Community Health Needs Assessment

2022

Northeast Nebraska
Rural Health Network

This report was prepared by staff of the
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in conjunction with VisionFusion and Intersections Consulting;
and staff from partner members including:
Pender Community Hospital;
Providence Medical Center;
Winnebago Public Health Department;
Midtown Health Center;
University of Nebraska Medical Center; and
Northeast Nebraska Public Health Department.

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List of agencies who provided CHNA input:

Carl T. Curtis Health Center
Cedar County Transit
Educational Service Unit #1
Hartington Senior Center
Haven House
La Michuacana
League of Human Dignity
Luna's Cafe
Midtown Health Center
Nebraska Association of Local Health Directors
Nebraska Department of Health and Human Services
Nebraska Extension
Northeast Nebraska Community Action Partnership
Northeast Nebraska Public Health Department
Pearl Street Counseling
Pender Medical Clinic
Pender Community Hospital
Providence Medical Center
Rural Region One Medical Response System
University of Nebraska College of Nursing Northern Division
University of Nebraska College of Public Health
Wayne Association of Congregations and Ministers
Wayne Community Schools
Wayne Family Coalition
Wayne Herald
Wayne Community Housing Development Commission
Wayne State College
Winnebago Health Department

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taught by Dr. Jeff Shelton)**

Executive Summary

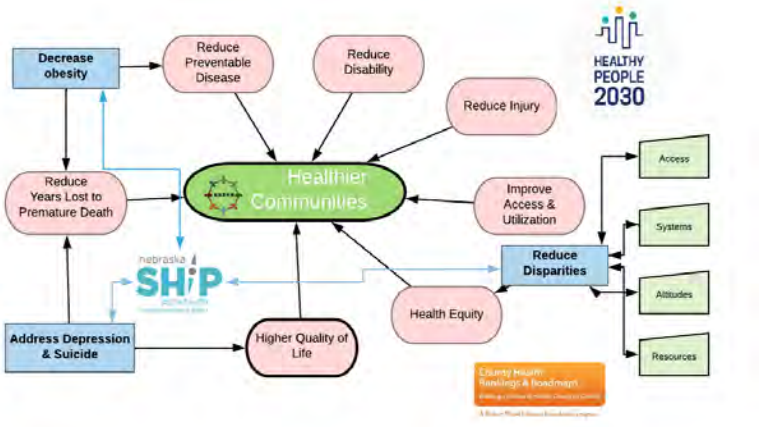
In 2021, as in 2018, Pender Community Hospital (PCH), Providence Medical Center (PMC), Northeast Nebraska Public Health Department (NNPHD) , University of Nebraska Medical Center and the Winnebago Public Health Department came together to conduct a single Community Health Needs Assessment for the geographic region containing the counties of Cedar, Dixon, Thurston and Wayne. These founding partners of the Northeast Nebraska Rural Health Network (NNRHN) were joined by new member Midtown Health Center (MHC) in these efforts, along with a Health Equity Advisory Council, various coalitions, and other stakeholders.

Board members of the network again formed the Core Steering Committee for this effort, along with the network director who was hired in the summer of 2021. Some members of this group also helped found the Health Equity Advisory Council. Both groups analyzed information from multiple secondary data sources (including US Census, BRFSS, etc.), community listening sessions, multiple meetings with various groups of stakeholders, and a community survey, all guided by the MAPP process. Findings of the previous CHNA and CHIP were also reviewed. Additionally, data was analyzed to determine the impact of COVID-19. Effects of the pandemic on those who were diagnosed with COVID-19, as well as on the rest of the population were considered. Indicators have been analyzed through the lens of social determinants of health (SDOH) and health equity, reflecting the commitments of NNRHN and its partners, to address upstream factors that contribute to poor health.

Over six hundred surveys were collected from across the health district. Live listening sessions were conducted in Cedar, Dixon and Wayne counties and Thurston County participated in a virtual session. Listening sessions with the area's Hispanic population, with interpretation by NNPHD staff, were facilitated by our Health Director. This led to the formation of a health consumer focused advisory council composed of members of the area's Latino Community. A series of five virtual conversations were held to update the findings of our 2019 Local Public Health System Assessment using the recently updated 10 Essential Services of Public Health, as well as the local system's experience with the COVID-19 pandemic. A Health Equity Advisory Council was started in December 2021 which has also given us feedback.

The Measures

This assessment provides information on (# of) indicators and is designed to give a comprehensive picture of the region served by the partners of the Northeast Nebraska Rural Health Network. These indicators were chosen by this committee because of their relationship not only to the goals of the Network, but also to state and national health improvement goals.



Key health outcomes

Health outcomes where health district averages, as well as those of one or more of our counties, are worse than state averages include:

- Cancer–colon and rectum (Dixon, Thurston, Wayne)
- Cancer-lung (Dixon, Thurston)
- Cancer-prostate (Cedar, Dixon, Wayne)
- Chronic Obstructive Pulmonary Disease (Cedar, Dixon, Thurston)
- Diabetes (Medicare) (Thurston)
- Heart disease (Dixon, Thurston, Wayne)
- Kidney disease (Cedar, Dixon, Thurston)
- High blood pressure (Cedar, Dixon, Thurston)
- Deaths of despair (Thurston)
- Mortality-Cancer (Thurston)
- Mortality-Coronary Heart Disease (Cedar, Dixon, Thurston)
- Mortality-Heart Disease (Dixon, Thurston)
- Mortality-Motor Vehicle Crash, Alcohol-Involved (Thurston, Wayne)
- Mortality-Years of Potential Life Lost (Cedar, Thurston)
- Mortality-Stroke (Cedar)
- Mortality-Unintentional Injury-Accident (Cedar, Thurston)
- Obesity (Cedar, Dixon, Thurston, Wayne)

Key health factors

Health factors where health district averages are worse than state averages include:

- Low proportion of food budget on fruits and vegetables (individual county data not available)
- High proportion of food budget spent on soda (individual county data not available)
- Physical inactivity (Cedar, Dixon, Thurston)
- Current smokers (Dixon, Thurston)
- Tobacco expenditures (individual county data not available)
- Heavy alcohol consumption (individual county data not available)
- Chlamydia incidence (individual county data not available)

Disparities

- Language–over 500 of our residents are not proficient in English.
- Education
- Income
- Schedule of health care versus job schedule and transportation options
- Locations and transportation options

Concerns

- COVID-19, even in 2022, was expressed as a worry of approximately one-third of survey respondents, and cited as one of the TOP 3 concerns when asked to pick from a list.
- Mental health remained a top worry of survey respondents (similar to 2019). Social isolation was identified as a stressor which contributed to anxiety and depression.
- Cancer was a top worry of survey respondents, but the area has been underperforming in terms of screenings.
- While “obesity” was not one of the choices for the closed ended questions, respondents expressed concerns about access to healthy affordable food, the need to be more physically active and maintaining a healthy weight were mentioned frequently in the open-ended questions.
- Affording out-of-pocket costs for medical care, as well as maintaining insurance, were identified as concerns.
- Being able to get emergency or speciality care as needed, given distances to facilities, is a concern.
- Long-term care is another area of concern since a local facility recently closed.

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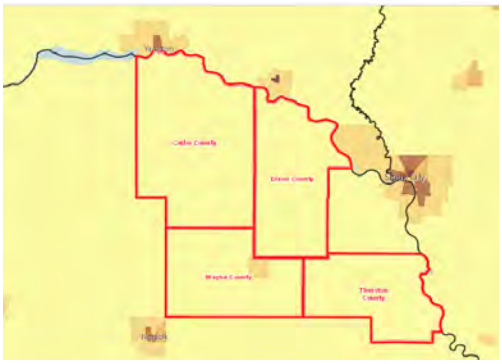
Introduction

The Report Area



The report area includes four counties in Northeast Nebraska: Cedar, Dixon, Thurston, and Wayne. Larger towns in this area include the four county seats: Wayne (Wayne) 5,930; Hartington (Cedar) 1,422; Pender (Thurston) 1,108 and Ponca (Dixon) 885. Other larger towns in the area include Wakefield, 1,363; Laurel, 901; and Randolph, 875; Winnebago, 760; and Macy, 988.

Within the borders of Thurston County lie the lands of the Winnebago Tribe and the Omaha Tribe.

Figure 1: The four county report area

This area comprises the **health district** served by the Northeast Nebraska Public Health Department. As this report is being prepared by the Northeast Nebraska Rural Health Network, which also serves these four counties, the report area will be referred to in tables as "NNRHN."

This area is served by two **Critical Access Hospitals** (Providence Medical Center and Pender Community Hospital), clinics administered by Faith Regional Services, out of Norfolk Nebraska, clinics administered by Avera and Sanford health systems out of neighboring South Dakota, and **Federally Qualified Health Centers**, located outside of the borders of these counties: Midtown Health Center, Norfolk, NE; Siouxland Community Health Center with locations in Sioux City, IA, and South Sioux City, NE; and Community Health Centers in Elk Point, SD; and Yankton, SD; run by Horizon Health Care.

	NNRHN	Cedar	Dixon	Thurston	Wayne
Number of Incorporated Towns	32	10	10	6	6
Total Land Area (Square Miles)	2052.85	740.24	476.11	393.58	442.92
Population Density (Per Square Mile)	14.84	11.32	11.77	17.21	21.89
2000 Census	32976	9615	6339	7171	9851
2010 Census	31387	8852	6000	6940	9595
2020 Census	30456	8380	5606	6773	9697

Figure 2: Population of the four counties in 2000, 2010, and 2020, US Census, October 21, 2021.

Change in Overall Population

Current population demographics and changes in demographic composition over time, play a determining role in the types of health and social services needed by communities. According to the United States Census Bureau Decennial Census, between 2010 and 2020, the population in the report area fell by 931 persons, a change of -2.97%. The only exception to this decrease was in Wayne County, which experienced a 1.06% increase during this decade. As can be seen in Figure 4, the decrease is mirrored in the other rural counties in Nebraska–whereas the urban counties continue to see increases. A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources. For more information on Demographics, see [Appendix 3.]

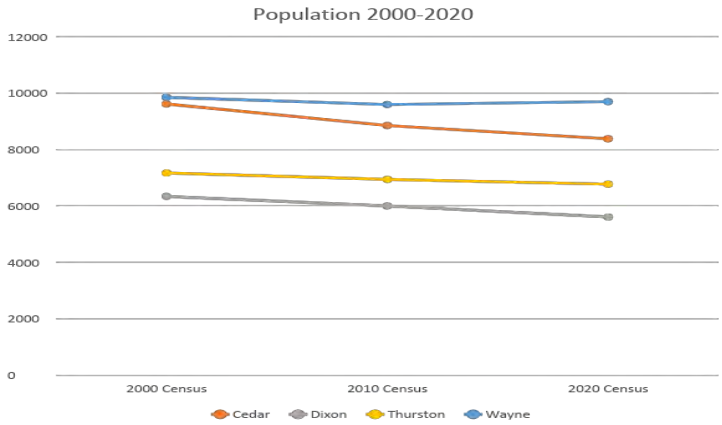


Figure 3: US Census, Trends for each County

	NNRHN	Cedar	Dixon	Thurston	Wayne	Total in remaining counties	Douglas	Hall	Lancaster	Sarpy	Urban Counties	Nebraska
2000 Census	32976	9615	6339	7171	9851	788,282	463,585	53,534	250,291	122,595	890,005	1,711,263
2010 Census	31387	8852	6000	6940	9595	774,991	517,110	58,607	285,407	158,840	1,019,964	1,826,342
2020 Census	30456	8380	5606	6773	9697	770,415	584,526	62,895	322,608	190,604	1,160,633	1,961,504.00

Figure 4: Population of NNRHN Counties versus urban counties in Nebraska via SparkMap, October 18, 2021

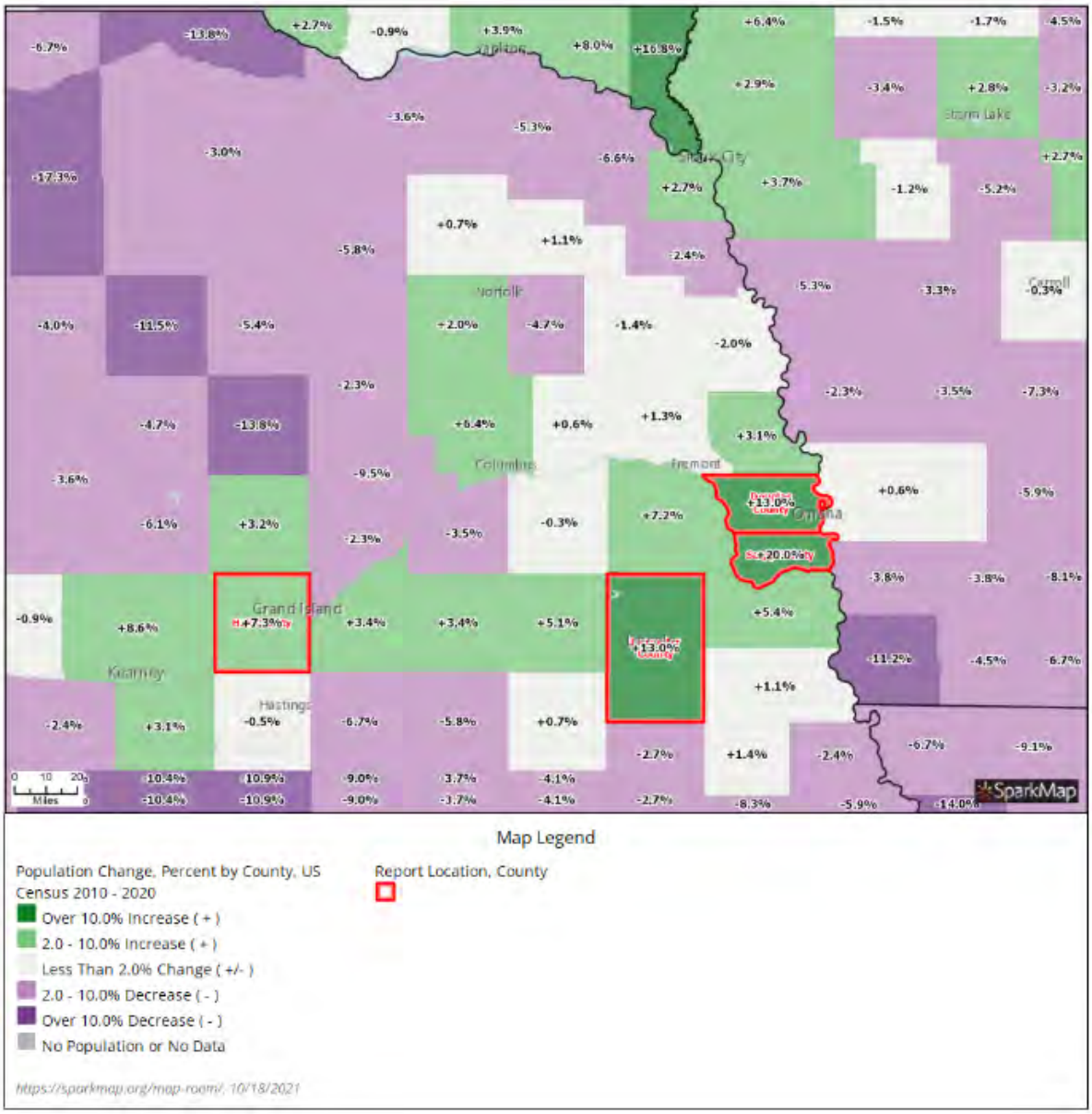


Figure 4.5: US Census Population Change 2010-2020 in each Counties, via SparkMap October 21, 2021

Race and Ethnicity

The racial and ethnic makeup vary among the four counties served by the NNRHN. While Cedar County is overwhelmingly White and Non-Hispanic, Thurston County, which has within its borders two American Indian reservations, Winnebago and Omaha, is less than 40% White.

The Hispanic population in this region grew by 68.40% from 2010-2020. See map at Figure 5. for Population, Hispanic or Latino, Total by ZCTA, ACS 2015-2019.

According to the Rural and Minority Health Research Center, Hispanic persons are the fastest growing population in rural America and are projected to be the largest rural minority in the U.S. by 2025 (“FINDINGS BRIEF”) .

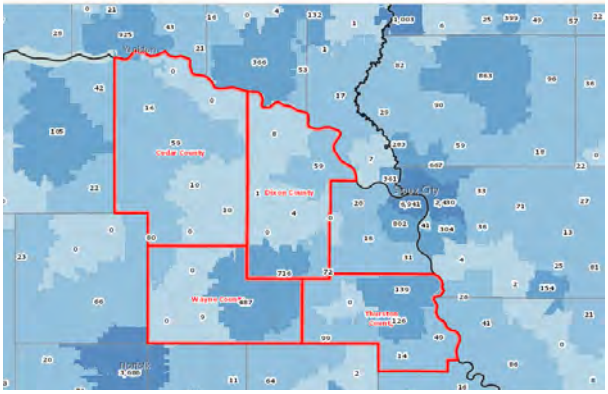


Figure 5: Hispanic Population, via SparkMap March 2022

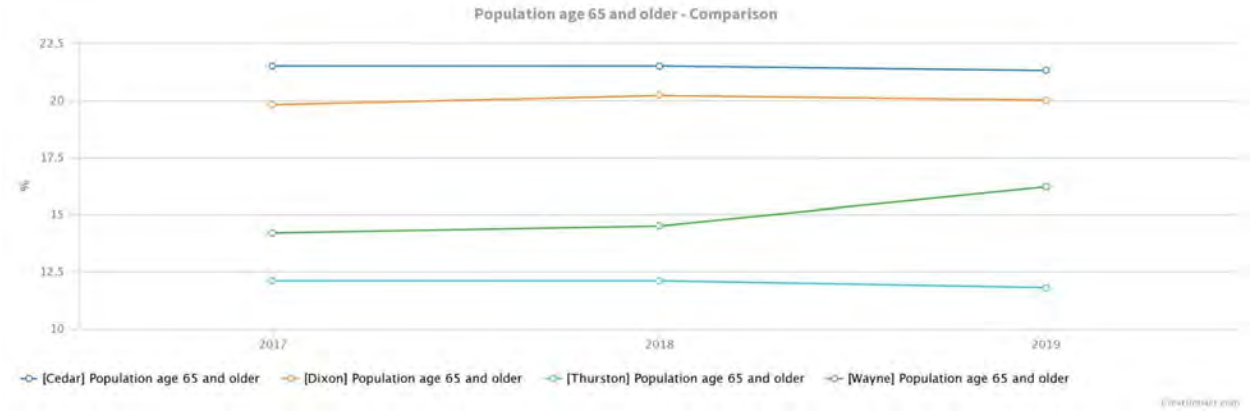
In addition to the Hispanic population, the Northeast Nebraska Rural Health Network has been collaborating with representatives of tribal nations within our borders in a number of ways. For example, the Winnebago Public Health Department is a member of the Network and several of their staff members are regular contributors to the Health Equity Advisory Council. NNRHN and NNPHD staff will be working on building on the increasing level of partnership that developed between NNPHD and Carl T. Curtis Health Education Center during the last two years during/throughout the pandemic.

	United States	Nebraska	NNRHN Region	Cedar County	Dixon County	Thurston County	Wayne County
Total:	**331,449,281**	**1,961,504**	**30,456**	**8,380**	**5,606**	**6,773**	**9,697**
White alone	204,277,273	1,538,052	23,297	8,064	4,735	2,475	8,023
Black or African American alone	41,104,200	96,535	421	28	18	24	351
American Indian and Alaska Native alone	3,727,135	23,102	4,087	13	33	3,980	61
Asian alone	19,886,049	52,951	165	12	22	9	122
Native Hawaiian and Other Pacific Islander alone	689,966	1,534	19	2	0	9	8
Some Other Race alone	27,915,715	105,167	1,217	76	408	84	649
Population of two or more races:	33,848,943	144,163	1,250	185	390	192	483

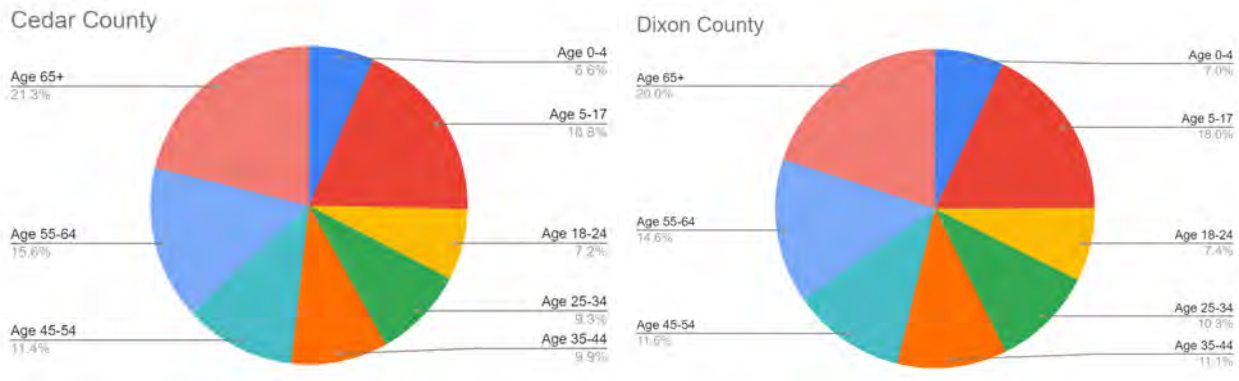
Figure 6: US Census 2020, October 21, 2021

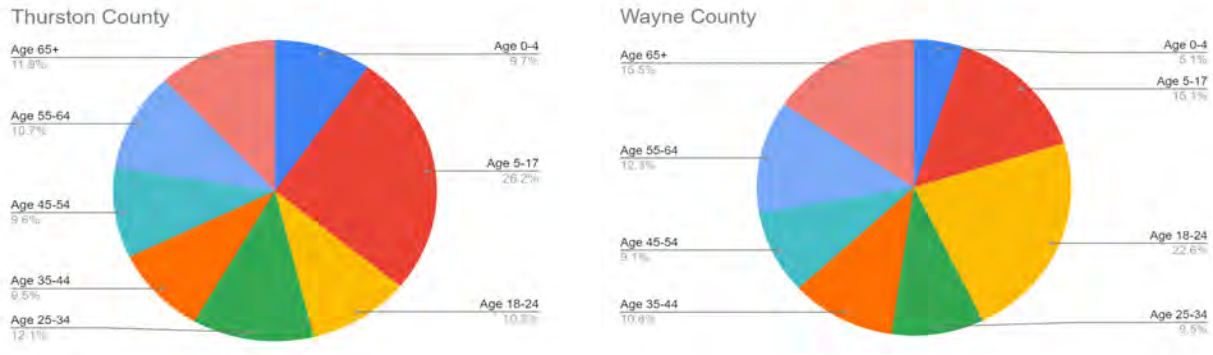
Age Distribution

Differences in age distribution in this area can affect health factors and outcomes. The median age ranges from 27.5 in Thurston County to 42.7 in Cedar County. Almost 36% of the population in Thurston County is under the age of 18, while 21.25% of the population in Cedar County is age 65 and older.



***Figures 7-11:** US Census Bureau, American Community Survey 2015-19, via SparkMap, May 18, 2022*





Migration rate

When an area is losing population, that can affect the resources that remain available. Figure 12 shows how people have been moving away from this area. This trend corresponds with what has been noted for rural areas for Nebraska.

Report Area	Starting Population (2000)	Ending Population (2010)	Natural Change	Net Migration	Migration Rate
NNNRHN	31,540	31,393	2,514	-2,657	**-7.80%**
Cedar	9,309	8,812	318	-815	-8.47%
Dixon	6,113	5,986	273	-403	-6.31%
Thurston	6,574	7,034	1,362	-897	-11.30%
Wayne	9,544	9,561	561	-542	-5.36%
Nebraska	1,625,832	1,826,810	191,166	9,812	0.54%

***Figure 12:** University of Wisconsin Net Migration Patterns for US Counties 2000 to 2010 via SparkMap April 20, 2022*

Additional demographic information can be found at Appendix 3.

The Process

The Mobilizing for Action through Planning and Partnership (MAPP) continues to be the model used by the Network and its partners for the Community Health Needs Assessment (CHNA). MAPP is the most common planning process used by local health departments and hospitals to develop CHNAs in Nebraska. MAPP is a partnership-based framework that was developed by the National Association of County and City Health Officials (NACCHO), in collaboration with the Centers for Disease Control and Prevention (CDC), in 1997. MAPP is a comprehensive approach that includes the collection and analysis of both qualitative and quantitative data.

The MAPP process has six key phases that are listed in the center of Figure 1. This CHNA will focus on the four MAPP assessments represented by the blue arrows. These assessments are the third phase of the MAPP process and will make up most of the information presented within this document.

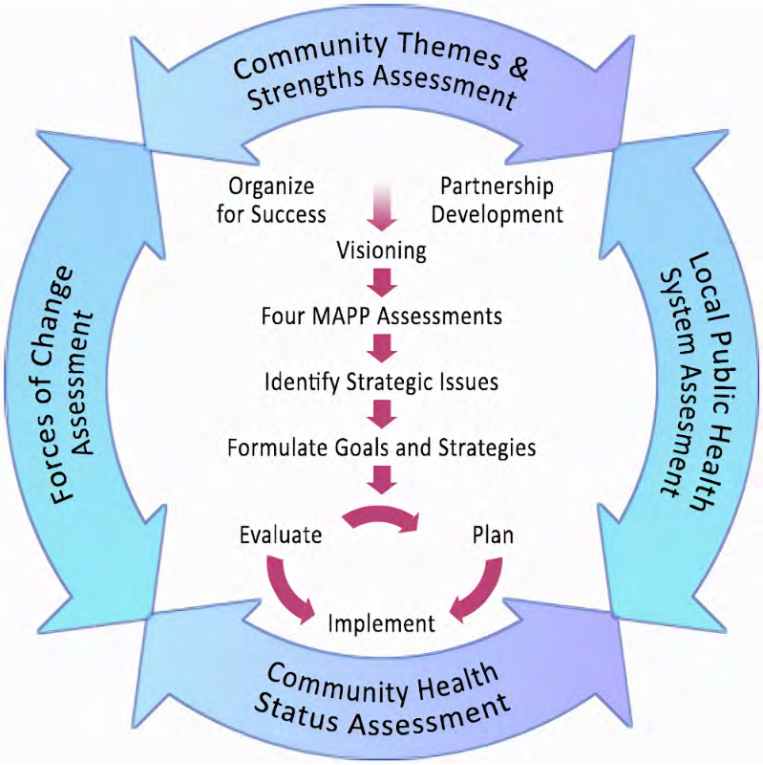


Figure 13: *Mobilizing for Action through Planning and Partnerships (MAPP)*

Partnership Development

In 2021, the group that ultimately formed the Northeast Nebraska Rural Health Network came together for the third time to produce a Community Health Needs Assessment and CHIP for the geographic area.

In 2020, the global COVID-19 pandemic caused immediate priorities to shift around the nation and in our immediate area. The Network Director, a position funded by the HRSARural Health Network Development grant, coordinated this CHNA effort under the direction of the Network board.

The core steering group was committed to building on the previous work done, identifying health disparities, and working toward health equity, with an increased focus on the Social Determinants of Health (SDOH). The network board approved a Health Equity Advisory Council (Equity Council) to be co-facilitated by the Network Director and the Minority Health Initiative Coordinator of the Northeast Nebraska Public Health Department. The Equity Council started meeting in December 2021 and has been consulted regularly during the CHNA process.

Visioning

In 2021, the Network Core team decided to maintain the Vision developed in 2018:

Working together we create a healthier community.

It was noted that this statement not only represents the overall dream for the future of the four-county area, but is a reflection of the lessons learned from the area's successful, collaborative response to the COVID-19 pandemic.

The Four MAPP Assessments

Each of the four assessments gather information and provide critical insights into the health challenges and opportunities confronting the community. These four assessments and the issues they address are described below. All four of the assessments are utilized in this Comprehensive Community Health Needs Assessment to gather information from a different viewpoint.

1) Community Themes and Strengths Assessment (CTSA). This MAPP assessment gathers information about what is important to people who live, work and play in the service area. Information is gathered by asking community populations questions directly. In this CHNA, listening sessions and community health surveys were used to gather the information. The questions help the organizations that make up the public health system to identify key strategic issues. The CTSA helps answer questions about how the quality of life in the NNPHD is perceived. In addition to answering questions, the CTSA also gathers information about what assets are available to improve community health.

2) Local Public Health System Assessment (LPHSA). This MAPP assessment looks at how well the entire local public health system (LPHS) is doing to meet the ten essential services of public health. The LPHS is a network of entities with differing roles, relationships, and interactions whose combined activities contribute to the health and well-being of the community. The NNPHD's LPHS is made up of many different agencies (see examples in Figure 14); a listing of the LPHS agencies that participated in this CHNA can be found in Appendix 11. The diverse agencies that make up any LPHSA are often represented by the diagram to the left. The LPHSA is a valuable tool for identifying areas for system improvement, strengthening local partnerships, and assuring that a strong system is in place for effective delivery of day-to-day public health services and response to public health emergencies.

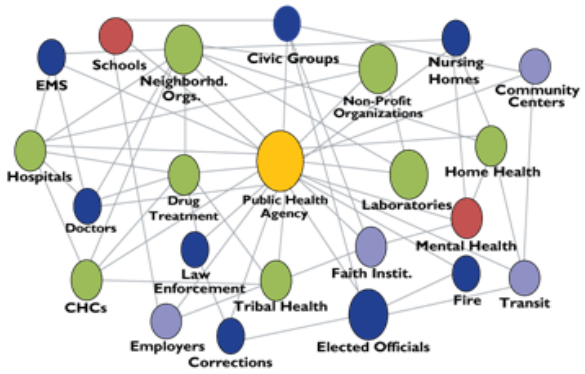


Figure 14: Public Health System

3) Forces of Change Assessment. Some assessment frameworks identify this assessment as an external environmental scan and others identify it as a Strengths, Weaknesses, Opportunities and Threats assessment. The exercise also helps the community better understand what factors may promote the success of any plan for improving the health of the community and what factors may become barriers to a plan for community health improvement. This assessment activity was held on November 18, 2021. The report can be found in Appendix 10.

4) Community Health Status Assessment. This MAPP assessment has health data, demographic data and economic data that can help inform the community on how healthy it is compared to a benchmark which has been the state average. Information gleaned from the other assessments are also incorporated into this assessment, which forms the majority of this report.

Identifying Strategic Issues

Identify strategic issues. Phase four is the identification of strategic issues and this phase is done after the data has been compiled and reviewed. The identification of community prioritized strategic issues is completed at the Community Health Improvement Plan (CHIP) meeting with involvement from a broad spectrum of community members. This CHNA assists to identify potential strategic issues through the analysis of the four MAPP assessments. The final identified strategic issues will be presented in the companion CHIP document.

Formulate Goals and Strategies

Formulate goals and strategies. Phase five will be addressed in the CHIP and will comprise the bulk of the CHIP. The CHIP will be based on the data collected in this assessment and the overall goals and objectives that the NNPHD community and the members of the Network Core Planning Team choose at the CHIP meeting. An emphasis will be made on presenting evidence-based interventions that have been proven to be effective to address specific strategic issues.

Take Action

Take action (implement, evaluate and plan). Phase six is a dynamic phase that lasts from the completion of the CHIP plan until the next CHIP is developed during the next MAPP cycle. It is a continuous improvement process cycle that begins with implementation of the goals and strategies, the evaluation section is the evaluation of the implementation of the CHIP and the planning includes the tweaking of the CHIP plan periodically to move the process forward. The CHIP is meant to be a living plan that changes to meet the challenges, needs and opportunities of the community.

Network Team Members

The backbone of the CHNA process is a Network Core Team comprised of representatives from Providence Medical Center (PMC), Pender Community Hospital (PCH), Midtown Health Center, Winnebago Public Health Department, University of Nebraska Medical Center (UNMC), as well as the NNPHD which serves as the district health department. Members of the core team provided guidance throughout the CHNA process and were charged with determining what data was included, gathering community input and where appropriate additional health data, as well as reviewing the data and sharing this data with community stakeholders.

Northeast Nebraska Public Health Department

Northeast Nebraska Public Health Department (NNPHD) is a local, governmental agency developed in 2002 and is authorized to provide public health services for Cedar, Dixon, Thurston and Wayne Counties through an interlocal agreement of the counties. Under State Statute, 71-1628.04, NNPHD is charged to carry out the three core functions of public health which are assessment, policy development and assurance. These functions include ten essential services (see discussion in the LPHSA section.) NNPHD serves a population of approximately 30,000 residents in the four-county health district which includes a growing Hispanic population and two Native American Tribes. NNPHD offers a wide variety of services and programs that address access to care, chronic disease, environmental health, emergency preparedness, infectious disease investigation and prevention, oral health, community assessment and planning. NNPHD currently has 11 full-time and 5 part-time employees who are all dedicated to the mission of public health. NNPHD has an 11-member board representative of the counties served which provides fiscal oversight and ensures accountability to the agency vision of *Healthy People in Healthy Communities*.

Pender Community Hospital

Pender Community Hospital District (PCHD) is a forward-thinking non-profit organization based out of Pender, Nebraska. Not only does our district proudly operate Pender Community Hospital—an award-winning critical access hospital—but four rural health clinics and three retail pharmacies, a child development center, and a facility for aging adults and seniors. We strive to ensure the people within our community have high quality, full spectrum care close to home. We do this with an extremely wide offering of innovative services combined with the implementation of the latest technology and equipment.

Pender Community Hospital (PCH) has been an integral part of Northeast Nebraska since the hospital was originally built in 1913. Over the years, it has become a trusted community healthcare partner, providing the best care possible for every person who walks through its doors. The hospital offers a wide range of healthcare services, utilizing innovative technology that rivals any larger healthcare system.

Providence Medical Center

Providence Medical Center (PMC) is a non-profit, 21 bed Critical Access hospital that has been serving the healthcare needs of our area since 1975. PMC currently employs over 200 individuals and provides state-of-the-art healthcare to more than 13,500 residents in our service area consisting of Wayne, Dixon, Cedar, Cuming and Thurston counties.

Providence Medical Center is a full-service hospital offering inpatient care, skilled care, emergency services, surgical services and a full range of diagnostic outpatient services
including laboratory, radiology respiratory therapy, occupational, speech and physical therapy. PMC operates a very robust outpatient services department and currently hosts twenty-six physicians in sixteen different medical specialty clinics.

Providence Medical Center also operates a Medicare certified Home Care agency, Hospice agency, Advanced Life Support ambulance service and a community wellness center.
Providence Medical Center has recently achieved 5-star status from the Center for Medicare and Medicaid Services for excellence in patient satisfaction. The Medical Center has also been named a 2020 Top 100 Critical Access Hospital by The Chartis Center for Rural Health. This is a direct reflection of our mission - Providing Quality Healthcare in the Spirit of Christ.

Winnebago Public Health Department

The Winnebago Public Health Department is a part of the Winnebago Comprehensive Health Care System (WCHS). The mission of the Winnebago Health Department works to create and maintain a healthy community by providing the ten essential public health services. These public health services strive to protect and promote the health of all people in all communities. The Winnebago Public Health Department works within an executive team of four as well as a five-member Board of Directors.

Together with WCHS, the Winnebago Public Health Department has announced the Winnebago Health Foundation. The mission of the Winnebago hHealth fFoundation is to build enduring relationships that maximize advocacy and philanthropy to support the health of the Winnebago community and the people served.

The Winnebago Public Health Department announced in June of 2021 their achievement of becoming the first tribal ambulance service to receive advanced service licensure in Nebraska.

University of Nebraska Medical Center

University of Nebraska Medical College (UNMC), College of Nursing (CoN) Northern Division has been involved with the Northeast Nebraska Rural Health Network beginning in 2019. Their involvement in NNRHN has included a NIH Clinical Trial examining the feasibility of using mobile technologies to support self monitoring of eating, activity, and weight in rural men for clinically significant weight loss.

UNMC CoN has developed evidence-based protocols for participant engagement, self-monitoring, re-engagement strategies, and technology troubleshooting. They are also developing a training curriculum for the program. UNMC is a NNHRN member and provides valuable insight into the emergence of new obesity prevention evidence and data collection gold standards, and program evaluation metrics supporting optimal weight loss program design, implementation, and evaluation.

Midtown Health Center

Midtown Health Center (MHC), formerly Norfolk Community Health Care Clinic, was established in 1999. In 2008, MHC became recognized as a Federally Qualified Health Center (FQHC) with a focus of offering health care services to the uninsured, underinsured, and those with additional barriers to obtaining health care services such as language, transportation, and social isolations. MHC is also recognized as a patient-centered medical home and is recognized by the Health Resources and Services Administration as a “Health Center Quality Leader.” Currently, MHC’s service area encompasses 15 counties in northeast Nebraska, including the counties of Cedar, Dixon, Thurston, and Wayne. Services are provided throughout northeast Nebraska with its main and express clinics located in Norfolk, two other clinics located in Madison and West Point, and a reproductive health clinic for college students in Wayne. In 2021, MHC saw 7,835 unduplicated patients of which 66.9% were at or below 200% of poverty. MHC’s mission is "to provide high quality medical, behavioral health, and dental services that are affordable, accessible, and patient focused."

The Four MAPP Assessments–Overarching Issues

Two issues, very much related, permeated the assessment process during this cycle. These issues are COVID-19 and Health Equity. They will be referred to throughout the rest of this report. Because of their significance and to tie them in better with the rest of the report, overviews of these issues are being provided prior to the discussion of the four assessments.

Health Equity and Disparities

The Northeast Nebraska Rural Health Network (NNHRN) is supportive of efforts to improve health outcomes for **everyone** in the four counties of Cedar, Dixon, Thurston and Wayne. The Network Director, along with the health department's Minority Health Initiative (MHI) Coordinator, started a Health Equity Advisory Council in December of 2021. The Network Director also encouraged the development of a consumer advisory council and is supportive of the community-based task force recently initiated by NNPHD's MHI Coordinator. The goals of NNRHN and its partners, including NNPHD, are very much in line with one of the goals of the Nebraska State Health Improvement Plan: Nebraskans will experience health equity and decreased health disparities as well as many of the health equity goals in Healthy People 2030.

The Health Equity Advisory Council has been very active with involvement from over a dozen individuals representing multiple key agencies including health care, education, schools and housing. These individuals participated in meetings that occurred in December, January, February, and April. In addition to providing assistance to and input in the Community Health Assessment process, they have been building a structure for long-term work. Their work in discussing values and goals resulted in a **draft vision** statement which, as of this writing, they are considering: "***Through Servant Leadership and with commitment to the values of acting with integrity, listening to understand and purposeful learning, we are working together to build a culture of health equity in Northeast Nebraska."***

Insights gathered from this council, as well as through listening sessions, especially the listening sessions conducted with the Hispanic population, have helped us to identify factors that likely have contributed to differences in health outcomes across our region, particularly in regards to minority populations. We also plan to continue to develop our working relationships with professionals and community members within the health district to continually assess not only health needs, but community strengths which we can support and celebrate.

Data gathered from other sources, including the US Census and the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) Dashboard, have also helped identify disparities in terms of outcomes as well as factors that can affect those outcomes. These will be addressed in the assessments below.

Key measures as well as other highlights regarding Health Equity and disparities in the following discussion will be in **bold cornflower blue** font. Examples of potential disparities are being compiled. See Figure 15. A corresponding Health Equity Scorecard is being developed and will be regularly reviewed with the Health Equity Advisory Council.

Indicator	Domains that exhibit Potential Disparity
Diabetes	**The difference between minority rate (18.2%) and white, non Hispanic (6.6%) in the health district is greater than at the state level (15.4% to 8.4%)**
Kidney disease	**While there is a difference at the state level between the percentage of minority versus white/non-Hispanic (3.9% to 2.0%) the difference is much greater in this health district (7.9% to 0.8%)**
COPD	**There is a greater difference in the minority population versus white people in the district (9.1% to 3.5%) versus the rates at the state level (7.0% to 5.0%).**
Depression	**Differences for this indicator according to income are more significant for those who make less money in the health district than at the state level**.
Aerobic and muscle strengthening	**The numbers of those who have less than a high school degree and met this standards are suppressed because they are so small which differs from the 26.4% on a state level with that level of education**
No primary care physician	**The disparity between white/non-Hispanic and minorities is even greater. On the state level the difference was almost 20% (37.2% versus 17.3%) while in our health district in 2019 the difference was 23 percentage points (34.4% to 11.4%).**
Lack of English Proficiency	**Over 500 individuals in our area that struggle with speaking or writing English face barriers in not only the access of health care, but also in terms of the other social determinants of health (housing, social capital, etc.)**

Figure 15: Examples of potential disparities that Have been identified in this assessment process

Other domains

While a number of disparities to explore have been identified through this process, it is recognized that more data needs to be gathered. This is true for larger population groups within our region, including persons who identify as Hispanic or American Indian, and also for persons with disabilities and people who identify as LGBTQ+.

COVID-19

Like the rest of the world, the four counties of the Northeast Nebraska Health District were significantly affected by the COVID-19 pandemic. In the early days of the pandemic, certain professions were affected by mask mandates set by the state. The Northeast Nebraska Public Health Department was charged with facilitating implementation of health mandates that had much political opposition. Schools were faced with how to carry out their roles given a region that did not have great broadband capabilities at the time. The capacity of our hospitals and clinics have been regularly pushed to their limits over the past two years with surge after surge. There have been 7,480 cases through 4/15/2022, and while some cases were mild, other cases were much more severe. There have been 88 confirmed deaths as of 04/15/2022. When asked about the last major health issue faced during the community health survey conducted November 2021 through March 2022,by far the largest percentage, 27% cited COVID-19 (other major health issues cited included diabetes, 11%; cancer, 8.3%, and influenza, 7.7%) Almost a quarter of the survey respondents (24.1%) discussed COVID-19 when asked about what worries them about their health and the health of their families. The second highest worry cited in the survey was obtaining healthcare (22.3%), a worry potentially exacerbated by the toll the pandemic has taken on our health systems.

Building on the partnerships developed through forming the Northeast Nebraska Rural Health Network, the Health Director, Julie Rother, led regular Zoom calls sharing information and promoting communication between key partners in the effort from across the health district, including long term care facilities, Tribal Health Systems, critical access hospitals, rural health clinics, and pharmacies in each county. NNPHD coordinated the distribution of vaccines among vaccinating partners as well as also contributing to the total number of vaccinated in NNPHD's health district which was 15,980 through 3/28/2022, representing 52.17% of the population. NNPHD also took the lead in keeping partners updated about the many and constant changes in the COVID-19 pandemic response, precautions and interventions. Most of the staff and the county emergency managers were heavily involved in the major distribution of over twenty different types of personal protective equipment (PPE), including gloves, masks and gowns, to 152 partners throughout the four counties (pictured is only a small portion of the inventory moved).

Upon the arrival of the authorized COVID-19 vaccine NNPHD also received, stored and distributed vaccine to partners in the 4 county area. NNPHD staff and contract workers completed 161 vaccination clinics throughout the health district from December 2020 through April 2022.

COVID-19 and Health Equity

The pandemic has shown a light on vulnerabilities and disparities, as well as strengths. The COVID-19 Impact Planning Report of the U.S. Census identifies key indicators for vulnerabilities, including the household characteristics detailed in the following table:

	Total Households	With Disability	65+ Living Alone	Without Vehicle	Below Poverty	Receiving Food Stamps/SNAP
Cedar	**3,506**	886	520	110	241	213
Dixon	**2,352**	645	318	104	246	114
Thurston	**2,176**	699	238	174	492	459
Wayne	**3,708**	726	435	91	663	116

Figure 16: ("Census COVID-19 Impact Planning Report, "2022) Accessed census.gov May 10, 2022

Households with Disability

According to the CDC, certain risk factors for individuals with disability include limited mobility, difficulty communicating and increased likelihood of underlying health conditions including heart disease and diabetes (CDC, 6/21/21, accessed 04/13/2022).

Households w/Population 65+ Living Alone

A recent study of 2601 older patients in the United Kingdom found that those living alone do seem to have worse health status and health behaviors versus those living with others, and are less likely to make use of non-acute medical services (Kharicha et al.). Social isolation and the mental and emotional toll it may be taking in the wake of the pandemic may be particularly significant (CDC, 4/29/2021, accessed 4/13/2022).

Households Without Vehicle

In rural settings, where distances are commonly measured in miles versus blocks, households without vehicles can be cut off from accessing food and other basic needs, as well as needed services, medical and otherwise. "In rural areas residents often travel longer distances during their commute, leading to a large number of car pools and ride sharing. Social distancing is difficult in shared transportation" (NOSORH, June 2020).

Households Below Poverty Level and Households Receiving Food Stamps/SNAP

Income is an important social determinant of health. In terms of vulnerability during the pandemic, these individuals were more likely to be essential workers and therefore have higher exposure(NOSORH, June 2020). For more income data on the health district, see the income section in the CHNA.

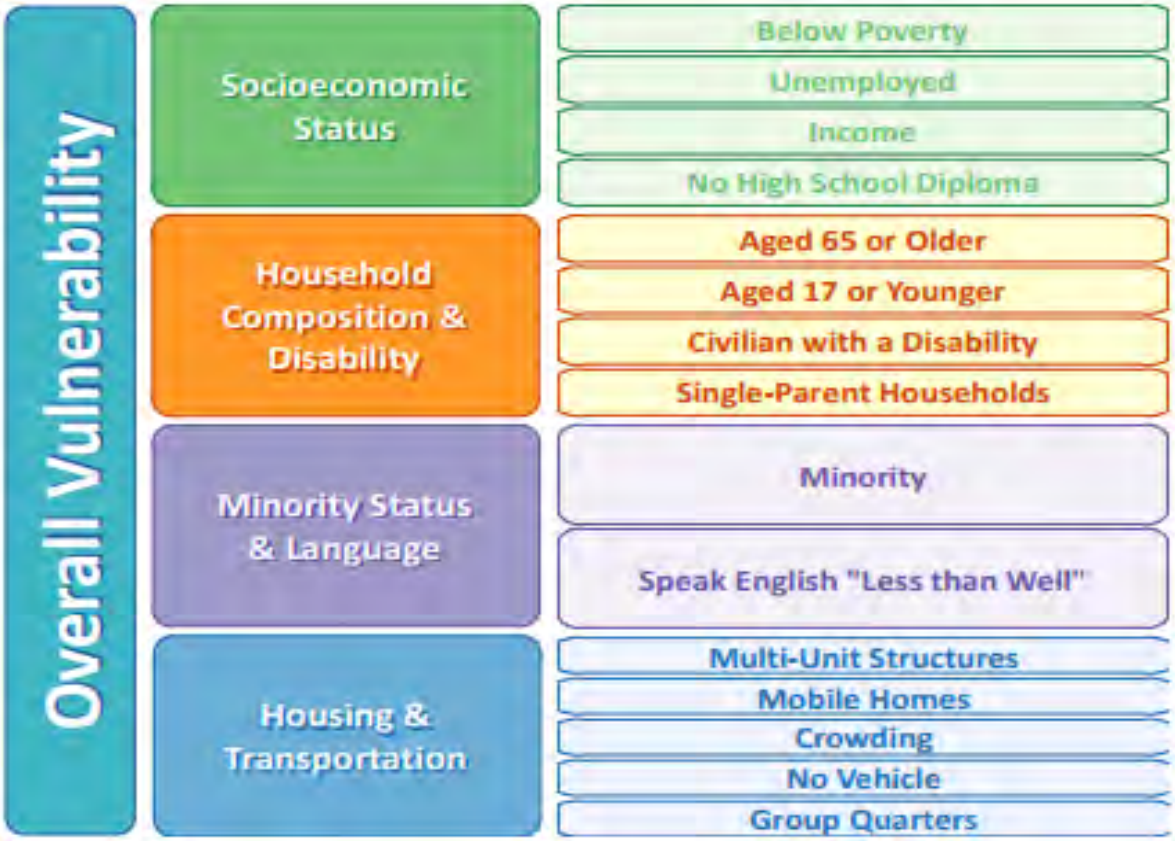


Figure 17: Social Vulnerability Index

The factors listed in Figure 16 are a small subset of the Social Vulnerability Index. The SVI was developed by the Centers for Disease Control and Prevention (CDC) and Agency for Toxic Substances (ATSDR) to assist with public health emergencies. The indicators of this index (listed in the Figure to the left) are being considered as the Network partners work to learn the lessons of COVID-19. However, as members of the Health Equity Advisory Council shared at the 4/12/2022 meeting, these factors should be examined with care, as the data may not tell the whole picture. For example, multiple family members in an indigenous household is likely considered a strength by those household members rather than a vulnerability. We are looking forward to the input of the Health Equity Advisory Council, as well as of one or more advisory groups of community members, and of our partners to help us better understand the interplay of culture as we look for strengths to build upon as well as potential "vulnerabilities" to address.

Forces of Change Assessment

Public involvement in the community health assessment process commenced with the Forces of Change meeting conducted on November 18, 2021. The purpose of the meeting was to gather input from the community about the trends, factors and events that are now influencing or could influence the health of the four-county area over the next three years. A complete report on the meeting can be found in the Appendix. The meeting was facilitated by John Beranek (Intersections Consulting) and Charity Adams (VisionFusion). A total of twenty-six individuals participated (see report in Appendix 10 for full list).

Using the "Wave" exercise, participants discussed ideas around the question "In the field of community health, what are the incoming and outgoing trends, patterns and innovative approaches?" Using this question, the group formed ideas around topics that they feel are becoming or need to become trends and practices. These topics included managing staff shortages, addressing mental health, and education on diverse patient populations. Trends and practices that are picking up are telehealth, community transportation, and an increased focus on social determinants of health. Lastly, trends that are being practiced and remain a standard are the partnerships between public health and local organizations as well as health education.

Using information from the activity, participants used the "Iceberg Theory" to discuss what structures and thinking hold the community back and what shift in this thinking could make the most impact on the community's health. Time and resources from staff & shortages, the new "normal" after the pandemic, diversity, and working together towards a common goal are some of the topics discussed that could hold the community back. The shift in thinking that could have the biggest impact were mindfulness of diversity among communities, "normal" is going to look different, and integration between health systems.

The meeting wrapped up sharing ideas on what was helpful or positive about the meeting, challenges, areas of growth and action steps that can be taken to make progress on the discussion. Participants shared their excitement with several stakeholders coming together to share ideas and the engaged collaboration. It could be a challenge to keep a routine with the meetings to keep them going and participants engaged. Finally, participants would like to see that research on the areas of interest are followed through on and continue to connect.

Community Themes and Strengths Assessment

There are four sections that make up this assessment. The first two sections gather the perceptions of those living or working in the service area. The defined service area for this Community Health Needs Assessment is Cedar, Dixon, Thurston and Wayne Counties which is the official service area of the NNPHD. The CHNA Network Core Team chose to gather subjective community input for this section of the CHNA report via electronic surveys available through a variety of websites and five in-person focus groups. The intent was to provide a deeper understanding of the issues that residents feel is important by answering questions such as: "What is important to our community?", "How is quality of life perceived in our community" and "How does the community perceive services that are being provided?"

Community Health Surveys

The Network Core Team reviewed the survey used as part of the CHNA process in 2018-2019 as well as a survey developed by the Nebraska Association of Local Health Directors (NALHD). It was decided to use the NALHD survey because of advantages it presented including: the open-ended questions would allow for more variety of data from the community members; use of at least these five questions in several health districts in Nebraska could lead to the opportunity of some comparability; and its integration into Qualtrics would allow for ease in repeatability not only in three years, but possibly more often. The survey was translated into Spanish and made active in November of 2021.

The goal was to have a minimum of 380 surveys completed which would provide for a statistically reliable sample based on a 95% confidence level with a +/- 5% degree of accuracy margin of error. The total number of surveys collected was 666 with 611 indicating zip codes within the NNPHD survey area. In part, because of the drive to increase our collection of surveys from our Hispanic population, Dixon and Wayne counties are overrepresented. However, we came close to our goals for Cedar and Thurston counties. Because of these differences, county breakdowns on key issues are provided throughout this report (as well as in further detail on the surveys provided in Appendix 5).

	Cedar		Dixon		Thurston		Wayne		
Population	8,483		5,682		7,218		9,388		**30,771**
380	105	27.57%	70	18.47%	89	23.46%	116	30.51%	
Total Surveys gathered	**100**		**155**		**76**		**280**		**611**

Figure 18: Surveys gathered from the four counties of the NNPHD health district

Approximately two-thirds of the respondents were female (a successful effort was made to target an increase in male participation from the previous cycle from 20% to 32%). Results from this survey can be found throughout this document and are identified as the Northeast Nebraska Rural Health Network 2021-2022 Survey or as the "community health survey". The full report can be found in Appendix 5.

Respondents represented a fairly even distribution of age groups, mirroring the area's age distribution.

