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# Summit Overview

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## Background

In 2014, Robert Wood Johnson Foundation President and Chief Executive Officer (CEO), Risa Lavizzo-Mourey, MD, MBA, described a culture of health in the United States.

She offered the following definition:

- Good health flourishes across geographic, demographic and social sectors.
- Attaining the best health possible is valued by our entire society - no one is excluded.
- Individuals and families have the means and the opportunity to make choices that lead to the healthiest lives possible.
- Business, government, individuals, and organizations work together to foster healthy communities and lifestyles.
- Everyone has access to affordable, quality health care because it is essential to maintain, or reclaim, health.
- Health care is efficient and equitable.
- The economy is less burdened by excessive and unwarranted health care spending.
- The health of the population guides public and private decision-making.
- Americans understand that we are all in this together.<sup>1</sup>

Four Nebraska nursing organizations, envisioning the role that nurses could have to influence the health of Nebraskans, arranged a summit to engage stakeholders in defining a culture of health in Nebraska. The four organizations in this collaborative effort were the Nebraska Action Coalition (NAC), the Nebraska Assembly of Nursing Deans and Directors (NANDD), the Nebraska Nurses Association (NNA), and the Nebraska Organization of Nurse Leaders (NONL). “When I talk about building a Culture of Health, we are talking about nurses.... So much of what you do is building a Culture of Health...We need a vibrant nursing profession for a Culture of Health, for improving community health” (Lavizzo-Mourey, 2014).

To engage stakeholders, the sponsoring organizations planned a two-day Summit at four locations in Nebraska to 1) define the current state of health in Nebraska and 2) discuss pathways to create a healthy future. The four locations - Omaha, Lincoln, Kearney, and Norfolk, worked in collaborative groups through the same processes for the two days. The sites were virtually connected for presentations and summations but worked independently to promote brainstorming and thinking from a community perspective. The objectives of the Summit included:

- Day One (broad, diverse audience including nurses):
  - Discuss the delivery of healthcare in Nebraska
  - Discuss health disparities in Nebraska
  - Identify actionable items to elevate a culture of health in Nebraska
- Day Two (nurses from Day One joined additional nurse attendees):
  - Review discussion from Day 1 Summit to elevate a culture of health in Nebraska
  - Discuss the national cultural of health
  - Compare the national culture of health to Nebraska’s culture of health

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<sup>1</sup> Defining a Culture of Health, retrieved from [http://www.rwjf.org/content/dam/files/rwjf-web-files/Annual\\_Message/2014\\_RWJF\\_AnnualMessage\\_final.pdf](http://www.rwjf.org/content/dam/files/rwjf-web-files/Annual_Message/2014_RWJF_AnnualMessage_final.pdf)

- Brainstorm SMART (Specific, Measurable, Attainable, Relevant, Timely) goals for building a culture of health in respective communities
- Discuss the power of collaboration between organizations to improve a culture of health

## Day 1 - Defining a Culture of Health in Nebraska

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Day One stakeholders included consumers, healthcare providers (nurses, public health, physicians, and allied health), insurance industry members, adult/juvenile corrections and probation staff, state legislators, dental hygienists, grocers, and local business leaders.

The outcomes rose beyond expectations with over 250 participants on Day One and rich, open dialogue. Participants heard from local and national speakers to establish a baseline for the collaborative discussion. Facilitated breakout sessions were held after each speaker to brainstorm and collect ideas and information from participants. Speakers for the two-day event:

### State Senator Sue Crawford of Bellevue



### ***Beyond Health Disparities: Healthy Outcomes for All***

Highlights from Sen. Crawford's presentation included:

- Thousands of Nebraskans could be helped through the Affordable Care Act's Medicaid expansion.
- Nebraska rates 46<sup>th</sup> in health equity – most states more responsive to those who are in need.
- Issues in Nebraska: alcohol abuse (implications for fetal alcohol syndrome and drunk driving), gaps in mental health treatment options, obesity (30% of population and growing).
- The neighborhood has a dramatic impact on health.
- Quality health care is impacted by these challenges - by access to service (20%), community factors of education and income (40%), health behaviors (30%), and environment (10%) (University of Wisconsin study).<sup>2</sup>

