Osmond General Hospital

Community Health Needs Assessment

2013

406 North Maple- Osmond NE 68765

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1. EXECUTIVE SUMMARY

The North Central District Health Department (NCDHD) is a state-approved district health department that provides a broad array of services to its service area. The NCDHD serves nine rural Nebraska counties – Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Rock and Pierce – that cover 14,455 square miles. The NCDHD has been state-approved as a multi-county public health department, a government body at the county level, since December 2001, providing education and services to the nine-county area. The NCDHD started out in 1999 as a nine-county community public health coalition, North Central Community Care Partnership (NCCCP), covering the same counties it does today as governmental public health department. NCCCP was instrumental in aligning all nine counties, with their elected officials, to sign an inter-local agreement, joining all nine counties together as a single governmental department. NCCCP continues to be vibrant today, working as a public health coalition for the NCDHD. In 2007 the Board of Health for the NCDHD voted to recognize NCCCP as the official strategic planning partner of NCDHD and its nine counties.

NCDHD is well recognized locally and state wide for its community health assessment, planning and implementation work. This is the third assessment and planning process completed in our nine counties since 1999; the first one completed by NCCCP and the last two directed under the guidance of NCDHD. The district has worked through many components of the Mobilizing for Action through Planning and Partnership (MAPP) process as this has been the guiding plan used by NCDHD and NCCCP. As this the third process assessment and planning the district has completed, it has been designed to be broader than either of the first two iterations and has been done to meet not only the Community Health Needs Assessment of the district, but also to meet the needs of the area hospitals, eight of which must comply with new Internal Revenue Service requirements.

2. PLAN OWNERSHIP

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

There are many reasons why, in our third process of community needs assessment and planning, it was logical for the North Central District Health Department to partner with the eleven district hospitals to complete a joint Community Health Improvement Plan (CHIP). The major reason is to improve overall community health through the assistance of multiple partners. Additional reasons for collaboration exist: eight of our eleven local hospitals are now required to complete both a Community Health Needs Assessment and Community Health Improvement Plan to meet IRS requirements to maintain their non-profit status. Those hospitals are:

Antelope Memorial Hospital, Neligh, NE (Antelope County)
Avera Creighton Hospital, Creighton, NE (Knox County)
Avera Saint Anthony's Hospital, O'Neill, NE (Holt County)
Osmond General Hospital, Osmond, NE (Pierce County)
Plainview Community Hospital, Plainview, NE (Pierce County)
Tilden Community Hospital, Tilden, NE (Antelope County)

Niobrara Valley Hospital, Lynch, NE (Boyd County)
West Holt Memorial Hospital, Atkinson, NE (Holt County)

While the other three hospitals are not required to complete a Community Health Needs Assessment or Community Health Improvement Plan, working with them to create community-specific plans will help to make NCDHD's overall Community Health Improvement Plan more meaningful. Those hospitals are:

Brown County Hospital, Ainsworth, NE (Brown County)
Cherry County Hospital, Valentine, NE (Cherry County)
Rock County Hospital, Bassett, NE (Brown County)

Some of the major drivers toward a new, higher level of collaboration between the health department and the hospital include:

1. Nebraska State Statutes

   Nebraska Statutes under 71-1628.04 provide guidance on the roles public health departments must play and provide the following four of ten required elements which fit into the public health role in the Community Health Improvement Plan.

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

2. A History of Working Together on Previous Community Improvement Plans

   The North Central Community Care Partnership (NCCCP) set the groundwork for public health assessment in our nine counties by completing a Community Health Needs Assessment and developing a community improvement plan in 1999. In that year, NCCCP worked collaboratively with many public health partners, including our local hospitals, and contracted with Tripp Umbach & Associates, Inc. to complete a random sample community health needs assessment. Since then, North Central District Health Department (NCDHD) has been using the MAPP process, and/or components thereof, to meet the requirements of the Nebraska Statute. The NCCCP and NCDHD have worked to involve all the hospitals in its service area in this process since 1999. Thus, we have three assessment processes and have benchmarks to measure against.

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

   The historic passage of the Patient Protection and Affordable Care Act (PPACA) has called on non-profit hospitals to increase their accountability to the communities they serve. PPACA creates a new Internal Revenue Code Section 501(r) clarifying certain responsibilities for tax-exempt hospitals. Although tax exempt hospitals have long been required to disclose their community benefits, PPACA adds several new requirements.

   Section 501(r) requires a tax-exempt hospital to:

   - Conduct a community health needs assessment every 3 years
     - The assessment must take into account input from persons who represent the broad interests of the community served, especially those of public health
   - Develop an implementation plan and strategy that addresses how a hospital plans to meet EACH of the health care needs identified by the assessment
     - This plan must be adopted by the governing body of the organization, and must include an explanation for any assessment findings not being addressed in the plan
   - Widely publicize assessment results

   As mentioned earlier, this requirement affects eight of the eleven hospitals in the NCDHD service area.

4. Redefinition of Hospital Community Benefit

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

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

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

5. Public Health Accreditation Requirements

   In July of 2011, the Public Health Accreditation Board (PHAB) released the first public health standards for the launch of national public health department accreditation. All local health departments (LHDs) must have completed a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PHAB Version 1.0 has standards that require the LHD to:

   - Participate in or conduct a collaborative process resulting in a comprehensive community health assessment
   - Collect and maintain reliable, comparable and valid data
   - Conduct a process to develop community health improvement plan
   - Produce a community health improvement plan as a result of the community health improvement process
   - Implement elements and strategies of the health improvement plan in partnership with others
   - Analyze public health data to identify health problems that affect the public's health
   - Provide and use the results of the health data analysis to develop recommendations regarding public health policy, processes, programs or interventions

3. PLANNING PROCESS

MAPP: The evidenced-based process used for the CHNA and CHIP
North Central District Health Department has been responding to the need for community assessments using the Mobilizing for Action through Planning and Partnership (MAPP) process. The MAPP process was developed by and is recommended for community assessment by the National Association of City and County Health Officials (NACCHO) and Centers for Disease Control (CDC). MAPP was also recommended by the Nebraska Rural Health Association in its *"Community Health Assessment Collaborative Preliminary recommendations for Nebraska's community, nonprofit hospitals to comply with new requirements for tax exempt status enacted by the Patient Protection and Affordable Care Act"* (September of 2011).

MAPP was chosen, in part, because the process allows for input from parties who represent broad interests in the communities. Input from diverse sectors involved in public health, including medically underserved, low-income, minority populations and individuals from diverse age groups, was obtained through surveys and targeted focus groups by way of invitations to community leaders and agencies.

Many of the 11 hospitals in this nine-county area have participated with the previous assessments. During this third iteration of the MAPP process, NCDHD served as the lead agency with support from all hospitals through both personnel and financial resources.

Understanding MAPP

MAPP involves gathering together multiple community stakeholders for a shared assessment, strategic planning, and implementation process. The MAPP cycle has well defined steps and processes to capture community input and move a community or organization to make positive changes.

