January 1, 2017-December 31, 2019

St. Francis Memorial Hospital

Sponsored by the Franciscan Sisters of Christian Charity

Community Health Needs Assessment

In Collaboration with:

ELKHORN PUBLIC HEALTH LOGAN VALLEY DEPARTMENT

Oakland MERCY HOSPITAL
A partner with Mercy Medical Center-Sioux City

FAITH REGIONAL HEALTH SERVICES

TABLE OF CONTENTS

SAINT
FRANCIS
MEMORIAL
HOSPITAL

430 North Monitor Street
West Point, NE 68788-1595
402-372-2404 Fax 402-372-2360

Dear Partners and Citizens of Burt, Cuming, Stanton and Madison Counties,

Every three years St. Francis Memorial Hospital conducts a Community Health Needs Assessment. During 2016 our hospital, along with Oakland Mercy Hospital and Faith Regional Hospital (Norfolk), collaborated with the Elkhorn Logan Valley Public Health Department, with ELVRDH taking the lead to complete a health needs assessment for the citizens of our service area. A research firm compiled the results of the survey and combined them with pieces of data specific to the service area. With this, a group of public health stakeholders gathered to discuss and share concerns and strengths of our communities, and to identify priorities that we can work on together to improve the health status of all people living in Burt, Cuming, Stanton and Madison Counties in Nebraska.

This is the second time that ELVPHD has completed this process. There were some changes to the plan. Most of the changes involved taking previously-broad focus areas and narrowing the efforts in a way that we could better concentrate on particular areas, and hopefully achieve more substantial outcomes. In the area of access to care, the focus was broadened beyond behavioral health to now include all healthcare sectors. The four main priority areas:

1. Obesity;
2. Access to Care;
3. Cancer Prevention and Screening; and
4. Standard Motor Vehicular Safety.

In addition, the department's Strategic Plan includes several goals that formed the foundation to support the four priority areas listed above. Those goals include: 1). Offering opportunities for community citizens to participate in activities that promote healthy and safe living; 2). Marketing to better inform the public about what public health is and what services are available in the district; 3). Increasing collaboration and partnerships with other organizations in the community; and 4). Maintaining a formal Quality Improvement process throughout health department operations and programs.

St. Francis will accept responsibility for providing certain aspects of the Community Health Needs Assessment and will include our goals in our Community Health Needs Implementation Plan.

We want to thank Elkhorn Logan Valley Public Health Department and their Executive Director, Gina Uhing, RN, for their leadership, resources and collaboration in making this Community Health Needs Assessment a success.

Sincerely,

Jerry Wordekemper

Jerry Wordekemper, MHA, ACHE
President/CEO
St. Francis Memorial Hospital

Plan Ownership

Background Data to Support Hospital and Local Public Health Joint Ownership in the Community Health Improvement Plan

There are many reasons why it remains logical for Elkhorn Logan Valley Public Health Department to partner with the three district hospitals to complete a joint Community Health Assessment and Community Health Improvement Plan (CHIP). The major reason is to improve overall community health through the assistance of multiple partners.

Additional reasons for collaboration exist: all three local hospitals continue to be required to complete a Community Health Needs Assessment to meet Internal Revenue Service (IRS) requirements to maintain their non-profit status. Those hospitals are:

Oakland Mercy Hospital—Oakland, NE
St. Francis Memorial Hospital—West Point, NE
Faith Regional Health Services—Norfolk, NE

In addition, the Norfolk Community Health Care Clinic has to satisfy requirements for their federal funding and periodically assesses the needs of the community to validate the necessity of their services based upon data that is available. For this reason, working with them to achieve their data needs in the same process helped to make the assessment more meaningful for all partners.

Some of the major drivers in continuing a high level of collaboration between the health department and the hospitals include:

1. Nebraska State Statutes

Nebraska Statutes (under 71-1628.04) provides guidance on the roles public health departments must play and provides the following four (of the ten) required public health essential services, which fit into the public health role in the Community Health Improvement Plan.

...Each local public health department shall include the essential elements in carrying out the core public health functions, to the extent applicable, within its geographically-defined community, and to the extent funds are available. The essential elements include, but are not limited to, (a) monitoring health status to identify community health problems, (b)diagnosing and investigating health problems and health hazards in the community, (c) informing, educating, and empowering people about health issues, (d) mobilizing community partnerships to identify and solve health problems...

2. The Patient Protection and Affordable Care Act Impact on Hospitals

The historic passage of the Patient Protection and Affordable Care Act (PPACA) called on non-profit hospitals to increase their accountability to the communities they served. PPACA created a new Internal Revenue Code Section 501(r), which clarified certain

responsibilities for tax-exempt hospitals. Although tax exempt hospitals had long been required to disclose their community benefits, PPACA added several new requirements. Section 501(r) required a tax-exempt hospital to:

- Conduct a community health needs assessment every three years
    - The assessment must continue to take into account input from persons who represent the broad interests of the community served, especially those of public health
- Develop an implementation plan and strategy that addresses how a hospital plans to meet EACH of the health care needs identified by the assessment
    - This plan must continue to be adopted by each hospital's governing body of the organization, and must continue to include an explanation for any assessment findings not being addressed in the plan
- Widely publicize assessment results

As mentioned earlier, this requirement affects all three hospitals in the ELVPHD service area.

3. Redefinition of Hospital Community Benefit

Hospitals have been providing community benefits for many years in a variety of ways. In return, hospitals receive a variety of local, state, and federal tax exemptions. The activities listed under "community benefit" are reported on the hospital's IRS 990 report.

Community benefit was recently defined by the IRS as "the promotion of health for a class of persons sufficiently large so the community as a whole benefits." Simply put, community benefit is composed of programs and services designed to address identified needs and improve community health. To qualify as community benefit, initiatives must respond to an identified community need and meet at least one of the following criteria:

- Improve access to healthcare services
- Enhance health of the community
- Advance medical or health knowledge
- Relieve or reduce the burden of government or other community efforts

4. Public Health Accreditation Board Requirements

In July of 2011, the PHAB released the first public health standards for the launch of national public health department accreditation. All local health departments pursuing voluntary public health accreditation must have completed a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PHAB Version 1.5 has standards that required the local health departments to:

- Participate in, or lead, a collaborative process resulting in a comprehensive community health assessment
- Collect and maintain reliable, comparable and valid data that provide information on conditions of public health importance and on the health status of the population

- Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health
- Provide and use the results of the health data analysis to develop recommendations regarding public health policy, processes, programs or interventions

Overview of the Development Process

Step One: The multi-step process began with the **M**obilizing for **A**ction through **P**lanning and **P**artnership **(MAPP)** process at Elkhorn Logan Valley Public Health Department. The MAPP process was developed by, and is recommended for community assessment by, the National Association of City and County Health Officials (NACCHO) and Centers for Disease Control (CDC).

The most current MAPP processes were conducted by ELVPHD in 2014, and again in 2016. That process involved a number of individuals and organizations (with a common interest in public health) that contributed to identifying the trends, factors and events that influence the health and quality of life in our communities and/or the work of the public health system. Contributors represented a variety of arenas, sectors and backgrounds. Extreme effort was placed on having equal and fair representation across all counties and sector focus areas. Participants from the following sector groups were involved:

- Elected officials
- Hospital administration
- Behavioral health practitioners
- Community-based organizations
- Community college administrators
- Public Health students
- Health education directors
- Minority community leaders
- Business leaders
- Community Action Agency leaders
- Youth-serving organizations
- Long-term care facilities
- Organizations for persons with disabilities
- University representatives
- Hospice centers
- Educational Service Units
- Ponca Tribe representatives
- Federally-qualified health center leaders
- Organizations representing the elderly
- Housing officials
- Domestic violence organizations
- Chamber of Commerce leaders
- Veterans organizations
- City health officials

MAPP involves gathering together multiple community stakeholders for a shared assessment, strategic planning, and implementation process. The MAPP action cycle has well defined steps and processes to capture community input and move a community or organization to make positive changes. An image of the action cycle is included below:

Details regarding the outcomes of the most recent MAPP Assessment are found in the 2014-2017 Elkhorn Logan Valley Public Health Department Strategic Plan, included as an attachment in Appendix I.

Step Two: Data Collection and Analysis

ELVPHD contracted with a private research firm, Ionia Research, to assist with the data collection and analysis component of the process. Data gathering was accomplished using both primary and secondary sources.

Primary data sources included:

- The results of the four MAPP model assessments—1). Community Themes and Strengths Assessment, 2). Local Public Health System Assessment, 3). Community Health Status Assessment and 4). Forces of Change Assessment
- Data collected through community-level health surveys administered online and through regular mail. The most recent assessment findings are available online for public review at www.elvphd.org. Patrons were invited to take the survey by means of several routes—including public press releases and radio public service announcements; Chamber of Commerce newsletters; through employers, senior citizen centers; social media posts; and flyers that were posted or flyers that were distributed to school students via mass distribution efforts.

Those interested in taking the survey were encouraged to do so online, or were invited to request a hard-copy survey. Surveys were also available in Spanish (in hard copy form) by calling the toll-free number listed, or by requesting a Spanish copy via any ELVPHD bilingual employee. Included in these mailings were postage-paid return envelopes.

In an effort to ensure broad participation throughout the health district, ELVPHD focused special attention from gathering assessments from minorities, the elderly and veterans.

Some of the methods to ensure that these special population's input was gained included:

- The community health assessment was translated into Spanish;
- Two bilingual ELVPHD staff engaged the Hispanic community directly and through various partners to ensure broad participation;
- ELVPHD worked with Midtown Health Center (MHC), the local Federally-Qualified Health Center, to engage their patients to complete the assessment (approximately 36.95% of MHC patients are minorities);
- ELVPHD engaged the Ponca Tribe of Nebraska to encourage tribal members to complete the assessment;
- ELVPHD placed a staff member at various WIC and immunization clinics in the area to reach lower-income consumers;
- ELVPHD has staff visit local senior centers to complete assessments on site; and
- The ELVPHD Veterans Services Programming Coordinator worked with veterans to complete assessments.

Secondary data sources included:

- CDC
    - 2010-2014 Behavioral Risk Factor Surveillance System (BRFSS) detailed table http://dhhs.ne.gov/publichealth/Pages/brfss_reports.aspx
    - National Vital Statistics System 2009-2013
      Diabetes Report Card 2014
    - Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census
    - National Program of Cancer Registries (NPCR), CDC/NCCDPHP
    - National Health Interview Survey (NHIS), CDC/NCHS
    - Healthier Food Retail: Beginning the Assessment Process in Your State or Community. Atlanta: U.S. Department of Health and Human Services 2014
    - Pregnancy Risk Assessment Monitoring System (PRAMS)
    - California's Maternal and Infant Health Assessment (MIHA), California Department of Public Health (CDPH)
    - National Immunization Survey (NIS), CDC/NCIRD and CDC/NCHS
- 2013 ELVPHD CHA report
- HP2020 Goals
- American Community Survey
- 2010-2014 American Community Survey 5-Year Estimates http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP03&prodType=table
- Nebraska Risk and Protection Factor Surveillance System
- US Census Bureau
- Healthy Counties database (Population Health Institute and the University of Wisconsin: Robert Wood Johnson Foundation)
- Health Status Indicators

- Community Health Needs Assessment (CHNA)
- County Health Rankings 2016
- Surveillance, Epidemiology, and End Results Program (SEER), NIH/NCI
- National Survey on Drug Use and Health (NSDUH), SAMHSA
- Employee Benefits Survey, Society for Human Resource Management (SHRM)
- Web MD: http://www.webmd.com/beauty/sun/sunscreen-and-your-makeup-routine.
- Cancer.gov: http://www.cancer.gov/about-cancer/causes-prevention/risk/radiation/electromagnetic-fields-fact-sheet.
- National Cancer Institute
- International Agency for Research on Cancer (IARC), a component of the World Health Organization
- National Fire Protection Association
- NSP/DOT data publications
- Nebraska Vital Records; National Center for Health Statistics

In the spirit of holding true to the 'community-driven' intent of this process, community engagement was an overarching concept encompassing the Community Health Needs Assessment and the subsequent formation of the Community Health Improvement Plan. During the implementation of the plan in the years ahead, this community engagement is anticipated to continue. As such, community engagement is discussed under each focus area.

Step Three: Community Health Improvement Plan Stakeholder/Focus Groups

Preparation:
During the implementation of the Community Health Assessment, ELVPHD began planning for the next step in the process, the Community Health Improvement Plan Stakeholder/Focus Groups. Due to the geographic spread of the ELVPHD health district, two separate groups were planned—one on the east end of the jurisdiction and one on the west end of the jurisdiction. Planning meetings were conducted with each of the three hospitals in the district, and partnership plans for collaboratively hosting the focus groups were formed.

Approximately 325 individuals/agencies were identified by the collaborative partners as key stakeholders in the public health system. Eight weeks prior to the scheduled events, save-the-date postcards were sent to all of the identified potential participants for the events respective to the geographic locale; and formal invitations were sent four weeks prior to the events with a request for RSVPs at that time. Of those, roughly 160 invitations were sent in the counties of Cuming and Burt, while 165 were sent in the counties of Stanton and Madison. (Invitation list is included as Appendix I). An informational attachment was included in the invitations that outlined the community health improvement planning process, as well as the potential benefits to participation. Results of preliminary information on selected health indicators from the public survey process were also included in the mailings to the stakeholders. In addition, preliminary data findings were also distributed to the public at-large by press release and by posting a preliminary

data findings brief to ELVPHD's website. The public was invited to provide input on the preliminary data and to attend the focus groups, as well.

Prior to the meeting, the planning team—including four ELVPHD staff, and a contracted facilitator and research firm representative, created tools and ancillary materials to be used on the days of the events. Such items included:

- The participation toolkit for each participant. The toolkit included focus group agendas, Forces of Change assessment information, participant worksheets, and data notes.
- Strategic issue discussion prompts- disseminated to event participants to guide discussion after participants self-selected into teams to discuss in further detail the particular focus area.
- Strategic planning issue planning grid- disseminated to event participants to reference during the round-table discussion portion of the planning day; also used by selected dialogue recorders (ELVPHD staff) and round-table discussion leaders (hospital staff) to directly facilitation discussion and record content as discussed.
- Request for data form so that participants could receive personal copies of the Community Health Assessment data analysis report, upon request.

Also prepared prior to these events was the expanded data analysis report prepared by Ionia Research. The "Analysis and Report of Community Health" document was prepared for ELVPHD using the various secondary data sources. The intent was to summarize trends in data and differences between the counties served by ELVPHD and the rest of the state of Nebraska.

A complete copy of this report is included in the attachments as Appendix VIII.

Process:

The objectives of the Community Health Improvement Plan Stakeholder/Focus Groups were:

- To identify the trends, factors and events that influence the health and quality of life in our communities and/or the work of the public health system
- To prioritize (based on data) focus areas in which to concentrate efforts
- To develop logical, evidence-based action steps towards each priority area
- To instill community ownership of and commitment to the ongoing process of creating healthy communities

The overarching strategic focus question guiding the discussion was:
"Based on our community assessments, what are our communities' priority strategic issues and how will we impact them?"

The agenda was the same for each meeting and was outlined as follows:

- Welcome and context
- Forces of Change Assessment

- Data summary report—Dr. Joe Nitzke, Ionia Research, presented a summary of community health-related data compiled from a variety of surveys and other sources. This data framed the discussion of potential priorities for community planning and action. Persons interested in obtaining a complete copy of the data report were encouraged to request a copy of the report via the Data Request Form
- Priority (Strategic) Issue Confirmation and Workshop—confirmation of relevance of 2013 CHIP Focus areas and discussion regarding any changes or additions to the priority areas. Criteria used to prioritize issues included: amount of demonstrated need, economic impact of the problem, available and potential resources (cost), morbidity and mortality impact, gaps contributing the problem, cultural environment, opportunities for both short- and long-term success, and potential to make a difference
- Round-table discussion—prioritization exercises to come to consensus around evidence-based strategies that could be employed to improve community health and well-being in regards to each priority focus area
- Debrief
- Next Steps

Strategic issues were defined as "fundamental policy choices facing Elkhorn Logan Valley Public Health Department's vision, mandates, values, services, clients, resources or operations."

This year, participants made three substantial changes in the scope of the plan. The first change was to broaden *Priority Area #2—Behavioral/Mental Health*, and change that priority to include all other healthcare sectors. As such, that priority area is now defined as—*Priority Area #2—Access to Care*, and encompasses primary, dental, and behavioral health access.

The other two changes involved narrowing of the scope of *Priority Area #3—Prevention* and *Priority Area #4—Risky Behaviors*. This change was necessary to better concentrate some of the efforts on particular areas, and hopefully achieve more substantial outcomes. The narrowing of the scope resulted in the following changes: *Priority Area #3—Cancer Prevention and Screening* and *Priority Area #4—Standard Motor Vehicle Safety*.

Each group independently came to consensus around four primary strategic issues to guide and inform the Community Health Planning process. A copy of the summary outlining the discussion at each focus group is included in the attachments as Appendix IX.

Participation:
On April 13th, 2016, the Burt and Cuming County Community Health Improvement Plan stakeholder focus group was convened at the Nielsen Community Center in West Point, NE. On April 14th, 2016, the Stanton and Madison County stakeholder focus group was convened at the Ponca Tribe Transit Facility in Norfolk, Ne. The combined attendance totaled 87 unduplicated participants and 5 duplicated participants (the ELVPHD staff team

working to conduct the events), with 40 attending from West Point and 52 attending from Norfolk. Lunch was provided at both events.

A complete roster of the meeting participants is attached in Appendix III. Meeting participation reflected diversity, including the following sectors:

- Elected officials
- Hospital administration
- Behavioral health practitioners
- Community-based organizations
- Community college administrators
- Public Health students
- Health education directors
- Minority community leaders
- Business leaders
- Community Action Agency leaders
- Youth-serving organizations
- Long-term care facilities
- Organizations for persons with disabilities
- University representatives
- Hospice centers
- Educational Service Units
- Ponca Tribe representatives
- Federally-qualified health center leaders
- Organizations representing the elderly
- Housing officials
- Domestic violence organizations
- Chamber of Commerce leaders
- Veterans organizations
- City health officials

Written Drafts and Review Process:

For the drafts of each section of this plan, the information from the community meetings was compiled and served as the foundation for each section. Community discussion and priority strategies and actions were reviewed in the context of the following resources when determining whether proposed strategies were considered to be evidence-based:

- National Association of County & City Health Officials (NACCHO) *The Guide to Community Preventive Services (Community Guide)*, a resource designed to help identify evidence-based programs, practices and policies.
- National Registry of Evidence-based Programs and Practices (NREPP), a registry of evidence-based substance abuse prevention interventions.
- Network of Care: Model Practices, a database provided by NACCHO, which includes a registry of model practices and promising practices with evidence of improved health outcomes.

The drafts were also written to assure that multiple partners from diverse backgrounds would be able to implement related components of the plan. Hospital partners participated throughout the formation of the plan, and reviewed and approved the draft upon completion. Participating partners contributing at the stakeholder/focus groups were invited via a postcard to receive a draft copy of the plan upon their request, or to retrieve their own draft copy of the plan via the department's website.

St. Francis Memorial Hospital considers this a point-in-time document that is open for review and revision as new information and insight is gained at the local, state and national levels.

Community Description and Demographic Data

Community and demographic data were analyzed to get an understanding of who the constituents are that are being served by this plan and to understand how the constituents compare to the state, since ELVPHD is an agency operating within the state. Likewise, such information provided context for the responses provided in the Community-Level Health Survey (for example: Of course responses favor services for the 65 and over age group because one fourth of the populations is in this age group, already, and others fast approaching this age group).

Overview of Priority Areas and Strategies

Priority Area #1: Obesity

Justification: *Obesity rates for three of the four counties increased from 2013 to 2014, according to BRFSS data. Studies indicate that obesity is the causing agent of other diseases and contributes to the rising costs of healthcare.*

Goals:
Increase fruit and vegetable consumption.
Increase physical activity.

Strategies:

- Promote healthy vending machines in communities, schools (including concession stands), and workplaces
- Establish West Point as a site for the Bountiful Basket program
- Promote healthy lifestyles for families through education related to family-based health tips and interventions, including—shopping and cooking healthy, healthy meals 'on-the-go,' and healthy meals on a budget
- Promote worksite wellness policies/plans and implementation of evidence-based worksite wellness programs
- SFMH health coaches and registered dietician will provide nutritional counseling and healthy eating habits for our patients, staff and local students

Priority Area #2: Access to Care

Justification: *Barriers in recruitment, training and retention of health providers is contributing to a lack-of-access situation in the ELVPHD district, and across rural Nebraska. All four counties in the ELVPHD health district are designated shortage areas in primary care, dental health and behavioral health (HRSA, 2016).*

Goal:
Increase access to behavioral/mental health services in the ELVPHD health district.
Promote healthcare careers in the ELVPHD health district.

Strategies

- Enhance public knowledge of resources available within the community
- Work with existing behavioral health providers to become mentor/hosts to student interns
- Education regarding necessity of Medicaid expansion in Nebraska
- Enhance the availability of age-appropriate adult immunizations opportunities
- Continue active involvement with the Northeast Nebraska Behavioral Health Network
- Collaborate with Area Health Education Center (AHEC) to familiarize youth about careers in medicine, dentistry, psychiatry, and public health

Priority Area #3: Cancer Prevention and Screening

Justification: *Prevention and screening is the most cost-effective way to lessen the chances of cancer development or diagnosis of cancer at an advanced stage. This increases life expectancy, decreases medical costs, and improves quality of life.*

Goals:
Increase cancer prevention activities within the ELVPHD health district.
Increase cancer screening rates within the ELVPHD health district.

Strategies:

- SFMH will provide on-site preventative screening at a reduced cost to the community and area businesses through Business Health
- SFMH will provide free skin checks for employees as well as the community
- SFMH will remind individuals in our service area of the need for colonoscopies, mammography's, etc. via letters or phone calls
- Increase cervical cancer screen (Pap test) for women between the ages of 21 to 65
- Continue radon screening program on fee-for-kit basis

Priority Area #4: Standard Motor Vehicular Safety

Justification: *Vehicular/transportation-related risk behaviors rated #1 in terms of impact on the ELVPHD Community Level Health Survey. Outcomes of such risk behaviors are financially significant and emotionally impactful on communities.*

Goal:
Reduce standard motor vehicle accidents and injuries.

Strategies:

- SFMH to support high schools in promoting safe driving programs
- Collaborate with Nebraska State Patrol to host selective enforcement checks
- Increase child safety seat usage and proper installation of child safety seats

Aligning the Goals and Strategies

The Local Public Health System (LPHS) provides the foundation for all of the health priorities listed in the section above. To meet these for each priority, the goals and objectives were harmonized with the current strategic issues being addressed by ELVPHD.

Current Strategic Issues Include:

1. Offering opportunities for community citizens to participate in activities that promote healthy and safe living;
2. Marketing to better inform the public about what public health is and what services are available in the district;
3. Increasing collaboration and partnerships with other organizations in the community; and
4. Maintaining a formal Quality Improvement process throughout health department operations and programs.

Detailed Plans for Priority Areas and Strategies

PRIORITY 1: **OBESITY**

Problem Statement: "Obesity is among the most common, costly, and preventable of all health problems in Nebraska and throughout the United States. A healthy diet, physical activity, breastfeeding, and maintaining healthy body weight all significantly contribute to preventing obesity..." – Nebraska Physical Activity and Nutrition State Plan 2011-2016

Baseline Data:

- Throughout the ELVPHD area, obesity rates as reported:
  - In 2013, there were an estimated 12,616 adults who were obese (29.4%). By county: Burt, 1,624; Cuming, 2,029; Madison, 7,489; and Stanton, 1,474. [1,2]
  - In 2014, there were an estimated 13,328 adults who were obese. (23.4%). By county: Burt, 1,668; Cuming, 1,970; Madison, 8,551; and Stanton, 1,494. [1,2]
- 33.9% of respondents to the 2013 survey were obese. 39.4% of the respondents of the 2016 survey were obese. [3]
- Respondents in 2016 consumed considerably less fruit than those of 2013. [3]

	2013	2016
0 servings/day	2.0%	11.5%
1-2 servings/day	53.0%	72.0%
3-4 servings/day	21.0%	15.0%
5+ servings/day	5.3%	1.5%

- Respondents in 2016 consumed considerable less vegetables than those of 2013. [3]

	2013	2016
0 servings/day	10.5%	5.0%
1-2 servings/day	56.0%	71.0%
3-4 servings/day	26.0%	22.0%
5+ servings/day	7.5%	2.0%

- In 2016, the weight difference by gender are significant, with a larger proportion of males (28% more) either overweight or obese. [3]
- In 2013, 66% of survey respondents reported exercising for 20-30 minutes, 3 times per week or less. In 2016, 72% of survey respondents reported exercising for 20-30 minutes, 3 times per week or less. [3]

Data Source:

- BRFSS, 2013, 2014 [1]
- County Health Rankings, 2013 and 2016 [2]
- 2013, 2016 ELVPHD community-level health survey [3]

Linkage with ELVPHD Strategic Plan: health promotion, marketing, collaboration and partnerships, quality improvement

Linkage with State and National Initiatives: The Healthy People 2020 (HP2020) goal for a healthy weight is 33.9% from a U.S. baseline of 30.8%. The current healthy weight for ELVPHD is 33.3%. HP2020 Objective NWS-14: Increase the contribution of fruits to the diets of population aged 2 years and older. HP2020 Objective NWS-15: Increase the variety and contribution of vegetables to the diets of the population aged 2 years and older. HP2020 Objective PA-1: Reduce the proportion of adults who engage in no leisure-time physical activity. HP2020 Objective PA-4: Increase the proportion of the Nation's public and private schools that require daily physical education for all students. HP2020 Objective Michelle Obama's Let's Move Childcare and School lunch initiatives encourage increased health for children and families. The 2011-2016 Nebraska Physical Activity and Nutrition State Plan. Healthy eating and active living are focus areas of this plan. Both are listed under this priority area align with the focus areas of this statewide plan.

Linkage with DHHS Community Health Improvement Plan:

- Reducing heart disease and stroke.
- Reduce cancer morbidity and mortality.
- Expand health promotion capacity.
- Improve the integration of public health and health care services.
- Expand capacity to collect, analyze and report health data.