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<sup>2</sup> <http://www.countyhealthrankings.org/our-approach>

**Courtney N. Phillips, CEO, Nebraska Department of Health and Human Services (DHHS)**  
*Culture of Health in Nebraska Summit*



Ms. Phillips' vision for a Culture of Health in Nebraska included:

- Revamping DHHS – Employees must have fire and passion to work here. We can only accomplish that through:
  - Better integration of services
  - Working to better leverage technology
  - Advancing health equity
  - Promoting wellness
  - Seeking partnerships and collaboration
  - Seeking Public Health Accreditation for our divisions
- Inviting nurses to share expertise by:
  - Serving on professional boards
  - Seeking involvement in disaster response plans/initiatives
  - Considering a career in public service

## Day 2 - Nurses: Transforming a Culture of Health in Nebraska

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**Kathryn Wehr MPH, Program Officer- Robert Wood Johnson Foundation (RWJF)**  
*From Vision to Action: An Overview of a Culture of Health*



Highlights from Ms. Wehr's presentation included:

- Stop defining health as not being sick
- Stretch our current understanding of health to include clean air and water, safe places to live and play, affordable housing, & healthy food
- Culture of Health Action Framework <http://www.cultureofhealth.org/#action-framework>
- Need for inter-professional collaboration
- County Health Roadmaps and Rankings  
<http://www.countyhealthrankings.org/app/nebraska/2015/overview>

- Shared examples of RWJF Culture of Health prize winners
- What a Culture of Health can look like for Nebraska's communities

### Data Analysis

The plethora of data derived from the two days of discussion and brainstorming were compiled into spreadsheets according to day and site. A summary discussion from Day One was also compiled into a spreadsheet. The data were reviewed three times according to location and organized into minor themes for each site, aggregated into major themes from rural and urban perspectives and then into final, merged themes. Verbatim language was used for the first review to capture the essence of content. The data were then coded into categories for the second review. Lastly, the data were organized into overarching theme categories. The primary categories of health disparities, health priorities, and action plans, following the organization of the collaborative, were used to guide the analysis. Both manual coding and the NVivo 10 (QSR International.org) computer program were used to quantify data.

## A Culture of Health in Nebraska

Each of the four sites hosting one or more collaborative groups followed the same process outlined for each of the two days. The following depicts key aspects of the discussions regarding health disparities and contributing factors, health priorities, and potential community health projects gleaned from each site. Kearney and Norfolk are more rural and agricultural communities while Lincoln and Omaha are primarily urban areas. The content was clustered into categories from the original data and maintained actual language of participants whenever possible.

Thirteen intervention project ideas were captured across the two days of Summit activity. These ideas are detailed on the following pages. Some projects are more highly developed than others; all projects are given equal weight and importance as outputs of a highly participative and engaged community. It is intended that communities and organizations might refer to these project ideas and find them well-grounded in the process and audience-engagement that characterized the Culture of Health Summit.

## Omaha

### **Discussion of Health Disparities and Contributing Factors**

Five Key Priorities Emerged from Discussion of Disparities & Contributing Factors on Day 1:

**Lack of Mental/Behavioral healthcare** - provider shortage, insurance and medication costs, lack of services, preventative care.

**Lack of Access to Care** - for vulnerable populations: mental/behavioral health, chronic health problems, elderly, veterans, homeless, teen pregnancy, prenatal, immigrants/refugees, and disadvantaged youth. In addition access to care affected by transportation, health care provider shortage, inadequate child care, and end of life/hospice.

**Diversity** - English as a second language (ESL), job opportunities, lack of culturally responsive care.

**Economically disadvantaged/poverty** - Medicaid/insurance coverage unavailable or extremely costly, food insecurity, medication costs, housing, and violence.

