Community Health Needs Assessment

Approved: October 21, 2021

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I. Introduction

Merrick Medical Center has prepared and submitted this Community Health Needs Assessment (CHNA), fulfilling the requirements established by the patient Protection and Affordable Care Act requiring that non-profit hospitals conduct community health needs assessments at least every three years. The health assessment and priority community health needs identified in this report constitute a collaborative effort between Merrick Medical Center, Memorial Community Health, CHI St. Francis, Grand Island Regional Medical Center, Central District Health Department and the Nebraska Association of Local Health Directors (NALHD), gathering extensive input from individuals representing a broad interest of Central City, Merrick County, Hall County and Hamilton County. Merrick Medical Center is a 22-bed critical access hospital with two rural health clinics located in Central City and Fullerton. For the purposes of this report, the communities served is all of Merrick County, as well as Fullerton, which is in Nance County.

II. Description of Community Served

For the purpose of this report, the community served by Merrick Medical Center in Merrick County, Nebraska. Merrick County is 485.7 square miles of land area and is the 77th largest county in Nebraska by total area. The population within this county accounts for 7,668 people. According to the Nebraska Health Information System, 76% of Merrick Medical Center's inpatient discharges and outpatient visits came from patients residing within Merrick County. *(Source: Nebraska Health Information Systems; Inpatient and Outpatient Data: January 1, 2019 to December 31, 2019).*

The following communities are located in Merrick County: Central City (population 2,903), Clarks (population 374), Chapman (population 254), Palmer (524), Silver Creek (409), Archer (population 51) and Worms (unincorporated). For the purposes of this report Fullerton (population 1,446) is also included in our service area, which is northeast of Central City.

Merrick County has a current population estimate in 2020 of 7,668 people with a -1.3% decline in population from 2010-2019. Towns that have shown growth in population over the past ten years are Silver Creek (32%), Clarks (6%), Palmer (4%) and Central City (less than 1%). Towns that have experienced a decline in population are Archer (-66%) and Chapman (-51%). Fullerton is not in Merrick County, but they too experienced a decline in population of 5%. *(Source: U.S. Census Bureau 2010 & 2019: American Community Survey 5-Year Estimates).*

Population Demographics

Merrick County has a median age of 43.6 which is 0.5% higher than Nebraska's average of 36.8. The county also has 20.7% of its population 65 years and over to be higher than Nebraska's average of 16%. The primary race / ethnicity is comprised of 5% Hispanic, 92% non-Hispanic, white and 3% non-Hispanic, other races. The primary language spoken by the county is English (94%) and the secondary language of Spanish (4.2%). *(Source: U.S. Census Bureau, 2020 Census). (Source: U.S. Census Bureau, 2019 American Community Survey 5-Year Estimates).*

Economic Characteristics

Merrick County has a 64% employment rate and an unemployment rate of 2.7%, which may seem unbalanced, but if 20% of the population is at retirement age and 22% is under the age of 18 then this is where the variance occurs. The median household income of $53,411 is lower than Nebraska's average is $63,290. The county's poverty level is higher at 12% compared to Nebraska's average of 9.9%.

An educational summary for Merrick County:

Merrick County	**Nebraska**
94% have completed high school	91% have completed high school
73% have completed some college	72% have completed some college
18% have completed a Bachelor's Degree	32% have completed a Bachelor's Degree

Merrick County has 236 employers in the county. Merrick Medical Center in Central City is one of the largest employers in that town with the public school being a close second. *(Source: U.S. Census Bureau 2019 Quick Facts on Merrick County Nebraska).*

III. Merrick Medical Center and Community Assets

Merrick Medical Center, a 22-bed critical access hospital is a non-profit organization owned by Bryan Health and is located in Central City, NE. It has two rural health clinics, Central City Medical Clinic located in Central City and Fullerton Medical Clinic located in Fullerton that provides family medicine from birth to end of life. It has a specialty outpatient clinic located within the hospital that provides: cardiology, ENT, general surgery, mental health therapy,

nephrology, OB/GYN, orthopedics, pulmonology and urology. The hospital also provides a cardiac rehab, emergency department, infusions, laboratory, radiology, physical therapy, occupational therapy, speech therapy and surgery.

For the fiscal year 2020, Merrick Medical Center performed 152 surgical procedures, had 128 acute discharges, 39 swing bed discharges and 1,317 emergency room visits. The specialty clinic had 1,703 visits, the Central City Medical Clinic had 10,600 visits and the Fullerton Medical Clinic had 1,232 visits.

Good Samaritan - Litzenberg Memorial Long Term Care is a skilled nursing, rehabilitation and long term care facility that is managed by Good Samaritan Society and is adjoined to Merrick Medical Center. They are licensed for 46 beds and provide 24 hour nursing care.

Merrick County Senior Services is senior center located in Central City. This senior center offers the following services: center meal, home delivered meals, information and assistance, outreach and transportation.

Central City Care Center is a 63 bed senior care community located in Central City. It offers memory care, assisted living and nursing home care.

Central District Health Department serves Merrick, Hall and Hamilton counties. As a health department, it provides Community Health, Environment Health, Health Projects and Food & Safety Permits.

Food Bank for the Heartland offers a once a month mobile food pantry that is free for individuals and families. It provides fresh produce, bakery goods, dairy products, meat and various shelf-stable items for Merrick County residents.

The Heartland United Way serves a four county area including Merrick County and partners with close to 20 community partners to provide various services throughout the four county area. Each year, with funding from the United Way, these partner agencies provide programs, services and resources.

IV. Evaluation of Previous Implementation Plan

Following the completion of the community health needs assessment in 2018, Merrick Medical Center 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. The following evaluation of the implementation plan shows the progress that has been made by Merrick Medical Center to address three key priorities established in the previous community health needs assessment.

Goal A: Access to Care

Merrick Medical Center hosted Men's Night and Ladies Night health events that were open and

free for the community to attend. The event included over twenty community partners that showcased fun, self-defense, health screening, wellness tips with good food and beverages.

Merrick Medical Center continues to improve access to specialty care by adding specialists, training, and equipment. We have added specialists in ENT, urology, interventional radiology, and nephrology. The specialty clinic has also increased clinic days in cardiology, orthopedics and general surgery. Rehab Services implemented a new pediatric speech therapy program by onboarding a fulltime speech therapist and adding a pediatric occupational therapist. Additional training to the medical staff and nurses in Pediatric Advanced Life Support (PALS) now allows us to provide pediatric surgery. We secured home sleep study equipment to increase the number of studies that can be performed at home by our patients.

In 2020, Merrick Medical Center created a physician controlled COVID Drive Thru Clinic and a Community COVID Vaccine Clinic. A pandemic surge plan transitioned four patient rooms into an isolated COVID hall to keep patients local and closer to their home.

Merrick Medical Center began a Financial Assistance Program available for those who qualify in order to remove any financial barriers to access. Another cost savings solution that began in 2021 is a once a month health fair to provide preventative lab work at a reduced rate for patients.

In September 2020, Merrick Medical Center broke ground on a new 55,000 square foot facility with a move in date of May 2022. The new hospital will enhance and increase services to our residents in Merrick, Nance and Hamilton Counties.

Goal B: Increase Behavioral Health Access

Merrick Medical Center began offering Behavioral Telehealth for patient visits and provider consults. Additional mental health providers are being sourced to help meet the needs of the community.

Goal C: Decrease Community Obesity and Inactivity

Due to COVID precautions and restrictions, Merrick Medical Center altered patient communication and interactions. Resolution to these changes created Shape My Health virtual support, virtual cooking classes, dietician outreach, fitness challenges, personalized diabetic education and the implementation of Continuous Glucose Monitoring Program. Our local businesses are offered a Wellness Connection Program to support employees' wellness and preventative health needs through education, activities and screenings. Our providers also strengthened the Sports Medicine Program by offering additional sporting event coverage.

V. 2021 Community Health Needs Assessment

This community health assessment gathered data from secondary sources such as Behavioral

Risk Surveillance Survey (BRFSS), County Health Rankings, American Community Survey/US Census Bureau, Centers for Disease Control, Nebraska Department of Education, and so on to assess the health status of the Central District Health Department (CDHD) region to identify emerging issues and trends, when possible, and to gauge big changes from the previous 2019 Community Health Improvement Plan priorities.

At the beginning of 2020, local health departments in Nebraska began the response to a global pandemic resulting from a novel virus, Coronavirus 2019. While eager to know the impact of COVID-19 on population health, this data was not available at the time of this community health assessment. In efforts to learn more about the impact of COVID-19 on communities in the CDHD area, CDHD launched a 5-question survey. The survey was developed by the Nebraska Association of Local Health Directors (NALHD) as an open-ended survey design intended to allow respondents to tell LHDs their experience related to their health and the health of their community to identify emerging issues in the community. The NALHD made the survey accessible to all LHDs across Nebraska to identify statewide impact and trends. The survey is intended to be initially launched during the community health assessment and released more frequently throughout the community health improvement process to keep current on emerging issues in the community; however, results discussed throughout this report are from the initial launch in June 2021. This survey will assist CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The survey assessed experiences of community members related to major health issues for them or their family, what it means to be healthy, top health concerns, and ways to be healthy in their community and was made available in English, Spanish, Somali and Arabic by print and online. The survey was distributed through CDHD tri-county area of Merrick, Hall and Hamilton, CDHD partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey online when waiting for appointments. In all, 665 responses were collected (see Appendix D for a table of respondent demographics).

Additionally, a resource inventory survey was launched to partners of CDHD in August 2021 as a way to provide insight into available medical resources, resources that help people prevent and manage personal health risks, and resources that help people thrive. In all, 15 responses were collected. Respondents self-identified from the following sectors: 20% non-profit, 20% hospitals, 13% Federally Qualified Health Centers, and 6% from each of the following sectors: business, faith-based organizations, health departments, higher education/academic institutions, law enforcement/judicial systems, and medical clinics.

June 15 of 2021, 35 partners participated in a focused discussion to identify forces that impact health in communities within the CDHD area as part of this community health assessment (also found in Appendix A). The results are as follows:

Appendix A Sign-In Sheet
June 15, 2021

First and Last Name	Organization or role you represent	What new ways of working is COVID showingto us?
Randy See	Hall County Juvenile Services	Working on-line
Diane Keller	MCHI	Daily changes
Alisa Schurr	Bryan Health Merrick Medical	Telemed a
Brenda Lamb	Bryan Health Rural Division	Virtual meetings are at an all-time high, so even if a pandemic hityou can still connect for meetings
Liz Mayfield	Hope Harbor	It has highlighted new ways to connect virtually with clients
Todd McCoy	GI Parks and Recreation	When there is a will there's a way!
Lindy Flynn	MCHI	Made us think of new and sometimes more efficient ways
Rachel Sazama	CDHD/WIC	Completing services remotely
Jeff Edwards	Northwest Public Schools	
Deb Ross	Head Start CFDP Inc.	Providing virtual services to families and children
Carlos Barcenas	iChoosePurple Consulting	Creating meaningful Virtual Connections
Alaina Friest	Grand Island Regional Medical Center	
Cindy Johnson	Grand Island Chamber of Commerce	Service delivery in new ways
Heather Roy	Hall County Housing Authority	
Colette Evans	Central District Health Department	Working remotely, zoom connections
Anna Rodriguez	Central District Health Department	Remote communication/services
Jeremy Collinson	CDHD	Zoom Meetings
Jerry Janulewicz	City of Grand Island	Zoom meetings
Jennifer Hubl	CDHD	
Ron Peterson	Hall County Commissioner	

Katie Usasz	Prevention Project	Working remotely, working together with people who in regularcircumstances
Teresa Anderson	CDHD	Collaboration is even more important than ever!!!
Nathan Albright	Bryan Health	Collaboration with other entities
Sarah Stanislav	CHI Health	Strength in new partnerships
Tami Smith	Heartland Health Center	Telemedicine and new partnerships
Sondra Nicholson	NAHLD	
Susan Bockrath	NAHLD	
Chuck Haase	GI City Council, BOH	
Linda Flynn	Aurora Community Health	
Karen Rathke	United Way	
Shoaib Junejo	CHI Health/CDHD Intern	
Eric Melcher	City of Aurora	
Julie Nash	H3C	
Liza Ayala		
Connie Homes	Council of Alcoholism and Addictions	

<table>
<tr><td>Economic</td><td>Businesses impacted by COVID-19
Poverty rate
Healthcare worker shortage
Jobs/workers not returning to jobs
Online shopping impacts small brick/mortar businesses
Employers' expansion of remote working and other flexibility that wasn't an option before COVID</td></tr>
<tr><td>Environmental</td><td>Housing shortage
Flood recovery
Access to clean water</td></tr>
<tr><td>Legal/Political</td><td>Political concerns regarding safety/masks
Medicaid expansion
Vaccines turned very political
Issues (COVID, other) were politicized (for good/bad) and dealing with social perceptions as the after effect</td></tr>
<tr><td>Social/Family</td><td>Lower volume of employees returning to work
Primarily women choosing to stay home instead of going back to a lower paying job
Increase in depression related to social distancing/isolation
Everyone (age, generational) impacted by stress/is under stress</td></tr>
<tr><td>Technological/ Scientific</td><td>Tele-health access for those without internet
Navigating technology
Telehealth potential was more clearly demonstrated than before (+)
Trend toward expanding broadband… more internet
Flipside: still need to help many folks navigate using tech</td></tr>
<tr><td>Other…</td><td>Additional hospital/second hospital
Employment
Migration changes
Workforce not returning… women not reentering workforce
Stress for folks of all ages
Job losses
Impact of new
Reluctance to get usual care… staying home hurts local rural business
High achieving children may have had easier time than those who struggle. Teachers had to <u>adapt</u> daily.
Stressful year for everyone in GI and across the state
Summer school attendance is higher than any other year
Students playing catch up
Teachers and families learned to manage and to adapt
Schools found ways to meet needs of kid… academic and basic (food)
Trends:
Increasing obesity rates for child and adults
Alcohol consumption and alcoholism increasing
Growing population overall and more diverse</td></tr>
</table>

September 2 of 2021, the CDHD held a second meeting to discuss the finding from a five question survey. 33 participants attended this meeting from Merrick, Hall and Hamilton. The summary of the survey and next steps is found in the following section as well as Appendix B. Below is the listing of attendees that participated in this meeting:

Appendix B Sign-in sheet

September 2, 2021

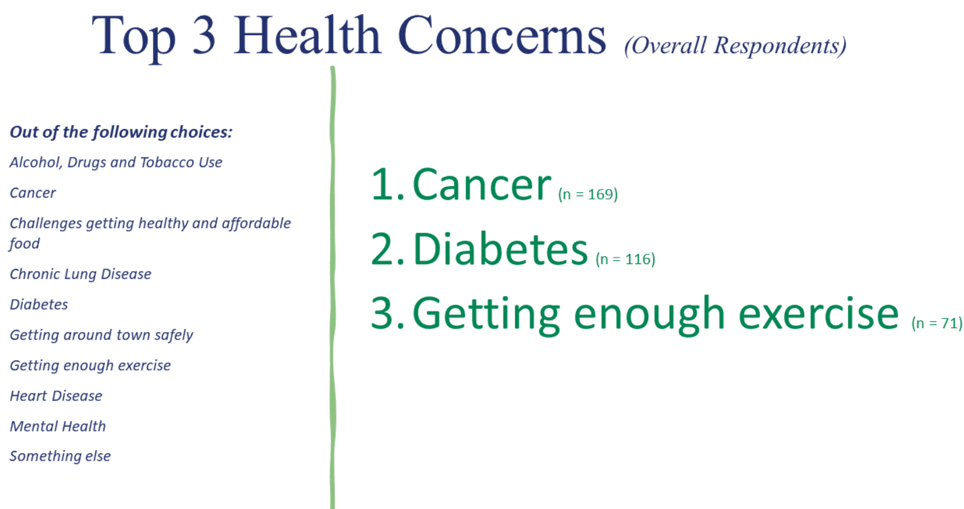
Sign In	
Central District Community Health Assessment Meeting Sept 2, 2021	
Name	**Organization**
Alissa Schurr	Merrick Medical Center
Daniel Petersen	Multicultural Coalition
Eric Melcher	City of Aurora
Eric Garcia-Mendez	Heartland United Way
Deb Ross	Head Start CFDP Inc.
Jerry Janulewicz	City of Grand Island
Sarah Stanislav	CHI Health St. Francis
Karen Rathke	Heartland United Way
Lindy Flynn	Memorial Community Health Inc
Cami Wells	Nebraska Extension
Jeff Edwards	NWPS
Holly Boeselager	Grand Island Public Schools, H3C
Katie Usasz	Prevention Project
Brenda Lamb	Bryan Health Rural Division - Supporting Merrick Medical Center
Nathan Albright	Bryan Health
Liz Mayfield	Hope Harbor
Jennifer Hubl	CDHD
Robin Dexter	Grand Island Public Schools
Liza Thalken	CDHD
Randy See	Hall Co. Juvenile Services
Rachel Sazama	CDHD- WIC Supervisor
Andrew Hills	(C.D.H.D.)
Connie Holmes	Council on Alcoholism and Addictions
Teresa Anderson	Central District Health Department
Susan Bockrath	NALHD
Sondra Nicholson	Nebraska Association of Local Health Directors (NALHD)
Jeremy Collinson	CDHD
Ron Peterson	Hall County Commissioner, CDHD Board
Alaina Friest	Grand Island Regional Medical Center
Diana Kellog	CHI Foundation, HC3 Board
Kamrie Peterson	CDHD
Diane Keller	Memorial Community Health
Kathleen Stolz	Central NE DHHS

VI. Summary: Assessment and Priorities

Central District Health Department launched a 5-question survey, developed by the Nebraska Association of Local Health Directors (NALHD), to learn more about the impact of COVID-19 on communities in the CDHD area and to assess community health related to things people do to be healthy, top health concerns, and major health issues. This open-ended survey design, intended to allow respondents to tell LHDs their experience related to their health and the health of their community, provides insight into to emerging issues in the community. The survey was made available in English, Spanish, Somali, and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey while waiting for appointments.

There were 665 responses (see Appendix C for full details on the demographics of survey respondents and summary of responses), of which most survey respondents self-identified as non-Hispanic, White women between ages 30-64. While not representative of the population of the region, as a whole, many of the survey responses are consistent with other data collected as part of this Community Health Assessment. Survey findings are also consistent with anecdotal input from key stakeholders (from the priority setting meetings) who are connected to many of the diverse community groups not directly represented in survey responses. The survey revealed the following:

Figure 1. Top 3 Health Concerns, Community Survey Respondents

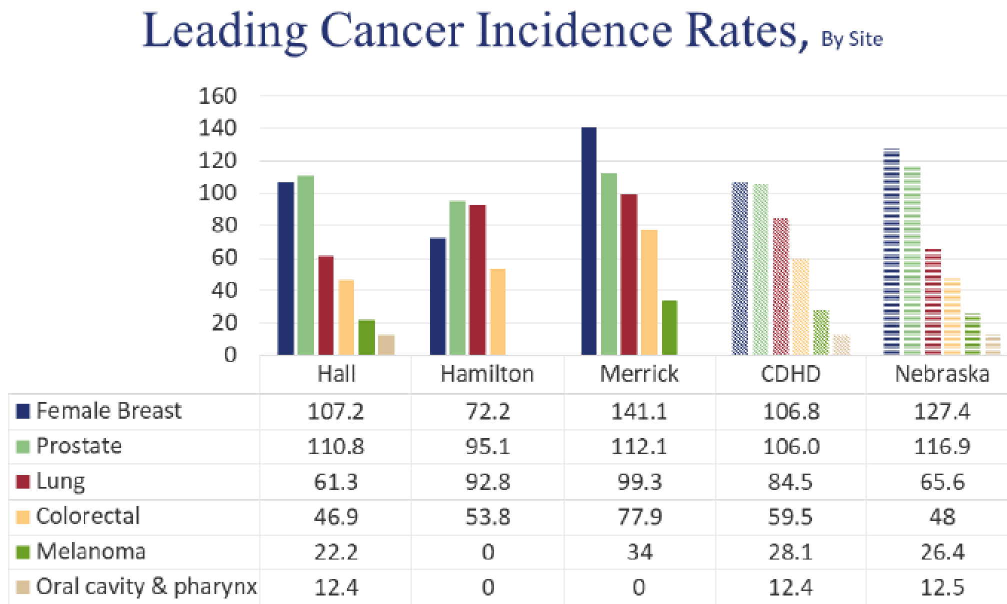


When looking at the survey data by ethnicity and race, Hispanic and non-White respondents listed the same top two concerns as in Figure 59; however, the third concern was challenges getting healthy and affordable food. Even given the low response to the resource inventory survey, partners identified the need to increase the availability of bilingual/interpretation for services and programs to ultimately enhance and improve the health of all residents within the CDHD area.

Cancer

Cancer is a leading cause of death in the CDHD district and across the state. In the CDHD region, female breast cancer was the leading type of cancer diagnosed (106.8/100,000 population), which was lower than the state (127.4/100,000 population, respectively). Prostate cancer followed as a close second for CDHD district (106.0/100,000 population) and was lower than the state (116.9/100,000 population, respectively). Notably, Merrick County residents experience more cancer than their counterparts in Hall or Hamilton counties and the state.

Figure 31. Cancer Incidence Rates, CDHD District

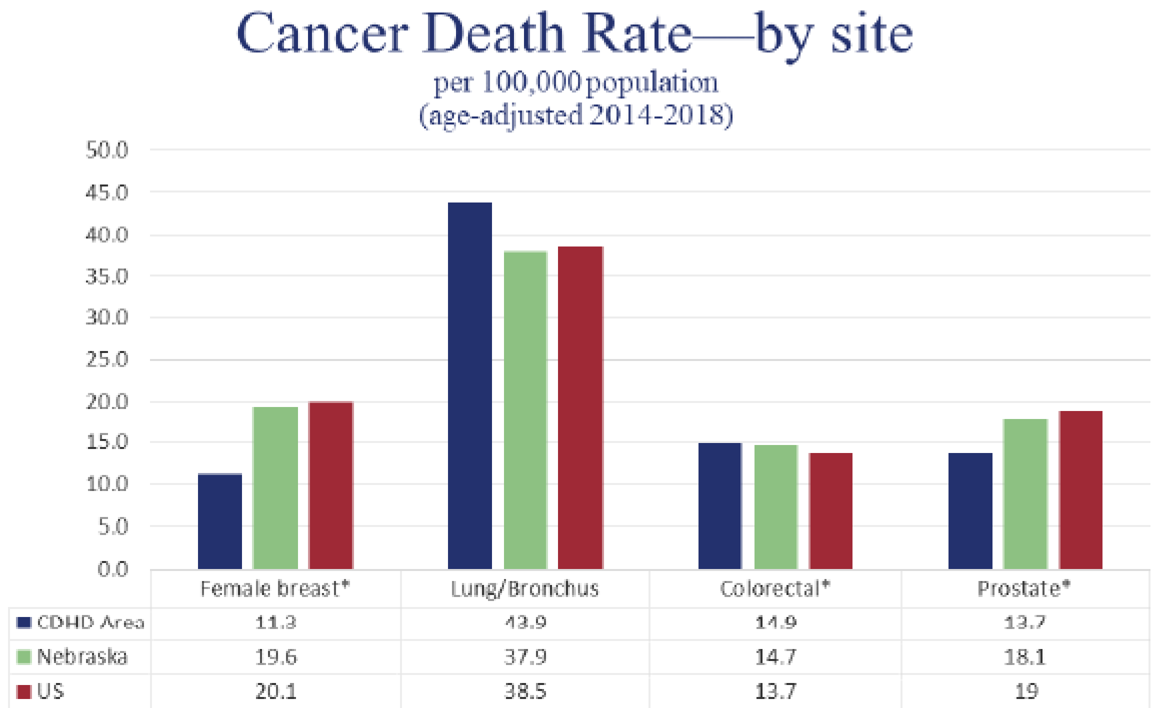


	Hall	Hamilton	Merrick	CDHD	Nebraska
Female Breast	107.2	72.2	141.1	106.8	127.4
Prostate	110.8	95.1	112.1	106.0	116.9
Lung	61.3	92.8	99.3	84.5	65.6
Colorectal	46.9	53.8	77.9	59.5	48
Melanoma	22.2	0	34	28.1	26.4
Oral cavity & pharynx	12.4	0	0	12.4	12.5

Cancer mortality rates are on the decline in the CDHD district, state, and nation. Despite this trend, cancer remained one of the top two leading causes of death in the CDHD district through 2017. Cancer mortality data by race and ethnicity was not readily available for the CDHD district. Native Americans, African Americans, and Whites across Nebraska had cancer mortality rates in excess of the state target of 145.2/100,000 population (see Figure 29). More information is needed about the cause of cancer incidence and death rates in the CDHD area.

Although cancer mortality data by county was not readily available, lung (and bronchus) cancer was the leading type of cancer that resulted in death in the CDHD district (see Figure 33).Tobacco smoking remains the leading cause of lung cancer, responsible for about 80% of lung cancer deaths. Other causes include exposure to secondhand smoke and radon.

Figure 33. Leading Cancer Death Rates in CDHD (per 100,000 population)



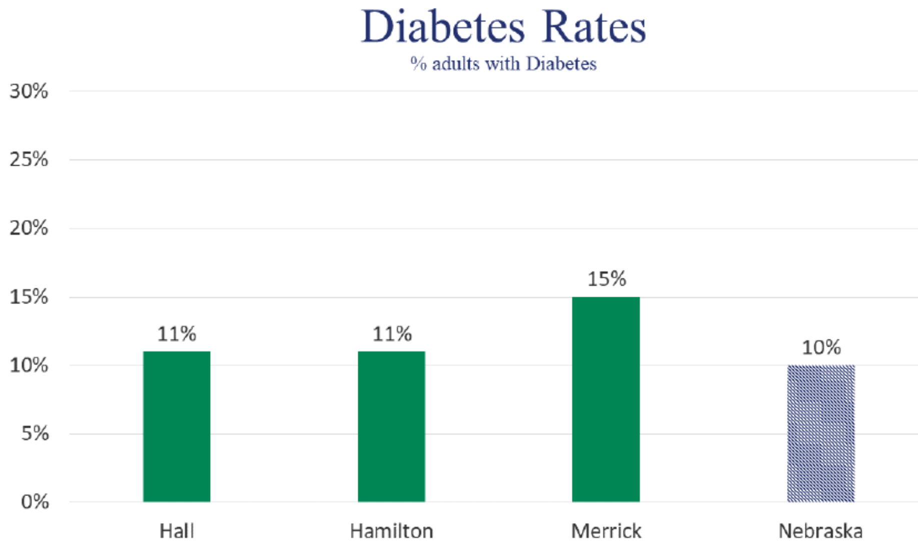
	Female breast*	Lung/Bronchus	Colorectal*	Prostate*
CDHD Area	11.3	43.9	14.9	13.7
Nebraska	19.6	37.9	14.7	18.1
US	20.1	38.5	13.7	19

As affirmation to the above prevalence and factors contributing to cancer, respondents to the CDHD Community Survey identified cancer as one of the top three health concerns.

Diabetes

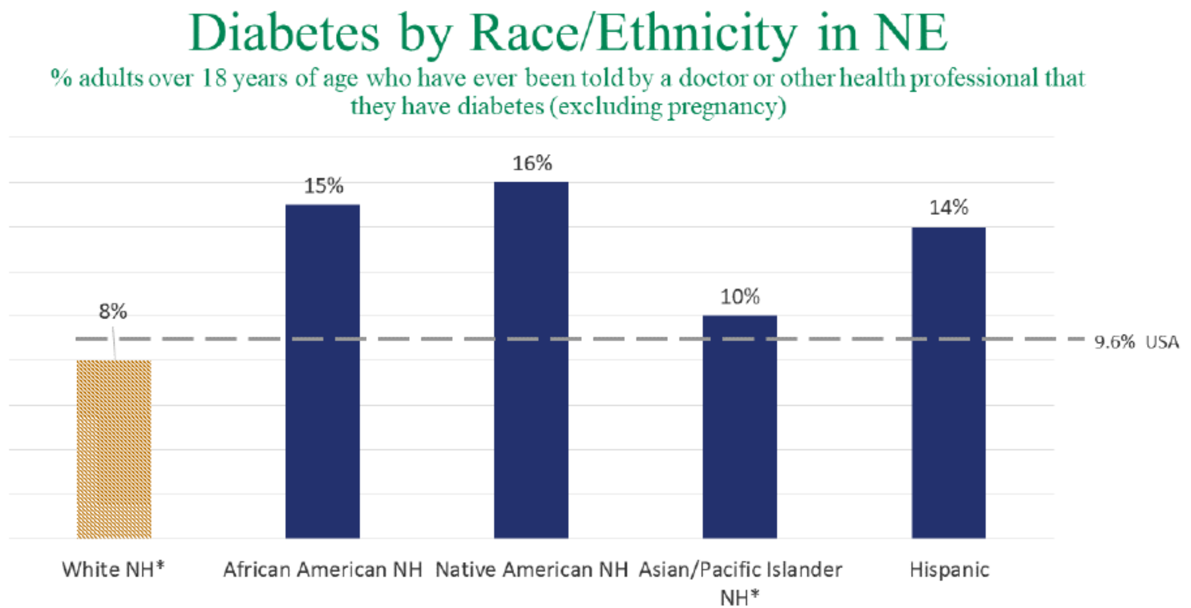
Diabetes is a chronic disease that impacts how a body gets energy from food. Diabetes is the 7th leading cause of death in the US with more than 88 million US adults diagnosed with diabetes. Over the past 20 years, the number of adults diagnosed with diabetes has more than doubled. Overweight/obesity and age are factors that impact the risk of diabetes. Often times, diabetes and heart disease are co-occurring. A person with diabetes is 2 times more likely to have heart disease or stroke, the leading causes of death. Generally, diabetes rates in CDHD region are similar to the state rate, except for Merrick County which experienced a slightly higher diabetes rate than the other counties within CDHD perhaps due to a higher proportion of an aging population in this county.

Figure 29. Diabetes rates—by county, CDHD District



Diabetes data broken down among race/ethnicity is not available by county, diabetes rates among racial/ethnic populations is available at the state level. There are dramatic gaps between racial/ethnic populations when looking at the state diabetes rates. Notably, African American/Black (15%), American Indian/Alaskan Native (16%), and Hispanic (14%) populations experience almost 2 times the rates of diabetes compared to non-Hispanic, Whites (see Figure 30). As affirmation to the above prevalence and factors contributing to diabetes, respondents to the CDHD Community Survey identified diabetes as one of the top three health concerns.

