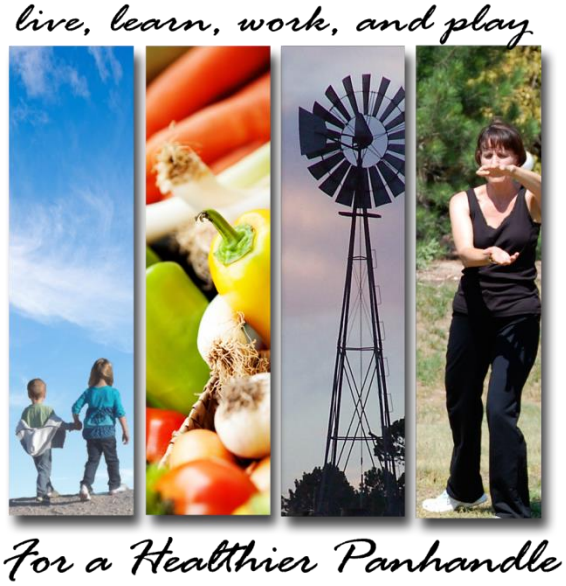
2020

Community Health Needs Assessment & Community Health Improvement Plan of Sidney Regional Medical Center



PREPARED BY

Panhandle Public Health District

IN COLLABORATION WITH

Rural Nebraska Healthcare Network
Scotts Bluff County Health Department
Box Butte General Hospital
Chadron Community Hospital
Gordon Memorial Hospital
Kimball Health Services
Morrill County Community Hospital
Perkins County Health Services
Regional West Garden County
Regional West Medical Center
Sidney Regional Medical Center
Panhandle Partnership
Panhandle Area Development District
Nebraska Department of Health and Human Services

WITH SPECIAL THANKS TO

Daniel Bennett, Civic Nebraska
formerly of Panhandle Area Development District

FOR MORE INFORMATION

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LETTER FROM THE CHAIRMAN OF THE BOARD

To our valued community members:

On behalf of the Sidney Regional Medical Center (SRMC) staff and employees I would like to share our appreciation for the opportunity to care for you, your family and friends.

Our vision at SRMC is to be the healthcare system of choice. We do so by an ongoing focus toward providing care options and opportunities that best address the evolving healthcare needs for those in our region. Through collaboration with other healthcare systems and regional resources we are improving the health of our communities that benefit the whole person through all stages of life.

As a Critical Access Hospital located in a rural area, SRMC strives to provide care that supports our patients desire to receive high-quality health care close to home.

To support our mission and vision, as a nonprofit hospital, we have dedicated resources that are designed to manage the requirements enacted by the 2010 Patient Protection and Affordable Care Act and the Community Health Needs Assessment (CHNA). A CHNA is essentially a review of current health activities, resources, initiatives, gaps and limitations in order to identify areas of improvement needed in our community.

Every three years an assessment is completed and a plan is created to address the most important identified initiatives that are learned from the assessment. We are pleased to present you with the results of our 2020 CHNA and the Community Health Improvement Plan (CHIP). We invite your feedback and comments, as your input will help guide and impact our next CHNA which will be undertaken again in three years.

Sincerely,

Bill Pile

William Pile

Chairman of the Board
Sidney Regional Medical Center

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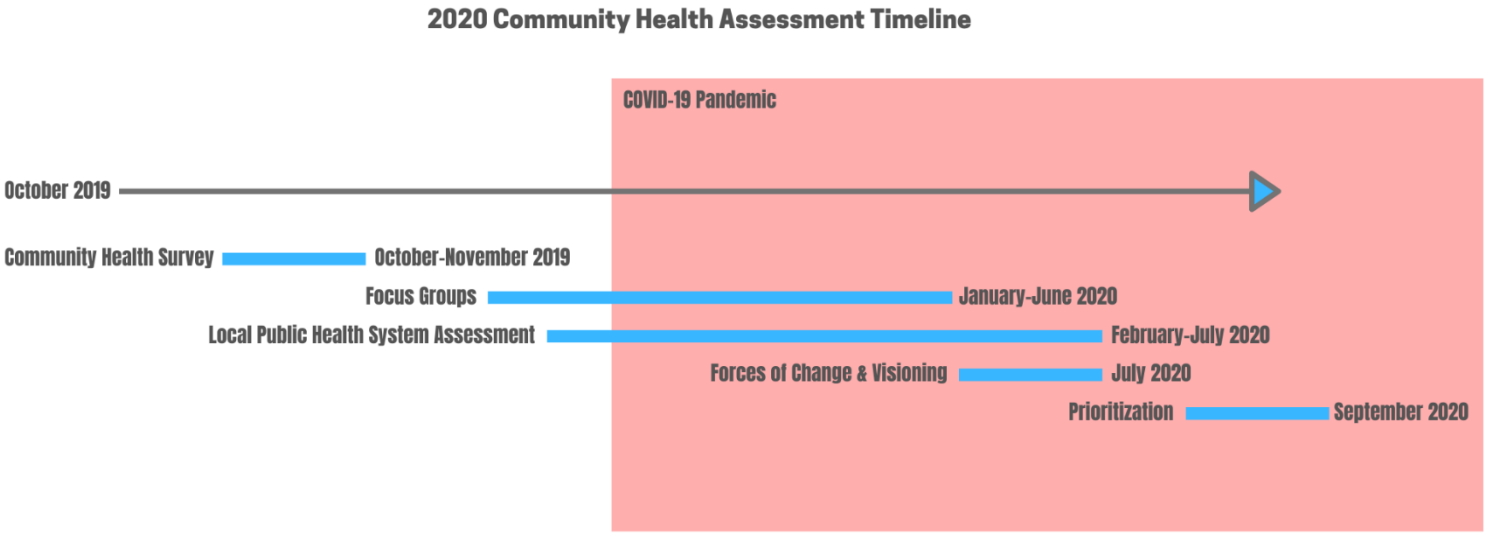
FIGURES

NOTE ON COVID-19 PANDEMIC

The 2020 Community Health Assessment fell across 2019 and 2020, with some aspects completed prior to the start of the COVID-19 Pandemic. This is important to keep in mind as the data in this report are interpreted, as the concerns of Panhandle residents may have changed as the Pandemic progressed. The pieces of the Community Health Assessment that were completed after the pandemic began may reflect different concerns.



DATA AVAILABILITY

In spring of 2020, the work of many public health workers in Nebraska was shifted to focus on the COVID-19 Pandemic. Because of this, some data that would normally be included in this report is missing; notably morbidity, mortality, and health disparity data.

INTRODUCTION

Panhandle Public Health District (PPHD) is accredited by the Public Health Accreditation Board (PHAB), which requires the health department to conduct a comprehensive Nebraska Panhandle Community Health Assessment (CHA) every five years. However, Internal Revenue Service (IRS) regulations require tax-exempt hospitals to conduct a CHA every three years. In 2014, PPHD made the decision to collaborate with hospitals on the CHA process by syncing the health department process with the hospital process, meaning that PPHD completes a CHA every three years, in tandem with area hospitals. Thus, PPHD now facilitates a joint CHA and planning process with the eight hospitals in the Nebraska Panhandle and one in Perkins County, all of which are members of the Rural Nebraska Healthcare Network (RNHN).

The purpose of the CHA process is to describe the current health status of the community, identify and prioritize health issues, better understand the range of factors that can impact health, and identify assets and resources that can be mobilized to improve the health of the community.

OVERVIEW OF MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

Mobilizing for Action through Planning and Partnerships (MAPP), a partnership-based framework, has been used for the CHNA and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHNA and CHIP. MAPP emphasizes the partnership with all sectors of the public health system to evaluate the health status of the region it serves, identify priority areas, and develop plans for implementation.

The MAPP model has six key phases:

1. Organize for success/Partnership development
2. Visioning
3. Four MAPP assessments
    a. Community Health Status Assessment
    b. Community Themes and Strengths Assessment (CTSA)
    c. Forces of Change Assessment
    d. Local Public Health System Assessment
4. Identify Strategic Issues
5. Formulate Goals and Strategies
6. Take Action (plan, implement, and evaluate)

MAPP PHASE 1: ORGANIZE FOR SUCCESS/PARTNERSHIP DEVELOPMENT

A MAPP Steering Committee was formed in 2014, made up of representatives from each of the nine RNHN hospitals (see list of members on page 10). Committee members provide guidance throughout the MAPP process and are charged with reviewing data and progress on the chosen priority areas, using quality improvement to modify implementation plans as needed, and sharing results with stakeholders.

LOCAL PUBLIC HEALTH SYSTEM COLLABORATIVE INFRASTRUCTURES

The Panhandle region enjoys a robust, well-established collaborative infrastructure, which provides the foundation for the local public health system communication and engagement process. This infrastructure includes:

- **Rural Nebraska Healthcare Network** (RNHN) which includes nine hospitals in the region, all rural health clinics, and assisted living/nursing homes that are a part of the RNHN member systems, including the Trauma Network. See page 10 for a list of RNHN members.
- **Public health partnerships** including collaborative work groups such as the Panhandle Regional Medical Response System (PRMRS) and Panhandle Worksite Wellness Council (PWWC), as well as the two public health Boards of Health (PPHD and SBCHD), which include elected officials.
- The **Panhandle Partnership** is a large, not-for-profit organization which promotes collective impact through planning and partnership. This inclusive, membership-based organization has and continues to be an integral part of the regional assessment and planning process. See page 11 for a list of Panhandle Partnership members.

MAPP STEERING COMMITTEE MEMBERS

Community Action Partnership of Western Nebraska	Betsy Vidlak
Rural Nebraska Health Care Network	Boni Carrell
Regional West Garden County Health Services	Bradley Howell Stacey Chudomelka Jenny Moffat Ricca Sanford
Gordon Memorial Health Services	Doris Brown Amanda Kehn Kim South
Box Butte General Hospital	Lori Mazanec Dan Newhoff
Panhandle Area Development District	Megan Kopenhafer
Sidney Regional Medical Center	Evie Parsons Tammy Meier
Chadron Community Hospital	Nathan Hough
Western Community Health Resources/ Chadron Community Hospital	Sandy Montague-Roes
Perkins County Health Services	Neil Hilton Rhonda Theiler
Panhandle Public Health District	Kim Engel Jessica Davies Kelsey Irvine Sara Williamson Tabi Prochazka
Regional West Medical Center	Joanne Krieg Julie Franklin
Scotts Bluff County Health Department	Paulette Schnell
Kimball Health Services	Ken Hunter Laura Bateman Stephanie Pedersen Cheryl Delaplane Kerry Ferguson
Educational Service Unit 13	Nicole Johnson
Morrill County Community Hospital	Robin Stuart Sylvia Lichius Connie Christensen Tracy Sterkel Jenn Ernest Jennifer Compton
Panhandle Partnership	Faith Mills

RURAL NEBRASKA HEALTHCARE NETWORK MEMBERS

Chadron Community Hospital	Nathan Hough
Sidney Regional Medical Center	Jason Petik
Perkins County Health Services	Neil Hilton
Regional West Medical Center	John Mentgen
Kimball Health Services	Ken Hunter
Box Butte General Hospital	Lori Mazanec
Morrill County Community Hospital	Robin Stuart
Gordon Memorial Hospital	Doris Brown
Regional West Garden County Health Services	Bradley Howell

PANHANDLE PARTNERSHIP MEMBERS

- Aging Office of Western Nebraska
- Bayard Public Schools
- Box Butte General Hospital
- CAPSTONE
- CAPWN
- Carolyn Escamilla
- Central Plains Center for Services
- Chadron Community Hospital
- Chadron Public Schools
- Cirrus House
- City of Chappell
- City of Hay Springs
- City of Scottsbluff
- Department of Health and Human Services
- Disability Rights Nebraska
- Doves
- Educational Service Unit 13
- Garden County Health Services
- Garden County Public Schools
- Housing Authority of Scottsbluff
- Immigrant Legal Center
- Independence Rising
- Joan Cromer
- Kimball County
- Kimball Health Services
- Legal Aid of Nebraska
- Mediation West
- Minatare Public Schools
- Monument Prevention Coalition
- Morrill County Community Hospital
- Native Futures
- NE Children's Home Society
- Kim Anderson, LMHP
- Nebraska Civic Engagement
- Nebraska Commission for the Deaf & Hard of Hearing
- Nebraska Department of Labor
- Nebraska Foster & Adoptive Parent Association
- Nebraska Panhandle Area Health Ed Center
- Nebraska Senior Health Insurance Information Program
- NW Community Action Partnership
- Open Door Counseling
- Optimal Family Preservation
- PADD
- Panhandle Equality
- Panhandle Public Health District
- Panhandle Trails Intercity Public Transit
- PlainsWest CASA
- Region 1 Behavioral Health Authority
- Region 1 Office of Human Development
- Regional West Medical Center
- Roger Wess
- Scotts Bluff County
- Shirley Belk
- Snow Redfern Foundation
- United Way of Western Nebraska
- UNL Panhandle Extension Center
- Volunteers of America
- Well Care
- Western Community Health Resources
- Western Nebraska Community College

MAPP PHASE 2: VISIONING

The MAPP Visioning process was intended to take place at a large in-person event in March 2020, which would have been the kick-off event for the 2020 Community Health Assessment. Due to the COVID-19 Pandemic, this event was cancelled, and a virtual event took place on July 30, 2020, to complete the Visioning process. See Appendix A for the meeting work product (including details on the process) and see the next page for the full Vision.

2020 VISION

What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?							
Healthy Eating	**Promote Emotional Resilience**	**Environments and Events for Active Living**	**Establish Healthy Habits Early On**	**Focus on Long-term impact of Pandemic**	**Improve Access to Healthcare**	**Prevent and Reduce Substance Use**	**Access to Basic Needs**
• Community gardens • Healthy food options • Increase nutrition awareness through programming (SNAP, food bank, commodities, etc.) • Access to affordable healthy foods • Incorporation of local healthy food options (farmers market, farm to table, etc.)	• Improve emotional well-being • Healthier ways to deal with stress • Improve access to behavioral health services • Community support for behavior change • Promote healthy stress management techniques • Overcome cost as a barrier to behavioral health treatment	• Safe environments for walking and biking in communities • Opportunities for physical activity (5k type activities, family activities) • Workplace culture of wellness, both in office and WFH • Distance-friendly opportunities for physical activity (virtual, etc.) • Incentives for healthy lifestyle changes • Cultivate culture of health • Active living environments accessible to people of all abilities	• Educate children on whole body health (food choices and activity; access to nutritious foods; access to walkways and activity; emotional health) • Provide parents with education and support for healthy children (nutrition, physical activity, emotional health) • Elementary school education about healthy habits • Health literate resources • Support healthy family programming (Healthy Families, WIC, etc.) • Address environmental health concerns that impact children (e.g., lead) • Focus on all health factors, not only weight	• Promote kindness and compassion during unusual times • Decrease politization of public health measures • Accessible technology for older adults • Accessible technology for vulnerable populations • Virtual opportunities for physical activity • Maintain opportunities for health screenings • Healthcare opportunities for those who experience gap in health insurance due to job loss	• Improved access to eye care • Transportation to/from medical appointments • Increased health care coverage • Mobile health services • Increased resources to care for older adults • Population health perspective • Decrease chronic disease • Link healthcare providers to community programs • Medicaid Expansion	• Tobacco free • Local taxes on tobacco and alcohol • Reduce binge drinking rates • Reduce substance abuse (misuse of prescription drugs, illegal opioids) • Reduce e-cigarette use among youth (tobacco and marijuana) • Improve access to sites for safe medication disposal	• Accessible and affordable public transportation • Safe, quality, and affordable housing • Quality and affordable childcare • Emergency housing for homeless individuals • Jobs with livable wages and benefits • Payer sources to keep hospitals and clinics paid/open

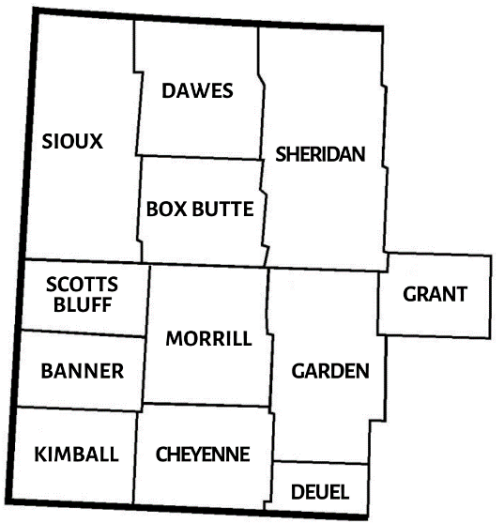
MAPP PHASE 3: FOUR MAPP ASSESSMENTS

COMMUNITY HEALTH STATUS ASSESSMENT

COMMUNITY PROFILE

Located along the nationwide trade arterial of I-80, Cheyenne and Deuel Counties are home to seven incorporated communities. The city of Sidney is an important service and trade hub for the southern Panhandle and has been home to several major regional employers. Chappell, an attractive community, is the county seat of Deuel County and is a goods and service hub for the extreme southeastern Panhandle. Lodgepole, Potter, Dalton, Gurley, and Big Springs are smaller communities which along with their small town charm, are home to several small businesses and agricultural activities, and also serve as bedroom communities for Sidney job opportunities. Agriculture, retail, recreation, energy, and transportation industries lead the area's economy and the counties also benefit considerably from their proximity to I-80 and the front-range of Colorado and Wyoming. The counties are home to four school districts, Sidney Public Schools, Potter-Dix Public Schools, Leyton Public Schools (Dalton-Gurley), Creek Valley Public Schools (Lodgepole-Chappell), and South Platte Public Schools (Big Springs). Sidney is also home to Sidney Regional Medical Center, a private not for profit hospital serving seven counties in Nebraska and northeastern Colorado.

Cheyenne and Deuel Counties are a part of the larger regional community of the Nebraska Panhandle which also consists of Banner, Box Butte, Dawes, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux. The Panhandle Public Health District (PPHD) service area additionally consists of Grant County, for a total of 12 counties covered. Throughout this document, the PPHD service area will be referred to as the Panhandle.



Cheyenne and Deuel County Quick Facts:

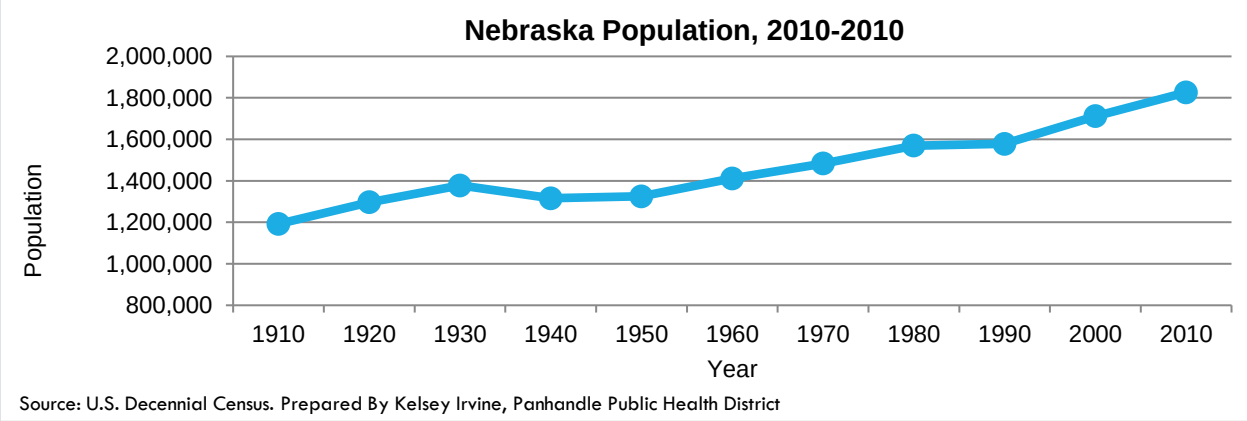
	Cheyenne	Deuel
Population:	10,012	1,901
Unemployment rate:	2.8	3.0
Total land area:	1,196 sq. miles	441 sq. miles

Source: 2013-2017 American Community Survey 5-Year Estimates

POPULATION

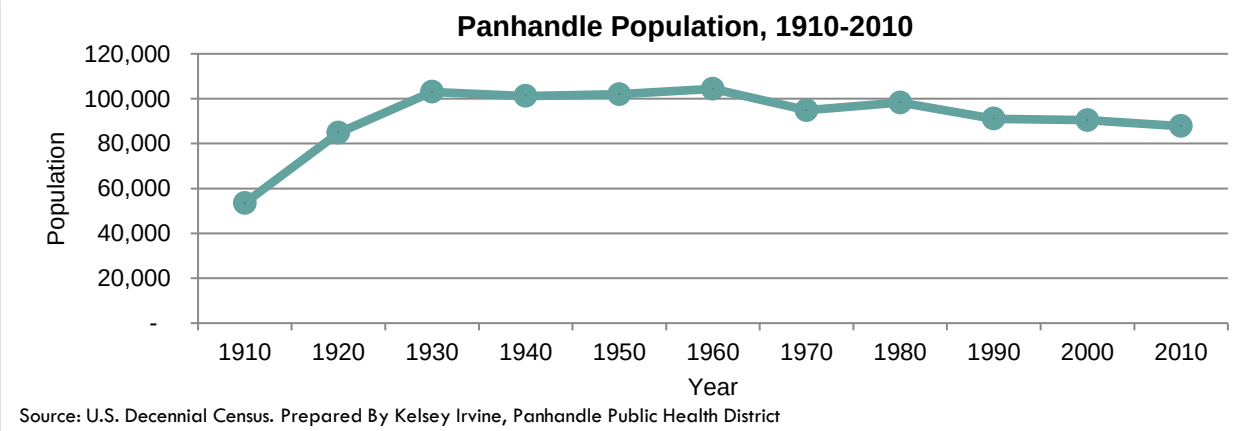
While the population of Nebraska has been slowly but steadily increasing over the past 60 years, the Panhandle's population peaked in the 1960s. Much of Nebraska's growth can be attributed to the metropolitan areas. In Cheyenne County, population has increased in recent decades while in Deuel County, the population has steadily declined for most of the past century.

Figure 1: Nebraska Population, 1910-2010



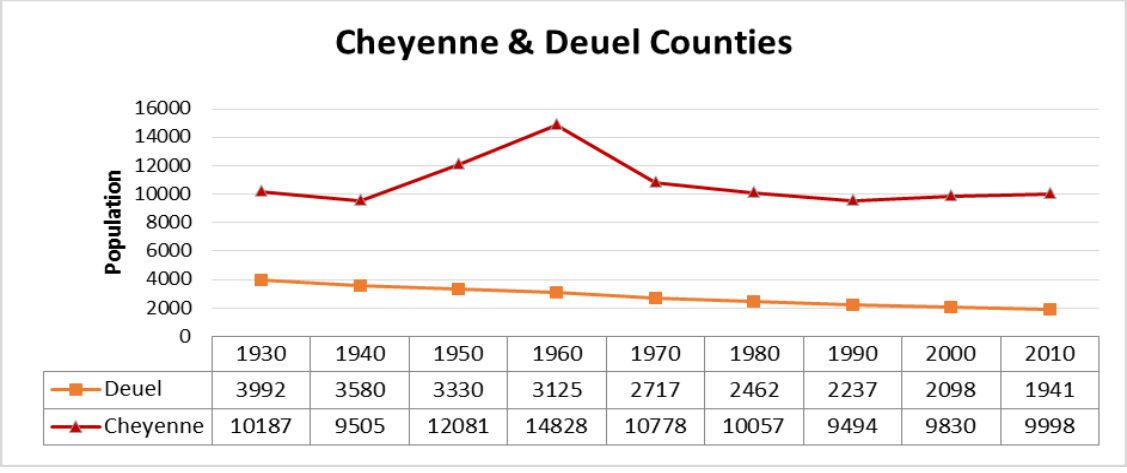
Source: U.S. Decennial Census. Prepared By Kelsey Irvine, Panhandle Public Health District

Figure 2: Panhandle Population, 1910-2010



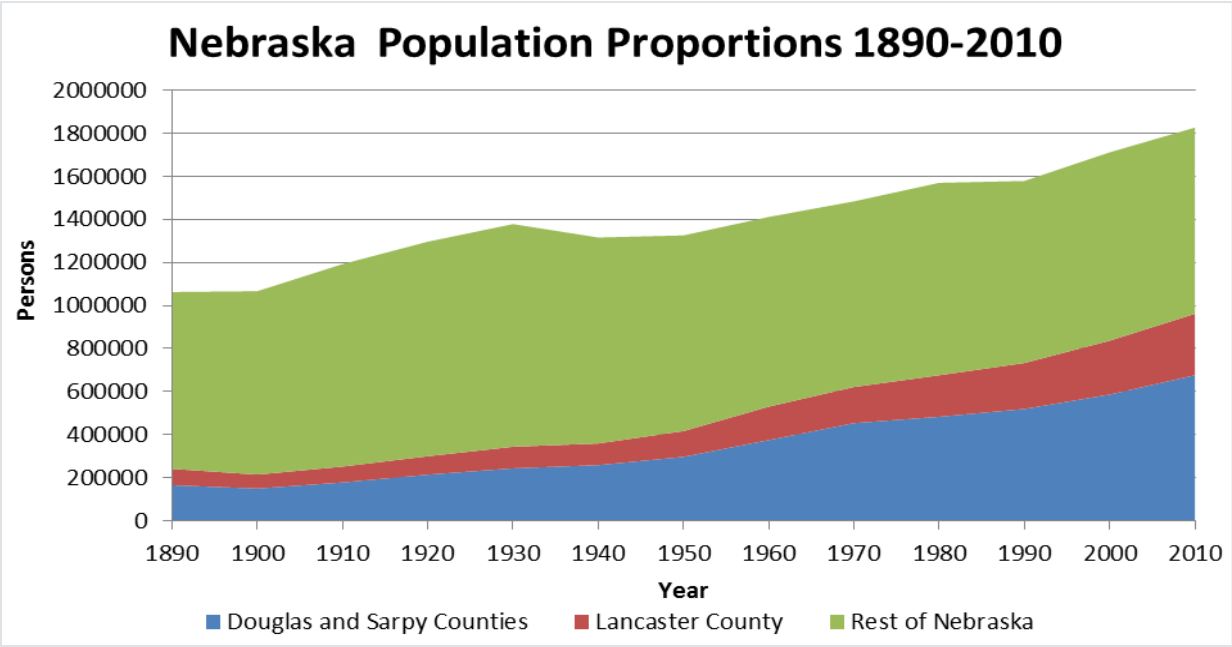
Source: U.S. Decennial Census. Prepared By Kelsey Irvine, Panhandle Public Health District

Figure 3: Cheyenne and Deuel County Population, 1930-2010



	1930	1940	1950	1960	1970	1980	1990	2000	2010
Deuel	3992	3580	3330	3125	2717	2462	2237	2098	1941
Cheyenne	10187	9505	12081	14828	10778	10057	9494	9830	9998

Figure 4: Nebraska Population, Omaha and Lincoln metro areas and rest of state

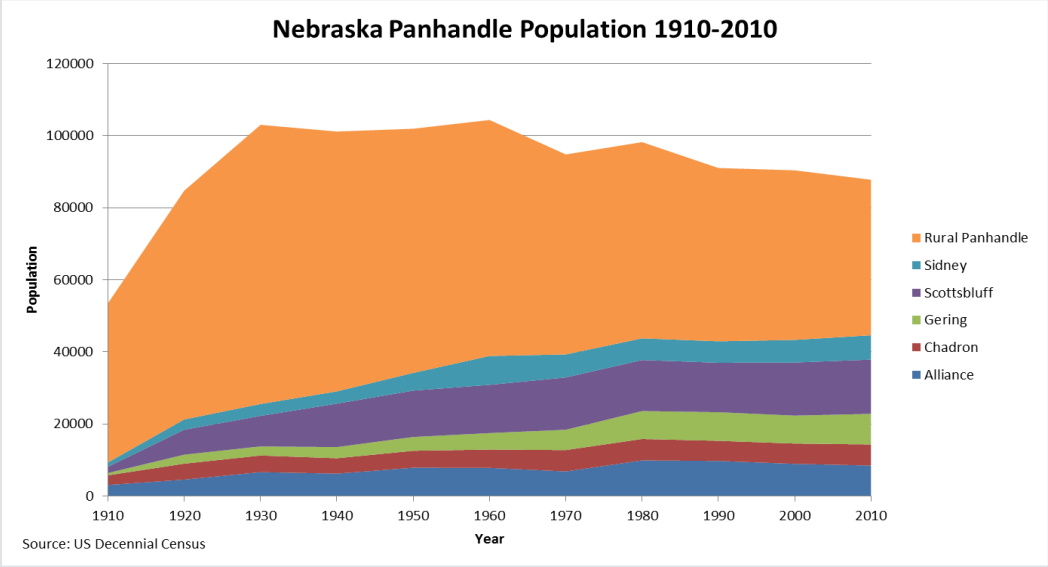


Source: U.S. Decennial Census

Nebraska's population growth has been concentrated almost entirely in the metropolitan counties of Douglas, Sarpy, and Lancaster in the eastern part of the state. These counties are home to the Omaha metropolitan area and the state capital metropolitan area of Lincoln.

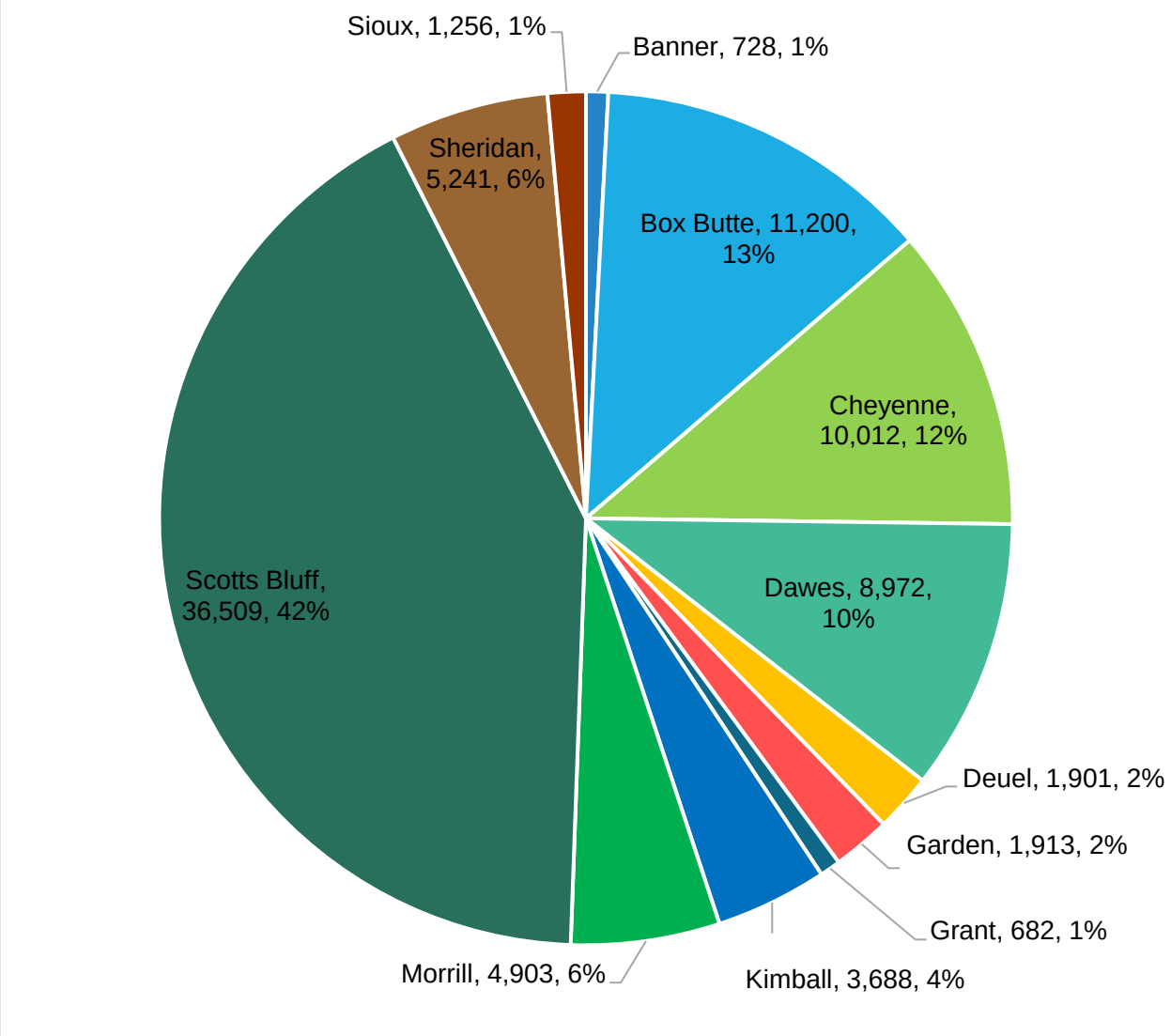
Cheyenne and Deuel Counties have not been immune to the worldwide trend of population consolidation. Sidney has been one of the larger communities in the region which has benefited from the shift to a more urban population composition. The recent loss of Cabela's as a major employer has impacted the community significantly.

Figure 5: Nebraska Panhandle Population Consolidation: 1910-2010



Cheyenne County is one of the 'big four' trade counties in the Panhandle and accounts for about 12% of the region's population. It serves as a population, employment, and service hub for the southern Panhandle and some of northeastern Colorado. Deuel County makes up just two percent of the region's population with fewer than 2,000 residents. Connecting rural Cheyenne and Deuel County residents to services and opportunities in larger communities in the region will help them to remain viable places to live. Collaboration among governments and service providers in these communities helps stretch resources further.

Figure 6: Panhandle Population by County, Count and Percentage



Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

POPULATION PROJECTIONS

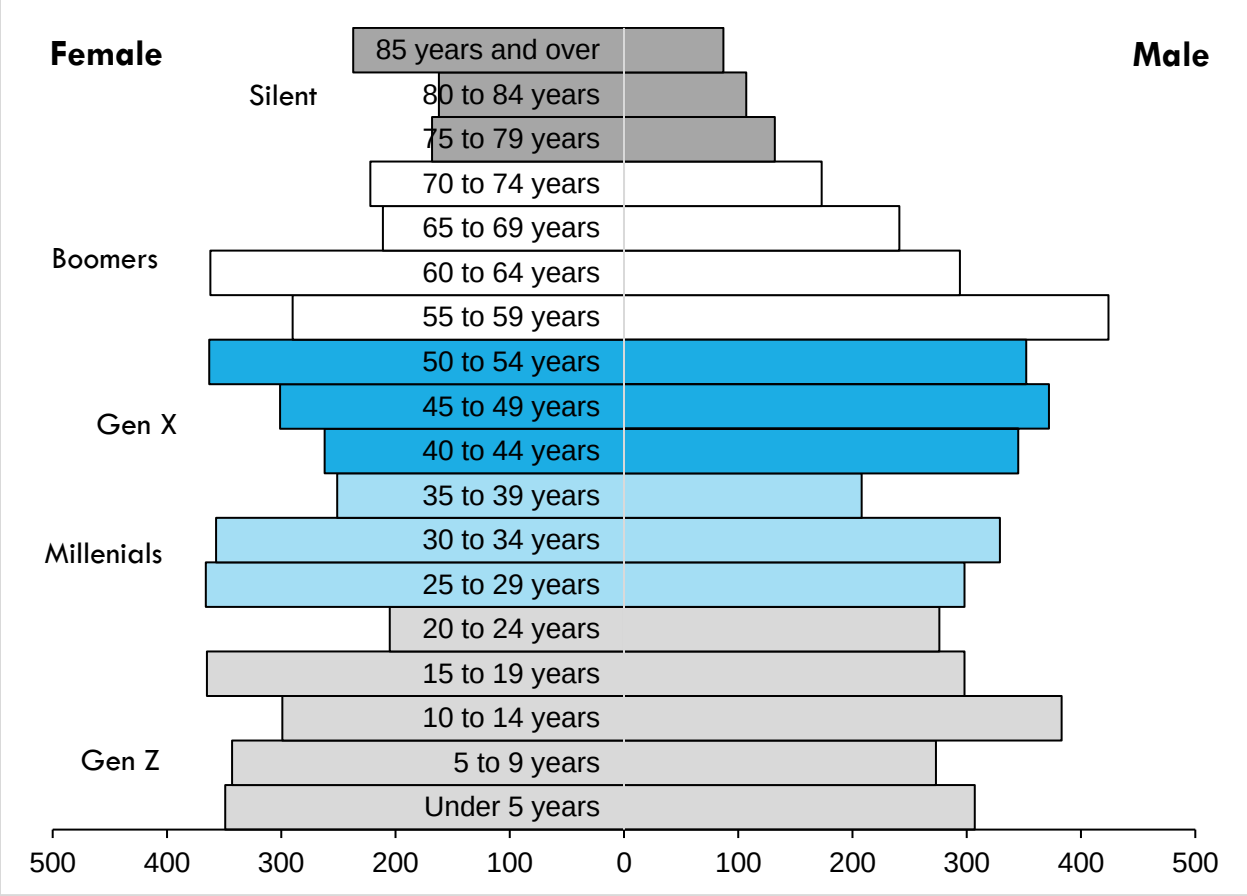
The population pyramids from 2013-2017 American Community Survey shows the general age make-up of Cheyenne and Deuel Counties with a still strongly pronounced baby boom generation and, different than the region, also a sizeable baby boom echo generation. This pyramid and the migration trends both show larger numbers of school age children than in the 20-44 age cohorts. The first cohorts of baby boomers reached age 65 in 2015 and the service and mobility needs of a growing elderly population will provide opportunities and challenges for the county.

Figure 7: Population by Sex and 5-Year Age Group, Cheyenne County

	Both Sexes		Male	Female
	Estimate	Percent	Estimate	Estimate
Total Population	10,012		4,899	5,113
Under 5 years	656	6.6%	307	349
5 to 9 years	616	6.2%	273	343
10 to 14 years	682	6.8%	383	299
15 to 19 years	663	6.6%	298	365
20 to 24 years	481	4.8%	276	205
25 to 29 years	664	6.6%	298	366
30 to 34 years	686	6.9%	329	357
35 to 39 years	459	4.6%	208	251
40 to 44 years	607	6.1%	345	262
45 to 49 years	673	6.7%	372	301
50 to 54 years	715	7.1%	352	363
55 to 59 years	714	7.1%	424	290
60 to 64 years	656	6.6%	294	362
65 to 69 years	452	4.5%	241	211
70 to 74 years	395	3.9%	173	222
75 to 79 years	300	3.0%	132	168
80 to 84 years	269	2.7%	107	162
85 years and over	324	3.2%	87	237

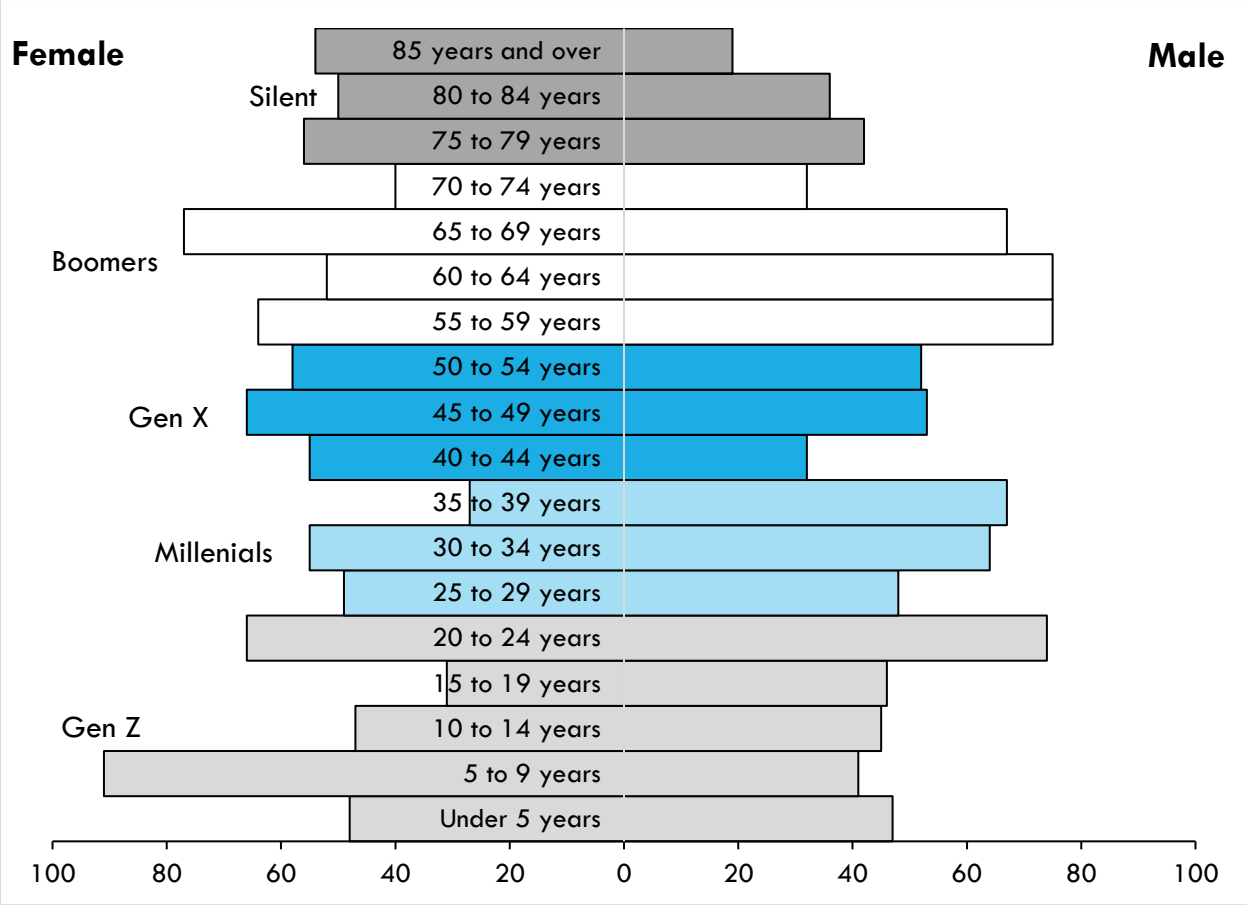
Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 8: Cheyenne County Population Pyramid



Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

Figure 9: Deuel County Population Pyramid



Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

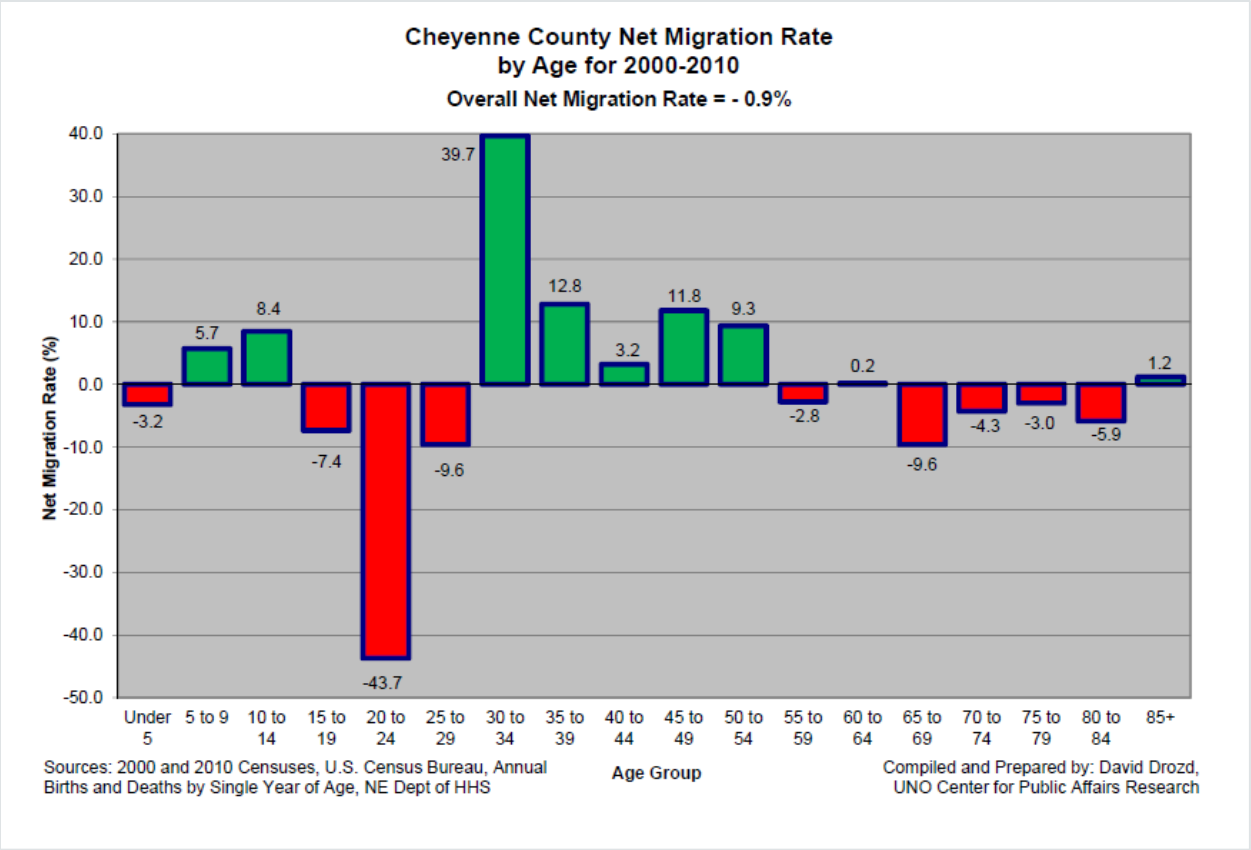
Figure 10: Population by Sex and 5-Year Age Group, Deuel County

	Both Sexes		Male	Female
	Estimate	Percent	Estimate	Estimate
Total Population	1,901		915	986
Under 5 years	95	5.0%	47	48
5 to 9 years	132	6.9%	41	91
10 to 14 years	92	4.8%	45	47
15 to 19 years	77	4.1%	46	31
20 to 24 years	140	7.4%	74	66
25 to 29 years	97	5.1%	48	49
30 to 34 years	119	6.3%	64	55
35 to 39 years	94	4.9%	67	27
40 to 44 years	87	4.6%	32	55
45 to 49 years	119	6.3%	53	66
50 to 54 years	110	5.8%	52	58
55 to 59 years	139	7.3%	75	64
60 to 64 years	127	6.7%	75	52
65 to 69 years	144	7.6%	67	77
70 to 74 years	72	3.8%	32	40
75 to 79 years	98	5.2%	42	56
80 to 84 years	86	4.5%	36	50
85 years and over	73	3.8%	19	54

Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

Cheyenne County migration patterns from 2000-2010 are different from any other Panhandle county with large gains of in-migration of working age and young adult populations. This trend is largely attributed to the presence of job expansion at Cabela's world headquarters in Sidney and its continuance is uncertain with the buyout of Cabela's. The county does, however, share the trend of large out-migration of people following high school age as they presumably seek education, jobs, or experiences outside of the area.

Figure 11: Cheyenne County Net Migration Rate by Age for 2000-2010



RACE AND ETHNICITY

Race patterns in a population are important to assess because they reveal social patterns. Health and economic disparities in America have long existed along racial and ethnic lines. Examining social and economic patterns along racial and ethnic lines can help reveal the extent to which disparities exist and are either improving or worsening to spur thinking and action about equality of opportunity, economic mobility, and improving health for all citizens.