4. COMMUNITY HEALTH NEEDS ASSESSMENT METHODOLOGY AND PROCESS

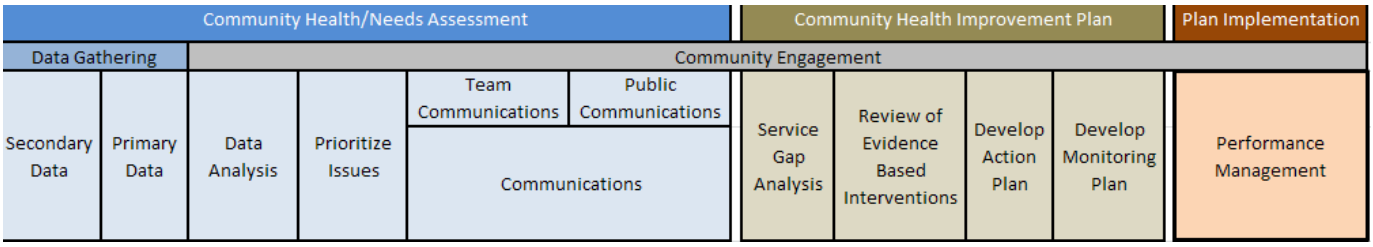
Gathering Data

In looking at the plan process template below, it can be seen that data gathering is the first step in completing the CHNA. Data gathering was accomplished using the four MAPP model assessments and included both primary and secondary data sources.

The Community Health Needs Assessment (CHNA) has been completed three times since 1999, with the most recent assessment completed by October of 2012. The most recent assessment findings are available online for public review at www.ncdhd.ne.gov.

The table below can serve as a summary of the process used in planning the joint CHNA and joint CHIP for the NCDHD, 11 area hospitals, and other district partners. As you can see, the plan involves three major themes: the Community Health Needs Assessment (CHNA), the Community Health Improvement Plan (CHIP) and the Plan Implementation. Various activities that are part of the overall process appear under each section.

It is important to note that Community Engagement is an overarching concept encompassing the majority of the CHNA and CHIP process and will be discussed under each area. Community Engagement was also a major part of the data gathering process.



The first assessment is the Community Themes and Strengths Assessment which is a subjective look at how the community views their health to capture the perceived needs of the community. This assessment ranks high for community involvement. This step was completed through focus groups in the counties, as well as telephone surveys conducted by the state of Nebraska. The data for this assessment was collected over a six-month period and included 500 written and/or 500 telephone surveys.

The second assessment is the Forces of Change assessment. This assessment is done in one town hall-style meeting to capture the community's perception of current trends affecting the health of the community.

North Central Community Care Partnership (NCCCP) conducted a "Forces of Change" session. NCCCP members brainstormed what forces of change exist outside of the control of individuals in their communities. These are the things that affect the local health system of the community. They looked at social, economic, political, technological, environmental, scientific, legal and ethical issues. The group discussed the trends, events and factors that affect the community and identified a significant number of forces of change:

- Insurance issues
- Health reform
- Lack of medical specialists
- Lack of understanding rural issues
- Population isolation
- Loss of jobs
- Technology gaps
- Pipeline
- Water issues
- Government regulations
- Change in moral values
- Air quality issues
- Noise pollution

- Skin cancer
- Grant and budget cuts
- Lack of affordable quality housing
- Lack of activities for youth
- Increasing elderly population
- Migration of gangs and increasing drug issues
- Language barriers
- Outside corporations buying land
- Community apathy
- Increase in natural disasters
- Cost of gasoline
- Merging of school systems
- Decreasing retirement resources
- Higher taxes
- Disposable society
- Increase of on-line education
- Loss of social skills
- Cyber bullying
- Decreasing sense of accountability
- Lack of trust and respect
- Lack of dollars to improve structure of older buildings

The third assessment is the Community Health Status Assessment. This assessment provides data from the federal government (such as Census data), state (such as vital statistic data), and NCDHD as a district health department (such as immunization rates for the district or parental views on substance abuse). Data gathered for compilation came from many sources, including national surveys such as the Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, US Census, and Youth Protective Factor Survey. In total there are around 30 sources of data: community profiles, access to health care/quality of life, mental health, physical health, health risk factors, social programs, and crime. Data collected represents every age group from prenatal to elderly.

Community Involvement in Data Gathering

The MAPP process currently underway is the most thorough assessment to date, and involves the most participants to date with more than 100 individuals participating thus far. This number does not include the 1,000 individuals surveyed or those who took part in focus groups.

The Community Health Needs Assessment – A Stand-Alone Document

To accomplish the health and quality of life improvement goal, community health surveys were distributed to 5,000 randomly selected households (proportionate to county population) in north-central Nebraska. This household health survey reveals information about the health and risk behaviors of the residents of the study area that is not available from other sources. It also allows the NCDHD to look at sub-groups within the area to identify groups with the greatest need. The survey was initially sent to

selected households via two mailings of postcards and provided the option for selected participants to take the survey online. A second set of mailings was sent to the group of randomly selected households. This mailing provided a hard-copy survey to complete with return postage paid, and excluded those households that had already completed the survey online. 1,774 completed surveys were recorded for an overall response rate of 35%.

MAPP process adapted from previous iterations

In the past, NCDHD completed community health needs assessments, community health improvement plans and NCDHD strategic plans every five years. The first cycle was completed in 2000 and the second cycle in 2006. This planning process has been essential in driving forward the work of the department and the strategic plans have been actively and regularly reported on to the governing board of NCDHD. This third MAPP process differs significantly from the first two processes in many ways. While NCDHD was due for a repeat of the three tiered process in 2012, the process will now occur every three years instead of every five years. This will require the department to become more efficient at the gathering of data for the Community Health Needs Assessment (CHNA). Previously, the entire cost of the CHNA has been borne by the NCDHD. For the current planning process, the local hospitals have shared in the planning and cost. While NCDHD has always worked with district hospitals as one of many planning partners on past CHIP efforts, this is the first time hospitals shared a responsibility with NCDHD for the development and implementation of the CHIP plans. In the past, the primary ownership of the CHIP rested with the NCDHD. Ownership of the plan is now shared between district hospitals and NCDHD, with NCDHD maintaining primary ownership and serving as a collaborative partner and technical consultant.

Special knowledge or expertise for MAPP and CHIP processes

Roger Wiese, the NCDHD Executive Director, has participated in a national effort to strengthen and transform public health through Collaboration for a New Century in Public Health: Turning Point Collaborative. NCCCP has been recognized by the National Association of City and County Health Officials (NACCHO) for the collaborative role they have played in the advancement of public health assessments. NCCCP was part of 41 communities awarded support from NACCHO, the Robert Wood Johnson Foundation and the W.K. Kellogg Foundation to develop a Turning Point: A New Collaboration In Public Health. This process was completed in March, 2003.

5. COMMUNITY DESCRIPTION AND DEMOGRAPHIC DATA

5A. OVERALL DISTRICT DEMOGRAPHICS

The community of North Central District Health Department is located in a very rural area in the north-central region of Nebraska. Our community outreaches throughout a 14,455 square mile area and includes the nine counties of Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce and Rock.

