

2020 Community Health Needs Assessment of Regional West Medical Center

live, learn, work, and play



For a Healthier Panhandle

PREPARED BY

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Panhandle Public Health District

IN COLLABORATION WITH

Rural Nebraska Healthcare Network
Scotts Bluff County Health Department
Box Butte General Hospital
Chadron Community Hospital
Gordon Memorial Hospital
Kimball Health Services
Morrill County Community Hospital
Perkins County Health Services
Regional West Garden County
Regional West Medical Center
Sidney Regional Medical Center
Panhandle Partnership
Panhandle Area Development District
Nebraska Department of Health and Human Services

WITH SPECIAL THANKS TO

Daniel Bennett, Civic Nebraska
formerly of Panhandle Area Development District

FOR MORE INFORMATION

www.rwhs.org

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LETTER FROM THE CEO

At Regional West we are proud of our longstanding tradition of both providing quality health care and also connecting with the community to address local and regional health care needs and concerns. Doing so is our both mission and the basis of our growth from a small community hospital to a regional referral center.

We are required by the Patient Protection and Affordable Care Act to conduct a community needs assessment to determine unmet health care needs in the community.

Regional West continues to work collaboratively with the Scotts Bluff County Health Department and Panhandle Public Health District, focus groups, community boards, advisory groups, and area residents to discuss and review local health initiatives, resources, and gaps in health care. This assessment involves the collection of data to steer our efforts to address pressing health issues.

A task force of staff from Regional West and Scotts Bluff County Health department ranked unmet needs based on data analysis and the recommendations of the individuals and organizations who participated in the assessment. Key issues were identified as top priorities include: Access to services, Mental Health and Well-Being, and Poverty and Economic Hardship with focuses including Injury Prevention, Aging Population Health and Prevention Management. The task force will develop a three-year Community Health Improvement Plan (CHIP) for implementation and interventions to address these local needs.

Regional West is committed to improving the health of our region by continually working with community partners to address the health needs of Scotts Bluff County and regional residents. We intend the result of this assessment and the goals it establishes helps to improve the lives of those we are honored to serve.

John Mentgen, FACHE

President and CEO

Regional West Health Services

ABOUT REGIONAL WEST MEDICAL CENTER

Regional West Health Services in Scottsbluff, Neb. Includes Regional West Medical Center, a 188-bed regional referral center and the only Level II Trauma Center in Nebraska west of Kearney, and other hospitals and health system affiliates, including a residential care facility and an insurance company. The trauma program includes Air Link air ambulance services and the hospital is fully accredited by The Joint Commission.

As the region's only tertiary referral medical center, Regional West offers care that spans more than 32 medical specialties provided by over 28 physician clinics. With nearly 300 providers, and approximately 2,000 employees, Regional West provides comprehensive and innovative health care services for the people of western Nebraska and the neighboring states of Colorado, South Dakota, and Wyoming.

Regional West Health Services includes

- Regional West Medical Center—188-bed regional referral center and a Level II Trauma Center
- Regional West Physicians Clinic—Western Nebraska's and central eastern Wyoming's largest multispecialty medical and surgical group.
- Regional West Garden County, Oshkosh—A 10-bed critical access care hospital, rural health care clinic, and 40-bed intermediate care facility that serves residents in the southeastern Nebraska panhandle.
- Regional West Laboratory Services— a clinical laboratory offering a full range of laboratory services, including reference laboratory services, to health care providers. It is accredited by the Commission on Laboratory Accreditation of the College of American Pathologists (CAP).
- Regional Care, Inc. (RCI)—Based in Scottsbluff, RCI is an independent third-party administrator for health care benefits; providing cost, medical, and claims management for clients throughout the United States.
- The Village at Regional West—A full-service residential care community of 100 beds located adjacent to Regional West Medical Center that offers both independent and assisted living apartments for persons age 55 and older.
- Regional West Foundation—A non-profit organization developed to enhance the services, programs, and projects of Regional West Health Services through donations, planned giving and fundraising.

Regional West is an active leader in the Rural Nebraska Healthcare Network (RNHN) and supports the following Critical Access Hospitals in Nebraska:

- Regional West Garden County—Oshkosh
- Chadron Community Hospital—Chadron
- Gordon Memorial Health Services—Gordon
- Kimball Health Services—Kimball
- Box Butte General Hospital—Alliance
- Morrill County Community Hospital—Bridgeport
- Perkins County Health Services—Grant
- Sidney Regional Medical Center—Sidney

Award Winning Care

- The Joint Commission—Full accreditation by the Joint Commission demonstrates our commitment to providing the very best for our patients—quality, safety, and innovation.
- Level II Trauma Center—Regional West Medical Center is the only Level II Trauma Center in Nebraska west of Kearney.
- Healthgrades—Regional West has achieved 5-stars for its performance in Stroke (2017-2019), Sepsis (2017, 2018), Pneumonia (2018), and Respiratory Failure (2017-2020) treatment from Healthgrades.
- American College of Surgeons Commission on Cancer— Regional West’s Cancer Services program has been recognized several times for Outstanding Achievement by the ACoS Commission on Cancer.
- Bariatric Surgery—Regional West is accredited as a comprehensive center under the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program, known as MBSAQIP®, a joint program of the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery as well as designated a Blue Distinction Center for Bariatric Surgery.
- Commission on Accreditation of Rehabilitation Facilities (CARF)—Regional West’s Acute Rehabilitation Unit and Stroke Care program are both certified by the Commission on Accreditation of Rehabilitation Facilities.
- AACVPR Certified—Regional West’s AACVPR certified cardiovascular rehabilitation program is recognized as a leader in the field of cardiovascular rehabilitation by offering the most advanced practices available.
- Air Link Certification—The Regional West Air Link program was awarded a full three-year accreditation in 2019 by the Commission on Accreditation of Medical Transport Systems (CAMTS).
- Regional West Medical Center has received the Get With The Guidelines®-Stroke GOLD PLUS with Honor Roll Elite Achievement Award by The American Heart Association and American Stroke Association.
- Vizient 2018 Top Performer for Performance Solutions Excellence among their community-based hospital members. Regional West was one of five member hospitals chosen nationally for its outstanding work focused on enhancing operational efficiency and aligning clinical care delivery to achieve documented cost savings over the course of 2017.
- The Chartis Center for Rural Health/iVantage Health Analytics and the National Organization of State Office of Rural Health (NOSORH)
- Top 100 Rural & Community Hospitals—in 2017, Regional West was named one of the Top 100 Rural & Community Hospitals in the United States by iVantage Health Analytics and The Chartis Center for Rural Health.

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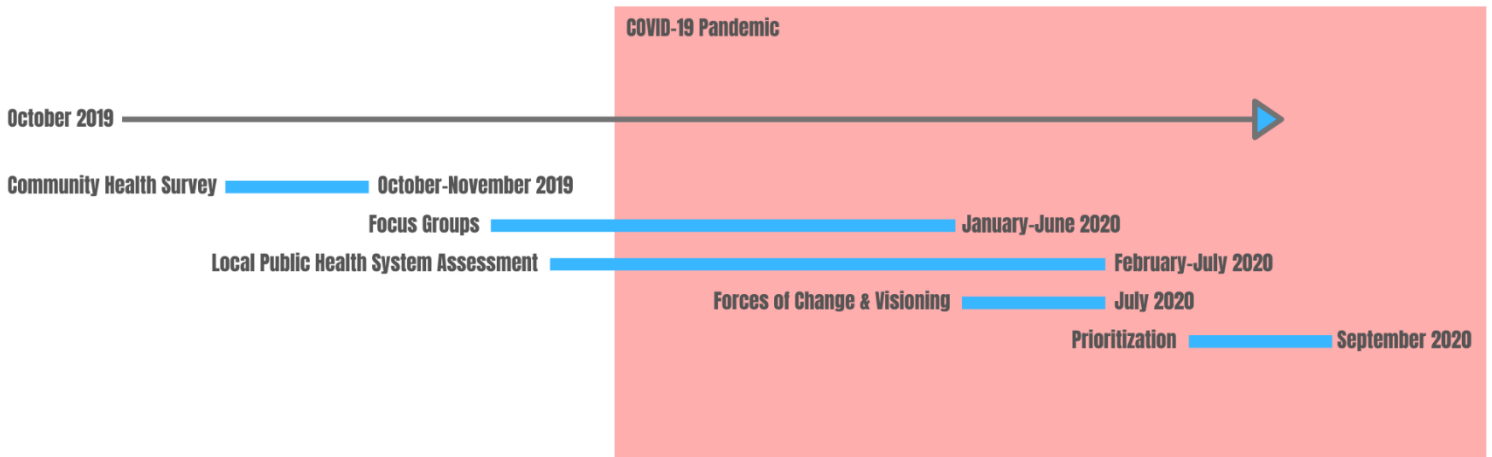
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NOTE ON COVID-19 PANDEMIC

The 2020 Community Health Assessment fell across 2019 and 2020, with some aspects completed prior to the start of the COVID-19 Pandemic. This is important to keep in mind as the data in this report are interpreted, as the concerns of Panhandle residents may have changed as the Pandemic progressed. The pieces of the Community Health Assessment that were completed after the pandemic began may reflect different concerns.

2020 Community Health Assessment Timeline



DATA AVAILABILITY

In spring of 2020, the work of many public health workers in Nebraska was shifted to focus on the COVID-19 Pandemic. Because of this, some data that would normally be included in this report is missing; notably morbidity, mortality, and health disparity data.

INTRODUCTION

Panhandle Public Health District (PPHD) is accredited by the Public Health Accreditation Board (PHAB), which requires the health department to conduct a comprehensive Nebraska Panhandle Community Health Assessment (CHA) every five years. However, Internal Revenue Service (IRS) regulations require tax-exempt hospitals to conduct a CHA every three years. In 2014, PPHD made the decision to collaborate with hospitals on the CHA process by syncing the health department process with the hospital process, meaning that PPHD completes a CHA every three years, in tandem with area hospitals. Thus, PPHD now facilitates a joint CHA and planning process with the eight hospitals in the Nebraska Panhandle and one in Perkins County, all of which are members of the Rural Nebraska Healthcare Network (RNHN).

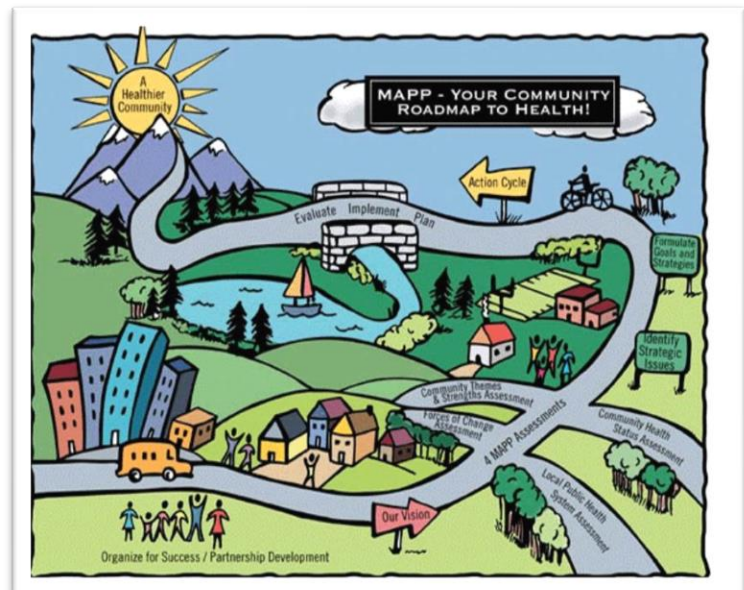
The purpose of the CHA process is to describe the current health status of the community, identify and prioritize health issues, better understand the range of factors that can impact health, and identify assets and resources that can be mobilized to improve the health of the community.

OVERVIEW OF MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the CHA and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHA and CHIP. 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 model has six key phases:

1. Organize for success/Partnership development
2. Visioning
3. Four MAPP assessments
 - a. Community Health Status Assessment
 - b. Community Themes and Strengths Assessment (CTSA)
 - c. Forces of Change Assessment
 - d. Local Public Health System Assessment
4. Identify Strategic Issues
5. Formulate Goals and Strategies
6. Take Action (plan, implement, and evaluate)



This document contains information for phases one through four. Phases five and six can be found in the associated Community Health Improvement Plan (CHIP).

MAPP PHASE 1: ORGANIZE FOR SUCCESS/PARTNERSHIP DEVELOPMENT

A MAPP Steering Committee was formed in 2014, made up of representatives from each of the nine RNHN hospitals (see list of members on page 10). Committee members provide guidance throughout the MAPP process and are charged with reviewing data and progress on the chosen priority areas, using quality improvement to modify implementation plans as needed, and sharing results with stakeholders.

LOCAL PUBLIC HEALTH SYSTEM COLLABORATIVE INFRASTRUCTURES

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

- **Rural Nebraska Healthcare Network** (RNHN) which includes nine hospitals in the region, all rural health clinics, and assisted living/nursing homes that are a part of the RNHN member systems, including the Trauma Network. See page 10 for a list of RNHN members.
- **Public health partnerships** including collaborative work groups such as the Panhandle Regional Medical Response System (PRMRS) and Panhandle Worksite Wellness Council (PWWC), as well as the two public health Boards of Health (PPHD and SBCHD), which include elected officials.
- The **Panhandle Partnership** is a large, not-for-profit organization which promotes collective impact through planning and partnership. This inclusive, membership-based organization has and continues to be an integral part of the regional assessment and planning process. See page 11 for a list of Panhandle Partnership members.

MAPP STEERING COMMITTEE MEMBERS

Community Action Partnership of Western Nebraska	Betsy Vidlak
Rural Nebraska Health Care Network	Boni Carrell
Regional West Garden County	Bradley Howell Stacey Chudomelka Jenny Moffat Ricca Sanford
Gordon Memorial Health Services	Doris Brown Amanda Kehn Kim South
Box Butte General Hospital	Lori Mazanec Dan Newhoff
Panhandle Area Development District	Megan Kopenhafer
Sidney Regional Medical Center	Evie Parsons Tammy Meier
Chadron Community Hospital	Nathan Hough
Western Community Health Resources/ Chadron Community Hospital	Sandy Montague-Roes
Perkins County Health Services	Neil Hilton Rhonda Theiler
Panhandle Public Health District	Kim Engel Jessica Davies Kelsey Irvine Sara Williamson Tabi Prochazka
Regional West Medical Center	Joanne Krieg Julie Franklin
Scotts Bluff County Health Department	Paulette Schnell
Kimball Health Services	Ken Hunter Laura Bateman Stephanie Pedersen Cheryl Delaplaine Kerry Ferguson
Educational Service Unit 13	Nicole Johnson
Morrill County Community Hospital	Robin Stuart Sylvia Lichius Connie Christensen Tracy Sterkel Jenn Ernest Jennifer Compton
Panhandle Partnership	Faith Mills

RURAL NEBRASKA HEALTHCARE NETWORK MEMBERS

Chadron Community Hospital	Nathan Hough
Sidney Regional Medical Center	Jason Petik
Perkins County Health Services	Neil Hilton
Regional West Medical Center	John Mentgen
Kimball Health Services	Ken Hunter
Box Butte General Hospital	Lori Mazanec
Morrill County Community Hospital	Robin Stuart
Gordon Memorial Hospital	Doris Brown
Regional West Garden County	Bradley Howell

PANHANDLE PARTNERSHIP MEMBERS

- Aging Office of Western Nebraska
- Bayard Public Schools
- Box Butte General Hospital
- CAPSTONE
- CAPWN
- Carolyn Escamilla
- Central Plains Center for Services
- Chadron Community Hospital
- Chadron Public Schools
- Cirrus House
- City of Chappell
- City of Hay Springs
- City of Scottsbluff
- Department of Health and Human Services
- Disability Rights Nebraska
- Doves
- Educational Service Unit 13
- Garden County Health Services
- Garden County Public Schools
- Housing Authority of Scottsbluff
- Immigrant Legal Center
- Independence Rising
- Joan Cromer
- Kimball County
- Kimball Health Services
- Legal Aid of Nebraska
- Mediation West
- Minatare Public Schools
- Monument Prevention Coalition
- Morrill County Community Hospital
- Native Futures
- NE Children's Home Society
- Kim Anderson, LMHP
- Nebraska Civic Engagement
- Nebraska Commission for the Deaf & Hard of Hearing
- Nebraska Department of Labor
- Nebraska Foster & Adoptive Parent Association
- Nebraska Panhandle Area Health Ed Center
- Nebraska Senior Health Insurance Information Program
- NW Community Action Partnership
- Open Door Counseling
- Optimal Family Preservation
- PADD
- Panhandle Equality
- Panhandle Public Health District
- Panhandle Trails Intercity Public Transit
- PlainsWest CASA
- Region 1 Behavioral Health Authority
- Region 1 Office of Human Development
- Regional West Medical Center
- Roger Wess
- Scotts Bluff County
- Shirley Belk
- Snow Redfern Foundation
- United Way of Western Nebraska
- UNL Panhandle Extension Center
- Volunteers of America
- Well Care
- Western Community Health Resources
- Western Nebraska Community College

MAPP PHASE 2: VISIONING

The MAPP Visioning process was intended to take place at a large in-person event in March 2020, which would have been the kick-off event for the 2020 Community Health Assessment. Due to the COVID-19 Pandemic, this event was cancelled, and a virtual event took place on July 30, 2020, to complete the Visioning process. See [Appendix A](#) for the meeting work product (including details on the process) and see the next page for the full Vision.

What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?

Healthy Eating	Promote Emotional Resilience	Environments and Events for Active Living	Establish Healthy Habits Early On	Focus on Long-term impact of Pandemic	Improve Access to Healthcare	Prevent and Reduce Substance Use	Access to Basic Needs
<ul style="list-style-type: none"> • Community gardens • Healthy food options • Increase nutrition awareness through programming (SNAP, food bank, commodities, etc.) • Access to affordable healthy foods • Incorporation of local healthy food options (farmers market, farm to table, etc.) 	<ul style="list-style-type: none"> • Improve emotional well-being • Healthier ways to deal with stress • Improve access to behavioral health services • Community support for behavior change • Promote healthy stress management techniques • Overcome cost as a barrier to behavioral health treatment 	<ul style="list-style-type: none"> • Safe environments for walking and biking in communities • Opportunities for physical activity (5k type activities, family activities) • Workplace culture of wellness, both in office and WFH • Distance-friendly opportunities for physical activity (virtual, etc.) • Incentives for healthy lifestyle changes • Cultivate culture of health • Active living environments accessible to people of all abilities 	<ul style="list-style-type: none"> • Educate children on whole body health (food choices and activity; access to nutritious foods; access to walkways and activity; emotional health) • Provide parents with education and support for healthy children (nutrition, physical activity, emotional health) • Elementary school education about healthy habits • Health literate resources • Support healthy family programming (Healthy Families, WIC, etc.) • Address environmental health concerns that impact children (e.g., lead) • Focus on all health factors, not only weight 	<ul style="list-style-type: none"> • Promote kindness and compassion during unusual times • Decrease politicization of public health measures • Accessible technology for older adults • Accessible technology for vulnerable populations • Virtual opportunities for physical activity • Maintain opportunities for health screenings • Healthcare opportunities for those who experience gap in health insurance due to job loss 	<ul style="list-style-type: none"> • Improved access to eye care • Transportation to/from medical appointments • Increased health care coverage • Mobile health services • Increased resources to care for older adults • Population health perspective • Decrease chronic disease • Link healthcare providers to community programs • Medicaid Expansion 	<ul style="list-style-type: none"> • Tobacco free • Local taxes on tobacco and alcohol • Reduce binge drinking rates • Reduce substance abuse (misuse of prescription drugs, illegal opioids) • Reduce e-cigarette use among youth (tobacco and marijuana) • Improve access to sites for safe medication disposal 	<ul style="list-style-type: none"> • Accessible and affordable public transportation • Safe, quality, and affordable housing • Quality and affordable childcare • Emergency housing for homeless individuals • Jobs with livable wages and benefits • Payer sources to keep hospitals and clinics paid/open

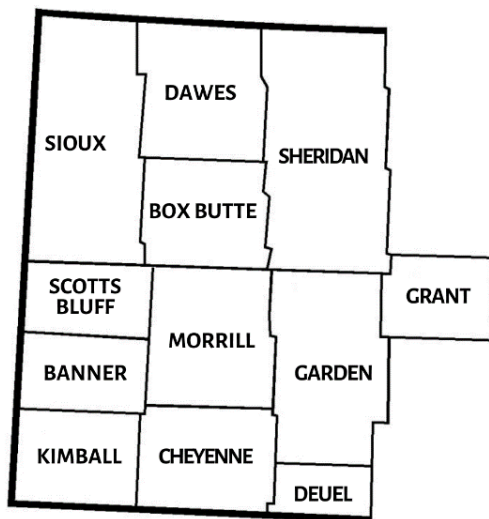
MAPP PHASE 3: FOUR MAPP ASSESSMENTS

COMMUNITY HEALTH STATUS ASSESSMENT

COMMUNITY PROFILE

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

The Nebraska Panhandle consists of the counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux. The Panhandle Public Health District (PPHD) service area additionally consists of Grant County, for a total of 12 counties covered. Throughout this document, the PPHD service area will be referred to as the Panhandle.



Scotts Bluff County Quick Facts:

Population:	36,509
Unemployment rate:	3.2
Total land area:	745 sq. miles

Source: 2013-2017 American Community Survey 5-Year Estimates

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. In Cheyenne County, population has increased in recent decades while in Deuel County, the population has steadily declined for most of the past century.

Figure 1: Nebraska Population, 1910-2010

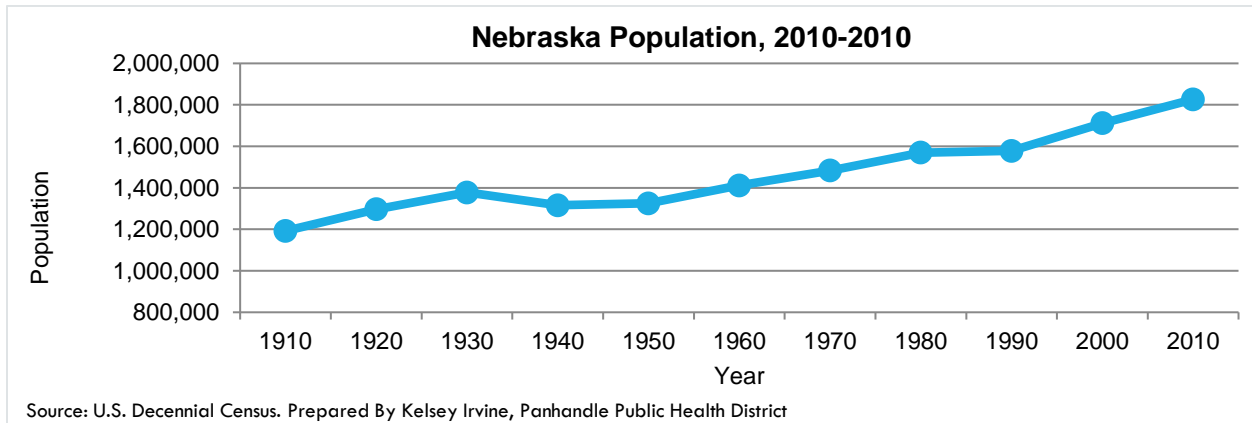


Figure 2: Panhandle Population, 1910-2010

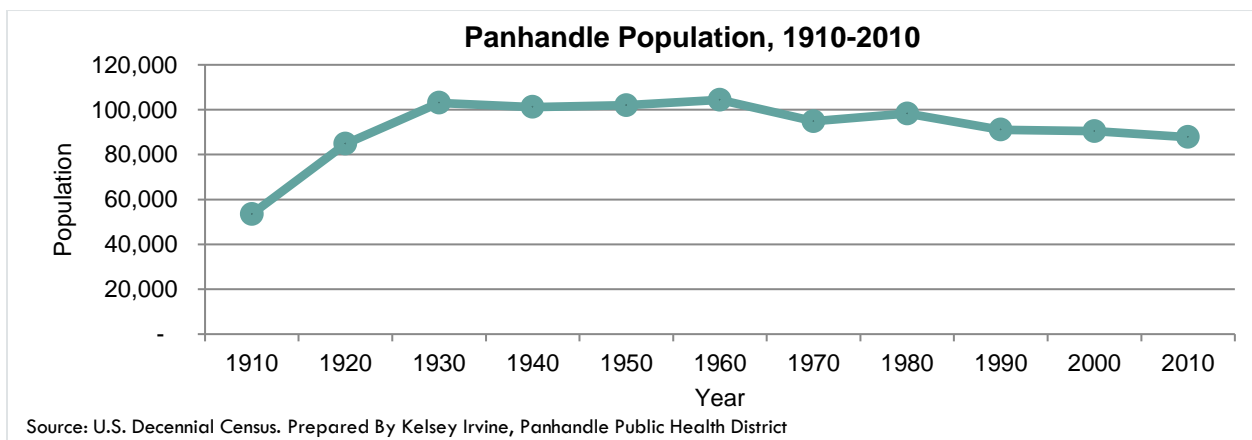


Figure 3: Scotts Bluff County Population, 1920-2010

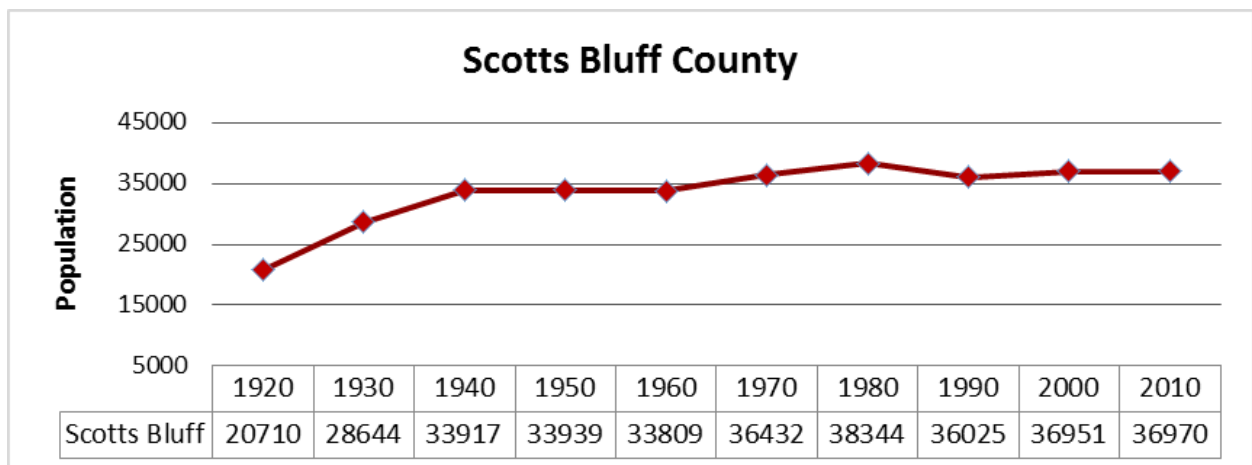
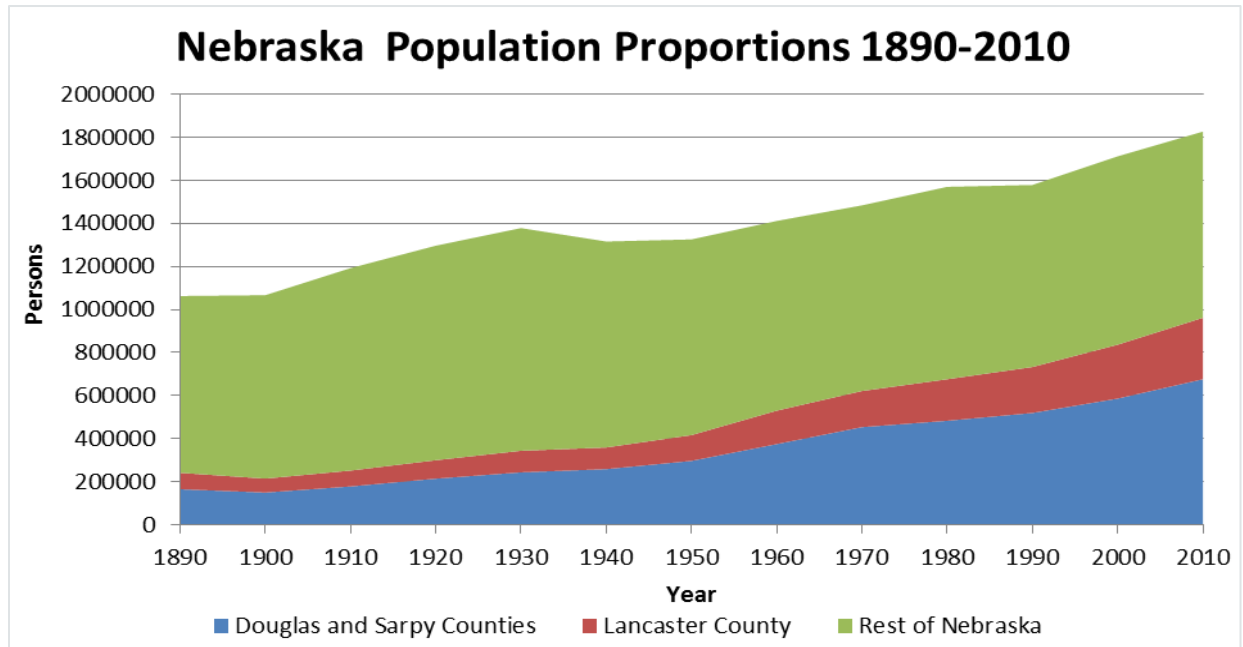


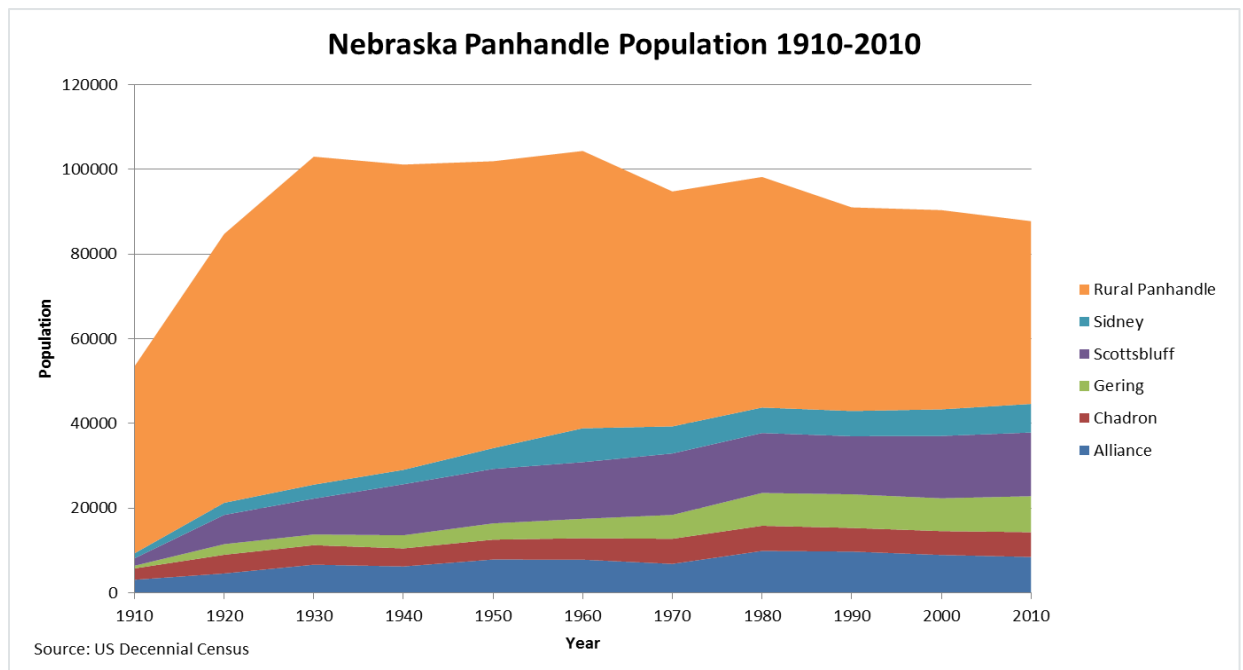
Figure 4: Nebraska Population, Omaha and Lincoln metro areas and rest of state



Source: U.S. Decennial Census

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.

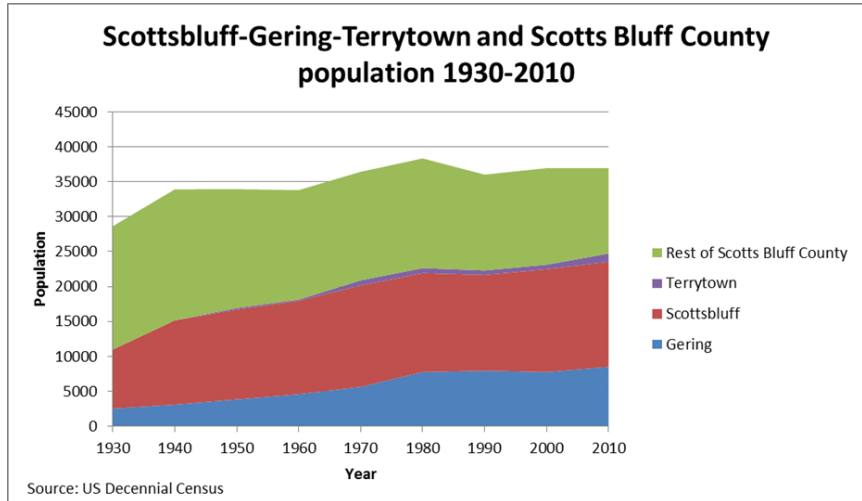
Figure 5: Nebraska Panhandle Population Consolidation: 1910-2010



Source: US Decennial Census

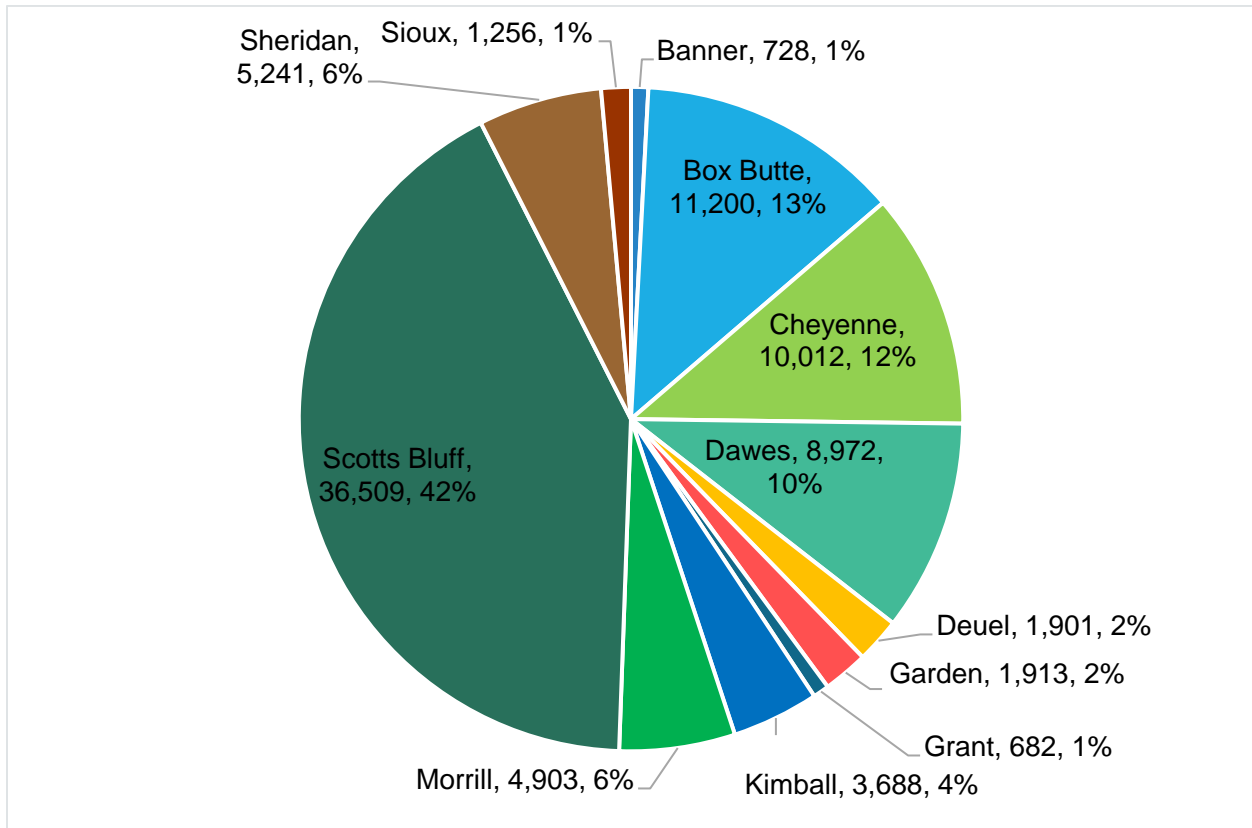
Population consolidation away from rural areas is not new, and is a global phenomenon. This consolidation has also been occurring within the county. In 2010, over two thirds of the county population lived in the Scotts Bluff-Gering-Terrytown community, a number that has been increasing since the early twentieth century. The Scottsbluff-Gering area has

Figure 6: Scotts Bluff County Population, Urban and Rural



benefitted from this trend and become the primary service and shopping center for over a 100 mile radius, and it will continue to benefit in the future. For smaller communities, measured strategies which maintain or improve the quality of life at a smaller level of population may help capture some of Scottsbluff-Gering based workforce who desire to live in a smaller community. Loss of population in rural and small communities also requires collaboration to meet needs with fewer resources and people. What these communities lack in critical mass of resources and people, it must make up for in creative solutions and the strengthening of partnerships.

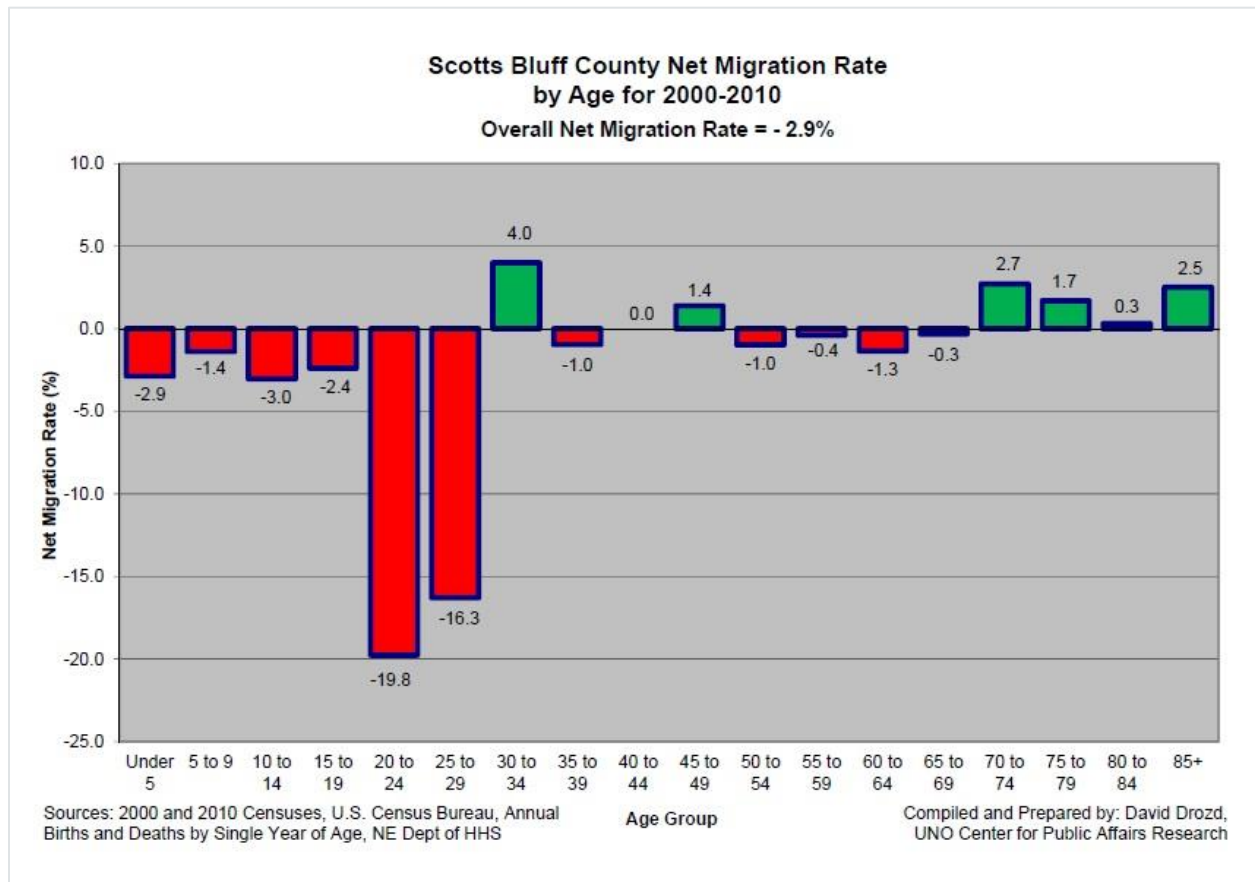
Figure 7: Panhandle Population by County, Count and Percentage



Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

Migration patterns show the out-migration for young adults as the economic, educational, and social opportunities of metropolitan and other areas draw them away. The county has gained population from cohorts over 65 and some in the 30-49 age range. As more baby boom echo generation cohorts have moved into twenties and thirties age groups this decade, in-migration from these generations may have increased from 2000-2010 rates.

Figure 8: Net Migration Rate by Age for 2000-2010



POPULATION PROJECTIONS

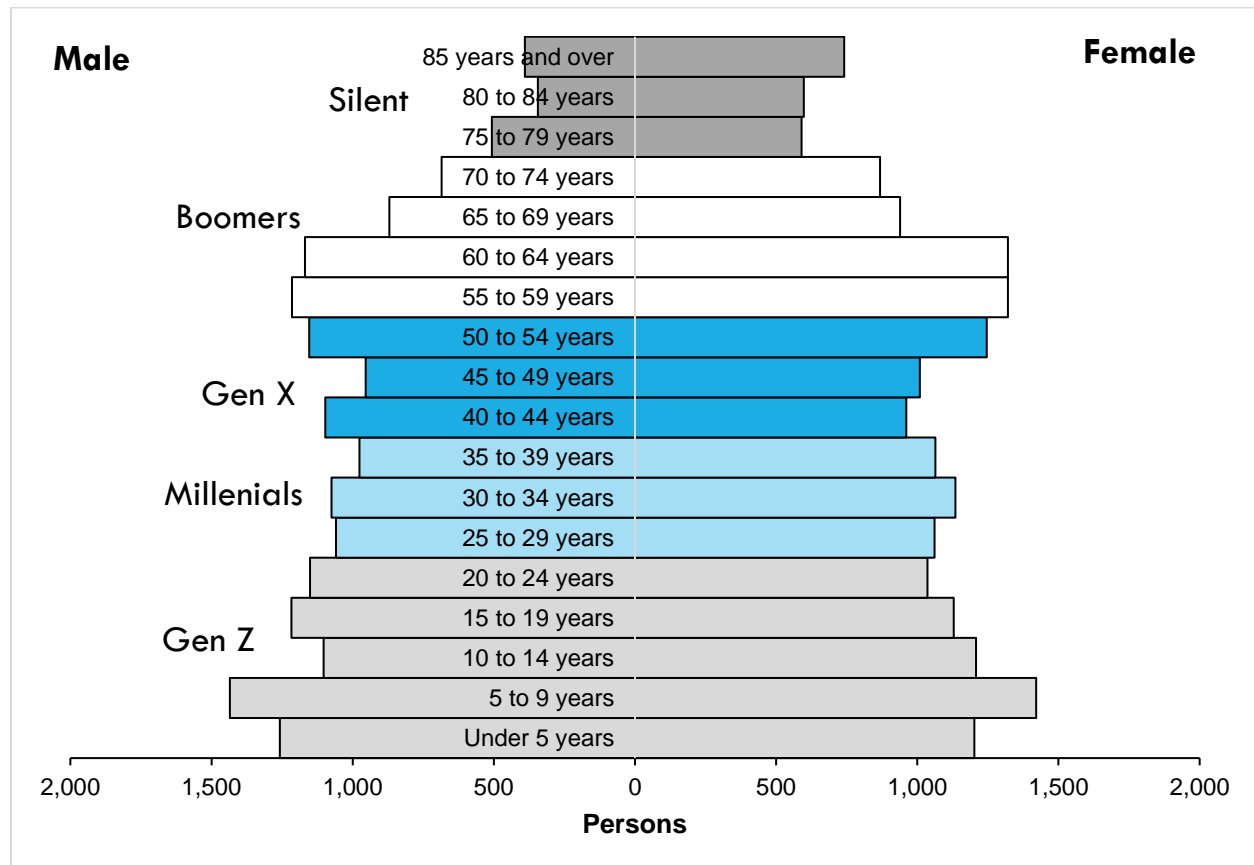
The population pyramid from 2017 ACS Estimates shows the general age make-up of Scotts Bluff County with a still strongly pronounced baby boom generation. Unlike most counties in the Panhandle which show a thinning of the pyramid, Scotts Bluff County has retained a fairly strong baby boom “echo” population, reflecting the more plentiful and diverse job opportunities available in the county than elsewhere in the region.

Figure 9: Population by Sex and 5-Year Age Group, Cheyenne County

	Both Sexes		Male	Female
	Estimate	Percent	Estimate	Estimate
Total Population	36,509		17,659	18,850
Under 5 years	2,460	6.7%	1,258	1,202
5 to 9 years	2,856	7.8%	1,435	1,421
10 to 14 years	2,311	6.3%	1,103	1,208
15 to 19 years	2,346	6.4%	1,217	1,129
20 to 24 years	2,187	6.0%	1,151	1,036
25 to 29 years	2,120	5.8%	1,059	1,061
30 to 34 years	2,210	6.1%	1,075	1,135
35 to 39 years	2,040	5.6%	976	1,064
40 to 44 years	2,058	5.6%	1,097	961
45 to 49 years	1,963	5.4%	954	1,009
50 to 54 years	2,400	6.6%	1,154	1,246
55 to 59 years	2,536	6.9%	1,215	1,321
60 to 64 years	2,490	6.8%	1,169	1,321
65 to 69 years	1,809	5.0%	870	939
70 to 74 years	1,553	4.3%	685	868
75 to 79 years	1,097	3.0%	507	590
80 to 84 years	942	2.6%	344	598
85 years and over	1,131	3.1%	390	741

Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

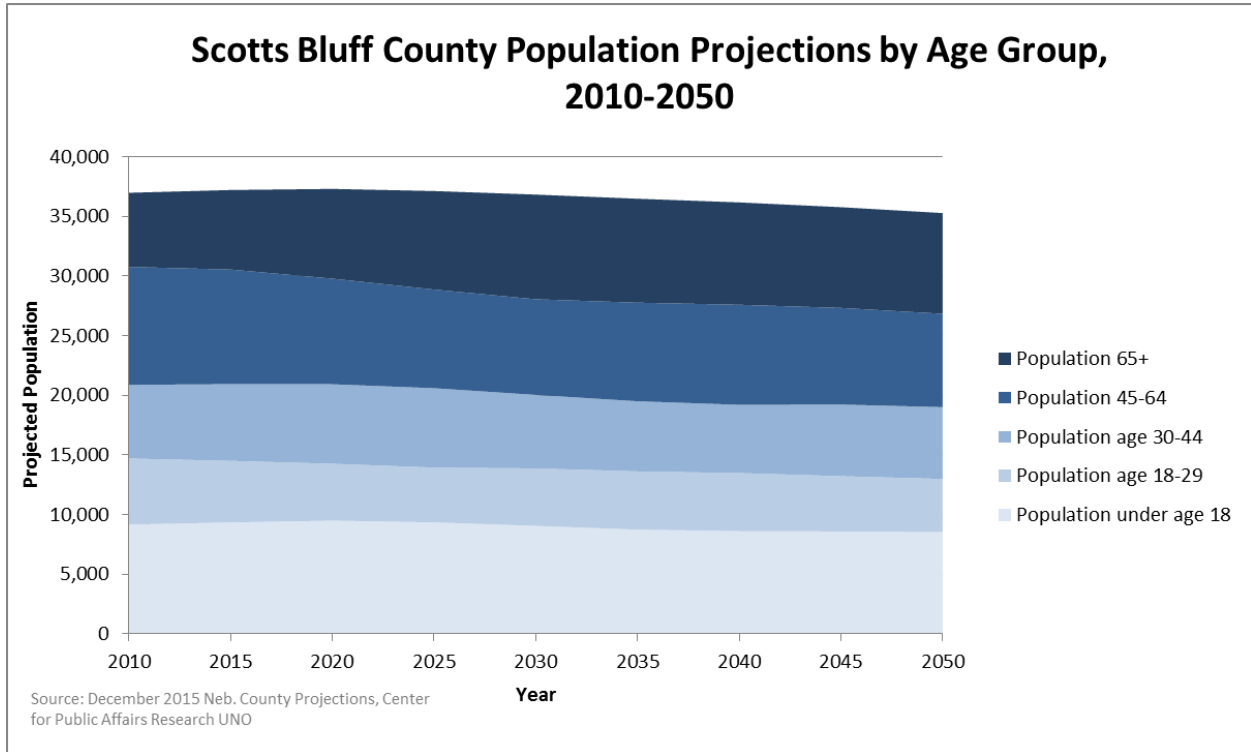
Figure 10: Scotts Bluff County Population Pyramid



Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

Population projections for Scotts Bluff County show a slight growth in population through 2025, after which the population is then projected to decline slightly. The county is expected to maintain fairly even distribution across age groups despite 41% growth in the population age 65 and older. By 2030 the population under 18 is expected to still comprise nearly a quarter of the total population.

