Central District Health Department
HALL•HAMILTON•MERRICK

Comprehensive Community Health Assessment

2018-2022

Prepared by:

Central District Health Department

In collaboration with:

CHI St. Francis

Merrick Medical Center

Memorial Community Health

Focus Groups:

CHI & Community Partners

CDHD Board of Health

CDHD Staff

Hall County Community Collaborative (HC3)

Minority (Higher Health Risks and Poorer Health Outcomes)

Veterans (Higher Health Risks and Poorer Health Outcomes)

Leadership Tomorrow

Merrick Medical Center and Community Partners

Memorial Health Center

Aurora Community Partners

Foreword

About Redwoods….

You may be wondering why redwoods were chosen to represent the work contained in this document and in the planning to follow.

First of all, we know that redwoods have shallow root systems that extend outward over 100 feet from the base of the tree, intertwining with the roots of other redwoods. This increases the redwoods' stability to weather strong winds and floods. Secondly, we know that diversity is crucial to the redwood forest; every plant, tree, and even fallen logs play a vital role in the balanced ecosystem in which all living organisms thrive.

We as a community intertwine our roots just as the redwoods do for strength and endurance to tackle challenging health-related issues. Together we are stronger, Additionally, each organization or agency is similar to a plant, tree, or fallen log in the forest in that we each fill a specific role, working together as a community we represent the diversity needed for success.

Teresa Anderson, MSN APRN-CNS, BC
Health Director
Central District Health Department
1137 South Locust Street
Grand Island, NE 68801-6771

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Introduction

Overview of the Comprehensive Community Health Assessment

Under the direction of Central District Health Department (CDHD) the 2018-2022 Comprehensive Community Health Assessment (CHA) has been developed for the three counties in the Central Health District: Hall, Hamilton, and Merrick Counties in Nebraska. This assessment was conducted in partnership with multiple agencies within the district and will be the basis for the Community Health Improvement Plan (CHIP). This assessment will also serve as a reference document for the three non-profit hospitals in the district to assist in strategic planning. It is the purpose of this assessment to inform all interested parties about the health status of the population within the district, to provide community partners with a wide array of data that can be used to educate and mobilize the community, and resources to improve the health of the population.

The Comprehensive Community Health Assessment process is collaborative and is intended to serve as a single data report for multiple coalitions, organizations, and hospitals in the three-county region unified by Central District Health Department. It is the goal of the CHA to describe the health status of the population, identify areas for health improvement, determine factors that contribute to health issues, and identify assets and resources that can be mobilized to address public health improvement. This assessment will be updated and revised every 3 years to stay aligned with hospital timelines, thus providing communities with up to date data to evaluate progress made towards identified health priorities and for the selection of new ones.

This report contains three sections. The first section describes the state of the public health system in the Central District, including the 10 Essential Public Health Services, the availability of health resources, and perceptions of community need. Section two contains a broad collection of demographic and public health data and provides the main body of the report. Section three contains qualitative and quantitative data collected from community meetings.

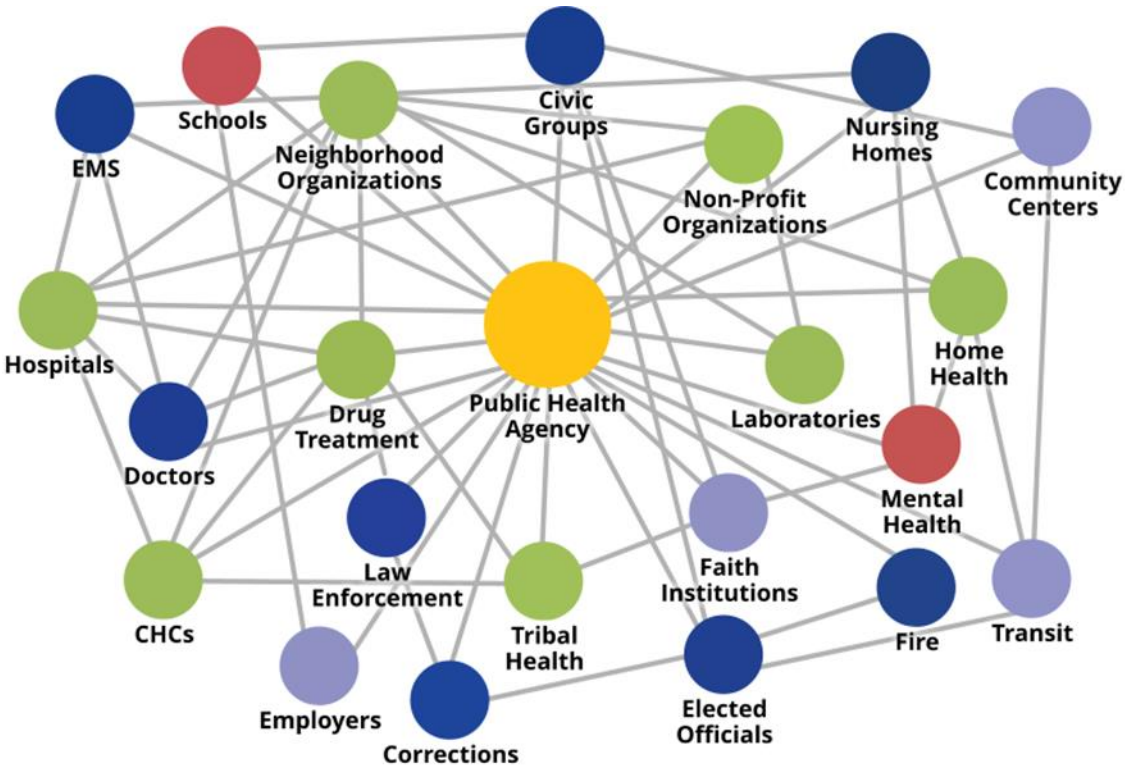
The data collection for the CHA was largely done through the process of Mobilizing for Action through Planning and Partnerships (MAPP). The original MAPP process was completed in 2016 and Garrison Consulting assembled the assessment of public health and community well-being. In 2018, a modified MAPP process was completed to update the CHA. Contents in section three represent the 2018 modified MAPP process with exception to the forces of change process, due to the forces of change being consistent over the years.

Community Health and the Local Public Health System

Community health includes a broad array of issues addressed by numerous agencies. Topics that fall under community health include such things as: access to health care, perceptions of the well-being of the community, utilization of social programs, child welfare, crime, alcohol and tobacco use, drug use, poverty, obesity, diabetes, teen pregnancy and sexual activity, healthy children, environmental factors affecting health, cancer, heart disease, and a broad array of other epidemiological topics.

Addressing needs of community health goes far beyond the work of hospitals and the public health department. A broad network of agencies must work in collaboration to meet the diverse health needs of the community. An example of the local public health system network is shown in Figure 1 below, in which over 20 agencies collaborate in various ways to multi-effectively address the health needs of the community.

Figure 1: The Local Public Health System



(Source: Centers for Disease Control and Prevention)

Mobilizing for Action through Planning and Partnerships

Mobilizing for Action through Planning and Partnerships (MAPP) is the framework used by the Central District Health Department to gather data, select public health priorities, and foster collaboration among multiple health care providers. MAPP is a community-driven strategic planning tool for improving community health. Facilitated by public health leaders, this tool helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment tool; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

The MAPP process has six phases: 1) organize for success and partnership development, 2) visioning, 3) the four MAPP assessments, 4) identify strategic issues, 5) formulate goals and strategies, and 6) take action. The essential building blocks of MAPP are the four assessments which provide critical insights into the health challenges and opportunities confronting the community. These four assessments and the issues they address are described below. All four of the assessments are utilized in this Comprehensive Community Health Needs Assessment. See also Figure 2.

1. The Community Health Status Assessment identifies community health and quality of life issues. Questions answered by this assessment include: "How healthy are our residents?" and "What does the health status of our community look like?" The Community Health Status Assessment contains a comprehensive data collection process. It includes public health data collected by Nebraska DHHS, as well as data from the Adult Risk Behavior Factors Surveillance System (BRFSS), Nebraska Risks and Protective Factors Student Survey (NRPFSS), among other data sources. The Community Health Status Assessment provides the majority of data in this report.

2. The Community Themes and Strengths Assessment (see Appendices A, B, and C) provides a deep understanding of the issues that residents feel are important by answering questions such as : “What is important to our Community?”, “How is quality of life perceived in our community,” and “What assets do we have that can be used to improve community health?”. This assessment includes focus groups and a community survey.

3. The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?"

4. The Local Public Health System Assessment focuses on all the organizations and entities that contribute to the public health. The LPHSA answers questions such as: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

Figure 2: The MAPP Conceptual Model

(Source: National Association of County and City Health Officials)

Section I

The Public Health System in the Central District

Below are the 10 Essential Public Health Services and CDHD's scores on the essential services.

Figure 3: The 10 Essential Public Health Services

1. Monitor health status to identify and solve 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 and action 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 competent public 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

Based upon the responses provided during the Local Public Health System Assessment, an average was calculated for each of the ten Essential Services. Each Essential Service score can be interpreted as the overall degree to which our public health system meets the performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

In Figure 4 below, scores on a range from 1 to 100 for each of the 10 services were obtained from the representatives of various community agencies through a complex process that involved comparison to a "golden standard", sub-committee work, analysis of individual components for each of the 10 services, identification of gaps, group brainstorming and discussion, and finally ballot voting. Each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. Note – The Priority rating and agency contribution scores will be blank if the Priority of Model Standards Questionnaire and the Agency Contribution Questionnaire are not completed.

Figure 6 displays the average score for each Essential Service, along with an overall average assessment score across all ten Essential Services. Take a look at the overall performance scores for each Essential Service. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of reported performance score responses within each Essential Service.

Figure 4: Essential Public Health Service score for the Central District

Model Standards by Essential Services	Performance Scores
ES 1: Monitor Health Status	**50.0**
1.1 Community Health Assessment	58.3
1.2 Current Technology	41.7
1.3 Registries	50.0
ES 2: Diagnose and Investigate	**88.9**
2.1 Identification/Surveillance	83.3
2.2 Emergency Response	83.3
2.3 Laboratories	100.0
ES 3: Educate/ Empower	**50.0**
3.1 Health Education/Promotion	33.3
3.2 Health Communication	41.7
3.3 Risk Communication	75.0
ES 4: Mobilize Partnerships	**39.6**
4.1 Constituency Development	37.5
4.2 Community Partnerships	41.7
ES 5: Develop Policies/Plans	**60.4**
5.1 Governmental Presence	50.0
5.2 Policy Development	66.7
5.3 CHIP/Strategic Planning	25.0
5.4 Emergency Plan	100.0
ES 6: Enforce Laws	**68.8**
6.1 Review Laws	81.3
6.2 Improve Laws	50.0
6.3 Enforce Laws	75.0
ES 7: Link to Health Services	**53.1**
7.1 Personal Health Service Needs	56.3
7.2 Assure Linkage	50.0
ES 8: Assure Workforce	**61.6**
8.1 Workforce Assessment	25.0
8.2 Workforce Standards	100.0
8.3 Continuing Education	65.0
8.4 Leadership Development	56.3
ES 9: Evaluate Services	**55.4**
9.1 Evaluation of Population Health	56.3
9.2 Evaluation of Personal Health	60.0
9.3 Evaluation of LPHS	50.0
ES 10: Research/Innovations	**22.2**
10.1 Foster Innovation	37.5
10.2 Academic Linkages	16.7
10.3 Research Capacity	12.5
Average Overall Score	**55.0**
Median Score	**54.3**

Figure 5: Performance Scores by Essential Public Health Service for Each Model Standard

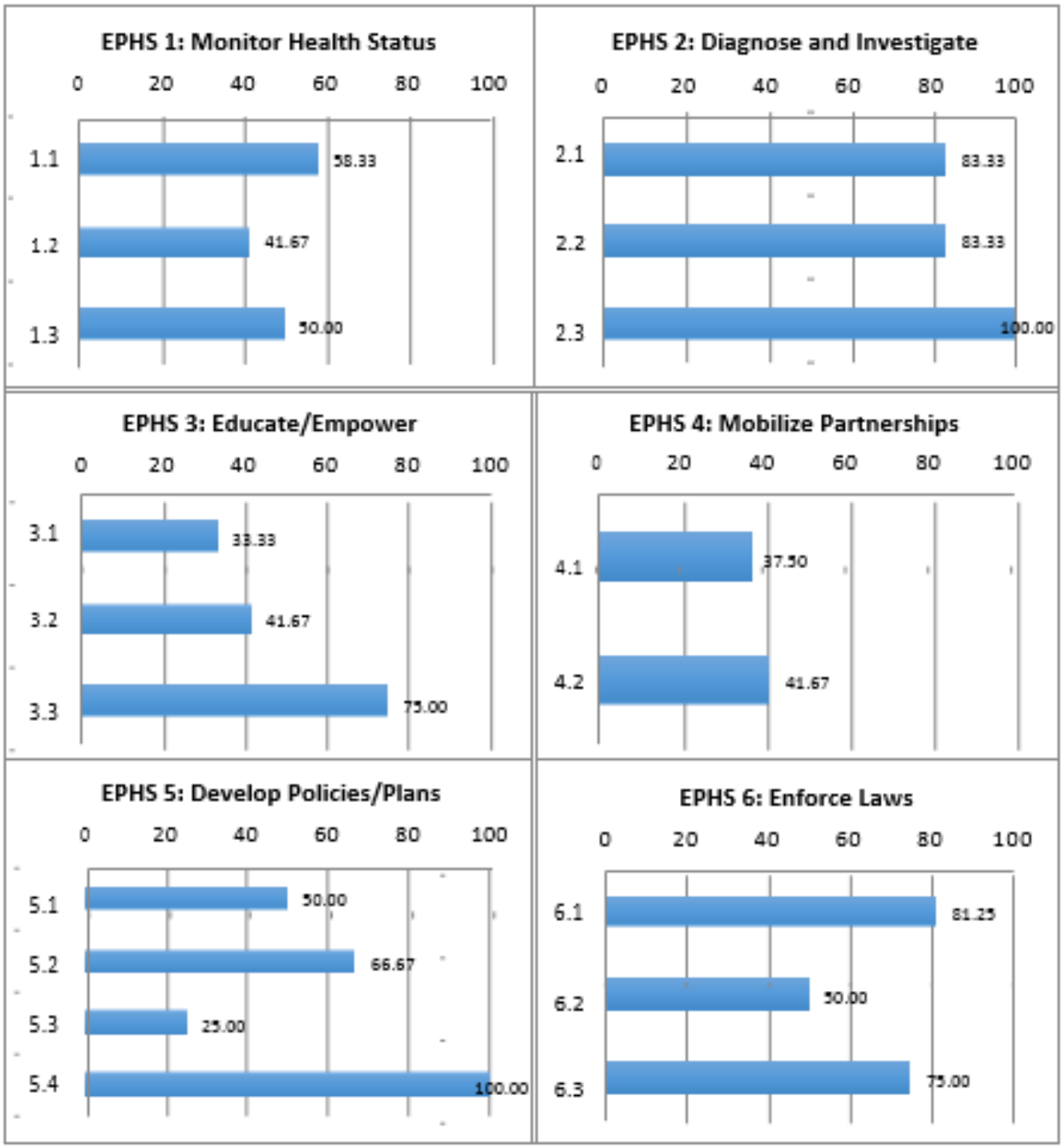
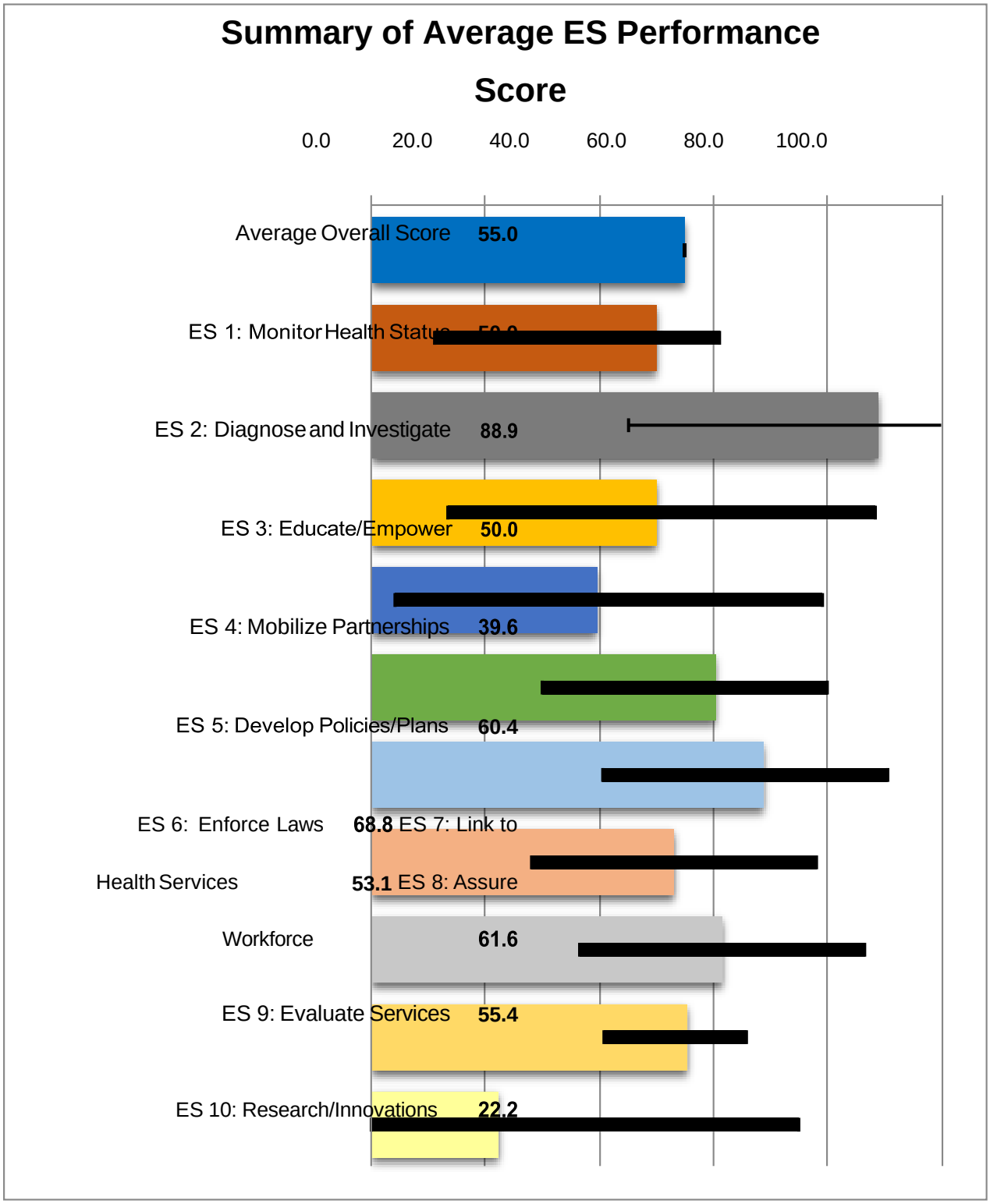


Figure 6: Summary of Average Essential Public Health Service Performance Scores



Community Resources

Among several medical clinics and the Central District Health Department, there is one hospital located in each of the three counties of the Central District, plus Heartland Health Center, a Federally Qualified Health Center in Grand Island. The three hospital providers in the Central District are St. Francis Medical Center (located in Grand Island, Hall County), Aurora Memorial Community Health Hospital (located in Aurora, Hamilton County), and Merrick Medical Center (located in Central City, Merrick County. Each hospital and clinic provide an array of services. In addition to the hospitals, there are many other organizations addressing health issues (listed below).

Description of County Hospitals/Health Clinic

St. Francis Medical Center

St. Francis Medical Center, located in Hall County, is a regional referral center, with more than 100 physicians and 1,100 employees working together to build a healthier community. The goal of St. Francis is to provide patents with high-quality medical care close to home, where they can be supported by their family, friends, and community. In 2018, the St. Francis Cancer Treatment Center became a QOPI Certified Practice. This acknowledgement means the St. Francis Cancer Treatment Center meets certain defined quality and safety standards in the administration of cancer care. In 2015, St. Francis was named one of the "100 Great Community Hospitals for 2015" by Becker's Hospital Review.

Services provided by St. Francis Medical Center include: behavioral care, breast cancer care, cancer care, diabetes education, emergency and trauma, general surgery, heart care, home care, imaging maternity center, neurosurgery, nursing, orthopedics, pediatrics, primary care, rehabilitation care, respiratory care, sleep disorders, and wound and ostomy center.

Memorial Community Health, Inc.

Aurora Memorial Community Health Hospital is a Critical Access Hospital in Aurora, Hamilton County, Nebraska which offers residents a diverse, modern health care system that includes three family practice clinics, an acute hospital, outpatient specialty and diagnostic services, independent and assisted living facilities, and a nursing home. Memorial Community Health is fully licensed by the State of Nebraska and approved by Medicare and Medicaid which sets and oversees the standards of quality for health care institutions; while also being members of the American Hospital Association, the Nebraska Hospital Association, the Nebraska Nursing Home Association and the Nebraska Assisted Living Association. Memorial Community Health is a not for profit organization and is entirely dependent upon revenue from patient services, resident care, and philanthropy.

Merrick Medical Center

Merrick Medical Center, formerly Litzenberg Memorial County Hospital, promotes and provides personalized, compassionate, and quality healthcare services for the people in Merrick County and the surrounding area. Merrick Medical Center is located in Central City, Merrick County, Nebraska and is a critical access hospital with 25 licensed beds and two physician clinics. On July 1, 2017, Bryan Health, a non-profit, Nebraska owned health system partnered with the former Litzenberg Memorial County Hospital to establish Merrick Medical Center. Merrick Medical Center provides health care services, fitness and wellness programs, telehealth technology and works with community partners to make health a commitment.

Heartland Health Center

Located in Grand Island, Hall County, Nebraska, Heartland Health Center serves resident of Hall County and the surrounding area. Heartland Health Center became operational in 2014 as the seventh Federally Qualified Health Center in the state of Nebraska. Federally Qualified Health Centers (FQHC) are an integral part of the nation's health delivery system, providing cost effective, community oriented, and comprehensive primary health care services. Offering payment options on a sliding scale for patients who would be otherwise unable to afford health care, a FQHC serves medically underserved areas and/or populations and receives Public Health Service funds. Medical services provided include men's health, women's health, sports physicals, health education, general medical care, pediatric care, outreach and eligibility. Dental services provided include dental check-ups, fillings, crowns, and rood canals, pediatric dental care, partial dentures, and school check-ups, and sealants.

Central District Health Department

Central District Health Department (CDHD) provides services to Hall, Hamilton, and Merrick Counties in Nebraska, with approximately 78,000 residents living within the district's coverage area. The organization provides comprehensive public health services based on the needs of the community and the priorities of its residents, with focused efforts in Environmental Health, Community Health, and Health Project Services.

Other Community Resources

Public school systems: Public school systems in each of the Central District counties provide and partner with organizations that address health issues. Grand Island Public Schools (GIPS) is the largest school district with 10,000 students.

Nebraska Extension: Nebraska Extension's mission is, "Helping Nebraskans enhance their lives through research-based education." The extension provides food, nutrition and health education along with many other educational program areas.

Head Start: Head Start provides a number of programs and services to young families.

Parks and Recreation: Parks and Recreation programs in each of the three Central District Counties provide and encourages physical activity for all ages.

Hall County Community Collaborative (H3C) whose vision is, “A safe, healthy thriving community of families.” This collaborative meets bimonthly. The focus is on creating environments where children can grow up healthy in nurturing family settings. H3C’s membership includes schools, health facilities, Head Start, Boys Town, behavioral health, DHHS, and social service agencies.

Forces of Change

Central District Health Department convened separately with the three county hospitals and the communities for a community strategy meeting to share data and prioritize key areas to focus on as a community over the next three years in their efforts to positively impact community health. Broad participation from a range of community health care entities and organizations gathered as representatives of the local public health system. Robust participation lead to collective thinking and, ultimately, will suggest effective, sustainable solutions to complex problems.

The public health leaders in each county gathered to identify the key forces that are or will impact the public health system in the Central District Health Department service area. Following is a bulleted summary of the key forces that were identified for each county.

Figure 7	Forces of Change - Hall County
Political	• Limited support for behavioral health issues in youth and aging populations • Health care reform • Moving of the Veterans Home • Lack of public transportation • Minimum wage law • Hall County Community Collaborative • Grow Grand Island initiative • Demographically, geographically segregated community • Lack of immigration reform • Overpopulation in the prison system
Economic	• 2nd hospital being built in Grand Island • Increasing transitional poverty • Over representation of low skilled blue collar and entry level jobs • Absence of skilled workers • Increasing cost of medical care • Upgrade of 3rd City Clinic • Arrival of a Federally Qualified Health Care Center • Decreasing employment rates • Nursing and medical provider shortage • Many physicians close to retirement • Impact of agricultural economy

Social	• Rapidly changing demographics • Rapid community growth • Behavioral health issues with aging population and youth • Housing needs and substandard housing • Increasing aging population and youth population • 40% of youth in foster care related to parents using substances
Technological	• Increased access to virtual medicine • Increased use of technology
Environmental	• Climate change • Natural disasters
Scientific	• Infectious diseases • Global diseases
Legal	• Health care reform • Lack of immigration reform
Ethical	• Lack of moral compass • Need for instant gratification

Figure 8	Forces of Change - Hamilton County
Political	• International relations and trade agreements • Increased immigration with high medical needs and limited medical history • Obama Care • Presidential election and legislative changes • Lack of public awareness of the insurance industry • CNS assisted living – Final Rule • Perception of "bigger is better" to the detriment of smaller towns • Excellent hospital • Health fair
Economic	• Changing revenue streams in healthcare • Shorter hospital stays – fewer readmissions • High co-pays & economic stress • Insurance companies entering healthcare • New hospital and clinic construction • Transfer of patients from the community to facilities with more services • Housing shortage • Poverty • Young moving back to the area • Backpack program • Food pantry • Fast food

Social	• Aging population & changing demographics • A lack of desire to be healthy • Desire for immediacy in all things including healthcare • More elderly staying at home as opposed to going into the nursing home • Busy life increasing familial stress • Obesity epidemic • Decreasing activity levels • Ignorance regarding nutrition and healthy eating • Increased activity levels by segments of the population • Drug abuse • Single parent homes • Increasing divorce rate • Frenetic pace of life and exhausted families • Lack of family mealtime • Loneliness
Technological	• Increasing use of technology • Social media • Rural farming relying more on technology and thus less physically demanding • Data breeches and security issues • Disconnect with technology among certain demographics
Environmental	• Changes in the use of personal gardening • Climate change • Amenities such as fitness trails • Abundance of clean water • Community garden • Farmers market • Organic movement
Scientific	• Increase of super-bugs • Reoccurrence of measles, mumps & pertussis • Antibiotic over use • Increased sleep disorders • Drug resistant antibiotics

Legal	• Knowledge based-society demands increasing transparency in medical records • Disjoined medical records and a lack of the continuum of care
Ethical	• Generational differences in the approach to healthcare

Figure 9	Forces of Change – Merrick County
Political	• Effective law enforcement • Sex trafficking • Lack of understanding about healthcare and insurance • Cultural dissonance • Falling through the health care cracks
Economic	• Supplemental food programs • Poverty • Bountiful baskets • Backpack program • Lack of mental health care professionals • Delays in seeking treatment
Social	• Lack of parental support • Parenting skills • Single parents • Teen center • Parent education • Increasing teen pregnancy • Cultural dissonance • Increased levels of obesity • Aging population
Technological	• Social media • Technology gaps
Environmental	• Fitness center • Trails and parks
Scientific	• Super bugs • STI's and STD's • Immunizations • Prevention and wellness trends
Legal	• Lack of insurance
Ethical	• Generational differences in the approach to healthcare

The broader environment is constantly affecting communities and local public health systems. State and federal legislation, rapid technological advances, changes in the organization of health care services, shifts in economic forces, and changing family structures and gender roles are all examples of Forces of Change. These forces are important because they affect, either directly or indirectly, the health and quality of like in the community and the effectiveness of the local public health system. The data gathered from this focus group will help Central District Health Department and Hall, Hamilton, and Merrick Counties prioritize public health issues and identify resources for addressing them.

Section II

Demographics and Public Health Data

Demographics

The Central District continues to grow yearly. Much of the Central District area is located along Interstate 80 and one town of the district area, Grand Island, is the fourth largest city in Nebraska. Grand Island also homes more than 90 manufacturing plants providing jobs for over 7,000 people.

From 2013 to 2017 the total population in the Central District has grown by approximately 2.5%. The population in Hall County has grown by 3%, while the populations in Hamilton and Merrick Counties have basically remained stable with a less than 1% growth (Figure 10).

Figure 10	**Total Population (2013 – 2017)**					
	2013	**2014**	**2015**	**2016**	**2017**	**% Change (2013 to 2017)**
Hall	59,431	60,223	60,792	61,105	61,233	3.03%
Hamilton	9,090	9,098	9,100	9,118	9,149	0.65%
Merrick	7,802	7,790	7,776	7,793	7,829	0.35%
CDHD	76,323	77,111	77,668	78,016	78,211	2.47%
(Source: U.S. Census/American Community Survey 5–Year Estimates)						

With the large amount of manufacturing business in Hall County that provide many job opportunities, Hall County has a larger minority population percentage, more than double that of the state. Outside of Hall County, there are few other minorities in the Central District (Figure 11).

