Community Health Assessment

and

Community Health Improvement Plan

for Fillmore, Gage, Jefferson, Saline, and Thayer counties

Partners for a Healthy Community

2018-2023

Our Vision

"Healthy opportunities where we live, learn, work, and play."

Community Health Assessment/ Community Health Improvement Plan (CHA/CHIP)

35 community stakeholders from across the district signed on to form Partners for a Health Community.

Regional Steering Committee meetings were held from May through December, with over 100 hours of time provided by community stakeholders.

FOUR ASSESSMENTS WERE COMPLETED:

01 Online community health survey (offered to the community)

02 Forces of Changes assessment (completed by the Regional Steering Committee)

03 Local Public Health System assessment (completed by community partners)

04 Assessment of gathered data from a wide variety of health, wellness, and environmental indicators.

FOUR PRIORITIES IDENTIFIED:

01 Mental Health (including mental and emotional well-being and substance abuse)

02 Chronic Disease (specifically obesity, hypertension, high cholesterol, and diabetes)

03 Access to Resources and Opportunities (health equity)

04 Environmental Health (focused on safe and healthy community environments)

A new, collective vision emerged:

"Healthy opportunites where we live, learn, work, and play."

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Foreword

Public Health Solutions

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There is a tremendous power in collaboration. This Community Health Assessment and Community Health Improvement Plan is the result of more than thirty community stakeholders coming together, over a six-month period, and devoting their time and expertise to the shared goal of healthier communities. Although a community health assessment is a requirement for many of our organizations, it is, more importantly, the foundation upon which strategic planning, resource allocation, and collaborative partnerships are based.

Public Health Solutions would like to thank the Regional Steering Committee members who spent hours attending meetings, completing assessments, reviewing data, and identifying health priorities. Your work will provide direction and guidance for years to come. We look forward to working with you as we begin tracking the priority areas highlighted in this plan.

Below is a summary of the work completed and priorities identified by Partners for a Healthy Community. Thank you for your interest in the health and wellness of our communities. For more information on this plan or to become a part of this effort, please visit Public Health Solutions website at phsneb.org. All information and progress on the goals identified within and as a result of this plan will be available for review on the website.

Thank you for reviewing our plan for community health improvement. Working together, we can create healthy, thriving communities with opportunities for everyone.

Kim Showalter, RN, BSN
Health Director
Public Health Solutions

Prevent. Promote. Protect.

Serving Fillmore, Gage, Jefferson, Saline and Thayer Counties

Acknowledgements

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Nebraska Association of Local Health Directors
Public Health Solutions District Health Department

In collaboration with:
Beatrice Community Hospital and Health Center
Beatrice Public Schools
Blue River Area Agency on Aging
Blue River Women's Center
Blue Valley Community Action
Bruning-Davenport School District
Crete Area Medical Center
Crete Police Department
Crete Public Schools
Doane University
Educational Services Unit #6
Fairbury Public Schools
Fillmore County Board of Commissioners
Fillmore County Hospital
Gage County Board of Commissioners
Hebron Chamber of Commerce
Homestead National Monument
Jefferson Community Health & Life
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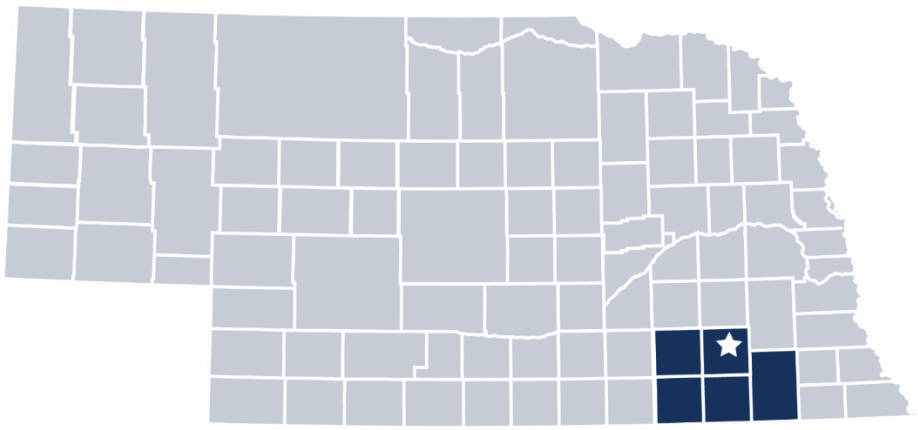
Introduction

Public Health Solutions District Health Department (PHS) serves 54,327[1] people within a five-county district comprised of Fillmore, Gage, Jefferson, Saline and Thayer counties in southeastern Nebraska. All of these counties are classified as rural counties by the Federal Office of Rural Health Policy[2].



PHS was formed in 2002 as a result of State legislation that applied Tobacco Master Settlement funds to organize local health departments statewide. The mission of PHS is to prevent disease and injury, promote wellness, and protect the personal, community, and environmental health of all people in Fillmore, Gage, Jefferson, Saline, and Thayer counties in Nebraska.

As Chief Health Strategist—who convenes coalitions that investigate and take action to make meaningful progress on complex health community issues[3]—for this five-county district, PHS conducts a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) every five years. The CHA is a process of gathering and interpreting information from multiple and diverse sources in order to develop a deep understanding of the health and wellbeing of a community/jurisdiction. The CHA process describes the current health status of the community, identifies and prioritizes health issues and develops a better understanding of the range of factors that influence and impact health. The CHIP - a five-year community-wide plan that outlines the priority health factors realized in the CHA—is developed based upon the CHA. The CHIP includes community-wide goals and objectives for addressing CHA priorities and applies evidence-based public health programs and strategies to address health priorities in the CHA. Local partners (including, but not limited to, the local public health department) use the CHIP as a strategic guide to improve community health. The CHIP includes measures that are used to show progress. This CHIP belongs to the public health system partners in Fillmore, Gage, Jefferson, Saline and Thayer counties and is coordinated by PHS.

Mobilizing for Action through Planning and Partnerships (MAPP)

Public Health Solutions (PHS) utilized the partnership-based approach and framework, Mobilizing for Action through Planning and Partnerships (MAPP), this CHA and CHIP process and incorporated pieces of this framework in previous CHAs and CHIPs. The MAPP process emphasizes input from community

[1] US Census Bureau, 2012-2016 American Community Survey 5-year estimates
[2] https://www.ruralhealthinfo.org/am-i-rural#
[3] Public Health Foundation. Becoming a Community Chief Health Strategist. Retrieved 10/17/2018 at http://www.phf.org/consulting/Pages/Becoming_the_Community_Chief_Health_Strategist.aspx

members, key stakeholders, and all sectors of the public health system to evaluate the health status of the community/jurisdiction, identify priority areas and develop action plans with evidence-informed strategies to address said priority areas.

The MAPP framework has six key phases:

1. Organize for Success and Partnership Development
2. Vision for Community Health
3. Four Assessments
   - Community Themes and Strengths
   - Forces of Change
   - Community Health Status
   - Local Public Health System
4. Identify Strategic Issues
5. Formulate Goals and Strategies
6. Take Action (Plan, Implement and Evaluate)

The CHA process incorporates MAPP phases one through four. The CHIP process incorporates MAPP phases five and six.

Organize for Success and Partnership Development

To ensure the CHA/CHIP process allowed PHS staff to participate in the processes, PHS contracted with the Nebraska Association of Local Health Directors (NALHD) to plan and facilitate the CHA/CHIP process. NALHD met weekly from February to June 2018 and bi-weekly from July to September 2018 with the Leadership Team from PHS to plan and implement the CHA process. In March 2018, NALHD conducted the Technology of Participation (ToP) Circle of Involvement activity with the PHS staff to identify public health system and community partners. This activity ensured a diverse yet strategic representation from a variety of sectors across the five-county jurisdiction. Once key stakeholders were identified, PHS staff invited these strategic partners to serve on the Regional Steering Committee (RSC) and secured letters of commitment from each. PHS designed and implemented a communication plan for the RSC and community-at-large. As a part of this communication plan, PHS dedicated a page on their website

(http://phsneb.org/regional-steering-committee/) to share documents and pertinent information generated during this process, sent regular emails to the RSC members, and used social media to promote community member participation during this process.

The RSC was convened in May 2018 comprised of 41 members (see Appendix A for a full list). This committee acted as the core community group that created a vision, conducted the Forces of Change assessment and gaps analysis, reviewed data and determined the types of data needed, determined target populations to involve and participate in the CHA/CHIP process, participated in a public health system capacity assessment, and selected strategic issues, priorities, and goals for the CHIP. The RSC met monthly until the CHA/CHIP process was complete. NALHD utilized ToP facilitation methods to facilitate these meetings. The RSC kept the following schedule:

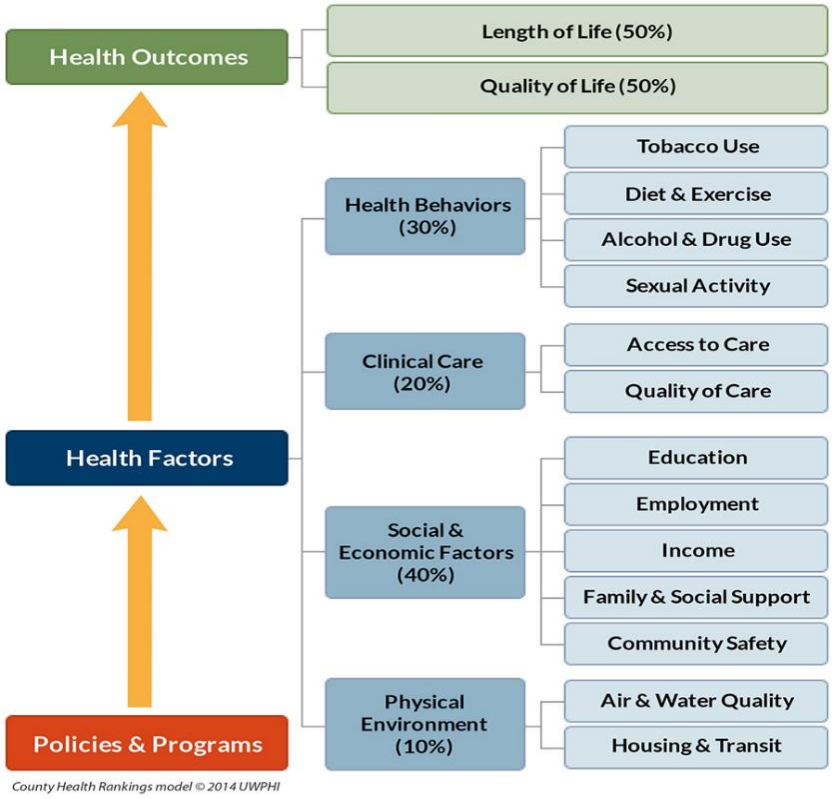
- May 17, 2018—Kick-off and Visioning Meeting held at Doane University, Crete, NE—meeting host: Public Health Solutions
- June 20, 2018—Forces of Change assessment held at Geneva Public Library, Geneva, NE—meeting host: Fillmore County Hospital
- July 26, 2018—Data plan review held at The Brewhouse, Crete, NE—meeting host: Crete Area Medical Center
- August 29, 2018—Review of data and identification of key issues held at Jefferson Community Health and Life, Fairbury, NE—meeting host: Jefferson Community Health and Life
- September 27, 2018—Presentation of data/key issues, identification of health-related priorities, development of the CHIP at Homestead National Monument, Beatrice, NE—meeting host: Homestead National Monument

County Health Rankings and Roadmaps

County Health Rankings and Roadmaps (CHRR), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin that provides reliable local data and evidence to communities to help them identify opportunities to improve their health. The RSC utilized the CHRR model as the foundation of the CHA/CHIP process to better understand the broad factors that influence health, to address health equity, and to develop programs/strategies to address health-related priorities. The CHRR[4] approach illustrates how the conditions in which we live, work, and play impact our health—often more than clinical care. Health outcomes (length of and quality of life) for a community is greatly impacted by health factors—modifiable conditions within a community—such as social and economic factors, health behaviors, physical environment, and clinical care, which in turn are influenced by local, state and national policies and programs. Figure 1 illustrates the CHRR model which demonstrates this approach to community health.

[4] County Health Rankings and Roadmaps http://www.countyhealthrankings.org/what-is-health

Figure 1. County Health Rankings and Roadmaps



Vision for Community Health

In May 2018, the Regional Steering Committee (RSC) completed a visioning process for community health. The meeting was held at Doane University in Crete, NE and served as the kick-off to the CHA/CHIP process. NALHD facilitated a ToP consensus workshop to establish the five-year vision statement that was adopted by the RSC for all five counties:

Creating healthy opportunities where we live, learn, work and play

During this workshop, the RSC was asked to brainstorm ideas to answer the following focused question: *What does a healthy community mean to you?* (see Appendix D for the full 2018 Partners for a Healthy Community Five-Year Visioning Process Results). The main factors of the five-year vision include:

- Quality Affordable Housing
- Full-Spectrum Wellness
- Community Connected Education
- Strong Families
- Safe and Thriving Communities
- Social Equity

The RSC then voted on their vision statement based upon these factors. During the CHA/CHIP process, these factors provided the guide for data collection and criteria for priority selection.

Four Assessments

As Chief Health Strategist, Public Health Solutions (PHS) provided the Regional Steering Committee (RSC) with guidance for the data collection phase of this CHA process by gathering available data and implementing a community health survey. The data gathering plan and matrix of sources were presented at the July 26, 2018 RSC meeting where the RSC members determined gaps and assisted in addressing those gaps by 1) providing data gathered from their respective organizations, 2) pushing the community survey out to community members and 3) participating in the local public health system assessment. During this meeting, the RSC decided to use the next regularly scheduled RSC meeting (August 29) as a time for interested RSC members to review the data collected from the four assessments. NALHD facilitated three, two-hour data review meetings on August 29, 2018. Group 1 reviewed the Community Health Status data. Group 2 reviewed the Community Health Survey data. Group 3 reviewed the Forces of Change and Public Health System assessments. Each group established the following criteria to ensure consistency when looking at the data and identifying key issues:

1. Degree of impact to our vision
2. Measurable
3. Common areas of need
4. Feasibility
5. Population based vs. individual impact
6. Data supported

The data gathered and reviewed for this CHA/CHIP included:

- Survey responses from the community in the five-county area to determine the **Community Themes and Strengths**. This 80-question survey assessed the communities' perception regarding the issues that are important to their health and wellbeing, the quality of life in their respective communities, and the assets they feel are important in their respective communities. This survey was available in English and Spanish and in print and online. PHS offered an incentive to increase participation.

- Results of the ToP facilitated workshop with the RSC members on June 20, 2018 held in Geneva, NE to assess the **Forces of Change**. This assessment focused on identifying forces (such as legislation, technology, environmental, social, political, and so on) that affect the context in which the community and its public health system operate.

- Data gathered from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), CHRR, American Community Survey/US Census Bureau, Centers for Disease Control, Nebraska Crime Commission, Nebraska Department of Education, US Bureau of Labor Statistics, and so on to assess the **Community Health Status**. This assessment identifies priority community health and quality of life issues and looks at the leading causes of mortality and morbidity, the general health status of community members, the disparities in health, the access and availability of behavioral and health care, etc.

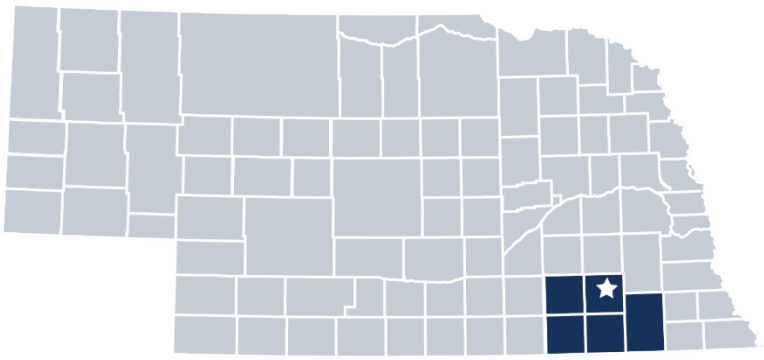
- Survey responses from the RSC members to assess the capacity of the **Local Public Health System.** An open-ended survey was developed to determine the strengths, areas of improvement, and opportunities for health and wellbeing advancement in the public health system within the five-county area.

The following sections highlight the data considered by the RSC from each of the four assessments.

Community Health Status Assessment

Public Health Solutions District Health Department District Overview

Public Health Solutions District Health Department (PHS), headquartered in Saline County, serves 54,327 [5] people within a five-county district comprised of Fillmore, Gage, Jefferson, Saline and Thayer counties in the southeastern part of Nebraska. PHS is bordered by Kansas to the south.



Since the PHS district is rural, agriculture/forestry/fishing/hunting and health care/social assistance are major economic drivers.

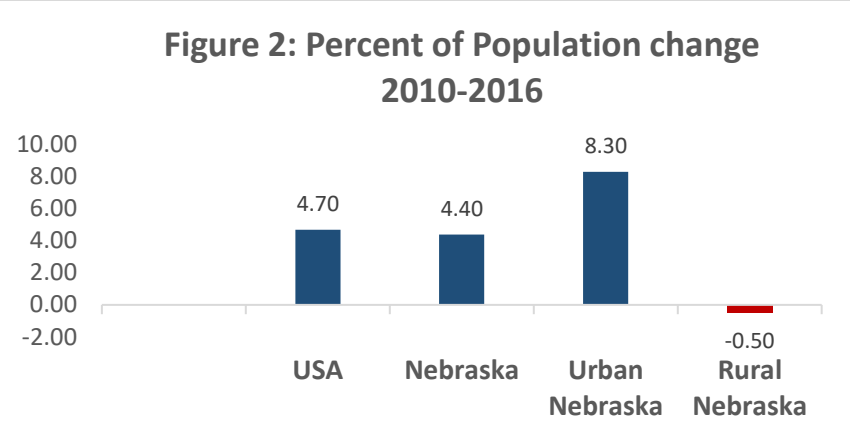
Quick Facts for PHS Region:[6]

Population (2010): **55,176**
Population Change (2000-2010): **-5.0%**
Unemployment Rate (2012-2016 avg.): **1.88%**
Total Land Area: **3,146 square miles**

Demographics

Nebraska's rural population is decreasing while the urban population is increasing. Nebraska's population in the 2016 Census was estimated at 1,907,116. This count was up 4.4% from the 2010 Census and consistent with the national increase of 4.7% during the same period. Growth has occurred in all four of the urban counties of Nebraska. Conversely 71% (63 out of 89) of the rural counties lost population during the same period. The decrease of 4,621 rural Nebraskans on the 2016 census estimates represents a 0.5% total decrease in the population living in rural Nebraska.

[5] US Census Bureau, 2012-2016 American Community Survey 5-year estimates
[6] US Census Bureau, 2012-2016 American Community Survey 5-year estimates



(US Census Quick Facts, 2016)

According to the US Census, all counties within the PHS district experienced a decrease in population (ranging from 3% to 13% decrease) between 2000 and 2010 except for Saline County, which experienced a 2.5% growth in population. Most notably, Saline County experienced a 268% increase in the Hispanic population from 2000 to 2010. Saline County's Hispanic population grew over two times faster than the Hispanic population in Nebraska within this timeframe. Nearly 1/3 of the population in Saline County in 2016 was minority--the largest minority population of all counties in the PHS district. Of the minority population in Saline County, 1 in 4 people were of Hispanic ethnicity compared to 1 in 10 people in Nebraska[7]. Nebraska has a high Hispanic growth rate, between 2005 and 2014, the Latino population growth rate was more than five times higher than the overall population growth rate (55% vs. 10%).[8] The Hispanic population represented 5.6% of the total population in Nebraska in 2000, 9.2% in 2010, and 10.4% in 2015. It is estimated that by 2025, the Hispanic population will make up nearly a quarter of Nebraska's population (23.4%). Hispanics in Nebraska are from a variety of countries, but Mexico is the primary country of origin (76%).

Median Age The average median age in the PHS district was 44.5 years in 2016, which was nearly a decade older than the average in Nebraska. Furthermore, nearly 25% of the population in Jefferson, Fillmore and Thayer counties were aged 65 and older.[9]

Socio-Economic Status

Economics According to the American Community Survey five-year estimate (2012-2016), the median household income for Nebraska is $54,384, and the median household income for the PHS region was $48,068. An average of nearly 1 in 4 children were from single family homes across the PHS region, which was less than the state average of 29%.[10] The average percentage of students eligible for free/reduced meals at schools across the PHS region was 40.2%, just below the state average of 44.0%.[11] Moreover, there were 15.2% of children living in poverty across all counties within the PHS region,

[7] US Census Bureau, 2012-2016 American Community Survey 5-year estimates
[8] University of Nebraska Omaha, Office of Latino/Latin American Studies, "*Latinos and the Economic Downturn in Nebraska*", July 2016 https://www.unomaha.edu/college-of-arts-and-sciences/ollas/_files/pdfs/publications-presentations/report-latinos-and-the-economic-downturn-2016.pdf, page 1
[9] US Census Bureau, 2012-2016 American Community Survey 5-year estimates
[10] County Health Rankings, 2017 http://www.countyhealthrankings.org/app/nebraska/2018/measure/factors/82/data
[11] County Health Rankings, 2016

which is similar to the state rate of 14%.[12] PHS regional unemployment rate was 1.88%, almost half of the unemployment rate for Nebraska (2.6%).[13] Despite the low unemployment rate across the PHS region, families in all counties still struggled to make ends meet.

Table 1: Economic Indicators	PHS region	Nebraska
Median Household Income (2012-2016)	$48,068	$54,384
Single Parent Households (2012-2016)	22.8%	29.0%
Students eligible for free/reduced meals at schools	40.2%	44.0%
Percentage of children under age 18 in poverty	15.2%	14.0%
Unemployment	1.88%	2.6%

Educational Level In terms of educational attainment, the PHS region has a higher percentage of adults that have at least a high school degree (counties within the PHS district range from 91.7% to 93.2%)[14] than state average (90.7%[15]) except for the population of Saline County (82.8%[16]), which fell below the state and national averages (87%[17]). On the contrary, Saline County (39.1%[18]), and all other counties of the PHS region (range from 33.9% to 37%)[19], surpassed the state average (33.7%[20]) for those who have completed some college or an Associate's Degree. However, the state and national average (30.3% and 30% respectively)[21] for those who have completed a Bachelor's Degree is over two times higher than the average for all counties in the PHS region (range from 8.3% to 14.5%)[22].

