Community Health Needs Assessment

Fiscal year ending 2018

Approved by the Mary Lanning Board of Trustees
May 2, 2019

Mary Lanning Healthcare • Hastings, NE 68901

Mary Lanning
HEALTHCARE

I. Executive Summary

BACKGROUND AND PROCESS

Mary Lanning Healthcare (MLH) conducted its Community Health Needs Assessment in 2018 using the Mobilizing for Action through Planning and Partnerships (MAPP) process. This was conducted in partnership with the South Heartland District Health Department (SHDHD). The Community Health Needs Assessment enabled Mary Lanning's administrative team and Board of Trustees to include the findings in the overall strategic plan and to create an implementation strategy that is in alignment with the SHDHD's CHIP (Community Health Improvement Plan) as both plans work together to address the needs in the identified community.

NEEDS IDENTIFIED

The preliminary health issues that were identified through the focus groups, the Community Themes Strengths Assessment (CTSA) and health department expertise were: cancer, aging problems, environmental issues, child abuse and neglect/domestic violence, obesity, diabetes, cardiovascular disease, injury, mental health and substance abuse.

PRIORITIZED NEEDS

Community stakeholders in the MAPP process met on two separate occasions to establish priority areas. The first meeting focused on access to care and gap analysis. The second meeting centered on the eleven previously identified health issues with a goal of narrowing down to four. After completing the prioritization process, the identified needs in order were: mental health, substance abuse, obesity and related health conditions, and cancer.

IMPLEMENTATION STRATEGY

The implementation strategy includes multiple departments in Mary Lanning that have potential to positively impact the community in the five identified areas of need. Each strategy is assigned a team responsible for executing the plan. These teams will work with partners within the Mary Lanning system as well as community partners to develop best practice strategies and attain goals. The Mary Lanning Healthcare Corporate Strategy for 2019 includes "collaboration with the SHDHD to meet the priority needs identified in the Community Health Needs Assessment" under the Stakeholder/Community goal section of the document.

II. Community Description

Mary Lanning Healthcare is the only hospital in Adams County. Adams County is the primary service area and is defined as the MLH community for the purposes of this needs assessment. According to the Census estimate from 2018, the population of Adams County is 31,511. The median income is $51,721.00 and there are 12.1 percent of residents below the poverty level. Hispanic or Latino is the largest minority group at 10.3 percent. According to the Bureau of Labor Statistics the unemployment rate in March of 2019 for Adams County was 2.8 percent.

III. Community Health Needs Assessment Partners

The South Heartland District Health Department (SHDHD) was the primary partner and conducted the needs assessment using the MAPP process. SHDHD also conducted the needs assessment for Brodstone Memorial Hospital and both Mary Lanning and Brodstone worked together as well. Both entities served on the core planning team along with Webster County Hospital and the United Way. All assisted with the implementation of the assessment and the identification of stakeholders as well as providing in-kind and monetary resources to support the process.

IV. Community Health Needs Assessment Methodology and Process

The SHDHD used the MAPP strategic approach to facilitate the data collection required to improve the health and quality of life in the community. This process helps identify needs and promote partnerships within the community to foster collaborative relationships to help meet those needs. The 2018 MAPP implementation included 1) a health system assessment, 2) community themes and strengths assessment survey (CTSA) and 3) health status assessment. Each of these collection methods are summarized below.

1. **Health System Assessment —** This method included gathering data on assets and gaps from a variety of sources including state findings, local facility data and information from the CTSA. Focus group information was also collected in this stage. Two focus groups were focused on users of health care – one Spanish speaking group and one English speaking group, and the other focus group was conducted among providers and community leaders.
2. **Community Themes and Strengths Assessment —** this was an anonymous, comprehensive community health assessment survey containing 81 Likert scale questions as well as several short answer and open-ended questions about personal health and access to healthcare. The survey was provided and collected in both English and Spanish and distributed through websites, Facebook, e-mails, news releases, events and coalitions. A total of 563 respondents in Adams County participated.
3. **Community Health Status Assessment —** This method consisted of the SHDHD surveillance staff gathering data from a variety of local, state and national sources in a range of categories. Data summaries were created based on this assessment and used by stakeholders to help prioritize community needs.

V. Identified Community Needs

Using the assessment tools of the MAPP process, ten health issues were identified as being risk areas for the community.

IDENTIFIED NEEDS

The preliminary needs that were identified through the assessment process were: cancer, aging problems, environmental issues, child abuse and neglect/domestic violence, obesity, diabetes, cardiovascular disease, injury, mental health and substance abuse.

PROCESS FOR PRIORITIZING

Community stakeholders met at two separate meetings to identify five priority areas to address over the next six years. The first meeting focused on access to care and root causes, gaps in service and barriers to accessing services. Participants were asked to identify and vote on the top two barriers to accessing healthcare and the top two gaps in service. The top two gaps for Adams County were mental health and substance abuse prevention and treatment. The second priority setting meeting provided an overview of the previously identified health issues through "fact sheets" researched and developed by the SHDHD. Experts in most of the health issues were also part of the process and were consulted when needed to clarify or provide information. Results from the access to care meeting were also included in the conversation. Stakeholders were asked to rank the health issues based on four criteria: incidence/prevalence, trends, community burden and community perception of importance. Each criteria was then weighted to determine their importance to the stakeholders. The final score took the criteria and the weighting into account. The top four issues that emerged were: mental health, substance abuse, obesity and related health conditions and cancer.

Continued on next page »

VI. Mary Lanning Healthcare Implementation Strategy

Mary Lanning has developed strategies to address the priority needs identified by the community. The Implementation Strategy will also focus on aligning desired outcomes with the SHDHD's CHIP, which supports a partnership for the betterment of the health of the community. The priority areas identified in the CHNA are also identified in the overall Mary Lanning Healthcare Strategic plan and budgeting processes.

HOW MLH WILL ADDRESS THE HEALTH NEEDS?

The accompanying Implementation Strategy identifies each priority need area, the strategic goals and the impact they will have, the activities that support that strategy, and ultimately, update the progress made on the goal. Because the critical objective is to meet the needs of the community, Mary Lanning recognizes the necessity for the ongoing financial commitment to these areas and allocation of human resources to implement the strategies. It is anticipated that several areas of need will overlap and one activity may help meet the strategic goal in several areas and may also have a positive impact on needs that are identified but not in the top five priority areas. For example, addressing nutrition under the priority area of obesity would logically have an impact on prevalence of diabetes and heart disease as well as increasing access to care. These strategies are also closely aligned, not only with the CHIP, but with other stakeholders in the community creating a partnership effect with an end result that produces a healthier living environment for the whole population.

The South Heartland District Community Health Assessment
2018

A Four-County Needs Assessment using the Mobilizing for Action through Planning and Partnerships (MAPP) Process

Michele Bever, PhD, MPH; SHDHD Executive Director

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

Adams, Clay, Nuckolls and Webster Counties in Nebraska

Approved by Board of Health, 03.06.19

Acknowledgements

The staff at South Heartland District Health Department (SHDHD) would like to recognize the many community partners who contributed to the development of this plan. Community members, educators, government officials, service organizations, health care providers and many more participated in a district-wide process called *Mobilizing for Action through Planning and Partnerships* (MAPP). Their input and commitment were instrumental to a productive and successful MAPP process and the completion of the Community Health Improvement Plan (CHIP). We also are indebted to the external MAPP Core Team members, who provided guidance, advice and county-level assistance throughout this process. The assessments and planning were supported by funds from the Nebraska Department of Health and Human Services Office of Community and Rural Health, Brodstone Memorial Hospital, Webster County Community Hospital and Mary Lanning Healthcare.

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Public Health
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South Heartland District Health Department

Board of Health
(January 2019)

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	Donna Fegler-Daiss	
Clay County	Eric Samuelson, Board of Supervisors	
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Public Health Core Functions and Essential Services

(1) Core Public Health Function: Assessment

Essential Service 1: **Monitor health status and understand health issues facing the community.**
What's going on in our District? Do we know how healthy we are?

Essential Service 2: **Protect people from health problems and health hazards.**
Are we ready to respond to health problems or threats? How quickly do we find out about problems? How effective is our response?)

(2) Core Public Health Function: Policy Development

Essential Service 3: **Give people the information they need to make healthy choices.**
How well do we keep all people and segments of our district informed about health issues?

Essential Service 4: **Engage the community to identify and solve health problems.**
How well do we really get people and organizations engaged in health issues?

Essential Service 5: **Develop policies and plans that support individual and community health efforts.**
What policies promote health in our district? How effective are we in planning and in setting health policies?

(3) Core Public Health Function: Assurance

Essential Service 6: **Enforce laws and regulations that protect health and ensure safety.**
When we enforce health regulations are we up-to-date, technically competent, fair and effective?

Essential Service 7: **Help people receive health services.**
Are people receiving the medical care they need?

Essential Service 8: **Maintain a competent public health workforce.**
Do we have a competent public health staff? How can we be sure that our staff stays current? How are we assisting our community and professional partners to stay current on public health interventions?

Essential Service 9: **Evaluate and improve programs and interventions.**
Are we doing any good? Are we doing things right? Are we doing the right things?

Essential Service 10: **Contribute to and apply the evidence base of public health.**
Are we discovering and using new ways to get the job done?

SHDHD Mission: The South Heartland District Health Department is dedicated to preserving and improving the health of residents of Adams, Clay, Nuckolls and Webster counties. We work with local partners to develop and implement a Community Health Improvement Plan and to provide other public health services mandated by Nebraska state statutes.

South Heartland's Vision: Healthy People in Healthy Communities

Introduction

Building a healthy community requires active partnerships and investment from individuals that value their own health. Realizing the goal of optimal community health requires a thorough understanding of how healthy we are and what will be required for improvement. An important part of the planning process toward optimal health is the evaluation of our current health status in order to plan and measure improvement in the health of our district's population. Conducting a comprehensive community health assessment every 5-6 years allows us to project improvements for community health and collaborate with partners to bring about change. In 2018, South Heartland conducted a comprehensive community health assessment (the fourth since our formation) for residents of Adams, Clay, Nuckolls and Webster counties.