There are an estimated 45,135 people living in this north-central Nebraska community, allowing this area population to commune as 3.1 people per square mile. The median age of the people in our community is 45.6 years, and consists of mostly White at 88.3%, followed by 8.4% Hispanic or Latino and 4.3% Black or African American.

The median household income of our rural community is $37,938 and the per capita income is $28,482. The educational attainment level of the people here is at 88.5% as high school graduates for the percent of persons age 25+ and the percent of persons with less than a 9th grade education is at 7.7% in this community.

Other interesting facts:

- The land area of the district comprises one-fifth (19%) of the land area of Nebraska, while their population is 2.5% of the state population.
- Like much of rural Nebraska, the population in the district is declining, 11.4% in the last decade, and it is aging.
- Nearly one-third of the health district population is in the 45-64 age demographic, compared to 25% for Nebraska.
- One in five persons in the district is over the age 65 (NCDHD, 20%; NE, 13%).
- Just under half (49%) of the health district population is under the age 45, compared to nearly two-thirds (61%) for Nebraska.

5B. COUNTY-SPECIFIC DEMOGRAPHICS

North Central District Health Department Community Demographics									
County	**Population**	**Population by Gender Male**	**Population by Gender Female**	**Population Density**	**Median Age**	**Population Age: 0-24**	**Population Age: 25-64**	**Population Age: 65-84**	**Population Age: 85+**
Antelope	6,652	3,294	3,358	7.7	45.0	2,127	3,146	1,121	258
Boyd	2,063	1,002	1,061	3.9	46.9	566	994	408	95
Brown	3,062	1,515	1,547	2.5	47.5	859	1,477	588	138
Cherry	5,474	2,744	2,730	0.9	42.9	1,682	2,773	842	177
Holt	10,011	4,922	5,089	4.2	45.5	3,227	4,731	1,651	402
Keya Paha	802	395	407	1	45.4	231	389	153	29
Knox	8,378	4,089	4,289	7.6	45.5	2,620	3,886	1,488	384
Pierce	7,184	3,623	3,561	12.5	41.5	2,467	3,574	931	212
Rock	1,509	741	768	1.5	50.2	382	789	272	66
NCDHD	45,135	22,325	22,810	3.1	45.6	14,161	21,759	7,454	1,761
Nebraska	1,796,619	891,652	904,967	23.8	36.2	648,434	907,555	201,086	39,544
Data source: Community Health Assessment Measures, 2010, Nebraska Department of Health and Human Services									

6. DATA ANALYSIS, PUBLIC HEALTH DATA AND INDICATORS

North Central District Health Department contracted with Dr. Joseph Nitzke, PhD of Ionia Research, to review and publish an analysis of the district's data. The "Report Analysis and Comments Public Health Data (PHAN)" document has been prepared for NCDHD using Public Health Agencies of Nebraska (PHAN) data as the primary source. The intent is to summarize trends in data and differences between the counties served by NCDHD and the rest of the state of Nebraska.

The observations within the report are based on the application of formulas to evaluate "dependent crude rates/ratios" (Crude Rate Analysis), comparing the NCDHD district rates or percentages for an indicator with those of the state to determine whether or not those differences are significant. These observations are also placed in the context of other reports where appropriate, including the Behavior

Risk Factor Surveillance System (BRFSS 2007-2008), the 2005 Data Book produced by the Nebraska Health Information Project, prior assessments, and state profiles.

7. COMMUNITY INVOLVEMENT / PLAN DEVELOPMENT PARTICIPANTS

Involvement of community members from several entities was key to the success of the overall process and plan development. An effort was made to involve community members during each step of the planning process. Entities that were invited to meetings included hospitals, physicians, dentists, community action agencies, law enforcement, social services, mental health providers, senior care services, schools, media, city/county officials, representatives of minority populations, clergy, Nebraska Department of Health and Human Services and other community-based services. The community members were contacted via mail, email and telephone prior to each step of the process to invite and encourage their participation in the planning process.

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

- Ainsworth Community Schools
- Alegent Creighton Health/Plainview
- Antelope County Supervisors
- Antelope Memorial Hospital
- AseraCare
- Avera Creighton Hospital
- Avera St. Anthony's Hospital
- Avera St. Anthony's Mission Services
- Boyd County Ambulance
- Boyd County Sheriff's Department
- Bright Horizons
- Brown County Hospital
- Building Blocks and Counseling Enrichment
- Cherry County Hospital
- Cherry County Sheriff's Department
- Central Nebraska Community Services
- Counseling & Enrichment Center
- Creighton Community School
- Dietician
- Early Development Network
- Emmanuel Lutheran Church – Tilden
- Faith Regional Health Services

- Heartland Counseling
- Jacy's Grace Home Health
- Mayor of O'Neill
- North Central Community Cares Partnership
- North Central District Health Department
- NCDHD Board of Health members
- Nebraska Department of Health and Human Services
- Nebraska State Patrol
- Niobrara Valley Hospital
- O'Neill Police Department
- O'Neill Public Schools
- Osmond General Hospital
- Pierce County Commissioner
- Prairie View Assisted Living
- Region 24 Emergency Management
- Region 4 Behavioral Health System
- Rock County Hospital
- Santee Health Clinic
- St. Mary's High School
- Tilden Community Hospital
- Trinity Lutheran Church
- UNL Extension in the Brown-Keya Paha-Rock counties
- Valentine Dental Clinic
- West Holt Memorial Hospital
- Community members / by invite

8. COMMUNITY HEALTH IMPROVEMENT PLANNING

8A. OCTOBER 2012 MEETING

A Community Health Improvement Planning meeting was held on October 12, 2012 at the O'Neill Country Club. The purpose of this meeting was to pull together a diverse group of individuals from several entities representative of our nine county district to review the data for the district, which included the community health needs assessment and secondary data from multiple assessment sources. Participants referred back to the data that was presented (see appendix) as they engaged in the strategic planning process. Dr. Joe Nitzke of Ionia Research provided an executive summary of the community health assessment and the secondary data. Deb Burnight of Burnight Facilitated Resources facilitated the process of identifying focus areas and priority issues, and guided the strategic planning sessions in the afternoon.

Community members were invited to this planning meeting via email through a list developed in the NCDHD database. Entities that attended included: NCDHD, NCCCP, NCDHD Board of Health members, UNL Extension in the BKR counties, Avera St. Anthony's Hospital, Alegent Creighton Health/Plainview, Region 4 Behavioral Health System, CNCS, Osmond General Hospital, Heartland Counseling, Region 24 Emergency Management, Antelope Memorial Hospital, Early Development Network, Brown County Hospital, Niobrara Valley Hospital, Bright Horizons, O'Neill Public Schools, Tilden Community Hospital, Nebraska State Patrol, Antelope County Supervisors, West Holt Memorial Hospital, Building Blocks and Counseling Enrichment, Faith Regional Health Services, AseraCare, Nebraska Department of Health and Human Services, and Jacy's Grace Home Health.