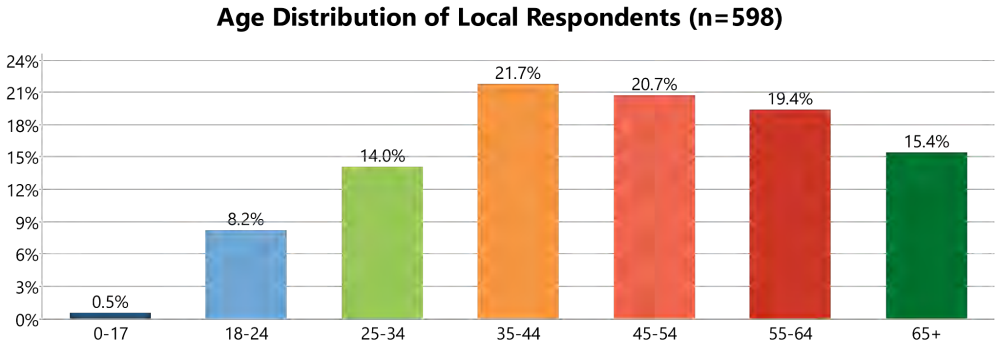


Figure 19: Age ranges of survey participants

While four of the five questions were open-ended, which required a coding process described in the full report in the Appendix 5, one of the questions gave a list of choices, from which respondents could pick three **health concerns in the Northeast Nebraska Public Health Department District**:

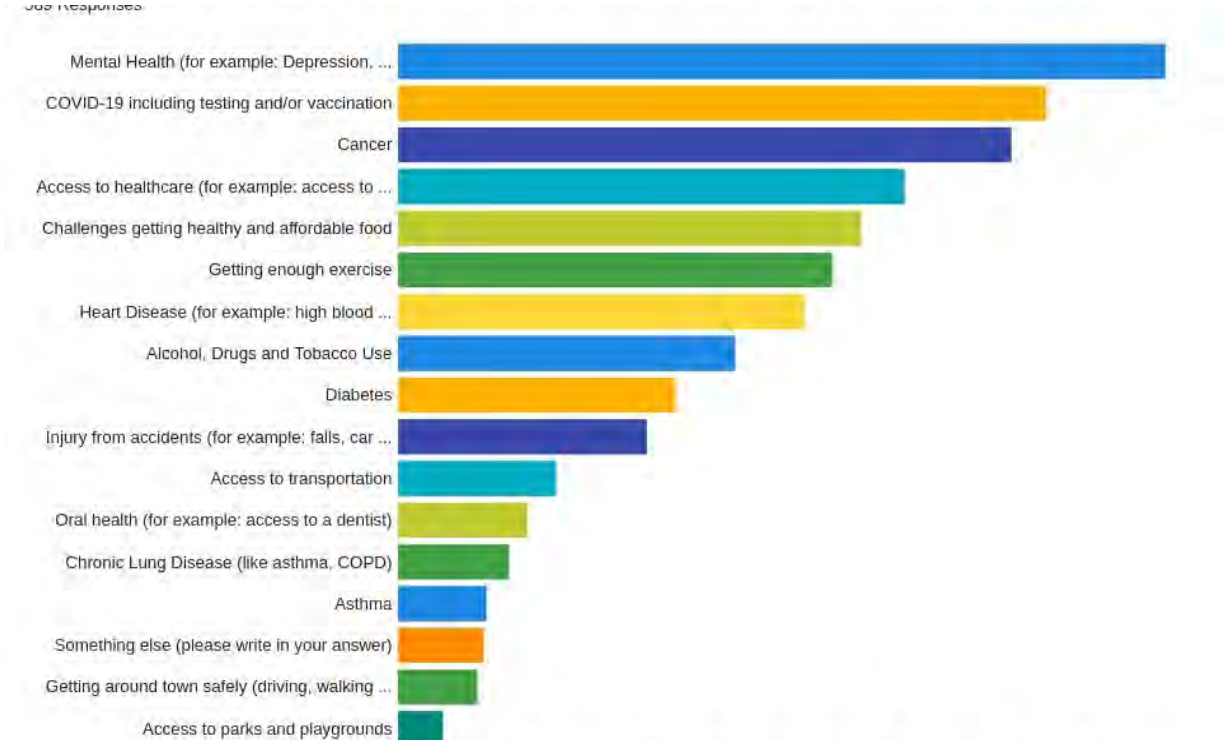


Figure 20: Top Health Concerns in the Northeast Nebraska Public Health Department District

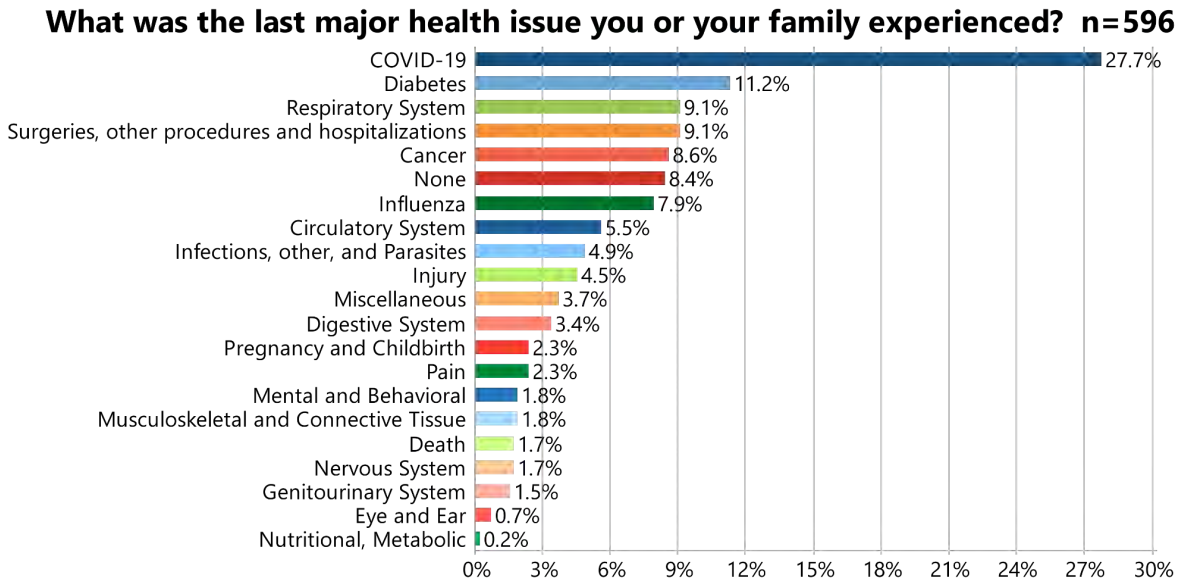


Figure 21: What was the last major health issue you or your family experienced?

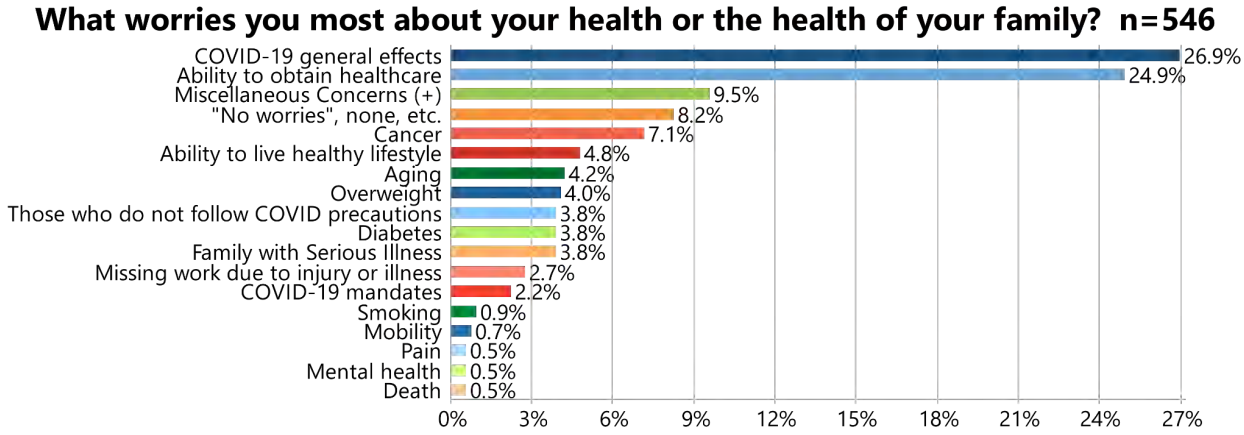


Figure 22: What worries you most about your health or the health of your family?

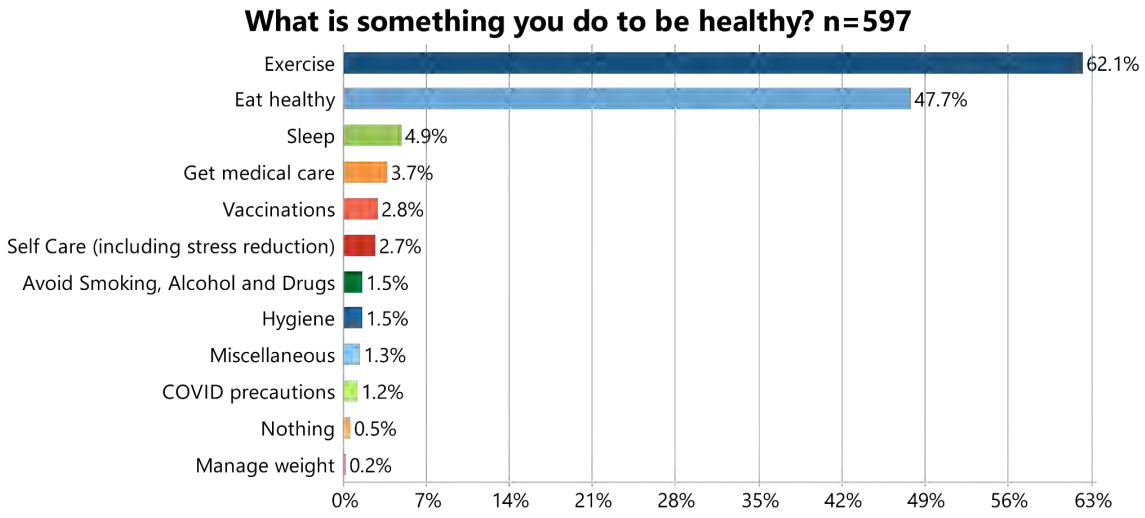


Figure 23: What is something you do to be healthy?

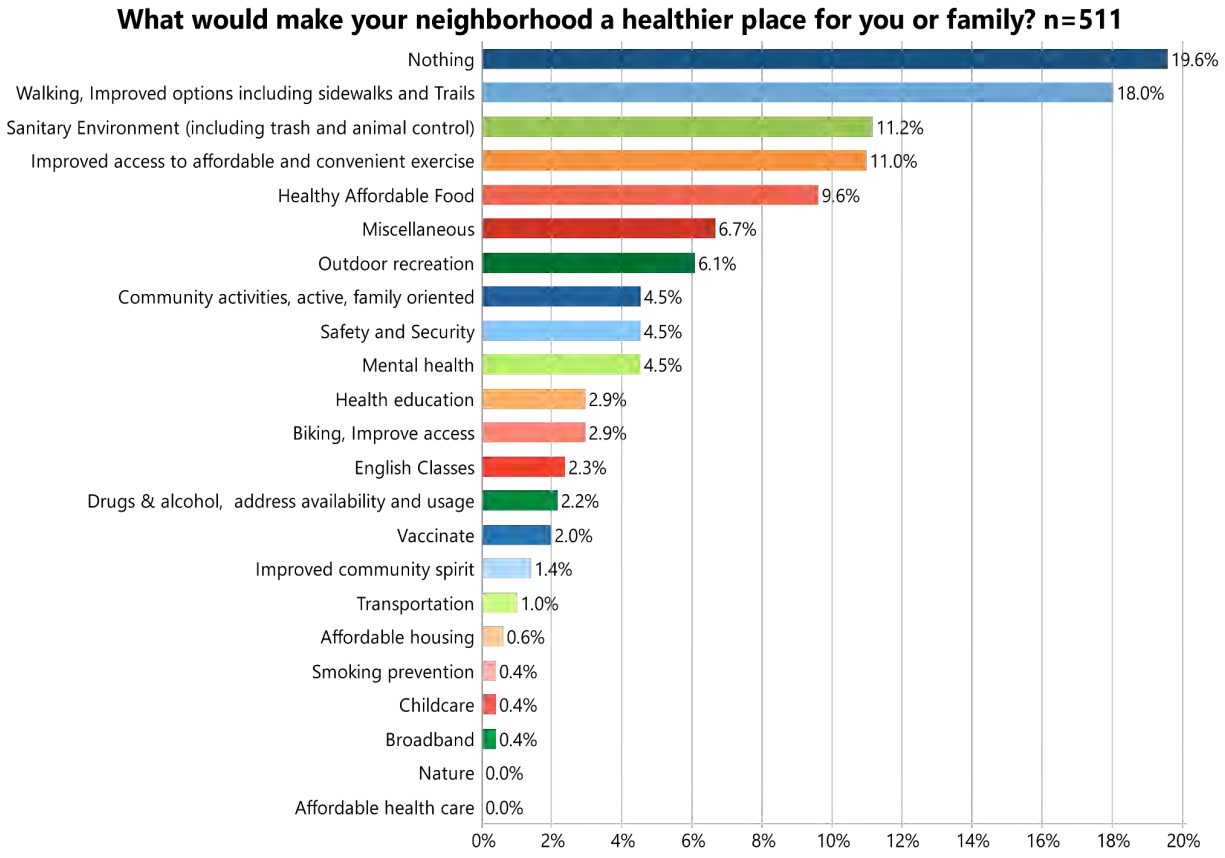


Figure 24: What would make your neighborhood a healthier place for you or your family?

More information about these surveys and data gathered are in Appendix 5.

Listening Sessions

As part of the Community Themes and Strengths Assessment of the MAPP process, a total of six listening sessions were held in 2021 and 2022. Three live sessions were held in December 2021 in Laurel, Hartington and Wayne. One virtual session was held in February 2022. These sessions were facilitated by the consultant team, John B and Charity Adams. NNPHD Health Director, Julie Rother facilitated live sessions with Hispanic community members in Wakefield and Wayne in March of 2022. While each listening session identified issues specific to their community, certain themes were common to most of the sessions. The full reports are found in Appendix 4 and Appendix 12.

Three questions guided the conversations:

1. What would you say are the top five things that affect people's health in our community?
2. What worries you most about your health or the health of your family?
3. What are two things you would like to see in place that would make our community healthier?

Laurel
December 7, 2021
Trends in the conversation during this listening session were:

- Behavioral Health: access, education and mental health caused by stressors relating to health and health costs
- Finances: related to health, cost, affordability
- Senior care: meals, care at home, long term care, housing and community for elders
- Physical activity

Hartington
December 8, 2021
Trends in the conversation during this listening session were:

- Finances: costs, loss of insurance, affordable
- Senior care: meals, mindset, finances
- Health Education: awareness, simple language

Wayne
December 8, 2021
Trends in the conversation during this listening session were:

- Finances: income, cost of insurance, cost to travel to specialists
- Behavioral Health: depression, teenage low self-esteem
- Physical Activity: change in farming means not as physical, parents transport vs. walking to school, slowing down, not as fast as used to be
- Nutrition: fast food, no time, packed schedule

Virtual Session

February 24, 2022
Trends in the conversation during this listening session were:

- Mental Health Care: access geographically, stigma, and improved screenings
- Health costs: affordable health services, lack of access to good food
- Access to health care in rural areas: distance of specialists, access to good health care providers

Wakefield
March 16, 2022
Trends in the conversation during this listening session were:

- Lack of bilingual medical services
- Medical home: building trust with a doctor who can address health needs as they arise, language barrier and cost are a few barriers
- Fear: misinformation about COVID19

Wayne
March 24, 2022
Trends in the conversation during this listening session were:

- Poor eating habits, fast food and lack of physical activity
- Lack of bilingual health care staff
- Uninsured and health care costs
- Desire for ESL classes offered at the workplace

Community Resource Overview

The purpose of this section is to help the reader to understand what services are currently available in what counties within the service area and help identify gaps in health care as well as addressing the social determinants of health. Not all health gaps in services need to be addressed to have a healthy community, for example some services may have little utilization if available due to population size and make more sense from an economies of scale viewpoint to be offered in a larger metropolitan area.

A directory of community resources can be found on the NNPHD website. However, discussion of certain domains is important. The healthcare providers that serve residents of these four counties include:

- Avera Health which operates
    - Avera Medical Group Hartington - Hartington, NE,
    - Avera@Home - Home Health - Hartington, NE,
    - Avera@Home - Home Health - Hartington, NE; Hospice
- Faith Regional Health Services | Norfolk, NE (frhs.org) which operates in our area
    - FRPS Laurel Family Medicine
    - FRPS Wakefield Family Medicine
    - FRPS Wayne Family Medicine
- Midtown Health Center:
- Northeast Nebraska Community Action Partnership
- Pender Community Hospital which includes Pender Medical Clinic
- Providence Medical Center
- Sanford Vermillion Ponca Clinic in Ponca, NE
- Carl T. Curtis Health Education Center
- Twelve Clans Unity Hospital

All four counties of focus for this assessment process are served by Region 4 of the Nebraska Behavioral Health System. Developments that may impact behavioral health in the future include: Avera Health System, one of the systems that serves this region, recently opened (in March 2022) the Helmsley Behavioral Health Center in Sioux Falls South Dakota, increasing the psychiatric beds available at this hospital (located within a two hours drive of most of the NNRHN region) to 146 ("Avera Health Opens Expanded Behavioral Health Services to Meet Growing Needs") In addition, it was reported in April 2022 that an estimated $50 million inpatient behavioral health facility (to serve children ages 5 to 18) is being planned for Omaha's Immanuel Medical Center (Anderson). Wayne State College has received a million dollar grant to help service behavioral health care needs in rural Nebraska ("WSC Receives $1M Grant to Help Serve Behavioral Health Care Needs in Rural Nebraska".)

Transportation options in the county include: Cedar County Transit; City of Wayne HandiVan; Ponca Express; Telelift; Wakefield Senior Center Transportation; Winnebago Public Health Transportation

High impact social service agencies and organizations include: Northeast Community Action Partnership – NENCAP, local offices of the Nebraska Department of Health and Human Services (ne.gov), and coalitions addressing key needs, including Wayne County Family Coalition - Home | Facebook, as well as a strong network of senior centers.

This area also has some major resources that are supportive of addressing public health in this region beyond:

- Wayne State College. Professors and students participate in the Health Equity Advisory Council as well as the CHNA.
- University of Nebraska Medical Center Norfolk campus. A partner in the Network.
- Area churches and ministerial alliances. Churches have been the sites of a number of the COVID vaccination clinics as well as other public health activities.
- Norfolk Area Diversity Council: Network Director to represent this region to share ideas and information.

Healthcare Workforce Needs and Gaps

Healthcare Workforce is a key issue for the four county area being studied in this assessment, in the state of Nebraska, and the rest of the nation. Information on the availability of primarily health care providers, dental health providers, and mental health providers, among others, will be addressed in indicators in the NNRHN Clear Impact Scorecards, along with updates on what is being done about this workforce availability.

In this report, see the following sections on Continuing Public Health Workforce Development and Community Resources Inventory Survey, as well as:

- Essential Public Health Service #8 (*Build and support a diverse and skilled public health workforce)*;
- Rate of Primary Care Providers indicator on Clear Impact Scorecard;
- Appendix 8: Health Workforce Additional Statistics.

Healthcare Workforce Development

Colleges in Northeast Nebraska are responding to the shortage of healthcare providers by developing programs that allow students to do their course work and clinical experiences in underserved rural communities. Wayne State College has received grants and made affiliation agreements with UNMC and local healthcare institutions to train clinical mental health providers and provide a pathway to a bachelor's degree for nursing students. The Nebraska Indian Community College offers a licensed drug and alcohol counselor certificate program that nontraditional students can complete while holding a job.

Wayne State College received a one-million-dollar grant that will increase access to behavioral healthcare in Northeast Nebraska. Some of the grant funds will provide clinical mental health counseling graduate students a scholarship that will support them while they complete their final experiential training. The grant from the Human Health Resources and Services Administration will also train forty practitioners to serve as clinical training supervisors for the counseling students. The project is called "Addressing Rural Behavioral Health Needs Through Clinical Placements and Supervision." and will take place over the next four years. The goal of the program is to increase access to behavioral healthcare in Northeast Nebraska by providing financial and supervisory support to clinical mental health graduate students who live in underserved communities ("WSC Receives $1M Grant to Help Serve Behavioral Health Care Needs in Rural Nebraska").

The Nebraska Indian Community College is offering a Licensed Drug and Alcohol Counselor certificate program ("NICC Programs").

UNMC and WSC are working together to create an opportunity for students to earn a Bachelor of Science in Nursing at the UNMC College of Nursing Northern Division in Norfolk, Nebraska. The Early Admission Pathway agreement will allow students who qualify to have a seamless transition between their pre-nursing course work at WSC and early admission to the BSN program at UNMC Northern Division. Students will be able to stay in Northeast Nebraska for their coursework and clinical experiences ("UNMC, Wayne State team to open pathway to nursing | UNMC").

Continuing Public Health Workforce Development

Northeast Nebraska Public Health Department offers internship opportunities for college students interested in public health during the fall, spring and summer semesters. Interns are assigned a wide variety of tasks including health education and promotion, assisting with existing public health programs such as Creating New Smiles and Building Healthy Families, and maintaining emergency preparedness supplies. Interns are encouraged to participate in certifications and trainings with public health staff.

Wayne State College offers a minor in public and global health that consists of 21 credit hours ("Public and Global Health Minor"). The core requirements include classes covering an introduction to public and global health, social science statistics and research methodologies. Students can choose to specialize in the areas of biostatistics and epidemiology, health policy, systems and administration, environmental health, prevention and promotions. Staff members of NNPHD done presentations in public health classes and one has served as an instructor for the introduction class. Wayne State College also offers a 21-hour minor in the area of emergency management ("Emergency Management Minor").

Northeast Community College offers a Community Health Worker certification and an associate of science degree in public health ("Public Health - AS"). Students in both programs often take part in the Project HELP program which assists students who will continue their education to pursue high demand healthcare careers such as nursing, nutrition, medical technology, pharmacy, physical therapy, Physicians Assistant, surgical technology, and dentistry. One NNPHD staff member holds a Community Health Worker certificate from NECC ("Community Health Worker - Certificate").

Community Resources Inventory Survey

The Community Resource Inventory collected by the Northeast Nebraska Rural Health District between the dates of February 5, 2022 and March 5, 2022 collected 48 responses from community members in Cedar, Dixon, Thurston and Wayne Counties. Their positions ranged from hospital staff making up most responses to public health staff making up the second largest group to complete the survey.

Respondents scored on topics related to community resources. The scale included:

- **Not Present in the County**
- **Present but Not Adequate to Meet the Needs of the County**
- **Present and Nearly Adequate to Meet the Needs of the County**
- **Present and Adequate to Meet the Needs of the County**

Not Present in the County

The topics that largely fell into this scale option included specialty health services in certain counties, substance abuse services, health education, and weight loss programs for adults and children.

In the area of specialty health services, respondents in Thurston and Cedar Counties indicated the service of neurology, urology, and pulmonary were not present in the county.

All counties favored this response for substance abuse services, education in the areas of heart disease, chronic disease, and colon cancer, and weight loss services for adults and children in their areas.

Present but Not Adequate to Meet the Needs of the County

The topics that largely fell into this scale option included housing, transportation, bilingual services, specialty health services in certain counties, and behavioral health services.

Responses about questions referring to safe, affordable housing and home modification, respondents mostly reported a presence but not adequate to meet the needs of the county. Comments regarding this topic include a concern with the cost of housing, housing availability, and housing shortages.

Transportation responses varied between counties. There were responses in all options from not present in the county to adequately meets need in the county. There appears to be a lack of awareness around this service and whether or not it exists in each area.

Thurston county had a majority of responses for primary care physicians scored in this area. Thurston county also indicated a high response in specialty health services OB-GYN, Cardiology, and Orthopedic.

All counties favored this area in behavioral health indicating a need for adequate services in their areas.

Present and Nearly Adequate to Meet the Needs of the County

The topics that most largely fell into this scale option included emergency economic assistance.

Respondents reported a presence in emergency economic assistance but not adequate in meeting the community needs. It was reported that there is a worry with families being short on food and a missing education piece around resources and services available to residents living on the Winnebago Reservation.

Present and Adequate to Meet the Needs of the County

The topics that largely fell into this scale option included emergency response resources, specialty health in certain counties, dental services, and vaccine clinics.

The majority of the respondents in every county favored this selection for emergency response resources indicating a presence and adequately meeting the needs of each county. This area also received the most responses regarding primary care for adults and children for 3 of the 4 counties. Thurston county had an overwhelming majority who scored not adequate in meeting the needs of the county.

In the area of specialty health services, respondents in Wayne and Dixon counties mostly indicated that the services were present and adequate. Some of these services include OB-GYN, neurology, urology, radiology and many other specialty health services.

All counties in the areas of cardiac rehab, physical therapy, occupational therapy, dental services, vaccine clinics, and education on breast and cervical cancer indicated a presence and adequate service in these areas.

Full report on this survey can be found in Appendix 9.

Additional Health Workforce Data can be found in Appendix 8.

Previous Themes from past CHNA/CHIP

Once again, a major factor in implementation rollout and success was unexpected events. During the previous cycle, it was noted that responding to the tornados in 2015 required a sustained response from the public health department and other members of the Network. The discussion during the last CHNA process "included a suggestion that the Network Core Team keep a focus on emergency preparedness and community resilience in the process of community improvement planning."

Other lessons learned during the last implementation cycles will be kept in mind during the next CHIP implementation cycle.

- Plan and discuss how the NNPHD service area can move from planning to implementation using action plans that have timelines, agency and person responsible and regular evaluation and reporting for accountability.
- Ask for community volunteers to assist in leading CHIP strategic sections so that there is depth in organizational leadership and leadership does not fall on one agency.
- No one agency should be responsible for CHIP implementation and activities.
- Narrow down the strategic issues and keep CHIP goals that support strategic issues to a reasonable number.
- Focus on some prevention activities within the strategic issues chosen.
- Attention should be paid to how resources will be allocated to support the CHIP strategic issues.

Local Public Health System Assessment Update

The purpose of the National Local Public Health System Assessment (LPHSA) is to promote continuous improvement that will result in positive outcomes for system performance. Benefits of the LPHSA include:

- Better understand the Local Public Health Systems (LPHS) current performance
- Identify and prioritize areas of strengths, weaknesses and opportunities for improvement
- To help articulate the value that quality improvement initiatives bring to the LPHS

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. The participants at each LPHSA meeting were provided with a summary of the Essential Service of focus, a powerpoint presentation about this service and a summary of what is happening in the local health district that addresses the essential service. These meetings were also facilitated by John and Charity. The decision was made to update the LPHSA assessment from 2019. While participants were not asked to submit evaluation scores during the process this cycle, they were encouraged to review the previous 2019 scores as well as the strengths and weaknesses identified during the last cycle. See full report in Appendix 11.

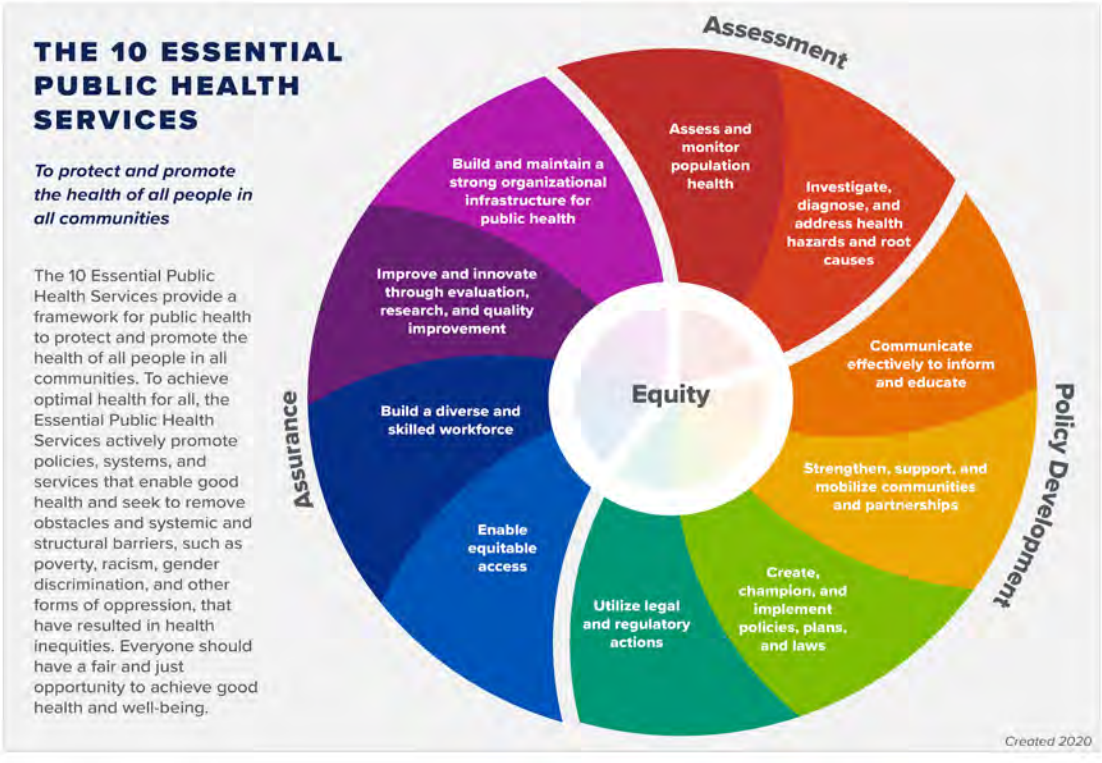


Figure 25: The 10 Essential Public Health Services as reviewed in the update to the Local Public Health System Assessment

10 Essential Services of the Local Public Health System

In 2019, the Network performed a full Local Public Health System Assessment using the accepted framework and guidance documents available at that time. The LPHSA that was performed in 2019 was over the model of the 10 Essential Services which were in effect at that time, and used the Model Standards for assessing those services. In part, because the 10 Essential Services were revised in 2020, and with no new guidance document being available, an "update" was performed in 2022.

Essential Public Health Service #1

Assess and monitor population health

The 2019 findings indicated a strength in professional partners' involvement in the Community Health Assessment (CHNA). Accessing and utilizing the CHNA was a concern and a focus on promoting this information was noted to become a priority. Other findings included technology in place for the infectious disease registry, but no other registries. It was determined that improvements could be made in managing health information to find problems.

A review of the Essential Public Health Services in 2022 indicated that more of our partners and consumers were accessing health information through data visualization on social media. The outcome was improved communication and outreach with partners and the community. It was also found that new partners and community members became involved, including communities whose first language is not English. Barriers to these improvements are ensuring that with improved communication through access to technology, we work towards accurate, credible information being shared. Continued efforts are being made to work through the impacts of COVID. It should be noted that it is a trend throughout all essential service areas that many needs identified were not a priority as the pandemic became the focus for all staff.

Essential Public Health Service #2

Investigate, diagnose, and address health problems and hazards affecting the population

In the 2019 findings, partners and community reported awareness of NNPHD's involvement in a system to address health problems and threats. This includes awareness of the Emergency Coordinator position and information on the disease, disaster and emergency response provided to the community. It was observed that there is more limited awareness of some other resources such as the 24/7 public health emergency telephone number.

It was identified in the recent review of the Essential Services that since 2019, improvements have been made in communication at the state level, written policies and procedures, and the work completed to share COVID 19 information. Improvement was also noticed in the system gaps. Areas of improvement or concern included all communication systems, including ongoing community planning, written policies and procedures among all partners, emergency contact lists, and reporting. Additionally, concerns with testing supplies and delays with results were reported.

Essential Public Health Services #3

Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it

It was recognized that participants who attended meetings to discuss essential services all represent a health agency who each offer an emergency response plan. Partners do not always work together on health education and promotion. In reference to health communication, it was noted that larger agencies provide a public information officer responsible for communication. As it relates to risk communication, a strength is noted regarding emergency response plans. All agencies have a plan but it is a concern that different audiences want different information and it is difficult to keep up with partner contact information.

Comparing findings from 2019, it was noted that communication has improved. Several areas of communication changes to work towards improvement were noted including communication among partners, social media activities, the switch from phone calls to DIS e-mails within NNPHD, group zoom meetings, and an easy website navigation at NNPHD. It was agreed that some barriers from 2019 to now are a lack of time and resources and an overwhelming amount of information during COVID. This has caused barriers to getting information out timely, information overload, plans not always followed, keeping contact information updated, and other public health emergencies taking a back seat to provide urgency to COVID19.

Essential Public Health Service #4

Strengthen, support, and mobilize communities and partnerships to improve health

In the 2019 data, it was recognized that in this essential service everyone keeps a maintained directory. However, most organizations are not aware of the directory. The Network was identified as being a strength in improving community partnerships. A lack of funding was noted as a barrier in improving these services.

Comparing the data, communication has changed in many ways. It is noted that this is due to the pandemic. New community partners are now aware and included in conversations, partners are meeting more frequently, more of the community is now aware of what public health is, and there are increased facilitated conversations on health. Barriers noted are that the CHIP was not implemented due to the pandemic. Through the pandemic there was a lot of staff turnover and underserved communities still need support and to be heard.

Essential Public Health Service #5

Create, champion and implement policies, plans and laws

The LPHSA report from 2019 found that there was good representation among the county and hospital partners. Strategic planning improved using the MAPP process and attendees participated in the emergency planning process. Challenges at this time indicated a lack of funding, policy was not a focus, and smaller agencies did not have designated staff to complete the CHIP process.

In 2022, the representation among counties and hospitals continues. Previous challenges have been addressed. There has been an increase in funding, more staff employed, and partnerships have grown and assisted in the planning process. New challenges identified are the political environment around Public Health since the pandemic and their role in creating policies. Although there is an increase in funding, hiring staff and staff retention is a concern. Finally, due to an increased focus on COVID-19, other programs have been put on hold.

Essential Public Health Service #6

Utilize legal and regulatory actions designed to improve and protect the public's health

In 2019, attendees involved in the public health conversations were all agencies familiar with laws and regulations prior to public health's existence. Public Health at this time had limited involvement in policies. It was observed during the 2022 update of these services, that more of the population is aware of public health policy. There continues to be a lot of change at the state level and this causes confusion among local agencies.

Essential Public Health Service #7

Ensure an effective system that enables equitable access to the individual services and care needed to be healthy

Comparing 2019 data to recent 2022 updates, there have been improvements in health service needs that were a result of the pandemic. It has opened up more communication, added new partners, offered options for remote access to services such as telehealth and access to the functional needs population. Although there are several strengths as a result of the pandemic, several setbacks to other identified health needs have been interrupted due to an increased focus on COVID-19. Staff shortages, loss of face-to-face contact, facilities closing, access to internet services for rural population, and necessary coalitions on hold, to name a few.

Essential Public Health Service #8

Build and support a diverse and skilled public health workforce

In looking back at 2019, improvements noted over the past few years are the increase in staff at the Public Health Department. The number of full-time staff has doubled and includes a communication specialist. The increased use of technology to host virtual meetings has helped with cost and allowed for more partners in the community to become involved. With these changes, the community has become more aware of public health.

With the new awareness, there are also some negative feelings towards public health and a political divide. Educating the community and elected officials around public health and the many responsibilities is important. Challenges in completing these important steps relies heavily on staff quality and retention. Maintaining the increased number of staff is a concern once COVID funds have diminished.

For more information, see Continuing Public Health Workforce Development.

Essential Public Health Service #9

Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement

Through the forced use of technology during the pandemic, sharing of information increased over the past few years. Partnerships grew and now include a multilayer approach when implementing programs and services. The pandemic experience created a focussed awareness of evidence based information. With the positive changes that came with the pandemic, there are also noticed challenges. Some challenges identified are a loss in trust in the health care system from the public, research on other health topics slowed or stopped, difficult to return to other practices, and coalitions on hold.

Essential Public Health Service #10

Build and maintain a strong organizational infrastructure for public health

Reviewing updates from 2019, changes made included the addition of a communication specialist to help with the growing use of technology for educating, sharing information, and meetings among partners and the community. Public Health leadership was also recognized for being ethical and skilled through all of the challenges.

Along with the improvements, some challenges were recognized. Locating quality IT personnel to work with our schedules and systems is difficult. There is an awareness that educating the population outside of health to work towards the same vision is needed. This includes educating elected officials and working towards local funding for public health. Finally, hiring and retaining quality public health staff is needed to maintain a strong organizational infrastructure.

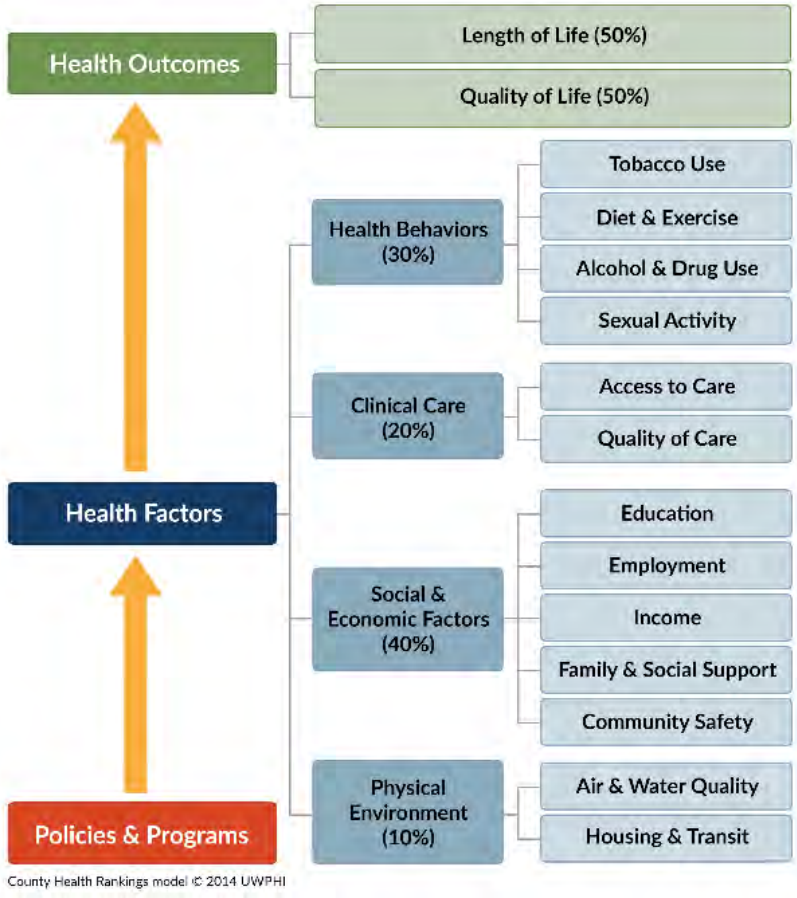
Summary Findings from Essential Public Health Services Discussion

In concluding the review of the Essential Public Health Service discussions, the impacts of the pandemic is a trending theme that has influenced our work significantly. Highlights of the findings from the 2022 process include those impacts such as an increase in the use of technology, improved communication, strengthened partnerships as well as new partnerships, funding challenges and additions, a refocus of priorities, a lack of time and resources, educating the community and elected officials, as well as staff turnover.

Moving forward, ideas shared to help improve those impacts include refocusing after the pandemic, continuing to strengthen and maintain partnerships, standardized systems, staff retention, and educating and engaging the community.

Community Health Status Assessment

The Community Health Status Assessment identifies priority community health and quality of life issues. This assessment uses the County Health Ranking model to organize discussion of Health Outcomes and Health Factors in the area served by NNRHN. Indicators measured include those that have been measured in the past by the Network. Areas of potential improvement have been identified. There has also been an increasing focus on aligning overarching goals and indicators at the local level with those at the state and federal levels, especially in terms of addressing health disparities. Those indicators that are connected to Health People 2030 and Nebraska State Health Improvement plan objectives are marked accordingly on the Clear Impact Scorecards.



The County Health Rankings & Roadmaps is a completed by the University of Wisconsin Population Health Institute, supported by the Robert Wood Johnson Foundation. For the past decade they have been building awareness of the factors that affect health outcomes through their model (see Figure 26). Counties in each state are ranked according to key health outcomes and key health factors. This model identifies areas where each county is doing well, as well as areas in which each county could improve. This program has also been collecting a database of evidence-based interventions for these factors which will continue to be a resource to the network.

Figure 26: County Health Rankings Model

In addition to reviewing population level indicators measured in previous community health assessment documents, especially the document produced in 2019 for use in the community health improvement process, this CHNA is also looking at indicators that have been determined on the state and national levels as having a particular significance. The goals of the Nebraska State Health Improvement Plan (SHIP) 2017-2021 also overlap with goals of the Northeast Nebraska Rural Health Network including obesity. The Nebraska 2017-2021 State Health Improvement Plan includes the following:

- Nebraska will have an integrated health system that values public health as an essential partner.
- Nebraska will have a coordinated system of care to address depression and suicide.
    - See also (DHHS Behavioral Health Strategic Plan 2022-2024)
- Nebraskans will have decreased rates of obesity.
- Nebraskans will experience improved utilization and access to healthcare services.
- Nebraskans will experience health equity and decreased health disparities.

Healthy People 2030 "sets data-driven national objectives to improve health and well-being over the next decade." This set, updated from Healthy People 2020, includes 355 measurable objectives, as well as developmental and research objectives. Of these core objectives, a subset have been identified as Leading Health Indicators (LHI). These Healthy People 2030 (HP2030) Leading Health Indicators being measured in this report will be noted as such (HP2030-LHI).

Leading Health Indicators (LHI) for all ages* as identified by Healthy People 2030 which are measured in this CHNA include:

- Household food insecurity
- Persons who are vaccinated annually against seasonal influenza
- Persons who know their HIV status (13+ years)
- Persons with medical insurance (<65 years)

Figure 27: Healthy People 2030 Model

Other Healthy People 2030 Indicators being tracked include:

- Increase access to comprehensive, high-quality health care services.
- Increase the proportion of people with health insurance.
- Increase the proportion of adults who get recommended evidence-based preventive health care.
- Increase the proportion of people with a usual primary care provider.
- Decrease the proportion of adults who report poor communication with their health care provider
- Reduce the proportion of people who can't get the dental care they need when they need it
- Reduce the proportion of people who can’t get medical care when they need it
- Increase the proportion of low-income youth who have a preventative dental visit
- Create neighborhoods and environments that promote health and safety
- Increase the proportion of adults with broadband internet
- Increase the proportion of adults who walk or bike to get places
- Increase the proportion of smoke free homes
- Increase the proportion of high school students who graduate in 4 years
- Increase the proportion of children who participate in high-quality early childhood education programs

Health Outcomes

Overall Health and Quality of Life

Health outcomes include not only mortality and length of life, but also quality of life. One way of measuring quality of life is how often in a month someone has felt unhealthy or that their regular activities were impaired by their health. One important source for information on health is the Behavioral Risk Factor Surveillance System (BRFSS) Nebraska provides this data through their Department of Health and Human Resources to support program development and evaluation. Of the respondents from our health district to this survey, the trends for key quality of life indicators are all going in a negative direction other than physical unhealthy days. Because BRFSS data only goes through 2019, data gathered through the listening sessions and the community health surveys have been important to helping to develop an overall picture. This is especially important for impact of COVID-19

- **The percent of adults reporting fair or poor health (age-adjusted)** is one of the key factors used by County Health Rankings. In the NNRHN region (the health district served by NNPHD) 16% were reporting fair or poor health while the average in Nebraska was 14% (2018).
- **The average number of physically unhealthy days reported in past 30 days (age-adjusted)** in 2019 was 2.7 days versus the state average of 3.4 days. From 2013 when both the region and the state average was 3.1 days, the average for the state has been going up while the average for the local region has generally been going down.
- **The average number of mentally unhealthy days reported in past 30 days (age-adjusted)** which has been lower than the state average for most of the last decade, was once again approaching the state average (3.6% to 3.7%).
- The **adults that experience poor physical or mental health which limited their usual activities on 14 or more of the past 30 days**, in the NNRHN region did experience a slight decrease from 2018 to 2019 (6.4 to 6.1), mirroring the state trend. This will be yet another trend likely to be affected by the pandemic.

NOTE: The Northeast Nebraska Rural Health Network (NNRHN) has been developing Clear Impact scorecards to help develop an online dynamic framework for continuing community health assessment, as well as the Action Step of the MAPP process. While other scorecards are in development, the indicators referred to in this document via the **green hyperlinks** are in the Overall Indicators for Northeast Nebraska Rural Health Network. This use of the Clear Impact application is a key component of NNRHN's local contribution to help facilitate the Collective Impact strategy on the state level (Nebraska Department of Health and Human Services, Division of Public Health) as well as to ground that collective impact work with Results-Based Accountability (Friedman).

Clear Impact uses the Results-Based Accountability framework to link population level data to theory to descriptions of local programming efforts and their results. The plan is to build on the population level indicators reported on in this report (green hyperlinks) with additional information about these indicators, as well as activities and programming in this health district that are addressing these indicators.

Length of Life

Length of life is a common measure for health outcomes. There are different ways of measuring even this outcome. This report focuses on life expectancy at birth and years of potential life lost.

Life Expectancy

Life Expectancy at Birth was trending upward as of 2014.

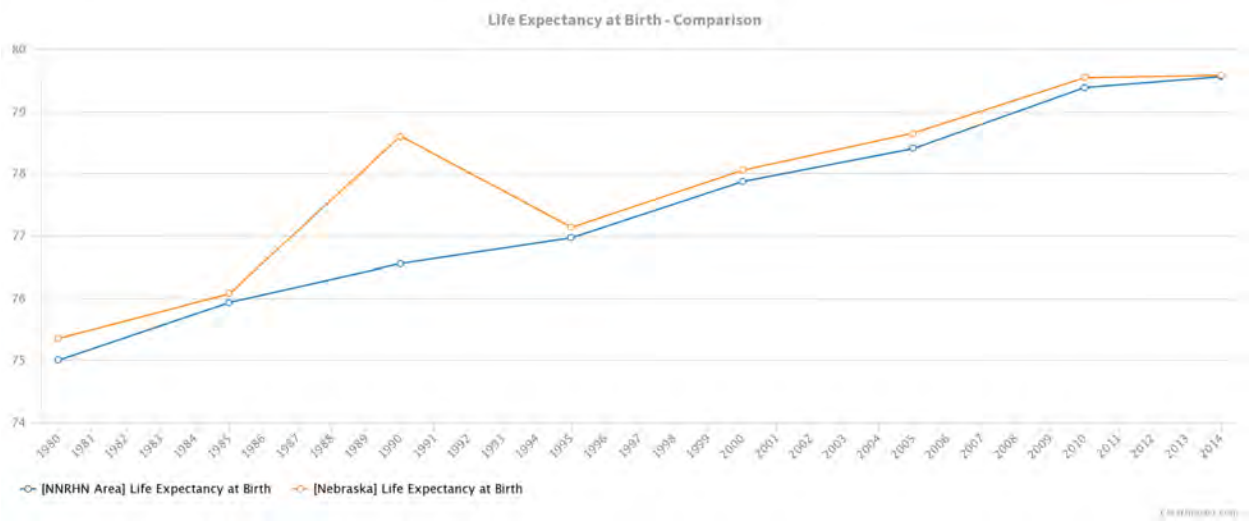


Figure 28:** Institute for Health Metrics and Evaluation **via SparkMap.org May 7, 2022

Where you live matters for how well and how long you live.

Years of Life Lost

Years of potential life lost before age 75 per 100,000 population (age-adjusted) is another key factor in the County Health Rankings, reflecting their attention "on deaths that could have been prevented." This indicator emphasizes deaths of younger persons, whereas statistics that include all mortality are dominated by deaths of the elderly."

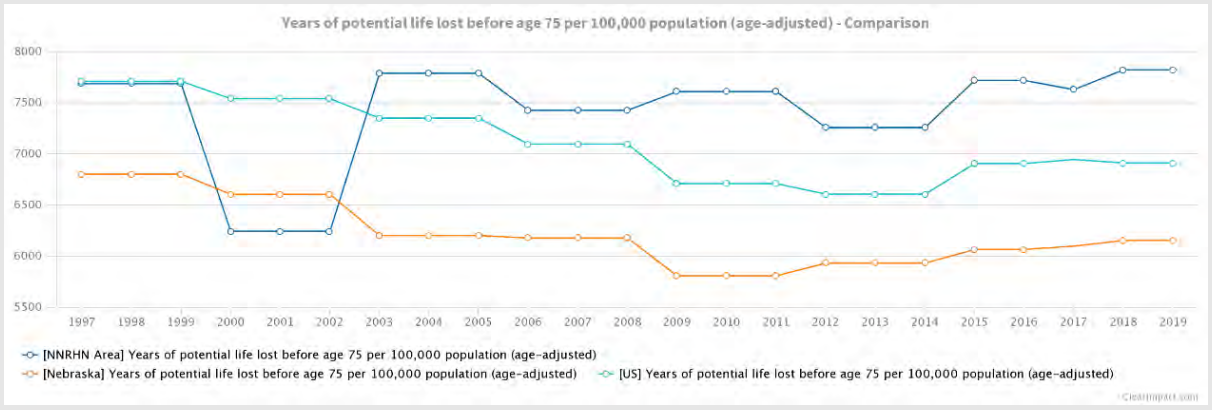


***Figure 29:** University of Wisconsin Population Health Institute, County Health Rankings. via SparkMap May 5, 2022*

As the next chart illustrates, **the YPPL for Thurston County continues to be higher than in the other three counties**. The continuing community health assessment to be conducted by the Northeast Nebraska Rural Health Network will work on stratifying (breaking down) data not only by geographic area (especially county, but also census tract and even zip codes when appropriate and feasible), but also by gender, age, and race/ethnicity.

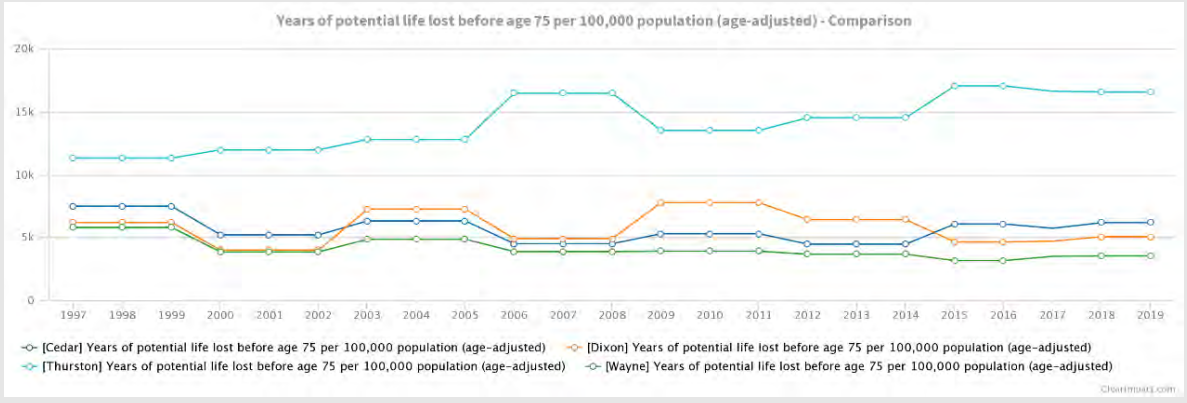


***Figure 30:** University of Wisconsin Population Health Institute, County Health Rankings. via SparkMap May 5, 2022*

Causes of Death

Causes of death which contribute to a disparity between rural and urban include “heart disease, unintentional injuries, cancer, COPD and pneumonia/influenza” (Taylor, 2019). In this health district, mortality rates by cause key indicators:

- **Lung disease** in the counties and in the health district is less than the state average, although this does not include lung cancer.
- **Motor Vehicle crash alcohol involved.** Report area higher than state average,
- By **stroke** higher than state average,
- **Unintentional Injury**, higher than state average,.

In 2014, approximately 62% of all deaths in the United States comprised the five leading causes of death. The number of excess deaths from the five leading causes in rural areas was higher than those in urban areas. According to the CDC, “Targeted, needs-based prevention efforts, combined with improved access to treatment for chronic conditions, might reduce the rural-urban gap in age-adjusted death rates and potentially excess deaths from the five leading causes of death. (Garcia)

Cancer

Within the report area, there are a total of 312 **deaths due to cancer.** This represents an age-adjusted death rate of 158.4 per every 100,000 total population, which is higher than both the state rate, 150.3 and the national rate, 149.3. This indicator reports the 2016-2020 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population. Figures are reported as crude rates, and as rates age-adjusted to year 2000 standard. Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. SparkMap 04/05/2022. See map.

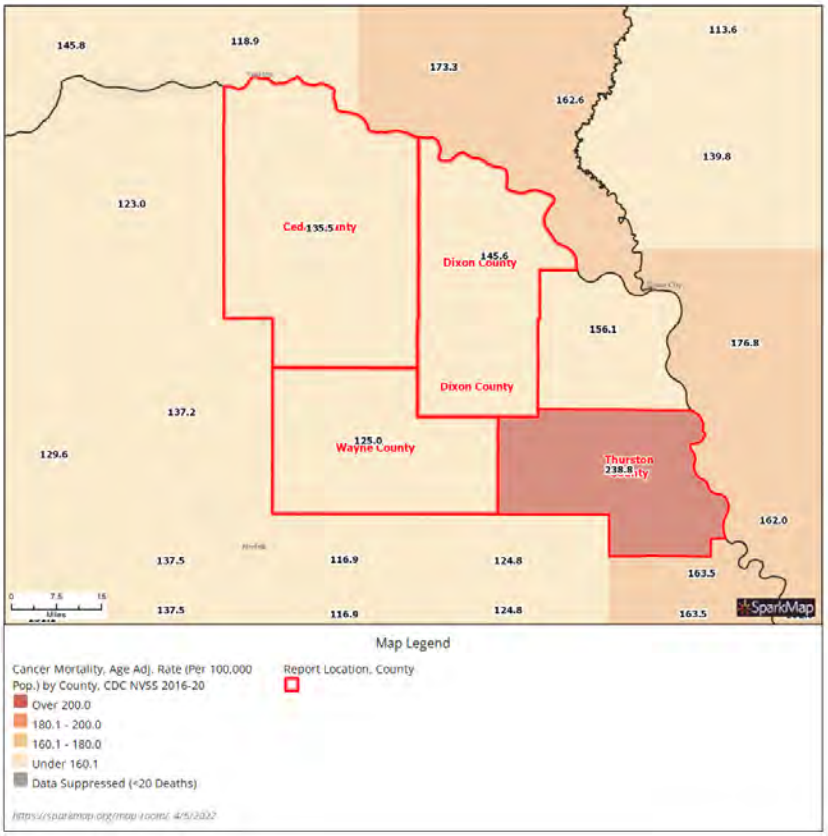


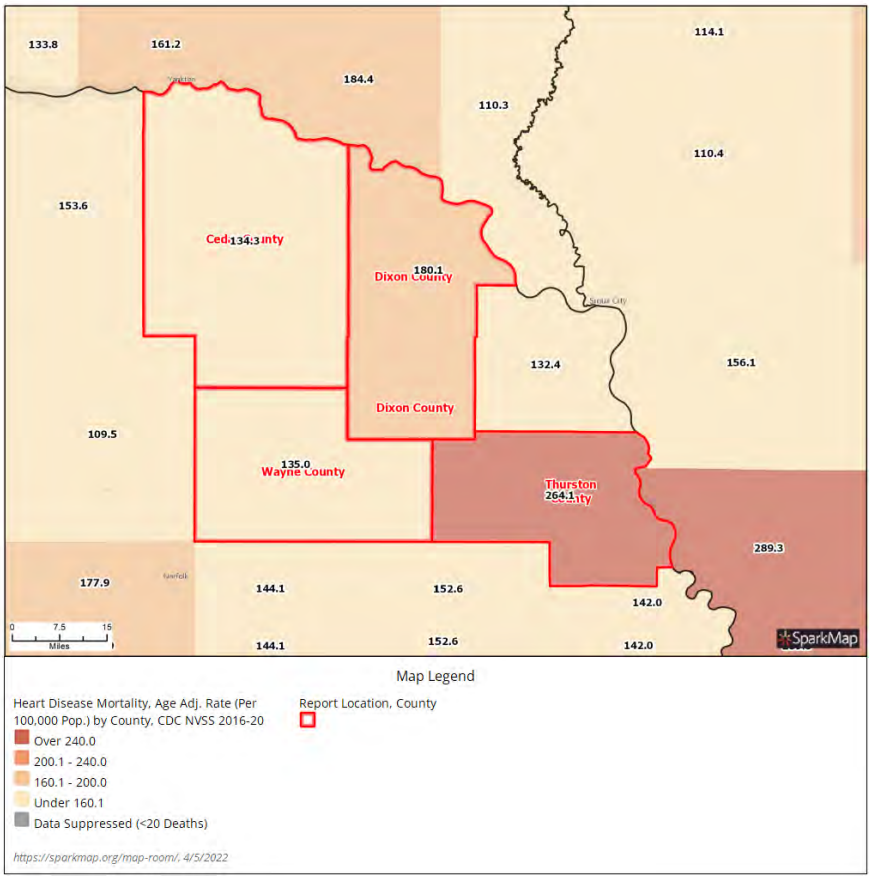
***Figure 31:** Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020, via SparkMap May 7, 2022*

"Cancer was the second leading cause of mortality among Nebraska residents in 2018, surpassed by heart disease with 65 deaths. By primary site, cancers of the lung, colon and rectum, pancreas and female breast accounted for just under half (46.7%) of Nebraska's cancer deaths in 2018" (Nebraska Department of Health and Human Services). The cancer death rates in regions like this health district "might reflect higher prevalence of tobacco-use and obesity in rural areas and lack of access to cancer screening services, follow-up to abnormal tests, quality care for cancer patients, and cancer survival care" (Garcia).

