Community Health Needs Assessment

Antelope Memorial Hospital: Antelope County

2016

NCDHD
North Central District Health Department

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ACKNOWLEDGEMENTS

SPONSORED BY

North Central District Health Department

Antelope Memorial Hospital

Avera Creighton Hospital

Avera St. Anthony's

Brown County Hospital

Cherry County Hospital

CHI Plainview

Niobrara Valley Hospital

Osmond General Hospital

Rock County Hospital

West Holt Memorial Hospital

DATA CONTRACTING

Ionia Research- Joseph Nitzke, PhD

North Central District Health Department and the partnering district hospitals contracted with Dr. Joseph Nitzke for data collection, compilation, analysis, and presentation for this community health assessment process. Dr. Nitzke is a partner in Ionia Research, Newcastle, Nebraska. Previously (2004-2011), he was the Director of the Social Sciences Research Center at Wayne State College (NE). Ionia Research provides consulting and contract services for government and nonprofit agencies, including health departments, hospitals, community agencies, colleges and universities. Current projects include program evaluation, needs assessment, survey research, and the development of data resources to support organizational planning.

PROJECT OVERVIEW

PURPOSE

The purpose of the community health assessment is to learn about the community: the health of the population, contributing factors to higher health risks or poorer health outcomes of identified populations, and community resources available to improve the health status. Community health assessments describe the health of the population, identify areas for health improvement, identify contributing factors that impact health outcomes, and identify community assets and resources that can be mobilized to improve population health.

This Community Health Needs Assessment, a continuation of an ongoing project last conducted in 2013, will be used to inform decisions and guide efforts to improve the health and wellness of residents in the North Central District Health Department service area.

The vision of this project as defined by the participants is:

To live healthy through ACCESSIBILITY (*resources across the lifespan*), COMMUNICATION (*sharing information)*, EMPOWERMENT (*accountability & ownership*), LEADERSHIP (*guiding & growing*), and COLLABORATION (*working together*).

METHODOLOGY

This assessment incorporates a broad range of both qualitative and quantitative data. The quantitative data is primary (as derived from the NCDHD Community Health Survey) and secondary (as derived from statistics from large datasets, as well as hospital-specific data); these resources allow for trends and comparisons to be made to both state and national levels. Qualitative data input is also derived from the NCDHD Community Health Survey and focus group meetings.

DATA SOURCES

- Behavior Risk Factor Surveillance System
- Healthy Counties Database
    - Population Health Institute, University of Wisconsin: Robert Wood Johnson Foundation
- Community Health Status Indicators
- Community Health Needs Assessment (CHNA)
- Bureau of Census
- Youth Behavior Risk Survey
- Focus Groups (Conducted by NCDHD)

COORDINATION

As a local public health department, one of the core functions of North Central District Health Department is to assess the health needs of the community. This involves systematically collecting and assembling information on the public health status of the community, in cooperation with others, including statistics on health status, community health needs, environmental health, epidemiologic, and other studies of health, and making the information available to the public.

Non-profit, tax-exempt hospitals are required by the 2010 Patient Protection and Affordable Care Act to conduct a Community Health Needs Assessment (CHNA) every three years. To meet requirements, impacted hospitals must analyze and identify the health needs of their communities and develop and adopt an implementation strategy to meet the identified needs.

The health department functionality and the IRS requirement for hospitals serve to form a natural platform for coordination of completing the community health assessment. Therefore, NCDHD and the district hospitals partner together to complete a joint community health assessment and community health improvement plan.

There are seven district hospitals subject to the IRS requirement**:**

Antelope Memorial Hospital, Antelope County

Avera Creighton Hospital, Knox County

Avera Saint Anthony's Hospital, Holt County

Osmond General Hospital, Pierce County

Plainview Community Hospital, Pierce County

Niobrara Valley Hospital, Boyd County

West Holt Memorial Hospital, Holt County

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

Brown County Hospital, Brown County

Cherry County Hospital, Cherry County

Rock County Hospital, Rock County

BACKGROUND

NORTH CENTRAL DISTRICT HEALTH DEPARTMENT

North Central District Health Department (NCDHD) is a state-approved district health department that serves nine rural Nebraska counties—Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock. 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.

Nebraska Statute 71-1628.04 provides guidance on the role public health departments must play and provides the following required elements, which align with NCDHD's role in the community health assessment and community health improvement plan process.

> *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*

North Central Community Care Partnership (NCCCP), a community grassroots effort that served as the local public health coalition prior to the formation of NCDHD, set the groundwork for public health assessment in our nine counties by completing the first district Community Health Needs Assessment and developing a community health improvement plan in 1999. Through that process, NCCCP worked collaboratively with many public health partners, including our local hospitals, to complete a random sample community health needs assessment. In 2007, the NCDHD Board of Health voted to recognize NCCCP as the official strategic planning partner of NCDHD and its nine counties.

To further support efforts committed to the assessment and planning process, NCDHD is preparing to pursue local public health department accreditation. All local health departments must have completed a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) as a prerequisite to applying for accreditation. Accreditation standards require the health department to:

- *Participate in or lead a collaborative process resulting in a comprehensive community health assessment*
- *Collect and maintain reliable, comparable and valid data that provide information on conditions of public health importance and on the health status of the population*
- *Analyze public health data to identify health problems, environmental public health hazards, and social and economic factors that affect the public's health*

- *Provide and use the results of the health data analysis to develop recommendations regarding public health policy, processes, programs or interventions*
- *Conduct a comprehensive planning process resulting in a community health improvement plan*
- *Engage with the public health system and the community in identifying and addressing health problems through collaborative processes*

DISTRICT HOSPITALS

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 (CHNA) at least once every three years and adopt an implementation strategy to meet the community health needs identified through the CHNA
- Define the community it serves and assess the health needs of that community
- Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health
- Make the CHNA widely available to the public
- Document the CHNA in a written report ("CHNA report") that is adopted for the hospital facility by an authorized body of the hospital facility

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*

ANTELOPE MEMORIAL HOSPITAL: SERVICE AREA AND FACILITY INFORMATION

Antelope Memorial Hospital is a not-for-profit critical access hospital located in the northeast Nebraska community of Neligh, population 1,600. The hospital serves approximately 6,500 residents in the eight rural communities of Neligh, Brunswick, Clearwater, Elgin, Oakdale, Orchard, Royal and part of Tilden. Antelope Memorial Hospital offers a full range of acute and preventive health care services, including acute inpatient care, restorative/rehabilitative (swing bed) care, an emergency services department, home healthcare, same day surgery, state of the art radiology, ultrasound, and mammography services, laboratory services, physical, speech, and occupational therapy, wellness, dietary consultations, and a wide range of specialty outpatient clinics and services. Antelope Memorial Hospital has served Neligh and Antelope County since 1952.

Antelope Memorial Hospital is affiliated with the Heartland Health Network and Mid America Health Alliance. The Mid America Health Alliance provides Antelope Memorial with education and access to the University of Nebraska Medical Center as a resource. The Heartland Health Network provides education and assists to improve quality of services and health status of our communities, while encouraging autonomy as a stand-alone facility.

SERVICES OFFERED BY ANTELOPE MEMORIAL HOSPITAL

Nursing Care Services
- Medical
- Surgical
- OB/GYN
- Pediatric
- Skilled Nursing Care

Surgical Services
- Orthopedic
- Surgery

Emergency Care

Specialty Clinics
- Home Health Care
- Cardiology
- Urology
- ENT
- Pulmonary
- Podiatry
- Ophthalmology
- Orthopedic
- Surgery
- OB/GYN
- Weight
- Oncology
- Vascular
- Neurology

Mammography

Ultrasound

CT Scan

Diagnostic Radiographic Services

MRI

Interventional Radiology

Dietary Counseling

Blood Bank

Laboratory

Pharmacy

Physical Therapy

Occupational Therapy

Speech Therapy

Respiratory Therapy Services

Stress Testing Services

Holter Monitoring

Pastoral Care

Social Services

Cardiopulmonary Rehab Services

AICD—Pacer Checks

Audiology

Nuclear Medicine

PROJECT METHODOLOGY

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS: THE EVIDENCED-BASED PROCESS

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. MAPP 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. The MAPP cycle has well defined steps and processes to capture community input and move a community or organization to make positive changes. As with previous assessments, NCDHD served as the lead agency during this fourth iteration of the MAPP process, with support from all hospitals through both personnel and financial resources.

TIMELINE

- July – September 2015: Organize, Coordinate Participants, Prepare for Process
- October 2015 - March 2016: Community Health Needs Assessment Data Collection
- December 2015: Community Themes & Strengths, Forces of Change
- January 2016: Local Public Health System Assessment, Visioning
- February 2016: Community Health Needs Assessment Results Presentation
- March – May 2016: CHNA Report Completed, Adopted by Hospital Governance; Goals & Strategies for Community Health Improvement Plan

- June - September 2016: Community Health Improvement Plan Completed, Adopted by Hospital Governance; Action Cycle

PARTICIPANT IDENTIFICATION

Beginning in July, 2015 a core team of NCDHD staff members working with key partners from participating hospitals began preparing for the next round of community health assessment activities. Work during this phase involved thoroughly reviewing and using MAPP guidance resources on the National Association for City and County Health Officials (NACCHO) website.

As the participant element of the process is critically important for building commitment, engaging community members, and achieving a plan that is truly community-owned and community-driven, several initiatives were undertaken to achieve significant progress in this arena. Key activities included a brainstorming session with NCDHD staff members and NCCCP members using public health sector categories, frequent requests to current participants – via email at least monthly and at in-person meetings – to identify and contact potential participants, research by a core team of NCDHD Staff to identify people serving in key roles within public health sectors, and phone or email contact with identified individuals to extend requests for participation in the CHA/CHIP process.

Due to the importance of participation from a wide range of community members, efforts to identify and contact potential participants continue to be an ongoing area of focus.

DATA COLLECTION

Data gathering was accomplished using the four MAPP model assessments and included both primary and secondary sources for quantitative data, and primary sources for qualitative data. The four MAPP assessments are:

- Community Themes and Strengths
- Local Public Health System
- Community Health Status
- Forces of Change

The Community Health Needs Assessment encompasses all four MAPP assessments and has been completed four times since 1999, with the most recent assessment completed in January, 2016. The most recent assessment findings are available online for public review at www.ncdhd.ne.gov.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

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, and was completed through:

- A community stakeholder meeting held on December 17, 2015

  Participants broke up into small groups and completed worksheets to capture input about health issues, resources, and quality of life in their communities. 28 participants representing a broad range of community organizations attended this meeting. Additional meeting materials can be found in Appendix A.

- County focus groups meetings held in January and February, 2016

  County focus group meetings were held at locations in the following NCDHD service area counties: Antelope, Boyd, Brown, Cherry, Holt, Knox, Pierce, and Rock. Keya Paha residents were invited to the Brown County focus group meeting. Focus group meetings were held during the evening to accommodate schedules of community members who work during the day. The meetings consisted of informal, open-ended questions about community characteristics, strengths, concerns, and potential areas to focus health improvement efforts. Information was recorded anonymously to allow for a comfort level in sharing information. County focus group meeting notes can be found in Appendix B.

- Surveys targeted to specific populations at higher health risk or that have poorer health outcomes, identified in this community as low-income, Hispanic, Native American and elderly residents.

  Using partnerships with district senior centers, community action agencies, and tribal agencies, surveys were distributed to obtain input from the low-income, elderly, and Native American population. NCDHD staff worked to identify a contact person for the Hispanic community, which is primarily centralized in Holt County, to distribute surveys and obtain feedback. Survey questions and results can be found in Appendix C.

FORCES OF CHANGE ASSESSMENT

The second assessment in the MAPP process is the Forces of Change assessment. This assessment is done to capture the community's perception of current trends affecting the health of the community.

The Forces of Change assessment was completed at a community meeting held on December 17, 2015. Participants were given information to help explain and define the concepts of events, factors, and trends as they relate to this assessment. They then broke up into small groups and completed worksheets to document forces of change that 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 moved on to complete another worksheet identifying the impact of these forces of change from the perspective of threats posed and opportunities created. 28 participants representing a broad range of community organizations attended this meeting. Additional meeting materials can be found in Appendix A.

COMMUNITY HEALTH STATUS ASSESSMENT

The third assessment is the Community Health Status Assessment. This assessment gathers 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, Youth Protective Factor Survey, and US Census.

To gain additional community health status information directly from community members, NCDHD also created an online community health survey using SurveyMonkey. Distribution and availability of the survey was accomplished by posting the survey on the NCDHD website and Facebook page, as well as websites from a number of other community websites. NCDHD staff contacted community members currently participating in the CHA/CHIP process to request their partnership in posting the survey on their websites and social media platforms, and also reached out to a number of other representatives throughout the district to request having the survey placed on their websites and social media platforms. While not a true random-sample survey, this instrument still provides beneficial information about the health and risk behaviors of the residents of the study area that is not available from other sources. The survey was available between December 2015 and February 2016, with a total number of 608 surveys completed. Survey results can be found in the 2016 Community Health Status Assessment: Community Health Survey section of this document.

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

This assessment focuses on all organizations and entities that contribute as part of the local public health system in the North Central District Health Department service area and answers the questions: "What are the components, activities, competencies, and capacities of our local public health system?" and "What does the health status of our community look like?" The Local Public Health System assessment was completed during a community meeting held on January 14, 2016. Participants were given a worksheet listing each of the 10 essential services of public health and instructed to list information about services provided by their organization related to each essential service. Attendees were divided into small groups. Each group was assigned three or four of the essential services and completed the assessment using the National Public Health Performance Standards Local Assessment Instrument. Participants worked through the instrument questions, sharing information about what their respective organizations provide for each essential service, and responded to the instrument questions using colored voting cards.

10 ESSENTIAL PUBLIC HEALTH SERVICES:

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts

6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

23 participants representing a broad range of community organizations attended this meeting. Additional meeting materials can be found in Appendix D.

VISIONING

While typically conducted before the assessment phase in the MAPP process, the visioning phase was conducted at the second community meeting held on January 14, 2016. Due to the geographic nature of our district and travel time required for participants to meet in a central location, meeting structure and arrangement of activities to be completed at each meeting was organized in an attempt to maximize the time available with community participants. Fortunately, a fundamental component of the MAPP model is to tailor the process to the unique needs and characteristics of the community. Participants at this meeting broke up into small groups and completed a visioning worksheet. This was done by brainstorming ideas about an ideal future that will be accomplished through efforts as a result of the planning process and implementation of strategies, as well as the values and key behaviors that will be necessary to achieve the vision. Participants were also instructed to consider the best format for a vision statement. NCDHD staff members collected information from each workgroup's brainstorming session and created a draft vision statement, which was presented at the February 18 community meeting. Attendees at that meeting were instructed to review the draft and provide approval or feedback for possible revisions. 23 participants representing a broad range of community organizations attended this meeting. Additional meeting materials can be found in Appendix D.

DATA PRESENTATION: IDENTIFICATION OF SIGNIFICANT COMMUNITY HEALTH NEEDS AND PRIORITIZATION OF STRATEGIC ISSUES

On February 18, 2016, community stakeholders again convened to review results from the data collection efforts and completed MAPP assessments. Dr. Joseph Nitzke, PhD. of Ionia Research provided data collection, compilation, and analysis activities for this process. At the February meeting, Dr. Nitzke presented the data results, highlighting statistics of importance and explaining relationships between various data, as appropriate.

In order to determine our community needs, data was analyzed according to whether the indicators were failing to meet the national HP2020 targets, whether indicators were trending in the wrong direction, whether there were apparent disparities, whether there were significant discrepancies between district and state indicators, whether the issue affects a large number of district residents,

and/or whether the issue was identified as a significant problem based on community input. If these criteria were present, the indicator was identified as a need. Indicators were grouped and examined by topic area, which were further identified as community needs.

Prior to the data presentation, participants were given strategic issue identification worksheets and instructed to record potential strategic issues they noticed during the presentation, as well as the specific significant health need data that caused them to identify it as a potential strategic issue. Definitions and criteria for strategic issues were also provided. Following the data presentation, participants broke up into small groups and completed strategic issue consolidation worksheets by reviewing the strategic issues recorded on the identification worksheet, ensuring the issues are strategic using the definitions and criteria provided, eliminating duplicates, and grouping the remaining issues by topic or theme. Finally, the grouped areas of strategic issues were given headings to describe the general health category of that topic area. Each workgroup presented their information to the larger group and strategic issue categories were documented on flip charts, which were subsequently posted around the room. To prioritize the significant health needs, attendees were given three colored stickers and instructed to vote for the three categories they identified as the most important priorities to address by placing their colored stickers on the flip chart sheet for that category. Participants were also advised to consider whether the issues are within our scope of control, realistic/achievable, and whether resources were available to address the issues. Once all votes were placed, a spirited discussion took place in an effort to achieve consensus on the top three or four priority areas that would be chosen for the implementation plan phase of the process. The group was aiming for three or four focus areas in order to make the plan more realistic, manageable, and achievable. The initial list of health categories available for voting on the flip chart, and corresponding number of votes, is as follows:

Health Category	Number of Votes
Community Health	0
Access to Care	1
Safety	2
Chronic Disease	3
Substance Abuse	6
Aging Population & Related Illnesses	17
Housing / Environmental	18
Mental Health	25
Wellness / Prevention / Weight Management	36

In an effort to work toward deciding on three or four priority areas, some group suggestions included elimination of categories with fewer votes and consolidation of like categories. There were concerns voiced about elimination of categories for the reason that those issues may have received fewer votes not because they are unimportant, but simply because another issue was identified as more important. Concern was expressed about needing a more thorough review of the data with more time spent to cover issues that didn't receive adequate discussion, such as chronic illness and substance abuse, among others. Some participants were worried about how this affected the outcome of the vote and subsequent group discussion. Concerns were voiced about consolidation of like categories because as the category is broadened to include more issues, it would be easier for some of the issues within that category to be forgotten and/or left unaddressed due to of resources being exhausted on the other issues. 38 participants representing a broad range of community organizations attended this meeting. Additional meeting materials can be found in Appendix E.

While the data presentation meeting resulted in identification of significant health needs in the community, as described in the Summary of Findings section of this document, additional work was needed to finalize the focus areas that will serve as the foundation for the community health improvement plan.

A meeting was held on April 12, 2016 to finalize prioritization of health needs and set goals, strategies, and objectives for the community health improvement plan. At this meeting, discussion continued about the health categories established at the February data presentation meeting, and their corresponding votes. The housing and environmental category was eliminated due to the issue being outside the scope of our control; this issue is being addressed by other organizations in the community. The access to care, safety, and chronic disease categories were eliminated as stand-alone categories, as they can be addressed through the final priority areas that were chosen. Through the discussion and consensus voting, the following community health priority areas for the district were approved:

PRIORITY AREA 1: PHYSICAL WELLNESS

PRIORITY AREA 2: MENTAL WELLNESS

PRIORITY AREA 3: AGING POPULATION & RELATED ISSUES

PRIORITY AREA 4: SUBSTANCE ABUSE

COMMUNITY INVOLVEMENT

As stated earlier, strong community involvement is a critical element for the most effective outcome. Participant engagement has remained and will continue to be a significant area of focus throughout

the process. Representatives from the following organizations have played an active role in the assessment process.

PARTICIPATING COMMUNITY MEMBERS AND ORGANIZATIONS	
North Central District Health Department (NCDHD)	NorthStar Services
Antelope Memorial Hospital	NCDHD Board of Health
Avera Creighton Hospital	North Central Community Care Partnership
Avera St. Anthony's Hospital	Area Substance Abuse Prevention Coalition
Brown County Hospital	O'Neill Chamber of Commerce
Cherry County Hospital	Central Nebraska Economic Development
CHI Health Plainview Hospital	Holt County Economic Development
Niobrara Valley Hospital	Knox County Economic Development
Osmond General Hospital	Neligh Economic Development
Rock County Hospital	Pierce County Economic Development
West Holt Memorial Hospital	University of Nebraska Lincoln Extension Office, Brown-Rock-Keya Paha County
The Evergreen Assisted Living Facility[2]	Ewing Public School
Cottonwood Villa Assisted Living Facility[2]	Lynch Public School
Good Samaritan Society – Atkinson[2]	O'Neill Public School Board
Pregnancy Resource Center	O'Neill Ministerial Association
Finish Line Chiropractic	West Holt Health Ministries
Counseling & Enrichment Center / Building Blocks	O'Neill Lions Club
Region 4 Behavioral Health System	O'Neill Rotary Club
Central Nebraska Community Action Partnership[1]	Mitchell Equipment – O'Neill, NE
Northeast Nebraska Community Action Partnership[1]	Family Service Child Care Food Program
Northwest Nebraska Community Action Partnership[1]	

SPECIAL POPULATION CONSIDERATION

As indicated previously, specific populations at higher health risk or that have poorer health outcomes were identified in this community as low-income, Hispanic, Native American, and elderly residents. In addition to using existing relationships with organizations who work with these populations to distribute targeted community surveys, representatives from these organizations also participated in community meetings throughout the assessment process. Organizations in the community involvement table above are marked with 1 to indicate representation of the low-income population and 2 to indicate representation of the elderly population. Representatives of all four special populations were included on invitations to every community meeting, although representatives for

the Hispanic and Native American populations did not attend. Representatives of the Native American population did participate in the county focus group meeting for Knox County.

NEXT STEPS: GOALS AND STRATEGIES

Completion of this community health assessment report signals the transition from the assessment phase of the process to the community health improvement plan phase. The next MAPP phase involves using the community health assessment results and identified priority health needs to develop a community health improvement plan that will outline the goals, objectives, strategies, key activities, and performance indicators for each of the priority areas identified by the community members. These priority areas are strategic issues selected by community members that need to be addressed to allow the community's vision to come to fruition. The community health improvement plan will be completed by September 1, 2016. This is followed by the action cycle, where community members and representatives from the public health sector organizations work to achieve progress on the established goals. The action cycle will begin in September 2016 and will continue through 2019 when the assessment and implementation process will be repeated.

EVALUATION OF IMPACT ON 2013 HEALTH PRIORITIES

Access to Care/Cancer Prevention & Education

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.
RESULTS/IMPACT:
Telemedicine services were expanded upon to include emergency care, mental health crisis support, trauma support, hospitalized patient support, psychiatry, urology, and cardiology. We also added an APRN, a PA, and a physician to our medical staff.

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.
RESULTS/IMPACT:
The AMH Wellness Center offers a variety of opportunities for the public and hospital employees to exercise and take fitness classes. The center is open to the public on weekdays with varying hours depending on the time of year and current events being offered. Employees have the opportunity to exercise there at no charge 24 hours a day. The wellness center currently has a group of members who have been coming consistently for many years, and recently has seen several returning and new members.

In 2015, the Wellness Center staff made presentations at the hospital's annual Health Fair, and also had a booth that offered BMI and Body Fat Percentage checks at both the Health Fair and the Diabetes Awareness event that was held toward the end of the year by the Cardiac Rehab department. Wellness staff will be making a presentation at the public Library in June 2016 to talk about the benefits of exercise and eating right.

The annual Walk-at-Lunch has been offered one day in April for several years to employees in order to promote a healthy alternative to sitting during lunch break. The Wellness Center staff also helped host a "Bowl Down Cancer" fundraiser in 2015 at the local bowling alley to help promote the hospital's new 3D mammography now offered by the Radiology Department. 2015 was the first year AMH Wellness participated in the Blue Cross and Blue Shield of Nebraska Walking Works Corporate Challenge. Hosted by BCBS, it provided weekly information about the benefits of walking and a convenient way of tracking exercise as a group. This was open to AMH staff and their spouses. The annual AMH employee walking challenge, which is only for AMH employees, was also held later in the year. Lastly, a new employee challenge was attempted in April of 2016. This 5 day challenge encouraged employees to pick up 5 healthy habits given to them to see how they feel after 5 days. This new challenge may be attempted again in the future.

In 2015, the Wellness staff also began creating a monthly Wellness Newsletter that is shared to all hospital employees and wellness members. These newsletters contain information about exercise, healthy eating, and other lifestyle wellness information, as well as advertising for current or coming events in AMH Wellness.

For several years now, AMH Wellness has offered the "Biggest and Best Loser" Contest for weight loss, beginning in January each year. This contest has served to promote health awareness via healthy eating, exercise habits, and accountability. Many AMH employees and/or their spouses participate each year and assist with the contest, and members of the community participate as well. It has proven to be a life changing experience for many individuals, and many people have participated multiple years because they enjoy the helpful information provided as well as appreciate the S.T.A.C. class. Over the years this contest has expanded and many people encourage loved ones and/or friends to participate as well.

The Strength Training and Cardio (S.T.A.C.) class was first offered in early 2013 and has been offered every year since, including 2016. Many participants have enjoyed the S.T.A.C. class during the Biggest and Best Loser, and so it will once again be offered this year, twice a week during the 10 week contest. The participants in the class are offered a variety of exercises that span many different fitness levels, and staff is always on hand to offer guidance and support. Again, many people take the class every year and still find it helpful and enjoyable.

AMH Wellness hosts another weight-loss event during the summer months. Though this contest isn't as big as the Biggest and Best Loser contest, the last couple years have had consistent numbers of participants. This event, as with the Biggest and Best Loser, offers weekly informational tips and tricks in regards to health and wellness.
Total weight loss from AMH Wellness "Biggest and Best Loser" contest for employees/public:

2014: 1,541.25 pounds (245 participants)
2015: 1,691.5 pounds (184 participants)
2016: 1,085.25 pounds (109 participants)

Goal 3: Increase the health literacy of residents in the NCDHD area.
Objective 1: Increase the proportion of persons who report their health care provider always gives them easy-to-understand instructions about what to do to take care of their illness or health conditions.
RESULTS/IMPACT:
AMH Family Practice continues to offer a morning walk-in clinic (8 – 9 am, M – F) to decrease the number of non-emergent patients in the ER. Practitioners continue to educate patients on proper use of the ER and what steps to take appropriately. Patients are given educational materials at a 5th grade reading level that explain their illness/disease and when to contact their health care provider. This can be translated to Spanish.

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

Goal 5: Increase the percentage of adults who are vaccinated against pneumococcal disease.
Objective 1: Increase the percentage of non-institutionalized adults age 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.
RESULTS/IMPACT:
AMH continues to advertise via signs/fliers/radio/newspaper ads/Facebook. Flu shot clinics are offered to area businesses and schools. They are also offered at AMH's annual Health Fair. Local pharmacies also offer influenza vaccines.

Flu Vaccine	2013-2014	2014-2015
7 area businesses/schools	43	101
Pneumonia Vaccine		
Over 65 yrs	16	21
High Risk under 65 yrs	11	10

AMH continues to strongly encourage all employees to receive a flu shot at no cost. Employees who choose not to receive the shot are required to sign a declination form and wear a mask during high influenza outbreaks in the area.

2013: Out of 165 employees, 16 declined the flu shot.
2014: Out of 164 employees, 21 declined the flu shot
2015: Out of 162 employees, 20 declined the flu shot.

AMH continues with the standard protocol of addressing the influenza and pneumococcal vaccines with patients. The computerized order sets are still in place to remind the practitioner to address these vaccines.
AMH Cardiac/Pulmonary Rehab, Diabetes Education and Anticoagulation Clinics as well as Home Health continue to educate their patients on the importance of vaccinations.

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 preventive dental service during the past year.

RESULTS/IMPACT:

AMH continues to assist NCDHD by putting brochures in the clinics to help educate the public.

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

RESULTS/IMPACT:

AMH's Diabetes Education Program continues to encourage and educate patients about dental care and preventative measures. All skilled patients are assisted with arranging dental visits if they need it. AMH continues to work with NCDHD by encouraging area schools to utilize the system.

Goal 7: Increase the percentage of men in the NCDHD area who visit their care provider for preventive care.