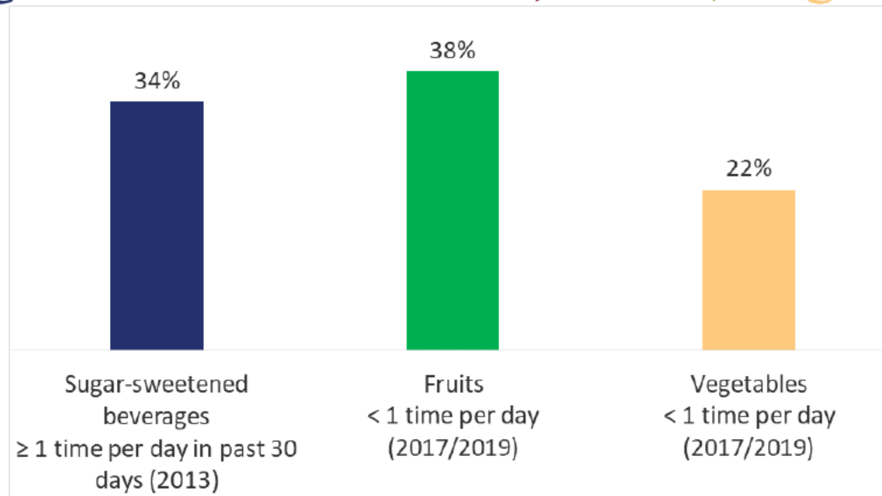
Figure 30. Diabetes rates—by race and ethnicity, Nebraska



Physical Activity and Nutrition

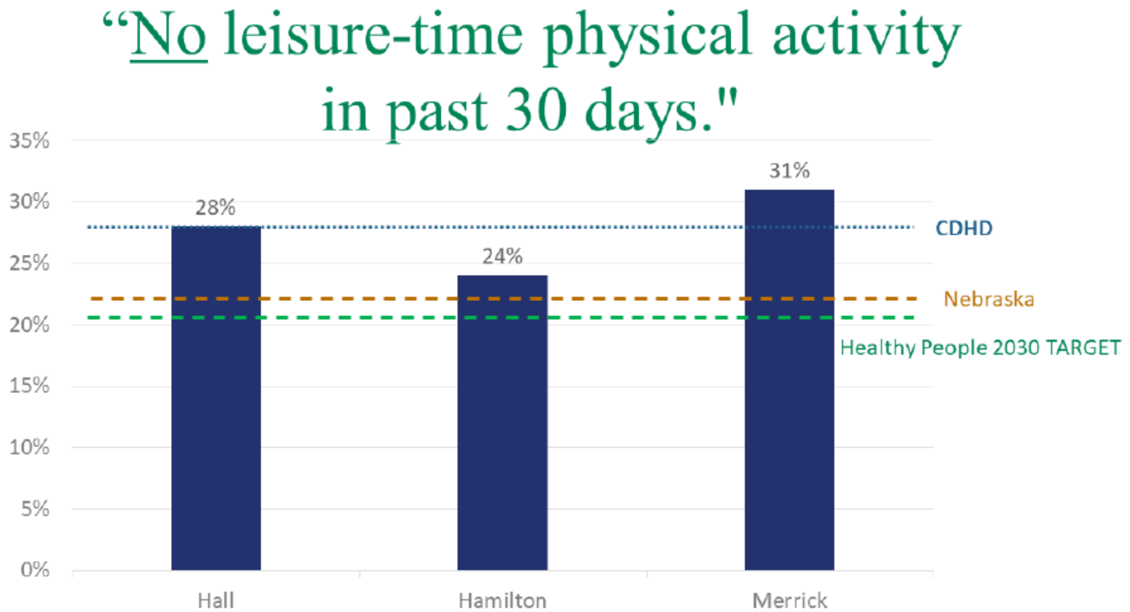
According to the Nebraska BRFSS, healthy eating and active living was not a routine behavior for many adults in the CDHD district. Nearly 40% of adults in this area reported consuming fruits less than 1 time per day and about 1 in 4 adults consumed vegetables less than 1 time per day.

Figure 25. Nutrition Behaviors, CDHD District



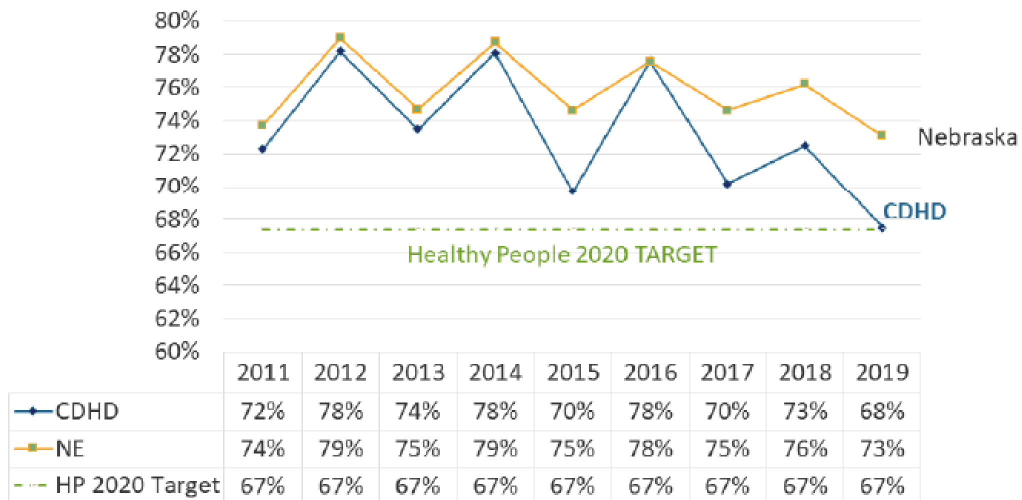
Despite the majority of adults (85%) in the CDHD region indicating that they had access to safe places to walk in their neighborhoods, roughly 1 in 3 adults reported no leisure-time physical activity in the past 30 days. Also of concern, the 2012 to 2017 trend line indicates that the percentage of CDHD residents reporting no leisure-time physical activity is increasing. As affirmation to the above indicators related to nutrition, non-White, Hispanic respondents to the CDHD Community Survey identified challenges getting healthy and affordable food as one of top three health concerns.

Figure 26. Physical Activity—No Leisure-Time, CDHD District



Source: CHRR 2020

Figure 27. Physical Activity—At Least Some Leisure-Time, CDHD District



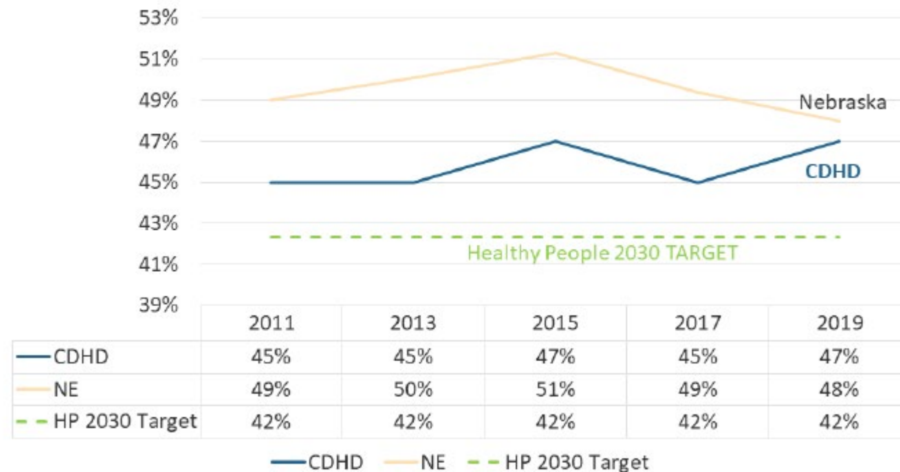
	2011	2012	2013	2014	2015	2016	2017	2018	2019
CDHD	72%	78%	74%	78%	70%	78%	70%	73%	68%
NE	74%	79%	75%	79%	75%	78%	75%	76%	73%
HP 2020 Target	67%	67%	67%	67%	67%	67%	67%	67%	67%

Source: BRFSS 2011-2019

Nearly 50% of people in the CDHD region did not meet the aerobic physical activity recommendations (at least 150 minutes of moderate-intensity physical activity per week—such

as brisk walking or 75 minutes of vigorous physical activity per week). Safe community environments, such as walking paths, sidewalks, and walking/biking trails to move throughout the area, encourage residents to engage in healthy eating and active living, which are key to preventing chronic disease. As affirmation to the above indicators related to physical activity, respondents to the CDHD Community Survey identified getting enough exercise as one of the top three health concerns.

Figure 28. Physical Activity—Met Recommendations, CDHD District



	2011	2013	2015	2017	2019
CDHD	45%	45%	47%	45%	47%
NE	49%	50%	51%	49%	48%
HP 2030 Target	42%	42%	42%	42%	42%

Health Summary: CDHD District

The majority of the adult population within the CDHD district reported their general health was good or better in the BRFSS between 2011-2019. However, nearly 1 in 10 people within the CDHD district indicated they experienced frequent mental distress. Table 20 summarizes the general health of the adult population within the CDHD district.

Table 1. General Health Indicators, CDHD District

General Health Indicators	CDHD District	NE
General health fair or poor	17%	14%
Average number of days physical health was not good in past 30 days	3.3	3.1
Physical health was not good on 14 or more of the past 30 days	10%	10%
Average number of days mental health was not good in past 30 days	3.2	3.2
Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	10%	10%
Average days poor physical or mental health limited usual activities in past 30 days	2.0	1.9
Poor physical or mental health limited usual activities on 14 or more of the past 30 days	6%	6%

Similar to the state, the CDHD district experienced shortages in primary care, dental, and mental health professionals, and further reducing access to needed health services. The Years of Potential Life Lost (YPLL), a measurement of preventable deaths, in the CDHD district surpassed the state rate. More specifically, Hall and Merrick counties' YPLL rate was higher than the state rate. Multiple factors impact how well and how long we live. Things like education, availability of jobs, access to healthy foods, social connectedness, and housing conditions all impact our health outcomes. Conditions in which we live, work, and play have an enormous impact on our health, long before we ever see a doctor. It is imperative to build a culture of health where getting healthy, staying healthy, and making sure our kids grow up healthy are top priorities.

VII. Next Steps

Merrick Medical Center will have a shared responsibility to their community and other hospitals within the Central District Health Department to create a CHI plan. Each hospital will share their success and challenges for others to replicate. Our tri-county wide hospital planning begins in January of 2022. Once we have identified our focus, we will bring it to our community stakeholders to vet and create actionable tactics that complement our strategic plan, community and county residents.

VIII. Adoption/Approval

This Community Health Needs Assessment was approved and adopted by the Merrick Medical Center Board of Trustees on Thursday, October 21, 2021.

Appendix A

Central District Health Department Community Health Assessment Process

2021
Community Health Assessment Process
Summary

Facilitated by Sondra Nicholson, MPH, CHES
The Nebraska Association of Local Health Directors (NALHD)
Summary Submitted September 16, 2021

Central District Health Department (CDHD) contracted with the Nebraska Association of Local Health Directors (NALHD) to facilitate two, four-hour workshops to review data, to determine any additional data collections and mining needs and to set priorities. The workshops occurred via Zoom on June 15, 2021, and September 2, 2021. The participants engaged in a Technology of Participation (ToP) facilitated process.

Agenda June 15, 2021	**Agenda September 2, 2021**
Welcome, Introductions, and Context	Welcome, Introductions, and Context
Identify forces at play	Recap of data and reveal of new data
Review data	Discuss themes and identify priorities
Determine next steps	Plan for action
Closing conversations	Closing conversations and Next Steps
Participants: 24 participants (see sign-in sheets)	**Participants**: 25 participants (see sign-in sheets)

Rules of ENGAGEment:

- Make room for every voice

June 15, 2021, Meeting

To begin this workshop, a welcome and introductions were given. The NALHD facilitator broke out participants into small groups to identify the forces affecting health in their community and came back as a large group to discuss. The results follow:

Economic	• Businesses impacted by COVID-19 • Poverty rate • Healthcare worker shortage • Jobs/workers not returning to jobs • Online shopping impacts small brick/mortar businesses • Employers' expansion of remote working and other flexibility that wasn't an option before COVID
Environmental	• Housing shortage • Flood recovery • Access to clean water
Legal/Political	• Political concerns regarding safety/masks • Medicaid expansion • Vaccines turned very political • Issues (COVID, other) were politicized (for good/bad) and dealing with social perceptions as the after effect
Social/Family	• Lower volume of employees returning to work • Primarily women choosing to stay home instead of going back to a lower paying job • Increase in depression related to social distancing/isolation • Everyone (age, generational) impacted by stress/is under stress
Technological/ Scientific	• Tele-health access for those without internet • Navigating technology • Telehealth potential was more clearly demonstrated than before (+) ***Trend*** toward expanding broadband… more internet • Flipside: still need to help many folks navigate using tech
Other…	• Additional hospital/second hospital • Employment • Migration changes • Workforce not returning… women not reentering workforce • Stress for folks of all ages • Job losses • Impact of new • Reluctance to get usual care… staying home hurts local rural business • High achieving children may have had easier time than those who struggle. Teachers had to adapt daily. • Stressful year for everyone in GI and across the state • Summer school attendance is higher than any other year • Students playing catch up • Teachers and families learned to manage and to adapt • Schools found ways to meet needs of kid… academic and basic (food) ***Trends***: Increasing obesity rates for child and adults Alcohol consumption and alcoholism increasing Growing population overall and more diverse

Next, the group participated in small groups to review secondary data gathered for the community health assessment to identify what was known, what leaves them curious, and what opportunities exist for health in the CDHD area. A large group discussion followed to recap highlights of small group conversation. Results follow:

Data Recap: Health Behaviors

What do we know from looking at the data:

- **Obesity rates are alarming.**
- **Obesity and physical activity are related.**
- **Merrick County access to healthy foods relates to obesity rates.**
- **Sugared drink percentages are likely higher compared to what data presents**
- **PE is being decreased in schools- affects physical and mental status.**
- **Is diabetes higher in Merrick because of higher percentage of elderly?**
- **Merrick County has a very nice fitness center and a zero entry pool.**

What leaves us curious:

- **We are behind in physical activity in last 30 days.**
- **It would be interesting to compare health behaviors to issues like depression, etc.**

What opportunities stand out to you related to the data reviewed?

- **Opportunity to educate/promote community gardens, trails, and other community resources that may not be as well known as they can be, (or learn where we need more of these resources.)**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Healthcare Access

What do we know from looking at the data:

- **Hall County uninsured rate is too high.**
- **Ratio of mental health providers and primary care physicians in Merrick county are astronomically high**
- **Dentists and dental care are an issue.**
- **Mental health providers are always an issue as there are not enough.**
- **Merrick County uses a team-based approach to compensate for high panel rate.**
- **Mammogram rates are unacceptably low. Same with colon cancer.**
- **There is a lack of medicaid providers in our area**

What leaves us curious:

- **Medicaid expansion allowed people to get screenings that were desperately needed - how can we make this a long-term reality?**

What opportunities stand out to you related to the data reviewed?

- **We need to expand behavioral health.**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Health Outcomes

What do we know from looking at the data:

- **Really shocking stats about cancer death, compared to the national average**
- **Alzheimer's cases in Hall County are high.**
- **Rates of breast cancer in Merrick County/ also unintentional injuries are much higher than state average**
- **Breast cancer in merrick.**
- **Disparities in cancer types across counties**
- **Leading causes of death - alzheimers, pneumonia, unintentional injuries (Merrick County)**

What leaves us curious:

- **What is causing these high rates of cancer related deaths**?

What opportunities stand out to you related to the data reviewed?

- **Promote screenings now to catch lifestyle illnesses that are leading causes of death.**
- **Public health had to let some of these initiatives go on the back burner.**
- **Cancer education in Merrick County**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Housing and Transportation

What do we know from looking at the data:

- **% of Homes Occupied by Owner - more renters in Hall Co**
- **Residential value - seems low**
- **Transportation - texting and driving - low percentage**
- **Crowding houses - seems really low**
- **Vehicle data - we see families have only 1vehicle, so husbands take it to work but then the wife and kids don't have a vehicle to get to appts, etc.**
- **% households with severe housing problems**
- **Alcohol impairment seems really low.**
- **Cell phones and texting while driving is problematic.**

What makes us curious from looking at the data:

- **Due to younger population, single parent households, poverty? What is the key factor here**
- **What is severe housing problems?**
- **What is all considered in Group Quarters?**
- **Higher percentage of no vehicles in Merrick County. - Do they have public transportation? Is that an opportunity for them?**
- **With the other stats on single parent households and poverty, and a large amount of manufacturing and shift work expanded transportation seems to be a need**

What opportunities stand out to you related to the data reviewed?

- **Grand Island has high housing costs, and the statistics bear these out (high house values, low percentages of houses occupied by owners). Last year has exacerbated housing problems (people needing housing assistance, etc.)**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Minority and Language Status

What do we know from looking at the data:

- **Expected a higher percentage of origin hispanic people in Hall county**
- **Businesses needing more interpreters, we were surprised that the percentages weren't higher**
- **Hard to differentiate between race and ethnicity.**
- **"To me the most important piece on this is those who perceive themselves to speak English well"**
- **In Hamilton and Merrick there are less who speak English well, but there are greatly limited resources**

What leaves us curious:

- **What's the definition of Speaks English well (what is well?).. Hall county is only at 6.2%**

What opportunities stand out to you related to the data reviewed?

- **Generate opportunities for exposure to other communities within our town/city/county.**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Population Characteristics

What do we know from looking at the data:

- **Education and income differences**
- **Disparity in median household income Merrick vs. district**
- **Population growth in Hall vs the other counties**
- **A growth in second generation bilingual population, but not a growth of opportunity at the same rate**
- **Merrick county population decreased**
- **Working class population**

What leaves us curious:

- **Why is there more growth in Hall County vs other counties?**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

Data Recap: Socioeconomic Status

What do we know from looking at the data:

- **Single parent households, especially in Hall County**
- **Disparity in income by ethnicity *YES- to add to that almost $40,000 difference between hispanic and white median income in Hamilton Co, $10,000 in Hall, and $5000 in Merrick**
- **Hall & Merrick county have higher poverty rates than NE state average**
- **Hall Co has about double the single parent households compared to the other counties- and higher than the state in general.**
- **Hall & Merrick counties have a lower median household income thank NE average, especially for hispanic households**
- **Differences in Salary**
- **Bachelor degrees are low**

What makes us curious from looking at the data:

- **Do the single-parent households qualify for Medicaid and if so, are there enough providers?**
- **Why is the median income disparity between Whites and Hispanics so large, especially in Merrick Co?**
- **How does the Hall Co single parent rate compare to other urban areas?**

What opportunities stand out to you related to the data reviewed?

- **Many opportunities to grow in the future; will the opportunities be scattered among entrepreneurs and small business, or focused on a single group?**
- **Opportunity to empower the Hispanic communities to grow their median household income**

Source: Notes from group discussions reviewing data during the June 2021 Community Health Assessment kick-off meeting

The participants reviewed a draft 5-question survey, developed by NALHD (adapted from Lincoln-Lancaster County Health Department) translated in 3 languages (Arabic, Somali and Spanish—provided by Central District Health Department) in addition to English, intended to allow respondents to tell LHDs their experience related to their health and the health of their community to identify emerging issues in the community. The survey will assist CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The group reviewed and agreed to launch the survey to community residents in person and by print through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Summary of all data is in the Community Health Assessment Report given to CDHD.

Closing and Next Steps

NALHD and Central District Health Department staff gave closing remarks. The group will reconvene September 2, 2021, to review the new data from the surveys and identify issues, prioritize said issues and plan for action.

September 2, 2021, Meeting

To begin this workshop, a welcome, introductions and context were given. NALHD facilitators broke participants into small groups to review the community health survey and resource inventory survey responses along with a recap of the review of secondary data presented during the June 15, 2021, meeting. In small groups participants were asked to respond to the following questions. Results from small group discussions follow.

What do we know about health in our community?
• Mental health: people unwilling to share or are unable to recognize. Screenings are down. People see it in others but not necessarily in themselves. Ask a kid why he uses a substance, and he can't tell you, but he can tell you why kids use substances. • There are more instances where healthy people who are unvaccinated are getting sick. Wonder if they share their stories about being vaccinated. • Intense fear of COVID and an intense fear of the vaccine. Leads to mental health issues. • Continuous cortisol dumps lead to health issues (physical and mental). • Ask your trusted health professional (not what you read or hear) but they are not asking until it is too late. • People listen to who they trust- not necessarily a health professional. • Conspiracy theory- do you really believe that doctors and health leaders are evil and are not being helpful? • Humanize the folks who are in these positions. They are not aliens. This is just a kid that went into science. He learned a lot and is the best we have. It instills just a bit of doubt. • Health Foods: Is it understanding, expense, transportation? • Is it a challenge to get healthy food or to get healthy affordable food. • Food may look healthy and when you see the ingredients, you see a lot of salt, etc. • I see more related to "affordable" - healthy food is more expensive. • Our org works with low income, when food is an issue, you take want you can get. • Make neighborhoods healthier: Culturally desirable foods are sometimes less affordable. • Varying neighborhoods- some have access to sidewalks, and opportunities for physical activity. • If you work long shifts or two jobs, you don't have access to parks, etc. • Do you feel safe in the neighborhood- how do you find out about drug deals and child molestation. • Walking paths- are they safe from animals and traffic? • Do we have access to hike/bike trails? • Air quality- powder coat welding in neighborhood. • Crowded housing. Where can kids play safely. • Substance free- no drug deals in neighborhoods? Is this an issue for safety and health.

- Where we live is different- county and city demographics are different.
- Environmental Health: Our environment is contributing to poor health in a variety of ways.
- There may be a stigma on mental health issues, need for therapists, Food deserts-need for affordable food, lack or transportation to get to affordable foods...

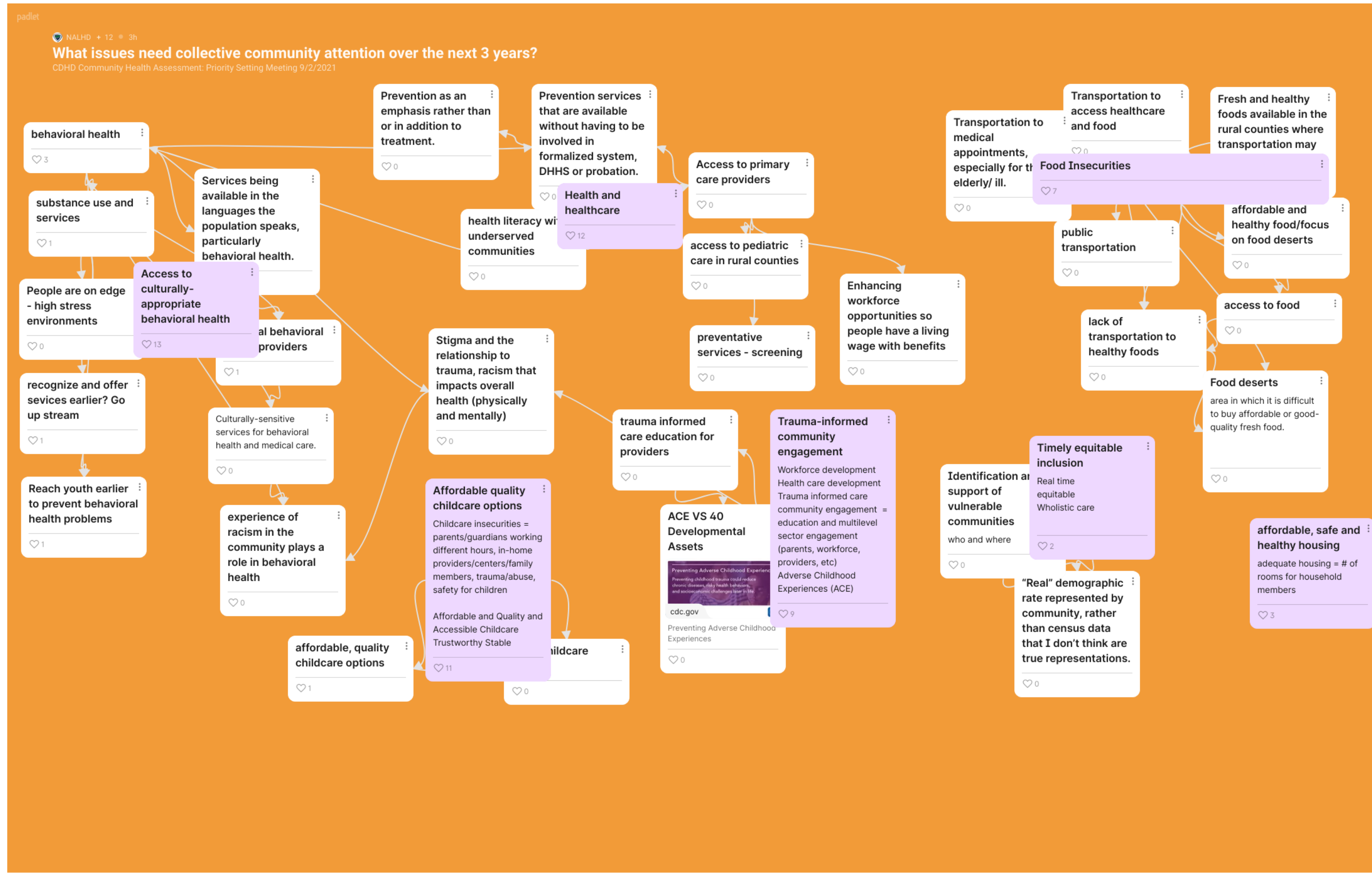
What are our areas of strength?	What are our areas of opportunities?
• data analysis in a group setting is useful involving the community • Childcare "Step-up to Quality" (H3C) • smoking rates seem to be trending in the right direction (unexpected but good to see) • good provision of youth activities and facilities in Hamilton and Merrick but not so much in Hall • we have good services- just inadequate overall	• access to services - lack of public transport • access to local and healthier foods. Transportation is a key factor in getting families to grocery stores to get the healthier food. The main option is gas station food for most lower income families • inadequate provision and access to childcare and affordable childcare • need more involvement of youth in the survey as the answers to the provision of youth activities might be answered by adults who might think there is adequate provision when the reality may be different • focus on mental health providers; need further discussion with the public via survey results; further discussion with nonprofit, local leaders, bilingual providers for services, why covid-19 impacted families (sickness, death, mental health, etc.) ** When our community comes together and discusses these issues our whole community wins! • further to the above - possible disconnect between perceptions and realities between respondents assessing the needs outside their own group • need to do a better job at informing people of available services

What new vantage point has this given us?

- We expected to see higher numbers of mental health responses. But we wonder if people are hesitant to reveal this information.
- that covid and diabetes is a bigger problem in the counties than first thought
- Language uses may not know what resources are available.
- unclear as to whether there's a problem for bilingual services as there is a lot of, I don't know
- Expand on language translation services.

Identify emerging issues and prioritizing issues—Large Group Work

NALHD asked the participants to focus on answering this question: **What issues need collective community attention over the next 3 years?** For the next part of the workshop. NALHD facilitators asked participants to write down 3-5 connections that are emerging from the data and conversation. Ideas were presented, grouped, and named by group consensus. Results from this workshop are as follows.



Participants were given 3 votes to divide up how they choose among the purple boxes. Voting was based on the following criteria:

- Size = many people affected
- Seriousness = many deaths, disabilities, hospitalizations
- Trends = getting worse, not better
- Equity = some groups affected more
- Intervention = proven strategies exist
- Values = our community cares about this
- Resources = Builds on current work
- Other?

Priorities chosen by the group included:

1. **Access to culturally appropriate behavioral health** = *13 votes*
2. **Health and healthcare** = *12 votes*
3. **Affordable quality childcare options** = *11 votes*

- Trauma-informed community engagement = *9 votes*
- Food insecurities = *7 votes*
- Timely equitable inclusion = *2 votes*

Plan for action

NALHD facilitators had participants self-select into the priority group of their choice to work on a plan for action. Groups were asked to define the priority; identify systems/beliefs that hold the problem in place; identify assets and opportunities to address the priority; decide what the group is really committed to doing over the next year. Results follow for each priority area.

***Priority 1:* Access to culturally appropriate behavioral health**
Group members:

padlet

NALHD • 3h

Access to culturally-appropriate behavioral health

CDHD Community Health Assessment: Priority Setting Meeting 9/2/2021

Define the Priority.

Notes

Rate 1

Anonymous 3h
Our priority is to address the increasing need for behavioral health access.

Add comment

What systems/beliefs are holding this problem in place?

Notes

Rate 4

Anonymous 3h
• Stigma and judgements around the subject.

Anonymous 3h
• Knowledge about telehealth options.

Anonymous 3h
• Understanding of insurance or self-pay options.

Anonymous 3h
• Support and education about diversified modes of behavioral healthcare.

Add comment

What assets and opportunities do we have to address this priority?

Notes

Rate 3

Anonymous 3h
Telehealth opportunties

Anonymous 3h
Youth mental health first aid, 40 Developmental Assets, Trauma informed care, Know when to refer,Community trainings

Anonymous 3h
The aftereffects of COVID-19 have helped to reduce the stigma surrounding behavioral health and substance dependency treatment.

Add comment

In light of all of these, what is this group really committed to achieving over the next 3 years?

Notes

Rate 5

Anonymous 3h
• Training providers and community members about technologies that increase behavioral healthcare capacity.

Anonymous 3h
• Forming partnerships with organizations with additional resources.

Anonymous 3h
• Completing research to uncover more evidence-based, culturally-appropriate practices.

Anonymous 3h
• Identifying community partners that have not yet come to the table to contribute feedback.

Anonymous 3h
• Develop preventive methods to address behavioral health needs prior to crises.

Add comment

***Priority 2:* Health and healthcare**

Group members: Brenda Lamb, Sarah Stanislav, Diana Kellogg?

padlet

NALHD • 1 • 13d

Health and healthcare

CDHD Community Health Assessment: Priority Setting Meeting 9/2/2021

Define the Priority

- **Recruitment for Providers and Clinical Staff**
- **Workforce Development and Improvement** – Educating new and existing staff to increase focus on preventative care in addition to episodic care
- **Health Literacy**

What systems/beliefs are holding this problem in place?

- Lower minority representation in the workforce
- Fee for service vs. value based care
- Recruitment - Limited capacity or lack of desire to live in a rural area
- Limited options for student loan forgiveness
- Not understanding diverse cultural differences and educational level
- Educational training in med school and nursing school focuses on problem focus vs. preventative

What assets and opportunities do we have to address this priority?

- Middle school and high school involvement within the hospital / clinic settings
- Scholarships, sponsorships and student loan forgiveness
- Bridging the gap for minority students for college and healthcare opportunities
- Consider value based models to move towards the preventative care (ACO, CPC+, etc)
- Educational sessions with the community and healthcare team on value based care by subject matter experts

In light of all of these, what is this group really committed to achieving over the next 3 years?

- Partnering with schools to elevate student knowledge about healthcare opportunities within their community
- Education on value based models of care

***Priority 3:* Affordable quality childcare options**
Group members:

padlet

NALHD • 1m

Affordable quality childcare options

CDHD Community Health Assessment: Priority Setting Meeting 9/2/2021

Define the Priority.

Notes

Rate 1

Anonymous 3h
Lack of Childcare

Add comment

What systems/beliefs are holding this problem in place?

Notes

Rate 3

Anonymous 3h
Value of family and friends as safe

Anonymous 3h
Family and friends are more affordable

Anonymous 3h
Increasing childcare licensing accessibility

Add comment

What assets and opportunities do we have to address this priority?

Notes

Rate 2

Anonymous 3h
Working with H3C

dross97 3h
The Sixpence Child Care Partnership as well as the Infant Toddler Initiative are both resources to assist providers, people interested in being providers and as resource and referral for parents. They provide training, support etc. Also Rooted in Relationships which provides coaching to existing childcares.

Add comment

In light of all of these, what is this group really committed to acheiving over the next 3 years?

Notes

Rate 2

Anonymous 3h
Working with H3C to help promote, educate, increase the quality, and expand options for childcare

dross97 3h
increase the number of slots/ child cares and the quality and affordability of childcare

Add comment

Closing and Next Steps

NALHD will summarize this group work in a report for CDHD. Additionally, NALHD will finalize a draft CHA report for CDHD to review and make final. Once final, CDHD will distribute the CHA report to partners and convene partners around the first part of 2022 to launch the Community Health Improvement Planning process. CDHD gave closing remarks.