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population	Age-Adjusted Death Rate (Per 100,000 Population)
NNRHN	30,796	312	202.6	**158.4**
Cedar	8,493	96	226.1	135.5
Dixon	5,691	64	224.9	145.6
Thurston	7,219	81	224.4	**238.8**
Wayne	9,393	71	151.2	125.0
Nebraska	1,925,684	17,518	181.9	150.3

***Figure 32:** Centers for Disease Control and Prevention, CDC - National Vital Statistics System. Accessed via CDC WONDER. 2016-2020, via SparkMap May 7, 2022*

Cancer was cited by 7.1% of the community health survey respondents when asked about what worried them about the health of themselves and their families, which still made it among the top three topics in this open-ended question (after COVID-19 and ability to obtain health care). However, in the close-ended survey question when presented with a list of choices about top health concerns in the district, it was third only to mental health and COVID-19.



Heart Disease

Within this area, there were a total of 383 deaths due to heart disease, during the years 2016-2020. This represents an age-adjusted death rate of 173.4 per every 100,000 total population. Two of the counties had rates much higher than the other two and higher than Nebraska's: Dixon at 180.1 and Thurston at 264.1 (versus Cedar at 134.3 and Wayne at 135.0) As might be noted by the map in Figure 33, these counties do border at least one county with a similar rate, but other rates in the region are on the low side. This indicator is relevant because heart disease is a leading cause of death in the United States. *Centers for Disease Control and Prevention, National Vital Statistics System*.

***Figure 33:** Accessed via CDC WONDER 2016-2020 SparkMap May 16, 2022*

Report Area	Total Population, 2016-2020 Average	Five Year Total Deaths, 2016-2020 Total	Crude Death Rate (Per 100,000 Population)	Age-Adjusted Death Rate (Per 100,000 Population)
NNRHN	30,796	383	248.7	**173.4**
Cedar	8,493	116	273.2	134.3
Dixon	5,691	81	284.6	**180.1**
Thurston	7,219	91	252.1	**264.1**
Wayne	9,393	95	202.3	135.0
Nebraska	1,925,684	17,514	181.9	**144.8**

***Figure 34:** Accessed via CDC WONDER. 2016-2020 SparkMap.May 16, 2022*

Quality of Life

Other quality of life indicators include low birthweight and impacts of chronic disease.

Low Birthweight

Low birthweight has been linked to a greater risk of chronic diseases later in life. (Minelli & Inungu, n.d.) In the health district the **Percent of live births with low birthweight (< 2500 grams)** has steadily declined. This indicator is also important because of the connections to developmental disabilities, although more research needs to be done in this area (Schieve 2016) .

Impacts of Chronic Disease

The incidence of chronic disease in this region is significant for several reasons. Treatment of heart disease, kidney disease and cancer is not only financially expensive and challenging for providers but can also take a toll on the people who are dealing with one or more of these conditions. Mental health, transportation. Social workers and other mental health clinicians are rare in rural communities. For example, rural cancer survivors can experience higher rates of depression and emotional distress, but social workers and other mental health clinicians are rare in these communities (Taylor, 2019, 23).

Cancer

Cancer was rated third only to mental health and COVID-19 when given choices of community concerns in the community health surveys to rank. In answering the open ended question,"What worries you most about your health or the health of your family?"7.1% specifically mentioned cancer, especially being concerned about family history, as well as risk factors including smoking. Within the report area, there were 168 new cases of cancer reported (2014-2018). This means there is a rate of 439.2 for every 100,000 total population. This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancer (all sites) adjusted to 2000 U.S. standard population age groups. Dixon and Thurston counties had much higher rates (see table below) The rates for various types of cancer are also higher in each of our counties than the state average (as noted by the figures in the red boxes in Figure 35).

	Total Incidence Rate	Prostate	Lung & Bronchus	Breast	Colon & Rectum	Melanoma of the Skin	Stomach	Oral Cavity & Pharynx
Cedar	**413.6**	**143.5**	48.4	116.6	39.2	**29.8**		
Dixon	**8.549**	**146.1**	**70.5**	95	**50**	suppressed		
Thurston	468.2	suppressed	**70.8**	**163.1**	**62.2**		suppressed	
Wayne	**409.3**	**142.4**	**112.1**	46.9	**47.4**			suppressed
NNRHN*	***439.2***	*144.0*	*75.5*	*105.4*	*49.7*	*29.8*		
Nebraska	467.7	123.3	55.9	130.5	42.9	27.9		

***Figure 35:** age-adjusted incidence rates of the five most common newly diagnosed cancers by site for the 5-year period 2014-2018 Data Source: State Cancer Profiles, 2014-18 via SparkMap May 16, 2022*

Other Chronic Conditions:

- **Cardiovascular disease** is an important issue for rural areas. Studies shows that older women in rural areas had a greater risk for depression and less access to treatment. "Geographic isolation, food insecurity, physical inactivity and obesity complicated CHD in older rural women." P. 16 (Taylor, 2019) Since 2011, the **Percent of Adult Population ever told they had a heart attack or Coronary Heart Disease** has gone up and down in the health district, similarly to the state levels, but more volatile. It has also been higher than the state rate. Current rates are higher in Thurston County, small portions of Dixon and Wayne, as well as central Cedar. **Those who have been told they have high blood pressure,** as well as **those who are currently taking blood pressure medications.** is also going up.

- **Cerebrovascular Disease/Stroke:** The percentage of adults in the health district **who were ever told they had a stroke** up 68% from 2011 to 2019. This rate has gone up and down, but more years than not is above the state average. There are ***disparities*** in this report region for both gender and minorities. ***Females in the health district saw a 5.6% rate versus 2.7%*** where in the state the difference was much smaller .3% (3.0 to 2.7). However, ***the difference in the rates for the minority population in the NNRHN*** area versus the white population ***(4.7% to 2.8%)*** is similar to the rates in the state of Nebraska (4.2% to 2.3%).

- **Diabetes:** The **Percent of adults aged 20 and above with diagnosed diabetes** is trending upward as of 2019. This is significant because the high blood glucose can damage blood vessels and the nerves that control those vessels and the heart and lead to health conditions such as stroke and kidney disease. Diabetes, Heart Disease, & Stroke | NIDDK (nih.gov) ***The difference between minority rate (18.2%) and white, non Hispanic (6.6%) in the health district is greater than at the state level (15.4% to 8.4%)*** *Thirteen percent (13%) of* community health survey respondents cited being affected by diabetes, and four percent of the Hispanic respondents indicate being worried about diabetes.

- **Kidney Disease:** The percentage of adults in this region who report that they were **ever told they have Kidney Disease,** has vacillated between less than 2% to highs of near and above 4%. ***The difference in the rates between women and men was higher in the health district (4.0% to 1.4%)*** as compared to the state (2.7% to 2.1%). When looking at age, the highest percentage is in the 65+ group in both the health district and the state, as to be expected. However, while at the state level only 0.7% of the population 18-44 report having ever been told they had kidney disease, 2.8% of that age group reported this in the health district. ***While there is a difference at the state level between the percentage of minority versus white/non-Hispanic (3.9% to 2.0%) the difference is much greater in this health district (7.9% to 0.8%) (2019).***

- **Chronic Obstructive Pulmonary Disease (COPD):** **There is a greater disparity in the rates of adults that were told they ever had COPD in the minority population versus white people in the district (9.1% to 3.5%) versus the rates at the state level (7.0% to 5.0%)**

Other Health Issues

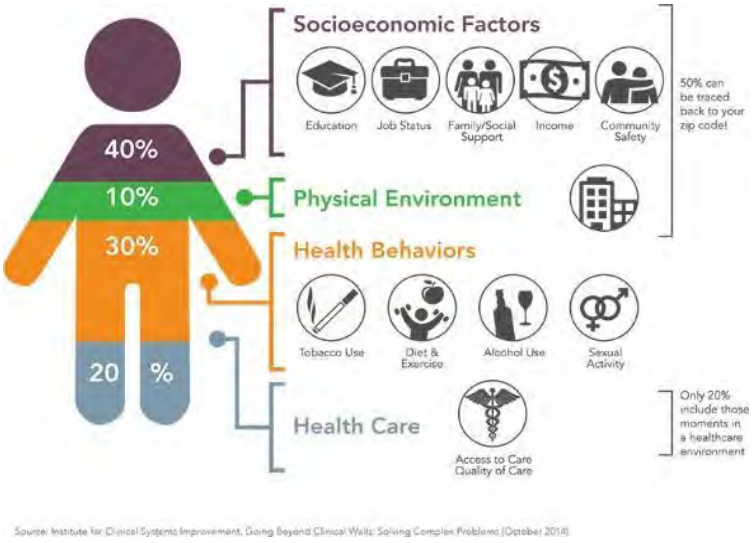
- **Depression:** Among **adults that have been ever told they have depression,** the rate in this region has vacillated since 2011, but trending up in 2019 (13.9%) from 2011 (9.7%). This will be another important indicator to watch in 2020 and beyond because of the effects of the COVID-19 pandemic (Kato et al). ***Differences for this indicator according to income are more significant for those who make less money in the health district than at the state level*** (2019). **Adolescent depression** was tracked for the first time in 2018 in the Nebraska Risk and Protective Factor Student Survey Results profile for the Northeast Nebraska Public Health Department and will also be another important indicator to track through the unprecedented challenges that youth have had to face as a result of the pandemic.

- Mental Distress While only fourteen community health survey respondents specifically disclosed mental health issues, including anxiety and depression, mental health was the top picked issue of health concerns of the district when given a list of choices. Mental health was also a major theme in the Forces of Change assessment as well as three of the six Listening Sessions.

- Tooth Decay is an important indicator for quality of life. Tooth decay can cause a diminished quality of life. Left untreated, it can progress and lead to infection, more expensive treatments, and, ultimately, tooth loss. It can also affect essential aspects of daily living, including eating, speaking, and performing at home, school, or work. People without dental insurance are more likely to have heart disease, diabetes, and osteoporosis. People with dental insurance are more likely to visit a dental professional, take their children to a dental professional, receive recommended preventive screenings and treatments, and have better overall health. P. A-4) (Agency for Healthcare Research and Quality, 2021) The percent of local residents reporting that they **had any permanent teeth extracted due to tooth decay or gum disease, 18+** had been 4% in the local district versus the state (as of 2012) but dropped farther and faster than the state, with only a ½ percent separating them (38.3% to 37.8%).

Health Factors

Leaders in this health district, including members of the Northeast Nebraska Rural Health Network, have recognized the importance of and desire to address the social determinants of health.



Social Determinants of Health

According to the US Center for Disease Control, CDC, the Social determinants of health (SDOH) "are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes." The World Health Organization defines them as "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics." (2013)

Socioeconomic Factors

Social and economic factors (including income, education, community safety and social supports) "are not commonly considered when it comes to health, yet strategies to improve these factors can have an even greater impact on health over time than those traditionally associated with health improvement, such as strategies to improve health behaviors."(County Health Rankings, 04/19/2022)

Physical Environment

"The physical environment is where individuals live, learn, work, and play. People interact with their physical environment through the air they breathe, water they drink, houses they live in, and the transportation they access to travel to work and school." (County Health Rankings, 04/19/2022)

Health Behaviors

"Health behaviors are actions individuals take that affect their health…. It is important to consider that not everyone has the means and opportunity to make healthy decisions. …Addressing health behaviors requires strategies to encourage individuals to engage in healthy behaviors, as well as ensuring that they can access nutritious food, safe spaces to be physically active, and supports to make healthy choices."(County Health Rankings, 04/19/2022)

Health Care

"Access to affordable, quality, and timely health care can help prevent diseases and detect issues sooner, enabling individuals to live longer, healthier lives….Health care access and quality also vary widely both by place and by race, ethnicity, and income." (County Health Rankings, 04/19/2022)

Health Behaviors

Tobacco Use

Tobacco use is an important indicator to be watching in light of the COVID-19 pandemic. While the CDC recently reported that cigarette smoking decreased to an all time low in 2020, CDC says smoking in the U.S. reached new all-time low during pandemic (nbcnews.com) there have been reports that the trends 11have been the other direction in some regions ("Cigarette Smoking and Risk Perceptions During the COVID-19 Pandemic Reported by Recently Hospitalized Participants in a Smoking Cessation Trial").

> "Tobacco use increases the risk for developing and dying from heart disease, stroke, and Chronic Lower Respiratory Disease (CLRD). **Cigarette smoking is the leading cause of preventable disease and death in the United States.** Nationally, the prevalence of cigarette smoking among adults living in rural counties is higher than in urban counties. Understanding where tobacco use in rural areas is higher than urban areas can help prioritize resources to reduce tobacco use and secondhand smoke exposure and begin to address the increasing numbers of CLRD-related deaths in rural areas. Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States | MMWR (cdc.gov) Mortality

The **percent of adults that report smoking every day or some days** has been climbing from a low of 13% to 16% in 2019. This is another indicator which could see a rise in 2020 and 2021 due to pandemic quarantine, stress, etc. **E-Cigarette Use** has stayed lower in this region than in the state of Nebraska since 2016. While the state rate has been increasing since 2017, the local rate plateaued between 2018 and 2019. This could change with the introduction of a vape shop in Wayne in 2022. On the other hand, the use of **Smokeless Tobacco** has been higher in this region than in the state as a whole, except for 2016. In our region, there is some evidence that at least before the pandemic people had **attempted to quit smoking.** In the health district, the trend for having a **rule for no smoking in the home** has been increasing, to almost 91% in 2019, although this indicator has been below the state average since 2014. Having a **Rule for No Smoking in the family Vehicle** has plateaued at less than 88%.

While less than 1% of the community health respondents specifically mentioned being worried about smoking, two thirds of these individuals are worried about the smoking of family members.

Diet & Exercise

Obesity

It might be said that obesity is both a health factor, as noted in County Health Rankings, for example, and an outcome, as in the Nebraska 2017-2021 State Health Improvement Plan.

While there are limitations to BMI as a diagnostic criteria for obesity (Minelli and Inungu 198), it is still a useful indicator on a population level as well as in treating individual patients. BMI, or Body Mass Index, is a measure calculated for each individual using their weight and height. While there is more focus on obesity (BMI equal to or greater than 30) because of the increased health risks, the risks actually start to accumulate when people are overweight (BMI >=25).**Percent of adults that have a BMI of 25 or above**, are commonly referred to as overweight versus obese. While the local rate (70.5%) was experiencing a drop from 2018 to 2019, it was still higher than the state average (69%).

While only three percent of community survey respondents confessed being worried about their weight, four percent expressed concern about the very related issue of diabetes. While it was one of the top issues chosen in a list of community concerns in the 2019 survey, obesity was not listed as a choice on the close-ended question in the survey completed in 2022. However, two of the top six choices (coming in only after mental health, COVID-19, cancer and access to healthcare) were: "Challenges getting healthy and affordable food" and "Getting enough exercise". In addition, this issue along with the related issues of physical activity and nutrition came up in Listening Sessions.

Percent of adults that report a BMI >= 30 is also higher in this health district than the state (36.075% versus 33.3%) In the state of Nebraska, American Indian and African American populations had the highest numbers of individuals who were obese. Hispanics were most likely to be overweight (NE DHHS, 2021). **In this health district, Thurston County showed 41.5% obesity in 2019 versus Cedar (34.0%), Dixon (35.0%) and Wayne 33.8%.**

Report Area	Population Age 20+	Adults with BMI > 30.0 (Obese)	Adults with BMI > 30.0 (Obese), Percent
NNRHN	21,430	7,660	35.7%
Cedar County, NE	6,105	2,094	34.0%
Dixon County, NE	4,074	1,434	35.0%
Thurston County, NE	4,397	1,829	41.5%
Wayne County, NE	6,854	2,303	33.8%
Nebraska	1,405,098	469,291	33.3%
United States	243,082,729	67,624,774	27.6%

Figure 36: National Center for Chronic Disease Prevention and Health Promotion (Sparkmap, December 28, 2021)

The rate for youth 10 to 17 in Nebraska was on its way back up in 2019-2020. The Network plans to work with NNPHD and local schools to gather data to see if the local trend is similar.

Location	Data Type	2016 - 2017	2017 - 2018	2018 - 2019	2019 - 2020
Nebraska	Percent	29%	26%	26%	28%

Figure 37: U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, National Survey of Children's Health. For more information on the NSCH, see http://childhealthdata.org/learn/NSCH April 13, 2022

Contributing factors to such a large portion of our health district being overweight or obese are not unique to our area. "Jobs have become less strenuous and people must pay a high price for exercise, arenas, or equipment. Calories have become relatively cheaper and exercise has become relatively more expensive." loc 411 of The Economics of Obesity) Rural areas such as ours face more obstacles, however. The new neighborhood markets, "Dollar stores are especially dense in regions of the country where childhood obesity rates are the highest. The question of how dollar stores could contribute to dietary health should be considered in efforts to combat childhood obesity" (Alavi Hojjat and Hojjat 440) COVID-19 Self-quarantine and Weight Gain Risk Factors in Adults - PMC (nih.gov) A 12-year study found that working aged men who were unemployed gained weight. Other studies have found correlation between income inequality and obesity. (Alavi Hojjat and Hojjat 1149)

The risks of obesity are many. People with high BMI are less likely to get screenings for breast, cervical, and colorectal cancers among others (Alavi Hojjat and Hojjat 561). "Adults with excess weight are at even greater risk during the COVID-19 pandemic: Having obesity increases the risk of severe illness from COVID-19. Having obesity may triple the risk of hospitalization due to a COVID-19 infection. Obesity is linked to impaired immune function. Obesity decreases lung capacity and reserve and can make ventilation more difficult. The increased risk for hospitalization or death was particularly pronounced in those under age 65." Obesity, Race/Ethnicity, and COVID-19 | Overweight & Obesity | CDC

More than 900,000 adult COVID-19 hospitalizations occurred in the United States between the beginning of the pandemic and November 18, 2020. Models estimate that 271,800 (30.2%) of these hospitalizations were attributed to **obesity**.

In a study of COVID-19 cases in **patients aged 18 years and younger**, having **obesity** was associated with a 3.07 times higher risk of hospitalization and a 1.42 times higher risk of severe illness (intensive care unit admission, invasive mechanical ventilation, or death) when hospitalized.

Obesity, Race/Ethnicity, and COVID-19 | Overweight & Obesity | CDC

Obesity was identified as a priority in the last Community Health Improvement Plan, and promoting quality measures and interventions regarding obesity were written into a funded HRSA proposal which is now in the process of being implemented after a delay caused by COVID-19. Facilitating increased emphasis on obesity among the area's providers would likely fit in well with increased emphasis on chronic care management and integrated behavioral health care, especially Patient Centered Medical Home (PCMH) initiatives.

Healthy Eating

"Rural environments are often synonymous to food deserts, areas with limited accessibility to nutritionally dense foods." (Minelli & Inungu,129). Cheap processed food, bigger portion sizes, and food eaten away from home (Minelli & Inungu, n.d.) While less than two percent of survey respondents acknowledged they were worried about unhealthy eating habits, over 60% of the respondents indicated that they are trying to eat more healthy. Some of the things that they say they are trying to do include preparing more meals at home and avoiding junk food . Comments shared by not only the survey respondents, that they "don't have time to prepare healthy meals every night," they are busy and "spend a lot of time eating on the run" were echoed at listening sessions. Food needs to taste good and, yet, be affordable. "The greater the economic constraints on individuals, the poorer the nutritional quality of the foods selected." (Alavi Hojjat and Hojjat 395). Fifty one of the community health survey respondents said that improved access to affordable healthy food would make their neighborhoods healthier.

Consumption of Fruits and Vegetables

Consumed Fruits Less than 1 time per day, 18 years and older had been a lower rate than that for the state but caught up in 2019. ***Consumed vegetables less than 1 time per day, Adults 18 and older*** has climbed higher and faster than the state rate since 2017. While efforts have been made to improve access (for example, the city of Wayne has a community garden and facilitates a farmers market in season) access to fresh produce in more limited in the smaller towns in this region. Estimated expenditures for fruits and vegetables purchased for in-home consumption, as a percentage of total food-at-home expenditures are listed in Figure 38, with expenditures data suppressed for single counties.

Report Area	State Rank	Z-Score (US)	Z-Score (Within-Neb)	Average Expenditures	Percentage of Food-At-Home Expenditures
NNRHN	Suppressed	-2.02	-1.07	$669.18	**11.34%**
Cedar	69	-1.81	0.29	Suppressed	Suppressed
Dixon	58	-1.76	0.58	Suppressed	Suppressed
Thurston	93	-2.28	-2.72	Suppressed	Suppressed
Wayne	92	-2.19	-2.14	Suppressed	Suppressed
Nebraska	No data	-0.86	No data	$636.19	11.45%
US	No data	No data	No data	$744.71	12.68%

Figure 38: Nielsen SiteReports 2014 via SparkMap March 30, 2022

Wayne and Thurston counties rank in the bottom of Nebraska counties for fruits and vegetable expenditures (As may be noted on the map Figure 39), so there may be room for improvement.

When asked what they do to be more healthy 47.7% of the community health survey respondents reported that they have been making efforts to eat more eat more healthy, Of this group, many of them had specific strategies including not only eating more vegetables (including especially greens) 33.1% and fruit (8.9%) as well as avoiding junk food (4.0%), raising their own food (2.4%) and cooking meals at home (8.1%).

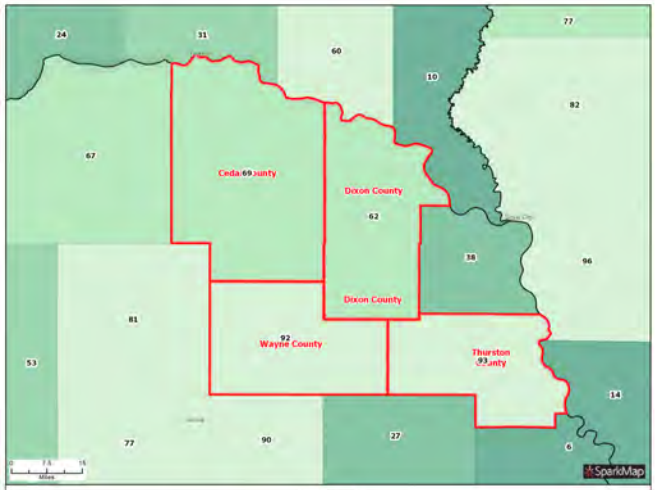


Figure 39: Nielsen SiteReports 2014 via SparkMap May 10, 2022

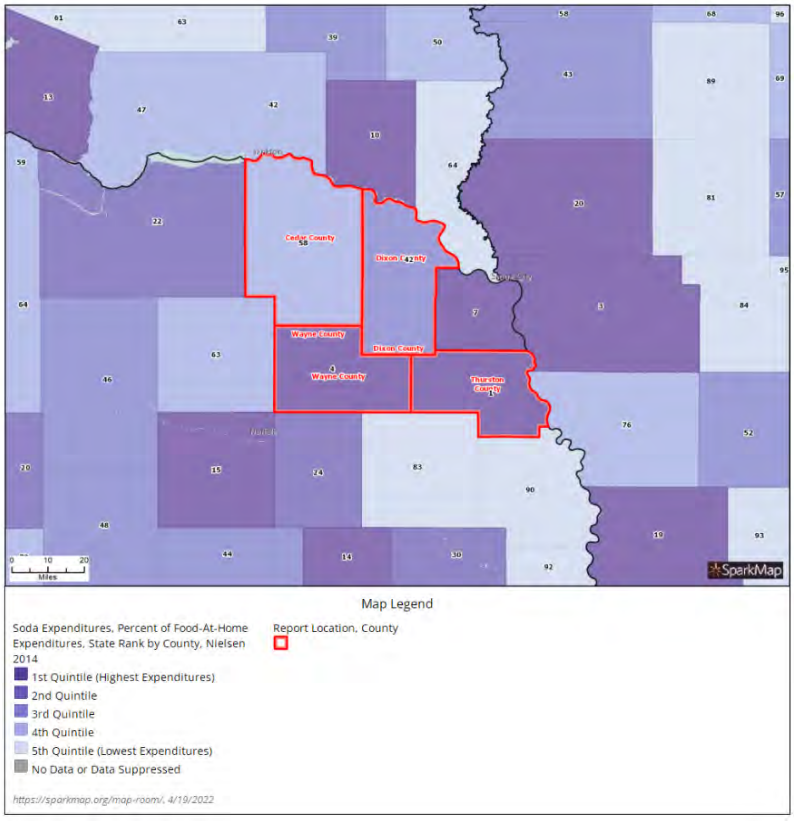


Figure 40: Nielsen SiteReports 2014 via SparkMap May 10, 2022

Soda and sugary drinks

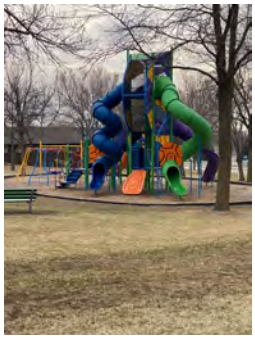
On the other side of the coin, it is possible to look at Soda Expenditures from 2014 to note that at that time two of our counties were top spenders on this unhealthy beverage as demonstrated on the map below. When asked what they do to be more healthy, 52 survey respondents said they would drink more water and nine specifically said they avoid soda.

Physical Activity

Those adults reporting **no leisure-time physical activity in past 30 days** were 29.9% of the local health district versus the state average of 26.9% in the state. There are a number of factors that could contribute to a relative lack of physical activity in our area. For example, "Workers who desire more exercise than their work affords must in many cases pay for the opportunity…" (Alavi Hojjat and Hojjat 677). Furthermore, "Rural populations are typically sicker than urban populations, therefore, physical inactivity is more pervasive in rural populations as a result of debilitating chronic conditions" (Taylor 14).

Aerobic Activity peaked in 2017 and decreased through 2019. **Muscle Strengthening** has been steadily rising for the NNRHN area and is now higher than the state average (as of 2019) The percentage or people **who engage in both of these activities** on a regular basis had been rising since 2011, but decreasing since 2017. In terms of potential disparities, **the numbers of those who have less than a high school degree and met this standard are suppressed because they are so small which differs from the 26.4% on a state level with that level of education.** However, in this region a greater percentage of minorities meet these activity standards than on the state level (38.6% versus 33.4%).

BFRSS data from 2015 to 2017 indicates that the percentage of residents in this area who believed that they had **access to safe places to walk** is 10% lower than the state average. *Fifteen percent of survey respondents identified improved opportunities for walking as something that would make their neighborhoods healthier.*



Twenty three percent of Community Health Survey respondents made suggestions for their neighborhoods regarding improved access to exercise. *Nine percent suggested improving other exercise opportunities, including making gyms and fitness centers more affordable, as well as making an indoor pool available.*

Four hundred and fifty one of the six hundred and eleven survey respondents from the four country region reported that they do some sort of exercise to be more healthy, with 129 of these individuals specifically mentioning walking.

Alcohol & Drug Use

The rate of **Heavy Drinking** (defined as an average of 2 drinks daily in last month for men and 1 daily for women) has been higher in this region than the state, although it dipped below in 2012. The Nebraska Behavioral Risk Factor Surveillance System (BRFSS) Dashboard reports 2.2% of minority residents in report area versus 6.8% of white residents (2019) **Binge drinking** has also been higher in the region than in the state, although the region's rate has trended downward. This is another important indicator to watch through 2020 and 2021. *Figures 41-43 look at this indicators through a minority perspective:*

	2019	2018	2017	2016	2015	2014	2013	2012	2011
White, NH	6.80%	7.60%	8.70%	6.90%	7%	9.10%	8.00%	5.20%	7.90%
Black. NH	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed
American Indian, NH	1.40%	6.40%	suppressed	suppressed	4.20%	6.40%	4.40%	6.30%	1.20%
Multiracial, NH	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed
Hispanic	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed

Figure 41: Nebraska Behavioral Risk Factor Surveillance System (BFRSS) Dashboard (05/09/2022) Heavy Drinking defined as: Percentage of men 18 and older who report drinking more than 60 alcoholic drinks (an average of more than two drinks per day) during the past 30 days and the percentage of women 18 and older who report drinking more than 30 alcoholic drinks (an average of more than one drink per day) during the past 30 days May 9, 2022

Binge Drinking	2019	2018	2017	2016	2015	2014	2013	2012	2011
White, NH	27.9	27	30.3	27.3	25.2	27.3	25.6	30.5	33.2
Black. NH	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed
American Indian, NH	14.8	21.3	Suppressed	Suppressed	36.4	26.6	25.3	30.9	22.8
Multiracial, NH	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed
Hispanic	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed	Suppressed

Figure 42: Nebraska Behavioral Risk Factor Surveillance System (BFRSS) Dashboard (05/09/2022) Binge defined as: Percentage of adults 18 and older who report having five or more alcoholic drinks for men/four or more alcoholic drinks for women on at least one occasion during the past 30 days May 9, 2022

Any Drinking/ 30 days	2019	2018	2017	2016	2015	2014	2013	2012	2011
White, NH	64.80%	68.50%	69.20%	64.00%	62.30%	66.80%	62.10%	69.3%	68.4%
Black. NH	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed
American Indian, NH	23.80%	39.80%	suppressed	suppressed	40.50%	37.30%	37.20%	39.8	33.4
Multiracial, NH	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed
Hispanic	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed	suppressed

Figure 43: Nebraska Behavioral Risk Factor Surveillance System (BRFSS) Dashboard. Percentage of Adult 18 and Older who report having at least one alcoholic beverage during the past 30 days May 9, 2022

Youth Indicator data in this area can be found at the Nebraska Risk and Protective Factor Student Survey website. Applicable indicators are also being added to the Clear Impact scorecards.

Deaths due to alcohol impaired driving are an issue with the annual rate per 100,000 at the end of the 2015-2019 measuring period at 38.4 for Thurston County and 13.9 for Wayne County versus 7.0 for the state of Nebraska (Cedar, 3.8, and Dixon at 0.0) *Note: Fatality counts are based on the location of the crash and not the decedent's residence.*

The trend in **opioid misuse in the past year, for adults,** has only been measured by the Behavioral Risk Factor Surveillance System (**BRFSS**) in Nebraska since 2018. Both the regional and state rates did decrease in 2019. In 2019, there was a similar difference between female and male rates in the NNRHN report area and the state: 3.1% to 2.0% and 3.9% to 2.9%. In the NNRHN area, minority data was small enough to be suppressed, while in the state minority rate was 6.7% to 2.6% for whites.

According to the Nebraska Risk and Protective Factor Student Survey **use of prescription drugs** by 10th and 12th graders was decreasing in 2018, but increasing for 8th graders.

Opioid misuse is a target of current programming by the Northeast Nebraska Public Health Department. As part of their intervention, they conducted a public community readiness survey which can be found in Appendix 6 .

Sexual Activity

Teen births and Sexually Transmitted Diseases are two key factors measured by County Health Rankings. They are also indicators in Healthy People 2030.

Teen Births

Teen births not only is an indicator regarding sexual activity, but also a factor for both the babies born to those young females, as well as to the females themselves. It is a goal of Health People 2030 to reduce pregnancies in adolescents because "Babies born to teen mothers are more likely to be premature, have a low birth weight, and even to die. Having a baby can also negatively impact teen mothers' health and their educational and job opportunities" ("Reduce pregnancies in adolescents — FP-03 - Healthy People 2030 | health.gov").

Regarding the **teen birth rate per 1,000 female population (ages 15-19)** the local region has seen a decrease in the rate of births (number reported each year is for that year and the previous six) during the last decade mirroring that of the state, even though the region's average is still higher than that of the state. Similarly, the national rate has been decreasing–however, **disparities still exist by race and ethnicity** ("About Teen Pregnancy") . There is a difference in the rate by county, as demonstrated in the graph Figure 44..

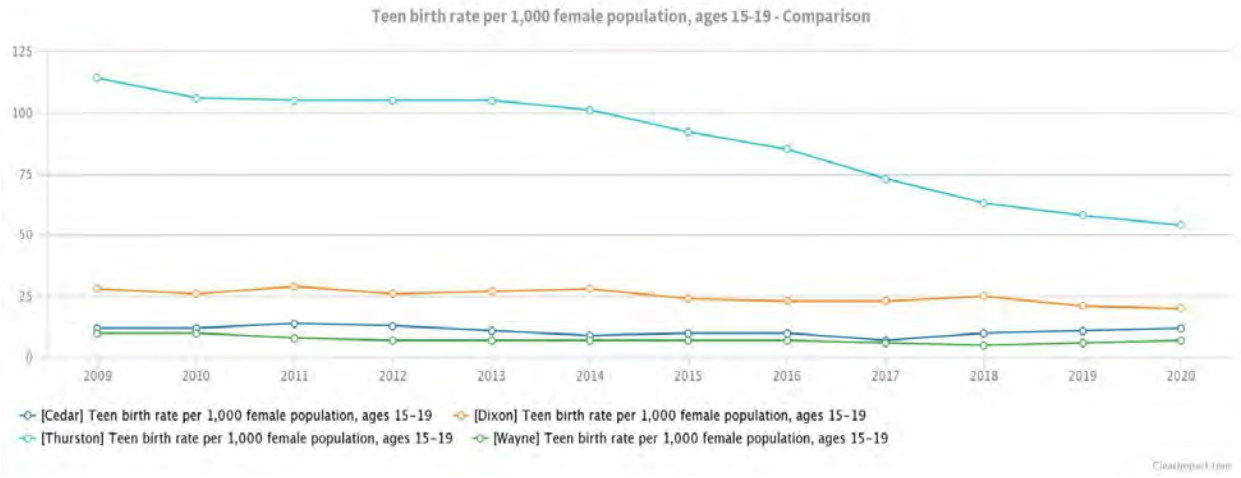


Figure 44: National Center for Health Statistics-Natality files via County Health Rankings via SparkMap May 10, 2022

Sexually Transmitted Diseases

"Sexually transmitted Infections are another indicator regarding sexual activity. STIs are associated with a significantly increased risk of morbidity and mortality, including increased risk of cervical cancer, infertility, and premature death." Sexually transmitted infections | County Health Rankings & Roadmaps

"Chlamydia incidence rates are associated with unsafe sexual activity. Chlamydia is the most common bacterial sexually transmitted infection (STI) in North America and is one of the major causes of tubal infertility, ectopic pregnancy, pelvic inflammatory disease, and chronic pelvic pain." Sexually transmitted infections | County Health Rankings & Roadmaps. While the rate for the US and for Nebraska have been slowly but steadily going up, the **Chlamydia rate per 100,000 population** has been going up and down since 2005. However, the local rate, while it had been less, did go above the state average in 2018.

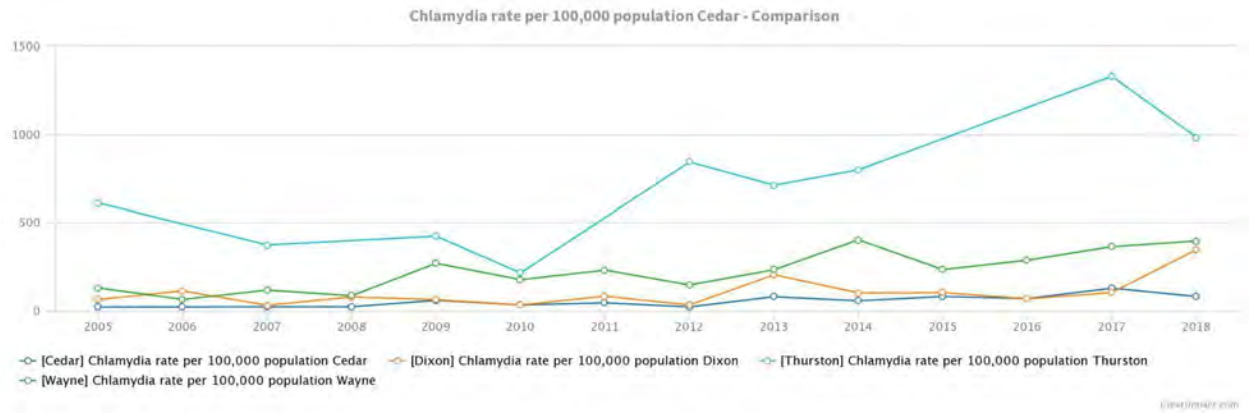


***Figure 45:** Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention 2018 via SparkMap May 10, 2022*

Clinical Care

Not surprising, both Healthy People 2030 and the Nebraska State Health Improvement Plan (SHIP) address this factor. Specifically NNRHN, through supporting and strengthening the local healthcare network , will help Northeast NE reach the goal that (Northeastern) Nebraskans will experience improved utilization and access to healthcare services.

"Lack of access to care is important in selecting patients who might fail to control their chronic conditions and need additional support. Social support represents another variable not normally accounted for in traditional risk stratification schema. Lack of social support and social isolation may identify high-risk individuals" (Mayzell 32770).

Twenty-two percent of those responding to the community survey expressed concern about access to clinical care, from not having money for out of pocket costs to lack of insurance coverage to not being able to identify serious health issues in time.

Access to Care

Potential barriers to care include lack of health insurance coverage, inability to afford out of pocket costs, lack of transportation, language barriers and being uncomfortable in the medical environment and distrust of providers. Nebraska state report card: Access to Health Services (clearimpact.com)

Insurance and Out-of-pocket

Lack of insurance, or even the ability to cover out of pocket costs, is going to mean that medical treatment is likely to be delayed. This can be especially significant when it comes to more advanced stages of cancer. It is estimated that age-specific mortality is 25% higher in the uninsured than in the privately insured population (King, Jr. , et al., 2016).

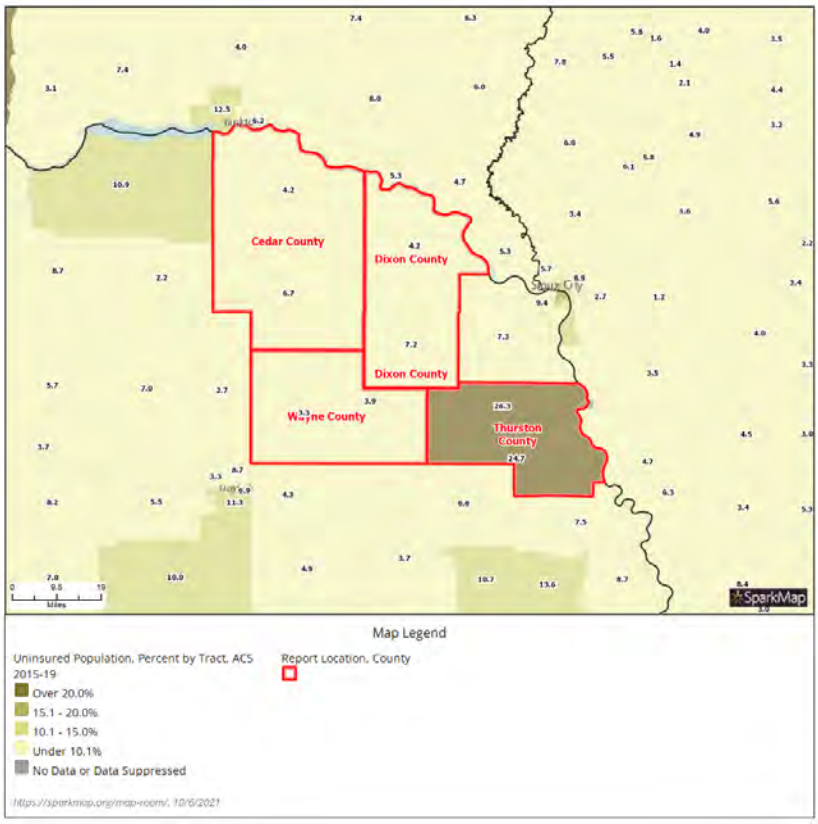


Figure 46: US Census, American Community Survey 2015-19 via SparkMap May 10, 2022

The **Uninsured Population Under Age 18** has been trending in the right direction, although it did show an increase from 2018 to 2019.**No health care coverage, Adults 18-64 years old** has not been as high in this health district as it has been in the state as a whole (13.7% versus 17.1% in 2019). Both rates were trending up as of 2019. Medicaid safety net in Nebraska may not be as broad in Nebraska as in other states. While expansion was approved in 2018, there was a two year delay in implementation. System was overhauled in late 2020 into a program called Heritage Health. (Norris).The table below reports information about the Medicare population, including the number of beneficiaries enrolled in parts A & B (the fee-for-service population) and the number enrolled in Medicare Advantage.

Report Area	Total Medicare Beneficiaries	Medicaid Advantage Beneficiaries	Fee-for-Service Beneficiaries	Medicaid Eligible, Percentage	Average Age
NNRHN	5,518	1,001	4,517	10.92%	74
Cedar	1,893	393	1,500	7.47%	74
Dixon	1,219	326	893	9.07%	74
Thurston	942	63	879	22.98%	72
Wayne	1,464	219	1,245	9.16%	74
Nebraska	334,898	76,571	258,327	11.25%	73

***Figure 47**: Centers for Medicare and Medicaid Services, CMS - Geographic Variation Public Use File , 2020 via SparkMap*

The **percent of adults from the NNRHN region who could not see a doctor in the past 12 months because of cost** was quickly climbing as of 2019, coming close to the state rate.

No doctor

The indicator regarding area adult residents having **no personal doctor or health care provider** was going in the right direction, dropping from 20.6% to 15.9%. This is important because "Patients who have a usual source of care report greater trust and satisfaction with their providers, are more likely to receive treatment for chronic health conditions, and report fewer unmet service needs. Having a usual place and usual provider are associated with an increased likelihood of receiving preventive services and recommended screenings compared with having no usual source of care." "However, people without insurance are less likely to have a usual source of care, often due to out-of-pocket costs related to receiving care." P A-22. (Agency for Healthcare Research and Quality, 2021)

The 2019 figures indicate that men and minorities have higher rates of lacking a primary care provider(PCP) in both this health district and the state. The disparity between men and women is not as significant in the report region as it is in the state. In the NNRHN area it was 19.1% for males versus 12.7% for females while it was 26.2% to 14.7% on the state level. **The disparity between white/non-Hispanic and minorities is even greater. On the state level the difference was almost 20% (37.2% versus 17.3%) while in our health district in 2019 the difference was 23 percentage points**

(34.4% to 11.4%). Respondents to the community health surveys and participants at our listening sessions point to some key reasons for this difference, including not only language barriers and costs, but also trust issues. See Appendix 5 and Appendix 4.

Availability of Medical Providers and Facilities

According to the Center for Medicare and Medicaid Services, The average ate **Primary Care Providers** in the health district was 72.24 , compared to 91.61 for the state in May 2021. County rates ranged from 17.84 in Dixon to 47.73 in Cedar 61.87 in Wayne and 162.41 in Thurston. This region is surrounded by health care facilities just outside of their boundaries, including Midtown Health Center in Norfolk and Avera Sacred Heart in Yankton. However, transportation can still be an issue.

Access to Care-Dental Health (providers) is lower than state average as well. See Figure 48 for a map of hospitals in the area. More information on healthcare workforce for this region can be found in Appendix 8.

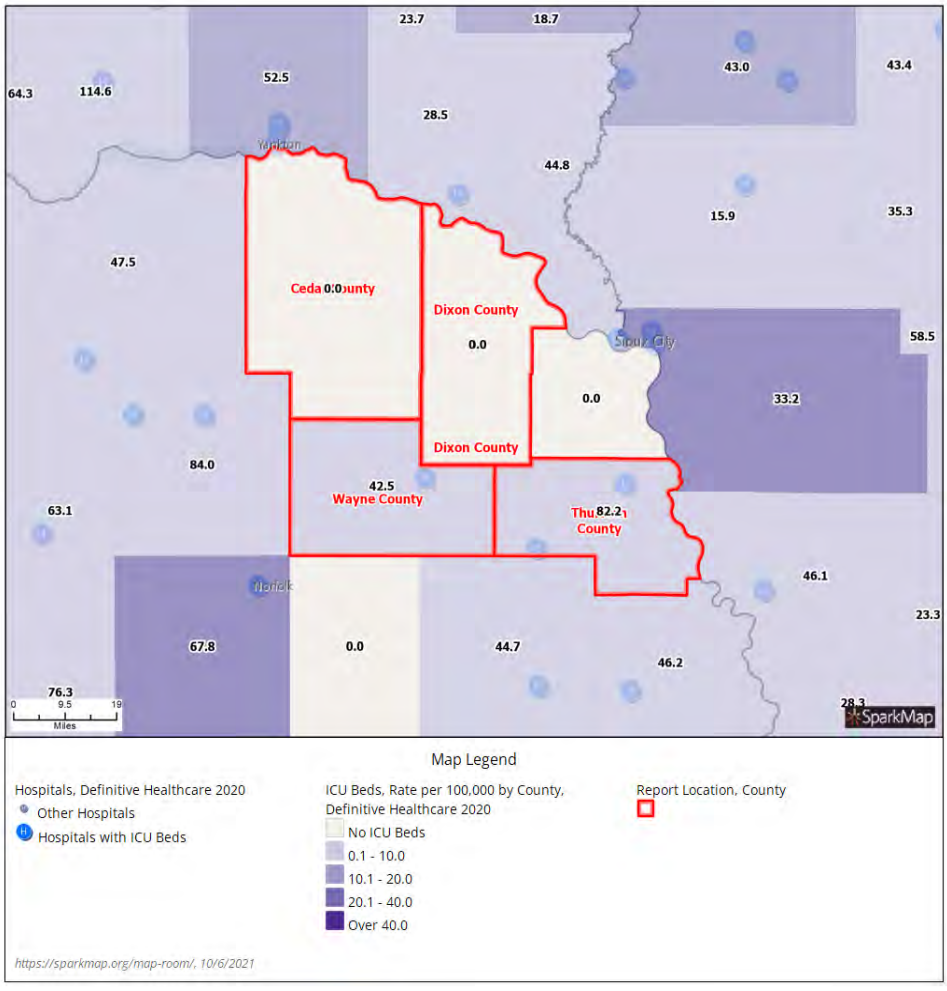


Figure 48: Area Hospitals

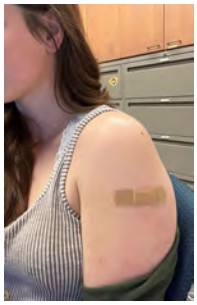
Quality of Care

"Predisposing characteristics refer to health beliefs and culture, care-seeking behaviors, trust in health care and other social institutions, and related characteristics that may influence whether, when, and from whom an individual decides to obtain health care when needed (Mayzell 1196). " A number of factors can affect when and whether a person is going to seek medical care, especially routine or preventative care. For example, the community health surveys completed by Hispanic members of our population indicated that language is still a major issue. This was also a key factor shared at the listening sessions in Wakefield and Wayne with members of the Hispanic community.

Routine Check-ups

The rate of adults in the region that **reported a routine checkup in the past year** has been steadily increasing since 2014 and is up from 58.3 percent in 2013 to 74.9% in 2019. The pandemic will undoubtedly have an impact on this trend as routine checkups, as well as screenings, were interrupted especially during the first surge.

Vaccinations

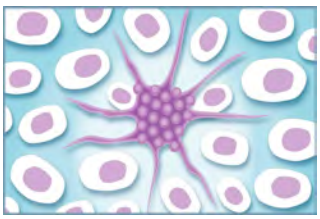


Vaccinations are a key preventative tool. **Pneumonia Vaccination, 65 and Older** had been trending in a positive direction as of 2019. **Flu Vaccination, 18 and Older** has stayed consistently below the state average, with the up and down trend following that of the state. While NNPHD provides leadership in the health district in this area, especially in public awareness and education, NENCAP is a major provider for public vaccination clinics. Pharmacies have also been key partners, especially in the areas of COVID-19 and flu vaccinations.

Screenings

Cancer

No one wants to hear the "c-word" (cancer) from their doctors. Screenings however can make a real difference. Rural populations can be less likely to pursue cancer prevention including screening. "Fatalism regarding cancer events was consistent with thoughts of pessimism or hopelessness that nothing can be done to reduce cancer risk, a lack of understanding on which cancer recommendations for prevention were effective or the perception that everything caused cancer." (Taylor, 2019) While the primary source of information continues to be the primary care provider (PCP), rural residents who used the internet for cancer information have been less fatalistic. (Taylor, 2019) See discussions of health information and broadband access.



Up-to-date on breast cancer screening, Females 50-74 trending in a positive direction, while the ***percent of female Medicare enrollees that receive mammography screening*** had plateaued in 2017.

Cancer Screening - Sigmoidoscopy or Colonoscopy is an issue in this region considering frequency of colon cancer. The rate in the local district has stayed below the state average since 2012, (59.7% to 68.7%). In the state of Nebraska, the Hispanic population was least likely to report having a colonoscopy in the past 10 years at 40.4%, with American Indians at 49.4%, compared with African Americans slightly less than Whites (Zhang).

Up-to-date on Cervical Cancer Screening, Females 21-65 years old had been trending in a negative direction as of 2018 (a 22% decrease from 2012).

Other Screenings

The percentage of **Adults that had their blood pressure checked in the previous year** was going down in 2017. The percentage of residents in the health district who reported that they **were ever told they had high blood pressure (excluding pregnancy)** rose to 33.2% in 2019 from 29.6% in 2017. The percentages of those currently taking blood pressure medicine has risen as well.

Adults who had their cholesterol checked in the last five years

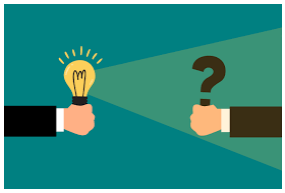
High cholesterol increases risk for heart disease and stroke. Cholesterol checks are recommended at least every 4-6 year, more often if there is a family history of early heart attacks or heart disease (NE DHHS, 2021). In the state of Nebraska, the Hispanic population was least likely to report having their cholesterol checked in the most recent five years reported (NE DHHS, 2021)

Those who have **ever been tested for HIV (excluding blood donation)** is lower locally than at the state level, but like the state it has been trending up since 2018.

The percentage of health district **adults who had gotten their teeth cleaned in the last year** was going up as of 2018 (up to 67.8% from 62.6% in 2016).

Health Information and Literacy

A major focus of the local public health system in this region is health literacy. This was important pre-pandemic as coalitions from the last CHNA and CHIP process emerged to work on behavioral health and obesity. It gained a new significance during the pandemic as misinformation rivaled lack of information as negative influences on health outcomes. While there were key indicators (**understandable information from medical professionals** and **understandable written information**) regarding health literacy trending up through 2019, the estimated percentage of residents who found it **very easy to get needed advice or information about health or medical topics** went down from over 70% in 2016 to less than 65% in 2019. NNPHD has recently added a communications coordinator to help meet this need.



This theme came up in the Forces of Change Assessment, the update to the Local Public Health System Assessment, as well as at least one of the Listening Sessions. In addition, twelve community health survey respondents made suggestions regarding health education. Some of these suggestions included:

- " Access to information for family and individual health care;"
- "Better resources teaching you how to be healthy;"
- "Workshops for healthy eating;" and
- "Motivate all people not to have a sedentary life."

Social and Economic Factors

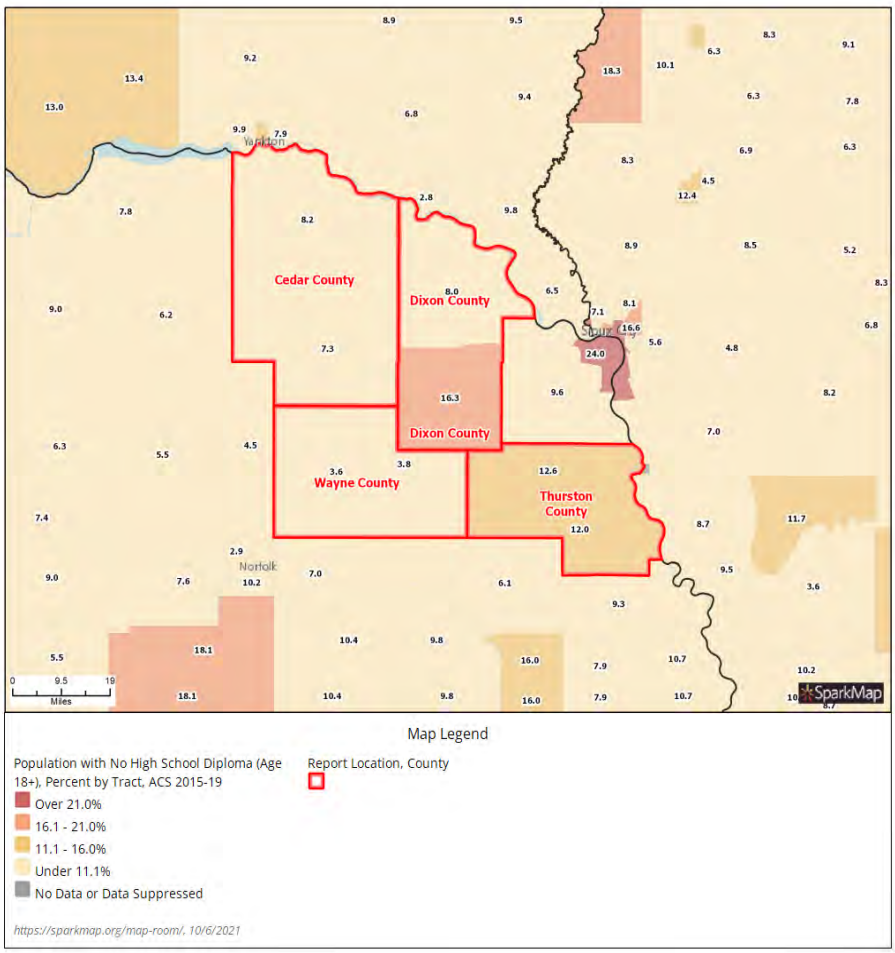
Education, income, employment, household structure, social support, and community safety are all factors that have been shown to have a major connection to health outcomes. Economic factors affect the overall health of a community and can affect community infrastructure such as safe walking routes, access to educational opportunities and access to health care. When families live paycheck to paycheck, not only can they not afford healthy foods, but they also may not spend on health insurance and forego savings. Without health insurance or savings, working families are at risk from unplanned events and/or expenses which may plummet them into poverty. Families living in poverty or at the edge of poverty are put in a flight or fight response long-term that makes them more susceptible to disease.

