Community Health Needs Assessment

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

2019

A Joint Assessment

CHI Health

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Executive Summary

"The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities."

CHI Health is a regional health network consisting of 14 hospitals, two stand-alone behavioral health facilities, a free standing emergency department, 136 employed physician practice locations and more than 11,000 employees in Nebraska 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 wall. 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 community health needs assessment (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.

CHI Health St. Francis (St. Francis) is a 159-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 a 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.

Community Health Needs Assessment

In Fiscal Year 2019 (FY19), St. Francis and the SNU conducted a Community Health Needs Assessment (CHNA) in partnership with Central District Health Department 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 five priority health needs for Hall County. With the community, the Hospitals will further work to identify our role in addressing these health needs and develop measureable, 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 2019.

The process and findings for the CHNA are detailed in the following report. If you would like additional information on this Community Health Needs Assessment please contact Kelly Nielsen, Kelly.nielsen@alegent.org, (402)343-4548.

Introduction

Hospital Description

CHI Health is a regional health network with a unified mission: nurturing the healing ministry of the Church while creating healthier communities. Headquartered in Omaha, the combined organization consists of 14 hospitals, two stand-alone behavioral health facilities, a free standing emergency department, and more than 136 employed physician practice locations in Nebraska and southwestern Iowa. More than 11,000 employees comprise the workforce of this network that includes 2,180 licensed beds and serves as the primary teaching partner of Creighton University's health sciences schools. In fiscal year 2018, the organization provided a combined $179.3 million in quantified community benefit including services for the poor, free clinics, education and research. Seven hospitals within the system are designated Magnet or Pathway to Excellence. With locations stretching from North Platte, Nebraska, to Corning, Iowa, the health network is the largest in Nebraska, providing care for over one million patients each year and serves residents of Nebraska and southwest Iowa. For more information, visit CHIhealth.com.

CHI Health St. Francis (St. Francis), located in Grand Island, Nebraska, is a nonprofit, faith-based healthcare provider as part of CHI Health. Founded in 1883 by the Sisters of St. Francis, this hospital is now a regional treatment center, with more than 100 physicians and 900 employees working together to build a healthier community. With 159 licensed beds, St. Francis has extensive experience in the treatment areas of:

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

The Saint Francis Skilled Nursing Unit (SNU) received its license to practice in 1986, at the same time of 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 assists close to 350 patients each year and served 322 patients during fiscal years 2017-2018. The nursing care encompasses skilled nursing procedures, observations and assessment of the patients' changing needs. The Unit 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.

Community Definition

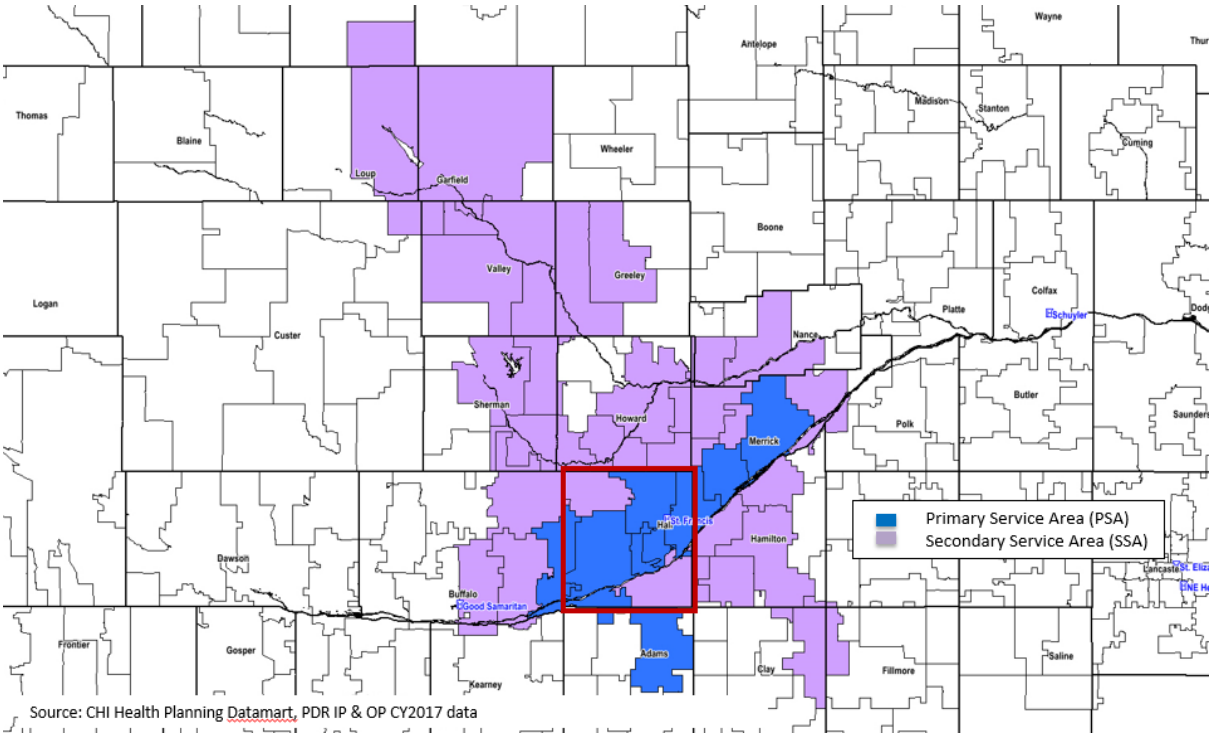
For the purpose of the CHNA and future implementation strategy, St. Francis and the SNU considers its primary community to be Hall County, Nebraska. This definition was determined by internal hospital leaders engaged in the hospital's Community Benefit Action Team (CBAT) and the local health department,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

Hall County covers approximately 550 square miles, including five communities with over 61,000 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: Community Served



Community Description

Population

As shown in Table 1, the 2018 population estimate for Hall County is 61,607, and has increased by 5% since 2010. The percent of African American increased from 2.7% of the population to 3.3% since the 2014 Census estimate, and Hispanic populations have increased from 25.9% in 2014 to 27.9% in 2018. Foreign born population makes up much more significant portion of the population in Hall County

13.8%) compared to the State (6.9%).[1] Hall County is uniquely a multicultural community. The most common foreign languages spoken in Hall County are Spanish or Spanish Creole (over 10,000 speakers), African Languages (375 speakers) and Laotian (over 220 speakers).[2] As of 2017, over 13% of Hall County residents were born outside the U.S., however this is a decrease from 14.4% in 2016. 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.

Table 1: Population Characteristics[1]

	Hall County	Nebraska
Total Population 2018	61,607	1,929,268
Population per square mile (density)	107.3	23.8
Age		
% below 18 years of age	27.2%	24.8%
% 65 and older	14.6%	15.4%
Gender		
% Female	49.5%	50.1%
Race		
% Black or African American	3.3%	5.1%
% American Indian and Alaskan Native	1.9%	1.5%
% Asian	1.5%	2.6%
% Native Hawaiian/Other Pacific Islander	0.5%	0.1%
% Hispanic	27.9%	11.0%
% Non-Hispanic White	66.8%	79.0%
% Foreign born persons	13.8%	6.9%

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 poverty rates. Poverty rates have declined from 14.7% in 2014 to 12.0% in 2018 for Hall County, and from 12.9% to 10.8% for Nebraska overall. Interestingly the percentage of children in poverty (17% for Hall County) is lower overall since 2013, however is still higher than the State at 14%.[3] When looking at the percentage of children in poverty by race and ethnicity, we see a large disparity as shown in Table 2. Since the 2016 CHNA, Hall County and Nebraska overall have seen slight improvement in unemployment rates, while education rates have remained steady. The percent

[1] Census.gov/quickfacts, accessed 4/23/19
[2] DataUSA https://datausa.io/profile/geo/hall-county-ne/#demographics, accessed 4/23/19
[3] County Health Rankings, countyhealthrankings.org, accessed 4/23/19

of population under 65 years of age without health insurance has dropped dramatically from 22% down to 13.4% in Hall County, and from 16% to 9.6% in Nebraska overall. Importantly, Nebraska voters approved Medicaid expansion during the 2018 legislative session, so the state uninsured rate should further decline over the next several years.

Table 2: Socioeconomic Factors*Error! Bookmark not defined.*

	Hall County	Nebraska
Income		
Median Household Income	$53,807	$55,675
Poverty Rates		
Persons in Poverty	12.0%	10.8%
Children in Poverty[3] % children in poverty (Black) % children in poverty (Hispanic) % children in poverty (White)	17% 51% 31% 11%	14%
Unemployment		
Unemployment Rate[3]	3.4%	2.9%
Education		
High School Graduation Rates[3]	90%	89%
Some College[3]	55%	71%
Uninsured		
% of Population under 65 without insurance	13.4%	9.6%
% of Uninsured Children[3]	7%	5%

Unique Community Characteristics

Doane College and Central Community College provide students local opportunities to pursue associates and bachelor's degrees. In addition, Grand Island is home to the Nebraska State Fair, drawing a crowd of over 300,000 from around the State and region each year in September.

Other Health Services

Grand Island has a 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. A new 17,000 square foot hospital is slated to open in 2019, and some of the prominent health providers available throughout the county, include:

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

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 Central District Health Department (CDHD) and involved a secondary data review and three 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.

Community Input Sessions

- On January 7, 2019, St. Francis hosted a broad group of community stakeholders convened by CDHD for a data presentation (available in Appendix A) and 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.
- On January 9, the health department then led a meeting with members of the Hall County Community Collaborative (H3C). Similarly, the data was presented, and discussions were held within small groups to prioritize needs.
- Finally on January 14, the CDHD Board of Health reviewed the data and had a similar discussion to prioritize top needs for the three-county region of the Central District Health Department (Hall, Hamilton, and Merrick Counties).

Following completion of the community process and three meetings hosted by CDHD, the internal multi-disciplinary team Community Benefit Action Team (CBAT) was convened to validate the community findings and confirm the top identified health needs.

Community Benefit Action Team Members (CBAT) 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
- Melissa Griffith, Director of Foundation, CHI Health St. Francis
- Diana Kellogg, Foundation Coordinator, CHI Health St. Francis
- Jeff Vipond, CHI Health Partners
- Theresa Jorgensen, Director Skilled Care, CHI Health St. Francis Skilled Nursing Facility
- Arli Boustead, Healthier Communities Coordinator, CHI Health

The top identified needs were then shared with the St. Francis Community Board on January 17, 2019 for further validation, and to begin to prioritize health needs that St. Francis and SNU would address in the forthcoming Implementation Strategy Plan.

Gaps in Information

Primary gaps in information relate to availability of health need data by race and ethnicity. During the community input session on January 7, the community called out the need to review the data across race and ethnicity. Often data is not available to compare disparate outcomes among populations, despite the large percentage of minority populations present in the region, however the health department has committed to digging deeper into data related to prioritized health needs, as they form their health improvement plans in partnership with the community. Additionally, data related to opioid use is not available at the county level. Data will be sought from community partners to address gaps in information as needs are further prioritized.

Input from Community & Public Health

The process of obtaining input for this CHNA process was led and supplemented by the local health department (CDHD), and input from the community was primarily sought through three community-based meetings described above. 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.

Organizations providing input at the community engagement session on January 7, 2019 included:

- Central District Health Department (CDHD) staff and leadership
- CDHD Board of Health
- Central Nebraska Coalition on Alcoholism and Addiction
- Central Plains Center for Services
- CHI Health
- CHI Health St. Francis
- CHI Health Partners
- City of Grand Island (City Clerk)
- Grand Island Community Foundation
- Grand Island Latino Network
- Grand Island Police Department
- Heartland United Way
- Heartland Workers Center
- Mid-Plains Center
- Midland Area Agency on Aging
- Multicultural Coalition of Grand Island
- Nebraska Department of Health & Human Services
- Nebraska Extension
- Region 3 Behavioral Health Services

For a detailed summary of the input provided as part of the January 7 meeting, see Appendix B.

As mentioned above, the community input session on January 9 was conducted with H3C, a collective impact coalition dedicated to improving behavioral health and overall health outcomes in the community, and the January 14, 2019 meeting was a presentation and discussion with the Central District Health Department Board of Health.

In addition to the community meeting and attendees described above, St. Francis and SNU leadership presented the findings from these CHNA meetings to the hospital's Grand Island Community Board for further validation of the top identified health needs for Hall County.

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 Central District Data Presentation attached in Appendix A. Detailed findings related to identified health needs are listed below in Table 3.

Data provided by CDHD (health department) was presented to community stakeholders, St. Francis and SNU hospital administration community benefit team, and the hospitals' community board for validation of the top identified needs. All parties who reviewed the data found the data to accurately represent the needs of the community.

Prioritization

Central District Health Department (CDHD) conducted facilitated conversations in the three community input sessions described above, to engage participants in prioritizing health needs. The health department asked participants to prioritize health needs based on:

- Prevalence
- Severity
- Trend
- Disparities, and
- Existing resources

Upon completion of the three sessions, the health department aggregated the scoring of the community stakeholders to identify seven top health needs prioritized by the community.

Prioritized Health Needs (Top Identified Health Needs)

Below (Table 3) is a listing and rationale for the top seven identified health needs that are driving poor health outcomes in Hall County.

Table 3: Top Identified Health Needs

Significant Health Need	Rationale

Access to Care	• Ratio of population to provider: Primary care physician 1,510:1 Hall Cty, 1,320:1 NE
	• 24% of population has no personal doctor in Hall compared to 19.9% in NE
	• 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
	• Community highlighted needs related to:
	  • Nebraska has high rate of high deductible health plans
	  • Immigration status discrepancies affect accuracy of records
	  • Access to quality child care (Heartland UW)
	  • Transportation

	• Homelessness
Aging Issues	• 29.5% age 45 and older had a fall in the past year • 9.1% age 45 and older were injured due to a fall • 20% were ever told they have depression • Community reports challenges with adequate housing for seniors • Community reports transportation for seniors is a challenge in Hall County
Behavioral Health (Includes mental health & substance abuse)	• Community ranked substance abuse highest need across community input sessions • Suicide the 10th leading cause of death in Central District three-county region • Youth substance abuse related to Juuling on the rise according to schools and law enforcement • Drug and Opioid-related overdose fatalities 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. • Community reports quality affordable housing is lacking in Hall County area

Culture of Health (Also identified as Social Determinants of Health)	• Social needs driving behavioral health challenges
	  • 3.4% Unemployment rate higher than State at 2.9%
	  • 17% Children live in poverty in Hall County compared to 14% in State
	  • 38% Children live in single-parent households compared to surrounding counties: 19% in Hamilton County; 29% in Merrick
	  • Median household income = $52,100 (state =$57,000)
	• 61% Children eligible for free/reduced lunches compared to surrounding counties: 35% Hamilton; 44% Merrick

Maternal, Infant & Child Health	• 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 • Teen births by Health District (%) 2011-2015 Central District: 9.0 (NE: 5.9); 2015 Central District: 7.0 (NE: 5.2) • 11.0% of live births in Hall County are delivered premature compared to 9.9% in NE • In 2015 Births to unmarried women is 406.4 per 1,000 in Hall County compared to 239.2 in NE • Community reports need for additional prenatal OB services within FQHC for local deliveries

Obesity	• Obesity still trending up in the Central District three-county region with 2017 rate at 36.% of population at a BMI of 30 or greater, where 2011-2017 average was 34.6%, and slightly above the state rate in 2017 of 32.8%
	• Percent of population considered overweight (BMI of 25+) at 70.9% just over the state rate of 69%
	• From the Behavioral Risk Factor Surveillance System (BRFSS), 39.8% are watching salt intake
	  • Average fruit serving/day of BRFSS respondents is 1
	  • 39.3% eat less than one fruit serving/day
	  • Average vegetable serving/day -1.6
	  • 25.5% eat less than one vegetable serving/day
	  • 32.6% had no leisure-time physical activity in past 30 days
	  • 15.4% met both aerobic physical activity and muscle strengthening recommendations

Violence	• Domestic assaults increased dramatically across all types: Aggravated, simple, and arrests for both types trending up dramatically since 2014
	  • Aggravated domestic assault (use of a weapon): 97 in 2017 up from 48 in 2016
	  • Arrests for Aggravated domestic assaults: 81 in 2017, up from 9 in 2016
	  • Simple domestic assault (no weapon) 308 in 2017, up from 273 in 2016
	  • Arrests for simple domestic assault 176 in 2017, up from 19 in 2016

	• Accident death rate (age-adjusted) down in 2014 at 36 per 100,000 from 42 per 100,000 in 2009
	• Injury information from BRFSS:
	  • 72.5 % wear seatbelts when driving or riding in a car
	  • 31.6% texted while driving in the past 30 days
	  • 64% talked on cell phone while driving

Resource Inventory

Table 4 displays a list of resources assets and resources available as the GS and RYBHC 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
	• New Hospital slated to complete 2019
	• Dental (CDHD) Screenings, fillings, fluoride at HH (in partnership with Third City
	• 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

Aging	• Midland Area Agency on Agency • Living Well with Diabetes & Diabetes Prevention Program • 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
Culture of Health (Also identified as 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
Maternal, Infant & Child Health	• Women, Infants, and Children (WIC) • Central District Health Department • Heartland Health
Obesity	• 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
Violence (Includes Injury)	• School resource office (RSOs) • Central Nebraska Child Advocacy Center • St. Francis/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

Evaluation of FY17-FY19 Community Health Implementation Strategy Plan

The previous Community Health Needs Assessment for CHI Health St. Francis was conducted in 2016. The hospital completed the **c**ommunity benefit activities listed below for the community health priorities identified in 2016. The priority areas in 2016 were:

1. Behavioral Health
2. Injury & Violence
3. Access to Care

Priority Area # 1: Behavioral Health

Goal	To increase the preventive outreach, educational efforts and resources that support the resiliency of community members who experience mental health and substance use issues.
Community Indicators	**CHNA 2013** • 12.1% of adults 18+ reported frequent mental distress in the past 30 days. • The suicide death rate was 9.3 per 100,000 population (age-adjusted).
	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 TBD
Timeframe	FY17-19
Background	**Rationale for priority:** Behavioral health is consistently identified as a top health priority for the community. The suicide death rate has increased over time, access to behavioral health services and the cost of mental health services are reported barriers to accessing care for people with mental health problems in the community.
	Contributing Factors: Cost, fragmentation of services, lack of availability of services, societal stigma toward mental illness.
	National Alignment: Healthy People 2020 Goal is to improve mental health through prevention and by ensuring access to appropriate, quality mental health services.

1.1 Strategy & Scope: Expand behavioral health prevention that educates and engages parents of children and youth through the support of Parent University concept in Hall County, NE.