This summary of the community health assessment process, the resulting findings, and the resulting Community Health Improvement Plan (a separate document which addresses priority health needs through structured health goals and strategies) is intended for use by public health, our community partners, and the public. The SHDHD staff and board rely on this process and the resulting information to guide and focus our work which is supported by the ten essential services of public health (see page 4).

The South Heartland Health District

South Heartland District Health Department (SHDHD) was the first new district health department formed in 2001 after the passage of LB692, legislation which encouraged the formation of public health infrastructure in Nebraska. SHDHD was approved on November 8, 2001 by the state of Nebraska Health and Human Services Regulation and Licensure Division. SHDHD initially began with three participating counties in south central Nebraska: Adams, Nuckolls and Webster. In March 2002, Clay County signed an interlocal agreement to join the South Heartland Health District.

SHDHD is governed by a fifteen member Board of Health consisting of one appointed board member from the governing boards of each of the four counties, two public-spirited citizens from each county, and three professional representatives (physician, dentist, and veterinarian) appointed by the Board of Health. The Board of Health is responsible for policy development, resource stewardship, legal authority, partner engagement, continuous improvement, and oversight of the health department. A full-time Executive Director, six full-time staff and five part-time staff carry out the Department's Mission.

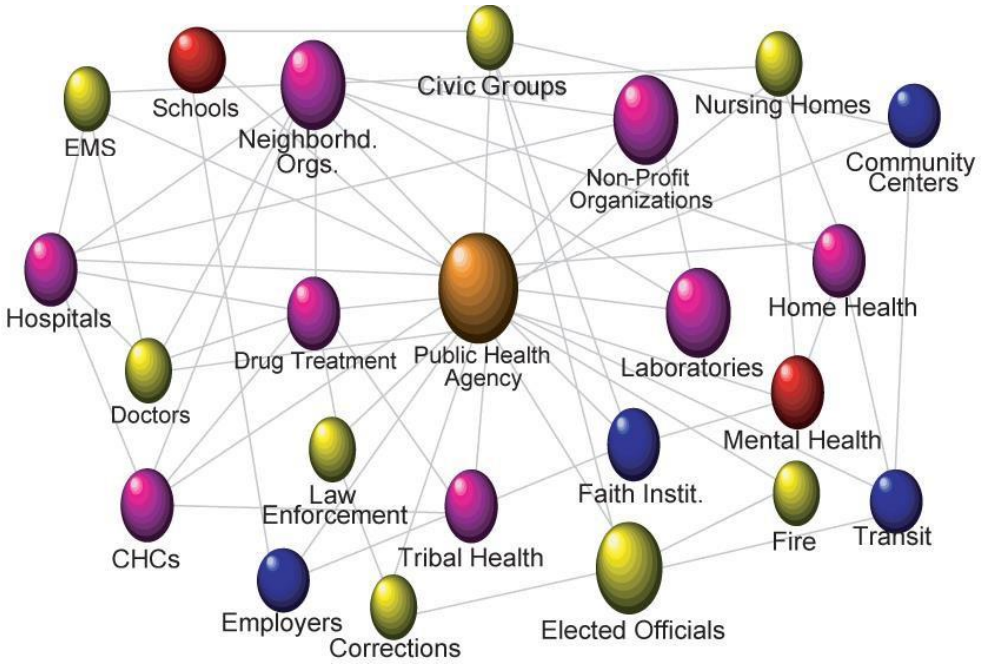
The four counties, each approximately 24 x 24 miles square, are laid out in a 2 x 2 block totaling 2,289 square miles. The SHDHD serves a population of 45,682 (U.S. Census, 2017) with just over half of the population residing in the city of Hastings.

Community Health Assessment – Process Overview [1]

Mobilizing for Action through Planning and Partnerships (MAPP) is a strategic approach to community health improvement. South Heartland District Health Department (SHDHD) used this tool to facilitate the 4-county health district in efforts to improve health and quality of life through community-wide and community-driven strategic planning. This process helps the district identify and plan use of resources, taking into account the unique circumstances and needs of the district and the individual component counties. It also promotes new and solidifies existing partnerships in our communities and across the district.

The MAPP assessment process leads to the development of a community-wide health improvement plan (CHIP), which can only be adopted and realistically implemented if the community has contributed to the plan development. SHDHD worked to ensure participation by a broad cross section of the district, inviting representatives from many sectors of our communities. In addition, MAPP also supports organizational action plan development by each of the participating entities, including the key hospital partners, for their service areas.

Through the MAPP process, the South Heartland Health District continues to strengthen the local public health system. We define the local public health system as all of the entities that contribute to the delivery of public health services within our communities[2]. This includes public and private entities, civic and faith-based organizations, individuals and informal associations, front-line and grassroots workers, and policy makers.



[1] Mobilizing for Action through Planning and Partnerships: Achieving Healthier Communities through MAPP. A User's Handbook.

[2] Refer to SHDHD's diagram of the Local Public Health System.

With MAPP as the framework for the community health needs assessment, SHDHD focuses on the 10 essential services of public health, but especially utilizing essential services 1, 4, 5 and 10 to support the MAPP process.

The 10 Essential Public Health Services are:

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships to identify and solve health problems.
5. Develop polices and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public health and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

The MAPP process is diagrammed by the following MAPP model:

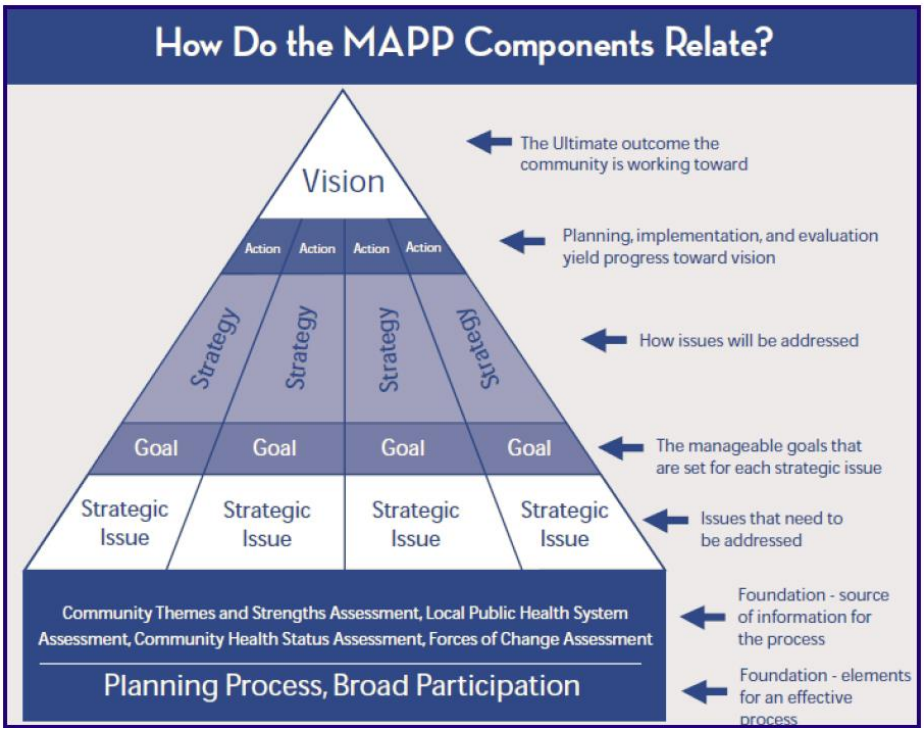
Health System Assessment
What are the gaps in services and barriers to accessing healthcare? What are the strengths of our healthcare system?

Community Themes and Strengths Assessment
What is important to our community? Perceptions about quality of life? What assets do we have?

Community Health Status Assessment
How healthy are our residents? What are the health risks in our communities? Who is impacted most?

In this model, the phases of the process are diagramed in the center. The entire process is informed by data and the assessments that can produce these data are shown in the arrows around the outside. The 2018 MAPP process was customized to meet our local needs and included 1) health status assessment, 2) community themes and strengths assessment (CTSA survey), and 3) a health system assessment (access to care and forces of change), which focused on identifying gaps in services, barriers to accessing care, and emerging healthcare needs. The health system assessment included data from the CTSA survey, a health system assets inventory, and focus groups conducted with both health system users and health system providers/community leaders.

The phases of the MAPP process are: Organizing/Partnership Development, Visioning, Assessment, Identifying Strategic Issues, Formulating Goals and Strategies, and the Action Cycle for the resulting Community Health Improvement Plan (CHIP).



2012-2015 Community Health Improvement Plan for Hennepin County Residents – Appendix 2

A. Community Health Assessment – South Heartland's Process

The SHDHD MAPP/CHIP process is a continuous process of assessment, evaluation and planning, working with partners to carry out our plans and reevaluating our activities. Our 2018 MAPP process started with evaluating our past process and forming a core team. This team was able to bring the right community partners together to carry out a thorough needs assessment.

Additionally, core team members were responsible to review the MAPP process, review stakeholder categories, identify stakeholders, determine timelines and discuss resources to implement the process. Core team members represented all four counties, all three hospitals, the United Way of South Central Nebraska, mental healthcare stakeholders, and SHDHD staff and board of health – each entity or representative contributing time, staff, data and/or resources.

Key Partners

The Core Team members served as the planning and decision-making body for the process, overseeing the assessment, identifying stakeholders (partners and community members), and committing in-kind and cash resources, including staff to be participants in the assessments. The core team included 11 members: hospital administrators and/or designated leadership from Brodstone Memorial Hospital, Mary Lanning Healthcare and Webster County Community Hospital; the Executive Director of United Way of South Central Nebraska, a representative from the behavioral health services sector, SHDHD Board of Health president, SHDHD director, and SHDHD staff members, one of whom facilitated the assessment processes.

Core Team Members:

- SHDHD staff members: Michele Bever (Executive Director), Susan Ferrone (Community Assessment Coordinator), Janis Johnson (Accreditation Coordinator/Standards and Performance Manager) and Jessica Warner (Health Surveillance Coordinator),
- SHDHD Board of Health member: BOH President Nanette Shackelford,
- Hospital Administration/Representatives: Becky Sullivan, Manager, Wellness Department at Mary Lanning Healthcare, Karen Tinkham, Public Relations Director, Brodstone Memorial Hospital, Kori Field, Director of Nursing, Brodstone Memorial Hospital, Mirya Hallock, CEO of Webster County Hospital,
- The United Way of South Central Nebraska: Jodi Graves (Executive Director) and
- A stakeholder from behavioral health services sector: Michelle Kohmetscher.