Table 2: Education Indicators	PHS region	Nebraska
High school graduate or higher, percentage of persons age 25+	90.5%	90.7%
Some college or Associate's Degree, percentage of persons age 25+	36.1%	33.7%
Bachelor's degree or higher, percent of persons age 25+	12.2%	30%

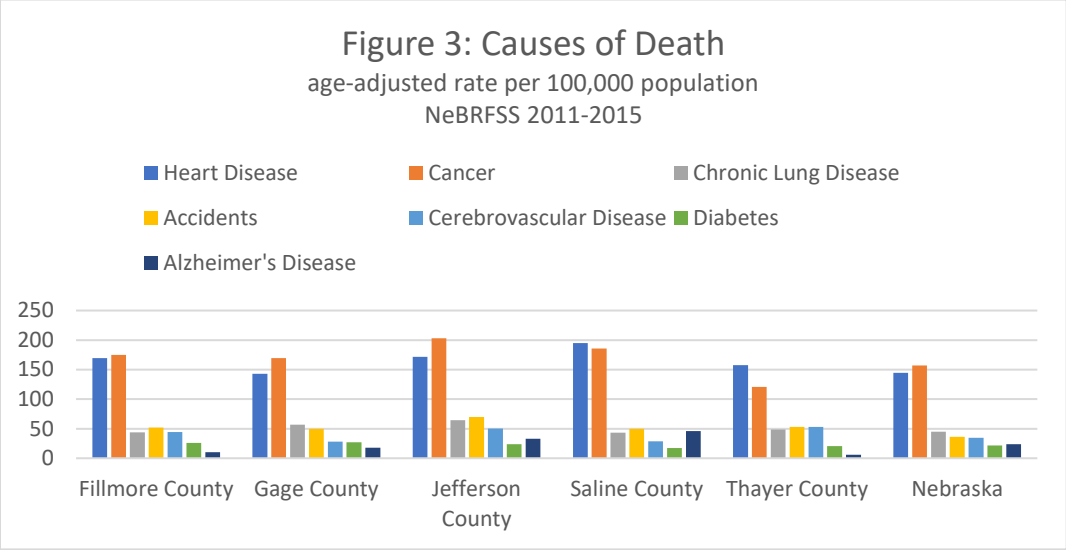
Health Outcomes

Leading Causes of Death

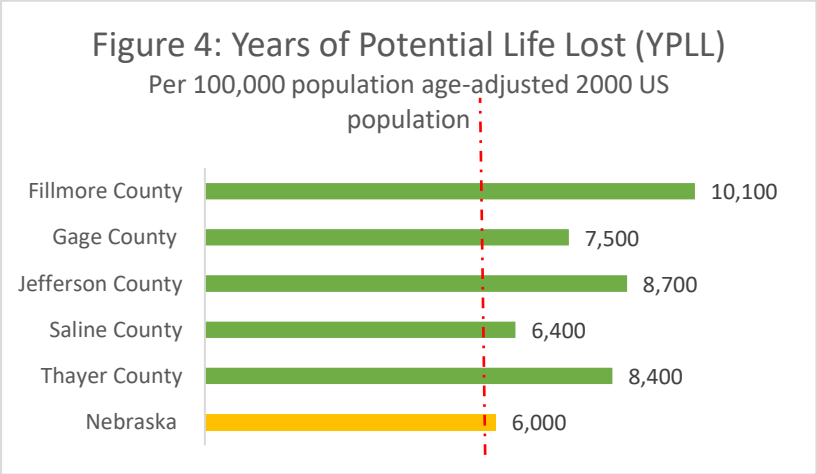
Table 3: Leading Causes of Death	
Nebraska[23]	United States[24]
1. Heart disease	1. Heart disease
2. Cancer	2. Cancer
3. Chronic lung diseases	3. Accidents (unintentional injuries)
4. Accidents	4. Chronic lower respiratory diseases
5. Cerebrovascular diseases	5. Stroke (cerebrovascular diseases)

[12] County Health Rankings, 2016, http://www.countyhealthrankings.org/app/nebraska/2018/measure/factors/24/data
[13] US Census Bureau, 2013-2017 American Community Survey 5-year estimates
[14] Western Economic Services, 2018
[15] US Census, 2012
[16] Western Economic Services, 2018
[17] US Census, 2012
[18] Western Economic Services, 2018
[19] Western Economic Services, 2018
[20] Statistical Atlas, 2015
[21] US Census, 2012
[22] Western Economic Services, 2018

Across the PHS district, leading causes of death by county within the PHS region.[23] In most cases, counties within the PHS region have higher rates of these causes of death than the state. Most all of these leading causes of death can be influenced by a healthy lifestyle and evidence-based public health strategies that include healthy eating and active living, not smoking, wearing a seatbelt and limiting alcohol consumption.



An indicator that helps communities focus on prevention is the Years of Potential Life Lost (YPLL), which is a measurement of premature mortality. YPLL is an estimate of the average years a person would have lived if he/she had not died prematurely—typically before the age of 75. YPLL emphasizes deaths of younger persons, whereas statistics that include all mortality are dominated by deaths of the elderly.[24] Figure 4[25] illustrates the average Years of Potential Life Lost for each county within the PHS region compared to the state in 2000.



[23] NE DHHS, Vital Statistics Report, 2015: http://dhhs.ne.gov/publichealth/Vital%20Statistics%20Reports/Vital%20Statistics%20Report%202015.pdf
[24] CHRR, http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-outcomes/mortality/premature-death/premature-death-ypll
[25] CHRR 2016 http://www.countyhealthrankings.org/app/nebraska/2018/measure/outcomes/1/data

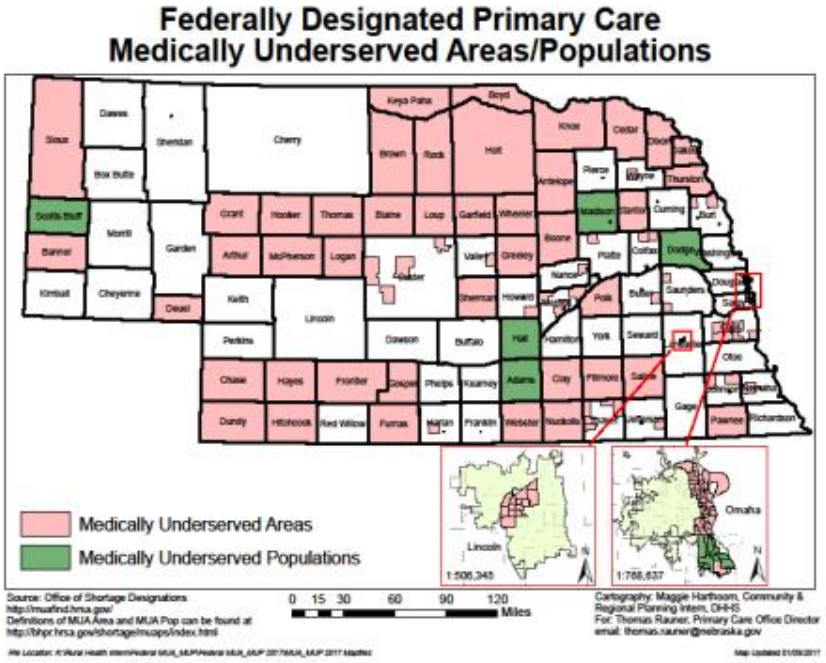
Health Care Access and Utilization

Nearly one in five adults aged 18-64 in the PHS district does not have health care coverage. Additionally, almost 40% of adults aged 18-64 in the PHS region did not get a routine check within the past year. However, only 12.2% of adults aged 18-64 stated that they needed to see a doctor but could not due to cost within the past year.

Table 4: Health Care and Mental Health Access Indicators[26]	**PHS Region**	**NE**
No health care coverage, 18-64 year olds	17.4%	16.9%
No personal doctor or health care provider	15.2%	19.3%
Has a personal doctor or health care provider (one or more than one)	84.8%	80.7%
Has a personal doctor or health care provider (one or more than one), aged 65 years and older	95.3%	95.0%
Needed to see a doctor but could not due to cost in past year	12.2%	12.3%
Had a routine checkup in past year	63.6%	61.4%

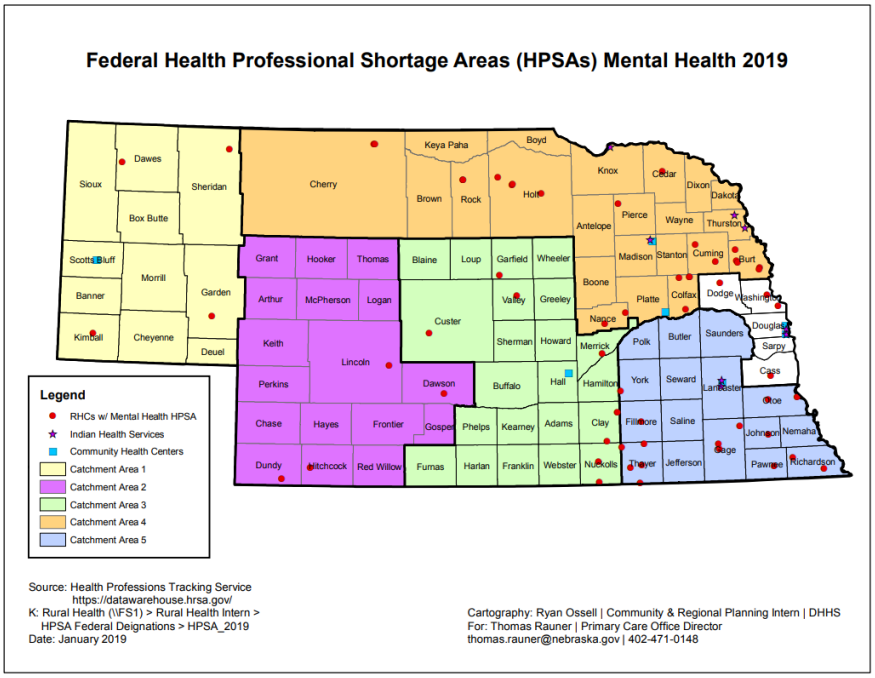
While lack of health insurance, cost of health care services and age of clientele may be contributing factors of not accessing health care, health professional shortages can compound the issue. According to the Health Resources and Services Administration (HRSA), some counties and areas within counties that comprise the PHS district were designated as Medically Underserved Areas (MUA). MUAs are "counties, a group of counties or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services." The following map (figure 5) illustrates the federal health professional shortage area for primary care across the state in 2018. Notably, all of Saline and Fillmore counties and parts of Thayer and Jefferson counties are designated as MUAs.

Figure 5



[26] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018

Across the state, there is also a shortage of mental health professionals. Access to mental health services, including behavioral health and substance use, continues to be a top priority need area for communities throughout the district.



Leading Types of Chronic Disease

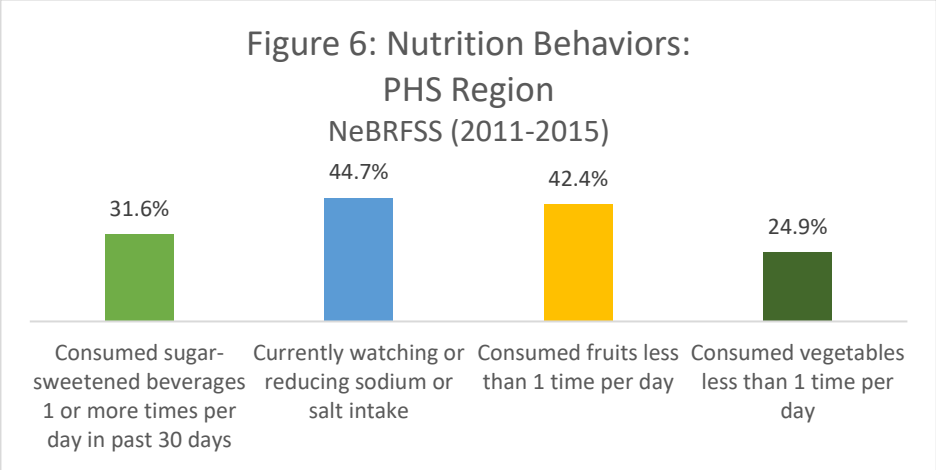
Four out of five of the leading causes of death in Nebraska were chronic diseases, i.e. heart disease, cancer, chronic lung disease and cerebrovascular disease. In addition to diabetes, these chronic diseases were the most common, costly and preventable of all health problems in the U.S.[27] Most of these leading types of chronic disease are generally preventable through a healthy lifestyle that includes healthy eating and active living, not smoking and limiting alcohol consumption. Furthermore, deaths by chronic disease comprised nearly 50% of the Years of Potential Life Lost (YPLL) among Nebraskans.[28]

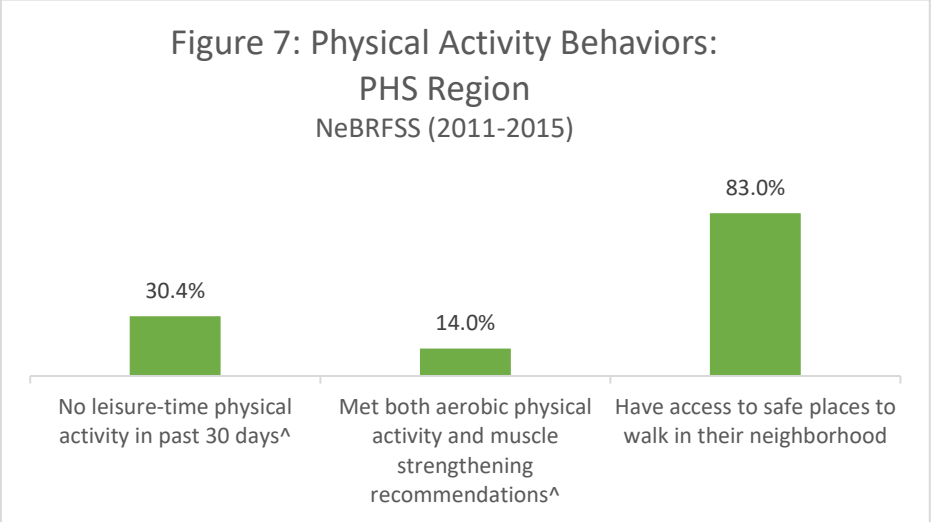
Table 5: Chronic Disease Indicators[29]	PHS Region	NE
Heart Disease		
Ever told they have high blood pressure (excluding pregnancy)	35.2%	29.6%
Currently taking blood pressure medication, among those ever told they have high BP	79.7%	78.1%
Had cholesterol checked in past 5 years	75.1%	73.6%
Ever told they have high cholesterol, among those who have ever had it checked	39.8%	36.9%
Cancer		
Ever told they have skin cancer	7.2%	5.8%
Ever told they have cancer other than skin cancer	8.4%	6.6%
Ever told they have cancer (in any form)	14.2%	11.1%

[27] NeDHHS, Chronic Disease Surveillance Report, 2011
[28] Ne DHHS, Injury in Nebraska Report 2009-2013
[29] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018

Up-to-date on colon cancer screening, 50-75 year olds	55.2%	63.3%
Up-to-date on breast cancer screening, female 50-74 year olds	70.2%	75.5%
Up-to-date on cervical cancer screening, female 21-65 year olds	80.4%	82.8%
Lung Conditions		
Ever told they have asthma	12.1%	11.6%
Currently have asthma	8.5%	7.4%
Ever told they have COPD	6.7%	5.4%
Overweight/Obese		
Obese (BMI=30+)	34.0%	29.6%
Overweight or Obese (BMI=25+)	70.3%	65.8%

According to the Nebraska BRFSS, healthy eating and active living was not a routine behavior for many people in the PHS district. Nearly 50% of the population in this area consumed fruits less than 1 time per day and nearly 25% consumed vegetables less than 1 time per day. Despite the majority of people in the PHS region who indicated that they had access to safe places to walk in their neighborhoods, nearly a third reported no leisure-time physical activity in the past 30 days, and 85% of people in this region did not meet both aerobic physical activity and muscle strengthening recommendations. Healthy eating and active living are imperative to prevent chronic disease.

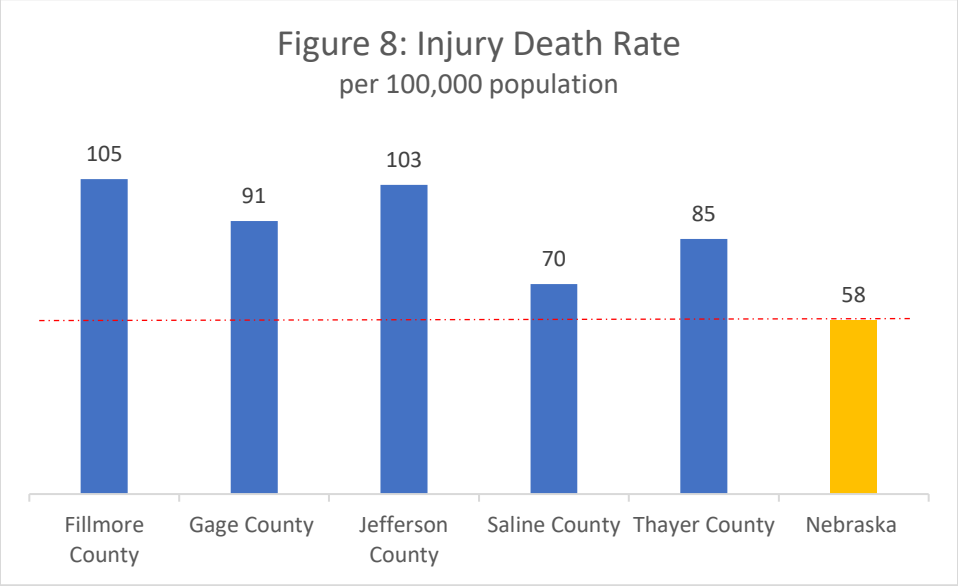




Leading causes of injury

Table 6: Leading causes of injury	
Leading causes of *death* by injury in Nebraska (2009-2013)	Leading causes of *hospitalizations* due to injury in Nebraska (2009-2013)
1. Motor vehicle crashes 1. Suicide 2. Unintentional falls 3. Unintentional poisoning	1. Unintentional falls 2. Unintentional injuries due to motor vehicle traffic 3. Self-inflicted injuries

Deaths by injury comprised approximately 20% of the total YPLL among Nebraskans.[30] In the PHS district, the death by injury rate was nearly 25% higher than the state (see Figure 8[31]).



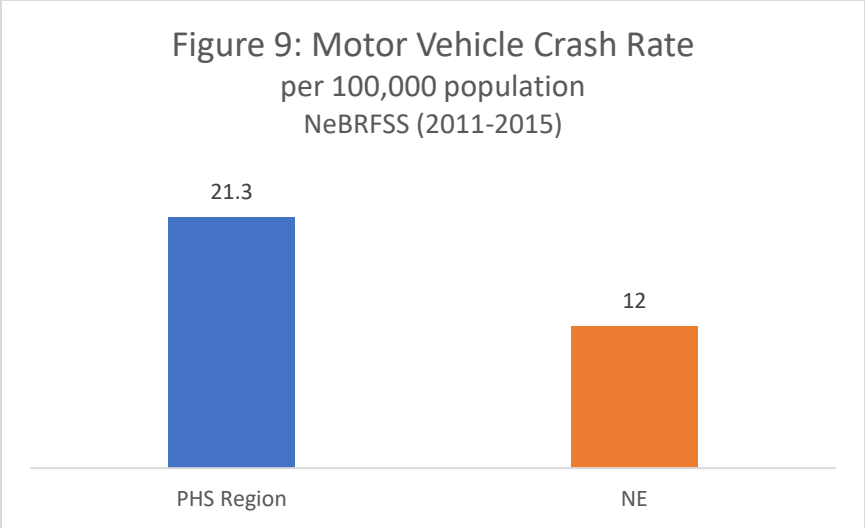
The motor vehicle crash rate is two times higher in the PHS district compared to the state (21.3 and 12 respectively, see Figure 9).[32] According to the Behavioral Risk Factor Surveillance System (BRFSS) 2018, indicators measuring risky behaviors while driving indicated that nearly 40% of people in PHS region did not always wear a seatbelt when driving or riding in a car (see Figure 10). Other risky behaviors while driving a vehicle in the PHS district did not surpass the state average; however, 1 in 5 people reported texting while driving a vehicle and 1 in 3 people reported talking on the cell phone while driving in the past 30 days. The proportion of deaths caused by alcohol-impaired driving averaged one-third higher in the PHS region (range 40% to 67%) than for the state as a whole (37%)[33].

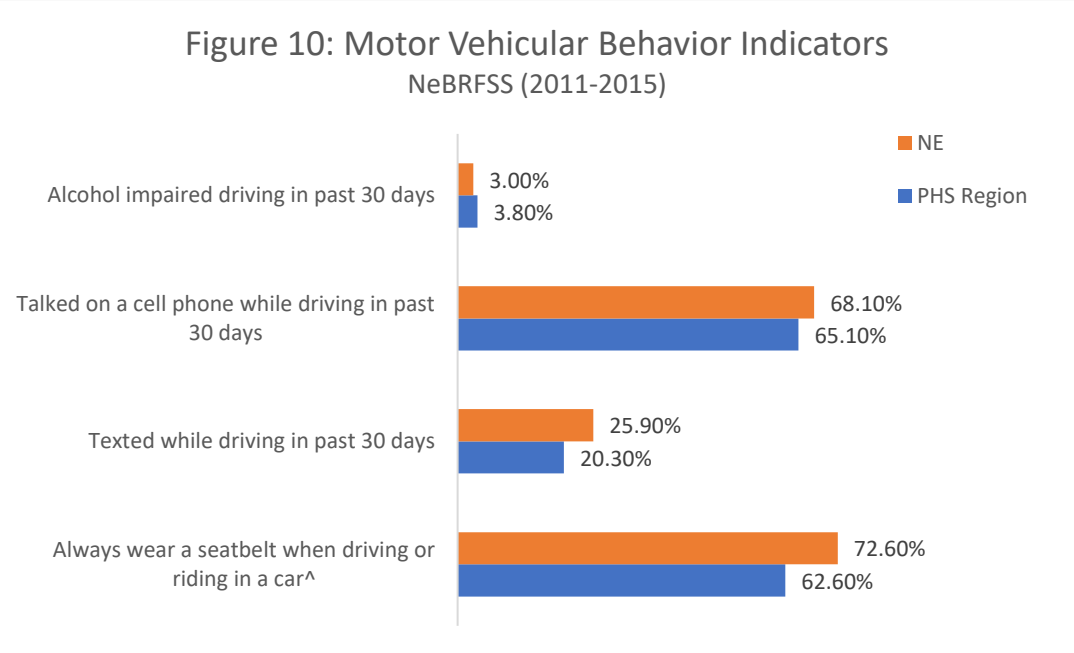
[30] Ne DHHS, Injury in Nebraska Report 2009-2013

[31] County Health Rankings, 2012-2016: http://www.countyhealthrankings.org/app/nebraska/2018/measure/factors/135/data

[32] County Health Rankings 2016

[33] County Health Rankings 2018 http://www.countyhealthrankings.org/app/nebraska/2018/compare/snapshot?counties=31_059%2B31_067%2B31_095%2B31_151%2B31_169





Work-related injury across the PHS district was minimal and mirrored the state average (5.4% and 5.1% respectively). Nearly 33% of PHS district population aged 45 years and older experienced a fall in the past year with 10% of those falls resulting in an injury.[34]

Behavioral/Mental Health and Related Risk Factors

Mental health impacts a person's ability to maintain good physical health and vice versa. Mental health is strongly associated with the risk, prevalence, progression, outcome, treatment and recovery of chronic diseases, including diabetes, heart disease and cancer. Good mental health is essential for a person to live a healthy and productive life. [35]

[34] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018
[35] CDC. (2019) Healthy People 2020: Mental health. Retrieved on 1/22/2019 https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health

According to the Nebraska Behavioral Health Needs Assessment in 2016, mental health illness was a common health problem in Nebraska. One in five Nebraskans reported any mental illness—defined as any diagnosable mental, behavioral or emotional disorder other than substance use disorder. Nebraska's rate is similar to the US rate (18.13%). Concerning, although less common, 4%-7% of Nebraskans reported having serious thoughts of suicide, a major depressive episode, or serious mental illness—defined as a mental disorder causing significant interference with one or major life activity.