Anticipated Impact	Hospital Role/ Required Resources	Partners
• Improved positive parent/child relationships • Parents indicate a more positive relationship with children, etc. • Improve children's knowledge and practice of good behaviors including dangers of alcohol, tobacco and drugs, etc. • Families stabilized through in-home Family Services. • Improvement in community child well-being indicators	CHI Health System (Behavioral Health Service Line)* Role(s): • Provide financial support • Strategic oversight • Grant management CHI Health St. Francis Role(s): • Local Sponsor • Fiscal Agency • Technical assistance staff (257 hours per year)	• Hall County Community Collaborative (H3C) • Grand Island Public Schools • Central Nebraska Council on Alcoholism And Addictions

	• Coordinator staff – .25 (580 hours) • Community Partner Required Resources: • CHI Mission an Ministry grant funding – 146,268 for 3 years • Other H3C and GIPS funding • Hall County Community Collaborative (H3C) Backbone Organization • Community partners	
Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Implement the Circle of Security- Parent (COSP) program and identify potential educators in the community to be trained (up to 2 individuals). • Offer up to 4 COSP classes in year one. ○ Offer up to 5 COSP classes in year 2 and 3 • Train and secure additional Discovery Kids staff to implement program in additional schools for the 2nd -5th grade children 5-6 series per year. • Expand Discovery Kids in the Elementary Schools of 5-6 series per year. • Begin developing a sustainability plan for post grant. • Finalize sustainability plan and prepare to implement.	• % of COSP parents that indicate a more positive relationship with children • % of Discover Kids showing increasing knowledge of steps to reach goals, who make good choices, and know about dangers of alcohol, tobacco, and drugs, etc. • Improvements in CWB indicators • Implementation plan developed? (yes/no) • # of individuals trained to be trainers • # of Circle of Security – Parent (COSP) classes offered • # of parents completing the COSP class • # of children participating in Discovery Kid • Began developing a sustainability plan? (yes/no) • Sustainability plan completed? (yes/no)	Data will be reviewed and reported annually by an internal team using the following data sources: • COSP Parent survey-post/at the end of the program • Discovery Kids pre/post program survey • Nebraska Children CWB indicators
Results		
RESULTS: **FY17 Key Activities:** ▪ Trained trainers in Circle of Security Parenting (COSP) and planning classes for FY18 ▪ Working to expand Discovery Kids sites in Grand Island Public Schools ▪ Planning groups working to ID long-term implementation and sustainability **FY17 Measures:** ▪ 71 youth participating in Discovery Kids after-school program at three locations ▪ 150 families took part in celebrations with Discovery Kids		

- 4 trained professionals ready to train others in COSP

FY18 Key Activities:

- CHI Health St. Francis collaborated with Hall County Community Collaborative (H3C) to administer grant funding for the Parent University concept in Hall County, NE led by the Central Nebraska Council on Alcoholism and Addictions (CNCAA).
- CNCAA delivered two primary programs as a result of the grant funding
    - Circle of Security (COS), which is an evidence-based program to help parents increase positive and secure attachments with their children.
    - Discovery Kids is a youth resilience program offered to elementary-aged school children in a group setting.
- CHI Health St. Francis and H3C also worked to address sustainability of these programs upon in anticipation of grant ending at the end of FY19.
    - COS program has been wrapped under a new grant through Nebraska Children and Families Foundation and the Rooted in Relationships programming offered to improve family stability and resilience.
    - Began to explore the Nebraska System of Care work convened by Nebraska Department of Health and Human Services, to ensure local work is in alignment with statewide efforts.

FY18 Measures:

- Trained two Spanish-speaking facilitators to provide COS
- Held 2 8-week sessions of COS involving 6 different organizations and 8 supporting staff
    - 36 parents were recruited from general community and child care centers in Hall County
    - 18 parents completed classes, which directly serves 67 children
        - October to November 2017: 5 began the class and 1 completed the survey
        - November to December 19, 2017: 5 individuals and 4 of those completed the end survey.
        - January 3 - February 21, 2018 5 individuals registered and 4 completed the end survey
        - January 25-March 3, 2018 6 individuals registered and 4 completed the end survey.
        - March 29-May 9, 2018 5 individuals registered and 5 completed the survey
        - May - June 7, 2018 -10 Individuals registered and 8 completed the class.
    - Outcomes from participant surveys responding to questions on a scale of 1 (strongly disagree) to 5 (strongly agree):
        - My level of stress about parenting is high – before average response 3.81, after program average 2.26
        - I have a positive relationship with my child – before average 3.67, after 4.37
        - I recognize the behaviors that trigger my negative response to my child – before 2.59, after 4.30
        - I identify and respond to my child's needs for support and for comfort and contact – before 2.89 after 4.52
        - When I fail to respond to my child's need, I look for a way to repair our relationship – before 2.78, after 4.37
        - I step back and think about what my child's behavior is telling me about his/her needs before I react – before 2.22, after 4.48
        - I feel confident that I can meet the needs of my child – before 3.11, after 4.70
- Discovery Kids was implemented at 7 elementary schools:
    - Starr Elementary School, Grand Island (20 of 20 youth completed the program)
    - Knickrehm Elementary School, Grand Island (14 of 14 youth completed the program)
    - Howard Elementary School, Grand Island (11 of 14 youth completed the program)

- Dodge Elementary School, Grand Island (16 of 17 youth completed the program)
- Lincoln Elementary School, Grand Island (18 of 18 youth completed the program)
- District 1-R School, Hall County (20 of 20 youth completed the program)
- Doniphan-Trumbull, Hall County (19 of 20 youth completed the program)
- 123 children served directly, and indirect contact with 309 parents.
- 9 organizations involved in implementation, with 5 staff supporting
- 118 of 123 youth completed Discovery Kids (96%)
- 86 of 102 families attended the family celebrations (84%)
- 72 of 74 parents who completed parent survey reported that they feel more prepared to talk with their child(ren) about alcohol, tobacco and other drugs (97%)

FY19 Results Pending

Priority Area # 2: Injury & Violence

Goal	**Reduce unintentional injuries and violence in Hall County, NE**
Community Indicators	**CHNA 2013** • 952 annual juvenile arrests in Hall County. • Unintentional injury death rate was 33.3 per 100,000 population (age-adjusted). • Motor vehicle crash death rate of 16.8 per 100,000 (age-adjusted). • Number of falls for adults 65+ was 192 in 2013.
	CHNA 2016 • 632 annual juvenile arrest in Hall County • Unintentional injury death rate was 47.7 per 100,000 population (age-adjusted). • Motor vehicle crash death rate of 23.7 per 100,000 (age-adjusted). • Number of fall for adults 65+ was 209 in 2014.
	CHNA 2019
Timeframe	FY17-19
Background	**Rationale for priority:** The juvenile arrest rate of 632 for Hall County ranks the third highest in the state in 2013. Poverty remain significant issues for Hall County. Unintentional injury death rate per 100,000 population has increased to 47.2, with falls being the leading cause of hospital injury data.
	Contributing Factors: The social environment has a notable influence on the risk for injury and violence through: individual social experiences, social relationships, community environment and societal-level factors.
	National Alignment: Healthy People target goal is to prevent unintentional injuries and violence, and reduce their consequences.

2.1 Strategy & Scope: Provide SANKOFA and Families and Schools Together (FAST) program at the middle schools in Hall County, NE.

Anticipated Impact	Hospital Role/ Required Resources	Partners

• Decrease youth arrest rate and gang recruitment. • Increased graduation rate. • Reduced crime/school violence.	CHI Health Saint Francis Role(s): • Leadership • Technical assistance • Participate in H3C steering committee and Executive Board • Grant management • Marketing assistance (1,500 per yr.) Required Resources: • CHI Mission and Ministry funding $145,189 • Project Coordinator(.3 FTE) • Community partners time (120 hours per yr) • Facilitator services • Interpreters	• Hall County community Collaborative • Gang Violence Prevention Coalition • Grand Island Police Department, • Grand Island Public Schools • Hall County Juvenile Services
Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Continue SANKOFA Program at the three middle schools. • Identify and recruit at least 180 students over a 3 year period for the SANKOFA program. • Provide an additional 6 week program called Beyond SANKOFA program for graduates of SANKOFA moving up into high school. • Develop continuity between the Families and Schools Together (FAST) program and the SANKOFA program, and improve link to the Beyond SANKOFA program. • Expand SANKOFA facilitators and adapt curriculum to enhance and further SANKOFA learning experience. • Monitor SANKOFA graduates to ensure sustained benefits/ skills over time.	• 75% of participants will complete the SANKOFA program. • 85% of SANKOFA graduates will say they improved personal assets. • 80% of SANKOFA graduates will improve attendance at middle school level • 70% of SANKOFA graduates will improve grades at middle school level. • 80% of SANKOFA graduates will avoid criminal and school-related trouble. • 50% of SANKOFA graduates will improve attendance at high school level. • 50% of SANKOFA graduates will improve grades at the high school level • 70% of SANKOFA graduates will avoid criminal and school-related trouble at high school level. • # of SANKOFA graduates	Data will be reviewed and reported annually by an internal team using the following data sources: • Grand Island Public School records • Grand Island Police records • Program documentation

	• # of SANKOFA enrolled in Beyond SANKOFA program	

Results

FY17 Key Activities

- Hall County Community Collaborative engaged in leading violence prevention efforts in Hall County, and working to braid funding for all violence initiatives
- Working with schools to identify sustainability of programming – ownership through schools

FY17 Measures

- 79.3% (280 of 353) of youth completed SANKOFA (CUMULATIVE over three grant years)
- 88.7% (79 of 89) completed SANKOFA (2016-17)
- 83.9% (235 of 280) improved personal skills (CUMULATIVE)
- 82% (73 of 89) improved pers. skills (2016-17)
- 80% (226 of 280) improved attendance (CUMULATIVE)
- 80.8% (72 of 89) improved attendance (2016-17)
- 81.8% (229 of 280) improved grades (CUMULATIVE)
- 70.7% (63 of 89) improved grades (2016-17)
- 80% stayed out of school/legal trouble (CUMULATIVE)
- 82% (73 of 89) stayed out of school/legal trouble (2016-17)
- 37 SANKOFA Grads enrolled in Beyond SANKOFA
- Of students participating in Beyond SANKOFA
    - 86% show improved attendance in high school
    - 75% maintain a C-average grade
    - 77% stay out of trouble

FY18 Key Activities:

- In direct partnership with the Grand Island Public Schools and Hall County Juvenile Services, funding was provided to offer SANKOFA Classes over FY18.
- While metrics identified in the grant such as (improved graduation rates and juvenile arrests) were addressed through this grant work, the school reports additional work related to gang violence prevention was attributing to improvements in these rates. Therefore, there is uncertainty that these improvements can be directly attributed to this grant for FY18.
- CHI Health St. Francis will work in FY19 to explore better alignment with schools, and meet their needs for violence prevention programming.

FY18 Measures:

- While the work of this grant was not directly tied to improved graduation rates, the work did support this overall community effort.
  - Graduation rate for 2017 was 89.5%, up from 76% in 2013
  - Additionally the following showed improvements over FY17:
    - 77% completion rate for SANKOFA
    - 80% improved personal skills
    - 77% improved attendance at schools
    - 80% improved grades
    - 87% stayed in school

FY19 Results Pending

2.2 Strategy & Scope: Provide Child Safety education to prevent injury in children of Hall County, NE.

Anticipated Impact	**Hospital Role/ Required Resources**	**Partners**
• Increase the number of children who are properly secured in safety seats. • Increased use of car seats	CHI Health St. Francis Role(s): • Funder • Implementer Required Resources: • Child Safety Coordinator (.5 FTE) • Supplies (car seats and booster seats) • Community Partnerships • Additional funding/grants	• Kohl's • Children's Day Festival • Conestoga Mall • Grand Island Daycares • AAA
Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Provide 8 educational Child Safety events each year on car seat safety and installation. • Provide 400 hospital postnatal LDRP/NICU car seat educational consultations, and car seat Inspection appointments.	• % of participants who increase knowledge of proper car seat installation. • # of car seats inspected • # of consultations • # of community events scheduled	Data will be reviewed and reported every 6 months by an internal team using the following data • Pre/post test

• Develop pre/post survey.		• Program documentation

Results

FY17 Key Activities:

- FTE Reductions restricted this work for child passenger safety seat stations
- CHI Health St. Francis participated as the child safety partner in the following events:
  - May water safety event
  - Trunk or Treat safety event (Halloween safety – streets, candy, adult presence)
  - Santa's Arrival night at the local shopping mall focusing on safe toys for kids 0-6, and mall safety (stranger danger/abduction)

FY17 Measures:

- 100 kids served at water safety event
- 1500 kids served at Trunk or Treat
- 120 kids served at Santa's Arrival

FY18 Actions and Impact

- CHI Health St. Francis continues to provide safety outreach and education in Hall County, although staff reductions have reduced the offering of child passenger safety check stations, they do continue.

FY 18 Measures:

- Served 176 individuals through scheduled, free car seat checks at CHI health St. Francis
- CHI Health St. Francis participated as the child safety partner in the following events:
  - Super Saver Health Fair (Car Seats) (July) serving 22 individuals
  - Health Department/Conestoga Mall Nursing Event (car seats) (July) –serving 34
  - Mifold Booster Seat Giveaway (Boosters) (Aug.) serving 14
  - Star Elementary Fall Expo (Car Seats) (Aug.) serving 25
  - Kohl's/Hy-Vee Trunk or Treat (Safety) (Oct.) serving 1500
  - Conestoga Mall Santa's Arrival (Stranger Danger) (Nov) serving 50
  - St Francis Santa's Arrival (Stranger Danger) (Nov) serving 90
  - Grand Island Library Bear Fair (Car Seats Ed) (Jan.) serving 27
  - CCC Early Childhood Ed Conference (Car Seats & Daycares) (Feb) serving 28
  - Conestoga Mall Health Fair (Grandparents & Car Seat Ed) (Apr) serving 33
  - Little Miracles Daycare (Car Seat Ed) (Apr) serving 11

- Grandparents Day (Car Seat Ed) (Apr) serving 12
- Distracted Driving Simulator
  - Hy-Vee (May) serving 18
  - Grand Island Library (May) serving 41
  - St Francis Lobby (June) serving 102
- Grand Island Library Summer Kick-Off (May)
  - Kids Reading Program (Bicycle Safety) serving 50
  - Teen Reading Program (Distracted Driving) serving 12
  - Adult Reading Program (Car Seat Ed) serving 21
- Making Waves Water Safety Event (June) serving 109
- YWCA Daycare (Car Seat Checks) (June) serving 11
- Hall County Public Transportation Driver's (Car Seat Ed) (June) serving 15
- Texas Roadhouse (Car Seat Ed) (June) – reach unknown

FY19 Results Pending

2.3 Strategy & Scope: Provide fall prevention programs targeted at residents aged 60 and over.

Anticipated Impact	Hospital Role/ Required Resources	Partners
• Decrease incidence of falls among program participants. • Increase balance among participants. • Increase strength and balance among program participants.	CHI Health St. Francis Role(s): • Financial support • Provide staff • Training and data collection support • Community Partner Required Resources: • Partnerships • Trauma program manager (.25) • Additional support staff time • Funding	• Saint Mary's Catholic Church • Community Nursing Homes • Grand Generation • YMCA • St. Francis Cardio Rehab
Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Train 10 new instructors for Tai Chi classes. • Find key locations to implement Tai chi programs (St. Mary's, Grand Generation, YMCA and St. Francis Cardio Rehab). • Offer three 12-week Tai Chi--Moving for Better Balance classes in Hall County and at the Litzenberg Memorial Hospital. • Train 2 instructors for a pilot program called "Stepping On" Program. • Pilot a 2 hour, 7-week "Stepping On" program at St. Francis Hospital with providing a home visit or follow-up phone call by program leader of "Stepping On." • Provide a three-month booster session (2 hours in length) for participants completing the "Stepping On" program.	• % increase in functional reach, the up and go test. • % increase in functional status among participants • % improvement balance among participants • % reduction in falls among participants • # of instructors trained for Tai Chi • # of instructors trained for Stepping On • # of Tai Chi classes offered • # of Stepping On classes offered • # of individuals participated in Tai Chi • # of individuals participated in Stepping On	Data will be reviewed and reported annually by an internal team using the following data: • Class attendance sheets • Pre/Post clinical assessments

• Discuss the number/key locations of the "Stepping On" Program in the community and other counties.		

Results

FY17 Key Activities:

- CHI Health St. Francis trained 10 individuals in Tai Chi for Balance to be able to conduct classes
  - Since training nearly all individuals had issue with capacity to conduct classes, and community members have asked that old version of tai chi (not evidence-based) be reinstated.
- Still holding old version of Tai Chi classes at YMCA, Grand Generation, and a local church
- Team considering hosting a fall prevention awareness event at the hospital for FY18 or FY19

FY17 Measures:

- 10 trainers trained in Tai Chi for Balance

FY18 Key Activities

- Of the 10 individuals trained in Tai Chi for Balance in FY17, nearly all individuals had issues with capacity to conduct classes through the evidence-based model. Community members have asked that former versions of tai chi, which were less time intensive (and do not follow the evidence-based model of tracking and reporting balance and strength measures), be reinstated.
- In FY18 the hospital trauma outreach team is still supporting and promoting former version of Tai Chi classes, as requested by the community at: YMCA, Grand Generation, and a local church. Tracking of attendance and participation is not part of the established process, and has proven difficult to initiate.
- Team explored hosting another training to better engage the right individuals, and train facilitators of Tai Chi for Balance, however capacity issues, and lack of community partner to help own the work (and ensure its sustainability) prevented the training from moving forward.
- This strategy will be re-evaluated for feasibility and community interest moving forward.

FY18 Measures:

- No measures to report at this time.

FY19 Results Pending

Priority Area # 3: Access to Care

Goal	**To improve access to health care services, especially for those in underserved communities.**
Community Indicators	**CHNA 2013** • 12.6% of adults 18 years or older reported that they needed to see a doctor but could not due to cost. • 19.2% of adults 18-64 years old have no health coverage
	CHNA 2016 • 14.1% of adults 18 years or older that needed to see a doctor but could not due to cost. • 18.2% of adults 18-64 years old have no health coverage.
	CHNA 2019
Timeframe	FY17-19
Background	**Rationale for priority:** Access to care is consistently identified as a top health priority for the community. Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone.
	Contributing Factors: With the passing of the ACA, Nebraska did not expand Medicaid, therefore, there remains a coverage gap for Hall County residents with incomes between 100% and less than 138% of the Federal Poverty Level who are not eligible for the Medicaid program as it currently exists in Nebraska and also not provided a subsidy for health insurance premiums through the Healthcare Marketplace. Additional contributing factors include: transportation, hours and locations of health services, language.
	National Alignment: Health People Target is to improve access to comprehensive, quality health care services.

3.1 Strategy & Scope: Provide assistance and support of Third City Community Clinic to improve access to healthcare for uninsured and underinsured populations in Hall County.

Anticipated Impact	Hospital Role/ Required Resources	Partners

• Reduce unnecessary healthcare costs. • Improve access to community resources resulting in better outcomes.	CHI Health St. Francis Role(s): • Financial support • Provide staff for clinic hours Required Resources: • Funding for supplies • RN: 1026 hours/year, PRN: 1026 hours/year, Data Specialist: 1026 hours/year. • Other Braided funding - 2 full time community health workers (CHW) • Administration support	• United Way • Third City Community Clinic • Mid-Plains Behavioral Health Center • Central Health Center
Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Provide financial support for clinic operations and functions • Promote the awareness of Third City Community Clinic. • Offer Community Health Workers (CHW) to assist in navigating community resources, programs and services. • Provide vouchers for transportation assistance to clinic.	• % reduced unnecessary ER visits • # of patients served at Third City Clinic • # of CHW referrals to community what resources/programs and type of referrals • # of vouchers	Data will be reviewed and reported annually by an internal team using the following data: • Hospital data • Third City Community Clinic data
Results		
FY17 Key Activities: ▪ Loss of APC at Third City Community Clinic (TCCC) has eliminated opportunity for PCMH implementation, however Community Health Worker still working to connect patients with other PCMH sites, as well as support access through insurance enrollment. ▪ Team evaluating sustainability plan for CHW as outcomes for ED utilization and re-admission is positive, as well as patient improvements in blood pressure, A1c and smoking rates. **FY17 Measures:** ▪ 37% of diabetics improved health per A1c readings ▪ 36% of patients improved blood pressure readings ▪ 1 of 2 patients seen for smoking has quit.		

FY18 Actions and Impact

- The grant for this work at TCCC began in FY15, and ended in FY17. St. Francis provided approximately $65,000 in funding throughout FY18 to extend the life of the grant one year, in an effort to pursue further sustainability.
- Whether this work can be sustained by TCCC will be determined in FY19, and leaders from St. Francis and TCCC Administration as well as TCCC Board are exploring future alignment needs.

FY18 Measures:

- Measures similar to what was reported for grant activities between FY15-FY17 were not provided by TCCC for FY18.

FY19 Results Pending

3.2 Strategy & Scope: Support preventive and early detection with health screenings for uninsured/underserved individuals in Hall County.

Anticipated Impact	Hospital Role/ Required Resources	Partners
• Increase screening rates for blood pressure, diabetes (glucose), cholesterol, breast cancer, HIV and dental.	CHI Health St. Francis Role(s): • Funder • Provide staff time • Data collection Required Resources: • Community partnerships • Funding (equipment and supplies) • Staff time – 4 staff (approx.. 96 hours/year)	• Central District Health Department, • Third City Clinic • Heartland Health Center • Hy-Vee • Old Walnut • Neighborhood Nursing • Central Health Center • HHS • UNL • Hall County Extension Office.