Figure 11	Population by Race/Ethnicity (2017)			
	Hall	Hamilton	Merrick	Nebraska
White	68.0%	95.2%	92.9%	79.8%
Hispanic/Latino	26.8%	3.2%	4.1%	10.5%
Black/African American	2.2%	0.7%	0.6%	4.6%
Asian	1.2%	0.1%	0.1%	2.2%
American Indian/Alaskan Native	0.3%	0.1%	0.2%	0.7%
Native Hawaiian/Pacific Islander	0.2%	0.0%	0.0%	0.1%
Two or More Races	1.0%	0.7%	2.1%	2.0%
Other	0.3%	0.0%	0.0%	0.1%
(Source: U.S. Census/American Community Survey 5–Year Estimates)				

Compared to the state and the nation, Central District has a higher percentage of the population that is aged 65 and over. In particular, Hamilton and Merrick Counties have a significantly higher percentage of the population that is aged 65 and older than either Nebraska or the United States (Figure 12).

Figure 12	Age Distribution (2017)				
	Hall	Hamilton	Merrick	Nebraska	United States
Under 5	7.5%	5.6%	6.0%	6.9%	6.2%
5 to 14	15.3%	13.8%	12.8%	13.9%	12.9%
15 to 24	13.1%	12.6%	11.3%	14.0%	13.6%
25 to 34	13.0%	10.4%	10.0%	13.4%	13.7%
35 to 44	12.5%	10.6%	11.7%	12.1%	12.7%
45 to 54	12.4%	13.7%	13.5%	12.4%	13.4%
55 to 64	11.9%	14.9%	14.7%	12.6%	12.7%
65 and Over	14.1%	18.3%	20.1%	14.8%	14.9%
(Source: U.S. Census/American Community Survey 5–Year Estimates)					

Although the total population in Hamilton and Merrick Counties remained relatively stable, the under 18 population declined from 2013 to 2017. With the exception of Hall County, which grew by 3.6% in the number of persons under 18 years old from 2013 to 2017 (Figure 13).

Figure 13	**Under 18 Population (2013 – 2017)**					
	2013	**2014**	**2015**	**2016**	**2017**	**% Change (2013 to 2017)**
Hall	16,047	16,277	16,438	16,571	16,632	3.6%
Hamilton	2,303	2,275	2,250	2,226	2,219	-3.6%
Merrick	1,866	1,836	1,773	1,776	1,765	-5.4%
CDHD	20,216	20,388	20,461	20,573	20,616	2.0%
(Source: U.S. Census/American Community Survey 5–Year Estimates)						

Hamilton and Merrick Counties in the Central District saw decreases in their median age from 2013 to 2017, while Hall County saw a slight increase. Hall County had a consistently lower median age than Nebraska and the United States; while, Hamilton and Merrick Counties had a consistently higher median age than Nebraska and the United States (Figure 14).

Figure 14	**Median Age (2013 – 2017)**					
Years	**2013**	**2014**	**2015**	**2016**	**2017**	**% Change (2013 to 2017)**
Hall	35.7	35.9	35.8	35.7	35.8	0.28%
Hamilton	42.9	42.8	42.9	42.5	42.3	-1.4%
Merrick	43.9	43.1	43.8	43.8	43.5	-0.9%
CDHD	40.8	40.6	40.8	40.7	40.5	-0.74%
Nebraska	36.3	36.2	36.2	36.2	36.3	-
United States	37.3	37.4	37.6	37.7	37.8	-
(Source: U.S. Census/American Community Survey 5–Year Estimates)						

Hamilton County has the highest median household income and per capita income in the Central District and compared to Nebraska and the United States. The Central District, as a whole, has a lower median household income and per capita income than Nebraska and the United States (Figure 15).

Figure 15	Income 2017	
	Median Household Income	Per Capita Income*
Hall	$53,807	$26,419
Hamilton	$61,944	$31,989
Merrick	$53,536	$27,223
CDHD	$56,429	$28,544
Nebraska	$56,675	$29,866
United States	$57,652	$31,177

*An average weighted by the population of each county.
(Source: U.S. Census/American Community Survey 5–Year Estimates)

Hall County's unemployment rate is on a par with the state unemployment rate, while Merrick County has a slightly higher rate. Hamilton County has a significantly lower unemployment rate than the rest of the Central District and Nebraska. However, the entire Central District has a very favorable unemployment rate when compared to the United States (Figure 16).

Figure 16	Unemployment 2017			
Hall	Hamilton	Merrick	Nebrask	United States
3.9%	1.3 %	2.3%	2.6%	4.1%

*An average weighted by the population of each county.
(Source: U.S. Census/American Community Survey 5-Year Estimates)

Poverty rates for the total population have decreased from 2013 to 2017. In 2014, Hamilton and Merrick Counties had poverty rates lower than the state and nation, while Hall County had poverty rates that were higher than the state and nation. As a whole, the Central District has a slightly lower poverty rate than the state (Figure 17).

Figure 17	Percentage of Population Below Poverty (2013-2017)					
	2013	2014	2015	2016	2017	% Change 2013-2017
Hall	13.7%	15.7%	15.3%	14.8%	13.5%	-1.50%
Hamilton	10.1%	9.1%	8.7%	9.0%	7.2%	-28.7%
Merrick	12.6%	11.1%	8.9%	10.0%	10.0%	-20.6%
Nebraska	12.8%	12.9%	12.7%	12.4%	12.0%	-6.25%
United States	15.4%	15.6%	15.5%	15.1%	14.6%	-5.19%

*An average weighted by the under 18 population of each county
(Source: U.S. Census/American Community Survey 5–Year Estimates)

Poverty rates for the under 18 population decreased considerably in the Central District from 2013 to 2017. It is interesting to note that the poverty rate for the under 18 population in Hamilton and Merrick Counties decreased from 2013 to 2017. However, the poverty rate for the under 18 population in Hall County increased (Figure 18).

Figure 18	Poverty Rates for the Under 18 Population (2013-2017)					
	2013	2014	2015	2016	2017	% Change 2013-2017
Hall	18.2%	22.5%	21.9%	21.8%	20.5%	12.6%
Hamilton	16.4%	13.7%	12.6%	14.4%	12.3%	-25.0%
Merrick	14.5%	11.0%	7.5%	8.7%	11.1%	-23.4%
Nebraska	17.4%	17.6%	17.1%	16.4%	15.6%	-10.3%
United States	21.6%	21.9%	21.7%	21.2%	20.3%	-6.02%

*An average weighted by the under 18 population of each county
(Source: U.S. Census/American Community Survey 5–Year Estimates)

In 2015, 29.1% of respondents to the BRFSS in the Central District reported housing insecurity. The 2013 and 2015 rates are higher compared to the state (Figures 19).

Figure 19	Housing Insecurity* in the Past Year among Adults Ages 18 and Over Who Own or Rent Their Home	
	2013	2015
Central District	33.10%	29.10%
Nebraska	28.80%	28.50%

*Percentage reporting that they were always, usually, or sometimes worried or stressed during the past 12 months about having enough money to pay their rent or mortgage.
(Source: Behavioral Risk Factors Surveillance Systems)

There is a much greater percentage of children in households determined living in poverty with female householders than there is with married-couple households or with male householders. Compared to the state, Hall County has a higher percentage of children in female householder, no husband present, family households, as well with children in married-couple family households. Hamilton and Merrick Counties have lower percentages in all categories than the state. Where the is an NA, there is not enough data to make calculations (Figure 20).

Figure 20	**Children in Households Determined Living in Poverty in the Past 12 Months, (2017)**		
	Children in married-couple family household	**Children in male householder, no wife present, family household**	**Children in female householder, no husband present, family household**
Hall	8.4%	19.3%	46.8%
Hamilton	5.8%	NA	35.4%
Merrick	4.5%	NA	36.2%
Nebraska	7.3%	20.9%	41.2%
United States	10.0%	24.7%	45.6%
(Source: U.S. Census/American Community Survey 5–Year Estimates)			

Children and Families

Looking at four-year averages of the percentage of children living in single-parent households, Hall County tends to have significant higher percentages than the state. However, Hamilton and Merrick Counties tend to have lower or equal percentages than the state. From 2009 to 2017, Hall Counties percentage has increased 6%, while the states percentage stays steady (Figure 21).

Figure 21	**Percentage of Children in Single-Parent Households**				
	2009-2013	**2010-2014**	**2011-2015**	**2012-2016**	**2013-2017**
Hall	33%	36%	35%	38%	39%
Hamilton	20%	19%	20%	19%	19%
Merrick	28%	27%	31%	29%	23%
Nebraska	28%	29%	29%	29%	28%
(Source: County Health Rankings and Roadmaps)					

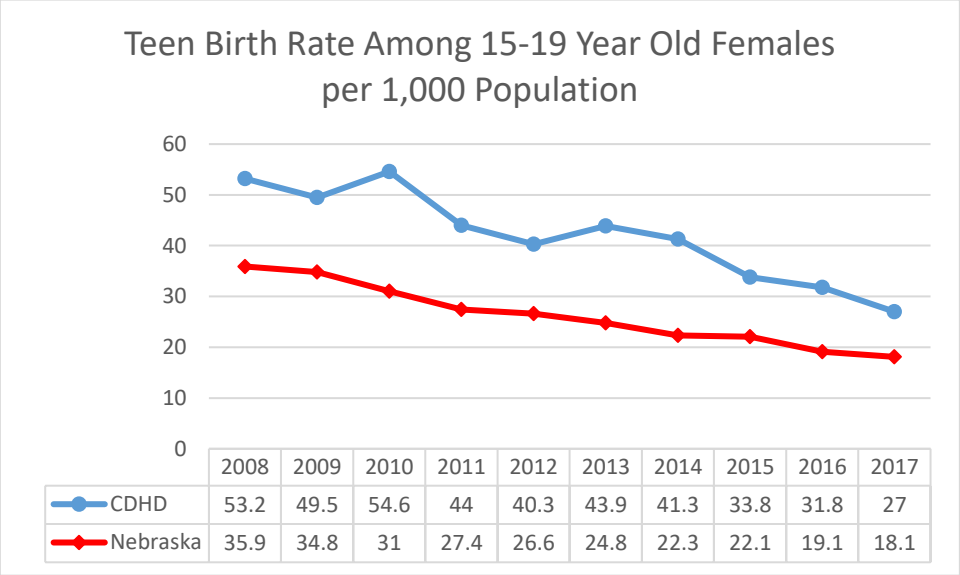
Central District has higher rates of births to unmarried women than the state. Hall County has higher rates than the state as well, where Hamilton and Merrick County's rates are lower than the states (Figure 22).

Figure 22	**Births to Unmarried Women by Place of Residence (2012-2016)**			
	2012-2016 #	**2012-2016** (rate)	**2016** #	**2016** (rate)
Hall	2,161	447.0	440	454.1
Hamilton	100	193.8	18	152.5
Merrick	136	284.5	27	275.5
Central District	*2,397*	*411.3*	*485*	*409.3*
Nebraska	43,530	329.5	8,589	323.0

*Rates = per 1,000 live births; rates based on small numbers may not be reliable
(Source: Nebraska Department of Health and Human Services-Vital Statistics)

From 2008 to 2017 the Central District had much higher rates of births to teen mother's ages 15 to 19 compared to the state. Although births to teen mothers are elevated across the district as compared to the state, they are on the decline for Central District and Nebraska (Figure 23).

Figure 23



*Rate per 1,000 15-19-year-old females' population
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
Source: Nebraska Vital Records; Nebraska DHHS, February 2019

Central District has significant lower numbers of infant deaths compared to the state, however, Central District's rates for Hall and Hamilton Counties are higher than the states (Figure 24).

Figure 24	Number and Rate* of Infant Deaths per 1,000 Live Births			
	2012-2016 #	2012-2016 (rate)	2016 #	2016 (rate)
Hall	29	6	7	7.2
Hamilton	4	7.8	1	8.5
Merrick	2	4.2	0	0
Nebraska	715	5.4	166	6.2

*Rates = per 1,000 live births; rates based on small numbers may not be reliable
(Source: Nebraska Department of Health and Human Services-Vital Statistics)

From 2013 to 2017 the number of substantiated cases of child abuse/neglect (maltreatment victims) increased in the Central District and the state from 70 cases to 117 cases and 2,892 cases to 3,612 cases respectively (Figure 25).

Figure 25	Number of Substantiated Cases of Child Abuse/Neglect				
	2013	2014	2015	2016	2017
Hall	59	97	135	106	113
Hamilton	5	6	8	6	0
Merrick	6	12	13	14	4
Nebraska	2,892	2,575	3,691	3,725	3,612

(Source: Kids Count Data Center: A Project of the Annie E. Casey Foundation)

From 2013 to 2017 the number of juvenile arrests increased in the Central District from 641 arrests to 654 arrests and the number of juvenile arrests decreased in the state from 10,532 to 9,876 (Figure 26).

Figure 26	Number of Juvenile Arrests				
	2013	2014	2015	2016	2017
Hall	632	593	593	543	641
Hamilton	7	5	1	8	2
Merrick	2	0	0	4	11
Nebraska	10,532	10,514	10,198	9,463	9,876

*Crude rates are masked for counties with less than five events due to the rates being unstable with such a small number of cases.
(Source: Kids Count Data Center: A Project of the Annie E. Casey Foundation)

From 2013 to 2017 the rate of children in state ward in out-of-home care in the Central District decreased (Figure 27).

Figure 27	State Wards in Out-of-Home Care, Rate per 1,000 Children	
	2013	2017
Hall	7.1	5.7
Hamilton	2.7	1.8
Merrick	3.8	2.2
Nebraska	7.6	7.3
(Source: Kids Count in Nebraska Report, 2018)		

The percentage of the population ages 5 and over speaking a language other than English at home in the Central District in 2017 was 9.4%. This is lower compared to the state. In Hall County in 2017, 21.6% of the population ages 5 and over speak a language other than English in the home. The overall percentage in the Central District is lower due to the lower percentage of the population speaking a language other than English in Hamilton and Merrick counties at 3% and 3.5% respectively (Figure 28).

Figure 28	Percentage of Population Ages 5 and Over Speaking a Language Other Than English at Home				
	2013	2014	2015	2016	2017
Hall	19.60%	20.60%	20.90%	21.70%	21.60%
Hamilton	2.50%	2.00%	2.20%	3.20%	3.00%
Merrick	3.10%	4.10%	3.60%	3.60%	3.50%
Nebraska	10.50%	10.70%	10.80%	11.00%	11.20%
An average weighted by the population of each county. (Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates)					

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a public health nutrition program under the USDA providing nutrition education, nutritious foods, breastfeeding support, and healthcare referrals for income-eligible women who are pregnant or post-partum, infants, and children up to age 5. The mission of WIC is to assure healthy pregnancies, healthy birth outcomes, and optimal growth and development of infants and children.

Figure 29	**WIC Unduplicated Participation by County, FFY (federal fiscal year), September 30, 2018**		
	Women including pregnant, post-partum, and breastfeeding	**Infants including breastfeeding and formula fed**	**Children ages 13 months thru 5 years' old**
Hall	992	1,134	1,461
Hamilton	31	35	35
Merrick	52	59	72
Nebraska	15,492	17967	22,475
(Source: Nebraska Department of Health and Human Services)			

Enrollment in the Supplemental Nutrition Assistance Program (SNAP) is higher in the Central District compared to the rest of the state. Hall County has notably higher SNAP participation as a percent of all children compared to Hamilton and Merrick counties, and the state (Figure 30).

Figure 30	**Supplemental Nutrition Assistance Program (SNAP) Participation Among Children (Percent of household with children receiving SNAP)**	
	2008-2012	**2012-2016**
Hall	21.0	22.3
Hamilton	13.4	15.7
Merrick	19.7	18.0
Nebraska	15.3	15.7
*Due to changes in data source, this data is not comparable to prior year's data. (Source: Kids Count in Nebraska Report, 2018)		

Hall County has a higher percentage of children receiving free and reduced school meals than Hamilton County, Merrick County, and Nebraska (Figure 31).

Figure 31	Children Receiving Free and Reduced School Meals (Percent of children eligible for free and reduced meals)	
	2012/2013	2016/2017
Hall	61.5%	60.4%
Hamilton	32.6%	34.2%
Merrick	42.2%	47.4%
Nebraska	44.2%	45.8%
Note: Percent and number determined on the last Friday in September.		

Hall and Hamilton Counties have notably higher percentages of 3- & 4-year-olds enrolled in school than the state, while Merrick County has a lower percentage. Hamilton County has just over half of their 3- and 4-year-olds enrolled in school (Figure 32).

Figure 32	Percent of 3- and 4-year-olds Enrolled in School	
	2008-2012	2012-2016
Hall	46.1%	46.9%
Hamilton	33.7%	51.0%
Merrick	40.4%	37.6%
Nebraska	47.4%	42.9%
(Source: Kids Count in Nebraska Report, 2018)		

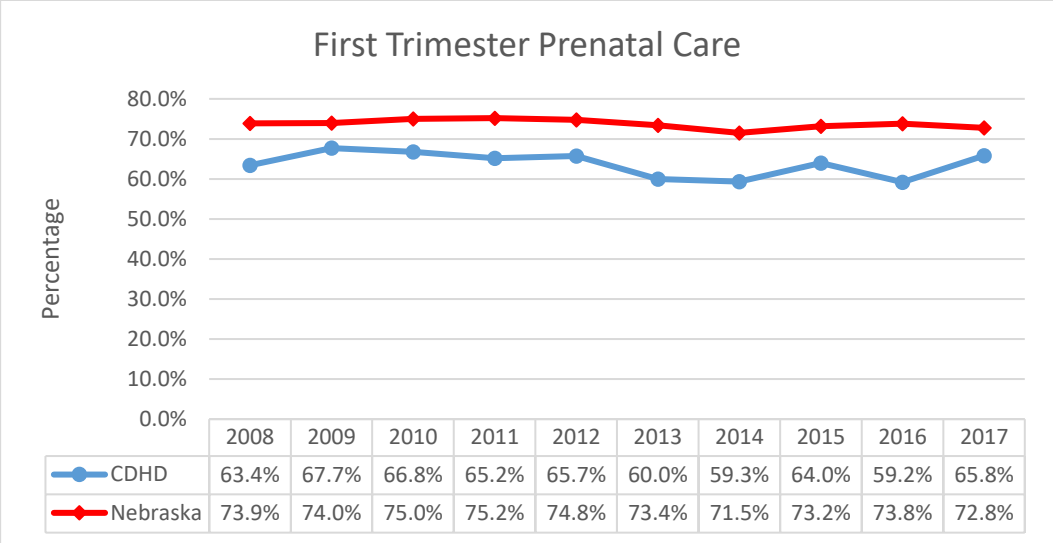
From the time frames of 2008-2012 to 2012-2016, the percentage of children enrolled in public health insurance for all three counties and the State of Nebraska have increased. Hall County has a notably higher percentage of children enrolled in public health insurance over time (Figure 33).

Figure 33	Percent of Children Enrolled in Public Health Insurance	
	2008-2012	2012-2016
Hall	34.30%	37.60%
Hamilton	23.10%	27.50%
Merrick	29.70%	32.60%
Nebraska	28.2%	29.5%
*Due to changes in data source, this data is not comparable to prior year's data. (Source: Kids Count in Nebraska Report, 2018)		

Newborn Child Health

The rate of pregnant women who received first trimester perinatal care in the Central District is lower compared to the stat (Figure 34).

Figure 34

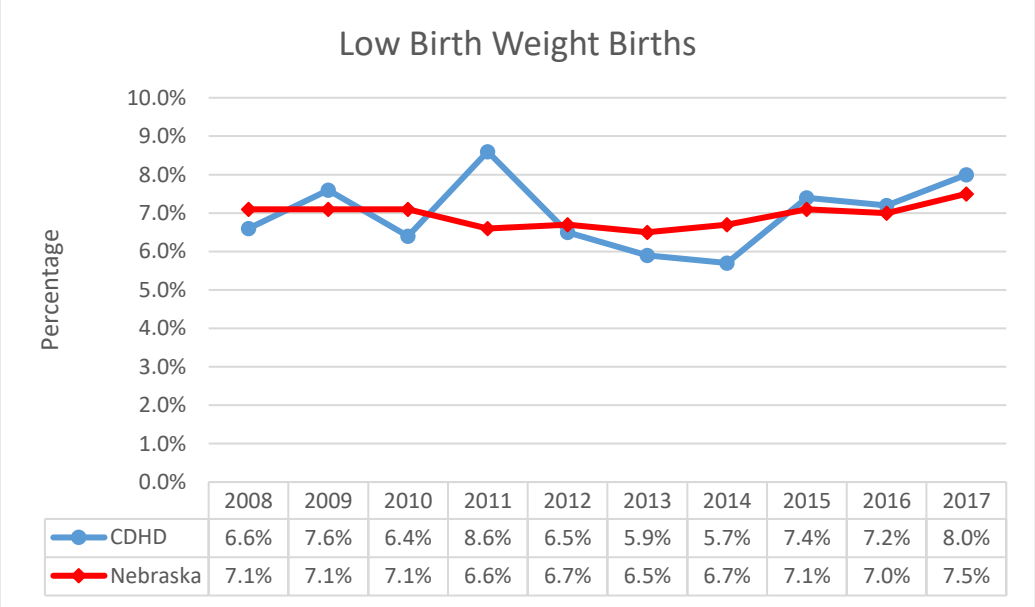


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	63.4%	67.7%	66.8%	65.2%	65.7%	60.0%	59.3%	64.0%	59.2%	65.8%
Nebraska	73.9%	74.0%	75.0%	75.2%	74.8%	73.4%	71.5%	73.2%	73.8%	72.8%

*Percentage of infants born to a woman receiving prenatal care beginning in the first trimester.
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
Date are Preliminary
Source: Nebraska Vital Records; Nebraska Department of Health and Human Services, February 2019

The percent of newborns with low birth weights (i.e., less than 2,500 grams/5.5 pounds) for Central District has been more than the state over the past three years, 2015-2017 (Figure 35).

Figure 35



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	6.6%	7.6%	6.4%	8.6%	6.5%	5.9%	5.7%	7.4%	7.2%	8.0%
Nebraska	7.1%	7.1%	7.1%	6.6%	6.7%	6.5%	6.7%	7.1%	7.0%	7.5%

*Percentage of live births weighing less than 2,500 grams (5.5 pounds)
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
Date are Preliminary
Source: Nebraska Vital Records; Nebraska Department of Health and Human Services, February 2019

The incidence of premature births (i.e., births occurring before 37 weeks of pregnancy) is comparable in Hall and Merrick Counties to the State, whereas, Hamilton county has lower percentages (Figure 36).

Figure 36	**Percent of Premature Births by County of Residence, 2016**	
	2016	**2012-2016**
Hall	11.6%	11.1%
Hamilton	7.6%	8.1%
Merrick	11.2%	10.9%
Nebraska	11.1%	10.9%

*Premature births are live births with <37 weeks of gestation.
(Source: Nebraska Department of Health and Human Services, Vital Statistics 2016)

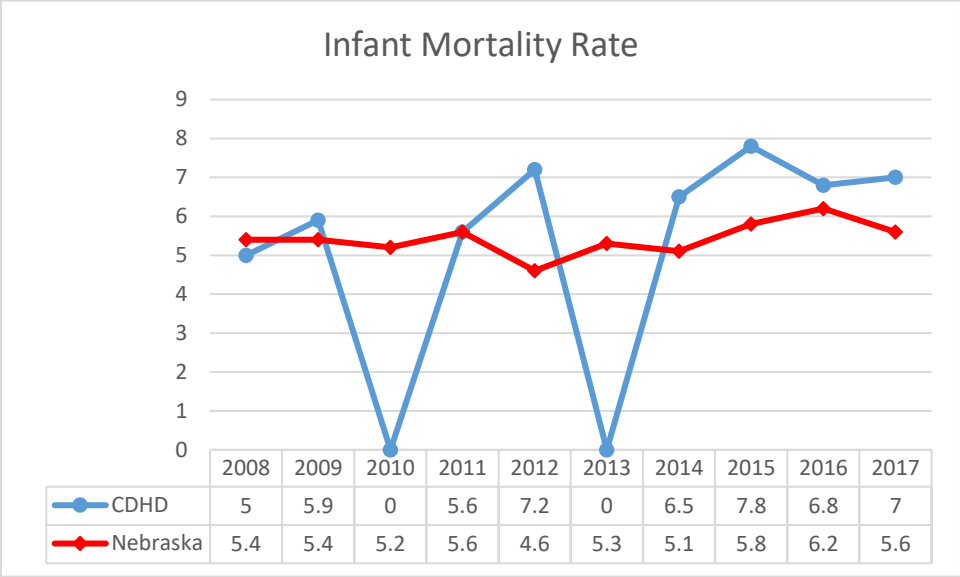
The percentage of birth defects in the Central District counties was lower than the state from 2012–2016. However, the incidence of birth defects is increasing in the Central District and the state from previous years data (Figure 37).

Figure 37	**Percent of Birth Defects by County of Residence, 2016**	
	2016	**2012-2016**
Hall	8.1%	5.7%
Hamilton	7.4%	5.0%
Merrick	10.2%	7.4%
Nebraska	11.6%	7.9%

Note: total number of live births and fetal deaths
(Source: Nebraska Department of Health and Human Services-Vital Statistics 2016)

From 2008 to 2017, rates of infant mortality have fluctuated in the Central District, as compared to the state. The rate of infant mortality in the Central District tends to be higher compared to the state (Figure 38).

Figure 38



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	5	5.9	0	5.6	7.2	0	6.5	7.8	6.8	7
Nebraska	5.4	5.4	5.2	5.6	4.6	5.3	5.1	5.8	6.2	5.6

*Number of deaths to infants (less than 12 months old) per 1,000 live births
** (0) Number of births/event and rate suppressed due to a small number of cases (i.e., fewer than 5) (2010 & 2013)
***Central District Health Department includes Hall, Hamilton, and Merrick Counties
Data are Preliminary
(Source: Nebraska Vital Records; Nebraska DHHS, February 2019)

Access to Health Care

The Central District as a whole, had a similar percentage of the population without health insurance, as compared to the state in 2017. Slightly over 14% of the population in Hall County was without health insurance in 2017. This is notably higher than Hamilton or Merrick Counties, as well as the state and nation (Figure 39).

Figure 39	**Percentage of Total Population without Health Insurance* (2017)**				
Hall	**Hamilton**	**Merrick**	**CDHD**	**Nebraska**	**United States**
14.1%	5.0%	8.6%	9.23%	9.0%	10.5%
*Those that have neither a private nor public health insurance plan *An average by the population of each county (Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates)					

Slightly over 8% of children under 18 in Hall County are without health insurance, a rate notably higher than Hamilton or Merrick Counties, as well as the state and nation. However, almost 5% of children under 18 in the Central District as a whole are without health insurance, a rate slightly lower than the state and nation (Figure 40).

Figure 40	Percentage of Under 18 Population without Health Insurance* (2016 & 2017)	
	Percent of Under 18 Population without Health Insurance (2016)	Percent of Under 19 Population without Health Insurance (2017)
Hall	8.3%	79%
Hamilton	4.3%	4.3%
Merrick	2.5%	3.8%
CDHD	5.0%	5.3%
Nebraska	5.3%	5.3%
United States	5.9%	5.7%
*Those that have neither a private nor public health insurance plan *An average by the population of each county (Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates)		

In 2017 there was a notable increase from the previous year 2016 among Central District respondents to the BRFSS reporting that they have no health care coverage. However, the Central District respondents had a consistently higher percentage of adults over ages 18 reporting they have no health care coverage compared to the state (Figure 41).

Figure 41	Percentage of Adults Ages 18 and Over Reporting They Have No Health Care Coverage			
	2014	2015	2016	2017
CDHD	18.2%	21.1%	16.6%	19.0%
Nebraska	15.3%	14.4%	14.7%	14.4%
(Source: Behavioral Risk Factors Surveillance Systems)				

In 2017, 24% of Central District respondents to the BRFSS reported that they have no personal doctor or health care provider, a rate that is higher than the state (Figure 42).

Figure 42	Percentage of Adults Ages 18 and Over Reporting They Have No Personal Doctor or Health Care Provider			
	2014	2015	2016	2017
CDHD	23.2%	20.6%	19.8%	24.0%
Nebraska	20.2%	19.7%	19.1%	19.9%
(Source: Behavioral Risk Factors Surveillance Systems)				

With the exception of 2016, in every year of the BRFSS from 2014 to 2017 there was a higher rate of Central District respondents reporting that they were unable to see a doctor due to cost, as compared to the state (Figure 43).

Figure 43	**Percentage of Adults Ages 18 and Over Reporting They Were Unable to See a Doctor Due to Cost in the Past year**			
	2014	**2015**	**2016**	**2017**
CDHD	14.1%	14.7%	11.2%	15.6%
Nebraska	11.8%	11.5%	12.1%	11.7%
(Source: Behavioral Risk Factors Surveillance Systems)				

The percentage of BRFSS respondents from the Central District reporting that they have had a routine checkup in the past 12 months has been lower than the state percentage from 2014 to 2017 (Figure 44).

Figure 52	**Percentage of Adults Ages 18 and Over Reporting They Had a Routine Checkup in the Past 12 Months**			
	2014	**2015**	**2016**	**2017**
Central District	62.4%	60.7%	63.0%	64.1%
Nebraska	63.3%	63.9%	65.4%	66.7%
(Source: Behavioral Risk Factors Surveillance Systems)				

Census of Health Care Professionals

Figure 53-55: State-Designated Medical Shortage Areas, Nebraska 2019

In 2019, Hamilton and Merrick Counties had state-designated shortage areas in family practice and general dentistry, while Hall County was not a designated state shortage area for these medical services. However, Hall, Hamilton, and Merrick Counties were all state-designated shortage areas for psychiatry and mental health. Figures 55-57 below are statewide maps of state-designated shortage areas.