The team also included representation from each county, which facilitated the processes of identifying partner organizations and gaps in services for the four counties:

Adams-Michele Bever, Susan Ferrone, Jessica Warner, Becky Sullivan and Jodi Graves
Clay- Nanette Shackelford, Janis Johnson
Nuckolls-Karen Tinkham, Kori Field
Webster-Mirya Hallock, Michelle Kohmetscher

By design, the initial Core Team included representation from health care and mental health, in addition to public health. We included a community mental health provider from Webster County who has expertise with seniors, adult and youth populations, long term care and school

settings, and experience in providing training in mental health first aid, substance abuse prevention/treatment, suicide prevention and trauma-informed care. Each of the three hospitals in the health district oversees one or more rural health clinics and could provide perspective from both hospital and clinic settings. The United Way of South Central Nebraska joined the Core Team prior to the priority-setting phase and was able to bring to the table a larger community view which led to an expanded inclusion of social determinants of health.

Additional key partners included the Nebraska Association of Local Health Directors (NALHD) for technical support and consultation, the State of Nebraska Department of Health and Human Services (DHHS) for some of the data and trends analysis.

Timeline

The assessment phase consisted of implementing three of the MAPP Assessments and was carried out during the period of April – October, 2018. The Core Team developed an overall timeline for the assessment phase as follows:

April 23, 2018	Logistics and Planning for MAPP/CHA cycle
April 28, 2018	Review CTSA, confirm questions, revise English/Spanish versions
May 8, 2018	Launch CTSA (English & Spanish)
	Begin Data Gathering for Health Status Assessment
May 21, 2018	Planning and Scheduling Health System Assessment focus groups
June 11, 2018	Progress of CTSA, additional planning for distribution/promotion
June 27, 2018	Focus Group Invitations / Preparation for Meetings
July 9-30, 2018	Conduct 10 Focus Groups
	Begin Data Gathering for Health System Assessment
August 1, 2018	Focus Group debrief, Finalize Process for Priority Setting Meetings
August 13, 2018	Invitations to Priority Setting Meetings
August 21, 2018	Planning for Priority Setting Meetings
September 4, 2018	Finalize Priority Setting Meetings; Complete Data Gathering for Health Status and Health System Assessments
September 18, 2018	Access to Healthcare Gaps & Barriers Priority Setting Meeting
September 25, 2018	Health Issues Priority Setting Meeting
October 9, 2018	Debrief Priority Setting Outcomes /Plan CHIP Strategy Development Process
October 19, 2018	Discuss Implementation of Steering Committee for CHIP

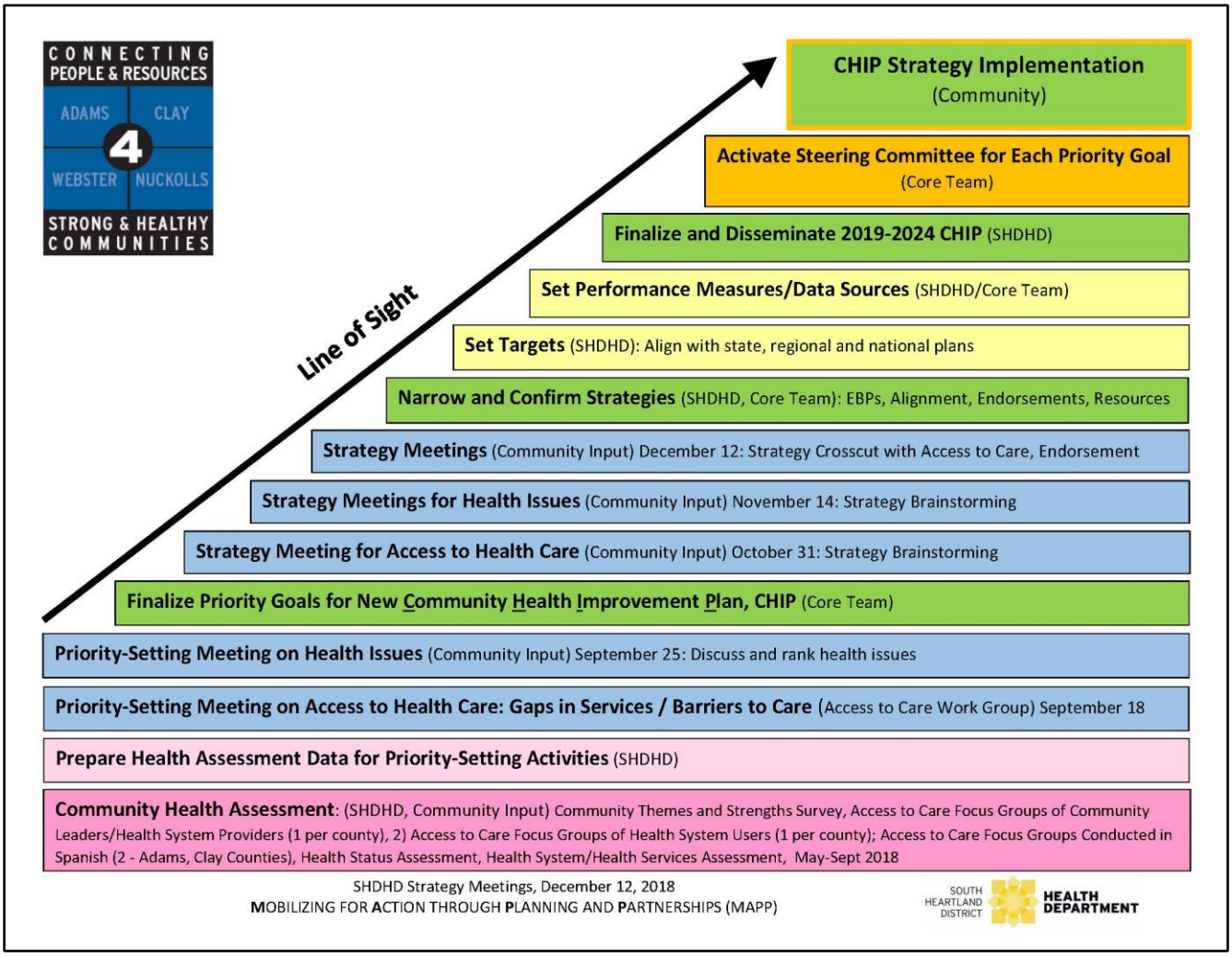
Following the assessment and priority-setting phases, community stakeholder work groups identified strategies for addressing the five priority issues at three additional meetings in November and December.

October 31, 2018	Strategy Meeting for Access to Care
November 14, 2018	Strategy Meetings for Health Issues Part I
December 12, 2018	Strategy Meetings for Health Issues Part II

Stakeholders were invited to contribute to each assessment, the data review, the priority setting, and the strategy meetings. We provided opportunities to participate in person at focus groups and meetings, by survey (electronic and hard copy), through key informant response, online data review and response, by contributing data, and by in person meetings linked across all four counties connected through GoToMeeting. A summary of MAPP participation and community engagement is provided in Attachment 1.

The Line of Sight (below) shows how SHDHD incorporated the phases of the MAPP process in conducting community health assessment and leading to the development and implementation of a new community health improvement plan.

SHDHD Community Health Assessment Process – Line of Sight



Assessments

1. Local Health System Assessment

This assessment focused on the population's access to needed healthcare services and capacity of the healthcare system to meet those identified needs. The health system assessment included:

1) **Gathering data on health system assets and gaps** from a variety of sources including DHHS Office of Rural Health (e.g., professional shortage areas), local health system partners (e.g., ER usage), community themes and strengths survey results.

Results:

Data gathering on local health system provided insight into assets and gaps within the health district. These are captured in the data summaries provided in Access to Care Participant Packets (Attachment 2).

Key Findings:

- Limited or lack of drug and alcohol assistance services in Clay, Nuckolls and Webster counties.
- Medicare/Medicare Advantage is the primary payment source for hospital inpatient services
- Barriers to Transfer/Service Referral from Emergency Departments:
    - No safe place for psych patients that do not meet Emergency Protective Custody or Inpatient Criteria until they can follow up with outpatient services
    - Limited detox center capacity
- Insurers/Medicare are limiting access to mental health services through restrictions on session length, high deductibles/co-pays, and other practices that are resulting in fewer providers accepting Medicare clients.
- Assets
    - Dental Workforce and Oral Health Care: Central Community College Dental Hygiene Program and Clinic
- Vulnerable or at-risk populations
    - *Ag families*: 25% -36% of the populations in Clay, Nuckolls and Webster counties are farm operators and laborers, a population that nationally has a higher percent of uninsured.
    - *Poverty:* Approximately 10% (in Clay) to nearly 13% (in Nuckolls) of the county populations have income below the federal poverty level
        - over 17% of the population less than 18 years old is living below 100% of the federal poverty level
    - *Veterans & their Families*: 7%-11% of the populations in Adams, Clay, Nuckolls and Webster counties are veterans
        - In Nebraska: 20.3% of those who are spouses/significant others of someone who served in the U.S. military reported that they needed to see the doctor but could not due to cost in the past year (versus 12.5% overall)

- *Elderly*: Approximately 15% to 24% of the county populations consist of individuals age 65 and older, which impacts types of health care needed and payment sources.

- Adams County is federally-designated for medically underserved populations.
- Clay, Nuckolls and Webster Counties are federally-designated for medically underserved areas.
- South Heartland District is characterized by shortage areas for most health professions in 3 of the 4 counties. All 4 counties are state-designated shortage areas for General Internal Medicine, Psychiatry & Mental Health and Pediatric Dentistry & Oral Surgery; 2 counties have clinics that are federally designated health professional shortage areas (HPSA) for mental health.

