Community Health Needs Assessment Report

Saline County, Nebraska

12/31/2018

Table of Contents

I. Introduction 3
II. Description of Community Served 3
III. Crete Area Medical Center and Community Assets 3
IV. Evaluation of Previous Implementation Plan 5
V. 2018 Community Health Needs Assessment 6
VI. Priority Community Health Needs Identified 6
VII. Summary: Assessment and Priorities 7
VIII. Next Steps 8
IX. Adoption/Approval 8

Appendices

Appendix A: County Health Rankings & Roadmaps, Saline County NE
Appendix B: Public Health Solutions Action Planning Results, September 27, 2018
Appendix C: CAMC Community Meeting Results, July and August 2018
Appendix D: Public Health Solutions Regional Steering Committee Members
Appendix E: Public Health Solutions CHA and CHI Process

I. Introduction

This Community Health Needs Assessment Report is prepared and submitted by Crete Area Medical Center in partnership with Public Health Solutions District Health Department (PHS). For the purposes of this report, the communities served include the City of Crete, Friend, Wilber and Saline County.

II. Description of Community Served

Saline County Overview	
Land area, 2015 (square miles)	574
Total population, 2017 estimate	14,441

The three largest communities in Saline County are Crete (Pop. 7,080), Wilber (Pop. 1,716), and Friend (Pop. 992). The City of Crete has experienced a 17% population growth since 2000, well above the average growth rate of Nebraska (8.44%) and the United States (11.61%).

Crete is served by the Crete Area Medical Center and Crete Medical Clinic as well as Saline Medical Specialties. Crete Area Medical Center also operates the Wilber Medical Clinic in Wilber and the Friend Medical Clinic in Friend. Friend is also served by the Friend Community Healthcare System. Public Health Solutions District Health Department serves a five county area in the region which includes Saline County.

The City of Crete is home to a large Hispanic population. The 2016 estimates from the American Community Survey indicate that persons of Hispanic origin make up 35.6% of the population in Crete and 23.3% of the population in Saline County versus 10.2% for Nebraska.

The major employers in Crete/Saline County include Bunge Milling, Smithfield Foods, Nestle Purina, and Crete Public Schools among others. In addition, Crete is home to Doane University, a private, Liberal Arts University.

According to the Nebraska Health information System Inpatient and Outpatient Data from quarter two (2) of 2018, 94.4% of Crete Area Medical Center's inpatients and 81.2% of its outpatients originated from Saline County.

III. Crete Area Medical Center and Community Assets

Crete Area Medical Center, a subsidiary of Bryan Health, features 24 private patient rooms, two surgery suites, physical, occupational therapy and cardiac rehabilitation space, a trauma area

within the emergency department and a helicopter pad. It serves approximately 340 inpatients per year with approximately 78,000 Outpatient visits. Crete Area Medical Center family practice clinics are fully staffed medical clinics that provide primary care to the residents of Crete and surrounding areas. The Crete Medical Clinic serves an estimated 19,500 patients per year, Wilber Medical Clinic serves an estimated 4,600 patients per year, and Friend Medical Clinic serves an estimated 4,100 patients per year.

Saline Medical Specialties, a fully staffed medical clinic, is part of the CHI Health Saint Elizabeth Physician Network. It serves residents of Crete and surrounding areas.

Friend Community Healthcare System, located in Friend**,** provides acute care, emergency care, primary care, outpatient clinics, outpatient surgery, skilled care and therapy.

Crete Public Schools, located in Crete, offers numerous special programs for adult students including adult basic education, GED preparation and testing, English language acquisition, Migrant Education Program, family literacy and the Sixpence parenting program.

Blue Valley Community Action Partnership (BVCA) operates over 30 programs that interact and complement each other. Their programs encompass basic needs, education, family development, health and nutrition (including Women, Infants & Children (WIC)), housing, transportation, and volunteer opportunities.

Tabitha of Crete is a skilled nursing, rehabilitation, long-term care and assisted living facility affiliated with Tabitha in Lincoln. Tabitha of Crete provides two residential-style houses designed to offer elder-centered care, along with an assisted living facility.

