CHI Health

Community Health Needs Assessment

CHI Health St. Francis & Skilled Nursing Unit - Long Term Care Hospital – Grand Island, NE 2022

A Joint Assessment

Contents

Executive Summary

CHNA Purpose Statement
The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs of the community served by CHI Health St. Francis and the Skilled Nursing Unit. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment and Mission Statement
The hospital's dedication to engaging with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

CHI Health Overview
CHI Health is a regional health network consisting of 28 hospitals and two stand-alone behavioral health facilities in Nebraska, North Dakota, Minnesota and Western Iowa. Our mission calls us to create healthier communities and we know that the health of a community is impacted beyond the services provided within our walls. This is why we are compelled, beyond providing excellent health care, to work with neighbors, leaders, and partner organizations to improve community health. The following CHNA was completed with our community partners and residents in order to ensure we identify the top health needs impacting our community, leverage resources to improve these health needs, and drive impactful work through evidence-informed strategies.

Hospital Overview
CHI Health St. Francis is a 155 bed hospital facility within CHI Health located in Grand Island, Nebraska. The Hospital provides services including alcohol and drug treatment, cancer treatment, heart care, neuroscience, orthopedic, and surgical services across several counties in central Nebraska. The Skilled Nursing Unit (SNU) offers high-level medical care provided by trained Registered Nurses, physical, occupational, and physical therapists, to those needing on-going care for recovery for an illness or injury. With 36 licensed beds, patient services available on the skilled unit include an in-house pharmacy, enterostomal and wound specialists, physical, occupational, and speech therapies, social services, nutritional services, and pastoral care.

CHNA Collaborators
- Central District Health Department (CDHD)
- Nebraska Association of Local Health Departments
- Grand Island Regional Medical Center
- Merrick Medical Center- Bryan Health
- Memorial Community Health

Community Definition
For the purposes of the CHI Health St. Francis and SNU CHNA, the primary service area was defined as Hall County, NE, based on patient data that demonstrated 75-90% of patients served in calendar year 2019 resided in Hall County. There were two zipcodes that are represent over 75% of IP/ED discharges in FY20: 68801 and 68603.

Assessment Process and Methods
In Fiscal Year 2022 (FY22), St. Francis and the SNU conducted a CHNA in partnership with CDHD and numerous community partners. The CHNA process included both primary and secondary data collection, and community engagement sessions to determine the needs of the community. The CHNA led to identification of eight significant health needs for Hall County. With the community, the Hospitals will further work to identify our role in addressing these health needs and develop measurable, impactful strategies to address prioritized health needs. A report detailing the implementation strategy plan (ISP) for St. Francis and SNU will be released in the fall of 2022.

Process and Criteria to Identify and Prioritize Significant Health Needs
CDHD conducted facilitated conversations in the two community input sessions they hosted to engage participants in prioritizing health needs. Participants were invited to vote on top needs based on the following criteria:
Size = many people affected
Seriousness = many deaths, disabilities, hospitalizations
Trends = getting worse, not better
Equity = some groups affected more
Intervention = proven strategies exist
Values = our community cares about this
Resources = Builds on current work

Prioritized Significant Health Needs

- **Access to Care:** The entirety of Hall County is designated as a Medically Underserved Area/Population for primary care and the cost of healthcare services can be a barrier to care for CDHD residents. Surpassing the state rate, about 1.5 out of every 10 adults aged 18-64 needed to see a doctor, but could not due to cost within the past year, and 1 in 5 adults aged 18-64 had no health care coverage. Nearly 1 in 5 adults in the CDHD district report not having a personal doctor or health care provider. Across the state, nearly 1 in 2 Hispanics reported not having a personal doctor or health care provider.
- **Behavioral Health:** Suicide is the 9th leading cause of death in Nebraska, and the second leading cause of death for individuals aged 10-34. Hall County is at higher risk for youth suicide ideation and attempts. In Hall County, approximately 1 in 4 Nebraska high school youth reported feeling depressed.
- **Cancer:** Cancer remains a leading cause of death in the district and across the state. In the district, female breast cancer was the leading type of cancer diagnosed and prostate cancer was second in the district.
- **Chronic Disease:** The death rate in Hall County due to chronic lung disease, cerebrovascular disease, and diabetes were higher than the state.
- **Maternal, Infant, and Child Health:** The overall birth rate (15.7/1,000) and teen birth rate (38/1,000) in Hall County was higher than other counties in the CHD and state.

- **Social Determinants of Health:** Severe housing problems are reported among 16% of Hall County residents, higher than the state rate of 13%. In Hall County, 59% of public school students receive free and reduced lunch, which is higher than the state average of 46%. The population ages 3-4 enrolled in school is 36% (NE 43.48). Only 22% of the population aged 25 and older have obtained a Bachelor's level degree or higher (NE 32%).
- **Violence/Injury:** In the district, all counties experienced higher rates of death by injury than the state. The death by injury rate in Hall County was nearly double the state. Leading causes of death by injury in Nebraska were car accidents, suicide, unintentional falls, and unintentional poisoning. In Hall County, there were a total of 39 deaths due to motor vehicle crashes. This represents an age-adjusted death rate of 13.0 per every 100,000 total population (NE 12.1%).

Resources Potentially Available

In addition to the services provided by CHI Health St. Francis and SNU, there are many assets and resources working to address the identified significant health needs in Hall County. The CDHD and Hall County Community Collaborative convene numerous coalitions to address the needs of the community. A complete list of resources can be found on their respective sites, https://cdhd.ne.gov/ and http://www.h3cne.org/members/.

Report Adoption, Availability and Comments

This CHNA report was adopted by the CHI Health Board of Directors in April 2022. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at CHI Health St. Francis and SNU. Written comments on this report can be submitted via mail to CHI Health, The McAuley Fogelstrom Center (12809 W. Dodge Rd., Omaha, NE 68154 attn. Healthy Communities); electronically at: **https://forms.gle/CHtYJgLYXa57iTRQ9** or by calling Kelly Nielsen, Division Vice President- Healthy Communities and Strategy at: (402) 343-4548.

Introduction

Hospital Description

CHI Health St. Francis, located in Grand Island, Nebraska, is a nonprofit, faith-based healthcare provider. Founded in 1883 by the Sisters of St. Francis, this hospital is now a regional treatment center, with more than 100 physicians and 1,100 employees working together to build a healthier community. With 155 licensed beds and designated as a Magnet organization by the American Nurses Credentialing Center (ANCC), St. Francis has extensive experience in the treatment areas of:

- Alcohol and Drug Treatment Center
- Cancer Care
- CHI Health at Home
- Dermatology
- Diabetes Education
- Emergency & Trauma
- Family Birthing Center
- Heart Care
- Imaging
- Neuroscience
- Ophthalmology
- Orthopedic Services
- Pediatric
- Podiatry
- Primary Care
- Pulmonary Medicine
- Psychiatry
- Rehabilitation
- Sleep Disorders
- Surgical Service
- Wound and Ostomy Center

The CHI Health St. Francis Skilled Nursing Unit (SNU) received its license to practice in 1986, at the same time as a merger between Saint Francis Medical Center and Grand Island Memorial Hospital into the community's sole acute care unit. The SNU provides inpatient skilled care to patients who require additional nursing or rehabilitative services after hospital discharge or cannot receive services in their home.

The Skilled Nursing Unit has 36 licensed beds and served 426 patients during fiscal years 2020-2021. The nursing care encompasses skilled nursing procedures, observations, and assessment of the patients' changing needs. The SNU complements existing health services in the area. Staff cooperates with other agencies to obtain financial assistance, personnel, and equipment for patient care. The services are provided under the direction of the patient's personal physician. A registered nurse is available 24 hours a day as well as licensed practical nurses and certified nursing assistants. Patient services available on the skilled unit include an in-house pharmacy, enterostomal and wound specialists, physical, occupational, and speech therapies, social services, nutritional services, and pastoral care. Referrals are accepted from physicians, hospitals, families, patients, and friends. The SNU was awarded the Best of Grand Island in 2018 by The Grand Island Independent readers.

Purpose and Goals of CHNA

CHI Health and our local hospitals make significant investments each year in our local communities to ensure we meet our Mission of creating healthier communities. A Community Health Needs Assessment (CHNA) is a critical piece of this work to ensure we are appropriately and effectively working and partnering in our communities.
The goals of this CHNA are to:

1. Identify areas of high need that impact the health and quality of life of residents in the communities served by CHI Health.
2. Ensure that resources are leveraged to improve the health of the most vulnerable members of our community and to reduce existing health disparities.
3. Set priorities and goals to improve these high need areas using evidence as a guide for decision-making.
4. Ensure compliance with section 501(r) of the Internal Revenue Code for not-for-profit hospitals under the requirements of the Affordable Care Act.

CHI Health St. Francis and SNU conducted this CHNA jointly. The following report outlines the community description, CHNA process, findings, and prioritized health needs for both CHI Health St. Francis and SNU.

Community Definition

For the purpose of the CHNA and future ISP, St. Francis and the SNU considers its primary community to be Hall County, Nebraska. This definition was determined by internal hospital leaders engaged in the hospital's Community Benefit Action Team (CBAT) and the local health department, Central District Health Department (CDHD).

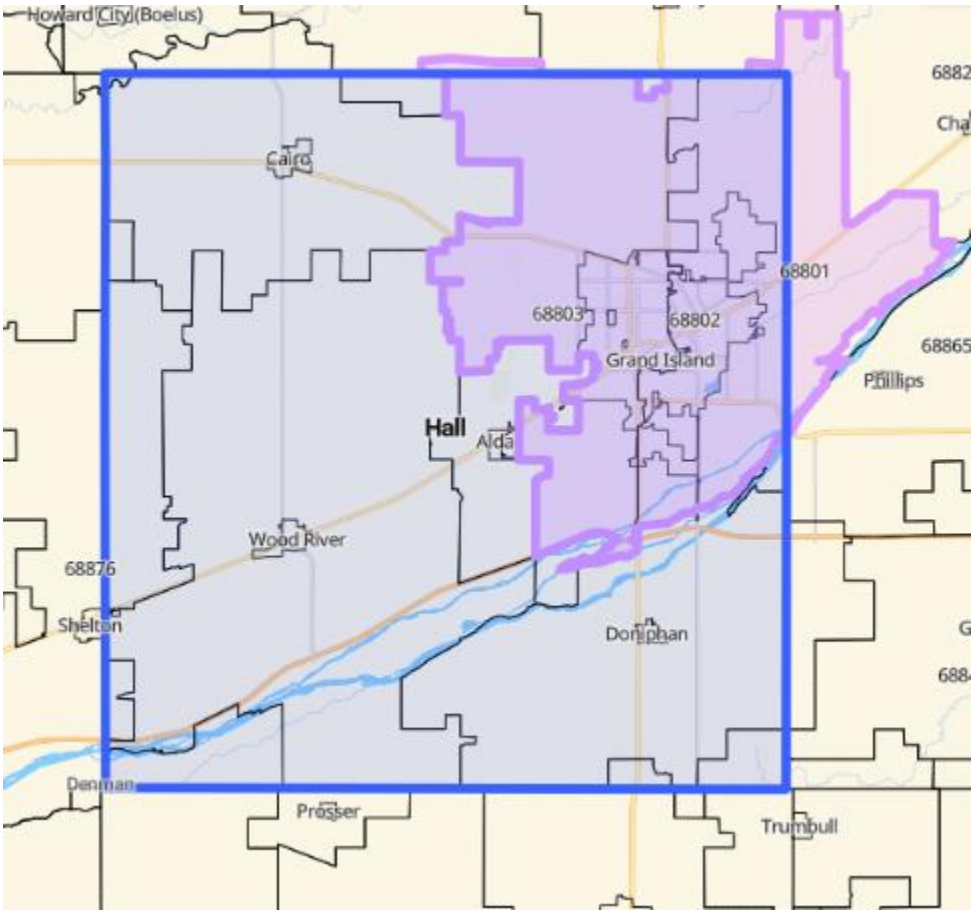
Key considerations for determining this community definition included the following:

- Hall County is the geographic area from which a significant number of St. Francis and SNU patients utilizing hospital services reside. While the CHNA considers other types of health care providers, hospitals are the single largest provider of acute care services. For this reason, the utilization of hospital services provides the clearest definition of the community.
- Surrounding counties of Hamilton and Merrick also have a significant number of St. Francis and SNU patients, however, both counties have a local hospital which is also undergoing a CHNA process. In all three counties the hospitals are working closely with CDHD to ensure input from, and alignment with CDHD.

There are two zipcodes that are represented by 76.49% of IP/ED discharges in FY20: 68801 and 68803.

Hall County covers approximately 550 square miles, including five communities with over 62,000 residents. It is bounded on the north by Howard County, on the east by Hamilton and Merrick, on the south by Adams and on the west by Buffalo.

Figure 1: CHI Health Grand Island Market Primary Service Area and CHNA Community (Hall County)[1]



Community Description

Population

As shown in Table 1, the 2020 population for Hall County was 62,895, and has increased by 7.3% since 2010.[2] As of 2019, 13.9% of residents in the county were born outside the United States and 90.9% were citizens, a slight increase from 2018. In 2019, 27.7% of the residents in Hall County were Hispanic.[3] Hall County is uniquely a multicultural community. Compared to neighboring counties of Hamilton and Merrick, with between one and two percent of their populations being foreign born, this is a significant portion of the Hall County population, and presents unique challenges for healthcare and other public sector services.

[1] PolicyMap. 2022. Accessed March 2022. PolicyMap Map retrieved from https://commonspirit.policymap.com/

[2] U.S. Census Bureau. Decennial Census. 2020. Source geography: Tract. Accessed February 2022. Retrieved from: CARES Engagement Network. https://engagementnetwork.org/assessment/chna_report/

[3] U.S. Census Bureau. American Community Survey 5- Year Estimates. 2015- 2019. Accessed March 2022. Retrieved from: Data USA. https://datausa.io/profile/geo/grandisland-ne/

Table 1. Community Demographics[2]

	Grand Island	Hall County	Nebraska
Total Population	53,131	62,895	1,961,504
Population per square mile[1] (density)	1,708.0	107.3	23.8
Total Land Area (sq. miles)	28.41	546.29	76,824.17
Rural vs. Urban	N/A	Urban (85.4% live in rural)	Urban (73.1% live in urban)
Age			
% below 18 years of age	28.0%	27.6%	24.6%
% 65 and older	14.0%	15.1%	16.2%
Gender			
% Female	49.6%	49.4%	50%
Race			
% White alone	82.0%	90.7%	88.1%
% Black or African American alone	3.2%	3.8%	5.2%
% American Indian or Alaskan Native alone	0.6%	2.1%	1.5%
% Asian alone	1.3%	1.4%	2.7%
% Native Hawaiian/ Other Pacific Islander alone	0.4%	0.5%	0.1%
% Two or More Races	1.9%	1.6%	2.8%
% Hispanic or Latino	31.6%	29.0%	11.4%
% White alone, not Hispanic or Latino	62.0%	65.1%	78.2%

Socioeconomic Factors

Table 2 shows key socioeconomic factors known to influence health including household income, poverty, unemployment rate, and educational attainment for the communities served by the hospital. A review of the socioeconomic factors show Hall County is slightly below the state for median household income, and slightly higher in overall poverty rates. Poverty rates have increased slightly from 12.0% in 2018 to 12.8% in 2019 for Hall County, while there was a decrease from 10.8% to 9.2% for Nebraska overall. The percentage of children in poverty (17.2% for Hall County) has remained the same since 2018, and is lower than the state at 18.5%. When looking at the percentage of children in poverty in Hall County by race and ethnicity, we see a large disparity with 21.9% of Hispanic or Latino and 46.2% of Black or African American children in poverty. Hall County also has a higher percent of children living in single parent households at 29% compared to 21% across the state.[4] These disparities are seen at both the state and national levels. Since the 2019 CHNA, Hall County and Nebraska overall have seen improvement in unemployment rates. The percent of the population under 65 years of age without

[4] U.S. Census Bureau. American Community Survey 5- Year Estimates 2015-2019. Source geography: Tract. Accessed February 2022. Retrieved from: CARES Engagement Network. https://engagementnetwork.org/assessment/chna_report/

health insurance has dropped from 13.4% down to 11.9% in Hall County, and from 9.6% to 8.2% in Nebraska overall.[4]

Table 2: Socioeconomic Factors[4]

	Hall County	Nebraska	United States
Income Rates			
Median Household Income	$57,104	$61,439	$62,843
Poverty Rates			
Persons in Poverty	12.8%	9.2%	11.4%
Children in Poverty	17.2%	13.9%	18.5%
Employment Rate[5]			
Unemployment Rate	1.5%	1.3%	3.7%
Education/Graduation Rates[6]			
High School Graduation Rates	86.5%	87.6%	87.7%
% Pop. age 25+ with a Bachelor's Degree or higher	21.5%	31.9%	32.2%
Insurance Coverage			
% of Population Uninsured	11.9%	8.2%	10.2%
% of Uninsured Children (under the age of 18)	6.3%	5.3%	6.1%

Hall County is designated a Health Professional Shortage Area in mental health with a HPSA Score of 11. The score ranges from 0-26 where the higher the score, the greater the priority.[7] Hall County is considered a Medically Underserved Area in Primary Care with an Index of Medical Unserved Score of 59.2 (to qualify for this designation, the score must be below or equal to 62.0 on a scale of 0 -100 with 100 being the lowest need).[8]

Community Need Index[9]

One tool used to assess health needs is the Community Need Index (CNI). The CNI analyzes data at the zipcode level on five factors known to contribute or be barriers to healthcare access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zipcode in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores. Hall County has an overall mean of 2.0 on the scale. There is one zipcode (68883) that has a score in the mid

[5] Bureau of Labor Statistics. 2022. Accessed February 2022. Source geography: County. Retrieved from: CARES Engagement Network. https://engagementnetwork.org/assessment/chna_report/

[6] US Department of Education, EDFacts. Additional data analysis by CARES. 2018-19. Source geography: School District. Accessed February 2022. Retrieved from CARES Engagement Network https://engagementnetwork.org/assessment/

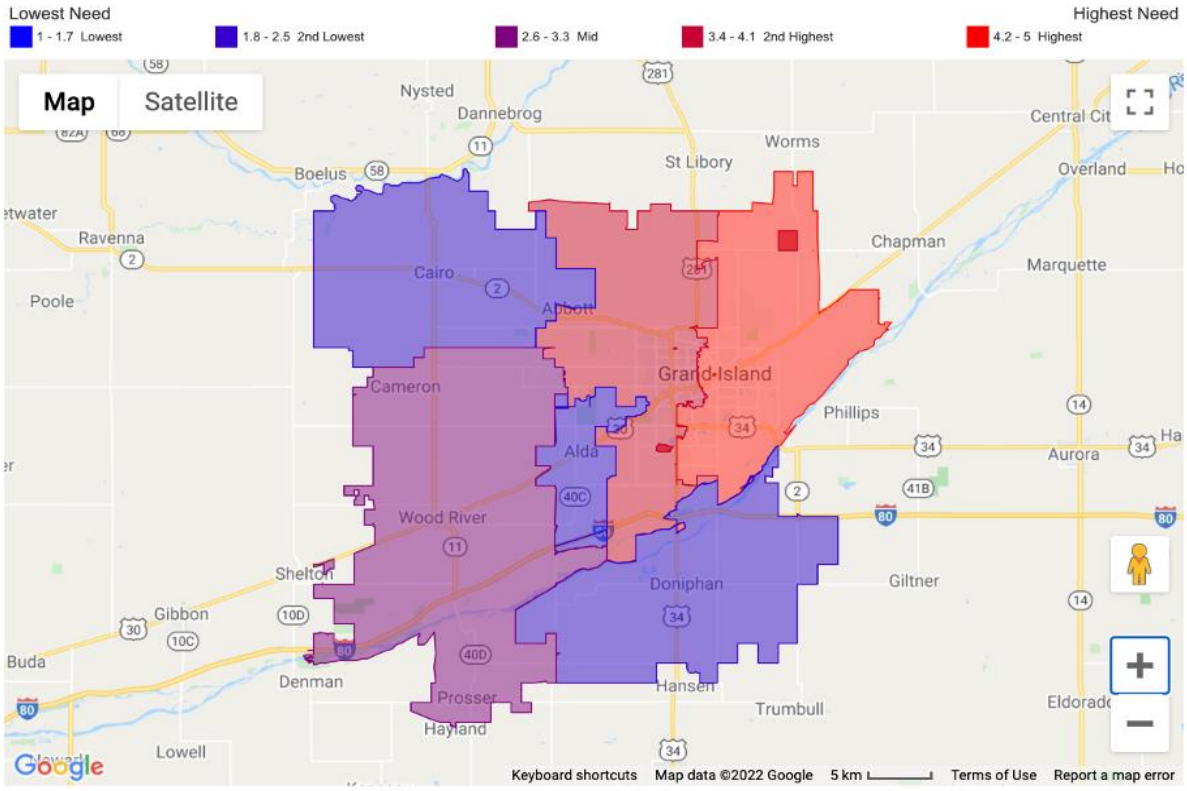
[7] HRSA Bureau of Health Workers, HPSA. 2022. Accessed March 2022. Retrieved from HPSA Find https://data.hrsa.gov/tools/shortage-area/hpsa-find

[8] HRSA Bureau of Health Workforce, MUA. 2022. Accessed March 2022. Retrieved from MUA Find https://data.hrsa.gov/tools/shortage-area/mua-find.

[9] Truven Health Analytics, 2021; Insurance Coverage Estimates, 2021; The Nielson Company, 2021; and Community Need Index, 2021. Retrieved from http://cni.dignityhealth.org/.

level of need. This mid level is anywhere between 2.6 and 3.3. Hall's County's overall mean is 2.9 with just two zip codes in the high and highest level of need (68801 and 68803).

Figure 2: Community Need Index by Zipcode



Mean(zipcode): 2.9 / Mean(person): 3.8 CNI Score Median: 2.7 CNI Score Mode: None

Zip Code	CNI Score	Population	City	County	State
68801	4.4	30347	Grand Island	Hall	Nebraska
68803	3.4	25152	Grand Island	Hall	Nebraska
68810	2.4	1052	Alda	Hall	Nebraska
68824	1.8	1361	Cairo	Hall	Nebraska
68832	2.2	1936	Doniphan	Hall	Nebraska
68883	3	2421	Wood River	Hall	Nebraska

Unique Community Characteristics

Central Community College and College Park, offering courses through University of Nebraska-Kearney, provide students local opportunities to pursue associates and bachelor's degrees. In addition, Grand Island is home to the Nebraska State Fair and the International Farm Progress Show, drawing crowds of outside visitors of over 500,000 combined each year in late August and early September.

Other Health Services

Grand Island has a wide range of healthcare providers, including medical, dental, and mental health services that not only address the needs of the local population, but also residents from throughout Central Nebraska and from across the state. Population health services are provided through community health workers and diabetes educators embedded within the health department and Multicultural

Coalition of Grand Island. Some of the prominent health providers available throughout the county, include:

- CHI Health Clinics in Grand Island
- Grand Island Regional Medical Center
- Heartland Health Center
- Third City Community Clinic
- Choice Family Health Care
- Urgent Care Clinics (Twin Rivers, CHI Health Quick Care)
- Central District Health Department
- CHI Health St. Francis
- St. Francis Cancer Treatment Center
- CHI Heart Health
- Grand Island VA Medical Center
- Grand Island Clinic
- Litzenberg Memorial County Hospital
- Memorial Community Health
- Mid-Plains Center for Behavioral Health

Community Health Needs Assessment Process

The process of identifying the community health needs in Hall County for the purposes of this CHNA was led by the Central District Health Department (CDHD) and involved primary data collection, a secondary data review, and two community input sessions. Following these activities, the Community Benefit Action Team (CBAT; described in more detail below) for St. Francis and SNU further validated the identified needs through the hospital's Grand Island Community Board.

The CDHD contracted with Nebraska Association of Local Health Departments (NALHD) for data collection, analysis, and community engagement throughout the needs assessment process. The community health assessment gathered data from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings, American Community Survey/US Census Bureau, Centers for Disease Control, Nebraska Department of Education, and other publicly available data sources to assess the health status of the CDHD region to identify emerging issues and trends, when possible, and to gauge big changes from the previous 2019 Community Health Improvement Plan priorities.

At the beginning of 2020, local health departments in Nebraska began the response to a global pandemic resulting from a novel virus, Coronavirus 2019. While eager to know the impact of COVID-19 on population health, this data was not available at the time of this community health assessment. In efforts to learn more about the impact of COVID-19 on communities in the CDHD area, CDHD launched a 5-question survey. The survey was developed by NALHD as an open-ended survey intended to allow respondents to share their experience related to their health and the health of their community to identify emerging issues in the community. The NALHD made the survey accessible to all LHDs across Nebraska to identify statewide impact and trends. The survey was intended to be initially launched during the community health assessment and released more frequently throughout the community health improvement process to keep current on emerging issues in the community; however, results discussed throughout this report are from the initial launch in June 2021. The survey asssited CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The survey assessed experiences of community members related to major health issues for them or their family, what it means to be healthy, top health concerns, and ways to be healthy in their community and was made available in English, Spanish, Somali and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition,

area hospitals, and other community partners. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey online when waiting for appointments. In all, 665 responses were collected (a table of respondent demographics can be found in the *2021 CDHD CHA* in Appendix A).

Additionally, a resource inventory survey was launched to partners of CDHD in August 2021 as a way to provide insight into available medical resources, resources that help people prevent and manage personal health risks, and resources that help people thrive. In all, 15 responses were collected. Respondents self-identified from the following sectors: 20% non-profit, 20% hospitals, 13% Federally Qualified Health Centers, and 6% from each of the following sectors: business, faith-based organizations, health departments, higher education/academic institutions, law enforcement/judicial systems, and medical clinics.

Input from the community was primarily sought through the community-based meetings described below. Stakeholders participating in these input sessions represent low-income, minority populations, medically underserved populations, and the aging population, as well as those affected by violence. NALHD facilitated two workshops to review data, determine additional data needs, and to set priorities. The workshops occurred via Zoom and participants engaged in a Technology of Participation (ToP) facilitated process. For a detailed summary of the input provided as part of the meetings, see Appendix B (2021 *CDHD CHA* Process Summary).

Community Input Sessions

On June 15, 2021, 35 participants gathered to identify forces impacting the health of the community and review secondary data related to health behaviors, access, and outcomes. The group also reviewed and approved the 5-question survey that was then distributed to the community.

On September 2, 2021, CDHD convened a broad group of community stakeholders to review data, and facilitated discussion to identify the top health needs in the community (see detail below). The group reviewed the secondary data for CDHD's three-county region, and took into consideration prevalence, mortality, and trend where possible to determine top needs. Following the data presentation, there was a large-group dialogue around the data to add context and uncover missing elements. Finally, participants split into smaller groups of 3-4 to prioritize the top health needs, and after a brief small-group discussion period each group reported out to the larger group in an effort to identify common priorities across participants.

Organizations providing input at the community engagement sessions:

- Aurora Community Health
- Bryan Health
- Bryan Health Merrick Medical Center
- Central District Health Department (CDHD)
- CDHD WIC Department
- CDHD Board of Health
- Central Nebraska DHHS
- Council of Alcoholism and Addiction
- Hall County Commissioner
- Hall County Community Collaborative (H3C)
- H3C Board of Directors
- Hall County Housing Authority
- Hall County Juvenile Services
- Heartland Health Center
- Heartland United Way
- Head Start CFBD Inc.

- CHI Health
- CHI Health St. Francis
- City of Aurora
- City Of Grand Island
- City of Grand Island City Council
- Grand Island Chamber of Commerce
- Grand Island Parks and Recreation
- Grand Island Public Schools
- Grand Island Regional Medical Center
- Grand Island Salvation Army
- Hope Harbor
- iChoosePurple Consulting
- Memorial Community Health
- Multicultural Coalition
- Nebraska Association of Local Health Directors
- Nebraska Extension
- Northwest Public Schools
- Prevention Project

Following completion of the community process and two meetings hosted by CDHD, the internal multi-disciplinary CBAT was convened to validate the community findings and confirm the top identified health needs. The following members participated in one or more meetings to determine top needs in Hall County.

Community Benefit Action Team (CBAT) Members include:

- Ed Hannon, President, CHI Health St. Francis
- Dr. Scott Frankforter, Vice President of Medical Affairs, CHI Health St. Francis
- Beth Bartlett, Vice President of Patient Care Services, CHI Health St. Francis
- Lisa Thavenet-Webb, Vice President of Finance, CHI Health St. Francis
- Kylie Grzywa, Vice President of Patient Care Services, CHI Health St. Francis
- Melissa Griffith, Director of Foundation, CHI Health St. Francis
- Diana Kellogg, Foundation Development, CHI Health St. Francis
- Alycia Packer, Director of Care Management, CHI Health St. Francis
- Annie Mollring, Market Development Representative, CHI Health St. Francis
- Brenda Miner, Director of Drug & Alcohol Center, CHI Health St. Francis
- Ben Rehtus, Director of Strategy, CHI Health St. Francis
- Matthew Lohmeier, Director of Mission, CHI Health St. Francis
- Cynthia Sestak, Market Director of Clinics, CHI Health Clinic
- Tracy Kimberly, Manager of Corporate Responsibility, CHI Health St. Francis
- Jenny Roush, Community Outreach, CHI Health Regional Cancer Centers
- Diane Stevenson, Skilled Nursing Supervisor, Skilled Nursing Unit
- Sarah Stanislav, Healthy Communities Coordinator, CHI Health

Written Comments Received

CHI Health St. Francis and SNU invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

Assessment Data and Findings

For a complete list of community health indicators reviewed in consideration of the Community Health Needs Assessment for St. Francis and SNU, please refer to the 2021 CDHD CHA attached in Appendix A. Detailed findings related to identified health needs are listed below in Table 3. Data provided by CDHD was presented to community stakeholders and St. Francis and SNU hospital administration community benefit team for validation of the top identified needs. All parties who reviewed the data found the data to accurately represent the needs of the community.

Gaps in Information

Although the CHNA is quite comprehensive, it is not possible to measure all aspects of the community's health, nor can we represent all interests of the population. This assessment was designed to represent a comprehensive and broad look at the health of the overall community. During specific hospital implementation planning, gaps in information will be considered and other data/input brought in as needed.

Prioritization Process and Significant Community Health Needs

CDHD conducted facilitated conversations in the two community input sessions described above, to engage participants in prioritizing health needs. Participants were given 3 votes to place on a number of health needs identified in the meeting. Voting was based on the following criteria:

Size = many people affected
Seriousness = many deaths, disabilities, hospitalizations
Trends = getting worse, not better
Equity = some groups affected more
Intervention = proven strategies exist
Values = our community cares about this
Resources = Builds on current work

Priorities chosen by the group included:
1. Access to culturally appropriate behavioral health = 13 votes
2. Health and healthcare = 12 votes
3. Affordable quality childcare options = 11 votes
4. Trauma-informed community engagement = 9 votes
5. Food insecurities = 7 votes
6. Timely equitable inclusion = 2 votes

Prioritized Significant Health Needs

Upon completion of the two community input sessions, review of the *2021 CDHD CHA,* and presentation and discussion of the CBAT, seven prioritized significant health needs were identified for the community. Below (Table 3) is a listing and rationale for the health needs that are driving poor health outcomes in Hall County.

Table 3: Prioritized Significant Health Needs

Health Need	Rationale

Access to Care	• The % of individuals uninsured in Hall County is worse than the Central District and state of NE (11.9% adults 65 years and older, 6.3% among youth under 18).
	• Compared to the state, more residents in the CDHD region did not see a doctor due to cost, had no personal doctor or healthcare provider and no health coverage.
	• The entirety of Hall County is designated as a Medically Underserved Area/Population for primary care.
	• Cost of healthcare services can be a barrier to care for CDHD residents. Surpassing the state rate, about 1.5 out of every 10 adults aged 18-64 needed to see a doctor, but could not due to cost within the past year, and 1 in 5 adults aged 18-64 had no health care coverage.
	• Nearly 1 in 5 adults in the CDHD district report not having a personal doctor or health care provider. Across the state, nearly 1 in 2 Hispanics reported not having a personal doctor or health care provider.
	• Ratio of population to provider: Primary care physician 1,620:1 Hall County, 1,310:1 NE.
	• Community highlighted needs related to:
	  ○ Immigration status discrepancies affect accuracy of records
	  ○ Access to quality child care (Heartland UW)
	  ○ Transportation
	  ○ Homelessness
	  ○ Care that is inclusive, trauma informed and focuses on vulnerable populations

Behavioral Health (Includes mental health & substance abuse)	• In 2019, depression rates in the CDHD region were aligned with the state as a whole but there are some disparities among males and females. 23% of females were told that they have depression compared to 12% of males and 12% of females reported poor mental health on 14 or more days in the past 30 days, compared to 9% of males. • Suicide is the 9th leading cause of death in Nebraska, and the second leading cause of death for individuals aged 10-34. Hall County is at higher risk for youth suicide ideation and attempts. • In Hall County, approximately 1 in 4 Nebraska high school youth reported feeling depressed. • 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.

	• In the CDHD, nearly 1 in 3 high school youth reported feeling depressed and 14% considered attempting suicide. • 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. • In the CDHD, there were an average of 1,731 people for every mental health provider. • 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. • Hall County has a lower provider per population ratio among dental and mental health services compared to the state and other counties within CDHD. • Youth substance abuse related to Juuling is on the rise according to schools and law enforcement. • Drug and Opioid-related overdose fatalities are greater across the US than NE, however local law enforcement and human service agencies warn the rates are rising locally, and are concerned overdose fatalities are more prevalent among minority and low-income populations. • Even though cigarette smoking was trending downwards in the CDHD district, e-cigarette usage was growing among CDHD adults, 1 in 5 adults in the district used e-cigarettes just slightly under the state rate of 25%. • Alcohol is the third-leading preventable cause of death in the US following tobacco and nutrition/physical activity. In 2019, 1 in 5 Nebraska adults binge drank or drank heavily (21.9%). • The Nebraska BRFSS survey in 2019 indicated 17% of adults in the CDHD region reported binge drinking in the past 30 days, and nearly 5% of adults in the CDHD region reported heavy drinking in the past 30 days, both of which were similar to the US averages.
Cancer	• While cancer mortality rates are declining overall, cancer remains a leading cause of death in the district and across the state. In the district, female breast cancer was the leading type of cancer diagnosed (106.8/100,000), which was lower than the state (127.4/100,000). Prostate cancer followed as a close second for CDHD district (106.0/100,000) and was lower than the state (116.9/100,000). • Tobacco smoking remains the leading cause of lung cancer, responsible for about 80% of lung cancer deaths. Other causes include exposure to secondhand smoke and radon. • The COVID-19 pandemic has impacted access to care and the percentage of people not up to date on cancer screenings will continue to become apparent as newer data becomes available, In 2018, the CDHD region and Hall County had the following screening rates: • 1 in 3 50-75 years olds were not up to date on colon cancer screening.

	• 1 in 2 women ages 65-74 were not up to date on breast cancer screening. • 1 in 4 women ages 50-75 were not up to date on breast cancer screening. • 1 in 5 women aged 21-65 were not up to date on cervical cancer screening.
Chronic Disease	• The death rate in Hall County due to chronic lung disease, cerebrovascular disease and diabetes were higher than the state. • In Hall County, there are a total of 229 deaths due to lung disease. This represents an age-adjusted death rate of 63.9 per every 100,000 total population (NE 47.7%). • Diabetes is the 7th leading cause of death in the US. Over the past 20 years, the number of adults diagnosed with diabetes has more than doubled. Weight and age are factors that impact the risk of diabetes and oftentimes, diabetes and heart disease are co-occurring. A person with diabetes is 2 times more likely to have heart disease or stroke, the leading causes of death. • Nearly 40% of adults in CDHD reported consuming fruits less than 1 time per day and about 1 in 4 adults consumed vegetables less than 1 time per day. • Roughly 1 in 3 adults in CDHD reported no leisure-time physical activity in the past 30 days and that number continues to increase. • In Nebraska, there are dramatic gaps between racial/ethnic populations when looking at the state diabetes rates. Notably, African American/Black (15%), American Indian/Alaskan Native (16%), and Hispanic (14%) populations experience almost 2 times the rates of diabetes compared to non-Hispanic, White populations. • Heart disease is one of the top two leading causes of death in the CDHD district and across the state. • Hall County experienced two times the death rate (43.5/100,000) due to Alzheimer's Disease than the state (23.7/100,000). • In Hall County there are a total of 16,909 adults aged 20 and older who reported having a BMI greater than 30.0. This represents 39.3% of the survey population (NE 33.3%). • In Hall County the estimated prevalence of fair or poor health among adults aged 18 years and older was 18.40%. This value is based on the crude number of adults who report their general health status as "fair" or "poor" (NE 15.07%).
Maternal, Infant, and Child Health	• The overall birth rate (15.7/1,000) and teen birth rate (38/1,000) in Hall County was higher than other counties in the CDHD district and state. • The Infant Mortality Rate was 6 per 1000, similar to the state. • Community reports need for additional prenatal OB services within FQHC for local deliveries.

Social Determinants of Health	• The community reports:
	  ○ quality affordable housing is lacking in Hall County area.
	  ○ challenges with adequate housing for seniors.
	  ○ transportation for seniors is a challenge in Hall County.
	• Severe housing problems are reported among 16% of Hall County residents, higher than the state rate of 13%.
	• Of the 23,096 total occupied housing units in the report area, 5,904 or 25.56% have one or more substandard conditions (24.95% in NE).

	• In Hall County, 58.59% of public school students receive free and reduced lunch, which is higher than the state average of 45.64%. • Population ages 3-4 enrolled in school is 36.31% (NE 43.48). • 21.51% of the population aged 25 and older have obtained a Bachelor's level degree or higher (NE 31.91%). • According to the latest American Community Survey (ACS), Hall County has a total of 5,556 non-Citizens, or 9.07% of the total population of 61,265 persons, in contrast to the state average of 4.40% of the population and the national average of 6.83% non-Citizens living in the United States.
Violence/Injury	• In the district, all counties experienced higher rates of death by injury than the state. The death by injury rate in Hall was nearly double the state. Leading causes of death by injury in NE were car accidents, suicide, unintentional falls and unintentional poisoning. • In Hall County, there are a total of 39 deaths due to motor vehicle crashes. This represents an age-adjusted death rate of 13.0 per every 100,000 total population (NE 12.1%). • Violent crime in Hall County is 288 per 100,000 (NE: 286). • In Hall County, 2,121 property crimes occurred in 2014 and 2016 (two years). The property crime rate of 3,435.2 per 100,000 residents is higher than the statewide rate of 2,334.9 per 100,000.