Linkage with UNMC College of Public Health Strategic Plan:

- Cancer prevention and control
- Community-based health transformation

Linkage with Public Health Association of Nebraska (PHAN) Strategic Plan:

- Expand Educational Opportunities
- Explore Diverse Funding

Current Programs/ Resources:	Analysis of Existing Gaps	Goal #1: Increase fruit and vegetable consumption in the ELVPHD district within the 3-year plan period.					
		Proposed Strategies/Activities	Policy Change	Evidence-Based	Potential Partners	Timeframe	Performance Measures
-Nutritional education in public settings (fair booths, schools, senior centers, newsletters, etc.)- FRHS, SFMH, OMH, NENCAP, ELVPHD -Child Care Food Program offered in licensed childcare centers -USDA school lunch regulations (Michelle Obama) -Nutritional counseling through Commodity Supplemental Food Program, Head Start/ Preschools and WIC—NENCAP -Healthy vending/ cafeteria options at worksites—SFMH, FRHS, OMH, ELVPHD -Nutritional counseling for patients through health coaching and/or case managers—SFMH, FRHS. -Coaching/ education as a component of home visitation programs -Presentations are being given in schools regarding physical activity/nutrition - ELVPHD Minority Health Program offers Eating Smart-Being Active program in Spanish -NENCAP Home Visitation Program offers an educational topic regarding 'rewarding children without food' -Norfolk has community garden in place. -Farm to School program is utilized by a few area schools -SNAP food program accepted at farmer's markets -HyVee offers nutritionist/cooking classes. -Some walking trails are available—Cowboy Trail, Skyview Lake, North Fork River Trail, Summit Lake Trails.	• Some people may not be aware of available resources—more marketing. • Food/candy is used as a reward at home, school and work places. • Food bank donations and general supply of food bank foods are often low quality and poor on the nutritional-value scale • Convenience foods (pre-packaged foods, fast foods, and drive thru options) are cheaper and fast—more appealing for busy, working people. • People "on the	1. Promote healthy vending machines in communities, schools (including concession stands), and workplaces.	X	X	Community leaders Schools Employers Hospitals Restaurants	2016 and ongoing	At least 3 sites (communities, schools, or workplaces) will develop and implement healthy vending polices. Health outcome will be measured by a reported increase in fruit and vegetable consumption in the next ELVPHD survey.
		2. St. Francis Hospital will work with Chamber of Commerce to establish West Point as a site for the Bountiful Basket program	X	X	Community-based organizations West Point Chamber of Commerce Hospitals	2016 and ongoing	Increase the availability of fresh fruits and vegetables through the Bountiful Basket program. Possibly having the Hospital as a pickup site for the baskets.
		3. Promote healthy lifestyles for families through education related to family-based health tips and interventions, including elements such as: • shopping and cooking healthy • healthy meals 'on-the-go' • healthy meals on a budget SFMH will have a healthy cooking demonstration at least four times per year for employees and explore offering it to community		TBD	Northeast Nebraska Community Action Partnership (NENCAP) Schools Hospitals	2016 and ongoing	At least 8 educational initiatives will be implemented each year in the through social media regarding family-oriented healthy lifestyles. Health outcome will be measured by a reported increase in physical activity in the next ELVPHD survey or by current initiatives sponsored by ELVPHD.

-ELVPHD has brochures for many communities with various walking routes mapped out. -Norfolk and West Point "Trails" Committee -Tai Chi offered in many communities as a physical activity option for seniors. -Many areas have fitness centers/gyms available to the public. Some with discounted options for low income. -Health coaches and case management available-SFMH, ELVPHD, MHC. -Outpatient Nutrition Services provided by various providers in the district. -Classes for diabetes education are offered throughout the district. -Pre-Diabetes Classes discusses what life changes can be made to prevent diabetes and other health problems. Topics covered include healthy weight, nutrition, cholesterol, high-blood pressure and glucose levels -Bountiful Baskets program going in several communities. This increases access to lower-cost fresh produce. -Most communities have parks identified as safe places for outdoor activities. -NAP SAAC program offers education to childcare providers regarding physical activity and nutrition.	go" resort to unhealthy vending. • Designated walking areas not available in all communities. • Schools continue to be pressured in standardized test scores that more time is spent in classroom and less on health. • All fitness places do not offer discounted memberships for low-income. • Lack of knowledge on how to find dieticians. • Lack of knowledge on how to find fitness trainers. • Seasonal challenges. • Lack of promotion of what is available.	**Goal #2:** Increase physical activity in the ELVPHD district within the 3-year plan period.

Proposed Strategies/Activities	Policy Change	Evidence-Based	Potential Partners	Timeframe	Performance Measures
1. Promote worksite wellness policies/plans and implementation of evidence-based worksite wellness programs.	X	X	Employers SFMH Health Coaches Chambers of Commerce	2016 and ongoing	Ten businesses in the ELVPHD jurisdiction will implement this strategy and will demonstrate improved health through specific health outcome measures.
2. SFMH health coaches and registered dietician will provide nutritional counseling and healthy eating habits for our patients, staff and local students.		X	SFMH Schools	2016 and ongoing	Education the community of the availability of nutritional council through social media. Educate local youth 2 times per year on the importance of healthy eating and exercise.

Obesity Workgroup Team Members			
Allison Brandes	Franciscan Care Services	Michael Ortmeier	Faith Regional health Services
Delaney Brudigan	Franciscan Care Services	Jacque Genovese	Faith Regional Health Services
Crystal Hunke	Franciscan Care Services	Jenny Simmons	Faith Regional Health Services
Alice Hunzeker	Franciscan Care Services	Jon Bailey	Northeast Nebraska Behavioral Health Network
Stacie Petersen	Franciscan Care Services	Susan Strahm	Northern Early Learning Connection
Tayler Hinrichs	Elkhorn Logan Valley Public Health Department	Larry Voegele	Ponca Tribe of Nebraska
Matt Connealy	Burt County Supervisor	Amanda Christiansen	Midtown Health Center, Inc.

How to get involved in obesity initiatives:
Stacie Petersen, Franciscan Care Services
402-372-2477
OR
Tayler Hinrichs, Elkhorn Logan Valley Public Health Department
402-529-2233
OR
Michael Ortmeier, Faith Regional Health Services
402-371-4880

PRIORITY 2: ACCESS TO CARE

Problem Statement: Barriers in recruitment, training and retention of healthcare providers is contributing to a lack-of-access situation in the ELVPHD district, and across rural Nebraska.

Baseline Data:

- All four counties in the ELVPHD health district are designated health provider shortage areas in primary care, dental health, and mental health. [1]
- Primary care provider density (ratio of population to primary care provider) [2]

	2013	2016
Nebraska	1,413:1	1,345:1
Burt County	3,425:1	3,287:1
Cuming County	3,052:1	2,999:1
Madison County	1,397:1	1,260:1
Stanton County	Not reported	

- Community survey respondents cited the following barriers that prevent them from seeking healthcare services or prescription drugs: [3]
  - Can't pay for health screenings/services 21.4%
  - Health insurance doesn't cover 12.2%
  - Deductibles or co-payments too high 30.6%
  - Lack of time to get health services 13.1%
  - Office hour limitations not convenient 5.6%
- 24% of survey respondents do not have dental insurance. [3]
- Dental appointments within the past year increases with income. For respondents with income <=$25,000, only 46% had a dental exam. [3]
- Hospital-specific community health survey respondents indicated a desire for increased services. [3]
- Only 41% of dental providers in the area accept Medicaid. [4]
- Only 27% of dental providers in the area accommodate Spanish-speaking patients via provision of an interpreter. [4]
- Behavioral health wait times for appointments is 2-3 weeks locally and 2-3 months for severe illness needing intense psychiatric services. [5]
- Chlamydia rates have doubled in the ELVPHD jurisdiction over the past 5years. [6]

Data Source:

- HRSA, HPSA Data Warehouse, 2016 [1]
- County Health Rankings, 2013 and 2016 [2]
- 2016 ELVPHD community-level health survey [3]
- 2016 ELVPHD phone survey of dental providers [4]
- Verbal report from provider to ELVPHD, 2015 [5]
- Nebraska Electronic Disease Surveillance System, 2015 [6]

Linkage with ELVPHD Strategic Plan: health promotion, collaboration and partnerships, quality improvement

Linkage with State and National Initiatives: HP2020 Objectives AHS-3: Increase the proportion of persons with a usual primary care provider. OH-7: Increase the proportion of children, adolescents and adults who used the oral health care system in the past year. MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral. The Obama Administration is committed to raising awareness about mental health issues, including expanding mental health coverage via ACA.

Linkage with DHHS Community Health Improvement Plan:

- Improve the integration of public health, behavioral health and health care services.
- Expand the capacity to collect, analyze and report health data.

Linkage with UNMC College of Public Health Strategic Plan:

- Health System Transformation
- Community-Based Health Transformation

Linkage with Public Health Association of Nebraska (PHAN) Strategic Plan:

- Expand educational opportunities.
- Explore diverse funding.

Current Programs/ Resources:	Analysis of Existing Gaps	**Goal #1:** Increase access to behavioral/mental health services in the ELVPHD district within the 3-year plan period.					
		Proposed Strategies/Activities	Policy Change	Evidence-Based	**Potential Partners**	Timeframe	**Performance Measures**
-Advocacy organizations exist that talk to elected officials -Existence of MHC—for primary care, dental and mental health services -Some providers offer Spanish translation services for patients -Public immunization clinic does exist. Other agencies are offering adult-based immunizations in innovative settings -There are concerned agencies/groups and individuals at large that want to mobilize to solve this issue -Smile In Style program in preschools and childcare facilities -Creation of the Northeast Nebraska Behavioral Health Network -Some areas are oversaturated with LMHPs -Healthy Communities Initiative Coalition in existence -DHHS conducting STD surveillance -1/3 of MHC staff are bilingual -Veteran's Advisory Committee exists (through ELVPHD's VetSET Coordinator) -Many employers offering Employee Assistance Programs	• Too many places for information, people now using internet in place of healthcare provider • Rural areas have more distinct ratios of providers to patients • Public immunization provisions have changed through the years • Negative stigma about mental health services and people that access them • Huge shortage of services—psychiatry. • Patients left overwhelmed by current system • Lack of providers for children (psychiatry) • Low amount of bilingual providers • Retention of providers is hard in rural area • Funding cuts to Komen's free mammogram program • No Urgent Care Centers in rural counties encouraged inappropriate use of ER • Transportation in rural areas is a huge shortage • High need for prescribers for behavioral health • High need for programs aimed at post-war veterans and their families. • Not all employers offer EAP	1. Education regarding necessity of Medicaid expansion in Nebraska.	X		Hospitals Midtown Health Center, Inc. (MHC) Friends of Public Health in Nebraska	2016 and ongoing	A minimum of 8 correspondences annually promoting Medicaid expansion to elected officials.
		2. SFMH will continue to have job shadowing available to individuals interested in healthcare		X	Hospitals/Medical Clinics	2016 and ongoing	Increase number of individuals that job shadow. First year will focus on baseline and establish % increase from baseline.
		3. Work with existing behavioral health providers to become mentor/host to student interns			NECC and UNMC	2016 and ongoing	Clinic will be willing to mentor student in behavioral health program with at least two students per year.

(EAPs) -TeamMates and other organized groups offer support systems for those in need -Some dental clinics are now accepting Medicaid -VetSET exists to help veterans with their access to care issues -Ponca Tribe of Nebraska, Norfolk Clinic opened a Behavioral Health Clinic for American Indians/Natives -Ponca Tribe of Nebraska ($5 each way) and Midtown Health Center offers transportation services, as well as Norfolk Public Transportation ($2 each way) available -Liberty Centre offers transportation (only to its members) -Psychiatric nurse practitioner from SFMH expanded her services to one more clinic (Hooper), now offering psychiatric services at 3 locations -Region 4 contracts for reimbursement for behavioral health services -Oasis telehealth- O'Neill and Jr. High School -Midtown Health Center working on contract with UNMC for behavioral medication management -Midtown Health Center hired therapist for all ages -Local Suicide Prevention Coalition is active	programs. • ELVPHD offers FOBT kits • Lack of utilization of STD screenings is a big issue • Law enforcement is not utilizing crisis team • Need for all agencies to share information at Continuum of Care meetings • Richard Young telehealth does not accept Medicare • Poor reimbursement for psych care • No support groups for people with certain diagnoses—no funding for such groups. • No geriatric behavioral health beds.	

Goal #2: Promote healthcare careers in the ELVPHD district within the 3-year plan period.

Proposed Strategies/Activities	Policy Change	Evidence-Based	Potential Partners	Timeframe	Performance Measures
1. Continue active involvement with the Northeast Nebraska Behavioral Health Network.		X	Northeast Nebraska Behavioral Health Network UNMC College of Nursing MHC Northern Nebraska AHEC Region 4 Behavioral Health System	2016 and ongoing	At least three correspondences with local AHEC per year.
2. Collaborate with Northern Nebraska Area Health Education Center (AHEC) to familiarize youth about careers in: • Medicine (primary care provider) • Psychiatry/mental or behavioral health • Public Health			AHEC UNMC College of Public Health Northeast Community College student nurses	2016 and ongoing	At least three correspondences with local AHEC per year.
3. Enhance public knowledge of resources available within the community for mental health.			Various program sponsors	2016 and ongoing	Provide community education about available resources at least four times a year using social media

-20 bed adult inpatients at FRHS
-Local Crisis Care Line
-Local Continuum of Care Chapter is active in Norfolk
-Parent to Parent Network is a resource
-Probation office provides 6 support groups
-Veterans Home has a psych provider
-Drug Court (Norfolk)

Access to Care Workgroup Team Members:

Sara Cameron	Oakland Mercy Hospital/ELVPHD Board of Health
John Werner	Oakland Mercy Hospital
Kara Andersen	Northeast Nebraska Behavioral Health Network
Jon Bailey	Northeast Nebraska Behavioral Health Network
Margarita Flores	Bridge Crisis Center
LaWanda Neveay	Stanton Health Center
Teri Wendel	Nebraska Children's Home Society
Tina Bileghe Bi Ndong	West Point Chamber of Commerce
Jennifer Smidt	The League of Human Dignity
Robin Claussen	Liberty Centre
Angie Rodman	Early Development Network/NENCAP
Donna Benson	Norfolk Family Coalition
Julie Johnson	Woman's Empowering Lifeline
Mary Lotts	UNL Extension-Burt County
Lee Sherry	UNL Extension-Madison County
Carol Kampschneider	Franciscan Care Services
Courtney Gotsch	One2One Patient Connect
Beth Buss	Elkhorn Logan Valley Public Health Department
McKayla Hammond	Elkhorn Logan Valley Public Health Department
Laura Holtz	Elkhorn Logan Valley Public Health Department
Melissa Nemec	Elkhorn Logan Valley Public Health Department
Myriar Jackson	Elkhorn Logan Valley Public Health Department
Kathy Becker	Elkhorn Logan Valley Public Health Department
Terri Ford-Wolfgram	Midtown Health Center, Inc.
Kathy Nordby	Midtown Health Center, Inc.
Tony Mobley	Faith Regional Health Services
Monica Emery	Faith Regional health Services
Steve Hecker	Region 4 Behavioral Health Services
Mark Stortvedt	Oasis Counselling International
Addisen Beck	Cuming County Juvenile Diversion
Sara Ruda	Ascera Care Hospice

How to get involved in Access to Care initiatives:
McKayla Hammond, Elkhorn Logan Valley Public Health Dept.
402-529-2233
OR
Kathy Nordby, Midtown Health Center, Inc.
402-371-8000
OR
(for behavioral health)
Jon Bailey, Northeast Nebraska Behavioral Health Network
402-844-7928

PRIORITY 3: CANCER PREVENTION AND SCREENING

Problem Statement: When preventative practices and cancer screenings are not utilized, larger and costlier cancer conditions can result, which increases medical costs, and decreases quality of life and life expectancy.

Baseline Data:

- Both genders, 50-75 years old, up-to-date on colon cancer screening: [1]

	2012	2013	2014
ELVPHD	60.6%	53.3%	59.8%
State of Nebraska	61.1%	62.8%	64.1%

- Women, 50-74 years old, up-to-date on breast cancer screening: [2]

	2012	2014
ELVPHD	75.5%	77.2%
State of Nebraska	74.9%	76.1%

- Women, 21-65 years old, up-to-date on cervical cancer screening: [3]

	2012	2014
ELVPHD	84.2%	80.3%
State of Nebraska	83.9%	81.7%

- One in 5 adults in the ELVPHD jurisdiction (18.2%) are current smokers. State average is one in 6 (17.4%). The percent of current smokers for ELVPHD did not change 2011-2014. [4]

Data Source:

- BRFSS, 2012, 2013, 2014.[5]

Linkage with ELVPHD Strategic Plan: Promotion of safe and healthy lifestyles, marketing, collaboration, quality improvement

Linkage with State and National Initiatives: HP2020 Objective C-15: Increase the proportion of women who receive a cervical cancer screening based on the most recent guidelines. HP2020 Objective C-16: Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines. HP2020 Objective C-17: Increase the proportion of women who receive a breast cancer screening consistent with current guidelines.

Linkage with DHHS Community Health Improvement Plan:

- Reducing cancer morbidity and mortality.
- Expand health promotion capacity.
- Improve the integration of public health, behavioral health and health care services.

Linkage with UNMC College of Public Health Strategic Plan:

- Cancer prevention and control.
- Community-Based Health Transformation
- Health System Transformation

Linkage with Public Health Association of Nebraska (PHAN) Strategic Plan:

- Expand educational opportunities.
- Explore diverse funding.

Current Programs/ Resources:	Analysis of Existing Gaps	**Goal #1:** Increase cancer prevention activities within the ELVPHD district within the 3-year plan period.					
		Proposed Strategies/Activities	**Policy Change**	**Evidence-Based**	**Potential Partners**	**Timeframe**	**Performance Measures**
-Some health fair screenings available -Hospital outreach services to business community -Radon test kits disseminated through County Extension offices -Elkhorn Logan Valley Colon Cancer Prevention Coalition -New occult blood test screening has become available -Entitlement programs such as Every Woman Matters for breast and cervical cancer screening -Stay in the Game Nebraska Colon Cancer Screening Program -Midtown Health Center is a resource for under- and uninsured -Funding available through Komen and Avon for breast health -With new electronic health records, screening needs are flagged -Several community resources exist, now we need better coordination	• Access in rural communities is limited. • Busy people don't have time to make prevention a priority. • No policies in place to help people make prevention a priority. • Constant community awareness is lacking—many times efforts focus on an awareness week or month, then the messages fade away. • Doctor availability for preventative visits is limited. • Some cannot afford the price of such screenings. • Transportation services are lacking, especially in smaller communities. • People "know" issues but choose not to act on issues. Others don't know what they have or have not had in terms of screenings. They "do it" because their doctor told them to but don't know what it is or what the purpose is. • Under-insured yet "over-income" for resources. • More providers are offering screenings at fee-for-service. • Some providers only want to address "one thing at a time." If the office visit is for another reason, other than preventative care, screening discussions are more than	1. SFMH will provide on-site preventative screening at a reduced cost to the community and area businesses through Business Health	X	X	Business owners SFMH Business Health	2016 and ongoing	Will have at least one community health fair. Continue to offer on-site Business Health to area businesses. First year will focus on baseline and establish % increase from baseline
		2. Explore additional cancer prevention programs, such as permanent shade structures, radon mitigation programs, etc. SFMH will provide free skin checks for employees as well as the community.		X	Physician/PA	2016 and ongoing	Provide at least two free skin check per year to the community.

likely missed.
- Different organizations support different screening frequencies.
- Health dept. needs more marketing
- There is still a gap in education. There is a generation that only utilizes computers. Other generations don't use computers.
- E-cigarettes is a huge problem in the area

Goal #2: Increase cancer screening rates within the ELVPHD district within the 3-year plan period.

Proposed Strategies/Activities	Policy Change	Evidence-Based	Potential Partners	Timeframe	Performance Measures
1. SFMH will remind individuals in our service area of the need for colonoscopies, mammography's, etc. via letters or phone calls.		X	Hospitals Medical Clinics PATCH	2016 and ongoing	Increase exams by 10% Current fecal occult blood test (FOBT) within the past year is 22.9% and colonoscopy with past 10years is 60.3%. Current mammogram within the past year is 61.2%.
2. Increase cervical cancer screen (Pap test) for women between the ages of 21 to 65.		X	ELVPHD and partners	2016 and ongoing	Increase Pap test within the last three years by 5%. Cuming county currently at 65.4% and NE is at 81.7% in 2014.
3. Continue radon screening program on fee-for-kit basis. American Cancer Society endorses radon screening and mitigation programs.	X	X	County Extension Offices Realtors Elected Officials	2016 and ongoing	Increase participation in the service area by 5% each year. Outcome measures for participants will also be subject to ELVPHD Performance Measure: • 65% of radon kits will be returned each year.

Cancer Prevention and Screening Workgroup Team Members:

Kendra Oss Hurn	Goldenrod Regional Housing Agency	Jayma Brown	OakLand Mercy Hospital	**How to get involved in cancer prevention and screening initiatives:** Tracy Benjes, Elkhorn Logan Valley Public Health Department 402-529-2233
Anastasia Stoney	Franciscan Care Services	Nikki Pierce	Northeast Nebraska Community Action Partnership	
Teresa Cortez	Ponca Tribe of Nebraska	Connie Cooper	Northeast Nebraska Area Agency on Aging	
Lora Langley	Ponca Tribe of Nebraska	Scott Sloss	Faith Regional Health Services/Carson Cancer Institute	
Sara Pfeifer	Ponca Tribe of Nebraska	Ashley Petersen	Elkhorn Logan Valley Public Health Department	
Linda Miller	ELVPHD Board of Health/FRHS Board of Directors	Mason McCain	Elkhorn Logan Valley Public Health Department	
Shawn Smith	Oakland Mercy Medical Clinic			

PRIORITY 4: STANDARD MOTOR VEHICULAR SAFETY

Problem Statement: Motor vehicle crashes are a leading cause of injury and death; at the same time there are (according to the CDC) many proven prevention strategies. Components include the use of seat belts and child safety seats, and limiting behaviors that impair judgment while driving.

Baseline Data:

- Texting while driving was rated #1 in terms of impact for the ELVPHD jurisdiction for risk behavior in both the 2013 and 2016 community-level health survey. Talking on a cell phone while driving was rated #3 in terms of impact for the ELVPHD jurisdiction for risk behaviors in both the 2013 and 2016 community-level health survey. [1]
- Although the mortality rate for this cause of death (death or injury resulting from a motor vehicle crash) is improving, it remains the most frequent cause of unintentional injury deaths in Nebraska. [2]
- Traffic Data (ages 16-20) Rate per 10,000 Population[3]

	2011		2012		2013	
	ELVPHD	State	ELVPHD	State	ELVPHD	State
Alcohol-related fatal crashes	2.6	0.5	5.5	1.3	0.0	0.5
Alcohol-related injury crashes	10.5	8.8	16.6	11.6	10.8	6.0
Driving under influence (DUI)	13.1	14.8	16.6	14.7	18.9	11.7

Data Source:

- 2013, 2016 ELVPHD community-level health survey [1]
- Nebraska Statewide Health Needs Assessment, 2013 [2]
- Nebraska Department of Transportation, 2014 [3]

Linkage with ELVPHD Strategic Plan: promoting safe lifestyles, collaboration

Linkage with State and National Initiatives: HP2020 Objective IVP-11: Reduce unintentional injury deaths. HP2020 Objective IVP-12: Reduce nonfatal unintentional injuries; HP2020 Objective IVP-13: Reduce motor vehicle crash-related deaths; HP2020 Objective IVP-14: Reduce nonfatal motor vehicle crash-related injuries; HP2020 Objective IVP-15: Increase use of safety belts; and HP2020 Objective IVP-16: Increase age-appropriate vehicle restraint system use in children. American Association of State Highway and Traffic Officials (AASHTO) emphasis areas include: increasing seat belt usage, reducing alcohol-impaired driving, and keeping drivers alert. State and National laws have been considered in regards to motor vehicle safety and stiffening penalties for distracted or impaired driving.

Linkage with DHHS Community Health Improvement Plan:

- Expand health promotion capacity.

Linkage with UNMC College of Public Health Strategic Plan:

- Community-Based Health Transformation
- Health System Transformation

Linkage with Public Health Association of Nebraska (PHAN) Strategic Plan:

- Expand educational opportunities.

Current Programs/ Resources:	Analysis of Existing Gaps	Goal #1: Reduce standard motor vehicle accidents and injuries in the ELVPHD district within the 3-year plan period					
		Proposed Strategies/Activities	Policy Change	Evidence-Based	Potential Partners	Timeframe	Performance Measures
-Child safety seat checks occur in some communities regularly-generally sponsored by hospitals -Nebraska State Patrol has resources available -Laws have been adopted in attempt to eradicate distracted driving -Geriatric Driving Assessments being offered at some locations -Phone apps now available to deter distracted driving. -Car seats for qualifying individuals -Car seat technicians in some communities -Healthy Communities Initiative has an aim for reducing drunk-driving crashes	• Elderly driving is a difficult topic for families to address. • Legislatively, fines are not steep enough. • More signage is needed on roadways warning drivers of children, etc. • Personal attitudes/ accountability are huge issues in participation of risky behaviors. • Education needs to happen with parents so parents feel empowered to discuss risky behaviors with their children. • There continues to be a lack of awareness regarding the dangers of distracted driving. • Lack of knowledge regarding current resources available to deter distracted driving.	1. Raise community levels of awareness regarding the dangers of distracted driving. SFMH to support high schools in promoting safe driving programs.	X		Schools Community-based organizations Hospital	2016 and ongoing	Increase the number of students leaving or arriving at school with seatbelts on by 5% each year.
		2. Collaborate with Nebraska State Patrol to host selective enforcement checks. This practice limits drunk-driving.		X	Healthy Communities Initiative Nebraska State Patrol	2016 and ongoing	At least two enforcement checks will be held in the ELVPHD district annually. With increased enforcement, it is expected that citations will rise. Outcome measure will be a decrease in alcohol-related crashes over a 5-year period.
		3. Increase child safety seat usage and proper installation of child safety seats.		X	St. Francis Memorial Hospital Faith Regional Health Services NENCAP ELVPHD to promote agencies/events that provide this service	2016 and ongoing	At least three car seat safety checks will happen in the ELVPHD jurisdiction annually. Participation will increase by 5% each year across the jurisdiction. Outcome measure will be a decrease in injury and death of children from motor vehicle crashes over a 5 year period.

Standard Motor Vehicular Safety Workgroup Team Members:				How to get involved in vehicle safety initiatives:
Ashley Petersen	Franciscan Care Services	Dusti Sturm	Northeast Nebraska Community Action Partnership	Kathy Becker, Healthy Communities Initiative 402-529-2233 OR Mark Sears, Faith Regional Health Services 402-371-4880
Jerry Wardekamper	Franciscan Care Services	Nikki Mullenix	Elkhorn Logan Valley Public Health Department	
Alisa Brunsing	Franciscan Care Services	Melanie Thompson	Elkhorn Logan Valley Public Health Department	
Terry Ranig	Northeast Community College	Maritza Andrade	Elkhorn Logan Valley Public Health Department	
Cliff Morrow	Burt Co. Supervisor/ELVPHD Board of Health	Mark Sears	Faith Regional Health Services	
Christopher Johnson	Johnson Rehabilitation and Sports Performance	Barb Petersen	Faith Regional Health Services	
Sally Olson	Memorial Community Hospital Health System	Nora McGill	Faith Regional Health Services	

Follow-Up and Monitoring

The Health Department has assigned individual staff members to commit to continued service and monitoring on each of the priority areas. As such, staff members are responsible for:

- Organizing task groups on an as-needed basis, consisting of both field professionals and representative community members.
- Adhering to, and pursuing, the work outlined in the detailed plans.
- Holding true to Performance Measures and evaluation metrics as specified, including holding true to the ELPVHD Quality Improvement and Performance Management Plan.
- Assuring work is coordinated with ELVPHD programs, Strategic Plan, PHAB guidelines.
- Communicating appropriately with the community at large via traditional media, social media, website and newsletter.