Public Health Solutions District Health Department (PHS) is a district health department serving Fillmore, Gage, Jefferson, Saline, and Thayer counties. As a health department it covers a wide range of activities, including immunizations, family and individual health services, community training, community services, and population protection. Public Health Solutions has been in existence since January 2002.

Wilber Care Center, located in Wilber, is a city owned skilled nursing and assisted living facility. It offers 24 hour nursing care along with a meals on wheels program, and an outpatient physical, occupational and speech therapy program that serves people of all ages.

IV. Evaluation of Previous Implementation Plan

Following the completion of the community health needs assessment in 2015, Crete Area Medical Center (CAMC) worked with its community partners to outline goals for addressing each community priority as well as implementation actions that would work toward achieving each of these goals within the communities of Saline County. The following evaluation of the implementation plan shows the progress that has been made by CAMC and other community partners to address the four key priorities established in the previous community health needs assessment.

Goal A: Expand community exercise and wellness resources

Crete Area Medical Center (CAMC) hosted a Partners in Health Event that was open and free for the community to attend. The event included twenty-six (26) partners that showcased their role in health and wellness. The partners represented physical, social, dental, mental, and financial health and wellness. CAMC also hosts a bi-annual health fair and provides preventative screenings at reduced rates for community members in Crete, Wilber, and Friend. In addition, CAMC is a participant in health fairs across Saline County providing free blood pressure checks, weight checks, skin cancer screenings and preventative health education.

Goal B: Provide community education on various health topics and resources available

CAMC partnered with local community partners to develop an educational series on topics related to aging. In addition, CAMC hosted a monthly lunch and learn for the surrounding communities that included topics such as skin cancer, colon health, thyroid health, and advance directives, among others. CAMC participated in Farm Safety Days in Crete, where education related to the importance of exercise and smart beverage choices was delivered to a kid-based audience.

Goal C: Increase access and ease of providing behavioral health services

CAMC offers child psychology services in both their Crete and Wilber clinics and adult psychology services in their Crete clinic. Online behavioral health screening tools are available through the Bryan Health website.

Goal D: Ensure 100% of children have access to preventative care

CAMC has extended weekday hours and weekend hours at the Crete Medical Clinic. There is appointment availability for preventative care visits for children throughout those times. CAMC also has a Financial Assistance Program available for those who qualify in order to remove any financial barriers to access.

V. 2018 Community Health Needs Assessment

Information reviewed for the community health needs assessment included population demographics, health status indicators from the County Health Rankings & Roadmaps, and information gathered as part of the Public Health Solutions Regional Steering Committee.

Data from the County Health Rankings & Roadmap report revealed that Saline County excels in some health status categories, but it has also fallen behind the state average in a few areas of concern. Saline County has a higher rate of diabetes monitoring (91%) compared to the State of Nebraska (87%) as well as a lower rate of sexually transmitted diseases (364.9 compared to 422.9) and teen births (21 compared to 25) to the State of Nebraska.

Areas of concern include an above average rate of adult obesity – 34% compared to Nebraska's 31% – and physical inactivity at a rate of 32% compared to the state average of 23%. Both of these issues could relate back to access to exercise opportunities. In Saline County, only 66% of individuals have access, whereas the state average is 83%. Access to behavioral health providers in the area is also a concern. The ratio of population to providers in Saline County is 1,790:1 while the state average is 420:1.

Social & Economic factors also impact health needs within Saline County. The county has a lower education level than other areas with 51% of the population having at least some college completed, while the state average is 71%. Median household income for Saline County is $51,200 compared to the State average of $57,000. The uninsured rate for Saline County is 13% compared to a state average of 9%. While violent crime ranks lower than the state average (105 compared to 267), the number of injury deaths is higher (70 compared to 58).

Priority Community Health Needs Identified

The process for identifying the community health needs was two-fold. First CAMC participated in the Public Health Solutions Regional Steering Committee for the Partners for a Healthy Community. This Committee's purpose was to complete a comprehensive community health assessment and develop a community health improvement plan for the five (5) counties they serve, which includes Saline County. The committee consisted of thirty-four (34) multi-disciplinary individuals, eight (8) Public Health Solutions team members, and two (2) consultants. (Appendix D). The committee met monthly, beginning May 17, 2018 and concluded their meetings on September 27, 2018. The committee used a seven (7) step process (Appendix E), utilizing committee feedback, external data sources, as well as a public survey.