Appendix A
Sign-in sheet
June 15, 2021

First and Last Name	Organization or role you represent	What new ways of working is COVID showing to us?
Randy See	Hall County Juvenile Services	Working on-line
Diane Keller	MCHI	Daily changes
Alisa Schurr	Bryan Health Merrick Medical	Telemed a
Brenda Lamb	Bryan Health Rural Division	Virtual meetings are at an all-time high, so even if a pandemic hit you can still connect for meetings
Liz Mayfield	Hope Harbor	It has highlighted new ways to connect virtually with clients
Todd McCoy	GI Parks and Recreation	When there is a will there's a way!
Lindy Flynn	MCHI	Made us think of new and sometimes more efficient ways
Rachel Sazama	CDHD/WIC	Completing services remotely
Jeff Edwards	Northwest Public Schools	
Deb Ross	Head Start CFDP Inc.	Providing virtual services to families and children
Carlos Barcenas	iChoosePurple Consulting	Creating meaningful Virtual Connections
Alaina Friest	Grand Island Regional Medical Center	
Cindy Johnson	Grand Island Chamber of Commerce	Service delivery in new ways
Heather Roy	Hall County Housing Authority	
Colette Evans	Central District Health Department	Working remotely, zoom connections
Anna Rodriguez	Central District Health Department	Remote communication/services
Jeremy Collinson	CDHD	Zoom Meetings
Jerry Janulewicz	City of Grand Island	Zoom meetings
Jennifer Hubl	CDHD	

Appendix A
Sign-in sheet
June 15, 2021

Ron Peterson	Hall County Commissioner	
Katie Usasz	Prevention Project	Working remotely, working together with people who in regular circumstances
Teresa Anderson	CDHD	Collaboration is even more important than ever!!!
Nathan Albright	Bryan Health	Collaboration with other entities
Sarah Stanislav	CHI Health	Strength in new partnerships
Tami Smith	Heartland Health Center	Telemedicine and new partnerships
Sondra Nicholson	NAHLD	
Susan Bockrath	NAHLD	
Chuck Haase	GI City Council, BOH	
Linda Flynn	Aurora Community Health	
Karen Rathke	United Way	
Shoaib Junejo	CHI Health/CDHD Intern	
Eric Melcher	City of Aurora	
Julie Nash	H3C	
Liza Ayala		
Connie Homes	Council of Alcoholism and Addictions	

Appendix B
Sign-in sheet
September 2, 2021

Sign In	
Central District Community Health Assessment Meeting Sept 2, 2021	
Name	**Organization**
Alissa Schurr	Merrick Medical Center
Daniel Petersen	Multicultural Coalition
Eric Melcher	City of Aurora
Eric Garcia-Mendez	Heartland United Way
Deb Ross	Head Start CFDP Inc.
Jerry Janulewicz	City of Grand Island
Sarah Stanislav	CHI Health St. Francis
Karen Rathke	Heartland United Way
Lindy Flynn	Memorial Community Health Inc
Cami Wells	Nebraska Extension
Jeff Edwards	NWPS
Holly Boeselager	Grand Island Public Schools, H3C
Katie Usasz	Prevention Project
Brenda Lamb	Bryan Health Rural Division - Supporting Merrick Medical Center
Nathan Albright	Bryan Health
Liz Mayfield	Hope Harbor
Jennifer Hubl	CDHD
Robin Dexter	Grand Island Public Schools
Liza Thalken	CDHD
Randy See	Hall Co. Juvenile Services
Rachel Sazama	CDHD- WIC Supervisor
Andrew Hills	(C.D.H.D.)
Connie Holmes	Council on Alcoholism and Addictions
Teresa Anderson	Central District Health Department
Susan Bockrath	NALHD
Sondra Nicholson	Nebraska Association of Local Health Directors (NALHD)
Jeremy Collinson	CDHD
Ron Peterson	Hall County Commissioner, CDHD Board
Alaina Friest	Grand Island Regional Medical Center
Diana Kellog	CHI Foundation, HC3 Board
Kamrie Peterson	CDHD
Diane Keller	Memorial Community Health
Kathleen Stolz	Central NE DHHS

Appendix B

Central District Health Department Community Health Assessment 2021 Report

Community Health Assessment 2021 Report

For more information:
https://cdhd.ne.gov/

Contact:

Central District Health Department
Teresa Anderson, Health Director
Grand Island NE
308-385-5175

Prepared by Nebraska Association of Local Health Directors
For Central District Health Department

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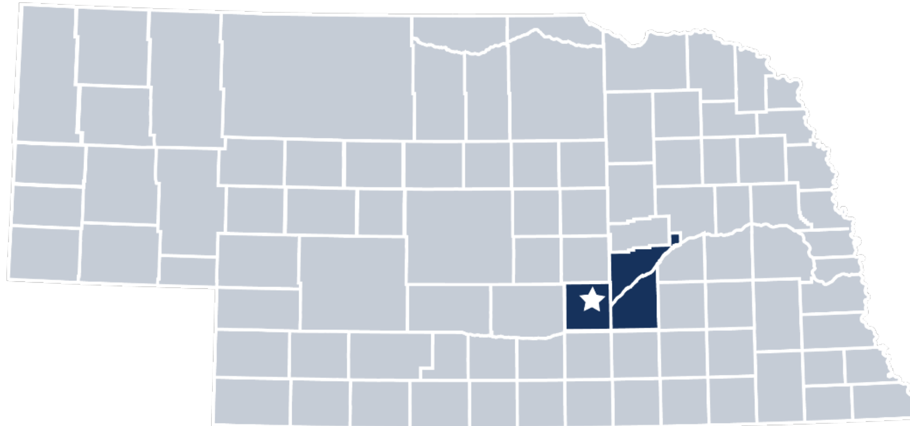
Introduction

Central District Health Department (CDHD) serves 78,432[i] people within a three-county district comprised of Hall, Hamilton, and Merrick counties in central Nebraska. CDHD was formed in 2002 as a result of State legislation that applied Tobacco Master Settlement funds to organize local health departments statewide. The mission of CDHD is to protect and improve the health and wellbeing of our community.



As Chief Health Strategist—who convenes stakeholders that investigate and take action to make meaningful progress on complex health community issues[ii]—for this three-county district, CDHD conducts a community health assessment (CHA) and community health improvement plan (CHIP) every three years. The CHA is a process of gathering and interpreting information from multiple and diverse sources in order to develop a deeper understanding of the health and wellbeing of a community/jurisdiction. The CHA process describes the current health status of the community, identifies and prioritizes health issues, and develops a better understanding of the range of factors that influence and impact health. Data were gathered from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings and Roadmaps (CHRR), American Community Survey/US Census Bureau, Centers for Disease Control and Prevention (CDC), Nebraska Department of Transportation, Nebraska Department of Education, and the US Bureau of Labor Statistics. This assessment identifies leading causes and emerging issues that impact community health and quality of life, including the leading causes of mortality and morbidity, the general health status of community members, disparities in health outcomes, the access and availability of behavioral and health care, etc.

CHI Health Saint Francis, located in Grand Island, Hall County, is a regional referral center, with more than 100 physicians and 1,100 employees working together to build a healthier community. The goal of CHI Health Saint Francis is to provide patients with high-quality medical care close to home, where they can be supported by their family, friends, and community. In 2018, the CHI Health Regional Cancer Center became a QOPI Certified Practice. Services provided by CHI Health Saint Francis include behavioral care, breast cancer care, cancer care, diabetes education, emergency and trauma, general surgery, heart care, home care, imaging

maternity center, neurosurgery, nursing, orthopedics, pediatrics, primary care, rehabilitation care, respiratory care, sleep disorders, and wound and ostomy center.

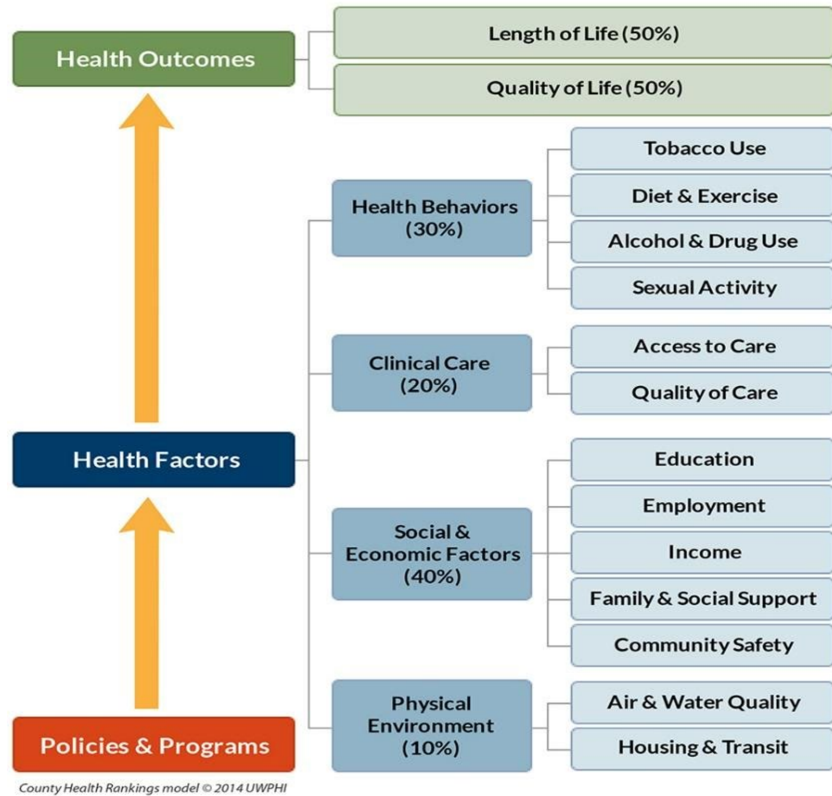
Grand Island Regional Medical Center is an acute care hospital located in Grand Island, Hall County, that aims to bring additional patients and health care talent to the area. Grand Island Regional Medical Center is a locally owned and organized nonprofit organization, offering a broad range of specialties and services including a maternity center and a variety of surgical, medical, clinical, and emergency services. The hospital opened its doors in August 2020 and is accredited by the Center for Improvement in Healthcare Quality (CIHQ).

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

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

County Health Rankings and Roadmaps (CHRR), a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin, provides reliable local data and evidence to communities to help them identify opportunities to improve their health. The CHRR model was used as the lens for this community health assessment.

Figure 1. County Health Rankings and Roadmaps Framework



This community health assessment gathered data from secondary sources such as Behavioral Risk Surveillance Survey (BRFSS), County Health Rankings, American Community Survey/US Census Bureau, Centers for Disease Control, Nebraska Department of Education, and so on to assess the health status of the CDHD region to identify emerging issues and trends, when possible, and to gauge big changes from the previous 2019 Community Health Improvement Plan priorities.

At the beginning of 2020, local health departments in Nebraska began the response to a global pandemic resulting from a novel virus, Coronavirus 2019. While eager to know the impact of COVID-19 on population health, this data was not available at the time of this community health assessment. In efforts to learn more about the impact of COVID-19 on communities in the CDHD area, CDHD launched a 5-question survey. The survey was developed by the Nebraska Association of Local Health Directors (NALHD) as an open-ended survey design intended to allow respondents to tell LHDs their experience related to their health and the health of their community to identify emerging issues in the community. The NALHD made the survey accessible to all LHDs across Nebraska to identify statewide impact and trends. The survey is intended to be initially launched during the community health assessment and released more frequently throughout the community health improvement process to keep current on emerging issues in the community; however, results discussed throughout this report are from the initial launch in June 2021. This survey will assist CDHD by highlighting community themes and strengths that may not be identified solely with the use of secondary data sources. The survey assessed experiences of community members related to major health issues for them or their family, what it means to be healthy, top health concerns, and ways to be healthy in their community and was made available in

English, Spanish, Somali and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey online when waiting for appointments. In all, 665 responses were collected (see Appendix D for a table of respondent demographics).

Additionally, a resource inventory survey was launched to partners of CDHD in August 2021 as a way to provide insight into available medical resources, resources that help people prevent and manage personal health risks, and resources that help people thrive. In all, 15 responses were collected. Respondents self-identified from the following sectors: 20% non-profit, 20% hospitals, 13% Federally Qualified Health Centers, and 6% from each of the following sectors: business, faith-based organizations, health departments, higher education/academic institutions, law enforcement/judicial systems, and medical clinics.

Finally in June 2021, 35 partners participated in a focused discussion to identify forces that impact health in communities within the CDHD area as part of this community health assessment. The results follow:

Economic	• Businesses impacted by COVID-19 • Poverty rate • Healthcare worker shortage • Jobs/workers not returning to jobs • Online shopping impacts small brick/mortar businesses • Employers' expansion of remote working and other flexibility that wasn't an option before COVID
Environmental	• Housing shortage • Flood recovery • Access to clean water
Legal/Political	• Political concerns regarding safety/masks • Medicaid expansion • Vaccines turned very political • Issues (COVID, other) were politicized (for good/bad) and dealing with social perceptions as the after effect
Social/Family	• Lower volume of employees returning to work • Primarily women choosing to stay home instead of going back to a lower paying job • Increase in depression related to social distancing/isolation • Everyone (age, generational) impacted by stress/is under stress
Technological/ Scientific	• Tele-health access for those without internet • Navigating technology • Telehealth potential was more clearly demonstrated than before (+) ***Trend*** toward expanding broadband… more internet • Flipside: still need to help many folks navigate using tech
Other…	• Additional hospital/second hospital • Employment • Migration changes • Workforce not returning… women not reentering workforce • Stress for folks of all ages • Job losses • Impact of new • Reluctance to get usual care… staying home hurts local rural business • High achieving children may have had easier time than those who struggle. Teachers had to adapt daily. • Stressful year for everyone in GI and across the state • Summer school attendance is higher than any other year • Students playing catch up • Teachers and families learned to manage and to adapt • Schools found ways to meet needs of kid… academic and basic (food) ***Trends***: Increasing obesity rates for child and adults Alcohol consumption and alcoholism increasing Growing population overall and more diverse

District Overview & Health Equity

Central District Health Department (CDHD), headquartered in Hall County, serves 78,432[iii] people within a three-county district comprised of Hall, Hamilton, and Merrick counties in the central part of Nebraska. Main economic drivers in CDHD include agriculture/forestry/fishing/hunting, health care/social assistance and manufacturing[iv].

Quick Facts for CDHD Region:[v]

Population (2020): **79,992**[1]
Population Change (2010-2019): **5.7%**
Unemployment Rate: **3.2%**[vi]
Total Land Area (2010): **1,574 square miles**

While Hall County is classified as a metropolitan statistical area, Hamilton and Merrick counties are classified as rural counties by the Federal Office of Rural Health Policy[vii]. Rurality is associated with a number of negative health outcomes, specifically higher premature mortality rates, infant mortality rates, and age-adjusted death rates. Rurality is also associated with a number of negative health behaviors that contribute to chronic disease and death, such as unhealthy diets and limitations in meeting moderate or vigorous physical activity recommendations.[viii] These data paint a stark picture of health disparities given one factor, geography. Additionally, it is important to understand that there are disparities related to race and ethnicity independent from geography, and there are disparities related to geography independent from race and ethnicity. When disparities from independent factors overlap, such as race/ethnicity overlapping with geography, the result is a dual disparity resulting in some of the poorest health statuses seen in the nation.[ix] Other obstacles that can impede someone from achieving their full health potential include literacy/language barriers, military status, disability, age, social vulnerability, and key social and economic factors (like poverty and income-level, housing, education status, etc.). These obstacles are described in detail below for the CDHD area; however, race/ethnicity data for many of these factors are limited.

Literacy and Language Barriers

Literacy and primary language must be taken into account in all health contexts. It is estimated that only 1 in 10 American adults have the skills needed to use health information that is routinely available in health care facilities, retail outlets, and the media.[x] *"Being able to read does not necessarily mean one will be health literate, however, the lack of basic literacy skills does mean that patients almost certainly will have difficulty reading and understanding basic health information".*[xi] Basic literacy and health literacy levels are also factors associated with health disparities.

Language barriers also contribute to health disparities and exacerbate difficulties understanding and acting on health information.[xii] The CDHD district is home to multiple immigrant populations and residents whose second language is English, with concentrations from Mexico, Somali, and Arabic nations and smaller populations from other areas.

[1] US Census data was updated with 2020 data where applicable in this report. Note: granular Census data is not available from US Census Bureau until later 2021.

Table 1 summarizes the health literacy indicators within the CDHD district. Nearly 1 in 2 adults in the CDHD district reported that written health information and verbal health information given by medical professionals is not easy to understand.

Table 1. Health Literacy Indicators, CDHD District

Health Literacy Indicators[xiii]	**CDHD Region**
Very easy to get needed advice or information about health or medical topics	70%
Written health information very easy to understand	57%
Very easy to understand information that medical professions tell you	56%

Veterans

Overall, CDHD district Veteran's population is consistent with the state (see Table 2). Although the US Department of Veteran Affairs (VA) assists Veterans in accessing health care and other services, eligibility status for these services depends greatly upon the branch of service, time served, and discharge status. Even when Veterans access services, challenges still exist for health care professionals to effectively understand and treat health issues in Veterans due to complex military histories and medical needs. Unlike previous generations, many younger Veterans experienced frequent deployments to multiple conflict areas, exposure to explosions in close proximity and longer tours of duty.[xiv]

Table 2. Veteran Status, CDHD District

Veteran Status[xv]	**% Veterans (age 18+)**
Hall County	5%
Hamilton County	7%
Merrick County	7%
CDHD District	6%
Nebraska	**6%**

Disability

In the US, one in four adults reported having a disability that impacts their major life activities. Women, non-Hispanic American Indians/Alaska Natives and adults with lower income experience disabilities more than other groups. Mobility disability is the most common type of disability followed closely by cognition, independent living, hearing, vision, and self-care. Adults aged 65 and older who experience disability are more likely to have health insurance, a primary doctor and receive routine health check-ups in the past year compared to adults under 65 years of age with disabilities.[xvi]

Figure 2. Disability types among adults in Nebraska[xvii]

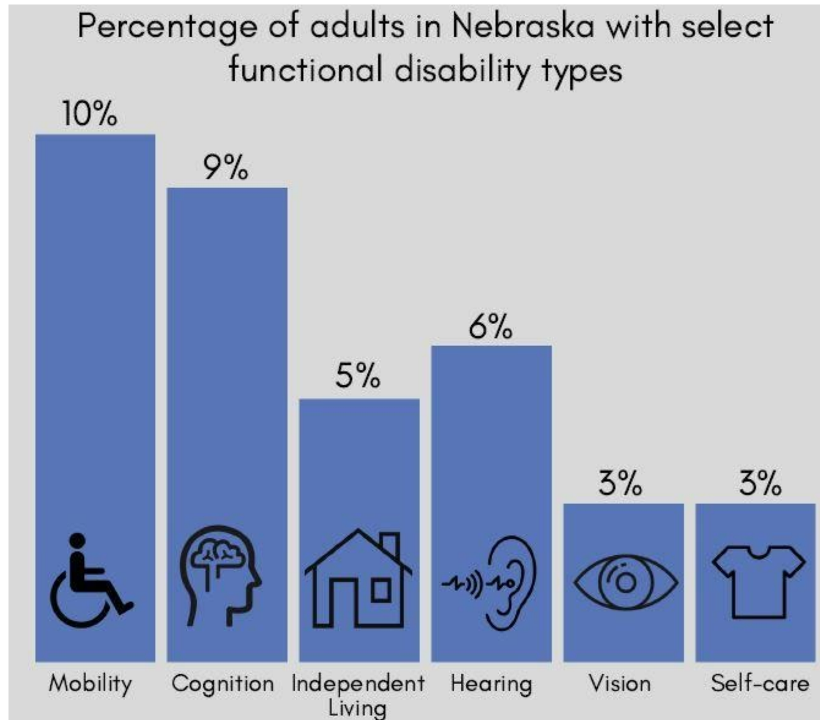
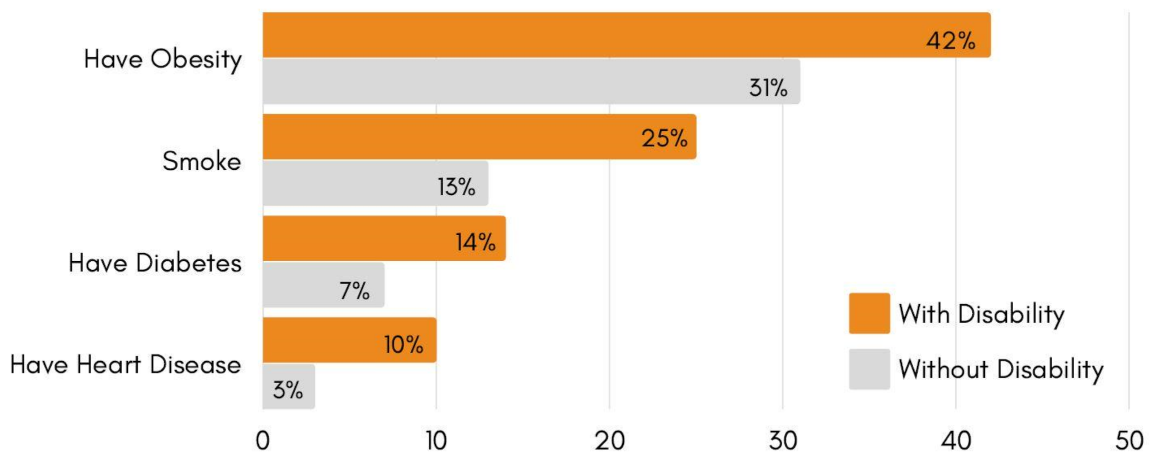


Figure 3. Disability and Health Disparities among adults in Nebraska[xviii]



In the CDHD district, over 1 in 12 adults under age 65 reported having a disability (12.3% Merrick, 5.4% Hamilton, and 8.7% Hall)[xix]. Disabilities become more common as people age. Care coordination and better access to health care services are key to better health by helping people with disabilities adopt healthy behaviors.

Aging

Currently, 16% of the US population is aged 65 and older. This number is expected to grow over the next 40 years to 25%.[xx] As Americans age, many older adults aged 65 and older make rural living their home. Older adults typically reside in rural areas in part due to the attractiveness of the scenic and recreation amenities available in rural communities and due to younger people moving out of rural areas, essentially leaving an older generation behind.[xxi] Older adults have a higher risk of developing chronic diseases and illnesses, including dementia, heart disease, diabetes, arthritis, and cancer. These diseases and illnesses tend to be the leading causes of death and disability in the state and nation and leading drivers of health care costs.[xxii] In the US, more than 25% of older adults were considered "high-need", meaning they were managing three or more chronic conditions or required help with basic tasks of everyday living.[xxiii]

In the CDHD area, almost 1 in 5 people are 65 years or older, slightly higher than the state rate (16%). Alzheimer's Disease is a more commonly known disease among the older adult population. In Hall County, the adult population that experience Alzheimer's Disease (43.5/100,000) is over two times the rate of the state (23.7/100,000 population, respectively) and four times more than adults in Hamilton and Merrick counties (18.3 and 16.6/100,000 population, respectively)[xxiv]. The ability to remain active, healthy and independent as long as possible is key for older adults to live a quality, long life.

Socially Vulnerable Populations

Certain factors, such as gender, age, income level, education level, housing conditions, limited English proficiency, disability, limited transportation and so on, can influence personal health risk of disease, illness, and risk of being seriously affected by an emergency (i.e. flooding, tornadoes, and infectious disease outbreaks). People at higher risk of being seriously affected by the aforementioned public health outcomes and emergencies are considered socially vulnerable. The Centers for Disease Control and Prevention established a Social Vulnerability Index (SVI) as a tool to provide information to community stakeholders in effort to better prepare communities for response to these public health outcomes and emergencies with the overall goal of decreasing both human suffering and economic loss.

The SVI produces a vulnerability score of populations within each US Census tract among four main themes and a score for each theme. Themes include: ***socioeconomic status***, such as poverty level, employment status, income level and high school diploma; ***household composition and disability***, such as aged 65 and older, aged 17 and younger, single-parent households and disabilities among age 5 and older; ***minority status and language***, such as race/ethnicity and English proficiency; ***housing type and transportation***, such as mobile homes/multi-level structures, crowding, and lack of transportation. For the CDHD area, the CDC produces an overall SVI score and a SVI score by theme for each county (see Table 3 for results). Hall County has the highest vulnerability out of all counties within the CDHD area, which is not a surprise given the population characteristics illustrated in upcoming sections of this report. Community stakeholders can use the SVI as a snapshot into where the most vulnerable communities reside and assist with honing in on areas of focus to help reduce risk of public health outcomes and emergencies.

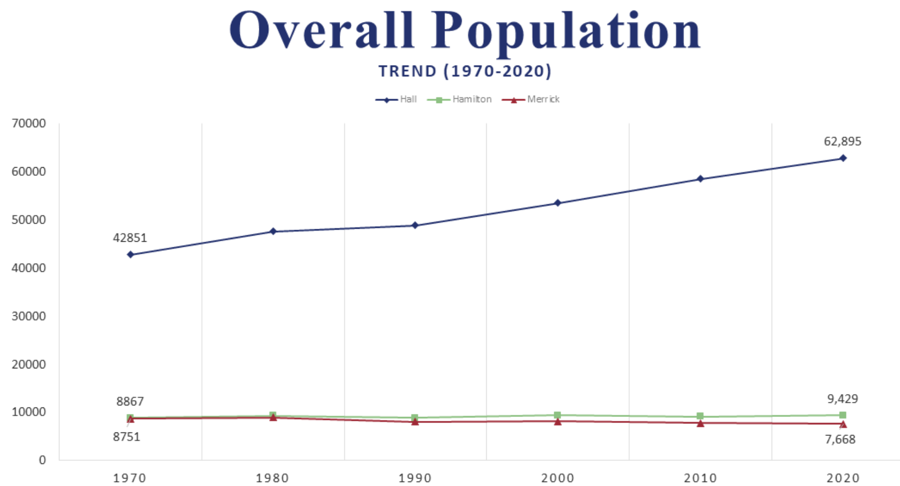
Table 3. Social Vulnerability Index, CDHD District

Social Vulnerability Index			
	Hall County	Hamilton County	Merrick County
Overall Score	**0.6701**	0.0089	0.1975
Socioeconomic Status	***0.4455***	*0.0194*	*0.1086*
Household Composition and Disability	***0.7163***	*0.2865*	*0.3114*
Minority Status and Language	***0.8838***	*0.0675*	*0.2165*
Housing Type and Transportation	***0.5909***	*0.0185*	***0.5587***
Scale: lowest vulnerability = 0.0 highest vulnerability = 1.0			

Population Demographics

Overall, Nebraska's rural population is decreasing while the urban population is increasing. Nebraska's population in the 2019 Census was estimated at 1,934,408. This count was up 5.9% from the 2010 Census and consistent with the national increase of 6.3% during the same period. Growth has occurred in all four of the urban counties of Nebraska. Conversely according to the US Census, all counties within the CDHD district experienced an increase in population (ranging from 2% to 5% increase) between 2010 and 2019 except for Merrick County, which experienced a 1.3% decrease in population. Over a 50-year period (see Figure 4), population in the CDHD area has trended upward in Hall County and remained relatively flat (or a slight downward trend) for Hamilton and Merrick counties.

Figure 4. Overall Population Trend, CDHD (1970-2019)



Race and Ethnicity

Nebraska has a high Hispanic growth rate. Between 2005 and 2014, the Latino population growth rate was more than five times higher than the overall population growth rate in Nebraska (55% vs. 10%).[xxv] Hispanics represented 5.6% of the total population in Nebraska in 2000, 9.2% in 2010, and 11.4% in 2019, and it is estimated that by 2025, the Hispanics will make up nearly a quarter of Nebraska's population (23.4%). Hispanics in Nebraska are from a variety of countries, but Mexico is the primary country of origin (76%). According to the Center for Public Affairs Research at the University of Nebraska-Omaha, populations over time in Nebraska increased in racial/ethnic diversity resulting in positive net migration in Nebraska as of late (see Figure 5). In the future, as the children of today grow up and have children of their own, racial/ethnic diversity is expected to increase (see Figure 6).

Figure 5. Net migration over time, Nebraska (1920-2019)

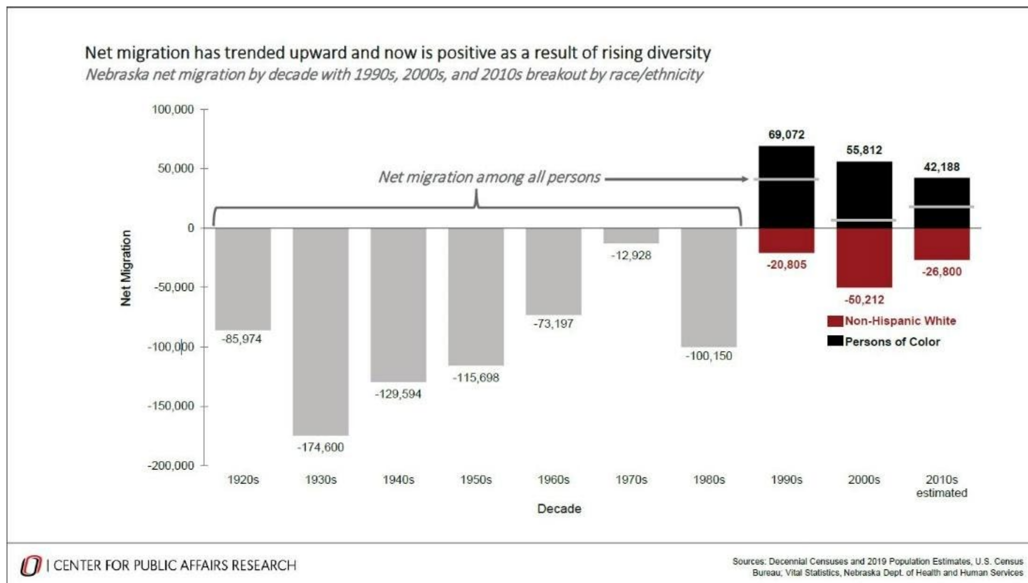
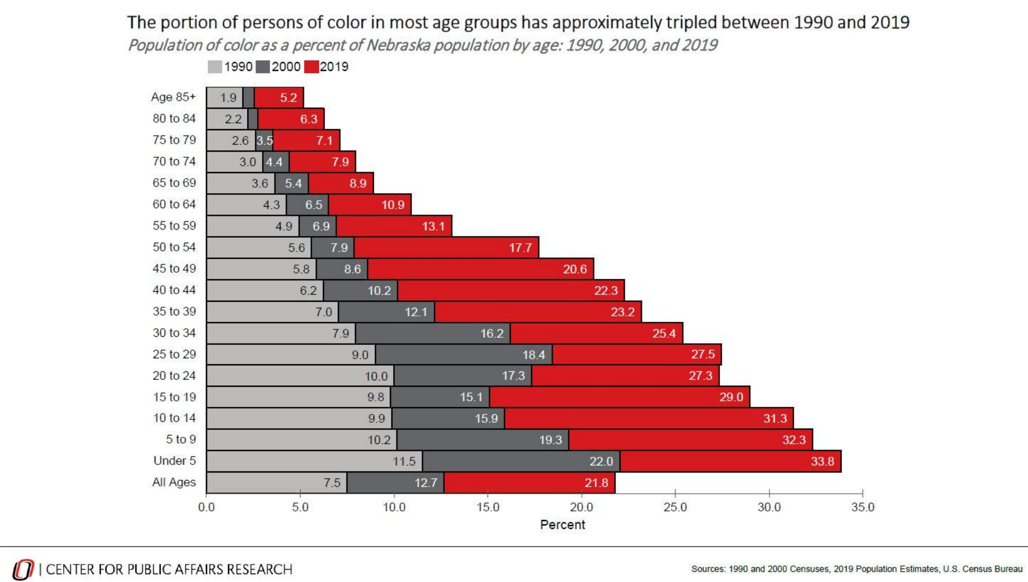
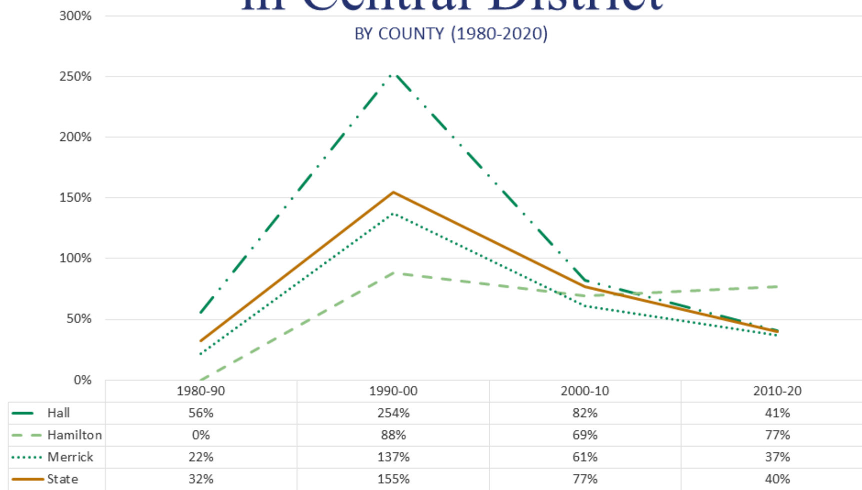


Figure 6. Persons of color by age group, Nebraska (1990-2019)



According to the 2020 County Health Rankings in the CDHD district, Hispanics represented 12%, consistent with the state (11%)[xxvi]. Among counties within the CDHD district, the Hispanic/Latino percent population change over the last 30 years mimicked the state trend peaking between 1990 and 2000 ending with a downward trend in 2020, except for Hamilton County. Hamilton County experienced a slight upward trend in Hispanic/Latino percent population change between 1980-2020 (see Figure 7).

