



2026-2028

DOUGLAS, SARPY, CASS, & POTTAWATTAMIE COUNTY

# Metro Region Community Health Improvement Plan



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# Letter to the Community

Dear community members,

For more than a decade, Douglas, Sarpy, Cass & Pottawattamie counties have collaborated to understand and improve the health of our region. Every three years, we come together to conduct a shared Community Health Assessment (CHA) and identify regional priorities that reflect the lived experiences, needs, and hopes of our residents.

As we introduce the **2026–2028 Metro Region Community Health Improvement Plan (CHIP)**, we do so with gratitude for the thousands of community members, partners, and organizations who shaped this plan. Your insights guided our priorities and ensured the CHIP reflects the realities and strengths of our diverse communities.

The **2024 CHA** revealed meaningful trends and opportunities for collective action. Residents expressed a desire for increased access to mental health services, stronger social supports, safer and more connected neighborhoods, and systems that respond to the root causes of inequity. These insights reaffirm our region's ongoing commitment to **mental health, trauma-informed practices, community connection, and accessible care for all**.

This plan represents not just a roadmap, but a commitment:

**A commitment to listen to our communities,**

**To strategically align regional efforts,**

**And to advance balanced health opportunities across all neighborhoods.**

The Regional Health Council (RHC)—representing the region's three public health departments, key healthcare partners including **All Care Health Center, Charles Drew Health Center, CHI Health, Children's Nebraska, NE Methodist Health System, Nebraska Medicine, and OneWorld Community Health Centers, and The Wellbeing Partners**—will continue to convene, coordinate, and champion this work. Yet the success of the CHIP depends on all of us.

We invite you to remain engaged through community conversations, surveys, roundtables, and collaborative opportunities. Together, we can create a region where every person has the opportunity, support, and conditions to thrive.

In partnership and good health,

## The Regional Health Council



# Executive Summary

## Introduction to the RHC and the CHIP

The CHIP is a strategic, community-driven roadmap that identifies the region’s priority health needs and outlines goals, strategies, and actions to improve health outcomes. The CHIP is informed by the 2024 CHA and developed by the RHC, a collaborative of:

- All Care Health Center
- Charles Drew Health Center, Inc.
- CHI Health
- Children’s Nebraska
- Douglas County Health Department
- Methodist Health System
- Nebraska Medicine
- OneWorld Community Health Centers
- Pottawattamie County Public Health
- Sarpy/Cass Health Department
- The Wellbeing Partners

Over the past year, partners engaged in a comprehensive, equity-centered CHA process that included community surveys, listening sessions, key-informant interviews, asset mapping, and an analysis of health, social, and environmental data. This work identified the most pressing issues affecting residents’ ability to achieve and maintain good health, as well as the community strengths and systems that can be leveraged to create change.

Following the CHA, the RHC facilitated a collaborative priority-setting process that brought together public health experts, healthcare systems, federally qualified health centers (FQHCs), behavioral health providers,

community coalitions, and residents. Through this process, the region aligned around **three priority areas** for the 2026–2028 CHIP:

### 1 Mental & Behavioral Health



### 2 Social Determinants of Health: Nutrition and Transportation



### 3 Access to Health Services



These priorities reflect both the data gathered and the lived experiences shared by community members. For each priority, the CHIP establishes **clear goals, measurable objectives, and actions that build on community strengths, reduce barriers to care, and promote system-level change.**

The CHIP aligns efforts across sectors—including healthcare systems, schools, nonprofit organizations, government agencies, businesses, and community residents—to drive **collective and equitable improvement** across the four-county region. The strategies that follow represent the shared commitment of partners to improve health and wellbeing for all who live, work, and learn in the metro area.

As we enter the implementation phase of the 2026–2028 CHIP, partners across the region recognize that meaningful progress requires continued coordination, transparent communication, and shared accountability. The following values and guiding principles anchor how the RHC engages with communities and collaborates with partners, ensuring that this plan not only reflects community voice but also results in measurable and sustainable impact.

# Grounding the Plan in the Region's Values

The RHC is grounded in a shared commitment to advancing the health and wellbeing of all residents across the metro region. These values guide how partners collaborate, how decisions are made, and how strategies are implemented throughout the 2026–2028 CHIP. They ensure that the work ahead remains aligned, transparent, and focused on meaningful, measurable improvement. These values also provide a consistent framework for how partners engage with communities and one another, reinforcing accountability as we work toward sustained regional impact.

## Dignity and Respect



We prioritize fair and just opportunities for all people to achieve optimal health. This includes identifying and addressing systemic barriers, such as racism, discrimination, and limited access to resources, and ensuring that communities most impacted by these challenges have influence and representation in decision-making. Dignity and respect guide both the selection of strategies and the evaluation of their impact, ensuring improvements benefit those facing the greatest barriers to health.

## Collaboration



We recognize that improving community health requires unified action across public health, healthcare, education, community organizations, businesses, and residents. The RHC fosters cross-sector partnerships that align goals, share resources, and strengthen regional impact. Collaboration also ensures that work is not duplicated, and that regional assets are leveraged efficiently to address shared priorities.

## Community Voice



We value the lived experiences and insights of community members, especially those disproportionately affected by health disparities.

We engage residents as co-designers of solutions and ensure that their voices shape priorities, strategies, and evaluation practices. This commitment ensures that strategies remain grounded in real experiences and responsive to community-defined needs.

## Communication



We commit to open, consistent, and transparent communication among partners and with the broader community. This includes sharing data, progress updates, community input, and emerging needs to maintain trust and support collective learning. Proactive communication also strengthens partner alignment and supports continuous quality improvement throughout the CHIP cycle.

## Impact



We are accountable for achieving measurable improvements in health and wellbeing. RHC strategies are grounded in data, evidence, and shared metrics. We continuously evaluate progress, make adjustments as needed, and pursue actions that lead to lasting, system-level change. Impact is monitored through shared indicators and transparent reporting, ensuring that progress is visible and actionable for all partners.

## RHC Leadership and Structure

The RHC was established in 2018 as a partnership among the region's local health departments and The Wellbeing Partners. The RHC was created to strengthen collaboration, align priorities, and increase regional impact across Douglas, Sarpy, Cass and Pottawattamie counties. What began as a shared focus on mental health has evolved into a broader, more integrated commitment: addressing the conditions that support or hinder health and wellbeing for all residents. Over time, the RHC's structure has expanded to include sustained engagement with health systems, FQHCs, community organizations, and resident leaders to ensure a coordinated regional response to evolving health needs.

The Wellbeing Partners (TWP) served as the neutral facilitator and primary author of this CHIP. In this role, TWP coordinated the overall planning process; convened quarterly system and FQHC meetings; hosted community roundtables; and led surveys, listening sessions, and targeted outreach to ensure that diverse resident perspectives informed the CHA and priority-setting process. TWP also facilitated meetings and workgroups, synthesized qualitative and quantitative data, drafted CHIP content, and supported alignment across participating partners and counties. Implementation responsibility for CHIP strategies resides with the **identified lead organizations and workgroups**, as outlined in the action plans.

During the 2024 CHA cycle, the RHC worked closely with **health care systems, FQHCs, managed care organizations, nonprofit partners, coalitions, and community members** to create continuous feedback loops and meaningful engagement opportunities. These engagement methods helped surface disparities, identify assets, and validate emerging themes that shaped the CHIP priorities.

As a collaborative, the RHC remains committed to listening deeply to community members, businesses, organizations, schools, faith communities, and elected officials to understand the most pressing health challenges and to activate a regional response that:

- **Centers community members as co-creators and leaders** in shaping strategies and guiding implementation
- **Upholds shared goals across all four counties** while recognizing and elevating the unique needs, assets, and contexts of each community
- **Shares leadership and governance**, ensuring that each county contributes its strengths and that decisions are informed by regional collaboration
- **Aligns resources and responsibilities across partners**, including health systems, FQHCs, public health departments, and community organizations
- **Strengthens access for all across strategic priorities** by dismantling systemic barriers to health, safety, and opportunity.

Together, this structure ensures that the CHIP remains community-guided, data-informed, and regionally coordinated—supporting long-term improvements in health and wellbeing for all residents.

## 2026–2028 RHC Leadership Roster

### All Care Health Center

Joel Dougherty *CEO*

### Charles Drew Health Center

Kenny McMorris *CEO*

### CHI Health

Ashley Carroll *Market Director, Healthy Communities & Population Health*

Edna Dsouza *Healthy Communities Manager*

Emily Scarcello *Healthy Communities Manager*

### Children’s Nebraska

Chrissy Tonkinson *Data & Evaluation Project Manager, Community Health & Advocacy*

Jennifer Patten Benson *Manager, Community Benefit and Engagement, Community Health & Advocacy*

### Douglas County Health Department

Dr. Lindsay Huse *Health Director*

Jamin Johnson *Division Chief, Public Health Strategy, Innovation, and Planning; Health Equity Advisor*

### Methodist Health System

Stephen Jackson *Manager, Community Benefit*

### Nebraska Medicine

Becky Jackson *Manager, Community Health & Community Impact*

### OneWorld Community Health Centers

Andrea Skolkin *CEO*

### Pottawattamie County Public Health

Maria Sieck *Administrator*

### Sarpy/Cass Health Department

Sarah Schram *Health Director*

### The Wellbeing Partners

Aja Anderson *CEO*

Lori Thomas *Director of Strategy and Operations*

Claire Brown *Programs Manager*

The RHC roster reflects diverse leadership across sectors, ensuring representation from health systems, public health, and community-based organizations.

## RHC Vision

We envision a region in which every person thrives in a state of wellbeing—where individuals recognize their own abilities, can cope with life’s normal stresses, work productively and meaningfully, and contribute to their families, neighborhoods, and communities. This vision reflects the region’s shared commitment to fostering environments that support physical, mental, social, and emotional wellbeing for all residents.

## RHC Guiding Principle: Universal Goals with Community-Responsive Strategies

The RHC advances shared regional health goals while recognizing that communities experience different barriers and require varying levels and types of support to achieve those goals. This guiding principle supports population-level improvement while prioritizing communities facing the greatest challenges to health.

This approach emphasizes:

- Prioritizing populations experiencing the greatest barriers to health
- Designing strategies responsive to community-identified needs
- Allocating resources fairly—rather than equally—to support improved health outcomes

The RHC applies this principle by convening regional partners, supporting shared governance and decision-making, coordinating data to align strategies, and integrating this approach across planning, implementation, and evaluation.

This guiding principle informs how priorities were selected and will guide implementation and evaluation of the 2026–2028 CHIP across the region’s three priority areas.

