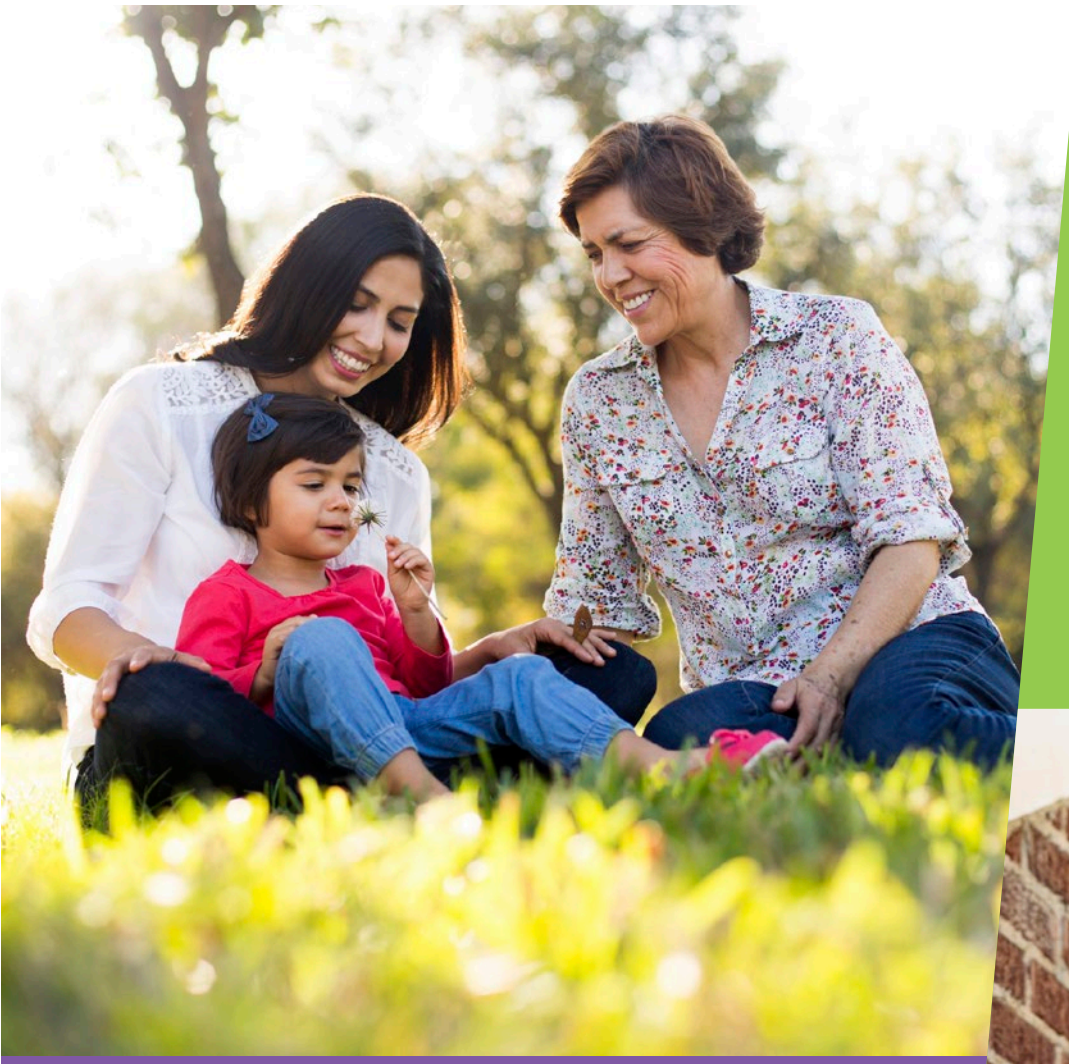
Community Health Needs Assessment

CHI Health St. Francis – Grand Island, NE

2016



CHI Health

CHI Health Saint Francis Community Health Needs Assessment Report

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Executive Summary

"The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities."

CHI Health is a regional health network consisting of 15 hospitals and two stand-alone behavioral health facilities in Nebraska and Western Iowa. Our mission calls us to create healthier communities and we know that the health of a community is impacted beyond the services provided within our wall. This is why we are compelled, beyond providing excellent health care, to work with neighbors, leaders and partner organizations to improve community health. The following community health needs assessment (CHNA) was completed with our community partners and residents in order to ensure we identify the top health needs impacting our community, leverage resources to improve these health needs, and drive impactful work through evidence-informed strategies.

CHI Health St. Francis is a 159-bed hospital facility within CHI Health located in Grand Island, Nebraska. The Hospital provides services including alcohol and drug treatment, cancer treatment, heart care, obstetrics, neuroscience, orthopedic and surgical services across several counties in central Nebraska.

CHI Health Saint Francis Community Health Needs Assessment

In fiscal year 2016, Saint Francis conducted a Community Health Needs Assessment (CHNA) in partnership with Central District Health Department and numerous community partners. The CHNA process included both primary and secondary data collection, and community engagement sessions to determine the needs of the community.

The CHNA led to identification of seven priority health needs for Hall, Hamilton and Merrick Counties. With the community, the Hospital will further work to identify each partner's role in addressing these health needs and develop measureable, impactful strategies. A report detailing Saint Francis' implementation strategy plan (ISP) will be released in November, 2016.

The process and findings for the CHNA are detailed in the following report. If you would like additional information on this Community Health Needs Assessment please contact Kelly Nielsen, Kelly.nielsen@alegent.org, (402)343-4548.

Introduction

Hospital Description

CHI Health is a regional health network with a unified mission: nurturing the healing ministry of the Church while creating healthier communities. Headquartered in Omaha, the combined organization consists of 15 hospitals, two stand-alone behavioral health facilities and more than 150 employed physician practice locations in Nebraska and southwestern Iowa. More than 12,000 employees comprise the workforce of this network that includes 2,820 licensed beds and serves as the primary teaching partner of Creighton University's health sciences schools. In fiscal year 2015, the organization provided a combined $172.1 million in quantified community benefit including services for the poor, free clinics, education and research. Eight hospitals within the system are designated Magnet, Pathway to Excellence or NICHE. With locations stretching from North Platte, Nebraska, to Missouri Valley, Iowa, the health network is the largest in Nebraska and serves residents of Nebraska and southwest Iowa.

Saint Francis, located in Grand Island, Nebraska, is a nonprofit, faith-based healthcare provider as part of CHI Health. Founded in 1883 by the Sisters of Saint Francis, this hospital is now a regional treatment center, with more than 100 physicians and 1,100 employees working together to build a healthier community. With 159 licensed beds, Saint Francis has extensive experience in the treatment areas of:

- Alcohol and Drug Treatment Center
- Cancer Care
- Wound/Ostomy Center
- Diabetes Education
- Emergency & Trauma
- Family Birthing Center
- Heart Care
- Home Care/Respiratory Care
- Imaging
- Lifeline
- Neuroscience
- Orthopedic Services
- Pediatric
- Rehabilitation
- Sleep Disorders
- Surgical Service

Purpose and Goals of CHNA

CHI Health and our local hospitals make significant investments each year in our local communities to ensure we meet our Mission of creating healthier communities. A Community Health Needs Assessment (CHNA) is a critical piece of this work to ensure we are appropriately and effectively working and partnering in our communities.

The goals of this CHNA are to:

1. Identify areas of high need that impact the health and quality of life of residents in the communities served by CHI Health.
2. Ensure that resources are leveraged to improve the health of the most vulnerable members of our community and to reduce existing health disparities.
3. Set priorities and goals to improve these high need areas using evidence as a guide for decision-making.
4. Ensure compliance with section 501(r) of the Internal Revenue Code for not-for-profit hospitals under the requirements of the Affordable Care Act.

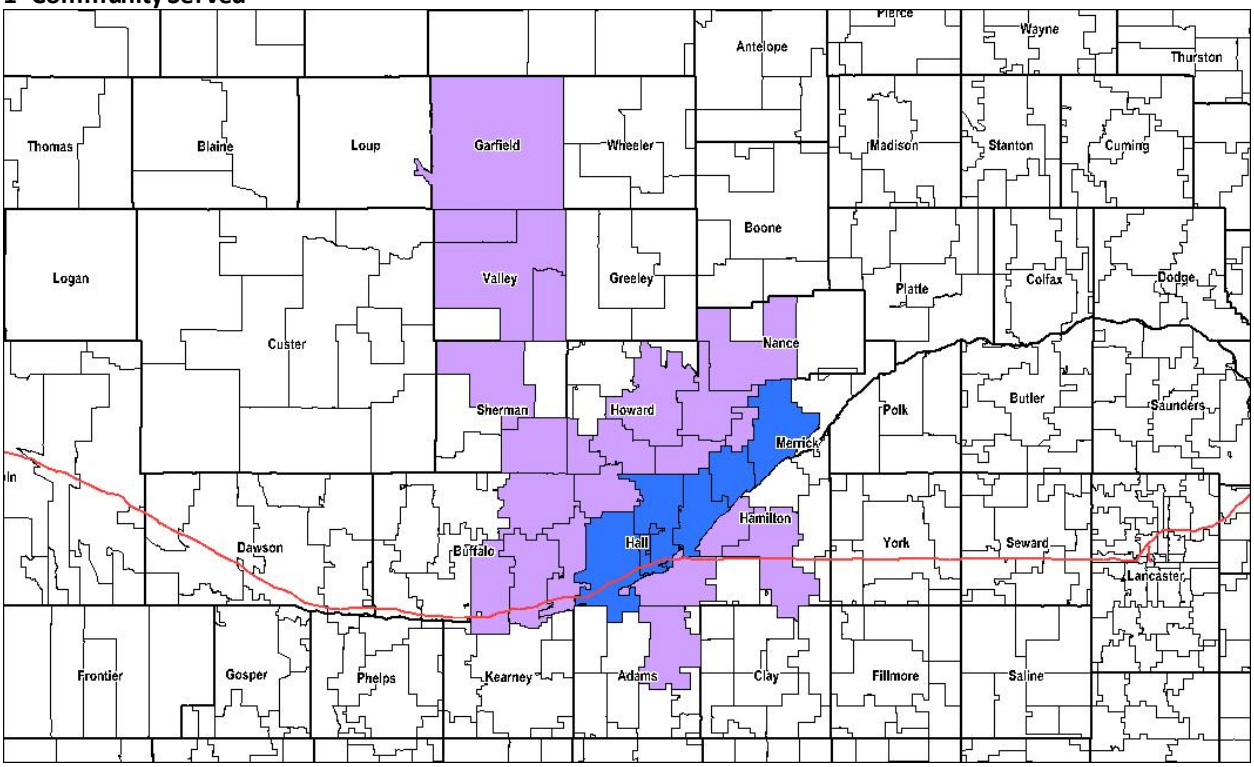
Community Definition

For the purposed of the CHNA and future implementation strategy, Saint Francis defines the communities served as Hall, Hamilton and Merrick counties in Nebraska. These counties include the primary service area and portions of the secondary service area for Saint Francis, thus covering between 75% - 90% of patients served by the hospital. This definition was confirmed by an interdisciplinary team from the hospital [Community Benefit Action Team (CBAT)] and aligns with a shared definition agreed upon with community partners and the local health department, Central District Health Department (CDHD).

Specific County Information:

- Hall County covers approximately 546.29 square miles, including five communities with 61,492 residents.[4] It is bounded on the north by Howard County, on the east by Hamilton and Merrick, on the south by Adams and on the west by Buffalo.
- Hamilton covers approximately 542.88 square miles, including six communities with 9,135 residents.[4] It is bounded on the east by York, south by Clay, west by Hall, and north by Merrick counties.
- Merrick covers approximately 484.88 square miles, including five communities with 7,766 residents.[4] It is bordered by Nance County on the north, the Platte River separating Polk and Hamilton Counties, on the east and south, and Hall and Howard Counties on the west.

Figure 1- Community Served[1]



Community Description

Population

As shown in Table 1, the 2014 population estimate for the three county area was 78,393.[4]

Hall County: Between 2010 and 2014, Hall County's population increased by 4.9% or from 58,607 people to 61,492 people. The number of persons from 15 to 24 years of age changed from 7,418 in 2010 to 8,072 in 2014, an increase of 8.8%. Between 2010 and 2014, the White population increased by 3.8%, while the Black population increased by 36.3%. The Hispanic population of any race changed from 13,653 to 15,912, an increase of 16.5%.[2,4]

Hamilton: Between 2010 and 2014, Hamilton County showed nearly no growth in population size (0.1%). Between 2010 and 2014, the White population decreased by 0.7%, while the Black population increased by 73.7%. The Hispanic population of any race changed from 181 to 269, an increase of 48.6%.[2,4]

[1] DSS IP/OP CY2015 data for all CHI Health hospitals

[2] Western Economic Services -United States Census Bureau. (2015). Retrieved from: http://www.westernes.com/nepdfs/current/Buffalo%20County.pdf

Merrick: Between 2010 and 2014, Merrick County's population decreased by 1.0%, or from 7,845 people to 7,766 people. Between 2010 and 2014, the White population decreased by 2.0%, while the Black population increased by 63.6%. The Hispanic population of any race changed from 271 to 313, an increase of 15.5%.[2,4]

Table 1-Population[4]

	Hall County	Hamilton	Merrick	Nebraska
Total Population 2014[4]	61,492	9,135	7,766	1,881,503
Population per square mile (density)	107.3	16.8	16.2	23.8
Age				
% below 18 years of age	26.7%	24.5%	23.3%	24.8%
% 65 and older	14.2%	17.8%	18.8%	14.4%
Gender				
% Female	49.7%	49.7%	50.1%	50.2%
Race				
% Black or African American	2.7%	0.4%	0.5%	4.9%
% American Indian and Alaskan Native	1.6%	0.3%	0.6%	1.4%
% Asian	1.3%	0.3%	1.0%	2.2%
% Native Hawaiian/Other Pacific Islander	0.5%	0.0%	0.1%	0.1%
% Hispanic	25.9%	2.9%	4.0%	10.2%
% Non-Hispanic White	69.4%	95.4%	93.0%	80.5%

Socioeconomic Factors:

Table 2 shows key socioeconomic factors known to influence health including household income, poverty, unemployment rates and educational attainment for the communities served by the hospital. A review of the socioeconomic factors show Hall and Merrick Counties have higher unemployment rates (3.8% and 3.7% respectively) compared to Hamilton (2.9%) and the State (3.3%).[6] The median household income in 2014 was $49,178 for Hall, $58,382 for Hamilton, and $49,637 for Merrick County. This compares to the State median household income of $52,400.[4] Poverty rates for 2014 were higher in Hall (14.7%) compared to the other counties and the State (12.9%). Poverty rates in Merrick County (10.4%) and Hamilton County (6.9%) are lower than the State level.[4] High school graduation rates were similar for Hall (90%), Hamilton, (94%) and Merrick County (92%), which are all higher than the state high school graduation rate of 87%.[7]

Hall County is uniquely a multicultural community. The community is 31.6%[3] minority and 30 language dialects are spoken at Grand Island High School. Latino residents, representing numerous Central and South American countries, are by far the largest minority block (26.7% of the general population).[3] Many of these families are young and in transition as evidenced by school enrollment data. More than half (56.1%) of the enrollment is minority and 12%[3] of the students are in English language-assisted programs. A total of 61.5% of all families qualify for the federally funded free or reduced-lunch programs. Meanwhile the non-Latino white population is aging and declined 4% in the 2010 Census.[15]

Table 2: Socioeconomic Factors

	Hall County	Hamilton	Merrick	Nebraska
Income[4]				
Median Household Income	$49, 178	$58,382	$49,637	$52,400
Poverty Rates				
Persons in Poverty[4]	14.7%	6.9%	10.4%	12.9%
Children in Poverty[5]	19%	10%	15%	16%
Unemployment[6]				
Unemployment Rate	3.8%	2.9%	3.7%	3.3%
Education				
High School Graduation Rates[7]	90%	94%	92%	87%
Some College[8]	52%	76%	70%	70%
Uninsured[9]				
% of Population under 65 without insurance	22%	11%	17%	16%
% of Uninsured Children	7%	5%	6%	6%

Unique Community Characteristics

In Grand Island, Doane College and Central Community College provide students opportunities to pursue associates and bachelor's degrees.

[3] United States Department of Education. (2014). Nebraska Department of Education. accessed 3/20/16 Retrieved from: http://drs.education.ne.gov/Pages/default.aspx

[4] Source: US Census Quick Facts table (V2014 estimates) accessed 3/20/16 Retrieved from: http://www.census.gov/quickfacts/table/AGE775214/31079,31081,31121,31

[5] County Health Rankings- Small Area Income and Poverty Estimates (SAIPE). Retrieved from: http://www.census.gov/did/www/saipe/data/statecounty/data/index.html

[6] Bureau of Labor Statistics (2016). Retrieved from: http://www.bls.gov/lau/tables.htm

[7] County Health Rankings- EDFacts. (2016). Retrieved from: http://www2.ed.gov/about/inits/ed/edfacts/data-files/index.html

[8] County Health Rankings- The American Community Survey (ACS). (2016). Retrieved from: http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

[9] County Health Rankings- The US Census Bureau's Small Area Health Insurance Estimates (SAHIE). (2015). Retrieved from: http://www.census.gov/did/www/sahie/data/20082013/index.html

Other Health Services

Grand Island has a has a wide range of healthcare providers, including medical, dental, and mental health services that not only addresses the needs of the local population, but also residents from throughout Central Nebraska and from across the state. Central District Health Department as well as state agencies provide population health services. Some of the prominent providers, but not all, include:

- Heartland Health Center
- Grand Island Veterans Administration Medical Center
- Third City Community Clinic
- Central Health Center
- Urgent Care Clinics
- Population Health
- Central District Health Department
- CHI Health Saint Francis
- Saint Francis Cancer Treatment Center
- CHI Heart Health
- Grand Island VA Medical Center
- Litzenberg Memorial County Hospital
- Memorial Community Health
- Memorial Hospital

Community Health Needs Assessment Process

The process of identifying the community health needs in Hall, Hamilton and Merrick Counties served by Saint Francis focused on the use of data and community input from processes led by Central District Health Department (CDHD) and validated by Saint Francis's CBAT (see membership list below). This process included:

- A quantitative data review and analysis of health needs of the community including information on disease prevalence, health indicators, health equity, and mortality. Indicators were selected to align with national benchmarks.
- The data was reviewed by the Data Steering Committee, made up of community partners, including review of previous data to analyze trends and comparison to like counties and other benchmarks (e.g., Healthy People 2020) to help prioritize significant health issues. [19] (See *Appendix for list of the Data Steering Committee members*)
    - The data reviewed were primarily collected from the following sources:
        - Centers for Disease CHSI[10]
        - BRFSS[11]
        - Centers for Disease Control & Prevention, Office of Public Health Science Services[12]
        - National Center for Health Statistics[13]
        - National Cancer Institute, State Cancer Profiles[14]
        - US Census Bureau[15]

[10] Centers for Disease Control and Prevention. (2016). Community Health Status Indicators (CHSI). Retrieved from: http://wwwn.cdc.gov/CommunityHealth/

[11] Nebraska Department of Health and Human Services. (2016). Behavioral Risk Factor Surveillance System (BRFSS). Accessed 4/12/2016. Retrieved from: http://dhhs.ne.gov/publichealth/Pages/brfss_index.aspx

[12] Centers for Disease Control & Prevention, Office of Public Health Science Services. (2016). Accessed 4/12/2016. Retrieved from http://www.cdc.gov/ophss/index.html

[13] Center for Disease Control and Prevention. (2016). National Center for Health Statistics. Accessed 4/12/2016. Retrieved from: http://www.cdc.gov/nchs/index.htm

[14] National Cancer Institute, State Cancer Profiles. (2014). State Cancer Profiles. Accessed on 4/12/2016. Retrieved from: http://statecancerprofiles.cancer.gov/

- US Department of Health & Human Services[16]
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)[17]
- Nebraska Department of Roads[21]

- A Community Engagement Session was hosted at Saint Francis for Hall County, and as part of an ongoing community health improvement planning supported by the CDHD. Additional community engagement sessions will also be conducted in Merrick and Hamilton County in June, 2016.
- Following completion of the process, Saint Francis's CBAT reviewed the methods and findings to validate the information which will inform the hospitals' implementation strategy plan.
- Saint Francis presented the identified community health needs to their Patient and Family Advisory Committee for input and validation.