Figure 7. Hispanic/Latino % population change, by county in CDHD



	1980-90	1990-00	2000-10	2010-20
Hall	56%	254%	82%	41%
Hamilton	0%	88%	69%	77%
Merrick	22%	137%	61%	37%
State	32%	155%	77%	40%

Source: Decennial Censuses, US Census Bureau; Prepared by David Drozd, UNO Center for Public Affairs Research, Aug 13, 2021

According to the County Health Rankings and Roadmaps, most of the Hispanic population within the CDHD district resides in Hall County (29%). Within Hall County, the Grand Island Public Schools District had the highest English Language Learners (17%) of all school districts within CDHD area. The percent of Hispanic residents in the other two counties was as follows: Hamilton, 4%; Merrick, 5%. Additionally, race by county is similar to ethnicity by county in that Hall County was home to more racially diverse residents (7.1%) than Hamilton and Merrick counties (1.1% and 2.2%, respectively) and is similar to the state (9.2%) (see Figure 8).

Figure 8. Hispanic Origin, CDHD District

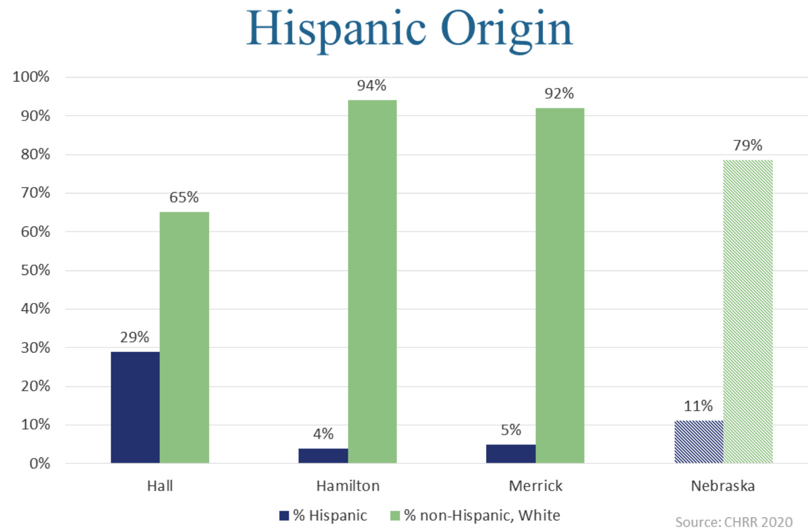
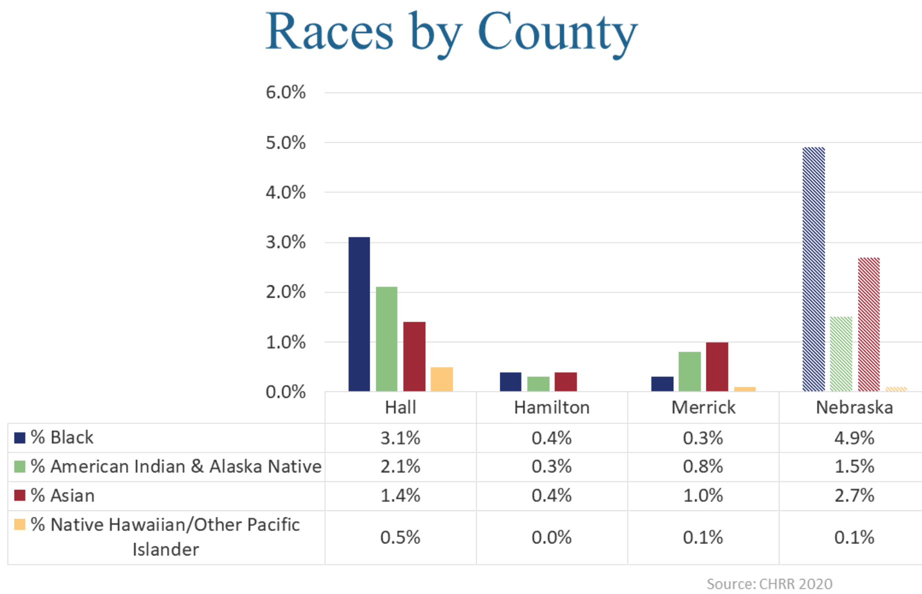


Figure 9. Races by County, CDHD District



	Hall	Hamilton	Merrick	Nebraska
% Black	3.1%	0.4%	0.3%	4.9%
% American Indian & Alaska Native	2.1%	0.3%	0.8%	1.5%
% Asian	1.4%	0.4%	1.0%	2.7%
% Native Hawaiian/Other Pacific Islander	0.5%	0.0%	0.1%	0.1%

Median Age

The median age in the CDHD district was 40 years in 2019, a little older than the average in Nebraska (36 years). Merrick County had the oldest median age of the counties within the CDHD area, almost eight years older than the state.

Figure 10. Age Distribution, Hall County

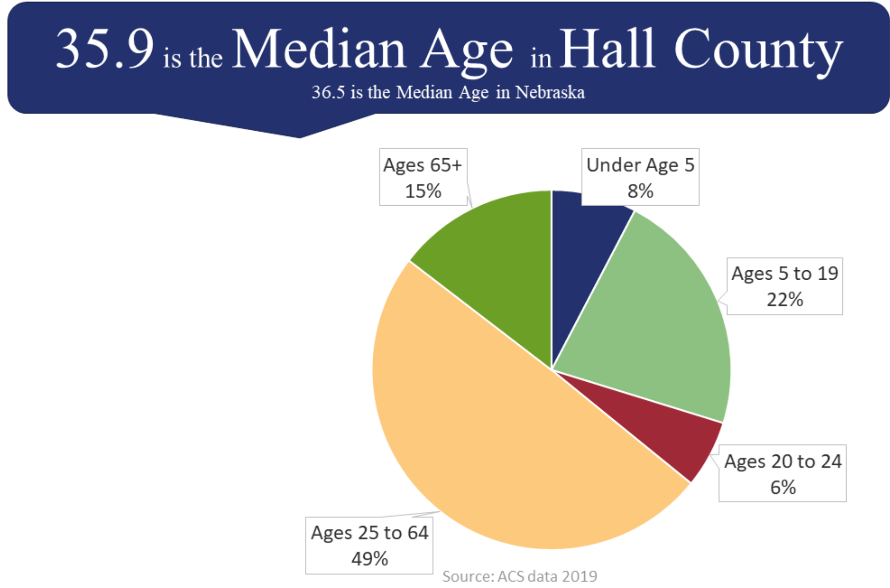


Figure 11. Age Distribution, Hamilton County

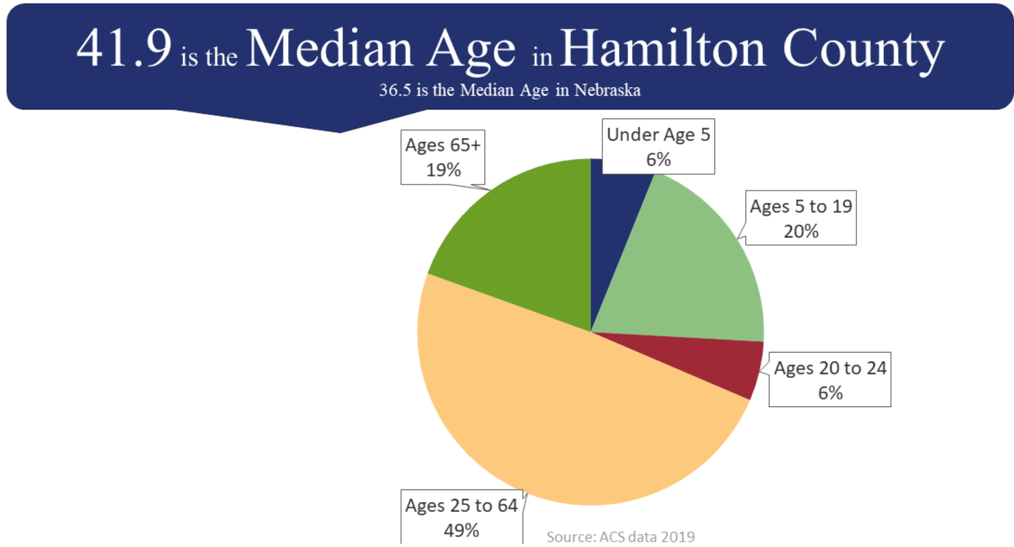
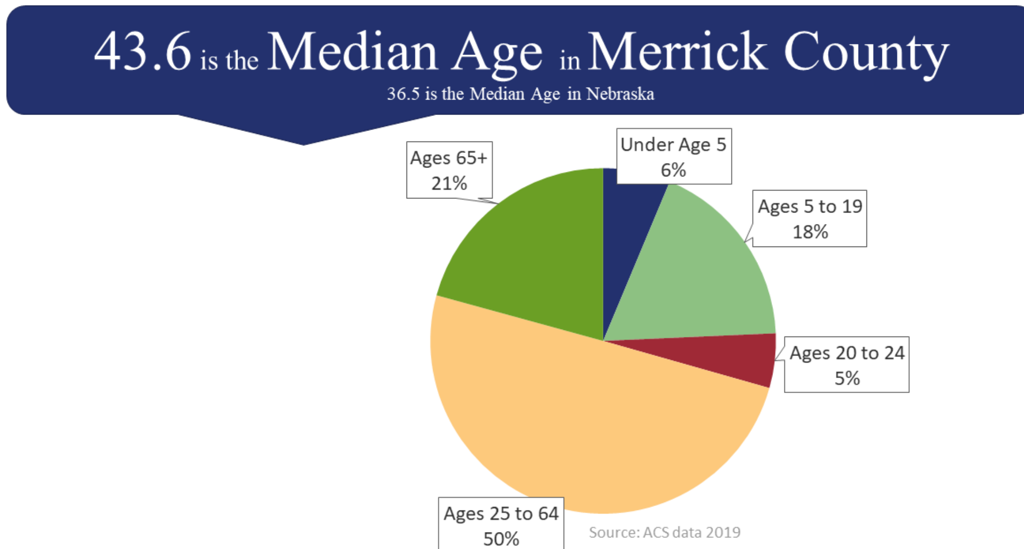
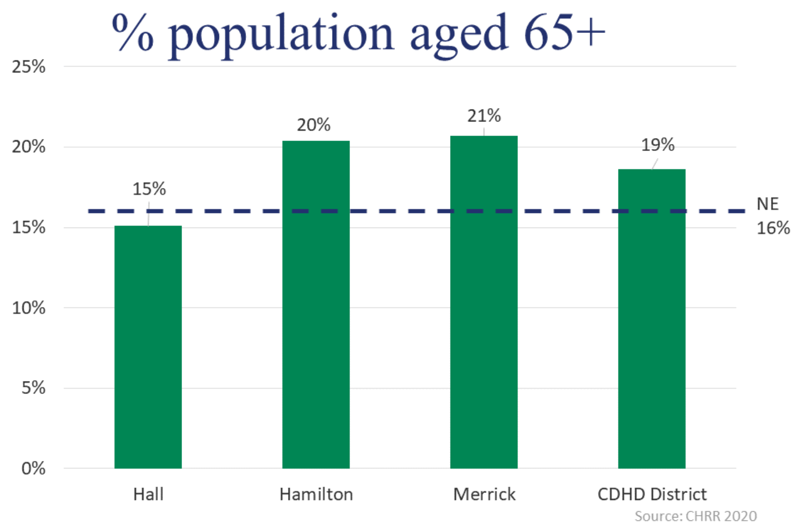


Figure 12. Age Distribution, Merrick County



Roughly 1 in 5 adults in Hamilton and Merrick counties were 65 years and older, and nearly 1 in 6 adults in Hall County were 65 years and older. The percentage of adults aged 65 years and older across the CDHD district (19%) was higher than the state (16%).

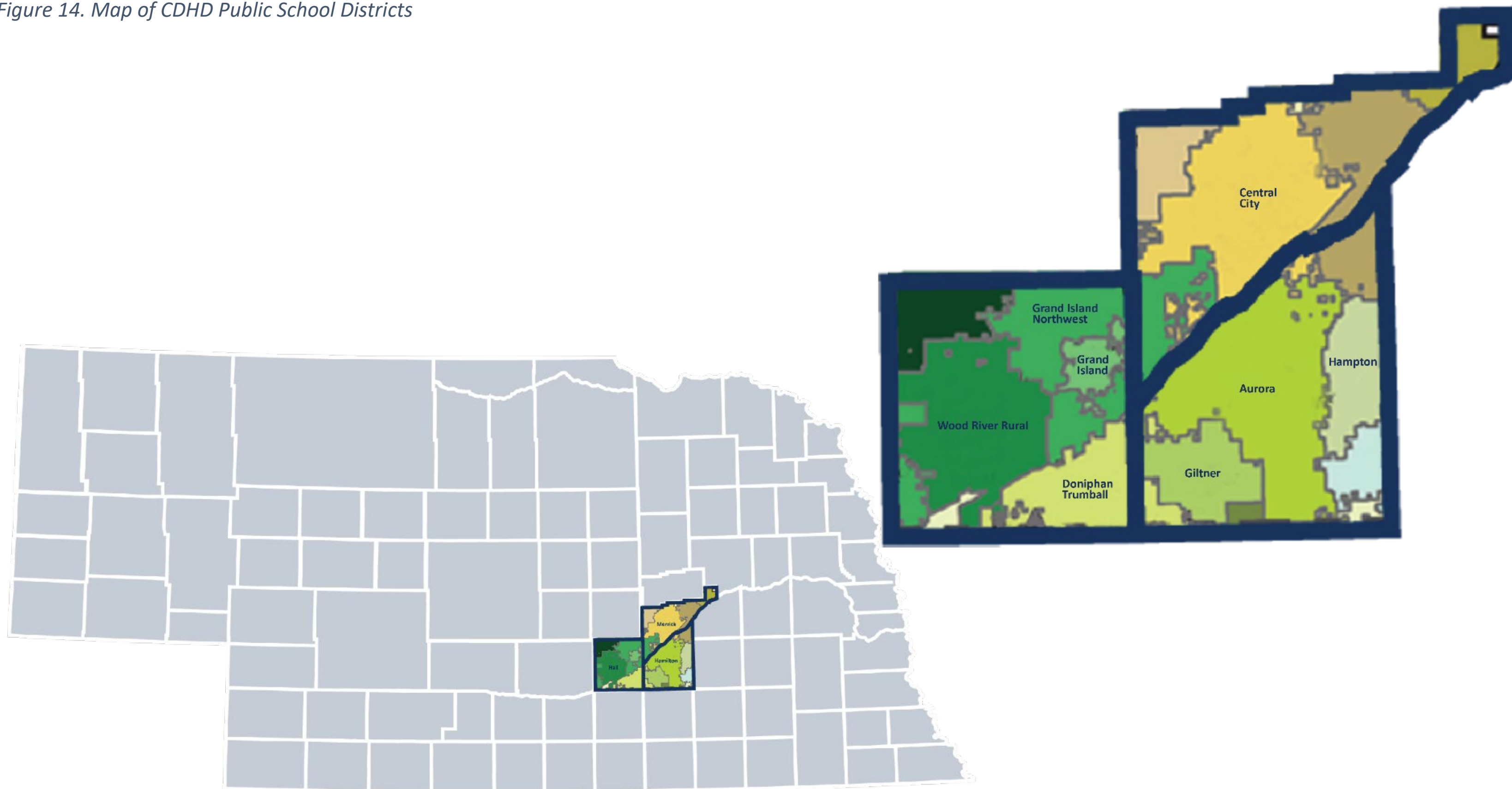
Figure 13. Percent Population Aged 65+, CDHD District



School District Profiles

School-related data can provide a timely picture of the cultural and socio-economic shifts in a community that influence health factors and health outcomes at a population level. Figure 14 illustrates the location of public-school districts within the CDHD district.

Figure 14. Map of CDHD Public School Districts



The following tables highlight key community-level indicators for each county and related public school districts:

Table 4. Public School District Profile--Hall County

Hall County Public School Districts Profile (2018-2019)[xxvii]						
		Doniphan-Trumball	Grand Island Northwest	Wood River	Grand Island Public Schools	State of Nebraska
Student Characteristics	**Enrollment**	460	1,574	512	10,070	329,290
	Graduation rate	93%	99%	90%	83%	88%
	College-Going rate	81%	76%	80%	61%	*
	% Receiving **free/reduced lunch**	24%	29%	49%	65%	46%
	% **English language learners**	*	1%	5%	17%	7%
	% Students in **special education**	12%	11%	13%	16%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in **language arts**	Cancelled due to COVID-19				Cancelled due to COVID-19
	% Proficient in **math**					
	% Proficient in **science**					

Quick Facts for Hall County:[xxviii]

Population (2020): **62,895**
Population Change (2010-2019): **4.7%**
% children under 18: **28%**
Median Household Income: **$57,371**
% total population in poverty: **10%**
% children living in poverty:[xxix] **14%**
Unemployment Rate: **2.8%**[xxx]
Race/Ethnicity--
% Hispanic: **29%**
% non-Hispanic, White: **65%**
% non-Hispanic, other races: **6%**

Table 5. Public School District Profile--Hamilton County

Hamilton County Public School Districts Profile (2018-2019)[xxxi]						
		Aurora	Hampton	Giltner	State of Nebraska
Student Characteristics	**Enrollment**	1283	177	222	329,290
	Graduation rate	92%	*	94%	88%
	College-Going rate	77%	87%	89%	*
	% Receiving **free/reduced lunch**	36%	28%	27%	46%
	% **English language learners**	*	*	*	7%
	% Students in **special education**	16%	24%	17%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in **language arts**	Cancelled due to COVID-19			Cancelled due to COVID-19
	% Proficient in **math**				
	% Proficient in **science**				

Quick Facts for Hamilton County:[xxxii]

Population (2020): **9,429**
Population Change (2010-2019): **2.3%**
% children under 18: **24%**
Median Household Income: **$68,236**
% total population in poverty: **7%**
% children living in poverty:[xxxiii] **8%**
Unemployment Rate: **2.8%**[xxxiv]
Race/Ethnicity--

% Hispanic: **4%**
% non-Hispanic, White: **94%**
% non-Hispanic, other races: **2%**

Table 6. Public School District Profile--Merrick County

Merrick County Public School Districts Profile (2018-2019)[xxxv]			
		Central City	**State of Nebraska**
Student Characteristics	**Enrollment**	767	329,290
	Graduation rate	95%	88%
	College-Going rate	71%	*
	% Receiving **free/reduced lunch**	46%	46%
	% **English language learners**	*	7%
	% Students in **special education**	17%	16%
Nebraska Student-Centered Assessment System Performance	% Proficient in **language arts**	Cancelled due to COVID-19	Cancelled due to COVID-19
	% Proficient in **math**		
	% Proficient in **science**		

Quick Facts for Merrick County:[xxxvi]

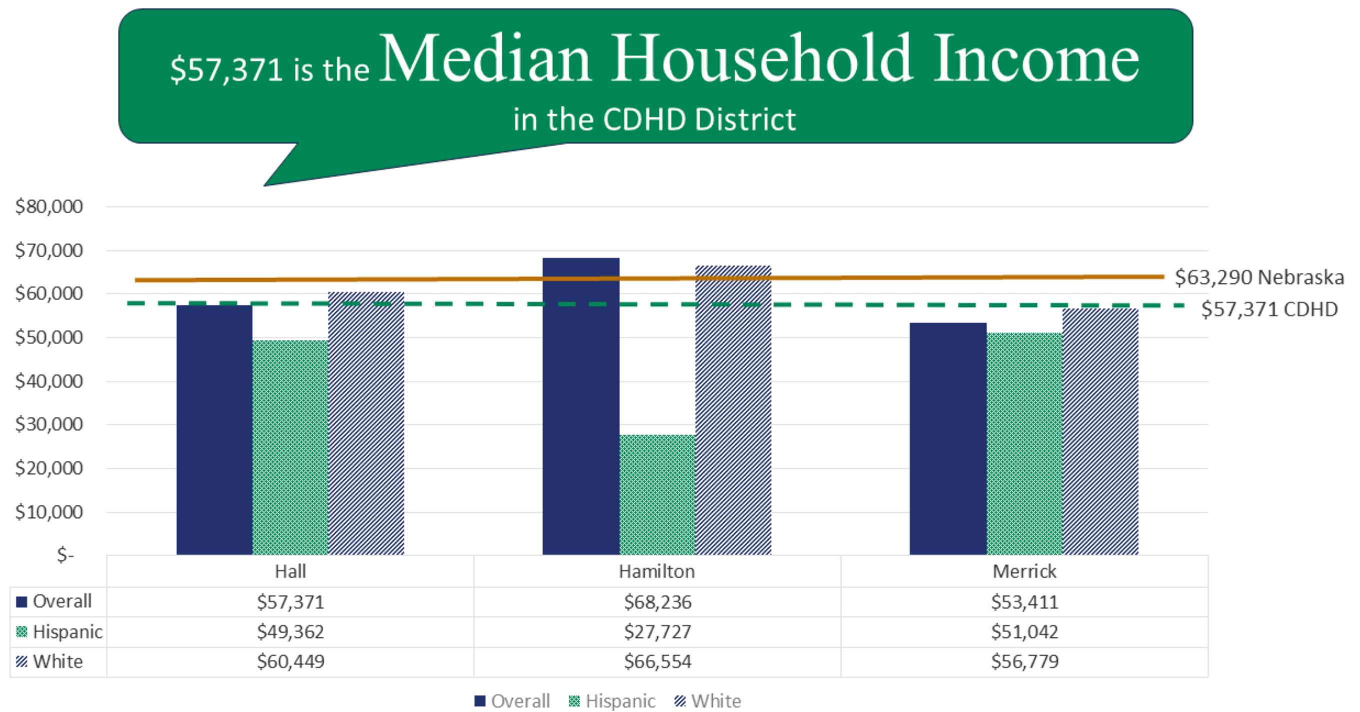
Population (2020): **7,668**
Population Change (2010-2019): **-1.3%**
% children under 18: **22%**
Median Household Income: **$53,411**
% total population in poverty: **11%**
% children living in poverty:[xxxvii] **14%**
Unemployment Rate: **2.7%**[xxxviii]
Race/Ethnicity--
% Hispanic: **5%**
% non-Hispanic, White: **92%**
% non-Hispanic, other races: **3%**

Socio-Economic Status

Economics

According to the 2020 County Health Rankings, the median household income for Nebraska was $63,290 with the median household income for CDHD region coming in a little less than the state at $57,371. Notably, Hamilton County was the only county in the CDHD area with a median household income ($68,236) higher than the state and the largest income gap between Hispanic and non-Hispanic, White households (a difference of $38,827) of any county within CDHD district.

Figure 15. Median Household Income, CDHD District



Nearly 1 in 5 children were from single family homes across the CDHD region, which was similar to the state average of 21%.[xxxix] Twelve percent (12%) of children were living in poverty across all counties within the CDHD region, which is same as the state rate of 12%.[xl] Also the same as the state, CDHD regional unemployment rate was 2.8%.[xli] Despite the low unemployment rate across the CDHD region, families still struggled to make ends meet.

Table 7. Economic Indicators, CDHD District

Economic Indicators	CDHD region	Nebraska
Median Household Income[xlii]	$57,371	$63,290
Children in Single-parent Households[xliii]	19%	21%
Percentage of children under age 18 in poverty[xliv]	12%	12%
Unemployment[xlv]	2.8%	2.8%

Figure 16. Poverty, CDHD District

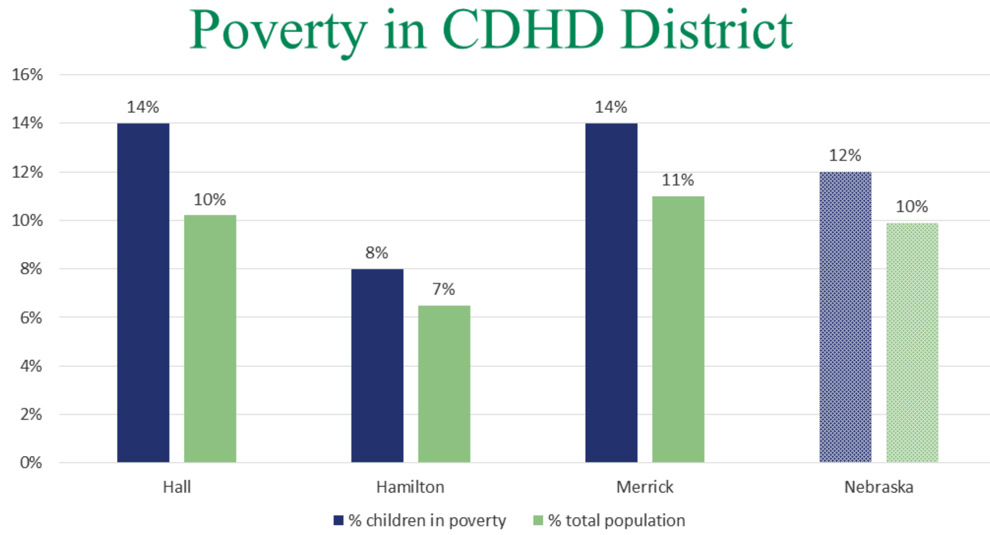


Figure 17. Children in Single-Parent Households, CDHD District

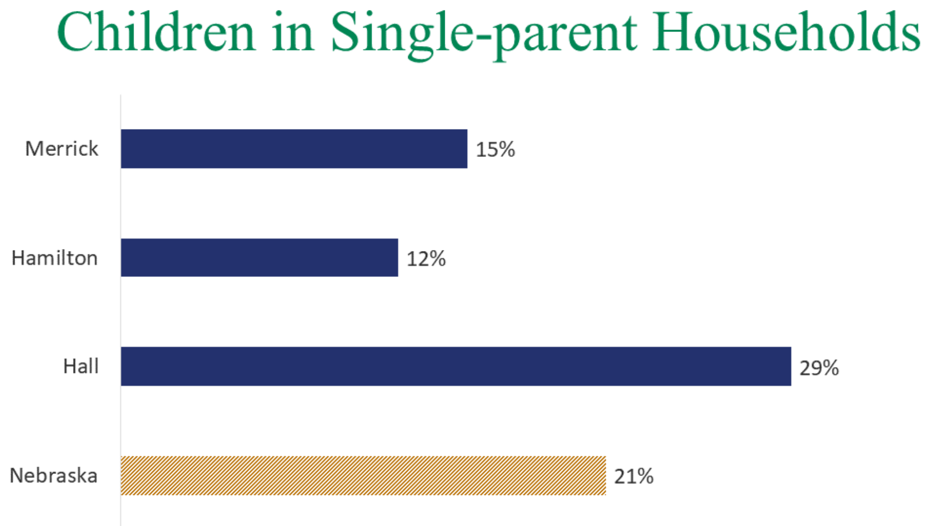


Figure 18. Average Residential Value, CDHD District

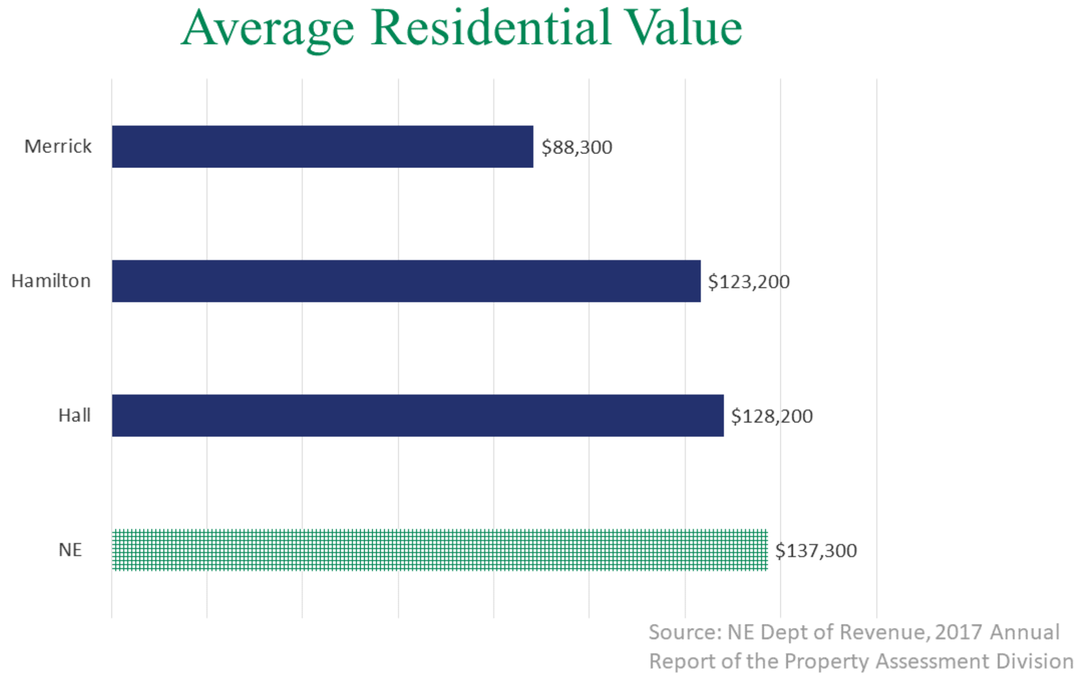


Figure 19. Percentage of Homes Occupied by Owner, CDHD District

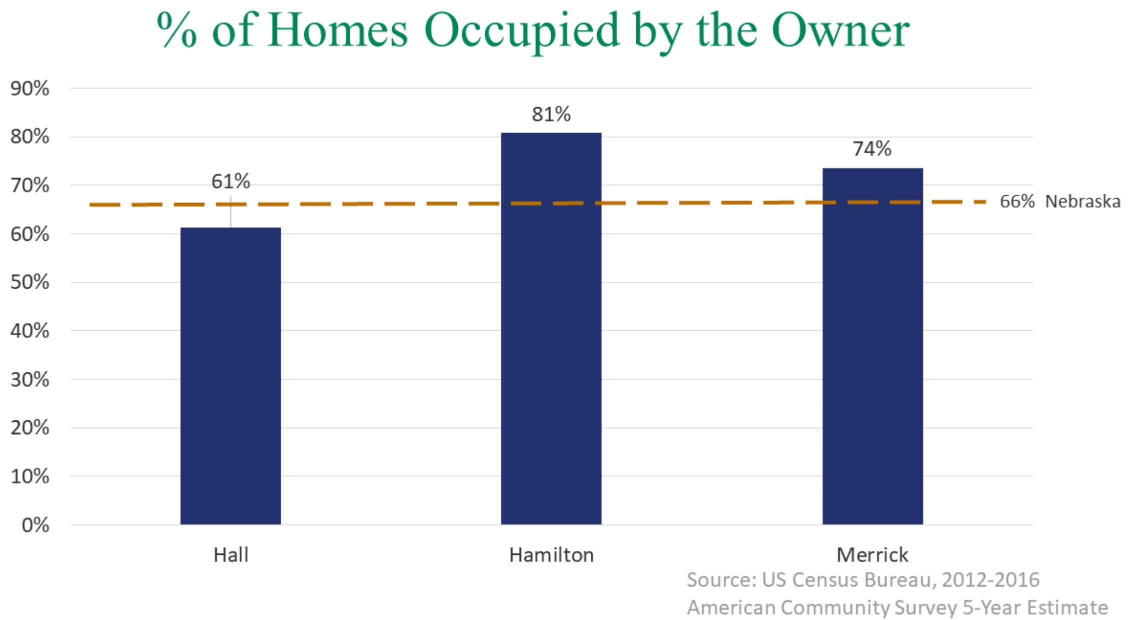
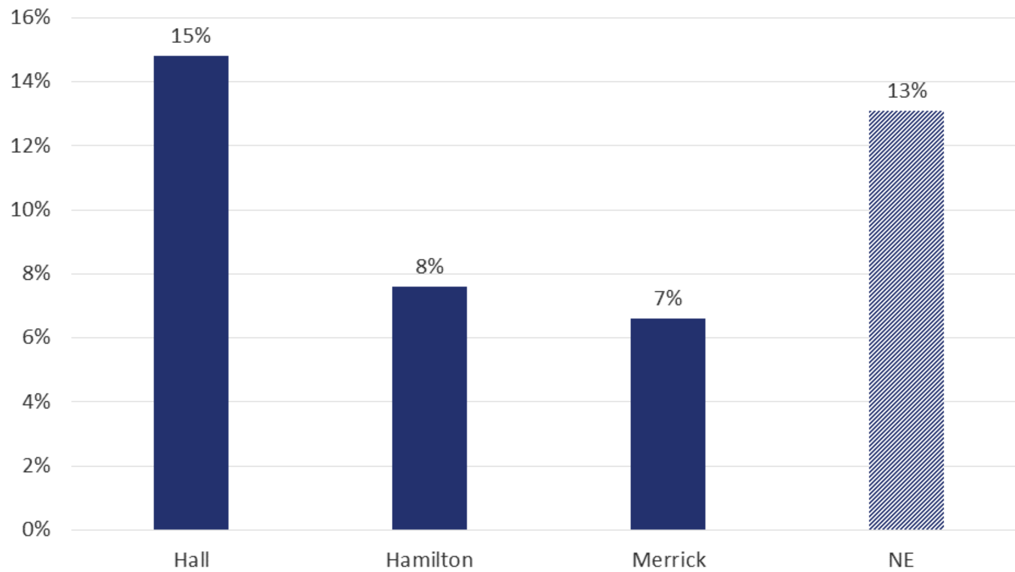


Figure 20. Percentage of Households with Severe Housing Problems, CDHD District



Housing problems as an indicator is designed to understand the housing needs of low-income households and other vulnerable populations. Figure 20 above is based on the percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities.