The agenda for the CHIP meeting was:

- Registration
- Welcome & introductions
- Presentation of executive summary and secondary data
- Focus areas determined
- Priorities developed for each focus area
- Strategic planning group sessions
- Adjourn

Following the time for networking, registration and breakfast, Roger Wiese, Executive Director for North Central District Health Department welcomed the participants to the session and provided background information about the CHIP process. Participants also introduced themselves and the agencies that they represented. Joe Nitzke was introduced and provided an overview of the community health assessment executive summary, which was emailed to invitees prior to the meeting, as well as secondary data that included selected data from community surveys, PHAN, BRFSS and Vital Statistics. Participants were provided with a worksheet so that during the presentation they could list major health problems or high-risk behaviors that were noticed and how the data to show these problems/behaviors were an issue.

After the data set was presented (see appendix), the entire group of participants worked together listing the issues they felt to be most important. Each table would decide upon the top five most critical priorities based on the data presented, the conversations they had been having throughout the day and the focus areas. A "sticky wall" was utilized during the process and every table brought their priorities to the "sticky wall". Once all priorities were on the wall, the group was able to identify common issues. All of the common issues were then placed together on the wall.

Participants at each table talked through the priorities listed on the wall and determined how they would prioritize the issues that were listed. Prioritization was based on issues that are doable/achievable, issues that address a critical need, resource availability – both human and financial, and those that could provide a community focus. Each participant was given dot stickers and asked to place their dots on the issues that were of the most concern to them.

A discussion was held about how many strategic areas the CHIP group could manage effectively. The participants then decided to choose five (5) focus areas around which to mobilize collaborative action over the next three years (with the understanding that other issues may be able to feed into the priority issues) or may be chosen in three years when the next planning process occurs.

IDENTIFIED PRIORITY NEEDS

In general, the CHIP group felt that it was important to not lose any of the priority issues, too many areas may dilute the entire process and make it less effective. The group determined that four broad focus areas would be adequate to cover the major health problems and high-risk behaviors discussed, and several priorities would be listed within each focus area. The identified community health needs led to the creation of the following focus areas (priorities related to each focus area are listed below the respective heading):

Access to Care / Cancer Prevention and Education

- **Access to affordable health care**
- **Health care for all**
- **Flu vaccination (general)**
- **Rx assistance**
- **Immigrant population**
- **Dental care**
- **Vision**
- **Colon cancer**
- **Colorectal screening**
- **Prostate screening**
- **Need increased mammography screening**
- **Preventative screening across all cancers**

Behavioral Health – Mental Health and Substance Abuse

- **Stress management**
- **Lack of mental health services and payment**
- **Mental health access**
- **Mental health (providers, awareness, low reimbursement)**
- **Tobacco use**
- **Alcohol use across lifespan**
- **Alcohol (Youth)**
- **Substance abuse – alcohol (binge), prescription drugs, tobacco**
- **Binge drinking**

Chronic Disease, Obesity, and Related Health Concerns

- **Cardiovascular, heart disease, stroke**
- **Cardio, CPR, response time, education, confusion**
- **Lack of exercise**
- **Weight issues (BMI)**
- **Over-weight & obesity**

Environment & Safety

- **Bike helmet usage**
- **Farm / agriculture safety**
- **Texting and driving**
- **Child safety seats**
- **Radon**
- **Domestic violence and child abuse**
- **Environmental issues in community**

Once the focus areas were decided upon, individuals selected a focus area that was of interest to them and the larger group then divided up into focus area groups. Each table focused on their topic of interest and associated priorities. The groups listed current resources to address the priorities, completed a gap analysis to identify where there were gaps and listed the benefits of addressing the priorities.

Prior to adjourning, it was discussed that community focus group meetings would be held in December and January to determine if there were other issues community members were aware of that needed to be addressed in the strategic planning sessions.

8B. NOVEMBER 2012 – JANUARY 2013 COUNTY FOCUS GROUP MEETINGS

The next step in the planning process was to conduct county focus group meetings. Ten (10) meetings were held between November 2012 and January 2013. Invitations were sent to attendees of the October 2012 meeting, along with other community members from each specific county. A written invitation was sent, followed by emails and phone calls.

The agenda for the county focus group meetings was:

- Introductions
- Past planning meetings
- Executive summary of Community Health Assessment Survey
- Secondary Data Executive Summary
- Community Health Improvement Plan
- Priorities
- Next Steps

County meetings were held on the following dates:

- Knox County – November 26, 2012
- Holt County – O'Neill – November 27, 2012
- Antelope County – Tilden – December 17, 2012
- Antelope County – Neligh – December 17, 2012

- Cherry County – December 18, 2012
- Brown County – December 18, 2012
- Boyd County - December 19, 2012
- Holt County – Atkinson – December 19, 2012
- Pierce County – December 20, 2012
- Rock County – January 10, 2013

Introductions were completed at each county focus group meeting. Roger Wiese, Executive Director with North Central District Health Department discussed the past planning efforts and how NCDHD had gotten to the point of conducting county focus group meetings. An executive summary and secondary data summary were presented and discussed. Information that was developed at the October 2012 CHIP meeting was presented and attendees from each county discussed other topics they felt were evident in their communities. These additions and comments were placed into documents and a summary was developed to use in future planning efforts. See appendix for county focus group meeting notes.

8C. FEBRUARY – MARCH 2013 STRATEGIC PLANNING SESSIONS

Following the community health improvement planning meeting held in October 2012 and county focus group meetings held from November 2012 through January 2013, CHIP strategic planning sessions were held at the Blarney Stone restaurant on February 8 and March 7, 2013.

The agenda for these meetings included the following items:

1. Introductions
2. Overview
   a) History and purpose of community health assessment
   b) Summary of planning process thus far
   c) Development of SMART goals leading to objectives and action planning
3. Next steps
   a) Ongoing planning, creating objectives and action items

During these meetings, participants were updated with the process so far. This included a recap of the October CHIP meeting, during which participants chose areas of focus; followed by a recap of county focus group meetings. The February 8 meeting addressed the focus areas of Chronic Disease, Obesity, and Related Health Concerns and Behavioral Health – Substance Abuse and Mental Health. The meeting on March 7 addressed the focus areas of Access to Care / Cancer Prevention and Education and Environment and Safety. Data sheets with state and district data and Healthy People 2020 Objectives were provided for each focus area. Each group reviewed the data and began the process of forming goals and objectives for the public health system. The workgroups were asked to articulate goals, determine the baseline of data to support the need for the goal, and develop SMART (Specific, Measureable, Achievable, Realistic, Time-Bound) objectives. The challenge for each group was to consider the focus area in terms of the entire nine (9) counties rather than setting goals and objectives specific to a county or facility. Participants in each focus area discussed how they would choose the

priority issues, agreeing to participate in subsequent meetings to accomplish this and further develop key strategies and activities. These meetings will be accomplished via Telehealth, telephone conference calls and/or face to face meetings. Workgroups will accomplish their work independently of the large group, with each group determining the frequency they will meet to keep the plan moving forward. Additional work completed by these groups to fine-tune objectives and establish action items will address policy change. Workgroups are encouraged to meet at least quarterly to continue planning and progress updates. The workgroups will be led by NCDHD staff and community partners. Participants are encouraged to invite other key individuals that may be interested in the focus area and bring additional perspective.

Work groups at the February and March strategic planning sessions were established by asking participants to choose their focus area of interest. Work group members, along with goals and objectives identified for each focus area are listed in the Implementation Plan section of this document.