Members of the CBAT included:

Bill Brennan- CHI Health Saint Francis; Grant Development Coordinator
Dr. Shu-Ming Wang- CHI Health Saint Francis; VP Medical Affairs
Sandra Krolikowski- CHI Health Saint Francis; Director-Oncology-Med Surgery
Tami Smith- CHI Health Saint Francis; Patient Access Lead - ER
Jeff Vipond- UniNet; Director-Clinical Informatics
Amelia Swanson- CHI Health Saint Francis; Supervisor-Nursing
Cristy McElroy- UniNet; Director of Social Work
Cathy Brockmeier- CHI Health; Director-Marketing-Communications
Pam Pohlenz- CHI Health Saint Francis; Performance Excellence Coach Sr.
Mark Harvey- TPN; Nurse Practitioner of Family Medicine
Kelly Nielsen- CHI Health; Director of Community Benefit-Healthier Communities
Christy Burrows- CHI Health; Program Coordinator-Healthier Communities

Gaps in information

Although the CHNA is quite comprehensive, it is not possible to measure all aspects of the community's health, nor can we completely represent all interests of the population. This assessment was designed to represent a comprehensive and broad look at the health of the overall community. During specific hospital implementation planning, gaps in information will be considered and other data/input brought in as needed.

Input from Community

[15] US Census Bureau. Accessed 4/12/2016. Accessed 3/14/2016. Retrieved from: http://www.census.gov/

[16] US Department of Health & Human Services (DHHS). Nebraska Department of Health and Human Services. Accessed 3/12/2016. Retrieved from: http://dhhs.ne.gov/Pages/default.aspx

[17] US Department of Health & Human Services, Health Resources and Services Administration (HRSA). Accessed on 3/14/2016. Retrieved from: http://www.hrsa.gov/index.html

To obtain feedback from the general public, a community engagement session co-sponsored by Saint Francis and CDHD was held in Hall County to solicit the community's opinion about the important health, social, and environmental issues for the community. These stakeholders represent low-income, minority populations, medically underserved populations and the aging population. A planning specialist with the College of Public Health, Office of Public Practice with the University of Nebraska Medical Center, facilitated the event. Similar sessions are scheduled for June, 2016 for Hamilton and Merrick Counties. The hospital will consider the outcomes of Hamilton and Merrick County community engagement sessions during the implementation planning. The community engagement sessions included a brainstorming session with community stakeholders to review data, narrow down the list of health priorities, and identify threats and opportunities to address the health issue.

Organizations providing input at the community engagement session included:

- CHI Health Saint Francis
- Central District Health Department
- Doane College
- Central Community College
- Third City Community Clinic
- Grand Island Public Schools
- Heartland Health Center
- Grand Island Police Department
- Heartland United Way
- UNL Extension
- Hall County Collaborative
- UNMC College of College of Public Health
- UniNet (clinically-integrated network)
- Nebraska Action Coalition
- HyVee grocers

In addition, the CHNA was presented to the Patient Family Advisory Council at Saint Francis, which includes more than 20 community members. This group will provide input to support development of implementation strategies for the prioritized needs for the plan that will be released in November 2016.

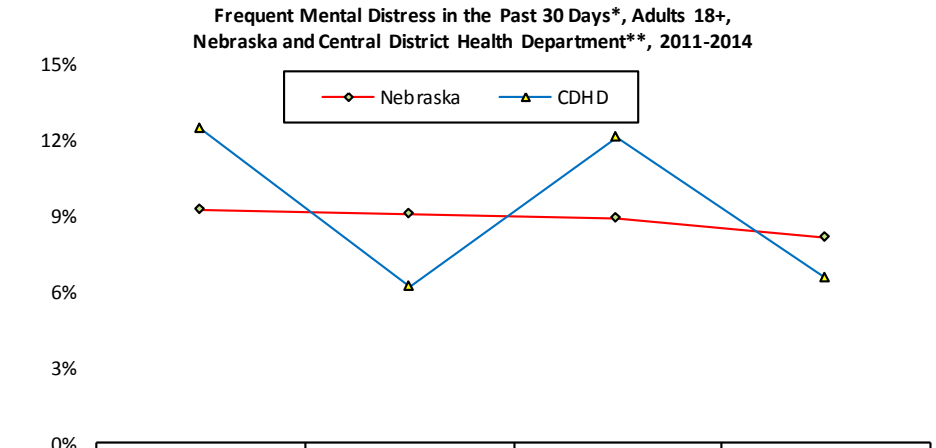
Findings

The following section provides information around each identified need and takes into account trends, benchmarks and disparities.

Behavioral Health / Mental Health

***Mental Distress*:** Percentage of adults 18 and older who report their mental health as "not good" (including stress, depression, and problems with emotions) in 2013 was 12.1%, which was higher than the State (8.9%), and has not reached the Healthy People 2020 (HP2020) Target (5.8%).[19]

Figure 2: Mental Distress[18]



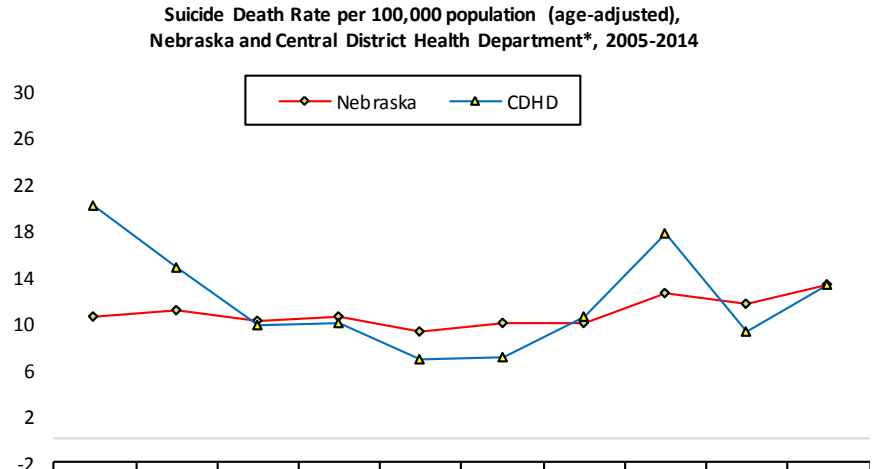
	2011	2012	2013	2014
Nebraska	9.2%	9.0%	8.9%	8.2%
CDHD	12.4%	6.2%	12.1%	6.6%

Suicide: The suicide death rate per 100,000 population (age adjusted) was 13.2 in 2014, is variable over time, [20] and has not reached the HP2020 Target (10.2).[19]

[18] Nebraska Department of Health and Human Services. (2015). Behavioral Risk factor Surveillance System (BRFSS). Accessed 4/18/2016. Retrieved from: http://dhhs.ne.gov/publichealth/BRFSS/BRFSS%202011-2014%20Detailed%20Tables%20for%20Central%20District.pdf

[19] U.S. Department of Health and Human Services. (2016). Healthy People 2020 Accessed 4/18/2016. Retrieved from: https://www.healthypeople.gov/

Figure 3: Suicide[20]

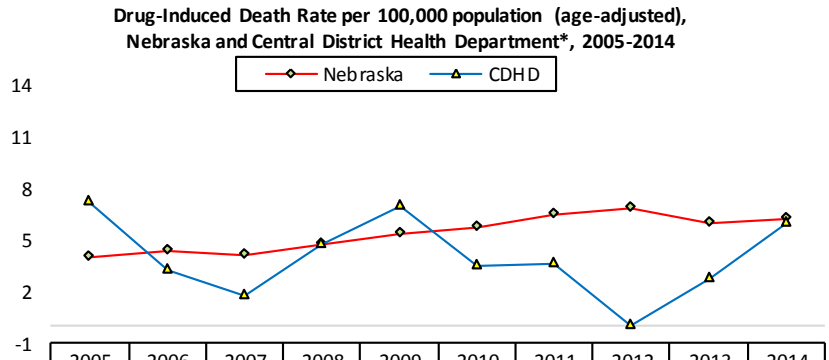


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	10.6	11.1	10.2	10.6	9.3	10.0	10.0	12.5	11.6	13.3
CDHD	20.1	14.8	9.8	10.0	6.9	7.1	10.6	17.6	9.3	13.2

Substance Use

Drug Induced Deaths: The age-adjusted drug-induced death rate (per 100,000) increased from 2.7 in 2013 to 5.9 in 2014, and has been consistently lower than the State rate from 2010 (5.7).[20]

Figure 4: Drug-induced Death Rate[18]

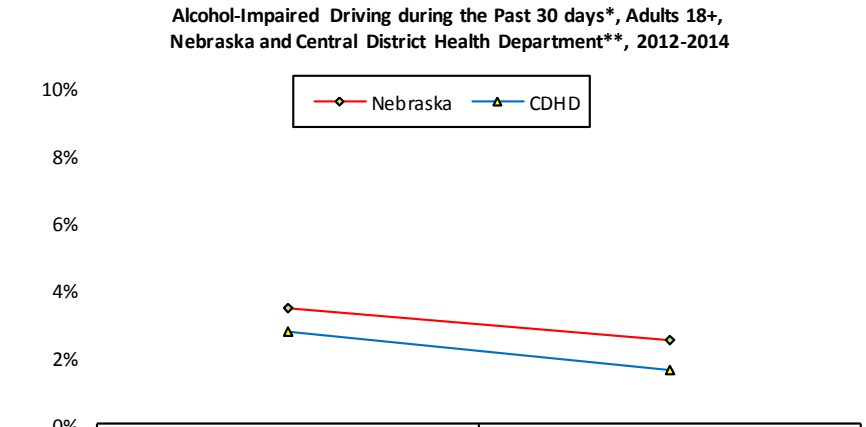


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	4.0	4.3	4.1	4.7	5.4	5.7	6.4	6.8	5.9	6.2
CDHD	7.2	3.3	1.7	4.7	6.9	3.5	3.6	0.0	2.7	5.9

Alcohol Impaired Driving: In 2014, adults 18+ reporting alcohol-impaired driving declined to 1.6%, which was slightly lower than the State (2.5%).[18]

[20] Nebraska Vital Records; National Center for health Statistics. Accessed 4/18/2016. Retrieved from: http://dhhs.ne.gov/Pages/stats.aspx

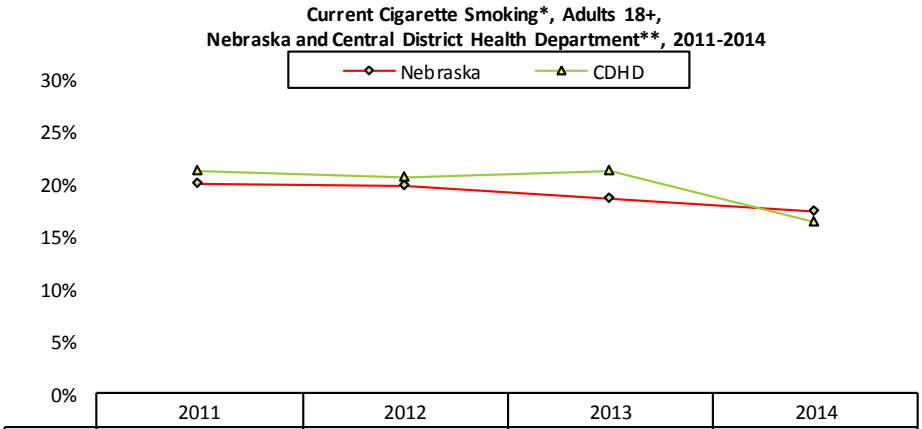
Figure 5: Alcohol Impaired Driving[18]



	2012	2014
Nebraska	3.4%	2.5%
CDHD	2.8%	1.6%

Tobacco Use: In 2014 16.2% of adults were current cigarette smokers, which is slightly lower than the State (17.4%)[18] and has not reached the HP2020 Target (12%).[19]

Figure 6: Current Smokers[18]

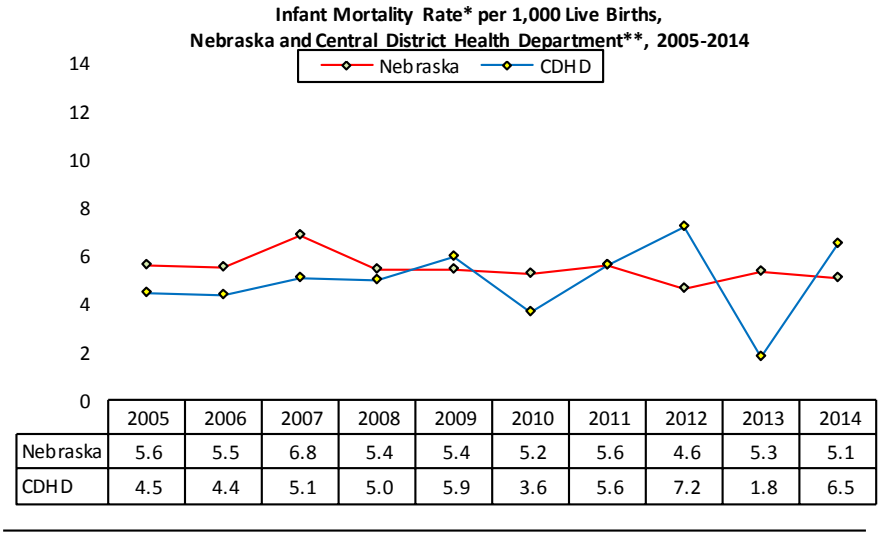


	2011	2012	2013	2014
Nebraska	20.0%	19.7%	18.5%	17.4%
CDHD	21.3%	20.6%	21.3%	16.2%

Maternal, Infant & Child Health

Infant Mortality: In 2014 the infant mortality rate was 6.5 per 1,000 births, which was higher than the state infant mortality rate (5.1)[20] and has not reached the HP2020 Target (6.0).[19]

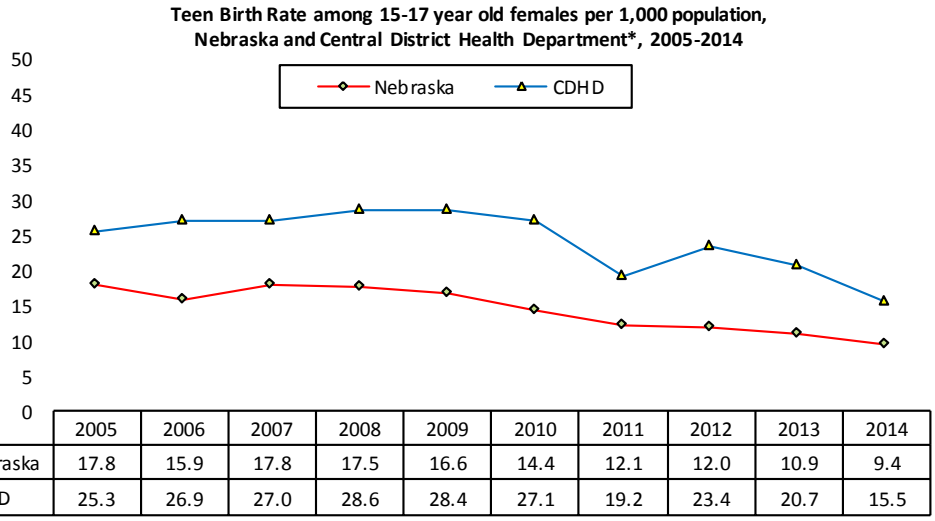
Figure 7: Infant Mortality Rate[20]



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	5.6	5.5	6.8	5.4	5.4	5.2	5.6	4.6	5.3	5.1
CDHD	4.5	4.4	5.1	5.0	5.9	3.6	5.6	7.2	1.8	6.5

Teen Births: The teen birth rate among 15-17 year old females was 15.5 per 1,000 population, which is higher than the State teen birth rate (9.4).[20]

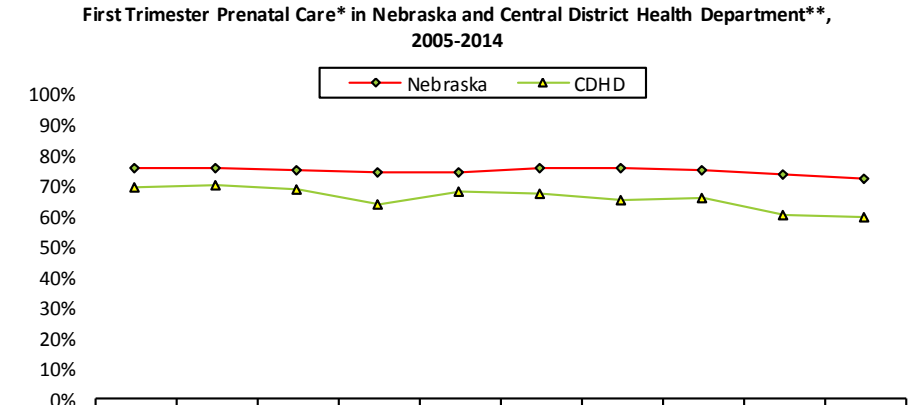
Figure 8: Teen Birth Rate among 15-17 years old Females per 1,000 population[20]



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	17.8	15.9	17.8	17.5	16.6	14.4	12.1	12.0	10.9	9.4
CDHD	25.3	26.9	27.0	28.6	28.4	27.1	19.2	23.4	20.7	15.5

***First Trimester Prenatal Care*:** The percent of women receiving prenatal care beginning in the first trimester for 2014 was 59.3%, which is lower than the State (71.5%)[20] and has not reached the HP2020 Target (77.9%).[19]

Figure 9: First Trimester Prenatal Care[20]