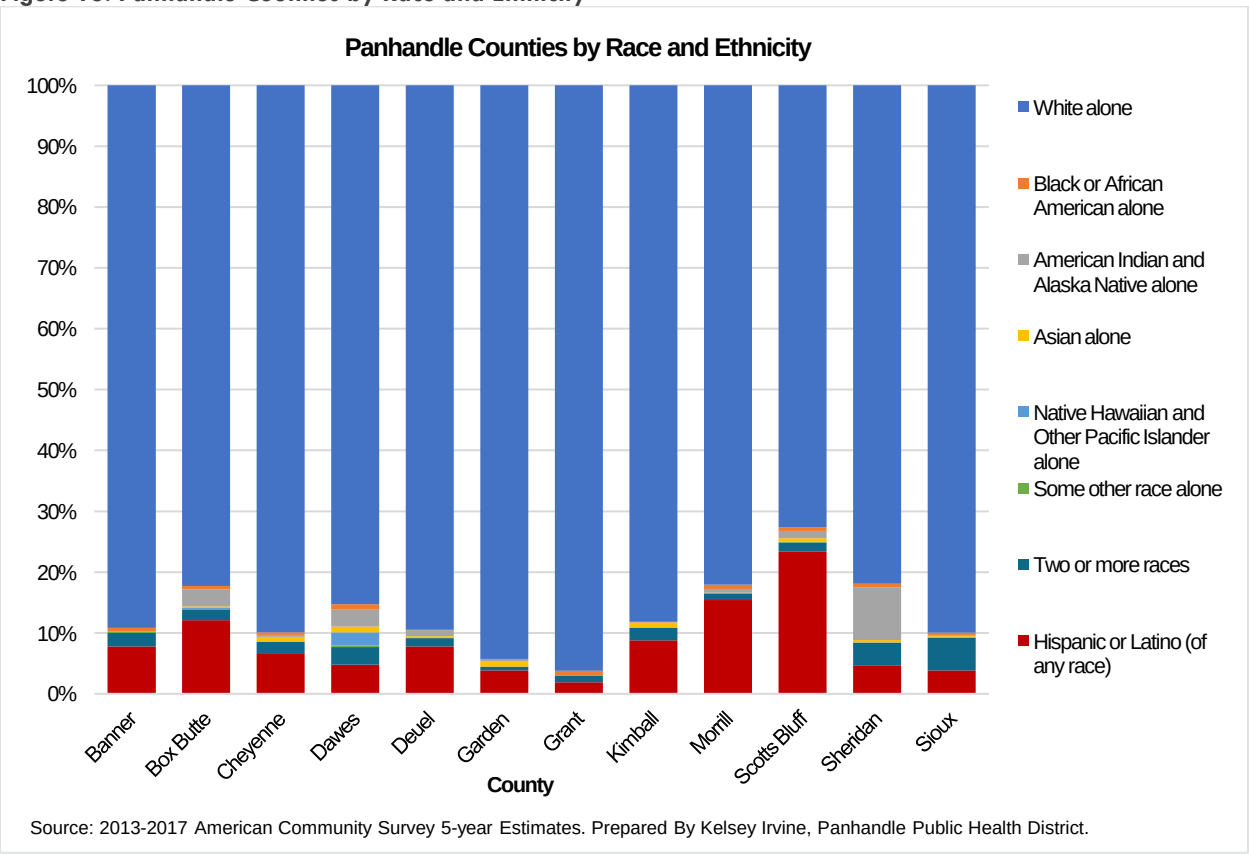
Cheyenne and Deuel Counties' largest minority population is Hispanic and Latino at about 6.7% of the Cheyenne County population and 7.8% of the Deuel County population. Both Cheyenne and Deuel Counties have about half of the rate of minority persons compared to the state and Panhandle.

Figure 12: Population by Race & Ethnicity, Cheyenne and Deuel County

	Cheyenne County		Deuel County		Panhandle	Nebraska
Total Population	10,012		1,901		87,005	1,893,921
Hispanic or Latino (of any race)	669	6.7%	148	7.8%	14.6%	10.5%
Not Hispanic or Latino	9,001	89.9%	1,701	89.5%		
White alone					80.3%	79.8%
Black or African American alone	41	0.4%	1	0.1%	0.6%	4.6%
American Indian and Alaska Native alone	31	0.3%	19	1.0%	1.8%	0.7%
Asia alone	81	0.8%	6	0.3%	0.6%	2.2%
Native Hawaiian and Other Pacific Islander alone	-	0.0%	-	0.0%	0.3%	0.1%
Some other race alone	-	0.0%	-	0.0%	0.1%	0.1%
Two or more races	189	1.9%	26	1.4%	1.9%	2.0%

Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

Figure 13: Panhandle Counties by Race and Ethnicity



Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

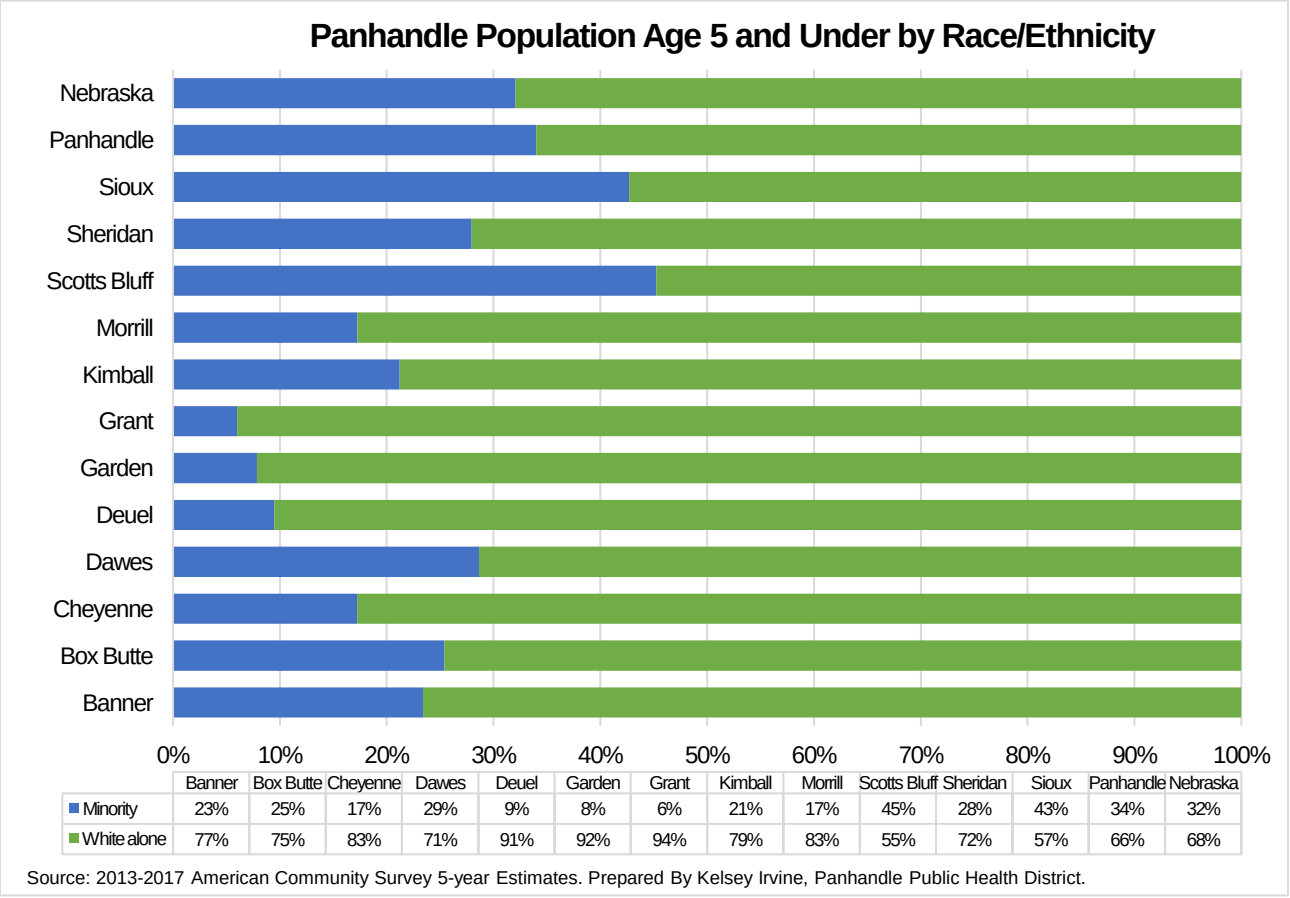
Along with smaller minority populations, Cheyenne and Deuel Counties have a lower rate of those not proficient in English. The vast majority of the Panhandle's Hispanic or Latino population was born in the US contributing to high English language proficiency compared to other counties with similar sized populations of people of Hispanic or Latino descent.

	United States	Nebraska	Banner Co.	Box Butte Co.	Cheyenne Co.	Dawes Co.	Deuel Co.
Speak English less than "very well"	8.5%	5.0%	0.0%	1.5%	0.9%	2.2%	2.5%
	Garden Co.	**Grant Co.**	**Kimball Co.**	**Morrill Co.**	**Scotts Bluff Co.**	**Sheridan Co.**	**Sioux Co.**
Speak English less than "very well"	1.0%	0.0%	1.0%	3.5%	3.3%	1.0%	0.0%

Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

The population in younger age groups is generally more diverse than that of the general population. Despite minority populations accounting for only 10% of the total Cheyenne County population, minority persons account for nearly 20% of the population age . Higher birthrates among minority populations contribute to this changing racial and ethnic population composition. A higher proportion of minority populations mean that a higher total proportion of the population may live with the health and economic disparities patterned by race.

Figure 14: Panhandle Population Age 5 and Under by Race/Ethnicity



	Banner	Box Butte	Cheyenne	Dawes	Deuel	Garden	Grant	Kimball	Morrill	Scotts Bluff	Sheridan	Sioux	Panhandle	Nebraska
Minority	23%	25%	17%	29%	9%	8%	6%	21%	17%	45%	28%	43%	34%	32%
White alone	77%	75%	83%	71%	91%	92%	94%	79%	83%	55%	72%	57%	66%	68%

Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

ECONOMY

Economic health is the driving force for opportunities and prosperity in a region or community. While it is not the only indicator of well-being, quality economic opportunities contribute heavily to the quality of income and the access to education and health care. Thriving local and regional economies also contribute to the vibrancy of communities and provide a base for shared investments in things like infrastructure, law enforcement, public spaces, and maintaining positive neighborhood environments.

Both Cheyenne and Deuel County's economies have their roots in a strong agricultural industry. While agricultural production and related industries are still cornerstones of the economy, service occupations in retail, health, education, and arts are now the largest employers in the area.

EMPLOYMENT AND WORKFORCE

Cheyenne County's unemployment rate is slightly below the region and state level and showed only a small increase during the recession, shown in the year 2010. Cheyenne and Deuel County's unemployment rates are just slightly above their pre-recession level.

Figure 15: Panhandle Unemployment Rate (%), 2000-2018 12-Month Average

County	2000	2008	2010	2016	2018
Banner County	3.0	2.5	4.4	3.4	3.4
Box Butte County	3.9	3.7	5.0	3.6	2.8
Cheyenne County	2.3	2.8	3.6	2.8	2.8
Dawes County	3.0	2.9	4.0	2.9	2.7
Deuel County	3.0	2.9	3.9	2.6	3.0
Garden County	2.6	3.0	4.1	3.3	2.3
Grant County	2.3	2.9	3.8	2.2	2.6
Kimball County	2.5	3.4	4.7	4.1	2.6
Morrill County	3.5	3.1	4.1	3.2	2.7
Scotts Bluff County	4.0	3.7	5.5	3.5	3.2
Sheridan County	2.9	2.7	3.5	2.9	2.6
Sioux County	1.9	3.4	3.7	2.7	2.6
Panhandle	**3.4**	**3.4**	**4.7**	**3.3**	**2.9**
Nebraska	**2.8**	**3.3**	**4.6**	**3.2**	**2.8**
United States	**4.0**	**5.8**	**9.6**	**4.9**	**3.9**

Source: Bureau of Labor Statistics. Prepared by Kelsey Irvine, Panhandle Public Health District.

LABOR FORCE

While unemployment can give us a quick glance as to the percentage of people out of work in an area, it does not account for the rate of people who are underemployed or who are working multiple jobs to make ends meet. In an economic downturn, someone who is self-employed or working multiple jobs could lose a significant amount of their work and still not technically be unemployed. Unemployment also does not account for size of the labor force which has decreased consistently across the region since 2000.

In the region, there has been a slow decrease in total labor force which continued through the recession and has continued even while the national economy has recovered. People leave the county labor force by not continuing to look for work, moving away, or retiring. It is unclear as to which of these three factors are most influential in the area's declining labor force, but it is possible that as older generations have retired there has not been the younger generations entering the labor force to take their place. Deuel County's labor force has declined slightly faster than its population since 2000. Cheyenne County's labor force has declined from 2010 to 2018, reflecting the loss of major employer Cabela's.

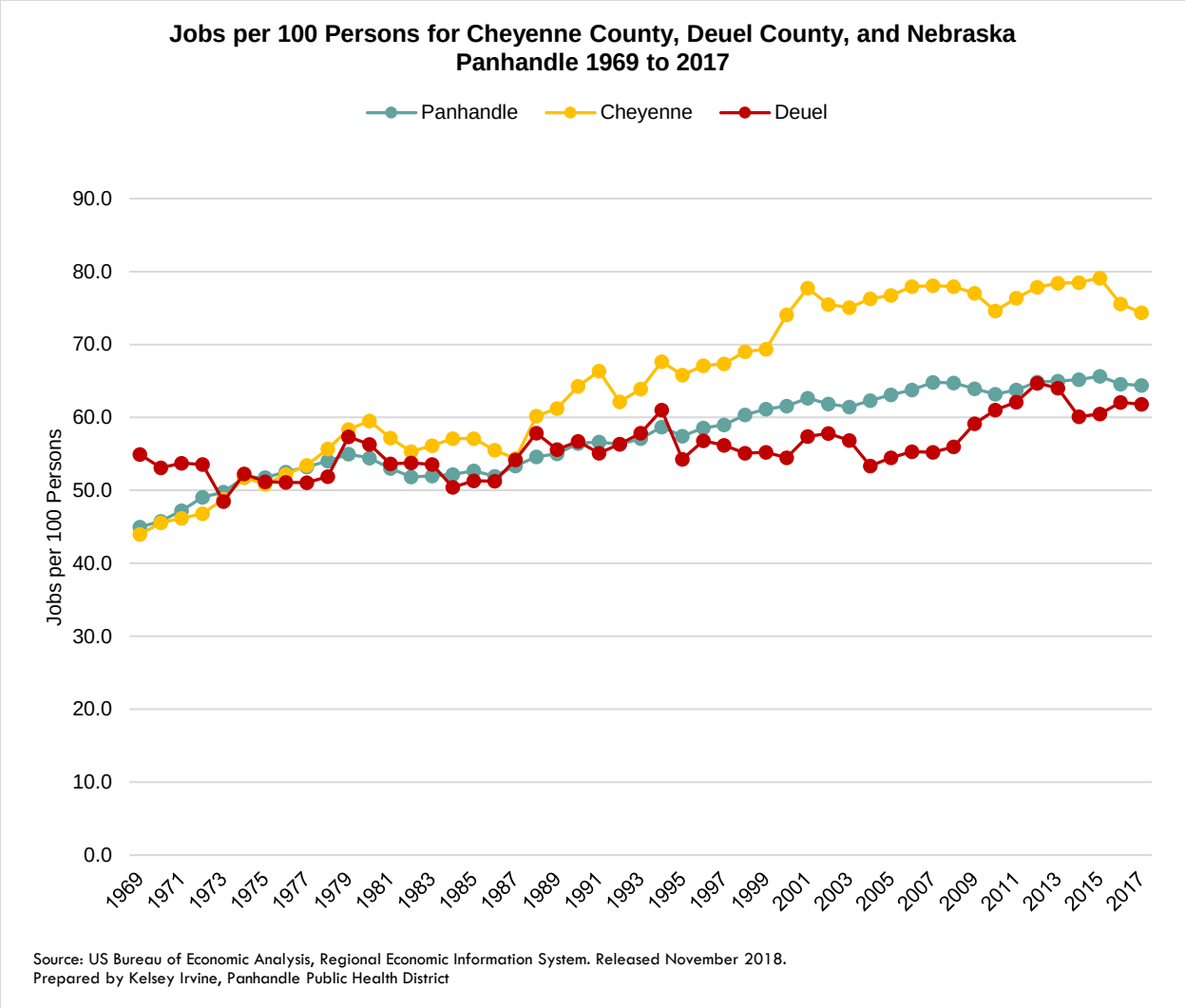
Figure 16: Panhandle Labor Force, 2000-2018

County	2000	2010	2018	Change 2000-2018
Banner County	428	413	381	-11.0%
Box Butte County	6,422	5,852	5,399	-15.9%
Cheyenne County	5,655	5,558	4,731	-16.3%
Dawes County	5,062	5,499	5,040	-0.4%
Deuel County	1,175	1,031	974	-17.1%
Garden County	1,217	1,266	1,192	-2.1%
Grant County	439	373	416	-5.2%
Kimball County	2,198	2,124	2,016	-8.3%
Morrill County	2,798	2,650	2,599	-7.1%
Scotts Bluff County	18,775	19,200	18,422	-1.9%
Sheridan County	3,295	2,821	2,690	-18.4%
Sioux County	802	835	743	-7.4%
Panhandle	**47,827**	**47,249**	**44,187**	**-7.6%**
Nebraska	**944,986**	**993,400**	**1,011,635**	**7.1%**
United States	**143,893,664**	**155,539,411**	**161,370,049**	**12.1%**

Source: Bureau of Labor Statistics. Prepared by Kelsey Irvine, Panhandle Public Health District.

Cheyenne County's position in the region as an employment hub is evident when looking at the jobs per 100 persons rate which accelerated particularly sharply in the early 2000s and remained high until a decrease after 2015. Deuel County has had rates typically below the regional average and although its rate has had an overall increase since 2000. Regionally, while jobs per 100 persons have increased significantly, wages have not had the same increase, emphasizing the importance in the type of jobs and wages paid when jobs are created.

Figure 17: Jobs per 100 persons, 1969-2017, Cheyenne County, Deuel County, and Panhandle



Source: US Bureau of Economic Analysis, Regional Economic Information System. Released November 2018.
Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 18: Jobs per 100 Persons, 2006-2017, Cheyenne County, Deuel County, and Panhandle

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Panhandle	63.8	64.8	64.8	63.9	63.2	63.8	64.8	65.0	65.2	65.6	64.6	64.4
Cheyenne County	78.0	78.1	78.0	77.0	74.6	76.4	77.9	78.4	78.5	79.1	75.6	74.3
Deuel County	55.3	55.2	56.0	59.1	61.0	62.1	64.7	64.0	60.1	60.5	62.1	61.8

Source: US Bureau of Economic Analysis, Regional Economic Information System. Released November 2018. Prepared by Kelsey Irvine, Panhandle Public Health District

INCOME

Cheyenne and Deuel Counties' numbers were towards the top of the median household and family incomes in the region. The 2017 estimated median income for Cheyenne County is higher than the state and regional median income. Deuel county falls slightly lower. Change in median household income varied from 2010 to 2017 estimates by county but Deuel County is estimated to have increased its median income substantially. Cheyenne County, meanwhile had a very slight increase in median income when adjusted for inflation. The data for 2017 includes data which would have been collected during the recession which likely accounts for the decrease in median household income at the state and national levels and could potentially have impacted Cheyenne County's numbers as well.

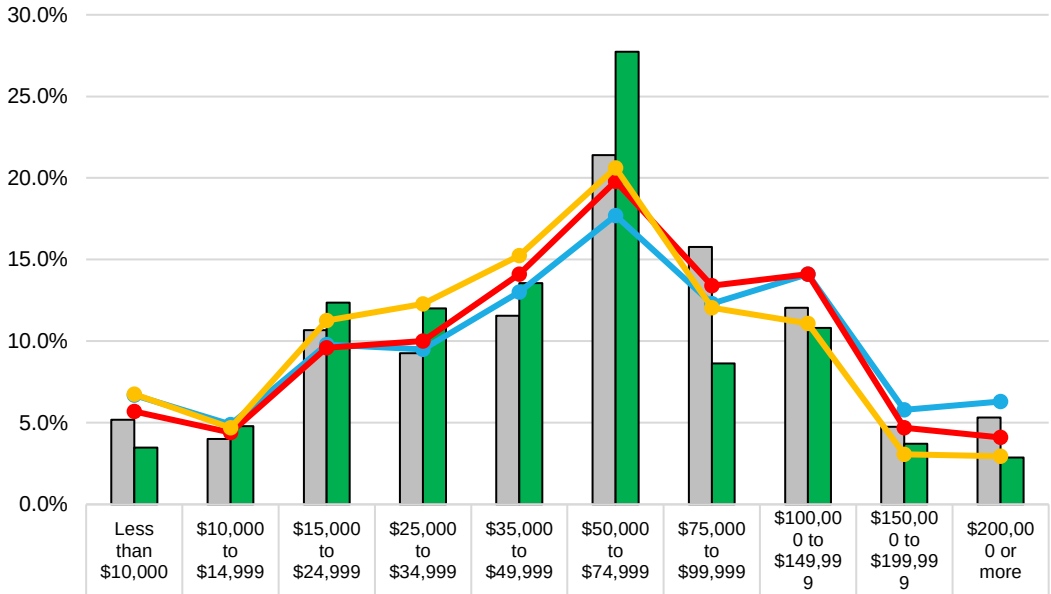
Figure 19: Median Household Income, Panhandle

County	2010	2017	Change
Banner County	$38,753	$55,000	41.92%
Box Butte County	$50,518	$56,328	11.50%
Cheyenne County	$56,308	$58,770	4.37%
Dawes County	$39,748	$46,146	16.10%
Deuel County	$42,263	$53,438	26.44%
Garden County	$37,194	$48,125	29.39%
Grant County	$44,667	$45,833	2.60%
Kimball County	$47,795	$43,017	-10.00%
Morrill County	$42,910	$44,201	3.01%
Scotts Bluff County	$44,375	$47,975	8.11%
Sheridan County	$38,236	$41,209	7.78%
Sioux County	$48,222	$45,375	-5.90%
Nebraska	**$56,136**	**$56,675**	**0.96%**
United States	**$59,062**	**$57,652**	**-2.39%**

Source: U.S. Census Bureau, 2006-2010 American Community Survey 5-Year Estimates; 2013-2017 American Community Survey 5-Year Estimates; Bureau of labor statistics CPI inflation calculator. Prepared by Kelsey Irvine, Panhandle Public Health District

Income distribution for the two counties shows a lot of people earning the middle income brackets with much more of a percentage of its households having income in the $50,000 to $150,000 range than the region.

Figure 20: Household Income Distribution, Panhandle, 2017 Inflation-Adjusted Dollars



	Less than $10,000	$10,000 to $14,999	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 to $99,999	$100,000 to $149,999	$150,000 to $199,999	$200,000 or more
Cheyenne County	5.2%	4.0%	10.7%	9.3%	11.6%	21.4%	15.8%	12.0%	4.8%	5.3%
Deuel County	3.5%	4.8%	12.4%	12.0%	13.6%	27.7%	8.6%	10.8%	3.7%	2.9%
United States	6.7%	4.9%	9.8%	9.5%	13.0%	17.7%	12.3%	14.1%	5.8%	6.3%
Nebraska	5.7%	4.4%	9.6%	10.0%	14.1%	19.8%	13.4%	14.1%	4.7%	4.1%
Panhandle	6.7%	4.7%	11.3%	12.3%	15.2%	20.6%	12.0%	11.1%	3.1%	2.9%

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates; Table Dp03. Prepared By Kelsey Irvine, Panhandle Public Health District.

Per capita income of counties is calculated by taking all the income in a county in a year and dividing it by the number of people in the county. This gives an idea of the general wealth circulating in the area and the strength of the economy.

Figure 21: Per Capita Income in the past 12 months, Panhandle, 2017 Inflation-Adjusted Dollars

County	Per capita income ($)
Banner County	30,736
Box Butte County	28,483
Cheyenne County	32,995
Dawes County	24,811
Deuel County	28,225
Garden County	35,602
Grant County	22,693
Kimball County	24,011
Morrill County	25,120
Scotts Bluff County	26,532
Sheridan County	25,817
Sioux County	26,852
Nebraska	**29,866**
United States	**31,177**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates; Bureau of labor statistics CPI inflation calculator. Prepared by Kelsey Irvine, Panhandle Public Health District

POVERTY

Poverty in the Panhandle is generally higher than in the rest of the state and nearby metro areas. Cheyenne and Deuel Counties are estimated to have lower poverty rates than the region and the state.

CHILDHOOD POVERTY

Cheyenne and Deuel Counties have higher rates of poverty in the Panhandle among children under 18. Cheyenne County has a slightly higher rate than the state, and Deuel County has a higher rate than both the state and the region. A higher ratio of minorities for younger age groups and the higher poverty rate for this ethnic group may lead to these high numbers. More children in poverty means more children growing up with potential obstacles to career, educational, and health care opportunities and threatens the overall prosperity of a community.

Figure 22: Percent of All Population with Income in Past 12-Months Below Poverty Line, Panhandle

County	%
Grant County	21.1%
Sheridan County	15.8%
Dawes County	14.3%
Scotts Bluff County	13.2%
Sioux County	12.4%
Garden County	11.7%
Kimball County	11.4%
Deuel County	11.1%
Box Butte County	10.9%
Cheyenne County	10.9%
Morrill County	9.4%
Banner County	8.9%
Panhandle	**12.6%**
Nebraska	**12.0%**
United States	**14.6%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 23: Percent of Children Under 18 With Income in past 12 Months Below Poverty Line, Panhandle

County	Percent
Grant County	33.8%
Sheridan County	27.5%
Scotts Bluff County	19.4%
Sioux County	18.7%
Deuel County	17.6%
Cheyenne County	16.3%
Box Butte County	14.3%
Morrill County	11.4%
Dawes County	10.8%
Banner County	10.5%
Garden County	10.5%
Kimball County	9.5%
Panhandle	**17.1%**
Nebraska	**15.6%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

RACE AND POVERTY

Cheyenne and Deuel County's largest minority group, Hispanic or Latino, shows an estimated 30.8% and 29.7% poverty rate, respectively, compared to just 10-11% for white alone (non-Hispanic). This data shows that disparities between ethnicities, even in counties where incomes in general are relatively high, are still present.

Figure 24: Percent of all Population with Income in past 12 Months Below Poverty Level, by Race and Ethnicity, Panhandle

County	White Alone	American Indian alone	Two or more races	Hispanic or Latino origin (of any race)	White alone, not Hispanic or Latino
Banner County	8.2%	-	43.8%	33.3%	6.0%
Box Butte County	7.5%	53.4%	67.8%	13.9%	6.8%
Cheyenne County	10.4%	0.0%	18.9%	30.8%	9.2%
Dawes County	13.1%	59.7%	7.0%	13.1%	13.1%
Deuel County	10.9%	0.0%	0.0%	29.7%	9.9%
Garden County	11.6%	0.0%	33.3%	0.0%	12.0%
Grant County	20.2%	0.0%	71.4%	0.0%	20.7%
Kimball County	12.0%	0.0%	0.0%	14.2%	11.5%
Morrill County	9.4%	0.0%	16.5%	22.6%	6.7%
Scotts Bluff County	12.7%	29.1%	14.2%	25.2%	8.9%
Sheridan County	11.4%	61.6%	5.8%	30.9%	10.8%
Sioux County	13.2%	0.0%	0.0%	14.6%	13.2%
Panhandle	**11.5%**	**45.7%**	**19.5%**	**23.4%**	**9.5%**
Nebraska	**10.3%**	**32.6%**	**20.5%**	**22.7%**	**9.0%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

POVERTY BY EDUCATIONAL ATTAINMENT

Similar to lower poverty rates within both counties, the rates of poverty amongst individuals holding a bachelor's degree or higher are lower than the regional and state rates.

Figure 25: Percent of Population in Poverty by Educational Attainment, Population 25+, Panhandle

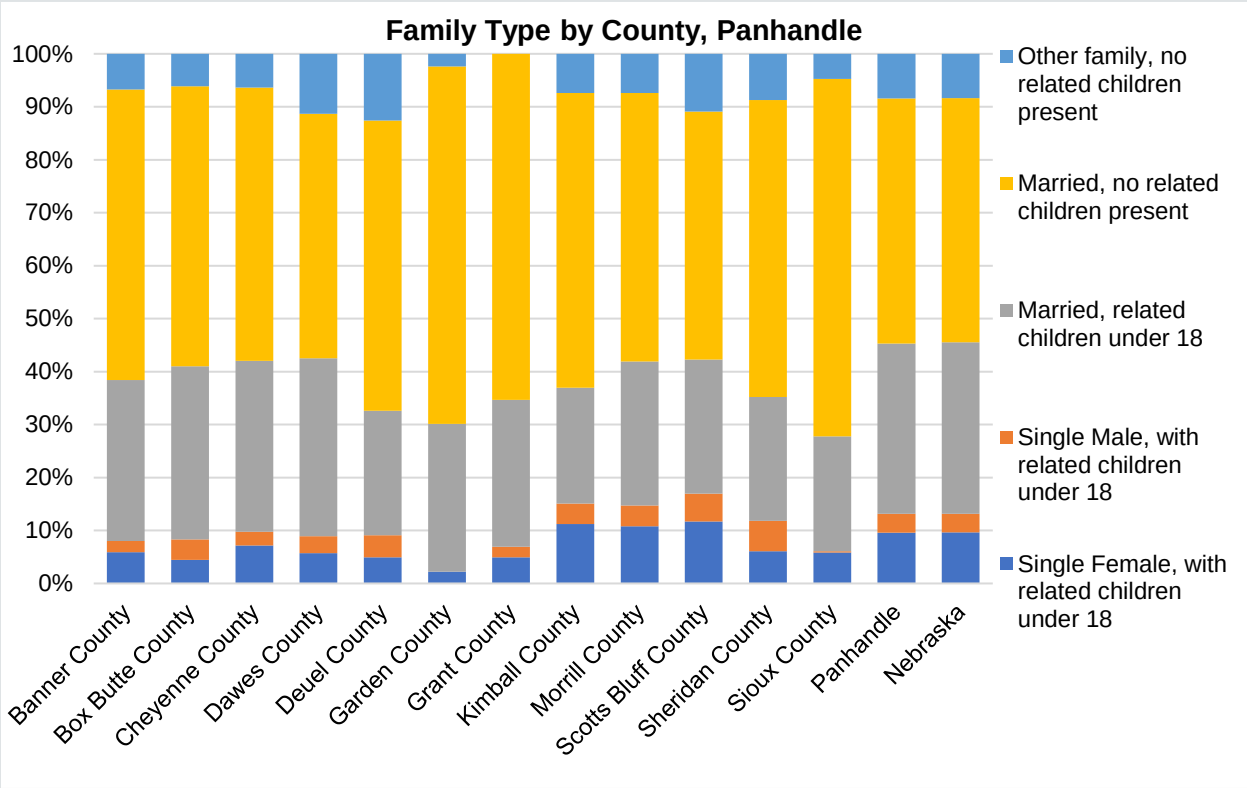
	Less than high school	High school graduate	Some college, associate's degree	Bachelor's degree or higher
Banner County	0.0%	11.2%	11.9%	0.0%
Box Butte County	17.8%	12.9%	6.6%	0.5%
Cheyenne County	12.6%	12.5%	8.2%	1.2%
Dawes County	25.2%	17.5%	10.6%	3.5%
Deuel County	14.8%	7.8%	9.4%	1.6%
Garden County	35.4%	13.3%	9.9%	6.3%
Grant County	25.2%	17.5%	10.6%	3.5%
Kimball County	18.6%	14.8%	8.2%	7.7%
Morrill County	16.8%	9.0%	5.0%	3.4%
Scotts Bluff County	22.8%	9.3%	9.3%	3.4%
Sheridan County	28.7%	9.7%	11.4%	8.5%
Sioux County	16.4%	13.6%	10.1%	7.0%
Panhandle	**21.2%**	**11.4%**	**8.9%**	**3.4%**
Nebraska	**22.5%**	**10.5%**	**8.3%**	**3.3%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

POVERTY BY FAMILY TYPE

Cheyenne County is one of the counties with the highest percentage of families with children less than 18 years of age while Deuel County has majority non-children households. Single parent families with children make up about 10% of all Cheyenne County families and about 9% of Deuel County families.

Figure 26: Family Type by County, Panhandle

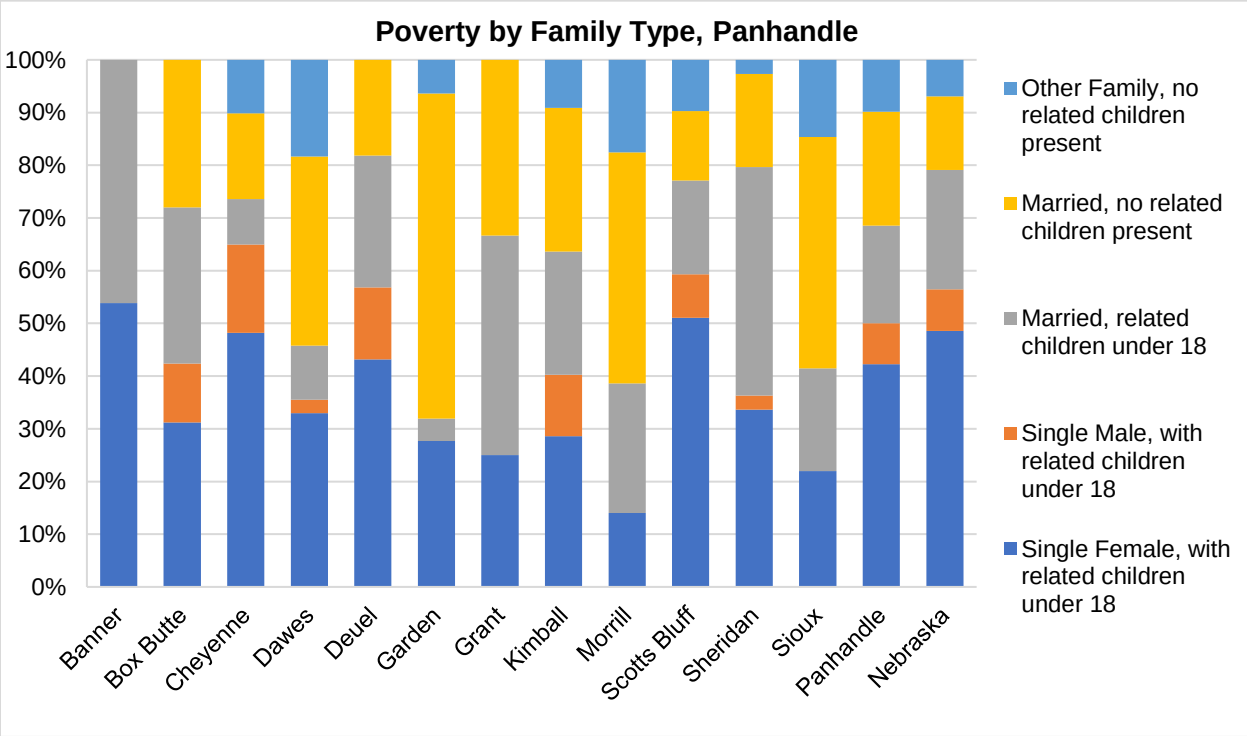


	Single Female, with related children under 18	Single Male, with related children under 18	Married, related children under 18	Married, no related children present	Other family, no related children present
Banner County	6%	2%	30%	55%	7%
Box Butte County	4%	4%	33%	53%	6%
Cheyenne County	7%	3%	32%	52%	6%
Dawes County	6%	3%	34%	46%	11%
Deuel County	5%	4%	23%	55%	13%
Garden County	2%	0%	28%	67%	2%
Grant County	5%	2%	28%	66%	0%
Kimball County	11%	4%	22%	56%	7%
Morrill County	11%	4%	27%	51%	7%
Scotts Bluff County	12%	5%	25%	47%	11%
Sheridan County	6%	6%	23%	56%	9%
Sioux County	6%	0%	22%	67%	5%
Panhandle	**10%**	**4%**	**32%**	**46%**	**8%**
Nebraska	**10%**	**4%**	**32%**	**46%**	**8%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates; Table B11003. Prepared By Kelsey Irvine, Panhandle Public Health District

Over approximately 60% of all families in poverty in both Cheyenne and Deuel Counties have children under 18. This helps explain the higher rate of childhood poverty, compared to overall poverty within the county as well as regional childhood poverty rates. Single female headed households with children account for just 7% of total families but account for nearly 50% of all the families in poverty in Cheyenne County. Deuel County also shows a relatively high percentage of single male headed households in poverty. It should be noted that Deuel County is estimated to only have 44 total households below the poverty level so small numbers can account for a large percentage of the total pool.

Figure 27: Poverty by Family Type, Panhandle



	Total number of households	Number of households below poverty line	Percentage of households below poverty line				
			Single Female, with related children under 18	Single Male, with related children under 18	Married, related children under 18	Married, no related children present	Other Family, no related children present
Banner County	237	13	53.8%	0.0%	46.2%	0.0%	0.0%
Box Butte County	3,062	125	31.2%	11.2%	29.6%	28.0%	0.0%
Cheyenne County	2,562	197	48.2%	16.8%	8.6%	16.2%	10.2%
Dawes County	2,140	273	33.0%	2.6%	10.3%	35.9%	18.3%
Deuel County	549	44	43.2%	13.6%	25.0%	18.2%	0.0%
Garden County	544	47	27.7%	0.0%	4.3%	61.7%	6.4%
Grant County	192	24	25.0%	0.0%	41.7%	33.3%	0.0%
Kimball County	1,014	77	28.6%	11.7%	23.4%	27.3%	9.1%
Morrill County	1,248	57	14.0%	0.0%	24.6%	43.9%	17.5%
Scotts Bluff County	9,395	877	51.1%	8.2%	17.8%	13.2%	9.7%
Sheridan County	1,432	113	33.6%	2.7%	43.4%	17.7%	2.7%
Sioux County	378	41	22.0%	0.0%	19.5%	43.9%	14.6%
Panhandle	**22,753**	**1,888**	**42.3%**	**7.7%**	**18.6%**	**21.6%**	**9.9%**
Nebraska	**482,941**	**38,789**	**48.6%**	**7.9%**	**22.6%**	**14.0%**	**6.9%**

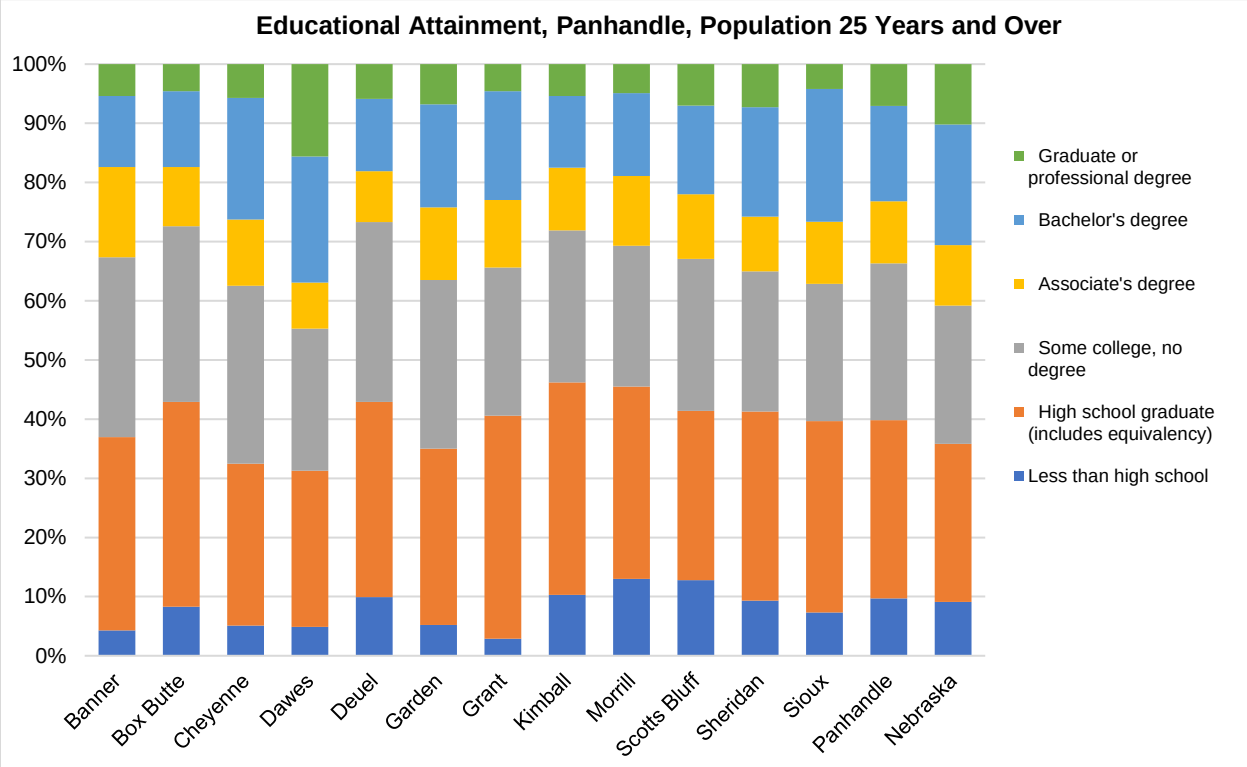
Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates; Table S1702. Prepared By Kelsey Irvine, Panhandle Public Health District.

EDUCATION

EDUCATIONAL ATTAINMENT

Lower levels of educational attainment in the Panhandle reflect the fact that many of the jobs available in agriculture, transportation, and manufacturing do not require a bachelor's degree. Deuel County has a more typical rural county level of educational attainment of approximately 18% bachelor's degree or higher, reflecting the differences in jobs available in Cheyenne and Deuel Counties. Both Deuel and Cheyenne Counties had very low rates of the population having less than a high school degree at just 5.1% for Cheyenne County and less than 9.9% for Deuel County.

Figure 28: Educational Attainment, Panhandle, Population 25 Years and Over



Source: 2013-2017 American Community Survey 5-Year Estimates; Table S1501. Prepared by Kelsey Irvine, Panhandle Public Health District.

	Less than high school	High school graduate	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
Banner County	4.3%	32.7%	30.4%	15.3%	12.0%	5.4%
Box Butte County	8.3%	34.6%	29.7%	10.0%	12.8%	4.6%
Cheyenne County	5.1%	27.4%	30.1%	11.2%	20.6%	5.7%
Dawes County	4.9%	26.4%	24.0%	7.8%	21.3%	15.6%
Deuel County	9.9%	33.0%	30.4%	8.6%	12.2%	5.9%
Garden County	5.2%	29.8%	28.5%	12.3%	17.4%	6.8%
Kimball County	10.3%	35.9%	25.7%	10.6%	12.1%	5.4%
Morrill County	13.0%	32.5%	23.8%	11.8%	14.0%	4.9%
Scotts Bluff County	12.8%	28.6%	25.7%	10.9%	15.0%	7.0%
Sheridan County	9.3%	32.0%	23.7%	9.2%	18.5%	7.3%
Sioux County	7.3%	32.3%	23.2%	10.5%	22.4%	4.2%
Panhandle	**9.8%**	**30.0%**	**26.5%**	**10.5%**	**16.1%**	**7.1%**
Nebraska	**9.1%**	**26.7%**	**23.4%**	**10.2%**	**20.4%**	**10.2%**

The 4-year graduation rate across the state of Nebraska for the 2017-2018 school year was 89%. Schools in Deuel and Cheyenne Counties were nearly at or above the graduation rate for the state in that school year. Potter-Dix Schools had too small of a graduating class size in 2017-2018 school year for a percentage to be calculated.

Figure 29: 4-Year Graduation Rate, Panhandle Public Schools and Nebraska

	2015-2016	2016-2017	2017-2018
Alliance Public Schools	89%	84%	83%
Banner County Public Schools	NA	NA	NA
Bayard Public Schools	100%	88%	100%
Bridgeport Public Schools	89%	87%	92%
Chadron Public Schools	90%	95%	96%
Crawford Public Schools	94%	92%	86%
Creek Valley Schools	91%	95%	87%
Garden County Schools	100%	100%	100%
Gering Public Schools	88%	87%	91%
Gordon-Rushville Public Schools	92%	91%	94%
Hay Springs Public Schools	100%	83%	92%
Hemingford Public Schools	88%	97%	89%
Hyannis Area Schools	100%	100%	100%
Kimball Public Schools	98%	94%	89%
Leyton Public Schools	100%	100%	100%
Minatare Public Schools	NA	93%	100%
Mitchell Public Schools	95%	95%	92%
Morrill Public Schools	83%	90%	96%
Potter-Dix Public Schools	93%	85%	NA
Scottsbluff Public Schools	92%	91%	91%
Sidney Public Schools	97%	95%	89%
Sioux County Public Schools	NA	NA	NA

Source: Nebraska Department of Education. Prepared by Kelsey Irvine, Panhandle Public Health District.

EARLY CHILDHOOD EDUCATION

The number of children 5 and under with all available parents working, meaning these children need out of home care, tends to be less in Panhandle counties when compared to the state of Nebraska. However, opportunities for licensed and quality early childcare and education tends to be less available in the Panhandle. For 2012-2016 combined, there were 622 children 5 and under with all available parents working in Cheyenne and Deuel Counties.

Figure 30: Children 5 and Under with all Available Parents Working, Panhandle & Nebraska

	2008-2012		2012-2016	
	#	%	#	%
Banner County	25	30.1%	37	58.7%
Box Butte County	406	51.5%	569	74.2%
Cheyenne County	550	74.9%	528	68.1%
Dawes County	396	74.9%	433	70.0%
Deuel County	63	70.8%	94	82.5%
Garden County	142	100.0%	101	91.8%
Grant County	27	75.0%	22	48.9%
Kimball County	162	60.7%	227	75.7%
Morrill County	193	58.5%	205	79.2%
Scotts Bluff County	2,170	73.0%	1,973	68.6%
Sheridan County	208	59.6%	210	79.5%
Sioux County	42	59.2%	83	82.2%
Nebraska	**112,004**	**73.9%**	**110,101**	**72.2%**

Source: U.S. Census Bureau, 2012 and 2016 American Community Survey 5-Year Estimates, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District.

There are three head start and early head start grantees that serve Panhandle counties: Northwest Community Action Partnership, Migrant and Seasonal Head Start, and Educational Service Unit (ESU) 13. These grantees served a total of 673 children in the 2016/2017 year. Cheyenne and Deuel counties are served by Educational Service Unit 13.

Figure 31: Panhandle Children Served by Head Start/Early Head Start

	2013/2014	2014/2015	2015/2016	2016/2017
Northwest Community Action Partnership	258	258	258	258
Migrant and Seasonal Head Start	46	65	65	65
Educational Service Unit 13	350	350	350	350
Total Served	**654**	**673**	**673**	**673**

Source: U.S. Census Bureau, 2012 and 2016 American Community Survey 5-Year Estimates, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District

There are 137 licensed childcare facilities in the Panhandle. Sioux and Banner Counties have no licensed childcare facilities. The table below shows total capacity, capacity for those who serve only children five and older (after school programs), and capacity for those who serve children starting at an age younger than five. In Cheyenne County there are 351 spots for children in centers who serve children starting at an age younger than five years old, and in Deuel County there are 65 spots.

