Children's
HOSPITAL & MEDICAL CENTER
OMAHA

Children's Hospital & Medical Center

IMPLEMENTATION STRATEGY PLAN

2019 - 2021

This report is provided in fulfillment of the requirement of IRS Notice 2011-52 addressing the Community Health Needs Assessment (CHNA) for charitable hospitals in section 501(r).

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Public comment on this report is encouraged and should be sent via email to:
ForEveryChild@ChildrensOmaha.org

All related public documents are accessible at:
www.ChildrensOmaha.org/advocacy-outreach

Introduction

The mission of Children's Hospital & Medical Center is to improve the life of every child through dedication to exceptional clinical care, research, education and advocacy. Children's is the only full-service, pediatric health care center in Nebraska, providing expertise in more than 50 pediatric specialty services to children across a five-state region and beyond. Children's has received recognition for the quality of its specialty care, including ranking as a 2018-19 Best Children's Hospital by *U.S. News & World Report* in Cardiology & Heart Surgery, Pulmonology, Gastroenterology & GI Surgery, Orthopedics and Diabetes & Endocrine Disorders.

The 145-bed, non-profit hospital operates the only Level IV Newborn Intensive Care Unit (NICU) in the region. Children's NICU and Pediatric Intensive Care Unit (PICU) were both awarded the American Association of Critical Care Nurses' Gold Beacon Award, which recognizes excellence in critical care in intensive care units. Children's is one of just two hospitals in the country with gold-level NICU and PICU status.

In 2018, Children's provided medical care for 149,700 children. In addition to serving Omaha youth and families, Children's provides for the health care needs of children from throughout the region, with outreach clinics in Columbus, Grand Island, Hastings, Kearney, Norfolk, Lincoln and North Platte, Neb.; Sioux City and Atlantic, Iowa; and Rapid City, S.D. Children's ensures that no child with a medical need is ever turned away due to a family's inability to pay.

Children's Center for the Child & Community is a statewide community outreach hub of Children's Hospital & Medical Center. The Center for the Child & Community was launched in 2016 to serve as the infrastructure for community health improvement, leading both internal and external partnerships around Pediatric Community Health Needs Assessment planning and implementation.

This document outlines Children's Implementation Strategy Plan (ISP) to address community pediatric health needs as determined by the 2018 Child & Adolescent Community Health Needs Assessment (CHNA), adopted by Children's Board of Directors on Nov. 29, 2018.

Children's Community Health Needs Assessment & Prioritization Process

Children's Strategic Plan 2025 embraces a vision to be a global leader for children's health. With values of safety, positive attitudes, service excellence, integrity, accountability, respect, wise use of resources and innovation, Children's aims to improve the life of every child. Strategies include partnering with the community to improve the well-being of children to achieve its mission. Community collaboration and innovation will be key in realizing this plan, as will internal and external coordination.

Children's Community Health Needs Assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary data collection (PRC Child & Adolescent Health Survey) and secondary data collection (vital statistics and other existing health-related data). These quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary data gathered through an Online Key Informant Survey.

On Nov. 5, 2018, findings from this Community Health Needs Assessment (CHNA) were presented at Live Well Omaha's 2018 Changemaker Summit (Figure 1). The Changemaker Summit is the region's largest multi-sector health conference, which gathers more than 170 leaders, including representatives from the region's local public health departments and major health systems (Douglas, Sarpy, Cass and Pottawattamie Counties), to celebrate the milestones of collective work and advance future work while learning from local, regional and national experts. At this event, Professional Research Consultants, Inc. (PRC) highlighted data reflecting the significant health issues identified from the data collection (CHNA Areas of Opportunity). In addition, data were shared specific to the Mobilizing Action through Planning and Partnerships (MAPP) process, including a Forces of Change Assessment, a Local Public Health Systems Assessment, and a Community Strengths and Themes Assessment.

Following the presentation, attendees broke into small groups for reflection and sharing, structured around the following criteria:

- Data shows that it is a critical problem
- Political will to address the issue
- Community capacity to address the problem
- Collaboration is possible in this space to move forward
- Aligns with current community efforts/assets

Figure 1: Community Stakeholder Priorities in Order of Importance

CHILD & ADOLESCENT HEALTH	ADULT HEALTH
Mental/behavioral health	Mental health
Nutrition, physical activity & obesity	Nutrition, physical activity, obesity & diabetes
Access to health services	Access to health services
Sexual health	Substance abuse
Tobacco, alcohol and other drugs	Injury and violence

After the community prioritization process, internal leaders reviewed the data to prioritize child health topics from PRC's "Areas of Opportunities Identified" based on the following criteria:

- Scope and severity of the problem
- Readiness and ability to impact change

Significant Health Needs to Be Addressed in Children's 2019-2021 Implementation Strategy Plan

Children's identified four priority child health needs from the Pediatric Community Health Needs Assessment based on internal and external prioritization input. Children's 2025 Strategic Plan, launched in December 2017, focuses on working to "improve the life of every child." To achieve this, Children's is committed to addressing the significant health needs identified in the Community Health Needs Assessment through programs, resources and collaborations targeting:

- Access to health services
- Mental/behavioral health
- Nutrition, physical activity & obesity
- Sexual health

Community Served

The study area for the CHNA survey effort (referred to as the "Metro Area" in this report) is defined as each of the residential ZIP codes comprising Douglas and Sarpy counties in Nebraska, as well as Pottawattamie County in Iowa. For more specific analysis, Douglas County is divided into five geographical areas—Northeast Omaha, Southeast Omaha, Northwest Omaha, Southwest Omaha and Western Douglas County.

The Implementation Strategy Plan, however, addresses not only the study area as described above, but includes statewide reach into communities receiving supports and services across Children's enterprise.

Implementation Strategy Plan Development Process

To conduct the implementation planning process, Children's Center team identified subject matter experts within Children's and within community-based organizations to engage in the planning process. In early 2019, three facilitated community partner conversations were held at Children's with internal and external stakeholders to discuss the identified child health priority, CHNA findings and current initiatives addressing the health priority, and to brainstorm opportunities for the 2019-2021 Implementation Strategy Plan (ISP). Additional internal stakeholder meetings were held to identify key strategies and desired outcomes for the ISP. Finally, drafts of the ISP were shared with key community stakeholders involved in implementation for feedback. Ongoing plan development will be fostered through annual plan revisions and updates to ensure that the ISP reflects a collaborative process that builds on internal and external partner strengths.

Implementation Strategy Plan Framework

Implementation and project management structure (Figure 2) for the ISP will be managed by Children's Center for the Child & Community to ensure and leverage alignment with local Community Health Improvement Plans.

Each identified health priority will have a Children's lead, and community engagement/implementation activities will be reported quarterly using a standardized reporting template.

For each identified child health priority, the following capacity infrastructure elements will be part of ongoing ISP performance management discussions:

- **Partnerships:** stakeholder engagement with shared vision and common agenda
- **Data:** data collection focuses on measuring results and performance management; data is collected and reported with shared accountability
    - Focus on social determinants of health
    - Identify related advocacy efforts and opportunities
- **Communication:** regular and open communication focused on building trust
- **Resource Support:** identified lead organization(s) with staff, resources and skills to convene and coordinate stakeholders
- **Health Equity:** addressing the needs of children from populations in the community that experience higher rates of poor health outcomes due to racial/ethnic disparities, poverty or other socioeconomic factors

In 2019, a key task of the ISP will include establishing and defining the **Targets and Impact Measures** for the described key actions across each priority health area. This will require collaboration of both internal support and community engagement to determine the most meaningful ongoing collection and reporting format.

Resources to Address Priority Health Needs

Funds and resources necessary to move implementation forward will be addressed through an annual budgeting and resource planning meeting. Children's Center will support the leverage of funding, encourage pooled community investments, elevate data support and develop or expand communication tools needed to advocate across the community.

A diverse pool of resources is needed to address community health needs. Depending on the health priority, some or all of the funding opportunities outlined below may support interventions to improve child health. Additional resources will be added as they are identified and become available.

- **Community Benefit:** In 2017, Children's provided more than $115.7 million in benefits to the broader community. This includes uncompensated care through financial assistance and unreimbursed Medicaid, fulfilling our commitment to ensure that no child with a medical need is ever turned away due to a family's inability to pay. Children's provides additional community benefits annually through subsidized health services, health care education and training, research and community health investments.
- **Grants & Contracts:** Children's collaborates with local, statewide and national partners and agencies to leverage grant support and resources to achieve community impact.
- **Foundation & Philanthropy:** Children's Foundation connects donors to the organizational mission, "To improve the life of every child." Children's capacity is extended by the generosity of donors who invest in the mission through our dedication to exceptional clinical care, research, education and advocacy.
- **Research:** The Child Health Research Institute (CHRI) is a foundational partner for community health improvement. One of CHRI's aims is to focus on community health outcomes for children by applying a research lens to the child health priorities identified in the 2018 Community Health Needs Assessment.