Education

As noted by County Health Rankings, the relationship between education and improved health outcomes is well known, with "a high school degree correlating strongly with higher life expectancies and improved quality of life. Educational level is associated with smoking status, exercise habits, as well as better physical health, such as lower rates of diabetes and improved self-reported health. Adults with high school degrees are more likely to be employed and earn more, on average, than their less educated counterparts." High school completion in Nebraska | County Health Rankings & Roadmaps. The range of educational achievement of the adults in the area can be found in Figure 45.

Report Area	No High School Diploma	High School Only	Some College	Associates Degree	Bachelors Degree	Graduate or Professional Degree
NNRHN	**8.1%**	32.6%	21.8%	14.1%	16.1%	7.2%
Cedar	7.51%	35.4%	20.3%	15.8%	14.8%	6.2%
Dixon	12.08%	35.3%	20.5%	10.9%	14.9%	6.3%
Thurston	10.91%	32.9%	27.2%	12.7%	11.0%	5.4%
Wayne	3.99%	27.5%	20.5%	15.7%	22.2%	10.2%
Nebraska	8.60%	26.1%	22.8%	10.6%	21.0%	10.9%
United States	12.00%	27.0%	20.4%	8.5%	19.8%	12.4%

Figure 49: US Census Bureau, American Community Survey. 2015-19 via Sparkmap May 10, 2022



The [percent of ninth grade cohort that graduates in 4 years] in this district had been lower than the state average until 2019 when it almost tied that average at 87.5%. The distribution of those over 25 years old without high school diploma throughout the region is illustrated in Figure 50.

At the other end of the continuum, the percentage of **3 and 4 year olds enrolled in school** in this district has consistently been higher than the state average, and Thurston County has seen consistently higher rates than the other three counties.

***Figure 50:** US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022*

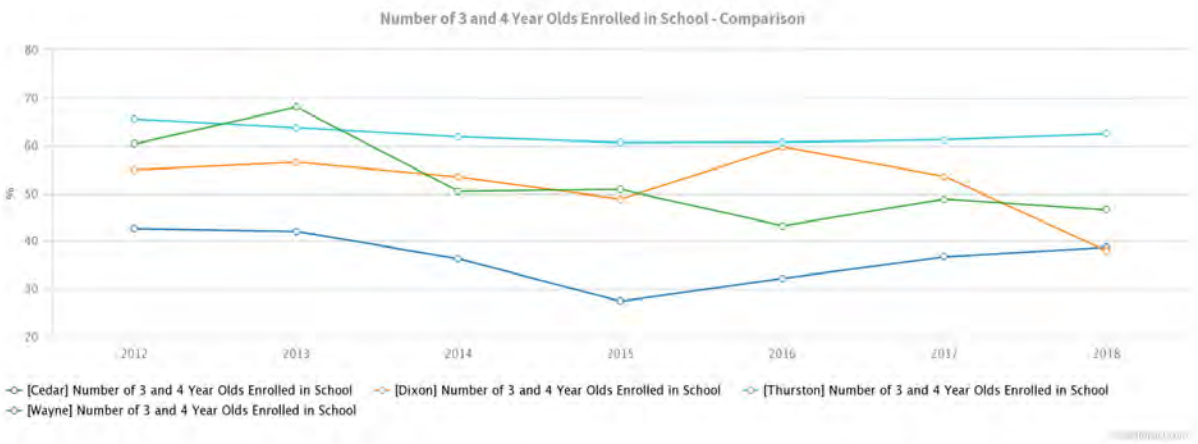


***Figure 51:** US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022*

Economic Factors

Economic factors affect the overall health of a community and can affect community infrastructure such as safe walking routes, access to educational opportunities and access to health care. When families live paycheck to paycheck, not only can they not afford healthy foods, but they may also not spend on health insurance and forego savings. Without health insurance or savings, working families are at risk from unplanned events and/or expenses which may plummet them into poverty. Families living in poverty or at the edge of poverty are put in a flight or fight response long-term that makes them more susceptible to disease.

Employment

Before the pandemic, unemployment overall was not much of an issue. However, another effect of COVID may be the changing nature of work and the workplace. Choices made by employers in this region will continue to have an effect on not only the economy, but also on health. Trends that were apparent before COVID are only more significant. Do those who have been working at home continue to do so? Will mothers who also work outside the home be able to work in the home? Might have to reimagine...

In 2017, the Federal Office of Rural Health Policy unveiled a new category "disconnected youth". While this is not a large population as evidenced by the table below, these individuals can be high risk for increased needs. This indicator reports the percentage of youth age 16-19 who are not currently enrolled in school and who are not employed. The report area has a total population of 2,469 between these ages, of which 82 are not in school and not employed.

Report Area	Population Age 16-19	Population Age 16-19 Not in School and Not Employed	Population Age 16-19 Not in School and Not Employed, Percent
NNRHN	2,469	82	**3.32%**
Cedar County	435	12	2.76%
Dixon County	237	0	0.00%
Thurston County	479	47	9.81%
Wayne County, NE	1,318	23	1.75%
Nebraska	104,191	4,707	4.52%

***Figure 52:** US Census Bureau, American Community Survey 2015-2019 via SparkMap, April 13, 2022*

Low unemployment puts pressure on employers. In general low and middle income working families are more vulnerable, need more support than those who make more because more flexibility and support go to the richer (Kaplan et al. 87). The Percent of population age 16+ unemployed but seeking work has not been an issue, as of late. However, just because people are employed, or at least are not looking for work, does not mean that they have sufficient income for their needs.

Income

Income Inequality can contribute to health disparities. There are a number of measures of Income inequality. **One accepted measure is the Gini index values range between zero and one.** The value of one indicates perfect inequality where only one household has any income. A value of zero indicates perfect equality, where all households have equal income. Index values are acquired from the 2015-19 American Community Survey. Map at this link. *Note: This indicator is compared to the state average.*
Data Source: US Census Bureau, American Community Survey. 2015-19.

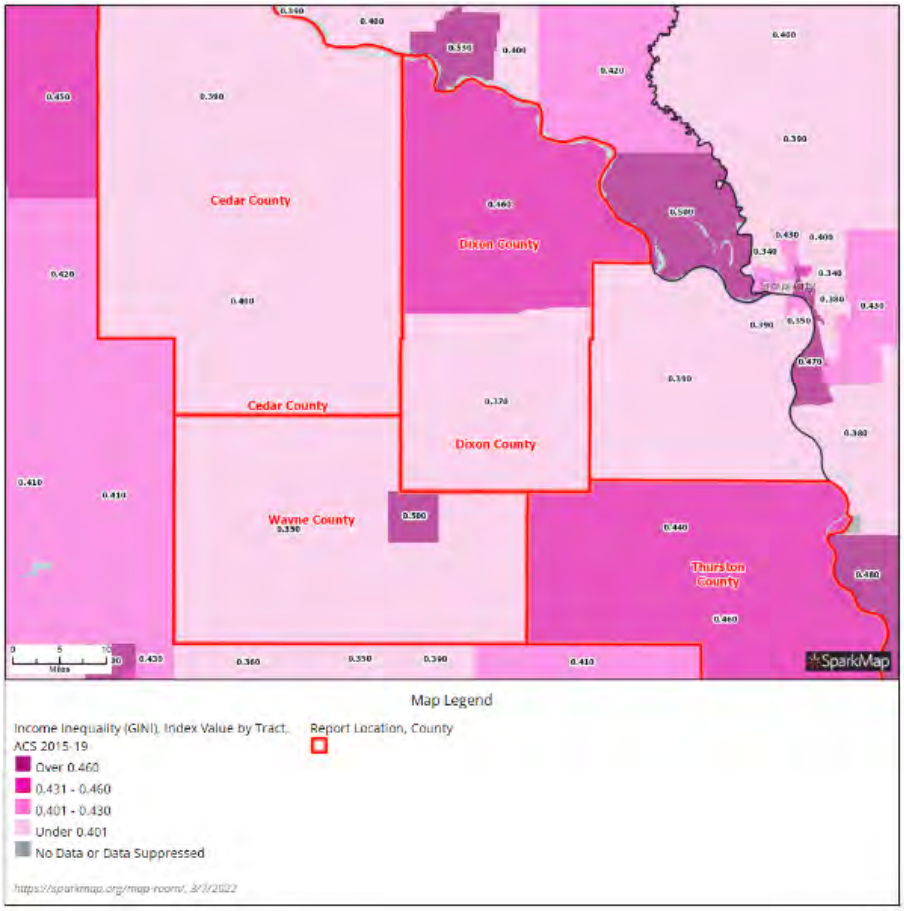


Figure 53: US Census Bureau, American Community Survey 2015-19 via SparkMap, May 10, 2022

While some may debate focus on income inequality, most seem to agree on the impact of poverty health outcomes, being one of the key factors to health disparities. Poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Poverty

Poverty - Population Below 100% FPL (Annual) stayed higher than the state average 2006 through 2015.

In the report area 16.07% or 1,270 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL):

Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
NNRHN	29,081	7,901	1,270	**16.07%**
Cedar County	8,310	2,115	185	8.75%
Dixon County	5,632	1,423	161	11.31%
Thurston County	7,103	2,538	858	**33.81%**
Wayne County	8,036	1,825	66	3.62%
Nebraska	1,859,691	464,544	64,599	13.91%
United States	316,715,051	72,235,700	13,377,778	18.52%

***Figure 54:** US Census Bureau, American Community Survey 2015-19 Via SparkMap, March 30, 2022*

Another indicator to consider is **how many children in the health district are eligible for free or reduced-price lunch.** Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

Out of 5,586 total public school students in the report area in the 2020-2021 school year, 3,263 were eligible for the free or reduced price lunch program in the latest report year. This represents 58.41% of public school students, which is higher than the state average of 46.39%. Two of our counties have averages in line with the state average: Cedar at 43.67% and Wayne at 45.41%. Thurston is much higher at 85.50%. Dixon County is lower at 33.0%--there may be factors to investigate as to the differences in these rates.

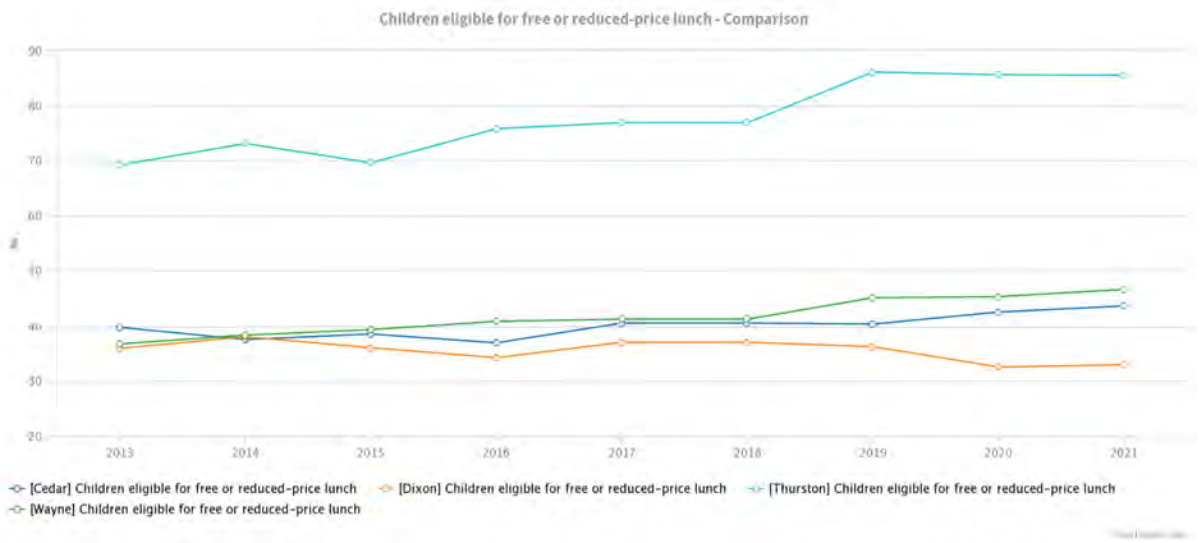


***Figure 55:** National Center for Education Statistics, NCES - Common Core of Data 2020-2021, via SparkMap, May 10, 2022*

Median and Per Capita Income

Median Household Income This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. At $51,034 Thurston is 5k below Dixon and Wayne and 10k below Cedar. Disparity is also apparent in this breakdown of **Median Household Income by Race / Ethnicity of Householder:**

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Cedar	$62,056	No data	No data	No data	No data	No data	$76,875	$60,250
Dixon	$56,029	No data	No data	No data	No data	No data	$22,917	$76,125
Thurston	$62,194	No data	No data	$39,125	No data	No data	No data	No data
Wayne	$57,002	No data	No data	No data	No data	No data	$75,833	$39,547
Nebraska	$64,768	$35,976	$58,586	$40,910	$35,625	$50,275	$45,606	$49,436
United States	$68,785	$41,935	$88,204	$43,825	$63,613	$49,221	$59,184	$51,811

Figure 56: US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022

Per Capita Income includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The per capita income in this report area is the average (mean) income computed for every man, woman, and child in the specified area. It varies from a high of $30,163 in Cedar to a low of $20,140 in Thurston. **Per Capita Income of the report area by race alone:**

Report Area	White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
NNRHN	$29,821.00	$7,932.00	$15,329.00	$11,358.00	No data	$18,002.00	$9,585.00
Cedar	$30,565.00	$18,823.00	$0.00	$10,562.00	No data	$21,803.00	$10,719.00
Dixon	$28,265.00	$13,728.00	$38,536.00	$18,268.00	No data	$19,709.00	$11,116.00
Thurston	$34,268.00	$13,807.00	$8,569.00	$11,342.00	No data	$0.00	$13,465.00
Wayne	$28,683.00	$5,200.00	$14,514.00	$9,143.00	No data	$7,439.00	$6,103.00
Nebraska	$34,139.00	$20,273.00	$27,284.00	$16,609.00	$31,290.00	$18,064.00	$15,027.00
United States	$37,326.00	$23,383.00	$40,524.00	$20,844.00	$24,961.00	$19,071.00	$20,296.00

Figure 57: US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022

Per Capita Income by Ethnicity Alone:

This indicator reports the per capita income of the report area by ethnicity alone.

Report Area	Hispanic or Latino	Not Hispanic or Latino
NNRHN	$14,504.00	$27,410.00
Cedar	$20,701.00	$30,362.00
Dixon	$16,797.00	$29,361.00
Thurston	$10,254.00	$20,766.00
Wayne	$12,579.00	$28,629.00
Nebraska	$17,085.00	$34,159.00
United States	$20,515.00	$37,088.00

***Figure 58:** US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022*

Effects of Income

Income has a number of potential effects of physical health, as well as emotional health. It also affects other stressors, including:

- **Food Insecurity;**
- **Housing insecurity in past year,** among those who own or rent their home available through the Nebraska BFRSS is fairly old. However, housing has been identified as an issue in area communities, including the largest community of Wayne;
- **Percent of households with severe housing cost burden (>=50% of household income)** was trending better as of 2019.

Family & Social Support

"People with greater social support, less isolation, and greater interpersonal trust live longer and healthier lives than those who are socially isolated. Neighborhoods richer in social capital provide residents with greater access to support and resources than those with less social capital." (County Health Rankings, 04/23/2022)

Household Structure

Single Parent Household

Percent of children that live in household headed by single parent has been decreasing in this health district since 2012 with a precipitous drop to 17% in 2019. This is another key health factor according to County Health Rankings because adults and children in single-parent households are at risk for adverse health outcomes, including mental illness (e.g. substance abuse, depression, suicide) and unhealthy behaviors (e.g. smoking, excessive alcohol use, food insecurity). Self-reported health has been shown to be worse among lone mothers than for mothers living as couples, even when controlling for socioeconomic characteristics.Mortality risk is also higher among lone parents. Children in single-parent households are at greater risk of severe morbidity and all-cause mortality than their peers in two-parent households.Children in single-parent households in Nebraska | County Health Rankings & Roadmaps

Age 65 and Older living alone

A key indicator for COVID Impact is the number of persons **age 65 and older** living alone.

Group Living

The table below reports the population living in group quarters by facility type.

Report Area	Correctional Facilities	Juvenile Detention Centers	Long-Term Care Facilities	College Dormitories	Military Barracks	Other Group Quarters
NNRHN	57	0	275	1,161	0	51
Cedar	9	0	96	0	0	0
Dixon	17	0	63	0	0	2
Thurston	31	0	67	20	0	36
Wayne	0	0	49	1,141	0	13
Nebraska	17,996	1,580	25,358	41,662	438	11,970

***Figure 59:** US Census Bureau, Decennial Census 2020 via SparkMap April 20, 2022*

Immigration Status and Language Barriers

There are a number of factors that affect the health of immigrants and other minorities: language barriers, lack of money, lack of insurance coverage for healthcare, legal status and also trust issues.

The percent of population not proficient in English in this health district has been smaller than in the state. However, this average is skewed because of the minimal number of such persons in Cedar County, see illustration below. This indicator is relevant because an inability to speak English well creates barriers to healthcare access, provider communications, and health literacy/education. Of the 28,594 total population aged 5 and older in the report area, 587 or 2.05% have limited English proficiency.

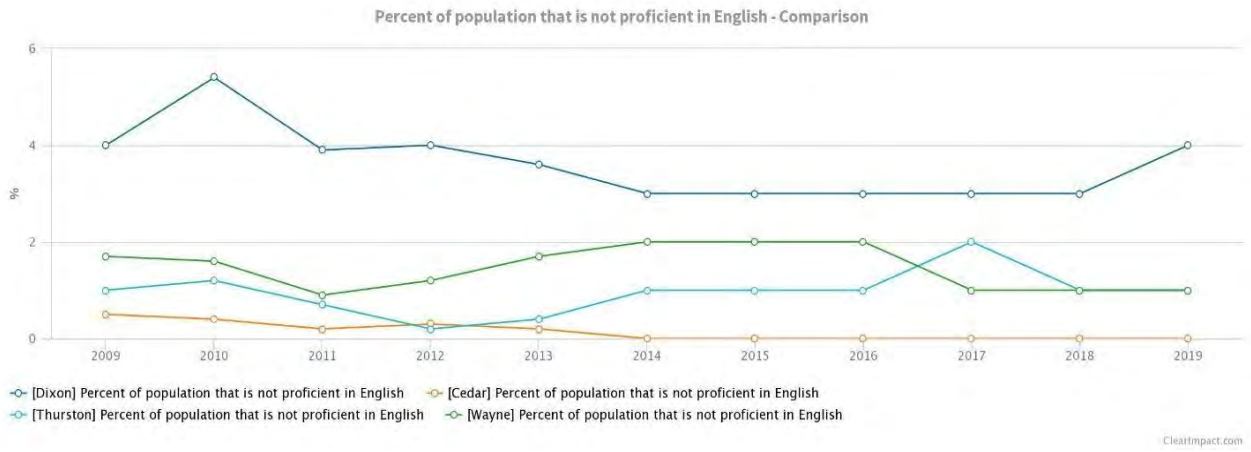


Figure 60: US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022

Spanish is the primary language spoken by those who are less than proficient in English in this region, as evidenced by the table below (although this may be an underestimate).

Report Area	Spanish	Other Indo-European Languages	Asian and Pacific Island Languages	Other Languages
NNRHN	543	1	31	12
Cedar	53	0	0	0
Dixon	323	0	0	0
Thurston	42	0	31	12
Wayne	125	1	0	0
Nebraska	60,470	6,997	16,442	7,091
United States	16,258,571	3,418,899	4,910,799	1,027,096

Figure 61: US Census Bureau, American Community Survey 2015-19 via SparkMap May 10, 2022

Participants at the March 24th, 2022 Listening Session suggested that English classes should be offered including by employers, and that more effort should be made to employ bilingual staff among providers. Of the 192 community surveys received from our Hispanic population, twelve specifically mentioned English classes as a need in their communities.

Immigrants continue to be an important part of the economy as well as of communities in the health district. They work on local farms as well as help power our industries. The foreign-born population includes anyone who was not a U.S. citizen or a U.S. national at birth. This includes any non-citizens, as well as persons born outside of the U.S. who have become naturalized citizens. The native U.S. population includes any person born in the United States, Puerto Rico, a U.S. Island Area (such as Guam), or abroad of American (U.S. citizen) parent or parents. The latest figures from the U.S. Census Bureau show that 868 persons in the report area are of foreign birth, which represents 2.82% of the report area population. This percentage is less than the national average of 13.55%.

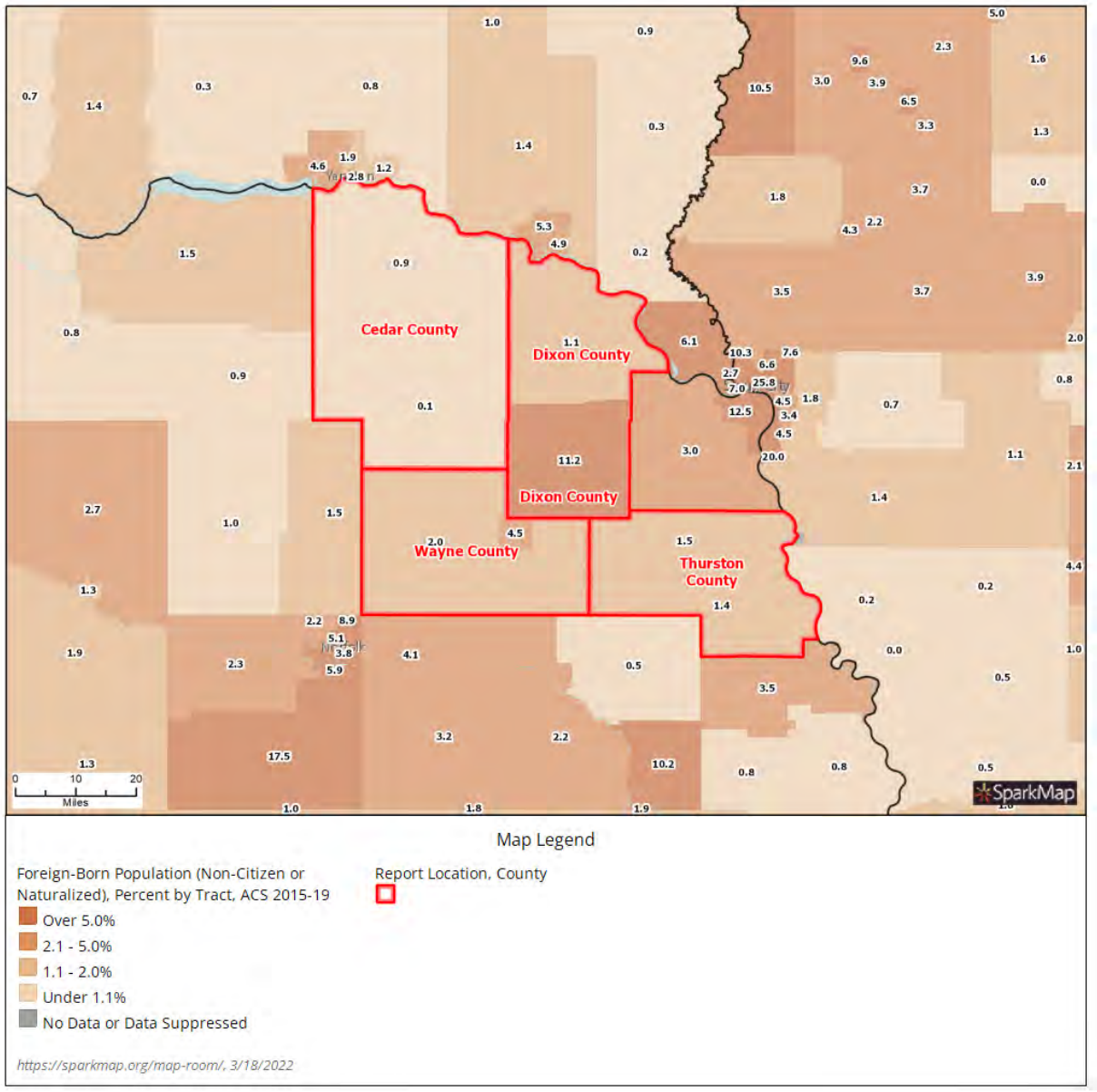


***Figure 62:** US Census Bureau, American Community Survey, 2015-19, via SparkMap May 10, 2022*

Community Involvement

Social Associations

Twenty three (4.5%) of the community health survey respondents said that more community activities would make their neighborhood healthier, from increasing socialization to more opportunities for physical activities to diversions from use of drugs and alcohol. This may be in part from missing activities which were sidelined because of the pandemic. There may be a benefit to spending more effort promoting community activities, especially those that occur in our smaller communities. It might also be beneficial to be promoting local organizations, including Rotary, Kiwanis, Lions, Boy Scouts, Girl Scouts, school boosters,and the like. See also Figure 63.1 for an idea of some of the types of social associations present in the region as represented by tax exempt 501(c)(3) and 501(c)(4) status.

Voter Participation

Another indicator of social capital and civic engagement is voter participation, as present in Figure 63:

	Total 18+	2020 Total Votes Cast	Voter Participation Rate (2020)	Total 18+ (2016)	2016 Total Votes Cast	Voter Participation Rate (2016)
NNRHN	22,118	14,706	**66.5%**	22,948	12,873	56.1%
Cedar	6,307	5,015	79.5%	6,514	4360	66.9%
Dixon	4,022	3,094	76.9%	4,348	2744	63.1%
Thurston	4,545	2,379	**52.3%**	4,498	2029	45.1%
Wayne	7,244	4,218	**58.2%**	7,588	3740	49.3
NE	1,366,078	956,379	**70%**	1,354,457	805,638	59.5%

***Figure 63:** Townhall.com Election Results via SparkMap, April 13, 2022*

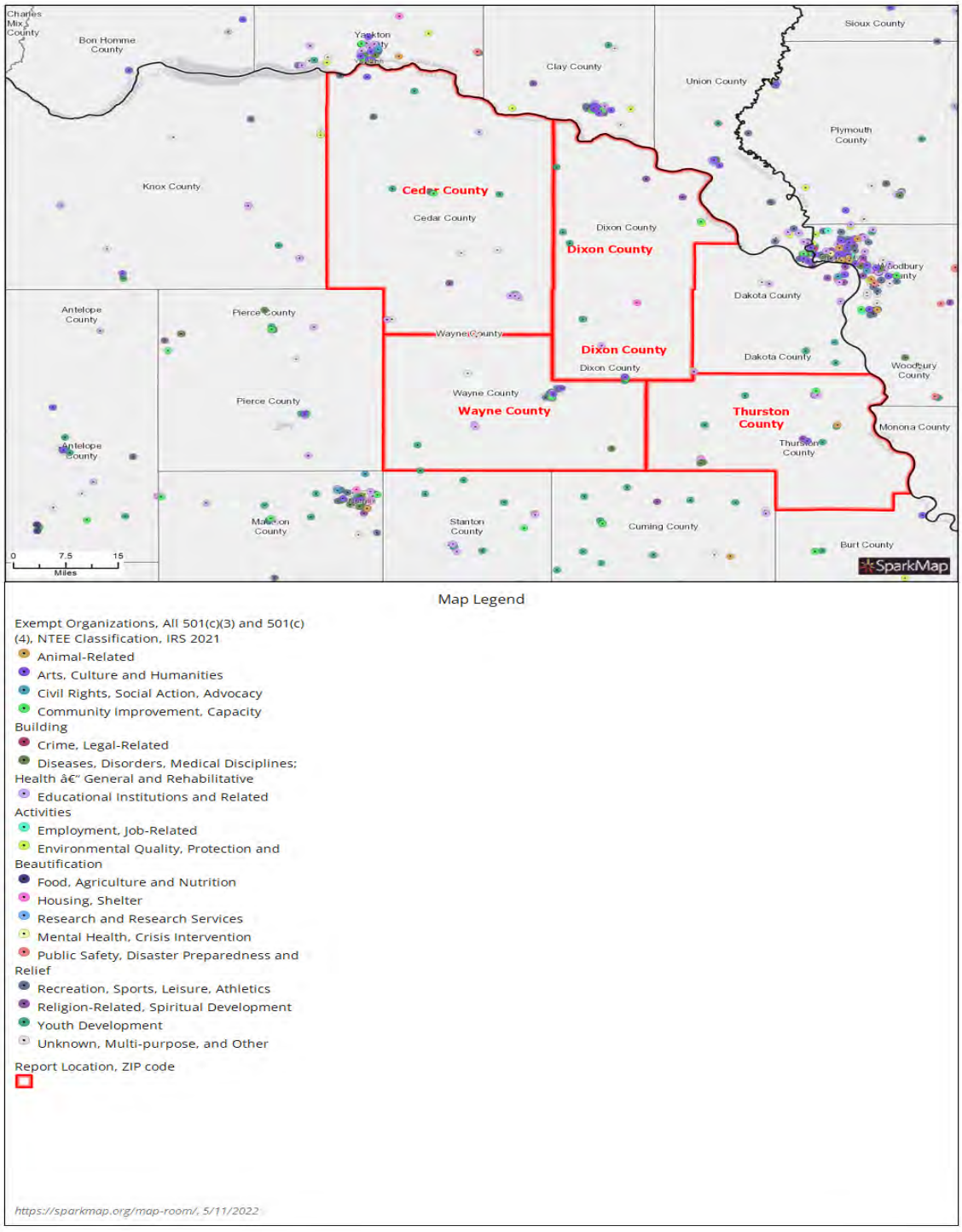


Figure 63.1: Exempt Organizations, All 501(c)(3) and 501(c)(4), NTEE Classification, IRS 2021, via SparkMap May 11, 2022

Community Safety

Violent Crime - Assault

Violent crime includes homicide, rape, robbery, and aggravated assault. Within the report area, the 3-year total of reported violent crimes was 287, which equates to an annual rate of 283.60 crimes per 100,000 people, **lower than the statewide rate of 286.40.**

Violent crime (assault): This indicator reports the rate of assault (reported by law enforcement) per 100,000 residents.Within the report area, the 3-year total of reported assaults was 236, which equates to an annual rate of 233.20 assaults per 100,000 people, **higher than the statewide rate of 184.90.**

Report Area	Total Population	Violent Crimes, 3-year	Violent Crimes, Annual (100k)
NNRHN	33,722	236	**233.20**
Cedar County, NE	11,773	47	133.00
Dixon County, NE	6,171	14	75.60
Thurston County, NE	6,437	152	**787.00**
Wayne County, NE	9,341	23	82.00
Nebraska	1,978,539	10,976	184.90

***Figure 64:** Federal Bureau of Investigation, FBI Uniform Crime Reports Additional analysis by the National Archive of Criminal Justice Data Accessed via the Inter-university Consortium for Political and Social Research 2014; 2016 via SparkMap*

Other Safety Concerns

Safety and Security

Twenty six health survey respondents made suggestions about improving the safety and security of their environment. with over half of these suggestions referring to improving traffic safety. However, lighting was also mentioned by a handful of people.

Physical Environment

County Health Rankings focus on two areas in this domain: air & water quality, and housing & transit. In addition, how the built environment affects behavior needs to be considered, as well as the impact of technology.

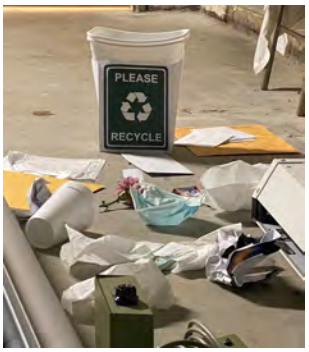
Air & Water Quality

"Clean air and water support healthy brain and body function, growth, and development" (County Health Rankings, 04/19/2022). The average person might assume that air & water quality are less likely to be issues in rural areas. However, Rural locations were often near agricultural waste sites which placed them at risk for exposure to animal excretions and mining materials, including arsenic or swine facilities. Soil contamination can occur from homegrown livestock and produce. (Taylor 1018)

Concentrated Animal Feeding Operations (CAFOs) currently use hog waste for crops or as a spray on Bermuda grass. However, the odorous wastes contain toxic materials such as hydrogen sulfide and ammonia which researchers found led to eye irritation, respiratory problems, diminished quality of life and high blood pressure as a result of mental stress in local residents, which can be a concern for rural residents (Taylor 1035). While these issues do not show up in the County Health Rankings for our area, concerns about chemicals being used in our area, in fields as well as on lawns, did show up in ten of the community health surveys.

CHR does identify issues with drinking water violations. in two of our counties. In addition to obvious concerns about the quality of drinking water, it is also an issue when water does not taste good, it can take extra effort to drink water on a regular basis (which was also noted by survey participants).

Other Concerns about the Environment



When asked about what would make their neighborhood healthier, 11.2% survey respondents suggested improving the cleanliness of their physical environment. Particular concerns mentioned multiple times included:

- chemicals used on lawns and fields (10);
- animal control (6); and
- trash and recycling (8).

In addition to potentially directly contributing disease and injury, these issues can also contribute to emotional and mental stress for citizens.

Housing & Transit

Not only can housing be difficult to afford, if it can even be found, it can also be substandard which can create issues as well. A person's asthma, for example, is going to be aggravated if there is mold or other toxins in the home, even if the air circulation is less than optimal (Hood). **Severe Housing problems,** defined as percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities, has been lower than the state average.

Other factors can affect the quality of housing, including age. A breakdown of the age of housing stock can be found at this link. The median age of housing stock by tract is reflected in the map Figure 65.

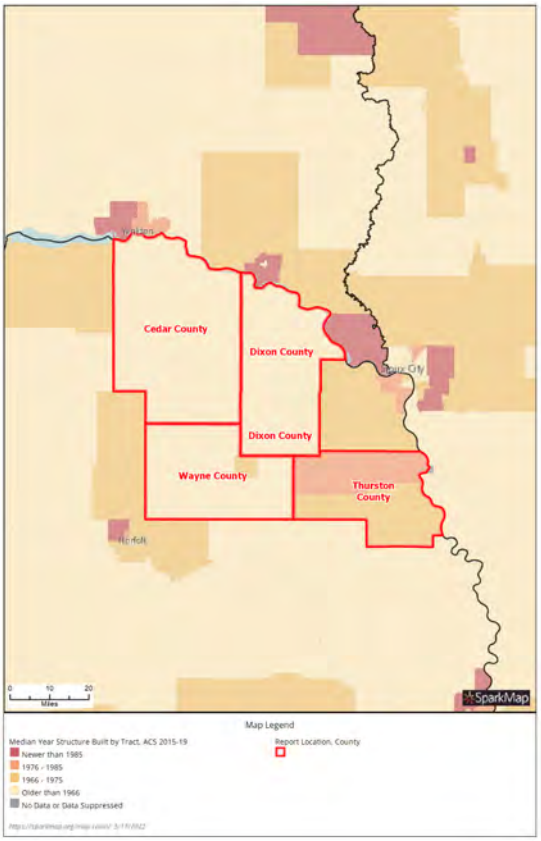


Figure 65: US Census Bureau, American Community Survey, via SparkMap May 17, 2022

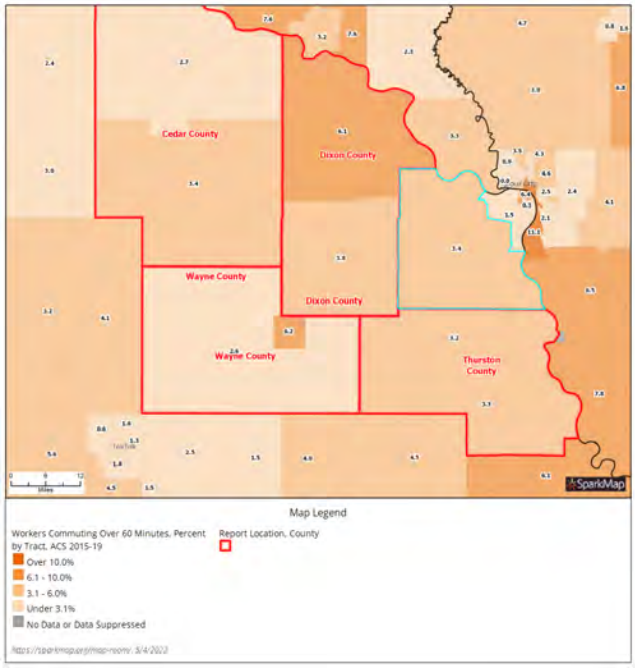


Figure 66: US Census Bureau, American Community Survey,via SparkMap, May 4, 2022

Traditional indicators for transit may not be as helpful in rural areas. However, one of the common issues for people living in the country is having to drive far for work. Only Cedar County had a smaller percentage (3.06%) of people commuting more than 60 minutes each way than the state average of 3.10%. Thurston County had 3.28% and Dixon and Wayne Counties both had 4.76% in 2019.

Regarding public transportation, while the city of Wayne and Cedar County have dedicated transportation providers, residents in other parts of the health district are dependent on providers that are not locally based.

Technology

COVID-19 accelerated the adoption of the use of technology to meet virtually, whether that be for students to attend school from home, for office workers to be able to meet while not endangering each other, or medical staff to minimize exposure using telehealth. Advancing Rural Telehealth and Addressing Its Challenges. A similar change was seen in this region the average percentage for **Broadband Access** in this region was much lower (than the state average) in this region as late as 2017. However, by the latter half of 2020 it had climbed to within 3 percentage points, (95.18%).

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Figure 65: US Census Bureau, American Community Survey

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Appendix 3: Quick Facts - Demographics

	Indicator	Cedar	Dixon	Thurston	Wayne	Nebraska	USA
Total Population	Total Population (2019)	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Total Land Area(Square Miles)	740.24	476.11	393.58	442.92	76823.79	3,532,069
	Population Density (Per Square Mile)	11	12	18	21	25	92
Total Population Change, 2010 - 2020	Total Population, 2010 Census	8,852	6,000	6,940	9,595	1,826,342	312,471,161
	Total Population, 2020 Census	8,380	5,606	6,773	9,697	1,961,504	334,735,155
	Population Change, 2010-2020	(472)	(394)	(167)	102	135,162	22,263,994
	Population Change, 2010-2020, %	-5.33%	-6.57%	-2.41%	1.06%	7.40%	7.13%
Total Population Change, 2000 - 2010	Total Population, 2000 Census	9,615	6,339	7,171	9,851	1,711,263	280,405,781
	Total Population, 2010 Census	8,852	6,000	6,940	9,595	1,826,341	307,745,539
	Population Change, 2000-2010	(763)	(339)	(231)	(256)	115,078	27,339,758
	Population Change, 2000-2010, %	-7.94%	-5.35%	-3.22%	-2.60%	6.72%	9.75%
Urban and Rural Population	Total Population	8,852	6,000	6,940	9,595	1,826,341	312,471,327
	Urban Population	-	-	-	5,557	1,335,686	252,746,527
	Rural Population	8,852	6,000	6,940	4,038	490,655	59,724,800
	Urban Population, Percent	0.00%	0.00%	0.00%	57.92%	73.13%	80.89%
	Rural Population, Percent	100.00 %	100.00%	100.00%	42.08%	26.87%	19.11%
Group Quarters Population	Total Population, 2020 Census	8,380	5,606	6,773	9,697	3,923,008	173,589,795
	Population Living in Group Quarters	105	82	154	1,203	99,004	4,235,824
	Population Living in Group Quarters, Percentage	1.25%	1.46%	2.27%	12.41%	2.52%	2.44%
Female Population	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Female Population	4,171	2,810	3,615	4,590	959,621	164,810,876
	Percent Female Population	49.08%	49.13%	50.34%	49.19%	50.12%	50.76%

	Indicator	Cedar	Dixon	Thurston	Wayne	Nebraska	USA
	Total Households	3,506	2,352	2,176	3,708	759,176	120,756,048
	Total Family Households	2,374	1,569	1,601	2,254	483,908	79,114,031
	Families w/Children (Under 18)	958	678	984	914	235,457	37,151,089
Families with Children	Families with Children (Under Age 18), %of Total Households	27.32%	28.83%	45.22%	24.65%	31.01%	30.77%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Median Age	**Median Age**	**42.7**	**40.8**	**27.5**	**32**	**36.5**	**38.1**
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Male Population	4,327	2,909	3,566	4,742	954,950	159,886,919
Male Population	Percent Male Population	50.92%	50.87%	49.66%	50.81%	49.88%	49.24%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Population Age 0-17	2,156	1,427	2,580	1,881	474,107	73,429,392
Population Under Age 18	Population Age 0-17, %	25.37%	24.95%	35.93%	20.16%	24.76%	22.61%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Population Age 0-4	562	398	699	477	131,473	19,767,670
Population Age 0-4	Percent Population Age 0-4	6.61%	6.96%	9.73%	5.11%	6.87%	6.09%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Population Age 5-17	1,594	1,029	1,881	1,404	342,634	53,661,722
Population Age 5-17	Population Age 5-17, %	18.76%	17.99%	26.19%	15.05%	17.90%	16.53%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Population Age 18-64	4,536	3,150	3,744	6,004	1,146,395	200,484,607
Population Age 18-64	Population Age 18-64, %	53.38%	55.08%	52.14%	64.34%	59.88%	61.74%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Population Age 18-24	615	425	734	2,113	189,438	30,646,327
Population Age 18-24	Percent Population Age 18-24	7.24%	7.43%	10.22%	22.64%	9.89%	9.44%

	Indicator	Cedar	Dixon	Thurston	Wayne	Nebraska	USA
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Population Age 25-34	Population Age 25-34	792	590	872	886	255,097	45,030,415
	Percent Population Age 25-34	9.32%	10.32%	12.14%	9.49%	13.32%	13.87%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Population Age 35-44	Population Age 35-44	838	635	681	1,010	236,450	40,978,831
	Percent Population Age 35-44	9.86%	11.10%	9.48%	10.82%	12.35%	12.62%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Population Age 45-54	Population Age 45-54	968	665	690	851	223,709	42,072,620
	Percent Population Age 45-54	11.39%	11.63%	9.61%	9.12%	11.68%	12.96%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Population Age 55-64	Population Age 55-64	1,323	835	767	1,144	241,701	41,756,414
	Percent Population Age 55-64	15.57%	14.60%	10.68%	12.26%	12.62%	12.86%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Population Age 65+	Population Age 65+	1,806	1,142	857	1,447	294,069	50,783,796
	Population Age 65+, Percent	21.25%	19.97%	11.93%	15.51%	15.36%	15.64%
	Total Population (For Whom Disability Status Is Determined)	8,351	5,631	7,145	9,301	1,884,850	319,706,872
Population with Any Disability	Population with a Disability	951	715	912	946	218,839	40,335,099
	Population with a Disability, %	11.39%	12.70%	12.76%	10.17%	11.61%	12.62%
	Total Population Age 5+	7,936	5,321	6,482	8,855	1,783,098	304,930,125
Population in Limited English Household	Linguistically Isolated Population	48	116	80	43	50,035	12,982,993
	Linguistically Isolated Pop.	0.60%	2.18%	1.23%	0.49%	2.81%	4.26%
	PopulationAge 5+	7,936	5,321	6,482	8,855	1,783,098	304,930,125
Population with Limited English Proficiency	Population Age 5+with Limited English Proficiency	53	323	85	126	91,000	25,615,365
	Population Age 5+with Limited English Proficiency,%	0.67%	6.07%	1.31%	1.42%	5.10%	8.40%

	Indicator	Cedar	Dixon	Thurston	Wayne	Nebraska	USA
	Total Population	8,393	5,635	7,060	9,263	1,889,942	320,984,519
Population Geo-graphic Mobility	Population In-Migration	505	370	276	1,196	129,688	19,919,535
	Population In-Migration,%	6.02%	6.57%	3.91%	12.91%	6.86%	6.21%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Naturalized U.S. Citizens	9	122	20	119	53,708	21,847,890
	Population w/o U.S. Citizenship	35	273	83	207	84,191	22,163,980
	Total Foreign-Birth Population	**44**	**395**	**103**	**326**	**137,899**	**44,011,870**
Foreign-Born Population	Foreign-Birth Population, %	0.52%	6.91%	1.43%	3.49%	7.20%	13.55%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
	Non-Hispanic Population	8,323	4,933	6,754	8,775	1,706,300	266,218,425
	Population Non-Hispanic, %	97.94%	86.26%	94.05%	94.03%	89.12%	81.99%
	Hispanic or Latino Population	175	786	427	557	208,271	58,479,370
Hispanic Population	Population Hispanic or Latino, %	2.06%	13.74%	5.95%	5.97%	10.88%	18.01%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Non-Hispanic White Population	Non-Hispanic White Population	8,195	4,818	2,566	8,392	1,512,111	197,100,373
	Population Non-Hispanic White,%	96.43%	84.25%	35.73%	89.93%	78.98%	60.70%
	Total Population	8,498	5,719	7,181	9,332	1,914,571	324,697,795
Black or African American Population	Black or African American Population	13	25	14	135	92,406	41,234,642
	Population Black or African American, %	0.15%	0.44%	0.19%	1.45%	4.83%	12.70%
	Native	8,439	5,294	7,064	8,962	1,760,995	275,537,270
	Born in a US Territory	-	-	4	-	2,419	2,019,168
	BornAbroad to US Citizens	15	30	10	44	13,258	3,129,487
	Naturalized	9	122	20	119	53,708	21,847,890
	Non-Citizen	35	273	83	207	84,191	22,163,980
Citizenship Status	Non-Citizen, %	0.41%	4.77%	1.16%	2.22%	4.40%	6.83%

	Indicator	Cedar	Dixon	Thurston	Wayne	Nebraska	USA
	Total Population Age 18+	6,342	4,287	4,601	7,451	1,434,713	250,195,726
	Total Veterans	**565**	**382**	**315**	**496**	**117,466**	**18,230,322**
Veteran Population	Veterans, %	8.91%	8.91%	6.85%	6.66%	8.19%	7.29%
	Starting Population (2000)	9,309	6,113	6,574	9,544	1,625,832	267,981,052
	Ending Population (2010)	8,812	5,986	7,034	9,561	1,826,810	309,745,042
	Natural Change	318	273	1,362	561	191,166	30,987,709
Migration Patterns - Total Population	Net Migration	(815)	(403)	(897)	(542)	9,812	10,776,072
	Migration Rate	**-8.47%**	**-6.31%**	**-11.30%**	**-5.36%**	**0.54%**	3.60%

Appendix 4: Hispanic Listening Sessions Reports

Two listening sessions with members of the Hispanic community have been conducted as part of the community health assessment process. It is planned to have additional sessions with members of our population who identify as Hispanic, as well as with members of other groups, as part of a continuing community health assessment process.

Wakefield Evangelical Covenant Church Notes from Listening Session March 16, 2022

Session started at 16:35 with an introduction. There were 2 attendees from the community, and four staff from Northeast Nebraska Public Health Department in attendance.

Everyone introduced themselves and shared something they would like to do to improve their health.

Attendee A is an immigrant from Nicaragua who arrived about 3 months ago. She fled her country with her husband and baby. Attendee A shared that after the election in Nicaragua a lot of problems started in the country, so for safety reasons they came to the US. Attendee A shared that her baby has been sick, and she has encountered problems with interpreting in the medical clinics. She calls places but there is no one to translate. Attendee A shared that she feels free here compared to Nicaragua. Now that she is somewhere safe she wants to take a walk with her daughter but it's been too cold. Attendee A shared that her baby almost died from the journey from Nicaragua, and had suffered from malnutrition and low iron. It was a very difficult journey. Her baby is getting better but still has problems with constipation and low iron.

Attendee B is from Guatemala. She likes to walk and cycle. She used to do group workouts and exercise but now she is working 6 days a week so she works out less. Attendee B also shared concerns about lack of Spanish speaking staff/interpreters in the medical clinics. Sometimes people can't make appointments because there won't be anyone available to interpret. Wakefield has no bilingual staff, they use an iPad when someone needs interpreting services at an appointment. Pender has maybe one bilingual staff. Spanish speaking individuals often have to rely on their friends/acquaintances.

Attendee A said that a very nice local woman has been helping her find a low-income/sliding fee clinic with Spanish speaking staff, as well as other services regarding family and health.

Attendee B said that it is also difficult for people who speak indigenous languages from Central America to get services.

Theme: lack of bilingual medical services.

Attendee A shared that she has been grateful for help she has gotten here because no one wants to leave their house, town, or country.

Attendee B shared that the community needs more information, and better communication about where to go.

Attendee B would like to see signage in the post office. Attendee A agrees. Everyone in Wakefield has to have a PO Box, so this is a good place for communication.

Question 1: What are the top health concerns for you in your community?

The attendees shared that if there were a doctor or nurse that spoke Spanish, more people would trust them and get their health needs taken care of. There is an eye doctor in Wayne who speaks Spanish.

Attendee A shared that she wishes there were one place where she could go for medical concerns where someone is able to listen, understand, and take care of her, and that offered payment plans. Especially urgent medical concerns, where someone can understand her immediately. Facilitators clarified that being comfortable with a medical provider is important to attendees.

Attendee A shared that she has felt ashamed because she has had to ask for things. She shared she is an independent person but when there are emergencies, a person has to ask for help. She reiterated that a payment plan would be helpful.

Question 2: When you think about health conditions, what are the big concerns for your community?

COVID-19 is the big concern lately for both attendees.

Attendee A shared that she takes COVID precautions, she doesn't spend time around large groups of people. What worries her the most is not having a place to go to see the doctor and make sure it's not covid. She drinks herbal teas, and other things she can find in the Mexican grocery store to stay healthy. But then she feels more worried wondering if it's COVID or not. Attendee A said she has gotten the first COVID-19 vaccine and is ready to get her second one. Molly shared that NNPHD has COVID-19 vaccine clinics at this church every Tuesday except the second, and she could come next Tuesday if she wanted to get her second one.

Attendee B shared that people are afraid to get the second COVID-19 shot because they hear a lot of misinformation. Attendee B shared that recently there was someone who was in the hospital and she told everyone it was because of the second shot, but Attendee B does not think that it was the shot that caused her to be sick. Facilitator asked if Attendee B though that this misunderstanding had to do with language differences, and Attendee B said yes. Attendee B shared that she really encouraged her co-workers to get the COVID-19 shot. Attendee B asked if there was going to be another COVID-19 shot. Molly said that likely in the future, but we really don't know for sure. It depends on what the virus does.

Facilitator asked attendees if they get their flu shots. They reported that they do. Attendee B said she has a yearly physical and also got her shingles shot.

Question 3: What is the biggest health concern for yourself or your family?

Both attendees shared that it is not having a trusted medical provider because of language barrier and cost. Attendee A said if she starts feeling sick now, she doesn't have a place to go for help. Attendee A shared they arrived to the area about 3 months ago, and her husband doesn't have work right now, and

they want to work because apart from having money working is good for a person. Julie asked if she knew about Midtown Health Clinic in Norfolk and offered to provide information to Attendee A because they speak Spanish, have payments, and have transport.

Attendee B mentioned that she would like to see more people at these meetings. She thought that having a meeting on a Friday late afternoon might work better in terms of having more community members attend. She also mentioned that a lot of people say they want help, but they don't attend meetings.

Attendee A said she would like to attend meetings to get to meet people. She is a social person. Attendee A then share about something that she experienced on her journey from Nicaragua:

When you leave, you have to leave a lot of clothes behind because clothes can get heavy. We did bring clothes for the baby. I encountered a woman whose baby got sick on the journey. At immigration, they took everything from us. But, because I am a mother, I tied 2 scarfs together into a blanket for the baby and when I saw the woman with the sick baby who was dehydrated, and because of that the baby had vomited all over its clothes, since I had 2 scarves, I gave one to the mother for her baby. So when there is someone who needs help, if I can help them I do. And I like to meet people, I don't always just look for people when I need something. If I'm invited, I come. I'm Catholic, but if someone invites me to an evangelical church service, I go because they're still going to talk about God, right? That's how I am.

I used to cry but now I have to accept it.

Attendees and facilitators thanked Attendee A for sharing her story.

Attendees said that the same church is a good place to have future meetings.

Attendee A said she is registered for WIC.

Wayne Listening Session: Luna's Restaurante Mexicano, 03.24.2022, 5:30-7:00

Number of community members in attendance: 10

NNPHD staff: Julie Rother, Lori Steffen, Molly Herman Georgina Bernal and Meagan Rodriguez

Julie Rother welcomed everyone and attendees introduced themselves. Attendees mentioned they wanted to walk more, exercise more, return to exercise, get better sleep, eat healthier, learn how to eat healthier, and help their communities.

Question 1: What are the top 5 things that affect people's health in our community?

Fast food. Being lazy. Car exhaust, air quality. Over-eating. Many attendees were taught to clean their plate as a child. Julie mentioned that restaurants have very large portion sizes. Facebook, too much screen time. Technology has spoiled us. We don't cook the way we used to. Technology has made us kind of like robots. Technology has also given us a lot; we can connect via the internet with people who are far away.

Work schedules can be a health problem. One attendee reported that her husband arrives home from work at 10 pm and he is hungry, and has no time to have anything healthy.

Sometimes motivation is hard to find because you have to make the time to exercise and eat healthy.

We are not really eating healthy the way we are supposed to because of work schedules.

Question 2: What worries you most about your health or the health of your family?

There is a lot of info now about how to eat healthy, and I've already eaten for most of my life fried food with oils that are not healthy/recommended. And so I've passed that onto my kids, and it has consequences. It can provoke dementia and Alzheimer's.

Some kids don't want to use the microwave because of the radiation and cancer.

I've been marinating food overnight so I can cook it over the lunch hour the next day. I can go home and come back. I have more free time than other people who are stuck inside a factory.

It all depends on what type of job you have, it affects your eating habits.

Diabetes is a concern. Overweight. Julie shared that about 2/3 or HD residents are overweight or obese.

Some of the kids in school don't want to eat the food. So they wait until the end of the day to eat, and then they want fast food or junk food.

Julie asked how does how we eat now compare to how we ate growing up?

