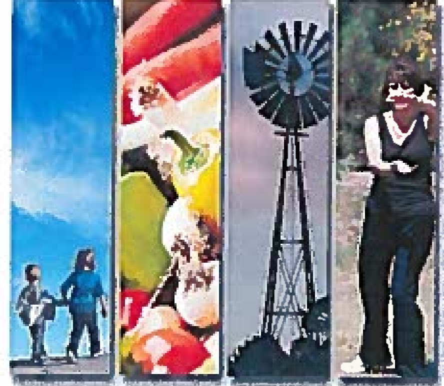

Chadron Community Hospital

2014-2016

Community Health Needs Assessment and Health Improvement Plan

CHADRON COMMUNITY HOSPITAL & HEALTH SERVICES

Big Enough to Serve, Small Enough to Care

Panhandle Public Health District

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CHADRON COMMUNITY HOSPITAL & HEALTH SERVICES

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January 1, 2015

Letter from the CEO

Chadron Community Hospital & Health Services is committed to serving the community and enhancing the quality of life for individuals, families and communities we serve. Our goal with the attached community health needs assessment is to better understand the range of issues affecting our health. We look forward to working with you and our community partners to optimize health and continue to meet our mission which is *"To provide and support health care and community service programs of excellence in the communities we serve."*

The significance of better understanding our community's needs was highlighted with the Patient Protection and Affordable Care Act requirements passed in March 2010. New requirements for tax-exempt hospitals include that we regularly conduct a community health needs assessment to adopt implementation strategies to address applicable needs detected during the assessment process.

The Rural Nebraska Healthcare Network worked together with the Panhandle Public Health District and Scotts Bluff County Health Department to complete the Mobilizing for Action through Planning and Partnership for each of the Nebraska Panhandle hospital service areas during 2014. The results are summarized in the attached report and align with the priorities in the regional Panhandle Community Health Improvement Plan 2012-2017.

A special thank you to the community members who took the time to attend a focus group, listen to presentations on the process, or participated in the stakeholder meeting. It is our desire that the community be healthy today and even healthier tomorrow.

Harold L. Krueger, Jr.
Chief Executive Officer

About Chadron Community Hospital & Health Services (CCH&HS)

Chadron Community Hospital and Health Services is a Critical Access Hospital with 25-beds for all patient types – acute, observation, intensive care and OB, with a staff of over 180 employees providing a variety of services, including:

- 24/7 Emergency Department
- Laboratory
- Medical Imaging (X-ray , CT ,MRI, Nuclear Medicine, Mammography, Ultrasound, Imaging, Bone Density/DEXA Scan)
- Diabetic Education
- Dialysis
- Obstetrics
- Oncology
- Rehabilitation (including Cardiac-Pulmonary Rehab, Occupational Therapy, Physical therapy, Sports Rehab, and Speech Therapy)
- Respiratory Therapy
- Wound Care
- Respite Care
- Swing Bed
- Behavioral Health

CCH &HS offer a variety of outpatient services through its Multi-Specialty Clinic. Current specialties offered include: Cardiology; ENT; General Surgery; Gynecology; Oncology; Ophthalmology; Oral Surgery; Behavioral Health and Pulmonology.

The organization additionally operates Legend Buttes Health Services a Rural Health Clinic in Crawford, NE and Prairie Pines Lodge which provides independent and assisted living apartments for the elderly.

CCH &HS is the recipient of a variety of contracts to provide health and human service programming provided by the Western Community Health Resources department which includes: WIC (Women Infant and Children), Family Reproductive Health Services, HIV Testing and Counseling, Immunization, Ryan White Part C, Early Development Network and others. These services are provided primarily throughout the northern Nebraska Panhandle area.

Mobilizing for Action through Planning and Partnerships (MAPP)

Chadron Community Hospital participated with other hospitals in the Rural Nebraska Healthcare Network (RNHN) in a joint planning process facilitated by Panhandle Public Health District. Mobilizing for Action through Planning and Partnerships (MAPP) is a partnership-based framework to conduct a community health needs assessment and develop a community health improvement plan. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation.

MAPP consists of four assessments:

1. Community Themes and Strengths Assessment: focus groups addressing the community concerns about what is important, how quality of life is perceived, and the assets that exist that can be used to improve community health
2. Local Public Health System Assessment: identifies the components, activities, competencies, and capacities of the public health system and how the essential services are being provided
3. Forces of Change Assessment: identifies what is occurring, or might occur, that affects the health of the community; the opportunities and threats factors that are currently at play
4. Community Health Status Assessment: identifies priority community health and quality of life issues; economic data provided by Panhandle Area Development District and health data provided by Panhandle Public Health District

MAPP was used in 2011 to conduct the Regional Community Health Assessment and the priorities chosen for the 2012-2017 Regional Community Health Improvement Plan are:

- Healthy Living: Healthy Eating, Active Living, Breastfeeding
- Mental and Emotional Well Being
- Cancer Prevention: Primary Prevention, Early Detection
- Injury and Violence Prevention

The hospitals in the RNHN and PPHD partnered to complete the MAPP process again in 2014 and will continue to do so every three years. These participants make up the MAPP Steering Committee. The Steering Committee will be charged with reviewing data and progress on the chosen priorities, using quality improvement to modify implementation plans as needed, and sharing results with stakeholders.

Prioritization Process

In April 2014, the hospitals came together in an initial meeting to discuss the MAPP framework and review current data. The group reviewed the elements of the 2011 CHA and 2012 CHIP. As part of the work with the hospitals, all affirmed the regional priorities, and acknowledged that their own chosen priorities will impact the regional priorities. Participants also completed the *Forces of Change Assessment*. The resulting work product is available in Appendix A.

CCH hosted focus groups for residents of the service area in June and July 2014 as part of the *Community Themes and Strengths Assessment*. These focus groups were targeted at the community at-large, and also to address the youth and Native American communities served by the hospital. The focus groups centered on community themes and strengths, including how participants view the community, the health and service needs of the community, and how residents receive health care information. A summary of the Focus Group notes is available in Appendix B.

A stakeholder meeting was held in August to reaffirm the vision for Dawes County. Members of the Dawes County Joint Planning group have been meeting since 2011 to work on a unified vision for the community. Participants included representatives from the hospital, public school system, media, Veteran's Office, USDA Forest Service, Chadron State College, UNL Extension, Dawes County, economic development, local businesses, non-profit and service organizations, and the City of Chadron. Over the course of the meeting, as part of the *Community Health Status* Assessment, participants were presented with health data relevant to the Panhandle, socioeconomic data specific to Dawes County, leading causes of death for the Panhandle compared to the State of Nebraska, the impact of Adverse Childhood Experiences (ACE), and Child Well Being Data. Presenters also gave an outline of the MAPP process, and the current priority areas of the Panhandle Community Health Improvement Plan. The resulting work product is available in Appendix C.

Participants were then led through a consensus workshop to reaffirm the elements of their original vision based on the focus question "What do we see in place in 3-5 years as a result of our actions?" The elements of the vision include:

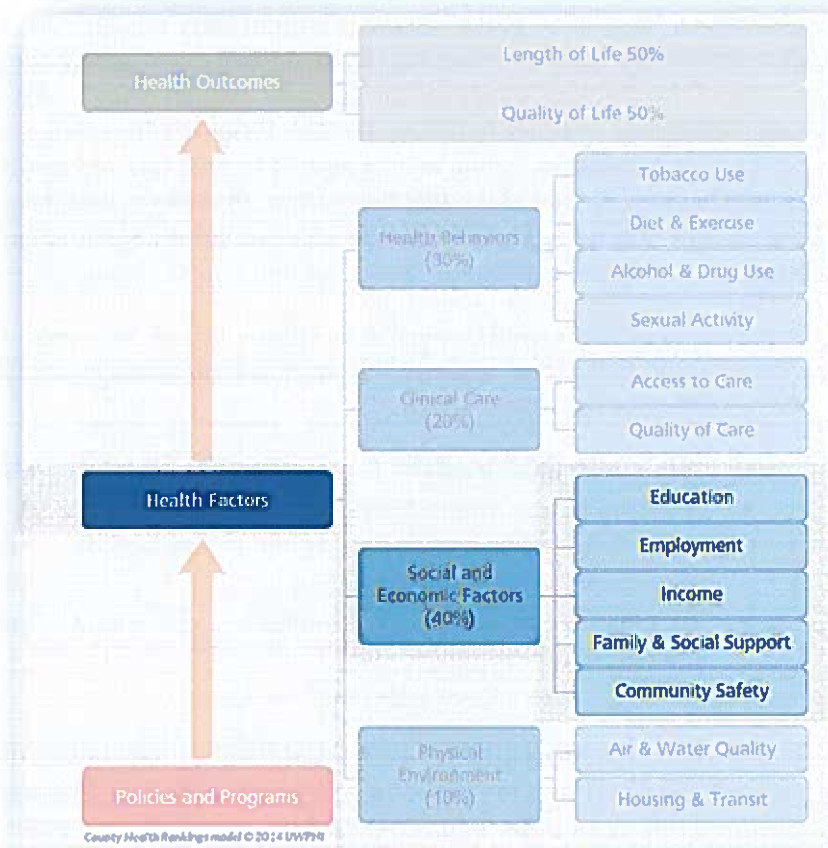
- Community Beautification
- Efficient Physical Connections
- Active Outdoor Living
- Year Round Tourism Destination
- Thriving, Diverse Business Recruitment and Retention
- Enhanced Involved Community
- A Culture of Wellness
- Advanced Technology and Infrastructure
- Improved Agricultural Opportunities

The results of the focus groups, stakeholder meeting, and health data was presented to a smaller committee of CCH staff in October and November 2014 to determine priority areas. Participants reviewed the socioeconomic and health data presented during the stakeholder meetings. Based on the information presented, the participants scored the data based on the availability of data, the percentage of the population affected, the resources available to the hospital and within the community to address the issue, and the seriousness of the issue. The priority areas identified are:

- Healthy Lifestyle
    - Healthy Diet
    - Physical Activity
    - Breastfeeding
    - Cancer Prevention
- Mental & Emotional Well-Being
- Injury & Violence Prevention.

Social and Economic Data

Overview



Social and Economic Factors in Population Health

Some of the biggest predictors of health in an individual's life come from social and economic factors. This section addresses what social and economic factors of health such as education, income, and social support look like in the Nebraska Panhandle and what the data indicate about the health of Panhandle citizens.

Key Trends and Patterns

Population Consolidation
One prevalent on going trend in the county is population consolidation from rural areas to larger communities, mainly Chadron. This means that a majority of economic growth and development will likely occur in the areas around Chadron or Crawford and outmigration of local young people to larger metropolitan areas may continue.

Aging Baby Boomers
The baby boom generation makes up a large portion of Dawes County's population and its members are beginning to enter retirement and senior citizenship. For the county, this means increasing demand for medical and living assistance services as well as a call to get creative about how to engage young adults in the community.

Relatively high rates of poverty
While rates of poverty vary greatly by location, poverty is generally more prevalent in the Nebraska Panhandle than in other parts of the state, with an overall rate around 15% for the region. Minority populations and single parent households have particularly high rates of poverty. Poverty can have significant health consequences by posing barriers to quality nutrition, health care, education, and living environments among other things.

Low unemployment and some key growing industries
Strong agricultural, self-employed, and government sectors have kept unemployment low in Dawes County. Education and health care are two important and in demand industries that continue to grow jobs and draw people to the county while mining and transportation are important economic drivers in

the Crawford area. Economic development brings opportunities for jobs and increased wealth which supports the financial stability of families.

Economic Disparity by Race
Minority populations have drastically higher rates of poverty and lower incomes than the Non-Hispanic White population. This speaks to certain family, environmental, and social patterns that perpetuate economic and social outcomes among families. To improve the health of the population, the patterns that increase the chances of negative health outcomes must be addressed.

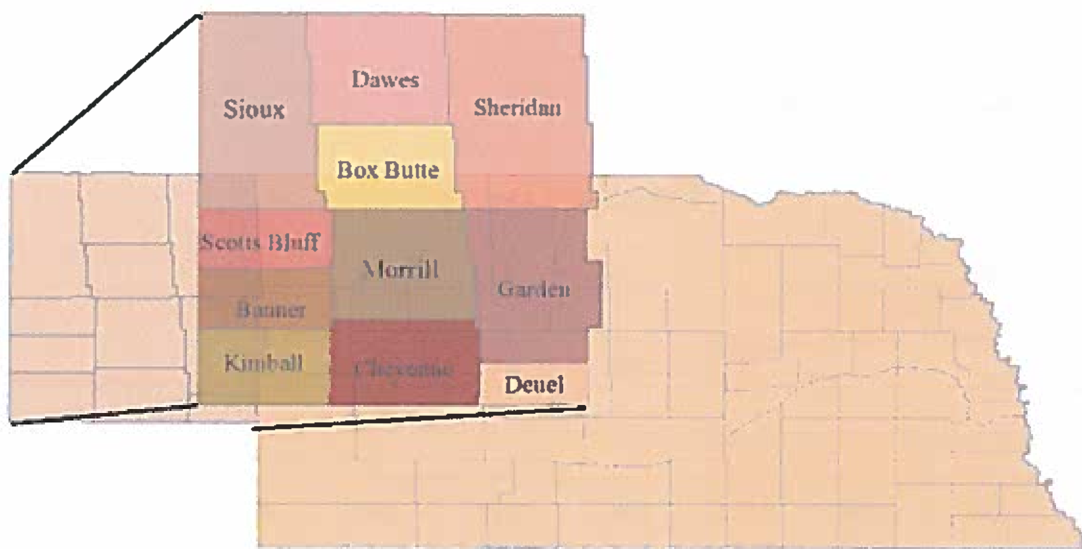
Basics

The Nebraska Panhandle is a rural region on the high plains, surrounded by neighbors of Wyoming to the west, Colorado to the south, and South Dakota to the north. Its agricultural backbone perhaps has insulated it from the most recent economic downturn but has likely also contributed to out-migration as fewer opportunities have been available compared to larger cities for young adults with diverse professional trades. Population consolidation continues, wages remain lower than the state and national averages, and the median age continues to increase as the baby boomers age, birth rate stabilizes, and out-migration of youth continues. The unique bluffs, escarpments, and open space are some of the most treasured assets in the region lay the foundation for tourist and historic attractions.

The Nebraska Panhandle consists of the counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux.

Quick Facts for Dawes County:

Population (2012)	9,176
Population change (2000-2010)	1.3%
Incorporated municipalities	3
Unemployment Rate (July 2014)	4.4%
Total Land Area	1,401 sq. miles



Population

While the population of Dawes County has generally declined throughout the 20th century, the most recent decades and years have shown slight population growth in a time when most Great Plains communities are losing population.