Table 1: SHDHD Gaps in Health Services by County

Gap in Services – Professional Shortage Areas, SHDHD	Adams	Clay	Nuckolls	Webster
HPSA Mental Health – 4 rural health clinics		2	2	
Medically Underserved Area		X	X	X
Medically Underserved Populations	X			
State-designated Shortage Area: Family Practice		X		X
State-designated Shortage Area: General Dentistry		X	X	X
State-designated Shortage Area: General Internal Medicine	X	X	X	X
State-designated Shortage Area: General Pediatrics		X	X	X
State-designated Shortage Area: General Surgery		X	X	X
State-designated Shortage Area: Obstetrics & Gynecology		X	X	X
State-designated Shortage Area: Psychiatry & Mental Health	X	X	X	X
State-designated Shortage Area: Occupational Therapy		X		
State-designated Shortage Area: Ped. Dentistry/Oral Surgery	X	X	X	X
State-designated Shortage Area: Pharmacist		X	X	X

2) Input from stakeholders through focus groups to determine perceptions of the health system, gaps in services, barriers to accessing care and emerging issues. The Core Team identified populations who experience gaps in services and barriers to accessing care in order to include their perspective (user focus groups) and representatives from organizations that serve these populations (providers and community leader focus groups).

Methods for Focus Groups:

South Heartland District Health Department (SHDHD) conducted ten focus groups to explore use of and access to health care by stakeholders living and working in the four counties that comprise the South Heartland District (Adams, Clay, Nuckolls, and Webster). The core team chose to focus on access to healthcare and our health system for these focus groups to provide assessment and assure improvement goals for Essential Service 7 (Help people receive health services) and to align with public health accreditation standards.

- ❖ Six of the ten focus groups targeted consumers (users) of health care (Table 2)
  - Two of six focus groups targeting consumers of health care were comprised of Spanish-speaking community members. These focus groups were conducted by a

bilingual facilitator from SHDHD assisted by a bilingual facilitator from the Head Start migrant education program.

- Four of the ten focus groups targeted providers and community leaders of local organizations and businesses. Leader/professional representation included community-based organizations (e.g., education, government/ law enforcement, financial and insurance, health and wellness centers, media, etc.) and healthcare professionals (hospitals, health and mental health providers and healthcare administrators). (Table 3)

Table 2. User Focus group characteristics

Users of Health Care		
Location	**Number of Participants**	**Characteristics**
Clay Center, NE First Congregational Church	10	3 Men 7 Female English-speakers
Harvard, NE Harvard Public School	7	2 Men 5 Women Spanish-speakers
Hastings, NE Hastings Library	7	2 Men 5 Women Spanish-speakers
Hastings, NE Mary Lanning HealthCare	14	6 Men 8 Female English-speakers
Red Cloud, NE Webster County Community Hospital	8	4 Men 4 Women English-speakers
Superior, NE Brodstone Memorial Hospital	12	4 Men 8 Women English-speakers

Table 3. Leader Focus group characteristics

Providers and Community Leaders		
Location	**Number of Participants**	**Characteristics**
Clay Center, NE First Congregational Church	14	7 Men 7 Women English-speakers
Red Cloud, NE Webster County Community Hospital	8	3 Men 5 Women English-speakers
Superior, NE Brodstone Memorial Hospital	5	3 Men 2 Women English-speakers
Hastings, NE Mary Lanning HealthCare	43	11 Men 32 Female English-speakers

Focus Groups discussed and addressed the following questions:

- Where do you (or your contingency) go for healthcare?
- Where do you (or your contingency) get most of your (their) health information?
- What are the biggest concerns you (or your contingency) have about health care?
- What kinds of health care services are used (or not used) by people you know?

- What kinds of health care services do you use to prevent health problems?
- What do you view as strengths of our local health care?
- What do you view as future demands of our local health care system?

The facilitator provided a brief background of SHDHD and the community health assessment process, as well as a handout of current County Health Rankings for the four counties, followed by a facilitated discussion of the seven questions listed above. Each focus group was provided the same information in all four counties. Due to the number of participants in the Hastings group, discussions were divided up into small groups and the facilitator brought these groups together for large group discussion around four questions. NALHD staff attended all focus groups conducted in English and received translated results of the focus groups conducted in Spanish. NALHD then compiled a summary of themes and ideas related to gaps in services and barriers to accessing care in the South Heartland Health District see Attachment 3 and 4.

Results:

Focus groups provided insight into many issues that community members encounter within our local healthcare system. These are captured in the focus groups summary report (Attachment 3) and focus group summary tables (Attachment 4). The focus group summary tables provide themes by county and by user/leader/Spanish-speaker focus groups.

Key Findings:

- When focus groups were asked about their biggest concerns related to healthcare, cost of services and insurance was a leading concern. Additional concerns included shortage of EMS/ambulance services in smaller communities, senior care, respite care, lack of transportation, shortage of mental health providers and access to MH services.
- When focus groups were asked about future demands on the healthcare system, participants identified the need for mental health services focusing on prevention, and treatment services for substance abuse issues. Healthcare needs related to obesity will continue to be a future demand on our local system. Future concerns also included: affordable healthcare, EMS/EMT burnout, bilingual services, addiction services, assisted living and access for vulnerable populations, including veterans and seniors.

2. Community Themes and Strengths Assessment

The Community Themes and Strengths Assessment (CTSA) helps us to understand how residents view our communities. This CTSA survey was the third to be administered to our communities, with few modifications. The survey asks residents to consider:

- What is important in our community?
- How is quality of life and healthcare perceived in our community?
- What assets do we have that can be used to improve community health?

The survey also asked residents to identify and rank the top health concerns and the most important risky behaviors in their communities. From these results, we created an overall ranking of perceived health concerns by county and district-wide, which was utilized as a contributing factor in the priority-setting activities.

Methods:

The CTSA survey is a comprehensive health assessment containing 81 Likert scale*, short answer and open-ended questions on many aspects of personal health and access to healthcare.
**Likert Scale: Strongly Agree/Agree/Neutral/Disagree/Strongly Disagree*

Our CTSA survey contained five categories of questions including:

- Healthcare access and services (satisfaction with overall system)
- Community resources, economy, housing and assets
- Social supports
- Health status of our community and personal health
- Demographics: Location, household size, income, race, education

This survey used a convenience sample method (intercept survey). Thoughtful attempts were made to distribute surveys or survey links to a broad demographic to include underserved populations, as well as the general population, and to meet preset goals to have equal percentage representation from all four counties. The survey was provided and collected in English and Spanish (with literacy assistance in some cases). A link was provided on our website and Facebook with news releases in local newspapers, promotions handed out at events, stakeholder meetings, and coalitions, and emailed by core team members to various stakeholders and groups.

Responses were collected through Survey Monkey, although some were collected by hard copy and entered into Survey Monkey for complete analysis. A Total of 925 respondents participated in this survey.

For full CTSA results see attachment 5.

Findings:

The CTSA intercept survey assessed community satisfaction, community assets, individual health and community health. The following table and charts provide highlights of the report.

Highlights of the report include:

CTSA Question	Strongly Agree/ Agree
Enough behavioral health services in my region (1 hour from home):	39%
Hospital care being provided within my region is excellent	74%
Cost is a barrier to accessing needed healthcare	56%
No dental services in the past 12 months	31%
Among respondents with no medical home: I delay care as long as possible or refuse care	19%
Quality housing is affordable for the average person	23%

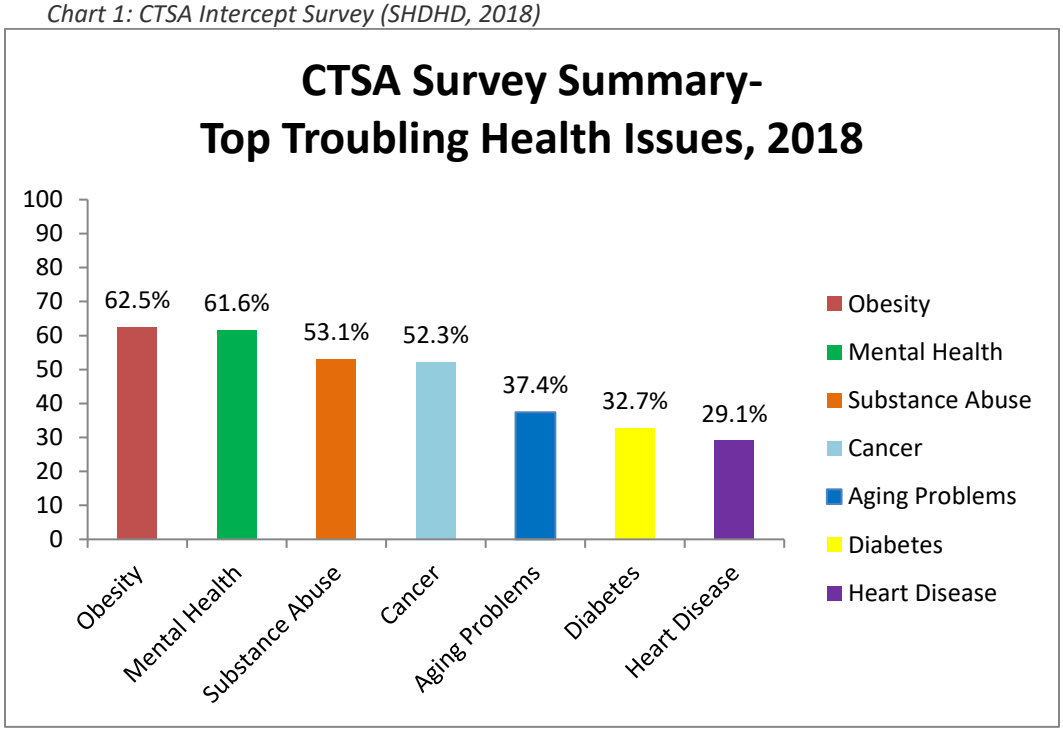
Other findings:

- Residents perceived their communities as good places to raise children, but were concerned about the lack of affordable childcare and lack of after school opportunities for children
- Need for local employment opportunities and local leisure time activities for adults
- Lack of "family friendly" jobs in local communities (flexible scheduling, health insurance, etc.)
- Distracted Driving – 49% felt this ranked third in the top 5 risky behaviors that impact their communities, *see chart 2.*

The CTSA results included a ranking of perceived health-related problems in the South Heartland District communities, *see chart 1.*

❖ *Responses to top five most troubling health–related problems in our community*