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

RESULTS/IMPACT:

Year	PSA Count
2013	290
2014	310
2015	303

Goal 8: Increase the percentage of adults 50 years and older in the NCDHD area who are screened for colorectal cancer.

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

RESULTS/IMPACT:

AMH Anticoagulation Clinic continues to do screening every six months (with hematests) for colorectal cancer and referral for colonoscopy if needed. AMH continues to educate and encourage the public.

Goal 9: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines in the NCDHD area.

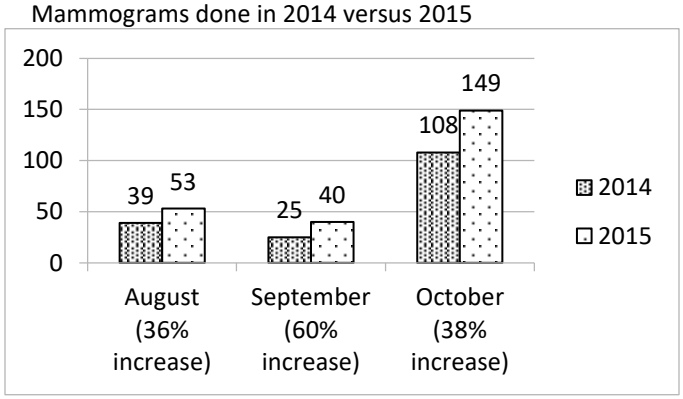
Objective 1: Increase the number of women who self-report completing self-breast exams based on the most recent guidelines.

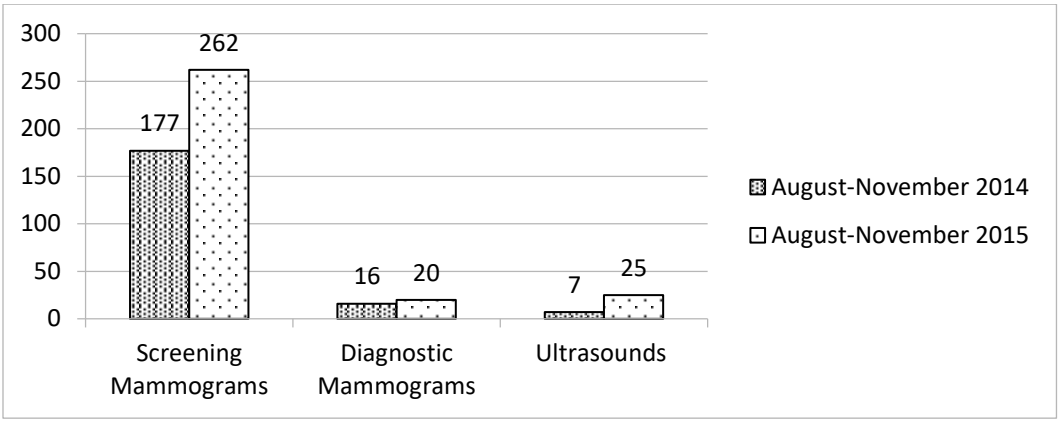
Objective 2: Increase the number of women who were counseled by their provider about mammograms.

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

RESULTS/IMPACT:

AMH now has three Radiology Techs on staff who are certified in Mammography. AMH Radiology started 3D tomosynthesis mammography on August 4, 2015. This has been promoted on Facebook as well as local and surrounding community parades over the summer. This resulted in an increase in mammograms being done.





AMH Radiology offered a "Women's Night Out" on October 21, 2015, in an effort to get women in for their mammogram screens. A glass of wine and hors d'oeuvres were provided as well as a free wine glass. This was well-advertised to the public and the response was so well-received that Radiology offered a second "Women's Night Out" for the month of October (22 women the first night, 25 women the second night).

On October 20, 2015, AMH's Radiology supervisor and Radiology Tech certified in mammography attended the PEO (Philanthropic Educational Organization) meeting and discussed 3D mammography and breast health.

Goal 10: Increase the percentage of women in the NCDHD area who visit their health care provider for preventive care.

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.

RESULTS/IMPACT:

AMH continues to distribute flyers and pamphlets to the public and increase provider education.

Goal 11: Increase education about skin cancer and sun safety to all residents in the NCDHD area.

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

RESULTS/IMPACT:

Dr. Roger Rudloff has given free skin cancer screenings at AMH Health Fairs. Carol Anderson, APRN, also educates farmers on sun protection at various agri-business health fairs.

Behavioral Health: Mental Health & Substance Abuse

Goal 1: Increase access to therapeutic mental health services.

Objective 1: Assist providers to become Medicaid/Medicare providers.

RESULTS/IMPACT:

AMH expanded Telehealth Services to include a Behavioral Health Nurse Practitioner who is a Medicaid/Medicare provider.

Objective 2: Determine what mental health services and resources are available and develop a database.

Objective 5: Educate community and public health agencies on resources available.

RESULTS/IMPACT:

AMH Social Services Director has compiled a database of referrals for mental health transitional care. Bryan Health also assists AMH in referrals via Telehealth mental health crisis support. Katie DeMuth, PA-C, attended the *No Wrong Door* Training & Networking to learn about military culture, PTSD and Brain Injury influences on emotions and behaviors, and available resources and support through the VA and other organizations. Tami Kester, RN, AMH Family Practice Clinic Manager, attended UNMC's *Mood Disorders* educational conference.

Objective 3: Research options for implementing a program encouraging providers to relocate here after schooling.

RESULTS/IMPACT:

The Neligh Economic Development Director has given tours of Neligh to providers applying to AMH.

Objective 4: Identify and implement a uniform screening tool for primary care settings to detect mental health issues/needs.

RESULTS/IMPACT:

AMH currently does not have a screening tool; however, we utilize Telehealth mental health crisis support.

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

Objective 1: Determine options for eliminating transportation problems as a barrier to treatment.

RESULTS/IMPACT:

Patients no longer have to drive out of town to see a mental health provider as AMH offers mental health via Telehealth.

Objective 2: Educate communities about mental health resources available to ensure treatment is provided as soon as possible when concerns arise.

RESULTS/IMPACT:

AMH has advertised our Telehealth mental health providers via community newsletters, Facebook, AMH website, flyers and provider education.

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

Objective 1: Identify effective methods of reducing bullying.

RESULTS/IMPACT:

AMH has continued to distribute pamphlets and flyers from referral agencies. AMH also offers mental health counseling through Telehealth.

Goal 4: Reduce the suicide and attempted suicide rate.

Objective 1: Determine what mental health services and resources are available and develop a database.

Objective 2: Identify/create and implement screening tools for primary care settings to detect mental health issues/needs.

Objective 3: Educate community and public health agencies on resources available.

RESULTS/IMPACT:

AMH Social Services Director has compiled a database of referrals for mental health transitional care. Bryan Health also assists AMH in referrals via Telehealth mental health crisis support. AMH has included in its community newsletters our telehealth mental services.

Objective 4: Identify additional areas of the community (schools, parents, workplace, etc.) where suicide prevention education is needed.

RESULTS/IMPACT:

AMH was unable to connect with the school administration and teachers.

Objective 5: Identify demographic areas of the community (ages, careers, sexual orientation, etc.) that have risk factors that lead to suicide attempts.

RESULTS/IMPACT:

AMH was unable to address due to lack of resources available.

Objective 6: Identify uniform tool to assess risk for adolescent suicide in mental health provider locations.

RESULTS/IMPACT:

This is addressed through our telehealth mental health crisis support program.

Goal 5: Increase domestic and dating violence awareness and prevention.

Objective 1: Provide education regarding self-advocacy skills for adolescents.

RESULTS/IMPACT:

AMH continues to supply fliers from Bright Horizons in bathrooms and other public places and routinely asks children if they feel safe at home and in a relationship.

Objective 2: Provide education through schools, extension about recognition of what healthy relationships and personal boundaries are.

RESULTS/IMPACT:

AMH was unable to connect with the school administration and teachers.

Goal 6: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
Objective 1: Assess risk factors leading to binge drinking behavior.
Objective 2: Identify options for impacting adult acceptance/"cultural norm" status of binge drinking.
RESULTS/IMPACT:
AMH asks youth if they drink/how much/etc. AMH has been unable to coordinate educational sessions/seminars with police on the effects of drinking to include Spanish due to lack of time/resources but plans to get involved with the ACDC (Antelope County Does Care) Coalition in 2016 to plan an upcoming educational event for junior high-aged kids and their parents on substance abuse.

Goal 7: Reduce the past-year, non-medical use of prescription drugs.
Objective 1: Evaluate current practices of prescription drug dispensing.
RESULTS/IMPACT:
AMH will be implementing E-script and NEHII, which will make it easier for practitioners to monitor potential prescription drug abuse.
Objective 2: Increase awareness for perceived risk.
Objective 3: Investigate the options for having a stationary drug take-back location.
RESULTS/IMPACT:
AMH has advertised on their website the drug take-back program, which is located at the Antelope County Jail. AMH Pharmacist is available to the public for education.

Goal 8: Reduce the past-year use of illegal substance.
Objective 1: Develop a program encouraging employers to conduct drug testing on employees.
RESULTS/IMPACT:
AMH offers drug testing for other employers.

Goal 9: Reduce tobacco use.
Objective 1: Increase the recognition for risks of smokeless tobacco.
RESULTS/IMPACT:
Education is given at AMH Clinics. Local dentists check for oral cancers at routine checkups and educate patients on the risks of smokeless tobacco use.
Objective 2: Provide tobacco-free workplace tools to employers.
RESULTS/IMPACT:
AMH is beginning discussions on making our facility a smoke-free/tobacco-free campus.

Chronic Disease, Obesity & Related Health Conditions

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 by offering fruits or vegetables whenever other food is offered or sold.
RESULTS/IMPACT:
AMH was unable to connect with school administration and teachers.
Objective 2: Increase the proportion of children and adolescents who do not exceed recommended limits for screen time (electronics).
RESULTS/IMPACT:
AMH educates parents and children on healthy choices at clinic visits.
Objective 3: Reduce the proportion of adults who do not engage in any leisure time physical activity.
RESULTS/IMPACT:
(See description of AMH's Wellness Program above).

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.
RESULTS/IMPACT:

Carol Anderson, APRN, and her staff hold a diabetic conference at the Legion every November. Wellness, Pharmacy, the local optometrist, Ambulance, Ag Safety, and Dr. Brian Bossard (Bryan Telemedicine) were also involved in 2015.

Objective 3: Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education.

RESULTS/IMPACT:

AMH has a Diabetic Education Program led by Carol Anderson, APRN.

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.

RESULTS/IMPACT:

AMH Clinic measures BMI yearly and more often if warranted. AMH plans to implement an electronic health record at clinics, which will include BMI calculation. AMH has developed a Weight Loss Management Program led by Carol Anderson, APRN. In 2014, Radiology offered a Whole Body Comp Scan to the Biggest and Best Loser Contest participants and gave away 10 free exams; however, none of the participants came back for their follow-up exam and the program was never completed. The Whole Body Comp Scan measures the fat versus the muscle (body composition), targeting the areas on the body that participants need to work on to reduce the fat.

Goal 4: Increase overall cardiovascular health of 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.

RESULTS/IMPACT:

EMTs educated the public on early warning signs and symptoms of a heart attack at November's Diabetic Conference at the Legion. AMH Nursing staff also goes out to local businesses to take blood pressures. The Ag Safety Program led by Carol Anderson, APRN, goes to local ag businesses to hold health fairs. AMH holds an annual Health Fair, which includes blood pressure/cholesterol checks and education.

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

RESULTS/IMPACT:

AMH is exploring Health Fairs to include school-aged children. Blood pressures are taken from children age 5 years and up at AMH clinic visits.

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.

RESULTS/IMPACT:

The Ag Safety Program led by Carol Anderson, APRN, addresses this issue at Health Fairs held at local ag businesses.

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

RESULTS/IMPACT:

AMH continues to support the community in these efforts.

Objective 3: Increase the number of households, testing for specific hazardous living conditions: radon, unsafe water, toxic chemicals, lead and mold.

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

RESULTS/IMPACT:

AMH continues to support police/social services in public education. AMH offers babysitting classes to the public.

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

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

RESULTS/IMPACT:

AMH was unable to measure due to lack of resources.

Objective 2: Reduce non-fatal physical assault injuries.

RESULTS/IMPACT:

AMH continues to support police/social services in public education.

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

RESULTS/IMPACT:

AMH nurses and providers continue to offer assistance and support in this area through education.

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

RESULTS/IMPACT:

The Ag Safety Program led by Carol Anderson, APRN, addresses this issue at Health Fairs held at local ag businesses. AMH Home Health evaluates their clients' home environment and educates them on safety.

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

RESULTS/IMPACT:

The Ag Safety Program led by Carol Anderson, APRN, addresses this issue at Health Fairs held at local ag businesses.

SUMMARY OF FINDINGS

SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY

The following chart displays significant health needs identified throughout this report, based on the information within this assessment as well as the guidelines of Healthy People 2020.

Areas of Opportunity Identified through This Assessment	
Access to Healthcare Services	▪ Lack of access to facilities, physicians, rate of uninsured, financial hardship, transportation, cultural competency, coverage limitations
Cancer	▪ Cancer deaths: Lung, Prostate, Colorectal ▪ Cancer Incidence: Prostate, Lung, Skin, Breast ▪ Cancer Screening: Cervical, Colon, Breast ▪ *Cancers ranked as a top concern*
Aging Problems (e.g. arthritis, hearing/vision loss, etc.)	▪ Increasing older population ▪ Disability prevalence ▪ *Aging problems ranked as a top concern*
Diabetes	▪ Diabetes Deaths ▪ Diabetes Incidence ▪ Risky behaviors (see Nutrition, Physical Activity & Weight)
Heart Disease & Stroke	▪ Mortality ▪ Awareness o Incidence decreasing ▪ *Heart Disease & Stroke ranked as top concern*
Injury & Violence	▪ Safety seat/safety belt usage (children) ▪ Texting while driving ▪ Using cell phones while driving
Mental Health	▪ Access to care ▪ Stigma
Nutrition, Physical Activity & Weight	▪ Overweight prevalence (adults) ▪ Amount of physical activity ▪ Access to recreation/fitness centers ▪ *Nutrition, weight and physical activity ranked as top concern*
Respiratory Diseases	▪ Chronic Obstructive Pulmonary Disease (COPD) ▪ Asthma
Oral Health	▪ Incidence of tooth extraction ▪ Incidence of tooth decay ▪ Regular dentist visits
Environmental Health	▪ Adequate housing

Immunizations	▪ Vaccinations
	  o Pneumonia
	  o Influenza

Substance Abuse	▪ Binge drinking ▪ Seeking help for alcohol/drug issues ▪ Substance abuse among children (youth survey) ▪ Tobacco use

ANTELOPE MEMORIAL HOSPITAL: ANTELOPE

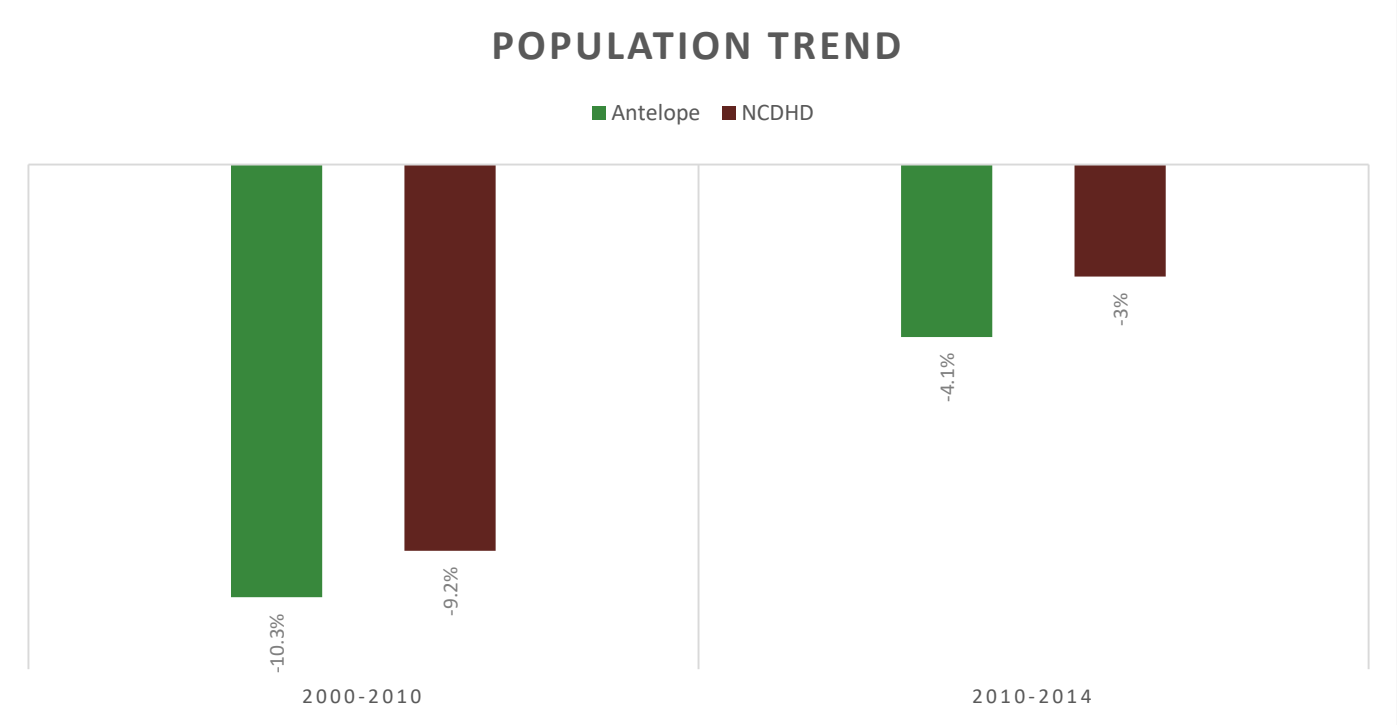
POPULATION CHARACTERISTICS

TOTAL POPULATION

According to the most recent census estimates, Antelope County encompasses 857 square miles and 6,414 residents; the county is 100% rural. The North Central District is 87.8% rural, whereas the state of Nebraska is 26.9% rural, thus explaining North Central District's low population density of about 3.18 persons per square mile.

POPULATION CHANGE

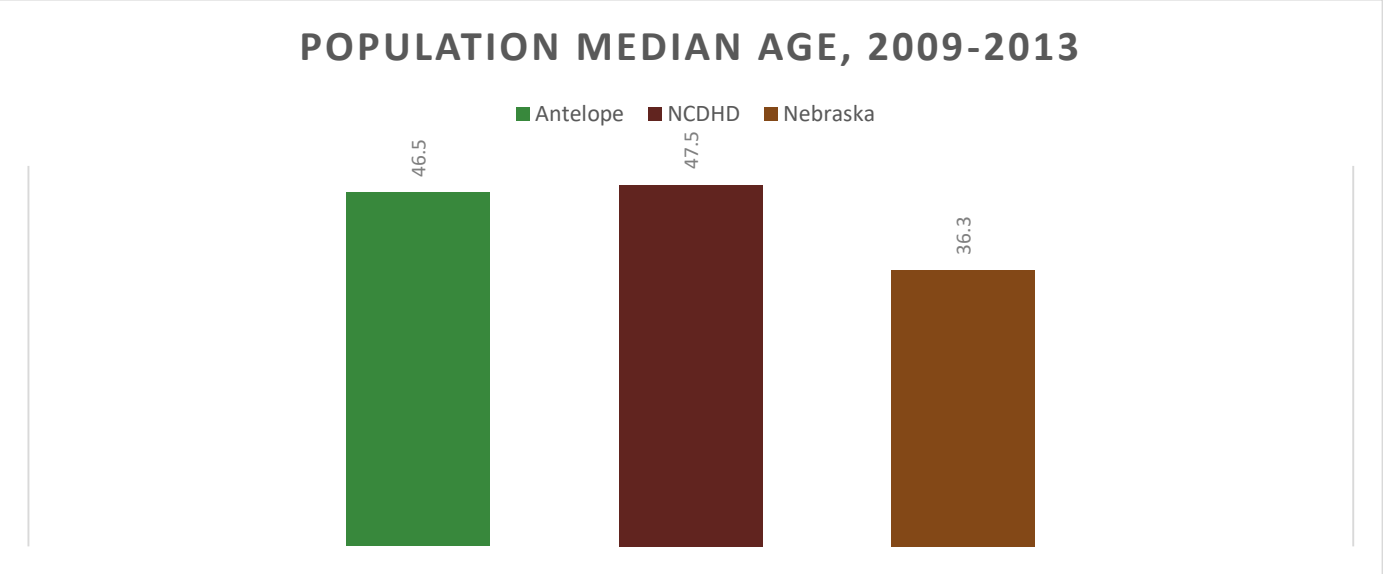
A significant negative shift in total population over time can impact healthcare providers available for the service area and the utilization of community resources. Between 2000-2010 US Censuses, Antelope County's total population has decreased by 10.29%, while from 2010-2015 the total population for Antelope County decreased by only 4.1%.



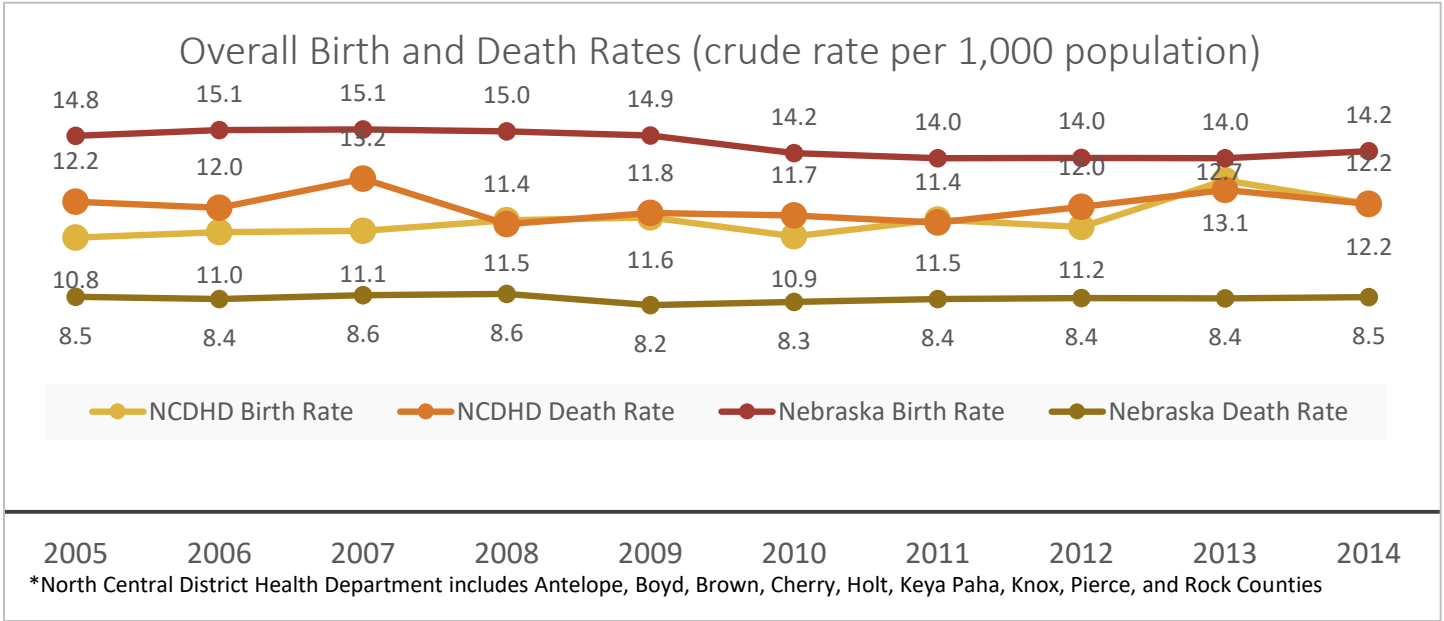
POPULATION DEMOGRAPHICS

The majority of the residents in Antelope County (98.5%) are non-Hispanic, white residents. The remaining minority proportion is 0.4% Asian, 0.3% Black and 0.2 Hispanic or Latino. Approximately 18.3% of the Antelope County population over the age of 25 has a Bachelor's degree or higher; 91.1% have at least a

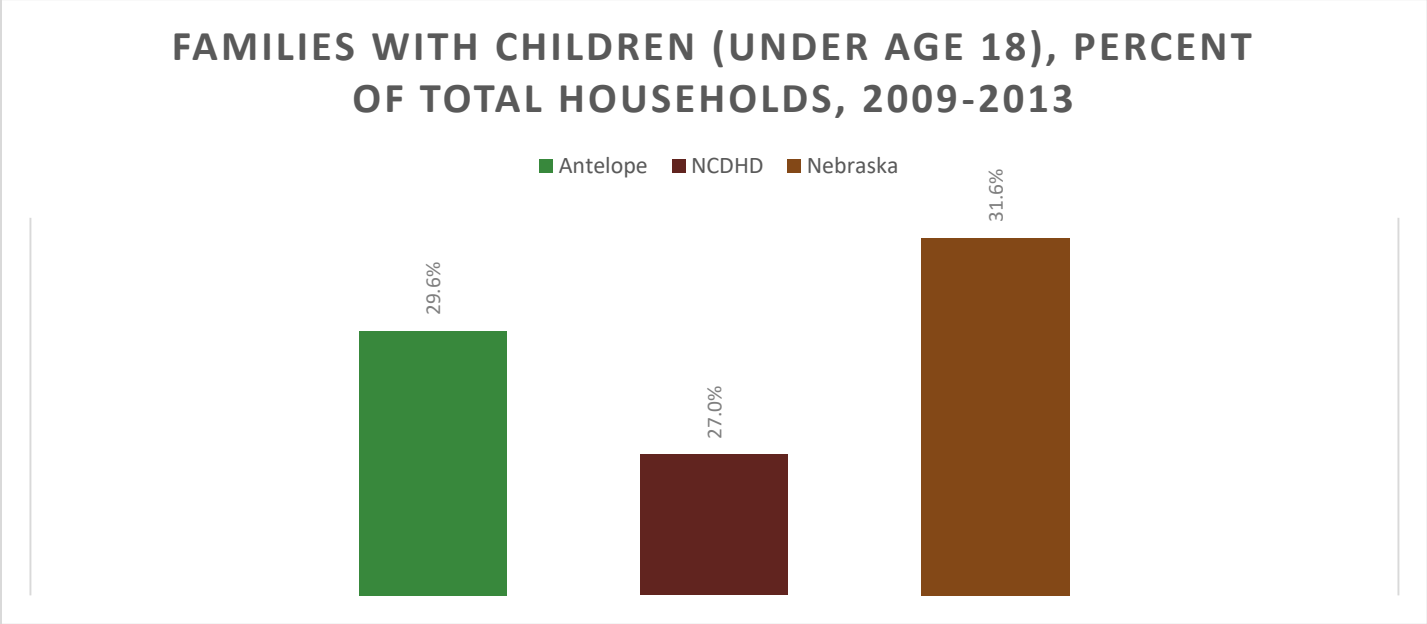
high school diploma. The median household income for Antelope County is $45,417, while the Nebraska median household income is $51,502. For the district, approximately 64% report being married, while 82% of survey participants were married.