Table 7 below summarizes the 2011-2015 BRFSS data regarding mental health indicators for Nebraska and the PHS district. Females, adults age 18-44 and adults with limited formal education fared worse across all indicators. Compared the state as a whole PHS is relatively aligned across all five indicators. For the indicator "Poor physical or mental health limited usual activities on 14 or more of the past 30 days." the rate for the PHS district is 7.0% (compared to 5.9% statewide). Female, lower-income and older adult (65+ years) populations were higher.

Table 7: Mental Health problem indicators in PHS District: Based on 2011-2015 Behavioral Health Risk Factor Surveillance System Data

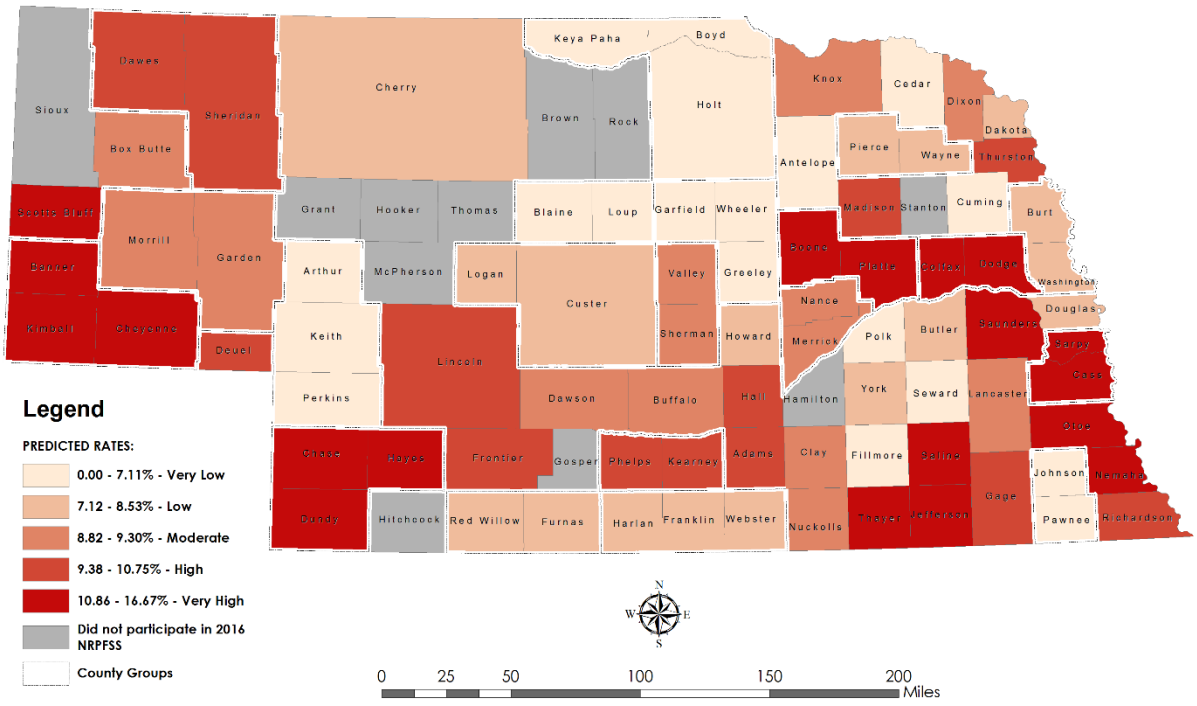
	Ever told they have depression (%)	Average days mental health was not good in past 30 days	Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	Average days poor physical or mental health limited usual activities in past 30 days	Poor physical or mental health limited usual activities on 14 or more of the past 30 days
Nebraska	17.4%	3.0	8.8%	1.9	5.9%
PHS District	17.0%	3.1	9.1%	2.2	7.0%
Gender					
Male	11.6%	2.6	7.2%	1.7	5.1%
Female	22.3%	3.6	10.9%	2.7	8.8%
Age					
18-44	19.4%	3.9	10.7%	1.7	4.7%
45-64	17.9%	3.2	10.1%	2.8	9.2%
65+	12.4%	1.8	5.5%	2.2	7.3%
Income					
<$25,000	27.5%	5.7	18.8%	4.3	14.9%
$25,000-$49,999	15.6%	2.3	6.4%	1.7	4.9%
$50,000-$74,999	13.3%	2.5	6.7%	1.1	2.8%
$75,000+	10.9%	1.3	2.7%	0.9	2.0%
Education					
Less than High School	18.5%	5.2	16.7%	4.2	14.1%
High School/GED	15.7%	2.6	8.0%	2.1	7.2%
Some College	18.8%	3.3	9.3%	1.9	5.6%
College Graduate	15.4%	2.2	5.7%	1.6	4.5%

According to the Nebraska Youth Risk Behavior Survey (YRBS) 2014-2015 data, approximately 1 in 4 Nebraska high school youth reported feeling depressed compared to nearly 1 in 3 youth nationwide (24.1% vs 29.9%). Female students had a significantly higher rate of depression (31.4% vs. 17.1%), of

considering a suicide attempt (18.0% vs. 11.3%) and of making a suicide plan (17.0% vs. 9.8%) compared to male students.[36]

In Nebraska, the rate of suicide across all ages was similar to the rate of suicide for the US (13.05 vs. 13.42—per 100,000 population). Suicide is the 10th leading cause of death in Nebraska. Suicide is the second leading cause of death for ages 15-34.[37] Many counties within the PHS district were at higher risk for youth suicide ideation and attempts. **Figure 16** shows this risk for each county across the state based on the average responses to two questions on the Nebraska Risk and Protective Factors Surveillance System in 2016: 1) "During the past 12 months did you ever seriously consider attempting suicide?" and 2) "During the past 12 months, did you actually attempt suicide?"

Figure 11: Risk level for youth suicide ideation and attempts by county based on the 2016 results from the Nebraska Risk and Protective Factors Surveillance System



Veterans are at higher risk for several negative behavioral health outcomes – most alarmingly, suicide. Data from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) show that veteran families are also impacted. Statewide, when compared to other demographic groups, Nebraska's

[36] Watanabe-Galloway, S., et al. 2016. Nebraska Behavioral Health Needs Assessment. University of Nebraska Medical Center, Omaha, NE.

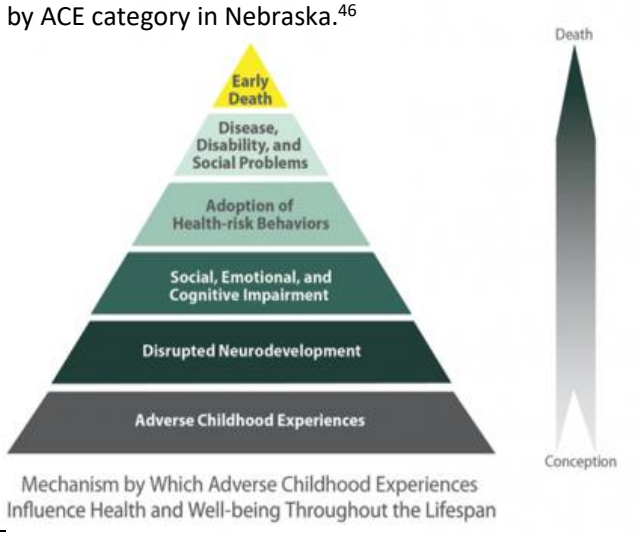
[37] American Foundation for Suicide Prevention. Suicide: Nebraska 2016 facts and figures. Retrieved 1/22/2019 from https://afsp.org/about-suicide/state-fact-sheets/#Nebraska

Veteran spouses and partners report having more poor mental health days and are more likely to have been told that they have depression.[38]

Adverse childhood experiences (ACEs) are one of the most accurate predictors of lifelong health and well-being.[39] ACEs are stressful or traumatic events that occur before age 18[40] and can include things such as a child experiencing abuse and neglect; family effects of struggling to get by financially; seeing/hearing violence in the home; witnessing and/or being the target of neighborhood violence; living with anyone mentally ill, suicidal, or depressed; living with anyone with alcohol or drug problems; experiencing parents who are divorced/separated or serving jail time.[41] The landmark Kaiser ACE study showed dramatic links between ACEs and the leading causes of death, risky behaviors, mental health and serious illness.[42] Figure 17 demonstrates the ACE Pyramid, used as the conceptual framework for the Kaiser Study.[43]

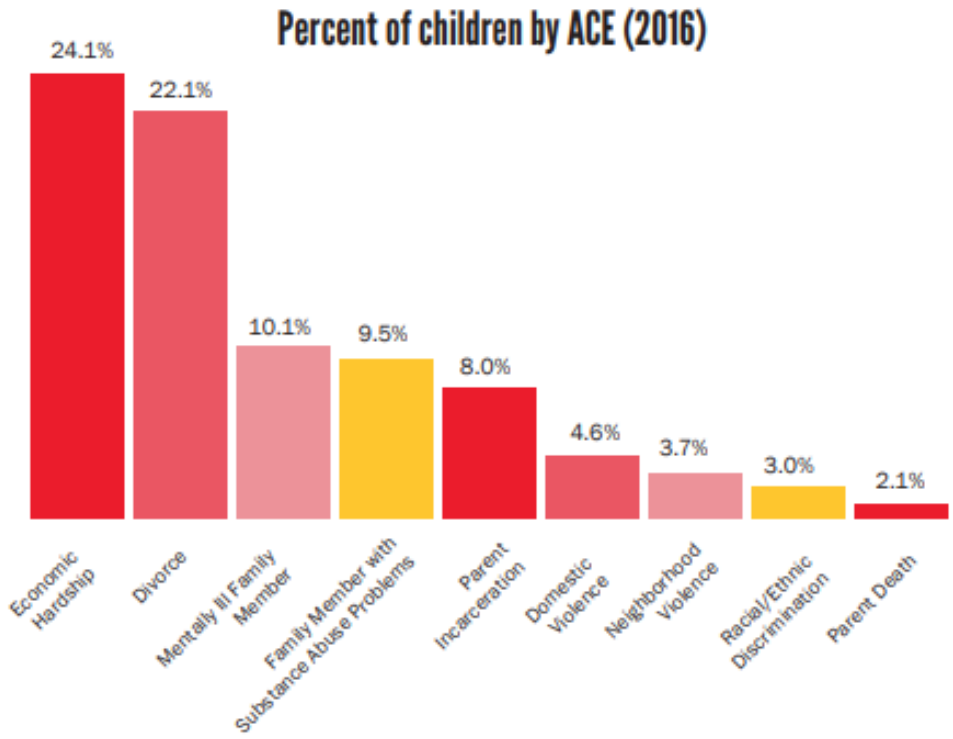
Figure 12: ACE Pyramid

In 2016 across the state, 42% of children experienced one (1) or more ACEs. Of those, 22% of children experienced 1-2 ACEs and 20% experienced 3+ ACEs[44], which was similar to the US rate of 21.7%[45]. Figure 12 illustrates the percent of children by ACE category in Nebraska.[46]



[38] http://nalhd.org/our-work/vetset/building-military-cultural-competence.html
[39] CDC. Adverse Childhood Experiences: looking at how ACEs affect our lives and society. Retrieved 1/23/19 from https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
[40] US Department of Health and Human Services. (2018) Adverse Childhood Experiences. Retrieved 1/23/19 from https://www.childwelfare.gov/topics/preventing/preventionmonth/resources/ace/
[41] ACEs Connection. 2017 Nebraska fact sheet. Retrieved 1/22/19 from https://www.acesconnection.com/g/state-aces-action-group/fileSendAction/fcType/0/fcOid/474051083497726557/filePointer/474051083543666247/fodoid/474051083543666191/2018%20-%20Nebraska.pdf
[42] CDC. Adverse Childhood Experiences: looking at how ACEs affect our lives and society. Retrieved 1/23/19 from https://vetoviolence.cdc.gov/apps/phl/resource_center_infographic.html
[43] CDC. CDC-Kaiser ACE Study. Retrieved 1/23/19 from https://www.cdc.gov/violenceprevention/acestudy/about.html
[44] Voices for Children in Nebraska. The Kids Count in Nebraska 2017 Report. Retrieved 1/23/19 from https://voicesforchildren.com/wp-content/uploads/2018/01/2017-Kids-Count-in-Nebraska-Report.pdf
[45] ACEs Connection. 2017 Nebraska fact sheet. Retrieved 1/22/19 from https://www.acesconnection.com/g/state-aces-action-group/fileSendAction/fcType/0/fcOid/474051083497726557/filePointer/474051083543666247/fodoid/474051083543666191/2018%20-%20Nebraska.pdf
[46] Voices for Children in Nebraska. The Kids Count in Nebraska 2017 Report. Page 37. Retrieved 1/23/19 from https://voicesforchildren.com/wp-content/uploads/2018/01/2017-Kids-Count-in-Nebraska-Report.pdf

Figure 13: Percent of children by ACE category in Nebraska



Resilience is the ability to adapt to stressful or traumatic events, such as ACEs. Resilience is not a genetic factor but more of a learned behavior. Resilience can be cultivated in anyone.[47] Children who experience protective family routines and habits, such as limited screen time, no TV/screen time in bedrooms, parents who have met all or most of the child's friends, and parents who participate in a child's extracurricular activities[48], are less likely to experience ACEs.[49] Community-based strategies to provide safe, stable, nurturing relationships and environments to increase resilience and to reduce ACEs can include:

Program based[50]:

- Home visiting programs for pregnant women and families with newborns
- Parenting training programs
- Intimate partner violence prevention programs

[47] American Psychological Association. The road to resilience. Retrieved 1/23/19 from https://www.apa.org/helpcenter/road-resilience.aspx
[48] Data Resource Center for Child & Adolescent Health. 2016 National Survey of Children's Health: Indicator 6.28. Retrieved 1/23/19 from http://www.childhealthdata.org/browse/survey/results?q=4853&r=1
[49] America's Health Rankings. (2018) Public Health Impact: Adverse Childhood Experiences. Retrieved 1/23/19 from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/NE
[50] America's Health Rankings. (2018) Public Health Impact: Adverse Childhood Experiences. Retrieved 1/23/19 from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/NE

- Social support for parents
- Teen pregnancy prevention and parent support programs for teens
- Treatment for mental illness and substance abuse
- High quality, affordable child care
- Sufficient income support for low-income families

System/Policy based[51]:

- Increase awareness of ACEs and their impact on health within both the professional and public spaces
- Increase capacity of health care providers to assess for the presence of ACEs and appropriate response
- Enhance capacity of communities to prevent and respond to ACEs through investment in evidence-based prevention programming, trauma interventions and increased access to needed mental health and substance abuse services
- Increased funding for ACE-specific surveys in order to increase their utility and scope

Generally, emergency rooms and primary care offices are the most common place where people with behavioral health needs seek care. Often clinicians in these settings do not have the resources and/or training to appropriately respond to behavioral health needs. Overall, 66% of primary care providers report that they are unable to respond to people with behavioral health needs due to a shortage of mental health providers and insurance barriers.[52]

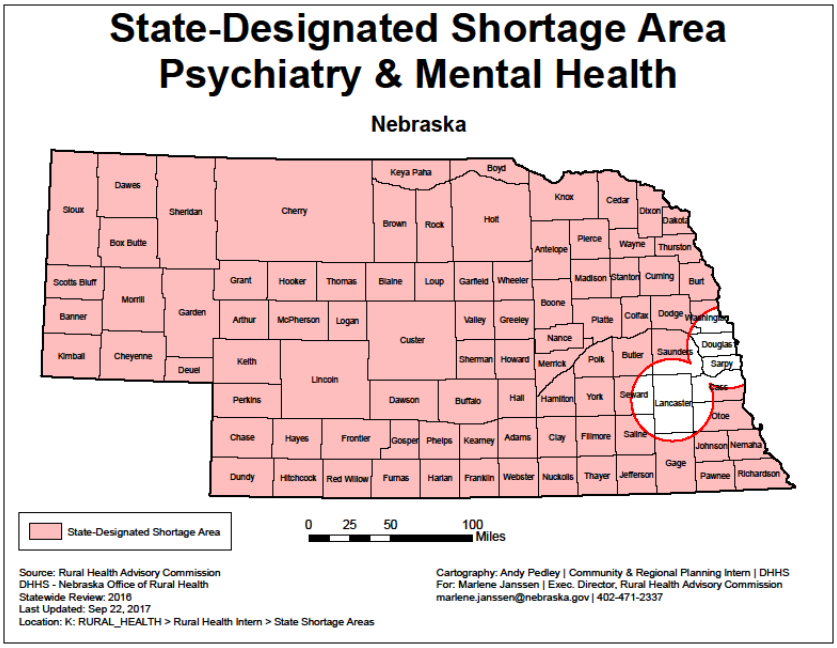
Most all counties in the state are designated as mental health professional shortage areas (see figure 19). In the PHS district, there were an average of 1,606 people for every one mental health provider (range: 570:1 to 2,550:1), nearly 4 times as many people to mental health provider as the state and US averages (420:1, 470:1 respectively).[53] According to the 2016 Nebraska Behavioral Health Needs Assessment, only 47% of adults in Nebraska with any mental illness received treatment. Additionally, only 43% of youth in Nebraska with depression received treatment. Furthermore, only 11% of persons aged 12 or older in Nebraska with illicit drug dependence or abuse received treatment.

Even with PHS's known mental health professional shortage area designation, access to behavioral health care may be further compounded by other barriers, including lack of insurance coverage and stigma often associated with mental illness.[54] Notably, access to care makes up about 20% of the overall factors that influences a person's health according to the County Health Rankings and Roadmaps

[51] America's Health Rankings. (2018) Public Health Impact: Adverse Childhood Experiences. Retrieved 1/23/19 from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/NE
[52] Alliance for Health Policy. (2017) The Sourcebook: Essentials of Health Policy. Chapter 8-Mental Health and Substance Abuse. Retrieved 1/22/19 from http://www.allhealthpolicy.org/sourcebook/mental-health-and-substance-abuse/
[53] County Health Rankings
[54] Alliance for Health Policy. (2017) The Sourcebook: Essentials of Health Policy. Chapter 8-Mental Health and Substance Abuse. Retrieved 1/22/19 from http://www.allhealthpolicy.org/sourcebook/mental-health-and-substance-abuse/

framework, suggesting that focusing community-based efforts in creating safe, stable, nurturing relationships and environments may help to address health care professional shortage areas.

