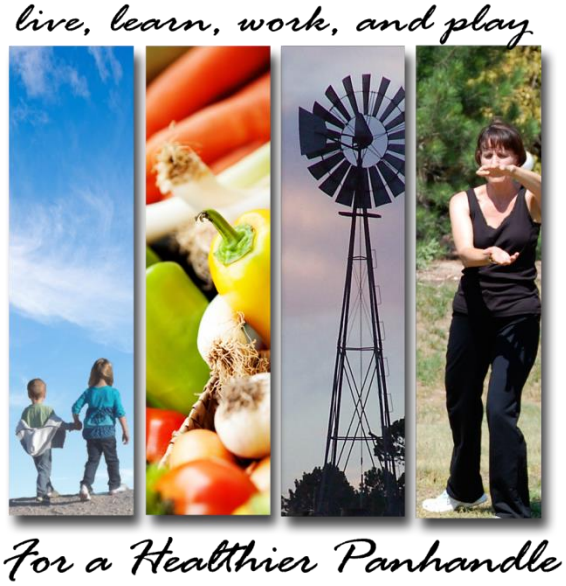
2020 Community Health Assessment of the Nebraska Panhandle

Approved by the PPHD Board of Health 12/10/2020



PREPARED BY

Kelsey Irvine, Community Health Planner
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

www.pphd.org

CONTACT

Panhandle Public Health District
P.O. Box 337
Hemingford, NE 69348

Kim Engel, Health Director
kengel@pphd.org
(308)760-2415

LETTER FROM THE DIRECTOR

Dear Panhandle Communities,

Every three years we come together in the Panhandle to complete a Community Health Needs Assessment and Community Health Improvement Plan. During 2020, people across the region worked collaboratively to review data, share concerns and strengths of our communities, and identify priority areas that we can work on together to improve the health status for all people living in the Panhandle. The planning process used was Mobilizing for Action through Planning and Partnerships (MAPP). The ultimate goal of MAPP is optimal community health – a community where residents are healthy, safe and have a high quality of life.

Panhandle Public Health District partnered with the hospitals and health systems as well as the rest of the local public health system and completed this process for the good of all 12 Panhandle counties. The public was encouraged to participate throughout the process through surveys, focus groups, and participatory planning processes.

2020 was a tumultuous year for all as our lives were upended by the COVID-19 Pandemic. Even through the Pandemic, our communities came together to give input in the health assessment process. We were able to adjust our in-person meetings to be virtual, using new technology and tools to get the work done.

We thank you for your participation in the community health assessment process and encourage you to continue to be engaged in helping solve these complex issues.

Sincerely,

Kimberly A. Engel

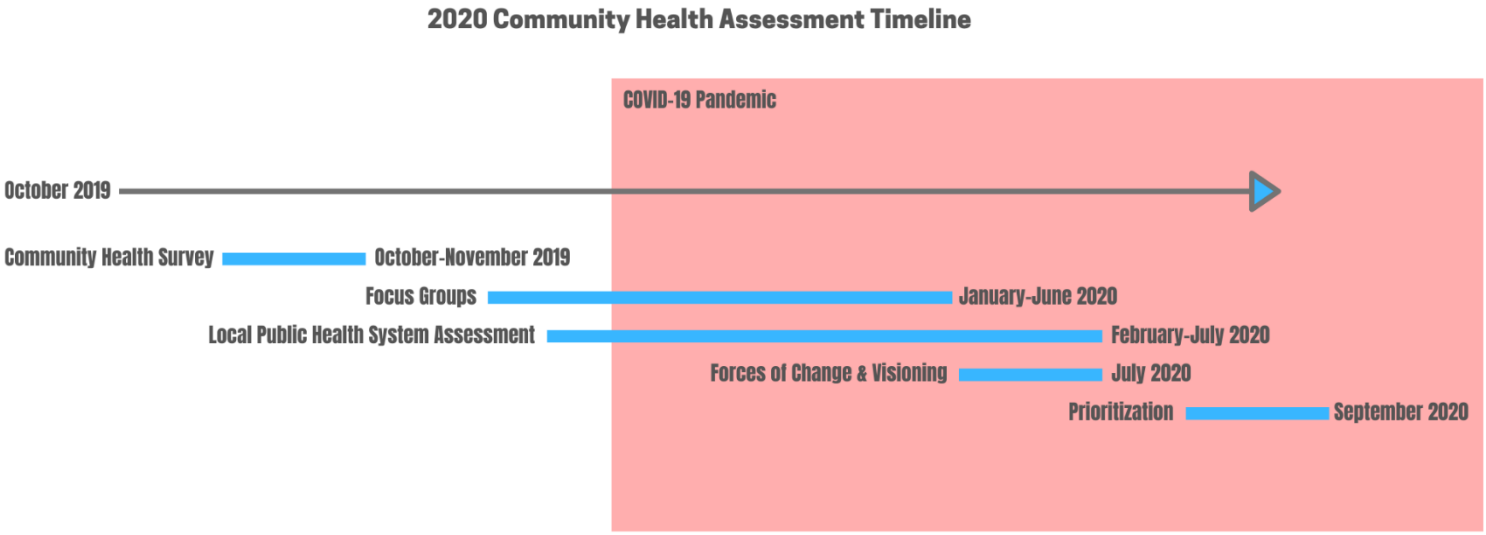
Health Director
Panhandle Public Health District

Table of Contents

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.

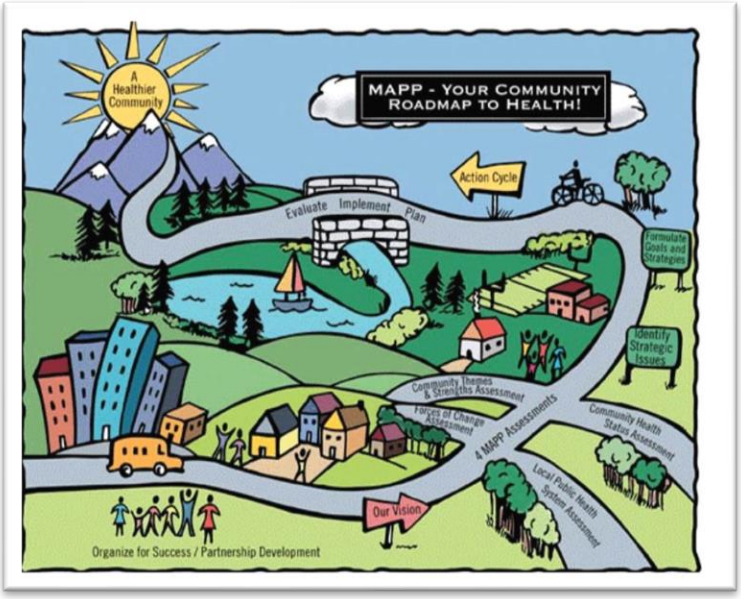
INTRODUCTION

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 CHA and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011, and continued to be used for this round of the CHA 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 P
    d. Local Public Health System Assessment
4. Identify Strategic Issues
5. Formulate Goals and Strategies
6. Take Action (plan, implement, and evaluate)

This document contains information for phases one through four. Phases five and six can be found in the 2021-2023 Panhandle Community Health Improvement Plan (CHIP).

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	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	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

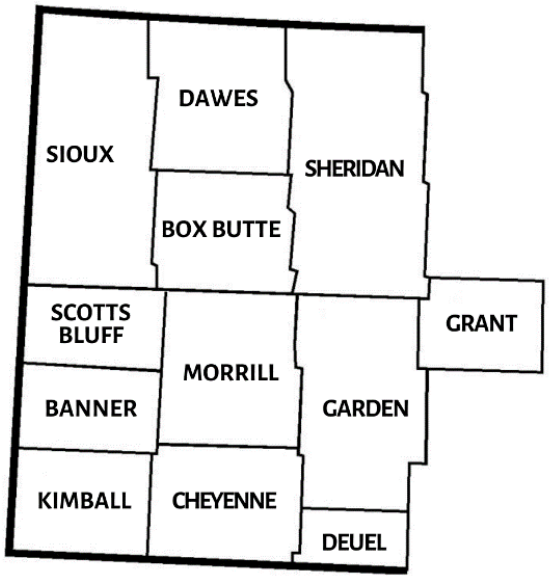
MAPP PHASE 3: FOUR MAPP ASSESSMENTS

COMMUNITY HEALTH STATUS ASSESSMENT

COMMUNITY PROFILE

The Nebraska Panhandle is a rural region on the high plains, surrounded by neighbors of Wyoming to the west, Colorado to the south, and South Dakota to the north. Its agricultural backbone perhaps has insulated it from historical economic downturns but has likely also contributed to out-migration as fewer opportunities have been available compared to larger cities for young adults with diverse professional trades. Population consolidation continues, wages remain lower than the state and national averages, and the median age continues to increase as the baby boomers age, birth rate stabilizes, and out-migration of youth continues. The unique bluffs, escarpments, and open space are some of the most treasured assets in the region which lay the foundation for tourist and historic attractions.

The geographic Nebraska Panhandle consists of the counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Grant, 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.



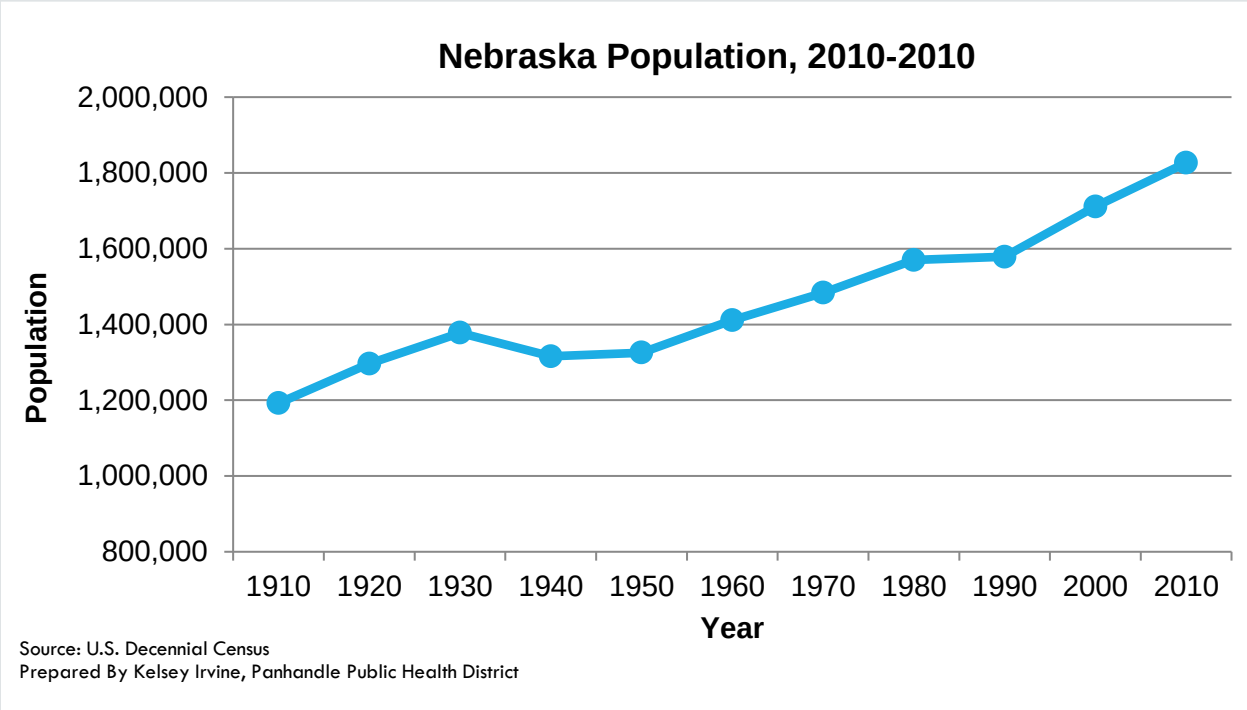
PPHD Service Area Quick Facts:
Population: 87,005
Unemployment rate: 2.9%
Total land area: 14,963 square miles

Source: 2013-2018 American Community Survey 5-Year Estimates

POPULATION

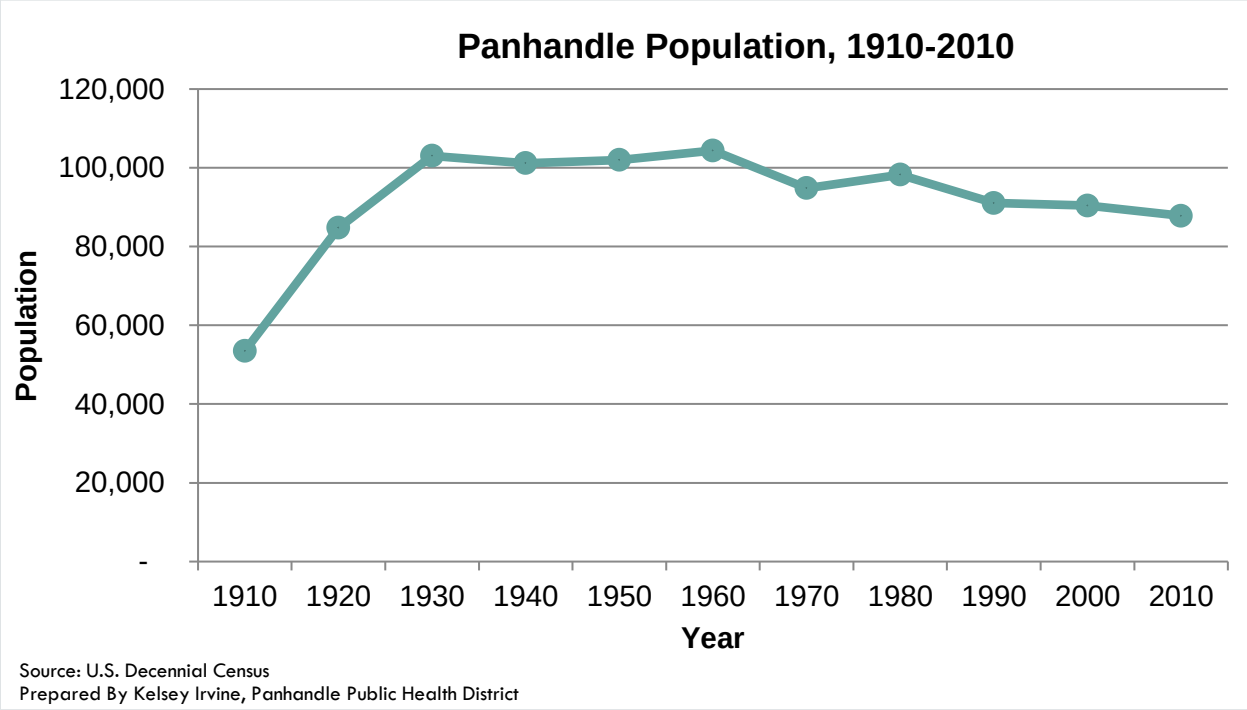
While the population of Nebraska has been slowly but steadily increasing over the past 60 years, the Panhandle's population peaked in the 1960s. Much of Nebraska's growth can be attributed to the metropolitan areas.