Data Source: CHNA (US Census Bureau, American Community Survey. 2009-13)

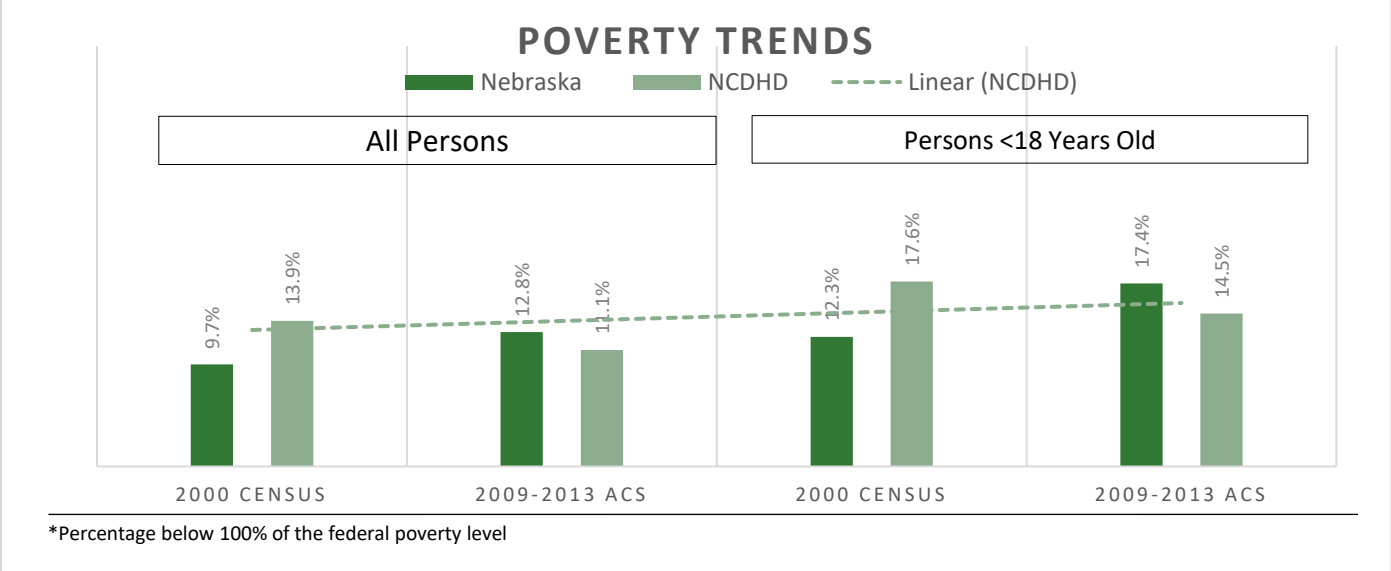


*North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties



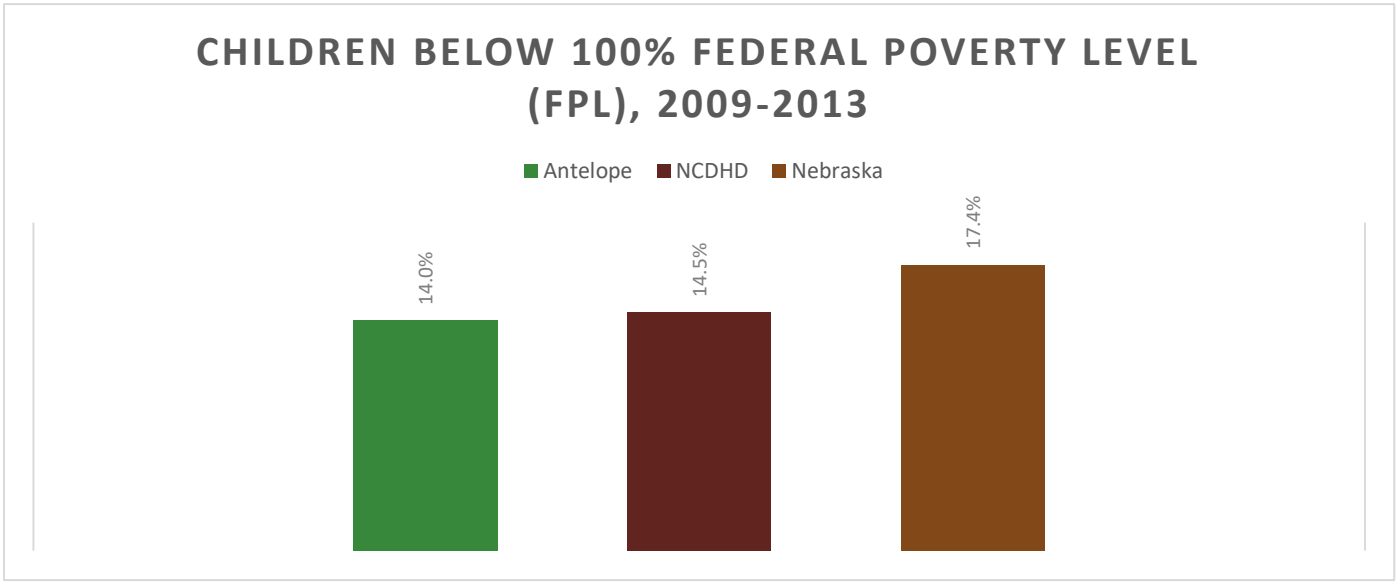
Data Source: US Census Bureau, American Community Survey. 2009-13. Source geography: Tract

POVERTY

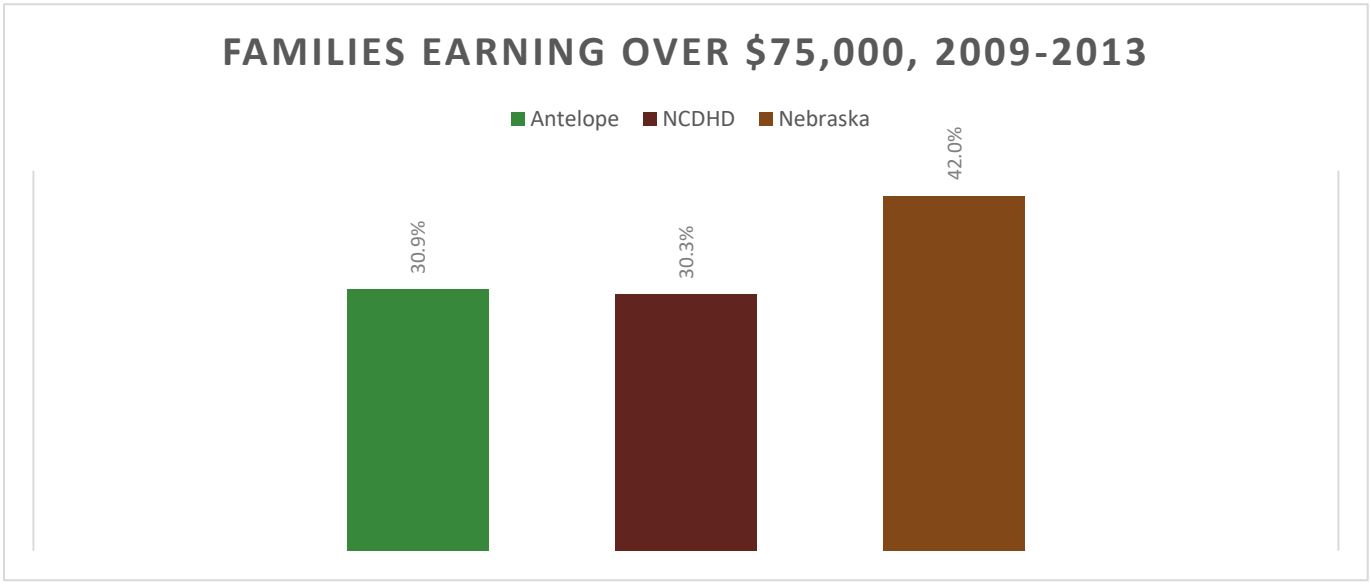


Poverty is identified as a barrier to many public health-related issues including: access to care, nutrition, education, etc. Within Antelope County, there are 216 (14%) children living below the Federal Poverty

Level (FPL), and 2,386 (37%) individuals living in households with income below 200% of the FPL.



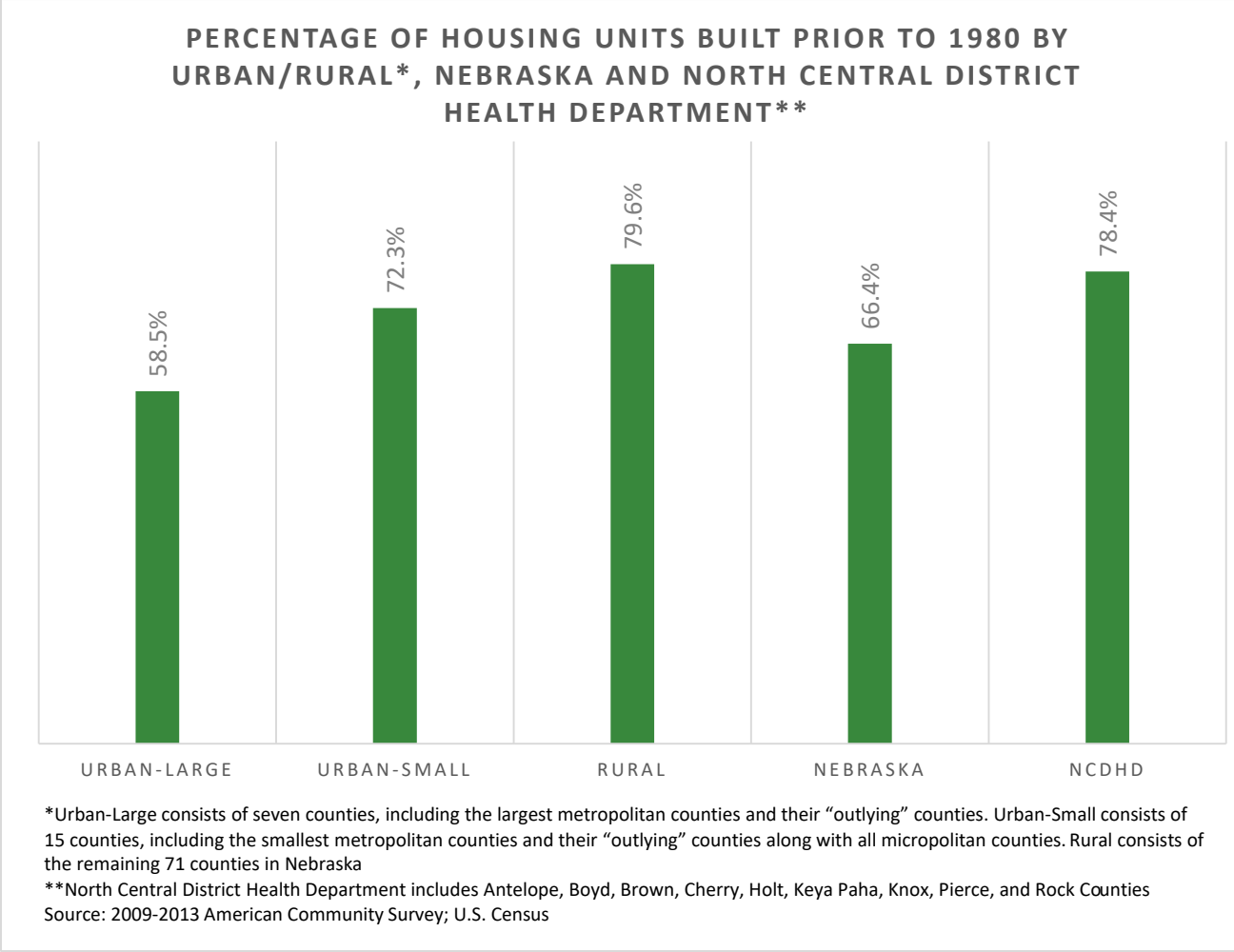
Data Source: CHNA (US Census Bureau, American Community Survey. 2009-13)



Data Source: CHNA (US Census Bureau, American Community Survey. 2009-13)

HOUSING ENVIRONMENT—SUBSTANDARD HOUSING

Substandard housing is identified as homes where the quality of living and housing can be considered substandard due to lack of complete plumbing facilities, lack of complete kitchen facilities, 1.01 or more occupants per room, monthly owner costs as a percentage of household income greater than 30%, and gross rent as a percentage of household income greater than 30%. Approximately 21% of Antelope County's occupied housing units (rented or owned) meet at least one of these aforementioned criteria.



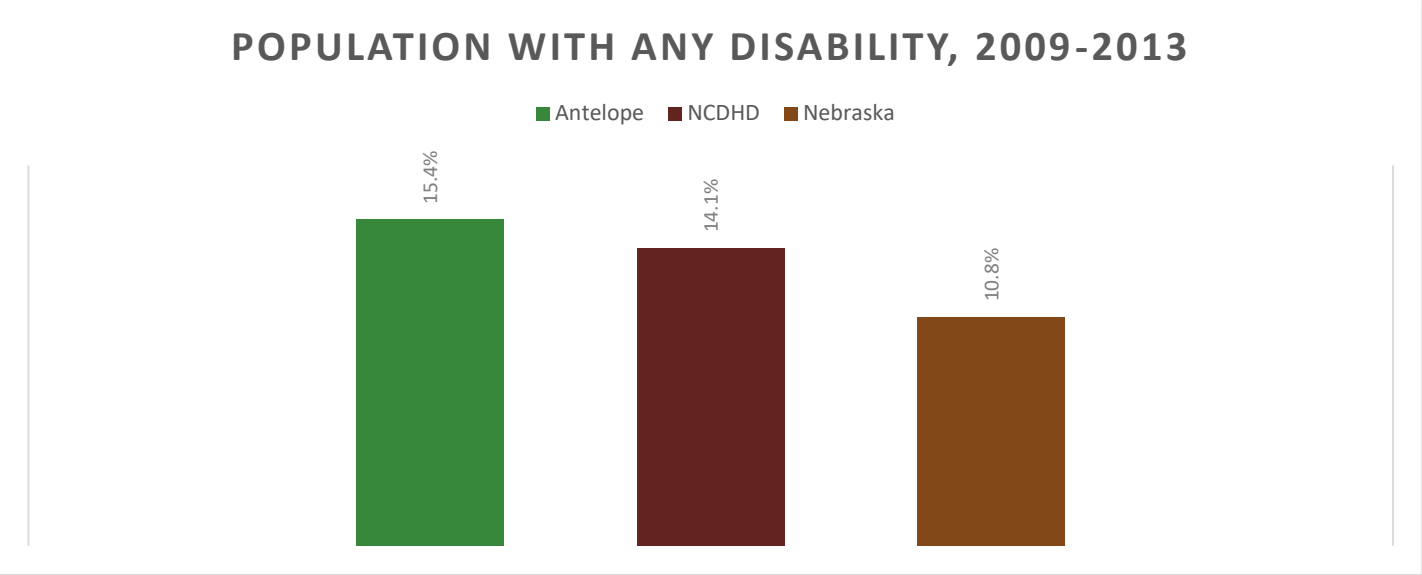
*Urban-Large consists of seven counties, including the largest metropolitan counties and their "outlying" counties. Urban-Small consists of 15 counties, including the smallest metropolitan counties and their "outlying" counties along with all micropolitan counties. Rural consists of the remaining 71 counties in Nebraska

**North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties

Source: 2009-2013 American Community Survey; U.S. Census

DISABILITY

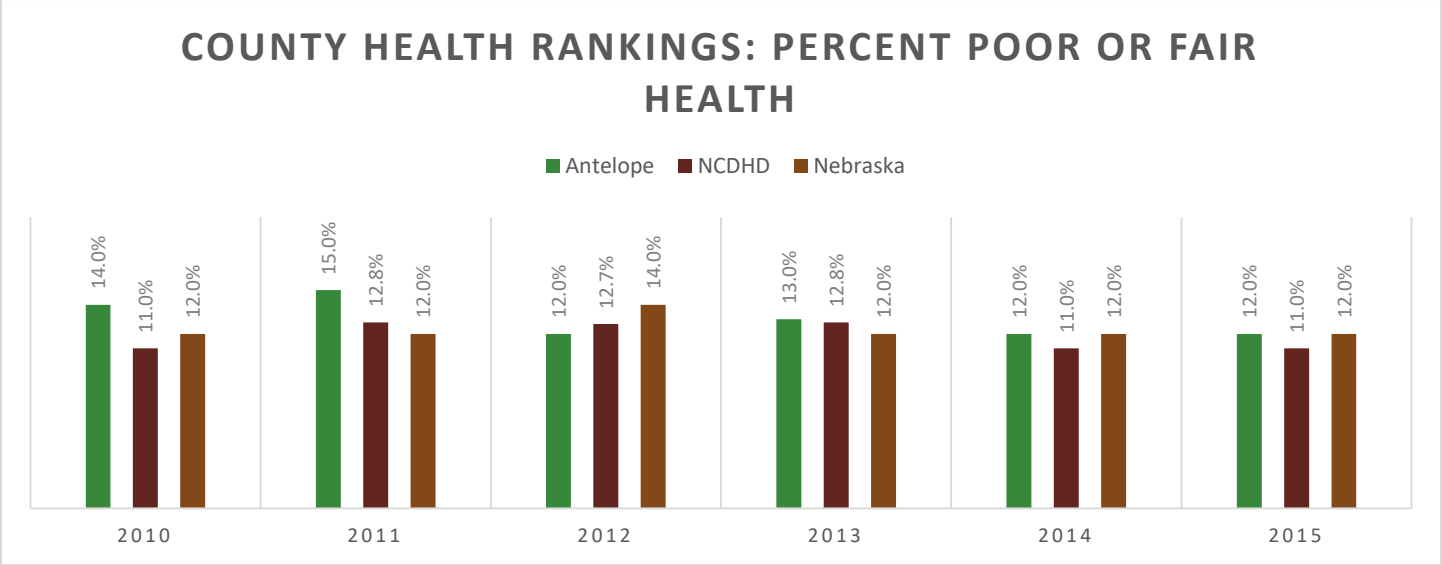
Disability status is defined as the civilian non-institutionalized population with a disability. This is a relevant metric for the Community Health Needs Assessment, because providers consider disabled individuals a vulnerable population that require targeted services and outreach. Within Antelope County, 15.4% of households have at least one disabled individual residing there. The age breakdown is as follows: 6.4% under 18 years of age, 10.5% are 18-64 years of age, and 39.7% are 65 year or older.



Data Source: CHNA (US Census Bureau, American Community Survey. 2009-13)

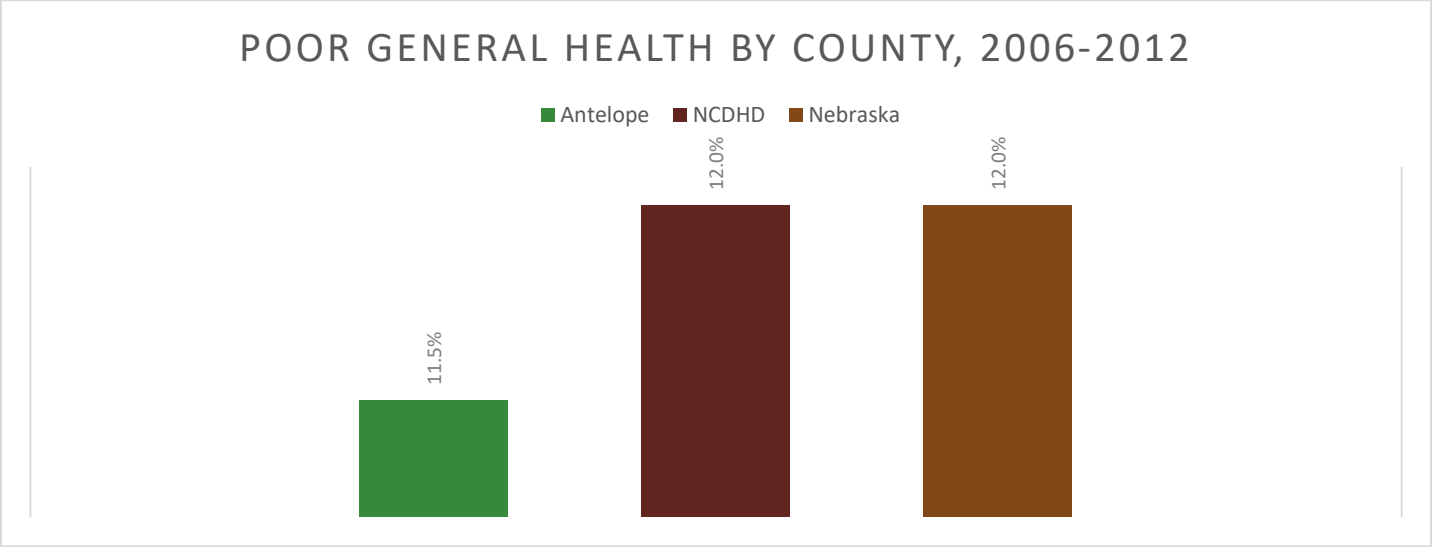
GENERAL HEALTH STATUS

From the Healthy County Rankings data, those that reported poor or fair health from within the service area has varied slightly from 2010 to 2015. The percent of Antelope County residents who said they had poor or fair general health was 14% in 2010, peaked at 15% in 2011 and fell to 12% by 2014.



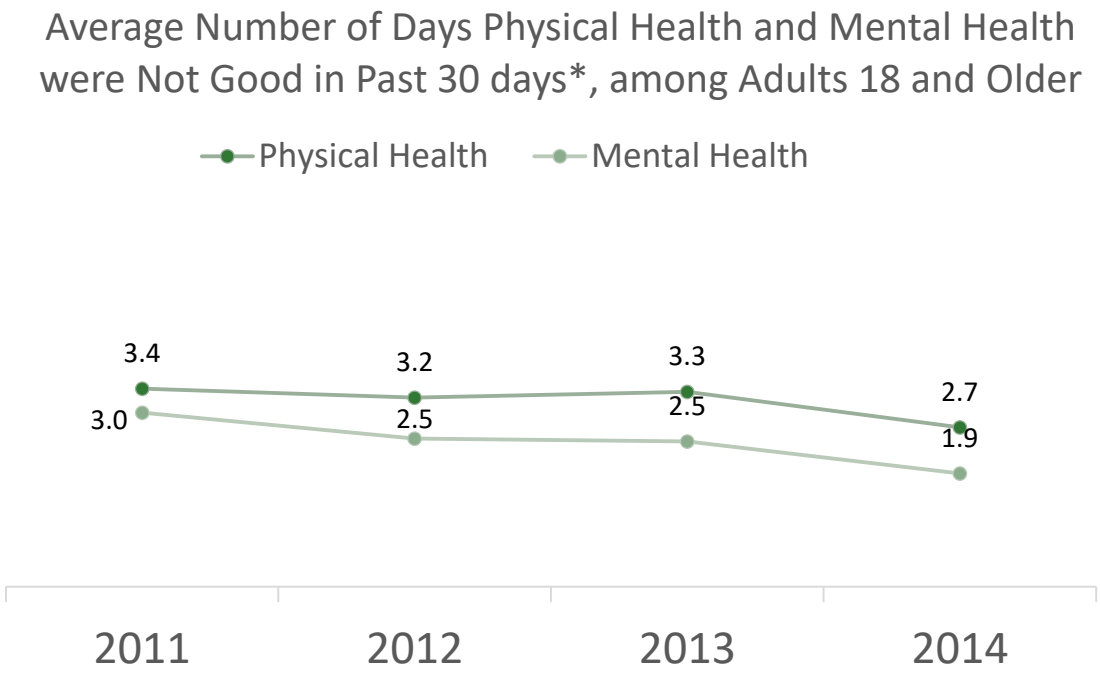
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

The average percent that claimed poor general health from 2006 to 2012 can be seen below.



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

MENTAL HEALTH

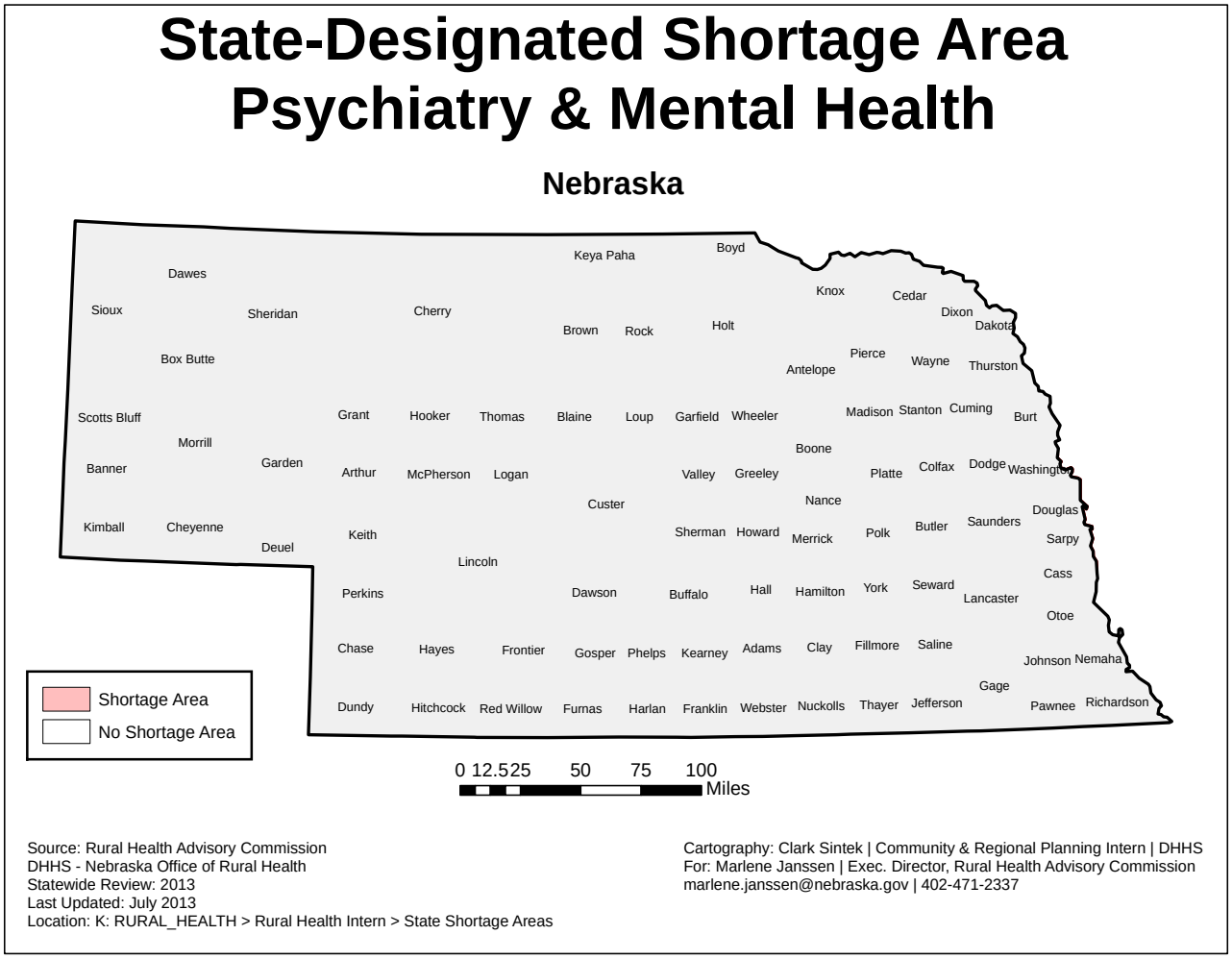


*Average number of days during the previous 30 that adults 18 and older report (1) their physical health (illness and injury) was not good and (2) their mental health (including stress, depression, and emotions) was not good

**North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties

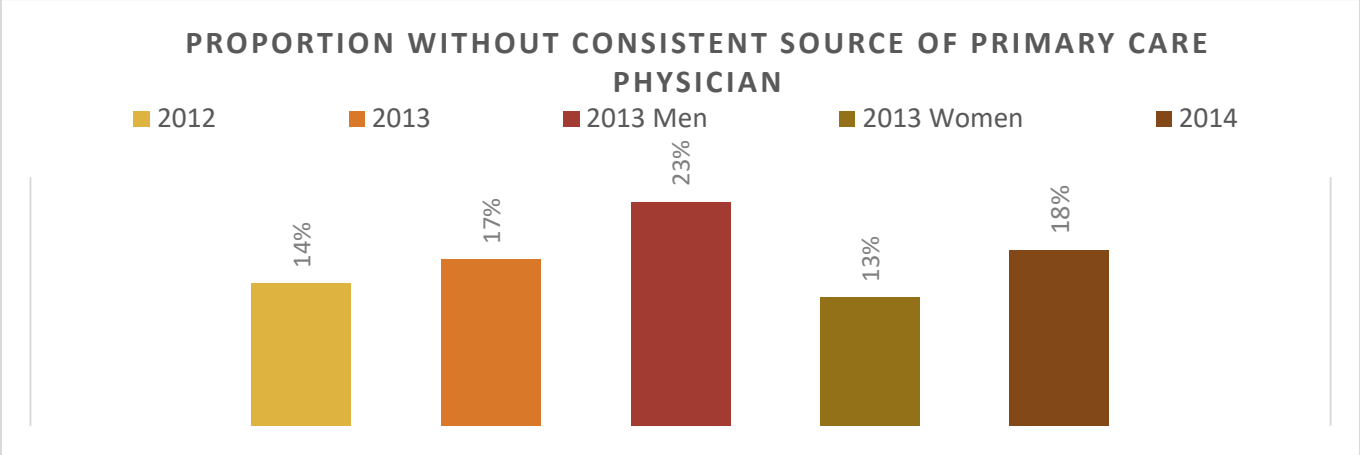
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Mental health issues can range from displaying issues to resisting seeking care due to associated stigma. The 2014 Behavioral Risk Factor Survey (BRFSS) reported that approximately 12% of the survey respondents had been told they have depression, which has decreased from 15% in 2011. This is significantly lower than the state proportion of those reported to have depression, which is approximately 18%. Frequent mental distress in the past 30 days was reported by 5% of respondents of the service area survey. In 2012, 7% of respondents reported taking medication for a mental health condition, and 1% experienced symptoms of a serious mental illness within the last 30 years. All counties within the district are state-designated shortage areas for psychiatry and mental health.