**Education/employment** - family development, lack of home technology, job skills, job opportunities/diversity, underemployment (less than 30 hours/week).

### **Proposed Community Health Projects**

- Mental/Behavioral Health
  - Best practice model People's Health Center (FQHC) in Lincoln and Lutheran Family Services where Behavioral Health Consultants (LCSW/LIMHP) and Psychiatric Nurse Practitioners support the primary care providers (PCP) but do not conduct the traditional 50 minutes therapy sessions. The consultant takes on a role of education and support, creating additional time for the PCP to see more patients (Proposal I).
  - Churches: a safe place for mental/behavioral health education.
- Development of a multi-generational reading literacy partnership for grades K – 3 to support reading competency and mentorship (Proposal VIII).
- School/Community Health Fairs presented by Colleges of Nursing – already a successful model developed by Nebraska Methodist College Department of Nursing in collaboration with Minne Lusa elementary school in N.E. Omaha. The action plan includes developing an evidence-based toolkit for school-based health fairs accessible online on Nebraska Action Coalitions website and free of cost to schools across the state by end of year 2016 (Proposal X).
- Community Gardens (Proposal IX).
- Healthy kids/healthy families collaborative – collaboration between grocers/interdisciplinary partners/community members to facilitate healthy eating (Proposal III).
- End of life care - having the conversation. Worksheet/booklet including Advance Directives, legal advice, and toolkit (Proposal XI).

## Lincoln

### **Discussion of Health Disparities and Contributing Factors**

Five Key Priorities Emerged from Discussion of Disparities & Contributing Factors on Day 1:

**Mental Health** - Needs to be better integrated into medical practice and more convenient. Factors: stigma, alcohol and drug use, co-morbidities, fetal alcohol exposure.

**Access & Availability** – Factors: fragmentation of community services, lack of primary care providers and mental health services and providers of elder care. Additional challenges: Co-morbidities/chronic diseases. Other factors: technology/broad band access, transportation, rising medication costs, healthy foods, educational opportunities.

**Economic factors-poverty** resulting in lack of: affordable healthcare, health literacy, healthy food, Medicaid gap/insurance - none or underinsured, childcare and early education. Other factors: violence, criminal justice disparities; domestic/child abuse, mistrust of system.

**Quality of care** regarding childcare, coordination of care, health outcomes, treatment of chronic diseases, unhealthy behaviors.

**Cultural disparities** of race, language barriers, and health care underutilization, often due to mistrust/stigma, institutional racism, lack of culturally responsive care. Healthcare is underused by men and residents of rural areas. Need a diverse workforce.

### **Proposed Community Health Projects**

- Improve fragmented community services, developing a team approach to care coordination that includes methods for improving knowledge of health professionals about community services and networking (Proposal IV & V).
- Improve access to mental health and integrated physical health services, with activities ranging from workforce topics (loan repayment for Psychiatric Nurse Practitioners) to reimbursement policies, to language barriers (Proposal II).
- Empower women to be safe, effective health leaders in their homes and communities (Proposal XII).

## **Kearney**

### **Discussion of Health Disparities and Contributing Factors**

Five Key Priorities Emerged from Discussion of Disparities & Contributing Factors on Day 1:

**Lack of mental/behavioral health** due to lack of insurance, stigma, comorbidities, and lack of qualified providers/services.

**Finances/poverty** with finances of farmers described as “dirt rich but cash poor,” low income, unemployment, cost of care and medications, side effects, availability, knowledge, and access, and insurance cost, coverage, and deductibles.

**Health Professions Workforce Shortage** Nurse Practitioners (NPs) are leaving the state. There is a lack of entry into healthcare education programs. Primary Care Providers (PCPs) are designing employment models.

**Diversity** due to cultural beliefs and/or bias, immigration status, lack of understanding, and provider bias.



**Access to care** regarding lack of education, provider shortages, lack of dental services, loss of APRNs to full practice states, PCPs preferring employment status, and distance to services.