Figure 1: Nebraska Population, 1910-2010



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

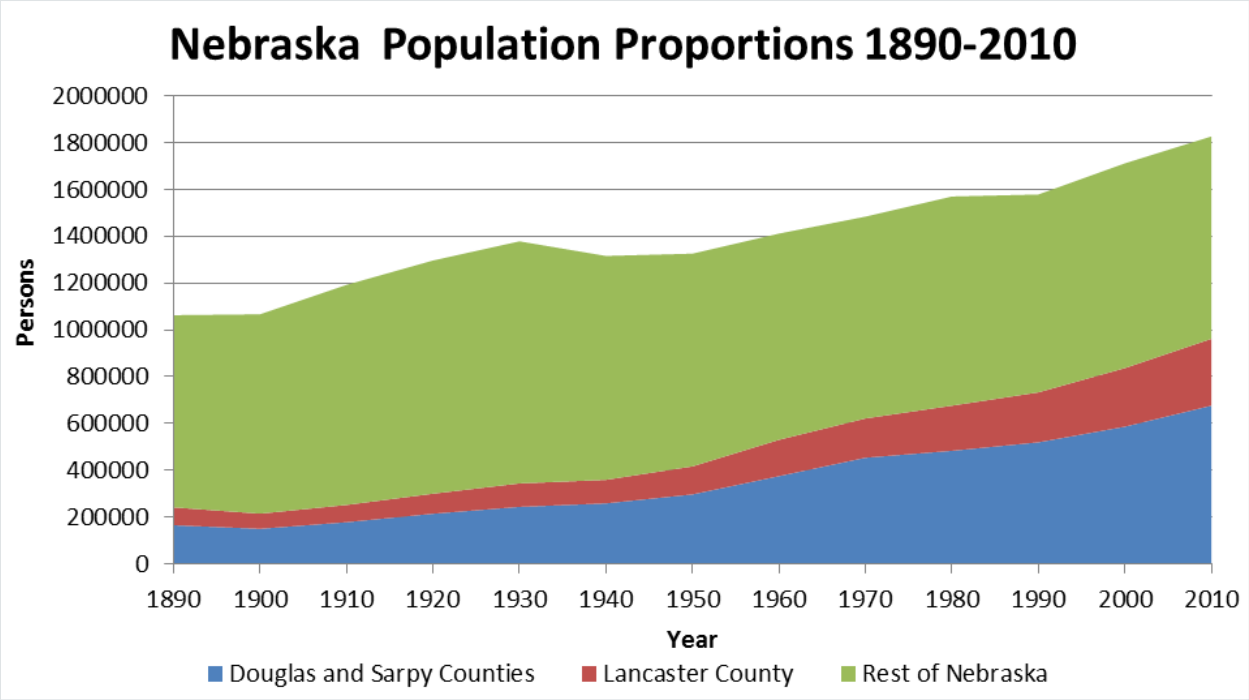
Figure 2: Panhandle Population, 1910-2010



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

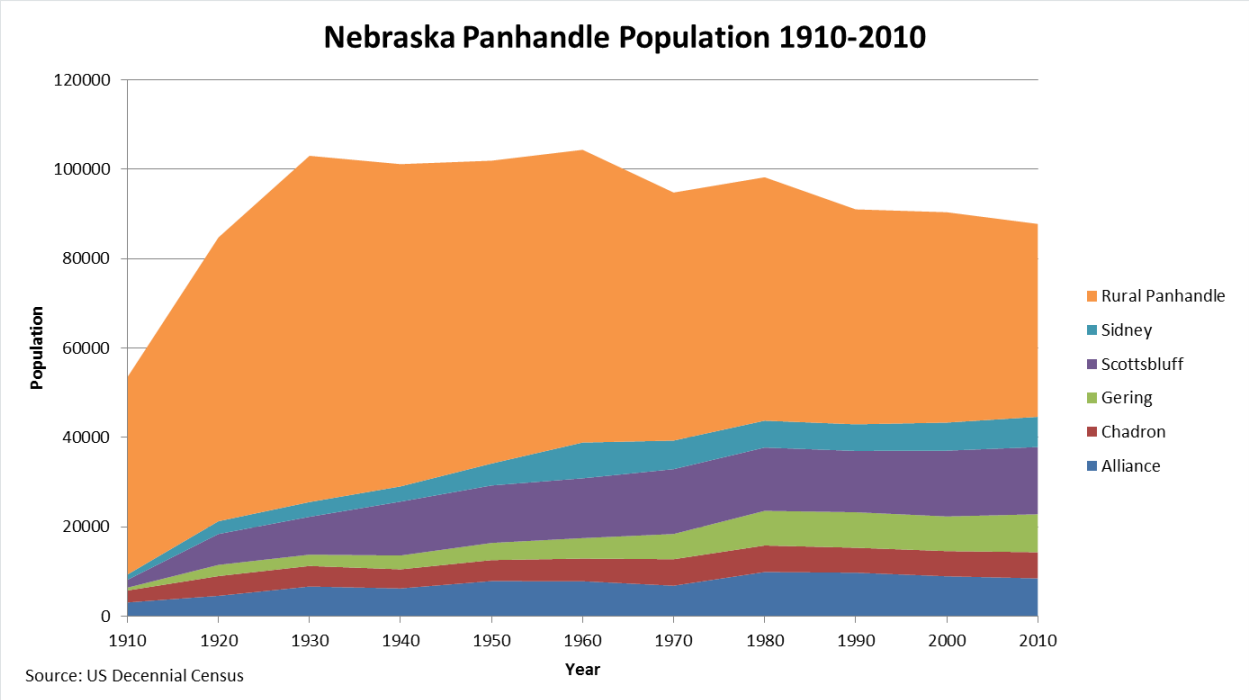
Nebraska's population growth has been concentrated almost entirely in the metropolitan counties of Douglas, Sarpy, and Lancaster in the eastern part of the state. These counties are home to the Omaha metropolitan area and the state capital metropolitan area of Lincoln.

Figure 3: Nebraska Population, Omaha and Lincoln metro areas and rest of state



Source: U.S. Decennial Census

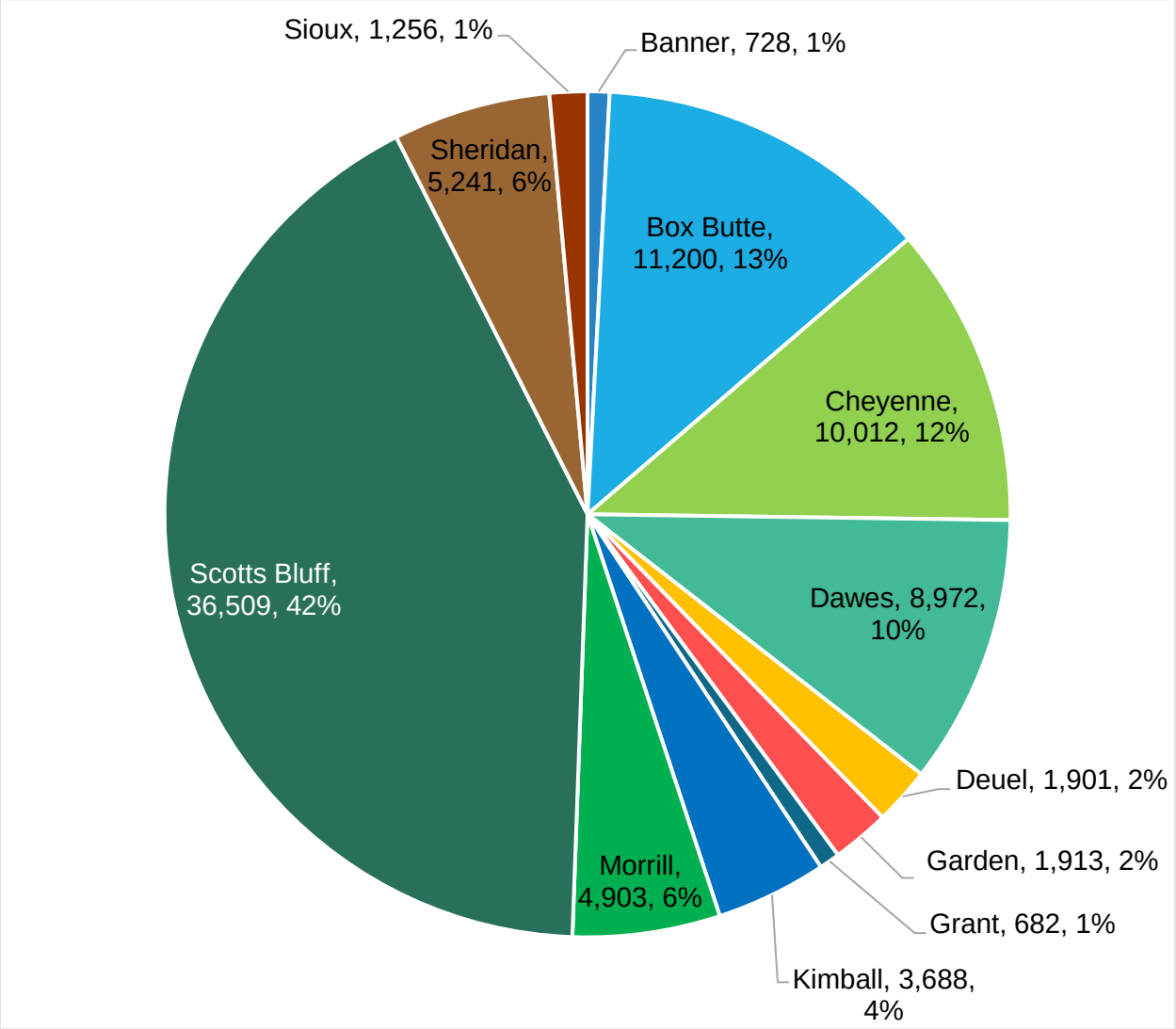
Figure 4: Nebraska Panhandle Population Consolidation: 1910-2010



Population consolidation away from rural areas is not new, is a global phenomenon, and has also been occurring within our region. The emergence of the service and innovation-based economy and decrease of farm employment practically ensures this pattern will continue into the future. For this reason, communities should not undertake frantic efforts to stop population loss but rather measured strategies which aim to steadily improve quality of life and opportunities for their citizens. What the Panhandle lacks in critical mass of resources and people, it must make up for in creative solutions and the strengthening of partnerships to build a collective impact.

Seventy-seven percent of the Panhandle's population is concentrated in the 4 'trade counties' of Scotts Bluff, Box Butte, Cheyenne, and Dawes. These counties are home to the cities that draw from large areas that tend to have more amenities, retail, and services. Many of the 'rural counties' also boast communities with excellent local services. However, in the rural counties, travel time, available labor, and lower levels of public revenue pose obstacles for economic growth and community vitality.

Figure 5: 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

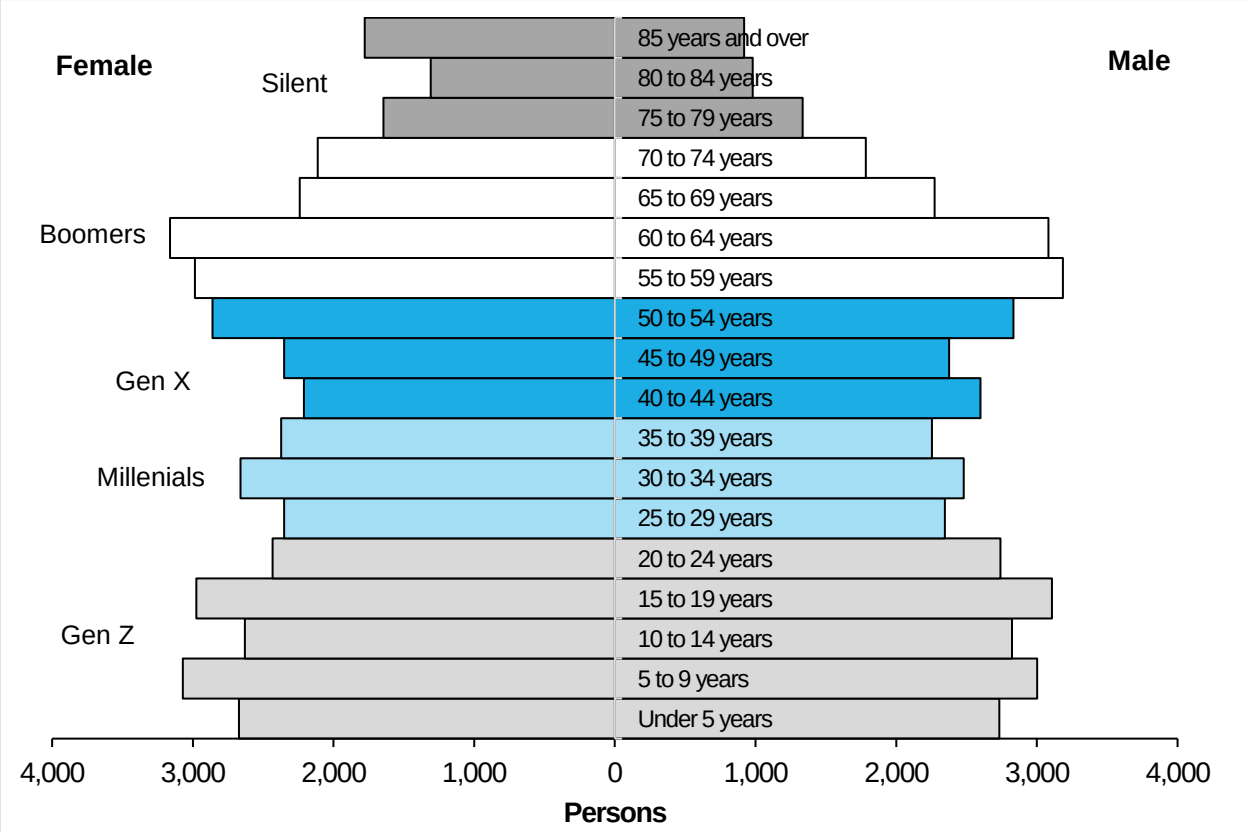
The population pyramid from 2013-2017 American Community Survey Estimates shows the general age make-up of the Nebraska Panhandle. Typically, in a population pyramid you see a pyramid shape, hence the name population pyramid. When the graph displays as a pyramid, it means that the population is growing, and older generations are producing larger newer generations. With a more rectangular shape, older generations are being replaced with newer generations of about the same size. In the population pyramid for the PPHD service area, you see a strongly pronounced baby boom generation. The shape of this pyramid shows issues both in opportunities for young adults and taking care of an aging population. Decreased family sizes also affect the straight 'trunk' rather than the wide base.