ACCESS TO CARE

Access to care is a primary concern of rural areas. This is a lack of various healthcare resources including: facilities, physicians, insurance, transportation, cultural competency, and health literacy. Within the North Central District, lack of a consistent source of primary care physician shows to be a growing concern. This seems to be disproportionately displayed by gender (see table below). In addition, this can cause declining prevention of major health issues as well as an increase in emergency department visits. Despite this, the percentage of North Central District respondents that had received routine health check-ups in the past 12 months has increased from 59% in 2011 to 64% in 2014 (although where the healthcare was received was not noted).

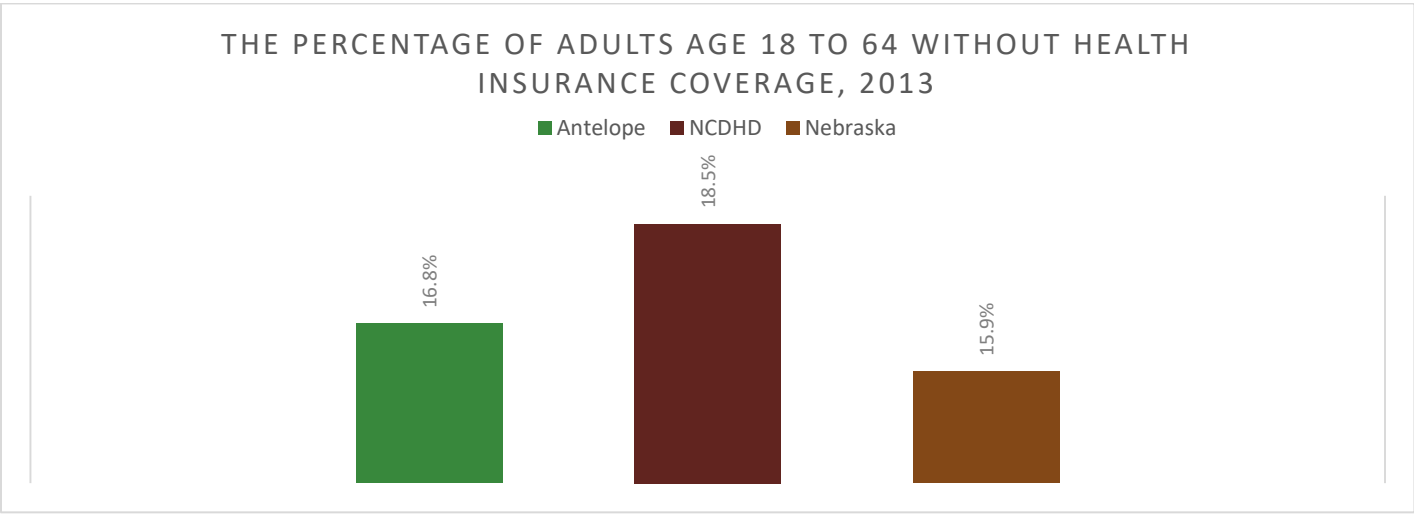


COST OF HEALTHCARE

Cost also surfaced in the survey responses as a barrier to obtaining proper healthcare. However, these numbers have been decreasing in recent years (11% in 2013 to 8.5% in 2014). Survey respondents reported paying for their health services as follows: 3% pay cash; 81% private health insurance; 2.3% Medicaid; 6% Medicare; 1.4% Veteran's Administration; 0.2% Indian Health Services and 7% other.

INSURANCE COVERAGE

Within the Antelope Memorial service area, the proportion of uninsured adults is approximately 16.8%, which is more than the 15% of uninsured adults within Nebraska and 18.5% in our health district. Within Antelope County, there were 591 uninsured adults in 2013 and 839 adults covered with Medicaid. In addition, there are 134 uninsured children (8.6%) within the service area. The proportion of uninsured individuals for the service area was found to be lower than that of the health district and higher than the state of Nebraska.



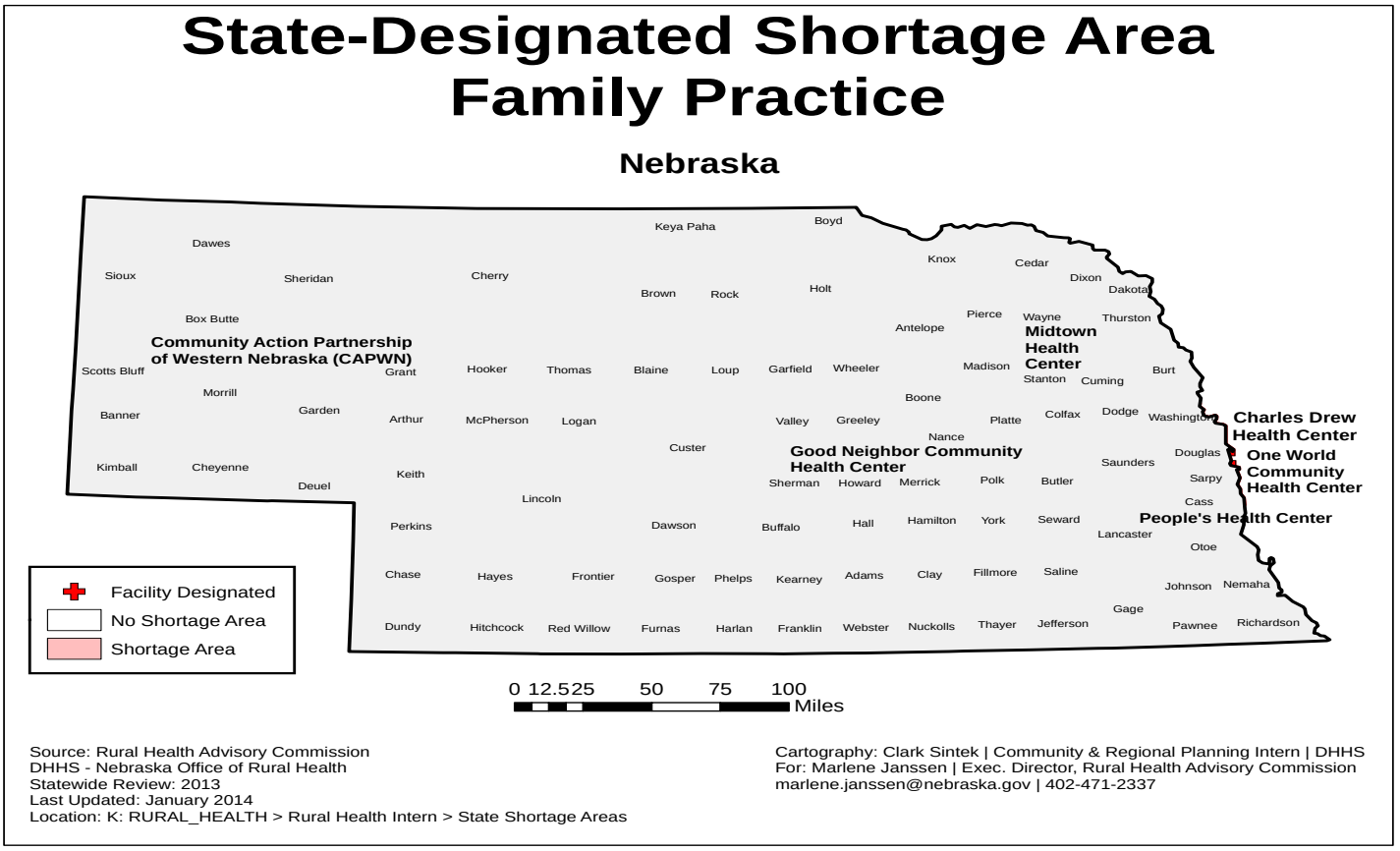
Data Source: US Census Bureau, Small Area Health Insurance Estimates. 2013.

HEALTH LITERACY AND ACCESS

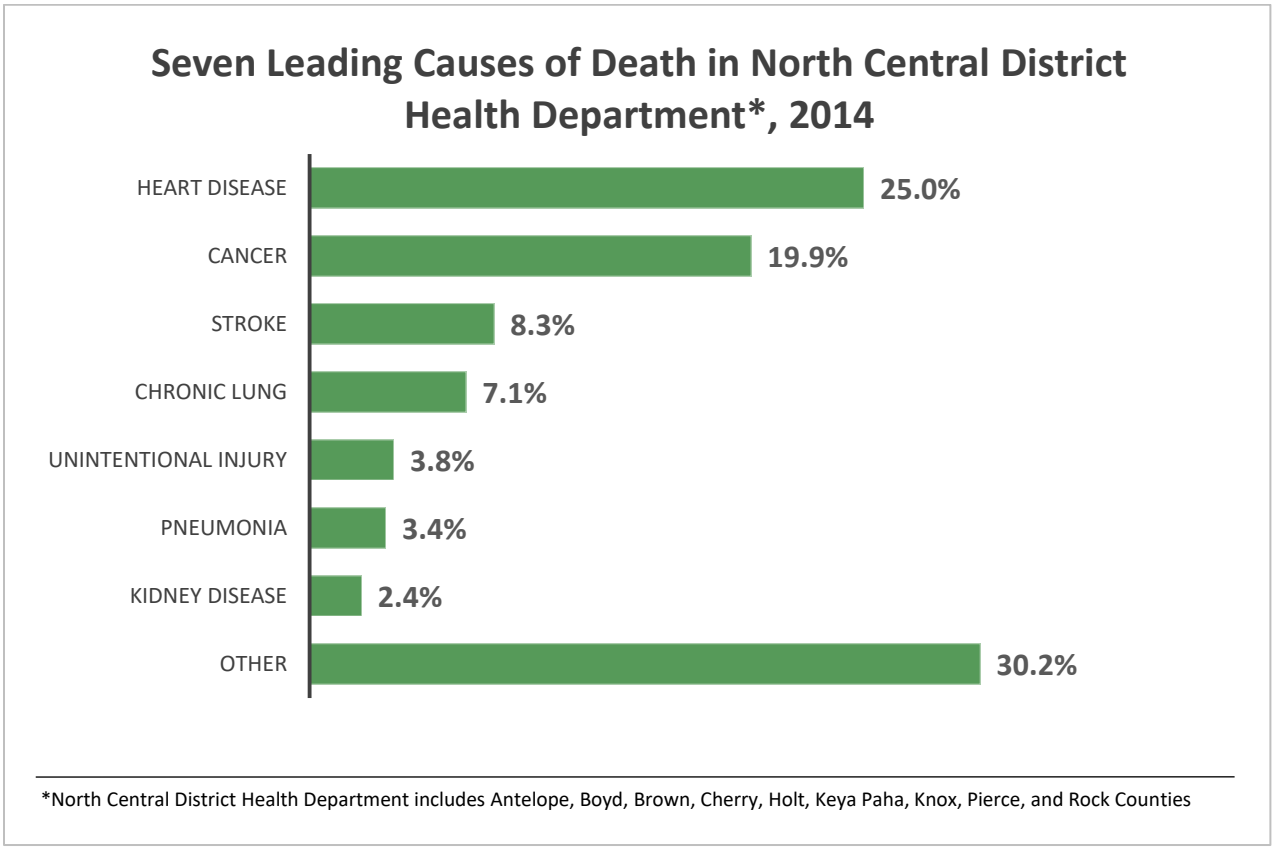
Understanding health information can be directly correlated with access and quality of healthcare. Health Literacy Nebraska is one organization that supports efforts to improve health literacy. With these efforts, 68% of respondents acknowledged that written health information is always or almost always easy to understand. While, on the contrary, 11% said they always or nearly always had help reading health information.

HEALTH PERSONNEL SHORTAGE AREAS

Shortage areas are defined by Health Resources and Services Administration (HRSA) shortage designation criteria, which determine whether or not a geographic area or a specific population group qualifies as a Health Professional Shortage Area or a Medically Underserved Area or Population. Given this information, Antelope County is a state-designated shortage area for General Pediatrics, Obstetrics/Gynecology, General Surgery, and Psychiatry/Mental Health.



LEADING CAUSES OF DEATH



Leading Causes of Death in North Central District Health Department*

2005-2009 Combined				2010-2014 Combined			
Rank	Cause of Death	Number Deaths	% of Total	Rank	Cause of Death	Number Deaths	% of Total
1	Heart Disease	823	28.8%	1	Heart Disease	688	25.0%
2	Cancer	607	21.3%	2	Cancer	586	21.3%
3	Stroke	209	7.3%	3	Stroke	204	7.4%
4	Unintentional Injury	164	5.7%	4	Chronic Lung	158	5.7%
5	Chronic Lung	135	4.7%	5	Unintentional Injury	127	4.6%
6	Alzheimer's	110	3.9%	6	Alzheimer's	95	3.5%
7	Diabetes	91	3.2%	7	Pneumonia	89	3.2%
8	Pneumonia	73	2.6%	8	Diabetes	86	3.1%
9	Kidney Disease	50	1.8%	9	Kidney Disease	49	1.8%
10	Parkinson's	35	1.2%	10	Parkinson's	37	1.3%
	Total	2,856			Total	2,750	

LEADING HOSPITAL DISCHARGE DIAGNOSES

2014		2015	
Antelope Memorial Hospital, Antelope		**Antelope Memorial Hospital, Antelope**	
1	Pneumonia	1	Pneumonia
2	Live Born in Hospital w/o Cesarean Section	2	Cellulitis of Leg
3	Congenital Heart Failure	3	Chronic Obstructive Bronchitis w/ Acute Exacerbation
4	Atrial Fibrillation	4	Intestinal Obstructive
5	Birth Outside of Hospital, Hospitalized	5	Gastrointestinal Hemorrhage

Leading Causes of Inpatient Hospitalization*, North Central District Health Department, 2013**

Cause	#	%
Circulatory System Diseases	726	15.8
Respiratory System Diseases	546	11.9
Pregnancy & Childbirth	462	10.0
Digestive System Diseases	405	8.8
Musculoskeletal System Diseases	327	7.1
Neoplasms	160	3.5
Endocrine, Nutritional, Metabolic, Immunologic Disorders	160	3.5
Genitourinary System Diseases	155	3.4
Infections & Parasitic Diseases	130	2.8
Mental Disorders	128	2.8
Skin & Subcutaneous Tissue Diseases	85	1.8
Nervous System & Sense Organ Diseases	68	1.5
Injury & Poisoning	51	1.1
Anemia & Diseases of the Blood and Blood -Forming Organs	45	1.0
Congenital Anomalies	11	0.2
All Others	1,142	24.8
Total	4,601	100.0

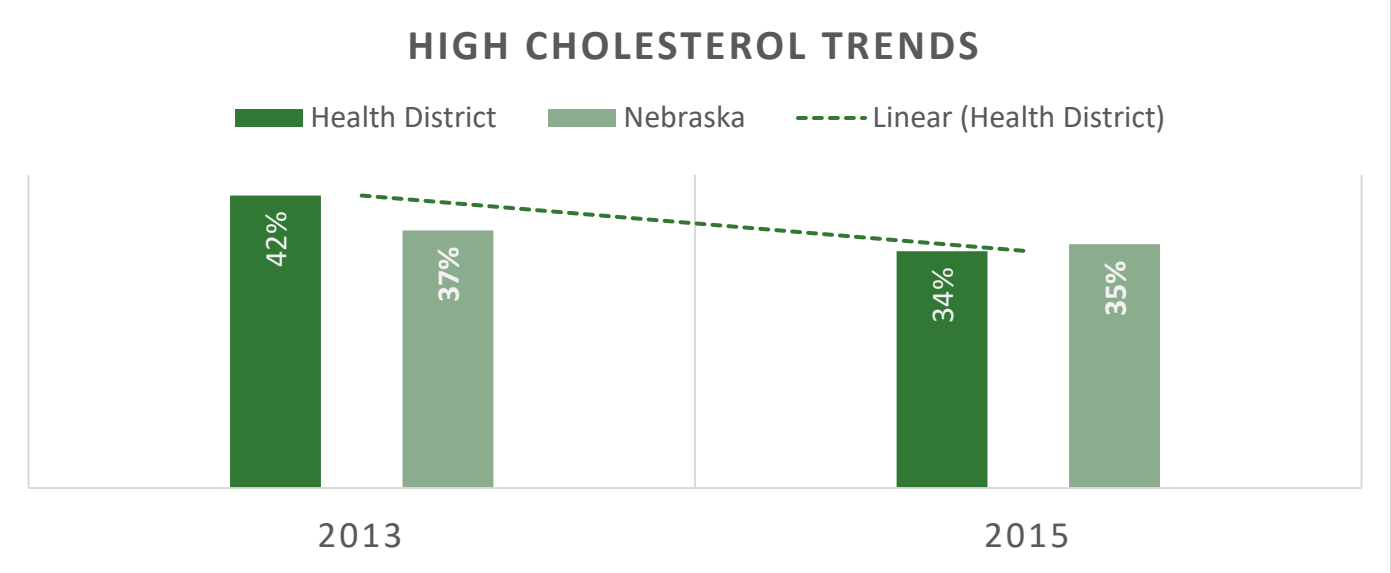
*Based on the general ICD-9-CM categories
**North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties
Source: Nebraska Hospital Discharge Data, NDHHS

CHRONIC CONDITIONS

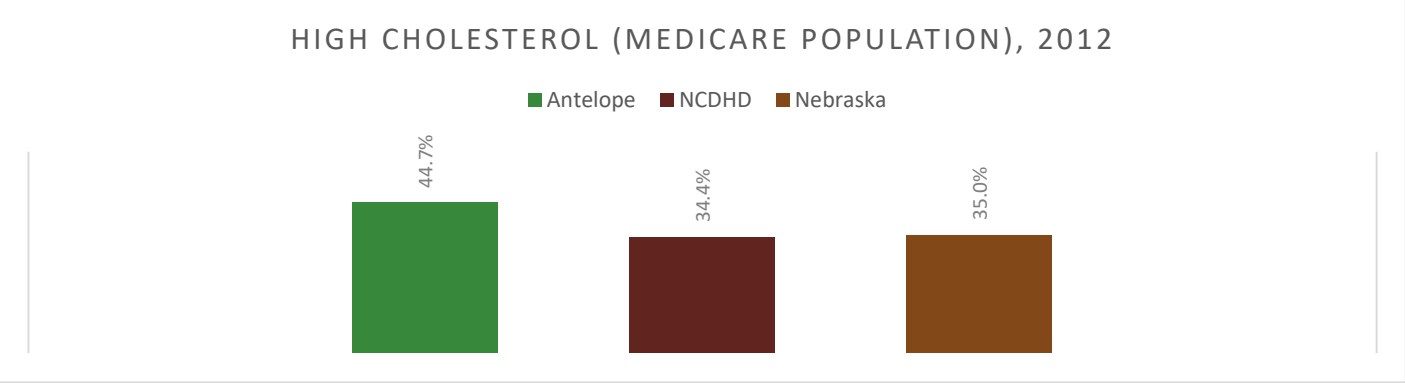
CLINICAL RISK FACTORS: CHOLESTEROL, BLOOD PRESSURE & SCREENING

CHOLESTEROL

In the state of Nebraska, heart disease has been a leading cause of death since 2013, with approximately 3,378 deaths annually attributed to this ailment. The BRFSS in Nebraska reports a prevalence (self-reported) of 74% with high cholesterol. Of those who reported being tested for high cholesterol, 38% and 37% (in 2011 and 2013, respectively) confirmed high cholesterol.



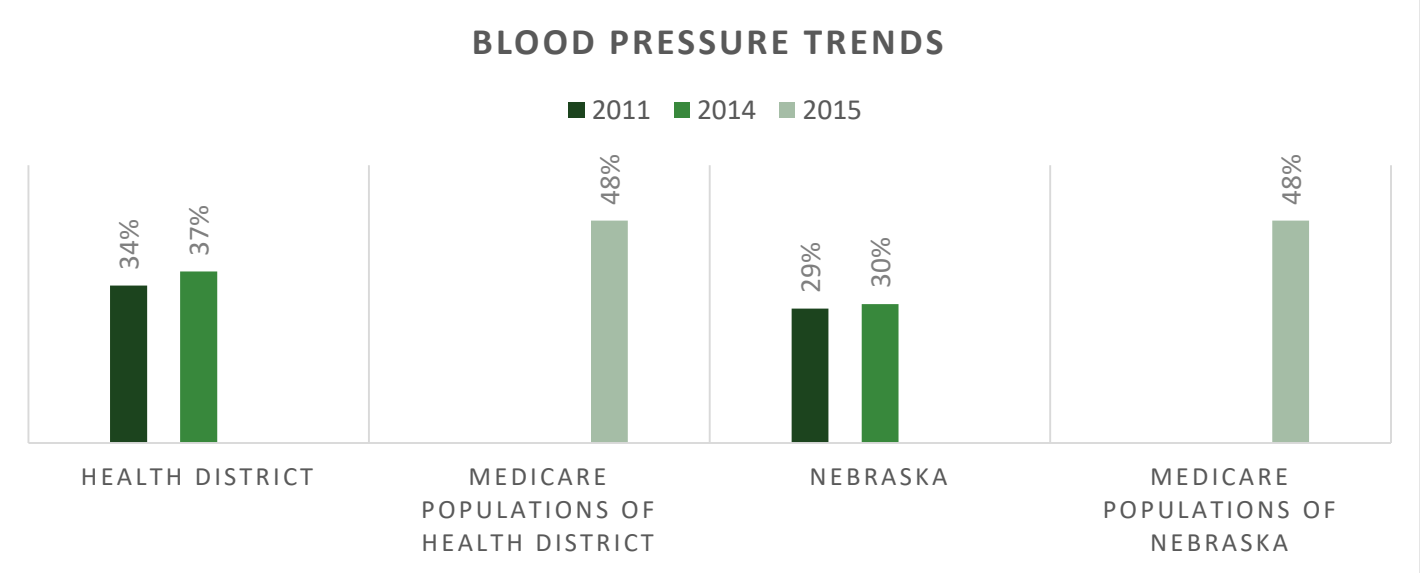
County-specific data on the Medicare population's prevalence of high cholesterol showed that 44.7% of the Antelope County Medicare population had high cholesterol. Seventy-four percent of the North Central District population reported being screened for high cholesterol within the past five years, which was higher than the state (72%) in 2013.



Data Source: Centers for Medicare and Medicaid Services. 2012.

BLOOD PRESSURE

High blood pressure is a common condition that increases the risk for heart disease and stroke, two leading causes of death in Americans. It is suspected by the Centers for Disease Control and Prevention (CDC) that only approximately 52% of those with high blood pressure have it under control. The prevalence of high blood pressure for the health district was 34% (self-reported, NE DHHS). The CHNA Medicare Population showed 58% with high blood pressure, which was the same as what was reported for the state (see below). The prevalence of high blood pressure in Antelope County was 55% through the Medicare population and 21% of adults in Antelope County age 18 and older that have been told by a doctor of having elevated blood pressure or hypertension.



SCREENING

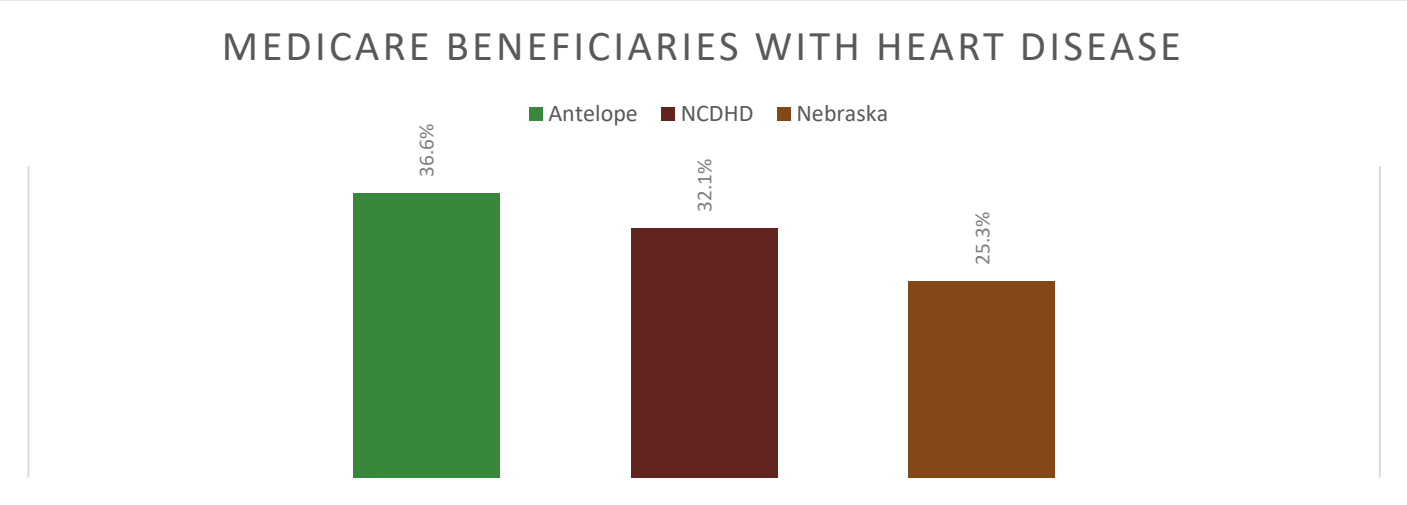
Blood pressure screening for the North Central District is less than that of the state of Nebraska (82% and 85%, respectively). Screening is of importance, because if detected early, high blood pressure can be more effectively managed and treated. Males were slightly lower in terms of screening than females (78% and 88%, respectively). The proportion of those currently taking blood pressure medications within the health district medications decreased from 85% in 2011 to 79% in 2013. This, too, showed differences among gender, with 77% of males and 95% of females currently taking blood pressure medications in 2011 decreasing to 71% and 88% in 2013.