Figure 53

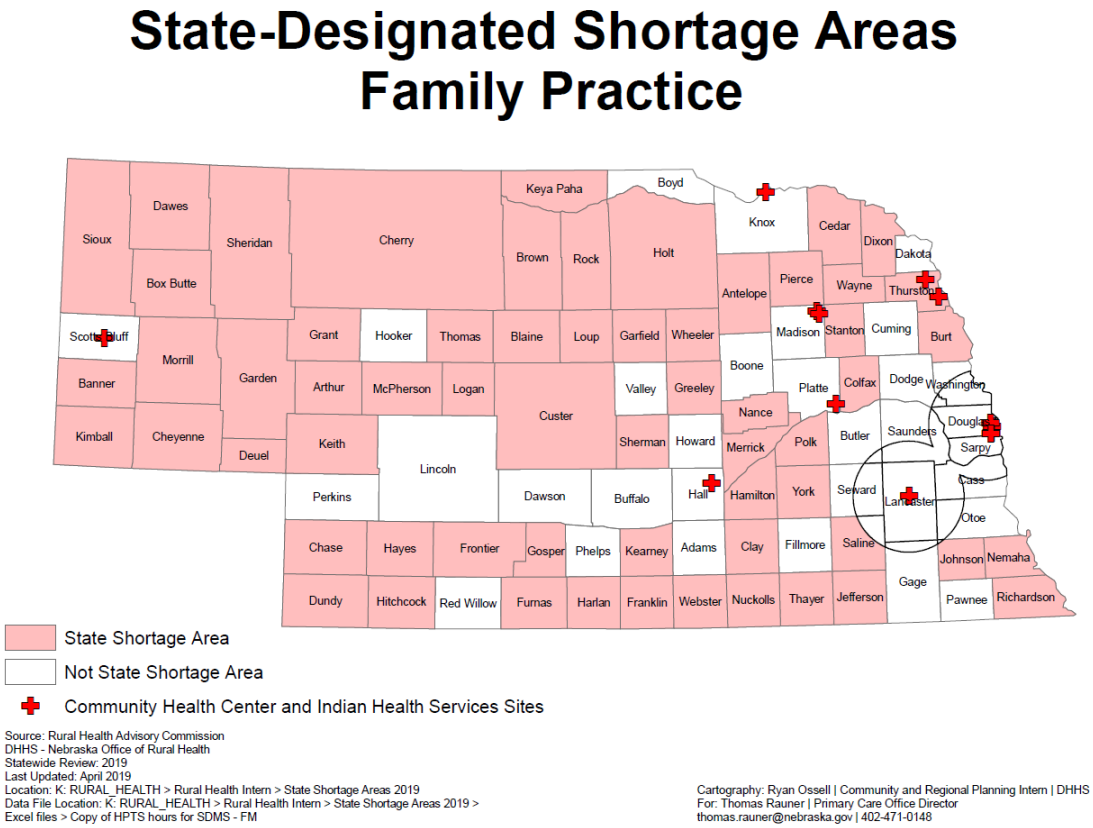
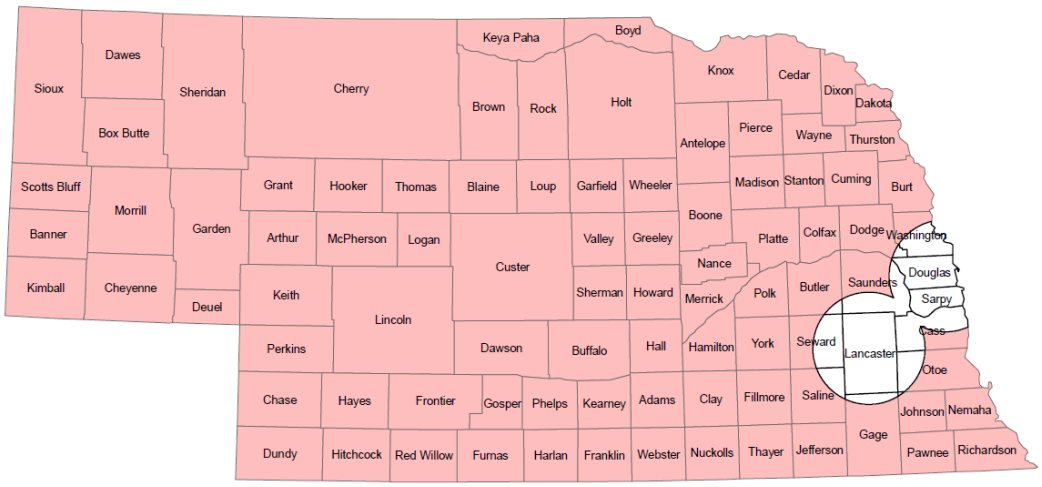


Figure 54

State-Designated Shortage Areas
Psychiatry and Mental Health

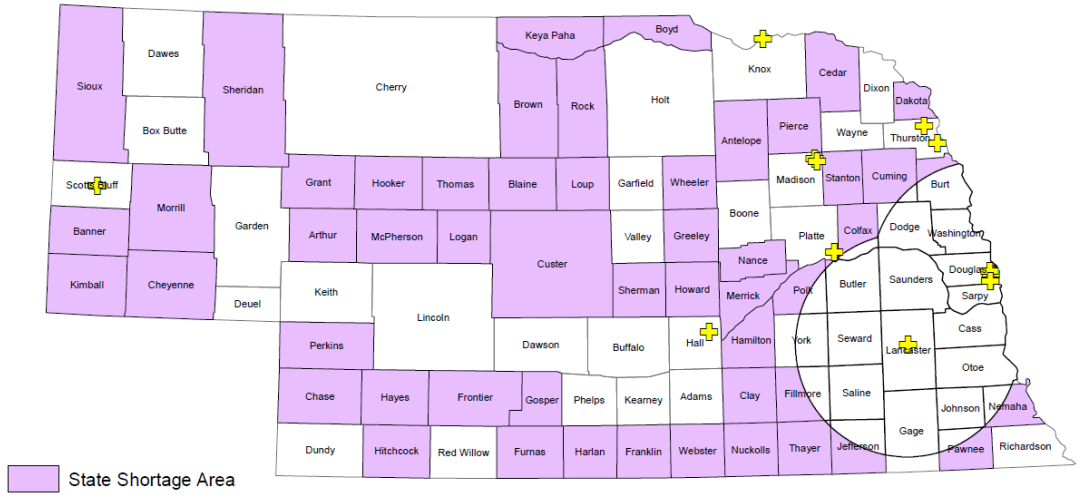


Source: Rural Health Advisory Commission
DHHS - Nebraska Office of Rural Health
Statewide Review: 2019
Last Updated: April 2019
Location: K: RURAL_HEALTH > Rural Health Intern > State Shortage Areas 2019
Data File Location: K: RURAL_HEALTH > Rural Health Intern > State Shortage Areas 2019 > Excel files > Copy of HPTS hours for SDMS - IM

Cartography: Ryan Ossell | Community and Regional Planning Intern | DHHS
For: Thomas Rauner | Primary Care Office Director
thomas.rauner@nebraska.gov | 402-471-0148

Figure 55

State-Designated Shortage Areas
General Dentistry



Source: Rural Health Advisory Commission
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Quality of Life

County Health Rankings

County Health Rankings and Roadmaps provides health outcomes rankings at the county-level for every state in the country. There are two primary sub-categories that comprise the health outcomes ranking: length of life and quality of life. The county that is ranked 1st is considered the healthiest county in the state. The number of ranking counties can vary from year to year. In 2019, Hall county was ranked 52nd which is towards the bottom of the Nebraska County rankings. Hamilton County was ranked 9th in terms of health outcomes out of 79 counties in Nebraska that were included in the rankings and Merrick County was ranked 17th. From 2017 to 2019 all three counties in the Central District improved their rankings moving (Figure 56).

Figure 56	County Health Outcomes Rankings (length of life and quality of life)		
	2017 (out of 78 counties)	2018 (out of 80 counties)	2019 (out of 79 counties)
Hall	53rd	33rd	52nd
Hamilton	16th	20th	9th
Merrick	54th	67th	17th
(Source: County Health Rankings & Roadmaps)			

County Health Rankings and Roadmaps also provides health factors rankings at the county-level for every state in the country. The sub-categories that comprise the health factors rankings include health behaviors, clinical care, social and economic factors, and physical environment. Hamilton County had exemplary rankings in 2017, 2018, and 2019. Both Merrick and Hall Counties improved their rankings from 2017 to 2019 (Figure 57).

Figure 57	County Health Factors Rankings (health behaviors, clinical care, social and economic factors, and physical environment)		
	2017 (out of 78 counties)	2018 (out of 80 counties)	2019 (out of 79 counties)
Hall	76th	70th	71st
Hamilton	2nd	1st	3rd
Merrick	55th	52nd	30th
(Source: County Health Rankings & Roadmaps)			

General Health, Physical Health, and Mental Health

From 2014 to 2017, the number of respondents to the BRFSS from the Central District reported their general health as fair or poor (Figure 58). This is notably higher compared to the state with the exception of the year 2016.

Figure 58	General Health Reported as Fair of Poor* Among Adults Ages 18 and Over			
	2014	2015	2016	2017
CDHD	20.4%	17.6%	13.5%	20.4%
Nebraska	13.2%	13.9%	14.7%	14.9
(Source: Behavioral Risk Factors Surveillance Systems)				

From 2014 to 2017, the percentage of BRFSS respondents from the Central District who reported that their physical health was not good on 14 or more of the past 30 days has increased and is higher than the state, with the exception of the year 2016 (Figure 59).

Figure 59	Percent of Adults Ages 18 and Over Reporting Physical Health Was Not Good on 14 or More of the Past 30 Days			
	2014	2015	2016	2017
CDHD	10.1%	10.6%	8.1%	11.1%
Nebraska	9.0%	9.6%	9.8%	10.3%
(Source: Behavioral Risk Factors Surveillance Systems)				

From 2014 to 2017, 6.0% and 6.8% of BRFSS respondents from the Central District reported poor physical or mental health limited their activities on 14 days or more in the past 30 days. This represents a slight increase. Central District reports higher percentages than the state with the exception of the year 2016 (Figure 60).

Figure 60	Percent Reporting that Poor Physical or Mental Health Limited Usual Activities on 14 or More of the Past 30 Days			
	2014	2015	2016	2017
CDHD	6.0%	6.6%	5.5%	6.8%
Nebraska	5.8%	5.9%	6.2%	6.7%
(Source: Behavioral Risk Factors Surveillance Systems)				

From 2014 to 2017, the number of respondents to the BRFSS in the Central District reported having 14 or more days in the past 30 days when their mental health was not good increased from 6.6% to 11.0%. Nebraska's percentage also increase from 8.2% to 10.5%. Central District's number is higher compared to the state (Figure 61).

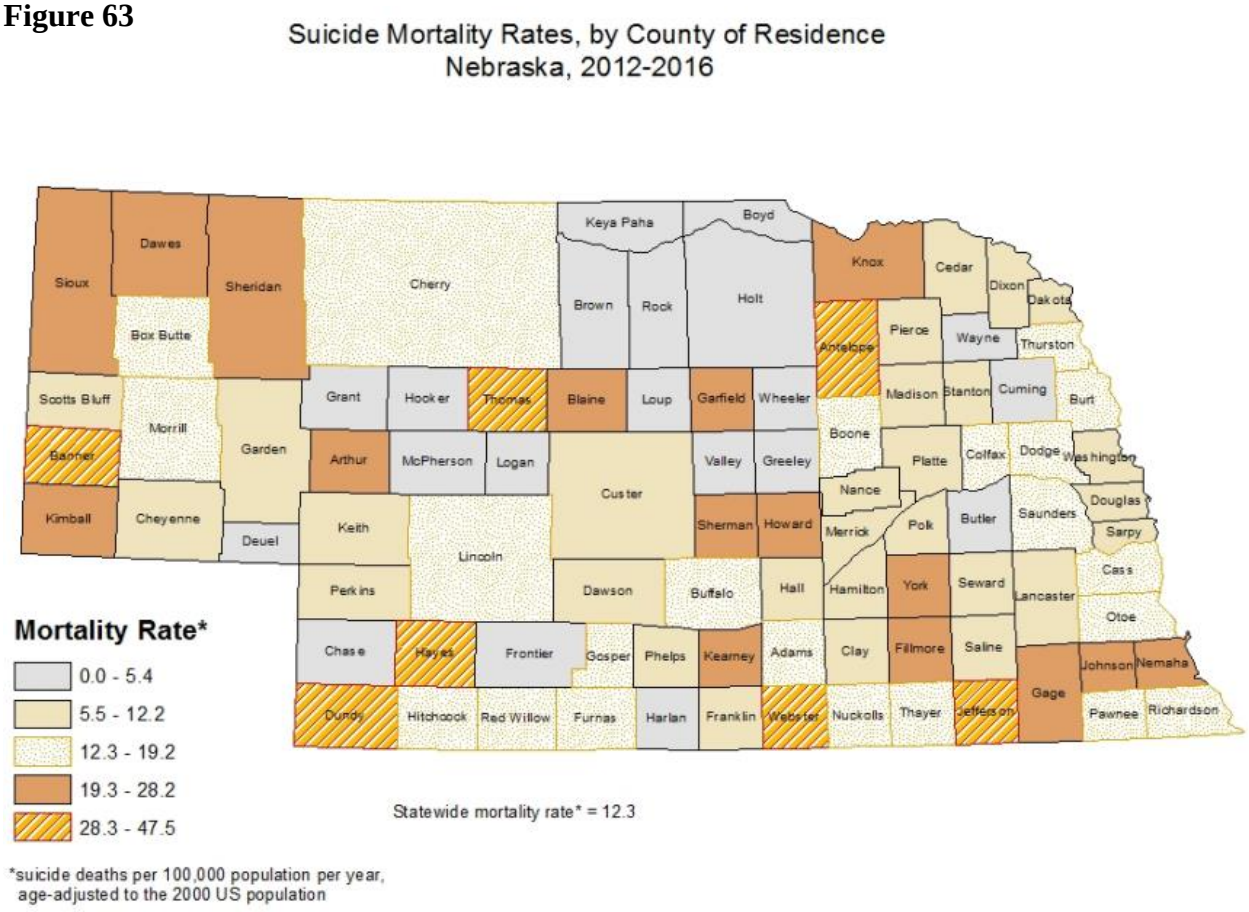
Figure 61	Percent of Adults Ages 18 and Over Reporting Mental Health Was Not Good on 14 or More of the Past 30 Days			
	2014	2015	2016	2017
CDHD	6.6%	10.4%	7.2%	11.0%
Nebraska	8.2%	8.9%	9.5%	10.5%
(Source: Behavioral Risk Factors Surveillance Systems)				

From 2014 to 2017, Central District respondents (ages 18 and over) to the BRFSS reported increasing depression percentages. The rate of depression increased from 15.3% in 2014 to 20.2% in 2017. Nebraska's percentage also increased from 17.7% to 19.4%, yet, Central District's percentage in 2017 is higher than the state (Figure 62).

Figure 62	**Percent of Adults Ages 18 and Over Ever Told They Have Depression**			
	2014	**2015**	**2016**	**2017**
CDHD	15.3%	20.9%	16.5%	20.2%
Nebraska	17.7%	17.5%	17.8%	19.4%
(Source: Behavioral Risk Factors Surveillance Systems)				

Suicide mortalities in the Central District range from 5.5 to 12.2 per 100,000 population. Nebraska's statewide mortality rate is 12.3 (Figure 63).

Figure 63



Youth Substance Abuse

Lifetime and current substance use percentages among Central District and Nebraska's youth are displayed below in Figure 64 and Figure 65. Central District's percentages tend to be lower than the States (Figure 64, 65).

Figure 64	**Substance Use: Alcohol and Tobacco, 2016**					
	8th Grade CDHD	**8th Grade NE**	**10th Grade CDHD**	**10th Grade NE**	**12th Grade CDHD**	**12th Grade NE**
Lifetime* Alcohol Use	22.1%	23.0%	41.2%	42.3%	58.6%	61.2%
Current Alcohol Use**	5.6%	7.3%	19.5%	20.0%	31.1%	34.4%
Current Binge Drinking^**	0.9%	1.0%	5.3%	6.9%	10.4%	16.1%
Lifetime* Tobacco Use^^	8.8%	9.5%	21.5%	21.8%	32.6%	34.3%
Current Tobacco Use^^**	3.4%	3.5%	6.1%	10.3%	13.3%	17.8%
Lifetime* Electronic Vapor Use	12.8%	12.4%	24.5%	28.0%	35.8%	43.4%
***Current** Electronic Vapor* Use**	6.4%	6.0%	7.6%	12.3%	8.5%	18.7%

*Percentage who reported using the named substance one or more times in his or her lifetime. **Percentage who reported using the named substance one or more times during the past 30 days. ^Percentage who reported having five or more drinks of alcohol in a row, within a couple of hours. ^^Tobacco use includes cigarettes and smokeless tobacco. (Source: Nebraska Risk and Protective Factor Student Survey, 2016)

Figure 65	Substance Use: Other Drugs, 2016					
	8th CDHD	8th NE	10th CDHD	10th NE	12th CDHD	12th NE
Lifetime* Marijuana Use	5.1%	5.4%	20.8%	17.4%	35.5%	32.4%
Current Marijuana Use**	2.9%	2.8%	10.1%	8.8%	15.8%	15.7%
Lifetime* Heroin Use	0.0%	0.1%	0.2%	0.3%	0.2%	0.5%
Lifetime* Ecstasy Use	0.3%	0.1%	1.5%	1.2%	1.5%	2.4%
Lifetime* Synthetic Drug Use	0.7%	0.6%	1.2%	1.4%	1.3%	2.2%
Current Synthetic Drug Use**	0.4%	0.2%	0.7%	0.3%	0.0%	0.3%
Lifetime* Prescription Drug Misuse	1.4%	1.6%	5.5%	5.6%	7.2%	9.1%
Current Prescription Drug Misuse**	0.3%	0.5%	3.0%	2.6%	3.1%	3.4%
Lifetime* Other Illicit Drug Use^	3.6%	4.9%	8.9%	8.1%	10.5%	12.7%

*Percentage who reported using the named substance one or more times in his or her lifetime. **Percentage who reported using the named substance one or more times during the past 30 days. ^Percentage who reported having five or more drinks of alcohol in a row, within a couple of hours. ^^Tobacco use includes cigarettes and smokeless tobacco.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

In the Central District, 2016 respondents in the 8th grade, 10th grade and 12th grade report similarly to the State. The reporting percentage of perceived substance use to actual substance use greatly differs for both the Central District and the State (Figure 66).

Figure 66	**Perceived* and Actual Past 30 Day Substance Use, 2016**						
		8th Grade CDHD	**8th Grade Nebraska**	**10th Grade CDHD**	**10th Grade Nebraska**	**12th Grade CDHD**	**12th Grade NE**
Smoked Cigarettes	Perceived %	7.5%	7.6%	22.0%	20.6%	29.5%	24.3%
	Actual %	2.0%	2.3%	3.6%	6.7%	9.4%	11.9%
Drank Alcohol	Perceived %	7.8%	9.1%	33.9%	30.7%	45.8%	42.8%
	Actual %	5.6%	7.3%	19.5%	20.0%	31.1%	34.4%
Smoked Marijuana	Perceived %	8.5%	8.0%	33.7%	24.6%	41.8%	30.3%
	Actual %	2.9%	2.8%	10.1%	8.8%	15.8%	15.7%

*Perceived based on following question: "Now thinking about all the students in your grade at your school. How many of them do you think? <insert substance use behavior> during the past 30 days?
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

A higher percentage of Central District respondents reported that marijuana and drugs like cocaine, LSD, and amphetamines are sort of easy or very easy to obtain compared to the state (Figure 67).

Figure 67	**Percentage Reporting that the Following Substance are Sort of Easy or Very Easy to Obtain*, 2016**				
	Cigarettes	**Beer, wine, hard liquor**	**Marijuana**	**Prescription drugs for non-medical use**	**Drugs like cocaine, LSD, amphetamines**
8th Grade CDHD	19.5%	24.7%	15.9%	16.9%	6.5%
8th Grade Nebraska	21.5%	31.5%	13.3%	17.6%	4.7%
10th Grade CDHD	37.7%	49.5%	40.0%	26.1%	14.2%
10th Grade Nebraska	39.8%	52.8%	34.9%	26.4%	12.0%
12th Grade CDHD	57.5%	62.3%	49.0%	31.5%	19.4%
12th Grade Nebraska	62.9%	67.4%	49.8%	32.0%	17.6%

*Percentage who reported it is sort of or very easy to obtain each substance based on the following scale: Very hard, Sort of hard, Sort of easy, Very easy. Based on the question "If you wanted to, how easy would it be for you to get: <insert substance use behavior>."
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

The percent of respondents in 8th grade, 10th grade, and 12th grade in the Central District in 2016 reporting it is wrong to use tobacco, alcohol, and other drugs, generally were comparable or higher to the state (Figure 68).

Figure 68	Percent Reporting Wrong or Very Wrong to Substance Use Behavior*: 2016					
	8th Grade CDHD	8th Grade Nebraska	10th Grade CDHD	10th Grade Nebraska	12th Grade CDHD	12th Grade Nebraska
Smoke Cigarettes	94.8%	94.6%	89.4%	87.4%	76.7%	72.8%
Use Smokeless Tobacco	94.4%	93.9%	88.2%	84.9%	76.1%	69.5%
Drink alcohol at least once or twice a month	89.8%	88.0%	76.4%	74.7%	65.0%	58.5%
Drive after drinking alcohol	98.7%	98.5%	97.2%	96.8%	96.3%	94.9%
Smoke marijuana	90.9%	90.9%	69.7%	76.3%	59.8%	63.5%
Misuse prescription drugs	95.9%	95.4%	91.1%	92.8%	92.5%	91.7%
Use other illegal drugs	98.5%	98.3%	95.0%	96.1%	95.6%	94.5%

*Percentage who reported how wrong they think different substance behaviors are based on the following scale: Very wrong. Wrong, a little bit wrong, Not wrong at all.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

Generally, a lower percentage of Central District respondents reported that the following substance use behaviors place people at great risk compared to the state (Figure 69).

Figure 69	Percentage Reporting that the Following Substance Use Behaviors Place People at Great Risk*: 2016					
	8th Grade CDHD	8th Grade Nebraska	10th Grade CDHD	10th Grade Nebraska	12th Grade CDHD	12th Grade Nebraska
Smoking 1 or more packs of cigarettes daily	62.4%	67.8%	69.2%	69.3%	70.0%	69.5%
Being exposed to other people's cigarette smoke	29.6%	26.4%	27.0%	26.5%	28.5%	27.9%
Use smokeless tobacco daily	48.7%	50.7%	45.5%	44.5%	42.8%	41.4%
Taking 1 or 2 drinks nearly every day	39.7%	38.3%	33.8%	34.1%	34.4%	28.8%
Having 5+ drinks of alcohol 1 or 2 times a week	54.4%	57.4%	51.5%	54.1%	50.0%	47.1%
Trying marijuana once or twice	29.3%	32.1%	16.4%	20.5%	11.4%	14.0%
Smoking marijuana 1 or 2 times a week	45.3%	51.6%	28.7%	36.3%	21.9%	24.7%
Misusing prescription drugs	54.0%	59.5%	54.5%	59.0%	58.0%	58.4%
Using inhalants	56.6%	60.5%	58.4%	61.4%	60.7%	65.4%

*Percentage who reported great risk associated with each substance behaviors based on the following scale: No risk, Slight risk, Moderate risk, Great risk. Based on the question "How much do you think people risk harming themselves (physically or in other ways) if they: <insert substance use behavior>."
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

A higher percentage of Central District respondents in the 8th grade obtained alcohol in the past 30 days at a party than the state. Respondents in the 10th and 12th grade reported obtaining alcohol from other family members at a higher percentage than the state (Figure 70).

Figure 70	**Sources for Obtaining Alcohol during the Past 30 days, among Students who Reported Drinking during the Past 30 Days*, 2016**					
	8th Grade CDHD	**8th Grade Nebraska**	**10th Grade CDHD**	**10th Grade Nebraska**	**12th Grade CDHD**	**12th Grade Nebraska**
Bought it in liquor store, gas station, or grocery store	0.0%	0.9%	2.3%	3.1%	3.0%	5.4%
Got it at a party	21.6%	19.8%	42.4%	48.1%	56.3%	59.9%
Gave someone money to buy it for me	5.3%	5.8%	13.3%	21.0%	33.3%	38.6%
Parents gave or bought it for me	9.2%	12.5%	11.7%	13.3%	11.9%	13.1%
Other family member gave or bought it for me	6.5%	9.5%	20.0%	15.0%	17.2%	16.2%
Took it from home without my parents' permission	23.7%	23.2%	27.7%	28.1%	17.8%	18.6%
Got it or took it from a friend's house	16.9%	20.1%	21.1%	28.4%	23.1%	24.9%

*Among past 30-day alcohol users, the percentage who reported obtaining alcohol in each manner during the past 30 days.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

A higher percentage of Central District respondents in the 10th and 12th grade reported they drank alcohol at home with their parents' permission than the state. Students in the 12th grade in the Central District also reported higher percentages of drinking alcohol at someone else's home with their parents' permission than the state (Figure 71).

Figure 71	**Places of Alcohol Use during the Past 30 Days, among Students who Reported Drinking during the Past 30 Days*, 2016**					
	8th Grade CDHD	**8th Grade Nebraska**	**10th Grade CDHD**	**10th Grade Nebraska**	**12th Grade CDHD**	**12th Grade Nebraska**
My home with my parents' permission	14.7%	18.1%	22.3%	20.0%	24.6%	22.1%
My home without my parents' permission	22.4%	22.0%	27.3%	29.6%	25.6%	23.8%
Someone else's home with their parents' permission	6.9%	6.7%	9.2%	13.0%	24.8%	20.4%
Someone else's home without their parents' permission	17.8%	21.4%	27.7%	40.1%	26.9%	42.9%
Some other place (not listed)	21.3%	26.1%	39.2%	43.0%	43.6%	55.1%

*Among past 30-day alcohol users, the percentage who reported obtaining alcohol in each manner during the past 30 days
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

A higher percentage of Central District respondents who drank alcohol in the past 30 days consumed no usual type of alcohol (Figure 72).

Figure 72	Types of Alcohol Usually Consumed during the Past 30 Days, Among Students Who Drank Alcohol during the Past 30 Days, 2016					
	8th Grade CDHD	8th Grade Nebraska	10th Grade CDHD	10th Grade Nebraska	12th Grade CDHD	12th Grade Nebraska
No usual type	16.7%	13.8%	13.8%	11.9%	10.5%	9.4%
Beer	31.0%	27.2%	28.4%	23.5%	24.2%	27.3%
Flavored malt beverage	16.7%	12.0%	11.2%	12.9%	20.2%	15.5%
Wine coolers	0.0%	2.0%	6.0%	2.1%	3.2%	2.6%
Wine	7.1%	11.7%	5.2%	6.3%	6.5%	4.1%
Liquor	26.2%	26.1%	31.9%	39.4%	32.3%	39.2%
Some other type (not listed)	2.4%	7.2%	3.4%	3.9%	3.2%	1.9%

*Among past 30-day alcohol users, the type of alcohol that they usually drank during the past 30 days.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

The percentage of Central District and Nebraska respondents who reported driving a vehicle when had been drinking is much less than those who responded they rode in a vehicle driven by someone who had been drinking. Central District's percentages are lower by 1-2% than the States, except for 8th graders who reported driving a vehicle when had been drinking (Figure 73).

Figure 73	**Past 30-Day Alcohol-Impaired Driving, 2016**					
	8th Grade CDHD	**8th Grade Nebraska**	**10th Grade CDHD**	**12th Grade Nebraska**	**12th Grade CDHD**	**12th Grade Nebraska**
Drove vehicle when had been drinking*	2.1%	1.0%	1.2%	2.1%	4.0%	6.4%
Rode in vehicle driven by someone who had been drinking**	12.9%	14.0%	10.4%	12.4%	11.9%	13.3%

*Percentage who reported "Yes" to the question "During the last 30 days did you drive a car or other vehicle when you had been drinking alcohol? **Percentage who reported "Yes" to the question "During the last 30 days did you ride in a car or other vehicle driven by someone who had been drinking alcohol?"
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

A higher percentage of Central District respondents in the 8th grade reported obtaining cigarettes from other family members or took them from home without parents' permission than the state. Respondents in the 12th grade, reported a higher percentage than the state for obtaining cigarettes in another way than what is listed below (Figure 74).

Figure 74	**Sources for Obtaining Cigarettes during the Past 30 days, among Students who Reported Smoking during the Past 30 Days,* 2016**					
	8th Grade CDHD	**8th Grade Nebraska**	**10th Grade CDHD**	**10th Grade Nebraska**	**12th Grade CDHD**	**12th Grade Nebraska**
Bought them myself with a fake ID	0.0%	0.6%	0.0%	1.2%	0.0%	1.8%
Bought them myself without a fake ID	0.0%	1.2%	0.0%	4.4%	26.8%	25.5%
Gave someone money to buy them for me	2.7%	6.7%	11.0%	25.0%	15.7%	26.7%
Borrowed them from someone else	11.0%	19.1%	28.8%	41.8%	28.2%	44.8%
My parents gave them to or bought them for me	0.0%	0.5%	0.0%	3.9%	7.0%	5.5%
Other family member gave them to or bought them for me	6.8%	3.4%	2.5%	7.5%	8.5%	8.6%
Took them from home without my parents' permission	21.9%	15.1%	11.3%	16.2%	1.4%	7.4%
Got them some other way (not listed)	11.0%	14.9%	16.0%	18.2%	17.1%	12.8%

*Among past 30-day cigarette users, the percentage who reported obtaining cigarettes in each manner during the past 30 days. These scores may include students 18 and older.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

The percentage of Central District students who reported obtaining prescription drugs and where they got them is listed below. Among Central District 8th grade respondents, 23.5% obtained prescription drugs by someone giving them to them, the state's percentage was 16%. (Figure 75).