Figure 6: Panhandle Population by Sex and 5-Year Age Group

	Both Sexes		Male	Female
	Estimate	Percent	Estimate	Estimate
Total Population	86,323		42,506	43,817
Under 5 years	5,434	6.3%	2,733	2,701
5 to 9 years	6,088	7.1%	3,002	3,086
10 to 14 years	5,468	6.3%	2,823	2,645
15 to 19 years	6,107	7.1%	3,107	3,000
20 to 24 years	5,181	6.0%	2,741	2,440
25 to 29 years	4,719	5.5%	2,346	2,373
30 to 34 years	5,158	6.0%	2,480	2,678
35 to 39 years	4,635	5.4%	2,254	2,381
40 to 44 years	4,814	5.6%	2,598	2,216
45 to 49 years	4,749	5.5%	2,376	2,373
50 to 54 years	5,727	6.6%	2,834	2,893
55 to 59 years	6,198	7.2%	3,185	3,013
60 to 64 years	6,272	7.3%	3,082	3,190
65 to 69 years	4,537	5.3%	2,273	2,264
70 to 74 years	3,919	4.5%	1,784	2,135
75 to 79 years	2,995	3.5%	1,335	1,660
80 to 84 years	2,296	2.7%	980	1,316
85 years and over	2,708	3.1%	919	1,789

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

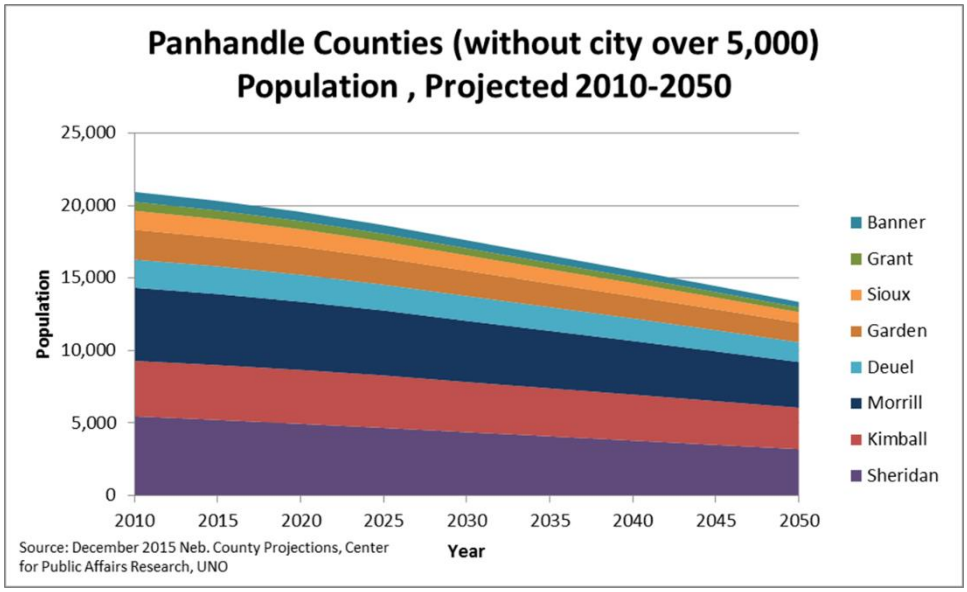
Figure 7: Panhandle Population Pyramid

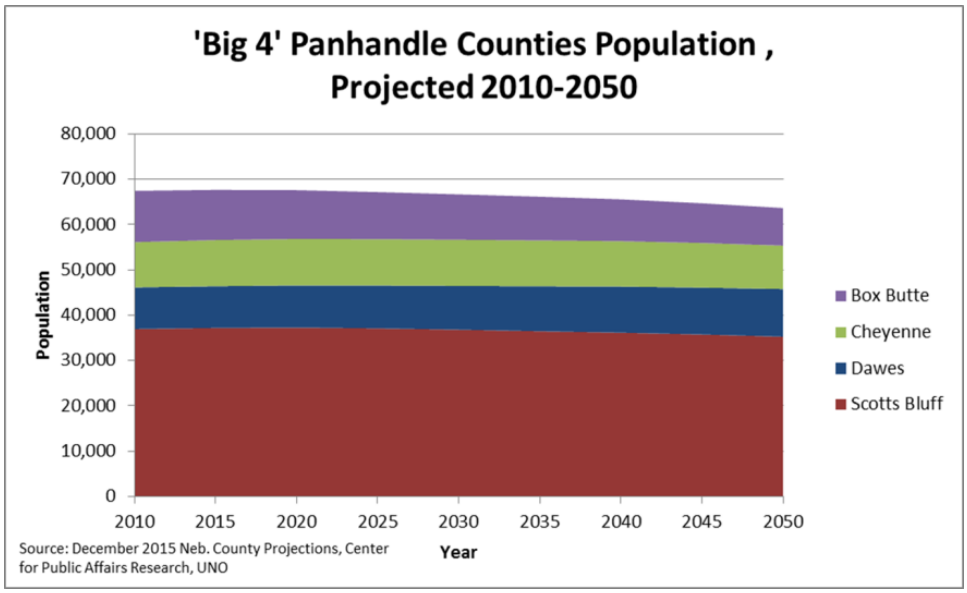


Source: 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

Population projections for the Panhandle counties show a slight growth or steady population in Cheyenne, Scotts Bluff and Dawes Counties and steady to significant decline in all other counties through 2030.

Figure 8: Panhandle projected populations by county



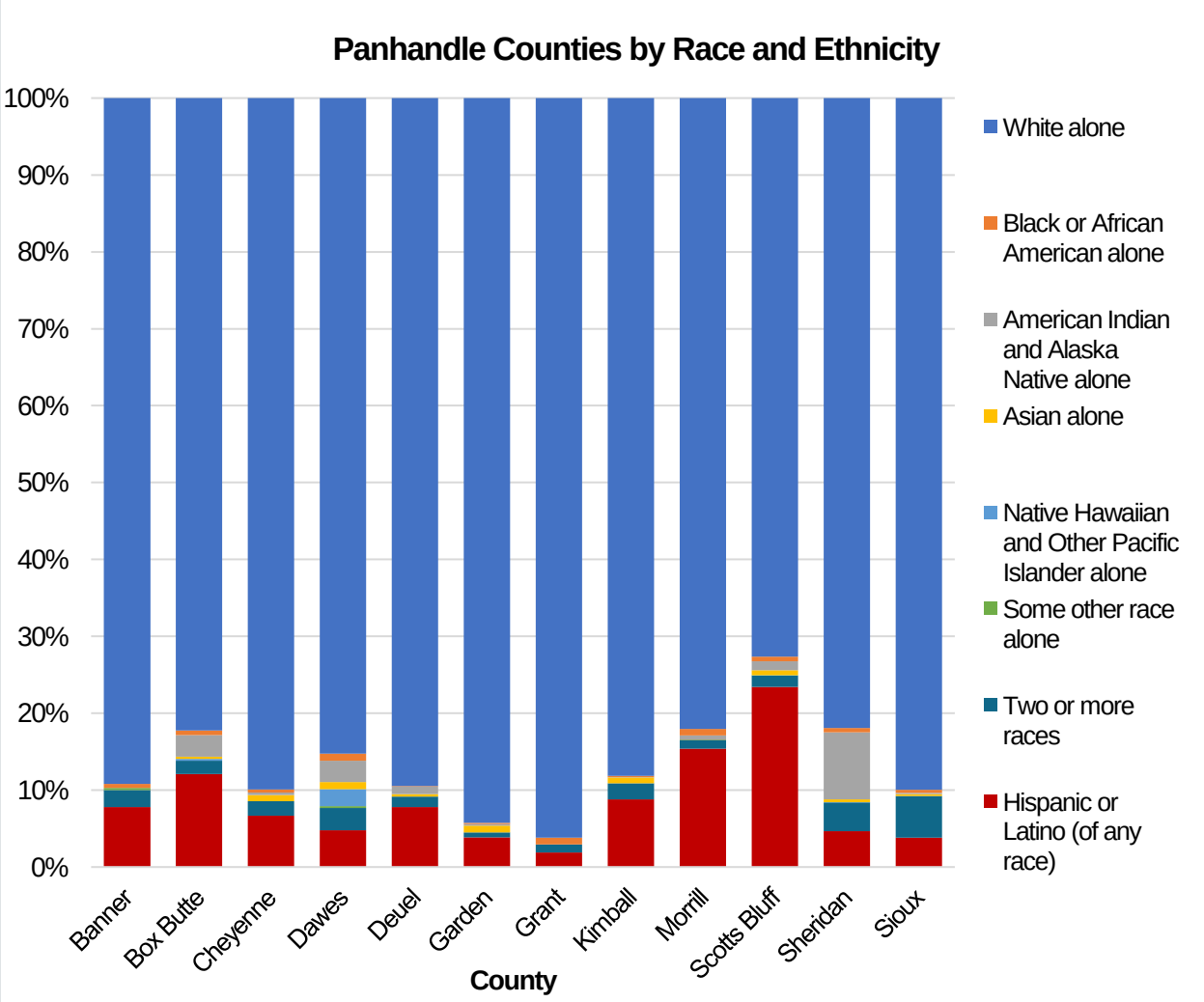


RACE AND ETHNICITY

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.

In the Nebraska Panhandle, the majority race is non-Hispanic White, but some communities have Hispanic persons making up 15 to 30 percent of their population and some also have relatively large American Indian populations. Scotts Bluff and Morrill counties show higher Hispanic populations while Sheridan County shows an almost 10% American Indian population. As the high English proficiency and low foreign-born rates show, however, many Hispanic families have been in the area for multiple generations.

Figure 9: Panhandle Counties by Race and Ethnicity



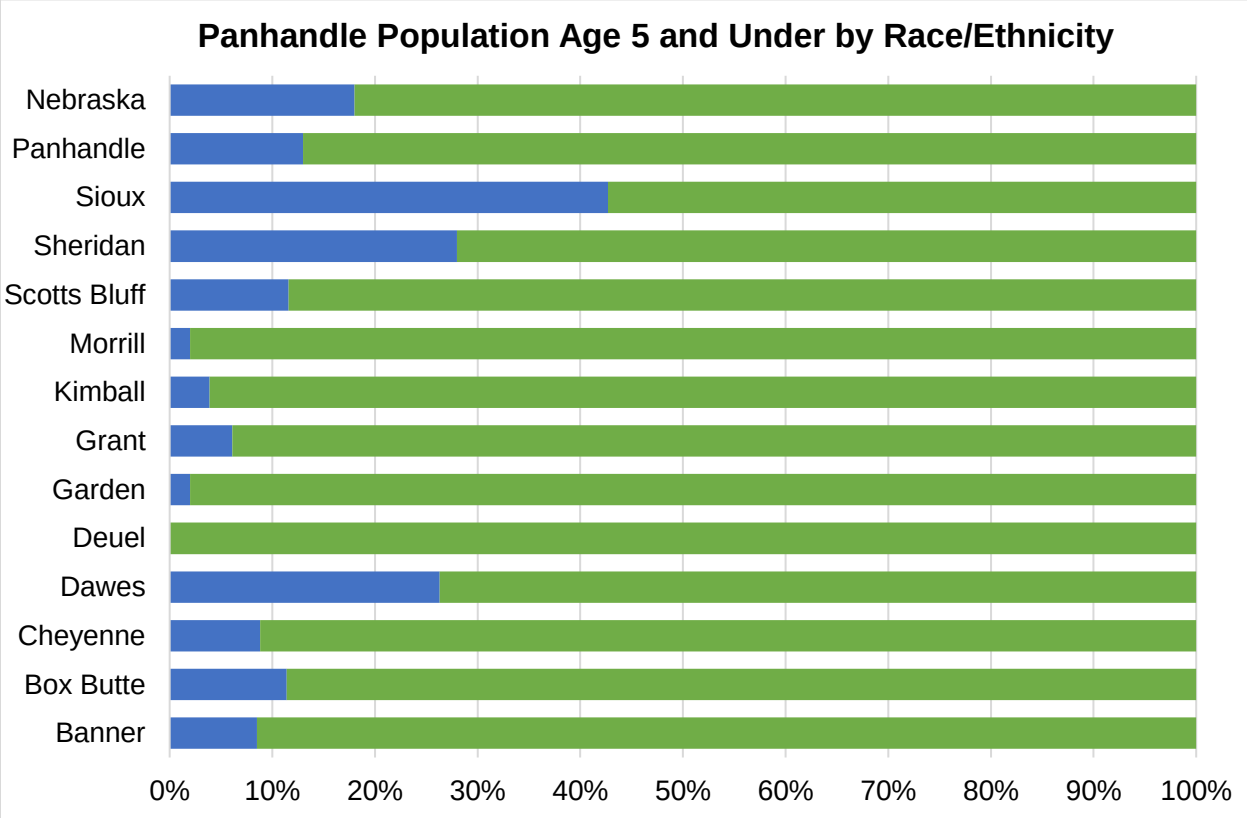
Source: 2013-2017 American Community Survey 5-year Estimates. Prepared By Kelsey Irvine, Panhandle Public Health

Like the rest of Nebraska, younger generations of new Nebraskans born to Hispanic or Latino families is the driver behind the growth of Hispanic or Latino populations in the region. However, unlike other parts of Nebraska, the Panhandle's Hispanic population is largely US born and has been for decades. New generations of Nebraskans in the Panhandle born to Hispanic families are often second, third, or fourth generation Americans.

	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%

The population in younger age groups is generally more diverse than that of the general population. In Dawes, Sheridan, and Sioux Counties nearly or over one third of all children were counted to be of minority race or ethnicity (something other than non-Hispanic, White).

Figure 10: 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	8.5%	11.4%	8.8%	26.3%	0.0%	2.0%	6.1%	3.9%	2.0%	11.6%	28.0%	42.7%	13.0%	18.0%
White alone	91.5%	88.6%	91.2%	73.7%	100.0%	98.0%	93.9%	96.1%	98.0%	88.4%	72.0%	57.3%	87.0%	82.0%

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.

The Nebraska Panhandle has its roots in a strong agricultural economy and has fared well in economic downturns, maintaining unemployment rates often much lower than the nation. Wages and professional opportunities, however, lag behind the state and nation as the region has struggled to compete with the metropolitan areas' pool of talent and innovation.

EMPLOYMENT AND WORKFORCE

The Panhandle generally has a similar unemployment rate (2.9%) when compared to Nebraska (2.8%) and has a low unemployment rate compared to the nation (3.9%). While unemployment rose in Nebraska and Panhandle counties during the recession (as seen in 2010), it was not nearly to the extent of the nation as a whole which had an unemployment rate that reached nearly 10% during the height of the recession.

Figure 11: 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 since 2000.

People leave the county labor force by not continuing to look for work, moving away, or retiring. While unemployment is typically lower than the nation in the Panhandle counties, the change in labor force is negative overall and relatively high in some counties. Banner, Box Butte, Cheyenne, Deuel, and Sheridan counties all recorded double digit percentage decreases in total labor force from 2000 to 2018. This sharp decrease in total labor force is a trend that continued through the recession and has continued even while the national economy has recovered.