Key Activities	Measures	Data Sources/Evaluation Plan
• Provide 3 screening a year for blood pressure, diabetes (glucose), cholesterol, breast cancer, HIV and dental decay. • Develop pre/post evaluation to determine increase in knowledge.	• % who show an increased knowledge of early prevention • # of screenings events/# of referrals • # of total screenings/# of referrals • # of blood draw screenings/# of referrals • # of dental screenings/# of referrals • # of breast exams/# of referrals • # of HIV Screenings/# of referral	Data will be reviewed and reported annually by an internal team using the following data: • Pre/post survey • Program documentation

Results

FY17 Key Activities:

- Team focus for screening offerings was on diabetes and cancer screening outreach.
- Team working to identify community partners (i.e. local Health Department) to identify what screenings are, and are not happening, and align resources where possible to ensure screenings critical to the community will continue.

FY17 Measures:

- 231 community members provided diabetes education and screenings through 4 health fair events, and 5 support group events
- 174 served through cancer screening events (breast exam or dermatologist skin screening) at three community events
- 16 participants served in Time to Heal classes to promote self-care specific to cancer patients

FY18 Key Activities

- Based on capacity, the focus was on cancer screening, and raising awareness of preventive screenings.
- Additionally, Existing work happening through Central District Health Department around community based health screenings unrelated to cancer.
- Conversations in FY18 expanded to include Heartland Health (Federally Qualified Health Center) to work to identify gaps in services and work to align resources for prevention and health promotion where possible to ensure screenings critical to the community will continue.

FY18 Measures:

- 57 Fecal occult blood test (FOBT) for colon cancer screening were distributed and 40 tests were submitted for processing.
  - 37 negative results and 3 positive results which received follow-up, and all three scheduled and received colonoscopies.
- 64 community members received screening from DermaScan technology through various community events, and 3 were referred for abnormal results, 1 of the three received a biopsy

FY19 Results Pending

3.3 Strategy & Scope: Provide convenient mental and physical health care in a school-based health care facility for middle and high schools students in Grand Island, NE.		
Anticipated Impact	**Hospital Role/ Required Resources**	**Partners**
• Improve teens' access to mental health services. • Improve teens' access to health care services. • Improve in youth disciplinary issues. • Improvement in attendance.	CHI Health St. Francis Role(s): • Funder • Provide staff • Community Partner • Data collection support Required Resources: • Community partnerships • Supplies and equipment • Staff from Richard Young Behavioral Center (RYBHC): 1 PRN-FTE, 3 PT staff	• Third City Community Clinic • Grand Island Public Schools • Heartland Health Center • Health and Human Services • Richard Young Behavioral Center (RYBHC)
Key Activities	**Measures**	**Data Sources/Evaluation Plan**
• Hold a clinic at the high school 5 days a week to provide medical care. • Offer 2 behavioral health therapists at the high school 5 days a week for behavioral health counseling. • Offer psychotherapist through RYBYC using telehealth 2 times a month at the high school. • Recruited and contract with community therapist to provide 1 day behavioral health counseling to 3 middle schools (16 hours of on-site). • Develop a strategy to improve awareness of services. • Establish strategy or partnership to assist on increasing insurance coverage for all students. • Established sustainability of school health clinic through insurance reimbursement for primary care services provided by nurse practitioner/ in schools.	• % decrease in student disciplinary actions. • % increase in student attendance. • # of students served at the clinic for mental health care. • # of students served at the clinic for health care. • # of students receiving psychotherapy via telehealth • # of students who are uninsured.	Data will be reviewed and reported annually by an internal team using the following data: • Student Wellness Center (SWC) counseling records • GIPS School records
Results		

FY17 Key Activities:

- Continued to provide health services to Grand Island High School five days/week, although demand is higher than capacity – each year school begins in August and panel fills and a waitlist begins by October.
- Psychiatric NP (qualified for med mgmnt)-physically present 1day/month (new patients), FU appts are telehealth from her office in RYBHC
- Team working to identify best alignment of partnership with the schools to ensure all who need are served, especially connecting students to insurance and medical homes.

FY17 Measures:

- 408 registered for service -not total StBdy
- 66 with no insurance
- 205 of 408 qualified for financial assistance per our policy
- 133 HS students served at mental health care clinic
- 12 MS students served at mental health care clinic
- 239 HS students served at health care clinic
- 25 MS students served at health care clinic
- 25 HS students receiving psychiatric med management
- 1 MS students receiving psychiatric med management
- 59 risk assessments (referrals coming from various organizations)

FY18 Actions and Impact

- Continued to provide physical and mental health services to Grand Island High School five days/week.
- Psychiatric NP (qualified for medication management)-physically present 1day/month (new patients), follow up appointments are provided through telehealth from her office at Richard Young Behavioral Health Center.
- Team continues to explore best alignment of partnership with the schools to ensure all who need are served, especially connecting students to insurance and medical homes.

FY18 Measures:

- 350 students served through medical and behavioral health services – 100 of 350 are receiving behavioral services
- 62 with no insurance
- 198 of 350qualified for financial assistance per CHI Health policy
- 130 HS students served at mental health care clinic
- 12 MS students served at mental health care clinic
- 229 HS students served at health care clinic
- 22 MS students served at health care clinic
- 25 HS students receiving psychiatric med management
- 1 MS student receiving psych med management

FY19 Results Pending

Dissemination Plan

CHI Health St. Francis and Skilled Nursing Facility will make its CHNA widely available to the public by posting the written report on http://www.chihealth.com/chna. A printed copy of the report will be available to the public upon request, free of charge, by contacting Kelly Nielsen at Kelly.nielsen@alegent.org or (402) 343-4548. In addition, a paper copy will be available at the Hospital Information Desk/Front Lobby Desk.

Approval

On behalf of the CHI Health Board, the Executive Committee of the Board approved this CHNA on May 10, 2019.

Appendices

Appendix A: Central District Health Department Data Presentation 1/7/19

Stakeholders gathered at CHI Health St. Francis for a meeting co-hosted by Central District Health Department (CDHD) on January 7, 2019. CDHD presented the data and a large group discussion ensued, followed by small group prioritizing and discussions.

Appendix B Community Input Session Report 1/7/19

A report containing the large group discussion input as well as the small group prioritization and reporting is provided following the data presentation.

WELCOME!

CHI Health St. Francis
Central District Health Department

Community Health Needs Assessment
Community Meeting
January 7, 2019

Central District Data

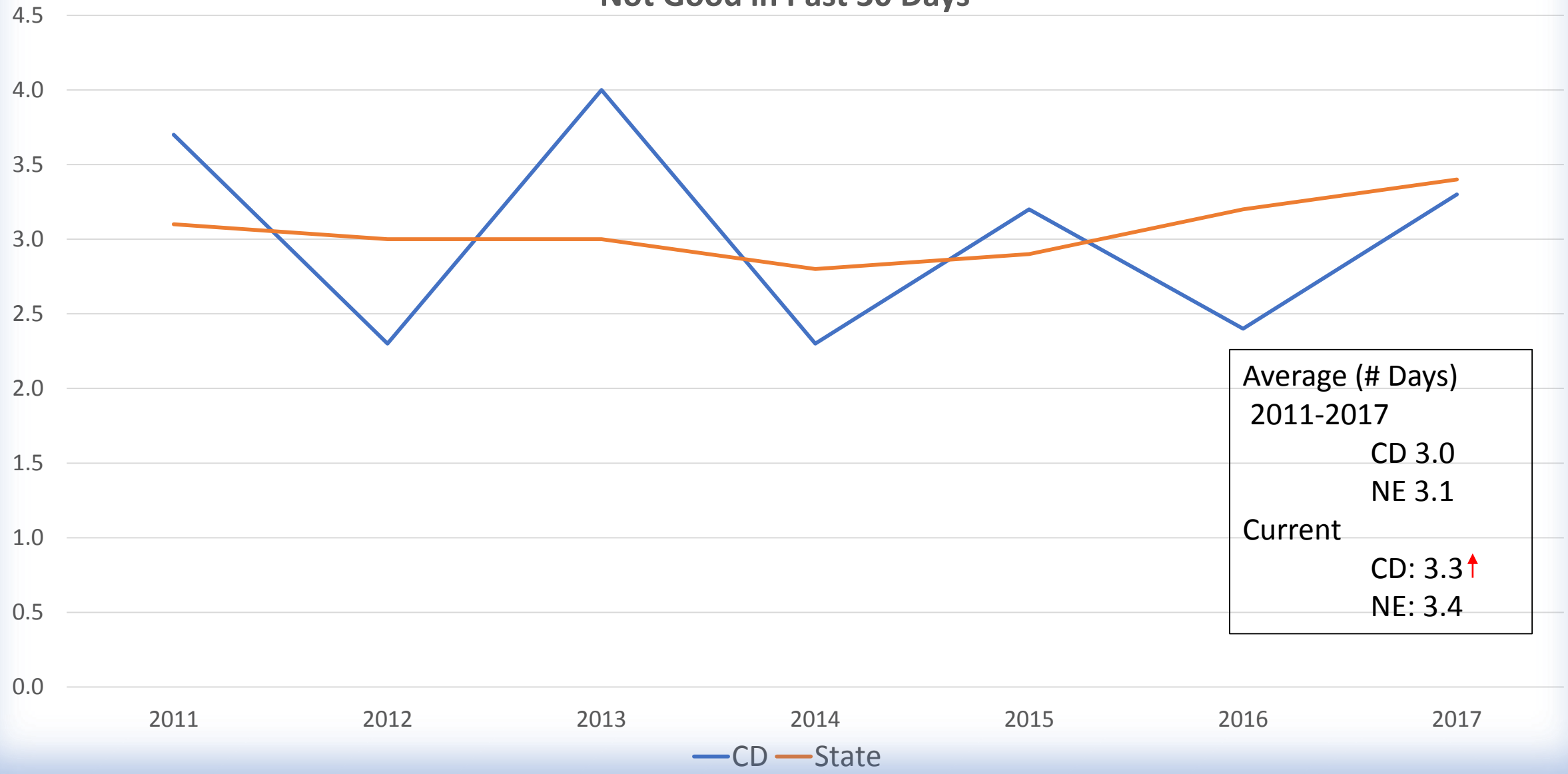
Hamilton	Hall	Merrick

Central District Data

Behavioral Health

Hamilton Hall Merrick

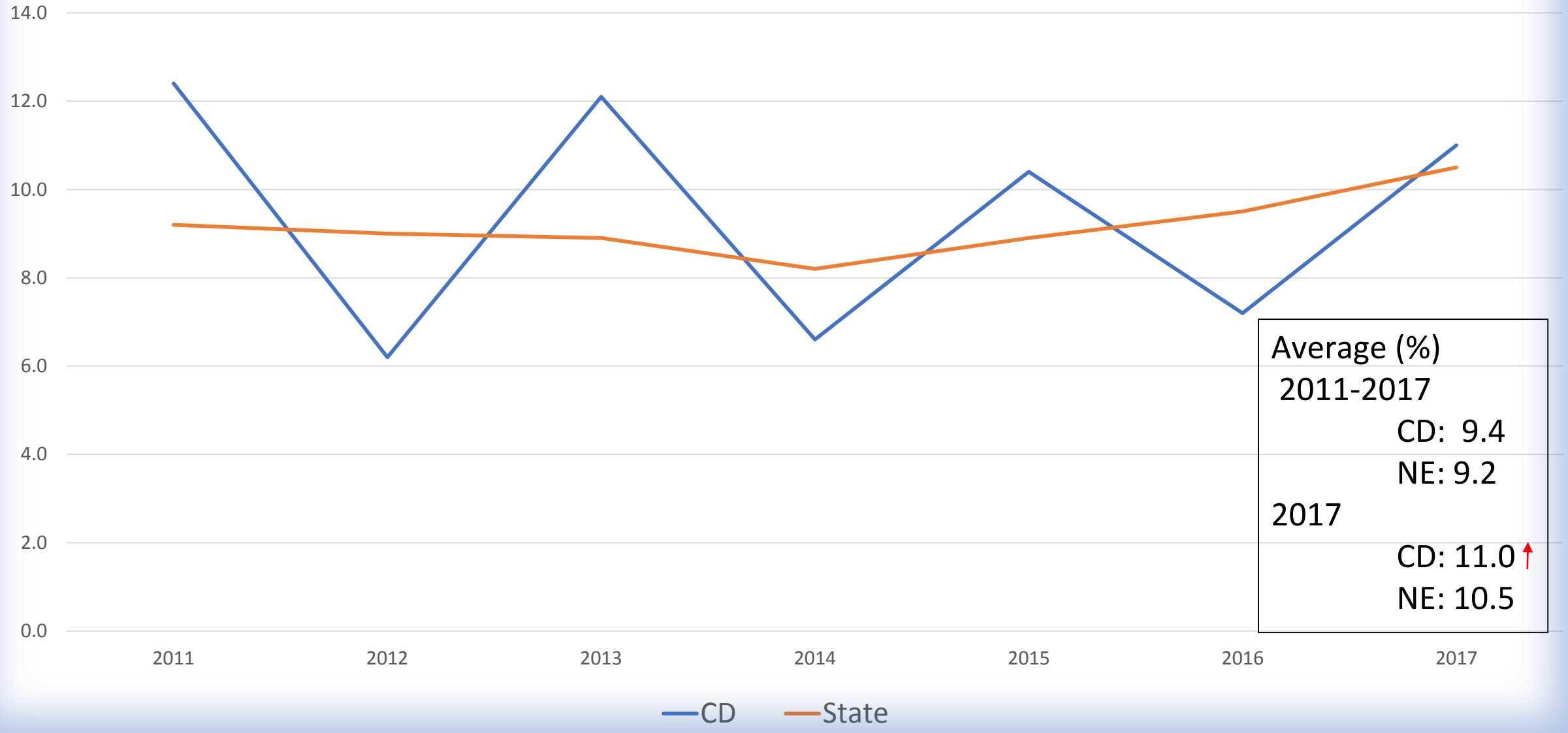
Average Number of Days Mental Health Not Good in Past 30 Days



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

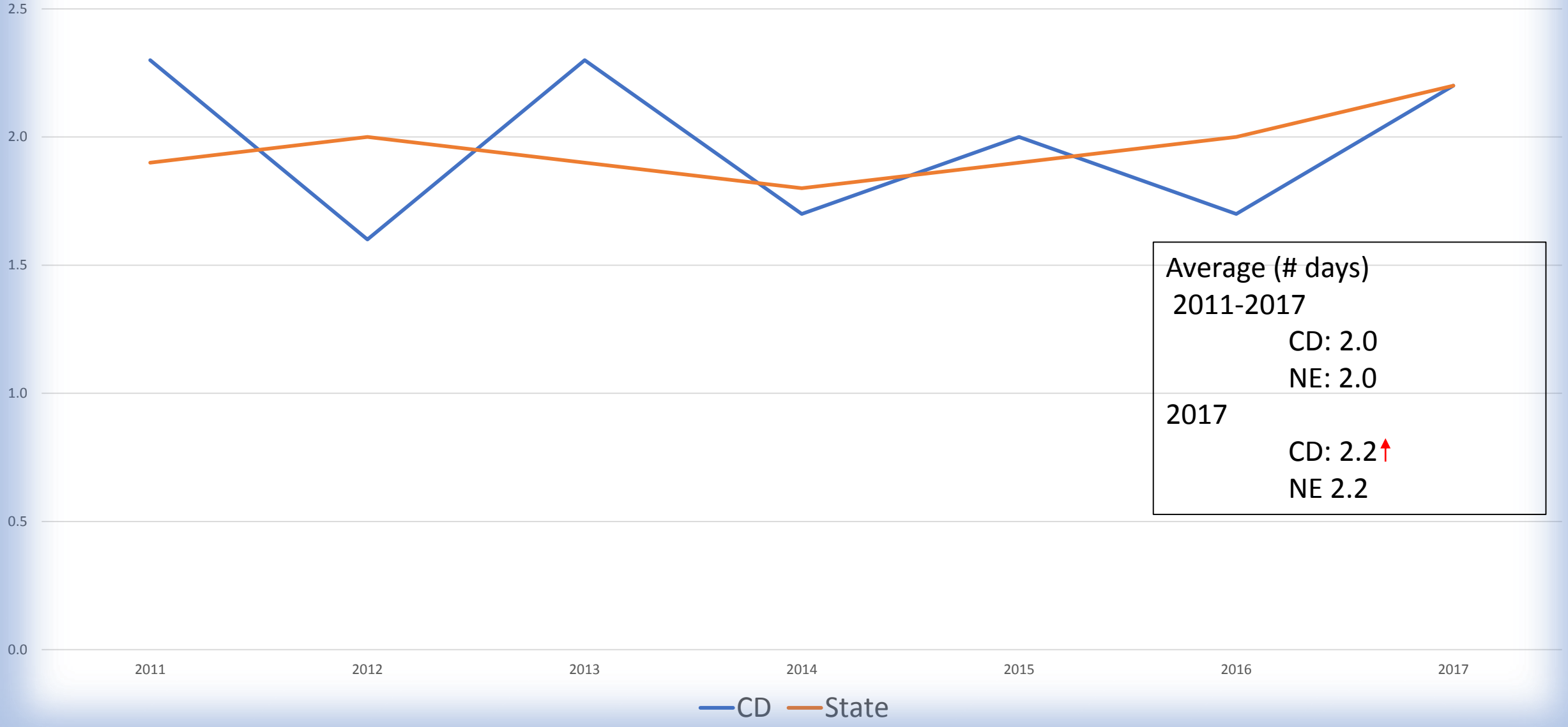
Central District Health Department
HALL • HAMILTON • MERRICK

Mental Health Not Good on 14 or More of Past 30 Days (Frequent Mental Distress)



Average (%)
2011-2017
CD: 9.4
NE: 9.2
2017
CD: 11.0 ↑
NE: 10.5

Average Number of Days Poor Physical or Mental Health Limited Usual Activities



Average (# days)
2011-2017
CD: 2.0
NE: 2.0
2017
CD: 2.2↑
NE 2.2

Central District Data

Substance Abuse

Hamilton	Hall	Merrick

What we do…

- 50% had any alcohol in the past 30 days
- 5% drank heavily in past 30 days
- 3.4% participated in alcohol impaired driving
- 32.8% took pain meds prescribed by doctor in past year
- 48.3% had leftover pain meds after last prescription filled
- 31.2% get less than 7 hrs. of sleep per day

