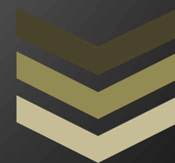
Community Health Assessment



Nebraska Panhandle

Panhandle Public Health District, Scottsbluff County Health Department, Panhandle Partnership for Health and Human Services, Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Kimball Health Services, Morrill County Community Hospital, Regional West Garden County, Regional West Medical Center, Sidney Regional Medical Center

2014

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Table of Contents

Introduction 1

Mobilizing for Action through Planning and Partnerships 1

- Organization 2
- Local Public Health System Collaborative Infrastructure 2
- Visioning 2
- MAPP Assessments 3

Community Health Status Assessment 4

- Economic and Demographic Data 4
  - Overview 4
  - Nebraska Panhandle 6
  - Population 7
  - Race 13
  - Economy 15
    - Employment and Workforce 15
    - Educational Attainment 17
    - Income 17
    - Poverty 19
    - Family Type 21
    - Poverty by Family Type 22
- Health Data 24
  - Overview 24
  - Health Status 25
  - Behavioral Risk Factor Surveillance System 25
  - Health Disparity 27
  - Youth Risk Factors 31
  - Injury and Violence 32
  - Child Well Being 33
  - Adverse Childhood Experiences 34
  - County Health Rankings 38
- 2014 Stakeholder Meeting 41

Forces of Change Assessment 43

- Methodology 43
- Results 43

Local Public Health System Assessment 44

Community Themes and Strengths Assessment 49

- Introduction 49

Methodology ... 49
Summary of Themes ... 50
Comparison to 2011 Focus Groups ... 53
Conclusion ... 54

Prioritization Process ... 55

References ... 57

Appendices ... 58

Appendix A: Panhandle Partnership for Health & Human Services Members ... 59
Appendix B: 2011 Visioning Work Product ... 60
Appendix C: Forces of Change Worksheet ... 61
Appendix D: 2014 Forces of Change Assessment Work Product ... 62
Appendix E: Focus Group Instructions and Invitation Template ... 63
Appendix F: Focus Group Guide for Community Themes and Strengths ... 64
Appendix G: Dates of Hospital Prioritization Meetings ... 66
Appendix H: Prioritization Worksheet Template ... 67

List of Figures

Figure 1: Nebraska Population, 1930-2010 ... 7

Figure 2: Panhandle Population, 1930-2010 ... 7

Figure 3: Metropolitan County Share of Nebraska Population, 1890-2010 ... 8

Figure 4: Panhandle Population Consolidation, 1910-2010 ... 9

Figure 5: Panhandle Population Distribution by County, 2010 ... 9

Figure 6: Births, Deaths, and Natural Change for 11 Panhandle Counties, 1946-2012 ... 10

Figure 7: Net Migration Rates for 11 Panhandle Counties, 2000-2010 ... 11

Figure 8: Nebraska Panhandle Population Pyramid, 2010 ... 12

Figure 9: Race composition in the 11 Panhandle Counties, 2012 ... 13

Figure 10: Comparison Between Hispanic/Latino and White Alone Races, Scott Bluff County ... 14

Figure 11: Employed Population by County, 2012 ... 16

Figure 12: Jobs per 100 Persons, 1969-2011 ... 16

Figure 13: Household Income Distribution, Panhandle, 2012 ... 18

Figure 14: Percent Below Poverty by County, 2011 ... 19

Figure 15: Poverty for Children Under 18 years, 2011 ... 20

Figure 16: Family type for 11 Panhandle Counties ... 21

Figure 17: Poverty by Family Type ... 22

Figure18: % of Deaths Caused by the Seven Leading Causes of Death, Panhandle, 2012 ... 24

Figure 19: % of Deaths, Seven Leading Causes of Death, PPHD vs. SBCHD, 2012 ... 24

Figure 20: Percentage of Panhandle Adults with No Health Coverage, By Ethnicity, 2011-2013 ... 27

Figure 21: Percentage of Panhandle Adults with No Health Coverage, By Income, 2011-2013 ... 28

Figure 22: Percentage of Panhandle Adults Who Need to See a Doctor But Could Not Because of Cost, By Race, 2011-2013 ... 28

Figure 23: Percentage of Panhandle Adults Who Need to See a Doctor But Could Not Because of Cost, By Income, 2011-2013 ... 29

Figure 24: Percentage of Adults Who Reported Their General Health as Fair or Poor, By Income, 2011-2013 ... 29

Figure 25: Percentage of Adult Smokers, By Race/Ethnicity, 2011-2013 ... 30

Figure 26: Percentage of Adult Smokers, By Income, 2011-2013 ... 30

Figure 27: Alcohol Use, Binge Drinking and Impaired Driving Among 8th, 10th and 12th Graders in the Panhandle, Trend Data 2003-2012 ... 31

Figure 28: Crude Death Rates Due to Injury per 100,000 Population, Panhandle and State, 2007-2012 ... 32

Figure 29: Crude Death Rates Due to Injury and Violence per 100,000 Population, Panhandle and State, 2007-2012 ... 33
Figure 30: ACE Data from 2011 BRFSS, PPHD and SBCHD ... 37
Figure31: County Health Rankings Model ... 38
Figure 32: Nebraska Health Outcomes Ranking, 2014 ... 39
Figure 33: Nebraska Health Factors Ranking, 2014 ... 39

List of Tables

Table 1: County and Panhandle population and change 2000-2010 ... 9
Table 2: Percent Not Proficient in English, Panhandle Counties, 2012 ... 13
Table 3: Panhandle Foreign Born Rates, 2012 ... 14
Table 4: Unemployment Rates, 2012 ... 15
Table 5: Educational Attainment by Panhandle County, 2012 ... 17
Table 6: Median Income by County, 2011 ... 17
Table 7: Household Income Distribution, 2012 ... 18
Table 8: Household Income, 2012 ... 19
Table 9: Poverty by Race, 2011 ... 20
Table 10: Educational Attainment and Poverty, 2011 ... 21
Table 11: Poverty by Family Type, Counts, 2012 ... 21
Table 12: BRFSS Health Data, PPHD, SBCHD, Panhandle Region and State, 2011-2013 ... 26
Table 13: Child Well Being Indicators, Panhandle Counties, 2012 ... 35
Table 14: County Health Rankings, Panhandle Counties, 2014 ... 40
Table 15: Priority Health Areas, Panhandle Hospitals, 2014-2016 ... 56

Introduction

Panhandle Public Health District (PPHD) and Scotts Bluff County Health Department (SBCHD) collaborated in early 2011 to conduct a comprehensive Nebraska Panhandle Community Health Needs Assessment (CHNA). Due to the new IRS regulations which require tax-exempt hospitals to conduct a CHNA every three years, PPHD facilitated a joint community health needs assessment and planning process with the eight hospitals in the Nebraska Panhandle, all of which are members of the Rural Nebraska Healthcare Network (RNHN) in 2014. This is the first year that PPHD is transitioning into conducting the CHNA every three years instead of every five years to align with the timeline required of tax-exempt hospital organizations by the Internal Revenue Service according to the Patient Protection and Affordable Care Act.

The purpose of the CHNA process is to describe the current health status of the community, identify and prioritize health issues, better understand the range of factors that can impact health and identify assets and resources that can be mobilized to improve the health of the community.

The priority health areas identified in the 2011 Nebraska Panhandle CHNA and addressed in the 2012-2017 Nebraska Panhandle Community Health Improvement Plan (CHIP) are:

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

Mobilizing for Action through Planning and Partnerships (MAPP)

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, was again used to conduct this round of community health needs assessment and community health improvement plan development. 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.

The MAPP process includes two preliminary steps – Organization and Vision.

Organization

Panhandle Public Health District was charged with the leadership of the project. This role included establishing timely schedules, allocation of personnel resources, contracting for additional services, promotion and media relations, and production of templates for each hospital's final report. PPHD's leadership team provided oversight and quality assurance to the process.

A MAPP Steering Committee was formed with representatives from each of the eight Panhandle hospitals. Committee members provided guidance throughout the process and are charged with reviewing data and progress on the chosen priorities, using quality improvement to modify implementation plans as needed, and sharing results with stakeholders.

Local Public Health System Collaborative Infrastructure

The region enjoys a robust, well-established collaborative infrastructure which provided the foundation for the local public health system communication and engagement process. This infrastructure includes:

- Rural Nebraska Healthcare Network (RNHN) which includes all eight hospitals in the region, all Rural Health clinics, and Assisted Living/Nursing Homes that are part of the RNHN member systems. This group includes the Trauma Network.
- Public Health Partnerships including collaborative work groups such as the Panhandle Regional Medical Response System (PRMRS), and Panhandle Worksite Wellness Council as well as the two Public Health Boards of Health, which include elected officials.
- Panhandle Partnership for Health and Human Services (PPHHS) is a large not-for-profit organization which promotes collective impact through planning and partnership. The inclusive membership-based organization has and continues to be an integral part of the regional assessment and planning processes. See Appendix A for list of PPHHS members

Visioning

A formal visioning process was completed on February 4, 2011 as part of the 2011 CHNA process which included forty-one (41) persons from throughout the Panhandle. The group represented a cross-section of the region including: citizens at large, County Commissioners, public health, hospitals/healthcare, faith-based organizations, Area Office on Aging, behavioral health and substance use, schools, youth serving organizations, domestic violence organizations, Area Health Education Center, University Extension, not-for-profit agencies, business/economic development, minority health and emergency medical services.

The group came together to answer the question: "How will we, over the next three to five years, continue to develop and enhance our panhandle community to improve the health and safety for all who live, work, learn and play here?"

The first step in answering that question was to create a practical vision, answering the question: "What do you see in place in three to five years as a result of our actions?" In summary, the answers to the vision questions are:

- *Access to Services: cost and accessibility for medical and dental services, health insurance, distance and number of providers, patient education*
- *Safer Communities: intentional and unintentional injury, abuse, emergency preparedness*

- *Compassionate Integrative Care: treating physical, mental and social aspects, more humanity and interpersonal contact in service provision, prevention*
- *Healthier Eating Environments: community gardens, healthy school lunches and fast food options, obesity prevention*
- *Active Living Opportunities: more options for physical activity, walking trails, obesity prevention, worksite wellness*
- *Decreased Substance Abuse: tobacco use, legal and illegal substance abuse, responsible alcohol use*
- *Policy to Promote Healthy Environments: assure funding, educate policy makers, environmental supports*
- *Quality of Life for all Ages: intergenerational contacts, strengthen families, culture of health*
- *Educated and Informed Community: graduation rates, mental health awareness, affordable college education*

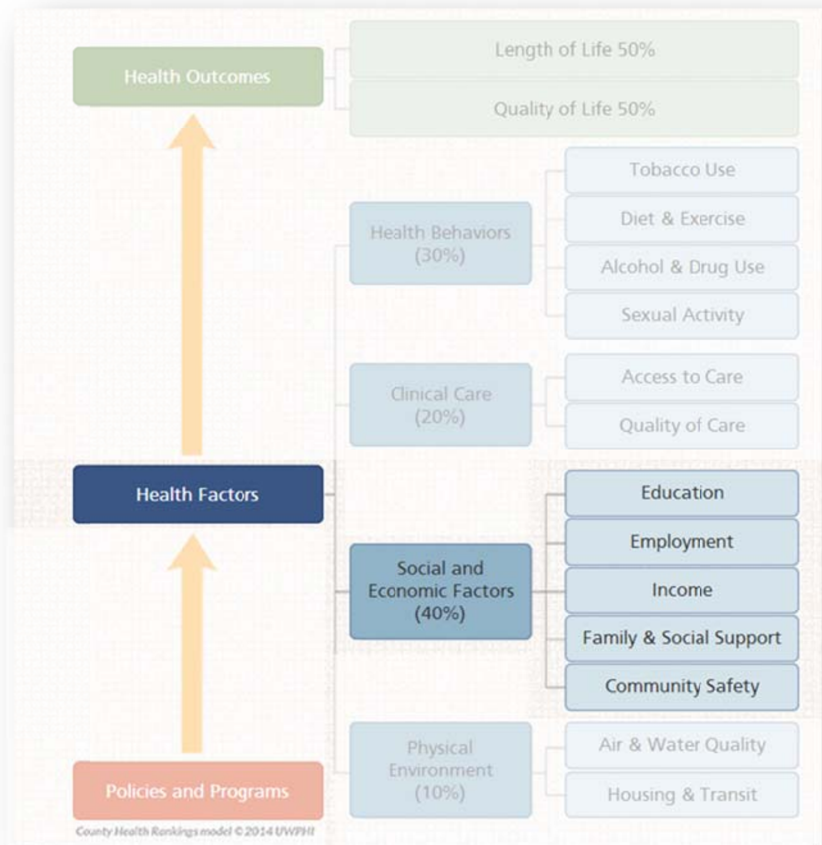
The 2014 MAPP Steering Committee was presented with the work product from the visioning session in 2011 (See Appendix B) on April 3, 2014. The Steering Committee reaffirmed the vision developed in 2011.

MAPP 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 and 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

Community Health Status Assessment
Economic and Demographic 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 is population consolidation from rural areas to larger communities. For the region this means a larger percentage of activity happening in the economic centers and continued outmigration to larger metropolitan areas.

Aging population
Another trend that continues is the general aging of the population through both outmigration of youth and aging of the still large baby boom cohorts. For the region, 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.

Stark social and economic contrasts between minority and majority populations
Hispanic origin and American Indian populations in the Panhandle have much lower median incomes and levels of educational attainment than the majority population (white, non-Hispanic). Attention should be made to promote economic and social parity between different races.

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, large middle class, low comparative wages

Strong agricultural, self-employed, and transportation sectors have kept unemployment low in the Panhandle, with many opportunities existing which do not require high levels of education. These opportunities are reflected in the region's large proportion of households in middle income brackets. However, with a few local exceptions, wages lag behind the state and other nearby markets due to fewer opportunities for high skilled and professional workers. What this means for the region is typically a desire to recruit higher skilled job opportunities and promote entrepreneurship.

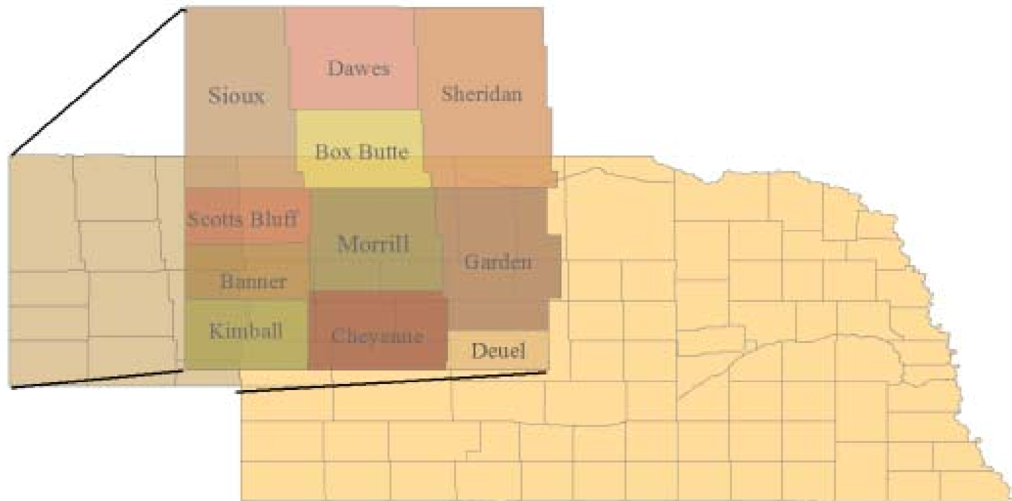
Nebraska Panhandle

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 and 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 11 Panhandle Counties:

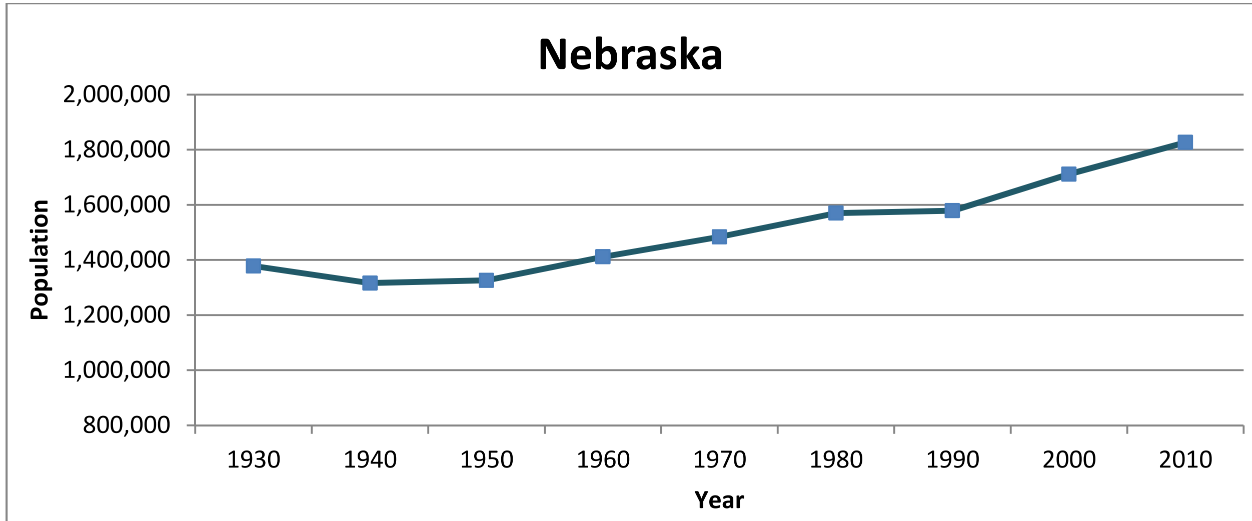
Population (2010)	87,789
Population change (2000-2010)	-2.9%
Incorporated municipalities	35
Unemployment Rate (July 2014)	3.9%
Total Land Area	14,180 sq. miles



Population

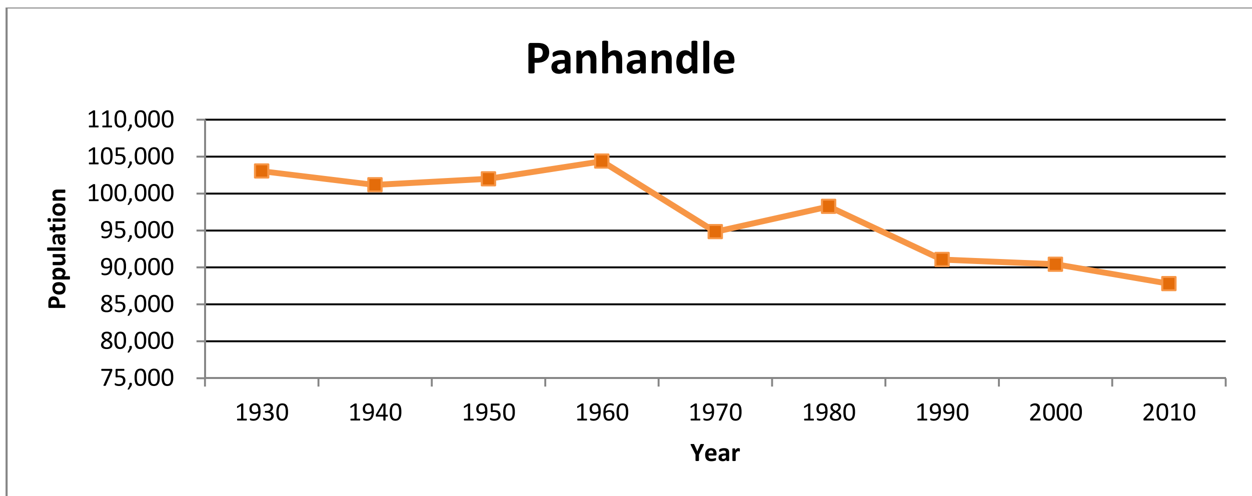
While the population of Nebraska has been slowly but steadily increasing over the past 60 years, the Panhandle's population peaked in the 1960s.   Much of Nebraska's growth can be attributed to the metropolitan areas.