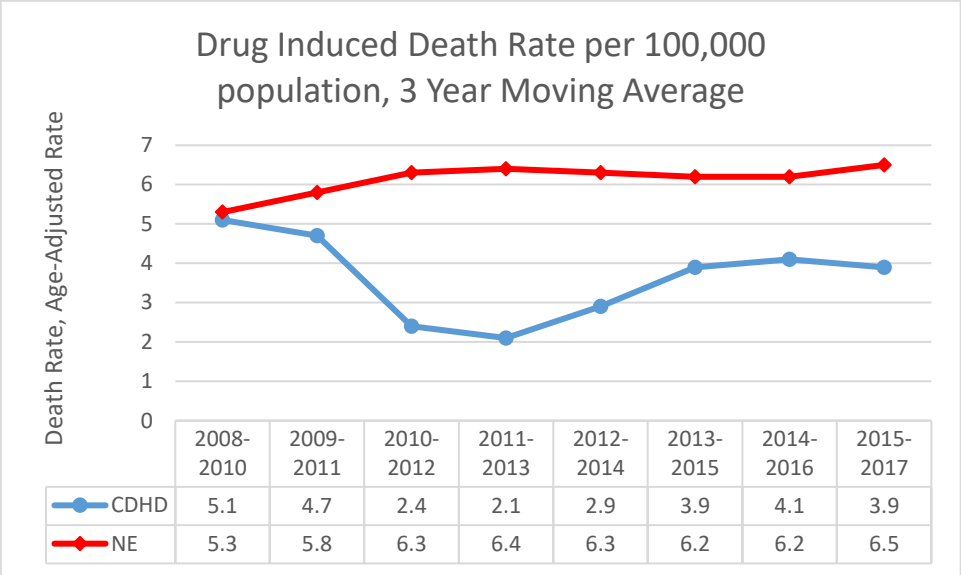
Figure 75	Sources for Obtaining Prescription Drugs during the Past 30 days, among Students who Reported Using Them during the Past 30 Days,* 2016					
	8th Grade CDHD	8th Grade Nebraska	10th Grade CDHD	10th Grade Nebraska	12th Grade CDHD	12th Grade Nebraska
Took them from home without my parents' permission	47.1%	42.2%	15.6%	30.7%	30.0%	23.8%
Bought them from someone	17.6%	8.9%	15.6%	17.3%	20.0%	27.1%
Someone gave them to me	23.5%	16.0%	25.0%	29.0%	35.0%	32.3%
Took them from someone else without their knowledge	0.0%	5.1%	9.4%	4.0%	0.0%	1.7%
Got them some other way (not listed)	11.8%	27.8%	34.4%	19.1%	15.0%	15.1%

*Among past 30-day prescription drug users, the usual manner they used for obtaining prescription drugs during the past 30 days.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

Adult Alcohol and Tobacco Abuse

Between 2008 and 2017 the drug induced death rate per 100,000 population (age-adjusted), in the Central District has fluctuated compared to the state. From 2008 to 2017, the Central District drug induced death rate had decreased from 5.1 to 3.9, which is lower compared to the state's rates of 5.3 to 6.5, respectively (Figure 76).

Figure 76



	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017
CDHD	5.1	4.7	2.4	2.1	2.9	3.9	4.1	3.9
NE	5.3	5.8	6.3	6.4	6.3	6.2	6.2	6.5

(Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019)

Past month use of any alcohol declined slightly among adults in the Central District from 2013 to 2017 from 50.9% to 50.1%, however, there was an increase in alcohol consumption in 2016 at 52.9%. Alcohol consumption in the Central District is lower compared to the state (Figure 77).

Figure 77	**Any Alcohol Consumption in the Past 30 Days among Adults Ages 18 and Over**	
	CDHD	**Nebraska**
2013	50.9%	57.5%
2014	49.9%	59.2%
2015	49.7%	57.6%
2016	52.9%	59.8%
2017	50.1%	60.2%
(Source: Behavior Risk Factors Surveillance Survey)		

Binge drinking declined in the Central District over the past five years and remained relatively the same for Nebraska, among respondents to the BEFSS. From 2013 to 2017, binge drinking declined from 18.7% to 14.7% among Central District residents (Figure 78).

Figure 78	Binge Drank in the Past 30 Days among Adults Ages 18 and Over	
	CDHD	Nebraska
2013	18.7%	20.0%
2014	16.6%	20.3%
2015	15.8%	19.5%
2016	17.8%	20.0%
2017	14.7%	20.6%
(Source: Behavior Risk Factors Surveillance Survey)		

From 2013 to 2017 Central District adults who reported heavy drinking increased from 4.8% to 5.0%. This is lower compared to the state, 6.8% to 7.0% respectively (Figure 79).

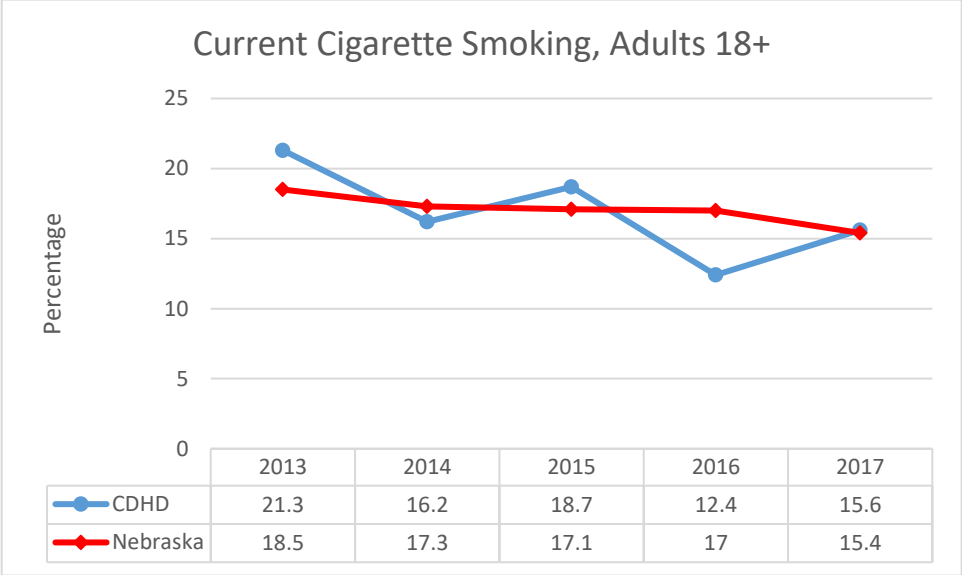
Figure 79	Heavy Drinking in the Past 30 Days among Adults Ages 18 and Over	
	CDHD	Nebraska
2013	4.8%	6.8%
2014	5.0%	6.4%
2015	2.6%	5.7%
2016	5.8%	6.6%
2017	5.0%	7.0%
(Source: Behavior Risk Factors Surveillance Survey)		

Between 2012 and 2016 the percentage of alcohol impaired driving in the past 30 days among adults ages 18 and over in the Central District declined from 2.8% to 1.9%. This is lower compared to the states 3.4% (Figure 80).

Figure 80	Alcohol Impaired Driving in the Past 30 Days among Adults Ages 18 and Over	
	CDHD	Nebraska
2013	2.8%	3.4%
2014	1.6%	2.5%
2016	1.9%	3.4%
(Source: Behavior Risk Factors Surveillance Survey)		

The percentage of cigarette smoking among adults 18 years of age and older in the Central District and the state decreased from 2013 to 2017. The current percentage of cigarette smoking in the Central District among adults is comparable to the state in 2017 at 15.6% to 15.4% respectively (Figure 81).

Figure 81



*Percentage of adults 18 and older who report that they currently smoke cigarettes either every day or on some days
(Source: Behavioral Risk Factor Surveillance System)

Among adults who reported currently being smokers in the Central District, between 49.8% and 59.5% reported that they attempted to quit smoking during the years 2013 to 2017. The percentage of respondents to the BRFSS for the state of Nebraska had a decline of attempts to quit cigarette smoking, 57.1% to 55.6% respectively (Figure 82).

Figure 82	**Attempted to quit smoking in past year, among current cigarette smokers**	
	CDHD	**Nebraska**
2013	49.8%	57.1%
2014	63.7%	58.2%
2015	56.9%	59.1%
2016	51.3%	54.6%
2017	59.5%	55.6%
(Source: Behavior Risk Factors Surveillance Survey)		

An average of 6.48% of Central District adults reported using smokeless tobacco products from 2013 to 2017. Central District has a higher average percentage than the state average of 5.3 (Figure 83).

Figure 83	Current Smokeless Tobacco Use among Adults Ages 18 and Over	
	CDHD	Nebraska
2013	6.5%	5.3%
2014	6.4%	4.7%
2015	7.2%	5.5%
2016	5.9%	5.7%
2017	6.4%	5.3%
(Source: Behavior Risk Factors Surveillance Survey)		

Education

Educational Attainment

From 2011-2012 to 2015-2016, the four-year high school graduation percentages in the Central District counties were higher compared to the state (Figure 84).

Figure 84	High School Graduation - Percentage of Ninth-Grade Cohort that Graduates in Four Years				
	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016
Hall	87.0%	90.0%	NA	89.0%	90.0%
Hamilton	94.0%	94.0%	NA	95.0%	98.0%
Merrick	NA	92.0%	NA	NA	89.0%
Nebraska	86.0%	87.0%	NA	87.0%	89.0%
(Source: County Health Rankings & Roadmaps: Nebraska Department of Education)					

Central District respondents over 25 years of age had a notably lower level of bachelor's degrees or graduate or professional degrees compared to the state and nation. However, Central District respondents had a higher frequency of Associate degrees (Figure 85).

Figure 85	Highest Level of Educational Attainment – Individuals 25 Years and Over (2017)				
	Hall	**Hamilton**	**Merrick**	**NE**	**United States**
Less Than 9th Grade	7.80%	1.90%	2.50%	4.10%	5.40%
9th to 12th Grade, no Diploma	8.30%	4.40%	4.40%	5.00%	7.20%
High School (or GED/Equivalent)	31.20%	31.70%	34.40%	26.70%	27.30%
Some College, no Degree	24.00%	25.60%	30.10%	23.40%	20.80%
Associate degree	8.90%	10.80%	10.90%	10.20%	8.30%
Bachelor's Degree	13.80%	18.00%	14.20%	20.40%	19.10%
Graduate or Professional Degree	6.00%	7.70%	3.40%	10.20%	11.80%

*An average weighted by the over 25 population of each county
(Source: U.S. Census Bureau, 2013-2017 American Community Survey, 5-year Estimate)

From 2014 to 2017 the percentage of population ages 25 and over with at least a high school degree/GED/equivalent or higher in the Central District counties and the State of Nebraska did not have a significant change (Figure 86).

Figure 86	Percentage of the Population Ages 25 Years and Over with at Least a High School Degree or GED/Equivalent or Higher (2014-2017)			
	2014	**2015**	**2016**	**2017**
Hall	83.00%	82.80%	83.20%	83.90%
Hamilton	94.40%	93.80%	93.5.%	93.60%
Merrick	91.30%	92.20%	92.50%	93.00%
NE	90.50%	90.70%	90.70%	90.90%

*An average weighted by the over 25 population of each county
(Source: U.S. Census Bureau, 2013-2017 American Community Survey, 5-year Estimate)

The percentage of the population ages 25 and over with at least a bachelor's degree or higher in the Central District counties is notably lower than the state percentage of 30.60% (Figure 87).

Figure 87	Percentage of the Population Ages 25 Years and Over with at Least a Bachelor's Degree or Higher (2014-2017)			
	2014	2015	2016	2017
Hall	17.70%	18.30%	19.00%	19.80%
Hamilton	24.80%	25.20%	25.30%	25.70%
Merrick	16.00%	16.80%	16.00%	17.60%
NE	29.00%	29.30%	30.00%	30.60%

*An average weighted by the over 25 population of each county
(Source: U.S. Census Bureau, 2013-2017 American Community Survey, 5-year Estimate)

Youth Violence and Bullying

Similar percentages from Central District and Nebraska students reported dating violence (Figure 88).

Figure 88	Percentage Reporting Dating Violence, among Students who Reported Dating during the Past 12 Months, by Type of Dating Violence*, 2016					
	CDHD 8th Grade	NE 8th Grade	CDHD 10th Grade	NE 10th Grade	CDHD 12th Grade	NE 12th Grade
Physically hurt by date^	2.8%	3.7%	6.6%	6.3%	7.7%	5.9%
Controlled or emotionally hurt by date^^	16.2%	16.1%	28.7%	27.7%	29.1%	27.4%

*Among students that dated or went out with anyone during the past 12 months, the percentage who reported experiencing each type of dating violence. ^Percentage who reported "Yes" to the question "During the past 12 months, did someone you were dating or going out with physically hurt you on purpose?" ^^Percentage who reported one or more occurrences of being purposely controlled or emotionally hurt by someone they were dating or going out with during the past 12 months.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

Across the state and in the Central District, youth reports of being bullied tend to be higher among 89th grade students and decrease with age. In the Central District in 2016, 63.7% of 8th graders reported experiencing any type of bullying in the past 12 months (Figure 89).

Figure 89	Percentage that were Bullied during the Past 12 Months, by Type of Bullying*, 2016					
	CDHD 8th Grade	NE 8th Grade	CDHD 10th Grade	NE 10th Grade	CDHD 12th Grade	NE 12th Grade
Any bullying**	63.7%	65.1%	55.0%	59.6%	48.6%	51.0%
Physically	29.1%	27.8%	17.6%	19.9%	12.9%	12.2%
Verbally	53.6%	55.7%	47.9%	50.9%	39.3%	42.3%
Socially	44.1%	47.0%	41.0%	45.2%	38.2%	40.1%
Electronically	24.9%	22.2%	23.7%	23.4%	23.1%	20.1%

*Percentage who reported one or more occurrences of each type of bullying. **Percentage of students who reported one or more occurrences of one or more of these types of bullying.
(Source: Nebraska Risk and Protective Factor Student Survey, 2016)

Health Screening

Various data on health screenings (including blood pressure, cholesterol, and various types of cancer screening) are displayed below. In 2017, Central District respondents to the Nebraska Behavioral Risk Factors Surveillance System had a higher percentage of screenings than the state for cholesterol and cervical cancer; but had a lower percentage of screenings than the state for blood pressure, colon cancer, and breast cancer (Figure 90-94).

Figure 90	Had Blood Pressure Checked in the Past Year among Adults Ages 18 and Over	
	CDHD	Nebraska
2013	82.8%	84.6%
2015	83.8%	88.0%
2017	83.4%	86.3%

(Source: Behavioral Risk Factors Surveillance System)

Figure 91	Had Cholesterol Checked in the Past 5 Years among Adults Ages 18 and Over (2017)	
	CDHD	Nebraska
2017	86.2%	84.4%
(Source: Behavioral Risk Factors Surveillance System)		

Figure 92	Up-to-Date on Colon Cancer Screening (Ages 50-75 Year Olds)	
	Central District	Nebraska
2013	62.1%	62.8%
2014	67.9%	64.1%
2015	64.9%	65.2%
2016	64.0%	66.0%
2017	60.3%	68.3%
*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 **Central District Health Department includes Hall, Hamilton, and Merrick Counties Source: Behavioral Risk Factor Surveillance System (BRFSS)		

Figure 93	Up-to-date on breast cancer screening, female 50-74 year olds (2012 – 2016)	
	Central District	Nebraska
2012	71.3%	74.9%
2014	79.3%	76.1%
2016	72.8%	73.4%
(Source: Behavioral Risk Factors Surveillance System)		

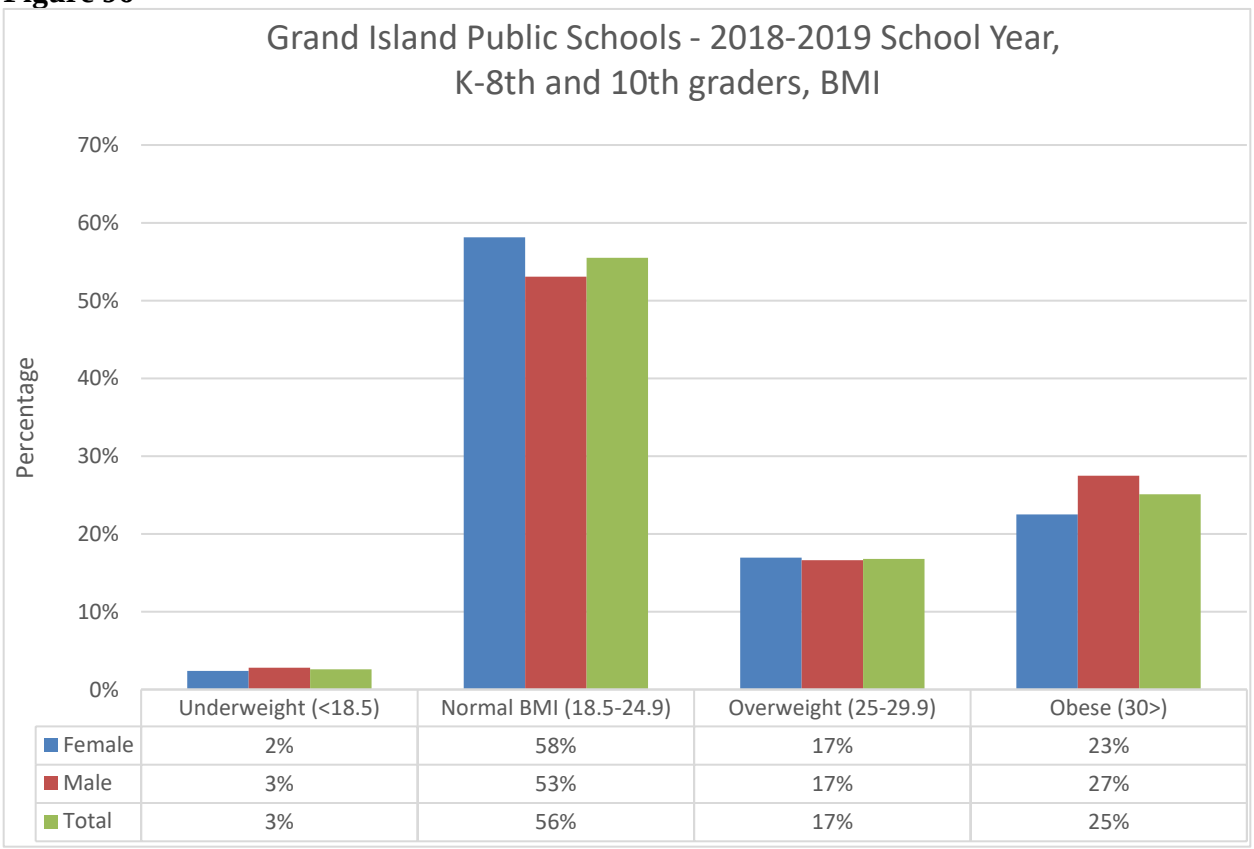
Figure 94	Up-to-date on cervical cancer screening, female 21-65 year old (2012 – 2016)	
	Central District	Nebraska
2012	83.2%	83.9%
2014	84.4%	81.7%
2016	80.4%	77.7%
(Source: Behavioral Risk Factors Surveillance System)		

Obesity and Physical Activity

Figure 95
During the 2018-2019 school year, over 50% of K-8th graders and 10th grade students at Grand Island Pubic Schools in Hall County were in the normal BMI category. A quarter of the students were in the obese category and 17% were in the overweight category (Figure 95-96).

Count of student_studentNumber Row Labels	Column Labels F	M	Grand Total
Normal BMI	2021	1975	3996
Obese	783	1023	1806
Overweight	589	619	1208
Underweight	83	105	188
Grand Total	**3476**	**3722**	**7198**

Figure 96

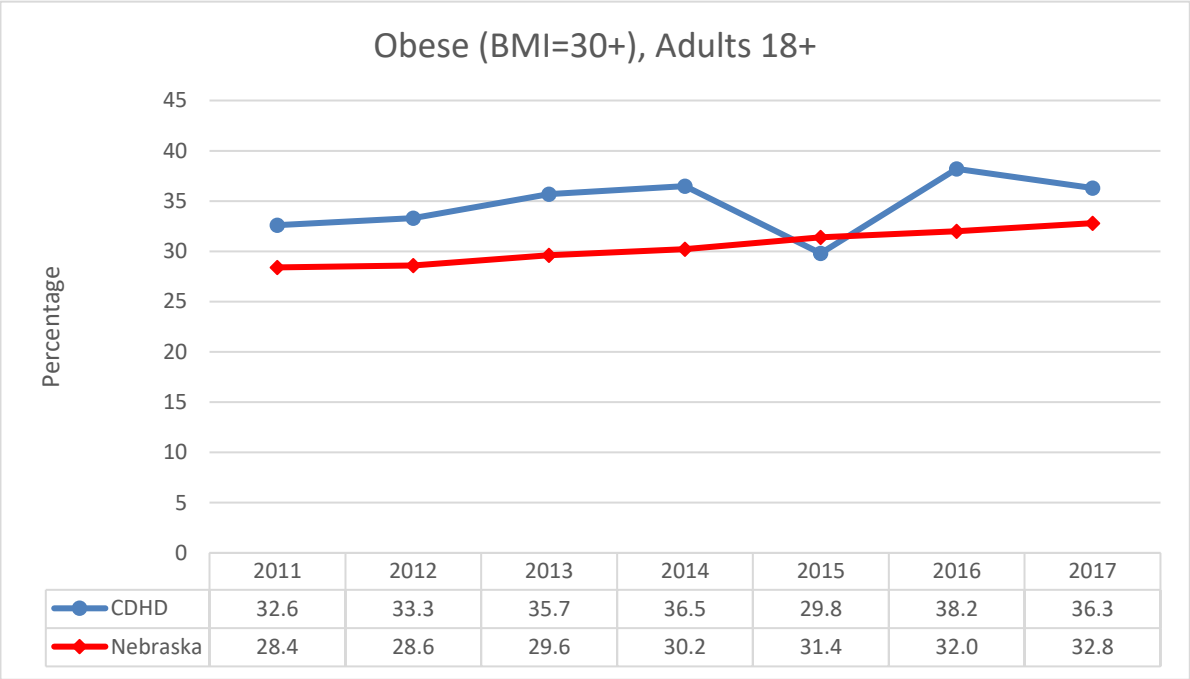


The percentage of the adult population ages 18 and older that is overweight or obese stayed generally the same for the Central District, however, for the state the percentage has increased by about 2% (Figure 97).

Figure 97		Percent of the Adult Population Ages 18 and Older that is Overweight or Obese (BMI 25 or higher) (2014– 2017)					
Central District (2014)	Nebraska (2014)	Central District (2015)	Nebraska (2015)	Central District (2016)	Nebraska (2016)	Central District (2017)	Nebraska (2017)
70.60%	66.70%	70.80%	67.00%	75.10%	68.50%	70.90%	69.00%
(Source: Behavioral Risk Factors Surveillance System)							

Since 2011, Central District respondents to the BRFSS that have been identified as obese based on body mass index (BMI) data of 30 or more has increased. BMI is a calculation based on height and weight. Central District has notably higher rates of obesity than the state in every year since 2011 except for in 2015 (Figure 98).

Figure 98

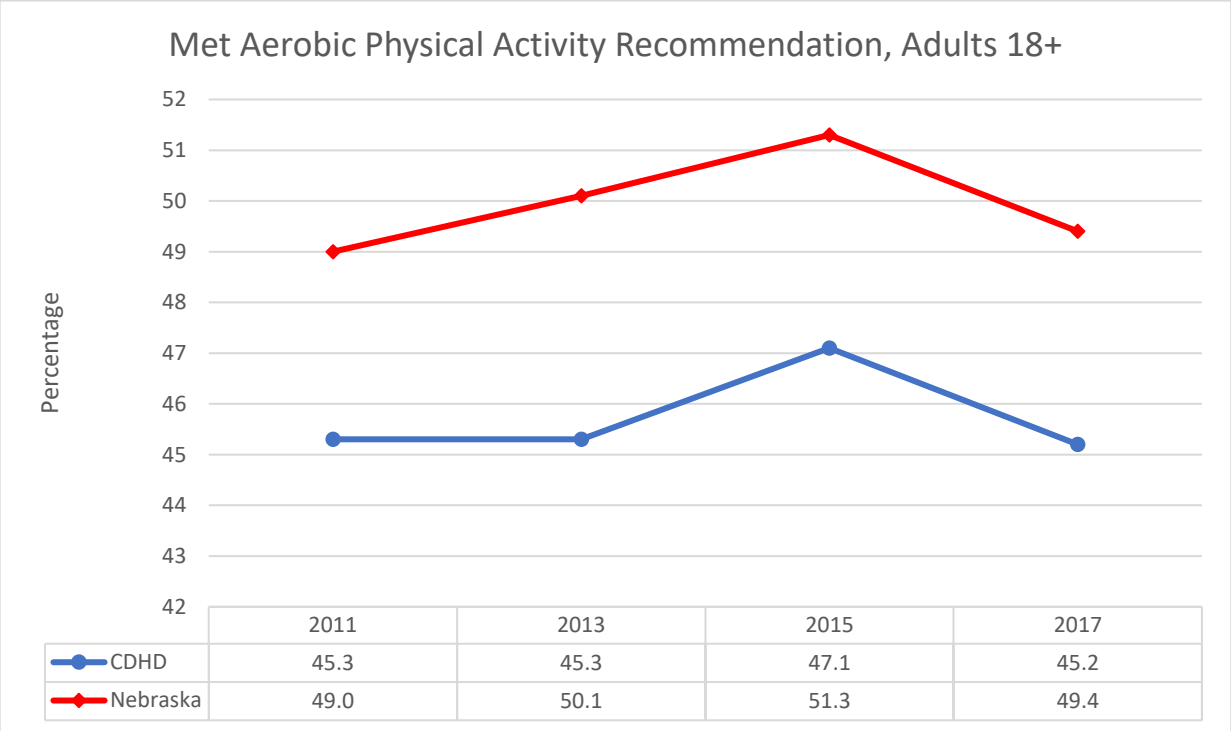


*Percentage of adults 18 and older with a body mass index (BMI) of 30.0 or greater, based on self-reported height and weight

**Central District Health Department includes Hall, Hamilton, and Merrick Counties Source: Behavioral Risk Factor Surveillance System (BRFSS)

The next three Figures (99-101) show the percentages of the met aerobic physical activity and muscle strengthening recommendations, separate and combined data. There has not been a significant change in data in these years recorded. Central District has lower rates than the state. It is interesting that in the year 2015, the percentage increased for CDHD and Nebraska but then went back down in 2017, in the physical activity category (Figure 99).

Figure 99



*Percentage of adults 18 and older who report at least 150 minutes of moderate-intensity physical activity, or at least 75 minutes of vigorous-intensity physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity per week during the past month
b Weighted mean, median, or percentage (percentages are followed by the % symbol) among adults 18 and older (unless different age group noted)
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Behavioral Risk Factors Surveillance System)

Figure 100	**Percent of the Adult Population Ages 18 and Older that Met Muscle Strengthening Recommendation (2015, 2017)**		
Central District (2015)	**Nebraska (2015)**	**Central District (2017)**	**Nebraska (2017)**
25.40%	31.20%	24.70%	29.80%
(Source: Behavioral Risk Factors Surveillance System)			

Figure 101	Percent of the Adult Population Ages 18 and Older that Met Both Aerobic Physical Activity and Muscle Strengthening Recommendation (2015, 2017)		
Central District (2015)	**Nebraska (2015)**	**Central District (2017)**	**Nebraska (2017)**
15.20%	21.80%	15.40%	19.10%
(Source: Behavioral Risk Factors Surveillance System)			

Percent of the Central District population ages 18 and over that reported they had no leisure-time physical activity in past 30 days is notably higher compared to the state (Figure 102).

Figure 102	Percent of the Adult Population Ages 18 and over that Reported They had No Leisure-Time Physical Activity in Past 30 Days	
	Central District	**Nebraska**
2014	28.30%	21.30%
2015	31.40%	25.30%
2016	25.40%	22.40%
2017	32.60%	25.40%
(Source: Behavioral Risk Factors Surveillance System)		

Nutrition

In 2017, Central District respondents to the BRFSS indicated consuming fruits and vegetables at higher rates compared to the state (Figure 103).

Figure 103	Indicators of Nutrition among Adults Ages 18 and Over (2017)	
	Central District	**Nebraska**
Consumed fruits less than 1 time per day	39.3%	36.9%
Consumed vegetables less than 1 time	25.5%	20.0%
(Source: Behavioral Risk Factors Surveillance System)		

Food insecurity in the Central District decreased from 25.2% in 2013 to 23.9% in 2015. In 2013 and 2015 the Central District had a higher rate of food insecurity than the state (Figure 104).

Figure 104	Food Insecurity* in the Past Year among Adults Ages 18 and Over	
	2013	2015
Central District	25.20%	23.90%
Nebraska	19.00%	21.00%
*Percentage reporting that they were always, usually, or sometimes worried or stressed during the past 12 months about having enough money to pay their rent or mortgage. (Source: Behavioral Risk Factors Surveillance Systems)		

Cancer

Figures 105 – 107 present BRFSS data on Cancer. In 2017, 6.2% of Central District respondents reported that they have ever been told that they have skin cancer, 7.2% reported that they have a cancer other than skin cancer, and 12.1% that they have cancer of any form. These rates are slightly higher compared to the state.