Figure 14



Like mental health, substance use disorders are among the top causes of disability in the US and can make daily activities hard to accomplish.[55] Furthermore, substance use and addiction can advance the development of mental illness due to the effects of substances in changing the brain in ways that make a person more likely to develop a mental illness. Likewise, mental illness can lead to drug use and substance use disorders.[56]

Cigarette smoking is the leading cause of preventable disease and death in the US. According to the CDC, the smoking rate among adults in the US has dropped from 20.9% in 2005 to 15.5% in 2016.[57] The smoking rate among adults in the PHS region was 21.5%[58], higher than the national and state smoking rate (17%). While Nebraska has a clean indoor air ordinance prohibiting smoking in all government and private workplaces, schools, childcare facilities, restaurants, bars, casinos/gaming establishments, retail stores and recreational/cultural facilities, tobacco products are relatively easy to access and inexpensive. Nebraska's tobacco tax is $0.64 per pack, $1.09 lower than the national average, ranking Nebraska 42nd

[55] SAMHSA. Substance Abuse and Mental Illness Prevention. Retrieved 1-22-2019 at: https://www.samhsa.gov/find-help/prevention

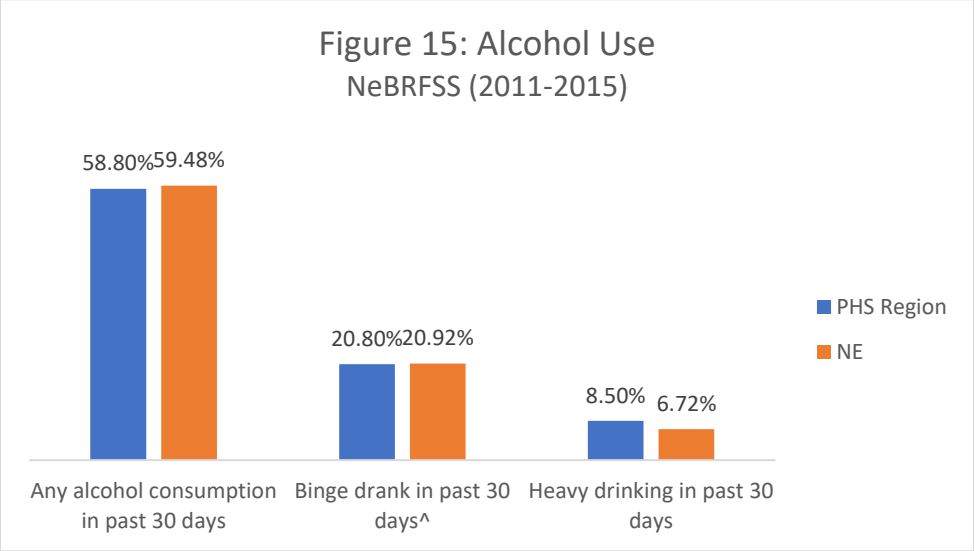
[56] NIH, National Institutes on drug abuse. (August 2018) Comorbidity: Substance use disorders and other mental illnesses. Retrieved 1/21/2019: https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

[57] CDC https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm

[58] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018

in the US for its cigarette tax[59]. Youth tobacco use in Nebraska is lower than the national rate (7.4% and 8.8% respectively). Furthermore, Nebraska has three youth access laws: 1) a minimum age (18 years) of sale for tobacco products in Nebraska, 2) minors are prohibited from buying e-cigarettes, and 3) the sale of tobacco products through self-service displays is prohibited—making tobacco access for youth more difficult. [60] Over 85% of adults in the PHS region have a rule not allowing smoking anywhere inside their home.[61]

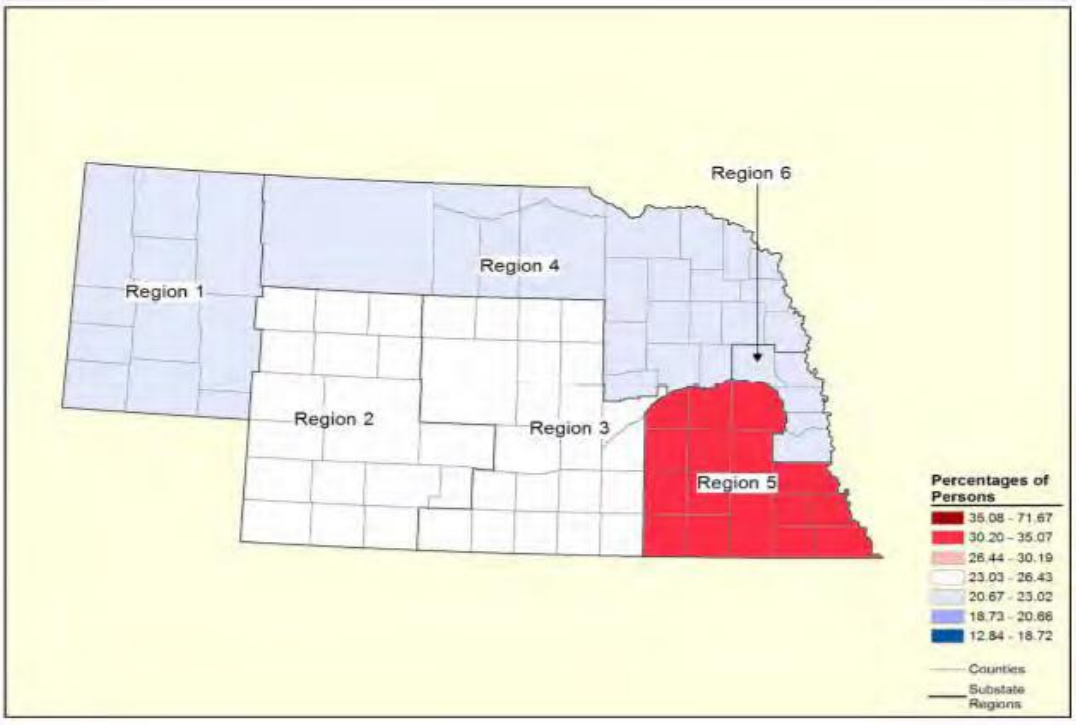
In 2015, Nebraska ranked 47th in the nation for the prevalence of binge drinking (20.3%), a stark difference when compared to West Virginia (ranked 1st, less than 10%).[62] Excessive alcohol consumption, in either the form of binge drinking (more than 4 drinks on one occasion for men or more than 3 drinks on one occasion for women) or heavy drinking (drinking more than 14 drinks per week for men or more than 7 drinks per week for women), is associated with an increased risk of many health problems[63], including unintentional injuries, chronic disease like cardiovascular diseases, and others[64]. The Nebraska BRFSS survey in 2018 indicated 1 in 5 adults in the PHS region reported binge drinking in the past 30 days, and nearly 1 in 10 adults in the PHS region reported heavy drinking in the past 30 days, both of which were higher than the US (17% and 6% respectively).



Public Health Solutions district falls within the Nebraska Behavioral Health Region V. According to the Nebraska Behavioral Health Needs Assessment, the prevalence of alcohol use in the past month among persons aged 12 or older was significantly higher in Region V (59.38%) than in Regions I or III (47.40% and 48.40% respectively). Additionally, Region V had a significantly higher prevalence of alcohol use in the past month among people aged 12-20 (32.26%) compared to Regions I, IV, VI (22.91%, 22.63% and 22.43% respectively). Figure 20 shows this comparison.

[59] https://truthinitiative.org/tobacco-use-nebraska
[60] https://truthinitiative.org/tobacco-use-nebraska
[61] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018
[62] Watanabe-Galloway, S., et al. 2016. Nebraska Behavioral Health Needs Assessment. University of Nebraska Medical Center, Omaha, NE.
[63] CDC https://www.cdc.gov/alcohol/data-stats.htm
[64] NE Office of Men's Health http://dhhs.ne.gov/publichealth/Pages/hew_menshealth_bingedrink.aspx

Figure 16: Alcohol use in the past month among persons aged 12 to 20 in Nebraska[65]



Maternal and Child Health

Infant mortality (death of an infant before his/her first birthday) is an indicator of maternal and child health within a community. More importantly, this indicator is a marker of overall health of a community due to the associations between the causes of infant death and other factors that are likely to influence health—such as social and economic factors, general living conditions and other quality of life factors.[66] The infant mortality rate (the number of infant deaths per 1,000 live births in the same year) in the US was 5.9 in 2016.[67]

Nebraska fairs a little bit better than the US with an infant mortality rate of 5.[68] Figure 17 illustrates the stark differences between counties across the PHS district regarding infant mortality.[69]

[65] Watanabe-Galloway, S., et al. 2016. Nebraska Behavioral Health Needs Assessment. University of Nebraska Medical Center, Omaha, NE.

[66] Reidpath DD, Allotey P. Infant mortality rate as an indicator of population health. *Journal of Epidemiology & Community Health* 2003; **57**:344-346.

[67] cdc 2016 https://www.cdc.gov/reproductivehealth/MaternalInfantHealth/InfantMortality.htm

[68] County Health Rankings 2016

[69] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018

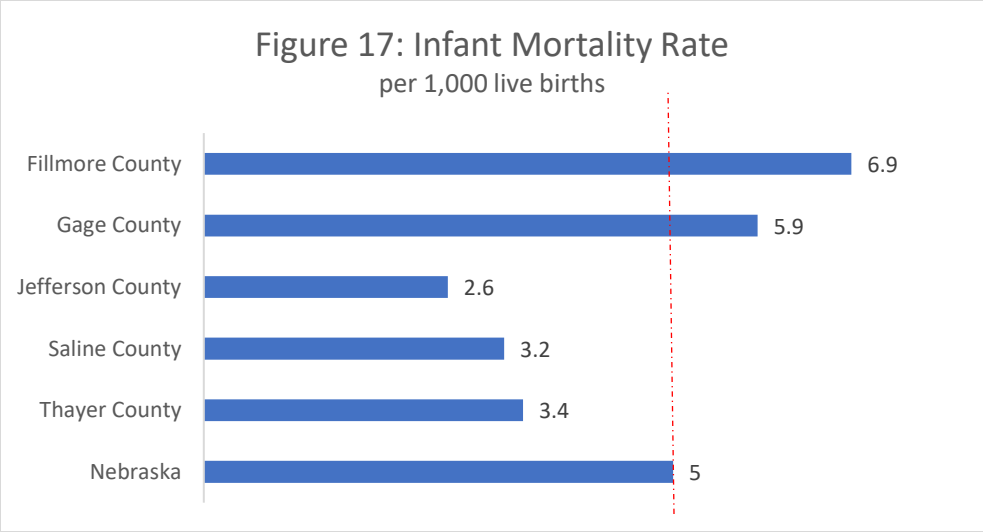


Table 8 provides an overview of the birth statistics, maternal and child health indicators. Notably, the teen birth rate in Fillmore County was half the rate of other counties in the PHS district and the state rate (an average of 22 and 25, respectively).

Table 8: Maternal and Child Health Indicators	Fillmore	Gage	Jefferson	Saline	Thayer	PHS District	NE
Birth rate[70]	10.5	11.2	13.5	13.3	10.6	11.8	13.9
Teen birth rate[71]	12	25	29	21	23	22	25
Low birthweight[72]	4%	6%	6%	6%	6%	5.6%	7%

Health Disparities

Rurality is associated with a number of negative health outcomes, specifically higher premature mortality rates, infant mortality rates, and age-adjusted death rates. Rurality is also associated with a number of negative health behaviors that contribute to chronic disease and death, such as unhealthy diets and limitations in meeting moderate or vigorous physical activity recommendations.[73] These data paint a stark picture of health disparities given one factor, geography. There are disparities related to race and ethnicity independent from geography, and there are disparities related to geography independent from race and ethnicity. When disparities from independent factors overlap, such as race/ethnicity overlapping with geography, the result is a dual disparity resulting in some of the poorest health statuses seen in the nation.[74]

[70] The number of resident live births per 1,000 population. NE DHHS, Vital Statistics Report, 2015: http://dhhs.ne.gov/publichealth/Vital%20Statistics%20Reports/Vital%20Statistics%20Report%202015.pdf

[71] County Health Rankings 2018 http://www.countyhealthrankings.org/app/nebraska/2018/compare/snapshot?counties=31_059%2B31_067%2B31_095%2B31_151%2B31_169

[72] County Health Rankings 2018 http://www.countyhealthrankings.org/app/nebraska/2018/compare/snapshot?counties=31_059%2B31_067%2B31_095%2B31_151%2B31_169

[73] Bennett, KJ, Olatosi, B, Probst, JC. 2008. Health Disparities—A Rural-Urban Chartbook. 2008. South Carolina Rural Health Research Center retrieved from http://rhr.sph.sc.edu/report/(7-3)%20Health%20Disparities%20A%20Rural%20Urban%20Chartbook%20-%20Distribution%20Copy.pdf

[74] Meit, M., Knudson, A., Gilbert, T., Yu, A. T. C., Tanenbaum, E., Ormson, E., & Popat, M. S. (2014). The 2014 update of the rural-urban chartbook. *Rural Health Reform Policy Research Center*.

Another factor associated with health disparities is basic literacy and health literacy levels—relative to everyday literacy demands. According to the U.S. Department of Health and Human Services 2010 National Action Plan to Improve Health Literacy[75], some populations are more likely to experience limited health literacy; 1) Recent refugees and Immigrants; 2) Racial and ethnic groups other than White; and 3) Non-native speakers of English. In the 2003, National Assessment of Adult Literacy Report, Hispanics presented the lowest average health literacy of all racial/ethnic groups. About one third of Hispanics presented with low health literacy.[76] These findings were supported in a 2013 study of the Program for the International Assessment of Adult Competencies.[77] Literacy, cultural competency and primary language must be taken into account when working with all immigrants—Mexican, Central American, African, or any other immigrant population.

While health literacy is a significant problem among recent immigrants, it is also a significant problem for Americans born in the USA. In 2004, IOM released a report that approximately 90 million people, almost half of the United States (US) population, have inadequate health literacy skills.[78] As pointed out by the Indian Health Service's *White Paper on Health Literacy* published in August of 2009, *"Being able to read does not necessarily mean one will be health literate, however, the lack of basic literacy skills does mean that patients almost certainly will have difficulty reading and understanding basic health information".*[79] The ability to understand information on health issues and prevention strategies depends upon health literacy which is, in turn, dependent in part upon basic literacy and math skills.

Table 9 summarizes the health literacy indicators within the PHS district. About half of the adult population in the PHS district lacks the confidence in their ability to fill out health forms. Additionally, 30% of the population in the PHS district reported that written health information is not always easy to understand.

Table 9: Health Literacy Indicators[80]	PHS Region
Lacking confidence in their ability to fill out health forms	42.1%
Written health information is always or nearly always easy to understand	70.0%
Always or nearly always get help reading health information	13.0%

Community Health Status Assessment Methods

The community health status assessment gathered data from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings, American Community Survey/US Census Bureau,

[75] https://health.gov/communication/initiatives/health-literacy-action-plan.asp

[76] Kutner, Mark, et al. "The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy. NCES 2006-483." *National Center for Education Statistics* (2006)

[77] Prins, E., & Monnat, S. (2015). Examining associations between self-rated health and proficiency in literacy and numeracy among immigrants and US-born adults: Evidence from the Program for the International Assessment of Adult Competencies (PIAAC). *PloS one*, *10*(7), e0130257.

[78] Nielsen-Bohlman, L., Panzer, A., & D, K. (2004). A Prescription to End Confusion. Washington, DC: Institute of Medicine; National Academies Press.

[79] Indian Health Service Health Literacy Workgroup. (2017, July 17). *Indian Health Service: White Paper on Health Litracy*. Retrieved from Indian Health Service: page 2 https://www.ihs.gov/healthcommunications/includes/themes/newihstheme/display_objects/documents/IHSHealthLiteracyWhitePaper.pdf

[80] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018

Centers for Disease Control, Nebraska Crime Commission, Nebraska Department of Education, U.S. Bureau of Labor Statistics, and so on to assess the health status of the PHS region.

Health Summary: PHS District

The majority of the adult population within the PHS district reported their general health was good or better in the BRFSS between years 2011-2015. However, nearly 1 in 10 people within the PHS district indicated they experienced frequent mental distress. Table 10 summarizes the general health of the adult population within the PHS district.

Table 10: General Health Indicators[81]	**PHS District**	**NE**
General health fair or poor	17.3%	13.9%
Average number of days physical health was not good in past 30 days	3.6	3.1
Physical health was not good on 14 or more of the past 30 days	11.0%	27.1%
Average number of days mental health was not good in past 30 days	3.1	3.0
Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	9.1%	8.8%
Average days poor physical or mental health limited usual activities in past 30 days	2.2	1.9
Poor physical or mental health limited usual activities on 14 or more of the past 30 days	7.0%	5.9%

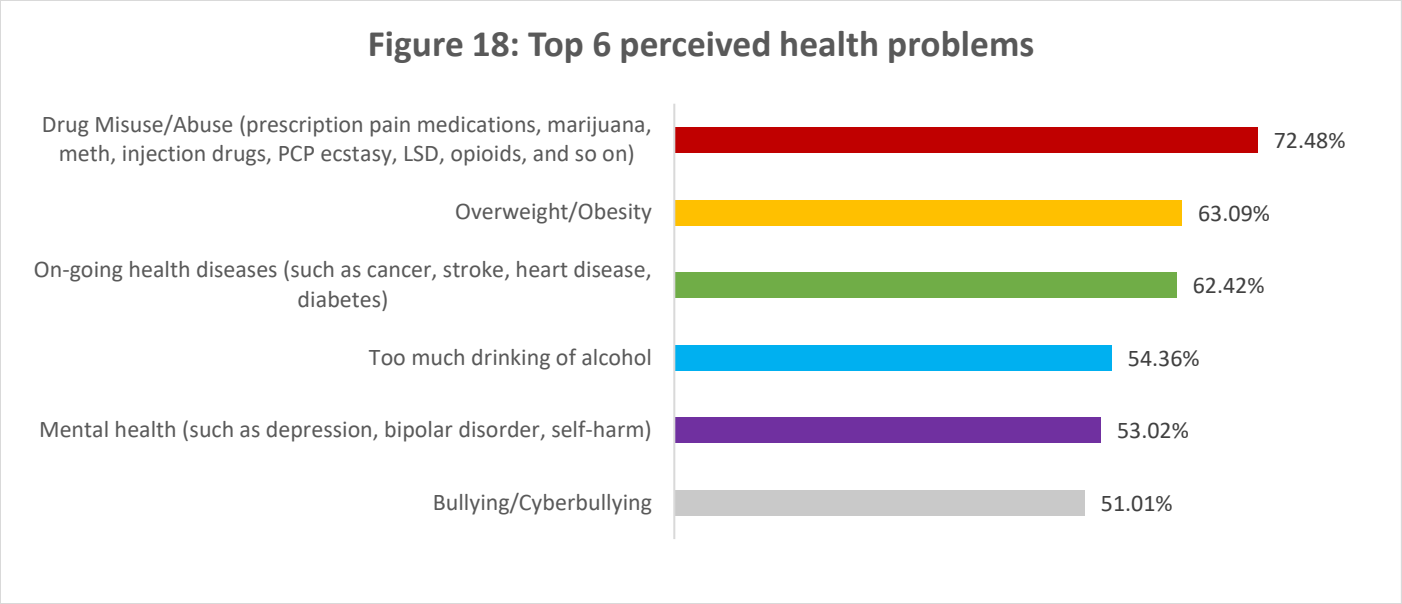
Not unlike the state, the PHS district experienced primary care and mental health professional shortages, reducing access to needed health services. The Years of Potential Life Lost (YPLL), a measurement of preventable deaths, in the PHS district surpassed the state rate. More specifically, Fillmore County's YPLL rate was one-third higher than the state rate. Multiple factors impact how well and how long we live. Things like education, availability of jobs, access to healthy foods, social connectedness, and housing conditions all impact our health outcomes. Conditions in which we live, work and play have an enormous impact on our health, long before we ever see a doctor. It is imperative to build a culture of health where getting healthy, staying healthy and making sure our kids grow up healthy are top priorities.

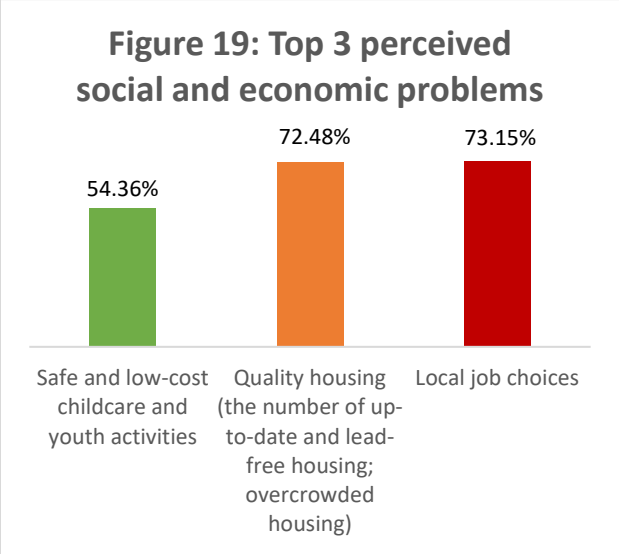
Community Themes and Strengths Assessment

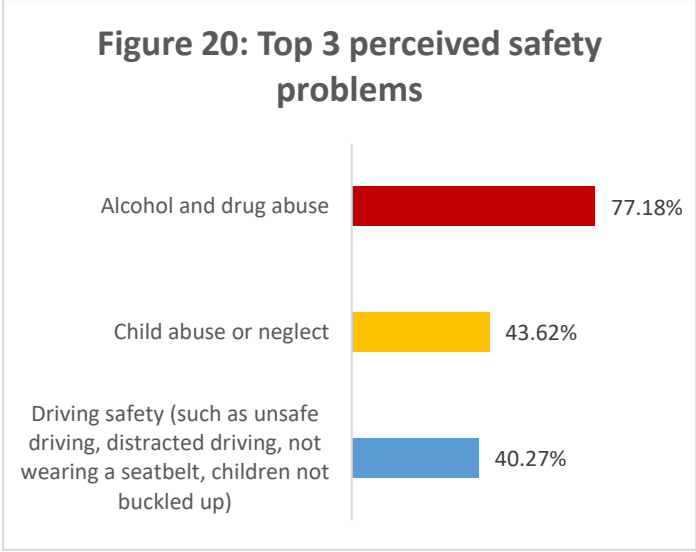
A community health survey was distributed across the Public Health Solutions' (PHS) region to determine the Community Themes and Strengths. This survey assessed respondents' perceptions of important health issues, including wellbeing and quality of life. It also asked about the assets available in communities. This survey was available in English and Spanish and in print and online. Print copies were distributed through the RSC member organizations and other community-based organizations. Additionally, PHS posted the survey link on the PHS website and Facebook pages and sent a mailer to homes across the five-county area. PHS offered a chance to win $100 gift card per county as an incentive to increase participation.

This 80-question survey was made up of Likert-scale, open-ended and multiple-choice questions (see Appendix E for survey questions). In all, 182 responses were collected from within the PHS district (including people that did not indicate a county). The survey revealed the following:

[81] Nebraska Behavioral Risk Factor Surveillance System (BRFSS), years 2011-2015 combined, published January 2018







The majority of survey respondents self-identified as white, middle to upper-middle class, and college educated. While not representative of the population of the region as a whole, many of the survey responses point to alignment with other data collected as part of the CHA process. Survey findings are consistent with anecdotal input from RSC members connected to many of the diverse community groups who are not well-represented in survey responses.

Forces of Change Assessment

During the June 2018 RSC meeting, NALHD facilitated a ToP workshop to define the forces of change at work within the district. The Forces of Change assessment, an environmental scan, identifies the trends, factors and events that impact the health and wellbeing within the PHS district. NALHD provided a pre-meeting worksheet to help the RSC members think about the potential forces of change. During the June 2018 meeting, NALHD divided the RSC members into groups to brainstorm ideas for the following focused question: *What trends, factors and events are or will be influencing the health and quality of life*

for our communities and/or the work of our public health system? Once the forces were agreed upon, NALHD divided up the RSC members into groups to brainstorm threats and opportunities for each identified force. The results of this Forces of Change assessment were reviewed by the RSC members as a part of the August 2018 data review meeting and presented as a frame-of-reference during the September 2018 RSC meeting where health-related priorities and action planning occurred.