Figure 11: Scotts Bluff County Population Projections by Age Group



RACE AND ETHNICITY

Race patterns in a population are important to assess because they reveal social patterns. Health and economic disparities in America have long existed along racial and ethnic lines. Examining social and economic patterns along racial and ethnic lines can help reveal the extent to which disparities exist and are either improving or worsening to spur thinking and action about equality of opportunity, economic mobility, and improving health for all citizens.

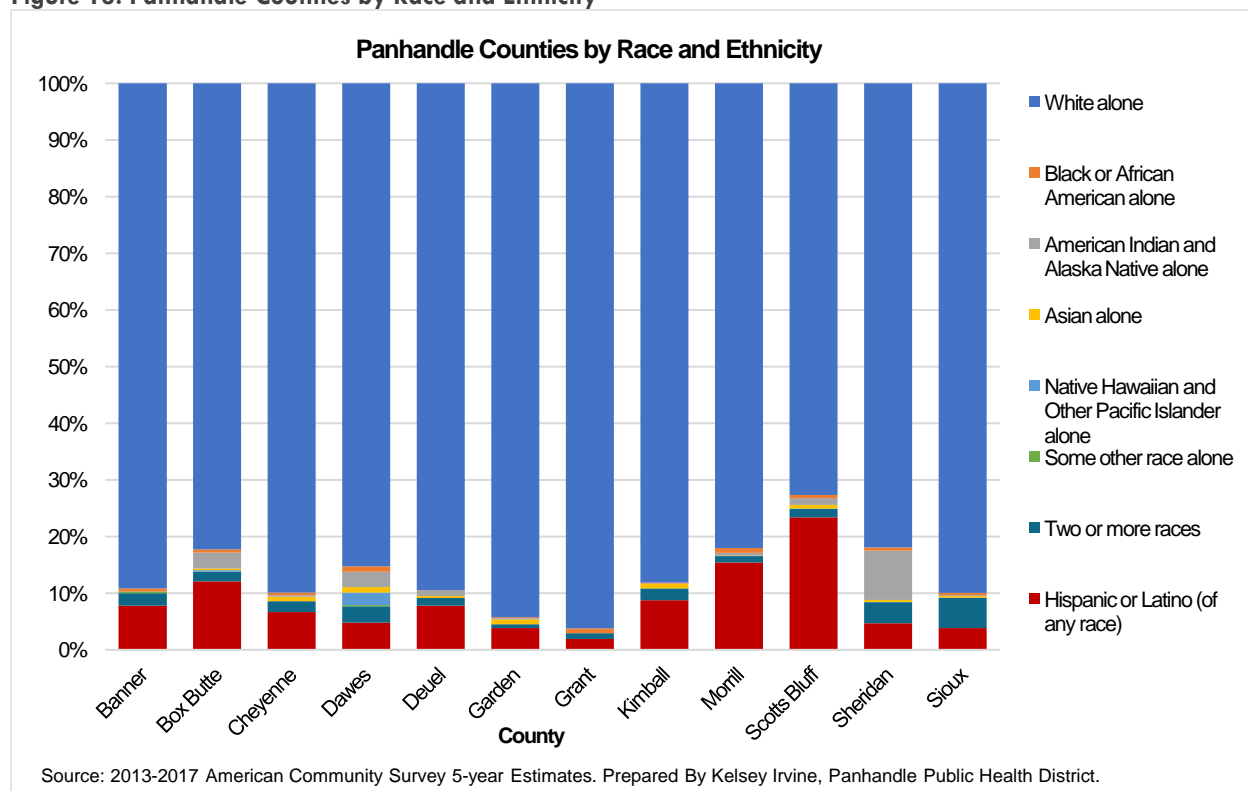
Scotts Bluff County has a predominantly White, Non-Hispanic population, at 72.6% and has a largest minority group being Hispanic or Latino (of any race) at an estimated 23.4% of the population. This percentage of the total population being of Hispanic or Latino descent is the highest among Panhandle counties.

Figure 12: Population by Race & Ethnicity, Scotts Bluff County

	Scotts Bluff County		Panhandle	Nebraska
Total Population	36,509		87,005	1,893,921
Hispanic or Latino (of any race)	8,545	23.4%	14.6%	
Not Hispanic or Latino				
White alone	26,517	72.6%	80.3%	79.8%
Black or African American alone	225	0.6%	0.6%	4.6%
American Indian and Alaska Native alone	427	1.2%	1.8%	0.7%
Asia alone	228	0.6%	0.6%	2.2%
Native Hawaiian and Other Pacific Islander alone	0	0.0%	0.3%	0.1%
Some other race alone	23	0.1%	0.1%	0.1%
Two or more races	544	1.5%	1.9%	2.0%

Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

Figure 13: Panhandle Counties by Race and Ethnicity



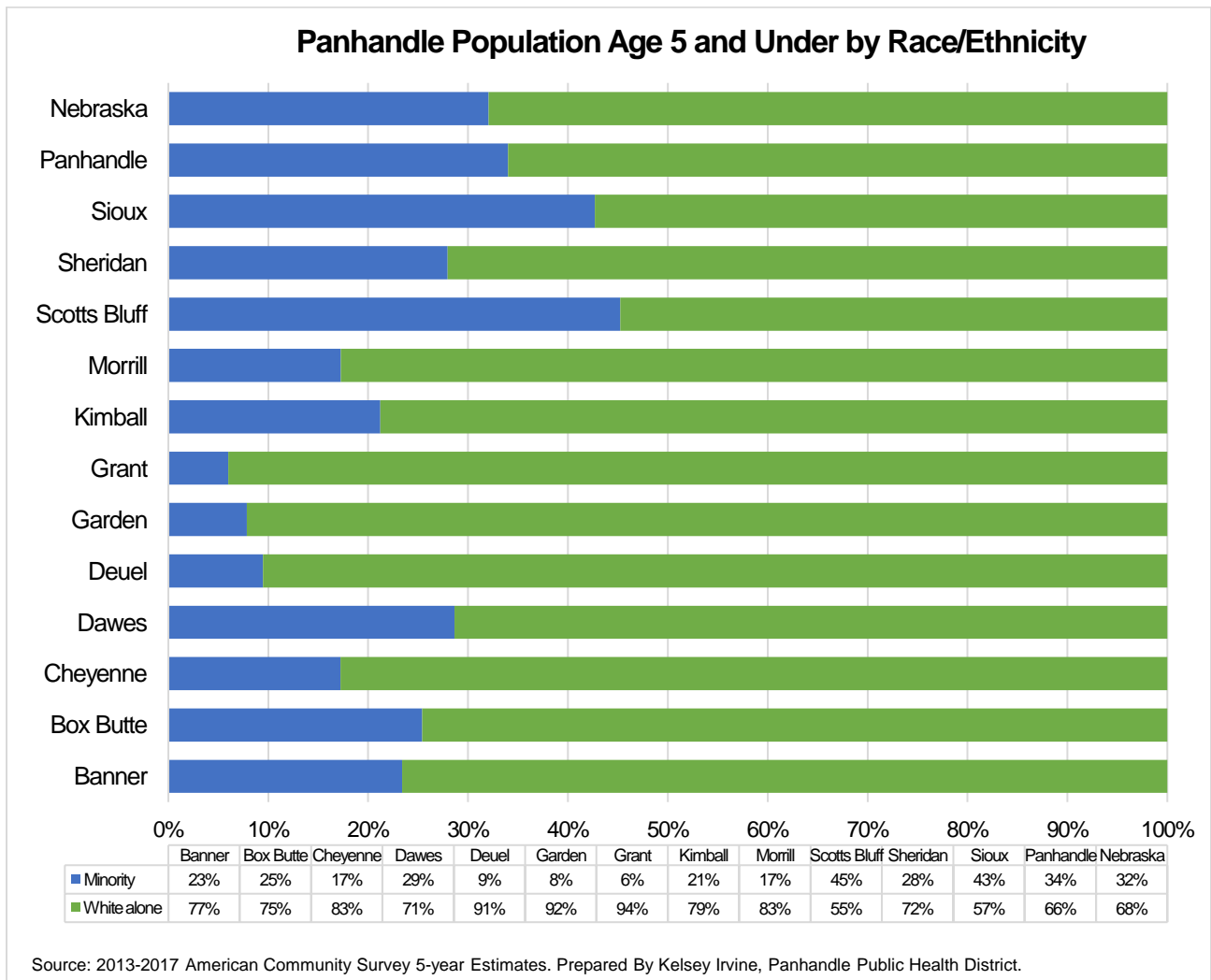
Like other counties in the Panhandle, Morrill County’s rate of people who speak English less than ‘very well’ is low. The vast majority of the Panhandle’s Hispanic or Latino population was born in the US contributing to high English language proficiency compared to other counties with similar sized populations of people of Hispanic or Latino descent.

	United States	Nebraska	Banner Co.	Box Butte Co.	Cheyenne Co.	Dawes Co.	Deuel Co.
Speak English less than “very well”	8.5%	5.0%	0.0%	1.5%	0.9%	2.2%	2.5%
	Garden Co.	Grant Co.	Kimball Co.	Morrill Co.	Scotts Bluff Co.	Sheridan Co.	Sioux Co.
Speak English less than “very well”	1.0%	0.0%	1.0%	3.5%	3.3%	1.0%	0.0%

Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

The population in younger age groups is generally more diverse than that of the general population. In Scotts Bluff County, minority races or ethnicities make up nearly half of the population under 5 years old.

Figure 14: Panhandle Population Age 5 and Under by Race/Ethnicity



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. Wages and professional opportunities, however, 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

Scotts Bluff County has had a slightly higher unemployment rate when compared to the region and Nebraska but still has a low rate compared to the nation. While unemployment rose during the recession (as seen in 2010), it was not nearly to the extent of the nation as a whole, which had an unemployment rate that reached nearly 10% during the height of the recession.

Figure 15: Panhandle Unemployment Rate (%), 2000-2018 12-Month Average

County	2000	2008	2010	2016	2018
Banner County	3.0	2.5	4.4	3.4	3.4
Box Butte County	3.9	3.7	5.0	3.6	2.8
Cheyenne County	2.3	2.8	3.6	2.8	2.8
Dawes County	3.0	2.9	4.0	2.9	2.7
Deuel County	3.0	2.9	3.9	2.6	3.0
Garden County	2.6	3.0	4.1	3.3	2.3
Grant County	2.3	2.9	3.8	2.2	2.6
Kimball County	2.5	3.4	4.7	4.1	2.6
Morrill County	3.5	3.1	4.1	3.2	2.7
Scotts Bluff County	4.0	3.7	5.5	3.5	3.2
Sheridan County	2.9	2.7	3.5	2.9	2.6
Sioux County	1.9	3.4	3.7	2.7	2.6
Panhandle	3.4	3.4	4.7	3.3	2.9
Nebraska	2.8	3.3	4.6	3.2	2.8
United States	4.0	5.8	9.6	4.9	3.9

Source: Bureau of Labor Statistics. Prepared by Kelsey Irvine, Panhandle Public Health District.

LABOR FORCE

While unemployment can give us a quick glance as to the percentage of people out of work in an area, it 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. Unemployment also does not account for size of the labor force which has decreased consistently across the region since 2000.

People leave the county labor force by not continuing to look for work, moving away, or retiring. While unemployment is typically lower than the nation in Scotts Bluff County, the size of the labor force decreased from 2010 to 2018. Box Butte, Kimball, and Sheridan counties all recorded double digit percentage decreases in total labor force. It is unclear as to what is the cause of the decreasing size of labor force but a retiring baby boom generation could be a large contributor in years to come if jobs aren't retained for younger generations to fill. Scotts Bluff County's relative strength in retaining young adults bodes well for the labor force being sustained into the future.

Figure 16: Panhandle Labor Force, 2000-2018

County	2000	2010	2018	Change 2000-2018
Banner County	428	413	381	-11.0%
Box Butte County	6,422	5,852	5,399	-15.9%
Cheyenne County	5,655	5,558	4,731	-16.3%
Dawes County	5,062	5,499	5,040	-0.4%
Deuel County	1,175	1,031	974	-17.1%
Garden County	1,217	1,266	1,192	-2.1%
Grant County	439	373	416	-5.2%
Kimball County	2,198	2,124	2,016	-8.3%
Morrill County	2,798	2,650	2,599	-7.1%
Scotts Bluff County	18,775	19,200	18,422	-1.9%
Sheridan County	3,295	2,821	2,690	-18.4%
Sioux County	802	835	743	-7.4%
Panhandle	47,827	47,249	44,187	-7.6%
Nebraska	944,986	993,400	1,011,635	7.1%
United States	143,893,664	155,539,411	161,370,049	12.1%

Source: Bureau of Labor Statistics. Prepared by Kelsey Irvine, Panhandle Public Health District.

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 17: Jobs per 100 persons, 1969-2017, Panhandle & Scotts Bluff Counties

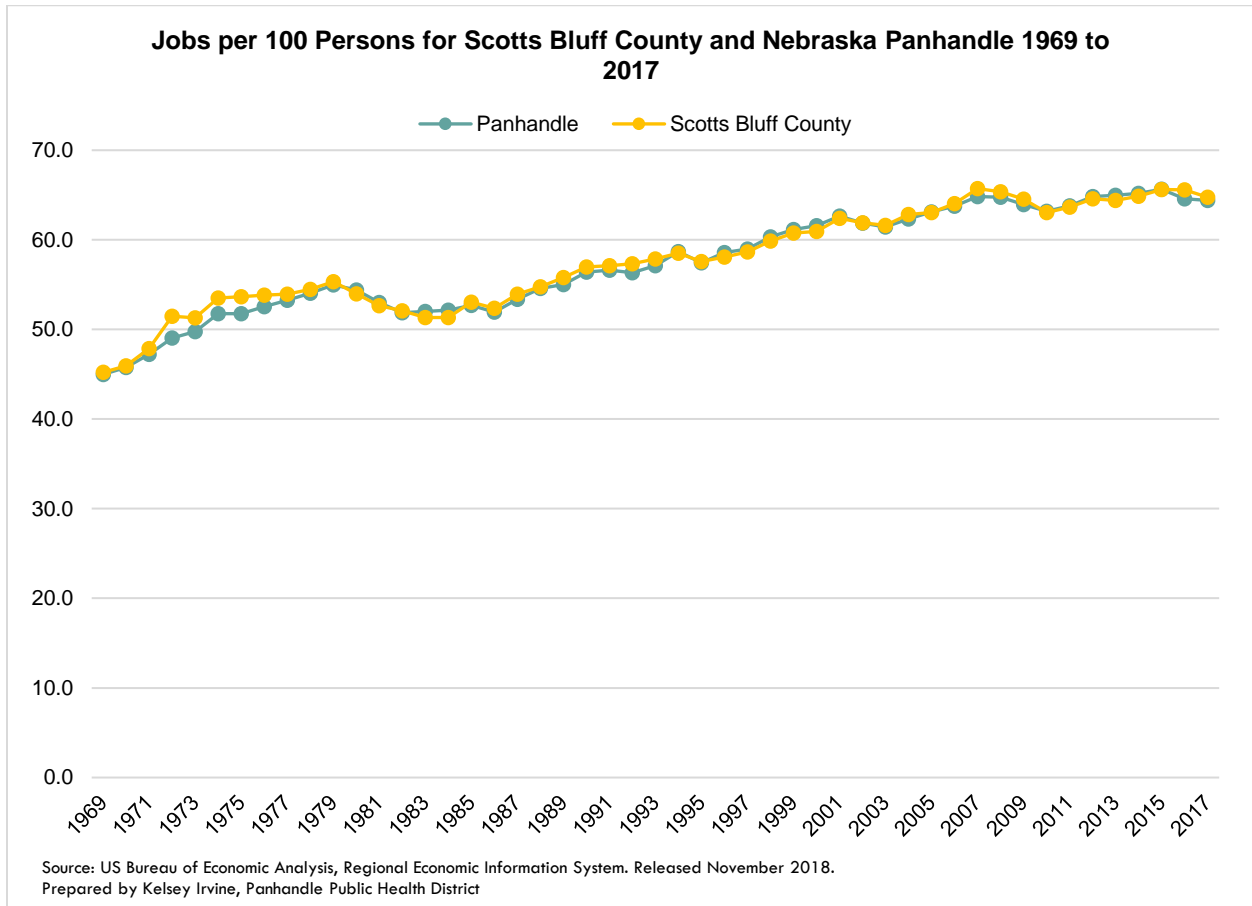


Figure 18: Jobs per 100 Persons, 2006-2017, Panhandle & Scotts Bluff County

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Panhandle	63.8	64.8	64.8	63.9	63.2	63.8	64.8	65.0	65.2	65.6	64.6	64.4
Scotts Bluff County	64.0	65.7	65.4	64.5	63.0	63.7	64.6	64.4	64.9	65.6	65.6	64.8

Source: US Bureau of Economic Analysis, Regional Economic Information System. Released November 2018. Prepared by Kelsey Irvine, Panhandle Public Health District

INCOME

At \$47,975, household income in the county is well below the median for both Nebraska and the nation. The state median household income is \$56,675. While the cost of living expenses are generally lower in the Panhandle, wages are still relatively low and are a noted problem by citizens and community leaders across the region.

Median income remains low even though Scotts Bluff County reported an 8% increase in median income from 2010 to 2017. The data contains data from years of the recession which likely accounts for the decrease in income on the national and state levels.

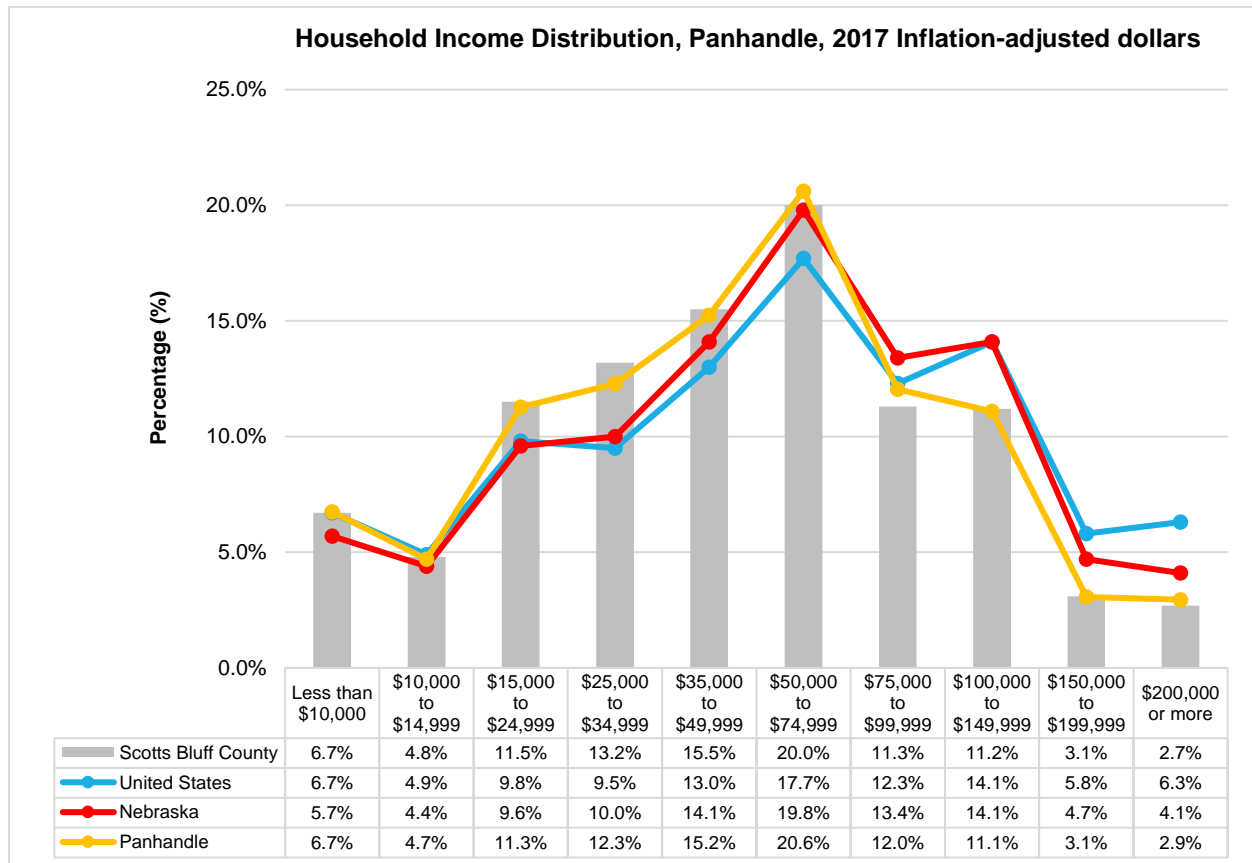
Income distribution in the Panhandle shows a lot of households in the middle of the spectrum with the distribution slightly heavier towards the low income side. Maintaining this large middle income population is important as too much of a gulf between the low and high income earners can indicate a lack of upward mobility opportunities. The county has about 20% of its households in the \$50,000-74,999 bracket. It has a lower percentage in the \$75,000-149,999 brackets when compared to the under \$35,000 brackets.

Figure 19: Median Household Income, Panhandle

County	2010	2017	Change
Banner County	\$38,753	\$55,000	41.92%
Box Butte County	\$50,518	\$56,328	11.50%
Cheyenne County	\$56,308	\$58,770	4.37%
Dawes County	\$39,748	\$46,146	16.10%
Deuel County	\$42,263	\$53,438	26.44%
Garden County	\$37,194	\$48,125	29.39%
Grant County	\$44,667	\$45,833	2.60%
Kimball County	\$47,795	\$43,017	-10.00%
Morrill County	\$42,910	\$44,201	3.01%
Scotts Bluff County	\$44,375	\$47,975	8.11%
Sheridan County	\$38,236	\$41,209	7.78%
Sioux County	\$48,222	\$45,375	-5.90%
Nebraska	\$56,136	\$56,675	0.96%
United States	\$59,062	\$57,652	-2.39%

Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates; 2013-2017 American Community Survey 5-Year Estimates; Bureau of labor statistics CPI inflation calculator. Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 20: Household Income Distribution, Panhandle, 2017 Inflation-Adjusted Dollars



Per capita income of counties is calculated by taking all the income in a county in a year and dividing it by the number of people in the county. This gives an idea of the general wealth circulating in the area and the strength of the economy.

**Figure 21: Per Capita Income in the past 12 months, Panhandle, 2017
Inflation-Adjusted Dollars**

County	Per capita income (\$)
Banner County	30,736
Box Butte County	28,483
Cheyenne County	32,995
Dawes County	24,811
Deuel County	28,225
Garden County	35,602
Grant County	22,693
Kimball County	24,011
Morrill County	25,120
Scotts Bluff County	26,532
Sheridan County	25,817
Sioux County	26,852
Nebraska	29,866
United States	31,177

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates; Bureau of labor statistics CPI inflation calculator. Prepared by Kelsey Irvine, Panhandle Public Health District

POVERTY

Poverty in the Panhandle is generally higher than in the rest of the state and nearby metro areas. Scotts Bluff County shows a slightly higher rate of poverty than the and region.

CHILDHOOD POVERTY

Scotts Bluff County has the third highest rate of poverty among children under 18 in the Panhandle. 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. One trend to note in recent estimates is a decline in poverty and childhood poverty in the region, which may have spiked during the recession beginning in 2009. This recent decrease is good news but still exposes the vulnerability of area workers to changes in economy and lay-offs from major employers. Such downturns not only affect the workers but also families, children, and schools.

Figure 22: Percent of All Population with Income in Past 12-Months Below Poverty Line, Panhandle

County	%
Grant County	21.1%
Sheridan County	15.8%
Dawes County	14.3%
Scotts Bluff County	13.2%
Sioux County	12.4%
Garden County	11.7%
Kimball County	11.4%
Deuel County	11.1%
Box Butte County	10.9%
Cheyenne County	10.9%
Morrill County	9.4%
Banner County	8.9%
Panhandle	12.6%
Nebraska	12.0%
United States	14.6%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 23: Percent of Children Under 18 With Income in past 12 Months Below Poverty Line, Panhandle

County	Percent
Grant County	33.8%
Sheridan County	27.5%
Scotts Bluff County	19.4%
Sioux County	18.7%
Deuel County	17.6%
Cheyenne County	16.3%
Box Butte County	14.3%
Morrill County	11.4%
Dawes County	10.8%
Banner County	10.5%
Garden County	10.5%
Kimball County	9.5%
Panhandle	17.1%
Nebraska	15.6%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

RACE AND POVERTY

The poverty rate among Scotts Bluff County's minority population is estimated to be more than double compared to the poverty rate of the White alone, not Hispanic population. American Indian was the group with the highest rate of poverty in the county, which is similar statewide.

Figure 24: Percent of all Population with Income in past 12 Months Below Poverty Level, by Race and Ethnicity, Panhandle

County	White Alone	American Indian alone	Two or more races	Hispanic or Latino origin (of any race)	White alone, not Hispanic or Latino
Banner County	8.2%	-	43.8%	33.3%	6.0%
Box Butte County	7.5%	53.4%	67.8%	13.9%	6.8%
Cheyenne County	10.4%	0.0%	18.9%	30.8%	9.2%
Dawes County	13.1%	59.7%	7.0%	13.1%	13.1%
Deuel County	10.9%	0.0%	0.0%	29.7%	9.9%
Garden County	11.6%	0.0%	33.3%	0.0%	12.0%
Grant County	20.2%	0.0%	71.4%	0.0%	20.7%
Kimball County	12.0%	0.0%	0.0%	14.2%	11.5%
Morrill County	9.4%	0.0%	16.5%	22.6%	6.7%
Scotts Bluff County	12.7%	29.1%	14.2%	25.2%	8.9%
Sheridan County	11.4%	61.6%	5.8%	30.9%	10.8%
Sioux County	13.2%	0.0%	0.0%	14.6%	13.2%
Panhandle	11.5%	45.7%	19.5%	23.4%	9.5%
Nebraska	10.3%	32.6%	20.5%	22.7%	9.0%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

POVERTY BY EDUCATIONAL ATTAINMENT

Scotts Bluff County has an unusually low rate of poverty among people holding less than a high bachelor's degree. This low rate may point to the presence of high-wage positions which require more training and skill development as opposed to an advanced degree.

Figure 25: Percent of Population in Poverty by Educational Attainment, Population 25+, Panhandle

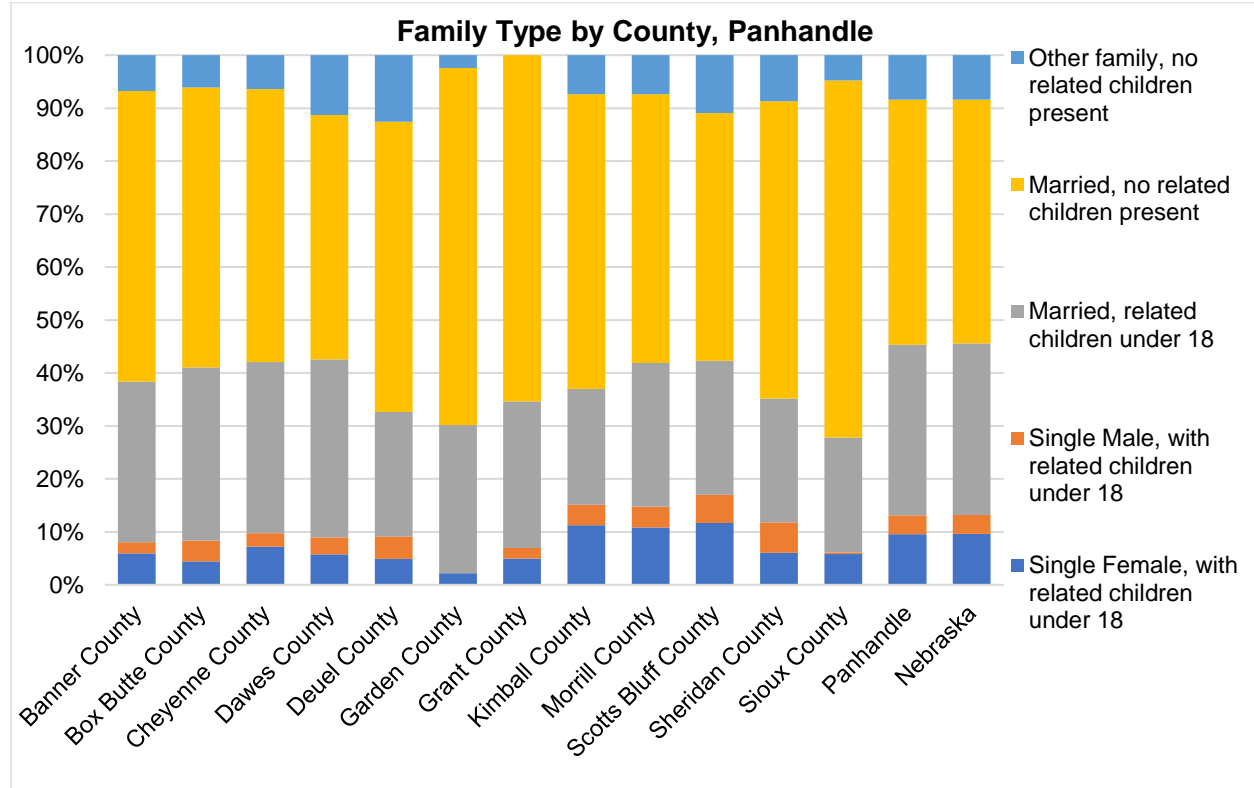
	Less than high school	High school graduate	Some college, associate's degree	Bachelor's degree or higher
Banner County	0.0%	11.2%	11.9%	0.0%
Box Butte County	17.8%	12.9%	6.6%	0.5%
Cheyenne County	12.6%	12.5%	8.2%	1.2%
Dawes County	25.2%	17.5%	10.6%	3.5%
Deuel County	14.8%	7.8%	9.4%	1.6%
Garden County	35.4%	13.3%	9.9%	6.3%
Grant County	25.2%	17.5%	10.6%	3.5%
Kimball County	18.6%	14.8%	8.2%	7.7%
Morrill County	16.8%	9.0%	5.0%	3.4%
Scotts Bluff County	22.8%	9.3%	9.3%	3.4%
Sheridan County	28.7%	9.7%	11.4%	8.5%
Sioux County	16.4%	13.6%	10.1%	7.0%
Panhandle	21.2%	11.4%	8.9%	3.4%
Nebraska	22.5%	10.5%	8.3%	3.3%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

POVERTY BY FAMILY TYPE

Scotts Bluff County has just over half of its families without children. Single parent household represent about 17% of all families in Scotts Bluff County.

Figure 26: Family Type by County, Panhandle

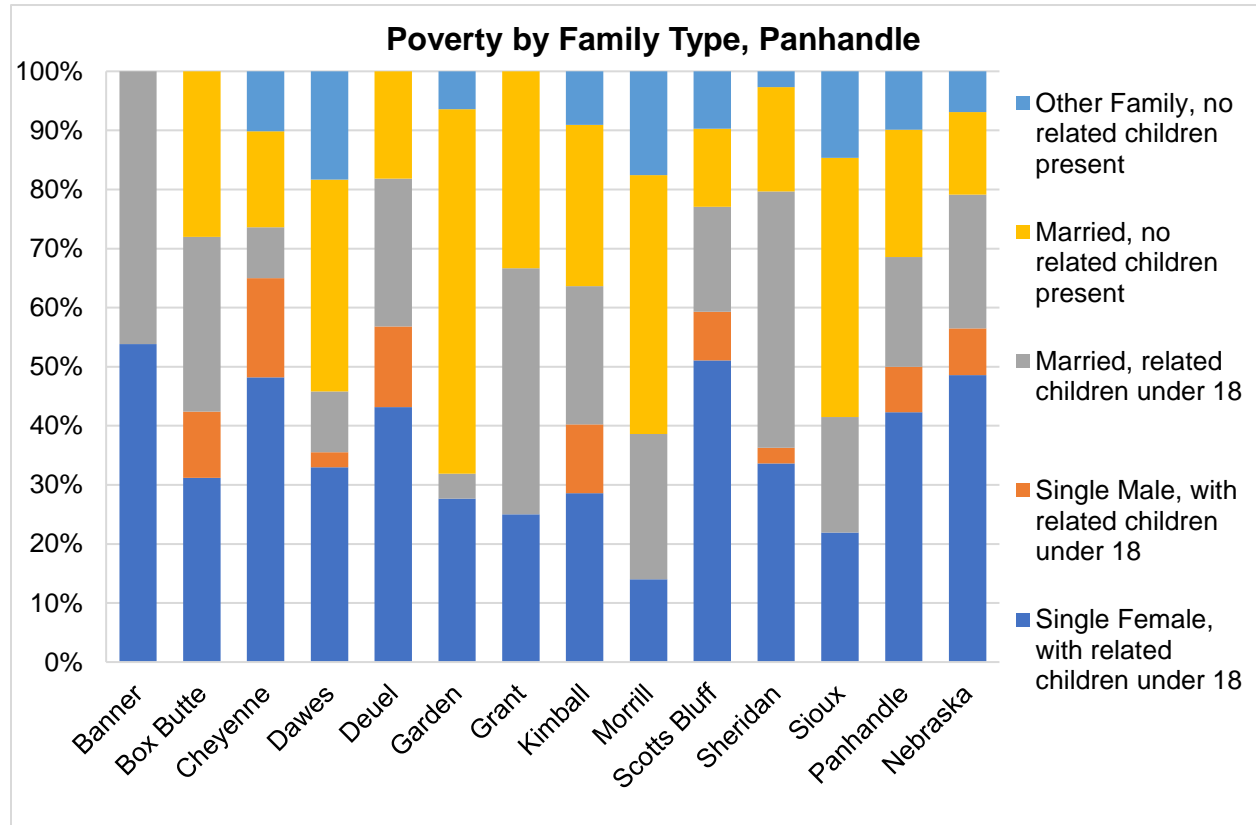


	Single Female, with related children under 18	Single Male, with related children under 18	Married, related children under 18	Married, no related children present	Other family, no related children present
Banner County	6%	2%	30%	55%	7%
Box Butte County	4%	4%	33%	53%	6%
Cheyenne County	7%	3%	32%	52%	6%
Dawes County	6%	3%	34%	46%	11%
Deuel County	5%	4%	23%	55%	13%
Garden County	2%	0%	28%	67%	2%
Grant County	5%	2%	28%	66%	0%
Kimball County	11%	4%	22%	56%	7%
Morrill County	11%	4%	27%	51%	7%
Scotts Bluff County	12%	5%	25%	47%	11%
Sheridan County	6%	6%	23%	56%	9%
Sioux County	6%	0%	22%	67%	5%
Panhandle	10%	4%	32%	46%	8%
Nebraska	10%	4%	32%	46%	8%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates; Table B11003. Prepared By Kelsey Irvine, Panhandle Public Health District

When looking at the families with income at or below poverty, we find that the vast majority 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 over 40% of all families in the Panhandle with an income level below the poverty line. The poverty rate among single female headed households is much higher in Scotts Bluff County when compared to most other Panhandle counties.

Figure 27: Poverty by Family Type, Panhandle



	Total number of households	Number of households below poverty line	Percentage of households below poverty line				
			Single Female, with related children under 18	Single Male, with related children under 18	Married, related children under 18	Married, no related children present	Other Family, no related children present
Banner County	237	13	53.8%	0.0%	46.2%	0.0%	0.0%
Box Butte County	3,062	125	31.2%	11.2%	29.6%	28.0%	0.0%
Cheyenne County	2,562	197	48.2%	16.8%	8.6%	16.2%	10.2%
Dawes County	2,140	273	33.0%	2.6%	10.3%	35.9%	18.3%
Deuel County	549	44	43.2%	13.6%	25.0%	18.2%	0.0%
Garden County	544	47	27.7%	0.0%	4.3%	61.7%	6.4%
Grant County	192	24	25.0%	0.0%	41.7%	33.3%	0.0%
Kimball County	1,014	77	28.6%	11.7%	23.4%	27.3%	9.1%
Morrill County	1,248	57	14.0%	0.0%	24.6%	43.9%	17.5%
Scotts Bluff County	9,395	877	51.1%	8.2%	17.8%	13.2%	9.7%
Sheridan County	1,432	113	33.6%	2.7%	43.4%	17.7%	2.7%
Sioux County	378	41	22.0%	0.0%	19.5%	43.9%	14.6%
Panhandle	22,753	1,888	42.3%	7.7%	18.6%	21.6%	9.9%
Nebraska	482,941	38,789	48.6%	7.9%	22.6%	14.0%	6.9%

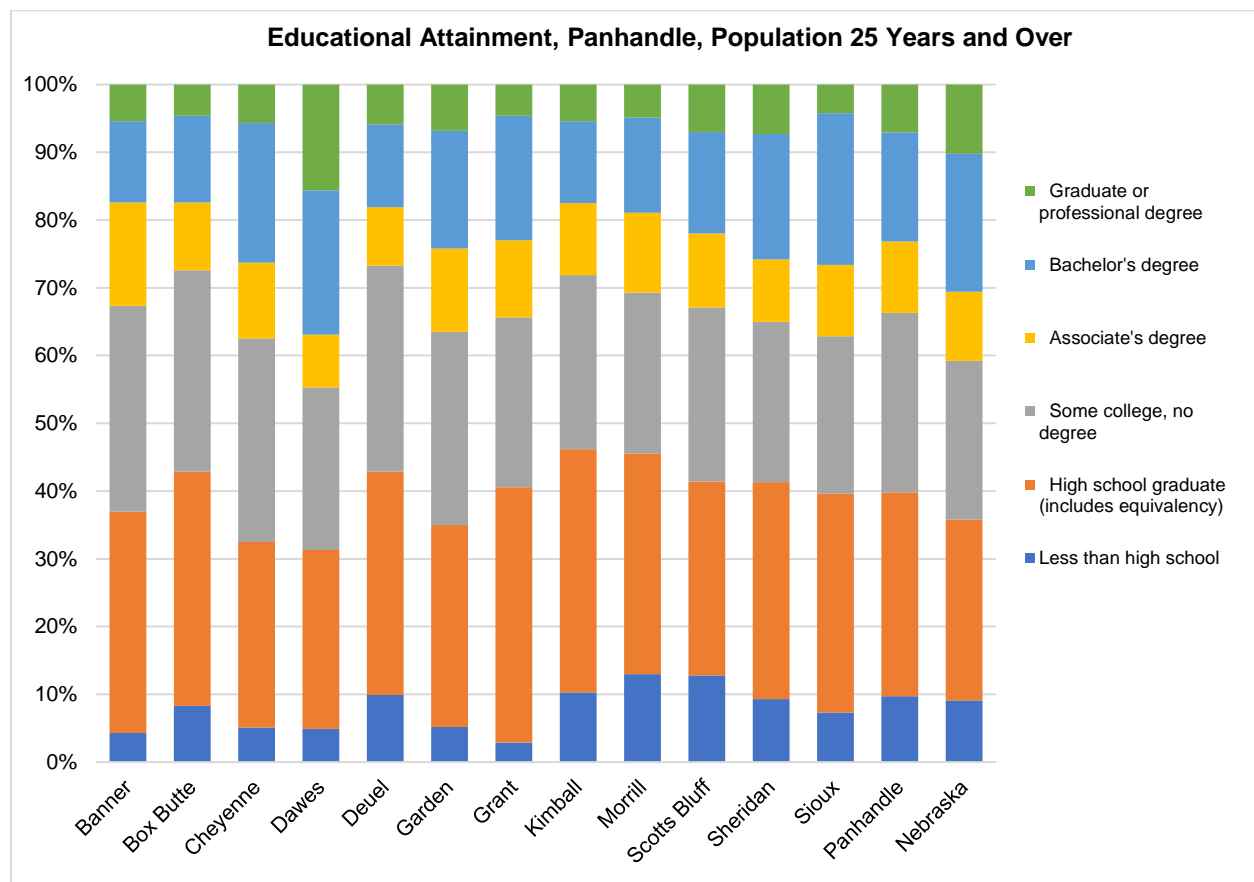
Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates; Table S1702. Prepared By Kelsey Irvine, Panhandle Public Health District.

EDUCATION

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, the county's workforce falls below the region and state rates for population 25 or older with a bachelor's degree or higher.

Figure 28: Educational Attainment, Panhandle, Population 25 Years and Over



Source: 2013-2017 American Community Survey 5-Year Estimates; Table S1501. Prepared by Kelsey Irvine, Panhandle Public Health District.

	Less than high school	High school graduate	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
Banner County	4.3%	32.7%	30.4%	15.3%	12.0%	5.4%
Box Butte County	8.3%	34.6%	29.7%	10.0%	12.8%	4.6%
Cheyenne County	5.1%	27.4%	30.1%	11.2%	20.6%	5.7%
Dawes County	4.9%	26.4%	24.0%	7.8%	21.3%	15.6%
Deuel County	9.9%	33.0%	30.4%	8.6%	12.2%	5.9%
Garden County	5.2%	29.8%	28.5%	12.3%	17.4%	6.8%
Kimball County	10.3%	35.9%	25.7%	10.6%	12.1%	5.4%
Morrill County	13.0%	32.5%	23.8%	11.8%	14.0%	4.9%
Scotts Bluff County	12.8%	28.6%	25.7%	10.9%	15.0%	7.0%
Sheridan County	9.3%	32.0%	23.7%	9.2%	18.5%	7.3%
Sioux County	7.3%	32.3%	23.2%	10.5%	22.4%	4.2%
Panhandle	9.8%	30.0%	26.5%	10.5%	16.1%	7.1%
Nebraska	9.1%	26.7%	23.4%	10.2%	20.4%	10.2%

The 4-year graduation rate across the state of Nebraska for the 2017-2018 school year was 89%. Scottsbluff and Gering schools both fell above the state graduation rate in the 2017-2018 school year.

Figure 29: 4-Year Graduation Rate, Panhandle Public Schools and Nebraska

	2015-2016	2016-2017	2017-2018
Alliance Public Schools	89%	84%	83%
Banner County Public Schools	NA	NA	NA
Bayard Public Schools	100%	88%	100%
Bridgeport Public Schools	89%	87%	92%
Chadron Public Schools	90%	95%	96%
Crawford Public Schools	94%	92%	86%
Creek Valley Schools	91%	95%	87%
Garden County Schools	100%	100%	100%
Gering Public Schools	88%	87%	91%
Gordon-Rushville Public Schools	92%	91%	94%
Hay Springs Public Schools	100%	83%	92%
Hemingford Public Schools	88%	97%	89%
Hyannis Area Schools	100%	100%	100%
Kimball Public Schools	98%	94%	89%
Leyton Public Schools	100%	100%	100%
Minatare Public Schools	NA	93%	100%
Mitchell Public Schools	95%	95%	92%
Morrill Public Schools	83%	90%	96%
Potter-Dix Public Schools	93%	85%	NA
Scottsbluff Public Schools	92%	91%	91%
Sidney Public Schools	97%	95%	89%
Sioux County Public Schools	NA	NA	NA

Source: Nebraska Department of Education. Prepared by Kelsey Irvine, Panhandle Public Health District.

EARLY CHILDHOOD EDUCATION

The number of children 5 and under with all available parents working, meaning these children need out of home care, tends to be less in Panhandle counties when compared to the state of Nebraska. However, opportunities for licensed and quality early childcare and education tends to be less available in the Panhandle. For 2012-2016 combined, there were 1,973 children 5 and under with all available parents working in Morrill County.

There are three head start and early head start grantees that serve Panhandle counties: Northwest Community Action Partnership, Migrant and Seasonal Head Start, and Educational Service Unit (ESU) 13. These grantees served a total of 673 children in the 2016/2017 year. Scotts Bluff County is served by Migrant and Seasonal Head Start and Education Service Unit 13.

Figure 30: Children 5 and Under with all Available Parents Working, Panhandle & Nebraska

	2008-2012		2012-2016	
	#	%	#	%
Banner County	25	30.1%	37	58.7%
Box Butte County	406	51.5%	569	74.2%
Cheyenne County	550	74.9%	528	68.1%
Dawes County	396	74.9%	433	70.0%
Deuel County	63	70.8%	94	82.5%
Garden County	142	100.0%	101	91.8%
Grant County	27	75.0%	22	48.9%
Kimball County	162	60.7%	227	75.7%
Morrill County	193	58.5%	205	79.2%
Scotts Bluff County	2,170	73.0%	1,973	68.6%
Sheridan County	208	59.6%	210	79.5%
Sioux County	42	59.2%	83	82.2%
Nebraska	112,004	73.9%	110,101	72.2%

Source: U.S. Census Bureau, 2012 and 2016 American Community Survey 5-Year Estimates, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District.

Figure 31: Panhandle Children Served by Head Start/Early Head Start

	2013/2014	2014/2015	2015/2016	2016/2017
Northwest Community Action Partnership	258	258	258	258
Migrant and Seasonal Head Start	46	65	65	65
Educational Service Unit 13	350	350	350	350
Total Served	654	673	673	673

Source: U.S. Census Bureau, 2012 and 2016 American Community Survey 5-Year Estimates, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District

There are 137 licensed childcare facilities in the Panhandle. Sioux and Banner Counties have no licensed childcare facilities. The table below shows total capacity, capacity for those who serve only children five and older (after school programs), and capacity for those who serve children starting at an age younger than five. In Scotts Bluff County, there are 1,656 spots for children in centers who serve children starting at an age younger than five years old.

Figure 32: Licensed Child Care and Preschool Programs in Nebraska Panhandle, as of 9/20/2019

	Number of Facilities	Total Capacity	Capacity for Children under 5
Banner County	0	0	0
Box Butte County	13	246	246
Cheyenne County	12	746	351
Dawes County	23	378	378
Deuel County	3	65	65
Garden County	3	84	44
Grant County	1	12	12
Kimball County	3	34	34
Morrill County	4	83	83
Scotts Bluff County	65	2,126	1,656
Sheridan County	10	127	127
Sioux County	0	0	0
Panhandle	137	3,901	2,996

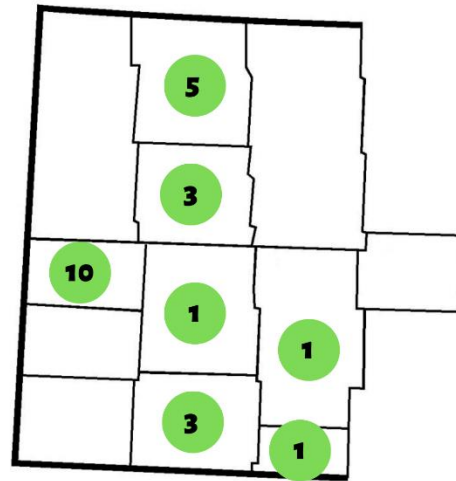
Source: Roster Of Licensed Child Care And Preschool Programs In Nebraska, Nebraska DHHS. Prepared By Kelsey Irvine, Panhandle Public Health District

STEP UP TO QUALITY

Nebraska Step Up to Quality is an early childhood quality rating and improvement system. The goal of the system is to improve early care and education quality and increase positive outcomes for young children.

As of September 2018, there were 24 Step Up to Quality programs in seven Panhandle counties, including ten in Scotts Bluff County. These 24 programs represent just 19% of the 128 childcare facilities who offer care to children starting at an age younger than five years old.