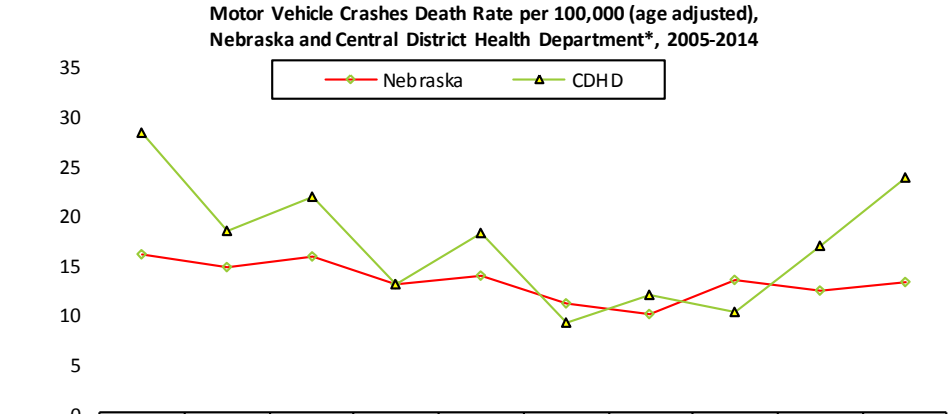


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	75.3%	75.4%	74.8%	73.9%	74.0%	75.0%	75.1%	74.7%	73.1%	71.5%
CDHD	68.8%	69.6%	68.1%	63.4%	67.6%	66.7%	65.2%	65.6%	59.9%	59.3%

Injury and Violence

***Motor Vehicle Crash Death*:** The 2014 motor vehicle crashes death rate per 100,000 (age adjusted) was 23.7, which is higher than the state rate (13.3)[21] and has not reached the HP2020 Target (12.4).[19]

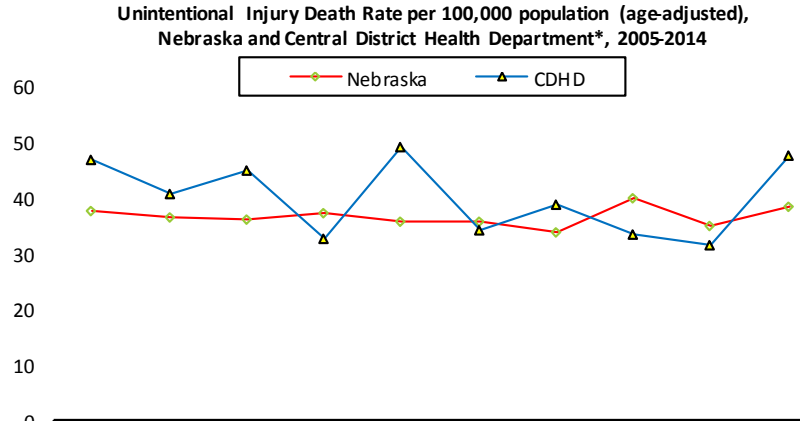
Figure 10: Motor Vehicle Crash Death Rate[21]



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	16.0	14.8	15.7	13.1	13.9	11.1	9.9	13.5	12.4	13.3
CDHD	28.3	18.4	21.9	12.9	18.1	9.2	11.9	10.2	16.8	23.7

Unintentional Injury Death: The 2014 unintentional injury death rate per 100,000 population (age adjusted) was 47.2, which is higher than the State (38.3)[20] and has not reached the HP2020 Target (36.4).[19]

Figure 11: Unintentional Injury Death Rate[20]



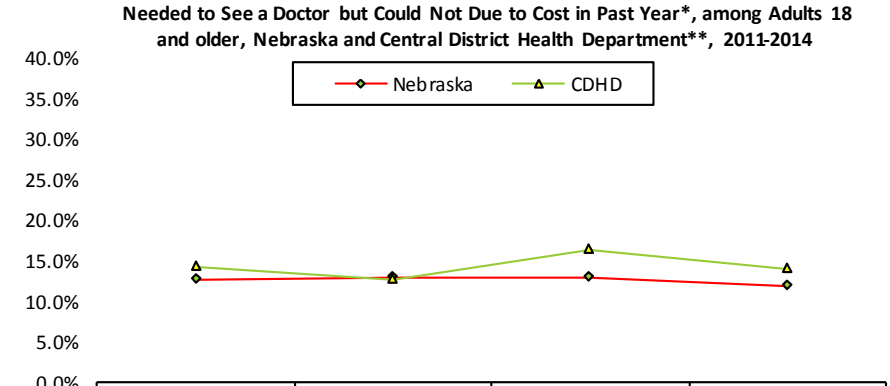
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	37.5	36.3	35.8	37.1	35.5	35.4	33.7	39.6	34.8	38.3
CDHD	46.5	40.4	44.5	32.4	48.7	34.0	38.7	33.3	31.1	47.2

[21] Nebraska Department of Roads; Nebraska Office of highway Safety. Accessed 4/20/2016. Retrieved from: http://www.transportation.nebraska.gov/nohs/

Access to Health Services

Barriers to Care: Individuals needing to see a doctor but could not due to cost in the past year for 2014 was 14.1%, which is higher than the State (11.9%)[18] and has not reached the HP2020 Target (9.0%).[19]

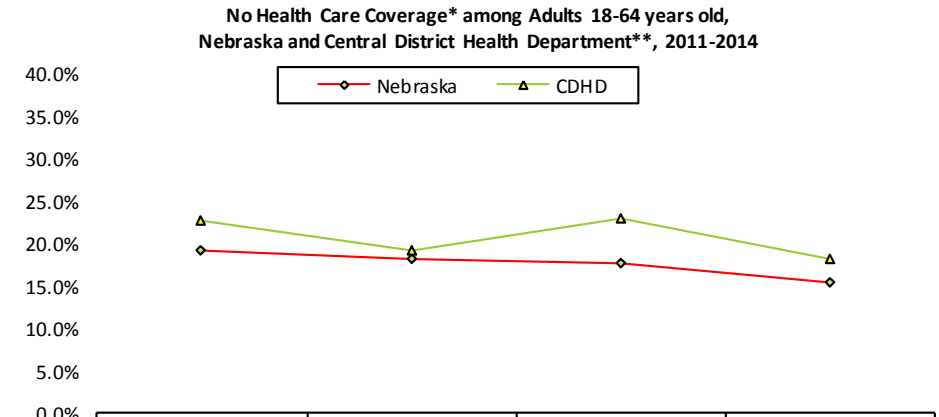
Figure 12: Needed to See a Doctor but Could Not Due to Cost in Past Year[18]



	2011	2012	2013	2014
Nebraska	12.5%	12.8%	13.0%	11.9%
CDHD	14.2%	12.6%	16.3%	14.1%

Health Insurance: Residents with no health coverage among adults 18-64 years for 2014 was 18.2%, which is higher than the State (15.3%)[18] and has not reached the HP2020 goal of universal coverage, or 0% of the population is uninsured.[19]

Figure 13: No Health Insurance Coverage[18]

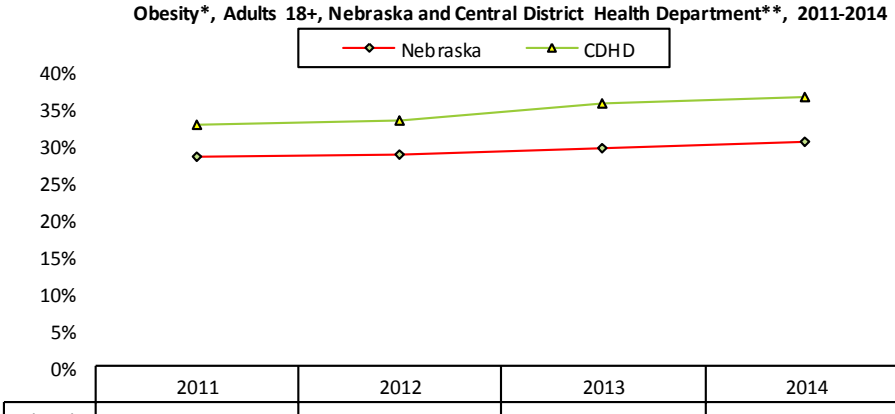


	2011	2012	2013	2014
Nebraska	19.1%	18.0%	17.6%	15.3%
CDHD	22.6%	19.2%	22.8%	18.2%

Obesity

Adult Obesity: Adults with body mass index (BMI) of 30.0 or greater in 2014 was 36.5%,[18] which is higher than the State (30.3%) and has not reached the HP2020 Target of 30.5%.[19]

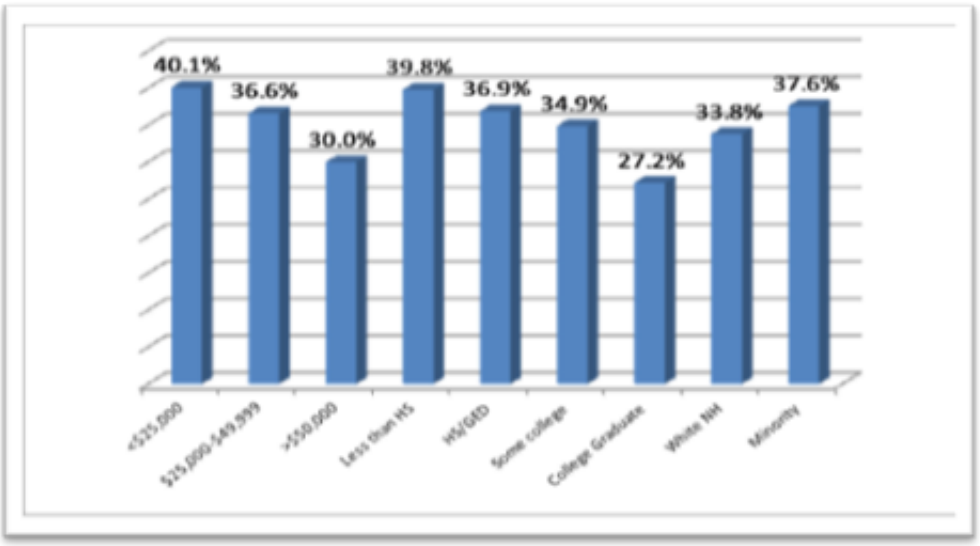
Figure 14: Percentage of adults 18 and older with a body mass index (BMI) of 30.0 or greater[18]



	2011	2012	2013	2014
Nebraska	28.4%	28.6%	29.6%	30.3%
CDHD	32.6%	33.3%	35.7%	36.5%

***Overweight by Socioeconomic Factors*:** Figure 15 show obesity and overweight by Socioeconomic Factors for Hall, Hamilton and Merrick County. The data shows individuals with lower SES, less than HS education and minority have higher rates of being overweight and/or obese.[18]

Figure 15: Overweight by socioeconomic factors



Prioritization Process

Prior to the community engagement session the Data Steering Committee met to review the data and select top "Areas of Opportunity". These areas were selected based on consideration of various criteria, including: standing in comparison with benchmark data; identified trends; and the magnitude of the issue in terms of the number of persons affected.

The following issues were identified to be presented at the Community Engagement Sessions:

Behavioral Health/Mental Health
Injury and Violence
Obesity
Maternal, Infant, and Child Health
Access to Health Care
Substance Abuse

At the community engagement session, described above, participants were asked to vote for their top health needs. As part of the discussion, the community added "culture of health" to the priority list in addition to the issues listed above. Taking into consideration the quantitative data review and analysis of health needs of the community, stakeholder's prioritized the health issues using the following set of criteria:

- Size
- Seriousness

- Trends
- Equity
- Intervention
- Values
- Resources
- Impact on a key social determinant

The following lists the community's priorities in order of importance based on the voting:

- Behavioral Health/Mental Health
- Substance Abuse
- Culture of Health
- Maternal, Infant, and Child Health
- Injury and Violence
- Access to Health Care
- Obesity

Prioritized Health Needs

Table 3 provides an overview of the data for each priority need.

Table 3: Prioritized Community Health Needs

Health Need Statement	Reason(s) for high priority
1. Behavioral Health/Mental Health	**The data shows:** • Percentage of adults 18+ who report their mental health was not good including stress, depression, and problems with emotions) in 2013 was 12.1%, which was higher than the State (8.9%)[11] and has not reached HP2020 Target (5.8%).[19] • The suicide death rate per 100,000 population (age adjusted) was 13.2[20] in 2014, as variable over time, and has not reached the (HP2020) Target of 10.2.[19] Feedback was obtained from stakeholders representing low-income, minority populations, medically underserved populations and the aging population. Below is the input that was provided by community members regarding barriers, challenges, weaknesses holding us back in the identified priority need areas. **Challenges/barriers identified in the community engagement session:** ○ Lack of providers at all levels, from psychiatrists to counselors ○ Access to care ○ Stigma ○ Uninformed ○ Challenges of culturally competent services ○ Lack of prevention/wellness

	○ Transportation to services ○ The nature of mental illness ○ No access for undocumented ○ EPC process ○ Poverty – do not seek services ○ Lack of providers for those without means, plenty of providers if you have means ○ Those with limited family/friend who relapse because no one is keeping them on track
2. Substance Abuse	**The data shows:** ▪ In 2014, adults 18+ reported alcohol-impaired driving after having too much to drink during the Past 30 Days was 1.6%, slightly lower than the State (2.5%)[18] **Challenges/barriers identified in the community engagement session:** ○ Changing population (new cases) ○ Funding ○ Ethnic and cultural difference on what is acceptable ○ I-80 corridor for drugs and human trafficking ○ Lax and permissive attitude towards marijuana use ○ Over prescription of legal drugs (oxy, hydro), doctor shopping to get meds ○ Weak or limited resources, especially for those in the criminal justice system ○ Large Hispanic population allows cartels to move drugs in and out of Grand Island and hide in the community ○ Limited # of providers doing screenings, then few policies to refer to for treatment, especially for adolescents
3. Culture of Health	**Challenges/barriers identified in the community engagement session:** ○ Our community seems more focused on acute care and not preventive care ○ We want to be focused on a cultural of health and wellness
4. Maternal, Infant, and Child Health	**The data shows:** ▪ The infant mortality rate of (6.5) is higher than the State (5.1)[20], has not reached the HP2020 Target of 6.0 infant deaths per 1,000 live births.[19] ▪ Teen birth rate among 15-17 year old females is 15.5 per 1,000 population, and higher than the State (9.4 per 1,000).[20] ▪ 59.3% of women received first trimester prenatal care, which is lower than the State (71.5%)[20] and has not reached the HP2020 Target (77.9%).[19] **Challenges/barriers identified in the community engagement session:** ○ High poverty rate ○ Postnatal visitation for all new parents needed ○ Lack of prenatal care in 1st trimester to prevent complications, identify potential problems and have healthy babies (may be due to a lack of medical coverage)

	○ Lack of education ○ Lack of parent education and engagement ○ Lack of funding for CN Child Advocacy Center ○ Lack of funding rooted in relationship expansion ○ Teen pregnancy and STD rates ○ Lack of transportation to prenatal appointments, work, etc. ○ Fear (undocumented) of seeking services ○ Living wage for families, parents, childcare providers ○ Lack of 24-hour child care services and quality centers
5. Injury and Violence	**The data shows:** ▪ The motor vehicle crashes death rate is 23.7 per 100,000 (age adjusted) is higher than the State (13.3).[21] ▪ The unintentional injury death rate (47.2 per 100,000; age-adjusted) is higher than the State (38.3)[20] and has not reached the HP2020 Target of (36.4)[19] **Challenges/barriers identified in the community engagement session:** ○ Ethnic/cultural conflicts ○ Gang recruitment of marginal youth ○ Blue collar/lower income community ○ Alcohol/drug abuse, leads to assaultive behavior ○ Lack of, and cost of, drug treatment ○ Emphasis on prevention- healthy relationships, physical activity ○ Agriculture and meat processing industries are very high in injury rates ○ Coordinated suicide prevention efforts ○ Influx of new gang cultures ○ Media, movies, video games
6. Access to Health Care	**The data shows:** • In 2014, the percentage of residents who needed to see a doctor but could not due to cost was 14.1%, which is higher than the State (11.9%)[18] and has not reached the HP2020 Target of (9.0%).[19] ▪ In 2014, the percentage of residents with no health coverage among adults 18-64 years old was 18.2%, which is higher than the State (15.3%)[18] and has not reached the HP2020 goal of universal coverage, or 0% of the population is uninsured.[19] **Challenges/barriers identified in the community engagement session:** ○ Language access ○ Cost $$, higher co-pays ○ Knowledge ○ Large need ○ Lack of providers ○ Provider burnout ○ Transportation to care ○ High cost of insurance, high deductibles ○ Lack of Medicaid expansion

	○ Lack of insurance ○ Navigation of the process and system of Access Nebraska
7. Obesity	**The data shows:** • Obesity for adults 18+ was 36.5%[18], which is higher than the State (30.3%) and has not reached the HP2020 Target of 30.5%[19] **Challenges/barriers identified in the community engagement session:** ○ The data shows individuals with lower SES, less than a high school degree, and from a minority race/ethnicity have higher rates of being overweight and/or obese ○ Health Coaching not recognized and paid for ○ Healthy foods more costly than fast, unhealthy foods ○ Poverty – see other needs as more important ○ Sedentary effects of technology ○ Long winter ○ Poor understanding of real impact on a community ○ Buy in from community ○ Access and promotion of community activity such as hike/bike trails, youth activities center, etc. ○ Lack of health insurance incentives to be healthy ○ Time, education, stress

Resource Inventory

Table 4 shows potential assets and resources to address the top community health needs.