Chart 1: CTSA Intercept Survey (SHDHD, 2018)



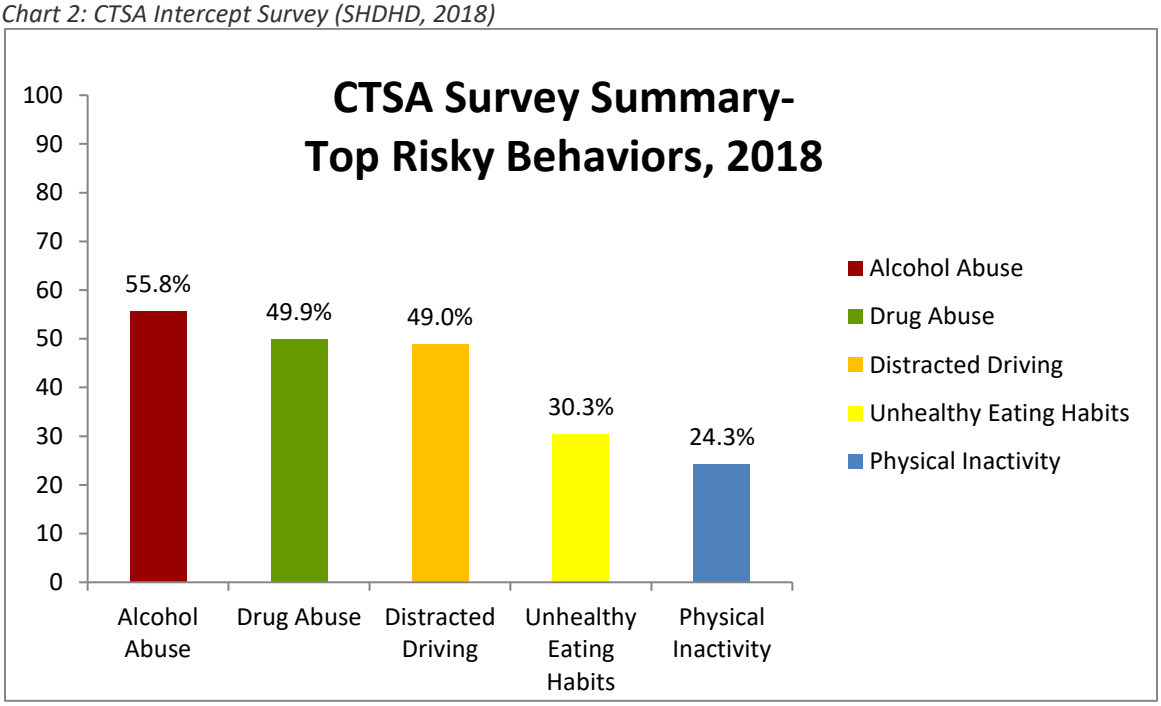
❖ *Respondents answered the following when asked to "name the one health problem you think your community should address first?"*

- Mental Health including Depression (32%)
- Substance Abuse (16%)
- Obesity (13%)
- Cancer (10%)
- Aging Problems (4%)
- Suicide, Diabetes, and all other (25%)

The CTSA results included a ranking of perceived risky behaviors in the South Heartland District communities, *see chart 2*.

❖ *Responses to top five risky behaviors that influence the health of community members*

Chart 2: CTSA Intercept Survey (SHDHD, 2018)



❖ *Respondents answered the following when asked to "name the one risky behavior you think your community should address first?"*

- Substance Abuse including Alcohol, Drugs, Tobacco Abuse (43%)
- Distracted Driving (24%)
- Poor Eating Habits (7%)
- Mental Health/Stress, Drunk Driving, and Lack of Physical Exercise (4% each)

The CTSA survey open-ended questions generated a wealth of responses. Response highlights and themes were identified by text analysis and representative comments (Attachments 2 and 6). Themes included care, services, mental health, providers, community, driving, health, drugs, and stress.

3. Community Health Status Assessment

The Health Status Assessment focuses on the community's health and quality of life by gathering and analyzing information on health status and risk factors. It helps answer these questions:

- How healthy are our residents?
- What are the health risks in our communities?
- Who is impacted most?

Adams County stakeholders review health status data.

Methods:

South Heartland health surveillance staff gathered data from a variety of local, state and national sources such as, but not limited to, Nebraska Vital Records, Behavioral Risk Factor Surveillance System reports, Youth Risk and Behavior Surveillance, Nebraska Risk & Protective Factor Student Survey, Nebraska Cancer Registry, DHHS injury data, US Census, County Health Rankings, hospital discharge data, local mental health needs assessment, and local infectious disease reports (Additional Data Appendices 1- 8). Categories of data included:

- Population characteristics
- Socioeconomic characteristics
- Quality of Life
- Behavioral Risk Factors
- Substance Abuse/Misuse
- Environmental Health Indicators
- Social and Mental Health
- Hospital ER usage
- Cancer Data
- Death, Illness and Injury
- Infectious Disease

Webster County stakeholders review health status data.

Results:
Data sets were collected at the county level when possible and compared to the 4-county health district, the state of Nebraska, and the United States, and data sets from multiple years were analyzed to assess trends. We created data summaries in the form of fact sheets to help stakeholders more readily review and understand the data. Fact sheet topics were chosen based on focus group and CTSA results, as well as SHDHD expertise. In addition to health status data, the fact sheets included economic impact, community burden, health disparities, quick facts taken from a variety of sources, and/or additional information on risk factors or prevention strategies. Selected results from the Community Themes and Strengths survey and the County Health rankings accompanied the fact sheets. The 10 fact sheets listed below were included in participant packets (Attachment 6) for the priority-setting activities:

- Cancer
- Aging Problems
- Environmental
- Child Abuse & Neglect/ Domestic Violence
- Obesity
- Diabetes
- Cardiovascular
- Injury
- Mental Health
- Substance Abuse - Alcohol, Tobacco and Other Drugs

Population Demographics Highlights:

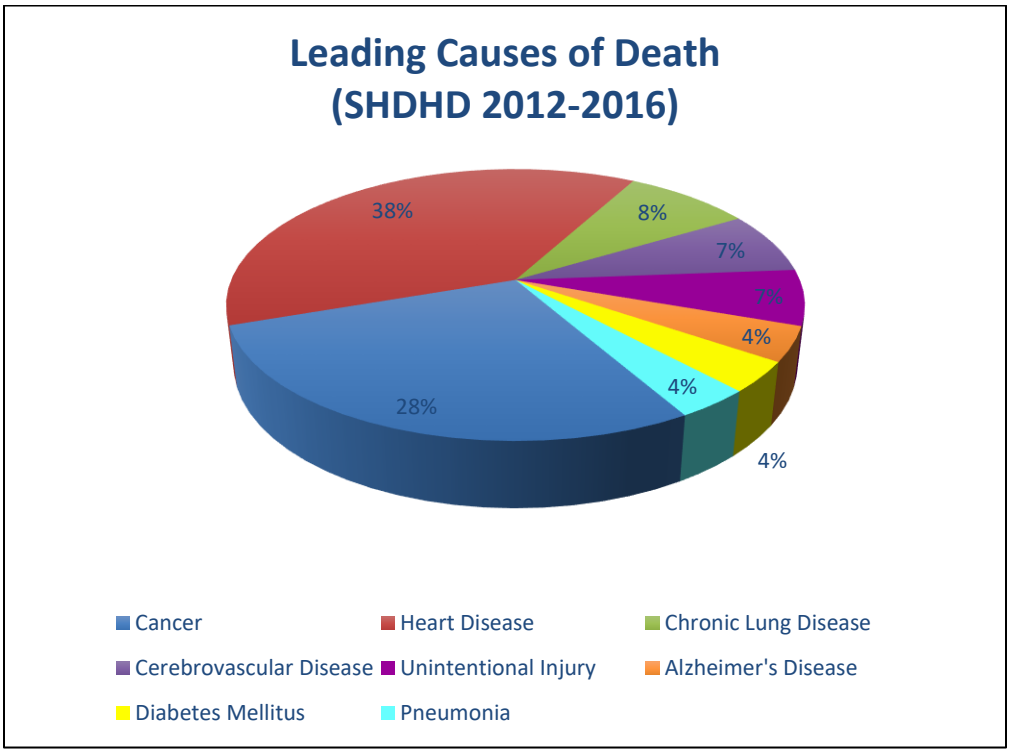
- Population declined in three of the four counties: (U.S. Census, 2010 to 2017)
    - Adams County (+1.0%)
    - Clay County (-5.1%)
    - Nuckolls County (-5.3%)
    - Webster County (-7.5%)
- Adams and Clay Counties have the largest minority populations (first number). The percentage of the total population that is Hispanic/Latino by county (second number): (U.S. Census, 2010 to 2017)
    - Adams County 10.7% / 8.1%
    - Clay County 8.7% / 7.7%
    - Nuckolls County 2.7% / 2.2%
    - Webster County 4% / 3.5%
- Percent of the population below poverty level: (U.S. Census, 2010 to 2017)
    - Adams County 12.4%
    - Clay County 11.1%
    - Nuckolls County 10.8%
    - Webster County 11.3%

Leading Causes of Death and Hospitalization highlights:

- Cardiovascular disease (heart disease plus cerebrovascular disease) is the leading cause of death for the South Heartland District and the second leading cause of death in Nebraska, *see chart 3*.