## Public Health Accreditation Board Requirements

The **Public Health Accreditation Board (PHAB)** is the national accrediting body for public health departments, with a mission to advance and transform public health practice by championing performance improvement, strong infrastructure, and innovation. Accreditation reflects the degree to which a health department meets a comprehensive set of **evidence-based, practice-focused standards** that promote quality, accountability, and continuous improvement. PHAB accreditation also signals to the community that a health department meets national expectations for delivering essential services in a consistent, transparent, and equitable manner.

Achieving and maintaining accreditation involves implementing PHAB’s standards and measures to strengthen organizational performance, improve population health outcomes, and institutionalize high-quality public health practices. As part of these standards, PHAB requires health departments to use a **validated community health assessment and improvement planning model** when developing a community health improvement plan.

These requirements align directly with PHAB Domain 1 (Assessment), Domain 4 (Engagement), Domain 5 (Planning), and Domain 9 (Quality Improvement). The Metro Region includes three local health departments:

- **Douglas County Health Department**
- **Sarpy/Cass Health Department**
- **Pottawattamie County Public Health**

Each department is at a different point in the PHAB accreditation process, yet all are committed to meeting national public health standards and advancing quality across the region. To support alignment and consistency, the 2024 CHA and this 2026–2028 CHIP were completed using the **Association for Community Health Improvement (ACHI) CHA Toolkit**. Use of the ACHI toolkit ensures that the CHA and CHIP follow a recognized, structured, and repeatable model, strengthening accreditation documentation for all three health departments.

FQHCs are required by the Health Resources and Services Administration (HRSA) to demonstrate and document the needs of their target population. To meet this requirement, FQHCs must conduct periodic needs assessments that:

- Identify health status, access barriers, and social determinants of health within their service area.
- Inform and improve the delivery of health center services to ensure alignment with community health priorities.
- Utilize the most recent available data and address medically underserved populations.

These findings are incorporated into the health center’s Service Directory Plan, which is submitted to HRSA for compliance and funding purposes.

The Internal Revenue Service (IRS) requires non-FQHC health systems to conduct a CHA every three years and develop a three-year Implementation Strategy to address identified needs. These publicly available plans outline how hospitals and health systems will invest resources and collaborate with partners to improve community health.


(See page 18 of this document for a list of local health system implementation plans).



## Summary of Strategic Action Plan


### PRIORITY AREA: **MENTAL & BEHAVIORAL HEALTH**

#### Action Areas:

- Strengthen 211 Mental Health Navigation 
- Coalition Collaboration & Resource Awareness
- Funding & Capacity Expansion
- MHFA Certification for CHWs
- Systemwide Mental Health Training
- Shared Culturally Relevant Communication


### PRIORITY AREA: **ACCESS TO HEALTH SERVICES**

#### Action Areas:

- CHW Identification & Connection 
- Standardized CHW Certification Framework
- Multi-Modal Health Access Communications
- Community Education on CHWs
- Health Care Access Overlay Map
- Funding & Workforce Sustainability Assessment


### PRIORITY AREA: **SOCIAL DETERMINANTS OF HEALTH - NUTRITION**

#### Action Areas:

- Attract Grocery Stores & Markets 
- Transit Adjustments for Food Access
- Regional Food Access Communications Plan

### PRIORITY AREA: **SOCIAL DETERMINANTS OF HEALTH - TRANSPORTATION**

#### Action Areas:

- Mapping & Infrastructure Analysis 
- Expand Healthcare Transportation Model
- Safety & Lighting Improvements
- Shared Transportation Communications Plan

# The 2024 Community Health Assessment

The 2024 CHA provides a comprehensive picture of the health status, needs, and lived experiences of adults across the four-county Metro Region: Douglas, Sarpy, Cass, and Pottawattamie. Using the ACHI model, collaborating organizations worked to gather and analyze more than 200 pages of quantitative and qualitative data. The CHA integrates:

- **A representative, scientifically valid survey** of Metro Area adults ages 18+
- **Key informant input** from 118 leaders representing health systems, FQHCs, nonprofits, social services, and resident-serving organizations
- **Secondary public health data** from state and national sources
- **Population-focused analysis** across race, ethnicity, age, income, geography, gender, and LGBTQ+ identity.

Together, these data sources create a comprehensive assessment that highlights current health trends, disparities, and opportunities for system-level improvement across the region.

## Summary Tables: Comparisons With Benchmark Data

The following tables summarize key indicators from the 2024 CHA and compares Metro Area results with county-level findings, statewide and national benchmarks, and Healthy People 2030 targets. Indicators shown reflect areas of strength, gaps in access, and disparities that guide the priorities and actions of the 2026–2028 CHIP.

## Reading the Summary Tables

■ **The group of columns furthest to the left** provide comparisons among the five subareas within Douglas County, identifying differences for each as “better than” ☀️, “worse than” ☁️, or “similar to” ☁️ the combined opposing areas of the county.

■ **The second grouping of columns** provide comparisons among the four counties assessed, identifying differences for each as “better than” ☀️, “worse than” ☁️, or “similar to” ☁️ the combined opposing counties.

■ **The columns to the right of the Metro Area column** provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the Metro Area compares favorably ☀️, unfavorably ☁️, or comparably ☁️ to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

**Tip:** Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.



## Summary Table: Mental Health

MENTAL HEALTH	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				METRO AREA	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	23.2	27.5	22.9	20.6	17.5	22.7	20.9	20.4	26.2	<b>22.7</b>			24.4	9.0	
% Diagnosed Depression	33.6	35.9	30.9	34.6	29.4	33.3	28.3	29.0	34.4	<b>32.3</b>	17.0	18.5	30.8	19.5	
% Symptoms of Chronic Depression	47.4	49.4	39.3	40.2	38.3	43.0	37.1	35.0	44.9	<b>41.8</b>			46.7	25.1	
% Typical Day Is "Extremely/Very" Stressful	19.1	16.9	17.4	19.7	16.2	18.2	16.4	13.5	22.1	<b>18.1</b>			21.1	11.5	
Suicide Deaths per 100,000 (AgeAdjusted)						13.8	12.4		19.0	<b>14.1</b>	14.8	16.7	13.9	12.8	10.1
% Have Someone to Turn to All/Most of the Time	70.7	59.7	76.3	79.8	81.6	73.5	79.1	77.1	72.9	<b>74.6</b>				86.1	
% Recent Anxiety	29.7	27.4	25.1	24.6	23.0	26.2	24.4	17.7	28.9	<b>25.9</b>				20.0	
% Recent Depression	25.1	20.1	17.4	20.0	15.9	20.1	14.9	10.6	21.2	<b>18.9</b>				15.1	
% Moderate to Severe Anxiety/Depression (PHQ-4 Score of 6+)	25.8	20.4	20.3	19.6	17.1	21.1	15.6	12.4	24.2	<b>20.0</b>				15.6	
Mental Health Providers per 100,000						28.6	72.4	33.8	143.1	<b>214.5</b>	184.5	136.7	183.8		
% Receiving Mental Health Treatment	28.2	25.8	31.7	29.9	22.2	28.7	27.3	23.2	32.1	<b>28.6</b>			21.9	14.4	
% Unable to Get Mental Health Services in Past Year	16.6	14.1	11.0	12.2	7.0	12.8	7.9	9.6	13.8	<b>11.8</b>			13.2	2.7	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Source: 2024 PRC Community Health Survey, PRC, Inc.

## Summary Table: Social Determinants to Health



SOCIAL DETERMINANTS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				METRO AREA	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)						☁️ 3.1	☁️ 1.2	☀️ 0.3	☁️ 1.5	<b>2.5</b>	☁️ 2.6	☁️ 1.9	☀️ 3.9		
Population in Poverty (Percent)						☁️ 11.0	☀️ 5.5	☀️ 5.6	☁️ 11.3	<b>9.7</b>	☁️ 10.4	☁️ 11.1	☀️ 12.5	☁️ 8.0	
Children in Poverty (Percent)						☁️ 13.2	☀️ 5.8	☀️ 5.4	☁️ 15.6	<b>11.6</b>	☁️ 12.0	☁️ 13.0	☀️ 16.7	☁️ 8.0	
No High School Diploma (Age 25+, Percent)						☁️ 8.6	☀️ 4.3	☀️ 4.6	☁️ 9.4	<b>7.7</b>	☁️ 8.1	☁️ 7.0	☀️ 10.9		
Unemployment Rate (Age 16+, Percent)						☁️ 2.6	☁️ 2.2	☁️ 2.3	☁️ 2.9	<b>2.5</b>	☁️ 2.3	☀️ 2.9	☀️ 3.6		☀️ 4.0
% Unable to Pay Cash for a \$400 Emergency Expense	☁️ 31.8	☁️ 38.4	☀️ 19.6	☀️ 17.9	☀️ 15.9	☁️ 24.9	☀️ 19.5	☁️ 20.3	☁️ 31.1	<b>24.3</b>		☀️ 34.0		☁️ 18.7	
% Worry/Stress Over Rent/Mortgage in Past Year	☁️ 38.3	☁️ 39.5	☁️ 32.4	☀️ 29.9	☀️ 26.4	☁️ 33.8	☀️ 29.0	☁️ 28.9	☁️ 32.3	<b>32.5</b>		☀️ 45.8		☁️ 20.1	
% Unhealthy/Unsafe Housing Conditions	☁️ 21.8	☁️ 21.2	☀️ 9.3	☀️ 10.0	☀️ 6.4	☁️ 14.1	☀️ 8.9	☁️ 10.1	☁️ 15.8	<b>13.1</b>		☀️ 16.4		☁️ 6.1	
% Went Without Electricity, Water, or Heat	☁️ 12.4	☁️ 14.9	☁️ 12.5	☀️ 6.4	☁️ 11.6	☁️ 11.2	☀️ 6.9	☁️ 8.3	☁️ 12.2	<b>10.3</b>				☁️ 5.2	
Population With Low Food Access (Percent)						☀️ 11.9	☁️ 36.7	☀️ 18.4	☁️ 30.6	<b>19.3</b>	☁️ 21.9	☁️ 20.0	☀️ 22.2		
% Worried About Food in the Past Year	☁️ 38.6	☁️ 37.7	☀️ 20.6	☀️ 19.6	☀️ 17.1	☁️ 27.0	☀️ 19.8	☁️ 22.1	☁️ 29.0	<b>25.6</b>		☀️ 40.7		☁️ 18.8	
% Ran Out of Food in the Past Year	☁️ 30.6	☁️ 33.4	☀️ 15.2	☀️ 15.9	☀️ 10.7	☁️ 21.7	☀️ 15.3	☁️ 17.8	☁️ 24.7	<b>20.6</b>		☀️ 32.6			
% Food Insecure	☁️ 41.2	☁️ 42.2	☀️ 21.9	☀️ 20.8	☀️ 18.7	☁️ 29.1	☀️ 21.8	☁️ 23.8	☁️ 31.9	<b>27.8</b>		☀️ 43.3			

Source: 2024 PRC Community Health Survey, PRC, Inc.

