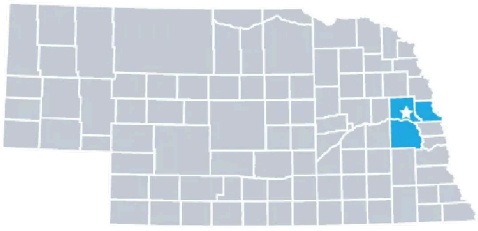
THREE RIVERS PUBLIC HEALTH DEPARTMENT

Dodge, Saunders & Washington Counties

OCTOBER 21, 2026

THREE RIVERS PUBLIC HEALTH DEPARTMENT

Community Health Improvement Plan 2026–2030



2 PRIORITIES 3 GOALS
9 OBJECTIVES
14 STRATEGIES 2 WORKGROUPS

Dodge, Saunders & Washington Counties, Nebraska

IN PARTNERSHIP WITH

Methodist Fremont Health

Be Well. Saunders Medical Center

Memorial Community Hospital & Health System
Blair • Fort Calhoun • Tekamah

PLANNING FACILITATED BY

UNMC Breakthroughs for Life.

UNMC College of Public Health, Office of Public Health Practice

OUR PLAN ON A PAGE · 2026–2030

PRIORITY 1

Mental Health

Goal 1. Improve the mental health and wellbeing of community members.

- More peer support specialists and CHWs
- Year-round mental health care for youth
- 3 youth-led substance use campaigns
- Parent education on social media and technology

PRIORITY 2

Access to Care

Goal 2. Build partnerships so services are culturally appropriate and responsive.

Goal 3. Improve preventive and primary care for rural and underserved residents.

- More bilingual providers and CHWs
- Provider recruitment in Saunders and Washington
- Insurance enrollment and fewer non-emergent ED visits

Two standing workgroups meet at least quarterly to carry out this plan, share feedback and report progress. Year 1 runs October 2026 – September 2027.

GROUNDED IN THE 2026 COMMUNITY HEALTH ASSESSMENT

886 community surveys, Jan–Apr 2026	**131** partners and residents at 3 county forums	**31** youth voices in 3 focus groups	**4** planning meetings per workgroup

Every goal in this plan traces back to what residents, partners and the data told us. The full assessment and the live data dashboard are available at threeriverspublichealth.org.

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How this plan fits together

TARGET SET IN YEAR 2 = the workgroup is setting this target now and will add it in Year 2.

- **2** Priorities
- **3** Goals
- **9** Objectives
- **14** Strategies
- **9 + 5** Strategies in action

Mental Health · Access to Care
The health issues the district chose to focus on together.

Goal 1
The long-term change we want to see.

MH-1
Measurable: who, what, by when and by how much.

MH 1.1
What partners will do to reach each objective.

YEAR 1 · YEAR 2
Nine start in Year 1 (Oct 2026); five begin in Year 2.

WHERE THIS PLAN FITS IN THE CYCLE

1	2	3	4	5
ASSESS	PRIORITIZE	PLAN	ACT	MONITOR
2026 CHA	2 priorities	This CHIP · you are here	Year 1 calendars	Quarterly + annual
Aug 2025–Aug 2026	June 2026	Summer 2026	Oct 2026 –	Ongoing

01 · A MESSAGE FROM OUR DIRECTOR

From listening to doing.

Dear partners and residents,

Our 2026 Community Health Assessment asked you what matters most for health in Dodge, Saunders and Washington Counties. You answered: 886 of you on the community survey, 131 partners and residents at our county forums, 31 young people in focus groups, and Spanish-speaking neighbors in their own language. Two priorities rose above the rest in every source: **Mental Health** and **Access to Care**.

This plan is how we act on what you told us, and it is different from our last one in three ways.

It focuses. Our 2022 plan spread our energy across fifteen county-by-county issues. This plan concentrates the whole district on two shared priorities where the need is clear and our partners have real capacity to make progress.

It connects every strategy to a result. Our workgroups built a theory of change for each priority, linking the root causes partners named to evidence-informed strategies and the changes we expect to see.

It is built to last. Two standing workgroups of community partners will keep meeting, keep reporting back and keep this plan current. Our live mySidewalk dashboard lets anyone follow the data between assessment cycles.

Some of the change we want will take a decade. That is why this plan looks ten years ahead while committing to a clear first year of action. Thank you to our workgroup members and co-leads, our Steering Committee and our hospital partners, who have already given so much. I invite you to join us.

Dr. Terra Uhing, EdD
Executive Director, Three Rivers Public Health Department

Health issues take decades to change. This plan is built for the long view, and for everyone who will carry it.

The idea behind the 2026–2030 CHIP



Two priorities. Two workgroups. One district.

02 · CREDITS AND ACKNOWLEDGEMENTS

This plan belongs to the people who built it.

Community Health Improvement Plan 2026–2030 · September 2026

PREPARED BY

Dr. Terra Uhing, EdD, Executive Director, Three Rivers Public Health Department, with the Mental Health and Access to Care workgroups and the CHA/CHIP Steering Committee.

CHA/CHIP Steering Committee

Guided the assessment using NACCHO's MAPP framework and selected the CHIP priorities on June 22, 2026.

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With gratitude.

This plan exists because partners gave their time, expertise, data and trust.

HOSPITAL PARTNERS

Methodist Fremont Health · Be Well Saunders Medical Center · Memorial Community Hospital & Health System — Blair • Fort Calhoun • Tekamah

Methodist Fremont Health, **Saunders Medical Center** and **Memorial Community Hospital & Health System** invested directly in the CHA/CHIP, which made the UNMC partnership and the mySidewalk dashboard possible. Their staff also serve on the Steering Committee and both workgroups.

ACADEMIC PARTNER

UNMC BREAKTHROUGHS FOR LIFE.

The **UNMC College of Public Health, Office of Public Health Practice** (Celeste Ehrenberg, MS, CHES; Colleen Svoboda, MPH; Dr. Katie Brandert, PhD, MPH; Dr. Anne Rogers, PhD, MPH; Dr. Brian Sims, PhD, MA; Dr. Natalia Santos, PhD, MPH) facilitated the assessment and the first four workgroup planning meetings, then handed facilitation to 3RPHD so the work continues locally.

State and regional partners

- ✓ **Nebraska DHHS Division of Public Health**, for the Accreditation Grant and the Minority Health Initiative
- ✓ **Nebraska Association of Local Health Directors**, for the mySidewalk partnership and community survey model
- ✓ **Lincoln-Lancaster County Health Department**, which developed the community survey instrument

Our community

- ✓ The **Fremont Family Coalition** and every organization at the workgroup table
- ✓ The **Three Rivers Board of Health**
- ✓ 3RPHD staff and Community Health Workers
- ✓ Every resident, young person and partner who shared their experience

> **“This is what partnership looks like: three hospitals and a public health department coming together for the good of our communities.”**
>
> Dr. Terra Uhing, EdD, Executive Director · 2026 CHA

Two priorities. Clear goals. Partners at the table.