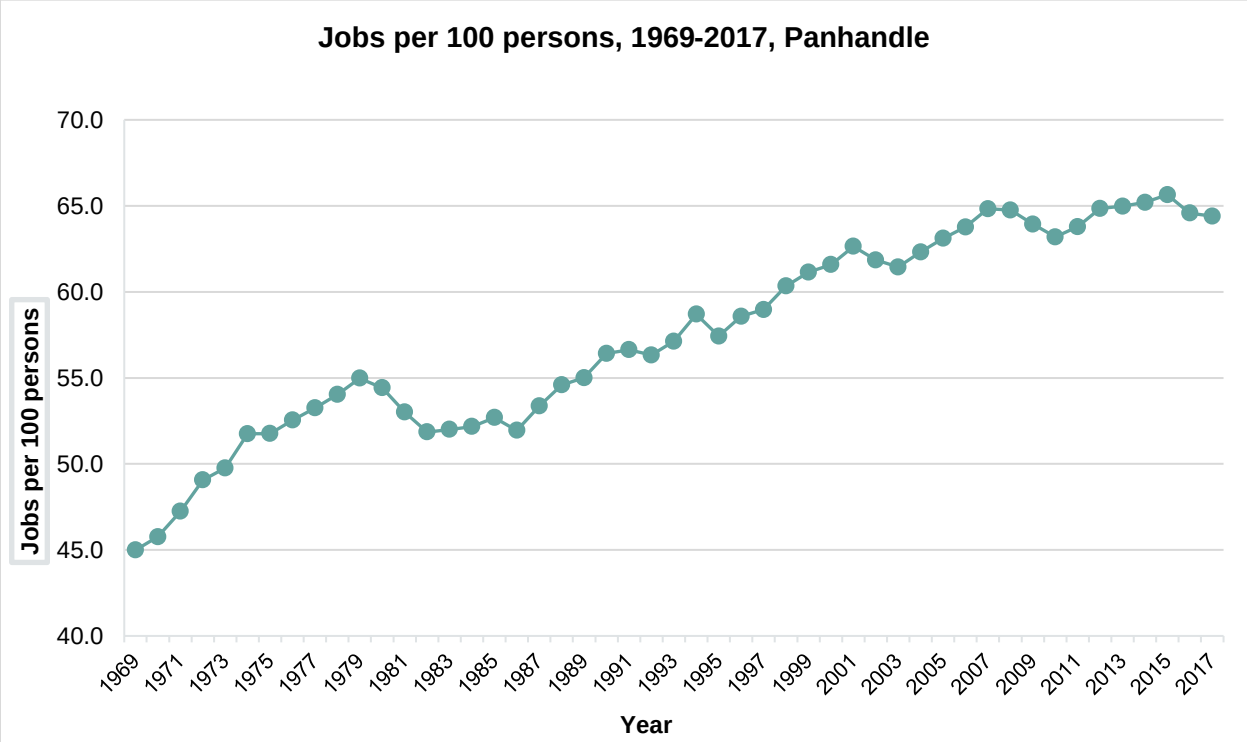
Figure 12: Panhandle Labor Force, 2000-2018

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.

Historically, the number of jobs available per 100 persons has increased while wages continue to remain below the national and state averages. While this ratio's increase can be partly attributed to loss of population in the region, it also illustrates the importance of the quality of jobs we grow in the region, not just the quantity of jobs. Families with parents who work multiple jobs run a risk of instability since the parents are not able to be home as often.

Figure 13: Jobs per 100 persons, 1969-2017, Panhandle



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

Figure 14: Jobs per 100 Persons, 2006-2017, Panhandle

2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
63.8	64.8	64.8	63.9	63.2	63.8	64.8	65.0	65.2	65.6	64.6	64.4

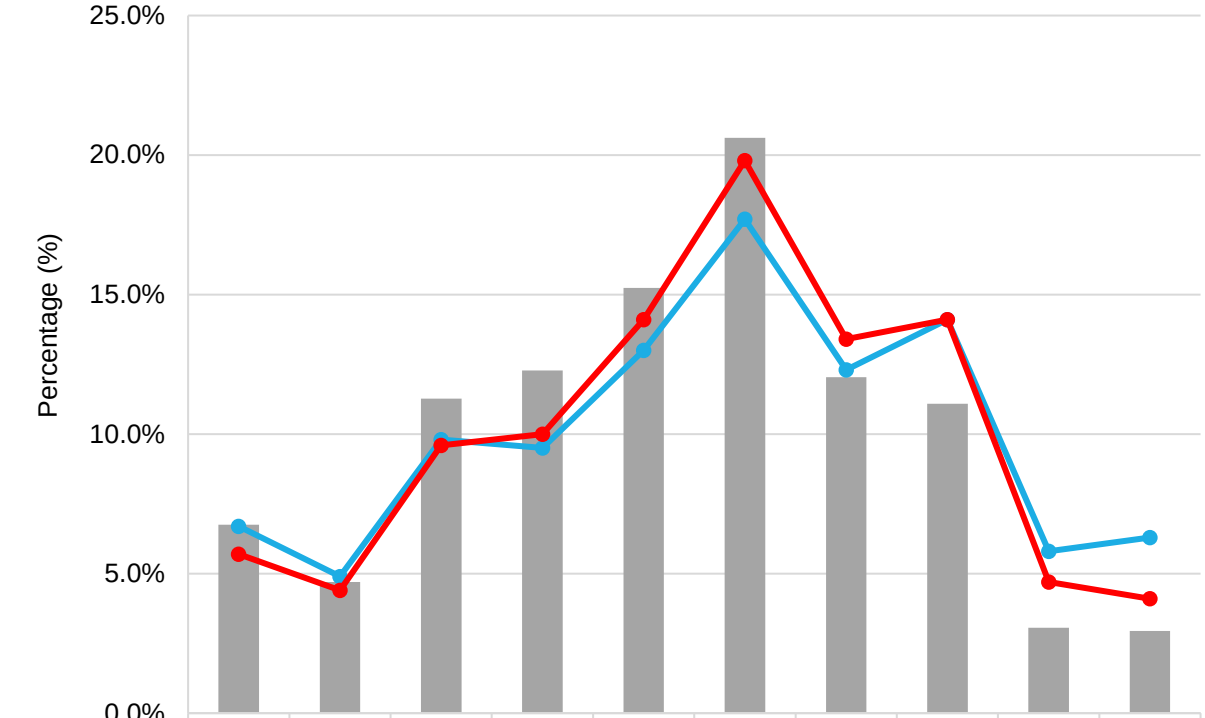
Source: US Bureau of Economic Analysis, Regional Economic Information System. Released November 2018. Prepared by Kelsey Irvine, Panhandle Public Health District

INCOME

Wages are generally well below the average for both Nebraska and the nation. The state median household income is $56,675. Only Cheyenne County recorded a higher median income in the most recent estimates; however, this is likely to change with recent closing of a large employer in the community. While the costs of living expenses are generally lower in the Panhandle, wages are still relatively low and are a noted problem by citizens and community leaders across the region.

Income distribution in the Panhandle shows a lot of households in the middle of the spectrum, with the distribution slightly heavier towards the low-income side. Maintaining this large middle-income population is important as too much of a gulf between the low- and high-income earners is detrimental for a community. While the Panhandle has a similar percentage of its households in the $50,000-74,999 bracket as the state, it has a lower percentage in the $75,000-$149,000 brackets and more in the under $35,000 brackets. Fewer professional, science, and technology-based jobs likely lead to this outcome.

Figure 15: 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
Panhandle	6.7%	4.7%	11.3%	12.3%	15.2%	20.6%	12.0%	11.1%	3.1%	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%

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

Change in median household income varied from 2010 to 2017 by county with small counties such as Banner, Garden, and Deuel counties showing the largest gains and Kimball and Sioux counties recording a decrease in household median income. The data contains data from years of the recession which likely accounts for the decrease in income on the national and state levels.

Figure 16: 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

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 17: 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. The college student population in Dawes County skews the poverty rate in that county, but three other Panhandle counties had estimated poverty rates over the state average by the most recent estimates. This is a decrease in the number of counties with an estimated poverty rate above the state average in past years.

CHILDHOOD POVERTY

Particularly high poverty rates exist for children under 18, with five of the eleven counties having childhood poverty rates higher than that of the latest state estimate. Sheridan County has the highest rate at 27.5%, then Scotts Bluff, Sioux, Deuel, and Cheyenne Counties. 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. Although five of the eleven counties have a higher child poverty rate when compared to the state, there has been an overall decline in poverty and childhood poverty in the region, which may have spiked during the recession beginning in 2009. This recent decrease is good news but still exposes the vulnerability of the area to changes in economy and lay-offs from major employers.

Figure 18: 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 19: 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

By race, American Indian and Hispanic or Latino origin (of any race) are the largest minority groups in the Panhandle and have poverty rates higher than the area average. White (not Hispanic) race had the lowest prevalence of poverty.

Figure 20: 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

The Panhandle's lower rate of poverty among people with lower educational attainment likely reflects the good paying jobs available for non-bachelor degree levels of education. The region's 30% poverty rate for those with a high school degree or less is drastically lower than big cities such as Denver (43%), Rapid City (45%), or Omaha (42%). Regional poverty rates also give credence to the benefit of higher education in accessing higher paying opportunities, with just 3% of those with a bachelor's degree or higher being below the poverty level.

Figure 21: Percent of Population in Poverty by Educational Attainment, Population 25+, Panhandle

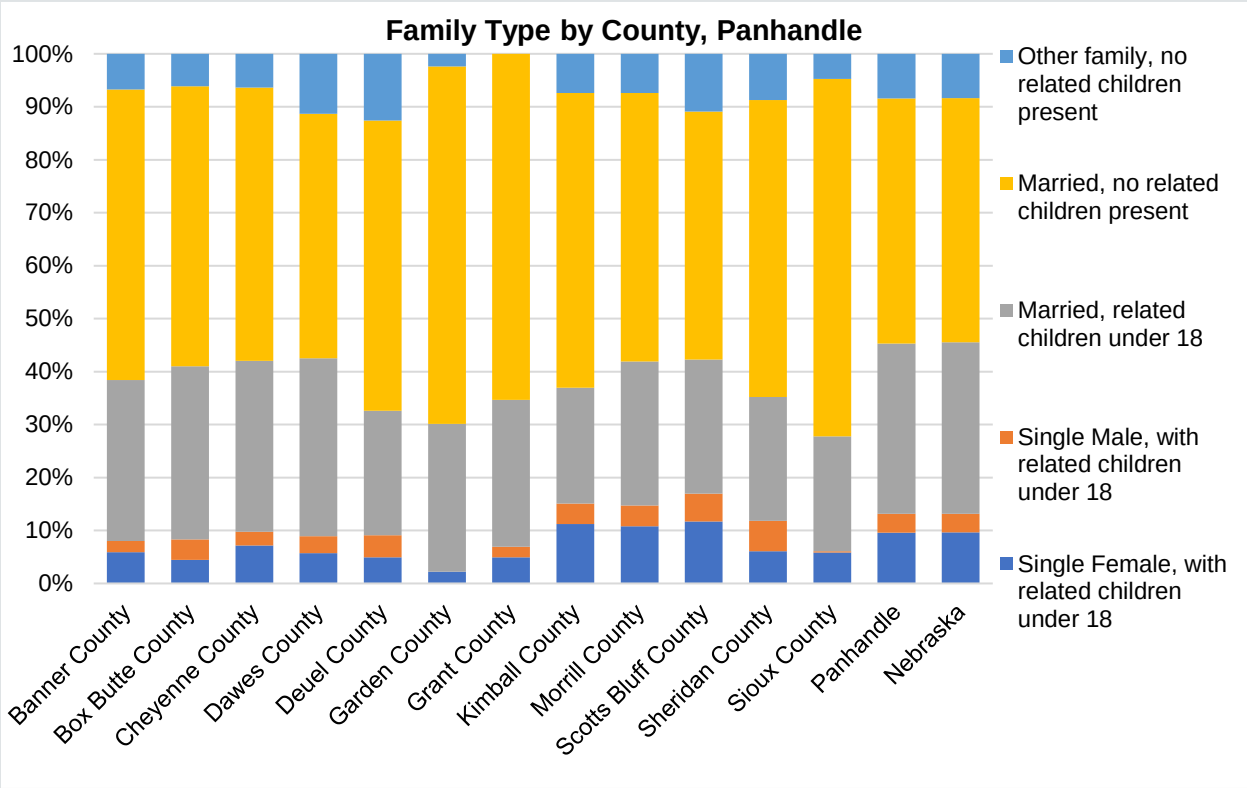
	Less than high school	High school graduate	Some college, associate's degree	Bachelor's degree or higher
Banner County	0.0%	11.2%	11.9%	0.0%
Box Butte County	17.8%	12.9%	6.6%	0.5%
Cheyenne County	12.6%	12.5%	8.2%	1.2%
Dawes County	25.2%	17.5%	10.6%	3.5%
Deuel County	14.8%	7.8%	9.4%	1.6%
Garden County	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

Most families in the Panhandle do not have children under 18 years of age. Single parent families with children make up about 14% of all Panhandle families. The highest rates of single parent families with children occur in Kimball, Morrill, and Scotts Bluff Counties, with highest rates of married families occurring in the more rural counties of Banner, Deuel, Garden, and Sioux.

Figure 22: Family Type by County, Panhandle

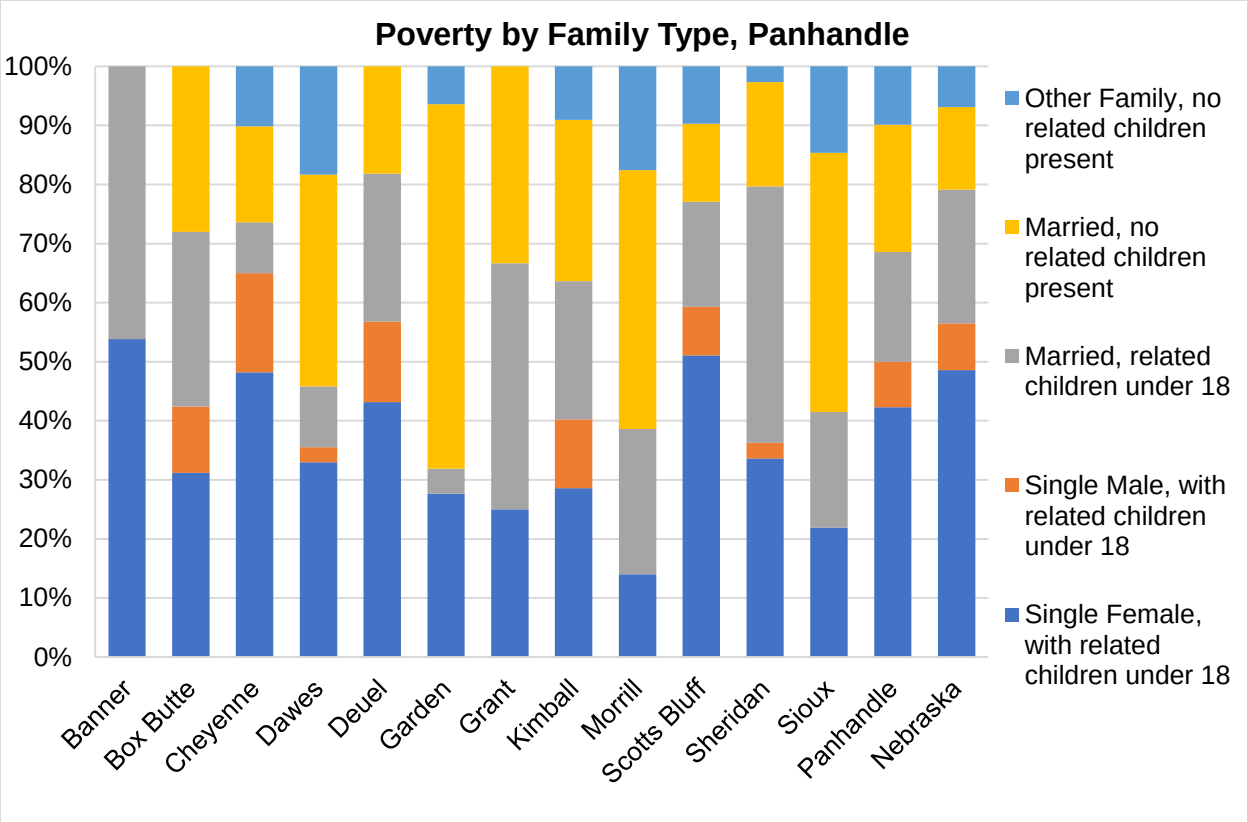


	Single Female, with related children under 18	Single Male, with related children under 18	Married, related children under 18	Married, no related children present	Other family, no related children present
Banner County	6%	2%	30%	55%	7%
Box Butte County	4%	4%	33%	53%	6%
Cheyenne County	7%	3%	32%	52%	6%
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

When looking at the families with income at or below poverty, we find that the vast majority of families in poverty are families with children under 18 years of age. Single female headed families with children are particularly prevalent among families in poverty, making up over 40% of all families in the Panhandle with an income level below the poverty line. More dependents increases the strain to make ends meet, particularly if a household only has one income to contribute.