## Summary Table: Social Determinants to Health (continued)



SOCIAL DETERMINANTS	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				METRO AREA	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% Treated With Less Respect Than Others	☁️ 35.4	☁️ 32.0	☁️ 25.9	☁️ 25.7	☁️ 25.4	☁️ 28.9	☁️ 25.5	☁️ 26.4	☁️ 29.5	28.2				☁️ 25.1	
% Receive Poorer Treatment at Restaurants/Stores	☁️ 17.2	☁️ 12.5	☀️ 6.7	☁️ 9.2	☁️ 7.9	☁️ 10.8	☀️ 8.0	☀️ 6.7	☁️ 10.6	10.1				☁️ 7.7	
% Treated as Less Intelligent	☁️ 20.9	☁️ 23.5	☀️ 13.2	☁️ 17.2	☁️ 15.7	☁️ 18.0	☁️ 17.0	☁️ 13.5	☁️ 19.6	17.8				☁️ 13.3	
% Threatened or Harassed	☁️ 8.4	☁️ 9.0	☁️ 8.3	☁️ 8.9	☀️ 5.2	☁️ 8.4	☀️ 5.0	☀️ 4.7	☁️ 6.9	7.4				☁️ 4.8	
% Disagree That the Community Welcomes All Races	☁️ 12.9	☁️ 13.2	☁️ 11.3	☁️ 11.4	☁️ 12.6	☁️ 12.1	☀️ 7.3	☁️ 12.6	☁️ 10.4	11.0				☁️ 11.3	
% Treated as Someone to Fear	☁️ 11.9	☁️ 10.6	☁️ 8.2	☁️ 7.9	☀️ 4.1	☁️ 9.1	☀️ 6.8	☁️ 9.0	☁️ 10.2	8.7				☁️ 7.4	
% 4+ Adverse Childhood Experiences (High ACEs Score)	☁️ 30.4	☁️ 28.6	☁️ 24.4	☀️ 20.4	☁️ 22.9	☁️ 25.1	☀️ 19.9	☁️ 23.7	☁️ 29.6	24.4		☁️ 25.5		☁️ 15.1	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Source: 2024 PRC Community Health Survey, PRC, Inc.

## Summary Table: Nutrition, Physical Activity & Weight



NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				METRO AREA	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	☁️ 29.5	☁️ 29.5	☁️ 24.0	☀️ 17.4	☀️ 16.6	☁️ 23.8	☀️ 19.4	☁️ 26.0	☁️ 30.1	23.7		☀️ 30.0		☁️ 22.8	
% 7+ Sugar-Sweetened Drinks in Past Week	☁️ 30.9	☁️ 33.8	☁️ 23.4	☀️ 22.3	☁️ 24.2	☁️ 26.3	☁️ 25.3	☁️ 28.2	☁️ 31.1	26.8				☁️ 28.3	
% No Leisure-Time Physical Activity	☁️ 26.3	☁️ 32.3	☁️ 22.5	☁️ 23.2	☁️ 21.2	☀️ 25.2	☁️ 27.1	☁️ 30.3	☁️ 32.0	26.5	☁️ 24.7	☁️ 25.9	☀️ 30.2	☁️ 21.8	☁️ 16.7
% Meet Physical Activity Guidelines	☁️ 21.8	☁️ 25.8	☁️ 28.8	☀️ 31.5	☀️ 33.8	☀️ 27.9	☁️ 24.7	☁️ 21.1	☁️ 22.1	26.4	☀️ 20.9	☀️ 20.1	☁️ 30.3	☁️ 29.7	☀️ 22.0
Recreation/Fitness Facilities per 100,000						☀️ 20.4	☁️ 13.1		☁️ 13.9	17.5	☀️ 14.2	☀️ 12.1	☀️ 14.8		
% Lack of Sidewalks/ Poor Sidewalks Prevent Exercise	☁️ 33.2	☁️ 25.7	☀️ 16.1	☀️ 15.0	☁️ 16.8	☁️ 21.2	☀️ 12.5	☁️ 40.6	☁️ 26.3	20.6				☁️ 20.1	
% Lack of Trails/Poor Quality Trails Prevent Exercise	☁️ 26.6	☁️ 21.7	☀️ 14.7	☀️ 13.9	☀️ 13.6	☁️ 18.2	☀️ 12.5	☁️ 23.9	☁️ 18.6	17.2				☁️ 12.9	
% Heavy Neighborhood Traffic Prevents Exercise	☁️ 29.1	☁️ 29.4	☁️ 19.9	☀️ 16.6	☀️ 12.7	☁️ 22.1	☀️ 9.7	☀️ 6.7	☁️ 20.3	18.9				☁️ 16.7	
% Lack of Street Lights/ Poor Street Lights Prevent Exercise	☁️ 17.6	☁️ 17.6	☁️ 10.0	☀️ 7.0	☁️ 9.5	☁️ 12.1	☀️ 7.0	☁️ 21.3	☁️ 17.6	12.0				☁️ 9.4	
% Crime Prevents Exercise in the Neighborhood	☁️ 34.2	☁️ 24.8	☀️ 12.0	☀️ 7.8	☀️ 5.1	☁️ 17.4	☀️ 4.1	☀️ 3.9	☁️ 17.0	14.2				☁️ 11.0	
% Overweight (BMI 25+)	☁️ 69.7	☁️ 73.7	☁️ 70.1	☁️ 67.2	☁️ 70.4	☀️ 69.8	☁️ 75.4	☁️ 70.1	☁️ 80.1	72.2	☁️ 70.4	☁️ 71.2	☁️ 63.3	☁️ 67.5	
% Obese (BMI 30+)	☁️ 39.8	☁️ 36.7	☁️ 35.9	☁️ 32.6	☁️ 33.3	☀️ 35.7	☁️ 41.9	☁️ 46.1	☁️ 45.4	38.4	☁️ 35.3	☁️ 37.4	☁️ 33.9	☁️ 36.0	☁️ 30.3
% Have Received Professional Advice to Lose Weight	☁️ 24.3	☁️ 25.9	☁️ 26.8	☁️ 27.7	☁️ 24.5	☁️ 26.2	☁️ 22.8	☁️ 24.1	☁️ 25.4	25.3				☁️ 24.7	

Note: In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Source: 2024 PRC Community Health Survey, PRC, Inc.

## Summary Table: Access to Healthcare



ACCESS TO HEALTHCARE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				METRO AREA	METRO vs. BENCHMARKS				TREND
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	
% [Age 18-64] Lack Health Insurance	☁️ 11.1	☁️ 16.5	☀️ 4.7	☀️ 5.2	☀️ 4.6	☁️ 8.5	☁️ 7.0	☁️ 7.6	☀️ 4.9	<b>7.8</b>	☀️ 10.8	☁️ 6.7	☁️ 8.1	☁️ 7.6	☀️ 12.1
% Difficulty Accessing Health Care in Past Year (Composite)	☁️ 43.6	☁️ 42.8	☁️ 42.6	☁️ 43.5	☁️ 39.1	☁️ 42.8	☁️ 41.7	☁️ 39.4	☁️ 39.8	<b>42.2</b>			☀️ 52.5		☁️ 33.4
% Cost Prevented Physician Visit in Past Year	☁️ 18.6	☁️ 19.9	☁️ 17.1	☁️ 14.9	☀️ 11.5	☁️ 16.9	☁️ 15.1	☁️ 15.0	☁️ 16.0	<b>16.4</b>	☁️ 10.2	☁️ 7.2	☀️ 21.6		☁️ 14.5
% Cost Prevented Getting Prescription in Past Year	☁️ 18.8	☁️ 18.2	☁️ 18.8	☁️ 16.3	☀️ 11.6	☁️ 17.5	☀️ 12.4	☁️ 13.9	☁️ 18.1	<b>16.4</b>			☀️ 20.2		☁️ 14.3
% Difficulty Getting Appointment in Past Year	☁️ 21.8	☁️ 21.5	☁️ 20.5	☁️ 22.3	☁️ 20.9	☁️ 21.5	☁️ 20.3	☁️ 17.7	☁️ 20.9	<b>21.1</b>			☀️ 33.4		☁️ 10.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	☁️ 19.0	☁️ 16.2	☁️ 20.7	☁️ 15.5	☁️ 15.5	☁️ 17.7	☁️ 17.9	☁️ 19.1	☁️ 18.0	<b>17.9</b>			☀️ 22.9		☁️ 12.5
% Difficulty Finding Physician in Past Year	☁️ 16.0	☁️ 16.7	☁️ 11.1	☀️ 9.2	☀️ 5.5	☁️ 12.2	☁️ 11.1	☁️ 10.2	☁️ 11.8	<b>11.9</b>			☀️ 22.0		☁️ 6.6
% Transportation Hindered Dr Visit in Past Year	☁️ 16.7	☁️ 17.8	☀️ 7.8	☀️ 6.1	☀️ 5.0	☁️ 10.8	☀️ 5.7	☀️ 4.8	☁️ 11.3	<b>9.7</b>			☀️ 18.3		☁️ 4.7
% Language/Culture Prevented Care in Past Year	☁️ 3.7	☁️ 4.4	☁️ 1.6	☁️ 1.6	☁️ 1.7	☁️ 2.6	☀️ 0.7	☀️ 0.5	☁️ 1.6	<b>2.0</b>			☀️ 5.0		☁️ 0.9
% Stretched Prescription to Save Cost in Past Year	☁️ 21.2	☁️ 18.5	☁️ 18.4	☁️ 15.4	☀️ 11.4	☁️ 17.7	☁️ 15.3	☁️ 13.8	☁️ 17.5	<b>17.0</b>			☁️ 19.4		☁️ 13.6
% Treated Worse Than Other Races (Health Care)	☁️ 8.5	☁️ 5.6	☁️ 3.7	☀️ 2.7	☁️ 3.0	☁️ 4.8	☀️ 2.1	☁️ 2.2	☁️ 4.0	<b>4.1</b>			☀️ 6.1		☁️ 4.3
Primary Care Doctors per 100,000						☀️ 149.7	☁️ 52.5	☁️ 7.5	☁️ 48.0	<b>114.1</b>	☁️ 98.3	☁️ 109.7	☁️ 113.2		

Source: 2024 PRC Community Health Survey, PRC, Inc.