Figure 18: Nebraska Population, 1930-2010



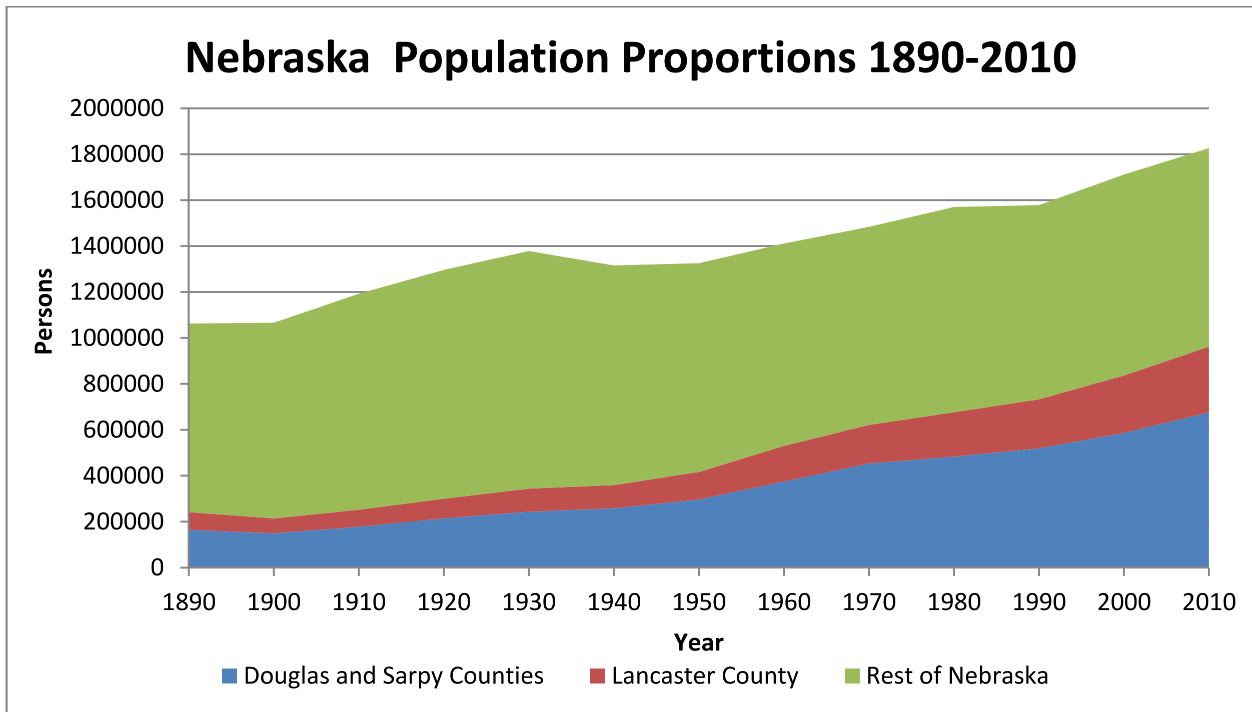
Source: U.S. Census Bureau

Figure 19: Panhandle Population, 1930-2010



Source: U.S. Census Bureau

Figure 20: Metropolitan County Share of Nebraska Population, 1890-2010



Source: U.S. Census Bureau

Figure 3 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

However, population consolidation away from rural areas is not new, is a global phenomenon, and as Figure 4 shows, has also been occurring within our region. The emergence of the service and innovation based economy and decrease of farm employment practically ensures this pattern will continue into the future. For this reason, communities should not undertake frantic efforts to stop population loss but rather measured strategies which aim to steadily improve quality of life and opportunities for their citizens. What the Panhandle 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 21: Panhandle Population Consolidation, 1910-2010

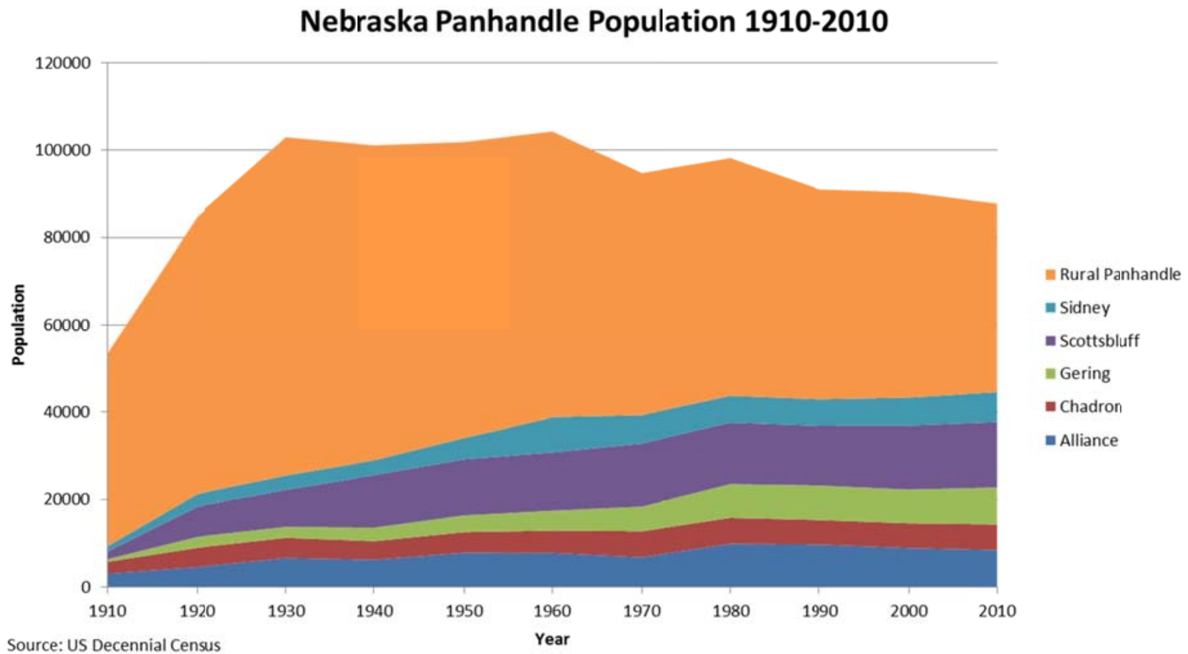


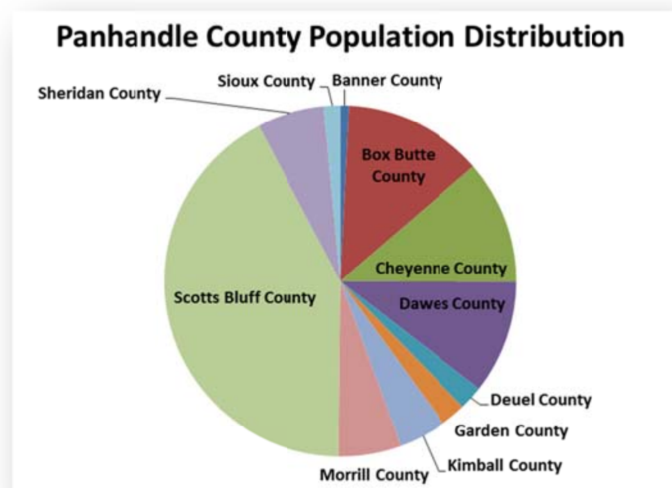
Table 12: County and Panhandle Population and Change, 2000-2010

	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

Source: U.S. Census Bureau, Decennial Census

As Figure 5 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.

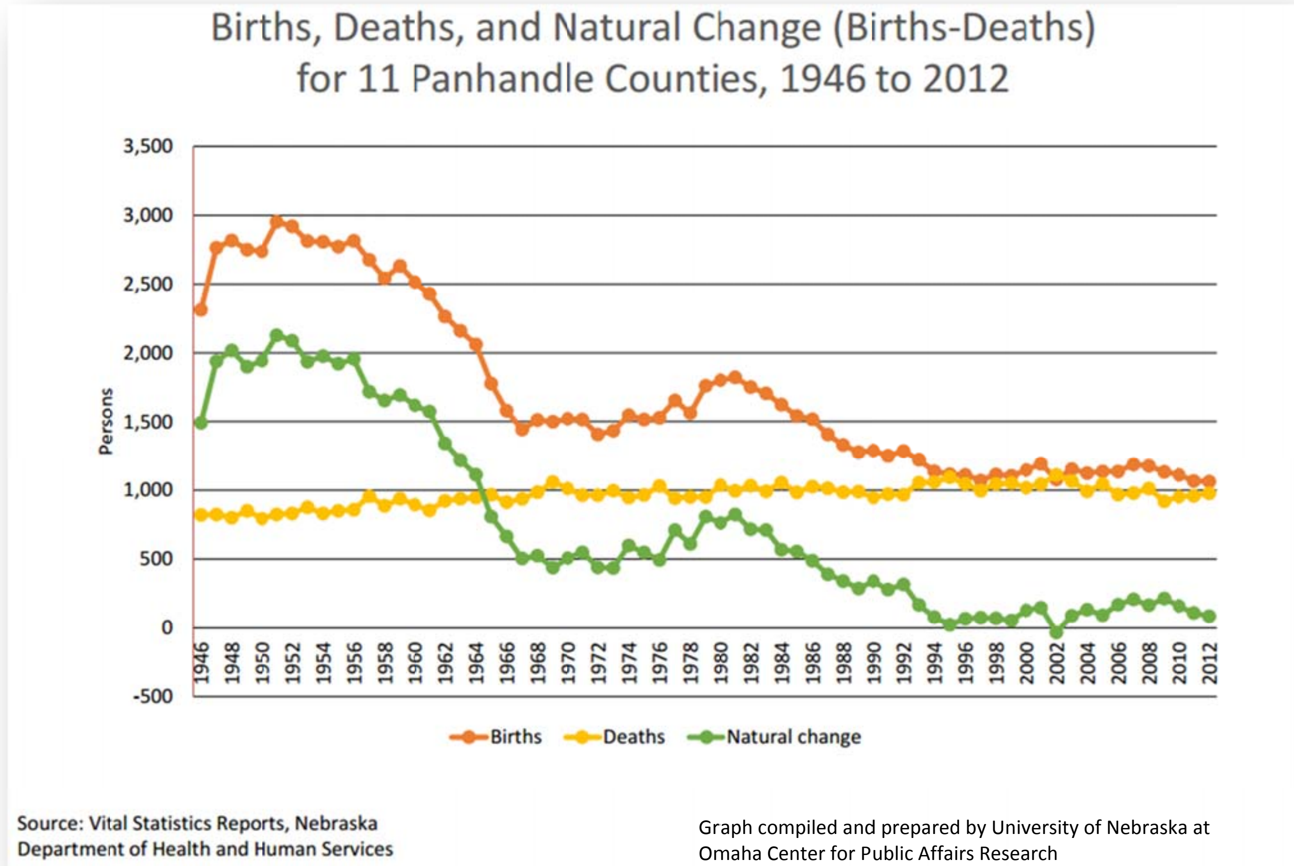
Figure 22: Panhandle Population Distribution by County,



Source: U.S. Census Bureau, 2010 Census

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 23: Births, Deaths, and Natural Change for 11 Panhandle Counties, 1946-2012



Migration patterns show the out-migration for young adults as the economic, educational, and social opportunities of metropolitan and other areas draw them away. Population centers of the Panhandle, such as Chadron, Alliance, and Scottsbluff also have higher in-migration among older generations over 65, but this is usually from rural areas within the Panhandle.

Figure 24: Net Migration Rates for 11 Panhandle Counties, 2000-2010

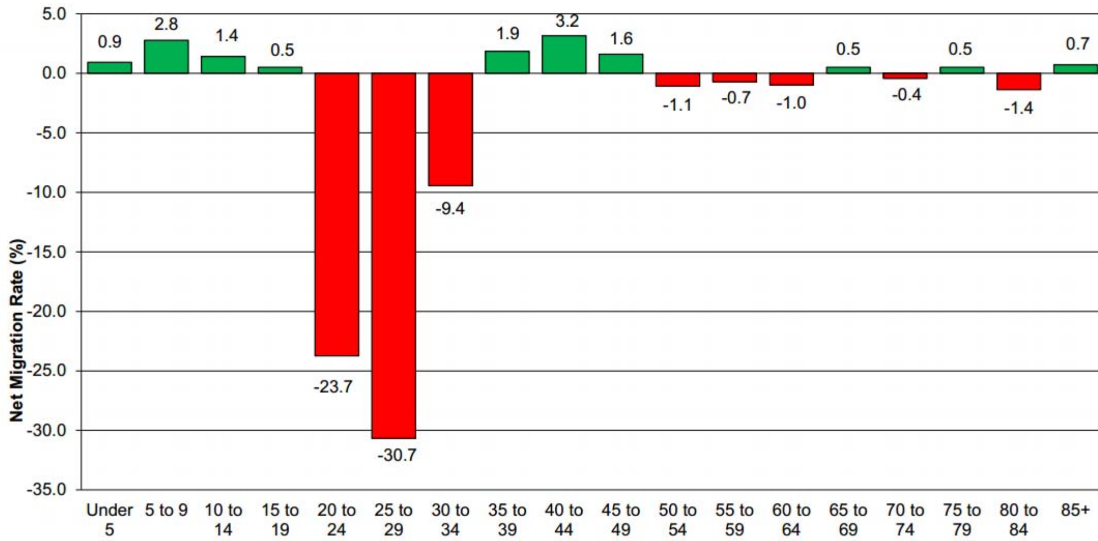
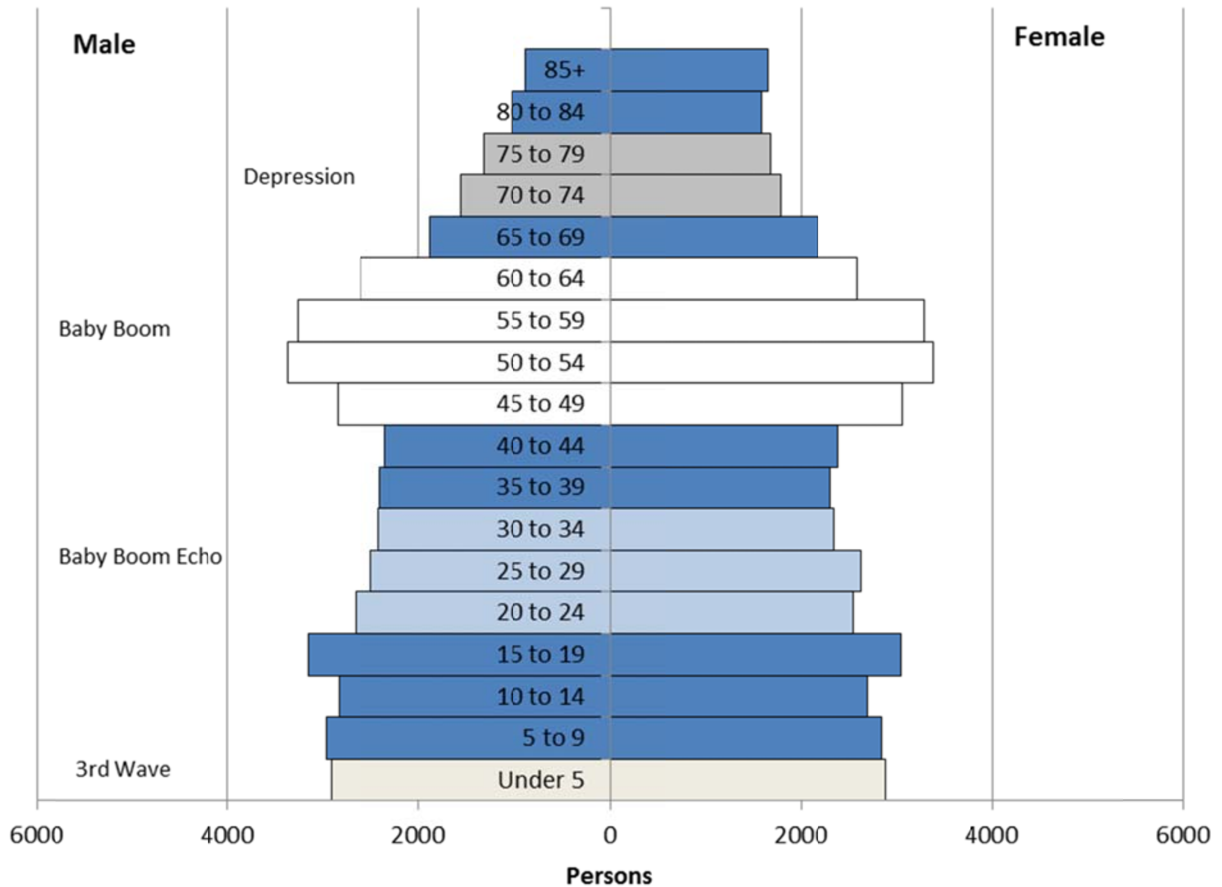
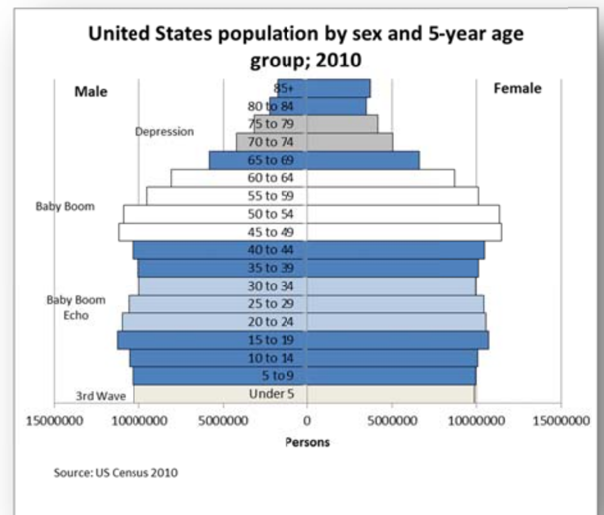


Figure 25: Nebraska Panhandle Population Pyramid, 2010



Source: US Census 2010

The population pyramid from 2010 shows the general age make-up of the Nebraska Panhandle with a still strongly pronounced baby boom generation but a thinning of the pyramid where the baby boom "echo" should be. The shape of this pyramid shows issues both in opportunities for young adults and taking care of an aging population. Decreased family sizes also affect the straight 'trunk' rather than the wide base.