In order to zero in on the needs of Saline County, CAMC hosted community rounding sessions in Crete, Wilber, and Friend. The rounding sessions were held with various individuals and industries in the communities. These included:

- City of Crete – Tom Ourada, City Administrator
- Crete Public Schools – Dr. Mike Waters, Superintendent

- Doane University – Dr. Jacque Carter, President
- Bunge Milling – Julie O'Brien, Environmental Health and Safety Manager
- Crete Police Department – Steve Hensel, Chief of Policy
- City of Wilber – Roger Chrans, Mayor
- Friend Public Schools – Elizabeth Stutzman, Principal
- Friend Fire & Rescue – Kelly Paulsen, President
- Saline County – Willis Luedke, Commissioner

Community Rounding sessions were held from July 2018 thru August 2018. During the sessions various questions were asked, including areas where CAMC was meeting needs, items of importance, and future focus areas (Appendix C).

VI. Summary: Assessment and Priorities

Once priorities were identified, goals and implementation actions for each of the priority health issues were developed. The proposed goals and implementation actions recommended are as follows:

I. Metabolic Syndrome

a. Metabolic Syndrome is a cluster of conditions – increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels – that occur together, increasing the risk of heart disease, stroke and diabetes.

Goal: Reduce the incidence of metabolic syndrome

Implementation Action:

1. Participate in the Public Health Solutions Metabolic Syndrome cohort. The cohort's goal is to increase awareness of metabolic syndrome and the risks associated, develop standard processes and protocols in the diagnosis and treatment of metabolic syndrome, and collaborate to provide resources to reduce the number of patients diagnosed with metabolic syndrome.

2. Develop a nutritional wellness model / program aimed at reversing metabolic syndrome conditions

II. Behavioral Health

Goal: Increase awareness of behavioral health. Increase access to behavioral health services.

Implementation Action:

1. Participate in the Public Health Solutions Behavioral Health cohort. The cohort's goal is to increase awareness and access to behavioral health services.

2. Collaborate with internal and external resources to provide behavioral health education for Staff in community schools

III. Physical Activity Opportunities

Goal: Increase walkability of the City of Crete

Implementation Action:

1. Collaborate with Crete community partners on expanding walkability of City

VII. Next Steps

Crete Area Medical Center will incorporate the priority health needs identified in the Community Health Needs Assessment into their strategic planning process. An Implementation Strategy Report will be developed, which outlines how CAMC will work with the community to address the priority health needs of Saline County

VIII. Adoption/Approval

This Community Health Needs Assessment was approved and adopted by the Crete Area Medical Center Board of Trustees on Tuesday, November 27, 2018.

Appendix A

County Health
Rankings & Roadmaps
Building a Culture of Health, County by County

Saline (SA)

County Demographics

	County	State
Population	14,331	1,907,116
% below 18 years of age	24.5%	24.8%
% 65 and older	15.3%	15.0%
% Non-Hispanic African American	0.8%	4.7%
% American Indian and Alaskan Native	1.6%	1.4%
% Asian	3.0%	2.5%
% Native Hawaiian/Other Pacific Islander	0.6%	0.1%
% Hispanic	24.7%	10.7%
% Non-Hispanic white	70.1%	79.6%
% not proficient in English	9%	3%
% Females	48.7%	50.2%
% Rural	51.1%	26.9%