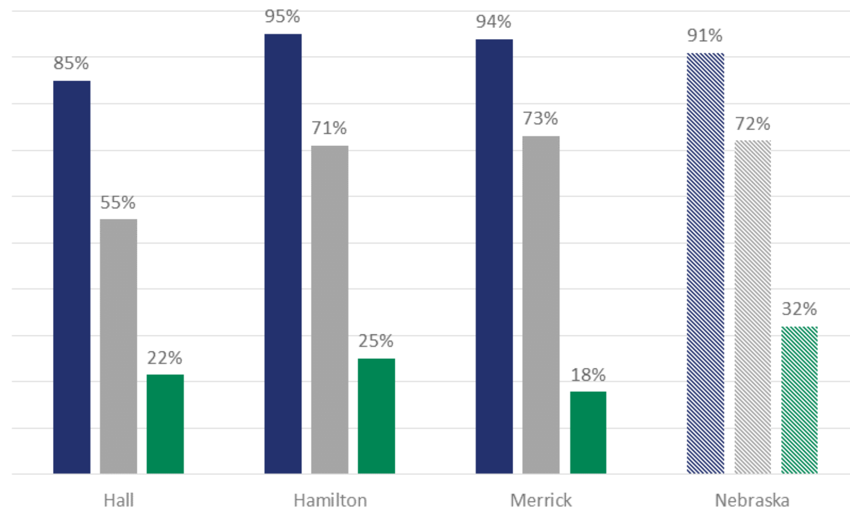
Educational Level

In terms of educational attainment, available data indicate that the CDHD region has a similar high school completion rate (91%) as the state (91%). The Central District region had a slightly lower rate for adults who had some college (counties within the CDHD district range from 55% to 73%) than the state (72%). The state and national averages (32% and 30% respectively) for those who had completed a bachelor's degree was higher than the average for all counties in the CDHD region (range from 18% to 25%).

Table 8. Education Indicators, CDHD District

Education Indicators	CDHD region	Nebraska
High school graduation rate[xlvi]	91%	91%
Some college[xlvii]	66%	72%
Bachelor's degree or higher, percent of persons age 25+[xlviii]	21%	32%

Figure 21. Education Levels, CDHD District



Health Outcomes

The aforementioned social and economic factors, along with health behaviors, clinical care, and physical environment—otherwise known as modifiable health factors, directly impact how well and how long an individual lives. Furthermore, health outcomes (quality and length of life) are compounded by the presence or the absence of policies and programs that promote health and longevity.

Leading Causes of Death

Across the CDHD district, cancer and heart disease were the leading causes of death, similar to state and national trends.

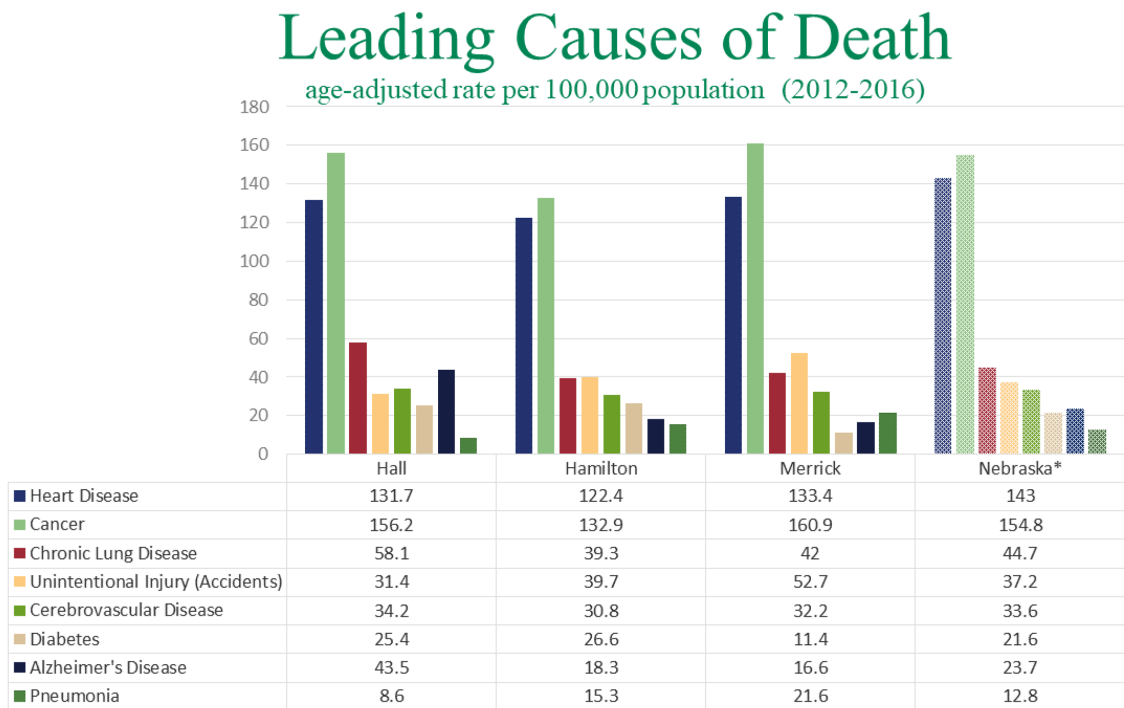
Table 9. Leading Causes of Death, Nebraska & US

Leading Causes of Death	
Nebraska[xlix]	United States[l]
1. Cancer	1. Heart disease
2. Heart disease	2. Cancer
3. Chronic lung diseases	3. Accidents (unintentional injuries)
4. Accidents	4. Chronic lower respiratory diseases
5. Cerebrovascular diseases	5. Stroke (cerebrovascular diseases)

Figure 22 illustrates the leading causes of death by county within the CDHD region.[li] In most cases, counties within the CDHD region have higher rates of death due to cancer, accidents and diabetes than does the state. Of particular note, Merrick County experienced almost twice the death rate

(52.7/100,000 population) due to accidents/unintentional injuries than the state (37.2/100,000 population) and Hall County experienced two times the death rate (43.5/100,000 population) due to Alzheimer's Disease than the state (23.7/100,000 population). The death rate due to heart disease for counties in CDHD was lower than the state. The death rate in Hall County due to chronic lung disease and stroke (58.1 and 34.2/100,000 population, respectively) were slightly higher than the state (44.7 and 33.6/100,000 population). Most all of these leading causes of death can be influenced by a healthy lifestyle and evidence-based public health strategies that include healthy eating and active living, not smoking, wearing a seatbelt, and limiting alcohol consumption by way of programs that help people prevent and manage personal health risks and policies that help people thrive in their communities.

Figure 22. Leading Causes of Death, CDHD District



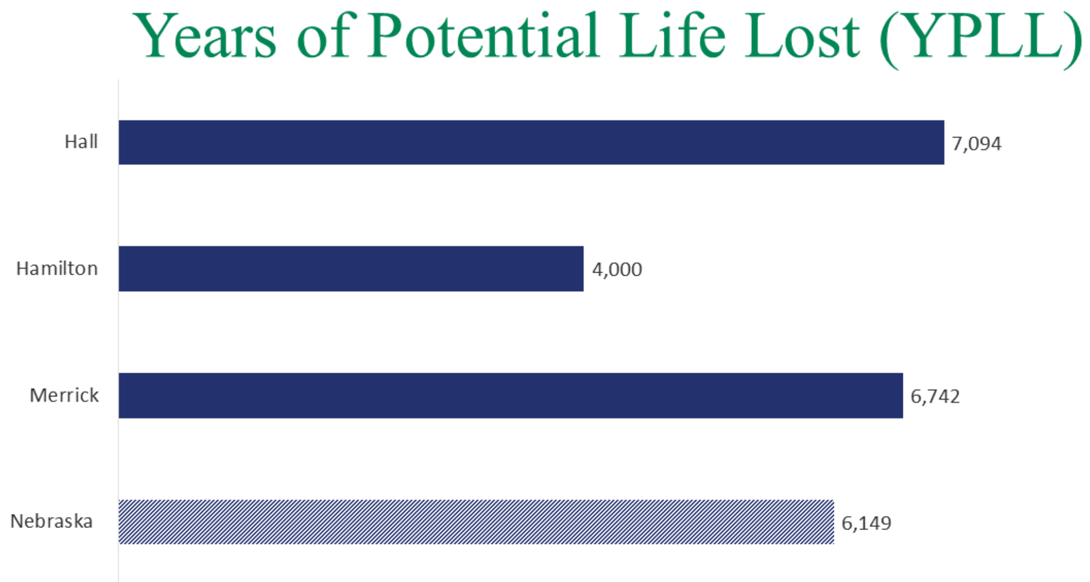
	Hall	Hamilton	Merrick	Nebraska*
Heart Disease	131.7	122.4	133.4	143
Cancer	156.2	132.9	160.9	154.8
Chronic Lung Disease	58.1	39.3	42	44.7
Unintentional Injury (Accidents)	31.4	39.7	52.7	37.2
Cerebrovascular Disease	34.2	30.8	32.2	33.6
Diabetes	25.4	26.6	11.4	21.6
Alzheimer's Disease	43.5	18.3	16.6	23.7
Pneumonia	8.6	15.3	21.6	12.8

*Nebraska rates (age-adjusted to 2000 US population) Source: NEDHHS Vital Statistics Report 2016

An indicator that helps communities focus on prevention is the Years of Potential Life Lost (YPLL), which is a measurement of premature death (mortality). YPLL is an estimate of the average years a person would have lived if he/she had not died prematurely—typically before the age of 75. YPLL emphasizes deaths of younger persons, whereas statistics that include all mortality are dominated by deaths of the elderly.[lii] Figure 23[liii] illustrates the average Years of Potential Life Lost for each county within the CDHD region compared to the state.

Hall and Merrick counties had a higher YPLL than the state, which may be due to having had higher rates of death by cancer, chronic lung disease, accidents/unintentional injuries, and diabetes than the state.

Figure 23. Years of Potential Life Lost (YPLL), CDHD District



Leading Types of Chronic Disease

Four out of five of the leading causes of death in Nebraska were chronic diseases, including heart disease, cancer, chronic lung disease and cerebrovascular disease. In addition to diabetes, these chronic diseases were the most common, costly and preventable of all health problems in the U.S.[liv] Furthermore, deaths by chronic disease comprised nearly 50% of the Years of Potential Life Lost (YPLL) among Nebraskans.[lv] Most of these leading types of chronic disease are generally preventable through a healthy lifestyle that includes healthy eating and active living, not smoking and limiting alcohol consumption rooted in the social and economic factors by which an individual lives.

Overweight/Obesity

According to the 2020 County Health Rankings, nearly 1 in 3 (28%) adults in the CDHD district were considered obese (Body Mass Index [BMI] = 30+), slightly lower than the state (33%). According to the Nebraska BRFSS (2011-2019), 72% of adults in the CDHD district reported being overweight or obese (BMI = 25+), slightly higher than the state (67%), with rates higher among males than females (78% and 65%, respectively).

Figure 24. Obesity Rates, CDHD District

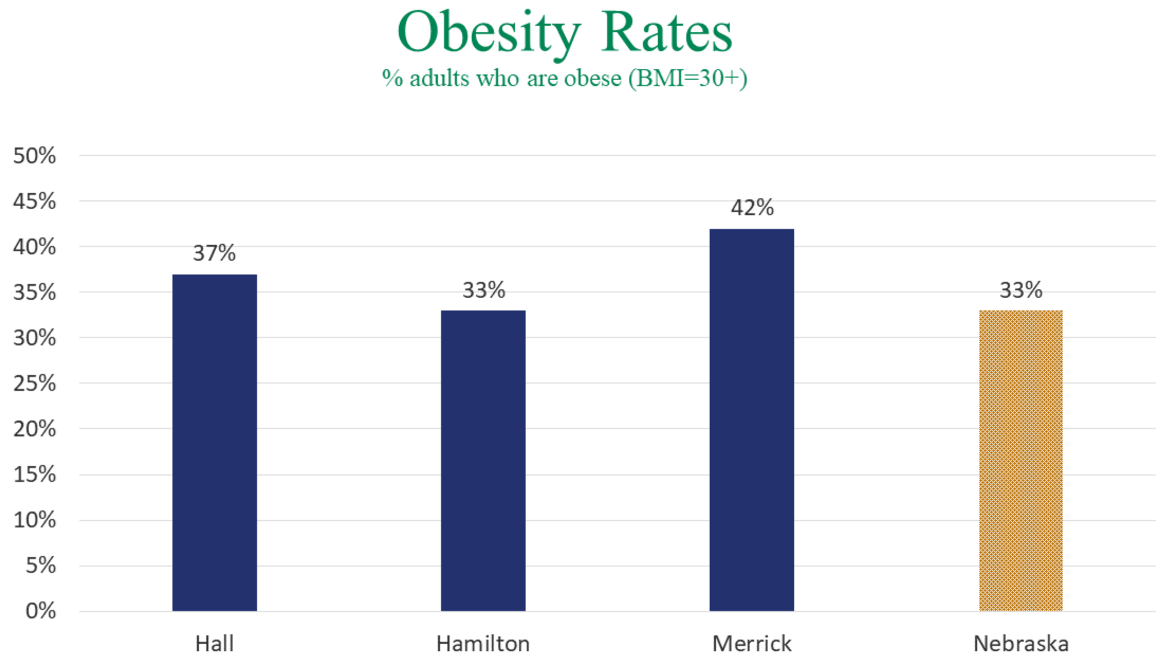


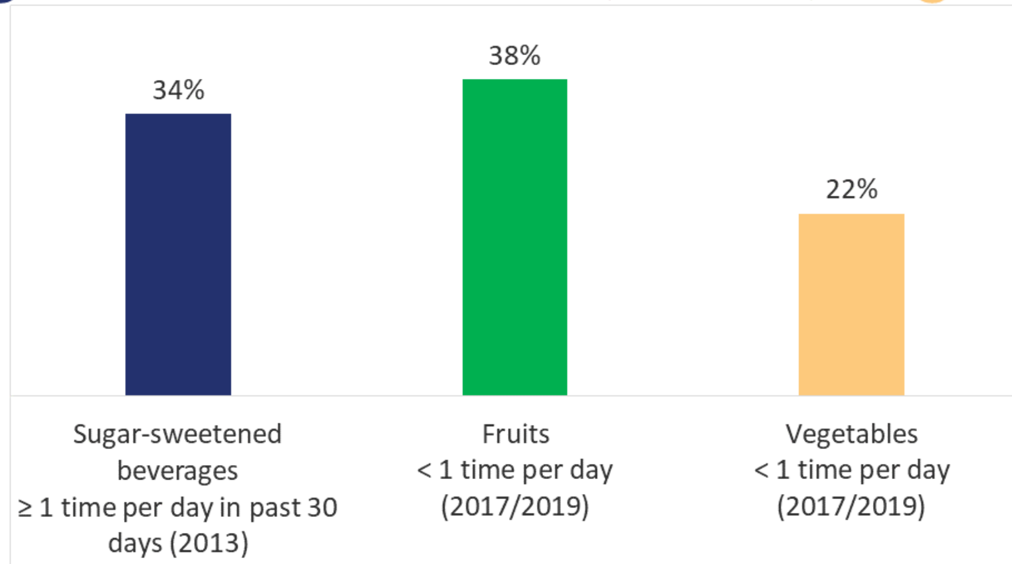
Table 10. Overweight/Obesity Rates, CDHD District

Overweight/Obesity Rates[lvi] *(BRFSS, 2011-2019)*	Overweight or Obese **(BMI = 25+)**	Obese **(BMI = 30+)**
Nebraska	67%	31%
CDHD District	**72%**	35%
Men	**78%**	36%
Women	**65%**	35%

Physical Activity and Nutrition

According to the Nebraska BRFSS, healthy eating and active living was not a routine behavior for many adults in the CDHD district. Nearly 40% of adults in this area reported consuming fruits less than 1 time per day and about 1 in 4 adults consumed vegetables less than 1 time per day.

Figure 25. Nutrition Behaviors, CDHD District



Source: BRFSS 2011-2019

Despite the majority of adults (85%)[lvii] in the CDHD region indicating that they had access to safe places to walk in their neighborhoods, roughly 1 in 3 adults reported no leisure-time physical activity in the past 30 days. Also of concern, the 2012 to 2017 trendline indicates that the percentage of CDHD residents reporting no leisure-time physical activity is increasing. As affirmation to the above indicators related to nutrition, non-White, Hispanic respondents to the CDHD Community Survey identified challenges getting healthy and affordable food as one of top three health concerns.

Figure 26. Physical Activity—No Leisure-Time, CDHD District

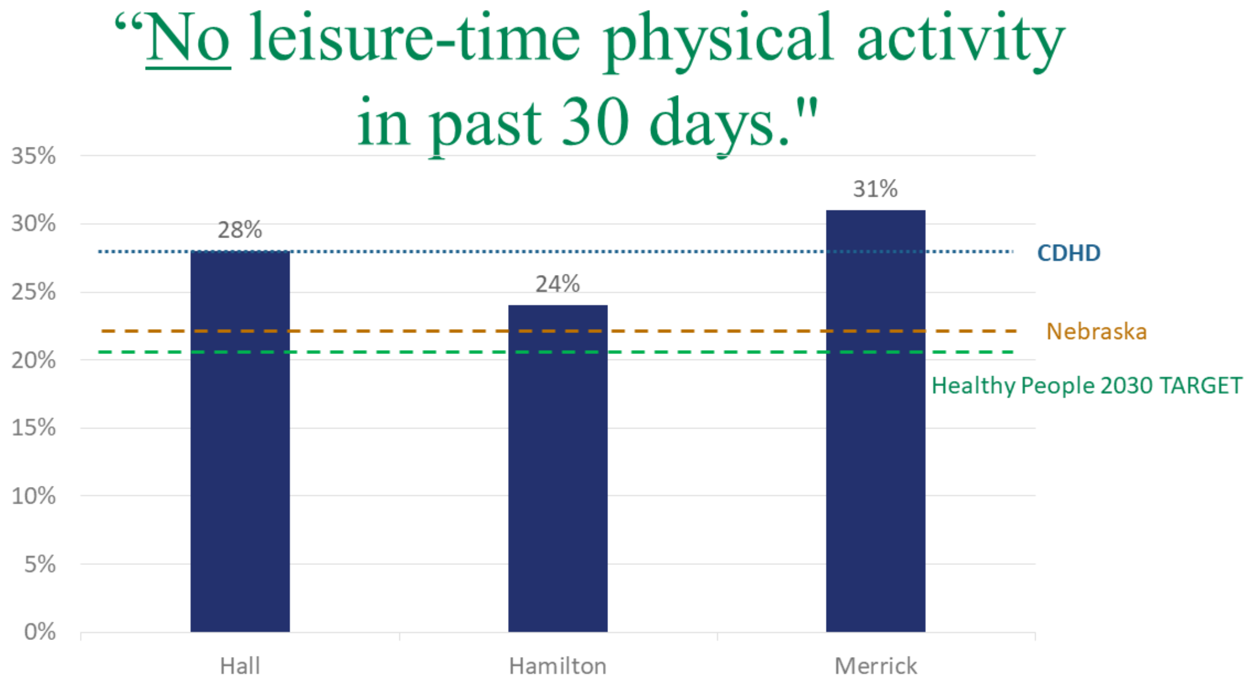
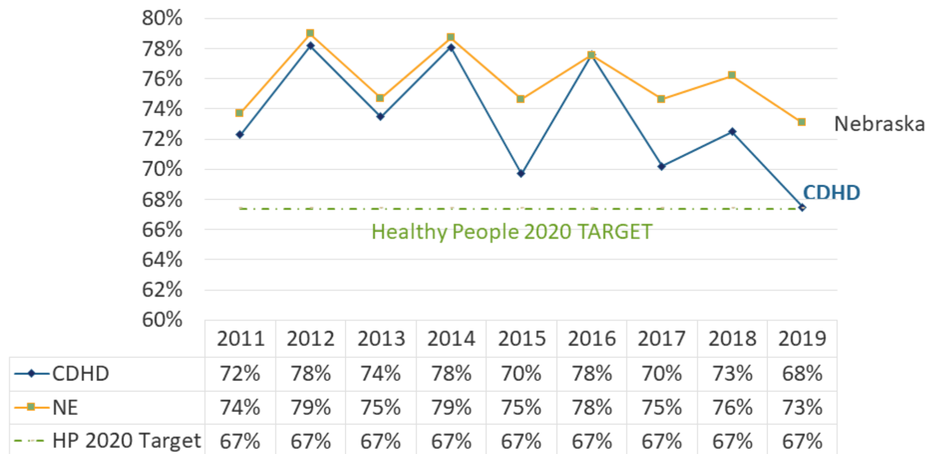


Figure 27. Physical Activity—At Least Some Leisure-Time, CDHD District

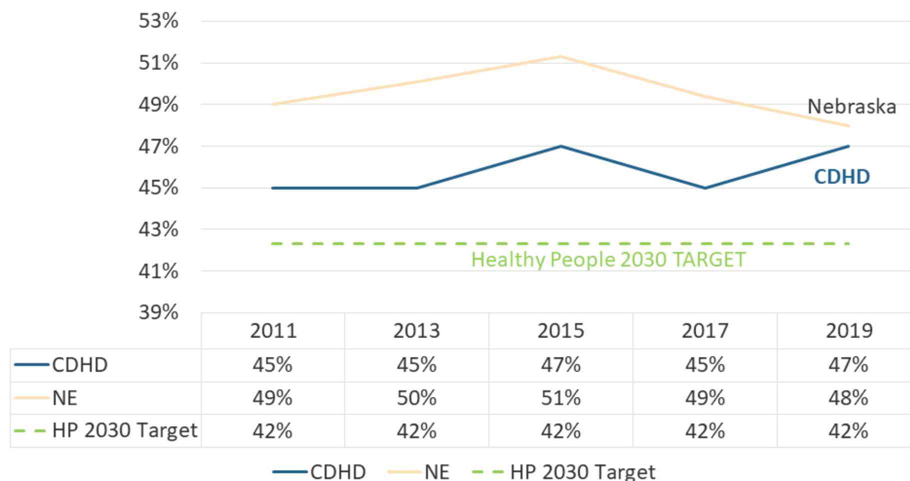


	2011	2012	2013	2014	2015	2016	2017	2018	2019
CDHD	72%	78%	74%	78%	70%	78%	70%	73%	68%
NE	74%	79%	75%	79%	75%	78%	75%	76%	73%
HP 2020 Target	67%	67%	67%	67%	67%	67%	67%	67%	67%

Nearly 50% of people in the CDHD region did not meet the aerobic physical activity recommendations (at least 150 minutes of moderate-intensity physical activity per week—such as brisk walking or 75 minutes of vigorous physical activity per week). Safe community environments, such as walking paths, sidewalks, and walking/biking trails to move throughout the area, encourage residents to engage in healthy eating and active living, which are key to preventing chronic disease. As affirmation to the above indicators related to physical activity, respondents to the CDHD Community Survey identified getting enough exercise as one of the top three health concerns.

Figure 28. Physical Activity—Met Recommendations, CDHD District

Met Aerobic Physical Activity Recommendation



	2011	2013	2015	2017	2019
CDHD	45%	45%	47%	45%	47%
NE	49%	50%	51%	49%	48%
HP 2030 Target	42%	42%	42%	42%	42%

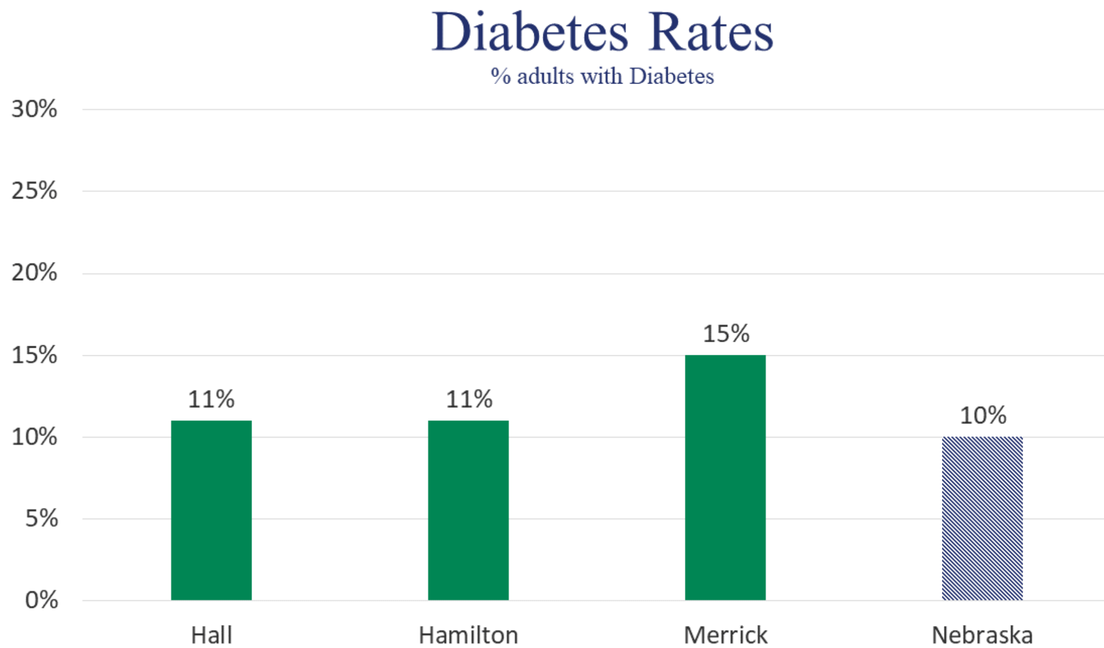
CDHD NE HP 2030 Target

Source: BRFSS 2011-2019

Diabetes

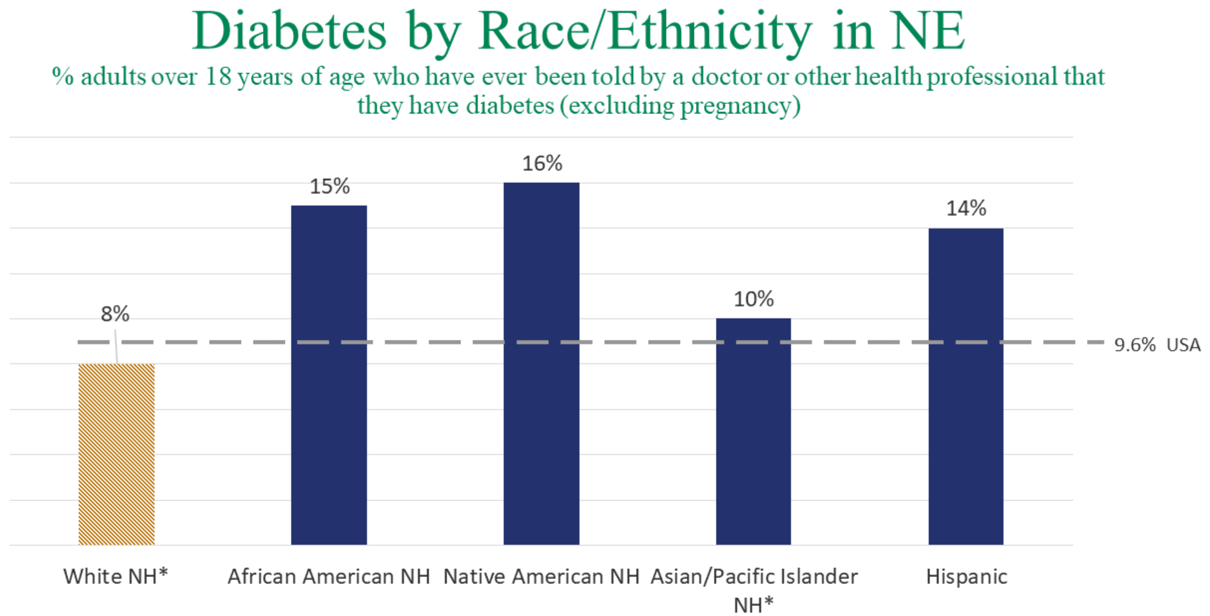
Diabetes is a chronic disease that impacts how a body gets energy from food. Diabetes is the 7th leading cause of death in the US with more than 88 million US adults diagnosed with diabetes. Over the past 20 years, the number of adults diagnosed with diabetes has more than doubled. Overweight/obesity and age are factors that impact the risk of diabetes.[lviii] Often times, diabetes and heart disease are co-occurring. A person with diabetes is 2 times more likely to have heart disease or stroke, the leading causes of death.[lix] Generally, diabetes rates in CDHD region are similar to the state rate, except for Merrick County which experienced a slightly higher diabetes rate than the other counties within CDHD perhaps due to a higher proportion of an aging population in this county.