Table 4: Resource Inventory

Significant Health Need	Assets/Resources
Behavioral Health/Mental Health	• CCC – Care teams for students • Boys Town adolescent therapy and support groups • Teen Chat – Nebraska Children's Home Society • Crisis Center – Middle school teen dating violence group • Mid-Plains Center for Behavioral Healthcare • Goodwill community support programs for behavioral health • Student Wellness Center (GISH) • CCC – Veteran's Services • Social workers, school counselors, school intervention workers • Central navigation for disconnected youth
Substance Abuse	• Alcohol and drug treatment center at St. Francis • Halfway house

	• Hope Harbor • Strong AA group • SROs in schools, student wellness center evaluations and counselors • Drug court • Regional drug task force • Goodwill community support program • CNCAA and Discovery Kids • Mid-Plains Stabilization Unit
Culture of Health	• Saint Francis • Central Health Center • Heartland Health Center • United Way • Nebraska Action Coalition • Grand Island Public Schools- Coordinated School Health • Center District Health Department • UNL Extension • DHHS Office of Health Disparities & Health Equity • Multicultural Coalition of Grand Island
Maternal, Infant, and Child Health	• WIC • Out of school, after school programs • Breastfeeding support • CHC reproductive health • Sixpence for teen parents • Sex education curriculum in schools • Focus on family unit in churches • Central Nebraska Child Advocacy Center • Heartland Community Health clinic NP seeing uninsured teens • Teen pregnancy and STD prevention groups at United Way • School nurse in every school • Rooted in Relationships – social emotional workforce development in childcares • Central access navigation intake and referrals for unconnected youth • Parenting programs • Faith based work
Injury and Violence	• School resource office (RSOs) • Central Nebraska Child Advocacy Center • St. Francis/SANKOFA • Cooperative gang intelligence system • Anti-gang violence enforcement • Tai Chi classes for balance training, fall prevention • School intervention workers @ GISH and BARR • Drug court and diversion • Crisis center • Hope Harbor

Access to Health Care	• Senior Health Insurance Information program (SHP), educate Medicare beneficiaries • Project HELP at CCC – training providers • Third City Community Clinic • Student Wellness Center (GISH) • Navigation assistance • CDHD CHW helping to navigate systems • Heartland Health Center sliding fee scale • Mid-Plains Center for Behavioral Health • CHI: charity care, care coordination, network of providers • CDHD 1st point of contact, referral services • WIC, often 1st point of contact, strong referral services
Obesity	• GIPS food policy • Worksite wellness programs • Doane • CDHD offers Diabetes Prevention Program in English and Spanish "Road to Health" in Spanish • Community walking paths • Farmer's markets in summer • Third City Community Clinic is working with community gardens • NE Extension does nutrition education with limited-resource youth and families • City of Grand Island Parks and Recreation is working to increase physical activity with a Walk and Bike Trail • CDHD is working to increase access to healthy foods with a health retail grant (1422)

Evaluation of Hospital's Impact FY14-FY16

Saint Francis participated in a Community Health Needs Assessment (CHNA) in fiscal year 2013. The CHNA was led by the Central District Health Department (CDHD) and involved stakeholders from across the community. The CHNA informed a community health improvement plan that included goals and objectives for all community partners to help improve the health status of Hall County residents. These goals and objectives became key pieces of Saint Francis' FY14-FY16 Implementation Strategy Plan. Saint Francis contributed to these goals in various ways including as a strategic partner, funder, and implementer. The overall goals and outcomes of this work are summarized below (please note, only the objectives and goals for which Saint Francis contributed are reported). Additional detail can be found on the CDHD website: www.cdhd.ne.gov

<table>
<tr><th colspan="4">Health Area: Access to Care</th></tr>
<tr><th>Goals/Objectives</th><th>Overarching Activities</th><th>Hospital Contribution</th><th>Impact</th></tr>
<tr>
<td>Overall Goal 1: Improve access to healthcare and health literacy for at-risk patients with a focus on low income and minority residents</td>
<td>Objective 1.1: Reduce admissions to CHI Health Saint Francis emergency room among uninsured patients

Objective 1.2 Reduce the readmission rate of patient with heart failure and pneumonia.</td>
<td>Saint Francis supported the development and sustainability of Third City Community Clinic, a clinic serving uninsured and underinsured patients. Saint Francis also covers unpaid hospital admissions and ER costs, hired two community health workers, and supports a full-time Advanced Nurse Practitioner to better serve and coordinate care.</td>
<td>The overall impact was to expand access to healthcare services, eliminate barriers, and increase knowledge and awareness of heart failure and pneumonia.
<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th></tr>
<tr><td>Reduced Third City patients' use of the Emergency Department</td><td>NA</td><td>5%</td><td>10.9%</td></tr>
<tr><td>Reduced hospital admissions by Third City patients</td><td>NA</td><td>32.40%</td><td>18.4%</td></tr>
<tr><td>successful patient touches at Third City Community</td><td>NA</td><td>12.7</td><td>15.1</td></tr>
<tr><td>Reduced admission rates</td><td>7.3%</td><td>7.35%</td><td>4.04%</td></tr>
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<tr><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Objective 1.3: Assure that at least 780 minority and low-income residents will receive community screenings and education (260 per year).</td><td>Supported 12 screenings over a three year period. (July 1, 2012-June 30, 2015),</td><td>The overall impact was to expand access to healthcare services, eliminate barriers and increase knowledge and awareness of blood pressure and cholesterol management. Screening reached nearly 1,000 patients.

<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th><th>Total</th></tr>
<tr><td>Glucose Referrals</td><td>42</td><td>31</td><td>44</td><td>177</td></tr>
<tr><td>Glucose follow-up</td><td>37</td><td>28</td><td>37</td><td>102</td></tr>
<tr><td>Cholesterol Referrals</td><td>37</td><td>44</td><td>44</td><td>125</td></tr>
<tr><td>Blood Pressure Referrals</td><td>44</td><td>51</td><td>45</td><td>140</td></tr>
<tr><td>Blood Pressure Follow-ups</td><td>39</td><td>47</td><td>41</td><td>127</td></tr>
<tr><td>Dental referrals</td><td>75</td><td>55</td><td>27</td><td>157</td></tr>
<tr><td>Dental Follow-ups</td><td>68</td><td>51</td><td>26</td><td>145</td></tr>
</table></td></tr>
<tr><td></td><td>Objective 1.4: Assure that least 60% of identified moderate or high-risk screening participants for glucose, cholesterol or high blood pressure are referred to an evidenced-based nutrition and fitness program.</td><td>Provided 12 screenings during the 3 year reporting period.</td><td>The overall impact was to expand access to healthcare services, eliminate barriers, and increase knowledge and awareness of blood pressure and cholesterol management.

<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th><th>Total</th></tr>
<tr><td>Glucose Screenings</td><td>175</td><td>144</td><td>159</td><td>478</td></tr>
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<table>
<tr><td>Glucose positive results (high or elevated)</td><td>42</td><td>31</td><td>44</td><td>117</td></tr>
<tr><td>Cholesterols screenings</td><td>175</td><td>144</td><td>159</td><td>478</td></tr>
<tr><td>Cholesterol positive results (high or elevated)</td><td>37</td><td>44</td><td>44</td><td>125</td></tr>
<tr><td>Blood pressure screenings</td><td>180</td><td>270</td><td>134</td><td>584</td></tr>
<tr><td>Blood pressure positive results (high or elevated)</td><td>44</td><td>51</td><td>45</td><td>140</td></tr>
<tr><td>Dental screenings</td><td>125</td><td>110</td><td>90</td><td>325</td></tr>
<tr><td></td><td>75</td><td>55</td><td>27</td><td>157</td></tr>
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<tr>
<td>Overall Goal 2: Assure patients can receive quality cancer treatment in their own community</td>
<td>Objective 2.1: Provide high quality cancer diagnostic and treatment services to minimize cost, travel and discomfort for area patients.</td>
<td>St. Francis Cancer Treatment Center continues to expand services,</td>
<td>The overall impact is to expand services for cancer diagnostic and treatment.
• Providing Oncoplastic surgical capabilities and digital imaging for breast cancer patients.
• Saint Francis now retains 98% of its patients for treatment, compared to losing 60-80%.</td>
</tr>
<tr>
<td>Overall Goal 3: Become a Breast Cancer Center for Excellence to provide high quality cancer diagnostic and treatment services to minimize cost, travel and discomfort for area patients.</td>
<td>Objective 3.1: Explore the opportunity to understand and build acceptance with medical staff to develop Onco-plastic surgical capabilities in the Grand Island community for breast reconstructive surgery</td>
<td>Provide cancer treatment and services to community members.</td>
<td>The impact is to assure quality care to patients within the Breast Cancer of Excellence through 3 pillars: 1) NAPBC; 2) ACR accreditation; 3) NQMBC</td>
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<tr>
<td></td>
<td>Objective 3.2: Expansion to two digital mammography screening systems, and use of two Breast Cancer

Objective 3.3: Education Kiosks for outreach and education of low-income, minority and rural women</td>
<td>Imaging Center added second digital screening equipment in 2012.</td>
<td>The expansion of 2 digital screening equipment provides:
Increased services to minority and low-income women.
Assistance program for low-income residents with cancer.
Outreach and referral program to have at-risk women checked for breast cancer.
Two breast cancer awareness kiosks, which provide 10 assessment questions, are placed at sites accessible to low-income residents.</td>
</tr>
<tr>
<td></td>
<td>Objective 3.4: Provide Nurse Navigation assistance and Implement
Objective 3.5: Implement “A Time to Heal” for recovering breast cancer patients</td>
<td>Saint Francis provided two Navigators at Cancer Treatment Center.</td>
<td>Navigators assist patients through cancer treatment programs and services, Patients are able to prepare and adapt to the process of cancer treatment and recovery leading to better outcomes.</td>
</tr>
<tr>
<td>Overall Goal 4: Assure that at least 100 residents receive a Health Assessment. Assessments provide information to the educator on what cancer should be reviewed during the education. Also provides minimum insurance information to be able to refer them to</td>
<td>Objective 4.1: Place bi-monthly advertisements in the local newspaper to feature cancer of the month with screening guidelines and possible symptoms;
Objective 4.2: Place Breast Cancer Awareness Kiosks (two) throughout various Grand Island businesses</td>
<td>Provided four on site screenings and education, St. Francis Marketing department provide education messages through various media outlets and information to employers.</td>
<td>The overall impact is to Increase awareness of cancer issues and prevention services.
<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th><th>Total</th></tr>
<tr><td>Breast Cancer screenings</td><td>125</td><td>110</td><td>90</td><td>325</td></tr>
<tr><td>Breast Cancer referrals to Every Woman Matters</td><td>17</td><td>14</td><td>14</td><td>45</td></tr>
<tr><td>Breast Cancer follow-ups</td><td>12</td><td>11</td><td>8</td><td>31</td></tr>
</table>
</td>
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</table>

<table>
<tr><td>Every Women Matters, Central Health Center, or Third City Community Clinic.</td><td>and local community charities
Objective 4.3: Increase frequency of health fair screenings to four times;
Objective 4.4: Provide on-site education with screenings.
Objective 4.5: Provide Referrals and follow-up for moderate or high –risk participants</td><td></td><td></td></tr>
<tr><td colspan="4">Health Area: Violence Prevention</td></tr>
<tr><td>Goals/Objectives</td><td>Overarching Activities</td><td>Hospital Contribution</td><td>Impact</td></tr>
<tr><td rowspan="2">Overall Goal 5 Reduce gang violence and gang recruitment of at-risk youths</td><td>Objective 5.1: Identify and recruit at least 60 at – risk middle-school age students into a violence prevention program;

Objective 5.2: Assure that at least 50% participants in program will improve grades, improve attendance and stay in school</td><td>St. Francis sought funding through CHI Violence Prevention grant and provides grant management and partnership support to the community</td><td>Hall County Crime rate per 1,000 students dropped from 837arrests in 2011 to 543 arrests in 2014
<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th><th>Total</th></tr>
<tr><td>SANKOFA enrollments</td><td>62</td><td>70</td><td>64</td><td>196</td></tr>
<tr><td>SANKOFA graduates</td><td>38</td><td>60</td><td>58</td><td>156</td></tr>
<tr><td>Improved grades</td><td>32</td><td>41</td><td>73</td><td>146</td></tr>
</table>
<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th><th>Total</th></tr>
<tr><td>Improved personal skills</td><td>22</td><td>51</td><td>47</td><td>120</td></tr>
<tr><td>Improved attendance</td><td>24</td><td>52</td><td>44</td><td>120</td></tr>
<tr><td>Stayed in school</td><td>36</td><td>52</td><td>38</td><td>126</td></tr>
<tr><td>Stayed out of trouble</td><td>38</td><td>53</td><td>39</td><td>130</td></tr>
</table></td></tr>
<tr><td>Objective 5.3: Implement</td><td>St. Francis supports</td><td>2015- Family and students together (FAST) Program</td></tr>
</table>

<table>
<tr><td></td><td>a prevention program for at-risk youth at the elementary level</td><td>Hall County Collaborative through strategic partnership</td><td>serves four elementary schools with a significant number of students at-risk. The parent engagement program helps children thrive by building strong relationships at home.</td></tr>
<tr><td colspan="4">Health Area: Healthy Weight in Adults and Youth</td></tr>
<tr><td>Goals/Objectives</td><td>Overarching Activities</td><td>Hospital Contribution</td><td>Impact</td></tr>
<tr><td rowspan="2">Overall Goal 6: Improve the capacity at the local level to address chronic disease linked to overweight and obesity through proper nutrition by policy change</td><td>Objective 6.1: Strengthen the capacity of Health Department in the area of workplace nutrition and fitness in local schools and businesses.</td><td>Supported and partnered with Health Department and Schools.</td><td>Encourage and support partner collaboration and raised awareness.
-27 policy or environmental improvements were implemented in worksites.
-44 onsite food environment and policy consultations with employers were conducted.
-2 educational sessions were provided with 145 people in attendance</td></tr>
<tr><td>Objective 6.5: Partner with Grand Island Public Schools on student wellness.</td><td>St. Francis Provides Funds to Grand Island Public Schools.</td><td>Students are enrolled at Student Wellness Center (only on-site clinic in Nebraska).
<table>
<tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th><th>Total</th></tr>
<tr><td>Students enrolled in Student Wellness Center</td><td>268</td><td>267</td><td>348</td><td>883</td></tr>
<tr><td>Students who received financial assistance</td><td>166</td><td>163</td><td>226</td><td>555</td></tr>
<tr><td>Suicide ideations risk assessments</td><td>27</td><td>34</td><td>40</td><td>101</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td></td><td>Objective 6.6: Partner with the Heartland United Way</td><td>St. Francis provides staff member time to</td><td>The overall impact is to increase high breastfeeding duration rates.</td></tr>
</table>

<table>
<tr><td></td><td>to develop Community Impact Health Council to bring experts together.
Objective 6.7: Increase duration and exclusivity of breastfeeding children utilizing WIC.</td><td>serve on the United Way Health Council</td><td></td></tr>
<tr><td colspan="4">Health Area: Family Support</td></tr>
<tr><td>Goals/Objectives</td><td>Overarching Activities</td><td>Hospital Contribution</td><td>Impact</td></tr>
<tr><td>Overall Goal 1- Help teen parents become self-sustaining and promote healthy child care.</td><td>Objective 7.1: At least 90% of the students who remain enrolled in the Teen Parenting Class gain the required skills and proficiencies and receive a passing grade
Objective 7.2: At least 70% of all students who receive 1-on-1 mentor and ongoing contact with a social worker contact will advance at least one grade level,
Objective 7.3: At least 60% of the identified pregnant or parenting teens will graduate from high school</td><td>St. Francis provides funding to Grand Island Public Schools.</td><td>The Sixpence Programs promote community level partnerships that focus on helping teen parents become more self-supporting and promote healthy child care.
<table><tr><th>PERFORMANCE MEASURES</th><th>2013</th><th>2014</th><th>2015</th></tr><tr><td># of students serving Sixpence program</td><td>NA</td><td>NA</td><td>48</td></tr></table></td></tr>
</table>

Dissemination Plan

Saint Francis will make its CHNA widely available to the public by posting the written report on http://www.chihealth.com/chna. A printed copy of the report will be available to the public upon request, free of charge, by contacting Kelly Nielsen at Kelly.nielsen@alegent.org or (402) 343-4548. In addition, a paper copy will be available at the Hospital Information Desk/Front Lobby Desk.

Approval

On behalf of the CHI Health Board, the Executive Committee of the Board approved this CHNA on June 24, 2016.
In addition, the CHNA was presented and reviewed by the Saint Francis Community Board on May 26th, 2016.

Appendices

See following pages

Central District Health Department* &
CHI Health St. Francis Medical Center

2016
Community Health Assessment Data

*Central District Health Department serves Hall, Hamilton and Merrick Counties.
Document created 02/2016

Current State: Similar but Nonaligned Community Health Improvement Frameworks

Public Health Accreditation, HRSA 330 Grants, United Way, & Other Community Assessments

Community Health Assessment Tools (MAPP, Community Tool Box, etc.)

Philanthropy, Federal/State grant making (CDC/CTGs, HUD, etc.)

HDs/FQHCs/ Community Agencies → Community Health Assessment → Community Health Improvement Plan → Community Investments → Improved Community Health Outcomes?

Hospitals → CHNA + Implementation Strategy → "Plan" → Hospital Community Benefit Projects → Improved Community Health Outcomes?

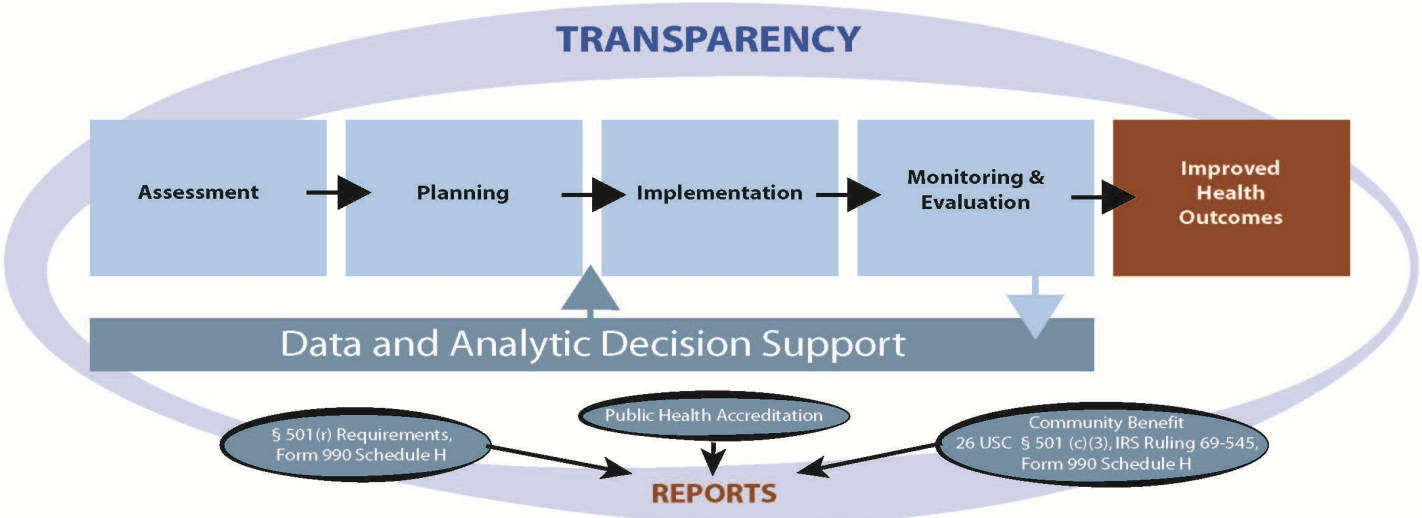
Catholic Health Assoc. Guide
ACHI (AHA) Toolkit
Private Vendors

IRS Hospital Community Benefit Compliance, State & Local Activities

501(r) Requirements, Form 990 Schedule H

26 USC 501(c)(3), IRS Ruling 69-545, and Form 990 Schedule H

Desired State: A Unified Community Health Improvement Framework Supporting Multiple Stakeholders



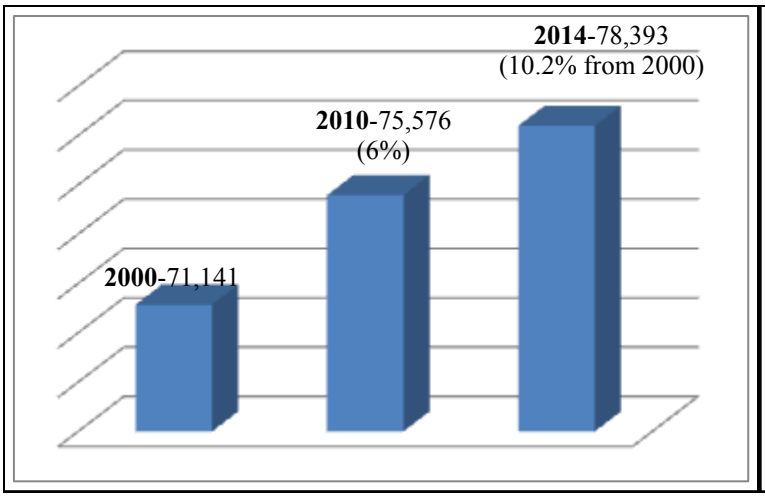
Community Engagement and Assuring Shared Ownership