Figure 33: Panhandle Step Up to Quality Programs by County, as of 9/14/2019



Source: Nebraska Department Of Education. Prepared By Kelsey Irvine, Panhandle Public Health District

HOUSING

AGE OF HOUSING

The age of housing stock is related to population growth and employment growth. There is less new housing stock in the Panhandle when compared to the broader state of Nebraska.

Figure 34: Housing Age by Year Built, Panhandle Counties

	2014 or later	2010 to 2013	2000 to 2009	1990 to 1999	1980 to 1989	1970 to 1979	1960 to 1969	1950 to 1959	1940 to 1949	1939 or earlier
Banner County	0.5%	1.5%	8.4%	4.7%	4.0%	15.3%	6.9%	10.4%	17.3%	31.1%
Box Butte County	0.0%	0.8%	1.5%	4.2%	12.1%	26.2%	6.3%	10.7%	7.8%	30.4%
Cheyenne County	2.3%	0.3%	9.3%	7.1%	6.2%	7.8%	6.0%	22.4%	12.6%	26.0%
Dawes County	0.5%	2.2%	3.9%	7.6%	5.0%	11.7%	10.4%	9.6%	7.0%	42.2%
Deuel County	0.0%	0.4%	6.0%	1.8%	2.8%	7.1%	10.3%	14.8%	17.7%	39.1%
Garden County	0.0%	2.2%	10.3%	3.4%	4.3%	6.4%	11.4%	10.1%	10.7%	41.2%
Grant County	1.6%	2.6%	4.1%	5.2%	10.4%	7.5%	10.9%	8.3%	8.0%	41.5%
Kimball County	0.0%	0.5%	3.1%	10.7%	1.5%	9.2%	17.6%	24.0%	6.2%	27.2%
Morrill County	0.2%	1.3%	5.2%	3.8%	6.9%	16.9%	11.4%	7.8%	10.6%	36.0%
Scotts Bluff County	0.2%	0.9%	6.6%	7.0%	7.7%	21.3%	12.5%	12.7%	9.4%	21.7%
Sheridan County	0.0%	0.1%	5.6%	6.5%	5.3%	11.4%	9.1%	12.2%	8.7%	41.0%
Sioux County	0.4%	0.2%	7.8%	5.0%	8.0%	5.6%	4.4%	6.7%	8.7%	53.2%
Panhandle	0.4%	0.9%	5.8%	6.3%	7.1%	16.6%	10.3%	13.3%	9.5%	29.7%
Nebraska	0.9%	2.6%	12.0%	11.5%	9.4%	16.2%	11.2%	9.7%	4.9%	21.4%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

Housing stock built before 1979 is more common in rural areas such as the Panhandle. Lead in residential paints was banned in 1978, which means houses built in 1978 or earlier are more likely to contain lead-based paint, which can lead to lead poisoning in children. It is more common for low income peoples or people of color to live in older housing, due to affordability, which contributes to disproportionate lead poisoning in these populations.

Lead poisoning is highly toxic to young children under the age of six and interferes with brain and organ development. The negative impacts of lead poisoning are irreversible. There are methods of lead abatement that can prevent these impacts.

Scotts Bluff County has a lower rate of pre-1979 housing stock when compared to the overall Panhandle region, but a higher rate when compared to the state of Nebraska.

Figure 35: Pre-1979 Housing Stock, Panhandle Counties

Banner County	81.0%
Box Butte County	81.4%
Cheyenne County	74.8%
Dawes County	80.9%
Deuel County	89.0%
Garden County	79.8%
Grant County	76.2%
Kimball County	84.2%
Morrill County	82.7%
Scotts Bluff County	77.6%
Sheridan County	82.4%
Sioux County	78.6%
Panhandle	79.4%
Nebraska	63.4%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

HOUSING TENURE

The majority of housing in the county is owner-occupied, with a slightly higher rate of owner-occupied housing units compared to the overall state of Nebraska.

Figure 36: Housing Tenure, Panhandle Communities

	Occupied housing units	Owner-occupied	Renter-occupied
Banner County	300	68.3%	31.7%
Box Butte County	4,610	71.7%	28.3%
Cheyenne County	4,400	70.7%	29.3%
Dawes County	3,557	62.5%	37.5%
Deuel County	833	75.2%	24.8%
Garden County	897	80.4%	19.6%
Grant County	274	81.4%	18.6%
Kimball County	1,546	66.7%	33.3%
Morrill County	2,017	71.3%	28.7%
Scotts Bluff County	14,425	68.9%	31.1%
Sheridan County	2,306	70.3%	29.7%
Sioux County	579	75.6%	24.4%
Nebraska	748,405	66.0%	34.0%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

EXCESSIVE HOUSING COST BURDEN

Housing costs that exceed 30% of household income are typically viewed as an indicator of housing affordability problems. Across Panhandle counties, there are significantly more renters than owners at lower income levels for which housing costs are 30% or more of household income. This is in line with the trend across the state of Nebraska as well. Scotts Bluff County has one of the higher rates of renter-occupied households with income less than \$20,000 whose housing costs make up more than 30% of their household income.

Figure 37: Monthly Housing Costs as 30% or more of Household Income in the Past 12 Months, by Income Level

	Less than \$20,000	\$20,000 to \$34,999	\$35,000 to \$49,999	\$50,000 to \$74,999	\$75,000 or more
Scotts Bluff County					
Owner-occupied	7.0%	6.4%	4.7%	3.2%	1.6%
Renter-occupied	22.9%	13.6%	3.3%	0.5%	0.2%
Nebraska					
Owner-occupied	5.6%	4.7%	3.3%	2.7%	1.4%
Renter-occupied	20.8%	13.3%	3.9%	1.1%	0.2%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

CHILD WELFARE

CHILD MALTREATMENT

In 2017, Scotts Bluff County was one of six Panhandle counties that had a child maltreatment rate higher than that of the state of Nebraska (7.6 per 1,000 children). The rate of child maltreatment in Panhandle communities can vary widely year-to-year due to small county numbers, but the rate has generally decreased over time.

Figure 38: Child Maltreatment Rate* (Per 1,000 Children), Panhandle Counties

	2010	2011	2012	2013	2014	2015	2016	2017
Banner County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Box Butte County	7.0	14.4	7.8	3.5	3.8	2.1	2.5	9.8
Cheyenne County	5.5	6.7	6.9	3.2	3.3	4.1	2.1	3.0
Dawes County	16.0	12.0	17.5	7.8	5.4	4.3	4.3	3.9
Deuel County	2.5	21.8	4.7	9.6	2.5	2.5	2.6	10.2
Garden County	0.0	5.3	17.1	0.0	0.0	0.0	8.2	8.0
Grant County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kimball County	7.0	15.5	19.7	14.8	8.5	0.0	6.1	5.0
Morrill County	8.2	7.4	13.4	7.6	6.7	7.6	5.1	9.6
Scotts Bluff County	17.9	21.8	17.0	6.9	9.4	10.5	9.7	8.9
Sheridan County	3.9	12.3	5.8	6.0	5.9	6.9	1.7	11.9
Sioux County	0.0	0.0	3.3	0.0	0.0	0.0	8.0	0.0
Nebraska	11.2	11.4	9.3	6.2	5.5	7.9	7.9	7.6

*Number of Substantiated Victims Of Child Maltreatment. Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District

The rate of state wards (per 1,000 children) in Scotts Bluff County has been higher than that of the broader state of Nebraska from year to year. The county has a historically higher rate of state wards when compared to other Panhandle counties.

Figure 39: State Wards, Rate per 1,000 Children, Panhandle Counties

	2011	2012	2013	2014	2015	2016	2017
Banner County	0.0	6.7	0.0	13.8	12.4	12.3	5.7
Box Butte County	11.2	10.6	5.6	4.5	4.5	4.9	4.4
Cheyenne County	17.6	12.6	10.9	11.4	11.1	13.3	13.9
Dawes County	14.2	9.4	7.2	11.4	5.6	9.2	12.2
Deuel County	21.8	16.4	16.8	12.3	9.9	10.3	20.3
Garden County	5.3	11.4	12.1	5.9	5.7	16.4	26.6
Grant County	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kimball County	32.2	26.6	16.0	18.3	17.5	13.4	8.8
Morrill County	9.9	7.5	8.4	5.1	3.4	6.0	9.6
Scotts Bluff County	28.2	22.6	21.2	17.9	18.4	22.2	24.0
Sheridan County	9.0	10.0	7.7	14.3	15.5	11.0	11.0
Sioux County	0.0	3.3	10.0	0.0	0.0	0.0	0.0
Nebraska	21.2	20.0	18.2	16.1	14.4	15.2	15.0

Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District

Removal from the home is a traumatic event for a child, with lasting impacts. In an effort to keep more children in the home with their parents, some children are involved in the child welfare system on a non-court basis. This means they stay in the home, and may not have a substantiated incident of child maltreatment, but are able to receive services as a measure to prevent potential future incidents of child maltreatment. In the Panhandle, Scotts Bluff County had a lower rate of children with non-court welfare involvement in 2017 when compared to that of the state.

Figure 40: Children with Non-Court Child Welfare Involvement, 2013 & 2017, Panhandle Counties

	2013	Rate per 1,000 children	2017	Rate per 1,000 children
Banner County	0	0.0	0	0.0
Box Butte County	21	7.4	14	5.1
Cheyenne County	29	11.7	18	7.8
Dawes County	21	12.6	1	0.6
Deuel County	7	16.8	0	0.0
Garden County	2	6.0	5	13.3
Grant County	0	0.0	0	0.0
Kimball County	25	30.8	1	1.3
Morrill County	15	12.6	10	8.7
Scotts Bluff County	201	22.0	30	3.3
Sheridan County	23	19.6	1	0.8
Sioux County	0	0.0	0	0.0
Nebraska	4,348	9.4	3,296	6.9

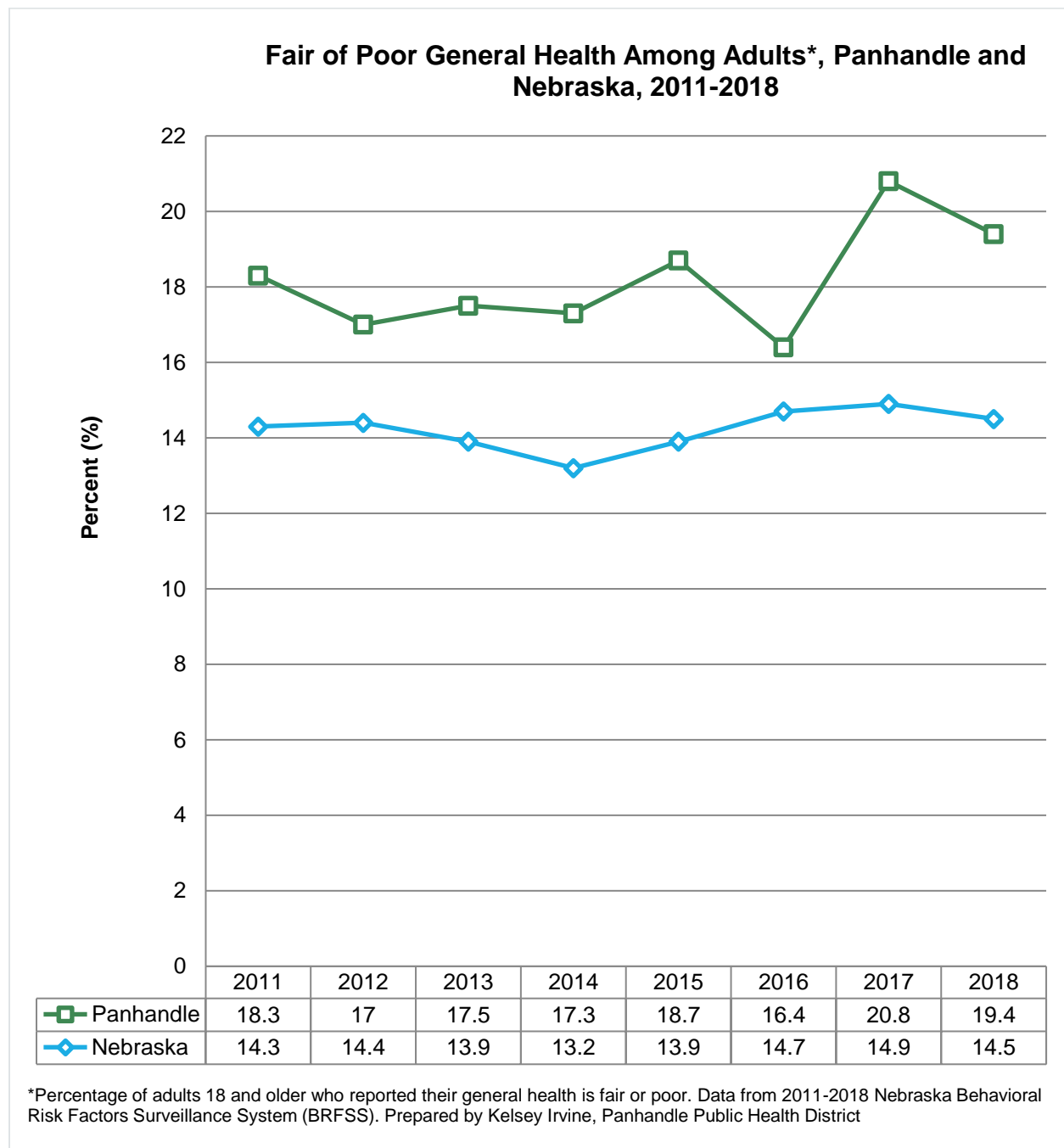
Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared by Kelsey Irvine, Panhandle Public Health District

GENERAL HEALTH STATUS

HEALTH-RELATED QUALITY OF LIFE

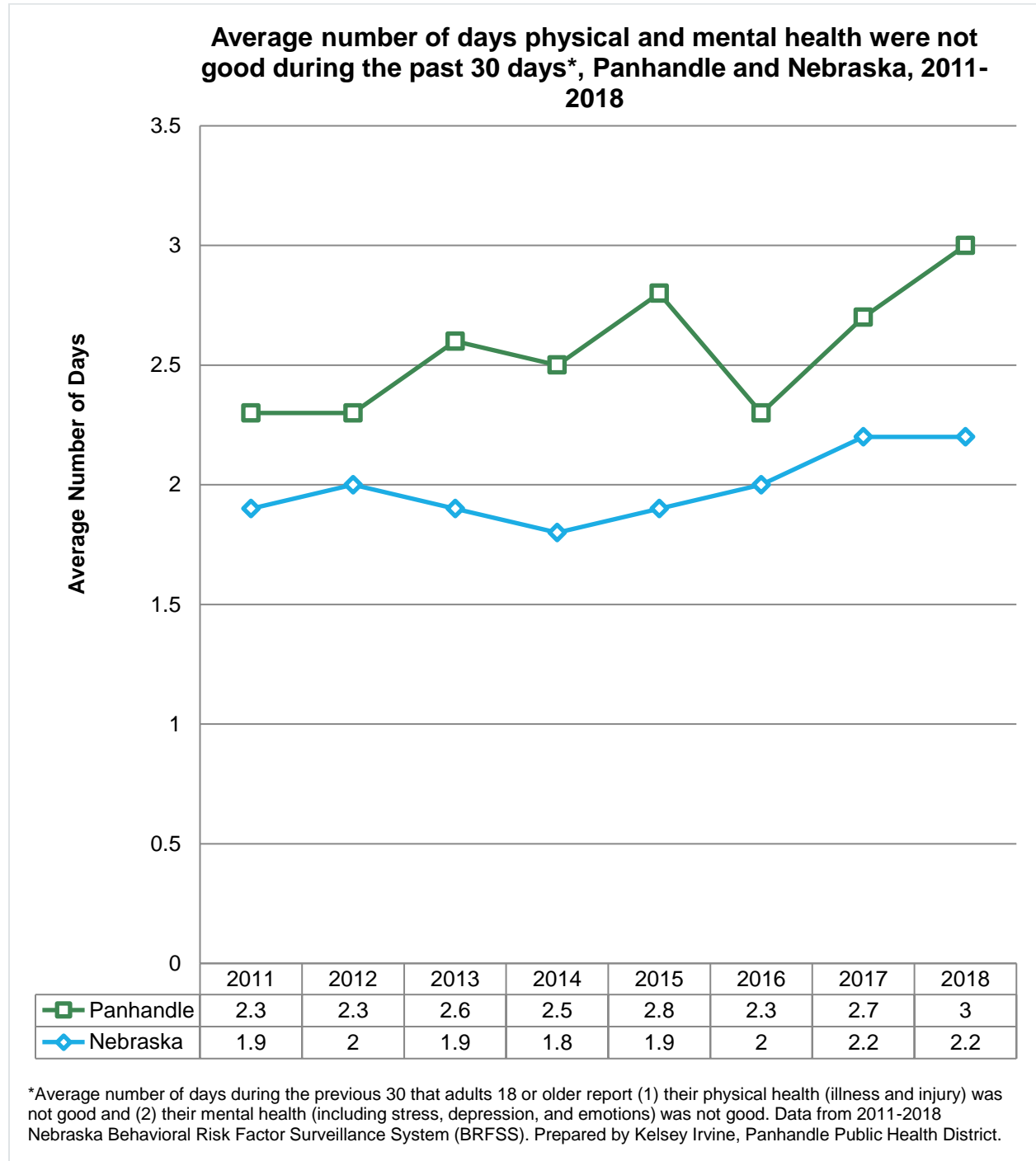
The percentage of adults who report their general health as fair or poor in the Panhandle has increased over the years, but saw a dip in 2016 and 2018. This percentage is historically higher in the Panhandle when compared to the state of Nebraska, with a significant difference between the two in 2011, 2013, 2014, 2015, 2017, and 2018.

Figure 41: Fair of Poor General Health Among Adults



The average number of days that physical and mental health limited the usual activities of Panhandle adults in the past 30 days has slowly increased from 2011 to 2018. This number is historically higher in the Panhandle than across the broader state of Nebraska, although a decrease was seen in 2016. However, the average number of days has continued to rise since then.

Figure 42: Average Number of Days Physical and Mental Health were not Good During the Past 30 Days

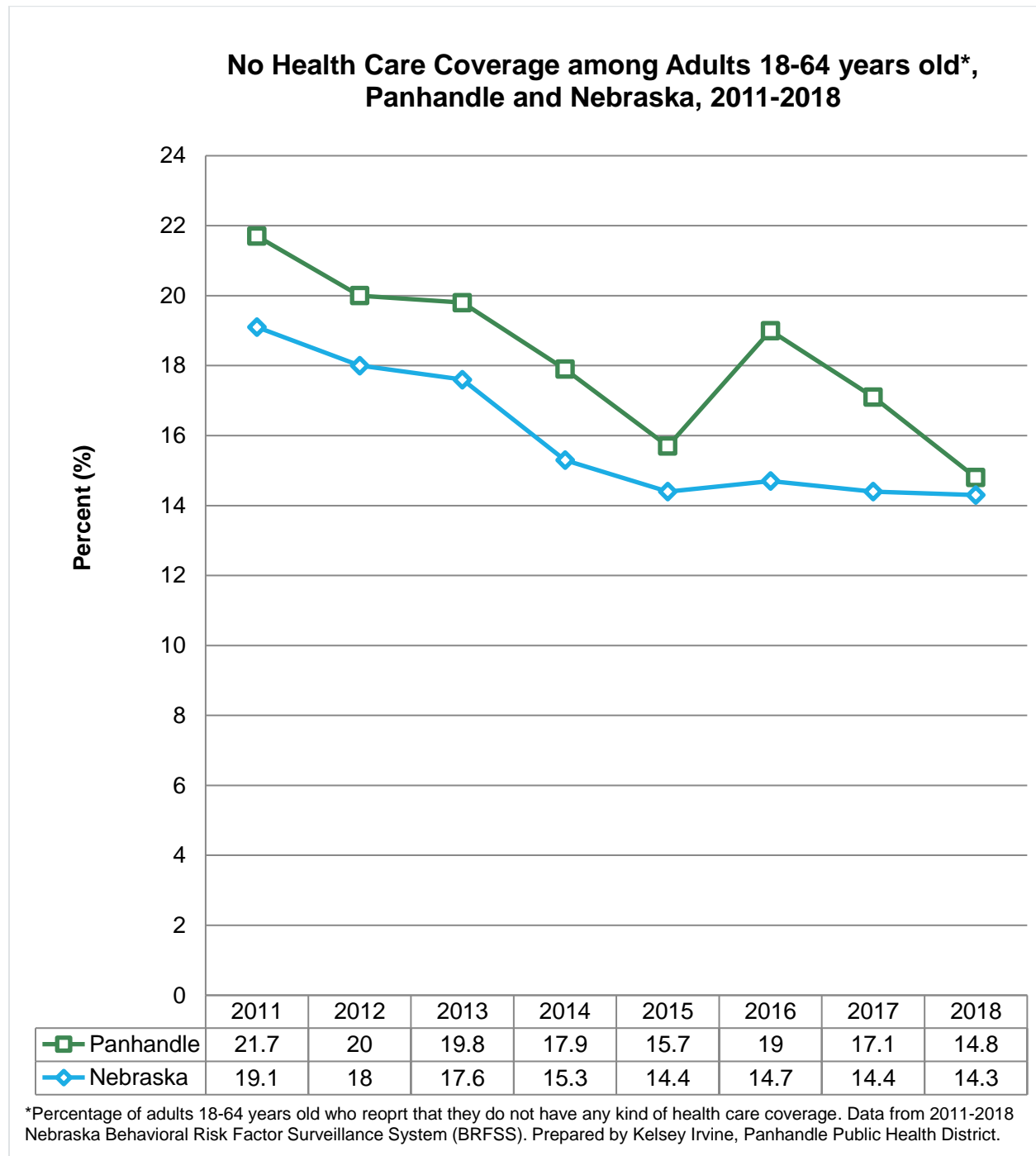


HEALTHCARE ACCESS AND UTILIZATION

HEALTHCARE COVERAGE

The percentage of adults who report they do not have health care coverage is historically higher in the Panhandle when compared to the broader state of Nebraska. However, this number has decreased over the years, outside of a noticeable jump in 2016. In 2018, the percentage was nearly equal to that of the state.

Figure 43: No Health Care Coverage Among Adults 18-64 Years Old

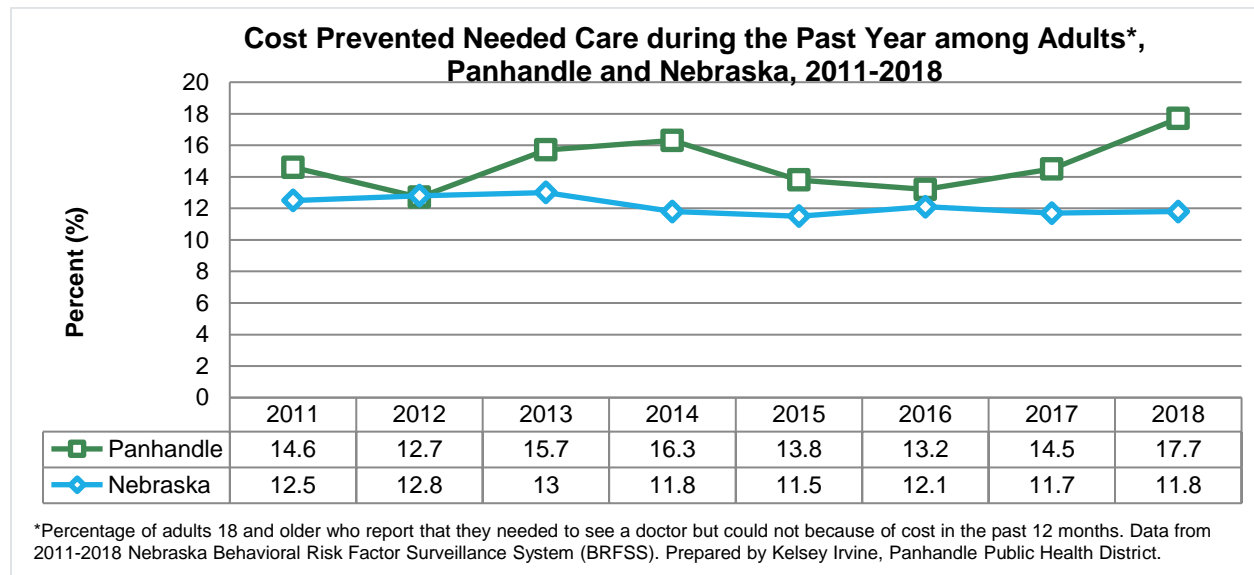


BARRIERS TO HEALTHCARE

COST AS A BARRIER TO CARE

The percentage of Panhandle adults who report they are unable to seek medical care due to cost has increased after hitting a low point in 2016. There was a significant difference between the percentage of adults who reported they could not seek medical care due to cost in 2014 and 2018 in the Panhandle when compared to the state of Nebraska. This could be due to complete lack of health insurance or out-of-pocket costs for those who do have health insurance coverage, such as co-pays or deductibles.

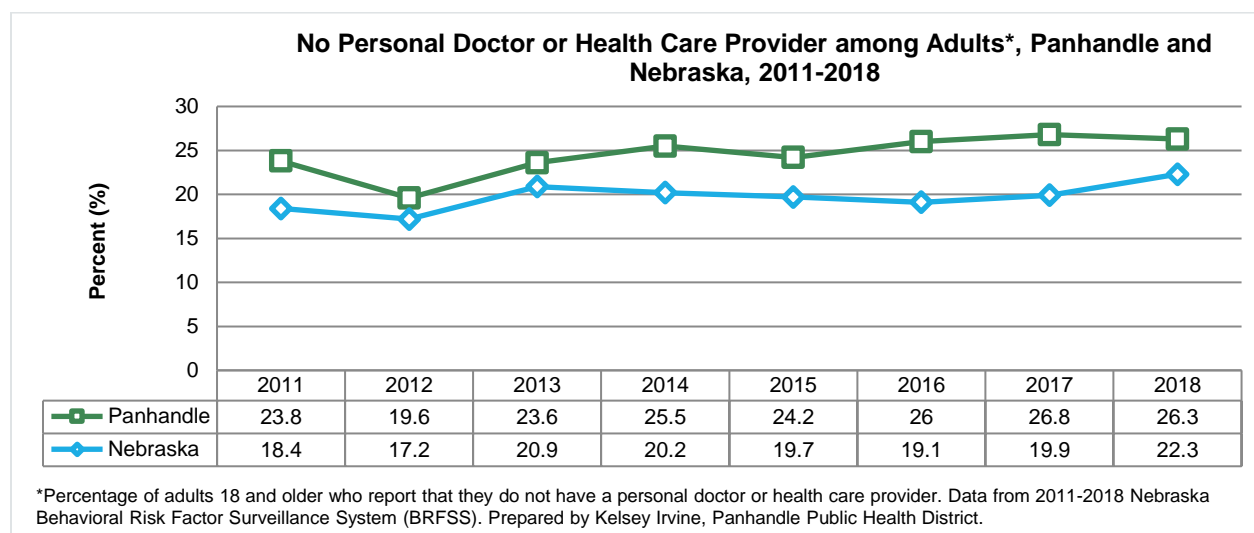
Figure 44: Cost Prevented Needed Care During the Past Year Among Adults



LACK OF PERSONAL HEALTHCARE PROVIDER

The percentage of adults who report they do not have a primary care provider has slowly increased over the years in the Panhandle, and is historically higher than the broader state of Nebraska.

Figure 45: No Personal Doctor or Health Care Provider among Adults



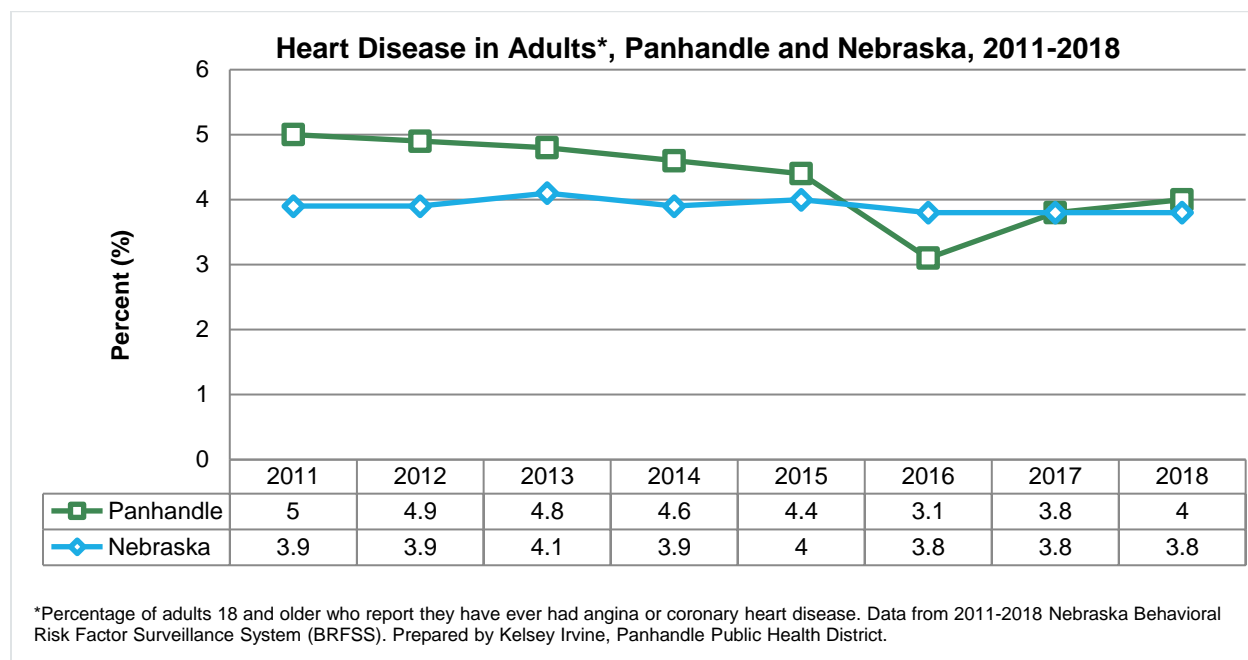
CHRONIC DISEASE

CARDIOVASCULAR DISEASE

Heart disease is the leading cause of death across the world and the United States. In the United States, one person dies every 37 second from heart disease.¹

The rate of heart disease in Panhandle adults has decreased over the years, and is relatively similar to the overall rate in the state of Nebraska.

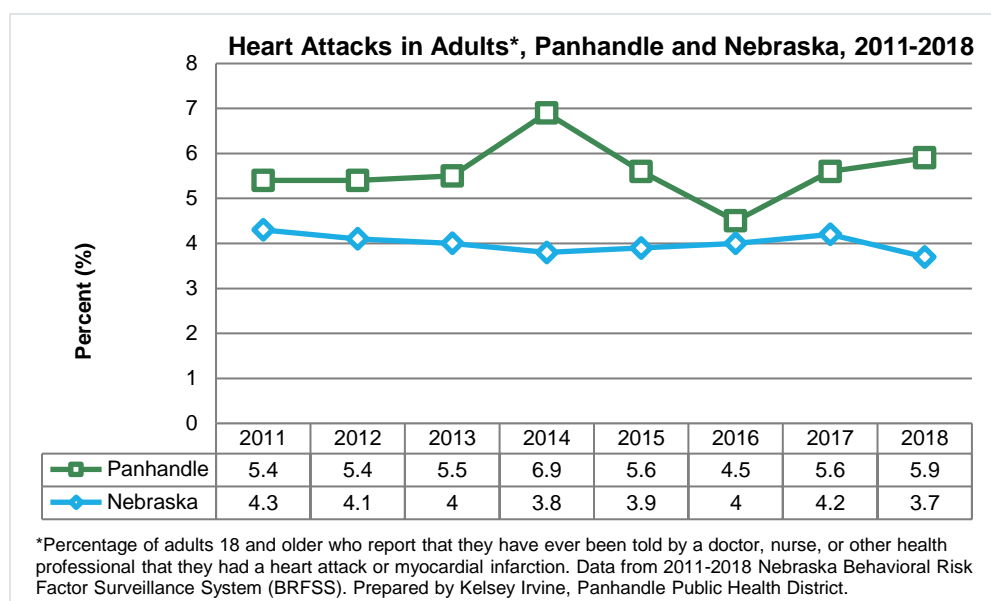
Figure 46: Heart Disease in Adults



HEART ATTACKS

The percentage of Panhandle adults who have ever had a heart attack is historically higher when compared to the state of Nebraska. There were significant differences in 2014, 2015, and 2018.

Figure 47: Heart Attacks in Adults



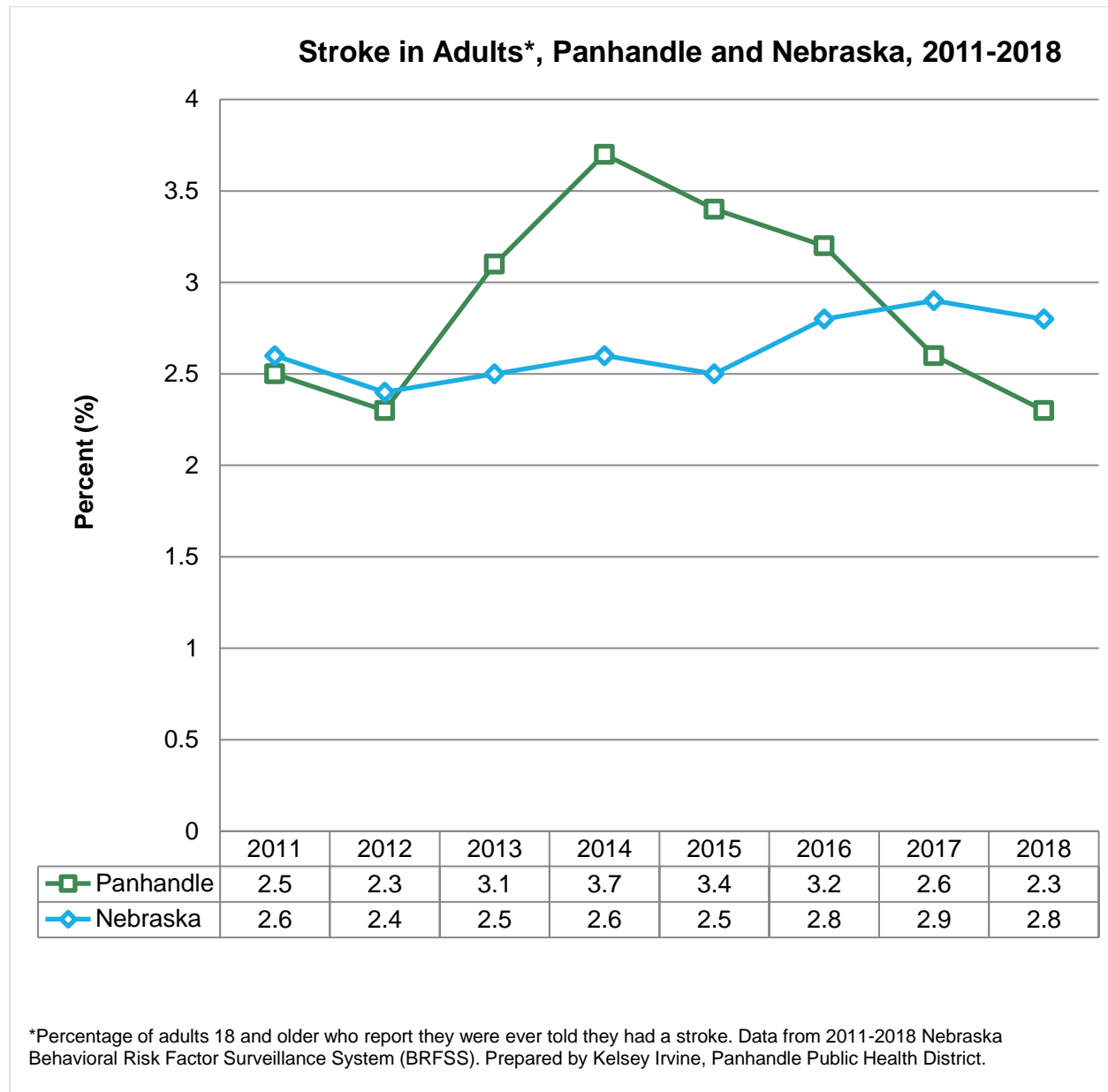
¹ CDC. (2020). Heart Disease Facts. Retrieved from: <https://www.cdc.gov/heartdisease/facts.htm>

STROKE

Stroke is a type of heart disease where blood supply to a part of the brain is blocked, or when a blood vessel in the brain bursts. This leads to brain damage, and can cause severe disability or even death.²

The rate of Panhandle adults who report they have ever had a stroke has steadily decreased since 2014, and is now lower than the broader state of Nebraska.

Figure 48: Stroke in Adults



² CDC. (2020). About Stroke. Retrieved from: <https://www.cdc.gov/stroke/about.htm>

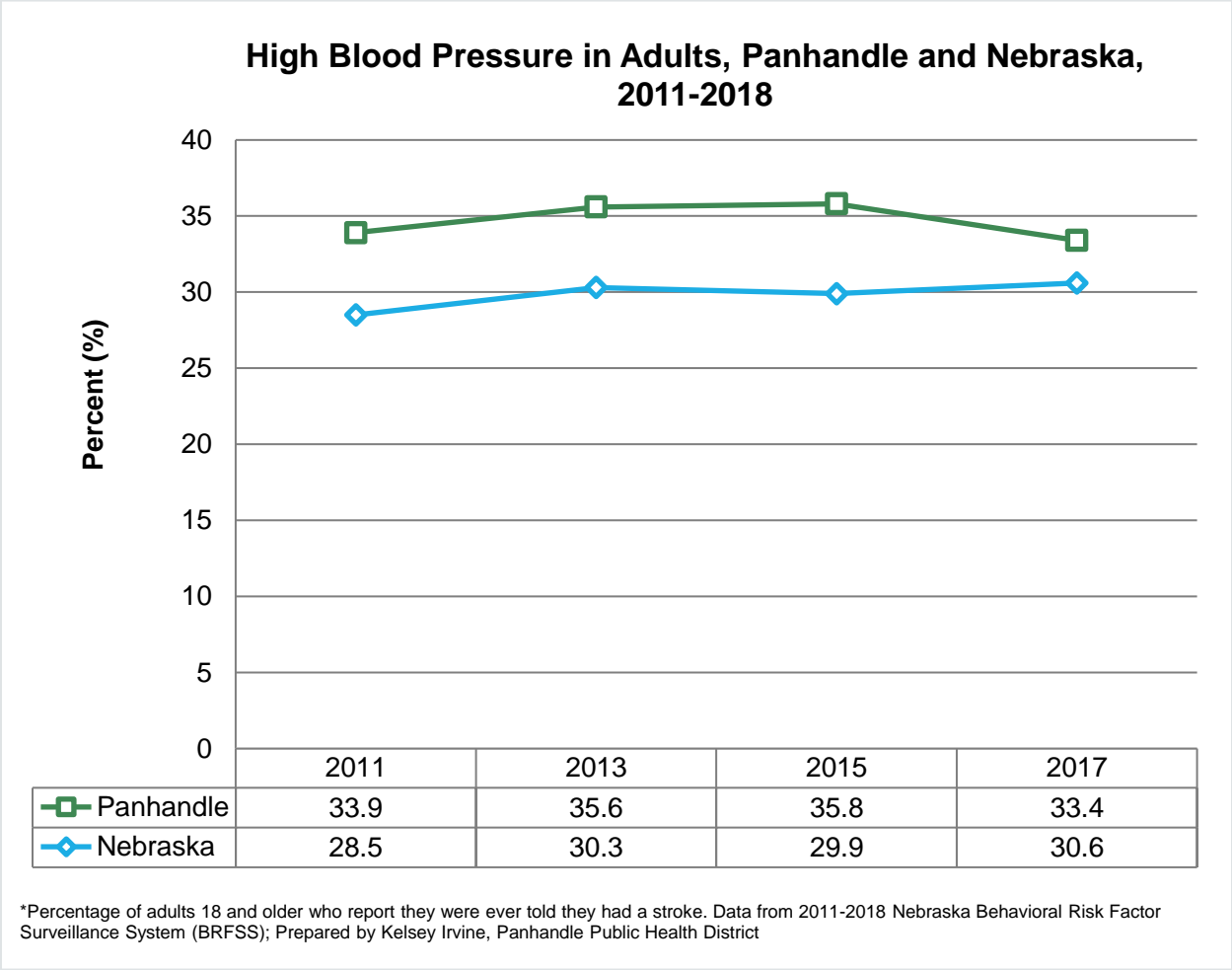
CLINICAL RISK FACTORS FOR HEART DISEASE

HIGH BLOOD PRESSURE (HYPERTENSION)

High blood pressure is defined as having a blood pressure of 140/90 mm Hg or higher. High blood pressure (hypertension) is a risk factor for heart disease. Almost half of US adults have high blood pressure and only about 25% of these people their high blood pressure under control.³

Panhandle adults historically report having high blood pressure at higher rates than adults across the broader state of Nebraska, although a slight decrease was seen from 2015 to 2017.

Figure 49: High Blood Pressure in Adults



Several programs offered in the Panhandle benefit those with high blood pressure. The National Diabetes Prevention Program is an appropriate program for those with high blood pressure, and assists with developing healthy diet and exercise habits. Living Well, a chronic-disease self-management program, can help people manage medications, deal with stress from a chronic condition, and eat well and exercise.

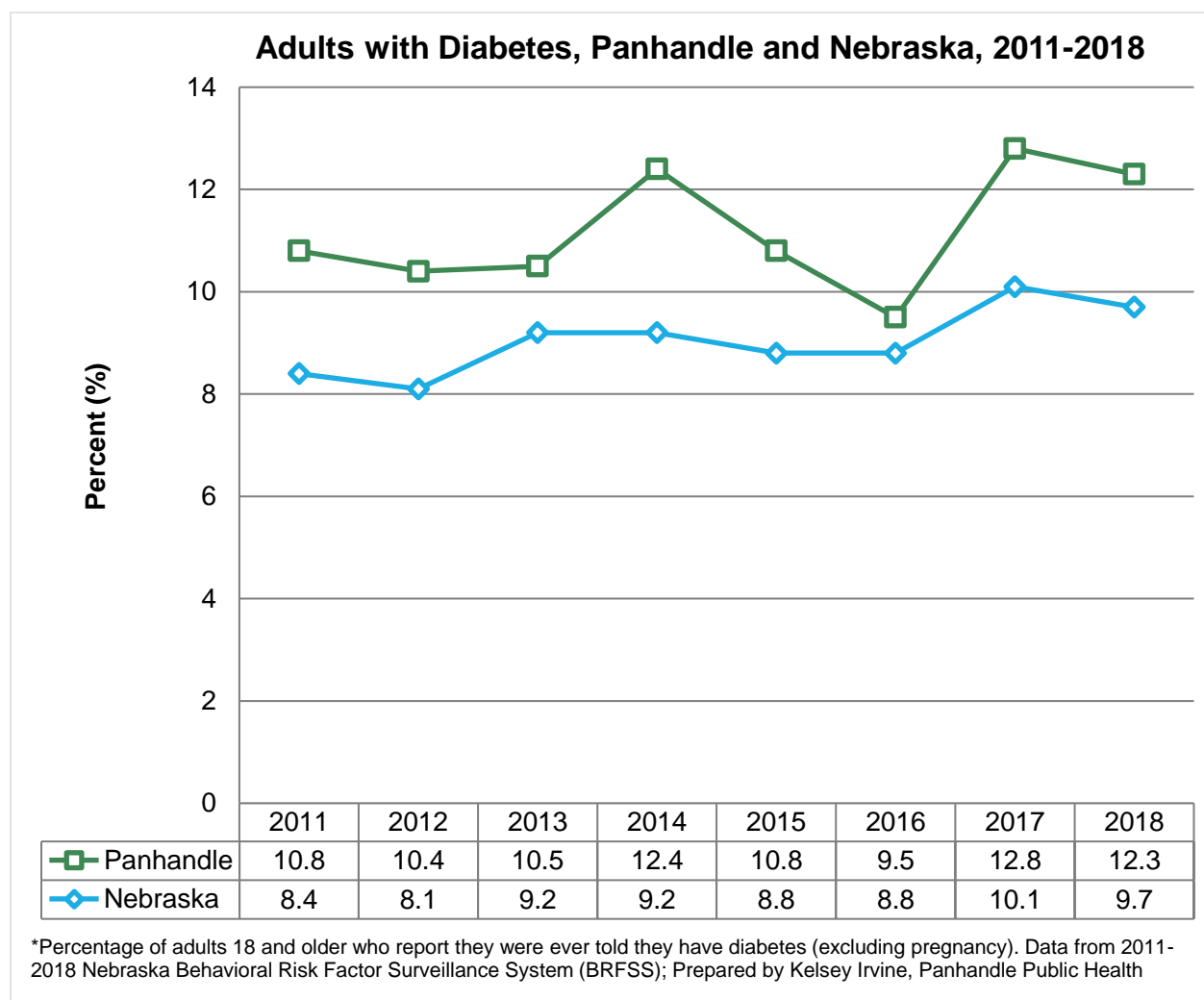
³ CDC. (2020). Facts About Hypertension. Retrieved from: <https://www.cdc.gov/bloodpressure/facts.htm>

DIABETES

Diabetes is a chronic illness in which blood glucose levels are above normal. There are two types of diabetes: type 1 and type 2. Type 1 diabetes, often referred to as juvenile-onset diabetes, occurs when the body cannot produce its own insulin, and makes up approximately 5-10% of diagnosed diabetes cases. Type 2 diabetes, also known as adult-onset diabetes, makes up 90-95% of diagnosed diabetes cases. Gestational diabetes is a form of diabetes that occurs in pregnant women, but generally disappears when pregnancy ends.⁴

The rate of diabetes in Panhandle adults decreased from 2014 to 2016, but has increased since. The rate of diabetes is historically higher in the Panhandle when compared to the state of Nebraska. There was a significant difference between the Panhandle and the state in 2011, 2014, and most recently in 2017.

Figure 50: Adults with Diabetes



The National Diabetes Prevention Program in the Panhandle aims to decrease the number of adults who develop type 2 diabetes through diet and exercise.

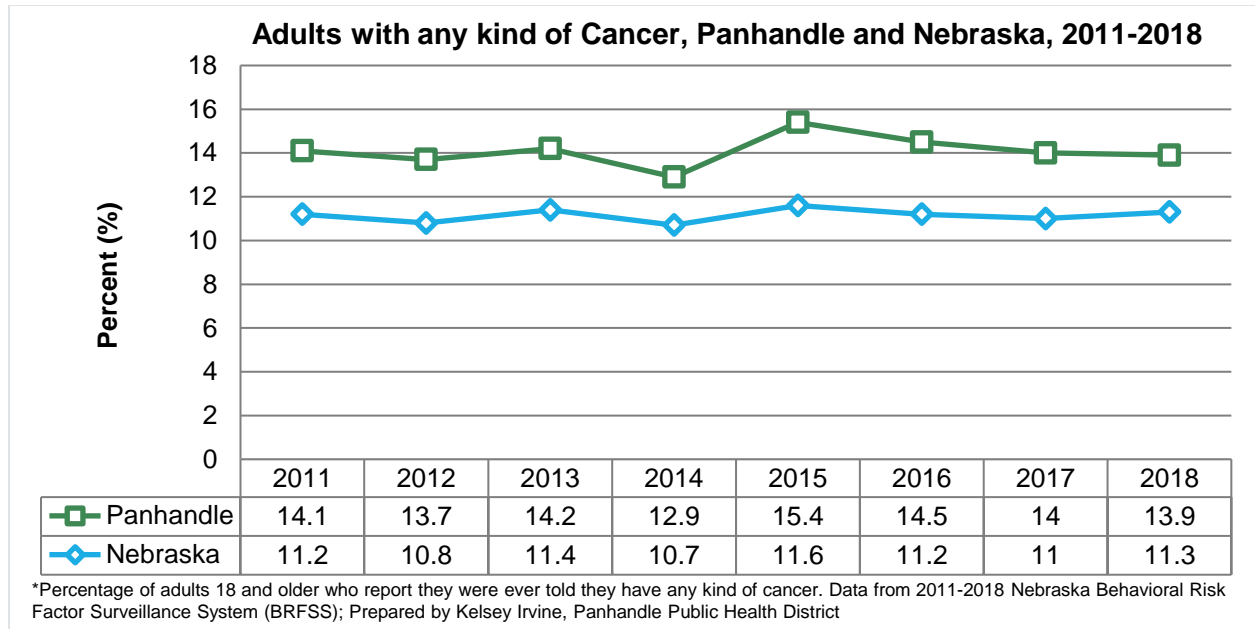
⁴ CDC. (2020). What is Diabetes? Retrieved from: <https://www.cdc.gov/diabetes/basics/diabetes.html>

CANCER

“Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues”.⁵ Cancer spreads throughout the body through the blood and lymph system. Cancer is not only one disease—there are more than 100 types of cancers.