Figure 1: Nebraska population 1930-2010

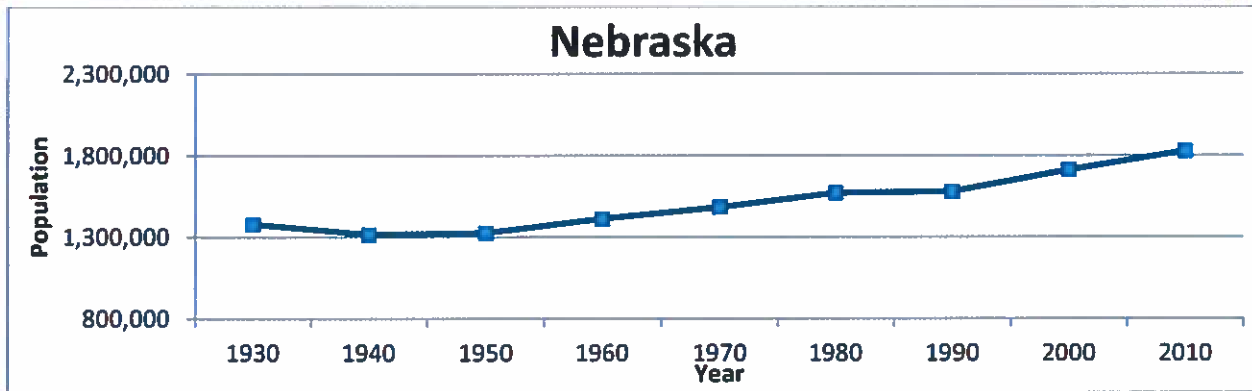


Figure 2: Panhandle population 1930-2010

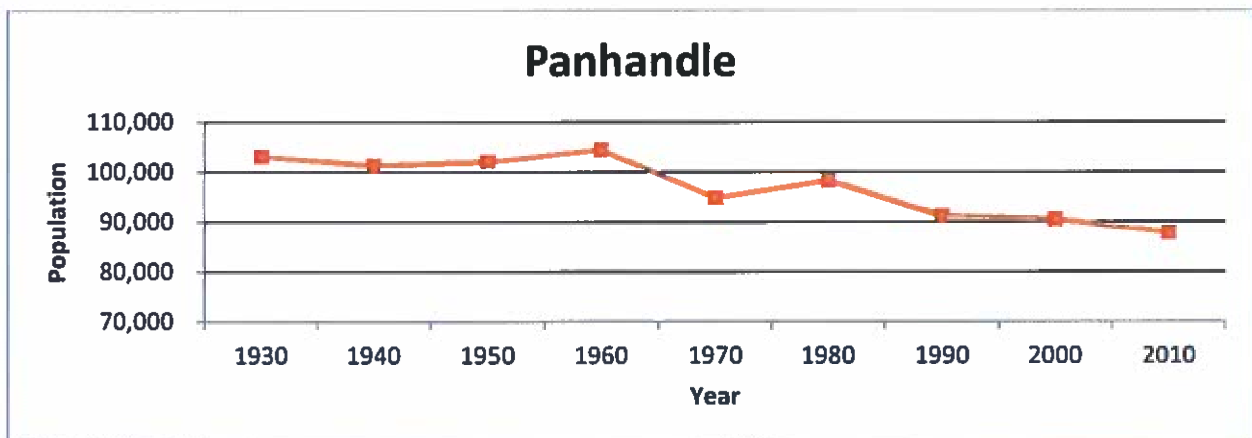


Figure 3: Dawes County population 1930-2010

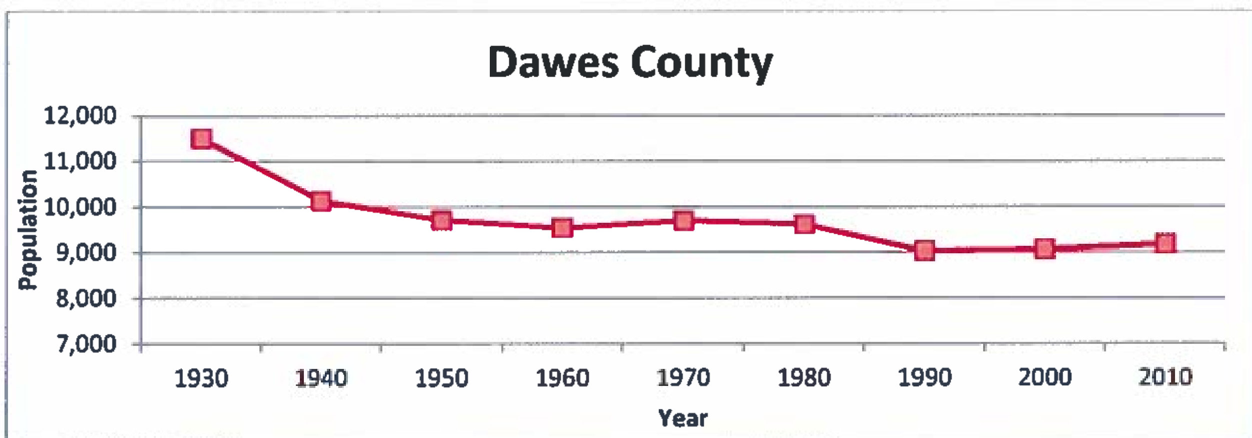


Figure 4: Metropolitan county share of Nebraska population

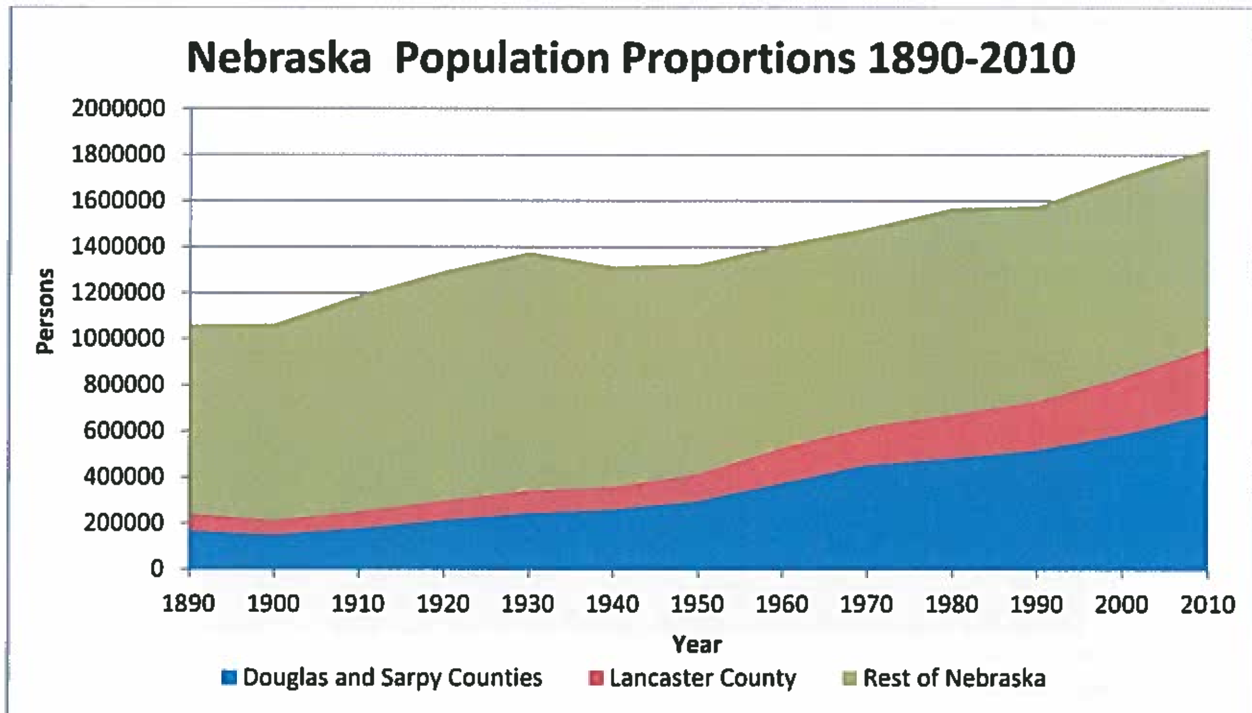


Figure 4 shows how Nebraska's population growth has been concentrated almost entirely in the metropolitan counties of Douglas, Sarpy, and Lancaster in the eastern part of the state. These counties are home to the Omaha metropolitan area and the state capital metropolitan area of Lincoln.

What does a declining population mean for our region?

- Decreased political influence in the state
- Impacted share of resources
- Threat of decreased vitality
- Need to reassess infrastructure needs vs. capacity

Dawes County is well positioned for growth in the age of a knowledge and innovation based economy with the presence of Chadron State College. While some of this growth correlates with the growth of the student population, the biggest gains in population change came from age groups just older than the 18-24 age group. With most of the county being rural, population consolidation will likely continue to be the trend so any population gains would occur in Chadron, though the county's scenic beauty could be a draw for more people in the rural areas of the county as well. Dawes County should continue to build from its assets and strengths, undergoing measured strategies which aim to steadily improve quality of life and opportunities for its citizens. In general, what the region lacks in critical mass of resources and people, it must make up for in creative solutions and the strengthening of partnerships to build a collective impact.

Figure 5: Panhandle population consolidation

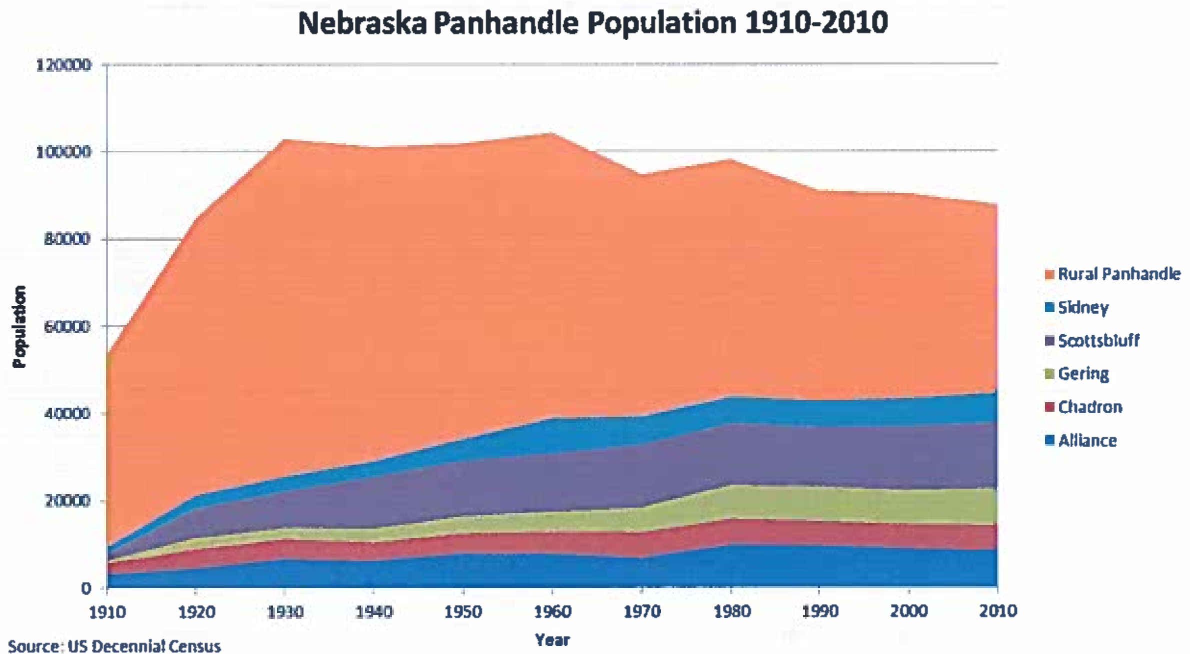
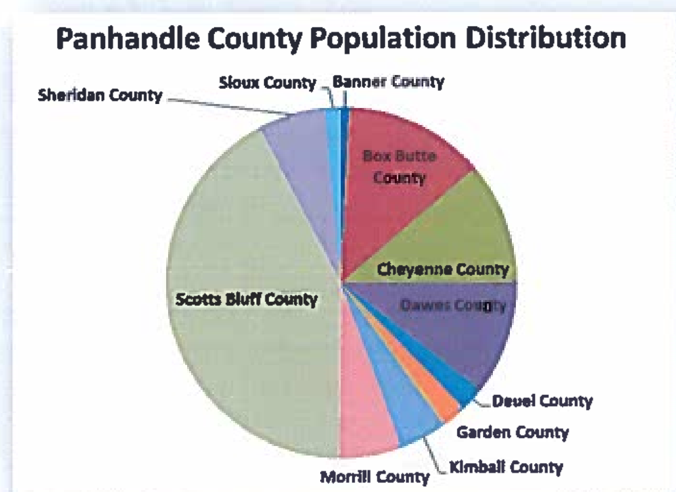


Table 1: County and Panhandle population and change 2000-2010

	Banner County	Box Butte County	Cheyenne County	Dawes County	Deuel County	Garden County	Kimball County	Morrill County	Scotts Bluff County	Sheridan County	Sioux County	Panhandle	% Change 2000-2010
2000	819	12,158	9,830	9,060	2,098	2,292	4,089	5,440	36,951	6,198	1,475	90410	
2010	690	11,308	9,998	9,182	1,941	2,057	3,821	5,042	36,970	5,469	1,311	87789	
Net Change	-129	-850	168	122	-157	-235	-268	-398	19	-729	-164	-2621	-2.9

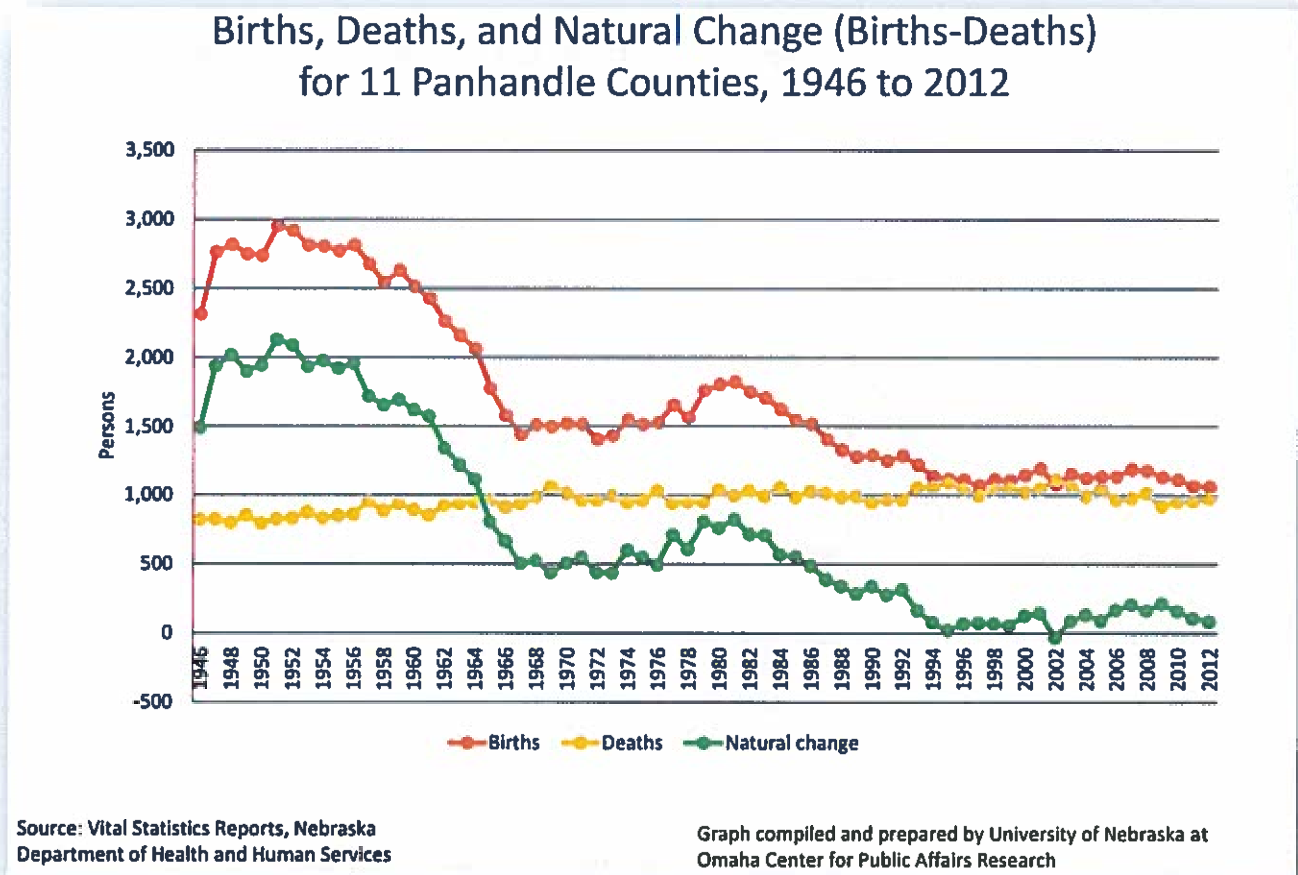
As Figure 6 emphasizes, 77% of the panhandle's population is concentrated in the 4 'trade counties' of Scotts Bluff, Box Butte, Cheyenne, and Dawes. These counties are home to the cities that draw from large areas that tend to have more amenities and draw from large areas for retail and services. Many of the 'rural counties' also boast communities with excellent local services. However in the rural counties, travel time, available labor, and lower levels of public revenue pose obstacles for economic growth and community vitality. This emphasizes Dawes County and its health services as a hub for the area.

Figure 6: Panhandle population distribution by county



The graph in figure 6 shows that natural change has leveled out around zero and in coming years, deaths are projected to exceed births. Because of years of youth outmigration and a decrease in family size, births are lower and population gains will likely depend on in migration. The region also has had around 15,000 children under the age of 18 for several years and so the prospect of young adult population would also rely on in-migration.

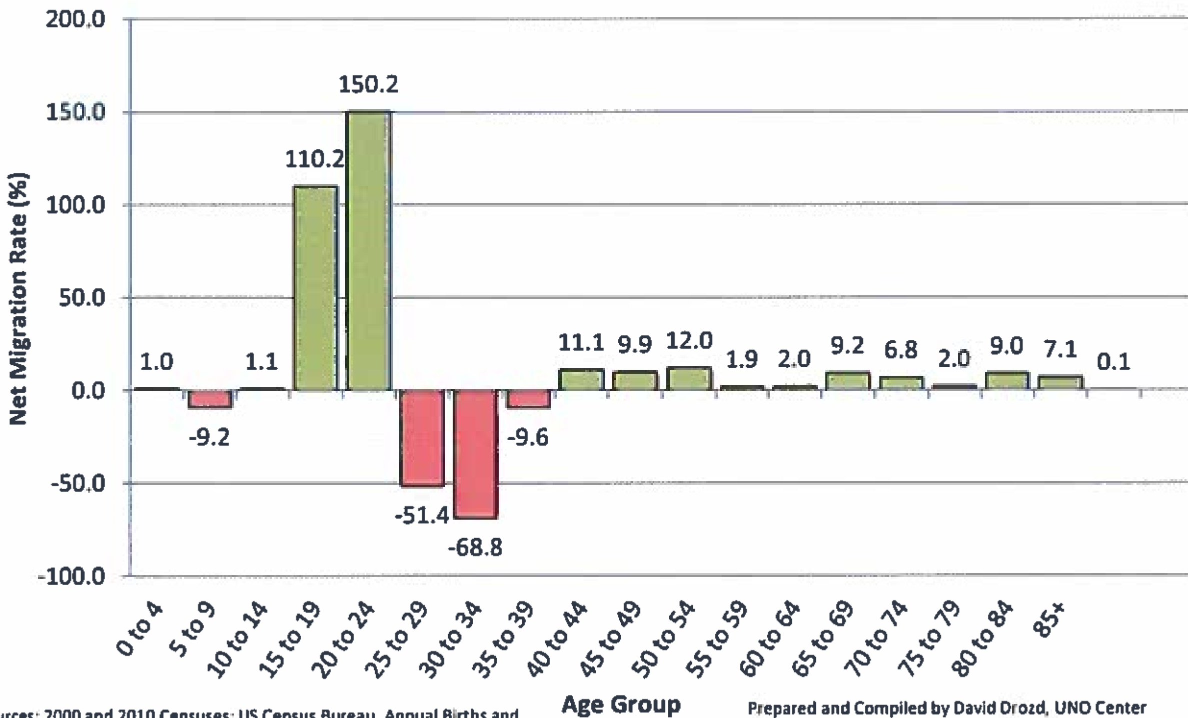
Figure 7: Births, deaths, and Natural Change for 11 Panhandle counties



Migration patterns show the huge influx of college students in the late teens and their departure upon completing college. Dawes County also shows higher migration rates for older populations and age groups in their middle age. The county could be gaining people in their 20s and early 30s from in-migration or students who stay after college, but the numbers would not show up because of the large number of students who leave after college.

Figure 8: Net migration rates for 11 panhandle counties 2000-2010

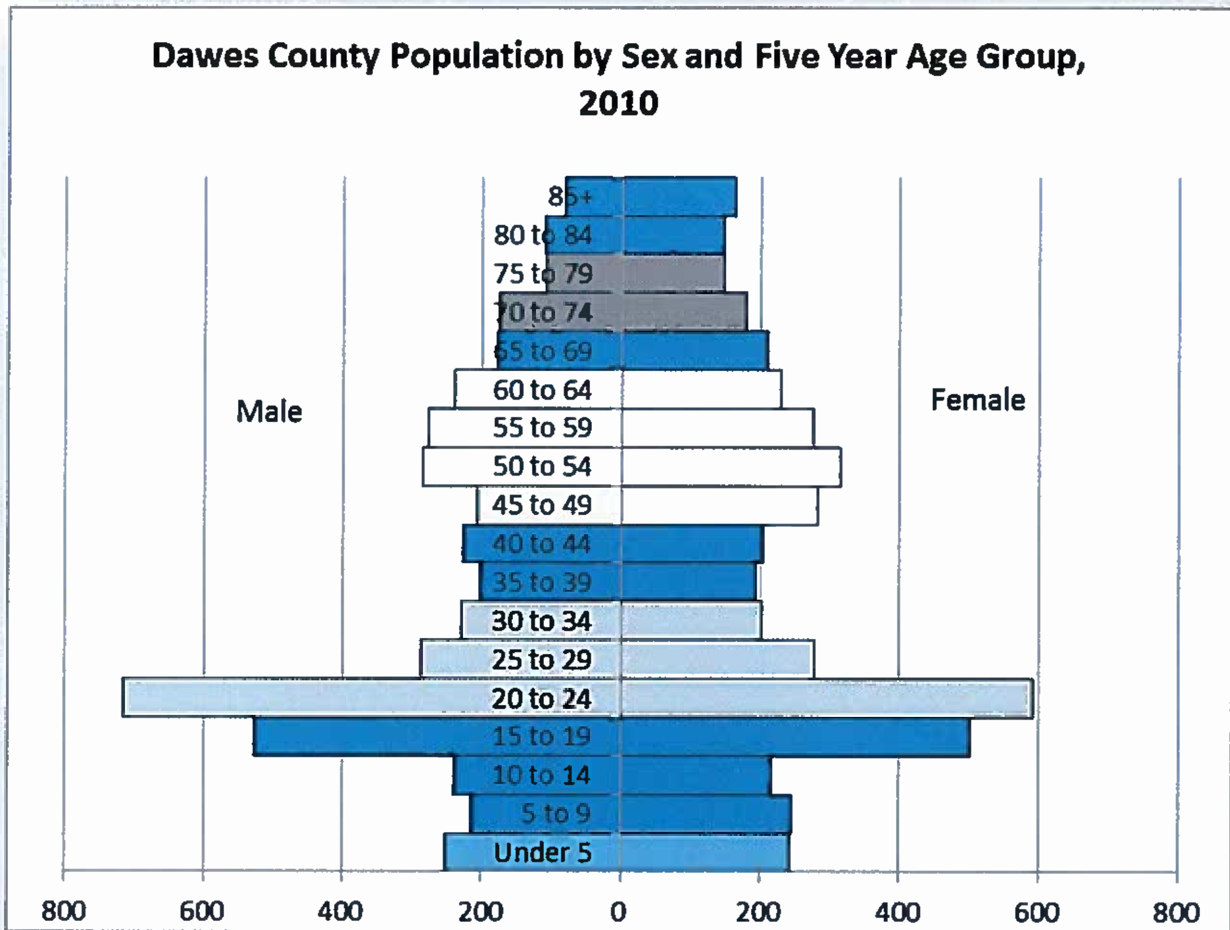
Estimated Net Migration Rate by Age; Dawes County 2000-2010



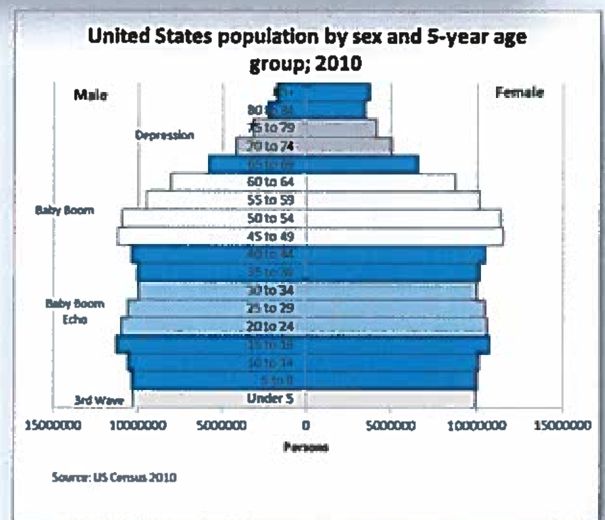
Sources: 2000 and 2010 Censuses; US Census Bureau, Annual Births and Deaths by Single Year of Age, NE Dept. of HHS

Prepared and Compiled by David Drozd, UNO Center for Public Affairs Research

Figure 9: 2010 Nebraska Panhandle population pyramid



Dawes County's large 18-24 population can be utilized to its advantage in business and cultural opportunities. One in four people in the county are between the ages of 15 and 24. The 'thinning' of the young adult population could be a point of concern as the baby boom generation ages and leaves roles of leadership vacant. Services for elderly will also be an issue to watch in coming years as this population becomes more dependent on services such as transportation and health care.