Figure 32: Licensed Child Care and Preschool Programs in Nebraska Panhandle, as of 9/20/2019

	Number of Facilities	Total Capacity	Capacity for Children under 5
Banner County	0	0	0
Box Butte County	13	246	246
Cheyenne County	12	746	351
Dawes County	23	378	378
Deuel County	3	65	65
Garden County	3	84	44
Grant County	1	12	12
Kimball County	3	34	34
Morrill County	4	83	83
Scotts Bluff County	65	2,126	1,656
Sheridan County	10	127	127
Sioux County	0	0	0
Panhandle	**137**	**3,901**	**2,996**

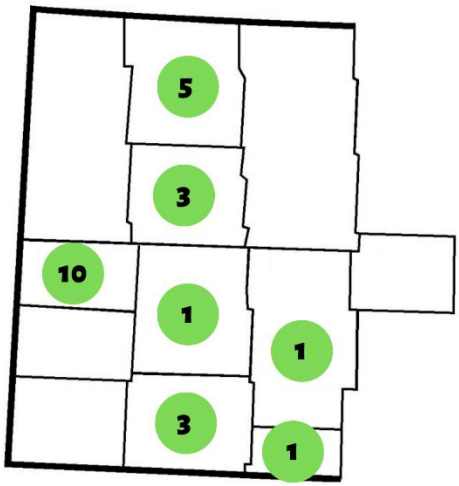
Source: Roster Of Licensed Child Care And Preschool Programs In Nebraska, Nebraska DHHS. Prepared By Kelsey Irvine, Panhandle Public Health District

STEP UP TO QUALITY

Nebraska Step Up to Quality is an early childhood quality rating and improvement system. The goal of the system is to improve early care and education quality and increase positive outcomes for young children.

As of September 2018, there were 24 Step Up to Quality programs in seven Panhandle counties. These 24 programs represent just 19% of the 128 childcare facilities who offer care to children starting at an age younger than five years old. There are 3 Step Up to Quality programs in Cheyenne County and one in Deuel County.

Figure 33: Panhandle Step Up to Quality Programs by County, as of 9/14/2019



Source: Nebraska Department Of Education. Prepared By Kelsey Irvine, Panhandle Public Health District

HOUSING

AGE OF HOUSING

The age of housing stock is related to population growth and employment growth. There is less new housing stock in the Panhandle when compared to the broader state of Nebraska.

Figure 34: Housing Age by Year Built, Panhandle Counties

	2014 or later	2010 to 2013	2000 to 2009	1990 to 1999	1980 to 1989	1970 to 1979	1960 to 1969	1950 to 1959	1940 to 1949	1939 or earlier
Banner County	0.5%	1.5%	8.4%	4.7%	4.0%	15.3%	6.9%	10.4%	17.3%	31.1%
Box Butte County	0.0%	0.8%	1.5%	4.2%	12.1%	26.2%	6.3%	10.7%	7.8%	30.4%
Cheyenne County	2.3%	0.3%	9.3%	7.1%	6.2%	7.8%	6.0%	22.4%	12.6%	26.0%
Dawes County	0.5%	2.2%	3.9%	7.6%	5.0%	11.7%	10.4%	9.6%	7.0%	42.2%
Deuel County	0.0%	0.4%	6.0%	1.8%	2.8%	7.1%	10.3%	14.8%	17.7%	39.1%
Garden County	0.0%	2.2%	10.3%	3.4%	4.3%	6.4%	11.4%	10.1%	10.7%	41.2%
Grant County	1.6%	2.6%	4.1%	5.2%	10.4%	7.5%	10.9%	8.3%	8.0%	41.5%
Kimball County	0.0%	0.5%	3.1%	10.7%	1.5%	9.2%	17.6%	24.0%	6.2%	27.2%
Morrill County	0.2%	1.3%	5.2%	3.8%	6.9%	16.9%	11.4%	7.8%	10.6%	36.0%
Scotts Bluff County	0.2%	0.9%	6.6%	7.0%	7.7%	21.3%	12.5%	12.7%	9.4%	21.7%
Sheridan County	0.0%	0.1%	5.6%	6.5%	5.3%	11.4%	9.1%	12.2%	8.7%	41.0%
Sioux County	0.4%	0.2%	7.8%	5.0%	8.0%	5.6%	4.4%	6.7%	8.7%	53.2%
Panhandle	**0.4%**	**0.9%**	**5.8%**	**6.3%**	**7.1%**	**16.6%**	**10.3%**	**13.3%**	**9.5%**	**29.7%**
Nebraska	**0.9%**	**2.6%**	**12.0%**	**11.5%**	**9.4%**	**16.2%**	**11.2%**	**9.7%**	**4.9%**	**21.4%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health District.

Housing stock built before 1979 is more common in rural areas such as the Panhandle. Lead in residential paints was banned in 1978, which means houses built in 1978 or earlier are more likely to contain lead-based paint, which can lead to lead poisoning in children. It is more common for low income peoples or people of color to live in older housing, due to affordability, which contributes to disproportionate lead poisoning in these populations.

Lead poisoning is highly toxic to young children under the age of six and interferes with brain and organ development. The negative impacts of lead poisoning are irreversible. There are methods of lead abatement that can prevent these impacts.

Cheyenne County has a higher rate of pre-1979 housing stock when compared to the overall state of Nebraska, and Deuel County has a higher rate when compared to both the region and the state.

Figure 35: Pre-1979 Housing Stock, Panhandle Counties

Banner County	81.0%
Box Butte County	81.4%
Cheyenne County	74.8%
Dawes County	80.9%
Deuel County	89.0%
Garden County	79.8%
Grant County	76.2%
Kimball County	84.2%
Morrill County	82.7%
Scotts Bluff County	77.6%
Sheridan County	82.4%
Sioux County	78.6%
Panhandle	**79.4%**
Nebraska	**63.4%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

HOUSING TENURE

The majority of housing in the Panhandle is owner-occupied, with higher rates of owner-occupied housing units compared to the overall state of Nebraska.

Figure 36: Housing Tenure, Panhandle Communities

	Occupied housing units	Owner-occupied	Renter-occupied
Banner County	300	68.3%	31.7%
Box Butte County	4,610	71.7%	28.3%
Cheyenne County	4,400	70.7%	29.3%
Dawes County	3,557	62.5%	37.5%
Deuel County	833	75.2%	24.8%
Garden County	897	80.4%	19.6%
Grant County	274	81.4%	18.6%
Kimball County	1,546	66.7%	33.3%
Morrill County	2,017	71.3%	28.7%
Scotts Bluff County	14,425	68.9%	31.1%
Sheridan County	2,306	70.3%	29.7%
Sioux County	579	75.6%	24.4%
Nebraska	**748,405**	**66.0%**	**34.0%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District

EXCESSIVE HOUSING COST BURDEN

Housing costs that exceed 30% of household income are typically viewed as an indicator of housing affordability problems. Across Panhandle counties, there are significantly more renters than owners at lower income levels for which housing costs are 30% or more of household income. This is in line with the trend across the state of Nebraska as well. Cheyenne County has one of the highest rates of renter-occupied households with income less than $20,000 whose housing costs make up more than 30% of their household income.

Figure 37: Monthly Housing Costs as 30% or more of Household Income in the Past 12 Months, by Income Level

	Less than $20,000	$20,000 to $34,999	$35,000 to $49,999	$50,000 to $74,999	$75,000 or more
Deuel County					
Owner-occupied	6.2%	9.4%	0.5%	0.3%	0.0%
Renter-occupied	6.8%	9.7%	0.0%	0.0%	0.0%
Cheyenne County					
Owner-occupied	6.7%	4.4%	1.9%	1.4%	0.5%
Renter-occupied	19.5%	7.5%	1.4%	0.0%	0.0%
Nebraska					
Owner-occupied	**5.6%**	**4.7%**	**3.3%**	**2.7%**	**1.4%**
Renter-occupied	**20.8%**	**13.3%**	**3.9%**	**1.1%**	**0.2%**

Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

CHILD WELFARE

CHILD MALTREATMENT

In 2017, Deuel County was one of six Panhandle counties that had a child maltreatment rate higher than that of the state of Nebraska. The rate of child maltreatment in Panhandle communities can vary widely year-to-year due to small county numbers, but the rate has generally decreased over time.

Figure 38: Child Maltreatment Rate* (Per 1,000 Children), Panhandle Counties

	2010	2011	2012	2013	2014	2015	2016	2017
Banner County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Box Butte County	7.0	14.4	7.8	3.5	3.8	2.1	2.5	9.8
Cheyenne County	5.5	6.7	6.9	3.2	3.3	4.1	2.1	3.0
Dawes County	16.0	12.0	17.5	7.8	5.4	4.3	4.3	3.9
Deuel County	2.5	21.8	4.7	9.6	2.5	2.5	2.6	10.2
Garden County	0.0	5.3	17.1	0.0	0.0	0.0	8.2	8.0
Grant County	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kimball County	7.0	15.5	19.7	14.8	8.5	0.0	6.1	5.0
Morrill County	8.2	7.4	13.4	7.6	6.7	7.6	5.1	9.6
Scotts Bluff County	17.9	21.8	17.0	6.9	9.4	10.5	9.7	8.9
Sheridan County	3.9	12.3	5.8	6.0	5.9	6.9	1.7	11.9
Sioux County	0.0	0.0	3.3	0.0	0.0	0.0	8.0	0.0
Nebraska	**11.2**	**11.4**	**9.3**	**6.2**	**5.5**	**7.9**	**7.9**	**7.6**

*Number of Substantiated Victims Of Child Maltreatment. Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District

The rate of state wards (per 1,000 children) in Cheyenne County has remained below that of the broader state of Nebraska from year to year. The rate of state wards in Deuel County has been higher across the years, and was much higher in 2017 than the state of Nebraska.

Figure 39: State Wards, Rate per 1,000 Children, Panhandle Counties

	2011	2012	2013	2014	2015	2016	2017
Banner County	0.0	6.7	0.0	13.8	12.4	12.3	5.7
Box Butte County	11.2	10.6	5.6	4.5	4.5	4.9	4.4
Cheyenne County	17.6	12.6	10.9	11.4	11.1	13.3	13.9
Dawes County	14.2	9.4	7.2	11.4	5.6	9.2	12.2
Deuel County	21.8	16.4	16.8	12.3	9.9	10.3	20.3
Garden County	5.3	11.4	12.1	5.9	5.7	16.4	26.6
Grant County	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kimball County	32.2	26.6	16.0	18.3	17.5	13.4	8.8
Morrill County	9.9	7.5	8.4	5.1	3.4	6.0	9.6
Scotts Bluff County	28.2	22.6	21.2	17.9	18.4	22.2	24.0
Sheridan County	9.0	10.0	7.7	14.3	15.5	11.0	11.0
Sioux County	0.0	3.3	10.0	0.0	0.0	0.0	0.0
Nebraska	**21.2**	**20.0**	**18.2**	**16.1**	**14.4**	**15.2**	**15.0**

Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared By Kelsey Irvine, Panhandle Public Health District

Removal from the home is a traumatic event for a child, with lasting impacts. In an effort to keep more children in the home with their parents, some children are involved in the child welfare system on a non-court basis. This means they stay in the home, and may not have a substantiated incident of child maltreatment, but are able to receive services as a measure to prevent potential future incidents of child maltreatment. In the Panhandle, Cheyenne County had a higher rate of children with non-court welfare involvement in 2013 and 2017 when compared to that of the state. The rate in Deuel County decreased from 2013 to 2017.

Figure 40: Children with Non-Court Child Welfare Involvement, 2013 & 2017, Panhandle Counties

	2013	Rate per 1,000 children	2017	Rate per 1,000 children
Banner County	0	0.0	0	0.0
Box Butte County	21	7.4	14	5.1
Cheyenne County	29	11.7	18	7.8
Dawes County	21	12.6	1	0.6
Deuel County	7	16.8	0	0.0
Garden County	2	6.0	5	13.3
Grant County	0	0.0	0	0.0
Kimball County	25	30.8	1	1.3
Morrill County	15	12.6	10	8.7
Scotts Bluff County	201	22.0	30	3.3
Sheridan County	23	19.6	1	0.8
Sioux County	0	0.0	0	0.0
Nebraska	**4,348**	**9.4**	**3,296**	**6.9**

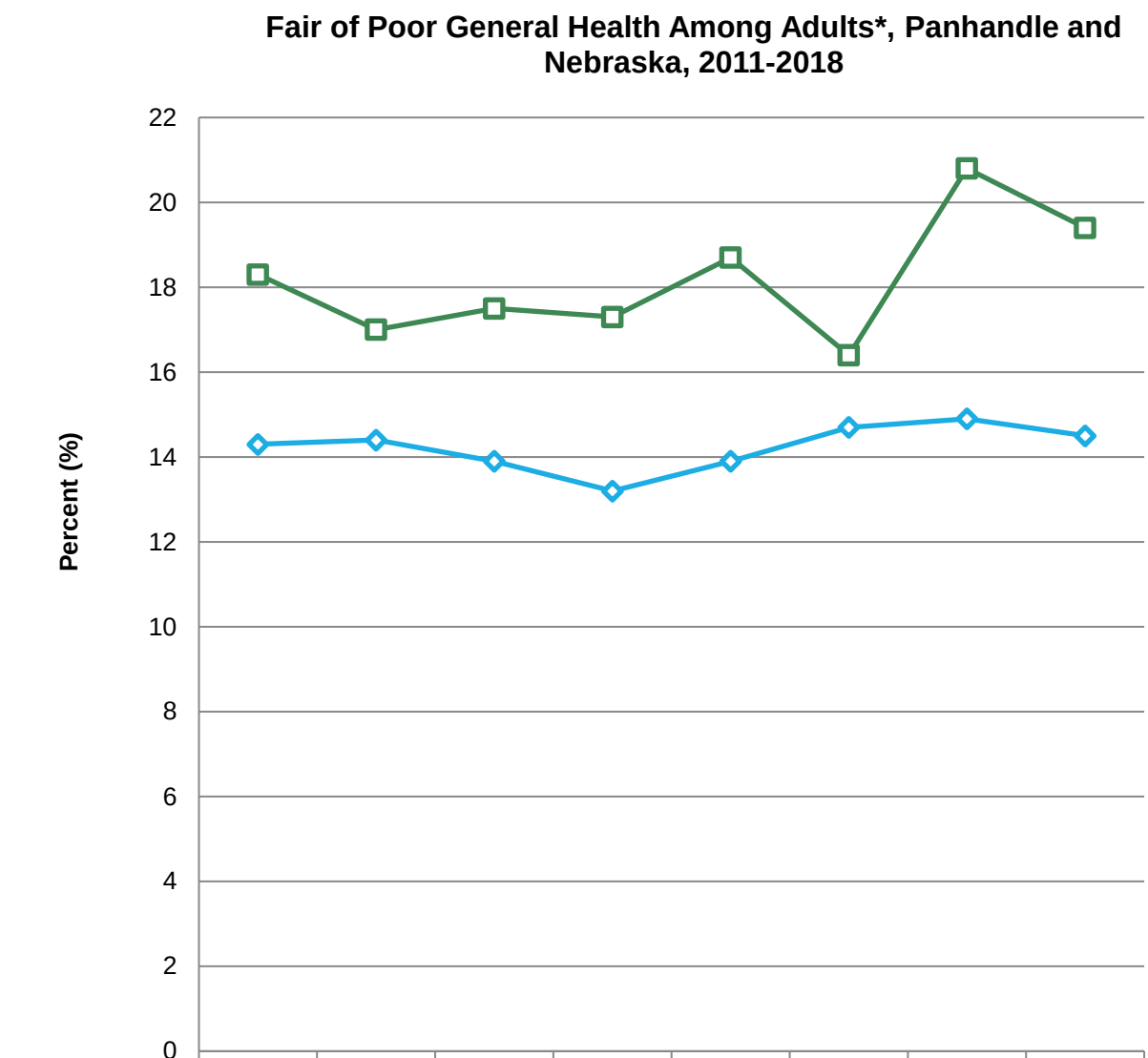
Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared by Kelsey Irvine, Panhandle Public Health District

GENERAL HEALTH STATUS

HEALTH-RELATED QUALITY OF LIFE

The percentage of adults who report their general health as fair or poor in the Panhandle has increased over the years, but saw a dip in 2016 and 2018. This percentage is historically higher in the Panhandle when compared to the state of Nebraska, with a significant difference between the two in 2011, 2013, 2014, 2015 2017, and 2018.

Figure39: Fair of Poor General Health Among Adults

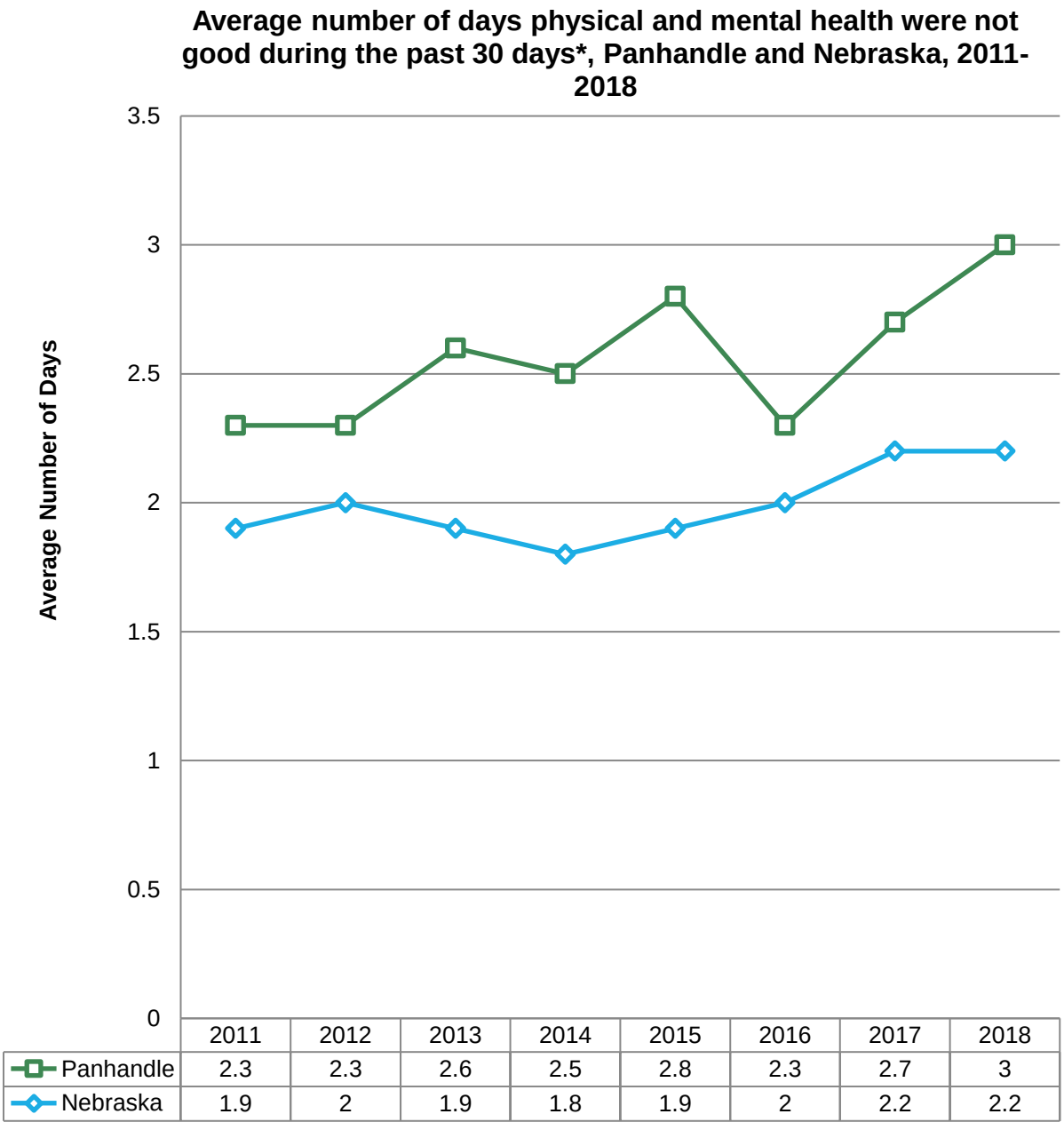


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	18.3	17	17.5	17.3	18.7	16.4	20.8	19.4
Nebraska	14.3	14.4	13.9	13.2	13.9	14.7	14.9	14.5

*Percentage of adults 18 and older who reported their general health is fair or poor. Data from 2011-2018 Nebraska Behavioral Risk Factors Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District

The average number of days that physical and mental health limited the usual activities of Panhandle adults in the past 30 days has slowly increased from 2011 to 2018. This number is historically higher in the Panhandle than across the broader state of Nebraska, although a decrease was seen in 2016. However, the average number of days has continued to rise since then.

Figure 40: Average Number of Days Physical and Mental Health were not Good During the Past 30 Days



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	2.3	2.3	2.6	2.5	2.8	2.3	2.7	3
Nebraska	1.9	2	1.9	1.8	1.9	2	2.2	2.2

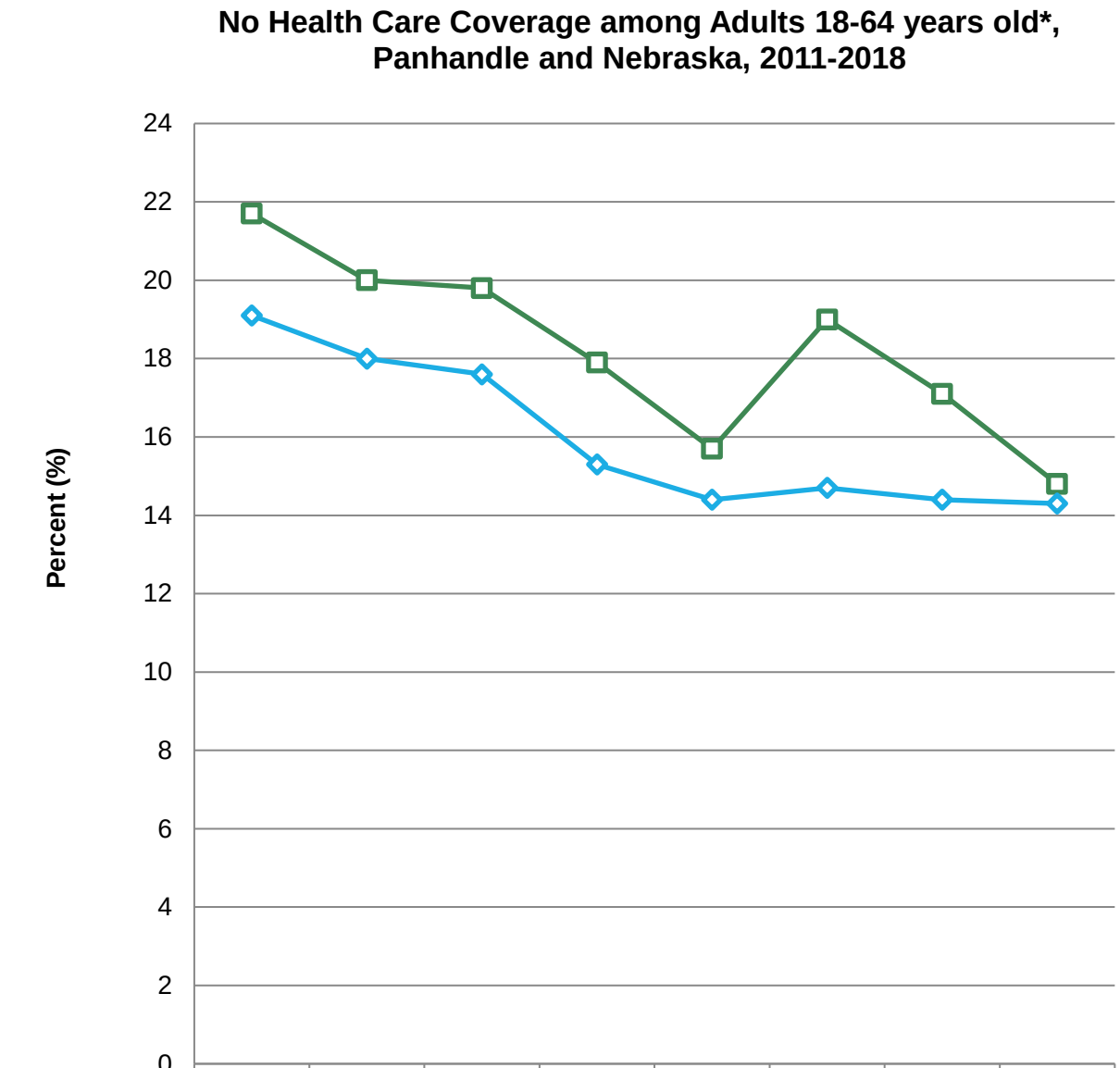
*Average number of days during the previous 30 that adults 18 or older report (1) their physical health (illness and injury) was not good and (2) their mental health (including stress, depression, and emotions) was not good. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

HEALTHCARE ACCESS AND UTILIZATION

HEALTHCARE COVERAGE

The percentage of adults who report they do not have health care coverage is historically higher in the Panhandle when compared to the broader state of Nebraska. However, this number has decreased over the years, outside of a noticeable jump in 2016. In 2018, the percentage was nearly equal to that of the state.

Figure 411: No Health Care Coverage Among Adults 18-64 Years Old



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	21.7	20	19.8	17.9	15.7	19	17.1	14.8
Nebraska	19.1	18	17.6	15.3	14.4	14.7	14.4	14.3

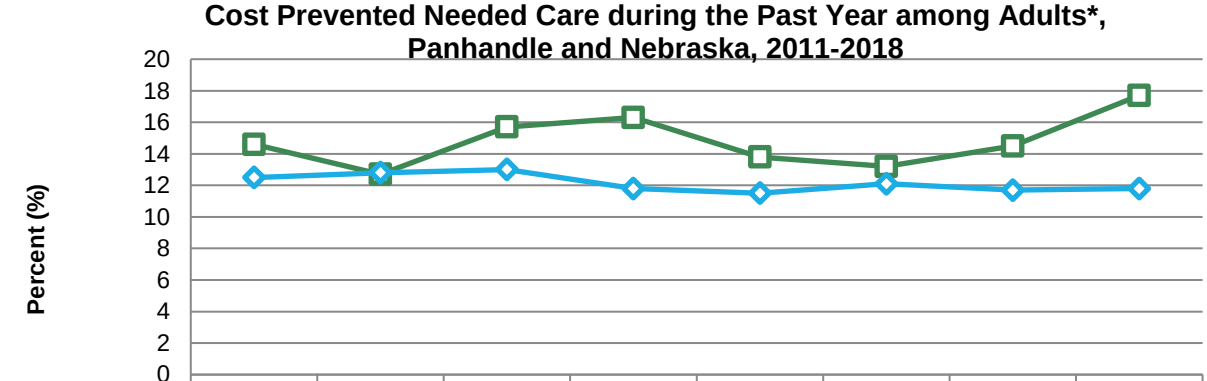
*Percentage of adults 18-64 years old who reoprt that they do not have any kind of health care coverage. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

BARRIERS TO HEALTHCARE

COST AS A BARRIER TO CARE

The percentage of Panhandle adults who report they are unable to seek medical care due to cost has increased after hitting a low point in 2016. There was a significant difference between the percentage of adults who reported they could not seek medical care due to cost in 2014 and 2018 in the Panhandle when compared to the state of Nebraska. This could be due to complete lack of health insurance or out-of-pocket costs for those who do have health insurance coverage, such as co-pays or deductibles.

Figure 42: Cost Prevented Needed Care During the Past Year Among Adults



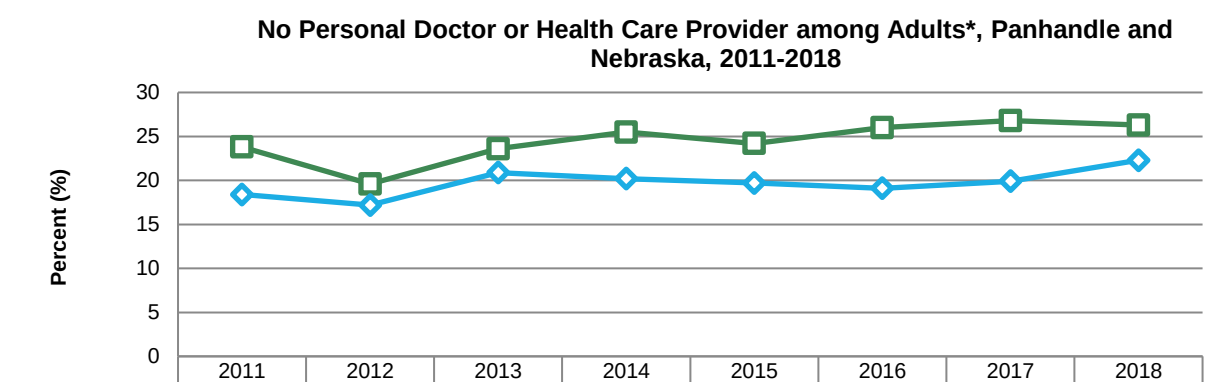
	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	14.6	12.7	15.7	16.3	13.8	13.2	14.5	17.7
Nebraska	12.5	12.8	13	11.8	11.5	12.1	11.7	11.8

*Percentage of adults 18 and older who report that they needed to see a doctor but could not because of cost in the past 12 months. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

LACK OF PERSONAL HEALTHCARE PROVIDER

The percentage of adults who report they do not have a primary care provider has slowly increased over the years in the Panhandle, and is historically higher than the broader state of Nebraska.

Figure 43: No Personal Doctor or Health Care Provider among Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	23.8	19.6	23.6	25.5	24.2	26	26.8	26.3
Nebraska	18.4	17.2	20.9	20.2	19.7	19.1	19.9	22.3

*Percentage of adults 18 and older who report that they do not have a personal doctor or health care provider. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

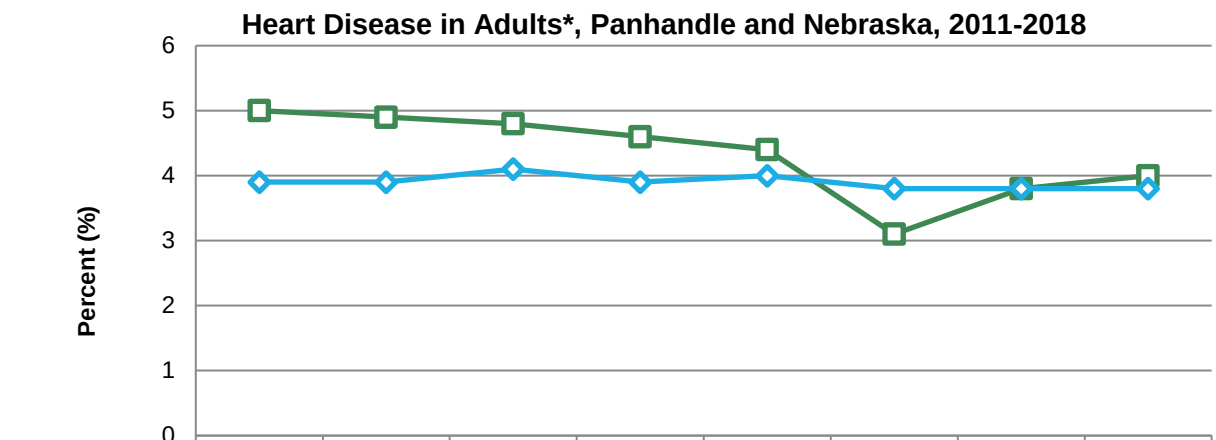
CHRONIC DISEASE

CARDIOVASCULAR DISEASE

Heart disease is the leading cause of death across the world and the United States. In the United States, one person dies every 37 second from heart disease.[1]

The rate of heart disease in Panhandle adults has decreased over the years, and is relatively similar to the overall rate in the state of Nebraska.

Figure 44: Heart Disease in Adults



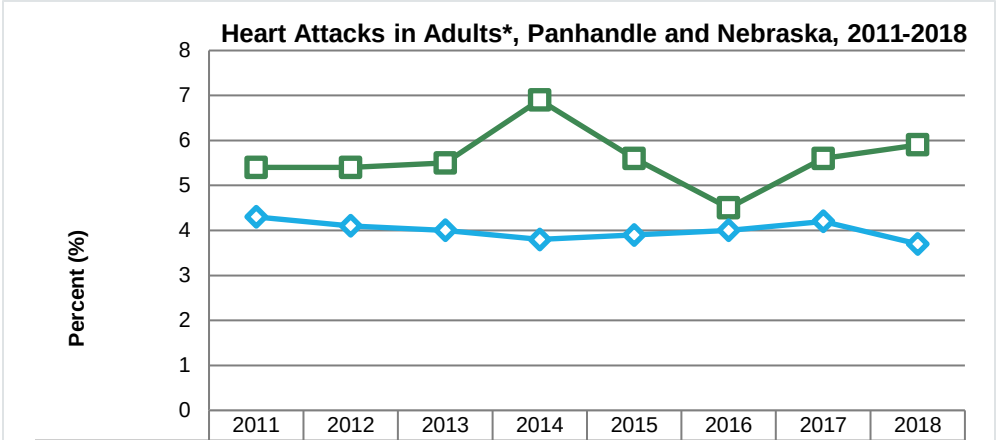
	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	5	4.9	4.8	4.6	4.4	3.1	3.8	4
Nebraska	3.9	3.9	4.1	3.9	4	3.8	3.8	3.8

*Percentage of adults 18 and older who report they have ever had angina or coronary heart disease. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

HEART ATTACKS

The percentage of Panhandle adults who have ever had a heart attack is historically higher when compared to the state of Nebraska. There were significant differences in 2014, 2015, and 2018.

Figure 45: Heart Attacks in Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	5.4	5.4	5.5	6.9	5.6	4.5	5.6	5.9
Nebraska	4.3	4.1	4	3.8	3.9	4	4.2	3.7

*Percentage of adults 18 and older who report that they have ever been told by a doctor, nurse, or other health professional that they had a heart attack or myocardial infarction. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

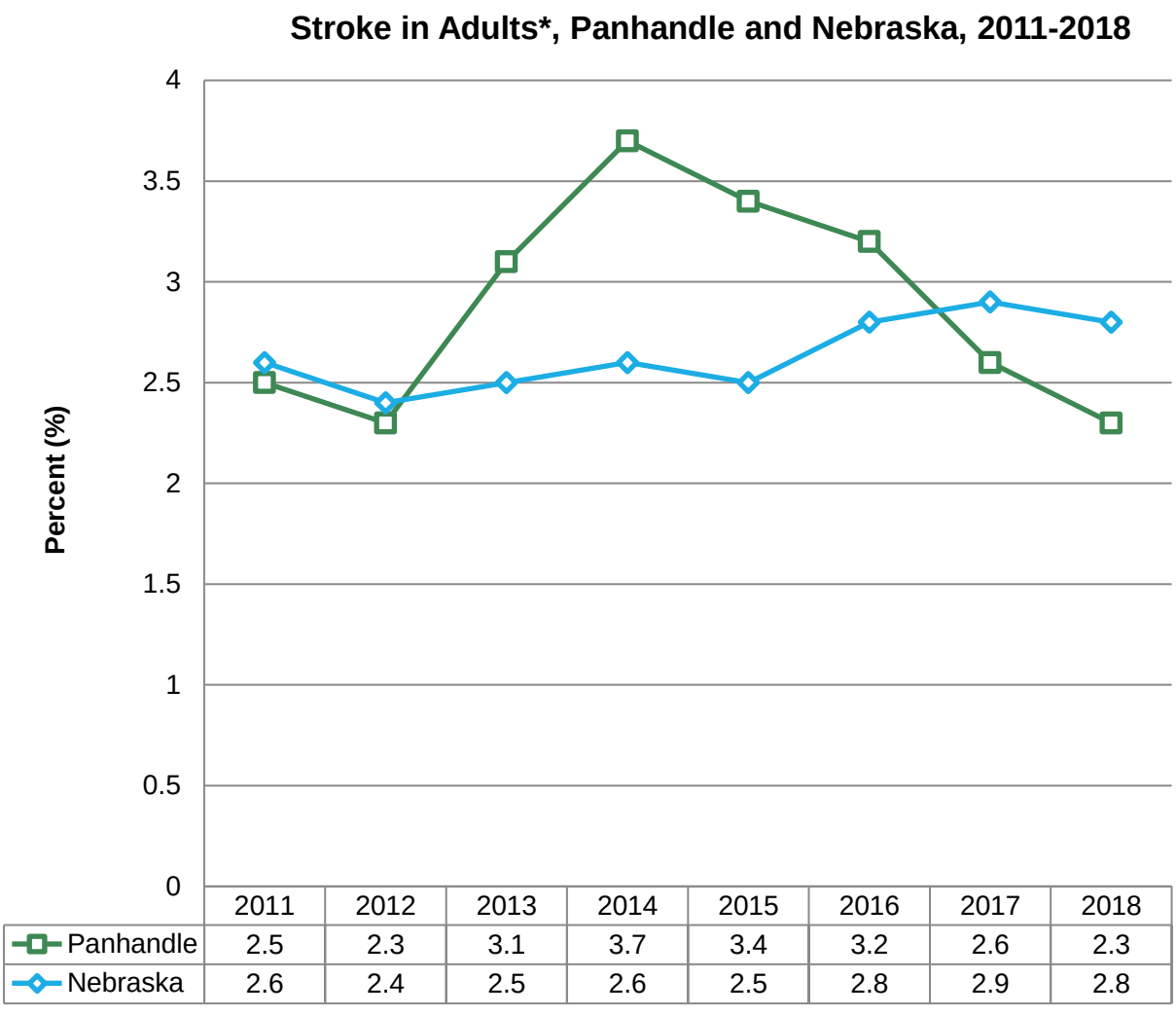
[1] CDC. (2020). Heart Disease Facts. Retrieved from: https://www.cdc.gov/heartdisease/facts.htm

STROKE

Stroke is a type of heart disease where blood supply to a part of the brain is blocked, or when a blood vessel in the brain bursts. This leads to brain damage, and can cause severe disability or even death.[2]

The rate of Panhandle adults who report they have ever had a stroke has steadily decreased since 2014, and is now lower than the broader state of Nebraska.

Figure 46: Stroke in Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	2.5	2.3	3.1	3.7	3.4	3.2	2.6	2.3
Nebraska	2.6	2.4	2.5	2.6	2.5	2.8	2.9	2.8

*Percentage of adults 18 and older who report they were ever told they had a stroke. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

[2] CDC. (2020). About Stroke. Retrieved from: https://www.cdc.gov/stroke/about.htm

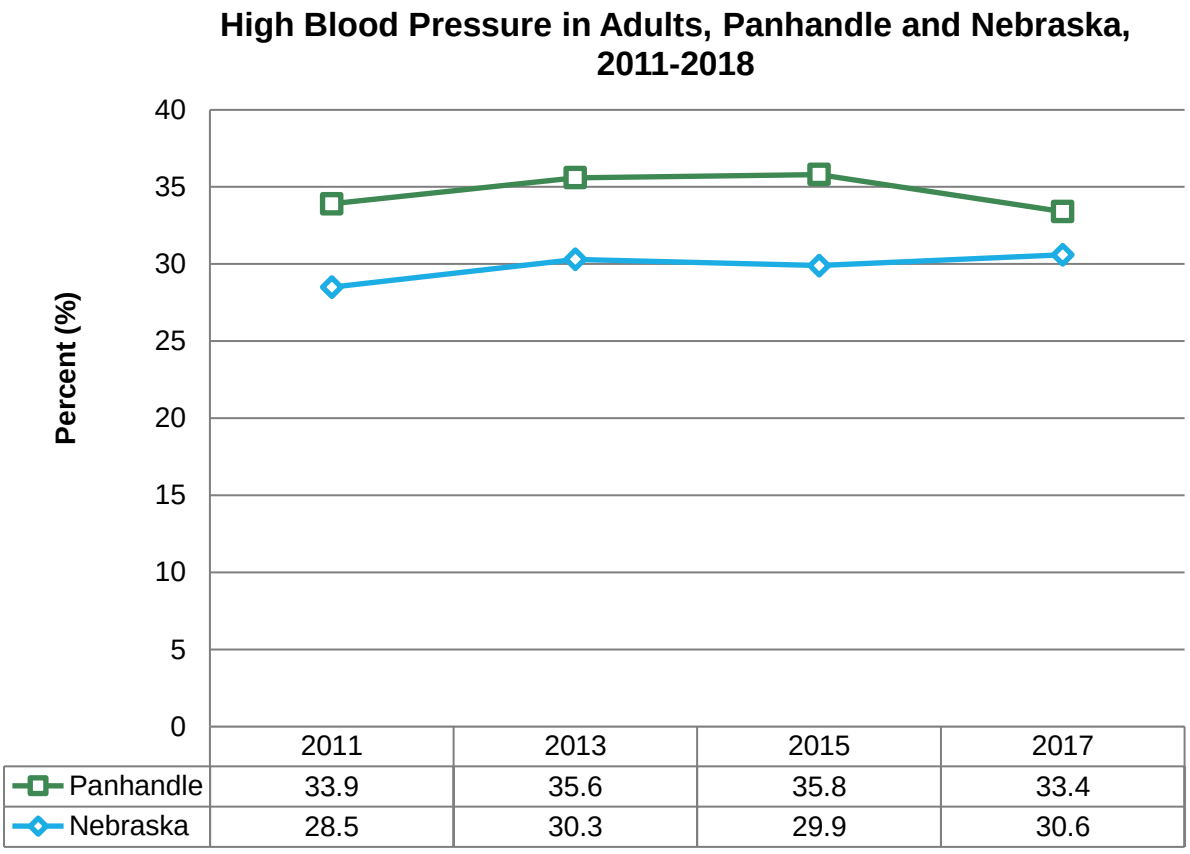
CLINICAL RISK FACTORS FOR HEART DISEASE

HIGH BLOODO PRESSURE (HYPERTENSION)

High blood pressure is defined as having a blood pressure of 140/90 mm Hg or higher. High blood pressure (hypertension) is a risk factor for heart disease. Almost half of US adults have high blood pressure and only about 25% of these people their high blood pressure under control.[3]

Panhandle adults historically report having high blood pressure at higher rates than adults across the broader state of Nebraska, although a slight decrease was seen from 2015 to 2017.

Figure 47: High Blood Pressure in Adults



*Percentage of adults 18 and older who report they were ever told they had a stroke. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

Several programs offered in the Panhandle benefit those with high blood pressure. The National Diabetes Prevention Program is an appropriate program for those with high blood pressure, and assists with developing healthy diet and exercise habits. Living Well, a chronic-disease self-management program, can help people manage medications, deal with stress from a chronic condition, and eat well and exercise.

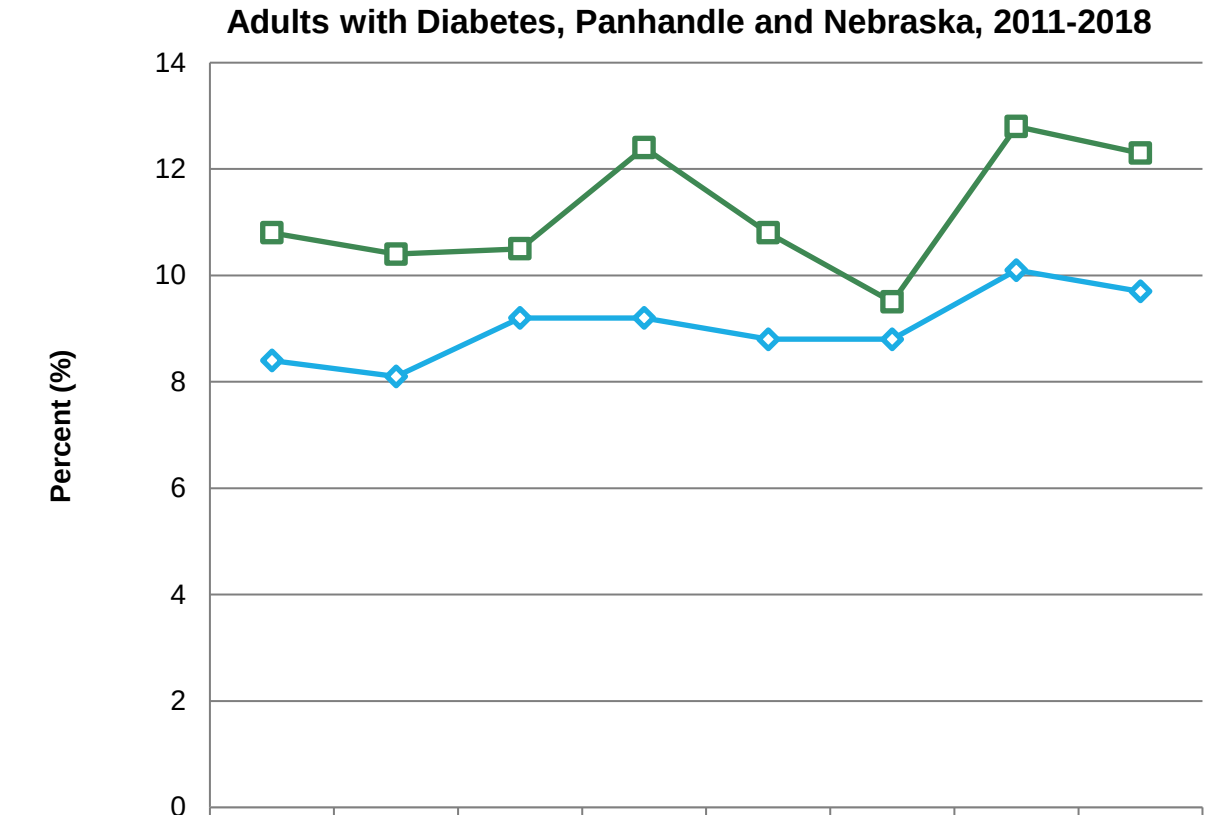
[3] CDC. (2020). Facts About Hypertension. Retrieved from: https://www.cdc.gov/bloodpressure/facts.htm

DIABETES

Diabetes is a chronic illness in which blood glucose levels are above normal. There are two types of diabetes: type 1 and type 2. Type 1 diabetes, often referred to as juvenile-onset diabetes, occurs when the body cannot produce its own insulin, and makes up approximately 5-10% of diagnosed diabetes cases. Type 2 diabetes, also known as adult-onset diabetes, makes up 90-95% of diagnosed diabetes cases. Gestational diabetes is a form of diabetes that occurs in pregnant women, but generally disappears when pregnancy ends.[4]

The rate of diabetes in Panhandle adults decreased from 2014 to 2016, but has increased since. The rate of diabetes is historically higher in the Panhandle when compared to the state of Nebraska. There was a significant difference between the Panhandle and the state in 2011, 2014, and most recently in 2017.

Figure 48: Adults with Diabetes



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	10.8	10.4	10.5	12.4	10.8	9.5	12.8	12.3
Nebraska	8.4	8.1	9.2	9.2	8.8	8.8	10.1	9.7

*Percentage of adults 18 and older who report they were ever told they have diabetes (excluding pregnancy). Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health

The National Diabetes Prevention Program in the Panhandle aims to decrease the number of adults who develop type 2 diabetes through diet and exercise.

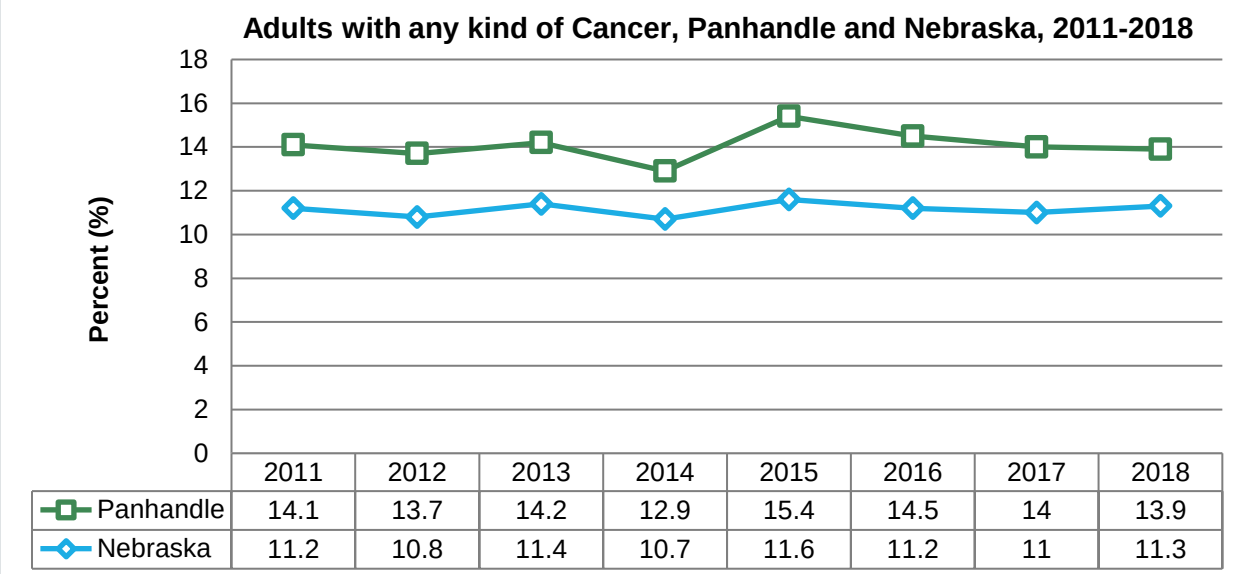
[4] CDC. (2020). What is Diabetes? Retrieved from: https://www.cdc.gov/diabetes/basics/diabetes.html

CANCER

"Cancer is a term used for diseases in which abnormal cells divide without control and can invade other tissues".[5] Cancer spreads throughout the body through the blood and lymph system. Cancer is not only one disease—there are more than 100 types of cancers.