		Saline County	Error Margin	Top U.S. Performers	Nebraska	Rank (of 80)
Health Outcomes						42
Length of Life						30
Premature death		6,400	4,900-7,800	5,300	6,000	
Quality of Life						59
Poor or fair health **		16%	15-16%	12%	14%	
Poor physical health days **		3.2	3.0-3.3	3.0	3.2	
Poor mental health days **		2.9	2.8-3.1	3.1	3.2	
Low birthweight		6%	5-8%	6%	7%	
% LBW	6%					
% LBW (Hispanic)	5%					
% LBW (White)	7%					
Additional Health Outcomes (not included in overall ranking)						
Premature age-adjusted mortality		390	330-450	270	310	
Child mortality				40	50	
Infant mortality				4	5	
Frequent physical distress		10%	10-10%	9%	9%	
Frequent mental distress		10%	9-10%	10%	10%	
Diabetes prevalence		9%	7-11%	8%	9%	
HIV prevalence				49	132	
Health Factors						50
Health Behaviors						55
Adult smoking **		16%	16-17%	14%	17%	
Adult obesity		34%	30-38%	26%	31%	
Food environment index		8.5		8.6	8.1	
Physical inactivity		32%	28-36%	20%	23%	
Access to exercise opportunities		66%		91%	83%	
Excessive drinking **		20%	19-21%	13%	21%	
Alcohol-impaired driving deaths		36%	21-50%	13%	37%	
Sexually transmitted infections		364.9		145.1	422.9	
Teen births		21	17-26	15	25	
Teen Birth Rate	21					
Teen Birth Rate (Hispanic)	60					
Teen Birth Rate (White)	11					
Additional Health Behaviors (not included in overall ranking)						
Food insecurity		9%		10%	12%	
Limited access to healthy foods		6%		2%	6%	
Drug overdose deaths				10	7	
Drug overdose deaths - modeled		8-11.9		8-11.9	6.4	
Motor vehicle crash deaths		21	13-32	9	12	
Insufficient sleep		29%	28-30%	27%	30%	
Clinical Care						40
Uninsured		13%	11-15%	6%	9%	
Primary care physicians		1,790:1		1,030:1	1,340:1	
Dentists		2,390:1		1,280:1	1,360:1	
Mental health providers		1,790:1		330:1	420:1	
Preventable hospital stays		42	32-51	35	48	
Diabetes monitoring		91%	77-100%	91%	87%	

	Saline County	Error Margin	Top U.S. Performers	Nebraska	Rank (of 80)
Mammography screening	58%	46-70%	71%	62%	
Additional Clinical Care (not included in overall ranking)					
Uninsured adults	15%	13-18%	7%	11%	
Uninsured children	8%	6-10%	3%	5%	
Health care costs	$10,280			$9,334	
Other primary care providers	1,592:1		782:1	988:1	

		Saline County	Error Margin	Top U.S. Performers	Nebraska	Rank (of 80)
Social & Economic Factors						55
High school graduation		87%		95%	87%	
Some college		51%	44-57%	72%	71%	
Unemployment		3.2%		3.2%	3.2%	
Children in poverty		13%	10-17%	12%	14%	
% Children in Poverty	13%					
% Children in Poverty (Hispanic)	24%					
% Children in Poverty (White)	8%					
Income inequality		3.7	3.0-4.3	3.7	4.3	
Children in single-parent households		20%	12-28%	20%	29%	
Social associations		15.4		22.1	13.9	
Violent crime		105		62	267	
Injury deaths		70	52-92	55	58	
Additional Social & Economic Factors (not included in overall ranking)						
Disconnected youth				10%	9%	
Median household income		$51,200	$44,800-57,700	$65,100	$57,000	
Household Income	$51,200					
Household Income (Hispanic)	$36,200					
Household Income (White)	$54,700					
Children eligible for free or reduced price lunch		46%		33%	44%	
Residential segregation - black/white				23	66	
Residential segregation - non-white/white		41		14	48	
Homicides				2	4	
Firearm fatalities				7	9	
Physical Environment						43
Air pollution - particulate matter **		9.3		6.7	8.2	
Drinking water violations		No				
Severe housing problems		12%	8-16%	9%	13%	
Driving alone to work		74%	70-78%	72%	81%	
% Drive Alone	74%					
% Drive Alone (Hispanic)	66%					
% Drive Alone (White)	79%					
Long commute - driving alone		25%	21-29%	15%	18%	

Areas to Explore   Areas of Strength

^ 10th/90th percentile, i.e., only 10% are better.
Note: Blank values reflect unreliable or missing data
** Data should not be compared with prior years

2018

Appendix B

Metabolic Syndrome

TOP ACCELERATED ACTION PLANNING – PART 1: INITIAL PLAN

1. THE GIVENS:

What is the goal of the project?
- Reduce # of patient current rates with metabolic syndrome
- Prevent future metabolic syndrome by ___%