Those leading the efforts include Elkhorn Logan Valley Public Health Department, Oakland Mercy Hospital, St. Francis Memorial Hospital, Faith Regional Health Services and Midtown Health Center, Inc. In order to increase efficiency and economies of scale, redundancy and capacity building is of key interest to all of the above mentioned partners. Further, collaboration on community health improvement efforts is of mutual benefit to all agencies, and moreover, better supports the philosophy of a community-driven improvement effort.

Follow-up meetings will be held face-to-face with the leading partners sporadically through the life of the plan, but a minimum of once per calendar year. Other communications will be held via phone, email, etc. on an as-needed basis throughout the course of the year. During these meetings, those in attendance will discuss progress towards the implementation of the plan and, if needed, will develop specific action steps within each priority area and will further develop areas that are lacking in progress. It is believed that this method will assure timely progress towards specific goals and measures, but will also decrease likelihood of duplicated efforts.

In addition, the following controls have been put into place at ELVPHD to assure accurate and timely progress in meeting plan objectives and goals:

- Regular discussion in ELVPHD staff meetings. At staff meetings, scheduled events, reports, and deadlines are discussed. Minutes and agendas to these meetings reflect this discussion and are available upon request.
- All field staff meet with their supervisor, generally once per week, but varies based upon the individual needs of the staff member/program, to assure that program outcomes/objectives, etc. are achieved.
- Board of Health receives updates on all programs during bi-monthly Board meetings. ELVPHD retains an 'open door' policy for any Board member and the general public at all times.
- Personnel policies and office procedures communicate expectations for all staff and assure a level of consistency in operations agency-wide and set the tone for a culture of quality and improvement.
- Job descriptions clearly identifying all duties, roles and responsibilities of all staff are signed by the employee on an annual basis and filed in each employee's respective personnel file.
- ELVPHD Administrative Assistant regularly informs Health Director of health-related happenings in the 4-county area as noted in newspapers and other media.

Community Health Needs Assessment
Implementation Plan
2017-2019

CHNA Priority #1—Obesity

- Promote healthy vending machines in communities, schools (including concession stands), and workplaces
- St. Francis Hospital will work with Chamber of Commerce to establish West Point as a site for the Bountiful Basket program
- SFMH will have a healthy cooking demonstration at least four times per year for employees and explore offering it to community
- SFMH health coaches and registered dietician will provide nutritional counseling and healthy eating habits for our patients, staff and local students

CHNA Priority #2—Access to Care

- SFMH will collaborate with Northern Nebraska Area Health Education Center (AHEC) to familiarize youth about careers in; Medicine (primary care), Psychiatry/mental or behavioral health, and Public Health
- SFMH will continue to have job shadowing available to individuals interested in healthcare
- SFMH will provide clinical rotations for mental health APRNs through our Psychiatric Nurse Practitioner
- SFMH will continue active involvement with the Northeast Nebraska Behavioral Health Network
- Enhance public knowledge of resources available within the community for mental health

CHNA Priority #3—Cancer Prevention and Screening

- SFMH will provide on-site preventative screening at a reduced cost to the community and area businesses through Business Health
- SFMH will provide free skin checks for employees as well as the community.
- SFMH will remind individuals in our service area of the need for colonoscopies, mammography's, etc. via letters or phone calls.

- Increase cervical cancer screen (Pap test) for women between the ages of 21 to 65
- Continue radon screening program on fee-for-kit basis

CHNA Priority #4—Standard Motor Vehicular Safety

- SFMH will provide 3 child safety seat checks in our service area per year
- SFMH to support high schools in promoting safe driving programs.
- SFMH will collaborate with Nebraska State Patrol to host selective enforcement checks. This practice limits drunk-driving

Organizations that were invited to the CHIP meeting, community focus group meetings and strategic planning sessions are listed below.

- Ace Optometry
- American Red Cross
- Anytime Fitness
- Authier Miller Pape Eyecare Consultants
- Baker Counseling
- Bancroft Rosalie High School
- Behavioral Health Specialists
- Big Brothers/Big Sisters
- Birthright
- Burgess Clinic
- Burt County Attorney
- Burt County Clerk
- Burt County Economic Development
- Burt County Extension Office
- Burt County Sheriff
- Burt County Supervisors
- But County Veterans Services
- Carson Cancer Center
- Center for Rural Affairs
- Central Valley Ag
- Chatt Senior Center
- Child Care Provider (Daycare)
- Christian Lutheran Church
- City of Lyons
- City of Norfolk
- City of Oakland
- City of Tekamah
- City of West Point
- Clyde Eyecare and Associates
- Colonial Haven
- Corner Drug
- Cottonwood Clinic
- Countryside Vet Clinic
- Craig Fire and Rescue
- Cuming County Board of Supervisors
- Cuming County Clerk
- Cuming County Economic Development
- Cuming County Emergency Management
- Cuming County Juvenile Diversion Office
- Cuming County Veterans Services
- Cuming County Sheriff's Office
- Decatur Fire and Rescue
- Decatur Police Department
- Diabetes and Wellness Clinic
- Dinklage Medical Clinic
- Dr. James Brosniham, DDS
- Elkhorn Valley Economic Development
- Exact Eye Care
- Faith Regional Family Practice
- Faith Regional Health Services
- Faith Regional Madison Family Medicine
- Family Dental Center
- Family Vision Center
- Feidler Eye Clinic
- Franciscan Care Services
- General Assistance/County Medicine
- Golden Living Center
- Golden Oaks
- Goldenrod Hills Regional Housing Agency
- Grace Lutheran Church
- Guardian Angels Central Catholic
- Happy Days
- Healthy Communities Initiative
- Helena Chemical Company
- Hofmann Pharmacy, Inc.
- Home Health Care
- Home Instead Senior Care
- Hy-Vee East Pharmacy
- Hy-Vee West Pharmacy
- Ionia Research
- Ivy Street Medical
- John A. Stahl Memorial Library
- Joseph's Retirement Community
- Kiddie Korral
- Kind Counseling Services, Inc.
- Land O'Frost
- Lloyds Drug Mart
- Logan Valley Manor
- Lutheran High Northeast High School
- Lyons Fire and Rescue
- Lyons Police Department
- Lyons-Decatur Northeast Schools
- Madison Public Schools
- Madison County Commissioners
- Madison County Juvenile Diversion
- Madison Medical Clinic
- MCH Clinics
- Meds & More
- Memorial Community Hospital

- Memorial Community Hospital Clinics
- Midwest Health Partners
- Midwest Veterinary
- Mount Olive Lutheran Church
- Nebraska Department of Agriculture
- Nebraska Department of Health and Human Services
- Nebraska EMS Program
- Nebraska State Senator, District 16
- Nebraska State Senator, District 19
- Nebraska State Senator, District 22
- Norfolk Area Chamber of Commerce
- Norfolk Catholic High School
- Norfolk Community Health Care Clinic
- Norfolk Dental Group, LLP
- Norfolk Economic Development
- Norfolk Family Medicine
- Norfolk Housing
- Norfolk Iron and Metal
- Norfolk Medical Group
- Norfolk Police Department
- Norfolk Public Schools
- Norfolk Regional Center
- Norfolk Rescue Mission
- Northeast Community College
- Northeast Nebraska Area Agency on Aging
- Northeast Nebraska Behavioral Health Network
- Northeast Nebraska Community Action Partnership
- Northeast Eye Care
- Northeast Nebraska EMS
- Northeast Nebraska Psychological Services, PC
- Northern Nebraska AHEC
- North Star Services
- Nucor Cold Finish
- Nucor Steel
- Oakland Chamber of Commerce
- Oakland Fire and Rescue
- Oakland Heights
- Oakland Mercy Hospital
- Oakland Police Department
- Oakland-Craig Schools
- One2One Patient Connect
- Pamida Pharmacy
- Ponca Tribe of Nebraska
- Premier Estates of West Point LLC
- Region 11 Emergency Manager
- Region 4 Behavioral Health Systems
- Region 5/6 Emergency Management
- Sacred Heart Elementary
- Saint Francis Memorial Hospital
- Salvation Army
- Santa Marianita Clinic
- Sears Center
- Senior Center
- Shopko Optical Center
- Shopko Pharmacy
- Smeal's Manufacturing
- St. Mary's Catholic Church
- Stanton Community Schools
- Stanton County Commissioners
- Stanton County Emergency Management
- Stanton Health Center
- Stanton Telecom
- State of Nebraska Judicial Branch
- Sunny Meadow Clinic
- Sunshine Center
- TeamMates Mentoring Program
- Tekamah Fire and Rescue
- Tekamah Police Department
- Tekamah-Herman Schools
- The Gallery Professional Center
- Tom's Rexall Drug
- Tyson Fresh Meats
- UNL Extension Office-Cuming County
- UNMC College of Nursing
- Urgent Care Clinic
- US92
- U-Save Pharmacy
- Valmont
- Village of Craig
- Village of Decatur
- Walgreen Pharmacy
- Walmart Pharmacy
- Wells Fargo Bank
- West Point-Beemer Public Schools
- West Point Chamber of Commerce
- West Point Crisis Center
- West Point Dairy Products
- West Point Emergency Management
- West Point EMS
- West Point Food Pantry

- West Point Head Start
- West Point Living Center
- West Point Police
- West Point Public Schools
- Wisner Area Chamber of Commerce
- Wisner Care Center
- Wisner City Administrator/Economic Development
- Wisner Community Development
- Wisner Pharmacy
- Wisner Preschool/Headstart
- Wisner-Pilger Public Schools
- Women's Empowering Lifeline
- Wragge Pharmacy
- YMCA

APPENDIX II

Analysis and Report
Community Health

Ionia Research

Elkhorn Logan Valley Public Health Department

Gina Uhing
Health Director

(Counties: Burt, Cuming, Madison, Stanton)

Joseph Nitzke

April 11, 2016

Contents

General Demographics

This initial section includes demographic data about the district from Census data, from the survey, and from the various data collection projects. *Since this report contains numerous statements based on the community survey, it is necessary to understand the demographics of the survey, and to place those within demographics from the Census, and to balance those against other survey instruments and their respective demographic contexts.*

Age. The median age for Nebraska (36.2) is lower than the median age in any of the Health District counties. In the 2016 Survey the median age was 45, much younger than in 2013 (53). This is higher than the census data because the survey is a household survey of adults, which removes ages 0-17 from the equation. In Nebraska, 24.9% of the population are under the age of 18 which is about the same as for the Health District (24.7%). Table 1 (above) shows the median age for census and survey respondents, and it also highlights the relative youthfulness of the Hispanic population.

Table 1: Median Age (Years)

	Census			Community Assessment	
	All	Hispanic	Non-Hispanic	2016 Median	*2016 Mean*
Burt	47.9	47.8	48.7	53.00	*49.78*
Cuming	43.8	21.6	46.6	51.50	*51.58*
Madison	37.1	21.7	42	42.00	*43.16*
Stanton	39.3	14.5	40.9	41.00	*44.48*
Nebraska	36.2	23	40		
2016 Survey	45.0			45.0	45.73
2013 Survey	53.0			53.0	51.85

Table 2: Under Age 18, Population W/ Percent

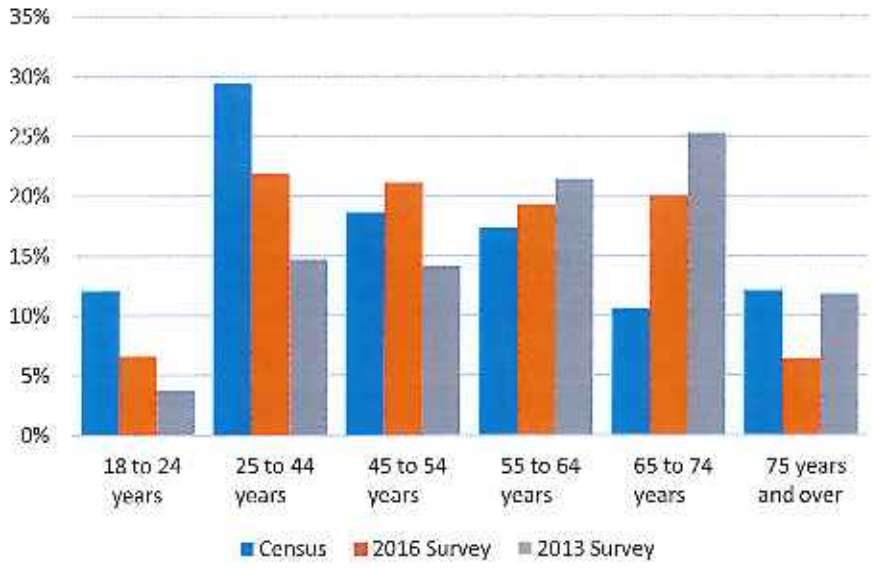
Report Area	Total Population	Population Age 0-17	Percent Population Age 0-17
ELVPHD	56,986	14,062	24.68%
Burt	6,690	1,448	21.64%
Cuming	9,081	2,223	24.48%
Madison	35,103	8,727	24.86%
Stanton	6,112	1,664	27.23%
Nebraska	1,855,617	462,653	24.93%

Data Source: US Census Bureau, American Community Survey, 2010-14.

Age Categories. As Figure 1 shows, respondents to the survey are overall older (distributed across older age categories) than the general population.

It is also clear that respondents to the 2016 Survey were younger than those of the 2013 Survey. The 2016 Survey age distributions increased for age groups 18-24, 25-44, and 45-54 while decreasing for ages 54-64, ages 65-74, and ages 75 and older as compared to the 2014 Survey.

Figure 1: ELVPHD Age Distributions



All age distributions in this chart are representative of only the ELVPHD health district. Census data has been adjusted to include only those age 18 and older from within the health district.

Gender:

The 2016 survey overrepresented females. In this survey, 86% of respondents were female and the remaining 14% male. Compare this to the 50:50 mix of Females and Males in the population as reported in the US Census (49.8% Female, 50.2% Male), and it is clear that females were more likely to fill out the survey.

Table 3: Gender Breakdown by County

County	Burt-2010	Burt - 2014	Cuming - 2010	Cuming - 2014	Stanton - 2010	Stanton - 2014	Madison - 2010	Madison - 2014
% Male	49.00%	49.50%	49.60%	50.10%	49.50%	50.40%	49.60%	49.60%
% Female	51.00%	50.50%	50.40%	49.90%	50.50%	49.60%	50.40%	50.40%

ELVPHD Average	2010	2014
Male	49.40%	49.90%
Female	50.50%	50.10%

Source: U.S. Census Bureau

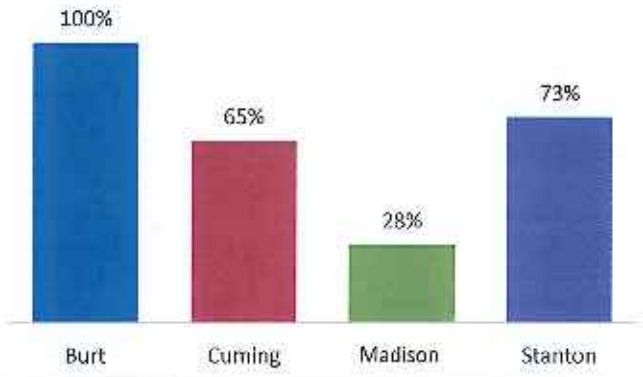
The differences between the 2016 Survey and Census data are in the status for single individuals, where a much smaller proportion of survey respondents are single (11% for the 2016 Survey compared to 25% in the Census), and, also for the survey, a much larger proportion (70% compared to 57% Census) are married.

Sexual Orientation

Sexual orientation demographic information is not reported due to very low estimates in the general population.

Urban/Rural Composition. Though just over half of the district population live in 'urban clusters', three of the counties are predominantly rural (cited in the 2016 County Health Rankings, University of Wisconsin). An urban cluster is defined as a population between 2,500 and 50,000 people.

Figure 2: Percent Rural by County

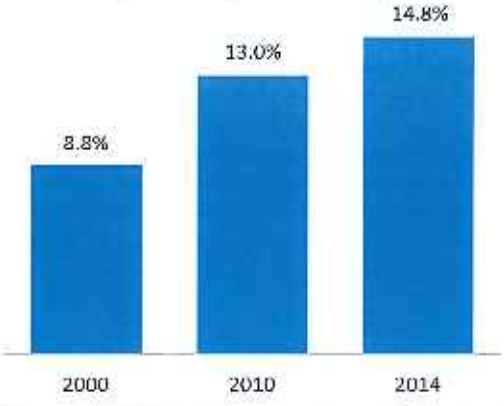


Race/Ethnicity. In the 2016 Survey, 95% said that *White* best describes their race (2013, 96%), the other 5% are spread thinly across five separate categories as shown in Figure 4 (bottom). In a follow-up question regarding ethnicity, 4.5% identify themselves as Hispanic.

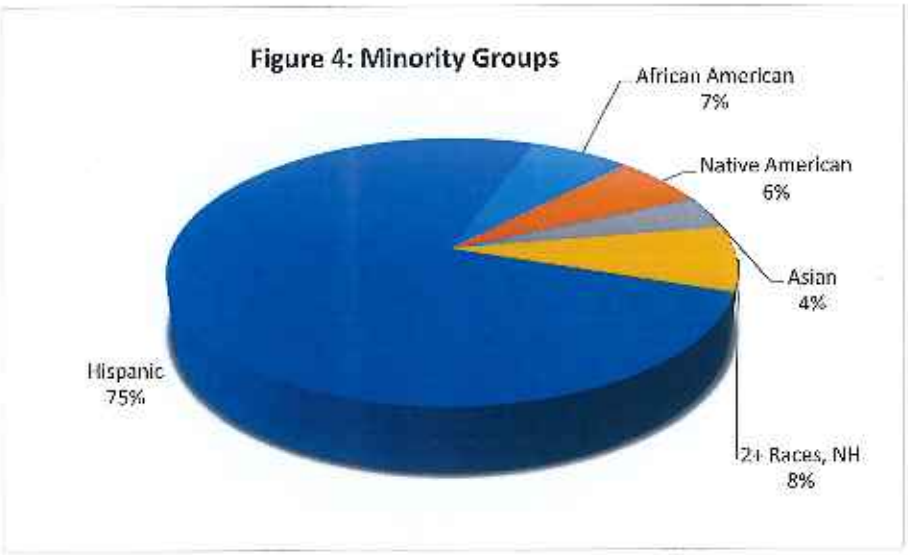
Recent Census reports (2014 in CHA for example) show respondents self-identifying as White at 85.2%, decreasing from 87% in 2010 and 91.2% in 2000. In terms of race/ethnicity, all categories except White Non-Hispanic have increased in the past 14 (Census) years:

- African American by 18%.
- Native American by 7%
- Asian/Pacific Islander by 63%
- 2+ Races by 19%
- Hispanic by 12%

Figure 3: Minorities as Percent of Population (Census Data)



While the numbers for most of these groups are not large (less than 1,000), the net effect is that they constitute the only growth demographic in the HD. The adjacent chart shows that growth in terms of what percent of the population minorities now represent, and the pie chart (below) shows the distribution just among those groups.

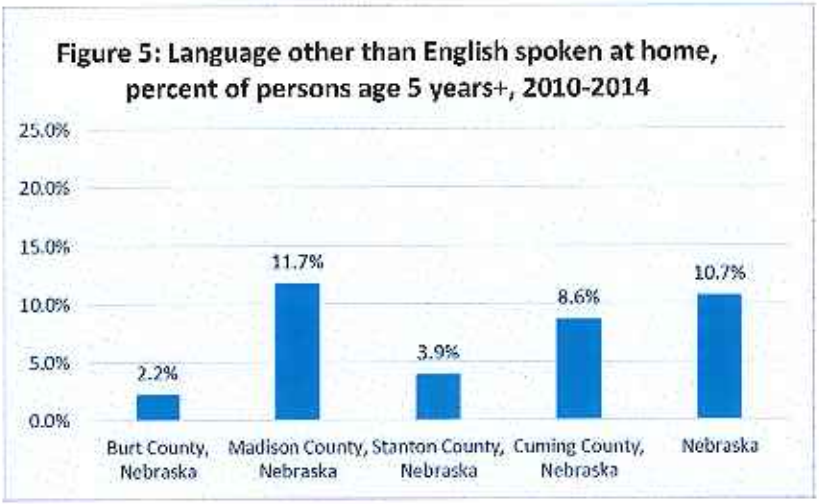


Immigrant Status

In the health district, the overall percentage of foreign born persons is 5.3%. This ranges from 1.2% in Burt County, to 7% in Madison County.

Language

According to the 2016 Survey, the primary language spoken in the home is English (97.7%), followed by Spanish (1.8%), and 0.5% replied "Other." Census data shows that this indicator is underreported by those speaking languages other than English, so CHA survey participants are more likely to speak English.



Census data in Figure 5 shows that most counties in the HD are below the state for languages other than English being spoken in the home. Only the most populous county, Madison County, was above the state in this measure.

Socioeconomic Status

Education

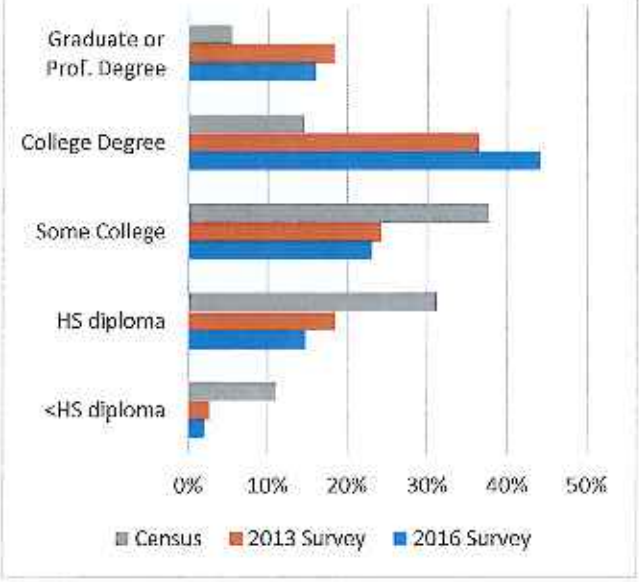
Overall, the education level of the survey respondents is higher than that of the district, even more so than in 2013. Based on Census data, for example:

College Degree. One in five (20%) in the HD have at least a College Degree (including Graduate), but in the 2016 Survey that population is over-represented threefold at 60% (2013, 54%).

Some College. One in three (38%) in the HD have attained up to Some College compared to one in four (23%; 2013, 24%) in the 2016 Survey.

The flipside is that educational attainment is lower for the HD when compared to that statewide. For example, the percent who have earned an Associate's level degree or higher is 34% in the HD compared to 39% statewide. The percent who have no high school diploma is 11% in the HD compared to 9.4% statewide.

Figure 6: Educational Attainment



As noted in 2013, survey respondents are better educated than HD residents overall. One possible explanation lies in how the Survey was administered, online, and therefore more accessible those who are better educated and younger; but, most likely, participation is a result of the interaction of multiple factors, including age, marital status, and the presence of children.

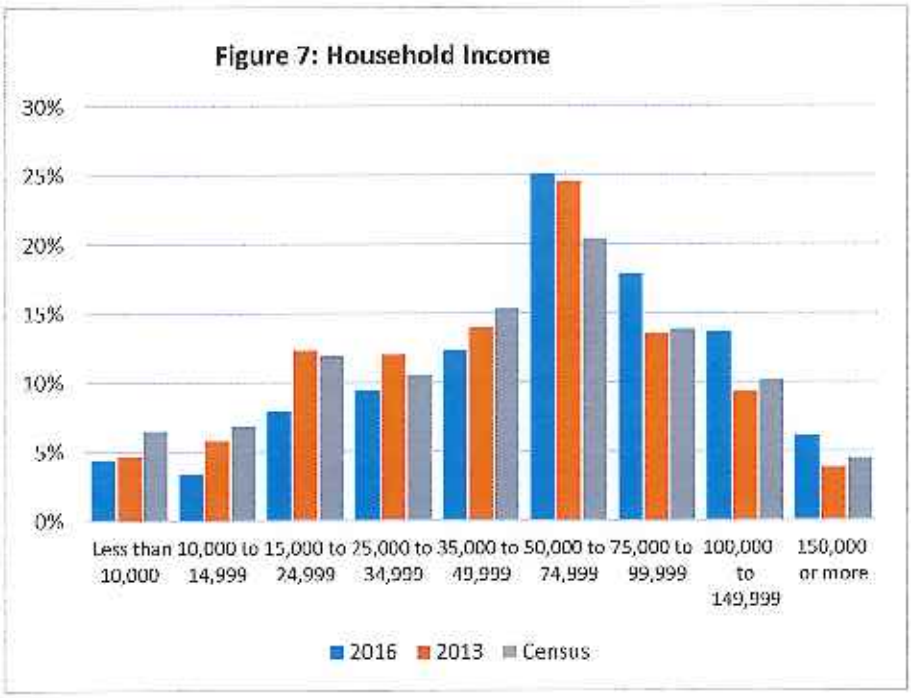
Income

Income is often a proxy of education; the two characteristics are closely correlated. Below is a chart and its source table (Table 3, in percent), with figures from the Census for the Health District along with survey responses from 2016 and 2013.

Table 4: What is your household income this year from all sources?

	2016 Survey	2013 Survey	Census ELVPHD
Less than 10,000	4%	5%	6%
10,000 to 14,999	3%	6%	7%
15,000 to 24,999	8%	12%	12%
25,000 to 34,999	9%	12%	11%
35,000 to 49,999	12%	14%	15%
50,000 to 74,999	25%	25%	20%
75,000 to 99,999	18%	14%	14%
100,000 to 149,999	14%	9%	10%
150,000 or more	6%	4%	4%

- The most commonly reported household income category is $50,000 to $75,000 (Survey, 25%; HD Census, 20%).
- 7% reported incomes below $15,000; (2013 11%; Census 13%)
- One in twelve (8%; 2013, 12%) households reported incomes from $15,000 to $24,999, with the same proportion for incomes $25,000 to $35,000 (9%, 2013, 12%).
- Overall, the income levels in the 2016 are higher than 2013 and that the actual Census. Visual evidence in the adjacent chart is the height of each blue bar on right side of the chart. Respondents in 2016 report higher household incomes (and higher employment below) than the general population in the Health District.



Employment

Table 5: Which of the following best describes your employment status?

		Frequency	Percent	2016 Valid Percent	2013 Valid Percent
	Employed/self-employed	1014	68.5%	84.7%	70.6%
	Out of work but seeking employment	12	.8%	1.0%	2.5%
	I do not work outside of the home	68	4.6%	5.7%	7.5%
	A Student	19	1.3%	1.6%	2.2%
	Retired	84	5.7%	7.0%	17.1%
	Total	1197	80.9%	100.0%	100.0%
	Skipped Question	283	19.1%		
Total		1480	100.0%		

Employment: Survey respondents. In the 2016 Survey seven of eight (85%) are employed; from the Census data two-thirds (68.9%) are employed. The proportion of *retired* respondents decreased from 7% in 2013 to 5.7% in 2016, as did the proportion of *unemployed,* from 2.5% to 1% (2.7% from 2015 Census for the HD).