The percentage of adults who were ever told they have any kind of cancer has remained relatively even in the Panhandle from 2011, with only a slight uptick in 2015. There is a significant difference between the Panhandle and the state in every year except for 2018, with the Panhandle higher in every year.

Figure 49: Adults with any kind of Cancer



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	14.1	13.7	14.2	12.9	15.4	14.5	14	13.9
Nebraska	11.2	10.8	11.4	10.7	11.6	11.2	11	11.3

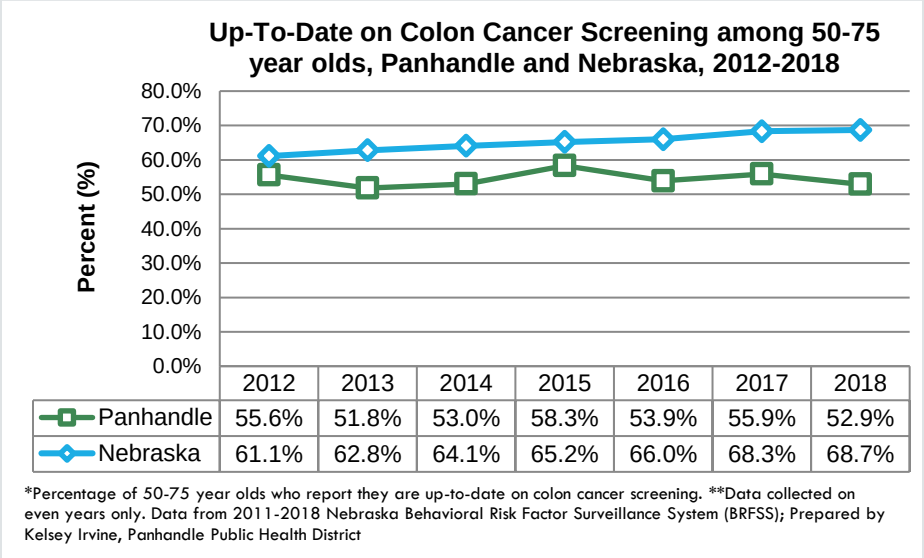
*Percentage of adults 18 and older who report they were ever told they have any kind of cancer. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

CANCER SCREENING

COLON CANCER SCREENING

The percentage of adults 50-75 years old who report being up to date on colon cancer screening is much lower in the Panhandle than across the state of Nebraska, and has decreased slightly in recent years.

Figure 50: Up-to-date on Colon Cancer Screening



	2012	2013	2014	2015	2016	2017	2018
Panhandle	55.6%	51.8%	53.0%	58.3%	53.9%	55.9%	52.9%
Nebraska	61.1%	62.8%	64.1%	65.2%	66.0%	68.3%	68.7%

*Percentage of 50-75 year olds who report they are up-to-date on colon cancer screening. **Data collected on even years only. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

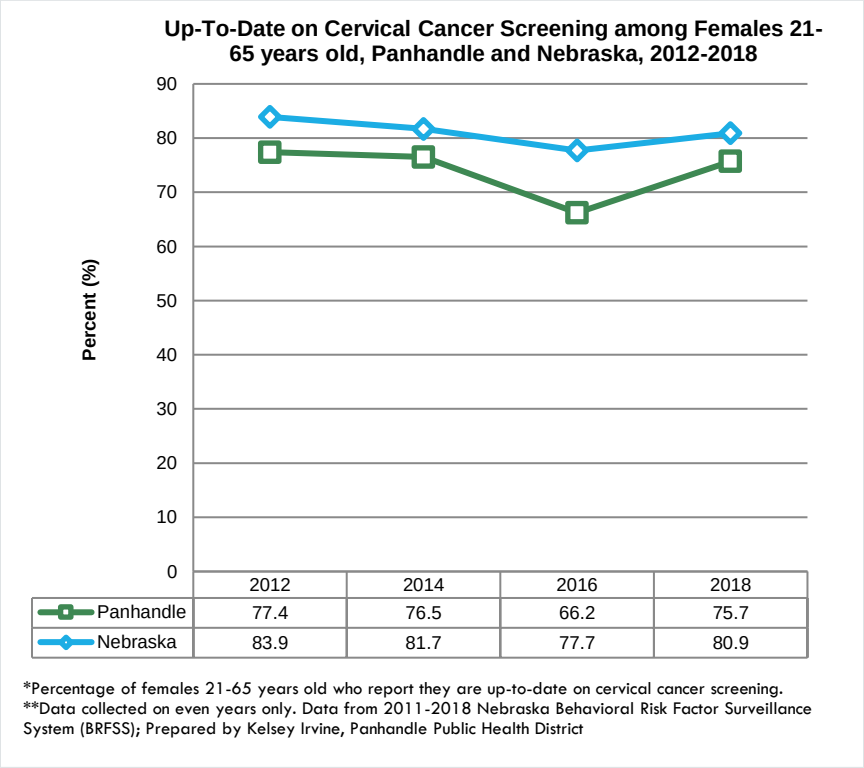
[5] CDC. (2020). How to Prevent Cancer or Find it Early. Retrieved from: https://www.cdc.gov/cancer/dcpc/prevention/index.htm

CERVICAL CANCER SCREENING

The percentage of females 21-65 years old that are up to date on cervical cancer screening is also lower in the Panhandle when compared to the state of Nebraska. While lower overall, trends in the Panhandle tend to echo trends at the state level, with a decrease from 2012-2016, and an uptick from 2016-2018.

Guidance on when cervical cancer screening (pap smear) should begin and how often it should occur has changed in recent years, which likely contributed to the pronounced decrease that was seen in 2016.

Figure 51: Up-To-Date on Cervical Cancer Screening

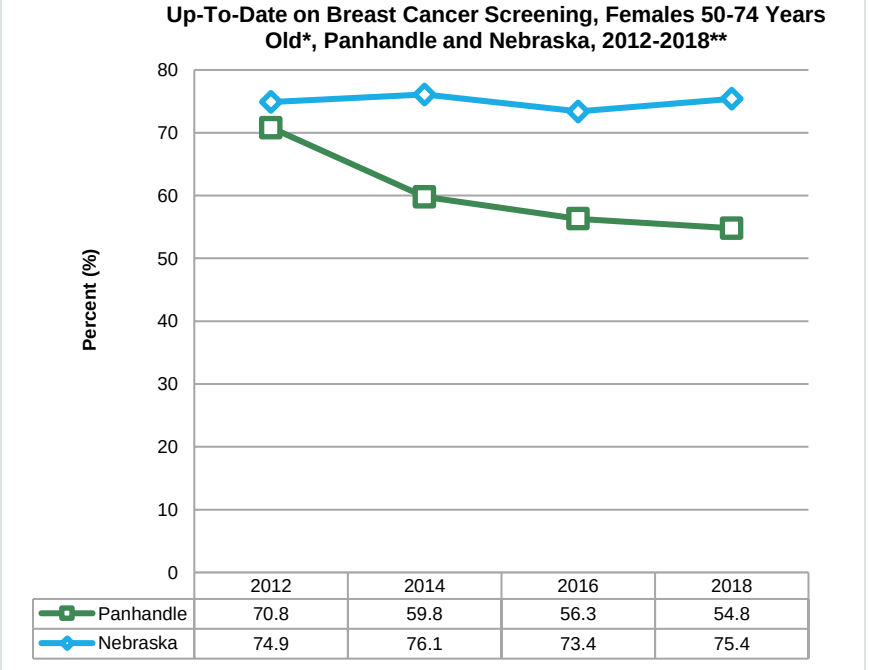


*Percentage of females 21-65 years old who report they are up-to-date on cervical cancer screening.
**Data collected on even years only. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

BREAST CANCER SCREENING

The percentage of females aged 50-74 who report being up-to-date on breast cancer screening in the Panhandle has decreased from 2012 to 2018, always remaining lower than the state percentage. Although the percentage that was up-to-date on breast cancer screening in the Panhandle in 2012 was relatively close to that of the state (70.8% vs. 74.9%), this gap widened in 2014 to an almost 20% difference (59.8% for the Panhandle vs. 76.1% for the state). Notably, the state percentage has remained relatively even while the Panhandle has decreased.

Figure 52: Up-to-Date on Breast Cancer Screening



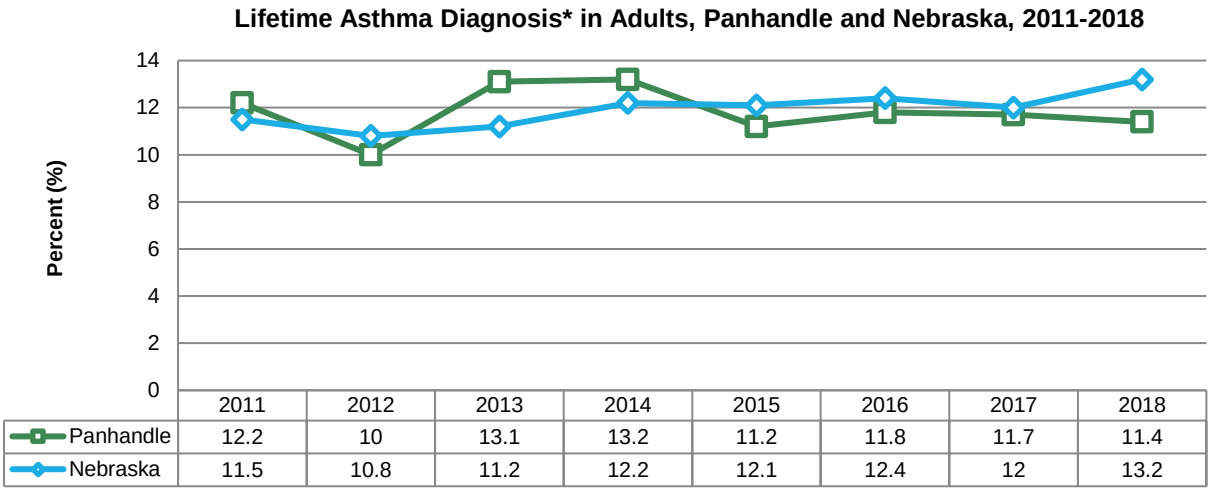
*Percentage of females 50-74 years old who report they are up-to-date on breast cancer screening. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

ASTHMA

Asthma is a disease that impact the lungs, causing repeated episodes of breathlessness, wheezing, nighttime or early morning coughing, and chest tightness. It can be controlled through medication and avoiding triggers of asthma attacks.[6]

Adults who have ever been diagnosed with asthma (lifetime asthma diagnosis) has decreased slightly in the Panhandle overall, from 12.2% in 2011 to 11.4% in 2018. It was slightly lower in 2018 when compared to the overall state of Nebraska.

Figure 53: Lifetime Asthma Diagnosis in Adults

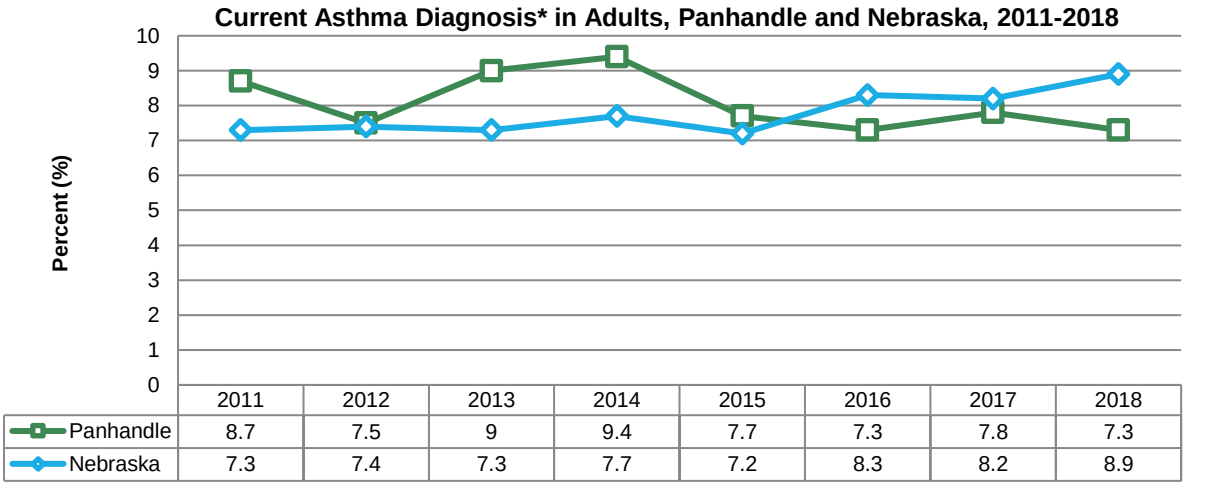


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	12.2	10	13.1	13.2	11.2	11.8	11.7	11.4
Nebraska	11.5	10.8	11.2	12.2	12.1	12.4	12	13.2

*Percentage of adults 18 and older who report they were ever told they have asthma. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

Adults who currently have asthma has also decreased in the Panhandle from 2011 to 2018, and was also slightly lower that the state in 2018.

Figure 54: Current Asthma Diagnosis in Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	8.7	7.5	9	9.4	7.7	7.3	7.8	7.3
Nebraska	7.3	7.4	7.3	7.7	7.2	8.3	8.2	8.9

*Percentage of adults 18 and older who report they currently have asthma. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

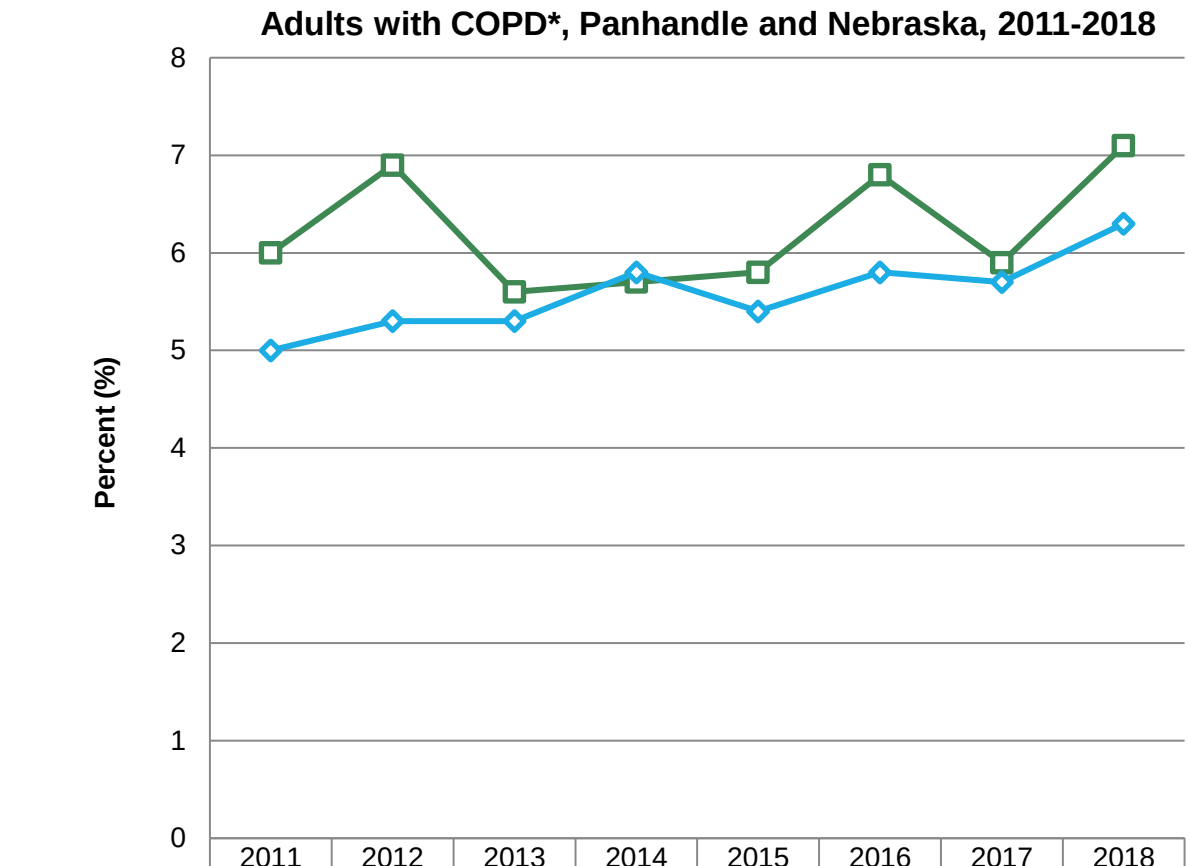
[6] CDC. (2020). Asthma. Retrieved from: https://www.cdc.gov/asthma/default.htm

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease (COPD) is a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema and chronic bronchitis.[7]

Nearly 16 million Americans are diagnosed with COPD, although the actual number with the disease may be higher. There is no cure for COPD, but it is treatable.

Figure 55: Adults with COPD



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	6	6.9	5.6	5.7	5.8	6.8	5.9	7.1
Nebraska	5	5.3	5.3	5.8	5.4	5.8	5.7	6.3

*Percentage of adults 18 and older who report they have ever been told by a doctor, nurse, or other health professional that they have chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

The percentage of adults in the Panhandle with COPD is slightly higher than the overall state of Nebraska.

One risk factor for COPD is age, with people aged 65 and older at higher risk for the disease. The Panhandle has a larger population of older adults when compared to the overall state of Nebraska, which may contribute to the higher rates of COPD in the region.

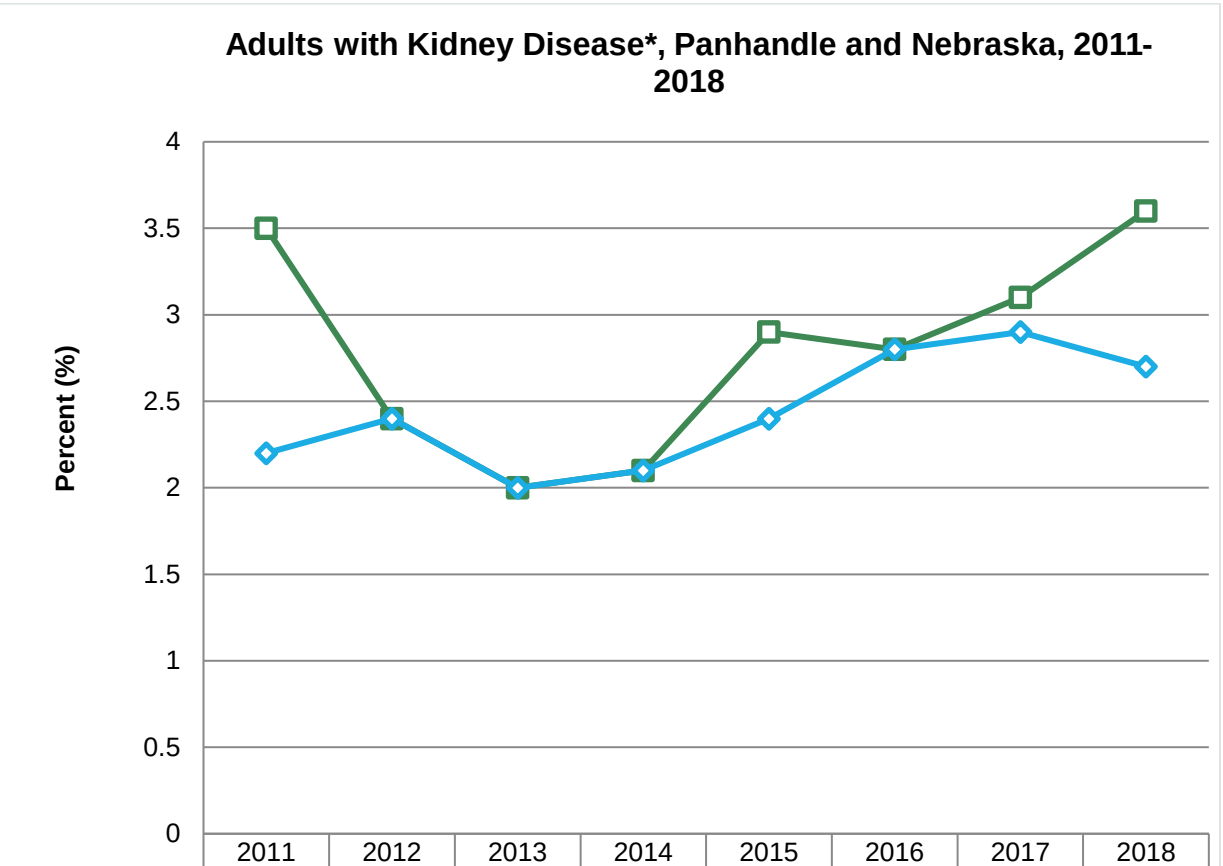
[7] CDC. (2018). Chronic Obstructive Pulmonary Disease. Retrieved from: https://www.cdc.gov/copd/index.html

KIDNEY DISEASE

Kidney disease means that your kidneys are damaged, and you are unable to filter blood the way that you should. This damage to your kidneys can cause wastes to build up in your body, among other things. Kidney disease may lead to kidney failure, which is only treatable with dialysis or a kidney transplant. More than 30 million American adults may have chronic kidney disease. Risk factors for kidney disease include: diabetes, high blood pressure, heart disease, and family history of kidney failure.[8]

The percentage of adults in the Panhandle who have been diagnosed with kidney disease has increased from 2013 to 2018, and has been higher when compared to the overall state of Nebraska in recent years.

Figure 56: Adults with Kidney Disease



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	3.5	2.4	2	2.1	2.9	2.8	3.1	3.6
Nebraska	2.2	2.4	2	2.1	2.4	2.8	2.9	2.7

*Percentage of adults 18 and older who report they were ever told they have kidney disease. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

[8] NIH. (2017). What is Chronic Kidney Disease? Retrieved from: https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease

RISK AND PROTECTIVE FACTOR FOR CHRONIC DISEASE

TOBACCO USE

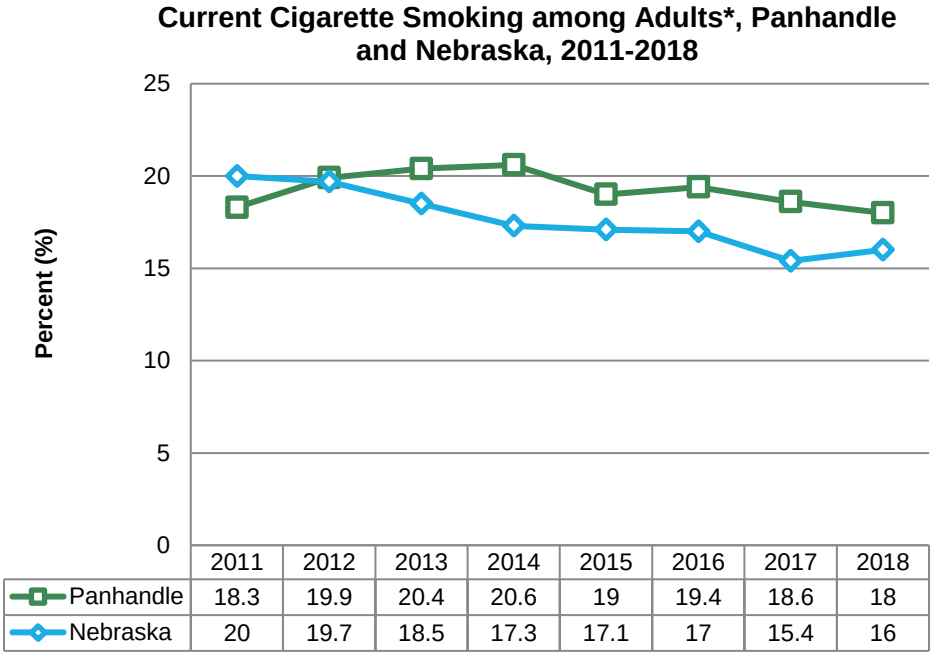
Tobacco use is the top cause of preventable death, disease, and disability in the United States. Smoking-related illness costs the US over $300 billion each year, including $170 billion in direct medical costs.[9]

ADULT TOBACCO USE

The percentage of adults who report smoking in the Panhandle was lower in 2011 and 2012, but has been higher when compared to the overall state of Nebraska from 2013 to 2018. However, the percentage of adults who smoke has gradually been decreasing since 2014, with a more than 2-point decrease from 2014 to 2018.

Smokeless tobacco use (chew, snuff, snus) has been consistently higher in the Panhandle when compared to the overall state of Nebraska, with a marked increase from 2014 to 2017. There has been a slight downward trend from 2017 to 2018. While the use of smokeless tobacco across the state has remained relatively flat, use in the Panhandle has seen more increases and decreases.

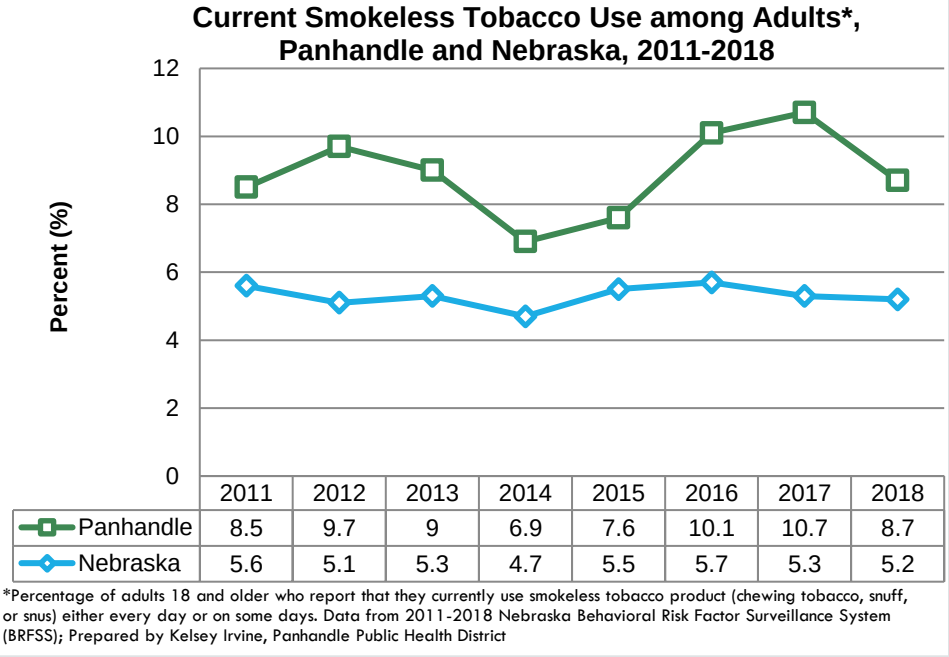
Figure 57: Current Cigarette Smoking Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	18.3	19.9	20.4	20.6	19	19.4	18.6	18
Nebraska	20	19.7	18.5	17.3	17.1	17	15.4	16

*Percentage of adults 18 and older who report that they currently smoke cigarettes either every day or on some days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public

Figure 58: Current Smokeless Tobacco Use Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	8.5	9.7	9	6.9	7.6	10.1	10.7	8.7
Nebraska	5.6	5.1	5.3	4.7	5.5	5.7	5.3	5.2

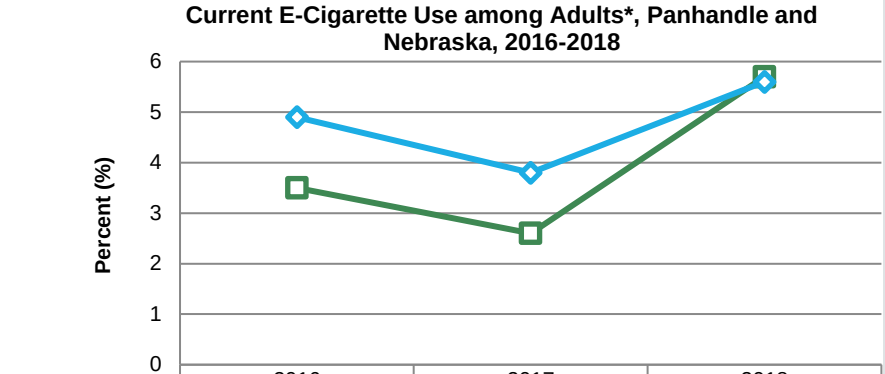
*Percentage of adults 18 and older who report that they currently use smokeless tobacco product (chewing tobacco, snuff, or snus) either every day or on some days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

[9] CDC. (2019). Tobacco Use. Retrieved from: https://www.cdc.gov/chronicdisease/resources/publications/factsheets/tobacco.htm

ADULT E-CIGARETTE USE

Data on adult e-cigarette use has only been collected for a handful of years. Since 2016, the percentage of Panhandle adults who report current use of e-cigarettes has increased slightly, from 3.5% to 5.7%, and in 2018 was essentially even to that of the overall state of Nebraska.

Figure 59: Current E-Cigarette Use Among Adults

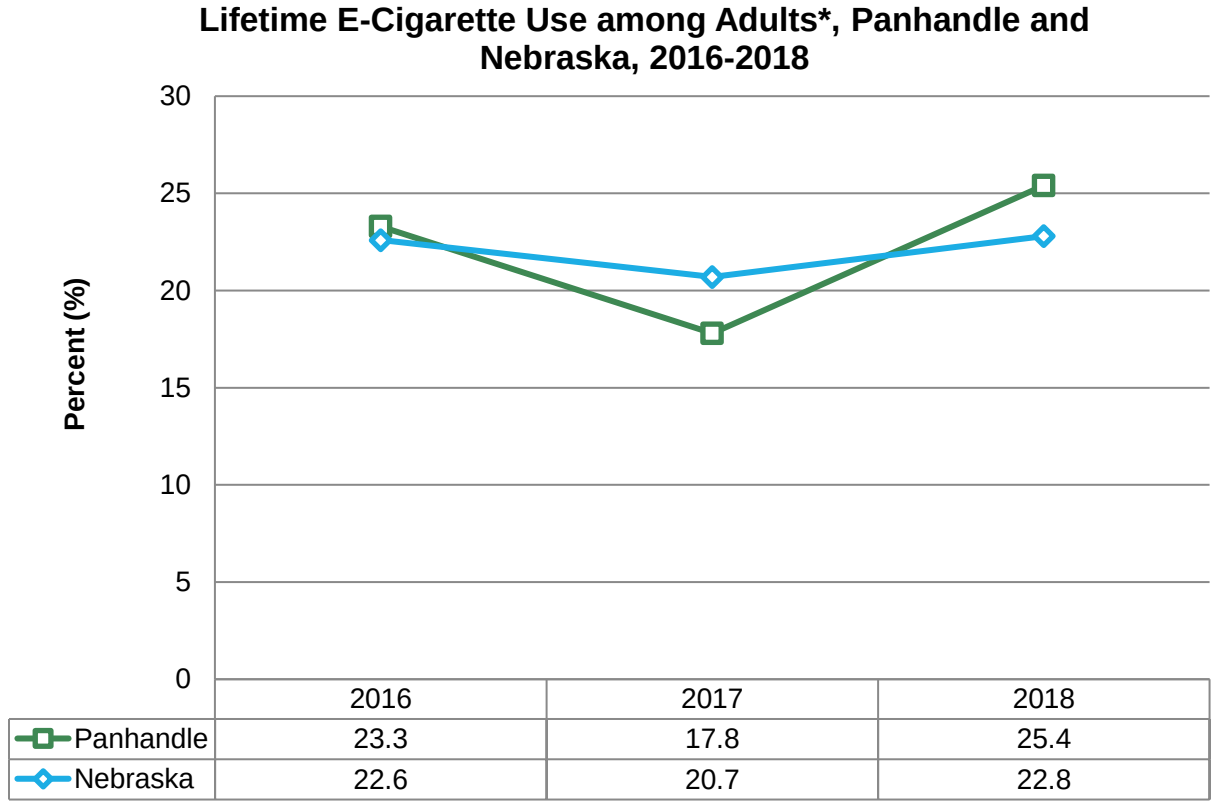


	2016	2017	2018
Panhandle	3.5	2.6	5.7
Nebraska	4.9	3.8	5.6

*Percentage of adults 18 and older who report that they currently use an e-cigarettes or other electronic "vaping" products either every day or on some days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

Lifetime e-cigarette use indicates the percentage of adults who have ever used an e-cigarette. The percentage of Panhandle adults who have ever used e-cigarettes is slightly higher than the overall state of Nebraska, but has not changed much from 2016.

Figure 60: Adult Lifetime E-Cigarette Use



	2016	2017	2018
Panhandle	23.3	17.8	25.4
Nebraska	22.6	20.7	22.8

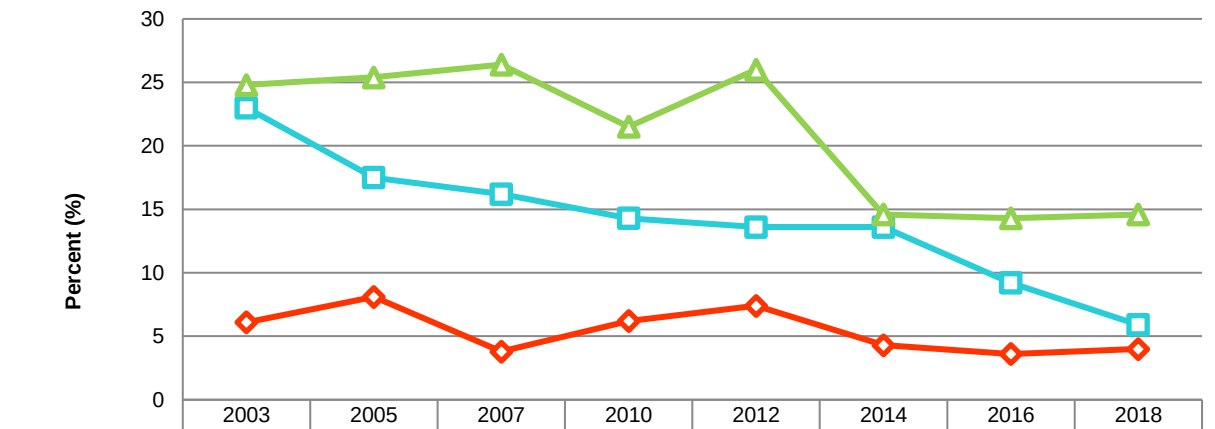
*Percentage of adults 18 and older who report that they have ever used an e-cigarette or other electronic "vaping" product, even just one time, in their entire life. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

YOUTH TOBACCO USE

CIGARETTE USE

Both current cigarette use (past 30 days) and lifetime cigarette use have been trending downward in Panhandle youth since 2003. For 12th graders and 8th graders, the current cigarette smoking downward trend appears to have plateaued from 2014 to 2018.

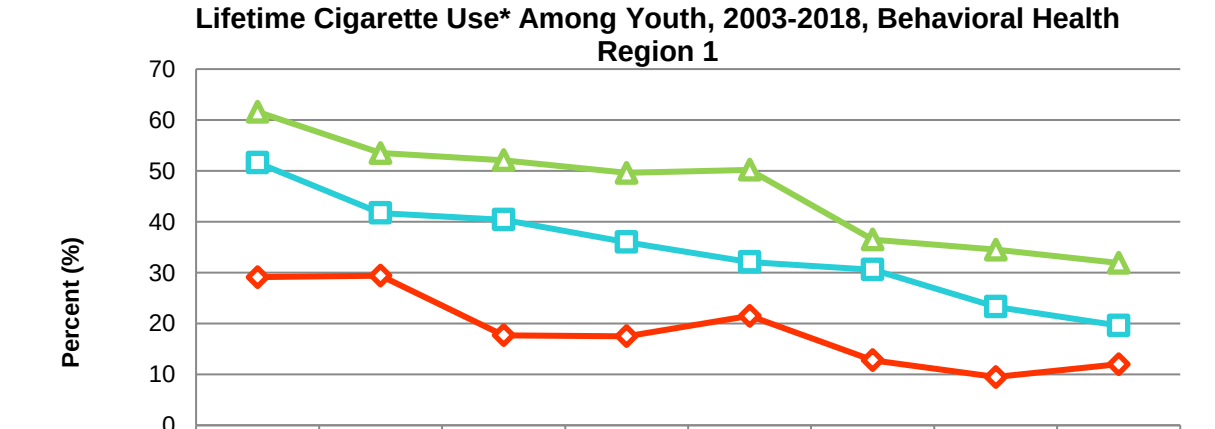
Figure 61: Past 30 Day Cigarette Use Among Youth



	2003	2005	2007	2010	2012	2014	2016	2018
8th Grade	6.1	8.1	3.8	6.2	7.4	4.3	3.6	4
10th Grade	23	17.5	16.2	14.3	13.6	13.6	9.2	5.9
12th Grade	24.8	25.4	26.4	21.5	26	14.6	14.3	14.6

*Percentage who reported using cigarettes one or more times during the past 30 days. Data from 2018 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 62: Lifetime Cigarette Use Among Youth



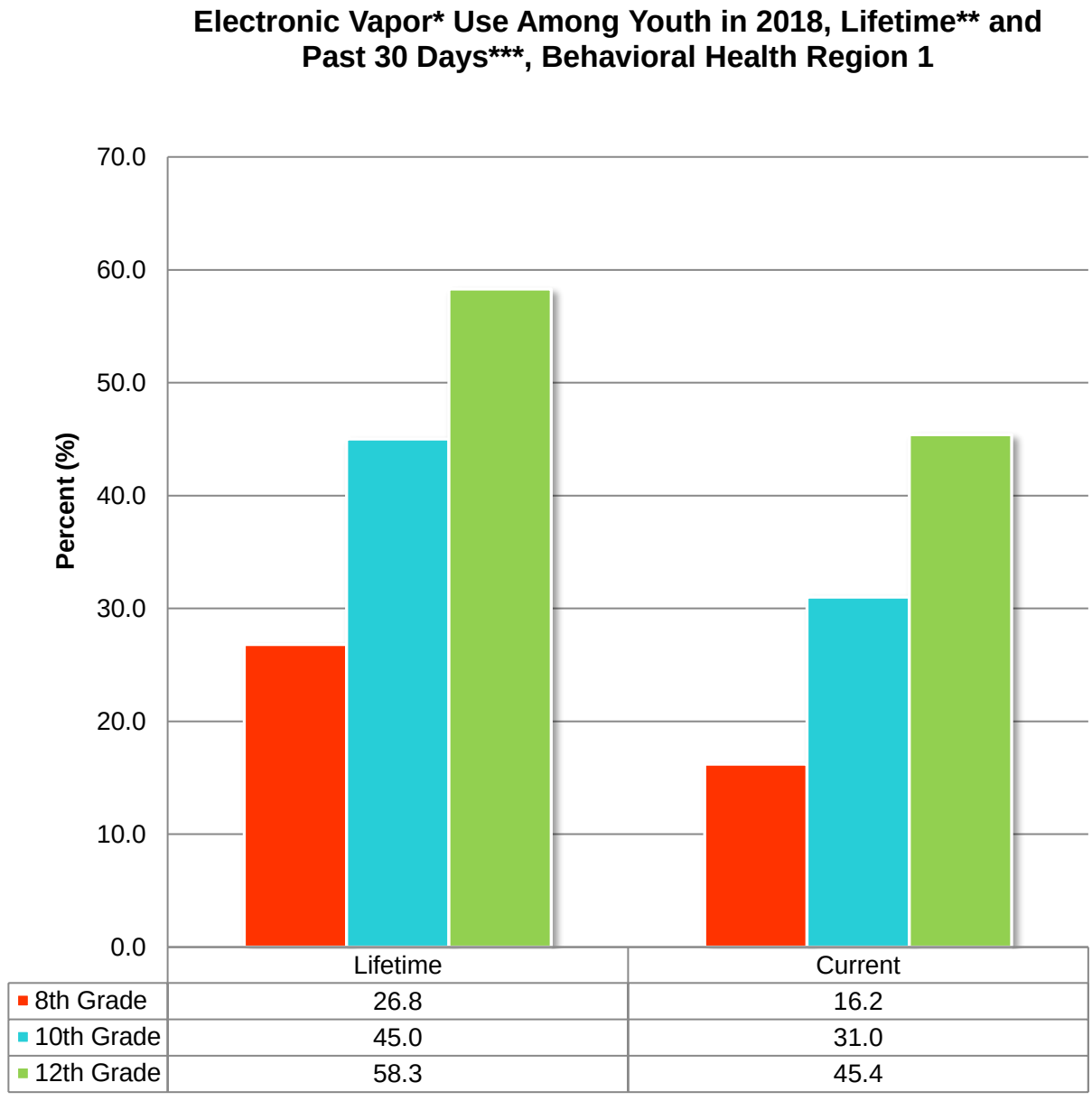
	2003	2005	2007	2010	2012	2014	2016	2018
8th Grade	29.1	29.4	17.7	17.5	21.5	12.8	9.5	12
10th Grade	51.6	41.7	40.4	36	32.1	30.6	23.3	19.6
12th Grade	61.6	53.5	52.1	49.6	50.2	36.5	34.5	31.9

*Percentage who reported using cigarettes one or more times in their lifetime. Data from 2018 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

E-CIGARETTE USE

E-cigarette use among youth was measured in 2018. Over half of 12th graders and nearly half of 10th graders reported they had ever used an e-cigarette, while slightly less (45.4% and 31%, respectively), currently use e-cigarettes. Nearly 30% of 8th graders had ever used an e-cigarette, with about 16% reporting they currently use one.

Figure 63: Electronic Vapor Use Among Youth in 2018, Lifetime and Past 30 Days

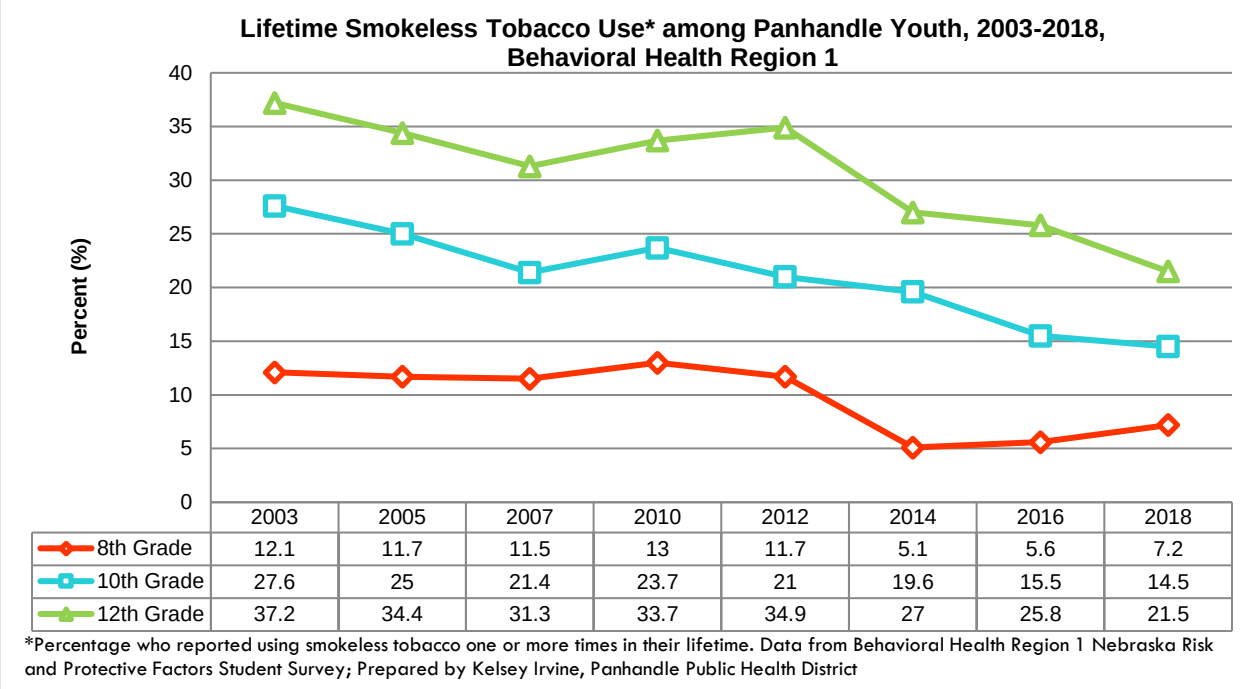


*An electronic vapor product is defined as e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookas, or hookah pens. **Percentage who reported using an electronic vaport device or or more times in their lifetime. ***Percentage who reported using an electronic vapor device one or more times during the past 30 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

SMOKELESS TOBACCO

The percentage of youth who have ever used smokeless tobacco (chew, snuff, plug, dipping tobacco or chewing tobacco) has held a downward trend from 2003 to 2018. Current smokeless tobacco use (past 30 day use) has decreased slightly among 12th and 10th graders, but increased slightly among 8th graders.