Key issues to Address to Promote Alignment between Accreditation, NP Hospital CB, and Other Community-Oriented Processes

- Arranging Assessments that Span Jurisdictions
- Using Small Area Analysis to Identify Communities with Health Disparities
- Collecting and Using Information on Social Determinants of Health
- Collecting Information on Community Assets
- Using Explicit Criteria and Processes to Set Priorities (use of evidence to guide decision-making)
- Assuring Shared Investment and Commitments of Diverse Stakeholders
- Collaborating Across Sectors to Implement Comprehensive Strategies
- Participatory Monitoring and Evaluation of Community Health Improvement Efforts

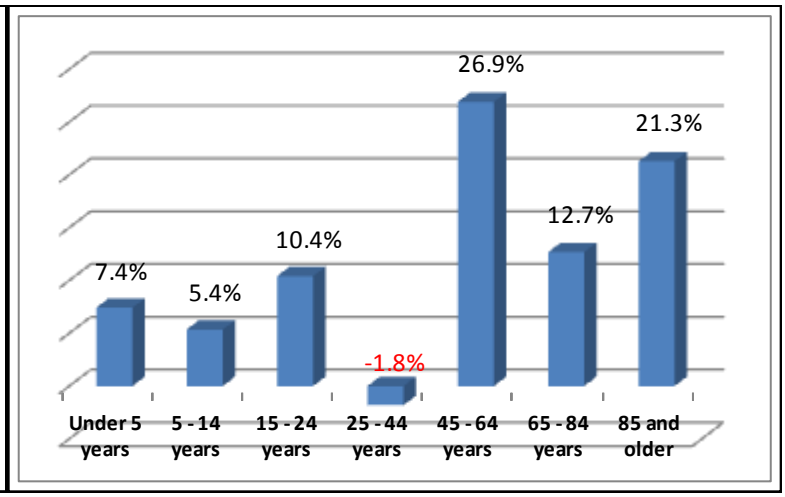
Demographics of the District

CDHD Total Population Change 2000-2014

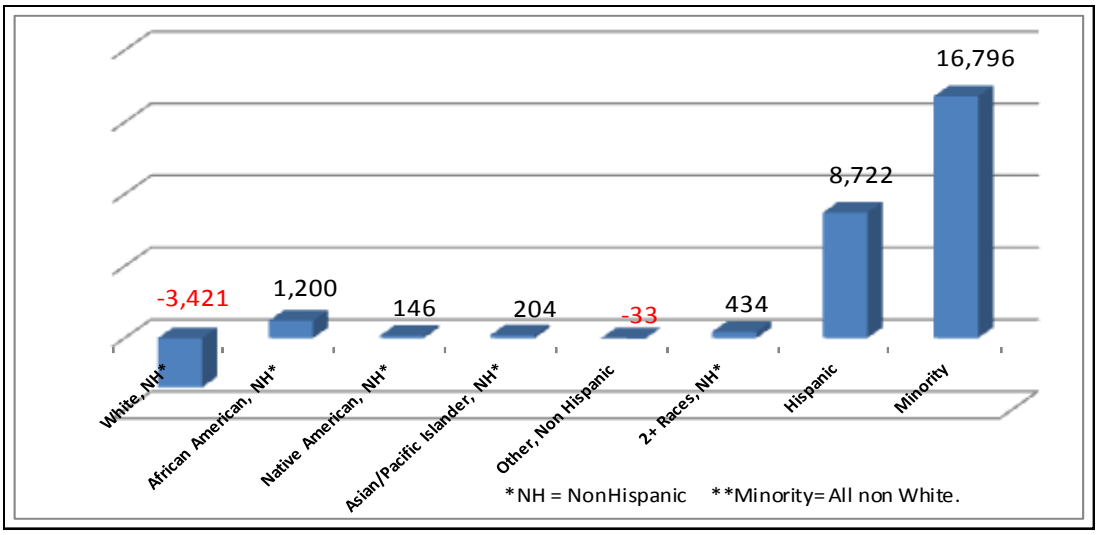


Source: US Census

CDHD Population Change by age 2000-2014

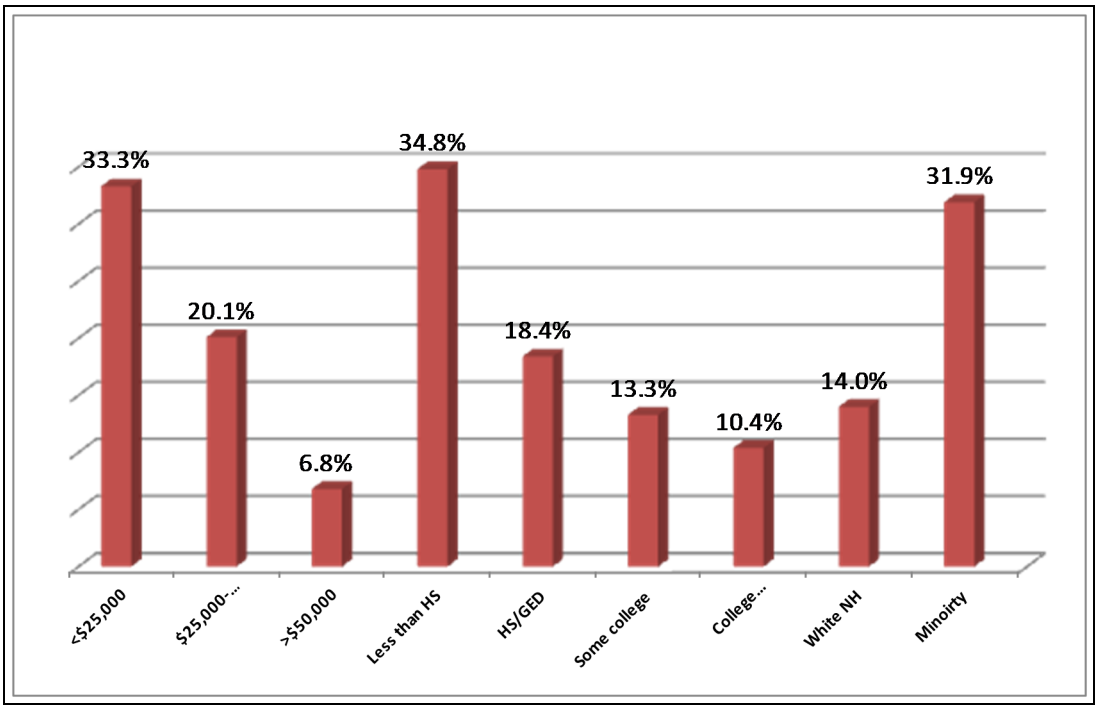


Source: US Census



CDHD Race/Ethnicity Change 2000-2014

Source: US Census

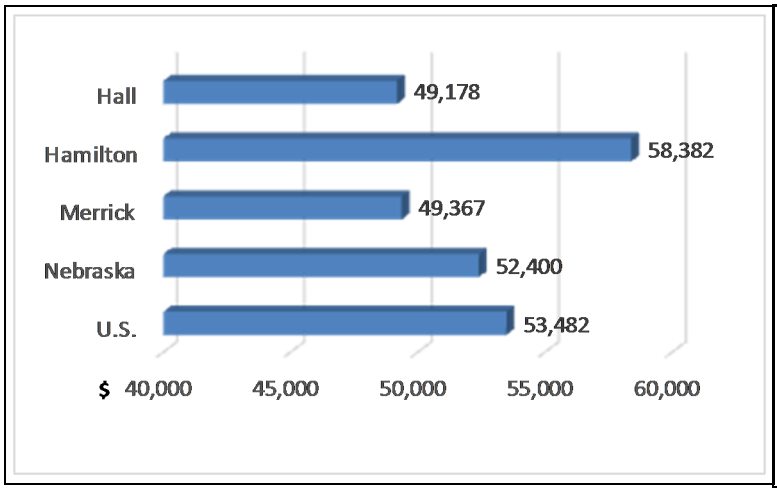


CDHD General Health Status Fair or Poor by Socioeconomic Factors

Source: Behavioral Risk Factor Surveillance System (BRFSS)

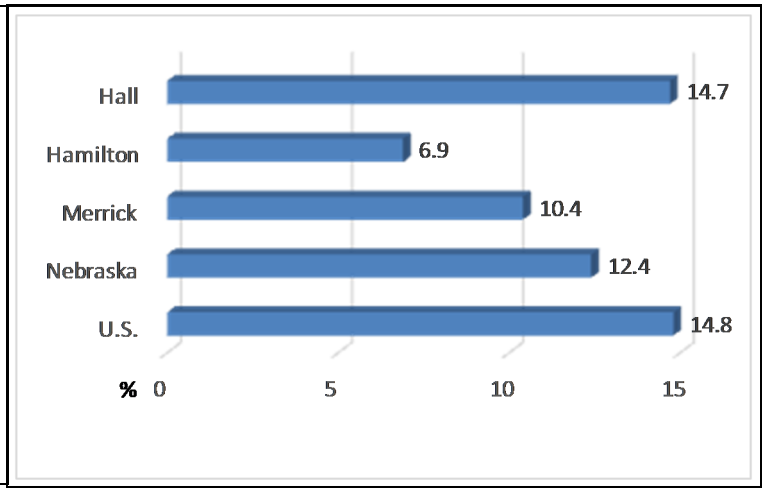
Demographics of the District

CDHD Median Household Income, 2010-2014

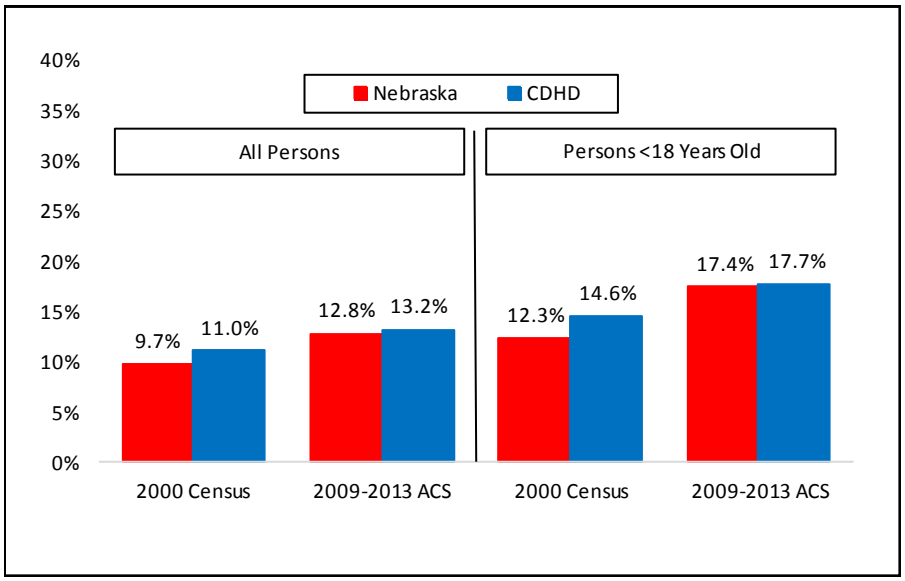


Source: US Census

CDHD Persons in Poverty, (%)



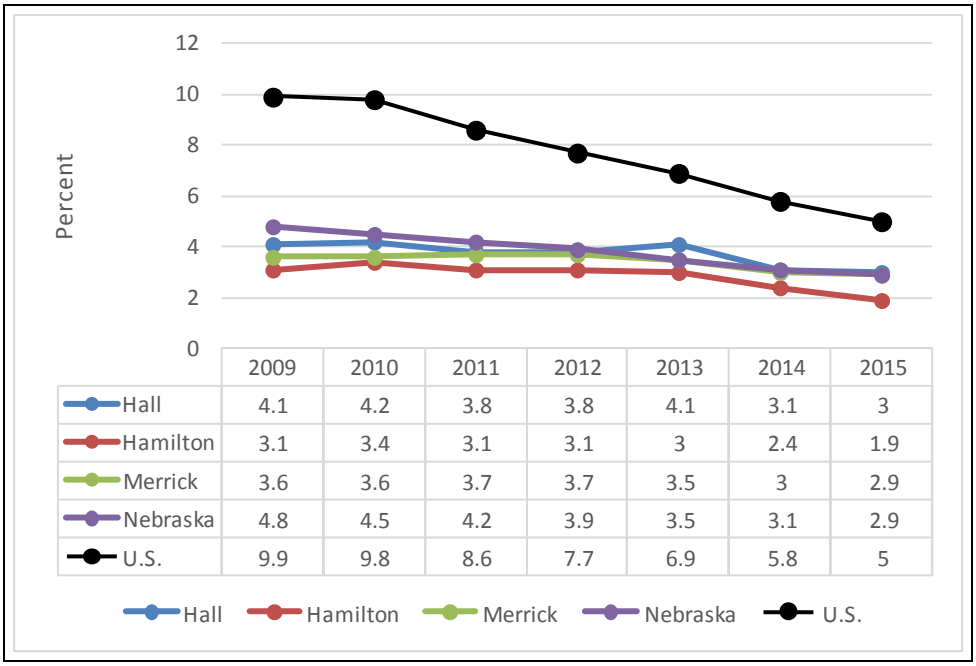
Source: US Census



Poverty Trends* in Nebraska and CDHD

*Percentage below 100% of the federal poverty level
Source: 2010 U.S. Census; 2009-2013 American Community Survey (ACS)

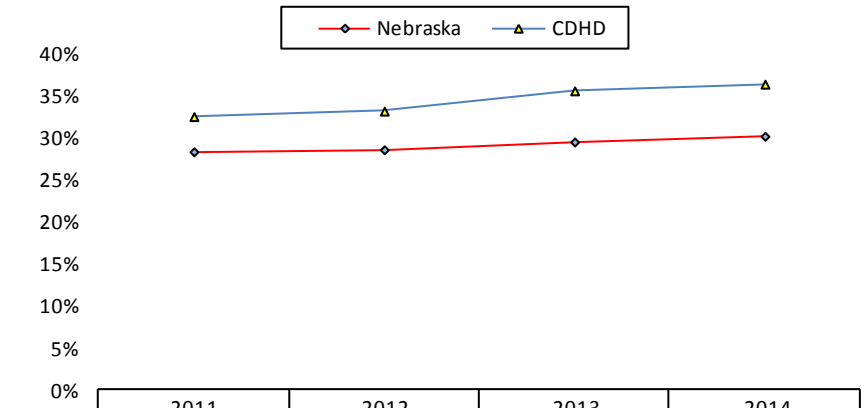
CDHD Unemployment Rates



	2009	2010	2011	2012	2013	2014	2015
Hall	4.1	4.2	3.8	3.8	4.1	3.1	3
Hamilton	3.1	3.4	3.1	3.1	3	2.4	1.9
Merrick	3.6	3.6	3.7	3.7	3.5	3	2.9
Nebraska	4.8	4.5	4.2	3.9	3.5	3.1	2.9
U.S.	9.9	9.8	8.6	7.7	6.9	5.8	5

Source: Bureau of Labor Statistics

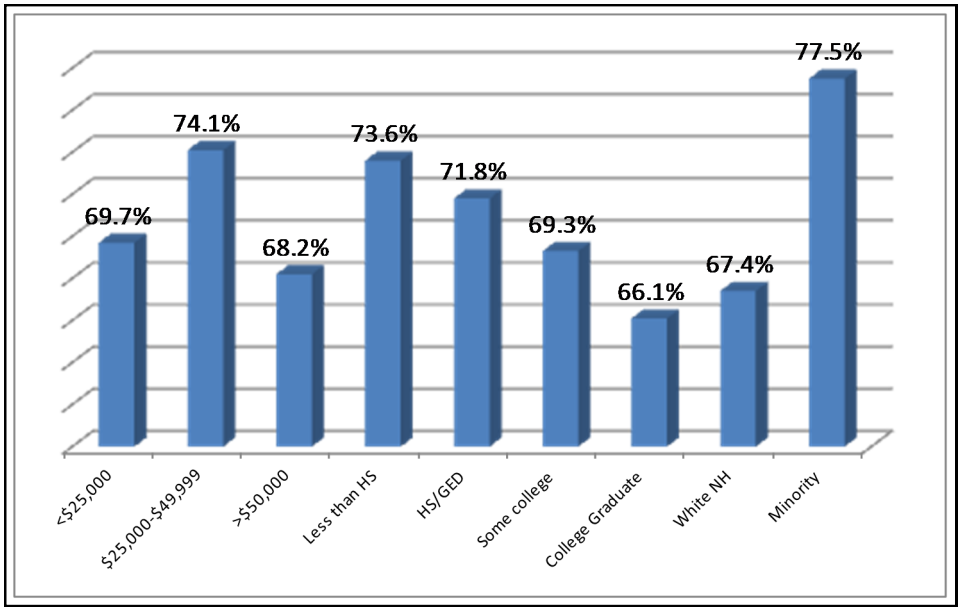
Lifestyle Behaviors—Obesity



	2011	2012	2013	2014
Nebraska	28.4%	28.6%	29.6%	30.3%
CDHD	32.6%	33.3%	35.7%	36.5%

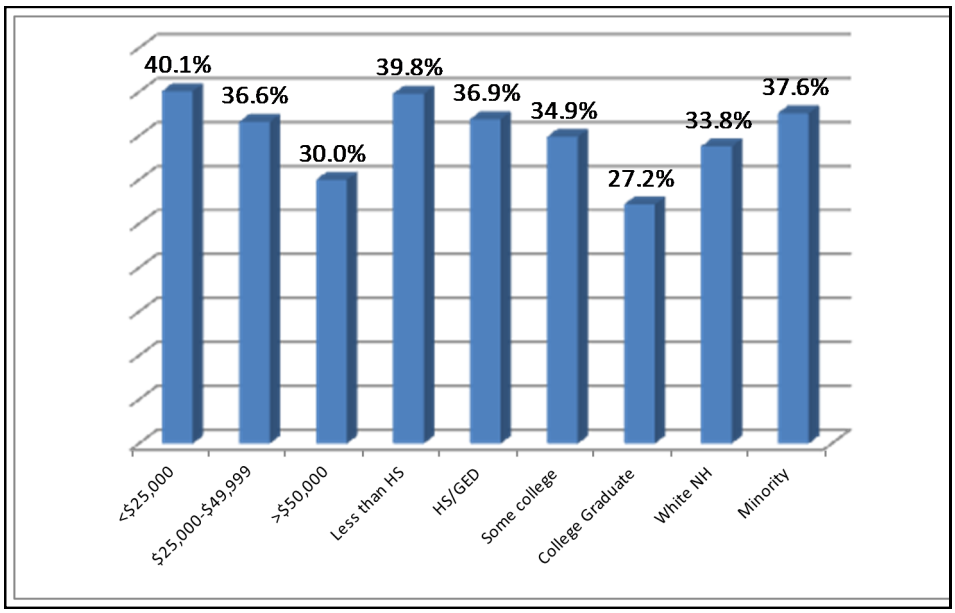
2011-2014 Obesity*, Adults 18+, Nebraska and CDHD