It's a total mess. We don't have the necessary time to have scheduled eating. We are not organized. In Mexico we have a schedule for our meals, Breakfast at 8, snack, lunch, dinner. Here, when can you find time to eat these meals? Sometimes you just eat once a day here because you're running everywhere.

What causes us to have this schedule? Time, work.

In my case I prep my lunch the night before. Sometimes I prepare the food while I'm eating. I have been trying to change my habits, healthy fats like avocado oil, vegetables, a bit of protein, less sugar, trying to eat small portions. I see the difference; I have more energy. But it's difficult.

I'm the reverse. I start my day with coffee and bread in the morning, lots of sugar in my coffee. But I'm grateful because in my childhood I ate when we had food. I lived in extreme poverty. At school, I would try to get 2 glasses of milk. From school, they would send us home to eat lunch. But sometimes when I came home for lunch there was nothing to eat. So here I used to go out at lunchtime to buy some fast food, but I thought it isn't right, so I'll pay whatever they charge at school for lunch as it's healthier. I work at the school.

It might be a combination of society because here we aren't educated as to what and how we should eat. We also work more here than in Europe. Also in the US you can buy all kinds of food that isn't permitted in other countries. We are buying products that we think are healthy but in reality are not.

Sometimes we don't know how to read the food labels.

The labels don't say that sugar can cause harm to a person's body.

There are two steps we have to do: educate ourselves on how to read product labels and what we are eating, and the other is to know in what state of health you're in.

Julie asked where people get their information.

YouTube

Social media: There is so much on social media that it's easier than going to the clinic and asking.

Julie asked how easy it is for people to go to a clinic?

Insurance and lack of bilingual staff is tricky.

The clinic doesn't accept payment plans. Or use an interpreter. They use a machine.

A machine can't express feelings.

The hospital does accept payment plans.

The clinic doesn't have a social worker.

Julie shared that we are going to collect this information into a report and share with our partners. The hospital is a partner, we are working on a partnership with the clinic.

A lot of people get sick but can't go to the doctor so they self-treat with over-the-counter medicine. There are a lot of reasons but for the Hispanic people there are requirements that they can't meet. I've seen it in a lot of families, like they have been sick for a long time but they haven't gotten treatment. They may not want to go to the doctor because they don't have health insurance, but more than this now they think they will get personal information from them.

A question, when are clinics and hospitals going to keep information confidential?

The only way to share the information if the hospital or clinic are connected, or if the patient asks and signs to share information.

Sometimes people don't know what they're signing.

There are laws, but we are also working with human beings. People break rules all the time. I work in Norfolk, and some years back, there were rumors that some clinics in Norfolk were informing immigration about people who didn't have social security numbers. It doesn't have to be true, but people will still be scared.

Julie shared that sometimes doctors are obligated to share information with public health department about infectious disease.

Question 3: What are 2 things that you would like to see in place that would make our community healthier?

Health insurance for people who may not be documented, even if they have to pay.

Attendee shared that you can call the Marketplace and get health insurance without an SSN.

If you don't pay a fee, there is nowhere to exercise inside. (CAC, PMC Wellness Center).

I think it would be good to teach our children about good health standards, diet, exercise. What we teach the children they are going bring home and want to do. Kids can motivate their parents.

I used to live in Minnesota and there was a sliding fee clinic. Can we get that here even once a month? The visit was free, treatment cost something.

Julie shared that we have been talking about that and that Midtown Clinic in Norfolk has a mobile clinic, and that when we start talking about things like that it starts getting political, but it doesn't mean we shouldn't talk about it.

A mobile clinic would help a lot because they go to Wakefield and a lot of kids are getting dental care this way. We can see that a lot of kids are being treated and are benefiting from it.

How can we engage local dentists and doctors to come here and listen to the Spanish speaking community?

Lori added that is important to serve people as soon as we can. When things wait, they get worse, and then more expensive. It's better for everyone to get the care when we get it.

Everything that we are sharing is important, but one really basic thing: the language that we speak. (English). Help learning English.

Lori shared that it might be an amazing service-learning project for high school students.

Sometimes people we work with they demand we speak English. How can we read the danger signs if they are only in English?

Prevention is the best treatment for health. And prevention is going to come with communication and education. But we won't have good communication if we don't understand what people are saying. There are people who want to teach, let's take advantage of that.

Sometimes there isn't time to go to a class. Could it be at the job, for half an hour.

Michael Foods offers GED and English classes before and after shifts, but it is not paid time.

One attendee works for a dairy and he could pay his employees for half an hour for an English lesson.

One can learn the language, but I think that the logical thing will that there will always be people who don't speak English, because the US always needs workers. It would be more logical for professionals to learn Spanish. However, here it is very political to learn or speak Spanish.

Julie commented that we need healthcare professionals that are from the culture they are serving.

There are doctors working at Michael Foods but because they don't speak English they can't advance their profession.

One attendee is an RN in Mexico but here she hasn't been able to work as a nurse because of the language barrier, especially the writing.

Is there a program or a class or scholarship for bilingual children to become medical professionals? Molly mentioned RHOP, which is a scholarship for rural students and requires them to work in a rural area for a certain number of years once they are done with med school.

Educated individuals here often leave to urban areas.

What can those of us who are here in this community, those who stay, do?

Cecilia Modrell's Notes:

- (Intro question)What do we want to do to be healthy?
- I would like to exercise more.
- I am in a program to do more exercise.
- I want to exercise and eat more healthy and help the community.
- Looking for more activities to help our community.
- I want to go back to the gym like I used to.
- I would like to do exercise.
- I would like to eat less sugar (I love chocolates).
- I would like to learn how to eat healthier.
- More exercise and learn how to learn healthier.
- More exercise and eat healthier.
- Affecting the Community
- Fast food
- Being lazy
- Pollution
- Overeating
- When we go to a restaurant we eat all of our plate.
- Too much Facebook
- Technology is giving us a lot of great things but also taking a lot from us.
- We are getting used to getting anything too easy and fast.
- Losing motivation
- We are not eating healthy because of our work shifts (long hours).
- What worries you most about your health or the health of your family?
- There is a lot of information about healthy eating, but it is also very expensive and takes time to cook.
- Eating junk food has its consequences as it can cause diseases such as Alzheimer's and dementia.
- We don't want to use a microwave because it can cause cancer and other diseases and I try to cook by marinating my food at night so I can cook easier and it's because my job allows it. Other people their work schedule doesn't allow it.
- We are concerned about diabetes and overweight.
- Two-thirds of our population is overweight or obese.
- The students at the school don't like the school food and they don't eat until they get home.
- Comparing today and today, what changes have there been?
- In Mexico we have schedules for our meals.
- Here sometimes we only eat one meal because there is no time.
- What causes us not to have those schedules?
- I prepare the food the day before and the next day it's ready. Sometimes when I'm finishing preparing the food I am snacking. But right now I've been trying to eat small amounts for at least 3 months. Vegetables, protein, fruits. I have stopped eating sugar and noted the change (but it's hard).

- If I don't have my coffee with sugar and my sweet bread I do not function.
- I am grateful because when I was a child I did not have enough to eat. Being at school, at lunch time I would go home to have a glass of milk.
- It may be a combination of society because we are not educated on how to eat healthy.
- These countries have rules.
- We don't know how much sugar we eat in the food we buy. For example, we do not know that corn sugar affects us and has consequences of illness.
- The labels don't say that certain ingredients can cause cancer.
- I consider at this point that we have to educate ourselves by reading food labels and visiting the doctor to find out our state of health.
- Where do you receive the information to understand your health?
- YouTube, the internet.
- It's a mistake. It's too much information and we don't know what's right.
- One thing that prevents us from going to a clinic…it is that we do not have insurance or we do not know how to communicate in your language.
- Well, we have to go through a process, we have to go through physical exams.
- Our debt grows a lot when we don't have insurance.
- It isn't the same, going to the clinic or the hospital.
- The clinic doesn't want an interpreter, they have a translator machine.
- I hope they understand that a machine cannot understand feelings.
- There is no social worker at the clinic.
- The Norfolk hospital has a social worker. We don't know why Wayne does not have one.
- Many individuals and families prefer to go to stores and buy over the counter medicine or remedies because there are no better possibilities.
- Many people are not healthy. They stay sick for a long time because they don't have insurance.
- Some people who go to a consultation are afraid because they are being scanned to take their information.
- Do clinics share patient information?
- Only if the clinics are combined and if the patient authorizes with a signature to share their clinical information.
- Sometimes we don't know what we are signing.
- Although there is a HIPPA law, how can we know if they really do not share information?
- I once heard that they shared information to immigration. Whether it was true or not the people who heard that rumor were scared.
- What would you like to see to improve the health of the community?
- Medical insurance.
- Could be a benefit if there were more access that makes it easier for us to attend the activity center. Why should we have to pay to exercise to be healthy?
- I lived in Minnesota two years ago. There was a mobile clinic. People did not have to pay. Getting a mobile clinic; would it be possible to have this here in Wayne?
- Norfolk mobile clinic is coming to Wakefield and there are children who have been cared for and benefiting.
- How can we make local doctors and dentists aware of the needs of the population?
- Prevention comes with communication.
- If we promote and English program with people willing to help—college kids may help?
- That companies provide 30 minutes of English classes because it is not easy to to go to classes due to work hours.

- I work for a dairy, workers are needed. They would be given the opportunity to learn 30 minutes of class and they would be paid.
- It would be good if general service providers learned Spanish.
- There will always be people who don’t speak the language (English).
- There is a Hispanic doctor who works at Michael Foods. Because he does not know the language, he cannot work in his profession.
- In Mexico I am a certified nurse. The biggest barrier is that I could not do translations, I did not feel capable of making a report. I can get the license, but the language is a barrier.
- My granddaughter is working in a hospital and is paid for her classes to be a registered nurse.

Appendix 5: Community Health Survey/Analysis

The Survey

The Network Core Team reviewed the survey used as part of the CHNA process in 2018-2019 as well as a survey developed by the Nebraska Association of Local Health Directors (NALHD). It was decided to use the NALHD survey because of advantages it presented including: the open-ended questions would allow for more variety of data from the community members; use of at least these five questions in several health districts in Nebraska could lead to the opportunity of some comparability; and its integration into Qualtrics would allow for ease in repeatability not only in three years, but possibly more often. The survey was translated into Spanish and made active in November of 2021. **A reproduction of the survey is included at the end of this Appendix. The five substantive questions were:**

- "What was the last major health issue you or your family experienced?"
- "What worries you most about your health or the health of your family?"
- "What is something you do to be healthy?"
- "What would make your neighborhood a healthier place for you or your family?"
- And finally survey participants were given a list of potential "health concerns in the Northeast Nebraska Public Health Department District" and were each asked to choose their top three.

The mechanics of survey distribution are described in greater detail in the next section. The survey more than reached the goal of 380 total surveys, and either came close or surpassed the goals for each county. More men participated this time, although women are still overrepresented. The efforts to increase minority representation in respondents was partially successful. Hispanics are in fact somewhat overrepresented in that they were 192 of the 611 respondents from the four county area. Those identifying as American Indian are underrepresented. This is due in part to not promoting the survey on the Winnebago Reservation as those residents have been recently involved in their own community health assessment process. Carl T. Curtis Health Center did help us promote the survey on the Omaha Reservation which did increase the respondents who identified as American Indian from 3 to 10 (8 within the 4 counties).

The survey results, which have also been broken down by ethnicity, age, and county, appear below in Survey Results. The coding of the answers to the open-ended questions were influenced by themes that came up in the discussion with residents and stakeholders that participated in the Forces of Change Assessment, the Listening Sessions, and the Local Public Health System Assessment Update, as well as the Health Equity Advisory Council. They are also influenced by the indicators of the Community Health Status Assessment, as well as the Top Answers in 2018-2019 Community Health Survey. In the question about the "last major health issue faced" the categories of the ICD 10 were used to group specific injuries and illnesses mentioned, while separating out the most commonly mentioned ailments.

Survey Distribution

The Community Health Survey was disseminated to those living in Cedar, Dixon, Thurston and Wayne Counties using multiple delivery methods including:

1) Postal mailing of a flyer that included how to access the survey in English and Spanish was sent in January to 68787 and 68484 zip codes. Another EDDM mailing was distributed in March 2022 in an attempt to increase the number of responses from indigenous population as well as

2) A postcard was developed that the Core Network Team partners used to hand out to clients who utilized their services. Over 200 postcards were distributed by This included a mailing of 450 sent by Midtown Health Center to their patients having mailing addresses within the geographic area of focus.

3) Facebook posts by NNPHD in English and Spanish, as well as Facebook advertisements, including one aimed at increasing the number of men participating and another aimed at participation by the residents of Cedar County. Carl T. Curtis Health Center also helped promote the survey through their Facebook page.

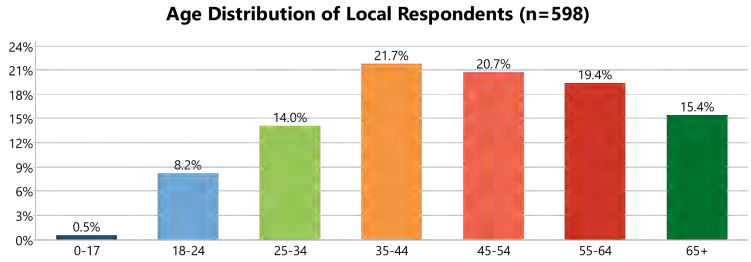
4) In order to better reach the Hispanic population, Rosa Brambila, proprietor of La Michuacana in Wakefield and Cecelia Modrell, community advocate in Wayne, were engaged to distribute and collect hard copies of the surveys, as well as conduct interviews with people who may have literacy challenges.

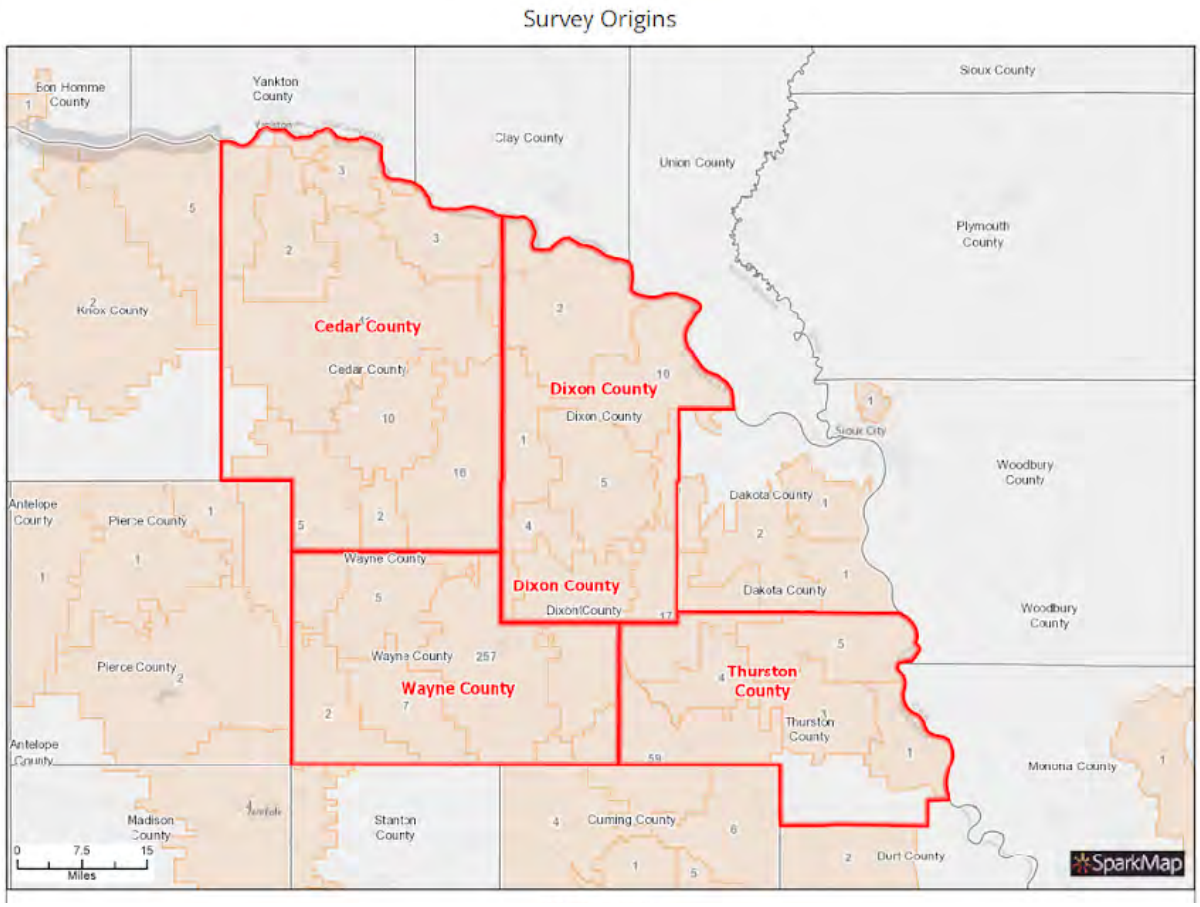
The map below reflects the zip code origins for surveys received. Because respondents were not asked to identify their county as well (the Network is planning to make sure that question is included in future surveys) surveys were coded as to the most likely county of origin for respondents, with for example, the 68484 zip code being allocated to Dixon the city of Wakefield is more so in that county.

The goal was to have a minimum of 380 surveys completed which would provide for a statistically reliable sample based on a 95% confidence level with a +/- 5% degree of accuracy margin of error. The total number of surveys collected was 666 with 611 indicating zip codes within the NNPHD survey area. In part, because of the drive to increase our collection of surveys from our Hispanic population, Dixon and Wayne counties are overrepresented. However, we came close to our goals for Cedar and Thurston counties. Because of these differences, county breakdowns on key issues are provided throughout this report.

	Cedar		**Dixon**		**Thurston**		**Wayne**		
Population	8,483		5,682		7,218		9,388		**30,771**
380	105	27.57%	70	18.47%	89	23.46%	116	30.51%	
Total Surveys gathered	**100**		**155**		**76**		**280**		**611**

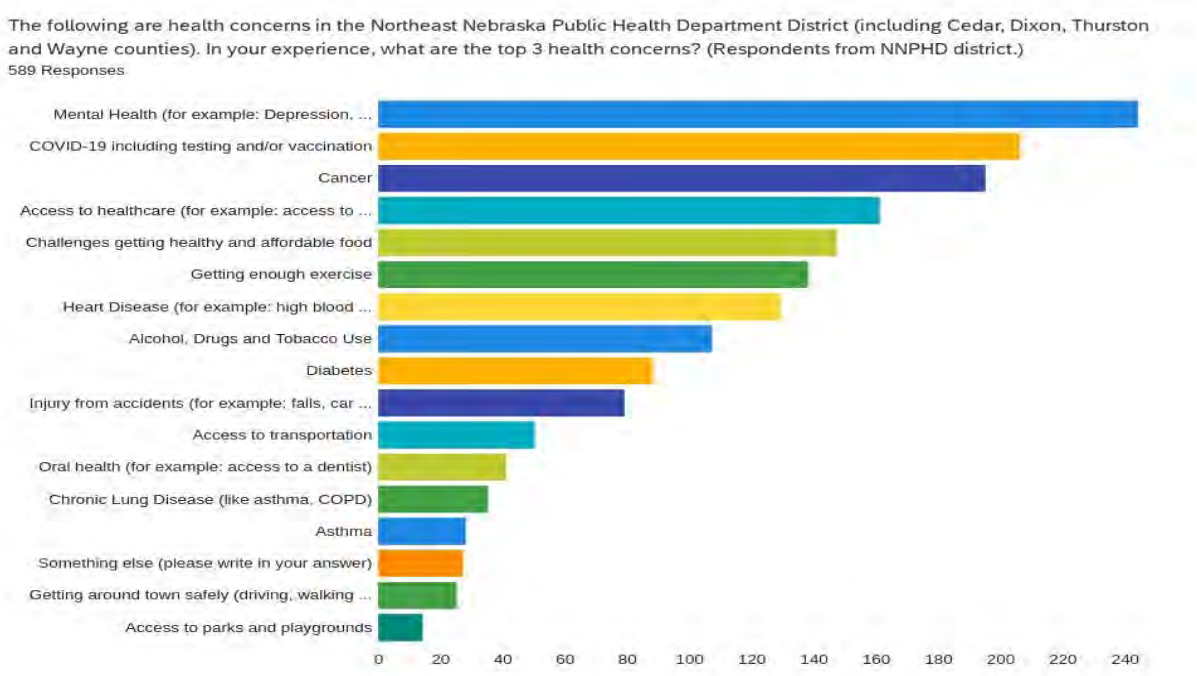
Approximately two-thirds of the respondents were female (a successful effort was made to target an increase in male participation from the previous cycle from 20% to 32%). Respondents represented a fairly even distribution of age groups, mirroring the area's age distribution.

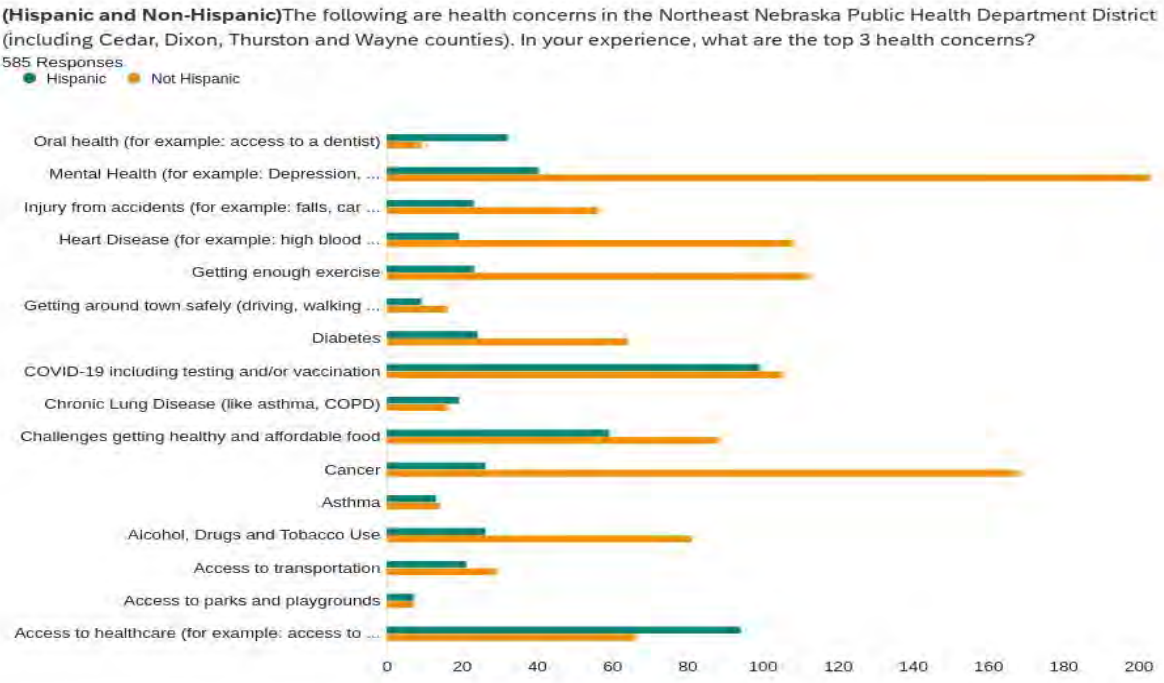




Survey Results

Answers Close-ended Question from Respondents from NNPHD district

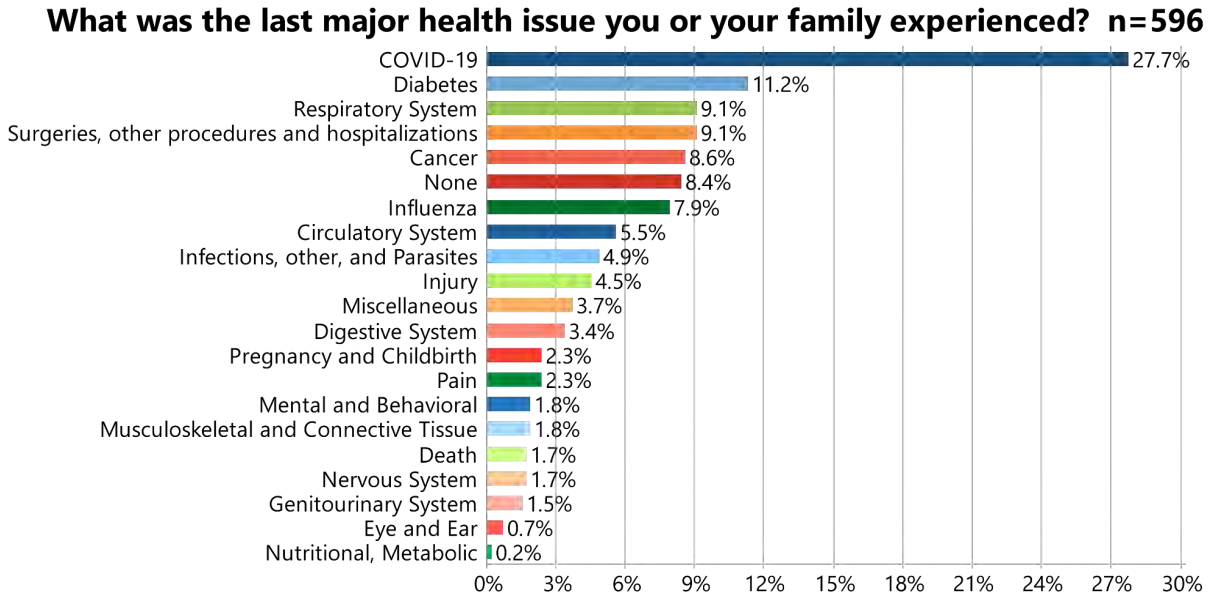


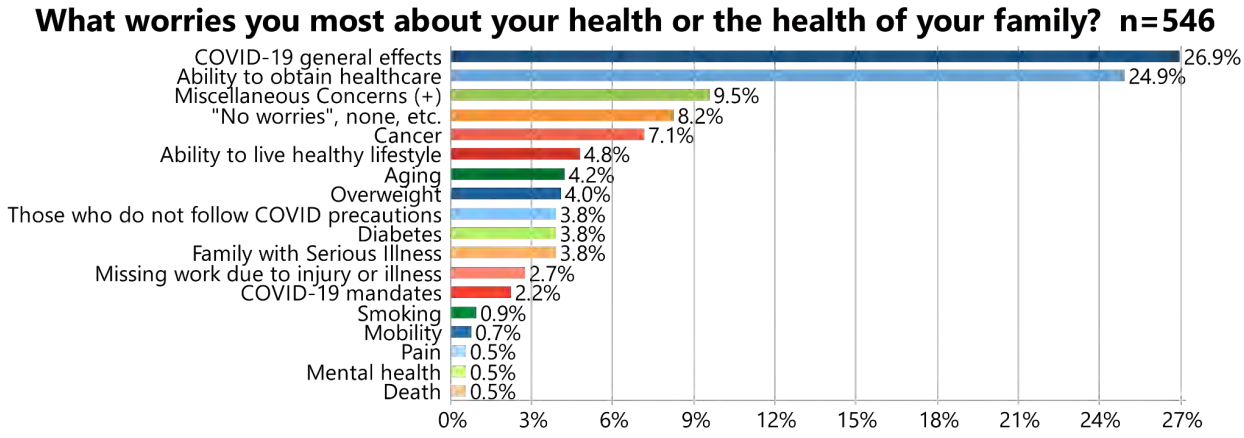


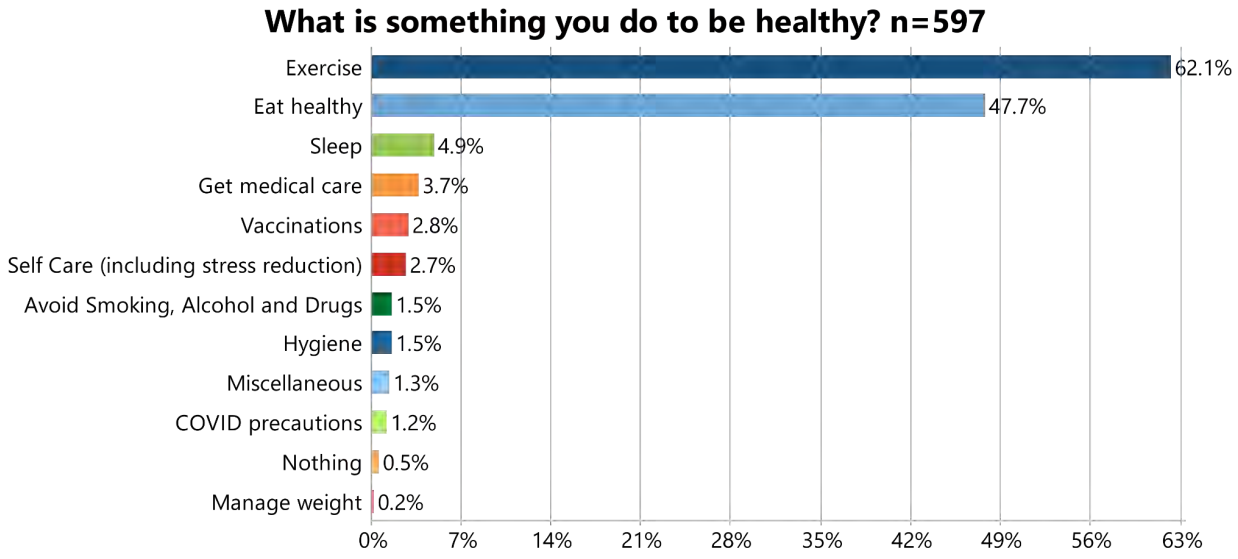
Answers Close-ended Question from Respondents from NNPHD district by County

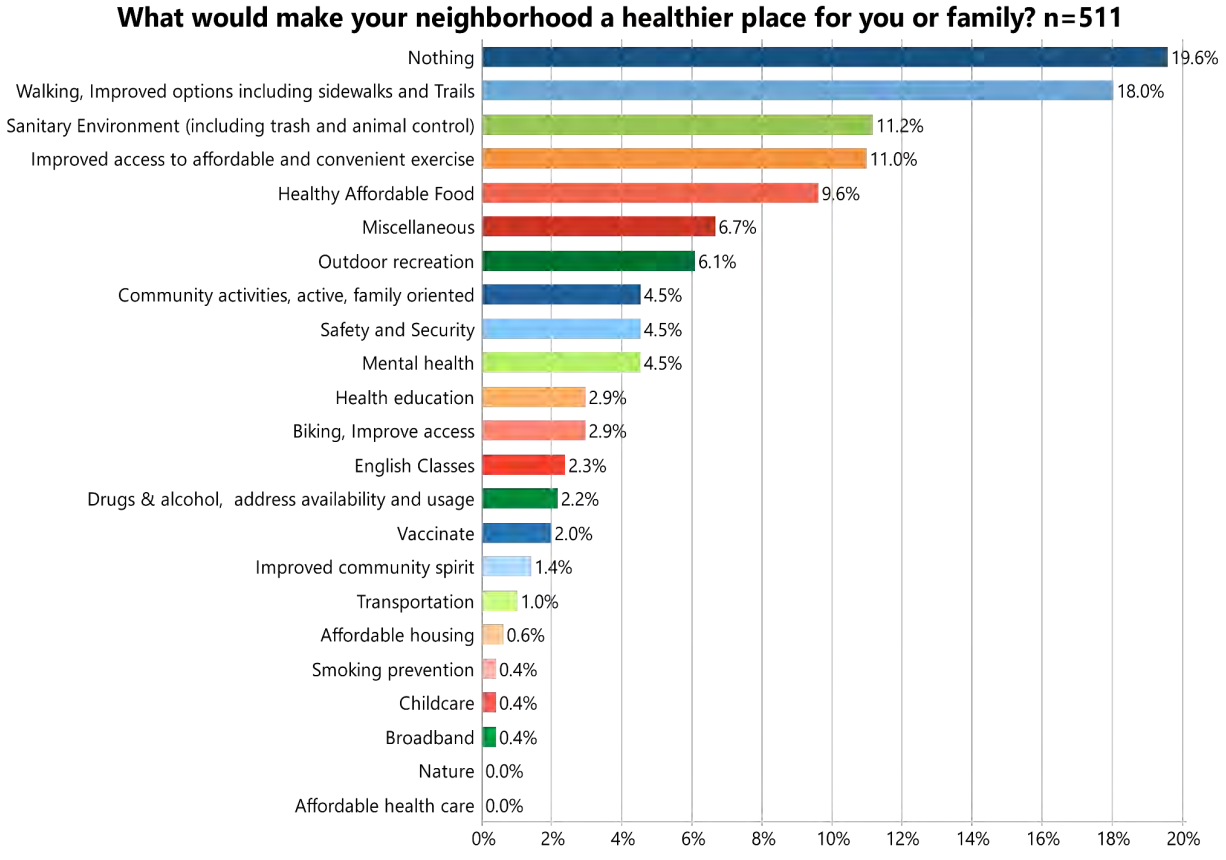
Choices	Cedar	Dixon	Thurston	Wayne
Access to healthcare (for example: access to a doctor)	20	20	9	48
Access to parks and playgrounds	3	1	1	2
Access to transportation	3	11	4	17
Alcohol, Drugs and Tobacco Use	22	13	16	37
Asthma	4	4	2	7
Cancer	43	24	34	68
Challenges getting healthy and affordable food	18	11	16	54
Chronic Lung Disease (like asthma, COPD)	5	6	3	7
COVID-19 including testing and/or vaccination	11	28	16	76
Diabetes	19	11	7	33
Getting around town safely (driving, walking and riding)	1	3	4	12
Getting enough exercise	30	17	26	46
Heart Disease (for example: high blood pressure and stroke, etc.)	33	20	17	40
Injury from accidents (for example: falls, car crash, burns)	16	7	8	30
Mental Health (for example: Depression, anxiety, post-traumatic stress, suicide, etc.)	42	27	33	110
Oral health (for example: access to a dentist)	2	6	1	11
Other	8	4	1	11

Overall Answers to Open-Ended Questions from Respondents from NNPHD district






What is something you do to be healthy? n=597
Exercise 62.1%
Eat healthy 47.7%
Sleep 4.9%
Get medical care 3.7%
Vaccinations 2.8%
Self Care (including stress reduction) 2.7%
Avoid Smoking, Alcohol and Drugs 1.5%
Hygiene 1.5%
Miscellaneous 1.3%
COVID precautions 1.2%
Nothing 0.5%
Manage weight 0.2%
0% 7% 14% 21% 28% 35% 42% 49% 56% 63%

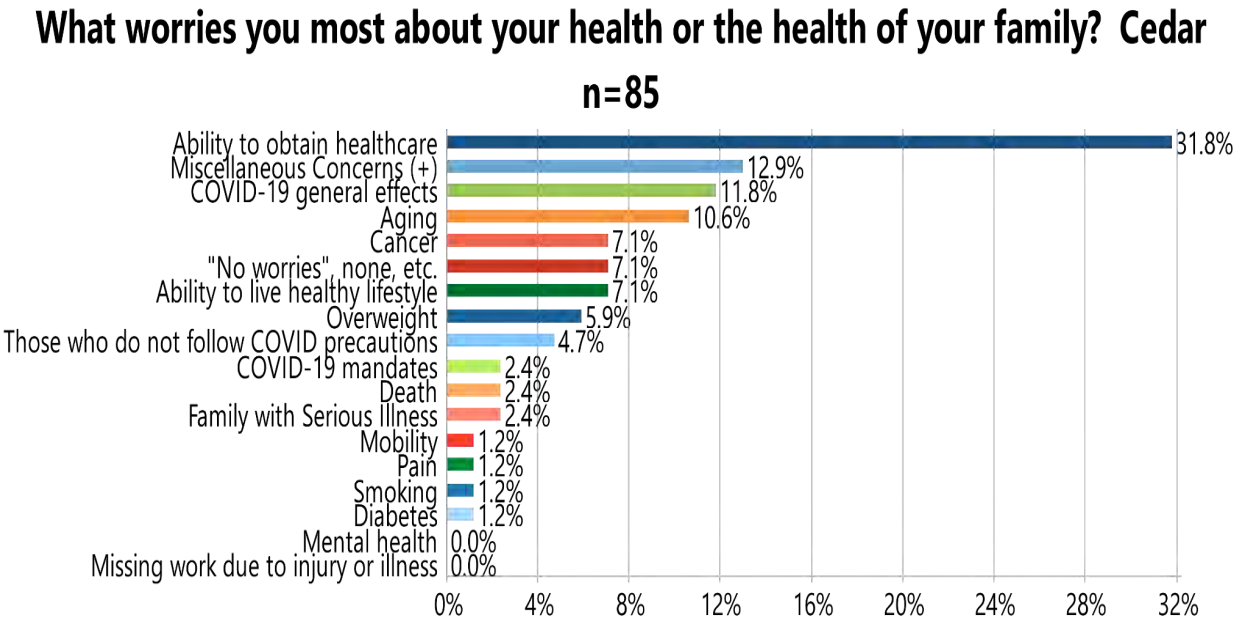

What would make your neighborhood a healthier place for you or family? n=511
Nothing 19.6%
Walking, Improved options including sidewalks and Trails 18.0%
Sanitary Environment (including trash and animal control) 11.2%
Improved access to affordable and convenient exercise 11.0%
Healthy Affordable Food 9.6%
Miscellaneous 6.7%
Outdoor recreation 6.1%
Community activities, active, family oriented 4.5%
Safety and Security 4.5%
Mental health 4.5%
Health education 2.9%
Biking, Improve access 2.9%
English Classes 2.3%
Drugs & alcohol, address availability and usage 2.2%
Vaccinate 2.0%
Improved community spirit 1.4%
Transportation 1.0%
Affordable housing 0.6%
Smoking prevention 0.4%
Childcare 0.4%
Broadband 0.4%
Nature 0.0%
Affordable health care 0.0%
0% 2% 4% 6% 8% 10% 12% 14% 16% 18% 20%

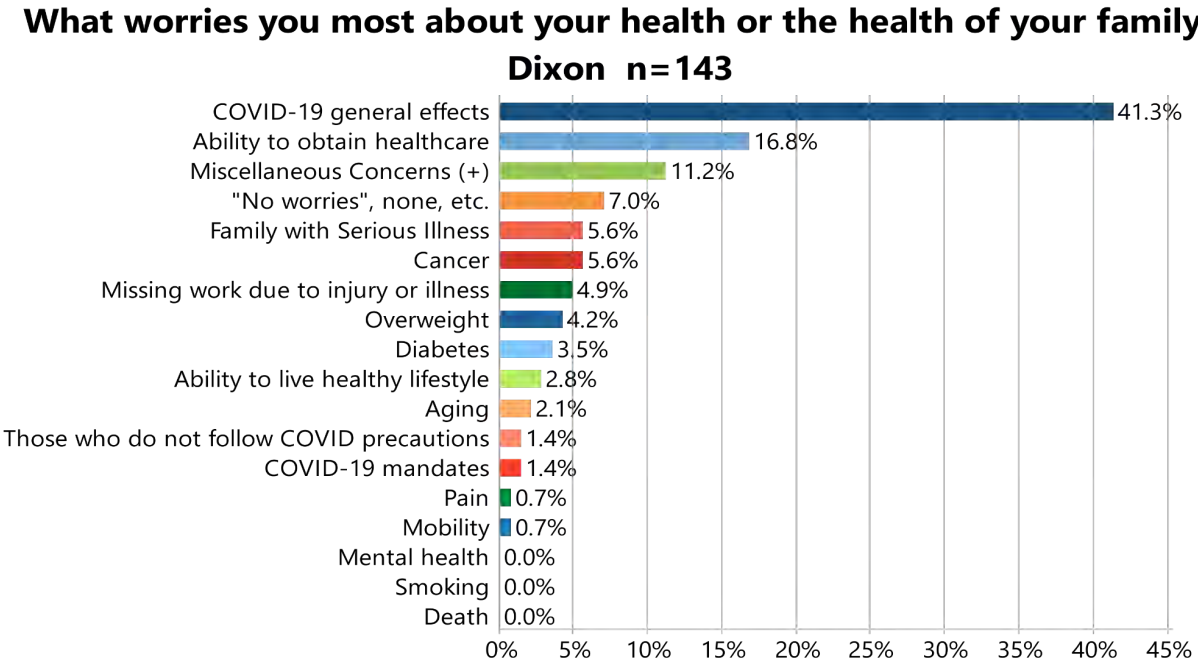
Breakdown by County

What was the last major health issue you or your family experienced?

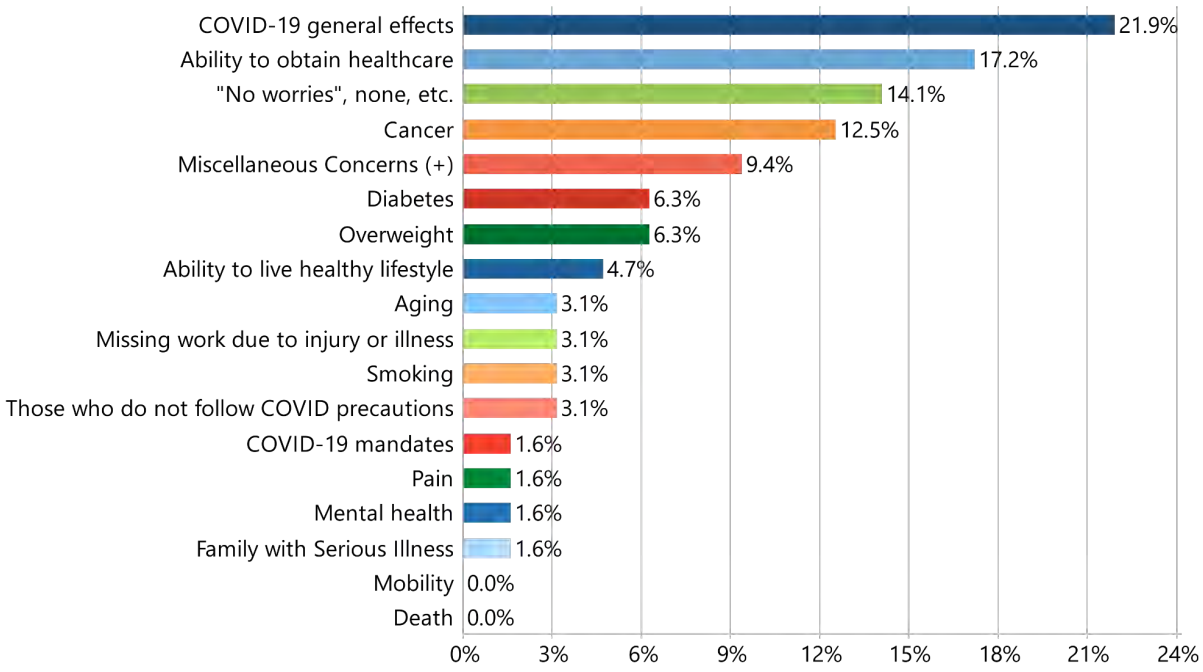
Due to the nature of this question, it is not being broken out by county.

What worries you most about your health or the health of your family?

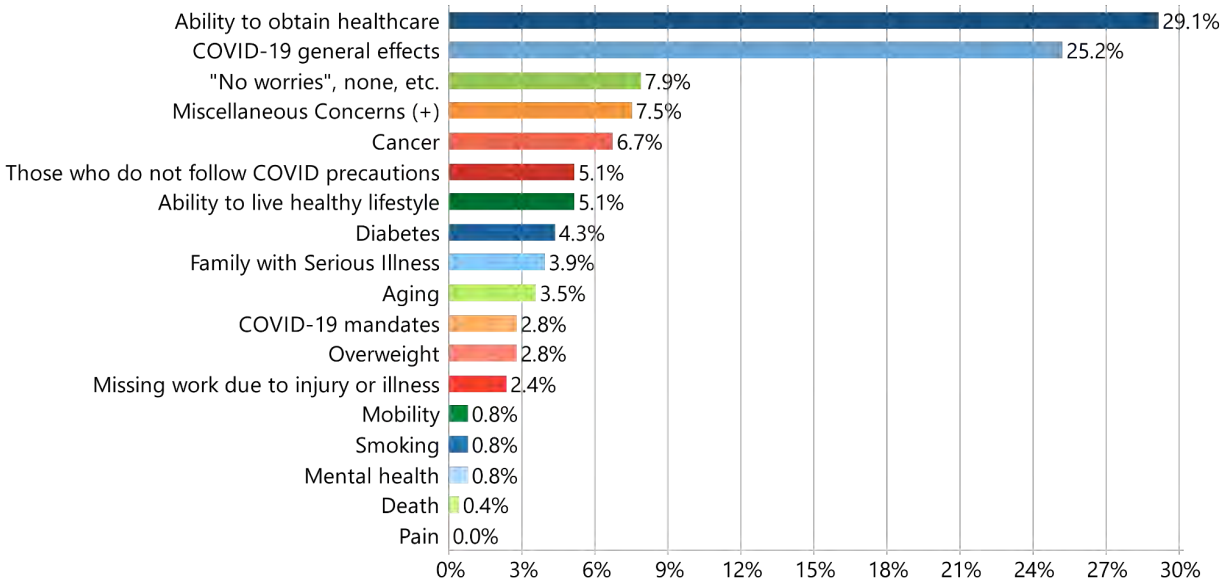




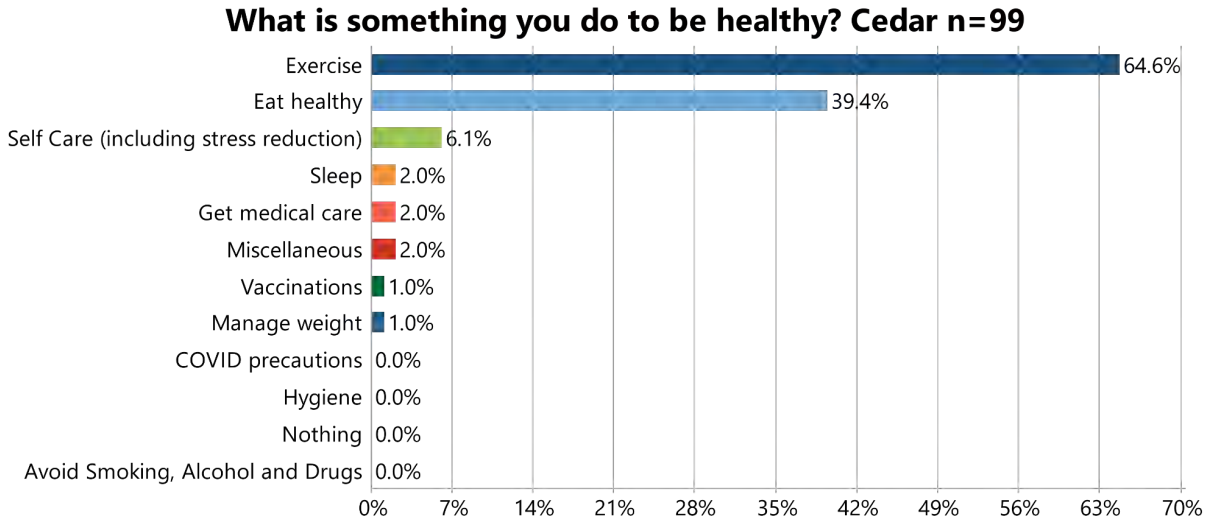
What worries you most about your health or the health of your family? Thurston n=64

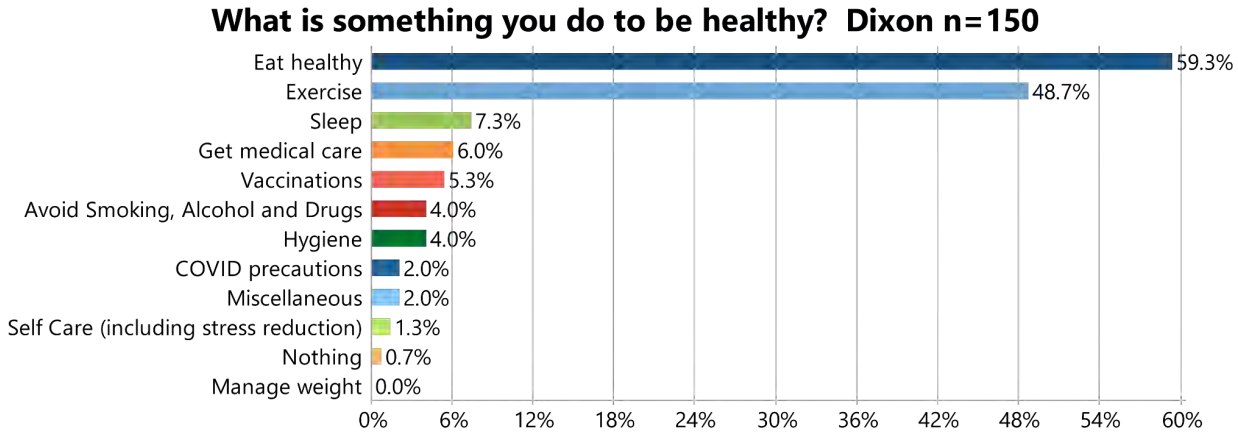


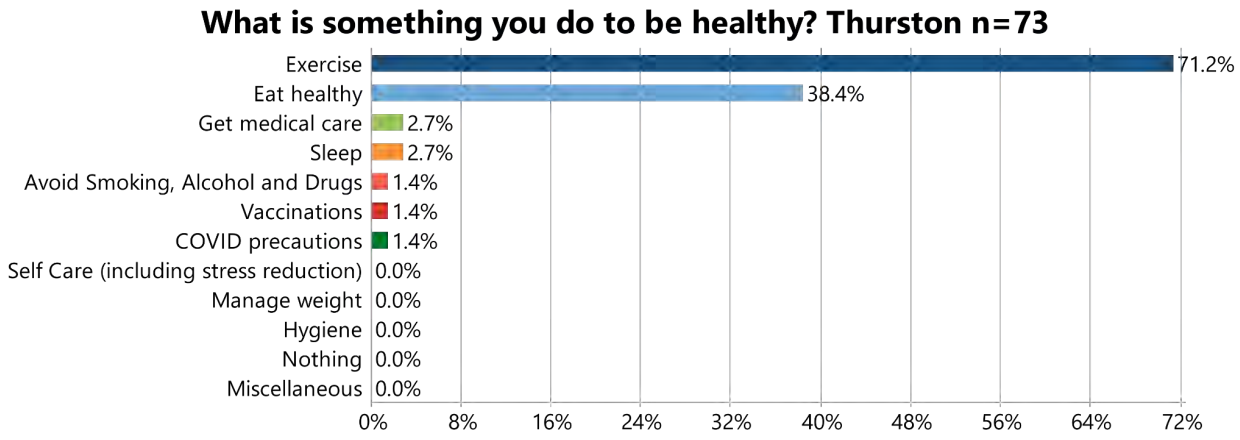
What worries you most about your health or the health of your family? Wayne n=254

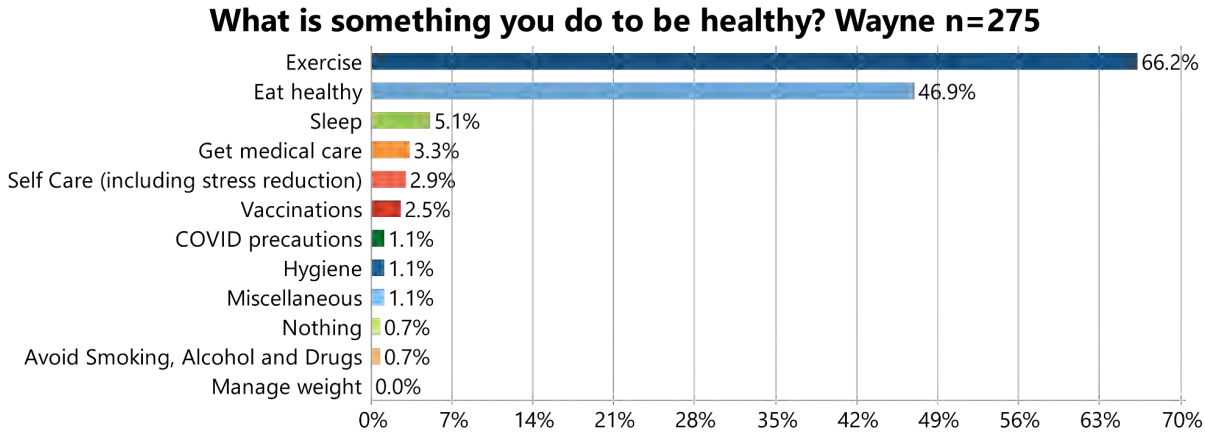


What is something you do to be healthy?