Figure 23: 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%**

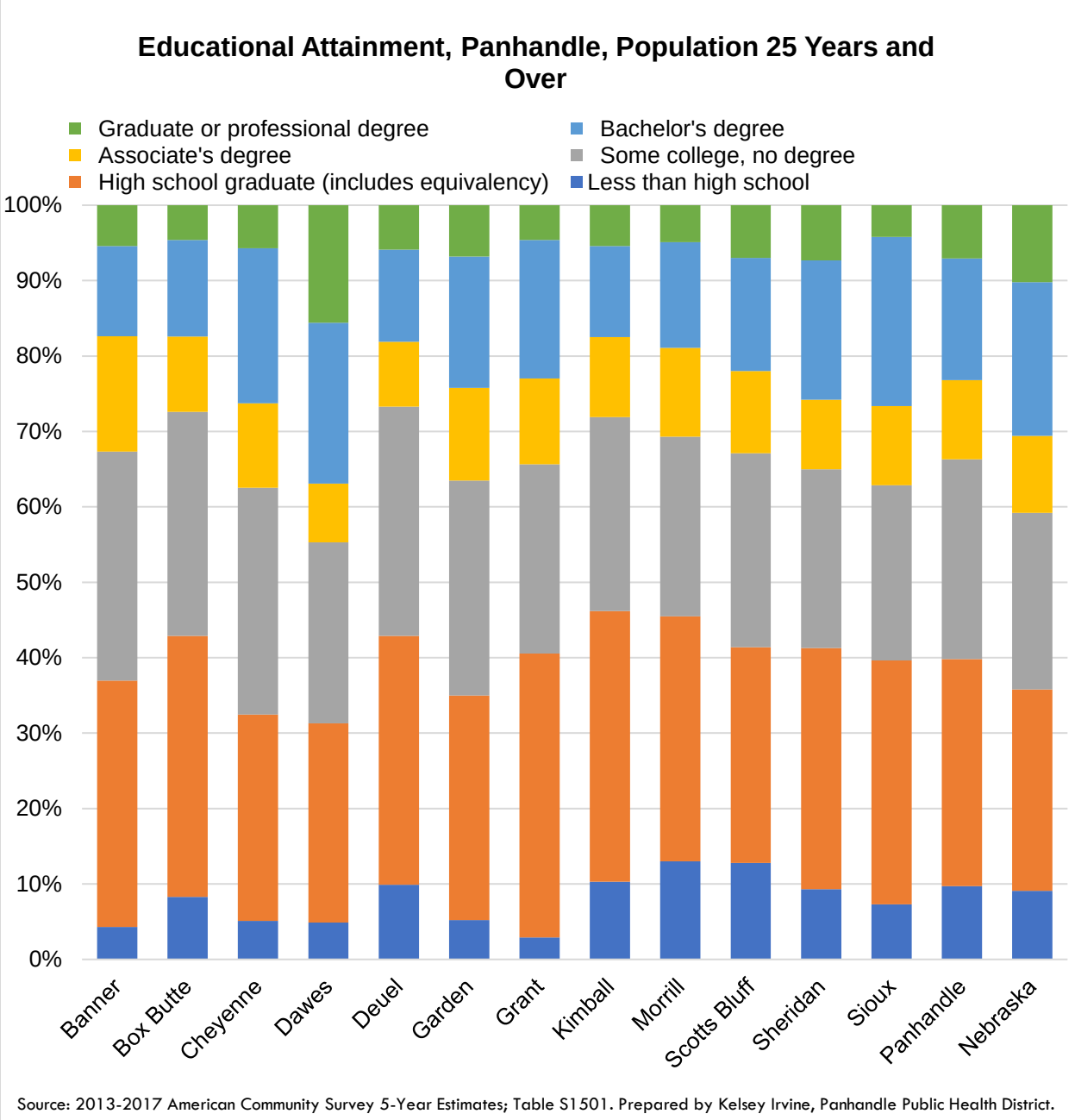
Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-year Estimates; Table S1702. Prepared By Kelsey Irvine, Panhandle Public Health District.

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. Currently, the region's workforce is about six percentage points below the state and national rates for population 25 or older with a bachelor's degree or higher. Dawes County is the exception where the presence of Chadron State College likely increases the percentage of the population with advanced degrees.

Figure 24: 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.

The 4-year graduation rate across the state of Nebraska for the 2017-2018 school year was 89%. Of public schools in the Educational Service Unit (ESU) 13 service area in the Panhandle, several fell under the state graduation rate: Alliance Public Schools, Crawford Public Schools, and Creek Valley Public Schools.

The 4-year graduation rate in many counties has remained virtually the same across the past 4 school years, although there are some stand out schools. Rates in Alliance Public Schools, Crawford Public Schools, Creek Valley Public Schools, and Sidney Public Schools have seen a decrease in graduation rates. Morrill Public Schools has seen an increase in graduation rates, from 67% in the 2014-2015 school year to 96% in the 2017-2018 school year. Some counties within the Panhandle have such small student numbers that their graduation rate may not be available for every year schools, signified by "NA".

Figure 25: 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, 4,482 children 5 and under had all available parents working.

Figure 26: 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. Sioux, Banner, and Grant Counties are not served by any head start or early head start programs.

Figure 27: 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. Overall, there are 2,996 spots for children in centers who serve children starting at an age younger than five years old.

With 673 spots available through Head Start or Early Head Start, and 2,996 children served through licensed childcare facilities, 3,669 total children under the age of 5 are served. This leaves approximately 800 children under 5 with both parents working outside of the home in some kind of non-regulated childcare situation.

Figure 28: 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**

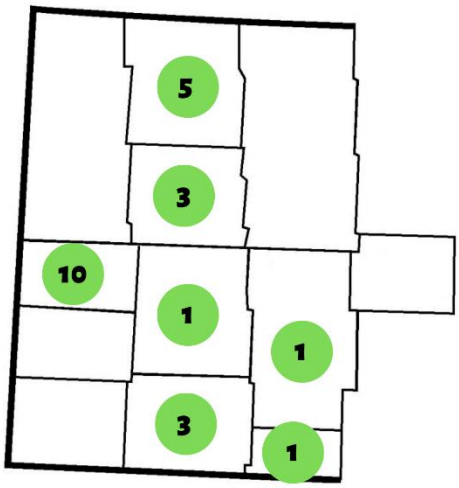
Source: Roster Of Licensed Child Care And Preschool Programs In Nebraska, Nebraska DHHS. Prepared By Kelsey Irvine, Panhandle Public Health District

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. Sioux, Sheridan, Banner, Kimball, and Grant Counties did not have any Step Up to Quality Programs at that time. 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.

Figure 29: 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

ROOTED IN RELATIONSHIPS

In 2018, 5 counties were implementing Rooted in Relationships (RiR) programs. Scotts Bluff acts as the Community Collaborative Hub for this work, where there is one cohort.

In addition to implementing the RiR Pyramid Package with 17 new providers in the Panhandle, the birth to eight subgroup chose for the systems portion of RiR to integrate the RiR Pyramid Package with 33 child care providers that had spent the last two years as part of the Sixpence Child Care Partnership grant in 3 Panhandle communities

Figure 30: 2018 Impact of Rooted Relationships in the Panhandle

Number of Rooted in Relationship Coaches	4	Programs engaged with coaches	50
Number of families served directly	21	Number of families served indirectly	256
Number of children served directly	384	Number of children served indirectly	328

Source: Rooted In Relationships 2017-2018 Evaluation Report. 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 31: 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.

Figure 32: 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. The exception to this is Dawes County, with an owner-occupied housing units rate of 62.5%, likely due to the renting college population in the Chadron community. Garden County has the highest rate of owner-occupied housing units, at 80.4%.

Figure 33: 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. Dawes County has the highest rate of renter-occupied households with income less than $20,000 whose housing costs make up more than 30% of their household income. This is likely related to the large college population in the Chadron area. Deuel, Morrill, and Sioux counties have the lowest rates of renter-occupied households with income less than $20,000 whose housing costs make up more than 30% of their household income. Sioux and Grant Counties have higher rates of owner-occupied housing units with housing costs making up more than 30% of their household income compared to renter-occupied units. This may be related to less rental units being available in these communities.

Figure 34: 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
Banner County					
Owner-occupied	4.9%	2.9%	1.0%	5.9%	0.0%
Renter-occupied	18.9%	0.0%	4.2%	0.0%	0.0%
Box Butte County					
Owner-occupied	5.4%	2.9%	2.9%	2.2%	0.6%
Renter-occupied	22.2%	15.7%	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%
Dawes County					
Owner-occupied	7.5%	2.7%	2.8%	0.9%	1.3%
Renter-occupied	26.7%	7.3%	0.0%	1.5%	1.0%
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%
Garden County					
Owner-occupied	7.5%	1.5%	2.4%	0.4%	0.0%
Renter-occupied	14.8%	0.0%	0.0%	0.0%	0.0%
Grant County					
Owner-occupied	17.9%	0.9%	4.0%	0.0%	1.3%
Renter-occupied	2.0%	0.0%	3.9%	0.0%	0.0%
Kimball County					
Owner-occupied	10.3%	9.9%	1.5%	1.6%	0.0%
Renter-occupied	17.1%	11.3%	0.2%	1.0%	0.0%
Morrill County					
Owner-occupied	8.2%	5.6%	3.1%	0.1%	0.0%
Renter-occupied	10.9%	13.5%	2.2%	0.0%	0.0%
Scotts Bluff County					
Owner-occupied	7.0%	6.4%	4.7%	3.2%	1.6%
Renter-occupied	22.9%	13.6%	3.3%	0.5%	0.2%
Sheridan County					
Owner-occupied	9.3%	4.0%	2.3%	0.5%	0.6%
Renter-occupied	14.8%	6.4%	2.0%	0.0%	0.0%
Sioux County					
Owner-occupied	11.4%	12.3%	0.7%	2.1%	0.0%
Renter-occupied	9.9%	0.0%	0.0%	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, six of the eleven Panhandle counties (Box Butte, Deuel, Garden, Morrill, Scotts Bluff, Sheridan) had a child maltreatment rate higher than that of the state of Nebraska (7.6 per 1,000 children). 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 35: 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 some Panhandle counties has consistently remained higher than that of the state of Nebraska. Scotts Bluff County specifically has a consistently high rate of state wards, with Garden and Deuel Counties also rising above the state rate in 2017.

Figure 36: 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, Garden and Morrill counties had higher rates of children with non-court welfare involvement in 2017 when compared to that of the state.

Figure 37: 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**

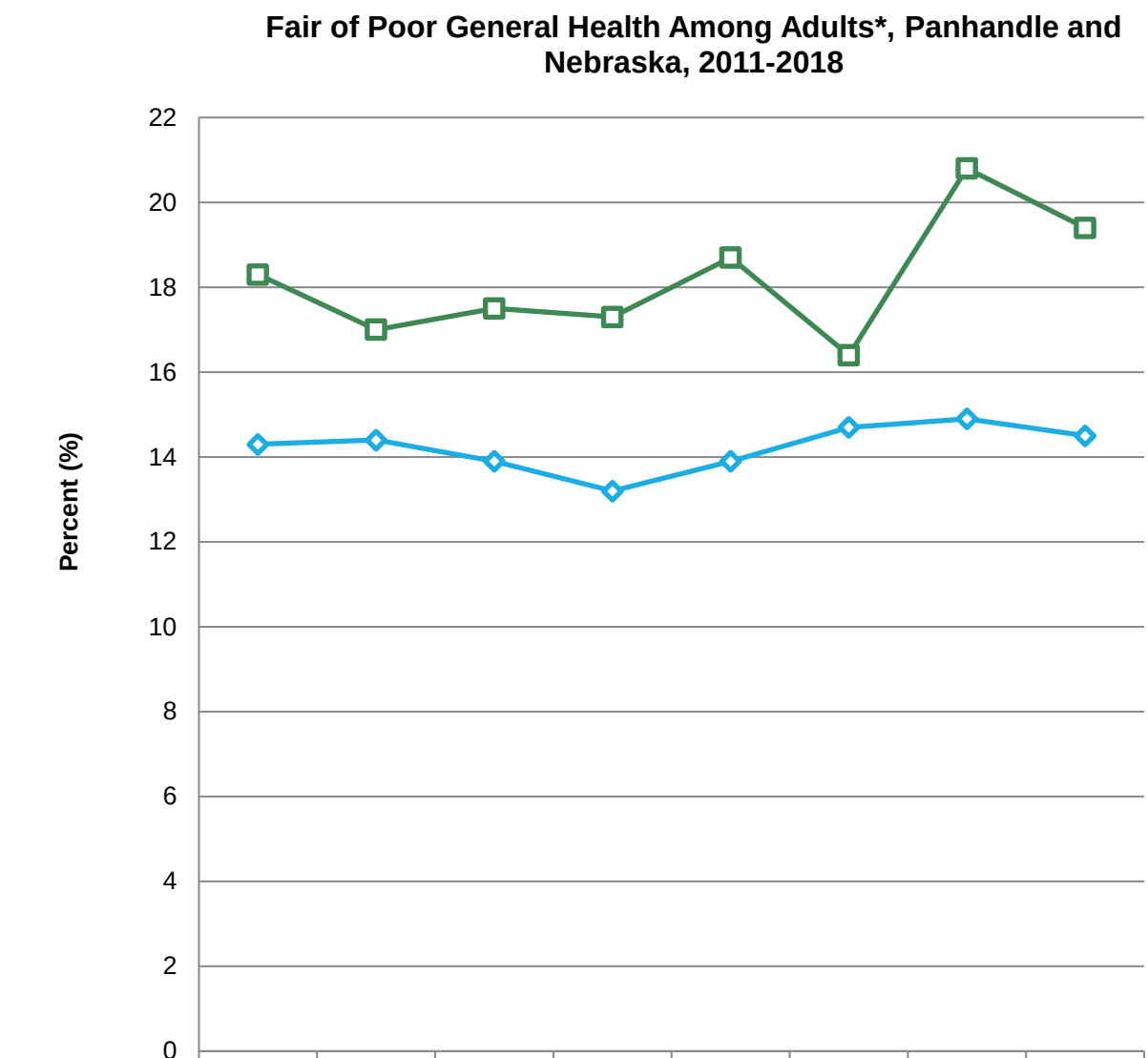
Source: Nebraska DHHS, As Cited By Kids Count In Nebraska Annual Report. Prepared by Kelsey Irvine, Panhandle Public Health District

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.