WORKGROUP TEAM MEMBERS

Attendees were asked to choose their focus area of interest. Workgroups were then formed based on the chosen focus areas.

GOALS AND OBJECTIVES ESTABLISHED TO ADDRESS IDENTIFIED PRIORITY NEEDS

Chronic Disease, Obesity and Related Health Concerns

Goal 1: Improve the nutrition and weight status of all citizens in the nine counties defined by NCDHD.

Objective 1: Increase the proportion of schools that offer nutritious food and beverage options outside of school meals.
Objective 2: Increase the proportion of children and adolescents who do not exceed recommended limits for screen time (electronics).
Objective 3: Reduce the proportion of adults who engage in no leisure time physical activity.

Goal 2: improve access to diabetes education and screening to all people in the counties defined by NCDHD.
Objective 1: Increase prevention behaviors in persons at high risk for diabetes with prediabetes.
Objective 2: Increase the proportion of persons with diabetes whose condition has been diagnosed.
Objective 3: Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education.

Goal 3: Decrease the overweight and obese citizens in the counties defined by NCDHD.
Objective 1: Increase the proportion of primary care physicians who regularly measure the body mass index (BMI) in patients.

Objective 2: Increase the proportion of physician office visits that include counseling or education related to nutrition or weight.

Objective 3: Increase the proportion of community members who are educated in nutrition and weight issues.

Goal 4: Increase overall cardiovascular health in citizens in counties defined by NCDHD.

Objective 1: Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether or not it was normal or high.

Objective 2: Increase the proportion of adults who have had their blood cholesterol checked within the preceding 2-5 years.

Objective 3: Increase the proportion of adults ages 20 years and older who are aware of and respond to, early warning signs and symptoms of a heart attack.

Objective 4: Increase the proportion of adults ages 20 years and older who are aware of and respond to early warning symptoms and signs of a stroke.

Objective 5: increase the proportion of children who have had their blood pressure measured within the preceding 2 years.

Environment & Safety

Goal 1: Reduce the number of reported families living in unsafe environments.

Objective 1: identify and collect current, relevant data to establish a reference baseline.

Objective 2: Increase the number of communities that enforce safe housing standards.

Objective 3: Increase the number of household testing for radon, unsafe water, toxic chemicals, lead and mold in the home environment.

Objective 4: Increase education and events to improve family structure.

Goal 2: Reduce fatal and non-fatal incidents and injuries.

Objective 1: Identify and collect current, relevant data to establish reference baseline.

Objective 2: Reduce the incidence of inter-personal violence.

Objective 3: Reduce the number of people injured as a result of distracted driving.

Objective 4: Reduce the number of injuries of people over 65 years old, in their home environment.

Objective 5: Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity as reported by employers.

Goal 3: Reduce food-borne illnesses.

Objective 1: identify and collect current, relevant data to establish a reference baseline.

Objective 2: Reduce infections caused by key pathogens transmitted by food.

Objective 3: improve food safety practices associated with food-borne illness in food service, retail establishments and in the home.

Behavioral Health/Substance Abuse and Mental Health

Mental Health:

Goal 1: Increase access to therapeutic mental health services

Objective 1: Assist providers to become Medicaid/Medicare providers.
Objective 2: Determine what mental health services and resources are available and develop a database.
Objective 3: Program to get providers back here RHOP recruitment.
Objective 4: Screening tools for primary care settings to detect mental health issues/needs.
Objective 5: Education community and public health agencies on resource available.

Goal 2: increase the proportion of children with mental health problems who receive treatment.

Objective 1: Transportation
Objective 2: Providing treatment when it happens and knowing where to go.

Goal 3: Reduce the number of youth who have been bullied in the past 12 months.

Objective 1: identify what bullying is
Objective 2: identify

Goal 4: Reduce the suicide rate and attempts.

Objective 1: Determine what mental health services and resources are available and develop a database.
Objective 2: Screening tools for primary care settings to detect mental health issues/needs.
Objective 3: Educating community and public health agencies on resource available.
Objective 4: Education
Objective 5: Identify risk factors that lead to suicide attempts
Objective 6: identify tools for assessing risk for mental health issues for adolescents

Goal 5: Domestic and dating violence awareness and prevention.

Objective 1: Self advocacy skills for adolescents
Objective 2: provide education through schools, extension about recognition of what health relationships and personal boundaries are.

Substance Abuse

Goal 1: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.

Objective 1: Assess risk factors
Objective 2: Adult acceptance – cultural norm

Goal 2: Reduce the past-year nonmedical use of prescription drugs.

Objective 1: Reduce the availability of prescription drugs
Objective 2: Increase awareness for perceived risk
Objective 3: Investigate the options for having a stationary drug take-back location.

Goal 3: Reduce the past-year use of illegal substances.

Objective 1: oppose legalization of marijuana

Objective 2: Encouraging employers to do drug testing on employees

Goal 4: Tobacco use reduction.

- Increase the recognition for risks of smokeless tobacco

Objective 1: tobacco free workplace tools?

Access to Care

Goal 1: Increase the number of primary care physicians serving the NCDHD area.

Objective 1: Increase the percentage of medical providers that utilize telemedicine options.

Objective 2: Secure an adequate level of reimbursement for telemedicine utilization.

Goal 2: increase the number of employers that offer incentives for investment in the employee's health in the NCDHD area.

Objective 1: increase the percentage of employers that offer worksite wellness programs.

Goal 3: Increase the health literacy of residents in the NCDHD area.

Objective 1: Educate the residents as to the benefits of utilizing the health care system in the appropriate manner.

Goal 4: Increase the percentage of children and adults who are vaccinated annually against seasonal influenza in the NCDHD area.

Objective 1: Increase the percentage of pregnant women who are vaccinated against seasonal influenza.

Objective 2: Increase the percentage of health care personnel who are vaccinated annually against seasonal influenza.

Objective 3: Increase the percentage of children aged 6 months to 18 years who are vaccinated against seasonal influenza.

Objective 4: Increase the percentage of adults aged 18-64 years who are vaccinated against seasonal influenza.

Goal 5: Increase the percentage of adults who are vaccinated against pneumococcal disease.

Objective 1: Increase the percentage of non-institutionalized adults ages 65 years and older who are vaccinated against pneumococcal disease.

Objective 2: Increase the percentage of non-institutionalized high-risk adults aged 18-64 years who are vaccinated against pneumococcal disease.

Goal 6: Increase the percentage of children and adults who see a dentist yearly for preventative care in the NCDHD area.

Objective 1: Increase the proportion of low-income children and adolescents who received any preventative dental service during the past year.

Objective 2: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months.

Cancer Prevention & Education

Goal 1: Increase the percentage of men who visit their care provider for preventative care in the NCDHD area.

Objective 1: Increase the proportion of men who have discussed with their health care provider whether to have prostate-specific antigen (PSA) test and digital rectal exam (DRE) to screen for prostate cancer.

Goal 2: Increase the percentage of adults 50 years and older who are screened for colorectal cancer in the NCDHD area.

Objective 1: Increase the percentage of adults who were counseled about colorectal cancer screening.