Figure 2: Strategic Plan Implementation Structure and Operational Support

ACTIVITY	TIME FRAME	PERSON(S) RESPONSIBLE	PURPOSE	DOCUMENTATION
Work group check-in meetings	Monthly - quarterly	Internal Priority Leads	Work groups gather to 1) report progress, 2) identify barriers and solutions, 3) adjust the action plan if necessary and 4) work.	Meeting notes
Implementation Team meetings	Three times per year	Center (coordinates)	Discussion of Children's health improvement plan activities and events. Work group reports on action plan implementation.	Meeting notes
Annual plan revisions	Annually	Center (coordinates)	To establish annual work plans and explore opportunities for quality improvement	Updated implementation work plans
Budget & resource planning	Annually & continuous	Center & Priority Leads	Maintain a budget for the implementation of plan activities	Annual budget

Integration with Operational Planning

Children's 2025 Strategic Plan includes strategies that align and integrate with ISP strategies.

- P**artner with the community to improve the well-being of children**, including leading advocacy efforts and addressing social determinants of health with the community
- **Transform Children's to thrive in a changing future**, including an integrated network of partnerships and operationalizing the clinically integrated network
- **Embrace workforce as a strategic asset**, including developing a diversity and inclusion strategy
- **Develop leading-edge organizational capabilities through technology, informatics and analytics**, including telehealth services and integrated pediatric network

Specifically, Children's Center for the Child & Community's role in the 2019-2021 community health Implementation Strategy Plan is to ensure alignment of advocacy efforts, foster strategic partnerships and address infrastructure capacity needed to implement the ISP to achieve optimal outcomes. In order to align and enhance community health improvement planning and activities, Children's is committed to continued collaboration and coordination with the local public health departments, community health stakeholders, other non-profit hospitals and children and families.

Priority Area: **Access to Care**

FY 2019 - FY 2021

Overarching Goal: To improve access to children's health care services, especially for those in underserved communities

STRATEGY: IDENTIFY THE ROOT CAUSES OF ACCESS TO CARE PROBLEM AND SPECIFIC POPULATION(S) IN WHICH TO INTERVENE		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Conduct root cause analysis to further define access to care problem in Omaha metro (beginning with analysis of PRC survey results) focusing on addressing the needs of children in underserved communities	• Define access to care and agree upon common language • Conduct focus groups • Complete a root cause analysis	• Number of community partner focus groups
Develop structure for access to care leadership and coordination team in the community (inclusive of other health systems and community partners representing underserved communities)	• Establish leadership team and meeting schedule • Key partners invited to participate in access to care forum • Identify specific populations for pilot	• Number of forum meetings • Number of community partners
Internal Strategy Owners: **Convener:** Center for the Child & Community **Internal Partners:** Children's Physicians; Children's Specialty Physicians; Children's Health Network; Care Coordination; Telehealth team; Children's Behavioral Health; Quality Improvement	**Potential Community Partners:** • UNMC, College of Public Health • CHRI, CityMatch • Live Well Omaha • Local Public Health Departments • Boys Town National Research Hospital • CHI Health • Federally Qualified Health centers • Professional Research Consultants (PRC)	
Anticipated Key Actions Years 2 – 3 • Complete Access to Care Plan for the community, including community data collection and reporting • Based on assessment results, identify a specific population to focus an access-to-care intervention		

Priority Area: **Access to Care**

STRATEGY: IMPROVE ACCESS TO CARE FOR SPECIFIC PATIENT POPULATIONS ACROSS CHILDREN'S ENTERPRISE		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Conduct a care gap analysis for specific patient populations, including: Trisomy Clinic, Medical Complexity, Obesity, Foster Care Clinic	• Established meetings for specific population groups • Documented specific patient groups • Gap analysis per population (focus groups) to identify barriers and needs	• Number of patients identifying in specific patient group
Pilot a Transgender Health Initiative and support LGBTQ children and adolescents	• Explore best practice • Develop an implementation plan and quality improvement project	• Established pilot site(s)
Document referral pathways and guidelines for specific service lines and identify educator role per service line to increase communication across different specialties	• Completed referral pathways and guidelines • Educator role defined	• Number of pathways documented
Internal Strategy Owners: **Convener:** Children's Physicians & Children's Specialty Physicians **Internal Partners:** Patient Experience; Family Resources; Child Life; Care Coordination; Behavioral Health; Marketing; IT; Center for the Child & Community; Educators, Foster Care Initiative, CAT team, key stakeholder nursing and provider specialists	**Potential Community Partners:** • Family support groups for specific populations • Referral providers: Top local referral providers • Community partners to deliver the community-based interventions • Community educators within other health systems and discipline organizations	
Anticipated Key Actions Years 2 – 3 • Continue to develop referral pathways for additional services lines • Identify quality improvement projects to address gaps in care as identified in the gap analysis for specific populations • Based on pilot results, expand and refine the Transgender Health Initiative		