Table 11

Forces of Change

Forces (Trend, Events, Factors)	Threats Posed	Opportunities Created
Lack of Early Intervention and Prevention • Changing roles of families • Coping skills/resiliency • Increased mental illness/children • Mental health issues • Increased mental health challenges/awareness • Chronic Disease • Opioid crisis	Increased incarceration, violence, school shootings, suicide & addiction Lack of funding Lack of providers in rural communities Social problems/untreated illness Changing family dynamics/generational cycle Increased societal costs Stigma Lack of awareness of services Inability to manage stressors Stability Feeling of belonging/being needed	Prevalence of chronic illness & untreated trauma Collaboration between stakeholders Align reimbursement incentives Avoiding stereotypes Maximize availability of services Non-traditional partnership Education Advocacy Research to support need Mental health credit courses in school Increased social support
Technology • Technology affecting information availability	Less social interaction Dependence on technology-what happens if it fails? Addiction (time lost) Bullying Lack of access (individual) Time to educate Need for instant gratification Development of new workforce skills National security Abundance of misinformation	Telehealth in-home care mental health specialist Big data Increased ability to share Health information Disease management Education Building relationships and/or networks Increase access to all (broadband capability) Innovation Development of new workforce skills Globalization
Access to Opportunities • Increased poverty • Affordable housing • Access to medical services	Poverty Lack of awareness of opportunities Social/economic prerequisites Lack of imagination Geographic location Stigma associated with services Lack of transportation to services Oppression of social classes/dominance of a social class	People care enough to help others Awareness Education – what is there? Disease prevention Health promotion Tele-medicine Lower stigma – more open conversations More transitional housing opportunities/equity
Competing Governmental Funding Priorities • Decreased funding for services • Federal/State budget decline • Politically-oriented funding opportunities	Instability Continued decreasing of services Lobbying becomes more important Competition favoring larger organizations Services driven by funding streams Loudest voice gets the funding Priorities determined by political party lines Lack of innovation and collaboration Put $ into corrections instead of education, intervention & prevention	Healthy Competition Data-driven incentives (showing value) Advocacy – research – job opportunity Drives innovation Increased interest in government participation Agency collaboration – strength in numbers Share great ideas Spend $ on root causes of problems
Political Environment • Political discord • Lack of community voice • Federal immigration policy	Population polarization Fear Limited dialogue Catastrophic event Gridlock "Popularity" doesn't equate to competence Lost civility Backlash/protest/riots Funding barriers to seek office	Voting Advocacy Activism Stronger unity (possibly after major event) The public is becoming aware that candidate selection is important to the choices we have on election day Political awareness Intergenerational involvement Innovation
Lost Civility	Violence Moral drift – lowering the bar on behavior Apathy Human cost Lack of respect/dialogue is missing Social isolation Despair Unwillingness to accept personal responsibility Technology/bullying Economic cost	Learn from things that are going wrong Bring untraditional groups together New leaders emerge Challenge social norms – where we were and what's happening now Freedom from "correctness" and ideas and opinions matter even if we disagree If we choose, we can treat each other with respect Exchange of ideas leads to greater opportunity and raises the standard of living for all

Local Public Health System Assessment

A Local Public Health System assessment focuses on the strengths, areas for improvement, and opportunities that exist or can be created around the components, activities, competencies and capacities of the local public health system. With the guidance of PHS leadership, NALHD developed and implemented an assessment of the local public health system capacity and opportunities in the PHS district. A survey was sent to all RSC members. Seventeen responded (see Appendix F) resulting in a 41% response rate. The results of the Local Public Health System assessment were reviewed by the RSC members as a part of the August 2018 data review meeting and presented during the September 2018 RSC meeting where health-related priorities and action planning occurred.

Identify Strategic Issues

NALHD facilitated three, two-hour data review meetings on August 29, 2018 to identify key issues from the results of the four assessments. Group 1 reviewed the Community Health Status data. Group 2 reviewed the Community Health Survey data. Group 3 reviewed the Forces of Change and Public Health Systems assessments (these two assessments were grouped together since the amount of data from each of these assessments were smaller compared to data in Group 1 and 2). Each group established the following criteria to ensure consistency when looking at the data to identify key issues:

- Degree of impact to our vision
- Measurability
- Common areas of need
- Feasibility
- Population based vs. individual impact
- Data-supported

For each data review group, NALHD provided a short time for group members to review the data individually. Then the members paired up to discuss what key issues stood out to them. They were charged with looking for specific "pressure points" that could trigger leverage toward a strategic response working within the key issues set by the group. NALHD facilitated a focused conversation around the question: **What does the data reveal about issues that should be considered if we are to achieve our vision in the five-county area?**

Group 1: Community Health Status

This assessment identifies priority community health and quality of life issues and looks at the leading causes of mortality and morbidity, the general health status of community members, the disparities in health, the access and availability of behavioral and health care, and so on. The following key issues (see Appendix G for a key issues summary table) were identified:

1. **Chronic Disease Health Behaviors and Outcomes**, as it relates to metabolic syndromes, such as obesity, high blood pressure, high cholesterol and diabetes
2. **Availability of Primary Care Physicians**
3. **Mental Health**
4. **Volunteer First Responders System**
5. **Availability of Environmental Supports**, as it relates to access to recreation and better housing
6. **Maintain Critical Access Hospitals**

7. **Quality of Life Issues**, as it relates to chronic disease health outcomes, physical activity and tobacco use health behaviors, preventative health screenings, quality affordable housing, single parent households, educational attainment and employment.

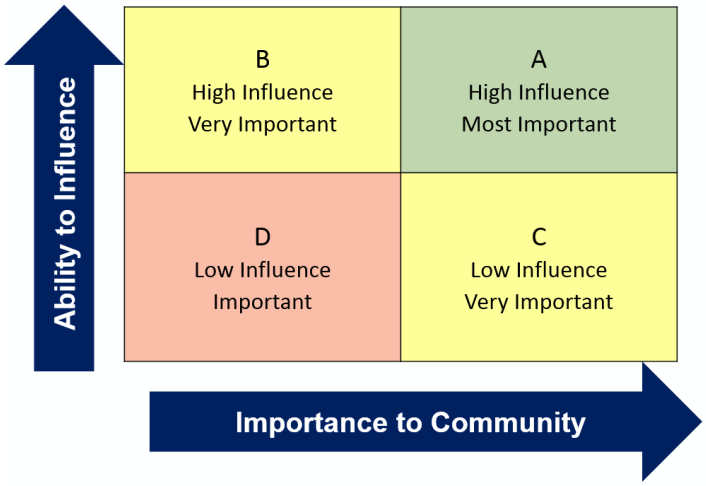
Group 2: Community Themes and Strengths
This assessment aims to identify the communities' perception regarding the issues that are important to their health and wellbeing, the quality of life in their respective communities, and the assets they feel are important in their respective communities. The following key issues (see Appendix H for a key issues summary table) were identified:

1. **Community Input and Engagement**
2. **Affordable Health Insurance**
3. **Housing**
4. **Drug Usage**
5. **Availability of Affordable, Quality Childcare**
6. **Resources for the Older Populations**
7. **Promotion within the Job**
8. **Community Connectedness**
9. **Social Support**
10. **Environmental Support,** as it relates to radon exposure and so on
11. **Gap between Those Who Have Resources and Those Who Do Not Have Resources**

Group 3: Forces of Change and Local Public Health System Assessment
The Forces of Change assessment focused on identifying forces (such as legislation, technology, environmental, social, political, and so on) that affect the context in which the community and its public health system operate, and the Local Public Health System assessment identified the strengths, areas of improvement and opportunities for health and wellbeing advancement in the public health system within the five-county area. The following key issues were identified (see Appendix I for a key issues summary table):

1. **Collaboration**
2. **Lack of awareness about opportunities, resources and how to be healthy**
3. **Social/Community Connectedness**
4. **Access to Resources and Opportunities**
5. **Technology**

During the September 27, 2018 prioritization meeting, NALHD presented the key issue findings by way of small group work. The RSC members self-selected into three groups (one group for each data review group) to review the key issues summary table and discuss the findings. Each group had a host who facilitated conversation, took notes and stayed behind for the next group to recap the discussion of the previous group. After 30 minutes, the facilitator had the groups rotate to a new data review group to repeat the process until all RSC members had a chance to visit all three groups. After considering the ability to influence (as a group) and the importance to the community, hosts recorded decisions made when groups determined which quadrant (see figure below) the key issue fell. Once all RSC members rotated through each group, NALHD asked the hosts to post the key issue in the appropriate quadrant.



The RSC members reviewed the posted key issues in each quadrant and reached consensus on key issues in each quadrant. The RSC members decided to record all issues that fell outside of quadrant A (high influence and most important) for consideration or discussion at a different time or in a different way. These issues will be reviewed in the future, during the quality improvement (QI) cycle.

Prioritization of Strategic Issues

During the September 27, 2018 prioritization meeting, each RSC member was given three green sticker dots and three pink sticker dots to vote on the strategic issues in quadrant A. RSC members placed green sticker dots on the strategic issue(s) that align with their individual organization's strategic priorities. Then RSC members placed pink sticker dots on the strategic issue(s) that align with issues that were important to the community. Stickers could be placed all on one issue or divided between several issues.

After all votes were tallied, the group reached consensus on three health-related priorities. The group was intentional in their decision to select three priorities as they wanted to assure their future capacity to devote resources. Focusing on a few areas will make the groups impact more feasible.

The following top health-related priorities for the five-county area include:

- **Mental Health,** including mental and emotional well-being and substance use
- **Chronic Disease,** specifically obesity, hypertension, high cholesterol, and diabetes
- **Access to Resources and Opportunities,** health equity
- **Environmental Health,** focused on safe and healthy community environments

Community Health Improvement Plan

RSC members self-selected into one of three priority areas (mental health, chronic disease, acess to resources and opportunities) to create a one-year action plan. NALHD facilitated this portion of the September 27, 2018 meeting using the Technology of Participation (ToP) process for accelerated action planning. The groups followed this ToP process to determine goals, outcomes, and a timeline of activities over the course of one year. Although there were three priority areas identified, the group working on the Access to Resources and Opportunities priority area decided that this issue was

overlapping with the other priority areas and disbanded to join either Mental Health or Chronic Disease priority areas resulting in two final priority areas. The priority of environmental health, focused on safe and healthy community environments, was added as a fourth priority area.

Priority Area 1: Chronic Disease

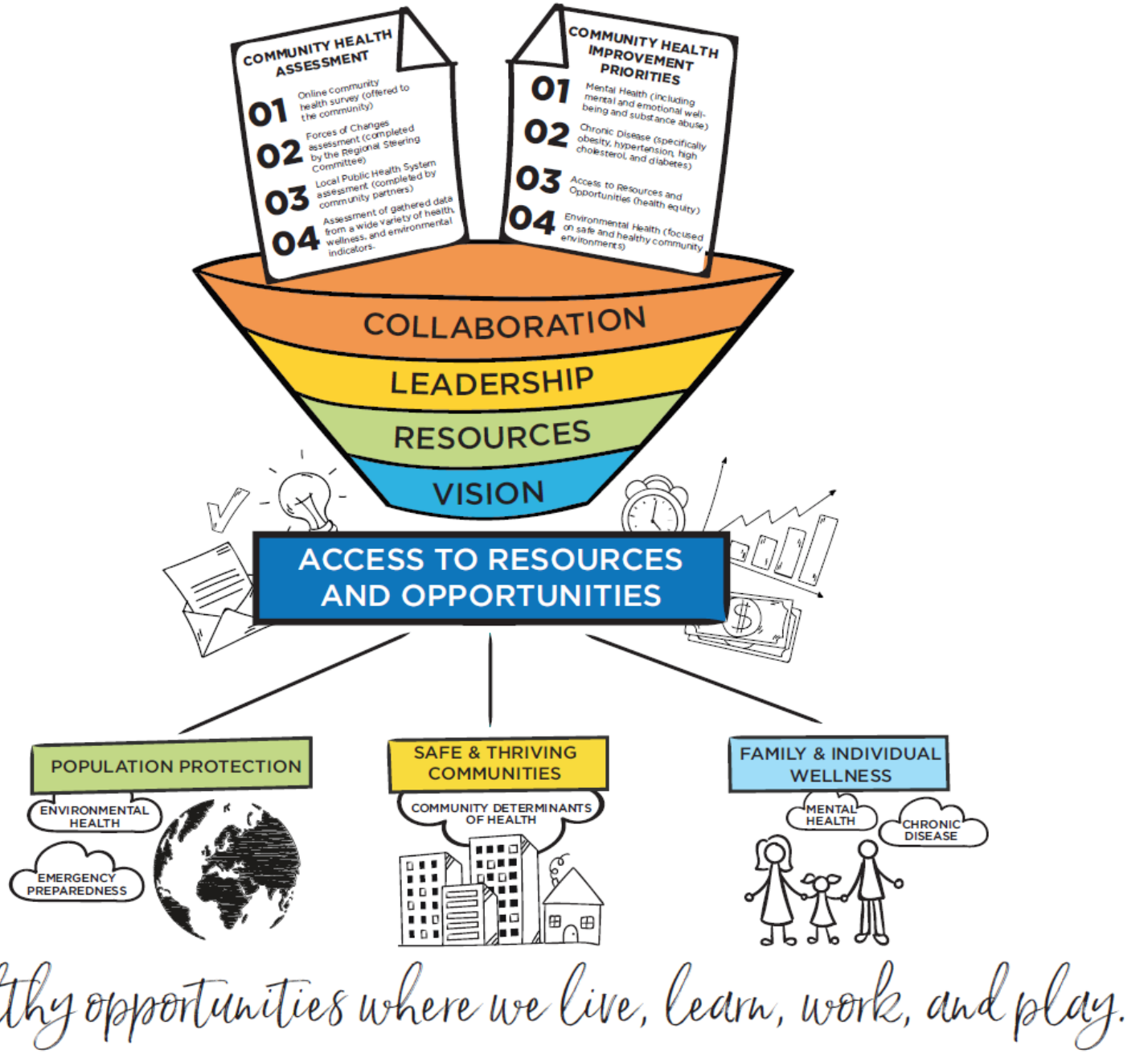
For this priority area, RSC members were committed to inventorying resources, sharing current resources, collaborating for additional needed resources and creating a baseline data inventory on current patient panels. For details of this action plan, see Appendix J.

Priority Area 2: Mental Health

For this priority area, RSC members were committed to working collaboratively/sharing resources, focusing on prevention and education, openly discussing mental health/reducing stigma, and engaging in early childhood mental health/prevention work. For details of this action plan, see Appendix K.

Next Steps

What happens next? In coming together and completing this process, it became abundantly clear that many partners around the table are working toward the same goal with a great deal of time, effort, and resources put into assessment and planning. Partners across the district have known this for a long time and worked together in collaborating on important initiatives. PHS will work to formalize the Partners for a Healthy Community into a district-wide coalition that shares community health assessment, community health improvement planning, and data resources. This partnership will allow community leaders, healthcare providers, public health, and community-based organizations to share limited resources, assist communities to leverage their own resources, and truly make an impact in the health and wellness of individuals and families living in Fillmore, Jefferson, Gage, Saline, and Thayer counties. PHS will begin discussions with key stakeholders from the Partners for a Healthy Community group and serve as facilitators to bring together this dynamic collaborative effort. The coalition will continue the work of identifying action steps that can be taken in each priority area and tracking progress via a joint online performance measurement system. All progress of this group will be available for review by the public to provide for accountability, transparency, and continuous quality improvement as needed. For more information on this plan, please visit the PHS website at phsneb.org.



Healthy opportunities where we live, learn, work, and play.

Appendices

Appendix A: Regional Steering Committee Membership List

Ament, Linda	Beatrice Community Hospital & Health Center *Chief Compliance Officer, BOH Member*
Barnes, Theresa	Blue River Women's Center *Director*
Bartels, Scott	Saline County Area Transit (SCAT) *Executive Director*
Burd, David	Thayer County Health Services *CEO*
Cerny, Larry	Fillmore County Commissioners *County Commissioner, BOH Member*
Clark, Trudy	Bruning Davenport School District *Superintendent, BOH Member*
Cook, Don	Southeast Nebraska CASA *Program Coordinator*
Dimas, Fabiola	Crete Public Schools *Sixpence Director*
Duis, Dusty	Southeast Community College *Practical Nursing Instructor*
Ebke, Laura	Nebraska Legislature *Senator – District 32*
Engler, Mark	Homestead National Park – Beatrice *Superintendent*
Erickson, Kathy	Blue Rivers Area Agency on Aging *CHOICES Unit Supervisor*
Gabriel, Pastor Greg	St. John Lutheran Church – Beatrice *Pastor*
Gutierrez, Josue D., MD	Saline Medical Specialties *MD, BOH Member*
Henning, Janet	Saline County Commissioners *County Commissioner, BOH Member*
Hensel, Steve	Crete Police Department *Chief of Police*
Hill, John	Gage County Commissioners *County Commissioner, BOH Member*
Jirovec, Kelly	Doane College – Crete *Director of Student Services*
Jurgens, Chad	Jefferson Community Health & Life *CEO*
Kennedy, Bruce, DDS	Kennedy Family Dentistry *Dentist, BOH Member*
Knight, Stephanie	Fillmore County Hospital *Behavioral Health Director, BOH Member*
Lucking, Christy	Fairbury Public School *Guidance Counselor, BOH Member*
Michl, Shari	Fillmore County Hospital *Director of Quality*

Miller, Shari	Blue Valley Community Action *Director of Children and Youth Services*
Mussman, Rebekah	Crete Area Medical Center *CEO*
Nichols, Chris	Fillmore County Hospital *CEO*
Pickering, Tim	Nebraska State Patrol *Sergeant*
Schoenrock, Mark	Jefferson County Commissioners *County Commissioner, BOH Member*
Small, Cara	Educational Service Unit (ESU) 6 *Early Learning Coordinator*
Smith, Patty	Fairbury Public Schools *Principal*
Sothan, Michael	Mainstreet Beatrice *Executive Director*
Tietjen, Jana	Hebron Chamber of Commerce *Chamber Director*
Timmerman, Missy	Beatrice Public Schools *Director of Beatrice Community Preschool*
PHS Management Team Members	
Showalter, Kim	PHS, Health Director
Chinchilla, Carmen	PHS, AHEC Program Manager
Garcia, Megan	PHS, Rooted in Relationships Program Manager
Hansen, Jennifer	PHS, Community Development Manager
Lange, Kate	PHS, Emergency Response Coordinator
Williamson, Sonya	PHS, Fiscal Administrator
Wooters, Laura	PHS, Healthy Families Gage and Jefferson Director
Wendelin, Deb	PHS, Front Office Manager

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Appendix D: 2018 Partners for a Healthy Community Five-Year Visioning Results

What does a healthy community mean to you in the next 5 years for people in the five-county area?					
Quality Affordable Housing	**Full Spectrum Wellness**	**Community Connected Education**	**Strong Families**	**Safe & Thriving Communities**	**Social Equity**
Housing (Safe & Affordable	Redefining What Complete Health Care Means	Education	Social Determinates	Vibrant Places/ Community Pride	Equity
Quality & Affordable Housing	Mental Health	Quality Education	Strengthening Family Unity	Safe Community	Equal Opportunity for All
	Access to Affordable Health Care		Quality Childcare	Thriving Community Growth	Living Wage
	Resources Identified & Available			Clean Physical Environment	Workforce Development
	Timely Emergency Response			Social Connectedness	Racial Bias
	Prevention of Disease Through Education			Forward Thinking	
				Access to Internet	
				Safety (Law, Crime Rate)	
				Lower Crime Rate	

Appendix E: 2018 Community Health Survey

For taking this survey, you can enter to win a $100 visa gift card at the end of the survey. There will be five $100 visa gift cards up for grabs.

This survey is for anyone who lives in Fillmore, Gage, Jefferson, Saline and Thayer Counties. If you are a student or living here only for a short time, we want to hear from you too. We want to know what you think the most important local health issues are in our county.

Most people need about 20 minutes to answers all the questions on this survey. If you exit the survey before you answer all the questions, you will not be able to go back and finish later. So please make sure you have time to complete the entire survey when you start it.

Your answers will be kept private. Remember to enter your contact information at the end of the survey to be entered into a drawing for a $100 visa gift card. Your answers will not be linked to you.

Clinical and Health Care System

This set of questions ask about the health care system where you live. For each statement, please mark how much you agree or disagree. (5-point scale—strongly agree to strongly disagree and I don't know):

1. There are enough places to go for urgent health care (from hospitals, emergency rooms, urgent care clinics, and so on) within a 30-minute drive from my home.
2. There are enough doctor's offices, health clinics, and so on within a 30-minute drive from my home.
3. There are enough places to go for medical specialists (a doctor who specializes in heart health, women's health, physical therapists, and so on) within a 30-minute drive from my home.
4. There are enough places to go for mental health care (counselors, licensed mental health practitioners) within a 30-minute drive from my home.
5. During the past 12 months, did you receive health care at a hospital or emergency room located—Yes/No
    a. Within a 30-minute drive from my home
    b. Lincoln
    c. Omaha
    d. Other city/town/state (please list)
6. I have one person I think of as my personal doctor or health care provider (where I go for most health care needs)
    a. Yes
    b. No
7. When I need them, I get my health care from (check all that apply):
    a. Free clinic/sliding-fee clinic
    b. Community Health Center
    c. Health Department/Shot Clinic
    d. Family Planning Clinic
    e. Emergency Room at a hospital
    f. Urgent Care Clinic
    g. I put-off care as long as I can or don't get care
    h. Other (please list name of place and town/city)

8. What town/city is your doctor's office or clinic of choice?
9. During the past 12 months, did you see your doctor/health care provider or receive health care from a doctor/health care provider?
    a. Yes
    b. No
10. Reasons I have not seen a doctor in the past year (select all that apply):
    a. No health insurance
    b. My health insurance is not taken
    c. Costs too much
    d. No ride
    e. I can't make it within the office hours
    f. Other (please list)
11. I have one person I think of as my personal dentist.
    a. Yes
    b. No
12. When I need them, I get my dental care from (check all that apply):
    a. Free clinic/sliding-fee clinic
    b. Community Health Center
    c. Health Department/Shot Clinic
    d. Emergency Room at a hospital
    e. Urgent Care Clinic
    f. I put-off care as long as I can or don't get care
    g. Other (please list name of place and town/city)
13. What town/city do you get your dental care?
14. During the past 12 months, have you received dental care from a dentist (including an orthodontist, oral surgeon, dental hygienists, and so on)?
    a. Yes
    b. No
15. Reasons I have not seen a dentist in the past year (select all that apply):
    a. No dental insurance
    b. My dental insurance is not taken
    c. Costs too much
    d. No ride
    e. I can't make it within the office hours
    f. Fear of dental work
    g. Other (please list)
16. I have one person I think of as my personal eye doctor.
    a. Yes
    b. No
17. When I need them, I get my eye care from (check all that apply):
    a. Free clinic/sliding-fee clinic
    b. Community Health Center
    c. Health Department/Shot Clinic
    d. Emergency Room at a hospital
    e. Urgent Care Clinic
    f. I put-off care as long as I can or don't get care
    g. Other (please list name of place and town/city)
18. What town/city do you get your eye care?