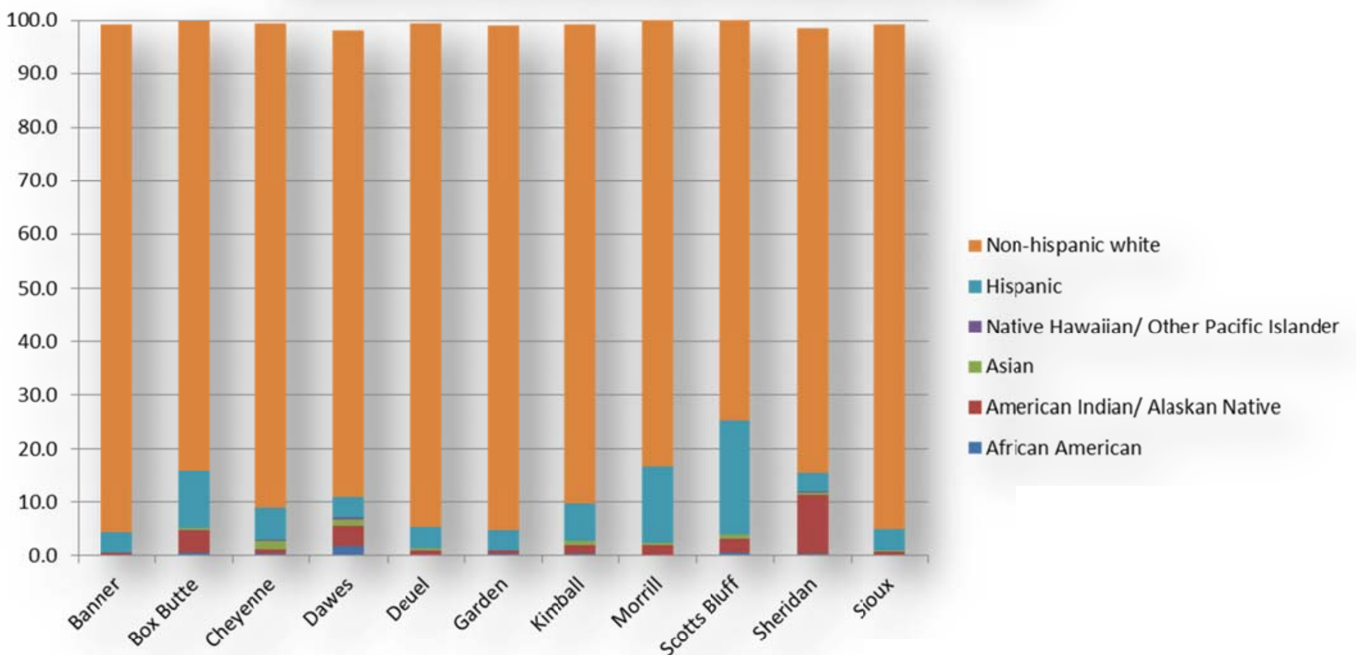
Race

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 Nebraska Panhandle, the majority race is non-Hispanic white but some communities have Hispanic persons making up 15 to 30 percent of their population and some also have relatively large American Indian populations.

Scotts Bluff and Morrill counties show higher Hispanic populations while Sheridan County shows an over 10% American Indian population. However as the high English proficiency and low foreign born rates show, many Hispanic families have been in the area for multiple generations.

Figure 26: Race Composition in the 11 Panhandle Counties, 2012



Source: U.S. Census Bureau, American Community Survey Estimates, 2012

Table 13: Percent Not Proficient in English, Panhandle Counties, 2012

	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

Source: U.S. Census Bureau, American Community Survey Estimates, 2012

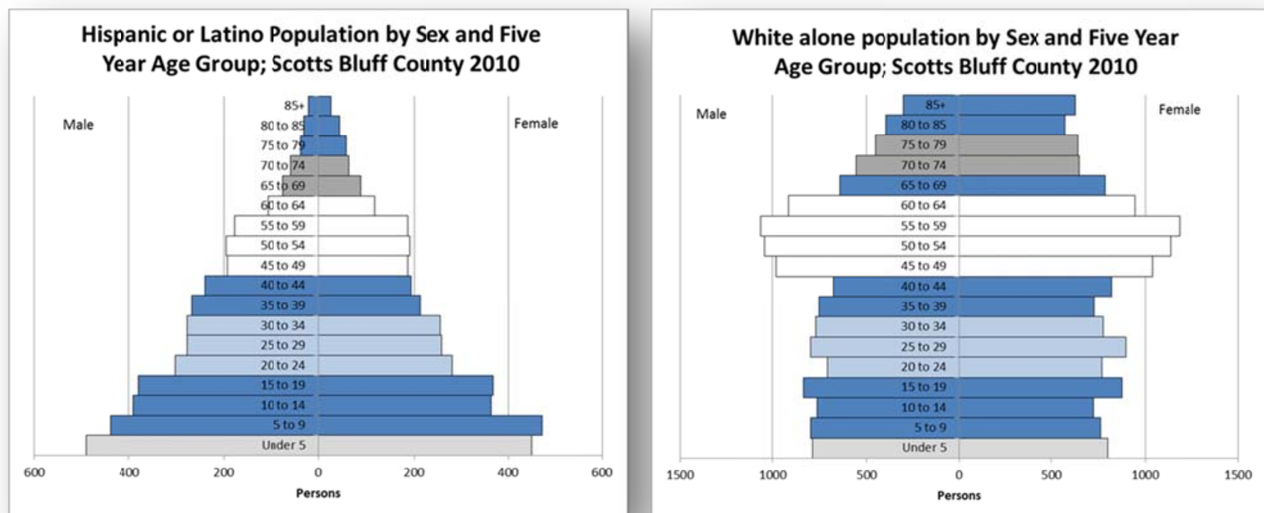
Table 14: Panhandle Foreign Born Rates,

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%

Source: U.S. Census Bureau, American Community Survey Estimates, 2012

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 27: 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 2012:	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.

The Nebraska Panhandle has its roots in a strong agricultural economy and has fared well in economic downturns, maintaining unemployment rates often much lower than the nation. However, wages and professional opportunities lag behind the state and nation as the region has struggled to compete with the metropolitan areas' pool of talent and innovation.

Employment and Workforce

The Panhandle generally has a similar unemployment rate (4.1%) when compared to Nebraska (3.7%) and has a low unemployment rate compared to the nation (6.7%).

Table 15: Unemployment Rates, 2012

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**

Source: Bureau of Economic Analysis; Bureau of Economic Analysis, August 2012

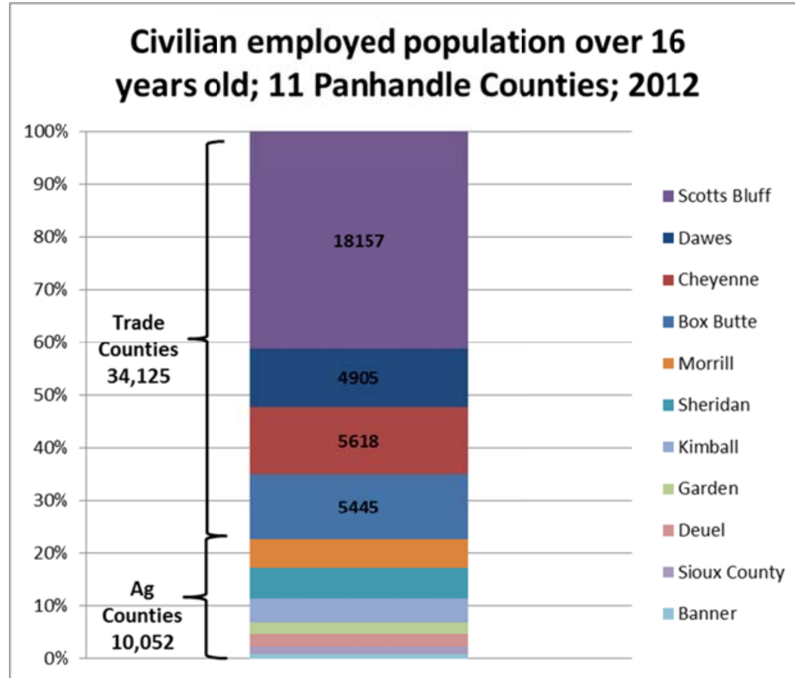
Nebraska	3.7%
United States	6.7%

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.

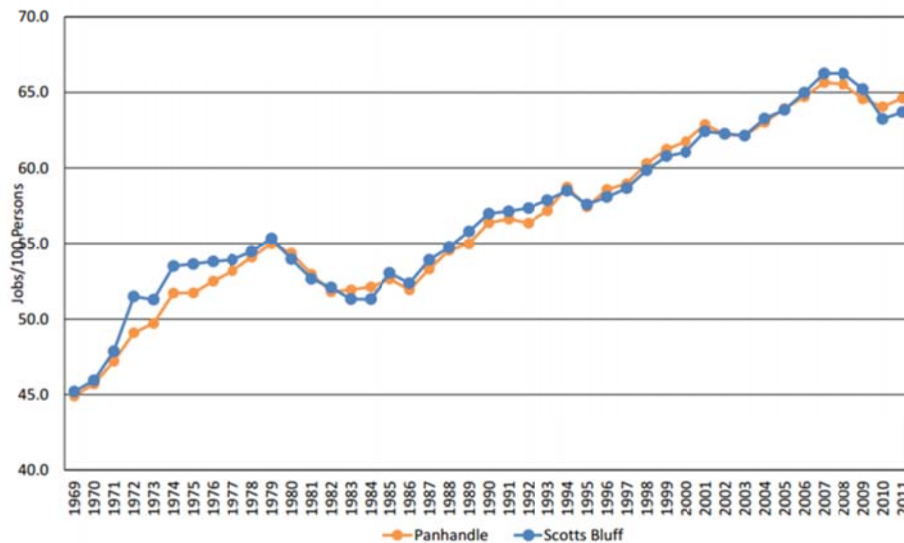
Historically, the number of jobs available per 100 persons has increased while wages still remain below the national and state averages. While this ratio's increase can be partly attributed to loss of population in the region, it also illustrates the importance of the quality of jobs we grow in the region, 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 28: Employed Population by County, 2012



Source: U.S. Census Bureau, 2012 American Community Survey Estimates

Figure 29: Jobs per 100 Persons, 1969 to 2011



Educational Attainment

Lower levels of educational attainment in the Panhandle reflect the fact that many of the jobs available in agriculture, transportation, and manufacturing do not require a bachelor's degree. Currently, our region's workforce is about six percentage points below the state and national rates for population 25 or older with a bachelor degree or higher.

Table 16: Educational Attainment by Panhandle County, 2012

	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%

Source: U.S. Census Bureau, American Community Survey Estimates, 2012

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 17: 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

Source: U.S. Census Bureau, American Community Survey Estimates, 2011

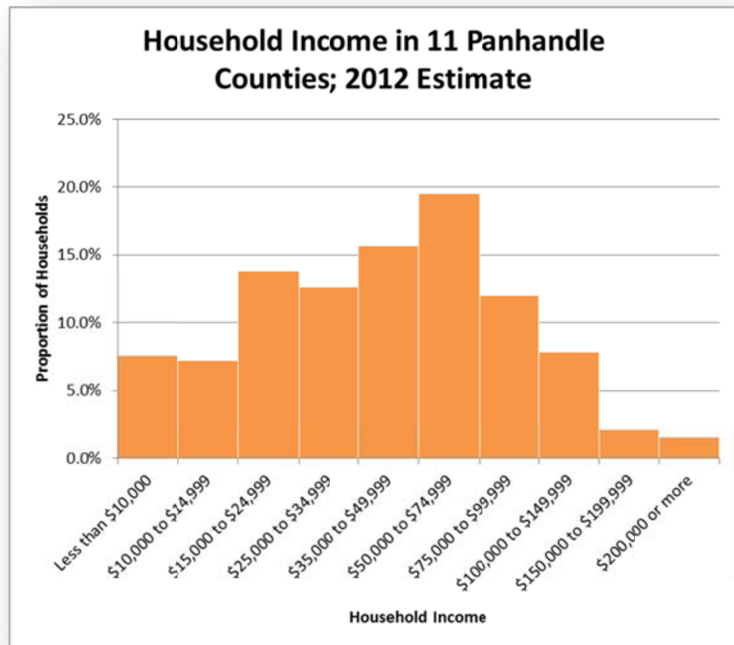
Income distribution in the Panhandle shows a lot of households in the middle of the spectrum with the distribution slightly heavier towards the low income side. Maintaining this large middle income population is important as too much of a gulf between the low and high income earners is detrimental for a community. While the Panhandle has about the same percentage (19%) of its households in the $50,000-74,999 bracket as the Omaha area, 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 18: Household Income Distribution, 2012

	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%

Source: U.S. Census Bureau, American Community Survey Estimates, 2012

Figure 30: Household income distribution in the Panhandle, 2012



Source: U.S. Census Bureau, American Community Survey Estimates, 2012

Table 19: Household Income, 2012

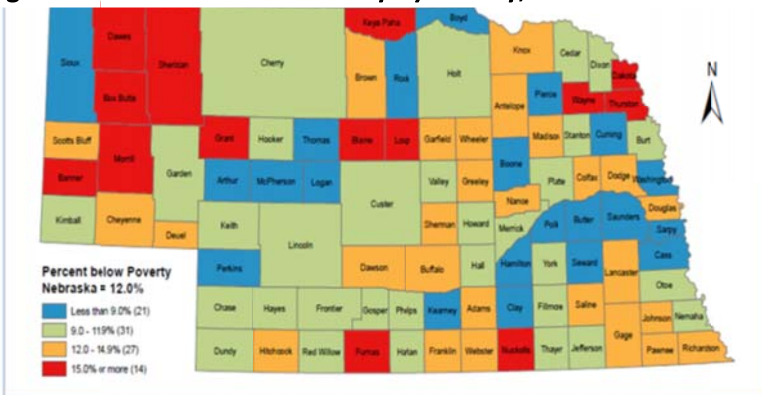
	Household Income	Per Capita Income	Total Households
Banner County	27,167	19,877	309
Box Butte County	44,118	24,389	4,849
Cheyenne County	50,143	27,296	4,438
Dawes County	36,396	20,345	3,772
Deuel County	37,500	24,821	854
Garden County	35,861	24,923	869
Kimball County	43,191	25,304	1,681
Morrill County	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

Source: U.S. Census Bureau, American Community Survey Estimates, 2012

Poverty

Poverty in the Panhandle is generally higher than in the rest of the state and nearby metro areas. The college student population in Dawes County skews the poverty rate in that county, but four other Panhandle counties had estimated poverty rates of over 15% in 2011.

Figure 31: Percent Below Poverty by County, 2011



Source: U.S. Census Bureau, American Community Survey Estimates, 2011

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 the Panhandle and have poverty rates of 33.1% and 25.6%, 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.

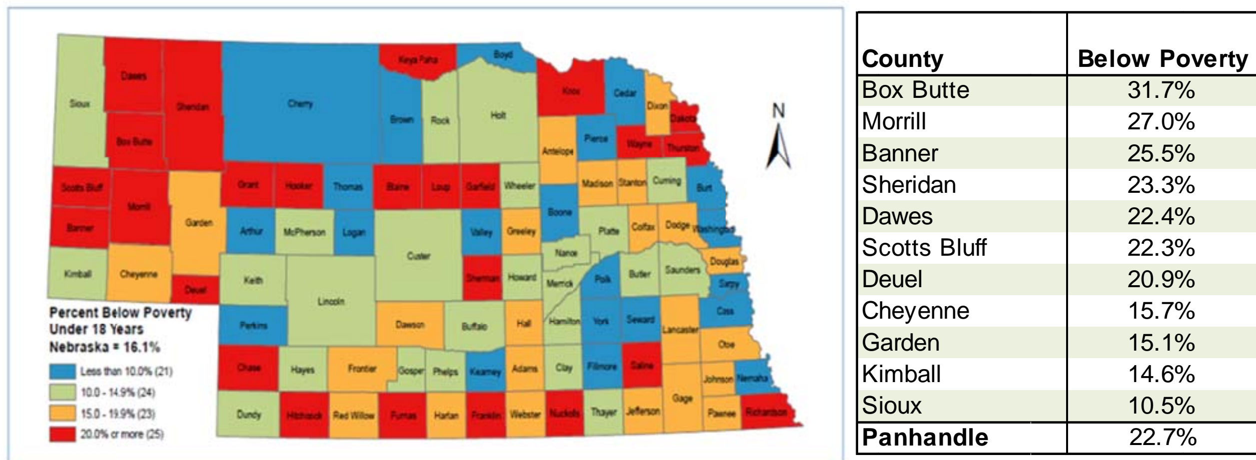
Table 20: Poverty by Race, 2011

	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	24.8%	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%	27.8%	12.1%	18.7%	26.1%	19.4%	24.1%	10.3%

Source: U.S. Census Bureau, American Community Survey Estimates, 2011

Particularly high poverty rates exist for children under 18, 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 32: Poverty for children under 18 years, 2011



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%

Source: U.S. Census Bureau, American Community Survey Estimates, 2011

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 21: Educational Attainment and Poverty, 2011

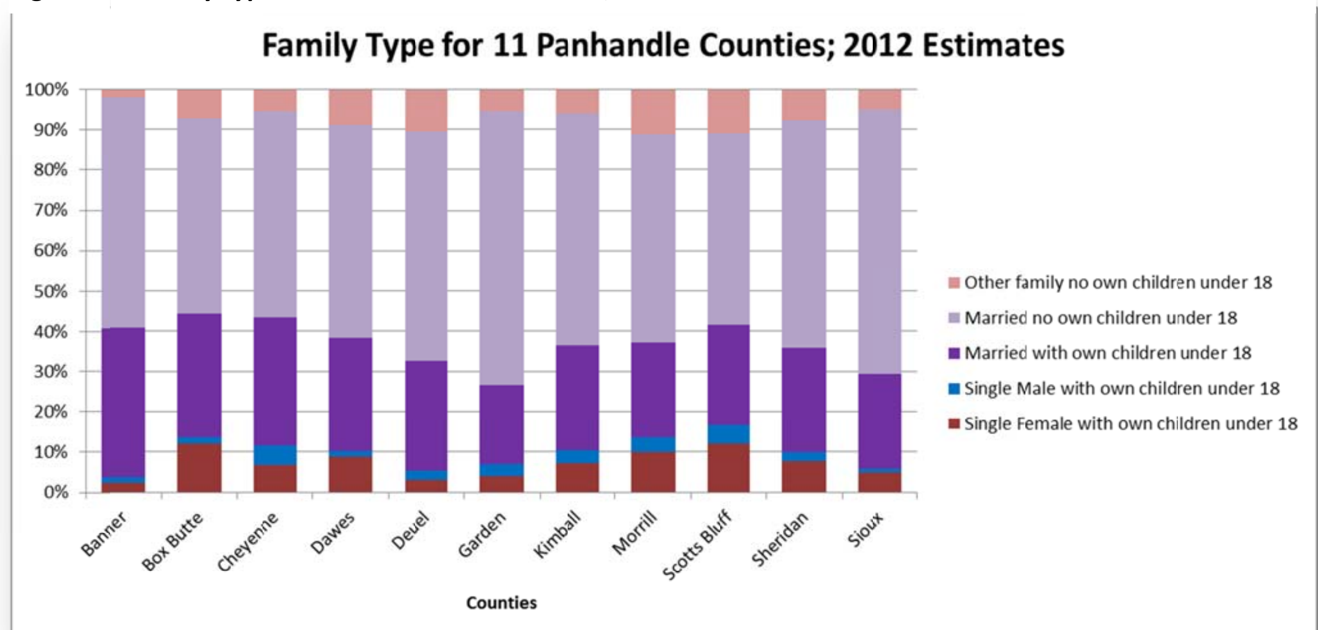
	Panhandle	Nebraska	United States
	Percent below poverty level	Percent below poverty level	Percent below poverty level
EDUCATIONAL ATTAINMENT			
Population 25 years and over	10.8%	8.8%	11.4%
Less than high school graduate	22.8%	23.1%	26.5%
High school graduate (includes equivalency)	11.1%	10.3%	13.1%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

Source: U.S. Census Bureau, American Community Survey Estimates, 2011

Family Type

Most families in the Panhandle do not have children under 18 years of age and counties with older while single parent families with children make up about 13% of all Panhandle families. Highest rates of single parent families with children occur in Box Butte, Dawes, Morrill, and Scotts Bluff Counties with highest rates of married families occurring in the more rural counties of Banner, Deuel, Garden, and Sioux.