Race

Race patterns in a population are important to assess because they reveal social patterns. Social issues tend to follow the lines of certain social classes and families, and families have tended to follow race lines. With this understanding we can see social and economic patterns for certain segments of the population.

In the Dawes County, the majority race is non-Hispanic white but Hispanic/Latino and American Indian populations each account for five percent of the population as well.

Figure 10: Race composition in the 11 panhandle counties

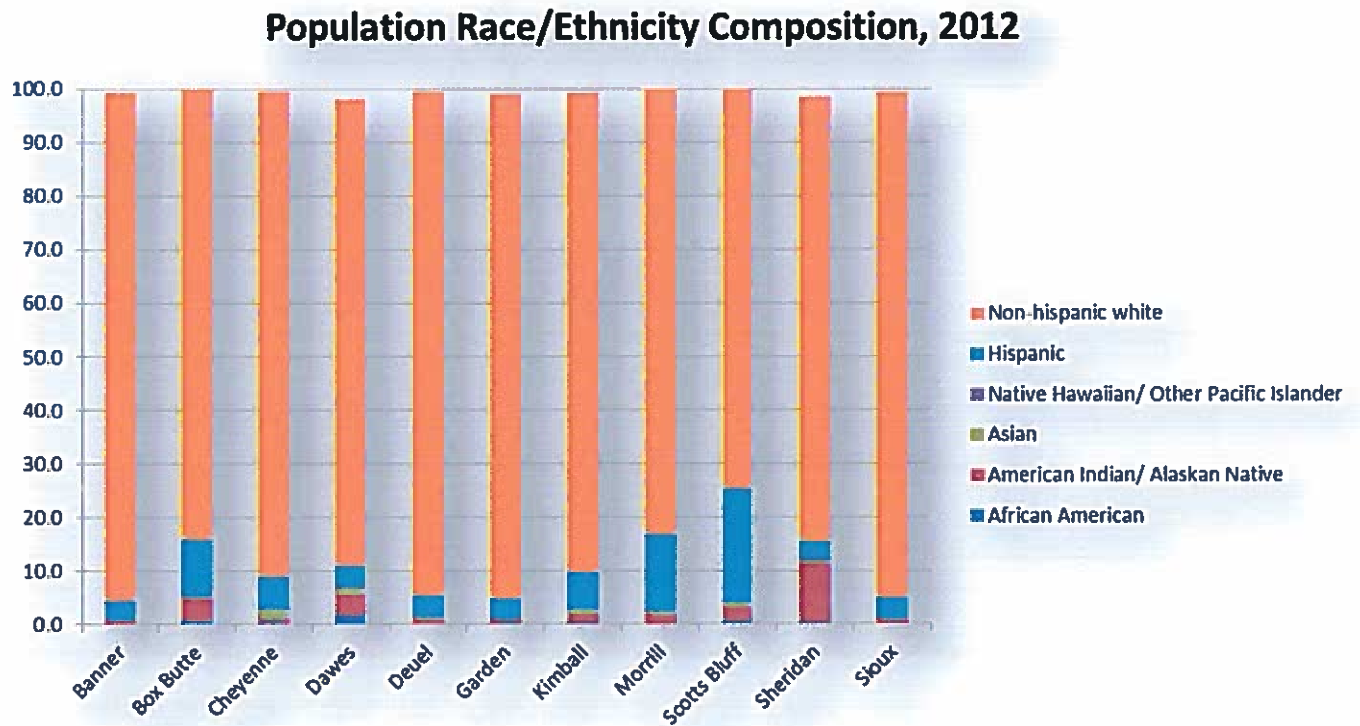


Table 2: Percent not proficient in English by County

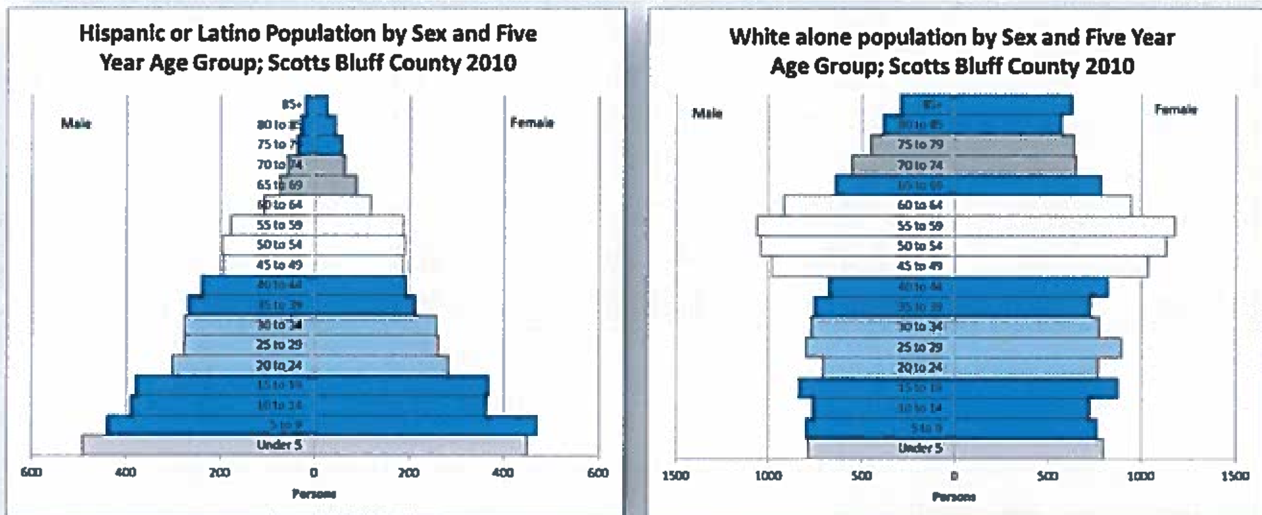
	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Kimball	Morrill	Scotts Bluff	Sheridan	Sioux
% not proficient in English	0.0	0.8	0.1	0.6	0.6	0.0	0.7	1.2	1.8	0.7	0.3

Table 3: Panhandle foreign born rates

County	Percent Foreign Born
Banner County	5.8%
Box Butte County	2.1%
Cheyenne County	3.0%
Dawes County	2.6%
Deuel County	1.4%
Garden County	0.9%
Kimball County	2.6%
Morrill County	4.7%
Scotts Bluff County	4.0%
Sheridan County	1.3%
Sioux County	1.0%
Colfax County	21.0%
Dawson County	18.4%

The foreign born rates in the Panhandle particularly show that the region's minority populations are mostly US citizens. This is different from Colfax and Dawson Counties, (home to Schuyler and Lexington, respectively), whose high Latino populations also include a high number of foreign born citizens. While language and other issues that come with a high foreign born population are not as prevalent in the Panhandle, a stark contrast still exists in economic measures between minority and majority populations, as indicated below by rates of higher education and income.

Figure 11: Comparison between Hispanic/Latino and White alone races in Scott Bluff County



Average Family Size:	3.54
Median Age:	24.5
Bachelor Degree or Higher 2012:	3.6%
Median HH Income 2012:	31,285

Average Family Size:	2.85
Median Age:	44.8
Bachelor Degree or Higher 2012:	25.5%
Median HH Income:	46,396

Economy

Economic health is the driving force for opportunities and prosperity in a region or community. While it is not the only indicator of well-being, quality economic opportunities contribute heavily to the quality of income and the access to education and health care. Thriving local and regional economies also contribute to the vibrancy of communities and provide a base for shared investments in things like infrastructure, law enforcement, public spaces, and maintaining positive neighborhood environments.

Dawes County has its roots in a strong agricultural economy and has fared well in economic downturns, maintaining unemployment rates often much lower than the nation. Now the largest employers were in education, health care, recreation and visitor industries, local and other government and mining.

Employment and Workforce

Dawes County has an unemployment rate slightly higher than the Panhandle and Nebraska (3.7%) and has a low unemployment rate compared to the nation (6.7%).

Table 4: Unemployment rates

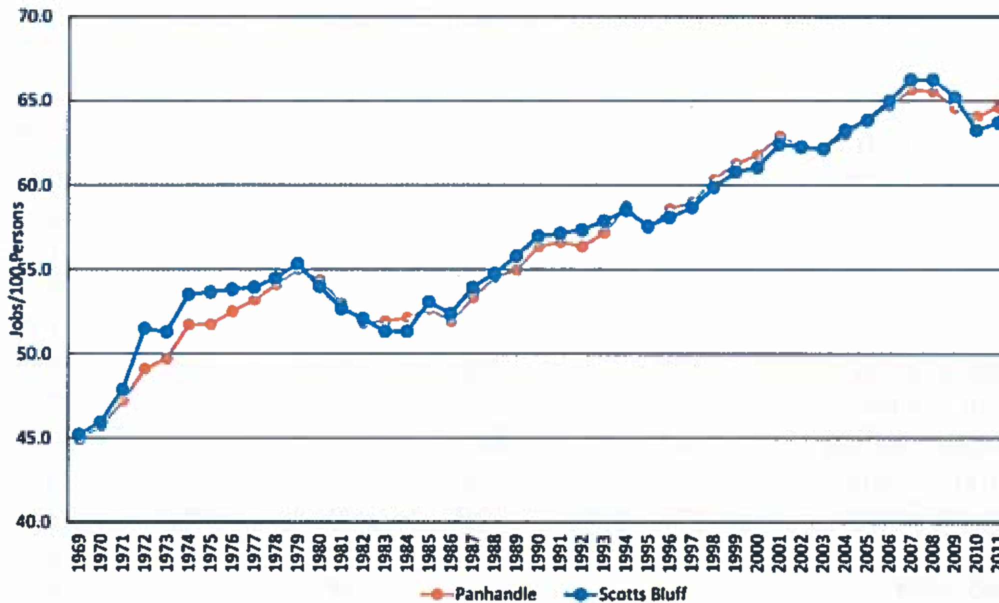
County	Labor Force	Employed	Unemployed	Unemployment Rate (%)
Banner County, NE	372	352	20	5.4
Box Butte County, NE	5,529	5,287	242	4.4
Cheyenne County, NE	5,124	4,972	152	3.0
Daw es County, NE	4,807	4,612	195	4.1
Deuel County, NE	1,253	1,213	40	3.2
Garden County, NE	1,146	1,108	38	3.3
Kimball County, NE	2,059	1,982	77	3.7
Morrill County, NE	2,873	2,795	78	2.7
Scotts Bluff County, NE	19,213	18,391	822	4.3
Sheridan County, NE	3,074	2,971	103	3.4
Sioux County, NE	749	721	28	3.7
Goshen County, WY	6,479	6,116	363	5.6
REGION	**52,678**	**50,520**	**2,158**	**4.1**
			Nebraska	3.7%
			United States	6.7%

Interpreting Unemployment

While unemployment can give us a quick glance as to how the economy of an area is doing, it also does not account for the rate of people who are underemployed or who are working multiple jobs to make ends meet. In an economic downturn, someone who is self-employed or working multiple jobs could lose a significant amount of their work and still not technically be unemployed.

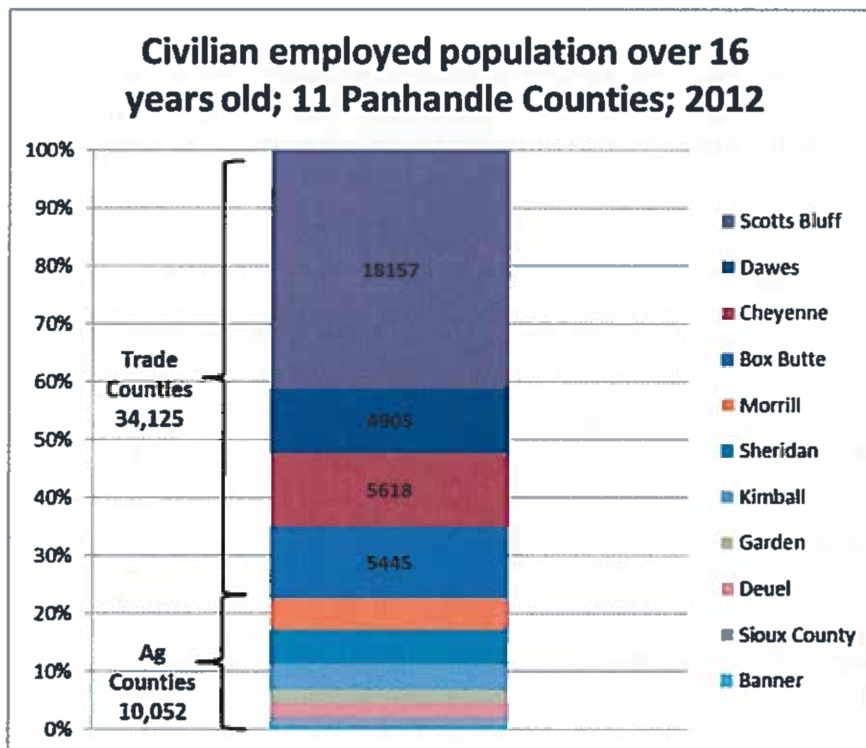
Historically, the number of jobs available per 100 persons has increased while wages still remain below the national and state averages. While this ratio's increase can be partly attributed to loss of population in the region, it also illustrates the importance of the quality of jobs we grow in the region, not just the quantity of jobs. Families with parents who work multiple jobs run a risk of instability since the parents are not able to be home as often.

Figure 12: Jobs per 100 persons 1969 to 2011



Source: US Bureau of Economic Analysis, Regional Economic Information System, released November 26, 2012

Figure 13: Employed population by county, 2012



Educational Attainment

Dawes County has a high percentage of people with a bachelor degree or higher which can be attributed to the college's presence. Dawes County can benefit from a built in talent pipeline in the county in the college as well as one of the highest rates of high school diploma attainment in the region.

Table 5: Educational attainment by Panhandle county

	Population 25 or older	Bachelor Degree or Higher		High School Diploma or Higher	
	Estimate	Estimate	Percent	Estimate	Percent
Banner County	514	107	20.8%	473	92.0%
Box Butte County	7,585	1329	17.5%	6784	89.4%
Cheyenne County	7,029	1775	25.3%	6558	93.3%
Dawes County	5,604	2021	36.1%	5141	91.7%
Deuel County	1,432	248	17.3%	1334	93.2%
Garden County	1,612	314	19.5%	1481	91.9%
Kimball County	2,757	478	17.3%	2397	86.9%
Morrill County	3,477	720	20.7%	2977	85.6%
Scotts Bluff County	24,458	4996	20.4%	21174	86.6%
Sheridan County	3,910	794	20.3%	3496	89.4%
Sioux County	914	239	26.1%	843	92.2%
Panhandle	59292	13021	22.0%	52658	88.8%
Nebraska			28.1%		90.4%
United States			28.5%		85.7%

Income

Wages are generally well below the average for both Nebraska and the nation. The state median household income is $50,695 and the median family income is $64,820; both are higher than Cheyenne County's relatively high income, granted the cost of living expenses are generally lower in the Panhandle as well.

Table 6: Median Income by county, 2011

	Household Income (dollars)	Family Income (dollars)	Married couple Family Income (dollars)	Non-Family Income (dollars)
Cheyenne County	50,143	62,392	72,907	31,860
Box Butte County	44,118	56,011	62,104	25,826
Kimball County	43,191	53,381	59,583	26,429
Sioux County	42,386	53,036	55,227	25,217
Morrill County	42,075	48,019	51,917	25,901
Scotts Bluff County	40,939	51,487	62,075	23,397
Deuel County	37,500	51,210	55,208	19,524
Dawes County	36,396	52,273	56,356	20,692
Garden County	35,861	46,979	57,721	21,658
Sheridan County	34,588	44,184	51,395	22,433
Banner County	27,167	42,361	42,361	19,531

Income distribution by household in Dawes County shows a lot of households in the middle to lower end of the spectrum. The family income distribution shows a different story with a heavy weight towards the higher income brackets. Regionally, the Panhandle has about the same percentage (19%) of its households in the $50,000-74,999 bracket as the Omaha area, but it has a lower percentage in the $75,000-$149,000 brackets and more in the under $35,000 brackets. Fewer professional, science, and technology based jobs likely lead to this outcome.