*Percentage of adults 18 and older with a body mass index (BMI) of 30.0 or greater, based on self-reported height and weight
Source: Behavioral Risk Factor Surveillance System (BRFSS)



CDHD Overweight by Socioeconomic Factor

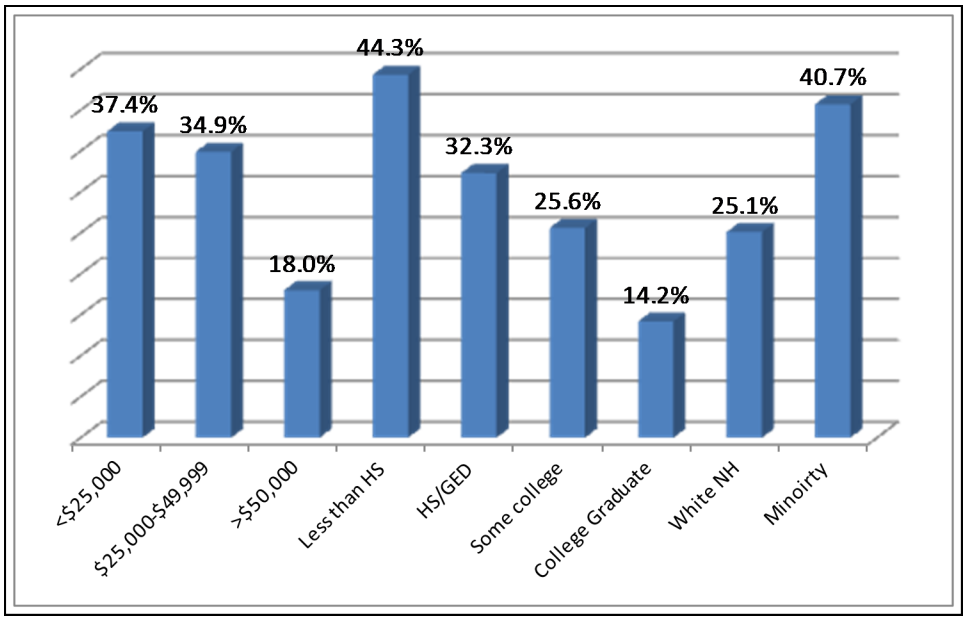
Source: Behavioral Risk Factor Surveillance System (BRFSS)



CDHD Obesity Rates

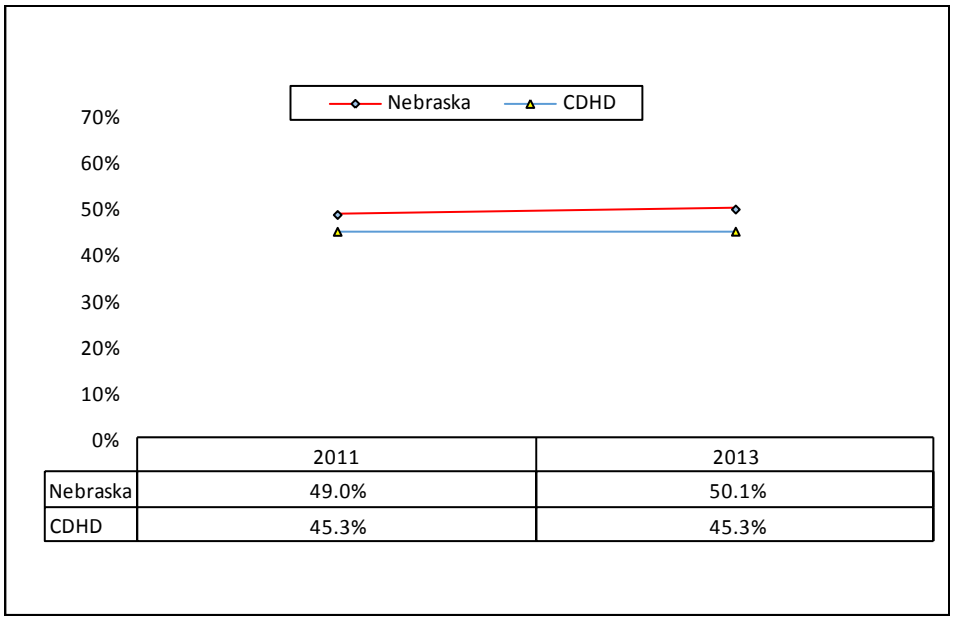
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Lifestyle Behaviors—Physical Activity



CDHD Physical Activity by Socioeconomic Factor

Source: Behavioral Risk Factor Surveillance System (BRFSS)

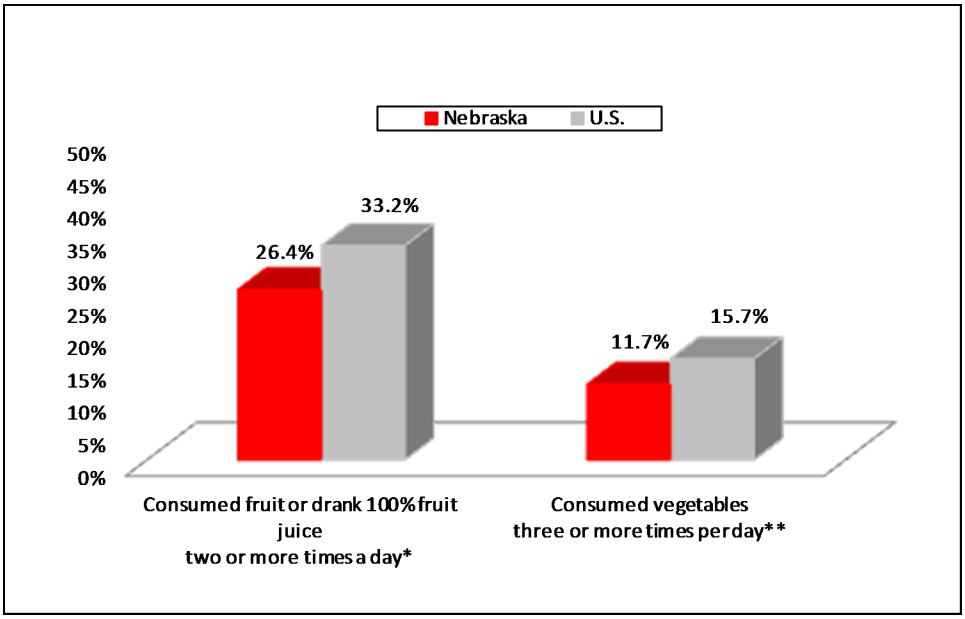


	2011	2013
Nebraska	49.0%	50.1%
CDHD	45.3%	45.3%

2011-2013 Met Aerobic Physical Activity Recommendation*, Adults 18+, Nebraska and CDHD

*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
Source: Behavioral Risk Factor Surveillance System (BRFSS)

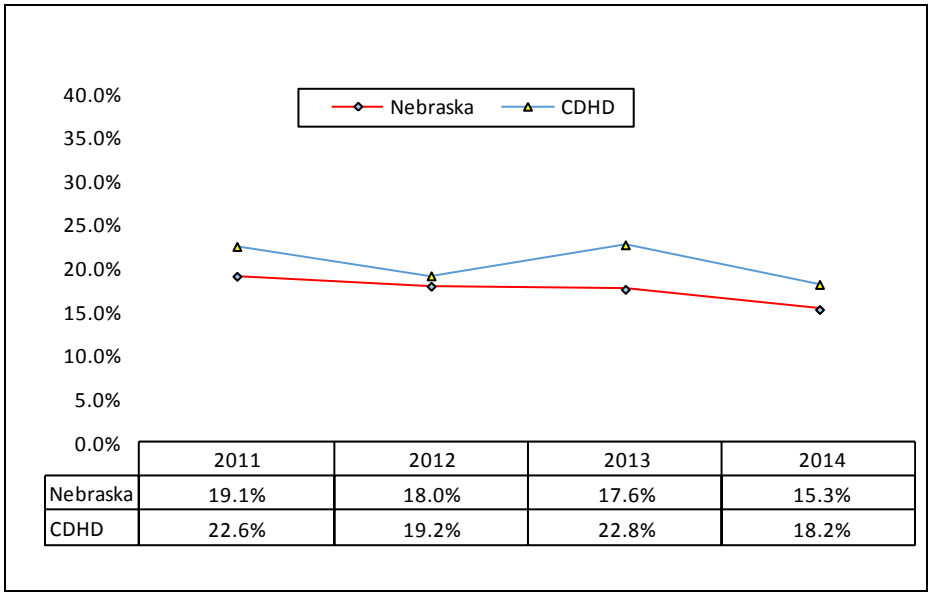
Lifestyle Behaviors—Nutrition



2013 Fruit and Vegetable Consumption among High School Students, Nebraska and U.S.

*Percentage of high school students who reported eating fruit or drinking 100% fruit juice two or more times per day during the past 7 days
**Percentage of high school students who reported eating vegetables 3 or more times per day during the past 7 days
Source: Youth Risk Behavior Survey (YRBS)

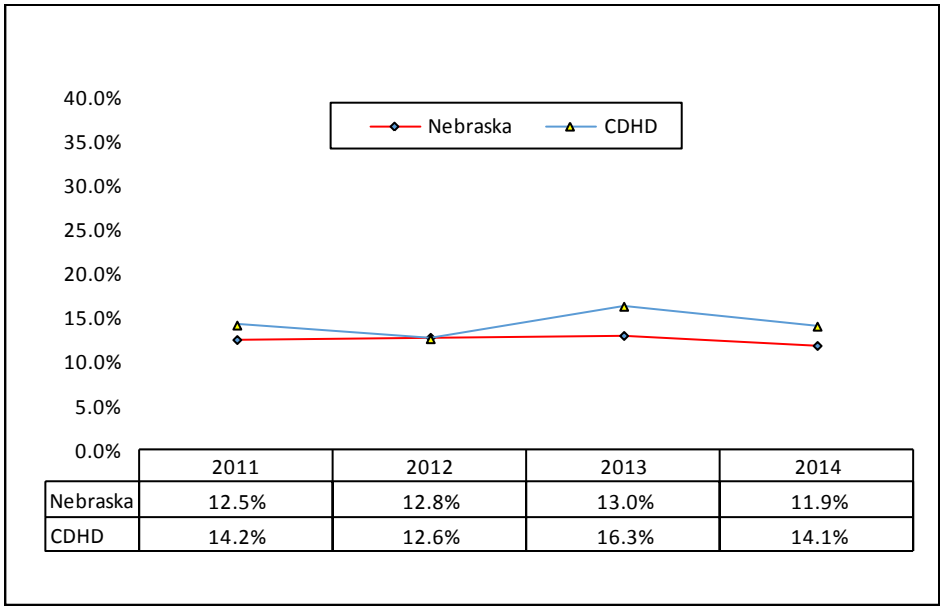
Family And Child Wellbeing—
Access to Health Services



	2011	2012	2013	2014
Nebraska	19.1%	18.0%	17.6%	15.3%
CDHD	22.6%	19.2%	22.8%	18.2%

2011-2014, No Health Coverage* among Adults 18-64 years old, Nebraska and CDHD

*Percentage of adults 18-64 years old who report that they do not have any healthcare coverage
Source: Behavioral Risk Factor Surveillance System (BRFSS)

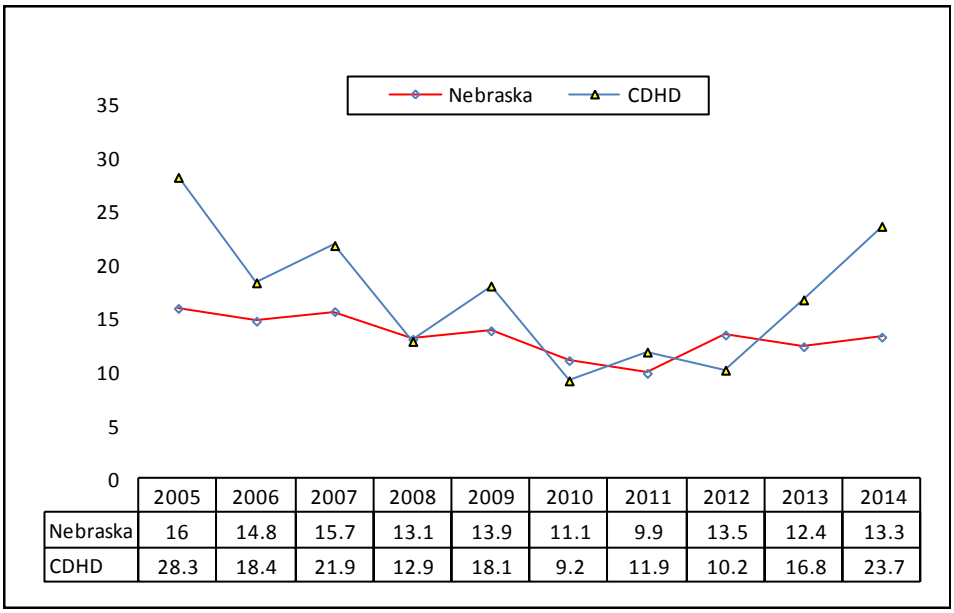


	2011	2012	2013	2014
Nebraska	12.5%	12.8%	13.0%	11.9%
CDHD	14.2%	12.6%	16.3%	14.1%

2011-2014 Needed to See a Doctor but Could Not Due to Cost in Past year*, among Adults 18+, Nebraska and CDHD

*Percentage of adults 18 and older who report that they needed to see a doctor but could not because of cost during the past 12 months
Source: Behavioral Risk Factor Surveillance System (BRFSS)

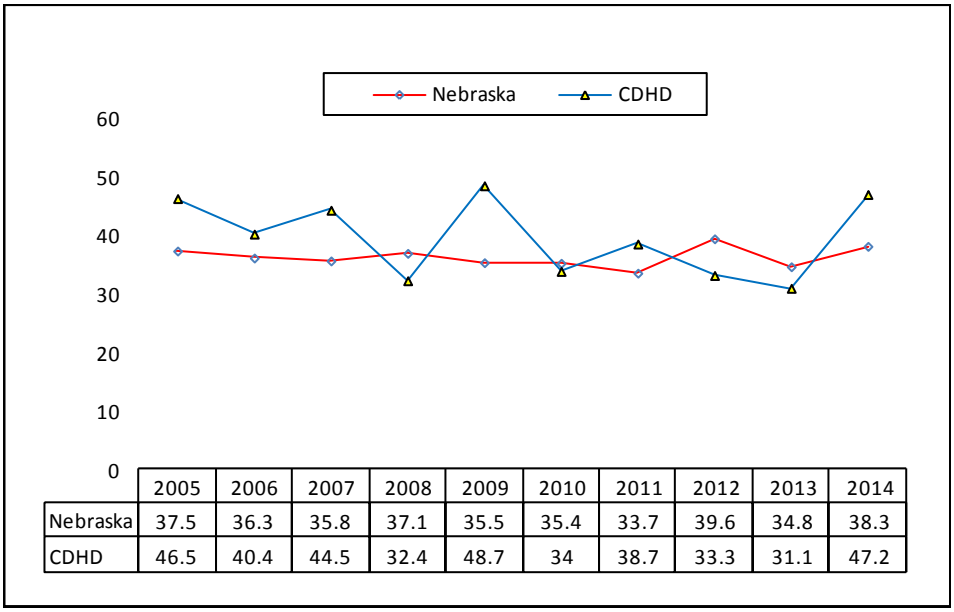
Family And Child Wellbeing—
Injury and Violence



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	16	14.8	15.7	13.1	13.9	11.1	9.9	13.5	12.4	13.3
CDHD	28.3	18.4	21.9	12.9	18.1	9.2	11.9	10.2	16.8	23.7

2005-2014, Motor Vehicle Crashes Death Rate per 100,000 (age adjusted), Nebraska and CDHD

Source: Nebraska Department of Roads; Nebraska Office of Highway Safety

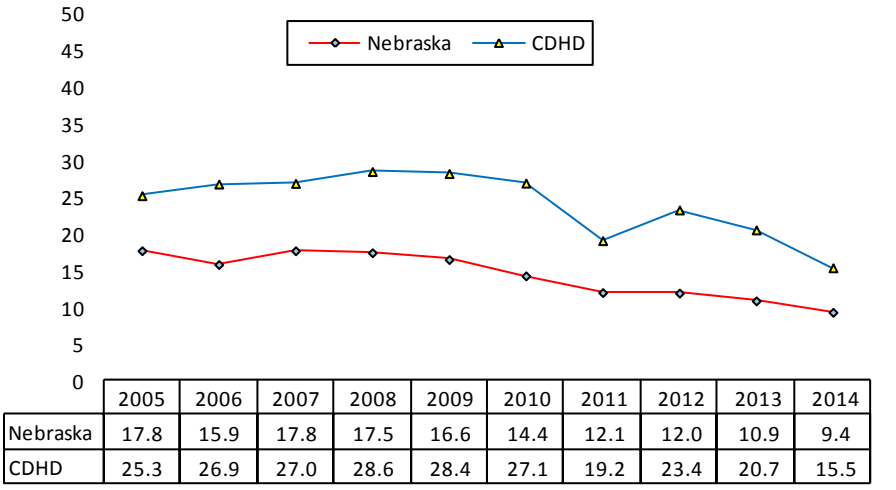


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	37.5	36.3	35.8	37.1	35.5	35.4	33.7	39.6	34.8	38.3
CDHD	46.5	40.4	44.5	32.4	48.7	34	38.7	33.3	31.1	47.2

2005-2014 Unintentional Injury Death Rate per 100,000 population (age adjusted), Nebraska and CDHD

Source: Nebraska Vital Records; National Center for Health Statistics

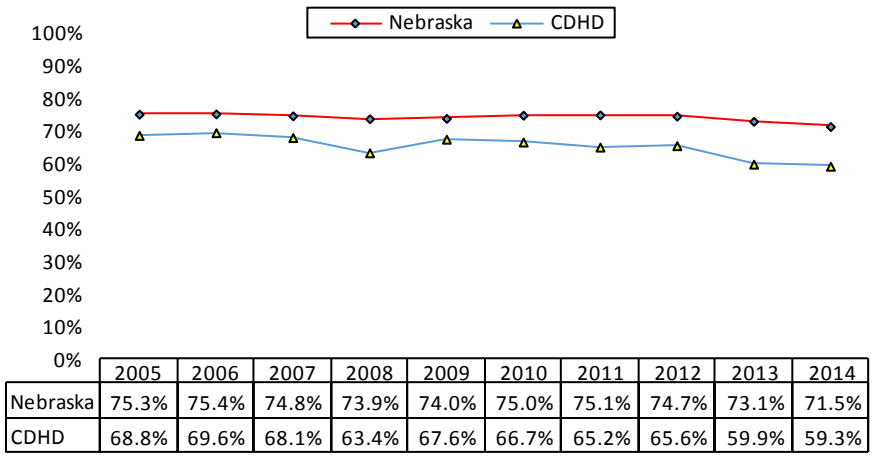
Family And Child Wellbeing—
Maternal, Infant & Child Health