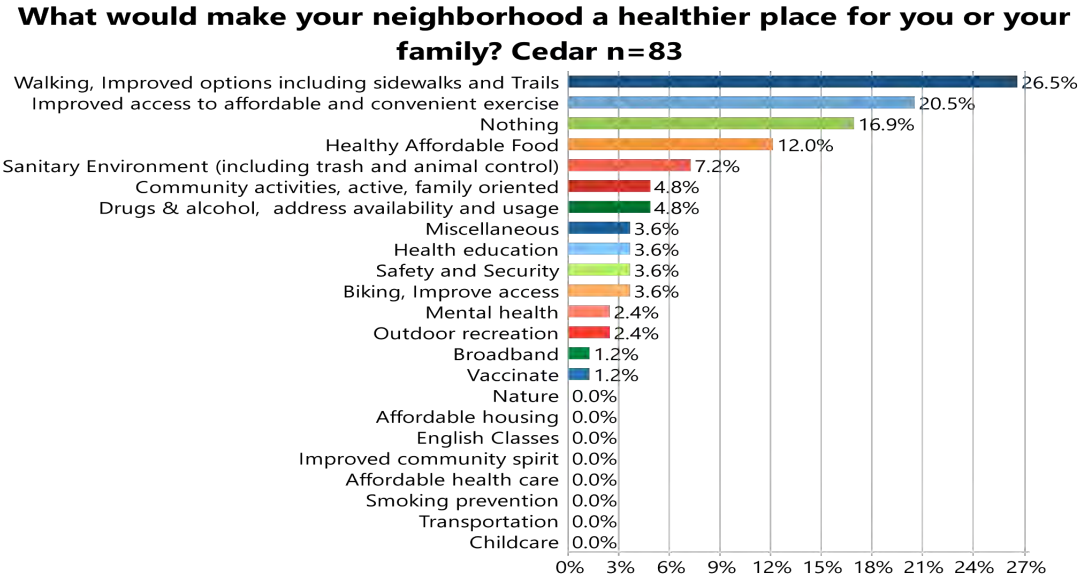


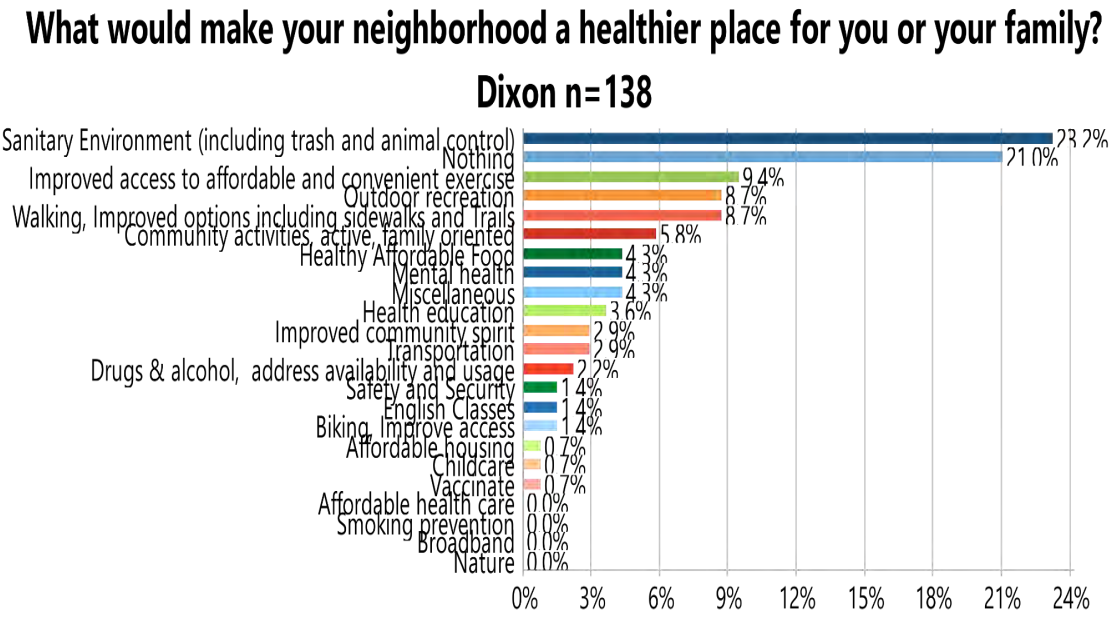



What is something you do to be healthy? Thurston n=73
Exercise
Eat healthy
Get medical care
Sleep
Avoid Smoking, Alcohol and Drugs
Vaccinations
COVID precautions
Self Care (including stress reduction)
Manage weight
Hygiene
Nothing
Miscellaneous
71.2%
38.4%
2.7%
2.7%
1.4%
1.4%
1.4%
0.0%
0.0%
0.0%
0.0%
0.0%
0%
8%
16%
24%
32%
40%
48%
56%
64%
72%

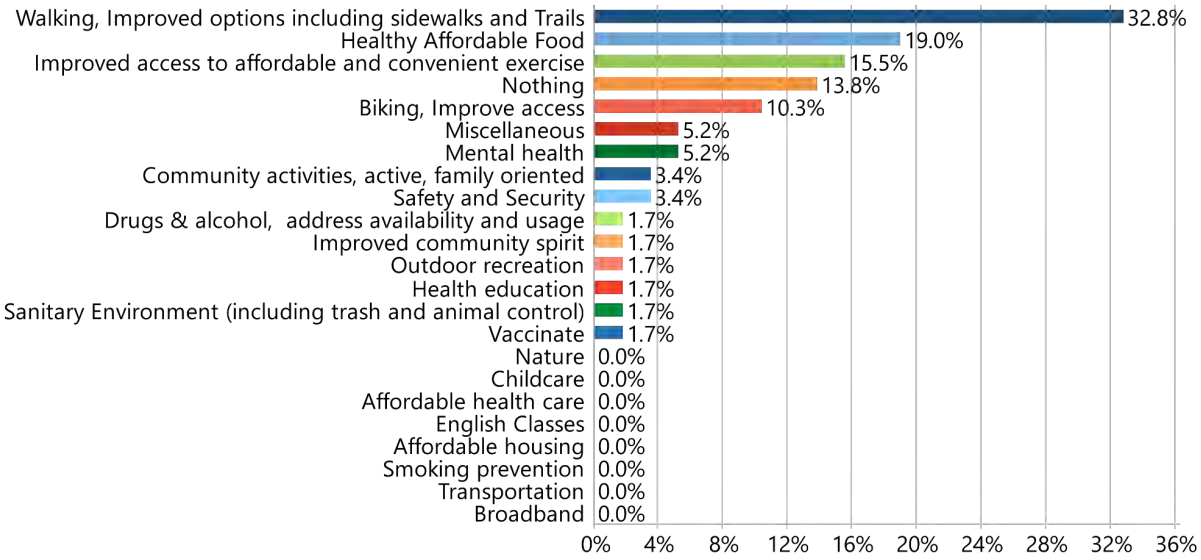

What is something you do to be healthy? Wayne n=275
Exercise
Eat healthy
Sleep
Get medical care
Self Care (including stress reduction)
Vaccinations
COVID precautions
Hygiene
Miscellaneous
Nothing
Avoid Smoking, Alcohol and Drugs
Manage weight
66.2%
46.9%
5.1%
3.3%
2.9%
2.5%
1.1%
1.1%
1.1%
0.7%
0.7%
0.0%
0%
7%
14%
21%
28%
35%
42%
49%
56%
63%
70%

What would make your neighborhood a healthier place for you or your family?

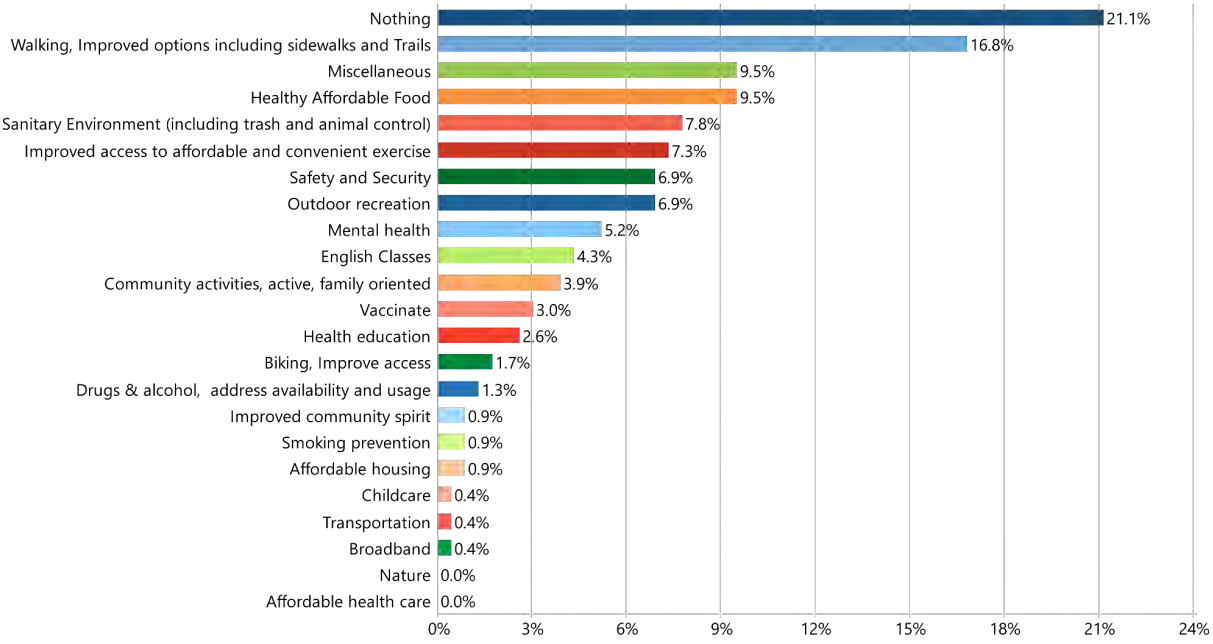




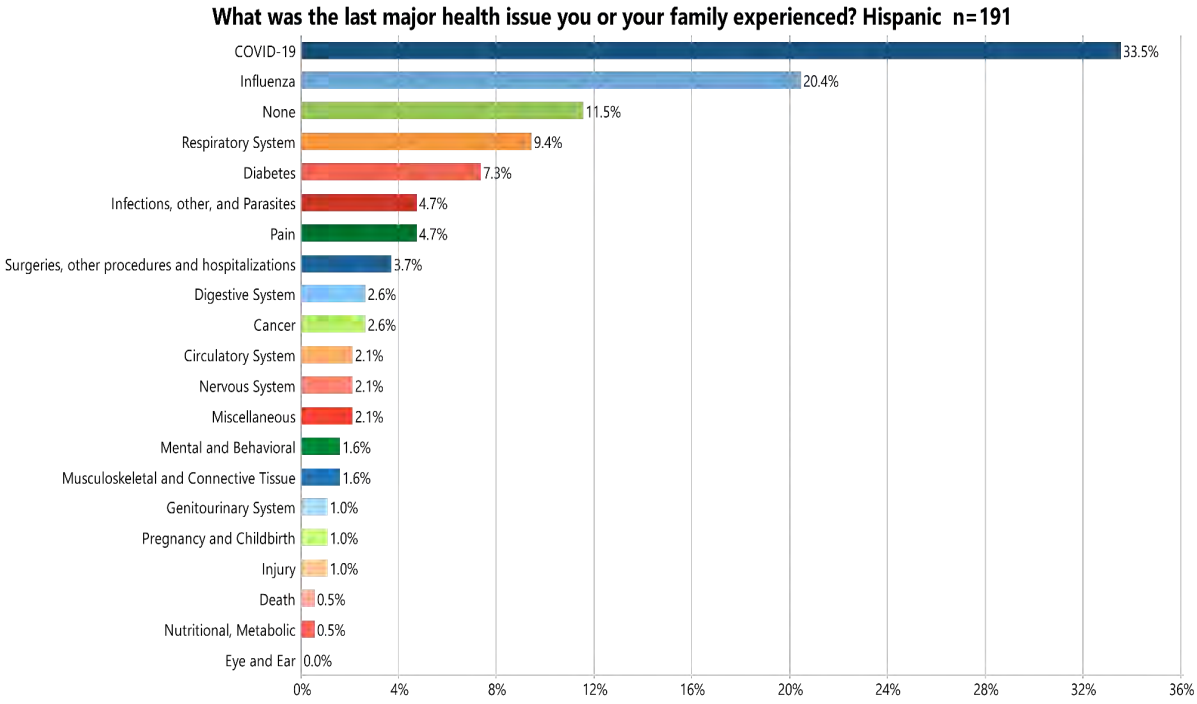
What would make your neighborhood a healthier place for you or family? Thurston n=58

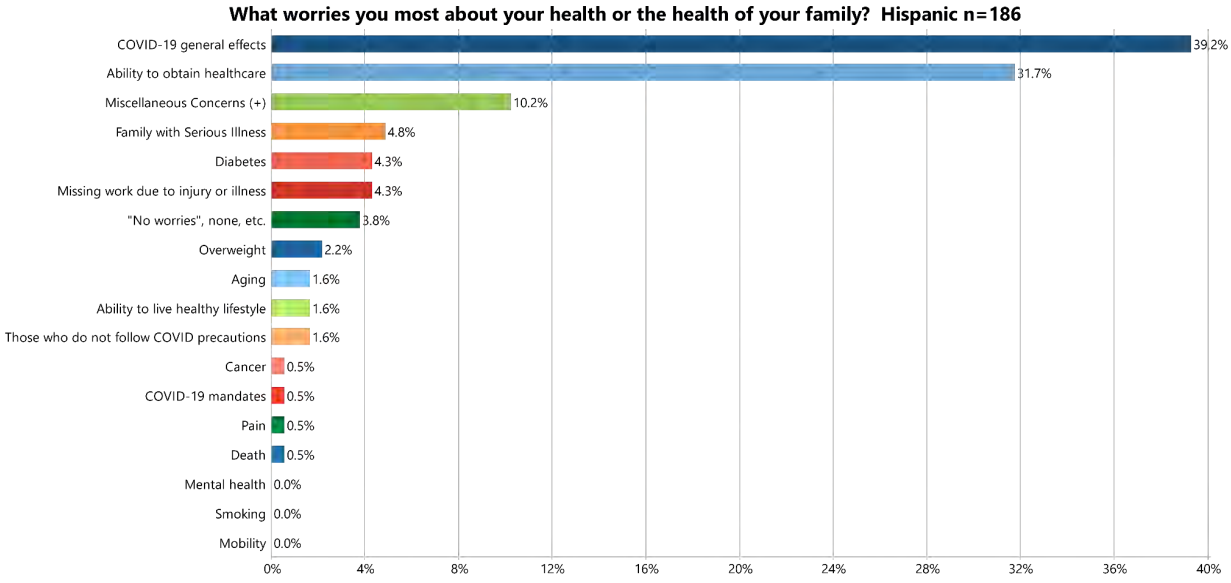


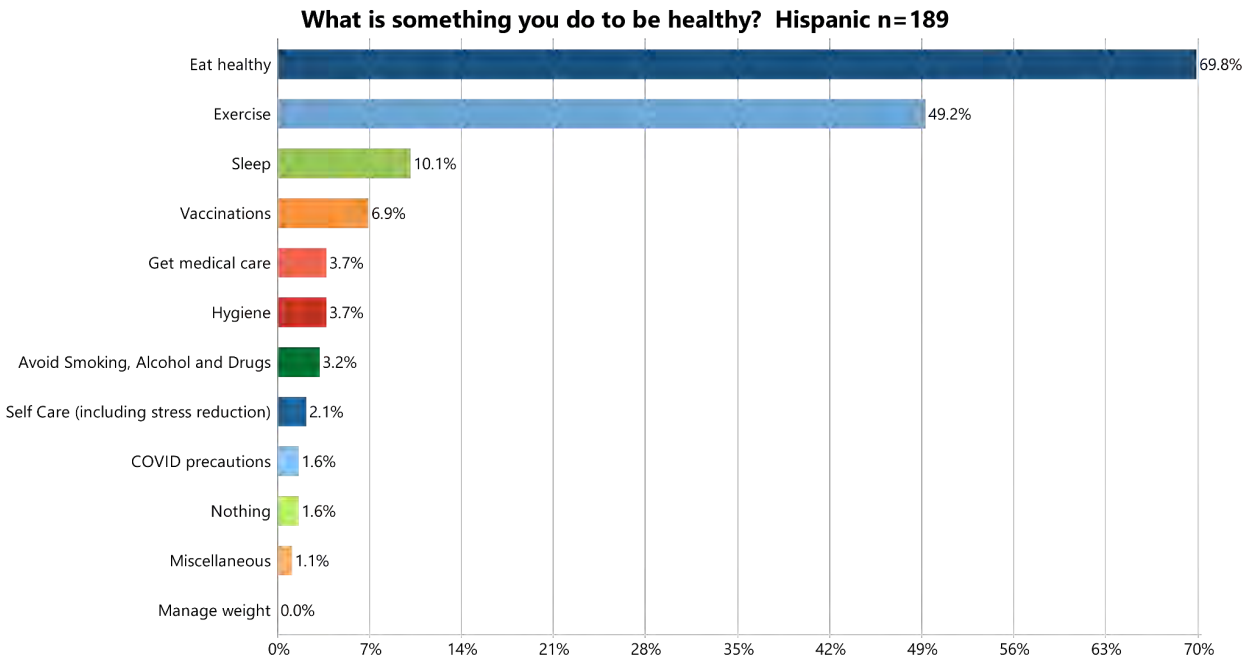
What would make your neighborhood a healthier place for you or your family? Wayne n=232

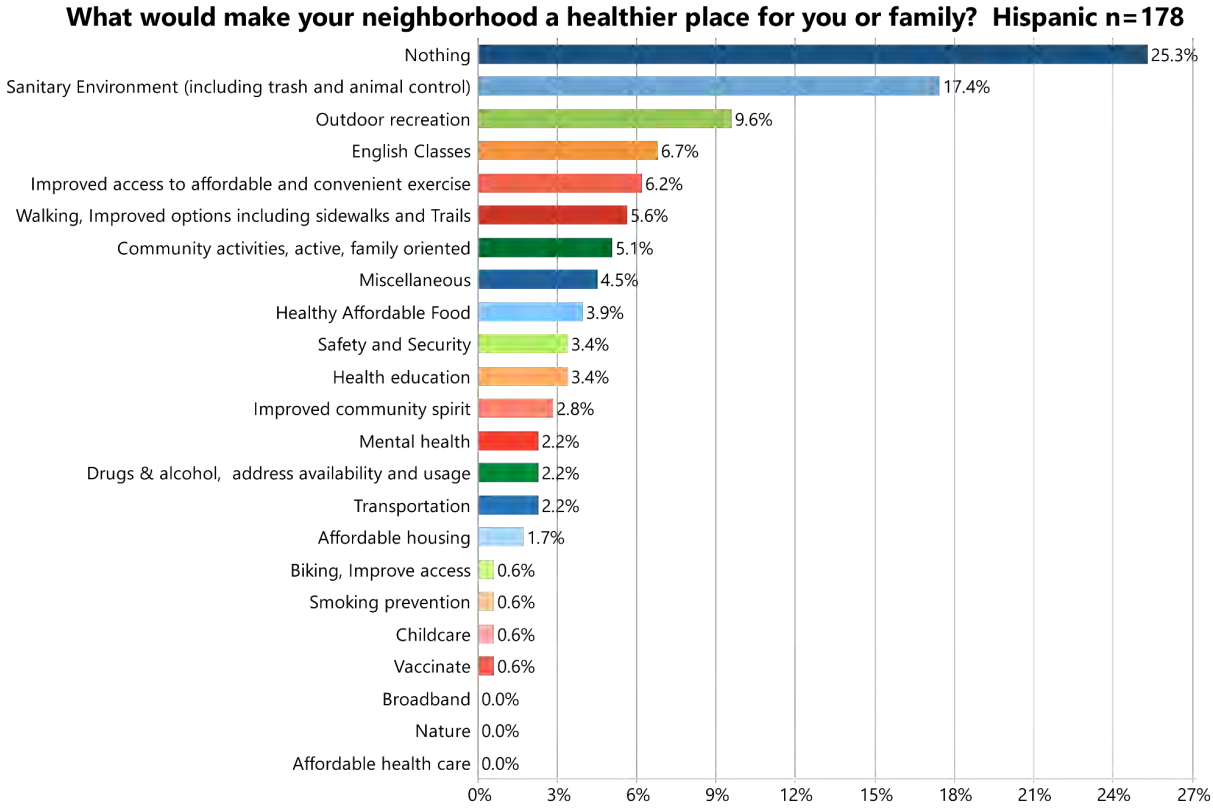


Hispanic Responses from NNPHD district n=192






What is something you do to be healthy? Hispanic n=189
Eat healthy 69.8%
Exercise 49.2%
Sleep 10.1%
Vaccinations 6.9%
Get medical care 3.7%
Hygiene 3.7%
Avoid Smoking, Alcohol and Drugs 3.2%
Self Care (including stress reduction) 2.1%
COVID precautions 1.6%
Nothing 1.6%
Miscellaneous 1.1%
Manage weight 0.0%
0% 7% 14% 21% 28% 35% 42% 49% 56% 63% 70%


What would make your neighborhood a healthier place for you or family? Hispanic n=178
Nothing 25.3%
Sanitary Environment (including trash and animal control) 17.4%
Outdoor recreation 9.6%
English Classes 6.7%
Improved access to affordable and convenient exercise 6.2%
Walking, Improved options including sidewalks and Trails 5.6%
Community activities, active, family oriented 5.1%
Miscellaneous 4.5%
Healthy Affordable Food 3.9%
Safety and Security 3.4%
Health education 3.4%
Improved community spirit 2.8%
Mental health 2.2%
Drugs & alcohol, address availability and usage 2.2%
Transportation 2.2%
Affordable housing 1.7%
Biking, Improve access 0.6%
Smoking prevention 0.6%
Childcare 0.6%
Vaccinate 0.6%
Broadband 0.0%
Nature 0.0%
Affordable health care 0.0%
0% 3% 6% 9% 12% 15% 18% 21% 24% 27%

Top Answers in 2018-2019 Community Health Survey

In the 2018-2019 survey, key questions were asked with a list of choices.

- Top choices are listed Health challenges you face
    - Overweight/obese
    - Joint or back pain
    - High blood pressure
- Areas to improve in the community to make it healthier
    - Overweight/obesity
    - Mental Health Problems
    - Heart Disease, Stroke, & High Blood Pressure
    - Healthy Choices when Eating out
    - Cancer
- What is needed to improve the health of family and neighbors
    - Mental Health Services
    - Free Affordable Health Screening
    - Healthier Food
    - Wellness Services
    - Safe Places to Walk, Play, Exercise
- Unhealthy behaviors of Youth
    - Poor Eating Habits
    - Alcohol Use
    - Lack of Exercise
    - Bullying
    - Being overweight
- Unhealthy behaviors of adults.
    - Being overweight
    - Lack of exercise
    - Alcohol Use
    - Poor eating Habits
    - Tobacco Use
- Gaps identified included
    - Mental Health Services
    - Services for Obesity
    - Controlling Cost of Health Care

Survey promotion cards:

Take our short Community Health Survey – We need your input!

Northeast Nebraska Rural Health Network

Take our short, 5-question survey to share your ideas about how to make a healthier community. The results of the survey will be used to develop a 3-year Community Health Improvement Plan. Your answers will be kept private and will not be connected to you.

Complete the survey by February 28, 2022, if you would like to be entered for a chance to win one of four $50 "Healthy Living" prizes!

Providence Medical Center, Wayne,
Pender Community Hospital, Pender,
Midtown Health Center, Norfolk,
University of Nebraska Medical Center,
Winnebago Public Health Department, and
Northeast NE Public Health Department
are working together to create a healthier community and we need your help!

You can make a difference!

Take the Survey in 1 of 3 ways:

1. At this website: www.nnphd.org
2. Use the QR Code to the right with the app on your smartphone or tablet.
3. Or at this link:
   https://nalhd.sjc1.qualtrics.com/jfe/form/SV_cOYj2IoRek6PNt4

For questions or more information contact Northeast Nebraska Public Health Department at 402-375-2200 or 800-375-2260.

Realice nuestra breve Encuesta de Salud Comunitaria—¡Necesitamos su opinión!

Northeast Nebraska Rural Health Network

Realice nuestra breve encuesta de 5 preguntas para compartir sus ideas de como hacer una comunidad más saludable. Los resultados de la encuesta serán usados para desarrollar un Plan de 3 años para Mejorar la Salud de la Comunidad. Sus respuestas se mantendrán privadas y no serán conectadas a usted.

Complete la encuesta antes del 28 de Febrero, 2022, si quisiera ser parte de una rifa para ganarse uno de cuatro premios de $50 "Viviendo Saludable."

Providence Medical Center, Wayne,
Pender Community Hospital, Pender,
Midtown Health Center, Norfolk,
University of Nebraska Medical Center, Norfolk,
Winnebago Public Health Department, y
Northeast NE Public Health Department,
Estamos trabajando juntos para crear una comunidad saludable y necesitamos su ayuda!

¡Usted puede hace una diferencia!

Realice la Encuesta en 1 de 3 maneras:

1. En este sitio web: www.nnphd.org
2. O use el Código QR a la derecha con su teléfono Smart o tableta.
3. O en este enlace: https://nalhd.sjc1.qualtrics.com/jfe/form/SV_cOYj2IoRek6PNt4

Para preguntas o más información contacte al Departamento de Salud Publica del Noreste de Nebraska al 402-375-2200 o 800-375-2260.

Survey Questions 2022

Q1 (Introduction)

This survey is a way to hear from you about how and what you experience in your life that affect your health. Each person's experience of "health" is impacted by so many things. Your view is important to us.

On this survey, we really want to hear your story. Your story and the story of people in your area will be added together to give a more accurate picture of how we can make a healthier community for everyone. This survey will only take about 5 minutes and has 11 questions.

If you answer every question in the survey, including name and contact information, you get a chance to win one of four prizes, your choice of "Healthy Living Supplies" such as exercise shoes, gym membership, healthy food package, etc., valued at $50 for each award! Your answers will not be connected to your name or contact information.

The Northeast Nebraska Rural Health Network includes Pender Community Hospital, Providence Medical Center, University of Nebraska Medical Center, Winnebago Health Department, and Northeast Nebraska Public Health Department. If you have any questions, please call the Northeast Nebraska Public Health Department at 402-375-2200.

_____

Q2 What was the last major health issue you or your family experienced?

_____

_____

_____

_____

_____

Q3 What worries you most about your health or the health of your family?

_____

_____

_____

_____

_____

Q4 The following are health concerns in the Northeast Nebraska Public Health Department District (including Cedar, Dixon, Thurston and Wayne counties). In your experience, what are the top 3 health concerns?

- ▢ Access to healthcare (for example: access to a doctor) (16)
- ▢ Access to parks and playgrounds (14)
- ▢ Access to transportation (17)
- ▢ Alcohol, Drugs and Tobacco Use (1)
- ▢ Asthma (12)
- ▢ Cancer (10)
- ▢ Challenges getting healthy and affordable food (4)
- ▢ Chronic Lung Disease (like asthma, COPD) (11)
- ▢ COVID-19 including testing and/or vaccination (13)
- ▢ Diabetes (2)
- ▢ Getting around town safely (driving, walking and riding) (7)
- ▢ Getting enough exercise (8)
- ▢ Heart Disease (for example: high blood pressure and stroke, etc.) (6)
- ▢ Injury from accidents (for example: falls, car crash, burns) (18)
- ▢ Mental Health (for example: Depression, anxiety, post-traumatic stress, suicide, etc.) (3)
- ▢ Oral health (for example: access to a dentist) (15)
- ▢ Something else (please write in your answer) (9) _____

Q5 What is something you do to be healthy?

_____

_____

_____

_____

_____

Q6 What would make your neighborhood a healthier place for you or your family?

_____

_____

_____

_____

_____

Q7 What is your zip code?

_____

Q8 What is your gender?

o Male (1)

o Female (2)

o Non-binary/third gender (3)

o Choose not to answer (5)

Q9 What is your race?

o White (1)

o Black or African American (2)

o Asian (3)

o American Indian or Alaska Native (4)

o Native Hawaiian or Pacific Islander (5)

o Some other race (please list) (6) _____

Q10 Are you of Hispanic or Latino origin?

o Yes (1)

o No (2)

Q11 What year were you born?

_____

Q12 What is your name? (Share only if you would like to be including in the drawing. Remember your name and contact information will not be attached to the rest of your answers.)

_____

Q13 How can we contact you? (Please give us at least one way including phone or email, to contact you if you would like to be eligible for a drawing to win a "Healthy Living" prize worth $50.)

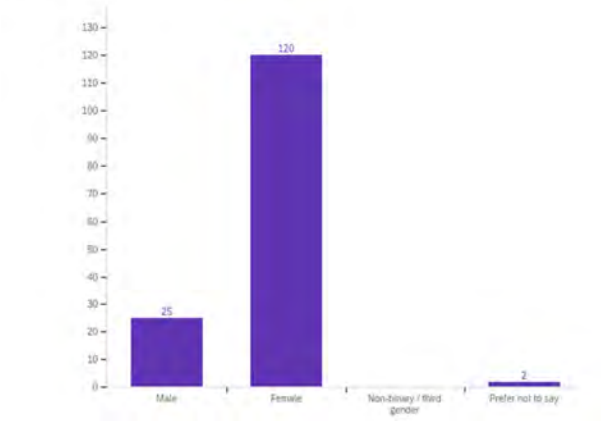
_____

Appendix 6: Community Readiness for Overdose Prevention Survey

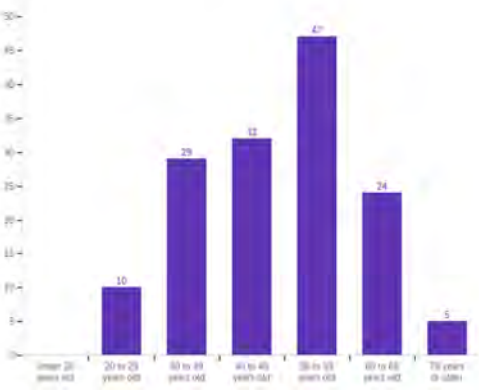
Results (November-December 2021)

Who were our respondents? N=210

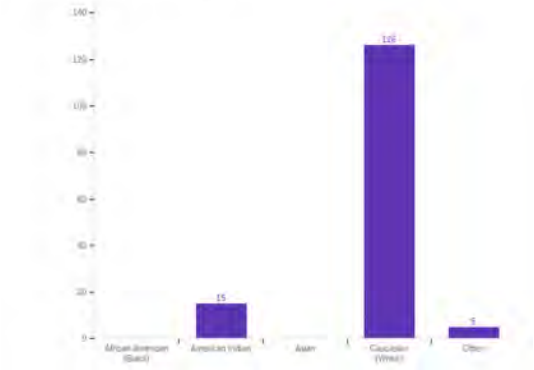
Q11 - GENDER-Which one describes your gender?



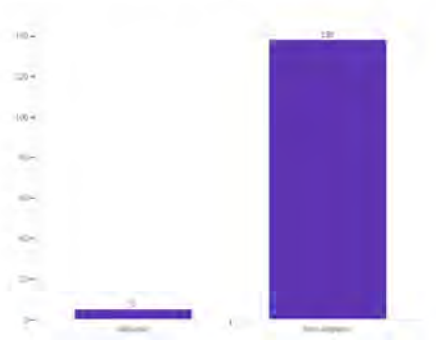
Q12 - AGE-Which of the following categories include your age?

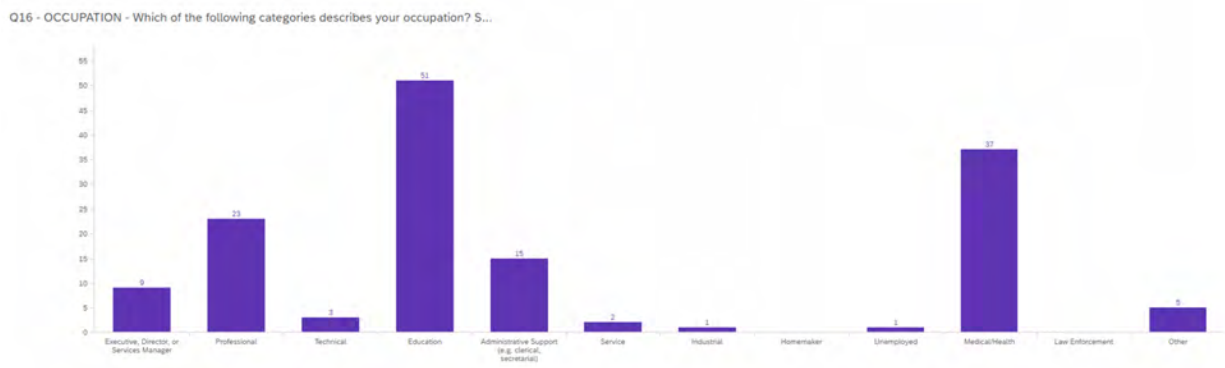


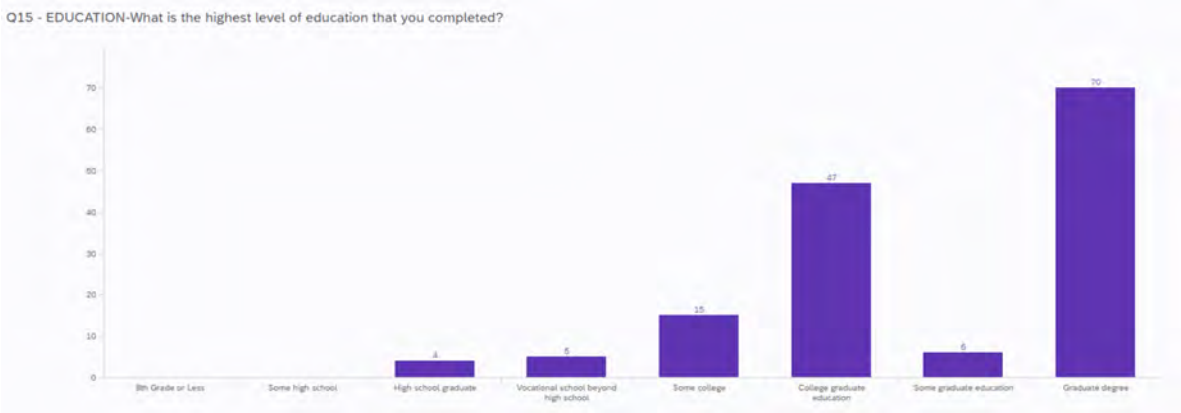
Q13 - RACE-Which of the following describes your race?



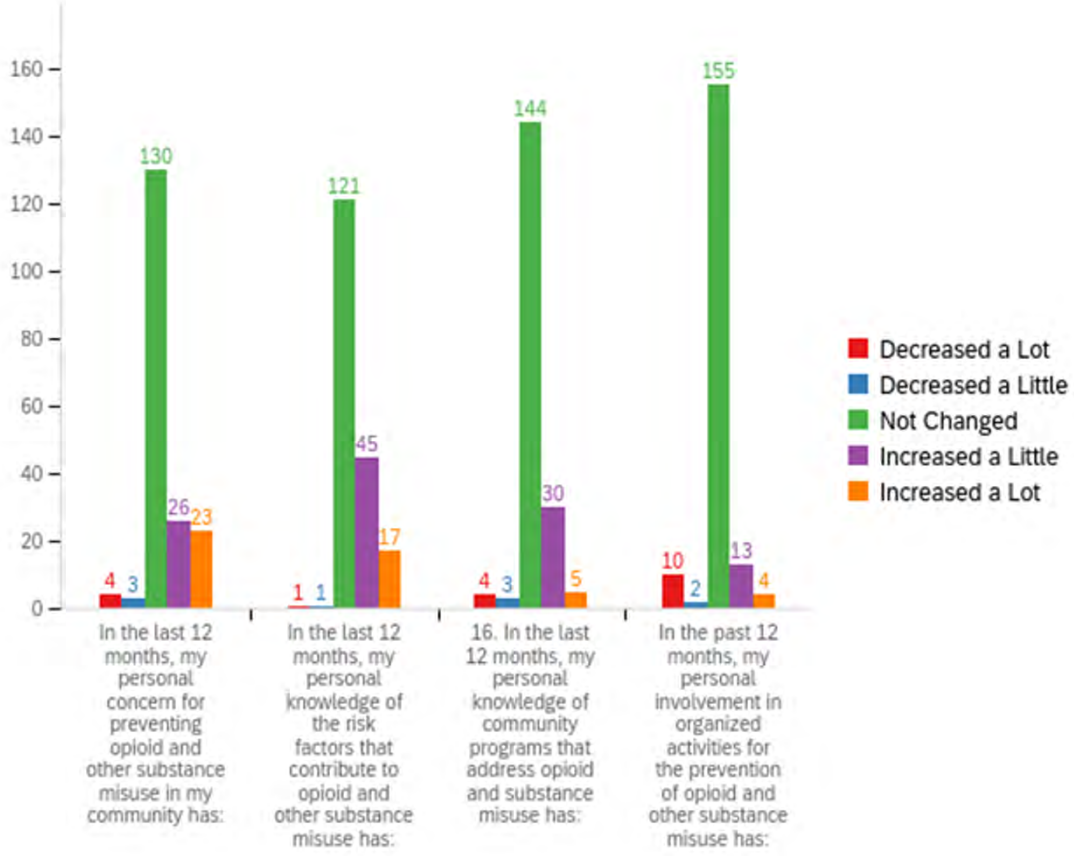
Q14 - ETHNICITY-Which of the following describes your ethnicity?



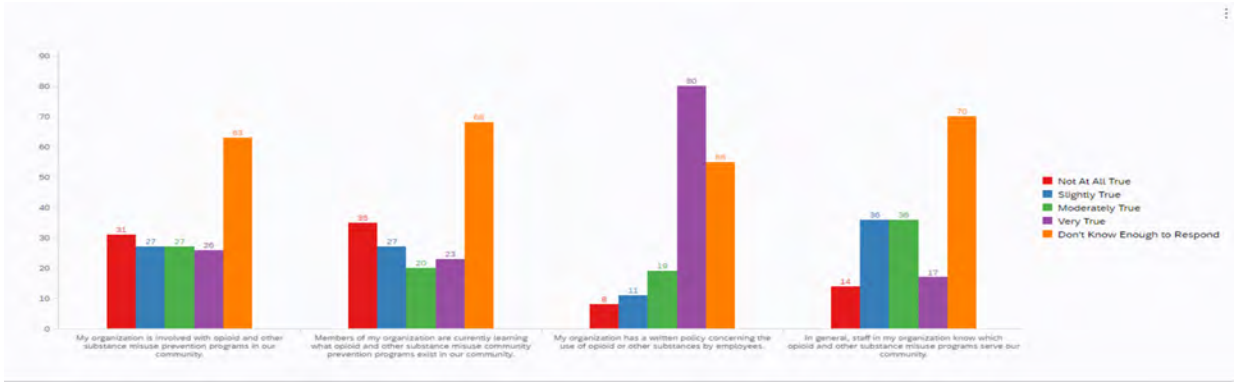

Q16 - OCCUPATION - Which of the following categories describes your occupation? S...
9
23
3
51
15
2
1
1
37
5
Executive, Director, or Services Manager
Professional
Technical
Education
Administrative Support (e.g. clerical, secretarial)
Service
Industrial
Homemaker
Unemployed
Medical/Health
Law Enforcement
Other

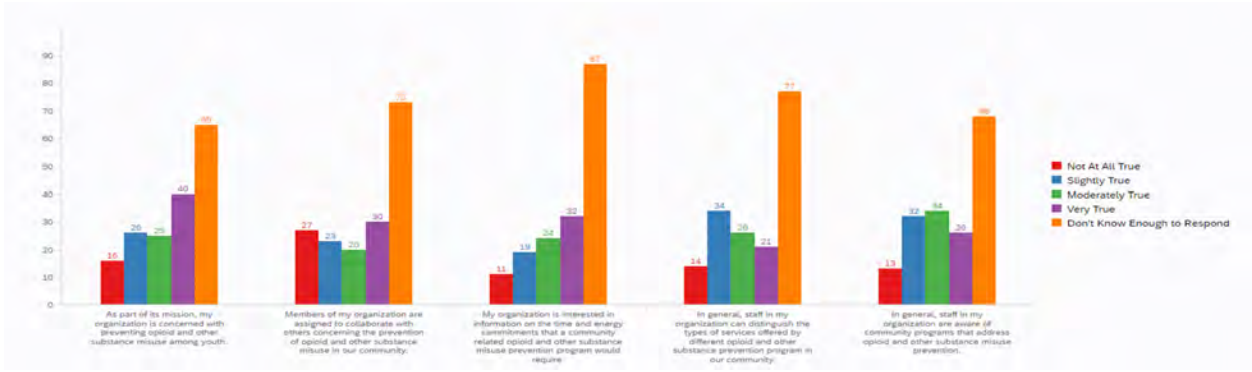

Q15 - EDUCATION-What is the highest level of education that you completed?
4
5
15
47
6
70
8th Grade or Less
Some high school
High school graduate
Vocational school beyond high school
Some college
College graduate education
Some graduate education
Graduate degree

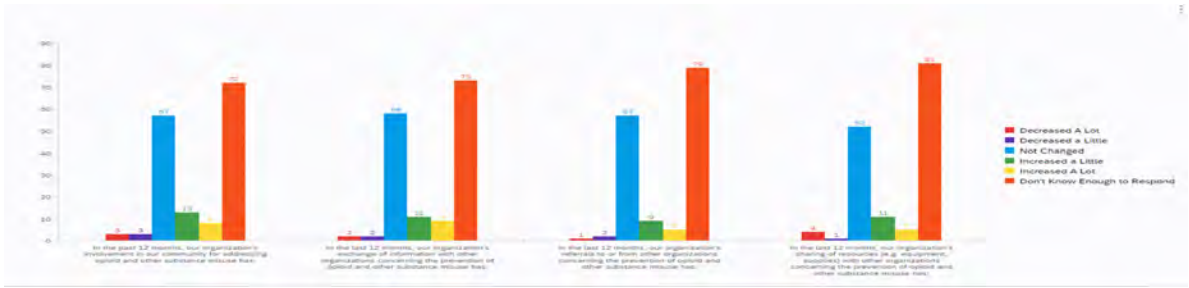
Personal concern, knowledge, and involvement in opioid and other substance misuse prevention in the last 12 months.

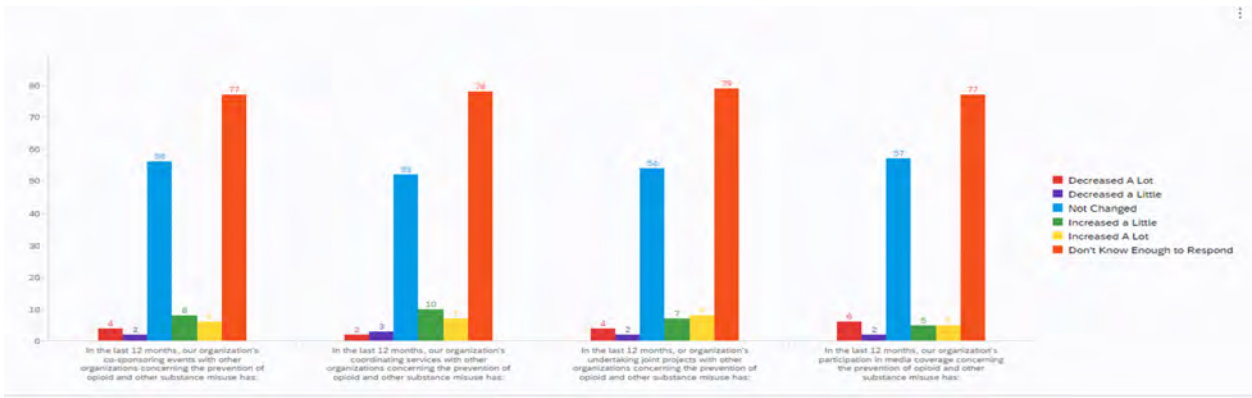


Organization's concern, knowledge, and involvement in opioid and other substance misuse prevention in the last 12 months.

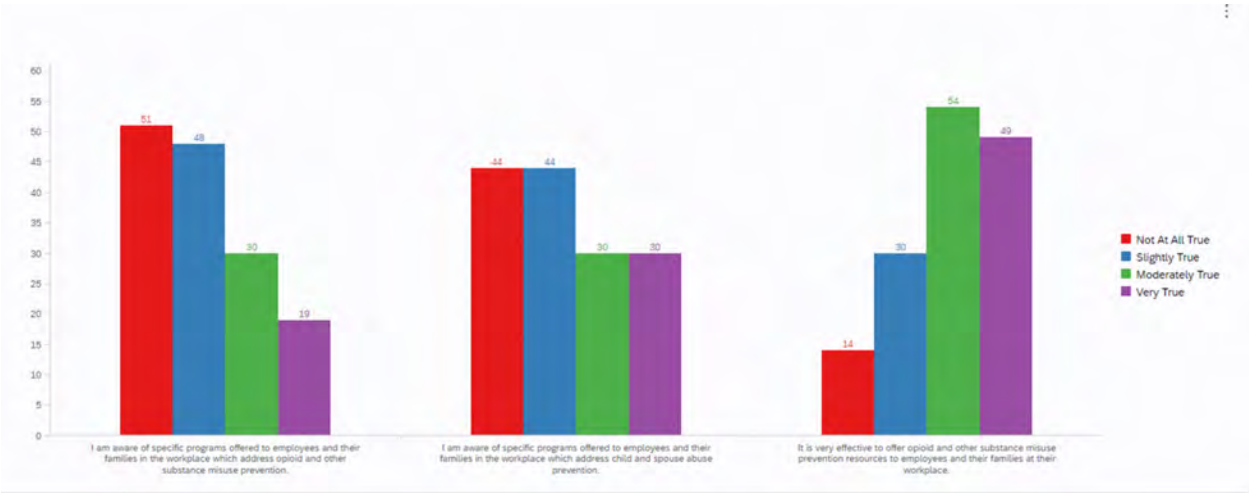

Not At All True
Slightly True
Moderately True
Very True
Don't Know Enough to Respond

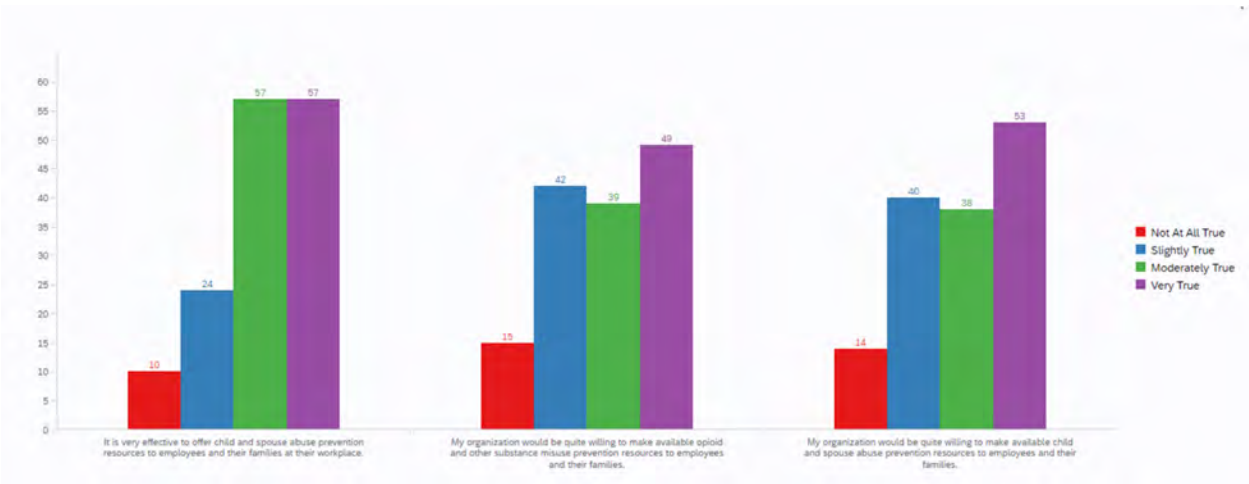

Not At All True
Slightly True
Moderately True
Very True
Don't Know Enough to Respond


Decreased A Lot
Decreased a Little
Not Changed
Increased a Little
Increased A Lot
Don't Know Enough to Respond


Decreased A Lot
Decreased a Little
Not Changed
Increased a Little
Increased A Lot
Don't Know Enough to Respond

Personal Opinion





Open-ended Responses

Open question 1: Please share anything else you would like to tell us about your personal concern, knowledge, and involvement in opioid and other substance misuse prevention in the last 12 months.

- I am not aware of any opioid prevention organized activities in our community.
- The last 12 months we have been extremely busy in healthcare dealing with the pandemic which decreases focus on opioid issues
- We talk about it. It appears to be a Monday - Friday concern. The abuse continues positive action needs to be 24/7, 365
- Enforce the law no matter who is involved
- Same as always! SOMETHING needs to be done to help those people on the drug!
- Meth is a severe epidemic and should be addressed too.
- Nearing retirement and it is not high on my short list of priorities although important.
- Involving the schools, where it usually starts
- There has not been any yet that I can remember.
- Don't interfere with physicians and legitimate pain management. Focus on the root causes of drug abuse in general. Stop going after glory and easy targets; try to actually help the community, not help yourself to more attention.
- Wish there were more individuals actually committed to the community needs, the people. not just what they going to get paid and numbers.
- I teach future high school coaches and would like to provide them with the tools to help prevent and identify opioid and other substance misuse within their teams/schools.
- These answers are because of the Series DOPESICK
- I'm already involved in talking circles, AIHRC activities, and am fully aware of our capabilities.
- Have not seen anything asking for involvement from others.

Open Question 2: Please share anything else you would like to tell us about your organization and opioid and other substance misuse prevention.

- I am not familiar with the programs my organization may have. I have not been directly affected by or connected to anyone who has opioid issues.
- Awareness is present.
- Meth is way more serious than opioid use.
- Misuse of opioids and other drugs
- I truthfully do not have any idea how my organization feels about this or if it does anything at all.
- I know we have to pass some sort of thing where they tell us all the names but that’s about it. Employer’s drug quiz also makes drugs sound like a good idea so they may want to change that. Putting things like euphoria or more energy isn’t something that would discourage most people from doing drugs FYI.
- I believe all programs are collaborating their efforts. This is an epidemic proportion.

Open question 3: Please share anything else you would like to tell us about your organization and opioid and other substance misuse prevention, specifically during the last 12 months.

- No idea if anything has changed as I don't know what my organization is fully doing
- I don't see a lot or any posters, newsletter addressing opioids or other drugs misuse
- Again, everybody's collaborating.

Open question 4: Please share anything else you would like to tell us about your personal opinion about opioid and other substance misuse prevention.

- I have no idea what my organization would be willing to do
- I think my organization would make resources available, but I think employees or families would who might need them would be hesitant to use them for fear of reprisal.
- Child and spousal abuse needs more attention. Drug abuse needs more attention. Don't interfere with legitimate pain management.
- I am a limited decision maker on what activities occur by our organization
- via HR and mandatory reporting.
- I believe everybody's willing. Effectiveness? Haven't seen any data to prove that.

Open question 5: Please share anything else you would like to tell us about your feelings about opioid and other substance misuse in your community.

- Cognitive impairment effects on unintentional misuse is a large factor in what I do
- I feel like all long-term opioids should be prescribed by pain clinic physicians.
- This survey is not health literate
- They are present in our community so their influence in the day to day life of our community is constant, because of that personal self development is not a part of the developmental picture.
- If you can't develop in a positive way the personal esteem, self worth suffers greatly. Its painful in every sense.
- Need Law enforcement regardless. Small community everyone know who is but politics and family ties stop real meaningful enforcement
- We need some place for your youth to go. I know there are lots of youth in our area that is watching their parents do this and when they ger old enough they try it and some like it. as early as 12 year old. we need help here.
- SOMETHING needs to be done! Its ruining families and people!
- I know about emergency overdose treatment like Narcan but not about long-term programs
- Opioids should not be combined with other substance abuse issues. There should be separate resources.
- It leads to suicide and child endangerment.
- I sense a general apathy towards the programs because success rates are not published or widely known.
- Making the community aware, signs, symptoms and referrals to drug rehabs
- Already a part of another Substance Abuse Prevention Coalition. Could these work together?
- METH SALES IS ONE OF THE BIGGEST PROBLEMS IN THIS COMMUNITY; ZERO PREVENTION TO MY KNOWLEDGE
- I am aware of AA classes that occur in my community but I am not aware of opioid misuse classes or if my community has them.
- Normalize substance abuse so those with struggles don't feel ashamed asking for help
- I'd be interested in knowing about resources to help parents of children I serve b-5.
- I believe that the use of opioids and other substance misuse is far more common than most people would like to believe. As someone who has been directly affected by another's substance abuse, I wish there were more quality programs in our area.
- I am aware that there are programs available for substance abuse of all types. I do not personally have anything to do with them, but am willing to help where help is needed. I like knowing there are resources for people who need assistance, as we all need to help each other through this world of ours.

- I think it's an important issue, but I think alcohol and other substance abuse is just as important in our communities.
- Legitimate users should not be stigmatized or targeted for your "help". Not everyone using opiates is using them recreationally, and official definitions of "abuse" are WRONG when they are targeting people like a disabled firefighter injured in line of duty who relies on patches, pills, and fentanyl pops to be able to make it through the day and do basic things like go to the bathroom unassisted and with dignity. This anti-opiate FAD has injured people and caused hardworking, honest men and women to go without adequate pain control or turn to illegal substances such as heroin. You should be ashamed of yourself if you have contributed to this situation. Stopping drug abuse is a worthy cause if you address the ROOT PROBLEMS that lead to drug abuse. When you are targeting the elderly and disabled and interfering with pain management, you're just a garden-variety virtue-signaling a**hole picking low-hanging fruit over what you've framed as an apple-pie issue. You're a self-aggrandizing bully. REMEMBER: when mice are given an enriched environment, they DO NOT abuse drugs. So much of what you people say and believe are absolute lies, and you hurt the very people you pretend that you want to help. Do better. Be better.
- Would like more community awareness and prevention activities that would serve larger numbers of people, not only certain number or specific age groups and services that would concentrate on the family as a whole.
- If I had the time and knowledge, I would be happy to be involved, but I have neither at this current point in my life.
- There’s no place to bring expired pills so they just sit around maybe the communities can work on that. AND make it so its not between 8-5 when I am working and can’t drop anything off.
- I am new to the community and therefore do not know much about services and programs offered.
- I am not aware of opioid or other substance misuse in the community - not even sure of the numbers. Seems like it's an issue in other areas, not here. Don't know if that's true.
- This is a side note: DOPESICK series (I think on Hulu or Prime) was very eye-opening for me personally.
- It has our Child and Family Services Program up to their ears with children
- More people and programs need to be involved in working together.
- Youth have access to opiods and substances at a young age, need to educate at a young age to deter them in the future

Appendix 7: Data Sources

Direct sources for secondary data in this report include US Census, American Community Survey, and the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) Dashboard. Indirect sources for secondary data include County Health Rankings and Roadmaps as well as the NNRHN's subscription to SparkMap.org. More Information about these key resources can be found below:

Nebraska Behavioral Risk Factor Surveillance System (BRFSS) Dashboard:

As noted on its website, "The BRFSS is a random-digit dialed telephone health survey of non-institutionalized adults 18 and older. Data are collected annually by landline and cellular telephone following data collection methods established by the CDC. Within this dashboard application, BRFSS data for years 2011-2019 are presented for the State of Nebraska overall as well as by geographic region and demographic population."

American Community Survey(ACS)

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different ("Understanding the ACS: The Basics").

US Census Bureau

The U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The census collects information about the age, sex, race, and ethnicity of every person in the United States. Race and ethnicity (Hispanic origin) are collected as two separate categories in the US Decennial Census based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the 2010 Census are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity.

County Health Rankings and Roadmaps(CHR)

CHR provide detailed information on the sources of data for the key measures. As noted on their website, they, "where possible…provide the margins of error (95% confidence intervals) for our measure values." This source was used to obtain trend data on a county level, as CHR has been gathering this data since 2011 and continues to make this historical data available.

SparkMap

Maps used in the main body of the CHNA, as well as in the indicators tracked in the Clear Impact Scorecard are being utilized to visualize this data because SparkMap hosts these dynamic maps and updates the data regularly. Therefore the links provided can be used to obtain maps with current data. Information about the data included in SparkMap maps and charts, , including especially when the data for various indicators was last updated, can be found at this link.

Note: Much of the data referred to in this Community Health Needs Assessment will be updated via these and other data sources and will be reported in the network Clear Impact Scorecards, including one or more to be produced based on the Community Health Improvement Plan.