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
HALL • HAMILTON • MERRICK

Adult Substance Use

Hall County 2017: Alcohol Impaired Driving

- 67/2171 total incidents involved alcohol
- 1/15 fatal incidents involved alcohol
- 26/814 incidents with injuries involved alcohol

https://dot.nebraska.gov/media/11330/county2017.pdf

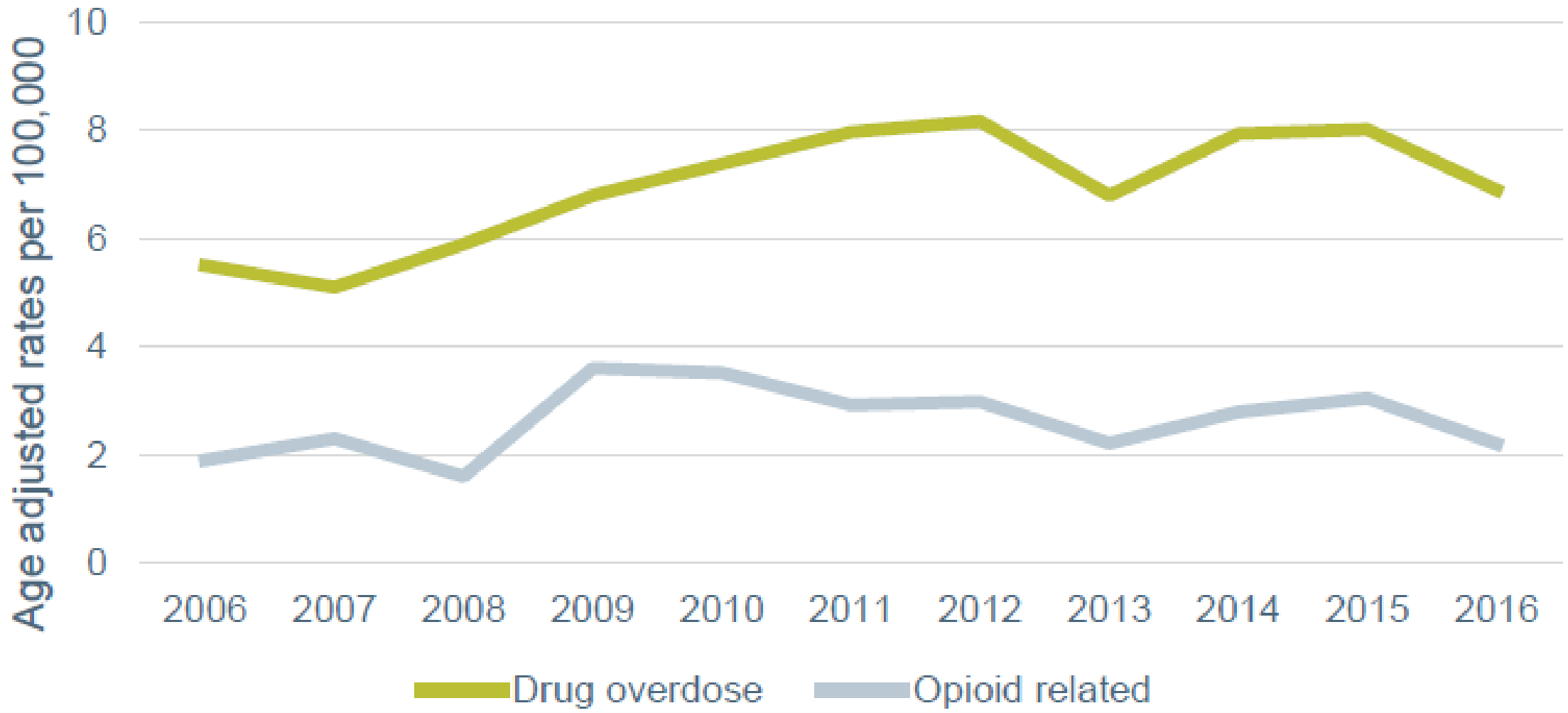
Central District: Adult Tobacco Use

- Current smoker
  - 2017: 15.6% (NE: 15.4%)
  - 2011: 21.3%
- Current smokeless tobacco use
  - 2017: 6.3% (NE: 5.3%)
  - 2011: 6.4% (NE: 5.6%)
- Current e-cigarette use
  - 2017: 2.7% (NE: 3.8%)
  - 2016: 5.5% (NE: 4.9%)

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
HALL • HAMILTON • MERRICK

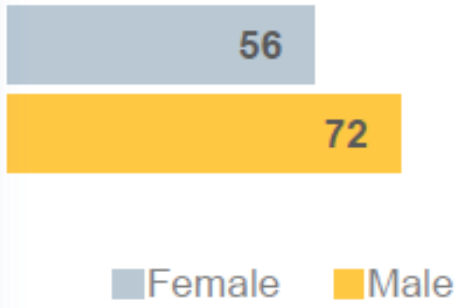
All Drug-related and Opioid-related Overdose Fatalities, Nebraska, 2006 - 2016



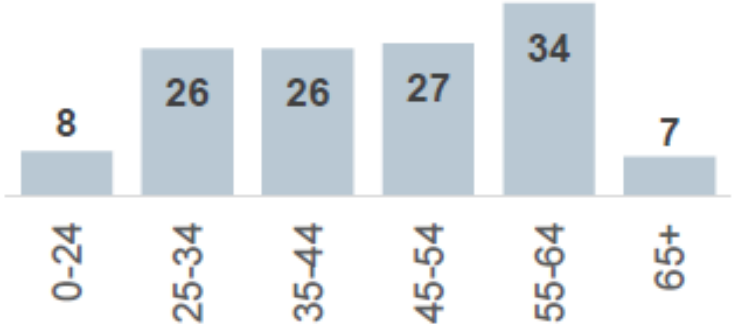
Central District Health Department
HALL • HAMILTON • MERRICK

Drug Overdose Deaths: Number by Demographic Characteristics and Intent [2]

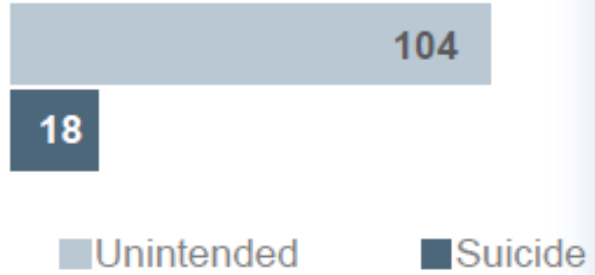
Number by Sex



Number by Age Group

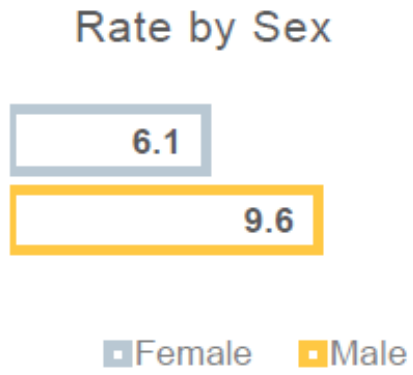


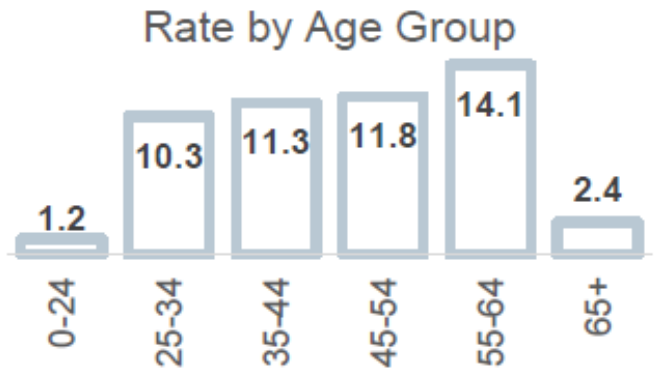
Number by Intent

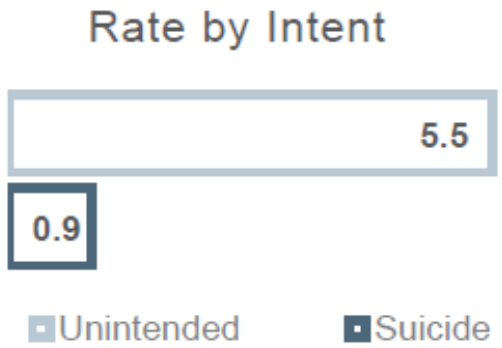


Central District Health Department
HALL • HAMILTON • MERRICK

Drug Overdose Deaths: Rate per 100,000 persons by Demographic Characteristics and Intent [2]







† Rates provided for groups with numbers less than 20 may be unreliable, these rates are provided for context and should be used with caution.

In 2016, 14.1% of all drug overdoses were identified as suicide or intentional with the majority identified as accidental or unintentional (81.3%). Males accounted for 56%, down from 61% in 2015. Individuals aged 55-64 had the highest rates of all age categories with 35-44 and 45-54 year olds trailing closely. In 2015, the highest age category rate was for 45-54 year olds.

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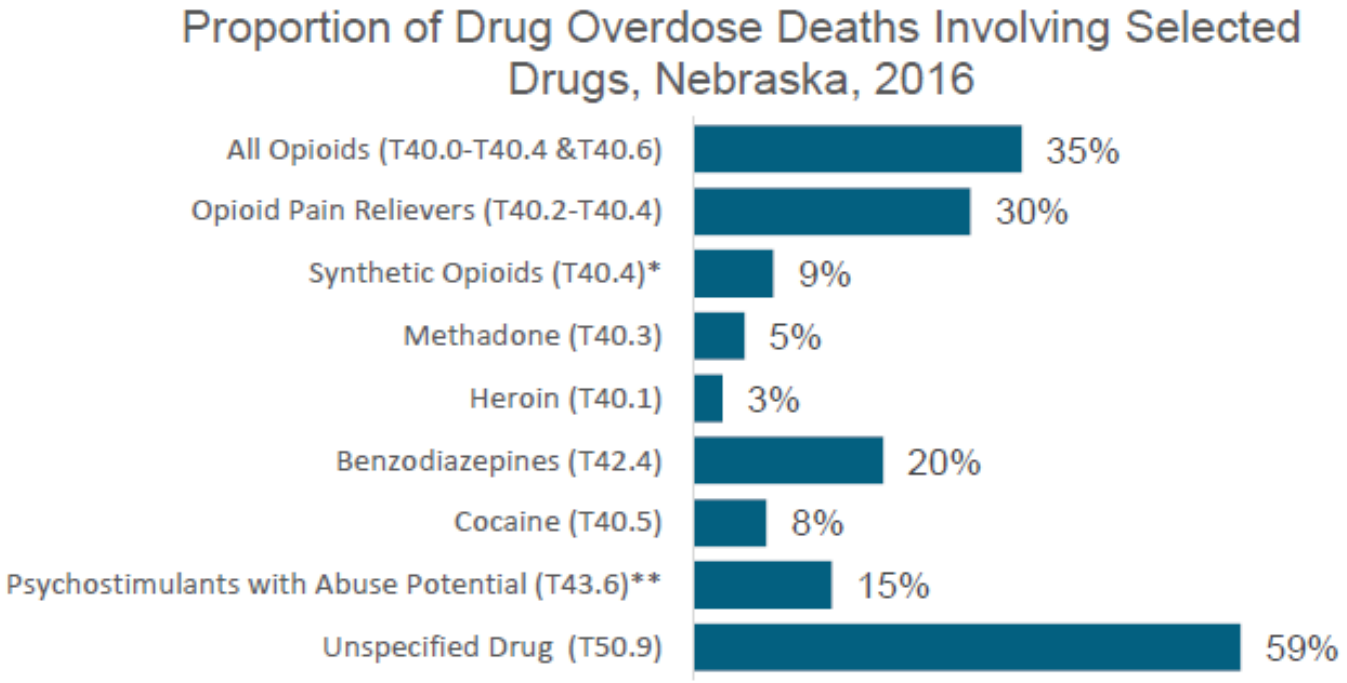
Drug Overdose Deaths: Proportion of Deaths Involving Selected Drugs [2]

Opioid Pain Relievers Contributed to 30% of Drug Overdose Deaths

Opioid pain relievers, such as oxycodone or hydrocodone, contributed to 38 (30%) of 128 drug overdose deaths in 2016. These results may be an undercount, because the percent of drug overdose deaths that had only unspecified drug(s) listed as contributing to the death accounted for 38% percent in 2016; up slightly from the 36% in 2015.



According to CDC , Nebraska had 6.7/100,000 age adjusted overdose deaths in 2010 compared to 6.4 in 2016. https://www.cdc.gov/drugoverdose/data/statedeaths.html

Youth: Risk and Protective Factor Student Survey 2016: Alcohol (Hall County)

- 8th grade:
  - Lifetime alcohol use: 22.1% (NE: 23%)
  - Current alcohol use: 5.6% (NE: 7.3%)
- 12th grade:
  - Lifetime alcohol use: 58.6% (NE: 61.2%)
  - Current alcohol use: 31.1% (NE: 34.4%)

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Youth: Risk and Protective Factor Student Survey 2016: Other Drugs (Hall County)

- 8th grade
  - Lifetime marijuana use: 5.1% (NE: 5.4%)
  - Current marijuana use: 2.9% (NE: 2.8%)
  - Current prescription drug misuse: 0.3% (NE: 0.5%)
  - Lifetime other illicit drug use: 3.6% (NE: 4.9%)
- 12th grade
  - Lifetime marijuana use: 35.5% (NE: 32.4%)
  - Current marijuana use: 15.8% (NE: 15.7%)
  - Current prescription drug misuse: 3.1% (NE: 3.4%)
  - Lifetime other illicit drug use: 10.5% (NE: 12.7%)

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Youth: Risk and Protective Factor Student Survey 2016: Tobacco (Hall County)

- 8th grade
  - Lifetime tobacco use: 8.8% (NE: 9.5%)
  - Current tobacco use: 3.4% (NE: 3.5%)
  - Lifetime electronic vapor use: 12.8% (NE: 12.4%)
  - Current electronic vapor use: 6.4% (NE: 6.0%)
- 12th grade
  - Lifetime tobacco use: 32.6% (NE: 34.3%)
  - Current tobacco use: 13.4% (NE: 17.8%)
  - Lifetime electronic vapor use: 36.8% (NE: 43.4%)
  - Current electronic vapor use: 8.5% (NE: 18.7%)

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Central District Data

Culture of Health

Hamilton Hall Merrick

Central District Health Department
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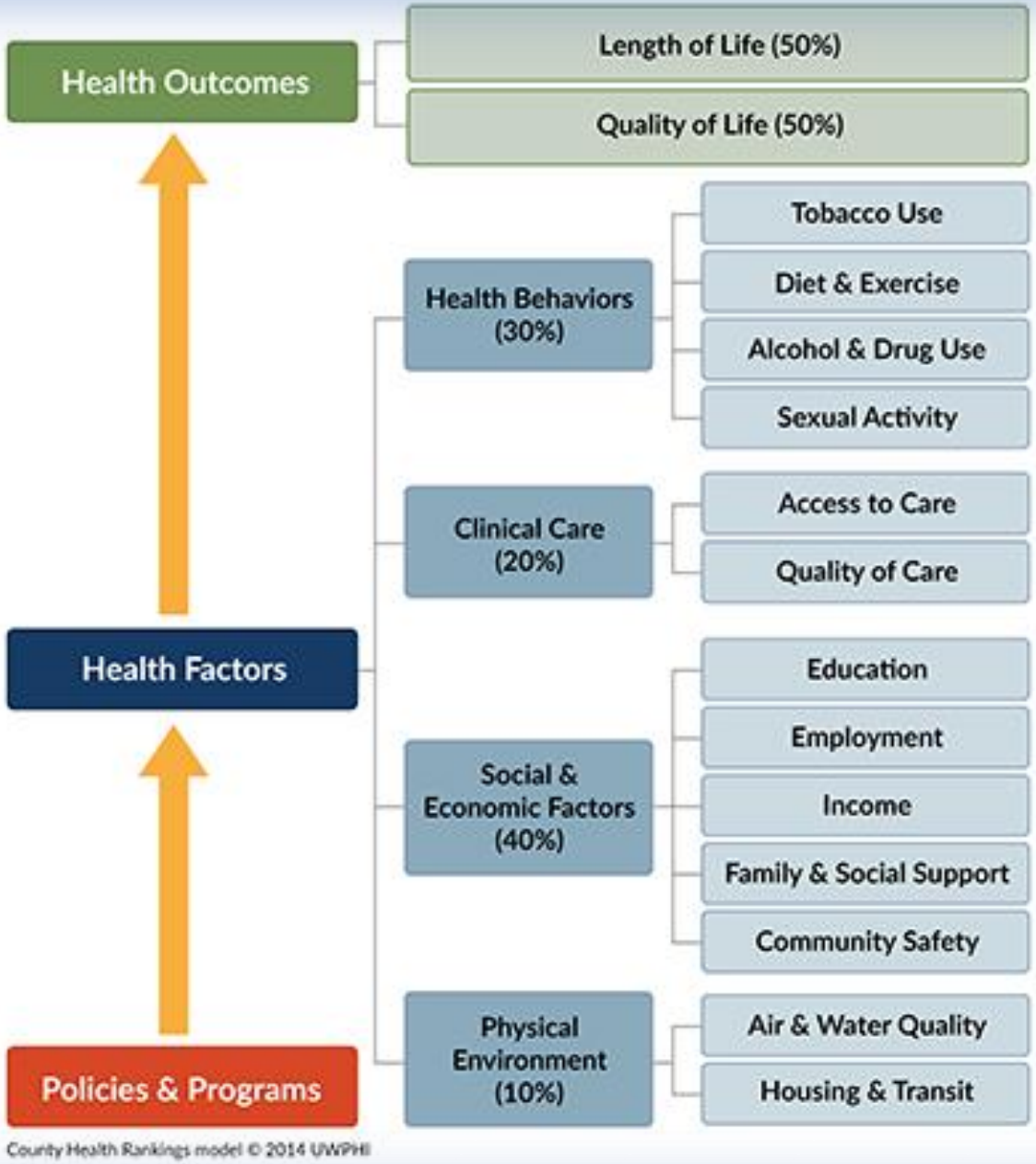

Building a Culture of Health

- Downstream Data
  - Health demands
  - Health needs
  - Use of services
  - Those with the greatest need may not be able to access services

- Upstream Data
  - Health determinants and status
  - Community engagement
  - Resources and services
  - Integration and responsiveness

Woodward et al.

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Building a Culture of Health

Central District Health Department
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Building a Culture of Health

- 3.8% Unemployment rate
- 17% Children live in poverty
  - 9% Hamilton; 14% Merrick
- 38% Children live in single-parent households
  - 19% Hamilton; 29% Merrick
- Median household income = $52,100 (state =$57,000)
- 61% Children eligible for free/reduced lunches
  - 35% Hamilton; 44% Merrick
- Injury deaths =69/100,000 (state = 58/100,000)
- Shortage of primary care, dental care, and mental health providers for geographic area

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A Bit More…

- 29.5% age 45 and older had a fall in the past year
- 9.1% age 45 and older were injured due to a fall
- 20% were ever told they have depression

- 29.1% had housing insecurity in the past year among those who own or rent their home
- 23.4% had food insecurity in the past year

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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Building a Culture of Health

- Community Health Improvement Plan
  - CHA used to establish priorities
    - What are the most pressing issues
  - Community experts answers these questions:
    - Who is currently doing what
    - Where do we need more resources
    - Where is the optimal progress being made
    - Who are likely partners on what issues
    - What resources are being used/are available/are needed

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Central District Data

Maternal Infant and Child Care

Hamilton Hall Merrick

Prenatal Care

- Premature Births by County of Residence (%)
  - 2011-2015
    - Hall: 9.2 (NE:9.2)
  - 2015

    Hall: 11.0 (NE:9.9)

- Teen births by Health District (%)
  - 2011-2015
    - Central District: 9.0 (NE: 5.9)
  - 2015
    - Central District: 7.0 (NE: 5.2)

Nebraska 2015 Vital Statistics Report

Central District Health Department
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Prenatal Care

- Prenatal Inadequate Care (%)
  - 2015
    - Central District: 21.3 (NE: 17.2)
    - Calculated by using the Kotelchuk Index. The Kotelchuk Index measures adequacy of prenatal care (adequate, inadequate, intermediate) by using a combination of the following factors: number of prenatal visits; gestation; and trimester prenatal care started.