## Summary Table: Access to Healthcare (continued)



ACCESS TO HEALTHCARE	DISPARITY WITHIN DOUGLAS COUNTY					DISPARITY AMONG METRO COUNTIES				METRO AREA	METRO vs. BENCHMARKS				
	NE Omaha	SE Omaha	NW Omaha	SW Omaha	Western Douglas	Douglas County	Sarpy County	Cass County	Pott. County		vs. NE	vs. IA	vs. US	vs. HP2030	TREND
% Have a Specific Source of Ongoing Care	71.5	72.1	77.4	79.8	78.6	76.0	77.2	76.8	78.6	<b>76.6</b>			69.9	84.0	66.1
% Routine Checkup in Past Year	70.4	67.2	72.5	73.5	74.7	71.5	70.5	71.1	72.8	<b>71.5</b>	74.7	78.3	65.3		66.8
% Two or More ER Visits in Past Year	18.3	13.9	9.5	8.3	9.0	11.8	11.2	10.3	13.1	<b>11.8</b>			15.6		4.9

**Note:** In the section above, each subarea is compared against all other areas combined. Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

Source: 2024 PRC Community Health Survey, PRC, Inc.

The full 2024 CHA report is publicly available and provides detailed findings across major domains of health and wellbeing, including Mental & Behavioral Health, Access to Care, Social Determinants of Health, Chronic Disease, Maternal & Child Health, and Injury Prevention.

# Population & Sample Overview

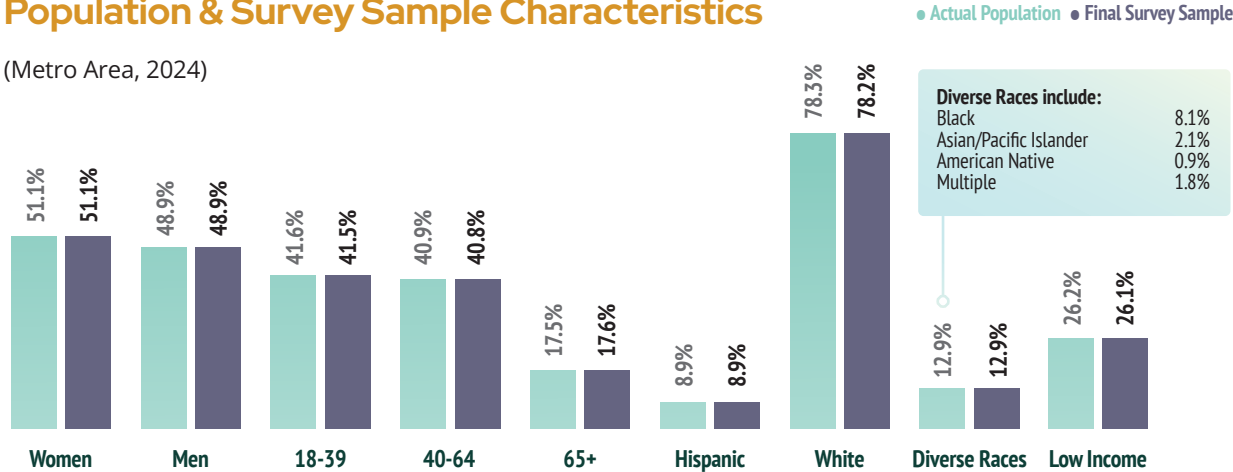
The **2024 CHA** utilized a rigorous sampling design and quality-control procedures to ensure a **representative and reliable picture** of the health, wellbeing, and lived experiences of residents across Douglas, Sarpy, Cass & Pottawattamie counties. The survey methods were developed to achieve demographic representation across age, gender, race, ethnicity, geography, and household income. As a result, findings may be generalized to the broader Metro Region population with a high degree of confidence.

The CHA sample reflects the region’s diversity and includes strong representation from historically underrepresented populations, ensuring that community voices meaningfully shaped the priorities of the 2026–2028 CHIP.

This representative sample enhances the accuracy of regional comparisons and allows for targeted analysis of disparities that inform strategy selection.

## Population & Survey Sample Characteristics

(Metro Area, 2024)



**Sources**

- US Census Bureau, 2016-2020 American Community Survey
- 2024 PRC Community Health Survey, PRC, Inc.

**Notes**

- "Low Income" reflects those living under 200% of the federal poverty level, based on guidelines established by the US Department of Health & Human Services.
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

## Inclusion of Vulnerable Populations and Addressing Health Disparities

The 2024 survey data illustrates that **economic status, race, ethnicity, and age** continue to shape health inequities in the region. The demographic patterns reflected in the 2024 CHA highlight several important disparities that directly inform the region's 2026–2028 CHIP priorities.

Ensuring that the sample closely mirrors the Metro Region population allows for a more accurate understanding of how health challenges—and opportunities—are experienced differently across communities.

Key disparities identified include higher rates of poor mental health among women, LGBTQ+ residents, and adults under 40; greater barriers to care among low-income households and Hispanic residents; and disproportionate transportation, food access, and chronic disease burdens among racially diverse communities. These disparities emphasize the need for targeted strategies designed to remove barriers and ensure access within each CHIP priority area.

### Implications for Priority 1: Mental & Behavioral Health



The proportional representation of younger, middle-aged, and older adults reveals that mental health needs are distributed across the lifespan, but disparities persist within specific groups:

- **Younger adults (18–39)**, who make up over 41% of both the population and survey sample, reported higher rates of stress, anxiety, and barriers to accessing mental health services.
- **Older adults (65+)**, though slightly underrepresented, face unique risks related to isolation, chronic conditions, and limited access to behavioral health providers trained in geriatric care.

- **Racially diverse residents**, particularly Black and American Indian respondents, experience higher exposure to trauma, structural racism, and chronic stress—factors closely linked to poorer mental health outcomes.

These patterns underscore the need for **culturally relevant communication, expanded Community Health Worker (CHW) and Mental Health First Aid (MHFA) training, and systemwide mental health literacy efforts** across the region.

### Implications for Priority 2: Social Determinants of Health – Nutrition & Transportation

The survey's strong representation of **low income households (26%)** reinforces the importance of addressing economic and environmental barriers:

#### Nutrition Disparities



- Low-income residents are more likely to live in areas with **limited access to fresh, affordable foods**, face higher food costs as a share of household income, and experience transportation barriers that limit access to grocery stores.
- Racially diverse households—especially Hispanic and Black residents—are disproportionately impacted by food insecurity and limited healthy food options.

These data justify CHIP actions such as **subsidized grocery delivery, food access mapping, and attracting new culturally relevant food retailers**.

#### Transportation Disparities



- Low-income and racially diverse residents rely more on public transit and report higher rates of unsafe walking routes, long travel times, and inadequate connection points.

- Older adults face unique barriers related to mobility, fixed incomes, and limited driving ability.

These disparities support CHIP actions including **route adjustments, infrastructure safety improvements,** and establishing a **multilingual transportation support line.**

## Implications for Priority 3: Access to Health Services

The demographic alignment highlights critical disparities in healthcare access:

- Low-income residents consistently report difficulty paying for care, delays in receiving treatment, and challenges navigating the health system.
- Racially diverse communities, particularly Hispanic residents, **face language barriers, lack of culturally responsive care,** and **limited insurance coverage.**
- Age groups differ in access needs—working-age adults face scheduling and affordability challenges, while older adults face mobility, coverage, and specialist access issues.

These disparities reinforce the need for CHIP strategies such as:

- **Building a diverse CHW workforce**
- **Developing a regional CHW certification model**
- **Providing multilingual access communications**
- **Strengthening health navigation supports**

By grounding the 2026–2028 CHIP priorities in these demographic realities, the region's strategies remain targeted, accessible, and aligned with the lived experiences of residents across all four counties.

The 2026–2028 CHIP integrates accessibility across all sections by:

- Stratifying CHA data by race, ethnicity, income, gender, age, geography, and language
- Prioritizing engagement from communities historically underrepresented
- Identifying disparities and tailoring strategies to remove barriers
- Incorporating lived experiences throughout the planning process

## Alignment to National, Statewide, & Metro Area Plans

This CHIP aligns with:

- [Healthy People 2030](#)
- [Nebraska State Health Improvement Plan](#)
- [Iowa State Health Improvement Plan](#)
- CHI Health [2026-2028 Implementation Strategy Plans](#)
- Nebraska Medicine [CHIP 2025](#)
- Boys Town National Research Hospital (Child & Adolescent) [2024 PCHNA Survey/ 2025-2028 Implementation Plan](#)
- Children's Nebraska [Implementation Strategy Plan 2025-2027](#)
- Methodist Health System [NMH Implementation Strategy 2024](#) [JEMH Implementation Strategy 2024](#)

# CHA & Improvement Planning Process

The development of the **CHA** and the **CHIP** follow the framework outlined in the **ACHI™ CHA Toolkit**. This nationally recognized model provides a structured, collaborative, and equity-centered approach to understanding community needs and guiding regional health improvement efforts.

The ACHI framework includes nine interconnected steps that take communities from partnership development through long-term evaluation. This approach ensures that assessment and planning are **data-driven, community-informed, and aligned across multisector partners**.

Using this model also supports PHAB accreditation requirements, ensuring that both the CHA and CHIP follow a validated, repeatable, and standards-based planning process.

This assessment was conducted by Professional Research Consultants, Inc. (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994. Throughout the 2024 CHA, partners across the region—including the three local health departments, health care systems, FQHCs, TWP, managed care organizations, nonprofit organizations, community coalitions, and residents—collaborated to complete **Steps 1–6** of the ACHI model. These steps focused on building partnerships, collecting and analyzing quantitative and qualitative data, engaging community voices, and prioritizing health issues.

The region conducted an additional round of targeted community engagement that strengthened the understanding of resident experiences and further shaped the priorities for this plan. For the 2026–2028 CHIP, the region will focus on **Steps 7–9**, which guide implementation, cross-sector alignment, and ongoing monitoring and evaluation. This deliberate sequencing

ensures continuity across CHIP cycles and reinforces a regional approach to learning and improvement.

The CHIP follows the ACHI model, which includes:

1. Building relationships
2. Developing community profiles
3. Increasing equity with data
4. Prioritizing needs and assets
5. Documenting and communicating results
6. Mapping development processes
7. Planning equity strategy
8. Developing action plans
9. Evaluating progress

Each step includes opportunities for community input, partner collaboration, and iterative refinement—ensuring that strategies remain responsive to evolving needs.