Figure 38: Fair of Poor General Health Among Adults

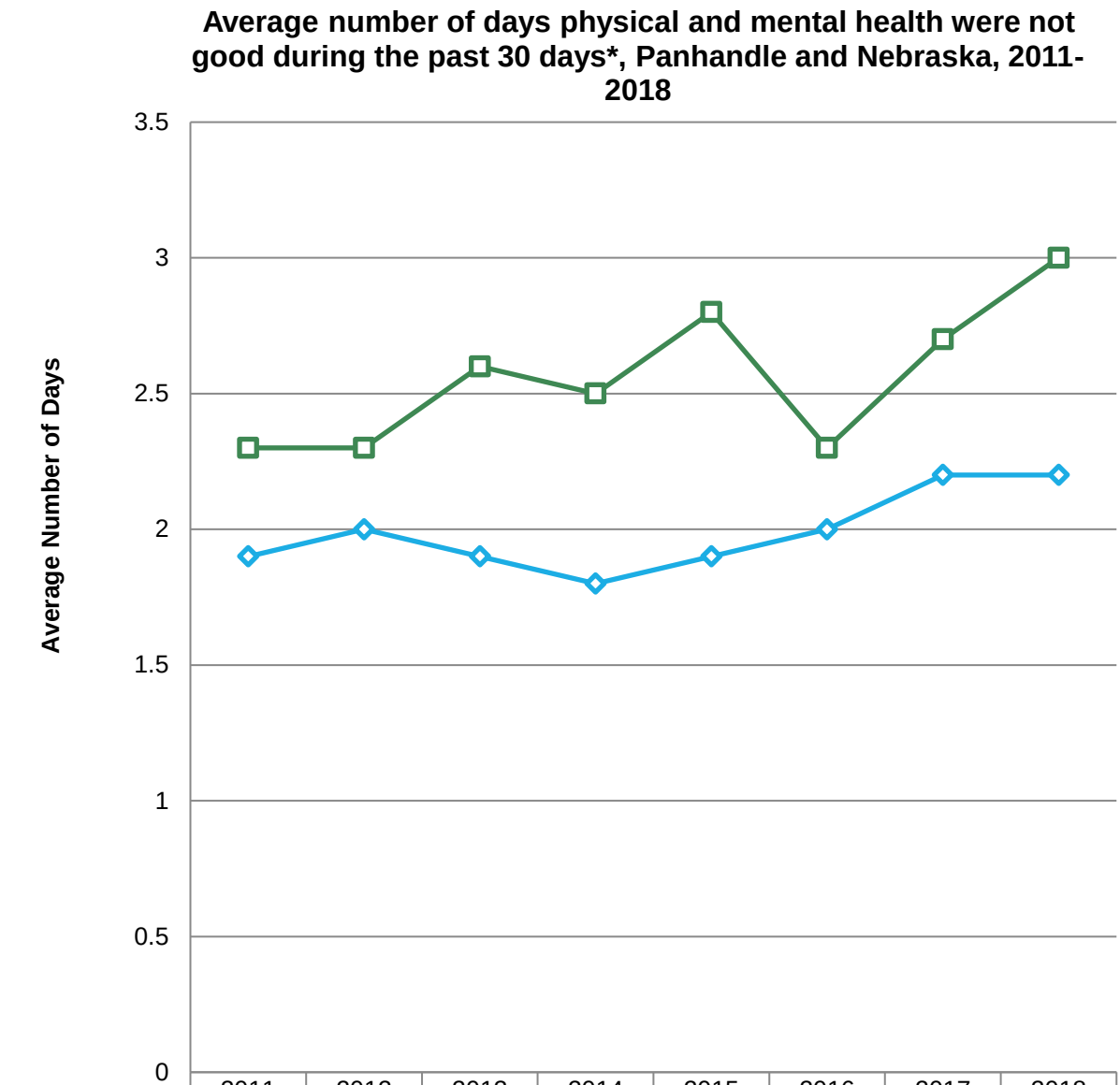


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	18.3	17	17.5	17.3	18.7	16.4	20.8	19.4
Nebraska	14.3	14.4	13.9	13.2	13.9	14.7	14.9	14.5

*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 39: 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

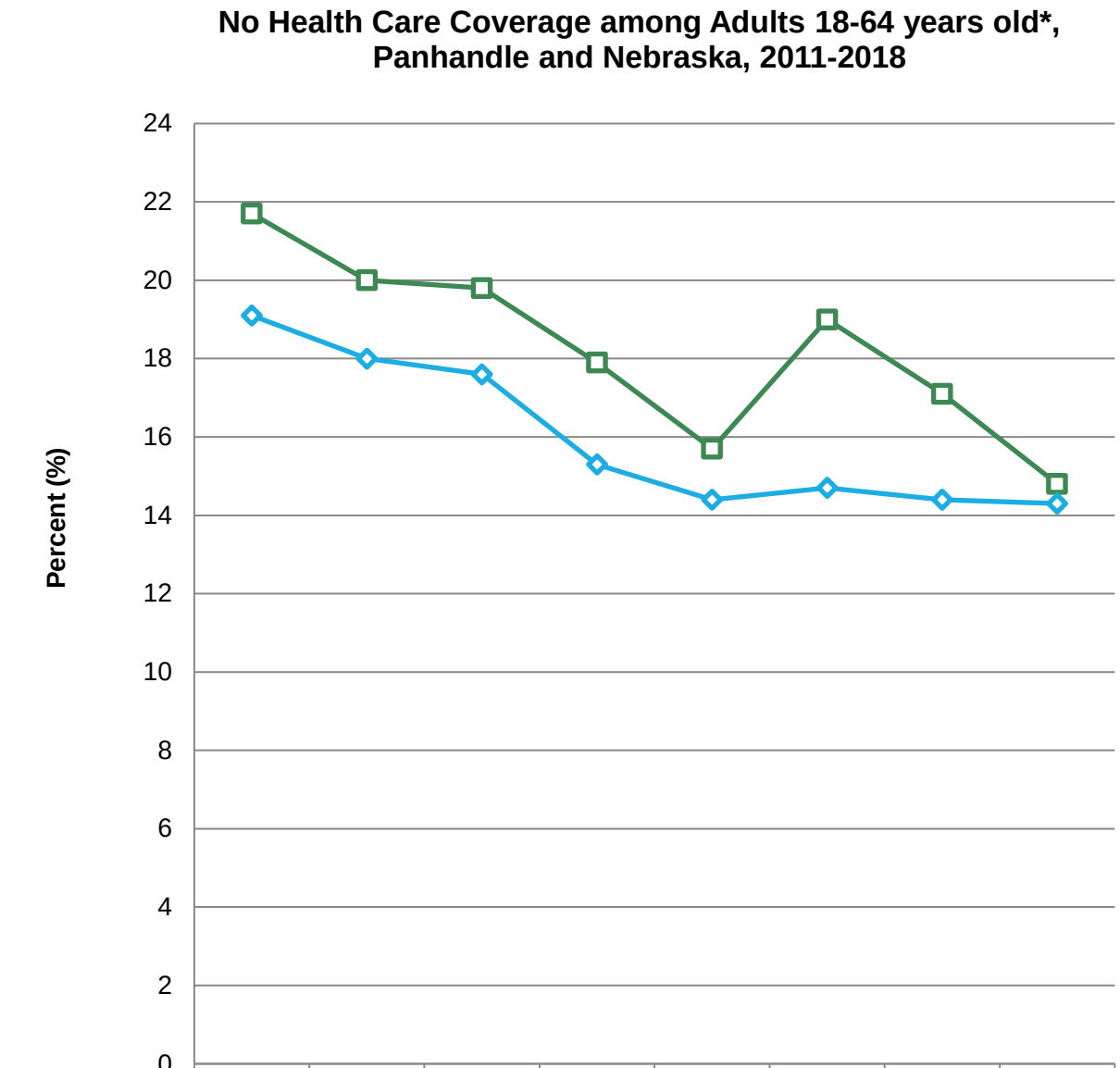
*Average number of days during the previous 30 that adults 18 or older report (1) their physical health (illness and injury) was not good and (2) their mental health (including stress, depression, and emotions) was not good. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). 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 40: 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

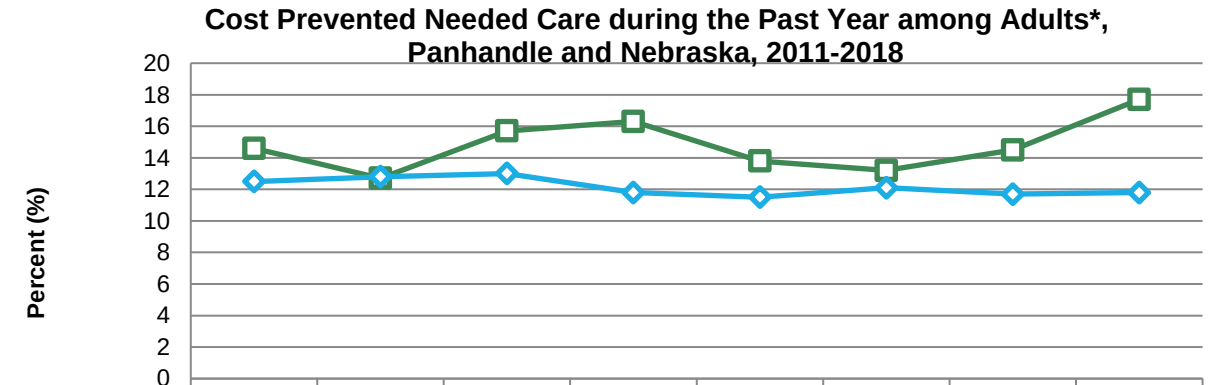
*Percentage of adults 18-64 years old who reoprt that they do not have any kind of health care coverage. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS). Prepared by Kelsey Irvine, Panhandle Public Health District.

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 41: Cost Prevented Needed Care During the Past Year Among Adults



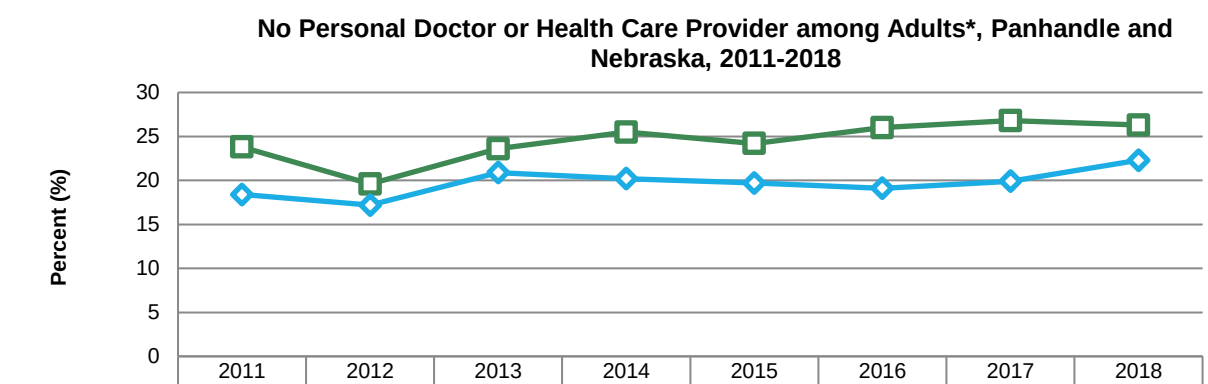
	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	14.6	12.7	15.7	16.3	13.8	13.2	14.5	17.7
Nebraska	12.5	12.8	13	11.8	11.5	12.1	11.7	11.8

*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 42: 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.

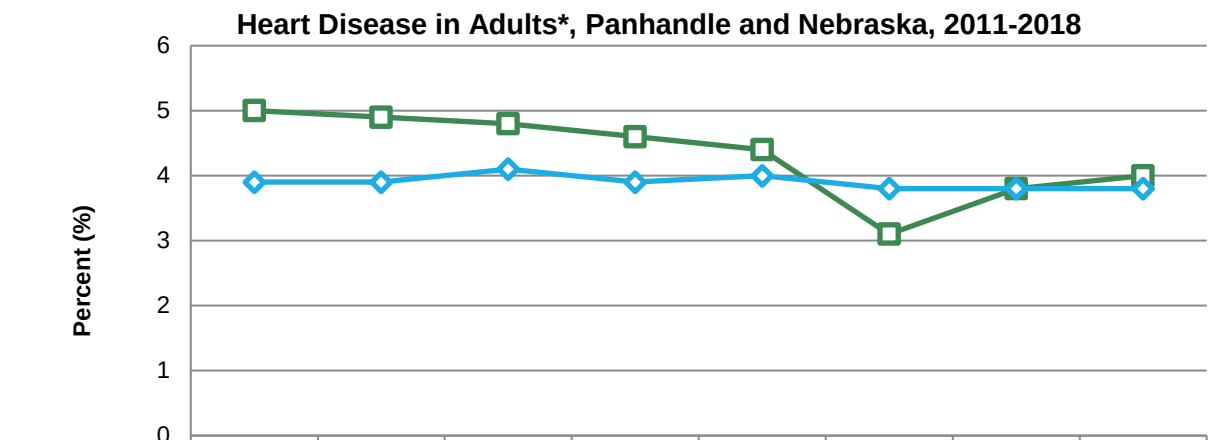
CHRONIC DISEASE

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 43: Heart Disease in Adults



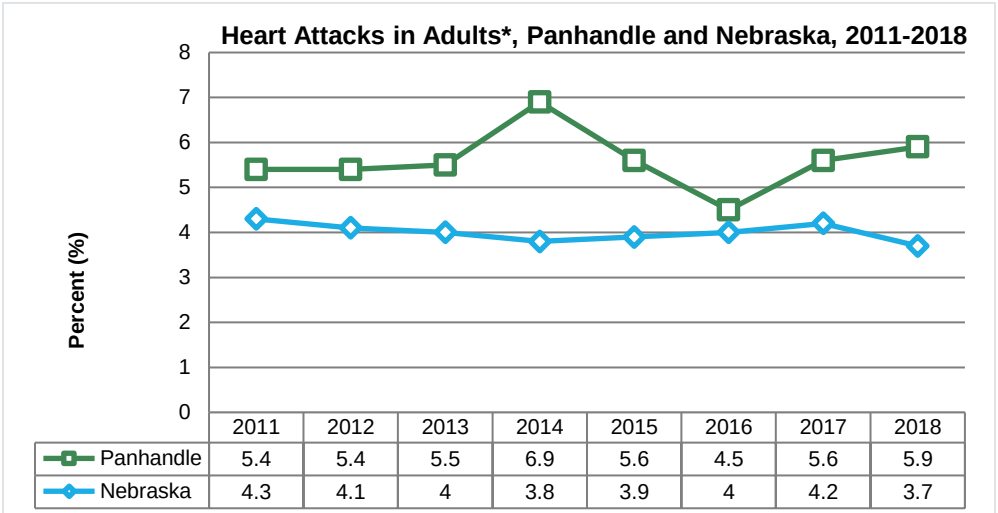
	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	5	4.9	4.8	4.6	4.4	3.1	3.8	4
Nebraska	3.9	3.9	4.1	3.9	4	3.8	3.8	3.8

*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 44: 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.