This Community Health Improvement Plan (CHIP) turns the findings of the 2026 Community Health Assessment into shared action. It sets goals, measurable objectives and evidence-informed strategies for the district's two priorities, names who is responsible, and lays out a 12-month implementation calendar running October 2026 through September 2027.

2	3	14	2
priorities chosen from 5 top health issues	goals and 9 measurable objectives	evidence-informed strategies	standing workgroups meeting at least quarterly

Mental Health

The #1 concern residents named in the survey (611 mentions). One in three carry stress from a family member's substance use or health. Our goal is to improve the mental health and wellbeing of community members through peer support and CHWs, the CCBHC approach, year-round care for students, youth-led substance use education and healthy technology habits.

Access to Care

Cost is the top health worry, and nearly 1 in 4 residents went without care in the past year because they could not afford it. Our goals are to build partnerships that make services culturally appropriate and responsive, and to improve access to preventive and primary care for rural and underserved residents.

How we'll know

Two standing workgroups meet at least quarterly and report progress every quarter, starting in December 2026. 3RPHD tracks outcome measures on the mySidewalk dashboard and publishes an annual CHIP progress report to partners and the Board of Health.

Built on the 2026 CHA

- **886** community surveys, January–April 2026
- **131** partners and residents at 3 county forums
- **31** youth voices in 3 focus groups
- A Spanish-language focus group
- A live dashboard of ~100 data sources

> Year 1 runs **October 2026 – September 2027**. Nine strategies start in Year 1; five are scheduled to begin in Year 2.

04 · PART 1 · BACKGROUND

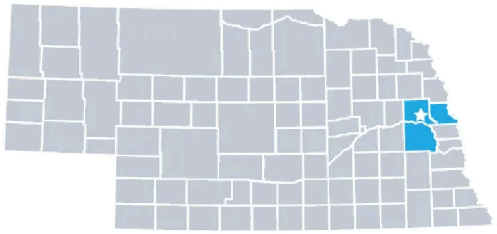
Our community.

Where we live, who we are and what shapes our health.

The community this plan serves

Three Rivers Public Health Department (3RPHD) serves Dodge, Saunders and Washington Counties in eastern Nebraska, a district of 81,505 residents anchored by Fremont, Wahoo and Blair. The district borders the Omaha metro yet remains largely rural, with small towns, farms and long drives to specialty care. The CHIP covers the full 3RPHD jurisdiction, the same community defined in the 2026 CHA.

Three Rivers is home to 81,505 people, up about 4% since 2012. Residents are slightly older than Nebraska overall, household incomes are higher and unemployment is low. The Hispanic/Latino population has grown about 58% since 2012 and makes up 18% of Dodge County.



Dodge, Saunders and Washington Counties in eastern Nebraska

81,505
residents

3
counties

WHO WE ARE	THREE RIVERS	NEBRASKA	DODGE	SAUNDERS	WASHINGTON
Population	**81,505**	1,978,707	37,351	23,048	21,106
Median age	**41.1**	37.1	38.9	40.4	42.6
Ages 65+	**19%**	16.7%	19.1%	18.5%	19.2%
Hispanic or Latino	**9.9%**	12.7%	18%	2.8%	3.3%
Limited English proficiency (5+)	**3.5%**	5.4%	6.9%	1%	0.4%
Living with a disability	**12.1%**	12.3%	13.9%	10.5%	10.7%
Median household income	**$88,102**	$76,475	$74,329	$94,066	$94,396
Uninsured adults 19–64	**8%**	10.1%	10.2%	6.8%	5.5%
Food insecurity (2023)	**—**	14.5%	14.6%	12.1%	11.7%
Renters paying 30%+ for housing	**35.7%**	41.9%	31.9%	37.2%	47%

Sources: U.S. Census Bureau ACS 5-year 2020–2024; Feeding America Map the Meal Gap 2023. From the 3RPHD CHA/CHIP Dashboard.

Who is most affected

Spanish-speaking and immigrant families

Nearly 7% of Dodge County residents have limited English proficiency. Partners named language and cultural barriers, and workplace barriers, as root causes of poor access.

People without insurance

About 8% of working-age adults are uninsured, rising to 10.2% in Dodge. Only about 70% of American Indian and Alaska Native residents have coverage.

Youth

Students describe stress, bullying, vaping and a shortage of trusted adults. Many “don’t” seek help.

Rural residents and older adults

19% of residents are 65+. Rural distance, limited public transit and provider shortages in Saunders and Washington make care harder to reach.

Renters and low-income households

More than 1 in 3 renters spend 30% or more of income on housing (47% in Washington). Dodge County reported the highest hardship on every survey measure.

Community strengths

- ✓ Three hospitals that invested directly in the CHA/CHIP
- ✓ Small-town connection: schools, churches and community events
- ✓ Bilingual CHWs and trusted messengers
- ✓ CCBHC services and school-based therapy already underway
- ✓ A live data dashboard 3RPHD now owns
- ✓ Higher-than-state household income and low unemployment

Community challenges

- ! Fewer primary care, mental health and dental providers than the state
- ! Cost of care, even for insured residents
- ! Rural distance and limited transportation
- ! Stigma and a “tough it out” culture around mental health
- ! Youth stress, vaping and technology overuse
- ! Language and health-literacy barriers

What is a CHIP?

> **A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process.**
>
> Public Health Accreditation Board, Acronyms and Glossary of Terms, Version 2022

The CHIP is the second half of a single cycle. The Community Health Assessment (CHA) told us *what* most affects health in our district. The CHIP says *what we will do about it, together*.

No one organization can move these issues alone. This plan gives hospitals, schools, nonprofits, funders, faith communities, employers and Three Rivers Public Health Department one shared set of goals. Partners may use different strategies, but we are all working toward the same results.

Major themes from the 2026 CHA

The dashboard's secondary data pointed to five issues, which forums, surveys and focus groups then explored.

1
Access to care
Cost, insurance, provider shortages and transportation came up in every forum.

2
Mental health
Limited providers, financial barriers and the need for crisis resources.

3
Chronic disease
Gaps in prevention; obesity (40%) and high blood pressure (35%) above the state.

4
Housing
A cross-cutting issue, especially for people with disabilities or mental health needs.

5
Youth well-being
Technology, self-regulation and the need for trusted adults and safe spaces.

How the priorities were chosen

All forum participants were invited to a partner webinar on June 9, 2026. Beforehand, each received an issue brief for all five health issues combining dashboard data, survey and focus group findings, forum themes and existing community assets. Partners then ranked the issues in a survey using two criteria, and on June 22, 2026 the Steering Committee chose the two with substantial need across multiple data sources and real capacity for progress.

Youth well-being, which tied for top investment at the forums, is carried into the Mental Health priority through strategies for students, youth-led education and healthy technology habits.