Resource Inventory

Table 4 displays a list of assets and resources available as the CHI Health St. Francis and SNU teams consider their work related to each prioritized health need.

Table 4: Resources Identified by Health Need Area

Significant Health Need	Assets/Resources
Access to Care	• Senior Health Insurance Information program (SHP), educate Medicare beneficiaries • Medicaid Expansion in NE • Third City Community Clinic (no Med home model) • Student Wellness Center (GI Snr High) • CDHD • CHW helping to navigate healthcare • 1st point of contact, referral services • Veteran's & refugee services • Heartland Health Center (Access focus, bilingual care) • CommUNITY school for dental/behavioral) • Mid-Plains Center for Behavioral Health • Grand Island Regional Medical Center • Dental (CDHD) Screenings, fillings, fluoride at HH (in partnership with Third City Community Clinic)

	• Lutheran Family Services – Veteran's services & refugees • Women, Infants, and Children (WIC) prenatal care (CDHD) • Homeless shelter (Basic needs) • Project HELP at CCC – training providers • Midland Area Agency on Agency • Meals on Wheels (Grand Generation) • Handi-bus
Behavioral Health (Mental Health & Substance Abuse)	• All BH related work informed through H3C BH subcommittee • Heartland Health BH services in progress • H3C Navigation assistance (Short-term/crisis response) • NE System of Care Plan to ID early BH issues and refer to relevant services (for parents) Circle of Security • Mid-Plains Behavioral Health (with stabilization unit) • Boys Town adolescent therapy and support groups • Teen Chat – Nebraska Children's Home Society • Crisis Center (free-standing) – BH services, and middle school teen dating violence group • Student Wellness Center (Grand Island Senior High) • Central Community College– Veteran's Services • Lutheran Family Services – Veteran's services & refugees • GIPS Central navigation for disconnected youth & Rooted in Relationships • Central NE Council on Alcohol and Addiction • Richard Young & Mary Lanning for in-patient • CDHD doing Mental Health First Aid (veteran funding) • Alcohol and drug treatment center at St. Francis • Hope Harbor • Alcoholics Anonymous • SROs in schools, student wellness center evaluations and counselors • Drug court • Regional drug task force • Goodwill community support program • Grand Island Police Department Resource Officers (Mental Health)
Cancer	• CHI Health St. Francis and CHI Health Clinics • Grand Island Regional Medical Center • Nebraska Cancer Specialists
Chronic Disease	• GIPS food policy • Worksite wellness programs • Doane College • CDHD offers Diabetes Prevention Program in English and Spanish "Road to Health" in Spanish • Community walking paths • Farmer's markets in summer • Third City Community Clinic • NE Extension • City of Grand Island Parks and Recreation

Maternal, Infant, and Child Health	• Women, Infants, and Children (WIC) • Central District Health Department • CHI Health Women's Clinic • Grand Island Regional Medical Center • Heartland Health
Social Determinants of Health	• Central District Health Department • Hall County Housing Authority • Lutheran Family Services • Goodwill Community support program • Heartland Health Center • Women, Infants, and Children (WIC) • Third City Community Clinic
Violence/Injury	• School resource office (RSOs) • Central Nebraska Child Advocacy Center • SANKOFA • Cooperative gang intelligence system • Anti-gang violence enforcement • Tai Chi classes for balance training, fall prevention • School intervention workers @ GISH and BARR • Drug court and diversion • Crisis Center • Hope Harbor • Grand Island Police Department Resource Officers (Mental Health)

Evaluation of FY20-FY22 Community Health Needs Implementation Strategy Plan

The previous CHNA for CHI Health St Francis and SNU was conducted in 2019. CHI Health St Francis and SNU completed the Community Benefit activities listed below around the priorities identified in 2019.

The two priority health needs identified in 2019 for inclusion on the CHI Health St Francis and SNU ISP were:

- Access to Care
- Behavioral Health

Priority Area # 1: Access to Healthcare Services	
Goal	**Ensure equitable access to clinic and community-based health services (medical and behavioral) to improve the overall health of all in the community**
Community Indicators	**CHNA 2016** • In 2014, the percentage of residents who needed to see a doctor but could not due to cost was 14.1%, which is higher than the State (11.9%) and has not reached the HP2020 Target of (9.0%) • 18.2% of population age 16-64 in Central District three-county region is without health coverage, compared to 15.3% in Nebraska overall
	CHNA 2019 • In 2017, the percentage of residents who needed to see a doctor but could not due to cost had increased to 15.6%, which is also higher than the State (11.7%) and the HP2020 Target of (9.0%) • Ratio of primary care physician to population is 1,510:1 (Hall County) 1,320:1 (Nebraska) • 24% of population has no personal doctor in Hall compared to 19.9% in Nebraska overall • 19% of population age 16-64 in Hall is without health coverage, compared to 14.7% in NE

	• 21.3% of pregnant women getting inadequate prenatal care compared to 17.2% in NE – (measure related to number of prenatal visits and trimester prenatal care started)
	CHNA 2022 TBD
Timeframe	FY2020-FY2022
Background	Rationale: • Access to quality, affordable, timely, and equitable healthcare for all in the community was identified as a top need by community stakeholders and community representatives for Hall County. • As healthcare evolves to keep patients well, instead of just treating the sick, engaging patients in preventive care with a primary provider, or medical home, will be critical in the new healthcare environment
	Contributing Factors: • The community is realizing high rates of uninsured and the community stakeholders report higher rates of high deductible health plans. • A significant portion of the population is Hispanic and of those in poverty, significantly more are Hispanic and/or African American. • Growth in the immigrant population puts tremendous strain on the system related to language access as well as navigating status discrepancies to deliver necessary care.
	National Alignment: • HP2020 Target – 9.0% of population needed to see a doctor but could not due to cost • HP2020 Target – 100% covered with medical insurance
	Additional Information: • Community stakeholders recognize an opportunity to bring together existing healthcare providers and services to collaborate and coordinate to optimize health-related service offerings, as well as coordinate care for individuals across a continuum to help

<table>
<tr><td></td><td colspan="2">patients find the right level of care, at the right place and time for the relevant need.</td></tr>
<tr><td colspan="3">1.1 Strategy & Scope: Support a health-department led work group in identifying and addressing known barriers to accessing timely and effective health care in Hall County, to ensure services are coordinated, optimized, and promoted.</td></tr>
<tr><td>Anticipated Impact</td><td>Hospital Role/ Required Resources</td><td>Partners</td></tr>
<tr><td>• Improved collaboration between healthcare service providers and community service agencies
• Increased percentage of residents who have a personal doctor
• Reduced percentage of people unable to see a doctor due to cost.</td><td>CHI Health System Role(s):
• Technical Assistance

CHI Health St. Francis/SNU's Role(s):
• Community partners
• Funder

Required Resources:
• Staff time
• Funding
• Community Partner time</td><td>• Central District Health Department
• Heartland Health
• Third City Community
• Clinic CommUNITY School & Heartland United Way
• Other potential partners:
  • Midlands Area Agency on Aging
  • Grand Generations – To be contacted
  • Midplains Behavioral Health
  • Transportation service providers
  • Language services providers</td></tr>
<tr><td>Key Activities</td><td>Measures</td><td>Data Sources/Evaluation Plan</td></tr>
<tr><td>• Collaborate with existing safety-net providers (Central District Health Department, Heartland Health, Third City Community Clinic, CommUNITY School & Heartland United Way, Others) through a health department led work group to identify and address gaps in the continuum of 9 healthcare and health related services for all. (St. Francis & Skilled Nursing Facility) Work may focus on:
  ○ Improving collaboration between emergency department and the safety net providers (Heartland Health – federally qualified health</td><td>• Increase in community partnerships
• Increase in funding to support community initiatives
• Increase in individuals with a primary medical home
• Increase in # of vaccines provided</td><td>Data will be reviewed and monitored by an internal team using the following data sources:
• CDHD reports
• Hospital records
• Community partner records</td></tr>
</table>

center, and Third City Community Clinic) to ensure referral of relevant patients to the FQHC medical home, and/or communicating with the patients primary care physician regarding ED visit ○ Ensure services are optimized across providers and reduce duplication where possible ○ Ensure the connection and communication to social service providers in support of meeting patients social needs which may be affecting their health ○ Identifying common barriers to accessing timely and effective care when needed (i.e. transportation, lack of child care, or hours of operation) and work collectively to identify strategies to reduce barriers ○ Assess and address gaps in accessing healthcare services for the aging population specifically (Skilled Nursing Facility) Explore work related to school-based primary health care and determine need and capacity to increase/improve services already offered by CHI Health St. Francis in school settings. (St. Francis)		
Results		
Fiscal Year 2020 Actions and Impact: • Regularly participated in the Health Department led work group until it was put on hold due to COVID-19 • Continued building relationship with Heartland Health. CHI Health St Francis leadership has toured Heartland Health four times and are helping them to expand services to ensure proper referrals both ways • Worked with Nebraska Cancer Coalition and Heartland Health to establish a referral system for colorectal cancer screening • Supported Third City Community Clinic through board participation and financial support during the COVID-19 pandemic • Received a grant through CommonSpirit Health to provide free flu vaccinations in the community • CHI Health St. Francis foundation was awarded an American Cancer Society grant to provide transportation to patients		

- Provided financial support to Grand Generation Center and Grand Island Salvation Army for assistance during COVID-19
- Continued to partner with JBS Beef Plant to provide vaccination clinics and clinical care on site

Measures:

- Financial support to Third City Community Clinic, Grand Generation Center and Salvation Army: $5,000 to each organization
- Number of vaccinations administered: approximately 95
- American Cancer Society grant: 751 one way rides (64 patients)

Fiscal Year 2021 Actions and Impact:

- Central District Health Department led work groups were largely on hold due to COVID-19, but did continue to partner on COVID-19 related strategies, such as testing and vaccines. CHI Health St. Francis staff participated in two community wide Community Health Improvement Planning sessions.
- CHI Health St. Francis supported the region's community health needs assessment process through planning meetings and financial support.
- CHI Health St. Francis continued building its relationship with Heartland Health. CHI Health St Francis leadership continues communication with Heartland Health and is helping them to expand services to ensure proper referrals both ways.
- CHI Health St. Francis helped facilitate Heartland Health's move to a larger, more functional space and plans to provide staff time to increase womens' services at the clinic.
- Completed a project with Nebraska Cancer Coalition and Heartland Health to establish a referral system for colorectal cancer screening. This project helped lay the foundation for an ongoing referral pathway between the systems and aided in clarifying financial assistance policies and changes so that applications could be submitted and processed as early as possible to ensure screening and treatment were available to patients as soon as they were ready.
- Supported Third City Community Clinic through board participation.
- Provided support to a Grand Island Public Schools and Heartland Health partnership to provide behavioral health services to financially qualifying students. Continuing to explore how this program aligns with wellness center services and telehealth services at the schools (to be launched in schools January 2022).
- Provided financial support to MultiCultural Coalition to assist with workforce development and emergency financial assistance.

Measures:

- Financial support to Grand Island Public Schools and Heartland Health: $20,000
- Measures for behavioral health services to be reported next year as provider capacity has been limited.
- Financial support to Multicultural Coalition: $15,000
    - Individuals impacted by employability programming and document verification and support: 36
    - Individuals supported by emergency financial assistance: 143
    - Total served: 179 individuals
- Partnership with Central District Health Department COVID-19 reponse:

- Number of clinic days: 10
- Number of covid tests: 5,483
- Assisted the Health Department in administering over 42,000 vaccines

Fiscal Year 2022 Results Pending

1.2 Scope and Strategy: Explore work related to school-based primary health care and determine need and capacity to increase/improve services already offered by CHI Health St. Francis in school settings. (CHI Health St. Francis)

Fiscal Year 2020 Actions and Impact:

- Continued to support clinic within Grand Island High School

Measures:

Grand Island Senior High School Clinic

- Students that received medical care: 127
- Students that received mental health care: 89
- Vaccinations provided to underserved population: 347

Fiscal Year 2021 Actions and Impact:

- Continued to support the wellness clinic within Grand Island Senior High School to ensure access to behavioral and physical health care for students.
- Provided no charge risk assessments on students identified by Grand Island Senior High as an immediate danger to themselves or others.

Measures:

- Grand Island Senior High School Wellness Clinic
  - Students that received medical care: 201
  - Number of primary care visits: 272
  - Students that received mental health care: 116
  - Number of behavioral health visits: 1048
  - No charge risk assessments: 10
  - Vaccines administered: 428

Fiscal Year 2022 Results Pending

Priority Area # 2: Behavioral Health (to include Mental Health, Substance Abuse, and Violence)

Goal	Improve services and crisis response efforts to ensure effective and timely behavioral health care for individuals dealing with mental health issues, substance abuse addictions, or violence
Community Indicators	**CHNA 2016** • 6.6% of adults 18+ reported frequent mental distress in the past 30 days. • The suicide death rate was 13.2 per 100,000 population (age adjusted).
	CHNA 2019 • 11.0% of adults 18+ reported frequent mental distress (defined as "not good on 14 or more of past 30 days). (NE at 10.5) • Domestic assaults increased dramatically across all types: Aggravated, simple, and arrests for both types trending up dramatically since 2014
	CHNA 2022 TBD
Timeframe	FY20-FY22
Background	**Rationale:** • Mental health, substance abuse, and violence identified as top needs in the community by key stakeholders • Developing relevant responses and services to address mental health, substance abuse, and violent behaviors is crucial to the long-term health of the community • Community ranked substance abuse highest need across community input sessions, and contributes to the overall need for robust behavioral health services across the region • Youth substance abuse related to Juuling on the rise according to schools and law enforcement • Drug and Opioid-related overdose fatalities are greater across the US than NE, and although county-level data, or data by race and ethnicity is not available, local law enforcement and human service agencies warn the rates are rising locally, and are concerned overdose fatalities are more prevalent among minority and low-income populations.

	• Simple and aggravated domestic assaults and arrests increased significantly between 2016 and 2017, and the community reports increased incidence of violent behavior overall	
	Contributing Factors: • Community reports quality affordable housing is lacking in Hall County area driving stress and related negative behaviors in the area • Poverty and children in poverty has increased in Hall County since previous CHNA • Community reports care for substance abuse and severe mental illness is a challenge due to a lack of access points with sufficient levels of rehab and psychiatric care • Local law enforcement report their capacity for effective processing and transfer of patients being involuntarily committed is low and creates increased use of hospital emergency departments for behavioral issues	
	National Alignment: • 10.2 Suicides per 100,000 population (HP2020 target) • 24.2 % of adults age 18 and over report that they engage in binge drinking in past 30 days (HP2020 target) • Other benchmark measures may be identified relevant to the work identified by the local collaborative	
	Additional Information: CHI Health St. Francis just finished a three-year grant from CHI Mission & Ministry Fund to build a local collective impact coalition to identify and implement strategies to promote improved social and emotional learning among children through family supports and evidence-based programming.	
2.1 Strategy & Scope: Engage with Central District Health Department and Hall County Community Collaborative (H3C) to improve clinical and community-based behavioral health services, and address gaps in care to ensure behavioral health services are optimized within the Hall County community		
Anticipated Impact	**Hospital Role/ Required Resources**	**Partners**

• Reduced emergency department use for non-emergent care by connecting patients to primary care and/or federally qualified health center for on-going and preventive care
• Increased community capacity to respond to those in crisis as seen by the reduction of emergency department use for mental health or substance abuse issues or those affected by violence)
	CHI Health System Role(s):
	• Provides financial support
	• System-level leadership by Behavioral Health Service Line
	• Strategic partner
	
	CHI Health St. Francis/SNU's Role(s):
	• Fiscal Agent
	• Funder
	• Community Partner
	
	Required Resources:
	• Staff time
	• Funding
		• Central District Health Department
		• H3C Behavioral Health sub-coalition
		• Region 3 (System of Care work)
		• Central Nebraska Council on Alcoholism and Addictions (CNCAA)
		• Others to be determined
		  • Law enforcement
		  • School districts

Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Engage with Central District Health Department (CDHD) leadership and Hall County Community Collaborative (H3C) to continue to build capacity and sustainability of the collective impact behavioral health coalition which may include funding and/or technical assistance (St. Francis) • Support the coalition to prioritize collective strategies to address mental health, substance abuse, and violence issues which may include (St. Francis): ○ Promote and support community-based trainings related to crisis response for community-based public health and social service providers.	• Increased awareness of community resources • Decrease in inappropriate ED use • Increase in community partnerships to address BH needs	Data will be reviewed and monitored annually as part of the coalition work using the following data sources: • CDHD • H3C Records • Hospital Records

○ Supporting Region 3 strategy to create a youth system of care ○ Collaborate with Law Enforcement on involuntary commitments to improve the relevant placement for BH patients (Civil protective custody) and explore opportunities to advocate for legislative change alleviating challenges with placement. ○ Continued support to family programs supporting parents and building stronger family connections (i.e. Rooted in Relationships and Circle of Security) and social emotional learning for children (i.e. Discovery Kids) ○ Explore gaps and build capacity to address opioid addiction in the area ○ Explore existing violence prevention efforts and identify and build capacity to address gaps in community response to violence		

Results

2.1.1: Engage with Central District Health Department (CDHD) leadership and Hall County Community Collaborative (H3C) to continue to build capacity and sustainability of the collective impact behavioral health coalition which may include funding and/or technical assistance (CHI Health St. Francis)

Fiscal Year 2020 Actions and Impact:

- Supported Community Response/Central Navigation through H3C and Heartland United Way, as well as helped identify and communicate web-based trainings for community members, mental health providers, social workers, etc. during COVID-19 restrictions.
- Spearheaded monthly Behavioral Health meeting/calls for professionals to share insight, experiences and needs. This was very well received and we anticipate will continue post-COVID-19.

Measures:

- Financial support provided to the Community Response Compassion Fund: $20,000

- Individuals supported with financial support to the Compassion Fund: 151
- Provided an additional $30,000 to community organizations to support basic needs, such as food stability and emergency housing, plus first responder safety provisions during the pandemic
- Behavioral Health Coalition board meetings: 12
- Behavioral Health Coalition subcommittee meetings: 48

Fiscal Year 2021 Actions and Impact:

- Supported Community Response/Central Navigation through H3C and Heartland United Way, as well as helped identify and communicate web-based trainings for community members, mental health providers, social workers, etc. during COVID-19 restrictions.
- Spearheaded monthly Behavioral Health meeting/calls for professionals to share insight, experiences and needs. This was very well received and they intend to continue after COVID-19.

Measures:

- Behavioral Health Coalition board meetings: 12
- Behavioral Health Coalition subcommittee meetings: 48

Fiscal Year 2022 Results Pending

2.2: Support the coalition to prioritize collective strategies to address mental health, substance abuse, and violence issues which may include (CHI Health St. Francis)

2.2.1 Strategy and Scope: Promote and support community-based trainings related to crisis response for community-based public health and social service providers.

Fiscal Year 2020 Actions and Impact:

- Continued to support numerous training opportunities through Hall County Community Collaborative

Measures: No measures to report.

Fiscal Year 2021 Actions and Impact:

- Continued to support numerous training opportunities through Hall County Community Collaborative.
- Supported the Crisis Center financially and through Board participation and leadership. They continue to see an increased need for their services during the pandemic.

Measures:

- Hall County Community Collaborative is currently going through leadership changes and training metrics will be reported in the following year.
- Financial support to Crisis Center: $25,000
    - Number of clients served/community members educated: 652

Fiscal Year 2022 Results Pending

2.2.2 Strategy and Scope: Supporting Region 3 strategy to create a youth system of care

Fiscal Year 2020 Actions and Impact:

- Continued to be directly involved with H3C, Region 3, Central District Health Department and Nebraska Children and Families Foundation to complete and continually update needs assessment and program priorities/goals/strategies/funding

Measures: No measures to report.

Fiscal Year 2021 Actions and Impact:

- Continued to be directly involved with H3C, Region 3, Central District Health Department and Nebraska Children and Families Foundation to complete and continually update needs assessment and programmatic needs. There has been some staff transition, but the meetings are on track and are currently determining specific strategies to address youth needs.

Measures:

- Participated in at least two meetings per month and supported subcommittees as needed.

Fiscal Year 2022 Results Pending

2.2.3 Strategy and Scope: Collaborate with Law Enforcement on involuntary commitments to improve the relevant placement for behavioral health patients (Civil protective custody) and explore opportunities to advocate for legislative change alleviating challenges with placement.

Fiscal Year 2020 Actions and Impact:

- Had preliminary discussions with a leader of Grand Island Police Department and St. Francis Community Board member to discuss challenges faced by current system. Agreed to continue discussions and build relationships with other local law enforcement and Licensed Mental Health Professionals representatives
- Continued to see a need for support, but strategy largely on hold due to COVID-19

Measures: No measures to report.

Fiscal Year 2021 Actions and Impact:

- Participated in at least two meetings per month and supported subcommittees as needed.

Measures:

- No measures to report; continuing to explore opportunities to partner and evolve services.

Fiscal Year 2022 Results Pending

2.2.4 Strategy and Scope: Continued support to family programs supporting parents and building stronger family connections (i.e. Rooted in Relationships and Circle of Security) and social emotional learning for children (i.e. Discovery Kids)

Fiscal Year 2020 Actions and Impact:

- Worked closely with Central Nebraska Coalition on Alcoholism and Addiction and H3C to ensure these programs continued. Due to COVID restrictions, Circle of Security (COS) has been offered as a web/telehealth opportunity for parents

Measures:

- Trained two additional Spanish speaking COS trainers
- Ensured COS curriculum's sustainability through leadership in H3C's behavioral health programming through provision of 100 English and Spanish workbooks for use by trained local program facilitators and parent participants

Fiscal Year 2021 Actions and Impact:

- Worked closely with the Central Nebraska Coalition on Alcoholism and Addiction and H3C to ensure these programs continued. Due to COVID-19 restrictions, Circle of Security (COS) has been offered as a web/telehealth opportunity for parents.

Measures:

- There were approximately six program facilitators trained in FY21 with sessions being offered in English and Spanish.

Fiscal Year 2022 Results Pending

2.2.5 Strategy and Scope: Explore gaps and build capacity to address opioid addiction in the area

Fiscal Year 2020 Actions and Impact:

- Healthy Communities team continued to meet with the director of the Alcohol and Drug Treatment Center to explore support and alignment. Strategy largely on hold due to COVID-19.

Measures: No measures to report.

Fiscal Year 2021 Actions and Impact:

- Healthy Communities team continued to meet with the director of the Alcohol and Drug Treatment Center to explore support and alignment. Strategy largely on hold due to COVID-19.

Measures: No measures to report.

Fiscal Year 2022 Results Pending

2.2.6 Strategy and Scope: Explore existing violence prevention efforts and identify and build capacity to address gaps in community response to violence

Fiscal Year 2020 Actions and Impact:

- Worked closely with the Crisis Center, H3C, Central Nebraska Community Action Partnership, Grand Island Public Schools and Hall County Juvenile Department to identify current and potential needs related to youth, domestic and intimate partner violence
- Provided financial support to the Crisis Center for the development of a Youth Advisory Board – active and meeting both in person and virtually, as appropriate

- Continued to partner with the Grand Island Coalition on Trafficking participated. One Forensic Nurse Examiner participated on one of their virtual panels

Measures:

- Schools participating in the Youth Advisory Board: 13
- Financial support provided to the Crisis Center: $5,000

Fiscal Year 2021 Actions and Impact:

- Continued to work closely with the Crisis Center, H3C, Central Nebraska Community Action Partnership, Grand Island Public Schools and Hall County Juvenile Department to identify current and potential needs related to youth, domestic and intimate partner violence.
- Continued partnership with the Crisis Center to support the Youth Advisory Board that was launched in FY20 – active and meeting both in person and virtually, as appropriate.
- Continued to partner with the Grand Island Coalition on Trafficking providing leadership board representation and community membership.
- Applied for and received $162,000 Mission and Ministries 3-year grant for Human Trafficking prevention and community education.

Measures:

- Schools participating in the Youth Advisory Board: 13
- Financial support provided to the Crisis Center: $25,000

Fiscal Year 2022 Results Pending

Appendices

Appendix A: 2021 Central District Health Department CHA

In 2021, CDHD contracted with NALHD to complete a CHA for the three counties in the Central District (Hall, Merrick, and Hamilton).

Appendix B: 2021 CHA Process Summary

CDHD contracted with the NALHD to facilitate two, four-hour workshops to review data, to determine any additional data collections and mining needs and to set priorities. The workshops occurred via Zoom on June 15, 2021, and September 2, 2021. The participants engaged in a Technology of Participation (ToP) facilitated process.

Community Health Assessment
2021 Report

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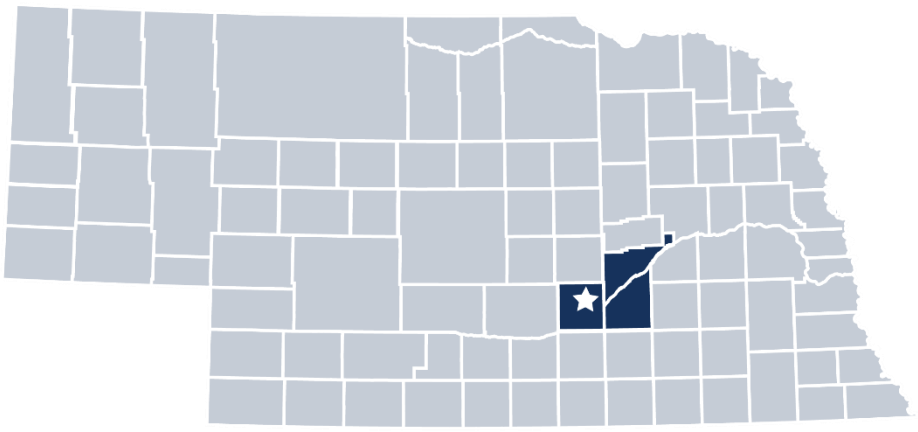
Prepared by Nebraska Association of Local Health Directors
For Central District Health Department

Contents

Introduction

Central District Health Department (CDHD) serves 78,432[i] people within a three-county district comprised of Hall, Hamilton, and Merrick counties in central Nebraska. CDHD 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 CDHD is to protect and improve the health and wellbeing of our community.



As Chief Health Strategist—who convenes stakeholders that investigate and take action to make meaningful progress on complex health community issues[ii]—for this three-county district, CDHD conducts a community health assessment (CHA) and community health improvement plan (CHIP) every three years. The CHA is a process of gathering and interpreting information from multiple and diverse sources in order to develop a deeper 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. Data were gathered from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings and Roadmaps (CHRR), American Community Survey/US Census Bureau, Centers for Disease Control and Prevention (CDC), Nebraska Department of Transportation, Nebraska Department of Education, and the US Bureau of Labor Statistics. This assessment identifies leading causes and emerging issues that impact community health and quality of life, including the leading causes of mortality and morbidity, the general health status of community members, disparities in health outcomes, the access and availability of behavioral and health care, etc.

Main partners who take the lead role in providing healthcare for the communities within CDHD region and play an important role in the development of this assessment include:

> **CHI Health Saint Francis**, located in Grand Island, Hall County, is a regional referral center, with more than 100 physicians and 1,100 employees working together to build a healthier community. The goal of CHI Health Saint Francis is to provide patients with high-quality medical care close to home, where they can be supported by their family, friends, and community. In 2018, the CHI Health Regional Cancer Center became a QOPI Certified Practice. Services provided by CHI Health Saint Francis include behavioral care, breast cancer care, cancer care, diabetes education, emergency and trauma, general surgery, heart care, home care, imaging

maternity center, neurosurgery, nursing, orthopedics, pediatrics, primary care, rehabilitation care, respiratory care, sleep disorders, and wound and ostomy center.

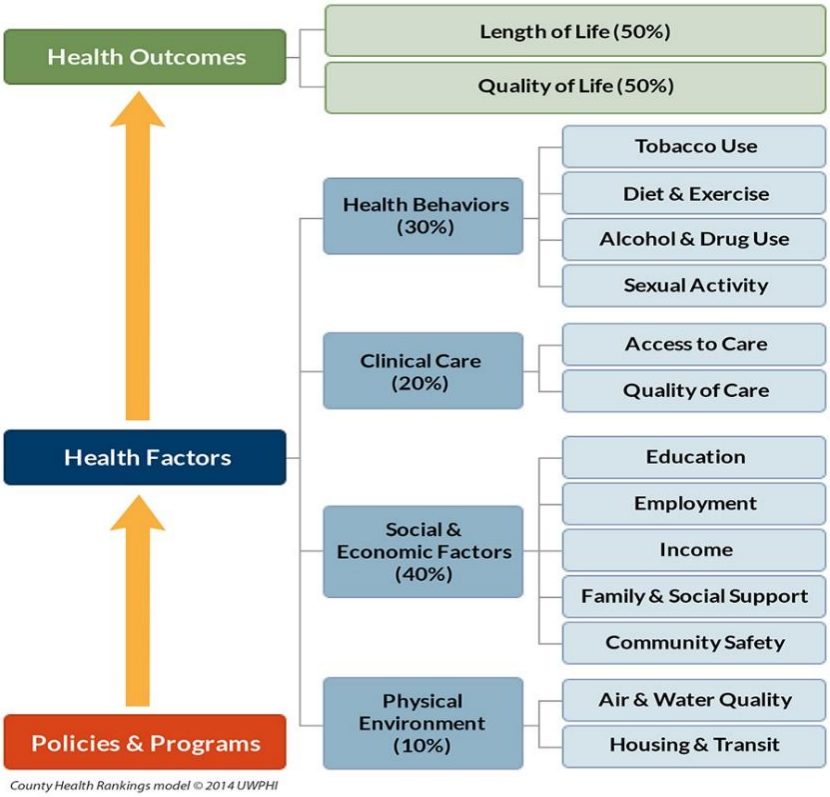
Grand Island Regional Medical Center is an acute care hospital located in Grand Island, Hall County, that aims to bring additional patients and health care talent to the area. Grand Island Regional Medical Center is a locally owned and organized nonprofit organization, offering a broad range of specialties and services including a maternity center and a variety of surgical, medical, clinical, and emergency services. The hospital opened its doors in August 2020 and is accredited by the Center for Improvement in Healthcare Quality (CIHQ).

Merrick Medical Center-Bryan Health, formerly Litzenberg Memorial County Hospital, promotes and provides personalized, compassionate, and quality healthcare services for the people in Merrick County and the surrounding area. Merrick Medical Center-Bryan Health is located in Central City, Merrick County, and is a critical access hospital with 25 licensed beds and two physician clinics. On July 1, 2017, Bryan Health, a non-profit, Nebraska owned health system partnered with the former Litzenberg Memorial County Hospital to establish Merrick Medical Center-Bryan Health. Merrick Medical Center-Bryan Health provides health care services, fitness and wellness programs, telehealth technology and works with community partners to make health a commitment.

Memorial Community Health is a Critical Access Hospital in Aurora, Hamilton County, which offers residents a diverse, modern health care system that includes three family practice clinics, an acute hospital, outpatient specialty and diagnostic services, independent and assisted living facilities, and a nursing home. Memorial Community Health is fully licensed by the State of Nebraska and approved by Medicare and Medicaid which sets and oversees the standards of quality for health care institutions; while also being members of the American Hospital Association, the Nebraska Hospital Association, the Nebraska Nursing Home Association, and the Nebraska Assisted Living Association. Memorial Community Health is a not-for-profit organization and is entirely dependent upon revenue from patient services, resident care, and philanthropy.

County Health Rankings and Roadmaps (CHRR), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin, provides reliable local data and evidence to communities to help them identify opportunities to improve their health. The CHRR model was used as the lens for this community health assessment.

Figure 1. County Health Rankings and Roadmaps Framework



Community Health Assessment Methods

This community health assessment gathered data from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings, American Community Survey/US Census Bureau, Centers for Disease Control, Nebraska Department of Education, and so on to assess the health status of the CDHD region to identify emerging issues and trends, when possible, and to gauge big changes from the previous 2019 Community Health Improvement Plan priorities.

At the beginning of 2020, local health departments in Nebraska began the response to a global pandemic resulting from a novel virus, Coronavirus 2019. While eager to know the impact of COVID-19 on population health, this data was not available at the time of this community health assessment. In efforts to learn more about the impact of COVID-19 on communities in the CDHD area, CDHD launched a 5-question survey. The survey was developed by the Nebraska Association of Local Health Directors (NALHD) as an open-ended survey design intended to allow respondents to tell LHDs their experience related to their health and the health of their community to identify emerging issues in the community. The NALHD made the survey accessible to all LHDs across Nebraska to identify statewide impact and trends. The survey is intended to be initially launched during the community health assessment and released more frequently throughout the community health improvement process to keep current on emerging issues in the community; however, results discussed throughout this report are from the initial launch in June 2021. This survey will assist CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The survey assessed experiences of community members related to major health issues for them or their family, what it means to be healthy, top health concerns, and ways to be healthy in their community and was made available in

English, Spanish, Somali and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey online when waiting for appointments. In all, 665 responses were collected (see Appendix D for a table of respondent demographics).

Additionally, a resource inventory survey was launched to partners of CDHD in August 2021 as a way to provide insight into available medical resources, resources that help people prevent and manage personal health risks, and resources that help people thrive. In all, 15 responses were collected. Respondents self-identified from the following sectors: 20% non-profit, 20% hospitals, 13% Federally Qualified Health Centers, and 6% from each of the following sectors: business, faith-based organizations, health departments, higher education/academic institutions, law enforcement/judicial systems, and medical clinics.

Finally in June 2021, 35 partners participated in a focused discussion to identify forces that impact health in communities within the CDHD area as part of this community health assessment. The results follow:

Economic	• Businesses impacted by COVID-19 • Poverty rate • Healthcare worker shortage • Jobs/workers not returning to jobs • Online shopping impacts small brick/mortar businesses • Employers' expansion of remote working and other flexibility that wasn't an option before COVID
Environmental	• Housing shortage • Flood recovery • Access to clean water
Legal/Political	• Political concerns regarding safety/masks • Medicaid expansion • Vaccines turned very political • Issues (COVID, other) were politicized (for good/bad) and dealing with social perceptions as the after effect
Social/Family	• Lower volume of employees returning to work • Primarily women choosing to stay home instead of going back to a lower paying job • Increase in depression related to social distancing/isolation • Everyone (age, generational) impacted by stress/is under stress
Technological/ Scientific	• Tele-health access for those without internet • Navigating technology • Telehealth potential was more clearly demonstrated than before (+) ***Trend*** toward expanding broadband… more internet • Flipside: still need to help many folks navigate using tech
Other…	• Additional hospital/second hospital • Employment • Migration changes • Workforce not returning… women not reentering workforce • Stress for folks of all ages • Job losses • Impact of new • Reluctance to get usual care… staying home hurts local rural business • High achieving children may have had easier time than those who struggle. Teachers had to adapt daily. • Stressful year for everyone in GI and across the state • Summer school attendance is higher than any other year • Students playing catch up • Teachers and families learned to manage and to adapt • Schools found ways to meet needs of kid… academic and basic (food) ***Trends***: Increasing obesity rates for child and adults Alcohol consumption and alcoholism increasing Growing population overall and more diverse

District Overview & Health Equity

Central District Health Department (CDHD), headquartered in Hall County, serves 78,432[iii] people within a three-county district comprised of Hall, Hamilton, and Merrick counties in the central part of Nebraska. Main economic drivers in CDHD include agriculture/forestry/fishing/hunting, health care/social assistance and manufacturing[iv].

Quick Facts for CDHD Region:[v]

Population (2020): **79,992**[1]
Population Change (2010-2019): **5.7%**
Unemployment Rate: **3.2%**[vi]
Total Land Area (2010): **1,574 square miles**

While Hall County is classified as a metropolitan statistical area, Hamilton and Merrick counties are classified as rural counties by the Federal Office of Rural Health Policy[vii]. 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.[viii] These data paint a stark picture of health disparities given one factor, geography. Additionally, it is important to understand that 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.[ix] Other obstacles that can impede someone from achieving their full health potential include literacy/language barriers, military status, disability, age, social vulnerability, and key social and economic factors (like poverty and income-level, housing, education status, etc.). These obstacles are described in detail below for the CDHD area; however, race/ethnicity data for many of these factors are limited.

Literacy and Language Barriers

Literacy and primary language must be taken into account in all health contexts. It is estimated that only 1 in 10 American adults have the skills needed to use health information that is routinely available in health care facilities, retail outlets, and the media.[x] *"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".*[xi] Basic literacy and health literacy levels are also factors associated with health disparities.

Language barriers also contribute to health disparities and exacerbate difficulties understanding and acting on health information.[xii] The CDHD district is home to multiple immigrant populations and residents whose second language is English, with concentrations from Mexico, Somali, and Arabic nations and smaller populations from other areas.

[1] US Census data was updated with 2020 data where applicable in this report. Note: granular Census data is not available from US Census Bureau until later 2021.

Table 1 summarizes the health literacy indicators within the CDHD district. Nearly 1 in 2 adults in the CDHD district reported that written health information and verbal health information given by medical professionals is not easy to understand.