### **Proposed Community Health Projects**

- “Farm to fork” opportunities with community gardens (Proposal XIII).
- Larger and year-round Farmer’s Markets.
- Teach canning and freezing.
- Community activities to promote fitness and safety including early childhood health behaviors, “walking school bus” (supervised walking to school).
- Central region “walk/run relays” between communities (Proposal XIII).

## **Norfolk**

### **Discussion of Health Disparities and Contributing Factors**

Five Key Priorities emerged from Discussion of Disparities & Contributing Factors on Day 1:

**Lack of mental/behavioral healthcare:** few providers (workforce) and difficult to access

**Lack of parental education/resiliency:** necessary to raise healthy kids, get appropriate resources

**Obesity**

**Lack of appropriate services for elderly:** inadequate resources

**Lack of insurance coverage**

### **Proposed Community Health Projects**

- Develop school based health coordinator role in local and neighboring school systems (Proposal VI).
- Expand school nurse role to include (Proposal VII):
  - Special attention to high risk children regarding better eating habits/food choices and more physical activity;
  - Identification of parents requiring education, support, guidance for raising healthy children and need for social services/coordination;
  - Consider seeking retired nurses to help fill these needs;
  - Seek collaboration with public health, home health, nursing colleges, Nebraska School Nurse Association, PTA, hospitals, physicians and other providers, funders;
  - Use metrics to measure wellness outcomes. Seek correspondence with academic outcomes.
- Nurse needed on local school boards for balanced perspective

## Actionable Priorities and Projects

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Throughout the two-day Summit, small groups at all sites discussed more than disparities, contributing factors, and priorities for a Culture of Health in Nebraska. Participants were prompted to discuss strategies and actionable steps to meet the community priorities and issues under discussion. The goal of these strategies and steps was to create an improved Culture of Health in Nebraska.

Mental/Behavioral Health Services and their availability, utilization, and adequacy for Nebraska's population across the lifespan were a near-constant source of discussion. Broadly speaking, participants recognized and spoke about the relationship of mental health issues related to: a culture that values wellness and well-being, healthy parenting, successful childhoods, poverty and adversity, exposure to violence and compounded risk factors, and poor outcomes in all social sectors and settings. The poignancy and urgency with which participants spoke about mental health as a component of Nebraska's Culture of Health cannot be overstated. Discussion included priorities and interventions for improvement. The discussion covered a broad range of areas: inadequate policies at national and state levels, needed change in payment systems, early identification and intervention services for children, and examination of mental health issues such as suicide, depression, and improper diagnosis of children experiencing trauma. Proposal I, *Integrated Practice Models*, and Proposal II, *Access to Mental Health Services*, capture a number of these topical recommendations.

In reviewing the project ideas, several additional strong themes emerged. Of the thirteen project ideas, three related to **Nutrition and Food Security**. These are Proposal XIII, *Farm to Fork*, Proposal IX, *Gardens, How Do They Grow?*, and Proposal III, *Healthy Kids-Healthy Families Collaboration between Grocers and Partners*.

Another theme found in three proposed projects highlighted opportunities to develop a Culture of Health by **Promoting Health in Our Schools**. Proposal VI, *School-based Health Coordinators in Each School*, recognizes the relationship between child health and school performance, and the link between a Culture of Health and an educated population. Proposal VII, *Expansion of School Nurses*, identifies the valuable role played by the school health professional who is embedded in the multidisciplinary team at school, helping each child succeed, coordinating care, coaching wellness, and connecting families to community and health system resources. Proposal X, *School/Community Health Fairs*, suggests viewing schools as health promotion venues for the entire community.