- Births to Unmarried Women (rate per 1,000 births)
  - 2011-2015
    - Central District: 320.6 (NE:264)
  - 2015
    - Central District: 406.4 (NE:239.2)

Nebraska 2015 Vital Statistics Report

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Central District Data

Injury and Violence

Hamilton Hall Merrick

Central District Health Department
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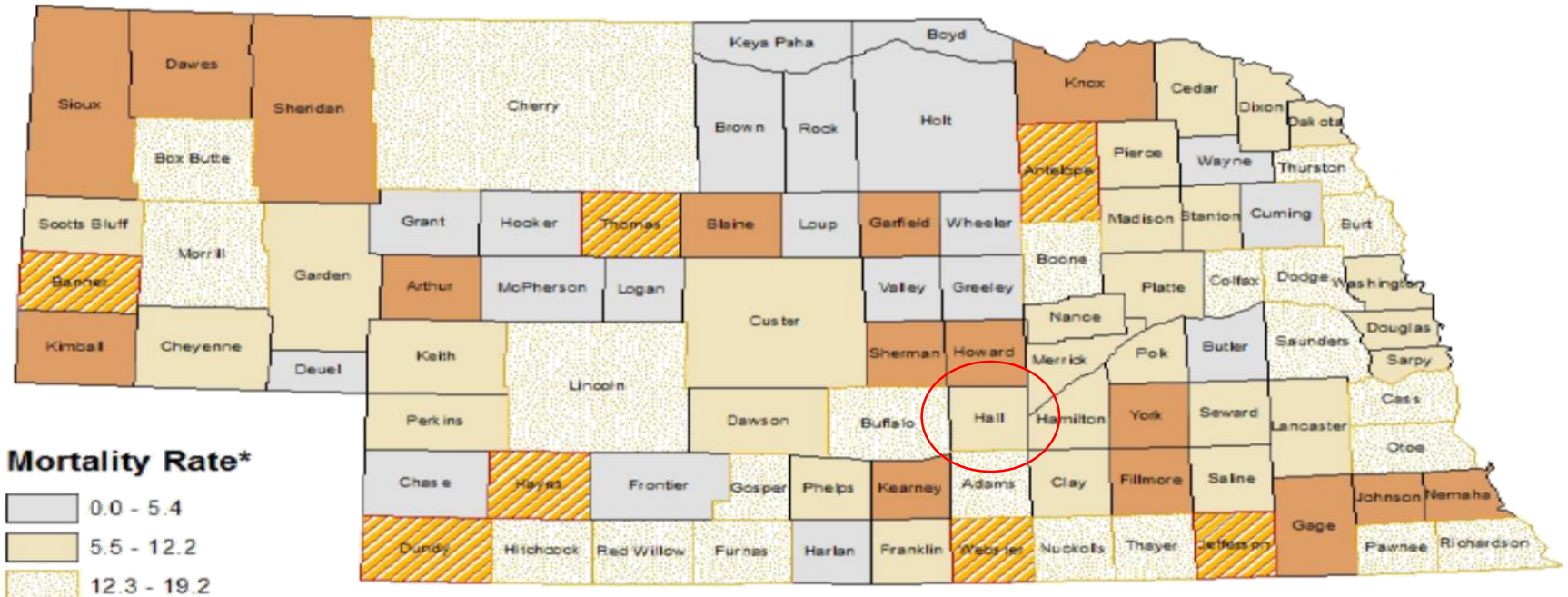
Map 14. Suicide Mortality Rates, by County of Residence
Nebraska, 2012-2016



Mortality Rate*

- 0.0 - 5.4
- 5.5 - 12.2
- 12.3 - 19.2
- 19.3 - 28.2
- 28.3 - 47.5

*suicide deaths per 100,000 population per year, age-adjusted to the 2000 US population

Statewide mortality rate* = 12.3

Hall County (rate per 100,000)
2012-16: 12.9
2016: 14 (NE: 12.3) ↑

Ne Vital Statistics 2016

Central District Health Department
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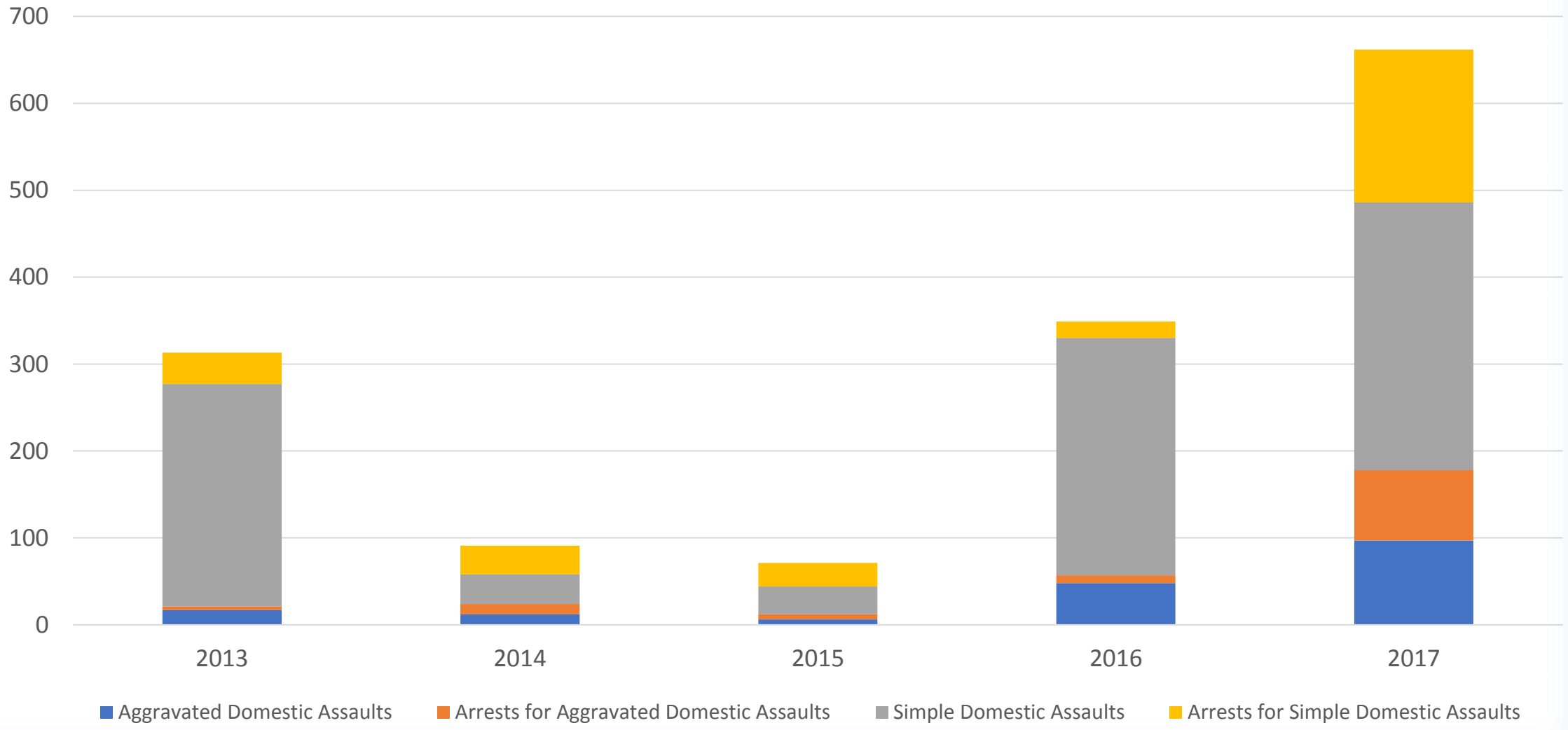
Domestic Assault Hall County Nebraska



https://ncc.nebraska.gov/stat-reports#Crime_in_Nebraska_Series

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NE Leading Causes of Death, 2016	Deaths	Rate***	State Rank*	U.S. Rate**
1. Cancer	3,477	153.6	32nd	155.8
2. Heart Disease	3,322	140.3	43rd	165.5
3. Chronic Lower Respiratory Disease	1,117	48.9	12th (tie)	40.6
4. Stroke	787	33.2	37th	37.3
5. Accidents	772	37.0	46th	47.4
6. Alzheimer's disease	634	26.2	34th	30.4
7. Diabetes	501	21.9	19th	21.0
8. Flu/Pneumonia	342	14.3	21st (tie)	13.5
9. Hypertension	268	11.2	6th	8.6
10. Suicide	246	13.1	37th	13.5

https://www.cdc.gov/nchs/pressroom/states/nebraska/nebraska.htm

Motor Vehicle Crashes

Hall County 2017

- All events
  - 1250 events; 10 fatal
- Pedestrian
  - 13 events; 2 fatal
- Pedal cyclist
  - 9 events; 0 fatal

Hall County 2016

- All events
  - 1240 events; 5 fatal
- Pedestrian
  - 4 events; 0 fatal
- Pedal cyclist
  - 8 events; 0 fatal

https://dot.nebraska.gov/media/11330/county2017.pdf

Central District Health Department
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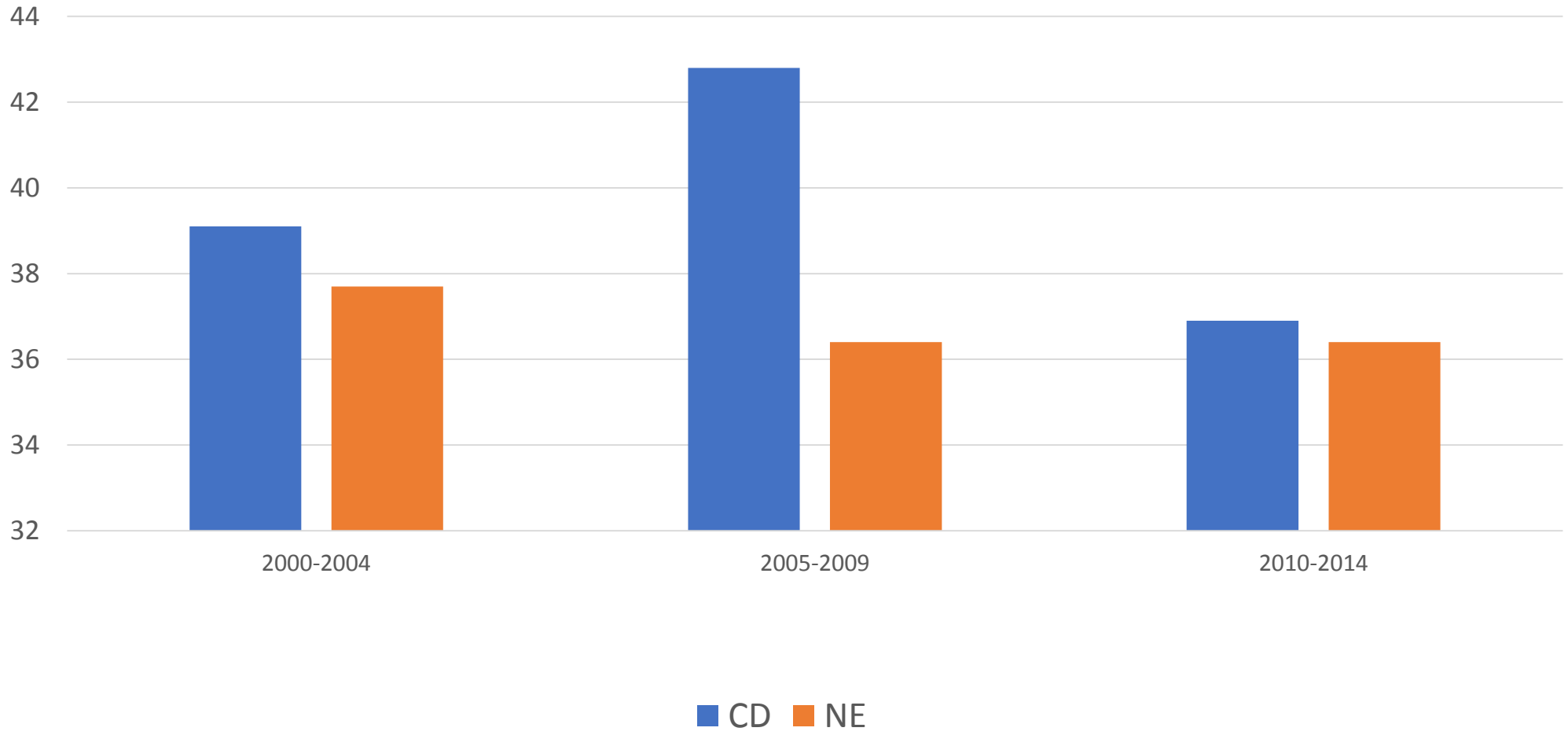
Accidents Death Rate per 100,000 (Age-Adjusted) 2000-2014



On the Estimation of Sex Trafficking Victims in Nebraska Dr's Ron Hampton and Dwayne Ball, Marketing Department, College of Business, University of Nebraska Sponsored by the Nebraska Governor's Task Force on Human Trafficking May 12, 2015.

"From our work, we can say that the known number of Nebraska school girls who become victims of sex trafficking is at least 47 per year. We are certain, based on the fact that our methodology, in order to avoid any possibility of overestimating, deliberately underestimates the number of Nebraska school girl victims, and that the true number is probably double this or greater. In addition, since it was infeasible to try to estimate the number of adults, males, and nonNebraskans who are sex trafficking victims, the total number of sex trafficking victims in the state is certainly much higher. "

Central District Health Department
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Central District Data

Access to Care

Hamilton	Hall	Merrick

Health Care Access and Use

- In 2017,it was reported:
  - 68.2% visited a dentist
  - 47% age 18 and older got a flu shot
  - 71.5% age 65 and older had ever gotten a flu shot in the past year
  - 82.8% age 65 and older had ever gotten a pneumonia shot
  - 61% had a tetanus shot since 2005
  - 40.6% age 50 and older had ever gotten a shingles shot
- Eye care
  - 42.6% age 40 and older had no health insurance for eye care
  - 67.2% age 40 and older had an eye exam in the past year
- Oral care
  - 68.2% had visited the dentist in the past year
  - 39.6% had any permanent teeth extracted due to tooth decay or gum disease

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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Central District Health Department
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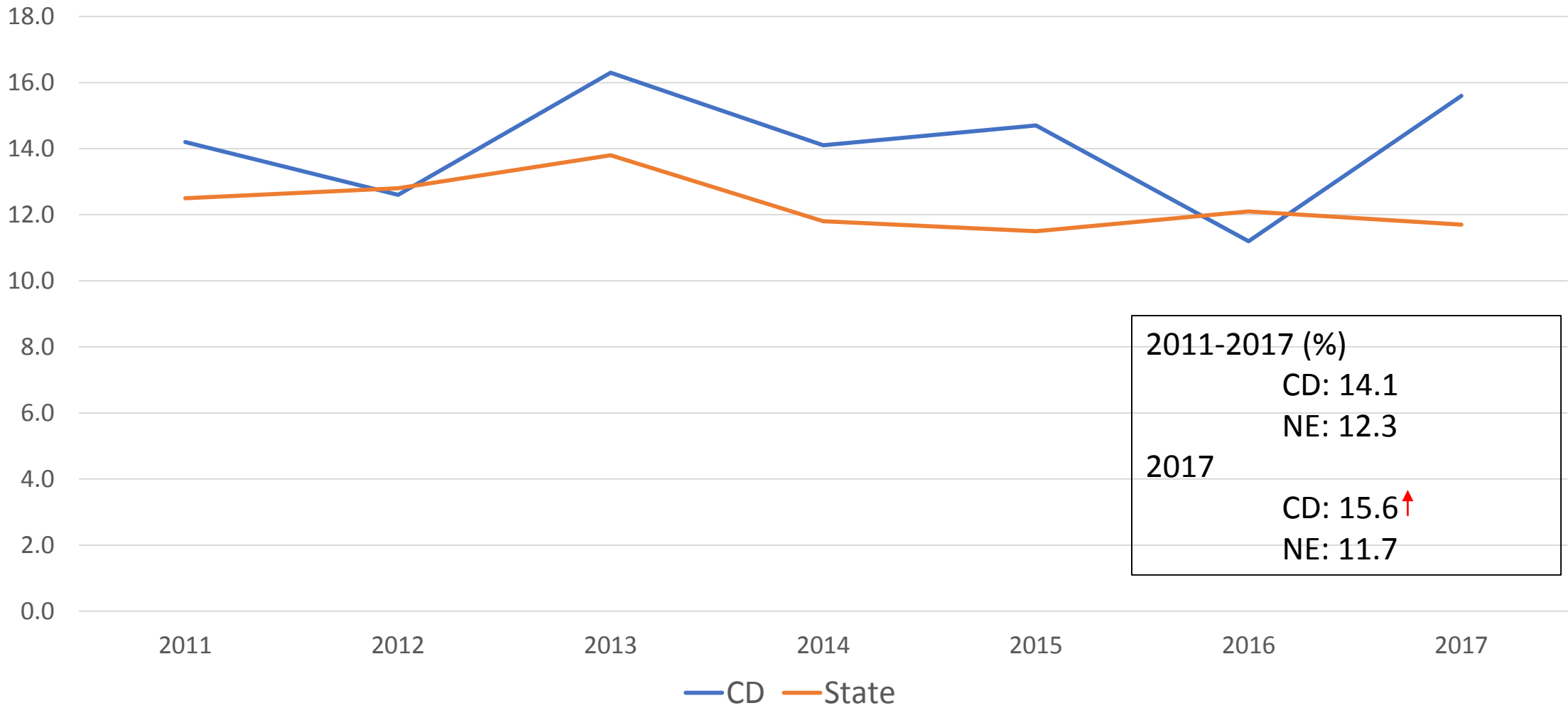
Needed to See a Doctor But Could Not Due to Cost in the Past Year (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Health Literacy

- 68.7% say it is very easy to get needed medical advice or information about health or medical topics
- 54.9% say it is very easy to understand what medical professionals tell you
- 54.2% say it is very easy to understand written health information

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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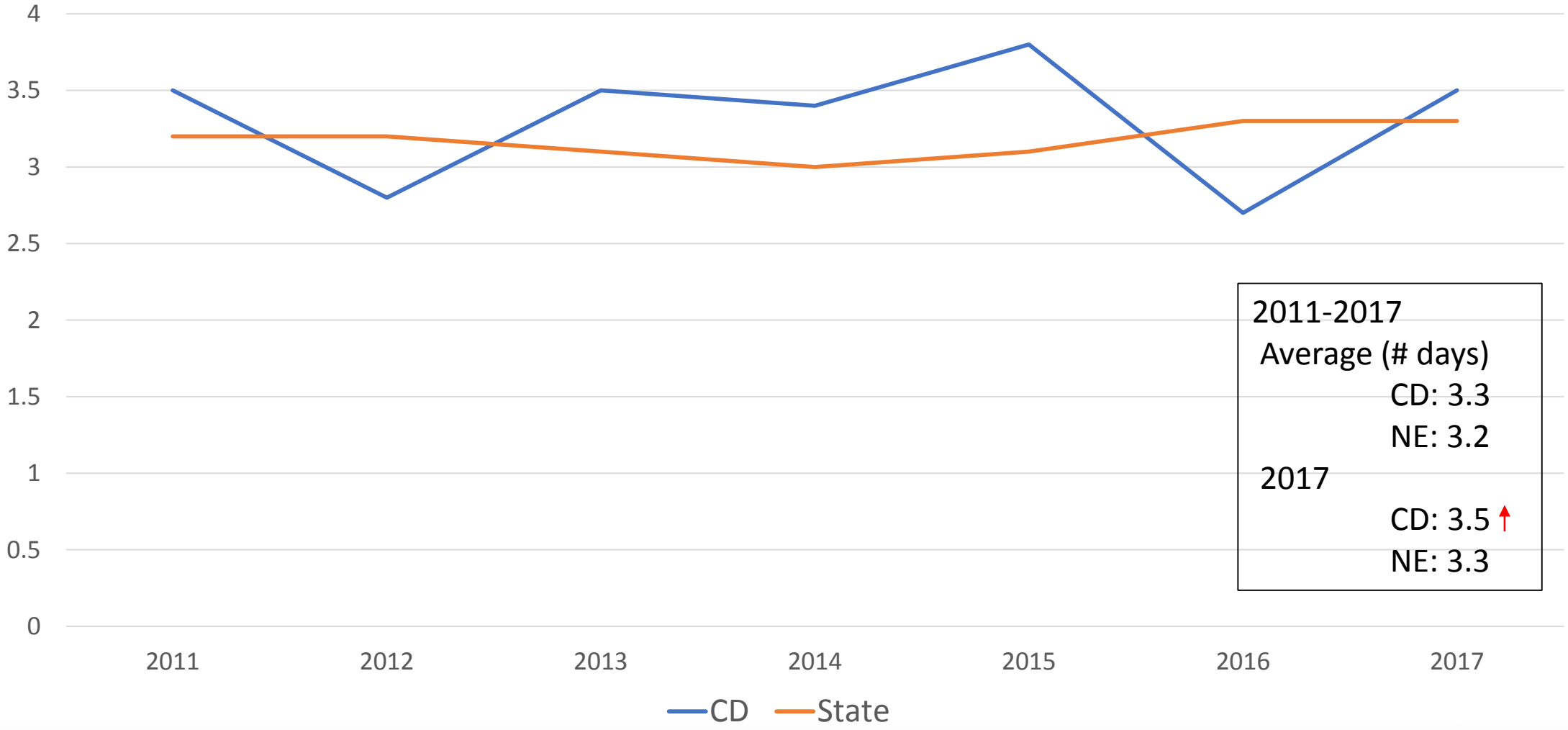
Average Number of Days Physical Health Not Good in Past 30 days