Priority Area: **Access to Care**

STRATEGY: INCREASE ACCESS TO CARE THROUGH CLINIC-TO-COMMUNITY STRATEGIES, FOCUSING ON HOME HEALTH, TELEHEALTH AND CARE COORDINATION SERVICES		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Utilize data to describe and map current and future Home Health service expansion	• Gather and analyze patient data • Identify potential Nebraska Home Health hub expansion sites	• Number of Home Health outreach communities • Number of patients/families served
Promote and implement Telehealth & Tele-mentoring efforts in Nebraska communities	• Telehealth service lines defined • Promotion of Telehealth & Tele-mentoring to target communities • Project ECHO schedule	• Number of Telehealth services • Number of Telehealth patients • Number of Telehealth sites/community partners • Number of Project ECHO spokes, communities and clinic sites
Complete an Outpatient Care Coordination Report to establish care coordination metrics, utilizing electronic health record data and family follow-up	• Defined core metrics, including social determinants of health • Defining appropriate level of care, Emergency Department, Urgent Care or Primary Care Provider • Completed report	• Number of families accessing care coordination • Number of referrals to/from community-based services • Number of appropriate Emergency Department visits at baseline vs. 2019 appropriate Emergency Department visits
Promote the use of transportation support via Uber Health to patients	• Promotional materials developed and disseminated to care coordination team/clinics • Identify patients needing support with transportation	• Number of clinics promoting Uber Health • Number of patients utilizing Uber Health • Patient satisfaction
Increase utilization of the Visionmobile	• Standardized workflow • Community outreach targeting health/eye providers	• Number of community/provider referrals • Number of students with Visionmobile visit
Conduct vision screening in partnership with area schools and student nurses	• Vision screening schedule • Train student nurses • Identify barriers to vision screening • Complete guide and vision of vision-screening process	• Number of screening events • Number of consented students receiving vision screening
Internal Strategy Owners: **Convener:** Home Health Management team; Care Coordination Management team; Telehealth; Ophthalmology team; Children's Physicians, Center for the Child & Community **Internal Partners:** Children's Physicians; Children's Specialty Physicians; IT; Marketing; Performance Improvement; Office of Education.	**Potential Community Partners:** • Family support groups for specific populations • Referral providers: Top local referral providers • Community partners to deliver the community-based interventions • Community educators within other health systems and discipline organizations	
Anticipated Key Actions Years 2 – 3 • Telehealth partnerships expanded and additional community sites established • Expand Project ECHO series to address identified topics from the provider assessment • Continuation of exploring and expanding interventions to decrease no shows, Emergency Department appropriate usage • Implement transportation support and calculate cost of savings • Identify opportunities to expand Visionmobile, vision screening and referrals in the community		

Priority Area: **Mental/Behavioral Health**

FY 2019 - FY 2021

Overarching Goal: To improve access to quality child and adolescent behavioral health care services, especially for those in underserved communities

STRATEGY: EXPAND INTEGRATED BEHAVIORAL HEALTH CARE MODEL ACROSS CHILDREN'S ENTERPRISE, INCLUDING INPATIENT, SPECIALTY CARE AND PRIMARY CARE		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Expand the PATCH program beyond pilot status. The PATCH program develops individual care plans to assist in medical procedures for children on the autism spectrum	• Expand beyond pilot status, with individual care plan being used in other areas of the enterprise	• Number of children with individual care plans • Percentage increase from 2018 • Number of enterprise departments utilizing individual care plans
Evaluate the addition of mental health specialists in three new clinics: Neurodevelopmental Brain Tumor clinic, Oncology Survivors clinic and Functional Abdominal Pain clinic	• Complete evaluation • Decision made	
Continue to provide psychological treatment for patients in the Omaha and Lincoln HEROES clinics	• Behavioral Health staffed in Lincoln & Omaha HEROES clinics	• Number of HEROES patients receiving Behavioral Health assessment and treatment
Expanding in-home telepsychology for patients with insulin-dependent Diabetes Mellitus and Cystic Fibrosis	• Telepsychology visits and care provided to insulin-dependent Diabetes Mellitus and Cystic Fibrosis patients	• Number of insulin-dependent Diabetes Mellitus/Cystic Fibrosis patients receiving in-home telepsychology visits
Hire a tele-presenter for Children's Physicians offices to create more options for mental health providers to provide mental health care	• Hired tele-presenter	• Anticipated number of patients and Children's Physicians offices served by new hire
Train Children's Physicians social workers about responses to positive PHQ-9's and follow-up strategies.	• Completed training • Established follow-up strategies with quality improvement process	• Number of Children's Physicians social workers trained • Number of patients with positive PHQ-9's who received follow-up phone calls, referrals and screenings
Hire one additional nurse practitioner in 2019 to provide pediatric outpatient psychiatric care	• Hired nurse practitioner	• Anticipated number of patients served by new nurse practitioner
Provide telepsychiatry services to the Kearney Children's Physicians clinic	• Established service	• Number of children receiving telepsychiatry services
Train a post-doctoral Fellow in pediatric psychology	• Completed training of post-doctoral Fellow	
Internal Strategy Owners: **Convener:** Behavioral Health leadership **Internal Partners:** Care Transitions; executive leadership; IT; clinic partners; Patient Experience; Marketing; general counsel	**Potential Community Partners:** • Federally Qualified Health centers • Families of children • University Nebraska-Lincoln, Clinical Psychology Training Program • Rural primary care physicians affiliated with the telepsychiatry services • Steering committee advocating for early screening for autism • Home-based therapy providers	
Anticipated Key Actions Years 2 – 3 • Based on assessment results, identify a specific population needing access to care, and identify solution • Implement innovative access solution • Explore expanding in-home telepsychology services to patients with other chronic and complex medical conditions • E-consult growth dependent on physician usage • Potentially expand Trisomy parent care to other parent populations, such as Palliative Care		