CRITERION 1

The data show it is a problem.

CRITERION 2

The region has the capacity to address it.

IF YOU HAD $5,000 TO INVEST… (FORUM AVERAGE)



How we built this plan.

From kickoff in August 2025 to a plan in September 2026, and a first year of action starting in October.

AUG 2025
Kickoff
Steering Committee convened; CHA restructured using NACCHO's MAPP framework

OCT 2025
UNMC joins
UNMC College of Public Health begins co-designing the assessment

JAN–APR 2026
Listen
886 surveys, 3 county forums (131 people), youth and Spanish-language focus groups

JUNE 9, 2026
Partner webinar
Final CHA findings and issue briefs shared; partners rank priorities

JUNE 22, 2026
Priorities chosen
Steering Committee selects Mental Health and Access to Care

SUMMER 2026
Workgroups plan
Two workgroups hold four UNMC-facilitated planning meetings to build this plan

OCT 2026
Year 1 begins
Plan approved; 3RPHD leads the workgroups; first quarterly update in December

Four workgroup planning meetings

3RPHD formed two workgroups of 8–10 partners each, one per priority, with co-leads that include one person from 3RPHD. UNMC facilitated four planning meetings for each workgroup to build a theory of change, choose evidence-informed strategies, write goals and objectives, and create a 12-month implementation calendar. 3RPHD now facilitates the workgroups going forward.

MEETING 1
3 hours · in person
Confirm a theory of change for the priority and brainstorm evidence-informed strategies.

MEETING 2
2 hours · virtual
Confirm strategies, finish the theory of change and discuss resources needed.

MEETING 3
2 hours · virtual
Write goals and SMART objectives.

MEETING 4
3 hours · in person
Build 12-month implementation calendars and coordination agreements.

HOW TO READ A THEORY OF CHANGE

Starting conditions
Problems, gaps and assets

If we...
Strategies

Then people will...
How much did we do?

Resulting in...
How well did we do it?

And creating...
Is anyone better off?

What's different this time.

Our 2022 plan was a solid start. This plan was designed to be sharper, more connected and easier to track.

	2022 CHIP	2026–2030 CHIP
Scope	15 issues set county by county	**2 district-wide priorities**
Time horizon	3 years	**10-year horizon; first stage 2026–2030**
How strategies were chosen	Facilitated county meetings	**Theory of change linking root causes to results**
Who does the work	3RPHD with partners	**Two standing partner workgroups with co-leads and strategy leads**
Data for tracking	Static CHA tables	**Live mySidewalk dashboard**
Action plan	Strategy lists	**Quarter-by-quarter calendar with named leads and resources**

From 15 county issues to 2 shared priorities

DODGE · 2022

- Diversity, equity & inclusion in healthcare
- Behavioral health
- Barriers to care
- Unhealthy lifestyles
- Affordable housing

WASHINGTON · 2022

- Behavioral health
- Access to healthcare
- Senior wellbeing
- Youth wellbeing
- Awareness of affordable wellness
- Obesity

SAUNDERS · 2022

- Behavioral health
- Physical activity / obesity
- Health education & collaboration
- Access to health services

DISTRICT-WIDE · 2026–2030

Mental Health Access to Care

Behavioral health and access were priorities in all three counties in 2022. Now the whole district works on them together.

Part of something bigger.

This plan connects local work to national goals and to the core functions every public health department carries out.

Aligned with national priorities

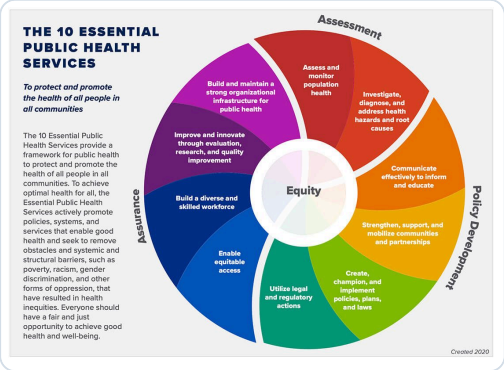
Our objectives connect to Healthy People 2030, the national framework for health improvement, so local progress contributes to national goals.

PRIORITY	HEALTHY PEOPLE 2030 TOPICS	RELATED NATIONAL OBJECTIVES
Mental Health	Mental Health and Mental Disorders; Drug and Alcohol Use; Adolescents	Reduce the suicide rate; increase treatment for people with depression; reduce adolescent substance use
Access to Care	Health Care Access and Quality; Health Insurance; Preventive Care	Increase the proportion of people with health insurance; increase the proportion of people with a usual primary care provider; increase cancer screening

Our work in action: the 10 Essential Public Health Services

The national framework that guides every public health department, with equity at its center. This plan puts six of the ten services into practice.

1. **Assess and monitor population health**
   Outcome measures and dashboard indicators for every objective
4. **Strengthen, support and mobilize communities and partnerships**
   Two standing workgroups; Fremont Family Coalition; Find Help
5. **Create, champion and implement policies, plans and laws**
   This plan; sustainability plan for CHW funding
7. **Assure an effective system that enables equitable access**
   Bilingual providers, insurance enrollment, mobile and workplace clinics
8. **Build and support a diverse and skilled workforce**
   Peer support specialists, CHWs and provider recruitment
9. **Improve and innovate through evaluation and quality improvement**
   Annual review; quality improvement referrals



The 10 Essential Public Health Services (2020). CDC and the Public Health National Center for Innovations.



05 · PART 2 · PRIORITY 1

Mental Health

Background and rationale

What is mental health?

Mental health includes our emotional, psychological and social well-being. It shapes how we think, feel, handle stress, relate to others and make choices. Anyone can experience poor mental health, with or without a diagnosed condition, and one in five U.S. adults struggles with their mental health at some point. This priority also covers substance use and youth well-being, which partners and young people tied closely to mental health.

611

mentions: the #1 “top health concern” in the survey

32%

of residents stressed by their own or a family member’s substance use or health

Why is it a concern for Three Rivers?

Mental health was the most-named concern in every community voice we heard, and the data show the need. Provider shortages in Saunders and Washington Counties mean many residents who need help cannot get it quickly, and young people say stigma and not knowing where to go keep them from asking.

Adult mental health (CDC PLACES 2023)

DIAGNOSED DEPRESSION

Three Rivers	17%
Nebraska	18.4%

FREQUENT POOR MENTAL HEALTH

Three Rivers	13.4%
Nebraska	14.4%

Similar to the state, but it means nearly 1 in 5 adults has experienced depression.

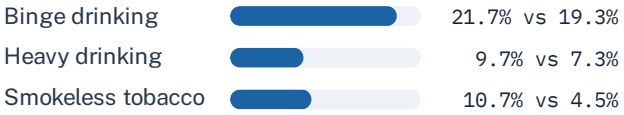
People per mental health provider (2025)

Nebraska	266
Dodge	402
Washington	2,345
Saunders	2,561

Higher = fewer providers. Saunders and Washington residents have about one-tenth the mental health provider availability of the state. Source: NPPES.

