department	Behavioral Health
Jason	Varga	Cause Collective	Behavioral Health
Marie	Dutra	El Centro de las Americas	Behavioral Health
David	Miers	Bryan Medical Center	Behavioral Health
Vickie	Acklie	Health Department	Behavioral Health
Michelle	Coleman	Educare of Lincoln	Behavioral Health
Sheila	Dorsey Vinton	Asian Community & Cultural Center	Behavioral Health
Kristy	Goodwin	City Impact	Behavioral Health
Emily	Gratopp	Nebraska Extension	Behavioral Health
Laila	Hasan	Asian Community & Cultural Center	Behavioral Health
Rose	Hood Buss	The HUB Central Access Point for Young Adults	Behavioral Health
Bill	Michener	Lighthouse After School Program	Behavioral Health

Tom	Randa	Good Neighbor Community Center	Behavioral Health
Wendy	Rau	Lincoln Public Schools	Behavioral Health
Sandy	Thompson	Families Inspiring Familis	Behavioral Health
Jennifer	Brown	Ponca Health Services	Behavioral Health
Ryan	Carruthers	CenterPointe	Behavioral Health
Lanetta	Edison-Soe	Asian Community and Cultural Center	Behavioral Health
Scott	Etherton	Mental Health Crisis Center	Behavioral Health
Tricia	Monzón	Ponca Tribe of Nebraska	Behavioral Health
Tricia	Monzón	Ponca Tribe of Nebraska	Behavioral Health
Lori	Seibel	Community Health Endowment	Behavioral Health
Lori	Seibel	Community Health Endowment	Behavioral Health
Katie McLeese	Stephenson	HopeSpoke	Behavioral Health
Shirley	Terry	Lutheran Family Services	Behavioral Health
Maria Elena	Villasante	Asian Community and Cultural Center	Behavioral Health
Lacie	Bolte	Nebraska AIDS Project	Chronic Disease
Kayla	Colgrove	Nebraska Extension in Lancaster County	Chronic Disease
Morgan	Hermanek	Community Health Endowment	Chronic Disease
Ansley	Fellers	Nebraska Grocery Industry Association	Chronic Disease
David	Humm	LLCHD	Chronic Disease
Suzanne	Mealer	Ponca Tribe of NE | Ponca Health Services	Chronic Disease
Karri	Ahlschwede	Nebraska Wesleyan University	Injury Prevention
Sara	Weber	LLCHD	Injury Prevention
Brian	Baker	LLCHD	Injury Prevention
Denise	Bollwitt	Animal Control LLCHD	Injury Prevention
Tommy	George	Lincoln-Lancaster County HD	Injury Prevention
Karen	OHara	Aging Partners	Injury Prevention