HEART ATTACK, HEART DISEASE AND STROKE

HEART ATTACK

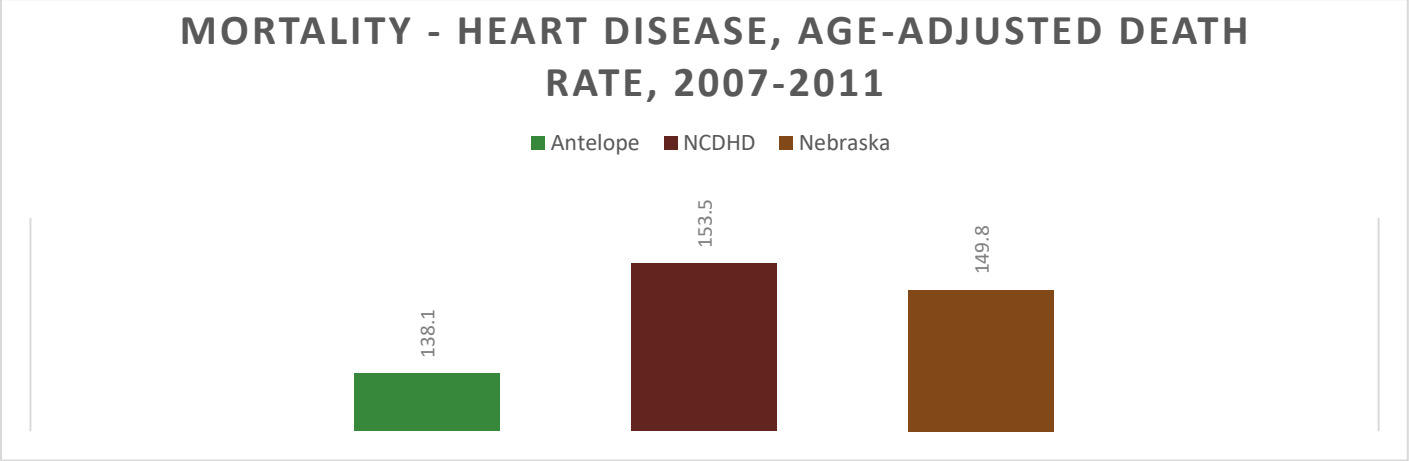
According to the BRFSS data in 2014, 4.6% of residents in the health district reported having had a *heart attack*, which was slightly higher than the 3.8% of the state. From 2011 to 2013, the proportion of those having suffered from a heart attack has varied somewhat (6%, 8% and 6%, respectively). Heart attack incidence ranged by gender, from 12.5% of males to 3.6% of females within the health district in 2012.

HEART DISEASE



Data Source: Centers for Medicare and Medicaid Services. 2012.

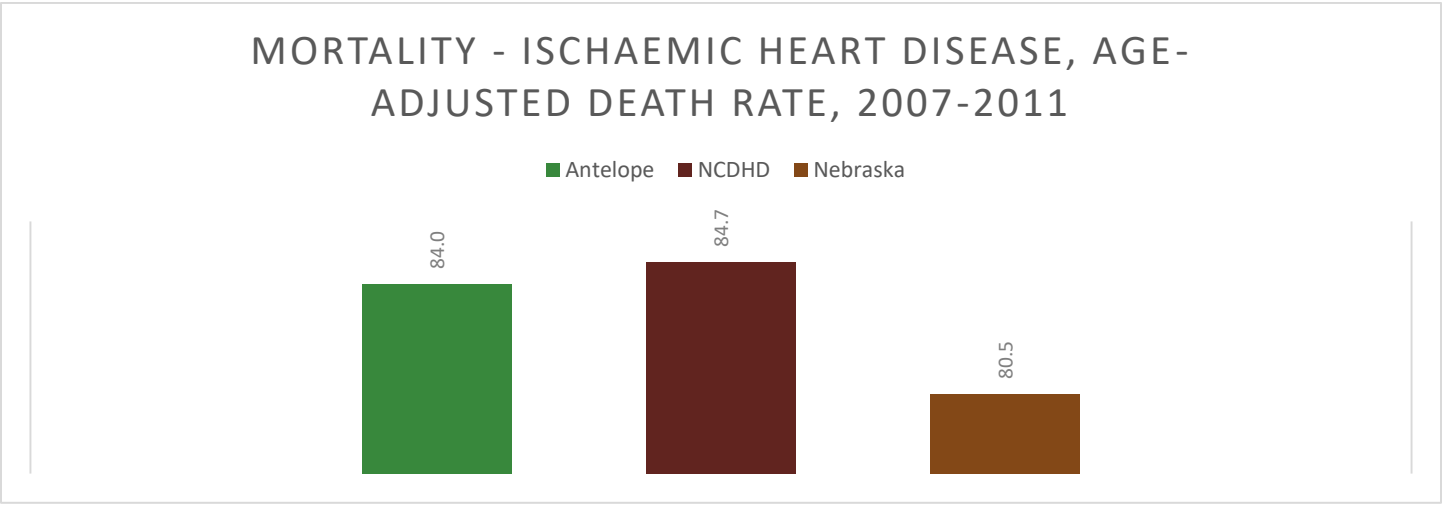
Heart disease encompasses many variations of heart conditions including: Coronary Artery Disease (Coronary Heart Disease), Cardiomegaly, Heart Attack, Atrial Fibrillation, Heart Valve Disease, Congenital Heart Disease, and several others. Within the service area, 36.6% of the Antelope County Medicare Population reported having any heart disease, which is more than 25% reported from the state and 32% from the district. The age-adjusted death rate attributed to heart disease, for the health district was 153.5 per 100,000 and for Nebraska was 149.8 per 100,000.



Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2009-13.

CORONARY HEART DISEASE

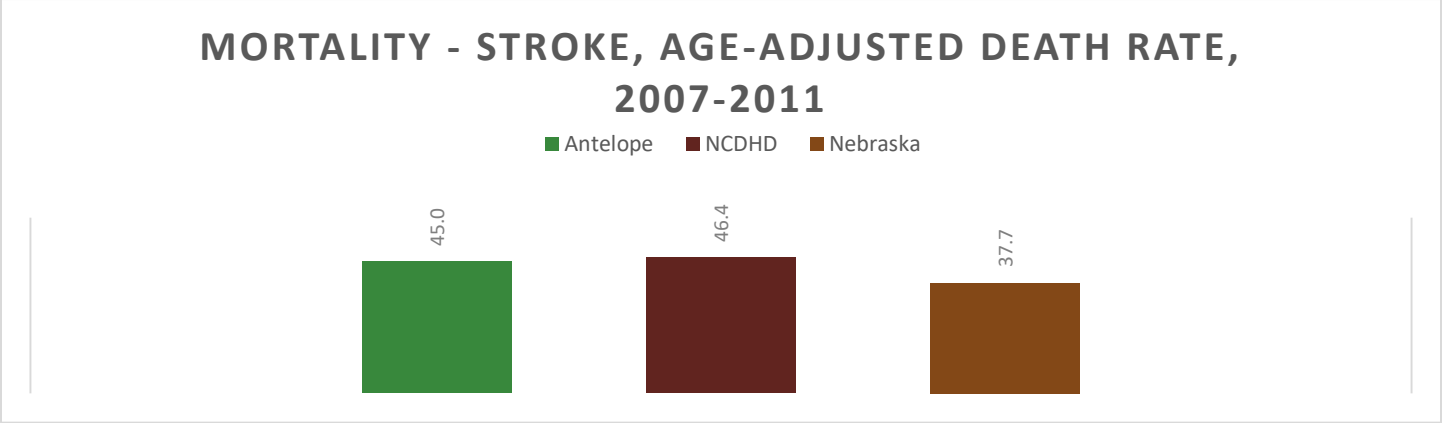
Coronary heart disease (or Ischaemic Heart Disease) was prevalent in 4% of the district population, which was nearly the same as the state's prevalence for 2015. This is lower than what was reported in 2012 and 2013 (7.8% and 5.8%, respectively). Those residents of the North Central District area that reported they had a *heart attack or coronary heart disease* was not significantly different from that of the state for 2013 (8% and 6%, respectively). The age-adjusted death rate attributed to Ischaemic heart disease, for the health district was 84.7 per 100,000 and for Nebraska was 80.5 per 100,000; both were less than the Healthy People 2020 goal of less than 103.4 per 100,000. Antelope County had a lower coronary heart disease death rate (84 per 100,000 population) comparted to the health district. Nationwide the rate was 126.7 and the Health People 2020 target is 103.4.



Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2009-13.

STROKE

In 2014, those from the health district who reported having a stroke had declined since 2011 (2.5% to 3.3%, respectively), which was not significantly different from that of the state. The age adjusted death rate for the health district, attributed to stroke, was 46.4 per 100,000 and for Nebraska was 37.7 per 100,000; both were more than the Healthy People 2020 goal of less than 33.8 per 100,000. Antelope County age-adjusted death rate was 45 per 100,000 which was slightly less than the district.



Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2009-13.

COMMUNITY HEALTH SURVEY RESPONSE

Approximately half of the community health survey respondents (46%) ranked *Heart Disease and Stroke* as a major health concern of the community, elevating this issue to an overall ranking of third in the problems identified. It was more common of survey respondents with income over $65,000 to rank this issue higher. It was also more common to see respondents of older ages (>55) select this as a top-ranking issue of the community.

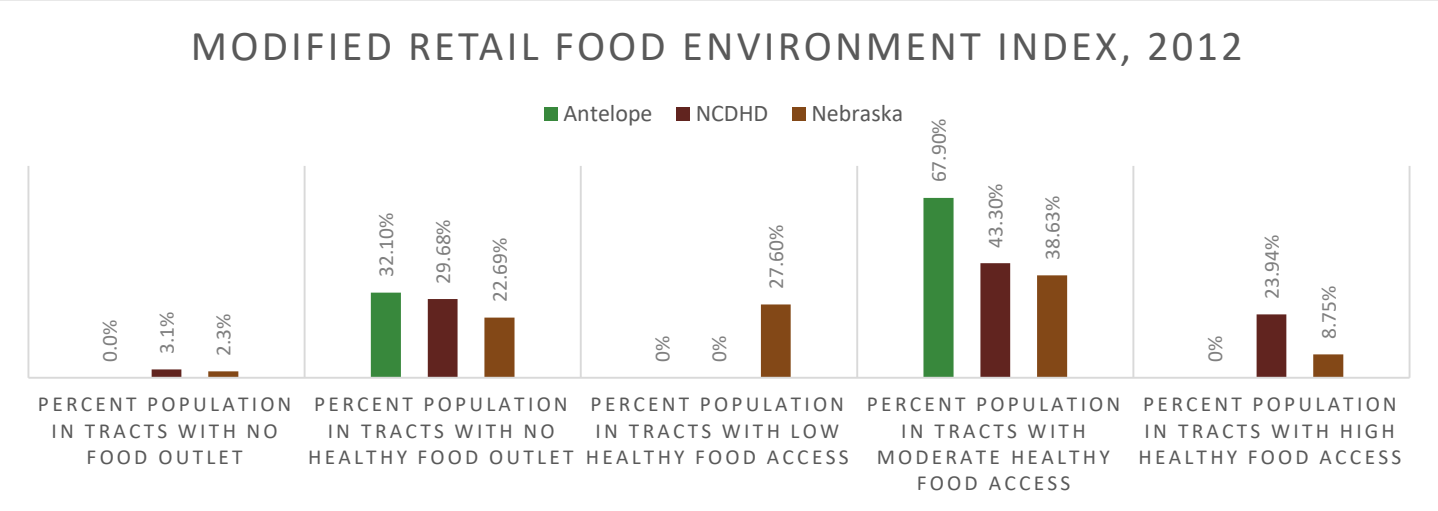
NUTRITION, PHYSICAL ACTIVITY & WEIGHT MANAGEMENT

NUTRITION

Data for the state of Nebraska (BRFSS) shows that on average, 40% of Nebraskans consume fruits less than once a day and 26% have vegetables less than once a day. Correspondingly, 41% of Nebraska adolescents have less than one serving of fruits per day and 38% have less than one serving of vegetables per day.

Another indicator of proper nutrition includes healthy food retail in community settings such as schools, child care, early education, and food systems support. California, for example, has 22 local food policy councils and Nebraska, in comparison, has one. Indicators of Nebraska's nutrition status include: less than

1% of cropland designated to fruits and vegetables, 60% of census tract have healthier food retailer within ½ mile, Nebraska has no State-level policy council, and 16% of middle/high schools in Nebraska offer fruits and vegetables at celebrations, ranking Nebraska second to last only to South Dakota at 12.5%.

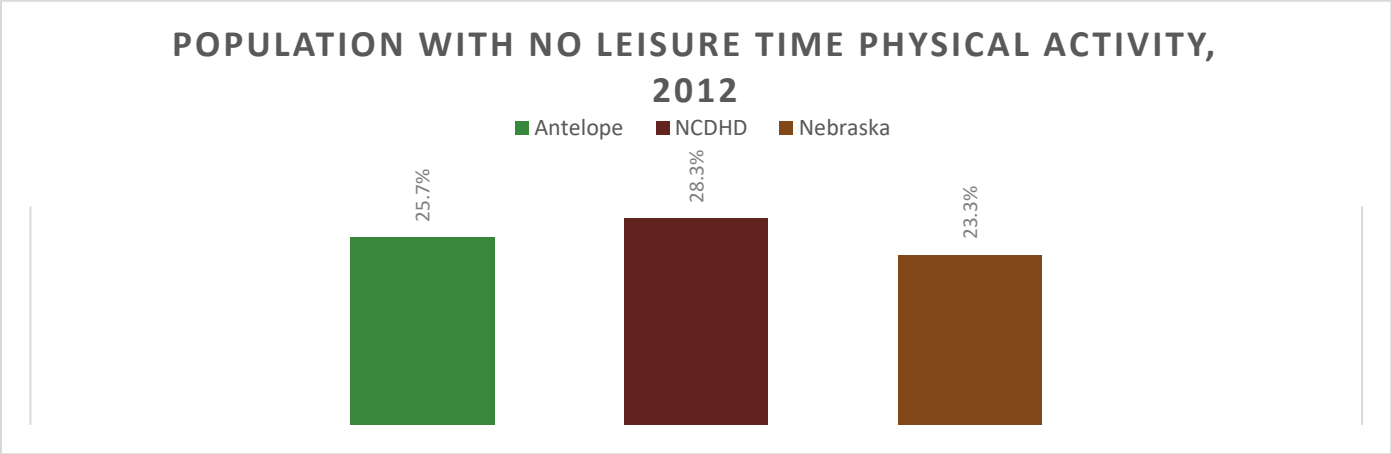


Data Source: Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. 2011.

Within the health district, BRFSS indicators of 2013 report many other nutritional statistics including: sugar-sweetened beverages are consumed by 27% of adults (1 or more in the last 30 days), 47% of adults reported either watching or reducing their sodium intake, 42% consumed fruits less than once a day, 22% consumed vegetables less than once a day. Forty-one percent of community health survey respondents noted “poor eating habits” as their top risky behavior. The proportion of respondents concerned about their eating habits decreased with age. Almost sixteen percent of low income residents of Antelope County did not live near a grocery store, thus limiting access to healthy foods.

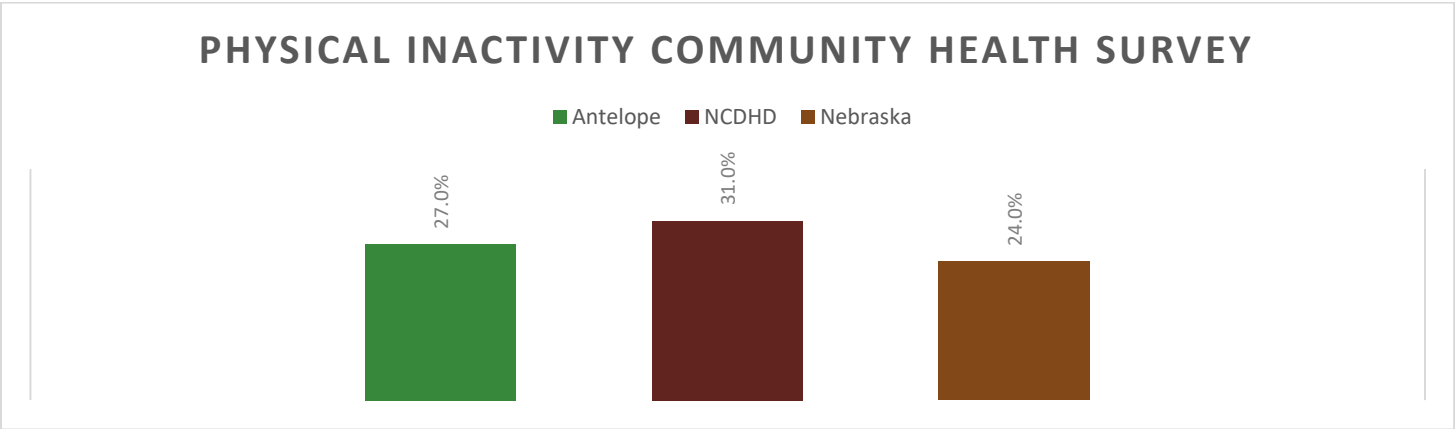
Food insecurity was reported in the BRFSS data, present in 10% of the health district, which was less than the 18% for Nebraska in 2012. However, these numbers increased in 2013 to 17% for the health district and 19% for Nebraska.

PHYSICAL ACTIVITY



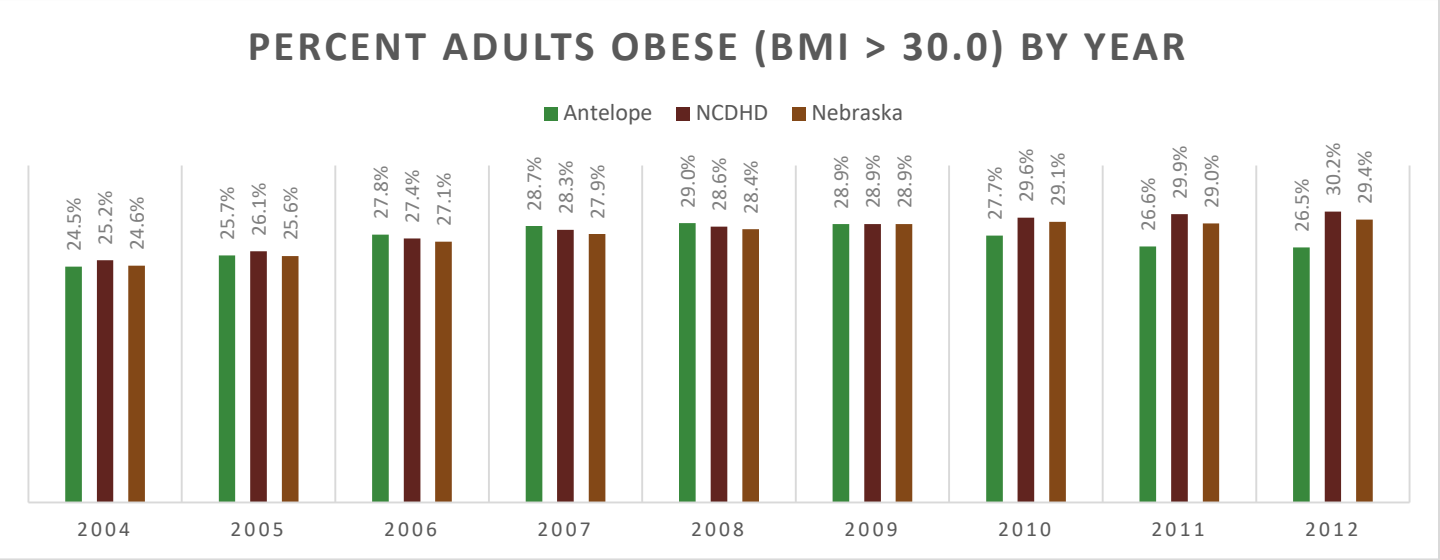
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012

According to the Centers for Disease Control and Prevention (CDC) guidelines, proper daily exercise for adults (ages 18 to 64) include weight training on two or more days per week incorporating all major muscle groups and walking 150 minutes per week, or jogging 75 minutes per week and weight training on two or more days a week incorporating all major muscle groups. Overall, the health district area is more physically inactive than the state of Nebraska (31% and 24%, respectively). Antelope County reported 27% of the population being physically inactive. In 2014, the percentage of those in the health district area with no leisure time activity was 26%, which had decreased from 32% in 2011. The proportion of those who met the aerobic physical activity requirements varied from 45% in 2011 to 51% in 2013. Similarly, the muscle strength recommendation in 2013 was met by 21% of the health district population (lower than 28% of Nebraskans). Overall, in the community health survey, "lack of exercise" ranked 4th as a community health problem. Trends in the community health survey showed "lack of exercise" identified as a health problem decreased with age and increased with income and with education. "Lack of exercise" also tied for third in the ranking of risky behaviors of the community.

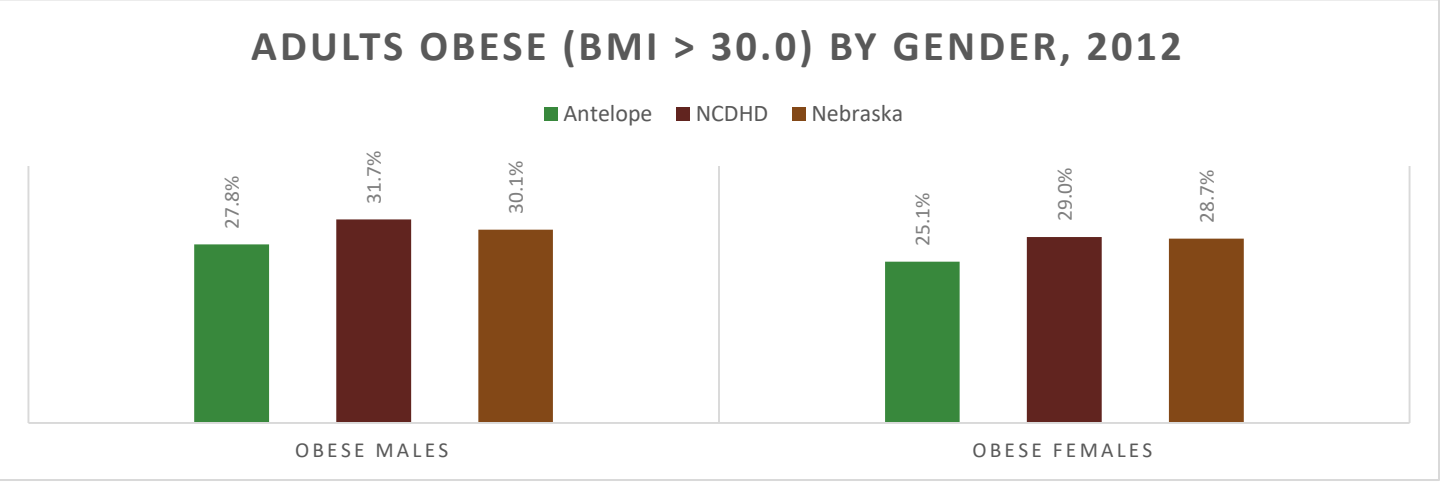


WEIGHT MANAGMENT

Obesity is a chronic disease that impacts one-third of U.S. adults. The definition of being obese is a BMI of 30kg/m^2 or greater. The general trend since the 1970s is a rapid increase in the number of Americans that are obese. In recent years; however, this trend seems to have plateaued for all age and gender groups except for women over 60 years old. Nebraska is ranked 20th for highest adult obesity rate in the nation with 30%.



Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County



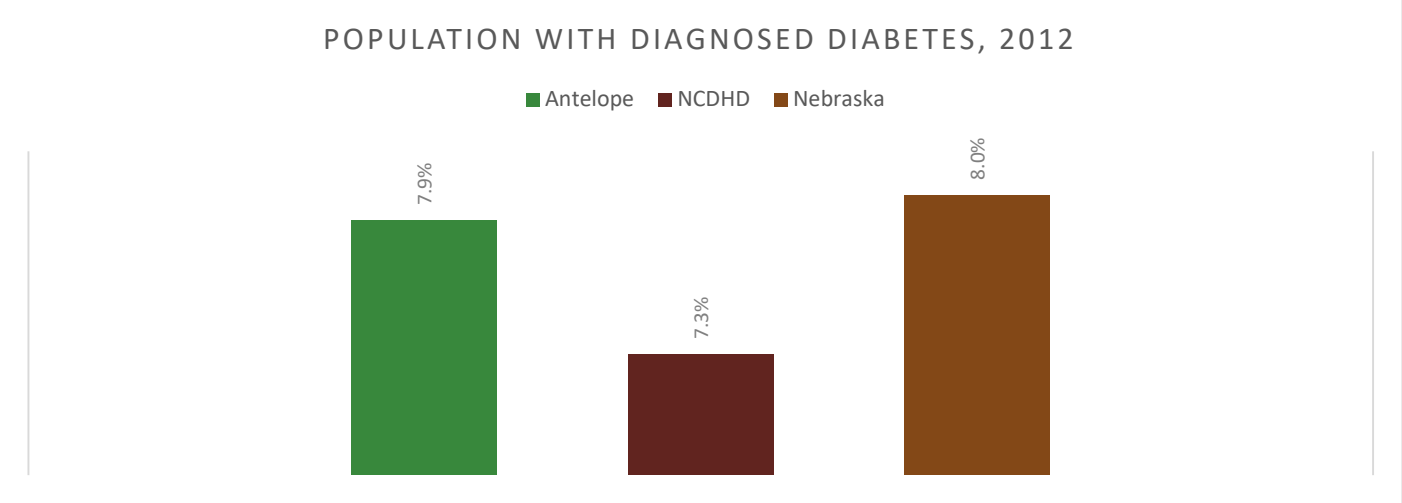
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012. Source geography: County

In 2014 BFRSS, 72% of North Central District adults were either overweight or obese, significantly greater than the 67% reported at the state level. Further, 32% of these were obese, which was approximately the

same as Nebraska's 30%. Twenty eight percent of males and twenty five percent of females in Antelope County have a BMI greater than 30.

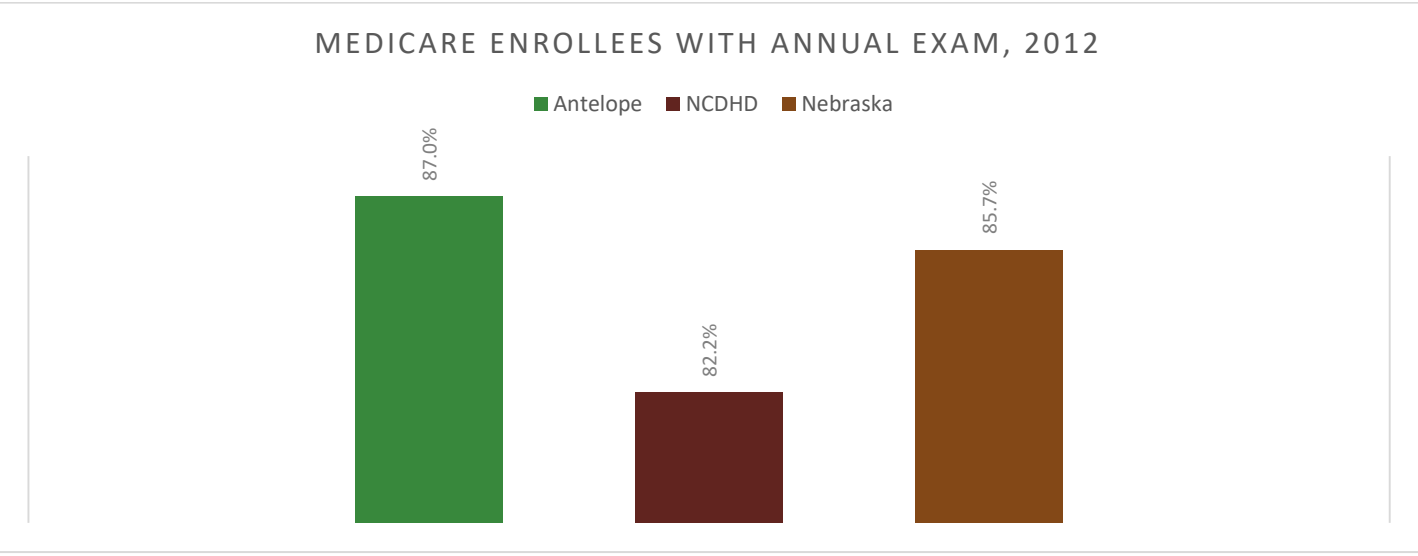
DIABETES

The prevalence of diabetes has increased fourfold or 287% since 1980. In Nebraska, the percent of adults with diabetes has been increasing from 4% in 1990 to 9% in 2014. The health district rate was 10% in 2014, while 4% reported being told they had pre-diabetes, which is down from 7% in 2013.