Table 1. Health Literacy Indicators, CDHD District

Health Literacy Indicators[xiii]	CDHD Region
Very easy to get needed advice or information about health or medical topics	70%
Written health information very easy to understand	57%
Very easy to understand information that medical professions tell you	56%

Veterans

Overall, CDHD district Veteran's population is consistent with the state (see Table 2). Although the US Department of Veteran Affairs (VA) assists Veterans in accessing health care and other services, eligibility status for these services depends greatly upon the branch of service, time served, and discharge status. Even when Veterans access services, challenges still exist for health care professionals to effectively understand and treat health issues in Veterans due to complex military histories and medical needs. Unlike previous generations, many younger Veterans experienced frequent deployments to multiple conflict areas, exposure to explosions in close proximity and longer tours of duty.[xiv]

Table 2. Veteran Status, CDHD District

Veteran Status[xv]		% Veterans (age 18+)
	Hall County	5%
	Hamilton County	7%
	Merrick County	7%
	CDHD District	6%
Nebraska		**6%**

Disability

In the US, one in four adults reported having a disability that impacts their major life activities. Women, non-Hispanic American Indians/Alaska Natives and adults with lower income experience disabilities more than other groups. Mobility disability is the most common type of disability followed closely by cognition, independent living, hearing, vision, and self-care. Adults aged 65 and older who experience disability are more likely to have health insurance, a primary doctor and receive routine health check-ups in the past year compared to adults under 65 years of age with disabilities.[xvi]

Figure 2. Disability types among adults in Nebraska[xvii]

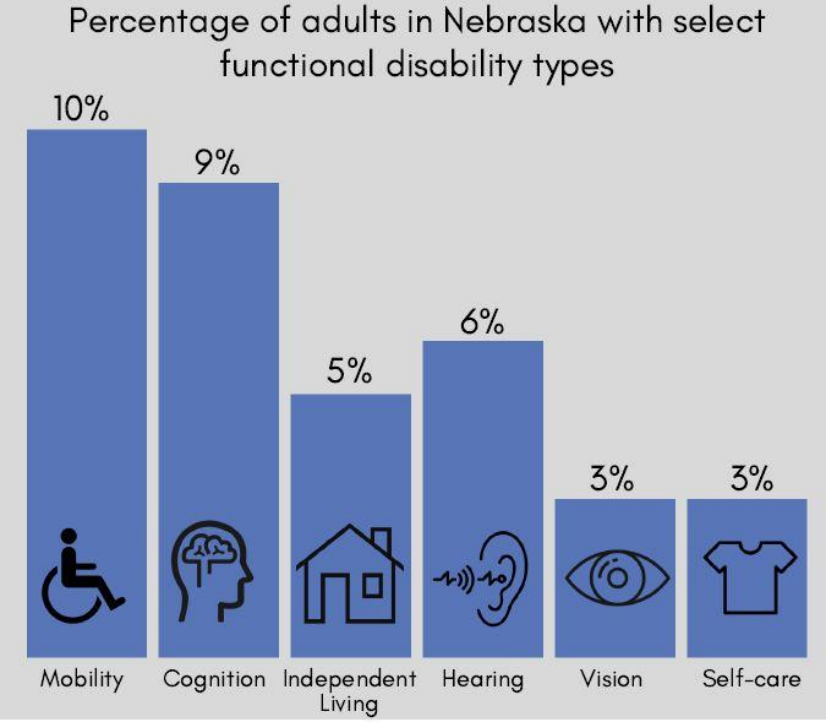
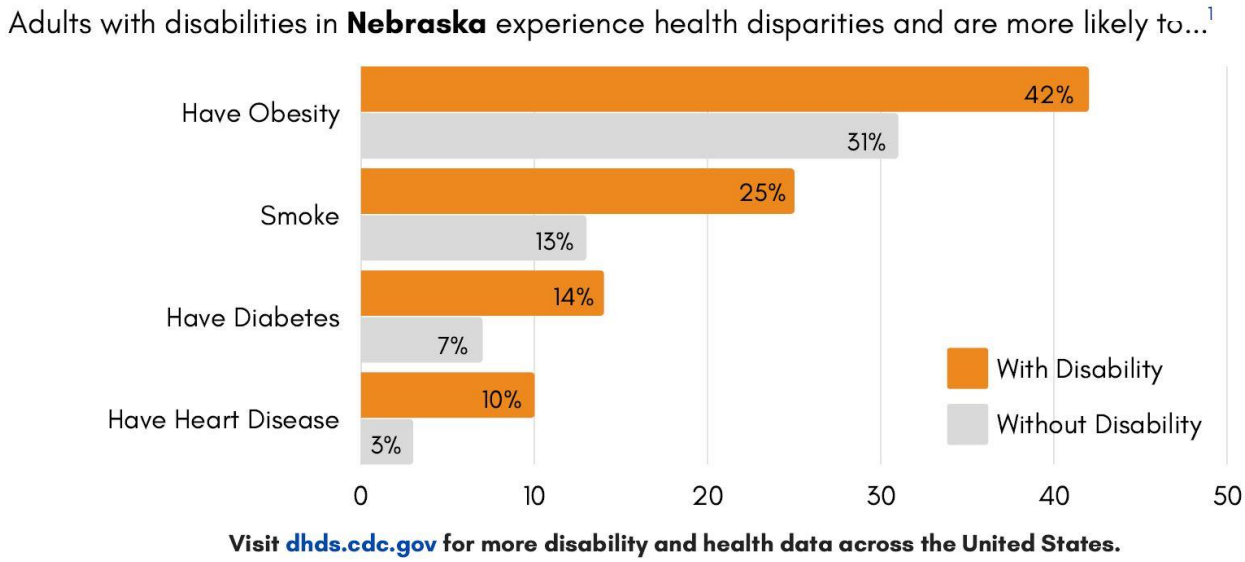


Figure 3. Disability and Health Disparities among adults in Nebraska[xviii]



In the CDHD district, over 1 in 12 adults under age 65 reported having a disability (12.3% Merrick, 5.4% Hamilton, and 8.7% Hall)[xix]. Disabilities become more common as people age. Care coordination and better access to health care services are key to better health by helping people with disabilities adopt healthy behaviors.

Aging

Currently, 16% of the US population is aged 65 and older. This number is expected to grow over the next 40 years to 25%.[xx] As Americans age, many older adults aged 65 and older make rural living their home. Older adults typically reside in rural areas in part due to the attractiveness of the scenic and recreation amenities available in rural communities and due to younger people moving out of rural areas, essentially leaving an older generation behind.[xxi] Older adults have a higher risk of developing chronic diseases and illnesses, including dementia, heart disease, diabetes, arthritis, and cancer. These diseases and illnesses tend to be the leading causes of death and disability in the state and nation and leading drivers of health care costs.[xxii] In the US, more than 25% of older adults were considered "high-need", meaning they were managing three or more chronic conditions or required help with basic tasks of everyday living.[xxiii]

In the CDHD area, almost 1 in 5 people are 65 years or older, slightly higher than the state rate (16%). Alzheimer's Disease is a more commonly known disease among the older adult population. In Hall County, the adult population that experience Alzheimer's Disease (43.5/100,000) is over two times the rate of the state (23.7/100,000 population, respectively) and four times more than adults in Hamilton and Merrick counties (18.3 and 16.6/100,000 population, respectively)[xxiv]. The ability to remain active, healthy and independent as long as possible is key for older adults to live a quality, long life.

Socially Vulnerable Populations

Certain factors, such as gender, age, income level, education level, housing conditions, limited English proficiency, disability, limited transportation and so on, can influence personal health risk of disease, illness, and risk of being seriously affected by an emergency (i.e. flooding, tornadoes, and infectious disease outbreaks). People at higher risk of being seriously affected by the aforementioned public health outcomes and emergencies are considered socially vulnerable. The Centers for Disease Control and Prevention established a Social Vulnerability Index (SVI) as a tool to provide information to community stakeholders in effort to better prepare communities for response to these public health outcomes and emergencies with the overall goal of decreasing both human suffering and economic loss.

The SVI produces a vulnerability score of populations within each US Census tract among four main themes and a score for each theme. Themes include: ***socioeconomic status***, such as poverty level, employment status, income level and high school diploma; ***household composition and disability***, such as aged 65 and older, aged 17 and younger, single-parent households and disabilities among age 5 and older; ***minority status and language***, such as race/ethnicity and English proficiency; ***housing type and transportation***, such as mobile homes/multi-level structures, crowding, and lack of transportation. For the CDHD area, the CDC produces an overall SVI score and a SVI score by theme for each county (see Table 3 for results). Hall County has the highest vulnerability out of all counties within the CDHD area, which is not a surprise given the population characteristics illustrated in upcoming sections of this report. Community stakeholders can use the SVI as a snapshot into where the most vulnerable communities reside and assist with honing in on areas of focus to help reduce risk of public health outcomes and emergencies.

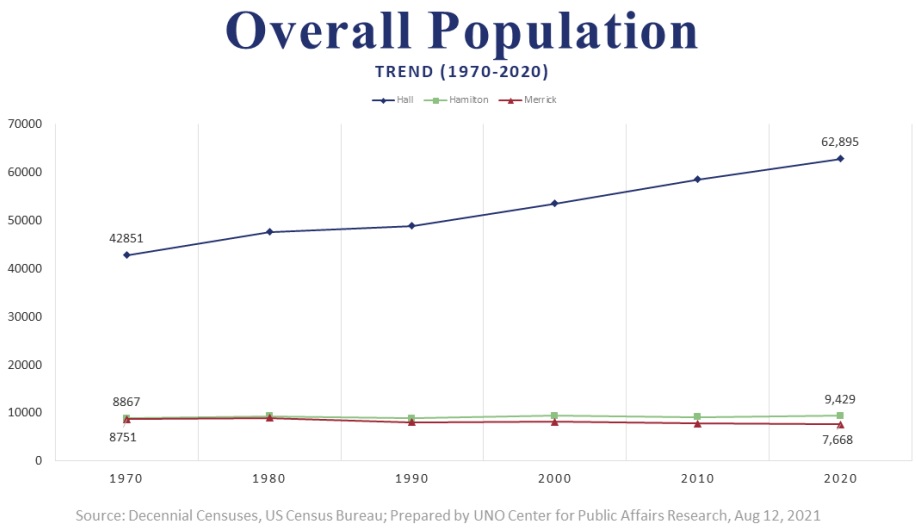
Table 3. Social Vulnerability Index, CDHD District

Social Vulnerability Index			
	Hall County	Hamilton County	Merrick County
Overall Score	**0.6701**	0.0089	0.1975
Socioeconomic Status	***0.4455***	*0.0194*	*0.1086*
Household Composition and Disability	***0.7163***	*0.2865*	*0.3114*
Minority Status and Language	***0.8838***	*0.0675*	*0.2165*
Housing Type and Transportation	***0.5909***	*0.0185*	***0.5587***
		Scale: lowest vulnerability = 0.0	*highest vulnerability = 1.0*

Population Demographics

Overall, Nebraska's rural population is decreasing while the urban population is increasing. Nebraska's population in the 2019 Census was estimated at 1,934,408. This count was up 5.9% from the 2010 Census and consistent with the national increase of 6.3% during the same period. Growth has occurred in all four of the urban counties of Nebraska. Conversely according to the US Census, all counties within the CDHD district experienced an increase in population (ranging from 2% to 5% increase) between 2010 and 2019 except for Merrick County, which experienced a 1.3% decrease in population. Over a 50-year period (see Figure 4), population in the CDHD area has trended upward in Hall County and remained relatively flat (or a slight downward trend) for Hamilton and Merrick counties.

Figure 4. Overall Population Trend, CDHD (1970-2019)



Race and Ethnicity

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 in Nebraska (55% vs. 10%).[xxv] Hispanics represented 5.6% of the total population in Nebraska in 2000, 9.2% in 2010, and 11.4% in 2019, and it is estimated that by 2025, the Hispanics 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%). According to the Center for Public Affairs Research at the University of Nebraska-Omaha, populations over time in Nebraska increased in racial/ethnic diversity resulting in positive net migration in Nebraska as of late (see Figure 5). In the future, as the children of today grow up and have children of their own, racial/ethnic diversity is expected to increase (see Figure 6).

Figure 5. Net migration over time, Nebraska (1920-2019)

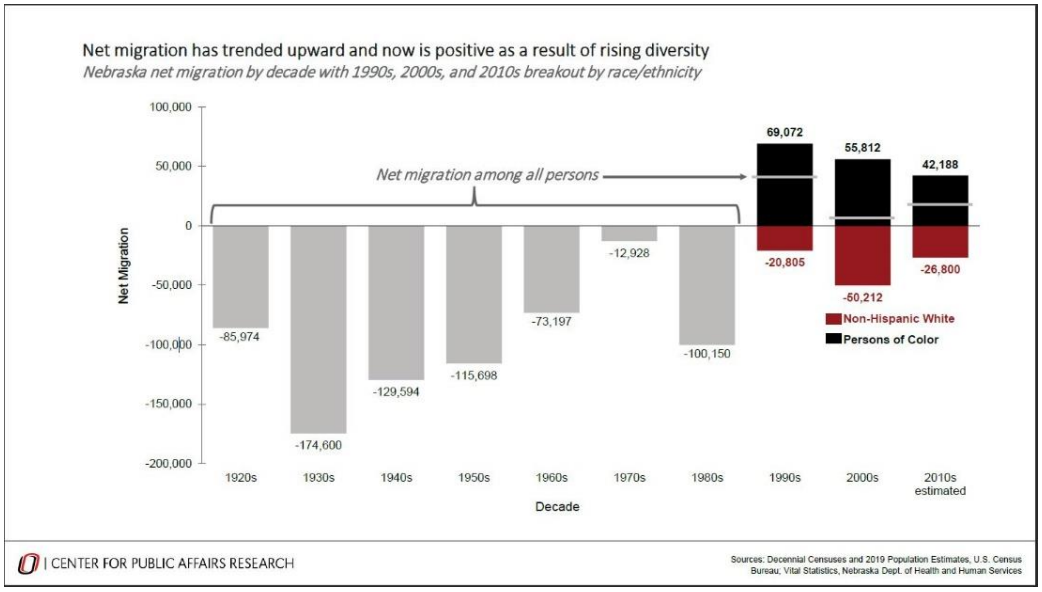
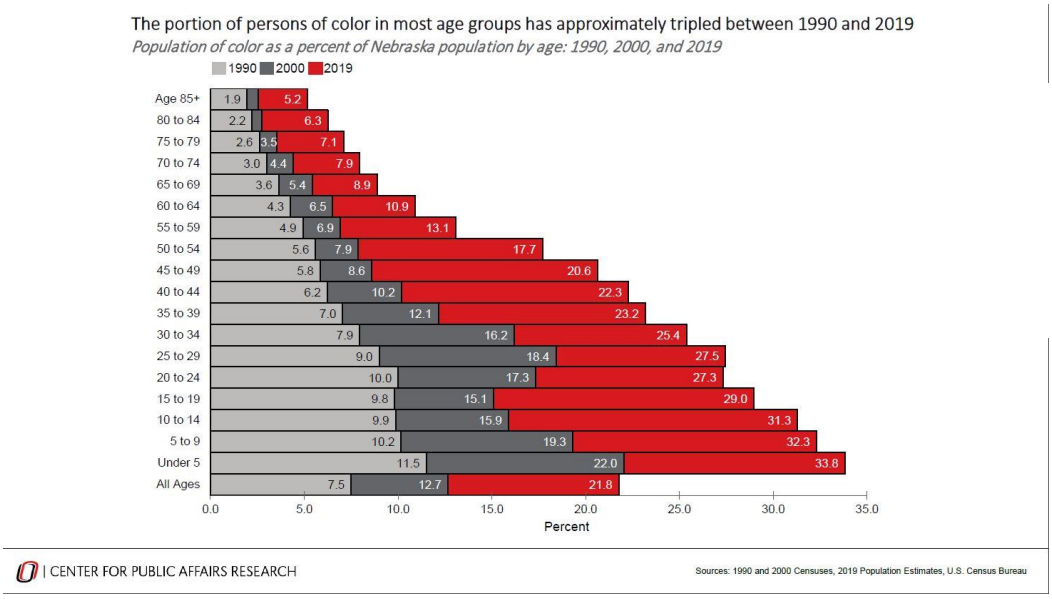
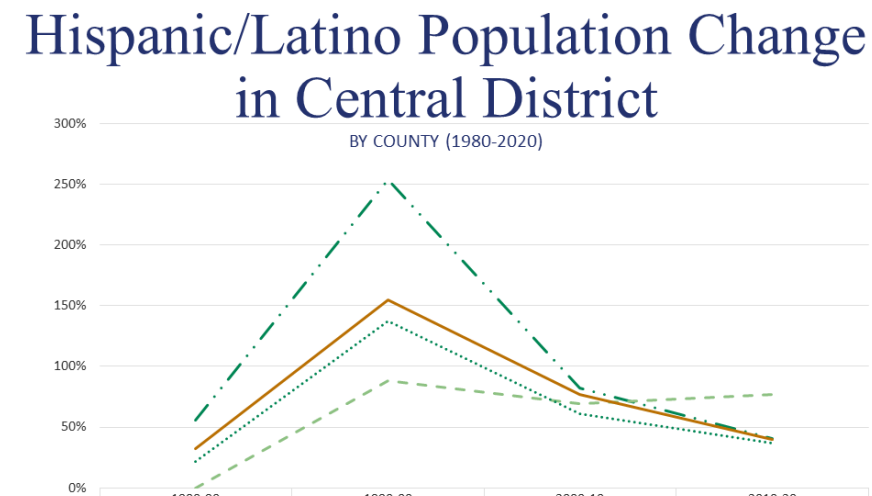


Figure 6. Persons of color by age group, Nebraska (1990-2019)



According to the 2020 County Health Rankings in the CDHD district, Hispanics represented 12%, consistent with the state (11%)[xxvi]. Among counties within the CDHD district, the Hispanic/Latino percent population change over the last 30 years mimicked the state trend peaking between 1990 and 2000 ending with a downward trend in 2020, except for Hamilton County. Hamilton County experienced a slight upward trend in Hispanic/Latino percent population change between 1980-2020 (see Figure 7).

Figure 7. Hispanic/Latino % population change, by county in CDHD



	1980-90	1990-00	2000-10	2010-20
Hall	56%	254%	82%	41%
Hamilton	0%	88%	69%	77%
Merrick	22%	137%	61%	37%
State	32%	155%	77%	40%

Source: Decennial Censuses, US Census Bureau; Prepared by David Drozd, UNO Center for Public Affairs Research, Aug 13, 2021

According to the County Health Rankings and Roadmaps, most of the Hispanic population within the CDHD district resides in Hall County (29%). Within Hall County, the Grand Island Public Schools District had the highest English Language Learners (17%) of all school districts within CDHD area. The percent of Hispanic residents in the other two counties was as follows: Hamilton, 4%; Merrick, 5%. Additionally, race by county is similar to ethnicity by county in that Hall County was home to more racially diverse residents (7.1%) than Hamilton and Merrick counties (1.1% and 2.2%, respectively) and is similar to the state (9.2%) (see Figure 8).

Figure 8. Hispanic Origin, CDHD District

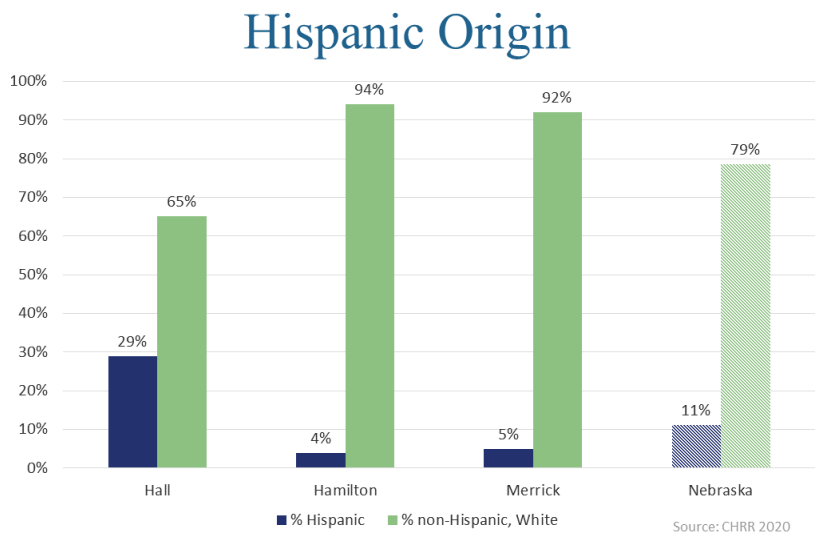
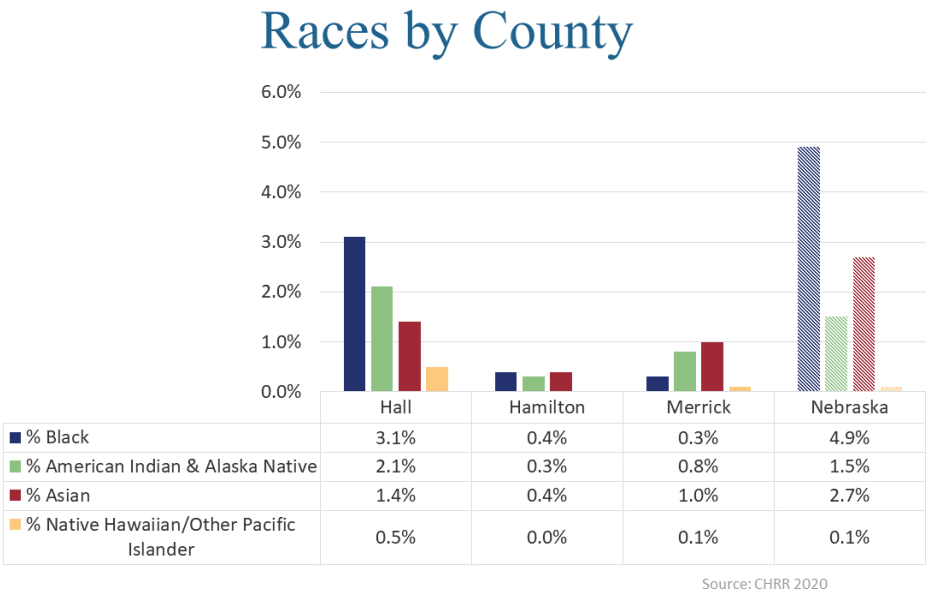


Figure 9. Races by County, CDHD District



	Hall	Hamilton	Merrick	Nebraska
% Black	3.1%	0.4%	0.3%	4.9%
% American Indian & Alaska Native	2.1%	0.3%	0.8%	1.5%
% Asian	1.4%	0.4%	1.0%	2.7%
% Native Hawaiian/Other Pacific Islander	0.5%	0.0%	0.1%	0.1%

Median Age

The median age in the CDHD district was 40 years in 2019, a little older than the average in Nebraska (36 years). Merrick County had the oldest median age of the counties within the CDHD area, almost eight years older than the state.

Figure 10. Age Distribution, Hall County

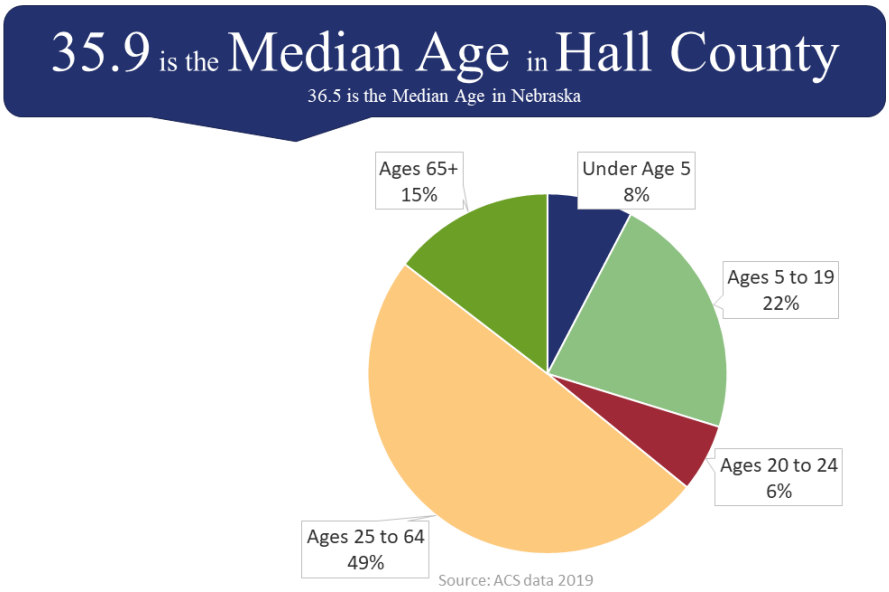


Figure 11. Age Distribution, Hamilton County

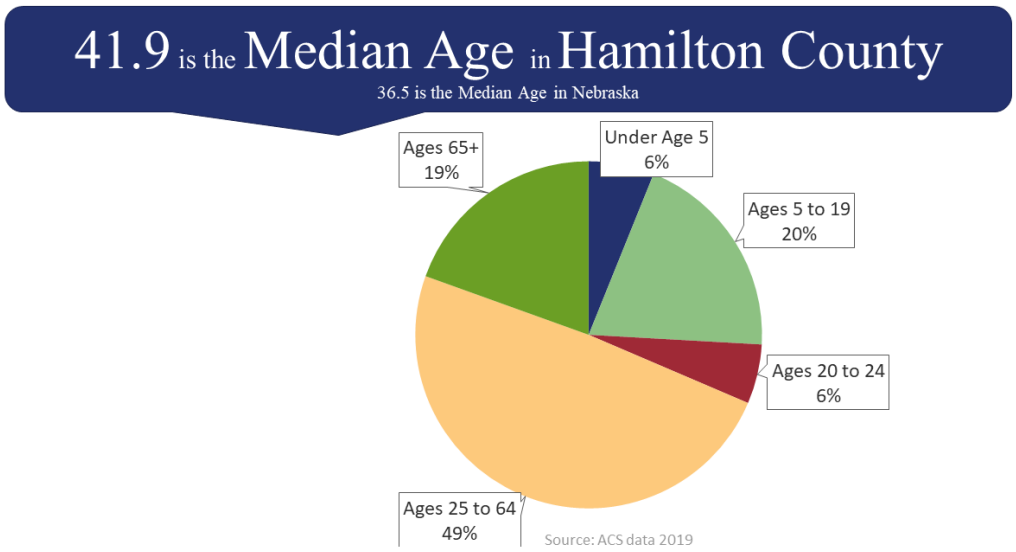
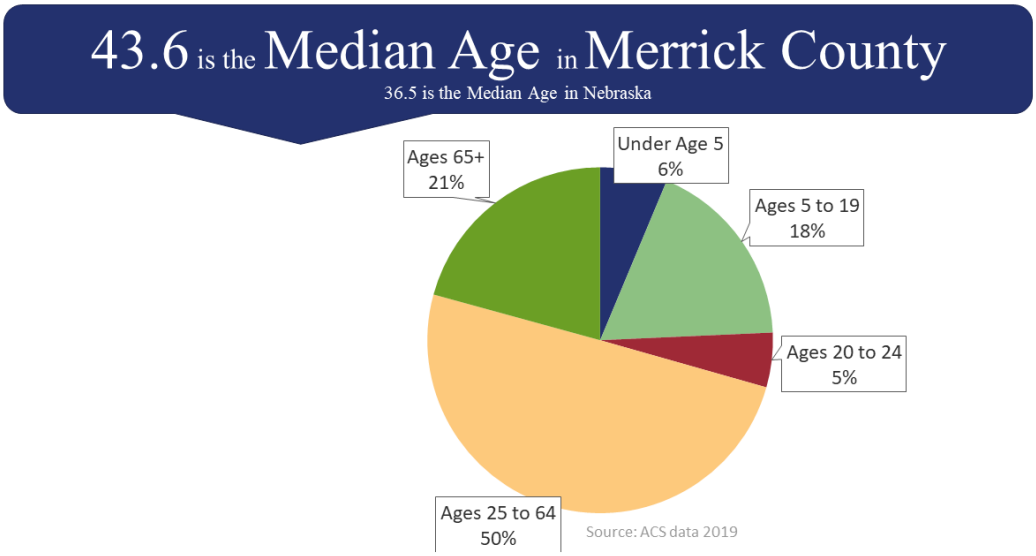
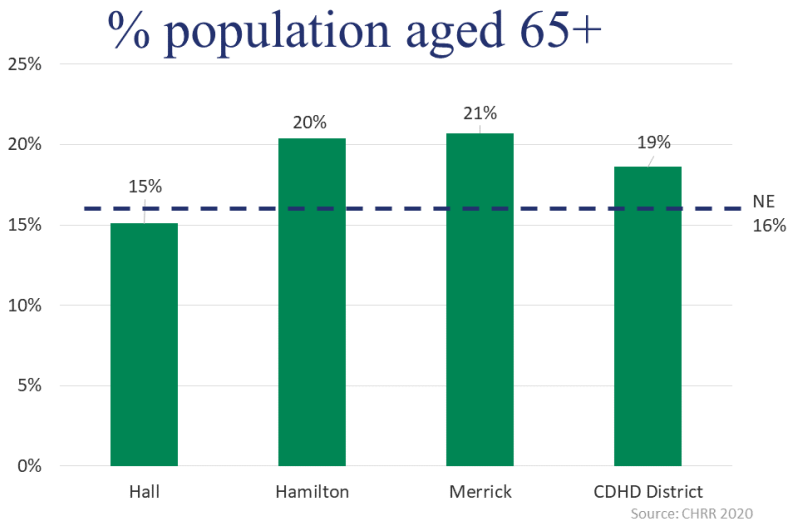


Figure 12. Age Distribution, Merrick County



Roughly 1 in 5 adults in Hamilton and Merrick counties were 65 years and older, and nearly 1 in 6 adults in Hall County were 65 years and older. The percentage of adults aged 65 years and older across the CDHD district (19%) was higher than the state (16%).

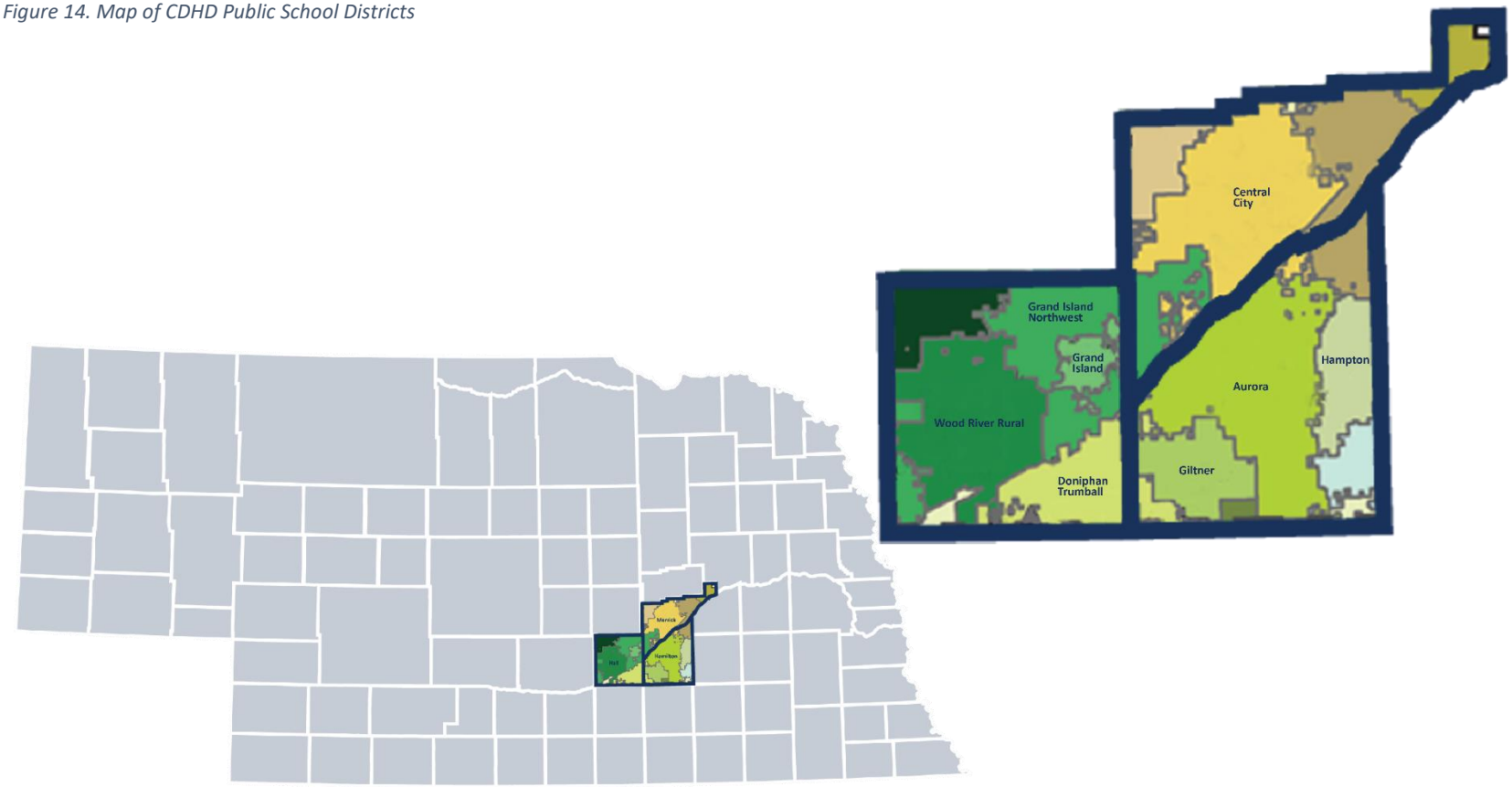
Figure 13. Percent Population Aged 65+, CDHD District



School District Profiles

School-related data can provide a timely picture of the cultural and socio-economic shifts in a community that influence health factors and health outcomes at a population level. Figure 14 illustrates the location of public-school districts within the CDHD district.

Figure 14. Map of CDHD Public School Districts



The following tables highlight key community-level indicators for each county and related public school districts:

Table 4. Public School District Profile--Hall County

Hall County Public School Districts Profile (2018-2019)[xxvii]						
		Doniphan-Trumball	**Grand Island Northwest**	**Wood River**	**Grand Island Public Schools**	**State of Nebraska**
Student Characteristics	**Enrollment**	460	1,574	512	10,070	329,290
	Graduation rate	93%	99%	90%	83%	88%
	College-Going rate	81%	76%	80%	61%	*
	% Receiving **free/reduced lunch**	24%	29%	49%	65%	46%
	% **English language learners**	*	1%	5%	17%	7%
	% Students in **special education**	12%	11%	13%	16%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in **language arts**	Cancelled due to COVID-19				Cancelled due to COVID-19
	% Proficient in **math**					
	% Proficient in **science**					

Quick Facts for Hall County:[xxviii]

Population (2020): **62,895**
Population Change (2010-2019): **4.7%**
% children under 18: **28%**
Median Household Income: **$57,371**
% total population in poverty: **10%**
% children living in poverty:[xxix] **14%**
Unemployment Rate: **2.8%**[xxx]
Race/Ethnicity--
- % Hispanic: **29%**
- % non-Hispanic, White: **65%**
- % non-Hispanic, other races: **6%**

Table 5. Public School District Profile--Hamilton County

Hamilton County Public School Districts Profile (2018-2019)[xxxi]					
		Aurora	**Hampton**	**Giltner**	**State of Nebraska**
Student Characteristics	**Enrollment**	1283	177	222	329,290
	Graduation rate	92%	*	94%	88%
	College-Going rate	77%	87%	89%	*
	% Receiving **free/reduced lunch**	36%	28%	27%	46%
	% **English language learners**	*	*	*	7%
	% Students in **special education**	16%	24%	17%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in **language arts**	Cancelled due to COVID-19			Cancelled due to COVID-19
	% Proficient in **math**				
	% Proficient in **science**				

Quick Facts for Hamilton County:[xxxii]

Population (2020): **9,429**
Population Change (2010-2019): **2.3%**
% children under 18: **24%**
Median Household Income: **$68,236**
% total population in poverty: **7%**
% children living in poverty:[xxxiii] **8%**
Unemployment Rate: **2.8%**[xxxiv]
Race/Ethnicity--
- % Hispanic: **4%**
- % non-Hispanic, White: **94%**
- % non-Hispanic, other races: **2%**

Table 6. Public School District Profile--Merrick County

Merrick County Public School Districts Profile (2018-2019)[xxxv]			
		Central City	**State of Nebraska**
Student Characteristics	**Enrollment**	767	329,290
	Graduation rate	95%	88%
	College-Going rate	71%	*
	% Receiving **free/reduced lunch**	46%	46%
	% **English language learners**	*	7%
	% Students in **special education**	17%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in **language arts**	Cancelled due to COVID-19	Cancelled due to COVID-19
	% Proficient in **math**		
	% Proficient in **science**		

Quick Facts for Merrick County:[xxxvi]

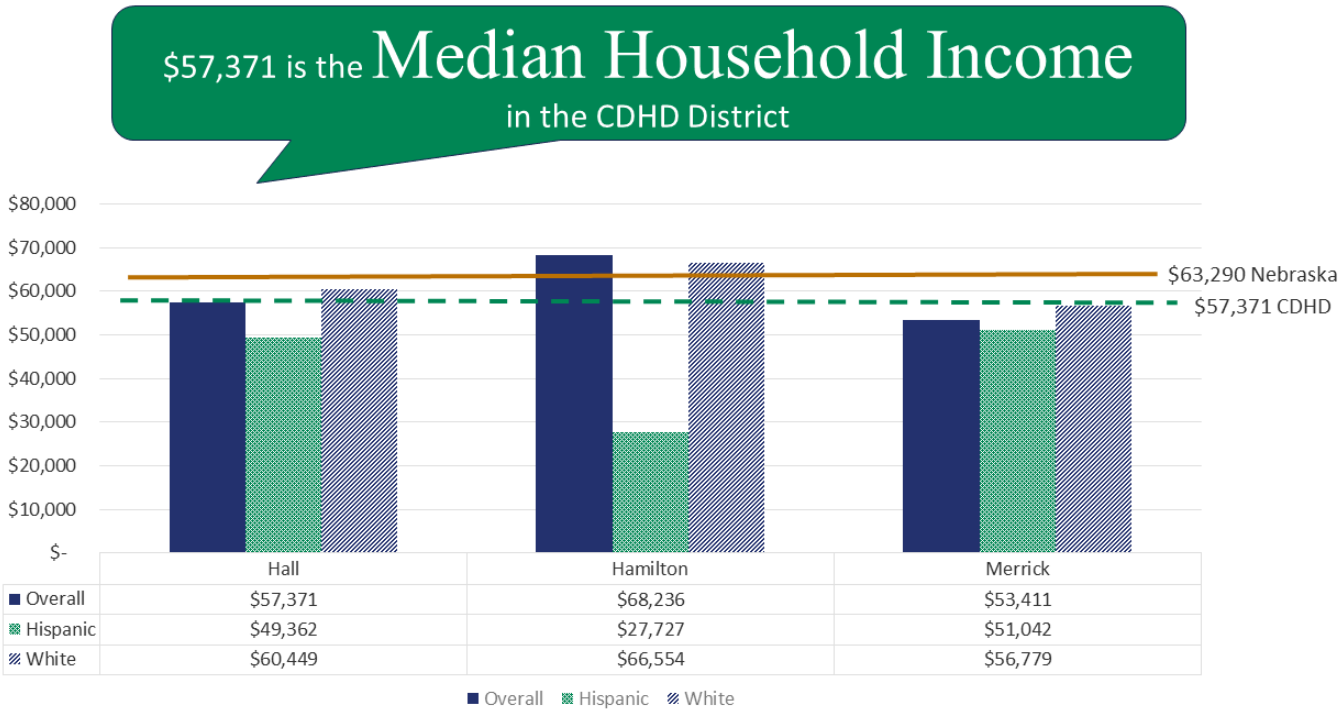
Population (2020): **7,668**
Population Change (2010-2019): **-1.3%**
% children under 18: **22%**
Median Household Income: **$53,411**
% total population in poverty: **11%**
% children living in poverty:[xxxvii] **14%**
Unemployment Rate: **2.7%**[xxxviii]
Race/Ethnicity--
- % Hispanic: **5%**
- % non-Hispanic, White: **92%**
- % non-Hispanic, other races: **3%**

Socio-Economic Status

Economics

According to the 2020 County Health Rankings, the median household income for Nebraska was $63,290 with the median household income for CDHD region coming in a little less than the state at $57,371. Notably, Hamilton County was the only county in the CDHD area with a median household income ($68,236) higher than the state and the largest income gap between Hispanic and non-Hispanic, White households (a difference of $38,827) of any county within CDHD district.