Poverty

Children under 18. In the Health District 18.33% or 2,540 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Table 6: Poverty Status for Children Under 18

	Total Population	*Population Under Age 18*	*Population Under Age 18 in Poverty*	*Percent Population Under Age 18 in Poverty*
ELVPHD	*55,561*	*13,857*	*2,540*	*18.33%*
Burt	*6,589*	*1,443*	*113*	*7.83%*
Cuming	*8,915*	*2,212*	*404*	*18.26%*
Madison	*33,976*	*8,550*	*1,790*	*20.94%*
Stanton	*6,081*	*1,652*	*233*	*14.1%*
Nebraska	*1,801,893*	*454,094*	*79,766*	*17.57%*

Data Source: US Census Bureau, American Community Survey. 2010-14.

Poverty - Population Below 100% Federal Poverty Level. Poverty is considered a key driver of health status. Within the report area 13.28% or 7,378 individuals are living in households with income below the Federal Poverty Level (FPL). This is slightly greater than the Nebraska average, but lower than the U.S. average.

Table 7: Poverty - Population Below 100% Federal Poverty Level.

Report Area	*Total Population*	*Population in Poverty*	*Percent Population in Poverty*
ELVPHD	*55,561*	*7,378*	*13.28%*
Burt	*6,589*	*611*	*9.27%*
Cuming	*8,915*	*1,051*	*11.79%*
Madison	*33,976*	*5,087*	*14.97%*
Stanton	*6,081*	*629*	*10.34%*
Nebraska	*1,801,893*	*231,762*	*12.86%*
United States	*306,226,400*	*47,755,608*	*15.59%*

Data Source: US Census Bureau, American Community Survey. 2010-14.

Households.

When asking about household size, the 2016 survey asked for total number of individuals living in the home, which was worded differently from 2013 which asked for the total number of 'adults.' The average in 2016 was 2.8 per household (2013, 1.94), slightly more than 2.41 from Census data.

Census. Two-thirds (67%) of households in the HD are family households, with or without children.

Figure 8: Families with Children Less than 18

From Census data shown in Figure 8 (above), 32% of Nebraska households have children less than 18; for the HD the comparable proportion is 30%. Of households with children, 31% are single parent households[3].

In the 2013 Survey, 35% of respondents reported children under age of 18 living in their home. In the 2016 Survey, that proportion increased to 46% of responding households (leftmost column in Figure 8 above). One-third (36%) are households with one or more people 60 years and over.

Table 10: What is the total number of individuals living in your home?

		Frequency	Percent	Valid Percent	2013 Valid Percent
Valid	1	136	9.2%	11.4%	23.4%
	2	432	29.2%	36.1%	64.4%
	3	207	14.0%	17.3%	8.7%
	4	223	15.1%	18.6%	2.4%
	5	136	9.2%	11.4%	.8%
	6 or more	62	4.2%	5.2%	.4%
	Total	1196	80.8%	100.0%	100.0%
Missing	System	284	19.2%		
Total		1480	100.0%		

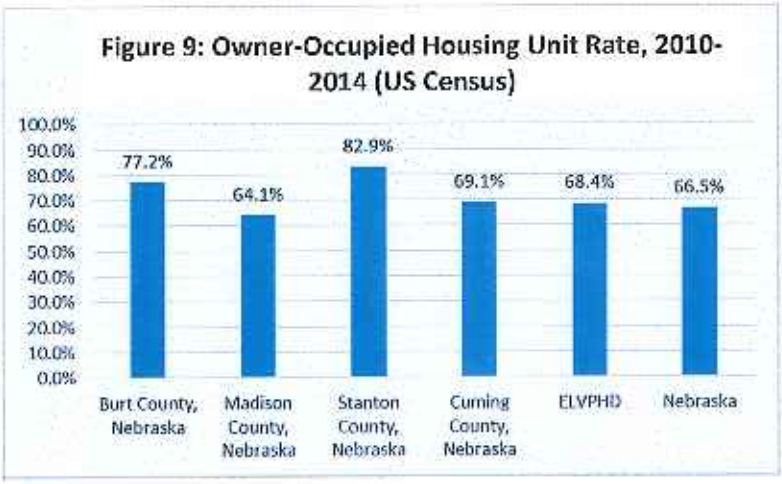
For the Health District, the majority of households are in Madison County (62%), followed by Cuming, Burt and Stanton counties. That percent from the 2016 Survey included the option *Other,* which reduced the percent for of the subsequent counties.

As in 2013, it appears that Cuming County was over represented, while Madison was under represented.

Table 11: In which county do you live?

		Frequency	Percent	2016 Valid Percent	2013 Valid Percent	Census
Valid	Other (please specify)	122	8.2%	10.1%	-	
	Burt	89	6.0%	7.4%	10.8%	11.6%
	Cuming	279	18.9%	23.2%	24.8%	15.9%
	Madison	591	39.9%	49.0%	54.9%	61.9%
	Stanton	124	8.4%	10.3%	9.4%	10.7%
	Total	1205	81.4%	100.0%	100.0%	
Missing	System	275	18.6%			
Total		1480	100.0%			

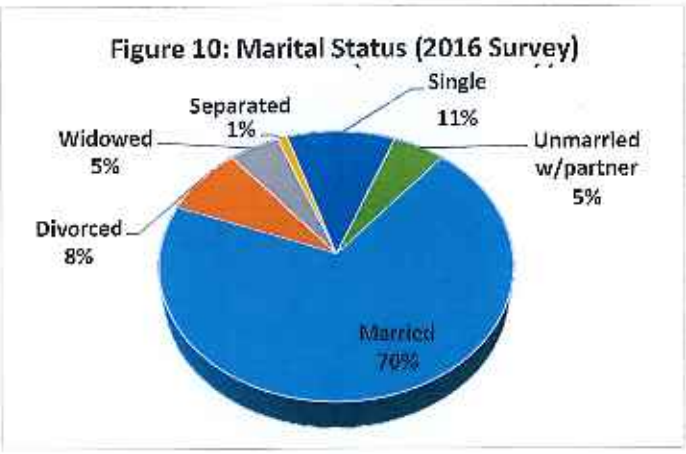
According to the U.S. Census, the owner-occupied housing unit rate (homeownership rate) for the health department is generally slightly higher than that for the state. With the exception of Madison County (64.1%), the rates of owner- occupied housing in each other HD County (Burt 77.2%, Stanton 82.9%, and Cuming 69.1%) are above that of the state (66.5%) as shown in Figure 9.



Marital Status. Of all households responding to the survey, seven out of ten (70%; 2013, 69%) are a married couple, and another 5% (2013, 3%) are an unmarried couple. About one in eight are either widowed or divorced (5% and 8% respectively), and 11% single.

Census data for the Health District shows

- One in four (25%) Never married
- One in ten (10.5%) divorced or separated.
- 7.3% widowed.
- Over half (57%) now married.



For both *marital status* and *families with children*, the disproportionate representation can be framed as a positive since it will provide a wealth of data about children, immunizations, vehicle safety, or safety in the home. However, it will perhaps produce less reliable information if the focus is on issues related to aging.

Health Status and Mental Health

Health Status

Health-related quality of life measures have been included in the BRFSS studies for a number of years, and they are also factor in the County Health Rankings. Health status questions show how persons perceive their own health and how well they function physically, psychologically, and socially during their usual daily activities. These indicators are considered important because they can assess dysfunction and disability not measured by standard data.

Questions about Health Status.

In the 2016 Survey (ELVPHD) only Question 1 asked about general health. In previous years, and other surveys (BRFSS), several questions are included, and those data are in the CHA report[1] which includes five questions about physical and mental health and how (or the extent to which) it impacts

activities. Those include the number of days physical and mental health was not good in the past 30, the proportion of respondents who had at least 14 days of 'not good' physical/mental health, and the effect of limited activities in the past 30 days.

Here the focus is on the *general health question and responses over time*. The other questions will be reported with reference CHA document.

Q1 Would you say that in general your health is... (Scale: Excellent = 1; Poor = 5).

In effect this question leads into a discussion of physical and mental health. Some mental health questions from the 2016 Survey appear later in this document; however, the information in the *next paragraph* is from the BRFSS and other source documents.

In the 2014 BRFSS for the HD, 16.9% (one in six) described their health as Fair or Poor. Over the four-year period covered in the CHA report, there is no difference within these levels with respect to the HD, meaning the responses, which range from 15.1% to 18.7% are not different (in a statistical sense). However, responses are different (statistically) when HD responses are compared to those across Nebraska. In 2013 and 2014 the levels of fair to poor health are higher than those for the state (**2013:** HD, 18.7%; NE, 13.9%. **2014:** HD, 16.9%; NE, 13.2%). *Note that there are no differences within the state readings for the four year period, which complicates statements about differences HD to state.*

The results from the BRFSS survey (2011-2014) and the HD community survey are presented in Table 22 below. The difference is that BRFSS reports one in six (16.9%) in fair or poor health, that drops to 7.4% for the respondents completing the HD survey in 2016 (2013, 8.9%).

The survey respondents are overall in better health than the general population (18 and over) in the Health District.

Based on the BRFSS for the HD, 7,240 adults report being in Fair or Poor Health (again, one in six).

Table 23: Would you say that in general your health is? ELVPHD and Nebraska

Year	Excellent	Very good	Good	Fair	Poor	HD Good-Excellent
Community Survey-2013	11.8%	43.8%	35.5%	7.5%	1.4%	91.1%
Community Survey 2016	11%	44%	37.5%	6.9%	0.5%	92.5%

BRFSS YEAR	Fair Poor	Good through Excellent
2011	15.1%	84.9%
2012	15.4%	84.6%
2013	18.7%	81.3%
2014	16.9%	83.1%
HD 2013	8.9%	91.1%
HD 2016	7.4%	92.6%

Table 24: General Health CHNA TABLE

Report Area	*Total Population Age 18*	*Estimated Population with Poor or Fair Health*	*Crude Percentage*	*Age-Adjusted Percentage*
ELVPHD	*42,645*	*6,008*	*14.1%*	*12.9%*
Burt	*5,355*	*760*	*14.2%*	*12.8%*
Cuming	*6,901*	*994*	*14.4%*	*12.5%*
Madison	*25,920*	*3,655*	*14.1%*	*13%*
Stanton	*4,469*	*599*	*13.4%*	*13.5%*
Nebraska	*1,357,819*	*171,085*	*12.6%*	*12%*
United States	*232,556,016*	*37,766,703*	*16.2%*	*15.7%*

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health Human Services, Health Indicators Warehouse. 2006-12.

General Health by Demographics

The ways in which poor mental/physical health correlate with age, income and education are consistent across those demographic variables, increasing in severity with age, decreasing with increases in education or income. Some of these are reported below.

Of those in the lowest income category, one in three (31%) report they are in Fair-Poor health.

Of those with less than a High School diploma, more than one in three (40%) report they are Fair-Poor Health.

Of those 65 and older, one in four report Fair-Poor health.

For the period 2011-2014, the CHA BRFSS report shows that Fair-Poor health

- Increases with age: 18-44, 11.4%; 45-64, 18.3%; 65+, 23%.
- Decreases as level of education increases: <HS, 39.7%; HS/GED, 18.3%; Some College, 9.7%; College Grad, 7.9%.
- Decreases as income increases: <$25,000, 30.5%; $25,000-49,999, 17%; $50,000+, 7.8%.

More about General Health (Unhealthy Days) by Age, Income, and Education

BRFSS Data—Days of poor physical and mental health

The previous question was a general rating of health, but this next puts into a metric of days (at least 14) of the past 30. For the remaining questions reported in the CHA document about one in ten respondents report mental/physical distress on 14 or more of the past 30 days.

Physically Unhealthy Days (Avg. number of days physical health was not good in past 30 days)[5]

9.2% in the BRFSS for ELVPHD reported that physical health was not good on 14 or more ofthe past 30 days. Which

- Increased with age: 5.7% for 18-44; 10.3% for 45-64; 17.3% for 65+.

[5] In the CHA, for this and the mental health question, responses are reported as a percent; it should be reported as a number of days and is not included here.

- Decreased as income increased: <$25,000, 19.1%; $25,000-49,999, 8.6%; $50,000+, 4.5%.
- Decreased as level of education increased: <HS, 19.0%; HS, 11.6%, Some College, 6.9%; College Grad, 4.3%.

Mentally Unhealthy Days (in the past 30). The average was 2.8 (from 2.3 to 3.3)

8.3% reported their mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress).

- Decreased with age: 18-44, 9.9%; 45-64, 8.0%; 65+, 5.2%.
- Decreased as income increased: <$25,000, 18.4%; $25,000-49,999, 8.6%; $50,000+, 4.5%.
- Decreased as level of education increased: <HS, 7.2%; HS, 6.8%, Some College, 4.2%; College Grad, 2.6% (but not to the extent of physical health).

Serious Mental Illness (in the past 30 days) was reported by 2.9% (CI of 1.0%-8.5%)

Other Data

An important consideration for those with mental illness is what proportion receive treatment in an underserved area (the health district); however, other data on mental illness is relevant:

- About one in six (16.1%) of adults receive a diagnosis of depression in their lifetime (BRFSS, 2008). For Males, 11%; Females, 21%.
- In Nebraska, 16.9% receive a diagnosis of depression in their lifetime.
- In Nebraska, 10.6% have been diagnosed with an Anxiety Disorder (12.3% nationally).
- Nationally, about 9% of adults are diagnosed with depression (2008, for example).[6]
- In Nebraska, 2.6% of adults reported serious psychological distress (BRFSS, 2008).

ELVPHD

- 15.8% reported in 2014 they had been told they have depression. Ever.
- 8.3% said they had experienced frequent mental distress in the past 30 days. Neither of those proportions had changed significantly over the period 2011 through 2014. Neither was different when compared to the statewide report.
- 11.2% are currently (2012 BRFSS) taking medication or receiving treatment for a mental health condition.

Table 25: Frequent Mental Distress in the Past 30 Days Adults 18+ in Nebraska and Elkhorn Logan Valley Public Health Department, 2011-2014

Year	Nebraska	ELVPHD
2011	9.2%	7.2%
2012	9.0%	8.0%
2013	8.9%	9.4%
2014	8.2%	8.3%

[6] Cf. http://www.cdc.gov/mentalhealth/data_stats/nspd.htm.

Table 26: BRFSS Demographic Summary Table for ELVPHD Adults 18 and Older Years 2011-2014 Combined

	Frequent mental distress: mental health not good on 14 of past 30 days	Poor physical/mental health limited usual activities on 14 of the past 30 days	Ever told they have depression	Currently taking medication or receiving treatment for a mental health condition	Symptoms of serious mental illness in past 30 days
Overall	8.2%	5.4%	15.8%	11.2%	2.9%
Male	6.0%	4.9%	10.4%	5.8%	0.0%
Female	10.4%	6.0%	21.0%	17.5%	6.3%
	* Female Higher		* Female Higher		* Female Higher
Age					
18-44	9.9%	2.8%	15.8%	7.4%	4.7%
45-64	8.0%	6.7%	17.7%	14.9%	2.6%
65+	5.2%	8.0%	13.0%	11.8%	0.2%
Income					
<$25,000	18.4%	11.4%	29.1%	11.7%	2.4%
$25,000-49,999	8.6%	4.5%	15.0%	13.6%	2.2%
$50,000+	4.5%	2.8%	10.2%	7.6%	0.0%
Education					
Less than High School	15.4%	7.2%	20.5%	-*	-*
High School/GED	10.4%	6.8%	16.3%	20.9%	6.7%
Some College	7.5%	4.2%	15.3%	9.2%	1.5%
College Graduate	5.7%	2.6%	13.9%	6.3%	0.0%

From Table 25 above

- Frequent mental distress decreases with gender (female higher), income, education and age.
- Limitations on usual activities increases with age, decreases with income and education.
- The diagnosis of depression is higher in females and decreases with income and education.
- Medications/treatment decreases with income and education (but not by gender).
- Symptoms of serious mental illness are higher with females, but decrease by age, gender, and education.

Mental Health & Hospitalization

According to the CHA document, *Mental Disorders* is listed as the 6th in the "Leading Causes of Inpatient Hospitalization (2013)" accounting for 4.7% of hospitalizations within the HD (16 causes are listed; Circulatory System Diseases is #1 with 14.1%).

Health Care Access and Treatment

Responses to questions in the General Health portion of the survey provide data that describe both health care experience, general health, and access to health care.

The ELVPHD community survey included a number of questions that cover a range of topics related to health care access. Topics that will be the focus of this section include: insurance coverage, who pays for coverage, what insurance plans cover, and what barriers respondents experience when seeking health care. One measure of access is whether or not respondents have a regular source of medical care. Questions in the community survey included:

2. Who do you get most of your medical care from? (Please select one option)

3. Where do you get most of your medical care?

4. How often do you have a regular visit at the...?

6. When were you most recently tested for any of the following?

7. Which of the following problems have stopped you from getting a health screening or other health care services, including prescription drugs? (Please check all that apply)

12. Have you been told by a health care professional that you have any of the following? (Please check all that apply):

13. Are you currently taking medication prescribed by a health care professional for any of the following? (Please check all that apply)

Physicians: A personal Doctor

In 2013 most (88%) of the survey respondents said they have a primary care doctor (a Yes/No question). In the 2016 Survey respondents were asked, "Who do you get most of your medical care from?" Nearly all (94.5%) selected at least one of the options in Table 26 (below), and of those three of four (74%) chose either a general practitioner (60%) or a specialist (14%). In the Table 27 (below), the preference for a PCP increases with Age (Other factors may interact with Age, such as Urban/Rural), and at the same time the preference for a specialist (OBGYN, for example) decreases with age.

Table 27: Main source of medical care: PCP (2. Who do you get most of your medical care from? (Please select one option)

	Frequency	Percent	Valid Percent	Cumulative Percent
Primary care provider (medical doctor)	880	59.5%	59.7%	59.7%
Other Medical doctor (OB/GYN, Pulmonologist, Cardiologist, I	208	14.1%	14.1%	73.8%
Non-medical doctor (Chiropractor)	45	3.0%	3.1%	76.8%
Other medical practitioner (physician assistant (P.A.), NP	261	17.6%	17.7%	94.5%
I do not seek medical care	81	5.5%	5.5%	100.0%
Total	1475	99.7%	100.0%	
Missing System	5	.3%		
Total	1480	100.0%		

Table 28: Who do you get most of your medical care from? BY Age

	BRFSS Age Categories			Total
	18-44	45-64	65 and over	All
PCP-Medical	55.3%	64.8%	71.8%	60.8%
Specialist-Medical	17.0%	12.1%	10.7%	14.4%
Non-Medical Doctor	3.0%	3.2%	.8%	2.8%
PA/NP	17.9%	16.6%	15.3%	17.1%
Don't Seek Med. Care	6.7%	3.4%	1.5%	4.9%
	100.0%	100.0%	100.0%	100.0%

In the table by **County** (Table 28), possible influences include access to a type of medical practitioner, cost, or distance traveled. In Madison, with expected access to a greater range of medical options, there is a broader the distribution than in Burt or Cuming. (*Other* was an optional response for county with the response written in. Many of those work in one of the HD counties.)

Income. Response to Question 2 did not vary so much by Income.

Table 29: Who do you get most of your medical care from? BY County

	In which county do you live?				
	Other	Burt	Cuming	Madison	Stanton
Primary care provider (medical doctor)	64.5%	73.0%	81.7%	51.6%	46.0%
Other Med.doctor (OB/GYN, Cardiologist)	10.7%	6.7%	5.8%	18.4%	23.4%
Non-medical doctor (Chiropractor)	3.3%	2.2%	1.8%	3.2%	3.2%
Other medical practitioner (PA, NP)	18.2%	14.6%	7.9%	21.0%	20.2%
I do not seek medical care	3.3%	3.4%	2.8%	5.8%	7.3%
	100.0%	100.0%	100.0%	100.0%	100.0%

Location: Source of Care

The primary source for care in the area are clinics (92.5%), including Medical Clinic, Sliding-fee or reduced fee-based clinic, Tribal health clinic, and Veterans' clinic/Hospital.

Table 30: Where (source) medical care?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital/Emergency room	27	1.8%	1.9%	1.9%
	Urgent Care	65	4.4%	4.7%	6.6%
	Medical Clinic	1218	82.3%	87.8%	94.4%
	Sliding-fee or reduced fee-based clinic	31	2.1%	2.2%	96.7%
	Tribal Health Clinic	12	.8%	.9%	97.5%
	Veterans Clinic/Hospital	21	1.4%	1.5%	99.1%
	I do not seek medical care	13	.9%	.9%	100.0%
	Total	1387	93.7%	100.0%	
Missing	System	93	6.3%		
Total		1480	100.0%		

Frequency of Visits

Table 31: How often do you have a regular visit at the...? (percent)

	Within past year (anytime less than 12 months ago)	Within past 2 years (More than 1 year but less than 2 years	Within past 5 years (More than 2 years but less than 5 year	5 or more years ago	Never
Primary care provider	74.5%	13.6%	5.7%	3.9%	2.3%
Eye doctor	53.0%	24.6%	10.8%	6.7%	5.0%
Dentist	73.1%	11.4%	6.4%	7.2%	1.9%
Chronic Disease Educator (Diabetes, blood pressure, asthma, etc.)	17.9%	5.3%	3.1%	5.1%	68.6%

PCP. Frequency of Medical Visits to the PCP varied with age, measured across visits within the past year: 65% of those 18-44; 82% of those 45-64; and 92% of those 65 and over.

Eye Doctor. A similar pattern for within the past year, with 50% of those 18-44; 55% of those 45-64; and 66% of those 65 and over.

Dentist. Visits within the past year were highest for those 45-64 (78%), about 8% less for those under 45 and those above 65. Dental appointments within the past year increased with income: <=$25,000, 46%; $25,000-$50,000, 66%; $50,000 and over, 82%.

Chronic Disease Educator. Visits increased with age: 7% of those 18-44; 22% of those 45-64; and 43% of those 65 and over.

Barriers to Screening

Over half (52%) said they had no barriers to screening in response to Question 7. (Which of the following problems have stopped you from getting a health screening or other health care services, including prescription drugs? Please check all that apply). Table 32 below presents responses excluding those responding 'None.'

The most common response (43%) is that their doctor hasn't recommended a screening, followed by High Deductible (31%), 25% not knowing what kind of screening to get (related to Dr. advice), and inability to pay (21%).

Table 32: When were you most recently tested for any of the following? (in percent)

	Within the past year	Within the past 1 or 2 years	Over 2 years ago	Never tested	Don't know
Blood pressure	91.1%	3.8%	2.0%	2.1%	.9%
Diseases of the eye	50.6%	19.1%	12.8%	11.9%	5.6%
Osteoporosis	16.2%	5.7%	11.9%	51.1%	15.1%
Diabetes	53.3%	8.7%	8.3%	22.8%	7.0%
HIV/AIDS	11.1%	5.7%	16.7%	55.0%	11.6%
STDs/infections	13.2%	7.3%	16.8%	52.4%	10.4%

Table 33: Which of the following problems have stopped you from getting a health screening or other health care services, including prescription drugs? (Excludes None)

	Responses		Percent of Cases
	N	Percent	
I don't know what kind of screening I need or when to get.	177	14.5%	25.4%
I don't know where to go for a health screening/services	50	4.1%	7.2%
My doctor hasn't recommended I get a health screening	301	24.6%	43.2%
I can't pay for health screenings/services	149	12.2%	21.4%
My health insurance doesn't cover health screenings/services	85	7.0%	12.2%
My deductible or co-payment is too high	213	17.4%	30.6%
Hospitals/Doctor won't take my insurance or medical assistance	10	.8%	1.4%
I couldn't get an appointment	7	.6%	1.0%
Health care provider has limited office hours	39	3.2%	5.6%
I don't trust the health care providers in my area	28	2.3%	4.0%
Health care services aren't close to where I live	8	.7%	1.1%
Language/interpretive services not provided	1	.1%	.1%
I don't have time to get a health screening/services	91	7.4%	13.1%
Other	64	5.2%	9.2%
Total	1223	100.0%	175.5%

Transportation a barrier?

Transportation was not perceived to be a barrier to care, as it was selected by only 2% of respondents.

Table 34: Is transportation a barrier to receiving health screenings or other health care services? Barriers would include: no car, can't afford gas, no driver's license, no public transportation, no one available to take me,etc.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	31	2.1%	2.2%	2.2%
	No	1391	94.0%	97.8%	100.0%
	Total	1422	96.1%	100.0%	
Missing	System	58	3.9%		
Total		1480	100.0%		

Current Medications

Respondents were asked for six conditions for which they had been prescribed medications (Table 34, below). Two-thirds (61%) of those said they were not taking medications for any of those conditions. The other 39% reported reasons for taking medications; of those, the most common was high blood pressure (56%), high cholesterol (44%), and for thyroid problems (40%). There was some crossover in the response, nearly two conditions per respondent (172%).

Table 35: Are you currently taking medication prescribed by a health care professional for any of the following? (Please check all that apply): Frequencies

Medications for diagnoses		Responses		
		N	Percent	Percent of Cases
	High cholesterol	233	25.5%	43.9%
	Heart problems	64	7.0%	12.1%
	Thyroid problems	211	23.1%	39.7%
	High blood pressure	299	32.7%	56.3%
	Diabetes	100	11.0%	18.8%
	Sexually transmitted diseases/infections	6	.7%	1.1%
Total		913	100.0%	171.9%

Issues and Behaviors that Impact the Health District

During 2011 the Nebraska Department of Human Services sponsored research to assess community themes and strengths, conducting a telephone survey throughout Nebraska. The resulting report provided responses for the local health department in comparison to those of the state on a topic by topic basis. The target population for each of the Health Districts (18) was 500 respondents, with a total of 9,077 completed surveys.

A section of the survey dealt with how respondents assessed the 'seriousness' of selected health issues, and another with how they assessed the impact of selected behaviors on their community (scale of 1-11, with 11 = greatest impact). The issues and the impacts were then ranked on the basis of their average scores.

Behaviors

ELVPHD used similar question in its 2013 and 2016 community surveys. Question 18 asked, "What is the impact of the following behaviors on the overall health of your community?" The list of issues included was similar to that of the 2013 Survey, though several items were added, and the scale was across 7 levels (1 = No impact; 7 = Major impact). Two items were added in 2016: Human Trafficking and Texting while walking resulting in injury.

Table 51 on the next page lists the responses frequencies across the scales in percent. In this table, columns 5 through 7 have been combined in the column at the far right. The summed scores are useful because they indicate what proportion of the respondents see a behavior as one with a major impact. In a second table (Table 52), those impact behaviors were ranked using that sum, and sorted in the order representing that rank.

In the 2013 response, all items in the question had an average rating above 4.5, which is the midpoint in the scale. In 2016, nine items had average ratings below the midpoint (midpoint was 4 for 2016). Notably, all of the items are in the same sequence from 2013 to 2016.