19. During the past 12 months, have you received eye care from an eye doctor?
    a. Yes
    b. No
20. Reasons I have not seen an eye doctor in the past year (select all that apply):
    a. No vision issues
    b. No vision insurance
    c. My vision insurance is not taken
    d. Costs too much
    e. No ride
    f. I can't make it within the office hours
    g. Other_____
21. I have one person I think of as my personal mental health provider.
    a. Yes
    b. No
22. When I need them, I get mental/behavioral health care (such as counseling, life coaching, and so on) from (check all that apply):
    a. Free clinic/sliding-fee clinic
    b. Community Health Center
    c. Health Department/Shot Clinic
    d. Emergency Room at a hospital
    e. Urgent Care Clinic
    f. Other (please list name of place and town/city)
23. What town/city do you get your mental/behavioral health care?
24. During the past 12 months, have you received mental/behavioral health care (such as counseling, life coaching, and so on)?
    a. Yes
    b. No
25. Reasons I have not seen a mental/behavioral health care provider in the past year (select all that apply):
    a. I don't have any problems that require mental health care
    b. No health insurance
    c. My health insurance is not taken
    d. Costs too much
    e. No ride
    f. I can't make it within the office hours
    g. Other_____
26. Most of the time, I am satisfied with the care that I get from my…(For each choice, please mark how much you agree or disagree)
    a. Hospital
    b. Doctor or provider (physician assistant, nurse practitioner, and so on)
    c. Dentist
    d. Eye doctor
    e. Mental/behavioral health provider
27. How do you pay for your health care (doctor's visits, hospital/emergency room visits, medications, and so on)?
    a. Pay cash (I do not have insurance)
    b. Employer provided health insurance

c. Health insurance purchased directly from an insurance company (such as Blue Cross, HMO, and so on)
d. Health Insurance purchased from the ACA Marketplace
e. Medicaid
f. Medicare
g. Medicare Part D (Prescription Drug Plan)
h. Indian Health Services
i. Veteran's Administration (VA)/TRICARE
j. Other type of health insurance or health coverage plan (please list)

28. How do you pay for your dental care?
    a. Pay cash (I do not have insurance)
    b. Employer provided health insurance
    c. Health insurance purchased directly from an insurance company (such as Blue Cross, HMO, and so on)
    d. Health Insurance purchased from the ACA Marketplace
    e. Medicaid
    f. Indian Health Services
    g. Veteran's Administration (VA)
    h. Other type of health insurance or health coverage plan (please list)
29. How often do these things stop you from getting the care you need? (5-point scale—never, rarely, sometimes, most of the time, all the time)
    a. Cost
    b. No ride
    c. Scheduling (such as limited hours, long waits, hard time getting an appointment)
    d. No translator
    e. Lack of specialty doctors
    f. Won't take my insurance

Employment in Community

30. This set of questions ask about jobs where you live. Please mark how much you agree or disagree with these statements (5-point scale—strongly agree to strongly disagree):
    a. There are enough jobs where I live.
    b. There are chances for getting a better job (promotions, job training, higher education).
    c. Jobs where I live are "family friendly" (allow for flexible scheduling, reasonable hours, health insurance, and so on).
31. Do you have a job for pay at this time?
    a. Yes
    b. No
32. What is the main reason you are not working? (skip to Q38 for each option)
    a. Ill or Hurt
    b. Student
    c. Retired
    d. Taking care of family
    e. Cannot find work
    f. Other (please list below)
33. How many hours a week do you work for pay?
34. How many jobs do you work for pay?

Worksite wellness refers to programs and/or benefits offered by workplaces to help workers be as safe, healthy and happy as possible. These questions ask about whether your workplace offers these programs and/or benefits either at no cost to you or for a fee.

35. Does your workplace offer any of these programs and/or benefits: (Y/N/I don't know/Does not apply to my workplace)
    a. Free or low-cost health screenings (to check blood pressure, to draw blood to measure cholesterol and blood sugar levels, and so on) or physical exams (not as a part of the worker's health insurance or job entrance exam).
    b. Education, support groups, counseling sessions, contests, and so on) to help you make changes in your habits (such as diabetes management, healthy eating, heart disease, and so on).
    c. Offers help stop smoking or using tobacco
    d. Healthier food choices (such as foods that are relatively lower in fat, calorie, sugar or sodium) and healthful drink choices (such as 100% juices, low-fat milk, or water) in *vending machines*.
    e. Healthier food choices (such as foods that are relatively lower in fat, calorie, sugar or sodium) and healthful drink choices (such as 100% juices, low-fat milk, or water) during *work time* (such as cafeterias, staff meetings and events).
    f. A private room to breast feed on-site that is not a bathroom.
    g. Employee assistance programs (EAP) with access to mental health care.
    h. Offers workers to use flextime or paid time to take part in in wellness programs and/or benefits mentioned here.
36. Does the place where you work allow smoking?
    a. Smoking is *never* allowed any place at work (outdoors or indoors).
    b. Smoking is allowed in *some* places or at *sometimes* at my work (such as outdoors or in your car).
    c. There are no rules against smoking at my work. We can smoke anytime and anywhere.
37. Does the place where you work allow vaping or use of e-cigarettes?
    a. Vaping/e-cigarettes are *never* allowed any place at work (outdoors or indoors).
    b. Vaping/e-cigarettes are allowed in *some* places or at *sometimes* at my work (such as outdoors or in your car).
    c. There are no rules against vaping/e-cigarettes at my work. We can use them anytime and anywhere.

Social Connectedness

38. Where I live has many choices to take part in things like volunteering, social clubs and organizations, churches, sports leagues, and so on (5-point scale—strongly agree to strongly disagree).
39. How well do each of these statements tell how you feel about where you live (4-point scale—not at all, somewhat, mostly or completely)
    a. I can trust people in this community.
    b. I can recognize most of the members of this community.
    c. Most community members know me.
    d. This community has symbols (like clothes, signs, art, architecture, logos, landmarks and flags) that people can recognize as ours.
    e. I put a lot of time and effort into being part of this community.
    f. Being a member of this community is part of my identity.
    g. It is very important to me to be a part of this community.

h. I am with other community members a lot and enjoy being with them.
i. I expect to be a part of this community for a long time.
j. I feel hopeful about the future of this community.
k. Members of this community care about each other.
l. My community can work together to improve its health.
m. My community has the resources to improve its health.
n. My community works together to make positive change for health.
o. I know my neighbors will help me stay healthy.

40. How often do you get the social and emotional support you need? (5-point scale—always, usually, sometimes, rarely, never)
41. How often do you get the social and emotional support you need from (5-point scale—always, usually, sometimes, rarely, never)
    a. Family members
    b. Close Friends
    c. Co-workers
    d. Neighbors

Home and Personal Safety

42. Do you have these items to keep you and your family safe in your home? (Y/N/Not sure for each)
    a. Radon kit
    b. carbon monoxide detectors
    c. smoke detectors
    d. fire extinguisher
    e. Other (please list)
43. Does your family have a plan in case of an emergency like a tornado, fire or other event? (Where to go, how to get ahold of each other, what actions to take, and so on)
    a. Yes
    b. No
    c. Unsure
44. Do you allow smoking inside your home?
    a. Smoking is *not* allowed any place inside my home
    b. Smoking is allowed in *some* places or at *sometimes* in my home.
    c. Smoking is allowed *any place* inside my home.
45. Do you allow smoking inside your cars?
    a. Smoking is *not* allowed anywhere inside my cars.
    b. Smoking is allowed *sometimes* in my cars.
    c. Smoking is allowed *anytime* inside my cars.

Childcare in the community

The next set of questions asks about how your community helps families raise children. Please mark how much you agree or disagree with the following statements (5-point scale—strongly agree to strongly disagree):

46. My community is a good place to raise children.
47. Good choices for childcare are available in my community.
48. Affordable **(low cost)** childcare is available in my community.
49. There are good choices for children and youth to stay busy after school (like sports teams, clubs, groups, and so on) in my community.
50. Please tell us why your community is or is not a good place to raise children.

Older Adults

The next set of questions asks about choices for older adults where you live. Please mark how much you agree or disagree with these statements (5-point scale—strongly agree to strongly disagree and I don't know):

51. My community is a good place to grow older.
52. There are choices (parks, trails, fitness centers) for older adults to be active where I live.
53. There are choices for older adults that are living alone to be social in my community.
54. There are housing choices (assisted living, retirement centers, and maintenance-free homes/apartments) for older adults where I live.
55. There are public buses, shuttles, handi-vans, taxis, and so on to take older adults to medical visits and shopping.
56. There are programs that give meals to older adults where I live.
57. There are local choices for people who need long-term care (residential care, and nursing homes).
58. Please tell us why where you live is or is not a good place to grow older.

Choices for relaxing and having fun.

The next set of questions asks about **choices for relaxing and having fun** where you live. Please mark how much you agree or disagree with these statements (5-point scale—strongly agree to strongly disagree and I don't know):

59. There are music, art, theater and cultural events where I live.
60. There are plenty of fun things to do where I live (such as groups, clubs, teams and other social activities) for adults between 20-65 years of age.
61. There are places to be active where I live (parks, walking/biking trails, swimming pools, gyms, fitness centers, and so on).
62. For fun where I live, I and/or my family goes to the:
    d. Parks
    e. Movie theater
    f. Live theater/concerts
    g. Social/Service clubs
    h. Rivers/lakes/State recreation areas
    i. Sports fields
    j. Swimming pools
    k. Health/Fitness club
    l. Yoga/Tai-Chi/Dance studio
    m. Church
    n. Senior center
    o. Library
    p. Other (please list)
63. How many hours per month are you active?
    a. None
    b. 1-5 hours
    c. 6-10 hours

d. Over 10 hours

64. Please tell us why where you live is or is not a good place **for relaxing and having fun**.

Quality of Health and Safety of Community

65. What health problems worry you the most where you live? Pick your top 6
    a. Age-related health problems (such as arthritis, Alzheimer's, hearing/vision loss, falls)
    b. Bullying/Cyberbullying
    c. Cleanliness of where you live (clean public places, trash on sidewalks and streets, and so on)
    d. On-going health diseases (such as cancer, stroke, heart disease, diabetes)
    e. Overweight/Obesity
    f. Poor dental health/teeth problems
    g. Teen pregnancy
    h. Sexually transmitted infections
    i. Flu
    j. Other infectious diseases (such as hepatitis, tuberculosis, and so on)
    k. Drug Misuse/Abuse (prescription pain medications, marijuana, meth, injection drugs, PCP, ecstasy, LSD, opioids, and so on)
    l. Tobacco use (cigarettes, e-cigarettes, chew, and so on)
    m. Exposure to second-hand tobacco and/or e-cigarette smoke (indoor or outdoor)
    n. Too much drinking of alcohol
    o. Mental health (such as depression, bipolar disorder, self-harm)
    p. Suicide
    q. Poor air quality (such as air pollution)
    r. Unclean drinking water
    s. Exposure to toxic substances (such as pesticides, radon, lead, and so on)
66. Please tell us anything else you would like us to know about the health problems where you live.
67. What social and economic problems worry you the most where you live? Pick your top 3.
    a. Quality housing (the number of up-to-date and lead-free housing; overcrowded housing)
    b. Homelessness
    c. Local job choices
    d. Safe and low-cost childcare and youth activities
    e. Volunteer choices
    f. Social events where you live
    g. Social services benefits (such as SNAP, housing assistance, WIC, subsidized child care, free/reduced school lunch, and so on)
    h. Racism
68. Please tell us anything else you would like us to know about the social and economic problems where you live.
69. What worries you the most about schools where you live? Pick 1.
    a. Access to quality education
    b. Availability of resources for special needs children
    c. Kids not completing school (elementary, middle or high school)
    d. Kids missing a lot of school days within a school year
    e. I don't see any problems with the schools in my community.

70. Please tell us anything else you would like us to know about the schools where you live.
71. What safety problems worry you the most where you live? Pick your top 3.
    a. Alcohol and drug abuse
    b. Availability of safe and clean places to be physically active (such as parks, sidewalks, bike paths)
    c. Child abuse or neglect
    d. Crime
    e. Domestic violence
    f. Getting hurt on the farm
    g. Car, bicycle, ATV crashes, and so on
    h. Rape/Sexual assault
    i. Unsafe roads and sidewalks
    j. Driving safety (such as unsafe driving, distracted driving, not wearing a seatbelt, children not buckled up)
    k. Violence (such as gun/weapons, gang fights, murders)
    l. Getting hurt at work
72. Please tell us anything else you would like us to know about the safety problems where you live.
73. What are the 3 most important things that make a healthy community for you?
    a. Safe place to live
    b. Social connectedness (choices to be involved in the where I live, time for family and friends)
    c. Health care access (cost, availability of providers and specialists, quality of care, and choices in health care)
    d. Mental health care(such as drug/alcohol rehab)
    e. Care for older adults (elder-friendly housing, ways to get around)
    f. Economic opportunity (job choices , low cost housing)
    g. Access to resources and support (healthy food, childcare, schools)
    h. Safe places to be active (such as recreation facilities, parks)
    i. Public buses, taxis, shuttles and so on
74. Please tell us anything else you would like us to know about the most important things that make a healthy community for you.
75. Most of the time, how would you rate the health of where you live? (Matrix / Rating Scale)
    a. Very Unhealthy
    b. Unhealthy
    c. Neutral
    d. Healthy
    e. Very Healthy
76. Most of the time, how would you rate the safety of where you live? (Matrix/Rating Scale)
    a. Very Unsafe
    b. Unsafe
    c. Neutral
    d. Safe
    e. Very Safe

Demographic Information (optional answers)

The next set of questions tells us a little about you. It is important to answer these questions to help us know whether we get input from a lot of people where you live.

77. Most of the time, would you say that your health is...? (Matrix / Rating Scale)
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor
    f. I don't know
78. How long have you lived in your community?
    a. Less than one year
    b. 1-2 years
    c. 3-4 years
    d. 5-9 years
    e. 10 or more years
79. Are you limited in any way in any activities because of physical, mental, or emotional problems? Yes/No
80. In which county do you live?
    a. Fillmore
    b. Gage
    c. Jefferson
    d. Saline
    e. Thayer
81. What is your zip code?
82. How many people live in your household?
83. How many children less than 18 years of age live in your household?
84. What is your date of birth? Please enter your month and year of birth (ex: 03/77 for March 1977)
85. What is your sex?
    a. Male
    b. Female
    c. Other
86. What is your marital/relationship status?
    a. Married
    b. Divorced
    c. Widowed
    d. Separated
    e. Living with a partner
    f. Never married
87. What is your race?
    a. White
    b. Black or African American
    c. Asian
    d. American Indian or Alaska Native
    e. Native Hawaiian or Other Pacific Islander
    f. Some other race (please list)
88. Are you of Hispanic or Latino origin?

a. Yes
b. No

89. How well do you speak English? (Very well, Well, Not well, Not at all)
90. Do you speak a language other than English at home? Yes (skip to Q91)/No (skip to Q92)
91. What is this language?
    a. English
    b. Spanish
    c. Vietnamese
    d. Other (please list)
92. What is the highest degree or level of school you have completed?
    a. No schooling completed
    b. Kindergarten
    c. Grades 1-11 (list grade level below)
    d. High school graduate or GED
    e. Some college, no degree
    f. Trade or technical school certificate
    g. Associate's degree (example: AA or AS)
    h. Bachelor's degree (example: BA or BS)
    i. Graduate degree or professional degree (example: PhD, MD, JD)
    j. (Please list grade level (Grade 1-11) here)
93. What is your gross household income last year before taxes from all sources?
    a. Less than $25,000
    b. $25,000 - $34,999
    c. $35,000 - $49,999
    d. $50,000 – $74,999
    e. $75,000 - $99,999
    f. $100,000 and over
94. Have you or anyone in your family served in the military?
    a. I served in the military.
    b. My husband, wife or significant other served in the military.
    c. My child served in the military.
    d. Other
    e. None of the above

Thank you for filling out this survey. To learn more about this survey and how you can be involved in solving some of our area's health concerns, please contact Public Health Solutions Health Department at _____. If you would like to be entered a drawing for a $100 visa gift card, please fill out the information below. We will not share your contact information or link your name to your answers.

Appendix F: Local Public Health System Assessment Summary of Results, N = 17

System Assessment

Q1 What are the strengths of our community system that contribute to good health and well-being of all who live our area? Provide any details that will help explain your thoughts to your fellow Steering Committee members.

Answered: 17 Skipped: 0

#	RESPONSES	DATE
1	Ability to find fresh, locally grown, produce. Availability of good quality health care.	8/24/2018 10:18 AM
2	The hospitals continue to try to make improvements to their facilities and equipment. Also medical providers that travel from Lincoln to see clients in the local areas	8/24/2018 9:50 AM
3	Local radio/news stations for advertising of health events, information, etc. The presence of local hospitals and physician clinics in our small towns. The health department visits our schools for immunizations and dental health. Health events-Go Red for Women, An Evening of Pink (BCH; not sure if they still do it) and the Women's Health Fair at JCHC.	8/23/2018 2:52 PM
4	Our strengths would be at school students are receiving second steps in the elementary classrooms. We also have hired a full time psychologist that supports students with mental health issues. We also have implemented PBIS at all levels in Fairbury Public Schools. Our nurse promotes good health to all staff via emails, contests, etc. We also have Jefferson Community Health and Life that promotes healthy living for all. They are also working with the school and promoting healthy living through education nights for families and promoting events for students.	8/23/2018 10:27 AM
5	Small communities Multiple ministerial organizations Wellness center youth sport organizations youth activity organizations Multiple community organizations Health education through local hospital	8/22/2018 5:24 PM
6	Safety Resources Positive Relationships Health Care School Systems Diversity Low Crime Rate Low Unemployment Rate Resources for Low Income Families	8/22/2018 3:51 PM
7	many community activities to promote well being	8/22/2018 10:32 AM
8	Have a clinic and hospital in the community, community members are able to use educational facilities to exercise, educational opportunities to community members to be educated about health issues, sports are available to young children through Parks and Recreation or school year around	8/22/2018 8:26 AM
9	Viable Hospitals with access to speciality type physician's which promote patrons to seek care without the added cost of time and travel. Communities have active year round sports and recreation available to the public.	8/21/2018 8:30 PM
10	our hospitals	8/21/2018 6:52 PM
11	Wellness Center in the community Walking trails Community garden Multiple walk/runs throughout the year Yoga studio Health education classes through the hospital	8/6/2018 10:38 PM
12	We care about each other. The school district offers access to mental health providers, and health screenings for children including vision and hearing. The school building is open to those who wish to walk and uses the weight deck.	8/3/2018 1:50 PM
13	provider knowledge, coalitions	8/1/2018 2:12 PM
14	Healthcare options (clinic and hospitals) in every County. Educational systems in every County.	8/1/2018 12:51 PM
15	Rural areas seem more open to coordinating and working together for a common cause. I can think of several coalitions such as the Safe Kids / Drug Free Communities work.	7/30/2018 12:10 PM
16	There is still the small-town feeling and people do look out for the frail ones. However, as younger families move into many of the small communities, that is being lost because people don't take the time to get to know new people, don't want to "get involved".	7/30/2018 10:44 AM
17	Excellent health care facilities. Public Health Solutions ascertaining needs and responding to those needs. Proud to be Nebraskans and the values associated with that. Healthy environment, clean air and water.	7/27/2018 7:21 PM

1 / 9

Q2 Considering this list above, are there strengths of our community system that you would like to add or elaborate on?

Answered: 12 Skipped: 5

#	RESPONSES	DATE
1	We need more drug and alcohol treatment centers, solutions, and prevention programs.	8/24/2018 10:18 AM
2	Organizations/coalitions/collaborations - need to know what is already in existence. Also need to know what programs and events already exist in our communities	8/24/2018 9:50 AM
3	Can't think of any	8/23/2018 2:52 PM
4	Fairbury Public Schools promoting PBIS	8/23/2018 10:27 AM
5	Low Crime Rate Safe	8/22/2018 3:51 PM
6	Educational programs in our community involve all populations (Early Head Start, Head Start, Migrant Program, Literacy Program, Sixpence, ELL & GED classes, Preschool Programs) Having bilingual personal at the city, library and other business make them approachable to many community residents that do not speak English.	8/22/2018 8:26 AM
7	No	8/21/2018 8:30 PM
8	In each community, I believe there is access to fitness centers & health clinics.	8/3/2018 1:50 PM
9	school system	8/1/2018 2:12 PM
10	Limited resources make it difficult to provide all the needed services. But this does bring about more willingness to collaborate amongst partners.	7/30/2018 12:10 PM
11	Beatrice is trying to organize some type of coalition to educate the local area on multiple health related topics. It is spearheaded by AseraCare Hospice and MOSAIC.	7/30/2018 10:44 AM
12	A good stable population that is proud of its heritage and working for the future. People look out for each other.	7/27/2018 7:21 PM

Q3 What are the areas of improvement needed so that our community system can effectively contribute to good health and well-being of all who live our area? Provide any details that will help explain your thoughts to your fellow Steering Committee members.

Answered: 16 Skipped: 1

#	RESPONSES	DATE
1	More solutions for homeless More solutions for children whose parents are incapable of caring for them due to their addictions. More solutions for those caught in addiction.	8/24/2018 10:20 AM
2	Need for more specialized health providers in our area or financial ways to assist families who have to travel a distance for quality or specialized care	8/24/2018 9:51 AM
3	*follow-up (how do we know they are really changing their diet habits or exercise habits?) *reaching those that aren't exposed to available events or are not aware of resources available to them	8/23/2018 3:01 PM
4	housing, child care, mental health supports outside of school, promotion of activities for all children, resources for families..	8/23/2018 10:31 AM
5	Access to healthier food options in grocery stores-like Whole Foods Access to mental health resources	8/23/2018 8:41 AM
6	Transportation Mental Health Resource Medical Specialists Housing Child Care	8/22/2018 3:57 PM
7	I think we have a good foundation resources to promote well being and good health however, I think there is a need to increase manpower behind those resources	8/22/2018 10:35 AM
8	Mental health services available to all in our community are limited. Housing is a problem in Crete, very expensive and poor living conditions, obesity among young ladies and children, not having a place to meet during the winter time (children are not able to play outside)	8/22/2018 8:35 AM
9	Mental health professionals availability to the rural areas.	8/21/2018 8:31 PM
10	Better lettership	8/21/2018 6:54 PM
11	I think central location or warehouse of resources would be beneficial. There is overlap of services, but oftentimes, folks, like myself, are unaware of all services offered.	8/3/2018 1:52 PM
12	funding, insurance, transportation, more providers, education	8/1/2018 2:13 PM
13	Better collaboration among healthcare - not duplicating services but complimenting services. Expanded Mental Health resources Expanded housing options	8/1/2018 12:52 PM
14	Small communities are sometimes lacking in the resources or expertise to develop and enforce city ordinances. This is particularly true for housing.	7/30/2018 12:13 PM
15	There are many homes in all communities that are in poor condition that folks are still living in. They need some type of assistance to improve the living conditions.	7/30/2018 10:46 AM
16	Infrastructure is always a challenge. Distances with a sparse population is a challenge. High speed internet, economic opportunities to keep our young people in SE Nebraska. Better access to specialty healthcare.	7/27/2018 7:23 PM

Q4 Are there other areas of improvement of the community system that you would like to add? Provide as much detail as you feel will help explain your thoughts to your colleagues.