Priority Area: **Mental/Behavioral Health**

STRATEGY: FOSTER AND SUPPORT COMMUNITY MENTAL/BEHAVIORAL HEALTH OUTREACH EFFORTS AND PARTNERSHIPS		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Pilot an e-Consult program for area physicians to have real-time access to psychiatry for psychiatric consultation	• Promote e-Consult program to area physicians	• Number of e-Consults completed • Number of area physicians using e-Consults • Patient satisfaction data will also be available for telehealth expansion
Complete a mental health-themed, 6-month ECHO series Spring of 2019 and plan to repeat the series based on evaluation outcomes	• Established ECHO curriculum • Completed ECHO sessions • Completed focus groups • 2020 ECHO Plan	• Number of providers/spokes • Number of continuing medical education/maintenance of certification provided • Participant feedback from ECHO
Participate in the annual Parenting U series; five sessions have mental health themes for 2019	• Mental health topics delivered to Parenting U audience	• Number of parents participating • Evaluation of five mental health theme sessions
Provide psychiatric care, education, and training in partnership with OneWorld in four Omaha Public Schools, eight hours per week	• School-based health care delivered, and education and training partnership completed	• Number of patients served • Number of trainings completed
Participating on the steering committee challenged with improving the practice of community screening for Autism prior to age 2.	• Develop a plan to improve the practice of Autism screening with steering committee	• Number of steering committee meetings • Number of providers participating in the steering committee
Increase onsite therapy service hours to Westside Community Schools to 20-plus hours a week	• Westside Community Schools therapy service provided	• Number of patients served • Number of referrals
Continue to serve as an active member of the committee on community-based mental health providers offering services in the schools.	• Participation in school-based community mental health collaborative	• Number of meetings • Meeting notes • Number of community stakeholders participating
Expand community collaboration with our community behavioral health partners to ensure a good fit with patient needs (i.e. home-based therapy, sliding scale agencies, Trauma and Attachment Center and Connections)	• Review Pediatric Community Health Needs Assessment Behavioral Health Data with community partners • Crosswalk and align community plans	
Internal Strategy Owners: **Convener:** Behavioral Health leadership **Internal Partners:** Center for the Child & Community; Care Transitions; executive leadership; IT; clinic partners; Patient Experience; Marketing; general counsel	**Potential Community Partners:** • Federally Qualified Health centers and other sliding-scale agencies • Rural primary care physicians affiliated with the telepsychiatry services • Steering committee advocating for early screening for Autism • Home-based therapy providers • Trauma and Attachment Center • Project Harmony and Connections • The Kim Foundation	
Anticipated Key Actions Years 2 – 3 • 2020 Continued Behavioral Health ECHO Series • Explore opportunities to expand and scale prevention models such as Mental Health First Aid Trainings and QPR model • Extended training opportunities with UNL School of Psychology graduate students and Creighton Psychiatry fellowship • Potential community partnership expansion evolving with Westside Community Schools, OneWorld, MMI, Boys Town and CHI • Host quarterly meetings with school-based service providers to discuss goals surrounding mental health direction of school-based service and standardized outcome measures		

Priority Area: **Nutrition, Physical Activity & Obesity**

FY 2019 - FY 2021

Overarching Goal: To develop programs, partnerships and policies to prevent, assess and treat children who are overweight or obese, focusing on addressing disparities and inequities