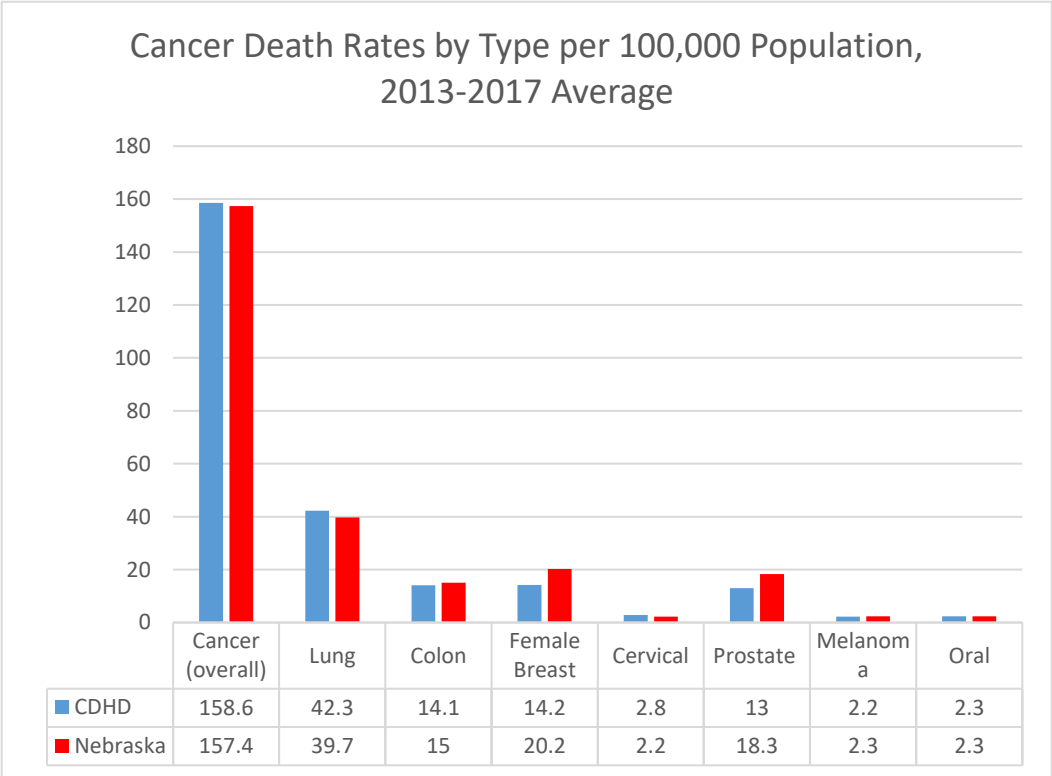
Figure 105	Percent of the Adult Population Ages 18 and Over Ever Told They Have Skin Cancer	
	Central District	Nebraska
2014	5.8%	5.7%
2015	7.3%	6.0%
2016	7.1%	5.5%
2017	6.2%	5.6%
(Source: Behavioral Risk Factors Surveillance System)		

Figure 106	Percent of the Adult Population Ages 18 and Over Ever Told They Have Cancer Other Than Skin Cancer	
	Central District	Nebraska
2014	6.3%	6.1%
2015	6.7%	6.9%
2016	8.5%	6.9%
2017	7.2%	6.6%
(Source: Behavioral Risk Factors Surveillance System)		

Figure 107	Percent of the Adult Population Ages 18 and Over Ever Told They Have Cancer (in any form)	
	Central District	Nebraska
2014	11.2%	10.7%
2015	12.9%	11.6%
2016	14.1%	11.2%
2017	12.1%	11.0%
(Source: Behavioral Risk Factors Surveillance System)		

Overall the Central District has had cancer incidence rates that are basically comparable to the state (Figure 108).

Figure 108



*Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019, Data are Preliminary)

High Blood Pressure and Cholesterol

In 2017 around 33.2% of BRFSS respondents in the Central District indicated that they have ever been told that they have high blood pressure. Central District's percentages for high blood pressure tend to be higher than Nebraska's percentages (Figure 109).

Figure 109	Ever Told They Have High Blood Pressure (excluding pregnancy), Adults 18 years or older			
	2011	2013	2015	2017
CDHD	31.8%	32.2%	30.9%	33.2%
Nebraska	28.5%	30.3%	29.9%	30.6%

*Percentage of adults 18 and older who report that they have ever been told by a doctor, nurse, or other health professional that they have high blood pressure (excluding pregnancy)
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Nebraska Behavioral Risk Factor Surveillance System)

In 2017, around 29.7% of BRFSS respondents in the Central District indicated that they have ever been told that they have high cholesterol. This is slightly lower than the states percentage of 31.9%. Previous years data is not comparable to 2017 data due to changes in question wording on the 2017 survey (Figure 110).

Figure 110	Ever Told They Have High Cholesterol, Among Those Who Have Ever Had it Checked, Adults 18+
	2017
CDHD	29.7%
Nebraska	31.9%

*2017 data are not comparable to earlier years due to changes in question wording on the 2017 survey
(Source: Nebraska Behavioral Risk Factor Surveillance System)

Heart Disease and Stroke

Heart Disease

Figures 146 through 148 present BRFSS data on heart disease. In 2017, 4.0% of Central District respondents reported that they have ever been told that they had a heart attack, 4.7% have a coronary heart disease, and 6.6% have had a heart attack or coronary heart disease. These rates are comparable to the state (Figures 111-113).

Figure 111	Percent of the Adult Population Ages 18 and Over Ever Told They Have Had a Heart Attack	
	Central District	Nebraska
2014	4.1%	3.8%
2015	4.4%	3.9%
2016	4.3%	4.0%
2017	4.0%	4.2%
(Source: Behavioral Risk Factors Surveillance System)		

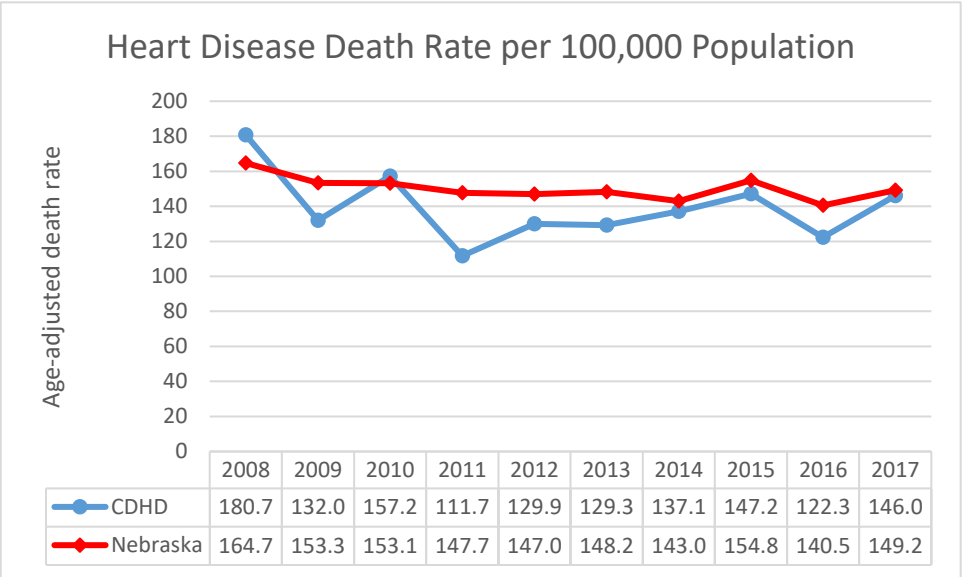
Figure 112	Percent of the Adult Population Ages 18 and Over Ever Told They Have Coronary Heart Disease	
	Central District	Nebraska
2014	4.9%	3.9%
2015	3.8%	4.0%
2016	2.8%	3.8%
2017	4.7%	3.8%
(Source: Behavioral Risk Factors Surveillance System)		

Figure 113	Percent of the Adult Population Ages 18 and Over Ever Told They Had a Heart Attack or Coronary Heart Disease	
	Central District	Nebraska
2014	6.8%	6.0%
2015	6.2%	5.8%
2016	5.3%	5.8%
2017	6.6%	6.1%
(Source: Behavioral Risk Factors Surveillance System)		

Overall, the rate of death due to coronary heart disease has been lower in the Central District compared

to the state. The rates have also decreased for both Central District and Nebraska (Figure 114).

Figure 114



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	180.7	132.0	157.2	111.7	129.9	129.3	137.1	147.2	122.3	146.0
Nebraska	164.7	153.3	153.1	147.7	147.0	148.2	143.0	154.8	140.5	149.2

(Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019, Data are Preliminary)

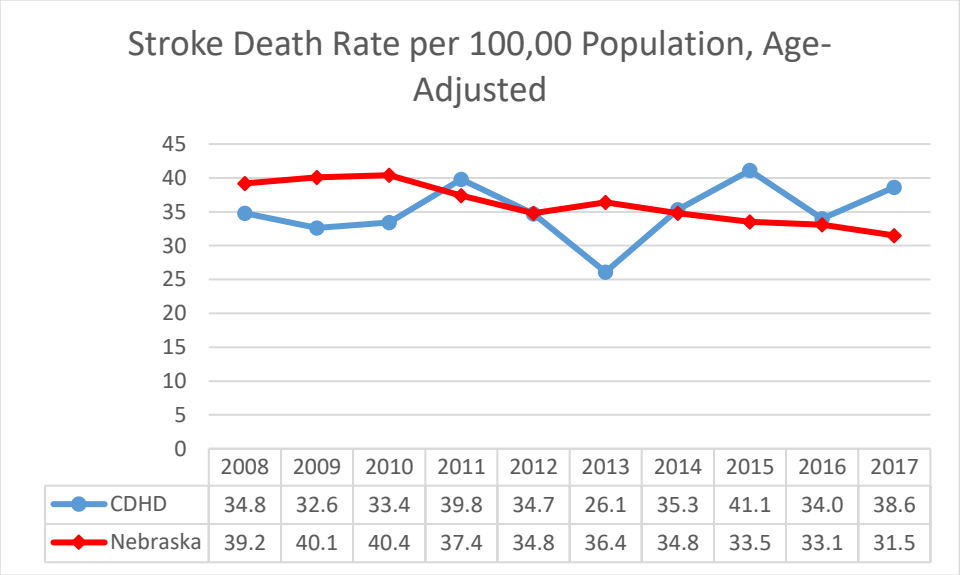
Stroke

From 2014 to 2017, 3.9% to 3.2% of BRFSS respondents in the Central District indicated that they have ever been told they had a stroke. This is higher compared to the state (Figure 115).

Figure 115	**Percent of the Adult Population Ages 18 and Over Ever Told They Had a Stroke**	
	Central District	**Nebraska**
2014	3.9%	2.6%
2015	2.7%	2.5%
2016	2.2%	2.8%
2017	3.2%	2.9%
(Source: Behavioral Risk Factors Surveillance System)		

The rate of deaths due to stroke has been higher in the Central District compared to the state from 2014 to 2017 (Figure 116).

Figure 116



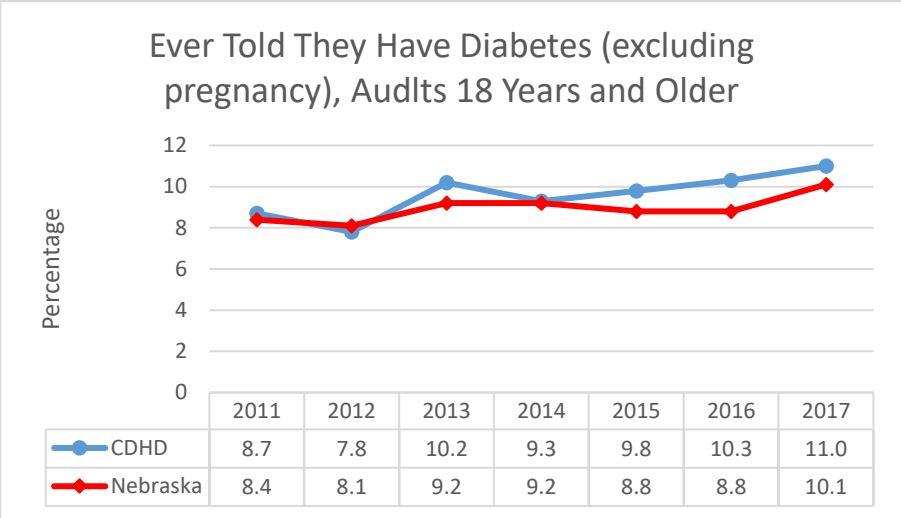
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	34.8	32.6	33.4	39.8	34.7	26.1	35.3	41.1	34.0	38.6
Nebraska	39.2	40.1	40.4	37.4	34.8	36.4	34.8	33.5	33.1	31.5

*Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019, Data are Preliminary)

Diabetes

The percentage of BRFSS respondents in both the Central District and the state reporting that they have ever been told that they have diabetes have been on the rise in recent years. As of 2017, 11% of respondents in the Central District indicted that they have ever been told that they have diabetes (Figure 117).

Figure 117

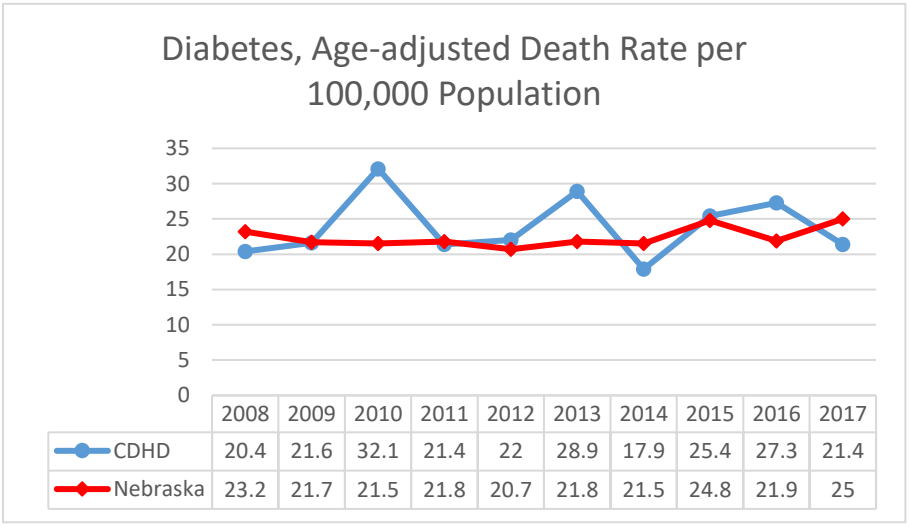


	2011	2012	2013	2014	2015	2016	2017
CDHD	8.7	7.8	10.2	9.3	9.8	10.3	11.0
Nebraska	8.4	8.1	9.2	9.2	8.8	8.8	10.1

*Percentage of adults 18 and older who report that they have ever been told by a doctor that they have diabetes (excluding pregnancy)
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Behavioral Risk Factors Surveillance System)

The rate of deaths due to diabetes in the Central District fluctuates between higher and lower rates than the state. In 2010, 2013, and 2016 the Central District had rates of diabetes-related deaths that were notably higher than the state, while the rate has remained relatively constant across the state (Figure 118).

Figure 118



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	20.4	21.6	32.1	21.4	22	28.9	17.9	25.4	27.3	21.4
Nebraska	23.2	21.7	21.5	21.8	20.7	21.8	21.5	24.8	21.9	25

*Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Sources: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019, Data are Preliminary)

Pulmonary Disease

Asthma

The prevalence of asthma in the Central District appears to be comparable to the state. In 2017, 10.1% of the Central District respondents to the BRFSS indicated that they have ever been told that they have asthma, and 6.7% indicated that they currently have asthma. Both rates are lower than the state (Figures 119 and 120).

Figure 119	Percent of the Adult Population Ages 18 and Over Ever Told They Have Asthma	
	Central District	Nebraska
2014	12.1%	12.2%
2015	10.5%	12.1%
2016	12.2%	12.4%
2017	10.1%	12.0%
(Source: Behavioral Risk Factors Surveillance System)		

Figure 120	Percent of the Adult Population Ages 18 and Over That Currently Have Asthma	
	Central District	Nebraska
2014	7.7%	7.7%
2015	7.4%	7.2%
2016	7.7%	8.3%
2017	6.7%	8.2%
(Source: Behavioral Risk Factors Surveillance System)		

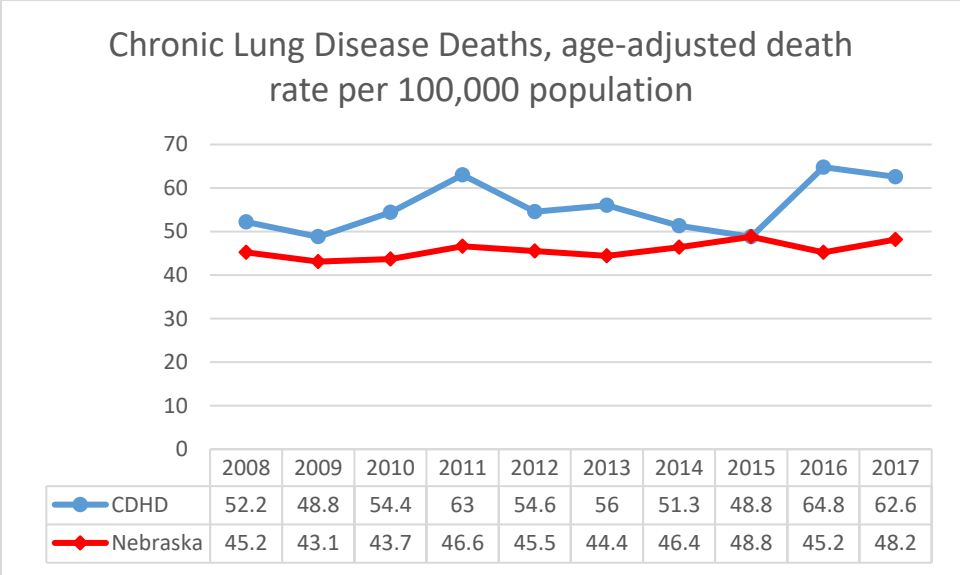
Lung Disease

The rate of incidence of Chronic Obstructive Pulmonary Disease (COPD) as reported by BRFSS respondents has decrease from 2014 to 2017. In 2017, Central District respondents were ever told they have COPD was the same rate as the state at 5.7% (Figure 121).

Figure 121	Percent of the Adult Population Ages 18 and Over Ever Told They Have COPD	
	Central District	Nebraska
2014	6.8%	5.8%
2015	5.2%	5.4%
2016	6.7%	5.8%
2017	5.7%	5.7%
(Source: Behavioral Risk Factors Surveillance System)		

Annual death rates due to chronic lung disease have been higher in the Central District compared to the state over the past 10 years and have increased (Figure 122).

Figure 122



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	52.2	48.8	54.4	63	54.6	56	51.3	48.8	64.8	62.6
Nebraska	45.2	43.1	43.7	46.6	45.5	44.4	46.4	48.8	45.2	48.2

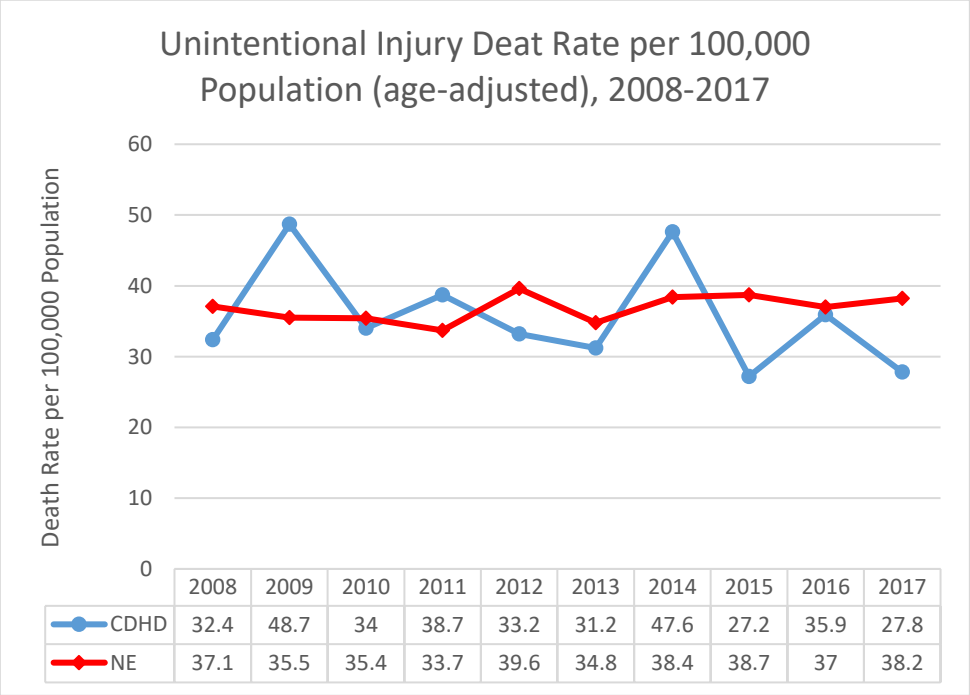
(Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019, Data are Preliminary)

Accidental Deaths

Figures 123 and 124 below show the rates of unintentional injury deaths.

Figure 123	Unintentional Injury Deaths by County of Residence, Age-Adjusted Rate, 2016	
	2016	2012-2016
Hall	40.6	31.4
Hamilton	6.1	39.7
Merrick	28.8	52.7
Nebraska	36.9	37.2
Note: per 100,000 estimated populations (Source: Nebraska Department of Health and Human Services-Vital Statistics 2016)		

Figure 124

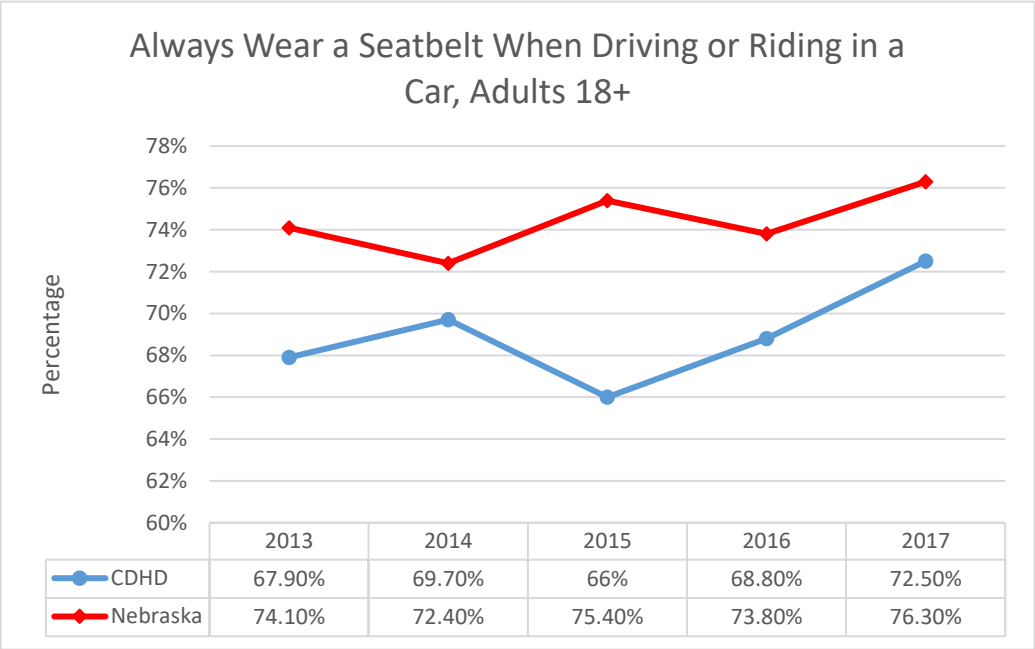


Note: Data are age-adjusted to the 2000 U.S. standard population
Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019

Motor Vehicle Safety

The percentage of adult respondents to the BRFSS in the district reporting that they always wear a seat belt when driving or riding in a car is lower compared with the state (Figure 125).

Figure 125



*Percentage of adults 18 and older who report that they always use a seatbelt when driving or riding in a car
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Behavioral Risk Factors Surveillance System)

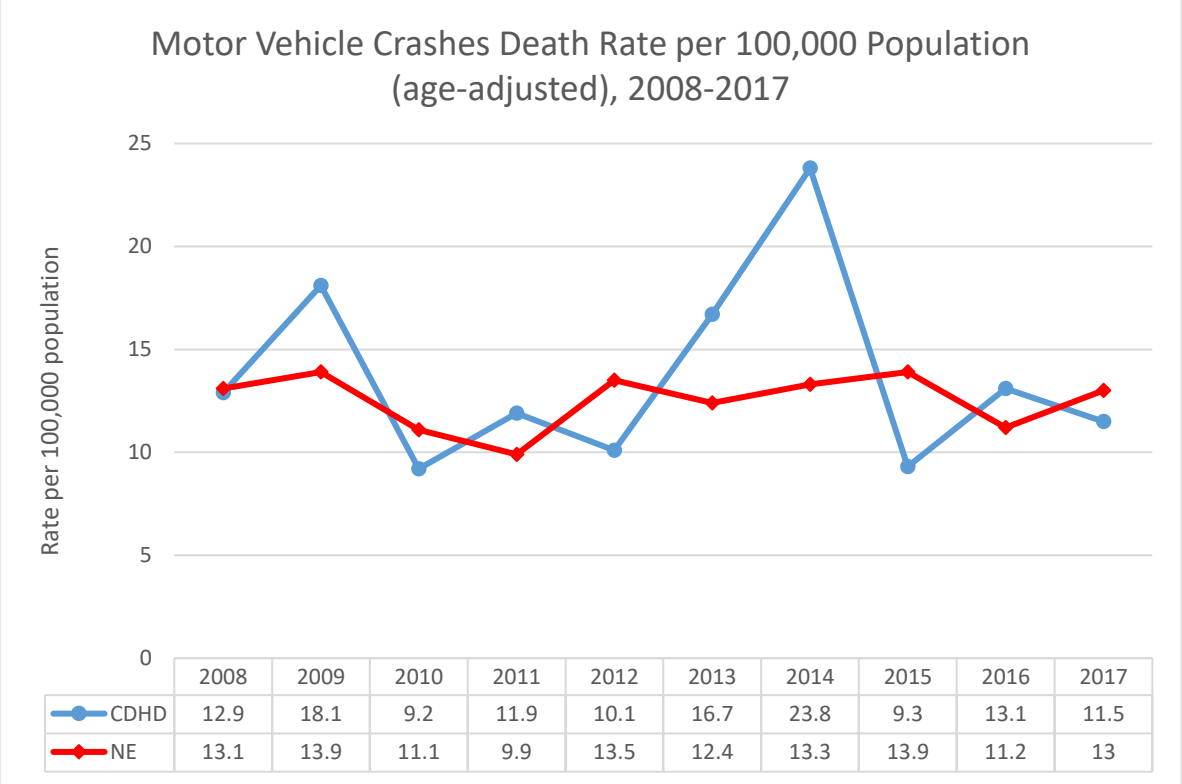
The percentage of BRFSS respondents ages 18 and over in the Central District who reported texting while driving was higher than the state in 2017. However, the percentage of BRFSS respondents ages 18 and over in the Central District who reported talking on a cell phone while driving was lower than the state in 2017 (Figure 126).

Figure 126	**Indicators of Distracted Driving among Adults Ages 18 and Over (2017)**	
	Central District	**Nebraska**
Texted while driving in the past 30 days	31.6%	26.6%
Talked on a cell phone while driving in the past 30 days	64%	66.5%
(Source: Behavioral Risk Factors Surveillance System)		

Total motor vehicle fatalities increased from 218 (2016) to 228 (2017) for the state (Figure 127).

Figure 127	Total Motor Vehicle Fatalities 2017
Hall	11
Hamilton	1
Merrick	1
CDHD	13
Nebraska	228
(Source: Nebraska Department of Transportation)	

Figure 128



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
CDHD	12.9	18.1	9.2	11.9	10.1	16.7	23.8	9.3	13.1	11.5
NE	13.1	13.9	11.1	9.9	13.5	12.4	13.3	13.9	11.2	13

Note: data are age-adjusted to the 2000 U.S. standard population
Data are Preliminary
(Source: Nebraska Vital Records, Nebraska Department of Health & Human Services, April 2019)

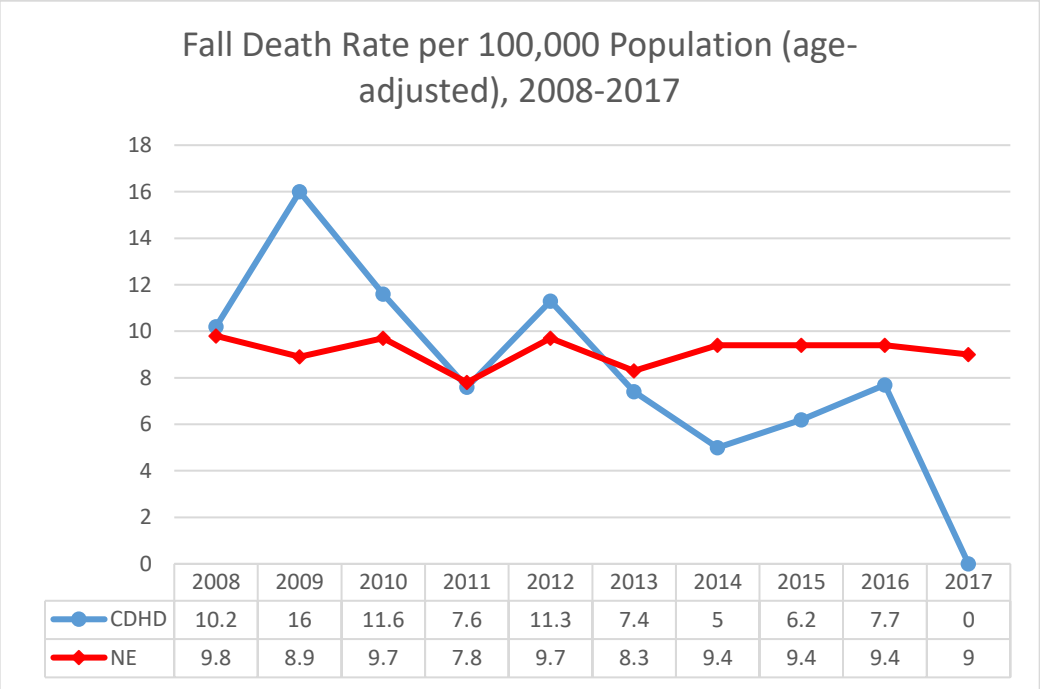
Falls

The number of falls among adults ages 45 and over have increase from 2014 to 2016 for the Central District and Nebraska (Figure 143).