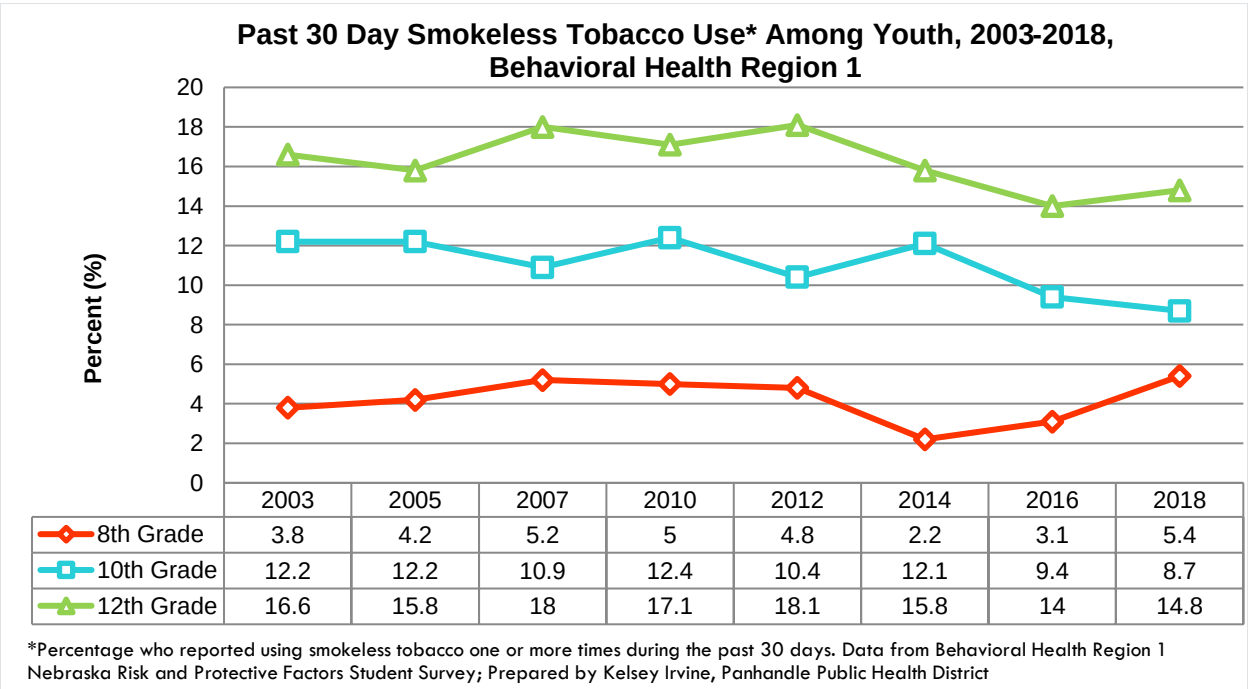
Figure 64: Lifetime Smokeless Tobacco Use Among Youth



	2003	2005	2007	2010	2012	2014	2016	2018
8th Grade	12.1	11.7	11.5	13	11.7	5.1	5.6	7.2
10th Grade	27.6	25	21.4	23.7	21	19.6	15.5	14.5
12th Grade	37.2	34.4	31.3	33.7	34.9	27	25.8	21.5

*Percentage who reported using smokeless tobacco one or more times in their lifetime. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 65: Past 30 Day Smokeless Tobacco Use Among Youth



	2003	2005	2007	2010	2012	2014	2016	2018
8th Grade	3.8	4.2	5.2	5	4.8	2.2	3.1	5.4
10th Grade	12.2	12.2	10.9	12.4	10.4	12.1	9.4	8.7
12th Grade	16.6	15.8	18	17.1	18.1	15.8	14	14.8

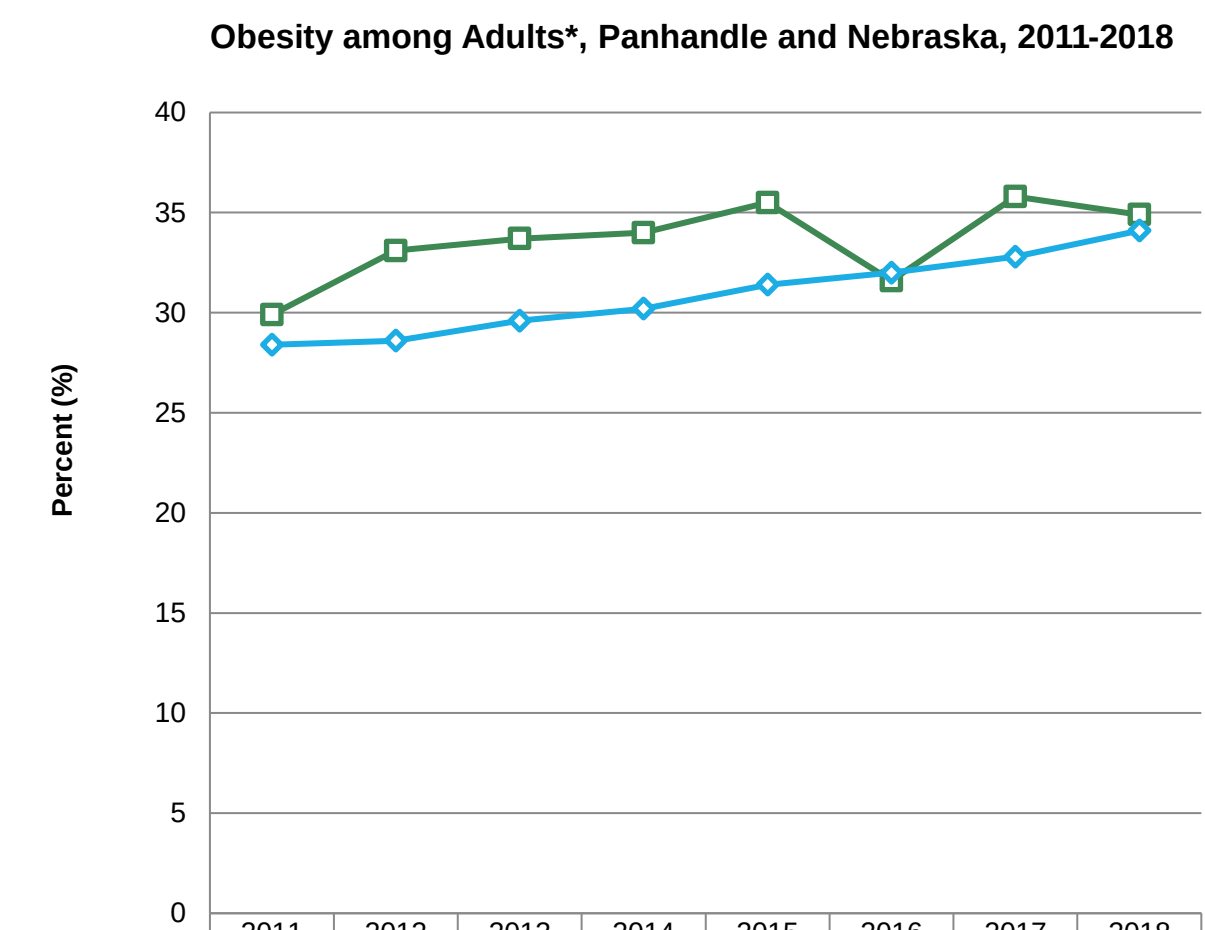
*Percentage who reported using smokeless tobacco one or more times during the past 30 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

OBESITY

Adult obesity is defined as a BMI (Body Mass Index) of 30 or higher. Heart disease, stroke, type 2 diabetes, and some cancers are related to obesity.[10]

Obesity in Nebraska is a growing trend, with the number of adults reporting they are obese rising each year in both the state of Nebraska and the Panhandle. The obesity rate has steadily increased across the entire state of Nebraska. In the Panhandle, there was a dip in 2016, but an increase in 2017 and 2018. In 2018, the percentage of adults who were obese were nearly the same between the Panhandle (34.9%) and the overall state of Nebraska (34.1%).

Figure 66: Obesity Among Adults



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	29.9	33.1	33.7	34	35.5	31.6	35.8	34.9
Nebraska	28.4	28.6	29.6	30.2	31.4	32	32.8	34.1

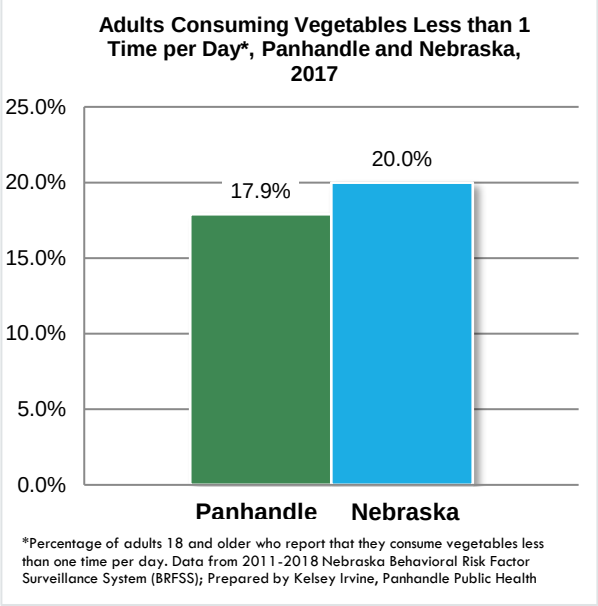
*Percentage of adults 18 and older with a body mass index (BMI) of 30.0 or greater, based on self-reported height and weight. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

[10] https://www.cdc.gov/obesity/data/adult.html

NUTRITION

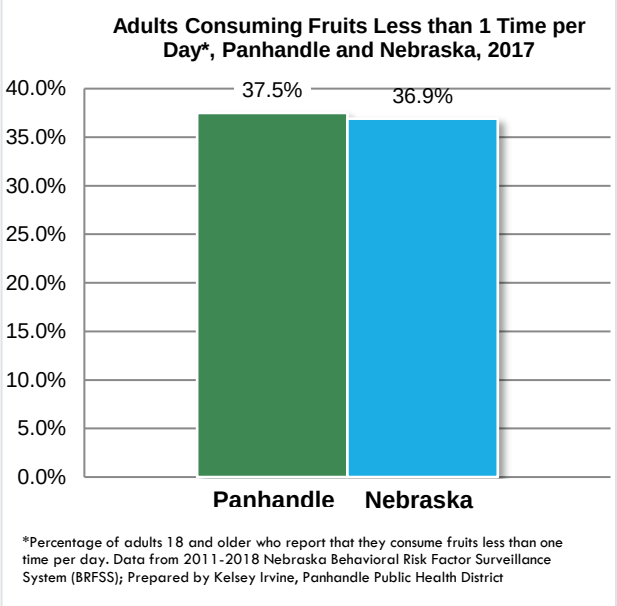
Adults are recommended to consume between 2 and 3 cups of vegetables per day and 1 and 2 cups of fruit per day. 17.9% of Panhandle adults report they consume vegetables less than one time per day, and 37.5% of Panhandle adults report they consume fruits less than one time per day.

Figure 67: Adults Consuming Vegetables Less than 1 time per day



*Percentage of adults 18 and older who report that they consume vegetables less than one time per day. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health

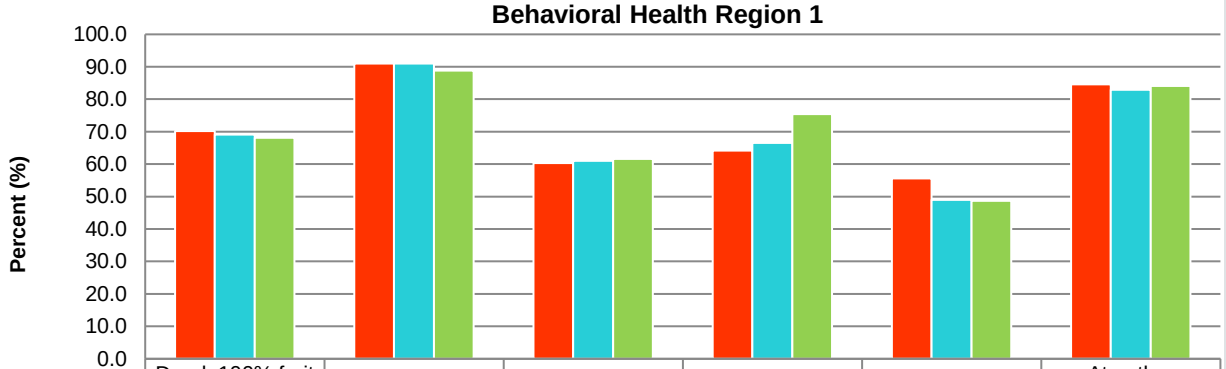
Figure 68: Adults Consuming Fruits less than 1 time per day



*Percentage of adults 18 and older who report that they consume fruits less than one time per day. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

Youth in grades 8th through 12th grade are recommended to consume 1 1/2-2 cups of fruit per day, and 2 1/2 to 3 cups of vegetables per day. A survey of youth fruit and vegetable consumption in 2018 found that the majority of youths ate a fruit or vegetable one or more times in the past week.

Figure 69: Youth Fruit and Vegetable Consumption



	Drank 100% fruit juice	Ate fruit	Ate green salad	Ate potatoes	Ate carrots	Ate other vegetables
8th Grade	70.2	91.0	60.3	64.2	55.6	84.6
10th Grade	69.1	91.0	61.0	66.5	49.0	82.9
12th Grade	68.1	88.8	61.6	75.4	48.7	84.1

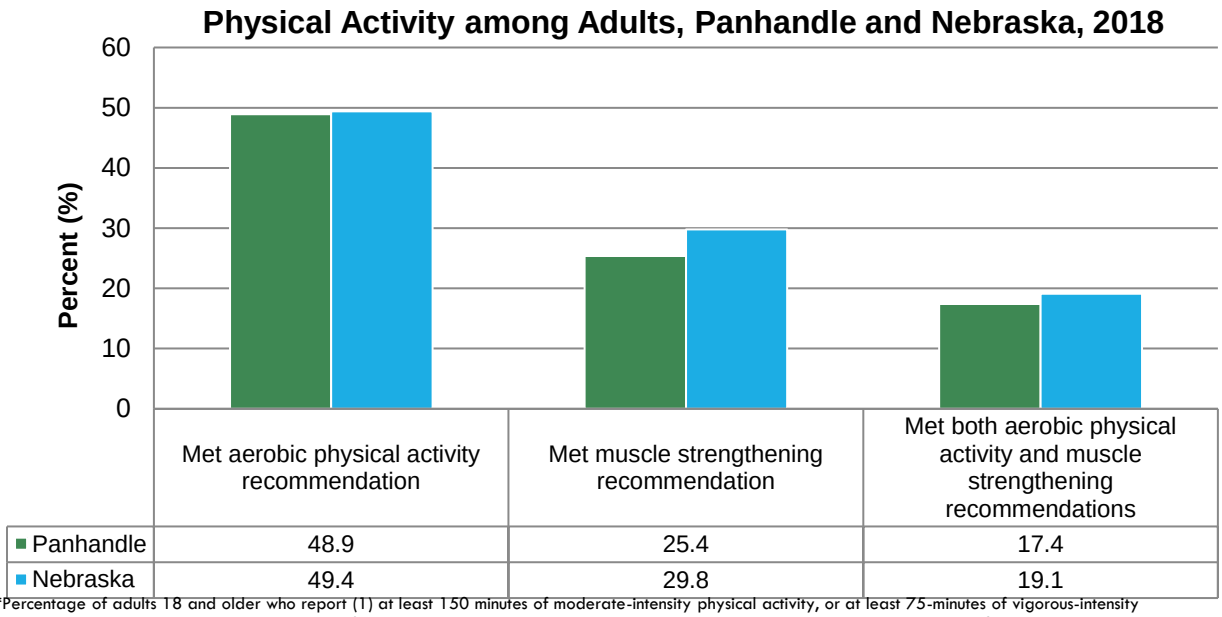
*Percentage who reported consuming the named drink or food one or more times during the past 7 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

PHYSICAL ACTIVITY

ADULTS

In 2018, 48.9% of Panhandle adults met aerobic physical activity recommendations, 25.4% met muscle strengthening recommendations, and just 17.4% met both recommendations. The Panhandle reports slightly lower rates across all types of physical activity when compared to the overall state of Nebraska.

Figure 70: Physical Activity Among Adults

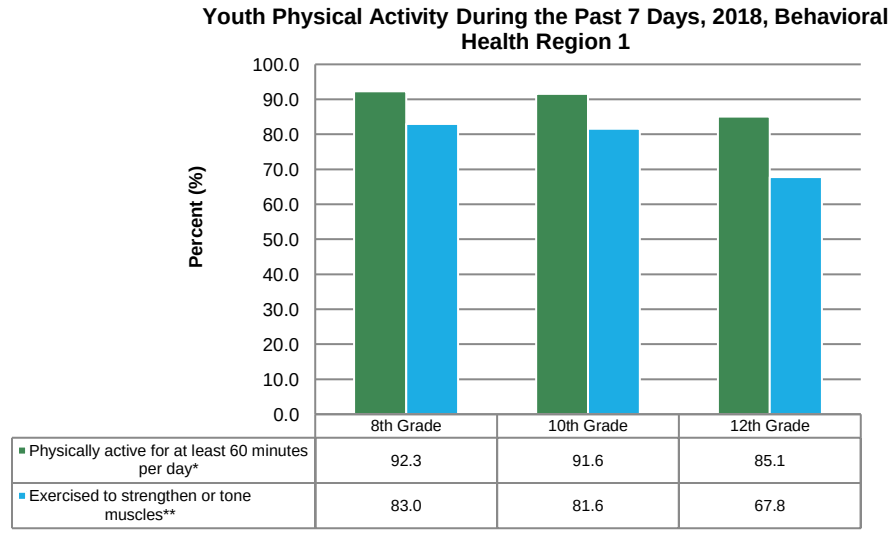


*Percentage of adults 18 and older who report (1) at least 150 minutes of moderate-intensity physical activity, or at least 75-minutes of vigorous-intensity physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity per week during the past month, (2) that they are engaged in physical activities or exercises to strengthen their muscles two or more times per week during the past month, (3) that they met both the aerobic and muscle

YOUTH

The majority of Panhandle youth report being physically active for at least 60 minutes per day, and that they regularly exercise to strengthen or tone muscles. The percentage that reports they regularly exercising to strengthen or tone muscles appears to decrease with age.

Figure 71: Youth Physical Activity



*Percentage who reported being physically active for a total of at least 60 minutes on one or more days during the past 7 days.
**Percentage who reported doing exercises to strengthen or tone muscles, such as push-ups, sit-ups, or weight lifting on one or more days during thep ast 7 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

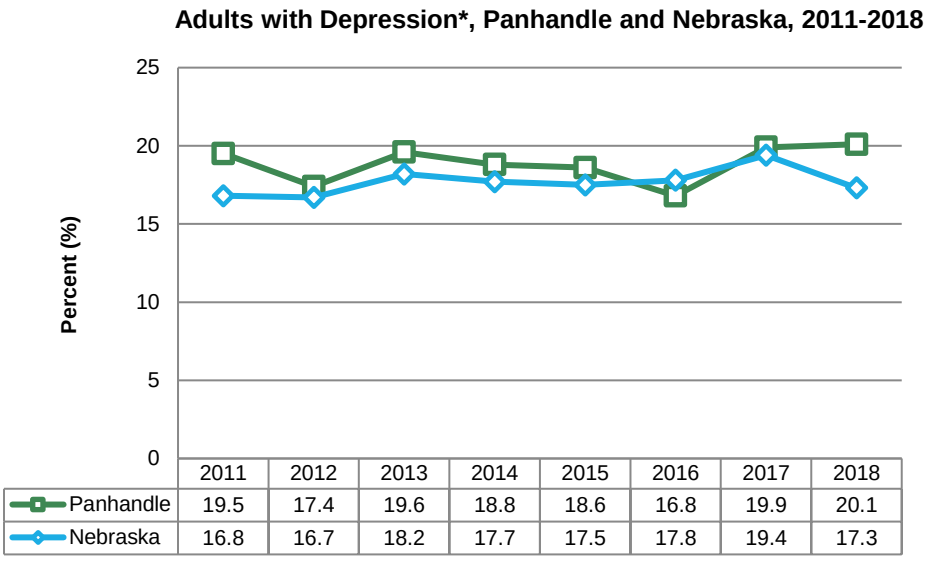
BEHAVIORAL HEALTH

MENTAL HEALTH

"A mental illness is a condition that affects a person's thinking, feeling, behavior or mood. These conditions deeply impact day-to-day living and may also affect the ability to relate to others." [11] Approximately 1 in 5 US adults experience mental illness, and 50% of all lifetime mental illness begins by age 14.

The percentage of Panhandle adults who have ever been diagnosed with depression has been relatively close to the overall state of Nebraska, with a slight uptick in 2018, whereas the state saw a downturn that year.

Figure 72: Adults with Depression

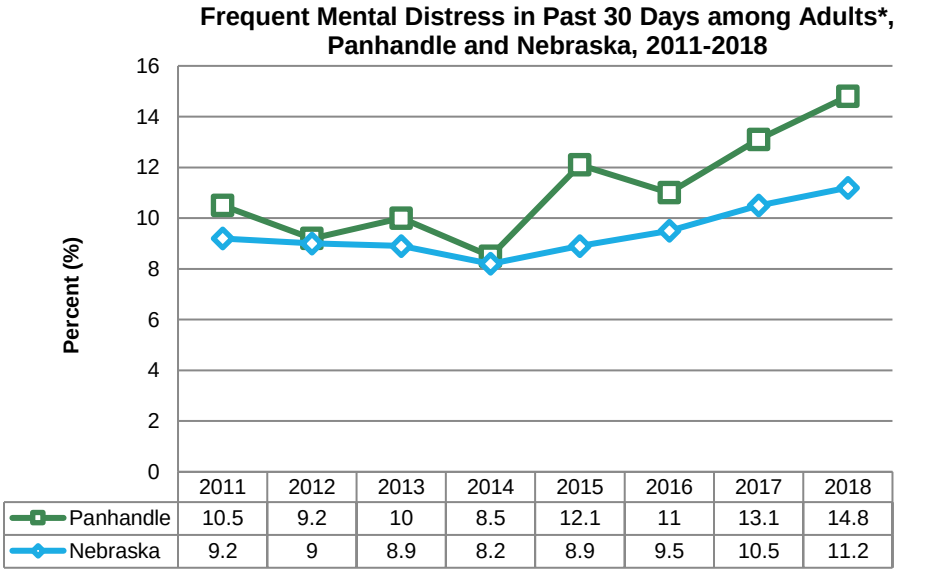


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	19.5	17.4	19.6	18.8	18.6	16.8	19.9	20.1
Nebraska	16.8	16.7	18.2	17.7	17.5	17.8	19.4	17.3

*Percentage of adults 18 and older who report that they have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder (depression, major depression, dysthymia, or minor depression). Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

The percentage of adults in the Panhandle who experienced frequent mental distress has been higher than the state, historically. There was a more rapid increase from 2014 to 2018 in the Panhandle when compared to the state.

Figure 73: Adult Frequent Mental Distress



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	10.5	9.2	10	8.5	12.1	11	13.1	14.8
Nebraska	9.2	9	8.9	8.2	8.9	9.5	10.5	11.2

*Percentage of adults 18 and older who report that their mental health (including stress, depression, and problems with emotions) was not good on 14 or more of the previous 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

[11] National Alliance on Mental Illness. (2020). Mental Health Conditions. Retrieved from: https://www.nami.org/learn-more/mental-health-conditions

SUBSTANCE ABUSE

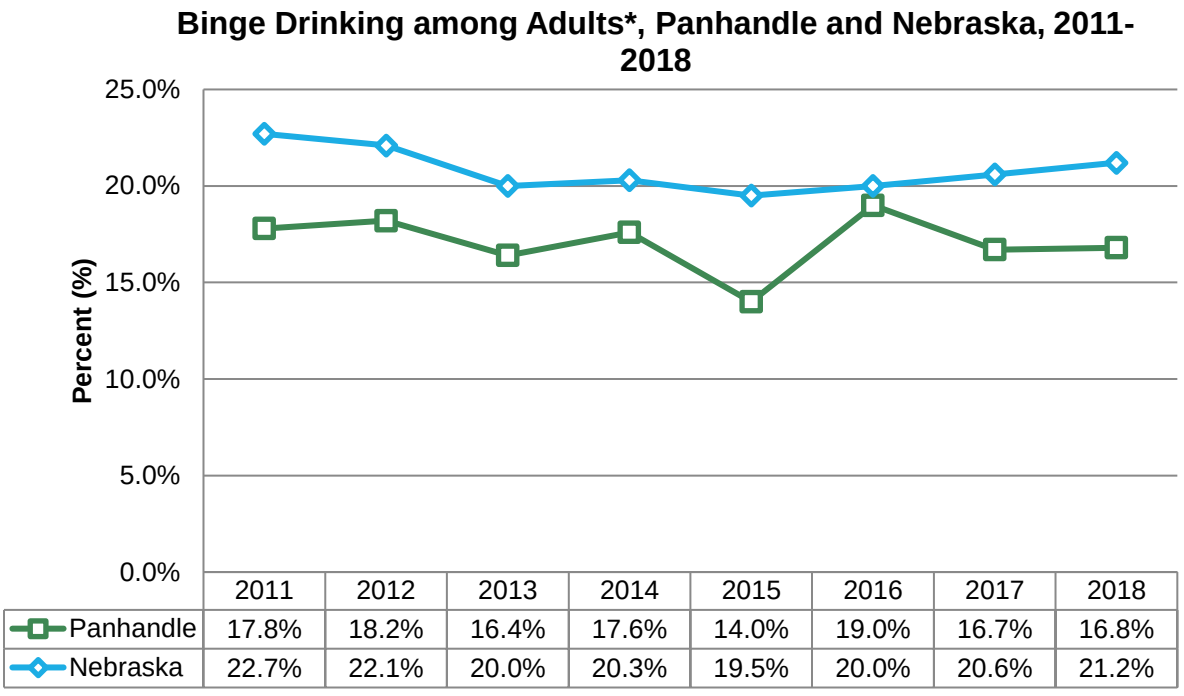
ALCOHOL

Misuse of alcohol includes underage drinking and binge drinking. Binge drinking is drinking 5 or more drinks in one occasion for men or 4 or more drinks in one occasion for women. Misuse of alcohol can contribute to increased health problems, such as injuries, violence, liver diseases, and cancer.[12]

BINGE DRINKING

Nebraska is known for its high rate of binge drinking. However, the Panhandle has a lower rate of binge drinking compared to the state.

Figure 74: Adult Binge Drinking



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	17.8%	18.2%	16.4%	17.6%	14.0%	19.0%	16.7%	16.8%
Nebraska	22.7%	22.1%	20.0%	20.3%	19.5%	20.0%	20.6%	21.2%

*Percentage of adults 18 and older who report having five or more alcoholic drinks for men/four or more alcoholic drinks for women on at least one occasion during the 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

ALCOHOL IMPAIRED DRIVING

Adults who report alcohol-impaired driving is fairly low across the state of Nebraska, and historically lower in the Panhandle.

Figure 75: Adult Alcohol Impaired Driving

Alcohol-Impaired Driving among Adults*, Panhandle and Nebraska, 2012-2018

	2012	2014	2016	2018
Panhandle	2.5%	2.5%	2.6%	2.2%
Nebraska	3.4%	2.5%	3.4%	3.0%

*Percentage of adults 18 and older who report driving after having had perhaps too much to drink during the past 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

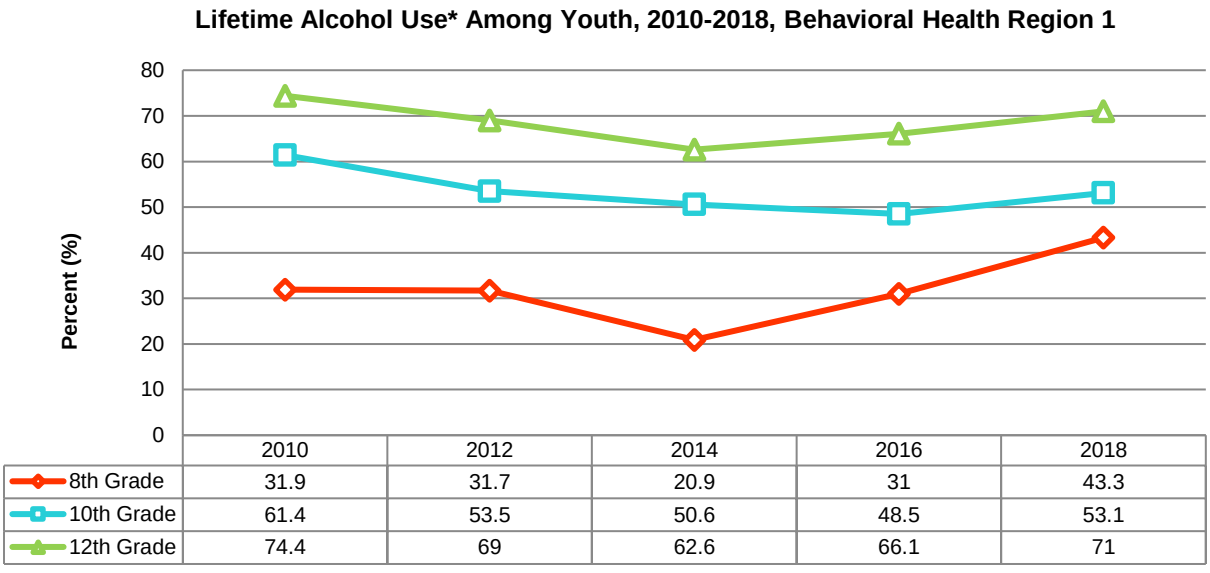
[12] CDC. (2019). Binge Drinking. Retrieved from: https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm

YOUTH ALCOHOL USE

The proportion of Panhandle youth who report they have ever tried alcohol (lifetime use) has decreased slightly in 10th and 12th graders over time, but slightly increased from 2014 to 2018 among 8th graders.

Youth current use (past 30 day) of alcohol decreased from 2010 to 2014, but an increase was seen from 2014 to 2018. Most notably, current alcohol use among 8th graders jumped from 8.8% in 2014 to 17% in 2018.

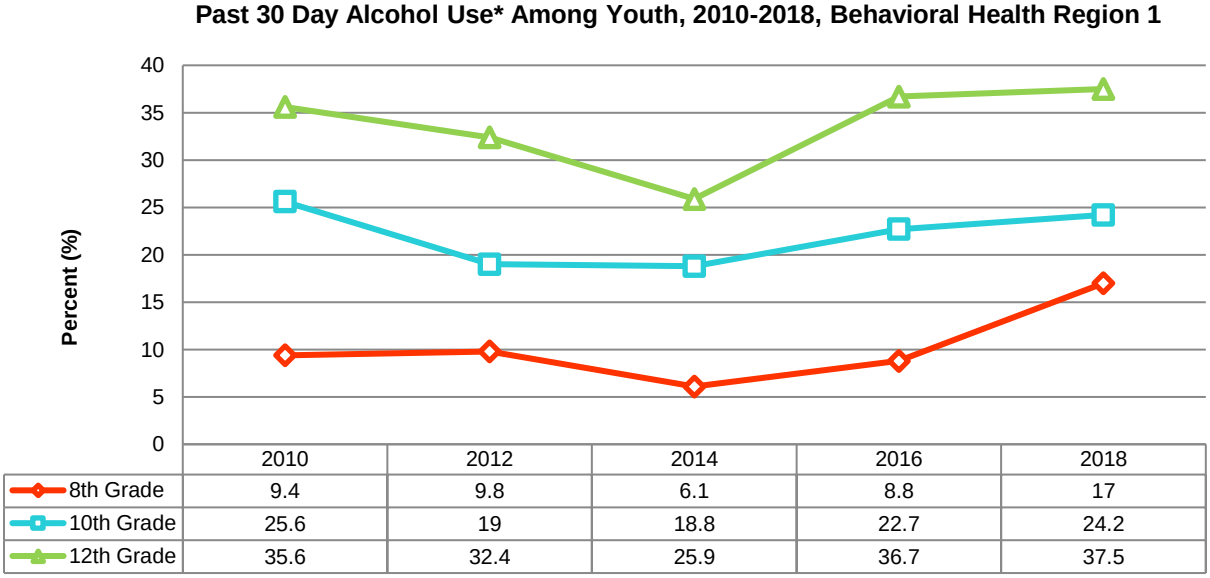
Figure 76: Youth Lifetime Alcohol Use



	2010	2012	2014	2016	2018
8th Grade	31.9	31.7	20.9	31	43.3
10th Grade	61.4	53.5	50.6	48.5	53.1
12th Grade	74.4	69	62.6	66.1	71

*Percentage who reported consuming alcohol one or more times in their lifetime. Data from 2018 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 77: Youth Current Alcohol Use

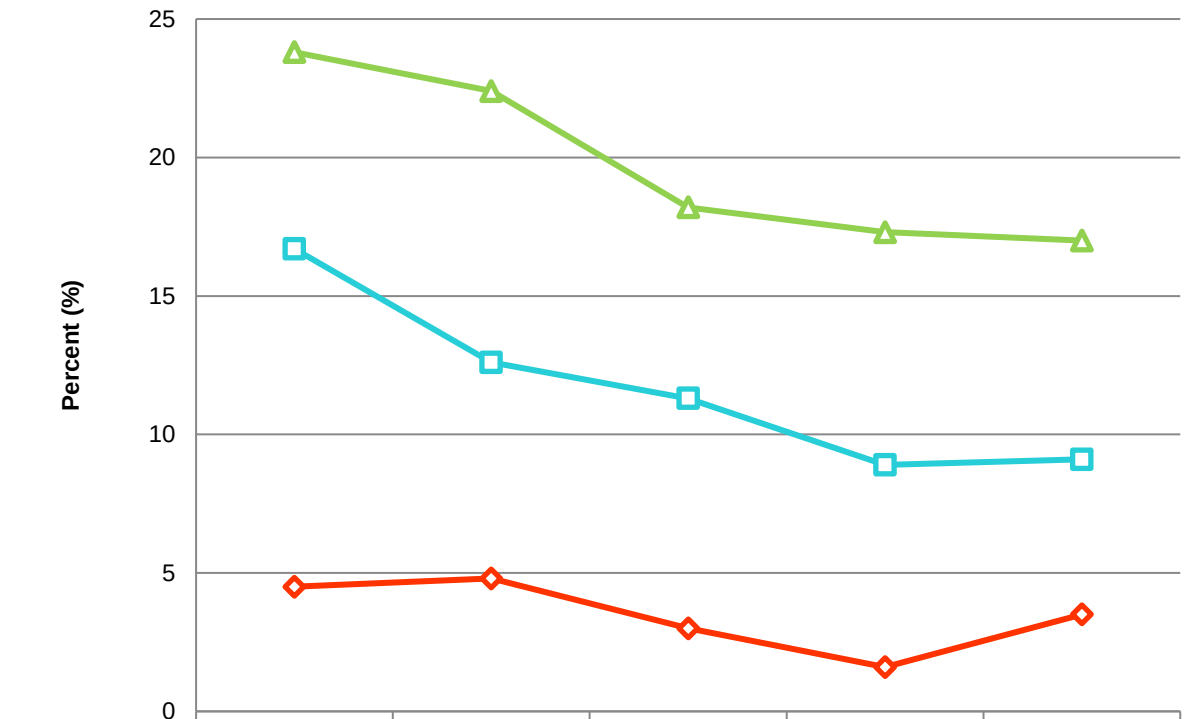


	2010	2012	2014	2016	2018
8th Grade	9.4	9.8	6.1	8.8	17
10th Grade	25.6	19	18.8	22.7	24.2
12th Grade	35.6	32.4	25.9	36.7	37.5

*Percentage who reported consuming alcohol one or more times in the past 30 days. Data from 2018 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

Binge drinking among youth has decreased considerably over the years. 8th graders have remained relatively even, with a very small percentage reporting they binge drink. The percentage of 10th graders who reported they binge drink decreased from 16.7% in 2010 to 9.1% in 2018, and in 12th graders decreased from 23.8% to 17%, respectively.

Figure 78: Youth Binge Drinking



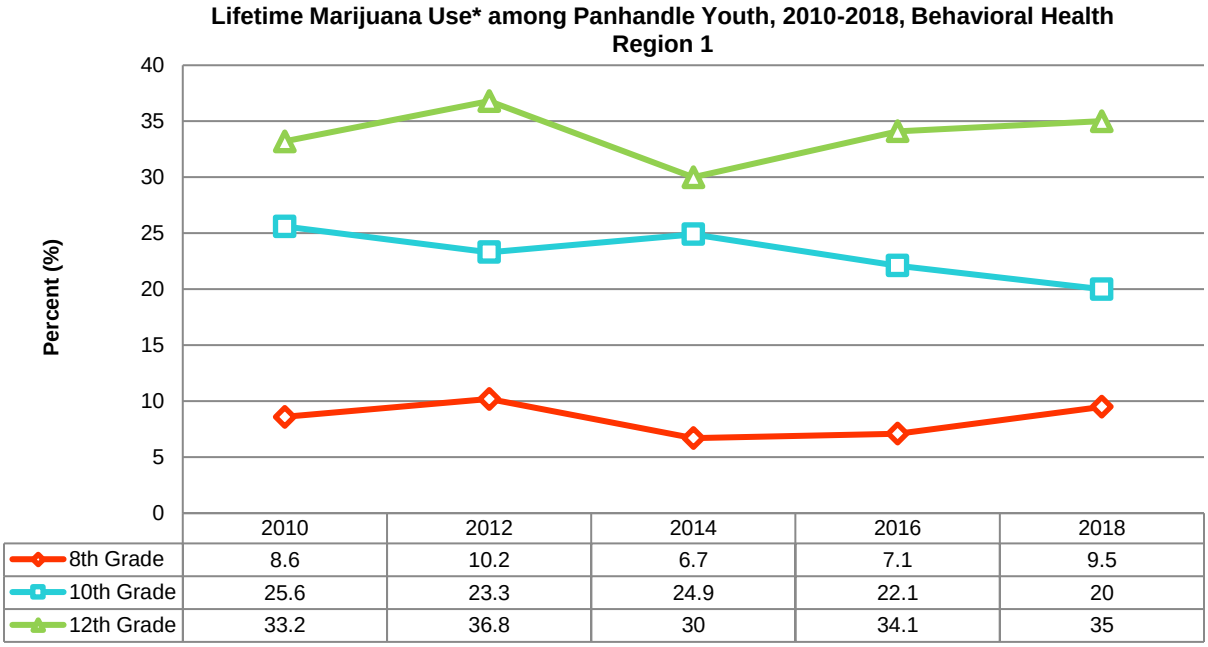
	2010	2012	2014	2016	2018
8th Grade	4.5	4.8	3	1.6	3.5
10th Grade	16.7	12.6	11.3	8.9	9.1
12th Grade	23.8	22.4	18.2	17.3	17

*Percentage who reported consuming 4 drinks or more for females and 5 drinks or more for males in a row within a couple hours in the past 30 days. Data from 2018 Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

MARIJUANA

The percentage of Panhandle youth who report they have ever tried or are currently using marijuana has remained relatively unchanged over the years.

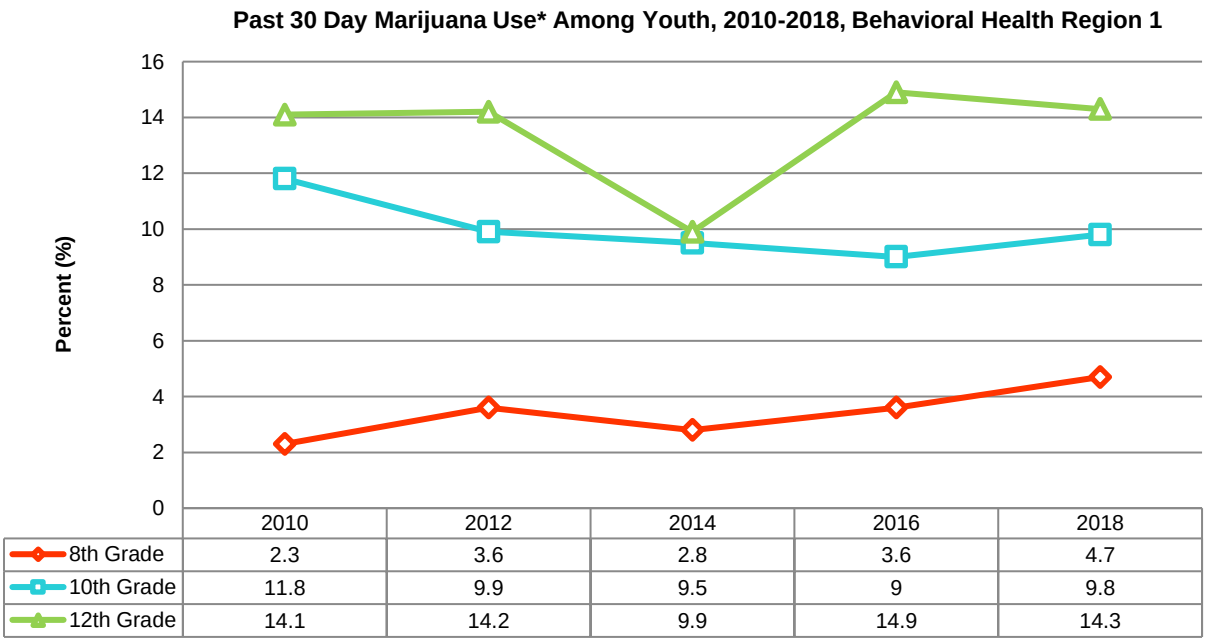
Figure 79: Youth Lifetime Marijuana Use



	2010	2012	2014	2016	2018
8th Grade	8.6	10.2	6.7	7.1	9.5
10th Grade	25.6	23.3	24.9	22.1	20
12th Grade	33.2	36.8	30	34.1	35

*Percentage who reported using marijuana one or more times in their lifetime. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 80: Youth Current Marijuana Use



	2010	2012	2014	2016	2018
8th Grade	2.3	3.6	2.8	3.6	4.7
10th Grade	11.8	9.9	9.5	9	9.8
12th Grade	14.1	14.2	9.9	14.9	14.3

*Percentage who reported using marijuana one or more times during the past 30 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

INJURY

MOTOR VEHICLE CRASHES

There were 1,468 motor vehicle crashes in the Panhandle in 2019, resulting in 611 injured individuals and 21 deaths. The rate of Panhandle adults that always wear a seatbelt is consistently lower than the broader state of Nebraska, by approximately 15 points.

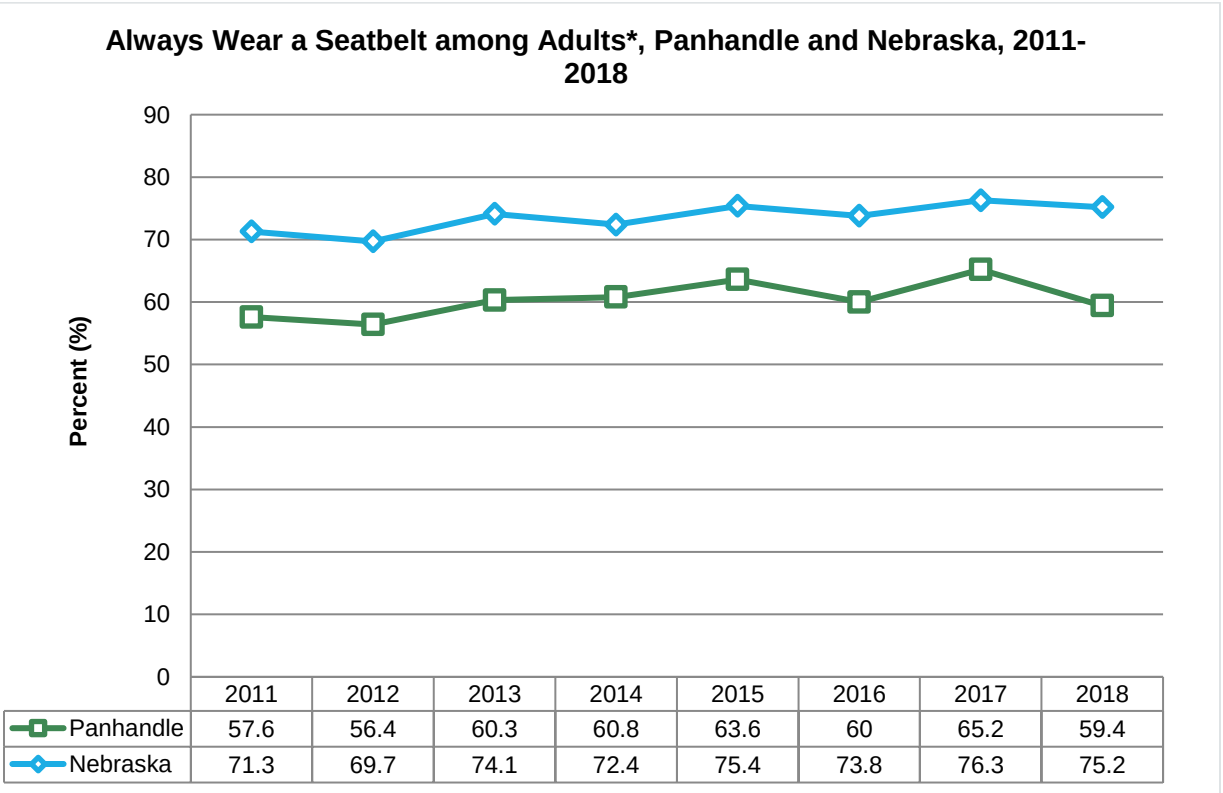
Figure 81: Panhandle Motor Vehicle Crash Data by County, 2019

County	Crashes				Persons killed and injured	
	Total	Fatal	Injury	PDO*	Killed	Injury
Banner	26	0	7	19	0	12
Box Butte	148	3	48	97	3	77
Cheyenne	186	2	32	152	2	46
Dawes	151	1	35	115	1	51
Deuel	48	1	12	35	1	17
Garden	35	1	5	29	1	6
Grant	5	0	2	3	0	2
Kimball	93	3	23	67	3	31
Morrill	83	2	19	62	7	25
Scotts Bluff	617	3	226	388	3	315
Sheridan	65	0	15	50	0	27
Sioux	11	0	2	9	0	2
Panhandle	**1,468**	**16**	**426**	**1,026**	**21**	**611**
Nebraska	**36,709**	**212**	**11,939**	**24,555**	**248**	**17,198**

*PDO = Property Damage Only

Source: 2019 Nebraska Traffic Crash Facts Annual Report

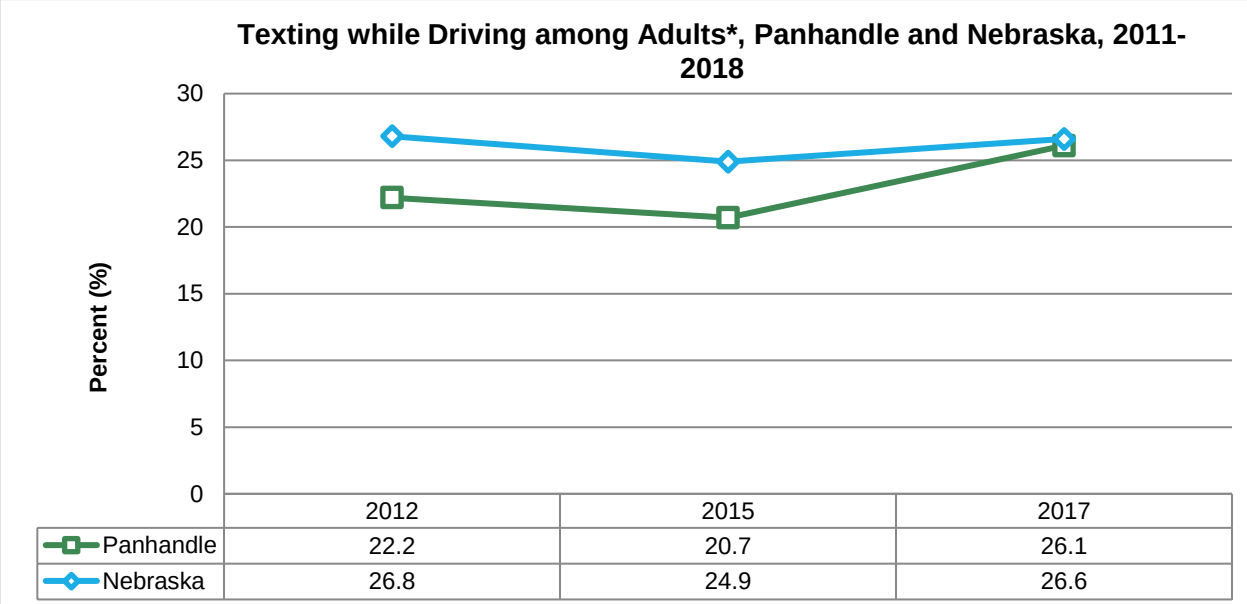
Figure 82: Adults Seatbelt Usage



*Percentage of adults 18 and older who report that they always use a seatbelt when driving or riding in a car. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

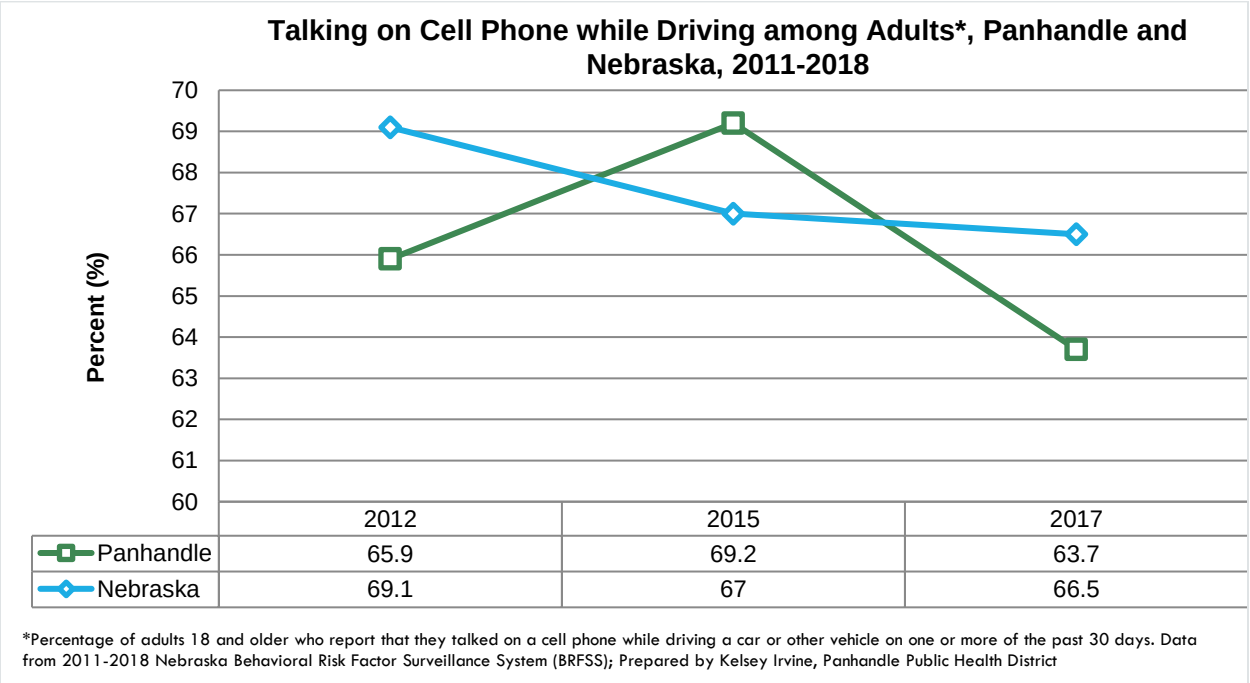
The rate of Panhandle adults that report they text while driving was lower than that of the overall state of Nebraska, but has increased in recent years to be at approximately the same rate. The proportion of adults who report they talk on the phone while driving in the Panhandle decreased from 69.2% in 2015 to 63.7% in 2017, dropping below the state (66.5%).