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	17.8	15.9	17.8	17.5	16.6	14.4	12.1	12.0	10.9	9.4
CDHD	25.3	26.9	27.0	28.6	28.4	27.1	19.2	23.4	20.7	15.5

2005-2014, Teen Birth Rate among 15-17 year old females per 1,000 population, Nebraska and CDHD

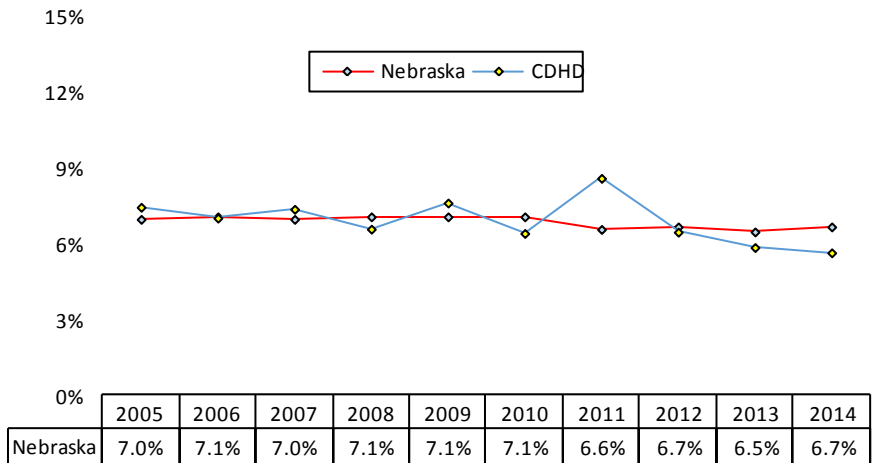
Source: Nebraska Vital Records; National Center for Health Statistics



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	75.3%	75.4%	74.8%	73.9%	74.0%	75.0%	75.1%	74.7%	73.1%	71.5%
CDHD	68.8%	69.6%	68.1%	63.4%	67.6%	66.7%	65.2%	65.6%	59.9%	59.3%

2005-2014 First Trimester Prenatal Care* in Nebraska and CDHD

*Percentage of infants born to a woman receiving prenatal care beginning in the first trimester.
Source: Nebraska Vital Records

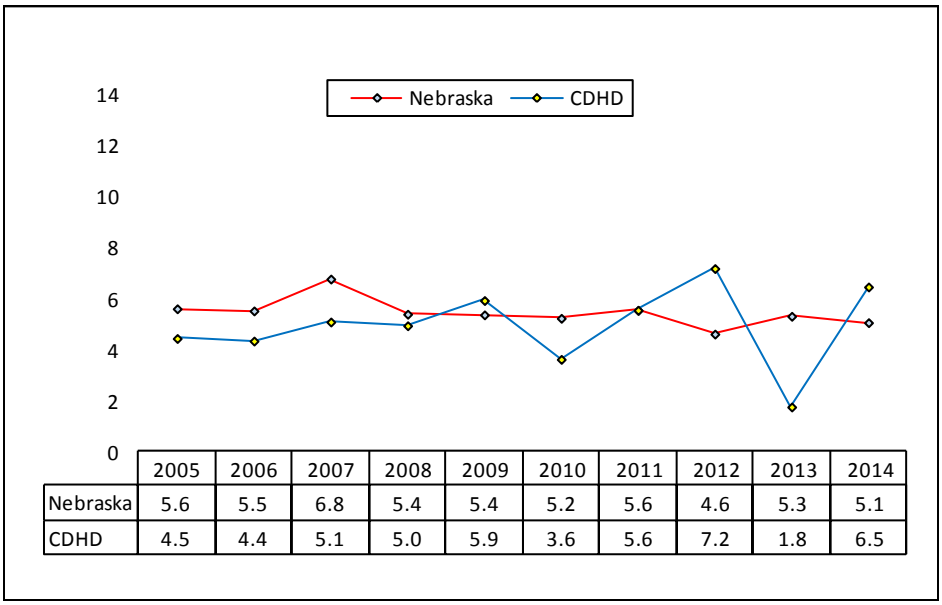


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	7.0%	7.1%	7.0%	7.1%	7.1%	7.1%	6.6%	6.7%	6.5%	6.7%
CDHD	7.5%	7.1%	7.4%	6.6%	7.7%	6.4%	8.6%	6.5%	5.9%	5.7%

2005-2014 Low Birth Weight Births*, Nebraska and CDHD

*Percentage of live births weighing less than 2,500 grams (5.5 pounds)
Source: Nebraska Vital Records; National Center for Health Statistics

Family And Child Wellbeing—Maternal, Infant & Child Health



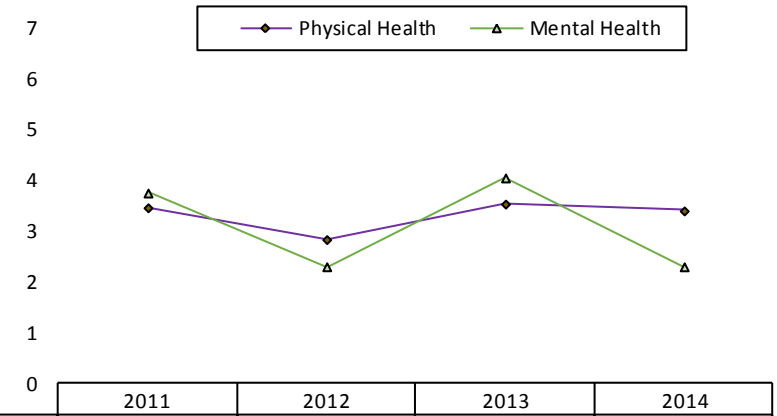
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	5.6	5.5	6.8	5.4	5.4	5.2	5.6	4.6	5.3	5.1
CDHD	4.5	4.4	5.1	5.0	5.9	3.6	5.6	7.2	1.8	6.5

2005-2014 Infant Mortality Rate* per 1,000 Live Births, Nebraska and CDHD

*Number of deaths to infants (less than 12 months old) per 1,000 live births

Source: Nebraska Vital Records; National Center for Health Statistics

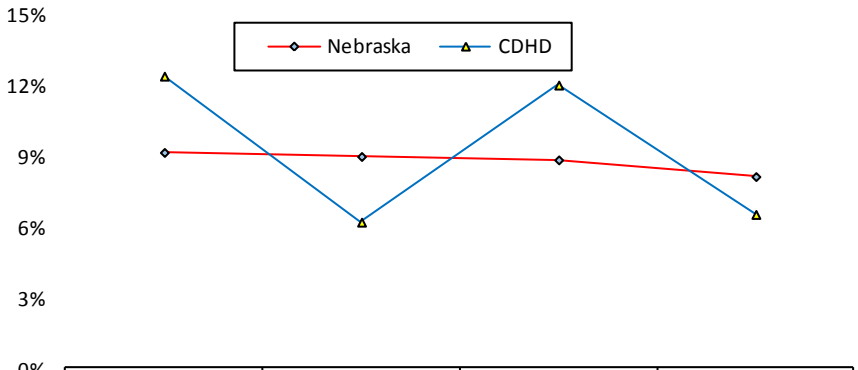
Behavioral Health / Substance Abuse—
Behavioral Health



	2011	2012	2013	2014
Physical Health	3.5	2.8	3.5	3.4
Mental Health	3.7	2.3	4.0	2.3

2011-2014 Average Number of Days Physical Health and Mental Health were Not Good in the Past 30days*, Adults 18+, Nebraska and CDHD

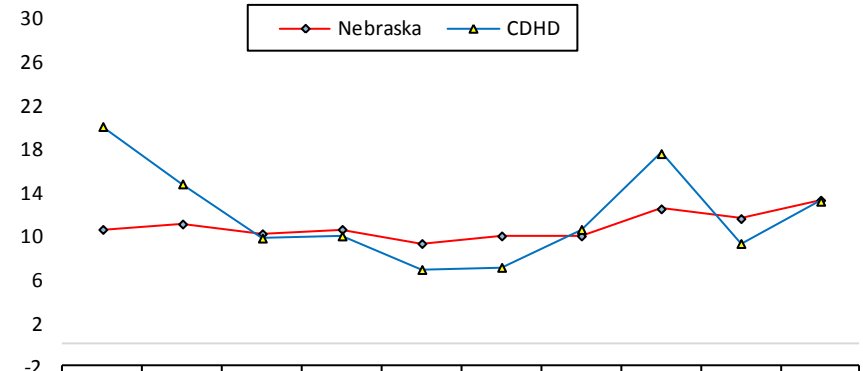
*Percentage of adults 18 and older who report that their mental health (including stress, depression, and problems with emotions) was not good on 14 or more of the previous 30 days
Source: Behavioral Risk Factor Surveillance System (BRFSS)



	2011	2012	2013	2014
Nebraska	9.2%	9.0%	8.9%	8.2%
CDHD	12.4%	6.2%	12.1%	6.6%

2011-2014 Frequent Mental Distress in the Past 30days*, Adults 18+, Nebraska and CDHD

*Percentage of adults 18 and older who report that their mental health (including stress, depression, and problems with emotions) was not good on 14 or more of the previous 30 days
Source: Behavioral Risk Factor Surveillance System (BRFSS)

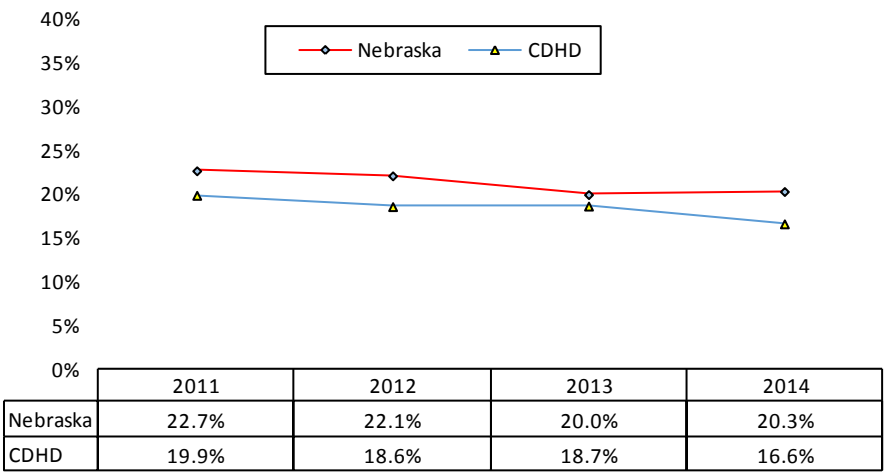


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	10.6	11.1	10.2	10.6	9.3	10	10	12.5	11.6	13.3
CDHD	20.1	14.8	9.8	10	6.9	7.1	10.6	17.6	9.3	13.2

2005-2014, Suicide Death Rate per 100,000 population (age adjusted), Nebraska and CDHD

Source: Nebraska Vital Records; National Center for Health Statistics

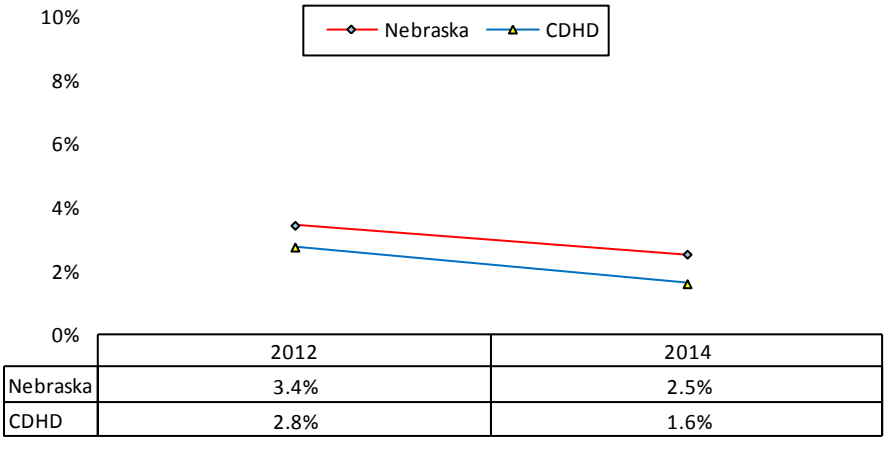
Behavioral Health / Substance Abuse—
Substance Abuse



	2011	2012	2013	2014
Nebraska	22.7%	22.1%	20.0%	20.3%
CDHD	19.9%	18.6%	18.7%	16.6%

2011-2014, Binge Drank in the Past 30 Days*, Adults 18+, Nebraska and CDHD

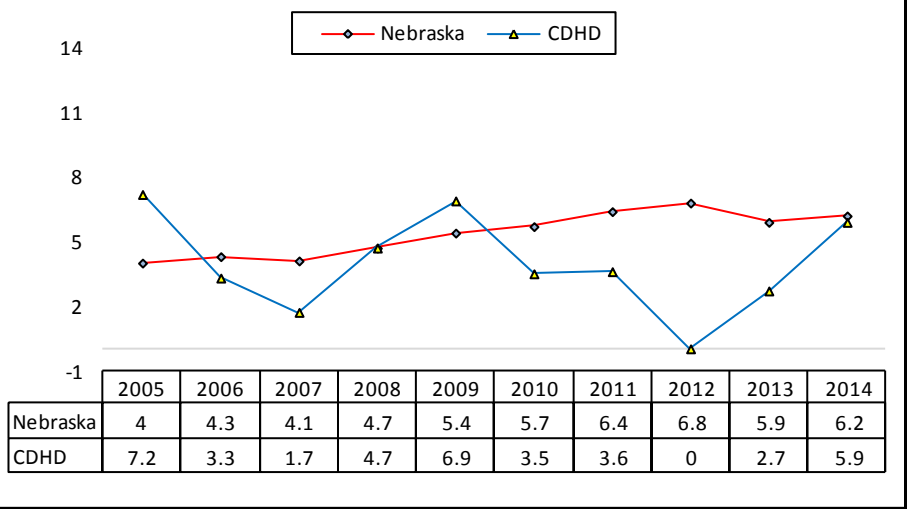
*Percentage of adults 18 and older who report having five or more drinks for men/four or more drinks for women on at least one occasion during the past 30 days
Source: Behavioral Risk Factor Surveillance System (BRFSS)



	2012	2014
Nebraska	3.4%	2.5%
CDHD	2.8%	1.6%

2012-2014 Alcohol-Impaired Driving during the Past 30 Days*, Adults 18+, Nebraska and CDHD

*Percentage of adults 18 and older who report driving after having had perhaps too much to drink during the past 30 days
Source: Behavioral Risk Factor Surveillance Survey (BRFSS)

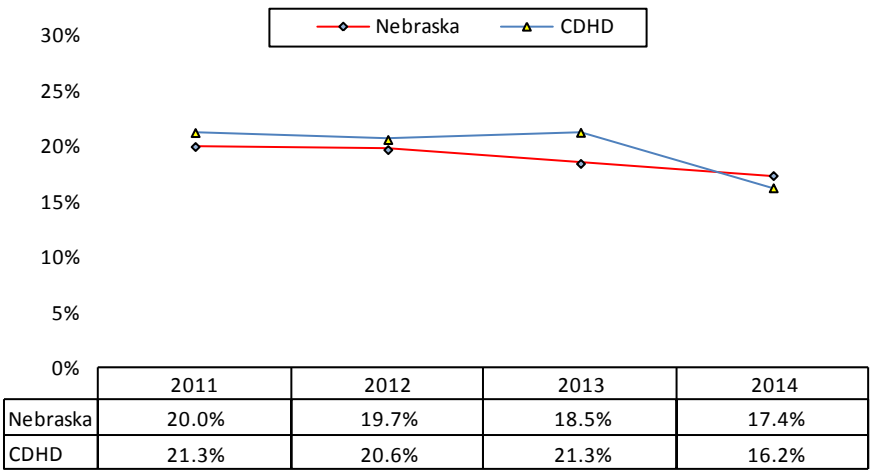


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nebraska	4	4.3	4.1	4.7	5.4	5.7	6.4	6.8	5.9	6.2
CDHD	7.2	3.3	1.7	4.7	6.9	3.5	3.6	0	2.7	5.9

2005-2014 Drug-Induced Death Rate per 100,000 population (age adjusted), Nebraska and CDHD

Source: Nebraska Vital Records; National Center for Health Statistics

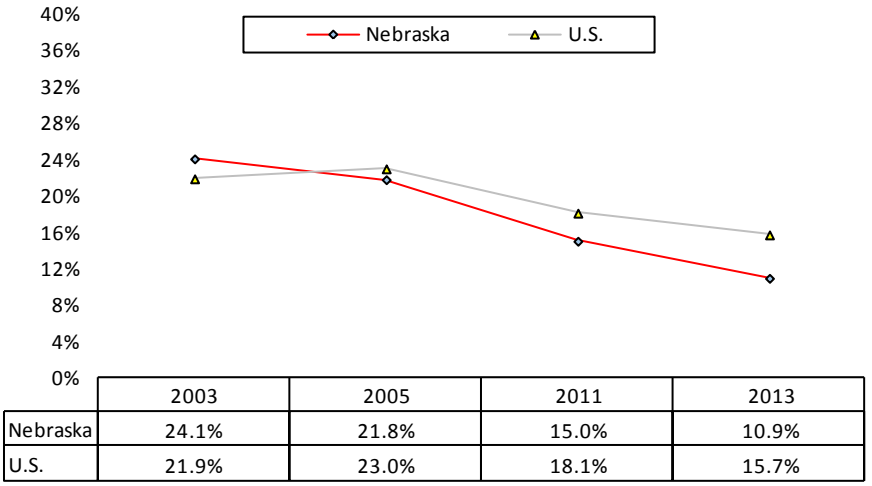
Behavioral Health / Substance Abuse—Tobacco



	2011	2012	2013	2014
Nebraska	20.0%	19.7%	18.5%	17.4%
CDHD	21.3%	20.6%	21.3%	16.2%

2011-2014, Current Cigarette Smoking*, Adults 18+, Nebraska and CDHD

*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 (BRFSS)



	2003	2005	2011	2013
Nebraska	24.1%	21.8%	15.0%	10.9%
U.S.	21.9%	23.0%	18.1%	15.7%

2003-2013 Smoked Cigarettes during the Past 30 Days* among High School Students, Nebraska and U.S.

*Percentage of high school students who reported smoking cigarettes on one or more of the past 30 days
Source: Youth Risk Behavior Survey (YRBS)

Community Health Assessment

Central District Health Department

CHI Health St. Francis

February 26, 2016

Facilitated by Kathleen Brandert, MPH, CHES
University of Nebraska Medical Center
College of Public Health, Office of Public Health Practice

Summary Report Submitted March 11, 2016

Central District Health Department and CHI Health St. Francis Hospital, both in Grand Island, NE, have embarked on a Community Health Assessment process. On February 26, 2016, the partners jointly sponsored 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.