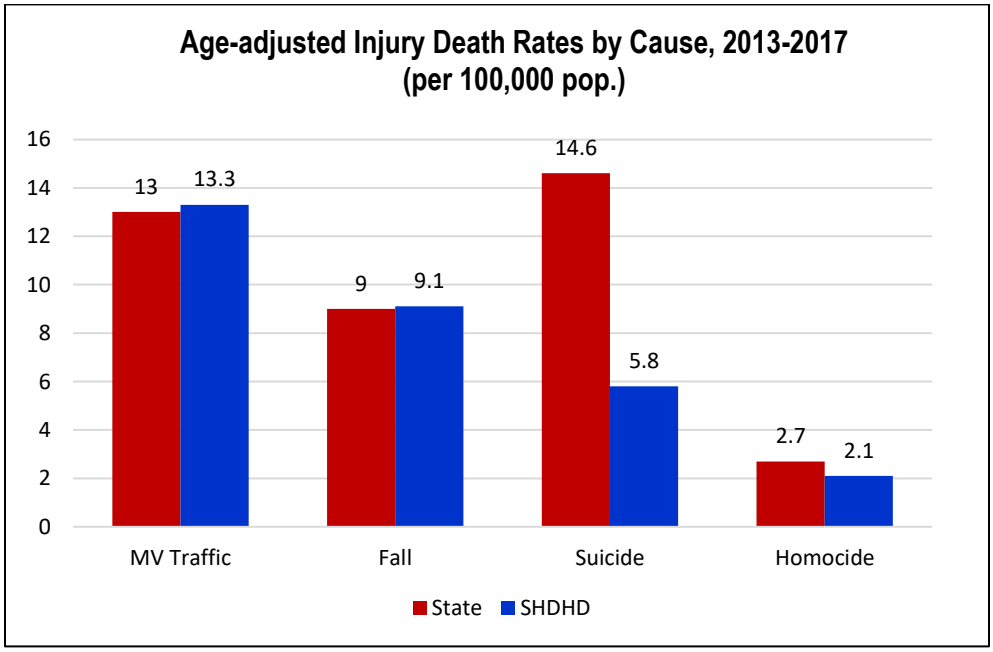
- Motor vehicle crashes were the leading cause of injury death in the counties served by SHDHD. Falls were the second leading cause of injury death; suicide was third, *see chart 4.*
- Heart disease is the leading cause of Years of Potential Life Lost (YPLL) Before Age 75 at 26.5%, followed by Cancer at 20.7% for the South Heartland District, *see chart 5*.

Chart 3



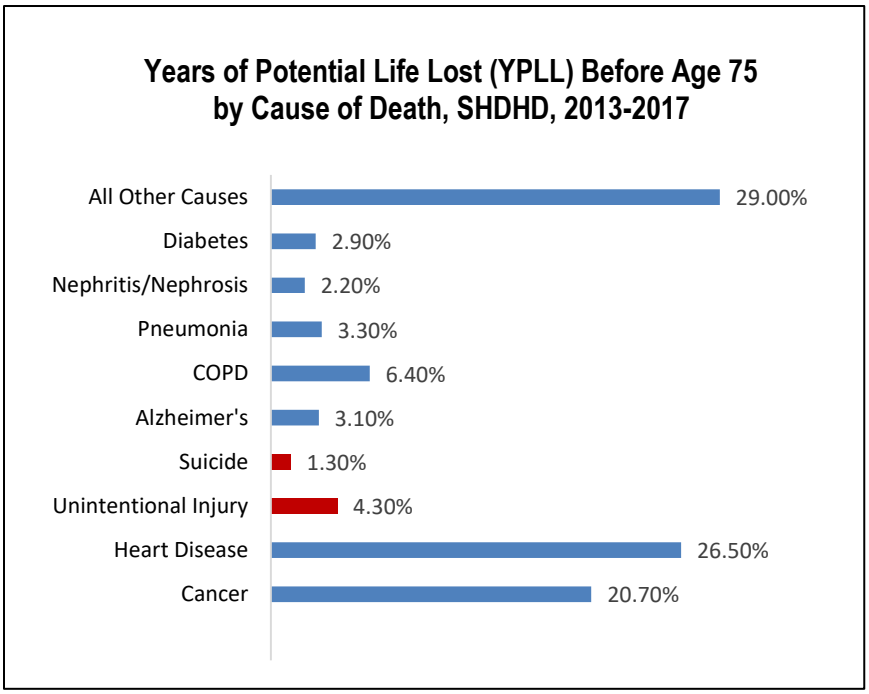
Source: Nebraska Vital Records

Chart 4



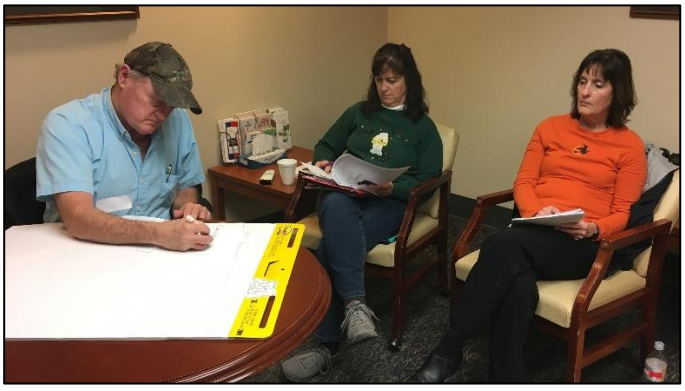
Motor vehicle crashes were the leading cause of injury death in the counties served by SHDHD. Falls were the second leading cause of injury death; suicide was third. Source: Nebraska Vital Records

Chart 5



***YPLL** is defined as the number of years between the age at death and a specified age (75); that is, the total number years "lost" by persons in the population who die prematurely of a stated cause. Ranking the causes of death can provide a description of the relative burden of cause-specific mortality. Source: Nebraska Vital Records*

Clay County stakeholders review health status data



Webster County stakeholder review health status data

B. Community Review of Needs Assessment Data and Priority Setting

Methods/Process:

Priority setting for health issues was accomplished during two separate meetings to identify five priority goals to address over the next six years. The two meeting were: 1) access to care gap analysis and 2) health issues priority setting. Meetings took place in four counties via video conferencing with primary facilitation occurring in Adams County. South Heartland staff members stationed in Clay, Nuckolls and Webster County meeting locations assisted the primary facilitator. A MAPP core team member was also present at each location. Nebraska Association of Local Health Directors (NALHD) provided technical support for teleconferencing via Go-to-Meeting to connect all four counties. Participant packets were developed for each meeting.)

Adams County stakeholders reviewing health system data. Clay, Nuckolls and Webster county stakeholders are connected by GoToMeeting (online meeting tool).

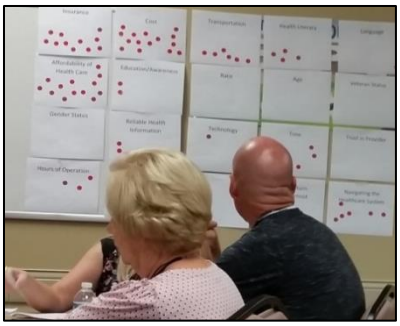
I. Access to Care Gap Analysis Priority Setting, September 18, 2018

Objectives: Share Data, Prioritize (Gaps in Availability of Health Care Services, Barriers to Accessing Health Care Services), Position for Strategy Development

Process:
This meeting allowed stakeholders to discuss root causes, gaps in services and barriers to accessing services in our local healthcare system. Participants reviewed and discussed data in small groups. Experts provided comments and/or additional information. Participants were then asked to identify and vote on the top two barriers to accessing healthcare and the top two gaps in services. Each participant submitted a worksheet with their votes and also voted at their location using colored stickers on a large grid mounted on the wall for a quick visual summary of that county's priorities. Voting sheets collected from all four counties were used to determine priority ranking by county and for the health district overall.

Agenda:

1. Brief Introductions & Housekeeping
2. Review of Objectives
3. Public Health System Overview
4. Data Review
5. Discussion
6. Prioritization



Adams county stakeholders

Informational Packets/Data:

Meeting Participant Packets provided data and other supporting information (see Attachment 2)

1. Agenda and Objectives
2. Public Health System Diagram
3. Social Determinants of Health Diagram *(Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes)*
4. Community Health Improvement Plan (CHIP) 2013-2018 Dashboard
5. County Health Rankings for Adams, Clay, Nuckolls and Webster Counties
6. Health System Focus Group Summaries
    a. Health System User Focus Groups, by County and Language
    b. Community Leader and Health System Provider Focus Groups, by County
7. Perceptions Regarding Access to Health Care, SHDHD 2018 Community Survey Results.
8. Professional Shortage Areas, Federal- and State-Designated
    a. Federal Health Professional Shortage Areas (HPSAs)
        i. Dental, 2018
        ii. Mental Health, 2018
        iii. Primary Care, 2018
        iv. Medically Underserved Areas/Populations, 2017
    b. State-Designated Shortage Areas (pp. 37-47)
        i. Family Practice, 2017
        ii. General Dentistry, 2017
        iii. General Internal Medicine, 2016
        iv. General Pediatrics, 2016
        v. General Surgery, 2016
        vi. Obstetrics & Gynecology, 2013
        vii. Psychiatry & Mental Health, 2017
        viii. Occupational Therapy, 2017
        ix. Pediatric Dentistry & Oral Surgery, 2016
        x. Pharmacist, 2016
        xi. Physical Therapy, 2017
    c. Governor-Designated Eligible Areas for Medicare Certified Rural Health Clinics, 2017
9. SHDHD Health Care Assets - Maps and Summaries
    a. Assisted Living Facilities Map
    b. Clinics Map
    c. Dental Providers Chart / Dental Hygiene Assets
    d. Drug & Alcohol Services Map
    e. Emergency Medical Services Map

f. Mental Health Providers Chart
g. Nursing Homes Map

10. Social Context and Vulnerable Populations for South Heartland District
    a. Food, Housing, & Financial Insecurities
    b. Poverty
    c. Agricultural Sector – Farm Families and Ag Workers
    d. Veteran, Military Service Men and Women and Their Families
    e. Veteran Barriers and Needs
    f. Special, At-Risk and Vulnerable Populations – Demographics
    g. Medicare Population and Access to Mental Health Services
    h. Hospital Emergency Department Usage and Payment Type
    i. Hospital Inpatient and Clinics – Payment Type
    j. Region 3 Behavioral Health - Services Summary, FY 2017-18

Additional Demographic References – on hand at each site:

a. Population Characteristics by County, American Community Survey, 2012-2016
b. Selected Economic Characteristics by County, ACS, 2012-2016

Results:

In each county, stakeholders participating in the health system assessment individually identified their selections for the top 2 gaps in services and top 2 barriers to accessing care. The aggregate results, by county and for the South Heartland District overall, are shown in Tables 1 and 2, below. Table 1 shows the ranked gaps in services by county and for the health district and Table 2 shows the ranked barriers to accessing care by county and for the health district.