STRATEGY: EXPAND COMMUNITY ENVIRONMENTAL SUPPORTS FOR HEALTHY EATING AND PHYSICAL ACTIVITY THROUGH COMMUNITY SYSTEMS		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Complete and disseminate Electronic Health Record data project, potentially including Z-score and severity of obesity	• Electronic Health Record obesity database in aggregate to apply Z-score and BMI percentage for children with severe obesity • Publish data in one peer-reviewed journal	• Increase from 0 to 1 the number of Electronic Health Record databases that measure Z-Score and severe obesity BMI percentage
Describe and map existing community support for families in the three zip codes with the highest percentage of children who are overweight or obese	• Engage community stakeholders to identify community supports • Develop maps • Obtain feedback from community partners on maps	• Number of community supports
Support healthy food access efforts (e.g., Double Up Food Bucks) in Omaha, Lincoln and rural communities	• Identify sites for Double Up Food Bucks implementation • Promote Double Up Food Bucks in communities	• Number of Electronic Benefit Transfer Double Up Food Bucks transactions • Number of Double Up Food Bucks customers • Number of farmers' markets participating • Number of grocery stores • Number of Double Up Food Bucks trainings
Utilize Electronic Health Record food insecurity data for healthy food access efforts	• Continued programming and training at three YMCA • Develop referral to food security resources, specifically Double Up Food Bucks	• Number of patients screened for food insecurity • Number of patients referred to Double Up Food Bucks resource
Expand community partnerships for family physical activity opportunities (YMCA)	• Continued programming and training at three YMCA branches in Lincoln • Established YMCA partnership in Omaha • Outreach to primary care providers	• Number of children participating • Number of YMCA staff trained • Number of trainings • Number of primary care physicians referring to ENERGY fitness
Launch the 2019 – 2020 PCO Grant Program & Learning Collaborative	• Fund 10 community-based organizations in the Greater Omaha and Lincoln communities • Establish Learning Collaborative Schedule	• Number of community-based organizations awarded PCO grants • Number of PCO grant learning collaborative sessions
Continue to support child care best practices through the implementation of Go NAP SACC	• Convene statewide steering committee • Host annual partner meeting • Train-the-trainer events	• Number of participating child care centers and homes • Number of trainings • Number of child care centers and homes with measured improvements in environmental policies in the areas of breastfeeding, nutrition and physical activity
Internal Strategy Owners: **Convener:** Center for the Child & Community **Internal Partners:** CHRI; Nebraska Pediatric Clinical Trials Unit; HEROES; Care Coordination; Children's Physicians; Children's Specialty Physicians (Cardiology, Pulmonary, GI, Endocrine); Children's Health Network; Marketing; IT; CHI Health	**Potential Community Partners:** • Nebraska Department of Health & Human Services • Nebraska Department of Education • UNL Extension • Gretchen Swanson Center for Nutrition • Live Well Omaha Kids • UNMC College of Public Health • YMCA of Lincoln & Greater Omaha • Federally Qualified Health centers • Local Public Health departments • Schools & Child Care Providers	
Anticipated Key Actions Years 2 – 3 • Develop Neighborhood Level Implementation plan to address obesity health inequities in Greater Omaha based on Year 1 mapping project • Expand ENERGY Fitness to other YMCA branches in rural communities • Continue to expand health food access strategies across Nebraska communities • Conduct a gap analysis using the integrated care model framework		

Priority Area: **Nutrition, Physical Activity & Obesity**

STRATEGY: TRAIN, ENGAGE AND PROVIDE RESOURCES TO PRIMARY CARE PHYSICIANS AND PROVIDERS (NCM/SW, RDS, RNS AND BEHAVIORAL HEALTH) ON NUTRITION, PHYSICAL ACTIVITY AND OBESITY BEST PRACTICES		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Develop a training plan building on Project ECHO curriculum for continued professional development on best practices	• Review Project ECHO obesity series evaluation and outcome data and identify • Outline a training plan and obtain feedback from the ECHO steering committee and ECHO spokes	• Number of Project ECHO obesity planning meetings held • Increase from 0 to 1 a plan for training primary care providers on level 1 and level 2 clinic-to-community interventions
Complete ENERGY nutrition videos and disseminate	• Completed videos • Dissemination plan to refer patients (HEROES/Children's Physicians) to nutrition videos	• Number of primary care clinics referring to nutrition videos • Number of nutrition video views
Define a quality improvement project for the targeted Children's Physicians offices (e.g., Spring Valley, Creighton and UNMC) & Federally Qualified Health centers in the zip codes with the highest percentage of overweight and obese children	• Develop a Children's Physicians quality improvement project focusing on BMI and social determinants of health screening • Establish referral to community healthy eating and active living resources	• Number of Children's Physicians clinics participating • Number of quality improvement projects developed and approved by the American Board of Pediatrics
Internal Strategy Owners: **Convener:** Center for the Child & Community, Children's Physicians **Internal Partners:** HEROES; Care Coordination; Children's Specialty Physicians (Cardiology, Pulmonary, GI, Endocrine); Children's Health Network; Marketing; IT; CHRI; Nebraska Pediatric Clinical Trials Unit	**Potential Community Partners** • Gretchen Swanson Center for Nutrition • UNL Extension • Live Well Omaha Kids • UNMC College of Public Health • YMCA of Lincoln & Greater Omaha • Local Public Health departments • Federally Qualified Health centers • Community providers; ECHO spokes	
Anticipated Key Actions Years 2 – 3 • Implement training plan for level 1 and level 2 clinic-to-community interventions • Develop & disseminate primary care package (Nutrition videos, ENERGY Fitness, motivational interviewing, Double Up Food Bucks, etc.) in rural Nebraska, specifically in Fremont, Kearney and Center for Disease Control School Health Districts • Plan 2021 Nebraska Healthy Kids Summit		