The percentage of adults who were ever told they have any kind of cancer has remained relatively even in the Panhandle from 2011, with only a slight uptick in 2015. There is a significant difference between the Panhandle and the state in every year except for 2018, with the Panhandle higher in every year.

Figure 51: Adults with any kind of Cancer

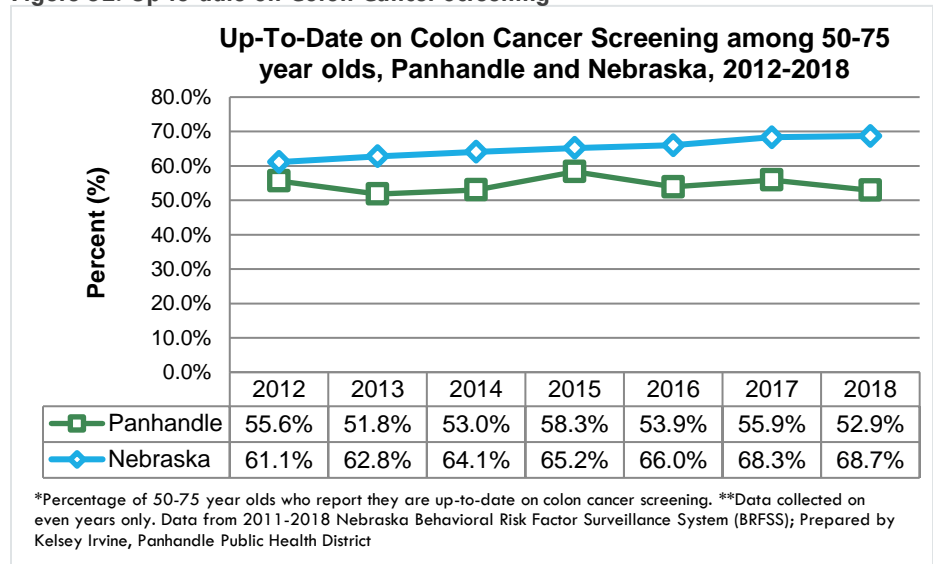


CANCER SCREENING

COLON CANCER SCREENING

The percentage of adults 50-75 years old who report being up to date on colon cancer screening is much lower in the Panhandle than across the state of Nebraska, and has decreased slightly in recent years.

Figure 52: Up-to-date on Colon Cancer Screening



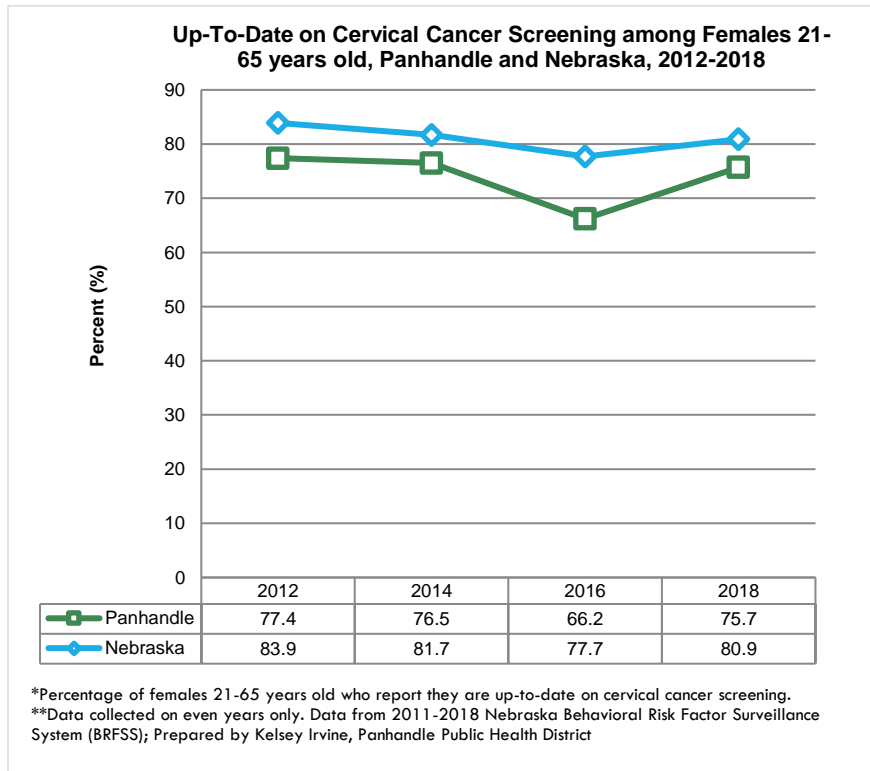
⁵ CDC. (2020). How to Prevent Cancer or Find it Early. Retrieved from: <https://www.cdc.gov/cancer/dcpc/prevention/index.htm>

CERVICAL CANCER SCREENING

The percentage of females 21-65 years old that are up to date on cervical cancer screening is also lower in the Panhandle when compared to the state of Nebraska. While lower overall, trends in the Panhandle tend to echo trends at the state level, with a decrease from 2012-2016, and an uptick from 2016-2018.

Guidance on when cervical cancer screening (pap smear) should begin and how often it should occur has changed in recent years, which likely contributed to the pronounced decrease that was seen in 2016.

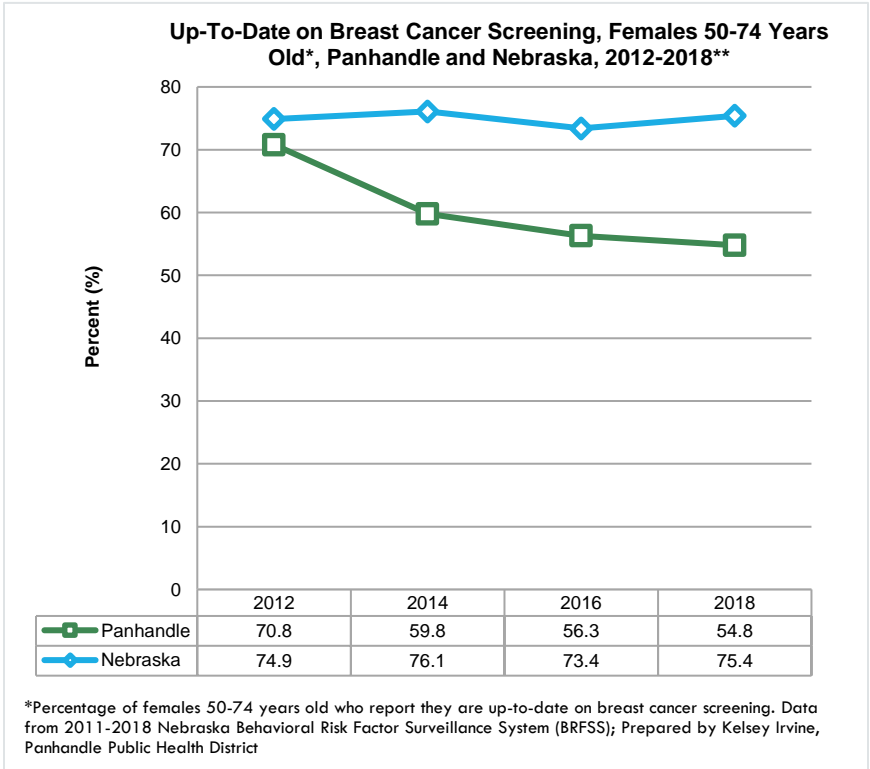
Figure 53: Up-To-Date on Cervical Cancer Screening



BREAST CANCER SCREENING

The percentage of females aged 50-74 who report being up-to-date on breast cancer screening in the Panhandle has decreased from 2012 to 2018, always remaining lower than the state percentage. Although the percentage that was up-to-date on breast cancer screening in the Panhandle in 2012 was relatively close to that of the state (70.8% vs. 74.9%), this gap widened in 2014 to an almost 20% difference (59.8% for the Panhandle vs. 76.1% for the state). Notably, the state percentage has remained relatively even while the Panhandle has decreased.

Figure 54: Up-to-Date on Breast Cancer Screening

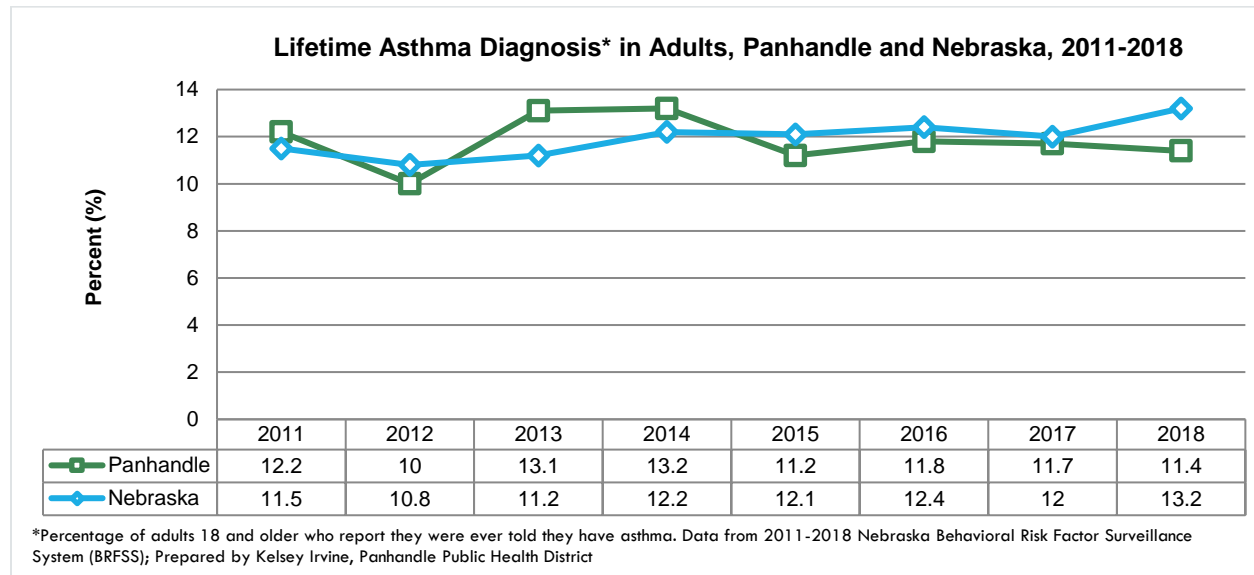


ASTHMA

Asthma is a disease that impact the lungs, causing repeated episodes of breathlessness, wheezing, nighttime or early morning coughing, and chest tightness. It can be controlled through medication and avoiding triggers of asthma attacks.⁶

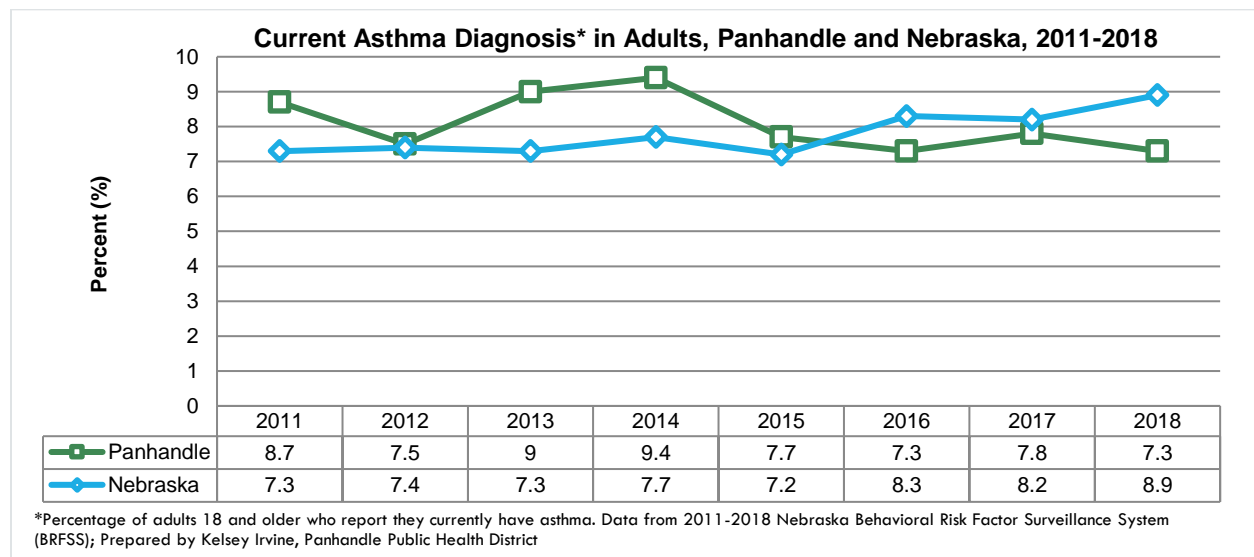
Adults who have ever been diagnosed with asthma (lifetime asthma diagnosis) has decreased slightly in the Panhandle overall, from 12.2% in 2011 to 11.4% in 2018. It was slightly lower in 2018 when compared to the overall state of Nebraska.

Figure 55: Lifetime Asthma Diagnosis in Adults



Adults who currently have asthma has also decreased in the Panhandle from 2011 to 2018, and was also slightly lower than the state in 2018.

Figure 56: Current Asthma Diagnosis in Adults



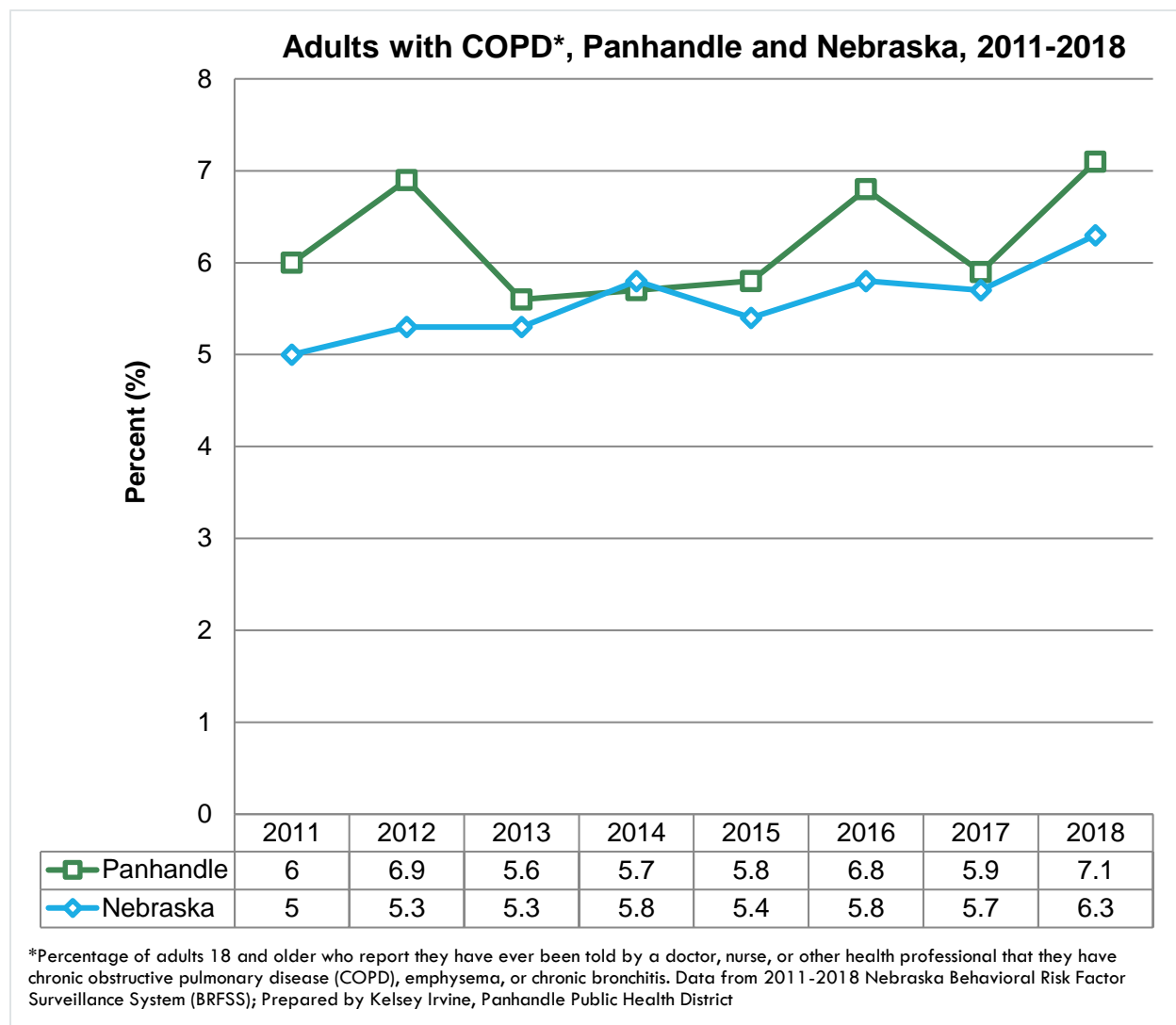
⁶ CDC. (2020). Asthma. Retrieved from: <https://www.cdc.gov/asthma/default.htm>

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease (COPD) is a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis.⁷

Nearly 16 million Americans are diagnosed with COPD, although the actual number with the disease may be higher. There is no cure for COPD, but it is treatable.

Figure 57: Adults with COPD



The percentage of adults in the Panhandle with COPD is slightly higher than the overall state of Nebraska.

One risk factor for COPD is age, with people aged 65 and older at higher risk for the disease. The Panhandle has a larger population of older adults when compared to the overall state of Nebraska, which may contribute to the higher rates of COPD in the region.

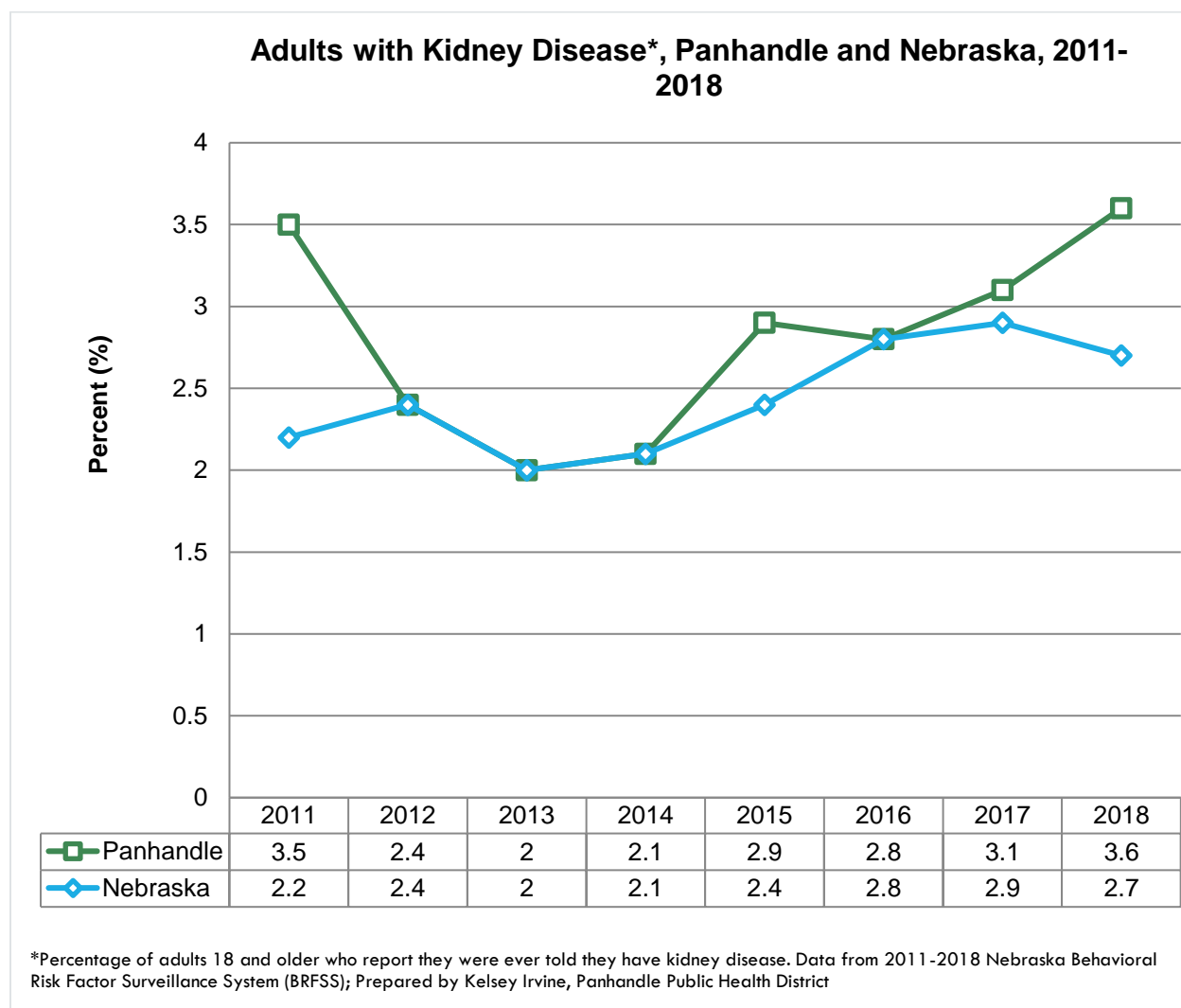
⁷ CDC. (2018). Chronic Obstructive Pulmonary Disease. Retrieved from: <https://www.cdc.gov/copd/index.html>

KIDNEY DISEASE

Kidney disease means that your kidneys are damaged, and you are unable to filter blood the way that you should. This damage to your kidneys can cause wastes to build up in your body, among other things. Kidney disease may lead to kidney failure, which is only treatable with dialysis or a kidney transplant. More than 30 million American adults may have chronic kidney disease. Risk factors for kidney disease include: diabetes, high blood pressure, heart disease, and family history of kidney failure.⁸

The percentage of adults in the Panhandle who have been diagnosed with kidney disease has increased from 2013 to 2018, and has been higher when compared to the overall state of Nebraska in recent years.

Figure 58: Adults with Kidney Disease



⁸ NIH. (2017). What is Chronic Kidney Disease? Retrieved from: <https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease>

RISK AND PROTECTIVE FACTOR FOR CHRONIC DISEASE

TOBACCO USE

Tobacco use is the top cause of preventable death, disease, and disability in the United States. Smoking-related illness costs the US over \$300 billion each year, including \$170 billion in direct medical costs.⁹

ADULT TOBACCO USE

The percentage of adults who report smoking in the Panhandle was lower in 2011 and 2012, but has been higher when compared to the overall state of Nebraska from 2013 to 2018. However, the percentage of adults who smoke has gradually been decreasing since 2014, with a more than 2-point decrease from 2014 to 2018.

Smokeless tobacco use (chew, snuff, snus) has been consistently higher in the Panhandle when compared to the overall state of Nebraska, with a marked increase from 2014 to 2017. There has been a slight downward trend from 2017 to 2018. While the use of smokeless tobacco across the state has remained relatively flat, use in the Panhandle has seen more increases and decreases.

Figure 59: Current Cigarette Smoking Among Adults

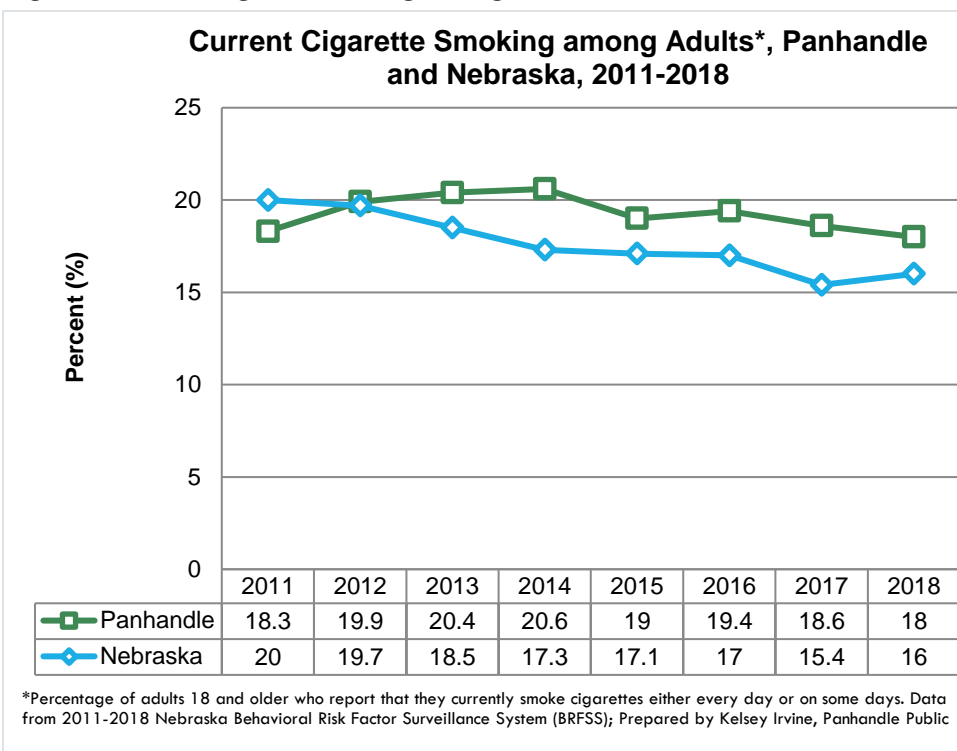
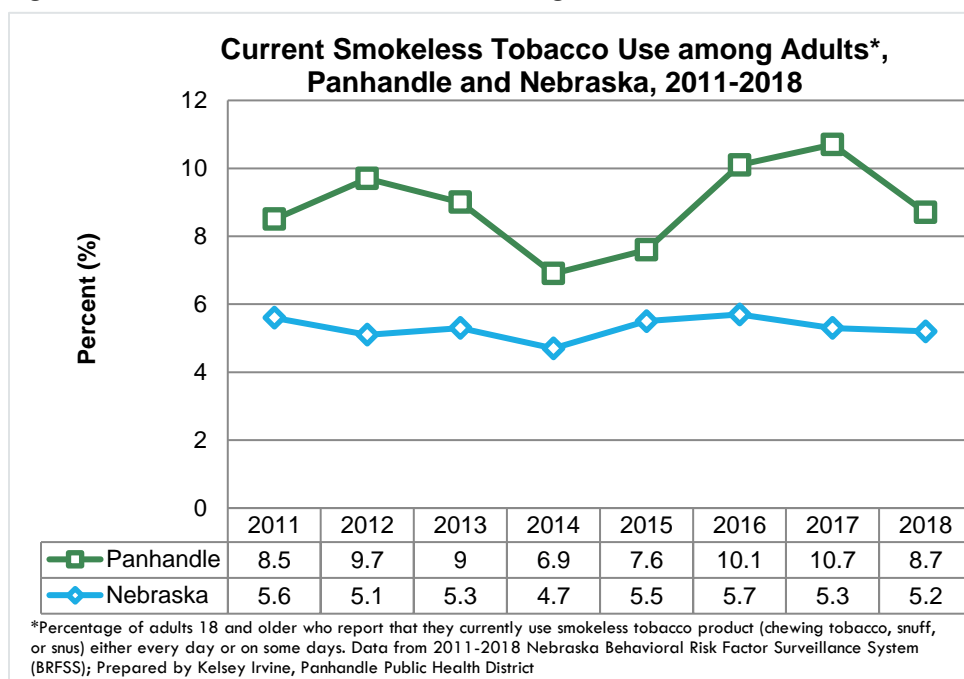


Figure 60: Current Smokeless Tobacco Use Among Adults

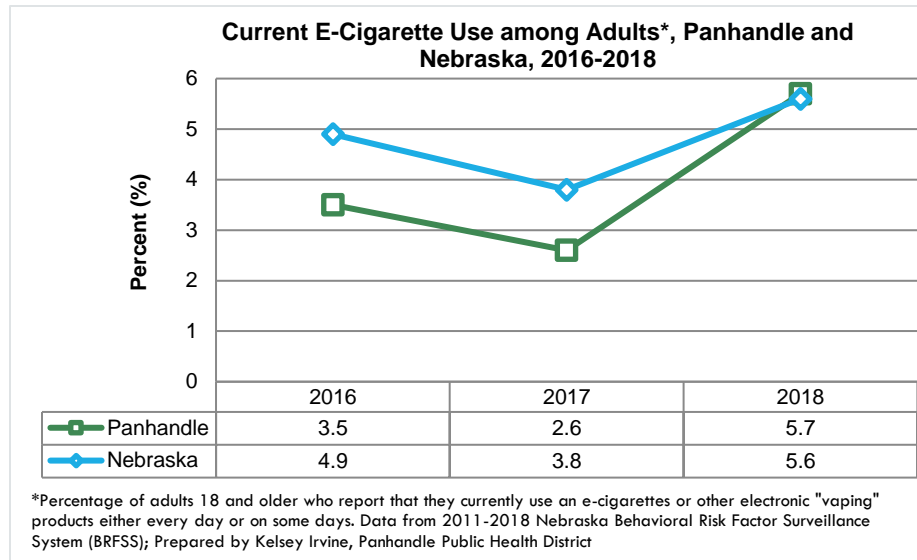


⁹ CDC. (2019). Tobacco Use. Retrieved from: <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm>

ADULT E-CIGARETTE USE

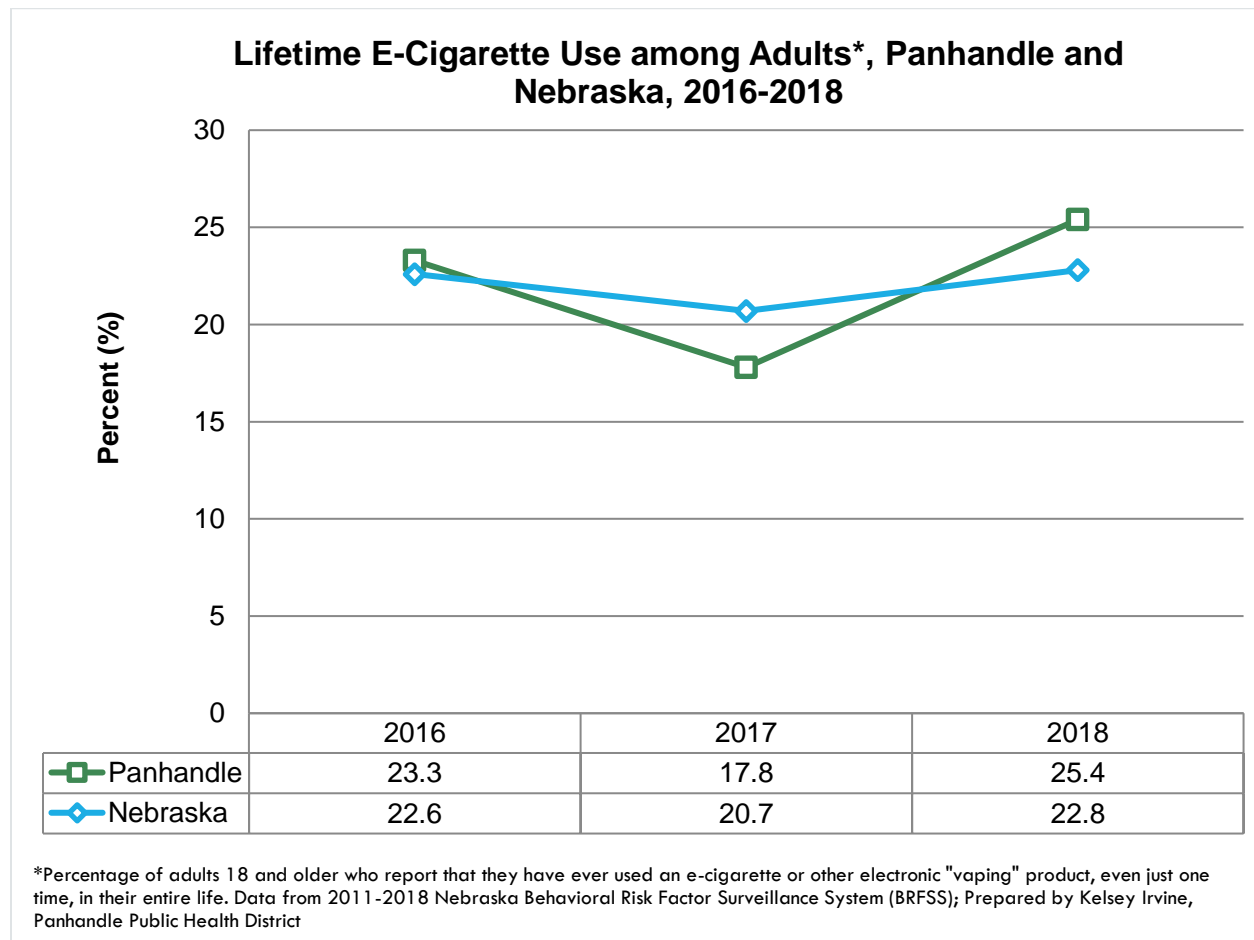
Data on adult e-cigarette use has only been collected for a handful of years. Since 2016, the percentage of Panhandle adults who report current use of e-cigarettes has increased slightly, from 3.5% to 5.7%, and in 2018 was essentially even to that of the overall state of Nebraska.

Figure 61: Current E-Cigarette Use Among Adults



Lifetime e-cigarette use indicates the percentage of adults who have ever used an e-cigarette. The percentage of Panhandle adults who have ever used e-cigarettes is slightly higher than the overall state of Nebraska, but has not changed much from 2016.

Figure 62: Adult Lifetime E-Cigarette Use



YOUTH TOBACCO USE

CIGARETTE USE

Both current cigarette use (past 30 days) and lifetime cigarette use have been trending downward in Panhandle youth since 2003. For 12th graders and 8th graders, the current cigarette smoking downward trend appears to have plateaued from 2014 to 2018.

Figure 63: Past 30 Day Cigarette Use Among Youth

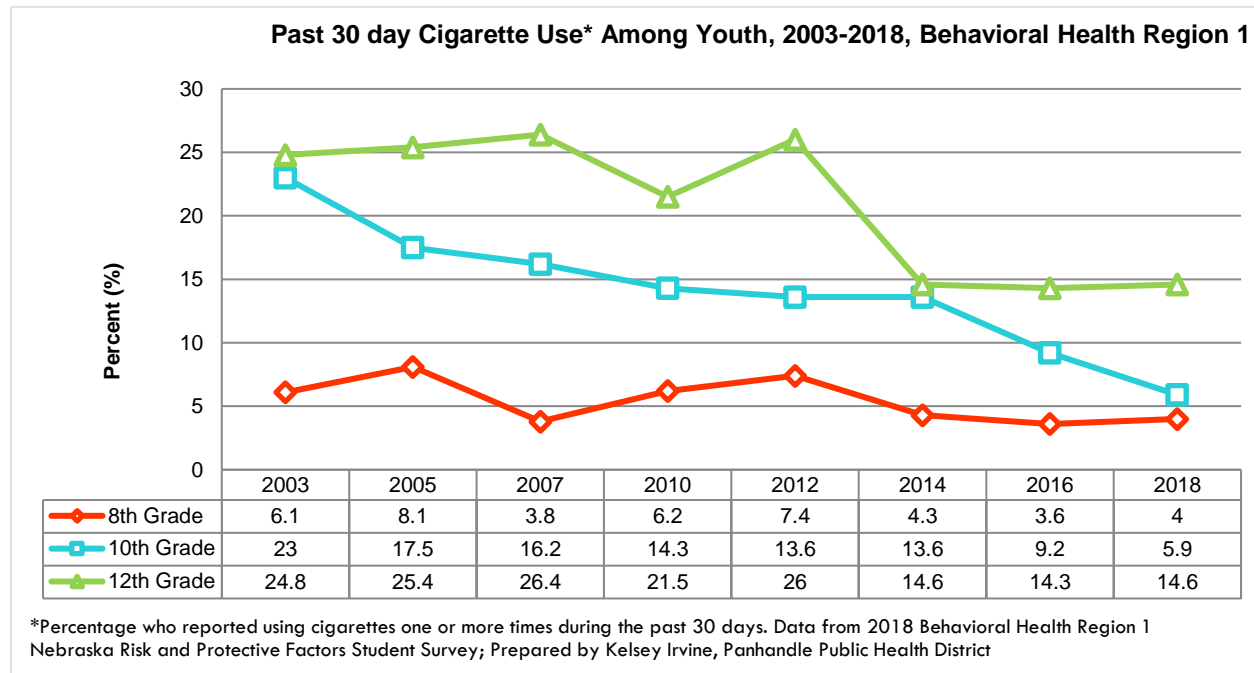
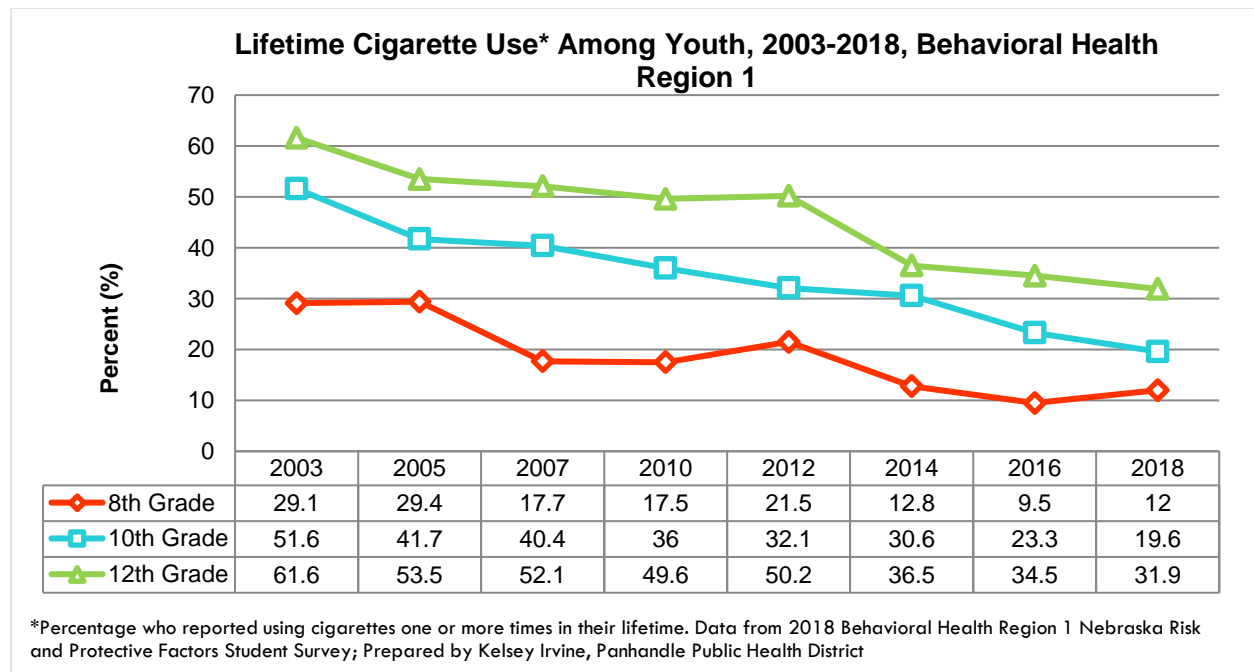


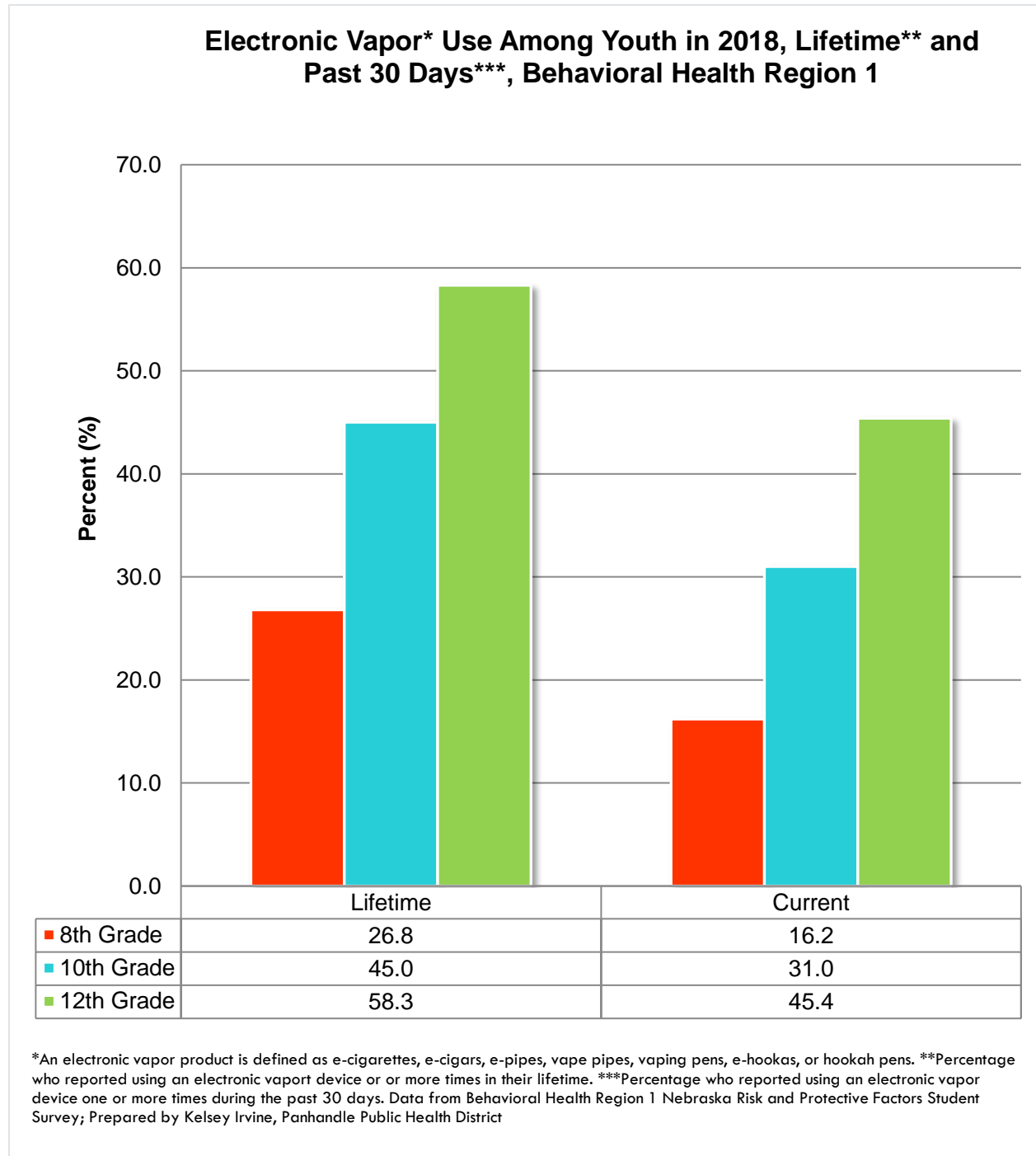
Figure 64: Lifetime Cigarette Use Among Youth



E-CIGARETTE USE

E-cigarette use among youth was measured in 2018. Over half of 12th graders and nearly half of 10th graders reported they had ever used an e-cigarette, while slightly less (45.4% and 31%, respectively), currently use e-cigarettes. Nearly 30% of 8th graders had ever used an e-cigarette, with about 16% reporting they currently use one.

Figure 65: Electronic Vapor Use Among Youth in 2018, Lifetime and Past 30 Days



SMOKELESS TOBACCO

The percentage of youth who have ever used smokeless tobacco (chew, snuff, plug, dipping tobacco or chewing tobacco) has held a downward trend from 2003 to 2018. Current smokeless tobacco use (past 30 day use) has decreased slightly among 12th and 10th graders, but increased slightly among 8th graders.