Answered: 10 Skipped: 7

#	RESPONSES	DATE
1	None	8/24/2018 9:51 AM
2	collaboration Not sure if this is the right spot for this idea but could we have an updated resource book/website that is kept current of various support groups, blood pressure clinics, etc. This would be a useful tool for doctor's offices, school nurses, etc. to help share resources to those that may benefit from them.	8/23/2018 3:01 PM
3	Promote family activities, promote positive aspects of Jefferson County,	8/23/2018 10:31 AM
4	Child Care Housing Transportation Mental Health Resources Medical Specialists	8/22/2018 3:57 PM
5	still need community gyms/recreation space	8/22/2018 10:35 AM
6	RESOURCES available when we have families in need. Medical, mental health services, or medical services for children that do not have insurance. More leaders community leaders that represent most community members in the community.	8/22/2018 8:35 AM
7	No	8/21/2018 8:31 PM
8	no	8/1/2018 2:13 PM
9	Resources are probably the biggest hindrance to improvement.	7/30/2018 10:46 AM
10	High speed internet could promote significant economic opportunities. High speed internet access makes location of employment or whatever process much less important, therefore creating opportunities to keep people in rural areas. Access to information and the ability to act on/process that information in a rural/small town environment is vital.	7/27/2018 7:23 PM

Q5 What opportunities exist within our community system that would contribute to good health and well-being of all who live our area? Provide any details that will help explain your thoughts to your fellow Steering Committee members.

Answered: 14 Skipped: 3

#	RESPONSES	DATE
1	We have good school systems We have good health care WE have high quality foods available We have access to trails, parks and other areas that help us to stay active and healthy	8/24/2018 10:32 AM
2	Wellness facilities and programs, collaborations are a must in order to pull resources together to support good health and well-being for all	8/24/2018 9:53 AM
3	*various health events I mentioned earlier *many local hospitals and physician clinics *various parks in our communities and exercise opportunities (fun runs) *fitness centers in small communities (Diller and Odell) *lots of churches	8/23/2018 3:04 PM
4	Health education through local hospital Multiple run/walks throughout the year Walking trail	8/23/2018 8:43 AM
5	School System--bus Hospital--Dr. Office Fitness Center Food Programs Library Community Centers Church Therapists ESU --Resources Youth Events/Activities	8/22/2018 4:02 PM
6	again, good base of resources	8/22/2018 10:38 AM
7	Education opportunities for all in the bigger cities, recreational opportunities during the summer time,	8/22/2018 9:14 AM
8	Exercise groups in the community like walking groups, running, biking hiking.	8/21/2018 8:33 PM
9	I refer to my previous answer...each community seems to have access to a fitness center or ways to exercise, clinics, and now mental health practitioners.	8/3/2018 1:53 PM
10	opportunity to engage multi-generational groups through integrated trainings	8/1/2018 2:15 PM
11	Collaboration to produce more expansive services for the people we serve Expanded mental health services (more access) Expanded housing options	8/1/2018 12:53 PM
12	The need to have industry become more active in the community process. Find a way to partner to address common needs.	7/30/2018 12:15 PM
13	The YMCA in Beatrice, the Wellness Center in Fairbury - both provide lots of opportunities to improve health and well-being. More specialists are coming to small communities so that people don't always have to travel to Lincoln or Omaha.	7/30/2018 10:50 AM
14	Access to rural and small town lifestyle and all that entails. Significant probability of being healthier. Sense of community and family that is often times missing in urban areas.	7/27/2018 7:24 PM

Q6 Are there other opportunities that exist within our community system that you would like to add? Provide as much detail as you feel will help explain your thoughts to your colleagues.

Answered: 8 Skipped: 9

#	RESPONSES	DATE
1	The true missing link for our community is access to drug and alcohol treatment. Most treatment programs cost in excess of $4000 a month which makes them cost prohibitive for most people. It has been proven over and over that Outpatient treatment doesn't work. There are likely more than 20,000 people in our community that struggle with some sort of life controlling problem. We keep doing the same thing over and over - prescribing more and more medications, throwing the same coping methods at them, none of which are working. We need to think outside the box. WE need to address the wounds of the heart if we are going to change their behavior. When we only address the behavior - which is linked to what they think and feel - we provide coping skills that only produce short term results. They key really lies in changing the heart. This isn't just for addicts - it is for all people. We are not just flesh and blood. We are body, mind, soul and spirit. So the missing link in good health is dealing with the spirit man. While we want to separate "church and state" you simply cannot separate these things if we truly want to address good health.	8/24/2018 10:32 AM
2	None	8/24/2018 9:53 AM
3	Can't think of any	8/23/2018 3:04 PM
4	urgent care facilities for after hour, non emergency situations and community recreation space	8/22/2018 10:38 AM
5	Health services and facilities, local services available to young children, opportunities for children to get involved in seasonal sports	8/22/2018 9:14 AM
6	No	8/21/2018 8:33 PM
7	The hospitals also offer diabetic teaching. Blue Rivers offers Tai Chi and Stepping On (both to help prevent falls and improve balance) as well as Powerful Tools for Caregivers (support for caregivers of all ages).	7/30/2018 10:50 AM
8	Opportunity to promote the advantages of rural and small town living!	7/27/2018 7:24 PM

Appendix G: Key Issues Summary Table—Community Health Status

Key Issue	Evidence that supports key issue And Location in assessment document	Discussion from Data Review Group 8/29/2018	Questions/Insights Raised
Metabolic Syndromes (obesity, high blood pressure, high cholesterol)	***Domain 7 – Health Outcomes*** Hypertension- Missing Fillmore Co. PHS District Avg is higher than state: 33.5%>29.9% (BRFSS 2015) Obesity: 35.7% (PHS)>32.0% (NE) (BRFSS 2016) High cholesterol-Only found the % for our PHS District: 38.8%, compared to 35.1% for NE (BRFSS 2015) Diabetes 10.9% (PHS)>8.8% (NE) (BRFSS 2016) **Domain 5: Safe & Thriving Communities** Access to physical activity: "Access to exercise opportunities: 46.4% (PHS)<83% (NE)	• # of health-related behaviors show the same across counties • Hypertension above national average • Lack of access to physical activity • Heart disease, diabetes, obesity, and high blood pressure are very prevalent in all counties • Remarkable similarities between counties • Some locations further advanced where other locations are behind • Stigma around hypertension	• Acknowledge the fact of how do we develop a plan to address what's out there? • After we have a plan, how do we allocate resources? • What do we think the requirements are? • What is the comparison to urban areas? • What can we learn from them? • How can we use that information to our benefit to move the needle?
Availability of Primary Care Physicians	***Domain 2 – Full Spectrum Wellness*** Indicator Group – Access to Affordable Health care: uninsured % is 0.8% higher than NE, % unable to see doctor due to cost is 9.3% for PHS district, 10% in NE. Indicator – Received Needed Care	• # of available primary care providers in rural areas • Even if cost doesn't matter, you still have to have a physician to go to, that trumps everything	
Mental Health (suicide, binge drinking, good and bad mental health days)	***Domain 2 – Full Spectrum Wellness*** Suicide: PHS rate: 18.6%> NE 10.7% Binge Drinking: PHS 20.2%< NE 21% Mental Health Days: Poor: PHS 3.02 < NE 3.2	• Suicide rate in adults who reported good/bad mental health days in the last 30 days shows 3.2%. The national average is 2.6%. Even though that is .6% higher, that relates to 25% more cases	• Wonder what the opioid numbers are? • With opioid usage numbers low in Nebraska, what can we do to affect this rate that's already low? • How can we use opioid grant dollars?

	Depression: PHS 14.2%< NE17.8% (BRFSS 2016) Frequent Mental Distress in the past 30 days: PHS 6.7%< NE 9.5% (BRFSS 2016) Mental Health Provider Ratio: NE: 420:1 Benchmark: 330:1 (90th %) Fillmore: 570:1 | Gage: 730:1 | Jefferson 2,390:1 | Saline: 1,790:1 Thayer: 2,550: 1 (county health rankings)	• Binge drinking in Gage County is above national average • Overlapping issues with binge drinking and mental health • It's not my responsibility – society owes you everything – not your personal responsibility • You would assume that in smaller communities the numbers would be lower than the national average • Nebraska ranks #49 in the United States in opioid usage – don't want to allocate our resources to a problem that really doesn't exist • Data is realistic of those that actually report emergency room overdose visits	
Volunteer First Responders System	***Domain 2 – Full Spectrum Wellness*** Indicator – Emergency Services - **number of volunteers much lower than state average**	• Volunteers are older, end up being patients themselves, lack of youth and engagement – not a lot of data available • Harder to recruit EMT's as requirements are stricter and hard for them to balance work, family and being a volunteer	• How is the decline of volunteers going to be handled? • What happens when there aren't volunteers to be on duty?
Availability of Environmental Supports (better housing, access to recreation-**much lower than Nebraska state average in all counties; yet, 3 counties higher than the national average**)**	***Domain 1 – Quality Affordable Housing*** Homelessness rate: no data for counties, just state Houses built before 1960: PHS 56.34%> NE36.6% ***Domain 5 – Safe & Thriving Communities*** Indicator – Built Environment - **All 5 counties were higher than state average for percent of radon tests with levels of 4pi/L or above; average daily density of fine particulate matter higher in all 5 counties than state and national averages and significantly higher than benchmark in. However, if I remember correctly, this didn't really rise to**	• More than quality of housing issue – more an overall quality of life issue – need more recreational opportunities to occupy people's time and where they can put their energy and focus to – maybe community service • In some areas doctors write prescriptions for their patients to go do parks – it is important to get people away from things that are causing the issues	• What roles can local hospitals take in wellness? • Crossing the Quality Chasm – we know what the right thing is to do, but how to we pay for it? How do we get reimbursed? • People who utilize wellness centers – are these the people we really need to target? • Can we consider building a recreation center?

	the top of the list for topics of discussion, though, so I highlighted in yellow. Population exposed to water exceeding a violation limit: Gage 3%, Jefferson County. None for the others **Air quality: Avg daily density of fine particulate matter: PHS 9.13 > 8.2 NE**		
Maintain critical access hospitals	**Main Industries** (Health Care and Social Services) ***Domain 6 – Social Equity*** Indicator – Employment - 4 of 5 counties top industry is "health care and social assistance"	• Employment by industry – four out of five counties the #1 employer is health care/social assistance – most of these people are probably working in hospitals – six critical access hospitals (25 beds or less) in our five-county service area – under tremendous financial strain – if little hospitals close, people have further to travel – really bad news for rural Nebraska	• What can we do to ensure we don't lose our rural hospitals?
Quality of Life	***Domain 7 – Health Outcomes*** Indicator – Adult Morbidity -Heart Disease above national average (NE, all counties) -Diabetes above national average (all counties except Saline) -Obesity -just below national average, all counties -HTN above national average, all counties -Cancer (all kinds, incidence) above national average, all counties. -Teen Birth Rates (mixed) At or Higher than state average (Gage, Jefferson). Below state average (Saline, Fillmore, Thayer) -Infant Mortality Rates (mixed); Higher than state average (Gage, Fillmore). Lower than state average (Saline Jefferson, Thayer) ***Domain 7 – Health Outcomes***	• It all comes down to personal choices (obesity, binge drinking, teenage pregnancy) • Availability of resources affects your ability to be healthy • Need to promote healthy choices • Generational – need to teach the next culture • Need to educate the public • People would rather rely on Facebook than come to a public meeting where the facts are at • Challenge is getting all information out to the people to make healthy choices • Changing the mindset of people • An issue in rural communities to not care – perceive it fun, cool not to care • High rate of vehicular death – more miles are driven at a higher rate of speed than in urban areas – just the nature of living in a rural area • Healthy messages don't resonate with people • Off their couch-off their phones	• Why is that person engaging in unhealthy behaviors? • Why aren't people doing some type of exercise to make themselves healthy? • What would people do or how would they react if they know the facts? • Do we have right data available to help? • How do we get people to care? • Is there a cultural awareness campaign that markets specific messages to people? • How do we get accurate information out to the public to help them make healthy choices? • What are some indicators for risky behavior? • Why are these people doing what they are doing? Don't they have a happy, healthy home?

	-Physical Inactivity-Higher than national average, all counties. -Adult Smoking-at or just below national average (all counties). ***Domain 7 – Health Outcomes*** -MVF (motor vehicle fatality) per 100,000. At or above state average for all counties reported. ***Domain 2 – Full Spectrum Wellness*** -% Woman 40+ who report mammogram within last 2 years. At or above state average: Saline, Jefferson, Fillmore. Below state average; Gage. No info for Thayer. -% adults 50+ report colonoscopy within 10 years. All counties below state average except Thayer (was above state average). -% adults reporting flu shot within last year: Saline over state average. All other counties below state average. ***Domain 1 – Quality Affordable Housing*** Number of houses built before 1960: All counties significantly higher than state average. Median household income. All counties below state average. Gage significantly below. ***Domain 4 – Strong Families*** **-Single parent households: All counties below state average except Saline County (same as state average)** **-% of children in single-parent households. All counties below state average except All counties below national**	• Inactivity, non-consumption of fruits and vegetables, binge drinking all drill down to what data we have and how we hone down on those behaviors and then give people healthy choices of how we want them to behave • It's both a cultural and educational shift in non-caring • Drill down to specific choices we can measure • Community is not my responsibility, society owes you everything, no personal responsibility • Some data that is missing is the obsession with social media – don't care about "real" life – has made us more disconnected than ever • Two-parent household more education going to that child – single parents working to make ends meet – family unit is not complete • Educational attainment – low rate of four-year degrees – people leaving community to go to school and not coming back – losing people that are going to have that community pride • Root causes start young – number of kids in foster care – domestic violence – kids not getting messages when they are supposed to get them • Behaviors are learned but behavior begins at home • All starts before age five – kids just surviving if being tossed around • Quality housing – the have's and have not's • Wage and benefits – families work two jobs to make ends meet, not at home with their kids, other issues than low unemployment rate • Can be unemployed and still on Medicaid and food stamps • Method of reimbursement – the Perspective Payment System (depends on diagnosis how	• Why is this person engaging in non-healthy behaviors? • Even though we have a low unemployment rate, what is the quality of that person's job? • How do we retain the professionals? Should that be one of our goals? •

	average except Jefferson (above state average). ***Domain 3 – Community Connected Education*** **-Educational Attainment of HS or more. All counties above state average except Saline County (below state average)** **Employment** (number of jobs, wage) ***Domain 6 – Social Equity*** % children in poverty. All counties above state average except Saline (slightly below state average). -% children receiving free/reduced meals: Gage, Fillmore, Thayer below state average. Saline & Jefferson above state average. ***Domain 6 – Social Equity*** -Unemployment rates: Gage, Saline, Jefferson above state average, Fillmore & Thayer below state average.	much hospital gets paid) changed to Critical Care Access (cost-based reimbursement where you get paid for whatever you bill Medicare). • All rural areas are having issues retaining their young workforce – lack of high-speed internet, jobs available not up-to-date with good benefits • Young people move to larger communities with more opportunities at a young age • Social connectivity, environmental supports, importance to recreation – more to life than work	

Appendix H: Key Issues Summary Table—Community Themes and Strengths

Key Issue	Evidence that supports key issue And Location in assessment document	Discussion from Data Review Group 8/29/2018	Questions/Insights Raised
Community input and engagement		• Survey was completed by predominately married females with high incomes in Jefferson County ($50-100,000). • Strategies to reach more community members: Churches, ESL classes, WIC clinics, supplemental food distribution at Blue Valley Community Action while waiting in line, Focus group with like-minded folks • Need more responses from low-income target • Partners who are helping to disseminate the survey need goals (number to reach). This will help keep motivated to get surveys completed. • Incentives for everyone (i.e. $20 gift card for everyone who completes a survey). • If the people who responded to the community survey are identifying and having issues, people in lower income and less educated target groups are likely to experience these issues and more.	• How do we engage community input on everything we do from surveys to program development to strategic planning, etc? • Do we need to

Affordable Health Insurance	25% responded that they put off health care as long as possible (survey respondents are predominately married females with high incomes in Fairbury ($50-100,000).	• Even if survey respondents are more affluent and have more resources, 25% responded that they put off health care as long as possible • Many people depend on their employer for health insurance • A lot of people aren't going to have insurance as it's too expensive • Even if you have employer-based insurance the deductible for out-of-pocket expenses is too high so you put off getting care	What happens if insurance gets so expensive the employer isn't able to provide anymore? Is the problem a matter of access to health insurance or is it the availability of health insurance?
Housing	**Category – Childcare in the Community** Page 40, Question 44	• If the people who responded to our survey are having housing issues, then the people of the demographics we didn't get a response from are even worse	
Drug usage	**Category – Childcare in the Community** Page 40, Question 44	• Data review group was shocked at the survey responses that drug usage is a problem • Public Health Solutions staff stated that drug abuse is not a big problem statistically but the survey respondents think there is a problem with drug abuse.	How do we validate the perception that drug use is a problem?
Childcare	**Category – Childcare in the Community** Page 40, Question 44	• Quality childcare should be affordable, flexible to parents with working hours, and provide transportation to and from activities	
Resources for the older population	**Category – Older Adults in the Community** Page 47, Question 46	• Not a lot of resources for the elderly population such as transportation and nursing homes •	How do people replace extended family who don't live close?

Promotion within the job	**Category – Employment in Community** Sub-Category – Job Availability Page 27, Question 27	• Chance for promotion, more economic opportunities, higher education, and job training • Social and economic gap between the haves and the have not's	
Community connectedness	**Category – Home and Personal Safety** Page 32, Question 36 **Category – Older Adults in the Community** Page 47, Question 46 • Data reflects people don't know or trust their neighbors • Only 5.45% say they could always get the social and emotional support from their neighbors that they needed		
Social support	**Category – Older Adults in the Community** Page 47, Question 46	• People with no close extended family have a lack of support • We have such a mobile society that people don't always live close to their family and don't have the traditional form of social support and their neighbors aren't neighborly anymore •	
Environmental support	**Category – Home and Personal Safety** Page 35, Question 39 • Of those people who responded 79% say they don't have a radon kit **Category – Childcare in the Community** Page 35, Question 35	• Our part of Nebraska sits on an underground ribbon of radon with higher-than-average rates of radon • Most homes don't have a radon mitigation system • Several people mentioned cancer rates were very high in their community	Is a radon kit something everyone should have?

Gap between those who have resources and those who do not have as many resources	"No one here cares. It takes a village to raise a baby. Unless you are from a prestigious family you are made to feel you don't belong and that gets forced on to your kids" **Category – Childcare in the Community** Page 40, Question 44 **Category – Older Adults in the Community** Page 47, Question 46 **Category – Relaxing & Having Fun in the Community** Page 55, Question 50	• Data review group stated that the following comment from a survey respondent	

Appendix I: Key Issues Summary Table—Forces of Change and Local Public Health Assessment

Key Issue	Evidence that supports key issue And Location in assessment documents	Discussion from Data Review Group 8/29/2018	Questions/Insights Raised
Collaboration = Sustainability	Partnership Survey – Q1, Q4	• Need to work together – resources will go further and provides the opportunity for collaboration • Need to be aware of what each partner is doing so we don't duplicate efforts	
Lack of Awareness about opportunities, resources and how to be healthy	Forces of Change – Lack of early intervention and prevention; Competing governmental funding priorities; Access to opportunities Partnership Survey – Q3; Q2 #2, 6	• Education was mentioned several times in regards to prevention, health promotion and opportunities • Lack of awareness among general public and RSC group	
Social/community connectedness	Lack of/reduced social interaction: Forces of Change – Technology, Lost civility Small community connectedness: Partnership Survey – Q1 #16; Q2 #12; Q3 #7 **Note:** Forces of change showed technology as a threat to social interaction, but the partnership survey identified small community connectedness as a strength of our rural communities. Seem to be somewhat competing arguments and may be worth noting during the meeting if either of these things comes up.	• When you look at this it's all about people wanting to be connected with their community • Social connectedness – if we could somehow connect people in their community with other people • In all these surveys it's all about social issues • We kind of thought we would see smoking among teens but it always comes back to social connectedness • If people know their neighbors, people are more likely to be civil to each other	

Access to resources and opportunities	Forces of Change – Access to opportunities Partnership Survey – Q1 #1-2, 4-5, 8, 11; Q2 #4, 6; Q3 #1-16; Q5; Q6	• Access to opportunities, housing, medical, everything – just like the access to awareness from the partner survey • It's like we are leaving people behind and not bringing them along with all the things that are available – leaving a whole population behind • Even if we do have the services and they don't know or have access to we are still leaving them behind • Distribution of wealth and privileges – social justice • Resource rich, awareness poor	
Technology	Forces of Change – Technology, Lost civility Partnership Survey – Q3 #16; Q4 #10	• Technology creates so many opportunities and imposes so many threats • Technology is a part of our lives • We are bombarded by so many things technologic we become immune to it • Youth are spending hours and hours on electronic devices and not spending time outdoors • Looking at the system assessment you aren't going to draw young people back to the community without technology • Disasters, shootings – just another day – desensitized • No value on human worth or suffering	

Appendix J: Priority Area 1: Chronic Disease Action Plan

<table>
<tr><th colspan="4">TOP ACCELERATED ACTION PLANNING – PART 1: INITIAL PLAN</th></tr>
<tr><td colspan="2">THE GIVENS:
What is the goal of the project?
Reduce # of patient current rates with metabolic syndrome
Prevent future metabolic syndrome by ___%
What have we accomplished to date? What do we have in place?
Have the data – need to be able to analyze and use
SMBP workflow at BCHHC (evidence-based guidelines)
JCHL Standard Order Set (referral to NDPP)
Metabolic syndrome reversal program – worksite wellness FCH
NDPP active in 3 out of 5 counties
What is the time frame?
1 year
What else do we already know about this project?
Takes entire community teamwork; access to foods, recreation, Pharmacists, CHW’s
Physicians must be on board
Need shared governance with providers
Living Well is state priority-funded trainings</td><td colspan="2">VICTORY
What do we see in place that indicates our success? The completed project is…
Reduction of patients diagnosed with metabolic syndrome
Increase awareness of metabolic syndrome and risks (health literacy)
Decrease obesity
Environmental support available (environmental scan)--Food pantries, grocers, recreation
Healthy choice=easy choice</td></tr>
<tr><th colspan="4">OUR CURRENT REALITY</th></tr>
<tr><td>Strengths
What are our strengths as a team?
Many pieces in place
Shared vision</td><td>Weaknesses
What are our weaknesses as a team?
Currently not shared or used widely across district
Ingrained silos
Communities are unique—EHR’s do “talk” to one another</td><td>Benefits
What benefits will our success bring?
Healthier community
Organizational collaboration</td><td>Dangers
What obstacles or dangers do we anticipate confronting when we are highly successful?
Reduce ER revenue!</td></tr>
</table>

			• If health system goes to preventative, health department duplicating?

Commitment—What are we <u>REALLY</u> committed to accomplishing as a team?