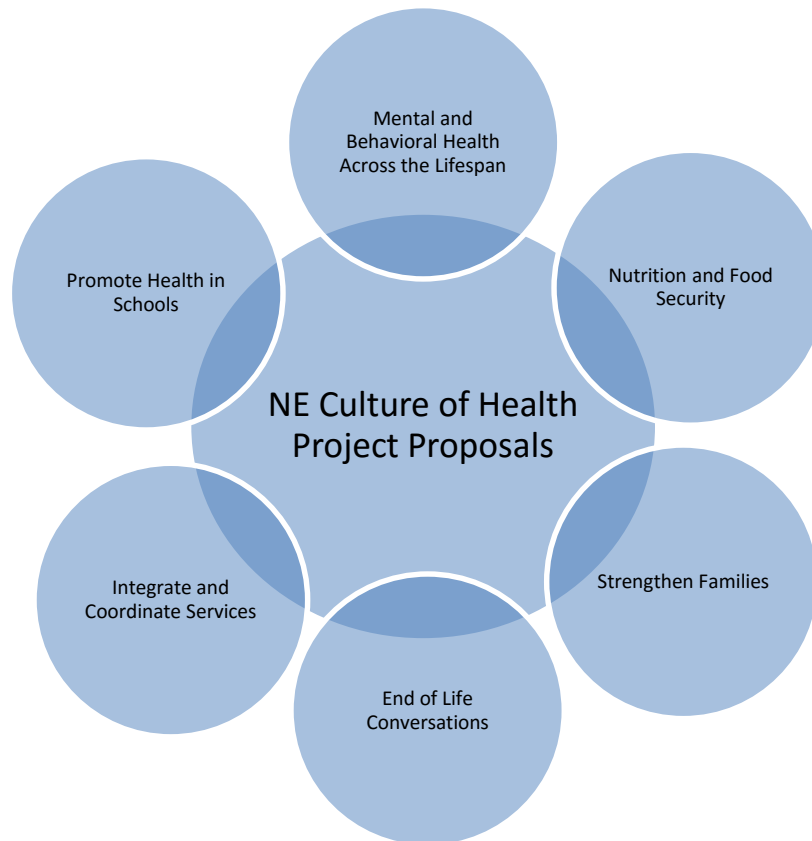
The theme of **Strengthening Families** emerged in two proposals. Proposal VIII, *The Reading Literacy Partnership*, lifts up an intergenerational school and community partnership to support reading competency as a key to a Culture of Health. Proposal XII, *We Envision Women as Safe, Effective Health Leaders in Their Families*, stemmed from a small group discussing how the behaviors of mothers can set the tone for generations of family members and how this should be supported and strengthened in our communities.

Two project proposals addressed improving health care service delivery for consumers by better **Integrating and Coordinating Services**. Proposal V, *Fragmented Community Services*, envisioned methods for helping providers become more aware and up-to-date about available services useful to families and consumers. Proposal IV, *Care Coordination*, brings forward a team approach to care, with each professional member of the team functioning at top level of licensure and scope.

Fittingly last but far from least, from the Summit emerged a project proposal about Proposal XI, **End of Life Conversations**. Here participants reckoned with the reality that the vast majority of health care spending occurs at the end of the life span. Our understanding of a Culture of

Health is that it begins at birth and transcends generations. Investments to offset the effects of risk factors and adversity must be made early, not late, in life. A small group at the Summit bravely advanced the proposal that community leaders who care about a Culture of Health can play a role in empowering citizens to discuss end of life directives with family members and their providers.

**Figure 1.**



**Project Proposals to Advance a Culture of Health in Nebraska –  
Summary of Projects**

## Addendum 1

# Community Health Project Proposals

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### **Proposal I**

#### ***Integration of Mental/Primary Health Care***

People's Health Center/Lutheran Family Services based on best practice model Cherokee Health Systems in Tennessee <http://www.cherokeetraining.com/>. People's Health Center Executive Director Brad Meyers has four components of BHC in a primary care setting:

- Improving health outcomes for those who live with severe mental illness through improved access to healthcare and management of illness.
- Management of behavioral health disorders in a primary care setting.
- Improve health outcomes for those who live with chronic conditions through the addition of behavioral interventions.
- Routine screening for early detection of depression, substance/alcohol use, and domestic violence.