What have we accomplished to date? What do we have in place?
- Have the data – need to be able to analyze and use
- SMBP workflow at BCHHC (evidence-based guidelines)
- JCHL Standard Order Set (referral to NDPP)
- Metabolic syndrome reversal program – worksite wellness FCH
- NDPP active in 3 out of 5 counties

What is the time frame?
- 1 year

What else do we already know about this project?
- Takes entire community teamwork ; access to foods, recreation, Pharmacists, CHW's
- Physicians must be on board
- Need shared governance with providers
- Living Well is state priority-funded trainings

2. VICTORY

What do we see in place that indicates our success? The completed project is…
- Reduction of patients diagnosed with metabolic syndrome
- Increase awareness of metabolic syndrome and risks (health literacy)
- Decrease obesity
- Environmental supports available (environmental scan)
  Food pantries, grocers, recreation
- Healthy choice=easy choice

3. OUR CURRENT REALITY

3a. Strengths	3b. Weaknesses	3c. Benefits	3d. Dangers
What are our strengths as a team? • Many pieces in place → • Shared vision	What are our weaknesses as a team? - Currently not shared or used widely across district - Ingrained silos - Communities are unique – EHR's do "talk" to one another	What benefits will our success bring? - Healthier community - Organizational collaboration	What obstacles or dangers do we anticipate confronting when we highly successful? - Reduce ER revenue! - If health system goes to preventative, health department duplicating?

4. Commitment – What are we <u>REALLY</u> committed to accomplishing as a team?
- Inventory current resources
- Sharing current resources
- Collaborating (pooling resources) for additional (identifying gaps) needed resources (healthy system + public health – leverage resources)
- Baseline data inventory on current patient panels

TOP ACCELERATED ACTION PLANNING – PART 2: CHARTING THE COURSE

______ **A.** Mark off the timeline. Determine when the project begins and ends and divide the time by 6. Fill in the months, weeks or dates across the top row in the blank boxes to create the overall project timeline.

______ **B.** Fill in the activity names down top half of the first column.

______ **C.** Decide how you will work together to complete the timeline. You may work in sub-teams, collectively or individually. Fill in members in the bottom part of the first column.

______ **D.** Decide the "Success Indicator" of each activity. Example: *At least 100 people are engaged in the campaign.*

______ **E.** Decide the "First Step" of each activity. Example: *Flyer prepared and mailed to community members.*

______ **F.** Place the task post-its along the timeline. Make new post-its, if needed.

______ **G.** Think about resources and budget needed for the sub-team to accomplish the task. Write and estimate in the "$" box at the end.

Activity Name	**First Step**	**6. THE ACCELERATED ACTION PLAN CALENDAR**						**Success Indicator**	
Member(s)		Oct/Nov	Dec/Jan	Feb/Mar	April/May	June/July	Aug/Sept		**$**
Rebecca	Identify contact within each organization who can get baseline data/inventory for metabolic syndrome patients		Rebecca to have contacted hospital CEO's asking for baseline data/contact for baseline data	Convene contacts/task force with baseline data				Electronic inventory of baseline data for metabolic syndrome patients developed	
Rebecca to initiate/all to participate in task force	Create inventory of protocols, practices, procedures related to metabolic syndrome indicators (include best practices, benchmarks)			Convene contacts/task force with baseline data				Comprehensive inventory of protocols, processes, procedures related to metabolic syndrome in shared format	
All	Share of annual RSC meeting on progress of action plan							Recorded in PM system	
Sonya Jen Sharon	Explore opportunities for shared files (drop box)							Adapt, Adopt, Abort	
Jen Sharon	Environmental scan of HF/recreation/pantries/ancillary care							Environmental scans complete for HF access, recreation, ancillary care providers	

Mental Health

TOP ACCELERATED ACTION PLANNING – PART 1: INITIAL PLAN

2. THE GIVENS:

What is the goal of the project?

- Awareness and integration of behavioral health into the whole health model

What have we accomplished to date? What do we have in place?