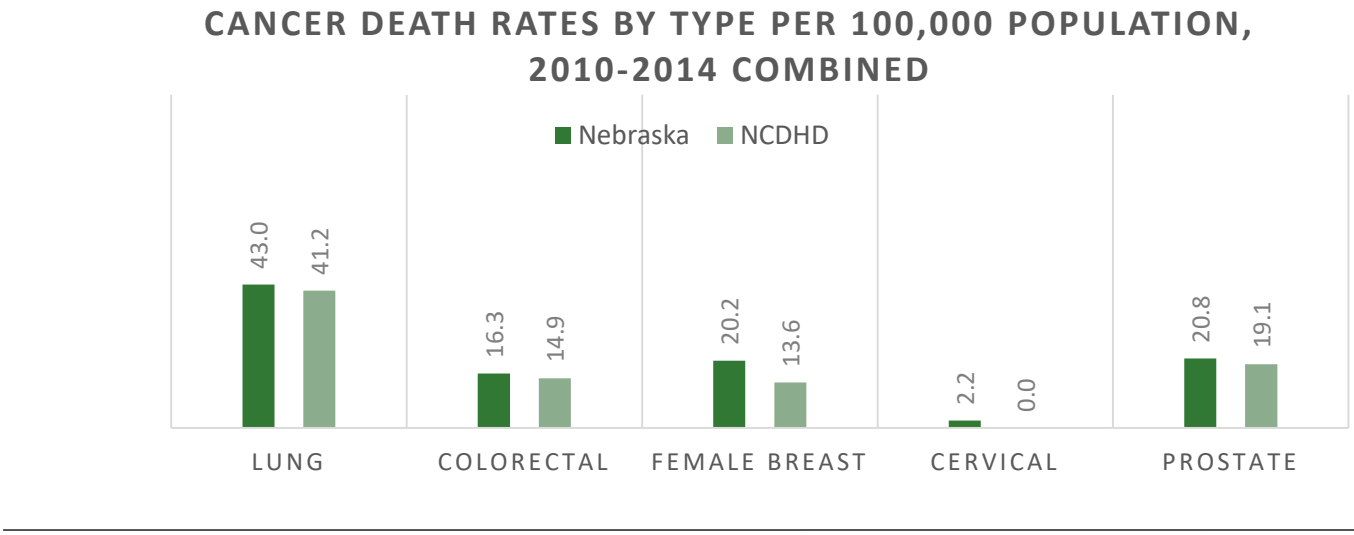
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2012.

Data from 2012 show 7.9% of the Antelope County population have been diagnosed with diabetes. Of the Medicare enrollees in the service area with diabetes, 87% have had an annual exam, which is important in preventing further complications due to diabetes. This compares to 82.2% for the health district and 85.7% for the state.



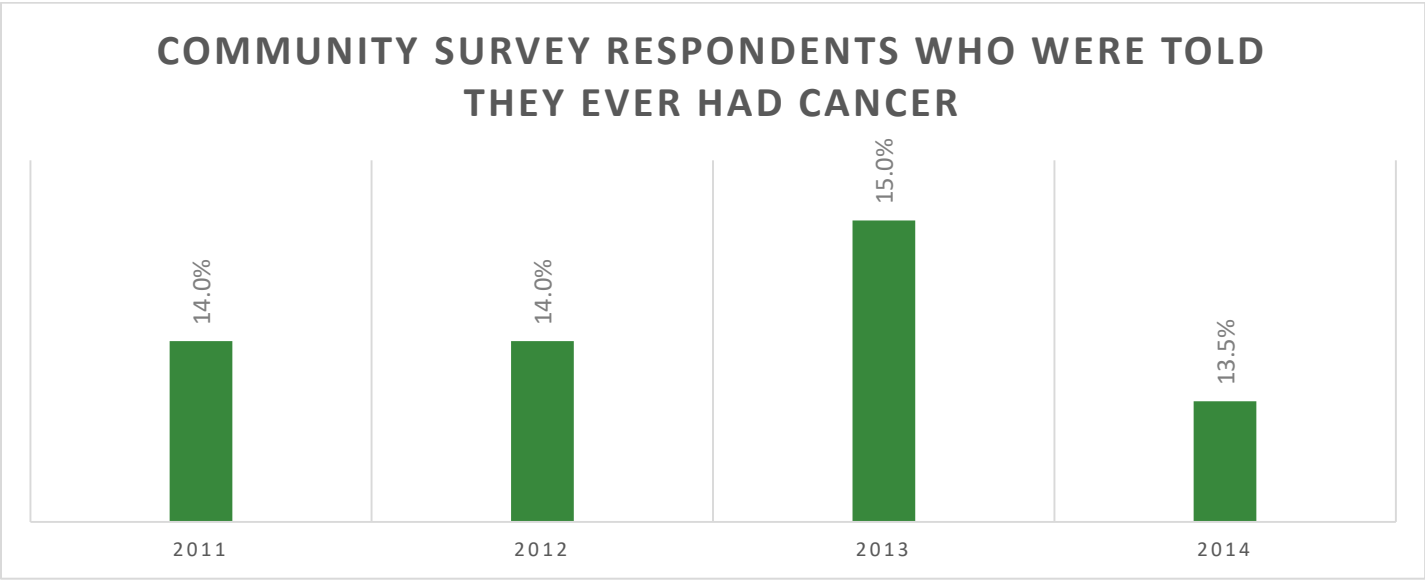
Data Source: Dartmouth College Institute for Health Policy Clinical Practice, Dartmouth Atlas of Health Care. 2012.

CANCER



*North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties

Cancer was the leading cause of death in 2013 for the state of Nebraska. Breast and prostate cancer were among the highest prevalence with 118 and 106 cases per 100,000, respectively. In the community health survey, 61% of respondents noted cancer as a "significant health problem." This proportion decreased with educational background of respondents and increased with age. In 2011, 14% of respondents were told they had a cancer, 14% in 2012, 15% in 2013 and 13.5% in 2014. There were approximately 500 individuals from the North Central District who had recently been told they had a cancer of any kind during the most recent year.



PROSTATE CANCER

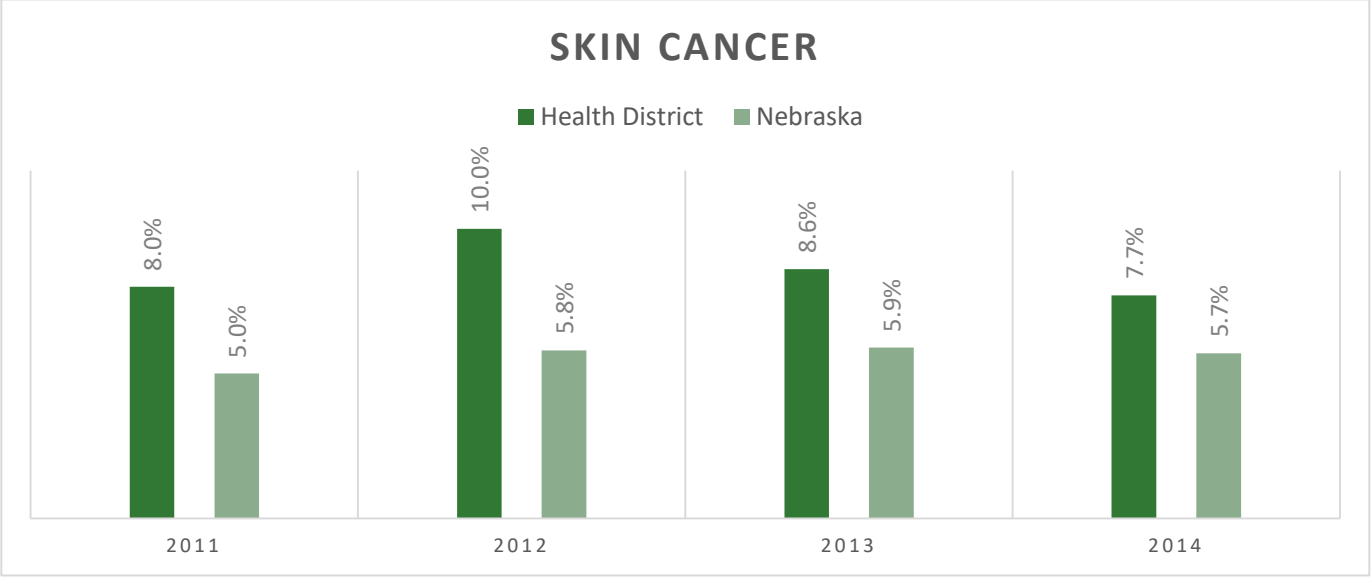
The health district has an estimated prostate cancer incidence of 143 per 100,000 and 168 per 100,000 in Antelope County which is the highest in the district.

LUNG CANCER

The health district has an estimated lung cancer incidence of 59 per 100,000. State Cancer Profiles estimate the incidence of lung cancer for Antelope County to be 58.9 per 100,000.

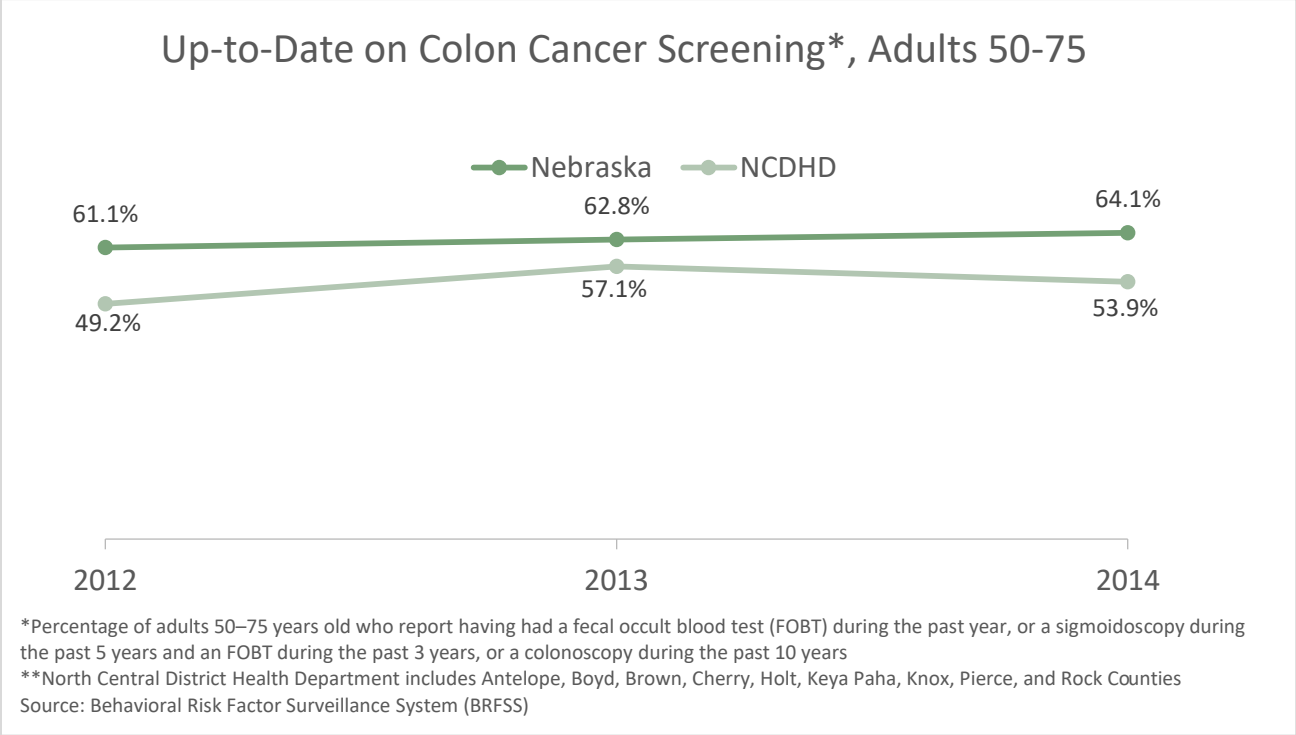
SKIN CANCER

The BRFSS report for the North Central District indicated 8% incidence of skin cancer in 2014.



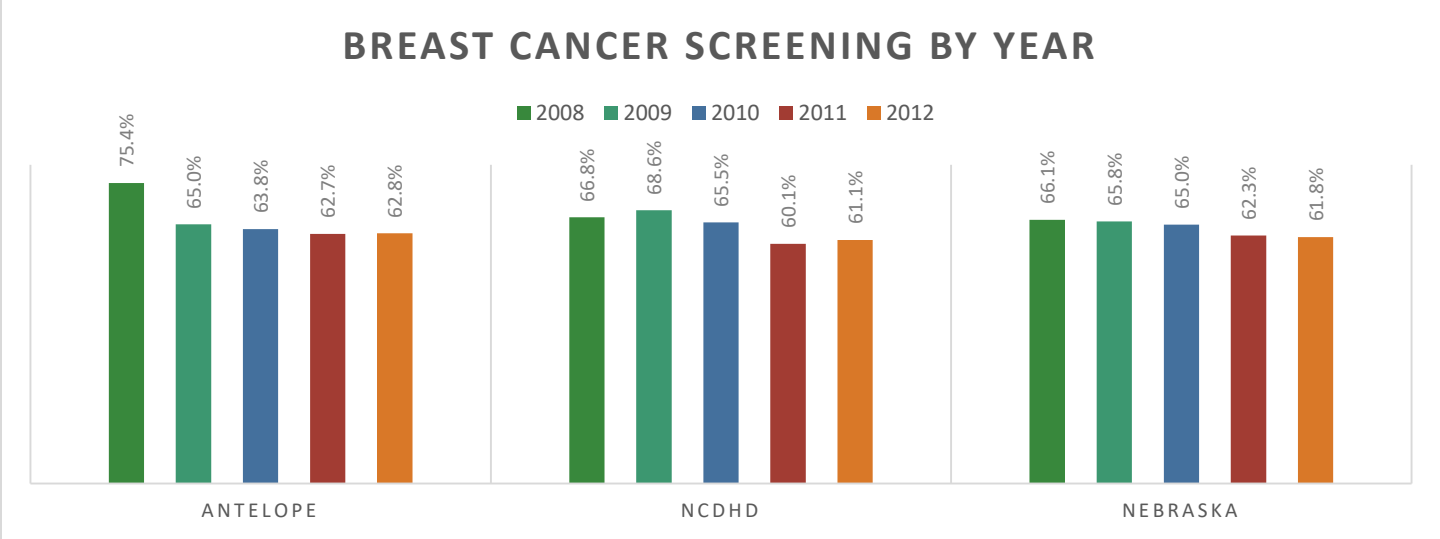
COLON CANCER

In 2012, 49% of North Central District residents ages 50 to 75 reported having been screened for colon cancer, which was significantly lower than the state's 61%. This proportion increased to 57% in 2013 (63% in Nebraska). There was no significant difference by gender in 2013. Then in 2014, 54% of district residents had been screened, again lower than 64% in Nebraskans aged 50 to 75. From 2006 to 2012, the community health survey data suggested nearly 48% of residents over the age of 50 had ever been screened for colon cancer with Antelope County reporting a screening rate of 50.8%.



*Percentage of adults 50–75 years old who report having had a fecal occult blood test (FOBT) during the past year, or a sigmoidoscopy during the past 5 years and an FOBT during the past 3 years, or a colonoscopy during the past 10 years
**North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties
Source: Behavioral Risk Factor Surveillance System (BRFSS)

BREAST CANCER

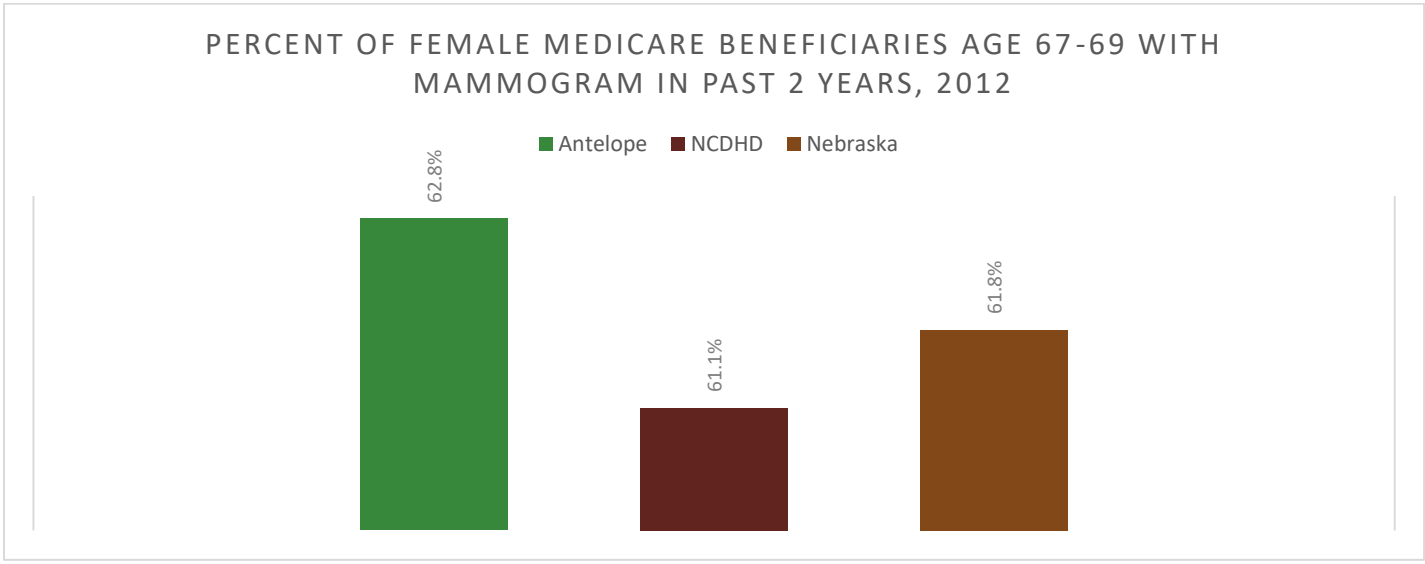


Data Source: Dartmouth College Institute for Health Policy Clinical Practice, Dartmouth Atlas of Health Care. 2012

The incidence of breast cancer from 2008 to 2012 for the health district was estimated at 109 per 100,000, lower than the 123 per 100,000 projected for the state.

In 2014, BRFSS reported women between the ages of 50 and 74 that had been screened for breast cancer within the health district was 74%, lower than the 76% reported for the state. Antelope County reported 62.8%, reflecting a general downward trend from 75.4% in 2008. The overall proportion of Medicare

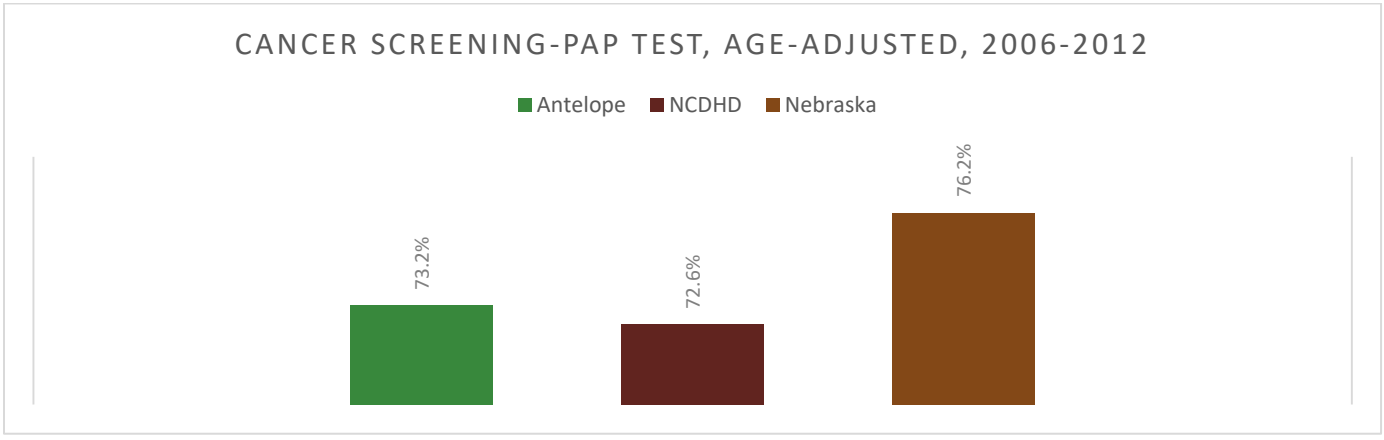
enrolled women ages 67-69 who reported having mammograms through the community health survey in 2012 was 61.1%, with 62.8% in Antelope County, while Nebraska reported 62%.



Data Source: Dartmouth College Institute for Health Policy Clinical Practice, Dartmouth Atlas of Health Care. 2012

CERVICAL CANCER

Cervical cancer screenings are the driving force of recognizing cervical cancer as a preventable disease. The proportion of women ages 21 to 65 reported to have had cervical screening in 2014 was 80% for the health district and 82% for the state. From 2006-2012, Antelope County reported 73.2%.



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

OTHER CANCERS

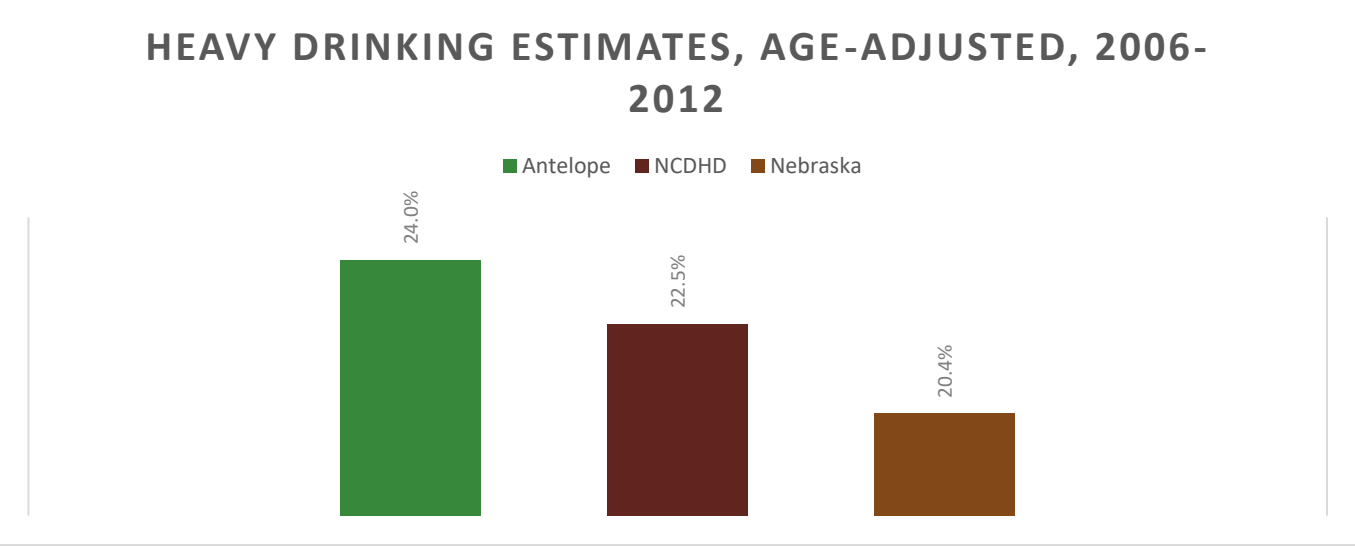
Approximately 7% of health district residents reported they had been told they "have cancer other than skin cancer" in 2014, which was higher than what was reported by residents throughout the state (6.5%). The incidence for the health district has changed from nearly 8% in 2011 to 8.6% in 2013. In 2012, the health district had 9.4% and the state had 6.5% of reported incidence.

ALCOHOL

According to BRFSS responses, the North Central District population who were current consumers (past 30 days) was approximately 54%, which was less than the state's 59%. There was a higher proportion of males that consumed alcohol than females (61-65% and 48-49%, respectively).

The National Institute on Alcohol Abuse and Alcoholism defines binge drinking as pattern of drinking that leads to a person's blood alcohol concentration reaching 0.08 grams percent or above. This is equivalent to 5 or more drinks for males, and 4 or more drinks for females. About 17% of adults within the North Central District engaged in binge drinking in the past 30 days, which has decreased since 2013 from 19%. Binge drinking varied by gender from 26% for males and 9% for females in 2014.

Heavy drinking is defined as consuming more than one drink per day on average for women and two drinks per day on average for men, as well as underage drinking and drinking by pregnant women. Proportions of the health district that had reported heavy drinking in the last 30 days ranged between 4.5-7%, which is approximately equal to Nebraska. Approximately 23% of health district inhabitants drank excessively in the last 30 days, compared to 20% for Nebraska. The estimated proportion of adults of adults drinking excessively was 24% in Antelope County.



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

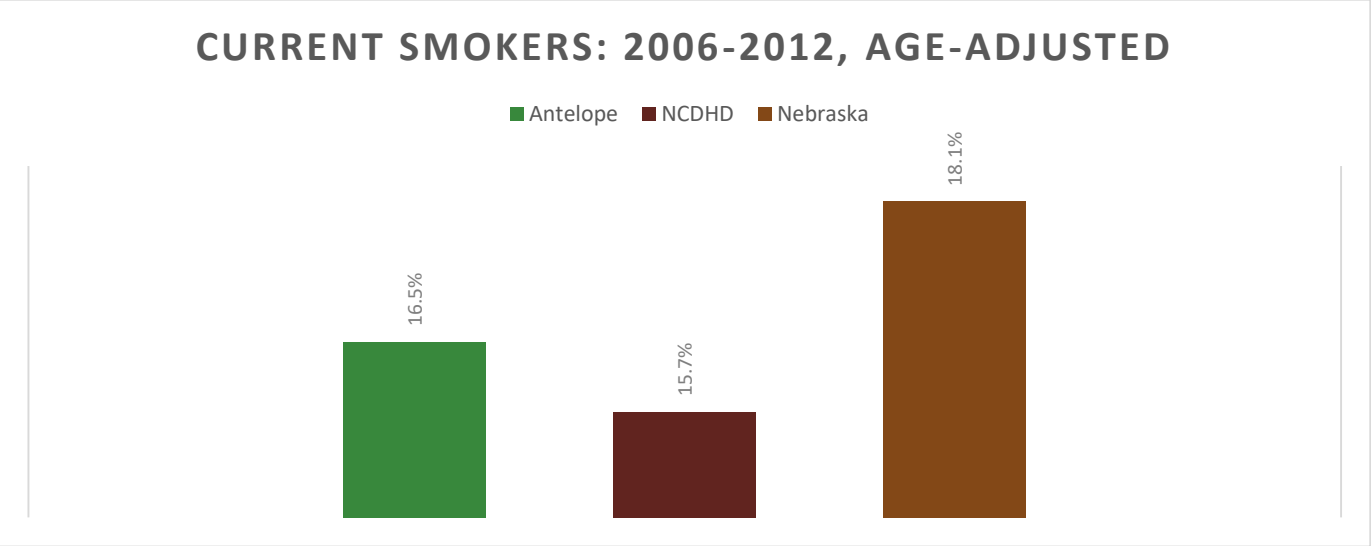
YOUTH

In 2013, the Youth Risk Behavior Survey (YRBS) reported 14.6% of statewide respondents engaged in binge drinking in the past 30 days. In 2012, the Nebraska Risk and Protective Factor Survey (NRPFSS) reported 20% of 12th graders in the health district had engaged in binge drinking in the past 30 days, which is 2% less than that of the state.