Adult substance use (NE BRFSS 2022)

THREE RIVERS VS NEBRASKA



All three are above the state, and higher among men.

Youth (NRPFSS 2023)

~45% of 12th graders reported depression*

50%+ of 8th, 10th and 12th graders were bullied in the past year

29.5% of 12th graders drank alcohol in the past 30 days (26.0% statewide)

*Just under 40% of 10th graders. Excludes Dodge County, where data were not available.

Dodge 35.1%, Saunders 28.5% reported added stress from substance use or health (community survey, 2026). Suicide: 13–17 deaths per 100,000 across the counties, similar to Nebraska's 15 (2019–2023). Drug overdose deaths are below the state but trending upward in all three counties.

What we heard

"Everyone is spending too much time on social media."

SAUNDERS COUNTY FORUM PARTICIPANT

"Willingness of people to reach out for care."

WASHINGTON COUNTY FORUM PARTICIPANT, ON STIGMA

Asked who they could turn to: "Does my dog count?"

YOUTH FOCUS GROUP PARTICIPANT

Root causes partners named

- The pace and stress of life
- Few coping strategies; "tough it out" norms
- Social isolation
- Stigma about asking for help
- Screens as a coping mechanism
- Provider shortages and low reimbursement
- No after-hours or urgent mental health care
- Easy access to vapes and unregulated substances

What partners and youth told us

- **Access is the #1 barrier.** Workforce shortages, especially providers and services for kids (pediatric providers, services in schools).
- **Special populations.** Unhoused residents, people at greater risk for suicide and people needing long-term care.
- **Cost.** Insurance coverage for mental health is limited, and reimbursement is lower.
- **Devices and social media.** Screen time and social media are hurting youth, and school phone rules are not enforced consistently.
- **Stigma.** People are reluctant to reach out; youth don't know where to go.
- **Inability to cope.** Anxiety, suicide, drug use and burnout came up in all three counties.

Assets we can build on

A full list by county is in Appendix A.

- CCBHC implementation
- Youth Mental Health First Aid
- QPR training
- Mobile crisis response
- Voluntary Crisis Response Center
- School-based therapy
- Credible Mind
- 988 Lifeline
- Region 6 Behavioral Healthcare

Goals and objectives framework.

One goal, four objectives and seven strategies, built by the Mental Health workgroup. Where a target reads “set in Year 2,” the workgroup is gathering baseline data now and will add the target to the plan in Year 2.

Goal 1 — Improve the mental health and wellbeing of community members.

MH-1 By 2036, increase the number of community health workers and peer support specialists available to support community members by `target set in Year 2`.

- MH 1.1 — Increase use of peer support and community health workers to help people connect to needed services
- MH 1.2 — Expand the Certified Community Behavioral Health Clinic (CCBHC) approach in our region
- MH 1.3 — Educate providers and other key audiences about CCBHC and associated services and opportunities

MH-2 By 2036, increase opportunities for youth to access mental health care and supports consistently throughout the year by `target set in Year 2`.

- MH 2.1 — Improve continuity of mental health care for students, so youth who receive services at school continue to receive them during the summer
- MH 2.2 — Implement youth-focused mental health interventions and activities: youth mental health classes (3RPHD), taking mental health activities to where people are (schools, primary care sites, churches) and intergenerational activities

MH-3 By 2036, increase the number of youth-led substance use education campaigns from 0 to 3.

- MH 3.1 — Launch a youth-led campaign to educate young people about emerging substance use and mental health topics (e.g., unregulated products and tainted substances)

MH-4 By 2036, increase the number of information and education efforts that help parents understand the impact of social media and technology on mental health by `target set in Year 2`.

- MH 4.1 — Share the impact of social media on mental health and wellbeing and promote healthy technology habits: partner with schools and PTOs to reach parents, provide region-wide education and disseminate current research

POPULATION INDICATORS WE WILL MONITOR

- Adult depression (17% diagnosed, CDC PLACES 2023)
- Frequent poor mental health (13.4% of adults)
- Youth depression and anxiety (Nebraska Risk & Protective Factor Student Survey)
- Youth and adult substance use, including vaping and 12th-grade alcohol use (29.5%)
- Suicide and drug overdose deaths

Theory of change.

How each strategy connects a starting condition to the change we want to see.

PATHWAY 1 Rates of depression and poor mental health

- High levels of stress and pressure are contributing to depression and poor mental health among adults and youth.
- Limited coping skills and stigma around seeking help contribute to depression and poor mental health.
- Social isolation and reduced meaningful connection are contributing to depression and poor mental health.

If we...	Then people will...	Resulting in...	And creating...
• Increase use of peer support and community health workers to connect people to services • Expand the CCBHC approach in our region • Implement youth-focused interventions: youth mental health classes, activities where people are, intergenerational activities	• Connect to needed services • Benefit from stronger provider partnerships (referrals and collaboration) • Have more peer support specialists and youth peer support • Access wraparound services • Engage in person and in community	• Improved coping skills and emotional regulation • Decreased social isolation; increased connectedness • Reduced stigma; normalized talk about mental health • More people recognize when they or others need help and seek support	• Decreased mental health stigma • Lower rates of depression and anxiety (adult and youth) • Less harm from the stress of busy lives • Healthy, connected and resilient communities

PATHWAY 2 Access to mental health care and provider availability

- A shortage of mental health providers limits timely access to care across the region.
- Gaps in services leave some populations without the care and support they need.
- Financial and system barriers (insurance coverage, limited evening and weekend hours) reduce access.

If we...	Then people will...	Resulting in...	And creating...
• Increase use of peer support and community health workers • Ensure youth who receive mental health services at school continue them during the summer • Educate providers and key audiences about CCBHC services and opportunities	• Connect to mental health services more quickly • Maintain continuity of care • Maintain emotional stability and wellness • Receive services in community settings	• Reduced wait times for care • Improved access to mental health services • Increased service utilization	• Timely mental health care • Fewer unmet mental health needs • Improved mental health outcomes • Increased peer support • A healthier school community

PATHWAY 3

Substance use

- Easy access to vaping products, alcohol and other substances contributes to youth use.
- Norms that treat substance use as normal increase the likelihood youth will experiment.
- Some youth use substances to cope with stress, anxiety and other challenges.
- Emerging and unregulated substances increase health risks.

If we...	Then people will...	Resulting in...	And creating...
• Launch a youth-led education campaign on emerging substance use and mental health topics (e.g., unregulated products and tainted substances)	• Gain knowledge and skills about substance use topics • Talk about substance use and mental health with less stigma • Parents gain knowledge about substances and how to support youth	• More communication with trusted adults about substance use and mental health	• Reduced youth vaping and substance use • More healthy coping strategies among youth • Delayed initiation of substance use

PATHWAY 4

Social media and technology

- Social media and technology use can harm youth mental, emotional and physical well-being.
- Many youth and adults struggle to self-regulate technology use, affecting attention and relationships.
- Inconsistent expectations and enforcement of technology policies make it hard to reduce harm.