Figure 15. Median Household Income, CDHD District



Source: CHRR 2020

Nearly 1 in 5 children were from single family homes across the CDHD region, which was similar to the state average of 21%.[xxxix] Twelve percent (12%) of children were living in poverty across all counties within the CDHD region, which is same as the state rate of 12%.[xl] Also the same as the state, CDHD regional unemployment rate was 2.8%.[xli] Despite the low unemployment rate across the CDHD region, families still struggled to make ends meet.

Table 7. Economic Indicators, CDHD District

Economic Indicators	CDHD region	Nebraska
Median Household Income[xlii]	$57,371	$63,290
Children in Single-parent Households[xliii]	19%	21%
Percentage of children under age 18 in poverty[xliv]	12%	12%
Unemployment[xlv]	2.8%	2.8%

Figure 16. Poverty, CDHD District

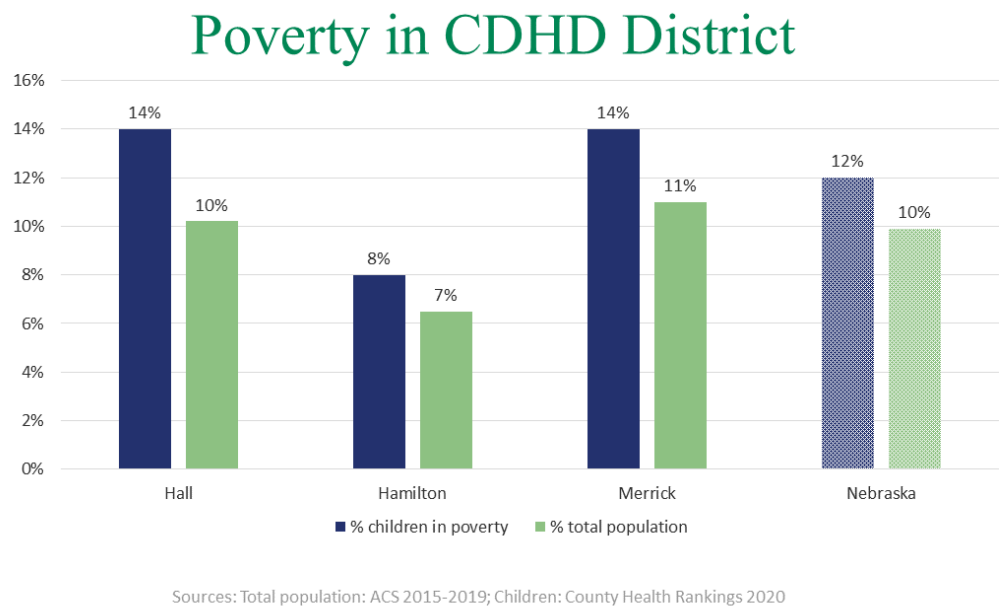


Figure 17. Children in Single-Parent Households, CDHD District

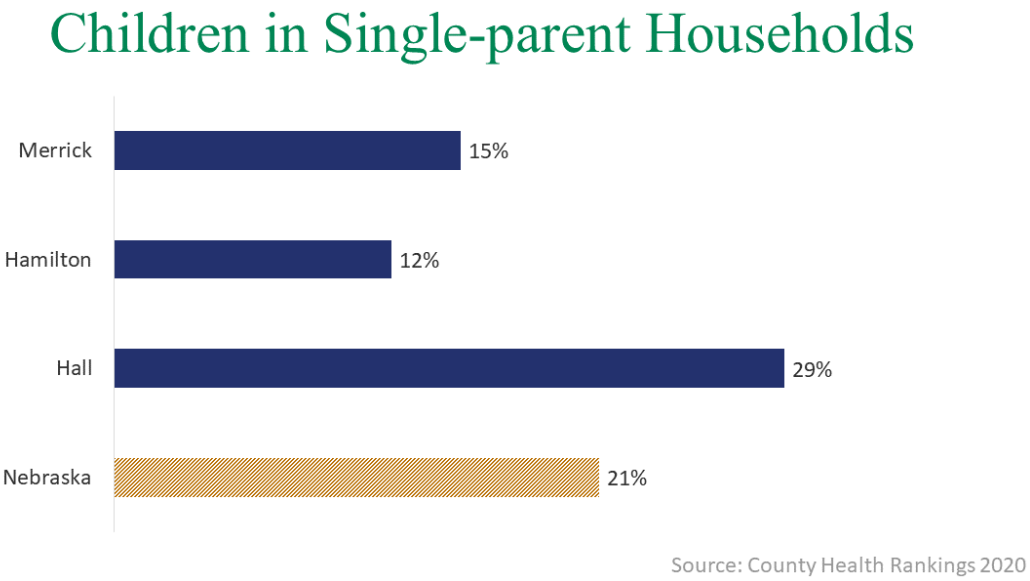


Figure 18. Average Residential Value, CDHD District

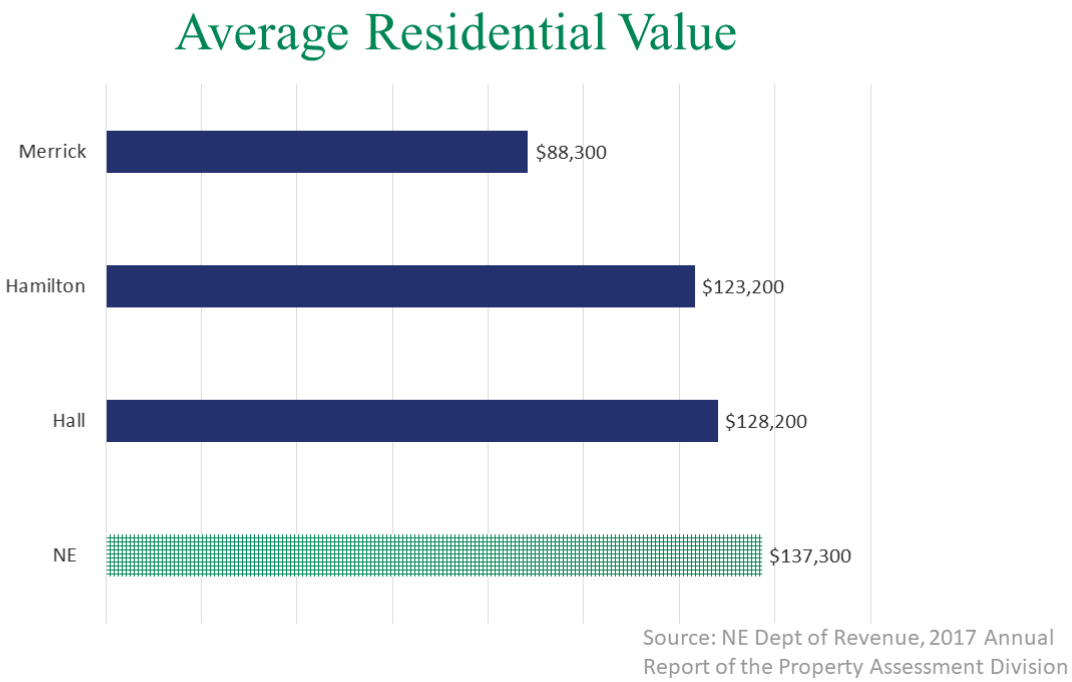


Figure 19. Percentage of Homes Occupied by Owner, CDHD District

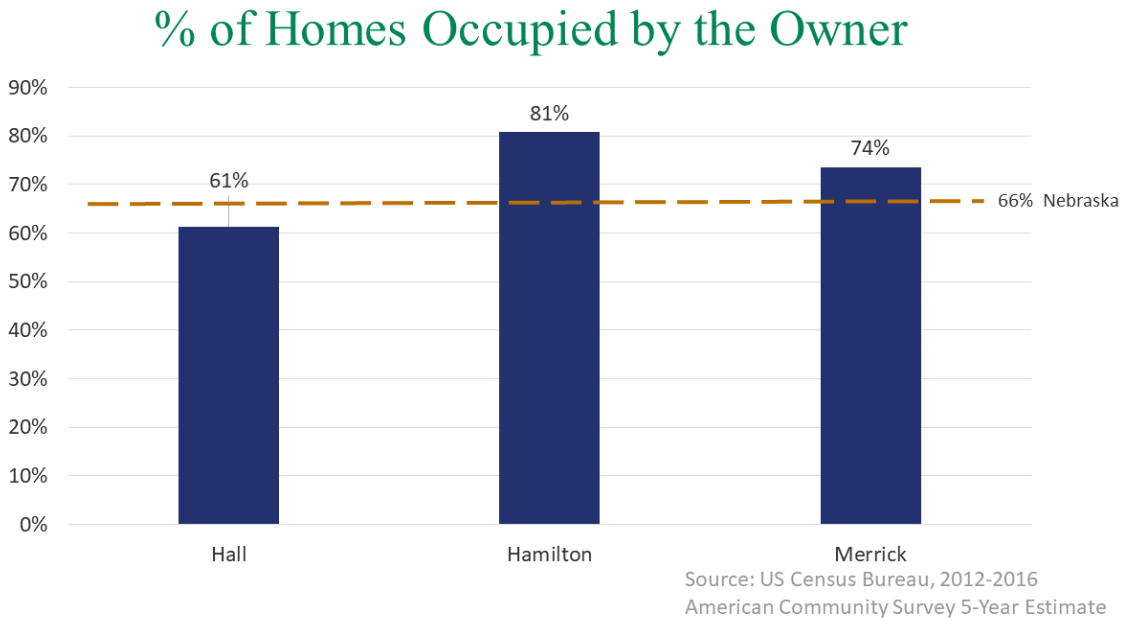
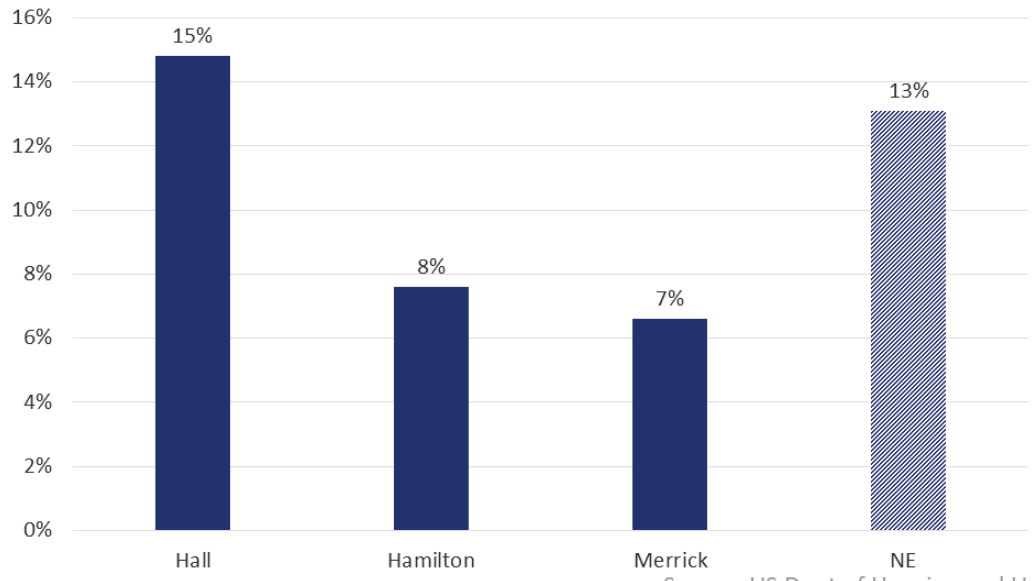


Figure 20. Percentage of Households with Severe Housing Problems, CDHD District



Source: US Dept of Housing and Urban Development, Comprehensive Housing Affordability Strategy, 2018

Housing problems as an indicator is designed to understand the housing needs of low-income households and other vulnerable populations. Figure 20 above is based on the percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities.

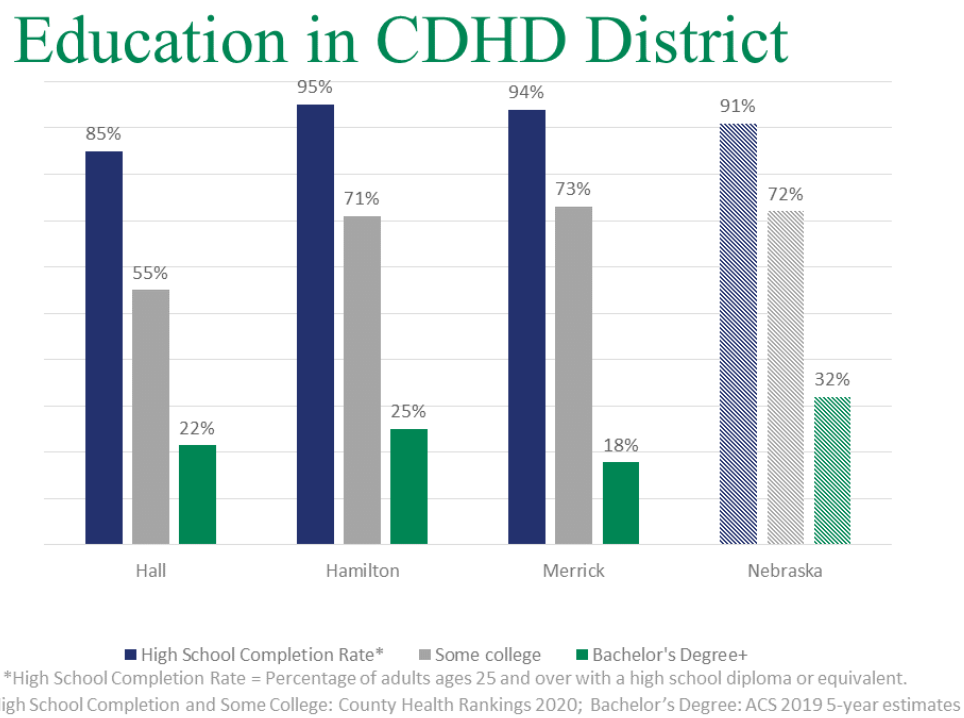
Educational Level

In terms of educational attainment, available data indicate that the CDHD region has a similar high school completion rate (91%) as the state (91%). The Central District region had a slightly lower rate for adults who had some college (counties within the CDHD district range from 55% to 73%) than the state (72%). The state and national averages (32% and 30% respectively) for those who had completed a bachelor's degree was higher than the average for all counties in the CDHD region (range from 18% to 25%).

Table 8. Education Indicators, CDHD District

Education Indicators	CDHD region	Nebraska
High school graduation rate[xlvi]	91%	91%
Some college[xlvii]	66%	72%
Bachelor's degree or higher, percent of persons age 25+[xlviii]	21%	32%

Figure 21. Education Levels, CDHD District



Health Outcomes

The aforementioned social and economic factors, along with health behaviors, clinical care, and physical environment—otherwise known as modifiable health factors, directly impact how well and how long an individual lives. Furthermore, health outcomes (quality and length of life) are compounded by the presence or the absence of policies and programs that promote health and longevity.

Leading Causes of Death

Across the CDHD district, cancer and heart disease were the leading causes of death, similar to state and national trends.

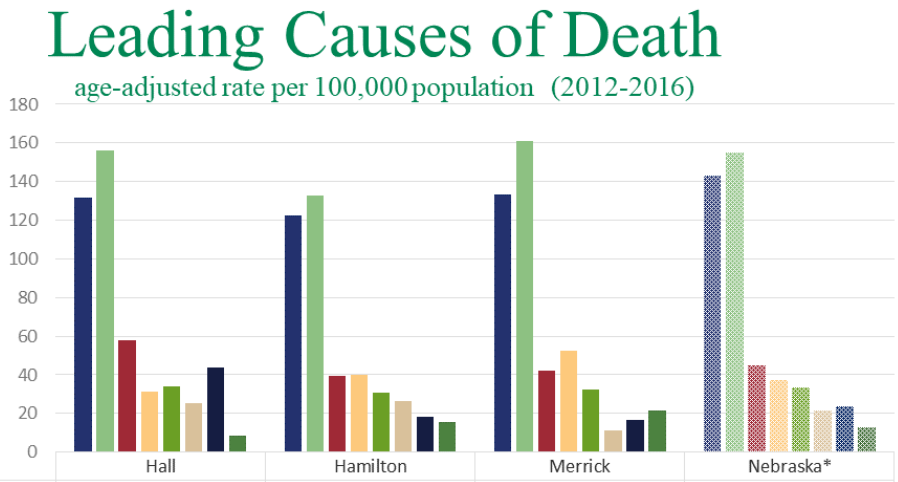
Table 9. Leading Causes of Death, Nebraska & US

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

Figure 22 illustrates the leading causes of death by county within the CDHD region.[li] In most cases, counties within the CDHD region have higher rates of death due to cancer, accidents and diabetes than does the state. Of particular note, Merrick County experienced almost twice the death rate

(52.7/100,000 population) due to accidents/unintentional injuries than the state (37.2/100,000 population) and Hall County experienced two times the death rate (43.5/100,000 population) due to Alzheimer's Disease than the state (23.7/100,000 population). The death rate due to heart disease for counties in CDHD was lower than the state. The death rate in Hall County due to chronic lung disease and stroke (58.1 and 34.2/100,000 population, respectively) were slightly higher than the state (44.7 and 33.6/100,000 population). 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 by way of programs that help people prevent and manage personal health risks and policies that help people thrive in their communities.

Figure 22. Leading Causes of Death, CDHD District



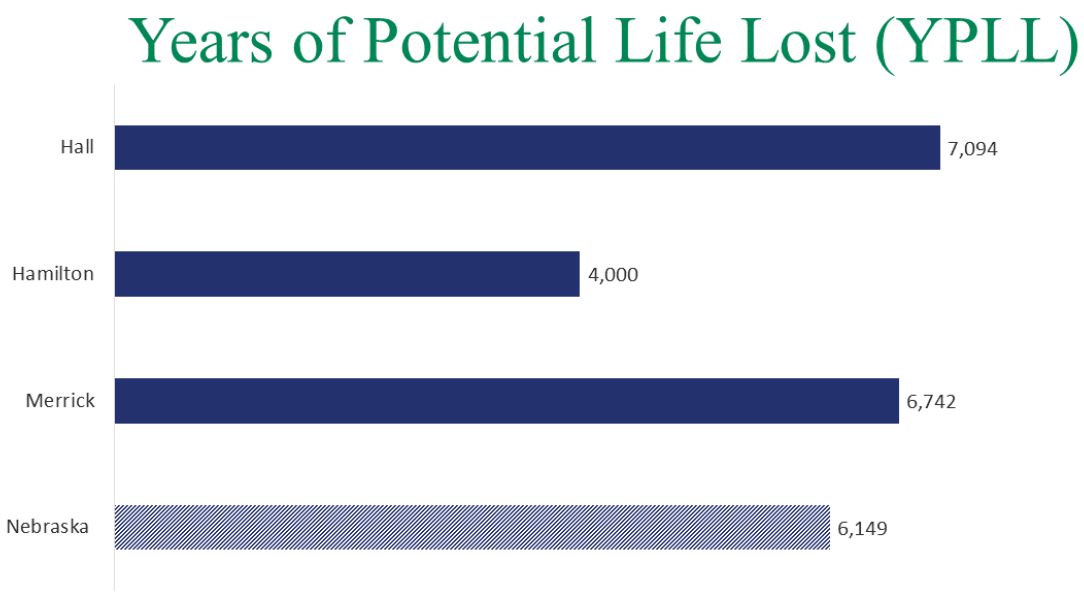
	Hall	Hamilton	Merrick	Nebraska*
Heart Disease	131.7	122.4	133.4	143
Cancer	156.2	132.9	160.9	154.8
Chronic Lung Disease	58.1	39.3	42	44.7
Unintentional Injury (Accidents)	31.4	39.7	52.7	37.2
Cerebrovascular Disease	34.2	30.8	32.2	33.6
Diabetes	25.4	26.6	11.4	21.6
Alzheimer's Disease	43.5	18.3	16.6	23.7
Pneumonia	8.6	15.3	21.6	12.8

*Nebraska rates (age-adjusted to 2000 US population) Source: NEDHHS Vital Statistics Report 2016

An indicator that helps communities focus on prevention is the Years of Potential Life Lost (YPLL), which is a measurement of premature death (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.[lii] Figure 23[liii] illustrates the average Years of Potential Life Lost for each county within the CDHD region compared to the state.

Hall and Merrick counties had a higher YPLL than the state, which may be due to having had higher rates of death by cancer, chronic lung disease, accidents/unintentional injuries, and diabetes than the state.

Figure 23. Years of Potential Life Lost (YPLL), CDHD District



Source: County Health Rankings 2020

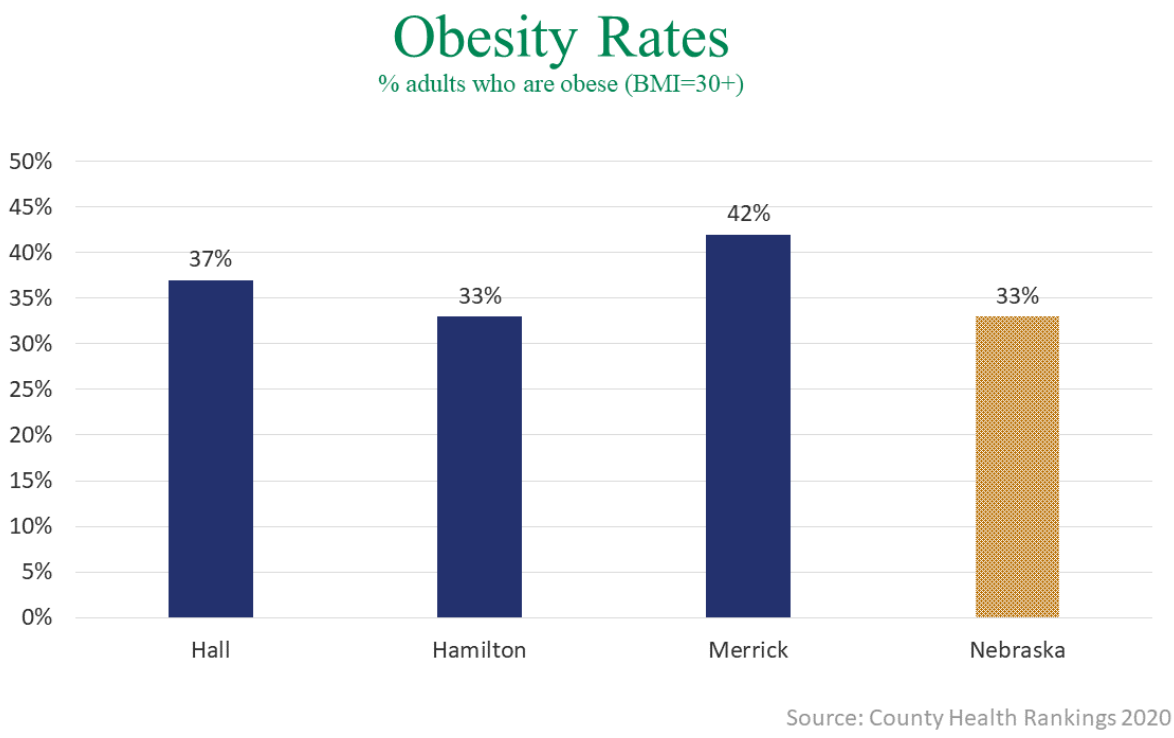
Leading Types of Chronic Disease

Four out of five of the leading causes of death in Nebraska were chronic diseases, including 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.[liv] Furthermore, deaths by chronic disease comprised nearly 50% of the Years of Potential Life Lost (YPLL) among Nebraskans.[lv] 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 rooted in the social and economic factors by which an individual lives.

Overweight/Obesity

According to the 2020 County Health Rankings, nearly 1 in 3 (28%) adults in the CDHD district were considered obese (Body Mass Index [BMI] = 30+), slightly lower than the state (33%). According to the Nebraska BRFSS (2011-2019), 72% of adults in the CDHD district reported being overweight or obese (BMI = 25+), slightly higher than the state (67%), with rates higher among males than females (78% and 65%, respectively).

Figure 24. Obesity Rates, CDHD District



Source: County Health Rankings 2020

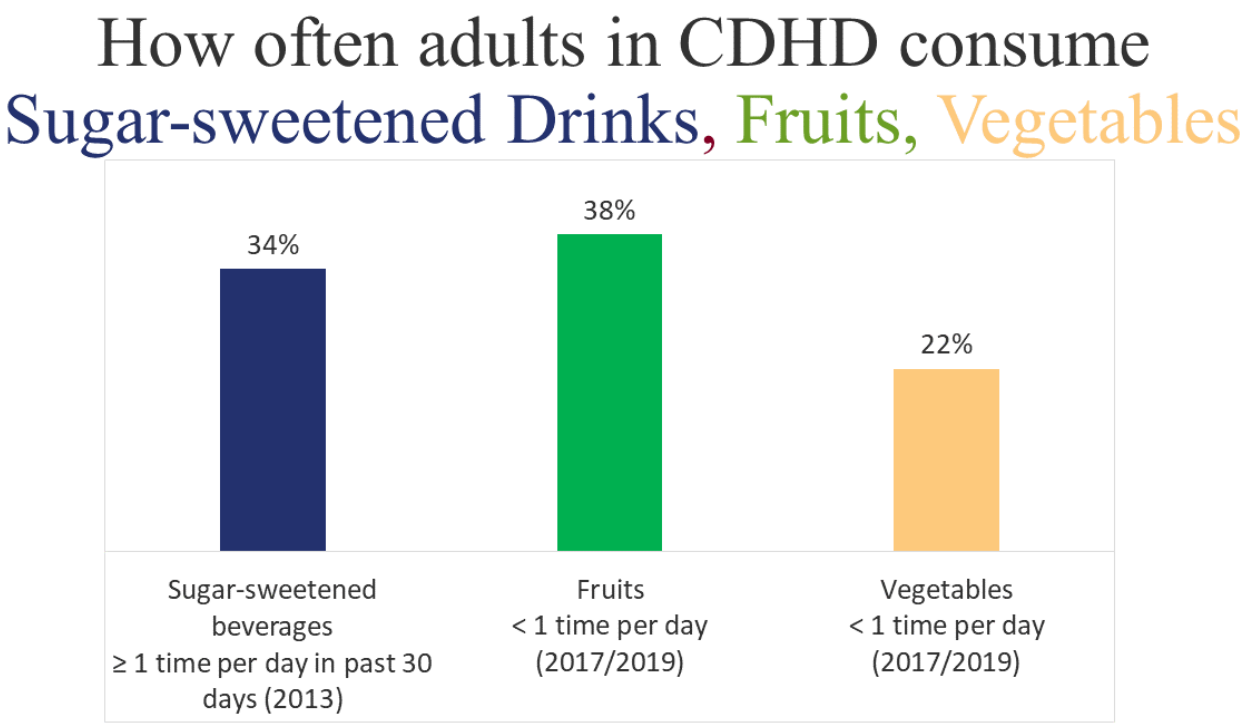
Table 10. Overweight/Obesity Rates, CDHD District

Overweight/Obesity Rates[lvi] *(BRFSS, 2011-2019)*	Overweight or Obese **(BMI = 25+)**	Obese **(BMI = 30+)**
Nebraska	67%	31%
CDHD District	**72%**	35%
Men	**78%**	36%
Women	**65%**	35%

Physical Activity and Nutrition

According to the Nebraska BRFSS, healthy eating and active living was not a routine behavior for many adults in the CDHD district. Nearly 40% of adults in this area reported consuming fruits less than 1 time per day and about 1 in 4 adults consumed vegetables less than 1 time per day.

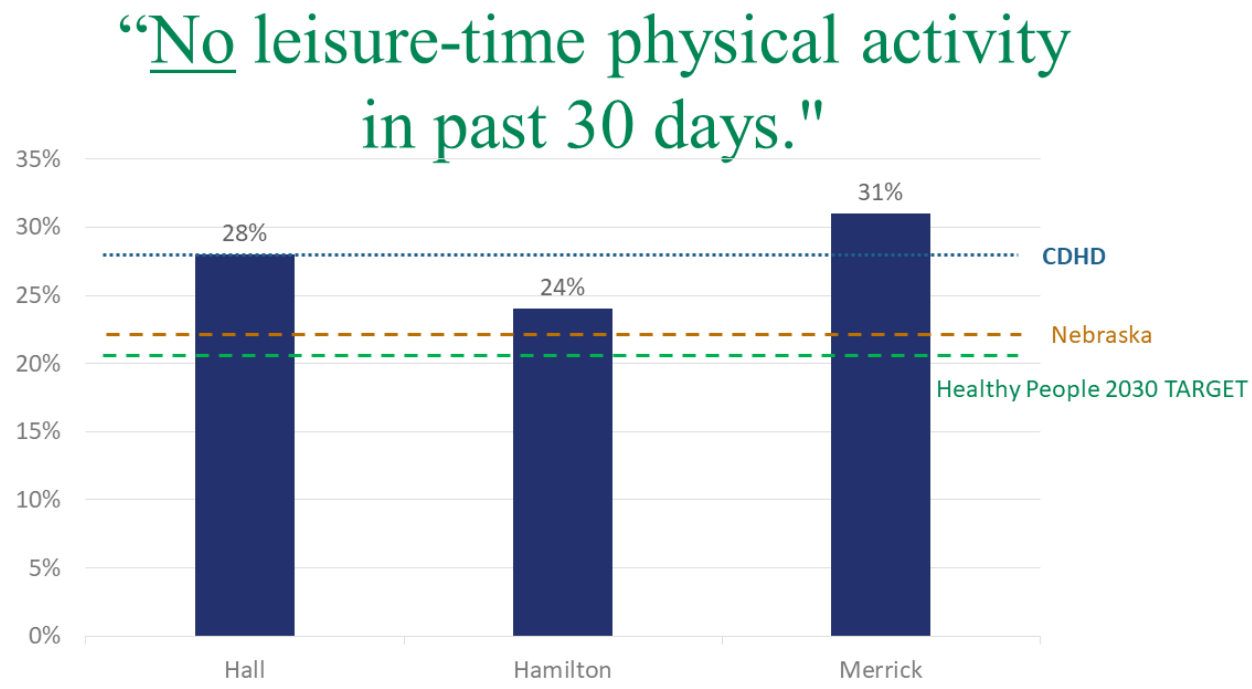
Figure 25. Nutrition Behaviors, CDHD District



Source: BRFSS 2011-2019

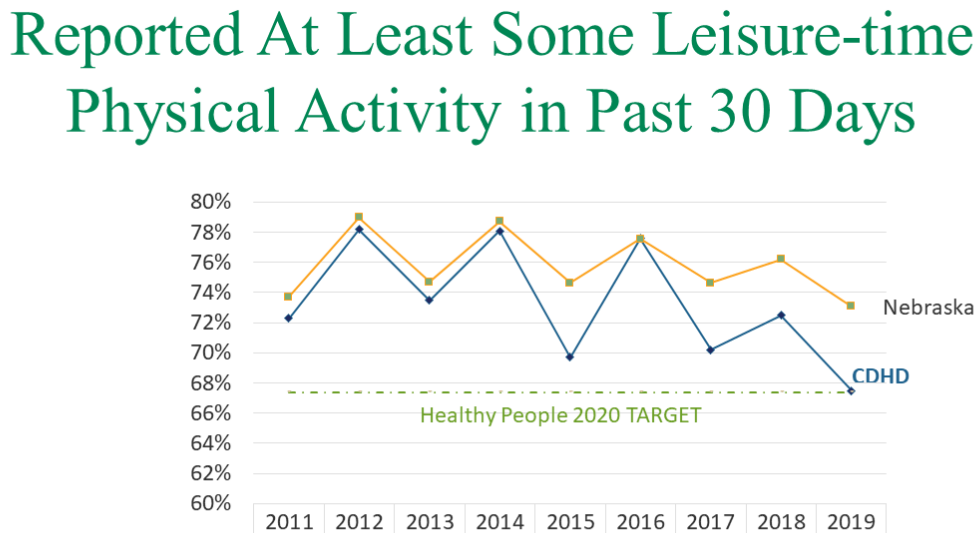
Despite the majority of adults (85%)[lvii] in the CDHD region indicating that they had access to safe places to walk in their neighborhoods, roughly 1 in 3 adults reported no leisure-time physical activity in the past 30 days. Also of concern, the 2012 to 2017 trendline indicates that the percentage of CDHD residents reporting no leisure-time physical activity is increasing. As affirmation to the above indicators related to nutrition, non-White, Hispanic respondents to the CDHD Community Survey identified challenges getting healthy and affordable food as one of top three health concerns.

Figure 26. Physical Activity—No Leisure-Time, CDHD District



Source: CHRR 2020

Figure 27. Physical Activity—At Least Some Leisure-Time, CDHD District

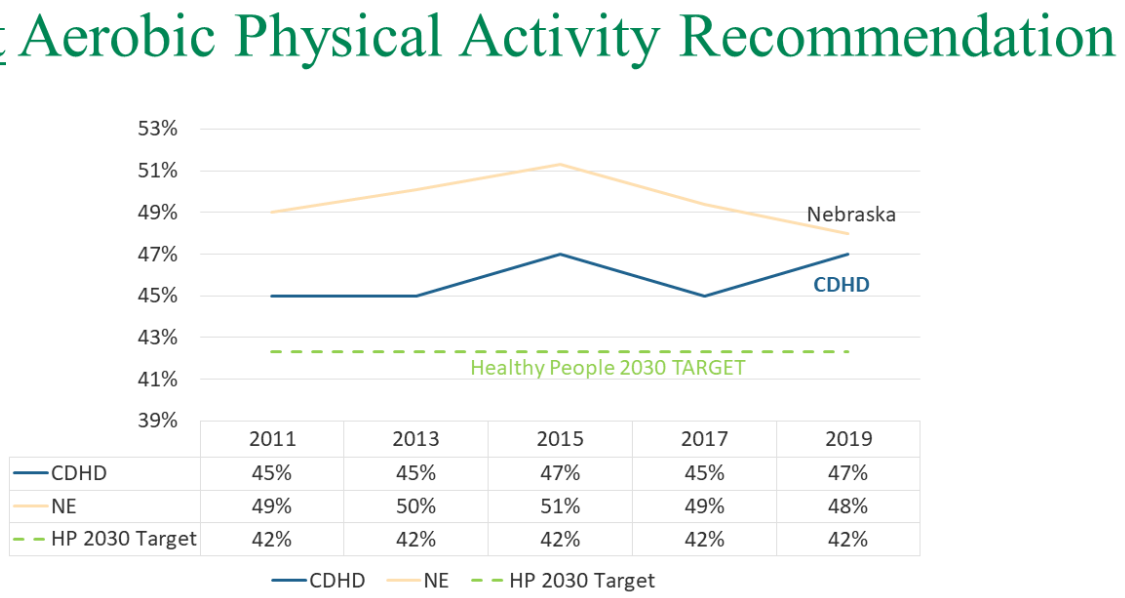


	2011	2012	2013	2014	2015	2016	2017	2018	2019
CDHD	72%	78%	74%	78%	70%	78%	70%	73%	68%
NE	74%	79%	75%	79%	75%	78%	75%	76%	73%
HP 2020 Target	67%	67%	67%	67%	67%	67%	67%	67%	67%

Source: BRFSS 2011-2019

Nearly 50% of people in the CDHD region did not meet the aerobic physical activity recommendations (at least 150 minutes of moderate-intensity physical activity per week—such as brisk walking or 75 minutes of vigorous physical activity per week). Safe community environments, such as walking paths, sidewalks, and walking/biking trails to move throughout the area, encourage residents to engage in healthy eating and active living, which are key to preventing chronic disease. As affirmation to the above indicators related to physical activity, respondents to the CDHD Community Survey identified getting enough exercise as one of the top three health concerns.