Figure 33: Family type for 11 Panhandle Counties, 2012

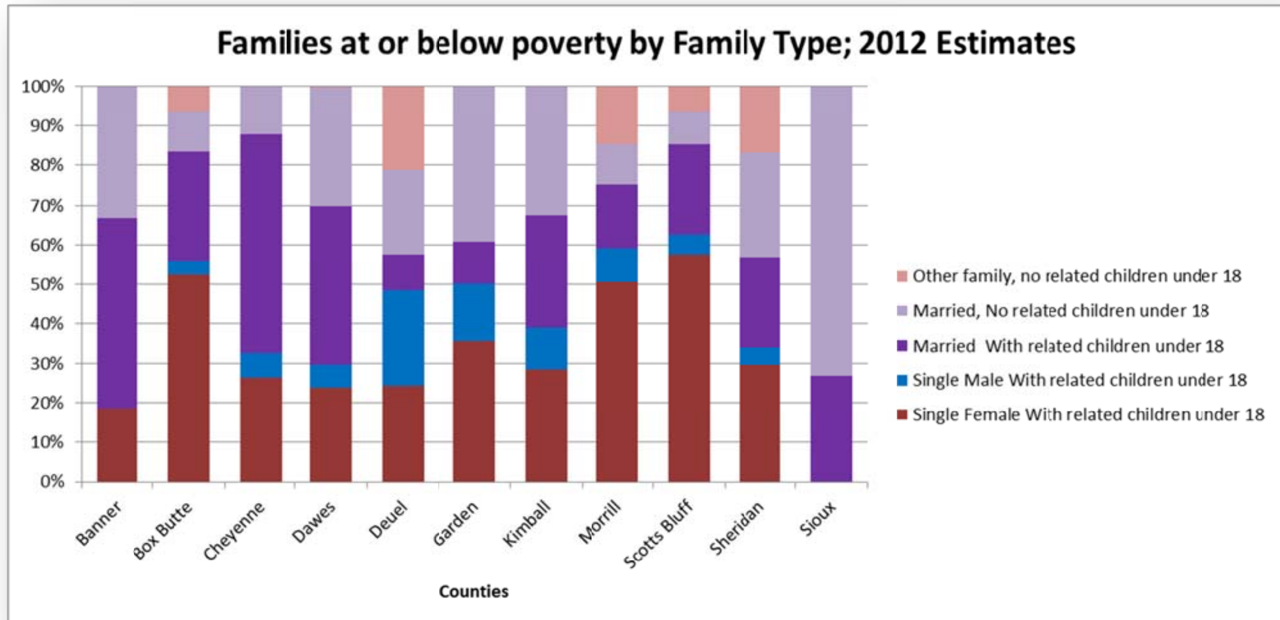


Source: U.S. Census Bureau, American Community Survey Estimates, 2012

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.

Figure 34: Poverty by Family Type, 2012



Source: U.S. Census Bureau, American Community Survey Estimates, 2012

Table 22: Poverty by Family Type, Counts, 2012

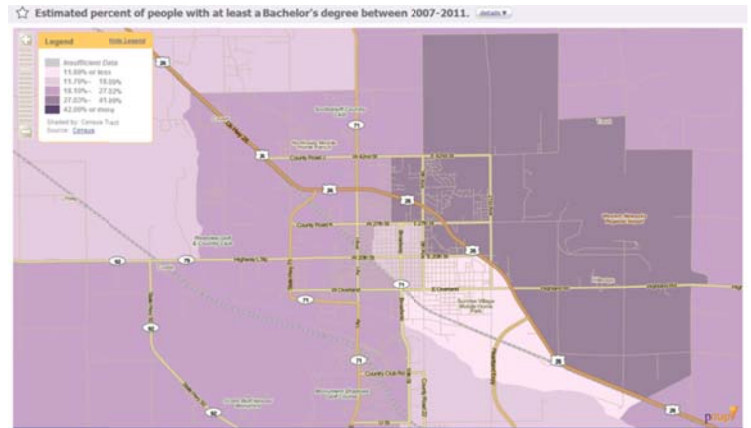
	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Kimball	Morrill	Scottsbluff	Sheridan	Sioux
Total families income below poverty in last 12 months:	27	509	224	310	33	28	95	164	1,075	232	26
Married, No related children under 18	9	52	27	93	7	11	31	17	92	61	19
Married With related children under 18	13	141	124	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

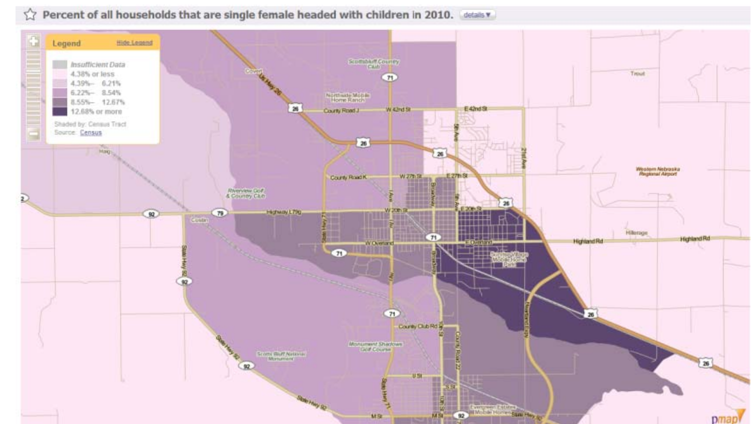
Source: U.S. Census Bureau, American Community Survey Estimates, 2012

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.[1]





Moving Forward

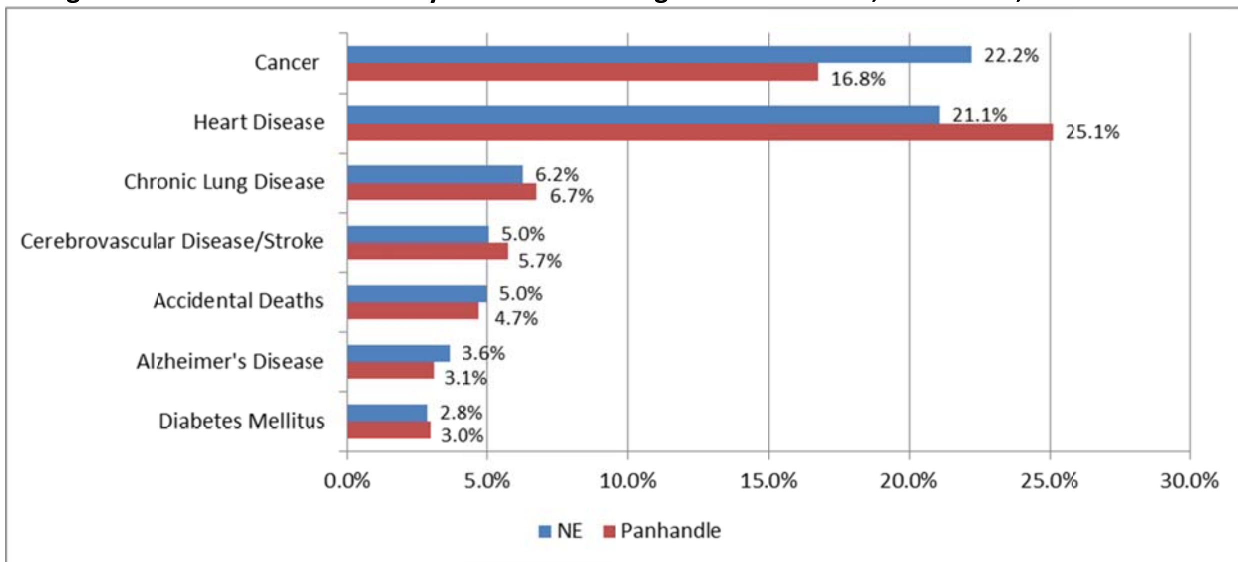
An individual's economic and social well being directly affects his or her health. While the Panhandle has many social and economic indicators that are worse than the state and surrounding regions, the positive is that many of the issues, while complex, are patterned and can be strategically addressed 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 the Nebraska Panhandle will drive sustainable, regional wellness.

Health Data

Overview

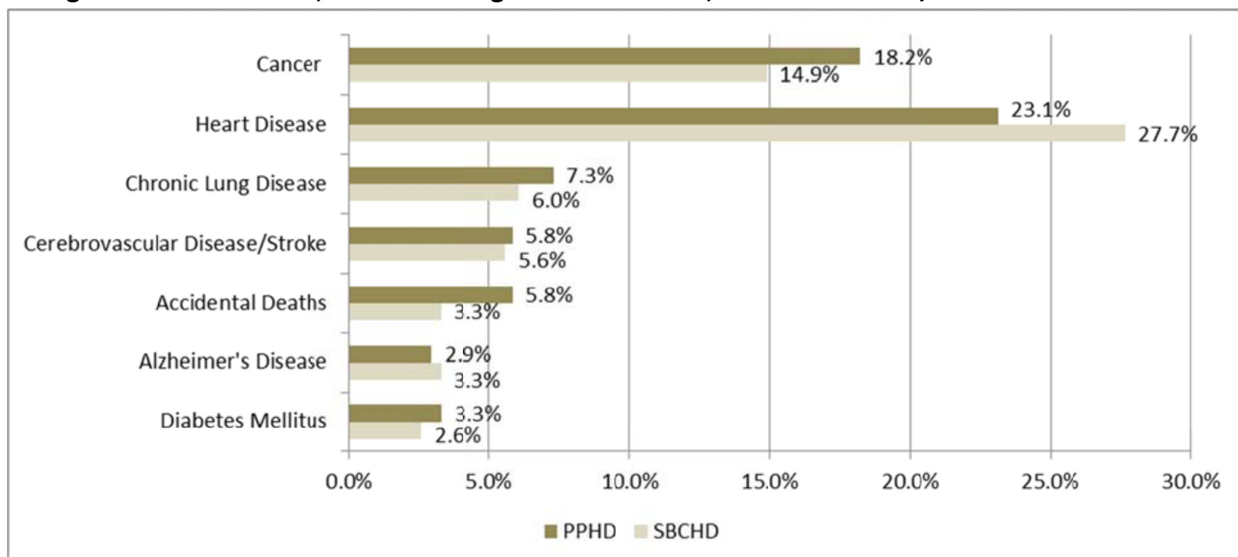
According to vital statistics data, cancer was the leading cause of death in Nebraska in 2012, followed by heart disease, as indicated in the figure below. In the eleven counties in the Panhandle, the leading cause of death that year was heart disease followed by cancer. Although in a slightly different order, the top seven leading causes of death are the same for both the Panhandle and the State. This has been the case since at least 2003. 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.

Figure18: % of Deaths Caused by the Seven Leading Causes of Death, Panhandle, 2012



Source: Nebraska Health and Human Services, Vital Statistics, 2012

Figure 19: % of Deaths, Seven Leading Causes of Death, PPHD vs. SBCHD, 2012



Source: Nebraska Health and Human Services, Vital Statistics, 2012

Health Status

Behavioral Risk Factors Surveillance System

Each year, Panhandle Public Health District and Scotts Bluff County Health Department, 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. BRFSS data is not available on a county-by-county level for the counties served by PPHD, 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.

There has been progress in the percentage of adults that have health insurance across the Panhandle community. The percentage of adults without health care coverage in 2013 was 18.1% for all of Panhandle, down from 21.7% in 2011. This increase in health care coverage parallels the increase in the percentage of adults who had a routine checkup in the past year from 53.6% in 2011 to 56.5% in 2013. 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. In addition, overall consumption of fruits and vegetables in the Panhandle is low. In 2013, 42% of residents reported consuming fruits an average of less than one time per day in the past month, while 24% reported consuming vegetables an average of less than one time per day in the past month.

Cigarette use declined a slightly among residents in the counties under PPHD's jurisdiction. However, it increased among residents in Scotts Bluff County, from 17.4% in 2011 to 23% in 2013. About 1 in 5 Panhandle adults still smokes. Current use of smokeless tobacco slightly increased among Panhandle adults from 8.5% to 8.9% between 2011 and 2013. Increase in use of smokeless tobacco is more evident among residents living in PPHD's jurisdiction compared to Scotts Bluff County. Alcohol use, binge drinking and heaving drinking are all slightly below the state average, but still impact factors such as violence and accidental injury. (Table 12). Seat belt use in the Panhandle (58.4%) is far below the state average (74.1%) and the target of 92% set by Healthy People 2020. More effort needs to be made in promoting the importance of wearing seat belts as the crude death rate in the Panhandle due to motor vehicle crashes are significantly higher (17.10/100,000) than that of the state's (10.48/100,000).

Table 12: BRFSS Health Data, PPHD, SBCHD, Panhandle Region and State, 2011-2013

	2011				2012				2013			
	SBCHD	PPHD	Panhandle	Neb	SBCHD	PPHD	Panhandle	Neb	SBCHD	PPHD	Panhandle	Neb
General Health Status												
General health fair or poor	19.0	18.0	18.4	14.3	20.5	14.4	17.0	14.4	20.2	15.8	17.6	13.9
Physical health not good on 14 or more of the past 30 days	12.9	11.5	12.1	9.6	14.0	10.3	11.8	9.8	17.3	12.8	14.7	9.2
Mental health not good on 14 or more of the past 30 days	11.1	10.3	10.6	9.2	10.8	8.1	9.3	9.0	9.4	10.4	10.0	8.9
Health Care Access												
No health care coverage, 18-64 years old	11.1	22.2	21.7	19.1	10.8	18.4	20.0	18.0	9.4	18.1	19.8	17.6
No personal health care doctor or health care	22.5	24.7	23.8	18.4	24.4	16.3	19.7	17.2	26.1	21.9	23.6	20.9
Needed to see a doctor but could not due to cost in past year	15.7	13.9	14.7	12.5	12.1	13.3	12.8	12.8	20.1	12.7	15.7	13.0
Had a routine checkup in past year	55.9	52.0	53.6	57.7	54.5	57.9	56.4	60.4	54.8	57.9	56.5	61.6
Visited a dentist or dental clinic for any reason in the past year	-	-	-	-	58.9	60.6	59.9	67.6	-	-	-	-
Cardiovascular												
Ever told they had a heart attack	4.5	6.2	5.5	4.3	6.3	4.8	5.5	4.1	6.7	4.7	5.6	4.0
Ever told they had coronary heart disease	4.6	5.3	5.0	3.9	4.1	5.6	5.0	3.9	5.5	4.2	5.6	4.0
Ever told they had a stroke	2.3	2.7	2.6	2.6	1.8	2.7	2.3	2.4	2.6	3.5	3.1	2.5
Had blood pressure checked in last year	-	-	-	-	-	-	-	-	83.7	88.7	86.5	84.6
Ever told they have high blood pressure (excluding pregnancy)	32.1	35.1	33.8	28.5	-	-	-	-	37.8	28.5	35.6	30.3
Had cholesterol checked in past 5 years	65.3	70.2	68.1	71.8	-	-	-	-	70.9	74.3	72.9	74.0
Ever told they have high cholesterol, among those checked	37.8	41.9	40.2	38.3	-	-	-	-	39.3	34.6	36.5	37.4
Tobacco												
Current cigarette smoking	17.4	19.1	18.3	20.0	20.9	19.5	20.1	19.7	23.0	18.7	20.5	18.5
Attempted to quit smoking in past year, among	59.5	56.2	57.5	55.6	71.5	53.3	61.2	57.1	63.3	62.6	62.9	57.1
Current smokeless tobacco use	6.6	9.9	8.5	5.6	6.7	11.9	9.7	5.1	6.5	10.6	8.9	5.3
Cancer												
Ever told they had skin cancer	6.9	8.0	7.5	5.6	7.5	7.9	7.7	5.6	7.7	7.6	7.6	5.9
ever told they have cancer, other than skin cancer	7.8	8.7	8.3	6.6	8.9	6.5	7.5	6.5	8.7	7.9	8.2	6.8
Ever told they had cancer (in any form)	13.1	14.6	13.9	11.2	14.8	12.9	13.7	10.8	14.3	14.1	14.2	11.4
Up-to-date on colon cancer screenings, 50-75 years old	-	-	-	-	53.9	56.9	57.7	61.1	52.1	50.0	52.0	62.8
Nutrition/Physical Activity												
Ever told they had diabetes (excluding pregnancy)	11.3	10.5	10.8	8.4	12.8	8.7	10.4	8.1	11.4	10.0	10.5	9.2
Obese (BMI =30+)	34.1	26.7	29.9	28.4	39.6	29.0	33.4	28.6	37.8	31.0	33.8	29.6
Overweight or Oobese (BMI=25+)	66.5	64.2	65.2	64.9	72.9	68.5	70.3	65.0	71.0	66.4	68.3	65.5
Consumed fruits less than 1 time per day	39.8	42.7	41.4	40.1	-	-	-	-	42.1	42.1	42.1	39.7
Consumed vegetables less than 1 time per day	24.6	23.1	23.7	26.2	-	-	-	-	23.4	24.4	24.0	23.3
Currently have activity limitations due to arthritis, among those told they have arthritis	49.1	54.6	52.2	45.2	-	-	-	-	49.0	42.0	45.1	42.4
No leisure time physical activity in the past 30 days	25.7	31.9	31.9	26.3	21.7	20.7	20.7	21.0	28.7	29.5	29.5	25.3
Mental Well Being												
Ever told they had depression	21.2	18.4	19.6	16.8	17.0	17.8	17.5	16.7	20.2	19.2	19.6	18.2
Alcohol												
Any alcohol consumption in the last 30 days	53.0	56.2	56.2	61.8	53.6	56.4	56.4	61.3	50.4	55.0	55.0	57.5
Binge drank in the past 30 days	18.0	18.8	18.8	22.7	18.3	21.4	21.4	22.1	16.4	18.8	18.8	20.0
Heavy drinking in the past 30 days	6.0	5.3	5.3	7.5	8.0	10.3	10.3	7.2	5.5	6.3	6.3	6.8
Injury												
Always wear a seatbelt when driving or riding in a car	57.6	55.9	55.9	71.3	56.2	53.9	53.9	69.7	60.4	58.4	58.4	74.1
Texted while driving in past 30 days	-	-	-	-	22.5	23.4	23.4	26.8	-	-	-	-
Talked on a cell phone while driving in the past 30 days	-	-	-	-	65.6	66.0	66.0	69.1	-	-	-	-
Had a fall in past year, aged 45 years and older	-	-	-	-	32.8	34.9	34.9	28.8	-	-	-	-
Injured due to a fall in past year, age 45 years and older	-	-	-	-	12.1	13.5	13.5	9.9	-	-	-	-

Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

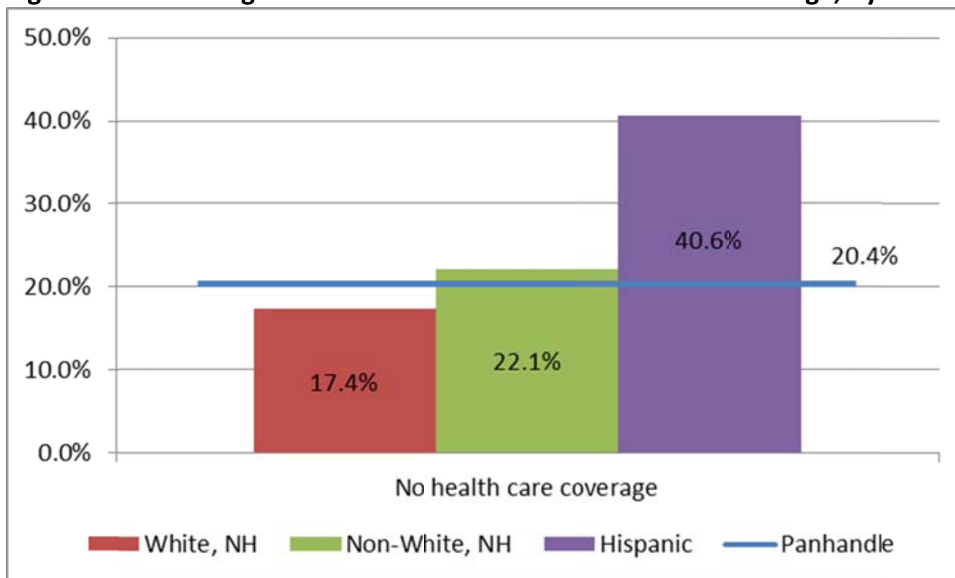
Health Disparity

Additional analysis of some of the BRFSS data was requested to further examine if disparity between race/ethnicity and income exists. Results were an eye opener. There were stark differences between race/ethnicity and between income levels in some of the indicators.