Appendix 8: Healthcare Workforce Additional Statistics

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians, the rate of uninsurance, financial hardship, transportation barriers, cultural competency, and coverage limitations affect access.

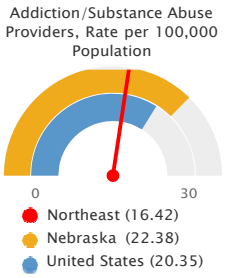
Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions.

Access to Care - Addiction/Substance Abuse Providers

This indicator reports the number of providers who specialize in addiction or substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The providers include Doctors of Medicine (MDs), Doctor of Osteopathic Medicine (DOs), and other credentialed professionals with a Center for Medicare and Medicaid Services (CMS) and a valid National Provider Identifier (NPI). The number of facilities that specialize in addiction and substance abuse treatment are also listed (but are not included in the calculated rate). Data are from latest Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) Downloadable File.

Within the report area there are 5 providers who specialize in addiction or substance abuse. This represents 16.42 providers per 100,000 total population.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Northeast Nebraska Rural Health Network	30,456	2	5	**16.42**
Thurston County, NE	6,773	2	5	73.82
	8,380	0	0	0.00
	5,606	0	0	0.00
	9,697	0	0	0.00
Nebraska	1,961,504	105	439	22.38
United States	334,735,155	15,157	68,113	20.35



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). May, 2021. Source geography: Address

View larger map

Addiction/Substance Abuse Providers, CMS NPPES May, 2021

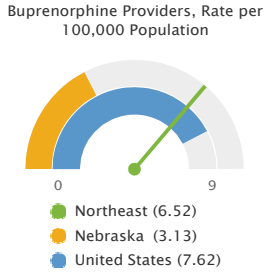
Addiction/Substance Abuse Providers, CMS NPPES May, 2021
Northeast Nebraska Rural Health Network

Access to Care - Buprenorphine Providers

Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Qualified physicians are required to acquire and maintain certifications to legally dispense or prescribe opioid dependency medications. The table below shows the number of providers authorized to treat opioid dependency with buprenorphine based on the latest available data from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Within the report area there are 2 providers treating opioid dependency with buprenorphine. This represents 6.52 providers per 100,000 total population.

Report Area	Total Population (2017)	Buprenorphine Providers, Number	Buprenorphine Providers, Rate per 100,000 Population
Northeast Nebraska Rural Health Network	30,670	2	**6.52**
Cedar County, NE	8,515	0	0.00
Dixon County, NE	5,746	0	0.00
Thurston County, NE	7,196	2	27.79
Wayne County, NE	9,213	0	0.00
Nebraska	3,831,894	120	3.13
United States	649,971,078	49,551	7.62



Note: This indicator is compared to the state average.
Data Source: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Feb. 2022. Source geography: Address

View larger map

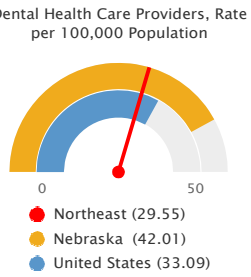
Physicians Authorized to Treat Opioid Dependency with Buprenorphine, SAMHSA Feb. 2022

Physicians Authorized to Treat Opioid Dependency with Buprenorphine, SAMHSA Feb. 2022
Northeast Nebraska Rural Health Network

Access to Care - Dental Health Providers

This indicator reports the number of oral health care providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist", "general practice dentist", or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Northeast Nebraska Rural Health Network	30,456	4	9	**29.55**
Thurston County, NE	6,773	1	4	59.06
Cedar County, NE	8,380	1	1	11.93
Dixon County, NE	5,606	2	1	17.84
Wayne County, NE	9,697	0	3	30.94
Nebraska	1,961,504	247	824	42.01
United States	334,735,155	50,377	110,751	33.09



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). 2021. Source geography: Address

View larger map

Dental Health Care Providers, CMS NPPES May, 2021

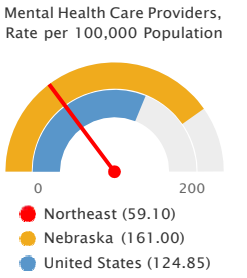
Dental Health Care Providers, CMS NPPES May, 2021
Northeast Nebraska Rural Health Network

Access to Care - Mental Health Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in mental health. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counselling, or child, adolescent, or adult mental health. The number of facilities that specialize in mental health are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Within the report area there are 18 mental health providers with a CMS National Provider Identifier (NPI). This represents 59.10 providers per 100,000 total population.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Northeast Nebraska Rural Health Network	30,456	4	18	**59.10**
Cedar County, NE	8,380	0	1	11.93
Dixon County, NE	5,606	1	1	17.84
Thurston County, NE	6,773	2	12	177.17
Wayne County, NE	9,697	1	4	41.25
Nebraska	1,961,504	649	3,158	161.00
United States	334,735,155	53,023	417,923	124.85



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). May, 2021. Source geography: Address

View larger map

Mental Health Providers, All, CMS NPPES May, 2021

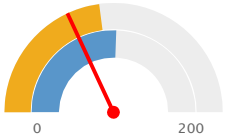
- Mental Health Providers, All, CMS NPPES May, 2021
- Northeast Nebraska Rural Health Network

Access to Care - Primary Care Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The number of facilities that specialize in primary health care are also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Northeast Nebraska Rural Health Network	30,456	6	22	**72.24**
Thurston County, NE	6,773	2	11	162.41
Cedar County, NE	8,380	3	4	47.73
Dixon County, NE	5,606	0	1	17.84
Wayne County, NE	9,697	1	6	61.87
Nebraska	1,961,504	524	1,797	91.61
United States	334,735,155	115,804	342,350	102.27

Primary Care Providers, Rate per 100,000 Population



- Northeast (72.24)
- Nebraska (91.61)
- United States (102.27)

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). May, 2021. Source geography: Address

View larger map

Primary Care Physicians, All, CMS NPPES May, 2021

- Primary Care Physicians, All, CMS NPPES May, 2021
- Northeast Nebraska Rural Health Network

Federally Qualified Health Centers

This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Within the report area, there are no Federally Qualified Heath Centers. As can be seen in the map below, there are FQHC's on the northern border of the health district, as well as one just southwest in Norfolk, NE

Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. September 2020. Source geography: Address

View larger map

Federally Qualified Health Centers, POS September 2020

Federally Qualified Health Centers, POS September 2020
Northeast Nebraska Rural Health Network

Health Professional Shortage Areas - All

This indicator reports the number and location of health care facilities designated as "Health Professional Shortage Areas" (HPSAs), defined as having shortages of primary medical care, dental or mental health providers. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Within the report area, there is a total of 9 Health Professional Shortage Areas (HPSAs).

Report Area	Primary Care Facilities	Mental Health Care Facilities	Dental Health Care Facilities	Total HPSA Facility Designations
Northeast Nebraska Rural Health Network	3	3	3	9
Cedar County, NE	1	1	1	3
Dixon County, NE	0	0	0	0
Thurston County, NE	2	2	2	6
Wayne County, NE	0	0	0	0
Nebraska	97	76	75	248
United States	3,979	3,617	3,432	11,028

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. May 2021. Source geography: Address

View larger map

Facilities Designated as HPSAs, HRSA HPSA Database May 2021

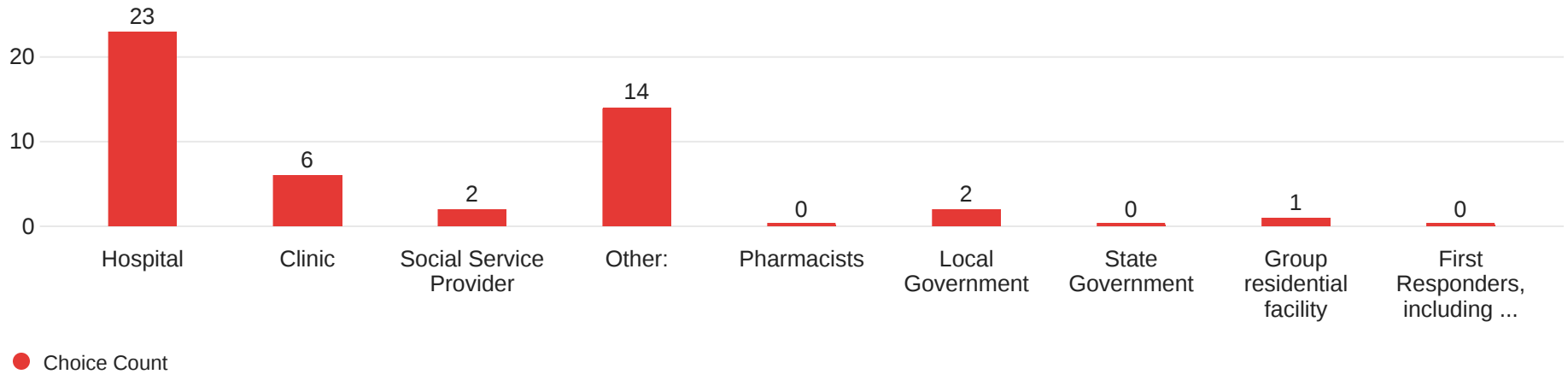
- Primary Care
- Mental Health
- Dental Health
- Northeast Nebraska Rural Health Network

https://sparkmap.org, 5/16/2022

Appendix ϕ: Community Resource Inventory Survey Results

Types of Respondents

48 Responses

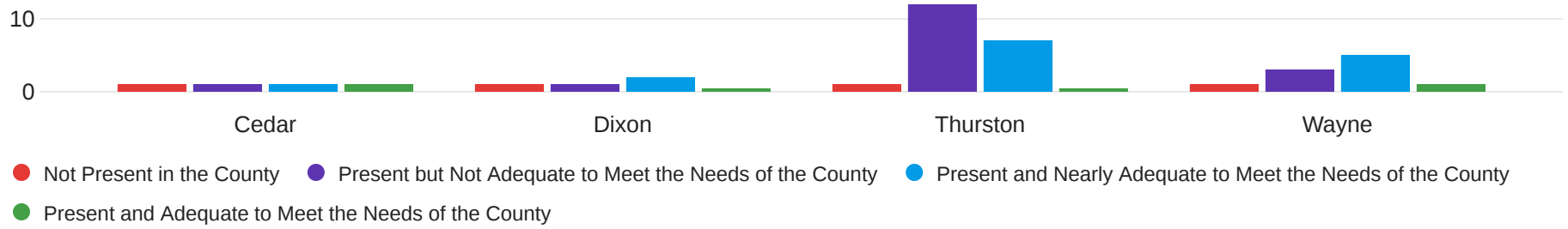


Other:

Other: - Text
LTC
LTCF
Tribal Public Health Department
Public Health Department
Public Health
tribal

Emergency Economic Assistance

25 Responses

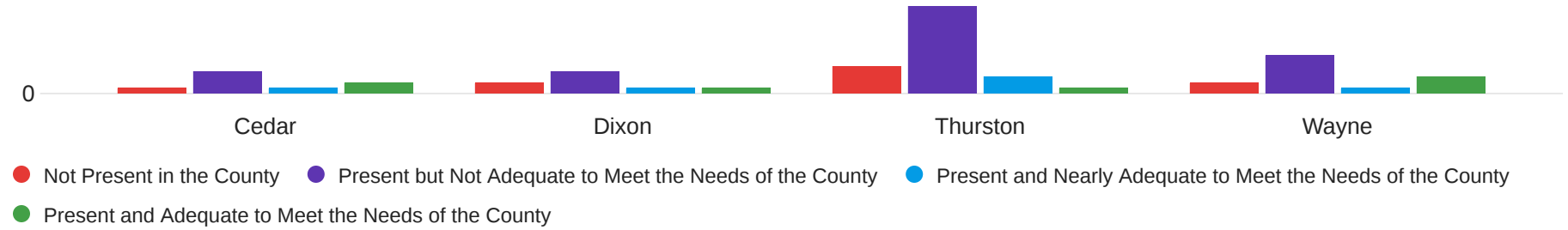


Comments. Please include information about specific resources, especially those that may not be well known.

Medicaid Waiver- meets the needs of the applicant but does not of the facility
I worry about families that are short on food
Some of these services provided through Winnebago Human Services Department
i dont know what services the counties have available for tribal members living in winnebago,thurston county

3 - Safe Affordable Housing(This refers to availability of housing, as well as...

33 Responses



Comments. Please include information about specific resources, especially those that may not be well known.

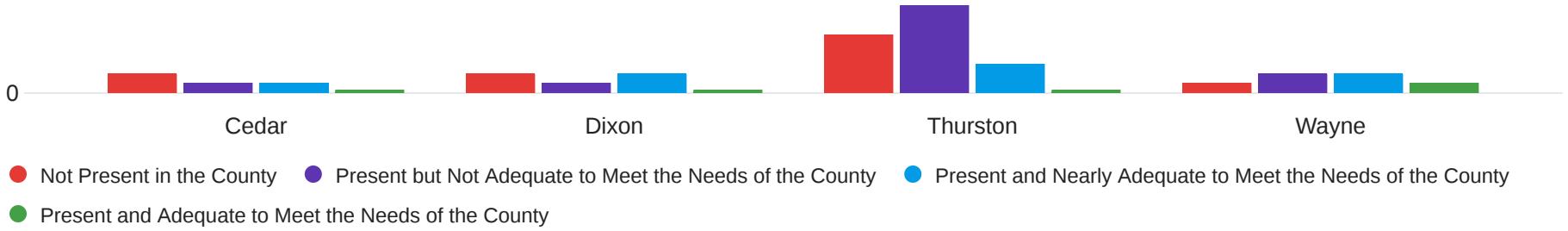
Housing is high in Pender

Severe shortage of housing. All rental housing in Winnebago have long wait lists.

no housing available affordable or available to single family with children or single people themselves with no children that want a place for themselves

Home Modification (This includes ramps, handrails and other modifications that provide for safety and accessibility.)

20 Responses

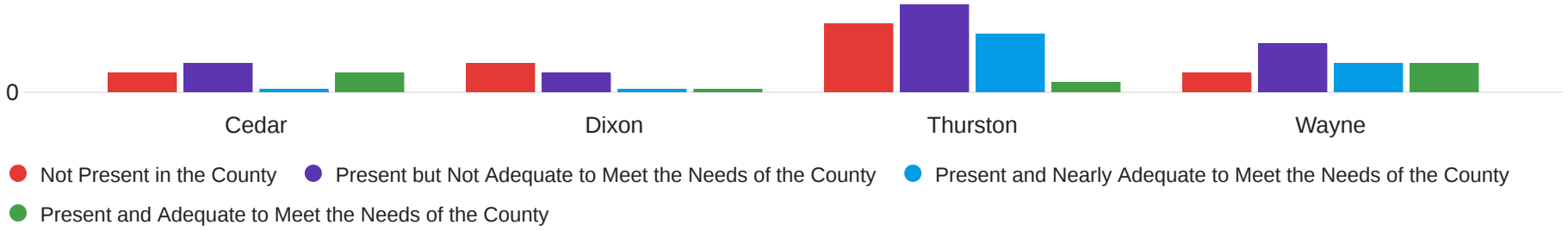


Comments. Please include information about specific resources, especially those that may not be well known.

Very limited assistance available for Winnebago tribal members through the Winnebago Tribe.

Transportation for Medical and Social Service Appointments

33 Responses



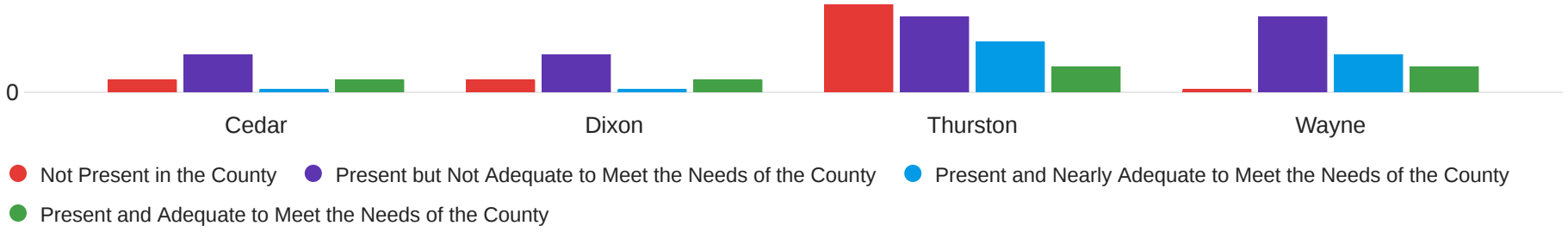
Comments. Please include information about specific resources, especially those that may not be well known.

We utilize the city transportation and Ponca Express.

Transportation is available for tribal members in Winnebago to medical appointments. Provided by the Winnebago Public Health Department.

Bilingual services for Spanish-English

26 Responses

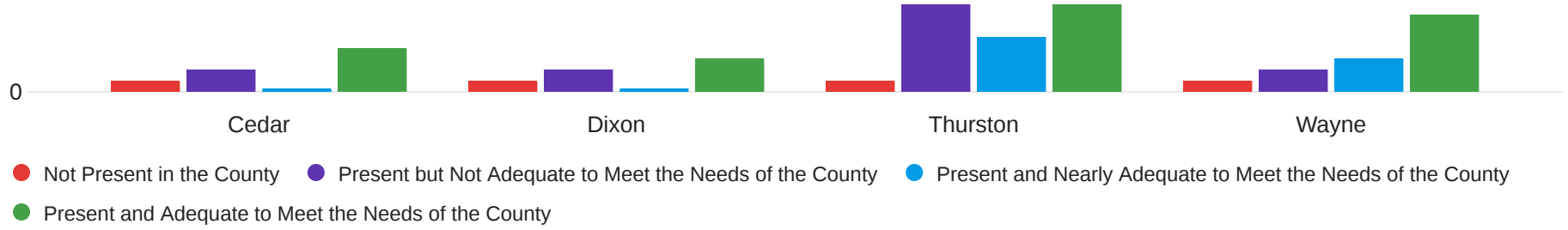


Comments. Please include information about other language resources or needs as well.

Spanish and other language interpretation available through contracted telephone service in ER at hospital.

Emergency Response Resources including Public Health

35 Responses



Comments. Please include any specific information you would like to share about this topic.

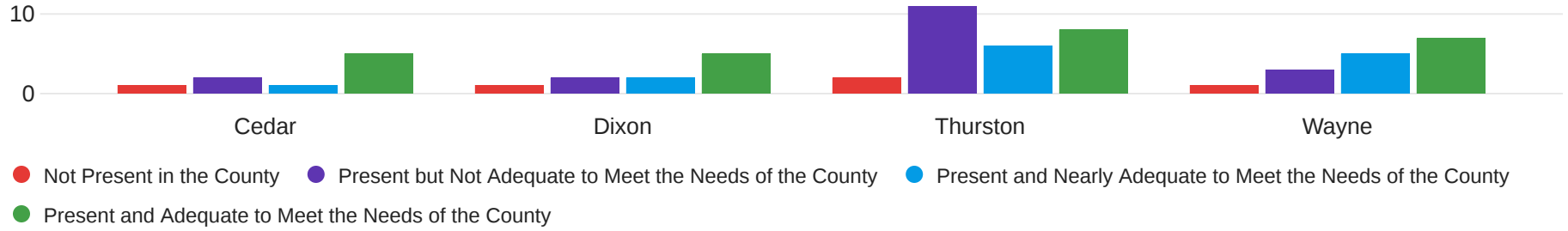
Public Health has been able to help us with needs sufficiently through Covid

A lot of responders are aging and there is a need for younger adults to step up

24/7 BLS EMS service in Winnebago. Limited ALS service recently started. Staffing is limited so if one crew is out, mutual aid must be called for additional needs.

Primary Care Physicians for Adults

35 Responses

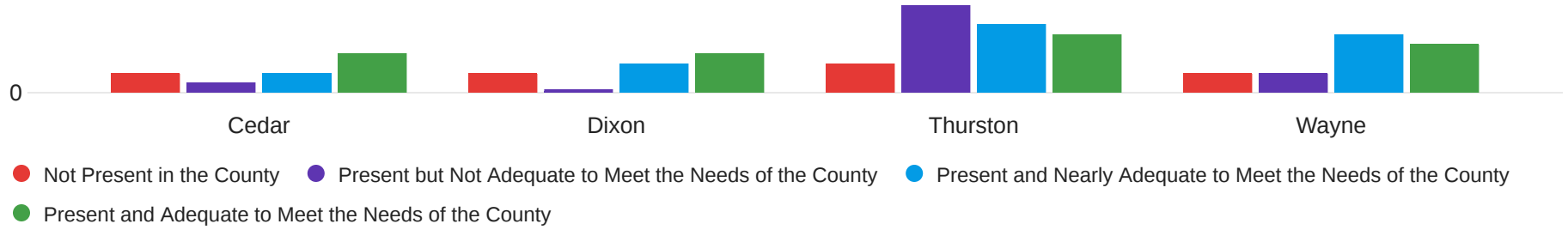


Comments. Please include any specific information you would like to share about this topic.

Primary care clinic at Twelve Clans Unity Hospital is currently staff primarily by NP/PAs. Recruitment for MD/DO staffing is ongoing and difficult.

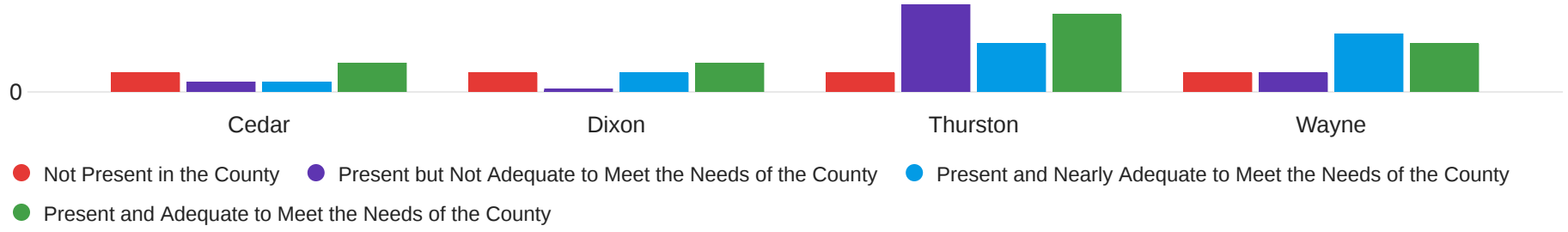
Primary Care Physicians for Children

35 Responses



OB/GYN Services

35 Responses

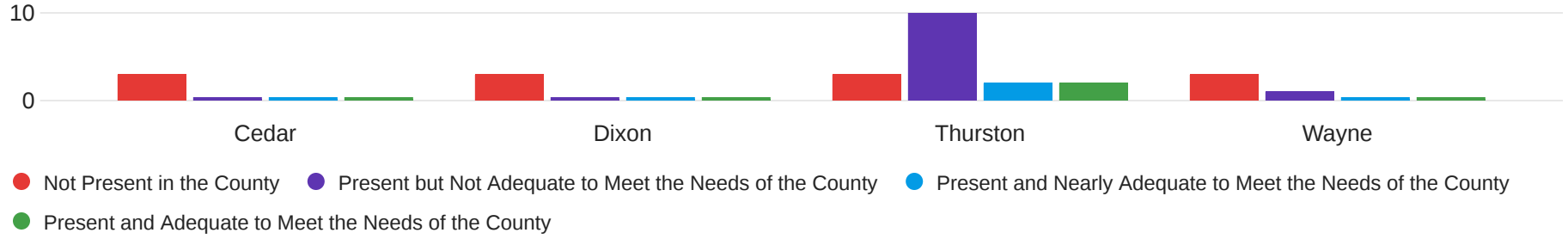


Comments. Please include any specific information you would like to share about this topic.

Twelve Clans Unity Hospital contracts with Siouxland Medical Education Foundation to provide OB/Gyn services for tribal members on a weekly basis at the clinic.

Services for Adolescent Sexual Health (Title X)

19 Responses

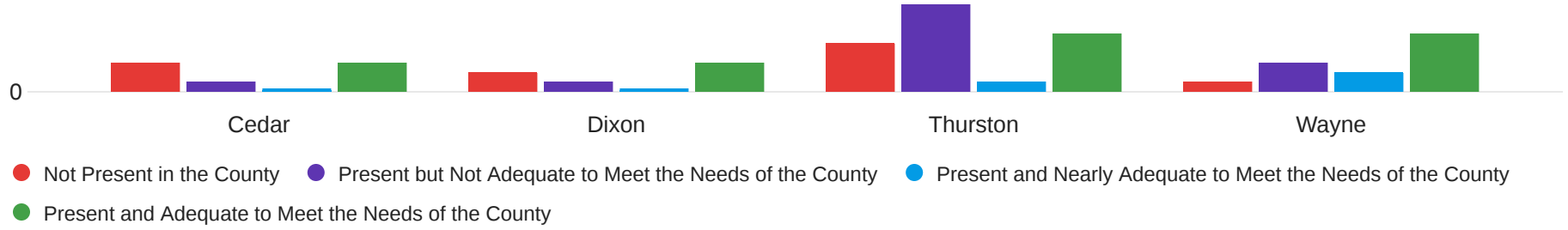


Comments. Please include any specific information you would like to share about this topic.

Education is provided in Winnebago by the Winnebago Public Health Nursing Program.

Cardiology Services

27 Responses

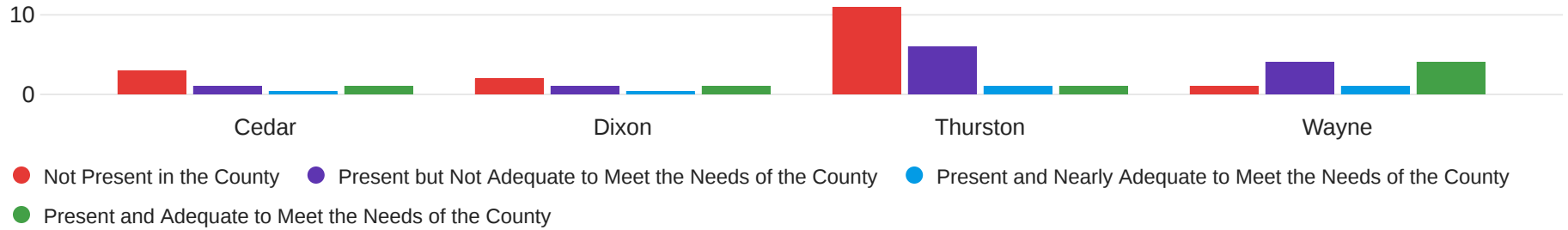


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. Cardiology needs are referred to outside specialists.

Neurology Services

25 Responses

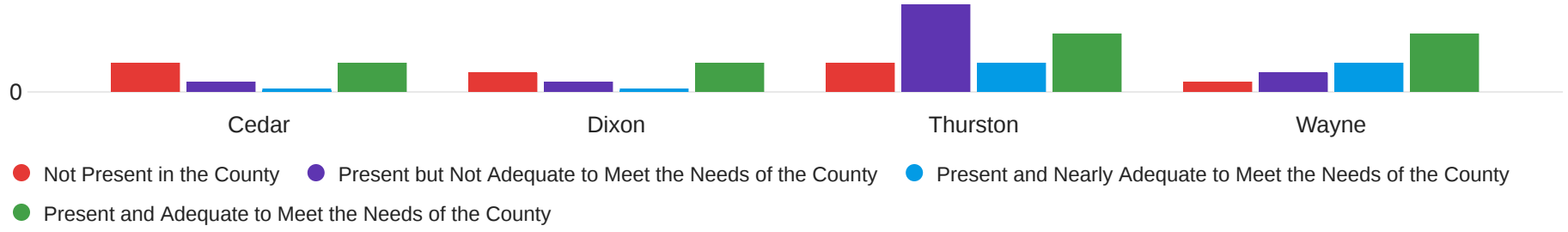


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. This specialty care is referred to outside providers.

Orthopedic Services

27 Responses

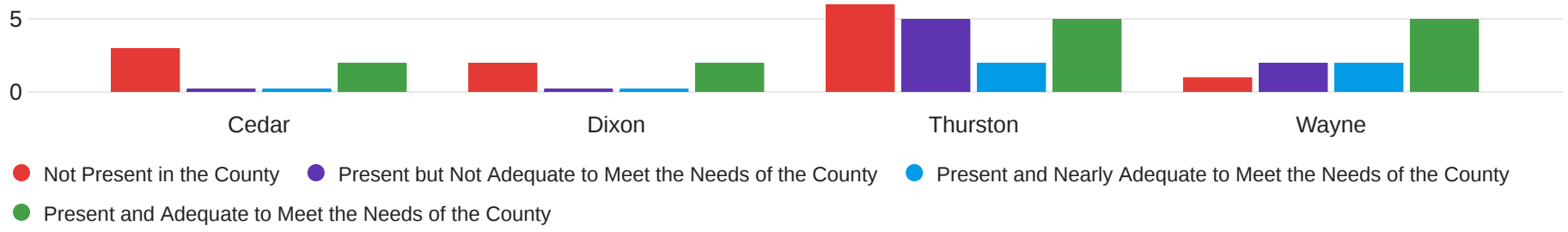


Comments. Please include any specific information you would like to share about this topic.

Twelve Clans Unity Hospital just started a new contract with CNOS to provide a monthly orthopedic clinic in Winnebago. All other needs are referred to outside specialists.

Urology Services

24 Responses

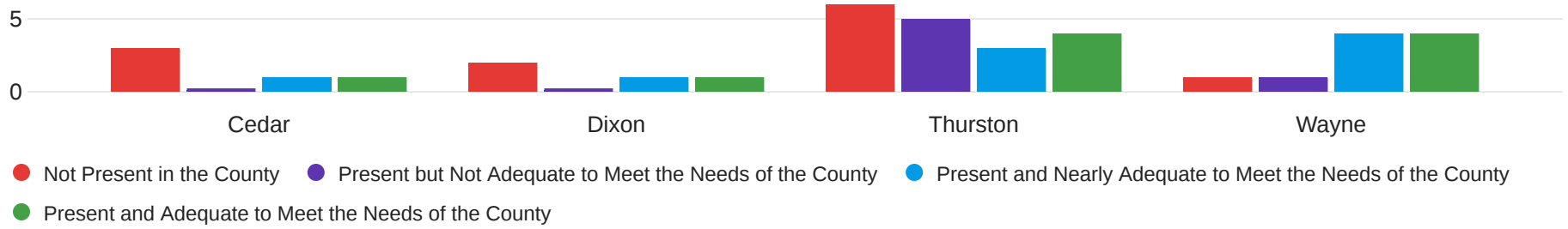


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. This specialty care is referred to outside providers.

Pulmonary Services

24 Responses

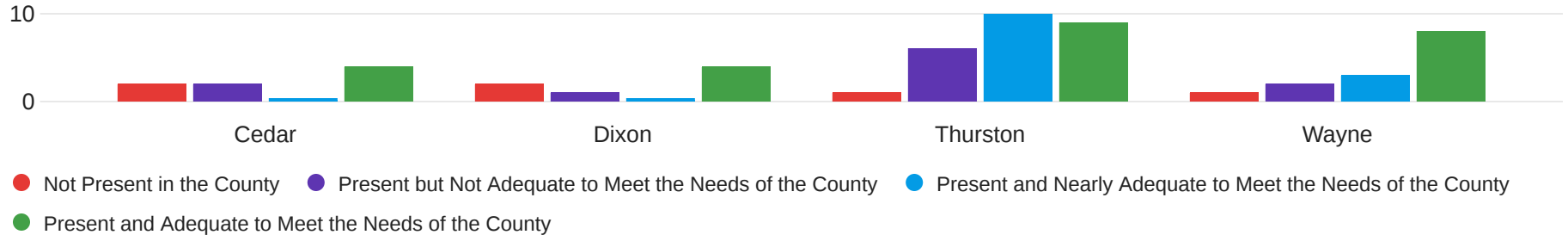


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. This specialty care is referred to outside providers.

Radiology and Imaging Services

33 Responses



Comments. Please include any specific information you would like to share about this topic.

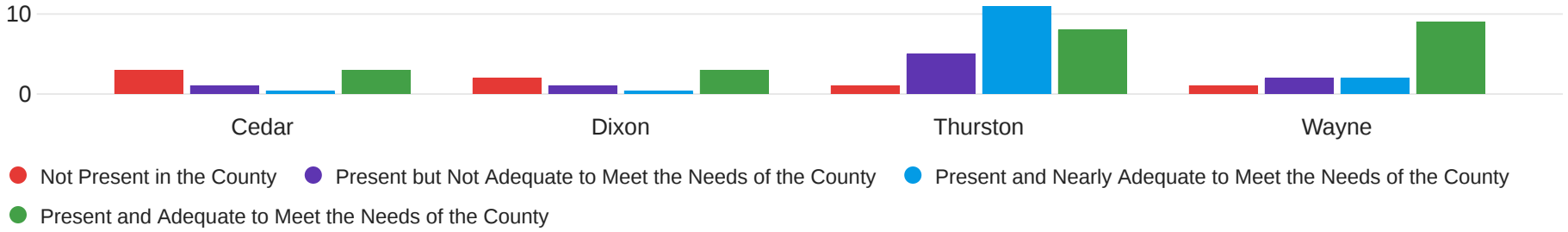
Referring to Winnebago health services

We have openings for these positions at Pender Community Hospital

Radiology and imaging services including ultrasound and mammography is available at Twelve Clans Unity Hospital in Winnebago. If specialty care is needed, this is referred to outside providers. Services are for tribal members.

Mammography

33 Responses



Comments. Please include any specific information you would like to share about this topic.

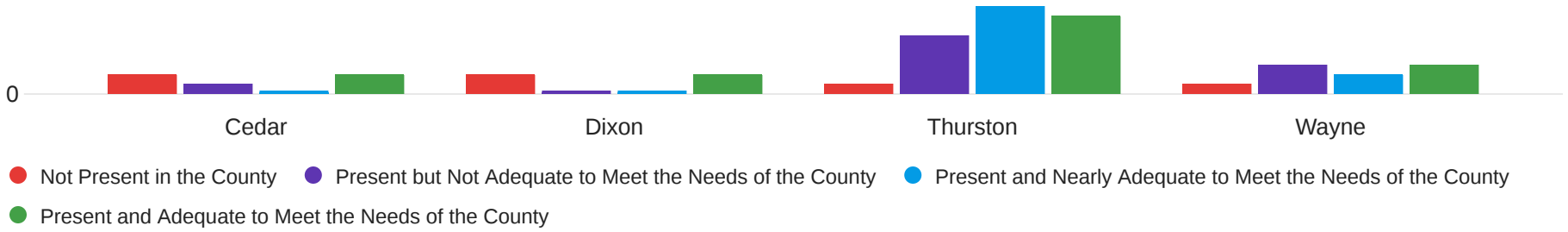
Referring to Winnebago health services

Again openings at PCH

Mammography is available at Twelve Clans Unity Hospital for tribal members.

Diabetes Education

29 Responses



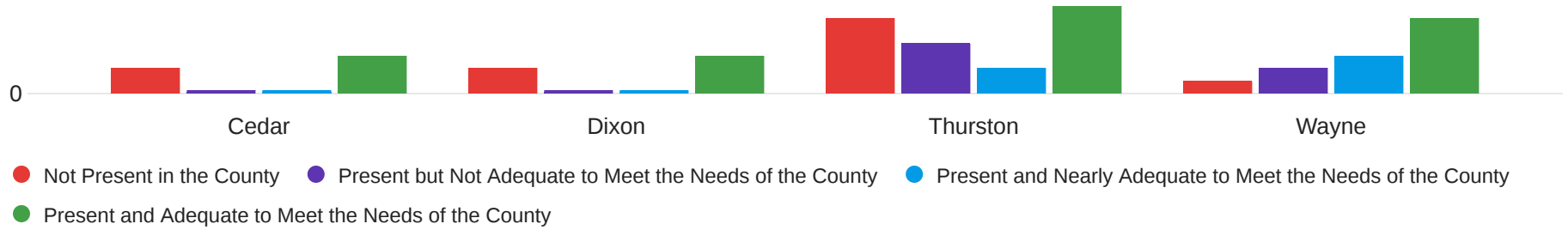
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Diabetes Education is provided for tribal members by the Winnebago Public Health Department. Diabetes rates are high though so more work and more resources are needed to continue to assist with prevention.

Cardiac Rehabilitation

26 Responses

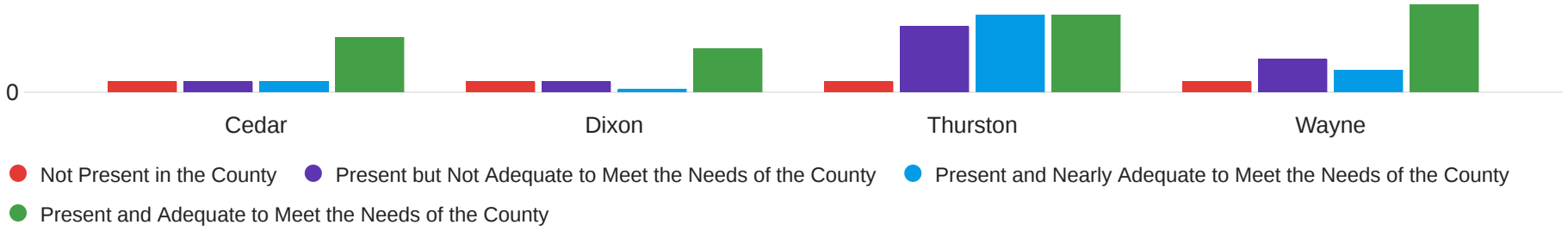


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. This specialty care is referred to outside providers.

Physical Therapy

31 Responses



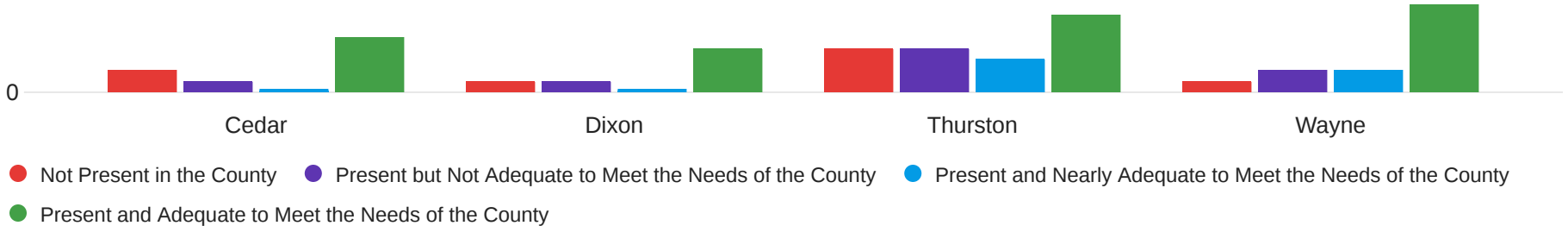
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Physical therapy services are available for tribal members at Twelve Clans Unity Hospital in Winnebago.

Occupational Therapy

27 Responses

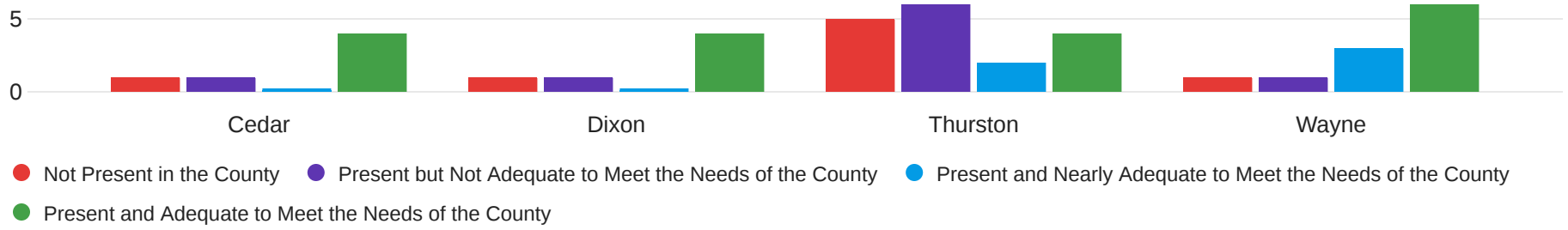


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. This specialty care is referred to outside providers.

Speech Therapy

24 Responses

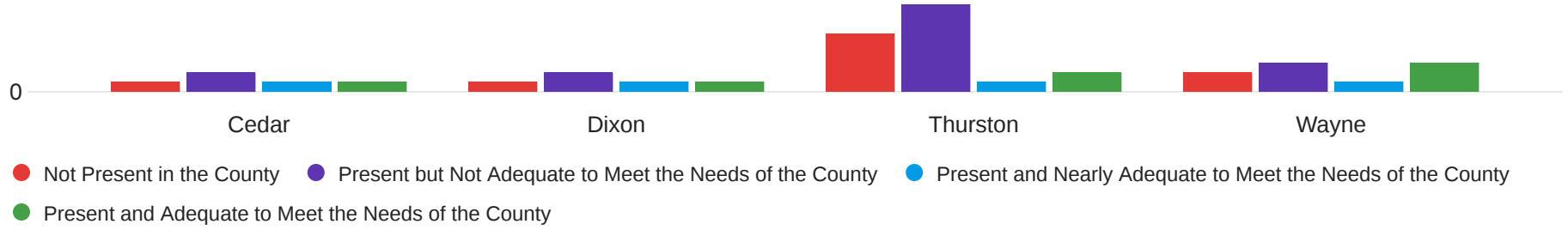


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago. This specialty care is not available through the clinics in Winnebago.

Respite Care for Adults

22 Responses



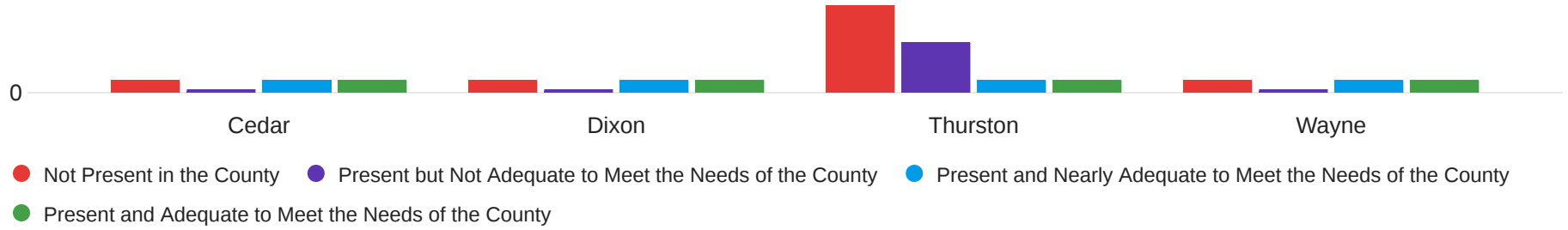
Comments. Please include any specific information you would like to share about this topic.

An adult daycare may be beneficial for seniors and caregivers

Answer is limited to Winnebago.

Respite Care for Children

13 Responses

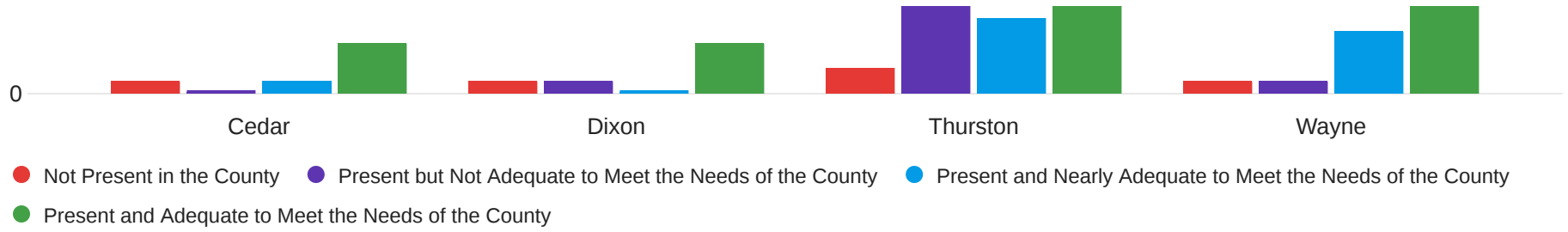


Comments. Please include any specific information you would like to share about this topic.

Answer is limited to Winnebago.

Dental Care Services for Adults

32 Responses



Comments. Please include any specific information you would like to share about this topic.

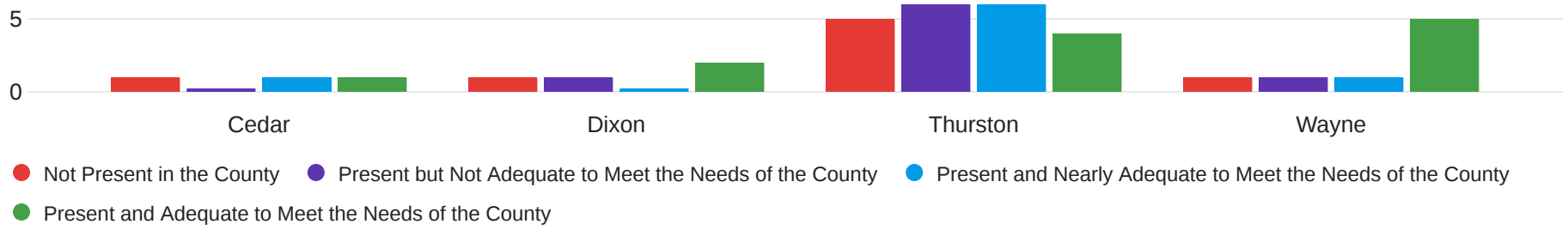
Referring to Winnebago health services

Winnebago Dental Clinic provides this service in Winnebago.

[redacted]

Dental Care Services for Children (Pediatric Dentistry)

26 Responses



Comments. Please include any specific information you would like to share about this topic.

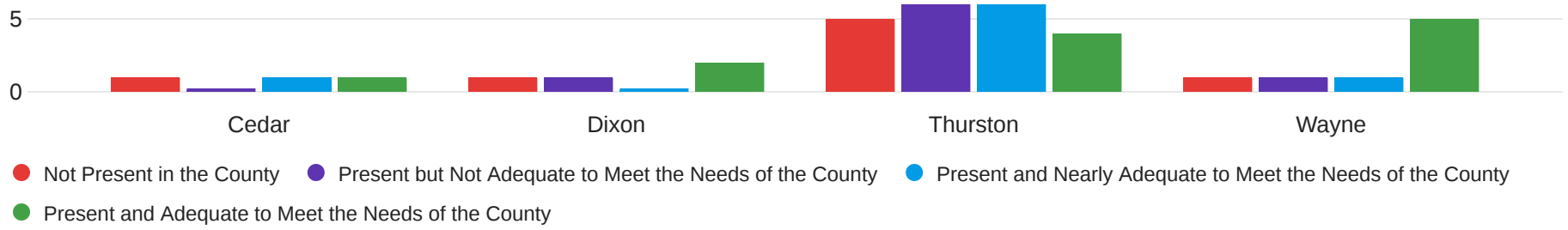
Referring to Winnebago health services

Winnebago Dental Clinic provides this on a limited basis in Winnebago. Specialty needs are referred to outside providers.

[redacted]

Dental Care Services for Children (Pediatric Dentistry)

26 Responses



Comments. Please include any specific information you would like to share about this topic.

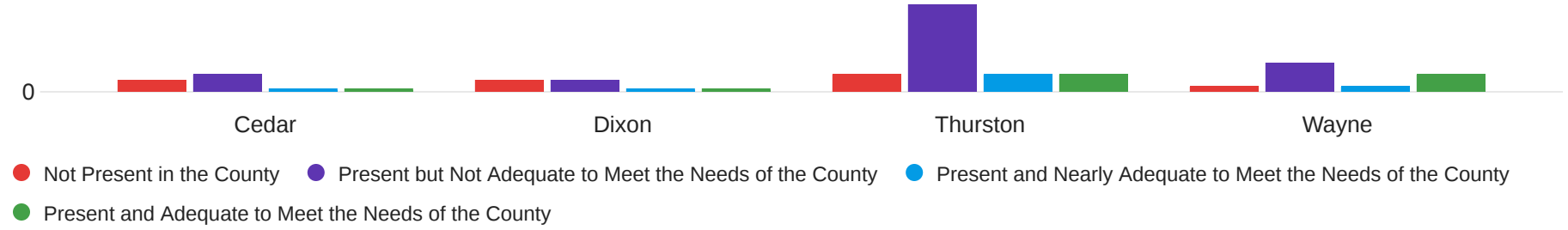
Referring to Winnebago health services

Winnebago Dental Clinic provides this on a limited basis in Winnebago. Specialty needs are referred to outside providers.

[redacted]

Behavioral Health Services

30 Responses



Comments. Please include any specific information you would like to share about this topic.

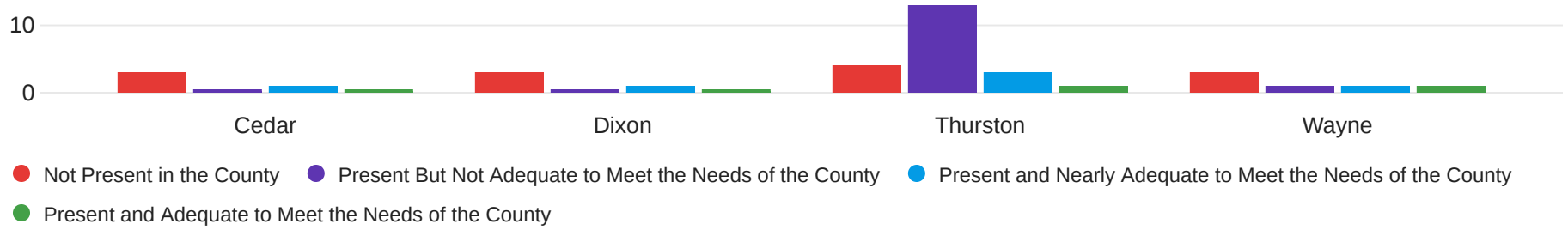
Referring to Winnebago health services

Winnebago Behavioral Health Program provides outpatient therapy services. Crisis needs for psychiatric evaluations and inpatients services must be referred or transferred out by the ER. This is a significant unmet need for Winnebago.

[redacted]

Substance Abuse Services

23 Responses



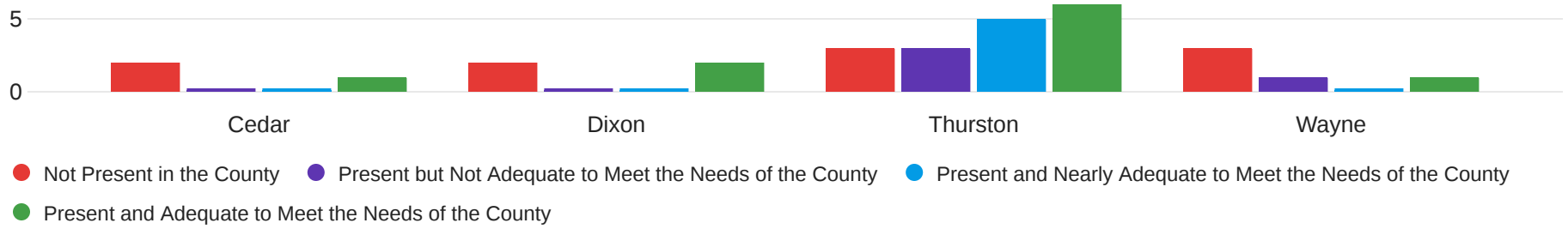
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

The Winnebago Alcohol Program provides outpatient substance abuse treatment services. The IHS Drug Dependency Unit provides inpatient substance abuse treatment but beds are severely limited and this is considered a regional facility. Substance abuse rates are high though so more resources are needed to successfully address this need.

Community Sites for Blood Pressure Checks

19 Responses



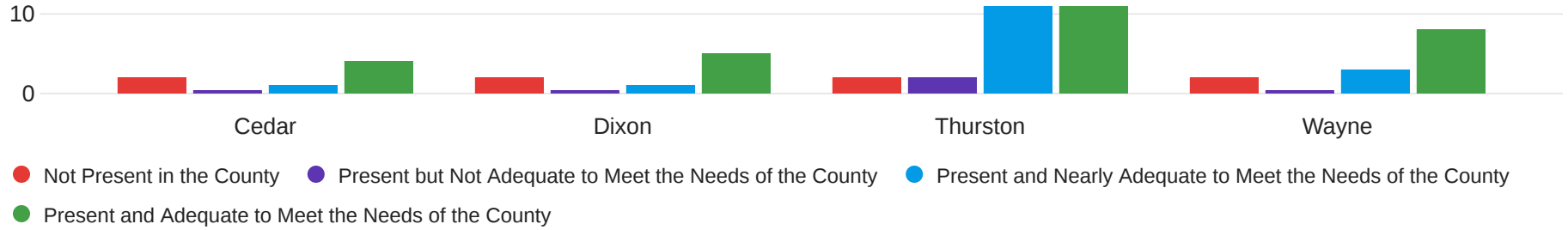
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Answer is limited to Winnebago. The Winnebago Community Health Representative Program is available to do blood pressure checks throughout the Winnebago community and for home visits in Winnebago.

Vaccination Clinics

32 Responses



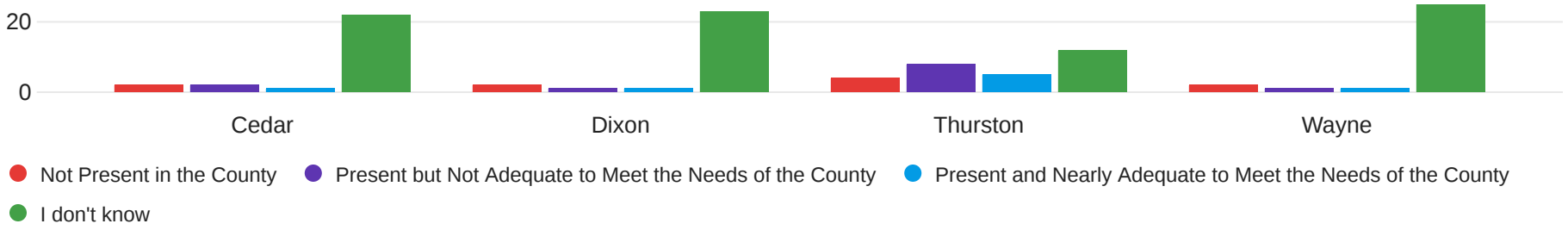
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

COVID-19 and flu vaccine clinics are provided by the Winnebago Public Health Nursing Program for tribal members in Winnebago. Other vaccines are available to tribal members through the Twelve Clans Unity Hospital Outpatient Clinic.