Table 52: What is the impact of the following behaviors on the overall health of your community? (Percent)

(1 = No impact; 7 = Major impact)	1	2	3	4	5	6	7	2016 5-7	2013 5-7
Texting while driving	9.4%	5.7%	8.7%	16.2%	17.3%	18.0%	24.6%	60.0%	66.8%
Not enough exercise	5.8%	6.2%	11.5%	18.4%	22.1%	21.1%	15.0%	58.2%	64.7%
Talking on a cell phone while driving	8.3%	6.9%	10.1%	17.1%	20.1%	18.4%	19.0%	57.6%	64.8%
Poor eating habits	7.1%	6.6%	12.4%	20.9%	20.1%	19.3%	13.6%	53.0%	59.8%
Tobacco use (cigarettes, smokeless, e-cigarettes)	11.8%	5.9%	10.1%	20.1%	16.4%	18.4%	17.4%	52.2%	61.1%
Drunk driving	14.0%	7.9%	11.5%	18.4%	17.3%	13.0%	17.9%	48.2%	58.8%
Drug abuse	15.9%	7.5%	13.4%	19.3%	15.3%	13.0%	15.7%	43.9%	54.1%
Alcohol abuse	16.5%	8.6%	14.0%	19.0%	17.0%	11.6%	13.3%	41.9%	59.1%
Not using seat belts while riding in a vehicle	14.0%	13.3%	15.6%	21.0%	14.3%	11.0%	11.0%	36.2%	46.4%
Violence (domestic violence, fighting, etc.)	17.2%	14.5%	16.7%	20.9%	13.1%	9.2%	8.5%	30.7%	44.6%
Teenage pregnancy	18.4%	17.4%	16.1%	18.8%	12.2%	10.1%	7.0%	29.3%	43.2%
Child abuse and neglect	18.5%	17.1%	14.8%	20.7%	11.7%	8.0%	9.3%	29.0%	45.3%
Not using child safety seats (or improper use)	20.7%	18.2%	14.9%	17.8%	9.9%	7.6%	10.9%	28.4%	39.9%
Texting while walking resulting in injury	26.3%	19.2%	14.6%	17.8%	9.0%	6.6%	6.4%	22.0%	
Not getting vaccinated to prevent disease	22.9%	20.9%	17.4%	17.1%	7.6%	6.7%	7.4%	21.7%	36.9%
Human Trafficking	40.8%	21.2%	10.6%	12.4%	4.5%	4.1%	6.5%	15.1%	

Table 53: What is the impact of the following behaviors on the overall health of your community? (0 = No impact; 7 = Major impact) (Ranked using Mean Scores)

Item Content	2016 Mean	Rank 2016	2013 Mean	Rank 2013
Texting while driving	4.7899	1	6.034	1
Not enough exercise	4.6807	2	5.885	2
Talking on a cell phone while driving	4.6528	3	5.882	3
Poor eating habits	4.5263	4	5.703	4
Tobacco use (cigarettes, smokeless, e-cigarettes)	4.4837	5	5.686	5
Drunk driving	4.2761	6	5.679	6
Drug abuse	4.1237	7	5.515	8
Alcohol abuse	3.9941	8	5.662	7
Not using seat belts while riding in a vehicle	3.8504	9	5.136	9
Violence (domestic violence, fighting, etc.)	3.5954	10	5.059	10
Child abuse and neglect	3.5115	11	5.047	11
Teenage pregnancy	3.4718	12	4.962	12
Not using child safety seats (or improper use)	3.4444	13	4.816	13
Not getting vaccinated to prevent disease	3.1544	14	4.600	14
Texting while walking resulting in injury	3.0936	15		
Human Trafficking	2.5687	16		

In the following tables (Tables 53 and 54), items are ranked by various demographic variables, and in a few cases (age, for example), some rankings change.

Table 54: What is the impact of the following behaviors on the overall health of your community? (Ranked by Mean, Age 45-64)

	Rank and Mean 18-44		Rank and Mean 45-64		Rank and Mean 65 and over		2016 total Rank
Not enough exercise	2	4.6088	1	4.9597	3	4.2992	2
Texting while driving	1	4.8246	2	4.9193	2	4.5635	1
Talking on a cell phone while driving	5	4.5550	3	4.8535	1	4.6772	3
Poor eating habits	3	4.5929	4	4.7113	7	3.7903	4
Tobacco use (cigarettes, smokeless, e-cigarettes)	4	4.5557	5	4.6837	5	4.0080	5
Drunk driving	6	4.2732	6	4.4735	4	4.0720	6
Drug abuse	7	4.1015	7	4.3694	6	3.9286	7
Alcohol abuse	8	4.0084	8	4.1783	8	3.7823	8
Not using seat belts while riding in a vehicle	9	3.9223	9	3.8979	9	3.6429	9
Violence (domestic violence, fighting, etc.)	10	3.5635	10	3.8174	11	3.2195	10
Child abuse and neglect	12	3.5279	11	3.6624	13	3.1626	11
Teenage pregnancy	13	3.5051	12	3.5711	12	3.1789	12
Not using child safety seats (or improper use)	11	3.5490	13	3.4501	14	3.0325	13

Texting while walking resulting in injury	15	2.9577	14	3.2809	10	3.3008	15
Not getting vaccinated to prevent disease	14	3.1794	15	3.2569	15	2.9106	14
Human Trafficking	16	2.6261	16	2.6178	16	2.3496	16

Table 55: What is the impact of the following behaviors on the overall health of your community? (Ranked by Mean, $25,000-$50,000)

	Rank and Mean <=$25,000		Rank and Mean $25,000-$50,000		Rank and Mean $50,000 and over	
Texting while driving	1	4.5593	1	4.8594	1	4.9051
Not enough exercise	4	4.3202	2	4.6345	2	4.8693
Talking on a cell phone while driving	3	4.4944	3	4.6290	3	4.7414
Tobacco use (cigarettes, smokeless, e-cigarettes)	2	4.5537	4	4.5385	5	4.5818
Poor eating habits	5	4.2034	5	4.5366	4	4.6850
Drunk driving	6	4.1525	6	4.3589	6	4.3783
Drug abuse	7	3.9716	7	4.1976	7	4.2393
Alcohol abuse	8	3.8352	8	4.0526	8	4.1128
Not using seat belts while riding in a vehicle	9	3.8305	9	3.9597	9	3.8857
Violence (domestic violence, fighting, etc.)	10	3.5257	10	3.6098	10	3.6754
Child abuse and neglect	12	3.4857	11	3.4919	11	3.5983
Teenage pregnancy	11	3.5170	12	3.4715	13	3.5103
Not using child safety seats (or improper use)	13	3.3125	13	3.4553	12	3.5199
Texting while walking resulting in injury	14	3.1136	14	3.2490	15	3.1047
Not getting vaccinated to prevent disease	15	2.9314	15	3.1053	14	3.2810
Human Trafficking	16	2.5200	16	2.5081	16	2.6341

Health Issues

The issues shown on Table 55 below represent how the respondents rated 16 health issues for perceived seriousness in their communities. As in question 18, the issues are listed, and they reflect surveys completed in 2013 and 2011. Note that in 2016 two were added: Injuries resulting from farm accidents; Injuries resulting from falls, etc.

Two columns were added here, a sum for columns 1-3 and the sum for 5-7 from 2013. The percentages vary from year to year, in part because the scale in 2013 was based on eight (8) levels of response.

Table 56: How serious are the following *health issues* in your Community? (Percentages on a 7-point scale ranging from 1=*Not serious at all* to 7=*Extremely serious)*

	Sum 1-3	1	2	3	4	5	6	7	Sum 5-7 2016	Sum 5-7 2013
Cancer	21.6%	5.6%	4.9%	11.2%	19.8%	23.0%	19.1%	16.4%	58.5%	62.7%
Overweight and obesity	25.3%	5.8%	7.3%	12.2%	19.4%	21.4%	18.1%	15.9%	55.3%	64.3%
High blood pressure	23.8%	5.8%	5.4%	12.7%	22.5%	22.7%	19.9%	11.0%	53.7%	52.1%
Heart disease	25.2%	6.5%	5.6%	13.1%	21.9%	21.2%	19.5%	12.1%	52.8%	49.3%
Diabetes	25.8%	5.9%	5.7%	14.1%	22.7%	21.5%	18.9%	11.2%	51.6%	46.4%
Mental health (including depression)	32.5%	7.2%	10.2%	15.1%	21.5%	20.0%	14.6%	11.3%	46.0%	42.0%
Aging problems (arthritis, hearing/vision loss)	31.8%	7.4%	7.9%	16.5%	23.9%	24.0%	12.6%	7.7%	44.3%	54.1%
Infectious diseases (flu, other viruses/ infections)	38.4%	7.6%	11.6%	19.2%	27.4%	18.0%	10.6%	5.6%	34.2%	40.2%
Stroke	40.8%	9.2%	12.4%	19.2%	26.1%	16.7%	10.1%	6.4%	33.2%	33.4%
Suicide	51.8%	16.3%	18.7%	16.8%	18.8%	11.8%	9.3%	8.2%	29.4%	21.8%
Poor dental health	46.9%	8.5%	17.0%	21.5%	25.5%	16.1%	6.8%	4.7%	27.5%	31.3%
Injuries resulting from farm accidents	49.8%	10.2%	18.5%	21.2%	24.2%	14.9%	7.4%	3.6%	25.9%	
Injuries resulting from falls, etc.	48.9%	9.6%	18.0%	21.3%	26.2%	14.4%	7.3%	3.3%	25.0%	
Injuries resulting from crashes (ATV, other vehicle)	51.1%	10.5%	18.2%	22.3%	25.1%	13.9%	6.7%	3.1%	23.8%	29.3%
Sexually transmitted diseases/infections (STIs)	59.8%	16.0%	22.6%	21.3%	21.4%	10.5%	4.6%	3.6%	18.8%	23.3%
Unsafe environment (poor air/water, chemical exposure)	70.7%	22.6%	29.0%	19.0%	15.6%	6.8%	3.9%	3.1%	13.7%	23.3%

Table 56 (next page) shows rank based on mean scores. Between years, the average/mean scores are calculated on a different basis. In 2013 the score is based on 8 categories, thus a higher mid-point (between 4 and 5), while the 2016 score is based on 8 categories (mid-point in 2016 is 4). This means that the 2016 results will appear to have higher scores although it may just be that the scale has been shifted.

Two issues moved notably in the rankings. Aging moved from #3 in 2013 to #7 in 2016 (#6 in 2011); a likely explanation is that respondents were overall younger (2016, average age = 45.7; 2013, 51.8). Further, some of the several other issues vary by age (additional tables inserted below).

Another health issue that moved is Suicide from #14 in rank to #13. Ignoring the added categories, Suicide moved ahead of Injuries resulting from crashes (ATV, other vehicle), Sexually transmitted diseases/infections (STIs), and Unsafe environment (poor air/water, chemical exposure)

Table 57: How serious are the following health issues in your Community? (On a 7-point scale ranging from 1=Not serious at all to 7=Extremely serious; 2013 scale 8 values, 0=Not at all serious to 7=Very serious.)

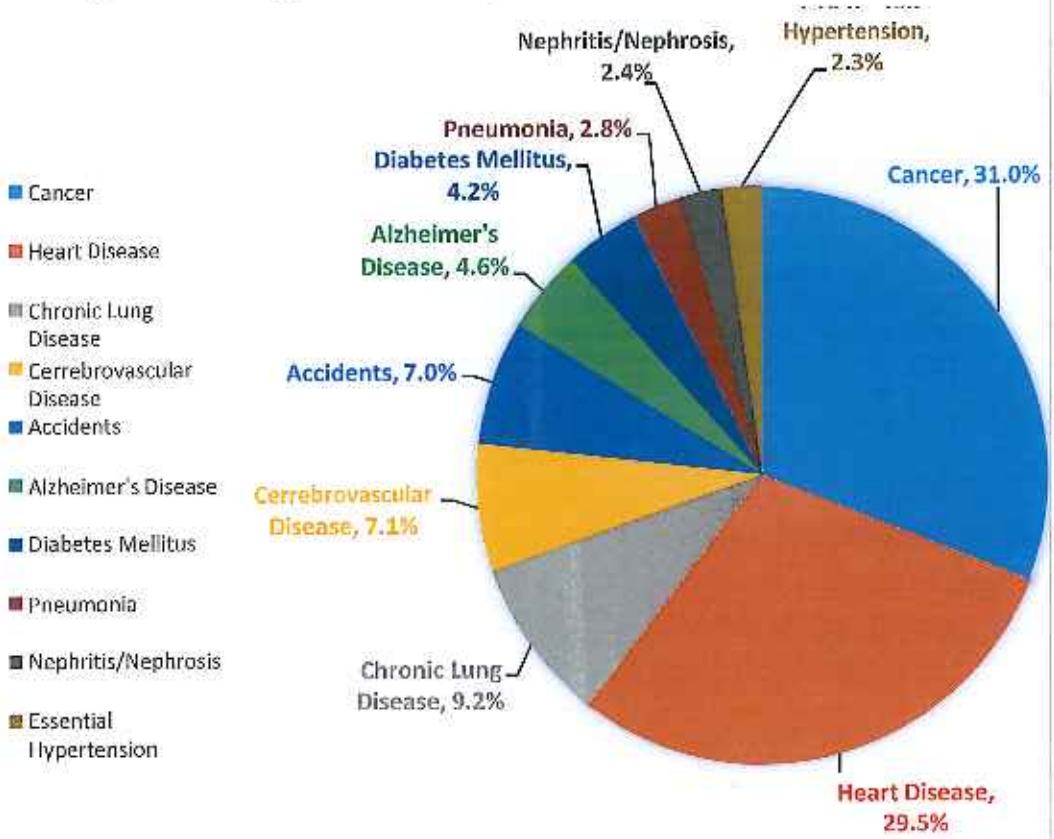
Health Issue	2016 Mean	2016 Rank	2013 Mean	2013 Rank
Cancer	4.7291	1	5.8662	2
Overweight and obesity	4.6098	2	5.8689	1
High blood pressure	4.5485	3	5.4115	4
Heart disease	4.5278	4	5.3519	5
Diabetes	4.4948	5	5.2651	6
Mental health (including depression)	4.2609	6	4.9895	7
Aging problems (arthritis, hearing/vision loss)	4.1787	7	5.4520	3
Infectious diseases (flu, other viruses/ infections)	3.9080	8	4.9809	8
Stroke	3.8446	9	4.7322	9
Poor dental health	3.6281	10	4.6894	10
Injuries resulting from falls, etc.	3.5293	11		
Injuries resulting from farm accidents	3.5204	12		
Suicide	3.5204	13	3.8386	14
Injuries resulting from crashes (ATV, other vehicle)	3.4640	14	4.5034	11
Sexually transmitted diseases/infections (STIs)	3.1633	15	4.0950	12
Unsafe environment (poor air/water, chemical exposure)	2.7884	16	3.8598	13

Cancer Screening

All Cancers

As shown below, cancer is the leading cause of death in Nebraska. This accounts for approximately one-third of all deaths in Nebraska as of 2014.

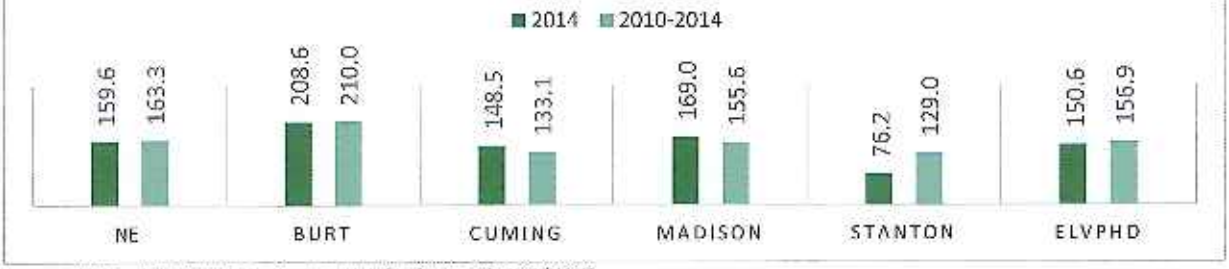
Figure 14: Leading Causes of Death, Nebraska 2014



Source: National Vital Statistics System-Natality (NVSS-N), CDC/NCHS

Cancer death rates by county range from 76.2 in Stanton County to 210 in Burt County in 2014. The 2010-2014 average age-adjusted cancer death rate by county is higher for all except Madison and Cuming Counties. As a whole, ELVPHD residents exhibit a cancer death rate that is lower than the state of Nebraska for both 2014 and the 2010-2014 average.

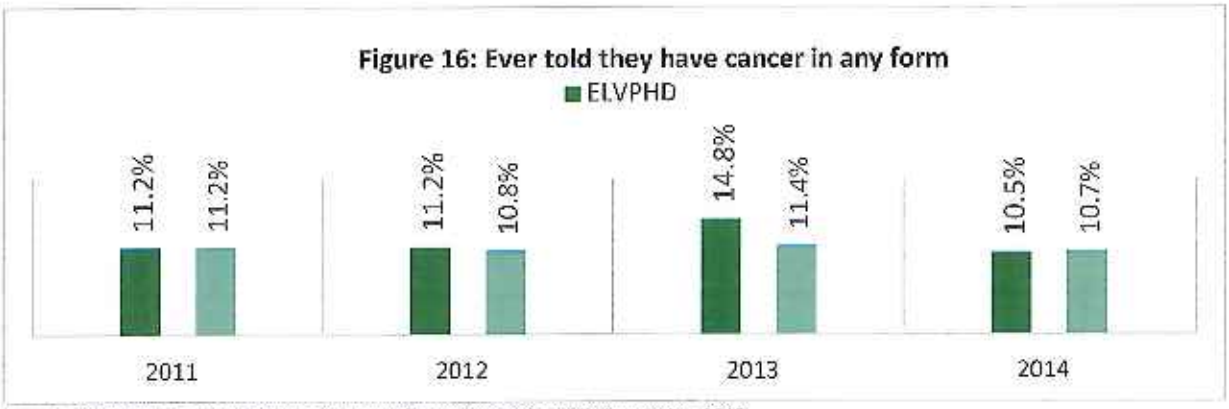
Figure 15: Cancer Deaths by County of Residence, Age-Adjusted Rate



Source: National Vital Statistics System-Natality (NVSS-N), CDC/NCHS

As shown below, the percentage of individuals who have ever been told they have cancer in any form has declined from 2013 to 2014 for the Elkhorn Logan Valley population. Elkhorn Logan Valley had higher percentages of individuals who had ever been told they have cancer in any form in 2012 and 2013 when compared to Nebraska, and less than Nebraska in 2014.

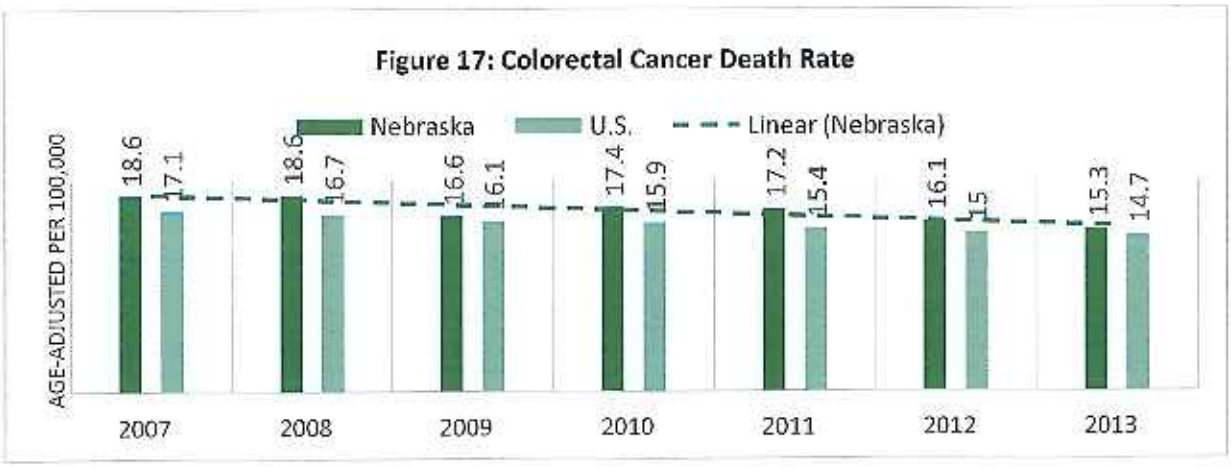
Figure 16: Ever told they have cancer in any form



Source: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), September 2015

Colorectal Cancer

As shown below, the Colorectal Cancer (CRC) death rate has been declining for both Nebraska and the U.S. from 2007 to 2013. As of 2013, the death rate for Nebraska was at 15.3 per 100,000, which is slightly above the Healthy People 2020 target of 14.5 per 100,000.

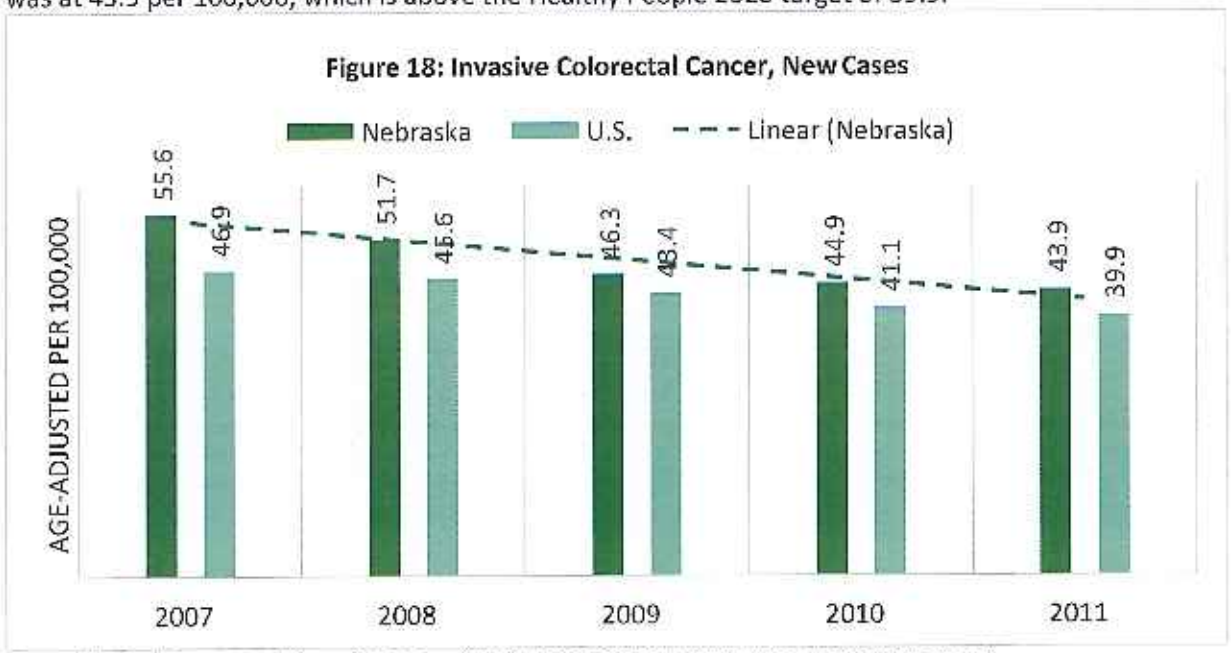


Source: National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

Healthy People 2020 Baseline (year): 17.1 (2007)

Healthy People 2020 Target: 14.5

As shown below, the new cases of invasive CRC has been declining for both Nebraska and the U.S. from 2007 to 2011. As of 2011, the age-adjusted case rate for Nebraska was at 43.9 per 100,000, which is above the Healthy People 2020 target of 39.9.



Source: National Program of Cancer Registries (NPCR), CDC/NCCDPHP; Surveillance, Epidemiology, and End Results Program (SEER), NIH/NCI; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

2020 Baseline (year): 46.9 (2007)

2020 Target: 39.9 1

Colon Cancer Screening

Approximately 41% of survey respondents were over the age of 50 (553 individuals). Of which, the following questions were asked.

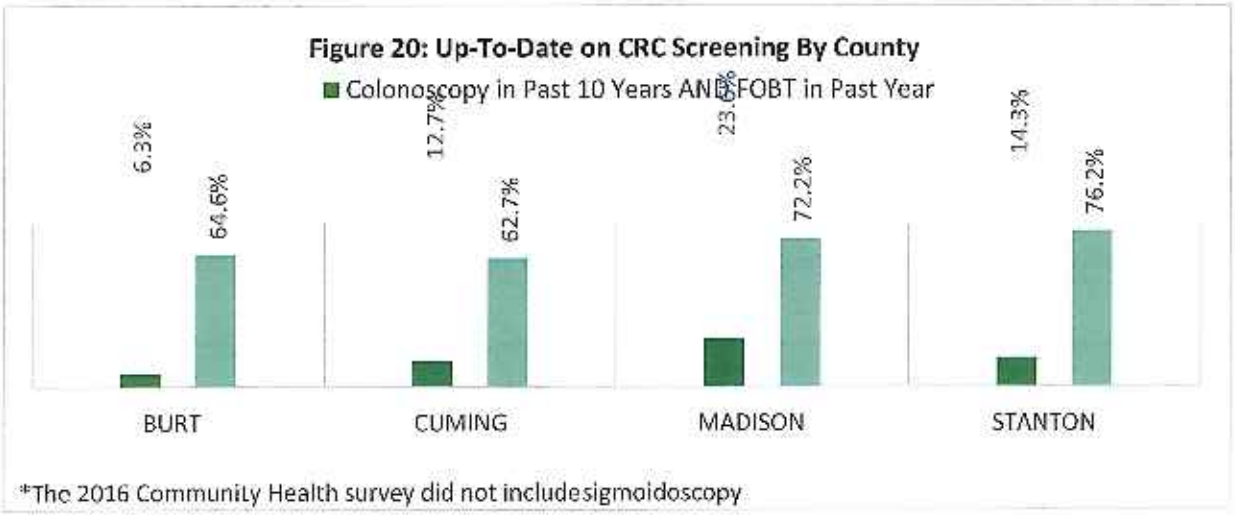
From the ELVPHD Community Health Survey, 36.5% of respondents had an FOBT more than a year ago, 22.9% had an FOBT within the past year, and 32.3% never had an FOBT. In addition, 63.5% had a Colonoscopy within the past 10 years, 5.6% had a Colonoscopy more than 10 years ago, and 29.8% of respondents over the age of 50 had never had a Colonoscopy.