Table 7: Household income distribution

	Panhandle	
	Estimate	Percent
Total households	36674	
Less than $25,000	10495	28.6%
$25,000 to $74,999	17552	47.9%
$75,000 or more	8627	23.5%

Figure 14: Household income distribution in Dawes County, 2011

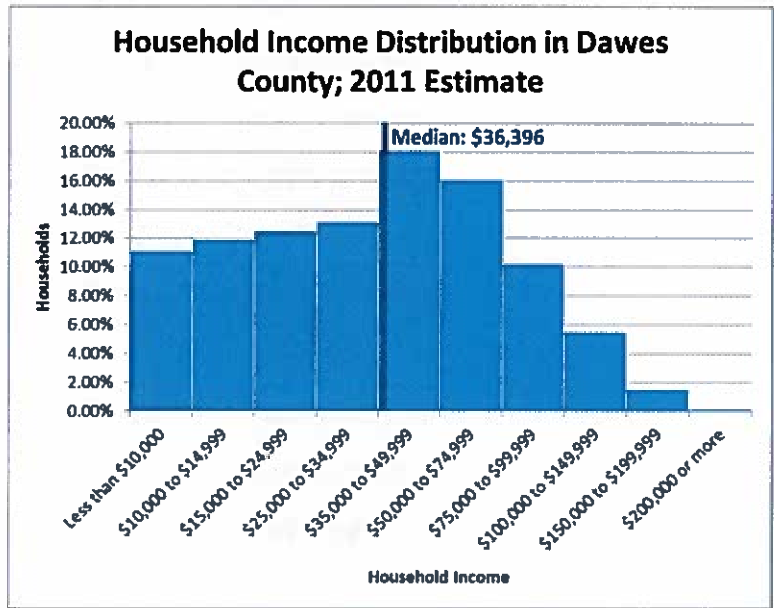
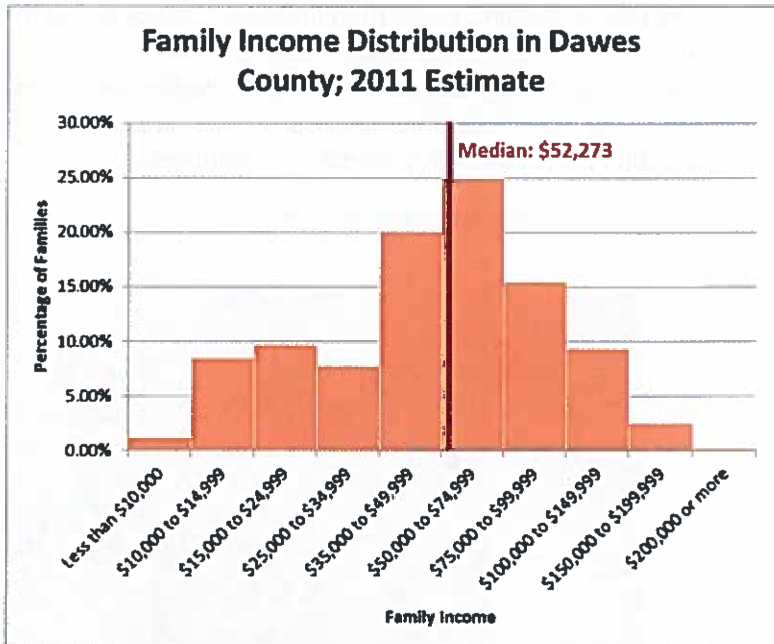


Figure 15: Family Income Distribution, Dawes County 2011

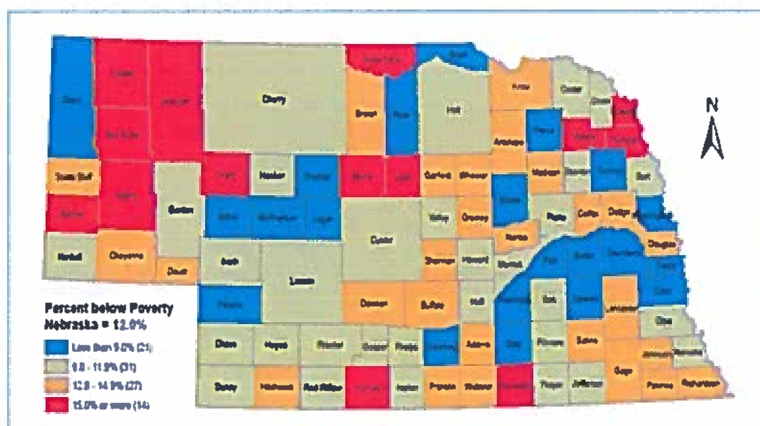


	Household Income	Per Capita Income	Total Households
Banner County	27,167	19,877	309
Box Butte County	44,118	24,389	4,849
Cheyenne County	50,143	27,296	4,438
Dawes County	36,396	20,345	3,772
Deuel County	37,500	24,821	854
Garden County	35,861	24,923	869
Kimball County	43,191	25,304	1,681
Morrill County	42,075	21,881	2,084
Scotts Bluff County	40,939	22,345	14,886
Sheridan County	34,588	22,576	2,373
Sioux County	42,386	31,635	559
Nebraska	50,695	26,113	715,703
Wyoming	56,380	28,952	219,628
South Dakota	48,010	24,925	318,466
Colorado	57,685	30,816	1,941,193

Poverty

The college student population in Dawes County skews the poverty rate which was recorded to be around 24.7% percent in 2011. This rate is more similar to the regional and state rates when the college population is not factored. Poverty affects the kinds of health care able to be afforded by an individual or family and affects other areas of life that impact health like home environment, healthful foods, transportation, and educational opportunities.

Figure 16: Percent below poverty by county



County	Below Poverty
Dawes	24.7%
Banner	17.8%
Sheridan	17.6%
Box Butte	16.6%
Morrill	15.2%
Scotts Bluff	14.7%
Cheyenne	12.9%
Deuel	12.5%
Kimball	11.2%
Garden	10.1%
Sioux County	8.9%
Panhandle	15.5%

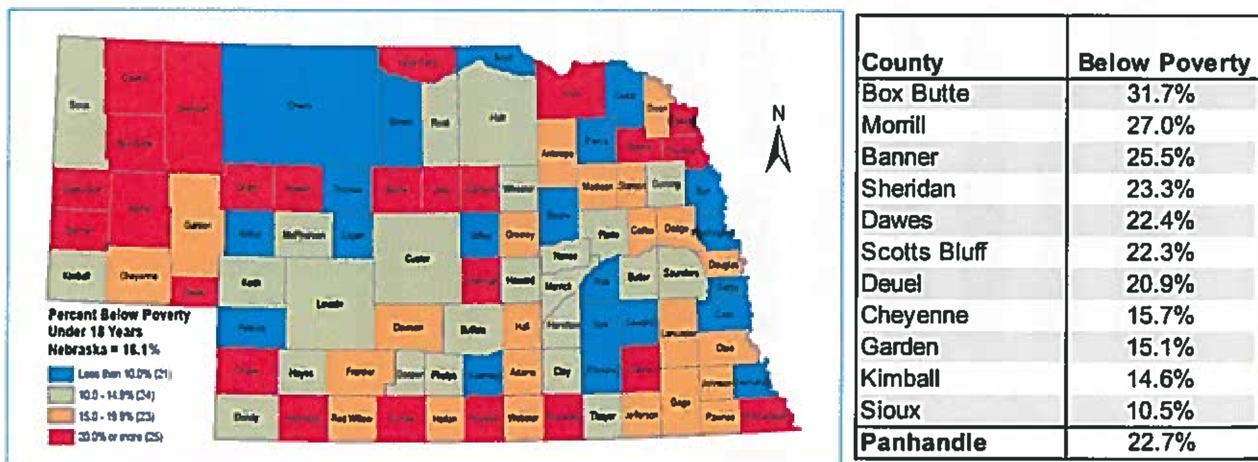
By race, the rate of poverty is high among basically all races except White and Asian. American Indian and Hispanic or Latino origin (of any race) are the largest minority groups in Dawes County and have poverty rates of 24.4% and 62.1%, respectively As was stated before, economic disparities in race represent patterns in economic, social, family, and educational environments. Identifying among which populations (by geography, age, race, etc.) certain patterns exist can help to narrow down which factors are leading to certain social and economic outcomes.

Table 9: Poverty by Race

	One race	White	Black or African American	American Indian and Alaska Native	Asian	Native Hawaiian and Other Pacific Islander	Some other race	Two or more races	Hispanic or Latino origin (of any race)	White alone, not Hispanic or Latino
Banner County	18.0%	18.0%	-	-	-	-	0.0%	0.0%	0.0%	18.2%
Box Butte County	16.3%	13.6%	0.0%	34.4%	2.3%	-	66.7%	30.0%	60.2%	11.1%
Cheyenne County	12.8%	13.1%	25.0%	11.8%	0.0%	-	0.0%	14.7%	41.4%	11.4%
Dawes County	24.6%	24.0%	78.0%	24.4%	19.5%	-	0.0%	17.6%	62.1%	22.7%
Deuel County	12.1%	12.2%	0.0%	-	-	-	0.0%	38.7%	10.0%	12.2%
Garden County	10.2%	10.2%	-	0.0%	0.0%	0.0%	-	0.0%	8.6%	10.3%
Kimball County	11.4%	11.6%	0.0%	0.0%	23.5%	-	0.0%	0.0%	39.3%	9.8%
Morrill County	15.5%	15.4%	-	14.7%	0.0%	0.0%	29.8%	2.7%	15.3%	15.5%
Scotts Bluff County	14.6%	13.0%	45.7%	50.3%	8.9%	0.0%	36.2%	18.3%	21.1%	12.0%
Sheridan County	15.5%	14.0%	100.0%	29.0%	36.4%	-	37.5%	56.7%	5.7%	14.3%
Sioux County	8.8%	8.8%	-	-	0.0%	-	0.0%	18.2%	20.0%	8.9%
Panhandle	15.4%	14.2%	54.8%	33.1%	8.6%	0.0%	40.3%	24.3%	26.6%	13.1%
Nebraska	12.2%	10.5%	32.5%	38.2%	16.0%	25.3%	24.3%	25.0%	25.4%	9.4%
United States	14.8%	12.1%	26.5%	27.6%	12.1%	18.7%	26.1%	19.4%	24.1%	10.3%

The poverty rate for children under 18 is fairly high in Dawes County and across the region with seven of the eleven counties having childhood poverty rates of over 20%. Box Butte County has the highest rate at 31.7% and Sioux County has the lowest at just over 10% of children under 18 below poverty. Large Latino family sizes and high rates of poverty for Hispanic and Latino origin families could be a contributor to these high numbers. More children in poverty means more children growing up with potential obstacles to career, educational, and health care opportunities and threatens the overall prosperity of a community.

Figure 17: Poverty for children under 18 years



County	Below Poverty
Box Butte	31.7%
Morrill	27.0%
Banner	25.5%
Sheridan	23.3%
Dawes	22.4%
Scotts Bluff	22.3%
Deuel	20.9%
Cheyenne	15.7%
Garden	15.1%
Kimball	14.6%
Sioux	10.5%
Panhandle	**22.7%**

The Panhandle's lower rate of poverty among people with lower educational attainment likely reflects the good paying jobs available for non-bachelor degree levels of education. Our region's 33% poverty rate for those with a high school degree or less is drastically lower than big cities such as Denver (50%), Rapid City (43%), or Chicago (52%). Table 4 also gives credence to the benefit of higher education in being financially stable, with fewer than 4% of those with a bachelor's degree or higher being below the poverty level.

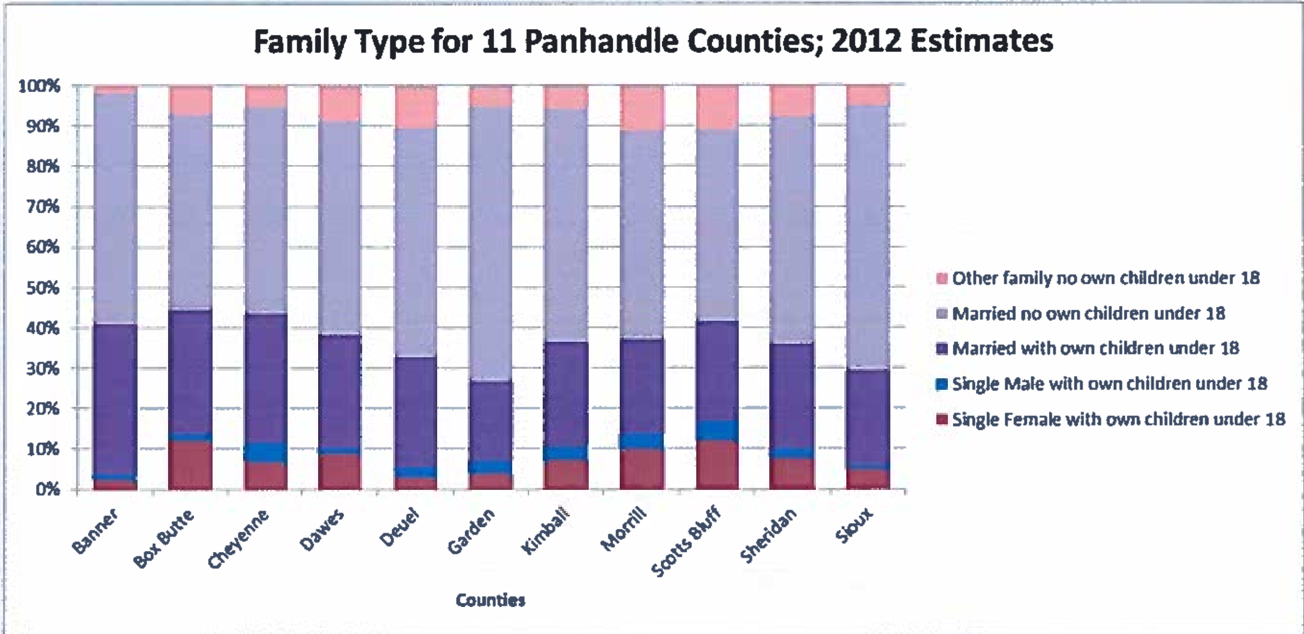
Table 10: Educational attainment and poverty

	Panhandle	Nebraska	United States
	Percent below poverty level	Percent below poverty level	Percent below poverty level
EDUCATIONAL ATTAINMENT			
Population 25 years and over	10.8%	8.8%	11.4%
Less than high school graduate	22.8%	23.1%	26.5%
High school graduate (includes equivalency)	11.1%	10.3%	13.1%
Some college, associate's degree	11.3%	8.4%	9.6%
Bachelor's degree or higher	3.9%	3.3%	4.1%

Family Type

Most families in the county do not have children under 18 years of age but single parent families with children make up about 10% of all Dawes County families. Being a single parent or growing up in a home with a single parent can sometimes mean that individuals in the family have a lack of social support.

Figure 18: Family type for 11 Panhandle Counties



Poverty by Family Type

When looking at the families with income at or below poverty, we find that 78% of families in poverty are families with children under 18 years of age. Single female headed families with children are particularly prevalent among families in poverty, making up 45% of all families in the Panhandle with income below poverty. In Dawes County, however, the single parent families make up a smaller portion of all families in poverty than in other counties in the region.

Figure 19: Poverty by family type

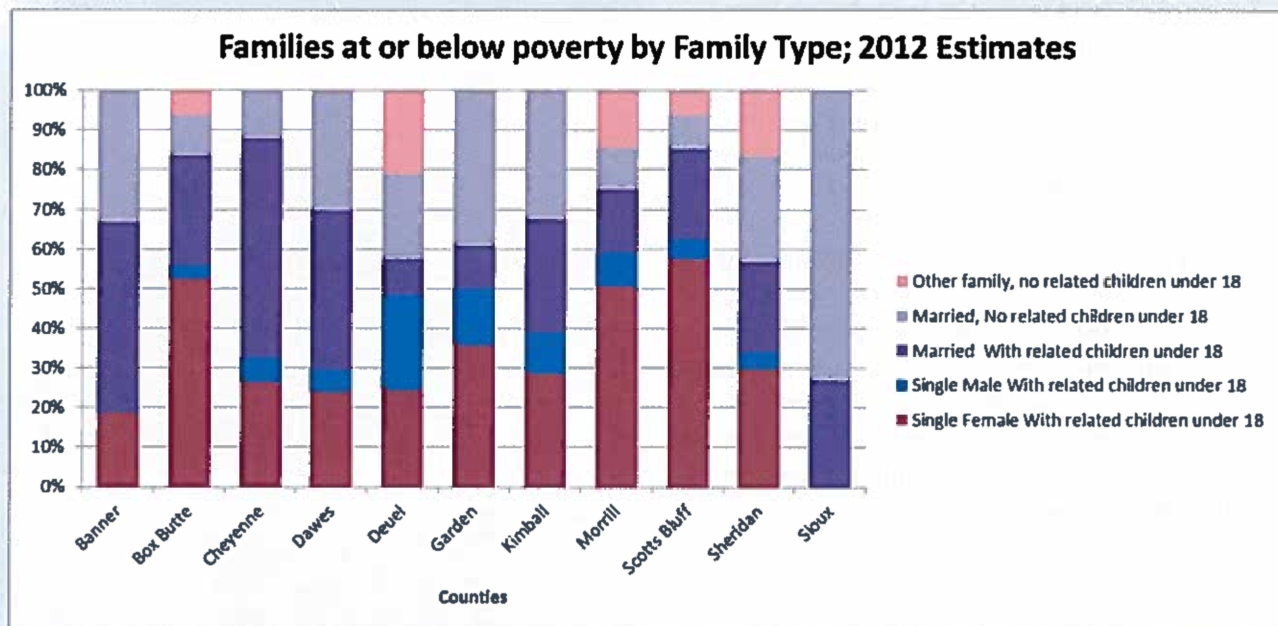


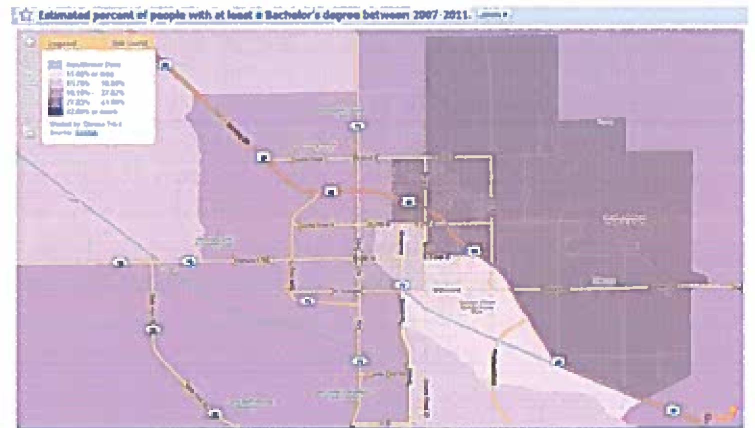
Table 11: Poverty by family type, counts

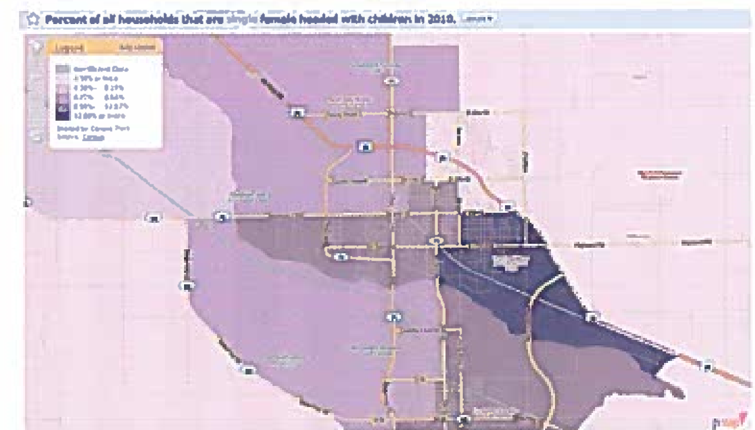
	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Kimball	Morrill	Scottsbluff	Sheridan	Sioux
Total families income below poverty in last 12 months:	27	509	224	310	33	28	95	164	1,075	232	26
Married, No related children under 18	9	52	27	93	7	11	31	17	92	61	19
Married With related children under 18	13	141	124	124	3	3	27	26	243	53	7
Single Male With related children under 18	0	17	14	18	8	4	10	14	54	10	0
Single Female With related children under	5	267	59	74	8	10	27	83	619	69	0
Other family, no related children under 18	0	32	0	1	7	0	0	24	67	39	0

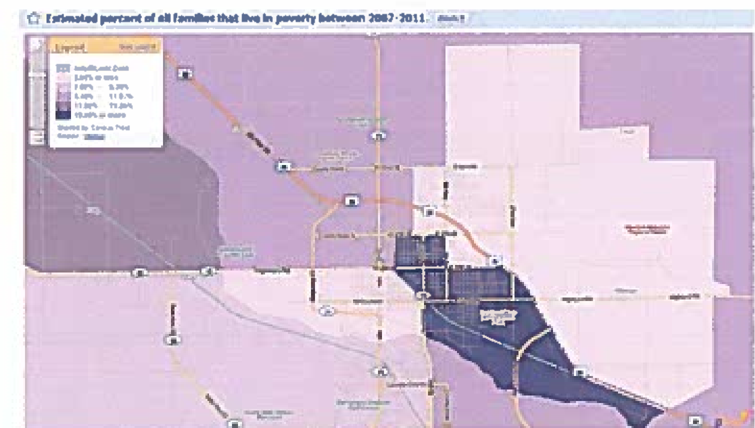
Correlation of factors and social environments

Economic and social factors that affect health do not exist independent of one another but are interrelated. For example, families headed by single parents not only run a higher risk of inadequate social support for children but also potentially bear a greater financial burden. The correlation of these factors points to solutions which touch multiple aspects of a person's life.