Figure 83: Adult Texting While Driving



*Percentage of adults 18 and older who report that they texted or e-mailed while driving a car or other vehicle on one or more of the past 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

Figure 84: Adult Talking on Cell Phone While Driving

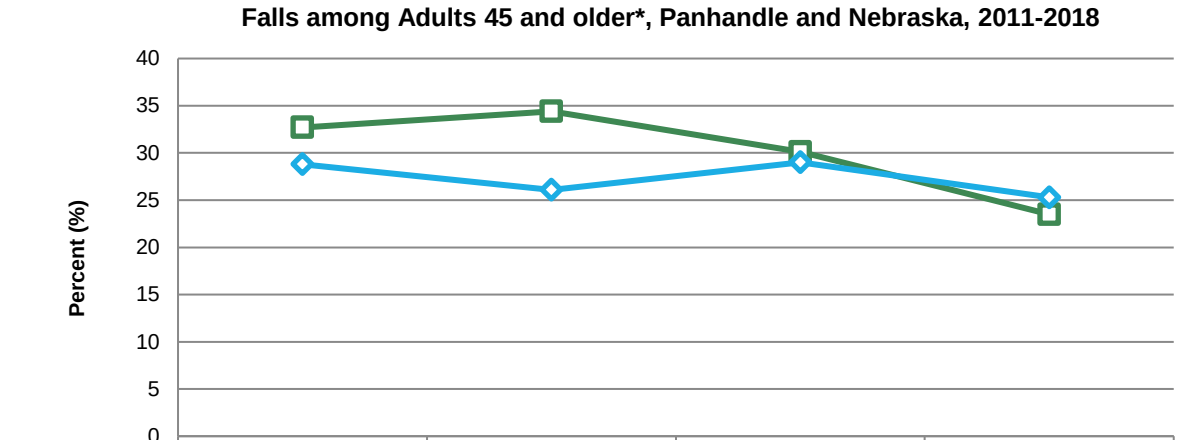


*Percentage of adults 18 and older who report that they talked on a cell phone while driving a car or other vehicle on one or more of the past 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

FALLS

The percentage of adults 45 and older who experienced a fall in the past year decreased in the Panhandle after a peak in 2014, and in 2018 was lower than falls in adults across the broader state of Nebraska. Injuries from falls was not measured by the 2018 BRFSS.

Figure 85: Falls Among Adults 45+



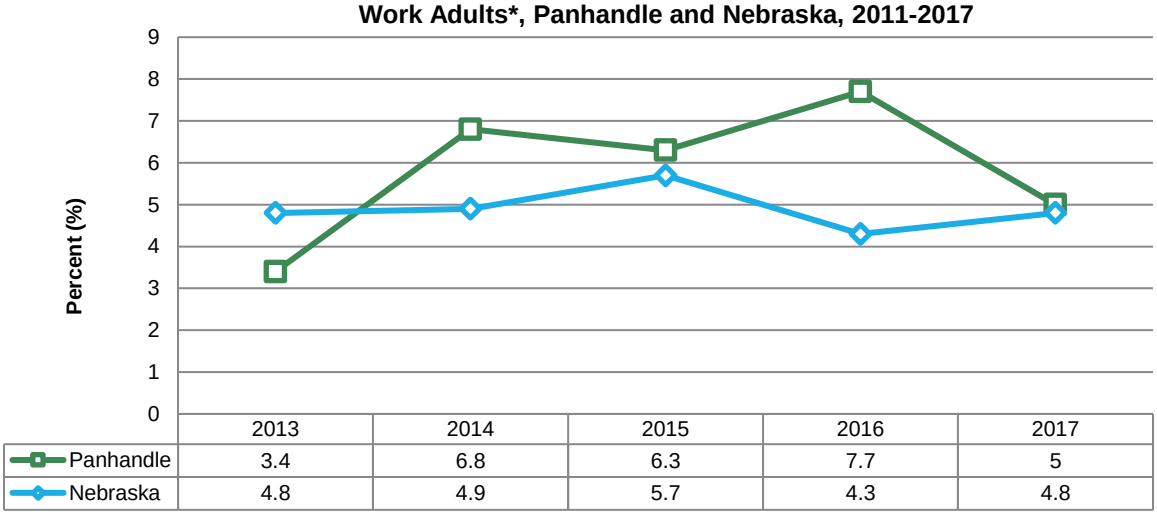
	2012	2014	2016	2018
Panhandle	32.7	34.4	30.1	23.5
Nebraska	28.8	26.1	29	25.3

*Percentage of adults 45 and older who report that they fell to the groun dor another lower level one or more times during the past 12 months. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

WORK RELATED INJURIES

The percentage of Panhandle adults who experienced a work-related injury in the past year was higher than that of the broader state of Nebraska in 2014, 2015, and 2016. A sharp decrease from 2016 to 2017 brought it down to approximately the same level as the state.

Figure 86: Work-Related Injury or Illness



	2013	2014	2015	2016	2017
Panhandle	3.4	6.8	6.3	7.7	5
Nebraska	4.8	4.9	5.7	4.3	4.8

*Percentage of employed or recently out of work adults who reported they had a work-related injury or illness in the past year. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

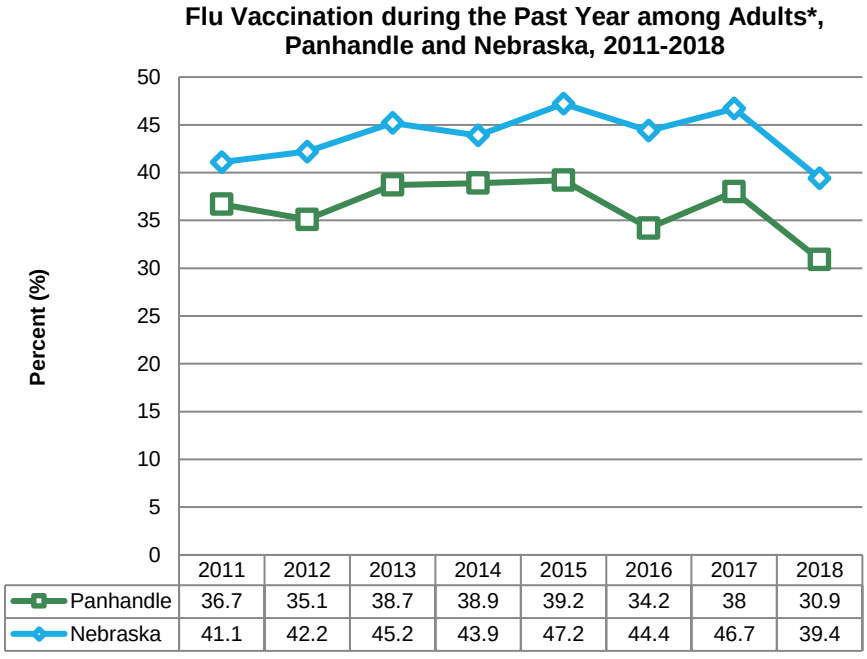
IMMUNIZATIONS

A large portion of infectious diseases have been eradicated or controlled by vaccination. However, a rising movement supporting anti-vaccination has led to under-immunized children, adolescents, and adults in the United States, leaving them susceptible to many vaccine preventable diseases.

INFLUENZA VACCINATION

The percentage of Panhandle adults that report having a flu vaccination during the past year has consistently been lower than the state of Nebraska. The number slowly increased from 2011 to 2015, but has seen an overall decrease since then.

Figure 87: Flu Vaccination during Past Year

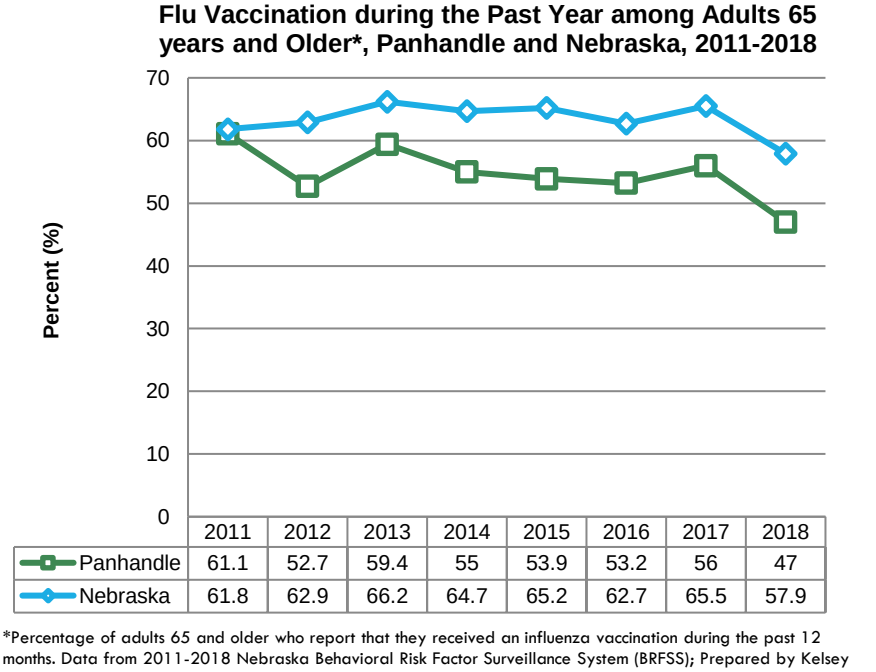


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	36.7	35.1	38.7	38.9	39.2	34.2	38	30.9
Nebraska	41.1	42.2	45.2	43.9	47.2	44.4	46.7	39.4

*Percentage of adults 18 and older who report that they received an influenza vaccination during the past 12 months. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System

The flu vaccination is highly recommended for people in vulnerable populations (children, pregnant people, and elderly people). The percentage of Panhandle adults 65 years and older that received a flu vaccination in the past year is much higher than the percentage of all adults, however is still lower than the state, and has decreased by nearly 15 points in the past decade.

Figure 88: Flu Vaccination During Past Year Adults 65+



	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	61.1	52.7	59.4	55	53.9	53.2	56	47
Nebraska	61.8	62.9	66.2	64.7	65.2	62.7	65.5	57.9

*Percentage of adults 65 and older who report that they received an influenza vaccination during the past 12 months. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

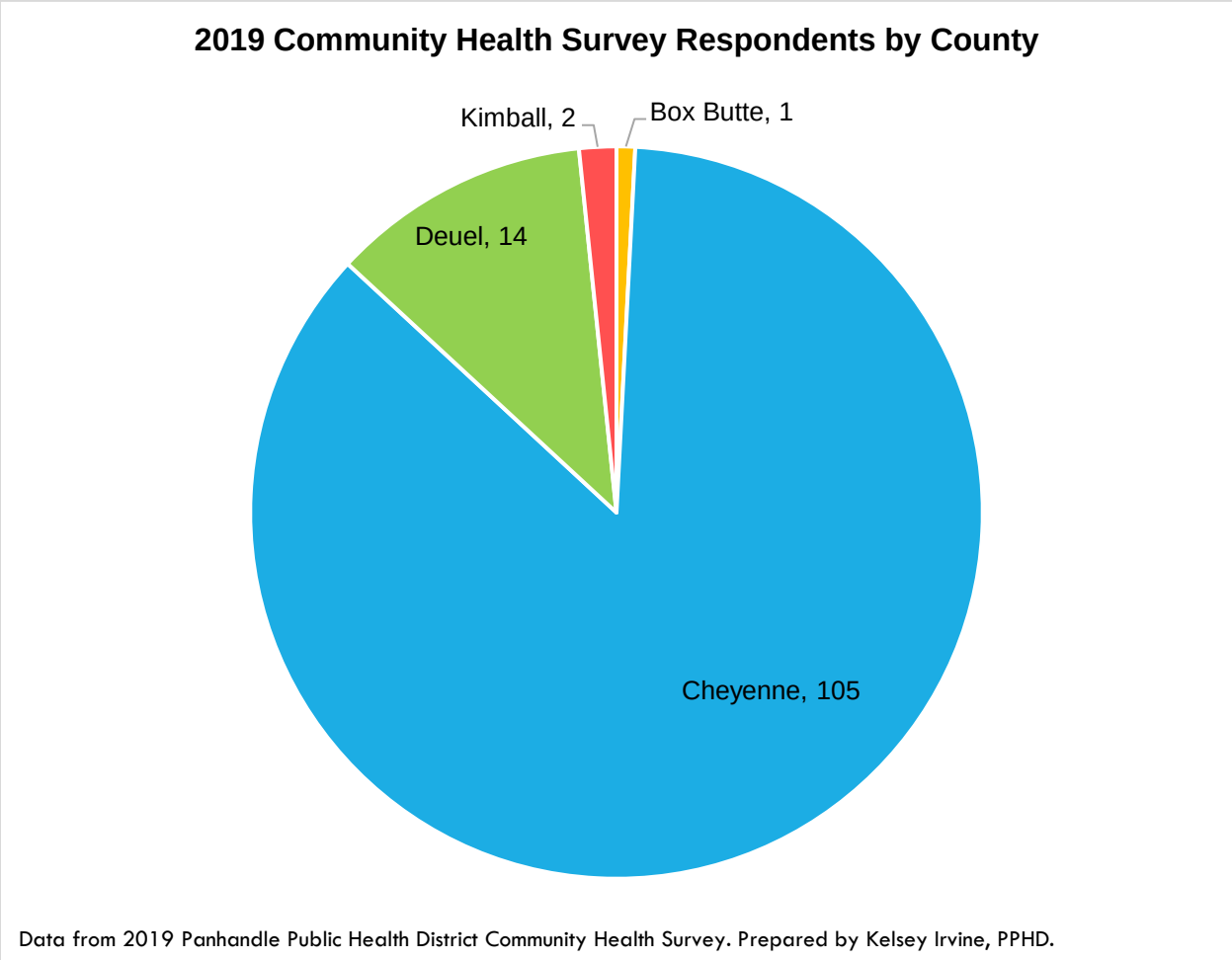
The Community Themes and Strengths Assessment is made up of two parts: the Community Health Survey and community Focus Groups. The top concerns of community members are determined from these two resources.

COMMUNITY HEALTH SURVEY

The Community Health Survey was distributed to Panhandle residents in October and November of 2019 via paper and electronic survey. See Appendix B for a copy of the survey. Paper copies of the survey were distributed by hospitals and community-based organizations. The electronic copy was administered using Qualtrics, and shared online by website, social media, and email by PPHD, local hospitals, and other community organizations. Counts and percentages from the survey responses were calculated using Microsoft Excel.

The following information includes responses from 123 people who live in Cheyenne or Deuel Counties, or reside elsewhere but indicate they receive their healthcare from Sidney Regional Medical Center.

Figure 89: 2019 Community Health Survey Respondents by County



Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

RESPONDENT DEMOGRAPHIC INFORMATION

Figure 90: 2019 Community Health Survey Selected Demographic Information, N = 123

County of residence:	**#**	**%**
Box Butte	1	0.8%
Cheyenne	105	85.4%
Deuel	14	11.4%
Kimball	2	1.6%
Gender identity:	**#**	**%**
Male	27	22.0%
Female	92	74.8%
Transgender male (female to male)	0	0.0%
Transgender female (male to female)	0	0.0%
Gender non-conforming	0	0.0%
Decline to answer	4	3.3%
Other	0	0.0%
Sexual orientation:	**#**	**%**
Heterosexual or straight	106	86.2%
Gay or lesbian	2	1.6%
Bisexual	5	4.1%
Decline to answer	10	8.1%
Other	0	0.0%
Highest level of education:	**#**	**%**
Less than high school graduate	1	0.8%
High school diploma or GED	37	30.1%
Associates or Technical Degree	30	24.4%
College degree or higher	50	40.7%
Decline to answer	5	4.1%
Other	0	0.0%
Race:	**#**	**%**
White	114	92.7%
Black or African American	1	0.8%
Asian	0	0.0%
Native Hawaiian or Other Pacific Islander	0	0.0%
American Indian or Alaska Native	3	2.4%
Decline to answer	4	3.3%
Other	0	0.0%
Two or more races	0	0.0%
Hispanic/Latino	*4*	*3.3%*

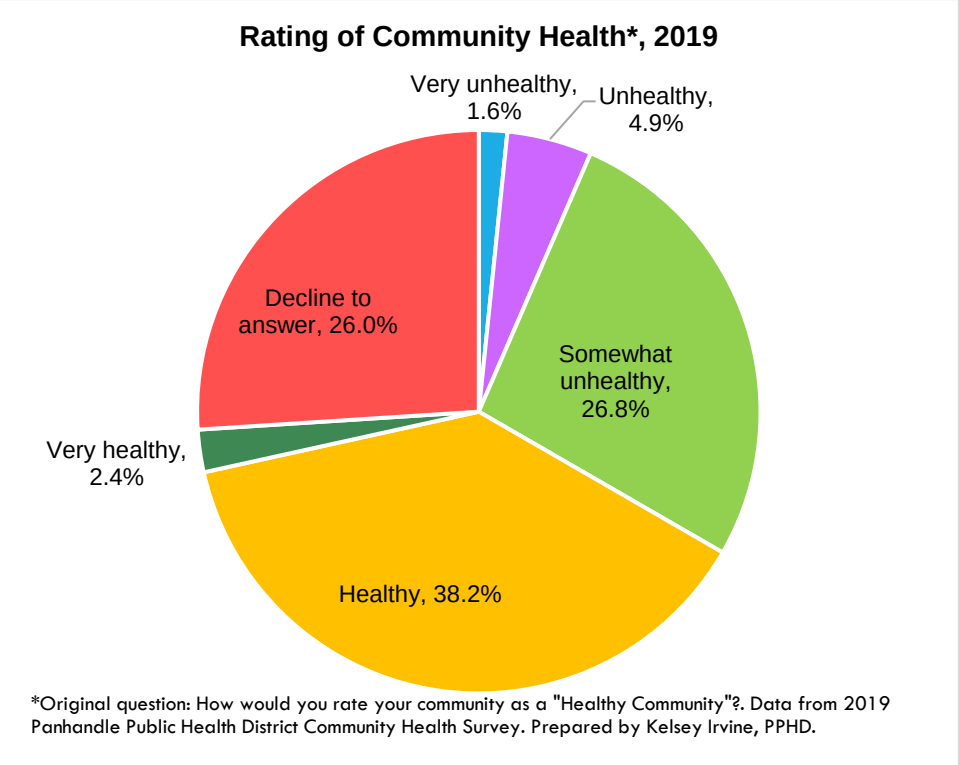
Age:	**#**	**%**
Under 18 years	0	0.0%
18-25 years	4	3.3%
26-39 years	28	22.8%
40-54 years	33	26.8%
55-64 years	31	25.2%
65-80 years	18	14.6%
Over 80 years	7	5.7%
Marital Status:		
Married/Partnered	86	69.9%
Divorced	10	8.1%
Never married	10	8.1%
Separated	0	0.0%
Widowed	9	7.3%
Decline to answer	8	6.5%
Other	0	0.0%
Household Income:		
Less than $20,000	6	4.9%
$20,000 to $29,999	13	10.6%
$30,000 to $49,999	20	16.3%
$50,000 to $74,999	26	21.1%
$75,000 to $99,999	16	13.0%
Over $100,000	27	22.0%
Decline to answer	15	12.2%

Demographic information for the respondents to the 2019 Community Health Survey can be found in the table above. The respondents were primarily female (74.8%) as opposed to male (22.0%). The age of respondents was relatively distributed. The majority of respondents were married or partnered (69.9%). The majority of respondents were white (92.7%), and 3.3% indicated they were Hispanic or Latino. Survey respondents were spread across a variety of income levels.

RATING OF COMMUNITY HEALTH

When asked to rank the health of their community, the majority of respondents indicated that the community is healthy (38.2%), with a ranking of somewhat unhealthy coming in a close second (26.8%). 2.4% ranked the community as being very healthy. 4.9% ranked community health as being unhealthy and 1.6% as very unhealthy. 26.0% of respondents declined to answer the question.

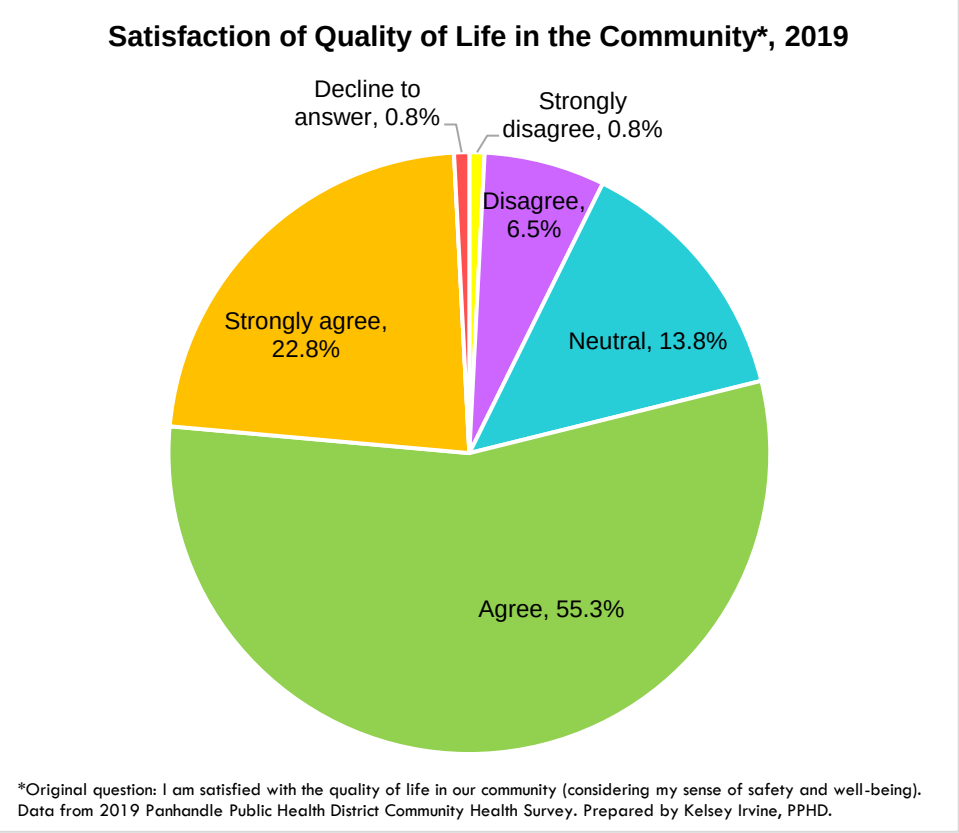
Figure 91: Rating of Community Health



QUALITY OF LIFE

When asked about their satisfaction with the quality of life in their community, the majority of respondents indicated they agreed with the statement (55.3%), and 22.8% strongly agreed. 13.8% of respondents felt neutral, 6.5% disagreed, 0.8% strongly disagreed, and 0.8% declined to answer.

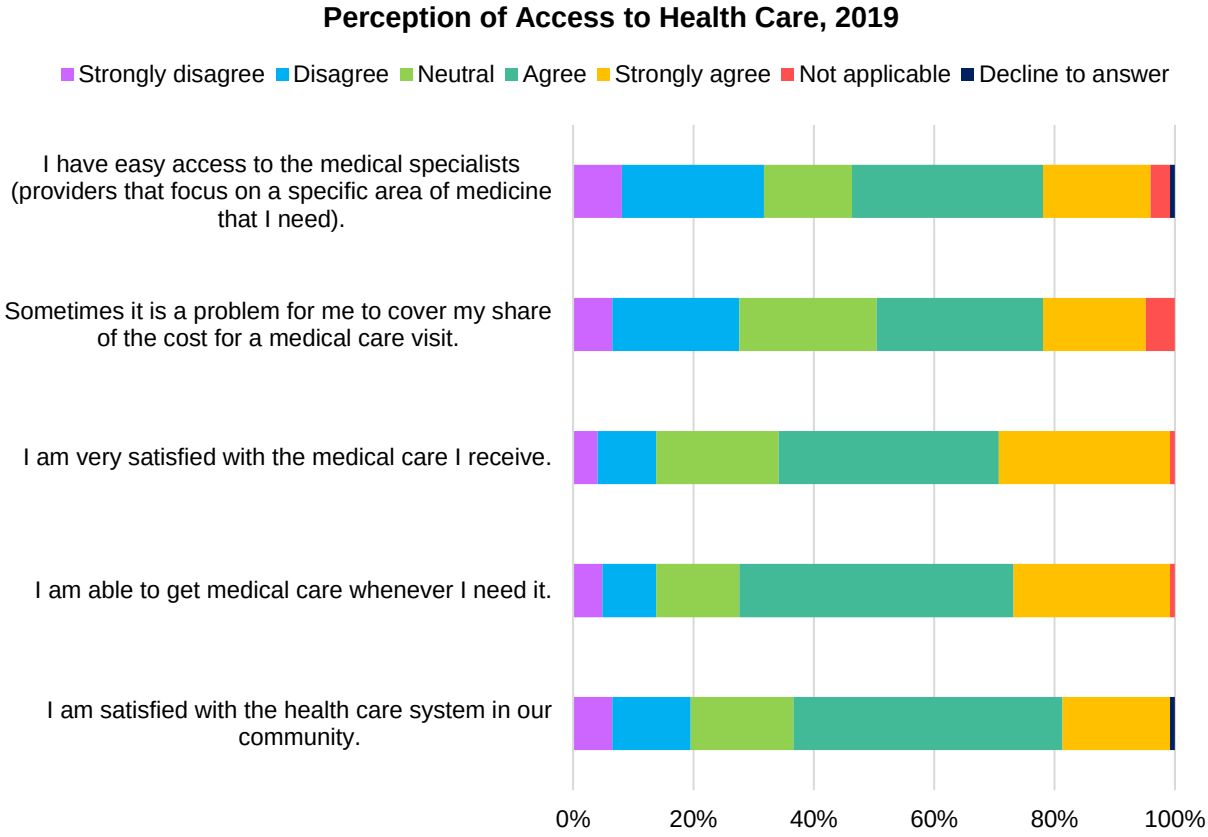
Figure 92: Satisfaction of Quality of Life in the Community



ACCESS TO CARE

The following section includes responses to questions about access to care in the Panhandle. Most respondents agree they are satisfied with and can access medical care in their community. Many respondents felt it is more difficult to access specialty care within their community than primary care.

Figure 93: Perception of Access to Health Care



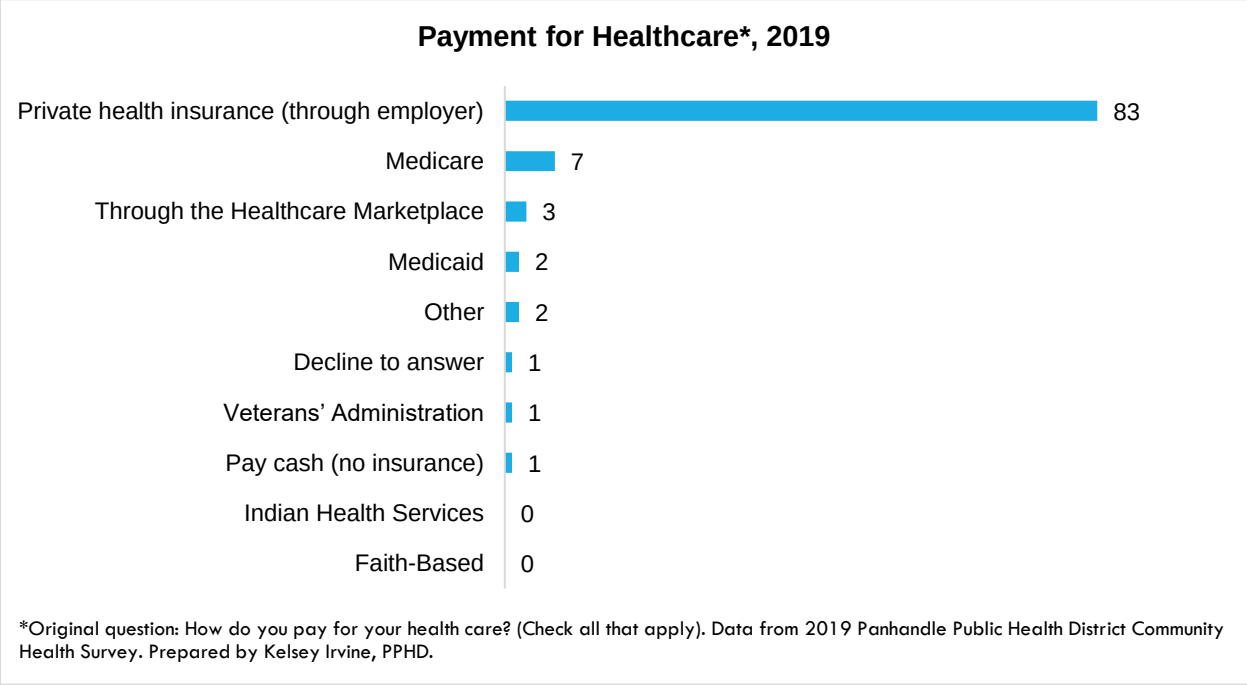
Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
I have easy access to the medical specialists (providers that focus on a specific area of medicine that I need).	8.1%	23.6%	14.6%	31.7%	17.9%	3.3%	0.8%
Sometimes it is a problem for me to cover my share of the cost for a medical care visit.	6.5%	21.1%	22.8%	27.6%	17.1%	4.9%	0.0%
I am very satisfied with the medical care I receive.	4.1%	9.8%	20.3%	36.6%	28.5%	0.8%	0.0%
I am able to get medical care whenever I need it.	4.9%	8.9%	13.8%	45.5%	26.0%	0.8%	0.0%
I am satisfied with the health care system in our community.	6.5%	13.0%	17.1%	44.7%	17.9%	0.0%	0.8%

PAYMENT FOR HEALTHCARE

The following section includes responses to questions about payment for healthcare in the Panhandle. The majority of survey respondents had private health insurance through their employer, with the second category receiving coverage from Medicare. Many respondents noted that they pay quite a bit of cash out of pocket before meeting their deductible on private insurance plans.

Figure 94: Payment for Healthcare

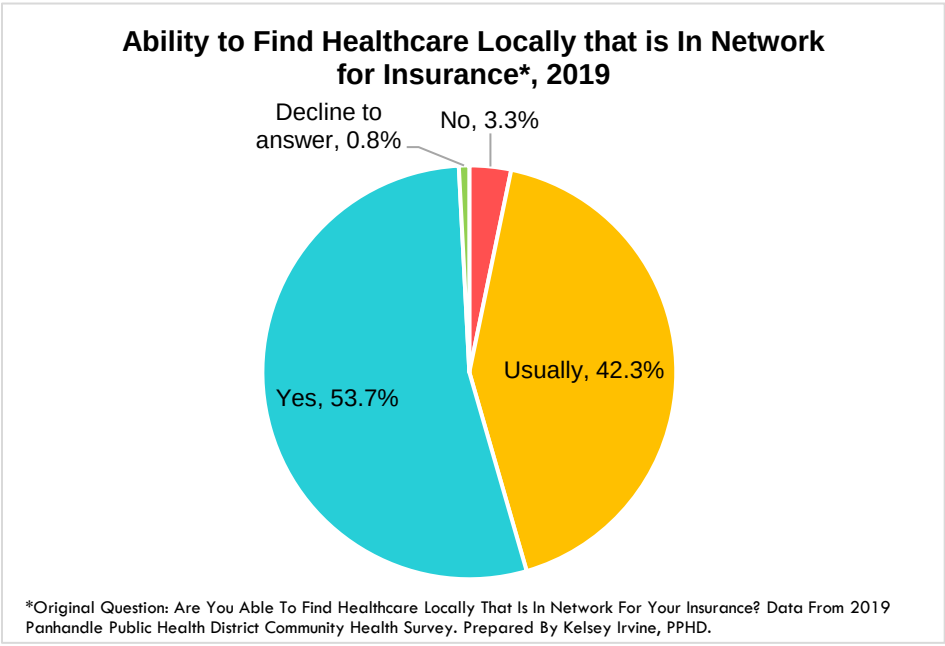


*Original question: How do you pay for your health care? (Check all that apply). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

IN NETWORK HEALTHCARE

Most respondents (53.7%) indicated they are able to find healthcare locally that is in-network for their insurance, and 42.3% indicated they can usually find healthcare locally that is in-network.

Figure 95: Ability to find Healthcare Locally that is in Network for Insurance

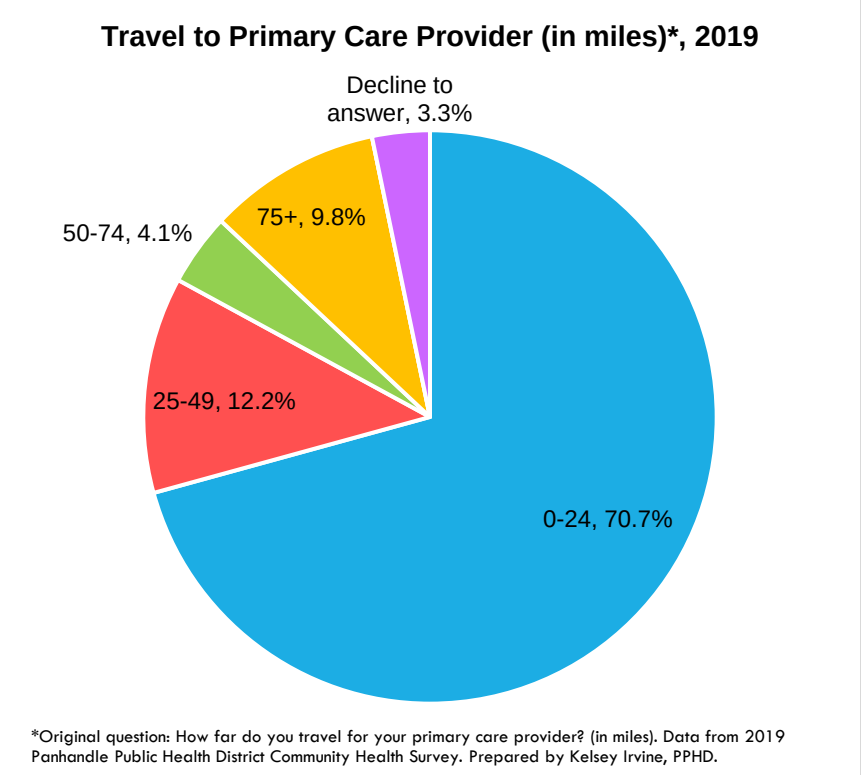


*Original Question: Are You Able To Find Healthcare Locally That Is In Network For Your Insurance? Data From 2019 Panhandle Public Health District Community Health Survey. Prepared By Kelsey Irvine, PPHD.

PRIMARY CARE

The majority of respondents (70.7%) travel 0-24 miles to their primary care provider. 12.2% indicated they travel 25 to 49 miles, and 13.9% indicated they travel 50 miles or more for healthcare. These findings indicate that the majority of people receive healthcare within their immediate community.

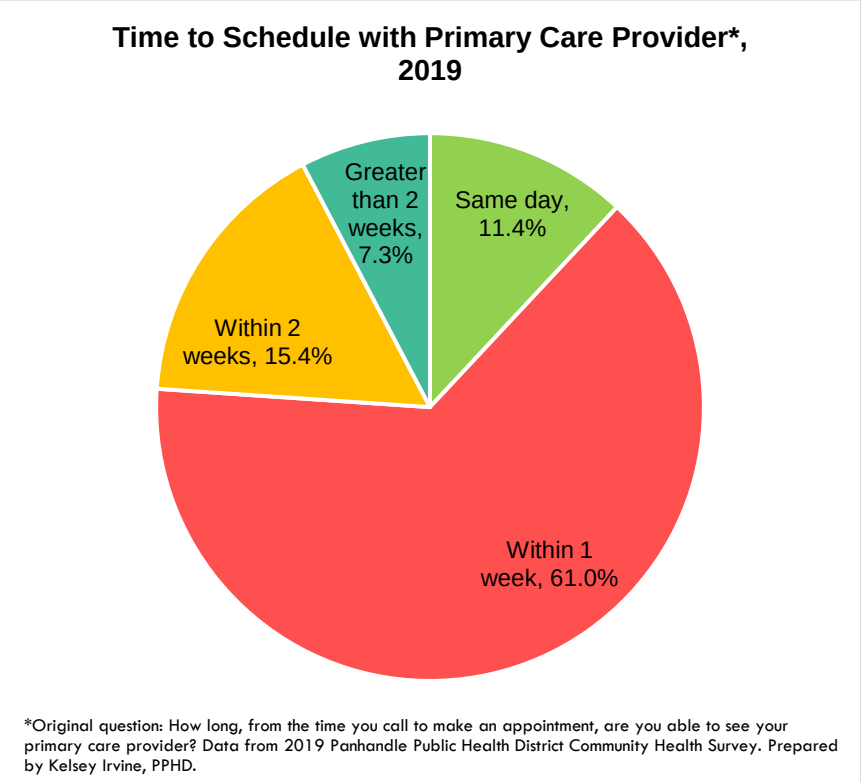
Figure 96: Travel to Primary Care Provider



*Original question: How far do you travel for your primary care provider? (in miles). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

Most respondents are able to schedule time with their primary care provider in the same day (11.4%) or within one week (61.0%) of calling to schedule an appointment. 15.4% of respondents are able to make appointments within two weeks. 7.3% of respondents indicated it took more than two weeks to get in to see their provider.

Figure 97: Time to Schedule with Primary Care Provider



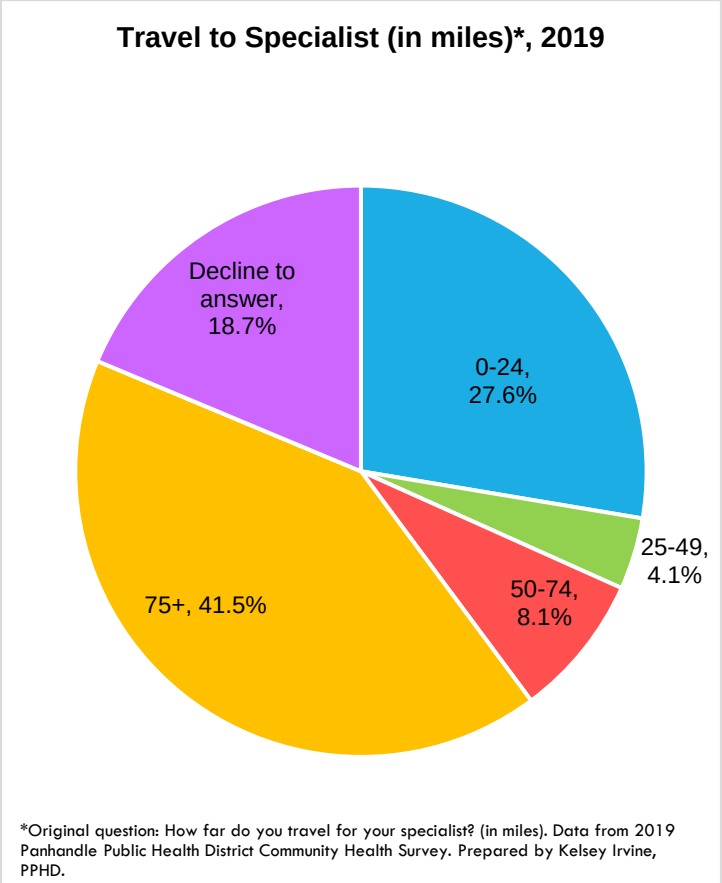
*Original question: How long, from the time you call to make an appointment, are you able to see your primary care provider? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

SPECIALTY CARE

Compared to the travel distance to see primary care providers, the data indicate that most survey respondents travel outside of their immediate community for specialty care. 49.6% of respondents travel 50 or more miles to see a specialist. 4.1% travel 25 to 49 miles, and 27.6% travel 0 to 24 miles.

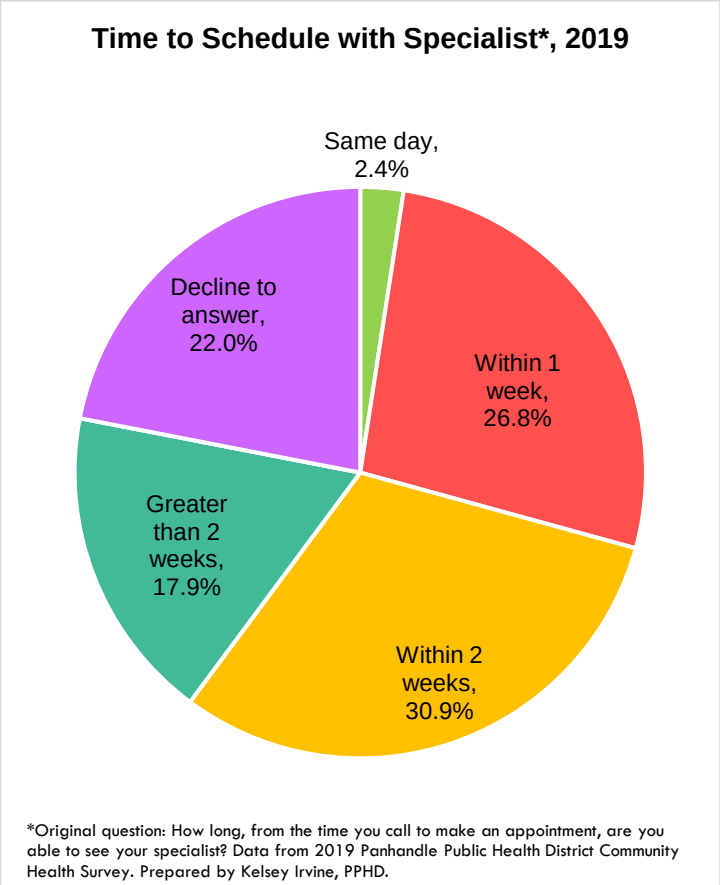
Similar to traveling longer distances to see a specialist, most respondents indicated it takes longer to get in to see a specialist. 17.9% of respondents indicated it takes greater than two weeks. 30.9% are able to see their specialists within two weeks, and 26.8% within one week. Only 2.4% of respondents indicated they were able to see their specialist on the same day as they called to make the appointment.

Figure 99: Travel to see Specialist



*Original question: How far do you travel for your specialist? (in miles). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

Figure 98: Time to Schedule with Specialist



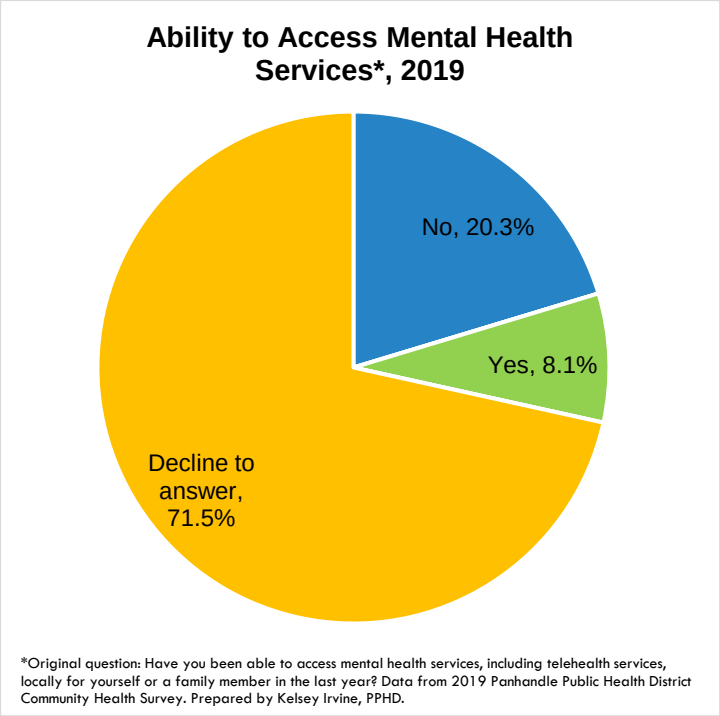
*Original question: How long, from the time you call to make an appointment, are you able to see your specialist? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

MENTAL HEALTH SERVICES

Of the respondents who responded to questions relating to mental health, most are unable to access mental health services within their community. Out of 28.4% of respondents who answered the questions 8.1% are able to access mental health services in their community. 20.3% indicated they are unable to access mental health services in their community.

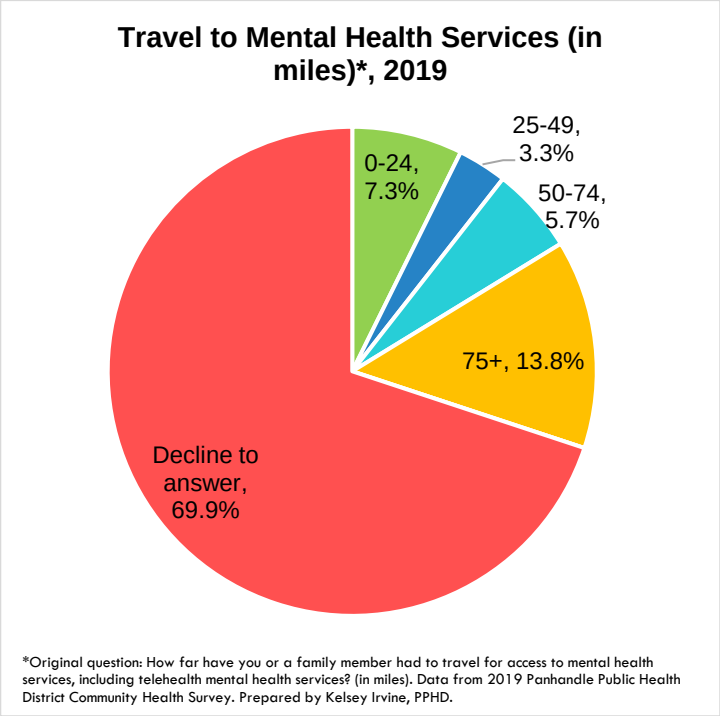
7.3% of respondents indicated they travel 0-24 miles to receive mental health services, suggesting they receive care in their immediate communities. The majority of those receiving mental health services travel 25 miles or more, perhaps traveling to neighboring communities.