- Inventory current resources
- Sharing current resources
- Collaborating (pooling resources) for additional (identifying gaps) needed resources (healthy system + public health – leverage resources)
- Baseline data inventory on current patient panels

Activity/Member(s)	First Step	THE ACCELERATED ACTION PLAN CALENDAR						Success Indicator	$
		Oct/Nov	Dec/Jan	Feb/Mar	April/May	June/July	Aug/Sept		
Rebecca	Identify contact within each organization who can get baseline data/inventory for metabolic syndrome patients		Rebecca to have contacted hospital CEO's asking for baseline data/contact for baseline data	Convene contacts/task force with baseline data				Electronic inventory of baseline data for metabolic syndrome patients developed	
Rebecca to initiate/all to participate in task force	Create inventory of protocols, practices, procedures related to metabolic syndrome indicators (include best practices, benchmarks)			Convene contacts/task force with baseline data				Comprehensive inventory of protocols, processes, procedures related to metabolic syndrome in shared format	
All	Share of annual RSC meeting on progress of action plan							Recorded in PM system	
Sonya Jen Sharon	Explore opportunities for shared files (drop box)							Adapt, Adopt, Abort	

Jen Sharon	Environmental scan of HF/recreation/pantries/ancillary care							Environmental scans complete for HF access, recreation, ancillary care providers	

Appendix K: Priority Area 2: Mental Health Action Plan

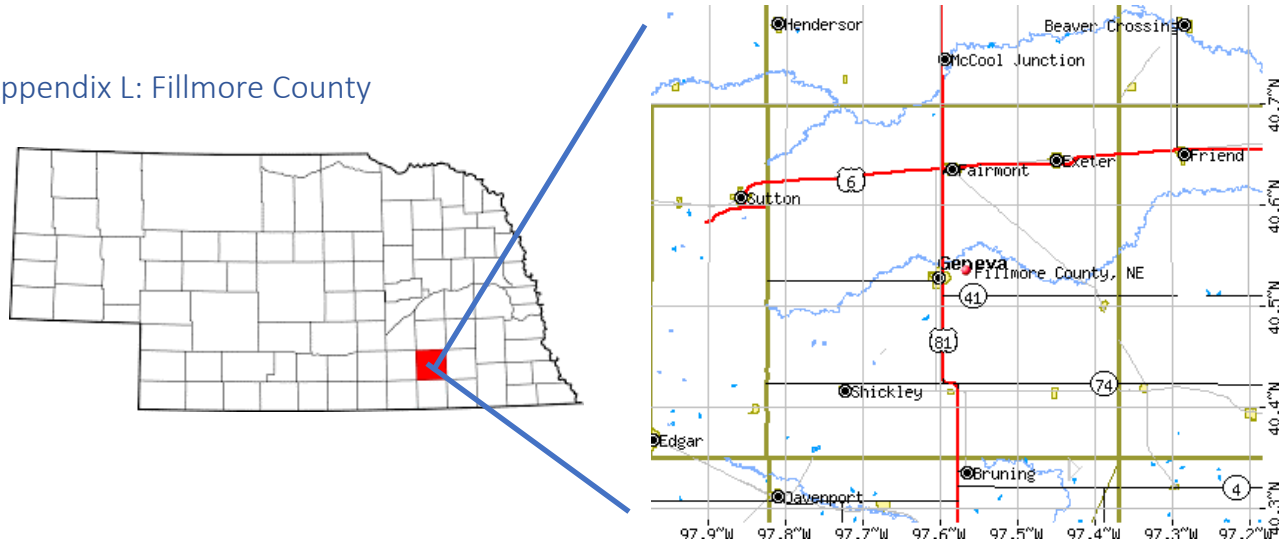
<table>
<tr><th colspan="4">TOP ACCELERATED ACTION PLANNING – PART 1: INITIAL PLAN</th></tr>
<tr><td colspan="2">THE GIVENS:
What is the goal of the project?
Awareness and integration of behavioral health into the whole health model
What have we accomplished to date? What do we have in place?
Rooted in Relationships/Pyramid Model
Early Childhood Prevention
QPR
Opened the mental health conversation
National attention re: opioid/drug abuse
Telehealth
Parity legislation
Grants found on EC, PIWI/PCIT/mental health
Mental health first aide
What is the time frame?
1 year</td><td colspan="2">VICTORY
What do we see in place that indicates our success? The completed project is…
Every person is aware of and has access to behavioral health services</td></tr>
<tr><th colspan="4">OUR CURRENT REALITY</th></tr>
<tr><td>Strengths
What are our strengths as a team?
Infrastructure
Champions of behavioral health
Networks
Grant funding
National attention</td><td>Weaknesses
What are our weaknesses as a team?
Resources
Accessibility
Stigma
Return on investment</td><td>Benefits
What benefits will our success bring?
Save health care $
Healthy families/healthy communities
Less incarceration
Increased graduation rates
Less teen pregnancy/poverty
Increased quality of life
Increased positive health outcomes</td><td>Dangers
What obstacles or dangers do we anticipate confronting when we are highly successful?
Increased burden/demands on system
Shortage of providers
Loss of hospital revenue
Over-diagnosis</td></tr>
</table>

Commitment—What are we <u>REALLY</u> committed to accomplishing as a team?

- Working collaboratively/shared resources
- Prevention and education focused
- Openly discussing mental health/reduce stigma
- Early Childhood mental health/prevention work

Activity/ Member(s)	First Step	THE ACCELERATED ACTION PLAN CALENDAR						Success Indicator	$
		Oct/Nov	Dec/Jan	Feb/Mar	April/May	June/July	Aug/Sept		
Screenings	Complete an environmental scan	Identify gaps	Provide education and get commitment where gaps exist	Support leveraging of resources	Develop central tracking system	Re-evaluate and monitor support		Every child/adult screened	
Resource Hub									
Telehealth Service									
Awareness/Education									
Develop Collaborations	Identify potential partners							MOU established in collaboration	

Appendix L: Fillmore County

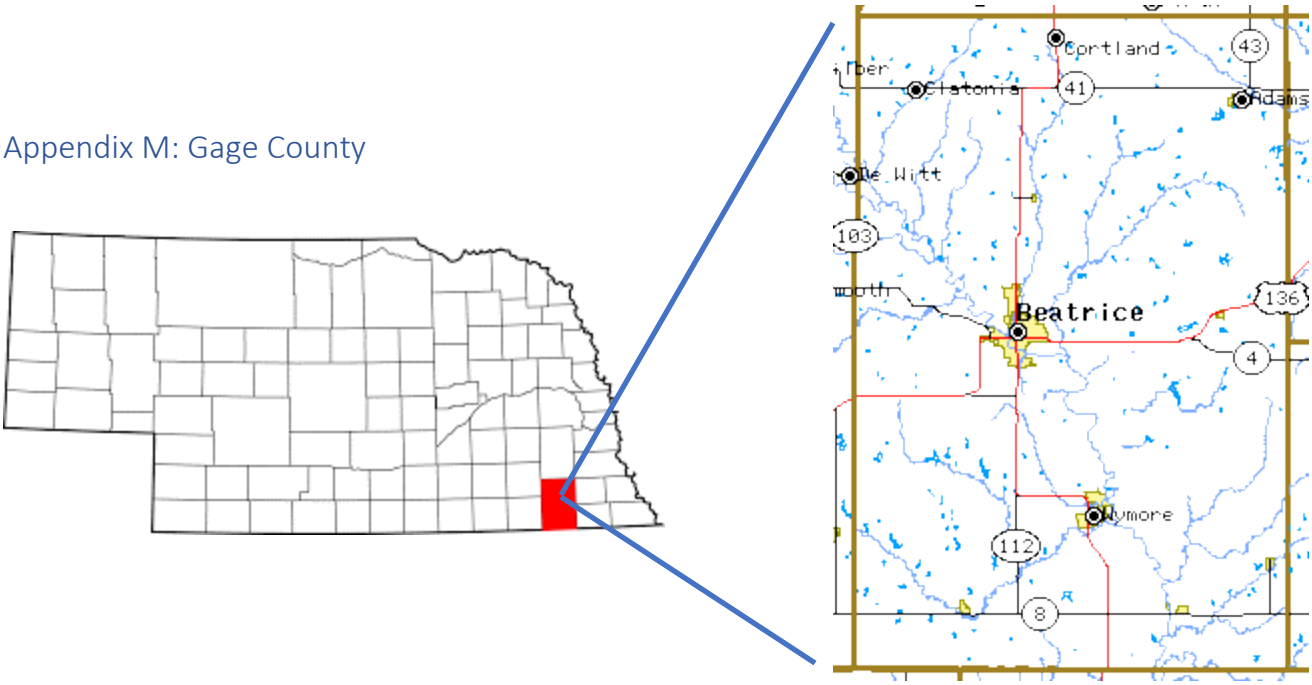


Fillmore County encompasses 577 miles with four state and federal highways running through the county. US Highway 81 crosses through the middle of the county and is a major north-south highway that extends from the Canadian border to Ft. Worth, TX. US Highway 6 and Nebraska highways 41 and 74 run East and West. The BNSF Railway crosses the northern part of the county from east to west. Incorporated communities in Fillmore County include Belle Prairie, Bennett, Bryant, Chelsea, Exeter-Fairmont, Franklin, Geneva (the largest town: population 2,122 (2017)), Glengary, Grafton, Hamilton, Liberty, Madison, Momence, Stanton and West Blue. Fillmore County is the 51/93 most populated county in Nebraska and is home to 5,890 residents[82] with a population density of 10.28 persons per square mile, less than the national average population density of 87.89 persons per square mile. The median age is 47.5[83] years and median household income is $52,070[84].

The major economic drivers in Fillmore County are agriculture/forestry/fishing/hunting and health care/social assistance[85]. Fillmore County Hospital is a county-owned, 20-bed critical access hospital providing health and wellness services to the greater Fillmore County area[86]. Youth Rehabilitation and Treatment Center located in Geneva is a state-operated juvenile correctional facility with 82 treatment beds[87]. There are three school districts within the county.

[82] US Census. American FactFinder. 2010 Demographic Profile
[83] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
[84] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
[85] U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates
[86] http://www.myfch.org/about.html
[87] http://dhhs.ne.gov/children_family_services/pages/jus_yrtc_aboutyrtcg.aspx

Appendix M: Gage County



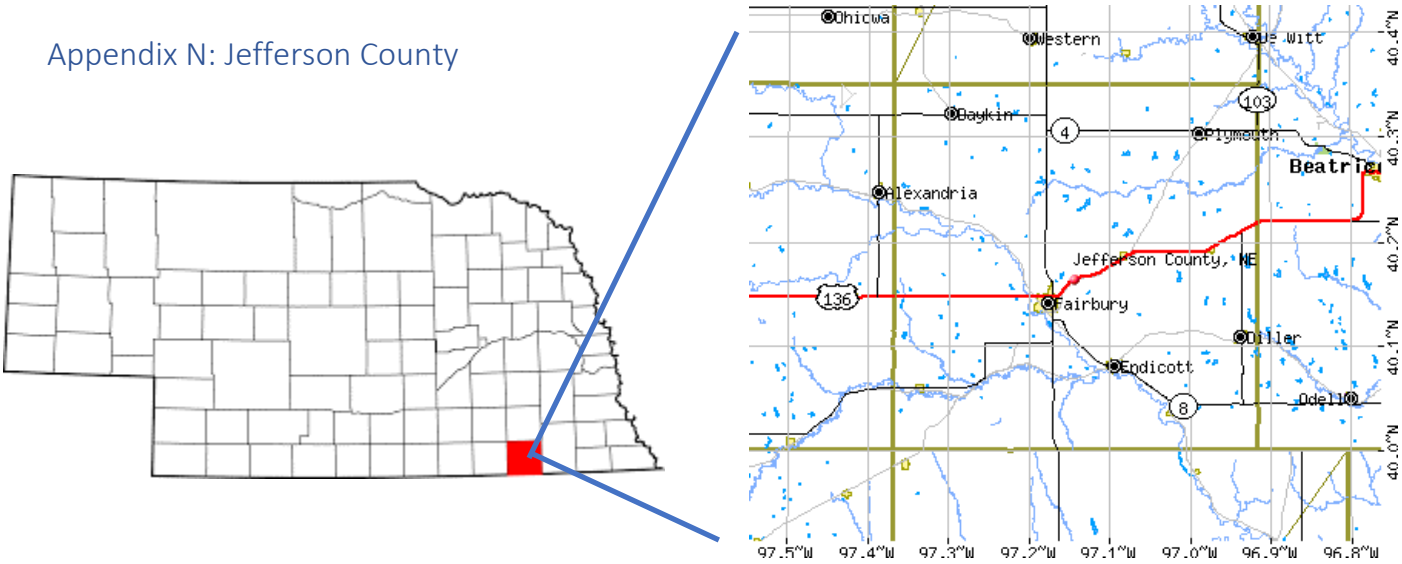
Gage County spans approximately 851 miles with four state highways running through the county. Nebraska Highway 77 crosses through the middle of the county and is a major north-south highway. Nebraska highways 8, 41 and 136 run East and West. Incorporated communities in Gage County include Adams, Barneston, Beatrice (the largest town: population 12,459), Blue Springs, Clatonia, Cortland, Filey, Liberty, Odell, Pickrell, Virginia and Wymore. Gage County is the 14/93 most populated county in Nebraska and is home to 21,806 residents with a population density of 26 persons per square mile, less than the national average population density of 87.89 persons per square mile. Kansas borders Gage County to the south. The median age is 44.8 and median household income is $48,731.

The major economic drivers in Gage County are agriculture/forestry/fishing/hunting, health care/social assistance and manufacturing. Beatrice Community Hospital and Health Center is a community, non-profit organization, the largest rural hospital in Southeast Nebraska, providing health and wellness services to the greater Gage County area[1].

Public School Districts: Beatrice Public Schools, Beatrice; Diller-Odell Public Schools, Diller and Odell; Freeman Public Schools, Adams; Southern School District 1, Wymore and Blue Springs.
Private Schools: St. Joseph Elementary School, Beatrice; St. Paul's Lutheran Elementary School, Beatrice; Zion Lutheran Evangelical Elementary School, Clatonia.

[82] http://www.beatricecommunityhospital.com/aboutus

Appendix N: Jefferson County

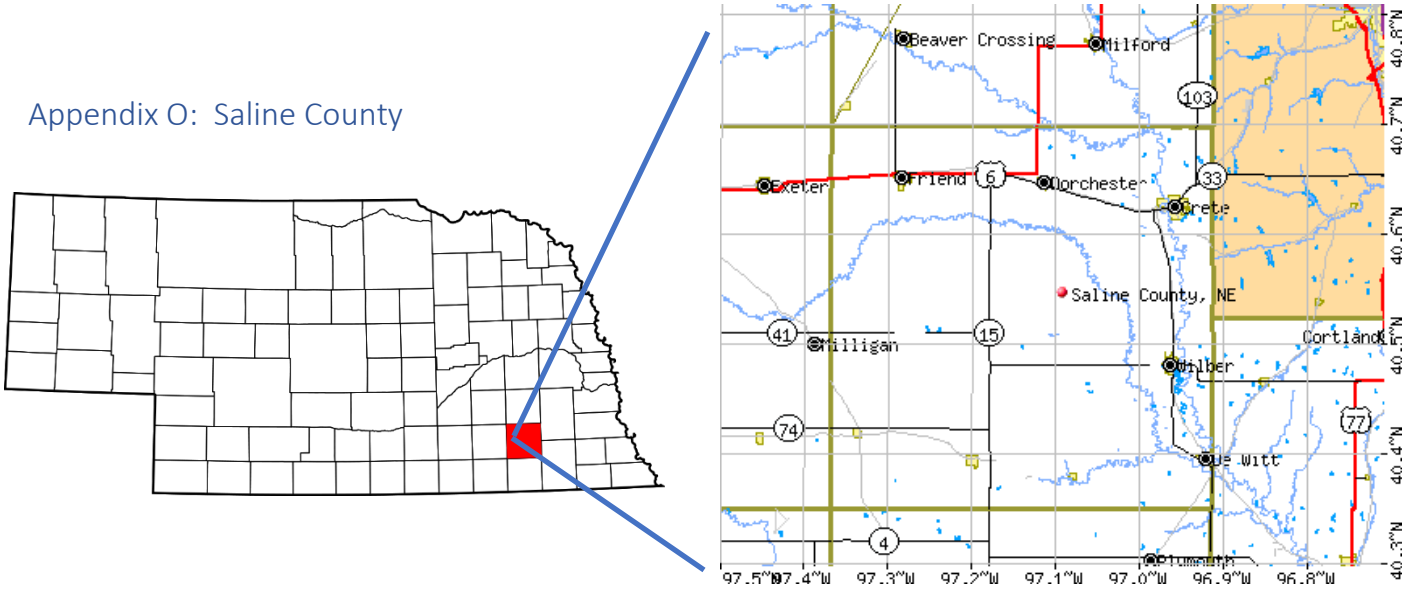


Jefferson County covers approximately 573 square miles. Incorporated communities in Jefferson County include Daykin, Diller, Endicott, Fairbury (the largest town: population 4,263), Gladstone, Jansen, Plymouth, Reynolds and Steele City. Jefferson County is the 39/93 most populated county in Nebraska and is home to 7,354 residents with a population density of 13 persons per square mile, less than the national average population density of 87.89 persons per square mile. Kansas borders Jefferson County to the south. The median age is 45.7 and median household income is $44,616.

The major economic drivers in Jefferson County are agriculture/forestry/fishing/hunting, utilities and health care/social assistance. Jefferson Community Health and Life is a 17-bed, acute care critical access hospital committed to integrating health and life services across the greater Jefferson County area.

- **Public School Districts:** Fairbury Public Schools, Fairbury; Meridian Public Schools, Daykin; Tri County Public School, DeWitt; Diller-Odell, Diller
- **Private Schools:** St. Michael's Elementary School, Fairbury; St. Paul's Lutheran Elementary School, Plymouth.

Appendix O: Saline County

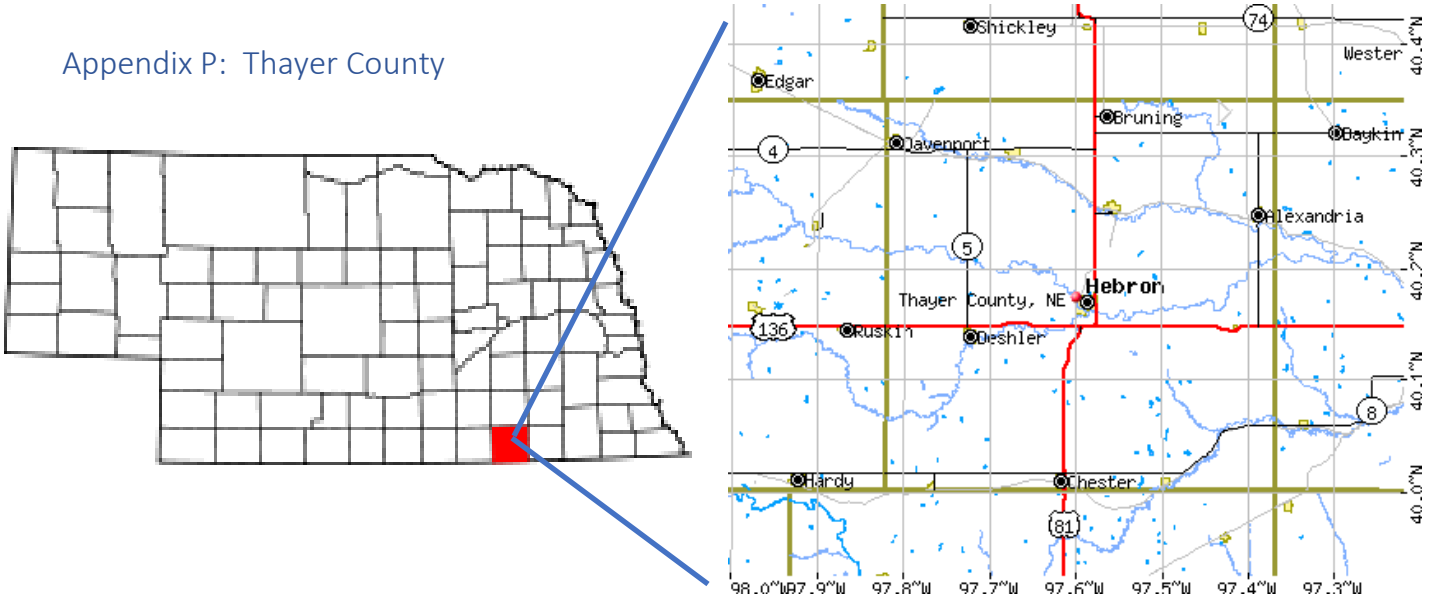


Saline County covers approximately 574 square miles. Incorporated communities in Jefferson County include Crete (the largest town: population 7,160 (2017)), De Witt, Dorchester, Friend, Swanton, Tobias, Western and Wilber. Saline County is the 20/93 most populated county in Nebraska and is home to 14,557 residents with a population density of 25 persons per square mile, less than the national average population density of 87.89 persons per square mile. Kansas borders Jefferson County to the south. The median age is 36.6 and median household income is $49,332.

The major economic drivers in Saline County are agriculture/forestry/fishing/hunting, manufacturing, health care/social assistance and educational services. Crete Area Medical Center, part of Bryan Health-a Nebraska nonprofit health system, is a community, non-profit organization dedicated to improving the health and life for the communities they serve in the greater Saline County area[1]. Doane University, a nationally recognized liberal arts and sciences university, has the second-highest four-year graduation rate of all Nebraska colleges and universities and is located in Crete[1].

Public School Districts: Crete Public Schools, Crete; Dorchester Public Schools, Dorchester; Friend Public Schools, Friend; Tri-County Public Schools, DeWitt; Wilber-Clatonia Public Schools, Wilber
Private Schools: St. James Elementary School, Crete; Zion Lutheran School, Tobias

Appendix P: Thayer County



Thayer County encompasses approximately 574 square miles with four state highways running through the county. Nebraska Highway 77 crosses through the middle of the county and is a major north-south highway. Nebraska highways 8, 41 and 136 run East and West. Incorporated communities in Thayer County include Alexandria, Belvidere, Bruning, Byron, Carleton, Chester, Davenport, Deshler, Gilead, Hebron (the largest town: population 1,511 (2017)) and Hubbell. Thayer County is the 55/93 most populated county in Nebraska and is home to 5,163 residents with a population density of 9 persons per square mile, less than the national average population density of 87.89 persons per square mile. Kansas borders Jefferson County to the south. The median age is 48.3 and median household income is $45,590.

The major economic drivers in Thayer County are agriculture/forestry/fishing/hunting, manufacturing and health care/social assistance. Thayer County Health Services is a county-owned, X-bed critical access hospital committed to being the provider of choice for the health and wellness needs of the citizens of Thayer County and neighboring communities in Nebraska and Kansas[82].

- **Public School Districts:** Thayer Central Community Schools, Deshler Public Schools, Bruning-Davenport USD

[82] https://thayercountyhealth.com/about-us/

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