Goal 3: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines in the NCDHD area.

Objective 1: Increase the number of women who self-report completing self-breast exams based on the most recent guidelines.

Objective 2: Increase the number of women who were counseled by their provider about mammograms.

Objective 3: Increase the number of women who receive mammograms according to recommendations/guidelines.

Goal 4: Increase the percentage of women who visit their health care provider for preventative care in the NCDHD area.

Objective 1: Increase the number of women aged 21-65 who are screened for cervical cancer according to current guidelines.

Objective 2: Increase the proportion of women who were counseled by their providers about Pap tests.

Goal 5: Increase education of skin cancer and sun safety to all residents in the NCDHD area.

Objective 1: Increase the proportion of children, adolescents and adults that receive education on sun safety and skin cancer prevention to promote personal health and wellness.

8D. NEXT STEPS

The Health Department has established individual teams to develop goals and implement strategies for each priority. Team leaders from the Health Department will be identified and commit to continued

service on each of the priority area teams. Each team leader is responsible for:

- Organizing a team which includes both field professionals and representative community members.
- Guiding the work of the team, including development of goals, logic model and work plan.
- Establishing metrics including measurable outcomes indicators.
- Assuring work is coordinated with other priority teams.
- Communicating appropriately with the community at large.

9. APPENDIX

NCDHD Community Health Improvement Planning

County Focus Group Meeting Notes – Summary of Corresponding Concerns

Comments from all county focus group meetings were reviewed to determine issues or concerns that came up in more than one location. Those concerns are captured in the list below. The following pages document all comments noted for each county focus group meeting.

Chronic Disease, Obesity and Related Health Concerns

- Education needed – prevention, nutrition, managing your chronic disease
- Diabetes concerns
    - Correlation between diabetes and heart disease, diabetes needs to be managed to prevent obesity or need for hospital care, lack of resources in place to assist with compliance
- School lunch concerns
    - Sometimes this is the only meal kids get, some kids don't eat at school, impact of school lunch regulations in relation to childhood obesity, there are calorie restrictions on school lunches

Behavioral Health – Substance Abuse

- Prescription drug abuse concerns
    - Significant need for electronic prescription medication database
- Elderly prescription concerns
    - Primarily attributed to education, medication management, or ability to take medications correctly
- Concerns with youth consumption of energy drinks
- Concerns with teen drinking or prescription drug abuse – learned behavior from parents or parental attitude/acceptance/environment does not serve to prevent
- Marijuana use increasing

Behavioral Health – Mental Health

- Access to care is most significant barrier – affordability, availability (lack of providers, facilities)
- Medication management or ability to afford medication leads to issues
- Emergency Protective Custody (EPC) issues
- Stigma prevents people from seeking care, especially in smaller communities
- Issues with being properly diagnosed

Access to Care

- Struggle with getting new providers (medical/dental/mental health) to come to rural areas, lack of providers who accept Medicaid
- Care for seniors and youth seem to suffer in smaller communities due to lack of services
- Access to care is related to economic situation
    - Affordability of health care, affordability/availability of in-home or nursing home care for elderly, gap between being able to afford care/insurance and not qualifying for Medicaid/Medicare, resources need to be available during food pantry hours, need more information about resources and charity care / free services
- Transportation is a big concern
- Insurance concerns – premium affordability, less adequate coverage, effect of health care reform, Medicaid/Medicare difficult to obtain and funds being cut
- Lack of medication/prescription availability
- Dental concerns
    - Dental health affects all aspects of a person's health, lack of financial resources to pay for own dental care
- Senior care concerns
    - Financial burden is a big concern, lack of resources/services, population is aging

Cancer Prevention and Education

- Focus is needed on education, awareness, and preventive measures

Environment and Safety

- Concerns about healthy home environments
    - Family values and morals have changed, family situations are different, quality family time needs to be important, child abuse/neglect is an issue, no follow-up or response to reports of abuse/neglect, truancy issues related to home environment
- Concerns over level of safety in schools
- Internet gives youth access to everything
- Lack of safe, affordable housing

County/Location: Antelope / Neligh

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• n/a
Behavioral Health	**Substance Abuse**	• Hospital does see some prescription drug abuse – need to have an electronic pharmacy registry to track when prescriptions are filled • Prescription med abuse in the elderly – don't take their medications properly: AMH has a lunch bag program that they have used that people bring their medications in to the clinic • Doesn't appear to be as much meth use as a few years ago • Marijuana is the gateway to meth use • Binge drinking is socially acceptable – parents do it so it is okay for their kids to do it
	Mental Health	• Many not able to get in to see counselors • Not a lot of services for adolescents • Have used Telehealth in the past for counseling services • Many are not able to afford mental health services
Access to Care		• Senior care is a burden on the health care system • Seniors lack money and often don't get proper nutrition • Not many places that provide services for the elderly and if they do they are very expensive and they can't afford it • Many schools with limited school nursing hours – they are unable to provide education on nutrition, physical activity, etc. • Dental care – unable to recruit new dentists • Not as many dental issues associated with meth as seen in the past • Hospital doesn't see a lot of people with dental issues • 10% of population in Neligh is Hispanic • Not able to find interpreters in health care settings – they are very much in need
Cancer Prevention and Education		• n/a
Environment and Safety		• Family values and morals have changed – violence in video games, on TV and internet access to everything • Training in schools for safety of staff and students • Have a police officer in the school to interact with students, can notice students experiencing difficulties and intervene (in the Norfolk high school at this time) • Lack of parental supervision, confusing family situations • No responsibility for parents to care for their children, a lot of co-dependency • Need major focus on children – able to change behaviors in young children • Elder abuse seen- they don't receive proper care, some families keep elderly at home to save money and others don't want the elderly in a nursing home and try to care for them on their own

County/Location: Antelope / Tilden

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Nutrition – many kids without breakfast and supper • School requires student to have a fruit and a vegetable for their meals – kids aren't eating them and there is a lot of waste • Calorie restrictions on amount of food served in schools
Behavioral Health	**Substance Abuse**	• Occurs in many households • Alcohol usage in schools has remained about the same over the past 20 years • Increase in usage of marijuana • Prescription drug abuse seen more in adults – kids have prescriptions that they aren't taking because parents are taking them instead • Youth drinking too many energy drinks although has seemed to decrease over past year
	Mental Health	• Have protocols and crisis response teams for school emergencies/tragedies • Lack of providers and mental health facilities • More mental health services for those directly involved in tragedies – how to get them the help they need • Need mental, physical and spiritual health for everyone, if one part of the three is missing the person is not whole • Spirituality is often taken out of things because it is offensive to some people
Access to Care		• Not enough providers – new providers typically don't come to rural areas • Youth with Medicaid are not able to access treatment • Many providers do not accept Medicaid • Lack of financial resources in families to pay for own dental care • Dental health affects all aspects of a person's life and health systems • Senior care services – they had a 45 bed nursing home that had to be closed • Have many resources: new assisted living facility, clinics, hospital, hospice and counseling services • Seniors have limited financial resources • Home health – staff are extended and business comes in spurts • Some seniors can't afford assisted living or care in homes • Difficult to find 24 hour care for seniors in their homes • Need to look to the future in regards to senior care and be more creative on how to handle growing population of seniors • Baby boomers are reaching senior ages soon and there is not adequate health care systems in place to handle the large increase in the senior population
Cancer Prevention and Education		• More education needs to be done
Environment and Safety		• School safety: are the schools really safe and what needs to be done in order to ensure the safety of the students and staff • Have first responders visit the schools so they are familiar with the layout of the school • Have a "safe place" designated in each school where the students and staff can go • Should a school staff member be allowed to have a concealed weapon in the school (training for how to respond to an incident) • Schools should have drills and have crisis response teams • Law enforcement present at all schools in mornings and periodically throughout the day • ID badging for school staff • Internet access – able to access all types of information • Family units/community togetherness – how to keep them together, values and morals have changed, we have a sense of "protection" that nothing bad will happen here