Figure 101: Ability to Access Mental Health Services



*Original question: Have you been able to access mental health services, including telehealth services, locally for yourself or a family member in the last year? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

Figure 100: Travel to Mental Health Services

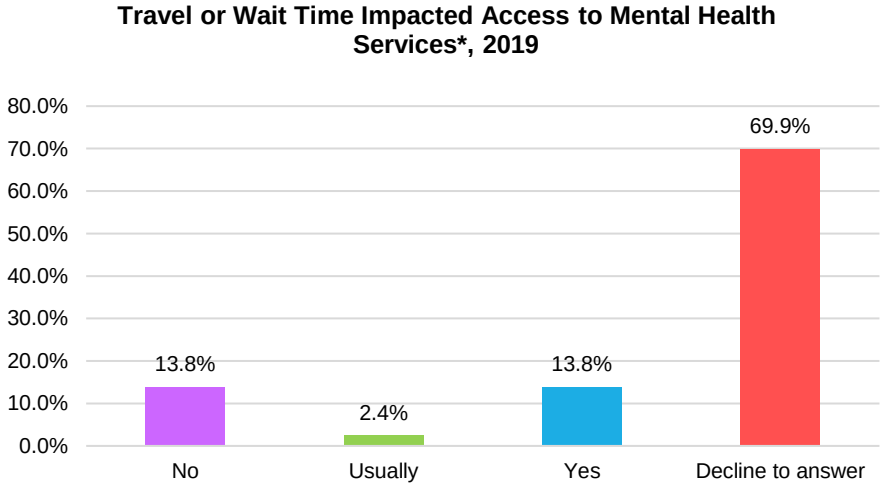


*Original question: How far have you or a family member had to travel for access to mental health services, including telehealth mental health services? (in miles). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

IMPACT OF TRAVEL OR WAIT TIME ON ACCESS TO MENTAL HEALTH SERVICES

Of the those who responded to the question, there was a nearly 50/50 split between those who indicated that wait time did and did not impact their ability to access mental health services.

Figure 102: Travel or Wait Time Impacted Access to Mental Health Services

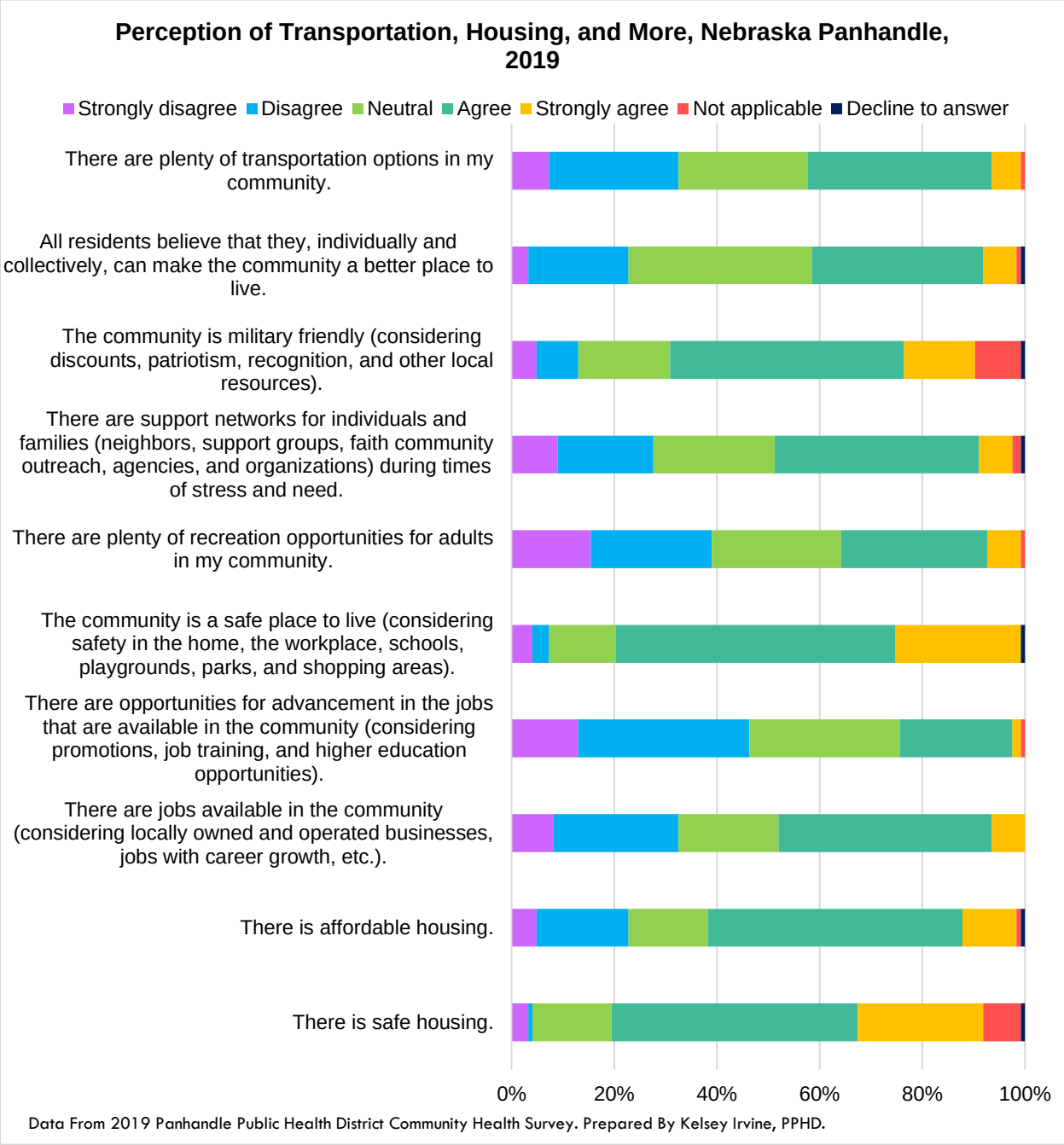


*Original question: Has travel distance or wait time for mental health services locally prevented you or a family member from seeking mental health services when needed? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

TRANSPORTATION, HOUSING, AND MORE

The following section includes responses to questions about transportation, housing, employment, and more in the Panhandle. Some notable findings: Most respondents indicated jobs are available, however there is less opportunity for advancement in the available jobs. Respondents indicated there is safe housing, but the available housing is not viewed as very affordable. Additionally, most respondents feel that there are few recreation opportunities for adults in communities.

Figure 103: Perception of Transportation, Housing, and More



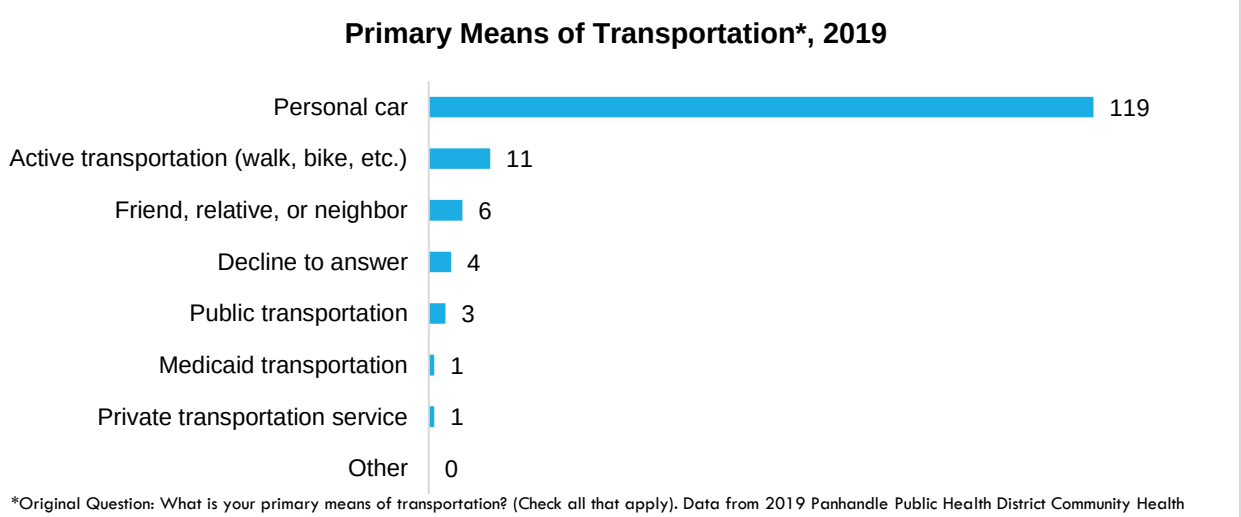
Data From 2019 Panhandle Public Health District Community Health Survey. Prepared By Kelsey Irvine, PPHD.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are plenty of transportation options in my community.	7.3%	25.2%	25.2%	35.8%	5.7%	0.8%	0.0%
All residents believe that they, individually and collectively, can make the community a better place to live.	3.3%	19.5%	35.8%	33.3%	6.5%	0.8%	0.8%
The community is military friendly (considering discounts, patriotism, recognition, and other local resources).	4.9%	8.1%	17.9%	45.5%	13.8%	8.9%	0.8%
There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	8.9%	18.7%	23.6%	39.8%	6.5%	1.6%	0.8%
There are plenty of recreation opportunities for adults in my community.	15.4%	23.6%	25.2%	28.5%	6.5%	0.8%	0.0%
The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas).	4.1%	3.3%	13.0%	54.5%	24.4%	0.0%	0.8%
There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).	13.0%	33.3%	29.3%	22.0%	1.6%	0.8%	0.0%
There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.).	8.1%	24.4%	19.5%	41.5%	6.5%	0.0%	0.0%
There is affordable housing.	4.9%	17.9%	15.4%	49.6%	10.6%	0.8%	0.8%
There is safe housing.	3.3%	0.8%	15.4%	48.0%	24.4%	7.3%	0.8%

TRANSPORTATION

Most survey respondents indicated they drive their own vehicle as their primary means of transportation.

Figure 104: Primary Means of Transportation

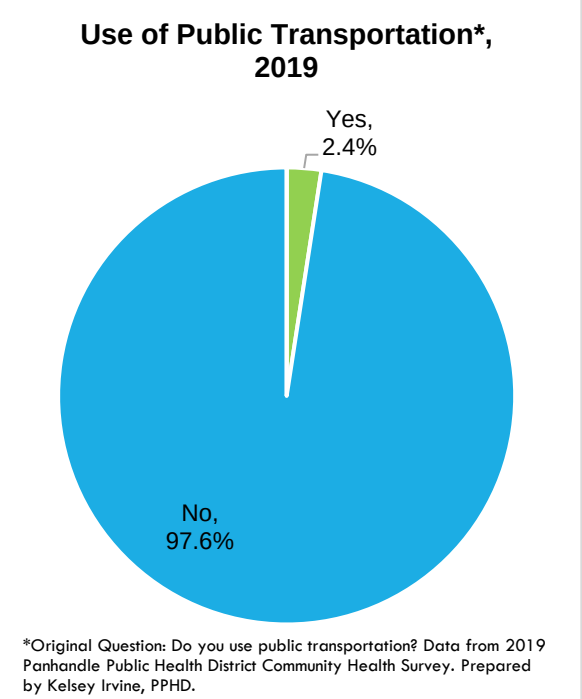


*Original Question: What is your primary means of transportation? (Check all that apply). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

PUBLIC TRANSPORTATION

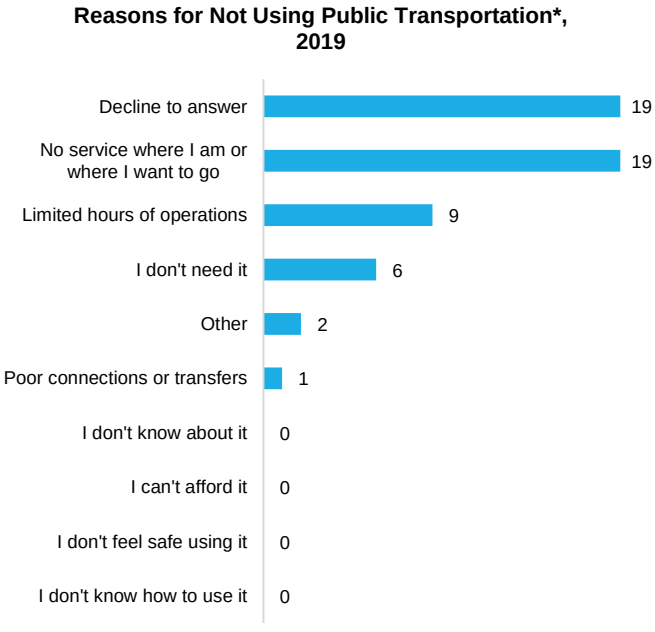
The majority of respondents (97.6%) do not use public transportation. Most indicated that there was no service where they are or where they need to go (19), followed by limited hours of operation (9) and no need to use it (6).

Figure 106: Use of Public Transportation



*Original Question: Do you use public transportation? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

Figure 105: Reasons for Not Using Public Transportation

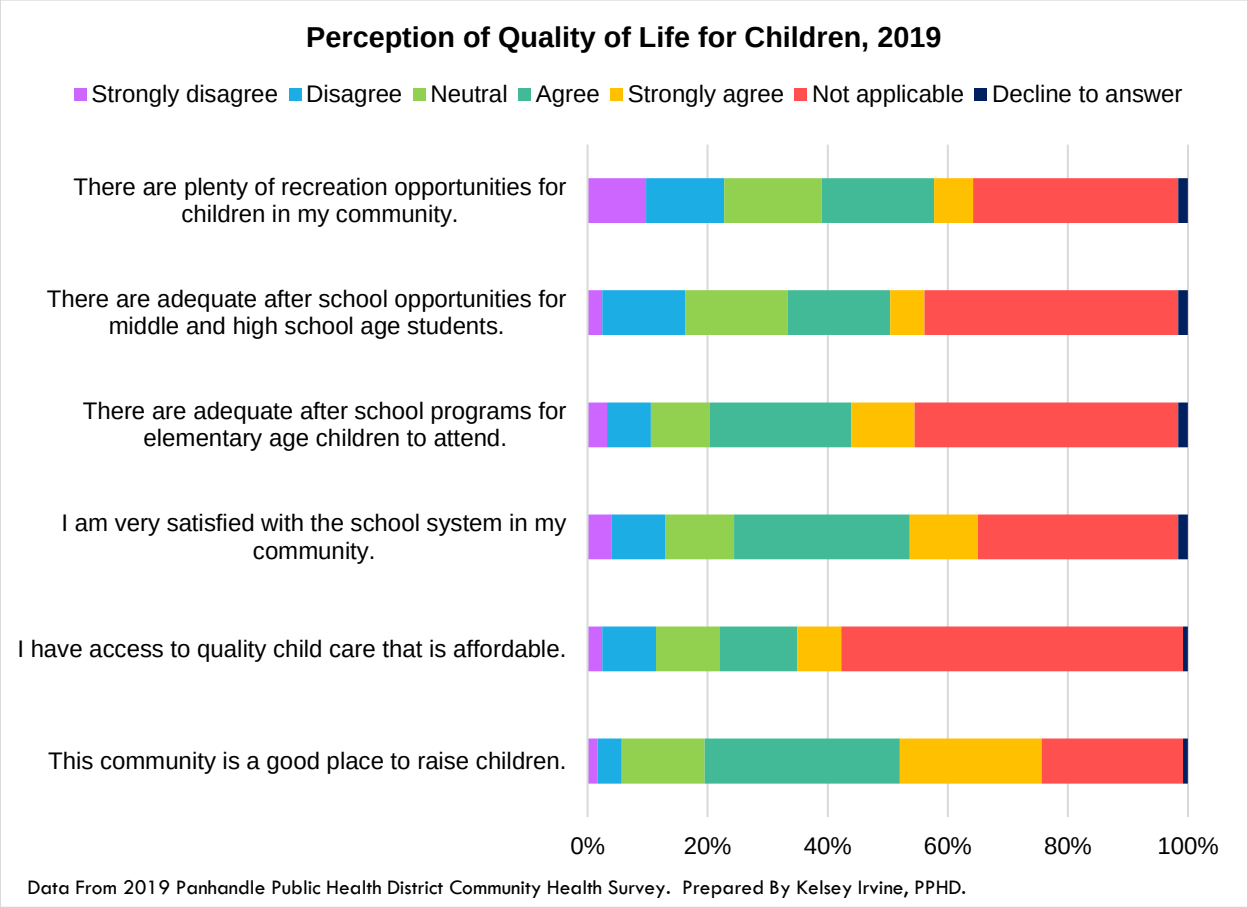


*Original Question: If no, why not? (Check all that apply). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

QUALITY OF LIFE FOR CHILDREN

The following section includes responses to questions about children, childcare, and education in the community. Only respondents with children in their care responded to these questions, therefore the "Not Applicable" bars are larger than seen in other charts. Many people agree the communities are a good place to raise children and there are good school systems. Many respondents felt there are not enough recreation opportunities for middle and high school aged children and access to quality childcare is a challenge.

Figure 107: Perception of Quality of Life for Children

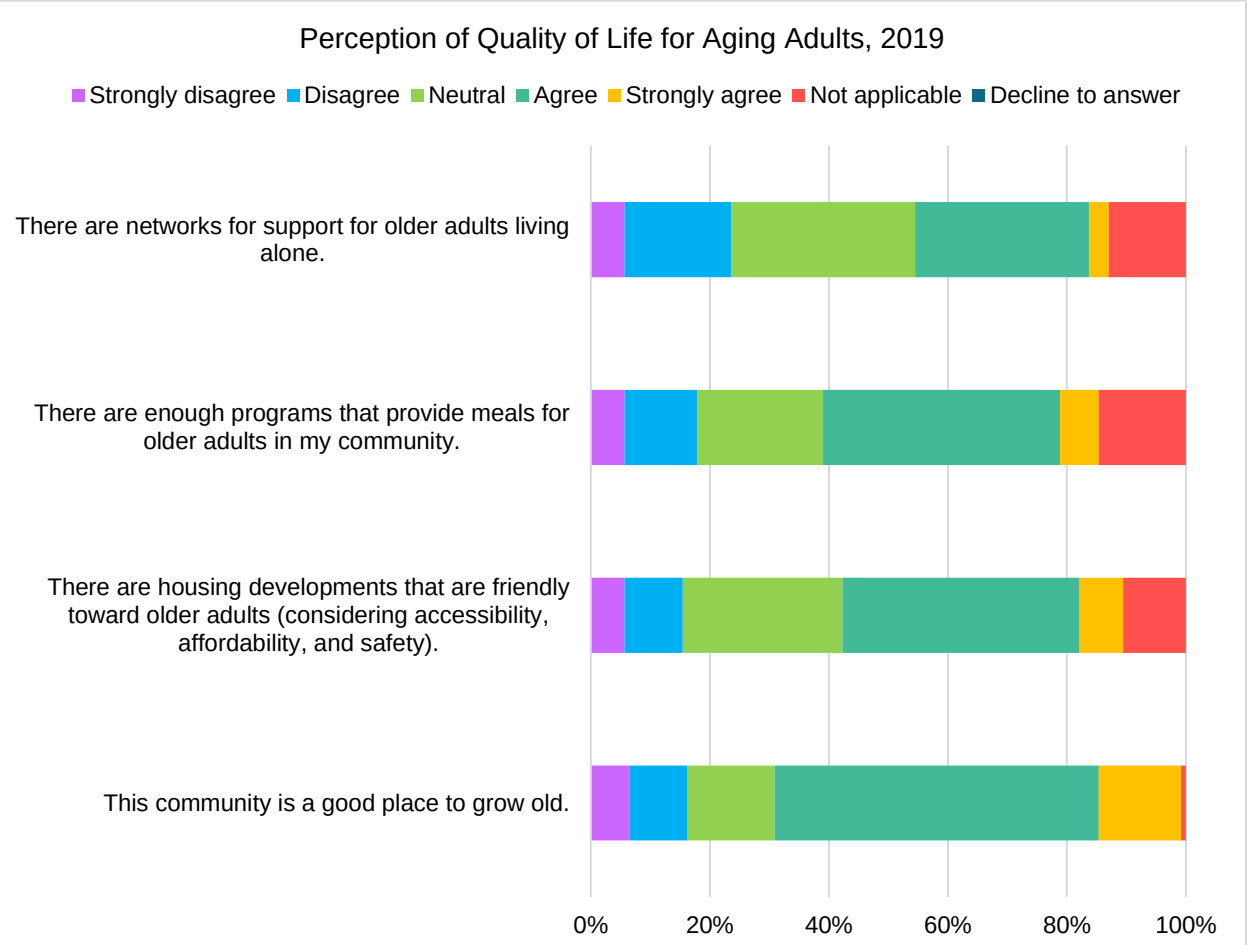


	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are plenty of recreation opportunities for children in my community.	9.8%	13.0%	16.3%	18.7%	6.5%	34.1%	1.6%
There are adequate after school opportunities for middle and high school age students.	2.4%	13.8%	17.1%	17.1%	5.7%	42.3%	1.6%
There are adequate after school programs for elementary age children to attend.	3.3%	7.3%	9.8%	23.6%	10.6%	43.9%	1.6%
I am very satisfied with the school system in my community.	4.1%	8.9%	11.4%	29.3%	11.4%	33.3%	1.6%
I have access to quality childcare that is affordable.	2.4%	8.9%	10.6%	13.0%	7.3%	56.9%	0.8%
This community is a good place to raise children.	1.6%	4.1%	13.8%	32.5%	23.6%	23.6%	0.8%

QUALITY OF LIFE FOR AGING ADULTS

The following section includes responses to questions about older adults in the Panhandle. Overall, respondents ranked items about quality of life for older adults on the positive side. The majority felt the community is good place to grow old (68.3% agreed or strongly agreed).

Figure 108: Perception of Quality of Life for Aging Adults



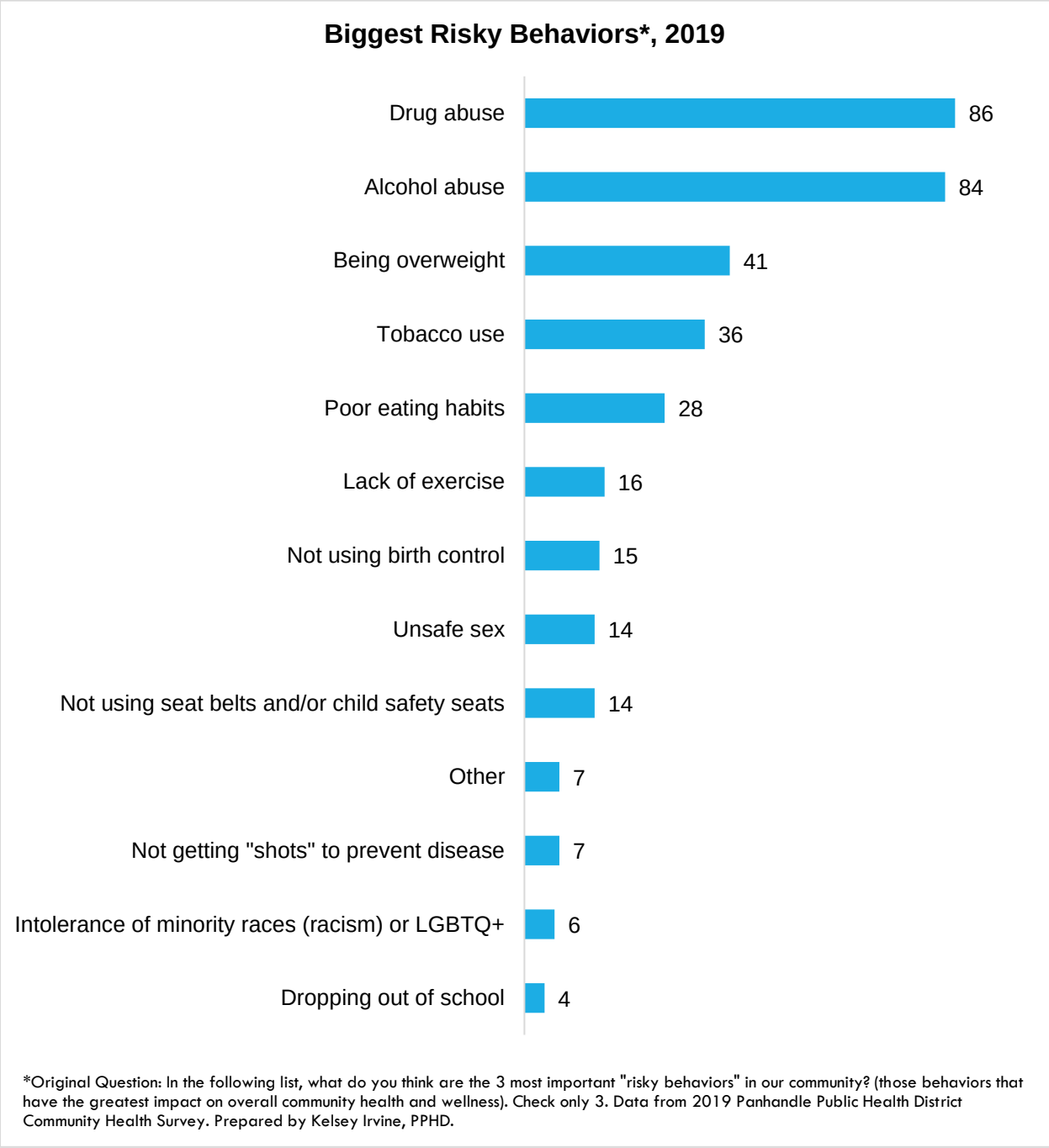
Data From 2019 Panhandle Public Health District Community Health Survey. Prepared By Kelsey Irvine, PPHD.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are networks for support for older adults living alone.	5.7%	17.9%	30.9%	29.3%	3.3%	13.0%	0.0%
There are enough programs that provide meals for older adults in my community.	5.7%	12.2%	21.1%	39.8%	6.5%	14.6%	0.0%
There are housing developments that are friendly toward older adults (considering accessibility, affordability, and safety).	5.7%	9.8%	26.8%	39.8%	7.3%	10.6%	0.0%
This community is a good place to grow old.	6.5%	9.8%	14.6%	54.5%	13.8%	0.8%	0.0%

TOP RISKY BEHAVIORS

The Community Health Survey asked respondents to rank the three most risky behaviors in the community. The top three risky behaviors were drug abuse, alcohol abuse, and being overweight, followed by tobacco use, poor eating habits, and lack of exercise.

Figure 109: 2019 Biggest Risky Behaviors

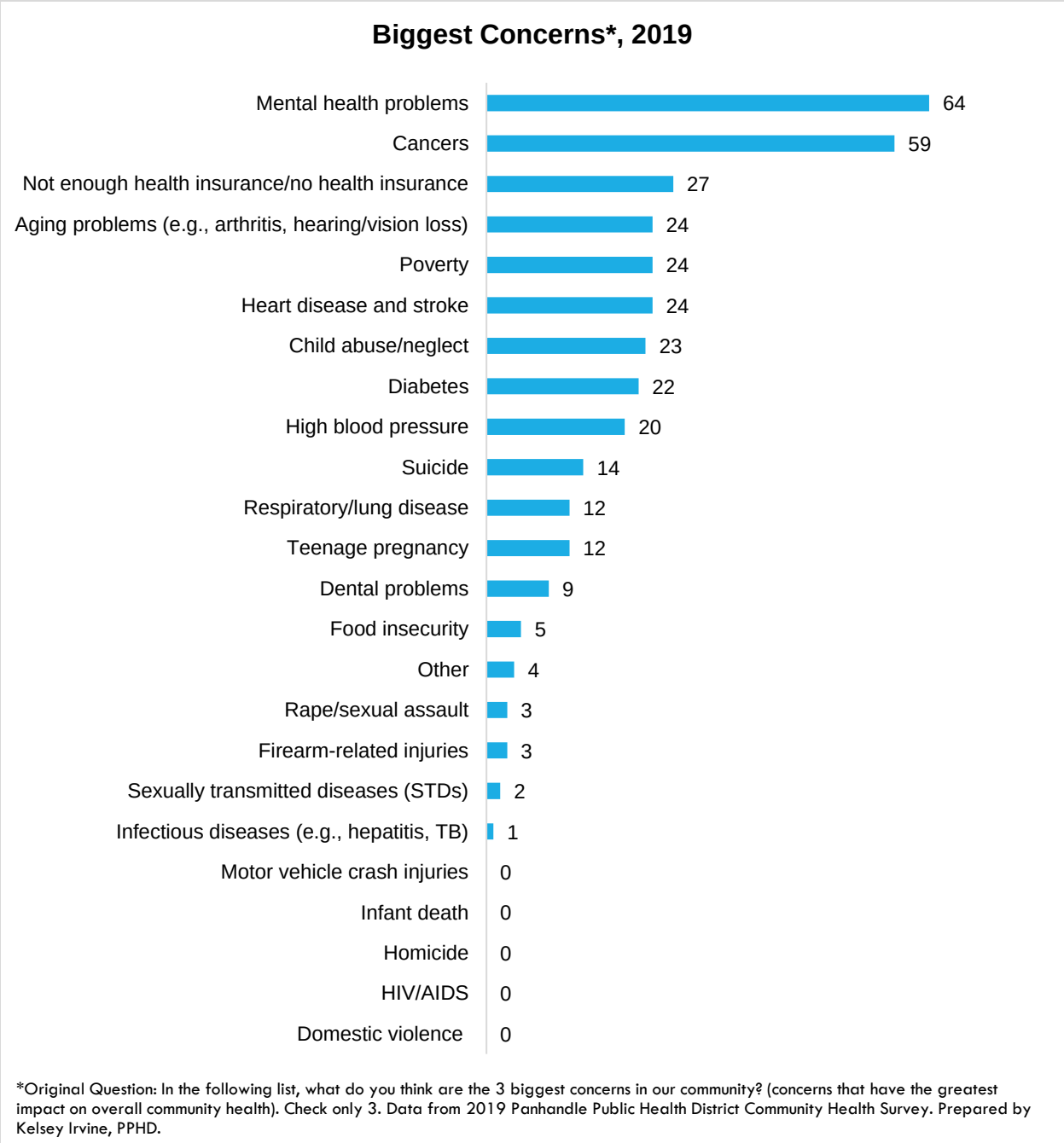


*Original Question: In the following list, what do you think are the 3 most important "risky behaviors" in our community? (those behaviors that have the greatest impact on overall community health and wellness). Check only 3. Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

BIGGEST CONCERNS

The Community Health Survey asked respondents to rate their three biggest concerns in the community. The top three concerns rated were mental health problems, cancers, and not enough health insurance/no health insurance, followed by poverty, heart disease and stroke, and child abuse/neglect.

Figure 110: 2019 Panhandle Biggest Concerns



*Original Question: In the following list, what do you think are the 3 biggest concerns in our community? (concerns that have the greatest impact on overall community health). Check only 3. Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

FOCUS GROUPS

PPHD collaborated with Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Kimball Health Services, Morrill County Community Hospital, Regional West Garden County, Regional West Medical Center, and Sidney Regional Medical Center to hold a series of focus groups across the Panhandle region. The purpose of the focus group is to gather input from community members in order to develop a better understanding of the issues they feel are important, their concerns, and their overall perception of their community. Focus groups were largely conducted in spring of the year 2020. Because of the COVID-19 pandemic, a handful of focus groups were completed via open-ended survey rather than in person.

Each hospital facilitated at least one focus group with residents in their service area, and hospitals with greater than 5% of a minority population in their service area made a concerted effort to include people representative of the minority population in the focus groups, to ensure full community representation. The individual hospitals were primarily responsible for recruiting focus group participants, with PPHD providing assistance when needed. As per the MAPP process, groups were intended to be made up of 8-10 people, although some variance occurred. Hospital representatives identified potential focus group participants from their community and reached out via phone calls, emails, and social media to invite them to attend a focus group session.

PPHD staff facilitated the focus group sessions for all hospitals. Each focus group had a facilitator and a scribe, and was approximately 60-minutes long. The process is as follows:

1. Facilitator gives a brief overview of the purpose of the focus group.
2. Facilitator, scribe, and participants introduce themselves.
3. Facilitator outlines the focus group ground rules.
4. Ask focus group questions.

Comments were captured by the scribe and analyzed collectively as a region. The analysis of the focus group data was guided by the Krueger approach. 29 Focus group transcripts were read, and prevailing themes were identified. Data was highlighted and sorted accordingly.

A total of 16 focus group sessions involving approximately 142 Nebraska Panhandle residents were completed.

The following section summarizes the focus group surveys distributed to Cheyenne and Deuel Counties (in-person focus groups were not possible due to the COVID-19 pandemic).

See Appendix C for the focus group guide and demographic survey, and see Appendix D for demographic information of focus group attendees.

FOCUS GROUP FINDINGS

As you read through the focus group strengths and needs you will notice contradictions. This may be due to the fact that the Sidney Regional Medical Center serves two counties: Cheyenne and Deuel, thus needs in one community may be a strength in another community, and vice versa. However, it can be gleaned that many of the same aspects were perceived to have both strengths and weaknesses, in different areas.

COMMUNITY DESCRIPTION

Community members described the community.

- The communities are **small**, in both geographical **size** and the **closeness of the residents**. They are **close-knit, friendly,** and **welcoming.**
- The communities are full of **caring people** that are **giving, friendly, helpful,** and **supportive.**
- The communities are **family friendly.** They are a **safe, quiet,** and **relaxed** place to raise children.

COMMUNITY STRENGTHS

Community members identified strengths of the community. Some strengths echoed how they would describe the community:

- The communities are full of **caring people**, that are **giving, friendly, helpful,** and **supportive.**

Some strengths were new:

- A consistent theme across the communities are the **strong school systems**.
- The communities have a lot of **community resources**, including shopping, businesses, and community assistance programs.
- The communities have strong **local healthcare** opportunities, including local **hospitals** and **clinics.**

COMMUNITY CHANGES

Community members described how the community has changed in the past 5-10 years.

- **Employment** changed in many ways, with **less local businesses** and **less job opportunities** in communities.
- **Out-migration** occurred as many young people left communities for education, job opportunities, and housing.

COMMUNITY NEEDS

Community members discussed community needs. The following needs were identified:

- **Employment** needs, including **lack of local job opportunities** and **low wages**.
- **Behavioral health** options (for mental health, alcohol, and drug use).
- **Senior care** options (both brick and mortar and **in-home care**) and **senior housing** options.
- **Housing**, including low housing stock, cost of housing, and quality of housing.

COMMUNITY INTERACTIONS

Community members described the interactions between community members of different backgrounds.

- Overall, the communities are **accepting** and **racially diverse**.

COMMUNITY CONCERNS

Community members viewed the top risky behaviors and biggest concern for their specific community from the 2019 Community Health Survey and discussed the findings. The community members agreed with the top risky behaviors and health concerns, listed here (ordered most important to least important):

Top Risky Behaviors:

1. Alcohol abuse
2. Drug abuse
3. Poor eating habits

Top Health Concerns:

1. Cancers
2. Aging problems
3. Poverty

Community members discussed things that might be missing, or should be viewed as more important:

- Resources to address an **aging population**, like home health care and senior living facilities.
- **Behavioral health**, specifically **alcohol abuse**, **mental health**, and **suicide**.
- **Health care coverage** (health insurance).

FORCES OF CHANGE ASSESSMENT

The Forces of Change assessment was intended to take place at a large in-person event in March 2020, which would have been the kick-off event for the 2020 Community Health Assessment. Due to the COVID-19 Pandemic, this event was cancelled, and a virtual event took place on July 30, 2020, to complete the assessment. See Appendix A for the meeting work product (including details on the process), and see the next page for the full Forces of Change assessment.

2020 FORCES OF CHANGE – WAVE METAPHOR

What is happening now that will impact our work?

Horizon	Emerging	Established	Disappearing	Undertow
• Creating a culture of health (personal accountability) • Healthy eating the standard/norm • Healthy choice is the easy choice • Get communities involved in gardens and growing food • Health at every size • Healthcare focus on prevention • Concierge medicine • # Unlimited access to care in rural Nebraska • ^ Uncertainty of health care coverage • # Rebuilding the sense of community and neighborhood – mutual reliance and responsibility • Investment in minority and immigrant peoples for high need jobs • Increase minimum wage to livable wage • Homeless shelter with wraparound services • Behavioral health assistance for employers	• Healthy convenient food choices • Nutritional programs in schools • # Healthy child nutrition program • ^ Uncertainty of continued federal funding for social service activities • # Increased awareness of benefits of physical activity • Physical activity opportunities in all communities • Community assistant nurse • Patient-centered medical homes • Increased use of technology to improve health care • # Telehealth • Telehealth for mental health • # Universal coverage • Best practices • Outcome-based provider reimbursement • # 2-year certificates, community colleges, online and on the job training • # Technology to improve access for all • Virtual delivery system for education and employee training • Virtual opportunities social interactions • Limited opportunities for in-person socialization may impact mental health • Usable consistent transportation • More rural transportation options • Understanding implicit biases at personal and systemic levels	• Public health • # PPHD Offerings – NDPP, radon, tobacco free campus, worksite wellness, Healthy Families America • # Faith based practices • # Panhandle Partnership • # Rural Nebraska Healthcare Network • Community coalition for change • # Collaboration between communities • # Standard of Collaboration among community, clinical and social services • ^ Acceptance of substance use • # Tobacco policies • #^ Agriculture • Limited funds to cities to make infrastructure changes • Legislative changes are difficult • Healthy nutrition options – MyPlate, farmers markets, bountiful baskets, NuVal – Choose Healthy Here, WIC, SNAP • Medical support – healthcare system, Airlink, Dr. Webb, visiting physicians, Dental Day • Activity options – community centers, walking path, 5 and 10Ks, ½ marathons, triathlons, public school athletics, after school programs, Kids Fitness and Nutrition Day • Revisit vaccinations for infectious disease prevention • Big employers closing	• Young generation leaving after college • # Bachelor's degree = necessary for good jobs • ^ ACA • Silos in the Panhandle • Single provider care management • Landline (Black outs) • Recruitment of big business will save us • Sugar is not as bad as fat • White/rural areas don't have poverty • ^ Business climate (getting loans investments, small farms, and ranches) • Silos in working toward better health outcomes • Shifting schools (country schools) • ^ Stigma of walking and biking to work • "It's always been that way" mentality	• Rural – decreasing population, aging population, decreasing political voice, decreasing tax base • Population trends • Political divide • Government regulations and politics • Public trust in prevention efforts • Mixed messaging through social and traditional media • ^ Discrimination • Cultural bias • Cultural acceptance of racism and prejudices • Increase in minority populations • Lack of job diversity • ^ Poverty • ^ Uncertainty of payment system to multiple sectors • Education and economic disparities • Lobbying and advertising around tobacco, alcohol, and sugar • Fierce Independence • Participation • Community norms for substance use • Potential legalization of medical/recreational marijuana • Quick changing substance abuse trends • Brain drain • COVID-19 Pandemic and long-term impacts • ^ Fear and resistance to change • Self-reliant attitude • Change in family unit

KEY
Green # = Pleasing/Positive
Red ^ = Concerning/Negative
BOTH = #^ BOTH

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The Local Public Health System Assessment (LPHSA) was completed across spring and summer of 2020. A summary of the results can be found in Appendix E.

Community members were invited to participate in the LPHSA at various meetings. They were provided with the Essential Service description and Model Standard narrative, and discussion questions for each Model Standard. A PPHD staff member facilitated the discussion in each group, and an additional PPHD member acted as a scribe.

Participants came to consensus on a rating for each Model Standard with a rating of one to five, where 1 = No Activity, 2 = Minimal, 3 = Moderate, 4 = Significant, and 5 = Optimal.

The facilitator and group also noted any strengths, weaknesses, short-term opportunities, and long-term opportunities associated with each Essential Service.

MAPP PHASE 4: IDENTIFY STRATEGIC ISSUES

Based on a review of the data, the priority areas for 2020-2023 are:

- Focus Area 1: Behavioral Health
- Focus Area 2: Chronic Care
- Focus Area 3: End of Life

MAPP PHASE 5: FORMULATE GOALS AND STRATEGIES

Goals and strategies for the priority areas are:

- Focus Area 1: Behavioral Health
    1. Weekly visits to school counselors to identify individuals with needs and proactively design plan of care
    2. Monthly articles, tips and techniques about mental health issues in area media vendors
    3. Raise awareness for Behavioral Health and Senior Life Solutions at SRMC
    4. Offer an annual survey to assess progress and areas of need
- Focus Area 2: Chronic Care
    1. Promote chronic care management 'program inserts' to community via social media/website with email signup for free download
    2. Research the viability and usage for the Living Well online program
    3. Determine three key areas for current Chronic Care Management participants to track improvements
    4. Promote Direct Access Testing
- Focus Area 3: End of Life
    1. Create annual Senior Life Healthfair promoting area available resources
    2. Offer doula training to develop a EOL volunteer support system
    3. Determine if partnering with Hospice of the Plains is a possible hospice provider of services for our area

MAPP PHASE 6: TAKE ACTION

IMPLEMENTATION

The CHIP will be implemented across the next three years, from January 2021 to December 2023. The CHIP will be implemented through collaboration between SRMC, local public health, and community organizations.

APPENDICES

2020 Community Health Assessment
Visioning & Forces of Change

Completed July 30, 2020

The Forces of Change assessment and Visioning process were completed via virtual meeting on July 30, 2020. The mode of meeting was virtual due to the COVID-19 pandemic. 48 people attended the meeting.

The agenda was as follows:

- Introductions
- Review the data
- Visioning
- Forces of Change
- Regroup and Review
- Conclusion

Kelsey Irvine (PPHD) provided a short presentation of health outcome and risk factor data, a brief summary of 2019 Community Health Survey results, and a brief summary of the 2020 focus group results.

Kelsey Irvine (PPHD) led the group in a focused conversation to update the Vision. Rather than create a brand-new vision for the 2020 CHA process, the group instead worked to update the Vision from the 2017 process. The group reviewed the 2017 Vision and discussed the following questions, with the overarching question of "What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?" kept in mind.

- What is a point in the vision that stuck out to you?
- What have we accomplished?
- Is anything no longer relevant?
- What remains true today?
- Where is more work needed?
- What are other things we need to consider?
- What are we really committed to?

The group then completed the Forces of Change Assessment in a similar format, by updating the 2017 Forces of Change Assessment rather than starting from scratch. Kelsey Irvine (PPHD) led the group through a review of the Wave process and format that was used to complete the Forces of Change Assessment. The Wave process is a Technology of Participation process that focuses on five areas:

- Horizon: Which new ideas are pushing or needing to become accepted trends and practices?
- Emerging: Which trends and practices are picking up momentum and acceptance?

- Established: Which trends and practices are mainstream or standard operating procedures?
- Disappearing: Which trends and practices are concepts whose variability is overtly questioned or not needed?
- Undertow: What are the deep patterns that cause trouble, even in the midst of success?

The entire group held a discussion to update the Horizon section. Then the group broke out into small groups to complete the discussion to update each of the other sections. The group then reconvened to review their discussion findings.

Facilitator:	**Section:**
Kelsey Irvine	Horizon
Cheri Farris	Emerging
Tabi Prochazka	Established
Melissa Haas	Disappearing
Jessica Davies	Undertow

The work products from 2017 were updated with the discussions that took place in the meeting, and posted on a Basecamp website for attendees, and those who were invited but unable to attend, to review and provide commentary.

The remaining pages include the participant list, 2020 Visioning and Forces of Change products, and 2017 Visioning and Forces of Change products.