Priority Area: **Nutrition, Physical Activity & Obesity**

STRATEGY: ADVOCATE FOR POLICIES AND PRACTICES THAT SUPPORT HEALTHY EATING, PHYSICAL ACTIVITY AND OBESITY PREVENTION		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Publish a quarterly For Every Child e-newsletter	• Expand the Child Health Champion Network through e-communications	• Number of For Every Child newsletters • Number of Child Health Champions • Number of opens of the newsletter
Identify opportunities to collaborate internally & externally on health messages for families	• Parenting U classes focused on nutrition, physical activity and obesity prevention • Identified health messages and channels to promote to families	• Number of clinics showing nutrition videos • Number of clinics with Double Up Food Bucks messaging
Partner with and support Nebraska Department of Education's School Health & Wellness Grant, enhancing school wellness policies across Nebraska	• State partner meetings	• Number of trainings with rural school districts • Number of schools participating
Internal Strategy Owners: **Convener:** Center for the Child & Community **Internal Partners:** Marketing; Government Affairs; Care Coordiantion; CHRI; Nebraska Pediatric Clinical Trials Unit; HEROES; Children's Physicians; Children's Specialty Physicians; Children's Health Network	**Potential Community Partners:** • UNL Extension • Gretchen Swanson Center for Nutrition • Live Well Omaha Kids • UNMC College of Public Health • YMCA of Greater Omaha • OneWorld • Charles Drew Health Center • Schools	
Anticipated Key Actions Years 2 – 3 • Further expand Child Health Champion Network • Identify a call-to-action for community adovacy messages		

Priority Area: **Sexual Health**

FY 2019 - FY 2021

Overarching Goal: To improve adolescent sexual health care and education through clinic-to-community collaboration

STRATEGY: CONTINUE TO SUPPORT AND PARTICIPATE IN THE ADOLESCENT HEALTH PROJECT (AHP), PRIMARY CARE AND COMMUNITY COLLABORATION		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Participate in the Adolescent Health Project Forum to contribute to the Adolescent Health Project 2.0 design	Establishment of pediatric sexual health care targets for the community and impact indicators for internal reporting	• Number of electronic health record measures to assess screening, referrals and treatment • Number of data reports shared with Adolescent Health Project
Utilize the Adolescent Health Project infographics and website to communicate the success and continued needs with internal & external partners	Review of key metrics with providers and key stakeholders	• Number of resources provided through Children's regarding sexual health
Identify areas of opportunity to further enhance the Adolescent Health Project clinic-to-community collaboration by convening community partners & providers in an open forum	Participate in Adolescent Health Project, and convene health systems to share data reports	• Number of forum meetings • Number of health systems convened
Review current efforts with Children's Physicians leadership groups for additional efforts to support adolescent health	Review best practice to support adolescent health efforts within Children's Physicians, inpatient and specialty care	• Number of leadership meetings convened • Increase from 0 to 1 plan developed to support adolescent health
Explore evidence-based parental resource (i.e., Get Checked)	Review of the infographics and Get Checked website for resources to share with families and partners	• Number of Children's Physicians clinics using Get Checked resources
Internal Strategy Owners: **Convener:** Children's Physicians & Center for the Child & Community **Internal Partners:** Children's Physicians, Children's Health Network, Care Coordination, IT, telehealth team	**Potential Community Partners:** • The Women's Fund Adolescent Health Project • Douglas County Health Department • Sarpy/Cass Health Department	
Anticipated Key Actions Years 2 – 3 • Increase child-to-adolescent transition of care to support youth in taking charge of their health within primary care and specialty care clinics • Collaborate to host an Askable Adult mentoring program training		