Figure 143	Falls among Adults Ages 45 and Over (2014, 2016)			
	CDHD 2014	NE 2014	CDHD 2016	NE 2016
Had a fall in the past year	24.0%	26.1%	29.5%	29.0%
Injured due to a fall in the past	7.5%	8.8%	9.1%	10.1%
(Source: Behavioral Risk Factors Surveillance System)				

The fall death rate from 2008 to 2017, shows some decreases and increases in falls throughout the years. The drop-in falls from 2016 to 2017 in the Central District is due to a lack of data (Figure 144).

Figure 144

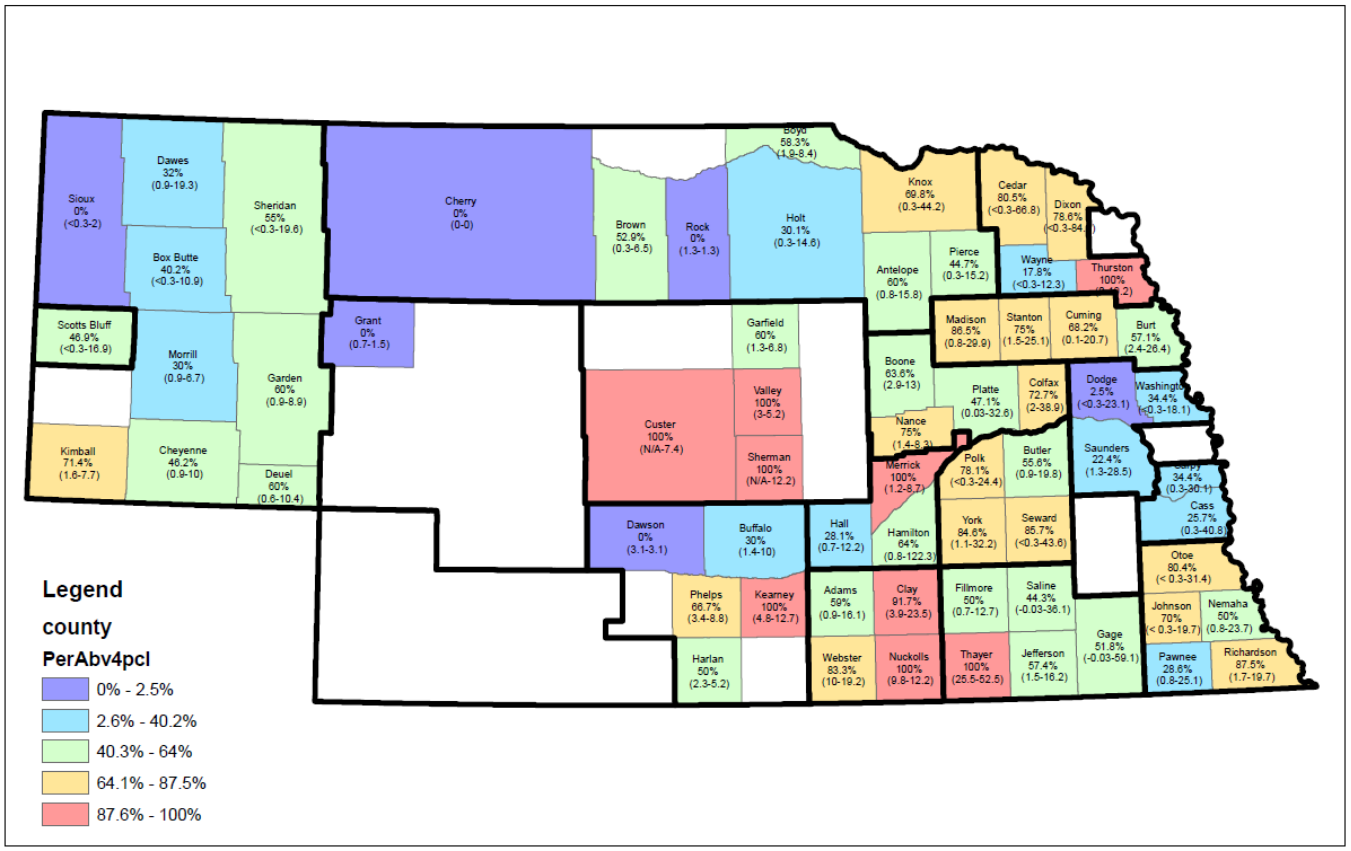


*Number of deaths and death rate suppressed due to a small number of deaths (i.e., fewer than 5), year 2017
Note: Data are age-adjusted to the 2000 U.S. standard population
Date are Preliminary
Source: Nebraska Vital Records, Nebraska Department of Health and Human Services, April 2019

Radon

Hamilton County has the highest average radon levels in the Central District at 10.27pCi/L. (Figure 145-146).

Figure 145



Percentage of Radon Test Samples that has more than 4pCi/L
Nebraska 2017-2018

Expression: County Name; Percentage of samples above 4pCi/L; Range of Minimum and Maximum Levels

Note: Blank County Data is not avaliable at this time

Data: Radon Test Samples summary data compiled from all the Local Health Districts.
Map: Map Created by PHIP, Lincoln Lancaster County Health Department

N
W E
S

04/15/2019

Figure 146

Central District Health Department Radon Test Results Summary

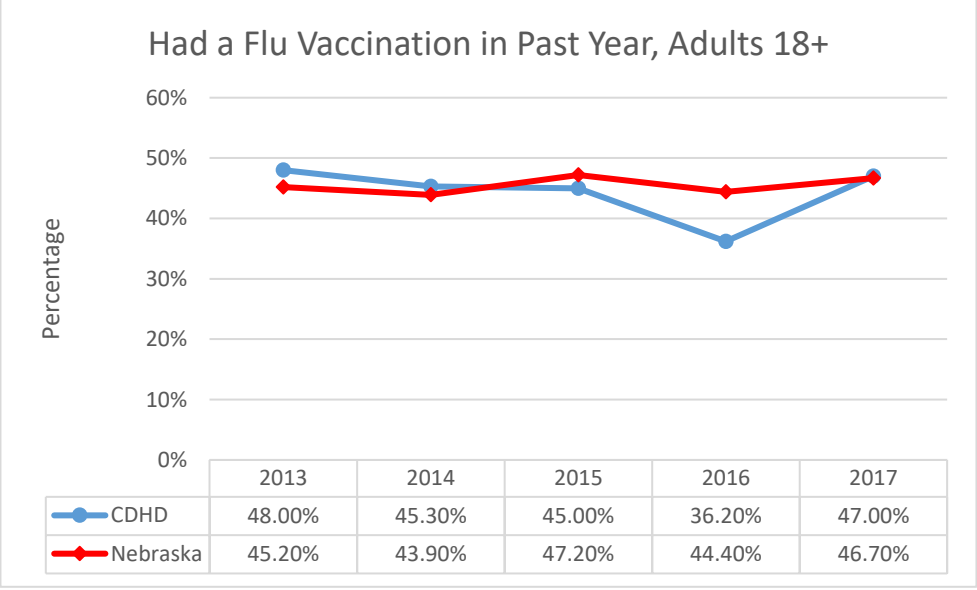
Date Range: 8/1/18 to 3/31/19

Health Department	County	Number of Test Kits Given out	Number of Test Kits used with No Errors	Number of Test results at or above 4.0 pCi/L (No Errors)	Minimum pCi/L	Maxmum pCi/L	Average pCi/L
CDHD	Hall	na	64	18	0.7	12.2	4.02
CDHD	Hamilton	na	25	16	0.8	122.3	10.27
CDHD	Merrick	na	12	12	1.2	8.7	3.5
(Source: Central District Health Department)							

Infectious Disease

The Central District decreased in the number of adults, 18 years and older, receiving a flu vaccination, compared to the state increasing flu vaccinations from 2014 to 2017 (Figure 147). The opposite goes for the Central District adults, 65 years and older, who received a flu vaccination compared to the state (Figure 148).

Figure 147

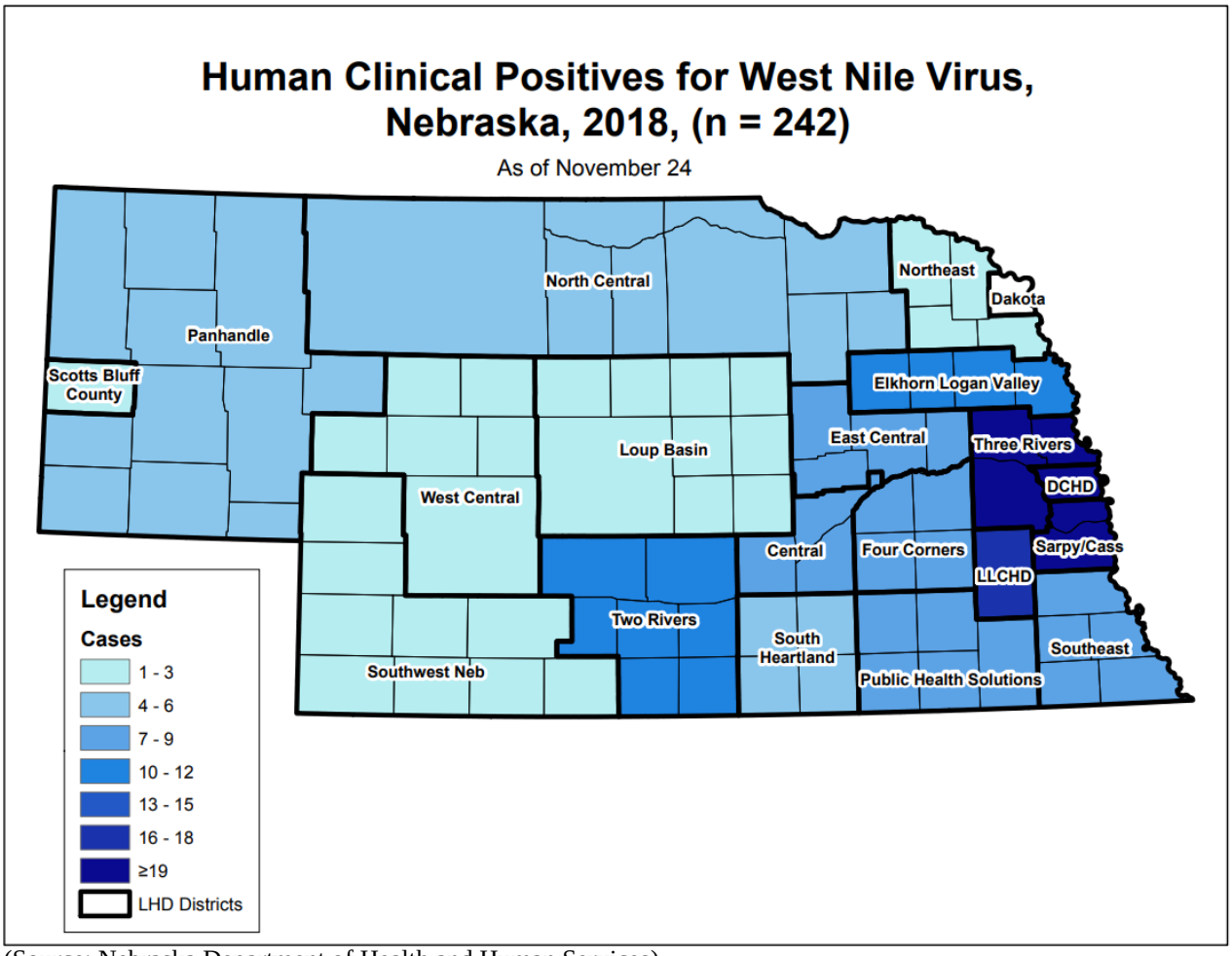


*Percentage of adults 18 and older who report that they received an influenza vaccination (shot or mist) during the past 12 months.
**Central District Health Department includes Hall, Hamilton, and Merrick Counties.
(Source: Behavioral Risk Factors Surveillance System)

Figure 148	Percent of Population over 65 that had a Flu Vaccination in the past Year	
	Central District	Nebraska
2013	64.6%	66.2%
2014	71.4%	64.7%
2015	64.1%	65.2%
2016	63.6%	62.7%
2017	71.5%	65.5%
(Source: Behavioral Risk Factors Surveillance System, BRFFS)		

Figure 149 below illustrates the Human Clinical Positives for West Nile in Nebraska for 2018. For the Central District counties, there were 7-9 positive cases.

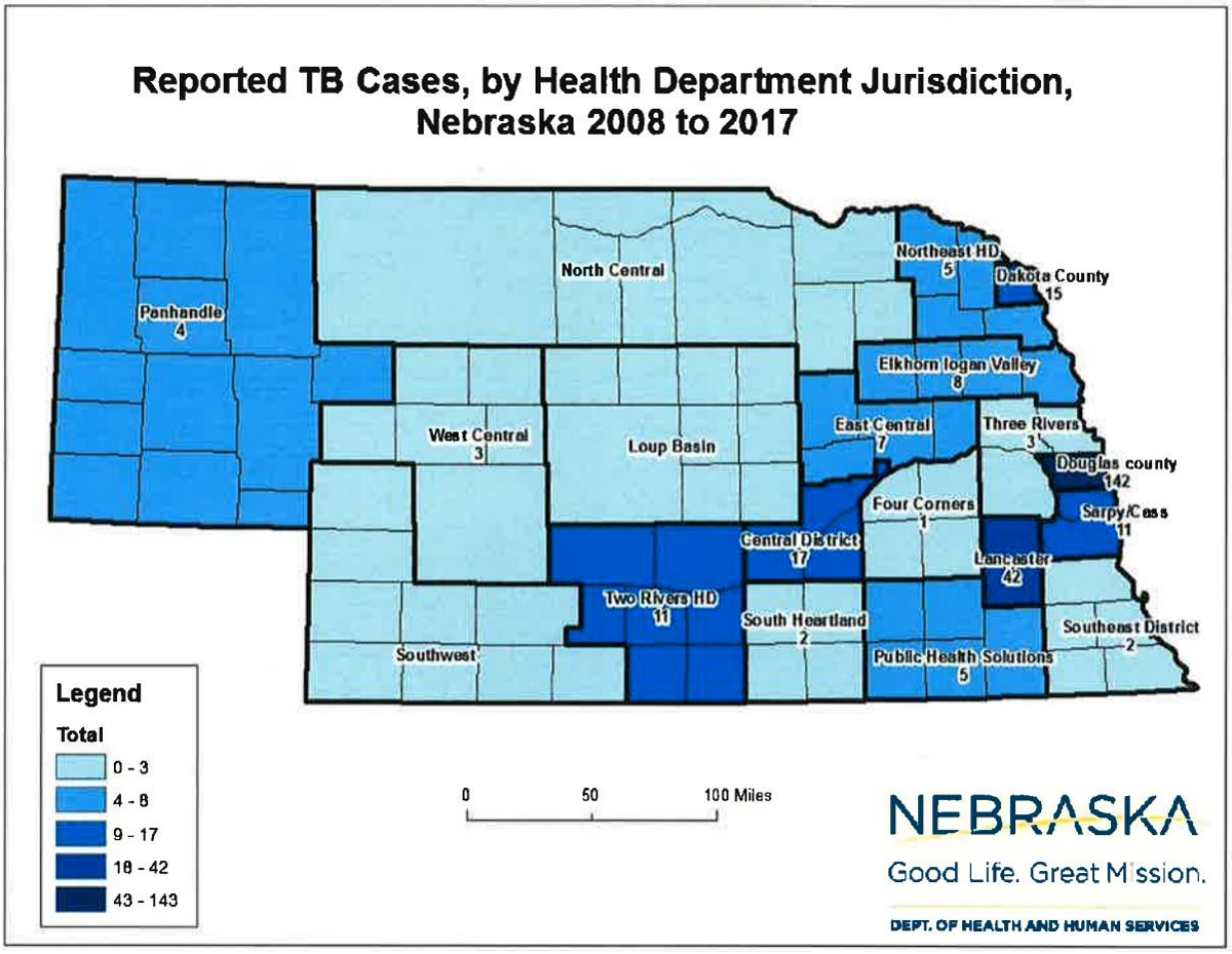
Figure 149



(Source: Nebraska Department of Health and Human Services)

Figure 150 below illustrates the Tuberculosis (TB) cases reported by Health Department Regions from 2008 to 2017. The total reported TB cases for the Central District during this time period was 17.

Figure 150

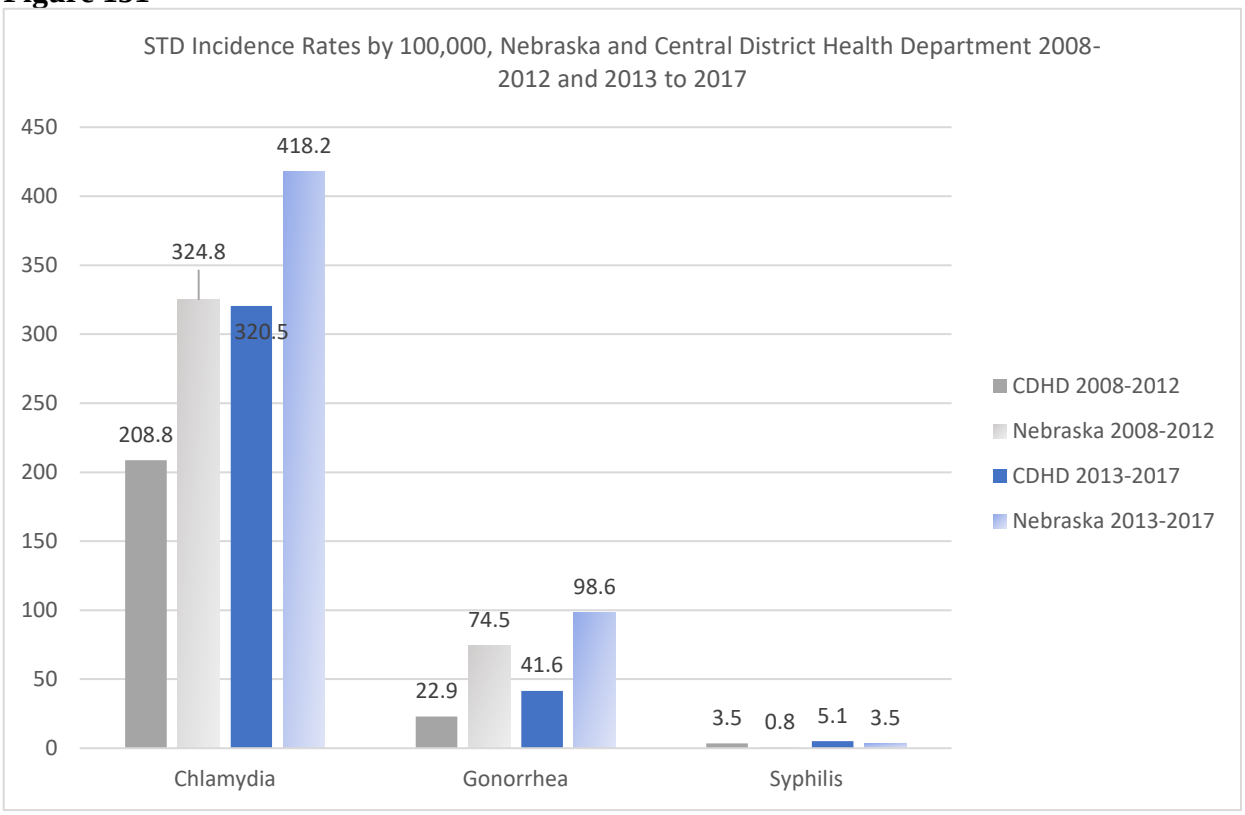


(Source: Nebraska Department of Health and Human Services)

Sexually Transmitted Diseases

Between 2008 to 20012 and 2013 to 2017 the incidence of chlamydia and gonorrhea in the Central District was notably lower compared to the state, however, Central District had higher rates of syphilis than Nebraska in these time frames. In the Central District and the state, the rate of chlamydia is higher than either the rate of gonorrhea or syphilis (Figure 151).

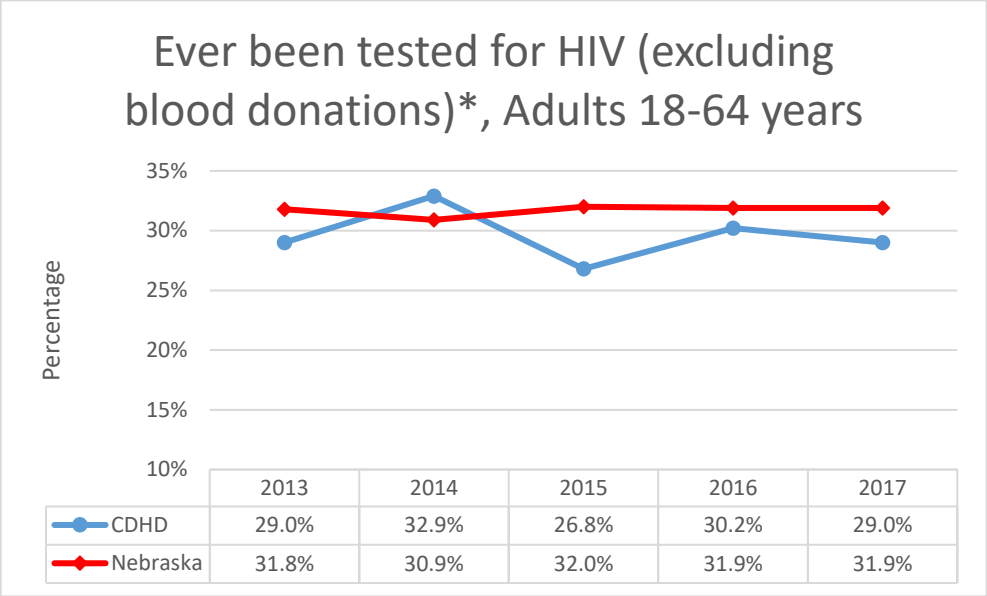
Figure 151



*Includes Primary and Secondary Syphilis
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Nebraska Department of Health and Human Services)

The average of five years between 2013 and 2017 rate of Central District respondents reporting they have ever been tested for HIV (other than blood donations) is lower than the state, 29.5% and 31.7% respectively (Figure 152).

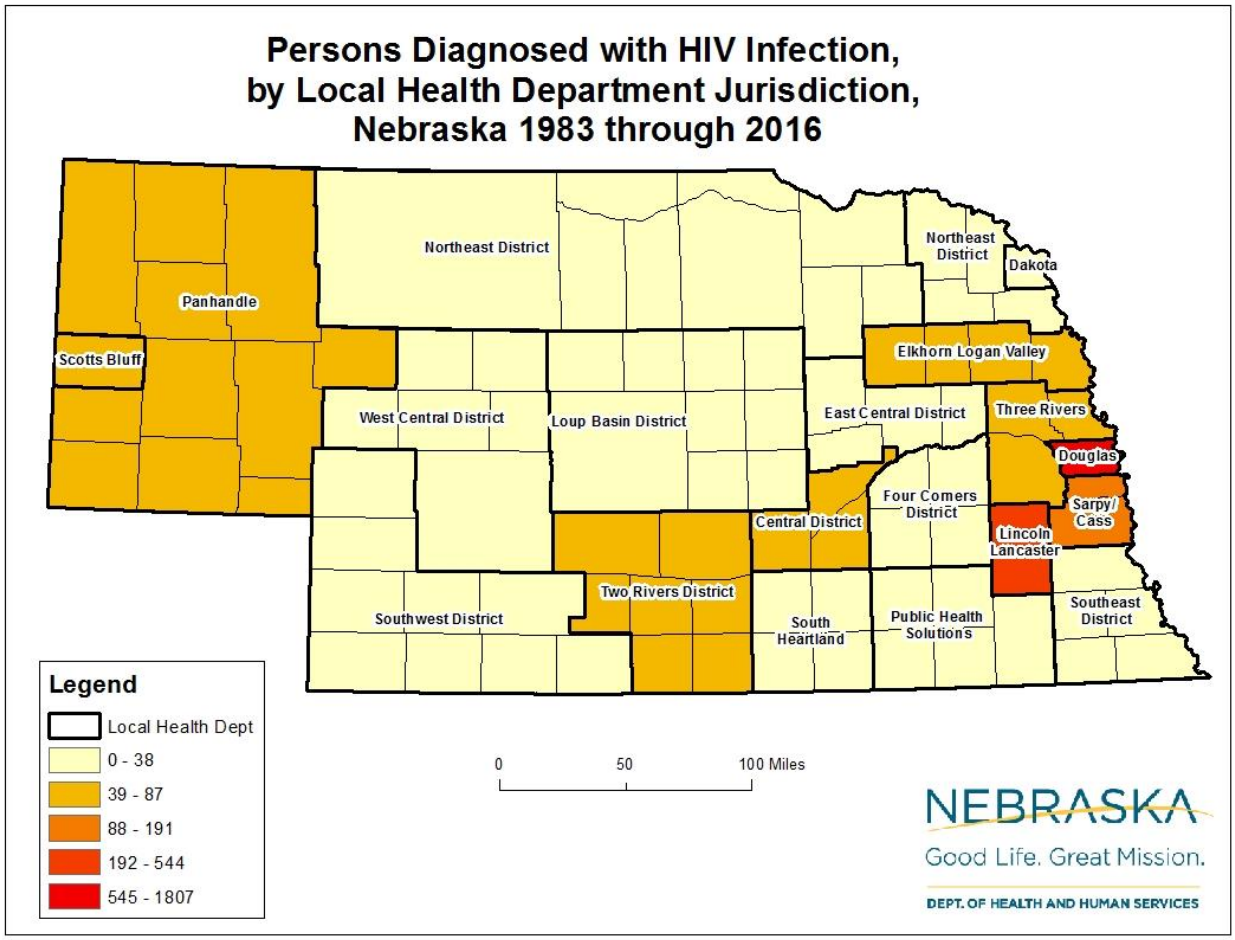
Figure 152



*Percentage of adults 18-64 years old who report that they have ever been tested for HIV other than testing that may have occurred during a blood donation.
**Central District Health Department Includes Hall, Hamilton, and Merrick Counties
(Source: Behavioral Risk Factors Surveillance System, BRFSS)

Between 1983 and 2016 the rate of HIV infection diagnosed in Central District was higher than most of its surrounding areas. The statewide cumulative total for HIV infections was 3111 through 2016 (Figure 153).

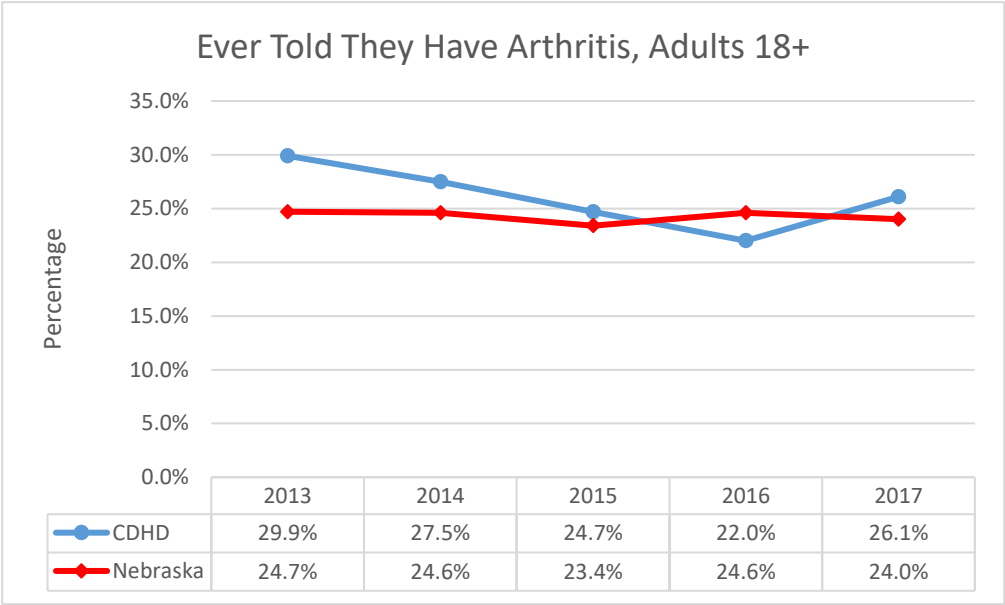
Figure 153



Arthritis

Slightly more than 1 in 4 Central District respondents to the BRFSS indicated that they had arthritis from 2013- 2017. This is higher compared to the state (Figure 154).