In 2014 NRPFSS, reported about 10% of 12th graders said they had driven a car after drinking alcohol and 17% reported riding with someone who was under the influence of alcohol (17% for 10th graders). Also in 2014, 98% of 12th graders said it was wrong to drive after drinking and 81% saw driving after drinking alcohol as a "great risk."

TOBACCO

In the United States, cigarette smoking is the cause of more than 480,000 deaths each year. Within the North Central District, an estimated 14% of adults reported smoking cigarettes either some days or every day. BRFSS data showed 16% of the district reported smoking cigarettes, which is less than the 18% of the state. The proportion of current smokers from 2006-2012 shows 16.5% of Antelope County adults. This proportion of current smokers of the district area has been fairly constant from 2011-2014.



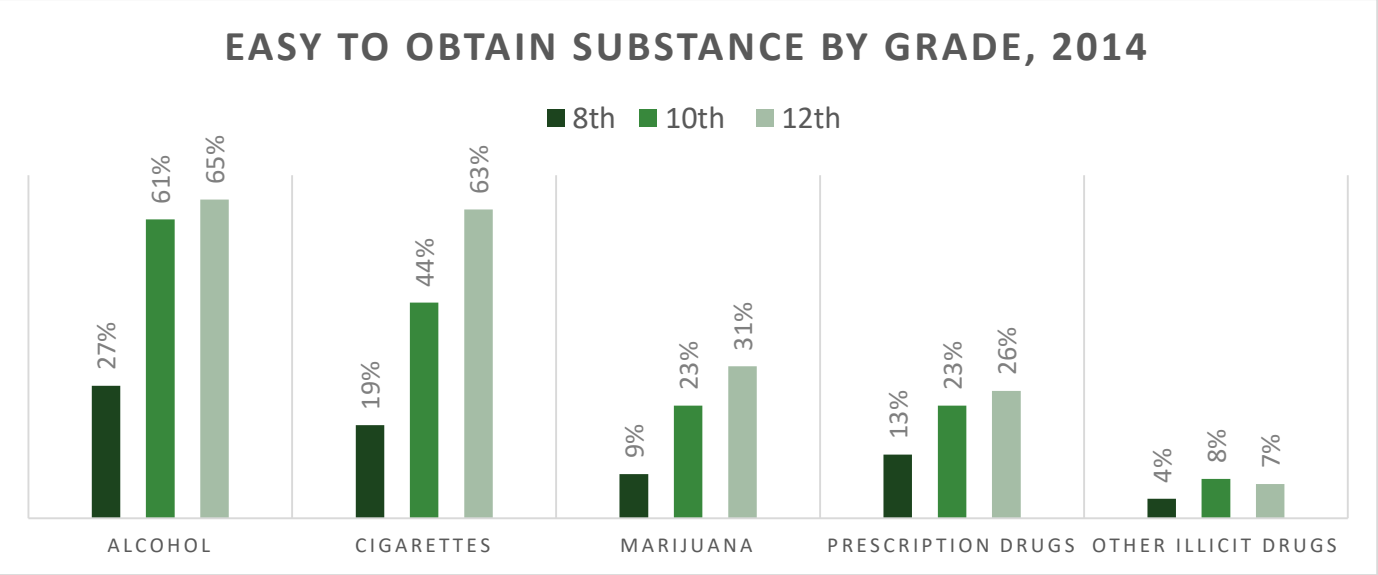
Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

Approximately 7% of the health district uses smokeless tobacco, less than the state's 8.6%. The number of current adult smokers that have attempted to quit was 57% in 2014, 62% in 2013, 50% in 2012 and 46% in 2011. The BRFSS also reported that 84% of respondents don't allow smoking in their home. The NRPFSS of 2014 reported that 16% of 12th graders were currently using smokeless tobacco and 12% were current smokers. In 2011, 44% of 10th grade students said it would be easy to get cigarettes, which increased to 63% in 2012.

SUBSTANCE ABUSE

YOUTH SUBSTANCE ABUSE

Marijuana use has declined between 2003 and 2014, the peak of substance abuse being in 2010. For 12th grade students, lifetime use fluctuates from 15% in 2007 to 19% in 2012 and to 15% in 2014. Current use of marijuana for 12th graders fluctuated from 5.6% in 2010 to 8.2% in 2012 then to 6.3% in 2014.



COMMUNITY PERCEPTION

The community perceives alcohol abuse as a greater problem than drug abuse for both adults and youth. Eighty percent said underage drinking is a problem within their community. Alcohol abuse among adults was perceived as a problem for the community by 65% of the respondents. Approximately 60% said that drug abuse is a problem among youth in the community, while 35% disagreed. From the 2016 community health survey, 32% selected drug abuse as a top-three risky behavior, thus ranking drug abuse as the 5th most commonly selected risky behavior.

PERSCRIPTION DRUG ABUSE

In the 2014 BRFSS data, 25% of respondents had been prescribed pain medication in the past year and 36% of these individuals had leftover medications in the household. Youth from focus groups mentioned the presence of Adderall and Hydrocodone at schools. Law enforcement confirmed that they have been witnessing the abuse of prescription drugs due to “using multiple doctors; people selling their own drugs; stealing; or using fake prescriptions.” This is prevalent from age ranges of teens to 40 years of age, according to law enforcement. Their experience is also that marijuana use is increasing across all age ranges, but primarily among teens. There have also been cases of parents using around children, or even contributing to the child’s access to marijuana.

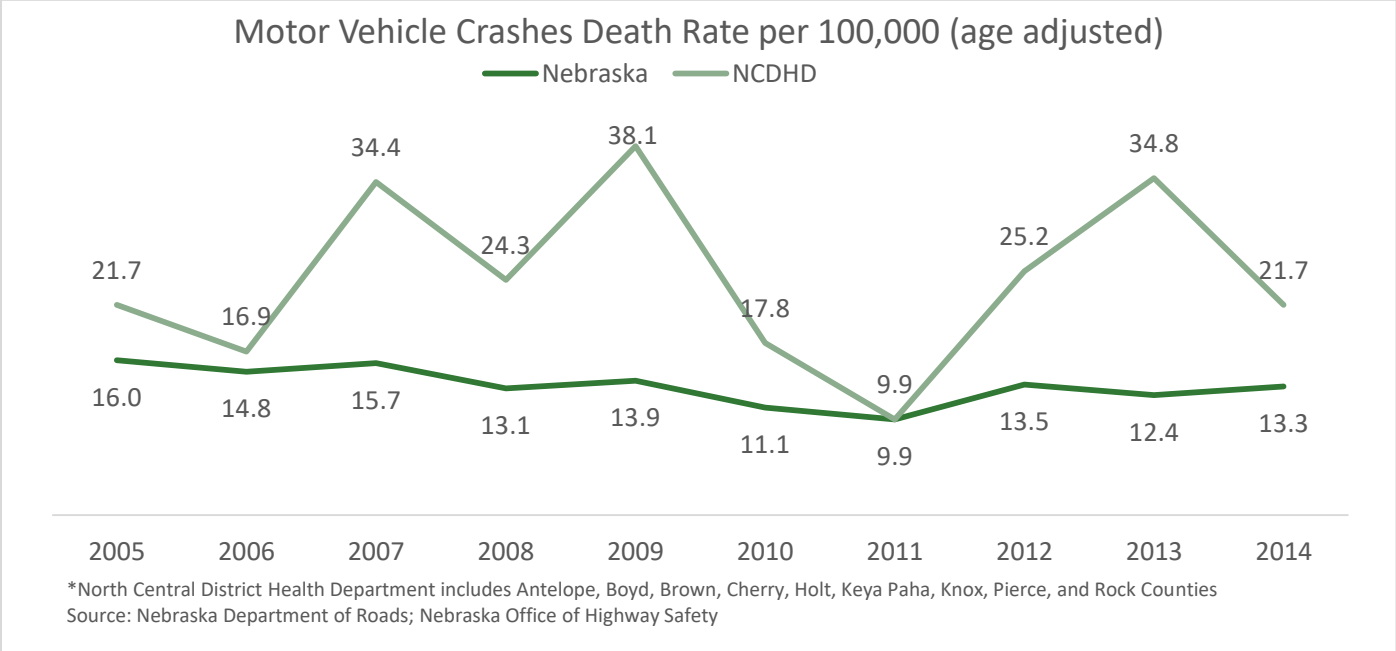
TREATMENT AND RESOURCES

The parent and school surveys demonstrated knowledge of where help and other resources for substance abuse can be sought out. Eighty-three percent of school employees said that if a child or youth they knew had an alcohol and/or drug problem, they know where to go to get help. Seventy-nine percent of parent respondents said they would also know where to go for help. When asked whom they would go to talk to first, 58% of school employees would go to the school counselor, while 32% of parents said they'd seek out a private counselor, 23% of parents said they'd go to the doctor, and 20% said school counselor. Of the barriers for treatment, 85% of both parent and teacher respondents said they could handle the situation without treatment and nearly 65% said they don't want others to find out.

RESPIRATORY DISEASES

Respiratory diseases include asthma and chronic obstructive pulmonary diseases (COPD) such as chronic bronchitis and emphysema. North Central District residents who had ever been told they had asthma was approximately 9% in the 2014 BRFSS, lower than the approximate 12% for the state. Those currently with asthma within the North Central District are 6.5%, which has decreased since 2011 (8%). COPD was prevalent in about 5% of the North Central District as of 2014, which is nearly the same for the state and has remained constant since 2011.

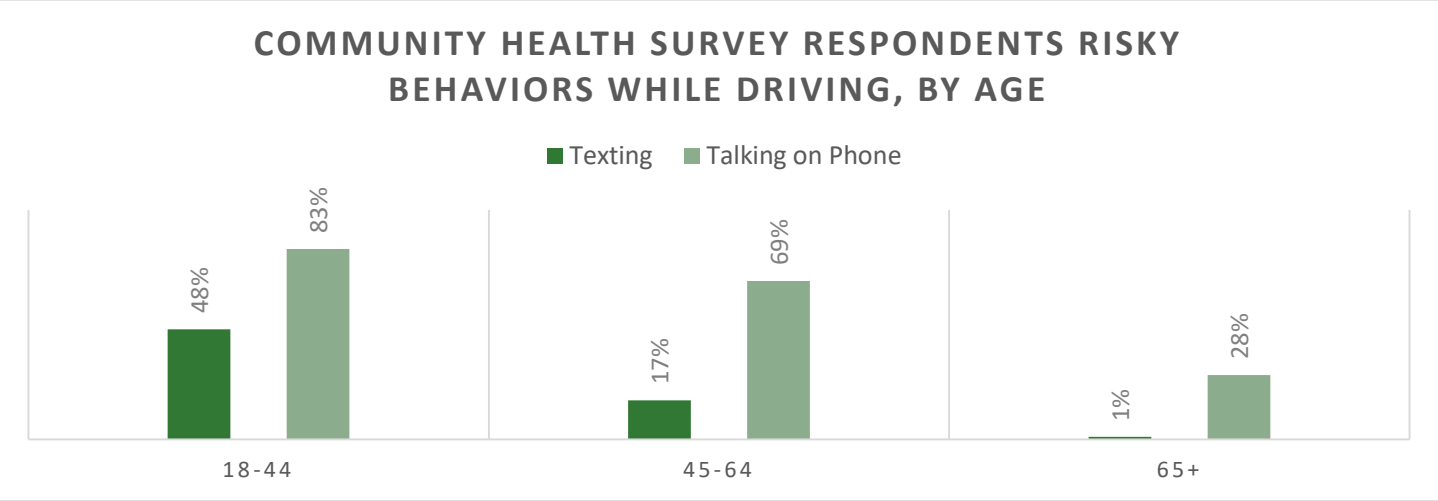
INJURY RELATED BEHAVIORS



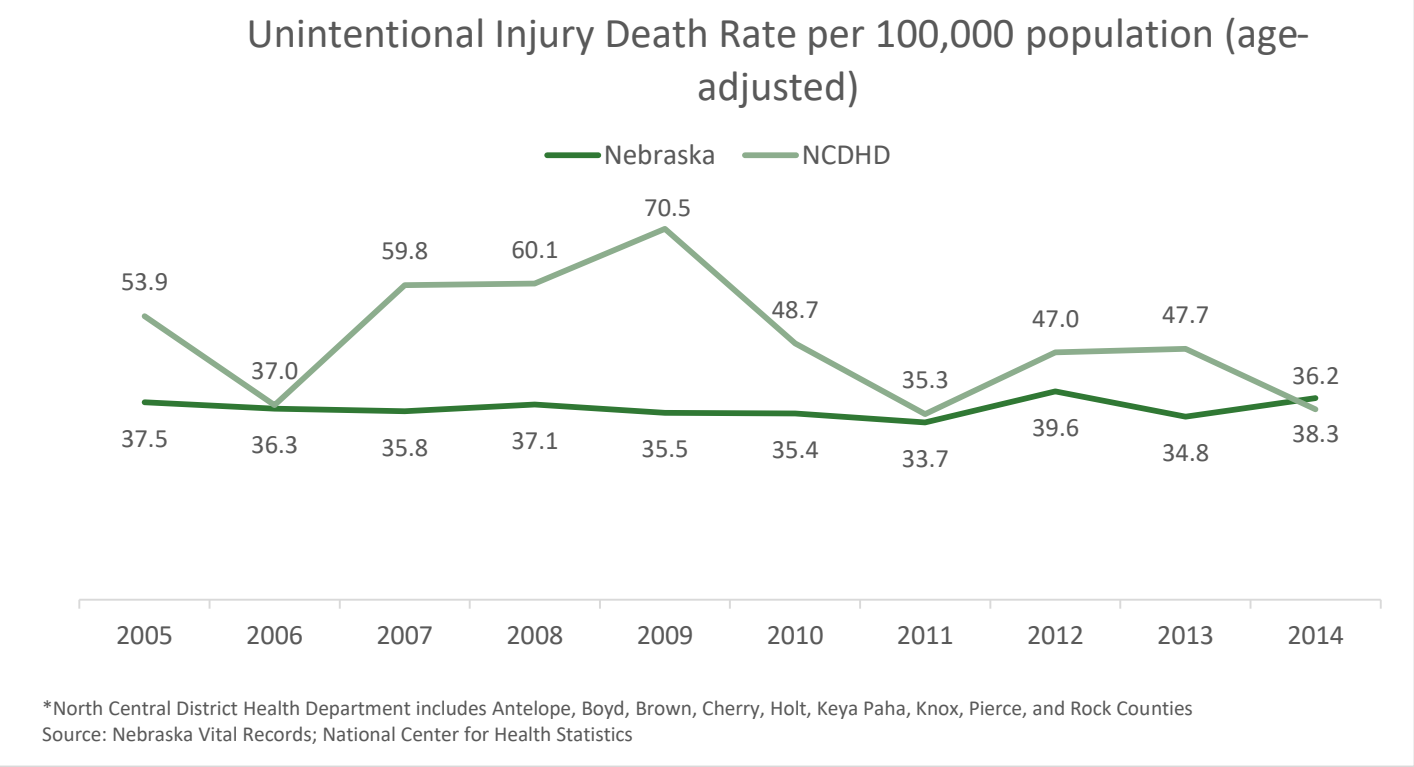
*North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties
Source: Nebraska Department of Roads; Nebraska Office of Highway Safety

The health district has shown significantly lower seatbelt usage than the state (48% and 72%, respectively) in 2014. Usage has been higher for females for the last four years than for males (62% and 38%, respectively). Age also influences seatbelt use, where only 40% of those 18-44 always wear seatbelts, while 64% of those 65 and older always wear theirs.

Adults over the age of 45 who have reported having a fall in the past year was approximately 29% in 2014, 8.6% reported being injured due to the fall.



Nearly 25% of respondents reported texting while driving in the past 30 days, 48% for those 18-44 years of age, 17% for those 45-64 years of age, and 1% for those 65 or older. Of respondents, 65% reported talking on a phone while driving, 83% for those between the ages of 18 and 44, 69% for those between 45 and 64, and 28% for those 65 or older.

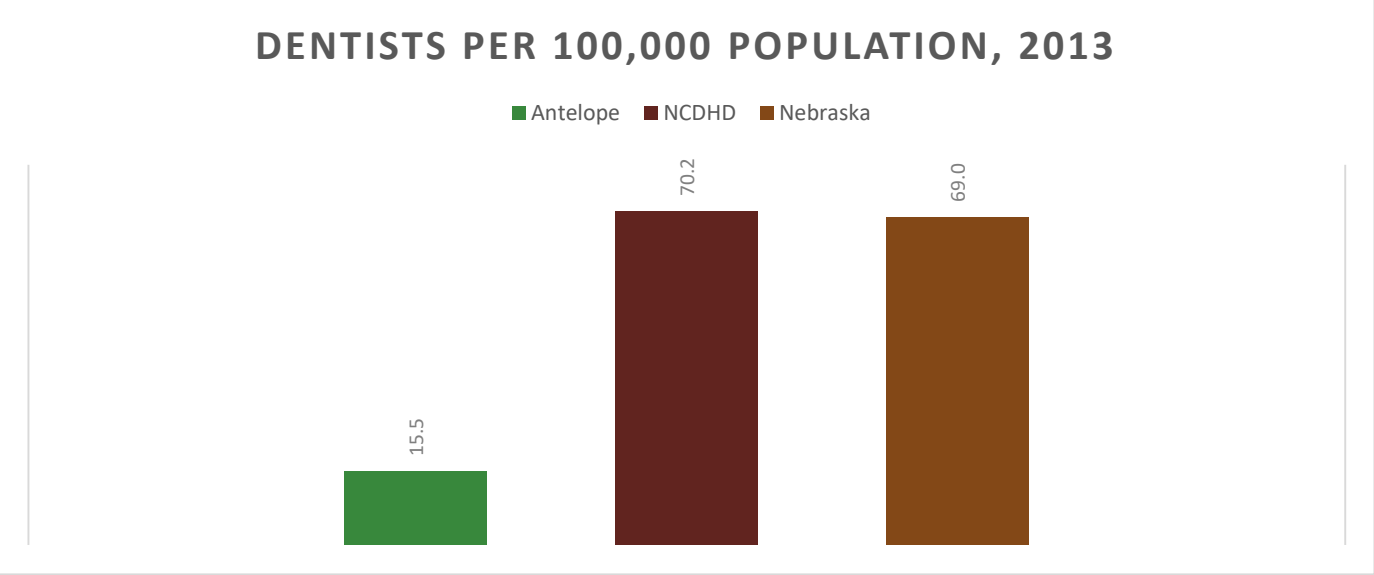


*North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties
Source: Nebraska Vital Records; National Center for Health Statistics

ORAL HEALTH

Dental health care shortages are another challenge of rural communities. The state and the health district are approximately equivalent in terms of the percentage of adults who had visited a dentist during the past year (66%). However, in 2014 nearly 49% of the health district's adult population had a tooth extracted due to gum disease or tooth decay, which is down from 52% in 2012. These are higher than the state's proportion of 39%. This was true for those ages 45 to 64 (51% for the district and 46% for the state) as well as those 65 or older (22% for district and 14% for the state).

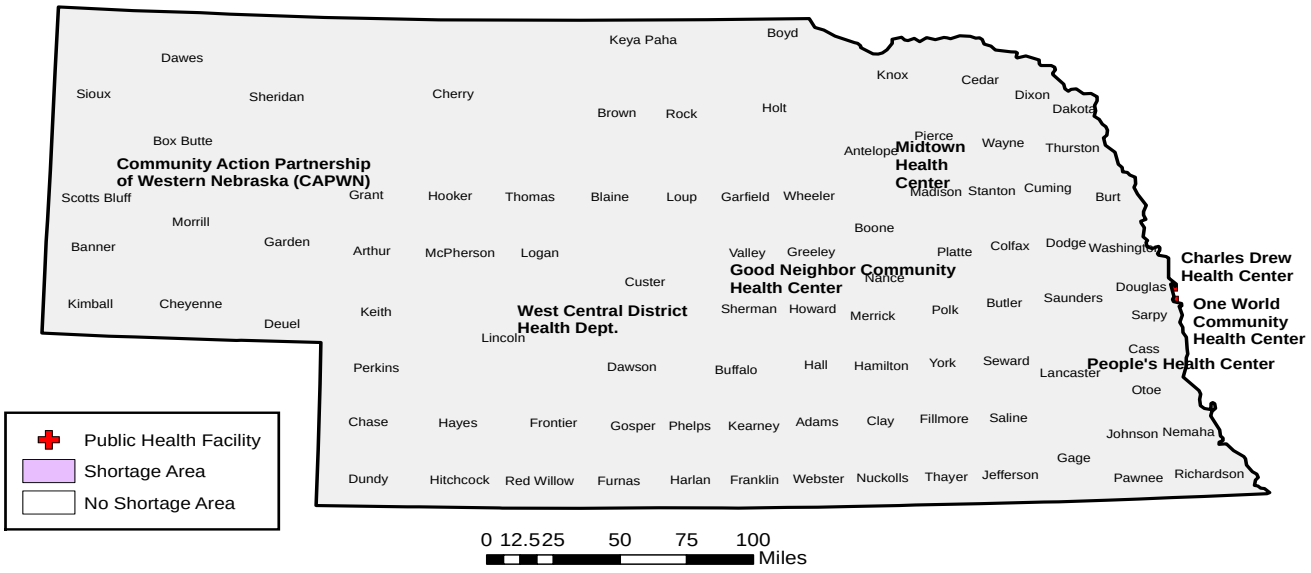
Fortunately, the North Central District is a participant in the Oral Health Access for Young Children Program, which focuses on preventive care for school children through screenings and provisions of fluoride varnish to help prevent long-term tooth decay. From the Oral Health Access for Young Children report in 2012, data was noted in contrast between North Central and the state. For example, the person-to-dentist ratio for North Central was 2,039:1 compared to 1,169:1 in Nebraska; area per dentist was 602.3 mi^2 compared to Nebraska's 49.2 mi^2. Statewide, 91% of children seen by dentists were ages 0-5, while North Central District has approximately 93% of their children 0-5 seen by a dentist.



Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2013.
Source geography: County

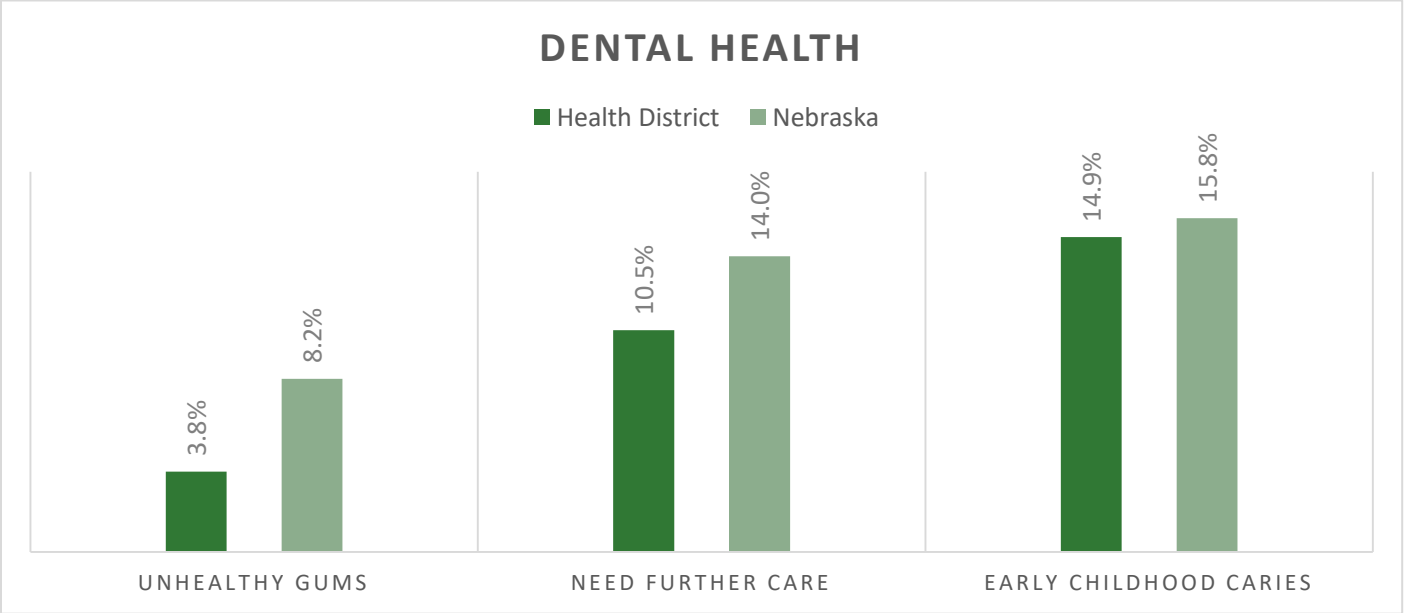
State-Designated Shortage Area General Dentistry

Nebraska



Source: Rural Health Advisory Commission
DHHS - Nebraska Office of Rural Health
Statewide Review: 2013
Last Updated: July 2013 (corrected 1/2015)
Location: K: RURAL_HEALTH > Rural Health Intern > State Shortage Areas

Cartography: Clark Sintek | Community & Regional Planning Intern | DHHS
For: Marlene Janssen | Exec. Director, Rural Health Advisory Commission
marlene.janssen@nebraska.gov | 402-471-2337

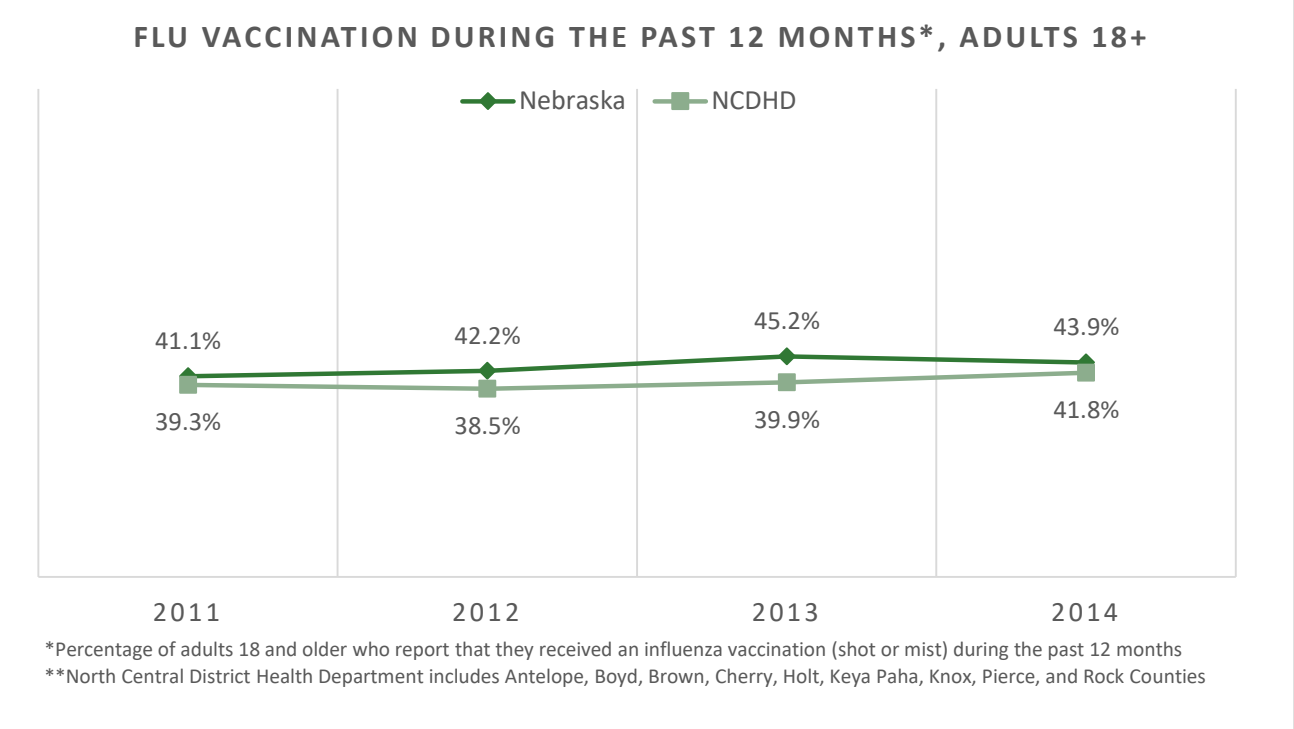


Overall, dental health was ranked as a low priority (14th) in the 2016 community health survey of health problems facing the North Central District community. It was more likely to be selected by those with an income below $20,000.