Access to quality, affordable and timely health care is critical for an individual to achieve the best possible health outcome. Common barriers to accessing health care include high cost, lack of insurance coverage, lack of transportation, and inability to communicate with providers due to language differences. These factors were all mentioned in both the 2011 and 2014 community themes and strengths focus group discussions. As mentioned earlier, health insurance coverage has increased in the Panhandle. However, when further analyzed by race/ethnicity and by income levels, disparity is evident. The percentage of Hispanic residents (40.6%) that do not have health coverage is more than double the percentage of White, Non-Hispanic residents (17.4%). (Figure 20) Disparity is even more evident when classified by income. Prevalence of uninsured adults with income less than $25,000 is about eight times greater than adults who are making at least $50,000. (Figure 21)

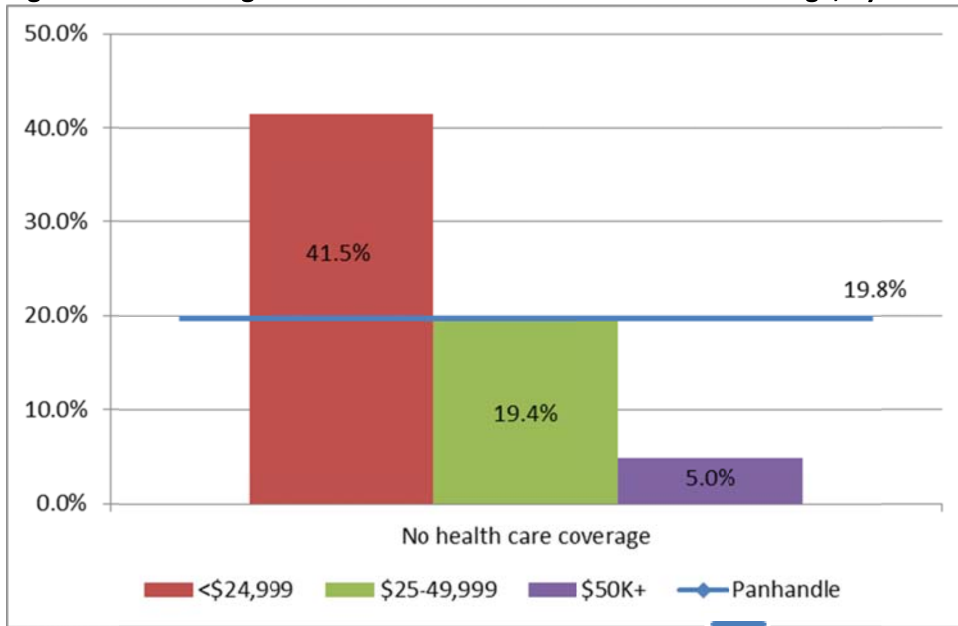
As expected, a similar pattern is observed when percentage of adults who did not seek needed medical care due to cost was calculated. (Figures 22 and 23) About 1 in 3 Hispanic residents and 1 in 4 Non-White, Non-Hispanic residents reported needing to see a doctor but could not due to cost in the past year, compared to 1 in 12 White, Non-Hispanic residents. The percentage of adults making less than $25,000 who did not seek needed medical care is nearly five times greater than adults who are making at least $50,000.

Figure 20: Percentage of Panhandle Adults with No Health Coverage, By Ethnicity, 2011-2013



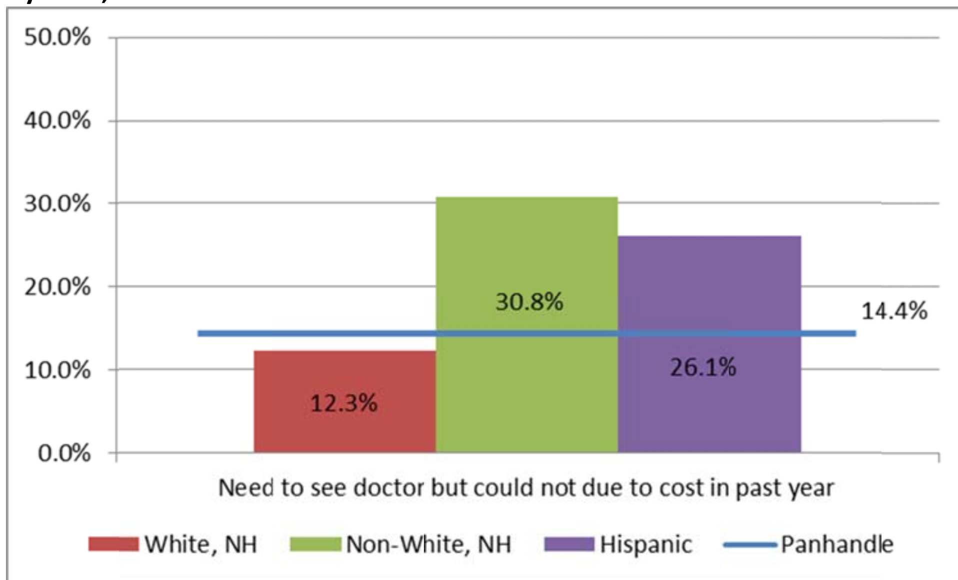
Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

Figure 21: Percentage of Panhandle Adults with No Health Coverage, By Income, 2011-2013



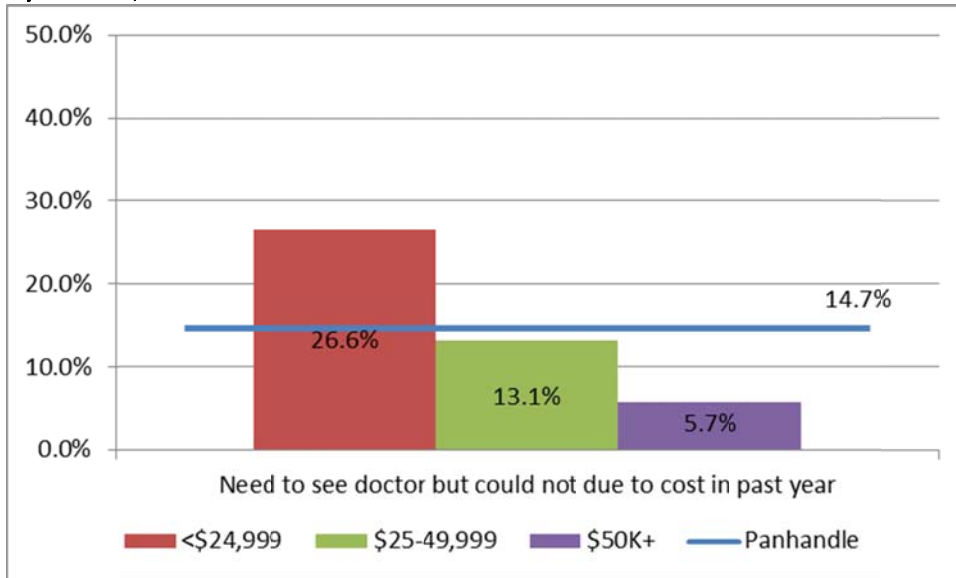
Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

Figure 22: Percentage of Panhandle Adults Who Need to See a Doctor But Could Not Because of Cost, By Race, 2011-2013



Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

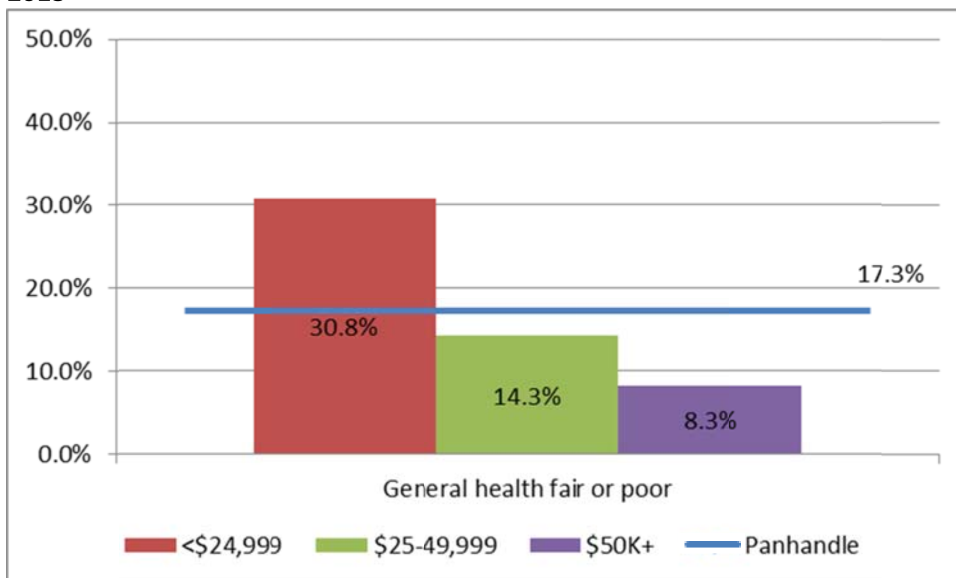
Figure 23: Percentage of Panhandle Adults Who Need to See a Doctor But Could Not Because of Cost, By Income, 2011-2013



Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

Income and health are tightly linked. The more income or wealth a person has, the better his/her health is. This association is also apparent in the Panhandle. Among adults making less than $25,000, approximately 31% reported their general health as either fair or poor. This figure decreased by half among adults making between $25,000 and $49,999 annually. An even greater difference is seen when compared to adults making at least $50,000, wherein only 8% perceived their health to be fair or poor.

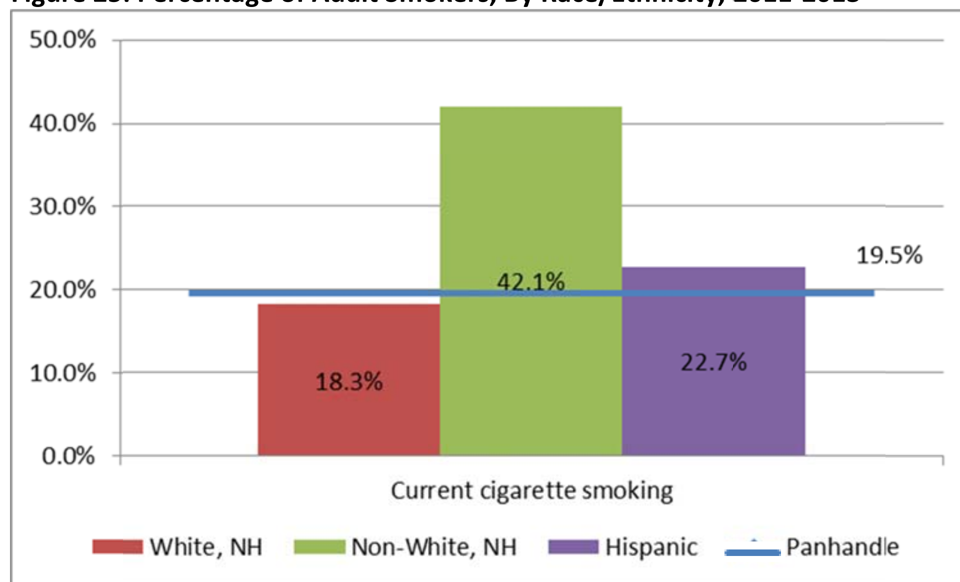
Figure 24: Percentage of Adults Who Reported Their General Health as Fair or Poor, By Income, 2011-2013



Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

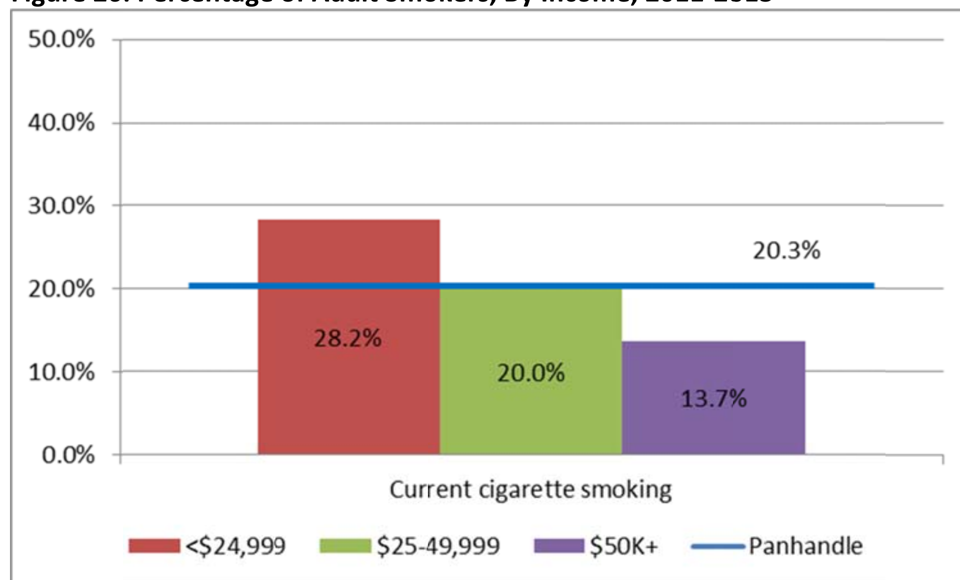
Marketing and advertisement of tobacco products disproportionately target specific vulnerable groups such as youth, racial/ethnic minorities, and those of low income and education in the United States.[2] The success of that marketing strategy is reinforced by the higher prevalence of smoking among Non-White and lower income Panhandle residents. Among adults, there are twice as many Non-White, Non-Hispanic smokers than there are White, Non-Hispanic smokers in the Panhandle. The same is true when comparing the prevalence of smoking between adults making less than $25,000 and those making at least $50,000.

Figure 25: Percentage of Adult Smokers, By Race/Ethnicity, 2011-2013



Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

Figure 26: Percentage of Adult Smokers, By Income, 2011-2013



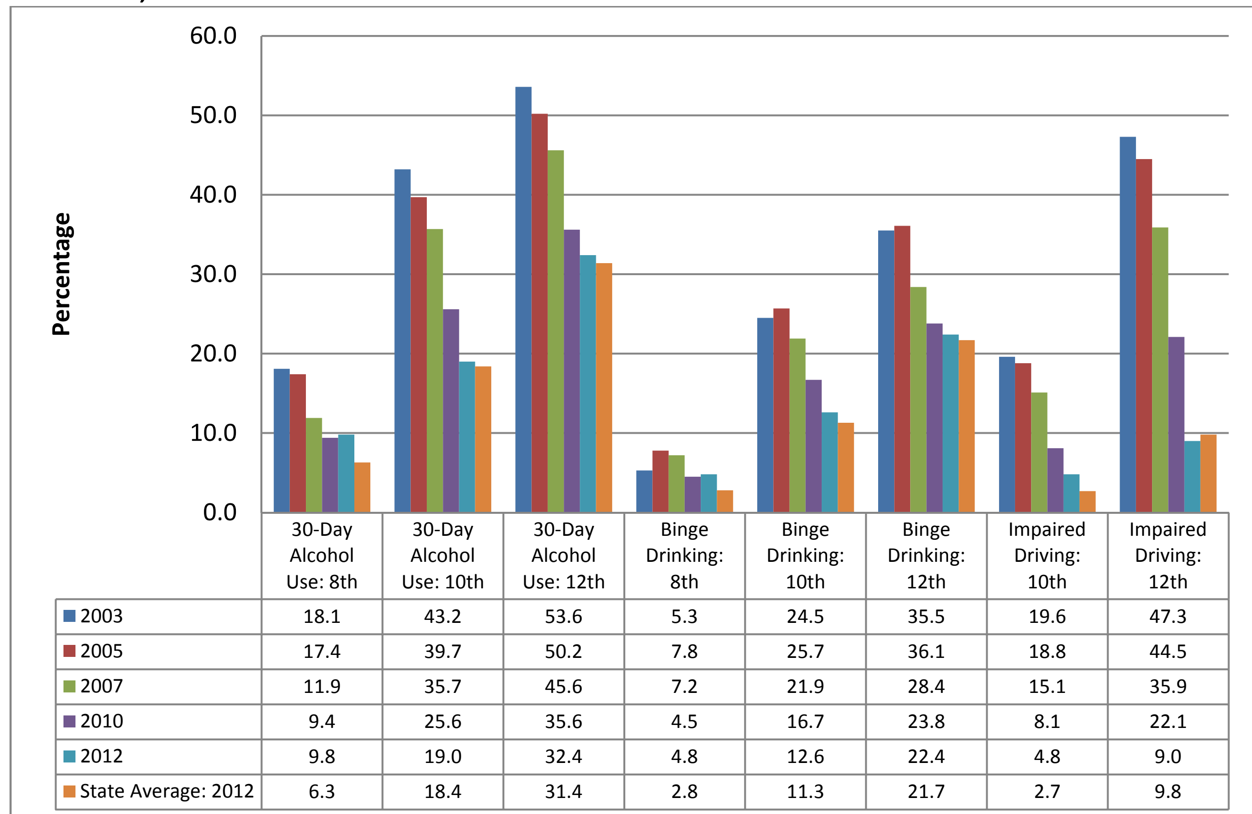
Source: Nebraska Behavioral Risk Factor Surveillance System, 2011-2013

Youth Risk Factors

The Nebraska Risk and Protective Factors Students 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 to receive local information on topics such as substance use/abuse, bullying, delinquent behaviors, and a variety of risk and protective factors associated with problem behaviors. These behaviors can have negative effects on rates of crime, teen pregnancy, and 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 significant improvement was observed in the percentage of impaired driving among 12th graders which saw a fivefold decrease between 2003 and 2012. A positive impact is being made through the efforts of schools, retailers, law enforcement, and community organizations to prevent youth alcohol use.

Although great strides have been made, there is still more room for improvement. Alcohol consumption and binge drinking among 8th, 10th and 12th grade students are higher than the state average. Especially concerning is alcohol consumption among 8th graders in the Panhandle (9.8%) which is about 55% higher than the state (6.3%). This is also the case with binge drinking. Close to 5% of 8th grade students reported binge drinking in the past 30 days, significantly higher than the state average of 2.8% in 2012. Although these percentages are relatively small, it is very disconcerting that young adolescents can gain access to alcohol.