- Rooted in Relationships/Pyramid Model
- Early Childhood Prevention
- QPR
- Opened the mental health conversation
- National attention re: opioid/drug abuse
- Telehealth
- Parity legislation
- Grants found on EC, PIWI/PCIT/ mental health
- Mental health first aide

What is the time frame?

- 1 year

What else do we already know about this project?

2. VICTORY

What do we see in place that indicates our success? The completed project is…

- Every person is aware of and has access to behavioral health services

5. OUR CURRENT REALITY

3a. Strengths

What are our strengths as a team?

- Infrastructure
- Champions of behavioral health
- Networks
- Grant Funding
- National Attention

3b. Weaknesses

What are our weaknesses as a team?

- Resources
- Accessibility
- Stigma
- Return on investment

3c. Benefits

What benefits will our success bring?

- Save healthcare $
- Healthy families/healthy communities
- Less incarceration
- Increased graduation rates
- Less teen pregnancy/poverty
- Increased quality of life
- Increased positive health outcomes

3d. Dangers

What obstacles or dangers do we anticipate confronting when we are highly successful?

- Increased burden/demands on system
- Shortage of providers
- Loss of hospital revenue
- Over-diagnosis

4. COMMITMENT – What are we REALLY committed to accomplishing as a team?

- Working collaboratively/shared resources
- Prevention and education focused
- Openly discussing mental health/reduce stigma
- Early childhood mental health/prevention work

Mental Health

TOP ACCELERATED ACTION PLANNING – PART 2: CHARTING THE COURSE

_____ **A.** Mark off the timeline**.** Determine when the project begins and ends and divide the time by 6. Fill in the months, weeks or dates across the top row in the blank boxes to create the overall project timeline.

_____ **B.** Fill in the activity names down top half of the first column.

_____ **C.** Decide how you will work together to complete the timeline. You may work in sub-teams, collectively or individually. Fill in members in the bottom part of the first column.

_____ **D.** Decide the "Success Indicator" of each activity. Example: *At least 100 people are engaged in the campaign.*

_____ **E.** Decide the "First Step" of each activity. Example: *Flyer prepared and mailed to community members.*

_____ **F.** Place the task post-its along the timeline. Make new post-its, if needed.

_____ **G.** Think about resources and budget needed for the sub-team to accomplish the task. Write and estimate in the "$" box at the end.

Activity Name Member(s)	**First Step**	**6. THE ACCELERATED ACTION PLAN CALENDAR**						**Success Indicator**	**$**
Screenings	Complete an environmental scan	Identify gaps	Provide education and get commitment where gaps exist	Support leveraging of resources	Develop central tracking system	Re-evaluate and monitor support		Every child/adult screened	
Resource Hub									
Telehealth Service									
Awareness/Education									
Develop collaborations	Identify potential partners							MOU established in collaboration	

Appendix C

Bryan CRETE AREA MEDICAL CENTER

Community Rounding – July and August 2018

What are we doing well to meet the service area's needs?

- Flexible (hours, many services offered, including specialists)
- ALS Program
- Small town service
- People get to know you as a person – not a number
- Quality of Care received
- Professional care
- Personal touch
- Staying with the times or ahead of the times
- Tremendous community partners (Crete)
- Serves as a draw to the community

Items of importance (must haves)

- The fact that you are here. Local hospital tied to a greater resource is immeasurable
- Having options here instead of driving to Lincoln
- 'Real' providers who care about you as a person and listen
- No gaps in coverage with provider transitions (Friend)
- Bedside manner
- Availability
- Reach of total care
- Affordability

Focus Areas

- Keep the door open to meet 'area' needs
- Immunizations (Friend)
- Mental Health
  - Education to parents / teachers
  - Services
- Sponsorship Opportunities
- Volunteer Opportunities for school kids
- Occupational Health Clinic
  - Services
  - Education to providers
- Health and Wellness (proactive care)
- Partnerships with higher education for a stronger pipeline of healthcare professionals