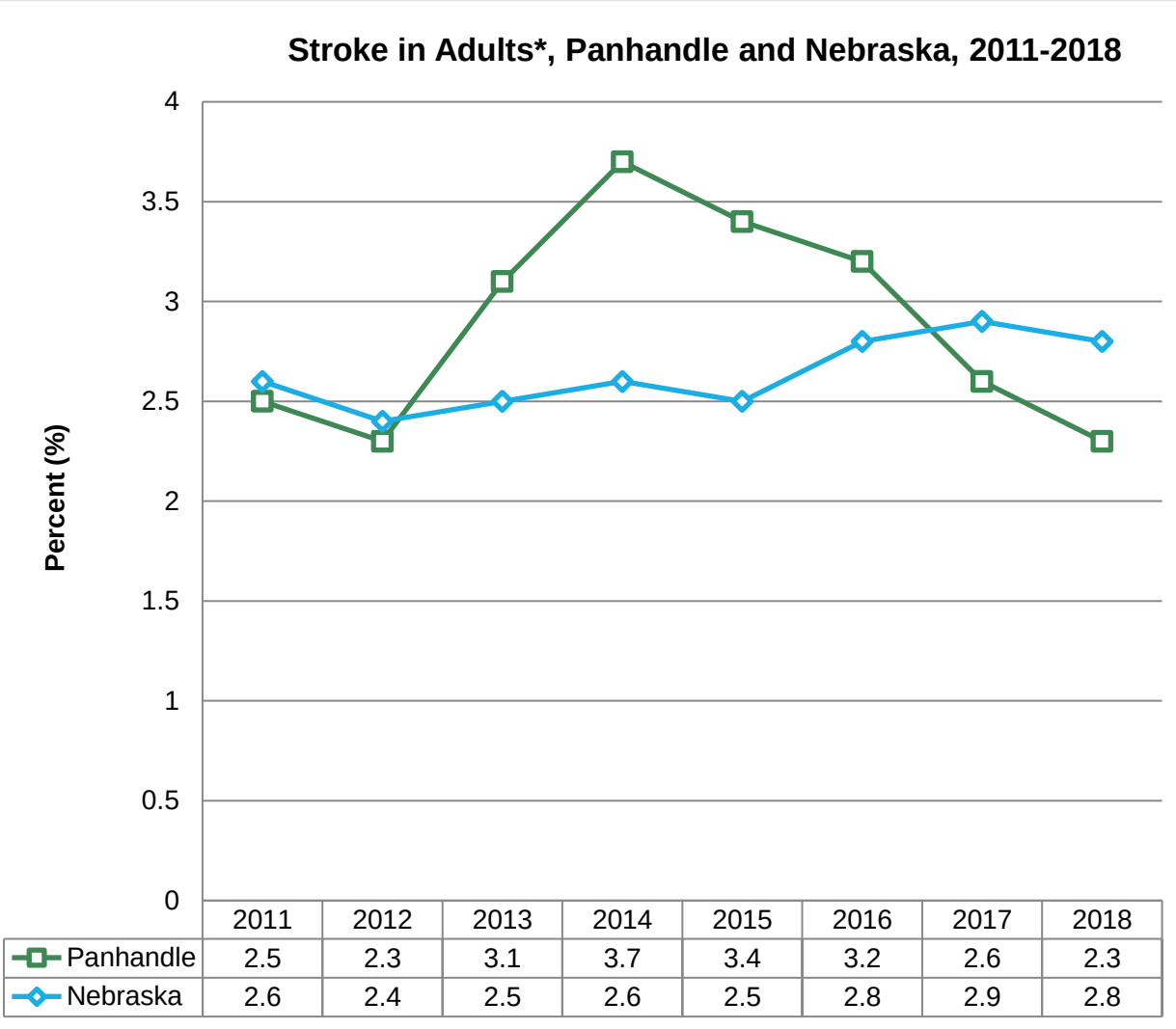
[1] CDC. (2020). Heart Disease Facts. Retrieved from: https://www.cdc.gov/heartdisease/facts.htm

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 45: 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

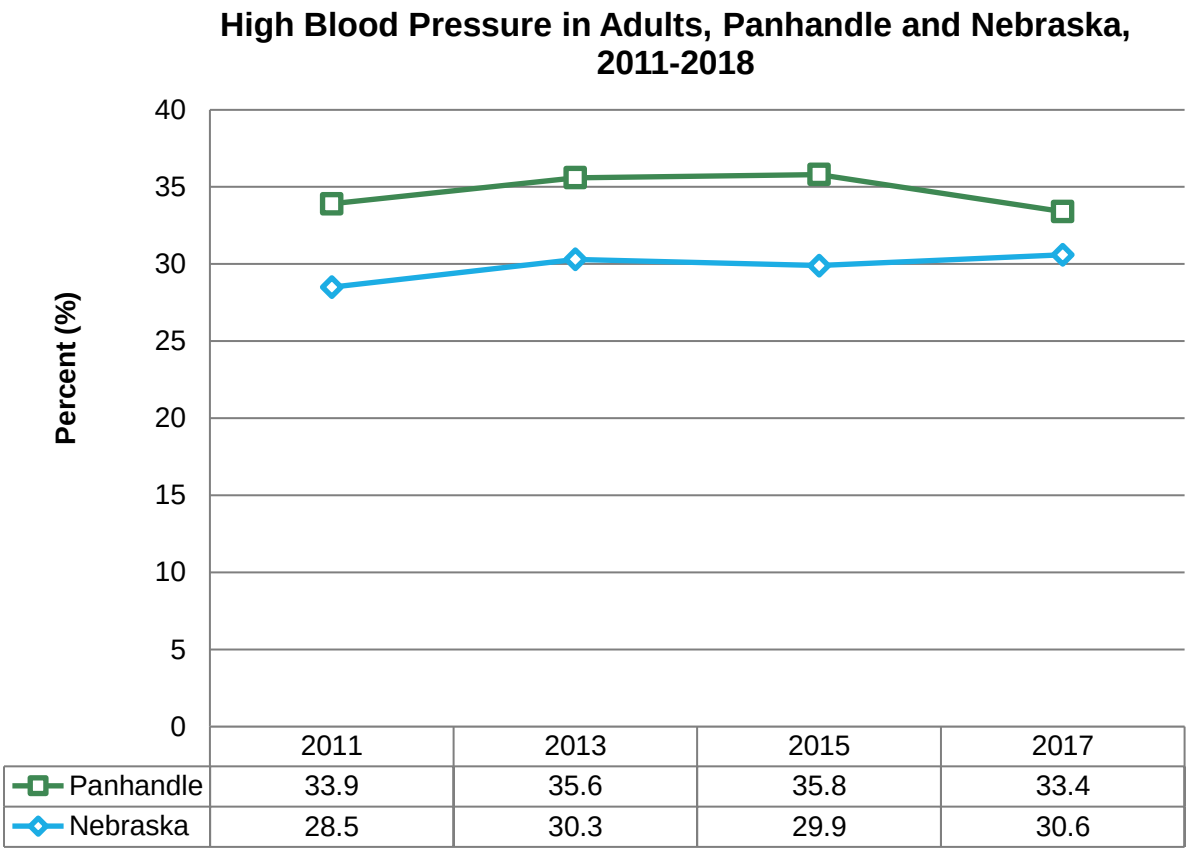
CLINICAL RISK FACTORS FOR HEART DISEASE

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 46: 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.

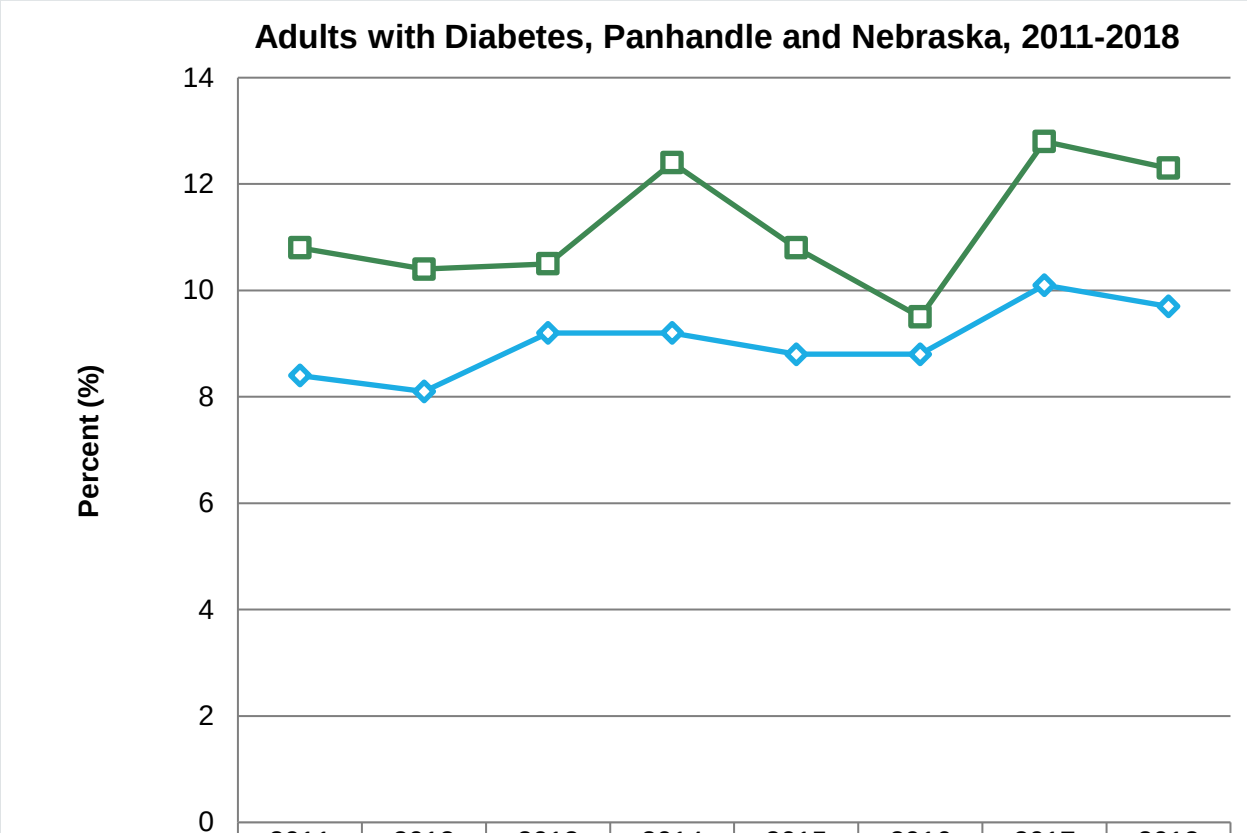
[3] CDC. (2020). Facts About Hypertension. Retrieved from: https://www.cdc.gov/bloodpressure/facts.htm

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 47: 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.

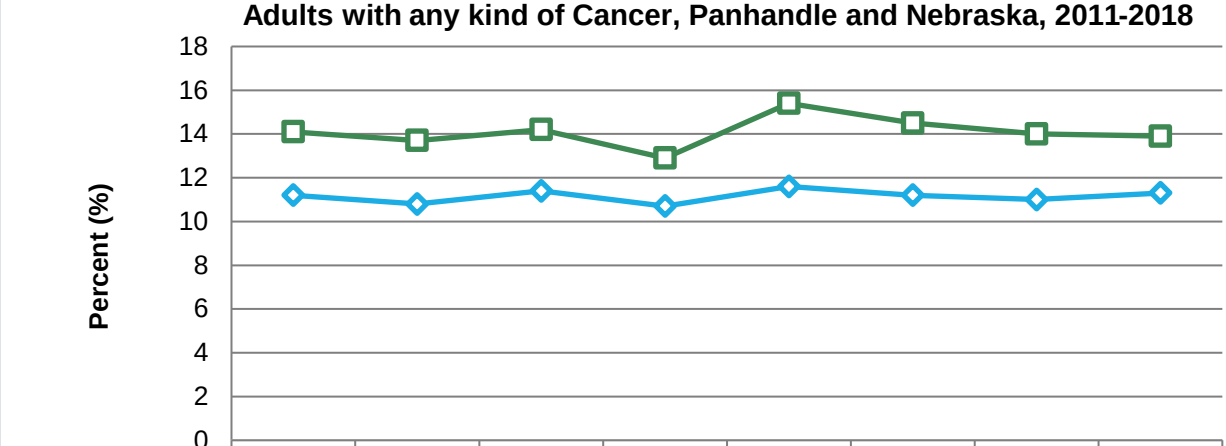
[4] CDC. (2020). What is Diabetes? Retrieved from: https://www.cdc.gov/diabetes/basics/diabetes.html

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 48: 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

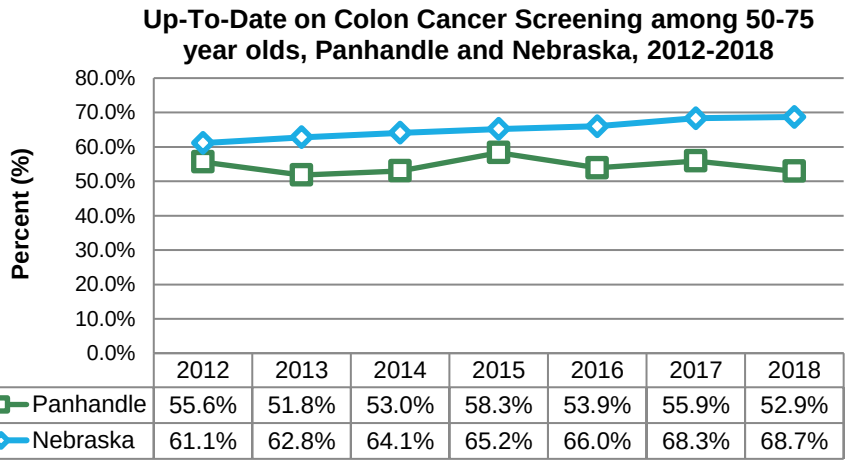
*Percentage of adults 18 and older who report they were ever told they have any kind of cancer. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

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 49: 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

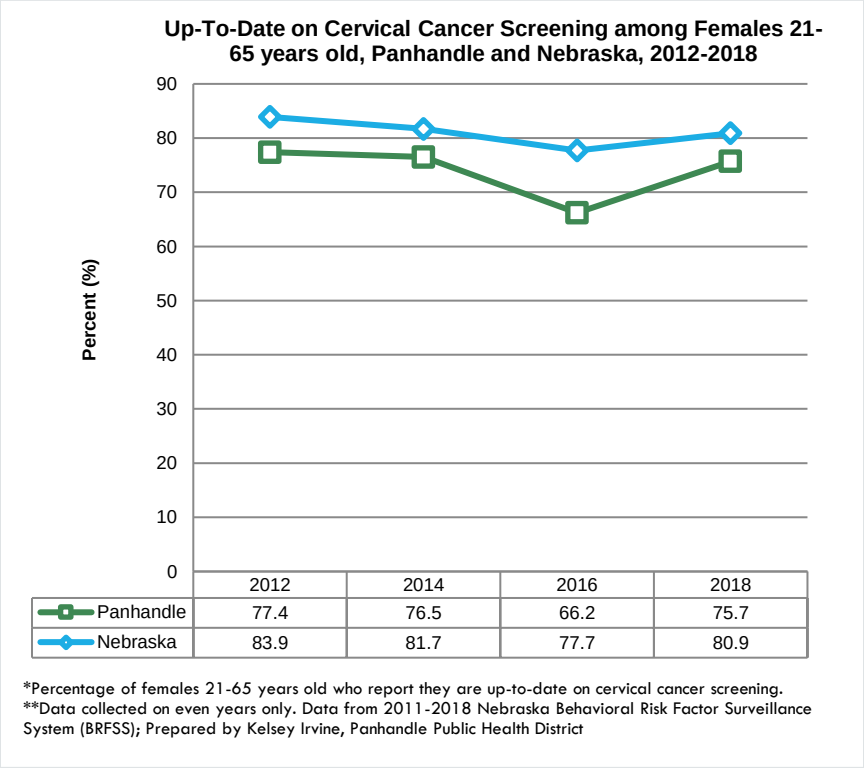
[5] CDC. (2020). How to Prevent Cancer or Find it Early. Retrieved from: https://www.cdc.gov/cancer/dcpc/prevention/index.htm