The correlation of social and economic factors also manifests itself geographically with those having lower incomes often locating in neighborhoods with lower cost housing. The images on this page show the southeastern census tract of Scottsbluff having the highest rates of poverty and single female headed households and also the lowest rate of educational attainment. These maps not only affirm the interrelation of social and economic health factors but also show the environmental implications of this correlation. Having a positive neighborhood and school environment is also important for personal health in developing positive developmental assets as well as physical health.







Moving Forward

An individual's economic and social well-being directly affects his or her health. Dawes County faces several issues including the aging of the baby boom generation, accessibility to care and opportunities, and poverty. Many of the issues, while complex, are patterned and can be strategically addressed to have the greatest positive impact. Strong partnerships among educational, governmental, non-profit, and business communities and polies that promote financial and social stability for all citizens of Dawes County will drive sustainable wellness.

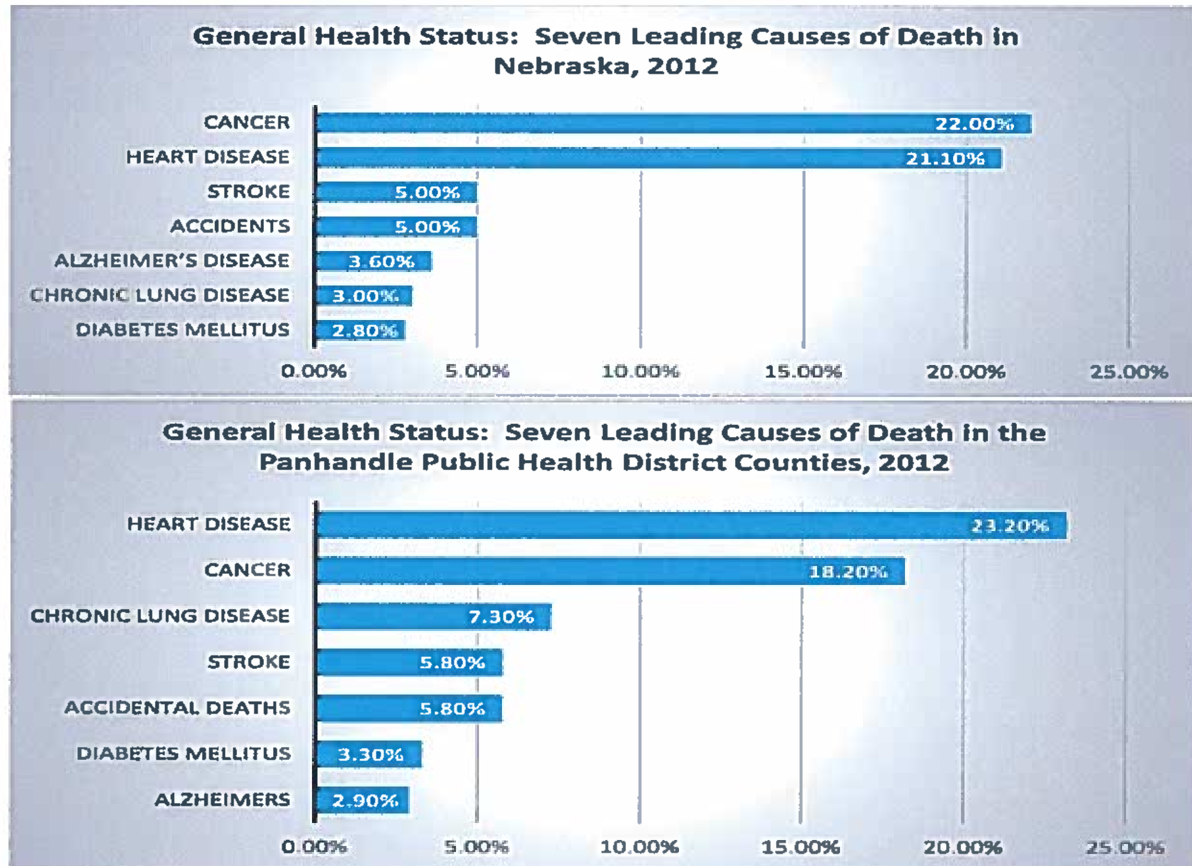
Community Health Data

Overview

According to vital statistics data, cancer was the leading cause of death in Nebraska in 2012, followed by heart disease, as indicated in the figure below. In the ten counties represented by Panhandle Public Health District, the leading cause of death that year was heart disease followed by cancer. Although in a slightly different order, the top seven leading causes of death are the same for both the Panhandle and the State.

By determining priorities and strategies at a local level that align with a regional or statewide priorities and efforts, a stronger impact on health outcomes can be made.

Figure 20: General Health Status – Leading Causes of Death



Health Status

Behavioral Risk Factors Surveillance System

Each year Panhandle Public Health District, working with the State of Nebraska, contracts the University of Nebraska Medical Center to conduct a telephonic survey to gather self-reported health data. This survey, the Behavioral Risk Factor Surveillance System (BRFSS), is done nationally and is coordinated with each of the states through the Centers for Disease Control and Prevention.

This survey is a great resource for public health planning efforts. It paints the picture of the region and allows for comparison to state and national data.

The following table represents BRFSS data used for Dawes County to determine their priority areas. BRFSS data is not available on a county-by-county level, but with similar populations, industries, and resources across the region, the data is a good representation of the health of any county in the Panhandle.

Table 12: BRFSS Health Data, Panhandle, 2011-2013

	2011		2012		2013	
	PPHD	Neb	PPHD	Neb	PPHD	Neb
General Health Status						
General health fair or poor	18.0	14.3	14.4	14.4	15.8	13.9
Physical health not good on 14 or more of the past 30 days	11.5	9.6	10.3	9.8	12.8	9.2
Mental health not good on 14 or more of the past 30 days	10.3	9.2	8.1	9.0	10.4	8.9
Health Care Access						
No health care coverage, 18-64 years old	22.2	19.1	18.4	18.0	18.1	17.6
No personal health care doctor or health care provider	24.7	18.4	16.3	17.2	21.9	20.9
Needed to see a doctor but could not due to cost in past year	13.9	12.5	13.3	12.8	12.7	13.0
Had a routine checkup in past year	52.0	57.7	57.9	60.4	57.7	61.6
Visited a dentist or dental clinic for any reason in the past year	-	-	60.6	67.6	-	-
Cardiovascular						
Ever told they had a heart attack	6.2	4.3	4.8	4.1	4.7	4.0
Ever told they had coronary heart disease	5.3	3.9	5.6	3.9	4.2	4.0
Ever told they had a stroke	2.7	2.6	2.7	2.4	3.5	2.5
Had blood pressure checked in last year	-	-	-	-	88.7	84.6
Ever told they have high blood pressure (excluding pregnancy)	35.1	28.5	-	-	28.5	30.3
Had cholesterol checked in past 5 years	70.2	71.8	-	-	74.3	74.0
Ever told they have high cholesterol, among those checked	41.9	38.3	-	-	34.6	37.4
Tobacco						
Current cigarette smoking	19.1	20.0	19.5	19.7	18.7	18.5
Attempted to quit smoking in past year, among current smokers	56.2	55.6	53.3	57.1	62.6	57.1
Current smokeless tobacco use	9.9	5.6	11.9	5.1	10.6	5.3
Cancer						
Ever told they had skin cancer, 18+	8.0	5.6	7.9	5.6	7.6	5.9
Ever told they have cancer, other than skin cancer	8.7	6.6	6.5	6.5	7.9	6.8
Ever told they had cancer (in any form)	14.6	11.2	12.9	10.8	14.1	11.4
Up-to-date on colon cancer screenings, 50-75 years old	-	-	56.9	61.1	50.0	62.8
Nutrition/Physical Activity						
Ever told they had diabetes (excluding pregnancy)	10.5	8.4	8.7	8.1	10.0	9.2
Obese (BMI =30+)	26.7	28.4	29.0	28.6	31.0	29.6
Overweight or Oobese (BMI=25+)	64.2	64.9	68.5	65.0	66.4	65.5
Consumed fruits less than 1 time per day	42.7	40.1	-	-	42.1	39.7
Consumed vegetables less than 1 time per day	23.1	26.2	-	-	24.4	23.3
Currently have activity limitations due to arthritis, among those told they have arthritis	54.6	45.2	-	-	42.0	42.4
No leisure time physical activity in the past 30 days	31.9	26.3	20.7	21.0	29.5	25.3
Mental Well Being						
Ever told they had depression	18.4	16.8	17.8	16.7	19.2	18.2
Alcohol						
Any alcohol consumption in the last 30 days	56.2	61.8	56.4	61.3	55.0	57.5
Binge drank in the past 30 days	18.8	22.7	21.4	22.1	18.8	20.0
Heavy drinking in the past 30 days	5.3	7.5	10.3	7.2	6.3	6.8
Injury						
Always wear a seatbelt when driving or riding in a car	55.9	71.3	53.9	69.7	58.4	74.1
Texted while driving in past 30 days	-	-	23.4	26.8	-	-
Talked on a cell phone while driving in the past 30 days	-	-	66.0	69.1	-	-
Had a fall in past year, aged 45 years and older	-	-	34.9	28.8	-	-
Injured due to a fall in past year, age 45 years and older	-	-	13.5	9.9	-	-
Substantiated Child Abuse - Dawes County Specific (per 1,000 pop)	5.3	7.4	7.9	5.5	-	-
Accessibility	Dawes	Neb	Dawes	Neb	Dawes	Neb
Occupied housing units with no vehicle available	4.5	5.7	5.3	5.8	-	-
Economic Health						
Individuals with Income Below Poverty	24.7	12.0	24.0	12.4	-	-
Minority Median HH Income per dollar of White Non-Hispanic Median	$0.44	$0.73	$0.39	$0.72	-	-
Median Income	$36,396	$50,695	$36,974	$51,381	-	-
Family Support						
Children Under 18 years below poverty	20.9	16.1	29.0	16.7	-	-
Single Parent with own Children under 18 years of age	11.9	13.0	10.2	13.1	-	-
Single parent families with children under 18 years below poverty as percentage of all families in poverty	22.3	56.8	29.7	56.6	-	-
Juvenile arrests (per 1,000 pop)	19.3	28.6	13.1	26.2	-	-
Population 65 years and older	16.1	13.5	16.5	13.5		
Educational Attainment						
Percent 25 years or older with High School Diploma or Higher	90.6	90.4	91.7	91.2	-	-
Percent 25 or older with associate degree or higher	44.9	37.0	43.6	37.5	-	-
Percent 25 or older with Bachelor's Degree or Higher	37.2	28.1	36.1	28.1	-	-
Unemployment						
Unemployment (July 2014)	-	4.5	-	4.0	5.8	4.0

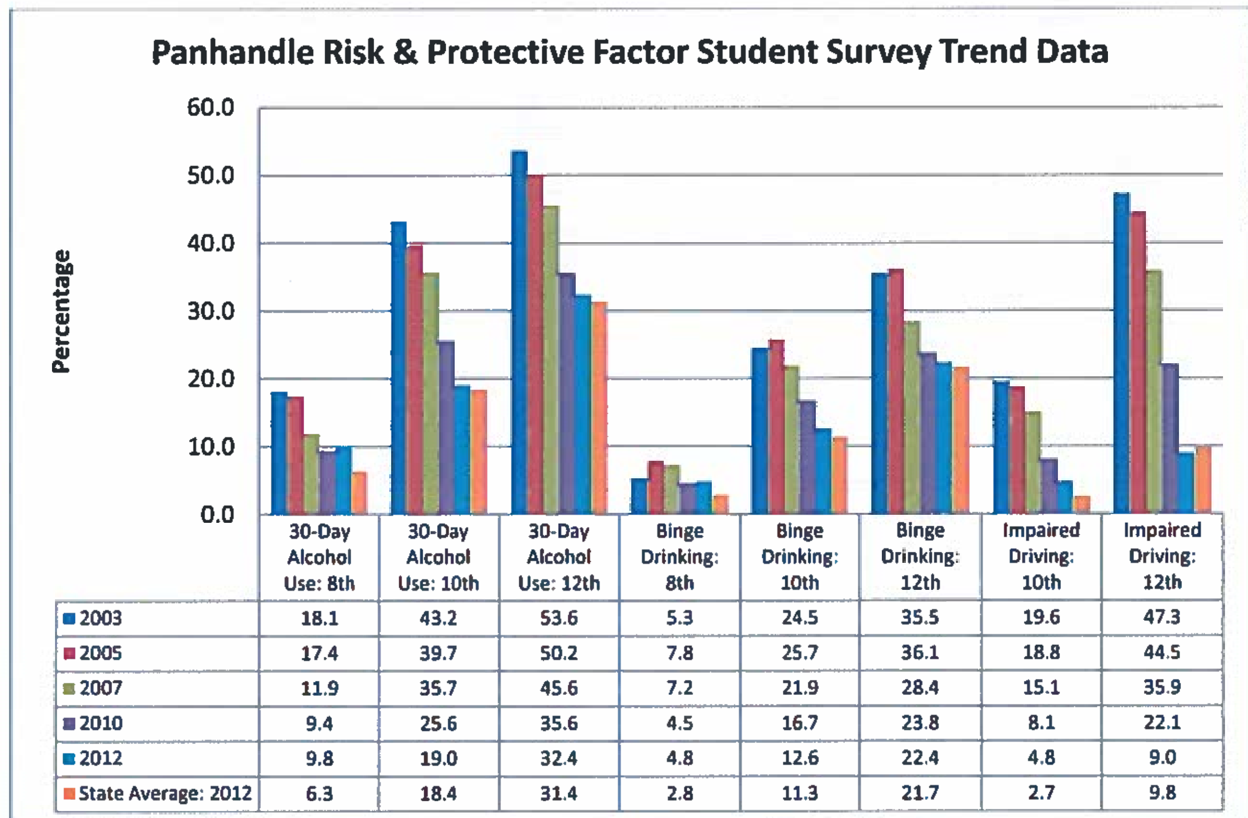
There has been progress in the percentage of adults that have health insurance. Factors that can influence this include a rebounding economy, decreasing unemployment, and the elements of the Affordable Care Act, such as adult children remaining on their parents' health insurance until age 26.

Unfortunately, the percentage of adults reporting they are overweight or obese continues to increase, following state and national trends. About one-third of residents have not had any leisure-time physical activity in the last 30 days. Tobacco use continues to decline, but about 1 in 5 adults still smokes. Alcohol use, binge drinking and heaving drinking are all below the state average, but still impact factors such as accidental injury. Seat belt use is far below the state average.

Youth Risk Factors

The Nebraska Risk and Protective Factors Student Survey (NRPFSS) is a biennial survey of students in grades 6, 8, 10, and 12. This is a survey that schools can choose to administer the survey to receive local information on topics such as substance use/abuse and other risky behaviors. These behaviors can have negative effects on rates of crime, teen pregnancy, high school completion, all of which can negatively affect socioeconomic status and health outcomes later in life. Although the data for the Panhandle is aggregated, a general downward trend is shown for all grades in the risk behaviors of alcohol use, binge drinking, and impaired driving. A positive impact is being made through the efforts of schools, retailers, law enforcement, and community organizations to prevent youth alcohol use.

Figure 21: Panhandle Nebraska Risk and Protective Factors Survey



	30-Day Alcohol Use: 8th	30-Day Alcohol Use: 10th	30-Day Alcohol Use: 12th	Binge Drinking: 8th	Binge Drinking: 10th	Binge Drinking: 12th	Impaired Driving: 10th	Impaired Driving: 12th
2003	18.1	43.2	53.6	5.3	24.5	35.5	19.6	47.3
2005	17.4	39.7	50.2	7.8	25.7	36.1	18.8	44.5
2007	11.9	35.7	45.6	7.2	21.9	28.4	15.1	35.9
2010	9.4	25.6	35.6	4.5	16.7	23.8	8.1	22.1
2012	9.8	19.0	32.4	4.8	12.6	22.4	4.8	9.0
State Average: 2012	6.3	18.4	31.4	2.8	11.3	21.7	2.7	9.8

Injury

Injury data that has been tracked over time is injury deaths due to falls, motor vehicle crashes and suicides. All of these categories are higher than the state crude rate for the same cause.