### **Proposal II**

#### ***Access to Mental Health Services***

- Loan repayment for Psychiatric Nurse Practitioners
- Co-locating and integrating behavioral health with primary care
- Reimbursement changes for same day appointments with dual services
- Habilitation concept and reimbursement
- Language and cultural barriers

Partners: UNMC, legislators, NE DHHS, Medicaid, payers, CLAS coalition, Area Health Education Centers (AHEC), Community Health Workers, and etc.

Measures: X amount of practitioners for every X population; by 20\_\_, every Nebraskan will live within 50 miles of integrated services and dual services are reimbursed. Ensure that habilitation reimbursement is adequate to avoid readmission-higher levels of care.

### **Proposal III**

#### ***Healthy Kids - Healthy Families***

A collaboration between grocers, interdisciplinary partners and customers to facilitate healthy, affordable eating.

Measurable: Reduction of weight in school children, variance in inventory of suggested foods.

Action: School nurses, grocers, registered dietitians, diabetes educators, students, families, social workers, health care providers, teachers, public health, researchers and etc.

- Stabilize inventory

- Identify problems, needs assessment
- Offer incentive
- Demonstration of cooking in store

Realistic: Yes

Timeframe: 6 months

### **Proposal IV** ***Care Coordination***

Team approach to care - team members functioning fully, based on training and licensure:

- Increase understanding of regulated professions
- Keep patients safe and out of hospital
- Team approach to care - social workers, other providers on language and culture
- Collaboration and shared leadership
- Case management approaches
- Networking opportunities for community providers

Measures: Start small - 80% of convenience sample agrees to contribute information to decrease fragmentation. Identify repository of information. Demonstrate that a group of providers can pool useful information on community services. Small evaluation project related to care coordination in medical homes. Focus on mental health and mental health practitioners.

### **Proposal V** ***Fragmented Community Services***

Addressing a lack of knowledge among providers about available resources and services in a community:

- Partner between organizations
- Develop an online directory resource for clinicians
- Develop the role of care coordinator in medical home practices
- Networking and communication between professionals
- Prepare professionals to practice in community settings

Measures: target small demonstration projects, then scale up and replicate.

### **Proposal VI** ***School-Based Health Care Coordinator in School Systems***

Measures: Increased academic test scores, improved BMI, decreased obesity numbers, decreased illness/truancy, decreased teen pregnancy, decreased risk behaviors/car accidents, and decreased dental caries.

Attainable: Pilot projects, collaboration, presentations/marketing, speakers at state nursing meetings and school board associations.

Realistic: Yes

Timeline: August 2018

## **Proposal VII**

### ***Expansion of School Nurse Collaboration***

School nurses will work effectively with:

- Home health and local department of health
- Nursing colleges/programs, nursing and school nurses' association-ESU
- Health instructors, parent groups (PTA)
- Health professionals-nurses (retired and practicing), hospitals, physicians, etc.
- State senators, state board of education, UNMC Public Health Policy Program
- Get nurses on local school boards and Board of Education

Partners/funding sources: RWJF-grants, Kiewit, Johnny Carson Foundation, Helmsley, RNs

## **Proposal VIII**

### ***Reading Literacy Partnership***

Develop a community, multigenerational partnership between public schools (K-3<sup>rd</sup> grade) to support reading competency and student mentorship.

Attainable: Schedule meetings with principal and teachers to explore needs of the target school and interest in the program, solicit elder and community volunteers from area community centers, parishes, and neighborhood resources, determine budgetary needs/funding sources, conduct background checks and training for volunteers working with children, develop metrics to monitor the program, provide recognition for students in supporting the program (nursing and education students).

Stakeholder groups: State health department, Building Healthy Programs, nursing and education associations, churches, 75 North, RWJF, Immanuel Vision Foundation, United Way, ENOA, NOAH, library, volunteers, retirement and community centers.