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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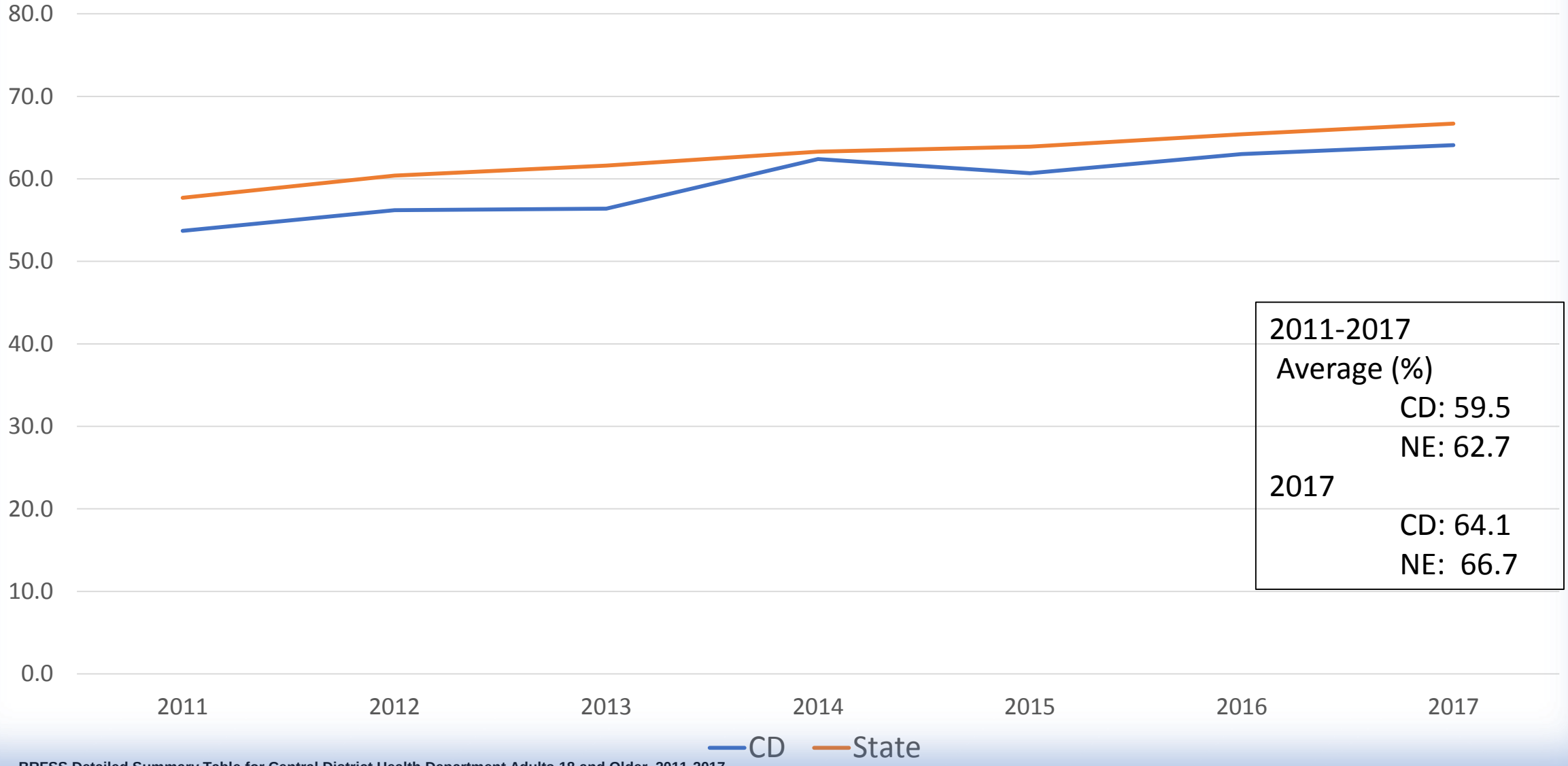
Had a Routine Checkup in the Past Year (%)



2011-2017 Average (%)	
	CD: 59.5
	NE: 62.7
2017	
	CD: 64.1
	NE: 66.7

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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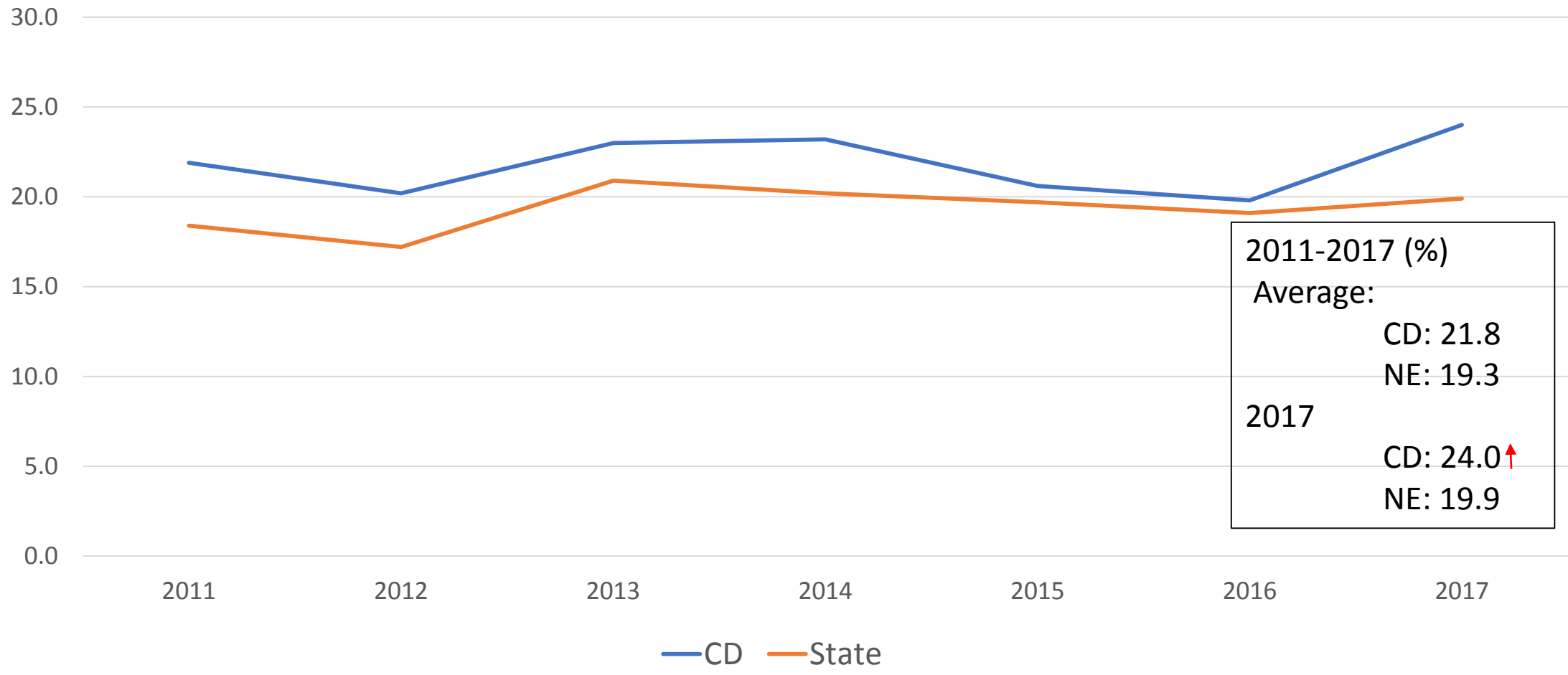
No Personal Doctor or HCP (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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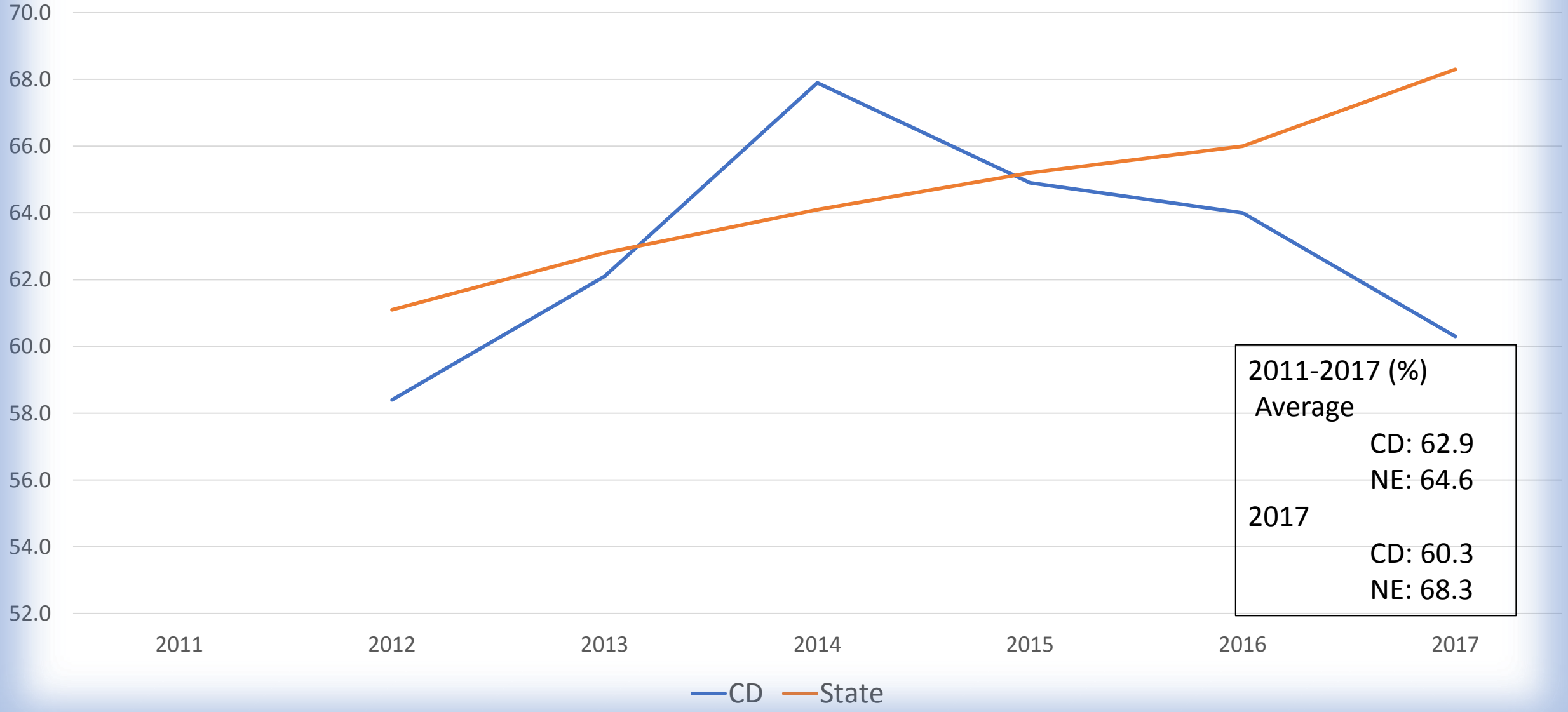
Up to Date on Colon Cancer Screenings (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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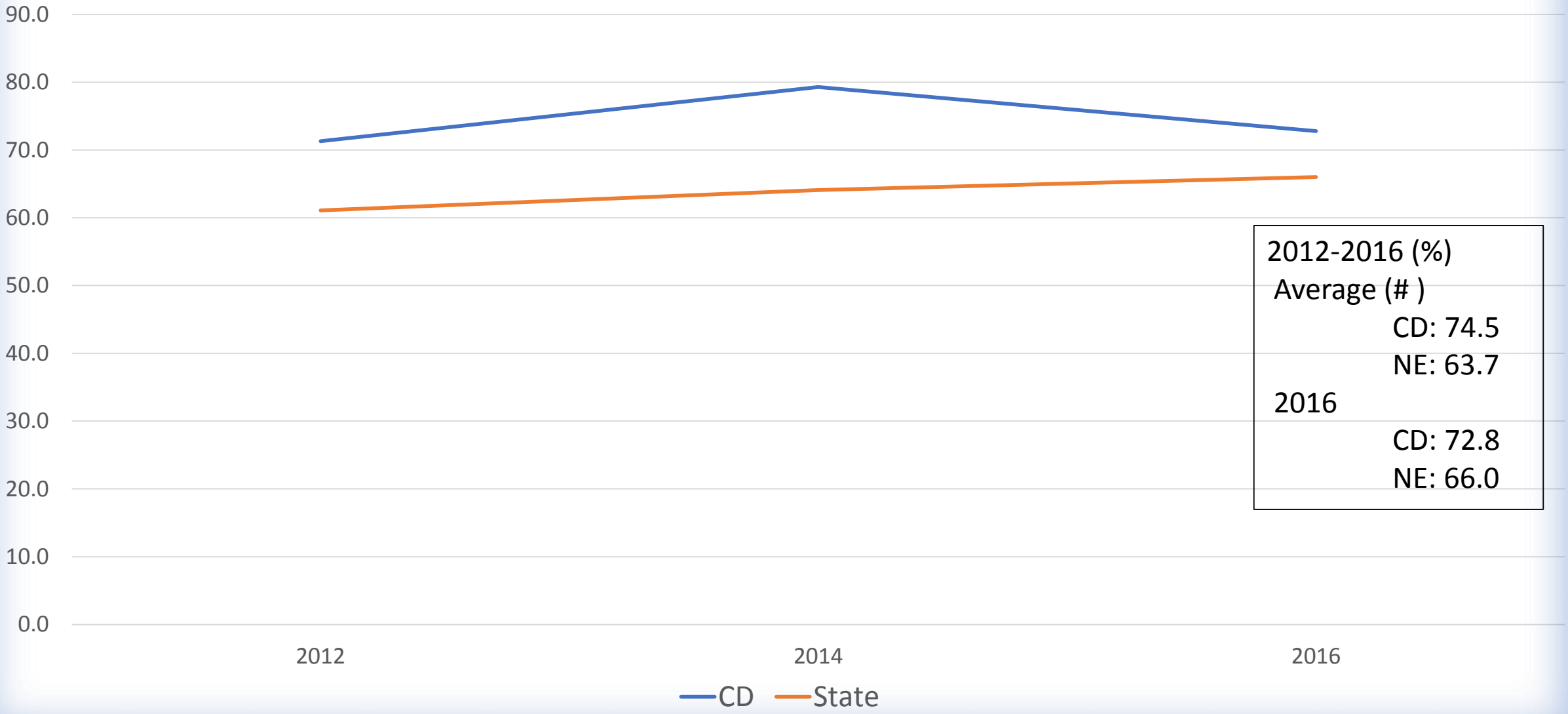
Up to Date on Breast Cancer Screening Female age 50-74 (%)