County/Location: Boyd / Spencer

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Diabetes and heart disease – need to have educational programs for the public • Seem to have active people in community in regards to physical activity, especially younger women • Weight room at the school in Spencer is open to the public • More education needed on diet & nutrition – food preparation, recipes, how to eat right
Behavioral Health	**Substance Abuse**	• Don't feel there is much prescription drug abuse • Canine units in schools may be good – where is the closest one located, bring it into schools for monthly checks to scare the kids into knowing that they will get caught • See a lot of people that use chewing tobacco
	Mental Health	• Difficult to find someone to help those who are in need • No mental health providers within the county • No psychiatrists around, usually only come for medication checks • Many people don't want to seek mental health services because of the stigma associated with this – small communities and people will see them and talk
Access to Care		• Smaller communities don't have as many services to offer – senior care and youth • Only 1 dentist in Boyd County, he is 70 years old and may not be taking any new patients – unable to recruit any new person to take his place • Location has been a hindrance for recruitment of dentists, physicians, etc. • Not many physicians, many are older and close to retirement • Need to promote health care fields in schools at career fairs, etc., maybe using telehealth • Access to care is difficult – need to have more free services available for communities • Many seniors need more care than they are receiving and there are not many services available to provide them with assistance • Have 1 nursing home and 2 assisted living facilities in Boyd County • There have been funding cuts to the Nebraska Area Agency on Aging
Cancer Prevention and Education		• Niobrara Valley Hospital looking to find new ways to promote colorectal cancer screening • Niobrara Valley Hospital conducted free prostate screening, will be done again in March or April
Environment and Safety		• Niobrara Valley Hospital is looking at implementing a bike helmet program and child safety seat checks • Some dilapidated buildings – communities are doing much better at taking care of this matter – city council has worked on this in Spencer • Lynch has a movie theater ran by local volunteers. • A lot of people in the area volunteer for many things, they are becoming extended and it is hard to implement any new activities. • A lot of community pride in keeping things nice.

County/Location: Brown / Ainsworth

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Childhood obesity as related to school lunch regulations • Increase of childhood obesity
Behavioral Health	**Substance Abuse**	• Need electronic database for prescription drugs • Marijuana use is increasing • Steroid use among youth • Use of energy drinks by youth
	Mental Health	• Identification of diagnosis • Resources not available or accessible. Transportation big issue • Access to care • Cost • Stigma • Waiting lists for care
Access to Care		• How does health care reform affect services • Shortage of some drugs • Oral health accessibility • Lack of fluoridation • Local Alzheimer's unit closed • Need for monitoring of seniors • Insurance-higher deductibles and less adequate coverage • Many people do not know about Charity Care or do not follow through • Do not have baselines concerning men's health • Need for more specialty physicians • Need breastfeeding and lactation support • No birthing facilities- must travel for prenatal classes
Cancer Prevention and Education		• n/a
Environment and Safety		• Internet safety • Physical safety at school, in hospital and businesses • Child abuse & neglect- unresponsive resources, increasing issues • Decent, affordable housing not available • Substandard housing- lead, mold and radon

County/Location: Cherry / Valentine

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Dietary services only covered for diabetics and kidney disease • Preventative education needed • Obesity & tobacco can be tied to most chronic disease
Behavioral Health	**Substance Abuse**	• Alcohol, prescription drugs, abuse of household products, huffing, Lysol, etc. • Prescription abuse is primarily from youth to middle age • Elderly abuse is related to medication management and understanding • Theft of prescription pads • People going to multiple providers • Not going away
	Mental Health	• Management issues • Economics- insurance/ preventative coverage • Need more providers • EPCs often don't get admitted
Access to Care		• Charity Care at hospitals going up • Health insurance premiums are a barrier • Stereotyping barriers keeps people from seeking care • Access to care is related to poverty, especially emergency services • Dental care- few providers • Dental status is related to other health issues • Many dental providers will not take Medicaid clients
Cancer Prevention and Education		• n/a
Environment and Safety		• Increased truck traffic • Child restraints • Bike helmets • Gun safety- is education taking place? • Housing- finding affordable housing • Substandard housing • Landlords not safety conscious • Native American issues: substance abuse, domestic violence, health issues, abuse of system, chronic disease- diabetes, cirrhosis of liver, health system complicated, detox & treatment issues, demographics in schools changing

County/Location: Holt / O'Neill

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Diabetes is a huge problem we are forgetting. • Diabetics need to keep up on their routine doctor checks so they do not end up needing hospital care. • Diabetics are also a big population that has cardiovascular problems. • Keeping up on healthy choices so they do not become obese.
Behavioral Health	**Substance Abuse**	• Prescription Drug (PD) use is a big problem in our district. • PD is very easy to get ahold of. • Most elderly have an array of prescription drugs they take every day. • Alcohol continues to be the #1 problem. • Teen drinking is a problem • The parent's perspective of drinking and how they portray it.
	Mental Health	• Can't afford health care so stop taking medication and end up going into Emergency Protective Custody (EPC) as a cause of it.
Access to Care		• Growing population of elderly - 65% of our district is elderly. • Medicaid availability for elderly in nursing homes. • Affordable care/insurance for elderly in nursing homes. • Medication management • A lot of people don't know how to access affordable health care. • Rural areas do not have free service facilities so people do not think it is an option. • 65 and older people lose jobs but cannot qualify for Medicaid and can't afford to live on having a part-time job. • Need a list of available resources, create a resource book. • Low paying jobs in our area, people can't afford care or to live here. • Have resources available during food pantry hours. • Using Economic Development as a resource.
Cancer Prevention and Education		• Putting off preventive care until it's too late. • Hospitals are doing a great job at promoting colon screenings. • Providing more checks/screenings during health fairs. • Providing services during food pantry hours.
Environment and Safety		• Home life stability, how that affects everything. • Children are not able to be home enough, involved in lots of activities, which is good, but less time is spent around the supper table as a family. • Housing owners do not want to enforce healthy environments. • Demolition of old abandoned houses that could be bad for one's health. • Elderly being stuck in their homes not knowing about the resources available to them. Unhealthy environment. • Rural youth work more jobs than urban youth.