Figure 66: Lifetime Smokeless Tobacco Use Among Youth

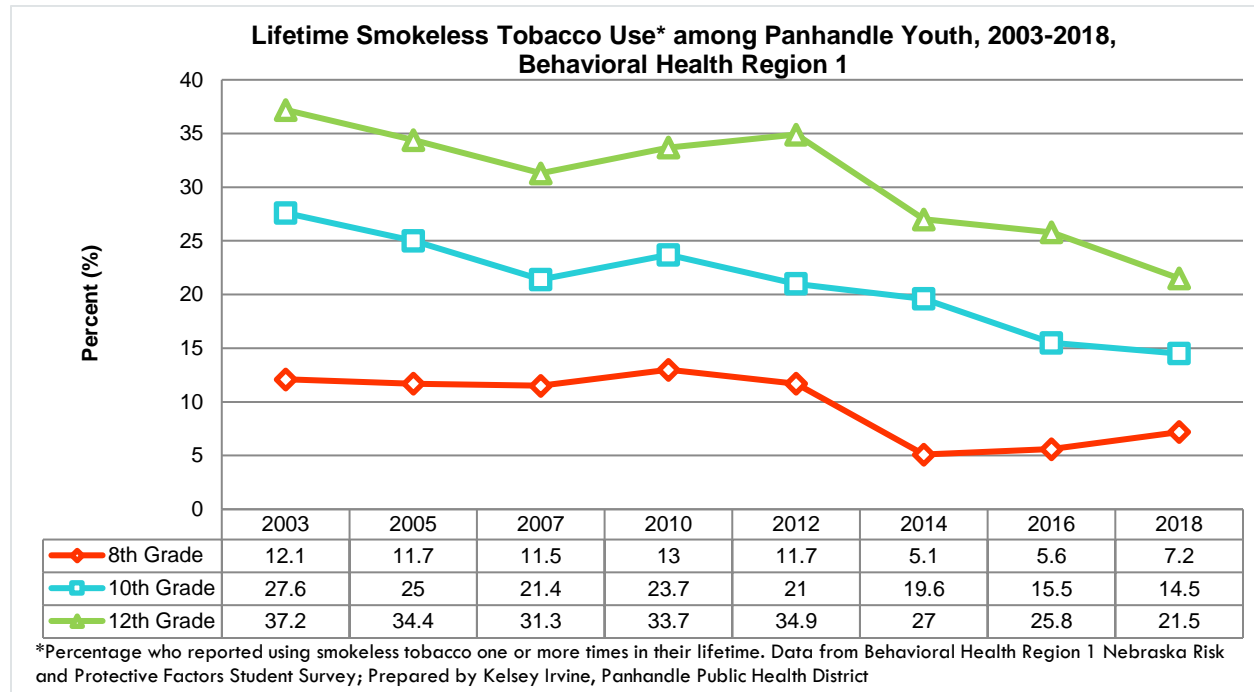
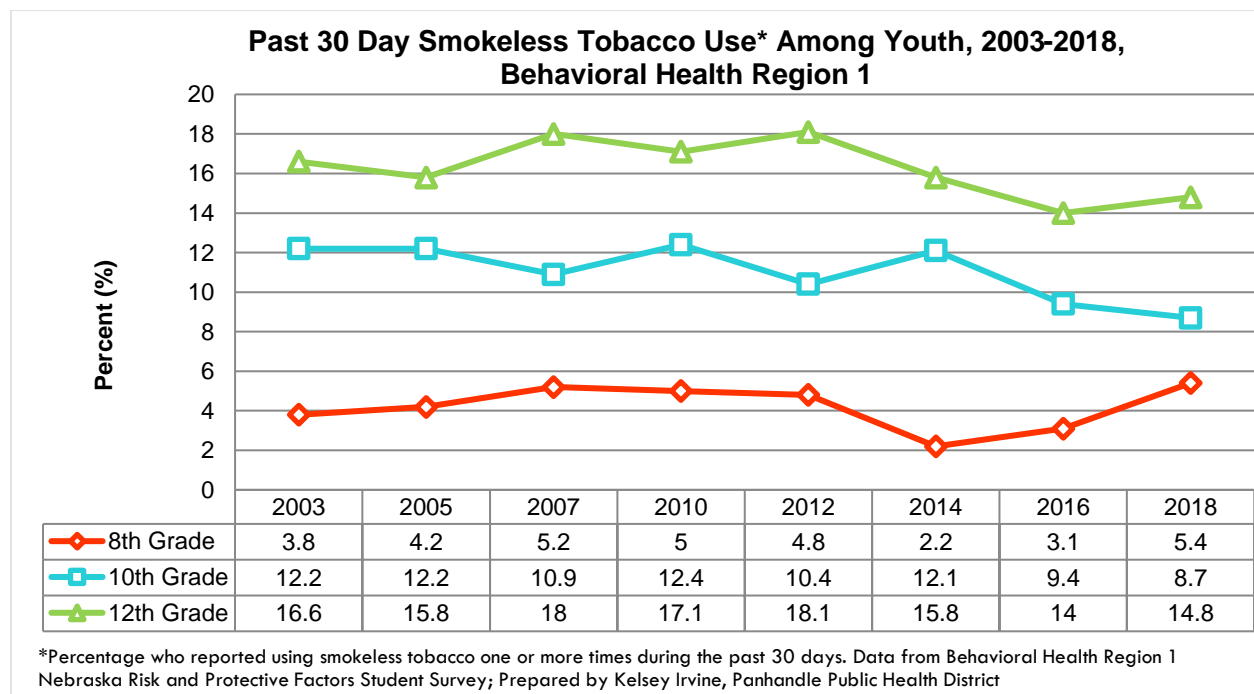


Figure 67: Past 30 Day Smokeless Tobacco Use Among Youth

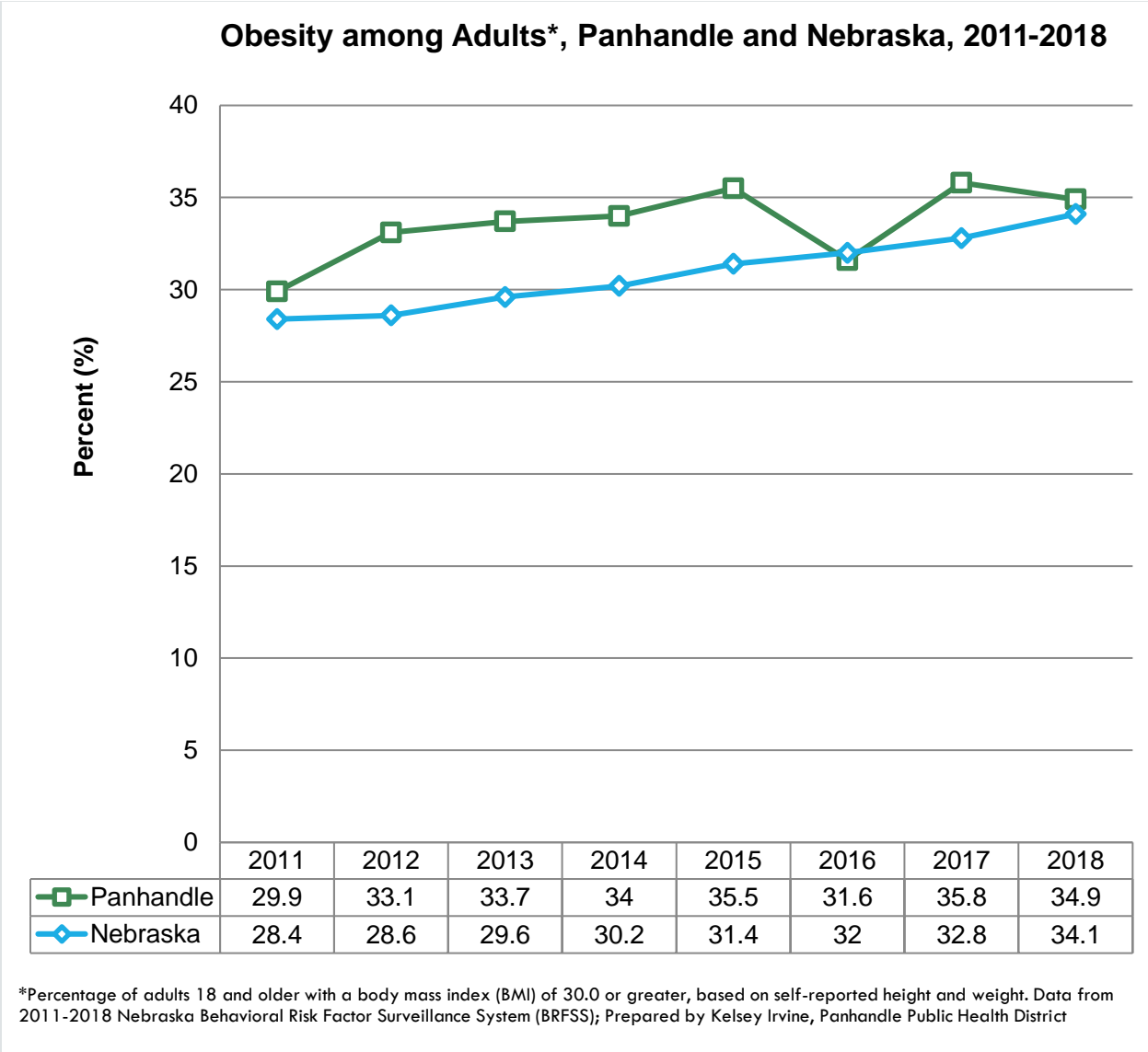


OBESITY

Adult obesity is defined as a BMI (Body Mass Index) of 30 or higher. Heart disease, stroke, type 2 diabetes, and some cancers are related to obesity.¹⁰

Obesity in Nebraska is a growing trend, with the number of adults reporting they are obese rising each year in both the state of Nebraska and the Panhandle. The obesity rate has steadily increased across the entire state of Nebraska. In the Panhandle, there was a dip in 2016, but an increase in 2017 and 2018. In 2018, the percentage of adults who were obese were nearly the same between the Panhandle (34.9%) and the overall state of Nebraska (34.1%).

Figure 68: Obesity Among Adults



¹⁰ <https://www.cdc.gov/obesity/data/adult.html>

NUTRITION

Adults are recommended to consume between 2 and 3 cups of vegetables per day and 1 and 2 cups of fruit per day. 17.9% of Panhandle adults report they consume vegetables less than one time per day, and 37.5% of Panhandle adults report they consume fruits less than one time per day.

Figure 69: Adults Consuming Vegetables Less than 1 time per day

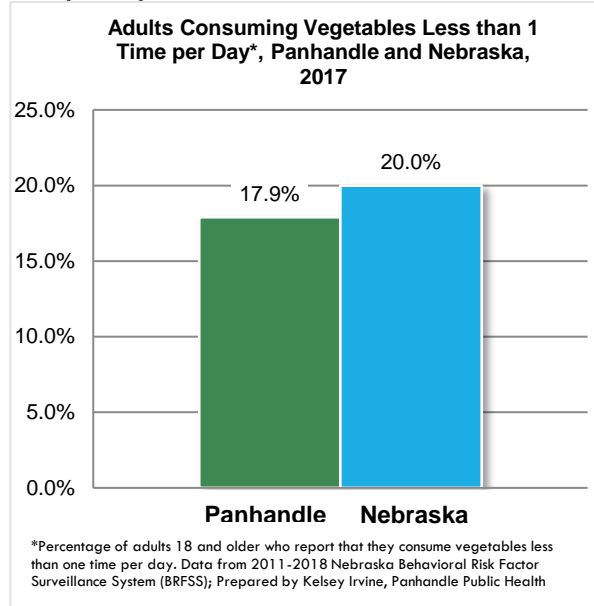
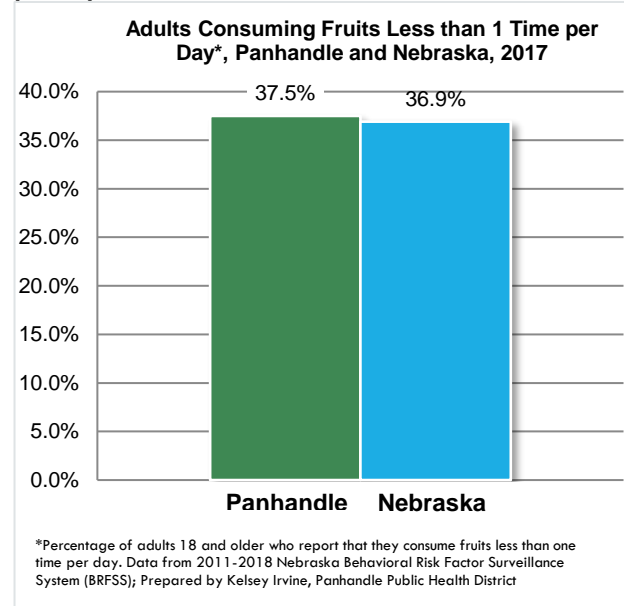
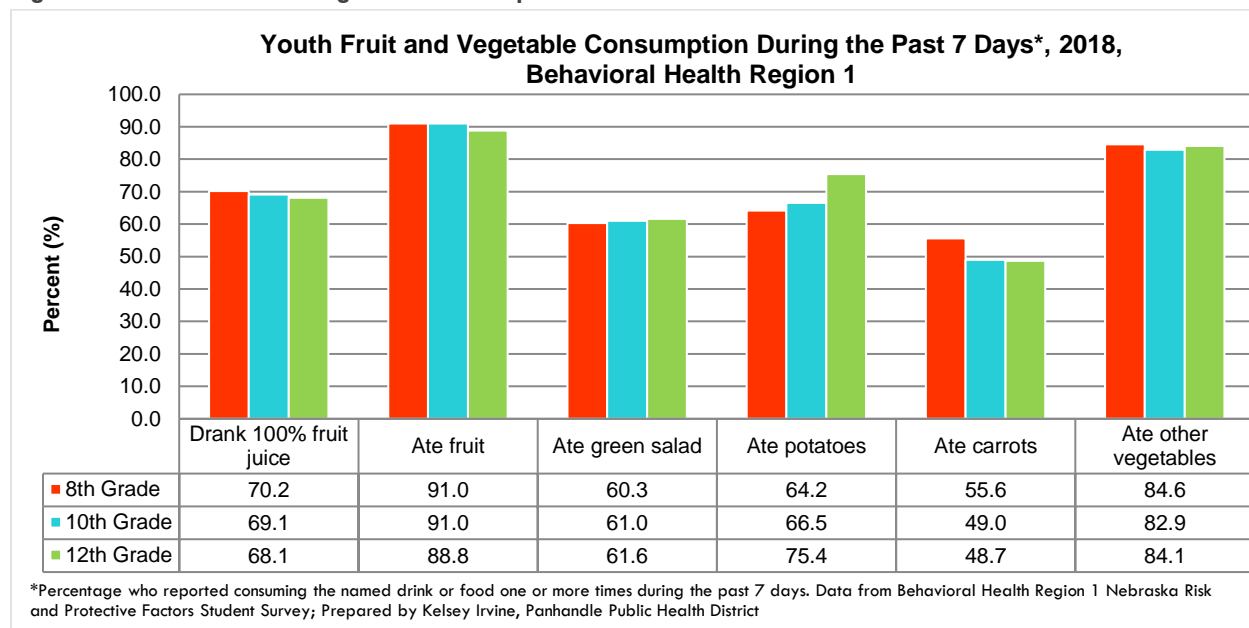


Figure 70: Adults Consuming Fruits less than 1 time per day



Youth in grades 8th through 12th grade are recommended to consume 1 1/2-2 cups of fruit per day, and 2 1/2 to 3 cups of vegetables per day. A survey of youth fruit and vegetable consumption in 2018 found that the majority of youths ate a fruit or vegetable one or more times in the past week.

Figure 71: Youth Fruit and Vegetable Consumption

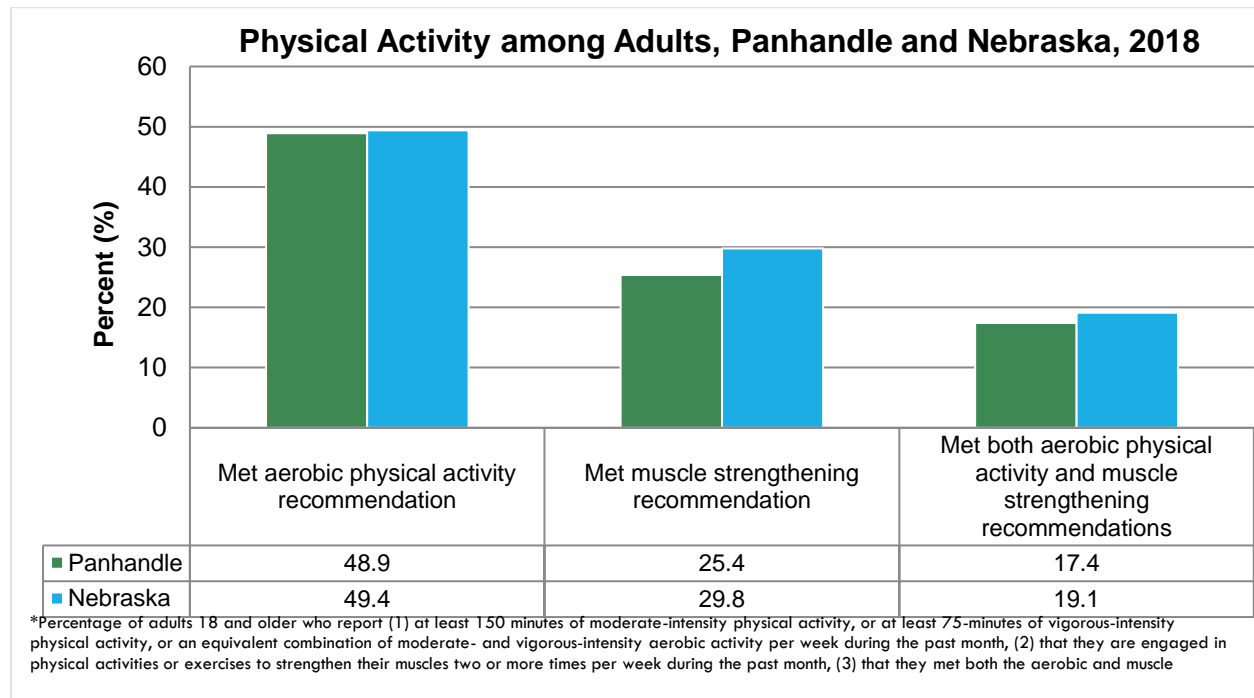


PHYSICAL ACTIVITY

ADULTS

In 2018, 48.9% of Panhandle adults met aerobic physical activity recommendations, 25.4% met muscle strengthening recommendations, and just 17.4% met both recommendations. The Panhandle reports slightly lower rates across all types of physical activity when compared to the overall state of Nebraska.

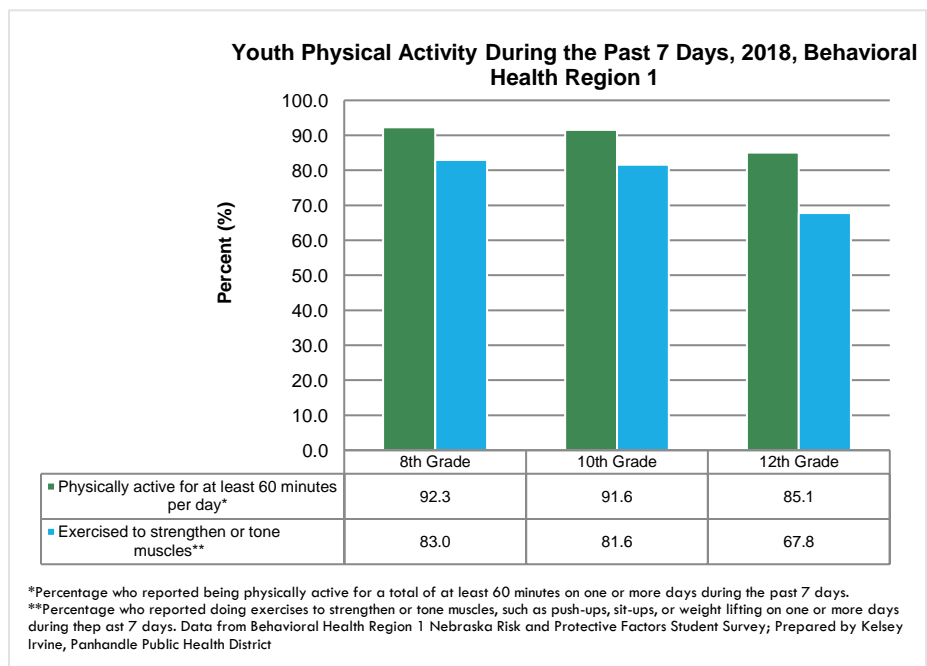
Figure 72: Physical Activity Among Adults



YOUTH

The majority of Panhandle youth report being physically active for at least 60 minutes per day, and that they regularly exercise to strengthen or tone muscles. The percentage that reports they regularly exercising to strengthen or tone muscles appears to decrease with age.

Figure 73: Youth Physical Activity



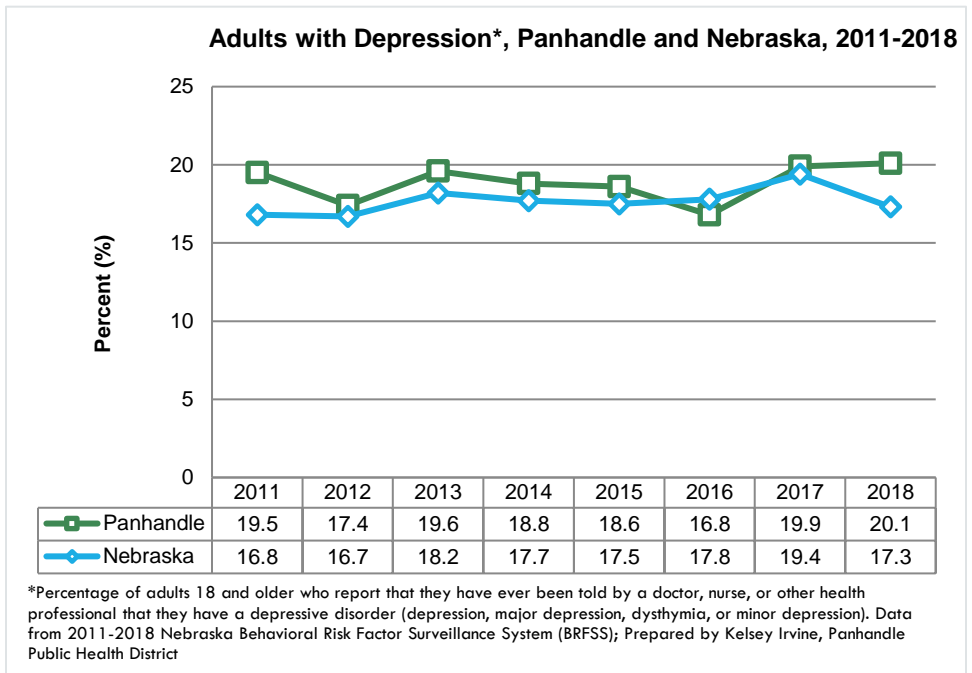
BEHAVIORAL HEALTH

MENTAL HEALTH

“A mental illness is a condition that affects a person's thinking, feeling, behavior or mood. These conditions deeply impact day-to-day living and may also affect the ability to relate to others.”¹¹ Approximately 1 in 5 US adults experience mental illness, and 50% of all lifetime mental illness begins by age 14.

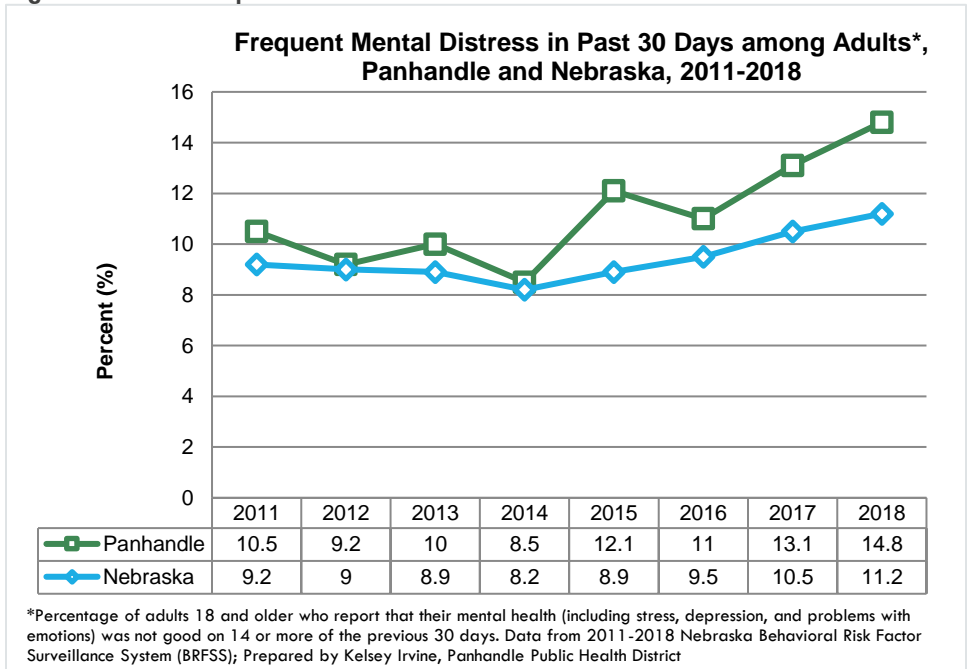
The percentage of Panhandle adults who have ever been diagnosed with depression has been relatively close to the overall state of Nebraska, with a slight uptick in 2018, whereas the state saw a downturn that year.

Figure 74: Adults with Depression



The percentage of adults in the Panhandle who experienced frequent mental distress has been higher than the state, historically. There was a more rapid increase from 2014 to 2018 in the Panhandle when compared to the state.

Figure 75: Adult Frequent Mental Distress



¹¹ National Alliance on Mental Illness. (2020). Mental Health Conditions. Retrieved from: <https://www.nami.org/learn-more/mental-health-conditions>

SUBSTANCE ABUSE

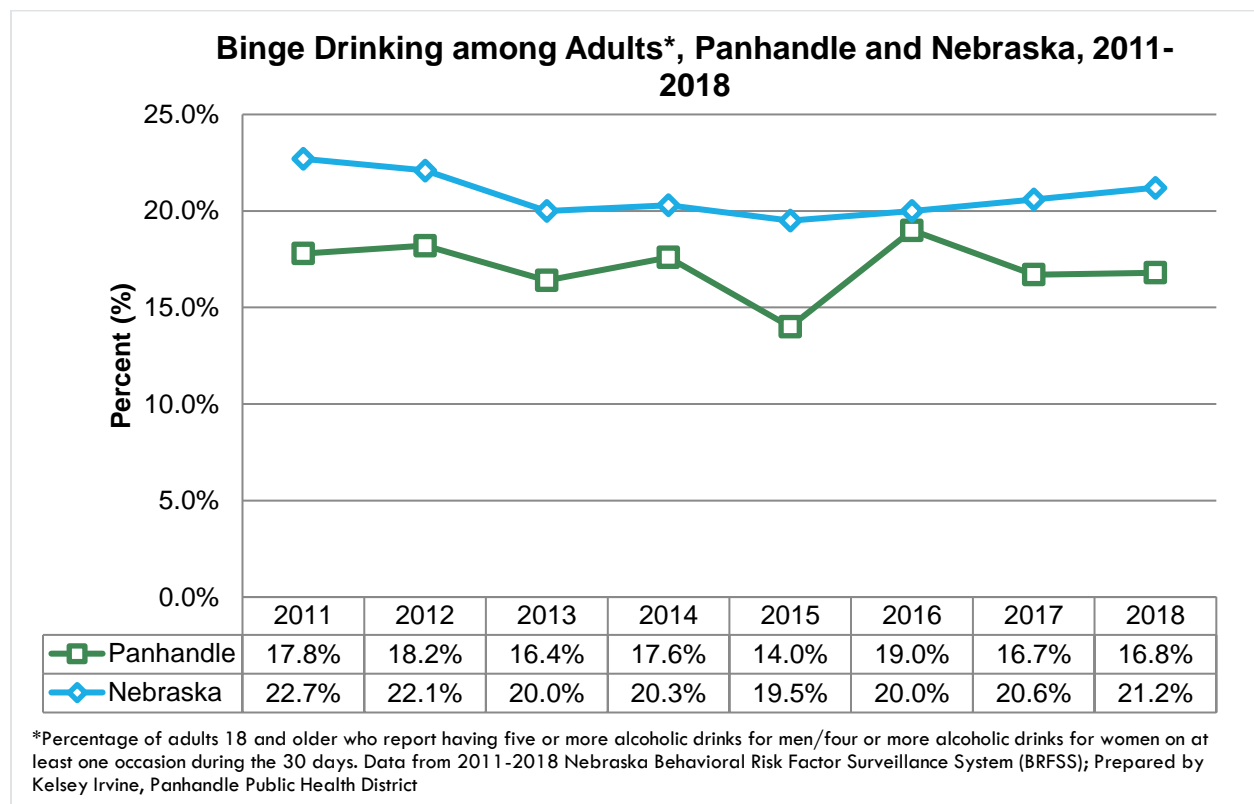
ALCOHOL

Misuse of alcohol includes underage drinking and binge drinking. Binge drinking is drinking 5 or more drinks in one occasion for men or 4 or more drinks in one occasion for women. Misuse of alcohol can contribute to increased health problems, such as injuries, violence, liver diseases, and cancer.¹²

BINGE DRINKING

Nebraska is known for its high rate of binge drinking. However, the Panhandle has a lower rate of binge drinking compared to the state.

Figure 76: Adult Binge Drinking



ALCOHOL IMPAIRED DRIVING

Adults who report alcohol-impaired driving is fairly low across the state of Nebraska, and historically lower in the Panhandle.

Figure 77: Adult Alcohol Impaired Driving

Alcohol-Impaired Driving among Adults*, Panhandle and Nebraska, 2012-2018

	2012	2014	2016	2018
Panhandle	2.5%	2.5%	2.6%	2.2%
Nebraska	3.4%	2.5%	3.4%	3.0%

*Percentage of adults 18 and older who report driving after having had perhaps too much to drink during the past 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

¹² CDC. (2019). Binge Drinking. Retrieved from: <https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm>

YOUTH ALCOHOL USE

The proportion of Panhandle youth who report they have ever tried alcohol (lifetime use) has decreased slightly in 10th and 12th graders over time, but slightly increased from 2014 to 2018 among 8th graders.

Youth current use (past 30 day) of alcohol decreased from 2010 to 2014, but an increase was seen from 2014 to 2018. Most notably, current alcohol use among 8th graders jumped from 8.8% in 2014 to 17% in 2018.

Figure 78: Youth Lifetime Alcohol Use

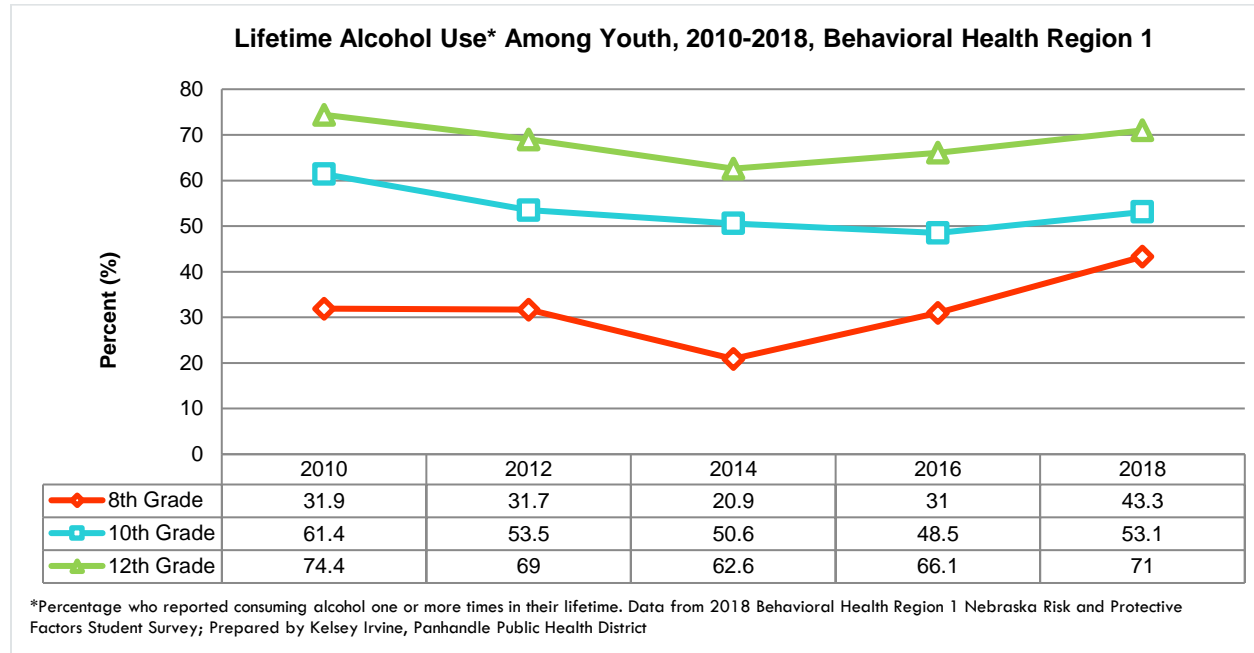
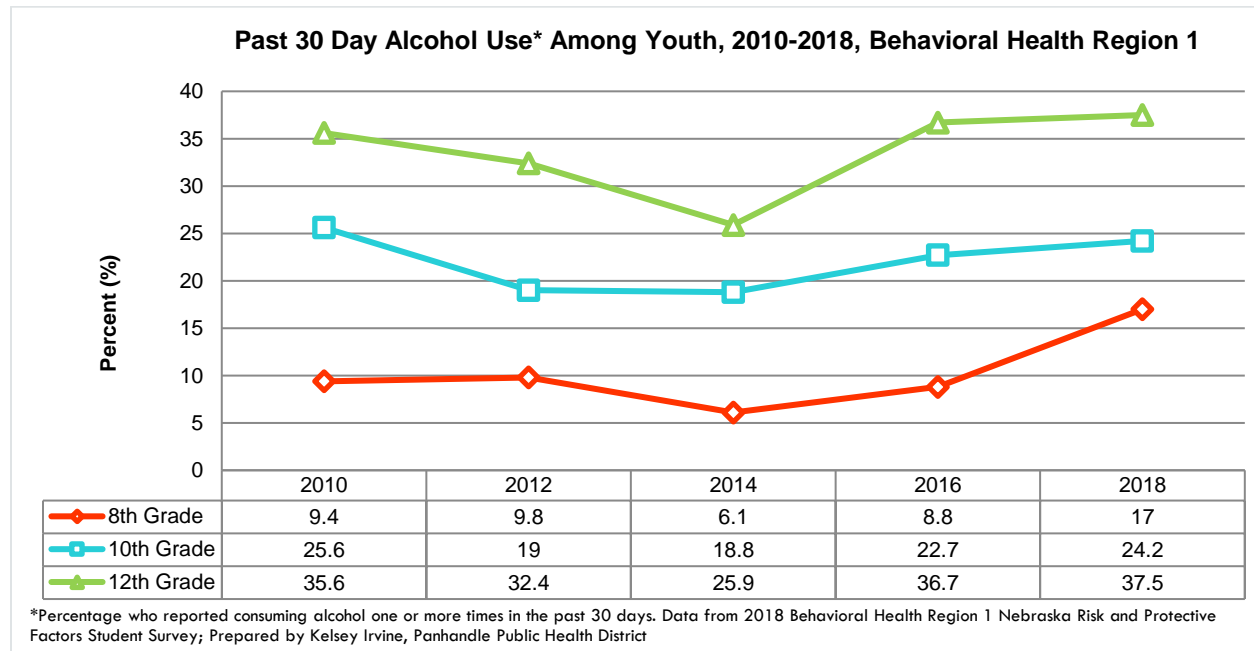
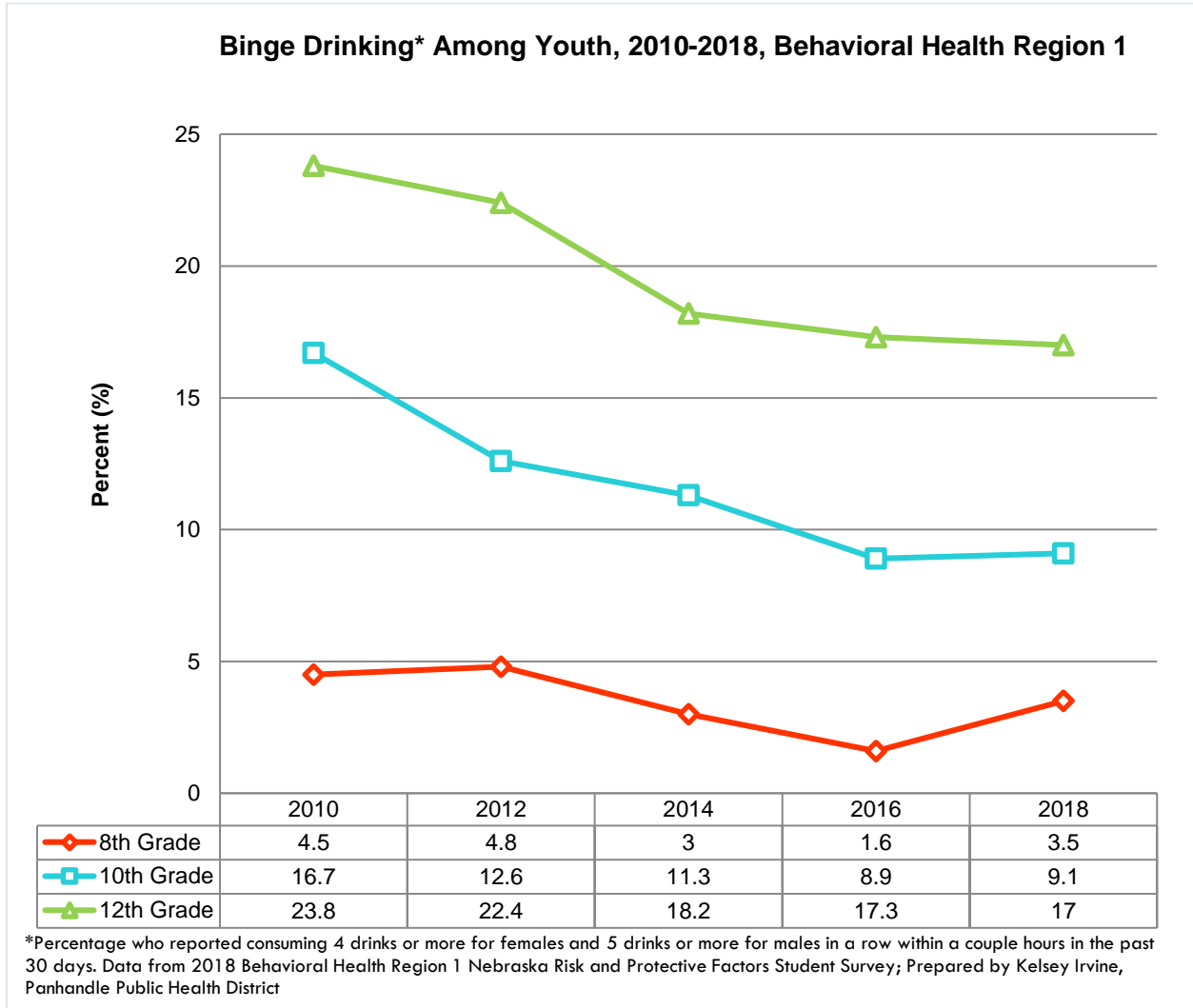


Figure 79: Youth Current Alcohol Use



Binge drinking among youth has decreased considerably over the years. 8th graders have remained relatively even, with a very small percentage reporting they binge drink. The percentage of 10th graders who reported they binge drink decreased from 16.7% in 2010 to 9.1% in 2018, and in 12th graders decreased from 23.8% to 17%, respectively.

Figure 80: Youth Binge Drinking



MARIJUANA

The percentage of Panhandle youth who report they have ever tried or are currently using marijuana has remained relatively unchanged over the years.

Figure 81: Youth Lifetime Marijuana Use

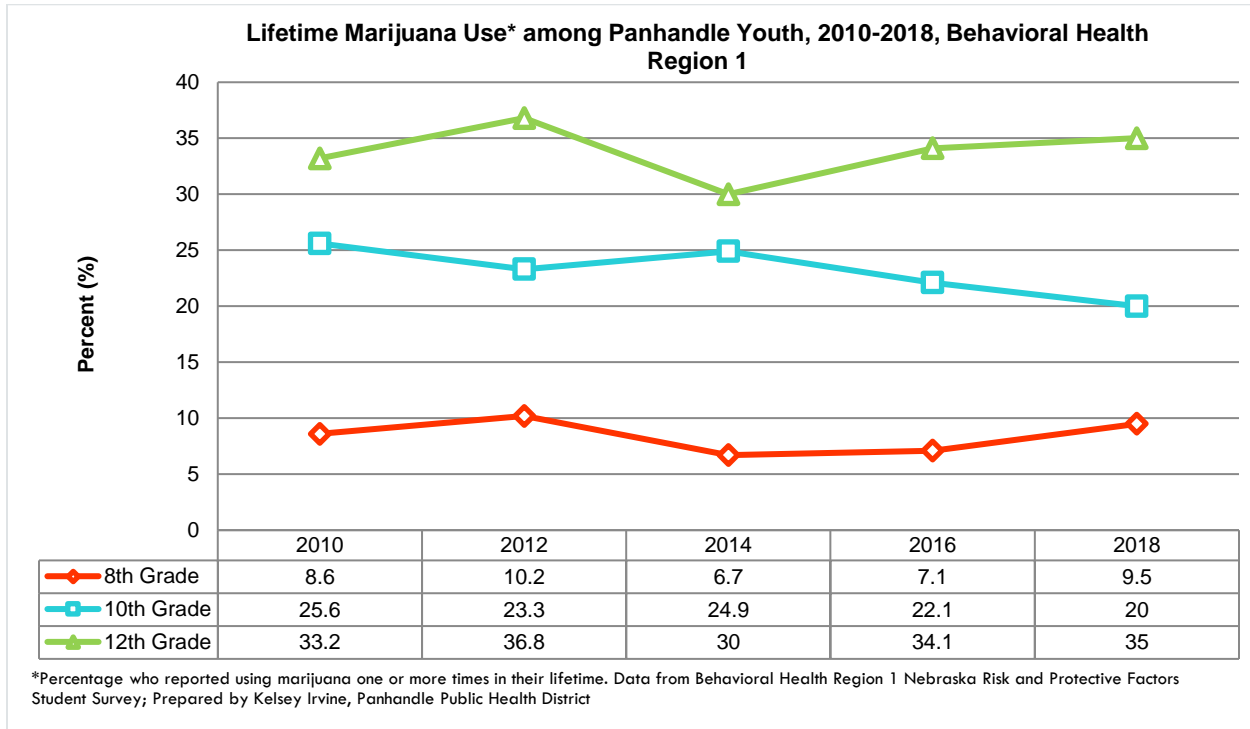
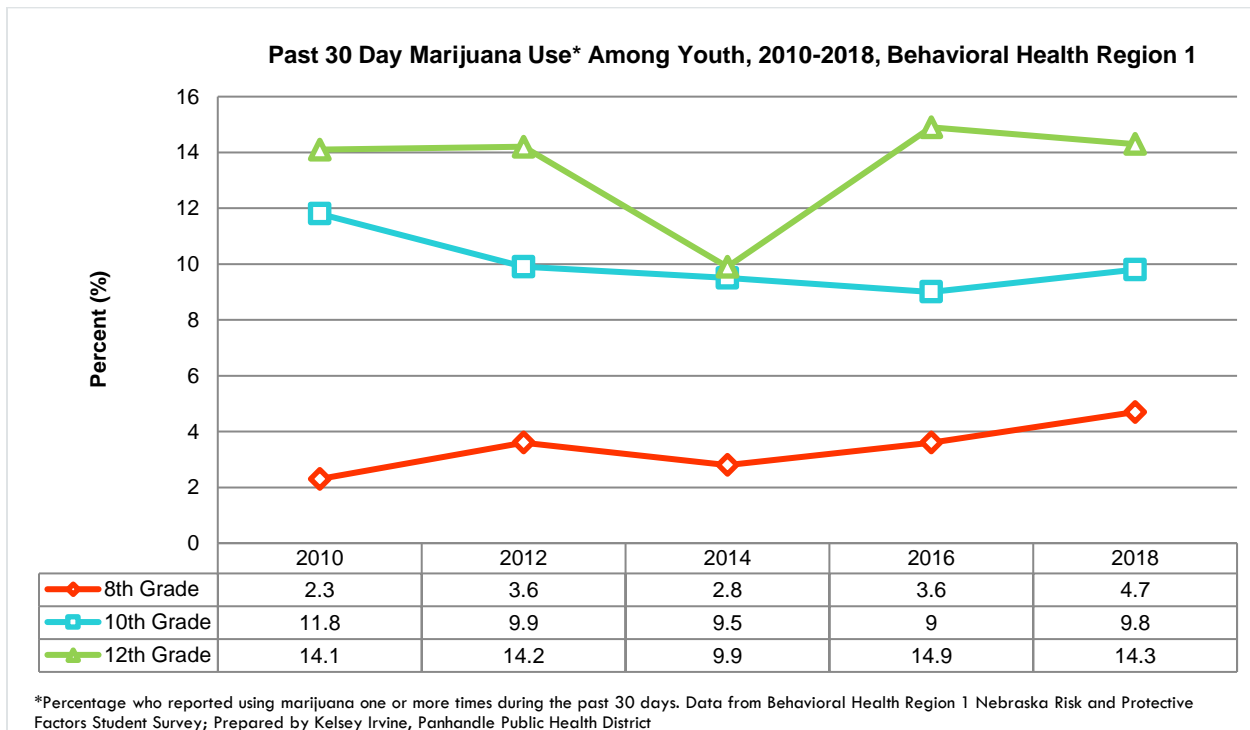


Figure 82: Youth Current Marijuana Use



INJURY

MOTOR VEHICLE CRASHES

There were 1,468 motor vehicle crashes in the Panhandle in 2019, resulting in 611 injured individuals and 21 deaths. The rate of Panhandle adults that always wear a seatbelt is consistently lower than the broader state of Nebraska, by approximately 15 points.

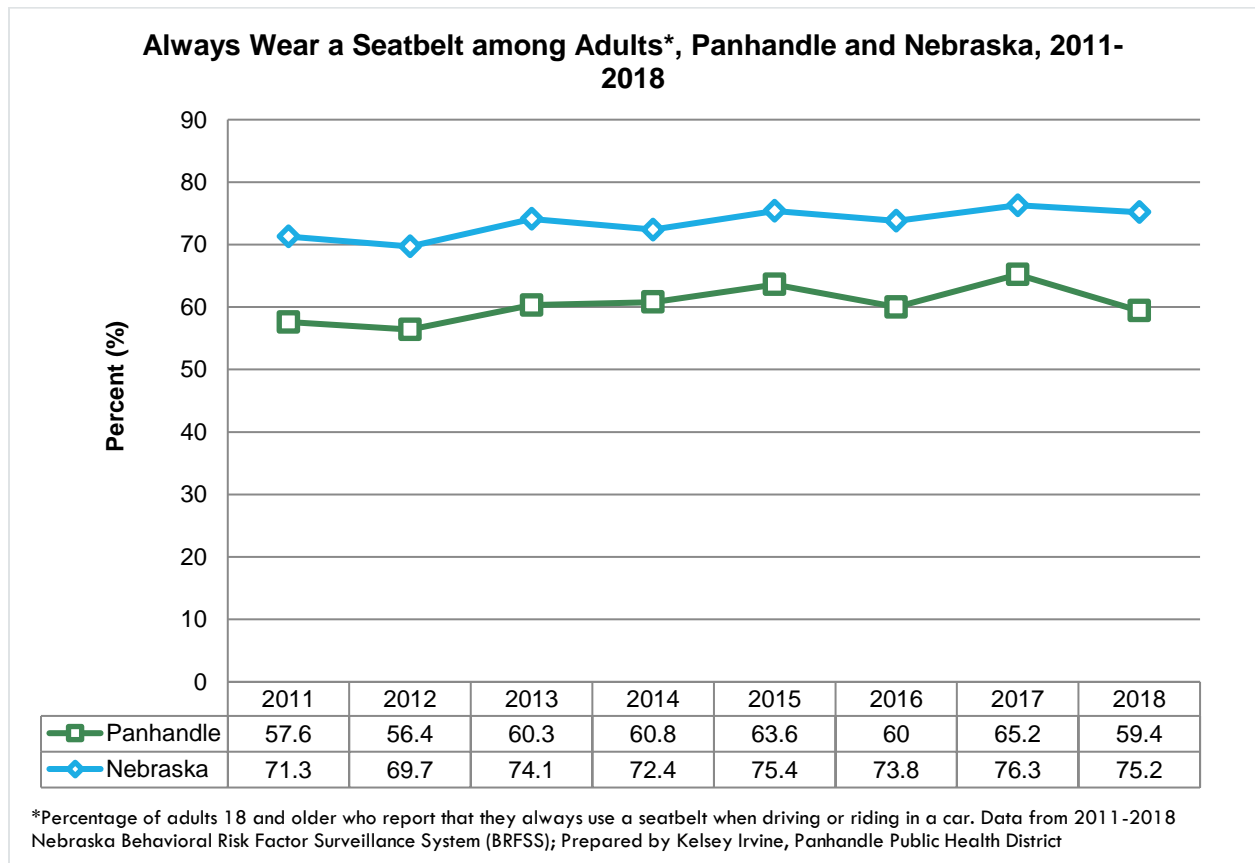
Figure 83: Panhandle Motor Vehicle Crash Data by County, 2019

County	Crashes				Persons killed and injured	
	Total	Fatal	Injury	PDO*	Killed	Injury
Banner	26	0	7	19	0	12
Box Butte	148	3	48	97	3	77
Cheyenne	186	2	32	152	2	46
Dawes	151	1	35	115	1	51
Deuel	48	1	12	35	1	17
Garden	35	1	5	29	1	6
Grant	5	0	2	3	0	2
Kimball	93	3	23	67	3	31
Morrill	83	2	19	62	7	25
Scotts Bluff	617	3	226	388	3	315
Sheridan	65	0	15	50	0	27
Sioux	11	0	2	9	0	2
Panhandle	1,468	16	426	1,026	21	611
Nebraska	36,709	212	11,939	24,555	248	17,198

*PDO = Property Damage Only

Source: 2019 Nebraska Traffic Crash Facts Annual Report

Figure 84: Adults Seatbelt Usage



The rate of Panhandle adults that report they text while driving was lower than that of the overall state of Nebraska, but has increased in recent years to be at approximately the same rate. The proportion of adults who report they talk on the phone while driving in the Panhandle decreased from 69.2% in 2015 to 63.7% in 2017, dropping below the state (66.5%).