Appendix D

REGIONAL STEERING COMMITTEE MEMBERS

Ament, Linda	Beatrice Community Hospital & Health Center *Chief Compliance Officer, BOH Member*	
Barnes, Theresa	Blue River Women's Center *Director*	
Bartles, Scott	Saline County Area Transit (SCAT) *Executive Director*	
Burd, David	Thayer County Health Services *CEO*	
Castañeda, Dulce	City of Crete *Community Assistance Director*	
Cerny, Larry	Fillmore County Commissioners *County Commissioner, BOH Member*	
Clark, Trudy	Bruning Davenport School District *Superintendent, BOH Member*	
Cook, Don	Southeast Nebraska CASA *Program Coordinator*	
Dimas, Fabiola	Crete Public Schools *Sixpence Director*	
Duis, Dusty	Southeast Community College *Practical Nursing Instructor*	
Ebke, Laura	Nebraska Legislature *Senator – District 32*	
Engler, Mark	Homestead National Park – Beatrice *Superintendent*	
Erickson, Kathy	Blue Rivers Area Agency on Aging *CHOICES Unit Supervisor*	
Gabriel, Pastor Greg	St. John Lutheran Church – Beatrice *Pastor*	
Gutierrez, Josue D., MD	Saline Medical Specialties *MD, BOH Member*	
Henning, Janet	Saline County Commissioners *County Commissioner, BOH Member*	
Hensel, Steve	Crete Police Department *Chief of Police*	
Hill, John	Gage County Commissioners *County Commissioner, BOH Member*	
Jirovec, Kelly	Doane College – Crete *Director of Student Services*	
Jurgens, Chad	Jefferson Community Health & Life *CEO*	
Kennedy, Bruce, DDS	Kennedy Family Dentistry *Dentist, BOH Member*	
Knight, Stephanie	Fillmore County Hospital	

	Behavioral Health Director, BOH Member
Lucking, Christy	Fairbury Public School *Guidance Counselor, BOH Member*
Michl, Shari	Fillmore County Hospital *Director of Quality*
Miller, Shari	Blue Valley Community Action *Director of Children and Youth Services*
Mussman, Rebekah	Crete Area Medical Center *CEO*
Nichols, Chris	Fillmore County Hospital *CEO*
Pickering, Tim	Nebraska State Patrol *Sergeant*
Schoenrock, Mark	Jefferson County Commissioners *County Commissioner, BOH Member*
Small, Cara	Educational Service Unit (ESU) 6 *Early Learning Coordinator*
Smith, Patty	Fairbury Public Schools *Principal*
Sothan, Michael	Mainstreet Beatrice *Executive Director*
Tietjen, Jana	Hebron Chamber of Commerce *Chamber Director*
Timmerman, Missy	Beatrice Public Schools *Director of Beatrice Community Preschool*
PHS Management Team Members	
Buser, Kim	PHS, Health Director
Chinchilla, Carmen	PHS, AHEC Program Manager
Garcia, Megan	PHS, Rooted in Relationships Program Manager
Hansen, Jennifer	PHS, Community Development Manager
Lange, Kate	PHS, Emergency Response Coordinator
Williamson, Sonya	PHS, Fiscal Administrator
Wooters, Laura	PHS, Healthy Families Gage and Jefferson Director
Yelkin, Sara	PHS, Front Office Manager
NALHD Members	
Bockrath, Susan	NALHD, Executive Director
Nicholson, Sondra	NALHD, Facilitator

Appendix E

Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) Process

Step 1
Establish the **Regional Steering Committee (RSC)**

↓

Step 2
Create a **Vision**

↓

Step 3
Assess the Communities' Health and Resources

- *What are the region's Strengths, Weakness, Opportunities and Threats for the promotion and protection of the public's health?*
- *How do community members perceive their health and quality of life concerns and do community members know about resources and assets in their community?*
- *What strengths and gaps exist in the 5 county Public Health system?*
- *What does the data say around quality of life, behavioral risk factors, and other measures that reflect the conditions in which community members live, work, play, and pray?*

↓

Step 4
Determine Health **Priorities**

↓

Step 5
Develop **Community Health Profile**

↓

Step 6
Choose effective CHIP strategies

- *Evidence based or informed strategies*
- *Action plan with goals and objectives*

↓

Step 7
Committee coordinate progress on CHIP strategies and incorporate designated priorities into organizational strategic plans.

Partners for a Healthy Community