If we...	Then people will...	Resulting in...	And creating...
• Share the impact of social media on mental health and promote healthy technology habits • Partner with schools and PTOs to inform parents • Provide region-wide education and share current research	• Know more about technology's impact on mental health and wellbeing • Build skills for healthy technology use	• Better self-regulation of technology • More parent and family engagement • More balance between online and offline life	• Greater awareness of social media's impact • Healthier technology habits • Fewer mental health harms from excessive technology use

Who's doing the work

The Mental Health workgroup is co-led by Anne Garinger (Three Rivers Public Health Department) and Kay Meints (Methodist Fremont Health), with a named lead for each Year 1 strategy. The group meets at least quarterly (more often while getting started), both virtually and in person, and may rotate meetings around the region. Anne Garinger schedules meetings and notifies participants. The group will set up a shared virtual workspace for coordination and documentation, and will connect with coalitions that already exist rather than duplicating them.

Why these first?

Year 1 builds the foundation: knowing where peer support and CHWs already exist, making sure providers understand CCBHC services, and mapping school mental health resources so students do not lose care over the summer.

Watching, not just doing

The workgroup will also monitor population measures it cannot move alone, including rates of depression, anxiety and substance use among adults and youth.

What they asked for

More people as the work grows, a shared workspace, and a plan to tell other providers and partners about the work after the first quarter.

Year 1 action plan.

12-month implementation calendar, October 2026 – September 2027.

STRATEGY · LEAD · RESOURCES	Q1 OCT–DEC 2026	Q2 JAN–MAR 2027	Q3 APR–JUN 2027	Q4 JUL–SEP 2027
MH 1.1 **Increase use of peer support and community health workers** LEAD Anne Garinger and Stephanie Gardeman (Three Rivers Public Health Department) RESOURCES Existing assessment tools; staff time	Create an assessment tool to document current availability of and resources for peer support and CHWs across the 3 counties	Complete the assessment across all 3 counties (documented). Celebrate!	Review assessment data to find gaps and saturation; choose strategies to improve utilization	Implement strategies to improve utilization
MH 1.2–1.3 **Expand the CCBHC approach by educating providers and key audiences** LEAD Heather Bird (Lutheran Family Services) RESOURCES Staff time	Identify key audiences and regular meetings in each county; build a presentation schedule; create talking points and a train-the-trainer for partners	Provide education opportunities (all 3 counties included)	Provide education opportunities (all 3 counties included)	Provide education opportunities (all 3 counties included)
MH 2.1 **Improve continuity of mental health care for students, including summer** LEAD Ted DeTurk (Three Rivers Board of Health); Kay Meints (Methodist Fremont Health) RESOURCES Staff time	Define key school mental health resources and initiatives in our 3 counties (landscape analysis)	Meet with ESU 2 to learn about its school mental health initiatives and share this strategy; bring findings to the workgroup and decide next steps	Next steps set by the workgroup based on Q2 findings	Next steps set by the workgroup based on Q2 findings
Planned for Year 2 Oct 2027–Sep 2028. Lead and resources to be named when the workgroup builds its Year 2 calendar.	MH 2.2 Implement youth-focused interventions and activities	MH 3.1 Launch a youth-led substance use education campaign	MH 4.1 Share the impact of social media and promote healthy technology habits	

A key milestone is a significant moment, deliverable or event that signifies progress.



06 · PART 2 · PRIORITY 2

Access to Care

Background and rationale

What is access to care?

Access to care means being able to get the right health care, at the right time, at a cost people can afford, from providers they can reach and understand. Getting the care we need helps us stay healthy, catch problems early and live longer. It also means fewer lost days of work, school and income.

Why is it a concern for Three Rivers?

Cost was the most common health worry in the community survey, and nearly one in four residents skipped care because of it. Our district has fewer primary care doctors per resident than the state, and Saunders and Washington Counties have far fewer mental health providers and dentists. Partners pointed to insurance barriers, transportation, health literacy and, in Dodge County, language and cultural barriers.

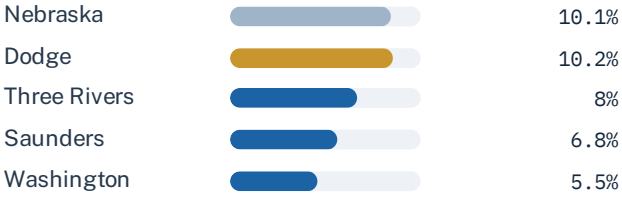
23%

skipped care in the past year because of cost

307

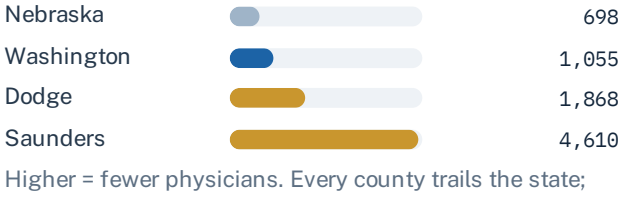
mentions: the #2 “top health concern” in the survey

Uninsured adults 19–64 (ACS 2020–2024)



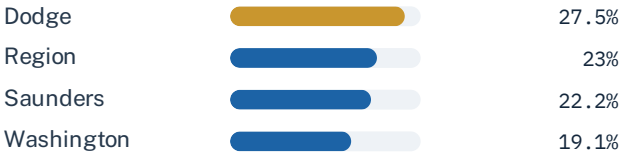
Coverage is lowest among American Indian and Alaska Native (70%), Black (74%) and Hispanic/Latino (81%) residents, compared with 96% of White residents.

People per primary care physician (2025)



Higher = fewer physicians. Every county trails the state; Saunders has one primary care physician for every 4,610 residents. Source: NPPES.

Skipped care because of cost (survey, 2026)



Share who agreed they had not received care (e.g., skipped medications or appointments) for financial reasons in the past 12 months.

Preventive care

76% of adults had a routine checkup last year, similar to the state

~40% of women 65+ are up to date on core preventive services

51% of men 65+ are up to date (CDC BRFSS)

Rates are similar to Nebraska, which means a large share of older adults miss recommended flu shots and cancer screenings.

What we heard

"Insurance is driving health decisions."

SAUNDERS COUNTY FORUM PARTICIPANT

"Healthcare is expensive, even with insurance."

DODGE COUNTY FORUM PARTICIPANT

"A doctor's visit will run an individual $300+ for just one visit. People can't afford that when it could go toward rent, utilities or groceries."