Figure 85: Adult Texting While Driving

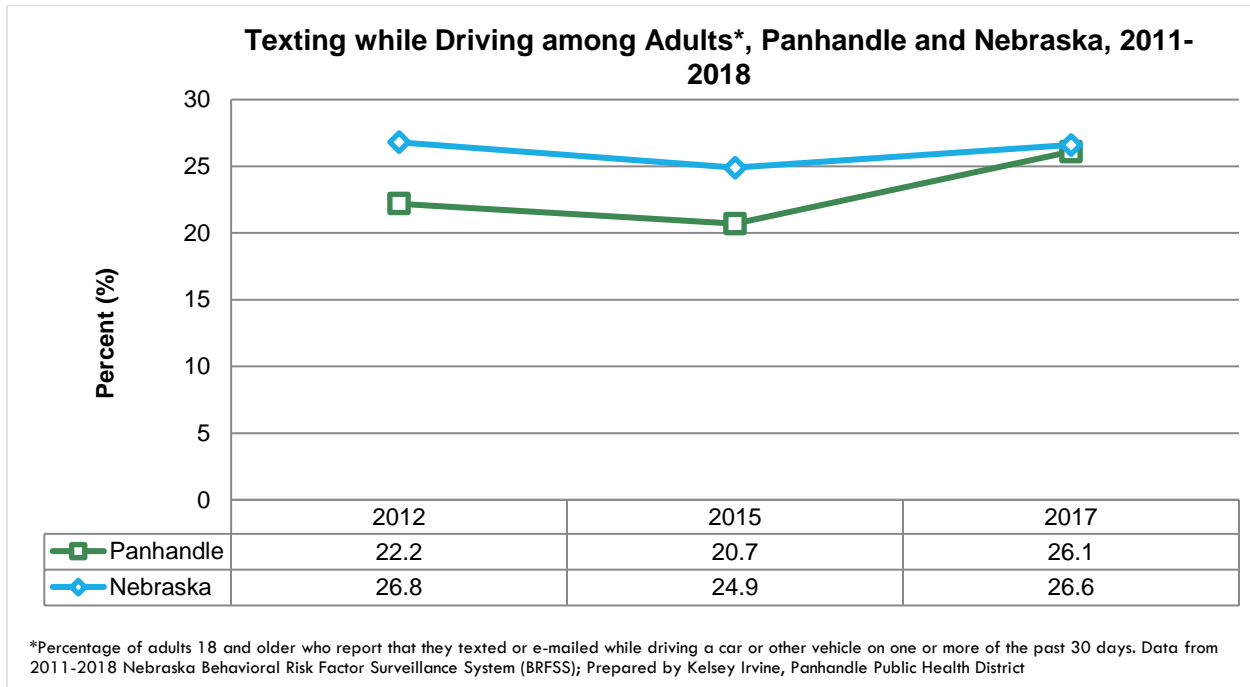
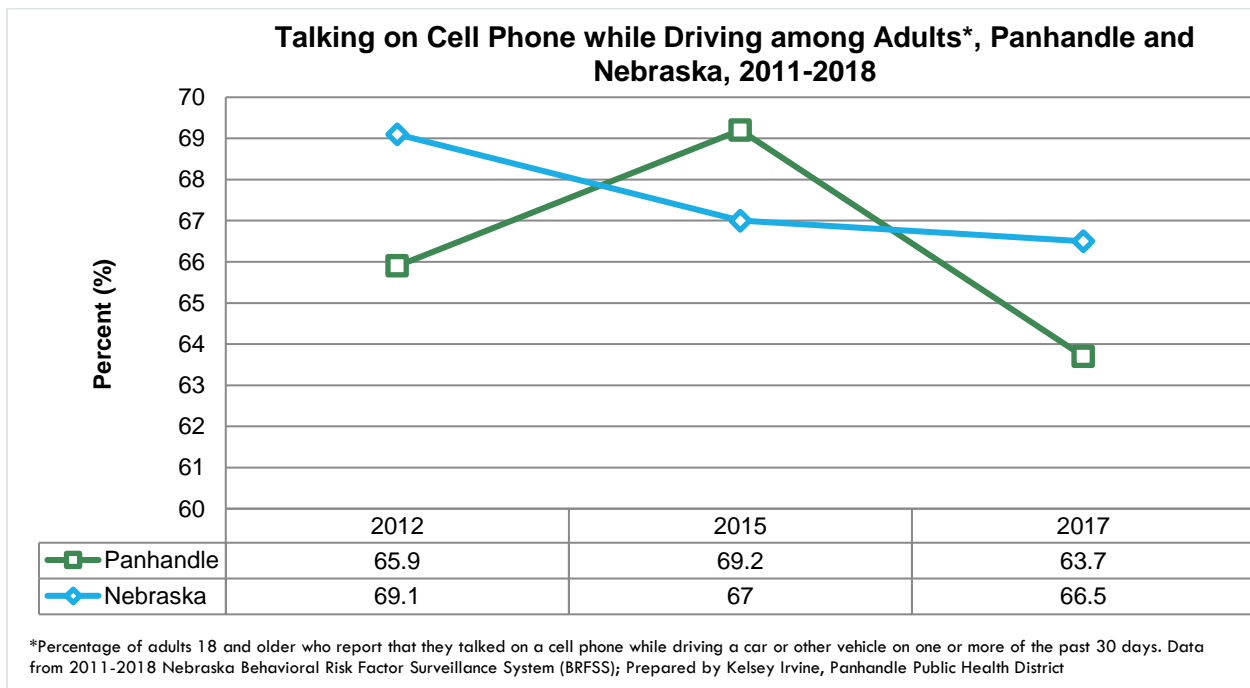


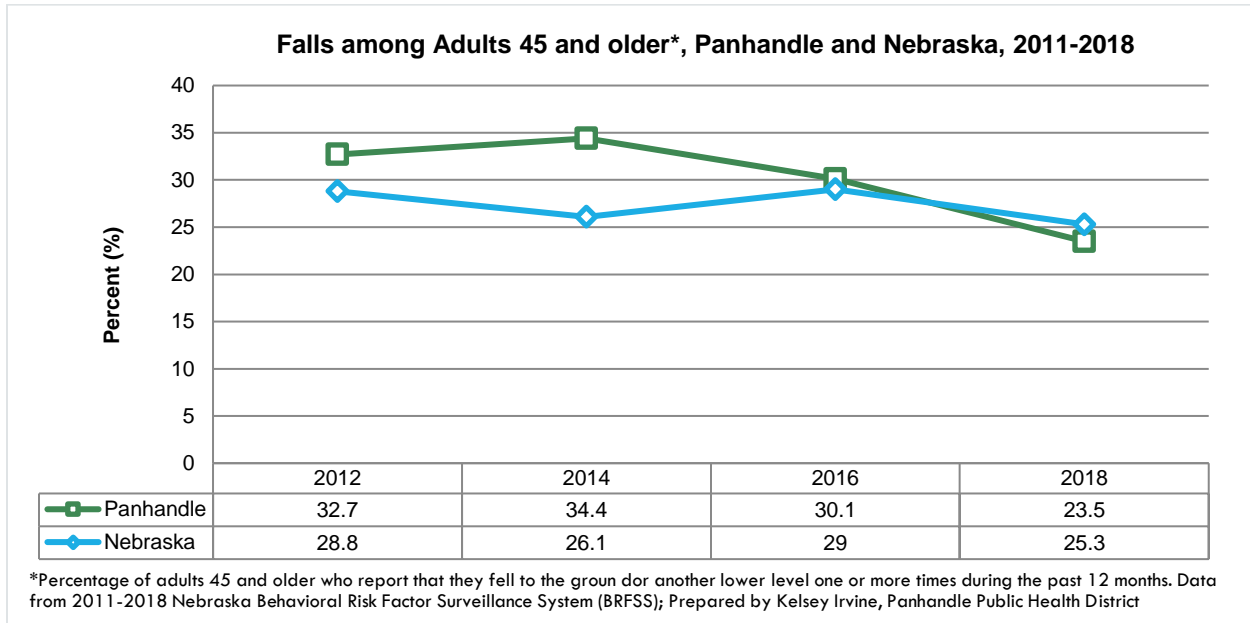
Figure 86: Adult Talking on Cell Phone While Driving



FALLS

The percentage of adults 45 and older who experienced a fall in the past year decreased in the Panhandle after a peak in 2014, and in 2018 was lower than falls in adults across the broader state of Nebraska. Injuries from falls was not measured by the 2018 BRFSS.

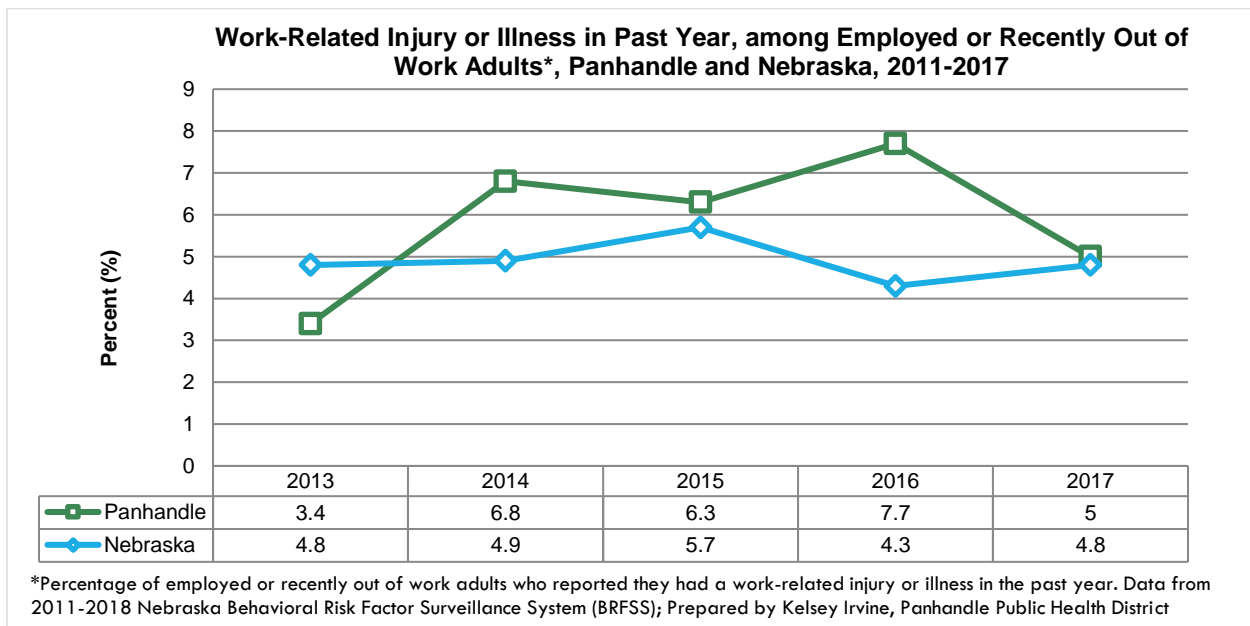
Figure 87: Falls Among Adults 45+



WORK RELATED INJURIES

The percentage of Panhandle adults who experienced a work-related injury in the past year was higher than that of the broader state of Nebraska in 2014, 2015, and 2016. A sharp decrease from 2016 to 2017 brought it down to approximately the same level as the state.

Figure 88: Work-Related Injury or Illness



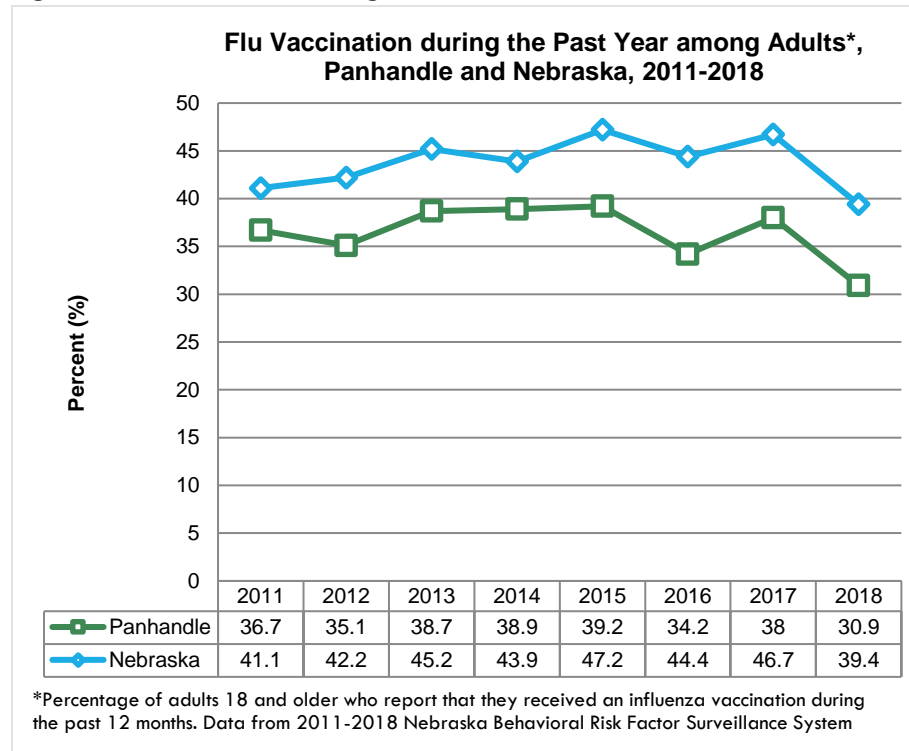
IMMUNIZATIONS

A large portion of infectious diseases have been eradicated or controlled by vaccination. However, a rising movement supporting anti-vaccination has led to under-immunized children, adolescents, and adults in the United States, leaving them susceptible to many vaccine preventable diseases.

INFLUENZA VACCINATION

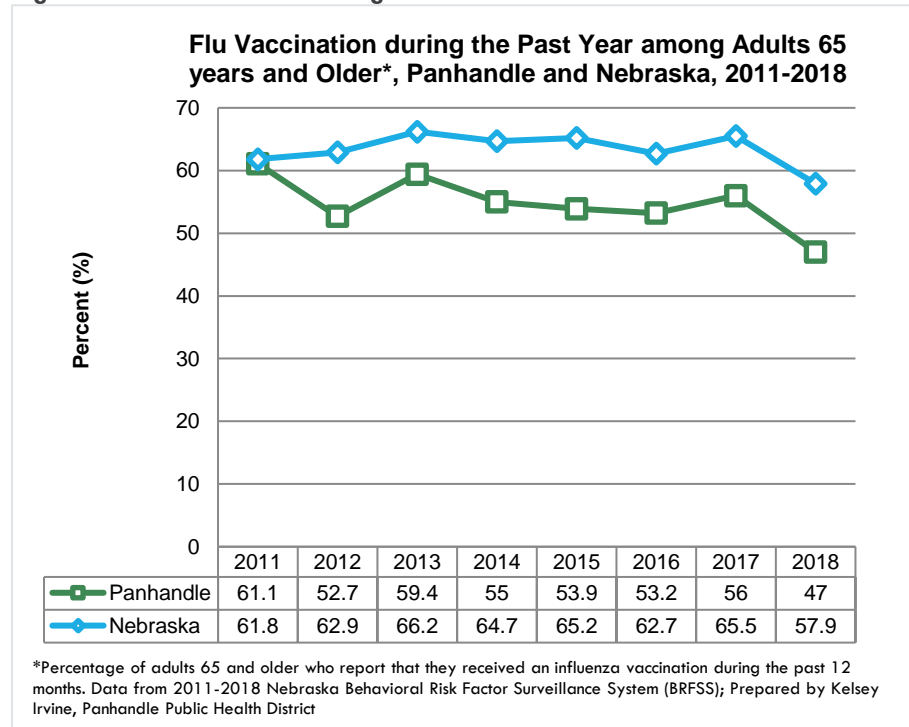
The percentage of Panhandle adults that report having a flu vaccination during the past year has consistently been lower than the state of Nebraska. The number slowly increased from 2011 to 2015, but has seen an overall decrease since then.

Figure 89: Flu Vaccination during Past Year



The flu vaccination is highly recommended for people in vulnerable populations (children, pregnant people, and elderly people). The percentage of Panhandle adults 65 years and older that received a flu vaccination in the past year is much higher than the percentage of all adults, however is still lower than the state, and has decreased by nearly 15 points in the past decade.

Figure 90: Flu Vaccination During Past Year Adults 65+



COMMUNITY THEMES AND STRENGTHS ASSESSMENT

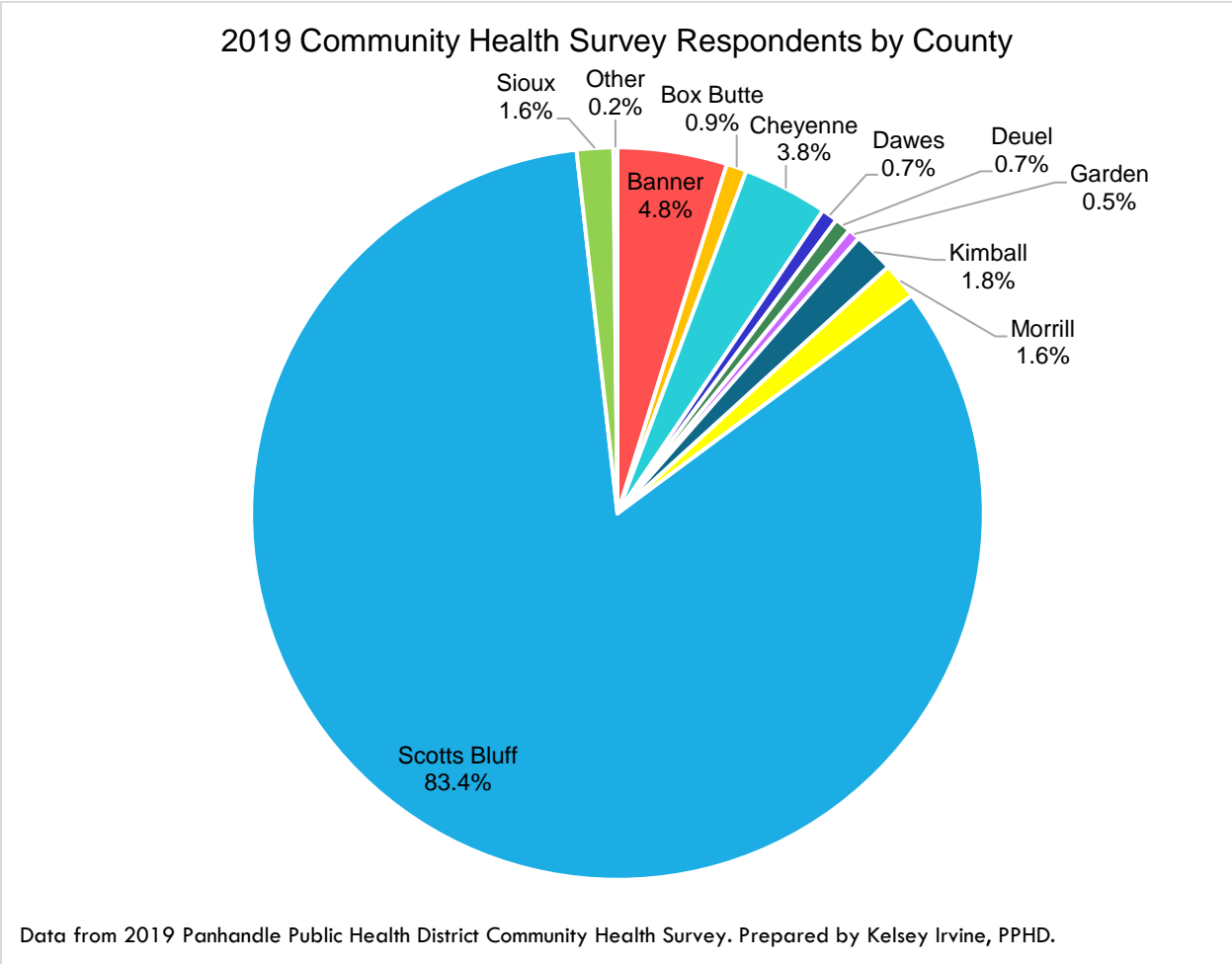
The Community Themes and Strengths Assessment is made up of two parts: the Community Health Survey and community Focus Groups. The top concerns of community members are determined from these two resources.

COMMUNITY HEALTH SURVEY

The Community Health Survey was distributed to Panhandle residents in October and November of 2019 via paper and electronic survey. See [Appendix B](#) for a copy of the survey. Paper copies of the survey were distributed by hospitals and community-based organizations. The electronic copy was administered using Qualtrics, and shared online by website, social media, and email by PPHD, local hospitals, and other community organizations. Counts and percentages from the survey responses were calculated using Microsoft Excel.

The following information includes responses from 559 people who live in Scotts Bluff and Banner Counties, or reside elsewhere but indicate they receive their healthcare from Regional West Medical Center or its affiliated locations.

Figure 91: 2019 Community Health Survey Respondents by County



RESPONDENT DEMOGRAPHIC INFORMATION

Figure 92: 2019 Community Health Survey Selected Demographic Information, N = 559

County of residence:	#	%
Banner	27	4.8%
Box Butte	5	0.9%
Cheyenne	21	3.8%
Dawes	4	0.7%
Deuel	4	0.7%
Garden	3	0.5%
Kimball	10	1.8%
Morrill	9	1.6%
Scotts Bluff	466	83.4%
Sioux	9	1.6%
Other	1	0.2%
<i>Goshen County, WY</i>	1	
Gender identity:	#	%
Male	102	18.2%
Female	448	80.1%
Transgender male (female to male)	0	0.0%
Transgender female (male to female)	0	0.0%
Gender non-conforming	2	0.4%
Decline to answer	7	1.3%
Other	0	0.0%
Sexual orientation:	#	%
Heterosexual or straight	504	90.2%
Gay or lesbian	9	1.6%
Bisexual	17	3.0%
Decline to answer	25	4.5%
Other	4	0.7%
Highest level of education:	#	%
Less than high school graduate	10	1.8%
High school diploma or GED	129	23.1%
Associates or Technical Degree	121	21.6%
College degree or higher	288	51.5%
Decline to answer	9	1.6%
Other	2	0.4%

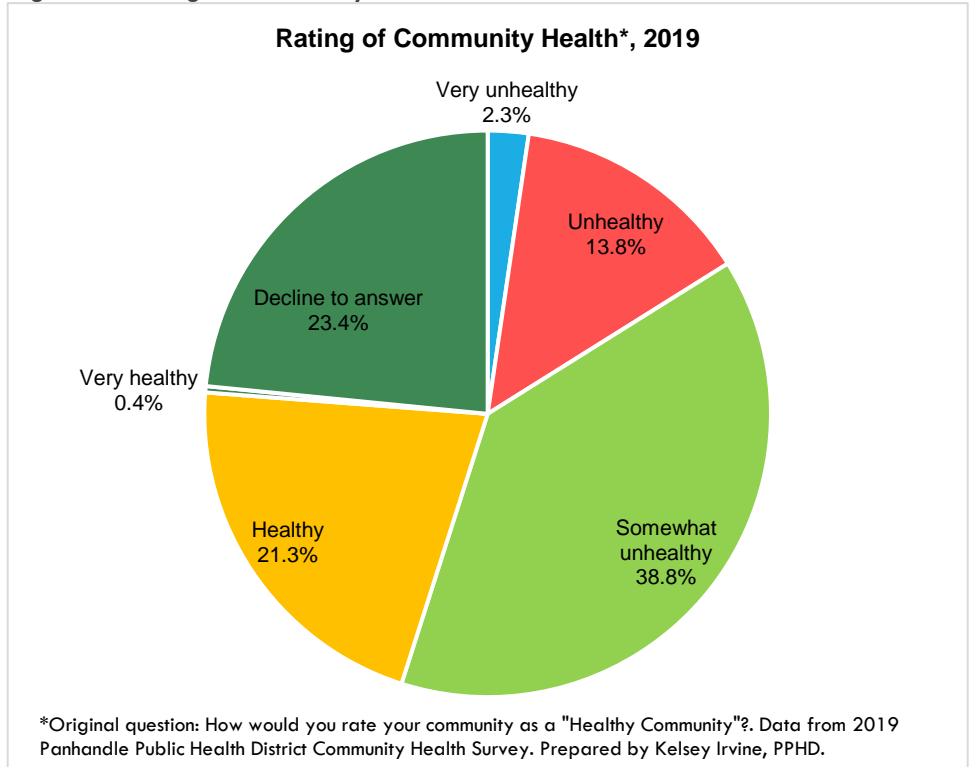
Race:	#	%
White	514	91.9%
Black or African American	2	0.4%
Asian	2	0.4%
Native Hawaiian or Other Pacific Islander	0	0.0%
American Indian or Alaska Native	5	0.9%
Decline to answer	20	3.6%
Other	11	2.0%
Two or more races	5	0.9%
<i>Hispanic/Latino</i>	49	8.8%
Age:	#	%
Under 18 years	3	0.5%
18-25 years	31	5.5%
26-39 years	133	23.8%
40-54 years	187	33.5%
55-64 years	125	22.4%
65-80 years	67	12.0%
Over 80 years	6	1.1%
Marital Status:	#	%
Married/Partnered	382	68.3%
Divorced	64	11.4%
Never married	67	12.0%
Separated	10	1.8%
Widowed	16	2.9%
Decline to answer	19	3.4%
Other	1	0.2%
Household Income:	#	%
Less than \$20,000	31	5.5%
\$20,000 to \$29,999	50	8.9%
\$30,000 to \$49,999	85	15.2%
\$50,000 to \$74,999	125	22.4%
\$75,000 to \$99,999	109	19.5%
Over \$100,000	95	17.0%
Decline to answer	64	11.4%

Demographic information for the respondents to the 2019 Community Health Survey can be found in the table above. The respondents were primarily female (80.1%) as opposed to male (18.2%). The age of respondents was relatively distributed. The majority of respondents were married or partnered (68.3%). The majority of respondents were white (91.9%), and 8.8% indicated they were Hispanic or Latino. Survey respondents were spread across a variety of income levels.

RATING OF COMMUNITY HEALTH

When asked to rank the health of their community, the majority of respondents indicated that the community is somewhat unhealthy (38.8%), with a ranking of healthy coming in a close second (21.3%). 0.4% ranked the community as being very healthy. 13.8% ranked community health as being unhealthy and 2.3% as very unhealthy. 23.4% of respondents declined to answer the question.

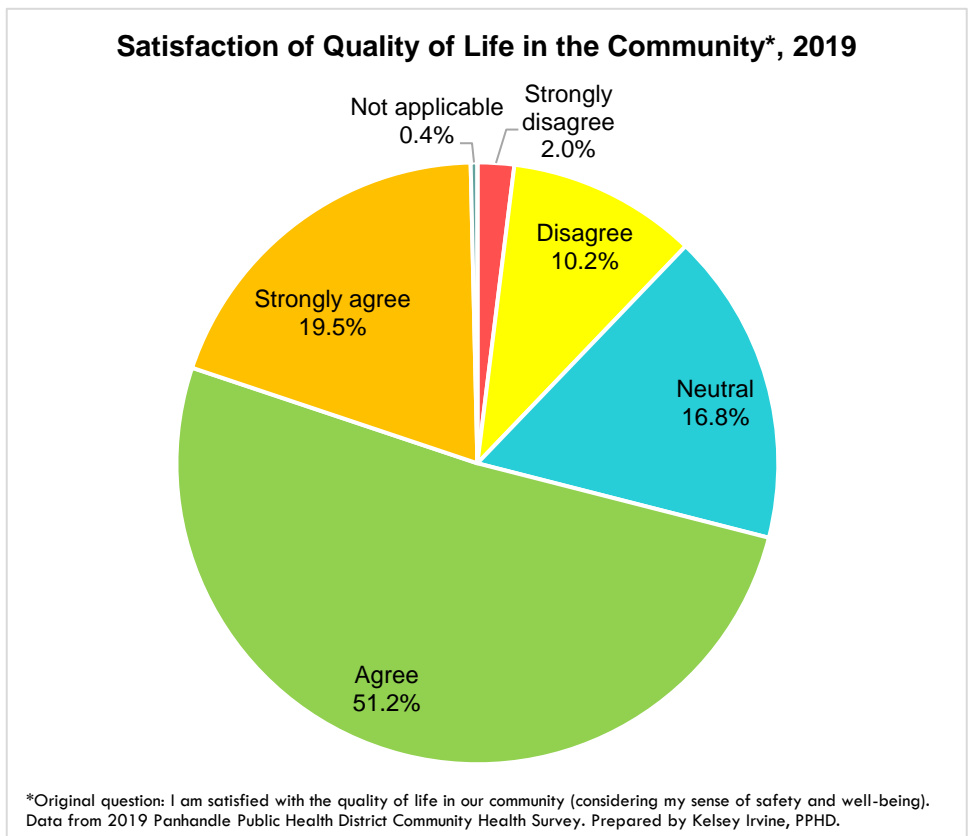
Figure 93: Rating of Community Health



QUALITY OF LIFE

When asked about their satisfaction with the quality of life in their community, the majority of respondents indicated they agreed (51.2%) or strongly agreed (19.5%) with the statement. 16.8% of respondents felt neutral, 10.2% disagreed, 2.0% strongly disagreed, and 0.4% indicated the question was not applicable to them.

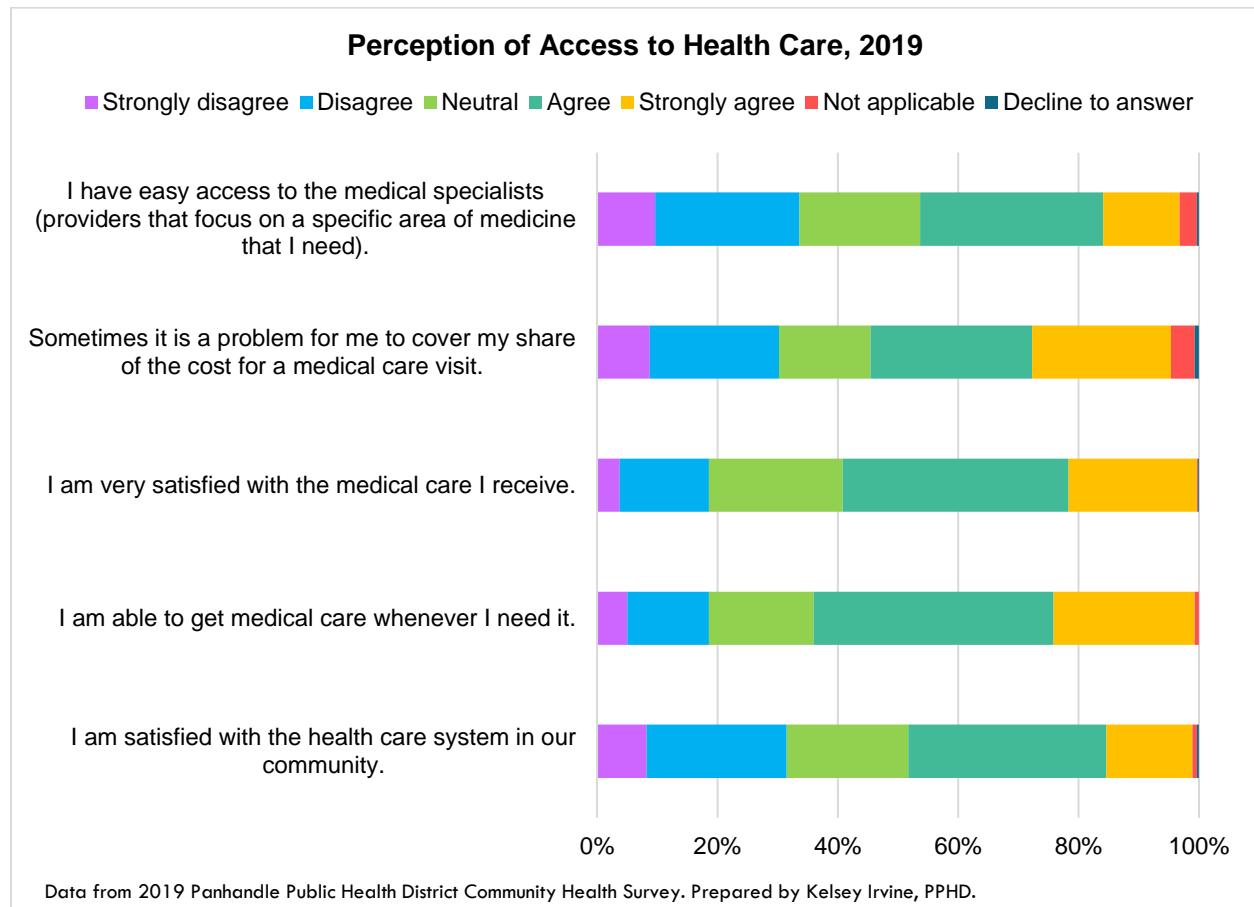
Figure 94: Satisfaction of Quality of Life in the Community



ACCESS TO CARE

The following section includes responses to questions about access to care in the community. Most respondents agree they are satisfied with and can access medical care. Many respondents feel it is not as easy to access specialty care within their community compared to primary care.

Figure 95: Perception of Access to Health Care



	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
I have easy access to the medical specialists (providers that focus on a specific area of medicine that I need).	9.7%	24.0%	20.0%	30.4%	12.7%	2.9%	0.4%
Sometimes it is a problem for me to cover my share of the cost for a medical care visit.	8.8%	21.5%	15.2%	26.8%	23.1%	3.9%	0.7%
I am very satisfied with the medical care I receive.	3.8%	14.8%	22.2%	37.6%	21.3%	0.2%	0.2%
I am able to get medical care whenever I need it.	5.0%	13.6%	17.4%	39.9%	23.4%	0.7%	0.0%
I am satisfied with the health care system in our community.	8.2%	23.3%	20.2%	32.9%	14.3%	0.7%	0.4%

PAYMENT FOR HEALTHCARE

The following section includes responses to questions about payment for healthcare in the Panhandle. The majority of survey respondents had private health insurance through their employer, with the second category receiving coverage from Medicare. Many respondents noted that they pay quite a bit of cash out of pocket before meeting their deductible on private insurance plans.

Figure 96: Payment for Healthcare

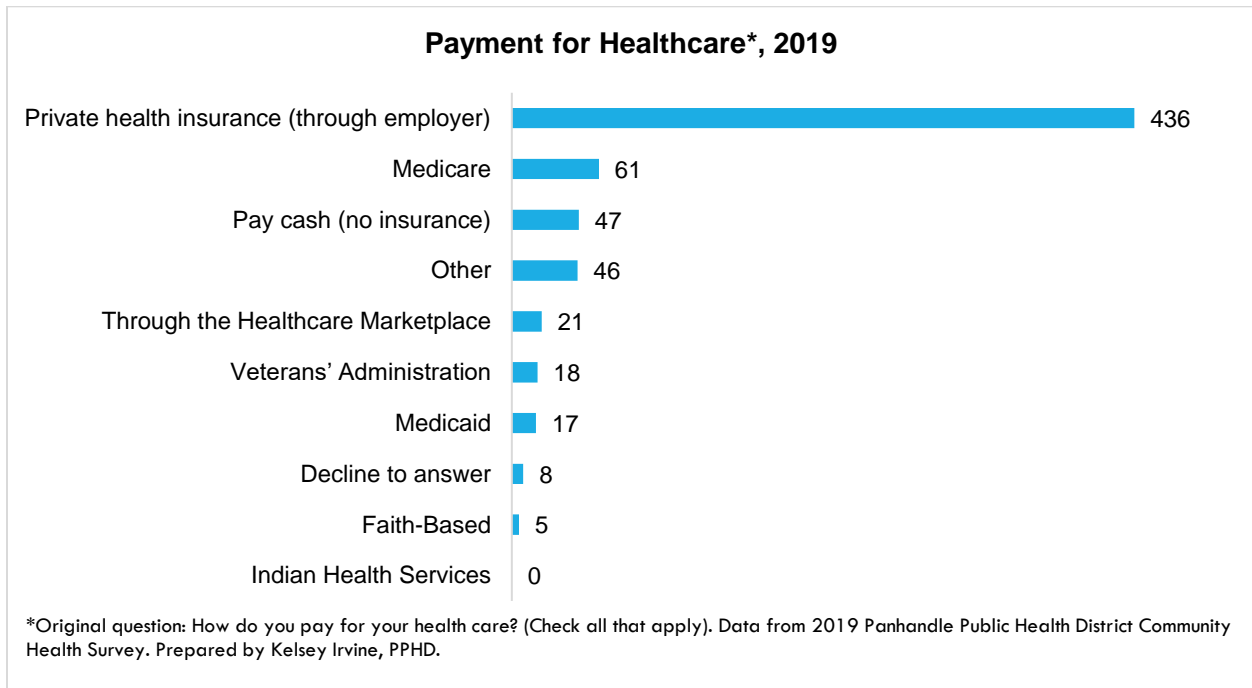
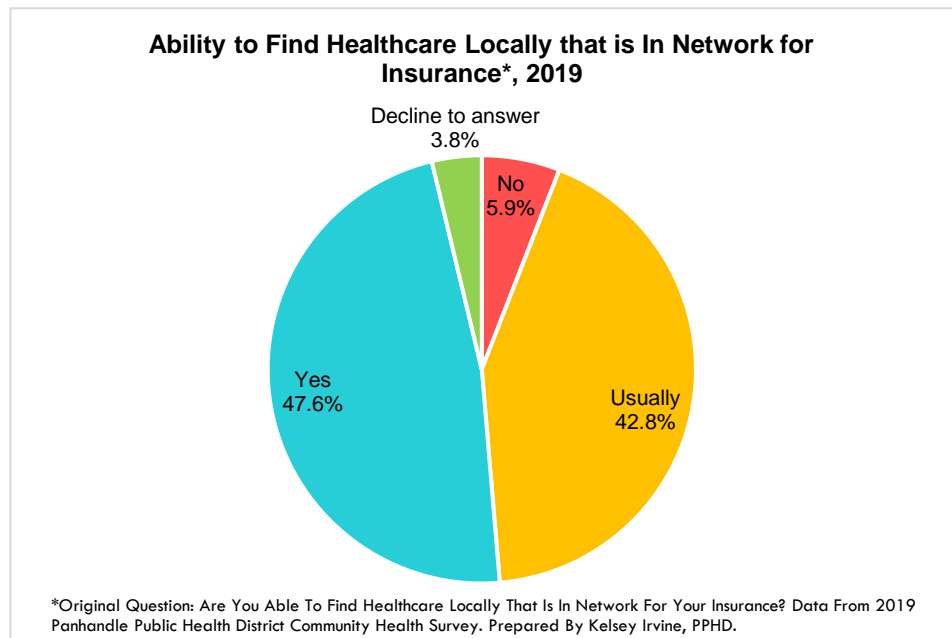


Figure 97: Ability to find Healthcare Locally that is in Network for Insurance

IN NETWORK HEALTHCARE

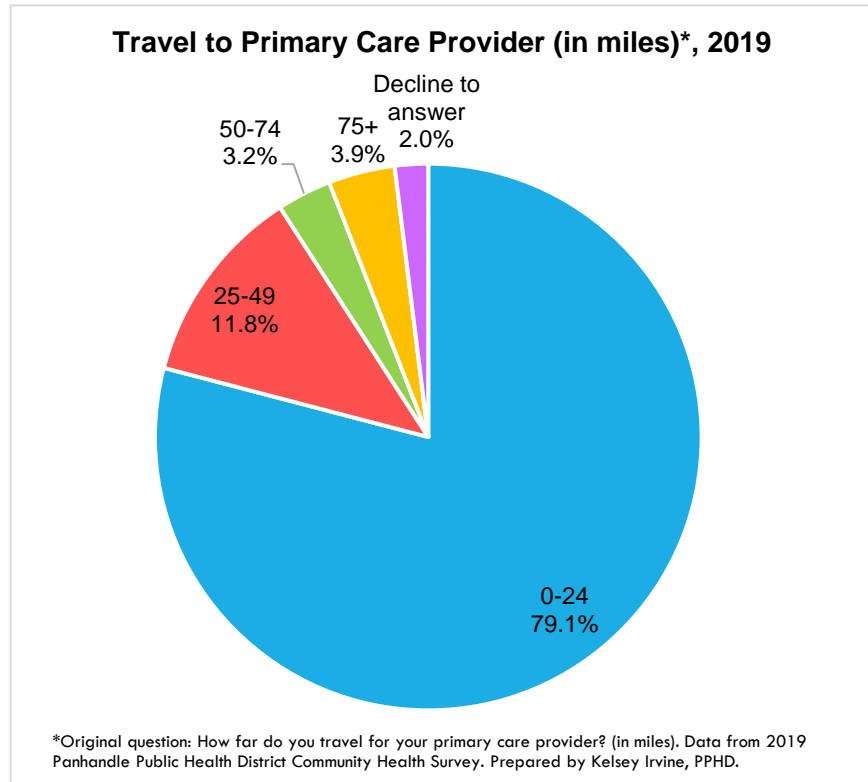
Most respondents (47.6%) indicated they are able to find healthcare locally that is in-network for their insurance, and 42.8% indicated they can usually find healthcare locally that is in-network.



PRIMARY CARE

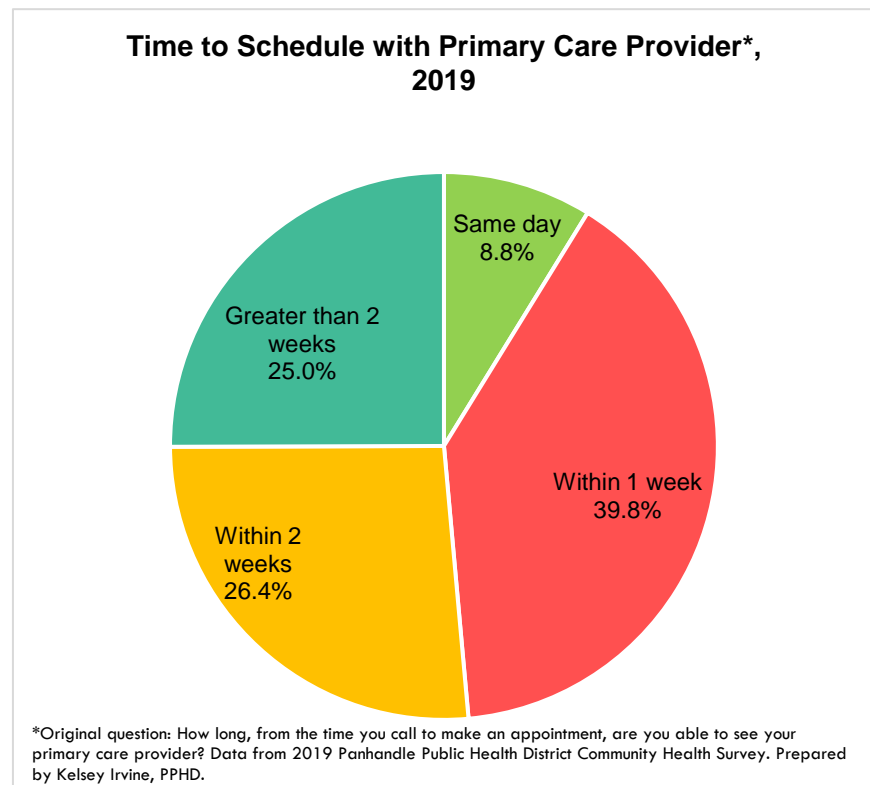
The majority of respondents (79.1%) travel 0-24 miles to their primary care provider. 11.8% indicated they travel 25 to 49 miles, and 7.1% indicated they travel 50 miles or more for healthcare. These findings indicate that the majority of people receive healthcare within their immediate community.

Figure 98: Travel to Primary Care Provider



Most respondents are able to schedule time with their primary care provider within one week (39.8%) of calling to schedule an appointment. 26.4% of respondents are able to make appointments within two weeks. 25.0% of respondents indicated it took more than two weeks to get in to see their provider, and only 8.8% were able to make an appointment on the same day.

Figure 99: Time to Schedule with Primary Care Provider



SPECIALTY CARE

Compared to the travel distance to see primary care providers, the data indicate that most survey respondents are able to receive specialty care within their community, with 42.0% of respondents traveling 0 to 24 miles to see a specialist. 32.9% of respondents travel 50 or more miles to see a specialist, and 5.2% travel 25 to 49 miles.

Most respondents indicated it takes longer to get in to see a specialist. 28.6% of respondents indicated it takes greater than two weeks. 24.9% are able to see their specialists within two weeks, and 21.8% within one week. Only 1.3% of respondents indicated they were able to see their specialist on the same day as they called to make the appointment.

Figure 100: Travel to see Specialist

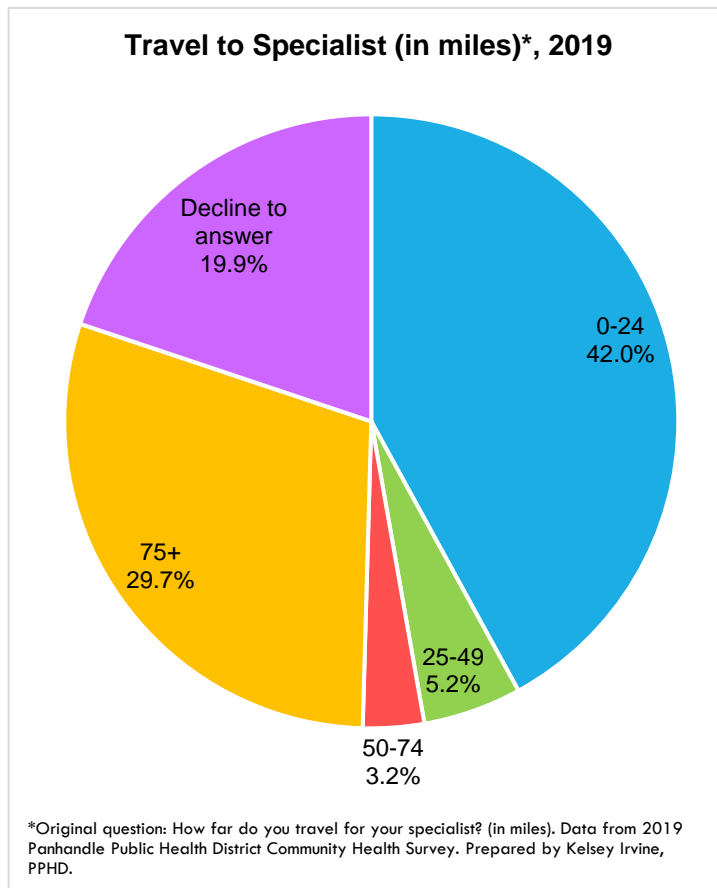
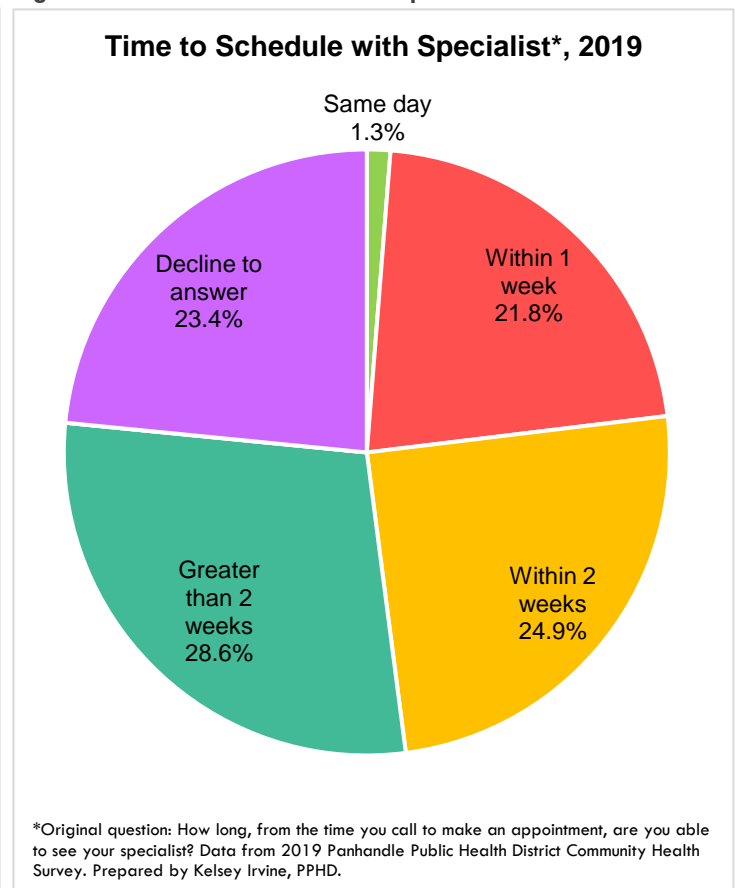


Figure 101: Time to Schedule with Specialist



MENTAL HEALTH SERVICES

Of the respondents who responded to questions relating to mental health, most are able to access mental health services within their community. Out of 38.3% of respondents who answered the questions 24.9% are able to access mental health services in their community. 13.4% indicated they are unable to access mental health services in their community.

25.9% of respondents indicated they travel 0-24 miles to receive mental health services, suggesting they receive care in their immediate communities. 9.5% of respondents travel 25 miles or more, perhaps traveling to neighboring communities.