Figure 19: FOBT and Colonoscopy Rates

28. When did you complete your last FOBT (a test to check solid waste/stool for blood)?	
Within the past year	**22.90%**
More than one year ago	**36.50%**
Never	**32.30%**
29. When was your last colonoscopy?	
Within the past 10 years	**63.50%**
More than 10 years ago	**5.60%**
Never	**29.80%**

According to the Centers for Disease Control and Prevention (CDC) and the Behavioral Risk Factor Surveillance System (BRFSS), being up to date on colorectal cancer screening means either, "having a fecal occult blood test (FOBT) during the past year, a colonoscopy during the past 10 years OR a sigmoidoscopy during the past 5 years and an FOBT during the past three years." Therefore, from the proportion of responses below who had an FOBT in the last year and a colonoscopy in the last 10 years, 17.3% of survey respondents from the ELVPHD service area were up-to-date on their CRC screenings. Approximately 69% had either an FOBT in the past year OR a Colonoscopy in the last 10 years from within the ELVPHD population.

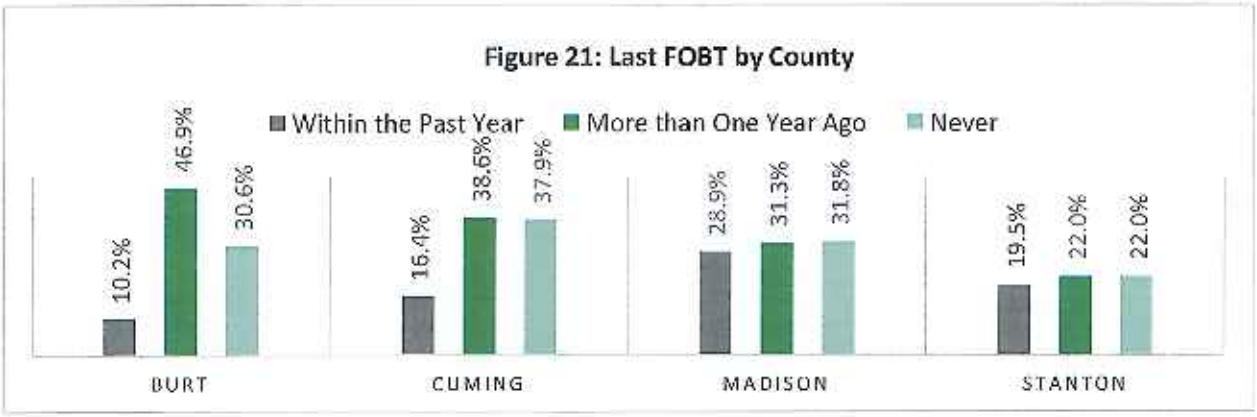
Figure 20: Up-To-Date on CRC Screening By County



*The 2016 Community Health survey did not include sigmoidoscopy

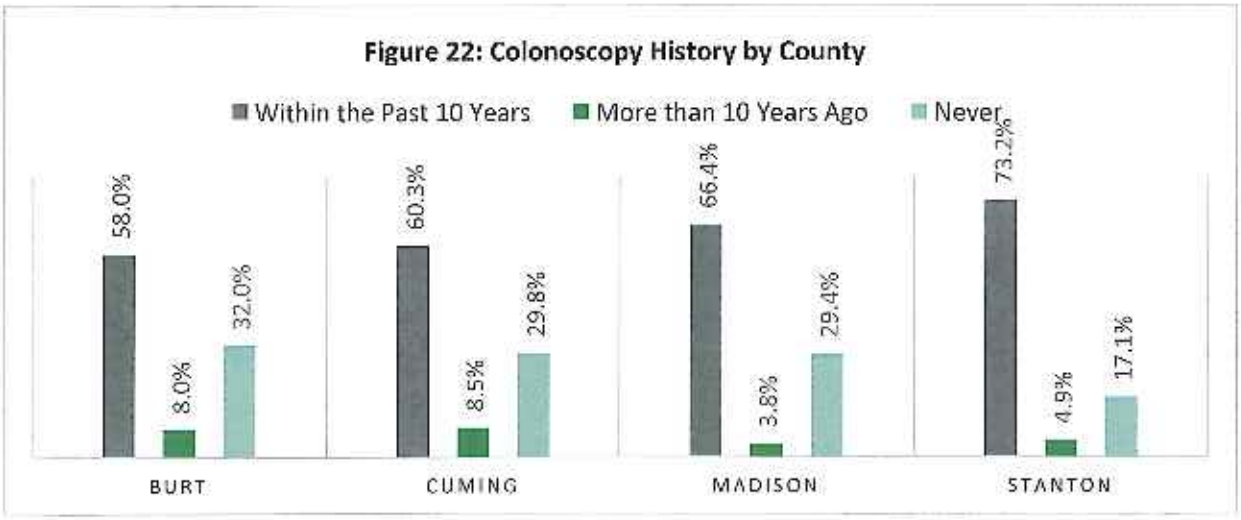
According to the Community Health Survey, the proportion of residents that were up-to-date on CRC screening according to CDC and BRFSS guidelines ranged from 6.3% in Burt County to 23.6% in Madison County. Those individuals that had one or the other component of up-to-date CRC screenings according to CDC and BRFSS guidelines ranged from 64.6% in Burt County to 76.2% in Stanton County (see above).

Figure 21: Last FOBT by County



When looking solely at FOBT by county, those that were screened in the last year ranged from 10.2% in Burt County to 28.9% in Madison County. Those that had been screened more than a year ago (longer than advised by the CDC and BRFSS guidelines), ranged from 22% in Stanton County to 46.9% in Burt County. Finally, those that reported never being screened with an FOBT ranged from 22% in Stanton County to 37.9% in Cuming County.

Figure 22: Colonoscopy History by County

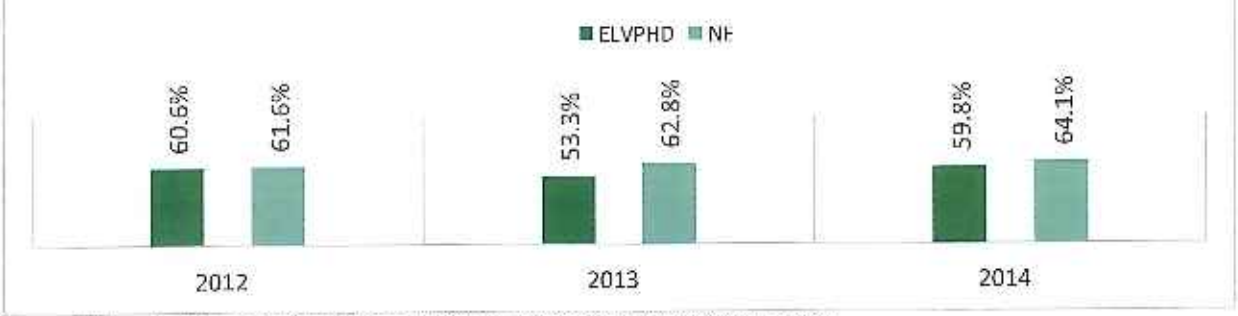


When looking solely at Colonoscopies by county, those that were screened in the last 10 years ranged from 58% in Burt County to 73.2% in Stanton County. Those that had been screened more than ten years ago (longer than advised by the CDC and BRFSS guidelines), ranged from 3.8% in Madison County to 8.5% in Cuming County. Finally, those that reported never being screened with a Colonoscopy ranged from 17.1% in Stanton County to 32% in Burt County.

In summary, there appears to be room for improvement with CRC screening. Healthy People 2020 guidelines aim for 70.5% of the population ages 50-75 receiving screening. According to BRFSS data, ELPHD population has fluctuated from 60.6% in 2012, 53.5% in 2013 to 59.8% in 2014. In comparison, the same years for the state of Nebraska are as follows: 61.6%, 62.8% and 64.1% (see below). ELVPHD is lower than the state in all years, and significantly lower than the HP 2020 goal.

Sources: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), September 2015; National Health Interview Survey (NHIS), CDC/NCHS

Figure 23: Up-To-Date Colon Cancer Screening, Ages 50-75

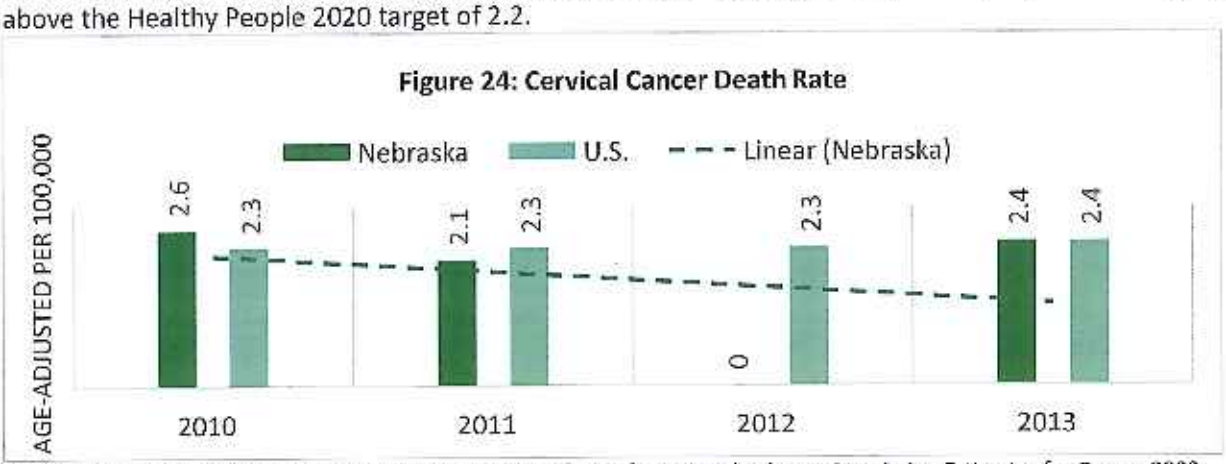


Source: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), September 2015

Cervical Cancer

As shown below, the overall Cervical Cancer death rate has been declining for both Nebraska and the U.S. from 2010 to 2013. As of 2013, the death rate for Nebraska was at 2.4 per 100,000, which is slightly above the Healthy People 2020 target of 2.2.

Figure 24: Cervical Cancer Death Rate

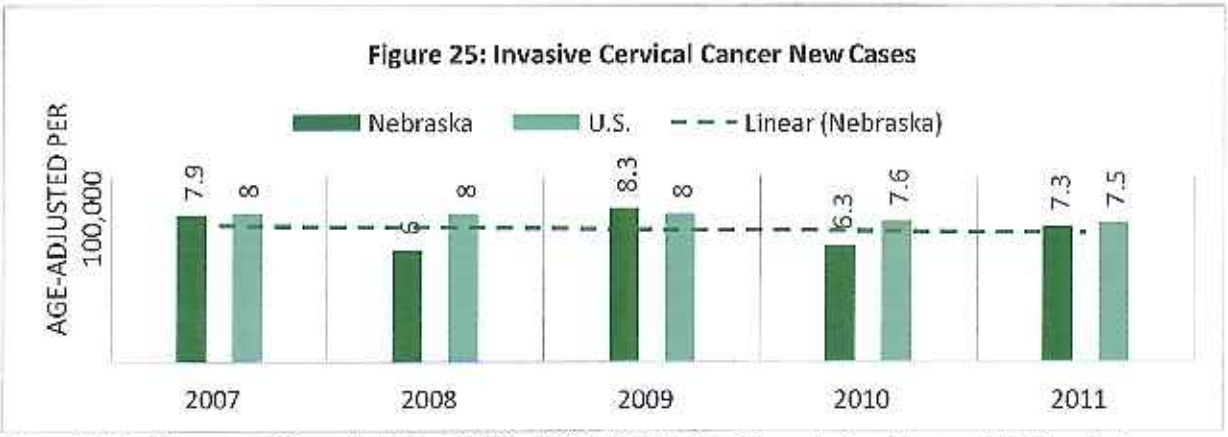


Source: National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

Healthy People 2020 Baseline (year): 2.4 (2007)

Healthy People 2020 Target: 2.2

As shown in Figure 25 below, the overall new case rate of invasive Cervical Cancer has remained fairly constant for Nebraska and the U.S. from 2007 to 2011. As of 2011, the death rate for Nebraska was at 7.3 per 100,000, which is slightly above the Healthy People 2020 target of 7.2. Healthy People 2020 Baseline (year): 8.0 (2007)

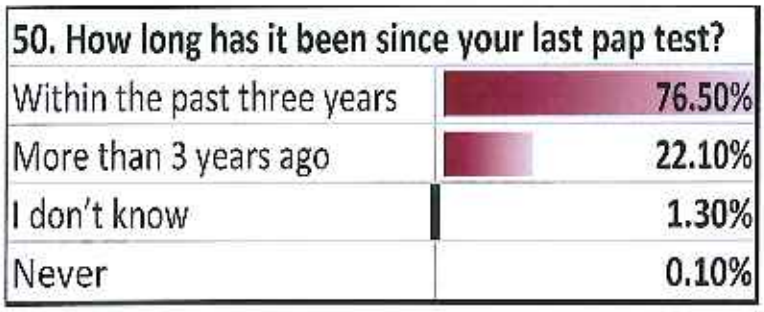


Source: National Program of Cancer Registries (NPCR), CDC/NCCDPHP; Surveillance, Epidemiology, and End Results Program (SEER), NIH/NCI; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

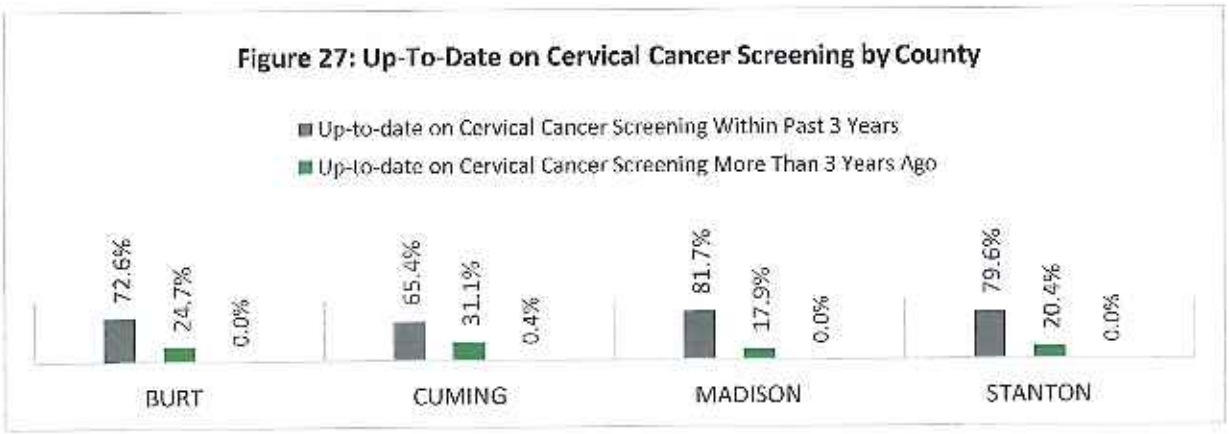
Cervical Cancer Screening

The median age of those survey respondents that had ever had a Pap test was 44 years. The median age of those that had had a Pap test within the past three years was 40.

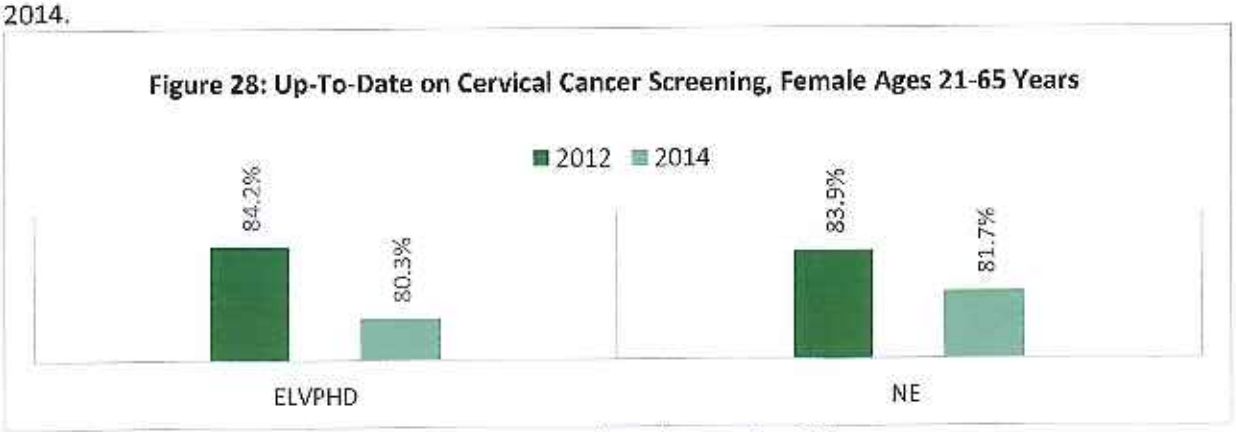
Figure 26: Pap Test Rates



According to the Community Health Survey Respondents, 76.5% had received screening as recommended by the CDC and 97.1% had ever had a Pap Test. The proportion of those that were up-to-date on Cervical Cancer Screening ranged from 65.4% in Cuming County to 79.6% in Stanton County.



According to CDC guidelines, average-risk women ages 21 to 65 should be screened every three years. In 2012, the BRFSS estimates that 84.2% of the ELVPHD population were up-to-date on their cervical cancer screening. This decreased to 80.3% in 2014. The corresponding proportions for the state were 83.9% in 2012 and 81.7% in 2014. Both state and district proportions have decreased from 2012 to 2014.

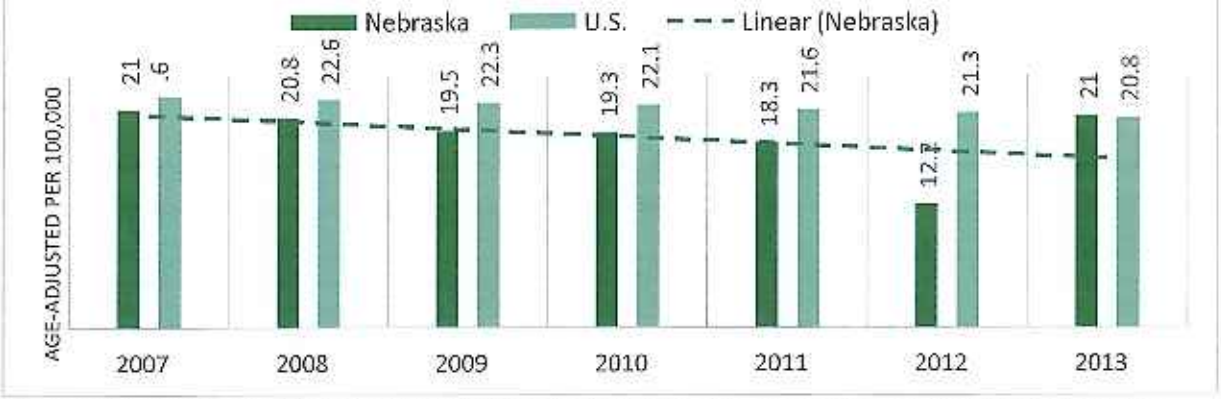


Source: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), September 2015

Breast Cancer

Overall, the female breast cancer death rate has been declining in Nebraska, however from 2012 to 2013 the death rate increased from 12.2 to 21. Nebraska female breast cancer death rate has remained lower than that of the country for all years except 2013, where the country had a rate of 20.8 and the state was 21, not statistically significant. The Healthy People 2020 goal is 20.7, which Nebraska reached from 2009 to 2012.

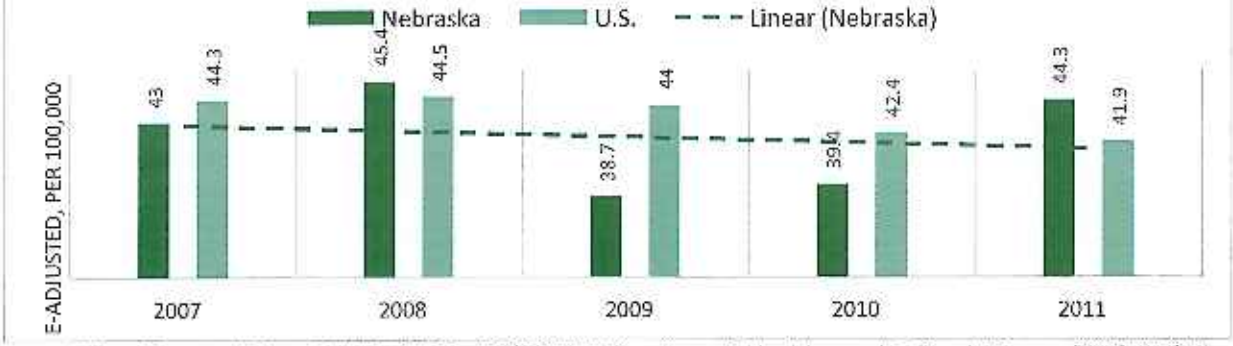
Figure 29: Female Breast Cancer Death Rate



Source: National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

Overall, the new cases of late-stage female breast cancer has been declining since 2007. However, in 2011, it rose to 44.3 from 39.4 in 2010. Nebraska had a lower new case rate than the country for 2007 to 2011 except in 2008 and in 2011 when the case rates were 45.4 and 44.3, respectively (44.3 and 41.9, respectively for the U.S.). The Healthy People 2020 goal is 42.1, which Nebraska had reached in 2009 and 2010.

Figure 30: Late-Stage Female Breast Cancer, New Cases



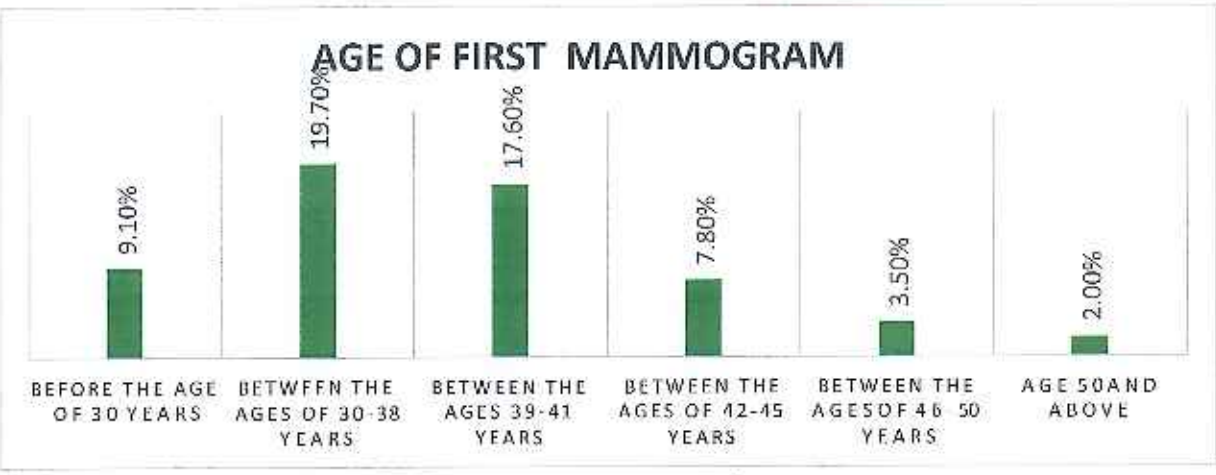
Source: National Program of Cancer Registries (NPCR), CDC/NCCDPHP; Surveillance, Epidemiology, and End Results Program (SEER), NIH/NCI; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

Breast Cancer Screening

According to the American Cancer Society guidelines, women ages 40-44 should get an annual mammogram if they choose. Women ages 45-54 should get mammograms every year, and women ages 55 and older should receive mammogram screenings ever two years. Given these guidelines, 19.7% of ELVPHD Community Health Survey respondents between the ages of 30 and 38 are being screened early, 17.6% between the ages of 39 to 41 are being screened early, and 9.1% of women under the age of 30 are being screened early. Nearly 8% of women ages 42 to 45 are being screened for the first time and 2.5% of women between 46 and 50 are initiating screening.

Figure 31: Breast Cancer Screenings and Self-Checks

46. Do you examine your breasts each month for lumps?	
Yes	62.20%
No	36.40%

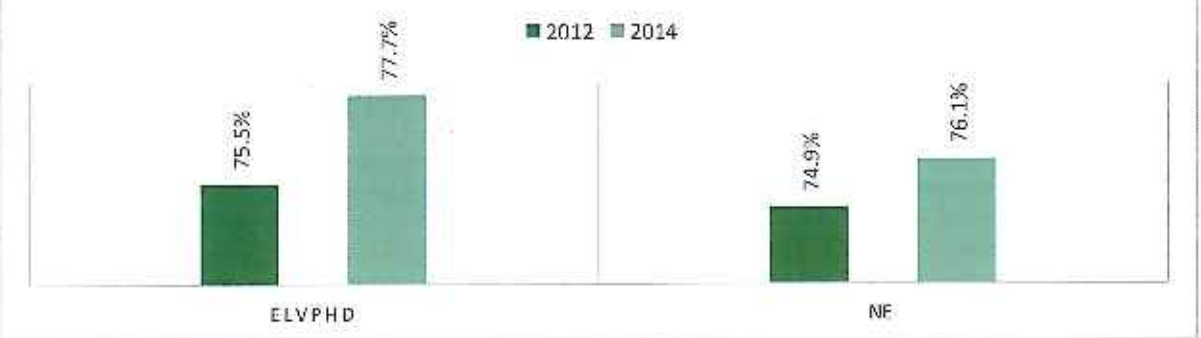


48. How long has it been since your last mammogram?	
Within the past one year	61.20%
More than 1 year ago	36.60%
I don't know	1.30%
Never	0.90%

Of those women from the Community Health Survey who had a mammogram in the past, 61.2% did so within the last year and 36.6% did so more than a year ago. According to the National Health Interview Survey (NHIS), in 2013 72.6% of women ages 50 to 74 had received a mammogram within the past two years, 72.4% in 2010 and 73.7% in 2008. The Healthy People 2020 target is 81.1%.

The BRFSS for Nebraska reported that of women ages 50 to 74 who were up-to-date on breast cancer screening was approximately 75.5% for residents of the ELVPHD community in 2012 and 77.7% in 2014, both of which were higher than the state percentages of 74.9% and 76.1% in 2012 and 2014, respectively.

Figure 32: Up-To-Date on Breast Cancer Screening, Females Ages 50-74 Years

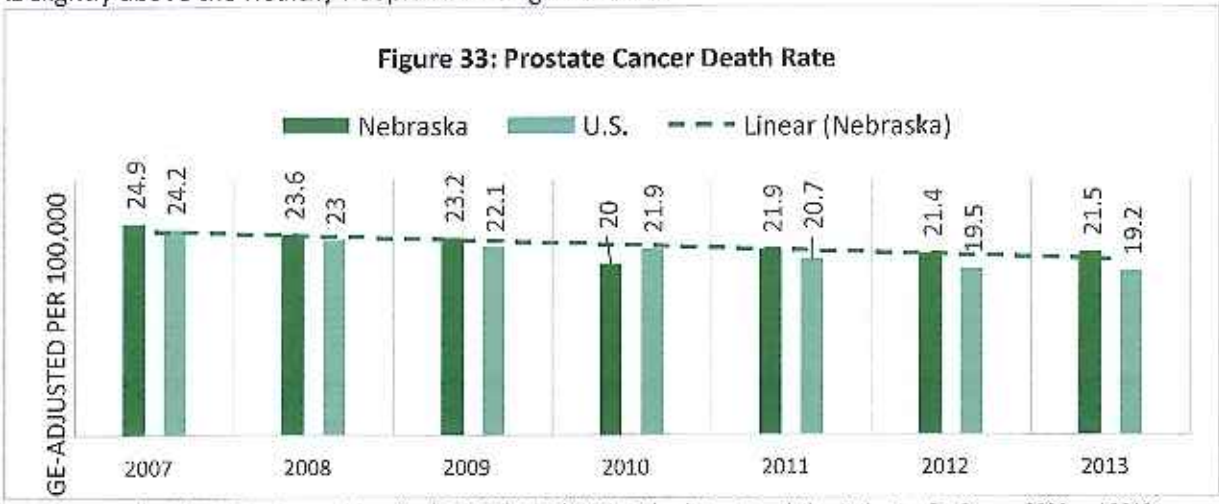


Source: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), September 2015

Prostate Cancer

As shown below, the overall Prostate Cancer death rate has been slightly declining for both Nebraska and the U.S. from 2007 to 2013. As of 2013, the death rate for Nebraska was at 21.5 per 100,000, which is slightly above the Healthy People 2020 target of 21.8.