Figure 154



*Percentage of adults age 18 and older who report that they have ever been told by a doctor, nurse, or other health professional that they have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.
**Central District Health Department includes Hall, Hamilton, and Merrick Counties.
(Source: Behavioral Risk Factors Surveillance System)

Kidney Disease

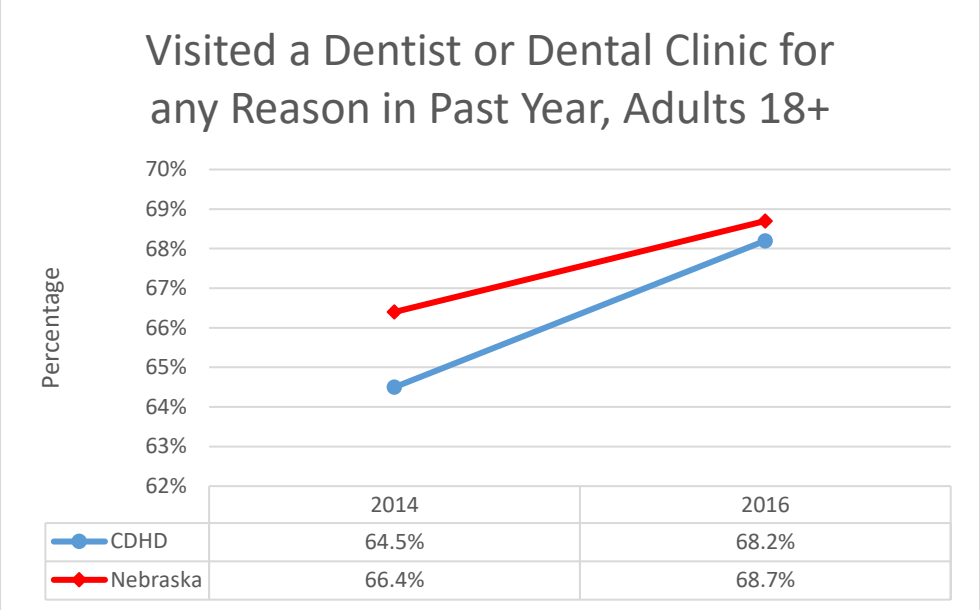
The percent of adults ages 18 and over every told they have kidney disease in the Central District is greater compared to the state (Figure 155).

Figure 155	**Percent of Adults Ages 18 and Over Ever Told They Have Kidney Disease**			
	2014	**2015**	**2016**	**2017**
CDHD	2.4%	3.3%	3.4%	3.3%
Nebraska	2.1%	2.4%	2.8%	2.9%
(Source: Behavioral Risk Factors Surveillance System)				

Oral Health

Compared to the state, a lower percentage of Central District respondents to the BRFSS reported that they visited a dentist or dental clinic in the past year (Figure 156).

Figure 156



*Percentage of adults 18 and older who report that they visited a dentist or dental clinic for any reason within the past year
**Central District Health Department includes Hall, Hamilton, and Merrick Counties
(Source: Behavioral Risk Factors Surveillance System

Figure 157	**Indicators of Oral Health among Adults Ages 18 and Over (2014, 2016)**			
	CDHD 2014	**NE 2014**	**CDHD 2016**	**NE 2016**
Visited a dentist or dental clinic for any reason in the past year	64.5%	66.4%	68.2%	68.7%
Ever had any permanent teeth extracted due to tooth decay or gum disease	42.7%	39.1%	39.6%	38.2%
Had all permanent teeth extract due to tooth decay or gum disease (adults ages 65 and older)	17.2%	14.1%	18.7%	13.2%
Had all permanent teeth extracted due to tooth decay or gum disease, 65-74 year olds	15.7%	10.9%	19.2%	10.4%
(Source: Behavioral Risk Factors Surveillance System, BRFSS)				

Health Issues

Obesity is increasingly common in the Central District. Contributing behaviors include poor food choices and lack of physical activity. Obesity is a contributing factor for diabetes, heart disease, stroke, and a less than optimal quality of life. The focus of this section in on diabetes, and how and why it has emerged as a serious public health problem.

Diabetes is a serious public health problem that disproportionately affects racial/ethnic minorities. Diabetes prevalence is 12.6% in African Americans, 11.8% in Hispanics, and 8.4% in Asians compared to 7.1% in whites. Possible reasons to explain this disproportionate burden of diabetes include genetic predisposition, family history, improper diet, limited physical activity, socioeconomic position, sex, and access to overall high-quality health care. Furthermore, the role of the environment, both physical (e.g., restaurants serving healthy foods, walking trails, and safe neighborhoods) and social (e.g., families, workplaces, and social support), contributes to cultural norms and the views and perspectives of individuals.

We now know that even with similar best practice treatments, interventions in medical treatment and diabetes education, substantially poorer health outcomes exist for vulnerable populations. In public health, we consider the impact of those environmental and social conditions which have either protective or compromising effects on individuals' health outcomes. Social determinants have been defined as factors in the social environment (e.g., socioeconomic status, housing, transportation, availability and accessibility of health care resources, and social support) that either positively or negatively affect the health of individuals and communities.

Healthy behavior and lifestyle alone do not solely explain poor health outcomes among lower socioeconomic groups. Even if behavior is held constant, people of lower socioeconomic status are more likely to die prematurely than are people of higher socioeconomic status. There are several social determinants that serve to potentially influence the pathways through which chronic diseases such as diabetes are produced and managed. Examples include health care organizational characteristics (e.g., health care provider practices, provision and degree of appropriate diabetes education, use of patient-reminder systems, health care provider training, and cultural competencies of medical staff), diabetes-related health care costs, family involvement, social support, and other factors such as housing, racism, availability and accessibility of healthy foods, and transportation.

Health is strongly influenced by the conditions of the environment in minority neighborhoods, where opportunities for good nutrition are often limited. The relationship between good nutrition and the prevention of chronic diseases is well established. Essential to good nutrition is having access to healthy foods in the community in which you live. The fair and equitable distribution of food is a basic human right. Residents of minority communities are more likely to be severely limited in their access to quality fruits, vegetables, and other healthy food options because of cost, lack of transportation, and lack of availability. Often, placement of food service outlets is strongly associated with the wealth and racial distribution of the neighborhood, with more than eight times as many individuals from minority populations living in low-income neighborhoods than in wealthier areas. Even when minority neighborhoods are not considered to be low-income, the availability of chain supermarkets and healthy

food options is still significantly less. In addition to the significant difference in the quality of food available at large chain supermarkets compared to non-chain supermarkets and smaller grocery stores, residents of urban neighborhoods are likely to pay 3–37% more than those in suburban areas for the same food purchases.

Regardless of income or housing cost, living in a predominately minority neighborhood increases the likelihood of having poor access to healthy food choices. As a result, minority communities are left primarily with smaller grocery and convenience stores or no grocery stores at all. Grocery stores with restricted shopping options for residents tend to have fewer fresh fruits and vegetables, less healthy cuts of meat, and less fish and chicken and to offer mostly processed foods that are high in fat, salt, and calories.

Contributing further to the lack of accessible healthy foods is the availability of resources such as private or public transportation needed to obtain them. In minority communities, limited or lacking transportation hinders the flexibility of residents to travel outside of their neighborhood to seek healthy foods. Neighborhoods with healthy food options are also more likely to be associated with other healthy living conditions (better built-environment resources) and health-protective factors (higher income, higher education, and lower BMI) and are more likely to be largely white.

Another issue related to the lack of access to healthy food choices in vulnerable populations is that of an overabundance of fast-food restaurants, as opposed to sit-down restaurants that usually offer more healthful food choices. The increased density of fast-food restaurants in predominantly minority communities provides convenient access to inexpensive food that have a low nutrient density and are high in calories and fat. Given the higher cost of fresh produce, poorer populations are already at a disadvantage in adhering to a healthy eating plan. The ability to adhere to recommended food guidelines becomes even more crucial for people who are at risk for or living with a chronic disease such as diabetes, for which food intake and nutrition habits play a significant role in optimal disease management.

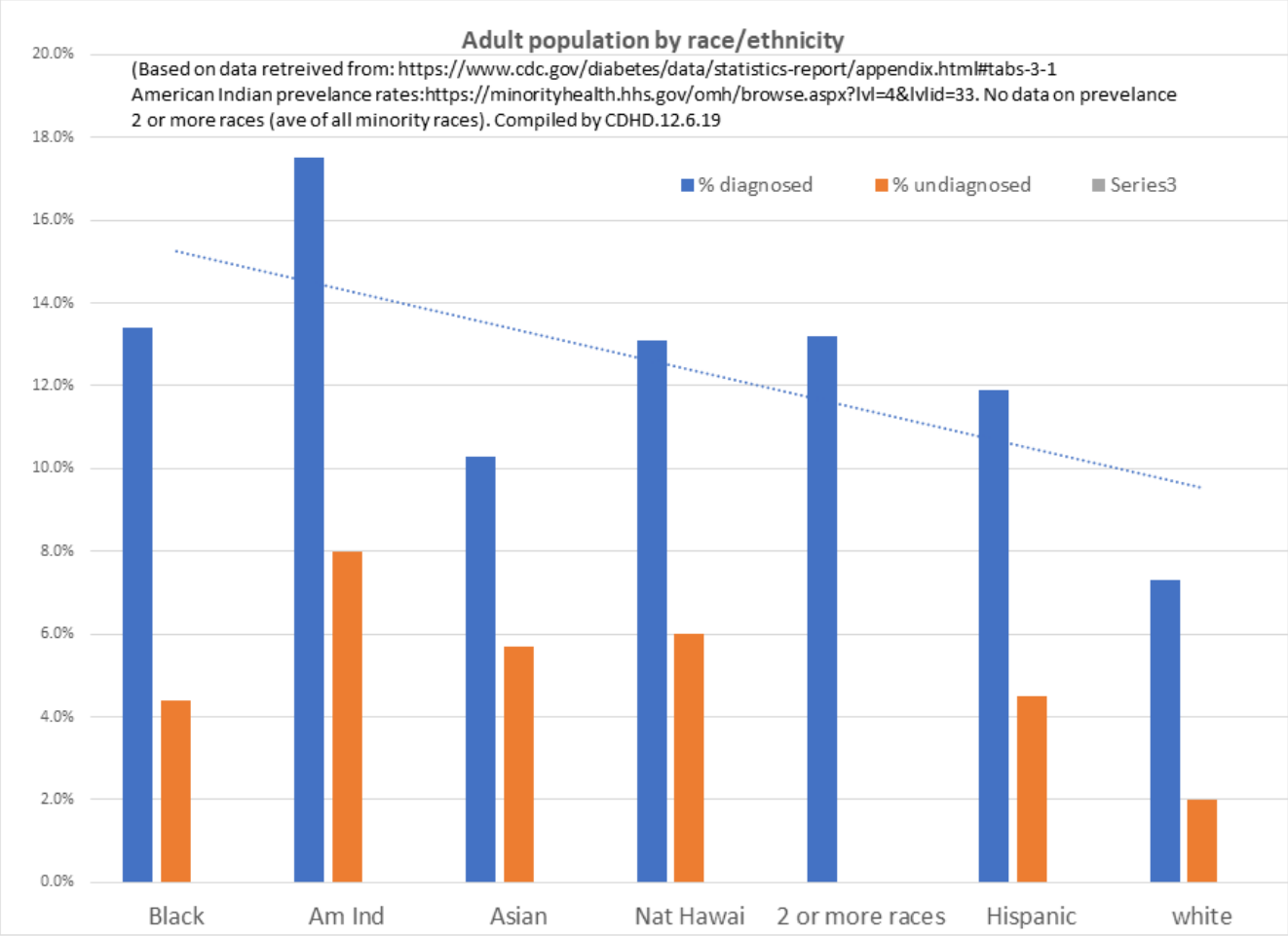
Certainly, diabetes in vulnerable populations is highly influenced by both genetics and weight status, which is the result of limited access to healthy foods, poor food choices, and lack of physical activity. However, the characteristics of minority neighborhoods provide serious points of consideration as to how and why minority populations continue to experience high rates of diabetes-related morbidity.

Environmental conditions can substantially impede opportunities to engage in appropriate lifestyle behaviors for much of the minority populations. Health disparities related to diabetes will continue to occur years into the future. Addressing diabetes in vulnerable populations will require multidisciplinary teams of organizations and professionals working together. Public health is in a prime position to organize and lead. As Chief Health Strategist, CDHD promotes a deeper understanding of and implementation of effective interventions achieved through complex and multidimensional relationships.

Adapted from: Leonard, Nkenge and Hayes. Social Determinants of Health in Minority Populations: A Call for Multidisciplinary Approaches to Eliminate Diabetes-Related Health Disparities (retrieved from the www:https://spectrum.diabetesjournals.org/content/25/1/)

This chart was compiled by CDHD from multiple sources of data to illustrate the racial/ethnic disparity in the incidence of diabetes. Based on data from 2018 U.S. Census estimates, and calculating the number of adults and minority populations in Hall and Merrick Counties, we estimated the number of minority adults with diagnosed diabetes to be 1,885.

CDHD has several programs to address Diabetes and pre-Diabetes. There is an enhanced effort to reach the minority population through CDHD's Community Health Worker Program (CHW's). Three bilingual/bicultural CHW's are trained in both the Diabetes Prevention Program and the Living Well with Diabetes (CDC programs). Additionally, two Registered Nurses are trained to deliver Living Well with Diabetes and three Registered Nurses are trained to provide the Diabetes Prevention Program. We have agreements with three medical clinics in Hall County to partner in addressing diabetes. We continue to work with community partners to address social determinants and resulting behaviors that contribute to the development and poor control of diabetes in minority populations.



Conclusion

Community Health Assessment Results

The broader environment is constantly affecting communities and local public health systems. State and federal legislation, rapid technological advances, changes in the organization of health care services, shifts in economic forces, and changing family structures and gender roles are all examples of Forces of Change. These forces are important because they affect, either directly or indirectly, the health and quality of life in the community and the effectiveness of the local public health system. The data gathered from all the different focus groups with each county help Hall, Hamilton, and Merrick Counties, and Central District Health Department prioritize public health issues and identify resources for addressing them.

The qualitative and quantitative data collected throughout the process of forming the Community Health Assessment establishes the foundation upon which priorities are determined and identify specific quality improvement (QI) projects to support priorities.

The Central District Health Department with partners has determined three top priorities to work on to better the health and wellness of the community. While there are three top priorities, the main focus will be on obesity. Complete details of how CDHD and community partners are working on these top priorities can be retrieved in the Community Health Improvement Plan (CHIP).

1. Obesity
2. Access to Care
3. Behavioral Health

Appendices

Appendix A. Hall County Focus Groups and Community Themes and Strengths Assessment

Appendix B. Hamilton County Focus Groups and Community Themes and Strengths Assessment

Appendix C. Merrick County Focus Groups and Community Themes and Strengths Assessment

Appendix A

Groups of Hall County met with Central District Health Department staff to revisit the needs of their community. The groups including CHI St. Francis, Hall County Community Collaborative, Leadership Tomorrow, Veterans, CDHD's Board of Health, and Latino reviewed data gathered by Central District Health Department for the health departments district area and data specific to Hall County.

While listening to the data, participants were asked to consider the data and comment with thoughts and questions. Below are the narrative notes for each focus group.

CHI St. Francis

COMMUNITY HEALTH ASSESSMENT MEETING
Location: CHI-SF Health
Date: 1/7/19
Attendees: See sign-in sheet
Community Health and Human Services Providers

DISCUSSION NOTES
Intro: Ed (CHI) & Teresa (CDHD)
Arli (CHI) – reviewed CHI benefit & work CHI is doing
Questions by group:

1. "How many community members/organizations of color are invited?"
   Response: Will need to find a way to get that input at another session.
2. "How many people were invited and how were they invited?"
   Response: Teresa and Arli worked together to create a list of folks within the community who are in the health/human service industry. CDHD intends to hold additional sessions for other homogenous groups.

Melissa (CHI) – CHI 3-year plan (July 2016-June 2019)

Access to care
Injury Prevention & Violence
Behavioral Health

Comment:

"Hall County Community Collaborative (H3C) is working to engage parents with schools"

Teresa reviewed current data through PowerPoint Presentation and asked for group to respond during presentation on data- ex: are you surprised, do you agree, what is missing?
Comments:

Alcohol/ Drugs: "Marijuana (smoking) on street is not a huge, because oils &other methods produce a high that lasts longer…"
"More people are using meth"
Drug deaths: Comments from several "feel number is low"
"May be misreporting on what is what as far as recording drugs, intentional/not intentional

deaths."

"Can we break down drugs data more…Is data broken down via race/ethnicity? Particularly suicide/behavioral"

Youth Risk Survey

Teresa noted that these data represent Hall County only and that GIPS was on participant, having the large percentage of students in the 3-county area. Skewed data

Comments:

"Marijuana is on the rise for both medicinal and leisure use"

"Voices for Children and Kids Count will come out in a couple of weeks and will provide additional data"

"Anecdotally marijuana is on the rise in youth"

"1 Choc chip cookie in Colorado = 12 servings of marijuana"

"Shatter = oil (looks like brown glass), and is smoked"

"Perception of risk in young is low"

"Charges for drug use are changing"

"Vapor use – more use now than data shown (2016 data shown- in year 2018, last couple years the use has grown"

Culture of Health

Poverty numbers – break down by ethnicity

Shortage of providers (Shortage of providers or shortage of acceptance of Medicaid?)

Comments:

"Unemployment & salaries for surviving"

"Looking at employment embedded in social determinants: the act of being employed"

"People need work for self-respect, to feel good about themselves, in addition to money"

"What about underemployment numbers, do we have any data?"

Maternal, Infant & Childcare

Comments:

"Do we have data on Birthweight among children of color?"

"What causes the lack of prenatal care?"

Injury & Violence

Comments

"People are talking about it more on social media"

"Cultures share that GI police are trusted"

"Increase in relationship disputes"

"Aggravated = more forceful harm,

"Strangulation = is a citation

"Sexual assault

"Better reporting by officers and better at asking questions. Better advocates. More people are reporting than before"

"Learned behaviors (from being brought up in violent homes) are repeated

"Better knowledge of what violence is"

Accidental Death Rate

Comments:

"Better 1st responders"
"Better equipment"
"Every police officer carries a tourniquet and Narcan"
"Better Medical procedures and technology"

Sex Trafficking
Comments

"Increased awareness in past two year"
"One true victim in our area"
"Prostitution – people get themselves into it to make a living – freely coming here
"White girls are being recruited"
"Sudanese/Somali – meth is provided for their service – they want to live like that because they get a roof over their head, food, and they get the meth they want but they don't get paid"

Access to Care
Comments:

"No public transportation in GI"
"People work long hours and may have one car to share"
"There is limited access to childcare"

Health Literacy
Comments:

None

Housing
Comments:

"It is substandard – No inspection for safe housing"
"Would appall a large portion of our population if they saw the conditions of homes"
"There was a committee working on Health in all policies"

What do you want to see more data on?
Comments**:**

"Subcultures"
"Sex trafficking"
"Prostitution"
"Housing"
"Prenatal: Lack of education, Drug use"
"Age over 60: Meds taking, Food insecurity, Readmissions into hospitals"

Small Group Work: 20 minutes

Small Group Reports -

1. **What are your top 3 priorities based on today's discussion?**
2. **What data are missing?**
3. **Who needs to be at the table going forward?**

Group 1.

1. Obesity – affects all
2. Behavioral health/mental health
3. Culture of Health – transportation

Missing: Schools need to be at the table

Group 2.

1. Behavioral Health
2.
3.
4.

The impact of the top 4 affect all others.

Missing: Crisis Center, Third City, Shelters, Literacy Council, Large employers (HR), schools (large & rural) need to be at the table.

Group looked at who they are serving = Latino / Migrant Groups

Group 3.

1. Substance abuse
2. Injury/Violence
3. Obesity
4. Access to affordable childcare
5. Transportation

Group 4.

1. Substance Abuse
2. Mental Health
3. Injury & violence / culture of health

Missing: DHHS, Legislature, Recovery community, Rehab, Goodwill, Dept. of Labor, Culture of disabilities, Choice family

Group 5.

1. Access to care – goes into access that goes into all high deductible affects access
2. Substance abuse
3. Obesity

Missing: Status discrepancies, GED, CCC-educational good ideas

Group 6.

Group based their decisions off of who they are serving

1. Maternal & Infant
2. Substance Abuse
3. Behavior/Mental Health

Missing: Probation, Economic Assistance (child care, SNAP) child protective services need to be at the table.

"Priorities are different for everyone. It's difficult to say that the community said this as an issue because we all have our own pockets we are in"

"We all have different pieces of puzzle"

Group 7.

1. Behavioral

Group 8.

1. Elderly Care
    a. Transportation – don't get out, watch TV, then we get a lot of falls
    b. Behavioral Health

Missing – transportation

Question to the whole group

Think of whole district: Who is missing?

Boy's Town
Bryan LGH
Officials & Government personnel (city and county)
Literacy Council
People of Color
Faith based community
Department of Labor
JBS should be included
Shelters
Housing

What were your "AH HA" Moments?

Health Department does a good job at partnering

What is missing overall?

Ability to communicate & logistics for languages other than English.
Interpreters
Language line is spoken, not written
Need pool of interpreters in the community
Lutheran Family Services – has some interpretive services

WRITTEN COMMENTS

During and following the meeting, attendees were asked to write down any thoughts and submit at the end of the meeting.

Written - CHI Individual Notes 1/7/2019

Organized by category

Access to care

Individuals not getting preventative care, just going in for health crisis situations care. Age dependent (i.e. young adults)
Costs need to be lowered – low income is high, but health care costs are high
Young adults accessing ER or Rapid care rather than Primary Doctor. They lack routine care
Meaningful & appropriate engagement with disparate populations
Push need for regular physician
Never enough resources.

Mental Health
Need some short-term center in GI, Not taking EPC to Kearney to be released in 1-2 days.
More Access to BH/MH services. Capacity and access by community across all income levels
Youth Higher Level Mental Health Care– Youth deemed unsafe and needing higher level of care have to go to Lincoln, Omaha or Scottsbluff
Services for the unstable but not suicidal – What can be done assist vulnerable adults who present as mentally unstable- but are not a threat to self or others so they cannot be put into emergency protective custody.
We feel if you address mental health & substance abuse it will impact injury & violence.

Substance Abuse
Need more resources for detox both short and long term – services in G.I are full but with people from outside area as well. No beds.
Detox options for prescription opioids and benzos
Access to care –Opioids & benzos account for 50% of recorded overdose BUT they have no detox solutions
Access to Detox after hours – Detox center unable to provide medical assisted detox after hours w/o 24 hr. pharmacy

Violence
Increase in reporting of domestic violence. Do we have enough resources for people that are now reporting?
Injury/Violence could be higher; however, we are working on the assumption that by working toward some of these other topics, this issue may be addressed as a subtopic

Reproductive
Need STD data, abortion data (teen and adult)
Sexual Health- Abortion > teen pregnancy rat %, & STD's
Abortions, STD's, other risky sexual bx's (behaviors) by youth. Abortion, teen births down…a factor?
Reproductive Health important?

Culture of Health
People often identify need for services and willingness to participate but don't have the transportation to get there.
Translation services – 24/7 access to translators to assist with translation needs associated with provision for adults and youth
Housing shortage
Transportation to services
Interpretation/ Translation
Rated maternal health and injury & violence & obesity as lower as feel if we address the top factors then we will impact these areas.

COMMUNITY HEALTH ASSESSMENT MEETING
Location: Grand Island Public Schools Administration Building
Date: 1/9/19

Attendees: see sign-in sheet
Hall County Community Collaborative (H3C): Education Providers

Intro –explained to group every 3 years we have to update CHA for (CHI and CDHD) and identify priority needs, reviewed CHI's grant –Mission & Ministry

Teresa reviewed current data through PowerPoint Presentation and asked for group to respond during presentation on data- ex: are you surprised, do you agree, what is missing?
Substance Use
Youth Risk – No schools in Merrick or Hamilton participated
Last 2 years number of youth Marijuana users has increases
Marijuana is not legalized but is down to misdemeanor - $100 fine and slap on wrist
One lady said she talked to her grandkids about Vaping – kids use them because they taste good, it's cool, easy to get, and not many restrictions on them.
Juul Advertised everywhere – good marketing, flavor marketing
Legislature to seek to move legal age up for vapor products

- No information yet
- One girl met with Senator Quick – something is being worked on
- Senators also met with Dr. Grover

Information about opioids was interesting – she had no idea there wasn't access for that
Opioids are working the way into our area and government is working to….
Opioids not recognized because it's not criminalized yet. I don't think we are giving them enough recognition and opioids are here, but we don't have care for them if they want to stop.
Over prescribed & not being used – after meeting with Behavioral Health meeting- hyvee is working on over prescriptions
NE is 1st state in union where Dr's enter a prescription into a system.
Prescription drug monitor system – Dr's have choice to train on it & use the system, pharmacies have to use it
Do No Harm – is a video on Opioids, playing at the Grand Theater on January 17th.
Meth is coming from Mexico with higher purity
Meth is fentanyl is being combined to increases the high, & overdose & side effects increase
Mexico has state of the art facilities –

- Drugs are coming in through postal service
- Fentanyl also coming from China

60 minutes did a show on Opioids

Culture of health – social determents … + add work life
Reproductive
Teen births significantly down in schools
Do you have any reason why teen births are down?
– Changes in health education programs and what can be talked about. Middle school teachers get the facts out and talk deep.

Injury and Violence
Domestic assault reports are up because people are reporting it more and posting on social media
Surprises?
- Validates information – concerns of community, we use data & current so there's no guessing on

things
- New immigrants coming into our community & minority is up – public health's job to work on this and provide services

WORK GROUPS report out

- "Scale does not make sense for some of the questions."

Top 3 issues & why

Group 1
1. Behavioral health/ Mental health
2. Access to health care – it ties into a lot of others
3. Other – Housing

Group 2
1. Substance abuse – overdose-opioids & ? - medical detox doesn't accept patients on those
2. Behavioral Health/Mental Health
3. Access to Healthcare

- group was very like-minded they stated

Group 3
1. Behavioral health/Mental health
2. Substance abuse
3. Injury and Violence – sex trafficking

Obesity
Housing

Group 4
1. Behavioral health/Mental health
2. Access to Healthcare
3. Obesity

Substance abuse

Group 5
1. Behavioral health/Mental health
2. Substance Abuse
3. Access to Healthcare

Group 6
1. Behavioral health/Mental health
2. Substance abuse
3. Access to healthcare

- large group of undocumented citizens –
- don't need verification at Heartland Health Center

Group 7
1. Behavioral Health/Mental Health
2. Substance Abuse
3. Access to Healthcare

Location: Central Community College
Date: 2/12/19
Attendees: See sign-in sheet
Leadership Tomorrow Class 33

Intro: Teresa presented the Central District Data PowerPoint, asking for feedback to data during the presentation. This session lasted approximately 45 minutes.

General Questions:

"How is the date collected?"

"I am interested in and want to get your take on why unmarried women is a measurement"

Violence/Injury

Comments:

"Why is sex trafficking lower than what you think it is?"

"Sex trafficking for now is not what it was 5 years ago, we are still working on criteria on what is sex trafficking. … Is she forced into this?"

"When interviewing a potential victim of sex trafficking, I heard, "I had to do this to make money"

"It is difficult to say if sex trafficking is voluntarily"

"Sex trafficking and prostitution…. they are opposites. Sex trafficking victims are not going in voluntarily"

"What is the difference between human trafficking vs. sex trafficking?"

"Labor trafficking is here…you can see it in parking lot of places in the early morning……Sudanese and Somali"

"It's hard to keep track of this especially when people are here one day and gone the next day"

"Interested in how you get sex trafficking data…. held against will, or safety of kids…to get data

"Attempt of parents to help…. told parents they were going to live with cousins, but living in Colorado with other adults"

Behavioral Health/Substance Abuse

Comments:

"What do you mean by lifetime use in the Youth Risk Survey?"

"I am surprised by the number of 8th graders and what they are doing"

"Juul use is going way up"

"Mental health numbers are going down?"

"Millennial generation getting into adult group with lower mental health"

Access to Healthcare

Comments:

"Why do providers hesitate to add Medicaid to their practice"

"Things are interconnected…so when you look at it all, it all goes together"

Location: Central District Health Department
Date: 2/13/19
Attendees: See sign-in sheet
CHA Community Input -Veterans

Intro: Teresa presented the Central District Data PowerPoint.

Tobacco

Comments:

"What kind of substances are in Juul?"
"Does it contribute to lung cancer?"