Figure 27: Alcohol Use, Binge Drinking and Impaired Driving Among 8th, 10th and 12th Graders in the Panhandle, Trend Data 2003-2012



	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

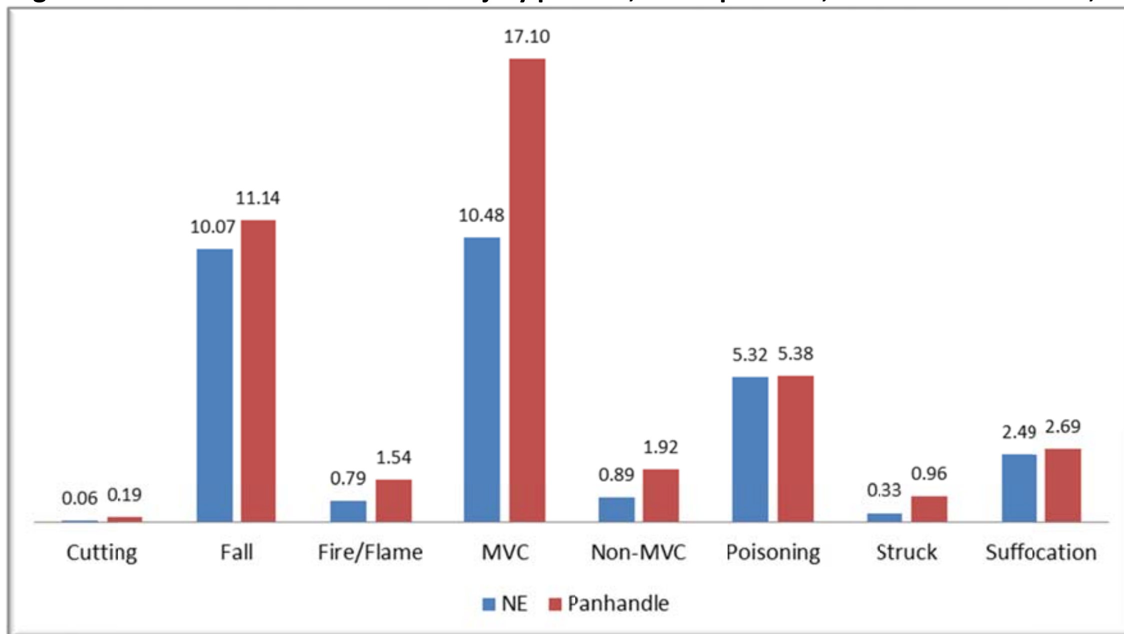
Source: Nebraska Risk and Protective Factor Student Survey, 2012

Injury and Violence

Injury deaths due to falls, motor vehicle crashes, and suicides have been tracked over time. All of these categories are higher than the state crude death rate for the same cause. Falls and motor vehicle crashes are the leading causes of injury deaths in both the Panhandle and the state. Deaths due to motor vehicle crashes in particular are notably high in the Panhandle. A study completed by the National Highway Traffic Safety Administration (NHTSA) in 2010 cited drunk driving, speeding, distracted driving and not wearing seat belts as factors contributing to motor vehicle crashes.[3]

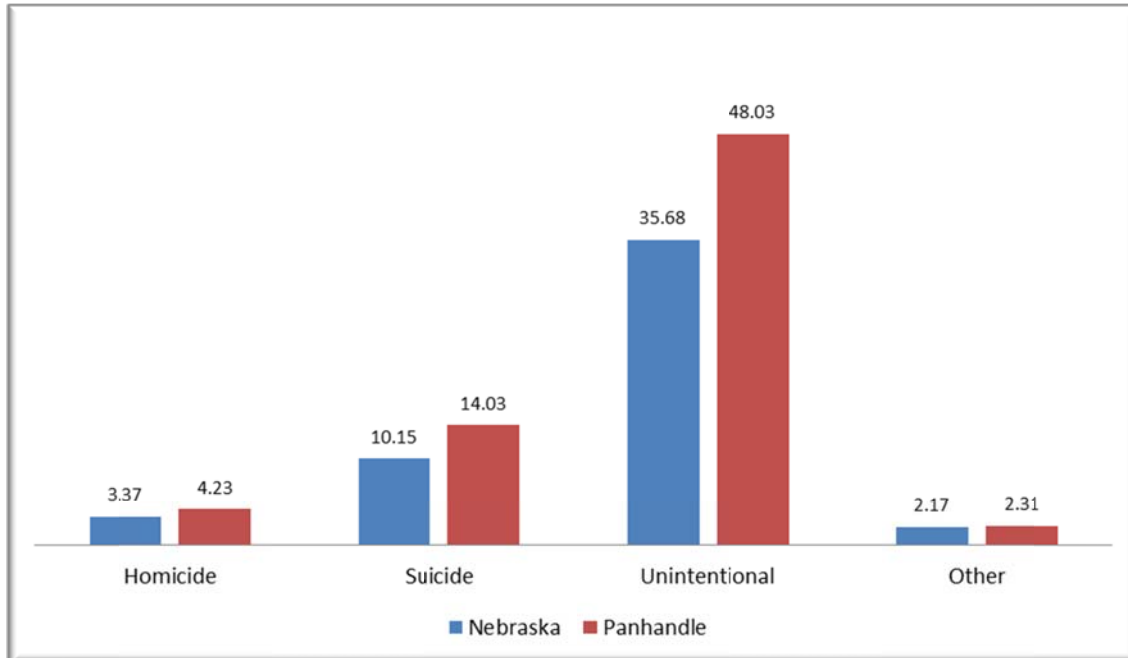
Similar to injury deaths, crude death rates for homicide, suicide, unintentional injuries are higher than the state. Unintentional injuries or accidents claimed many lives among Panhandle residents between 2007 and 2012, resulting in a crude mortality rate of 48.03 deaths per 100,000 residents in those five years.

Figure 28: Crude Death Rates Due to Injury per 100,000 Population, Panhandle and State, 2007-2012



Source: Nebraska Department of Health and Human Services, 2007-2012

Figure 29: Crude Death Rates Due to Injury and Violence per 100,000 Population, Panhandle and State, 2007-2012



Source: Nebraska Department of Health and Human Services, 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. In 2010, the Nebraska Department of Health and Human Services completed a statewide needs assessment to determine the counties within the state with the highest risk for poor outcomes that could potentially be addressed through home visitation. Data from several indicators that are available at a county-level were compiled, analyzed and scored. Based on the methodology used by the state, 17 counties, three of which are in the Panhandle, were determined to be at highest risk for poor outcomes. The Panhandle counties identified were Scotts Bluff, which was ranked #1 (most at-risk county), Box Butte (ranked #9), and Morrill (ranked #15).[4]

Table 13 summarizes the updated data for the same child well being indicators analyzed by the state for their needs assessment for all Panhandle counties. Differences in child well being indicators were observed among the Panhandle counties and between the Panhandle counties and the state. Numbers that are colored in red indicate areas where the county statistic is worse than the state average.

Maltreatment includes physical, emotional and sexual abuse and neglect. Abused and neglected children are more vulnerable for adverse psychological, behavioral and emotional outcomes in adulthood.[5,6] This subject matter is the focus of the Adverse Childhood Experiences (ACE) study which is discussed further in the next section. Rate of child abuse/neglect (CA/N) reports accepted for assessment per 1,000 children (defined as less than 18 years old) are the highest in Scotts Bluff (66.8), Kimball (42.1) and Deuel (41.6) Counties. Rate of substantiated CA/N reports in Scotts Bluff (15.2) is almost double than Kimball County (8.3) which has the second most substantiated CA/N reports per 1,000 children in the Panhandle.

Birth rate among teens (19 years and under) from 2008 to 2012 ranged from a low of 6.3% in Cheyenne to a high of 12.4% in Kimball. Seven of the nine Panhandle counties (two counties had its data suppressed because fewer than five events occurred) with reported data have a higher teen birth rate than the state average. Children of teenage mothers are at a higher risk for adverse birth outcomes such as pre-term delivery, low-birth weight, and neonatal mortality.[7] In addition, teenage mothers are less likely to receive their high school diplomas, and thus have fewer employment opportunities, putting her and her child at a higher risk of living in poverty.[8]

The juvenile arrest rate in Scotts Bluff and Morrill are the highest in the Panhandle and both are higher than the state average. While 26 children per 1,000 are arrested statewide, about 35 children each from Scotts Bluff and Morrill per 1,000 are being arrested.

Another area of great concern is violence in the home. Domestic violence has a long lasting impact on children. Children and youth who witness domestic violence are more susceptible to psychological, behavioral, emotional and social difficulties, similar to those experienced by children who were direct victims of child abuse.[9] The rates of domestic violence crisis line calls in all eleven Panhandle counties are greater than the statewide average.

Table 13: Child Well Being Indicators, Panhandle Counties, 2012

Factor	Indicator	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Kimball	Morrill	Scotts Bluff	Sheridan	Sioux	NE
Child Welfare	CA/N Reports (rate)	0.2	29.2	35.3	39.2	41.6	19.5	42.1	6.2	66.8	33.9	10.1	29.9
	CA/N Reports, substantiated (rate)	0.0	5.1	4.8	7.5	7.3	4.6	8.3	1.0	15.2	5.5	2.2	6.9
	Out of Home Care (rate)	0.0	6.5	8.0	6.2	14.1	5.7	6.8	7.4	13.7	5.0	3.2	11.8
Crime	Juvenile Arrests (rate)	7.6	1.1	14.3	13.1	14.8	0.0	34.8	18.2	35.6	23.6	3.4	26.2
	Juvenile Drug Arrests (rate)	0.0	0.4	1.3	3.4	15.0	0.0	0.0	0.9	5.5	0.9	0.0	2.8
	Juvenile DUI (rate)	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.0	0.2	1.7	0.0	0.3
	Juvenile Violent Crime Arrests (rate)	0.0	0.0	0.4	0.0	0.0	0.0	3.6	0.0	0.1	0.9	0.0	0.5
Economic	Poverty, All ages (%)	13.7%	13.9%	10.7%	19.3%	12.7%	15.8%	13.5%	16.1%	15.7%	23.6%	15.8%	12.6%
	Unemployment (%)	4.3%	4.6%	3.4%	4.2%	3.4%	4.2%	4.0%	3.2%	4.9%	3.3%	3.8%	4.4%
Education	Education less than 9th grade (%)	6.5%	5.1%	1.7%	2.6%	1.9%	1.7%	2.9%	6.0%	4.8%	4.0%	3.1%	4.1%
Health Behaviors	Adult Smoking (%)	N/A	21.0%	20.0%	18.0%	22.0%	21.0%	28.0%	21.0%	20.0%	11.0%	16.0%	18.0%
	Binge Drinking (%)	7.0%	20.0%	20.0%	22.0%	18.0%	15.0%	12.0%	16.0%	12.0%	14.0%	17.0%	19.0%
	Chlamydia Infections (rate)	0.0	63.0	50.0	12.0	53.0	0.0	28.0	60.0	213.0	75.0	0.0	305.0
	Inadequate Prenatal Care (%)	22.4%	17.1%	16.8%	19.8%	14.7%	21.8%	23.5%	14.7%	16.5%	18.7%	20.0%	14.3%
	No Prenat Care (%)	3.0%	0.9%	1.7%	1.2%	1.3%	2.2%	0.5%	1.0%	1.0%	1.4%	0.0%	0.7%
	Teen Births (%)	*	10.7%	6.3%	8.8%	9.2%	7.8%	12.4%	10.3%	12.9%	6.9%	*	7.6%
Pregnancy Outcomes	Low Birth Weight (%)	*	8.2%	7.7%	7.6%	*	10.0%	9.1%	7.7%	8.2%	4.0%	*	6.9%
	Very Low Birth Weight (%)	0.0%	1.0%	1.8%	*	0.0%	*	*	2.0%	1.3%	0.0%	0.0%	1.2%
	Prematurity (%)	*	12.2%	12.7%	9.4%	*	6.7%	14.3%	12.3%	12.8%	8.3%	10.2%	11.2%
	Infant Mortality (rate)	0.0	*	7.6	*	0.0	*	*	*	7.4	*	0.0	5.7
Health Outcomes	Poor/Fair Health (%; Self-reported)	10.0%	14.0%	12.0%	12.0%	10.0%	13.0%	18.0%	16.0%	15.0%	12.0%	13.0%	12.0%
	Poor Mental Health Days (Mean)	2.3	3.6	2.7	3.0	2.8	4.0	3.6	2.4	3.5	2.2	2.4	2.7
	Poor Physical Health Days (Mean)	3.6	3.2	3.5	3.1	2.7	2.8	3.4	3.6	3.7	2.6	2.3	2.9
	Premature Death (YPLL)	N/A	6,725.0	6,180.0	5,594.0	5,317.0	11,072.0	13,037.0	7,524.0	7,281.0	5,448.0	N/A	5,904.0
Social Welfare	Aggravated Domestic Violence Complaints (rate)	0.0	4.4	1.0	2.5	3.4	0.0	0.9	2.7	3.1	4.9	0.0	2.6
	Domestic Violence Crisis Line Calls (rate)	30.9	30.9	30.9	30.9	36.9	36.9	30.9	30.9	30.9	30.9	30.9	25.7
	Simple Domestic Violence Complaints (rate)	4.6	26.8	13.7	32.7	11.9	0.0	14.9	8.1	38.8	44.4	0.0	26.4
	Single Parent Household (%)	6.0%	35.0%	26.0%	26.0%	27.0%	36.0%	27.0%	30.0%	42.0%	18.0%	8.0%	27.0%

*Fewer than 5 events occur, data is suppressed because the number/rate would not be accurate due to the small number

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 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 than 100 conference and workshop presentations have been made.

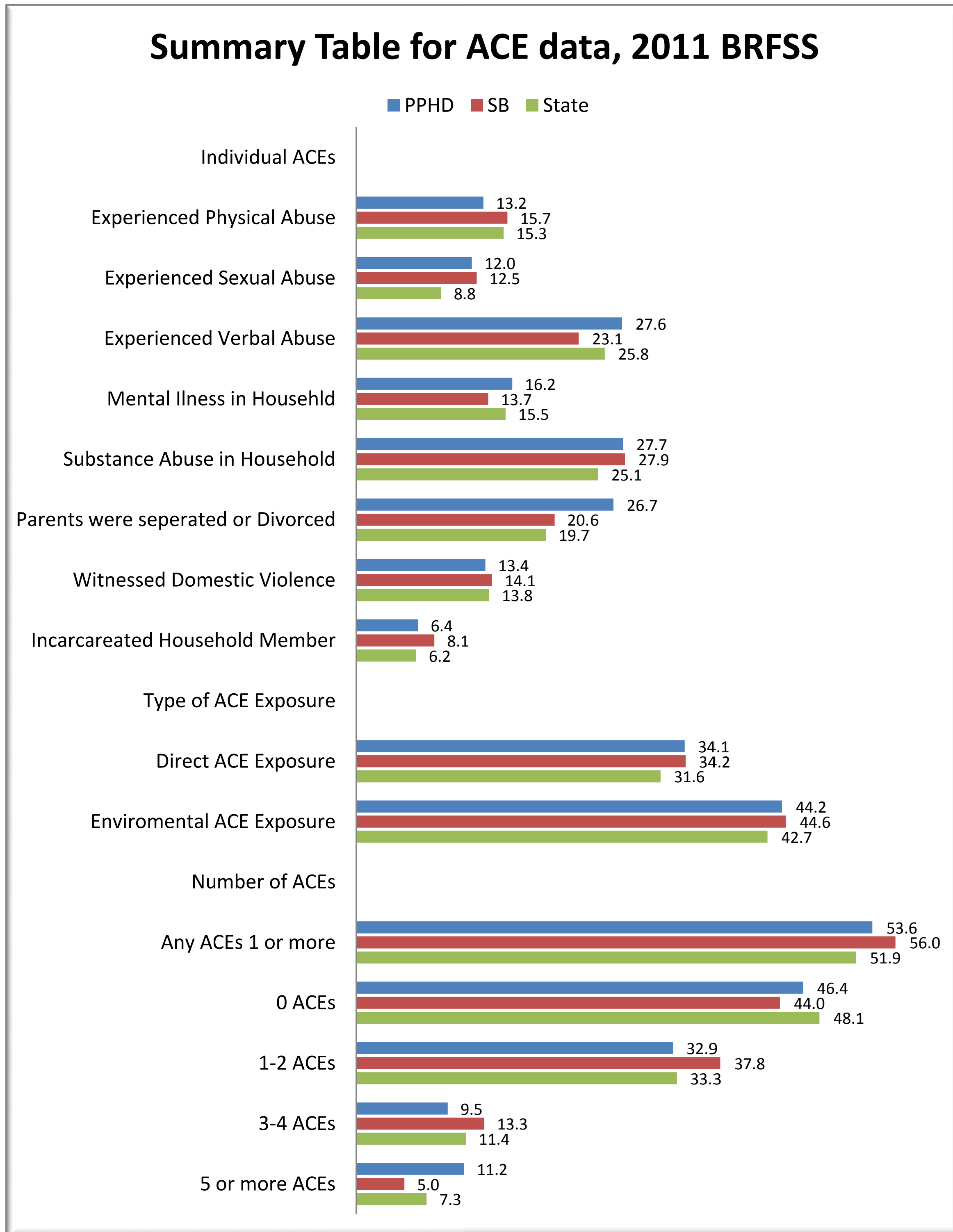
The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse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

Adverse Childhood Experiences, Nebraska, 2010–2011

In 2009, the Centers for Disease Control and Prevention (CDC) added an optional ACE module to the core BRFSS questions. Questions in the ACE module were adapted from the ACE study mentioned earlier. Nebraska administered the ACE module in 2011 to investigate the prevalence of adverse childhood experiences among Nebraskans. ACE Exposures that were examined were physical abuse, sexual abuse, verbal abuse, household mental illness, household substance abuse, witnessing domestic violence, household incarceration and divorce. Figure 30 summarizes the result of that study for PPHD, SBCHD and the state.

Nebraska's Behavioral Risk Factor Surveillance System (BRFSS) data, including data from the ACE module from 2011, was further 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 30: ACE Data from 2011 BRFSS, PPHD and SBCHD



Source: Nebraska Behavioral Risk Factor Surveillance System, ACE Module, 2011

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 to several with very small populations that cannot be fairly ranked. Ranking of 1st is considered the healthiest county and 79th the unhealthiest county. In the Panhandle region, Banner and Sioux counties are not included in the ranking. The score is made up of two main categories: 50% health outcomes and 50% health factors. Health outcomes which represent how healthy a county is include length of life (mortality) and quality of life (morbidity). Health factors which represent what influences the health of a county include health behaviors, clinical care, social and economic and physical environment factors.

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.