Figure 33: Prostate Cancer Death Rate



Source: National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; Bridged-Race Population Estimates for Census 2000 and 2010, CDC/NCHS and Census

Healthy People 2020 Baseline (year): 24.2 (2007)

Healthy People 2020 Target: 21.8

Prostate Cancer Screening

According to Healthy People 2020, the target for the year 2010 is 15.9% of men ever to be counseled about advantages and disadvantages of the PSA test. This goal, according to the Community Health Survey, has already been met in the ELVPHD population for men over the age of 50, but the aforementioned goal proportion was aimed towards men over the age of 40, so this proportion may be skewed. The state of Nebraska is approximately at the Healthy People 2020 goal, but has 1.5% of its male population over the age of 40 to go.

Figure 34: Prostate Cancer Screening, Discussions with Providers

30. Have male adults in your household, age 50 and over, discussed prostate cancer screening with their health care provider?

	2016 Survey	NE	HP2020
Men ever counseled about advantages and disadvantages of the PSA test (age adjusted, percent, 40+ years)	25.80%	14.40%	15.90%

Source: Nebraska Behavioral Risk Factor Surveillance System (BRFSS), September 2015; National Health Interview Survey

Exercise

Background. A lifestyle lacking in regular physical activity has been associated with an increased risk for cardiovascular illness, cancer, osteoporosis, and other debilitating conditions. Despite these risks, a large proportion of people remain inactive.

The CDC website lists multiple benefits received from exercise including weight control, reducing risk for cardiovascular disease, diabetes, some cancers, improved mobility and strength, and longer life.

Table 67: BRFSS Physical Activity Measurements

	No leisure-time physical activity in past 30 days	Met aerobic physical activity recommendation	Met muscle strengthening recommendation	Met both aerobic physical activity and muscle strengthening recommendations
Overall	26.1%	49.4%	24.9%	16.3%
Male	26.5%	48.5%	25.5%	16.3%
Female	25.7%	50.3%	24.4%	16.3%
Education				
Less than High School	39.0%	38.2%	13.2%	8.3%
High School/GED	30.6%	42.6%	27.0%	16.5%
Some College	21.4%	52.8%	28.6%	19.6%
College Graduate	14.8%	58.7%	30.7%	19.6%
Income				
<$25,000	31.6%	43.5%	21.6%	12.2%
$25,000-49,999	30.6%	45.6%	25.8%	16.0%
$50,000+	17.2%	56.0%	30.2%	20.6%
Age				
18-44	20.9%	48.8%	32.0%	19.7%
45-64	29.3%	45.8%	19.9%	14.2%
65 and older	30.3%	56.7%	19.6%	13.4%

HP2020 Goals and BRFSS HD reports

The CHA document includes district level data for four physical activity measurements:

1. No leisure-time physical activity in past 30 days. *The goal (PA-1) is to reduce the proportion of adults who engage in no leisure-time physical activity from a baseline of 36.2% to a target of 32.6%.*

Based on BFRSS data in the first column, ELVPHD exceeded that goal with 26.1% that engage in no physical activity.

Question 33 of the 2016 asked "How many days a week do you do at least 20-30 minutes of physical activity without stopping, in which you breathe heavier and your heart beats faster? Responses in 2016 were consistent to those in 2013 (2016, 15% Never exercised; 2013, 16.8% Never exercised).

Table 68: How many days a week do you do at least 20-30 minutes of physical activity without stopping, in which you breathe heavier and your heart beats faster?

		Frequency	Percent	2016 Valid Percent	2013 Valid Percent
Valid	6-7 days a week	94	6.4%	7.1%	11.1%
	4-5 days a week	279	18.9%	21.0%	21.1%
	2-3 days a week	475	32.1%	35.7%	33.2%
	1 day a week	283	19.1%	21.3%	17.8%
	Never	200	13.5%	15.0%	16.8%
	Total	1331	89.9%	100.0%	100.0%
Missing	System	149	10.1%		
Total		1480	100.0%		

2. Met aerobic physical activity recommendation. The second identified goal in the BRFSS report (PA-2.1) would increase the proportion of adults who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination. The baseline for the goal is from 2008 where 43.5% of adults engaged in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity. The target for this indicator was 47.9%.

In the BRFSS report for ELVPHD 49.4% met aerobic physical activity recommendation, which exceeded the target of 47.9%. For this, the levels of physical activity increased with education, income, and age.

For the survey respondents, it is plausible that those who exercise at least four days per week (28%) would meet the goal. For the third value (2-3 times per week, 35.7% of respondents), those who exercise 2 times would have 40-60 minutes per week, and those who exercise 3 times would have 60-90 minutes per week; a proportion of that latter (3 times per week) could meet that requirement.

3. Met muscle strengthening recommendation. The goal (PA-2.3) increases the proportion of adults who perform muscle-strengthening activities on 2 or more days of the week from a baseline of 21.9% to a target of 24.1%.

From the BRFSS report (no survey question) 24.9% met this recommendation and the HD met that goal. Here, again, the levels increased with education and income, but they decreased as age increased.

4. Met both aerobic physical activity and muscle strengthening recommendations. This goal (PA-2.4) combines two of the metrics with an increase of the proportion of adults who meet the objectives for aerobic physical activity and for muscle-strengthening activity. The baseline here is 18.2% and the target is 20.1%.

With 16.3% the HD did not meet this goal. Proportions here increased with income and education, but decreased with age.

Exercise x BMI

Both surveys included questions about weight and levels of exercise. The following table shows crosstabs the results for amount of exercise by BMI category and the year.

Table 69: Detailed Breakdown: How many days a week do you do at least 20-30 minutes of physical activity without stopping, in which you breathe heavier and your heart beats faster?

BMI Weight Categories		Year	6-7 days a week	4-5 days a week	2-3 days a week	1 day a week	Never	Total
	Underweight	2016	33.3%	13.3%	20.0%	13.3%	20.0%	100%
		2013	33.3%	16.7%	16.7%	-	33.3%	100%
	Healthy Weight	2016	9.3%	27.5%	39.0%	12.0%	12.3%	100%
		2013	15.1%	25.0%	37.2%	11.6%	11.0%	100%
	Overweight	2016	8.6%	20.7%	35.7%	22.2%	12.8%	100%
		2013	11.9%	23.8%	31.9%	15.7%	16.8%	100%
	Obese	2016	3.7%	16.8%	33.3%	27.5%	18.8%	100%
		2013	7.2%	14.9%	28.7%	27.1%	22.1%	100%
Total		2016	7.1%	21.0%	35.5%	21.3%	15.1%	100%
		2013	7.2%	14.9%	28.7%	27.1%	22.1%	100%

Healthy Weight. Just over one-third exercise at least 4 days per week, with a slight decrease in 2016 (37%; 2013, 40%).

Overweight. In 2016 29% exercised at least 4 days per week, lower than those at a Healthy weight and also less than Overweight in 2013 (35%). Overweight respondents reported exercising One-day a week or less at 35% (one in three).

Obese. In 2016, 21% exercised at least 4 days per week, the least amount of the four weight categories. This also was a slight decrease from 2013. Of those in the obese category, 46% exercised One-day a week or less (about half; 49% in 2013).

Nutrition

Two of the 2016 Survey questions asked the daily servings of fruit and vegetables (#34 and 35). Similar questions are included in the BRFSS report that is part of the DHHS CHA document.

Some comparisons of the 2016 Survey data with the 2013 Survey data.

Fruits (Question 35). Respondents in 2016 consumed considerably less fruit than those of 2013.

- None: 2013, 2%; 2016, 11.5%.
- 1-2 servings: 2013, 53%; 2016, 72%.
- 3-4 servings: 2013, 21%; 2016, 15%.
- 5 or more: 2013, 5.3%; 2016, 1.5%.

Vegetables (Question 36). Respondents in 2016 consumed considerably less/fewer than those of 2013.

- 1-2 servings: 2013, 56%; 2016, 71%.
- 3-4 servings: 2013, 26%; 2016, 22%.
- 5 or more: 2013, 7.5%; 2016, 2%.

Soda etc. (Question 37). Though the measures differed between surveys, it appears that respondents in 2016 decreased their soda/soft drink consumption (given the large increase in None).

- None: 2016, 56%; 2013, 44%.
- 1 per day: 2016, 39% (includes 1 and 2 per day); 2013, 51% (includes Occasionally, 1-2 per day).
- 2 per day
- Over 3 per day. 5%, same as 2013.

BRFSS: Sodium, Fruits, Vegetables, Sugar

HP2020 does not have specific goals here, but these are part of the BRFSS data tables in the CHA document.

With reference to questions 35 and 36 in the information above, the BRFSS data show a higher proportion of respondents with lower amounts of fruit/vegetable consumption. The measure here is *less than 1 serving per day*, which in other scales is sometimes represented as *Occasionally*.

- *Consumed fruits less than 1 time per day:* Four in ten, overall. Males eat less fruit than females, and eating fruits increases with levels of education, income, and age.
- *Consumed vegetables less than 1 time per day:* one in three. Males eat fewer servings of vegetables than females. Eating vegetables increases with education, income, and age.
- Sodium: About half are currently watching sodium/salt intake. It is relatively constant by levels of education, increasing with age, and decreasing with levels of income.
- Soft drinks: In the 2016 Survey 44% had at least one soft drink per day. This is lower in the BRFSS report (31%). Soft drink consumption decrease with levels of education, age, and income.
- Energy Drinks. In a separate question, 8.6% of respondents said they regularly drink energy drinks.

Table 70: BRFSS reports for reducing sodium, consuming fruits, vegetables and soft drinks.

	Currently watching or reducing sodium or salt intake	Consumed fruits less than 1 time per day	Consumed vegetables less than 1 time per day	Consumed sugar-sweetened beverages 1 or more times per day in past 30 days
Overall	49.3%	41.4%	29.4%	31.0%
Male	45.3%	46.6%	35.7%	41.9%
Female	52.6%	36.4%	23.4%	21.9%
Education				
Less than High School	-*	38.2%	28.5%	-*
High School/GED	49.1%	47.4%	35.1%	43.3%
Some College	46.2%	46.1%	30.5%	27.8%
College Graduate	49.6%	31.9%	20.8%	27.4%
Income				
<$25,000	59.0%	49.5%	34.6%	32.9%
$25,000-49,999	44.4%	44.8%	27.0%	38.9%
$50,000+	42.6%	38.0%	27.7%	29.0%

Table 67 (Continued.)				
	Currently watching or reducing sodium or salt intake	Consumed fruits less than 1 time per day	Consumed vegetables less than 1 time per day	Consumed sugar-sweetened beverages 1 or more times per day in past 30 days
Age				
18-44	35.9%	48.5%	34.8%	45.1%
45-64	55.9%	42.2%	26.7%	25.1%
65 and older	62.9%	26.9%	23.3%	15.6%

Table 71: Do you or someone in your household regularly drink energy drinks such as Red Bull, Monster, or 5-hr. Energy?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	114	7.7%	8.6%	8.6%
	No	1193	80.6%	89.6%	98.2%
	I don't know	24	1.6%	1.8%	100.0%
	Total	1331	89.9%	100.0%	
Missing	System	149	10.1%		
Total		1480	100.0%		

Healthy Food Environments and Access

People generally get most of their food from either 1) retail groceries, where they buy foods to prepare and eat from home, or from 2) food service venues, where they eat away from home. Grocery stores, corner stores, and farmers' markets are examples of food retail venues. Restaurants (including quick serve), child care facilities, schools, hospital and worksite cafeterias are examples of food service venues.

The difference between the two is in the range of choices for healthy food. The range is much broader in retail venues (except for processed/frozen meals), and much narrower in food service venues. The CDC in its literature points out that having healthy food available and affordable in food retail and food service settings allows people to make healthier food choices.[14] When healthy foods are not available, people may settle for foods that are higher in calories and lower in nutritional value. Thus, creating and supporting healthy food environments is an important part of public health work.

CDC suggests these strategies:

1) providing incentives for supermarkets or farmers' markets to establish their businesses in underserved areas;
2) having nutrition information and caloric content on restaurant and fast food menus; and
3) applying nutrition standards in child care facilities, schools, hospitals, and worksites.

[14] For example, http://www.cdc.gov/obesity/downloads/hfrassessment.pdf. Centers for Disease Control and Prevention. Healthier Food Retail: Beginning the Assessment Process in Your State or Community. Atlanta: U.S. Department of Health and Human Services; 2014.

2016 Survey: Food Choices

Question 42 asked about the sources of *fresh fruits/vegetables* in a multiple response question. Nearly all rely on a grocery store, but one in four (28%) do have a garden and one in five (20%) use the farmers market. Just one in twenty (5%) checked the Bountiful Baskets Coop. This and The Farmer's Markets are constant across the four counties. The *Own Garden* varied by county: Burt, 32%; Cuming, 37%; Madison, 24%; and Stanton, 27%. *Own Garden* increase with levels of age and income, and *Farmer's Market* increases with age.

Table 72: Where do you get your fresh fruits/ vegetables? Frequencies

		Responses		Percent of Cases
		N	Percent	
SOURCE OF FRESH FOOD 42MRF[a]	Grocery store	1299	63.2%	97.5%
	Farmer's market (seasonally appropriate)	269	13.1%	20.2%
	Grow in my own garden	375	18.3%	28.2%
	Bountiful Baskets	71	3.5%	5.3%
	Other	27	1.3%	2.0%
	I do not consume fresh fruits and vegetables	13	.6%	1.0%
Total		2054	100.0%	154.2%

a. Dichotomy group tabulated at value 1.

Food Service Venue

Two thirds (66%) of respondents eat Fast food or in Restaurants at least one time per week. Close behind that is Processed food (74% at least once per week). One difference in those who eat Processed Food and those who do not (None) is that 49% of the latter read food labels Very Often, compared to 27% of those who eat processed food.

Table 73: How many times per week do you eat the following foods:

	None	1-2 per week	3-4 per week	5 or more per week
Fast food	34.1%	58.7%	6.1%	1.1%
Restaurant food (sit down, not fast food)	37.0%	60.2%	2.0%	0.8%
Vending machine food	88.7%	9.9%	1.0%	0.4%
Workplace Cafeteria	70.9%	15.6%	9.0%	4.5%
Processed foods (frozen dinners, frozen pizza, boxed macaroni & cheese, etc.)	25.8%	54.8%	16.4%	3.0%

Table 74: How often do you typically read food/nutrition labels? All respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very Often	435	29.4%	32.7%	32.7%
	Sometimes	561	37.9%	42.1%	74.8%
	Rarely	249	16.8%	18.7%	93.5%
	Never	86	5.8%	6.5%	100.0%
	Total	1331	89.9%	100.0%	
Missing	System	149	10.1%		
Total		1480	100.0%		

When asked about how often respondents eat a healthy breakfast, Table 74 below shows that the average response is 5 days. The number of days increases significantly with age, but it does not with education or income. It decreases as BMI category increases (p = .065; marginally significant).

Table 75: How many times have you eaten a healthy breakfast in the past 7 days?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Day	107	7.2%	8.0%	8.0%
	2 Days	133	9.0%	10.0%	18.0%
	3 Days	157	10.6%	11.8%	29.8%
	4 Days	136	9.2%	10.2%	40.1%
	5 Days	208	14.1%	15.6%	55.7%
	6 Days	99	6.7%	7.4%	63.2%
	7 Days	347	23.4%	26.1%	89.2%
	None	143	9.7%	10.8%	100.0%
	Total	1330	89.9%	100.0%	
Missing	System	150	10.1%		
Total		1480	100.0%		

Worksite/School Issue: Vending Machines

Current HP2020 goals seek to improve / increase nutritious offerings in vending machines in schools. In the school version, the goal seeks to increase the proportion of schools that *do not* offer sweetened beverages (from 9.3% to 21.3%), as one vending option, and to increase the proportion that make fruits and vegetables available when other food is available or sold (6.6% to 18.6%).

This is also addressed by Question 43 of the 2016 Survey. The response (below) is that fewer than half 43% have access to healthy vending options.

Table 76: At your current employment (or school), do you have access to healthy vending options, such as: milk, 100% juice, water, granola bars, cheese, nuts, etc.?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	576	38.9%	43.3%	43.3%
	No	302	20.4%	22.7%	66.0%
	There are no vending options at my job	218	14.7%	16.4%	82.4%
	I do not work outside of the home	187	12.6%	14.1%	96.5%
	I don't know	47	3.2%	3.5%	100.0%
	Total	1330	89.9%	100.0%	
Missing	System	150	10.1%		
Total		1480	100.0%		

A related question (17) asked about workplace wellness. If those who do not work outside the home are excluded, the percent who have a workplace wellness program is 71%.

Table 77: At your current place of employment, is there a wellness program to encourage you to be healthy?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	831	56.1%	61.2%	61.2%
	No	283	19.1%	20.9%	82.1%
	I do not work outside of the home	194	13.1%	14.3%	96.4%
	I don't know	49	3.3%	3.6%	100.0%
	Total	1357	91.7%	100.0%	
Missing	System	123	8.3%		
Total		1480	100.0%		

Food Insecurity

Food Insecurity is defined as food insufficiency and hunger, at adult and child levels, resulting from inadequate household resources. This concept was originated by the USDA in 2006; it is a household related metric. The proportion of U.S. households that reported experiencing food insecurity during a 12-month period increased 21.8% between 1995 and 2012, from 11.9% to 14.5%.

The HP2020 target (NWS-13) is to Reduce household **food insecurity** and in doing so reduce hunger from a baseline of 14.6% of households that were food insecure in 2008 to a target of 6.0%.

ELVPHD (and Nebraska) do not meet the baseline, according to the BRFSS data included in the DHHS CHA document. For the HD, 17.8% experienced *Food Insecurity* in that report. Further, when the data are presented by gender, differences are significant (Males, 10.5%; Females, 25%). Though it is not clear what differentiates a male from a female household, focusing on other demographics show that *food insecurity* decreases as income, education, and age increase.

Fruit/Vegetable Consumption

In the health district an estimated 33,521, or 77.9% of adults over the age of 18 are consuming less than 5 servings of fruits and vegetables each day. This indicator is relevant because current behaviors are determinants of future health, and because unhealthy eating habits may be the cause of significant health issues, such as obesity and diabetes.

Table 78: Adult Fruit and Vegetable Consumption

Report Area	*Total Population (Age 18)*	*Total Adults with **Inadequate Fruit / Vegetable Consumption***	*Percent Adults with **Inadequate Fruit / Vegetable Consumption***
ELVPHD	*43,030*	*33,521*	*77.9%*
Burt	*5,407*	*3,915*	*72.4%*
Cuming	*6,956*	*5,273*	*75.8%*
Madison	*25,999*	*20,305*	*78.1%*
Stanton	*4,668*	*4,028*	*86.3%*
Nebraska	*1,326,139*	*1,037,041*	*78.2%*
United States	*227,279,010*	*171,972,118*	*75.7%*

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health Human Services, Health Indicators Warehouse. 2005-09.

Weight: Overweight and Obesity

The prevalence of overweight and obesity among adults, adolescents, and children has risen considerably over the past twenty years in the United States and in Nebraska, according to BRFSS reports.

Definitions. The Body Mass Index (BMI) was developed as an instrument to represent overall weight conditions and trends in survey populations. As such, its calculations sometimes 'overlook' relative muscle mass, consequently depicting athletes as being overweight (for example). In the most recent data, the CDC also includes the category of *Underweight.*[15] In the reports from the 2016 Survey, respondents reported height and weight and those were used to calculate individual BMI scores. The four categories are:

Underweight	(BMI 12.0-18.4)
Normal Weight	(BMI 18.5-24.9)
Overweight	(BMI 25.0-29.9)
Obese	(BMI 30.0 - 99.8)

Results from BRFSS Data

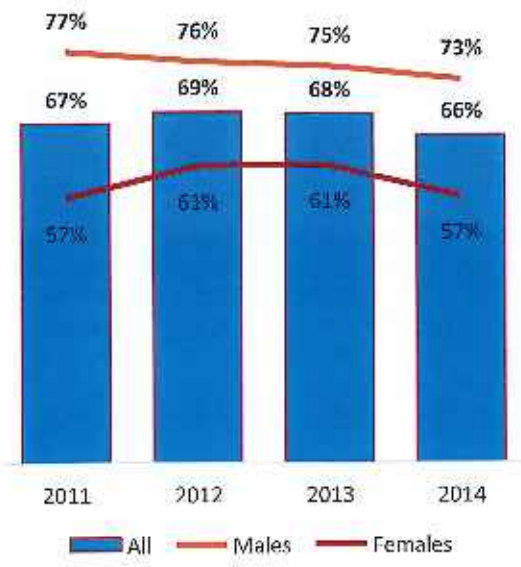
BRFSS reports for BMI and trends in weight show the proportions for those who are obese and also combine the Overweight and Obese categories, especially when looking at data for individual Health Districts. In 2014, 65.5% of adults in the HD were either obese or overweight, statistically the same proportion as statewide (66.7%).

In 1995, about half (46.7%) Nebraskans were at normal weight; that proportion decreased to one-third (34.5%) in 2014. During the same period the proportion of those overweight stayed about the same, 37% to 36.4%. The percentage of those in the obese category, however, increased from 16.3% in 1995 to 30.3% in 2014.

In each of the four years from 2011 through 2014, the proportion who are obese has remained about the same for the Health District and for the state.

The differences for the Health District (depicted in the adjacent chart) are not 'significantly' different year to year. The differences by gender, however, are significant, with a larger proportion of males (28% more) either overweight or obese.

Figure 35: ELVPHD District: Obesity and Overweight Rates



[15] The National Institute of Health has also published a definition with three levels (I-III) of obesity, thus six categories in all.

Table 79: BRFSS Data for Weight

	Obese (BMI=30+)	Obese (BMI=30+), among disabled	Overweight or Obese (BMI=25+)
Age			
18-44	26.5%	42.9%	59.4%
45-64	36.6%	46.3%	75.3%
65 and older	28.2%	40.0%	69.3%
Income			
<$25,000	34.4%	41.8%	65.6%
$25,000-49,999	32.1%	38.1%	67.0%
$50,000+	28.4%	39.3%	69.3%
Education			
Less than High School	34.1%	42.6%	66.3%
High School/GED	36.9%	42.7%	71.5%
Some College	27.0%	40.2%	63.5%
College Graduate	29.2%	41.3%	68.1%
Race/Ethnic Minority			
White, NH	29.3%	NA	66.1%
Hispanic	32.2%	NA	68.1%
Non-White, NH	46.2%	NA	63.3%
Minority	38.2%	NA	66.6%

Table 78 (left) presents BRFSS data from 2011-2014 for the HD disaggregated for demographic variables.

Age. Of the three categories reported by DHHS, greater proportions of those 45-64 are overweight or obese than are those 65 and over or under 45.

Income. The prevalence of obesity decreases as income increases. Being Overweight, however, does not.

Education. Proportions of obesity appear to decrease as levels of education increase.

Disability. DHHS included weight class data for disabled respondents; it is also an HP2020 goal. In this a greater proportion of disabled respondents are obese than those who are not disabled; however, with reference to statewide disabled populations, there are no significant differences and there are no differences within the HD on a year to year basis.

Based on the BRFSS data for 2014, there are an estimated 13,328 adults in the HD who are obese and 14,793 who are overweight. Obesity by county (with 2013 in parentheses): Burt, 1,668 (1,624); Cuming, 1970 (2029); Madison, 8,551 (7,489); and Stanton, 1,494 (1,474).

2016 Community Survey

In the 2016 Survey 17.5%[16] of respondents said they *had been told* they had health problems with being Obese/Overweight (Question 12, one of 17 possible diagnoses). Of those (n = 228), 91% were obese and 9% overweight. Further, 62% had a BMI above 35, and 34% of those had a BMI above 40. For these respondents the mean BMI was 38.45 (median, 36.86), while for all respondents the mean BMI was 29.62 (median, 28.19). (*There are several additional comments for this group below.)*

[16] Calculated using a Multiple Responses Frequency (Variable). The N = 1359.

Table 80: BRFSS Weight Categories

		Frequency	Percent	2016 Valid Percent	2013 Valid Percent
Valid	Underweight	15	1.0%	1.1%	1.4%
	Healthy Weight	367	24.8%	28.1%	31.9%
	Overweight	409	27.6%	31.3%	32.9%
	Obese	515	34.8%	39.4%	33.9%
	Total	1306	88.2%	100.0%	100%
Missing	System	174	11.8%		
Total		1480	100.0%		

In all, 71% of the 2016 Survey participants were overweight/obese (Table 79 above) based on the height/weight responses in the survey.

It is important to remember that these results represent only survey participants and are not necessarily generalizable to the HD population. At the same time, the proportions in survey responses is very close to that of the BRFSS reports for the district.

Looking at the survey respondents (crosstabs, BMI by demographic characteristic).

- BMI decreases as education level increases (a mean of 32.23 for those with less than a HS diploma to 29.07 for those with a college degree).
- BMI decreases as income increases.
- BMI is not significantly related to age category. The highest average BMI is for those 45-54 (30.44) and the lowest is for those 24 and under (27.39).

19. How serious are the following health issues in your Community?

This question included *Overweight and obesity* among 16 health issues ranked on a scale of 1 (Not Serious) to 7 (Extremely Serious). Treating '4' as a neutral response, leaves one in four (25%) saying it is *Not Serious* and half (55%) of respondents saying it is *Serious* (ranking it 5 or above). One in six (15.9%) see it as *Extremely Serious.*

Table 81: Overweight and Obesity: Perceived Seriousness as a Health Issue

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not Serious At All - 1	78	5.3%	5.8%	5.8%
	2	99	6.7%	7.3%	13.1%
	3	164	11.1%	12.2%	25.3%
	4	261	17.6%	19.4%	44.7%
	5	288	19.5%	21.4%	66.0%
	6	244	16.5%	18.1%	84.1%
	Extremely Serious - 7	214	14.5%	15.9%	100.0%
	Total	1348	91.1%	100.0%	
Missing	System	132	8.9%		
Total		1480	100.0%		

An analysis of the mean scores (for Weight as a health issue) by select demographic variables shows that their view of how serious Weight is as a health issue:

- Increases with age, especially for those 45-64, after which the rating drops some.