Figure 28. Physical Activity—Met Recommendations, CDHD District

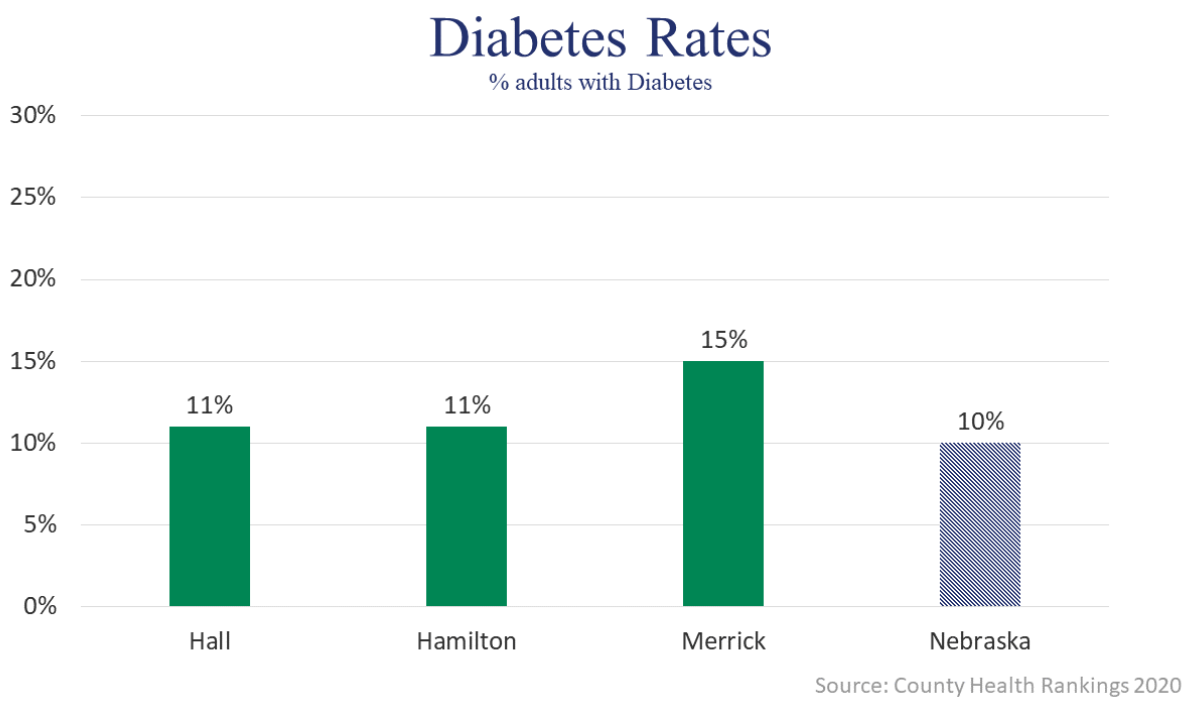


Source: BRFSS 2011-2019

Diabetes

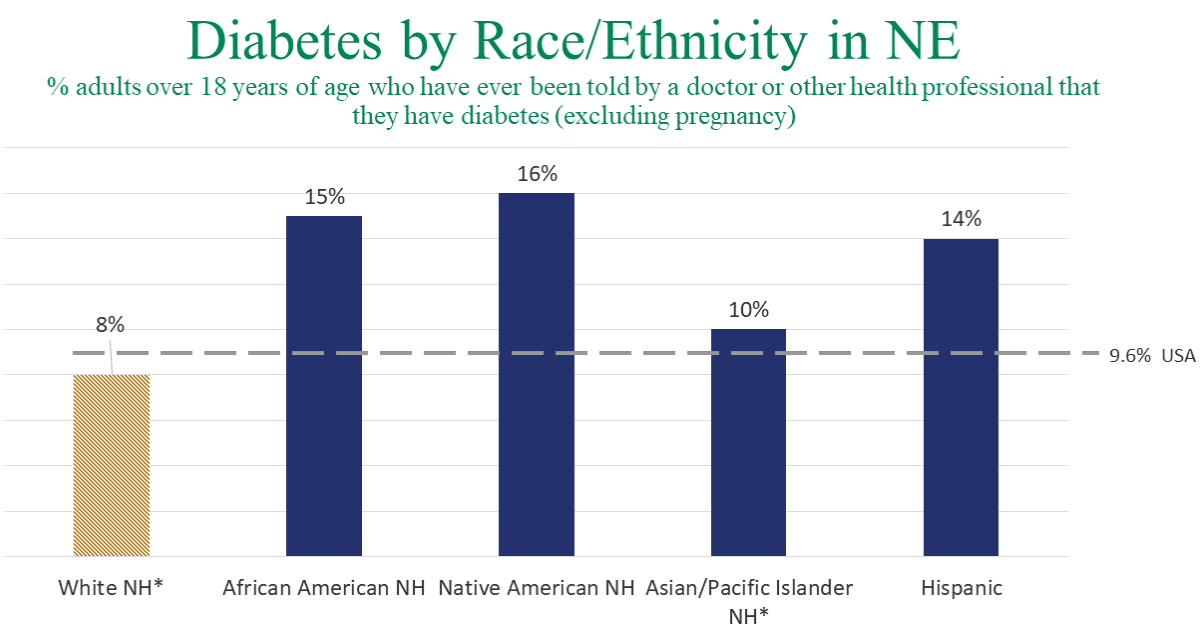
Diabetes is a chronic disease that impacts how a body gets energy from food. Diabetes is the 7th leading cause of death in the US with more than 88 million US adults diagnosed with diabetes. Over the past 20 years, the number of adults diagnosed with diabetes has more than doubled. Overweight/obesity and age are factors that impact the risk of diabetes.[lviii] Often times, diabetes and heart disease are co-occurring. A person with diabetes is 2 times more likely to have heart disease or stroke, the leading causes of death.[lix] Generally, diabetes rates in CDHD region are similar to the state rate, except for Merrick County which experienced a slightly higher diabetes rate than the other counties within CDHD perhaps due to a higher proportion of an aging population in this county.

Figure 29. Diabetes rates—by county, CDHD District



Diabetes data broken down among race/ethnicity is not available by county, diabetes rates among racial/ethnic populations is available at the state level. There are dramatic gaps between racial/ethnic populations when looking at the state diabetes rates. Notably, African American/Black (15%), American Indian/Alaskan Native (16%), and Hispanic (14%) populations experience almost 2 times the rates of diabetes compared to non-Hispanic, Whites (see Figure 30). As affirmation to the above prevalence and factors contributing to diabetes, respondents to the CDHD Community Survey identified diabetes as one of the top three health concerns.

Figure 30. Diabetes rates—by race and ethnicity, Nebraska



Source: NeDHHS, Office of Health Disparities and Health Equity, diabetes Dashboard

Heart Disease

Heart disease is one of the top two leading causes of death in the CDHD district and across the state. Leading a healthy lifestyle, including active living, healthy eating, not smoking and limiting alcohol use, and/or managing other medical conditions, such as high cholesterol, high blood pressure, or diabetes, reduces the risk of heart-related diseases, including heart attack and stroke. In Nebraska, non-Hispanic, White (81.1/100,000), African American (93.9/100,000), and Native American (94.6/100,000) populations have a higher rate of death due to heart disease than the state (77.4/100,000).[lx]

Table 11. Heart Disease Indicators, CDHD District

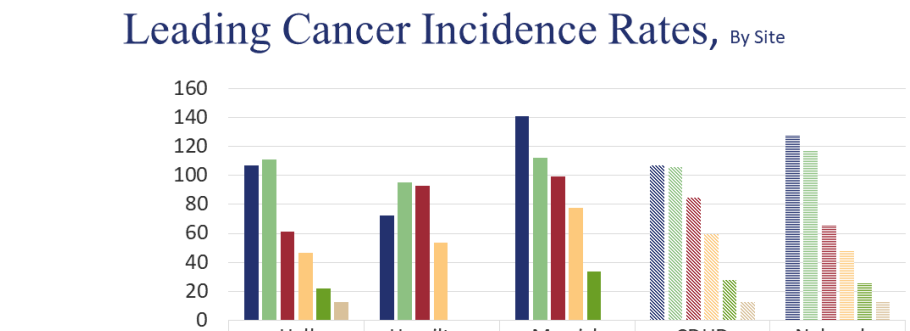
Heart Disease Indicators[lxi]	NE	CDHD Region		
		Overall	Female	Male
Ever told they have high blood pressure (excluding pregnancy)	30%	33%	30%	35%
Currently taking blood pressure medication, among those ever told they have high BP	78%	77%	86%	72%
Ever told they have high cholesterol, among those who have ever had it checked	32%	30%	30%	30%

Cancer

Cancer is a leading cause of death in the CDHD district and across the state. In the CDHD region, female breast cancer was the leading type of cancer diagnosed (106.8/100,000 population), which was lower than the state (127.4/100,000 population, respectively). Prostate cancer followed as a close second for CDHD district (106.0/100,000 population) and was lower than the state (116.9/100,000 population,

respectively). Notably, Merrick County residents experience more cancer than their counterparts in Hall or Hamilton counties and the state.

Figure 31. Cancer Incidence Rates, CDHD District

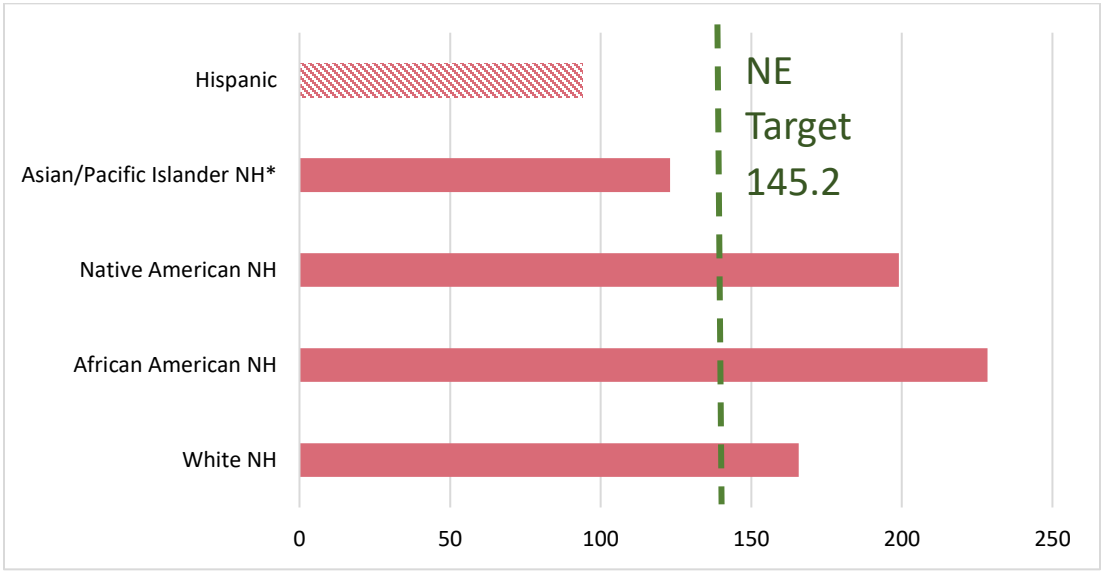


	Hall	Hamilton	Merrick	CDHD	Nebraska
Female Breast	107.2	72.2	141.1	106.8	127.4
Prostate	110.8	95.1	112.1	106.0	116.9
Lung	61.3	92.8	99.3	84.5	65.6
Colorectal	46.9	53.8	77.9	59.5	48
Melanoma	22.2	0	34	28.1	26.4
Oral cavity & pharynx	12.4	0	0	12.4	12.5

Source: State Cancer Profiles, 2013-2017

Cancer mortality rates are on the decline in the CDHD district, state, and nation.[lxii] Despite this trend, cancer remained one of the top two leading causes of death in the CDHD district through 2017. Cancer mortality data by race and ethnicity was not readily available for the CDHD district. Native Americans, African Americans, and Whites across Nebraska had cancer mortality rates in excess of the state target of 145.2/100,000 population (see Figure 29). More information is needed about the cause of cancer incidence and death rates in the CDHD area.

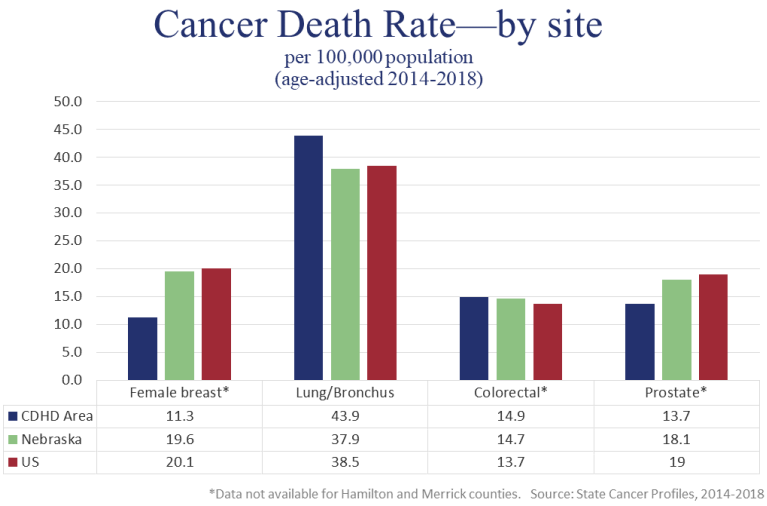
Figure 32. Cancer Mortality Rates--Nebraska Racial/Ethnic Comparison (per 100,000 population)



**NH = Non-Hispanic*

Although cancer mortality data by county was not readily available, lung (and bronchus) cancer was the leading type of cancer that resulted in death in the CDHD district (see Figure 33).[lxiii] Tobacco smoking remains the leading cause of lung cancer, responsible for about 80% of lung cancer deaths. Other causes include exposure to secondhand smoke and radon.[lxiv]

Figure 33. Leading Cancer Death Rates in CDHD (per 100,000 population)

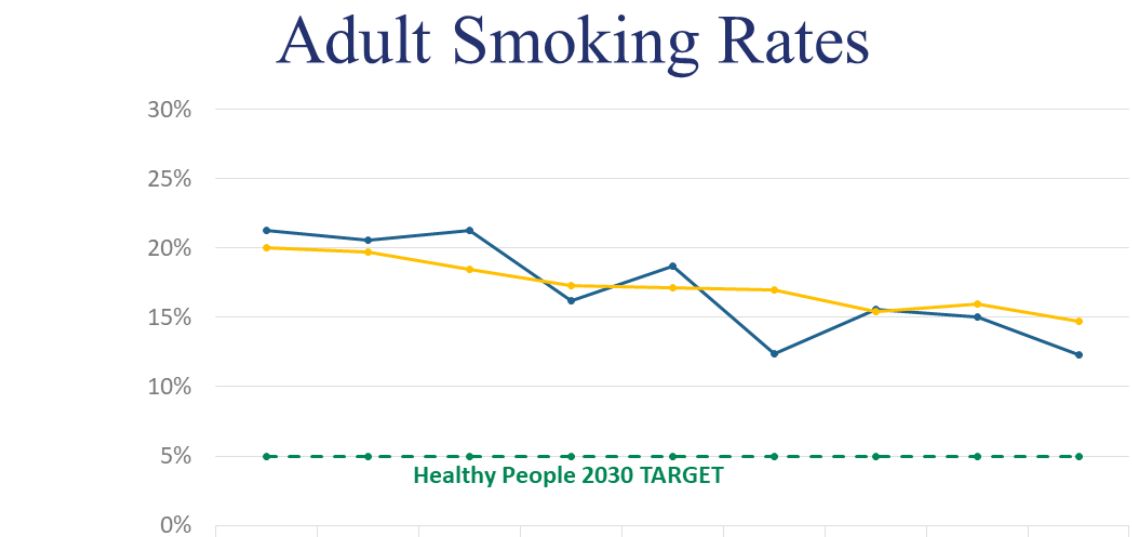


As affirmation to the above prevalence and factors contributing to cancer, respondents to the CDHD Community Survey identified cancer as one of the top three health concerns.

Tobacco and Nicotine Product Usage

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 14% in 2019.[lxv] According to the Nebraska BRFSS (2011-2019), the smoking rate among adults in the CDHD region and in the state has trended downward (see Figure 31), yet the adult smoking rate is higher than the Healthy People 2030 target of 5%. Smoking rates among male adults in the CDHD region was higher than female adults (see Figure 35).

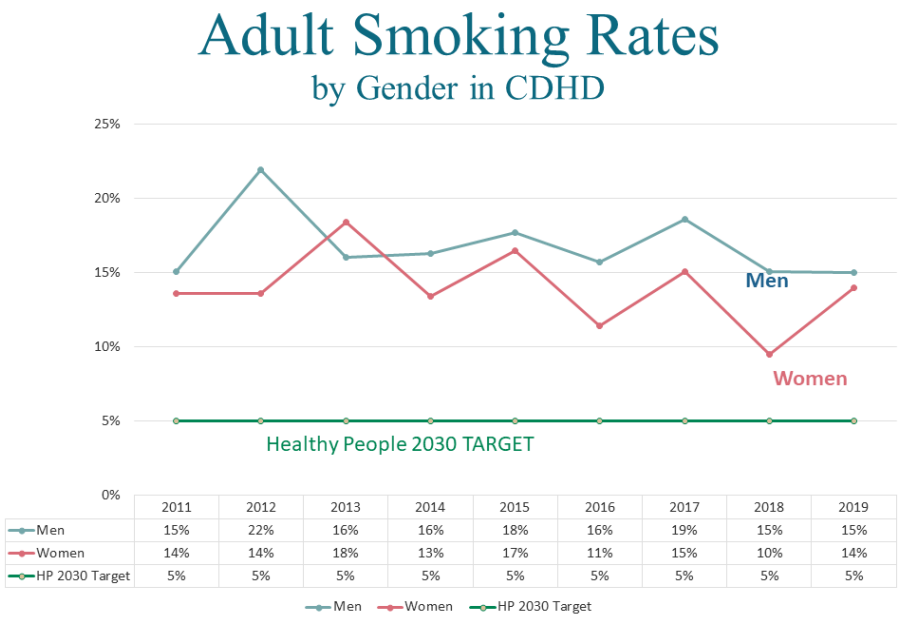
Figure 34. Adult Smoking Rates, CDHD District



	2011	2012	2013	2014	2015	2016	2017	2018	2019
CDHD	21%	21%	21%	16%	19%	12%	16%	15%	12%
NE	20%	20%	19%	17%	17%	17%	15%	16%	15%
HP 2030 Target	5%	5%	5%	5%	5%	5%	5%	5%	5%

Source: BRFSS 2011-2019

Figure 35. Adult Smoking Rates by Gender, CDHD District



	2011	2012	2013	2014	2015	2016	2017	2018	2019
Men	15%	22%	16%	16%	18%	16%	19%	15%	15%
Women	14%	14%	18%	13%	17%	11%	15%	10%	14%
HP 2030 Target	5%	5%	5%	5%	5%	5%	5%	5%	5%

Source: BRFSS 2011-2019

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, $1.18 lower than the national average, ranking Nebraska 42nd in the US for its cigarette tax[lxvi].

Even though cigarette smoking (otherwise known as combustible tobacco cigarette) was trending downwards in the CDHD district, e-cigarette usage was growing among CDHD adults. According to the 2019 NE BRFSS, 1 in 5 adults in the CDHD district used e-cigarettes just slightly under the state rate of 25%. E-cigarettes are devices that heat liquid solution to produce an aerosol that is inhaled. E-cigarettes contain varying amounts of nicotine depending on the type of e-cigarette; and although considered less harmful to individual health than inhaling smoke from combustible tobacco, still deliver harmful chemicals. E-cigarettes can be addictive due to the nicotine content.[lxvii]

The most commonly used tobacco product among youth was e-cigarettes, and e-cigarette usage among youth increased more than any other age group in recent years (see Figures 36, 37 and 38). E-cigarettes are marketed to youth with strategies that have been heavily regulated to reduce youth consumption of combustible cigarettes, i.e. kid-friendly flavors, scholarship opportunities for school, online/mobile and TV ads.[lxviii] CDHD district has experienced marked increases in e-cigarette use among youth. According to the Nebraska Risk and Protective Factor Surveillance Survey (NPRFSS) in 2018, the current e-cigarette usage rate among CDHD youth in 12th grade is 35.3% (see Figure 39) and nearly half of all 12th graders who responded to the NPRFSS survey reported ever using e-cigarettes.

Figure 36. E-Cigarette Use Rate-- Youth, Nebraska

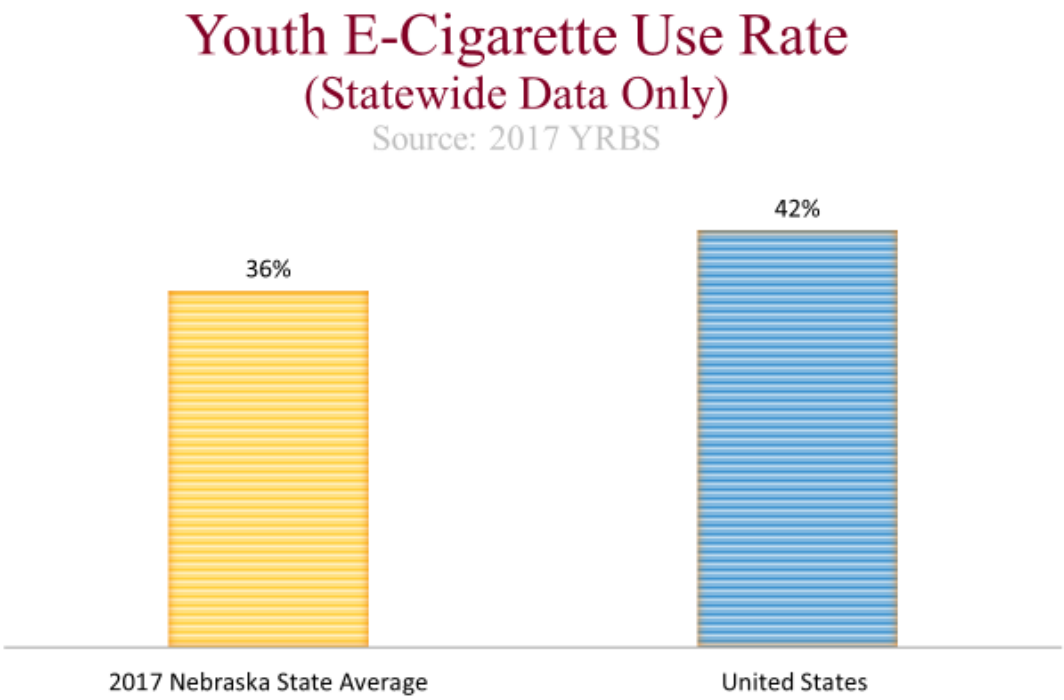


Figure 37. E-Cigarette Use Rate--Youth, Nebraska

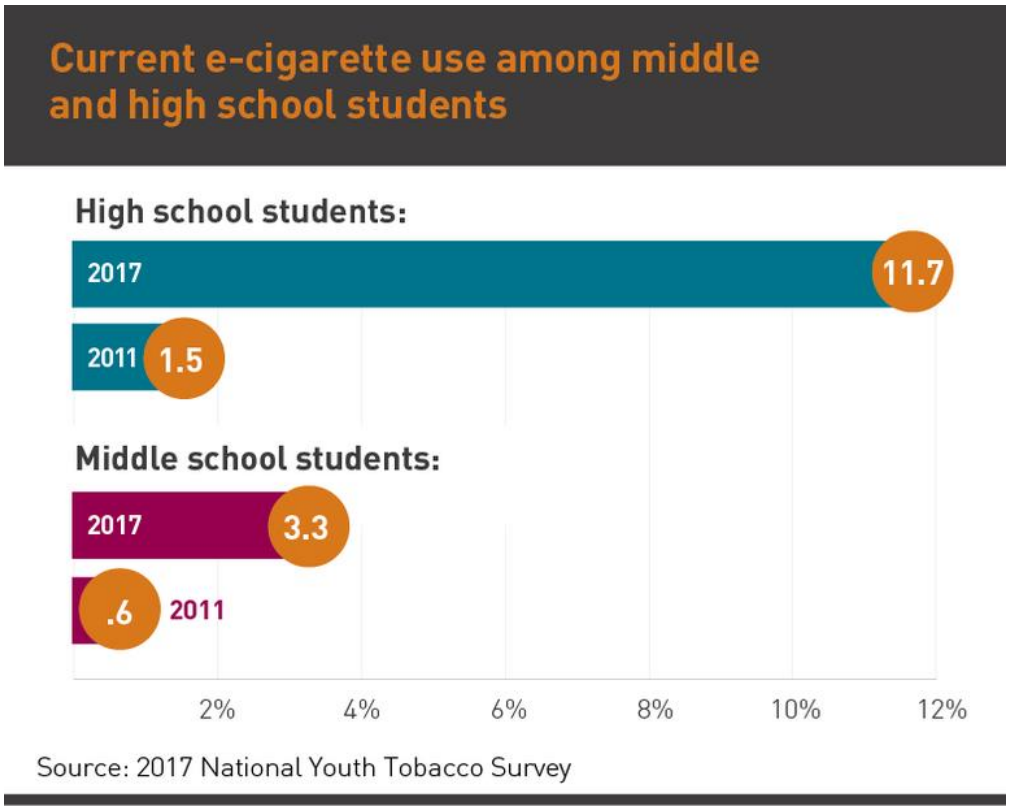


Figure 38. Tobacco Use—Other Tobacco Product Use Rate, Nebraska

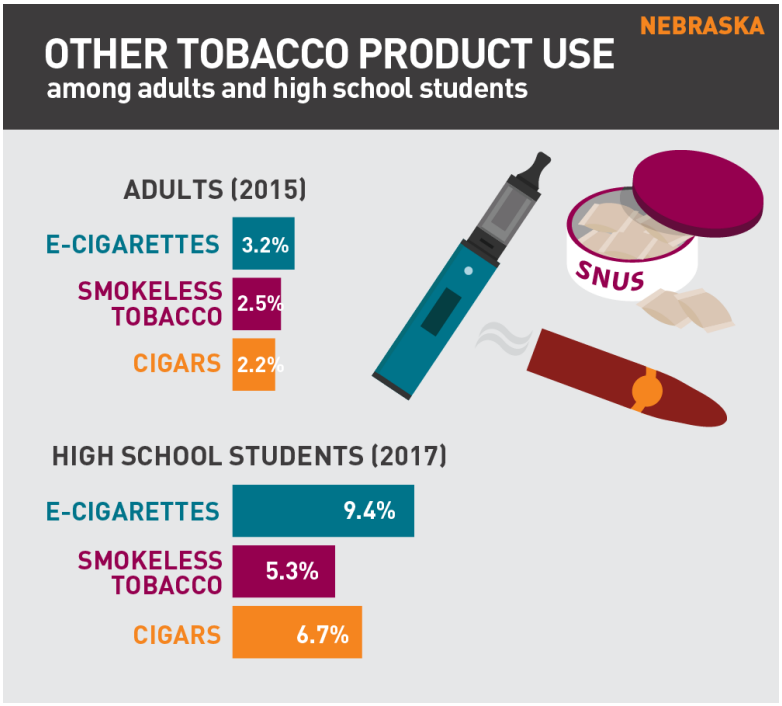
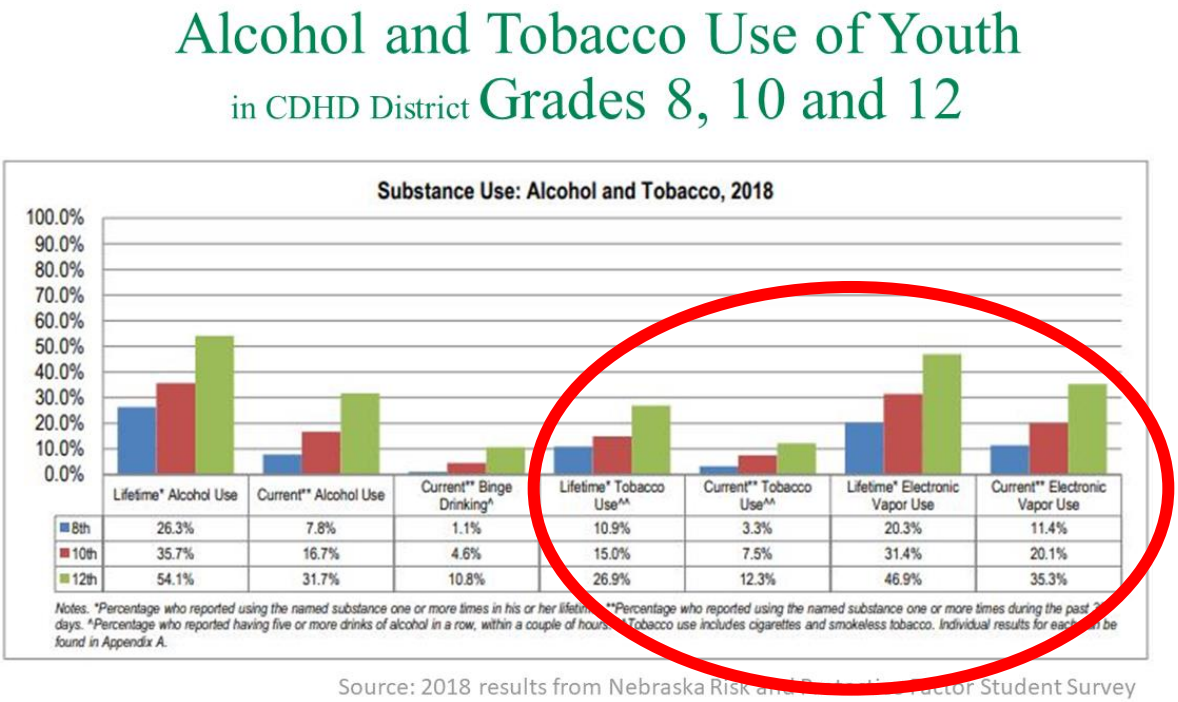


Figure 39. Tobacco and Alcohol Use Rate—Youth, CDHD District



Radon Risk

The second-leading cause of lung cancer, behind smoking, is breathing radon gas, a naturally-occurring, radioactive, colorless and odorless gas. Homes, schools, and workplaces are where most radon exposure occurs. Nebraska has a high statewide average radon level at 6.3 pCi/L, ranking it third across the US. Over half of the radon tests in the state were above the Environmental Protection Agency's recommended action level of >4.0 pCi/L. At least 70 of 93 Nebraska counties had an average radon level greater than 4.0 pCi/L, including Hamilton County.[lxix]

Leading Causes of Injury

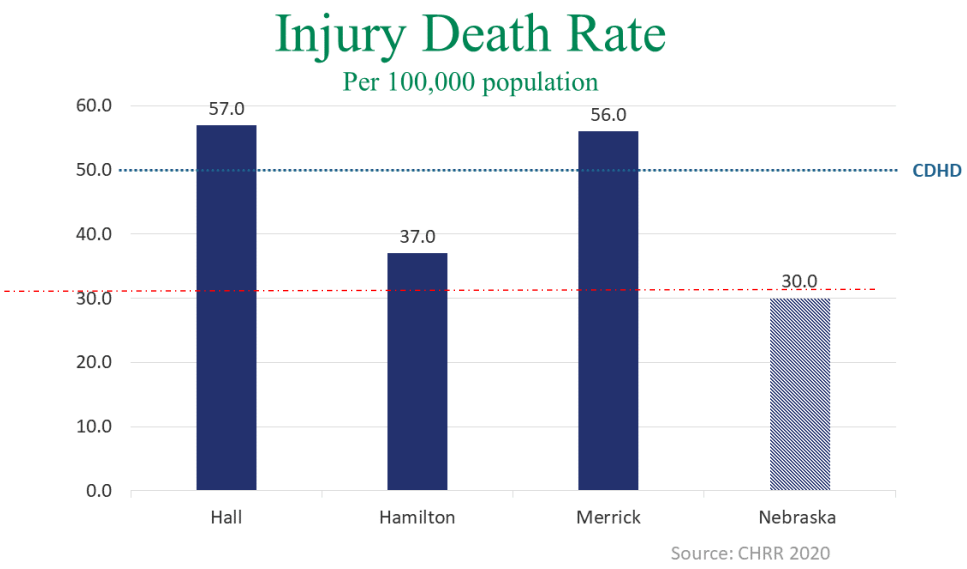
Deaths by injury comprised approximately 20% of the total YPLL among Nebraskans.[lxx]

Table 12. Leading causes of injury, Nebraska

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 2. Suicide 3. Unintentional falls 4. Unintentional poisoning	1. Unintentional falls 2. Unintentional injuries due to motor vehicle traffic 3. Self-inflicted injuries

In the CDHD district, all counties experienced higher rates of death by injury than the state. Of particular note, the death by injury rate in Hall and Merrick counties was nearly double than the state (see Figure 40[lxxi]).

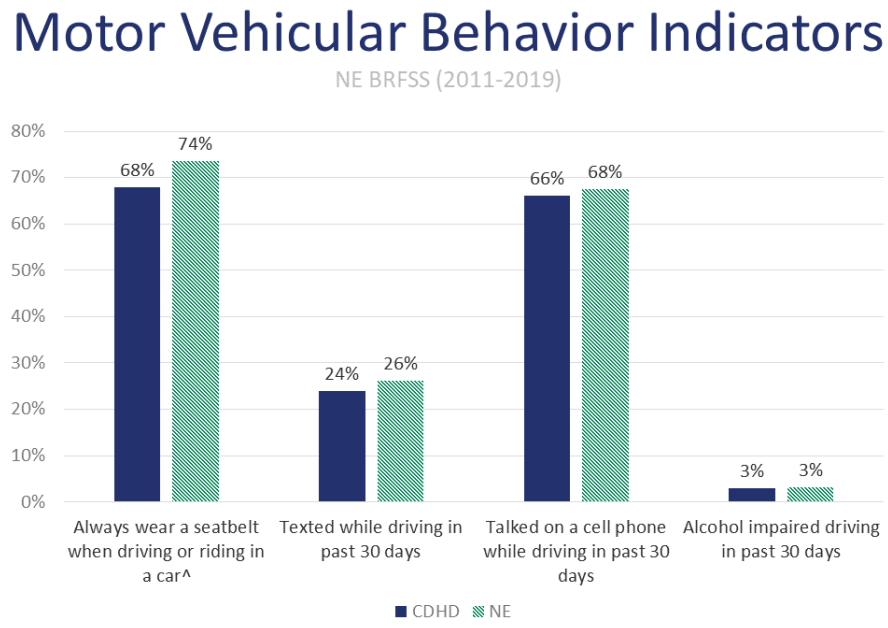
Figure 40. Injury Death Rate, CDHD District



Motor Vehicle Behaviors

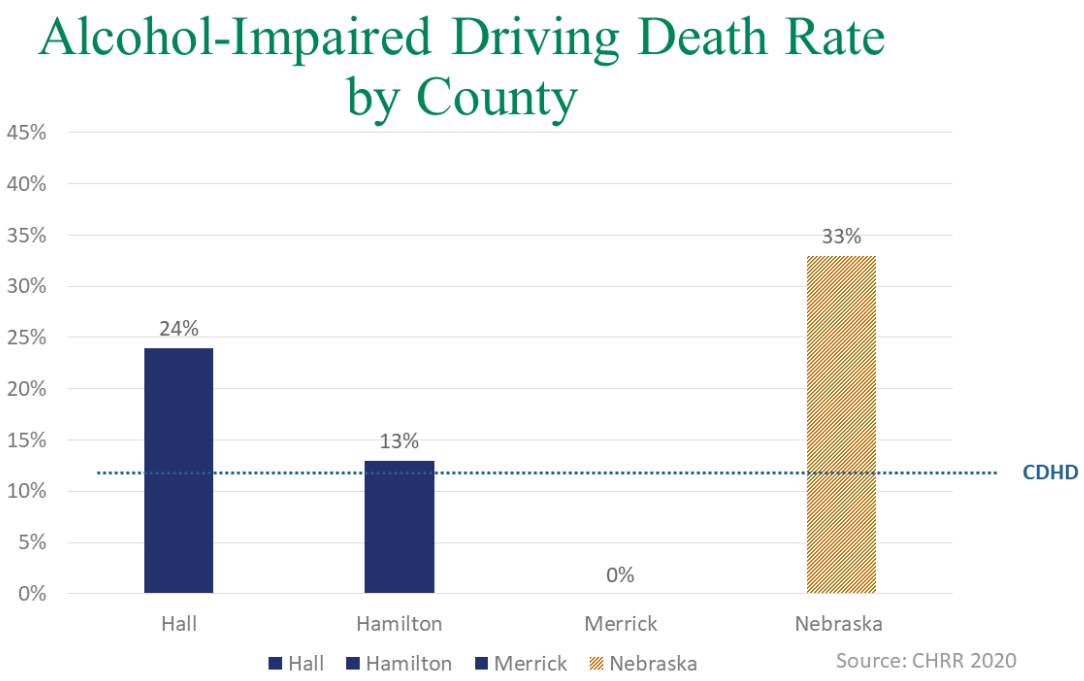
According to the Behavioral Risk Factor Surveillance System (BRFSS) 2019, 2 out of 3 adults in the CDHD district talked on a cell phone while driving in the past 30 days, similar to the state rate of 68%. Additionally, 3% of adults in the CDHD district reported driving under the influence of alcohol in the past 30 days, similar to the state rate (3%). Other risky behaviors while driving a vehicle in the CDHD district did not surpass the state average; however, 1 in 4 CDHD district adults reported texting while driving a vehicle, 1 in 3 CDHD adults did not always wear a seatbelt when driving or riding in a car.

Figure 41. Motor Vehicular Behavior Indicators, CDHD District



The death rate caused by alcohol-impaired driving in the CDHD district (12%) was lower than the state rate (33%)[lxxii].

Figure 42. Alcohol-Impaired Driving Death Rate, by County CDHD District



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. [lxxiii]

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 more major life activity.

Table 13 below summarizes the 2011-2019 BRFSS data regarding mental health indicators for Nebraska and the CDHD district. Women fared worse than men. Compared to the state, as a whole, CDHD is relatively aligned across all five indicators.

Table 13. Mental Health problem indicators in CDHD District

Mental Health Indicators

	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	18%	3.2	10%	2.0	6%
CDHD District	18%	3.2	10%	2	6%
Male	12%	2.5	9%	1.9	6%
Female	23%	2.5	12%	2.1	5%

Source: BRFSS 2011-2019

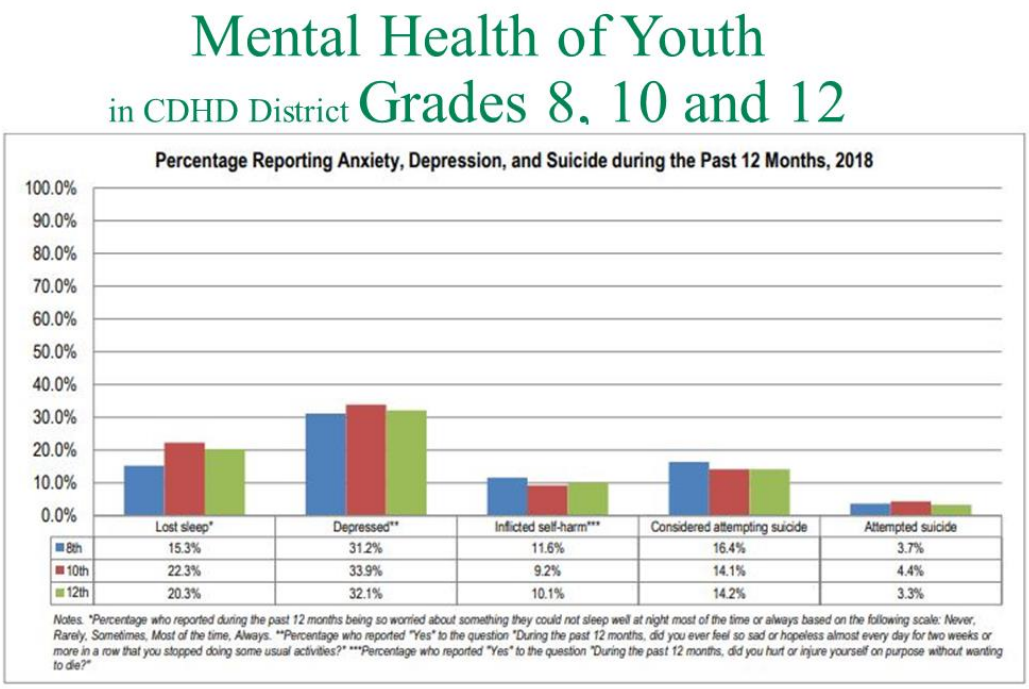
Table 14. Mental Health problem indicators in CDHD District by County

Mental Health Indicators	Average number of mentally unhealthy days in the past 30 days	Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)
Nebraska	3.6 (CHRR 2020)	10% (BRFSS 2011-2019)
CDHD District	2.8 (CHRR 2020)	10% (BRFSS 2011-2019)
Hall County (CHRR 2020)	3.8	12.0%
Hamilton County (CHRR 2020)	3.5	11.0%
Merrick County (CHRR 2020)	3.8	12.0%

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.[lxxiv] According to the NRPFSS 2018 in the CDHD, nearly 1 in 3 high school youth reported feeling depressed and 14% considered attempting suicide (see Figure 43).