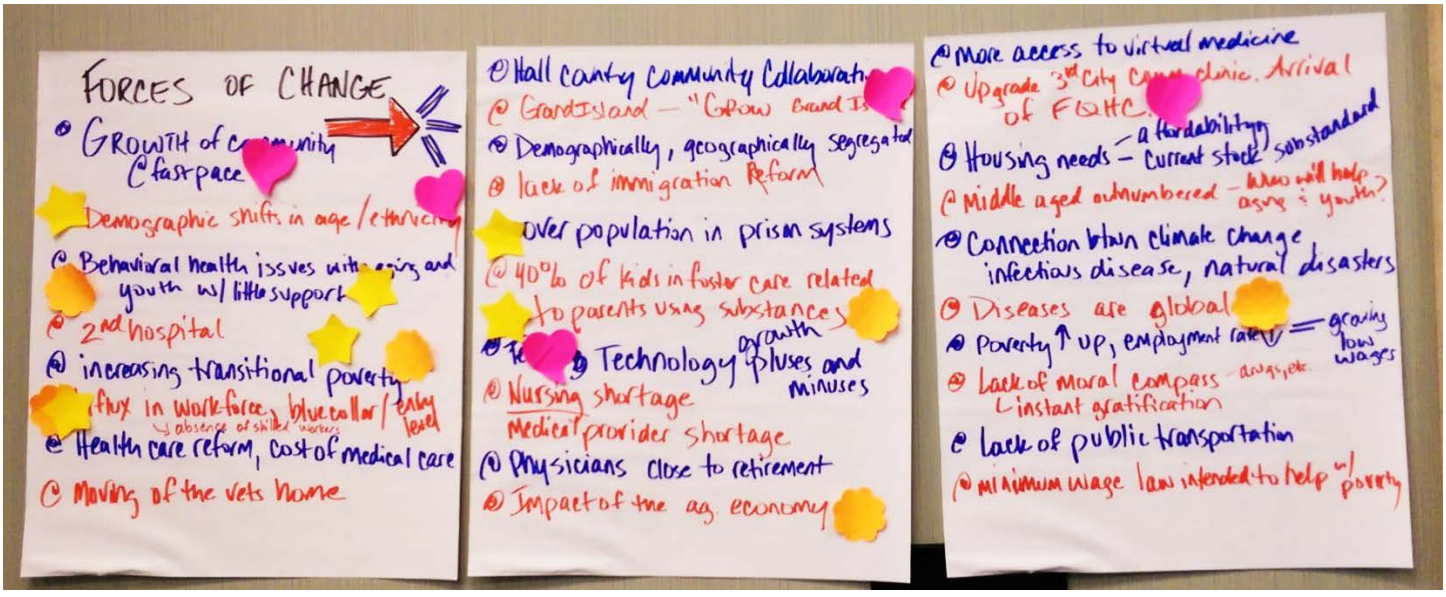
February 26, 2016 AGENDA

7:30	**Introductions and Data Presentation**
8:30	**Forces of Change Discussion**
8:45	**Gallery Walk (of identified areas of need)**
9:20	**Large Group Discussion on Priorities**
9:55	**Next Steps and Prioritization**

To begin the planning process, the Central District Health Department Director, Teresa Anderson, shared the findings from a comprehensive review of data relevant to the community. [For more information on this data, contact Central District Health Department.]

FORCES OF CHANGE

After listening to the data presentation, meeting participants were asked to contribute to a discussion called *Forces of Change* (a type of environmental scan). In small groups, participants read a descriptive document (found on the next two pages) and discussed Forces of Change they felt were impacting Hall County and the community of Grand Island.



Forces of Change Brainstorming Worksheet

What are Forces of Change?

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

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

What Kind of Areas or Categories Are Included?

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

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

How to Identify Forces of Change

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

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

As a small group, using the information from the previous page, list all brainstormed forces, including factors, events, and trends. Try to list at least 10 Forces of Change.

Star your top 3. Prepare to share them with the large group in a short synopsis (less than 2 minutes per group).

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

After each small group identified their Forces of Change, they were asked to share their top three with the larger group. Once all Forces of Change were written up, the following questions were discussed:

- What is your initial reaction to this list? (something you are excited about, feeling fearful/anxious about)
- What themes are we seeing across these Forces of Change that we should be paying special attention to as we discuss the health priorities in our community?
- What will be important to remember as we look next at our community data and determine our priorities?

Post-it shapes were used to identify:

- Forces that were exciting to see
- Forces that caused concern
- Forces that deserved attention as the group moved into prioritizing community health needs

Overall, the following Forces of Change were discussed:

- Growth of the community at a fast pace
- Demographic shifts in age/ethnicity
- Behavioral health issues with aging and youth, with little support
- 2nd hospital in Grand Island
- Increasing transitional poverty
- Influx in workforce: many blue collar/entry level, and an absence of skilled workers
- Health care reform, cost of medical care
- Moving of the Vets home
- More access to virtual medicine
- Upgrade of 3rd City community clinic; arrival of FQHC
- Housing needs: affordability, current stick is substandard
- Middle aged are outnumbered. Who will help aging and youth?
- Connection between climate change, infectious disease, and natural disasters
- Diseases are global
- Poverty rates are up, employment rates are down = growing low wages
- Lack of moral compass and need for instant gratification (drugs, etc.)
- Lack of public transportation
- Minimum wage law intended to help with poverty
- Hall County Community Collaborative
- Grow Grand Island initiative
- Demographically, geographically segregated community
- Lack of immigration reform
- Over population in prison system
- 40% of kids in foster care related to parents using substances
- Technology growth pluses and minuses
- Nursing and medical provider shortage
- Physicians close to retirement
- Impact of the agriculture economy

GALLERY WALK OF IDENTIFIED AREAS OF NEED

Next, the group was asked to walk around the room, stopping at each of 6 different sets of flip charts. Each set represented one area of need (issue) identified as important for the community to consider working on together over the next three years. These issues came out of the comprehensive data review findings shared earlier in the meeting.

For each issue participants were asked to answer three questions:

- What do we have going for us that will PROPEL US FORWARD in this area? (assets, resources, strengths)
- What are things that will HOLD US BACK in this area? (barriers, challenges, weaknesses)
- *Who* is already doing *what* in this area *in* or *for our community*?

Below is a compilation of the information gathered.

Behavioral Health l Mental Health		
Propel us forward	***Hold us back***	***Who is doing what?***
▪ Opportunity for virtual technology ▪ Improved independence for nurse practitioners ▪ Faith community ▪ Region III involvement ▪ Funding opportunity: CHI statewide initiative ▪ Circle of Security – parenting ▪ Telehealth and community health ▪ Veteran's Center ▪ H3C 12-24 Subcommittee ▪ CCC has human service program that has a focus on alcohol and drug counseling	▪ Lack of providers at all levels, from psychiatrists to counselors ▪ Access to care ▪ Stigma ▪ Uninformed ▪ Challenges of culturally competent services ▪ Lack of prevention/wellness ▪ Transportation to services ▪ The nature of mental illness ▪ No access for undocumented ▪ EPC process ▪ Poverty – do not seek services ▪ Lack of providers for those without means, plenty of providers if you have means ▪ Those with limited family/friend who relapse because no one is keeping them on track	▪ CCC – Care teams for students ▪ Boys Town adolescent therapy and support groups ▪ Teen Chat – Nebraska Children's Home Society ▪ Crisis Center – Middle school teen dating violence group ▪ Midplains Center ▪ Goodwill community support programs for behavioral health ▪ Student Wellness Center (GISH) ▪ CCC – Veteran's Services ▪ Social workers, school counselors, school intervention workers ▪ Central navigation for unconnected youth

Injury and Violence		
Propel us forward	***Hold us back***	***Who is doing what?***
▪ Central Nebraska child Advocacy Center ▪ Respected PD, knowledgeable and sensitive to issues ▪ Successful partnerships to reduce gang violence ▪ Data collection and tracking of gangs ▪ State/county/city law enforcement	▪ Ethnic/cultural conflicts ▪ Gang recruitment of marginal youth ▪ Blue collar/lower income community ▪ Alcohol/drug abuse, leads to assaultive behavior ▪ Lack of, and cost of, drug treatment ▪ Emphasis on prevention = healthy relationships, physical activity ▪ Agriculture and meat processing industries are very high in injury rates ▪ Coordinated suicide prevention efforts ▪ Influx of new gang cultures ▪ Media, movies, video games	▪ School resource office (RSOs) ▪ Central Nebraska Child Advocacy Center ▪ St. Francis/SANKOFA ▪ Cooperative gang intelligence system ▪ Anti-gang violence enforcement ▪ Tai Chi classes for balance training, fall prevention ▪ School intervention workers @ GISH and BARR ▪ Drug court and diversion ▪ Crisis center ▪ Hope Harbor

Obesity		
Propel us forward	***Hold us back***	***Who is doing what?***
▪ Doane RN, BSN trains RNs in health and wellness coaching, prevention, life style changes ▪ CDHD 1422 program (lifestyle) ▪ Nationally, this is a priority ▪ Wellness programs within businesses/companies ▪ Diabetes Prevention Program – healthy lifestyles coaches ▪ Funding is available ▪ Heroes for a Healthy Hall County ▪ Taxes on fast food and soda	▪ Coaching not recognized and paid for (value?) ▪ Healthy foods more costly than fast, unhealthy foods ▪ Poverty – see other needs as more important ▪ Sedentary effects of technology ▪ Long winter ▪ Poor understanding of real impact on a community ▪ Buy in from community ▪ Access and promotion of community activity = hike/bike trails, youth activities center, etc. ▪ Lack of health insurance incentives to be healthy ▪ Time, education, stress	▪ GIPS food policy ▪ Worksite wellness programs ▪ Doane (see 1st column) ▪ CDHD offers Diabetes Prevention Program in English and Spanish "Road to Health" in Spanish ▪ Community walking paths ▪ Farmer's markets in summer ▪ 3rd City is working with community gardens ▪ NE Extension does nutrition education with limited-resource youth and families ▪ Walk and Bike Grand Island working to increase physical activity ▪ Health retail grant with CDHD working to increase access to healthy foods.

Maternal, Infant, and Child Health		
Propel us forward	***Hold us back***	***Who is doing what?***
▪ H3C, CDHD, HHC, TCLL, NCFF, United Way collaborative environment ▪ Colleges ▪ Integrated clinics and low-income fee clinics ▪ Central Nebraska Child Advocacy Center - hired new director ▪ Working to increase immunization rates ▪ Strong group of pediatric providers in Grand Island ▪ Susan Buffett Foundation work in early childhood education ▪ H3C Birth to 11 subcommittee ▪ Early Childhood System of Care Assessment – completed 2015 ▪ Circle of Security – Parenting (to begin in fall 2016) ▪ Teen Pregnancy (& STD) Prevention Coalition, Un. Way ▪ CHC Early Detection STDs and pregnancy issues	▪ High poverty rate ▪ Postnatal visitation for all new parents needed ▪ Lack of prenatal care in 1st trimester to prevent complications, identify potential problems and have healthy babies (may be due to a lack of medical coverage) ▪ Lack of education ▪ Lack of parent education and engagement ▪ Lack of funding for CN Child Advocacy Center ▪ Lack of funding rooted in relationship expansion ▪ Teen pregnancy and STD rates ▪ Lack of transportation to prenatal appointments, work, etc. ▪ Fear (undocumented) of seeking services ▪ Living wage for families, parents, childcare providers ▪ Lack of 24-hour child care services and quality centers	▪ WIC ▪ Out of school, after school programs ▪ Breastfeeding support ▪ CHC reproductive health ▪ SixPence for teen parents ▪ Sex education curriculum in schools ▪ Focus on family unit in churches ▪ Central Nebraska Child Advocacy Center ▪ Heartland Community Health clinic NP seeing uninsured teens ▪ Teen pregnancy and STD prevention groups at United Way ▪ School nurse in every school ▪ Rooted in Relationships – social emotional workforce development in childcares ▪ Central access navigation intake and referrals for unconnected youth ▪ Parenting programs ▪ Faith based work

Access to Health Care		
Propel us forward	***Hold us back***	***Who is doing what?***
▪ Virtual health technology ▪ Third City Community Clinic, Heartland Health, Central Health Clinic – to help people who can't afford ▪ Great medical providers, skilled and compassionate ▪ Health care navigators, population health coaches, community health workers ▪ CHI offers virtual care through social media (e.g. Facebook) ▪ Community health workers – TCCC, CDHD ▪ Telehealth, virtual health	▪ Language access ▪ Cost $$, higher co-pays ▪ Knowledge ▪ Large need ▪ Lack of providers ▪ Provider burnout ▪ Transportation to care ▪ High cost of insurance, high deductibles ▪ Lack of Medicaid expansion ▪ Lack of insurance ▪ Political change? ▪ Navigation of the process and system of Access Nebraska	▪ Senior Health Insurance Information program (SHP), educate Medicare beneficiaries ▪ Project HELP at CCC – training providers ▪ Third City Community Clinic ▪ Student Wellness Center (GISH) ▪ Navigation assistance ▪ CDHD CHW helping to navigate systems ▪ Heartland Health Center sliding fee scale ▪ Midplains Center for Behavioral Health ▪ CHI: charity care, care coordination, network of providers ▪ CDHD 1st point of contact, referral services ▪ WIC, often 1st point of contact, strong referral services

Substance Abuse		
Propel us forward	***Hold us back***	***Who is doing what?***
▪ Funding ▪ Telehealth ▪ Data on gravity of the problem ▪ Strong police force, cooperation across the state ▪ Education ▪ Study adverse childhood experiences in community and increase trauma informed care (schools, law enforcement, health care)	▪ Funding ▪ Changing population (new cases) ▪ Ethnic and cultural difference on what is acceptable ▪ I-80 corridor for drugs and human trafficking ▪ Lax and permissive attitude towards marijuana use ▪ Over prescription of legal drugs (oxy, hydro), doctor shopping to get meds ▪ Weak or limited resources, especially for those in the criminal justice system ▪ Large Hispanic population allows cartels to move drugs in and out of Grand Island and hide in the community ▪ Limited # of providers doing screenings, then few policies to refer to for treatment, especially for adolescents	▪ Alcohol and drug treatment center at St. Francis ▪ Halfway house ▪ Hope Harbor ▪ Strong AA group ▪ SROs in schools, student wellness center evaluations and counselors ▪ Drug court ▪ Regional drug task force ▪ Goodwill community support program ▪ CNCAA and Discovery Kids ▪ Midplains Stabilization Unit

LARGE GROUP DISCUSSION

Next, highlights from each set of flip charts were shared with the whole group. This was followed by a group discussion on the following questions, intended to move the group towards prioritization of the six issues.

- With what issues do we already have a lot of energy within the community?
- Where do we see a need for attention?
- Which of these issues is most impacted by the Forces of change we discussed earlier?
- Are there any issues that, if prioritized, would make a larger impact on our community than others? Would impact other issues as well?
- Which issues will be most important to our citizens in Hall County? Which will have the biggest impact?

An important discussion occurred following the question: *Is there something important to our community that we are missing?* Meeting participants shared their views on there being a lack of a "culture of health" in the community. It was determined that they would like to see this concept as a category in and of itself.

A final framework (below) was shared offering a set of criteria participants might use as they move into prioritization of the health issues.

Size	How many people are affected?
Seriousness	Deaths, hospitalizations, disability
Trends	Is it getting worse or better?
Equity	Are some groups affected more?
Intervention	Is there a proven strategy?
Values	Does our community care about it?
Resources	Build on current work – available money?
Others	Impact on a key social determinant

PRIORITIZATION

Each person was given 3 "votes" to rank priorities for the next three years. As they made their decisions, they were asked to think about:

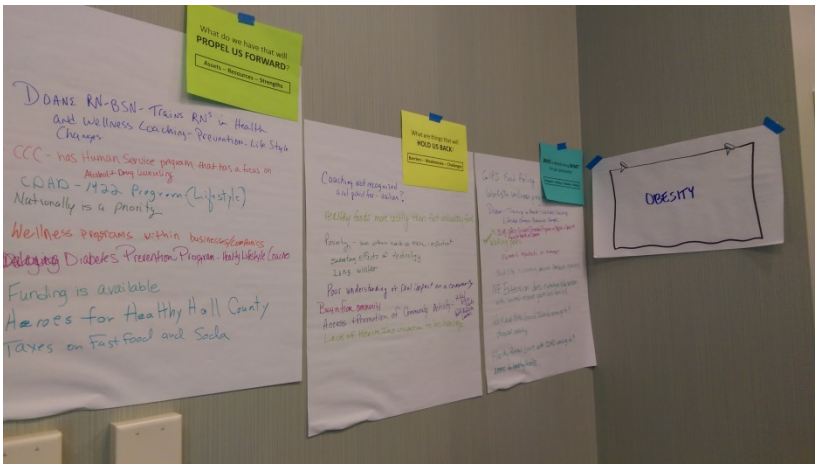
- Discussions regarding the issues, strengths, weaknesses and current partners working on those issues.
- The Forces of Change and how the trends discussed might truly impact the work.
- The discussed criteria for choosing health priorities.

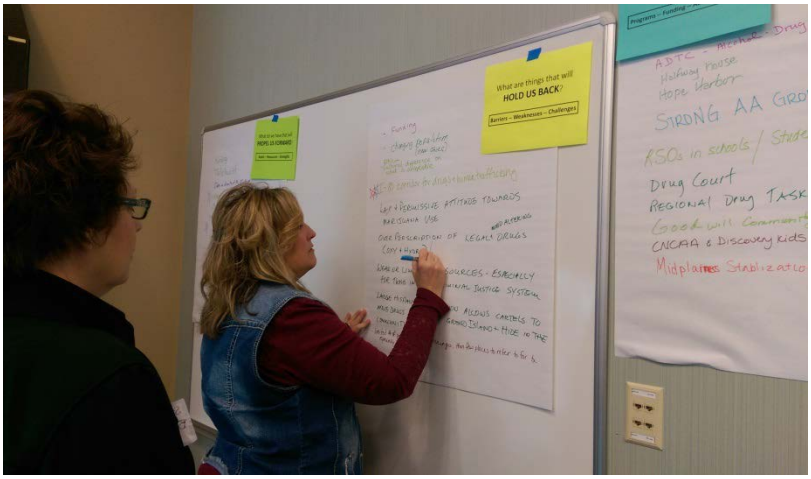
When adjourning the meeting, they were asked to vote on prioritization by answering the question:
Knowing that there is good work going on in the community, what should we focus on to have the biggest impact on health in the next three years?

The issues received the following number of votes:

- Behavioral Health l Mental Health = 24
- Substance Abuse = 16
- Culture of Health = 9
- Maternal, Infant, and Child Health = 7
- Injury and Violence = 6
- Access to Health Care = 4
- Obesity = 3

Congratulations to Central District Health Department and CHI Health St. Francis for completing this community health assessment prioritization process!






CHI Health