Priority Area: **Sexual Health**

STRATEGY: CONTINUE TO IMPLEMENT THE AAP ICARE 2.0 PROJECT WITH AN IDENTIFIED GROUP OF CHILDREN'S PHYSICIANS PROVIDERS		
KEY ACTIONS	**KEY MILESTONES**	**TARGETS & IMPACT MEASURES**
Implement ICare 2.0 educational programming and quality improvement efforts	Completed quality improvement efforts through ICare 2.0	• Number of patients screened • Number of physicians completing quality improvement and receiving Part 4 maintenance of certification
Using electronic health record data, identify the population at risk for STI and determine if appropriate testing has been completed	Aggregated electronic health record data identifies the population at risk for STI via risk assessment tool and determined if STI testing has been completed	• Number of patients identified at risk via risk assessment tools • Number of populations identified • Number of patients tested based on risk
Review, standardize and optimize work flow for risk assessment, STI screening & treatment	Increase from baseline the number of patients receiving adolescent risk assessments, STI screening and appropriate treatment	• Number of patients screened, compared to current baseline, with adolescent risk assessments • Number of at-risk patients screened for STI • Number of patients treated
Annually summarize the adolescent risk questionnaire data and testing data	Aggregate data and generate a report to be utilized for further implementation	• Number of summary data reports • Number of data presentations
Internal Strategy Owners: **Convener:** Children's Physicians & Center for the Child & Community **Internal Partners:** Children's Physicians, Children's Health Network, Care Coordination, IT, telehealth team	**Potential Community Partners** • The Women's Fund Adolescent Health Project • Douglas County Health Department • Sarpy/Cass Health Department • Federally Qualified Health centers	
Anticipated Key Actions Years 2 – 3 • Expand AAP ICare project with additional providers and locations		

Other Significant Health Issues Not Identified as Priorities Within the Implementation Strategy Plan

The four child health priority areas, access to care; nutrition, physical activity & obesity; mental/behavioral health; and sexual health, were selected based upon the scope and severity of the problem and our institution's and the community's readiness and ability to impact change.

As noted above, key informants from Children's and community partners worked together to evaluate and identify child health priorities and determined that an investment of time and resources into the four specific child health priorities, in collaboration with community stakeholders, will increase the impact and outcomes for children.

The 2018 Pediatric Community Health Needs Assessment completed by Professional Research Consultants (PRC) identified eleven overall areas of opportunity as significant child health issues. The other health topics that were noted as significant, but not identified as a priority within this Implementation Strategy Plan, include: cognitive and behavioral conditions; childhood diabetes; injury and violence; neurological conditions; oral health; tobacco, alcohol and other drugs; as well as vision, hearing and speech conditions. It should be noted that access to vision screening and care is a key activity described in the ISP health priority area of Access to Care.

Children's takes an active role in addressing the other significant child health issues by providing direct services and community outreach programming, such as Children's Injury Prevention Program, which coordinates with Safe Kids Douglas County. Children's is active in addressing many community-wide initiatives and child health priorities. Children's does not have the scope, capacity or resources to address community programming for all other significant child health priorities. A summary of both ISP and efforts across other significant health priorities will be collected and reported annually in the Community Benefit report.

Implementation Strategy Plan Approval

On April 25, 2019, the Executive Committee of the Board of Directors of Children's Hospital & Medical Center, which includes representatives from throughout the community, met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. The Executive Committee of the Board has the power to transact all regular business of Children's during the period between meetings of the Board of Directors. Upon review, the Executive Committee of the Board of Directors approved and adopted this Implementation Strategy Plan to undertake these measures to meet the health needs of the community.

Children's Board of Directors Approval & Adoption:

April 25, 2019

Acronym Library

AAP	American Academy of Pediatrics
BMI	Body Mass Index
CAT	Child Advocacy Team
CHI	Catholic Health Initiatives
CHNA	Child Health Needs Assessment
CHRI	Child Health Research Institute
ECHO	Extension for Community Healthcare Outcomes
FY	Fiscal Year
GI	Gastroenterology
Go NAP SACC	Nutrition and Physical Activity Self-Assessment for Child Care
HEROES	Healthy Eating with Resources, Options and Everyday Strategies
ISP	Implementation Strategy Plan
IT	Information Technology
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
MAPP	Mobilizing for Action through Planning and Partnerships
MMI	Munroe-Meyer Institute
NICU	Newborn Intensive Care Unit
PATCH	Patient Advocacy Team at Children's Hospital
PCO	Preventing Childhood Obesity
PHQ-9	Patient Health Questionnaire
PICU	Pediatric Intensive Care Unit
PRC	Professional Research Consultants
QPR	Question Persuade and Refer
STI	Sexually Transmitted Infections
UNL	University of Nebraska Lincoln
UNMC	University of Nebraska Medical Center


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