Figure 22: Injury Crude Death Rates, 2007-2012

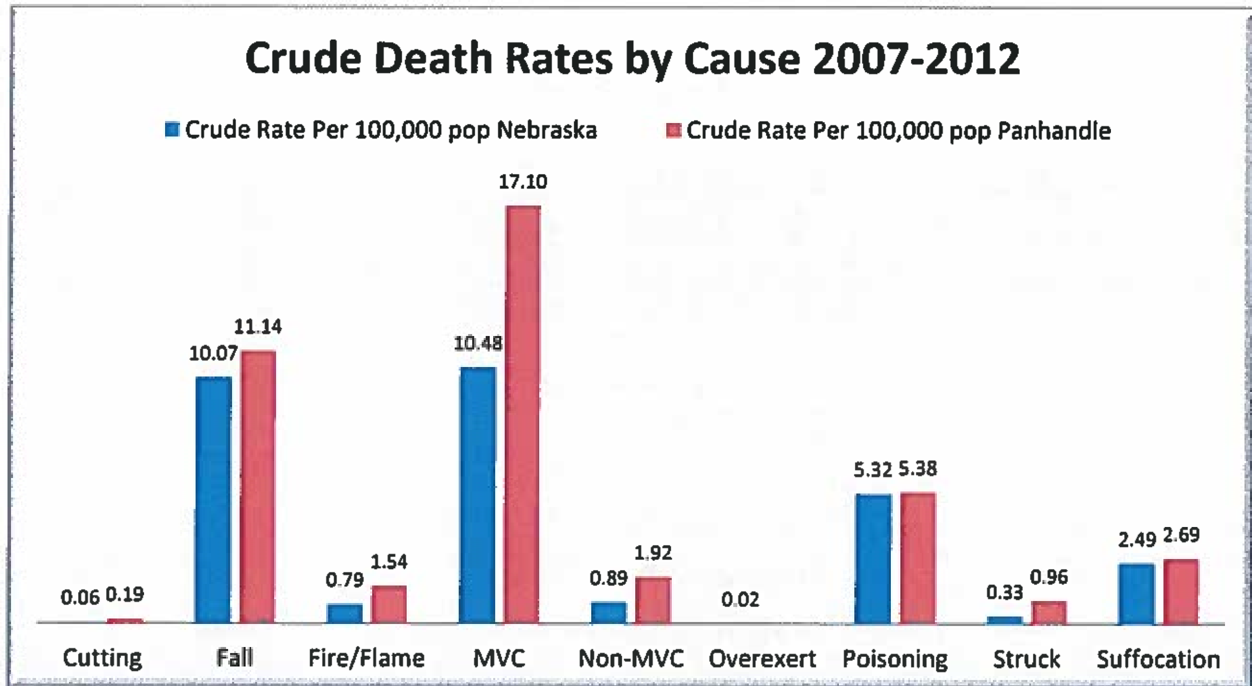
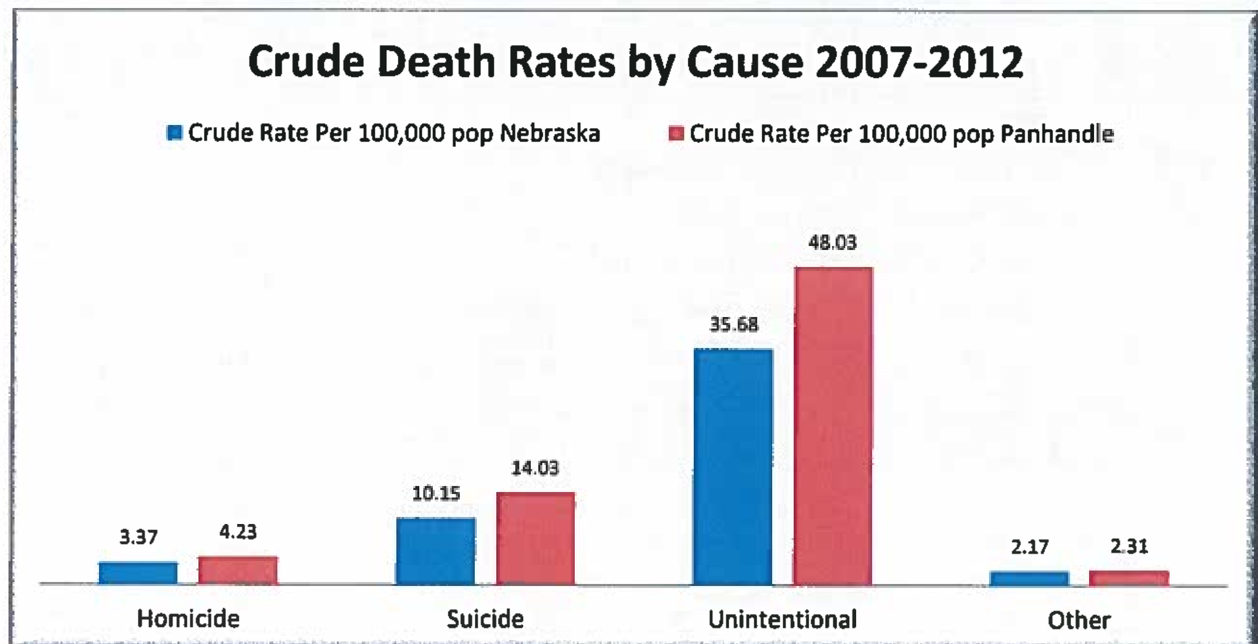


Figure 23: Crude Death Rates by Cause, 2007-2012



Child Well Being

Child Well Being is measured by taking into account child welfare, abuse, and neglect rates, juvenile crime rates, economic factors, educational attainment, adult health behaviors and health outcomes, pregnancy outcomes and social welfare reports. Nebraska conducts an annual evaluation of several indicators of child wellbeing as part of an assessment for home visitation programs.

Table 13: Child Well Being Data, July 2014

Dawes County

	Factor	Indicator	County	State
1.	Child Welfare	CA/N Reports (rate)	39.2	29.9
2.	Child Welfare	CA/N reports, substantiated (rate)	7.5	6.9
3.	Child Welfare	Out of home Care (rate)	6.2	11.8
4.	Crime	Juvenile Arrests (rate)	13.1	26.2
5.	Crime	Juvenile Drug Arrests (rate)	3.4	2.8
6.	Crime	Juvenile DUI (rate)	0.5	0.3
7.	Crime	Juvenile Violent Crime Arrests (rate)	0.0	0.5
8.	Economic	Poverty, All ages (%)	19.3%	12.6
9.	Economic	Unemployment (%)	4.2%	4.4%
10.	Education	Education less than 9th Grade (%)	2.6%	4.1%
11.	Health Behaviors	Adult Smoking (%)	18.0%	18.0%
12.	Health Behaviors	Binge Drinking (%)	22.0%	19.0%
13.	Health Behaviors	Chlamydia Infections (rate)	12.0	305
14.	Health Behaviors	Inadequate Prenatal Care (%)	19.8%	14.3%
15.	Health Behaviors	No Prenatal Care (%)	1.2%	0.7%
16.	Health Behaviors	Births to Teens (% teen births)	8.8%	76%
17.	Pregnancy Outcomes	Low Birth Weight (%)	7.6%	6.9%
18.	Pregnancy Outcomes	Very Low Birth Weight (%)	*	1.2%
19.	Pregnancy Outcomes	Prematurity (%)	9.4%	11.2%
20.	Pregnancy Outcomes	Infant Mortality(rate)	*	5.7
21.	Health Outcomes	Poor/Fair Health (%; self-reported)	12.0%	12.0%
22.	Health Outcomes	Poor Mental Health Days (mean)	3.0	2.7
23.	Health Outcomes	Poor Physical Health Days (Mean)	3.1	2.9
24.	Health Outcomes	Premature Death (YPLL)	5,594.0	5,904.0
25.	Social Welfare	Aggravated Domestic Violence Complaints (rate)	2.5	2.6
26.	Social Welfare	Domestic violence Crisis Line Calls (rate)	30.9	25.7
27.	Social Welfare	Simple Domestic violence Complaints (rate)	32.7	26.4
28.	Social Welfare	Single Parent Household (%)	26.0%	27.0%

Adverse Childhood Experiences

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

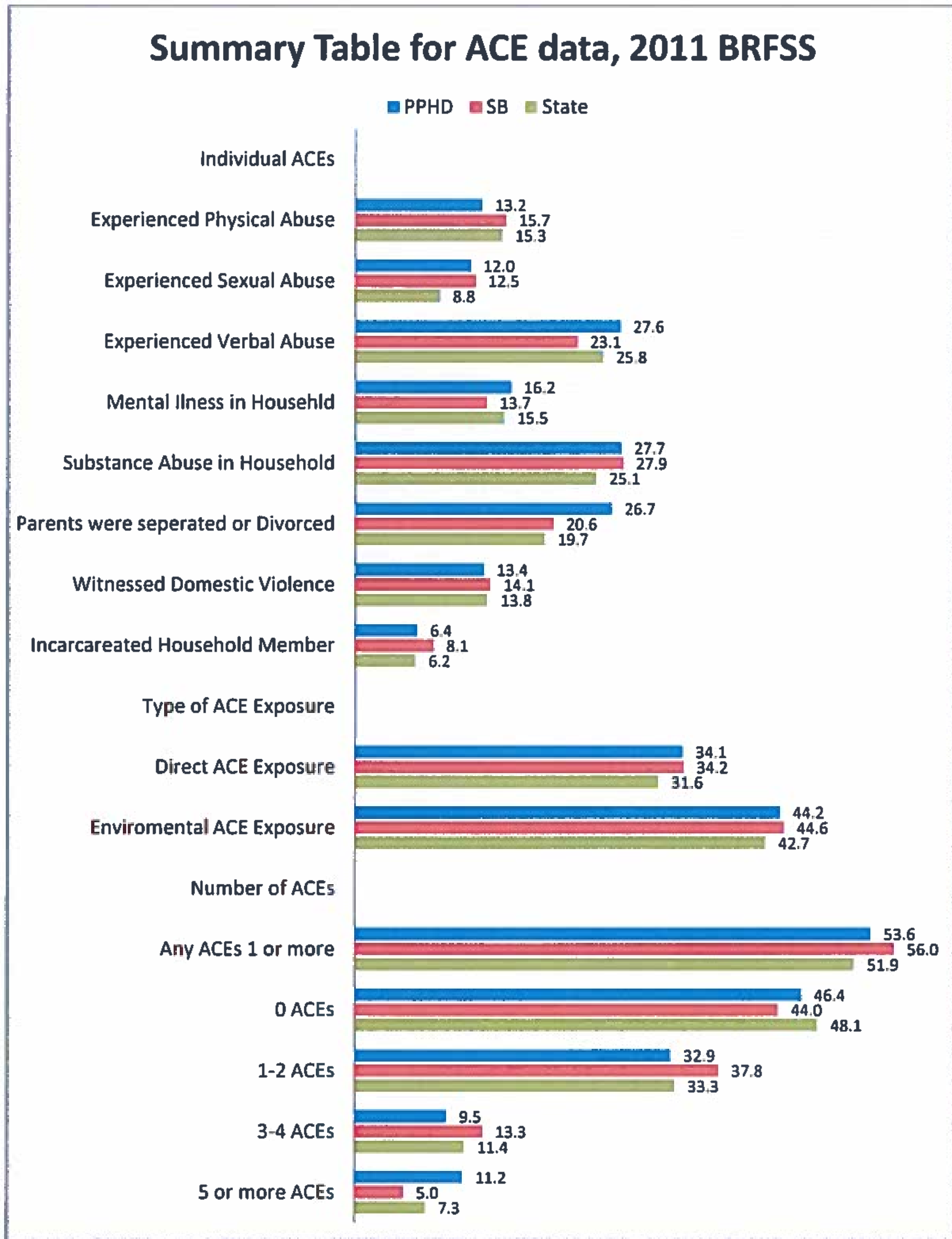
More than 17,000 Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery.

Adverse Childhood Experiences, Nebraska, 2010–2011

Nebraska's Behavioral Risk Factor Surveillance System (BRFSS) data from 2010 and 2011 were analyzed to evaluate associations between adverse childhood experiences (ACEs) and adverse health outcomes and behaviors during adulthood. Statistically significant associations were demonstrated between the number of ACEs and tobacco use, obesity, reporting poor general health, arthritis, cardiovascular disease, COPD, depression, diabetes, and disability. In addition, we demonstrated associations between individual ACEs and multiple adverse health outcomes. These findings highlight the need to detect and intervene in the lives of children affected by ACEs before they develop adverse health outcomes.

Figure 24: Adverse Childhood Experiences

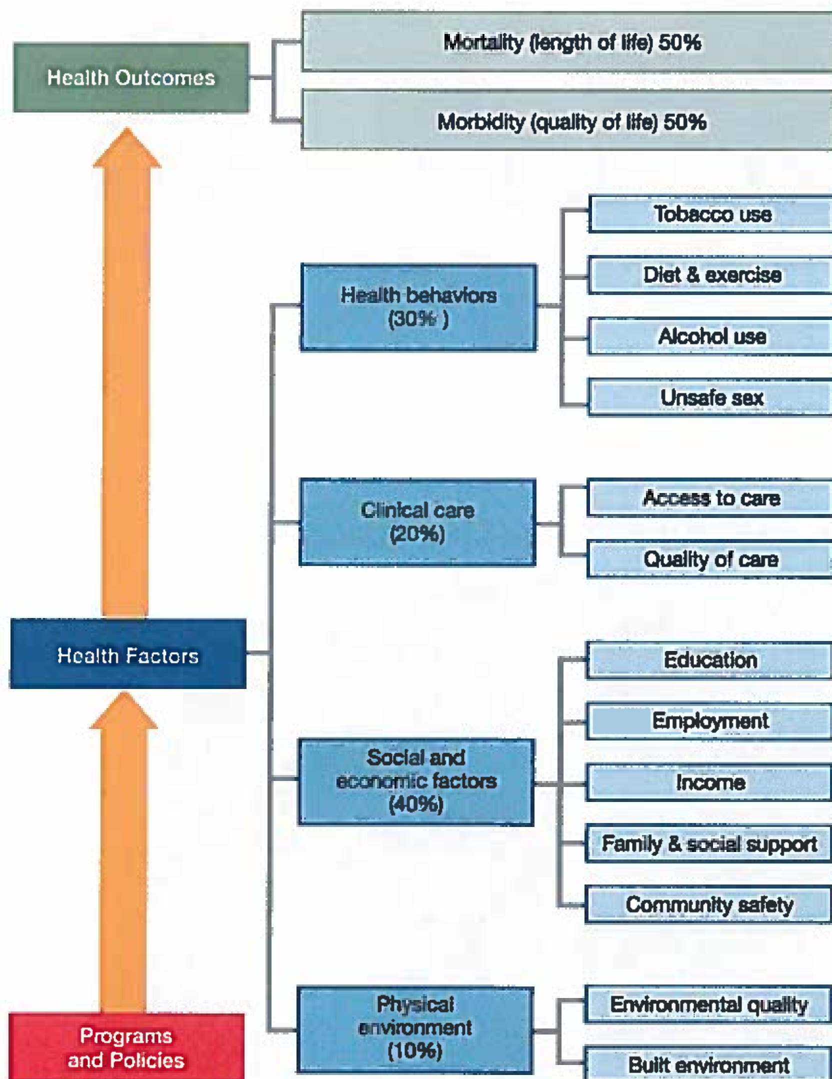


County Health Rankings

The Robert Wood Johnson Foundation releases an annual ranking of each county in each state of the nation. In Nebraska, 79 of the 93 counties are ranked due several with very small populations that cannot be fairly ranked. The score is made up of two main categories: 50% health outcomes, including length of life and quality of life; and 50% health factors including health behaviors, clinical care, social and economic factors, and the physical environment.

This model shows that it takes more than just exercise and good nutrition to be considered healthy. Where we live, our environment, education, medical care and the behavioral choices we make count just as much as how long we live.

Figure 25: County Health Rankings Model



County Health Rankings model ©2010 UWPHI

In 2014 Dawes County was ranked 42nd in the state in health outcomes and 65th in health factors.

Figure 26: 2014 Health Outcomes Rankings

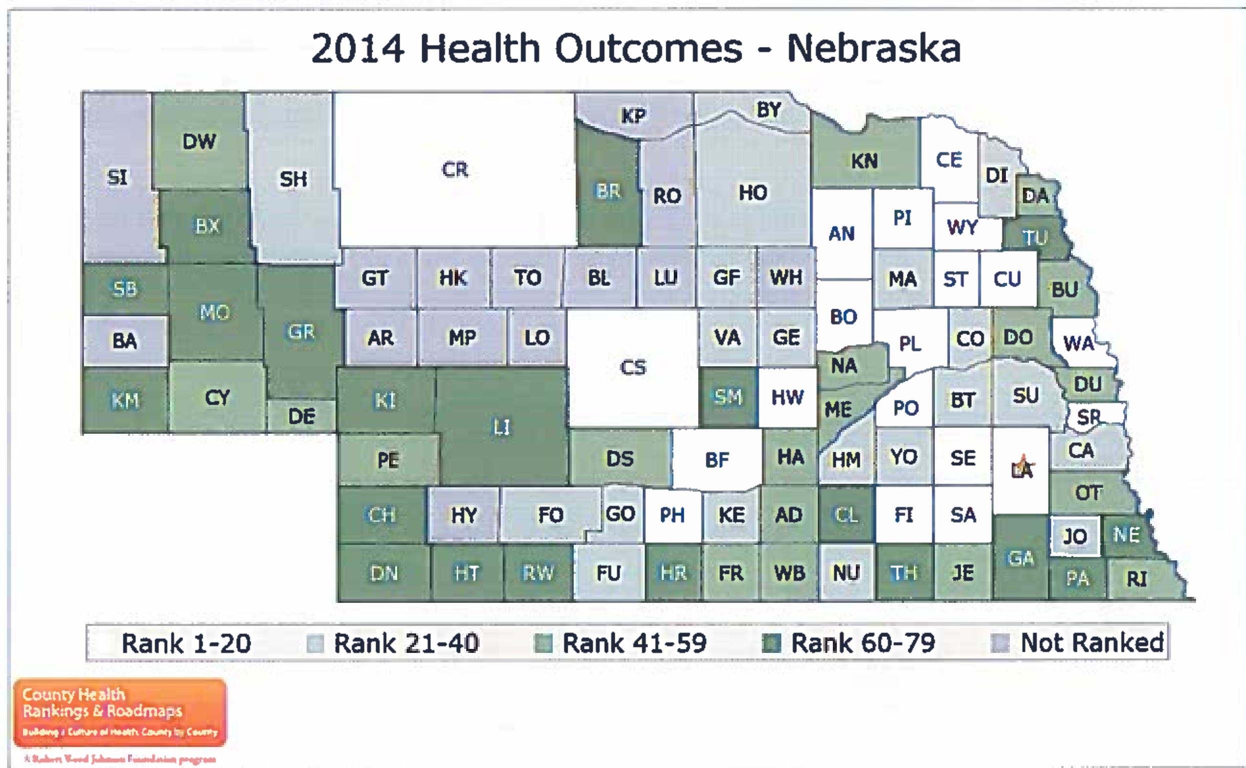


Figure 27: 2014 Health Factors Rankings

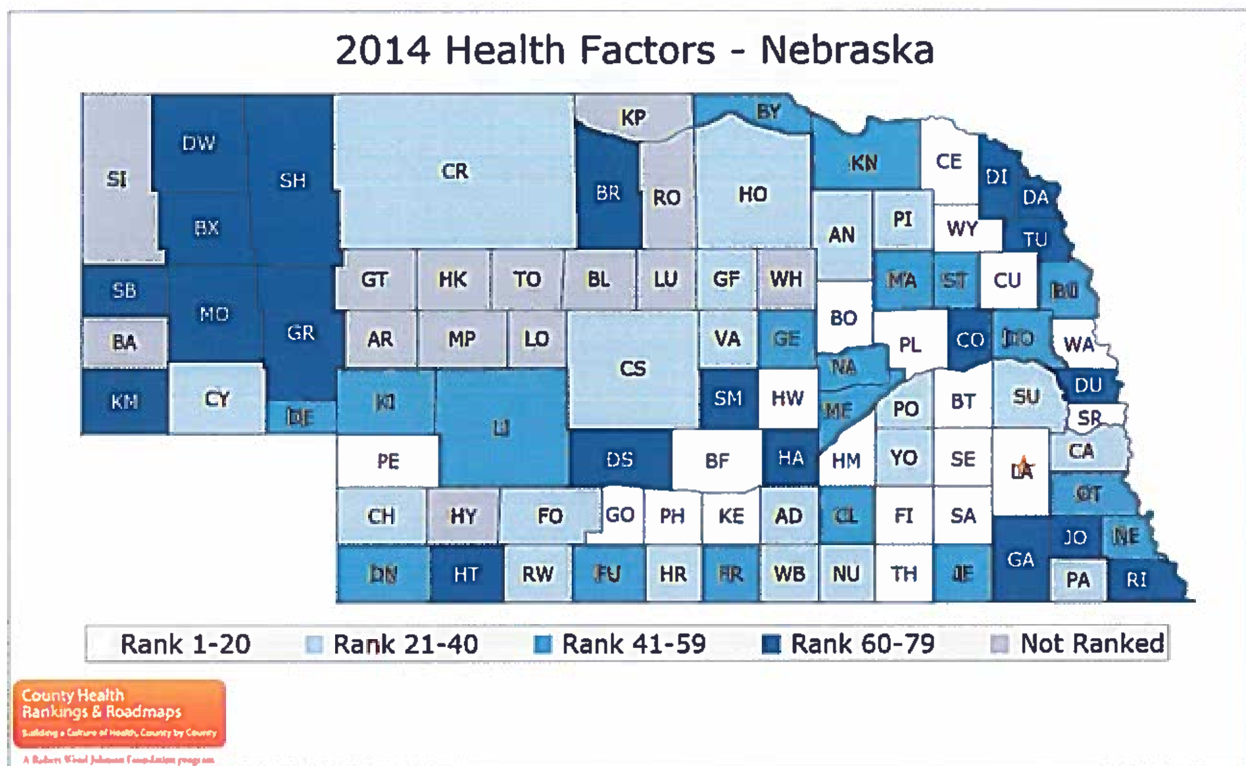


Table 14: Dawes County Health Rankings, 2014

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

Dawes (DW)