Figure31: County Health Rankings Model

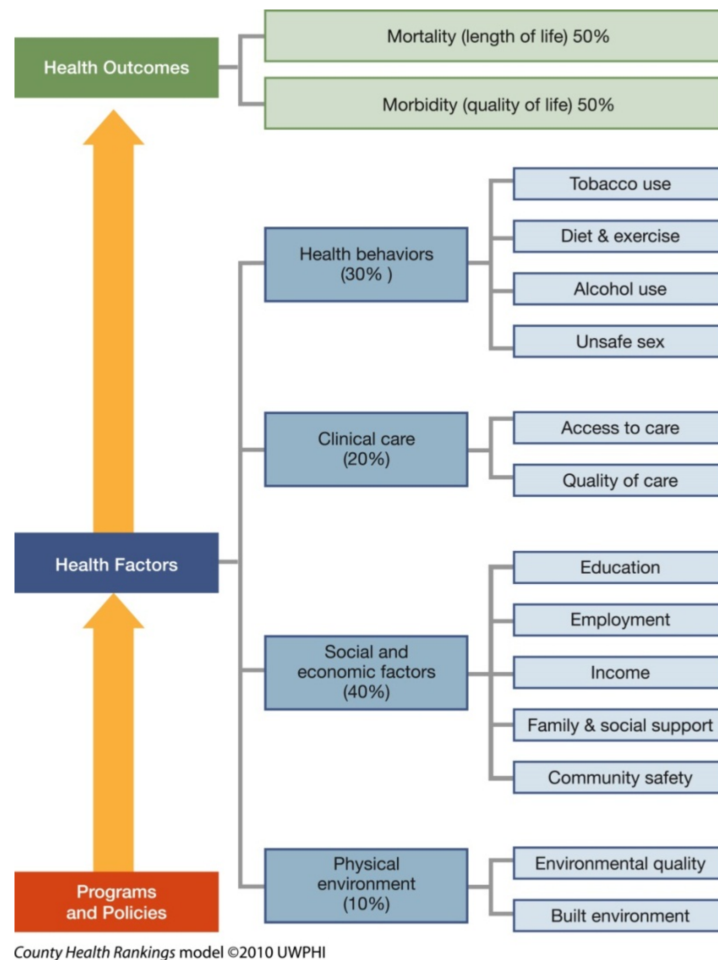
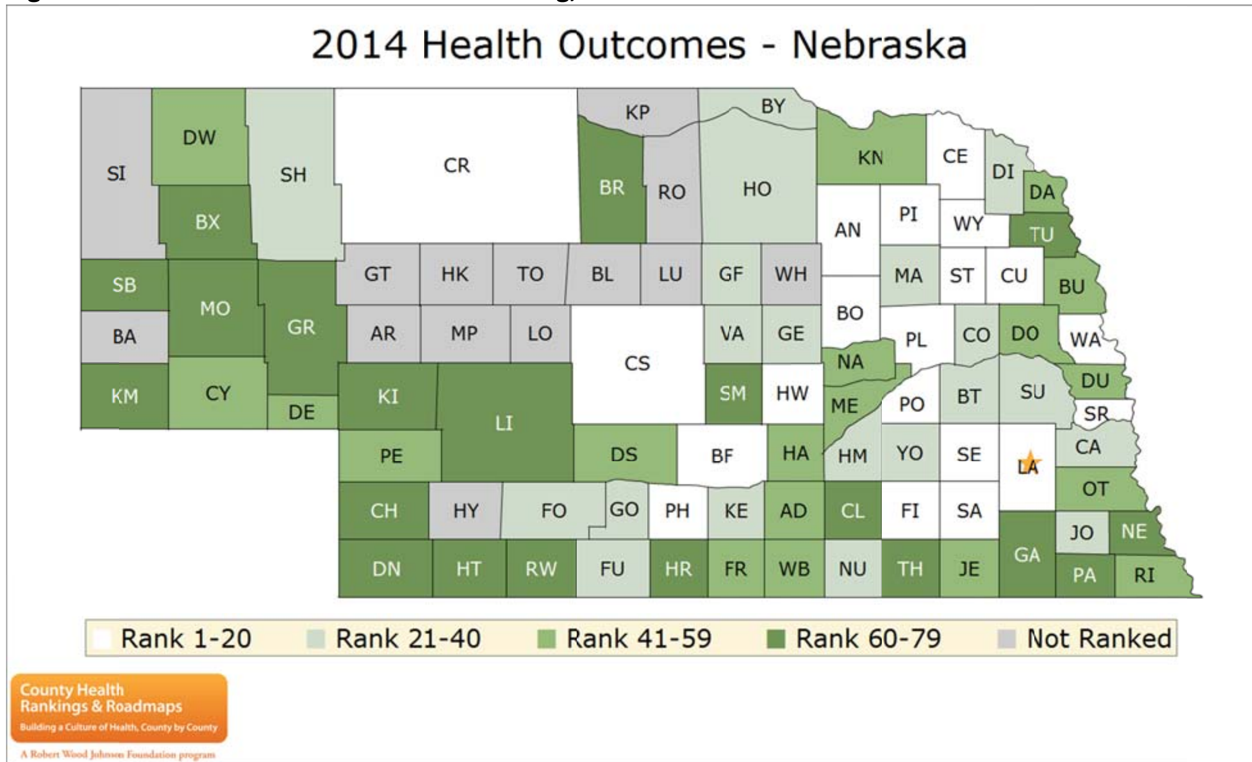
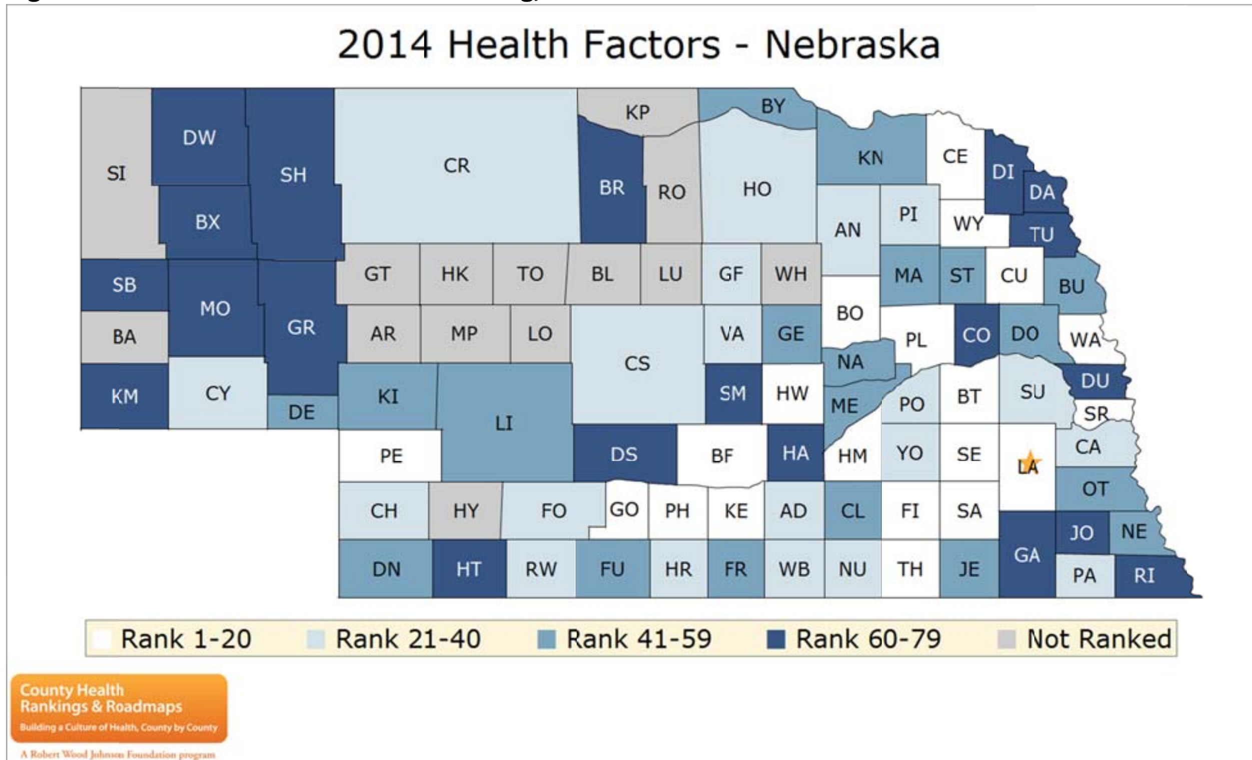


Figure 32: Nebraska Health Outcomes Ranking, 2014



Source: County Health Rankings, 2014

Figure 33: Nebraska Health Factors Ranking, 2014



Source: County Health Rankings, 2014

Table 14: County Health Rankings, Panhandle Counties, 2014

County	Health Outcomes Ranking	Health Factors Ranking
Banner	NR	NR
Box Butte	64	77
Cheyenne	52	34
Dawes	42	65
Deuel	46	49
Garden	76	66
Kimball	79	74
Morrill	69	70
Scotts Bluff	70	73
Sheridan	29	63
Sioux	NR	NR

Source, County Health Rankings, 2014

With the exception of Sheridan County, the other eight counties ranked in the Panhandle are in the bottom half of counties in Nebraska for health outcomes ranking. This demonstrates that many Panhandle residents are dying prematurely and people have a poor perception of their own health. For the health factors ranking, all but Cheyenne County was ranked in the bottom half of counties in Nebraska indicating that majority of our citizens do not practice healthy behaviors and that our socioeconomic environment and healthcare and physical infrastructure may not be as conducive to living healthy as it could be.

It is important to note that the County Health Rankings use broad measures that are standardized based on multiple years of data in order to account for counties of all sizes and make them comparable. Therefore, local data must take precedence. Regardless of the limitations of the County Health Rankings, it gives a snapshot of the health of the county and helps demonstrate how the Panhandle counties are doing in relation to each other and other counties in Nebraska. In addition it helps raise awareness of the many factors that influence health and hopefully encourage the community to take action to improve the health of the community.

2014 Stakeholder Meeting

Health status data, including demographic information, and the results of the community themes and strengths focus groups for the particular service area was shared with local stakeholders between June and August 2014. Local stakeholders were also informed of the current MAPP process and results of the 2011 needs assessment were reviewed. The table below lists the group and date of the health status data presentations.

Hospital	# of Participants	Date
Box Butte General Hospital	17	July 23, 2014
Chadron Community Hospital	23	August 12, 2014
Gordon Memorial Hospital	20	August 6, 2014
Kimball Health Services	8	July 17, 2014
Morrill County Community Hospital	10	June 19, 2014
Regional West Garden County	9	August 20, 2014
Regional West Medical Center	22	June 18, 2014
Sidney Regional Medical Center	22	July 29, 2014

In addition to the presentation of the preliminary findings of the current needs assessment, attendees of the local stakeholder meetings identified community assets and resources for the four priority health issues identified in 2011 – (1) Healthy Living, (2) Mental and Emotional Well-Being, (3) Injury and violence Prevention, and (4) Cancer Prevention. Assets were grouped according to the health issue(s) it addresses.

Assets Identified

Healthy Living – Healthy Eating, Active Living and Breastfeeding

- Panhandle Worksite Wellness Council
- School Wellness Councils –Coordinated school health
- Improved nutrition guidelines for schools
- National Diabetes Prevention Program in the Panhandle
- Farmer Markets and community gardens
- Nu Val System in local grocery stores
- Bountiful Baskets – fresh fruit and vegetables for low cost
- Senior meal programs
- Baseball parks
- Municipal Swimming pools
- City, state and national parks
- Walking trails in some communities
- Cowboy trail along Highway 20
- Clean air
- Girls on the Run program in most communities
- Schools allowing walkers to use the gym in adverse weather
- Recreational facilities and YMCA's
- Worksites making accommodations for nursing mothers
- Hospitals providing breast feeding consultants
- WIC peer support
- La Leche League

Mental and Emotional Well Being

- Panhandle Partnership Circle of Security Parenting Classes
- Early Head Start
- Healthy Families America Home Visitation
- Six Pence Home Visitation
- PPHHS System of Care of 08, System of Care for Older Youth
- Behavioral Health providers
- Families and Schools Together Program
- Early Learning Network – Step up to Quality for Child Care providers

Injury and Violence Prevention

- Panhandle Partnership Panhandle Prevention Coalition
- Fall prevention programs in area hospitals
- Tai Chi
- Silver Slippers strengthening programs
- Law enforcement – Click it or Ticket, sobriety checks, compliance checks

Cancer Prevention – Primary Prevention and Early Detection

- Municipal swimming pools participating in Pool Cool
- New statute to restrict youth from using tanning beds
- Indoor Air Act
- Tobacco Free campus policies
- Free radon testing
- Area hospital and health systems for early detection
- Free FOBT kits distributed by public health

Forces of Change Assessment

The purpose of the Forces of Change Assessment is to identify and analyze present and future external forces that can influence the health and safety of the community and/or the work of the public health system. Forces of change include:

- Trends – patterns over time
- Factors – discrete elements
- Events – one-time occurrences

Methodology

Sara Sulzbach led the MAPP Steering Committee through a Technology of Participation (ToP) consensus workshop process to identify the Forces of Change facing the Panhandle on April 2014. The focus question of the workshop was "What trends, factors, and events are or will be influencing the health and safety in our Panhandle community and/or the work of the public health system?"

Participants were numbered into five groups. Each person was given a worksheet (See Appendix C) defining forces of change, the categories of change, and ways to identify the forces. They were asked to brainstorm individually and create a list of forces – trends, factors and events – in the categories of social, economic, political, technological, environmental, scientific, legal and ethical.

After individual brainstorming was completed, participants shared ideas with their group and came up with a list of forces they felt were most relevant. The large group then grouped the ideas by common theme or idea.

Results

The group identified the following forces of change arranged by common theme:

- *Prevention funding decreasing* – funding for public health continues to be cut
- *Chronic disease* – increase prevalence of obesity, diabetes and heart disease
- *Injury and violence prevention* – potential increase in drug use due to legalization of marijuana in neighboring Colorado; increase incidences of child abuse and distracted driving
- *Access* – need for more health education, mental health services and long-term care
- *Demographics* – Aging population and increasing diversity; growing number of children in poverty
- *Policy decisions affecting the cost of care* –Affordable Care Act, diminishing resources through Medicare, Nebraska not expanding Medicaid, increasing out-of-pocket costs, confusion on health care insurance, reduction of cost reimbursement for Critical Access Hospitals
- *Societal mentality* – decreasing faith-based services, changing family and community structure, instant gratification culture, lack of personal accountability
- *Economy* – depressed economy, lack of quality jobs, middle class being squeezed, climate
- *Making the easy choice healthy* – food industry making small steps. Increased focus for active lifestyle, Bountiful Baskets
- *Political unrest* – quick turnover of elected officials, challenging political climate

See Appendix D for the complete work product of the Forces of Change group.

The group then compared the forces of change completed in 2011 to the one they just finished. There were many commonalities between the two documents such as healthcare uncertainties, demographic changes and healthy initiatives.

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 Regional Community Health Needs Assessment, forty persons attended the Panhandle Partnership for Health and Human Services 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, mobilize community partnerships to identify and solve health problems, because it is critical to the Public Health system priority area identified in 2011 for collective impact. The assessment was conducted during the PPHHS 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 black dot (●) and the 2014 scores by an (x). All but three 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 *4.1 Constituency Development*	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
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	•	

Essential Service #4: Mobilize community partnerships to identify and solve health problems *4.2 Community Partnership*	No	Minimal	Moderate	Significant	Optimal
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-0making 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			•	x	

Essential Service #4: Mobilize community partnerships to identify and solve health problems *4.2 Community Partnership*	No	Minimal	Moderate	Significant	Optimal
partnership participation in solving health problems?					
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	

Community Themes and Strengths Assessment

Introduction

Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Kimball Health Services, Morrill County Community Hospital, Regional West Garden County, Regional West Medical Center, and Sidney Regional Medical Center held a series of focus groups involving residents of their particular service area between May and July 2014. The focus group discussions were conducted to fulfill the Community Themes and Strengths Assessment component of the 2014 Mobilizing for Action through Planning and Partnerships (MAPP) process. Similarly, a series of focus group discussions were held in 2011 as part of that year's regional community health needs assessment cycle. The purpose of the focus group is to gather input from community members in order to develop a better understanding of the issues they feel are important, their concerns, and their overall perception of their community.

A total of 21 focus group sessions involving approximately 110 Nebraska Panhandle residents were completed by the eight hospitals in collaboration with the Panhandle Public Health District (PPHD). Each hospital facilitated at least two focus groups with residents from their service area. The individual hospitals were responsible for recruiting focus group participants. PPHD suggested having a small group of six to eight (or no more than 10) people per focus group. Hospital representatives identified potential focus group participant from their community and reached out via phone calls and e-mails inviting them to attend a focus group session (See Appendix E for template of invitation letter). PPHD also recommended that the hospitals consider holding a separate focus group with racial/ethnic minorities, especially if the minority makes up at least 5% of their service area's population. A purposive sampling was used in selecting focus group participants.

Methodology

PPHD staff facilitated the focus group sessions for Box Butte, Gordon, Kimball, Morrill, Garden County and Sidney. Regional West Medical Center and Chadron had their own staff facilitate the focus groups. However, PPHD provided them with a detailed facilitator's guide (See Appendix) to ensure that the process remained the same for all focus group sessions. Each focus group session had a facilitator and a note taker and was approximately 90-minutes long. The process is as follows:

1. Facilitator gives a brief overview of the purpose of the focus group.
2. Facilitator, note taker, and participants introduce themselves.
3. Facilitator outlines the focus group ground rules
4. Ask focus group questions. Prioritize questions in Bold.

Focus group discussions were held at different dates and times between May and July 2014. Box Butte, Chadron, Morrill, Regional West Medical Center and Sidney were able to hold separate focus groups with residents from minority groups and/or residents from another community within their service area.

Hospital	# of Focus Groups	Total # of Participants	Date
Box Butte General Hospital	3 (Hispanic, general and Native American communities)	15	June 5, June 23 and July 1
Chadron Community Hospital	4 (Hay Spring, general, Marshall Islands and Native American communities)	*	May 20, June 10, June 25 and July 10
Gordon Memorial Hospital	3 (All from the general population)	19	June 26
Kimball Health Services	3 (All from the general population)	11	June 25
Morrill County Community Hospital	3 (Bayard, Bridgeport and Hispanic communities)	11	May 29
Regional West Garden County	3 (All from the general population)	13	May 27
Regional West Medical Center	2 (Hispanic and general communities)	*	May 19 and May 22
Sidney Regional Medical Center	3 (general, Chappell and Hispanic communities)	18	June 24

* Number of participants not captured

Comments were captured by the note taker and analyzed by each individual focus group and collectively. The analysis of the focus group results was guided by the Krueger approach.[10] Focus group transcripts were read and prevailing themes were identified. Data was highlighted and sorted accordingly. Common themes were identified across all 21 focus groups when responses were categorized by (1) factors contributing to quality of life/strengths of the community and (2) factors decreasing quality of life/weaknesses of the community.

Summary of Themes

Factors Contributing to Quality of Life/Strengths of the Community:

Friendly and caring community

Most groups indicated that their community is caring, friendly and a good place to raise a family. One focus group member said, “People you meet [here] are a testament to the culture of friendliness.” Many groups mentioned that people are very supportive of each other and willing to help neighbors in need. One participant stated, “People don’t wait to be asked, people just do to help each other.” However, some also mentioned that even though they are a close-knit community, they are “not always welcoming to new people.”

Availability of health care services

"We are fortunate to have the hospital we have here." This statement of a focus group member seems to resonate with the Panhandle community. Although services are limited and they have to travel for some specialty care, all of the focus groups were very appreciative of the local healthcare system - having a hospital and clinics in their community. Community Action Partnership of Western Nebraska and Western Community Health Resources were mentioned as important pieces of the Panhandle health care delivery system.

Safe community

An overwhelming majority of the groups stated that the community is safe with one member saying, "Most people don't lock their houses." However, there were a few concerns with regards to the increasing drug use and its impact on the community's safety.

Employment opportunities and local commerce

Although high paying jobs are very limited, majority of the focus group participants agreed that there are adequate good job opportunities in the area. Largest employers in the Panhandle are hospitals, railroad, banks, school system, agriculture and private industries like Cabela's, Castronics and ethanol plant. Due to the ruralness of the region, there are very limited retail stores. However, one focus group participant summed up how a majority of the groups felt in saying "we don't have everything available, but [we have] everything [we] need." Local businesses have been affected by the stagnant economy. A lot of small businesses have closed, but many still remain because "the community is supportive and buy locally."

Civic support and engagement

According to majority of the groups, community service is an integral part of the Panhandle culture. People are invested in their community. "For the most part people don't wait to be asked, they just do it to help out each other and the community." Volunteerism is so strong that a focus group participant expressed concern that " [we] may be overwork[ing] the volunteers sometimes." Churches play a huge role in getting the community engagement and support. Reverend Mink was mentioned as a very important figure and source of assistance for the Native American community.

Excellent school system

The consensus was that the school system in the Panhandle, including Western Nebraska Community College, is a strong asset to the community. A focus group member stated, "School is the strongest part of the social life in a small community." The schools also offer quality education and a variety of strong in-school, after-school and summer programs. The closing and consolidation of some schools have posed challenges to families living in the country-side as their kids have to travel a distance to get to school. One group mentioned, "some kids leave before daylight and get home after dark."

Access to opportunities for physical activity

Majority of the focus groups cited the availability and accessibility to parks, recreation and open spaces as a community asset. There are lakes, swimming pools, tracks and walking trails accessible to the public. This affords the community an opportunity to engage in outdoor play and physical activity. In addition, outdoor activities such as fishing and hunting are good for tourism.

Factors Decreasing Quality of Life/Weaknesses in the Community:

Lack of awareness of services/resources available

There was a general consensus among the groups that people are not aware of what services and resources are available to them. One group said that we "need to have one source for what is available in the community." Many also mentioned the need to provide assistance to navigate health care and social service programs, such as completing a Medicare or Medicaid application.

Barriers to accessing healthcare

Although focus group members were appreciative of the health care services offered in the Panhandle, barriers such as long clinic wait times and limited clinic and pharmacy hours were cited frequently. People also have to occasionally travel long distances to Colorado, South Dakota and Lincoln to receive specialty care. Limited mental health care services were mentioned as a huge issue in the Panhandle. Tele health services are being offered but it's not enough to meet the need. Groups also reported greater difficulty in recruiting and retaining physicians.