- Increases as income increases.
- Increases as level of education increases.
- And it even varies (consistently) by county, ranked highest (of the four counties) in Madison, followed by Stanton, Cuming, and then Burt.

Its ranking, however, is not significantly associated with levels of BMI, either when viewed as four categories or six. It is viewed as most serious to those who are at a Healthy Weight, followed by those who are Obese, Overweight, and finally Underweight.

Current Weight Loss Attempts

34. Do you believe that you need to ...? (Lose weight, Stay at same weight, Gain weight, N/A – Pregnant)

Reading the table below shows that three of four (78.7%) would like to lose weight. By BMI category, that includes

- 47.4% of those at a Healthy Weight
- 86.3% of those Overweight
- 97.5% of those Obese.
- 60% of those who were Underweight wanted to stay the same, and 33% wanted to gain weight.

Of those who were told they weight presented a health problem, 98.7% said they would like to lose weight.

Table 82: Weight Goals, Do you believe that you need to..?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Lose weight	1048	70.8%	78.7%	78.7%
	Stay at same weight	225	15.2%	16.9%	95.6%
	Gain weight	26	1.8%	2.0%	97.6%
	N/A – Pregnant	32	2.2%	2.4%	100.0%
	Total	1331	89.9%	100.0%	
Missing	System	149	10.1%		
Total		1480	100.0%		

Table 83: Percent of Adults Obese (BMI>30.0) by Year, 2004 through 2012

Report Area	*2004*	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*	*2011*	*2012*
ELVPHD	24.51%	24.7%	26.36%	27.65%	28.3%	29.37%	29.82%	30.75%	31.55%
Burt	26%	26.22%	27%	28.6%	29.1%	30.9%	31.6%	31.4%	32.7%
Cuming	26.5%	25.75%	27.3%	28.2%	29.2%	29.3%	29.7%	28.6%	28.4%
Madison	23.5%	23.62%	25.5%	26.6%	27.3%	28.5%	29.3%	30.7%	31.9%
Stanton	25.2%	27.08%	28.8%	31.3%	31.3%	32.5%	30.9%	33.6%	33%
Nebraska	24.59%	25.59%	27.07%	27.87%	28.38%	28.92%	29.13%	28.99%	29.37%
United States	23.07%	23.79%	24.82%	25.64%	26.36%	27.35%	27.29%	27.19%	27.14%

HP2020 Goals and Weight

With respect to the Healthy People targets, the percent of obese and healthy weight may present considerable opportunities for improvement. The 2020 goal for a **healthy weight** is 33.9% from a baseline of 30.8%. **The current healthy weight for ELVPHD** is 34.5%, exceeding the target.

The revised goal (NWS-9) related to **obesity** is a target of 30.5%. From the 2014 BRFSS data, the HD is at 31.0% (CI 27.8%-34.5%), so that target is within the range of the confidence interval for the Health District.

With respect to the goals and demographic subgroups, however, it seems appropriate to recommend that the focus of activities be Males.

Radon

Question 93 asked about testing homes for radon levels.

In both years one in ten (10.5%; 2013, 10.4%) *do not know* if their house has been tested for radon. One in four (28%) have and two thirds (62%) have not. The adjacent chart (Figure 51) shows the variation in testing by county and by year.

Figure 51: Radon Testing

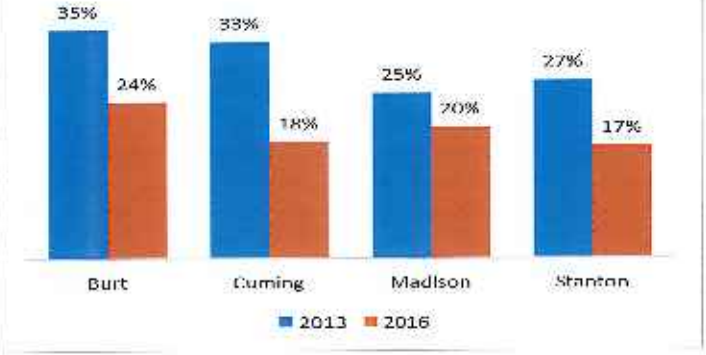


Table 113: Radon testing within the last two years, by County (Cross tabulation)

	In which county do you live?					Total
	Other (please specify)	Burt	Cuming	Madison	Stanton	
Yes	18.9%	23.6%	17.6%	19.8%	16.9%	19.2%
No	75.4%	66.3%	73.0%	68.4%	71.8%	70.3%
I don't know	5.7%	10.1%	9.4%	11.8%	11.3%	10.5%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Vehicle Safety

Motor vehicle crashes are a leading cause of injury and death; at the same time there are (according to the CDC) many proven prevention strategies. Components include use of seat belts, child and adult safety, and behaviors that impair judgement while driving.

Automobile Safety: Distracted Driving and Seat Belts

Seat Belts

The seat belt question used compressed categories; 91% of respondents *often/always* use a seat belt. The response is essentially the same as 2013, and because the *values* in the question are different, a direct comparison with the BRFSS report is not possible.

The Nebraska BRFSS question asks only if respondents *always* wear a seat belt, and the percent for the Health District is 62.6% overall, not different from the statewide proportion (72% in 2014). From the table below (based on BRFSS data), seat belt usage is higher among female respondents, and it increases, whether throughout the state or in the Health District, by age and education.

Table 126: Seat Belt Use

		Frequency	Percent	2016 Valid Percent	2013 Valid Percent
Valid	Rarely or never	16	1.1%	1.2%	1.8%
	Sometimes	86	5.8%	6.7%	7.4%
	Often or always	1180	79.7%	92.0%	90.6%
	I don't ride in a car	1	.1%	.1%	.2%
	Total	1283	86.7%	100.0%	100.0%
Missing	System	197	13.3%		
Total		1480	100.0%		

Distracted Driving: Behaviors related to driving confirm the prevalence of distracted drivers on the roadways. Talking on the cell phone is common for four of five (83%) respondents, as is riding with someone who is talking on the phone (86%). BRFSS data put the HD at 67%, which then decreases as age increases and increases with income.

The next most common practice listed in the 2016 Survey is eating/drinking while driving (86%) or riding with someone who is eating/drinking (82%). Most of the responses proportions are parallel to those from 2013, except for texting.

According to BRFSS data, one in four drivers (24%) has texted while driving (past 30 days, 2012). The 2016 response was greater at 33%, up from 27% in 2013. Riding with a driver who texted increased from 27% to 41% in 2016. The context, relevant demographic variables, from the BRFSS is that texting is inversely related to age, and it corresponds to education, both of which are biases of the 2016 Survey where respondents tend to be younger and better educated.

Table 127: BRFSS Data for Vehicle Safety

	Always wear a seatbelt when driving or riding in a car^	Texted while driving in past 30 days	Talked on a cell phone while driving in past 30 days	Alcohol impaired driving in past 30 days
Overall	62.6%	23.5%	66.8%	4.5%
Male	52.8%	27.8%	72.2%	6.8%
Female	72.2%	19.4%	61.6%	2.3%
	Female Higher			
18-44	56.4%	46.3%	88.7%	6.4%
45-64	65.4%	15.2%	68.2%	4.8%
65+	69.9%	0.8%	30.0%	0.8%
<$25,000	63.8%	23.1%	59.5%	2.6%
$25,000-49,999	56.0%	25.6%	75.4%	4.5%
$50,000+	64.2%	25.3%	81.8%	5.7%
Less than High School	71.2%	-*	-*	0.4%
High School/GED	55.7%	23.4%	75.6%	4.4%
Some College	61.1%	31.8%	71.7%	7.2%
College Graduate	66.9%	42.5%	88.3%	2.9%

Table 128: In the past month, have you driven a vehicle while doing the following:

		Responses		2016Percent of Cases	2013 Percent of Cases
		N	Percent		
Drive w/Distracted2[a]	Talked on Cell Phone	901	38.8%	83.4%	82.9%
	Texted	361	15.5%	33.4%	27.1%
	Read	75	3.2%	6.9%	2.9%
	Put on Make Up / Fix Hair	58	2.5%	5.4%	2.9%
	Eat / Drink	927	39.9%	85.8%	79.9%
Total		2322	100.0%	215.0%	195.8%

a. Dichotomy group tabulated at value 1.

Table 129: In the past month, have you ridden in a vehicle where the driver has done the following? (Please check all that apply)

	Responses		2016 Percent of Cases	2013 Percent of Cases
	N	Percent		
[a] Talked on Cell Phone	878	39.4%	85.9%	82.9%
Texted	415	18.6%	40.6%	27.1%
Read	64	2.9%	6.3%	2.9%
Put on Make Up/ Fix Hair	37	1.7%	3.6%	2.9%
Eat / Drink	835	37.5%	81.7%	79.9%
Total	2229	100.0%	218.1%	195.8%

Drinking and Driving

Over the past three BRFSS reports the proportion who admit to DUI seems to have decreased (2010, 6.3%; 2012, 5.6%; 2014, 3.4%). However (based on the confidence intervals), the differences year to year are not significant, nor are they significantly different from that statewide. In 2014, the proportions were significantly higher for males (BRFSS Table), and they decrease with age and increase with income.

The question from the 2016 Survey asked if respondents were driving after 2 drinks (past 30 days). About one in ten (8.9%; 2013), said Yes and 16.5% (2013, 9.9%) said they had been riding in a vehicle where the driver had more than two drinks.

Youth: Ride w/a drinking driver. On Drinking and Driving, three reports for the HD show decreased reported drinking and driving (2010, 12%; 2012, 9.9%; 2014, 8.1%).

Youth Vehicle Behavior Charts

Figure 53 below, from a previous report for the HD, show the trends consistently improving of youth alcohol behaviors. These are based on data in the NSP/DOT data publications.

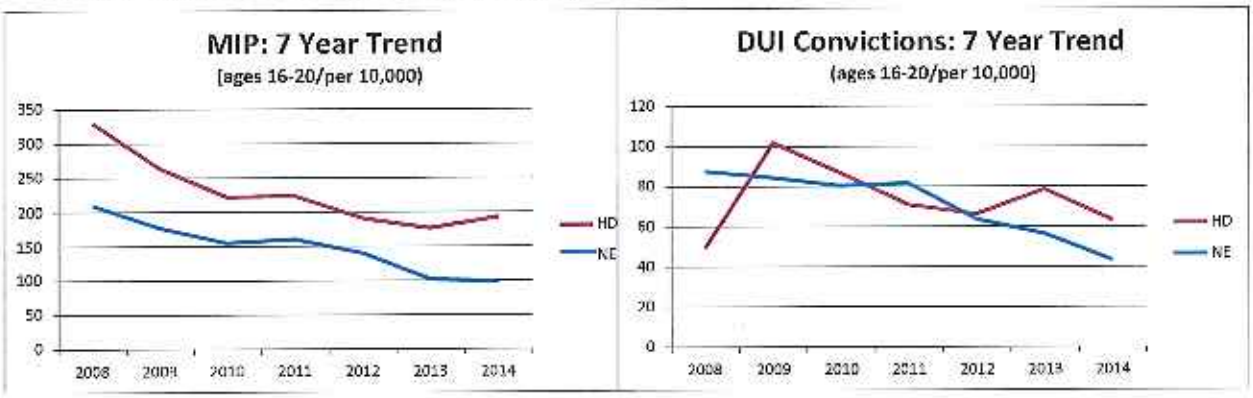


Figure 53: Alcohol and Driving Figures, MIP and DUI Rates 2008-2014 (Ages 16-20)

Automotive Safety: Child Seats and Seatbelts

In response to Question 118, 60.5% said they do transport children in household vehicles. The Yes response served as a filter for subsequent questions, so that after the initial filtering question/skip logic, many of the questions were qualified additional factors (age, weight, height). For the purposes here statements were developed to exclude cases (I don't have children under 4 years," for example), so that the proportions represent only those cases qualified to answer a question.

More examples of qualifying statements:

- I do not have a child under the age of 3.
- There are no infants/toddlers (through the age of 2) in my household.
- There are no school-aged children in my home.
- There are no school-aged children with a height of 4 ft. 9 inches.
- There is no child/ren ages 13 and older.

Table 130: Children and Vehicle Safety

	Yes	No	I don't know
118. Do you transport children in your vehicles? (N = 1,282)	60.5%	39.5%	
119. If you have a child under the age of 3, have you had a certified technician check the car seat in the past year? (N = 263)	40.7%	56.3%	3.0%
124. Do you have a fire extinguisher in your vehicle? (N = 1,480)	3.5%	95.1%	1.4%

Children and Restraints

	Rarely or never	Sometimes	Often	Always
120. When riding in a vehicle, my infants/toddlers use an infant carrier or convertible car seat in the rear-facing position until they reached the highest weight or height allowed by the car seat's manufacturer? (N = 251)	3.2%	3.6%	5.2%	88.0%
121. When riding in a vehicle, do your preschool-aged children (age 3 and up) that have outgrown the rear-facing weight and height limit for a convertible car seat use a car seat with a harness in the forward-facing position for as long as possible. (N = 428)	4.2%	4.9%	6.3%	84.6%
122. When riding in a vehicle, do your school-aged children use a booster seat until reaching a height of 4 ft. 9 in.? (N = 377)	10.3%	7.2%	8.8%	73.7%
123. When riding in a vehicle, how often do your child/ren ages 13 and above use a seat belt? (N = 421)	0.5%	3.3%	6.4%	89.8%

ATVs and Safety

125. Do you have an ATV (quad, quad bike, three-wheeler, four-wheeler, quadricycle)?	19.4%
126. If yes, do you use a helmet? (N = 245)	27.8%
127. Do you supervise riders that are under 16 years of age? (N = 151)	91.4%
128. Have drivers under the age of 16 completed an ATV Safety class? (N = 130)	11.5%

Concerns and Services Needed

The community survey included two open ended questions about health concerns in the community and services needed at the hospital.

In open ended items the first challenge is to sort responses into topics, which requires adding variables and codes. It is a subjective process. A second challenge is that these two questions allowed for multiple response, and for that multiple variables were added to the file. If a respondent entered three topics, for example, additional variables were added so that their responses could be preserved.

The tables, once assembled, were reviewed in the context of the 2013 Survey. While many topics are still on the agenda, many new ones have been added.

Non-response. For these questions, there was considerable non-response. It took two forms, blank spaces and the word "None." These are noted, but they were removed from the tables.

Health Concerns

Regarding health care concerns in the area, 34.4% left the items blank and 41.6% wrote in *none* or some variant. In all, 76% did not respond or had no concerns; 24% did.

Table 148: Health Care Concerns in the Area

	166. What concerns you most about health care in your area? (If you have no concerns enter none.)	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Access	25	2.6%	5.6%	5.6%
	Behavioral	11	1.2%	2.5%	8.1%
	Billing Practices	6	0.6%	1.3%	9.4%
	Cancer	4	0.4%	0.9%	10.3%
	Cost	125	13.1%	28.0%	38.3%
	Coverage	28	2.9%	6.3%	44.5%
	Distance	1	0.1%	0.2%	44.7%
	Endocrinology	2	0.2%	0.4%	45.2%
	Health Information	3	0.3%	0.7%	45.9%
	Hospital Administration	13	1.4%	2.9%	48.8%
	Limited Medical Resources	28	2.9%	6.3%	55.0%
	MD Shortage	23	2.4%	5.1%	60.2%
	Medicaid	5	0.5%	1.1%	61.3%
	Mental Health Services	29	3.0%	6.5%	67.8%
	Neurologist	1	0.1%	0.2%	68.0%
	Pediatrician	7	0.7%	1.6%	69.6%
	Pharmacy	12	1.3%	2.7%	72.3%
	Quality Care	9	0.9%	2.0%	74.3%
	Quality Medical Staff	69	7.2%	15.4%	89.7%
	Quality of Medical Services	18	1.9%	4.0%	93.7%
	Substance Abuse	3	0.3%	0.7%	94.4%
	Turnover	15	1.6%	3.4%	97.8%
	Miscellaneous	10	1.0%	2.2%	100.0%
	Total	447	46.8%	100.0%	
Missing	System	509	53.2%		
Total		956	100.0		

Table 149: Health Care Concerns in the Area (By County)

		Other		Burt		Cuming		Madison		Stanton	
		N	%	N	%	N	%	N	%	N	%
*	Access	3	6.8%	3	8.6%	9	10.1%	6	2.6%	3	6.5%
	Behavioral			1	2.9%			8	3.4%	2	4.3%
	Billing Practices	1	2.3%					4	1.7%	1	2.2%
	Cancer							4	1.7%		
*	Cost	13	29.5%	6	17.1%	33	37.1%	62	26.6%	11	23.9%
*	Coverage	5	11.4%	1	2.9%	9	10.1%			3	6.5%
	Distance					1	1.1%				
	Endocrinology							12	5.2%		
	Health Information							3	1.3%		
	Hospital Administration	1	2.3%					11	4.7%	3	6.5%
	Limited Medical Resources	3	6.8%	4	11.4%	3	3.4%	14	6.0%	4	8.7%
	MD Shortage	3	6.8%	1	2.9%	2	2.2%	14	6.0%	3	6.5%
	Medicaid	1	2.3%					4	1.7%		
*	Mental Health Services					7	7.9%	20	8.6%	2	4.3%
	Miscellaneous					2	2.2%	8	3.4%		
	Neurologist							1	0.4%		
	Pediatrician	2	4.5%					3	1.3%	2	4.3%
	Pharmacy			5	14.3%	6	6.7%			1	2.2%
*	Quality Care	2	4.5%			3	3.4%	5	2.1%		
	Quality Medical Staff	6	13.6%	9	25.7%	10	11.2%	35	15.0%	8	17.4%
	Quality of Medical Services	1	2.3%	4	11.4%	4	4.5%	8	3.4%	2	4.3%
	Substance Abuse							3	1.3%		
	Turnover	3	6.8%	1	2.9%			8	3.4%	1	2.2%
		44		35		89		233		46	

Access. Comments touched on the need for a wide range of practitioners, from dentists, pediatricians, retaining doctors, plus many more.

Verbatim (Examples):

- Limited access to health care services....
- Getting to see doctor on a day that works out for me. Getting prescriptions refilled in a timely manner. Picking up prescriptions when pharmacy is open/doesn't screw them up.
- the distance I have to go to get decent care that is in my PPO
- Would like after hours or extended clinic hours in West Point.
- Should be open in evening to help working class
- Sometimes, the doctors have no openings and will not work you in.
- Lack of availability

Behavioral Health. Comments related to behaviors and conditions, for example:

- Overweight and nutrition
- Increasing prevalence of conditions that can be affected by lifestyle changes
- Smokers, obesity
- Obesity in children and families because of poor eating habits and lack ofexercise

- Obesity, mental health, no healthcare services used, life-style choices that lead to healthcare issues

Costs. Generally mentioned was cost of care, but some talked about how to pay when expenses are high. Cost and Insurance were mentioned frequently.

Health Issues. Reflected on the major issues mentioned elsewhere in the survey, such as obesity and cancer.

Mental Health. Throughout #166 and #167 respondents expressed the need for mental health services and practitioners. Some of the responses include:

- Need closer children's psychiatric unit and support groups and parenting classes.
- Mental health services availability
- Lack of Ph.D./MD mental health practitioners
- We need to continue to extend the Mental Health Services
- Lack of knowledge in military culture Behavioral Health Providers shortage
- Psych coverage is minimal
- Mental health for the geriatric population
- An overburdened mental system and more pediatric care
- Mental health...a lot of people come to ER for mental health issues
- Lack of mental health providers

Health Services

There was, again, overlap in responses between Questions 166 and 167, and it appears that much of what respondents wanted to say about health, whether concerns or services appeared there.

167. Are there any services that are not currently offered at your hospital that you would like to see added? (If there are no services you would like to see added, enter none.)

Overall, 35.9% did not respond, 51.6% entered *'None'*, a total of 81% non-response.

Table 150: Are there any services that are not currently offered at your hospital that you would like to see added?

		Frequency	Valid Percent
Valid	Access	1	0.6%
	Alternative Medicine	2	1.1%
	Behavioral Health	2	1.1%
	Billings	1	0.6%
	Birth Services	5	2.8%
	Clinics	2	1.1%
	Daycare	3	1.7%
	Don't Know	13	7.3%
	Health Information	3	1.7%
	Facilities	2	1.1%
	Hospital Administration	2	1.1%

Table 149 Continued..

		Frequency	Valid Percent
	MD Shortage	5	2.8%
	Mental Health	15	8.4%
	Numerous	4	2.2%
	OBGYN	7	3.9%
	Pharmacy	2	1.1%
	Specialists	89	49.7%
	Support Groups	3	1.7%
	Wellness	5	2.8%
	Miscellaneous	13	7.3%
	Total	179	100.00%
Total		1480	

Table 151: Are there any services that are not currently offered at your hospital that you would like to see added? Those responding "None" by county

By county with the None response in percent:			
County	**% Blank**	**% None**	**%Total**
Other	27%	60.7%	87.7%
Burt	20.2%	69.7%	89.9%
Cuming	24%	64.9%	88.9%
Madison	19.8%	62.4%	82.2%
Stanton	25%	59.7%	84.7%

Table 152: Are there any services not currently offered at your hospital that you would like to see added? By County

	Other		Burt		Cuming		Madison		Stanton	
	N	%	N	%	N	%	N	%	N	%
Access					1	3.3%			1	5.3%
Alternative Medicine							2	2.0%	1	5.3%
Behavioral Health							2	2.0%		
Billings										
Birth Services			1	12.5%			3	3.1%		
Clinics			1	12.5%	1	3.3%				
Daycare					1	3.3%	2	2.0%	1	5.3%
Health Information					1	3.3%	3	3.1%		
Facilities					1	3.3%	1	1.0%	1	5.3%
Hospital Administration	1	9.1%					1	1.0%		
MD Shortage							4	4.1%		
Mental Health	3	27.3%					10	10.2%	2	10.5%
Numerous	2	18.2%					2	2.0%		
OBGYN					4	13.3%	1	1.0%		
Pharmacy					1	3.3%	1	1.0%		
Specialists	5	45.5%	6	75.0%	15	50.0%	52	53.1%	11	57.9%
Support Groups							2	2.0%	1	5.3%
Wellness					2	6.7%	2	2.0%	1	5.3%
Miscellaneous					3	10.0%	10	10.2%		
	11		8		30		98		19	

APPENDIX III

Organizations that participated in the CHIP meeting, community focus group meetings and strategic planning sessions are listed below. These entities had one or more participants in the process.

- Area Agency on Aging
- AseraCare
- Baker Counseling
- Bridge Crisis Center
- Burt County Board of Supervisors
- Central Nebraska Community Action Partnership, Inc.
- College of Public Health
- Congressman Jeff Fortenberry District Rep
- Cuming County Board of Supervisors
- Cuming County Juvenile Diversion
- Department of Health and Human Services
- Dinklage Medical Clinic
- Director of Emergency Services
- District 7 Probation
- Extension Educator- Madison County
- Faith Regional Health Services
- Franciscan Care Services
- Goldenrod Regional Housing Agency
- Home Instead Senior Care
- Ionia Research
- Johnson Rehabilitation & Sports Performance
- Land O'Frost
- Legal Aid of Nebraska
- Liberty Centre
- Madison Public Schools
- Memorial Community Hospital and Health System
- Midtown Health Center
- Mt. Olive Lutheran Church
- Nebraska Children Home/Right turn
- Nebraska State Senator, District 16
- Norfolk Community Health Care Clinic
- Norfolk Family Coalition
- Norfolk Police Division
- Norfolk Public Schools
- North Central District Health Department
- Northeast Community College
- Northeast Nebraska Area Agency on Aging
- Northeast Nebraska Behavioral Health Network
- Northeast Nebraska Community Action Partnership
- Northern Nebraska Behavioral Health Network
- Northern Early Learning Connection
- Oakland Heights
- Oakland Mercy Hospital
- Oakland-Craig Schools
- Oasis Counseling International
- One2One Patient Connect
- Ponca Tribe of Nebraska
- Region 4
- Saint Francis Memorial Hospital
- Saint Francis Home Health & Hospice
- Stanton Health Center
- UNL Extension
- West Point Chamber of Commerce
- West Point Living Center
- West Point Public Schools
- Wisner Care Center
- Women's Empowering Lifeline

Acronym Key

APPENDIX VI

AHEC	Area Health Education Center – Norfolk, NE
BOH	Board of Health – Elkhorn Logan Valley Public Health Department
BRFSS	Behavior Risk Factor Surveillance System
CHA	Community Health Assessment
CHNA	Community Health Needs Assessment
CDC	U.S. Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CHIP	Community Health Improvement Plan
DOT	Department of Transportation
DPP	Diabetes Prevention Program
DHHS	Department of Health and Human Services – Lincoln, NE
EAP	Employee Assistance Program
ELVPHD	Elkhorn Logan Valley Public Health Department
ER	Emergency Room
FOBT	Fecal Occult Blood Test kit
FRHS	Faith Regional Health Services – Norfolk, NE
HP2020	Healthy People 2020
HRSA	Health Resources and Services Administration
IARC	International Agency for Research on Cancer
LMHP	Licensed Mental Health Practitioner
LPHS	Local Public Health System
MAPP	Mobilizing for Action through Planning and Partnerships
MHC	Midtown Health Center, Inc.
MIHA	Maternal and Infant Health Assessment
NACCHO	National Association of City and County Health Officials
NAP-SAAC	Nutrition and Physical Activity Self-Assessment for Child-Care training
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCHS	National Center for Health Statistics
NCIRD	National Center for Immunization and Respiratory Diseases
NENCAP	Northeast Nebraska Community Action Partnership – Pender, NE
NHIS	National Health Interview Survey
NIS	National Immunization Survey
NPCR	National Program of Cancer Registries
NREPP	National Registry of Evidence-Based Programs and Practices
NSDUH	National Survey on Drug Use and Health
NSP	Nebraska State Patrol
NCIRD	National Center for Immunization and Respiratory Diseases
NENCAP	Northeast Nebraska Community Action Partnership – Pender, NE
NHIS	National Health Interview Survey
OMH	Oakland Mercy Hospital – Oakland, NE
PHAB	Public Health Accreditation Board
PPACA	Patient Protection and Affordable Care Act
PHAN	Public Health Association of Nebraska
PATCH	Planned Approach To Community Health, Inc. – Norfolk, NE
OMH	Oakland Mercy Hospital – Oakland, NE
PRAMS	Pregnancy Risk Assessment Monitoring System
SAMHSA	Substance Abuse and Mental Health Services Administration
SEER	Surveillance, Epidemiology, and End Results Program
SFMH	St. Francis Memorial Hospital – West Point, NE
SHRM	Society for Human Resource Management
SNAP	Supplemental Nutrition Assistance Program
STD	Sexually Transmitted Disease
TBD	To be determined
UNMC	University of Nebraska Medical Center
USDA	U.S. Department of Agriculture
WIC	Women, Infants, and Children Nutritional Program
YRBS	Youth Risk Behavior Survey