2012-2016 (%)
Average (#)
CD: 74.5
NE: 63.7
2016
CD: 72.8
NE: 66.0

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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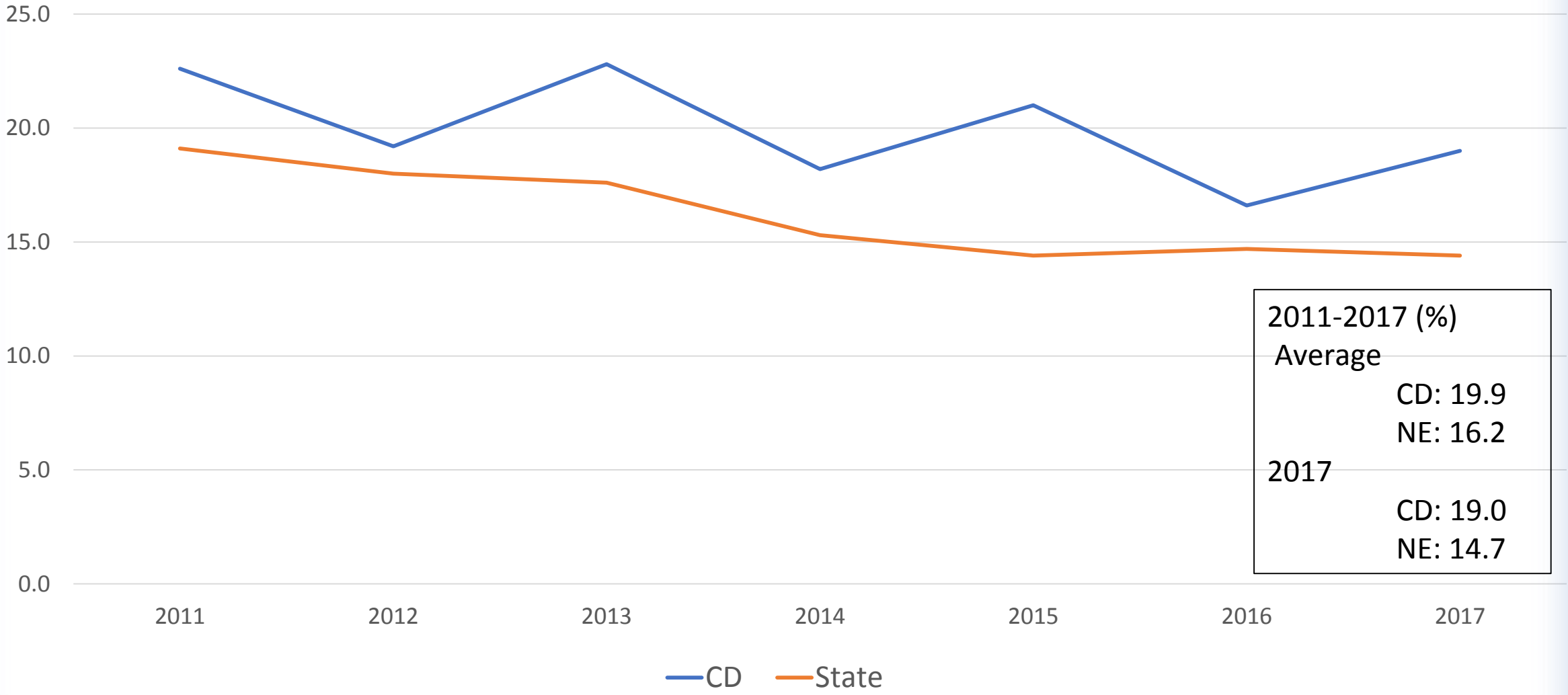
No Health Coverage Age 16-64 yrs. Old (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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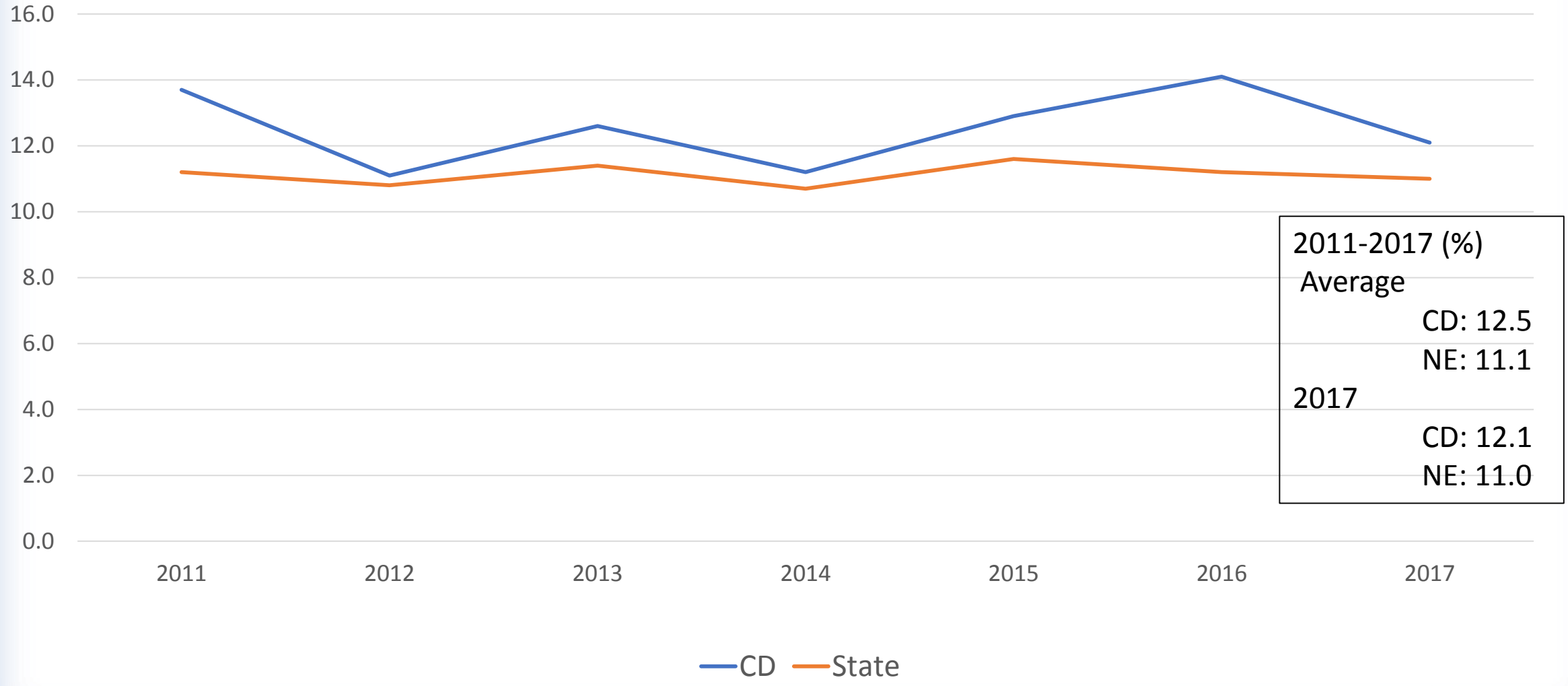
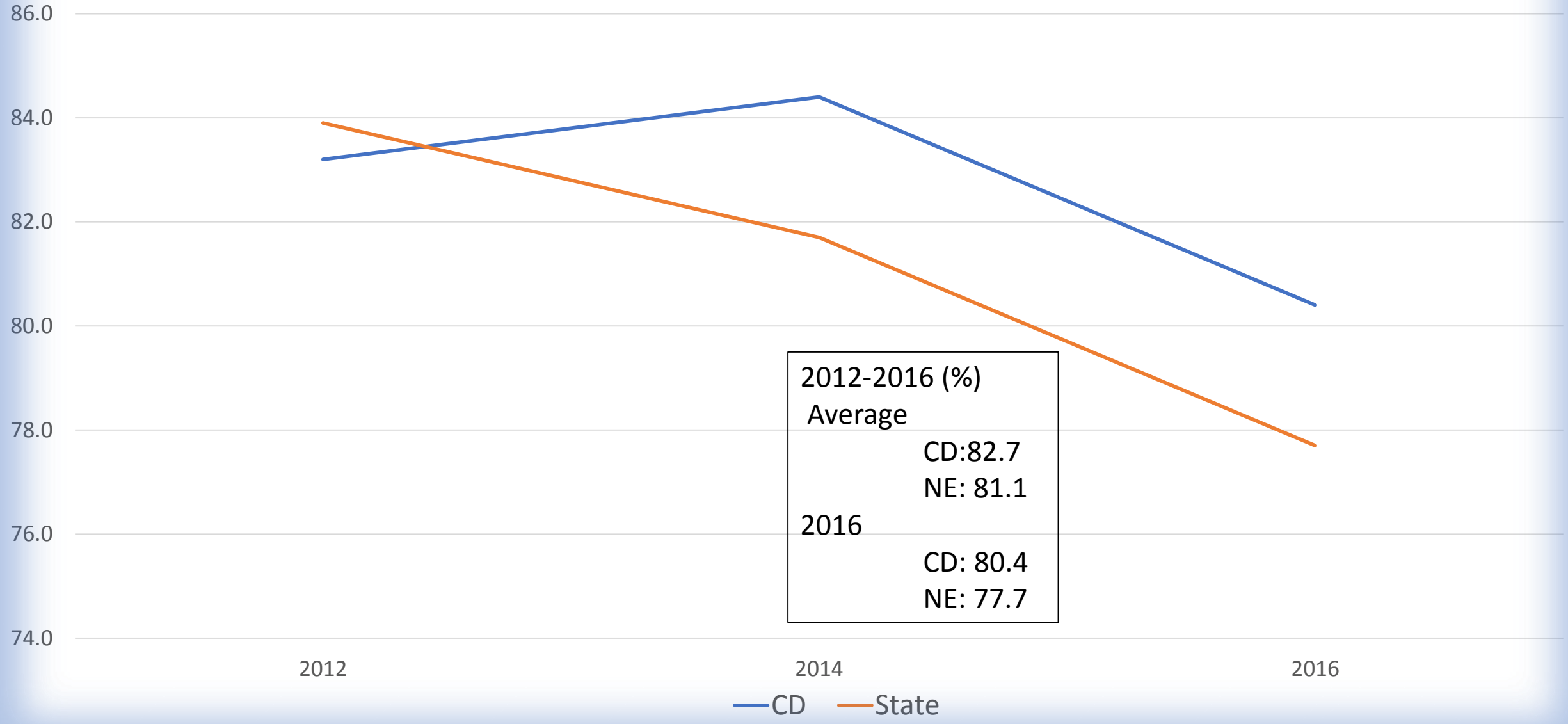
Ever Told They Had Cancer in Any Form (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Up to Date on Cervical Cancer Screening, Female Age 50-74 (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

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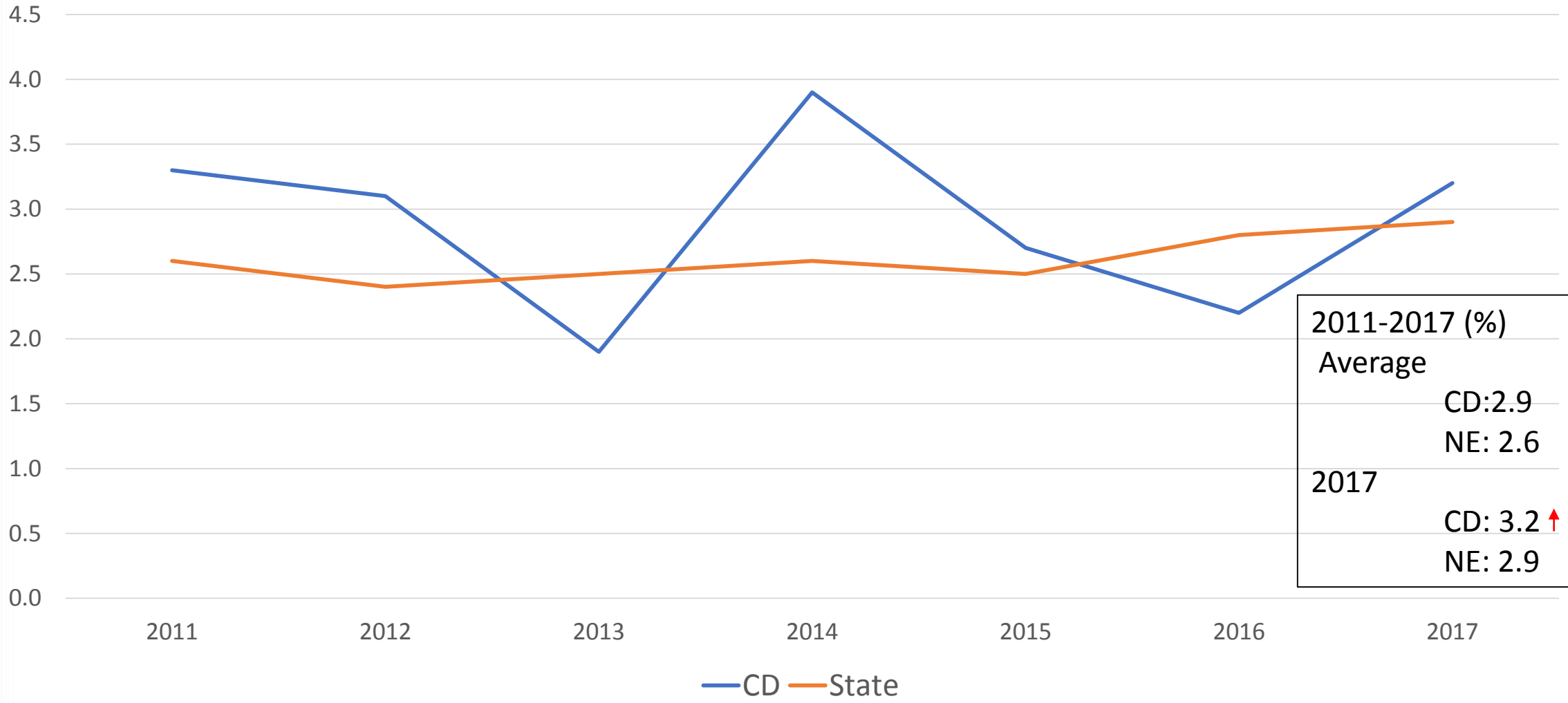
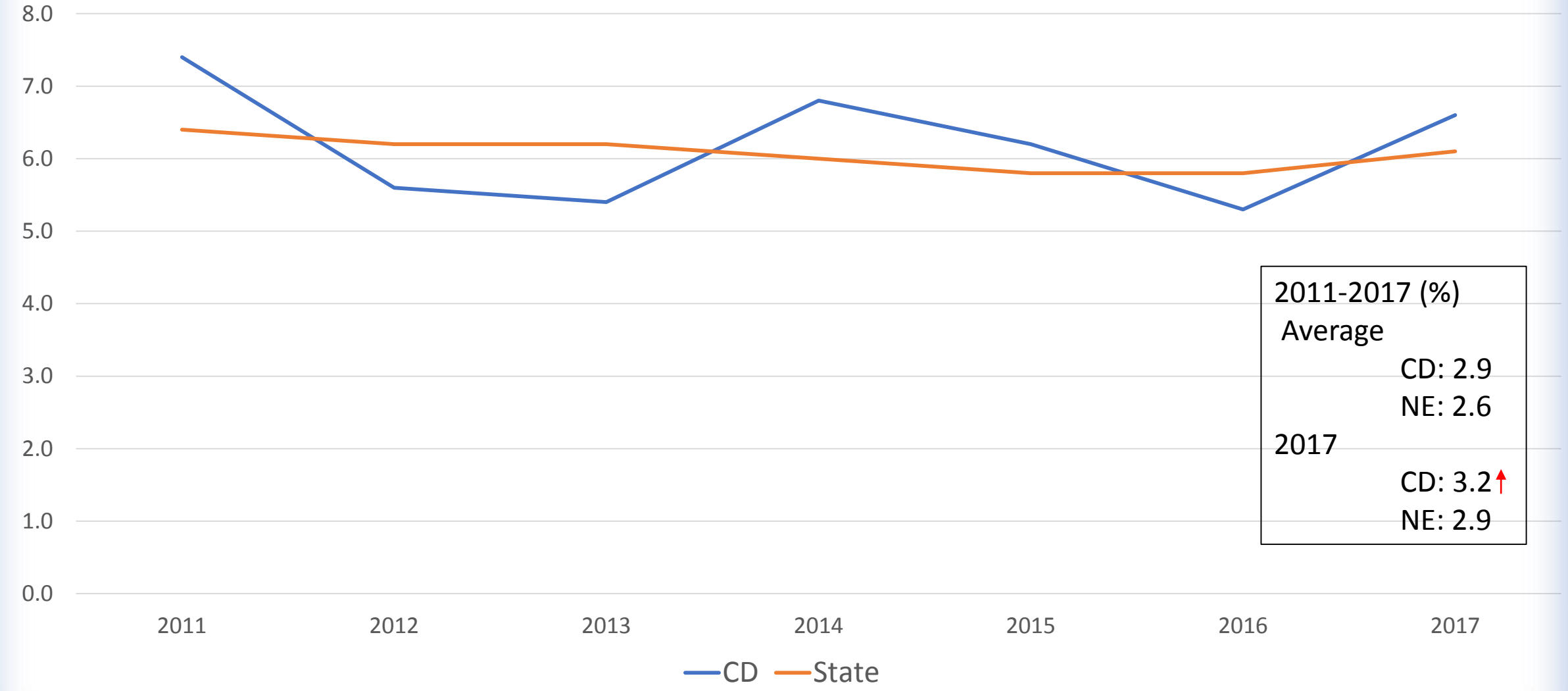
Ever Told They Had a Stroke (%)



2011-2017 (%)
Average
CD:2.9
NE: 2.6
2017
CD: 3.2 ↑
NE: 2.9

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Ever Told They Had a Heart Attack or Coronary Artery Disease (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Data

Obesity

Hamilton	Hall	Merrick

What we do…

- 39.8% are watching salt intake
- Average fruit serving/day =1
- 39.3% eat less than one fruit serving/day
- Average vegetable serving/day - 1.6
- 25.5% eat less than one vegetable serving/day
- 32.6% had no leisure-time physical activity in past 30 days
- 15.4% met both aerobic physical activity and muscle strengthening recommendations
- 72.5 % wear seatbelts when driving or riding in a car
- 31.6% texted while driving in the past 30 days
- 64% talked on cell phone while driving

BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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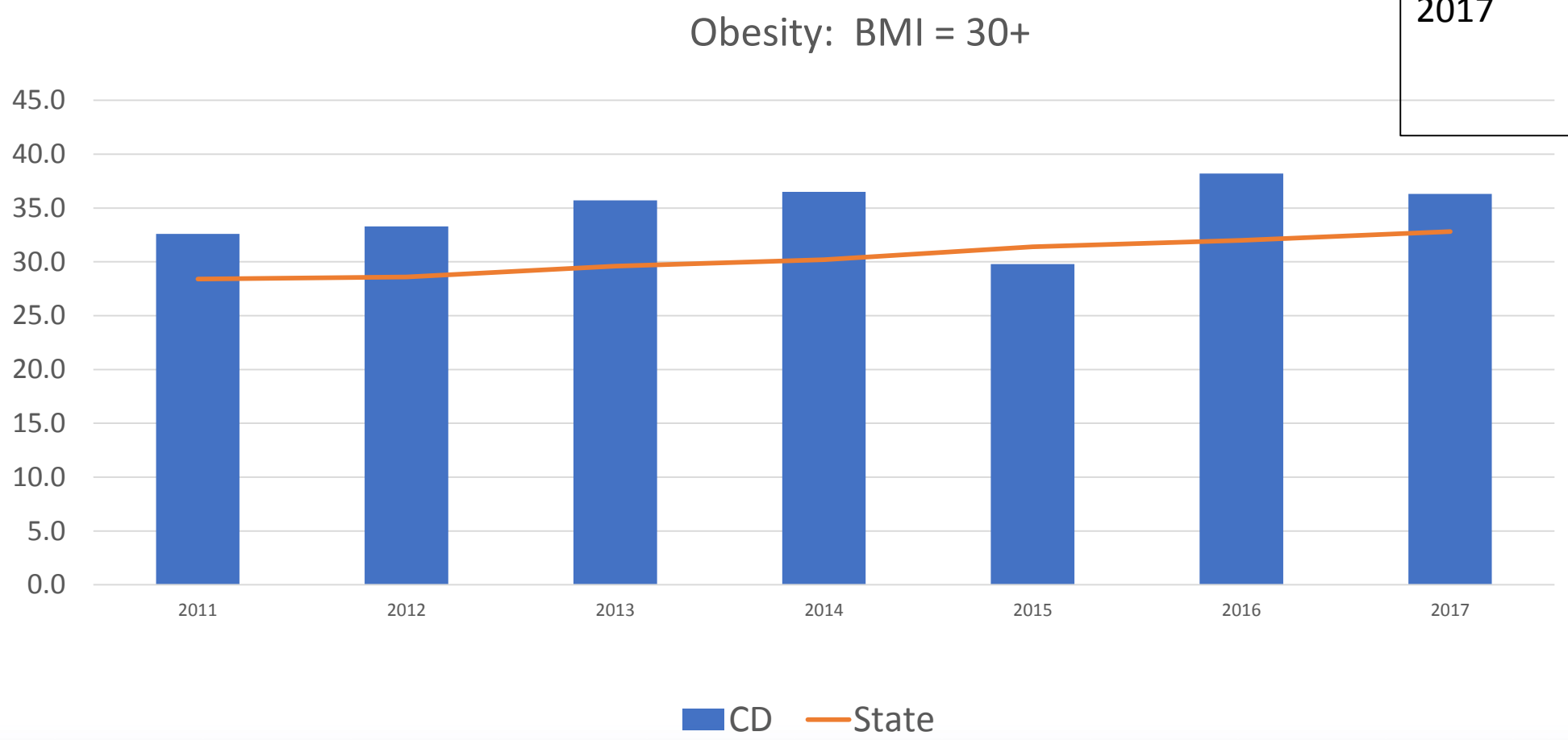
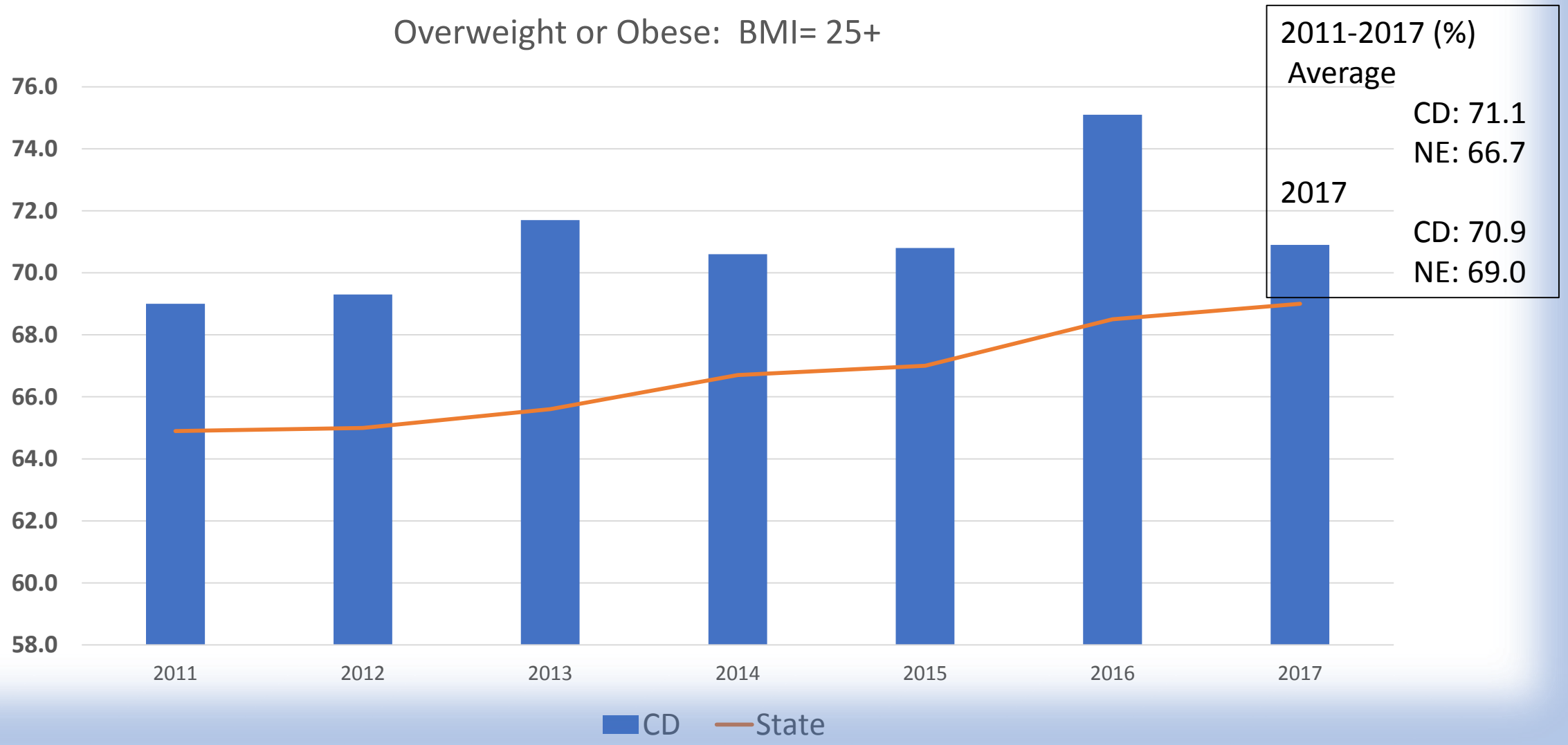
Obesity: Central District