Figure 102: Ability to Access Mental Health Services

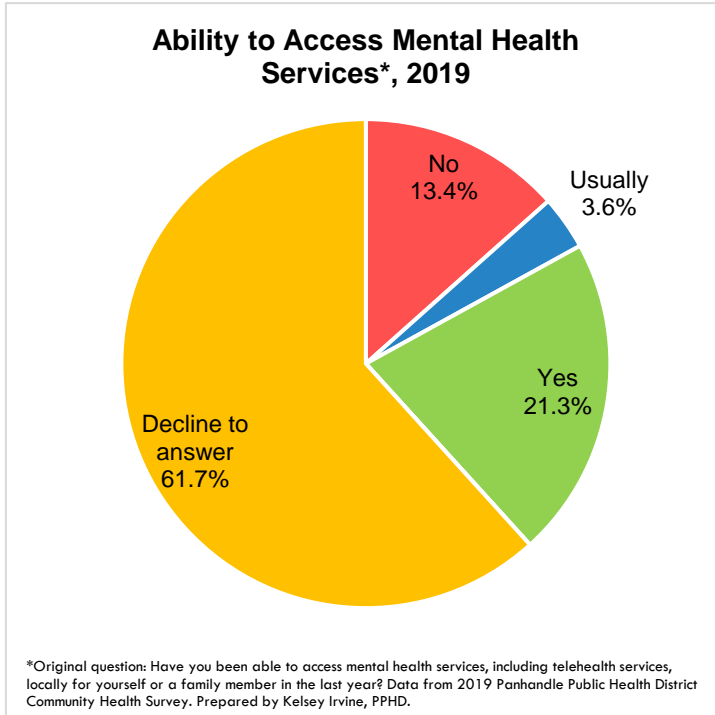
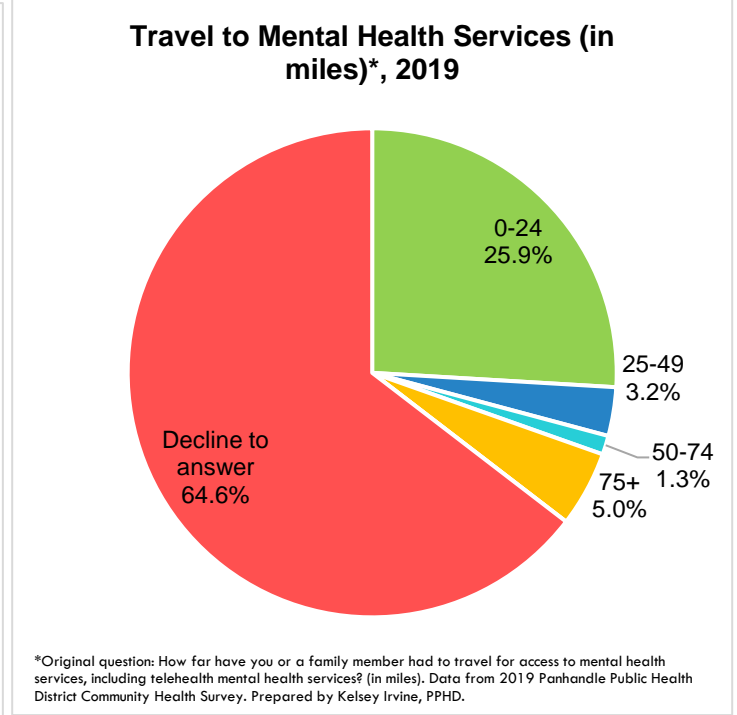


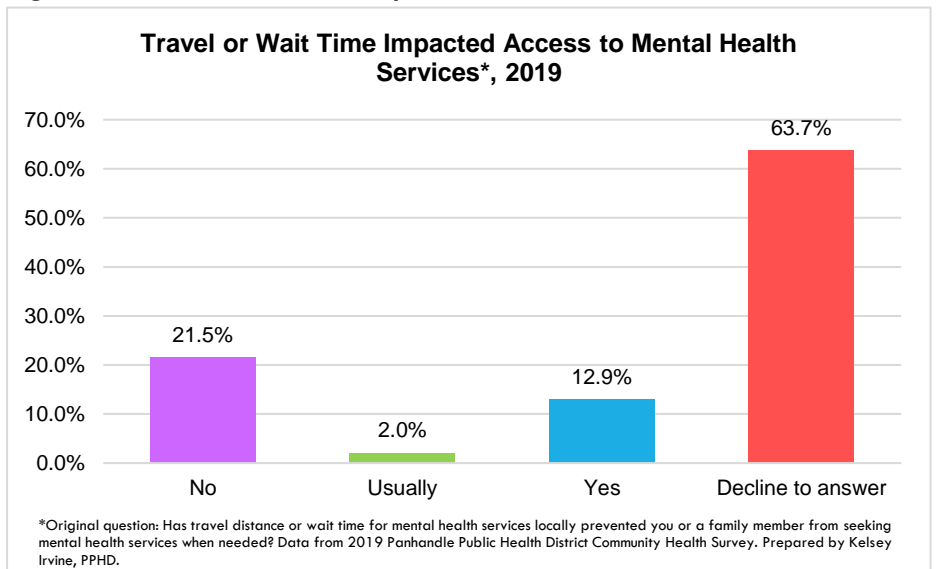
Figure 103: Travel to Mental Health Services



IMPACT OF TRAVEL OR WAIT TIME ON ACCESS TO MENTAL HEALTH SERVICES

Of the those who responded to the question, most indicated that wait time did and did not impact their ability to access mental health services.

Figure 104: Travel or Wait Time Impacted Access to Mental Health Services



TRANSPORTATION, HOUSING, AND MORE

The following section includes responses to questions about transportation, housing, employment, and more in the community. Some notable findings: Most respondents indicated jobs are available, however there is less opportunity for advancement in the available jobs. Respondents indicated there is safe housing, but the available housing is not viewed as very affordable. Additionally, most respondents feel that there are few transportation options in the community.

Figure 105: Perception of Transportation, Housing, and More

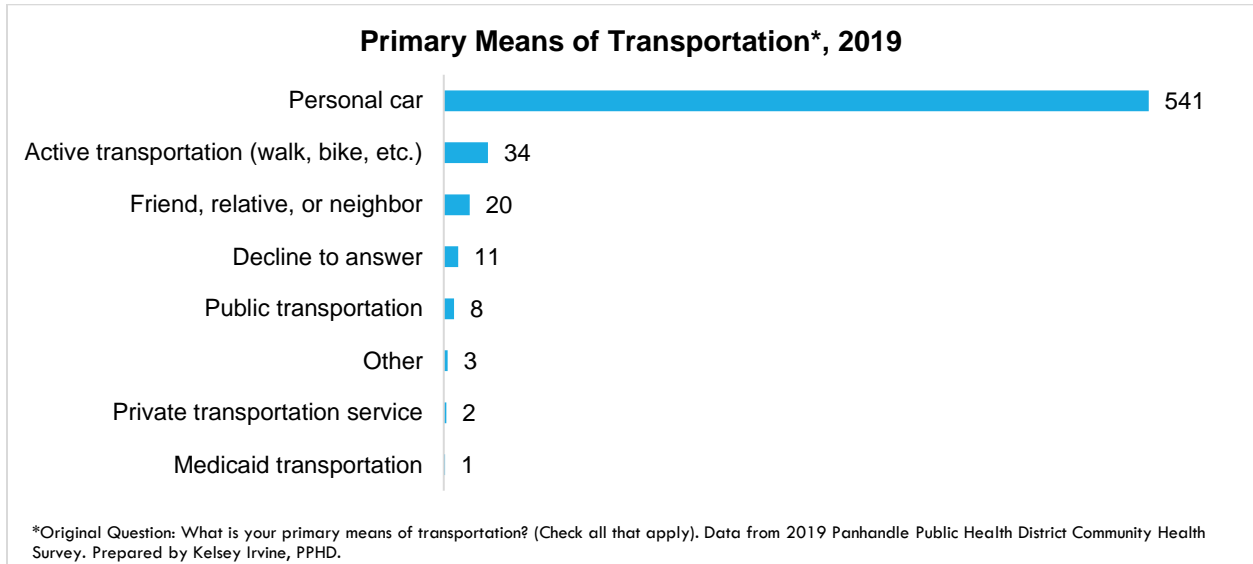


	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are plenty of transportation options in my community.	9.1%	23.6%	24.9%	36.1%	4.8%	0.9%	0.5%
All residents believe that they, individually and collectively, can make the community a better place to live.	5.4%	24.0%	35.1%	28.3%	6.1%	0.5%	0.7%
The community is military friendly (considering discounts, patriotism, recognition, and other local resources).	2.0%	7.5%	22.5%	42.9%	16.3%	7.9%	0.9%
There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	4.3%	14.3%	25.8%	44.9%	8.8%	1.6%	0.4%
There are plenty of recreation opportunities for adults in my community.	11.8%	31.8%	22.7%	26.7%	6.1%	0.4%	0.5%
The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas).	1.6%	6.6%	20.2%	56.5%	14.7%	0.2%	0.2%
There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).	9.8%	31.7%	23.4%	30.8%	3.2%	0.9%	0.2%
There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.).	4.5%	24.3%	19.0%	44.7%	6.6%	0.2%	0.7%
There is affordable housing.	6.6%	26.7%	23.4%	34.0%	7.3%	1.4%	0.5%
There is safe housing.	1.6%	7.5%	17.2%	54.2%	17.0%	2.3%	0.2%

TRANSPORTATION

Most survey respondents indicated they drive their own vehicle as their primary means of transportation.

Figure 106: Primary Means of Transportation



PUBLIC TRANSPORTATION

The majority of respondents (97.1%) do not use public transportation. Most indicated that there was no service where they had no need for it (391), followed by no service is needed areas (75).

Figure 107: Use of Public Transportation

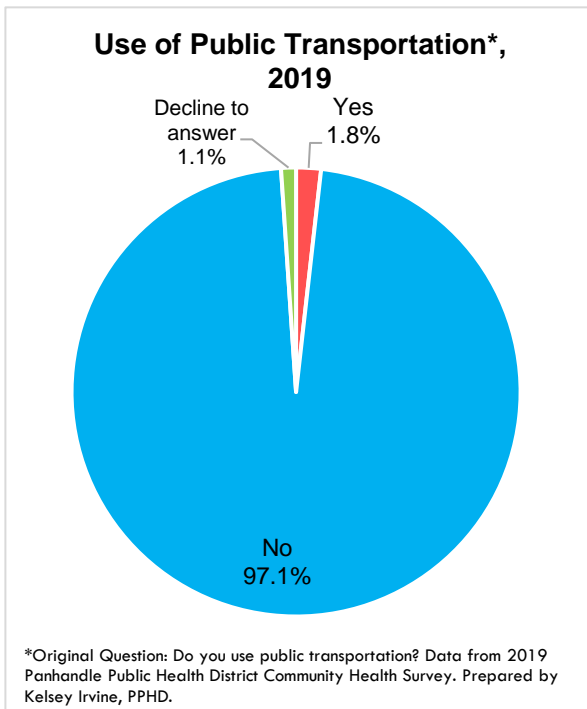
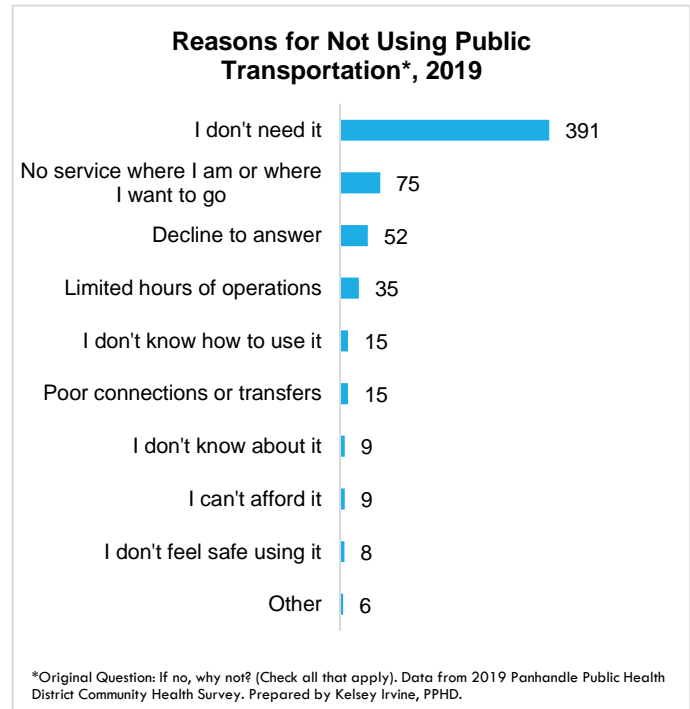


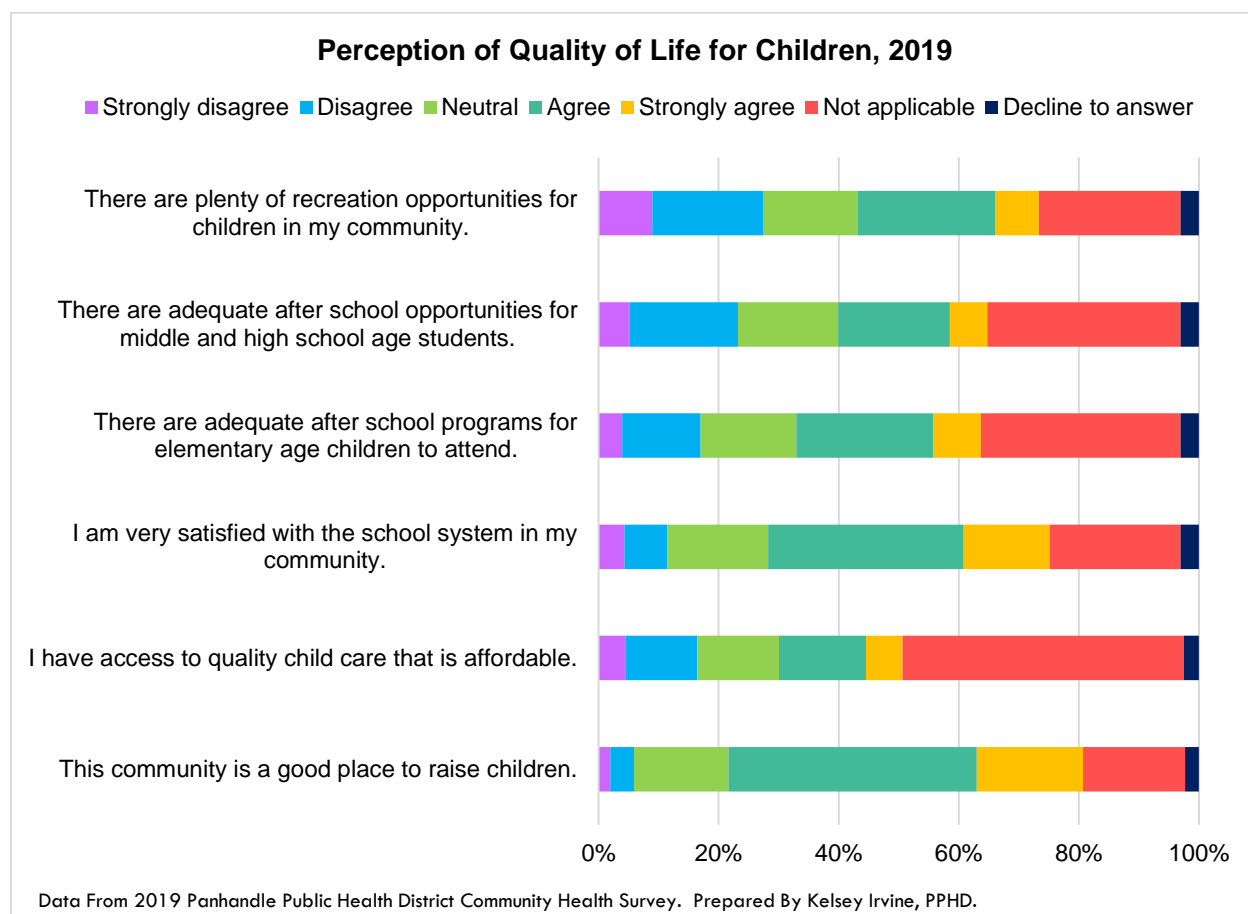
Figure 108: Reasons for Not Using Public Transportation



QUALITY OF LIFE FOR CHILDREN

The following section includes responses to questions about children, childcare, and education in the community. Only respondents with children in their care responded to these questions, therefore the "Not Applicable" bars are larger than seen in other charts. Many people agree the communities are a good place to raise children and there are good school systems. Many respondents felt there are not enough after school opportunities for middle and high school aged children and access to quality childcare is a challenge.

Figure 109: Perception of Quality of Life for Children

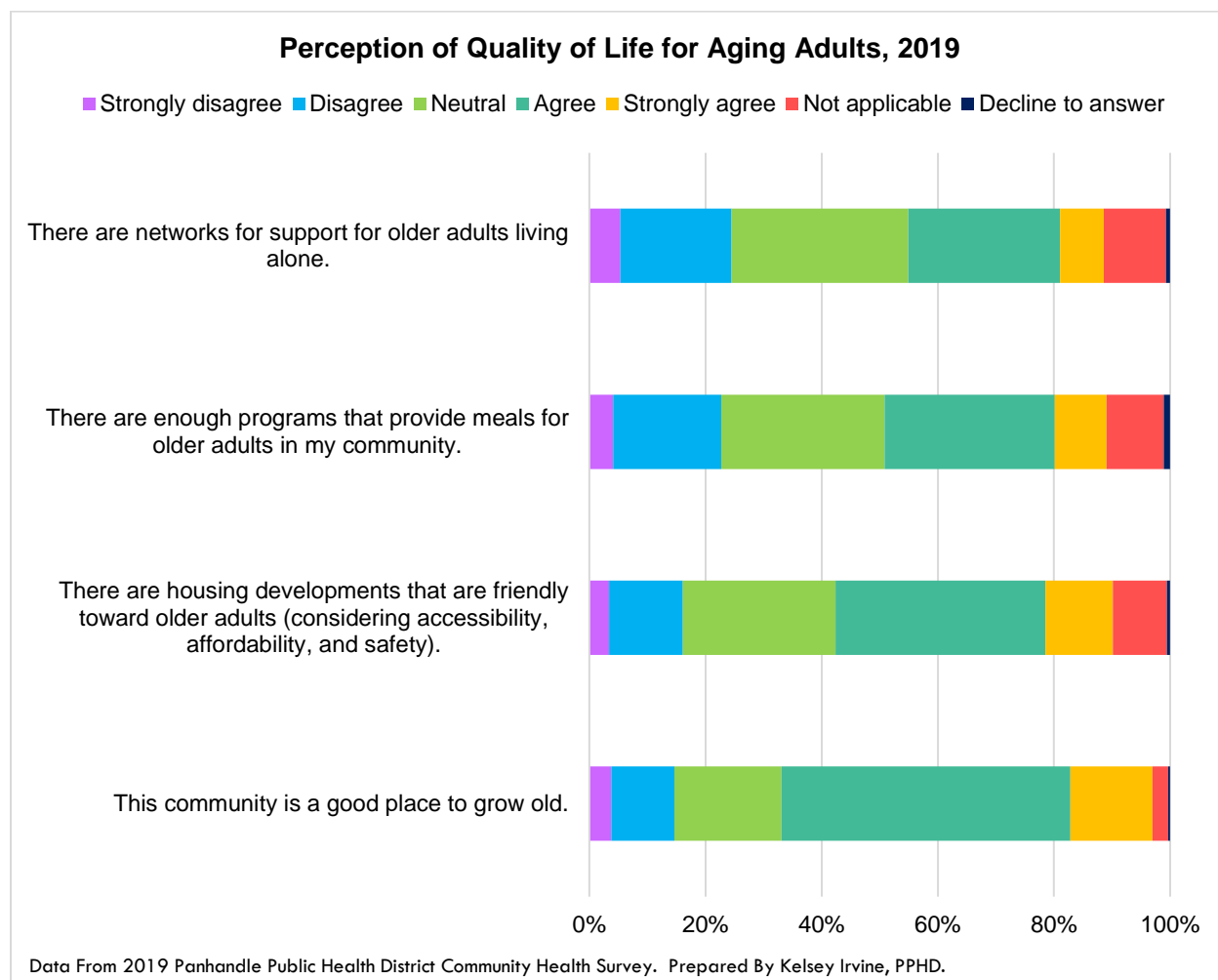


	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are plenty of recreation opportunities for children in my community.	8.9%	18.4%	15.7%	22.9%	7.3%	23.6%	3.0%
There are adequate after school opportunities for middle and high school age students.	5.2%	18.1%	16.6%	18.6%	6.3%	32.2%	3.0%
There are adequate after school programs for elementary age children to attend.	3.9%	13.1%	15.9%	22.9%	7.9%	33.3%	3.0%
I am very satisfied with the school system in my community.	4.3%	7.2%	16.8%	32.6%	14.3%	21.8%	3.0%
I have access to quality childcare that is affordable.	4.5%	12.0%	13.6%	14.5%	6.1%	46.9%	2.5%
This community is a good place to raise children.	2.0%	3.9%	15.7%	41.3%	17.7%	17.0%	2.3%

QUALITY OF LIFE FOR AGING ADULTS

The following section includes responses to questions about older adults in the community. Overall, respondents ranked items about quality of life for older adults on the positive side. The majority felt the community is good place to grow old (63.8% agreed or strongly agreed).

Figure 110: Perception of Quality of Life for Aging Adults

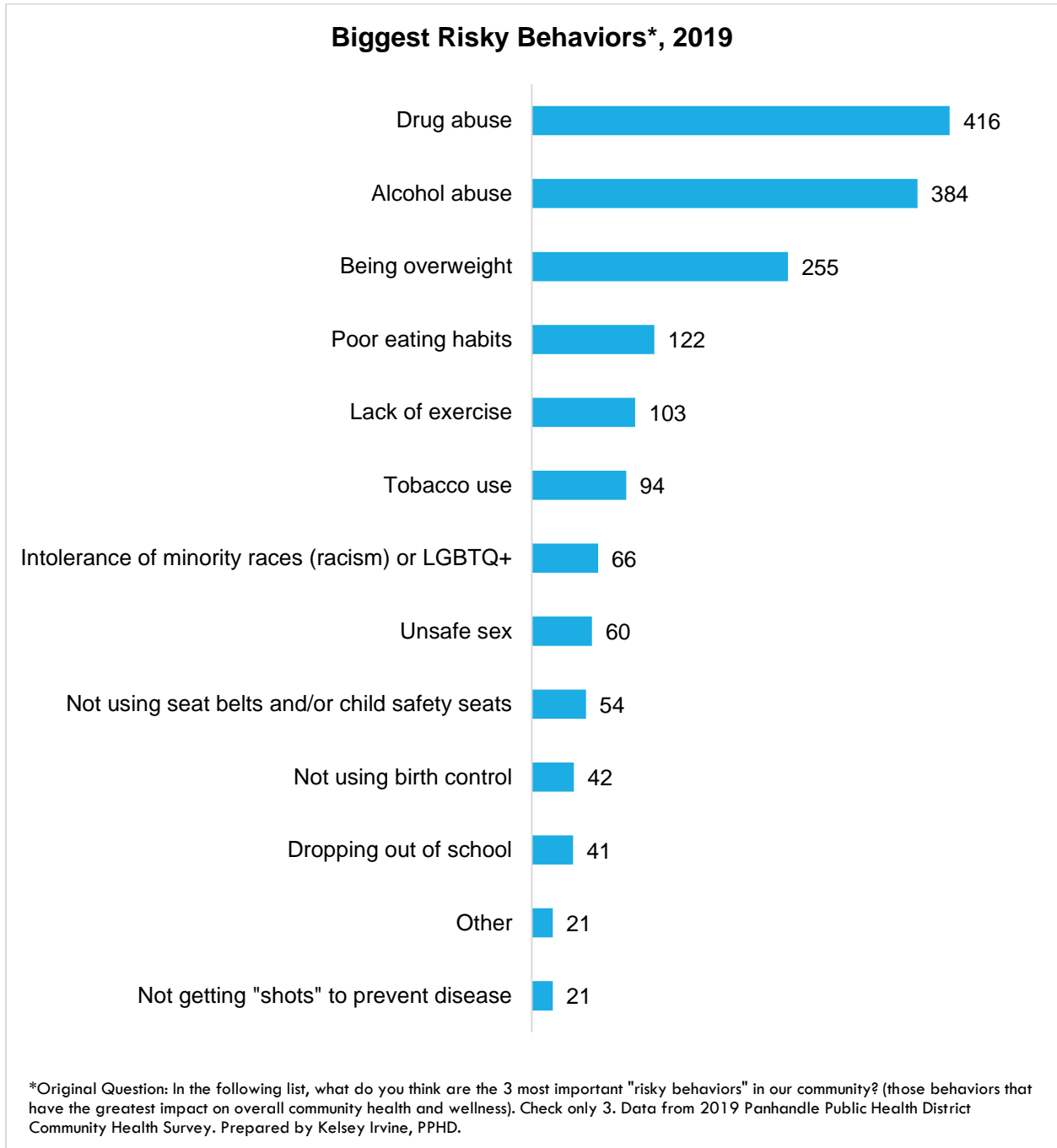


	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are networks for support for older adults living alone.	5.4%	19.1%	30.4%	26.1%	7.5%	10.7%	0.7%
There are enough programs that provide meals for older adults in my community.	4.1%	18.6%	28.1%	29.3%	8.9%	9.8%	1.1%
There are housing developments that are friendly toward older adults (considering accessibility, affordability, and safety).	3.4%	12.7%	26.3%	36.1%	11.6%	9.3%	0.5%
This community is a good place to grow old.	3.8%	10.9%	18.4%	49.7%	14.1%	2.7%	0.4%

TOP RISKY BEHAVIORS

The Community Health Survey asked respondents to rank the three most risky behaviors in the community. The top three risky behaviors were drug abuse, alcohol abuse, and being overweight, followed by poor eating habits, lack of exercise, and tobacco use.

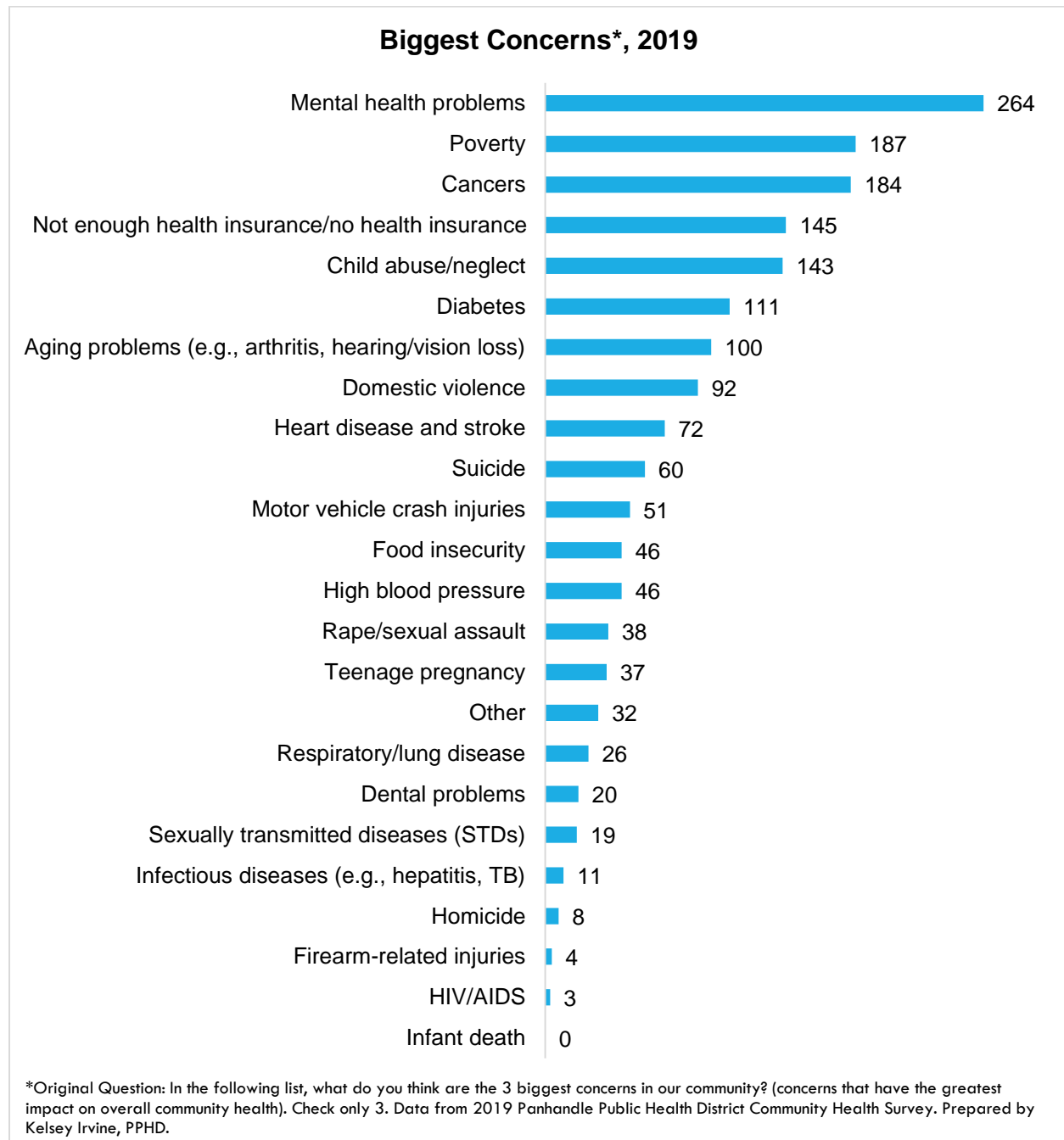
Figure 111: 2019 Biggest Risky Behaviors



BIGGEST CONCERNS

The Community Health Survey asked respondents to rate their three biggest concerns in the community. The top three concerns rated were mental health problems, poverty, and cancers, followed by not enough health insurance/no health insurance, child abuse/neglect, and diabetes.

Figure 112: 2019 Biggest Concerns



FOCUS GROUPS

PPHD collaborated with 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 to hold a series of focus groups across the Panhandle region. 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. Focus groups were largely conducted in spring of the year 2020. Because of the COVID-19 pandemic, a handful of focus groups were completed via open-ended survey rather than in person.

Each hospital facilitated at least one focus group with residents in their service area, and hospitals with greater than 5% of a minority population in their service area made a concerted effort to include people representative of the minority population in the focus groups, to ensure full community representation. The individual hospitals were primarily responsible for recruiting focus group participants, with PPHD providing assistance when needed. As per the MAPP process, groups were intended to be made up of 8-10 people, although some variance occurred. Hospital representatives identified potential focus group participants from their community and reached out via phone calls, emails, and social media to invite them to attend a focus group session.

PPHD staff facilitated the focus group sessions for all hospitals. Each focus group had a facilitator and a scribe, and was approximately 60-minutes long. The process is as follows:

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

Comments were captured by the scribe and analyzed collectively as a region. The analysis of the focus group data was guided by the Krueger approach. 29 Focus group transcripts were read, and prevailing themes were identified. Data was highlighted and sorted accordingly.

A total of 16 focus group sessions involving approximately 142 Nebraska Panhandle residents were completed.

The following section summarizes two focuses groups that took place in Scotts Bluff County and one in Banner County.

See [Appendix C](#) for the focus group guide and demographic survey, and see [Appendix D](#) for demographic information of focus group attendees.

FOCUS GROUP FINDINGS

As you read through the focus group strengths and needs you will notice contradictions. It can be gleaned that many of the same aspects were perceived to have both strengths and weaknesses, in different areas.

COMMUNITY DESCRIPTION

Community members described the community.

- The community is **small**, in both geographical **size** and the **closeness of the residents**.
- The community is **close-knit, friendly, and welcoming**.
- The community is full of **caring people** that are **giving, friendly, helpful, and supportive**.
- **Opportunities for recreation** abound in the area, including both **outdoor access** and **community recreation**.
- The community has **strong schools**.
- The community is largely **rooted in agriculture**.

COMMUNITY STRENGTHS

Community members identified strengths of the community.

Some strengths echoed how they would describe the community:

- **Opportunities for recreation** abound in the area, including both **outdoor access** and **community recreation**.
- The community has **strong schools**.
- The Panhandle has a lot of **community resources**, including shopping, businesses, and community assistance programs.

Some strengths were new:

- The community has strong **local healthcare** opportunities, including a local **hospital** and **clinic**.

COMMUNITY CHANGES

Community members described how the community has changed in the past 5-10 years.

- **Employment** changed in many ways, with **less local businesses** and **less job opportunities** in communities.
- **Community recreation** opportunities are available.

COMMUNITY NEEDS

Community members discussed community needs. The following needs were identified:

- **Employment** needs, including **lack of local job opportunities, lack of local workforce, and low wages**
- **Healthcare** needs, including **lack of behavioral health options** and **lack of emergency care options**.
- **Local businesses**, such as **retail shopping, grocery stores, and restaurants**.
- **Childcare** in general, and more specifically for those who work irregular hours.
- **Public transportation**, both within and between communities.
- **Community recreation**, such as local pools, recreation centers, and more.

COMMUNITY INTERACTIONS

Community members described the interactions between community members of different backgrounds.

- Overall, the community is **accepting** and **racially diverse**.
- The community experiences **geographical divides**, where minority or lower income individuals may live in specific pockets of the community.

COMMUNITY CONCERNS

Community members viewed the top risky behaviors and biggest concern for their specific community from the 2019 Community Health Survey and discussed the findings. The community members agreed with the top risky behaviors and health concerns, listed here (ordered most important to least important):

Top Risky Behaviors:

1. Drug abuse
2. Alcohol abuse
3. Being overweight

Top Health Concerns:

1. Mental health problems
2. Poverty
3. Cancers

FORCES OF CHANGE ASSESSMENT

The Forces of Change assessment was intended to take place at a large in-person event in March 2020, which would have been the kick-off event for the 2020 Community Health Assessment. Due to the COVID-19 Pandemic, this event was cancelled, and a virtual event took place on July 30, 2020, to complete the assessment. See [Appendix A](#) for the meeting work product (including details on the process), and see the next page for the full Forces of Change assessment.

What is happening now that will impact our work?

Horizon	Emerging	Established	Disappearing	Undertow
<ul style="list-style-type: none"> • Creating a culture of health (personal accountability) • Healthy eating the standard/norm • Healthy choice is the easy choice • Get communities involved in gardens and growing food • Health at every size • Healthcare focus on prevention • Concierge medicine • # Unlimited access to care in rural Nebraska • ^ Uncertainty of health care coverage • # Rebuilding the sense of community and neighborhood – mutual reliance and responsibility • Investment in minority and immigrant peoples for high need jobs • Increase minimum wage to livable wage • Homeless shelter with wraparound services • Behavioral health assistance for employers <div data-bbox="107 1114 464 1247" style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p align="center">KEY</p> <p>Green # = Pleasing/Positive Red ^ = Concerning/Negative BOTH = #^ BOTH</p> </div>	<ul style="list-style-type: none"> • Healthy convenient food choices • Nutritional programs in schools • # Healthy child nutrition program • ^ Uncertainty of continued federal funding for social service activities • # Increased awareness of benefits of physical activity • Physical activity opportunities in <u>all</u> communities • Community assistant nurse • Patient-centered medical homes • Increased use of technology to improve health care • # Telehealth • Telehealth for mental health • # Universal coverage • Best practices • Outcome-based provider reimbursement • # 2-year certificates, community colleges, online and on the job training • # Technology to improve access for all • Virtual delivery system for education and employee training • Virtual opportunities social interactions • Limited opportunities for in-person socialization may impact mental health • Usable consistent transportation • More rural transportation options • Understanding implicit biases at personal and systemic levels 	<ul style="list-style-type: none"> • Public health • # PPHD Offerings – NDPP, radon, tobacco free campus, worksite wellness, Healthy Families America • # Faith based practices • # Panhandle Partnership • # Rural Nebraska Healthcare Network • Community coalition for change • # Collaboration between communities • # Standard of Collaboration among community, clinical and social services • ^ Acceptance of substance use • # Tobacco policies • #^ Agriculture • Limited funds to cities to make infrastructure changes • Legislative changes are difficult • Healthy nutrition options – MyPlate, farmers markets, bountiful baskets, NuVal – Choose Healthy Here, WIC, SNAP • Medical support – healthcare system, Airlink, Dr. Webb, visiting physicians, Dental Day • Activity options – community centers, walking path, 5 and 10Ks, 1/2 marathons, triathlons, public school athletics, after school programs, Kids Fitness and Nutrition Day • Revisit vaccinations for infectious disease prevention • Big employers closing 	<ul style="list-style-type: none"> • Young generation leaving after college • # Bachelor’s degree = necessary for good jobs • ^ ACA • Silos in the Panhandle • Single provider care management • Landline (Black outs) • Recruitment of big business will save us • Sugar is not as bad as fat • White/rural areas don’t have poverty • ^ Business climate (getting loans investments, small farms, and ranches) • Silos in working toward better health outcomes • Shifting schools (country schools) • ^ Stigma of walking and biking to work • “It’s always been that way” mentality 	<ul style="list-style-type: none"> • Rural – decreasing population, aging population, decreasing political voice, decreasing tax base • Population trends • Political divide • Government regulations and politics • Public trust in prevention efforts • Mixed messaging through social and traditional media • ^ Discrimination • Cultural bias • Cultural acceptance of racism and prejudices • Increase in minority populations • Lack of job diversity • ^ Poverty • ^ Uncertainty of payment system to multiple sectors • Education and economic disparities • Lobbying and advertising around tobacco, alcohol, and sugar • Fierce Independence • Participation • Community norms for substance use • Potential legalization of medical/recreational marijuana • Quick changing substance abuse trends • Brain drain • COVID-19 Pandemic and long-term impacts • ^ Fear and resistance to change • Self-reliant attitude • Change in family unit

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The Local Public Health System Assessment (LPHSA) was completed across spring and summer of 2020. A summary of the results can be found in [Appendix E](#).

Community members were invited to participate in the LPHSA at various meetings. They were provided with the Essential Service description and Model Standard narrative, and discussion questions for each Model Standard. A PPHD staff member facilitated the discussion in each group, and an additional PPHD member acted as a scribe.

Participants came to consensus on a rating for each Model Standard with a rating of one to five, where 1 = No Activity, 2 = Minimal, 3 = Moderate, 4 = Significant, and 5 = Optimal.

The facilitator and group also noted any strengths, weaknesses, short-term opportunities, and long-term opportunities associated with each Essential Service.

MAPP PHASE 4: IDENTIFY STRATEGIC ISSUES

A prioritization process to identify strategic issues to focus on in the Community Health Improvement Plan (CHIP) was completed through a virtual consensus workshop on November 18, 2020. Eight people attended the meeting.

The agenda was as follows: Introductions, Consensus Workshop, Conclusion.

Respondents reviewed the top health concerns and risky behaviors from the 2019 Community Health Survey and focus group findings to rank the potential priority areas for the CHIP. Respondents also had the opportunity to note any areas they felt were missing.

The top priority areas from the pre-meeting survey were brought forward to the prioritization meeting:

- Drug abuse
- Access to care
- Being overweight
- Poor eating habits
- Lack of exercise
- Tobacco use
- Poverty
- Mental health problems
- Cancers
- Not enough health insurance/no health insurance
- Child abuse/neglect
- Diabetes
- Aging problems (e.g., arthritis, hearing/vision loss)
- Domestic Violence

A modified version of the Technology of Participation (ToP) consensus workshop process was completed to narrow and name the priority areas. Final priority areas for the 2021-2023 CHIP are:

Overarching priority areas:

- **Access to Services (mobility, affordability, availability)**
- **Mental Health & Well-Being**
- **Poverty & Economic Hardship**

Priority Area 1: Aging Population (65+)

- Falls
- Quality of Life
- Coordination of Care

Priority Area 2: Injury Prevention

Intentional injuries

- Domestic Violence
- Child abuse/neglect
- Substance abuse
- Suicide prevention

Unintentional injuries

- Falls
- Motor vehicle accidents
- ATV accidents

Priority Area 3: Prevention and Management Services

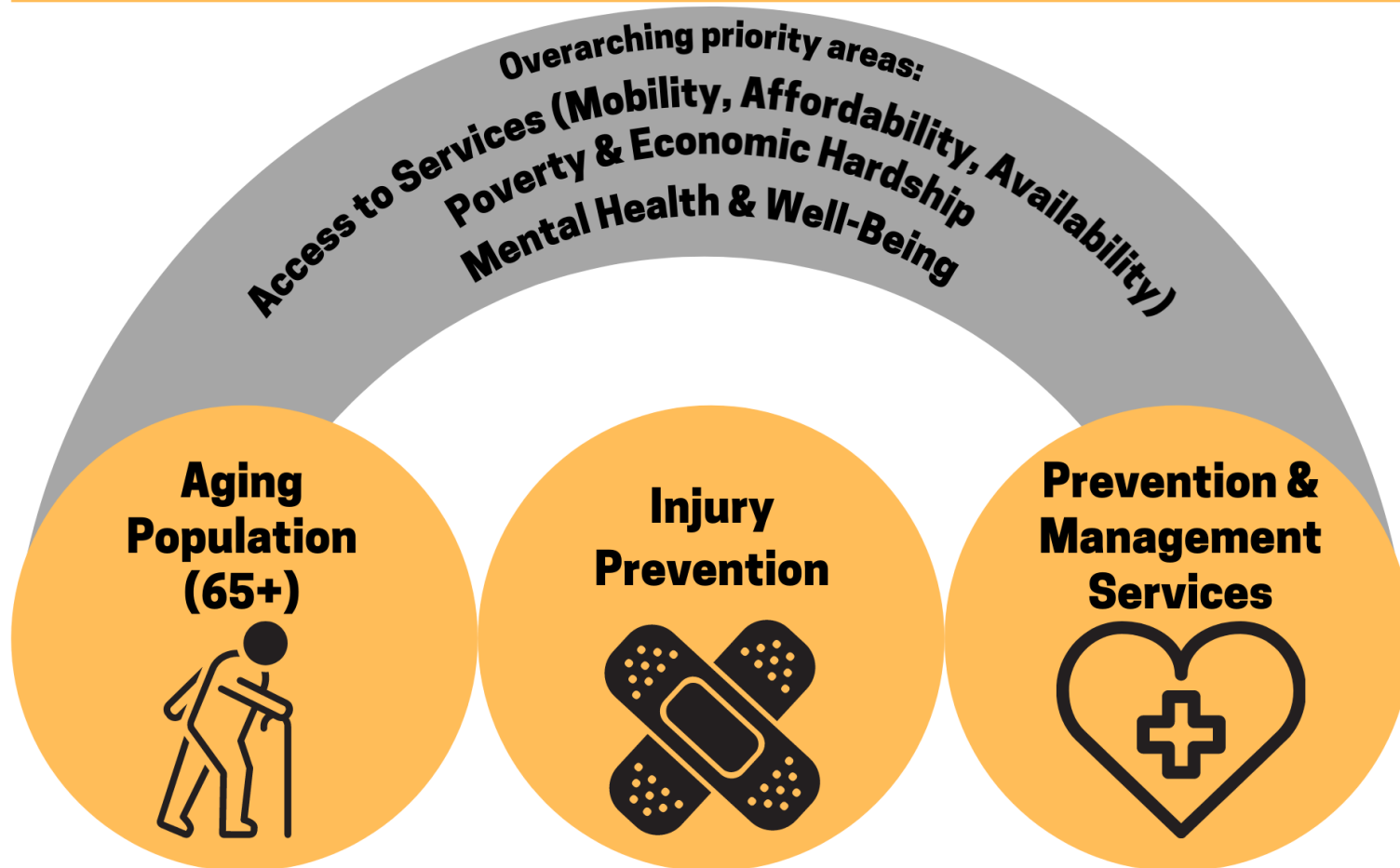
- Diabetes
- Cancer
- Cardio-pulmonary Disease
- Obesity

The following individuals attended the meeting:

Name:	Role:
Kelsey Irvine	PPHD – meeting facilitator
Paulette Schnell	Community Health
Marth Stricker	Regional Services
Randy Meininger	EMS
Jodi Willats	RW Case Management
Jeff Kriewald	Cancer Services
Renee Fink	Director of Finance
Tim Osterholm	Chief Operating Officer

The following page includes the a graphic of the 2021-2023 CHIP Priority Areas .

2021-2023 Regional West Medical Center Community Health Improvement Plan Priority Areas



APPENDICES

2020 Community Health Assessment

Visioning & Forces of Change

Completed July 30, 2020

The Forces of Change assessment and Visioning process were completed via virtual meeting on July 30, 2020. The mode of meeting was virtual due to the COVID-19 pandemic. 48 people attended the meeting.

The agenda was as follows:

- Introductions
- Review the data
- Visioning
- Forces of Change
- Regroup and Review
- Conclusion

Kelsey Irvine (PPHD) provided a short presentation of health outcome and risk factor data, a brief summary of 2019 Community Health Survey results, and a brief summary of the 2020 focus group results.

Kelsey Irvine (PPHD) led the group in a focused conversation to update the Vision. Rather than create a brand-new vision for the 2020 CHA process, the group instead worked to update the Vision from the 2017 process. The group reviewed the 2017 Vision and discussed the following questions, with the overarching question of “What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?” kept in mind.

- What is a point in the vision that stuck out to you?
- What have we accomplished?
- Is anything no longer relevant?
- What remains true today?
- Where is more work needed?
- What are other things we need to consider?
- What are we really committed to?

The group then completed the Forces of Change Assessment in a similar format, by updating the 2017 Forces of Change Assessment rather than starting from scratch. Kelsey Irvine (PPHD) led the group through a review of the Wave process and format that was used to complete the Forces of Change Assessment. The Wave process is a Technology of Participation process that focuses on five areas:

- Horizon: Which new ideas are pushing or needing to become accepted trends and practices?
- Emerging: Which trends and practices are picking up momentum and acceptance?

- Established: Which trends and practices are mainstream or standard operating procedures?
- Disappearing: Which trends and practices are concepts whose variability is overtly questioned or not needed?
- Undertow: What are the deep patterns that cause trouble, even in the midst of success?

The entire group held a discussion to update the Horizon section. Then the group broke out into small groups to complete the discussion to update each of the other sections. The group then reconvened to review their discussion findings.

Facilitator:	Section:
Kelsey Irvine	Horizon
Cheri Farris	Emerging
Tabi Prochazka	Established
Melissa Haas	Disappearing
Jessica Davies	Undertow

The work products from 2017 were updated with the discussions that took place in the meeting, and posted on a Basecamp website for attendees, and those who were invited but unable to attend, to review and provide commentary.

The remaining pages include the participant list, 2020 Visioning and Forces of Change products, and 2017 Visioning and Forces of Change products.