Language barrier was mentioned as an issue to accessing care. Some refuse to get care because they will not be able to communicate with the provider. A focus group member said, "because lack of confidence when there is a language barrier so only go seen if Emergent." Another said, "Hospital may have a couple translators but not designated so makes it hard to communicate so we just don't go." The issue of language barrier goes both ways. Some claim that they have difficulty understanding foreign doctors.

Undocumented immigrants were also identified as a vulnerable population. Many do not seek care for fear of deportation. As one focus group participant said, "some people are afraid to go for services because they don't want to be identified."

Intolerance

There is limited diversity in the Panhandle. Its largest racial/ethnic minority groups are Hispanics and Native Americans. Many mentioned that the community is "friendly and welcoming." However, prejudice against people of other ethnicity/race does exist in the Panhandle. One group stated, "race shouldn't matter but it does here." Another group commented that there is "shunning of Native Americans and African Americans" happening in the community. Bullying is also an issue in schools, especially. A group member said that "school systems do not discourage bullying, thus families choose to return to the reservation." But a focus group participant clarified that racism is not a pervasive issue in the Panhandle by saying that there's mostly "positive interactions between people with exceptions."

Intolerance not only exists due to differences in race/ethnicity but also with respect to differences in socio-economic background, age and political and religious views.

Drug use

Increasing drug use, especially of methamphetamine, is a huge concern for a majority of the focus groups. Some focus group participants pointed out that the legalization of marijuana in neighboring Colorado could potentially exacerbate the growing drug problem. This is a major concern as drug use is often linked with increased violence and crime. In addition, it also prevents individuals from getting a job. A focus group member said, "a lot of the big employers struggle to have potential employees pass the drug testing." The loss of detox services in the region poses an additional challenge to this growing problem.

Lack of transportation options

Many of the focus group participants mentioned transportation as a major challenge. Unfortunately, the low rural population density of the Panhandle region makes it difficult to have a strong, viable public transportation system. Lack of transportation is a key barrier to accessing health care and social service programs, especially among the elderly and low-income population. Among some Native American children, transportation is also a barrier to going to school.

Lack of Child Care options

Many families in the Panhandle struggle due to lack of child care options. The American Planning Association identified child care as "a critical component of livable communities."[11] A focus group member captured its importance in saying, "It's [Child care] vital to keep people working...Not everyone is able to shuffle and have family watch their kids."

Poverty

There are a lot of children in poverty living in the Panhandle region. Schools try to fill the gap through the free or reduced-priced meals and the backpack program which helps provide low-income kids with food on the weekends. It is difficult for many to earn a livable wage, especially for single mothers. Homelessness is also a growing issue that is not on people's radar. One focus group member commented, "[There's'] A lot more homeless people in this community than anybody knows… Higher up people do not have a clue about how many homeless people in community."

Lack of Affordable Housing

Lack of affordable housing to rent or purchase presents a challenge to the community. Properties are unkempt with one focus group participant saying, "[there's a] downturn in pride of ownership." This diminishes the curb appeal and makes it difficult to attract more people to live here.

Lack of Entertainment and Social Activities

Many mentioned that there is a lack of activities or places to go after work or after school. There is a need to have more activities available outside of school for all children and youth. Some focus groups also mentioned that this also makes it more difficult to recruit physicians because, "there's not a lot of the social aspects to entertain [the] wife…[like] shopping, dining

Comparison to 2011 Focus Groups

In the 2011 round of Community Health Needs Assessment, focus groups were also conducted throughout the Panhandle region. Fourteen focus groups were held in seven Panhandle counties, including separate focus groups with Hispanic and Native American community members.

When comparing the findings of the 2011 focus group with the 2014 focus group many similarities emerge. Both groups consider the Panhandle a good place to raise the family. The built environment of the Panhandle with plenty of open spaces, parks and recreation is viewed as an asset by both focus groups. However, both groups did cite that prejudice exists between people of different backgrounds, including race/ethnicity, socio-economic levels and ages.

Both 2011 and 2014 focus groups mentioned that good paying jobs with health benefits and affordable houses to purchase or rent are needed in the Panhandle. Limited health care services, especially mental

health services were cited as a huge issue by community members. Both groups also expressed concern about the rising drug and alcohol use.

Two topics that were raised in the 2014 focus group but not in 2011 was the limited childcare options and lack of awareness of services/resources available in the community. A majority of the focus groups in 2014 identified affordable childcare service as a huge need in the community. Because of the lack of childcare options, some families have to choose between working and staying home to take care of their kids. A prevailing theme in the 2014 focus group was the lack of awareness of services/resources available. Panhandle residents do not know that some of the services (be it health care or social service-related) that they are looking for is available locally. Having one common place that lists all the services and resources in the Panhandle was mentioned as something that may help solve this problem.

Conclusion

Although the Nebraska Panhandle is a geographically large area, several important themes resonated throughout all the focus groups conducted. Factors identified as strengths include: friendly and caring community, availability of health care services, safe community, employment opportunities and local commerce, civic support and engagement, excellent school systems, and access to opportunities for physical activity. Factors identified as weaknesses are: Lack of awareness of services/resources available, barriers to accessing to healthcare, intolerance, drug use, lack of transportation options, lack of childcare options, poverty, lack of affordable housing, and lack of entertainment and social activities. These findings are very similar to the focus group discussions completed in 2011, indicating that the Panhandle community has remained relatively unchanged in the past three years. Their issues of concern, values, and what they view as the strength of the community are still the same.

Some factors identified as strengths also had components that presented challenges to the community. First is that while health care services is available, it is limited. Lack of physicians, especially specialists, and limited clinic hours pose a challenge. In addition, for those who are unable to speak English, language barrier is a major issue to accessing care.

The groups also discussed that an adequate number of job opportunities available locally. However, many mentioned that a lot of the jobs do not pay a living wage, nor do they offer benefits. This makes it challenging for a lot of families, especially single-parent households, to make ends meet and overcome poverty.

Finally, the Panhandle region is generally considered a nice and safe place to live. However, there are areas where drug use is increasing, which threaten the safety of the community.

Overall, facilitators reported that the conversations were enlightening. The comments of all the focus group members provided a better understanding of the issues and concerns, perceptions about quality of life and assets in the Panhandle community.

Prioritization Process

In November 2011, a regional meeting with MAPP stakeholders was held to review the results of the needs assessment and begin the prioritization process for the health priorities. Priority health areas were based on the following criteria:

- Magnitude or size of the problem – the number or percentage of the population involved or affected
- Comparison with state results – how well are we doing compared to the rest of the state
- Historical trends – is the health issue getting better, worse, or remaining the same
- Economic and social impact – reflects the impact on workforce productivity, health care costs, crime rates, education, and the health of the population
- Changeability – indicates whether the health issue can be influenced at the local level in the next three to five years through prevention strategies and whether there are evidence-based programs, policies, and practices available that can significantly impact the issue
- Capacity of the local public health system – reflects the skills, awareness, interest, and support by public health partners within the region
- Readiness or political will – reflects the awareness, interest, and political support or lack of clear political opposition at both the state and community levels

Using a rating system provided by the Nebraska Department of Health and Human Services, participants reached a consensus and identified the following (in no particular order) to be the priority health areas of the Nebraska Panhandle:

1. *Healthy Living*
    - A. *Healthy Eating*
    - B. *Active Living*
    - C. *Breastfeeding*
2. *Mental and Emotional Well Being*
3. *Injury and Violence Prevention*
4. *Cancer Prevention*
    - A. *Primary Prevention*
    - B. *Early Detection*

Between September and November 2014, each hospital held a meeting with their staff members to determine its priority areas. See Appendix G for the hospitals' prioritization meeting dates. Hospital staff reviewed the socioeconomic and health data, and the results of the focus group discussions. Participants scored the data based on the availability of data, the percentage of the population affected, the resources available in the hospital and within the community to address the issue, and the seriousness of the issue. See Appendix H for a copy of the prioritization worksheet. The top three to four issues that had the highest score were identified as the hospital's priority health areas. Table 15 summarizes the 2014-2016 priority health areas of the eight Panhandle hospitals. Although there are slight differences due to the uniqueness of each hospital's service are, the community needs assessment and CHIP reports of the eight hospitals are aligned with each other and with the health priorities identified in 2011. Because many of the data, both qualitative and quantitative, remained relatively the same, the 2014

MAPP Steering Committee members reaffirmed the four priority areas identified in 2011 for the 2014 Regional Community Health Improvement Plan.

Table 15: Priority Health Areas, Panhandle Hospitals, 2014-2016

Hospitals	Healthy Eating & Active Living	Breastfeeding	Injury & Violence Prevention	Mental & Emotional Well being	Cancer Prevention & Tobacco Use	Access to Health Care	Cardiovascular	Substance Abuse & Alcohol Consumption	Hand Hygiene
Box Butte General Hospital	X		X			X			
Chadron Community Hospital	X	X	X	X	X				
Gordon Memorial Hospital	X					X	X		
Kimball Health Services	X			X	X		X		
Morrill County Community Hospital			X		X			X	
Regional West Garden County Hospital	X					X	X		
Regional West Medical Center	X	X	X	X	X				
Sidney Regional Medical Center	X							X	X

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Appendix

Appendix A: Panhandle Partnership for Health and Human Services Membership List

Aging Office of Western Nebraska

Box Butte County Family Focus

Box Butte General Hospital

CAPStone

Central Plains Center for Services

Chadron Community Hospital

Chadron Native American Center

Chadron State College

Cheyenne County

Cirrus House

City of Hay Springs

Community Action Partnership of Western Nebraska

DOVES

Educational Service Unit 13

Garden County

Garden County Health Services

Garden County Schools

Gordon Memorial Hospital

Heritage of Bridgeport

Housing Authority of Scottsbluff

Kids Plus

Kimball Health Services

League of Human Dignity

McConaughy Discovery Center

Mediation West

Nebraska Federation of Families

Northeast Panhandle Substance Abuse Center

Nebraska Panhandle Area Health Education Center

Northwest Community Action Partners

Panhandle Independent Living Services

Panhandle Mental Health Center

Panhandle Public Health District

Perkins County Health Services

Region 1 Office of Human Development

Regional West Medical Center

Rural Nebraska Healthcare Network

Speak Out

State of Nebraska Department of Health and Human Services

University of Nebraska College

Volunteers of America

Western Nebraska Community College

Appendix B: 2011 Visioning Work Product

Vision: What do we see in place in 3-5 years as a result of our actions?								
Access	**Safer Communities**	**Compassionate Integrative Care**	**Healthy Eating Environment**	**Active Living Opportunities**	**Decreased Substance Abuse**	**Policy to Promote Healthy Environment**	**Quality of Life for All Ages**	**Educated and Informed Community**
· Affordable and accessible youth friendly health care - mental - dental - medical · Access resources all ages · All people have health insurance · Eliminate disparities · Accessible public transportation (7 days/week) · Awareness…track what works and what does not · Resources available to everyone · Increase healthy provider visits (vs sickness only visits) · Health information exchange · Public education (all levels) · Easier to self-monitor healh - labs	· Reduce car crashes · Reduce suicide · Reduce child abuse · Reduce domestic violence · Neighbor-hood watch · Prevent unintentional injuries · Emergency prepared-ness	· Holistic approach - physical - mental - social · More smiles, less stress · More humanity in systems contact · Panhandle-wide beautification projects for com-munities · Focus on prevention of medical issues · Effective interpersonal relationship in service delivery	· Family gardens · Affordable healthy school lunches · Eat out healthy foods · Implementing community-wide programs to reduce obesity · Improved culture of health - better foods - walking paths - active families · Decrease childhood obesity	· Implement community-wide programming to reduce obesity · Increase physical activity/exercise · More opportunities for Activity in communities · Improved culture of health - better foods - walking paths - active families · Walking trails · Increased worksite wellness	· Reducing substance abuse (legal and illegal) · Less substance abuse · Decreased smoking · Responsible legal alcohol consumption · Prescription disposal	· Funding · Elected officials educated on "needs" · Increased taxes on tobacco, alcohol and sugary drinks · Policy development for improved health · Environments where healthy choice is easy choice	· Elderly quality of life · Engage levels of community – all ages- activities (barn dances) · Improved culture of health - better foods - walking paths - active families · Strengthen our families' structures · Maintaining autonomy of family	· Decreased high school dropout rate · Decreased stigma about mental health · Higher graduation rate with affordable college option · Better relationship education

Appendix C: Forces of Change Brainstorming Worksheet

The following two-page worksheet is designed for MAPP Committee members to use in preparing for the Forces of Change brainstorming session.

What are Forces of Change?

Forces are a broad all-encompassing category that includes trends, events, and factors.

- **Trends are patterns over time**, such as migration in and out of a community or a growing disillusionment with government.
- **Factors are discrete elements**, such as a community's large ethnic population, an urban setting, or a jurisdiction's proximity to a major waterway.
- **Events are one-time occurrences**, such as a hospital closure, a natural disaster, or the passage of new legislation.

What Kind of Areas or Categories Are Included?

Be sure to consider any and all types of forces, including:

- social
- economic
- political
- technological
- environmental
- scientific
- legal
- ethical

How To Identify Forces of Change

Think about forces of change — outside of your control— that affect the local public health system or community.

1. What has occurred recently that may affect our local public health system or community?
2. What may occur in the future?
3. Are there any trends occurring that will have an impact? Describe the trends.
4. What forces are occurring locally? Regionally? Nationally? Globally?
5. What characteristics of our jurisdiction or state may pose an opportunity or threat?
6. What may occur or has occurred that may pose a barrier to achieving the shared vision?

Also, consider whether or not forces identified were unearthed in previous discussions.

1. Was the MAPP process spurred by a specific event such as changes in funding or new trends in public health service delivery?
2. Did discussions during the Local Public Health System Assessment reveal changes in organizational activities that were the result of external trends?
3. Did brainstorming discussions during the Visioning or Community Themes and Strengths phases touch upon changes and trends occurring in the community?

Appendix D: 2014 Forces of Change Assessment Work Product

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 (w/in 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	• 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 E: Focus Groups Instructions and Invitation Template

- **No more than 6-8 attendees (ok to invite 10 as some may not show)**
- **Target is cross-section of community residents**
- **Invite Example:**
  - We are seeking <*insert community*> residents for a discussion about the strengths and needs of our community. Please join us on <*insert date*> from <*insert time*> at <*insert location*> and we ask that you confirm attendance by replying to this email or calling <*insert phone number*>. Thank you for considering this important opportunity to provide essential input on the health of our community!

APPENDIX F: Focus Group Guide for Community Themes and Strengths Assessment

We would like to talk with you today about your community and your ideas about the strengths and needs of your community. Everyone's opinion is important, so I want to make sure that all get a chance to talk. Feel free to respond to each other and give your opinion even if it differs from your neighbor. Occasionally I may interrupt to move on to the next question, but I will do so just to make sure we cover all the topics that we want to talk about today. It will never mean that I do not think what you are saying is important.

Let's take a minute to introduce ourselves before we get started. Could you please tell everyone your name and how long you have lived in name of community or health district? (*Have each person respond, but do not go around in a circle. Start with co-facilitator and end with facilitator*)

(You can review the following ground rules with the group if you would like)

Focus Group Ground Rules

We have a lot to cover, so we will all need to do a few things to get our jobs done:

1. Talk one at a time and in a voice at least as loud as mine.
2. We need to hear from every one of you during the discussion even though each person does not have to answer every question.
3. Feel free to respond to what has been said by talking to me or to any other member of the group. That works best when we avoid side conversations and talk one at a time.
4. There are no wrong answers, just different opinions. We are looking for different points of view. So just say what is on your mind.
5. We do have a lot to cover, so you may all be interrupted at some point in order to keep moving and to avoid running out of time.
6. We value your opinions, both positive and negative, and we hope you choose to express them during the discussion.
7. Everything you say in this group is to remain confidential. This means that we require that each one of you agree not to repeat anything talked about within this group to anyone outside of the group.

Again, this focus group is confidential. Notes will be made anonymously. We ask you to respect this understanding and refrain from speaking about specifics about this group with others afterwards.

Focus Group Questions: The questions in bold are the key questions to ask participants. The other questions are optional depending on how the focus group goes.

1. **First, I would like to start by getting an idea of how you would describe your community. If you were talking with a friend or family member who had never been here, how would you describe your community to him or her?** *Probes: What does it look like; get an idea of physical boundaries—definition of community; what is different about here compared to there; what types of things are available here; what activities do you do here?*

2. **What do you view as strengths of your community?**

3. How do you think your community has changed in the last 5-10 years?

4. **What are some of the things that you see as lacking in your community?** *Probes: Needs; health needs.*

5. **In your family or your friends' families, what are your biggest concerns?** *Probes: personal needs, health, employment, education*
    a. *Reread named community and personal needs*. Which of these needs would you say is the most important? Remember it is okay if people have different opinions. Why is it the most important? Next most important?

6. **How would you describe the interactions between community members from different backgrounds?** *Probe: those who have lived here longer vs. new and among different races (How has this changed?)*

7. Where do you go for health care? *Probe: explore their perceptions of health care services; barriers/facilitators*

8. From where do you get most of your health information? *Probe: are they satisfied or would they prefer somewhere else*

9. **If a task force was being formed to improve things in your community, what topics do you think they would need to address and why?**

Optional

10. What kind of services and businesses are used most by community members? *Probe: different segments of the community including ethnic groups, women vs. men, persons with disabilities, persons with lower incomes.*

11. What kinds of services are not used by community members? *Probe: different segments of the community including ethnic groups, women vs. men, persons with disabilities, persons with lower incomes.*

12. What kinds of services do community members wish they had for everyone? *Probe: different segments of the community including ethnic groups, women vs. men, persons with disabilities, persons with lower incomes.*

Thank you for taking time to come talk with us today. What you have shared will help us work together to understand more about the strengths and needs of the community. We will be working over the next few months to put together what everyone who is participating in these groups has shared, and then we will present the results and future plans in a community meeting. We will send you a postcard to let you know when the meeting.

Appendix G: Dates of Hospital Prioritization Meeting

Hospital	Date
Box Butte General Hospital	October 15, 2014
Chadron Community Hospital	November 2014
Gordon Memorial Hospital	October 29, 2014
Kimball Health Services	October 28, 2014
Morrill County Community Hospital	October 20, 2014
Regional West Garden County	October 31, 2014
Regional West Medical Center	September 9, 2014
Sidney Regional Medical Center	November 2014

Appendix H: Prioritization Worksheet Template

												Social and Economic Factors				
Criteria	Weight	Scoring Values	Health Care Access	Cardiovascular	Tobacco Use	Cancer	General Health Status	Nutrition/Physical Activity	Mental Well Being	Alcohol	Injury	Accessibilty	Economic Health	Family Support	Educational Attainment	Unemployment
Available Data: Is measurable data available?	1	0, 1, 2, 3, 4 0: no data 1: perceptual / anecdotal 2: perceptions and counts 3: perceptions and baseline 4: perceptions and trend														
Population Affected: What percentage of the population does this health issue affect?	2	1, 2, 3, 4, 5, 6, 7, 8, 9, 10 1 - 2: Less than 1% 3 - 4: 1.0 - 9.9% 5 - 7: 10 - 24.9% 8 - 10: 25% or greater														
Resources Available: Does the community hospital and do the community partners have the knowledge, skill, materials and equipment needed to address this health issue?	3	0, 1, 2, 3, 4 0: no hospital or community resources 1: minimal hospital resources 2: minimal hospital and community resources 3: adequate resources from one organization (partner or hospital) 4: adquate community resources														
Significance / Importance: What is the seriousness of this issue? Urgency - high death rate - hospitalization - premature death rate - economic burden - impact on others?	3	1, 2, 3, 4, 5, 6, 7, 8, 9, 10 1 - 2: Not serious / little impact 3 - 5: Moderate - illness 6 - 8: Serious - some death, impact 9 - 10: Very serious - high death														
		Total Score														

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