Participant List:

Name:	Organization:
Kelsey Irvine	Panhandle Public Health District
Cheri Farris	Panhandle Public Health District
Melissa Haas	Panhandle Public Health District
Melissa Norgard	City of Sidney Economic Development
Alex Helmbrecht	Chadron State College
Kim Engel	Panhandle Public Health District
Chelsie Herian	Box Butte Development
Monica Shambaugh	CAPstone
Dan Newhoff	Box Butte General Hospital
Robin Stuart	Morrill County Community Hospital
Karen Eisenbarth	Northwest Community Action Partnership
Jessica Davies	Panhandle Public Health District
Sandy Montague-Roes	Western Community Health Resources
Nici Johnson	ESU 13
Jennifer Sibal	Gering Public Schools
Erin Norman	Chadron State College
Susan Wiedeman	Panhandle Coop
Marie Parker	PPHD Board of Health
Sabrina Sosa	Community Action Partnership of Western Nebraska
Evie Parsons	Sidney Regional Medical Center
Betsy Vidlak	Community Action Partnership of Western Nebraska
Britt Miller	Chappell Community Development
Sara Williamson	Panhandle Public Health District
John Marrin	Western Nebraska Community College
Erika Guerrero	Title 1C Migrant Education
Boni Carrell	Rural Nebraska Healthcare Network
Doris Brown	Gordon Memorial Hospital
John Vesper	Western Nebraska Community College
Nicole Berosek	Panhandle Public Health District
Steph Black	United Way
Susan Unzicker	Alliance Chamber
Ricca Sanford	Regional West Garden County
Rhonda Theiler	Perkins County Health Services
Megan Kopenhafer	Panhandle Area Development District
Kendra Dean	Cirrus House
Tabi Prochazka	Panhandle Public Health District
Troy Unzicker	Alliance Public Schools
Carolyn Jones	Box Butte General Hospital
Patricia Wellnitz	PPHD Board of Health
Laura Bateman	Kimball Health Services
Karen Benzel	United Way of Western Nebraska
Travis Miller	Bayard Public Schools
Brenda Brooks	DHHS WSA
Faith Mills	Panhandle Partnership
Lori Mazanec	Box Butte General Hospital
Neil Hilton	Perkins County Health Services
Karen Anderson	Scottsbluff-Gering Chamber
Tyson Lambertson	The Rock Church

2020 Vision

What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?							
Healthy Eating	**Promote Emotional Resilience**	**Environments and Events for Active Living**	**Establish Healthy Habits Early On**	**Focus on Long-term impact of Pandemic**	**Improve Access to Healthcare**	**Prevent and Reduce Substance Use**	**Access to Basic Needs**
• Community gardens • Healthy food options • Increase nutrition awareness through programming (SNAP, food bank, commodities, etc.) • Access to affordable healthy foods • Incorporation of local healthy food options (farmers market, farm to table, etc.)	• Improve emotional well-being • Healthier ways to deal with stress • Improve access to behavioral health services • Community support for behavior change • Promote healthy stress management techniques • Overcome cost as a barrier to behavioral health treatment	• Safe environments for walking and biking in communities • Opportunities for physical activity (5k type activities, family activities) • Workplace culture of wellness, both in office and WFH • Distance-friendly opportunities for physical activity (virtual, etc.) • Incentives for healthy lifestyle changes • Cultivate culture of health • Active living environments accessible to people of all abilities	• Educate children on whole body health (food choices and activity; access to nutritious foods; access to walkways and activity; emotional health) • Provide parents with education and support for healthy children (nutrition, physical activity, emotional health) • Elementary school education about healthy habits • Health literate resources • Support healthy family programming (Healthy Families, WIC, etc.) • Address environmental health concerns that impact children (e.g., lead) • Focus on all health factors, not only weight	• Promote kindness and compassion during unusual times • Decrease politization of public health measures • Accessible technology for older adults • Accessible technology for vulnerable populations • Virtual opportunities for physical activity • Maintain opportunities for health screenings • Healthcare opportunities for those who experience gap in health insurance due to job loss	• Improved access to eye care • Transportation to/from medical appointments • Increased health care coverage • Mobile health services • Increased resources to care for older adults • Population health perspective • Decrease chronic disease • Link healthcare providers to community programs • Medicaid Expansion	• Tobacco free • Local taxes on tobacco and alcohol • Reduce binge drinking rates • Reduce substance abuse (misuse of prescription drugs, illegal opioids) • Reduce e-cigarette use among youth (tobacco and marijuana) • Improve access to sites for safe medication disposal	• Accessible and affordable public transportation • Safe, quality, and affordable housing • Quality and affordable childcare • Emergency housing for homeless individuals • Jobs with livable wages and benefits • Payer sources to keep hospitals and clinics paid/open

2020 Forces of Change – Wave Metaphor

What is happening now that will impact our work?				
Horizon	**Emerging**	**Established**	**Disappearing**	**Undertow**
• Creating a culture of health (personal accountability) • Healthy eating the standard/norm • Healthy choice is the easy choice • Get communities involved in gardens and growing food • Health at every size • Healthcare focus on prevention • Concierge medicine • # Unlimited access to care in rural Nebraska • ^ Uncertainty of health care coverage • # Rebuilding the sense of community and neighborhood – mutual reliance and responsibility • Investment in minority and immigrant peoples for high need jobs • Increase minimum wage to livable wage • Homeless shelter with wraparound services • Behavioral health assistance for employers **KEY** Green # = Pleasing/Positive Red ^ = Concerning/Negative **BOTH** = #^ BOTH	• Healthy convenient food choices • Nutritional programs in schools • # Healthy child nutrition program • ^ Uncertainty of continued federal funding for social service activities • # Increased awareness of benefits of physical activity • Physical activity opportunities in all communities • Community assistant nurse • Patient-centered medical homes • Increased use of technology to improve health care • # Telehealth • Telehealth for mental health • # Universal coverage • Best practices • Outcome-based provider reimbursement • # 2-year certificates, community colleges, online and on the job training • # Technology to improve access for all • Virtual delivery system for education and employee training • Virtual opportunities social interactions • Limited opportunities for in-person socialization may impact mental health • Usable consistent transportation • More rural transportation options • Understanding implicit biases at personal and systemic levels	• Public health • # PPHD Offerings – NDPP, radon, tobacco free campus, worksite wellness, Healthy Families America • # Faith based practices • # Panhandle Partnership • # Rural Nebraska Healthcare Network • Community coalition for change • # Collaboration between communities • # Standard of Collaboration among community, clinical and social services • ^ Acceptance of substance use • # Tobacco policies • #^ Agriculture • Limited funds to cities to make infrastructure changes • Legislative changes are difficult • Healthy nutrition options – MyPlate, farmers markets, bountiful baskets, NuVal – Choose Healthy Here, WIC, SNAP • Medical support – healthcare system, Airlink, Dr. Webb, visiting physicians, Dental Day • Activity options – community centers, walking path, 5 and 10Ks, ½ marathons, triathlons, public school athletics, after school programs, Kids Fitness and Nutrition Day • Revisit vaccinations for infectious disease prevention • Big employers closing	• Young generation leaving after college • # Bachelor's degree = necessary for good jobs • ^ ACA • Silos in the Panhandle • Single provider care management • Landline (Black outs) • Recruitment of big business will save us • Sugar is not as bad as fat • White/rural areas don't have poverty • ^ Business climate (getting loans investments, small farms, and ranches) • Silos in working toward better health outcomes • Shifting schools (country schools) • ^ Stigma of walking and biking to work • "It's always been that way" mentality	• Rural – decreasing population, aging population, decreasing political voice, decreasing tax base • Population trends • Political divide • Government regulations and politics • Public trust in prevention efforts • Mixed messaging through social and traditional media • ^ Discrimination • Cultural bias • Cultural acceptance of racism and prejudices • Increase in minority populations • Lack of job diversity • ^ Poverty • ^ Uncertainty of payment system to multiple sectors • Education and economic disparities • Lobbying and advertising around tobacco, alcohol, and sugar • Fierce Independence • Participation • Community norms for substance use • Potential legalization of medical/recreational marijuana • Quick changing substance abuse trends • Brain drain • COVID-19 Pandemic and long-term impacts • ^ Fear and resistance to change • Self-reliant attitude • Change in family unit

2017 Vision

What does a healthy Panhandle look like in the next 3 years for all who live, learn, work, and play here?									
Culturally Sensitive and Peer-Driven Services	**Environments and Events for Active Living**	**Promoting Emotional Resilience**	**Creating and Supporting a Culture of Wellness**	**Healthy Eating**	**Establishing Healthy Habits Early On**	**Improving Access**	**Community-Oriented Healthcare**	**Financing Our Future**	**Prevent and Reduce Substance Use**
• Culturally sensitive and peer-driven services	• Safe walkable and biking communities • Opportunities for physical activity • 5K – more runs available in different locations • More activity less technology • Family activities	• Healthier ways to deal with stress • Emotional well-being • Better access to mental health services • Access to behavioral health services for youth and adults • Community support group behavior change	• Wellness culture important in the workplace • Health education – wellness • Healthy lifestyles • Incentives for individuals leading a healthy lifestyle • Employers focused on well-being of families • Healthy incentives • Cultural change toward health	• Community and school gardens – teaching food skills • Healthy food options • Increase nutrition awareness with nutrition programs – SNAP, food bank, commodities • Universally available nutritious food options • Incorporation of local healthy food options • Access affordable healthy foods	• Focus on children – teaching about food choices and activity; access to nutritious foods; access to walkways and activity • Schools teaching elementary students healthy habits • Promoting a healthy lifestyle at a young age • Education – health literacy • Healthy family programs – nutrition, Healthy Families America • Parent education and support – nutrition, physical activity, how to cook	• Access to services • More access to dental and eye care • Availability of transportation for well-being • Access – enough providers, transportation, insurance • Resource list or online database of services available • Mobile health services • Increased resources for elderly care • Safe housing – homeless-ness	• Increase health screening and prevention • Integrated population health – community and clinic/ hospital • Decrease chronic disease • Linking health care providers to community programs • Continued community, organizational and personal collaboration and working together	• Jobs with livable wages and benefits • Payor sources to keep hospitals and clinics paid/open • Accessible quality childcare • Affordable transportation, housing, and childcare • Employers focused on well-being of families	• Tobacco free • Local taxes on tobacco, soda, and alcohol (booze) • Reducing binge drinking rates • Reduction – 20% in substance use

2017 Forces of Change – Wave Metaphor

What is happening now that will impact our work?				
Horizon	**Emerging**	**Established**	**Disappearing**	**Undertow**
• # Standard of Collaboration among community, clinical and social services • # Technology to improve access for all • Creating a culture of health (personal accountability) • Healthy eating the standard/norm (fruits/veggies accessible and desired by all) • Unified health services focus on prevention • # Unlimited access to care in rural Nebraska • # Rebuilding that sense of community and neighborhood – mutual reliance and responsibility • Physical activity opportunities in all of our communities • Usable consistent transportation • Investment in minority and immigrant for high need jobs • Concierge medicine • Healthy choice is the easy choice • ^ Uncertainty of health care coverage • Continue to expand telehealth networks • Get communities involved in gardens and growing food • Homeless shelter with wraparound services	• Healthy convenient food choices • Big employers closing • ^ Uncertainty of continued federal funding for social service activities • # Increased awareness of benefits of physical activity • Community assistant nurse • Sugar tax • Patient-centered medical homes • More rural transportation options • Increased use of technology to improve health care • Nutritional programs in schools • Growth of organic foods – bountiful baskets • # Universal coverage • Best practices • Telehealth mental health • # Healthy child nutrition program • Pay providers for keeping patients healthy (outcomes) • # Telehealth • # 2-year certificates, community colleges, online and on the job training **KEY** Green # = Pleasing/Positive Red ^ = Concerning/Negative **BOTH** = #^ BOTH	• PPHD • # Faith based practices • # Panhandle Partnership • ^ Acceptance of substance use • Health departments • #^ Agriculture • Community coalition for change • Limited funds to cities to make infrastructure changes • Legislative changes are difficult • ^ Stigma of walking and biking to work • # Tobacco policies • # Collaboration between communities • # PPHD Offerings – NDPP, radon, tobacco free campus, worksite wellness, Healthy Families America • Healthy nutrition options – MyPlate, farmers markets, bountiful baskets, NuVal – Choose Healthy Here, WIC, SNAP • # Rural Nebraska Healthcare Network • "It's always been that way" mentality • Medical support – healthcare system, Airlink, Dr. Webb, visiting physicians, Dental Day • Activity options – community centers, walking path, 5 and 10Ks, ½ marathons, triathlons, public school athletics, after school programs, Kids Fitness and Nutrition Day	• Young generation leaving after college • # Bachelor's degree = necessary for good jobs • ^ ACA • Silos in the Panhandle • Single provider care management • Landline (Black outs) • Recruitment of big business will save us • Sugar is not as bad as fat • White/rural areas don't have poverty • ^ Business climate (getting loans investments, small farms, and ranches) • Silos in working toward better health outcomes • Shifting schools (country schools)	• Population changes (decreasing total population, decreasing youth population, increasing aging population) • Self-reliant attitude • Change in family unit – everyone needs to work, childcare, mental health, lack of resources • ^ Prejudice – race, mental health, poverty • ^ Poverty • Lobbying and advertising around tobacco, alcohol, and sugar • Fierce Independence • Participation • Rural • ^ Uncertainty of payment system – to multiple sectors – healthcare, schools, etc. • Aging population • Cultural bias • Community norm – alcohol culture, drug abuse and availability of drugs • Brain drain • Lack of economic diversity – decreasing availability of good jobs/benefits • Increase in minority populations • Rural – decreasing population, aging population, decreasing political voice, decreasing tax base • Government regulations and politics • Cultural acceptance of racism and prejudices • Education and economic disparities • ^ Fear and resistance to change

APPENDIX B: 2019 COMMUNITY HEALTH SURVEY

2019 Community Health Survey

Please take about 10 minutes to complete this short survey. The purpose of this survey is to get your input about the health of your community. The Panhandle Public Health District, area hospitals, and economic development will use your responses to help identify the most pressing concerns. The survey is also available online at www.pphd.org.

1. How would you rate your community as a "Healthy Community?"

☐ Very unhealthy ☐ Unhealthy ☐ Somewhat unhealthy ☐ Healthy ☐ Very Healthy

Please indicate your level of agreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
2. I am satisfied with the quality of life in our community (considering my sense of safety and well-being).	☐	☐	☐	☐	☐	☐
3. I am satisfied with the health care system in our community.	☐	☐	☐	☐	☐	☐
4. I am able to get medical care whenever I need it.	☐	☐	☐	☐	☐	☐
5. I am very satisfied with the medical care I receive.	☐	☐	☐	☐	☐	☐
6. Sometimes it is a problem for me to cover my share of the cost for a medical care visit.	☐	☐	☐	☐	☐	☐
7. I have easy access to the medical specialists (providers that focus on a specific area of medicine that I need).	☐	☐	☐	☐	☐	☐

8. How do you pay for your health care? (Check all that apply)

☐ Pay cash (no insurance)
☐ Private Health insurance (through employer)
☐ Through the Healthcare Marketplace
☐ Faith-Based
☐ Medicaid
☐ Medicare
☐ Veterans' Administration
☐ Indian Health Services
☐ Decline to answer
☐ Other: _____

9. Are you able to find healthcare locally that is in network for your insurance?

☐ No ☐ Usually ☐ Yes ☐ Decline to answer

The following questions are about your primary care provider:

10. What clinic/hospital/health system do you go to for your primary care provider (the doctor you usually go to for medical care)?

_____

11. How far do you travel for your primary care provider? (in miles)

☐ 0-24 ☐ 25-49 ☐ 50-74 ☐ 75+ ☐ N/A

12. How long, from the time you call to make an appointment, are you able to see your primary care provider?

☐ Same day ☐ Within 1 week ☐ Within 2 weeks ☐ Greater than 2 weeks ☐ N/A

13. What other types of health care services would you use if available in your community?

_____

The following questions are about any specialists you may see:

14. What clinic/hospital/health system do you go to for your specialist?

_____

15. How far do you travel for your specialist? (in miles)

☐ 0-24 ☐ 25-49 ☐ 50-74 ☐ 75+ ☐ N/A

16. How long, from the time you call to make an appointment, are you able to see your specialist?

☐ Same day ☐ Within 1 week ☐ Within 2 weeks ☐ Greater than 2 weeks ☐ N/A

17. What other types of specialists would you see if available in your community?

_____

The following questions are about mental health care.

18. Have you been able to access mental health services, including telehealth services, locally for yourself or a family member in the last year?

☐ No ☐ Usually ☐ Yes ☐ N/A ☐ Decline to answer

19. How far have you or a family member had to travel for access to mental health services, including telehealth mental health services? (in miles)

☐ 0-24 ☐ 25-49 ☐ 50-74 ☐ 75+ ☐ N/A

20. Has travel distance or wait time for mental health services locally prevented you or a family member from seeking mental health services when needed?

☐ No ☐ Usually ☐ Yes ☐ N/A ☐ Decline to answer

The following questions are about the built environment, employment, and safety in your community. Please indicate your level of agreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
21. There is safe housing.	☐	☐	☐	☐	☐	☐
22. There is affordable housing.	☐	☐	☐	☐	☐	☐
23. There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.).	☐	☐	☐	☐	☐	☐
24. There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).	☐	☐	☐	☐	☐	☐
25. The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas).	☐	☐	☐	☐	☐	☐
26. There are plenty of recreation opportunities for adults in my community.	☐	☐	☐	☐	☐	☐
27. There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	☐	☐	☐	☐	☐	☐
	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Not Applicable**

28. The community is military friendly (considering discounts, patriotism, recognition, and other local resources).	☐	☐	☐	☐	☐	☐
29. All residents believe that they, individually and collectively, can make the community a better place to live.	☐	☐	☐	☐	☐	☐
30. There are plenty of transportation options in my community.	☐	☐	☐	☐	☐	☐

31. What is your primary means of transportation? (Check all that apply).

- ☐ Personal car
- ☐ Friend, relative, or neighbor
- ☐ Private transportation service
- ☐ Active transportation (walk, bike, etc.)
- ☐ Public transportation
- ☐ Medicaid Transportation
- ☐ Other: _____

32. If you don't drive a car, why not?

(Check all that apply).

- ☐ Can't drive due to a medical/physical condition
- ☐ Can't afford a car
- ☐ Can't afford gas/insurance
- ☐ Lost driver's license
- ☐ No need, everything I need I can access without a car
- ☐ Other: _____

33. Do you use public transportation? ☐ Yes ☐ No

33a. If no, why not? (Check all that apply).

- ☐ No service where I am or where I want to go
- ☐ Poor connections or transfers
- ☐ I don't know how to use it
- ☐ Limited hours of operations
- ☐ I don't feel safe using it
- ☐ I can't afford it
- ☐ I don't know about it
- ☐ I don't need it
- ☐ Other: _____

The following questions are about raising children in your community. Please only respond if you currently have a child that resides with you for whom you provide care. If you do not have children, please mark "Not Applicable". Please indicate your level of agreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
34. This community is a good place to raise children.	☐	☐	☐	☐	☐	☐
35. I have access to quality child care that is affordable.	☐	☐	☐	☐	☐	☐
36. My child care facility is licensed.	☐ Yes	☐ No	☐ Don't know	☐ Not applicable		
37. I am very satisfied with the school system in my community.	☐	☐	☐	☐	☐	☐
38. There are adequate after school programs for elementary age children to attend.	☐	☐	☐	☐	☐	☐
39. There are adequate after school opportunities for middle and high school age students.	☐	☐	☐	☐	☐	☐
40. There are plenty of recreation opportunities for children in my community.	☐	☐	☐	☐	☐	☐

The following questions are about older adults in your community. Please indicate your level of agreement with each of the following statements:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
41. This community is a good place to grow old.	☐	☐	☐	☐	☐	☐
42. There are housing developments that are friendly toward older adults (considering accessibility, affordability, and safety).	☐	☐	☐	☐	☐	☐
43. There are enough programs that provide meals for older adults in my community.	☐	☐	☐	☐	☐	☐
44. There are networks for support for older adults living alone.	☐	☐	☐	☐	☐	☐

The following questions are about risky behaviors and health problems in your community. The first section will ask about risky behaviors (those behaviors that have the greatest impact on overall community health) and the second section will ask about health problems (concerns that have the greatest impact on overall community health).

45. In the following list, what do you think are the 3 most important "risky behaviors" in our community? (those behaviors that have the greatest impact on overall community health and wellness). Check only 3:

- ☐ Alcohol abuse
- ☐ Being overweight
- ☐ Dropping out of school
- ☐ Drug abuse
- ☐ Lack of exercise
- ☐ Poor eating habits
- ☐ Not getting "shots" to prevent disease
- ☐ Intolerance of minority races (racism) or LGBTQ+
- ☐ Tobacco use
- ☐ Not using birth control
- ☐ Not using seat belts and/or child safety seats
- ☐ Unsafe sex
- ☐ Other _____

46. In the following list, what do you think are the **3 biggest concerns** in our community? (concerns that have the greatest impact on overall community health). Check only 3:

- ☐ Aging problems (e.g., arthritis, hearing/vision loss)
- ☐ Cancers
- ☐ Child abuse/neglect
- ☐ Dental problems
- ☐ Diabetes
- ☐ Domestic violence
- ☐ Firearm-related injuries
- ☐ Heart disease and stroke
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Homicide
- ☐ Poverty
- ☐ Infant death
- ☐ Infectious diseases (e.g., hepatitis, TB)
- ☐ Mental health problems
- ☐ Motor vehicle crash injuries
- ☐ Rape/sexual assault
- ☐ Respiratory/lung disease
- ☐ Sexually transmitted diseases (STDs)
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Not enough health insurance/no health insurance
- ☐ Food insecurity
- ☐ Other _____

46a. Of the problems that you marked on the previous page, which one would you most likely work on? Think of personal interests as well as professional interests.

_____

47. Are there emerging issues in the community that you think need to be focused on, that may not be in the above lists?

_____

The following questions are about your experiences as a child. If you are currently under the age of 18, think of your present or past. If you are an adult, think of when you were younger than 18. *If you need resources or assistance relating to anything in the following questions, please visit www.pphd.org for additional information.* As a child:

	Yes	No	Decline to Answer
48. Did you live with anyone who was depressed, mentally ill, or suicidal?	☐	☐	☐
49. Did you live with anyone who was a problem drinker or an alcoholic?	☐	☐	☐
50. Did you live with anyone who used illegal street drugs or who abused prescription medications?	☐	☐	☐
51. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	☐	☐	☐
52. Were your parents separated or divorced?	☐	☐	☐
53. Did parents or adults in your home slap, hit, kick, punch, or beat each other up?	☐	☐	☐
54. Did a parent or adult in your home hit, beat, kick, or physically hurt you in any way? Do not include spanking.	☐	☐	☐
55. Did a parent or adult in your home swear at you, insult you, or put you down?	☐	☐	☐
56. Did an adult or anyone at least 5 years older than you touch you in sexual way?	☐	☐	☐
57. Did an adult or anyone at least 5 years older than you try to make you touch them in sexual way?	☐	☐	☐

Please provide the following information about yourself. It will be used for demographic purposes only. Keep in mind you will NOT be identified in any way with your answers.

58. Zip code: _____

59. County of residence:

- ☐ Banner
- ☐ Box Butte
- ☐ Cheyenne
- ☐ Dawes
- ☐ Deuel
- ☐ Garden
- ☐ Grant
- ☐ Kimball
- ☐ Morrill
- ☐ Scotts Bluff
- ☐ Sheridan
- ☐ Sioux
- ☐ Other: _____

60. Gender identity:

- ☐ Male
- ☐ Female
- ☐ Transgender male (female to male)
- ☐ Transgender female (male to female)
- ☐ Gender non-conforming
- ☐ Decline to answer
- ☐ Other: _____

61. Sexual orientation:

- ☐ Heterosexual or straight
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Decline to answer
- ☐ Other: _____

64. Age:

- ☐ Under 18 years
- ☐ 18-25 years
- ☐ 26-39 years
- ☐ 40-54 years
- ☐ 55-64 years
- ☐ 65-80 years
- ☐ Over 80 years

62. Highest level of education:

- ☐ Less than high school graduate
- ☐ High school diploma or GED
- ☐ Associates or Technical Degree
- ☐ College degree or higher
- ☐ Decline to answer
- ☐ Other: _____

65. Marital Status:

- ☐ Married/Partnered
- ☐ Divorced
- ☐ Never married
- ☐ Separated
- ☐ Widowed
- ☐ Decline to answer
- ☐ Other: _____

63. Race:

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Decline to answer
- ☐ Other: _____

66. Household Income:

- ☐ Less than $20,000
- ☐ $20,000 to $29,999
- ☐ $30,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ Over $100,000
- ☐ Decline to answer

67. Are you Hispanic or Latino/a/x? ☐ Yes ☐ No ☐ Decline to answer

68. Military status (Check all that apply):

- ☐ I served or currently serve in the military
- ☐ My husband, wife, or significant other served or currently serves in the military
- ☐ My child served or currently serves in the military
- ☐ My parent served or currently serve in the military
- ☐ My brother/sister served or currently serves in the military
- ☐ None of the above
- ☐ Other: _____

Thank you for taking the time to respond to this survey. Your responses will help us identify where we need to focus work to improve health in the Panhandle.

APPENDIX C: 2020 FOCUS GROUP GUIDE

2020 Focus Group Guide for Community Themes and Strengths Assessment

We would like to talk with you today about your community and your ideas about the strengths and needs of your community. Everyone's opinion is important, so I want to make sure that all get a chance to talk. Feel free to respond to each other and give your opinion even if it differs from your neighbor. Occasionally I may interrupt to move on to the next question, but I will do so just to make sure we cover all the topics that we want to talk about today. It will never mean that I do not think what you are saying is important.

Let's take a minute to introduce ourselves before we get started. Could you please tell everyone your name and how long you have lived in name of community or health district?

Focus Group Ground Rules
We have a lot to cover, so we will all need to do a few things to get our jobs done:

1. Talk one at a time and in a voice at least as loud as mine.

2. We need to hear from every one of you during the discussion even though each person does not have to answer every question.

3. Feel free to respond to what has been said by talking to me or to any other member of the group. That works best when we avoid side conversations and talk one at a time.

4. There are no wrong answers, just different opinions. We are looking for different points of view. So just say what is on your mind.

5. We do have a lot to cover, so you may all be interrupted at some point in order to keep moving and to avoid running out of time.

6. We value your opinions, both positive and negative, and we hope you choose to express them during the discussion.

7. Everything you say in this group is to remain confidential. This means that we require that each one of you agree not to repeat anything talked about within this group to anyone outside of the group.

Again, this focus group is confidential. Notes will be made anonymously. We ask you to respect this understanding and refrain from speaking about specifics about this group with others afterwards.

1. **First, I would like to start by getting an idea of how you would describe your community. If you were talking with a friend or family member who had never been here, how would you describe your community to him or her?**
   Probes: What does it look like; get an idea of physical boundaries—definition of community; what is different about here compared to there; what types of things are available here; what activities do you do here?

2. **What do you view as strengths of your community?**

3. **How do you think your community has changed in the last 5-10 years?**

4. **What are some of the things that you see as lacking in your community?**
   Probes: Needs; health needs, specific services.

5. **How would you describe the interactions between community members from different backgrounds? Think about community members of different races, different abled (for example, handicapped), LGBTQ+, etc.**

6. **A Community Health Survey was recently completed in your community.**

The top 3 risky behaviors were:	**The top 3 biggest concerns were:**
1.	1.
2.	2.
3.	3.

   a) **Do you agree with these?**

   b) **Are there things we may be missing?**

7. **If you had a magic wand, what is one thing you would improve within your community?**

2020 Focus Group Participant Survey

Please provide the following information about yourself. It will be used for demographic purposes only. Keep in mind you will NOT be identified in any way with your answers.

1. Zip code: _____

2. County of residence:
   - ☐ Banner ☐ Box Butte ☐ Cheyenne
   - ☐ Dawes ☐ Deuel ☐ Garden
   - ☐ Grant ☐ Kimball ☐ Morrill
   - ☐ Scotts Bluff ☐ Sheridan ☐ Sioux
   - ☐ Other: _____

3. Gender identity:
   - ☐ Male ☐ Gender non-conforming ☐ Transgender male (female to male)
   - ☐ Female ☐ Decline to answer ☐ Transgender female (male to female)
   - ☐ Other: _____

4. Sexual orientation:
   - ☐ Heterosexual or straight ☐ Gay or lesbian ☐ Bisexual
   - ☐ Decline to answer ☐ Other: _____

5. Highest level of education:
   - ☐ Less than high school graduate ☐ High school diploma or GED
   - ☐ Associates or Technical Degree ☐ College degree or higher
   - ☐ Decline to answer ☐ Other: _____

6. Race:
   - ☐ White ☐ Black or African American
   - ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
   - ☐ American Indian or Alaska Native ☐ Decline to answer
   - ☐ Other: _____

7. Are you Hispanic or Latino/a/x?
   - ☐ Yes ☐ No ☐ Decline to answer

8. Age:
   - ☐ Under 18 years
   - ☐ 18-25 years
   - ☐ 26-39 years
   - ☐ 40-54 years
   - ☐ 55-64 years
   - ☐ 65-80 years
   - ☐ Over 80 years

9. Marital Status:
   - ☐ Married/Partnered
   - ☐ Divorced
   - ☐ Never married
   - ☐ Separated
   - ☐ Widowed
   - ☐ Decline to answer
   - ☐ Other: _____

10. Household Income:
   - ☐ Less than $20,000
   - ☐ $20,000 to $29,999
   - ☐ $30,000 to $49,999
   - ☐ $50,000 to $74,999
   - ☐ $75,000 to $99,999
   - ☐ Over $100,000
   - ☐ Decline to answer

11. Military status (Check all that apply):
   - ☐ I served or currently serve in the military
   - ☐ My husband, wife, or significant other served or currently serves in the military
   - ☐ My child served or currently serves in the military
   - ☐ My parent served or currently serve in the military
   - ☐ My brother/sister served or currently serves in the military
   - ☐ None of the above
   - ☐ Other: _____

APPENDIX D: 2020 FOCUS GROUP DEMOGRAPHIC INFORMATION

Demographics (N = 12)

		#	%
County	Banner	0	0.0%
	Box Butte	0	0.0%
	Cheyenne	6	50.0%
	Dawes	0	0.0%
	Deuel	6	50.0%
	Garden	0	0.0%
	Grant	0	0.0%
	Kimball	0	0.0%
	Morrill	0	0.0%
	Scotts Bluff	0	0.0%
	Sheridan	0	0.0%
	Sioux	0	0.0%
	Other	0	0.0%
Gender Identity	Male	6	50.0%
	Female	6	50.0%
	Transgender male (female to male)	0	0.0%
	Transgender female (male to female)	0	0.0%
	Gender non-conforming	0	0.0%
	Decline to answer	0	0.0%
	Other	0	0.0%
Sexual Orientation	Heterosexual or straight	12	100.0%
	Gay or lesbian	0	0.0%
	Bisexual	0	0.0%
	Decline to answer	0	0.0%
	Other	0	0.0%
Highest level of education	Less than high school graduate	0	0.0%
	High school diploma or GED	2	16.7%
	Associates or Technical Degree	5	41.7%
	College degree or higher	5	41.7%
	Decline to answer	0	0.0%
	Other	0	0.0%

		#	%
Race	White	11	91.7%
	Black or African American	0	0.0%
	Asian	0	0.0%
	Native Hawaiian or Other Pacific Islander	0	0.0%
	American Indian or Alaska Native	0	0.0%
	Decline to answer	0	0.0%
	Other	1	8.3%
Hispanic or Latino/a/x	Yes	0	0.0%
	No	12	100.0%
	Decline to answer	0	0.0%
Age	Under 18 years	0	0.0%
	18-25 years	0	0.0%
	26-39 years	0	0.0%
	40-54 years	4	33.3%
	55-64 years	4	33.3%
	65-80 years	4	33.3%
	Over 80 years	0	0.0%
	Decline to answer	0	0.0%
Marital Status	Married/Partnered	10	83.3%
	Divorced	2	16.7%
	Never married	0	0.0%
	Separated	0	0.0%
	Widowed	0	0.0%
	Decline to answer	0	0.0%
	Other	0	0.0%
Household Income	Less than $20,000	0	0.0%
	$20,000 to $29,999	0	0.0%
	$30,000 to $49,999	3	25.0%
	$50,000 to $74,999	4	33.3%
	$75,000 to $99,999	1	8.3%
	Over $100,000	4	33.3%
	Decline to answer	0	0.0%

APPENDIX E: LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT SUMMARY OF RESULTS

Essential Service 1: Monitor Health Status to Identify Community Health Problems

Monitoring health status to identify community health problems encompasses the following:

- Assessing, accurately and continually, the community's health status.
- Identifying threats to health.
- Determining health service needs.
- Paying attention to the health needs of groups that are at higher risk than the total population.
- Identifying community assets and resources that support the public health system in promoting health and improving quality of life.
- Using appropriate methods and technology to interpret and communicate data to diverse audiences.
- Collaborating with other stakeholders, including private providers and health benefit plans, to manage multi-sectorial integrated information systems.

Partners: Panhandle Area Development District, Educational Service Unit 13, Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Regional West Medical Center, Morrill County Community Hospital, Regional West Garden County, Kimball Health Services, Sidney Regional Medical Center, Panhandle Partnership, Community Action Partnership of Western Nebraska

Essential Service 1		No Activity	Minimal	Moderate	Significant	Optimal
1.1.1.	Conduct regular CHAs?					X
1.1.2.	Update the CHA with current information continuously?				X	
1.1.3.	Promote the use of the CHA among community members (harder population to meet) and partners? (well committed)				X	
1.2.1.	Use the best available technology and methods to display data on the public's health?					X
1.2.2.	Analyze health data, including geographic information, to see where health problems exist?			X		
1.2.3.	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?					X
1.3.1.	Collect timely data consistent with current standards on specific health concerns in order to provide the data to population health registries?					X
1.3.2.	Use information from population health registries in CHAs or other analyses?					X

Strengths	Weaknesses	Long Term Opportunities
• Numbers, partnerships, and relationships that continue to keep this work happening between public health and health system • Use of tech and ability to be on cutting edge, data dashboard, Qualtrics use for today; many LHDs don't use as much tech as we do • Windshield time drives use of tech to keep people connected, and be respectful of people's time, while still getting the work done • We do a good job using the registries we have access to	• Not as broad of a user base as we would like	• Improving updates through technology

Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards

Diagnosing and investigating health problems and health hazards in the community encompass the following:

- Accessing a public health laboratory capable of conducting rapid screening and high-volume testing.
- Establishing active infectious disease epidemiology programs.
- Creating technical capacity for epidemiologic investigation of disease outbreaks and patterns of the following: (a) infectious and chronic diseases, (b) injuries, and (c) other adverse health behaviors and conditions.

Partners: Region 22 Emergency Management, Region 21 Emergency Management, UNL Extension, Sidney Regional Medical Center, Kimball Health Services, Morrill County Community Hospital, UNMC Center for Preparedness Education, Regional West Medical Center, Scotts Bluff County Health Department, Regional West Garden County, Box Butte General Hospital, Community Action Partnership of Western Nebraska

Essential Service 2		No Activity	Minimal	Moderate	Significant	Optimal
2.1.1.	Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, and share information and understand emerging health problems and threats?				X	
2.1.2.	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?				X	
2.1.3.	Ensure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?				X	
2.2.1.	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?					X
2.2.2.	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?					X
2.2.3.	Designate a jurisdictional Emergency Response Coordinator?					X

Essential Service 2		No Activity	Minimal	Moderate	Significant	Optimal
2.2.4.	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?					X
2.2.5.	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?				X	
2.2.6.	Evaluate incidents for effectiveness and opportunities for improvement (such as After Action Reports, Improvement Plans, etc.)?				X	
2.3.1.	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?				X	
2.3.2.	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?					X
2.3.3.	Use only licensed or credentialed laboratories?					X
2.3.4.	Maintain a written list of rules related to laboratories, for handling samples (including collecting, labeling, storing, transporting, and delivering), determining who is in charge of the samples at what point, and reporting the results?					X

Strengths	Weaknesses
• Laboratory system throughout panhandle • Collaboration • Using consistent processes	• Distance • Rural

Essential Service 3: Inform, Educate, and Empower People about Health Issues

Informing, educating, and empowering people about health issues encompass the following:

- Creating community development activities.
- Establishing social marketing and targeted media public communication.
- Providing accessible health information resources at community levels.
- Collaborating with personal healthcare providers to reinforce health promotion messages and programs.
- Working with joint health education programs with schools, churches, worksites, and others.

Partners: Northwest Action Community Partnership, Box Butte General Hospital, Cheyenne County Community Center, Chadron Community Hospital, Western Nebraska Community College, Cirrus House, Panhandle Co-op

Essential Service 3		No Activity	Minimal	Moderate	Significant	Optimal
3.1.1.	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?			X		
3.1.2.	Coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?			X		
3.1.3.	Engage the community throughout the process of setting priorities, developing plans, and implementing health education and health promotion activities?				X	
3.2.1.	Develop health communication plans for media and public relations and for sharing information among LPHS organizations?				X	
3.2.2.	Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health information, matching the message with the target audience?				X	
3.2.3.	Identify and train spokespersons on public health issues?			X		
3.3.1.	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?			X		
3.3.2.	Make sure resources are available for a rapid emergency communication response?				X	
3.3.3.	Provide risk communication training for employees and volunteers?			X		

Strengths	Weaknesses	Long Term Opportunities
• Try hard to work together • Planning process • Unified organization • Education with preparedness • Training opportunities • Resources	• Community engagement is hard • Resources limited • Volunteers	• Training and use of volunteers

Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems

Mobilizing community partnerships to identify and solve health problems encompasses the following:

- Convening and facilitating partnerships among groups and associations (including those not typically considered to be health related).
- Undertaking defined health improvement planning process and health projects, including preventive, screening, rehabilitation, and support programs.
- Building a coalition to draw on the full range of potential human and material resources to improve community health.

Partners: United Way, Mediation West, Community Action Partnership of Western Nebraska, DOVES Program, Region 1, PALS, Northwest Community Action Partnership, Panhandle Trails, Capstone, Aging Office of Western Nebraska, Western Nebraska Community College, Educational Service Unit 13, Nebraska Extension, Western Community Health Resources, Panhandle Public Health District, Department of Health and Human Services, Regional West Medical Center, Scotts Bluff County Health Department, Monument Prevention Coalition, Panhandle Area Development District, Department of Labor

Essential Service 4		No Activity	Minimal	Moderate	Significant	Optimal
4.1.1.	Maintain a complete and current directory of community organizations?				X	
4.1.2.	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?				X	
4.1.3.	Encourage constituents to participate in activities to improve community health?					X
4.1.4.	Create forums for communication of public health issues?					X
4.2.1.	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?					X
4.2.2.	Establish a broad-based community health improvement committee?					X
4.2.3.	Assess how well community partnerships and strategic alliances are working to improve community health?					X

Strengths	Weaknesses	Short Term Opportunities	Long Term Opportunities
• Level of partnerships between organizations is very high and allows us to be on target with our goals • Partnership and public health have shared brain-trust (Kelsey) that allows the go-between for both worlds • Many partnership members wear many hats within the system • Relying on relationships is a great tool when the relationships are strong	• Fully engaging minority populations • Rely on partnerships could be problematic if relationships fall apart	• So many partners connect with minority populations, so there's opportunity to connect but is it intentional or are we waiting for someone else to do the work?	• Solidifying the connection with minority populations

Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts

Developing policies and plans that support individual and community health efforts encompasses the following:

- Ensuring leadership development at all levels of public health.
- Ensuring systematic community-level and state-level planning for health improvement in all jurisdictions.
- Developing and tracking measurable health objectives from the (CHIP) as a part of a continuous quality improvement plan.
- Establishing joint evaluation with the medical healthcare system to define consistent policies regarding prevention and treatment services.
- Developing policy and legislation to guide the practice of public health.

Partners: Panhandle Area Development District, Educational Service Unit 13, Box Butte General Hospital, Chadron Community Hospital, Gordon Memorial Hospital, Regional West Medical Center, Morrill County Community Hospital, Regional West Garden County, Kimball Health Services, Sidney Regional Medical Center, Panhandle Partnership, Community Action Partnership of Western Nebraska, PPHD Leadership Team

Essential Service 5		No Activity	Minimal	Moderate	Significant	Optimal
5.1.1.	Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?					X
5.1.2.	See that the local health department is accredited through the PHAB's voluntary, national public health department accreditation program?					X
5.1.3.	Ensure that the local health department has enough resources to do its part in providing essential public health services?					X
5.2.1.	Contribute to public health policies by engaging in activities that inform the policy development process?				X	
5.2.2.	Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?					X
5.2.3.	Review existing policies at least every three to five years?				X	

Essential Service 5		No Activity	Minimal	Moderate	Significant	Optimal
5.3.1.	Establish a CHIP, with broad-based diverse participation, that uses information from the CHA, including the perceptions of community members?					X
5.3.2.	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?					X
5.3.3.	Connect organizational strategic plans with the CHIP?					X
5.4.1.	Support a workgroup to develop and maintain emergency preparedness and response plans?					X
5.4.2.	Develop an emergency preparedness and response plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?					X
5.4.3.	Test the plan through regular drills and revise the plan as needed, at least every two years?					X

Strengths

- How well all the partners in the Panhandle work together with the health department, it's a very cohesive group and is noted by our state level partners
- Exceptional collaboration
- Groups are really good about sharing when policies will impact public health

Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety

Enforcing laws and regulations that protect health and ensure safety encompasses the following:

- Enforcing sanitary codes, especially in the food industry.
- Protecting drinking water supplies.
- Enforcing clean air standards.
- Initiating animal control activities.
- Following-up hazards, preventable injuries, and exposure-related diseases identified in occupational and community settings.
- Monitoring quality of medical services (e.g., laboratories, nursing homes, and home healthcare providers).
- Reviewing new drug, biologic, and medical device applications.

Partners: Panhandle Public Health District, Monument Prevention, Panhandle Partnership

Essential Service 6		No Activity	Minimal	Moderate	Significant	Optimal
6.1.1.	Identify public health issues that can be addressed through laws, regulations, or ordinances?				X	
6.1.2.	Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?				X	
6.1.3.	Review existing public health laws, regulations, and ordinances at least once every three to five years?			X		
6.1.4.	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?				X	
6.2.1.	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?				X	
6.2.2.	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?				X	
6.2.3.	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?				X	
6.3.1.	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?				X	
6.3.2.	Ensure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?				X	

Essential Service 6		No Activity	Minimal	Moderate	Significant	Optimal
6.3.3.	Ensure that all enforcement activities related to public health codes are done within the law?				X	
6.3.4.	Educate individuals and organizations about relevant laws, regulations, and ordinances?					X
6.3.5.	Evaluate how well local organizations comply with public health laws?			X		

Strengths	Weaknesses	Short Term Opportunities	Long Term Opportunities
• Organized in the fashion of coalitions and grass root movements • Adept in policy • Hard working individuals that care about others and do what they can for the community • PPHD is data savvy and data driven for decision • Comprehensive view of what public health is – homelessness, SUD, opioid use disorder • Health system of collaborative spirit • Tobacco has been phenomenal the resources are great – work to get policies changed • Policies around Narcan and opioid epidemic policies are being put into place • Meet people where they are - reduce barriers • We are looked at for data – very helpful when it comes to policy • Being looked at as Chief health strategist • Education on policies ordinances • Capacity for educating	• Capitalism vs. public health 12 lobbyists vs 3 on public health side • Funding limitations • Helping people understand policy and the importance of them is difficult • Conservative climate • Find the common ground • Public health law is a very comprehensive term affecting many levels – how do you affect at the city level	• Better or stronger understanding how well we evaluate what we do – it can take decades to see a long term impact – what does that mean	• Change in political • Finding the sag way/middle ground to say our children are important because – they mean something because. Speak to the community why policy level decisions are important priorities

Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable

Linking people to needed personal health services and assuring the provision of healthcare when otherwise unavailable (sometimes referred to as outreach or enabling services) encompass the following:

- Ensuring effective entry for socially disadvantaged and other vulnerable persons into a coordinated system of clinical care.
- Providing culturally and linguistically appropriate materials and staff to ensure linkage to services for special population groups.
- Ensuring ongoing care management.
- Ensuring transportation services.
- Orchestrating targeted health education/promotion/disease prevention to vulnerable population groups.

Partners: Box Butte General Hospital, Morrill County Community Hospital, Panhandle Public Health District, Aging Office of Western Nebraska, Western Community Health Resources, Chadron Community Hospital, Sidney Regional Medical Center

Essential Service 7		No Activity	Minimal	Moderate	Significant	Optimal
7.1.1.	Identify groups of people in the community who have trouble accessing or connecting to personal health services?				X	
7.1.2.	Identify all personal health service needs and unmet needs throughout the community?			X		
7.1.3.	Defines partner roles and responsibilities to respond to the unmet needs of the community?			X		
7.1.4.	Understand the reasons that people do not get the care they need?			X		
7.2.1.	Connect or link people to organizations that can provide the personal health services they may need?				X	
7.2.2.	Help people access personal health services in a way that takes into account the unique needs of different populations?			X		
7.2.3.	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?				X	
7.2.4.	Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?			X		

Strengths	Weaknesses	Short Term Opportunities	Long Term Opportunities
• Relationship and communication between the hospital and Public Heath • Acknowledging we are not getting all the care to all the people who needed – looking for change and opportunities to improve • Very strong hospital leadership that understand community services that are needed • Because they acknowledge they have needs that aren't meet they are comfortable talking to each other to get ideas • Assure population needs for specific populations – stay general – so rural hard to think specific	• Competing priorities • We don't know what we don't know – such as what certain groups can assess • Resources to meet the needs • Assure population needs for specific populations – stay general – so rural hard to think specific	• Promote what is available better – you don't know it exists until you need it. • Keep it in front of consumers what is available – could do this better • Partner resource directory – watch out for catchy names – just say what your service is • Remember to communicate services internally and externally to partners and clients	• Continue to build on unusual partnerships- or partners that haven't worked together like community table – business, hospital, community all working together to sustain – grass route entrepreneurial opportunities • Working with the community – where are we missing the boat?

Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce

Ensuring a competent public and personal healthcare workforce encompasses the following:

- Educating, training, and assessing personnel (including volunteers and other lay community health workers) to meet community needs for public and personal health services.
- Establishing efficient processes for professionals to acquire licensure.
- Adopting continuous quality improvement and lifelong learning programs.
- Establishing active partnerships with professional training programs to ensure community-relevant learning experiences for all students.
- Continuing education in management and leadership development programs for those charged with administrative/executive roles.

Partners: Panhandle AHEC, Sidney Regional Medical Center, UNMC College of Dentistry, Chadron State College, Panhandle Partnership, Rural Nebraska Healthcare Network

Essential Service 8		No Activity	Minimal	Moderate	Significant	Optimal
8.1.1.	Complete a workforce assessment, a process to track the numbers and types of LPHS jobs—both public and private sector—and the associated knowledge, skills, and abilities required of the jobs?		X			
8.1.2.	Review the information from the workforce assessment and use it to identify and address gaps in the LPHS workforce?		X			
8.1.3.	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?		X			
8.2.1.	Ensure that all members of the local public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and comply with legal requirements?		X			
8.2.2.	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the 10 Essential Public Health Services?		X			
8.2.3.	Base the hiring and performance review of members of the public health workforce in public health competencies?		X			
8.3.1.	Identify education and training needs and encourage the public health workforce to participate in available education and training?		X			

Essential Service 8		No Activity	Minimal	Moderate	Significant	Optimal
8.3.2.	Provide ways for public health workers to develop core skills related to the 10 Essential Public Health Services?		X			
8.3.3.	Develop incentives for workforce training, such as tuition reimbursement, time off for attending class, and pay increases?		X			
8.3.4.	Create and support collaborations between organizations within the LPHS for training and education?			X		
8.3.5.	Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?		X			
8.4.1.	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?		X			
8.4.2.	Create a shared vision of community health and the LPHS, welcoming all leaders and community members to work together?		X			
8.4.3.	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?		X			
8.4.4.	Provide opportunities for the development of leaders who represent the diversity of the community?		X			

Strengths	Weaknesses	Short Term Opportunities
• Trainings are being conducted • Sometimes resources are limited, trying to maximize what you can do with the resources you have • AHEC teaches Social Determinants of Health • AHEC Scholars program Social Determinants of Health is mandatory	• Doesn't seem like there is any structure in place or groups that do these assessments. • Not enough trainings or workshops • Communication, sometimes it is not knowing what's going on	• Communication • Always an opportunity, didn't know PPHD was offering a sealant program, UNMC didn't know, didn't get through to the local area, breakdown can create gap

Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

Evaluating effectiveness, accessibility, and quality of personal and population-based health services encompasses the following:

- Assessing program effectiveness through monitoring and evaluating implementation, outcomes, and effect.
- Providing information necessary for allocating resources and reshaping programs.

Partners: PPHD Leadership Team

Essential Service 9		No Activity	Minimal	Moderate	Significant	Optimal
9.1.1.	Evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?					X
9.1.2.	Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?			X		
9.1.3.	Identify gaps in the provision of population-based health services?				X	
9.1.4.	Use evaluation findings to improve plans, processes, and services?				X	
9.2.1.	Evaluate the accessibility, quality, and effectiveness of personal health services?			X		
9.2.2.	Compare the quality of personal health services to established guidelines?				X	
9.2.3.	Measure user satisfaction with personal health services?			X		
9.2.4.	Use technology, like the Internet or electronic health records, to improve quality of care?				X	
9.2.5.	Use evaluation findings to improve services and program delivery?			X		
9.3.1.	Identify all public, private, and voluntary organizations that contribute to the delivery of the 10 Essential Public Health Services?				X	
9.3.2.	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to the delivery of the 10 Essential Public Health Services?				X	

Essential Service 9		No Activity	Minimal	Moderate	Significant	Optimal
9.3.3.	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?				X	
9.3.4.	Use results from the evaluation process to improve the LPHS?			X		

Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems

Researching new insights and innovative solutions to health problems encompasses the following:

- Establishing full continuum of innovation, ranging from practical field-based efforts to fostering change in public health practice to more academic efforts that encourage new directions in scientific research.
- Continually linking with institutions of higher learning and research.
- Creating internal capacity to mount timely epidemiologic and economic analyses and conduct health services research.

Partners: PPHD Leadership Team

Essential Service 10		No Activity	Minimal	Moderate	Significant	Optimal
10.1.1.	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?			X		
10.1.2.	Suggest ideas about what currently needs to be studied in public health to organizations that conduct research?		X			
10.1.3.	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?					X
10.1.4.	Encourage community participation in research, including deciding what will be studied, conducting research, and sharing results?			X		
10.2.1.	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?			X		
10.2.2.	Partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?			X		
10.2.3.	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?		X			
10.3.1.	Collaborate with researchers who offer the knowledge and skills to		X			

Essential Service 10		No Activity	Minimal	Moderate	Significant	Optimal
	design and conduct health-related studies?					
10.3.2.	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?		X			
10.3.3.	Share findings with public health colleagues and the community broadly, through journals, web sites, community meetings, etc.?		X			
10.3.4.	Evaluate public health systems research efforts throughout all stages of work from planning to effect on local public health practice?		X			

Strengths	Weaknesses	Long Term Opportunities
• We believe in the scientific process of research; not our priority, not wasting resources on it if it's not a priority; we stay up on the latest best practices especially on new topics; written up in the community guide for using it! We know where to go to find the latest and best info, we don't have to develop it • Good relationship with UNMC and CSC, UNK – mutual respect for credibility; we focus our resources on implementation • We would allocate resources to it if we did it, but it's not a priority right now	• Don't have time/talent/resources for true research; could develop if it was our priority; the work we are doing isn't true research from an academic stance • We don't have the capacity for true research involvement • Limited number of research opportunities	• Continuous communication with academia (UNMC) for opportunities. • Internships with colleges, brainstorming, sharing across LHDs