Figure 43. Mental Health indicators for Youth, CDHD District

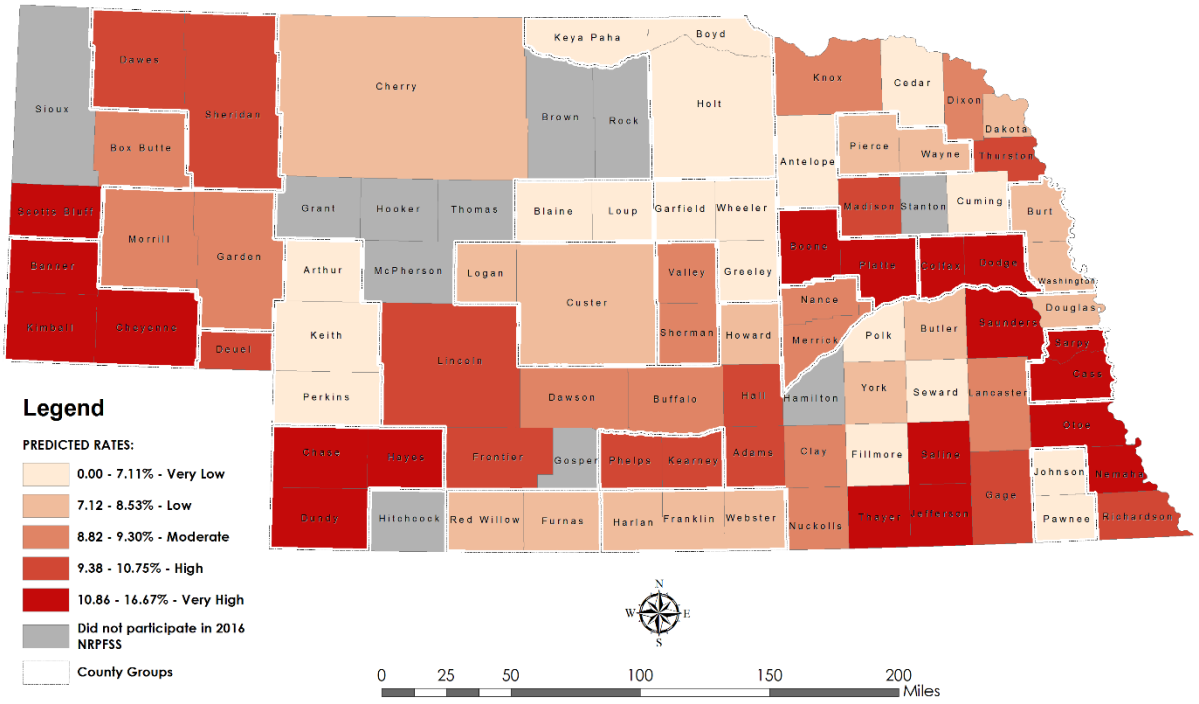


Source: 2018 results from Nebraska Risk and Protective Factor Student Survey

Suicide Risk

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 9th leading cause of death in Nebraska, and the second leading cause of death for ages 10-34.[lxxv] Hall County was at higher risk for youth suicide ideation and attempts. Figure 44 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 44. Risk level for youth suicide ideation and attempts by county based on the 2016 results from the Nebraska Risk and Protective Factors Surveillance System

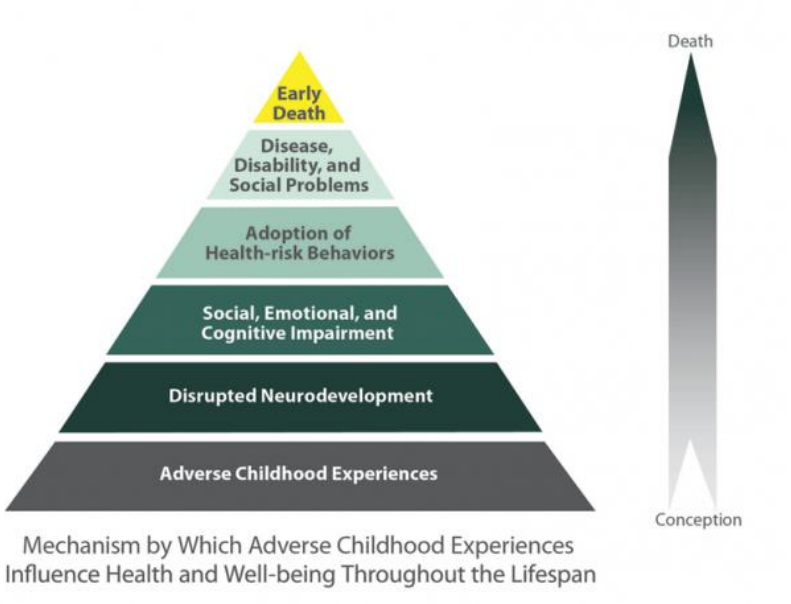


Veterans are at higher risk for several negative behavioral health outcomes – most alarmingly, suicide. Data from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) show that veteran families are also impacted. Statewide, when compared to other demographic groups, Nebraska's Veteran spouses and partners report having more poor mental health days and are more likely to have been told that they have depression.[lxxvi]

Adverse Childhood Experiences

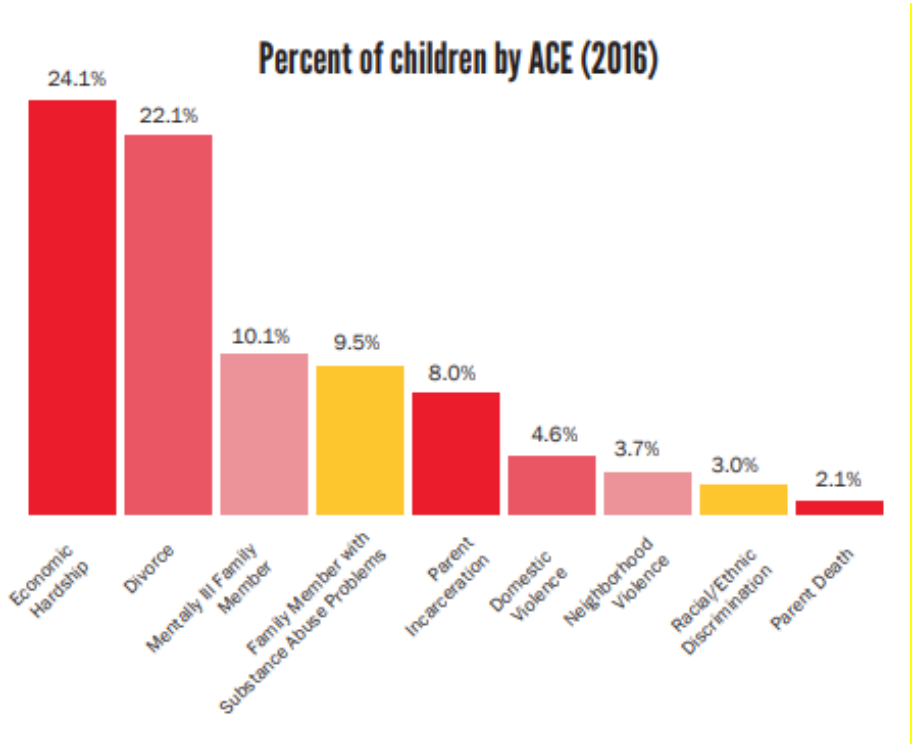
Adverse childhood experiences (ACEs) are one of the most accurate predictors of lifelong health and well-being.[lxxvii] ACEs are stressful or traumatic events that occur before age 18[lxxviii] and can include things such as a child experiencing abuse and neglect; family effects of struggling to get by 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; or experiencing parents who are divorced/separated or serving jail time.[lxxix] The landmark Kaiser ACE study showed dramatic links between ACEs and the leading causes of death, risky behaviors, mental health and serious illness.[lxxx] Figure 45 demonstrates the ACE Pyramid, used as the conceptual framework for the Kaiser Study.[lxxxi]

Figure 45. Adverse Childhood Experiences Pyramid



The last time Nebraska implemented the ACEs module of the BRFSS was in 2010 and 2011. At that time, roughly 30% of children experienced one to two ACEs. Around 10% of children experienced three to four ACEs and about 5% experienced 5+ ACEs[lxxxii]. Figure 46 illustrates the percent of children by ACE category in Nebraska.[lxxxiii]

Figure 46. 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.[lxxxiv] 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[lxxxv], are less likely to experience ACEs.[lxxxvi] Community-based strategies to provide safe, stable, nurturing relationships and environments to increase resilience and to reduce ACEs can include:

Program based[lxxxvii]:

- Home visiting programs for pregnant women and families with newborns
- Parenting training programs
- Intimate partner violence prevention programs
- Social support for parents
- Teen pregnancy prevention and parent support programs for teens
- Treatment for mental illness and substance abuse
- High quality, affordable childcare
- Sufficient income support for low-income families

System/Policy based[lxxxviii]:

- 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

Substance Use Disorders

Like mental health, substance use disorders are among the top causes of disability in the US and can make daily activities hard to accomplish.[lxxxix] 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.[xc]

Alcohol Use

Alcohol is the third-leading preventable cause of death in the US following tobacco and nutrition/physical activity. In 2019, 1 in 5 Nebraska adults binge drank or drank heavily (21.9%), a stark difference when compared to Utah (12%)—the state with the lowest prevalence of binge/heavy drinking. 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, including short-term risks that can increase the chances for accidents/unintentional injuries, violence, alcohol poisoning, and long-term risks that can increase the

chances for heart disease, stroke, liver disease, cancers, alcohol dependence, and more.[xci] The Nebraska BRFSS survey in 2019 indicated 17% of adults in the CDHD region reported binge drinking in the past 30 days, and nearly 5% of adults in the CDHD region reported heavy drinking in the past 30 days, both of which were similar to the US averages (17% and 6% respectively).

Figure 47. Alcohol Use, CDHD District, State and Nation

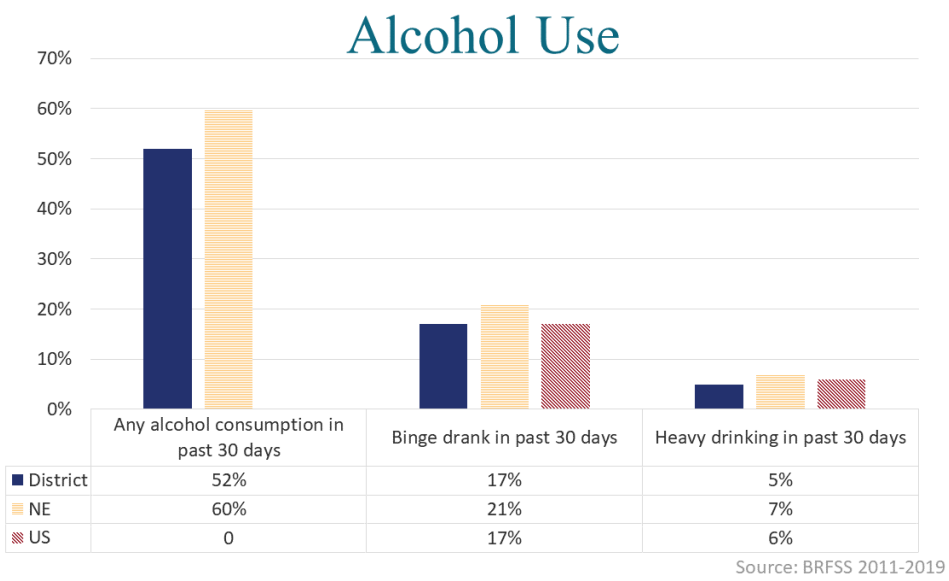
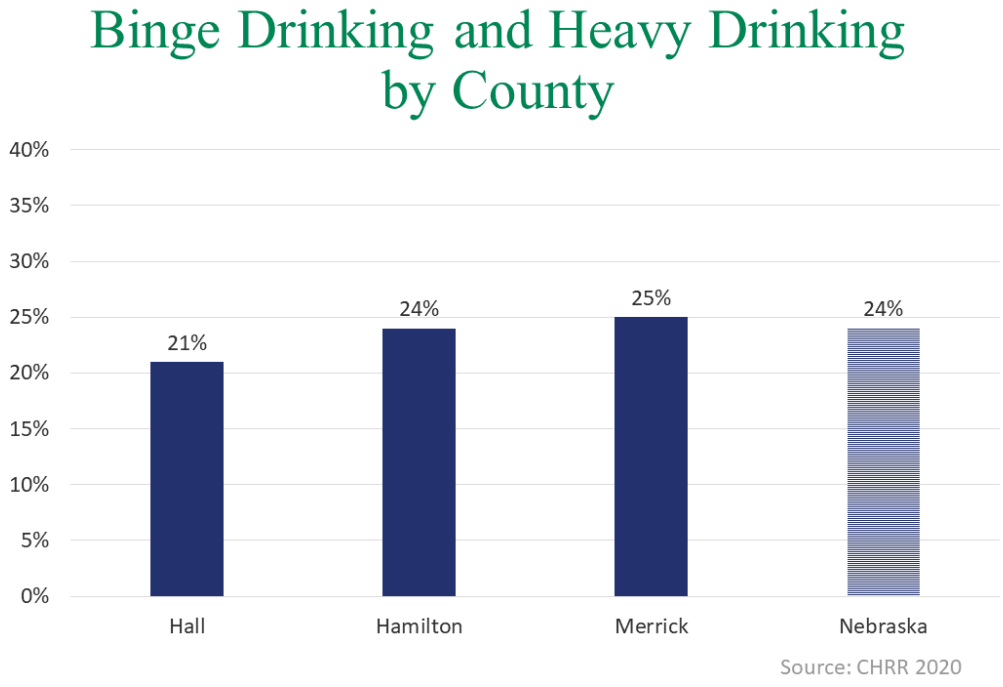


Figure 48. Binge and Heavy Drinking, by County in CDHD District



In general, excessive drinking is higher among men than women, younger adults (ages 18-44) compared to older adults (ages 45+), adults who graduated from high school compared to those who did not, and

among adults with higher income levels (>$75K). In addition, Hawaiian/Pacific Islander, Hispanic, and white adults have a higher prevalence of excessive drinking that Asian and black adults.

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.[xcii] The infant mortality rate (the number of infant deaths per 1,000 live births in the same year) in the US was 5.7 in 2018.[xciii]

Nebraska fairs a little bit better than the US with an infant mortality rate of 6.[xciv] Figure 49 illustrates the stark differences between counties across the CDHD district regarding infant mortality.[xcv] Hall and Hamilton counties' infant mortality rates were higher than the state rate and nearly 1.5 times higher than Merrick County.

Figure 49. Infant Mortality Rate, CDHD District

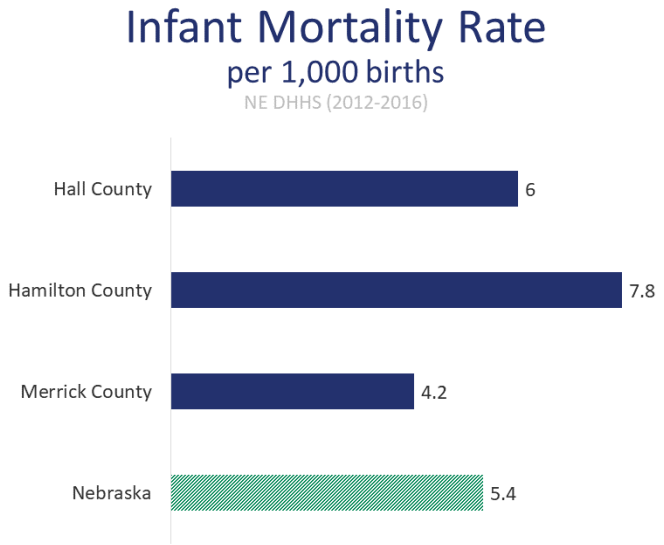


Table 15 provides an overview of the birth statistics and other maternal and child health indicators. Notably, the overall birth rate (15.7/1,000) and teen birth rate (38/1,000) in Hall County was higher than other counties in the CDHD district and state rate.

Table 15. Maternal and Child Health Indicators, CDHD District

Maternal and Child Health Indicators	Hall	Hamilton	Merrick	CDHD District	NE
Birth rate[xcvi]	15.7	12.8	12.5	13.7	13.9
Teen birth rate[xcvii]	38	9	20	22	25
Low birthweight[xcviii]	7%	5%	6%	6%	7%

Healthcare Access and Utilization

Healthcare Insurance Coverage

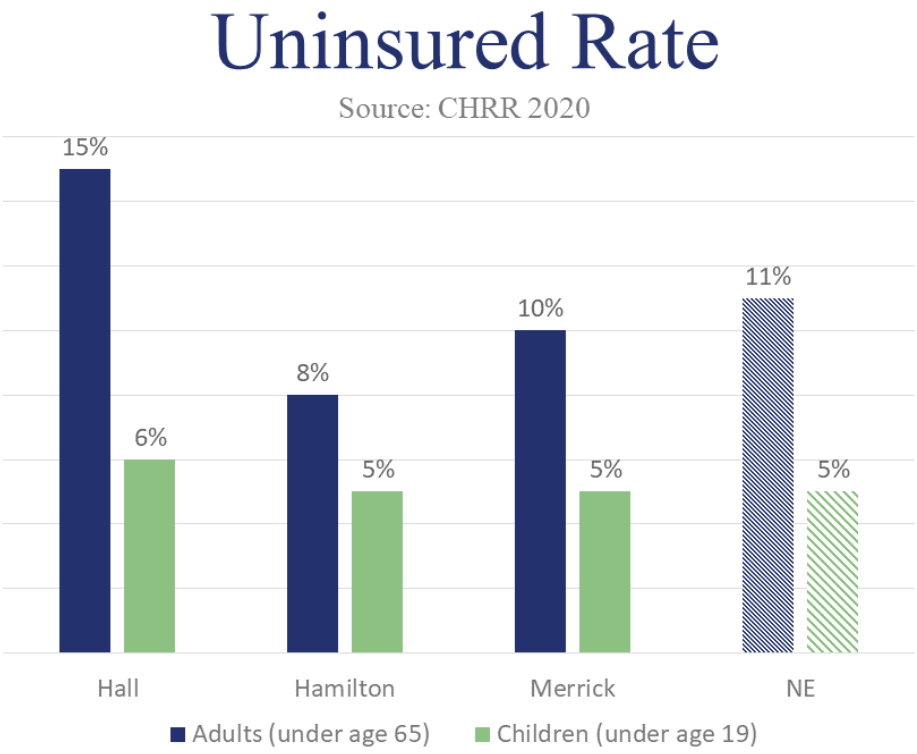
According to the Nebraska BRFSS (see Table 16), one in five adults aged 18-64 in the CDHD district did not have health care coverage.

Table 16. Health Care Access Indicators, CDHD District

Health Care Access Indicators[xcix] *(BRFSS, 2011-2019)*	**NE**	**CDHD Region**		
		Overall	**Male**	**Female**
No health care coverage, 18-64-year olds	16%	20%	21%	19%

To provide a county snapshot for uninsured among the population under the age of 65, the latest County Health Rankings (see Figure 50) reported that more adults under the age of 65 (15%) and under age 19 (6%) in Hall County were uninsured than the state average (11% and 5%, respectively).

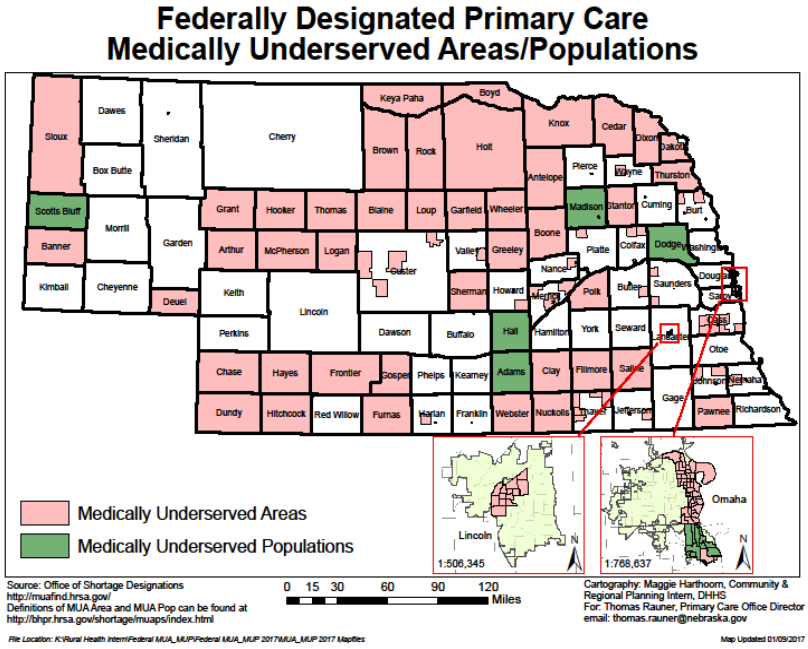
Figure 50. Uninsured Rates, CDHD District



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. About 3 of 4 adults in CDHD district had a personal doctor or healthcare provider.[c] According to the Health Resources and Services Administration (HRSA), some areas within CDHD 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 51) illustrates the federal health professional shortage area for primary care across the state in 2018.

Figure 51. Primary Care, Federally Designated Medically Underserved Areas/Populations

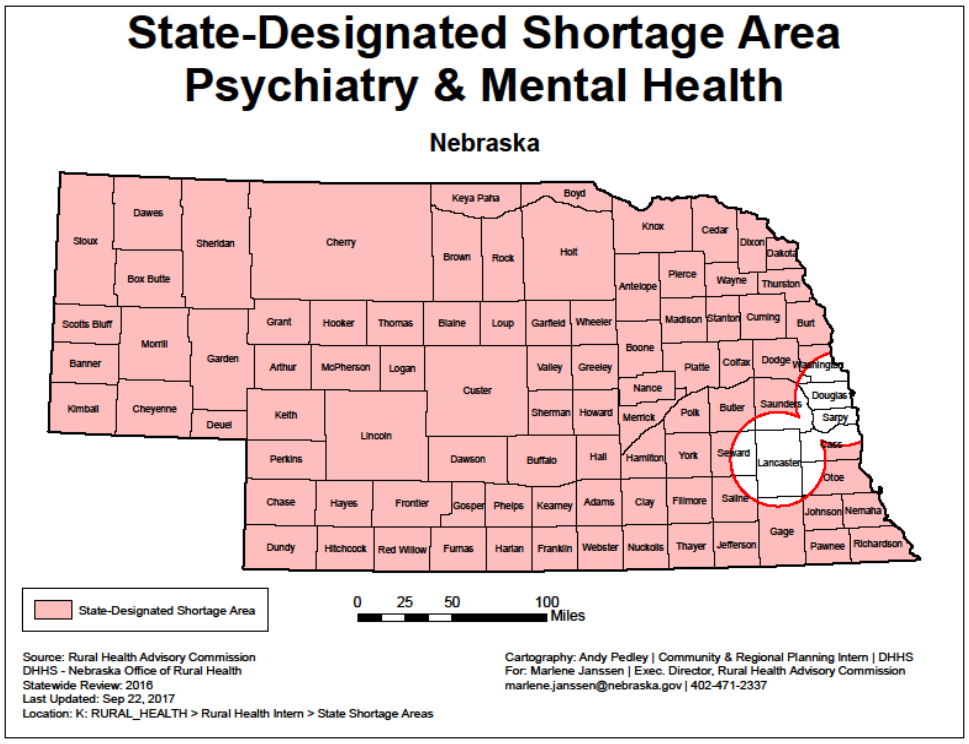


Notably, all of Hall County and parts of Merrick County were designated as MUA/MUPs for primary care. To help ease this provider shortage problem, Physician's Assistants (PA-Cs) and Nurse Practitioners (APRNs) were utilized in many primary care clinics in the CDHD region, and the Northern Nebraska Area Health Education Center (AHEC) worked with healthcare agencies to place students on training paths to be healthcare providers.

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 to insurance barriers.[ci]

Most counties in the state are designated as mental health professional shortage areas (see Figure 52). In the Central District Health Department district, there were an average of 1,731 people for every one mental health provider (range: 280:1 to 3,878:1), and nearly four times as many people to mental health provider as the state average (362:1).[cii] 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, 11% of persons aged 12 or older in Nebraska with illicit drug dependence or abuse received treatment. In addition to CDHD's known mental health professional shortage area designation, access to behavioral health care may be further complicated by other barriers, including lack of insurance coverage and stigma often associated with mental illness.[ciii]

Figure 52. Mental Health Care, State-Designated Shortage Areas



In other health professional care, including dentistry and pharmacy, counties within CDHD were designated as shortage areas. Figures 53, 54, and Table 17 illustrate these shortages.

Figure 53. Dentistry, State-Designated Shortage Areas

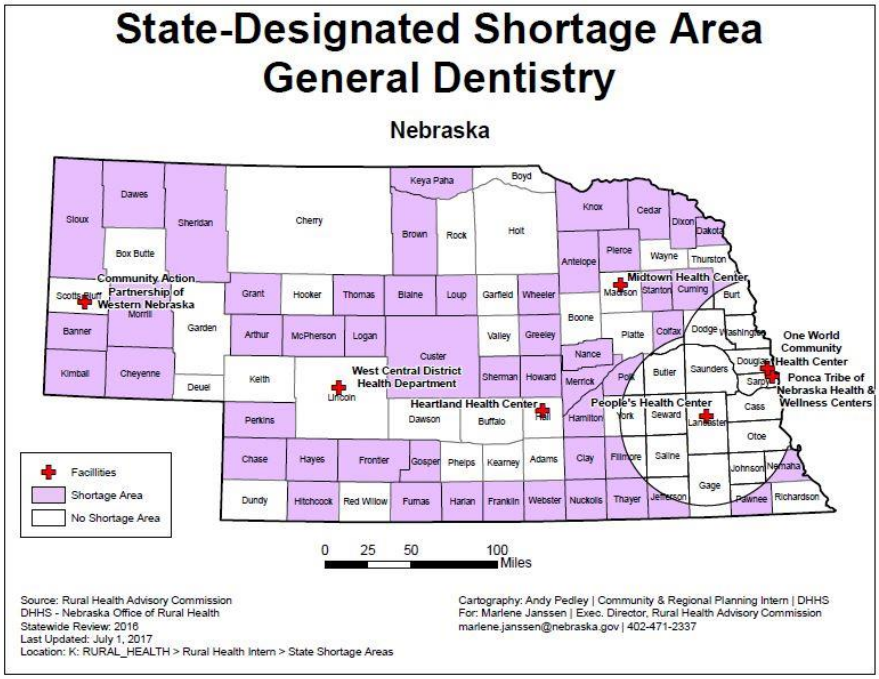
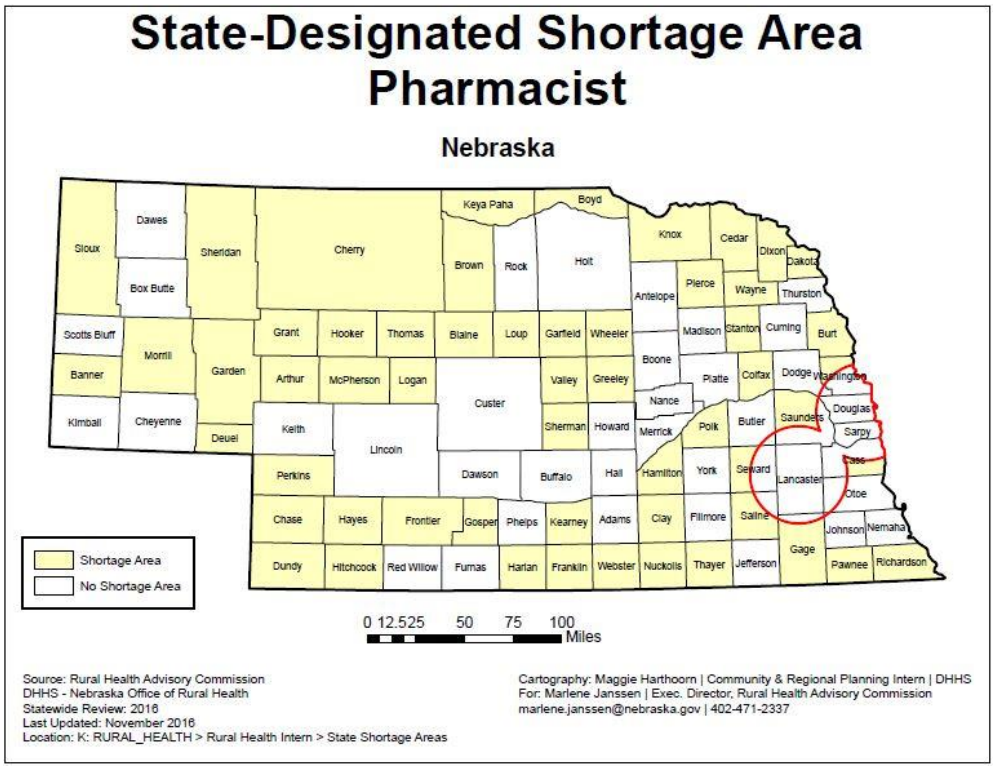


Figure 54. Pharmacist, State-Designated Shortage Areas



Stark disparities exist between counties when looking at population per provider type in the CDHD area. Merrick County has a significantly higher population per provider ratio for mental health (3,878:1) and primary care providers (3,867:1) than the state (362:1 and 1,330:1, respectively) as shown in Table 17.

Table 17. Ratio of Population per Type of Provider, CDHD District

Ratio of **Population : Type of Provider** (2020)

	NE	Hall	Hamilton	Merrick
Primary care physicians	1330:1	1621:1	1160:1	3867:1
Dentists	1272:1	1180:1	1865:1	1939:1
Mental health providers	362:1	280:1	1036:1	3878:1

Source: CHRR 2020

Although Hall County has a lower provider per population ratio among dental and mental health services compared to the state and other counties within CDHD, comments from respondents to the resource

inventory survey (n=15 partners in the CDHD area) included: Medicaid is not accepted at all dentist providers or specialty care providers; under/uninsured patients lack access to quality and routine care; patients not established with a mental health provider are offered only telehealth appointments with long waitlists for in person appointments and for those residents in the CDHD area with severe mental health problems lack the appropriate access to care; more substance abuse services are needed. Furthermore, bilingual/interpretation services offered among these providers may need enhanced to effectively serve and reach the growing minority population in this area.

Health Care and Prevention Assets

In the CDHD district, health care providers and services include four hospitals, namely CHI Health Saint Francis, Grand Island Regional Medical Center in Hall County, Memorial Community Health Inc. in Hamilton County, and Merrick Medical Center-Bryan Health in Merrick County. The area also has one Federally Qualified Health Center (FQHC; Heartland Health Center in Hall County). There are several medical clinics providing primary care and prevention services. Medical clinics in the CDHD district operate during traditional business hours (from 8:00am to 5:00pm, Monday through Friday, and Saturday mornings). Providers offering specialty services travel to these medical clinics from outside of the CDHD district and hold office hours from weekly to once monthly at select medical clinics/hospitals. Additionally, CDHD district has is home to several dental clinics as well as Heartland Health Center's dental clinic. Dental clinics are present in each county. Professional and Volunteer Emergency Medical Services are located throughout each county.

Access for Aging Populations:

Multiple assisted living and long-term care facilities are available in the CDHD district offering around the clock assistance and/or nursing care for residents. Home-health services are available in the CDHD district. Senior Centers are active in each county. The area is served by Midlands Area on Aging.

Central District Health Department offers several preventative programs s including Every Woman Matters, Diabetes Prevention Program and Living Well with Diabetes.

The Social Services for Aged and Disabled Adult Program (SSAD) provides services to individuals who are aged, blind, or disabled and need assistance in remaining as independent as possible. Eligibility is based on the client's income as well as their need for the requested service. The SSAD program provides services to clients who do not qualify for Medicaid or are ineligible to receive assistance from other programs. Services provided include: Chore services, Adult day care, Home delivered meals, Congregate meals, Homemaker services, and Transportation.

Access for Veteran Populations:

Multiple agencies in the CDHD district offer services for Veterans and their families. The Grand Island VA Medical Center provides inpatient, outpatient, and home visitation services. VA services also include a Community Living Center. The Community Living Center is a 65-bed facility providing extended care, rehabilitation, geriatric care, palliative care, respite care, supportive/restorative and long-term care, and general nursing home care. Each county has a Veterans Services Officer. Other support services for Veterans and their families are offered by agencies such as the Central Nebraska Community Action Partnership, local churches, local Veterans of Foreign Wars (VFW) posts, American Legions, County Veteran Service Officers and the Department of Labor.

Central District Health Department staff and partners have been trained in the No Wrong Door training, a day-long deep dive into military culture and life where participants learn about military experiences and how they influence emotions and behaviors by hearing from Veterans, their families, and experts in the field.

Preventative Screenings

Nearly 40% of adults in the CDHD district did not receive a routine checkup in the past year.

Table 18. Preventative Health Screening Indicators, CDHD District

Preventative Health Screening Indicators[civ] *(BRFSS, 2011-2019)*	**NE**	**CDHD Region**		
		Overall	**Male**	**Female**
Preventative Screenings				
Heart Disease				
Had cholesterol checked in past 5 years	84%	86%	85%	87%
Cancer				
Up to date on colon cancer screening, 50-75-year olds	65%	63%	61%	65%
Up to date on breast cancer screening, overall female 50-74-year olds	75%			74%
Up to date on cervical cancer screening, female 21-65-year olds	81%			82%
Routine Checkups				
Had a routine checkup in past year	65%	62%	56%	68%

The rate of adult population in the recommended age groups across the CDHD district who received appropriate preventative screenings such as breast, cervical and colon cancer screenings was similar to the state rate. While the majority of adults in the recommended age groups across the CDHD district received appropriate preventative screenings, the trend over a seven-year period was downward. Breast cancer was the second leading cause of death by type of cancer in the CDHD district, yet only 74% of CDHD area adults aged 50-75 years of age received this particular screening. Of particular note, about half of women ages 65-74, Medicare enrollees, are up-to-date on breast cancer screening. Breast cancer screening is a covered preventative measure by Medicare. About two-thirds of adults in CDHD area were up-to-date on their recommended colon cancer screening, and about 80% of women were up-to-date on recommended cervical cancer screenings.