## How the CHA Informed This CHIP

The 2024 CHA shaped every component of the 2026–2028 CHIP by:

- **Identifying the most pressing health needs** through quantitative and qualitative data
- **Elevating resident priorities** through community surveys, listening sessions, and targeted outreach
- **Highlighting disparities** across race, ethnicity, geography, income, and age
- **Mapping local assets and existing initiatives** that can be leveraged for greater regional impact
- **Revealing opportunities for systems alignment**, particularly around behavioral health, access to services, and transportation
- **Guiding the selection of the 2026–2028 priority areas** based on urgency, readiness, and regional consensus

*The RHC also recognizes the community health needs identified in the 2024 Pediatric Community Health Needs Assessment (PCHNA), led by Children's Nebraska. The PCHNA offers a comprehensive overview of the health status, needs, and lived experiences of children and adolescents in the Omaha metropolitan area. The PCHNA is sponsored by Children's Nebraska, Boys Town National Research Hospital, and Building Healthy Futures, in partnership with RHC members including Charles Drew Health Center, Inc., the Douglas County Health Department, OneWorld Community Health Center, and the Sarpy/Cass Counties Health Department. Although PCHNA data were not directly incorporated into the development of this CHIP, the RHC recognizes that the goals and strategies outlined in this document will have meaningful implications for children and families. As a member of the council, Children's Nebraska will lead and participate in activities across the CHIP, ensuring the pediatric perspective is represented.*

This alignment ensures the CHIP reflects both **community voice** and **actionable, data-informed needs** across all four counties.

Community feedback also validated the direction of priority strategies, ensuring they address root causes, gaps in services, and opportunities to strengthen regional systems.

This CHIP was shaped by an evidence-informed, community-driven process led by the voices of more than 4,065 residents and 176 organizations across the Metro Region. The timeline for the 2024 CHA and development of the 2026–2028 CHIP included the following steps:

1. **Summer through Fall of 2024:** PRC gathered data in the field as they conducted the CHA. They surveyed 3,651 individuals and heard from 59 organizations.
2. **February 28, 2025:** A press release was shared providing the CHA information and inviting community members to attend a conversation to discuss and add context to the data.
3. **Spring of 2025:** Conversations were hosted across the Omaha Metro in which community members were invited to hear about the data that was collected. 54 community members attended these conversations across all occurrences:

+ **Saturday, March 8 | 10:00am-1:00pm**

- Washington Library  
2868 Ames Avenue, Omaha, NE
- Louisville City Office  
210 Main Street, Louisville, NE

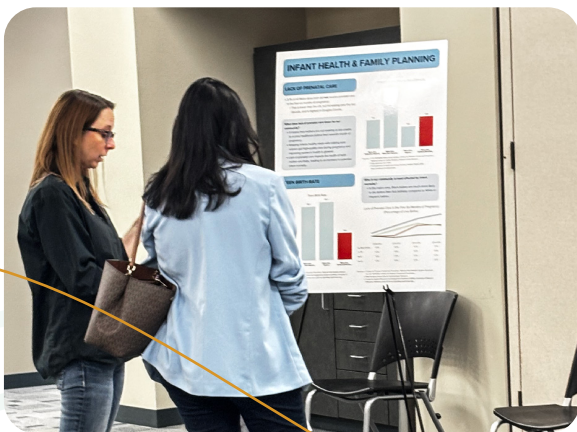
+ **Tuesday, March 11 | 3:00-6:00pm**

- Council Bluffs Chamber of Commerce  
149 W Broadway, Council Bluffs, IA
- South Omaha Library  
2808 Q Street, Omaha, NE

+ **Thursday, March 13 | 3:00-6:00pm**

- Bellevue Library  
2206 Longo Drive, Bellevue, NE
- Swanson Library  
9101 W Dodge Road, Omaha, NE




4. **Summer of 2025:** The RHC reviewed information learned from the community conversations and the 2024 CHA and began planning for the CHIP.
5. **August 20th 2025:** The RHC identified draft priorities to share with the community for feedback.
6. **Fall of 2025:** TWP conducted an environmental scan to gain insight on work that's happening in the community in relation to community health. The environmental scan survey was sent out to 742 community organizations and received responses from 46 organizations. This information was reviewed and shared with the RHC.
7. **September 3<sup>rd</sup> 2025:** The RHC identified draft goals, strategies, and action plans to address the priorities.
8. **September 17<sup>th</sup>:** The RHC completed a draft of the CHIP to share with the community and get feedback. Plans were made for community conversations to share this draft. Event information was shared with partners and community members.



9. **October-November 2025:** Community events were held in which the draft CHIP was shared, and feedback was received via conversation and survey. Overall, 5,394 community members were reached at the events and 220 provided feedback on the draft CHIP across the following opportunities:
  - + **October 11 | 8:45-11:30am**  
Empowerment Network  
Village Connector Meeting
  - + **October 21 | 6:30-7:30pm**  
Midtown Neighborhood  
Association Meeting
  - + **October 22 | 6:30-7:30pm**  
Facebook Live Event
  - + **October 22**  
**4:30-5:30pm (Spanish)**  
**4:30-5:30pm (English)**  
AllCare focus group
  - + **October 24 | 5:00-8:00pm**  
Sarpy County "Baseballween" Event
  - + **November 4-November 6 | 9:00am-4:00pm**  
Sarpy/Cass Health Department Open House
  - + **November 5 | 11:30am-12:30pm**  
Plattsmouth Senior Center Conversation
  - + **November 6 | 6:15-7:15pm**  
South Omaha Neighborhood Alliance Meeting
10. **November 19<sup>th</sup> 2025:** The feedback from community members was shared back to the RHC and adjustments were made to the draft CHIP.
11. **December 1<sup>st</sup> 2025:** The CHIP was completed and translation into Spanish began.
12. **February 2026:** The CHIP was published and shared back to the community.

# Strategic Priorities

The completion of the CHA and the adoption of the ACHI model laid the groundwork for selecting the region's most pressing health priorities. By combining community insights, partner expertise, and regional data, the RHC identified three interconnected priority areas for the 2026–2028 cycle:

- 1 Mental & Behavioral Health 
- 2 Social Determinants of Health: Nutrition and Transportation 
- 3 Access to Health Services 

The following section outlines the **goals, objectives**, and **strategic actions** that will guide regional collaboration through 2028. These strategies represent the shared commitment of partners to expand access to health, strengthen systems, and improve wellbeing for all residents in the Metro Region.

While the strategic action plan provides a clear roadmap for addressing these priorities, it is intended to be a dynamic and adaptable framework. The plan may be modified throughout the implementation timeline to reflect emerging needs, new data, and evolving community conditions.

## Strategic Action Plan

### Priority Area: Mental & Behavioral Health

GOAL	2024 INDICATOR	OBJECTIVE
By 2028, reduce the percentage of residents reporting poor mental health.	22.7%	Increase connection to tools and resources that promote mental wellbeing.

STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<i>Action Area: Strengthen 211 Mental Health Navigation</i>			
By December 2026, partner with 211 to complete a mental health navigation gap analysis and implement at least three improvements related to cultural relevance, language access, or resource completeness.	Douglas County Health Department	Nebraska Medicine, Methodist Health System, Pottawattamie County Public Health	<b>High</b> - Setting a shared regional expectation for annual mental health literacy or trauma-informed training introduces a system-level policy standard for all partner organizations.

## Priority Area: Mental & Behavioral Health, continued



STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: Coalition Collaboration &amp; Resource Awareness</b>			
Beginning in 2026, identify opportunities to collaborate with community coalitions, at least quarterly, connecting people with resources and services reaching 2,500 residents annually.	Pottawattamie County Public Health	All Care, Charles Drew Health Center, CHI Health, Children's Nebraska, Douglas County Health Department, Nebraska Medicine, Methodist Health System	
<b>Action Area: Funding &amp; Capacity Expansion</b>			
By June 2027, review existing funding and secure one new funding source to expand mental health support such as MHFA training and navigation.	CHI Health	Pottawattamie County Public Health, Sarpy Cass Health Department	
<b>Action Area: MHFA Certification for CHWs</b>			
By December 2026, ensure 25 culturally diverse CHWs are certified in MHFA to strengthen early intervention capacity.	Nebraska Medicine	Children's Nebraska, Pottawattamie County Public Health	
<b>Action Area: Systemwide Mental Health Training</b>			
By 2028, establish a shared regional expectation for annual mental health literacy or trauma-informed training, with all partners implementing it.	Children's Nebraska	CHI Health, Nebraska Medicine, Methodist Health System	
<b>Action Area: Shared Culturally Relevant Communication</b>			
Starting in 2026, disseminate quarterly, culturally relevant mental health communication, reaching 50,000 residents annually.	Sarpy/Cass Health Department	Douglas County Health Department, Nebraska Medicine, OneWorld, Pottawattamie County Public Health	

## Priority Area: Access to Health Services



GOAL	2024 INDICATOR	OBJECTIVE
By 2028, reduce the number of residents reporting difficulties accessing care.	42.2%	Support direct connection and navigation to health care services.

STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: CHW Identification &amp; Connection</b>			
By December 2026, build a regional roster of 50 diverse CHWs connecting them to a network of support.	Nebraska Medicine	CHI Health, Douglas County Health Department	<b>Moderate</b> - Creating a regional roster of CHWs and connecting them to a support network involves organizational policy alignment and coordination, but less regulatory change.
<b>Action Area: Standardized CHW Certification Framework</b>			
By June 2028, implement a standardized regional CHW certification and train 100 CHWs.	Douglas County Health Department	Nebraska Medicine, Pottawattamie County Public Health	<b>High</b> - Establishing a standardized regional certification for CHWs is a formal policy change that sets workforce qualifications and impacts health service delivery across the region.
<b>Action Area: Multi-Modal Health Access Communications</b>			
Beginning in 2026, release quarterly multilingual health access communications, reaching 40,000 residents annually.	OneWorld	Children's Nebraska	
<b>Action Area: Community Education on CHWs</b>			
By December 2027, conduct 50 engagements educating 10,000 residents on CHW roles.	Douglas County Health Department	Pottawattamie County Public Health, Sarpy Cass Health Department	

## Priority Area: Access to Health Services, continued



STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: Health Care Access Overlay Map</b>			
By June 2027, publish and annually update a regional Healthcare Services Access Overlay Map.	Methodist Health System	Charles Drew Health Center, Children's Nebraska	
<b>Action Area: Funding &amp; Workforce Sustainability Assessment</b>			
By December 2027, produce a funding strategy report with three recommendations to sustain FQHCs and healthcare workforce development.	All Care	Charles Drew Health Center	

## Priority Area: Social Determinants of Health - Nutrition



GOAL	2024 INDICATOR	OBJECTIVE
By 2028, reduce the number of residents reporting difficulties accessing fresh, affordable foods.	23.7%	Increase navigation and entry points to healthy foods.

STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: Attract Grocery Stores &amp; Markets</b>			
By 2028, partner with local chambers of commerce and/or economic development organizations to attract two new grocery stores, mobile markets, or culturally specific retailers to food deserts.	Charles Drew Health Center	Sarpy/Cass Health Department	<b>High</b> - Partnering with chambers and economic development organizations to attract grocery stores or culturally specific retailers requires policy-level incentives and zoning considerations.

## Priority Area: Social Determinants of Health - Nutrition, continued



STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: Transit Adjustments for Food Access</b>			
By 2027, partner with city, county, and community partners to implement three transit route adjustments improving access to food resources.	Charles Drew Health Center	CHI Health, Sarpy/Cass Health Department	<b>Moderate</b> - Adjusting public transit routes to improve food access involves municipal planning and transportation policy changes, but is less complex than economic development policies.
<b>Action Area: Regional Food Access Communications Plan</b>			
By March 2027, launch a multilingual food access communication plan, including a resource list in three languages, reaching 100,000 residents annually.	Sarpy/Cass Health Department	Children's Nebraska, Pottawattamie County Public Health	

## Priority Area: Social Determinants of Health - Transportation



GOAL	2024 INDICATOR	OBJECTIVE
By 2028, reduce the number of respondents reporting transportation barriers.	9.7%	Bring together Managed Care Organizations (MCO), city officials, and experts to identify infrastructure gaps.





STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: Mapping &amp; Infrastructure Analysis</b>			
By June 2026, partner with MAPA to develop a transportation overlay map and update annually.	Douglas County Health Department	CHI Health	<b>Moderate</b> - Developing and annually updating a transportation overlay map with MAPA requires planning policy integration and infrastructure prioritization.

**Priority Area: Social Determinants of Health - Transportation, continued**



STRATEGIC ACTION	LEAD	WORKGROUP	DEGREE OF POLICY IMPACT
<b>Action Area: Expand Healthcare Transportation Model</b>			
By December 2027, work with city and county planning departments to expand the healthcare transportation model to three additional high-need neighborhoods.	CHI Health	Charles Drew Health Center	<b>High</b> - Working with city and county planning departments to expand healthcare transportation models introduces structural policy changes affecting transit systems.
<b>Action Area: Safety &amp; Lighting Improvements</b>			
By 2028, partner with local planning offices to implement 10 safety enhancements along transit routes.	Douglas County Health Department	Pottawattamie County Public Health	<b>Moderate</b> - Implementing safety enhancements along transit routes involves local planning and infrastructure policy adjustments, but not full regulatory overhaul.
<b>Action Area: Shared Transportation Communications Plan</b>			
By 2028, partner with MAPA to launch a multilingual transportation communication plan, including a support line, reaching 75,000 residents annually.	Children's Nebraska	OneWorld	

## Monitoring & Evaluation Dashboard

PRIORITY AREA	KEY INDICATORS	REPORTING FREQUENCY	DATA SOURCES
<b>Mental &amp; Behavioral Health</b> 	% reporting poor mental health	2027 CHA	Surveys, 211, Partner Reports
	# CHWs certified	Annual	
	# residents reached		
	# of improvements related to cultural relevance, language access, or resource completeness		
	# of new funding sources to expand mental health support		
<b>Access to Health Services</b> 	% reporting difficulty accessing care	2027 CHA	Health Systems, FQHCs, Health Departments CHW Networks
	# CHWs trained	Annual	
	# CHWs added to regional roster		
	# of residents reached		
	# of engagements		
	# of recommendations		
<b>Nutrition</b> 	% reporting food access challenges	2027 CHA	Chamber Data, Partner Reports
	# new food access points	Annual	
	# of transit routes adjustments		
	# languages in which the food access resource list is published		
<b>Transportation</b> 	% reporting transportation barriers	2027 CHA	MAPA, MCOs, Call Line Reports
	# safety improvements	Annual	
	# of partners engaged		
	# of high-need neighborhoods where the transportation model is implemented		

# Community Collaboration

Improving health and wellbeing across the Metro Region is only possible through the collective action of community partners working toward shared goals. Each CHIP priority—**Mental & Behavioral Health, Social Determinants of Health (Nutrition and Transportation), and Access to Health Services**—requires coordinated efforts across sectors including public health, healthcare, education, transportation, social services, housing, business, philanthropy, and community-based organizations.



Across the four-county region, dozens of organizations, coalitions, health systems, FQHCs, and resident-led groups are actively engaged in addressing the needs identified in the 2024 CHA. Their ongoing work forms the foundation on which the 2026–2028 CHIP builds. The RHC recognizes these partners as essential contributors in designing and implementing strategies that advance equity, expand access, and strengthen community wellbeing.



The chart on the following pages highlights examples of ongoing and aligned efforts across the region. These initiatives were identified through partner outreach, environmental scanning, community engagement, and review of local CHNAs and strategic plans. **They are not intended to represent all the work happening across the Metro Region—only the efforts shared by organizations that responded to the regional partner survey used for this environmental scan.**



# 2026-2028 Environmental Scans

**KEY:** Counties: D = Douglas S = Sarpy C = Cass P = Pottawattamie  
 Strategic Priorities: M = Mental & Behavioral Health A = Access to Health Services N = Nutrition (SDOH) T = Transportation (SDOH)

ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>50 Mile March Foundation</b>  <a href="https://www.50milemarch.org">https://www.50milemarch.org</a>	<b>Annual Ruck:</b> Groups train year round for this 50-mile event as part of a peer-to-peer mental health model. In addition, on-campus methal health therapists were added in 2025.	S	M
<b>Access Period</b>  <a href="https://www.accessperiod.com">https://www.accessperiod.com</a>	<b>School Partnerships:</b> Provide free period products to school districts, schools, and educators to ensure students have consistent access.	D, S, C, P	A
	<b>Community Partners:</b> Distribute free period products (various kit types, underwear, and cups) through 60+ nonprofit partners who directly serve individuals and families in need.		
<b>All Seasons Foundation</b>	<b>Access Points:</b> Free 3-month period product kits are available at OneWorld Teen & Young Adult Health Centers (West and South) and the Union for Contemporary Art. Kits include tampons or pads, liners, wipes, and disposal bags.	D, S	A
	<b>Medicaid and SNAP Enrollment:</b> Provide a pantry, help clients enroll for Medicaid and SNAP benefits, and do outreach.	D, S	N
<b>REBOOT Recovery:</b> A 12-week trauma recovery program for individuals with PTSD, offered in three groups (Veterans, First Responders, and the general public) focused on healing from critical incident stress and trauma.	<b>Resource Facilitation:</b> A free service through the Brain Injury Association of Nebraska that assists individuals with brain injury, families and caregivers, and healthcare professionals find answers to questions about brain injury in Nebraska.	S	M, A
		D, S, C	M, A
<b>Brain Injury Association of Nebraska</b>  <a href="https://www.biane.org">https://www.biane.org</a>	<b>Policy &amp; Research Work:</b> Conducts research, publishes policy reports, and leads congressional briefings on child care, early education, TANF, early childhood mental health, and caregiver wellbeing. Also conducts Nebraska's child care market rate surveys.	D	M, A, N
<b>Buffett Early Childhood Institute at the University of Nebraska</b>  <a href="https://buffettinstitute.nebraska.edu">https://buffettinstitute.nebraska.edu</a>	<b>Ambassador Program:</b> Identifies and supports emerging leaders in the Southside Terrace-Indian Hill community in South Omaha. Ambassadors receive training and tools to strengthen their leadership skills and amplify resident voices. Together, they help guide families and neighbors toward the community's shared vision for the future.	D	M
<b>Canopy South</b>  <a href="https://canopysouth.org">https://canopysouth.org</a>	<b>Grief Digest Online Articles:</b> Free articles from others who have experienced the death of a loved one.	D, S, C, P	M
	<b>Bookstore:</b> Provides supportive grief resources, such as journals, books, and momentos in a home-like environment.		
<b>Centering Resources</b>  <a href="https://www.centering.org">https://www.centering.org</a>			

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ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>CHI Health</b>  <a href="https://www.chihealth.com">https://www.chihealth.com</a>	<b>Care Transitions:</b> CHWs, public health nurses, and navigators providing SDOH screenings for patients and sending referral to community organizations.	D, S	T
	<b>Diabetes Prevention Program:</b> Offered with certified diabetes educators in clinics.	D, S	N
	<b>Doula Program Pilot (In partnership with A Mother's Love):</b> Integration of perinatal system and community based maternal support services to improve pregnant and postpartum health outcomes and reduce maternal and infant health disparities.		
	<b>Lasting Hope Recovery Center:</b> Intensive Outpatient and Partial Hospitalization Program for co-occurring substance and mental health disorder for adults.	D, S	M
	<b>Maternal Health Access to Care:</b> Provides the CenteringPregnancy program, a group prenatal care program, for English and Karen speaking patients.	D, S	A
	<b>Question, Persuade, Refer (QPR) Program:</b> A nationally recognized, research-based suicide prevention training that teaches people to recognize the warning signs of a suicide crisis and how to respond. Available to staff and community members.	D, S, P	M
<b>Child Saving Institute</b>  <a href="https://childsaving.org">https://childsaving.org</a>	<b>Psychiatric Medical Institute for Children (PMIC) &amp; Crisis Center:</b> Offers acute mental health services.	P	M
	<b>Behavioral Health Center:</b> Offers outpatient mental health therapy for children, adults, and families.	D, S	M
<b>Children's Nebraska</b>	<b>School Mental Health Program:</b> Provides training, resources and networking supports to school mental health teams.	D, S, C	M
	<b>Clinic-based Pediatric Mental Health Care:</b> Offers pediatric clinical health care services in primary and specialty care settings.	D, S, C, P	M
	<b>COPE Program:</b> Offers training for primary care providers to learn best-practices and clinical strategies for youth mental health care diagnosis and treatment.		
	<b>Double Up Food Bucks:</b> Partner with No More Empty Pots and UNL Extension to offer produce incentives for families participating in SNAP.	D, S, C	N
	<b>Youth Peer-to-Peer Support Program Pilot:</b> Trauma Informed Peer Advocate (TIPA) program in partnership with UNO and local high schools.	D	M
	<b>Primary and Specialty Care Services:</b> Provides comprehensive primary care, home health services, and specialty care in over 50 different pediatric specialties.	D, S, C, P	N
	<b>Milk Depot:</b> Collects extra breastmilk from mothers and collaborates with the Denver milk bank.		
<b>Fetal Care Center:</b> Offers prenatal diagnostic services and care planning for mothers carrying babies who may need intervention or support after birth.			