Culture of Health
Comments

"How is the unemployment rate determined?"
"What are the numbers of married people vs. single people, because I've heard people that are married live longer and healthier because they have someone take care of them"
"I am a diabetic on insulin, and my weight is now what it was in high school…I don't know about obesity"
"So, we transition out of the military and get employed, and then you have to get off work to go to appointments…you are in pending discharge, but the military doesn't give you any tools"
"When you get discharged from the service, things aren't the same…the work is available, but if you take meds, sometimes you can't wake up in the morning"
"There is a Town Hall Meeting at Library with VA…February 28th @ 6:30 p.m"
"You are lucky if you have an employer that understand Veterans"
"There needs to be education for businesses on PTSD and incentives to keep Vets employed"
"Military go in young and lacking coping skills"
"In the military, we do what we're told to do…. you go into the service when you are young and immature, you start self-medicating, you don't know how to cope"
Military life compared to civilian life is more structured…and civilian life isn't structured like we were used to in the military"
"The Marine Corp makes you clean your barracks, keep things in order. …there is no routine once you are discharged"
"Military life is structured…. you do your job. The transition to civilian life…the job is not structured…. they just toss you out"
"They program you for months and then throw you out in the world"
"CDHD will not be successful changing the VA…. they need to focus on employers with hiring Vets, and on churches, first responders, etc."
"If we want to do something, we should focus on the community… educate them on what to expect from Veterans. Talk to first responders, provide education to churches: Tell them, these are the issues a Vet may bring to your site.
"Vets can offer tremendous benefits to employers"
"We're going to be the first ones there when the shit hits the fan"
"Vets are valuable part of community"
"There is a need to be more of a Veteran friendly community"
"We can't change the VA; it is a huge behemoth"
"What are the needs? How is the VA meeting those needs…? The VA needs to break barriers…. Vets have to give a better effort and can't use it as an excuse"
"My last employer told me that he hired 4 Vets and none work there now. …I worked for him, but I don't now"
"Vets have to get the help they need to be good employees"
"Let's go see the right people and talk about what's going on"
"What's going well? …The VA's been great for me overall, I had to wait for a bed for treatment at first, but they are good at getting people connected…like [redacted]"
"Hire Vets to help Vets"

"[redacted] at CCC works to help with educational issues… Vets need to certify every semester"
"VITAL program is not supported anymore…you have to certify school hours to get house payment"
"Lutheran Family Services helps with peer support, transportation, health care liaison, counseling (but not for now), telehealth appointments, aid in barriers to Veterans, and basic needs"
"Lodge 604 Elks provide food boxes, and distribute to Veteran's apartments…from Victory Place, every month on the second Wednesday of the month"
"When someone (Vet) moves into a place, they get a welcome home package"
"Is there a tax benefit to employers for hiring Vets…we can ask [redacted] at the Dept. of Labor, Hastings office, [redacted] at Dept of Labor or [redacted]- (supervisor to [redacted] at the Dept of Labor"
"We need more things that involve Community and Vets"
"Vets are hard to find, they don't come out to stuff, probably because of PTSD, their social skill/life is down the tube"
"Younger Vets don't want to be found. …some build a wall and don't let people in"
"I stay home because I don't have the resources"
"I build a wall and don't let people in"
"Vets have to have a person to connect them to other people and to be a resource"

Healthcare Access
Comments:

"One problem is, when you figure all this in for healthcare, some people with disabilities fall into loopholes because they don't fit the categories"
"I got a pneumonia shot from the VA about 5 years ago and I got it (pneumonia) that year, in the winter"
"One thing I want to know is when they are coming up with new flu vaccines is …do they consider environmental factors?"
"Working with Veterans, I always tell them to get a copy of their doctor's progress notes, so we can later review" (health literacy)
"My Healthy Vet – name of medical records program"
"Sign release form takes 10 day to get…you can go to CHI to get it faster"
"While in between jobs, I am looking for a job where I can get health benefits, so I don't have to go to the VA Hospital"
"Did you talk to [redacted]? He is the Director. He wants to hear if there is a problem"
"Transportation is an issue"
"Community Care Program- they go out into the community"
"They have Community Living Center and skilled care at the VA Hospital here. It isn't really a hospital"
"Is the new hospital going to make a difference, because the VA doesn't like working with CHI…They don't like working with any hospital"
"Grand Island VA is like a CBOC (Community Based Outpatient Clinic) – Omaha doesn't have one...they send them to Grand Island…for rehab care"
"So I'm on the phone with VA with people from Omaha….no phone calls returned, so then I got hooked up with NE Heart Institute…Got appointment set up the day I called, but then today I got a letter in the mail dated and signed from the person who helped me on the phone, saying that I couldn't be reached by phone to set up an appointment and after 14 days it expires….there is confusing communication"

"I'm in a study to detect the best type of vascular care…through the med center"
"Damn Choice Program from the VA"
"[redacted]… VA Director"
"The VA…. their main problem is they don't talk to each other. They are siloed in their departments"
"The only thing they have after 4:30 is on Tuesday…to get care at the VA"
"Their hours suck for a working guy, because you want to keep a job and then you live with problems"

Behavioral Health
Comments:

"I think also, not only with women but men are coming out more freely too" (mental health issues)
"Mental health is a huge gap, we have some services here, but I was lucky…. [redacted] helped connect me…. there is a lot of PTSD"
"The VA struggles with Psych services to get medications, find and reso they use teleconference – It's good for emergency situations, but you lose the personal connection and visual body language, and it's easy to prescribe medications"
"Getting Psych care in rural communities is difficult"
"They are giving scholarships to psychologists to come to rural areas"
There is a shortage of behavioral/mental health….my brother had to wait 1 1/2 months to get seen"
"There is a Resident Psychologist that rotate between departments at the VA…. 3 total, I think…the process is slow of getting psychologists"
"I have ADHD. I know that if you have to wait to get help and you wait 6 months, it is the difference between the suicide rate going up or coming down"
"When seeking Psych help, it's frustrating to not get the same person to talk to each time, because it takes 15 minutes to read records and then you have to start over with talking about everything"
"I don't like telecom- I want to be in front of them"
"I hated Telepsych…. then I went to Mid Plains and I had to fill out 3 pages of forms…then Region 3 assisted with my bills"
"Mid Plains has a sliding scale."
"The Grand Island VA is good with connecting to mental health, but they need providers there… but then there are snags…"
"The VA is good at connecting to providers at the VA"
"One snag is taking off time for appointments. You can lose your job if you miss work"
"There is a stigma to mental health issues"
"PTSD is a stigma…PTSD is on a spectrum, but you can't get service because of hours, which is hard because it leads to not getting treatments you need for conditions"
"A person may not know how to cope, be suicidal, have depression, etc."
"Years ago, there was a large recovery group meeting on the 4th floor in the evening"
"You don't get the treatment you need because you have to have a job to pay for life"
"People think that if you have PTSD you will be psychotic, angry and a dangerous person…that is not necessarily true"
"You may be depressed and suicidal"
"PTSD- They think for men it happens because of battle, and for women, it happens from sexual abuse. The truth is the sexual abuse goes on for men too"
"It takes 2 months to get a Telepsych appointment

Violence/Injury
Comments:

"Domestic Violence has a pretty broad definition"
"Would that include farming accidents?"

Location: Central District Health Department
Date: 3/11/19
Attendees: See sign-in sheet
CHA Community Input -CDHD Board of Health

Intro: Teresa presented the Central District Data PowerPoint.

Substance Use
Comments:
"I cannot believe kids in 8th grade are drinking alcohol"
"And some kids in 8th grade have tried marijuana…wow!"

Healthcare Access
Comments:
"So, in my (dental) practice, we know that Medicaid is difficult to work with and you don't get paid much….we work with patients who need dental care and then we just don't bill for it"

COMMUNITY HEALTH ASSESSMENT MEETING
Location: Extension Meeting Room
Date: 3.11.19
Attendees: See sign-in sheet
Latino Community Focus Group - CHA

Intro: Teresa Anderson
Teresa reviewed current data through PowerPoint Presentation and asked for group to respond during presentation on data- ex: are you surprised, do you agree, what is missing?

Alcohol and smoking in teens
Comments:

"Alcohol use is surprising to me. We are talking about 11 & 12-year olds. One out of every 4 – high number"
"My son is in 8th grade and some of his friends already tried alcohol or smoking"
"That's true" (to getting alcohol in parent's home)
"Alcohol education is needed for prevention for kids and parents"
"At the moment there are sessions for kids already affected by addictions, but not to prevent"
"Between a collaboration of 4 high schools, there is a lot of collaboration"
"There is video available to present by schools"
"New people are coming… drinking is normal in our countries at a young age"
"In Mexico, the legal age to start drinking is 18"

Teenage Pregnancy
Comments:

"we need data separating different ethnicities"
"There is some ethnic influence (culture) on domestic violence"
"Interested in teens…their ethnicity, pregnancy rates among different cultures…high in undocumented kids"
"A breakdown in ethnics for pregnancy in teens is not available"
"I know that pregnancy in Latino kids is high because of religion and culture"
"No access to prevention…. or ways to prevent"
"We need to work as a community to get the number down"
"See the male side too, not just the girl"
"When I was in high school, in sex ed class…didn't do much; just scared you about STD's, not pregnancy"
"Parents didn't authorize kids to attend the class because of religion and culture. Should not be able to opt out of these classes"

Access to Healthcare
Comments:

"Health Insurance is expensive"
"Small businesses cannot afford the insurance"
"JBS has you go through classes regarding their insurance and they go through the options. They do not go through it with you and explain it. Very quick class"
"JBS has a good insurance plan, but a lot of people that get hired there don't take insurance because think they don't need it"
"They think that they don't need it at the moment and prefer to send the money to their families"
"That's what happens with Cubans; in Cuba medical care is free, so think it is free here"
"The plans are presented to employees but there is no encouragement to use it, causing a lack of understanding"
"Too much money; the benefits are good but not worth it" (insurance)
"Latino community working on Latino business: doesn't get any kind of health insurance"
"It is $750 a month for husband and wife….Not worth it for me….Too expensive…we do not go to the doctor….would pay $9,000 for whole year…I do not spend $9,000 a year on medical care…When I go to the doctor, I do not spend $9,000 for care….Still do not see it worth it"
"More education is needed from insurance companies with different options"
"Access to healthcare is better in Florida; they have more options, and regulations are different in every state"

Healthy lifestyle
Comments:

"Diet, exercise" (obesity)
"Busy lives"
"Too cold to go out for a walk"
"Latino diet is high in carbohydrates…a lot of tortillas"
"Food with too much carbohydrates and fat"
"Drinks with a lot of sugar"
"When kids eat home cooked food, it is cooked the same way with a lot of carbs and fat"

"People are just too busy to cook"
"How many still cook home-made meals for kids or family"
"The DPP classes that the Health Department provides are really good, I was going with my mom and my 8-year old girl, but they did it when the weather wasn't good and I had to stop going to the classes…they need to change dates and times"
"There are no free places to go for kids in the cold weather"
"YMCA has a lot of activities that are not well promoted to all the community to use…a lot of Latino people are already participating"
"In my country they have Zumba free for people in parks… a lot of different options"
"People will change if they want to change… in our country, they are different"
"They come here and want to eat American food"
"It's not about the country…it is about you"
"It is our culture; we eat a lot of tortillas and rice"
"We have a lot of options…. either we want to change or not. We don't only have tortillas and rice, we also have vegetables and fruits"
"It doesn't matter if it is people with low level of education"
"Latinos are family- based, they stay home, eat together… Parents try to teach Spanish to kids, but we are losing all our good models"
"People prefer just to receive the benefits, but not listen to the teaching education"
"People are not listening…. too busy with activities in school… job is hard"
"There is a need to try to reach more people, even at church to try to teach them to eat healthy"
"Being healthy is too expensive"
"Healthy food is expensive"
"We like extremes, and can't figure out the middle"
"There is a need of community conversation"
"Hard to find parents to go to activities with their children"
"Eating healthy is expensive. I have 2 businesses – one my wife and I have for health and being healthy. A person gets a wakeup call when a mom or dad passes away. At a meat packing plant, I noticed a 60-year-old drank 2 Red Bulls – when he got home, he probably passed out"
"There is a lot of consumption of sugar drinks in the meat plant"
"Eating healthy is more cost, having access to health care and working overtime to pay insurance, but I try to be healthy to keep up for my kids"
"How to capture people? How to target the community? A commitment is needed"
"Insurance is expensive; how do we make a change in the next 25 years"
"How do we reach out to get a clearer snapshot of what is happening? Do we need to reach out in their language?"
"We have a lot of transition in the community…changing constantly; not aware of what is available"
"Talking about depression: In Latino communities you don't come out with being depressed – you are considered crazy"

Injury and Violence
Comments:
"How do we change it at the State's level?"

Housing
Comments:

"Good housing, but too expensive"
"House and rental options are expensive"
"There are programs to help, but not enough houses"
"Banks have a few programs for veterans and homeless to help them with houses"
"Need more support for help"
"A lot of people in the community don't have nothing and don't want help because of depression or other kind of problems.
"In Florida they sell apartments for a more accessible price"
"There is as list every year for people to sign up and qualify for help"
"There is a need for more affordable houses in Grand Island.
"People are forced to live in substandard housing"
"Grand Island doesn't have housing regulations, just Lincoln and Omaha… they are working on laws"
"Standard complex units: People think that at least it is better than what they used to have"
"How do you measure a standard, when they live in substandard housing and say it is still better then what lived in before?"
"Some people stay living in the same condition because is a cultural thing"

On July 27, 2016 during the last MAPP process participants discussed Forces of Change (results in table Figure 7) and determined top health priority areas. As the data was reviewed, Forces of Change was also asked to be considered and commented on. Forces of Change exercise was not repeated in 2018.

Six different areas of need were discussed:
1) Behavioral/Mental Health
2) Injury and Violence
3) Obesity
4) Maternal, Infant, and Child Health
5) Access to Health Care
6) Substance Abuse

For these areas, participants were asked to consider three questions, results below.

Behavioral Health – Mental Health (#1 – 21 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Social media • Bullying and suicides drive us to look for solutions	• Violence is related to mental health • Negative publicity • Lack of service • Lack of education and/or insurance • Lack of practitioners • Stigma • Lack of parental supervision • Lack of personal, one-on-one communication due to overuse of social media • Lack of flexibility to treat the patient at their worksite	• EAP • Governm ent mandate • A few counselors

Injury and Violence (4 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Police presence • Safety devices • Safety directors • Safety features in vehicles	• Violent video games • News • Unsupervised children • Desensitization • Lack of understanding of other cultures • Increased presence and use of drugs and alcohol abuse • I-80	• Police and law enforcement • School systems • Local business

Obesity (#2 – 13 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Employer wellness programs • Employers • Political climate • Technology – fit bit • Trail system • School focus on health	• Increased stress • Lack of time • Immediacy mentality • Increased amount of screen time • Lack of knowledge • Lack of motivation • Sedentary lifestyle • Lack of understanding on what motivates people to change • Fast food •	• Schools • Employers • Leaders in the community • City trails • UNL extension dietitian

Maternal, Infant, and Child Health (2 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Prenatal classes • Breast feeding class • Parental presence • Proximity to specialists • Public immunizations • Sports activities • Parks • WIC program • Stable family life	• Lack of parental presence • On the go mentality • Lack of education • High divorce rate • Lack of education • Lack of family stability	• MCHI • Bike inspection • Car seat inspection • Backpack program • Police department • Fire department • Food pantry • City maintaining parks

Access to Health Care (2 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Outside and specialty clinics • Early morning clinics • Healthcare directory • Patient portal • Health fair • School screenings • School impact • Concussion screenings • Rx assistance program	• Finances • Perceptions of bigger is better • Transportation • Poverty • Insurance	• School system • County ambulance

Substance Abuse (#3 - 9 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• AA • NA • DARE/Police • Counselors • CDC guidelines	• Denial of problem • Midwest mentality of alcohol abuse	• Police • EAP • School

Prioritization of these focus areas was then done with criteria to focus on what would have the biggest impact on health in the next three years. The 2016 top three picked were:

1. Behavioral health – Mental health
2. Obesity
3. Substance Abuse

Appendix B

Aurora Memorial Community Health

A group of Memorial Community Health staff and Central District Health Department staff met on September 25, 2019 to revisit the needs of their community. The group reviewed data gathered by Central District Health Department for the health departments district area and data specific to Hamilton County.

While listening to the data, participants were asked to consider the data and comment with thoughts and questions. Below are the narrative notes.

Location: Memorial Health Center
Aurora Nebraska
Date: September 25, 2019

Teresa presented data on Hamilton County by PowerPoint. Those in attendance were asked to voice their thoughts on the data presented, what was surprising, what was missing.

These are the comments captured during discussion
Comments
On Vaping….
Vaping affects kids so much faster than smoking
Vaping is scary for parents
Vaping is easy to hide
Vaping marketing says deaths are due to THC not vaping
1 vape cartridge is so addicting, it is the same as 1 whole pack of cigarettes
Vaping – higher than we know for teenagers
"Don't know a teen that doesn't (vape)"
Teens vape in the locker rooms at schools after sports events

On Cancer…
Higher rate of Cancer in Hamilton county?
Prostate cancer was high in the past, is it still now?
Possibly due to better early detection
http ://dhhs.ne.gov/Reports/Cancer%20Incidence%20and%20Mortality%20in%20Nebraska%20-%202015.pdf

On Parkinsons…
Heard possibly higher Parkinson's rate
Parkinson rates higher in NE & MN?

On Sex Trafficking…
Sex trafficking is something you just hear about
More attuned to sex trafficking news when you have young kids

On Lifestyle…
Obesity, how it relates to community behavior
Passion for wellness
Access to healthy food and clean water
Water is not as clean as it could be
City water is borderline pass

On behavioral health care…
Access to psychiatrist
Behavioral health, limited access
Mental health screenings
Identifying mental health issues early
Mental Health stigma
Need training on asking the right questions for mental health screenings for kids and adults
Memory care access for seniors

On Senior dental needs…
Senior long term care
Dental care for those without insurance is very limited
52 people in senior care last month needed extractions due to poor dental care access

On Using devices while driving…
Texting and driving or "device" and driving
Vision screening for elderly limited
Videoing self while driving

Then the attendees were asked to self-select to further discuss potential areas of focus. The group divided into two subgroups as follows:

In the "Lifestyles" group
Immunizations rates for over 65 seems low
Easier to get unhealthy food
Youth center gives free nachos for food
Rather than focus on just obesity, focus on whole health
Healthy behavior promotions needed
Work with key community stakeholders
Address habits
Access to food education
Childhood obesity is carried to adulthood
Poverty levels
Vaping use
Breakdown an area of focus per year
Difficult to eat healthy in Aurora

In the Behavioral Health Group
No providers
Unable to keep providers in the area

Can't get access earlier than 2 weeks
Telehealth rather than in person is not as effective
Other specialties not sending in mental health reports
Need more providers
Need wrap around care
Dual roll providers
No mental health counsellor in school
No follow-up on screenings
EAP (Employee Assistance Program) comes to town to see people
Recruitment issues
Medicaid coverage issues
Telehealth better than nothing but not great
Low referral rates from PCP's
Low patient follow-up for telehealth appointments due to trust
No ADD or ADHD for under 12

On June 29, 2016 during the last MAPP process participants discussed Community Themes and Strengths (results in table Figure 8) and determined top health priority areas. Community Themes and Strengths exercise was not repeated in 2018.

Six different areas of need were discussed:
1) Obesity
2) Behavioral Health – Mental Health
3) Substance Abuse
4) Maternal, Infant and Child Health
5) Injury and Violence
6) Access to Health Care

HAMILTON COUNTY COMMUNITY MEETING

Location: Bremer Community Center, Aurora Nebraska
Date: November 15, 2019
Attendees: See sign-in sheet
CHA Community Input -Hamilton County Community Members

QUESTIONS AND COMMENTS

DATA IN GENERAL
What was the reason for lack of school participation in survey?
Why is median used instead average for income?
There are so many questions when we go to Dr that it is depressing.
Questions regarding mental health in Dr's office have gone too far.
I don't know if just telling people they have depression is right.
Questions can be misleading.

Lots of subjective decisions made on answers.
Statistics skewed due to county numbers.
Hamilton county is not accurately represented in data.
Can we get teen birth rate for Hamilton Co.
Sex traffic data is for girls only?

CANCER
Cancer is perceived as an issue in Hamilton Co.

LIFESTYLE
No centralized place for physical activity.
Several individual places but not joint coordination.
Get dollar'ed and cent'ed to death for memberships in each place for exercise.
Need 1 central place with 1 membership for exercise.
When looking at obesity and overall health at centralized location or initiative would be great.
Hospital does great job with outreach and educational opportunities (Diabetes program).
Would be great to see numbers of attendees to classes offered by hospital.
Would be nice to have a warm water pool for those who have arthritis

VAPING
Would like to see true vaping numbers.
Don't agree with hospital vaping numbers.
Need to jump harder on the vaping issue now and don't wait like was done with smoking.
Don't know what is really in vaping juice.
It is definitely popular in schools.
Worried about kids and the nicotine addiction.
Nicotine is so addictive.
Do kids actually really know the info on vaping?
Is better education the key?
Would like to see Hamilton Co. Cities and villages go vape free
Need to be able to enforce it
When finally went smoke free, public did policing for most part.

BEHAVIORAL HEALTH
Providers for mental health are hard to access.
People go to GI or York.
Stigma is still an issue.
People don't realize that mental health is not about being "crazy."
Need to reduce stigma.
Veterans don't seek help as it is seen as weakness.
Locate mental health practitioners in the hospital so cars blend in with other services.
County supports Region 3 mental health.
People in county don't know about services.

NUTRITION
Food access – senior center and meals on wheels.
Hamilton Co. didn't qualify for FEMA funding during floods so meals on wheels staples boxes were cut.
Program at Leadership Center with food and games didn't qualify as a diversion program so it was was stopped after summer.
Program during summer provided care and food for kids at home with no parents and who relied on school meals.

Youth center run by [redacted].

SOCIAL DETERMINANTS
Low income – about 12 homes in mobile home park.
1 home doesn't have a door.
Mobile home park in very sad shape.
Worried that it is pest infested.
Kids that live in the mobile home park area play almost on street on highway 34.
Trail goes around mobile home park, so some people avoid using it.
Lot of kids at youth program came from park.

Health Concerns
Issue with trash dumping by Marquette.
Summer program was answer to food for kids on free lunch program.
Concerned about vaccinations rates for kids from low income.
VFC at hospital.
WIC in Aurora is through CNCAP.

WIND TURBINES
Wind turbines proposed for area.
Infra sound concerns for migraines, vibrations, tinnitus.
Where can people get facts?
Info on internet often skewed one way or other.

For these areas, participants were asked to consider three questions, results below.

Behavioral Health – Mental Health (#2 – 6 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Health care professionals • Demand • Stress	• Gap in Psychiatry/Psychology professionals. There is a lack of professionals to meet their need. • Stoic people not willing to admit that mental health is a disease. • Shame factor	• Hospital • Health care providers

Injury and Violence (1 vote)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Low levels of violence in the community • Police force in connection with schools	• Hidden issue of domestic violence • Rural agriculture and country road intersections present safety concerns.	• Police and law enforcement

Obesity (#1 – 8 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Swimming pool • Trails • Wellness programs at the hospital • Community sporting activities	• Too many fast food places. • Too many gadgets and electronics • Lack of healthy eating options • Is technology in school from kindergarten promoting a sit-down culture? • Increased levels of eye stain • Time factor • Portion size • Education (or lack of)	• Schools • Hospital dietician • Hospital • Community garden • Fitness Center • Community

Maternal, Infant, and Child Health (5 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Hospital still offers baby care and deliveries. • Birthing room at hospital • Availability of OB/GYNs in Grand Island • WIC • State run immunization clinics • Maternal educational level • Nutrition education	• Fast food • Lack of education • School meals could be more nutritional •	• Hospital • Schools

Access to Health Care (1 vote)		
Propel us forward	***Hold us back***	***Who is doing what?***
• More open discussions on mental health • Better insurance coverage for preventative health • Local access to a hospital and providers • More research on Alzheimer's and other prominent conditions	• Stigma • Today's young people are the first generation not expected to live as long as their parents.	• Hospital

Substance Abuse (#3 - 3 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Law enforcement • Legal system	• Availability of illegal drugs • Relatively easy to abuse prescription drugs • Easy to access and abuse pain pills in parent's medicine cupboard • Demand for illegal drugs • Lack of inter-personal relationships • Increased levels of stress • Skewed priorities • Lack of substance abuse counselors	• Law enforcement • Legal system

Prioritization of these focus areas was then done with criteria to focus on what would have the biggest impact on health in the next three years. The 2016 top three picked were:

1. Obesity
2. Behavioral Health – Mental Health
3. Substance Abuse

Appendix C

Merrick Medical Center

A group of Merrick Medical Center staff, Central City community members, and Central District Health Department staff met on November 11, 2018 to revisit the needs of their community. The group reviewed data gathered from a community survey hosted by Merrick Medical Center. Teresa Anderson, Executive Director of the Central District Health Department, shared data collected for the area served by the Central District Health Department and data specifically for Merrick County.

While listening to the data, participants were asked to consider the data and comment with thoughts and questions. As the data was reviewed, Forces of Change was also asked to be considered and commented on. Below are the narrative notes.

Location: Bryan Merrick County Medical Center
Date: 11/30/18
Attendees: See sign-in sheet
Community members and hospital staff

Teresa presented data on Merrick County by PowerPoint. Those in attendance were asked to voice their thoughts on the data presented, what was surprising, what was missing.

Access to Care
Comments:

"We need flex hours at the clinic" (identified by 3 people)
"We need to increase number of providers"
"For mental health access: We need more providers…. I see a lot of it in kids and parents both"
"A rheumatology specialist is needed"
"Are people applying for low income medication programs?"
"Sick kids can't get into the doctor because parents work….they are not available after hours"
"Health literacy….parents don't know when to go to doctor….they lack knowledge"
"Cost of health services….employers spend a lot on insurance"
"Parents come in (to the doctor) and want everything done; they can't take time off work, so they want all their needs met at one visit…we can't accommodate that….we are busy seeing sick people; the people who use the system appropriately."
"People who can't afford it…they have no way to get it. I feel extremely overwhelmed and a sense of guilt because I can't help them, but I have federal rules that include screenings, etc."
"We need to create news releases at a fifth-grade level; the health literacy issue is huge. How do we reach people?"
"People still don't know what is going on. I had a guy with a blood pressure of 170/120 and he didn't know that was high…I felt like a failure"
"Where do we educate people… I heard about a Lincoln School project in Grand Island with a community school project.

Culture of Health
Comments:

"Big increase in Obesity/Diabetes" (identified by 3 people)
"Access to exercise: the fitness center is great, but not everyone can afford it"
"The trail is wonderful when the weather is nice"

"Stromsburg School opens its gym to the public"
"High Plains School offers memberships at $10/month"
"Health screenings: not many people using them"
"People need education…education piece on prevention"
"Phones are in kids' hands constantly. This is the problem with today's society…there is nobody making mud pies anymore"
"The Merrick County Foundation will have open gym in its new building. …volleyball, jump rope, kids can hang out until 6p. This will give them an opportunity to have something to do"
"We need to start programs for young kids on exercise and eating right….start young"
"We don't have access to safe routes to school and Nebraska bike trails"
"Obesity leads to falls and balance issues"
"Teaching kids to eat healthy…I hear it is too expensive to eat healthy….they wouldn't listen to me"
"Someone should be at the grocery store, presenting information on buying healthy foods"
"There is nowhere to buy pre-prepared healthy meals like HyVee has… I end up buying Runza"
"Our local grocery store doesn't make pre-prepared foods"
"Mr. Jensen talked about opening the gym- but who will supervise?"
"Child Care has a long wait list"
"Diet information for kids and adults is needed"

Aging population
Comments:

"Bryan Life Point: socializing, exercise, mental health, decreasing comorbidities"
"Young people and old people can benefit from Tai Chi"
"There are areas where people live 15 years longer…sometimes they move in with their kids"
"Two key areas where people are more likely to die: at birth and at retirement"
"We need better follow up for med compliance. There are people at home….we need to help homebound people prevent falls"
"Paying for medications….people are staying in their homes longer when it isn't safe"

On May 2, 2016 during the last MAPP process participants discussed Forces of Change (results in table Figure 9) and determined top health priority areas. As the data was reviewed, Forces of Change was also asked to be considered and commented on. Forces of Change exercise was not repeated in 2018.

They determined six different areas including:
1) Behavioral/Mental Health
2) Injury and Violence
3) Obesity
4) Maternal, Infant, and Child Health
5) Access to Health Care
6) Substance Abuse

For these areas, participants were asked to consider three questions, results below.

Behavioral Health – Mental Health (#2 – 10 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Four group homes for behavioral health • Therapist in the community • Public school counselor • Strong communication between the group homes and Mary Lanning • Excellent relationships with law enforcement • Outpatient Clinics • Primary care providers	• Four group homes have guardians and caretakers who are not local • Lack of knowledge of inpatient care in the group homes • Lack of supervision in the group homes • Professional shortage is in behavioral health for counselors throughout the entire state but most pronounced in the rural areas • Lack of community understanding of behavioral health issues • Negative stigma associated with individuals receiving care for behavioral or mental health issues.	• Outpatient clinics • Group homes • Primary care providers • Schools • Mary Lanning crisis line • Mary Lanning support • Hospital

Injury and Violence (0 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Great law enforcement • Hospital is certified in trauma care • County attorney • Lack of acceptance in the community for violent behavior • Parenting plans for divorcing parents • Everyone is working well together.	• Socio economic status • Poverty • Drug superhighway (I-80 and Hwy 30) • No local crisis center • Many services needed in Merrick are only available in Grand Island – transportation to Grand Island can be a challenge. Thus, Merrick county residents do not access many services they could. • Proximity to a larger metro area (Grand Island) can increase some of the social problems. This is the case in Chapman. • Texting while driving • Technology/social media	• Law enforcement • Hospital • County services • Schools • Excellent collaboration among multiple stakeholders • Extension Parents Forever

Obesity (#1 – 11 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Walking trail • Pool • Fitness center • Weight watchers • Wellness center at the hospital • Wellness programs at the hospital • Community sporting activities	• Money • Expensive to eat health • Time – planning meals, shopping etc. • Lack of interest and/or understanding • Lack of linkage between obesity and health • Need stronger Parks & Rec. • More scheduled activities • Lack of educated adults • Lack of parenting skills	• Schools • Hospital dietician • Hospital • Community garden • Fitness Center\ • Community

Maternal, Infant, and Child Health (5 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Child development center • Youth programming at the fitness center • Head start • Adult center • Preschool • 4-H • Merrick County Youth Development center • CNCS • CDC education	• No pediatrician • No OBGYN • No child deliveries • Lack of education on the services we promote	• Merrick County Youth Development Center • Head Start – Home Visits • CNCS – Family Services • 4-H • CDC

Access to Health Care (#3 – 6 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Awesome hospital • Hospital does not turn anyone away • Four (young) physicians • Three Pas • Trauma certified • Multiple dentists (2) • Fully staffed hospital	• Some of the dentists do not see Medicaid patients • Lack of space and resources to expand services • Lack of extended hours • Lack of acute after hours' care	• Hospital • Specialist • Dentists • Eye Care Associates • Chiropractor • Two drug stores • Physical Therapist

Substance Abuse (4 votes)		
Propel us forward	***Hold us back***	***Who is doing what?***
• Merrick County Youth Counsel • AA • MAPS and COPE group	• Some struggles with providers • No drug and alcohol evaluations • Cultural acceptance of drug and alcohol use	• Hospital • Merrick County Counsel • AA

Prioritization of these focus areas was then done with criteria to focus on what would have the biggest impact on health in the next three years. The 2016 top three picked were:

1. Obesity
2. Behavioral health – Mental health
3. Access to health care

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