Figure 55. Colon Cancer Screening Rates, CDHD District

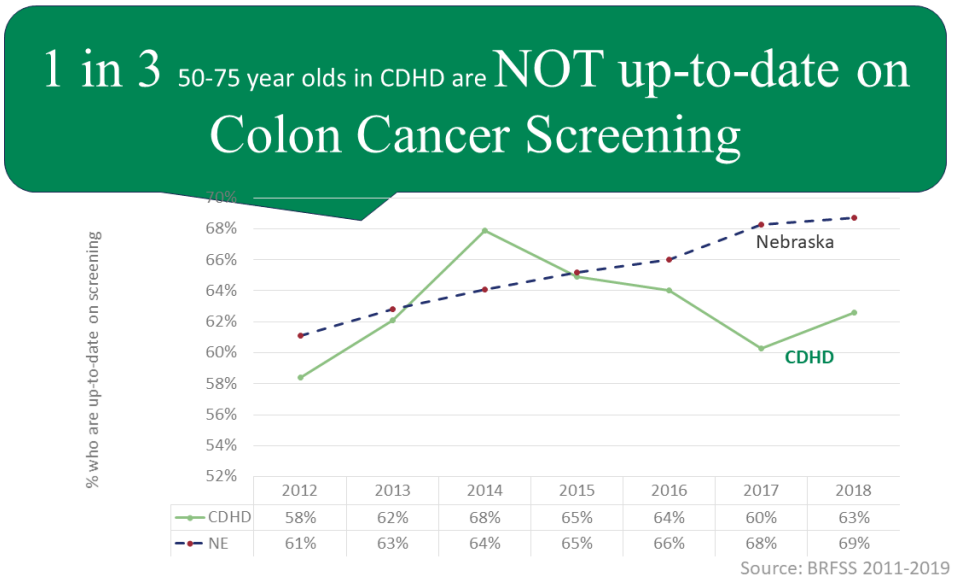


Figure 56. Breast Cancer Screening Rates adult population ages 50-75, CDHD District

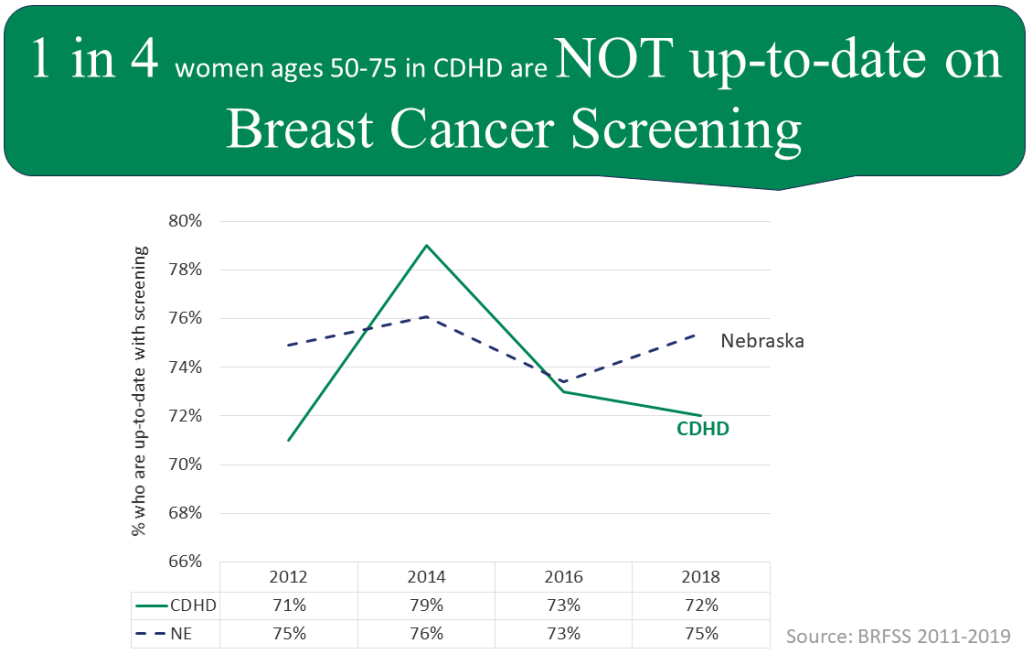


Figure 57. Breast Cancer Screening Rates among Medicare population ages 65-74, CDHD District

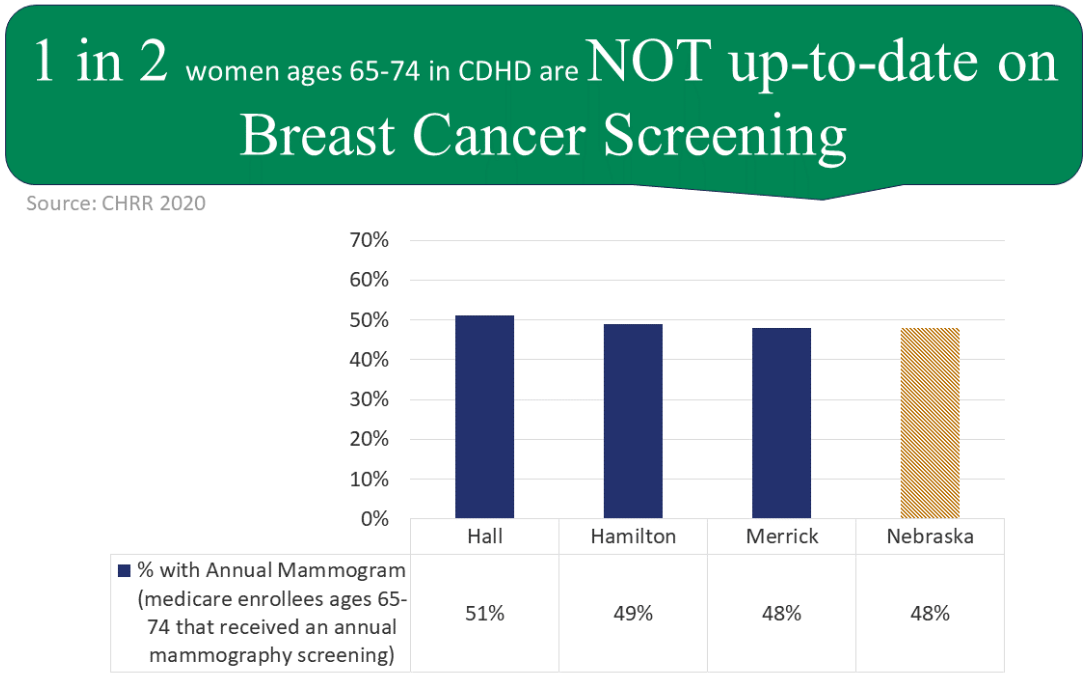
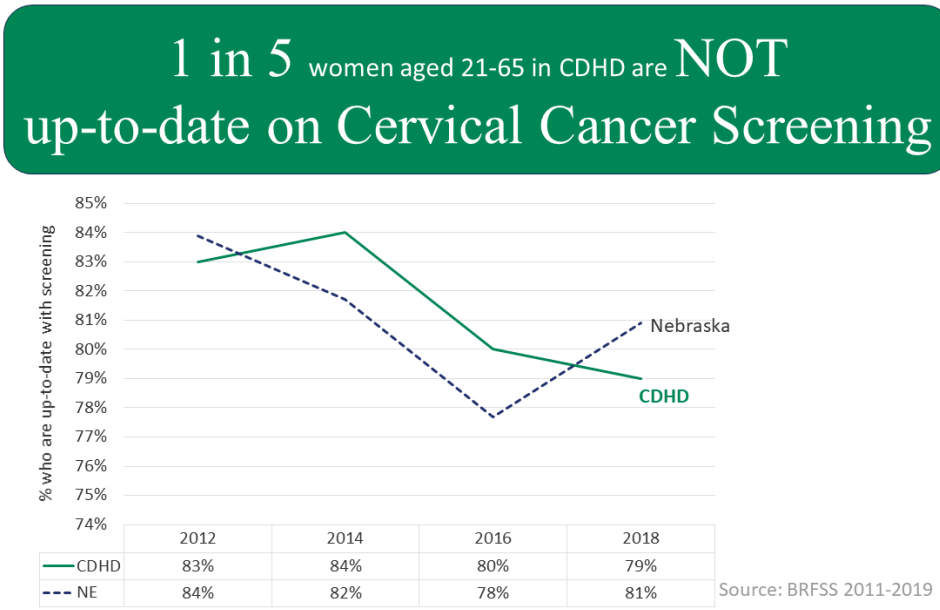


Figure 58. Cervical Cancer Screening Rates, CDHD District



Barriers to Accessing Health Care

Accessing health care is complicated by multiple factors, such as the ability to travel to care locations, location and number of healthcare providers, types and costs of services offered, insurance coverage, etc. Cost of healthcare services can be a barrier to care for CDHD residents. Surpassing the state rate, about 1.5 in 10 adults aged 18-64 needed to see a doctor but could not due to cost within the past year, and 1 in 5 adults aged 18-64 had no health care coverage.[cv] Though data are not available for CDHD by race/ethnicity, Hispanics had the highest uninsured rates of any racial or ethnic group across the state (57.7%)[cvi] and nation.[cvii] In the US, Medicare provides universal health coverage to adults 65 and older; however, cost-sharing and premium contributions continue to be a serious burden for many.[cviii]

Table 19. Access to Care Indicators, CDHD District

Access to Care Indicators[cix] *(BRFSS, 2011-2019)*	**CDHD Region**	**NE**
Needed to see a doctor but could NOT due to cost in past year	14%	12%
No personal doctor or health care provider	22%	20%
No health care coverage, 18-64-year olds	20%	16%

Healthcare professional shortages is another barrier to care for CDHD residents. Nearly 1 in 5 adults in the CDHD district report not having a personal doctor or health care provider. Furthermore, across the state, nearly 1 in 2 Hispanics and 65% of Native Americans reported not having a personal doctor or health care provider.[cx]

As affirmation to the above barriers contributing to inability to access health care, respondents to the CDHD Community Survey identified access to affordable and quality healthcare as a major health-related worry and as a way to make neighborhoods healthier.

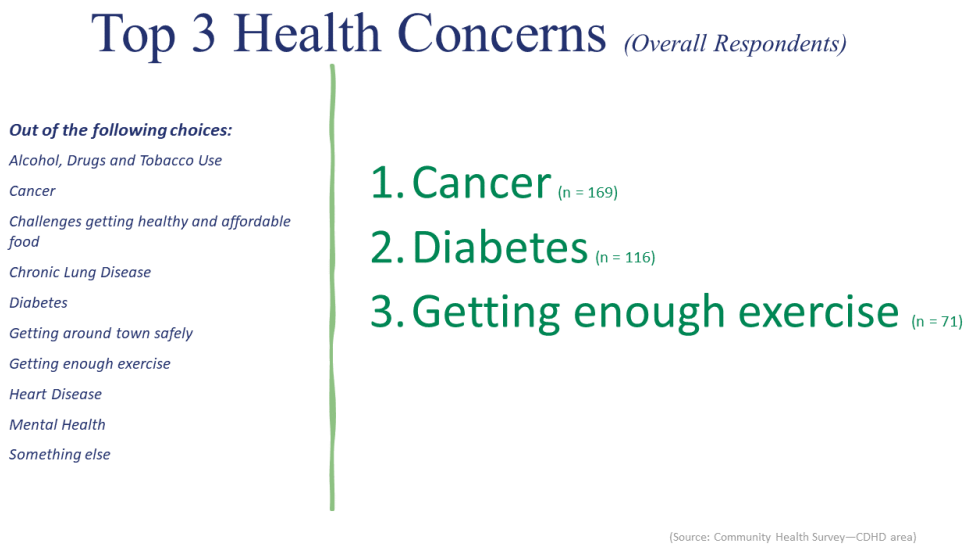
Community Themes and Strengths

Central District Health Department launched a 5-question survey, developed by the Nebraska Association of Local Health Directors (NALHD), to learn more about the impact of COVID-19 on communities in the CDHD area and to assess community health related to things people do to be healthy, top health concerns, and major health issues. This open-ended survey design, intended to allow respondents to tell LHDs their experience related to their health and the health of their community, provides insight into to emerging issues in the community. The survey was made available in English, Spanish, Somali, and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey while waiting for appointments.

There were 665 responses (see Appendix C for full details on the demographics of survey respondents and summary of responses), of which most survey respondents self-identified as non-Hispanic, White women between ages 30-64. While not representative of the population of the region, as a whole, many of the survey responses are consistent with other data collected as part of this Community Health Assessment. Survey findings are also consistent with anecdotal input from key stakeholders (from the

priority setting meetings) who are connected to many of the diverse community groups not directly represented in survey responses. The survey revealed the following:

Figure 59. Top 3 Health Concerns, Community Survey Respondents



When looking at the survey data by ethnicity and race, Hispanic and non-White respondents listed the same top two concerns as in Figure 59; however, the third concern was challenges getting healthy and affordable food. Even given the low response to the resource inventory survey, partners identified the need to increase the availability of bilingual/interpretation for services and programs to ultimately enhance and improve the health of all residents within the CDHD area.

Health Summary: CDHD District

The majority of the adult population within the CDHD district reported their general health was good or better in the BRFSS between 2011-2019. However, nearly 1 in 10 people within the CDHD district indicated they experienced frequent mental distress. Table 20 summarizes the general health of the adult population within the CDHD district.

Table 20. General Health Indicators, CDHD District

General Health Indicators[cxi]	**CDHD District**	**NE**
General health fair or poor	17%	14%
Average number of days physical health was not good in past 30 days	3.3	3.1
Physical health was not good on 14 or more of the past 30 days	10%	10%
Average number of days mental health was not good in past 30 days	3.2	3.2
Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	10%	10%

Average days poor physical or mental health limited usual activities in past 30 days	2.0	1.9
Poor physical or mental health limited usual activities on 14 or more of the past 30 days	6%	6%

Similar to the state, the CDHD district experienced shortages in primary care, dental, and mental health professionals, further reducing access to needed health services. The Years of Potential Life Lost (YPLL), a measurement of preventable deaths, in the CDHD district surpassed the state rate. More specifically, Hall and Merrick counties' YPLL rate was 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.

Appendices

Appendix A: List of Tables

Appendix B: List of Figures

Appendix C: Demographics of Community Survey Respondents (2021) compared to CDHD Census

		CDHD Overall Population (US Census 2019)	CDHD Survey Respondents (N = 665)	
Gender	Female	**50%**	71%	*470*
	Male	**50%**	27%	*178*
	No Response	**-**	2.5%	*17*
Age	Under 20	**27%**	3%	*20*
	20-29	**11%**	10%	*69*
	30-39	**12%**	24%	*159*
	40-49	**11%**	21.5%	*143*
	50-64	**21%**	27%	*178*
	65-74	**10%**	9%	*60*
	75+	**8%**	2%	*11*
	No Response	**-**	4%	*25*
Hispanic/Latino	Yes	**13%**	23%	*152*
	No	**84%**	75%	*498*
	No Response	**-**	2%	*15*
Race	American Indian or Alaska Native	**1.1%**	0.6%	*4*
	Asian	**0.9%**	0.5%	*3*
	Black/African American	**1.6%**	9%	*59*
	Native Hawaiian/Pacific Islander	**0.3%**	0.1%	*1*
	White	**94.3%**	76%	*505*
	Other	**1.3%**	11%	*71*
	No response	-	3%	*22*

Appendix C: Community Survey Responses by Overall, Hispanic and Non-White

Community Survey Summary: *Overall respondents*

Last Major Health Issue Experienced (*by self or by family*)

Community members identified many health issues. Highlights included:

- **COVID-19:** 139 responses including self or family sick from or death from COVID-19
- **Cancer:** 64 responses including self or family diagnosed with or death from Cancer
- **Cardiovascular Disease:** 68 responses including cholesterol, heart, high blood pressure, stroke
- **Surgery:** 60 responses related to knee, heart, back, shoulder, gallbladder, foot, hip and eye
- **Respiratory:** 34 responses related to sinus infection, RSV, bronchitis, pneumonia, flu
- **Diabetes:** 29 responses including self or family diagnosed or at-risk for diabetes
- **Mental Health:** 26 responses including depression, anxiety, and struggles in general and related to COVID-19 and postpartum
- **Suicide:** 4 responses
- **None:** 208 responses
- Other responses include burns, arthritis, osteoporosis, birth, broken/torn ligaments and bones, hip issues, kidney problems and stones, dental work, falls, accidents, stitches

Health-related Worries (for self or for family)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 146 responses including self or family sick from or death from COVID-19
- **Access to affordable and quality healthcare:** 109 responses including ability to cover costs, available healthcare facilities and staff to take care of loved ones, not having insurance, lack of access to emergency services, availability of health care resources, being able to see the doctor when needed, best care, insurance not covering things, being able to pay the doctor bills and/or pay for medications
- **Cancer:** 62 responses mentioned for either self or family diagnosed or death from Cancer
- **Maintaining healthy life:** 34 responses including staying health, general health, healthy now
- **Mental Health:** 32 responses including suicide, suffering from loss of family members to suicide, stress, depression, anxiety
- **Diabetes:** 28 responses mentioned self or family diagnosed or at risk
- **Aging:** 21 responses including aging in place, caring for aging parents, affordable aging care/long-term care, memory and mobility as we age, aging well
- **Cardiovascular Disease:** 19 responses including cholesterol, heart, high blood pressure
- **None:** 78 responses

Healthy Persons

Community members identified several actions that make them healthier. Highlights included:

- **Healthy eating:** 138 responses including drink water, eat healthy/healthier, homemade food, watch what I eat, fat-free meals, make fruits and vegetables available at home, track my foods, cook healthy meals at home, diet
- **Active living:** 190 responses including work out, exercise, walk, swim, play soccer with family, job requires a lot of walking/lifting, staying/keep active
- **Clinical Care:** 17 responses including visit doctor, follow doctor's instructions, take vitamins/supplements
- **Non-Pharmaceutical Interventions and vaccination:** 10 responses including clean, hand washing, mask, vaccinated
- **Mental Health:** 27 responses including see a therapist regularly, take care of yourself, worry storage, read more often, church/faith
- **Nothing:** 5 responses

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhood healthier. Highlights included:

- **Active Living:** 72 responses including access to walking paths, better and more sidewalks, more recreation parks, community centers where families can meet for recreational activities, outdoor space, green areas
- **Healthy Eating:** 22 responses including better access to affordable healthier food options for kids and families, healthier restaurants, bigger grocery store, farmer's markets
- **Environmental Health:** 45 responses including less farm chemicals sprayed and in water/food sources, clean communities, city-wide trash pick up, more trees/green space, water quality issues
- **COVID-19:** 45 responses including cleaning, vaccinations, stay healthy and maintain distance from others, everyone wear mask
- **Substance Free:** 13 responses including alcohol, drug and tobacco free, complexes be better at being tobacco free, no drug deals in neighborhoods
- **Safety:** 8 responses including more security, neighborhood watch, protection, police surveillance, mall security
- **Healthcare:** 8 responses including free/affordable healthcare, more community health services
- **Neighborhood/Neighbors:** 8 responses including communicate with neighbors when things like drug deals and molesting minors is happening in the neighborhood, take care of each other, good neighborhood relationships
- **Nothing:** 45 responses

****

Community Survey Summary: *Hispanic respondents*

LAST MAJOR HEALTH ISSUE EXPERIENCED (*BY SELF OR BY FAMILY*)

Community members identified many health issues. Highlights included:

- **COVID-19:** 38 responses included respondent or family member sick from or died from COVID-19
- **Diabetes:** 10 responses including diagnosed with diabetes
- **Cardiovascular Disease:** 7 responses including heart problems, heart attack and stroke
- **Cancer**: 4 responses including diagnosed with or death from Cancer
- **None:** 43 responses

HEALTH-RELATED WORRIES (FOR SELF OR FOR FAMILY)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 31 responses including self or family sick from or death from COVID-19
- **Access to affordable and quality healthcare:** 22 responses including proper care after surgery, hard to find a good doctor, impossible to switch to a different doctor in the same clinic, no health insurance, cost of doctors/care and medications
- **Cancer**: 12 responses mentioned for either self or family diagnosed or death from Cancer
- **Maintaining healthy life:** 6 responses including staying healthy
- **Children's Health:** 6 responses including concerned about the health and well-being of their children
- **None:** 78 responses

HEALTHY PERSONS

Community members identified several actions that make them healthier. Highlights included:

- **Healthy eating:** 71 responses including drink water, eat healthy/healthier, homemade food, watch what I eat, fat-free meals, make fruits and vegetables available at home, track my foods, cook healthy meals at home, diet
- **Active living**: 58 responses including work out, exercise, walk, swim, play soccer with family, job requires a lot of walking/lifting, staying/keep active
- **Clinical Care:** 8 responses including visit doctor, follow doctor's instructions, take vitamins/supplements
- **Non-Pharmaceutical Interventions:** 6 responses including clean, hand washing, mask, vaccinated
- **Mental Health:** 11 responses including protect me, read more often, organized, take care of us, go to church/faith, relaxation techniques, meditation, spend more time with family/kids

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhood healthier. Highlights included:

- **Active Living:** 29 responses. Comments included access to walking paths safe from animals and traffic, more recreation parks, community centers where families can meet for recreational activities and learn crafts, art, having places to go to near by to exercise regularly, have place to exercise, access to bike trails, outdoor space, green areas…for kids to play, better sidewalks…
- **Healthy Eating**: 13 responses. Comments included children and healthy eating, make more homemade food, accessible food market, healthier restaurants, eat healthy, education about healthy eating
- **Environmental Health:** 17 responses. Comments included clean street, less noise, less trash, tree naturalization care, keep the community clean, street pavement creating lagoon, air quality tests (powder coat/welding co) in neighborhood, landlords keep properties maintained and listen to renters when issues arise, less crowded housing
- **COVID-19:** 16 responses. Comments included cleaning, vaccinations, get the shot, stay healthy and maintain distance from others, everyone wear mask
- **Safety:** 7 responses. Comments included more security, neighborhood watch, protection, police surveillance, drug free
- **Access to Healthcare:** 3 responses. Comments included free/affordable healthcare, more community health services
- **Neighborhood/Neighbors:** 3 responses including communicate with neighbors when things like drug deals and molesting minors is happening in the neighborhood, take care of each other, good neighborhood relationships

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Community Survey Summary: *Non-White respondents*

LAST MAJOR HEALTH ISSUE EXPERIENCED (*BY SELF OR BY FAMILY*)

Community members identified many health issues. Highlights included:

- **COVID-19:** 30 responses including sick from or death from COVID-19
- **Diabetes:** 7 responses including diagnosed or at-risk for diabetes
- **Cardiovascular Disease:** 7 responses including cholesterol, heart, high blood pressure, stroke
- **Brain-related:** 5 responses including migraine, amnesia, cognitive memory loss, seizure
- **Cold/Flu:** 5 responses
- **Cancer**: 3 responses including diagnosed with or death from Cancer
- **None:** 54 responses

HEALTH-RELATED WORRIES (FOR SELF OR FOR FAMILY)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 45 responses including self or family sick from or death from COVID-19

- **Access to affordable and quality healthcare:** 10 responses including being able to afford doctors' visits or bills, unsure of where to go or how to pay for care for chronic conditions or acute issues, not having health coverage or money to pay for healthcare
- **Cancer**: 11 responses mentioned for either self or family diagnosed or death from Cancer
- **None:** 17 responses

HEALTHY PERSONS

Community members identified several actions that make them healthier. Highlights included:

- **Healthy Eating**: 53 responses including eat healthy, good nutrition, eat homemade food, watch my diet, drink water
- **Active Living:** 38 responses including exercise, walk, go to the gym, workout
- **Self-Care:** 14 responses including faith/church, protect me, take multi-vitamins, meditation, listen to music, spend time with family/people, go to park
- **Non-Pharmaceutical Interventions:** 9 responses including wear masks, wash hands

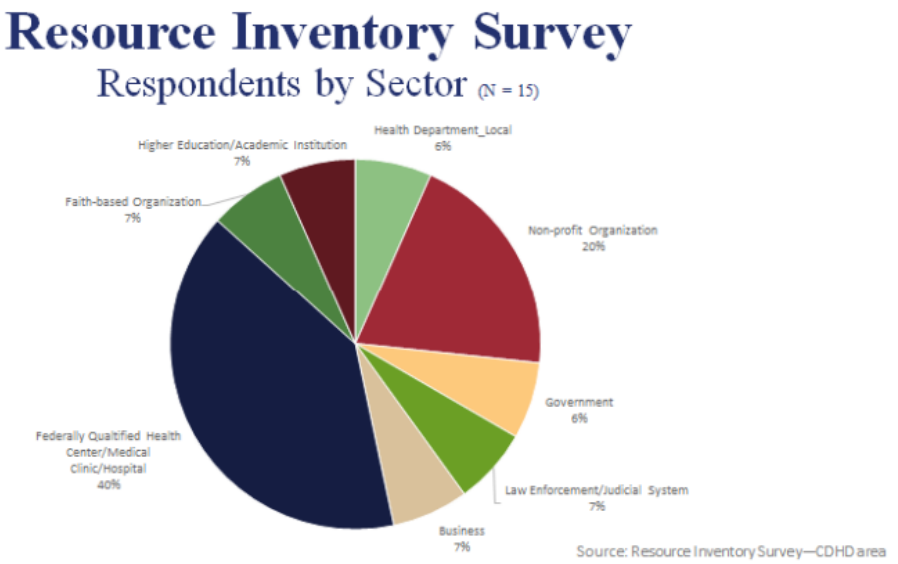
HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhoods healthier. Highlights included:

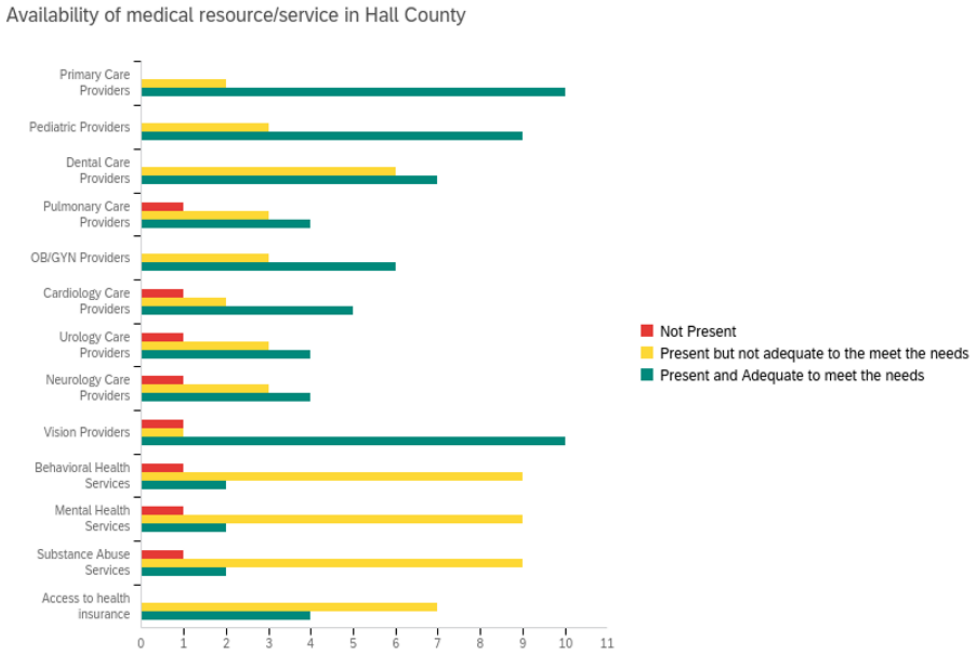
- **Non-Pharmaceutical Interventions and Vaccinations:** 41 responses including wear masks, clean/hygiene, get vaccinated, wash hands
- **Active Living**: 22 responses including more parks/green space for children, practice more sports, fishing, community centers for family fun
- **Environmental Health:** 19 responses including less noise, fix streets where water stands, clean community, air quality
- **Access to Healthcare:** 6 responses including education to know where to go for services, community health services/events, affordable healthcare
- **Substance free:** 5 responses including no drugs or smoking
- **None:** 14 responses

Appendix D: Resource Inventory Survey, August 2021

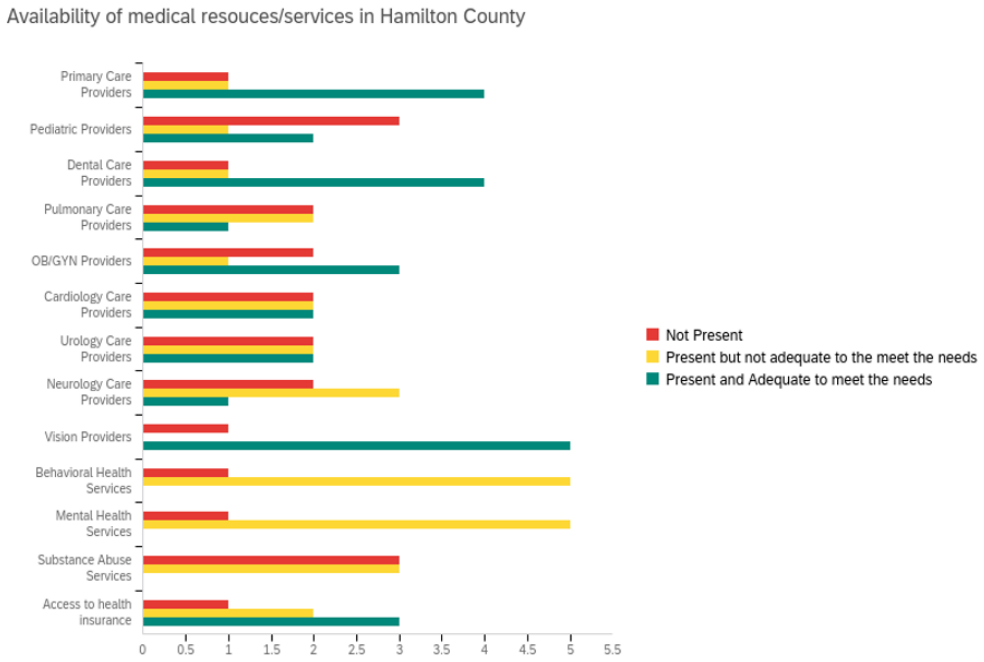
Resource Inventory Survey



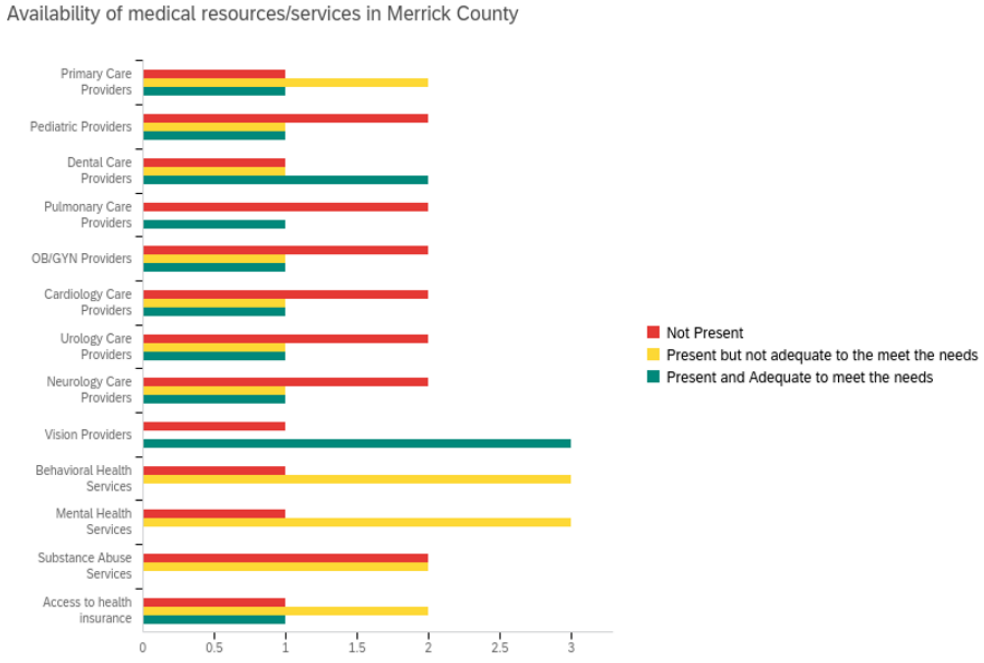
Q3#1 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - Hall County



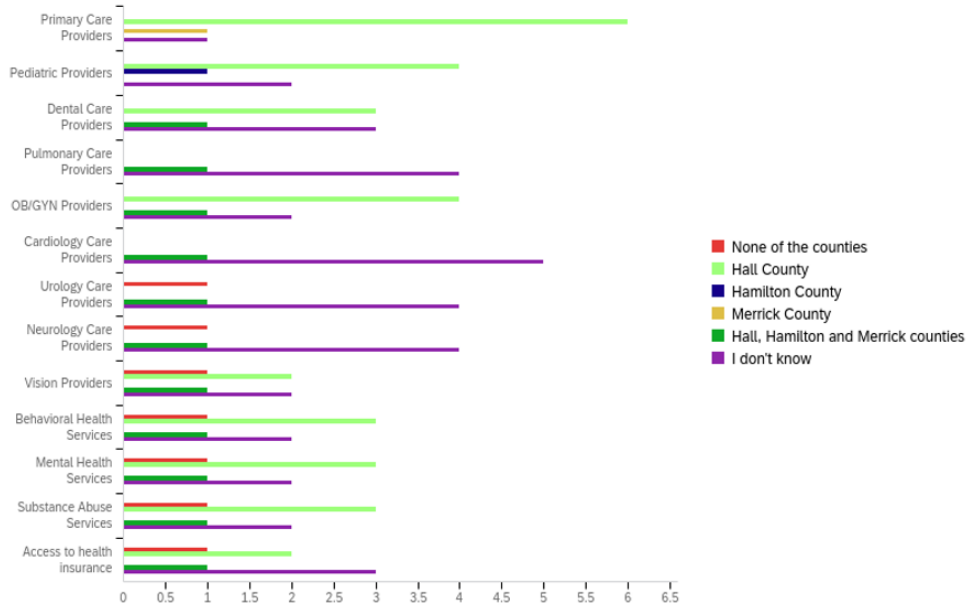
Q3#2 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - Hamilton County



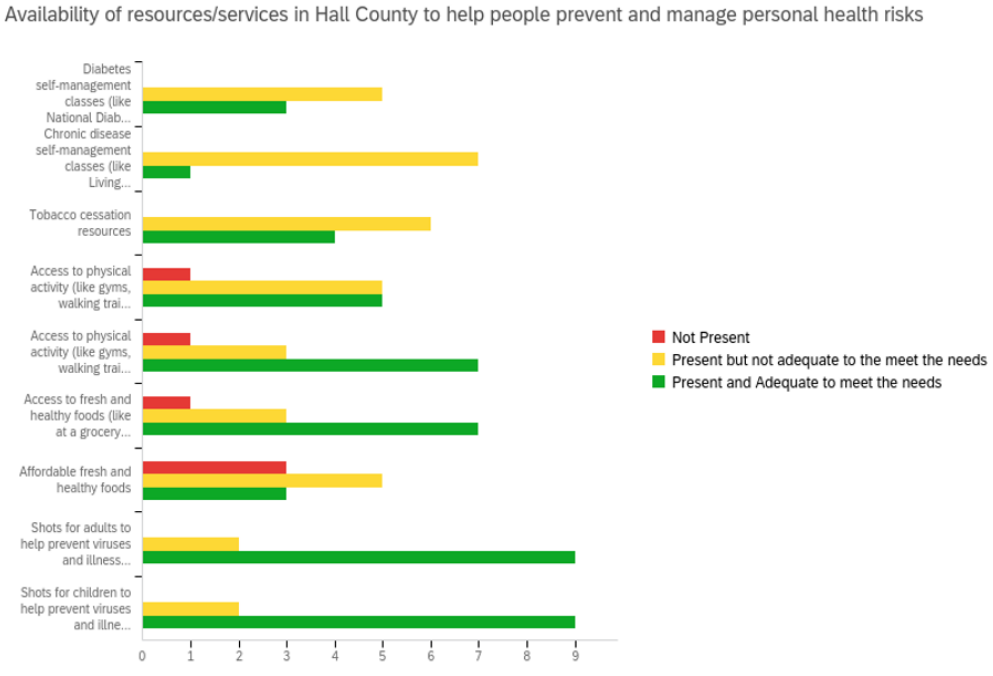
Q3#3 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - Merrick County



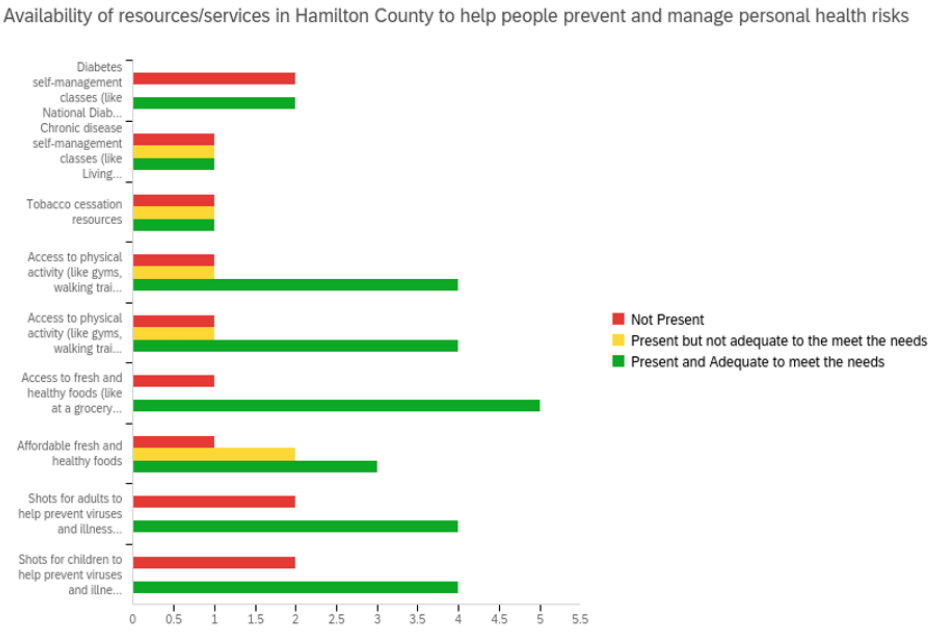
Q3#4 - Below is a list of medical resources/services. Please rate the availability of each resource/serv... - In which county is the resource/service available in other lanugages (by way of intrepration services or bilingual translation)?



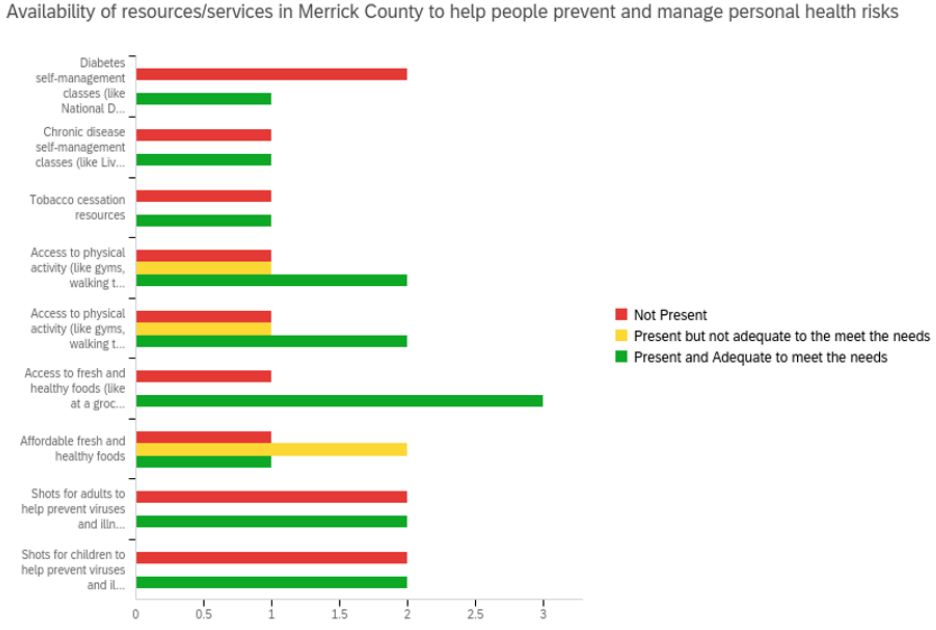
Q21#1 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - Hall County



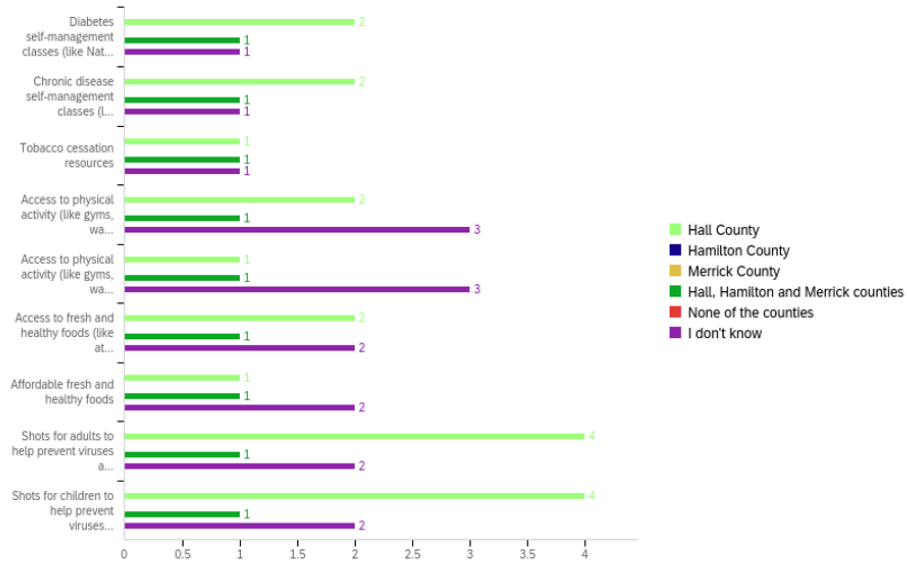
Q21#2 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - Hamilton County



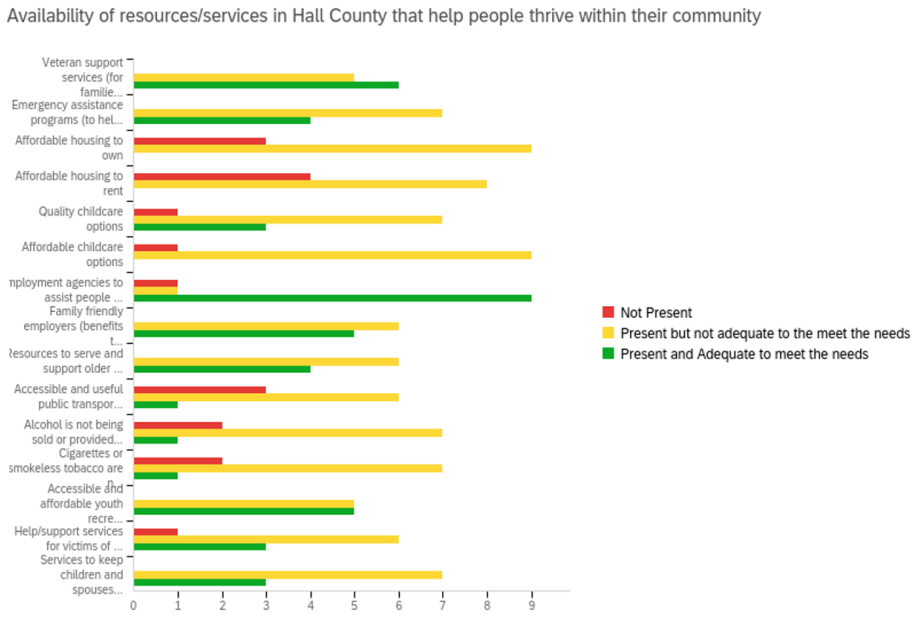
Q21#3 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - Merrick County



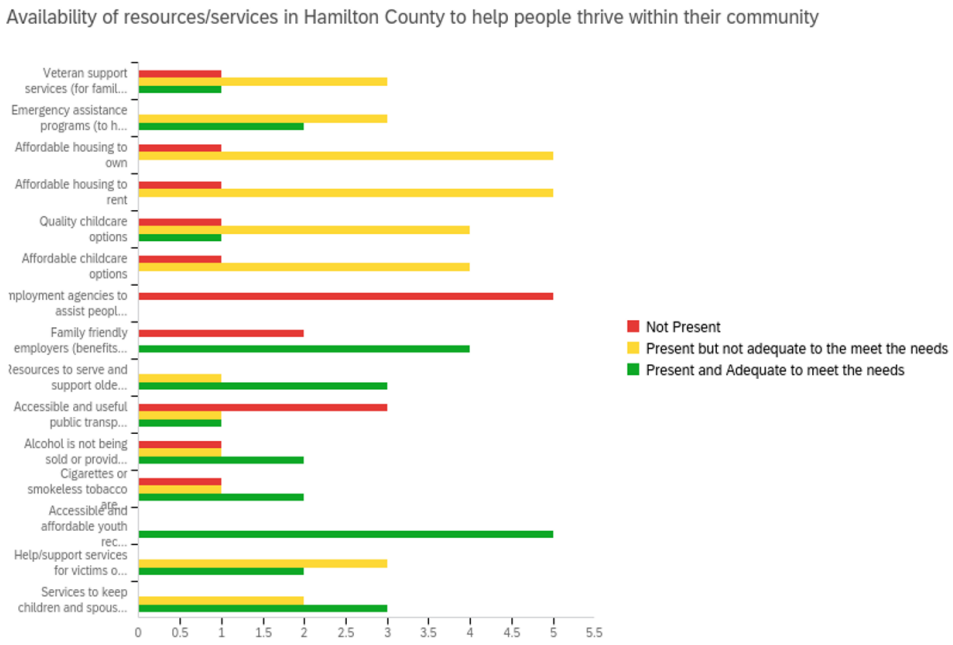
Q21#4 - Below is a list of resources/services to help people prevent and manage personal health risks. Pl... - In which county is the resource/service available in other lanugages (by way of intrepration services or bilingual translation)?