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ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>Children’s Nebraska, cont’d</b>  <a href="https://www.childrensnebraska.org">https://www.childrensnebraska.org</a>	<b>Transportation Support:</b> Care Coordination screens families for transportation needs and provides transportation services.	D, S, C, P	T
	<b>Virtual School Health Program Pilot:</b> Beginning SY25/26, provides virtual visits with pediatric nurse practitioners to address immediate student health needs and help keep kids in school.	D, S, C	A
	<b>Vision Screening &amp; Community Care:</b> Provides vision screenings and care through the Visionmobile in partnership with schools and community sites.	D, S, C, P	A
	<b>Project Austin:</b> Trains EMS and first responders to safely transport children with complex medical needs.		
	<b>Rainbow House &amp; Suites:</b> Offers free overnight accommodations for families with children receiving hospital care.		
<b>Collective for Hope</b>  <a href="https://CollectiveforHope.org">https://CollectiveforHope.org</a>	<b>Grief Support:</b> Free and inclusive for kids, adults, and families.	D, S, C, P	A
<b>Completely Kids</b>  <a href="https://completelykids.org">https://completelykids.org</a>	<b>Mental Health Program:</b> Provides individual and group therapy through an on-site team of licensed therapists.	D	M
	<b>Mobile Health Services Partnerships:</b> Partners with Methodist, Children’s, and OneWorld to bring mobile services to the community, including mammograms, dental care, flu/ COVID clinics, and diabetes screenings.	D	A
<b>CUES Fund</b>  <a href="https://cuesschools.org">https://cuesschools.org</a>	<b>Student &amp; Family Services:</b> Provides in-school case management connecting students and families to basic needs support, mental health referrals, benefits enrollment, and attendance plans. Uses data-informed check-ins, goal setting, and community partnerships to improve attendance, strengthen family stability, and respond quickly to crises.	D	M, N, T
	<b>School Counseling Services:</b> Offers counseling to students and families across CUES schools, focusing on mental health, academic support, and faith-based guidance. Helps students navigate challenges and thrive both personally and academically.		
	<b>LIFT Program (with Boys Town):</b> Implements a community-based, multi-tiered prevention model designed to address concerns early—before safety issues, chronic absenteeism, or schoolwide challenges develop—to support a healthier, more resilient school community.		
<b>Firefly</b>	<b>Food Access &amp; Obesity Reduction Coalitions:</b> participates in or facilitates coalitions including HSAC Food Access, ISU Extension’s LEAP Coalition, Southwest Iowa Breastfeeding Coalition.	P	N
	<b>Early Head Start - Home Visitation:</b> Home-based weekly parenting and health based visits supporting prenatal and infant populations.		



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ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>Girl Scouts Spirit of Nebraska</b>  <a href="https://www.girlscoutsnebraska.org/">https://www.girlscoutsnebraska.org/</a>	<b>Mental Wellness Patch Program:</b> Provides a free mental wellness program for Girl Scouts in grades 4–12, using creative and reflective activities—such as art and writing—to build resilience, emotional awareness, confidence, and connection. Developed in partnership with NAMI.	D, S, C	M, N
	<b>Body Appreciation Badge Program:</b> Supports Girl Scouts in grades K–12 with age-appropriate activities that promote body confidence, self-care, healthy boundaries, movement, and positive self-expression. Encourages lifelong physical and emotional well-being.		
	<b>Resilient. Ready. Strong. Program:</b> Offers activities that help Girl Scouts strengthen resilience, build practical coping skills, and support overall mental wellness. Participants earn a patch while learning strategies to stay confident and prepared for life's challenges.		
<b>Girls Inc of Omaha</b>  <a href="https://girlsincomaha.org/">https://girlsincomaha.org/</a>	<b>Building Healthy Futures:</b> Provides holistic health programming for girls ages 5–18, including education on physical health, nutrition, mental health, healthy sexuality, and relationship skills. Includes Farm-to-Table Cooking, expanded sports and wellness activities, and trauma-informed mental health workshops.	D	M, A, N
	<b>Empowering Voices:</b> Equips girls of color ages 8–13 with skills to communicate confidently about their mental and physical health. Includes health literacy education, communication skills training, and culturally responsive programming, with caregiver engagement through quarterly focus groups.		
	<b>Her Health, Her Choice:</b> Supports girls ages 10–18 in making informed sexual health decisions and understanding healthy relationships. Offers counseling, preventive health services, and education on contraception, consent, and reproductive justice, with added transportation supports and trauma-informed, culturally responsive staff training.		
	<b>Shaping Futures, Breaking Cycles:</b> Mental health and relationship-violence prevention program for girls in grades 9–12. Monthly sessions include discussions, role-playing, and guest experts to build communication, resilience, and skills to identify intimate partner violence; reduces stigma and strengthens emotional wellbeing.		
<b>Guided by Kids</b> <a href="https://www.guidedbykids.org">https://www.guidedbykids.org</a>	<b>Community Engagement via Action:</b> Students identify a community need, create an action plan, and complete a service project that benefits their local community.	D	M
<b>Heartland Workers Center</b>  <a href="https://www.heartlandworkerscenter.org">https://www.heartlandworkerscenter.org</a>	<b>Staff &amp; Community Wellness Programs:</b> Offers staff wellness sessions with Omaha Integrative Care, community support groups in partnership with AM Counseling, and management-focused wellness presentations led by the Executive Director that provide tools for emotional awareness and self-management.	D, S, C	M
	<b>Community Navigation &amp; Referrals:</b> Provides humanitarian support by connecting individuals to partner organizations and helping community members navigate services and systems.	D, S, C	A
<b>Hillcrest Foundation for Enhancing Lives</b> <a href="https://www.hillcrestfoundation.org">https://www.hillcrestfoundation.org</a>	<b>Safety, Support and Dignity for Seniors:</b> Provides essential items and assists with urgent needs to improve the quality of life for seniors.	D, S, C, P	N

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ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>Human Services Advisory Council</b> <a href="https://www.hsacinc.net">https://www.hsacinc.net</a>	<b>Networking, Collaboration and Referrals:</b> Provides opportunities for agencies to share information and collaborate with one another.	P	M, A, N
<b>Inspire Collaborative Health Association</b>  <a href="https://inspirehealthassociation.com/">https://inspirehealthassociation.com/</a>	<b>Vetted Provider Directory:</b> Maintains a trusted directory of vetted conventional and complementary health providers, ensuring quality, safety, and credibility across a wide range of care options.	D, S, C, P	M, A, N
	<b>Clinical Liaison Services:</b> Offers confidential 60–90 minute guidance calls to help individuals navigate healthcare options and connect with vetted providers across conventional and complementary care.		
	<b>Community Health Access Fund:</b> Provides direct financial assistance (\$250–\$1,000) for health services not covered by insurance, reducing cost barriers and expanding access to needed care.		
<b>Latino Center of the Midlands</b>  <a href="https://www.Latinocenter.org">https://www.Latinocenter.org</a>	<b>Community Health Referrals &amp; Events:</b> Partners with community organizations to provide referrals for vaccines, mammograms, and other preventive services, and to host one-time wellness events.	D, S, C, P	A
	<b>Cultivate Wellness (Urban Gardening):</b> Provides urban residents with training, education, and resources to grow fresh produce, improving food security, healthy living, and community connection.		
	<b>Attendance Support:</b> Supports middle and high school students with on-site academic and personal support, leadership development, and family engagement to improve attendance and engagement.		
	<b>Cultural Leadership Groups:</b> Engages participants in culturally based leadership programs that strengthen identity, goal-setting, and positive decision-making.		
	<b>Parental Commitment (Two-Generation Support):</b> Delivers holistic, two-generation services that support students and families in building healthy relationships and long-term stability.		
<b>Legal Aid of Nebraska</b> <a href="https://www.legalaidofnebraska.org">https://www.legalaidofnebraska.org</a>	<b>Health, Education, and Law Project (Medical-Legal Partnership):</b> Partners with hospitals and community organizations to provide integrated legal and health services that address patients' medical, social, and legal needs.	C, D, S	M, A, N
<b>Mutual of Omaha</b>	<b>Community Mental Health Support:</b> Partners with local organizations to promote mental health awareness through education, community events, and employee volunteer engagement.	D, S, C, P	M, A, N
	<b>Employee Assistance Program (EAP):</b> Provides confidential support for employees and household members, including counseling, stress management, and work-life resources.		
	<b>Mental Wellbeing Initiatives:</b> Offers employees ongoing mental health campaigns, mindfulness workshops, and wellness tools to reduce stress, build resilience, and support balance.		

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ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>Mutual of Omaha, cont'd</b>  <a href="https://www.mutualofomaha.com">https://www.mutualofomaha.com</a>	<b>Employee Resource Groups (ERGs):</b> Creates inclusive, peer-led spaces that foster connection, belonging, and engagement in mental health initiatives for employees.	D, S, C, P	M, A, N
	<b>Health Insurance Plans:</b> Offers comprehensive medical, dental, and vision coverage to support associates' and dependents' healthcare needs.		
	<b>Preventive Care &amp; Screenings:</b> Promotes preventive health through education, flu vaccine clinics, on-site mammograms, and colon cancer screening kits.		
<b>Nebraska Early Childhood Collaborative</b>  <a href="https://www.nebraskaeearly.org">https://www.nebraskaeearly.org</a>	<b>Early Head Start:</b> Provides comprehensive support for families with children ages 0–3, including health, nutrition, and developmental education; social-emotional observation, coaching, and mental health referrals; partnerships with licensed mental health providers; and coordination to ensure access to primary care, insurance, immunizations, screenings, and early intervention services.	D	M, A, N
	<b>Employee Benefits and EAP:</b> Offers all employees 30+ hours/week full time benefits that include access to an EAP provider.	D, S, C, P	A
	<b>Healthy Rest, Happy Nest:</b> A wellbeing program supporting early educators by strengthening support, recognition, and access to resources, including an Employee Assistance Program (EAP) for enrolled participants.	D, S, C	M
<b>Nebraska Extension in Douglas-Sarpy Counties</b>	<b>Growing Together Nebraska – Hope Center for Kids:</b> A SNAP-Ed–funded donation garden program that increases food security and healthy food access through community-managed gardens. Extension Master Gardener Volunteers partner with K–2 youth, families, and staff to provide hands-on gardening, nutrition education, and healthy lifestyle learning that promotes physical wellbeing.	D	N
	<b>Nebraska Double Up Food Bucks:</b> Matches SNAP purchases dollar-for-dollar (up to \$20/day) on fresh fruits and vegetables, helping families take home more produce while supporting local farmers and independent grocers at participating Omaha locations.	D, S	N
	<b>Growing Together Nebraska:</b> A SNAP-Ed–funded donation garden program that improves access to affordable, nutritious food and provides education on storing and preparing seasonal produce through partnerships with Extension Master Gardener Volunteers and community garden sites.		
	<b>Nebraska Extension Master Gardener Volunteer Program:</b> Provides horticulture training and volunteer service, equipping certified volunteers to share research-based gardening education, support community gardens and outreach, and foster community connection, purpose, and wellbeing through service.	D, S	M
	<b>Youth Nutrition Education (EFNEP):</b> Free nutrition and physical activity education for youth in schools, preschools, after-school programs, and camps. Topics include healthy eating, food safety, MyPlate, gardening, and movement through programs such as Marathon Kids, Food Smarts, and Learn, Grow, Eat & Go.	D, S, C	N
	<b>Adult Nutrition Education Classes:</b> Customized nutrition and cooking classes for community groups focused on healthy eating, seasonal produce, food preservation, and practical meal preparation. Classes are offered year-round at Extension offices or community locations.		