SURVEY RESPONDENT

Root causes partners named

- High costs, even with insurance
- Medicaid gaps and confusing enrollment
- Too few providers; few accept Medicaid
- Recruitment and retention challenges
- Rural distance; no public transit in much of the district
- Language barriers and medical jargon
- Low health literacy and system navigation
- Past negative experiences and mistrust

What partners told us

- **Insurance barriers.** Uninsured residents, Medicaid policy, lapses when people lack a permanent address, and a confusing ACA exchange.
- **Cost of care.** Patients cannot pay at the time of care; prescriptions cost too much.
- **Provider access.** No medical home, long waits, limited hours, and gaps in crisis mental health (Dodge) and labor and delivery (Saunders).
- **Transportation.** Affordability, limited hours and range of medical transit, and support for people with mobility issues.
- **Health literacy.** Knowing what level of care is needed and where and when to get it.
- **Language and culture.** In Dodge County, language and cultural barriers limit access.

Assets we can build on

A full list by county is in Appendix A.

- Sliding-scale fees
- Low/no-cost 3RPHD screenings
- Bilingual staff and interpreters
- Medicaid sign-up help
- Fremont Transit
- Volunteer drivers
- Urgent and minor care clinics
- Expanding specialists at MCH
- Health fairs and Lunch & Learns
- Find Help platform
- Senior Life Solutions

Goals and objectives framework.

Two goals, five objectives and seven strategies, built by the Access to Care workgroup. Where a target reads “set in Year 2,” the workgroup is gathering baseline data now and will add the target to the plan in Year 2.

Goal 2 — Build community partnerships in order to make services culturally appropriate and responsive to patient needs.

AC-1 By 2036, increase community member access to bilingual providers in Dodge County by `target set in Year 2`.

- AC 1.1 — Expand the number of providers and community health workers (CHWs) who can provide culturally and linguistically appropriate services
- AC 1.2 — Build relationships and awareness of services with the community through various channels

AC-2 By 2036, increase recruitment of providers in Saunders and Washington Counties by `target set in Year 2`.

- AC 2.1 — Create a sustainability plan that includes funding for CHWs

AC-3 By 2032, increase rates of chronic disease screenings among adults 65 and older by `target set in Year 2`.

- AC 3.1 — Collaborate with community partners already doing access-to-care work and ensure everyone is at the table

Goal 3 — Improve access to preventive and primary healthcare services for rural and underserved populations.

AC-4 By 2030, increase Medicaid or health insurance enrollment and utilization among eligible uninsured residents by `target set in Year 2`.

- AC 4.1 — Utilize community health workers to support insurance enrollment, care navigation, outreach, services and follow-up

AC-5 By 2032, reduce non-emergent emergency department visits among residents within the jurisdiction by `target set in Year 2`.

- AC 5.1 — Partner with workplaces to provide onsite clinical services
- AC 5.2 — Implement mobile clinics to provide clinical services at community organizations

Theory of change.

How each strategy connects a starting condition to the change we want to see.

PATHWAY 1 Health insurance and cost of care

- The cost of care, competing financial priorities and gaps in coverage make it hard for many residents to get preventive, routine and needed care.
- Language barriers, low health literacy and complex systems keep some residents from affordable services and continuous coverage.
- Medicaid eligibility gaps and coverage disruptions hit vulnerable and historically underserved populations hardest.

If we...

- Expand providers and CHWs who offer culturally and linguistically appropriate services
- Collaborate with partners already doing this work and ensure everyone is at the table
- Build relationships and awareness of services through various channels
- Create a sustainability plan that includes funding for CHWs

Then people will...

- Have increased access to bilingual providers
- Connect to services with completed referrals and standard points of connection
- Understand and enroll in health insurance
- Make and keep appointments; attend routine exams
- Manage chronic conditions; feel empowered and comfortable seeking care

Resulting in...

- Stronger partnerships and two-way referrals among providers
- More appointments kept
- More screenings; fewer late-stage cancers
- Less ER use for primary care needs
- Better language and cultural access; more trust in the healthcare system

And creating...

- Accessible, comprehensive care: affordable, appropriate levels of care and wraparound services
- A sustainable health system and workforce, with appropriate use of services

PATHWAY 2 Provider availability

- Limited primary care, dental and behavioral health providers reduce timely access across the region.
- Provider shortages, long waits and limited Medicaid participation create barriers, especially for underserved residents.
- Rural distances, transportation challenges and recruitment and retention struggles make it hard to get care close to home.

If we...

- Implement mobile clinics that provide clinical services at community organizations
- Partner with workplaces to provide onsite clinical services
- Utilize CHWs for insurance enrollment, care navigation, outreach and follow-up

Then people will...

- Access timely care closer to home or work
- Access services without transportation barriers
- Identify chronic conditions early and manage them
- Navigate care with clear communication at every literacy level
- Increase access to bilingual providers

Resulting in...

- Affordable services and Medicaid accepted across facilities
- Medicaid enrollment maintained once established
- Increased continuity of care: more touch points and closed-loop referrals
- Fewer missed appointments; fewer ED visits and hospitalizations

And creating...

- Healthier communities: better quality of life and lower chronic disease burden
- Accessible, comprehensive care for everyone

Choosing where to start.

The workgroup rated its strongest strategy ideas on impact and feasibility before building its first-year calendar.

How the workgroup weighed its options

Average member ratings, 1–5 (5 = very impactful / very easy).

	IMPACT		FEASIBILITY		COMBINED
Community partnerships		2.8		3.5	**3.2**
Mobile clinics		4.2		2.6	**3.4**
Expand telehealth	Not yet scored		Not yet scored		—

Why start with partnerships?

When asked what to work on first, the workgroup chose community partnerships: quick wins, data collection to demonstrate need, and relationships that make larger efforts possible later.

Why mobile clinics later?

Mobile clinics scored highest on impact but lowest on feasibility (funding, staffing, equipment, sustained operations). The workgroup sees them as a longer-term goal built on Year 1 partnerships, and the strategy it would most want to showcase.

Still on the table

Telehealth came up many times but was not scored. The workgroup will revisit it in Year 2.

POPULATION INDICATORS WE WILL MONITOR

- Uninsured adults ages 19–64 (8% region; 10.2% Dodge)
- Adults with a routine checkup in the past year (76.3%)
- Adults 65+ up to date on core preventive services (about 40% of women, 51% of men)
- Population per primary care physician, mental health provider and dentist, by county
- Residents who skipped care because of cost (23%, community survey)

Year 1 action plan.

12-month implementation calendar, October 2026 – September 2027.