Participant List:

Name:	Organization:
Kelsey Irvine	Panhandle Public Health District
Cheri Farris	Panhandle Public Health District
Melissa Haas	Panhandle Public Health District
Melissa Norgard	City of Sidney Economic Development
Alex Helmbrecht	Chadron State College
Kim Engel	Panhandle Public Health District
Chelsie Herian	Box Butte Development
Monica Shambaugh	CAPstone
Dan Newhoff	Box Butte General Hospital
Robin Stuart	Morrill County Community Hospital
Karen Eisenbarth	Northwest Community Action Partnership
Jessica Davies	Panhandle Public Health District
Sandy Montague-Roes	Western Community Health Resources
Nici Johnson	ESU 13
Jennifer Sibal	Gering Public Schools
Erin Norman	Chadron State College
Susan Wiedeman	Panhandle Coop
Marie Parker	PPHD Board of Health
Sabrina Sosa	Community Action Partnership of Western Nebraska
Evie Parsons	Sidney Regional Medical Center
Betsy Vidlak	Community Action Partnership of Western Nebraska
Britt Miller	Chappell Community Development
Sara Williamson	Panhandle Public Health District
John Marrin	Western Nebraska Community College
Erika Guerrero	Title 1C Migrant Education
Boni Carrell	Rural Nebraska Healthcare Network
Doris Brown	Gordon Memorial Hospital
John Vesper	Western Nebraska Community College
Nicole Berosek	Panhandle Public Health District
Steph Black	United Way
Susan Unzicker	Alliance Chamber
Ricca Sanford	Regional West Garden County
Rhonda Theiler	Perkins County Health Services
Megan Kopenhafer	Panhandle Area Development District
Kendra Dean	Cirrus House
Tabi Prochazka	Panhandle Public Health District
Troy Unzicker	Alliance Public Schools
Carolyn Jones	Box Butte General Hospital
Patricia Wellnitz	PPHD Board of Health
Laura Bateman	Kimball Health Services
Karen Benzel	United Way of Western Nebraska
Travis Miller	Bayard Public Schools
Brenda Brooks	DHHS WSA
Faith Mills	Panhandle Partnership
Lori Mazanec	Box Butte General Hospital
Neil Hilton	Perkins County Health Services
Karen Anderson	Scottsbluff-Gering Chamber
Tyson Lambertson	The Rock Church

What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?							
Healthy Eating	Promote Emotional Resilience	Environments and Events for Active Living	Establish Healthy Habits Early On	Focus on Long-term impact of Pandemic	Improve Access to Healthcare	Prevent and Reduce Substance Use	Access to Basic Needs
<ul style="list-style-type: none"> • Community gardens • Healthy food options • Increase nutrition awareness through programming (SNAP, food bank, commodities, etc.) • Access to affordable healthy foods • Incorporation of local healthy food options (farmers market, farm to table, etc.) 	<ul style="list-style-type: none"> • Improve emotional well-being • Healthier ways to deal with stress • Improve access to behavioral health services • Community support for behavior change • Promote healthy stress management techniques • Overcome cost as a barrier to behavioral health treatment 	<ul style="list-style-type: none"> • Safe environments for walking and biking in communities • Opportunities for physical activity (5k type activities, family activities) • Workplace culture of wellness, both in office and WFH • Distance-friendly opportunities for physical activity (virtual, etc.) • Incentives for healthy lifestyle changes • Cultivate culture of health • Active living environments accessible to people of all abilities 	<ul style="list-style-type: none"> • Educate children on whole body health (food choices and activity; access to nutritious foods; access to walkways and activity; emotional health) • Provide parents with education and support for healthy children (nutrition, physical activity, emotional health) • Elementary school education about healthy habits • Health literate resources • Support healthy family programming (Healthy Families, WIC, etc.) • Address environmental health concerns that impact children (e.g., lead) • Focus on all health factors, not only weight 	<ul style="list-style-type: none"> • Promote kindness and compassion during unusual times • Decrease politicization of public health measures • Accessible technology for older adults • Accessible technology for vulnerable populations • Virtual opportunities for physical activity • Maintain opportunities for health screenings • Healthcare opportunities for those who experience gap in health insurance due to job loss 	<ul style="list-style-type: none"> • Improved access to eye care • Transportation to/from medical appointments • Increased health care coverage • Mobile health services • Increased resources to care for older adults • Population health perspective • Decrease chronic disease • Link healthcare providers to community programs • Medicaid Expansion 	<ul style="list-style-type: none"> • Tobacco free • Local taxes on tobacco and alcohol • Reduce binge drinking rates • Reduce substance abuse (misuse of prescription drugs, illegal opioids) • Reduce e-cigarette use among youth (tobacco and marijuana) • Improve access to sites for safe medication disposal 	<ul style="list-style-type: none"> • Accessible and affordable public transportation • Safe, quality, and affordable housing • Quality and affordable childcare • Emergency housing for homeless individuals • Jobs with livable wages and benefits • Payer sources to keep hospitals and clinics paid/open

2020 Forces of Change – Wave Metaphor

What is happening now that will impact our work?				
Horizon	Emerging	Established	Disappearing	Undertow
<ul style="list-style-type: none"> • Creating a culture of health (personal accountability) • Healthy eating the standard/norm • Healthy choice is the easy choice • Get communities involved in gardens and growing food • Health at every size • Healthcare focus on prevention • Concierge medicine • # Unlimited access to care in rural Nebraska • ^ Uncertainty of health care coverage • # Rebuilding the sense of community and neighborhood – mutual reliance and responsibility • Investment in minority and immigrant peoples for high need jobs • Increase minimum wage to livable wage • Homeless shelter with wraparound services • Behavioral health assistance for employers 	<ul style="list-style-type: none"> • Healthy convenient food choices • Nutritional programs in schools • # Healthy child nutrition program • ^ Uncertainty of continued federal funding for social service activities • # Increased awareness of benefits of physical activity • Physical activity opportunities in <u>all</u> communities • Community assistant nurse • Patient-centered medical homes • Increased use of technology to improve health care • # Telehealth • Telehealth for mental health • # Universal coverage • Best practices • Outcome-based provider reimbursement • # 2-year certificates, community colleges, online and on the job training • # Technology to improve access for all • Virtual delivery system for education and employee training • Virtual opportunities social interactions • Limited opportunities for in-person socialization may impact mental health • Usable consistent transportation • More rural transportation options • Understanding implicit biases at personal and systemic levels 	<ul style="list-style-type: none"> • Public health • # PPHD Offerings – NDPP, radon, tobacco free campus, worksite wellness, Healthy Families America • # Faith based practices • # Panhandle Partnership • # Rural Nebraska Healthcare Network • Community coalition for change • # Collaboration between communities • # Standard of Collaboration among community, clinical and social services • ^ Acceptance of substance use • # Tobacco policies • # ^ Agriculture • Limited funds to cities to make infrastructure changes • Legislative changes are difficult • Healthy nutrition options – MyPlate, farmers markets, bountiful baskets, NuVal – Choose Healthy Here, WIC, SNAP • Medical support – healthcare system, Airlink, Dr. Webb, visiting physicians, Dental Day • Activity options – community centers, walking path, 5 and 10Ks, 1/2 marathons, triathlons, public school athletics, after school programs, Kids Fitness and Nutrition Day • Revisit vaccinations for infectious disease prevention • Big employers closing 	<ul style="list-style-type: none"> • Young generation leaving after college • # Bachelor’s degree = necessary for good jobs • ^ ACA • Silos in the Panhandle • Single provider care management • Landline (Black outs) • Recruitment of big business will save us • Sugar is not as bad as fat • White/rural areas don’t have poverty • ^ Business climate (getting loans investments, small farms, and ranches) • Silos in working toward better health outcomes • Shifting schools (country schools) • ^ Stigma of walking and biking to work • “It’s always been that way” mentality 	<ul style="list-style-type: none"> • Rural – decreasing population, aging population, decreasing political voice, decreasing tax base • Population trends • Political divide • Government regulations and politics • Public trust in prevention efforts • Mixed messaging through social and traditional media • ^ Discrimination • Cultural bias • Cultural acceptance of racism and prejudices • Increase in minority populations • Lack of job diversity • ^ Poverty • ^ Uncertainty of payment system to multiple sectors • Education and economic disparities • Lobbying and advertising around tobacco, alcohol, and sugar • Fierce Independence • Participation • Community norms for substance use • Potential legalization of medical/recreational marijuana • Quick changing substance abuse trends • Brain drain • COVID-19 Pandemic and long-term impacts • ^ Fear and resistance to change • Self-reliant attitude • Change in family unit
<p>KEY Green # = Pleasing/Positive Red ^ = Concerning/Negative BOTH = #^ BOTH</p>				

2017 Vision

What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?

Culturally Sensitive and Peer-Driven Services	Environments and Events for Active Living	Promoting Emotional Resilience	Creating and Supporting a Culture of Wellness	Healthy Eating	Establishing Healthy Habits Early On	Improving Access	Community-Oriented Healthcare	Financing Our Future	Prevent and Reduce Substance Use
<ul style="list-style-type: none"> • Culturally sensitive and peer-driven services 	<ul style="list-style-type: none"> • Safe walkable and biking communities • Opportunities for physical activity • 5K – more runs available in different locations • More activity less technology • Family activities 	<ul style="list-style-type: none"> • Healthier ways to deal with stress • Emotional well-being • Better access to mental health services • Access to behavioral health services for youth and adults • Community support group behavior change 	<ul style="list-style-type: none"> • Wellness culture important in the workplace • Health education – wellness • Healthy lifestyles • Incentives for individuals leading a healthy lifestyle • Employers focused on well-being of families • Healthy incentives • Cultural change toward health 	<ul style="list-style-type: none"> • Community and school gardens – teaching food skills • Healthy food options • Increase nutrition awareness with nutrition programs – SNAP, food bank, commodities • Universally available nutritious food options • Incorporation of local healthy food options • Access affordable healthy foods 	<ul style="list-style-type: none"> • Focus on children – teaching about food choices and activity; access to nutritious foods; access to walkways and activity • Schools teaching elementary students healthy habits • Promoting a healthy lifestyle at a young age • Education – health literacy • Healthy family programs – nutrition, Healthy Families America • Parent education and support – nutrition, physical activity, how to cook 	<ul style="list-style-type: none"> • Access to services • More access to dental and eye care • Availability of transportation for well-being • Access – enough providers, transportation, insurance • Resource list or online database of services available • Mobile health services • Increased resources for elderly care • Safe housing – homelessness 	<ul style="list-style-type: none"> • Increase health screening and prevention • Integrated population health – community and clinic/ hospital • Decrease chronic disease • Linking health care providers to community programs • Continued community, organizational and personal collaboration and working together 	<ul style="list-style-type: none"> • Jobs with livable wages and benefits • Payor sources to keep hospitals and clinics paid/open • Accessible quality childcare • Affordable transportation, housing, and childcare • Employers focused on well-being of families 	<ul style="list-style-type: none"> • Tobacco free • Local taxes on tobacco, soda, and alcohol (booze) • Reducing binge drinking rates • Reduction – 20% in substance use

2017 Forces of Change – Wave Metaphor

What is happening now that will impact our work?				
Horizon	Emerging	Established	Disappearing	Undertow
<ul style="list-style-type: none"> • # Standard of Collaboration among community, clinical and social services • # Technology to improve access for all • Creating a culture of health (personal accountability) • Healthy eating the standard/norm (fruits/veggies accessible and desired by all) • Unified health services focus on prevention • # Unlimited access to care in rural Nebraska • # Rebuilding that sense of community and neighborhood – mutual reliance and responsibility • Physical activity opportunities in <u>all</u> of our communities • Usable consistent transportation • Investment in minority and immigrant for high need jobs • Concierge medicine • Healthy choice is the easy choice • ^ Uncertainty of health care coverage • Continue to expand telehealth networks • Get communities involved in gardens and growing food • Homeless shelter with wraparound services 	<ul style="list-style-type: none"> • Healthy convenient food choices • Big employers closing • ^ Uncertainty of continued federal funding for social service activities • # Increased awareness of benefits of physical activity • Community assistant nurse • Sugar tax • Patient-centered medical homes • More rural transportation options • Increased use of technology to improve health care • Nutritional programs in schools • Growth of organic foods – bountiful baskets • # Universal coverage • Best practices • Telehealth mental health • # Healthy child nutrition program • Pay providers for keeping patients healthy (outcomes) • # Telehealth • # 2-year certificates, community colleges, online and on the job training <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p align="center">KEY</p> <p>Green # = Pleasing/Positive</p> <p>Red ^ = Concerning/Negative</p> <p>BOTH = #^ BOTH</p> </div>	<ul style="list-style-type: none"> • PPHD • # Faith based practices • # Panhandle Partnership • ^ Acceptance of substance use • Health departments • #^ Agriculture • Community coalition for change • Limited funds to cities to make infrastructure changes • Legislative changes are difficult • ^ Stigma of walking and biking to work • # Tobacco policies • # Collaboration between communities • # PPHD Offerings – NDPP, radon, tobacco free campus, worksite wellness, Healthy Families America • Healthy nutrition options – MyPlate, farmers markets, bountiful baskets, NuVal – Choose Healthy Here, WIC, SNAP • # Rural Nebraska Healthcare Network • “It’s always been that way” mentality • Medical support – healthcare system, Airlink, Dr. Webb, visiting physicians, Dental Day • Activity options – community centers, walking path, 5 and 10Ks, ½ marathons, triathlons, public school athletics, after school programs, Kids Fitness and Nutrition Day 	<ul style="list-style-type: none"> • Young generation leaving after college • # Bachelor’s degree = necessary for good jobs • ^ ACA • Silos in the Panhandle • Single provider care management • Landline (Black outs) • Recruitment of big business will save us • Sugar is not as bad as fat • White/rural areas don’t have poverty • ^ Business climate (getting loans investments, small farms, and ranches) • Silos in working toward better health outcomes • Shifting schools (country schools) 	<ul style="list-style-type: none"> • Population changes (decreasing total population, decreasing youth population, increasing aging population) • Self-reliant attitude • Change in family unit – everyone needs to work, childcare, mental health, lack of resources • ^ Prejudice – race, mental health, poverty • ^ Poverty • Lobbying and advertising around tobacco, alcohol, and sugar • Fierce Independence • Participation • Rural • ^ Uncertainty of payment system – to multiple sectors – healthcare, schools, etc. • Aging population • Cultural bias • Community norm – alcohol culture, drug abuse and availability of drugs • Brain drain • Lack of economic diversity – decreasing availability of good jobs/benefits • Increase in minority populations • Rural – decreasing population, aging population, decreasing political voice, decreasing tax base • Government regulations and politics • Cultural acceptance of racism and prejudices • Education and economic disparities • ^ Fear and resistance to change

APPENDIX B: 2019 COMMUNITY HEALTH SURVEY

2019 Community Health Survey

Please take about 10 minutes to complete this short survey. The purpose of this survey is to get your input about the health of your community. The Panhandle Public Health District, area hospitals, and economic development will use your responses to help identify the most pressing concerns. The survey is also available online at www.pphd.org.

1. How would you rate your community as a “Healthy Community?”
 Very unhealthy Unhealthy Somewhat unhealthy Healthy Very Healthy

Please indicate your level of agreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
2. I am satisfied with the quality of life in our community (considering my sense of safety and well-being).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I am satisfied with the health care system in our community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I am able to get medical care whenever I need it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I am very satisfied with the medical care I receive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sometimes it is a problem for me to cover my share of the cost for a medical care visit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I have easy access to the medical specialists (providers that focus on a specific area of medicine that I need).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How do you pay for your health care? (Check all that apply)

<input type="checkbox"/> Pay cash (no insurance)	<input type="checkbox"/> Medicare
<input type="checkbox"/> Private Health insurance (through employer)	<input type="checkbox"/> Veterans’ Administration
<input type="checkbox"/> Through the Healthcare Marketplace	<input type="checkbox"/> Indian Health Services
<input type="checkbox"/> Faith-Based	<input type="checkbox"/> Decline to answer
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other: _____

9. Are you able to find healthcare locally that is in network for your insurance? No Usually Yes Decline to answer

The following questions are about your primary care provider:

10. What clinic/hospital/health system do you go to for your primary care provider (the doctor you usually go to for medical care)?

11. How far do you travel for your primary care provider? (in miles)
 0-24 25-49 50-74 75+ N/A

12. How long, from the time you call to make an appointment, are you able to see your primary care provider?
 Same day Within 1 week Within 2 weeks Greater than 2 weeks N/A

13. What other types of health care services would you use if available in your community?

The following questions are about any specialists you may see:

14. What clinic/hospital/health system do you go to for your specialist?

15. How far do you travel for your specialist? (in miles)
 0-24 25-49 50-74 75+ N/A

16. How long, from the time you call to make an appointment, are you able to see your specialist?
 Same day Within 1 week Within 2 weeks Greater than 2 weeks N/A

17. What other types of specialists would you see if available in your community?

The following questions are about mental health care.

18. Have you been able to access mental health services, including telehealth services, locally for yourself or a family member in the last year?
 No Usually Yes N/A Decline to answer

19. How far have you or a family member had to travel for access to mental health services, including telehealth mental health services? (in miles)
 0-24 25-49 50-74 75+ N/A

20. Has travel distance or wait time for mental health services locally prevented you or a family member from seeking mental health services when needed?
 No Usually Yes N/A Decline to answer

The following questions are about the built environment, employment, and safety in your community. Please indicate your level of agreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
21. There is safe housing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. There is affordable housing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. There are plenty of recreation opportunities for adults in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable

28. The community is military friendly (considering discounts, patriotism, recognition, and other local resources).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. All residents believe that they, individually and collectively, can make the community a better place to live.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. There are plenty of transportation options in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. What is your primary means of transportation? (Check all that apply).	<input type="checkbox"/> Personal car <input type="checkbox"/> Friend, relative, or neighbor <input type="checkbox"/> Private transportation service <input type="checkbox"/> Active transportation (walk, bike, etc.)		<input type="checkbox"/> Public transportation <input type="checkbox"/> Medicaid Transportation <input type="checkbox"/> Other: _____			
32. If you don't drive a car, why not? (Check all that apply).	<input type="checkbox"/> Can't drive due to a medical/physical condition <input type="checkbox"/> Can't afford a car <input type="checkbox"/> Can't afford gas/insurance		<input type="checkbox"/> Lost driver's license <input type="checkbox"/> No need, everything I need I can access without a car <input type="checkbox"/> Other: _____			
33. Do you use public transportation?	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
33a. If no, why not? (Check all that apply).	<input type="checkbox"/> No service where I am or where I want to go <input type="checkbox"/> Poor connections or transfers <input type="checkbox"/> I don't know how to use it <input type="checkbox"/> Limited hours of operations <input type="checkbox"/> Other: _____		<input type="checkbox"/> I don't feel safe using it <input type="checkbox"/> I can't afford it <input type="checkbox"/> I don't know about it <input type="checkbox"/> I don't need it			
The following questions are about raising children in your community. Please only respond if you currently have a child that resides with you for whom you provide care. If you do not have children, please mark "Not Applicable". Please indicate your level of agreement with each of the following statements:						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
34. This community is a good place to raise children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I have access to quality child care that is affordable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. My child care facility is licensed.	<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Don't know	
36. My child care facility is licensed.	<input type="checkbox"/> Not applicable					
37. I am very satisfied with the school system in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. There are adequate after school programs for elementary age children to attend.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. There are adequate after school opportunities for middle and high school age students.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. There are plenty of recreation opportunities for children in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The following questions are about older adults in your community. Please indicate your level of agreement with each of the following statements:						

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
41. This community is a good place to grow old.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. There are housing developments that are friendly toward older adults (considering accessibility, affordability, and safety).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. There are enough programs that provide meals for older adults in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. There are networks for support for older adults living alone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions are about risky behaviors and health problems in your community. The first section will ask about risky behaviors (those behaviors that have the greatest impact on overall community health) and the second section will ask about health problems (concerns that have the greatest impact on overall community health).

45. In the following list, what do you think are the 3 most important “risky behaviors” in our community? (those behaviors that have the greatest impact on overall community health and wellness). Check only 3:

- | | |
|---|---|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Intolerance of minority races (racism) or LGBTQ+ |
| <input type="checkbox"/> Being overweight | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Not using birth control |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Not using seat belts and/or child safety seats |
| <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Unsafe sex |
| <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Not getting “shots” to prevent disease | |

46. In the following list, what do you think are the **3 biggest concerns** in our community? (concerns that have the greatest impact on overall community health). Check only 3:

- | | |
|--|--|
| <input type="checkbox"/> Aging problems (e.g., arthritis, hearing/vision loss) | <input type="checkbox"/> Infant death |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> Infectious diseases (e.g., hepatitis, TB) |
| <input type="checkbox"/> Child abuse/neglect | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Motor vehicle crash injuries |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rape/sexual assault |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Respiratory/lung disease |
| <input type="checkbox"/> Firearm-related injuries | <input type="checkbox"/> Sexually transmitted diseases (STDs) |
| <input type="checkbox"/> Heart disease and stroke | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Teenage pregnancy |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Not enough health insurance/no health insurance |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Food insecurity |
| <input type="checkbox"/> Poverty | <input type="checkbox"/> Other _____ |

46a. Of the problems that you marked on the previous page, which one would you most likely work on? Think of personal interests as well as professional interests.

47. Are there emerging issues in the community that you think need to be focused on, that may not be in the above lists?

The following questions are about your experiences as a child. If you are currently under the age of 18, think of your present or past. If you are an adult, think of when you were younger than 18. If you need resources or assistance relating to anything in the following questions, please visit www.pphd.org for additional information. As a child:

	Yes	No	Decline to Answer
48. Did you live with anyone who was depressed, mentally ill, or suicidal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Did you live with anyone who was a problem drinker or an alcoholic?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Did you live with anyone who used illegal street drugs or who abused prescription medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Were your parents separated or divorced?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Did parents or adults in your home slap, hit, kick, punch, or beat each other up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Did a parent or adult in your home swear at you, insult you, or put you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Did an adult or anyone at least 5 years older than you touch you in sexual way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Did an adult or anyone at least 5 years older than you try to make you touch them in sexual way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide the following information about yourself. It will be used for demographic purposes only. Keep in mind you will NOT be identified in any way with your answers.

58. Zip code: _____	60. Gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male (female to male) <input type="checkbox"/> Transgender female (male to female) <input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other: _____
59. County of residence: <input type="checkbox"/> Banner <input type="checkbox"/> Kimball <input type="checkbox"/> Box Butte <input type="checkbox"/> Morrill <input type="checkbox"/> Cheyenne <input type="checkbox"/> Scotts Bluff <input type="checkbox"/> Dawes <input type="checkbox"/> Sheridan <input type="checkbox"/> Deuel <input type="checkbox"/> Sioux <input type="checkbox"/> Garden <input type="checkbox"/> Other: _____ <input type="checkbox"/> Grant _____	
61. Sexual orientation: <input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Gay or lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other: _____	64. Age: <input type="checkbox"/> Under 18 years <input type="checkbox"/> 18-25 years <input type="checkbox"/> 26-39 years <input type="checkbox"/> 40-54 years <input type="checkbox"/> 55-64 years <input type="checkbox"/> 65-80 years <input type="checkbox"/> Over 80 years

<p>62. Highest level of education:</p> <p><input type="checkbox"/> Less than high school graduate</p> <p><input type="checkbox"/> High school diploma or GED</p> <p><input type="checkbox"/> Associates or Technical Degree</p> <p><input type="checkbox"/> College degree or higher</p> <p><input type="checkbox"/> Decline to answer</p> <p><input type="checkbox"/> Other: _____</p>	<p>65. Marital Status:</p> <p><input type="checkbox"/> Married/Partnered</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Never married</p> <p><input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Widowed</p> <p><input type="checkbox"/> Decline to answer</p> <p><input type="checkbox"/> Other: _____</p>
<p>63. Race:</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander</p> <p><input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> Decline to answer</p> <p><input type="checkbox"/> Other: _____</p>	<p>66. Household Income:</p> <p><input type="checkbox"/> Less than \$20,000</p> <p><input type="checkbox"/> \$20,000 to \$29,999</p> <p><input type="checkbox"/> \$30,000 to \$49,999</p> <p><input type="checkbox"/> \$50,000 to \$74,999</p> <p><input type="checkbox"/> \$75,000 to \$99,999</p> <p><input type="checkbox"/> Over \$100,000</p> <p><input type="checkbox"/> Decline to answer</p>
<p>67. Are you Hispanic or Latino/a/x? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to answer</p>	
<p>68. Military status (Check all that apply):</p> <p><input type="checkbox"/> I served or currently serve in the military</p> <p><input type="checkbox"/> My husband, wife, or significant other served or currently serves in the military</p> <p><input type="checkbox"/> My child served or currently serves in the military</p> <p><input type="checkbox"/> My parent served or currently serve in the military</p> <p><input type="checkbox"/> My brother/sister served or currently serves in the military</p> <p><input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Other: _____</p>	

Thank you for taking the time to respond to this survey. Your responses will help us identify where we need to focus work to improve health in the Panhandle.

APPENDIX C: 2020 FOCUS GROUP GUIDE

2020 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?

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.

- 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, specific services.

- 5. How would you describe the interactions between community members from different backgrounds? Think about community members of different races, different abled (for example, handicapped), LGBTQ+, etc.**

- 6. A Community Health Survey was recently completed in your community.**

The top 3 risky behaviors were:

- 1.
- 2.
- 3.

The top 3 biggest concerns were:

- 1.
- 2.
- 3.

a) Do you agree with these?

b) Are there things we may be missing?

- 7. If you had a magic wand, what is one thing you would improve within your community?**

2020 Focus Group Participant Survey

Please provide the following information about yourself. It will be used for demographic purposes only. Keep in mind you will NOT be identified in any way with your answers.

1. Zip code: _____

2. County of residence:

- | | | |
|---------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Banner | <input type="checkbox"/> Box Butte | <input type="checkbox"/> Cheyenne |
| <input type="checkbox"/> Dawes | <input type="checkbox"/> Deuel | <input type="checkbox"/> Garden |
| <input type="checkbox"/> Grant | <input type="checkbox"/> Kimball | <input type="checkbox"/> Morrill |
| <input type="checkbox"/> Scotts Bluff | <input type="checkbox"/> Sheridan | <input type="checkbox"/> Sioux |
| <input type="checkbox"/> Other: _____ | | |

3. Gender identity:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Gender non-conforming | <input type="checkbox"/> Transgender male (female to male) |
| <input type="checkbox"/> Female | <input type="checkbox"/> Decline to answer | <input type="checkbox"/> Transgender female (male to female) |
| <input type="checkbox"/> Other: _____ | | |

4. Sexual orientation:

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Heterosexual or straight | <input type="checkbox"/> Gay or lesbian | <input type="checkbox"/> Bisexual |
| <input type="checkbox"/> Decline to answer | <input type="checkbox"/> Other: _____ | |

5. Highest level of education:

- | | |
|---|---|
| <input type="checkbox"/> Less than high school graduate | <input type="checkbox"/> High school diploma or GED |
| <input type="checkbox"/> Associates or Technical Degree | <input type="checkbox"/> College degree or higher |
| <input type="checkbox"/> Decline to answer | <input type="checkbox"/> Other: _____ |

6. Race:

- | | |
|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Other: _____ | |

7. Are you Hispanic or Latino/a/x?

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Decline to answer |
|------------------------------|-----------------------------|--|

8. Age:

- | | | |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Under 18 years | <input type="checkbox"/> 18-25 years | <input type="checkbox"/> 26-39 years |
| <input type="checkbox"/> 40-54 years | <input type="checkbox"/> 55-64 years | <input type="checkbox"/> 65-80 years |
| <input type="checkbox"/> Over 80 years | | |

9. Marital Status:

- | | | |
|--|-----------------------------------|--|
| <input type="checkbox"/> Married/Partnered | <input type="checkbox"/> Divorced | <input type="checkbox"/> Never married |
| <input type="checkbox"/> Separated | <input type="checkbox"/> Widowed | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Other: _____ | | |

10. Household Income:

- | | |
|---|---|
| <input type="checkbox"/> Less than \$20,000 | <input type="checkbox"/> \$20,000 to \$29,999 |
| <input type="checkbox"/> \$30,000 to \$49,999 | <input type="checkbox"/> \$50,000 to \$74,999 |
| <input type="checkbox"/> \$75,000 to \$99,999 | <input type="checkbox"/> Over \$100,000 |
| <input type="checkbox"/> Decline to answer | |

11. Military status (Check all that apply):

- I served or currently serve in the military
- My husband, wife, or significant other served or currently serves in the military
- My child served or currently serves in the military
- My parent served or currently serve in the military
- My brother/sister served or currently serves in the military
- None of the above
- Other: _____

APPENDIX D: 2020 FOCUS GROUP DEMOGRAPHIC INFORMATION

Demographics (N = 35)

		#	%
County	Banner	3	8.6%
	Box Butte	0	0.0%
	Cheyenne	0	0.0%
	Dawes	0	0.0%
	Deuel	0	0.0%
	Garden	0	0.0%
	Grant	0	0.0%
	Kimball	0	0.0%
	Morrill	0	0.0%
	Scotts Bluff	30	85.7%
	Sheridan	0	0.0%
	Sioux	2	5.7%
	Other	0	0.0%
Gender Identity	Male	12	34.3%
	Female	23	65.7%
	Transgender male (female to male)	0	0.0%
	Transgender female (male to female)	0	0.0%
	Gender non-conforming	0	0.0%
	Decline to answer	0	0.0%
	Other	0	0.0%
Sexual Orientation	Heterosexual or straight	35	100.0%
	Gay or lesbian	0	0.0%
	Bisexual	0	0.0%
	Decline to answer	0	0.0%
	Other	0	0.0%
Highest level of education	Less than high school graduate	1	2.9%
	High school diploma or GED	9	25.7%
	Associates or Technical Degree	2	5.7%
	College degree or higher	21	60.0%
	Decline to answer	2	5.7%
	Other	0	0.0%

		#	%
Race	White	30	85.7%
	Black or African American	0	0.0%
	Asian	1	2.9%
	Native Hawaiian or Other Pacific Islander	0	0.0%
	American Indian or Alaska Native	0	0.0%
	Decline to answer	2	5.7%
	Other	2	5.7%
	Hispanic or Latino/a/x	Yes	30
No		4	11.4%
Decline to answer		1	2.9%
Age	Under 18 years	1	2.9%
	18-25 years	1	2.9%
	26-39 years	15	42.9%
	40-54 years	6	17.1%
	55-64 years	3	8.6%
	65-80 years	9	25.7%
	Over 80 years	0	0.0%
Decline to answer	0	0.0%	
Marital Status	Married/Partnered	29	82.9%
	Divorced	1	2.9%
	Never married	3	8.6%
	Separated	0	0.0%
	Widowed	1	2.9%
	Decline to answer	1	2.9%
Other	0	0.0%	
Household Income	Less than \$20,000	0	0.0%
	\$20,000 to \$29,999	1	2.9%
	\$30,000 to \$49,999	8	22.9%
	\$50,000 to \$74,999	7	20.0%
	\$75,000 to \$99,999	4	11.4%
	Over \$100,000	4	11.4%
	Decline to answer	0	0.0%

APPENDIX E: LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT SUMMARY OF RESULTS

Essential Service 1: Monitor Health Status to Identify Community Health Problems

Monitoring health status to identify community health problems encompasses the following:

- Assessing, accurately and continually, the community's health status.
- Identifying threats to health.
- Determining health service needs.
- Paying attention to the health needs of groups that are at higher risk than the total population.
- Identifying community assets and resources that support the public health system in promoting health and improving quality of life.
- Using appropriate methods and technology to interpret and communicate data to diverse audiences.
- Collaborating with other stakeholders, including private providers and health benefit plans, to manage multi-sectorial integrated information systems.

Partners: Panhandle Area Development District, Educational Service Unit 13, Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Regional West Medical Center, Morrill County Community Hospital, Regional West Garden County, Kimball Health Services, Sidney Regional Medical Center, Panhandle Partnership, Community Action Partnership of Western Nebraska

Essential Service 1		No Activity	Minimal	Moderate	Significant	Optimal
1.1.1.	Conduct regular CHAs?					X
1.1.2.	Update the CHA with current information continuously?				X	
1.1.3.	Promote the use of the CHA among community members (harder population to meet) and partners? (well committed)				X	
1.2.1.	Use the best available technology and methods to display data on the public's health?					X
1.2.2.	Analyze health data, including geographic information, to see where health problems exist?			X		
1.2.3.	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?					X
1.3.1.	Collect timely data consistent with current standards on specific health concerns in order to provide the data to population health registries?					X
1.3.2.	Use information from population health registries in CHAs or other analyses?					X

Strengths	Weaknesses	Long Term Opportunities
<ul style="list-style-type: none"> • Numbers, partnerships, and relationships that continue to keep this work happening between public health and health system • Use of tech and ability to be on cutting edge, data dashboard, Qualtrics use for today; many LHDs don't use as much tech as we do • Windshield time drives use of tech to keep people connected, and be respectful of people's time, while still getting the work done • We do a good job using the registries we have access to 	<ul style="list-style-type: none"> • Not as broad of a user base as we would like 	<ul style="list-style-type: none"> • Improving updates through technology

Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards

Diagnosing and investigating health problems and health hazards in the community encompass the following:

- Accessing a public health laboratory capable of conducting rapid screening and high-volume testing.
- Establishing active infectious disease epidemiology programs.
- Creating technical capacity for epidemiologic investigation of disease outbreaks and patterns of the following: (a) infectious and chronic diseases, (b) injuries, and (c) other adverse health behaviors and conditions.

Partners: Region 22 Emergency Management, Region 21 Emergency Management, UNL Extension, Sidney Regional Medical Center, Kimball Health Services, Morrill County Community Hospital, UNMC Center for Preparedness Education, Regional West Medical Center, Scotts Bluff County Health Department, Regional West Garden County, Box Butte General Hospital, Community Action Partnership of Western Nebraska

Essential Service 2		No Activity	Minimal	Moderate	Significant	Optimal
2.1.1.	Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, and share information and understand emerging health problems and threats?				X	
2.1.2.	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?				X	
2.1.3.	Ensure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?				X	
2.2.1.	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?					X
2.2.2.	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?					X
2.2.3.	Designate a jurisdictional Emergency Response Coordinator?					X

Essential Service 2		No Activity	Minimal	Moderate	Significant	Optimal
2.2.4.	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?					X
2.2.5.	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?				X	
2.2.6.	Evaluate incidents for effectiveness and opportunities for improvement (such as After Action Reports, Improvement Plans, etc.)?				X	
2.3.1.	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?				X	
2.3.2.	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?					X
2.3.3.	Use only licensed or credentialed laboratories?					X
2.3.4.	Maintain a written list of rules related to laboratories, for handling samples (including collecting, labeling, storing, transporting, and delivering), determining who is in charge of the samples at what point, and reporting the results?					X

Strengths	Weaknesses
<ul style="list-style-type: none"> • Laboratory system throughout panhandle • Collaboration • Using consistent processes 	<ul style="list-style-type: none"> • Distance • Rural

Essential Service 3: Inform, Educate, and Empower People about Health Issues

Informing, educating, and empowering people about health issues encompass the following:

- Creating community development activities.
- Establishing social marketing and targeted media public communication.
- Providing accessible health information resources at community levels.
- Collaborating with personal healthcare providers to reinforce health promotion messages and programs.
- Working with joint health education programs with schools, churches, worksites, and others.

Partners: Northwest Action Community Partnership, Box Butte General Hospital, Cheyenne County Community Center, Chadron Community Hospital, Western Nebraska Community College, Cirrus House, Panhandle Co-op

Essential Service 3		No Activity	Minimal	Moderate	Significant	Optimal
3.1.1.	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?			X		
3.1.2.	Coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?			X		
3.1.3.	Engage the community throughout the process of setting priorities, developing plans, and implementing health education and health promotion activities?				X	
3.2.1.	Develop health communication plans for media and public relations and for sharing information among LPHS organizations?				X	
3.2.2.	Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health information, matching the message with the target audience?				X	
3.2.3.	Identify and train spokespersons on public health issues?			X		
3.3.1.	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?			X		
3.3.2.	Make sure resources are available for a rapid emergency communication response?				X	
3.3.3.	Provide risk communication training for employees and volunteers?			X		

Strengths	Weaknesses	Long Term Opportunities
<ul style="list-style-type: none"> • Try hard to work together • Planning process • Unified organization • Education with preparedness • Training opportunities • Resources 	<ul style="list-style-type: none"> • Community engagement is hard • Resources limited • Volunteers 	<ul style="list-style-type: none"> • Training and use of volunteers

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

Mobilizing community partnerships to identify and solve health problems encompasses the following:

- Convening and facilitating partnerships among groups and associations (including those not typically considered to be health related).
- Undertaking defined health improvement planning process and health projects, including preventive, screening, rehabilitation, and support programs.
- Building a coalition to draw on the full range of potential human and material resources to improve community health.

Partners: United Way, Mediation West, Community Action Partnership of Western Nebraska, DOVES Program, Region 1, PALS, Northwest Community Action Partnership, Panhandle Trails, Capstone, Aging Office of Western Nebraska, Western Nebraska Community College, Educational Service Unit 13, Nebraska Extension, Western Community Health Resources, Panhandle Public Health District, Department of Health and Human Services, Regional West Medical Center, Scotts Bluff County Health Department, Monument Prevention Coalition, Panhandle Area Development District, Department of Labor

Essential Service 4		No Activity	Minimal	Moderate	Significant	Optimal
4.1.1.	Maintain a complete and current directory of community organizations?				X	
4.1.2.	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?				X	
4.1.3.	Encourage constituents to participate in activities to improve community health?					X
4.1.4.	Create forums for communication of public health issues?					X
4.2.1.	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?					X
4.2.2.	Establish a broad-based community health improvement committee?					X
4.2.3.	Assess how well community partnerships and strategic alliances are working to improve community health?					X

Strengths	Weaknesses	Short Term Opportunities	Long Term Opportunities
<ul style="list-style-type: none"> • Level of partnerships between organizations is very high and allows us to be on target with our goals • Partnership and public health have shared brain-trust (Kelsey) that allows the go-between for both worlds • Many partnership members wear many hats within the system • Relying on relationships is a great tool when the relationships are strong 	<ul style="list-style-type: none"> • Fully engaging minority populations • Rely on partnerships could be problematic if relationships fall apart 	<ul style="list-style-type: none"> • So many partners connect with minority populations, so there's opportunity to connect but is it intentional or are we waiting for someone else to do the work? 	<ul style="list-style-type: none"> • Solidifying the connection with minority populations

Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts

Developing policies and plans that support individual and community health efforts encompasses the following:

- Ensuring leadership development at all levels of public health.
- Ensuring systematic community-level and state-level planning for health improvement in all jurisdictions.
- Developing and tracking measurable health objectives from the (CHIP) as a part of a continuous quality improvement plan.
- Establishing joint evaluation with the medical healthcare system to define consistent policies regarding prevention and treatment services.
- Developing policy and legislation to guide the practice of public health.

Partners: Panhandle Area Development District, Educational Service Unit 13, Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Regional West Medical Center, Morrill County Community Hospital, Regional West Garden County, Kimball Health Services, Sidney Regional Medical Center, Panhandle Partnership, Community Action Partnership of Western Nebraska, PPHD Leadership Team

Essential Service 5		No Activity	Minimal	Moderate	Significant	Optimal
5.1.1.	Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?					X
5.1.2.	See that the local health department is accredited through the PHAB's voluntary, national public health department accreditation program?					X
5.1.3.	Ensure that the local health department has enough resources to do its part in providing essential public health services?					X
5.2.1.	Contribute to public health policies by engaging in activities that inform the policy development process?				X	
5.2.2.	Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?					X
5.2.3.	Review existing policies at least every three to five years?				X	

Essential Service 5		No Activity	Minimal	Moderate	Significant	Optimal
5.3.1.	Establish a CHIP, with broad-based diverse participation, that uses information from the CHA, including the perceptions of community members?					X
5.3.2.	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?					X
5.3.3.	Connect organizational strategic plans with the CHIP?					X
5.4.1.	Support a workgroup to develop and maintain emergency preparedness and response plans?					X
5.4.2.	Develop an emergency preparedness and response plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?					X
5.4.3.	Test the plan through regular drills and revise the plan as needed, at least every two years?					X

Strengths
<ul style="list-style-type: none"> • How well all the partners in the Panhandle work together with the health department, it's a very cohesive group and is noted by our state level partners • Exceptional collaboration • Groups are really good about sharing when policies will impact public health

Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety

Enforcing laws and regulations that protect health and ensure safety encompasses the following:

- Enforcing sanitary codes, especially in the food industry.
- Protecting drinking water supplies.
- Enforcing clean air standards.
- Initiating animal control activities.
- Following-up hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings.
- Monitoring quality of medical services (e.g., laboratories, nursing homes, and home healthcare providers).
- Reviewing new drug, biologic, and medical device applications.

Partners: Panhandle Public Health District, Monument Prevention, Panhandle Partnership

Essential Service 6		No Activity	Minimal	Moderate	Significant	Optimal
6.1.1.	Identify public health issues that can be addressed through laws, regulations, or ordinances?				X	
6.1.2.	Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?				X	
6.1.3.	Review existing public health laws, regulations, and ordinances at least once every three to five years?			X		
6.1.4.	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?				X	
6.2.1.	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?				X	
6.2.2.	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?				X	
6.2.3.	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?				X	
6.3.1.	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?				X	
6.3.2.	Ensure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?				X	

Essential Service 6		No Activity	Minimal	Moderate	Significant	Optimal
6.3.3.	Ensure that all enforcement activities related to public health codes are done within the law?				X	
6.3.4.	Educate individuals and organizations about relevant laws, regulations, and ordinances?					X
6.3.5.	Evaluate how well local organizations comply with public health laws?			X		

Strengths	Weaknesses	Short Term Opportunities	Long Term Opportunities
<ul style="list-style-type: none"> Organized in the fashion of coalitions and grass root movements Adept in policy Hard working individuals that care about others and do what they can for the community PPHD is data savvy and data driven for decision Comprehensive view of what public health is – homelessness, SUD, opioid use disorder Health system of collaborative spirit Tobacco has been phenomenal the resources are great – work to get policies changed Policies around Narcan and opioid epidemic policies are being put into place Meet people where they are - reduce barriers We are looked at for data – very helpful when it comes to policy Being looked at as Chief health strategist Education on policies ordinances Capacity for educating 	<ul style="list-style-type: none"> Capitalism vs. public health 12 lobbyists vs 3 on public health side Funding limitations Helping people understand policy and the importance of them is difficult Conservative climate Find the common ground Public health law is a very comprehensive term affecting many levels – how do you affect at the city level 	<ul style="list-style-type: none"> Better or stronger understanding how well we evaluate what we do – it can take decades to see a long term impact – what does that mean 	<ul style="list-style-type: none"> Change in political Finding the sag way/middle ground to say our children are important because – they mean something because. Speak to the community why policy level decisions are important priorities

Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable

Linking people to needed personal health services and assuring the provision of healthcare when otherwise unavailable (sometimes referred to as outreach or enabling services) encompass the following:

- Ensuring effective entry for socially disadvantaged and other vulnerable persons into a coordinated system of clinical care.
- Providing culturally and linguistically appropriate materials and staff to ensure linkage to services for special population groups.
- Ensuring ongoing care management.
- Ensuring transportation services.
- Orchestrating targeted health education/promotion/disease prevention to vulnerable population groups.

Partners: Box Butte General Hospital, Morrill County Community Hospital, Panhandle Public Health District, Aging Office of Western Nebraska, Western Community Health Resources, Chadron Community Hospital, Sidney Regional Medical Center

Essential Service 7		No Activity	Minimal	Moderate	Significant	Optimal
7.1.1.	Identify groups of people in the community who have trouble accessing or connecting to personal health services?				X	
7.1.2.	Identify all personal health service needs and unmet needs throughout the community?			X		
7.1.3.	Defines partner roles and responsibilities to respond to the unmet needs of the community?			X		
7.1.4.	Understand the reasons that people do not get the care they need?			X		
7.2.1.	Connect or link people to organizations that can provide the personal health services they may need?				X	
7.2.2.	Help people access personal health services in a way that takes into account the unique needs of different populations?			X		
7.2.3.	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?				X	
7.2.4.	Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?			X		

Strengths	Weaknesses	Short Term Opportunities	Long Term Opportunities
<ul style="list-style-type: none"> • Relationship and communication between the hospital and Public Health • Acknowledging we are not getting all the care to all the people who needed – looking for change and opportunities to improve • Very strong hospital leadership that understand community services that are needed • Because they acknowledge they have needs that aren't meet they are comfortable talking to each other to get ideas • Assure population needs for specific populations – stay general – so rural hard to think specific 	<ul style="list-style-type: none"> • Competing priorities • We don't know what we don't know – such as what certain groups can assess • Resources to meet the needs • Assure population needs for specific populations – stay general – so rural hard to think specific 	<ul style="list-style-type: none"> • Promote what is available better – you don't know it exists until you need it. • Keep it in front of consumers what is available – could do this better • Partner resource directory – watch out for catchy names – just say what your service is • Remember to communicate services internally and externally to partners and clients 	<ul style="list-style-type: none"> • Continue to build on unusual partnerships- or partners that haven't worked together like community table – business, hospital, community all working together to sustain – grass route entrepreneurial opportunities • Working with the community – where are we missing the boat?

Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce

Ensuring a competent public and personal healthcare workforce encompasses the following:

- Educating, training, and assessing personnel (including volunteers and other lay community health workers) to meet community needs for public and personal health services.
- Establishing efficient processes for professionals to acquire licensure.
- Adopting continuous quality improvement and lifelong learning programs.
- Establishing active partnerships with professional training programs to ensure community-relevant learning experiences for all students.
- Continuing education in management and leadership development programs for those charged with administrative/executive roles.

Partners: Panhandle AHEC, Sidney Regional Medical Center, UNMC College of Dentistry, Chadron State College, Panhandle Partnership, Rural Nebraska Healthcare Network

Essential Service 8		No Activity	Minimal	Moderate	Significant	Optimal
8.1.1.	Complete a workforce assessment, a process to track the numbers and types of LPHS jobs—both public and private sector—and the associated knowledge, skills, and abilities required of the jobs?		X			
8.1.2.	Review the information from the workforce assessment and use it to identify and address gaps in the LPHS workforce?		X			
8.1.3.	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?		X			
8.2.1.	Ensure that all members of the local public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and comply with legal requirements?		X			
8.2.2.	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the 10 Essential Public Health Services?		X			
8.2.3.	Base the hiring and performance review of members of the public health workforce in public health competencies?		X			
8.3.1.	Identify education and training needs and encourage the public health workforce to participate in available education and training?		X			

Essential Service 8		No Activity	Minimal	Moderate	Significant	Optimal
8.3.2.	Provide ways for public health workers to develop core skills related to the 10 Essential Public Health Services?		X			
8.3.3.	Develop incentives for workforce training, such as tuition reimbursement, time off for attending class, and pay increases?		X			
8.3.4.	Create and support collaborations between organizations within the LPHS for training and education?			X		
8.3.5.	Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?		X			
8.4.1.	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?		X			
8.4.2.	Create a shared vision of community health and the LPHS, welcoming all leaders and community members to work together?		X			
8.4.3.	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?		X			
8.4.4.	Provide opportunities for the development of leaders who represent the diversity of the community?		X			

Strengths	Weaknesses	Short Term Opportunities
<ul style="list-style-type: none"> • Trainings are being conducted • Sometimes resources are limited, trying to maximize what you can do with the resources you have • AHEC teaches Social Determinants of Health • AHEC Scholars program Social Determinants of Health is mandatory 	<ul style="list-style-type: none"> • Doesn't seem like there is any structure in place or groups that do these assessments. • Not enough trainings or workshops • Communication, sometimes it is not knowing what's going on 	<ul style="list-style-type: none"> • Communication • Always an opportunity, didn't know PPHD was offering a sealant program, UNMC didn't know, didn't get through to the local area, breakdown can create gap

Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

Evaluating effectiveness, accessibility, and quality of personal and population-based health services encompasses the following:

- Assessing program effectiveness through monitoring and evaluating implementation, outcomes, and effect.
- Providing information necessary for allocating resources and reshaping programs.

Partners: PPHD Leadership Team

Essential Service 9		No Activity	Minimal	Moderate	Significant	Optimal
9.1.1.	Evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?					X
9.1.2.	Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?			X		
9.1.3.	Identify gaps in the provision of population-based health services?				X	
9.1.4.	Use evaluation findings to improve plans, processes, and services?				X	
9.2.1.	Evaluate the accessibility, quality, and effectiveness of personal health services?			X		
9.2.2.	Compare the quality of personal health services to established guidelines?				X	
9.2.3.	Measure user satisfaction with personal health services?			X		
9.2.4.	Use technology, like the Internet or electronic health records, to improve quality of care?				X	
9.2.5.	Use evaluation findings to improve services and program delivery?			X		
9.3.1.	Identify all public, private, and voluntary organizations that contribute to the delivery of the 10 Essential Public Health Services?				X	
9.3.2.	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to the delivery of the 10 Essential Public Health Services?				X	

Essential Service 9		No Activity	Minimal	Moderate	Significant	Optimal
9.3.3.	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?				X	
9.3.4.	Use results from the evaluation process to improve the LPHS?			X		

Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems

Researching new insights and innovative solutions to health problems encompasses the following:

- Establishing full continuum of innovation, ranging from practical field-based efforts to fostering change in public health practice to more academic efforts that encourage new directions in scientific research.
- Continually linking with institutions of higher learning and research.
- Creating internal capacity to mount timely epidemiologic and economic analyses and conduct health services research.

Partners: PPHD Leadership Team

Essential Service 10		No Activity	Minimal	Moderate	Significant	Optimal
10.1.1.	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?			X		
10.1.2.	Suggest ideas about what currently needs to be studied in public health to organizations that conduct research?		X			
10.1.3.	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?					X
10.1.4.	Encourage community participation in research, including deciding what will be studied, conducting research, and sharing results?			X		
10.2.1.	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?			X		
10.2.2.	Partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?			X		
10.2.3.	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?		X			
10.3.1.	Collaborate with researchers who offer the knowledge and skills to		X			

Essential Service 10		No Activity	Minimal	Moderate	Significant	Optimal
	design and conduct health-related studies?					
10.3.2.	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?		X			
10.3.3.	Share findings with public health colleagues and the community broadly, through journals, web sites, community meetings, etc.?		X			
10.3.4.	Evaluate public health systems research efforts throughout all stages of work from planning to effect on local public health practice?		X			

Strengths	Weaknesses	Long Term Opportunities
<ul style="list-style-type: none"> • We believe in the scientific process of research; not our priority, not wasting resources on it if it's not a priority; we stay up on the latest best practices especially on new topics; written up in the community guide for using it! We know where to go to find the latest and best info, we don't have to develop it • Good relationship with UNMC and CSC, UNK – mutual respect for credibility; we focus our resources on implementation • We would allocate resources to it if we did it, but it's not a priority right now 	<ul style="list-style-type: none"> • Don't have time/talent/resources for true research; could develop if it was our priority; the work we are doing isn't true research from an academic stance • We don't have the capacity for true research involvement • Limited number of research opportunities 	<ul style="list-style-type: none"> • Continuous communication with academia (UNMC) for opportunities. • Internships with colleges, brainstorming, sharing across LHDs