Figure 29. Diabetes rates—by county, CDHD District



Diabetes data broken down among race/ethnicity is not available by county, diabetes rates among racial/ethnic populations is available at the state level. There are dramatic gaps between racial/ethnic populations when looking at the state diabetes rates. Notably, African American/Black (15%), American Indian/Alaskan Native (16%), and Hispanic (14%) populations experience almost 2 times the rates of diabetes compared to non-Hispanic, Whites (see Figure 30). As affirmation to the above prevalence and factors contributing to diabetes, respondents to the CDHD Community Survey identified diabetes as one of the top three health concerns.

Figure 30. Diabetes rates—by race and ethnicity, Nebraska



Heart Disease

Heart disease is one of the top two leading causes of death in the CDHD district and across the state. Leading a healthy lifestyle, including active living, healthy eating, not smoking and limiting alcohol use, and/or managing other medical conditions, such as high cholesterol, high blood pressure, or diabetes, reduces the risk of heart-related diseases, including heart attack and stroke. In Nebraska, non-Hispanic, White (81.1/100,000), African American (93.9/100,000), and Native American (94.6/100,000) populations have a higher rate of death due to heart disease than the state (77.4/100,000).[lx]

Table 11. Heart Disease Indicators, CDHD District

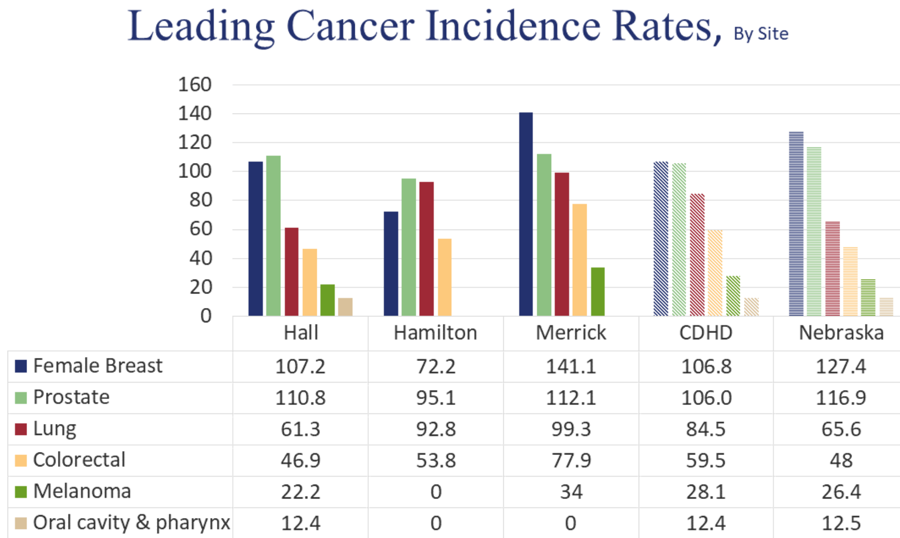
Heart Disease Indicators[lxi]	NE	CDHD Region		
		Overall	Female	Male
Ever told they have high blood pressure (excluding pregnancy)	30%	33%	30%	35%
Currently taking blood pressure medication, among those ever told they have high BP	78%	77%	86%	72%
Ever told they have high cholesterol, among those who have ever had it checked	32%	30%	30%	30%

Cancer

Cancer is a leading cause of death in the CDHD district and across the state. In the CDHD region, female breast cancer was the leading type of cancer diagnosed (106.8/100,000 population), which was lower than the state (127.4/100,000 population, respectively). Prostate cancer followed as a close second for CDHD district (106.0/100,000 population) and was lower than the state (116.9/100,000 population,

respectively). Notably, Merrick County residents experience more cancer than their counterparts in Hall or Hamilton counties and the state.

Figure 31. Cancer Incidence Rates, CDHD District



	Hall	Hamilton	Merrick	CDHD	Nebraska
Female Breast	107.2	72.2	141.1	106.8	127.4
Prostate	110.8	95.1	112.1	106.0	116.9
Lung	61.3	92.8	99.3	84.5	65.6
Colorectal	46.9	53.8	77.9	59.5	48
Melanoma	22.2	0	34	28.1	26.4
Oral cavity & pharynx	12.4	0	0	12.4	12.5

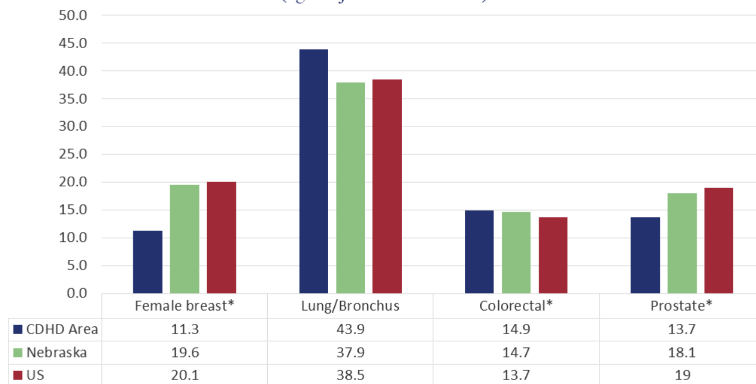
Cancer mortality rates are on the decline in the CDHD district, state, and nation.[lxii] Despite this trend, cancer remained one of the top two leading causes of death in the CDHD district through 2017. Cancer mortality data by race and ethnicity was not readily available for the CDHD district. Native Americans, African Americans, and Whites across Nebraska had cancer mortality rates in excess of the state target of 145.2/100,000 population (see Figure 29). More information is needed about the cause of cancer incidence and death rates in the CDHD area.

Figure 32. Cancer Mortality Rates--Nebraska Racial/Ethnic Comparison (per 100,000 population)

**NH = Non-Hispanic*

Although cancer mortality data by county was not readily available, lung (and bronchus) cancer was the leading type of cancer that resulted in death in the CDHD district (see Figure 33).[lxiii] Tobacco smoking remains the leading cause of lung cancer, responsible for about 80% of lung cancer deaths. Other causes include exposure to secondhand smoke and radon.[lxiv]

Figure 33. Leading Cancer Death Rates in CDHD (per 100,000 population)

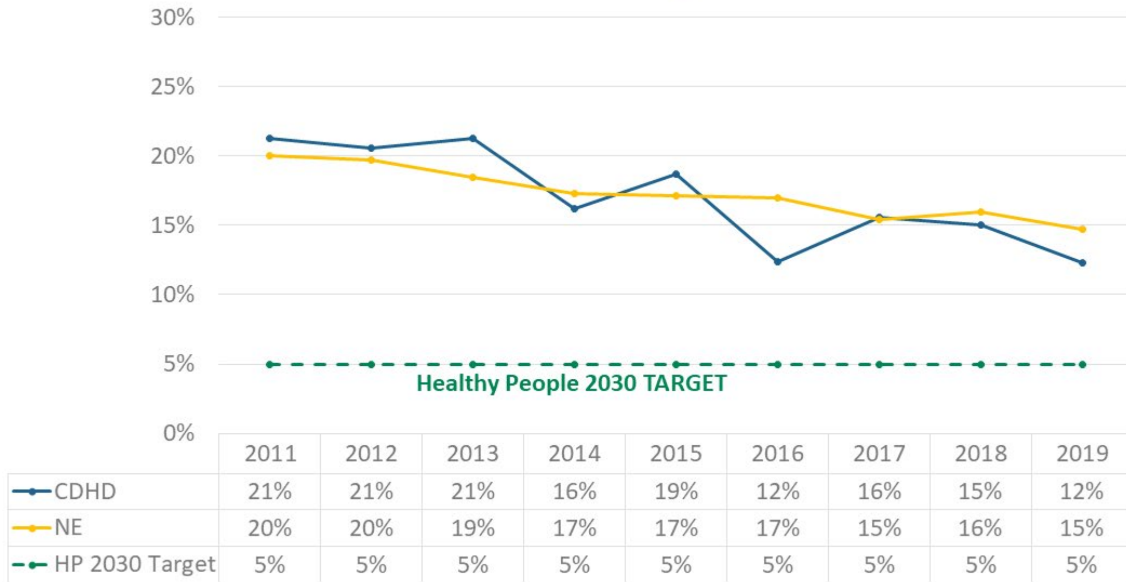


As affirmation to the above prevalence and factors contributing to cancer, respondents to the CDHD Community Survey identified cancer as one of the top three health concerns.

Tobacco and Nicotine Product Usage

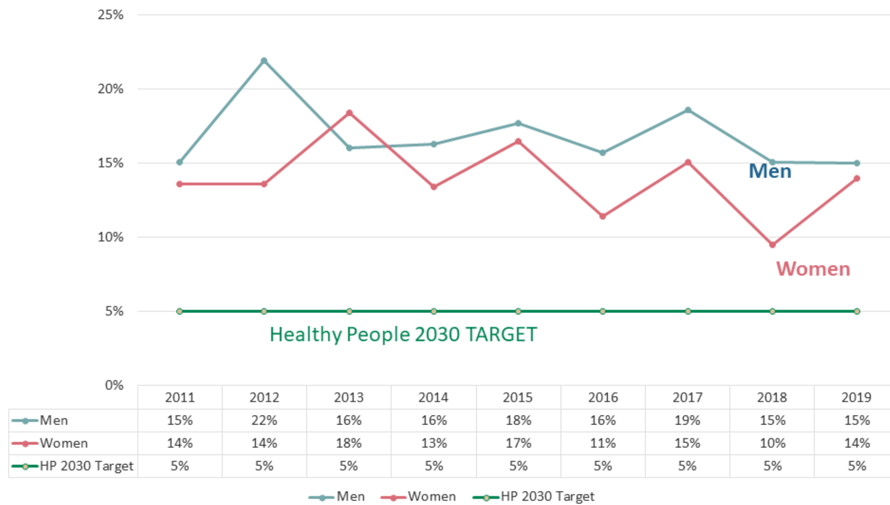
Cigarette smoking is the leading cause of preventable disease and death in the US. According to the CDC, the smoking rate among adults in the US has dropped from 20.9% in 2005 to 14% in 2019.[lxv] According to the Nebraska BRFSS (2011-2019), the smoking rate among adults in the CDHD region and in the state has trended downward (see Figure 31), yet the adult smoking rate is higher than the Healthy People 2030 target of 5%. Smoking rates among male adults in the CDHD region was higher than female adults (see Figure 35).

Figure 34. Adult Smoking Rates, CDHD District



	2011	2012	2013	2014	2015	2016	2017	2018	2019
CDHD	21%	21%	21%	16%	19%	12%	16%	15%	12%
NE	20%	20%	19%	17%	17%	17%	15%	16%	15%
HP 2030 Target	5%	5%	5%	5%	5%	5%	5%	5%	5%

Figure 35. Adult Smoking Rates by Gender, CDHD District



	2011	2012	2013	2014	2015	2016	2017	2018	2019
Men	15%	22%	16%	16%	18%	16%	19%	15%	15%
Women	14%	14%	18%	13%	17%	11%	15%	10%	14%
HP 2030 Target	5%	5%	5%	5%	5%	5%	5%	5%	5%

While Nebraska has a clean indoor air ordinance prohibiting smoking in all government and private workplaces, schools, childcare facilities, restaurants, bars, casinos/gaming establishments, retail stores and recreational/cultural facilities, tobacco products are relatively easy to access and inexpensive.

Nebraska's tobacco tax is $0.64 per pack, $1.18 lower than the national average, ranking Nebraska 42nd in the US for its cigarette tax[lxvi].

Even though cigarette smoking (otherwise known as combustible tobacco cigarette) was trending downwards in the CDHD district, e-cigarette usage was growing among CDHD adults. According to the 2019 NE BRFSS, 1 in 5 adults in the CDHD district used e-cigarettes just slightly under the state rate of 25%. E-cigarettes are devices that heat liquid solution to produce an aerosol that is inhaled. E-cigarettes contain varying amounts of nicotine depending on the type of e-cigarette; and although considered less harmful to individual health than inhaling smoke from combustible tobacco, still deliver harmful chemicals. E-cigarettes can be addictive due to the nicotine content.[lxvii]

The most commonly used tobacco product among youth was e-cigarettes, and e-cigarette usage among youth increased more than any other age group in recent years (see Figures 36, 37 and 38). E-cigarettes are marketed to youth with strategies that have been heavily regulated to reduce youth consumption of combustible cigarettes, i.e. kid-friendly flavors, scholarship opportunities for school, online/mobile and TV ads.[lxviii] CDHD district has experienced marked increases in e-cigarette use among youth. According to the Nebraska Risk and Protective Factor Surveillance Survey (NPRFSS) in 2018, the current e-cigarette usage rate among CDHD youth in 12th grade is 35.3% (see Figure 39) and nearly half of all 12th graders who responded to the NPRFSS survey reported ever using e-cigarettes.

Figure 36. E-Cigarette Use Rate-- Youth, Nebraska

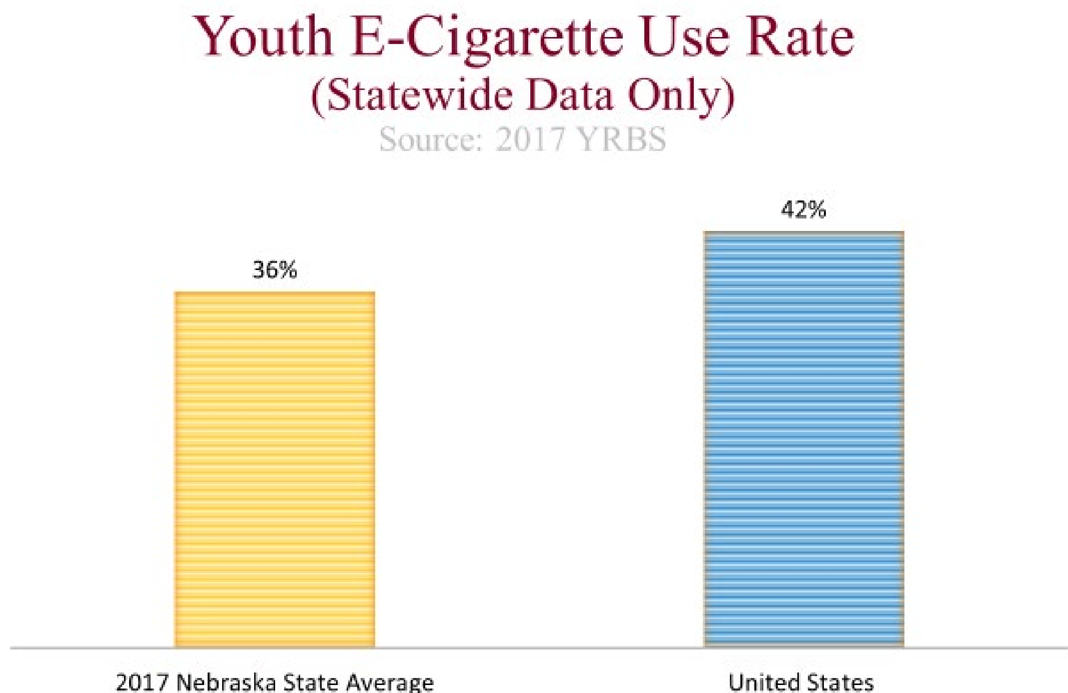


Figure 37. E-Cigarette Use Rate--Youth, Nebraska

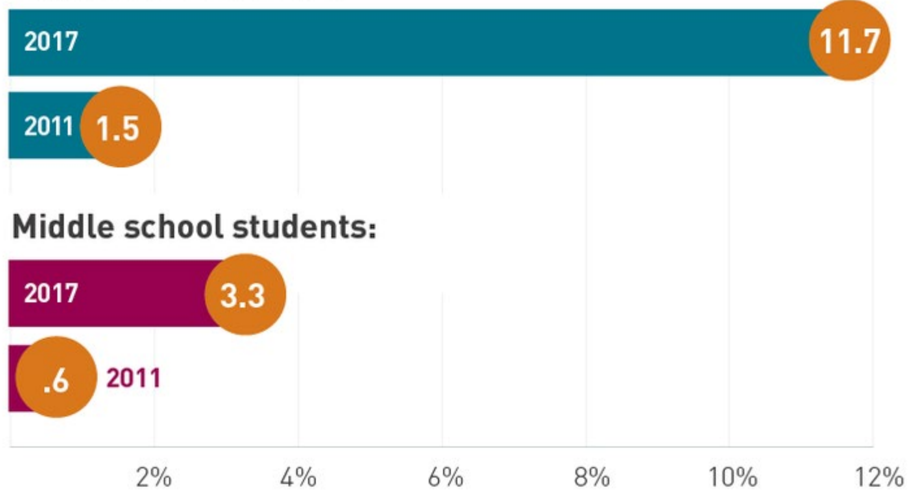
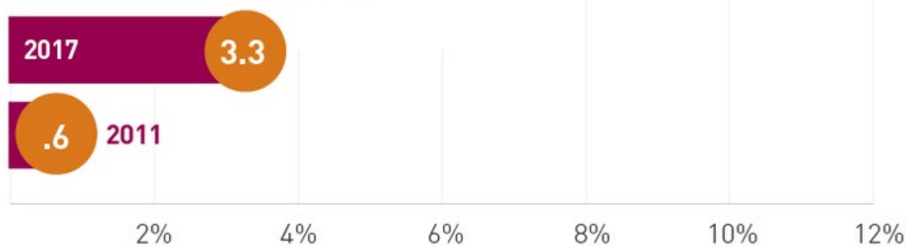



Figure 38. Tobacco Use—Other Tobacco Product Use Rate, Nebraska

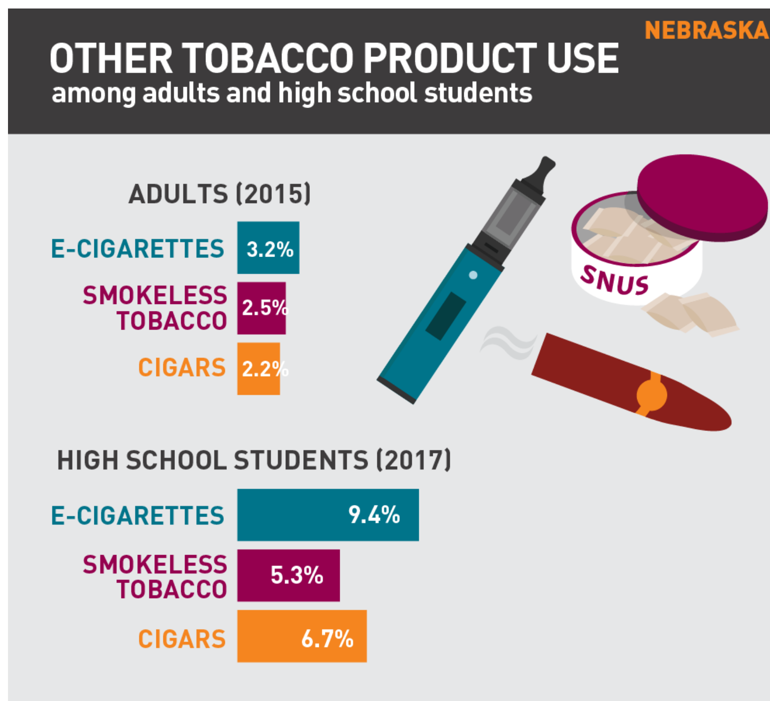
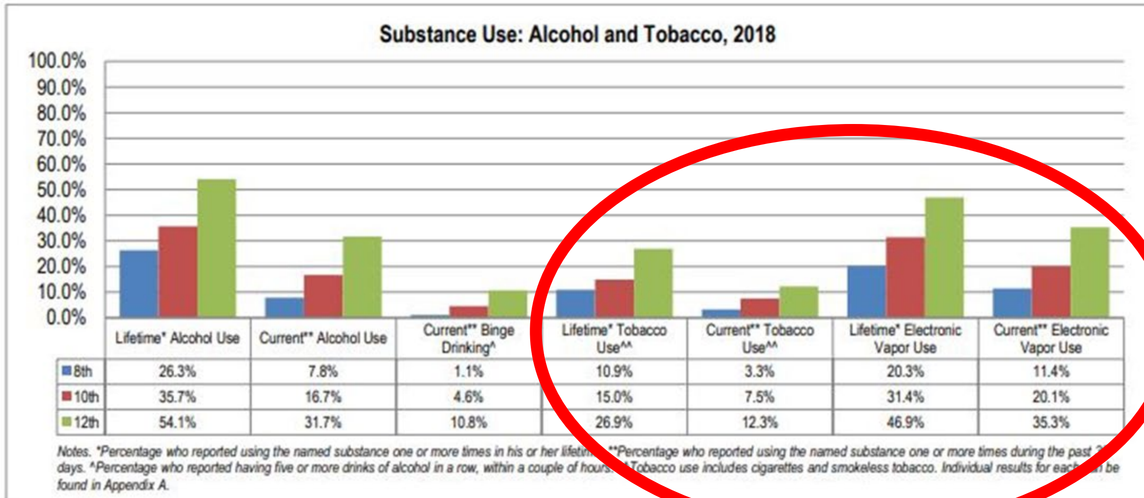


Figure 39. Tobacco and Alcohol Use Rate—Youth, CDHD District

Alcohol and Tobacco Use of Youth
in CDHD District Grades 8, 10 and 12



	Lifetime* Alcohol Use	Current** Alcohol Use	Current** Binge Drinking^	Lifetime* Tobacco Use^^	Current** Tobacco Use^^	Lifetime* Electronic Vapor Use	Current** Electronic Vapor Use
8th	26.3%	7.8%	1.1%	10.9%	3.3%	20.3%	11.4%
10th	35.7%	16.7%	4.6%	15.0%	7.5%	31.4%	20.1%
12th	54.1%	31.7%	10.8%	26.9%	12.3%	46.9%	35.3%

Source: 2018 results from Nebraska Risk and Protective Factor Student Survey

Radon Risk

The second-leading cause of lung cancer, behind smoking, is breathing radon gas, a naturally-occurring, radioactive, colorless and odorless gas. Homes, schools, and workplaces are where most radon exposure occurs. Nebraska has a high statewide average radon level at 6.3 pCi/L, ranking it third across the US. Over half of the radon tests in the state were above the Environmental Protection Agency's recommended action level of >4.0 pCi/L. At least 70 of 93 Nebraska counties had an average radon level greater than 4.0 pCi/L, including Hamilton County.[lxix]

Leading Causes of Injury

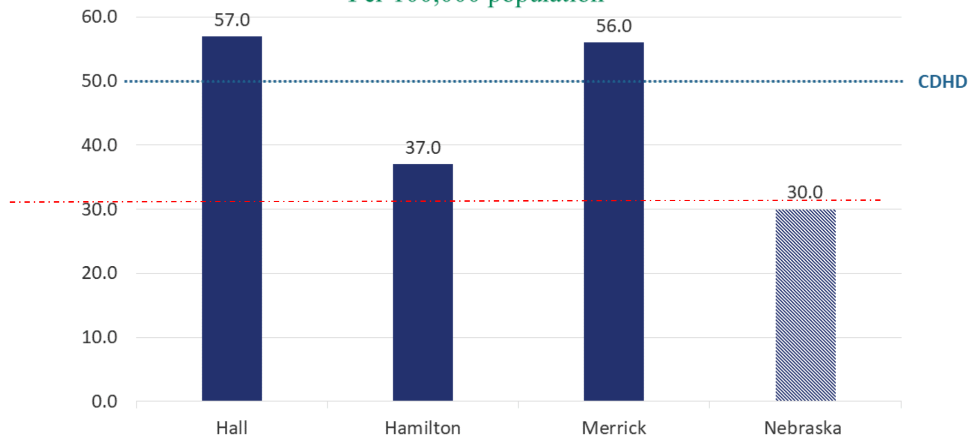
Deaths by injury comprised approximately 20% of the total YPLL among Nebraskans.[lxx]

Table 12. Leading causes of injury, Nebraska

Table 6: Leading causes of injury	
Leading causes of *death* by injury in Nebraska (2009-2013)	Leading causes of *hospitalizations* due to injury in Nebraska (2009-2013)
1. Motor vehicle crashes 2. Suicide 3. Unintentional falls 4. Unintentional poisoning	1. Unintentional falls 2. Unintentional injuries due to motor vehicle traffic 3. Self-inflicted injuries

In the CDHD district, all counties experienced higher rates of death by injury than the state. Of particular note, the death by injury rate in Hall and Merrick counties was nearly double than the state (see Figure 40[lxxi]).

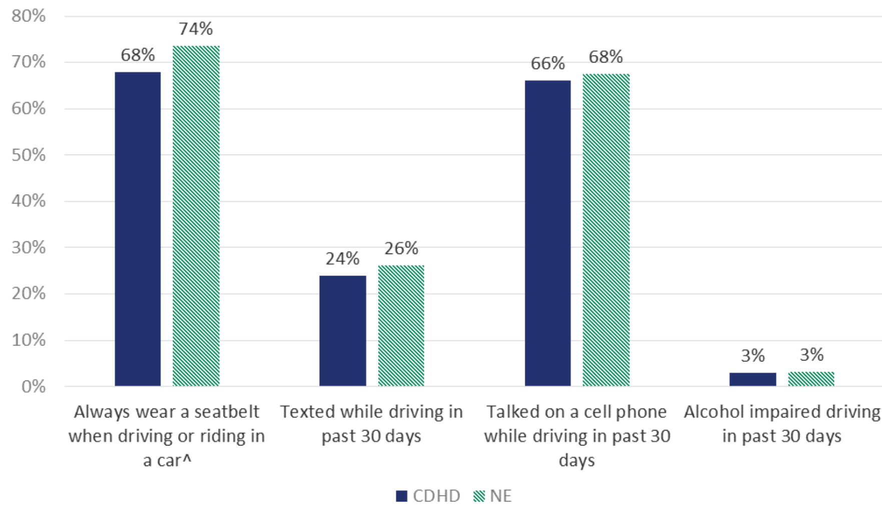
Figure 40. Injury Death Rate, CDHD District



Motor Vehicle Behaviors

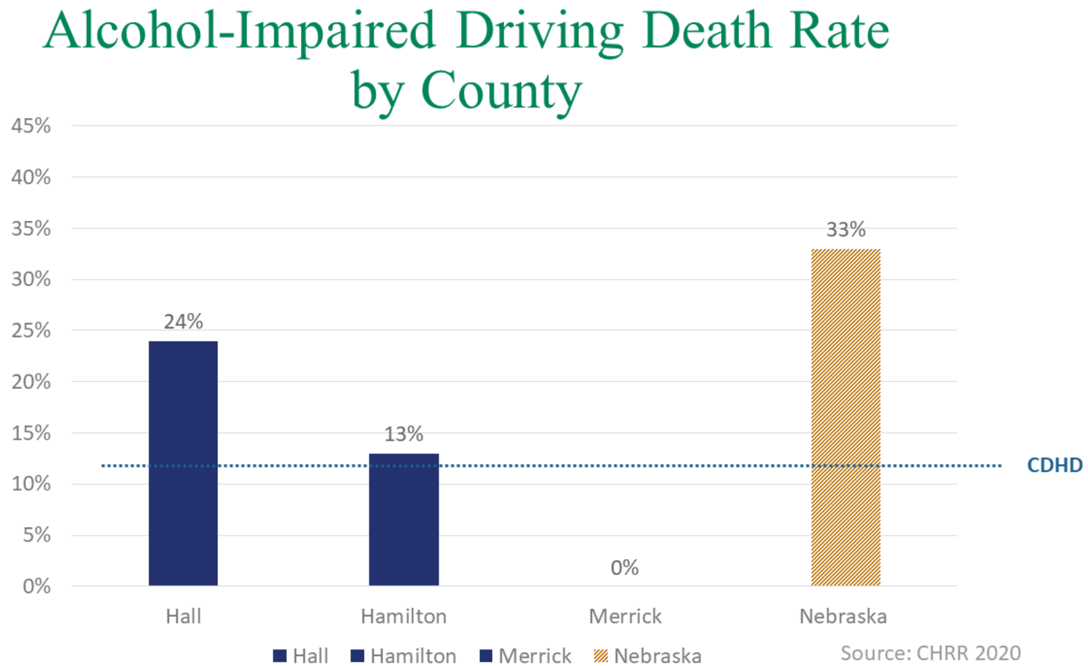
According to the Behavioral Risk Factor Surveillance System (BRFSS) 2019, 2 out of 3 adults in the CDHD district talked on a cell phone while driving in the past 30 days, similar to the state rate of 68%. Additionally, 3% of adults in the CDHD district reported driving under the influence of alcohol in the past 30 days, similar to the state rate (3%). Other risky behaviors while driving a vehicle in the CDHD district did not surpass the state average; however, 1 in 4 CDHD district adults reported texting while driving a vehicle, 1 in 3 CDHD adults did not always wear a seatbelt when driving or riding in a car.

Figure 41. Motor Vehicular Behavior Indicators, CDHD District



The death rate caused by alcohol-impaired driving in the CDHD district (12%) was lower than the state rate (33%)[lxxii].

Figure 42. Alcohol-Impaired Driving Death Rate, by County CDHD District



Behavioral/Mental Health and Related Risk Factors

Mental health impacts a person's ability to maintain good physical health and vice versa. Mental health is strongly associated with the risk, prevalence, progression, outcome, treatment and recovery of chronic diseases, including diabetes, heart disease and cancer. Good mental health is essential for a person to live a healthy and productive life. [lxxiii]

According to the Nebraska Behavioral Health Needs Assessment in 2016, mental health illness was a common health problem in Nebraska. One in five Nebraskans reported any mental illness—defined as any diagnosable mental, behavioral or emotional disorder other than substance use disorder. Nebraska's rate is similar to the US rate (18.13%). Concerning, although less common, 4%-7% of Nebraskans reported having serious thoughts of suicide, a major depressive episode, or serious mental illness—defined as a mental disorder causing significant interference with one or more major life activity.

Table 13 below summarizes the 2011-2019 BRFSS data regarding mental health indicators for Nebraska and the CDHD district. Women fared worse than men. Compared to the state, as a whole, CDHD is relatively aligned across all five indicators.