STRATEGY · LEAD · RESOURCES	Q1 OCT–DEC 2026	Q2 JAN–MAR 2027	Q3 APR–JUN 2027	Q4 JUL–SEP 2027
AC 1.1 **Expand providers and CHWs who provide culturally and linguistically appropriate services** LEAD Three Rivers Public Health Department; hospitals RESOURCES Funding; bilingual contacts; schools	Collect data: barriers to hiring and retaining providers; number of bilingual providers by county and by specialty; languages offered	Continue data collection on bilingual providers and hiring and retention barriers	Review the data and pull out the “so what”; check with the Mental Health workgroup for a crossover approach	Prioritize barriers by feasibility and research best-practice approaches to overcome them
AC 3.1 **Collaborate with partners already doing this work and ensure everyone is at the table** LEAD Access to Care workgroup (co-leads Robert Ball and Stacie Sabatka) RESOURCES Partner time; Fremont Family Coalition; Find Help platform	Add more community partners to the Fremont Family Coalition (FFC)	Work with FFC, which leads Find Help (referral and resource platform), to learn its mission and vision	Introduce CHWs to Find Help; increase the number of agencies that have “claimed” their program on Find Help	Offer training so agencies with claimed programs know what to do and how to do it
AC 2.1 **Create a sustainability plan that includes funding for CHWs** LEAD Three Rivers Public Health Department; Fremont Area Community Foundation; hospitals; United Way RESOURCES Data collected by CHWs; health system contacts	No work this quarter (CHW hiring in progress)	Analyze and review data already collected by CHWs	Identify who needs to be at the table for a meeting with the health systems about CHW work	Prepare the presentation. Year 2: hold an initial meeting with each health system in the district
AC 5.1 **Partner with workplaces to provide onsite clinical services** LEAD United Way; all workgroup members; hospitals and other health service providers RESOURCES Contacts in each community; data	Collect data: workplaces with onsite clinical services, services offered and current utilization	Continue gathering data and put it in a format that supports strategic planning	Review all data, discuss findings and research best practices	Identify gaps, barriers and interested workplaces with key stakeholders; educate the public and employees on available services

STRATEGY · LEAD · RESOURCES	Q1 OCT–DEC 2026	Q2 JAN–MAR 2027	Q3 APR–JUN 2027	Q4 JUL–SEP 2027
AC 4.1 **Utilize CHWs to support insurance enrollment, care navigation, outreach and follow-up** LEAD Community ownership; all workgroup members RESOURCES CHWs; navigators; social workers	Continue CHW recruitment; identify where CHWs are located, their roles and each community's needs	Educate identified partners on entry points to services; build collaboration among CHWs, navigators and social workers; develop a shared definition of a CHW	Develop standardized, easy-to-access resources (e.g., findhelp.org)	Establish outreach strategies; educate the public on available resources and services
Planned for Year 2 Oct 2027–Sep 2028. Lead and resources to be named when the workgroup builds its Year 2 calendar.	AC 1.2 Build relationships and awareness of services through various channels		AC 5.2 Implement mobile clinics to provide clinical services at community organizations	

A key milestone is a significant moment, deliverable or event that signifies progress.

Who's doing the work

The Access to Care workgroup brings together 8–10 partners from health systems, public health, United Way, funders and community organizations, co-led by Robert Ball (Three Rivers Public Health Department) and Stacie Sabatka (Saunders Medical Center). The group meets at least quarterly, works through the Fremont Family Coalition and Find Help, and coordinates with the Mental Health workgroup on shared strategies such as CHWs and provider recruitment.



07 · WHERE THE PRIORITIES CONNECT

Two priorities, one system.

Mental health care is health care. Many barriers, and many solutions, are shared.

Mental Health

Peer support · CCBHC · youth care · substance use · technology

Shared

CHWs · workforce · navigation and referrals · cost and coverage · stigma and trust

Access to Care

Bilingual providers · insurance enrollment · screenings · workplace and mobile clinics

Community health workers and peer support

Both workgroups rely on CHWs. Access uses them for enrollment and navigation (AC 4.1); Mental Health is mapping and expanding them (MH 1.1).

Workforce

Provider shortages drive both priorities. Access will share its bilingual provider and recruitment findings with Mental Health in Q3 (AC 1.1).

Navigation and referrals

Find Help, the CCBHC approach and closed-loop referrals serve both goals: getting people to the right care faster.

The Access to Care calendar builds in a Q3 2027 check-in with the Mental Health workgroup. 3RPHD will share each workgroup's quarterly update with the other so shared barriers and wins travel both ways.

08 · PART 3 · MONITORING AND EVALUATION

The workgroups keep going.

How we will track progress, share what we learn and adjust the plan.

UNMC facilitated the assessment and the first four workgroup planning meetings, then handed facilitation to 3RPHD. Our commitment is to keep this work going, not write a plan and set it aside. The workgroups keep meeting after this plan is approved, and every quarter they report on what they have done so the work stays visible. Progress is tracked at three levels: the milestones in each 12-month calendar, the outcome measures tied to each objective, and the population indicators on the mySidewalk dashboard.

Quarterly update schedule

OCT 2026
Plan approved
Year 1 begins

DEC 2026
Update 1
Q1 progress

MAR 2027
Update 2
Q2 progress

JUN 2027
Update 3
Q3 progress

SEP 2027
Update 4
+ annual report

DEC 2027
Update 5
Year 2 underway

AND ON
Every quarter
Dec · Mar · Jun · Sep

Our accountability rhythm

EVERY QUARTER

Workgroups meet

Review calendar milestones; share feedback, barriers and solutions; submit a one-page progress update to 3RPHD.

EVERY QUARTER

Progress posted

3RPHD compiles updates and posts a progress snapshot on its website and the CHIP page of the dashboard.

EVERY YEAR

Annual report

3RPHD reports progress on every objective, resources leveraged, lessons learned and success stories.

EVERY YEAR

Review and revise

Workgroups set the next 12-month calendar. The plan is updated and presented to the Board of Health.

What workgroups report each quarter

- ✓ Milestones completed, on track or delayed
- ✓ Community engagement activities
- ✓ Barriers encountered and solutions tried
- ✓ Resources leveraged and donations
- ✓ Unanticipated outcomes and lessons learned
- ✓ Success stories worth sharing

3RPHD's Executive Director and Associate Public Health Director update the plan each year and present it to the Board of Health. Updated versions are posted at threeriverspublichealth.org.

When a strategy stalls

If the annual review shows no progress, 3RPHD and the workgroup explain why and choose one path:

1. Continue as planned
2. Continue, with recommended changes
3. Refer to a quality improvement project
4. Retire the strategy and replace it

Outcome measures.

Baselines are established during Year 1, and the workgroups add remaining targets in Year 2. Results and actions are completed in each annual report.