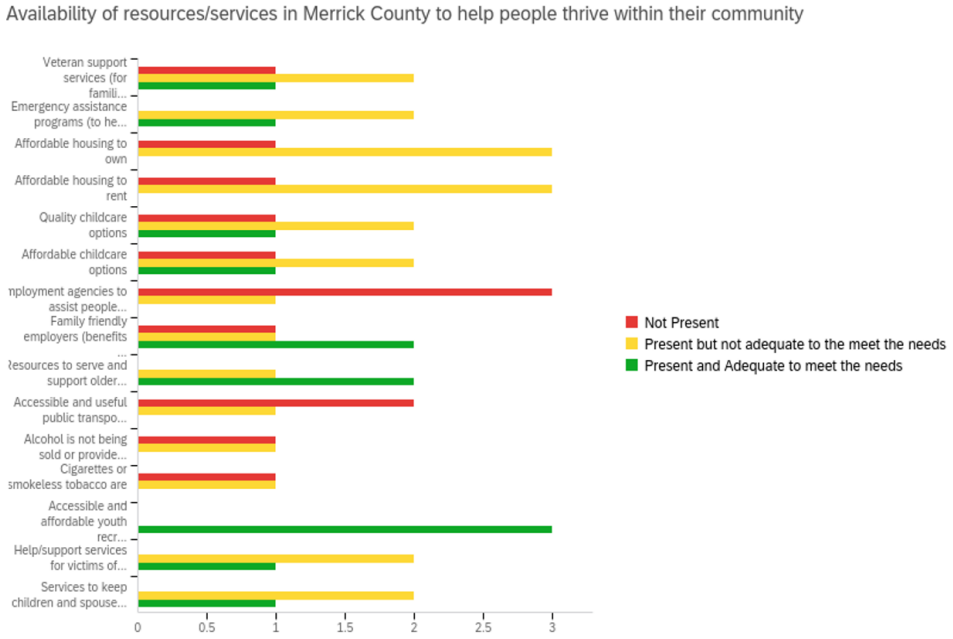
Q22#1 - Below is a list of resources/services that help people thrive within the Central District Health... - Hall County



Q22#2 - Below is a list of resources/services that help people thrive within the Central District Health... - Hamilton County



Q22#3 - Below is a list of resources/services that help people thrive within the Central District Health... - Merrick County



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Central District Health Department
HALL • HAMILTON • MERRICK

2021
Community Health Assessment Process
Summary

Facilitated by Sondra Nicholson, MPH, CHES
The Nebraska Association of Local Health Directors (NALHD)
Summary Submitted September 16, 2021

Central District Health Department (CDHD) contracted with the Nebraska Association of Local Health Directors (NALHD) to facilitate two, four-hour workshops to review data, to determine any additional data collections and mining needs and to set priorities. The workshops occurred via Zoom on June 15, 2021, and September 2, 2021. The participants engaged in a Technology of Participation (ToP) facilitated process.

Agenda June 15, 2021	**Agenda September 2, 2021**
Welcome, Introductions, and Context	Welcome, Introductions, and Context
Identify forces at play	Recap of data and reveal of new data
Review data	Discuss themes and identify priorities
Determine next steps	Plan for action
Closing conversations	Closing conversations and Next Steps
Participants: 24 participants (see sign-in sheets)	**Participants**: 25 participants (see sign-in sheets)

Rules of ENGAGEment:

- Make room for every voice

June 15, 2021, Meeting

To begin this workshop, a welcome and introductions were given. The NALHD facilitator broke out participants into small groups to identify the forces affecting health in their community and came back as a large group to discuss. The results follow:

Economic	• Businesses impacted by COVID-19 • Poverty rate • Healthcare worker shortage • Jobs/workers not returning to jobs • Online shopping impacts small brick/mortar businesses • Employers' expansion of remote working and other flexibility that wasn't an option before COVID
Environmental	• Housing shortage • Flood recovery • Access to clean water
Legal/Political	• Political concerns regarding safety/masks • Medicaid expansion • Vaccines turned very political • Issues (COVID, other) were politicized (for good/bad) and dealing with social perceptions as the after effect
Social/Family	• Lower volume of employees returning to work • Primarily women choosing to stay home instead of going back to a lower paying job • Increase in depression related to social distancing/isolation • Everyone (age, generational) impacted by stress/is under stress
Technological/ Scientific	• Tele-health access for those without internet • Navigating technology • Telehealth potential was more clearly demonstrated than before (+) ***Trend*** toward expanding broadband… more internet • Flipside: still need to help many folks navigate using tech
Other…	• Additional hospital/second hospital • Employment • Migration changes • Workforce not returning… women not reentering workforce • Stress for folks of all ages • Job losses • Impact of new • Reluctance to get usual care… staying home hurts local rural business • High achieving children may have had easier time than those who struggle. Teachers had to adapt daily. • Stressful year for everyone in GI and across the state • Summer school attendance is higher than any other year • Students playing catch up • Teachers and families learned to manage and to adapt • Schools found ways to meet needs of kid… academic and basic (food) ***Trends***: Increasing obesity rates for child and adults Alcohol consumption and alcoholism increasing Growing population overall and more diverse

Next, the group participated in small groups to review secondary data gathered for the community health assessment to identify what was known, what leaves them curious, and what opportunities exist for health in the CDHD area. A large group discussion followed to recap highlights of small group conversation. Results follow:

Data Recap: Health Behaviors

What do we know from looking at the data:

- **Obesity rates are alarming.**
- **Obesity and physical activity are related.**
- **Merrick County access to healthy foods relates to obesity rates.**
- **Sugared drink percentages are likely higher compared to what data presents**
- **PE is being decreased in schools- affects physical and mental status.**
- **Is diabetes higher in Merrick because of higher percentage of elderly?**
- **Merrick County has a very nice fitness center and a zero entry pool.**

What leaves us curious:

- **We are behind in physical activity in last 30 days.**
- **It would be interesting to compare health behaviors to issues like depression, etc.**

What opportunities stand out to you related to the data reviewed?

- **Opportunity to educate/promote community gardens, trails, and other community resources that may not be as well known as they can be, (or learn where we need more of these resources.)**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Healthcare Access

What do we know from looking at the data:

- **Hall County uninsured rate is too high.**
- **Ratio of mental health providers and primary care physicians in Merrick county are astronomically high**
- **Dentists and dental care are an issue.**
- **Mental health providers are always an issue as there are not enough.**
- **Merrick County uses a team-based approach to compensate for high panel rate.**
- **Mammogram rates are unacceptably low. Same with colon cancer.**
- **There is a lack of medicaid providers in our area**

What leaves us curious:

- **Medicaid expansion allowed people to get screenings that were desperately needed - how can we make this a long-term reality?**

What opportunities stand out to you related to the data reviewed?

- **We need to expand behavioral health.**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Health Outcomes

What do we know from looking at the data:

- **Really shocking stats about cancer death, compared to the national average**
- **Alzheimer's cases in Hall County are high.**
- **Rates of breast cancer in Merrick County/ also unintentional injuries are much higher than state average**
- **Breast cancer in merrick.**
- **Disparities in cancer types across counties**
- **Leading causes of death - alzheimers, pneumonia, unintentional injuries (Merrick County)**

What leaves us curious:

- **What is causing these high rates of cancer related deaths**?

What opportunities stand out to you related to the data reviewed?

- **Promote screenings now to catch lifestyle illnesses that are leading causes of death.**
- **Public health had to let some of these initiatives go on the back burner.**
- **Cancer education in Merrick County**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Housing and Transportation

What do we know from looking at the data:

- **% of Homes Occupied by Owner - more renters in Hall Co**
- **Residential value - seems low**
- **Transportation - texting and driving - low percentage**
- **Crowding houses - seems really low**
- **Vehicle data - we see families have only 1vehicle, so husbands take it to work but then the wife and kids don't have a vehicle to get to appts, etc.**
- **% households with severe housing problems**
- **Alcohol impairment seems really low.**
- **Cell phones and texting while driving is problematic.**

What makes us curious from looking at the data:

- **Due to younger population, single parent households, poverty? What is the key factor here**
- **What is severe housing problems?**
- **What is all considered in Group Quarters?**
- **Higher percentage of no vehicles in Merrick County. - Do they have public transportation? Is that an opportunity for them?**
- **With the other stats on single parent households and poverty, and a large amount of manufacturing and shift work expanded transportation seems to be a need**

What opportunities stand out to you related to the data reviewed?

- **Grand Island has high housing costs, and the statistics bear these out (high house values, low percentages of houses occupied by owners). Last year has exacerbated housing problems (people needing housing assistance, etc.)**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Minority and Language Status

What do we know from looking at the data:

- **Expected a higher percentage of origin hispanic people in Hall county**
- **Businesses needing more interpreters, we were surprised that the percentages weren't higher**
- **Hard to differentiate between race and ethnicity.**
- **"To me the most important piece on this is those who perceive themselves to speak English well"**
- **In Hamilton and Merrick there are less who speak English well, but there are greatly limited resources**

What leaves us curious:

- **What's the definition of Speaks English well (what is well?).. Hall county is only at 6.2%**

What opportunities stand out to you related to the data reviewed?

- **Generate opportunities for exposure to other communities within our town/city/county.**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Population Characteristics

What do we know from looking at the data:

- **Education and income differences**
- **Disparity in median household income Merrick vs. district**
- **Population growth in Hall vs the other counties**
- **A growth in second generation bilingual population, but not a growth of opportunity at the same rate**
- **Merrick county population decreased**
- **Working class population**

What leaves us curious:

- **Why is there more growth in Hall County vs other counties?**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Socioeconomic Status

What do we know from looking at the data:

- **Single parent households, especially in Hall County**
- **Disparity in income by ethnicity *YES- to add to that almost $40,000 difference between hispanic and white median income in Hamilton Co, $10,000 in Hall, and $5000 in Merrick**
- **Hall & Merrick county have higher poverty rates than NE state average**
- **Hall Co has about double the single parent households compared to the other counties- and higher than the state in general.**
- **Hall & Merrick counties have a lower median household income thank NE average, especially for hispanic households**
- **Differences in Salary**
- **Bachelor degrees are low**

What makes us curious from looking at the data:

- **Do the single-parent households qualify for Medicaid and if so, are there enough providers?**
- **Why is the median income disparity between Whites and Hispanics so large, especially in Merrick Co?**
- **How does the Hall Co single parent rate compare to other urban areas?**

What opportunities stand out to you related to the data reviewed?

- **Many opportunities to grow in the future; will the opportunities be scattered among entrepreneurs and small business, or focused on a single group?**
- **Opportunity to empower the Hispanic communities to grow their median household income**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

The participants reviewed a draft 5-question survey, developed by NALHD (adapted from Lincoln-Lancaster County Health Department) translated in 3 languages (Arabic, Somali and Spanish—provided by Central District Health Department) in addition to English, intended to allow respondents to tell LHDs their experience related to their health and the health of their community to identify emerging issues in the community. The survey will assist CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The group reviewed and agreed to launch the survey to community residents in person and by print through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Summary of all data is in the Community Health Assessment Report given to CDHD.

Closing and Next Steps

NALHD and Central District Health Department staff gave closing remarks. The group will reconvene September 2, 2021, to review the new data from the surveys and identify issues, prioritize said issues and plan for action.

September 2, 2021, Meeting

To begin this workshop, a welcome, introductions and context were given. NALHD facilitators broke participants into small groups to review the community health survey and resource inventory survey responses along with a recap of the review of secondary data presented during the June 15, 2021, meeting. In small groups participants were asked to respond to the following questions. Results from small group discussions follow.

What do we know about health in our community?

- Mental health: people unwilling to share or are unable to recognize. Screenings are down. People see it in others but not necessarily in themselves. Ask a kid why he uses a substance, and he can't tell you, but he can tell you why kids use substances.
- There are more instances where healthy people who are unvaccinated are getting sick. Wonder if they share their stories about being vaccinated.
- Intense fear of COVID and an intense fear of the vaccine. Leads to mental health issues.
- Continuous cortisol dumps lead to health issues (physical and mental).
- Ask your trusted health professional (not what you read or hear) but they are not asking until it is too late.
- People listen to who they trust- not necessarily a health professional.
- Conspiracy theory- do you really believe that doctors and health leaders are evil and are not being helpful?
- Humanize the folks who are in these positions. They are not aliens. This is just a kid that went into science. He learned a lot and is the best we have. It instills just a bit of doubt.
- Health Foods: Is it understanding, expense, transportation?
- Is it a challenge to get healthy food or to get healthy affordable food.
- Food may look healthy and when you see the ingredients, you see a lot of salt, etc.
- I see more related to "affordable" - healthy food is more expensive.
- Our org works with low income, when food is an issue, you take want you can get.
- Make neighborhoods healthier: Culturally desirable foods are sometimes less affordable.
- Varying neighborhoods- some have access to sidewalks, and opportunities for physical activity.
- If you work long shifts or two jobs, you don't have access to parks, etc.
- Do you feel safe in the neighborhood- how do you find out about drug deals and child molestation.
- Walking paths- are they safe from animals and traffic?
- Do we have access to hike/bike trails?
- Air quality- powder coat welding in neighborhood.
- Crowded housing. Where can kids play safely.
- Substance free- no drug deals in neighborhoods? Is this an issue for safety and health.

- Where we live is different- county and city demographics are different.
- Environmental Health: Our environment is contributing to poor health in a variety of ways.
- There may be a stigma on mental health issues, need for therapists, Food deserts-need for affordable food, lack or transportation to get to affordable foods...

What are our areas of strength?

- data analysis in a group setting is useful involving the community
- Childcare “Step-up to Quality” (H3C)
- smoking rates seem to be trending in the right direction (unexpected but good to see)
- good provision of youth activities and facilities in Hamilton and Merrick but not so much in Hall
- we have good services- just inadequate overall

What are our areas of opportunities?

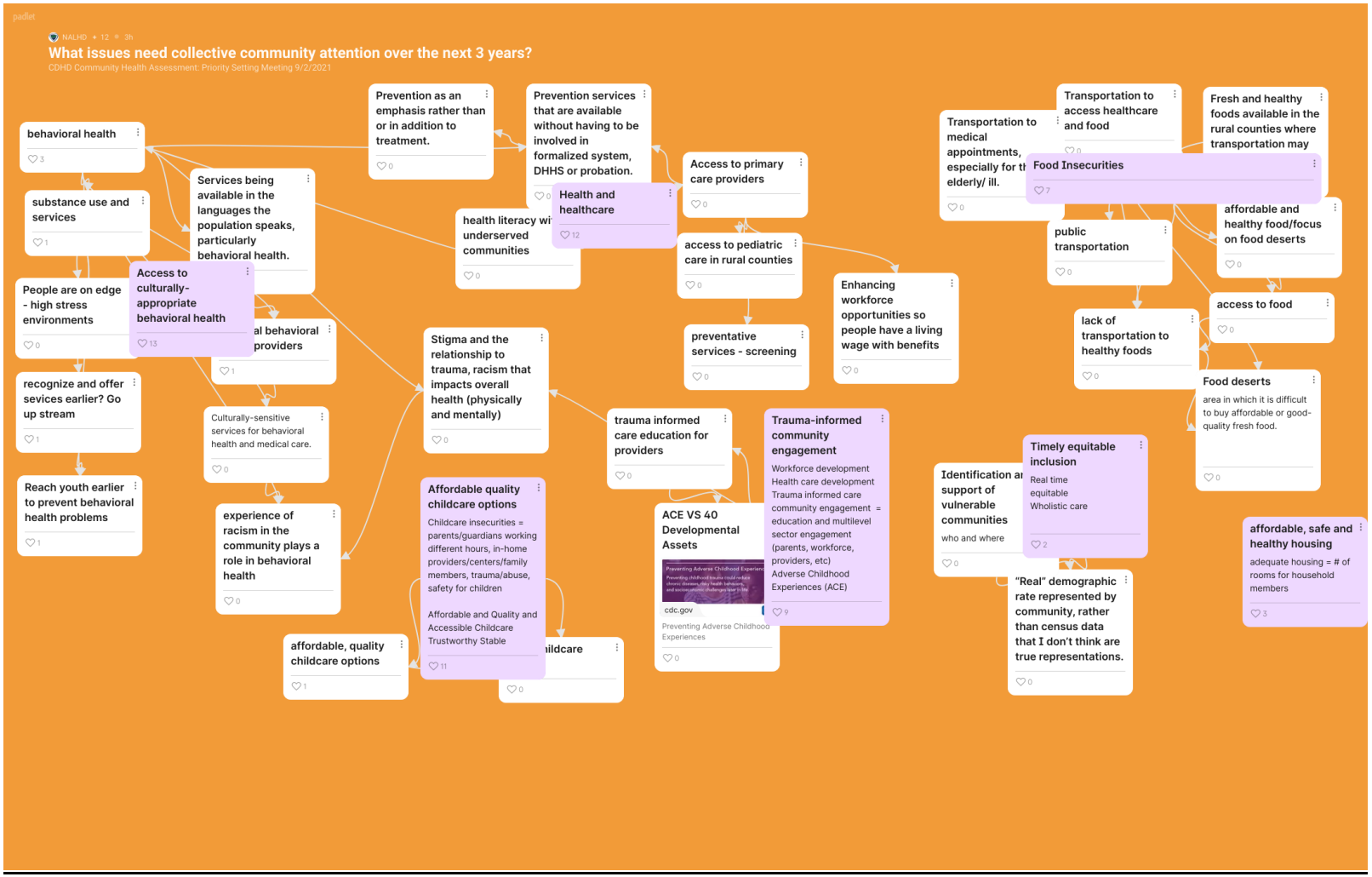
- access to services - lack of public transport
- access to local and healthier foods. Transportation is a key factor in getting families to grocery stores to get the healthier food. The main option is gas station food for most lower income families
- inadequate provision and access to childcare and affordable childcare
- need more involvement of youth in the survey as the answers to the provision of youth activities might be answered by adults who might think there is adequate provision when the reality may be different
- focus on mental health providers; need further discussion with the public via survey results; further discussion with nonprofit, local leaders, bilingual providers for services, why covid-19 impacted families (sickness, death, mental health, etc.) ** When our community comes together and discusses these issues our whole community wins!
- further to the above - possible disconnect between perceptions and realities between respondents assessing the needs outside their own group
- need to do a better job at informing people of available services

What new vantage point has this given us?

- We expected to see higher numbers of mental health responses. But we wonder if people are hesitant to reveal this information.
- that covid and diabetes is a bigger problem in the counties than first thought
- Language uses may not know what resources are available.
- unclear as to whether there's a problem for bilingual services as there is a lot of, I don't know
- Expand on language translation services.

Identify emerging issues and prioritizing issues—Large Group Work

NALHD asked the participants to focus on answering this question: **What issues need collective community attention over the next 3 years?** For the next part of the workshop. NALHD facilitators asked participants to write down 3-5 connections that are emerging from the data and conversation. Ideas were presented, grouped, and named by group consensus. Results from this workshop are as follows.



Participants were given 3 votes to divide up how they choose among the purple boxes. Voting was based on the following criteria:

- Size = many people affected
- Seriousness = many deaths, disabilities, hospitalizations
- Trends = getting worse, not better
- Equity = some groups affected more
- Intervention = proven strategies exist
- Values = our community cares about this
- Resources = Builds on current work
- Other?

Priorities chosen by the group included:

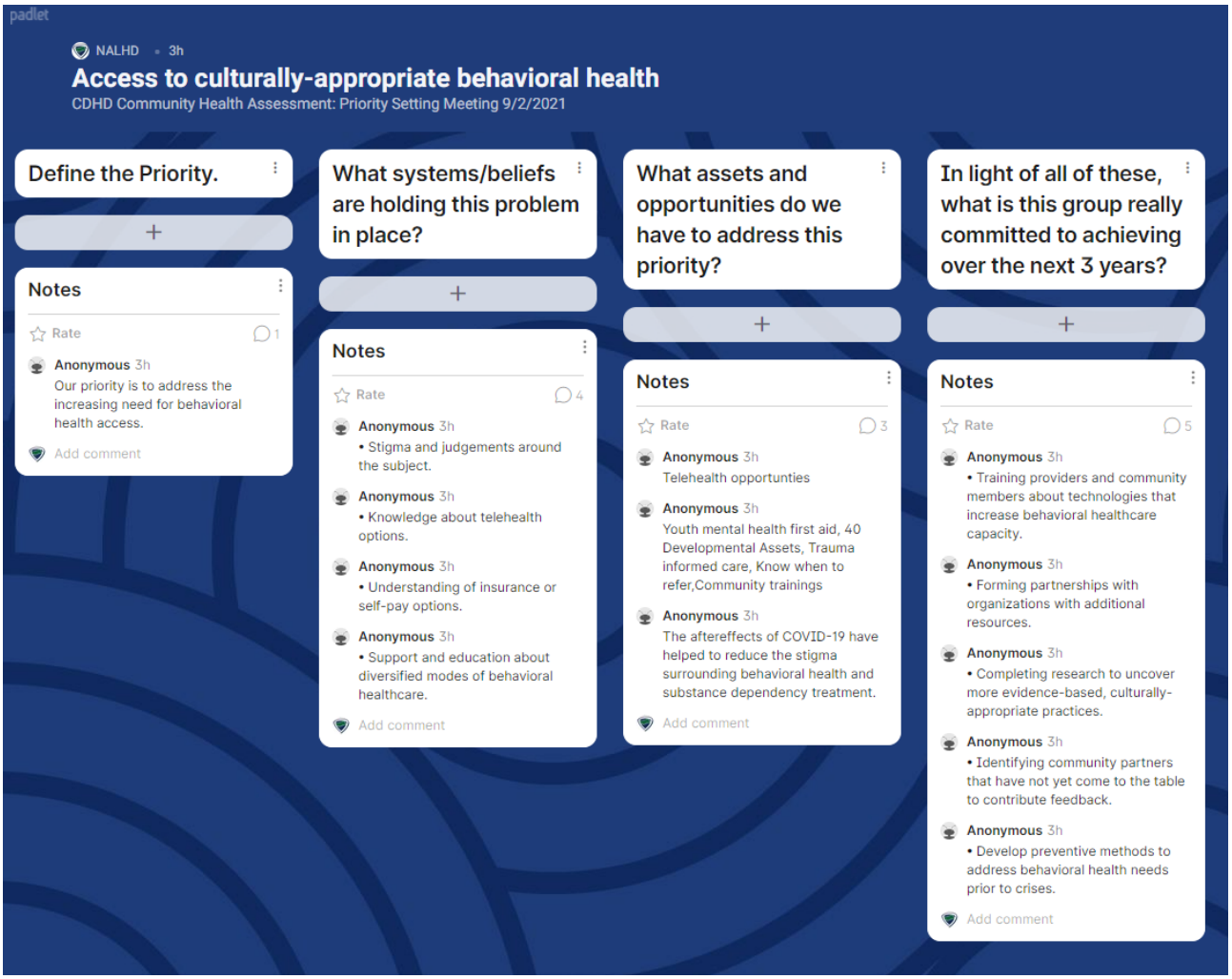
1. **Access to culturally appropriate behavioral health** = *13 votes*
2. **Health and healthcare** = *12 votes*
3. **Affordable quality childcare options** = *11 votes*

- Trauma-informed community engagement = *9 votes*
- Food insecurities = *7 votes*
- Timely equitable inclusion = *2 votes*

Plan for action

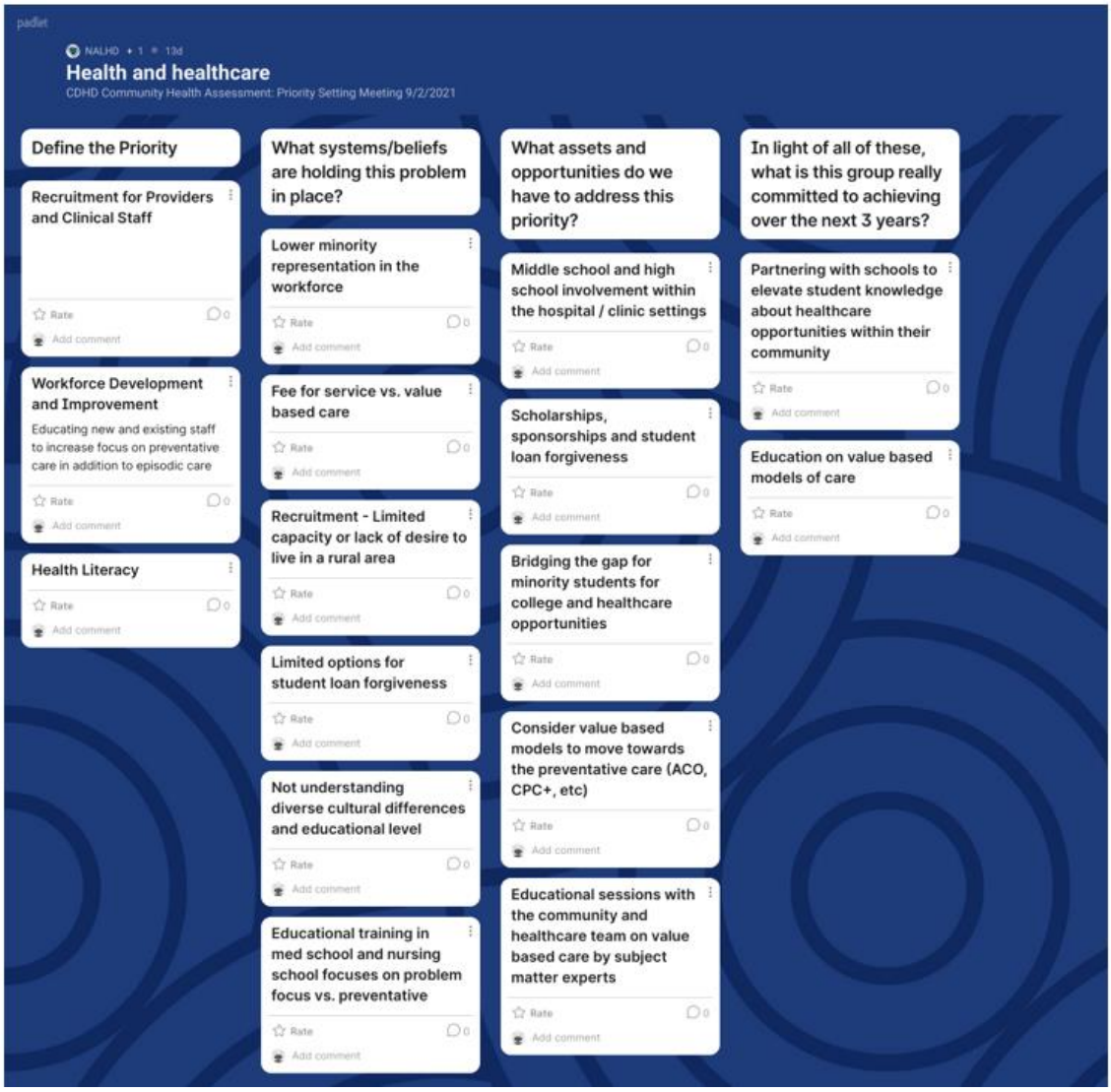
NALHD facilitators had participants self-select into the priority group of their choice to work on a plan for action. Groups were asked to define the priority; identify systems/beliefs that hold the problem in place; identify assets and opportunities to address the priority; decide what the group is really committed to doing over the next year. Results follow for each priority area.

Priority 1: **Access to culturally appropriate behavioral health**
Group members:

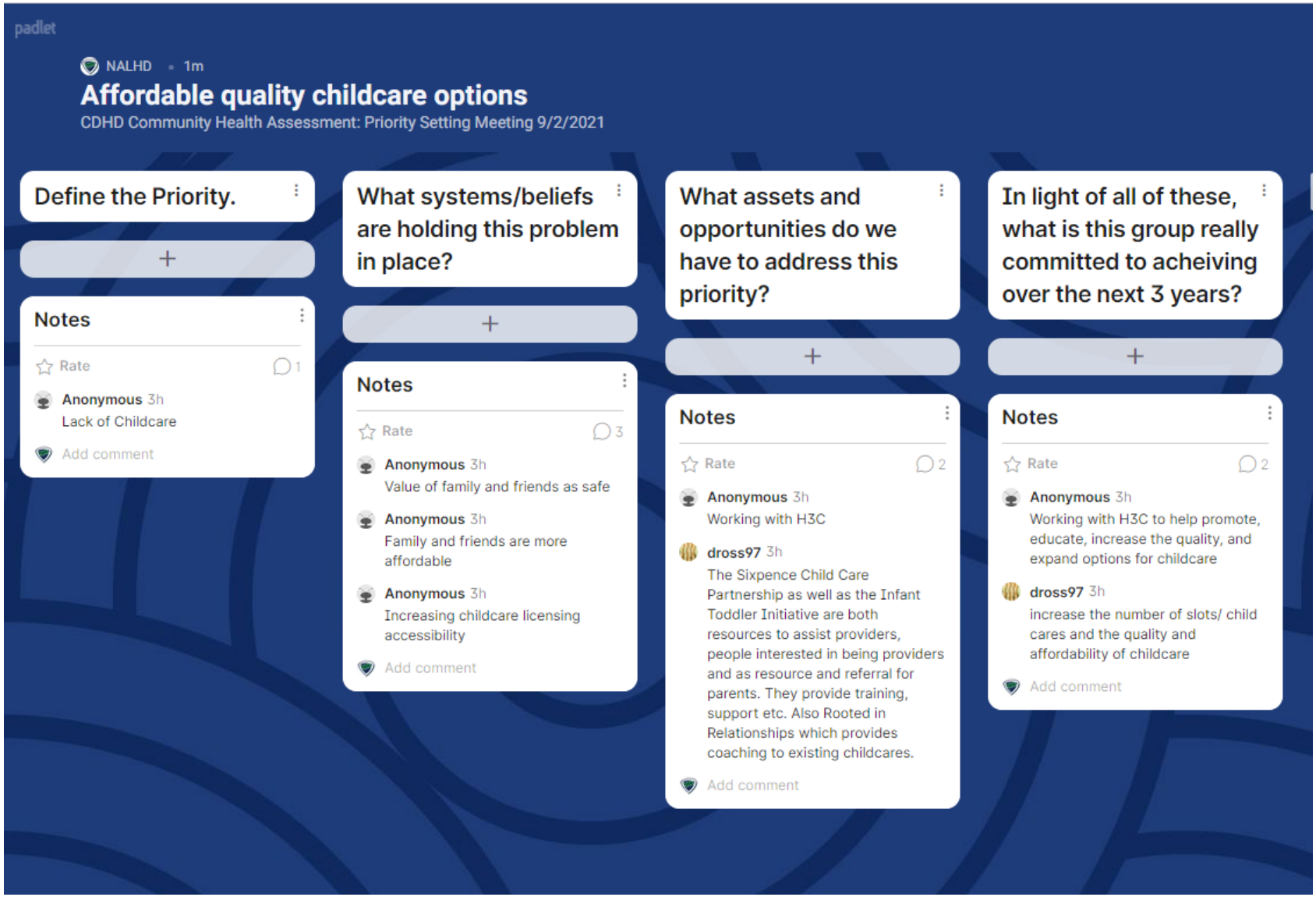


Priority 2: **Health and healthcare**

Group members: Brenda Lamb, Sarah Stanislav, Diana Kellogg?



Priority 3: **Affordable quality childcare options**
Group members:



Closing and Next Steps

NALHD will summarize this group work in a report for CDHD. Additionally, NALHD will finalize a draft CHA report for CDHD to review and make final. Once final, CDHD will distribute the CHA report to partners and convene partners around the first part of 2022 to launch the Community Health Improvement Planning process. CDHD gave closing remarks.

Appendix A
Sign-in sheet
June 15, 2021

First and Last Name	Organization or role you represent	What new ways of working is COVID showing to us?
Randy See	Hall County Juvenile Services	Working on-line
Diane Keller	MCHI	Daily changes
Alisa Schurr	Bryan Health Merrick Medical	Telemed a
Brenda Lamb	Bryan Health Rural Division	Virtual meetings are at an all-time high, so even if a pandemic hit you can still connect for meetings
Liz Mayfield	Hope Harbor	It has highlighted new ways to connect virtually with clients
Todd McCoy	GI Parks and Recreation	When there is a will there's a way!
Lindy Flynn	MCHI	Made us think of new and sometimes more efficient ways
Rachel Sazama	CDHD/WIC	Completing services remotely
Jeff Edwards	Northwest Public Schools	
Deb Ross	Head Start CFDP Inc.	Providing virtual services to families and children
Carlos Barcenas	iChoosePurple Consulting	Creating meaningful Virtual Connections
Alaina Friest	Grand Island Regional Medical Center	
Cindy Johnson	Grand Island Chamber of Commerce	Service delivery in new ways
Heather Roy	Hall County Housing Authority	
Colette Evans	Central District Health Department	Working remotely, zoom connections
Anna Rodriguez	Central District Health Department	Remote communication/services

Appendix A
Sign-in sheet
June 15, 2021

Jeremy Collinson	CDHD	Zoom Meetings
Jerry Janulewicz	City of Grand Island	Zoom meetings
Jennifer Hubl	CDHD	
Ron Peterson	Hall County Commissioner	
Katie Usasz	Prevention Project	Working remotely, working together with people who in regular circumstances
Teresa Anderson	CDHD	Collaboration is even more important than ever!!!
Nathan Albright	Bryan Health	Collaboration with other entities
Sarah Stanislav	CHI Health	Strength in new partnerships
Tami Smith	Heartland Health Center	Telemedicine and new partnerships
Sondra Nicholson	NAHLD	
Susan Bockrath	NAHLD	
Chuck Haase	GI City Council, BOH	
Linda Flynn	Aurora Community Health	
Karen Rathke	United Way	
Shoaib Junejo	CHI Health/CDHD Intern	
Eric Melcher	City of Aurora	
Julie Nash	H3C	
Liza Ayala		
Connie Homes	Council of Alcoholism and Addictions	

Appendix B
Sign-in sheet
September 2, 2021

Sign In	
Central District Community Health Assessment Meeting Sept 2, 2021	
Name	**Organization**
Alissa Schurr	Merrick Medical Center
Daniel Petersen	Multicultural Coalition
Eric Melcher	City of Aurora
Eric Garcia-Mendez	Heartland United Way
Deb Ross	Head Start CFDP Inc.
Jerry Janulewicz	City of Grand Island
Sarah Stanislav	CHI Health St. Francis
Karen Rathke	Heartland United Way
Lindy Flynn	Memorial Community Health Inc
Cami Wells	Nebraska Extension
Jeff Edwards	NWPS
Holly Boeselager	Grand Island Public Schools, H3C
Katie Usasz	Prevention Project
Brenda Lamb	Bryan Health Rural Division - Supporting Merrick Medical Center
Nathan Albright	Bryan Health
Liz Mayfield	Hope Harbor
Jennifer Hubl	CDHD
Robin Dexter	Grand Island Public Schools
Liza Thalken	CDHD
Randy See	Hall Co. Juvenile Services
Rachel Sazama	CDHD- WIC Supervisor
Andrew Hills	(C.D.H.D.)
Connie Holmes	Council on Alcoholism and Addictions
Teresa Anderson	Central District Health Department
Susan Bockrath	NALHD
Sondra Nicholson	Nebraska Association of Local Health Directors (NALHD)
Jeremy Collinson	CDHD
Ron Peterson	Hall County Commissioner, CDHD Board
Alaina Friest	Grand Island Regional Medical Center
Diana Kellog	CHI Foundation, HC3 Board
Kamrie Peterson	CDHD
Diane Keller	Memorial Community Health
Kathleen Stolz	Central NE DHHS