Table 13. Mental Health problem indicators in CDHD District

Mental Health Indicators

	Ever told they have depression (%)	Average days mental health was not good in past 30 days	Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	Average days poor physical or mental health limited usual activities in past 30 days	Poor physical or mental health limited usual activities on 14 or more of the past 30 days
Nebraska	18%	3.2	10%	2.0	6%
CDHD District	18%	3.2	10%	2	6%
Male	12%	2.5	9%	1.9	6%
Female	23%	2.5	12%	2.1	5%

Source: BRFSS 2011-2019

Table 14. Mental Health problem indicators in CDHD District by County

Mental Health Indicators	Average number of mentally unhealthy days in the past 30 days	Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)
Nebraska	3.6 (CHRR 2020)	10% (BRFSS 2011-2019)
CDHD District	2.8 (CHRR 2020)	10% (BRFSS 2011-2019)
Hall County (CHRR 2020)	3.8	12.0%
Hamilton County (CHRR 2020)	3.5	11.0%
Merrick County (CHRR 2020)	3.8	12.0%

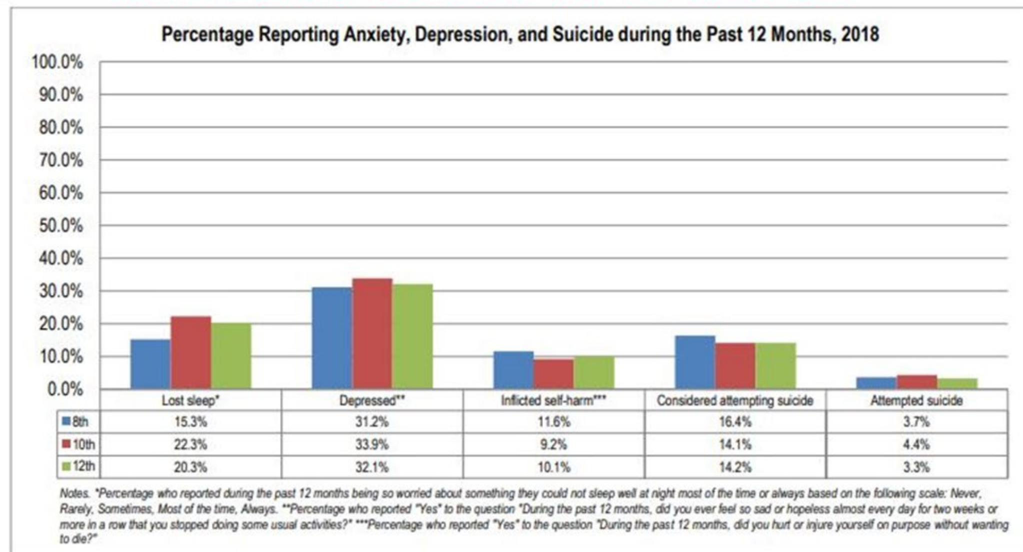
Approximately 1 in 4 Nebraska high school youth reported feeling depressed compared to nearly 1 in 3 youth nationwide (24.1% vs 29.9%). Female students had a significantly higher rate of depression (31.4% vs. 17.1%), of considering a suicide attempt (18.0% vs. 11.3%) and of making a suicide plan

(17.0% vs. 9.8%) compared to male students.[lxxiv] According to the NRPFSS 2018 in the CDHD, nearly 1 in 3 high school youth reported feeling depressed and 14% considered attempting suicide (see Figure 43).

Figure 43. Mental Health indicators for Youth, CDHD District

Mental Health of Youth

in CDHD District Grades 8, 10 and 12



	Lost sleep*	Depressed**	Inflicted self-harm***	Considered attempting suicide	Attempted suicide
8th	15.3%	31.2%	11.6%	16.4%	3.7%
10th	22.3%	33.9%	9.2%	14.1%	4.4%
12th	20.3%	32.1%	10.1%	14.2%	3.3%

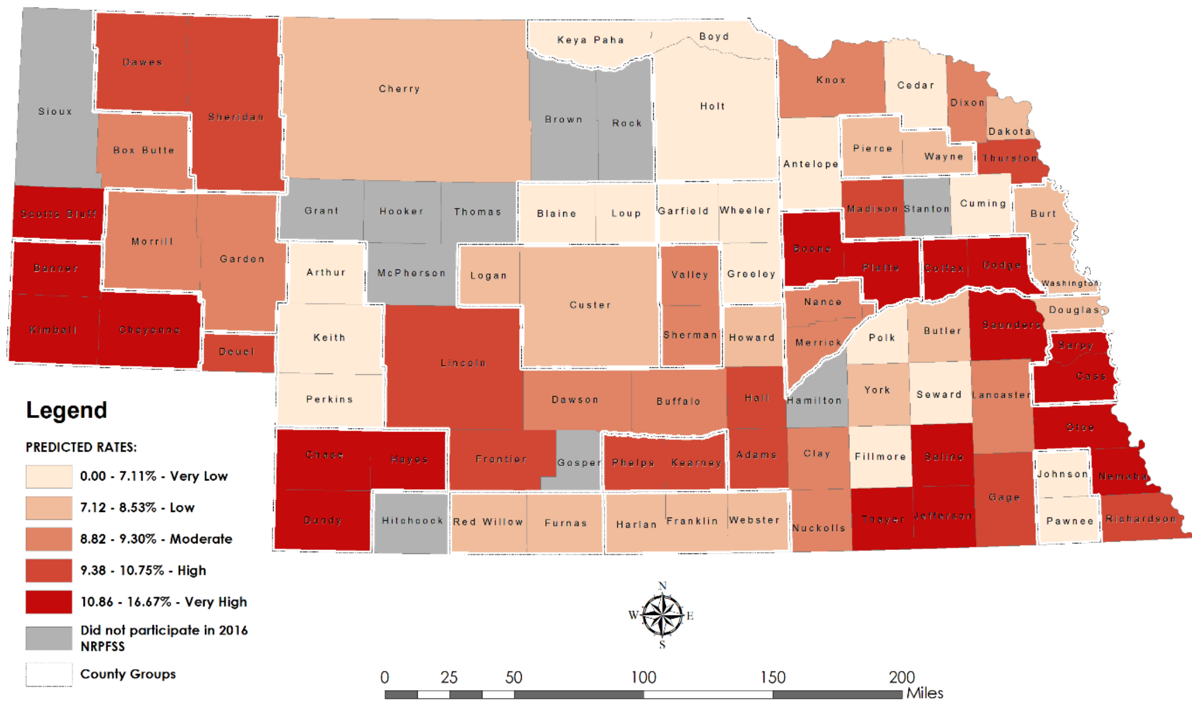
*Notes. *Percentage who reported during the past 12 months being so worried about something they could not sleep well at night most of the time or always based on the following scale: Never, Rarely, Sometimes, Most of the time, Always. **Percentage who reported "Yes" to the question "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?" ***Percentage who reported "Yes" to the question "During the past 12 months, did you hurt or injure yourself on purpose without wanting to die?"*

Source: 2018 results from Nebraska Risk and Protective Factor Student Survey

Suicide Risk

In Nebraska, the rate of suicide across all ages was similar to the rate of suicide for the US (13.05 vs. 13.42—per 100,000 population). Suicide is the 9th leading cause of death in Nebraska, and the second leading cause of death for ages 10-34.[lxxv] Hall County was at higher risk for youth suicide ideation and attempts. Figure 44 shows this risk for each county across the state based on the average responses to two questions on the Nebraska Risk and Protective Factors Surveillance System in 2016: 1) “During the past 12 months did you ever seriously consider attempting suicide?” and 2) “During the past 12 months, did you actually attempt suicide?”

Figure 44. Risk level for youth suicide ideation and attempts by county based on the 2016 results from the Nebraska Risk and Protective Factors Surveillance System

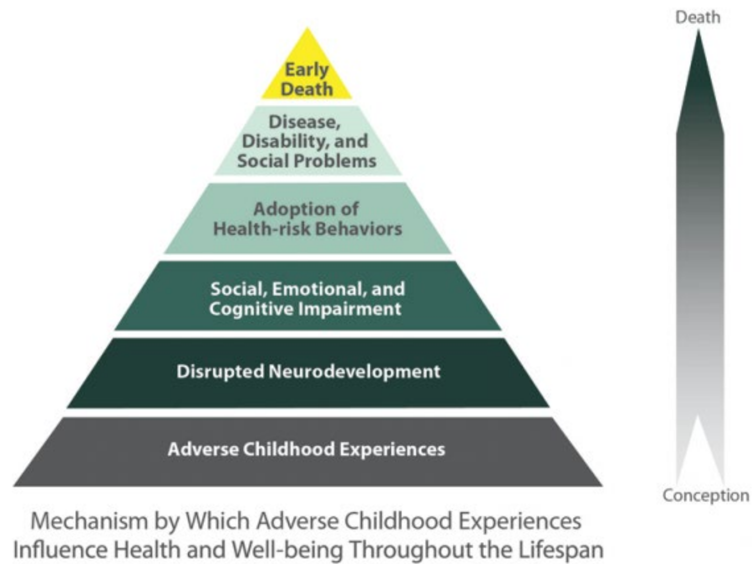


Veterans are at higher risk for several negative behavioral health outcomes – most alarmingly, suicide. Data from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) show that veteran families are also impacted. Statewide, when compared to other demographic groups, Nebraska's Veteran spouses and partners report having more poor mental health days and are more likely to have been told that they have depression.[lxxvi]

Adverse Childhood Experiences

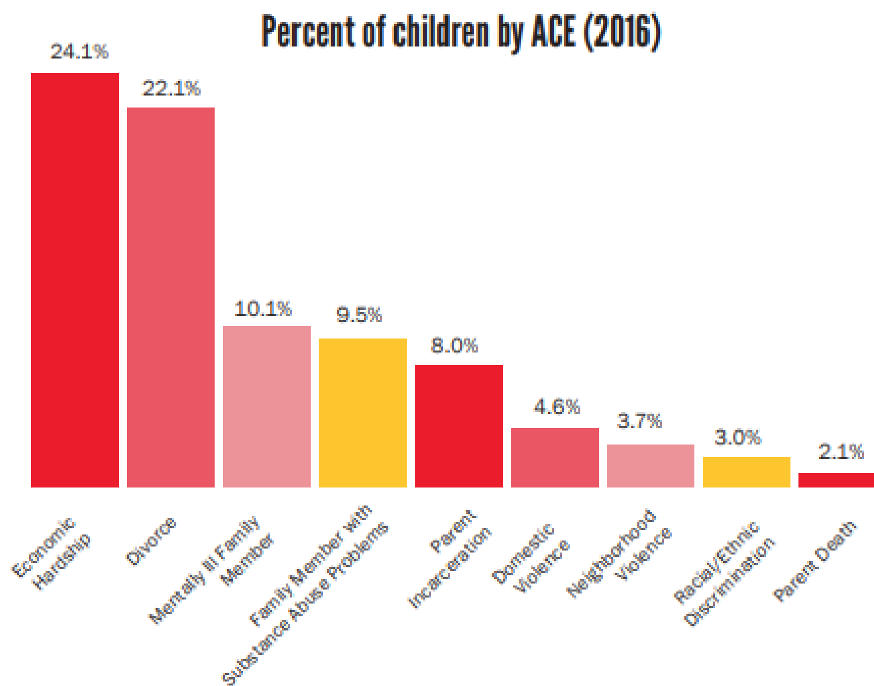
Adverse childhood experiences (ACEs) are one of the most accurate predictors of lifelong health and well-being.[lxxvii] ACEs are stressful or traumatic events that occur before age 18[lxxviii] and can include things such as a child experiencing abuse and neglect; family effects of struggling to get by financially; seeing/hearing violence in the home; witnessing and/or being the target of neighborhood violence; living with anyone mentally ill, suicidal, or depressed; living with anyone with alcohol or drug problems; or experiencing parents who are divorced/separated or serving jail time.[lxxix] The landmark Kaiser ACE study showed dramatic links between ACEs and the leading causes of death, risky behaviors, mental health and serious illness.[lxxx] Figure 45 demonstrates the ACE Pyramid, used as the conceptual framework for the Kaiser Study.[lxxxi]

Figure 45. Adverse Childhood Experiences Pyramid



The last time Nebraska implemented the ACEs module of the BRFSS was in 2010 and 2011. At that time, roughly 30% of children experienced one to two ACEs. Around 10% of children experienced three to four ACEs and about 5% experienced 5+ ACEs[lxxxii]. Figure 46 illustrates the percent of children by ACE category in Nebraska.[lxxxiii]

Figure 46. Percent of children by ACE category in Nebraska



Resilience is the ability to adapt to stressful or traumatic events, such as ACEs. Resilience is not a genetic factor but more of a learned behavior. Resilience can be cultivated in anyone.[lxxxiv] Children who experience protective family routines and habits, such as limited screen time, no TV/screen time in bedrooms, parents who have met all or most of the child's friends, and parents who participate in a child's extracurricular activities[lxxxv], are less likely to experience ACEs.[lxxxvi] Community-based strategies to provide safe, stable, nurturing relationships and environments to increase resilience and to reduce ACEs can include:

Program based[lxxxvii]:

- Home visiting programs for pregnant women and families with newborns
- Parenting training programs
- Intimate partner violence prevention programs
- Social support for parents
- Teen pregnancy prevention and parent support programs for teens
- Treatment for mental illness and substance abuse
- High quality, affordable childcare
- Sufficient income support for low-income families

System/Policy based[lxxxviii]:

- Increase awareness of ACEs and their impact on health within both the professional and public spaces
- Increase capacity of health care providers to assess for the presence of ACEs and appropriate response
- Enhance capacity of communities to prevent and respond to ACEs through investment in evidence-based prevention programming, trauma interventions, and increased access to needed mental health and substance abuse services
- Increased funding for ACE-specific surveys in order to increase their utility and scope

Substance Use Disorders

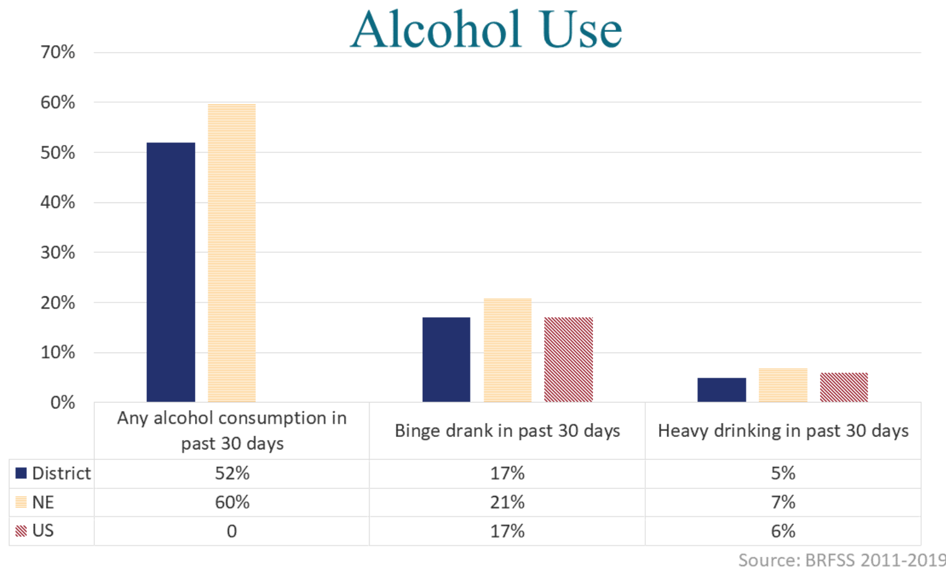
Like mental health, substance use disorders are among the top causes of disability in the US and can make daily activities hard to accomplish.[lxxxix] Furthermore, substance use and addiction can advance the development of mental illness due to the effects of substances in changing the brain in ways that make a person more likely to develop a mental illness. Likewise, mental illness can lead to drug use and substance use disorders.[xc]

Alcohol Use

Alcohol is the third-leading preventable cause of death in the US following tobacco and nutrition/physical activity. In 2019, 1 in 5 Nebraska adults binge drank or drank heavily (21.9%), a stark difference when compared to Utah (12%)—the state with the lowest prevalence of binge/heavy drinking. Excessive alcohol consumption, in either the form of binge drinking (more than 4 drinks on one occasion for men or more than 3 drinks on one occasion for women) or heavy drinking (drinking more than 14 drinks per week for men or more than 7 drinks per week for women), is associated with an increased risk of many health problems, including short-term risks that can increase the chances for accidents/unintentional injuries, violence, alcohol poisoning, and long-term risks that can increase the

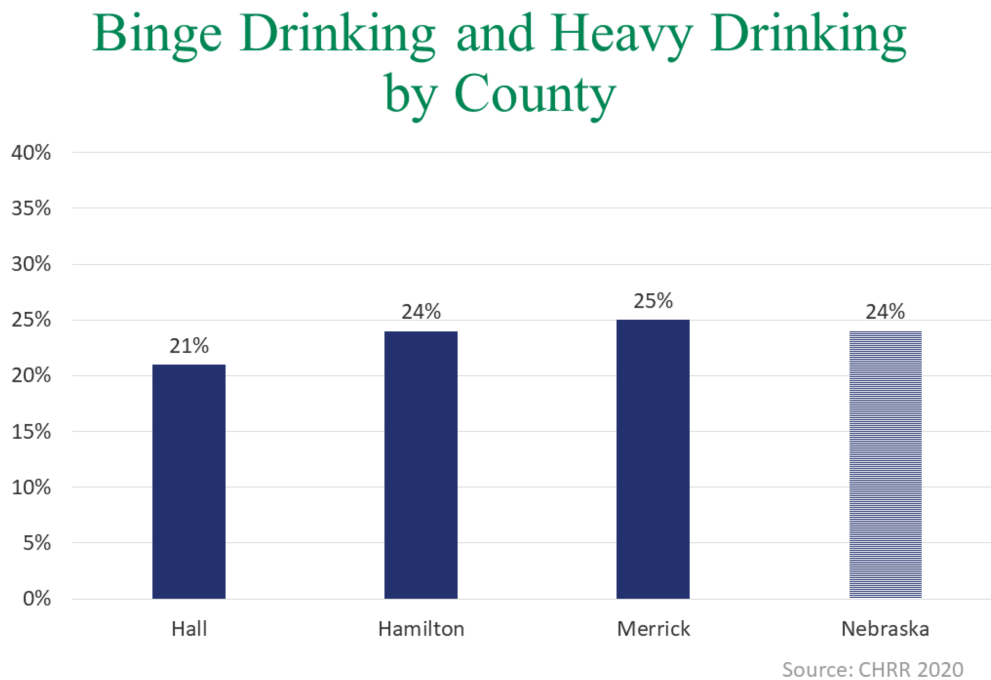
chances for heart disease, stroke, liver disease, cancers, alcohol dependence, and more. [xci] The Nebraska BRFSS survey in 2019 indicated 17% of adults in the CDHD region reported binge drinking in the past 30 days, and nearly 5% of adults in the CDHD region reported heavy drinking in the past 30 days, both of which were similar to the US averages (17% and 6% respectively).

Figure 47. Alcohol Use, CDHD District, State and Nation



	Any alcohol consumption in past 30 days	Binge drank in past 30 days	Heavy drinking in past 30 days
District	52%	17%	5%
NE	60%	21%	7%
US	0	17%	6%

Figure 48. Binge and Heavy Drinking, by County in CDHD District



In general, excessive drinking is higher among men than women, younger adults (ages 18-44) compared to older adults (ages 45+), adults who graduated from high school compared to those who did not, and

among adults with higher income levels (>$75K). In addition, Hawaiian/Pacific Islander, Hispanic, and white adults have a higher prevalence of excessive drinking that Asian and black adults.

Maternal and Child Health

Infant mortality (death of an infant before his/her first birthday) is an indicator of maternal and child health within a community. More importantly, this indicator is a marker of overall health of a community due to the associations between the causes of infant death and other factors that are likely to influence health—such as social and economic factors, general living conditions and other quality of life factors.[xcii] The infant mortality rate (the number of infant deaths per 1,000 live births in the same year) in the US was 5.7 in 2018.[xciii]

Nebraska fairs a little bit better than the US with an infant mortality rate of 6.[xciv] Figure 49 illustrates the stark differences between counties across the CDHD district regarding infant mortality.[xcv] Hall and Hamilton counties' infant mortality rates were higher than the state rate and nearly 1.5 times higher than Merrick County.

Figure 49. Infant Mortality Rate, CDHD District

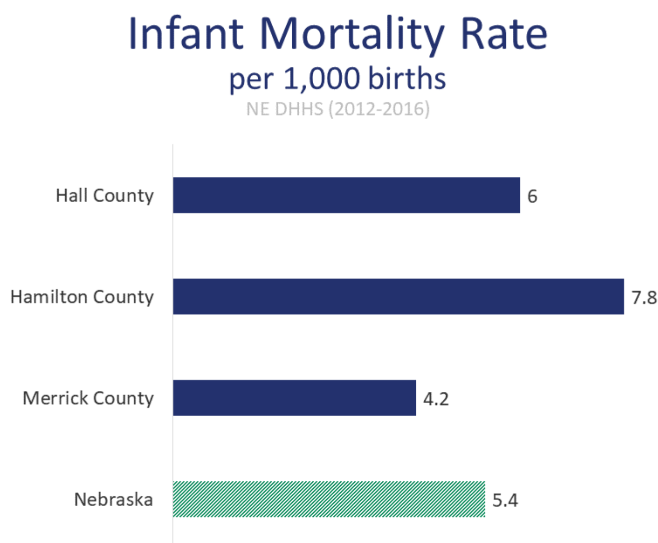


Table 15 provides an overview of the birth statistics and other maternal and child health indicators. Notably, the overall birth rate (15.7/1,000) and teen birth rate (38/1,000) in Hall County was higher than other counties in the CDHD district and state rate.

Table 15. Maternal and Child Health Indicators, CDHD District

Maternal and Child Health Indicators	Hall	Hamilton	Merrick	CDHD District	NE
Birth rate[xcvi]	15.7	12.8	12.5	13.7	13.9
Teen birth rate[xcvii]	38	9	20	22	25
Low birthweight[xcviii]	7%	5%	6%	6%	7%

Healthcare Access and Utilization

Healthcare Insurance Coverage

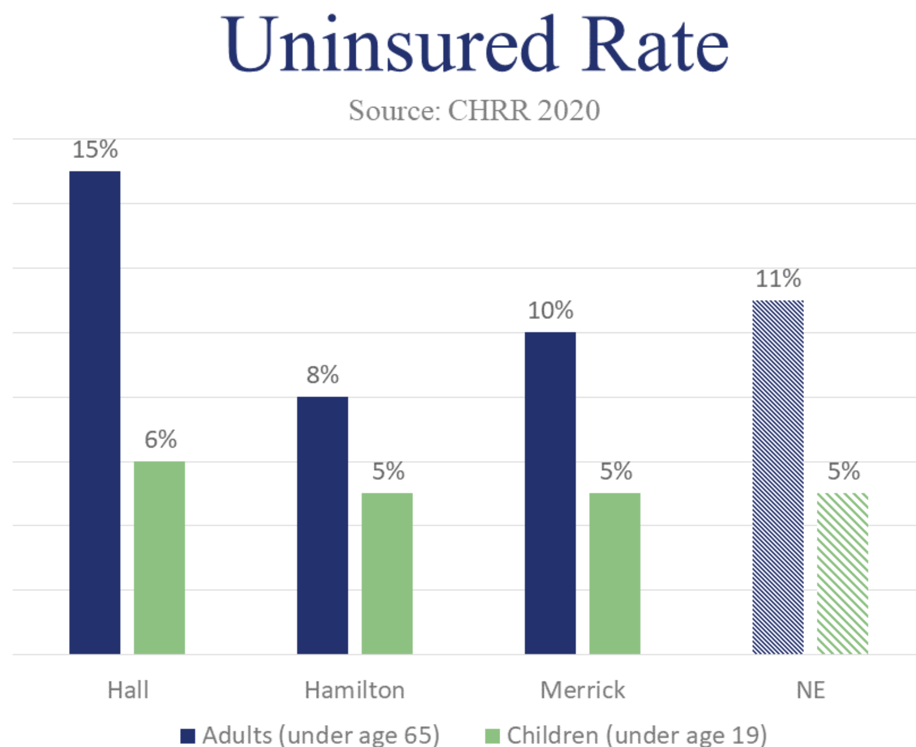
According to the Nebraska BRFSS (see Table 16), one in five adults aged 18-64 in the CDHD district did not have health care coverage.

Table 16. Health Care Access Indicators, CDHD District

Health Care Access Indicators[xcix] ***(BRFSS, 2011-2019)***	**NE**	**CDHD Region**		
		Overall	**Male**	**Female**
No health care coverage, 18-64-year olds	16%	20%	21%	19%

To provide a county snapshot for uninsured among the population under the age of 65, the latest County Health Rankings (see Figure 50) reported that more adults under the age of 65 (15%) and under age 19 (6%) in Hall County were uninsured than the state average (11% and 5%, respectively).

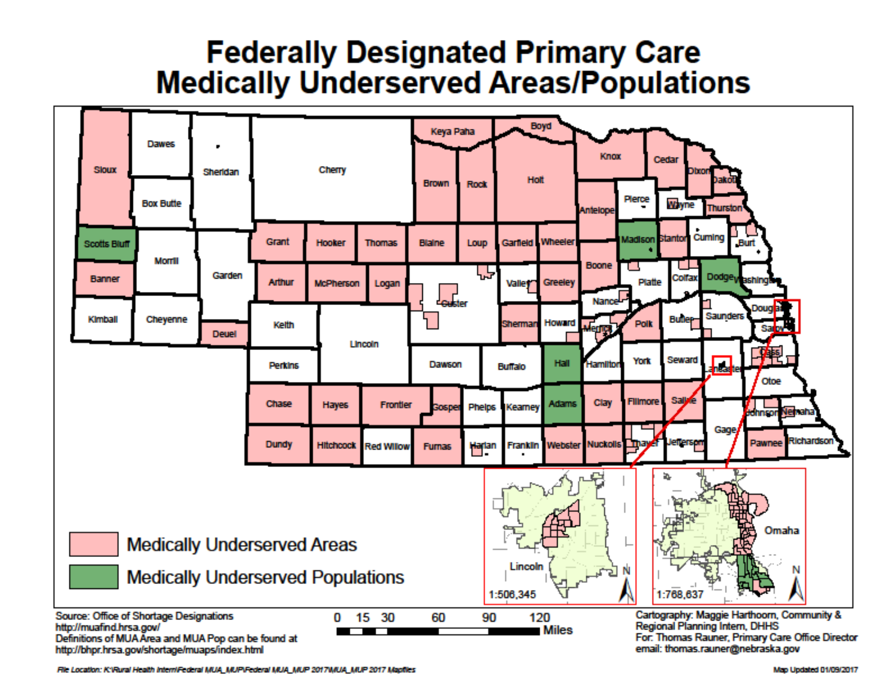
Figure 50. Uninsured Rates, CDHD District



While lack of health insurance, cost of health care services, and age of clientele may be contributing factors of not accessing health care, health professional shortages can compound the issue. About 3 of 4 adults in CDHD district had a personal doctor or healthcare provider.[c] According to the Health Resources and Services Administration (HRSA), some areas within CDHD were designated as Medically Underserved Areas (MUA). MUAs are "counties, a group of counties or civil divisions, or a group of

urban census tracts in which residents have a shortage of personal health services." The following map (Figure 51) illustrates the federal health professional shortage area for primary care across the state in 2018.

Figure 51. Primary Care, Federally Designated Medically Underserved Areas/Populations

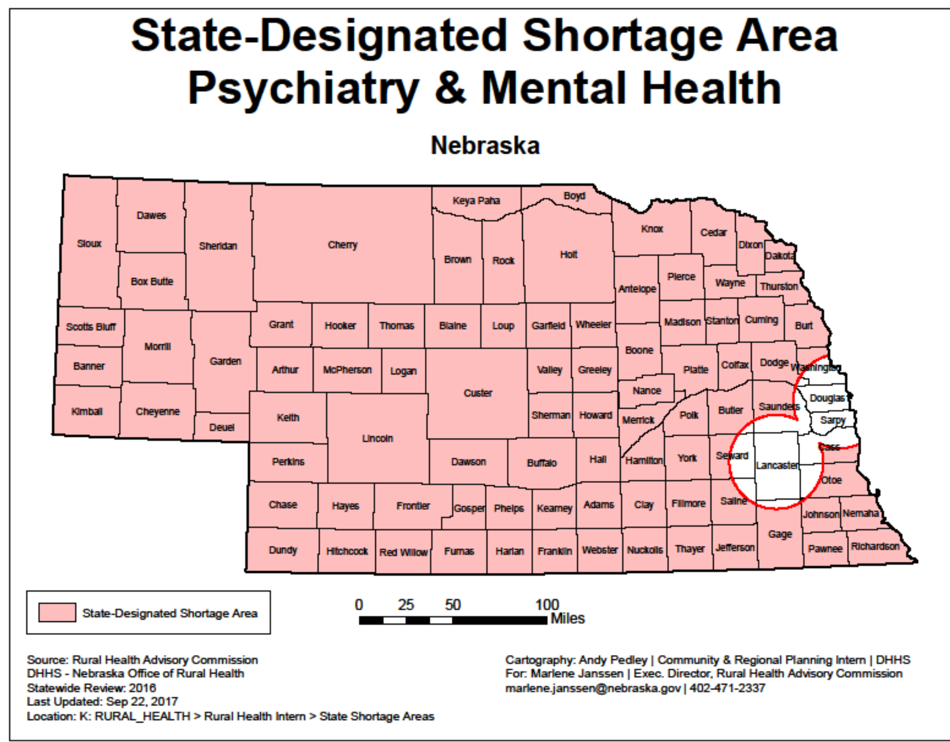


Notably, all of Hall County and parts of Merrick County were designated as MUA/MUPs for primary care. To help ease this provider shortage problem, Physician's Assistants (PA-Cs) and Nurse Practitioners (APRNs) were utilized in many primary care clinics in the CDHD region, and the Northern Nebraska Area Health Education Center (AHEC) worked with healthcare agencies to place students on training paths to be healthcare providers.

Generally, emergency rooms and primary care offices are the most common place where people with behavioral health needs seek care. Often clinicians in these settings do not have the resources and/or training to appropriately respond to behavioral health needs. Overall, 66% of primary care providers report that they are unable to respond to people with behavioral health needs due to a shortage of mental health providers and to insurance barriers.[ci]

Most counties in the state are designated as mental health professional shortage areas (see Figure 52). In the Central District Health Department district, there were an average of 1,731 people for every one mental health provider (range: 280:1 to 3,878:1), and nearly four times as many people to mental health provider as the state average (362:1).[cii] According to the 2016 Nebraska Behavioral Health Needs Assessment, only 47% of adults in Nebraska with any mental illness received treatment. Additionally, only 43% of youth in Nebraska with depression received treatment. Furthermore, 11% of persons aged 12 or older in Nebraska with illicit drug dependence or abuse received treatment. In addition to CDHD's known mental health professional shortage area designation, access to behavioral health care may be further complicated by other barriers, including lack of insurance coverage and stigma often associated with mental illness.[ciii]

Figure 52. Mental Health Care, State-Designated Shortage Areas



In other health professional care, including dentistry and pharmacy, counties within CDHD were designated as shortage areas. Figures 53, 54, and Table 17 illustrate these shortages.