Goal 1 · Improve the mental health and wellbeing of community members

OUTCOME MEASURE	BASELINE	TARGET	DATE	MONITORED BY · FREQUENCY	DATA SOURCE	RESULTS	ACTIONS TAKEN
MH-1 · CHWs and peer support specialists available	Set Q2 2027 (county assessment)	Set in Year 2	2036	Mental Health workgroup · annually	3RPHD peer support/CHW assessment tool	*Annual report*	*Annual report*
MH-2 · Youth with year-round access to mental health care and supports	Set Year 1 (landscape analysis)	Set in Year 2	2036	Mental Health workgroup · annually	School social worker reports; ESU 2	*Annual report*	*Annual report*
MH-3 · Youth-led substance use education campaigns	0	3	2036	Mental Health workgroup · annually	Workgroup activity log	*Annual report*	*Annual report*
MH-4 · Parent education efforts on social media and technology	Set Year 2	Set in Year 2	2036	Mental Health workgroup · annually	Workgroup activity log; school and PTO partners	*Annual report*	*Annual report*
Watch: adult depression / frequent poor mental health	17% / 13.4%	Decrease	2036	3RPHD · annually	CDC PLACES via mySidewalk	*Annual report*	*Annual report*
Watch: youth depression, anxiety and substance use	NRPFSS 2023	Decrease	2036	3RPHD · each survey cycle	Nebraska Risk & Protective Factor Student Survey	*Annual report*	*Annual report*

Goal 2 · Build community partnerships so services are culturally appropriate and responsive

OUTCOME MEASURE	BASELINE	TARGET	DATE	MONITORED BY · FREQUENCY	DATA SOURCE	RESULTS	ACTIONS TAKEN
AC-1 · Bilingual providers accessible in Dodge County	Set Q2 2027 (provider inventory)	Set in Year 2	2036	Access workgroup · annually	Workgroup provider inventory; hospital partners	*Annual report*	*Annual report*
AC-2 · Providers recruited in Saunders and Washington Counties	PCP ratio 4,610:1 (Saunders), 1,055:1 (Washington)	Set in Year 2	2036	Access workgroup · annually	NPPES provider data via mySidewalk; hospital HR	*Annual report*	*Annual report*
AC-3 · Core preventive services up to date, adults 65+	Women ~40%; men 51%	Set in Year 2	2032	Access workgroup · annually	CDC BRFSS / PLACES via mySidewalk	*Annual report*	*Annual report*

Goal 3 · Improve access to preventive and primary care for rural and underserved residents

OUTCOME MEASURE	BASELINE	TARGET	DATE	MONITORED BY · FREQUENCY	DATA SOURCE	RESULTS	ACTIONS TAKEN
AC-4 · Insurance/Medicaid enrollment and utilization among eligible uninsured	8% of adults 19–64 uninsured	Set in Year 2	2030	Access workgroup · annually	ACS 5-year; CHW enrollment records; Nebraska DHHS	*Annual report*	*Annual report*
AC-5 · Non-emergent emergency department visits	Set Year 1 (hospital data)	Set in Year 2	2032	Access workgroup · annually	Hospital partner ED data	*Annual report*	*Annual report*

NPPES = National Plan and Provider Enumeration System. NRPFSS = Nebraska Risk and Protective Factor Student Survey. Population indicators are tracked on the 3RPHD mySidewalk dashboard.

09 · PART 4 · SUMMARY AND NEXT STEPS

The work continues.

A ten-year horizon, a clear first year and partners who stay at the table.

Our road ahead

OCTOBER 2026

Plan approved. Year 1 calendars begin, and 3RPHD takes over facilitation of both workgroups from UNMC.

DECEMBER 2026

First quarterly progress update from both workgroups.

Q1–Q2 2027

Workgroups establish baselines using Year 1 assessments, inventories and dashboard data. Quarterly updates in March and June 2027.

SEPTEMBER 2027

Fourth quarterly update and first annual CHIP progress report. Workgroups add the remaining objective targets to the plan and build Year 2 calendars, including the strategies marked “Year 2.”

2028–2030

Quarterly updates continue every December, March, June and September. In 2030, review the first stage of the plan alongside updated assessment data and set the next stage of the 10-year work.

Our ten-year horizon



2026
Plan launched

2027
Year 1 complete; baselines set

2030
AC-4 target; first-stage review

2032
AC-3, AC-5 targets

2036
MH-1–4, AC-1, AC-2 targets

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APPENDIX A

Community assets by county.

Programs, services and partnerships partners identified at the 2026 community forums.

Mental Health

Dodge County

- Methodist Fremont mental health facility
- CCBHC resources being implemented
- Assertive Community Treatment (ACT)
- School-based and early childhood services
- Lutheran Family Services partnering with schools
- Social-emotional supports in early care (Pyramid strategies)
- Community programs; radio mentoring show

Saunders County

- Youth and adult Mental Health First Aid (free)
- Mobile crisis response
- Credible Mind
- Providers in schools
- QPR suicide prevention training
- VA S.A.V.E. (free course)
- 988 Suicide & Crisis Lifeline
- School training on sensory needs, autism and ADHD
- Voluntary Crisis Response Center (adults)

Washington County

- Networking and collaboration with LFS (CCBHC)
- Therapist in school; yearly mental health assessments
- Psychiatrist added at Memorial Community Hospital
- Psychiatry access through Fremont
- Region 6 Behavioral Healthcare

Access to Care

Dodge County

- Sliding-scale fees; medical bill write-offs
- Low-or no-cost 3RPHD screening services
- Cost estimates shared before appointments
- Bilingual staff, medical interpreters, translated information
- Recruiting bilingual and primary care practitioners
- Fremont Transit (sliding-scale options)
- Urgent care; health fairs; community collaboration and outreach

Saunders County

- Help finding free or reduced-cost care
- Community collaborative teams
- Community education and lunch events
- Local transportation (certain days and times)
- Increased veteran care

Washington County

- Minor care clinic
- Medicaid sign-up help (hospital)
- Health fairs; free Lunch & Learn education
- Church volunteer drivers; drivers for older adults
- Senior Life Solutions
- Expanding specialists at MCH; OB outreach
- Social worker resource support; MDsave

APPENDIX B

Glossary.

CCBHC	Certified Community Behavioral Health Clinic: a clinic model that provides a full range of mental health and substance use services to anyone who needs them, regardless of ability to pay.
CHW	Community health worker: a trusted frontline worker who connects residents to health and social services, often in their own language.
Peer support specialist	A person with lived experience of mental health or substance use recovery, trained to support others.
Theory of change	A map showing how strategies ("If we…") lead to short-term results, longer-term outcomes and, ultimately, the goal.
Find Help	An online referral and resource platform (findhelp.org), led locally by the Fremont Family Coalition.
ESU 2	Educational Service Unit 2, which supports school districts in the region.
mySidewalk dashboard	3RPHD's live CHA/CHIP data dashboard, updated automatically from about 100 data sources.
PHAB	Public Health Accreditation Board, the national accrediting body for public health departments.
QPR	Question, Persuade, Refer: a suicide prevention gatekeeper training.
Non-emergent ED visit	An emergency department visit for a condition that could have been treated in primary or urgent care.

THREE RIVERS PUBLIC HEALTH DEPARTMENT
Dodge, Saunders & Washington Counties

Three Rivers Public Health Department
2400 N. Lincoln Avenue, Fremont, NE 68025 · 402-727-5396 · threeriverspublichealth.org
2026–2030 Community Health Improvement Plan · September 2026