	Dawes County	Error Margin	Top U.S. Performers*	Nebraska	Rank (of 79)
Health Outcomes					42
Length of Life					23
Premature death	5,594	4,475-6,909	5,317	5,904	
Quality of Life					58
Poor or fair health	15%	12-18%	10%	12%	
Poor physical health days	3.3	2.6-3.9	2.5	2.9	
Poor mental health days	3.0	2.4-3.5	2.4	2.7	
Low birthweight	6.3%	4.5-8.1%	6.0%	7.0%	
Health Factors					65
Health Behaviors					50
Adult smoking	18%	14-22%	14%	18%	
Adult obesity	30%	26-34%	25%	29%	
Food environment index	7.2		8.7	8.1	
Physical inactivity	28%	24-32%	21%	25%	
Access to exercise opportunities	86%		85%	75%	
Excessive drinking	21%	17-26%	10%	20%	
Alcohol-impaired driving deaths	50%		14%	36%	
Sexually transmitted infections	315		123	368	
Teen births	18	14-23	20	33	
Clinical Care					49
Uninsured	17%	15-20%	11%	13%	
Primary care physicians	1,533:1		1,051:1	1,404:1	
Dentists	1,307:1		1,392:1	1,493:1	
Mental health providers	572:1		521:1	560:1	
Preventable hospital stays	39	28-50	46	64	
Diabetic screening	73%	55-91%	90%	85%	
Mammography screening	50%	35-65%	71%	62%	
Social & Economic Factors					67
High school graduation	54%			85%	
Some college	80%	66-94%	70%	69%	
Unemployment	3.9%		4.4%	3.9%	
Children in poverty	23%	17-28%	13%	17%	
Inadequate social support	16%	13-19%	14%	17%	
Children in single-parent households	25%	11-39%	20%	28%	
Violent crime	155		64	271	
Injury deaths	53	34-78	49	54	
Physical Environment					46
Air pollution - particulate matter	13.0		9.5	12.1	
Drinking water violations	7%		0%	10%	
Severe housing problems	17%	11-22%	9%	13%	
Driving alone to work	65%	60-70%	71%	80%	
Long commute - driving alone	11%	7-15%	15%	17%	

* 90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data

Implementation Plan

Healthy Lifestyle Implementation Plan

PRIORITY AREA: Healthy Diet

<table>
<tr><td colspan="5">Obesity and chronic diseases – such as cancer, diabetes, heart disease and stroke – are among the most common, costly, and preventable of all health problems in Nebraska and throughout the United States.
A <u>healthy diet</u>, physical activity, breastfeeding, and maintaining healthy body weight all significantly contribute to preventing obesity and chronic disease. – Nebraska Physical Activity and Nutrition State Plan 2011-2016</td></tr>
<tr><td colspan="5">Contributing FACTORS to Healthy Eating (including social determinants): Healthy eating is influenced by access to healthy, safe, and affordable foods as well as individual knowledge, attitudes, skills, social support, and societal and cultural norms.</td></tr>
<tr><td colspan="5"><u>Three Year GOAL for Improvement</u> (written as a SMART objective):
Reduce obesity in adults by 10% (SB-39.6, PPHD-29, 2012 BRFSS) by 2020.</td></tr>
<tr><th>Strategies to Achieve Goal</th><th>Specific Partners and Roles for each Strategy</th><th>Specific Actions to Achieve Strategies</th><th>Specific 3-year Process Measure(s) for Each Strategy</th><th>Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)</th></tr>
<tr><td>Availability and access of affordable healthier foods and beverages</td><td>Local grocers, worksites, food and beverage distributors, Bountiful Basket volunteer coordinators</td><td>Local assessment of food distribution systems and potential for impact.</td><td>Assessment findings, meetings with local resources and distributors.</td><td>Panhandle BRFSS trend, County Health Rankings</td></tr>
<tr><td rowspan="3">Access and promote healthful foods, including fruits, vegetables and water while limiting access to sugar-sweetened beverages in worksite settings</td><td rowspan="3">Hospital wellness committee, dietary staff, Worksite Wellness</td><td>Adopt internal policies for healthy meeting guidelines to include healthy catering options for meetings</td><td>Hospital HRA outcomes, policy adoption</td><td rowspan="3">Panhandle BRFSS trend, County Health Rankings</td></tr>
<tr><td>Assess cafeteria offerings to increase healthy options, decrease access to calorie dense foods, and provide a labeling system</td><td>Hospital HRA outcomes, cafeteria/dietary survey</td></tr>
<tr><td>Assess vending options to work increase access to fresh, refrigerated items and decrease access to sugar-sweetened beverages</td><td>Assessment findings, documentation of increased offerings and reduction of access to sugar-sweetened beverages</td></tr>
<tr><td>Policies at schools and child care facilities to promote healthier foods and beverages</td><td>School wellness committee, local child care provider teams, Early Childhood Centers, ESU, DHHS, public health, WIC, CAPWN, NCAP, Head Start, SOC 0-8</td><td>Active participation in Coordinated School Health Process and School Wellness Committees when possible</td><td>Policy adoption, meetings with school wellness teams</td><td>Panhandle BRFSS trend, County Health Rankings, YRBS</td></tr>
<tr><td rowspan="2">Affordable, appealing healthy choices in foods and beverages in schools outside of the child nutrition program</td><td rowspan="2">School wellness committee, local child care provider teams, Early Childhood Centers, ESU, DHHS, public health, WIC, CAPWN, NCAP, food banks, Head Start, SOC 0-8, local grocers, Bountiful Basket volunteers, Farmer's Market vendors</td><td>Assessment of key target areas of food and beverage procurement when not in school</td><td>Assessment findings</td><td rowspan="2">Panhandle BRFSS trend, County Health Rankings, YRBS</td></tr>
<tr><td>Marketing campaign promoting nutrition resources available locally (farmer's markets, local grocers, BB)</td><td>News release, promotional materials, Increased community awareness of local nutrition resources</td></tr>
<tr><td>Clinical interventions to prevent and control obesity</td><td>Local providers and clinics, hospital wellness committee, NDPP lifestyle interventionists & Panhandle coordinator</td><td>Unified screening and referral process for all overweight/obese adults and children.</td><td>Assessment findings of current process to include referrals to community programs like National Diabetes Prevention Program.</td><td>National Diabetes Prevention Program in the Panhandle data, Panhandle BRFSS trend data</td></tr>
</table>

PRIORITY AREA: Physical Activity

Obesity and chronic diseases – such as cancer, diabetes, heart disease and stroke – are 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 and chronic disease. – Nebraska Physical Activity and Nutrition State Plan 2011-2016

Contributing FACTORS to Physical Activity (including social determinants): advancing age, low income, lack of time, low motivation, rural residency, perception of great effort needed for exercise, overweight or obesity, perception of poor health, and being disabled are all factors negatively associated with adult physical activity

**Three Year GOAL for Improvement (written as a SMART objective): **
Reduce obesity in adults by 10% (SB-39.6, PPHD-29, 2012 BRFSS) by 2020.

Strategies to Achieve Goal	Specific Partners and Roles for each Strategy	Specific Actions to Achieve Strategies	Specific 3-year Process Measure(s) for Each Strategy	Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Enhance access to physical activity opportunities, including physical education in Panhandle schools, child care, and after school facilities	Schools, SOC 0-8, Head Start, CAPWN, NCAP, local child care provider teams, public health, community centers	Assess current PE offerings in local schools, child care regulations, and after school programs	Assessment findings, meeting minutes	Panhandle BRFSS Trend Data, County Health Rankings, YRBS
		Implement increased access to sustainable, evidence-based physical activity opportunities	Number of offerings	
Enhance policies for physical activity, inclusive of physical education, in Nebraska schools	Schools, SOC 0-8, Head Start, CAPWN, NCAP, local child care provider teams, public health, community centers	Assess current PE offerings and opportunities for increased physical activity throughout the school day	Policy adoption, assessment findings	Panhandle BRFSS Trend Data, County Health Rankings, YRBS
Enhance community planning and design practices through built environments and policy changes to improve physical activity in Panhandle communities	Local government, community parks & rec, community centers, schools, public health, community-spirited citizens, historical main street, chambers of commerce, economic development, community planning teams	Participation in community planning team or initiation of multi-sector comprehensive community planning process with key community partners	Planning documents, meeting minutes, planning and design documentation towards conducive built environment	Panhandle BRFSS Trend Data, County Health Rankings, YRBS, Economic Development and Tourism Data
		Training opportunity on built environment and working to increase physical activity with multi-sector community representatives	Training documentation	
Enhance parks and recreation built environment and policies to improve access to physical activity in the Panhandle	Local government, community parks & rec, community centers, schools, public health, community-spirited citizens, Historical main street, chambers of commerce, economic development, community planning teams	Participation in community planning team or initiation of multi-sector comprehensive community planning process with key community partners	Planning documents, meeting minutes, planning and design documentation towards conducive built environment	Panhandle BRFSS Trend Data, County Health Rankings, YRBS, Economic Development and Tourism Data
		Training opportunity on built environment and working to increase physical activity with multi-sector community representatives	Training documentation	
Enhance worksite and healthcare supports for physical activity	Worksite wellness, public health, local providers, chambers of commerce	Environmental facility assessment of policies and environmental supports to increase physical activity	Assessment findings, policy adoption, environmental supports, HRA outcomes	Panhandle BRFSS Trend Data, County Health Rankings
		Partner with worksite wellness to provide an informational overview to area employers on model practices to increase physical activity	# of attendees, training survey, # of worksites implementing policies, systems, and environments to increase physical activity	

PRIORITY AREA: Breastfeeding

<table>
<tr><td colspan="5">Obesity and chronic diseases – such as cancer, diabetes, heart disease and stroke – are among the most common, costly, and preventable of all health problems in Nebraska and throughout the United States.
A healthy diet, physical activity, <u>breastfeeding</u>, and maintaining healthy body weight all significantly contribute to preventing obesity and chronic disease. – Nebraska Physical Activity and Nutrition State Plan 2011-2016</td></tr>
<tr><td colspan="5">Contributing FACTORS to Breastfeeding (including social determinants): Breastfeeding success is determined in part by the desire of the mother, but it is also influenced by her hospital care experience, workplace support, community resources, and friends and family.</td></tr>
<tr><td colspan="5"><u>Three Year GOAL for Improvement</u> (written as a SMART objective):
Work in concerted effort with local and regional partners to implement policy, systems, and environmental supports to increase the breastfeeding initiation (ever breastfed 80.8), duration (6 months 53.8, 12 months 22.3), and exclusivity (3 months 48.6, 6 months 21.4) overall by 3% by 2017. Baseline measures - 2013 CDC Breastfeeding Report Card</td></tr>
<tr><th>Strategies to Achieve Goal</th><th>Specific Partners and Roles for each Strategy</th><th>Specific Actions to Achieve Strategies</th><th>Specific 3-year Process Measure(s) for Each Strategy</th><th>Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)</th></tr>
<tr><td rowspan="2">Increase support for breastfeeding in the workplace</td><td rowspan="2">Panhandle Worksite Wellness Council, chamber of commerce, local HR groups, local lactation consultants</td><td>Partner with Panhandle Worksite Wellness Council and Chamber of Commerce to hold an informational overview to area worksites.</td><td>Number of attendees, pre and post surveys, 6-month follow up survey with attendees, # of worksites implementing policies, systems, or environmental supports for breastfeeding in the workplace</td><td rowspan="2">BRFSS data, WW Annual Survey (regional), WW Annual Survey (statewide), CDC Breastfeeding Report Card</td></tr>
<tr><td>Assure organization provides necessary supports for internal employees to continue breastfeeding in accordance with FLSA.</td><td>Documentation of internal supports and policy adoption.</td></tr>
<tr><td rowspan="2">Increase numbers of peer and professional support programs/provid ers</td><td rowspan="2">local providers, WCHR, CAPWN, HFA, local pediatric providers, family physicians, WIC, prenatal classes</td><td>Increase access to lactation consultants by assessing current access, determining partnering/sharing opportunities, training and educational supports.</td><td>Assessment findings, # of IBCLCs per 1000 live births, trainings offered</td><td rowspan="2">CDC Breastfeeding Report Card, State WIC Program</td></tr>
<tr><td>Increase # of WIC peer counselors.</td><td># of WIC peer counselors and accessibility to community</td></tr>
<tr><td>Increase numbers of hospitals providing maternity care practices supportive of breastfeeding</td><td>Local providers, pediatric providers, family physicians</td><td>Begin assessment and implementation for baby-friendly hospital initiative in accordance with WHO standards</td><td># of baby-friendly hospital initiative steps complete, % of live births occurring at Baby-Friendly Facilities</td><td>mPINC Survey, National Immunization Survey, CDC Breastfeeding Report Card</td></tr>
<tr><td rowspan="2">Increase public acceptance and support of breastfeeding</td><td rowspan="2">Local lactation consultants, marketing/communications departments, MOPs, Northwest Community Action Head Start, HFA, WCHR, CAPWN, daycares, prenatal classes, Panhandle Worksite Wellness Council, RNHN, WIC, local BF groups</td><td>Awareness campaign positively portraying breastfeeding coupled with World Breastfeeding Week.</td><td>News release, # of organizations working directly with pre/post/peri natal mothers and families.</td><td rowspan="2">CDC Breastfeeding Report Card</td></tr>
<tr><td>Feature successful worksites providing supports for breastfeeding mothers, feature area community resources for breastfeeding supports</td><td>Campaign coverage and each</td></tr>
</table>

PRIORITY AREA: Cancer Prevention

Determinants: Lack of health care coverage and low socioeconomic status based on income, education level, occupation, social status in the community and geographic location. Also prevalence of risk factors (tobacco use, physical inactivityk obesity and excessive alcohol use).

Three Year GOAL for Improvement (written as a SMART objective):
Reduce adults who are current cigarette smokers baseline of 19.5 PPHD, 20.9 SB) by 10% (HP2020 12%) and reduce the adolescents who smoked cigarettes in the past 30 days by 10%. (HP2020 16%). Base line 26% 12th, 13.6% 10th, 7.4 % 8th.

Strategies to Achieve Goal	Specific Partners and Roles for each Strategy	Specific Actions to Achieve Strategies	Specific 3-year Process Measure(s) for Each Strategy	Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Support comprehensive tobacco free and other evidence-based tobacco control policies	Hospital, business, schools, city government, public health	Promote tobacco free campuses, and outdoor areas in the community	Number of tobacco free campuses in community Number of tobacco free outdoor areas in the community	Monitor BRFSS and NRPFSS
Reduce underage access to tobacco	Hospital, public health, Region 1 Behavioral Health, Retail liquor outlet employees	Provide use of tele-health equipment and proctor if needed	Request scheduled trainings from Faith Mills at Region 1 Track number of trainings held and attendees	Monitor BRFSS and NRPFSS
Clinician counseling and interventions to prevent tobacco use and tobacco caused disease in adults	Hospital, physicians,	Clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products	Monitor EMR reporting Monitor number of Quit Line calls from area	Monitor BRFSS and NRPFSS

Mental & Emotional Well-Being Implementation Plan

Determinants: Race, ethnicity, gender, age, income level, education level, sexual orientation, geographic location, social conditions such as interpersonal, family, and community dynamics, housing quality, social support, employment opportunities and work and school.

<u>Three Year GOAL for Improvement</u> (written as a SMART objective):

1. **Increase the quality of life for all ages and reduce child abuse and neglect rates by 2% annually by working through the PPHHS system of care for youth. Baseline for 2012 in CWB report.**

Strategies to Achieve Goal	Specific Partners and Roles for each Strategy	Specific Actions to Achieve Strategies	Specific 3-year Process Measure(s) for Each Strategy	Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Increase referrals to evidence base home visitation services for families with high stressors	Physician clinics, WIC providers, nurses, immunization clinics, schools, public health	Establish referral process to Healthy Families America, Six Pence or Early Head Start	Track referrals, sign ups and retention	Annual reconciliation of data compared to substantiated child abuse cases
Provide individuals and families with the support needed to maintain positive mental and emotional wellbeing	Schools, hospital, civic organizations, business, faith community, public health	Provide space, referrals and financial support for up to two Circle of Security Parenting Classes lasting 8 weeks	Referral process established and space provided Support given to provide for facilitator of COS course, either by staff becoming trained or paying for a trained facilitator	Annual reconciliation of data compared to substantiated child abuse cases
Provide individuals and families with the support needed to maintain positive mental and emotional wellbeing	Schools, hospital, civic organizations, business, faith community, public health	Enhance community education of the effects of adverse childhood experiences	Number of residents hearing the message of ACES Completion of ACES CME	Annual reconciliation of data compared to substantiated child abuse cases

<u>Three Year GOAL for Improvement</u> (written as a SMART objective):

1. **Decrease the percentage of adults who report that their mental health (including stress, depression, and emotional problems) was not good 10 or more of the last 30 days by 2%. Base line in BRFSS 2012.**

Strategies to Achieve Goal	Specific Partners and Roles for each Strategy	Specific Actions to Achieve Strategies	Specific 3-year Process Measure(s) for Each Strategy	Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Facilitate social connectedness and community engagement across the lifespan	Schools, hospital, civic organizations, business, faith community, public health	Provide an array of youth leadership programs which promote service learning and community generosity	Number of students involved in the health professions program, tracking minority, gender, and other demographic information	Monitoring the annual BRFSS data for the Panhandle.
Promote early identification of mental health needs and access to quality mental health services	Schools, hospital, civic organizations, business, faith community, public health	Allow community members to connect to task force via tele-health Assist in promotion of the task force and walk	Number of meetings held and number of participants at each location Number of walks held and number of participants at each location	Monitoring the annual BRFSS data for the Panhandle.
Promote early identification of mental health needs and access to quality mental health services	primary care physicians, ER's, home-visiting	Provide screenings and brief interventions	Train providers Track utilization numbers	Monitoring the annual BRFSS data for the Panhandle.

Injury & Violence Prevention Implementation Plan

Determinants: Physical environment, individual behaviors, access to services and social environment such as social norms, social relationships, cohesion of the community, cultural beliefs, attitudes, incentives and disincentives, laws and regulations.