2011-2017 (%)
Average
CD: 34.6
NE: 30.4
2017
CD: 36.3 ↑
NE: 32.8



Overweight or Obesity: Central District



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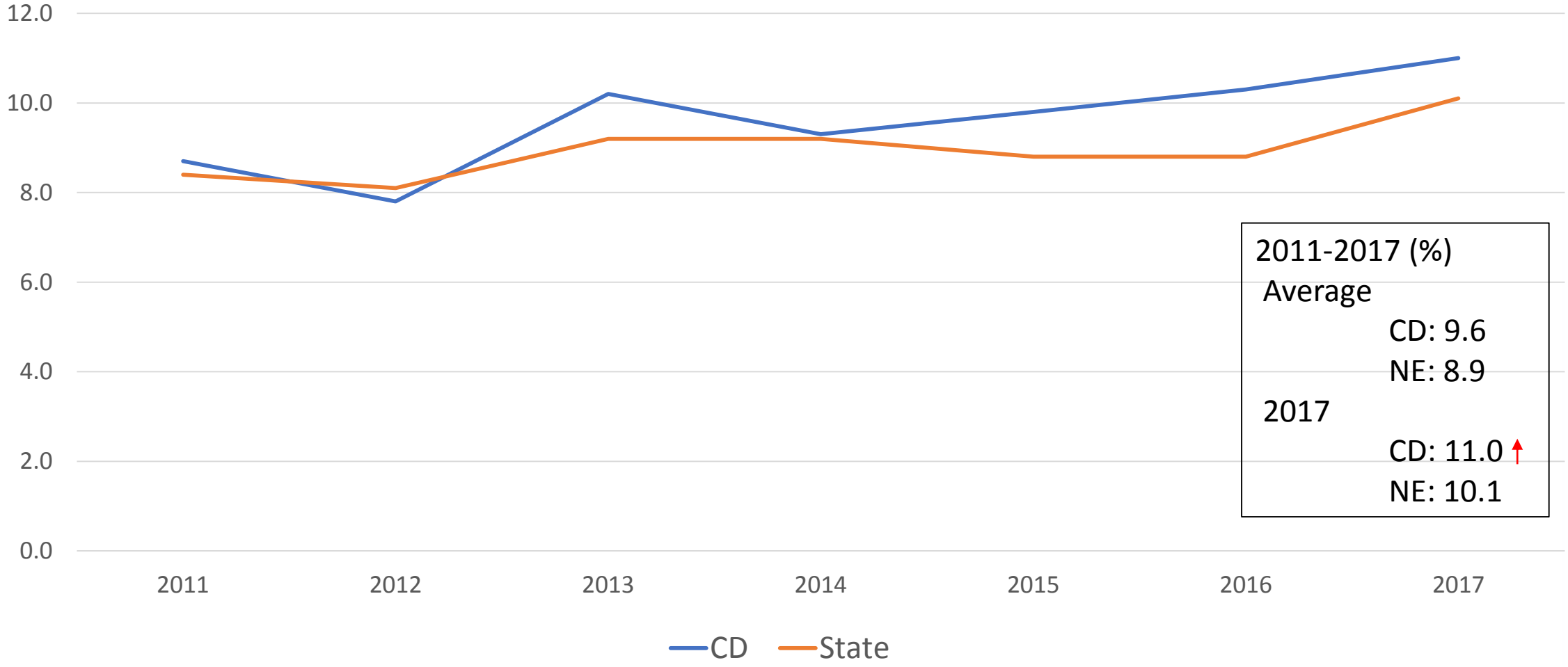
Ever Told They Had Diabetes (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Central District Health Department
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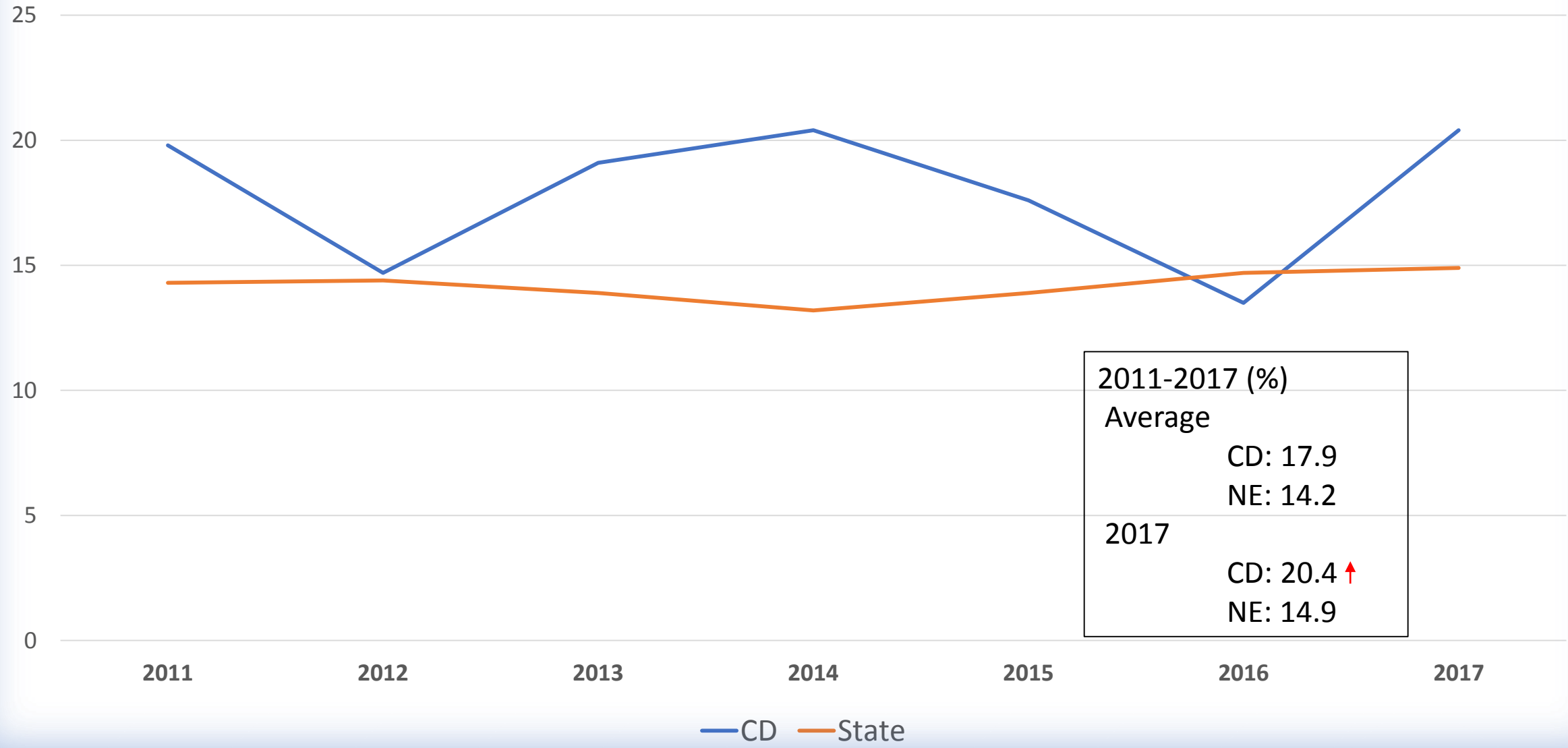
General Health Fair or Poor (%)



BRFSS Detailed Summary Table for Central District Health Department Adults 18 and Older, 2011-2017

Building a Culture of Health

- So now we know how healthy we are….
- What's next?

Now on to our work….

- Large Group Discussion
  - What is missing from this data?
  - What aligns with your perceptions?
  - What surprised you?
  - What is changing/has changed in our community?
  - Achieve consensus on priority health issues
- Small Group Work
  - Prioritize issues based on criteria and present to large group
- Wrap Up
  - Report out
  - Discussion

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Building a Culture of Health

- Questions?
- Thank you!

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Building a Culture of Health

Central District Health Department
Teresa Anderson MSN
Health Director
308-385-5175

Central District Health Department
Jennifer Hubl
Accreditation Coordinator
308-385-5175

Central District Health Department
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Public Health
Prevent. Promote. Protect.

COMMUNITY HEALTH ASSESSMENT MEETING
Location: CHI-SF Health
Date: 1/7/19
Attendees: See sign-in sheet
Community Health and Human Services Providers

DISCUSSION NOTES
Intro: Ed (CHI) & Teresa (CDHD)
Arli (CHI) – reviewed CHI benefit & work CHI is doing
Questions by group:

1. "How many community members/organizations of color are invited?"
   Response: *There is a need to work through community stakeholders to invite and include individuals of color who represent the general community and/or stakeholders who not only serve these populations, but also identify with these populations as planning moves forward to address identified community health needs.*
2. "How many people were invited and how were they invited?"
   Response: Teresa and Arli worked together to create a list of folks within the community who are in the health/human service industry. CDHD intends to hold additional sessions for other homogenous groups.

Melissa (CHI) – CHI 3-year plan (July 2016-June 2019)

Access to care
Injury Prevention & Violence
Behavioral Health

Comment:

"Hall County Community Collaborative (H3C) is working to engage parents with schools"

Teresa reviewed current data through PowerPoint Presentation and asked for group to respond during presentation on data- ex: are you surprised, do you agree, what is missing?
Comments:

Alcohol/ Drugs: "Marijuana (smoking) on street is not a huge, because oils &other methods produce a high that lasts longer…"
"More people are using meth"
Drug deaths: Comments from several "feel number is low"
"May be misreporting on what is what as far as recording drugs, intentional/not intentional deaths."
"Can we break down drugs data more…Is data broken down via race/ethnicity? Particularly suicide/behavioral"

Youth Risk Survey
Teresa noted that these data represent Hall County only and that GIPS was on participant, having the large percentage of students in the 3-county area. Skewed data
Comments:

"Marijuana is on the rise for both medicinal and leisure use"
"Voices for Children and Kids Count will come out in a couple of weeks and will provide additional data"
"Anecdotally marijuana is on the rise in youth"

"1 Choc chip cookie in Colorado = 12 servings of marijuana"
"Shatter = oil (looks like brown glass), and is smoked"
"Perception of risk in young is low"
"Charges for drug use are changing"
"Vapor use – more use now than data shown (2016 data shown- in year 2018, last couple years the use has grown"

Culture of Health
Poverty numbers – break down by ethnicity
Shortage of providers (Shortage of providers or shortage of acceptance of Medicaid?)
Comments:

"Unemployment & salaries for surviving"
"Looking at employment embedded in social determinants: the act of being employed"
"People need work for self-respect, to feel good about themselves, in addition to money"
"What about underemployment numbers, do we have any data?"

Maternal, Infant & Childcare
Comments:

"Do we have data on Birthweight among children of color?"
"What causes the lack of prenatal care?"

Injury & Violence
Comments

"People are talking about it more on social media"
"Cultures share that GI police are trusted"
"Increase in relationship disputes"
"Aggravated = more forceful harm,
"Strangulation = is a citation
"Sexual assault
"Better reporting by officers and better at asking questions. Better advocates. More people are reporting than before"
"Learned behaviors (from being brought up in violent homes) are repeated
"Better knowledge of what violence is"

Accidental Death Rate
Comments:

"Better 1st responders"
"Better equipment"
"Every police officer carries a tourniquet and Narcan"
"Better Medical procedures and technology"

Sex Trafficking
Comments

"Increased awareness in past two year"
"One true victim in our area"
"Prostitution – people get themselves into it to make a living – freely coming here

"White girls are being recruited"
"Sudanese/Somali – meth is provided for their service – they want to live like that because they get a roof over their head, food, and they get the meth they want but they don't get paid"

Access to Care
Comments:
"No public transportation in GI"
"People work long hours and may have one car to share"
"There is limited access to childcare"

Health Literacy
Comments:
None

Housing
Comments:
"It is substandard – No inspection for safe housing"
"Would appall a large portion of our population if they saw the conditions of homes"
"There was a committee working on Health in all policies"

What do you want to see more data on?
Comments**:**
"Subcultures"
"Sex trafficking"
"Prostitution"
"Housing"
"Prenatal: Lack of education, Drug use"
"Age over 60: Meds taking, Food insecurity, Readmissions into hospitals"

Small Group Work: 20 minutes

Small Group Reports -

1. **What are your top 3 priorities based on today's discussion?**
2. **What data are missing?**
3. **Who needs to be at the table going forward?**

Group 1.
1. Obesity – affects all
2. Behavioral health/mental health
3. Culture of Health – transportation

Missing: Schools need to be at the table

Group 2.
1. Behavioral Health
2.
3.
4.

The impact of the top 4 affect all others.

Missing: Crisis Center, Third City, Shelters, Literacy Council, Large employers (HR), schools (large & rural) need to be at the table.
Group looked at who they are serving = Latino / Migrant Groups

Group 3.

1. Substance abuse
2. Injury/Violence
3. Obesity
4. Access to affordable childcare
5. Transportation

Group 4.

1. Substance Abuse
2. Mental Health
3. Injury & violence / culture of health

Missing: DHHS, Legislature, Recovery community, Rehab, Goodwill, Dept. of Labor, Culture of disabilities, Choice family

Group 5.

1. Access to care – goes into access that goes into all high deductible affects access
2. Substance abuse
3. Obesity

Missing: Status discrepancies, GED, CCC-educational good ideas

Group 6.

Group based their decisions off of who they are serving

1. Maternal & Infant
2. Substance Abuse
3. Behavior/Mental Health

Missing: Probation, Economic Assistance (child care, SNAP) child protective services need to be at the table.
"Priorities are different for everyone. It's difficult to say that the community said this as an issue because we all have our own pockets we are in"
"We all have different pieces of puzzle"

Group 7.

1. Behavioral

Group 8.

1. Elderly Care
    a. Transportation – don't get out, watch TV, then we get a lot of falls
    b. Behavioral Health

Missing – transportation

Question to the whole group
Think of whole district: Who is missing?

Boy's Town

Bryan LGH
Officials & Government personnel (city and county)
Literacy Council
People of Color
Faith based community
Department of Labor
JBS should be included
Shelters
Housing

What were your "AH HA" Moments?

Health Department does a good job at partnering

What is missing overall?

Ability to communicate & logistics for languages other than English.

Interpreters
Language line is spoken, not written
Need pool of interpreters in the community
Lutheran Family Services – has some interpretive services

WRITTEN COMMENTS

During and following the meeting, attendees were asked to write down any thoughts and submit at the end of the meeting.

Written - CHI Individual Notes 1/7/2019

Organized by category

Access to care

Individuals not getting preventative care, just going in for health crisis situations care. Age dependent (i.e. young adults)
Costs need to be lowered – low income is high, but health care costs are high
Young adults accessing ER or Rapid care rather than Primary Doctor. They lack routine care
Meaningful & appropriate engagement with disparate populations
Push need for regular physician
Never enough resources.

Mental Health

Need some short-term center in GI, Not taking EPC to Kearney to be released in 1-2 days.
More Access to BH/MH services. Capacity and access by community across all income levels
Youth Higher Level Mental Health Care– Youth deemed unsafe and needing higher level of care have to go to Lincoln, Omaha or Scottsbluff
Services for the unstable but not suicidal – What can be done assist vulnerable adults who present as mentally unstable- but are not a threat to self or others so they cannot be put into emergency protective custody.
We feel if you address mental health & substance abuse it will impact injury & violence.

Substance Abuse

Need more resources for detox both short and long term – services in G.I are full but with people from outside area as well. No beds.

Detox options for prescription opioids and benzos
Access to care –Opioids & benzos account for 50% of recorded overdose BUT they have no detox solutions
Access to Detox after hours – Detox center unable to provide medical assisted detox after hours w/o 24 hr. pharmacy

Violence
Increase in reporting of domestic violence. Do we have enough resources for people that are now reporting?
Injury/Violence could be higher; however, we are working on the assumption that by working toward some of these other topics, this issue may be addressed as a subtopic

Reproductive
Need STD data, abortion data (teen and adult)
Sexual Health- Abortion > teen pregnancy rat %, & STD's
Abortions, STD's, other risky sexual bx's (behaviors) by youth. Abortion, teen births down…a factor?
Reproductive Health important?

Culture of Health
People often identify need for services and willingness to participate but don't have the transportation to get there.
Translation services – 24/7 access to translators to assist with translation needs associated with provision for adults and youth
Housing shortage
Transportation to services
Interpretation/ Translation
Rated maternal health and injury & violence & obesity as lower as feel if we address the top factors then we will impact these areas.

CDHD CHI St. Francis Health Community Meeting January 7, 2020

Participants ranked each health issue using the following criteria:
1) Is issue affecting a large % of the population or are there severe consequences?
2) Does issue affect people differently based on race, education, gender income?
3) Is the issue getting worse?
4) Have we heard the community say this is an issue?
5) Do we have the resources, partners, expertise in this area?
The following measure of ranking was used:
0=not serious, 1=Moderately serious, 2=very serious

Person #	Behavioral/Mental Health	Substance Abuse	Culture of Health	Access to Health Care	Maternal, Infant and Child Health	Injury & Violence	Obesity
1	8	8	7	8	6	8	8
2	8	9	5	6	2	8	3
3	8	8	6	7	5	7	6
4	8	9	7	8	7	8	6
5	7	10	5	8	6	10	10
6	8	8	5	9	9	5	6
7	9	8	7	7	6	6	8
8	10	9	6	10	7	5	5
9	8	9	5	8	6	5	9
10	7	10	5	8	7	10	10
11	7	10	5	8	6	10	10
12	10	9	10	10	6	6	9
13	10	9	10	10	6	7	9
14	10	9	10	10	6	6	9
15	6	10	5	10	4	4	9
16	8	8	8	5	7	7	9
17	9	8	8	7	9	10	10
18	9	10	6	9	8	7	8
19	8	8	7	8	6	8	9
20	7	9	7	10	7	8	10
21	9	8	8	7	8	8	10
22	9	8	8	7	8	8	10
23	9	8	8	7	8	8	10
24	10	10	10	10	6	5	8
Mean:	**8.4**	**8.8**	**7.0**	**8.2**	**6.5**	**7.3**	**8.4**
Mode:	**8**	**8**	**5**	**8**	**6**	**8**	**10**
	Behavioral/Mental Health	**Substance Abuse**	**Culture of Health**	**Access to Health Care**	**Maternal, Infant and Child Health**	**Injury & Violence**	**Obesity**

From the participant ranking, four areas emerged as the highest o=in both mean and mode. Behavioral health can include substance abuse
The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as including “the promotion of emotional health; the prevention of mental illnesses and substance use disorders; and treatments and services for mental and/or substance use disorders.”
https://nnphi.org/top-5-issues-to-consider-at-the-intersection-of-behavioral-health-and-public-health/
Based on this definition, we plan to combine behavioral/mental health and substance abuse into one prioritized issue referred to as “Behavioral Health.”

The other two issues prioritized at the CHI meeting were “Access to Care” and “Obesity.” Next steps will include additional community meetings of homogenous groups to gather additional community perspectives.


CHI Health