***Gaps*.** For the health district overall, the top gaps in services identified were: 1) mental health services and mental health practitioners, 2) substance abuse prevention and treatment services, 3) school-based health services, 4) specialty services, and 5) emergency services. In Nuckolls County, the top three priorities were the same as the overall ranking, but emergency services category was ranked #4 and specialty services category was ranked #5. Adams County prioritized the same top three gaps in services, but identified clinical preventative health services and dental as #4 and #5, respectively. In Webster County participants ranked substance abuse prevention and treatment services, holistic/alternative medicine, and eye/vision as their top three (tied) priorities, while Clay County ranked mental health services and mental health practitioners, substance abuse prevention and treatment services, and specialty services as the top three (tied) gaps in services.

Barriers. The top three barriers identified for the health district were:

1) Cost (e.g., prescriptions, office visits, hospital stays, co-pays, and deductibles)
2) Affordability
3) Insurance/Reimbursement (i.e., availability of coverage, provider accepts coverage)

Additional barriers included: transportation, education/awareness, poverty/ economic status, navigating the healthcare system, and health literacy. Individual counties differed in their ranking of barriers.

Results from Access to Care Priority Setting Meeting - September 18, 2018

Note: Ranking sorted by Total column values

Table 1.

Gaps in Available Health Care	Adams	Clay	Nuckolls	Webster	Total
Mental Health / Mental Health Practitioners	16	3	10	0	29
Substance Abuse Prevention & Treatment Services	13	3	9	2	27
School-Based Health Services (Nurse, Education, Screening, Wellness programs)	12	0	5	0	17
Specialty Services (Nephrology, Endocrinology, etc.)	5	3	4	1	13
Emergency Services (EMS, Fire/Rescue)	3	2	5	0	10
Chronic Disease Management Services (e.g., blood pressure monitoring programs)	5	0	3	1	9
Worksite Health Services (health fairs, screening, education, health coaching)	4	0	3	1	8
Wholistic/Alternative Medicine	4	0	2	2	8
Dental (pediatric or adult)	6	0	1	0	7
Clinical Preventative Health Services (i.e., immunization programs, cancer screening)	7	0	0	0	7
Community Preventative Programs (e.g., Health Fairs, Lifestyle change programs, Diabetes Prevention Classes)	4	0	3	0	7
Elderly Care/Geriatric Services	2	0	3	0	5
Faith-Based Health Services (Nurse, education programs, screening)	2	0	0	1	3
Eye/Vision	0	0	0	2	2
Pharmacy	0	2	0	0	2
Urgent Care/Emergency Care	0	1	1	0	2
In-patient Services (Hospital, Long Term Care, Assisted Living)	1	0	0	0	1
OB-GYN	0	0	0	0	0
Occupational Therapy/Physical Therapy/Speech Therapy	0	0	0	0	0

Results from Access to Care Priority Setting Meeting - September 18, 2018

Note: Ranking sorted by Total column values

Table 2.

Barriers in Accessing Health Care	Adams	Clay	Nuckolls	Webster	Total
Cost (e.g., prescriptions, office visits, hospital stay, co-pays, deductibles)	16	3	9	1	29
Affordability of Healthcare	14	3	7	0	24
Insurance/Reimbursement (availability of coverage, provider accepts coverage)	11	3	6	0	20
Transportation	5	2	5	0	12
Education/Awareness (importance of screening & prevention behaviors)	5	1	5	1	12
Poverty/Economic Status	8	0	1	2	11
Navigating the Healthcare System	7	0	2	2	11
Health Literacy (understand and use health information including billing and patient rights; understand discharge instructions, prescriptions/dosage, etc)	4	0	3	2	9
Time (appointment length, wait time to see/schedule a visit with a provider)	5	0	4	0	9
Hours of Operation (office hours)	3	0	3	0	6
Technology (apps, portals, telehealth, access & use of technology by patients and providers)	1	1	3	0	5
Provider turn-over/burnout	3	1	0	1	5
Reliable Health Information (knowledge of and access to valid & accurate sources)	2	0	1	1	4
Language	1	0	1	0	2
Veteran Status	0	1	1	0	2
Age	1	0	0	0	1
Trust in Provider	0	1	0	0	1
Race	0	0	0	0	0
Gender Status	0	0	0	0	0

II. Health Issues Priority Setting, September 25, 2018

Objectives: Share Data, Prioritize, Position for Strategy Development

Process:
The second priority-setting meeting, for Health Issues, was intended to provide an overview of community health status and specific information on ten health topics identified through CTSA as top concerns for the communities. This meeting also allowed stakeholders to discuss the results from the first meeting, access to care gap analysis (root causes, gaps in services and barriers in our local healthcare system) and how access to care impacted the various health issues. For each health issue, the process included small and large group discussion, brief presentation and Q&A with experts, and a scoring activity:

a. Participants briefly reviewed data on their own, and then discussed it with neighboring participants.
b. Experts provided highlights and/or additional information.
c. Each participant scored the four criteria for each health issue

Priority-setting methods:
Stakeholders were asked to rank the health issues based on four criteria: incidence/ prevalence, trends, community burden, and community perception of importance. Before reviewing the data, participants helped determine the relative importance of each of these criteria by contributing to a criteria weighting activity (i.e., should we pay more attention to how many people are affected by a condition or to how the community is impacted by the condition?). After data review and discussion, the participants were asked to rank the health issues based on these four criteria. Later, a sum of the scores for each health issue was weighted based on the weight of each criterion, resulting in a final weighted score for each health issue.

Results from the weighted scoring were presented by county and for South Heartland overall. These results were reviewed and top priorities finalized by the core team for inclusion in the new Community Health Improvement Plan.

Agenda:

1. Brief Introductions & Housekeeping
2. Review of Objectives
3. Criteria Weighting
4. Public Health System Overview
5. Data Reviews
6. Discussion
7. Assessing to Prioritize Community Health Issues
8. Evaluation

Nuckolls County stakeholders review health status data.

Informational Packets/Data: (Attachment 6)

1. Agenda and Objectives
2. Public Health System Diagram
3. Social Determinants of Health Diagram
4. Community Health Improvement Plan (CHIP) 2013-2018 Dashboard
5. County Health Rankings for Adams, Clay, Nuckolls and Webster Counties
6. Community Theme and Strengths Assessment, CTSA, Survey Summaries
   Included Community Perceptions of top health issues and top risky behaviors in their communities
7. Priority Fact Sheets
   Included the following information: Incidence and prevalence, demographics, comparisons, trends, perceived need/importance from Community Themes and Strengths Assessment, behavioral and other risk factors, disparities (when available), data sources, and other pertinent information.
   a. Cancer
   b. Aging Problems
   c. Environmental
   d. Child Abuse & Neglect/ Domestic Violence
   e. Obesity
   f. Diabetes
   g. Cardiovascular
   h. Injury
   i. Mental Health
   j. Substance Abuse - Alcohol, Tobacco and Other Drugs

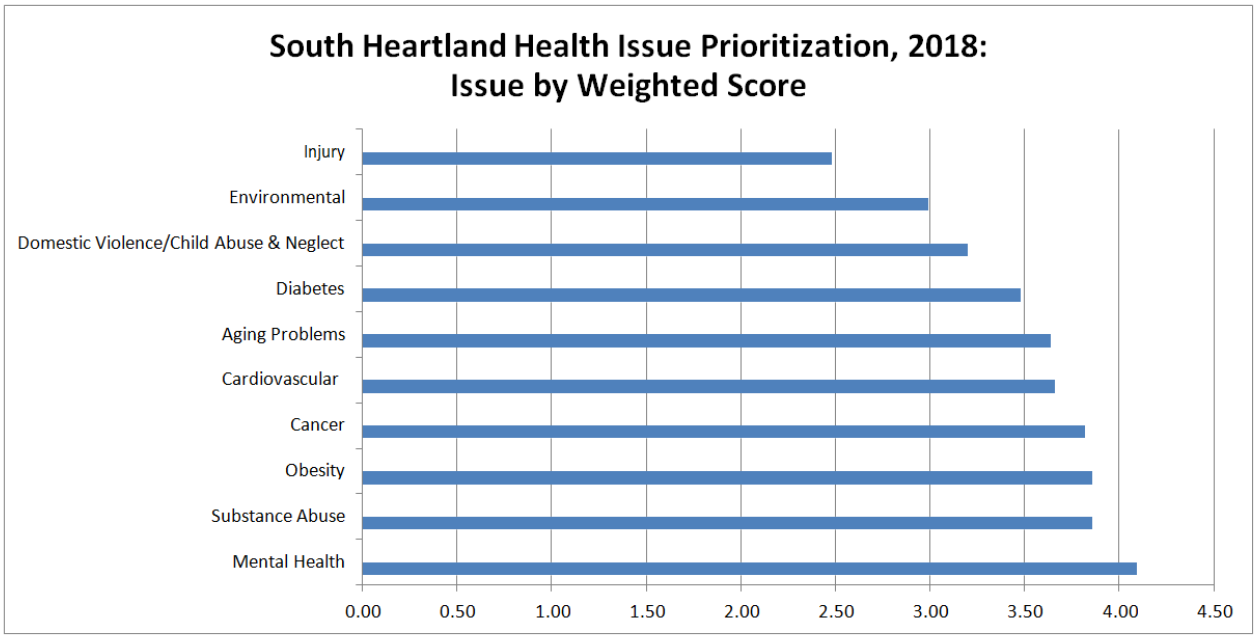
Results:

The results of the health issue priority setting activities are presented in Charts 1-4, below. Chart 1 presents the ranking of the health issues by weighted score for the health district overall. The top four issues are mental health, substance abuse, obesity and cancer.

We also analyzed the priorities by county for Nuckolls County (primary service area for Brodstone Memorial Hospital and for Adams County (primary service are for Mary Lanning Healthcare), non-profit hospitals with IRS requirements to complete community needs assessments. Chart 2 presents the health issues by weighted score for Nuckolls County, using criteria weights from Nuckolls County and Chart 3 presents the health issues by weighted score for Adams County, using criteria weights from Adams County. In each case, the same health

issues are in the top four priorities, with mental health the #1 priority, although the order varies for priorities #2-#4.

Chart 1.



SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT
CHA Health Issues
Priority-Setting Results
10.09.18

Chart 2.