Figure 53. Dentistry, State-Designated Shortage Areas

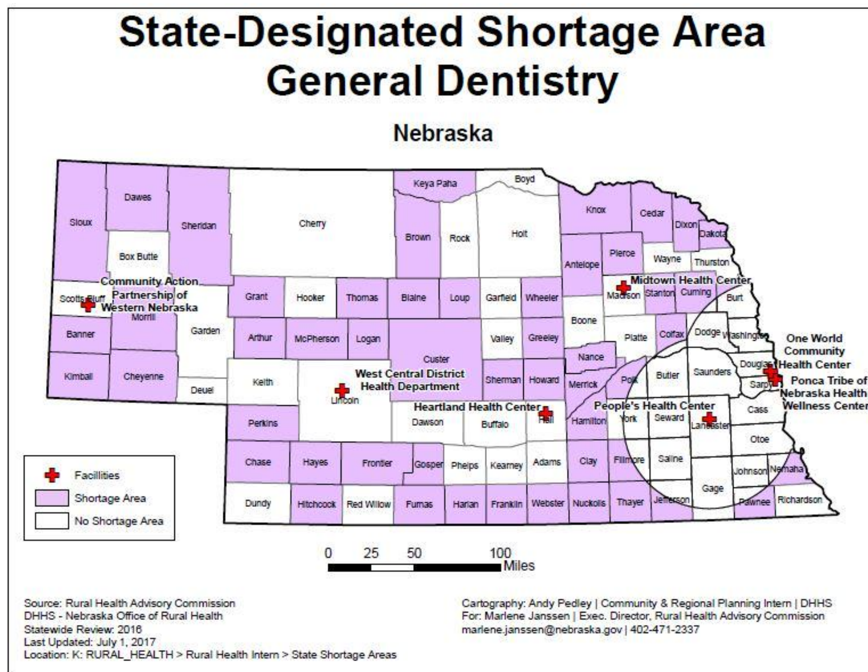
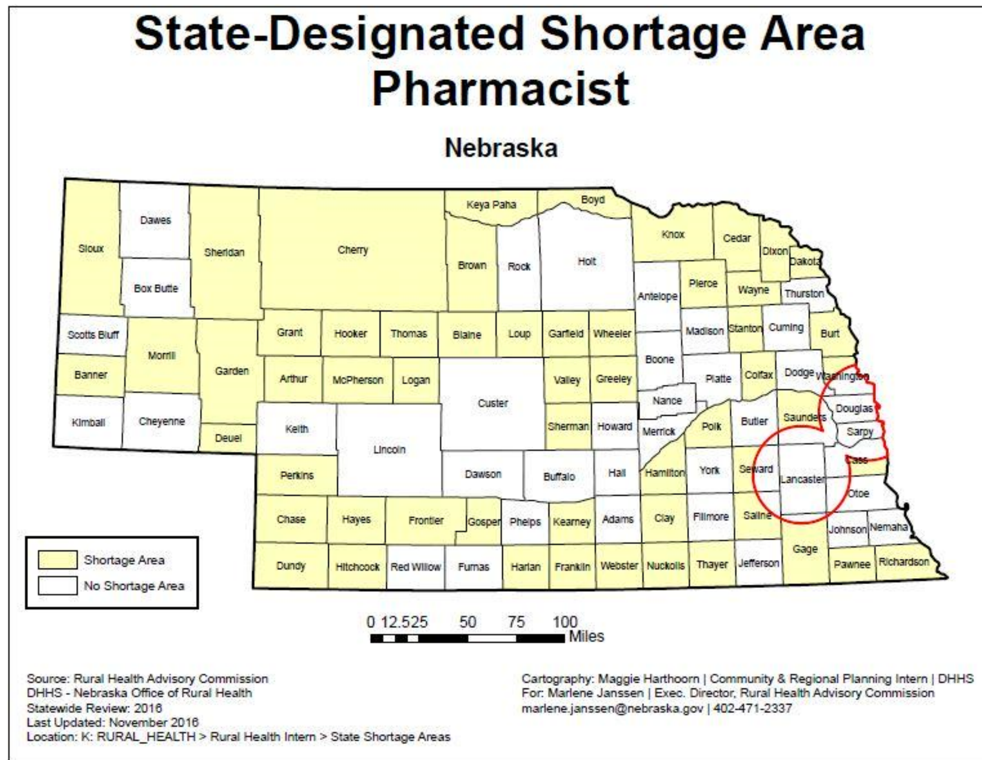


Figure 54. Pharmacist, State-Designated Shortage Areas



Stark disparities exist between counties when looking at population per provider type in the CDHD area. Merrick County has a significantly higher population per provider ratio for mental health (3,878:1) and primary care providers (3,867:1) than the state (362:1 and 1,330:1, respectively) as shown in Table 17.

Table 17. Ratio of Population per Type of Provider, CDHD District

Ratio of **Population : Type of Provider** (2020)

	NE	Hall	Hamilton	Merrick
Primary care physicians	1330:1	1621:1	1160:1	3867:1
Dentists	1272:1	1180:1	1865:1	1939:1
Mental health providers	362:1	280:1	1036:1	3878:1

Source: CHRR 2020

Although Hall County has a lower provider per population ratio among dental and mental health services compared to the state and other counties within CDHD, comments from respondents to the resource

inventory survey (n=15 partners in the CDHD area) included: Medicaid is not accepted at all dentist providers or specialty care providers; under/uninsured patients lack access to quality and routine care; patients not established with a mental health provider are offered only telehealth appointments with long waitlists for in person appointments and for those residents in the CDHD area with severe mental health problems lack the appropriate access to care; more substance abuse services are needed. Furthermore, bilingual/interpretation services offered among these providers may need enhanced to effectively serve and reach the growing minority population in this area.

Health Care and Prevention Assets

In the CDHD district, health care providers and services include four hospitals, namely CHI Health Saint Francis, Grand Island Regional Medical Center in Hall County, Memorial Community Health Inc. in Hamilton County, and Merrick Medical Center-Bryan Health in Merrick County. The area also has one Federally Qualified Health Center (FQHC; Heartland Health Center in Hall County). There are several medical clinics providing primary care and prevention services. Medical clinics in the CDHD district operate during traditional business hours (from 8:00am to 5:00pm, Monday through Friday, and Saturday mornings). Providers offering specialty services travel to these medical clinics from outside of the CDHD district and hold office hours from weekly to once monthly at select medical clinics/hospitals. Additionally, CDHD district has is home to several dental clinics as well as Heartland Health Center's dental clinic. Dental clinics are present in each county. Professional and Volunteer Emergency Medical Services are located throughout each county.

Access for Aging Populations:

Multiple assisted living and long-term care facilities are available in the CDHD district offering around the clock assistance and/or nursing care for residents. Home-health services are available in the CDHD district. Senior Centers are active in each county. The area is served by Midlands Area on Aging.

Central District Health Department offers several preventative programs s including Every Woman Matters, Diabetes Prevention Program and Living Well with Diabetes.

The Social Services for Aged and Disabled Adult Program (SSAD) provides services to individuals who are aged, blind, or disabled and need assistance in remaining as independent as possible. Eligibility is based on the client's income as well as their need for the requested service. The SSAD program provides services to clients who do not qualify for Medicaid or are ineligible to receive assistance from other programs. Services provided include: Chore services, Adult day care, Home delivered meals, Congregate meals, Homemaker services, and Transportation.

Access for Veteran Populations:

Multiple agencies in the CDHD district offer services for Veterans and their families. The Grand Island VA Medical Center provides inpatient, outpatient, and home visitation services. VA services also include a Community Living Center. The Community Living Center is a 65-bed facility providing extended care, rehabilitation, geriatric care, palliative care, respite care, supportive/restorative and long-term care, and general nursing home care. Each county has a Veterans Services Officer. Other support services for Veterans and their families are offered by agencies such as the Central Nebraska Community Action Partnership, local churches, local Veterans of Foreign Wars (VFW) posts, American Legions, County Veteran Service Officers and the Department of Labor.

Central District Health Department staff and partners have been trained in the No Wrong Door training, a day-long deep dive into military culture and life where participants learn about military experiences and how they influence emotions and behaviors by hearing from Veterans, their families, and experts in the field.

Preventative Screenings

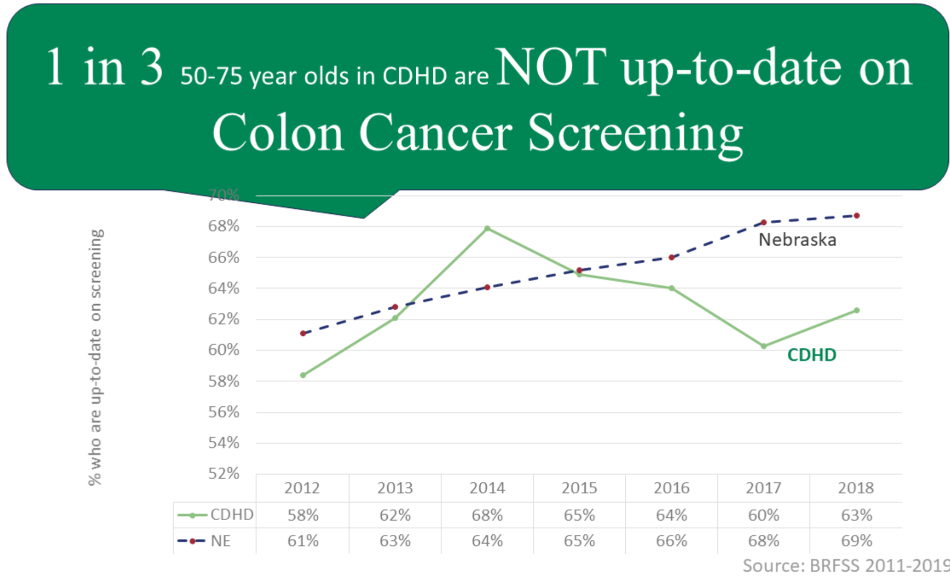
Nearly 40% of adults in the CDHD district did not receive a routine checkup in the past year.

Table 18. Preventative Health Screening Indicators, CDHD District

Preventative Health Screening Indicators[civ] *(BRFSS, 2011-2019)*	**NE**	**CDHD Region**		
		Overall	**Male**	**Female**
Preventative Screenings				
Heart Disease				
Had cholesterol checked in past 5 years	84%	86%	85%	87%
Cancer				
Up to date on colon cancer screening, 50-75-year olds	65%	63%	61%	65%
Up to date on breast cancer screening, overall female 50-74-year olds	75%			74%
Up to date on cervical cancer screening, female 21-65-year olds	81%			82%
Routine Checkups				
Had a routine checkup in past year	65%	62%	56%	68%

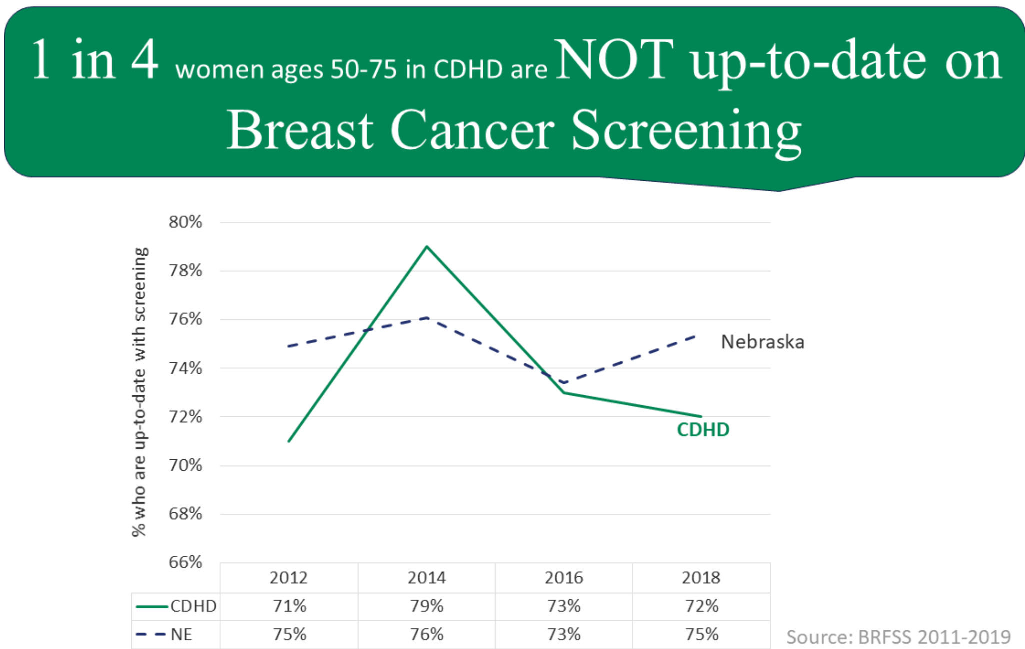
The rate of adult population in the recommended age groups across the CDHD district who received appropriate preventative screenings such as breast, cervical and colon cancer screenings was similar to the state rate. While the majority of adults in the recommended age groups across the CDHD district received appropriate preventative screenings, the trend over a seven-year period was downward. Breast cancer was the second leading cause of death by type of cancer in the CDHD district, yet only 74% of CDHD area adults aged 50-75 years of age received this particular screening. Of particular note, about half of women ages 65-74, Medicare enrollees, are up-to-date on breast cancer screening. Breast cancer screening is a covered preventative measure by Medicare. About two-thirds of adults in CDHD area were up-to-date on their recommended colon cancer screening, and about 80% of women were up-to-date on recommended cervical cancer screenings.

Figure 55. Colon Cancer Screening Rates, CDHD District



	2012	2013	2014	2015	2016	2017	2018
CDHD	58%	62%	68%	65%	64%	60%	63%
NE	61%	63%	64%	65%	66%	68%	69%

Figure 56. Breast Cancer Screening Rates adult population ages 50-75, CDHD District



	2012	2014	2016	2018
CDHD	71%	79%	73%	72%
NE	75%	76%	73%	75%

Figure 57. Breast Cancer Screening Rates among Medicare population ages 65-74, CDHD District

1 in 2 women ages 65-74 in CDHD are **NOT up-to-date on Breast Cancer Screening**

Source: CHRR 2020

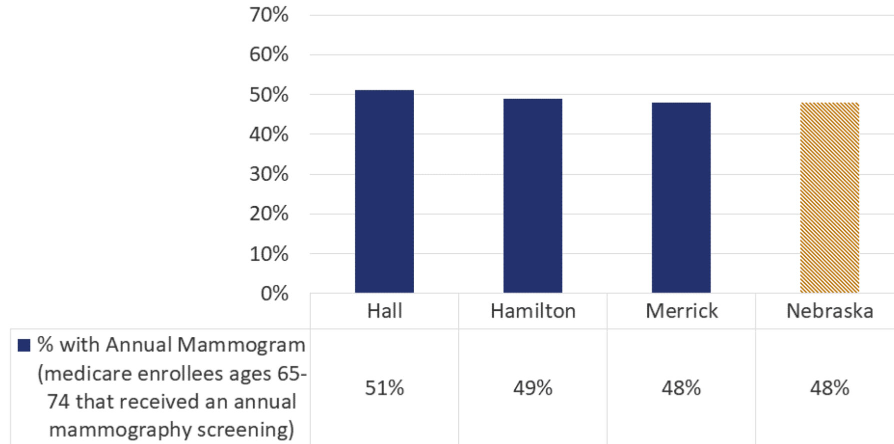
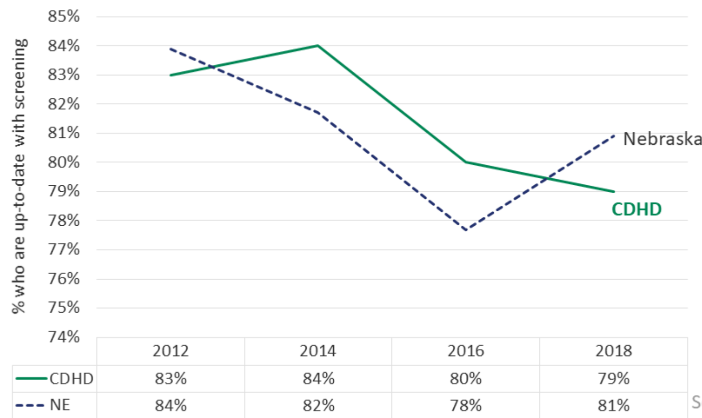


Figure 58. Cervical Cancer Screening Rates, CDHD District

1 in 5 women aged 21-65 in CDHD are **NOT up-to-date on Cervical Cancer Screening**



Source: BRFSS 2011-2019

Barriers to Accessing Health Care

Accessing health care is complicated by multiple factors, such as the ability to travel to care locations, location and number of healthcare providers, types and costs of services offered, insurance coverage, etc. Cost of healthcare services can be a barrier to care for CDHD residents. Surpassing the state rate, about 1.5 in 10 adults aged 18-64 needed to see a doctor but could not due to cost within the past year, and 1 in 5 adults aged 18-64 had no health care coverage.[cv] Though data are not available for CDHD by race/ethnicity, Hispanics had the highest uninsured rates of any racial or ethnic group across the state (57.7%)[cvi] and nation.[cvii] In the US, Medicare provides universal health coverage to adults 65 and older; however, cost-sharing and premium contributions continue to be a serious burden for many.[cviii]

Table 19. Access to Care Indicators, CDHD District

Access to Care Indicators[cix] ***(BRFSS, 2011-2019)***	**CDHD Region**	**NE**
Needed to see a doctor but could NOT due to cost in past year	14%	12%
No personal doctor or health care provider	22%	20%
No health care coverage, 18-64-year olds	20%	16%

Healthcare professional shortages is another barrier to care for CDHD residents. Nearly 1 in 5 adults in the CDHD district report not having a personal doctor or health care provider. Furthermore, across the state, nearly 1 in 2 Hispanics and 65% of Native Americans reported not having a personal doctor or health care provider.[cx]

As affirmation to the above barriers contributing to inability to access health care, respondents to the CDHD Community Survey identified access to affordable and quality healthcare as a major health-related worry and as a way to make neighborhoods healthier.

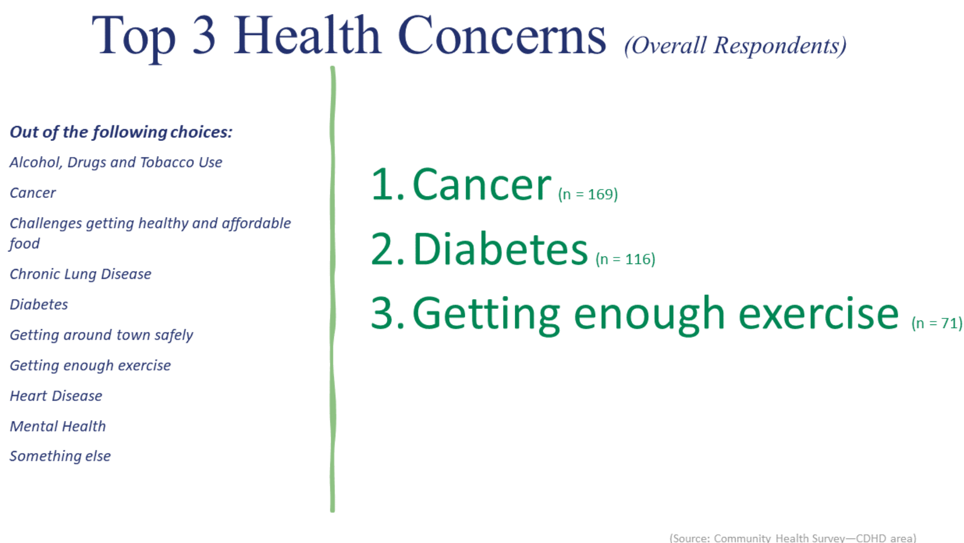
Community Themes and Strengths

Central District Health Department launched a 5-question survey, developed by the Nebraska Association of Local Health Directors (NALHD), to learn more about the impact of COVID-19 on communities in the CDHD area and to assess community health related to things people do to be healthy, top health concerns, and major health issues. This open-ended survey design, intended to allow respondents to tell LHDs their experience related to their health and the health of their community, provides insight into to emerging issues in the community. The survey was made available in English, Spanish, Somali, and Arabic by print and online. The survey was distributed through CDHD and their partners, including Multicultural Coalition, area hospitals, and others. Additionally, CDHD posted the survey link on the CDHD website and Facebook page and provided a kiosk station for clients attending vaccination clinics to fill out the survey while waiting for appointments.

There were 665 responses (see Appendix C for full details on the demographics of survey respondents and summary of responses), of which most survey respondents self-identified as non-Hispanic, White women between ages 30-64. While not representative of the population of the region, as a whole, many of the survey responses are consistent with other data collected as part of this Community Health Assessment. Survey findings are also consistent with anecdotal input from key stakeholders (from the

priority setting meetings) who are connected to many of the diverse community groups not directly represented in survey responses. The survey revealed the following:

Figure 59. Top 3 Health Concerns, Community Survey Respondents



When looking at the survey data by ethnicity and race, Hispanic and non-White respondents listed the same top two concerns as in Figure 59; however, the third concern was challenges getting healthy and affordable food. Even given the low response to the resource inventory survey, partners identified the need to increase the availability of bilingual/interpretation for services and programs to ultimately enhance and improve the health of all residents within the CDHD area.

Health Summary: CDHD District

The majority of the adult population within the CDHD district reported their general health was good or better in the BRFSS between 2011-2019. However, nearly 1 in 10 people within the CDHD district indicated they experienced frequent mental distress. Table 20 summarizes the general health of the adult population within the CDHD district.

Table 20. General Health Indicators, CDHD District

General Health Indicators[cxi]	**CDHD District**	**NE**
General health fair or poor	17%	14%
Average number of days physical health was not good in past 30 days	3.3	3.1
Physical health was not good on 14 or more of the past 30 days	10%	10%
Average number of days mental health was not good in past 30 days	3.2	3.2
Mental health was not good on 14 or more of the past 30 days (i.e., frequent mental distress)	10%	10%

Average days poor physical or mental health limited usual activities in past 30 days	2.0	1.9
Poor physical or mental health limited usual activities on 14 or more of the past 30 days	6%	6%

Similar to the state, the CDHD district experienced shortages in primary care, dental, and mental health professionals, further reducing access to needed health services. The Years of Potential Life Lost (YPLL), a measurement of preventable deaths, in the CDHD district surpassed the state rate. More specifically, Hall and Merrick counties' YPLL rate was higher than the state rate. Multiple factors impact how well and how long we live. Things like education, availability of jobs, access to healthy foods, social connectedness, and housing conditions all impact our health outcomes. Conditions in which we live, work, and play have an enormous impact on our health, long before we ever see a doctor. It is imperative to build a culture of health where getting healthy, staying healthy, and making sure our kids grow up healthy are top priorities.

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Appendix C: Demographics of Community Survey Respondents (2021) compared to CDHD Census

		CDHD Overall Population (US Census 2019)	CDHD Survey Respondents (N = 665)	
Gender	Female	**50%**	71%	*470*
	Male	**50%**	27%	*178*
	No Response	**-**	2.5%	*17*
Age	Under 20	**27%**	3%	*20*
	20-29	**11%**	10%	*69*
	30-39	**12%**	24%	*159*
	40-49	**11%**	21.5%	*143*
	50-64	**21%**	27%	*178*
	65-74	**10%**	9%	*60*
	75+	**8%**	2%	*11*
	No Response	**-**	4%	*25*
Hispanic/Latino	Yes	**13%**	23%	*152*
	No	**84%**	75%	*498*
	No Response	**-**	2%	*15*
Race	American Indian or Alaska Native	**1.1%**	0.6%	*4*
	Asian	**0.9%**	0.5%	*3*
	Black/African American	**1.6%**	9%	*59*
	Native Hawaiian/Pacific Islander	**0.3%**	0.1%	*1*
	White	**94.3%**	76%	*505*
	Other	**1.3%**	11%	*71*
	No response	**-**	3%	*22*

Appendix C: Community Survey Responses by Overall, Hispanic and Non-White

Community Survey Summary: ***Overall respondents***

Last Major Health Issue Experienced (*by self or by family*)

Community members identified many health issues. Highlights included:

- **COVID-19:** 139 responses including self or family sick from or death from COVID-19
- **Cancer:** 64 responses including self or family diagnosed with or death from Cancer
- **Cardiovascular Disease:** 68 responses including cholesterol, heart, high blood pressure, stroke
- **Surgery:** 60 responses related to knee, heart, back, shoulder, gallbladder, foot, hip and eye
- **Respiratory:** 34 responses related to sinus infection, RSV, bronchitis, pneumonia, flu
- **Diabetes:** 29 responses including self or family diagnosed or at-risk for diabetes
- **Mental Health:** 26 responses including depression, anxiety, and struggles in general and related to COVID-19 and postpartum
- **Suicide:** 4 responses
- **None:** 208 responses
- Other responses include burns, arthritis, osteoporosis, birth, broken/torn ligaments and bones, hip issues, kidney problems and stones, dental work, falls, accidents, stitches

Health-related Worries (for self or for family)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 146 responses including self or family sick from or death from COVID-19
- **Access to affordable and quality healthcare:** 109 responses including ability to cover costs, available healthcare facilities and staff to take care of loved ones, not having insurance, lack of access to emergency services, availability of health care resources, being able to see the doctor when needed, best care, insurance not covering things, being able to pay the doctor bills and/or pay for medications
- **Cancer:** 62 responses mentioned for either self or family diagnosed or death from Cancer
- **Maintaining healthy life:** 34 responses including staying health, general health, healthy now
- **Mental Health:** 32 responses including suicide, suffering from loss of family members to suicide, stress, depression, anxiety
- **Diabetes:** 28 responses mentioned self or family diagnosed or at risk
- **Aging:** 21 responses including aging in place, caring for aging parents, affordable aging care/long-term care, memory and mobility as we age, aging well
- **Cardiovascular Disease:** 19 responses including cholesterol, heart, high blood pressure
- **None:** 78 responses

Healthy Persons

Community members identified several actions that make them healthier. Highlights included:

- **Healthy eating:** 138 responses including drink water, eat healthy/healthier, homemade food, watch what I eat, fat-free meals, make fruits and vegetables available at home, track my foods, cook healthy meals at home, diet
- **Active living:** 190 responses including work out, exercise, walk, swim, play soccer with family, job requires a lot of walking/lifting, staying/keep active
- **Clinical Care:** 17 responses including visit doctor, follow doctor's instructions, take vitamins/supplements
- **Non-Pharmaceutical Interventions and vaccination:** 10 responses including clean, hand washing, mask, vaccinated
- **Mental Health:** 27 responses including see a therapist regularly, take care of yourself, worry storage, read more often, church/faith
- **Nothing:** 5 responses

Healthy Neighborhoods (for self or for family)

Community members identified several actions that would make their neighborhood healthier. Highlights included:

- **Active Living:** 72 responses including access to walking paths, better and more sidewalks, more recreation parks, community centers where families can meet for recreational activities, outdoor space, green areas
- **Healthy Eating:** 22 responses including better access to affordable healthier food options for kids and families, healthier restaurants, bigger grocery store, farmer's markets
- **Environmental Health:** 45 responses including less farm chemicals sprayed and in water/food sources, clean communities, city-wide trash pick up, more trees/green space, water quality issues
- **COVID-19:** 45 responses including cleaning, vaccinations, stay healthy and maintain distance from others, everyone wear mask
- **Substance Free:** 13 responses including alcohol, drug and tobacco free, complexes be better at being tobacco free, no drug deals in neighborhoods
- **Safety:** 8 responses including more security, neighborhood watch, protection, police surveillance, mall security
- **Healthcare:** 8 responses including free/affordable healthcare, more community health services
- **Neighborhood/Neighbors:** 8 responses including communicate with neighbors when things like drug deals and molesting minors is happening in the neighborhood, take care of each other, good neighborhood relationships
- **Nothing:** 45 responses

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Community Survey Summary: *Hispanic respondents*

Last Major Health Issue Experienced (*by self or by family*)

Community members identified many health issues. Highlights included:

- **COVID-19:** 38 responses included respondent or family member sick from or died from COVID-19
- **Diabetes:** 10 responses including diagnosed with diabetes
- **Cardiovascular Disease:** 7 responses including heart problems, heart attack and stroke
- **Cancer**: 4 responses including diagnosed with or death from Cancer
- **None:** 43 responses

Health-related Worries (for self or for family)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 31 responses including self or family sick from or death from COVID-19
- **Access to affordable and quality healthcare:** 22 responses including proper care after surgery, hard to find a good doctor, impossible to switch to a different doctor in the same clinic, no health insurance, cost of doctors/care and medications
- **Cancer**: 12 responses mentioned for either self or family diagnosed or death from Cancer
- **Maintaining healthy life:** 6 responses including staying healthy
- **Children's Health:** 6 responses including concerned about the health and well-being of their children
- **None:** 78 responses

Healthy Persons

Community members identified several actions that make them healthier. Highlights included:

- **Healthy eating:** 71 responses including drink water, eat healthy/healthier, homemade food, watch what I eat, fat-free meals, make fruits and vegetables available at home, track my foods, cook healthy meals at home, diet
- **Active living**: 58 responses including work out, exercise, walk, swim, play soccer with family, job requires a lot of walking/lifting, staying/keep active
- **Clinical Care:** 8 responses including visit doctor, follow doctor's instructions, take vitamins/supplements
- **Non-Pharmaceutical Interventions:** 6 responses including clean, hand washing, mask, vaccinated
- **Mental Health:** 11 responses including protect me, read more often, organized, take care of us, go to church/faith, relaxation techniques, meditation, spend more time with family/kids

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhood healthier. Highlights included:

- **Active Living:** 29 responses. Comments included access to walking paths safe from animals and traffic, more recreation parks, community centers where families can meet for recreational activities and learn crafts, art, having places to go to near by to exercise regularly, have place to exercise, access to bike trails, outdoor space, green areas…for kids to play, better sidewalks…
- **Healthy Eating**: 13 responses. Comments included children and healthy eating, make more homemade food, accessible food market, healthier restaurants, eat healthy, education about healthy eating
- **Environmental Health:** 17 responses. Comments included clean street, less noise, less trash, tree naturalization care, keep the community clean, street pavement creating lagoon, air quality tests (powder coat/welding co) in neighborhood, landlords keep properties maintained and listen to renters when issues arise, less crowded housing
- **COVID-19:** 16 responses. Comments included cleaning, vaccinations, get the shot, stay healthy and maintain distance from others, everyone wear mask
- **Safety:** 7 responses. Comments included more security, neighborhood watch, protection, police surveillance, drug free
- **Access to Healthcare:** 3 responses. Comments included free/affordable healthcare, more community health services
- **Neighborhood/Neighbors:** 3 responses including communicate with neighbors when things like drug deals and molesting minors is happening in the neighborhood, take care of each other, good neighborhood relationships

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Community Survey Summary: *Non-White respondents*

LAST MAJOR HEALTH ISSUE EXPERIENCED (*BY SELF OR BY FAMILY)*

Community members identified many health issues. Highlights included:

- **COVID-19:** 30 responses including sick from or death from COVID-19
- **Diabetes:** 7 responses including diagnosed or at-risk for diabetes
- **Cardiovascular Disease:** 7 responses including cholesterol, heart, high blood pressure, stroke
- **Brain-related:** 5 responses including migraine, amnesia, cognitive memory loss, seizure
- **Cold/Flu:** 5 responses
- **Cancer**: 3 responses including diagnosed with or death from Cancer
- **None:** 54 responses

HEALTH-RELATED WORRIES (FOR SELF OR FOR FAMILY)

Community members were worried about several health issues. Highlights included:

- **COVID-19:** 45 responses including self or family sick from or death from COVID-19

- **Access to affordable and quality healthcare:** 10 responses including being able to afford doctors' visits or bills, unsure of where to go or how to pay for care for chronic conditions or acute issues, not having health coverage or money to pay for healthcare
- **Cancer**: 11 responses mentioned for either self or family diagnosed or death from Cancer
- **None:** 17 responses

HEALTHY PERSONS

Community members identified several actions that make them healthier. Highlights included:

- **Healthy Eating**: 53 responses including eat healthy, good nutrition, eat homemade food, watch my diet, drink water
- **Active Living:** 38 responses including exercise, walk, go to the gym, workout
- **Self-Care:** 14 responses including faith/church, protect me, take multi-vitamins, meditation, listen to music, spend time with family/people, go to park
- **Non-Pharmaceutical Interventions:** 9 responses including wear masks, wash hands

HEALTHY NEIGHBORHOODS (FOR SELF OR FOR FAMILY)

Community members identified several actions that would make their neighborhoods healthier. Highlights included:

- **Non-Pharmaceutical Interventions and Vaccinations:** 41 responses including wear masks, clean/hygiene, get vaccinated, wash hands
- **Active Living**: 22 responses including more parks/green space for children, practice more sports, fishing, community centers for family fun
- **Environmental Health:** 19 responses including less noise, fix streets where water stands, clean community, air quality
- **Access to Healthcare:** 6 responses including education to know where to go for services, community health services/events, affordable healthcare
- **Substance free:** 5 responses including no drugs or smoking
- **None:** 14 responses

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