Three Year GOAL for Improvement (written as a SMART objective):

1. **Reduce fatal injuries from Motor vehicle crashes by 10%. Base line for 2007-2012 is 89 or 17.10 crude rate per 100,000 population. (HP2020 12.4 per 100,000)**

Strategies to Achieve Goal	Specific Partners and Roles for each Strategy	Specific Actions to Achieve Strategies	Specific 3-year Process Measure(s) for Each Strategy	Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Implement and strengthen policies and program to enhance transportation safety	Schools, hospital, civic organizations, business, faith community, public health	Provide child Safety Seat program and installation checks	Number of car safety seat checks completed	Monitoring the annual BRFSS data for the Panhandle.
Responsible Beverage Server Training using tele-health network to assure regional coverage at reduce cost	Hospital, public health, Region 1 Behavioral Health, Retail liquor outlet employees	Provide use of tele-health equipment and proctor if needed	Track number of trainings held and attendees	Monitor success rate of compliance checks
Community campaigns to educate youth about distracted driving (cell phones & texting)	Hospital, public health, schools, media	Use local media to message about distracted driving	Intensity and type of media used	Monitor crude death rates for Motor vehicle crashes

Three Year GOAL for Improvement (written as a SMART objective):

1. **Reduce the deaths due to fall injury by 10% by December 31, 2020. Baseline for 2007-2012 is 58 or 11.14 crude rate per 100,000 population. (HP2020 7.0% per 100,000)**

Strategies to Achieve Goal	Specific Partners and Roles for each Strategy	Specific Actions to Achieve Strategies	Specific 3-year Process Measure(s) for Each Strategy	Specific 3-year Outcome Measures for Strategies (should align with SMART Goal for Health Issue)
Promote and strengthen policies and programs to prevent falls, especially among older adults	Hospital, EMS, faith community, public health	Provide medication reviews for seniors	Number of reviews completed	Reduce the number of injuries from falls among all persons.
		Senior fitness and exercise programs including Tai Chi	Number of participants and their longevity in the program	
Promote and strengthen policies and programs to prevent falls, especially among older adults	Hospital, EMS, faith community, public health	Home Safety Inspections and adaptations	Number of inspections completed	Reduce the number of injuries from falls among all persons.
		Senior fall risk screening information and referral for assessments	Number of screenings completed	

Appendix

Appendix A: Forces of Change Assessment

What factors, trends, and events are or will be influencing the health and safety in our Panhandle community and or the work of the Public Health System?									
Prevention Funding Decreasing	**Chronic Disease**	**Injury and Violence Prevention**	**Access**	**Demographics**	**Policy Decisions Affecting the Cost of Care**	**Societal Mentality**	**Economy**	**Making the Easy Choice Healthy**	**Political Unrest**
• Prevention funding decreasing	• Childhood obesity and diabetes mellitus • Increased electronics = decreased activity • Increase in chronic disease, obesity, diabetes, heart disease	• Legalization of marijuana increases crime rate • Increase in drug use (Colorado legalizes drug use) • Child safety concerns • Increase in child abuse • Food safety • Increase in distracted driving	• Need more access to patient education and support • New additions to healthcare facilities • Mental health access • Transitioning elderly into long-term care, access • Far distance, frontier community	• Aging population • High number of children in poverty • Young people leaving • Minority/language cultural • Far distance, frontier community • Declining and more transient population • Cheyenne County growing population, meeting needs	• Wellness in Nebraska Act • Nebraska not expanding Medicaid • Reducing Critical Access Hospital (CAH) legislation (within 15-30 miles) • Sky-rocketing costs to provide healthcare • Confusion on healthcare insurance rates and ratings • Increased deductibles, increased out of pocket, insurance changes • Aging population and diminishing resources through Medicare • Healthcare reform, Medicaid expansion, ACA • Reduction of CAH-cost reimbursement decreases	• Faith-based services decreasing • Personal accountability, who is responsible? • Instant gratification culture • Change in family and community structure • Ease of access to social government support • Wellness readiness – lack of community acceptance	• Middle class being squeezed • Depressed economy (nationally and in Nebraska) • Lack of quality jobs • Economic development • Climate – fires, drought, wind • Education issues	• Food industry making small steps, NuVal • Increased focus for active lifestyle • Bountiful baskets	• Elected officials quick to change, turnover • Political climate is challenging

Appendix B: Focus Group Summary

Chadron Community Hospital hosted and facilitated four focus groups for residents of the service area in June and early July 2014. The focus groups represented the Chadron community in general, the Hay Springs community, the Native American community and the Marshall Island's children community. The following is a summary of the discussions:

Factors contributing to quality of life (Strengths)

Friendly, safe and welcoming - Participants cited that it is a welcoming community and the right size town to raise children. People feel safe and comfortable and most people are kind. Some had lived in bigger cities but prefer this area. You know everyone and people are willing to help out. Professionals that grew up here are returning to work and raise families. The college town keeps it geared toward young people. It is such a beautiful area.

- Hay Springs – Nice quiet and safe community with a low crime rate and good school. Hay Springs has tremendous community support with fundraisers for those in need. Some are returning to raise their family.

Collaborative culture –Everyone works together so well, the hospital, schools, police, college, parents.

Health care services– Most who participated receive their health care locally but do go to Scottsbluff and Rapid City for specialty or OB care. The access to specialty clinics locally is really appreciated. Access to dental care for low income is a strength. Mental health services are now available over tele health. Good mental health services for high school kids. There is a variety of resources. The prescription drug assistance program, and vision USA are very helpful. Having dialysis locally is very good. Legend Buttes Health Services was identified as strength with kind staff.

- Hay Springs – the clinic is appreciated and there is usually opening available when needed. There is strong community support for the nursing home and school children often go and perform or just visit. The fire/ambulance service is good

Employment opportunities and local commerce – Most jobs are lower to middle class – our income level keeps us humble. The group felt there were adequate job opportunities. Technology is making a difference. Industry is growing the new grain elevator an example.

- Hay Springs – Ag is the economic base. Farm sizes are getting larger and fewer people are needed to do the work. The chamber of commerce is active, more so than in a lot of other communities. Even with a stagnant economy, businesses have established roots and have stayed. The Community is supportive and buy locally.

School system – Teammates, the after school program, upward bound, and summer school program are all very positive. In the new future, all the school will have the same days off which will benefit the whole community.

- Hay Springs School – great community support and good following at events. The school is hosting a Hay springs Youth Program website that any community youth group/activity can use. The school distributes their newsletter to everyone in the community. There is a 15-17% increase in school enrollment in 2013-2014.

Civic support and engagement –. There are functions nearly every weekend. The masonic temple offers free lunches.

- Hay Springs – Friendly festival is the 3rd week in August. There are a lot of youth activities, especially church youth activities.

Acceptance of differences – Participants felt that the community was accepting but acknowledged there were race gaps, Native Americans are looked at differently. The Native American group felt there is an interest in working with them and learning from them. Participants noted that even when people are at different levels, we are down to earth and live in the same community. There are language barriers with the Marshallese people. Some churches have taken international students under their wings.

Factors reducing quality of life (Weaknesses)

- Hay Springs – The population has dropped 25-30% in 15 years. Participants felt there is a lack of leadership for the community. Concerns were expressed about the city water well-functioning at 40%. It was noted that it is primarily a retirement community. Could be friendlier and open to outsiders. Feels like a ghost town at night. There currently no law enforcement officer or agreement with Sheriff to provide coverage.

Transportation – additional transportation options or gas vouchers is needed.

- Hay Springs – identified transportation as a need.

Employment opportunities and local commerce – There have been a lot of little businesses lost; it is hard to compete with Walmart. It was noted that the prices at the Chadron Walmart are often higher than other Walmart because there is no competition. Participants felt that there is a lack of work ethic to put in the time to work up to higher paying jobs. There is too much of an instant gratification expectation and less pride in their work. It was also noted that people skills are lacking. We have an elderly population.

- Hay Springs – There is little employment opportunities, basically the nursing home, bank, NWPPD, and school.

Housing – Housing prices are high with plenty of houses to purchase but not to rent. Financing for home purchasing is hard.

- Hay Springs – Housing and rental availability is a worsening problem.

Health care services – There are significant clinic wait times periodically. Clinic visits cost more than it used to and participants felt that there was inconsistency in charges. The home town pharmacy is perceived more expensive. An urgent care clinic would be a plus. The dental care for low income is great, but more is needed. It would be so nice if medical information followed you were ever you went. Native people have a problem getting reimbursed for use of the Nebraska System.

- Hay Springs – Most participants sought health care locally, or in Chadron, Gordon, Rushville, Scottsbluff, Rapid City or the IHS. As a veteran it would be nice to receive care at home instead of having to drive. Often it is just as easy to go to the Chadron clinic because the appointments are full at the Hay Springs clinic and you have to wait for lab results to go back to Chadron anyway. It would be nice to have a school nurse. There is a need to provide help for elders at home who aren't in need of the nursing home yet.

School – More hands on education rather than book learning like apprentice type programs. Cultural knowledge in schools is needed K-12. Need more interaction with family with school connections like a school social worker.

Child care – Child care was identified as a need in the summer for older children.

Awareness of services available - A need that was identified is more understanding of what services are available and ways to get that information to the people who need it. It is common not to know where to go for resources.

- Hay Springs – identified Meals on Wheels and balanced meals as a need.

Social activities – There is a lack of activities for middle school age youth. If you are not into sports, what do you do? The movie theatre doesn't always have a "child appropriate" movie running. It was perceived that kids don't interact with each other or play outside anymore.

Civic support and engagement - volunteerism seems to be down at the Fur trade museum.

- Hay Springs – Same people run everything and burn out. Fewer people are attending church.

Acceptance of differences – participants identified racism as a problem. When there is bullying happening and not dealt with families move back to the reservation. There is even disrespect between generations in the community. The border towns seem to be worse than others.

- Hay Springs – Participants felt that there are people with pre-conceived opinions about others and they may not feel accepted, there needs to be more wiliness to give outsiders a change. The small town rumor mill is at work. There is a shunning of Native Americans and African Americans. Cultural competency training is needed for the community.

Appendix C: CCH Stakeholder Meeting Work Product

Practical Vision: What do we want to see in place in 3-5 years as a result of our actions?								
Community Beautification	Efficient Physical Connections	Active Outdoor Living	Year Round Tourism Destination	Thriving, Diverse Business Recruitment and Retention	Enhanced Involved Community	A Culture of Wellness	Advanced Technology and Infrastructure	Improved Agricultural Opportunities
• Beautification Landscaping • Clean towns, streets, yards • Curb appeal • Downtown revitalization • Highway 20, 2016 • College green space • City and CSC working on joint projects • Well landscaped and maintained Highway 20 corridor	• Heartland Express • Heartland Express 4 lane • Transportation System • Medical local with no cross county limitations for ambulance service • Heartland Expressway north of Chadron to South Dakota state line • Bike lanes • Safe routes built • Expand current transportation system (hours and routes) • Consistent and reliable air service	• Improved recreation opportunities • People outside, active and communicating • Outdoor recreation • Recreation development trails, multi-use • Better places to walk • Chadron State Park Plan • Clean up from fire • Sidewalk expansion and improvement • Well maintained public land trail system • Comprehensive non-motorized municipal transport system • Wilson Park Frisbee course • Implemented Memorial Park Plan • Connect Chadron to National Forest (south) • Pool complex heated by biomass	• Package Tourism – Connect Chadron, Crawford, Ft. Robinson, County Fair • Tourism –heritage, Native American, historical, Agro – "City Slickers", recreational • Historical Resort – Interpretation Center • New Game and Parks District with our own Commissioner • Lower fees charged by Nebraska G&P • Art Industry Festival • Conference Retreat Center • Restore historical downtowns • Birding, biking • Railroad history • Chadron Community 5K, 10K, etc. • Motels • Restaurants • Joint activities between city, county, CAB and Galaxy Series • Joint use of athletic facilities between CSC and CPS • Promote historical tourism	• Community acceptance of large industry • Industrial park • Business recruitment team, capital investors • 100 + workers round house • Retain 50-60% CSC graduates • Affordable housing • tax incentives to keep residences and business • Worksite wellness attract quality staff, • Art industry festival • Housing shortage • Green jobs • Training for the trades • No empty buildings on Main Street • Museum of Fur Trade Community involvement • "Maker Spaces" for rent • Solar voltaic farm or garden built • Digital "Maker Spaces" • What grads are we trying to retain and then grow business to match	• More community involvement • Recognize challenges work together, no politics • Community center holistic • Quality care and education for children • Personal freedoms restored • Better housing inventory • Library imaging living room of the community • Original sustainable Native American culture • Expanded early education/day care • Online all event county calendar • Reduce Dawes County poverty level • Meals expansion for low income and homeless • Increased voter turnout	• Community Center • Healthy food • Healthy choice is the easy choice • Coordinated wellness planning and implementation • Expanded health care • Radon awareness, testing, mitigation • Swimming pool • Organized recreation for aging • New swimming pool development • More use of local food • Helath and wellness retreat center • Certified pilates teacher • Resource listing availability (AA, NA, weight loss support groups)	• Broadband telework • Modern technology – market area – education • Alternative energy, wind, biomass, solar • Alternative energy jobs • Broad band internet including rural area • Rural phone service • Green and Tech jobs • Community support for infrastructure investment – sidewalks, streets, pool/communit y center, wellness equipment, speculative business park • Active senior housing built	• Support to/for agriculture industry • Develop local food production • Rangeland Lab at CSC • FFA partnership with college • Steam heating from college to community • Using biomass

Appendix D: Local Public Health System Assessment

The Local Public Health System Assessment, designed by National Public Health Performance Standards Program, measures the ten essential public health services. During the 2011 Assessment, forty persons attended the meeting which used a power point presentation of the questions and a clicker voting method to complete the assessment. All ten public health services were considered.

During the 2014 assessment, we focused on Essential Service #4 because it is critical to the Public Health System identified in 2012 for collective impact. The assessment was conducted during the Panhandle Partnership for Health and Human Services membership meeting on April 4, 2014. There were over 30 people in attendance representing a wide array of organizations.

The assessment consists of the following areas:

Essential Service #4: Mobilize Community Partnerships to Identify and Solve Health Problems

This service includes:

- Identifying potential stakeholders who contribute to or benefit from public health and increase their awareness of the value of public health.
- Building coalitions and working with existing coalitions to draw upon the full range of potential human and material resources to improve community health.
- Convening and facilitating partnerships and strategic alliances among groups and associations (including those not typically considered to be health-related) in undertaking defined health improvement activities, including preventive, screening, rehabilitation, and support programs, and establishing the social and economic conditions for long-term health.

LPHS Model Standard 4.1: Constituency Development

Constituents of the LPHS include all persons and organizations that directly contribute to or benefit from public health. Constituents may include members of the public served by the local public health system (LPHS), the governmental bodies it represents, and other health, environmental, and non-health-related organizations in the community. Constituency development is the process of establishing collaborative relationships among the LPHS and all current and potential stakeholders. As part of constituency development activities, the LPHS develops and operationalizes a communications strategy designed to educate the community about the benefits of public health and the role of the LPHS in improving community health. The LPHS operationalizes the communications strategy through formal and informal community networks, which may include businesses, schools, healthcare organizations, the faith community, and community associations.

For effective constituency development, the LPHS:

- Has a process to identify key constituents for population-based health in general and for specific health concerns (e.g., a particular health theme, disease, risk factor, life stage need).
- Encourages the participation of its constituents in community health activities, such as in identifying community issues and themes and engaging in volunteer public health activities.
- Establishes and maintains a comprehensive directory of community organizations.
- Uses broad-based communication strategies to strengthen linkages among LPHS organizations and to provide current information about public health services and issues.

LPHS Model Standard 4.2: Community Partnerships

Community partnerships and strategic alliances describe a continuum of relationships that foster the sharing of resources and accountability in undertaking community health improvement. Public health departments may convene or facilitate the collaborative process. The multiple levels of relationships among public, private, or nonprofit institutions have been described as 1) *networking*, exchanging information for mutual benefit; 2) *coordination*,

exchanging information and altering activities for mutual benefit and to achieve a common purpose; 3) *cooperation*, exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose; and 4) *collaboration*, exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose. Multi-sector collaboration is thus defined as a voluntary strategic alliance of public, private, and nonprofit organizations to enhance each other's capacity to achieve a common purpose by sharing risks, responsibilities, resources, and rewards.

Multi-sector partnerships such as community health improvement committees (community committees) exist in some communities as formally constituted bodies (e.g., a community health planning council) while in other communities they are less formal groups. The community committee is a dynamic collaboration designed to be comprehensive and inclusive in its membership and its approach to community health improvement.

To accomplish this, the LPHS:

- Establishes community partnerships and strategic alliances to assure a comprehensive approach to improving health in the community.
- Assures the establishment of a broad-based community health improvement committee.
- Assesses the effectiveness of community partnerships and strategic alliances in improving community health.

Assessment Results

In the following table the 2011 scores are indicated by a dot and the 2014 scores by an X. All but 3 areas were reviewed as holding steady or improved. Two of the areas that scored lower had to do with a communication strategy. It was recognized that even though the Panhandle is well known for its collaborate culture, there are some that are not aware of the Panhandle Partnership for Health and Human Services, which is a broad based collaborative with the ultimately goal of collective impact. The other area scoring lower is a broad representation of the community. Those present felt that often the people receiving services are not represented.

Essential Service #4: ***Mobilize community partnerships to identify and solve health problems*** 2011: • 2014: X	No	Minimal	Moderate	Significant	Optimal
Does the local public health system have a process for identifying key constituents or stakeholders?				•	X
Does the local public health system maintain a current list of the names and contact information for individuals and key constituent groups?			•		X
Are new individuals/groups identified for constituency building?			•		X
Are key constituents identified for general health issues (i.e. improved health and quality of life at the community level)?			•		X
Are key constituents identified for specific health concerns (i.e. a particular health theme, disease, risk factor, life stage need)?			•	•	x
Does the local public health system encourage the participation of constituents in improving community health?				•x	
Does the local public health system encourage constituents from the community-at-large to identify community issues and themes through a variety of means?			•		x

Essential Service #4: ***Mobilize community partnerships to identify and solve health problems*** 2011: • 2014: X	No	Minimal	Moderate	Significant	Optimal
Does the local public health system support, through recruitment, promotion and retention, opportunities for volunteers to help in community health improvement projects or activities?				•	X
Does the local public health system maintain a current directory of organizations that comprise the local public health system?				•	x
Is the directory easily accessible?			•	x	
Does the local public health system use communications strategies to build awareness of the importance of public health?				•x	
Do communications strategies exist for building awareness with the community at large?'			X	•	
Do communications strategies exist for facilitating communication among organizations?			X	•	
Do partnerships exist in the community to maximize public health improvement activities?				•x	
Do organizations within these partnerships exchange information?				•x	
Do organizations within these partnerships alter or align activities related to the Essential Public Health Services?				•x	
Do organizations within these partnerships conduct collaborative decision-Omaking and action?				•x	
Do organizations within these partnerships optimize resources to deliver Essential Public Health Services?				•	x
Do organizations within these partnerships share responsibilities to deliver Essential Public Health Services?				•x	
Do organizations within these partnerships include a broad representation of the community?		x		•	
Does the local public health system have a broad-based community health improvement committee?			•		x
Does this partnership participate in the community health assessment process?				•	x
Does this partnership participate in the implementation of a community health improvement process?				•	x
Does this partnership monitor and evaluate progress toward prioritized goals?			•	•x	
Does this partnership monitor and evaluate progress toward prioritized goals?			•	•x	
Does this partnership leverage community resources?				•x	
Does this partnership meet on a regular basis?				•	x
Does the local public health system review the effectiveness of community partnerships and strategic alliances developed to improve community health?			•	x	
Does the review include an assessment of the effectiveness of partnership participation in solving health problems?			•	x	

Essential Service #4: ***Mobilize community partnerships to identify and solve health problems*** 2011: • 2014: X	No	Minimal	Moderate	Significant	Optimal
Does the review include information on the satisfaction of constituents with partnership efforts?		•		x	
Does the review include an assessment of the expertise and system capacity needed to conduct partnership building activities?		•			
Does the review include identification of actions to improve the partnership process and capacity?		•		x	
Does the review include implementation of actions recommended to improve the partnership process and capacity?		•		x	