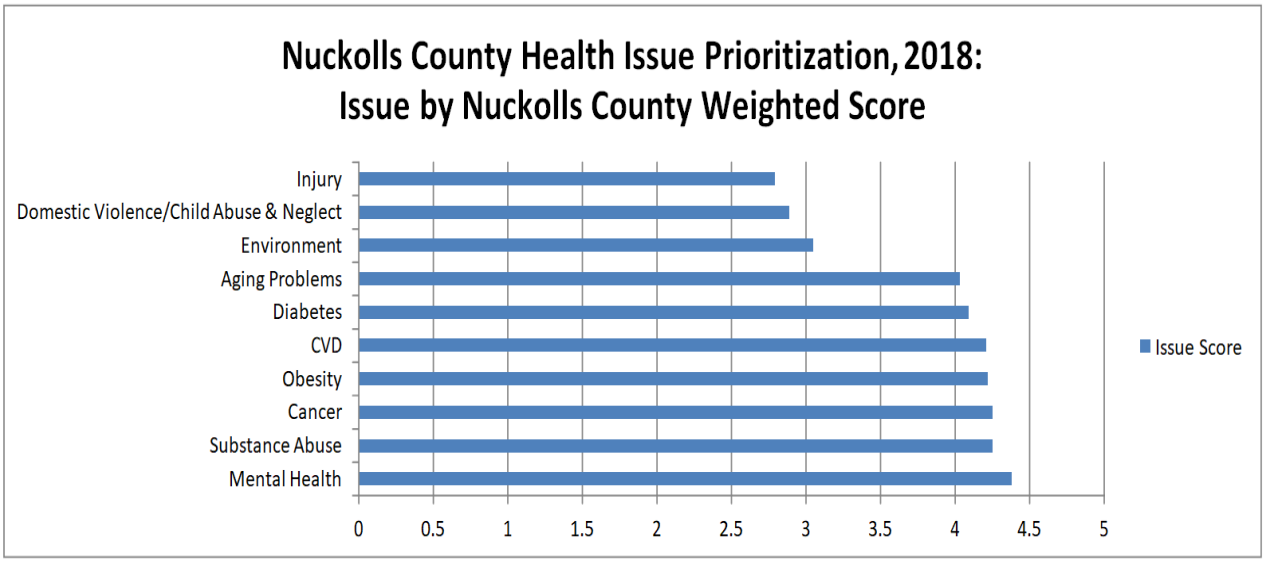
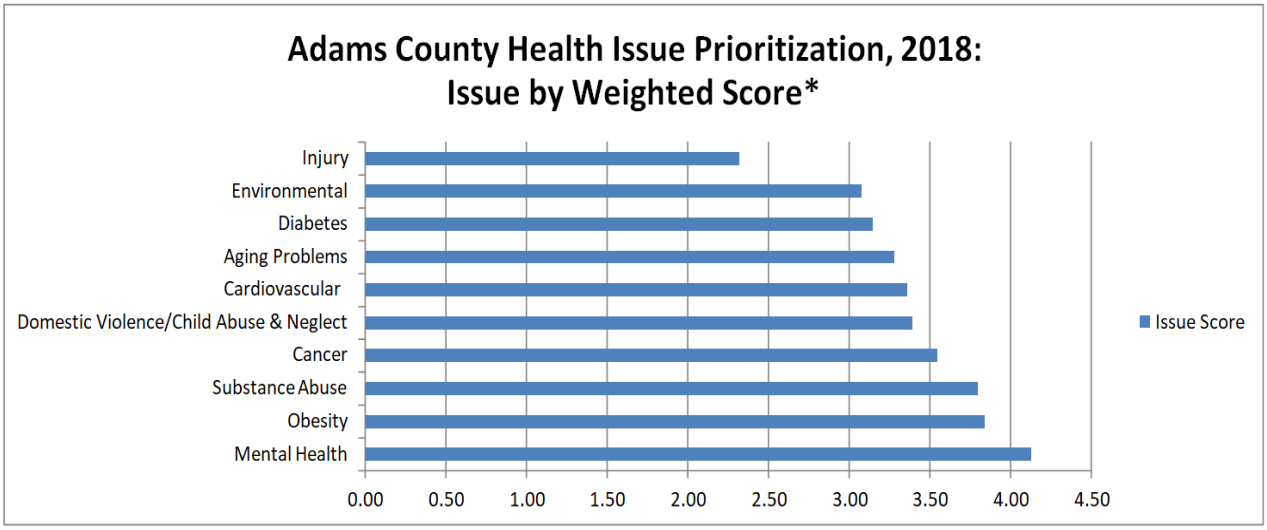


Chart 4.



*Adams County criteria weights = SHDHD criteria weights

The MAPP Core Team reviewed and discussed these priority-setting results and came to the agreement that mental health, substance misuse, obesity and cancer would be the priorities for the next community health improvement plan. The team agreed to include "related conditions" (e.g., diabetes, cardiovascular) with the obesity priority, as these share risk factors and many strategies addressing obesity also would be able to address associated chronic conditions.

The team also agreed that the older adult population, as a vulnerable, at-risk population, and should be taken into consideration during strategy development for each of the priorities.

Finally, the team agreed that accessing health care services is a fundamental priority for the health district. This priority is also woven through each of the other community health priorities.

The finalized community health priorities for the 2019-2024 Community Health Improvement Plan are shown along with goals for each priority in the graphic that follows:

SOUTH HEARTLAND DISTRICT HEALTH DEPARTMENT

CONNECTING PEOPLE & RESOURCES
ADAMS CLAY
4
WEBSTER NUCKOLLS
STRONG & HEALTHY COMMUNITIES

Community Health Priorities 2019-2024

C. Community Health Improvement Plan (CHIP) Development: Strategy Meetings for the Health Priorities

Process:
Three strategy meetings were held on October 31, November 14 and December 12, 2018. These meetings presented selected health system assessment (access to care) outcomes, Community Health Improvement Tracker for previous CHIP (Attachment 7), new priorities for 2019-2024, and resources (Attachment 8) for evidence based practices. National/State/Regional plans, and additional data links for each priority. These meetings allowed for brainstorming on new strategies for each health priority. Stakeholders from all four counties participated from a location in each county connected (Go-to-Meeting online meeting tool) to the South Heartland primary facilitator in Hastings. South Heartland staff members stationed in Clay, Nuckolls and Webster County meeting locations assisted the primary facilitator. At least one MAPP core team member was also present at each location. SHDHD staff trained in Go-to-Meeting provided technical support for videoconferencing to connect all four counties. Participant meeting packets were provided at all three meetings.

October 31 meeting: participants were asked to review access to care strategies from our 2012-2018 CHIP, and identify any strategies that would help address newly prioritized barriers and gaps.

November 14 meetings:
We held separate strategy meetings for each health priority, consecutively throughout the day. At each meeting, participants were asked to review existing partners and programs for that health issue and add partners and programs or strategies that were missing from the list.

Next, participants were asked 1) what new strategies might be needed, 2) what is missing and what should be added. Additional considerations for discussion included: 1) target population 2) how might this strategy address issues captured in the focus groups, and 3) resources, feasibility, community strengths, opportunities, threats, current partners and other partners to be included.

December 12 meetings:
Again, we held separate strategy meetings for each health priority, consecutively throughout the day. For each of the five priorities, SHDHD summarized the reoccurring themes from the October and November meetings and developed a strategy worksheet. The strategy worksheet was organized by overarching themes: Health System, Community Based, Empowerment, Resources, and Policy/Environment. Participants reviewed and discussed the proposed strategies and were asked to "endorse" strategies their organizations could support or that they thought should be included in the 2019-2024 CHIP.

Nuckolls County stakeholders discuss strategies to address priority issues.

Results:

Data to Action: Community Health Improvement Planning

Following the December strategy meetings, SHDHD created a final summary of strategies for each of the five priority areas, and categorized these by themes of health system, community based, resources, empowerment and policy/environment. SHDHD produced a crosswalk of these strategies with the list of organizations endorsing each strategy, as well as with known evidence-based strategies. The Community Health Improvement Plan 2019-2024 contains the final strategies for each priority to include goal and objective statements, measures, baselines, targets, evidence-based resources, and short-term, mid-term and long-term key performance indicators.

Community stakeholders collaborated on the facilitated development of the district wide Community Health Improvement Plan (CHIP). In 2019 and beyond, steering committees for each priority will move the plan components into the Action Phase (CHIP implementation).

Additional Data (Appendices 1 -8)

Attachments

Attachment 1: MAPP Participation

Attachment 2: Data Review and Priority Setting for Access to Healthcare - Meeting Packet

- County Health Rankings by Nebraska and SH Counties
- Community Themes and Strengths Survey Results
- Professional Shortage Areas
- SHDHD Healthcare Assets Maps and Summaries
- Social Context and Vulnerable Populations for South Heartland District
- Local Hospital and Clinic Data

Attachment 3: Focus Group Summary Report

Attachment 4: Focus Group Summary Tables

Attachment 5: SHDHD Community Themes & Strengths Intercept Survey

Attachment 6: Priority Setting for Health Issues - Meeting Packet with Fact Sheets

- Cancer
- Environmental
- Domestic Violence, Sexual Assault & Child Abuse/Neglect
- Overweight/Obesity
- Diabetes
- Cardiovascular, Heart Disease, Stroke
- Injury
- Mental Health
- Alcohol/Tobacco and Substance Abuse

Attachment 7: Community Health Improvement Tracker, 2016

Attachment 8: Resources for Each Priority (Evidence based practices, National/State/Regional Plans, additional data links)

Appendices - Additional Data:

Appendix 1: SHDHD Behavioral Risk Factor Surveillance System (BRFSS), 2016

Appendix 2: SHDHD BRFSS, 2011-16 Detailed Tables

Appendix 3: BRFSS 2016, Veterans and Their Families

Appendix 4: Youth Risk Behavior Survey 2016, Youth Mental Health

Appendix 5: SHDHD Nebraska Risk and Protective Factor Student Survey (NRPFSS), 2016

Appendix 6: NRPFSS 2016, Adams County

Appendix 7: NRPFSS 2016, Clay County

Appendix 8: NRPFSS 2016, Nuckolls County