Education for Breast and Cervical Cancer

34 Responses



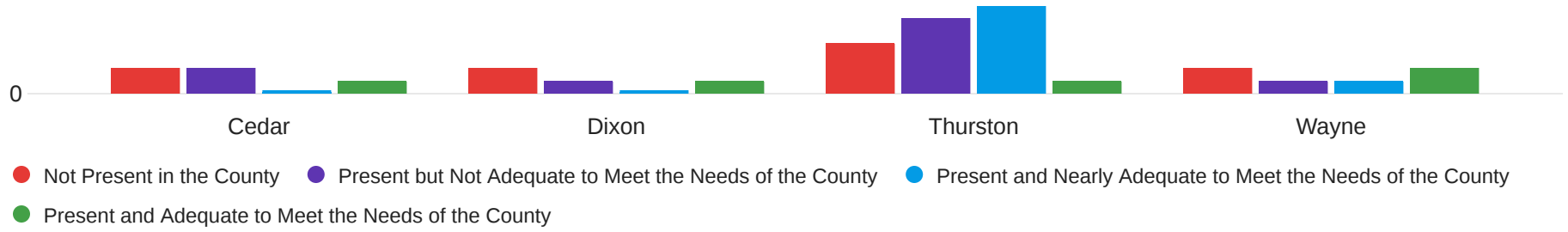
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Education is available through the Winnebago Public Health Nursing Department for tribal members in Winnebago.

Education for Colon Cancer

20 Responses



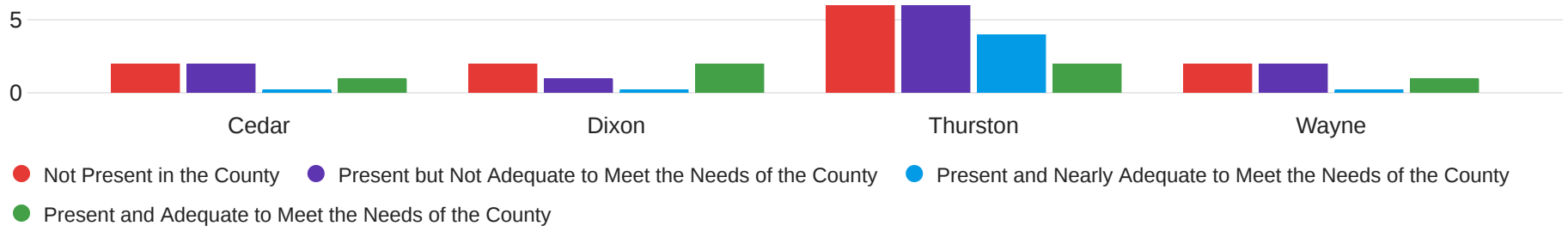
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Education is available through the Winnebago Public Health Nursing Department for tribal members in Winnebago.

Education for Living with Chronic Disease

19 Responses



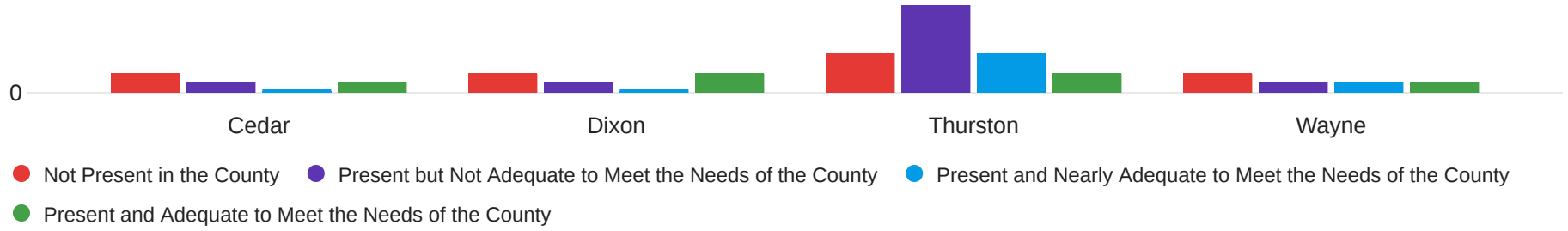
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Education is available through the Winnebago Public Health Nursing Department for tribal members in Winnebago.

Education for Heart Disease

20 Responses



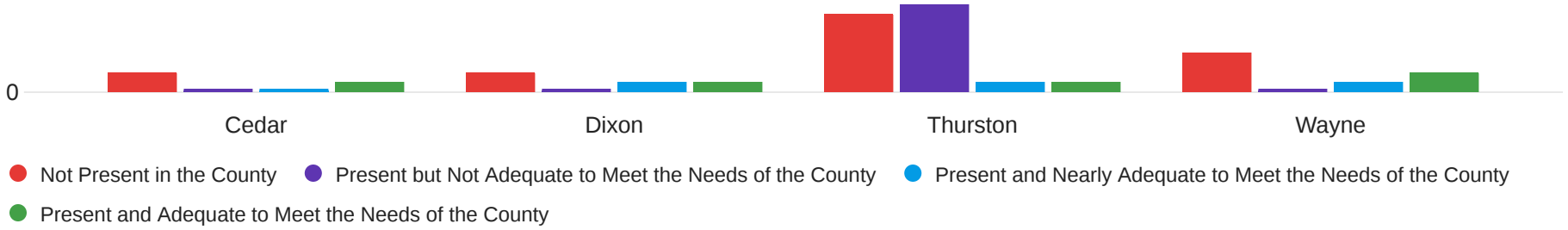
Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Education is available through the Winnebago Public Health Nursing Department for tribal members in Winnebago.

Weight Loss Programing for Adults

23 Responses

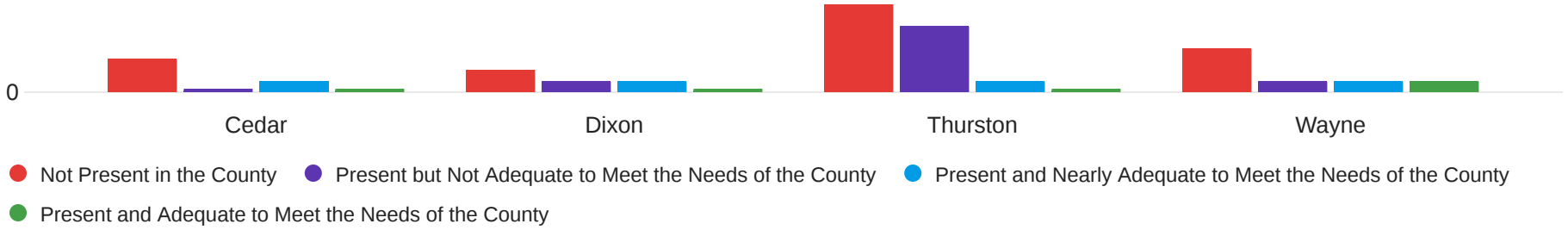


Comments. Please include any specific information you would like to share about this topic.

Nutrition consultation and fitness programs are available for tribal members through the Winnebago Public Health Department.

Weight Loss Programing for Children

20 Responses

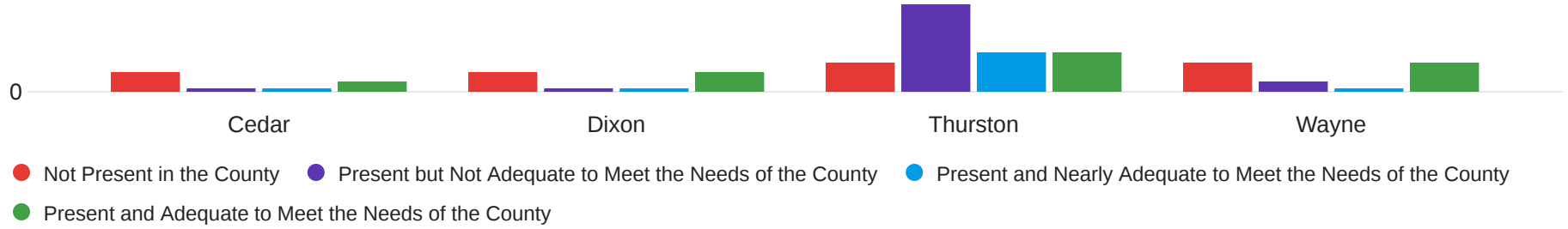


Comments. Please include any specific information you would like to share about this topic.

Nutrition consultation and fitness programs are available for tribal members through the Winnebago Public Health Department.

Diabetes Prevention Education

24 Responses



Comments. Please include any specific information you would like to share about this topic.

Referring to Winnebago health services

Education is available through the Winnebago Public Health Department.

Other Comments:

Referring to Winnebago health services

I believe the providers in these counties can obtain the needed care for their patients through outpatient clinics and referals. I don't expect the dept. of health to do that.

Please add other resources/services in Cedar, Knox, Thurston and Wayne counties.

FORCES OF CHANGE

Northeast Nebraska Rural Health Network

NNRHN

2021 - 2022

intersections consulting
THE ORCHESTRATION OF OUTCOMES

John J. Beranek
605.310.3226 • john@johnspeak.org
6404 West 55th St. • Sioux Falls, SD 57106
www.JohnSpeak.org

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Facilitation and Consulting

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TABLE OF CONTENTS

FORCES OF CHANGE

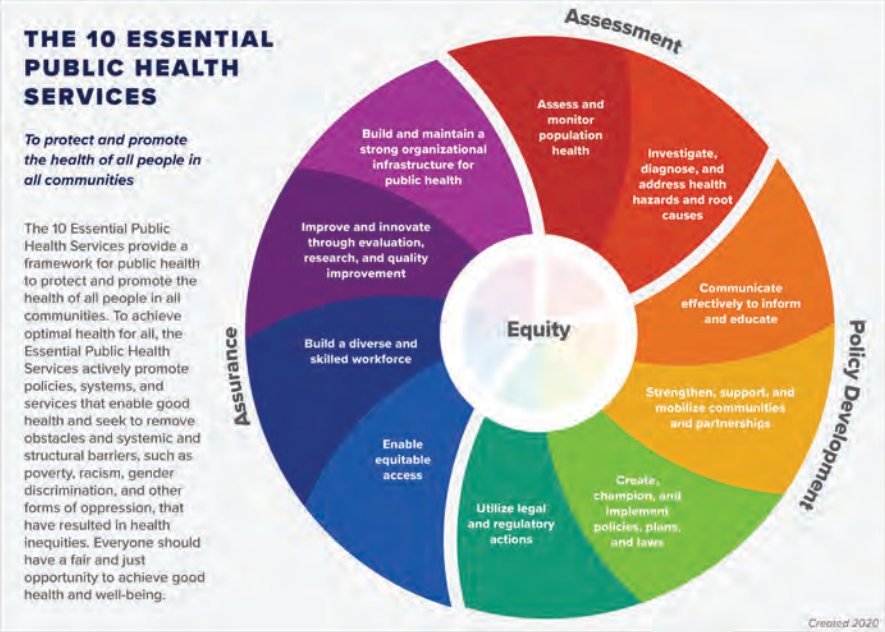
The Northeast Public Health Department, led by Julie Rother, began their community health needs assessment with the Forces of Change kickoff workshop. This meeting was conducted online using Zoom and Miro for data collection. Twenty-six individuals participated in the workshop providing valuable data to inform the community health needs assessment process.

The workshop was facilitated by John Beranek, Intersections Consulting, and Charity Adams, Vision Fusion Consulting.

DETERMINANTS OF HEALTH

Social determinants of health reflect the social factors and physical conditions of the environment in which people are born, live learn, play, work, and age. The workshop design team reviewed the determinants of change adding equity as an additional determinant of health.

The group used the determinants of change to inform there conversations throughout the workshop.



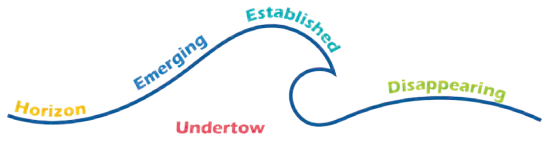
PARTICIPANTS

Lori Steffen
Amanda Kowalewski
Amy Munderloh
Christine Eisenhauer
Jarrett Dittmer
Julie Elbert
Julie Rother
Kathy Nordby
Katie Peterson
Kelsey Linzell
Kim Schultz
Krista Trimble
Kristine Giese
Linae Bigfire
Linda Kleinschmidt
Molly Herman
Mytzy Rodriguez-Kufner
Peggy Triggs
Sandy Williams
Sondra Nicholson
Susan Boust
Valerie Hangman
Heather Hacket
Clara Osten
Jeff Shelton
Peggy Hart

WAVE WORKSHOP

The group was asked to participate in a Wave exercise. The Wave exercise asks the question:

"In the field of community health, what are the incoming and outgoing trends, patterns and innovative approaches?



- What are those things that are on the **Horizon** but are not making waves yet.
- What trends, ideas, practices and approaches are **Emerging** and beginning to create waves.
- What is **Established** and on the crest of the wave in its current state of fullness and we should keep riding this way.
- **Undertow** - what might drag us down even in the midst of success.
- **Disappearing** - ebbing of the wave, it is flattening out and you can no longer surf on it because it may be outdated or no longer needed.

HORIZON

Which new ideas are pushing/needing to become accepted trends and practices?

- Telehealth
- Sharing information between providers
- Addressing social needs at the doc's office
- More & more providers getting paid by total population health
- Being creative in dealing with staffing shortages
- Maintaining pts at the local hospitals
- Whole health
- Continuity of care
- Empowering the patient
- Develop education for various cultures
- Expanding behavioral health services
- Expanded telehealth services
- Understanding other cultures
- Income based housing - making things more affordable
- Community food banks stationed around Wayne "leave what you can, take what you need"
- Problem with rural elderly access
- Increased focus on social determinant of health
- Outreach and inclusion of ethnically diverse

EMERGING

What trends or practices are picking up momentum and acceptance? What did we learn that we want to keep doing?

- Transportation: community transportation has become more available to citizens
- Access to care: tele-health allowing more people to see providers
- Health literacy has picked up amongst a diverse population

ESTABLISHED

Which trends and practices are mainstream or should remain standard operating procedures? What do we need to keep doing?

- Outreach and education; different avenues of reach
- Providing consistent and transparent information to the community
- Partnerships
- Regular calls with healthcare community to provide updates
- Virtual meetings/teleworking
- Partnerships between public health and local organizations (medical, schools, nonprofits, etc.)
- Infectious disease surveillance
- Health education to provide awareness
- Federal/state/local policies that impact health department abilities (both positive and negative)
- Flow of information/data

WAVE WORKSHOP CONTINUED

UNDERTOW

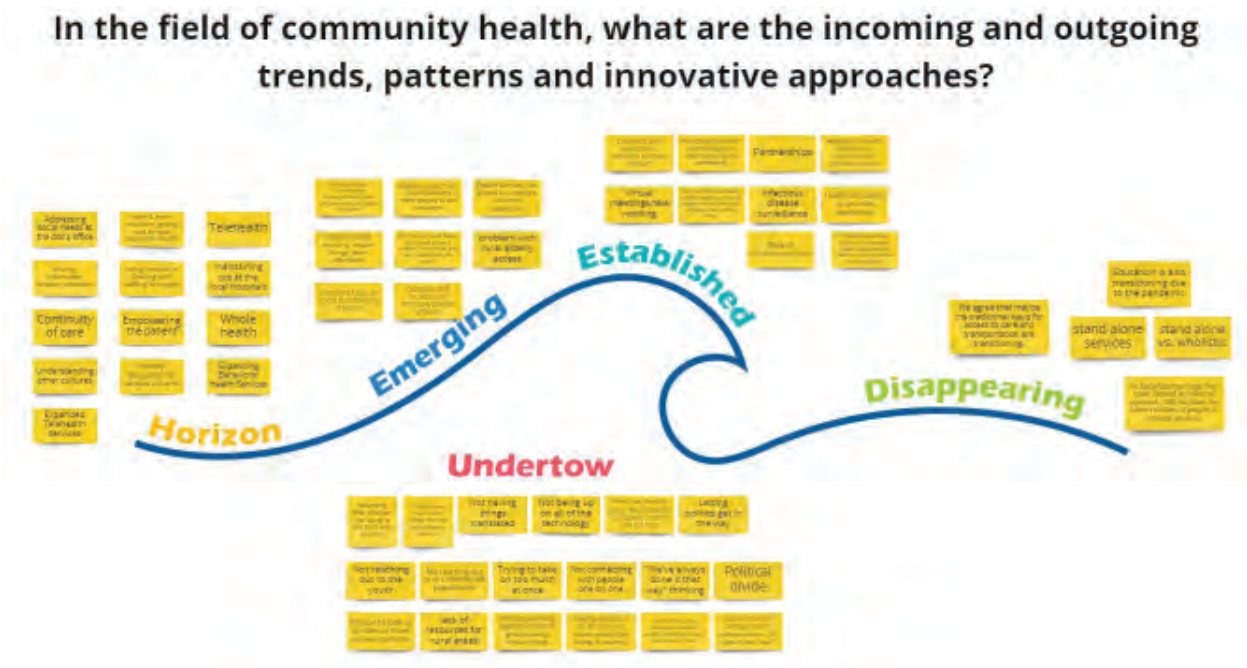
What old patterns could we fall into if we are not careful? Patterns that could cause trouble, even in the midst of success? Things that can drag us down?

- Assuming that what we are doing is the best way to do it
- Thinking we have to do things the way we've always done it
- Not having things translated
- Not being up on all of the technology
- Think we need to solve the problems ourselves / Don't ask for help
- Letting politics get in the way
- Not reaching out to the youth
- Not reaching out to all under-served populations
- Trying to take on too much at once
- Not connecting with people one on one
- "We've always done it that way" thinking
- Political divide
- Refusal to look at all sides or listen to new opinions
- Lack of resources for rural areas
- Difficulty working together-different groups doing similar things
- Poverty-existence of, tendency to blame people for being in poverty
- Lack of focus on education about public health (school, community, etc)
- Rural culture of taking pride in independence--"it's your own fault"

DISAPPEARING

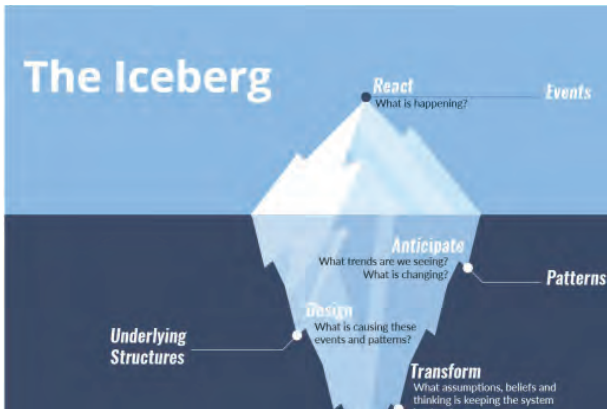
Which practices/trends are no longer relevant or needed? (may be outdated)

- Education is also transitioning due to the pandemic
- We agree that maybe the traditional ways for access to care and transportation are transitioning.
- As baby boomers age they have created an inverted pyramid. Will not have the same number of people to provide services.
- Stand alone services
- Stand alone vs. holistic



ICEBERG

The group reviewed the Iceberg Theory. The Wave process helped the group identify what's happening above the surface while the Iceberg process helped the group identify what's happening below the surface.



ROUND 1

What structures and thinking hold the community back right now?

- Problems with interactive health records -the HIE are clunky, difficult to know what info you can get
- Difficulties with LTC's , not HIE's even if EMR
- Transportation... Community based has to serve everybody. Lack of financial resources vehicles, and drivers.Technology use/knowledge is not as common as we think
- Ease of access to vaccine is not widely understood by minority populations
- Lack of transportation in rural communities
- The notion that "normal" will be the same as pre-pandemic
- Time and resources from staff; not enough to do complete outreach and education
- Socioeconomic status of the community
- Pandemic
- Resources
- Staffing
- Competitive nature of health care
- Fear of change
- Competing priorities/reactionary instead of proactive.
- Lack of trust (individual, community, population, and governmental)
- Adoption of innovation
- Funding
- Blaming people for the situation they are in
- Resistance to change: newcomers aren't "from" here, not thinking like I do
- Individuality amongst shared visions for a town. Not working together when sharing common goal
- Healthcare workers being overworked.
- "We don't want poverty to show here"

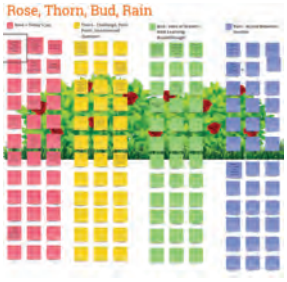
The group closed the Forces of Change meeting with the rose, thorn, bud, and rain reflection process.

ROSE Today's Joy

- Love to hear people's ideas
- It was great to see so many people participate in today's meeting
- Focus on diversity
- Liked this format
- Great meeting
- Seeing so many engaged stakeholders
- Collaboration
- Interactive learning
- Talking to others in a good environment
- Hearing everyone's ideas and seeing the overall picture
- Small group discussions
- Meeting other public health professionals in my area for the first time
- The voices and care of others

THORN Challenge, pain point, unanswered questions

- Keeping the momentum going with this group and process
- Painful to learn new technology quickly
- Finding the really small blue triangles for transitions
- Technology use for certain populations
- Not getting to interact with others in breakouts (while I loved that I had the same partner and enjoyed that too)
- Answering questions in the time allotted

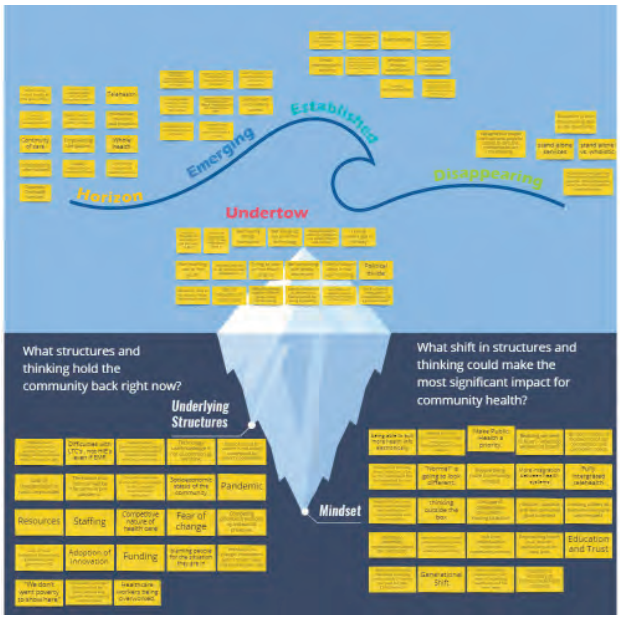


ICEBERG CONTINUED

ROUND 2

What shift in structures and thinking could make the most significant impact for community health?

- Make public health a priority.
- Being able to pull more health info electronically
- Making sure our providers have enough resources to adequately care for its patients
- Realizing we need to listen - where do we learn to listen?
- Be more mindful of the diversity of our communities and everyone's needs
- Change our thinking from "what's in it for us" to "how would this be important for my community".
- "Normal" is going to look different.
- People being more community-minded
- More integration between health systems
- Fully integrated telehealth
- Health officials need one voice messaging and professional communication and dissemination.
- Thinking outside the box
- This type of collaborative discussion - moving to action
- Mindset - curious and less personal goal oriented
- Treating others as humans-everyone with respect
- Diversity in leadership, representation across the community
- Winning doesn't mean someone has to lose-competition isn't always a good thing
- Shift from individualistic mindset to community mindset
- Emphasizing health in all policies, particularly at the local level
- Education and trust
- New standards and mandates changing continuously / how do you plan for post covid world?
- Generational shift
- There is balance between the "old" ways of accessing healthcare and the "new" ways
- Outreach is necessary to promote healthcare initiatives



BUD Area of growth, new learning, breakthrough

- Understand information exchange issue more
- Love the platform you are using
- Made me very happy to live in my community
- Learning new technology!
- Wonderful to hear others are thinking about some of the same things that I am
- Learning MIRO

RAIN Action between sessions

- New people to talk to
- John and Charity did an amazing job running an Online zoom. Kept everyone really engaged in the online environment which isn't easy
- BHECN/ WSC collaboration
- Lots of great things to think on
- More outreach to more people about what we are working on
- Research on areas that peaked interest

ESSENTIAL SERVICES

Northeast Nebraska Rural Health Network

NNRHN

2021 - 2022

intersections consulting
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ESSENTIAL SERVICES 1

MONITOR HEALTH STATUS TO IDENTIFY COMMUNITY HEALTH PROBLEMS
MARCH 8, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- More collaboration with varied partners
- We have started a way to continuously monitor the process and progress
- COVID has increased the communications between partners on infectious disease
- Technology has improved the communications between partners: schools, medical partners, public health, etc.
- More information has gotten out to the Spanish Language Community
- We are using more visual communications than before which simplifies communication for more people
- Active on NEDS, kept up with COVID changes
- Our department able to collect data for COVID and put into graphs and shared with social media.

FALLEN BACK

- Still playing catch-up from COVID disruption
- We have not solved the original problems (responses have been very similar)
- Conspiracy Theorists have challenged our communications of facts Reliable resources are not always included in the discussions to make appropriate changes (Take the easy route rather than the beneficial route.)
- Tracking Flu, etc. had to take a backburner because of COVID

Round 2: What ideas/suggestions do you have to improve this standard?

- Refocusing in a world with covid in it
- Outreach
- Consolidate collaborative efforts
- Work on reaching more groups/partners to inform process
- Communication from public health about positive cases has been helpful.
- COVID guidelines were very helpful (algorithms to use - visual cues)
- People have utilized health information for political purposes.
- Social Media
- People had more access to the vaccine and health care for COVID vaccine and testing
- Standardized Reporting for diseases Enforcement including consequences for not reporting for reportable diseases

Round 3: What will it take to keep making progress with this standard?

- More partner sharing of data
- Partners should know what expectations are
- Would like a data repository for health district data so that everyone can add and use data.
- Use Health Literacy more
- Work together with partners to use health literacy more often
- Meetings about what's new and best practices.
- Meetings to collaborate on what the message is rather than everyone giving a different message.
- Some standardization of health information
- Need to continue to reach Spanish and languages other than English
- Many families do not have Internet or TV at home so do not always have access to the news and messaging - need to learn other ways to get the information to the people
- Need improved transportation systems
- Working on Clear Impact Scorecard that will be available on the net.
- There are standardized ways to report disease, but not all partners follow the standard.
- Education, assistance, and state support on registries!
- Collecting/reviewing data from registries (i.e. ag or others?) That influence/impact health outcomes (i.e. cancer)
- Investigate involvement in a cancer registry

ESSENTIAL SERVICES 2

DIAGNOSE & INVESTIGATE HEALTH PROBLEMS & HAZARDS
MARCH 8, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Good combined effort to share C19 info and resources, across the HD
- Knowing who to reach out to at State level.
- Written policies and procedures to follow during a response have improved.
- Schools are working on emergency response plan updates.
- Increased awareness of the system gaps
- Awareness in the general public (COVID Home tests)

FALLEN BACK

- Lag of reporting in certain situations.
- No noticeable decrease in other pathogens. (just an observation, not necessarily negative)
- Unsure if all agencies have written plans in place in order to respond to an emergency.
- Need to have ongoing community planning and exercising.
- Communication systems need to be improved in order for all partners to be able to communicate via one system.
- Need a communication plan that includes positions from organizations to be contacted in case of emergency.
- Covid #'s challenged the system.
- Supplies for testing, etc. have been difficult. eg. blood lab tubes,
- Have had to send to alternate testing sites due to delays with COVID.

Round 2: What ideas/ suggestions do you have to improve this standard?

- Sharing of hazard vulnerability assessment
- Better assessment of SDOHs
- Better interstate sharing of labs
- Technology has improved communications easier - email groups, meeting attendance, etc.
- Turnover in organizations
- Information is changing so often, it's difficult to keep up.
- Always changing technology so need to learn new methods
- People do not always know how to use technology or have access to it.
- Pull up the reports from the last instances (eg avian flu)
- Work on communication processes
- How can we be more prepared (supplies, processes) for the next surge/ pandemic?
- Look ahead at the types of testing we are going to need.
- Work on public awareness and public education

Round 3: What will it take to keep making progress with this standard?

- Building on partnerships strengthened during covid
- Use the lessons that we were forced to learn
- Develop contingency plans for obstacles
- Preparedness /Legacy Plan
- Engage non-traditional health partners
- How to identify, engage and develop community ownership of programs
- More collaboration and engagement from more community partners.
- Keep pushing education to people (via email groups, etc...)
- Info is needed to the Hispanic Community about community sirens and what they mean.
- Engaging community groups, churches, etc. in this process
- More communication with the community of how to respond or where to go or what to do in emergencies.
- More education on when to go to the hospital.
- Need to figure out how to educate the kids so they have the facts and yet aren't afraid. Make education effective but fun.
- Community Wide Drill
- Increased awareness of public health department, and collaboration
- Reeducating population on the other activities of the health system including screenings
- Looking at how to proceed to normalcy, including promoting cancer screening, etc immunizations, etc.
- More courier support from NE DHHS for transporting specimens from rural health areas to NE Public Health Lab.

ESSENTIAL SERVICES 3

INFORM, EDUCATE & EMPOWER PEOPLE ABOUT HEALTH ISSUES
MARCH 23, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Social media activities have improved for several agencies
- NNPHD Website is easy to navigate
- Overall communication between partners has improved
- type here
- Went from phone calls to a DIS email list at NNPHD
- Group zoom calls from NNPHD
- Agreed on one message with everybody's logo
- Pandemic has helped improve communication among partners

FALLEN BACK

- Getting things out in a timely manner
- Information overload
- Hard to determine the best point of reference
- Have not improved the way we keep contact information updated
- Other emergency plans (in addition to pandemic) have taken a back seat
- Plans we had weren't always followed
- Need dedicated resources for communication challenges

Round 2: What ideas/ suggestions do you have to improve this standard?

- Hire and retain more staff (to help with timely distribution of info)
- Increase funding
- Clarify the role of public health directors vis a vis the governor
- NNPHD assume more directive in time sensitive situations
- Enough staff to handle the communication
- Need Just in Time message premade for all emergencies
- Have regular meetings of identified communications experts in each organization
- Identify high-level topics of messages that are needed for the different types of responses that could occur
- Some organizations may not have the resources such as a communications specialist
- Need to include health literacy
- Things changed very frequently
- Multi-agency guidance did not always match up

Round 3: What will it take to keep making progress with this standard?

- More funding
- Subject matter experts
- Continuity of partnerships
- Develop public health advocates in the community
- Keep reaching out to people in various ways (face to face but also virtual)
- Increase broadband access in rural areas
- Strengthen communication with data sharing between partners
- Be prepared with a plan only change as needed
- Identify consistent contact points
- Never assume that we are on the same page
- Pre-planning is key
- Need to include all partners, local, regional, state & federal in communications planning
- Make sure our communications plans are standardized and we all use that as a starting point for our plans

ESSENTIAL SERVICES 4

MOBILIZE COMMUNITY PARTNERSHIPS TO IDENTIFY & SOLVE HEALTH PROBLEMS
MARCH 23, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Winnebago area has a good network for sharing info between business and health organizations
- Identified key people during the pandemic
- Updated list of community organizations
- Increased facilitated conversations on health
- Health care partners in health district met regularly during pandemic response
- Increased the number and types of community partners (schools, elected officials, etc.) who met regularly during the pandemic
- People realized what public health was due to the pandemic response

FALLEN BACK

- Previous CHIP got interrupted by the pandemic
- Still need to reach under-served communities
- Employee turnover
- Not keeping college students informed.
- Decreased opportunity to meet among partners due to COVID pandemic
- Not all people liked public health due to the pandemic
- Can't get out and meet partners and stop programs during the pandemic

Round 2: What ideas/ suggestions do you have to improve this standard?

- Reaching out to area minority faith leaders
- Connect nnphd to county websites better
- Connect the medical clinic and the hospital
- Common goal of the pandemic response made it easier to come together for a common purpose
- Common calendar of events and activities that partners offer so we can all refer people to the events
- Begin to meet in person again
- Have a balance of in-person and virtual meetings to meet needs of more people

Round 3: What will it take to keep making progress with this standard?

- Setting up specific goals for reaching communities (SMART)
- Patience
- Community feels ownership in programs
- Bring in community leaders
- Repeat what works
- Learn how communication from the state has been working
- Use the CHNA/ CHIP process to create/engage more partnerships and for evaluation of the partnership process
- Shared responsibility for leading campaigns, events, etc.

ESSENTIAL SERVICES 3&4 THEMES

- Funding resources
- Creating community ownership
- Learning to live outside the pandemic
- Standardize data sharing

ESSENTIAL SERVICES 5

DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL & COMMUNITY HEALTH EFFORTS
MARCH 24, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Increased state funding
- Winnebago Public Health Dept has been very active in the community they serve
- NNPHD has strategic planning
- Health Department has employed more staff during pandemic to assist with this process
- Partnerships grew, began involving more partners in planning process
- 1st responders identified and trained
- People volunteer and come together
- Were able to pivot and change as needed
- Critical contact list as we contacted people

FALLEN BACK

- In other communities, public health dept is not very present
- Involvement in the community is very dependent upon funding
- Lack of programs
- Fairly new local health dept in the whole scheme of things
- We are not able to create policies (in terms of laws)
- Political environment threatens public health's role in policies
- We don't know what our role is exactly in policy planning
- Since pandemic, coalitions stopped
- Because of Pandemic there is more staff turnover
- Different communication tools used by different sectors
- Communication on health has decreased since COVID-19
- Communication in some communities not good (eg Pilger)
- Differing levels of training among parties

Round 2: What ideas/ suggestions do you have to improve this standard?

- Educate the public on public health depts
- Local funding is needed
- NE is not progressive in the big picture of public health
- More state funding is needed
- Learn Public Health's role in policy planning
- Getting all entities involved in planning
- Find a way to make the policy building process smoother
- Collecting data
- Starting coalitions again
- Implementing ideas brought forward from coalition
- Needs to be an interactive site where you can share contacts, changes in information
- To get everybody at the table
- Improve planning for vulnerable populations
- Shorter plans, more flexibility

Round 3: What will it take to keep making progress with this standard?

- Analyze health depts who have been in place for some time to see how they have been successful.
- Mentorship between older health depts & newer health depts - Involvement in NALHD
- Support staff to get education on public health topics
- Encourage students to consider a public health career
- Attend statewide events to network
- Educate the public about the importance of government (public health in particular)
- Tap into what UNMC College of Public Health has to offer to local systems
- Offer internships for public health students at local health department
- Strategic planning with partners
- Open and ongoing conversations
- Education as to the "why"
- Building strong community partnerships
- Support and active involvement from partners
- Continue to support small agencies in ways to help them be involved
- Funders to be more flexible regarding plans
- Getting more people at the table
- More input into the plans
- More staff to help write plans at phd and em resp
- Learning to use new communicate

ESSENTIAL SERVICES 6

ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY
MARCH 24, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Most people now know there is such a thing as public health policy - even if they don't always like it :)
- Might be able to identify gaps via CHNA
- (tribals) When explicit including data, seems like better compliance
- (Tribal) Public are becoming more aware of the process
- NNPHD got guidance out more efficiently

FALLEN BACK

- Awareness of public health legislation is very limited in the general public
- Communities in our area may need to share resources to address public health issues.
- We are not involved in this area, and should be!
- Still a lot of confusion on authority in general public.
- Change in administration of programs on state level.
- Still a lot of confusion on authority among agencies and levels
- More political disagreements

Round 2: What ideas/ suggestions do you have to improve this standard?

- Include community members to testify at legislative hearings to support public health laws
- Hold meetings or provide notifications to the public about any potential public health legislation
- Educate the public about how their involvement can impact local, state and federal policies
- Not always possible (and not always consistent) to enforce public health policies
- Education to health care providers about the importance of public health and infection control measures
- Don't always have policies to address the standards
- Providers don't always take (or are allowed) the time to thoroughly educate patients on their health conditions
- Get familiar with existing ordinances/ regulations
- Look at what other LHDs have done
- Funding
- Find a way to work with law-making bodies
- Community Feedback
- Standardize the processes

Round 3: What will it take to keep making progress with this standard?

- Improve the education for law enforcement about public health policy enforcement
- More education on public health in the schools
- Work towards LHD accreditation (best practices)
- Continue to build partnerships with policy-makers
- Expanding BOH membership (city council members)
- Improved guidance from state policy makers
- Give local agencies more authority
- Local officials need to be local public health advocates
- Finding community members to be public health champions

ESSENTIAL SERVICES 5&6 THEMES

- Education
- Partnerships
- More people at the table for planning
- Interactive process to keep contacts up to date
- Being thoughtful about how to motivate engagement for domains
- Not easy but must persevere

ESSENTIAL SERVICES 7

ENABLE EQUITABLE ACCESS
MARCH 30, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Remote access to services
- More vouchers for mental health services
- More grass roots opportunities for the public to get engaged (Health Equity Council, Community Coalitions, etc.)
- Pandemic opened up more channels of communication have been opened up (FB, newspapers, PSAs, etc) to provide info to the public on where to find services
- Pandemic helped us build new partnerships
- System that is new, 211 became Unite Us--followup easier
- Learned about gaps and taken steps
- Availability of telehealth increased, and good health outcomes
- Health Equity committee at the Health Department & now Health Council
- Enhanced ability to locate access and functional needs populations through COVID

FALLEN BACK

- Might still be some rural areas without broadband
- Interruption in other services due to COVID
- Pandemic caused our normal activities to be halted for a long time
- Pandemic prevented face to face encounters
- Pandemic increased the lack of access to affordable health care (transportation, testing, etc.)
- Not a lot of programs part of the new system Unite Us
- Still some gaps planning
- Staff shortages - inc clinical, harder to get appts
- Facilities closing, or less capacity
- Finding access and functional needs populations to include geographical isolated
- Not a good registry that everyone can access
- Limited because not everyone has connection to services if we do not have internet

Round 2: What ideas/ suggestions do you have to improve this standard?

- Keep moving forward with broadband access
- Community hotspots
- Find more funding to provide vouchers for mental health services
- CLAS training
- Removing language barriers
- Better lab courier services
- Increase use of telehealth services
- Not sure where to start to find resources/ services
- Increase use of telehealth services
- Increase the availability of interpretation services
- Use culturally appropriate handouts & info
- Increased funding
- Increased financial capacity for patients
- More services, including transportation
- Teaching patients technology
- Facilitating telehealth connections for BH and specialties
- Any residential care and daycare
- How partners can work together to serve all ethnic groups
- How to access all ethnic groups
- Finding interpreters that are in person vs. phone communication
- Use partners data systems to identify needs, especially with health disparities
- Difficult to make change within the Bureaucracy
- No functioning net for individuals with no health care
- Finding health care workers

Round 3: What will it take to keep making progress with this standard?

- One-stop shop for information
- Keep information up to date
- Maintain adequate staffing
- Listen to providers and consumers
- Keep up the momentum with the Health Equity Council and other Community Councils to address the identified issues
- Getting community champions to be part of the dialogue
- Publicize partnerships to show the benefit
- Keep resource page/booklet up to date & available
- Continue to meet with partners
- Share resources among partners
- Continue and grow in the listening sessions, add more groups and partners
- Continue in education in the community

ESSENTIAL SERVICES 9

IMPROVE AND INNOVATE THROUGH EVALUATION, RESEARCH, AND QUALITY IMPROVEMENT
MARCH 30, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- We know who to coordinate with at partner agencies
- More sharing of information
- People were "forced" to get better at technology
- Working w/University & Colleges to build partnerships and enhance research
- Multi layered approach w/partners to implement programs and services
- Pandemic has heightened the importance of the use of evidence based information (also has increased awareness w/the public)
- Know What is being evaluated? How to evaluate. Capture after action report. What is the plan for improvement?
- Lessons learned from the response with COVID regarding evaluating services, plans and laws as well as data collection
- Technology has improved communication

FALLEN BACK

- Misinformation of the pandemic has challenged the trust of the health care system from the public
- Research has slowed or stopped due to the diversion of the health care system toward the pandemic and away from normal practices
- It's been extremely difficult to return to previous practices from pandemic response
- Pandemic PTSD
- Silos--still lack of communication between.
- Care personnel were having to take extra time to report data
- More distrust of govt inc among govt officials
- Coalitions have been put on hold due to COVID
- CHNA/CHIP not health literate for community review

Round 2: What ideas/ suggestions do you have to improve this standard?

- Research into burnout factors
- Sufficient staffing for surge situations, so programs don't get interrupted
- Succession planning so that work is minimally disrupted during staff turnover
- Partnering with the University has been valuable in supporting evidence based practice
- Need dissemination agreements for data sharing
- Having the resources to appropriately analyze the data is needed
- Need more public health professionals
- Share a statistician among local health departments
- Give local information to the system, even about weakness
- Have overall standards that everybody uses
- Keep politics out of the system
- Make sure the system objectives are very clear
- Make members of system more available of the tools and systems for evaluation
- Community ownership of CHNA/CHIP
- Funding
- Dedicated staff

Round 3: What will it take to keep making progress with this standard?

- Go to schools and talk about careers in public health
- Share professionals between local health departments
- Hot washes
- Need to get buy in from everybody
- Use your strengths to build on your weaknesses
- Better use the system available (HC)
- Focus on quality improvement through evaluation
- Develop a repository for evidence based policy and procedures

ESSENTIAL SERVICES 7&9 THEMES

- Continue to grow collaboration
- Pandemic need to find better way to move forward
- Partners before crisis
- Cross training across agencies
- Health equity community
- Community engagement and education
- Educating public & professional what is in it for them?
- Establish evidence based practices
- Valuing staff
- Funding, funding, funding
- Public health staff available and ready for next response
- Encourage young people around opportunities in public health
- The importance of collaboration between local health care and universities
- Importance of collaboration between local and state DHHS
- Staff recognition events within or across agencies
- Marketing partnerships who are working together
- Multi media dissemination
- Focus on workforce, evaluation and access to care to the most needy
- Work with Wayne state college
- Similar systems to report & communicate into
- Spending more time being strategic on objectives
- Make more user friendly
- Create safe space to share mistakes & weaknesses

ESSENTIAL SERVICES 8

DIVERSE AND SKILLED WORKFORCE
APRIL 14, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Hired a communication specialist
- Increased staff-doubled full time staff
- Partnering with nurses in service area
- People are more aware of public health after pandemic
- Tribal college partners with unmc and wsc
- More affordable
- People started to understand one aspect of public health during covid-19

FALLEN BACK

- Staff retention
- Hiring specific public health nurses
- Political divide-evident during pandemic
- Ne are still trying to catch up
- Public not aware of what public health does for our community
- Still underfunded resources

Round 2: What ideas/ suggestions do you have to improve this standard?

- Recruiting bilingual staff into public health
- Maintaining number of staff after covid funds are gone
- Outreach to
- Educate elected officials
- Educate public
- Look for fellowships
- Fellowships in those areas, getting all groups involved
- Look nationally for education and professional development
- Make use of national associations for fellowships among other opportunities
- Cross training between departments
- Preplanned site visits, inc leadership
- Educating officials & the public
- Examining model programs
- Finding local advocates to help with public health objectives
- Getting county officials invested in public health

Round 3: What will it take to keep making progress with this standard?

- Public health providing training in the community
- Build in adult education into the work we are already doing
- Training in “braver angels” to decrease political divide
- Make $’s for graduate programs more available to staff

ESSENTIAL SERVICES 10

STRONG ORGANIZATIONAL INFRASTRUCTURE
ARPIL 14, 2022

Round 1: When you read through the model standard and review our 2019 results where have we improved or fallen back

IMPROVED

- Hired communication specialist
- Enhanced social media communication
- Audit on it system-working towards goals to improve system
- Business worked to share health information
- Public health leadership is ethical and skilled at navigating all of the challenges.
- System worked well with state labs it-team

FALLEN BACK

- IT is a struggle. Finding someone to work with us and our schedules
- Hard to find it to work after hours and support systems
- Which of the following is not part of the nims management characteristic of chain of command?
- Audits are time consuming.
- Underfunded mandates.
- Labor is not a line item on grant accounting sheets.

Round 2: What ideas/suggestions do you have to improve this standard?

- Partnering outside of COVID
- Working with community members not in health towards the same vision
- No local funding for public health.
- Elected officials change so they need to educated as to the needs of public health
- Funding for nurses and program supplies
- Difficult and time consuming to hire staff
- If state could better include everybody in surveillance system
- Better reporting options (technology) for data reporting

Round 3: What will it take to keep making progress with this standard?

- Partners working together to communicate the same message
- Begin coalitions again-put on hold during covid
- Combine coalitions for the same cause
- Educating officials
- Educating public
- Looking at model programs
- Find community advocates
- Getting county officials invested in public health
- Find partners to help with public health objectives

CLOSING DISCUSSION

- Partners working together to communicate the same message
- Begin coalitions again-put on hold during covid
- Combine coalitions for the same cause
- Working with young people to keep them interested in seeing potential area opportunities
- Offering internships and fellowship in rural public health departments
- Looking at other successful models
- Looking at other agency partners to enhance diversity and workforce
- Wayne state grant allows for paid mental health practitioner allows living expenses
- Covid allowed opportunity to collaborate - how we not disconnect
- Utilize the network to work beyond silos/turfs
- Developing bi-lingual community health workers (certified course)
- We take a beating and keep on ticking
- Take time following up with state without getting state acknowledgement
- Need to be intentional to maintain covid partnerships
- Avian flu outbreak
- Educating officials
- Educating public
- Looking at model programs
- Find community advocates
- Getting county officials invested in public health
- Find partners to help with public health objectives

LISTENING SESSIONS

Northeast Nebraska Rural Health Network

NNRHN

2021 - 2022

intersections consulting
THE ORCHESTRATION OF OUTCOMES

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LISTENING SESSION - IN PERSON

Three locations were selected to conduct listening sessions. Each group was asked to participate in a conversation about healthy communities. Facilitators John Beranek and Charity Adams facilitated conversations around three questions.

- What would you say are th top five things that affect people's health in our community?
- What worries you most about your health or the health of your family?
- What are two things you would like to see in place that would make our community healthier?

The results for each community are provided. All the results were collected and themed.

LAUREL

Laurel Learning Center
December 7, 2021

Round 1: What would you say are the top five things that affect people's health in our community?

- Facilities to exercise - bike trail swimming pool
- Affordable health care - sit on things longer than u should
- Low education on health care
- Support young mothers (single families)
- Working together /care for
- Burnout - everyone-care givers-just need someone to listen
- Senior Care -care at home
- Educate people more (counter the lack of trust)
- Knowing who has your back - hope everyone has someone
- Socio-economic
- Health literate education
- Language barriers
- No net for behavioral health
- Geography - rural doesn't have home resources

Round 2: What worries you most about your health or the health of your family?

- Mental health - shootings
- Not wanting to be a burden
- Will it break us financially/ mentally
- Caring for the caregiver
- Long-term care - costs/will they be cared for

Round 3: What are two things you would like to see in place that would make our community healthier?

- More public lands and outdoor space
- Universal health care
- Organized exercise
- Dog park
- Place for elders
  -apartment/commons for community
- Senior housing

HARTINGTON

Hartington Senior Center
December 8, 2021

Round 1: What would you say are the top five things that affect people's health in our community?

- Transportation
- Access to health care
- Affordable
- Education for what need/ simple language
- Local Dr's PA
- Housing/Therapy
- Meal Delivery to homes/food pantry

Round 2: What worries you most about your health or the health of your family?

- Don't have family here
- Medicare-please don't take away
- Increasing costs
- Availability
- Geography)of our doctors
- Health care costs
- Awareness

Round 3: What are two things you would like to see in place that would make our community healthier?

- Immediate help for families in tragedy
  -Haven House (30-60 days)
  -refuge services
- Opportunities for socialization
- Mindset - think they are not old
- Covid aged people by 5 years
- Well balanced meals/get 2 meals out of it
- People leave money in will donated to senior

LISTENING SESSION - IN PERSON

WAYNE

Wayne Community Center
December 8, 2021

Round 1: What would you say are the top five things that affect people's health in our community?

- Income - can afford access
- Depression/mental health - silence will kill us
  -impact of covid -affects elders
  -families can't come in to care facilities
  -short staffed
- Family history - heart/high blood pressure/obesity harsh up bringing /lingering
  -we don't want it to carry on
  -never share your feelings
- The change in farming - not as physical
  -wives have multiple jobs
  -producer of food/doctor/ carry the benefits
  -bookkeeping
- Transportation options are limited
- College students not following health guidelines
- Parents transporting vs walking to school
- Multiple jobs - don't have time

Round 2: What worries you most about your health or the health of your family?

- Knowing I am slowing down/ not as fast as you used to be
- Thinking about my schedule for next day 1 thing disrupts the schedule
- The cost of insurance/ access/rural we don't have the experts
  - should we travel to get served
- Genetic heart disease
- Teenagers eating fast food/ schedule too packed

Round 3: What are two things you would like to see in place that would make our community healthier? Focus on multiple ages (not just for kids) (pickle ball needs to be later)

- Transportation after school hours
- Indoor/outdoor pool
- Urgent care
- Evening day care/meet shift needs - Michael Foods
- Better local produce/snap
- Teenage low self esteem/ mental health services/ coaching -hearing it from others
- Where could we creatively collaborate
- Upstream thinking w/ resources $$$
- Shifting mindsets
- Spread the celebration center
- Get youth involved to connect w/elders
- Gathering places for you people (safe)
- Not wanting to be seen as older

The power of community to create health is far greater than any physician, clinic or hospital
~Mark Hyman, MD

LISTENING SESSION THEMES

EDUCATION

- Health literate education
- Low education on health care
- Health literate education
- Education
- Low education on health care
- Educate people more (counter the lack of trust)
- Education for what need/ simple language
- Educate people more (counter the lack of trust)

FACILITIES & ACTIVITIES

- Gathering places for you people (safe)
- Dog park
- Organized exercise
- Facilities to exercise - bike trail swimming pool
- Focus on multiple ages (not just for kids) (pickle ball needs to be later)
- Facilities and Activities
- Opportunities for socialization
- Indoor/outdoor pool
- Facilities to exercise - bike trail swimming pool
- More public lands and outdoor space
- Evening day care/meet shift needs - Michael Foods

ACCESS TO HEALTH CARE

- Urgent care
- Local Dr's PA
- Transportation
- Access to health care
- Geography)of our doctors
- Access to Health Care
- Transportation options are limited
- Availability
- Language barriers
- Travel to get served
- Geography - rural doesn't have home resources
- Transportation after school hours

MENTAL HEALTH

- Covid aged people by 5 years
- Mental health - shootings
- No net for behavioral health
- Teenage low self esteem/ mental health services/ coaching -hearing it from others
- Mental Health
- Depression/mental health - silence will kill us
- Families can't come into care facilities
- Mental health - impact of covid affects elders

HEALTHY FOOD

- Better local produce/snap
- Teenagers eating fast food/ schedule too packed
- Healthy Food
- Well balanced meals/get 2 meals out of it
- Meal Delivery to homes/food pantry

CARE GIVER SUPPORT

- Caregiver Support
- Burnout - everyone-care givers-just need someone to listen
- Knowing who has your back - hope everyone has someone
- Don't have family here
- Working together /care for
- Caregiver Support
- Burnout - everyone-care givers-just need someone to listen
- Knowing who has your back - hope everyone has someone
- Support young mothers (single families)
- Working together /care for
- Caring for the caregiver

HOW WE THINK

- Upstream thinking w/ resources $$$
- People leave money in will donated to senior center
- Spread the celebration
- How We Think
- Where could we creatively collaborate
- Awareness
- Shifting mindsets

AFFORDABLE HEALTH CARE

- Medicare-please don't take away
- Will it break us financially/ mentally
- Affordable health care - sit on things longer than u should
- Universal health care
- The cost of insurance/ access/rural we don't have the experts
- Increasing costs
- Long-term care - costs/will they be cared for
- Affordable Health Care
- Affordable health care - sit on things longer than u should
- Income - can afford access
- Socio-economic
- Socio-economic
- Affordable
- Health care costs

LISTENING SESSION ONLINE

FAMILY AND LIFESTYLE

- College students not following health guidelines
- Family history - heart/high blood pressure/obesity harsh up bringing /lingering
- Farmers' wives have multiple jobs
- Refuge services
- The change in farming - not as physical
- Family & Lifestyle
- Farmers' wives producer of food/doctor/carry the benefits
- Thinking about my schedule for next day 1 thing disrupts the schedule
- Immediate help for families in tragedy
- Genetic heart disease
- Farmers' wives bookkeeping
- Multiple jobs - don't have time
- '-Haven House (30-60 days)'
- Parents transporting vs walking to school

SENIOR LIVING

- Senior apartment/commons for community
- Senior housing
- Senior Care -care at home
- Senior Living
- Place for elders
- Knowing I am slowing down/ not as fast as you used to be
- Mindset - think they are not old
- Not wanting to be a burden
- Get youth involved to connect w/elders
- Not wanting to be seen as older
- Housing/Therapy
- Care facilities short staffed

FEBRUARY 24, 2022 ONLINE LISTENING SESSION

COMMUNITY ADVOCACY

- People not understanding their health insurance; need advocates
- More coordinated health services
- More community engagement

MENTAL HEALTH CARE

- Access to mental health treatment; adults and adolescents
- Better depression screenings
- Accessing mental and home health services
- Behavioral health
- Stigma of getting services
- More dual diagnosis

GEOGRAPHIC ACCESS TO HEALTH CARE

- Distance of health specialties
- Distance to travel for specialist
- Access to dietitians
- Lack of dietitians for diabetics
- Increased anxiety and mental health issues
- Access to health care providers

COST OF HEALTHY LIVING CARE

- Cost of health care
- Access to good food and afford it
- Fiscal impact of health care
- Affordable health services

OBSTACLES TO CREATING A HEALTHY LIFESTYLE

- Obstacles to fitness; collapse to netflix
- More walking trails and sidewalks
- Access and ability for gym and trails
- Fitness avoidance due to exhaustion of every day life

TRANSPORTATION TO HEALTH CARE

- Transportation for services
- Providing transportation to services

LONG TERM CARE NEEDS

- Long term care
- Access to home health
- Access to long term care services

DEFINING A HEALTHY LIFESTYLE

- Education on what is healthy living
- Not everyone has background of what is healthy

ENGAGING IN SELF CARE

- Take time for ourselves to better for taking care of others
- Walking clubs for all ages
- Stress of current society

RECOMMENDATIONS

- Need to encourage nonprofits of Dixon, Thurston Wayne and Cedar to talk together face to face or zoom
- Making the business case for investments in health
- Encourage non profits in communities
- Lunch and listen with employers
- Get some buy in from an employer. A lunch and "listen"
- Making the business case for investing in health
- Working on developing a long term vision
- Developing long term vision