Realistic: Yes

Timeline: requires planning 1 year prior to implementation at the beginning of the next school year

## **Proposal IX**

### ***Gardens - How do they grow? ... Older adults working with children and adolescents in North or South Omaha to grow healthy food***

Specific - identify leaders who are doing this work

Attainable - nurses visit to assess how to be involved. Partner with one group with statewide structure.

Time-bound - 6-9 months

## **Proposal X**

### ***School nurses as wellness coaches***

Partnering with nursing organizations to conduct professional development for nurses across the state:

- School-based health fair/education/screening
- Develop toolkit for nurse wellness coaches (PDSA - steps to develop and disseminate)
- Pilot the project with vulnerable populations
- Work with NANDD to partner with schools of nursing
- Break down into regions in NE

Partnerships: with nursing organizations, churches, schools, businesses, DHHS, North Omaha Area Health (NOAH), Healthy Kids, Douglas County Health Department, healthcare providers, School-Based Health Care, Building Healthy Futures, graduate students, Omaha Public School needs assessment, North Omaha, Parish nurses

Funding - RWJF

Goal - Reach 500 people in the spring, then expand to other schools/nursing schools

Measures - number screened, number served, RN student impact, kids and retention

## **Proposal XI**

### ***End of Life Care: Having the Conversation***

Create a booklet-handout/toolkit called "The GIFT" (L. Harlan - health consumer):

- Advance Directives-legal information and step by step process-material to read and forms to complete
- Tailor to reading level of most adults
- Presentations at churches and senior centers, assisted living, DHHS, pharmacies, mail order, Facebook, DMV, tax preparers, AARP, speakers bureau

Marketing: The best "gift" you can give your children

Partners: DHHS, College of Public Health, use example from Institute Healthcare Improvement

Funding: by a trusted organization

## **Proposal XII**

### ***We envision...women as safe, effective health leaders in their families (through empowerment)***

- Well women examinations
- Personal behaviors
- Children preventive care/screening
- Obesity, nutrition

Measure: Insurance performance measures, BFSS, ETOH, sleep, exercise, stress management, education

Questions: How do we empower? Need access to resources in the community

Attainable: Establish baseline, education, resources, uninsured

### **Proposal XIII**

#### ***“Farm to Fork”: With the development of community gardens and expanded Farmer’s Markets incorporating***

- Health education - fitness, safety, early childhood healthy behaviors
- Teach year-round food preservation - canning and freezing
- Community health behaviors supervising children walking to school and from school or to the school bus.
- Central Nebraska “walk/run relays” between communities. Get small local communities involved by developing relay teams that would walk/run between communities & hand-off to the next team. There would be a starting point with and a final destination. For example: Gibbon, Elm Creek, and Minden are all less than 15 miles from the hub of Kearney. Grand Island and Hastings have similar smaller towns around and could act as a hub.



## Addendum 2

### Resources

Senator Sue Crawford, Legislative District 45	<a href="mailto:scrawford@leg.ne.gov">scrawford@leg.ne.gov</a>
Nebraska Department of Health and Human Services – Courtney Phillips CEO	<a href="http://dhhs.ne.gov/">dhhs.ne.gov/</a>
Nebraska Action Coalition	<a href="http://neactioncoalition.org/">http://neactioncoalition.org/</a>
Nebraska Nurses Association	<a href="http://www.nebraskanurses.org/">http://www.nebraskanurses.org/</a>
Nebraska Organization of Nurse Leaders	<a href="http://nebraskaonl.org/">http://nebraskaonl.org/</a>
Robert Wood Johnson Foundation Kathryn Wehr – Program Officer	<a href="http://www.rwjf.org/">http://www.rwjf.org/</a>
National Academy of Sciences (formerly Institute of Medicine – IOM)	<a href="http://iom.nationalacademies.org/">http://iom.nationalacademies.org/</a>

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A special thank you to the volunteers who made this report possible:

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