INFECTIOUS DISEASES: IMMUNIZATIONS

INFLUENZA VACCINATION

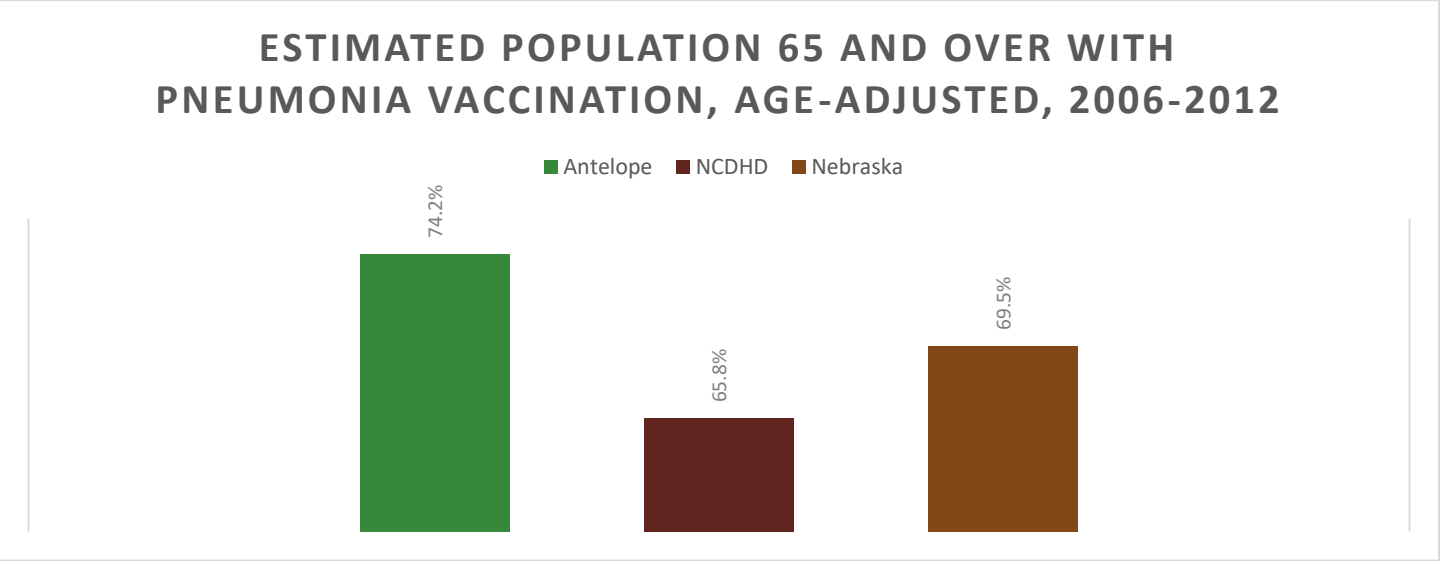
Influenza vaccinations were administered to nearly 42% of the health district population, less than the near 44% of the state that received the vaccine in 2014. The vaccination rates for influenza have had minute changes from 2011 to 2014, the peak being in 2014 and the lowest being in 2012 with 38.5% receiving the vaccine. Of those individuals residing in the North Central District over the age of 65, 63.5% received the vaccination, nearly the same as the 64.8% of the state. However, in past years the health district has remained below the state proportions for those over the age of 65 receiving the influenza vaccination.



*Percentage of adults 18 and older who report that they received an influenza vaccination (shot or mist) during the past 12 months
**North Central District Health Department includes Antelope, Boyd, Brown, Cherry, Holt, Keya Paha, Knox, Pierce, and Rock Counties

PENUMONIA VACCINATION

From 2006 to 2012, the proportion of individuals who received the pneumonia vaccination within the health district has been decreasing from approximately 71% in 2011 to 64% in 2014, which was overall significantly lower than the state's 72%. From 2006-2012, Antelope County estimate was at 74.2%.



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

TETANUS/SHINGLES VACCINATION

Over half of BRFSS respondents from within the health district reported having a tetanus vaccination since 2005 (56%), while nearly 60% of the state had reported receiving this vaccination. In 2014, approximately 26% for shingles and 28% of Nebraska.

2016 COMMUNITY HEALTH ASSESSMENT: COMMUNITY HEALTH SURVEY

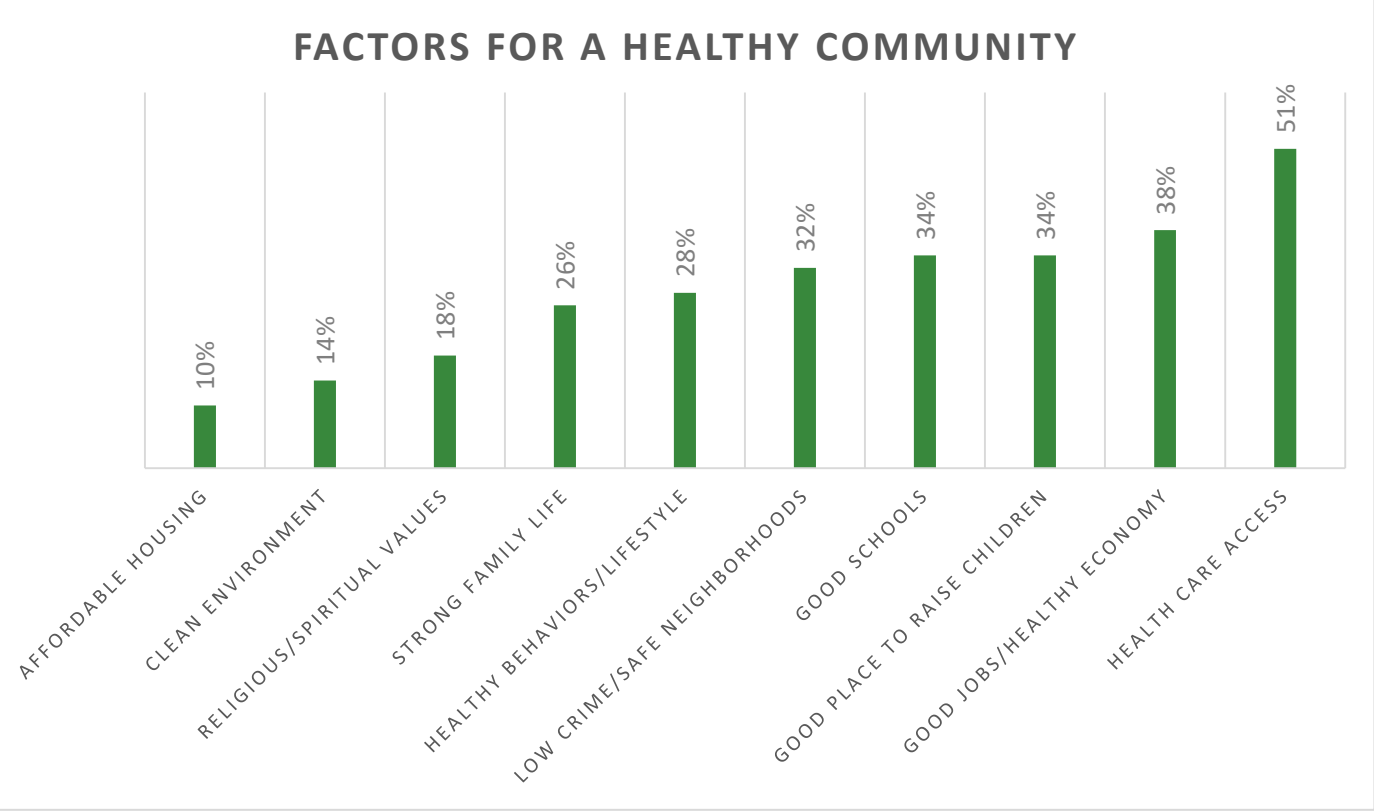
SURVEY DEMOGRAPHICS

Between December 2015 and February 2016, the North Central District Health Department administered surveys via the SurveyMonkey website to gain the perspective of the community regarding health, community health issues, and quality of life.

Of those that responded to the survey, 82% were married, 47% had a Bachelor's Degree or higher, 53% have 2 to 3 members in their household, they had a median age of 40 to 54, 79% had an income of $40,000 and 47% had an income of $65,000 or higher, and 99% were white.

COMMUNITY HEALTH

HEALTHY COMMUNITY



The two most common factors respondents said are necessary for a healthy community were health care access and good jobs/healthy economy. A good place to raise children was tied with good schools for the 3rd most commonly selected factor Among those that less than 5% of respondents selected as a key factor were: emergency preparedness, parks and recreation, low level of child abuse, low adult death and disease rates, "other," low infant deaths, arts and cultural events, and excellent race/ethnic relations.

All of the top five factors were also frequently mentioned in focus groups, however the focus groups also mentioned strengths of the health care and information system of the district such as: people are used to high level health care, we have services at the hospital and clinic that can be accessed without having to go to the city, the school is a draw to bring kids in and the hospital is also a strength, and outpatient clinic resources at the hospitals are a big plus.

These results varied slightly by household annual income. For example, the top factor ranked by individuals who have an annual income less than $20,000 was low crime/safe neighborhoods. As shown below, those with lower education did not rank access to health care as a top factor, nor did they rank good jobs and healthy economy. In contrast to the other education categories, they chose clean environment and affordable housing as top factors. Those in the highest education category felt that healthy behaviors and lifestyles were of higher ranking significance than the majority.

Community Health Factors Rank by Education

	Overall Rank	Less than high school	High school diploma or GED	Community College/Vo-Tech	Bachelor Degree or higher
Access to health care (e.g., family doctor)}...	1	25%	44%	55%	51%
Good jobs and healthy economy}...	2	25%	34%	35%	42%
Good place to raise children}...	3	50%	35%	36%	32%
Good schools}...	4	50%	33%	32%	35%
Low crime / safe neighborhoods}...	5	0%	49%	34%	26%
Healthy behaviors and lifestyles}...	6	0%	15%	30%	33%
Strong family life}...	7	0%	30%	26%	26%
Religious or spiritual values}...	8	0%	18%	17%	18%
Clean environment}...	9	50%	19%	12%	12%
Affordable housing}...	10	50%	11%	9%	11%

Antelope County differs from the selection of “Health Factor Rank” from the overall district. Antelope County Ranked “access to health care” as the first factor, “good schools” as the second most commonly chosen factor, and “good jobs and healthy economy” as third.

HEALTH PROBLEMS

When asked about the most important health problems facing the community, respondents chose cancers, aging problems, and heart disease most frequently (as shown below). "Heart disease and stroke" and "lack of exercise" were the 4th and 5th most frequently selected health problems of North Central District.

Health Problems Frequency		
Health Problems	Percent	Rank
Cancers...	20.30%	1
Aging problems (e.g., arthritis, hearing/vision loss, etc.).	15.90%	2
Heart disease and stroke...	15.20%	3
Lack of exercise...	13.00%	4
Diabetes...	9.10%	5
Mental health problems...	8.10%	6
High blood pressure...	5.70%	7
Respiratory / lung disease...	2.60%	8
Other (please specify)...	2.40%	9
Child abuse / neglect...	2.30%	10
Motor vehicle crash injuries...	1.60%	11
Domestic Violence...	1.30%	12
Teenage pregnancy...	0.80%	13
Dental problems...	0.80%	14
Suicide...	0.60%	15
Firearm-related injuries...	0.20%	16
HIV / AIDS...	0.10%	17
Homicide...	0.10%	18
Infectious Diseases (e.g., hepatitis, TB, etc.)...	0.10%	19
Sexually Transmitted Diseases (STDs)...	0.10%	20

When looking at the selection of health problems by age, there are some variations. For example, respondents ages 18 to 25 chose lack of exercise as the number one ranked health problem in the community, thus ranking cancers second.

Health Problems by Age Group						
	Rank	18-25	26-39	40-54	55-64	65 or older
Cancers...	1	40%	56%	63%	62%	86%
Aging problems	2	24%	38%	50%	55%	64%
Heart disease and stroke...	3	20%	45%	42%	54%	53%
Lack of exercise...	4	48%	43%	42%	32%	22%
Diabetes...	5	20%	34%	23%	29%	17%
Mental health problems...	6	28%	26%	27%	20%	17%
High blood pressure...	7	24%	19%	13%	18%	19%

The most commonly selected risky behavior was being overweight followed by alcohol abuse.

Risky Behaviors		
	Percent	Rank
Being overweight	23.40%	1
Alcohol abuse	19.80%	2
Lack of exercise	13.50%	3
Poor eating habits	13.50%	3
Drug abuse	10.60%	5
Tobacco use	9.30%	6
Not using seat belts / child safety seats	3.30%	7
Unsafe sex	1.80%	8
Not getting “shots” to prevent disease	1.40%	9
Not using birth control	1.20%	10
Dropping out of school	1.00%	11
Other (please specify)	0.50%	12
Unsecured firearms	0.30%	13
Racism	0.30%	14
Lack of maternity care	0.20%	15

QUALITY OF LIFE: SERIES OF SCALED QUESTIONS BY COUNTY

ANTELOPE COUNTY

	Strongly No	No	Neutral	Yes	Strongly Yes
Are you satisfied with the quality of life in your community? (Consider your sense of safety, well being, participation in community life and associations, etc.)	0.0%	2.5%	20.0%	60.0%	15.0%
Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, and options in health care)	2.5%	10.0%	20.0%	45.0%	20.0%
Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	0.0%	0.0%	20.0%	50.0%	27.5%
Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	0.0%	17.5%	7.5%	50.0%	22.5%
Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	2.5%	32.5%	22.5%	30.0%	10.0%
Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	0.0%	0.0%	7.5%	60.0%	30.0%
Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, organizations) during times of stress and need?	2.5%	12.5%	25.0%	47.5%	10.0%
Do all individuals and groups have the opportunity to make the community a better place to live?	0.0%	7.5%	17.5%	55.0%	17.5%
Are there a broad variety of health services in the community?	2.5%	25.0%	20.0%	37.5%	12.5%
Are there enough health and social services in the community?	2.5%	35.0%	30.0%	22.5%	7.5%
Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments?	2.5%	20.0%	35.0%	27.5%	12.5%
	Not at all	Minimally	Somewhat	Very	
How familiar are you with the priorities established in that assessment process?	30.0%	17.5%	32.5%	17.5%	
How familiar are you with the strategies and steps that have been taken in your community to address those priorities?	32.5%	27.5%	27.5%	10.0%	
	Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree
To what extent do you still agree with the priorities previously identified?	5.0%	10.0%	25.0%	37.5%	20.0%
	Unsuccessful	Somewhat Unsuccessful	Neutral	Somewhat Successful	Sucessful
How successful do you feel efforts to address these issues have been?	15.0%	7.5%	32.5%	15.0%	0.0%

LOCAL PUBLIC HEALTH RESOURCES AVAILABLE TO ADDRESS SIGNIFICANT HEALTH NEEDS

ANTELOPE COUNTY

AGING POPULATION AND RELATED ILLNESSES	
ASSISTED LIVING FACILITIES	The Willows 806 South Street Neligh, Nebraska 68756 402-887-9059
	Prairie View 100 South Street Tilden, Nebraska 68781 402-368-2250
DURABLE MEDICAL SUPPLIER	Elgin Pharmacy 112 South 2nd Street, P.O. Box 429 Elgin, Nebraska 402-843-5555
	Hilltop Drug 108 West 11th Neligh, NE 68756 402-887-5551
	Wanek Pharmacy 410 Main Street Neligh, Nebraska 68756 402-887-5426
EMERGENCY TRANSPORT SERVICES	Antelope Memorial Hospital Ambulance Service 102 West 9th Street Neligh, Nebraska 68756 402-887-4151
	Clearwater Volunteer Fire and Rescue P.O. Box 11 Clearwater, Nebraska 68726 402-485-2582
	Elgin Fire and Rescue Service P.O. Box 240 Elgin, Nebraska 68636 402-843-5300
	Orchard Fire and Rescue P.O. Box 141 Orchard, Nebraska 68764
	Midwest Medical Transport 909 O Street Neligh, Nebraska 68756

HOME HEALTH AGENCIES	Antelope Memorial Home Health 102 West 9th, P.O. Box 229 Neligh, Nebraska 68756 402-887-6291
HOSPICE	AseraCare 421 East Douglas Street O'Neill, Nebraska 68763
HOSPITALS	Antelope Memorial Hospital 402 West 9th, P.O. Box 229 Neligh, Nebraska 68756 402-887-4151
MEDICAL CLINICS	AMH-Clearwater Clinic Highway 275 Clearwater, Nebraska 68726 402-485-2277
	AMH-Elgin Clinic 1st and Cedar Elgin, Nebraska 68636 402-843-5444
	Elgin Veteran's Medical Clinic 116 North 2nd Street Elgin, Nebraska 68636 402-843-5910
	Antelope Memorial Hospital Family Practice 109 West 11th Street Neligh, Nebraska 68756 402-887-5440
	Neligh Clinic 1108 R Street Neligh, Nebraska 68756 402-887-4681
	AMH-Orchard Medical Clinic 103 Washington Street Orchard, Nebraska 68764 402-893-5155
	FRPS Tilden Family Medicine 306 West 2nd Street Tilden, Nebraska 68781 402-368-9964
NORTHEAST NEBRASKA AREA AGENCY ON AGING	119 West Norfolk Avenue Norfolk, Nebraska 68701
NURSING HOMES	Golden Living Center 1100 North T Street Neligh, Nebraska 68756

	402-887-5428
PHARMACIES	Elgin Pharmacy 112 South 2nd Street Elgin, Nebraska 68636 402-843-5555
	Hilltop Drug 108 West 11th Neligh, Nebraska 68756 402-887-5551
	Wanek Pharmacy 410 Main Street Neligh, Nebraska 68756 402-887-5426
SENIOR MEAL PROGRAMS/HOME DELIVERIES	Neligh Senior Citizens Program 206 M Street Neligh, Nebraska 68756
SENIOR CARE CENTERS	Elgin Senior Center P.O. Box 12 Elgin, Nebraska 68636 402-843-5757
HEALTH, WELLNESS AND PREVENTION	
BOUNTIFUL BASKETS	Norfolk YMCA
CHIROPRACTORS	Neligh Chiropractic & Acupuncture 324 Main Street Neligh, Nebraska 68756 402-887-4878
	Creekwood Chiropractic Clinic 413 Main Street Neligh, Nebraska 68756 402-887-5469
	Antelope County Chiropractic & Wellness 406 L Street Neligh, Nebraska 68756 402-887-4433
DENTISTS	Family First Dr. Terry Jensen Neligh, Nebraska 68756 402-887-5214
	Elgin Dental Clinic Dr. John Williams Dr. Kate Kusek 109 South 2nd, P.O. Box 205 Elgin, Nebraska 68636 402-873-2429

EYE CARE	Neligh Eye Physicians Mark A. Palmer, OD Russell M. Vetick, OD 304 North Street Neligh, Nebraska 68756 402-887-4506
FITNESS CENTER	719 Fitness Center 406 Main Street Neligh, Nebraska 68636
HEALTH DEPARTMENT	North Central District Health Department 422 East Douglas Street O'Neill, Nebraska 68763 402-336-2406
PHYSICAL AND OCCUPATIONAL THERAPY **CARDIAC/PULMONARY REHAH**	AMH Physical Therapy 102 West 9th, P.O. Box 229 Neligh, Nebraska 68756 402-887-6284
	AMH Occupational Therapy 102 West 9th, P.O. Box 229 Neligh, Nebraska 68756 402-887-6284
	AMH Cardiac/Pulmonary Rehab 102 West 9th Neligh, Nebraska 68756 402-887-6270
SPEECH THERAPY	AMH Speech Therapy 102 West 9th, P.O. Box 229 Neligh, Nebraska 68756 402-887-6284
WORKSITE WELLNESS PROGRAMS	AMH Wellness 102 West 9th, P.O. Box 229 Neligh, Nebraska 68756 402-887-6204
	North Central District Health Department Working on Wellness Program 422 East Douglas Street O'Neill, Nebraska 68763 402-336-2406
WALKING TRAILS	
HOUSING and ENVIRONMENTAL	
	City of Neligh 202 Main Street Neligh, Nebraska 68756 402-887-4066

CITY/COUNTY OFFICIALS	Neligh Economic Development 105 East 2nd Street Neligh, Nebraska 68756 402-887-4447
	Antelope County City Clerk: Lisa Payne Attorney: Joseph E.W. Abler 501 M Street Neligh, Nebraska 68756 402-887-4410
COMMUNITY ACTION AGENCIES	Northeast Nebraska Community Action Partnership 603 Earl Street Pender, Nebraska 68047 1-800-445-2505
DEPARTMENT OF HEALTH AND HUMAN SERVICES	501 Main, Room 10 Neligh, Nebraska 68756 402-887-4196
FOOD PANTRY	Neligh Mobile Food Pantry Third Tuesday of the month Neligh Legion Club
NATURAL RESOURCES	Joy Knapp, NRCS Clerk Neligh Field Office Upper Elkhorn NRD 301 North Harrison Street O'Neill, Nebraska 68763
INDOOR AIR ACT	State of Nebraska/North Central District HD 422 East Douglas Street O'Neill, Nebraska 68763
LAW ENFORCEMENT	Antelope County Sheriff 205 East 6th Street, P.O. Box 72 Neligh, Nebraska 68756 402-887-4147
	Neligh Police Department 202 Main Neligh, Nebraska 68756 402-887-4335
RADON TESTING	State of Nebraska/North Central District HD 422 East Douglas Street O'Neill, Nebraska 68763
MENTAL HEALTH/SUBSTANCE ABUSE	
	Antelope Memorial Hospital Telepsychiatry 102 West 9Th Street Neligh, Nebraska 68756 402-887-4151

MENTAL/BEHAVIORAL HEALTH PROVIDERS	Counseling and Enrichment Center 325 M Street #106 Neligh, Nebraska 68756 402-887-9000
	Faith Regional Health Services Behavioral Health 1500 Koenigstein Avenue Norfolk, Nebraska 68701
SOCIAL SERVICES	Antelope Memorial Hospital 102 West 9th Street Neligh, Nebraska 68756
SUBSTANCE ABUSE CENTERS	Valley Hope Association 1421 North 10th Street O'Neill, Nebraska 68763

DATA SOURCES

North Central District Health Department (NCDHD) and partnering district hospitals, as listed in the Acknowledgements section of this report, contracted with Dr. Joe Nitzke, PhD. of Ionia Research for data collection, compilation, analysis, and presentation services for the purpose of conducting this community health needs assessment. The following data sources, which include quantitative and qualitative sources of both primary and secondary data, were used. Data sources were accessed during the time period of October 2015 through February 2016; report years are noted, where applicable.

US CENSUS

QuickFacts Antelope County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31003

QuickFacts Boyd County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31015

QuickFacts Brown County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31017

QuickFacts Cherry County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31031

QuickFacts Holt County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31089

QuickFacts Keya Paha County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31103

QuickFacts Knox County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31107

QuickFacts Pierce County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31139

QuickFacts Rock County, Nebraska: http://www.census.gov/quickfacts/table/PST045215/31149

US Census Bureau, American Community Survey. 2009-13.

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

US Census Bureau, Small Area Health Insurance Estimates. 2013.

http://www.census.gov/did/www/sahie/data/

COUNTY HEALTH RANKINGS

http://www.countyhealthrankings.org/app/nebraska/2015/overview

COMMUNITY HEALTH STATUS INDICATORS

http://wwwn.cdc.gov/communityhealth

COMMUNITY HEALTH NEEDS ASSESSMENT

http://www.communitycommons.org/

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare and Medicaid Statistical Supplement. 2012.

https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicaremedicaidstatsupp/2012.html

HEALTH INDICATORS WAREHOUSE

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

http://www.healthindicators.gov/Resources/DataSources/BRFSS_21/Profile

NEBRASKA DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Rural Health, State and Federal Shortage Areas

http://dhhs.ne.gov/publichealth/RuralHealth/Pages/ShortageAreas.aspx

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

BRFSS 2011-2014 Detailed Tables for North Central

http://dhhs.ne.gov/publichealth/BRFSS/BRFSS%202011-2014%20Detailed%20Tables%20for%20North%20Central.pdf

BRFSS 2014 one-page table for North Central:

http://dhhs.ne.gov/publichealth/BRFSS/BRFSS%202014%20one-page%20table%20for%20North%20Central.pdf

NEBRASKA RISK AND PROTECTIVE FACTOR STUDENT SURVEY (NRPFSS)

Nebraska Risk and Protective Factor Student Survey Results for 2014 – Profile Report: Antelope County

http://bosr.unl.edu/Antelope%20County.pdf

Nebraska Risk and Protective Factor Student Survey Results for 2010 – Profile Report: Boyd County

http://bosr.unl.edu/Boyd%20County%20NRPFSS%202010.pdf

Nebraska Risk and Protective Factor Student Survey Results for 2014 – Profile Report: Cherry County

http://bosr.unl.edu/Cherry%20County.pdf

Nebraska Risk and Protective Factor Student Survey Results for 2014 – Profile Report: Holt County

http://bosr.unl.edu/Holt%20County.pdf

Nebraska Risk and Protective Factor Student Survey Results for 2014 – Profile Report: Knox County

http://bosr.unl.edu/Knox%20County.pdf

Nebraska Risk and Protective Factor Student Survey Results for 2014 – Profile Report: Pierce County

http://bosr.unl.edu/Pierce%20County.pdf

CENTERS FOR DISEASE CONTROL AND PREVENTION

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-12.

http://www.cdc.gov/brfss/data_tools.htm

NEBRASKA DEPARTMENT OF ECONOMIC DEVELOPMENT

http://www.neded.org/business/data-a-research/population

US DEPARTMENT OF AGRICULTURE

US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2010.

http://www.ers.usda.gov/data-products/food-access-research-atlas/.aspx

FOCUS GROUPS

Meeting minutes located in Appendix B of the North Central District Health Department Community Health Assessment report, available online at www.ncdhd.ne.gov

NCDHD COMMUNITY SURVEY: 2016

Results of the NCDHD Community Survey can be found in the North Central District Health Department Community Health Assessment report, available online at www.ncdhd.ne.gov