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ORGANIZATION	EFFORT	COUNTIES	STRATEGIC PRIORITIES
<b>Nebraska Extension in Douglas-Sarpy Counties, cont'd</b>  <a href="https://douglas-sarpy.unl.edu/">https://douglas-sarpy.unl.edu/</a>	<b>SNAP-Ed &amp; EFNEP Community Classes:</b> Community-based nutrition education for individuals and families with limited food budgets, supporting healthier food choices and cooking skills. Classes are hosted by service agencies and available to SNAP, WIC, and free/reduced lunch-eligible participants.	D, S, C	N
	<b>Breastfeeding Education &amp; Resources (CARE Project):</b> Provides educational videos and resources to support breastfeeding mothers returning to work or school, strengthening confidence, advocacy, and support networks for continued breastfeeding.		
<b>Nebraska Methodist College</b>  <a href="https://www.methodistcollege.edu/">https://www.methodistcollege.edu/</a>	<b>Best Care Employee Assistance Program (EAP):</b> Provides confidential, concierge-style employee wellbeing support through Methodist Health System. With over 40 years of experience, Best Care offers responsive services that prioritize accessibility, confidentiality, and compassionate care for employees and their families.	D, S, C, P	M
	<b>Campus Health:</b> Offers and refers employees and students to community healthcare.	D	A
	<b>THRIVE Employee Wellness Committee:</b> Focuses on the eight dimensions of wellness for staff and students.	D	M, N
<b>Nebraska Sports Council</b>  <a href="https://www.NebraskaSportsCouncil.com">https://www.NebraskaSportsCouncil.com</a>	<b>Wellpower Movement May Mental Health Challenge:</b> A month-long Mental Health Awareness Month challenge (May 1–31) that encourages participants to log miles for mental wellbeing activities such as meditation, sleep, movement, and mindfulness, each assigned a mileage value to promote daily mental health practices.	D, S, C, P	M
<b>Omaha Fire Department</b>  <a href="https://www.omaha-fire.org">https://www.omaha-fire.org</a>	<b>Omaha Fire Department Peer Support:</b> Trained firefighters provide confidential, peer-to-peer support for colleagues experiencing mental health challenges.	D, S	M
<b>One Omaha</b>	<b>Neighborhood Leadership &amp; Engagement:</b> Resident-led leadership academies, advisory boards, and mini-grants that strengthen community ownership, social connectedness, and protective factors for mental health and substance-use prevention.	D	M
	<b>Neighborhood Needs Assessment:</b> Collects resident-identified priorities and barriers—such as access to healthcare and physical wellbeing—and integrates them into citywide planning and decision-making.	D	A, N
	<b>COLLAB Services:</b> Provides technical assistance and facilitation for healthcare systems and agencies to engage residents on access to care, safe streets, and community wellness.		
	<b>Neighborhood Needs Assessment:</b> Community-driven tool that identifies local priorities, including barriers to healthcare access and physical wellbeing, and informs citywide planning and decision-making.	D	T
	<b>Economic Opportunity Initiatives:</b> Engagement and COLLAB projects connect neighborhoods to entrepreneurship, workforce, and civic resources that support economic stability and health.		
	<b>Environment &amp; Placemaking:</b> Programs such as From the Ground Up strengthen community identity, arts, and environmental justice, key factors influencing health outcomes.		









# Partners

The CHIP was shaped by the participation and leadership of:

**Regional health systems • FQHCs • Behavioral health organizations • Nonprofits • School districts**  
**Local government and coalitions • Community leaders and residents**

## Organizations

4th Judicial District	City Sprouts	Family, MCH Sealant Program	Iowa West Foundation
Dept of Correction Service	Citymatch	Firefly	Iowa Western Community College
50 Mile March Foundation	Claire Memorial United Methodist Church	First National Bank of Omaha	Iowa Workforce Development/ IowaWorks
Access Period	Coalition Rx	Fitucate Foundation	Latino Center of the Midlands
All Care Health Center	Code Z Outreach	Food Bank for the Heartland	Legal Aid of Nebraska
All Seasons Foundation	Collective for Hope	Gabriel's Corner Pregnancy Counseling	Lift Up Sarpy
Black and Pink	College of St. Mary	Girl Scouts Spirit of Nebraska	Louisville Medical Center
Black Men United	Community Alliance	Girls Inc of Omaha	Lutheran Family Services
Brain Injury Association of Nebraska	Completely KIDS	Goodwill Omaha	Malcolm X Foundation
Canopy South	Connections Area Agency on Aging	Guided by Kids	MAT
Carole's House of Hope	Council Bluffs Chamber of Commerce	Habitat for Humanity Council Bluffs	Mercy Housing
CASA for Douglas County	Council Bluffs Charles E Lakin YMCA	Heart Ministry Center	Methodist Community Health Clinic (MCHC)
CASA for Southwest Iowa	Council Bluffs Healthy Living Center	Heartland Family Service	Methodist Health
Cass County	Creighton University	Heartland Hope Mission	Metro Area Transit
Catholic Charities of Omaha	CUES Fund	Heartland Workers Center	Metropolitan Area Planning Agency (MAPA)
Center for Holistic Development	Disability Rights Iowa	Housing Foundation for Sarpy County	Micah House
Center for Nutrition & Health Impact	Doris Lassiter Consulting, LLC	Human Services Advisory Council	Midlands African Chamber
Centering Resources	Douglas County	IBBG	Midlands Latino Community Development Corporation
Centro Latino of Iowa	Douglas County Board of Health	Ignite Nebraska	Municipal Housing Agency
Charles Drew Health Center, Inc.	Douglas County General Assistance	Immanuel Pathways Southwest Iowa	Mutual of Omaha
CHI Health	DPD	Immigrant Legal Center	NAMI Omaha
Child Saving Institute	Eastern Nebraska Office on Aging	Inspire Collaborative Health Association	NE AIDS Project
Children's Nebraska	Easterseals Nebraska	Intercultural Senior Center	Nebraska Early Childhood Collaborative
City of Council Bluffs	Education Development Center	International Council for Refugees & Immigrants	Nebraska Extension in Douglas-Sarpy Counties
City of LaVista	Empowerment Network	Iowa Child Care Resource & Referral	Nebraska Medicine
City of Omaha	Family Connections, Inc	Iowa State University Extension & Outreach – West Pottawattamie County	
City of Omaha Planning	Family Housing Advisory Services	Iowa Vocational Rehabilitation Services	
City of Papillion	FAMILY, Inc		
City of Plattsmouth			

## Organizations, *continued*

Nebraska Methodist College	One Omaha	Seventy Five North	Together
Nebraska Sports Council	OneWorld Community Health Center	SHARE Omaha	Tri City Pantry
Nebraska Urban Indian Health Coalition	Play It Forward	Sheltering Tree	Underwood Family Practice
New Life Family Alliance	Pottawattamie County	Siena Francis House	United Way of the Midlands
New Visions Homeless Services	Pottawattamie County Board of Health	Simple Foundation	UnitedHealthcare
No More Empty Pots	Pottawattamie County WIC Program	Southeast NE Community Action	University of Nebraska Medical Center
Nonprofit Assoc. of the Midlands	Premier Family Medicine	Southwest Iowa MHDS	UNMC College Of Public Health
North Omaha Area Health	Project Intentional, Inc.	Stephen Center	UNO Counseling and Psychological Services
North Omaha Community Cares Council	Region 6	Syracuse Area Health	Urban League of Nebraska
NOVA Treatment Community, Inc	ReImagine Omaha	T.E.A.M	Visiting Nurse Association
Offutt Public Health	Restoring Dignity	Teen Center	VODEC
Ollie Webb Center	Salem Baptist Church	The Empowerment Network	WhyArts
Omaha Community Foundation	Santa Monica House	The Hearing Improvement Kids Endowment (HIKE) Fund	Women's Center for Advancement
Omaha Fire Department	Sarpy County	The Jewish Federation	Women's Fund of Omaha
Omaha for Us	Sarpy/Cass Board of Health	The Kim Foundation	YMCA
Omaha Housing Authority	Sarpy/Cass Health	Threshold CoC	Youth Emergency Services
Omaha Public Power District (OPPD)	Serenity Dental		

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# Appendix

## The Acronyms Used Throughout This CHIP

This document uses a number of acronyms and abbreviations to streamline content and avoid repetition. For ease of reference, the following page provides a comprehensive list of acronyms used throughout the document along with their corresponding definitions.

<b>ACHI</b> .....	AHA Community Health Improvement
<b>CHA</b> .....	Community Health Assessment
<b>CHIP</b> .....	Community Health Improvement Plan
<b>CHW</b> .....	Community Health Worker
<b>FQHC</b> .....	Federally Qualified Health Center
<b>MCO</b> .....	Managed Care Organizations
<b>MHFA</b> .....	Mental Health First Aid
<b>PCHNA</b> .....	Pediatric Community Health Needs Assessment
<b>PHAB</b> .....	Public Health Accreditation Board
<b>RHC</b> .....	Regional Health Council
<b>PRC</b> .....	Professional Research Consultants, Inc.
<b>TWP</b> .....	The Wellbeing Partners

**DEVELOPED BY THE WELLBEING PARTNERS ON BEHALF  
OF THE REGIONAL HEALTH COUNCIL, IN COLLABORATION  
WITH REGIONAL PARTNERS**



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