County/Location: West Holt / Atkinson

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• As related to risk for diabetes
Behavioral Health	**Substance Abuse**	• n/a
	Mental Health	• Families who live "on the fringe"- mental health issues, substance abuse • Suicide • Medication management/ family dynamics, priorities • Increased number of students taking medications • Bullying
Access to Care		• Big gaps • Are we measuring preventative services and effectiveness • Transportation issues • Medicaid issues • More Charity Care cases • More people coming to ER • Need more parish nurses • More students not getting preventative oral health • Waiting list- dentist • Need dental providers • No pediatric dentists • Transportation
Cancer Prevention and Education		• n/a
Environment and Safety		• Housing- need affordable and safe - many substandard, slum lords • Keeping kids in schools when family cannot find place to live • Lack of employable skills • Services are often reactive rather than preventative • Getting grant funding brings more regulations • School related issues- increase in those qualifying for free lunches, clothing needs, food, children run out of needed meds

County/Location: Knox / Creighton

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Those with chronic disease need more assistance, have difficulty navigating health care system • Many fall through the cracks • Tend to be non-compliant at home and many times have inpatient stays due to this • Health literacy is an issue – have been using the teach back method where patient states three things to ensure that learning has occurred; also use demonstration of skills • Santee has a large number of diabetics with specific diets that need to be followed– lack of fresh healthy foods available, the grocery store there doesn't have fresh produce, etc. and many times the residents are not able to afford driving to other communities to purchase these food items so there is a lot of noncompliance with their diets – they are looking into "Street Farmer" to show them how to grow their own fruits and vegetables • Some current issues with teens not eating in the schools • Nutrition in schools – an increase in students bringing their lunches, smaller portion sizes
Behavioral Health	**Substance Abuse**	• Teen drinking is a problem • Boredom for teens, lack of activities for them to participate in other than sports • Parents accept teen drinking in this area (parents did it so okay for their teens to drink) • Energy drinks (some contain alcohol) – Knox County Extension Office has a display regarding energy drinks – some communities have age limit on purchase (18 years and older) • Need Pharmacy Database so pharmacists can see when prescription medication was last refilled • Prescription drug abuse occurring in adults and teens - appears to be enabled by parents (parents take grandma's pills so they in turn take their parents' medications) • Patients go to many different facilities to seek prescriptions (typically for pain)
	Mental Health	• Only one mental health provider that offers home visits in the county • Lack of access • Use telehealth to address lack of access
Access to Care		• Lack of access to dental providers who accept Medicaid • Lack of access to dental screening • On-line training course to learn how to apply fluoride varnish, provides a certificate, does not need to be a dental hygienist or dentist • Staffing shortages in long-term care (CNAs and nurses) leads to lack in continuity of care • Abuse of the health care system – people are using the ER instead of waiting to see a provider during normal hours, mainly those with Medicaid • No urgent care available • Avera Creighton Hospital has an after hospitalization program called "Care Transitions" – the nurse completes a home visit and does a medication check to help with compliance, and make follow-up phone calls with the patient • There are many restrictions for home health coverage, if person is not homebound, they have to pay privately for the care • Many with chronic disease or elderly need assistance with daily chores
Cancer Prevention and Education		• People without health care plans don't see providers for screenings and checkups, so there is a lack of education about what screenings are needed and at what ages they should be done • For those without health care plans the screenings are cost prohibitive • Avera Creighton had a mobile mammogram unit – did not have as many people utilize this service as they were expecting
Environment and Safety		• Children not in healthy home environments – they are reported to the state according to protocol and follow the chain of command but nothing seems to get accomplished • Lack of resources for follow-ups listed above or no follow through • Not a lot of foster care homes available in the area • Lack of juvenile services available (detention centers) • Bullying by both adults and children • Truancy issues (particularly in Santee), parents don't enforce their children's attendance in school – this leads to an increase in the opportunity for teens to engage in high risk behaviors

County/Location: Pierce / Foster

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Diabetes is a factor in some cases of obesity. • Cardiovascular disease has decreased since smoking has been banned in bars. • Great that school lunch programs are reducing bad food, but now more kids bring lunch from home or go off campus to eat.
Behavioral Health	**Substance Abuse**	• Medical marijuana use is increasing. • Fear of it only being a matter of time before marijuana becomes legalized in more states. • Increase of prescription drug use. • Having more safe ways to take back prescription drugs. • Youth binge drinking will continue to be a problem.
	Mental Health	• People need to be treated, but it's hard to get in and see someone who can actually diagnose a mental illness. • Getting kids into a mental health program, and not knowing where to take them. • People don't think it's a big deal until it's too late. • EPC issues, where they take them and how long they can be kept.
Access to Care		• Finding where to go for children with mental health issues. • One of the problems could be that mental health provider jobs are being cut. • Making sure people show up for meetings and together try to get information out there. • Region 4 contracting with the hospitals is a good way to help spread information. • Medicaid and Medicare funding will be getting cut. • Some agencies cover such large areas and are strung out too thin. • Affordable nursing home care for our elderly. • 75% of the dentists in our district will be retiring soon. • The Hispanic populations in our area have difficulty finding oral health care. • Affordable dental insurance. • A gap of people who are being missed, those who can't afford dental care, but don't qualify for Medicaid or Medicare. • Pharmaceutical availability. • The delay when getting prescription drugs. There are so many drugs it's hard for pharmacists to keep them all in stock. • Medicaid is very difficult to get now. • Can't afford to have in home care for elderly and it is hard to find someone who will do it privately due to liability issues. • Nursing homes are having an overflow. • Can't afford to have health care. • Elderly having to give everything they own to afford to be taken care of in a nursing home.
Cancer Prevention and Education		• Believe it is helping that FOBT kits are being handed out so much more, especially at health fairs.
Environment and Safety		• Economic development. • The family structure. Sitting down as a family and having a meal. • School safety. • Has been helping since smoking was banned in bars.

County/Location: Rock / Bassett

Focus Area		Notes
Chronic Disease, Obesity and Related Health Concerns		• Sedentary life style for many • Youth not as physically active
Behavioral Health	**Substance Abuse**	• Mixing "Red Bull" with alcohol • Energy drinks are an issue • Prescription drug misuse by seniors • Transient population seeking drugs • Youth know who to contact to get drugs • Marijuana is present • Prevalent use of smokeless tobacco products by youth and adults
	Mental Health	• Only one mental health provider in county
Access to Care		• Issues for seniors to access DHHS services via computers • Many insurance issues • Payment difficulties for seniors utilizing Senior Center • Nail care not available • Inadequate dental services • Cost of dental care prohibitive for many • Vision care not available in the county • Concern about Medicare payment
Cancer Prevention and Education		• Appears to be high incidence of colon cancer in county • Must travel for cancer treatment
Environment and Safety		• Unsafe cell phone use • Lack of proper use of child safety seats an issue • Use of bicycle helmets is minimal • Lots of vandalism • Farm & ranch safety- people don't take precautions • Concern about farm chemicals used • Some child abuse, more child neglect • Children going home to empty, unsupervised houses • No after school program • Lots of single parent households • Housing issues- not the kind of housing people want, some substandard housing • Need for assisted living facility • Fluoride no longer in water system in Bassett • Population loss in community leading to loss of services • No adequate child care available