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 50: Up-To-Date on Cervical Cancer Screening

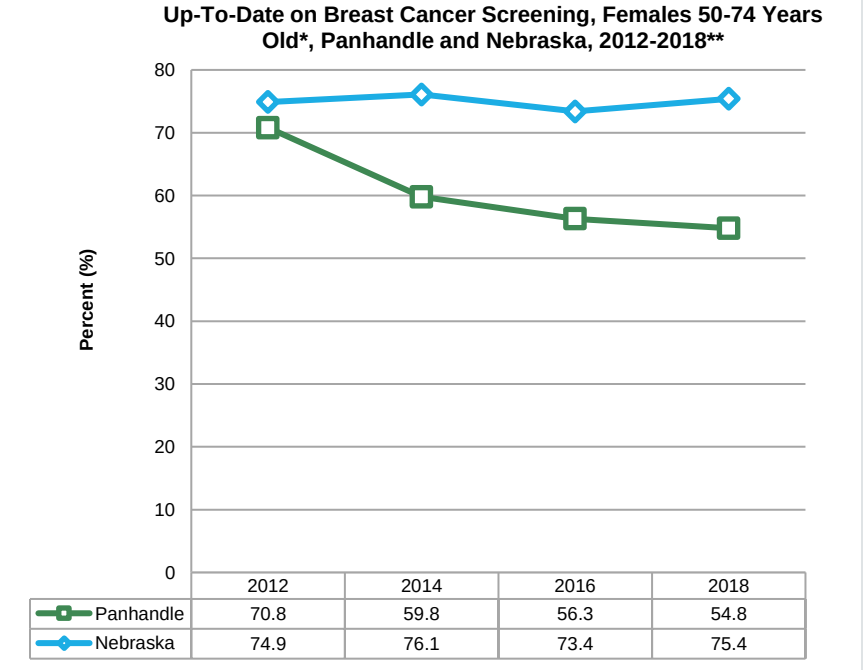


*Percentage of females 21-65 years old who report they are up-to-date on cervical cancer screening.
**Data collected on even years only. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

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 51: Up-to-Date on Breast Cancer Screening



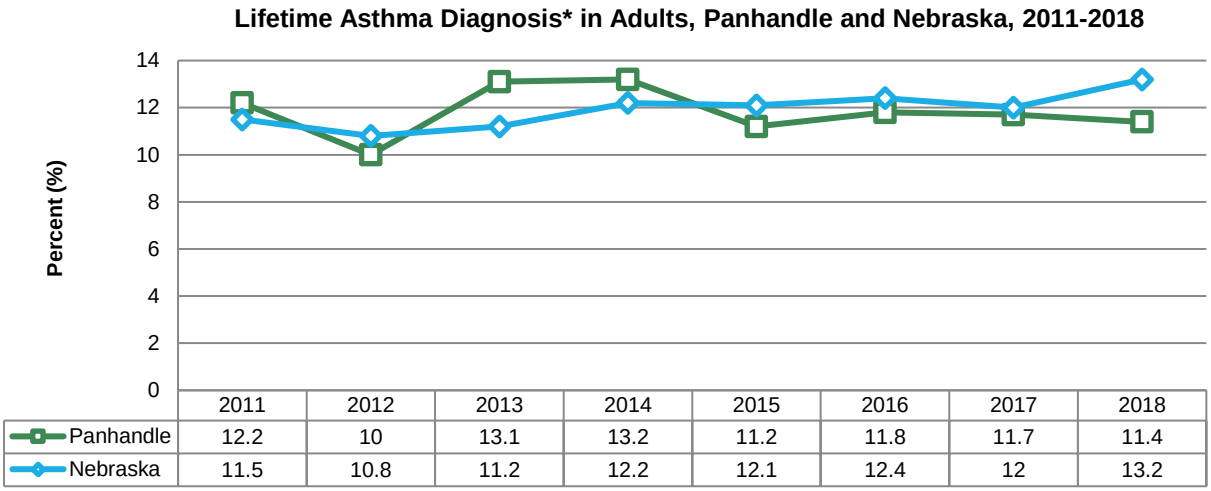
*Percentage of females 50-74 years old who report they are up-to-date on breast cancer screening. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

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 52: Lifetime Asthma Diagnosis in Adults

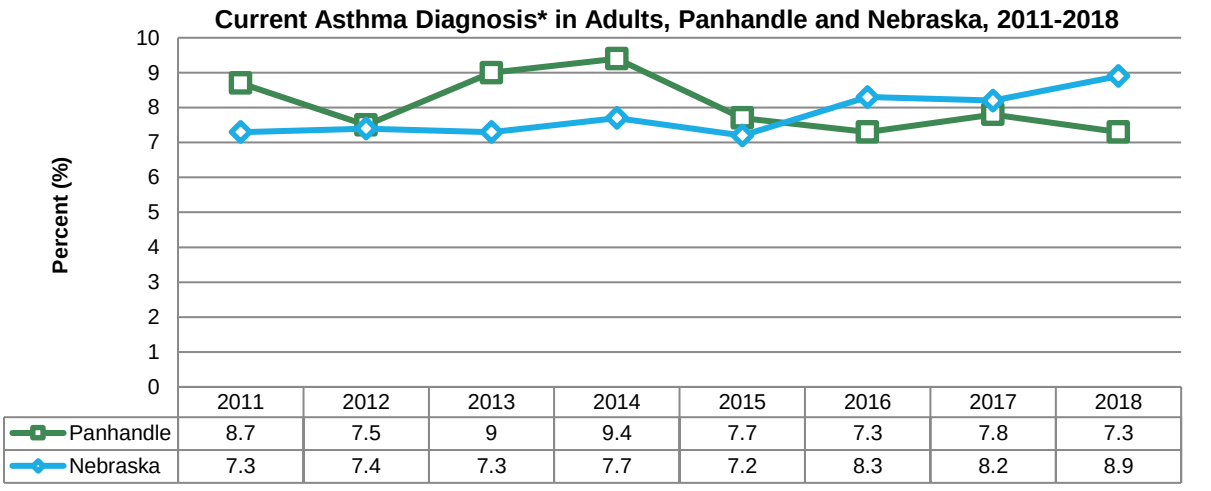


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	12.2	10	13.1	13.2	11.2	11.8	11.7	11.4
Nebraska	11.5	10.8	11.2	12.2	12.1	12.4	12	13.2

*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 53: 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

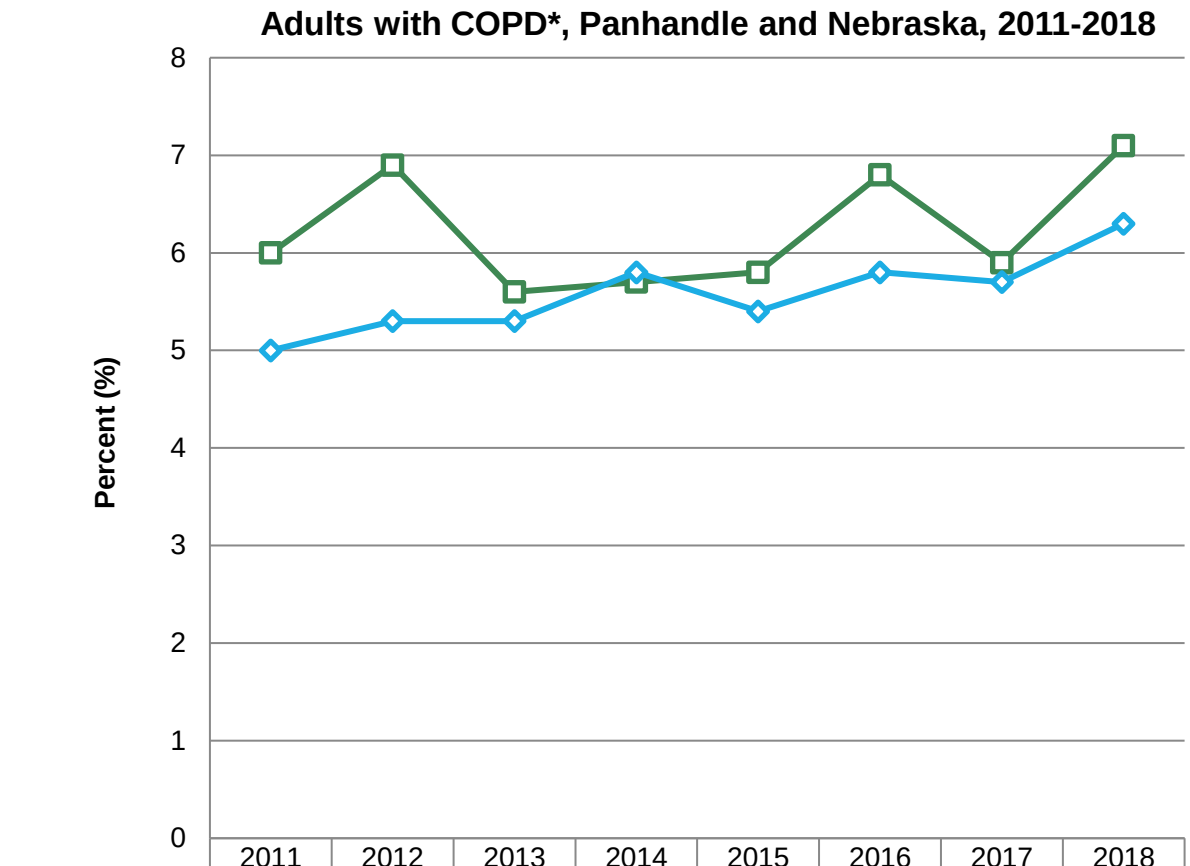
[6] CDC. (2020). Asthma. Retrieved from: https://www.cdc.gov/asthma/default.htm

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 54: 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.

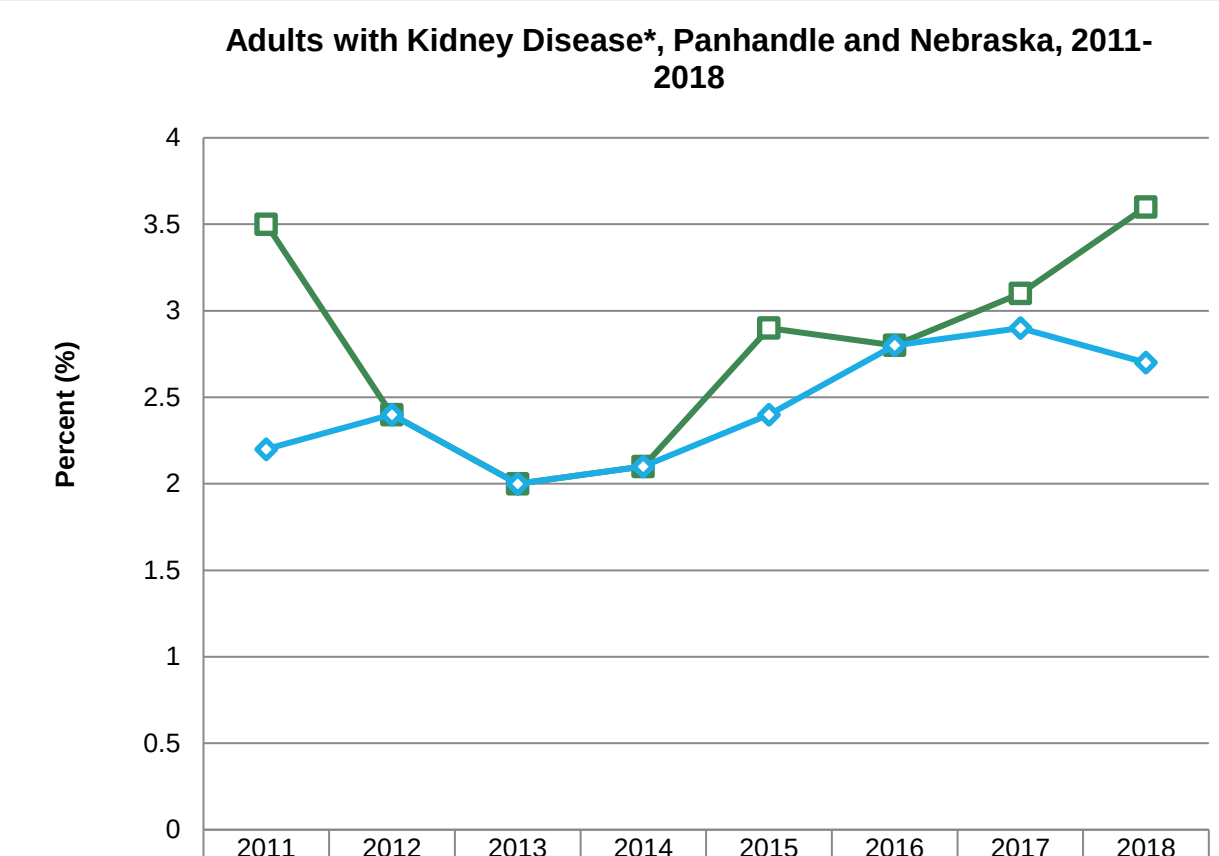
[7] CDC. (2018). Chronic Obstructive Pulmonary Disease. Retrieved from: https://www.cdc.gov/copd/index.html

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 55: 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

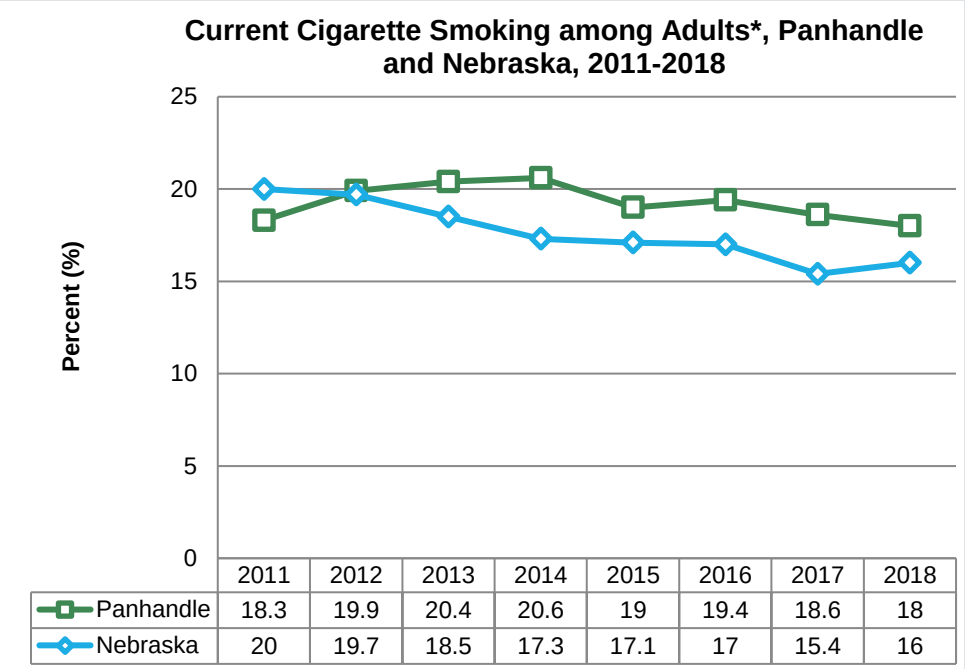
Tobacco use is the top cause of preventable death, disease, and disability in the United States. Smoking-related illness costs the US over $300 billion each year, including $170 billion in direct medical costs.[9]

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.

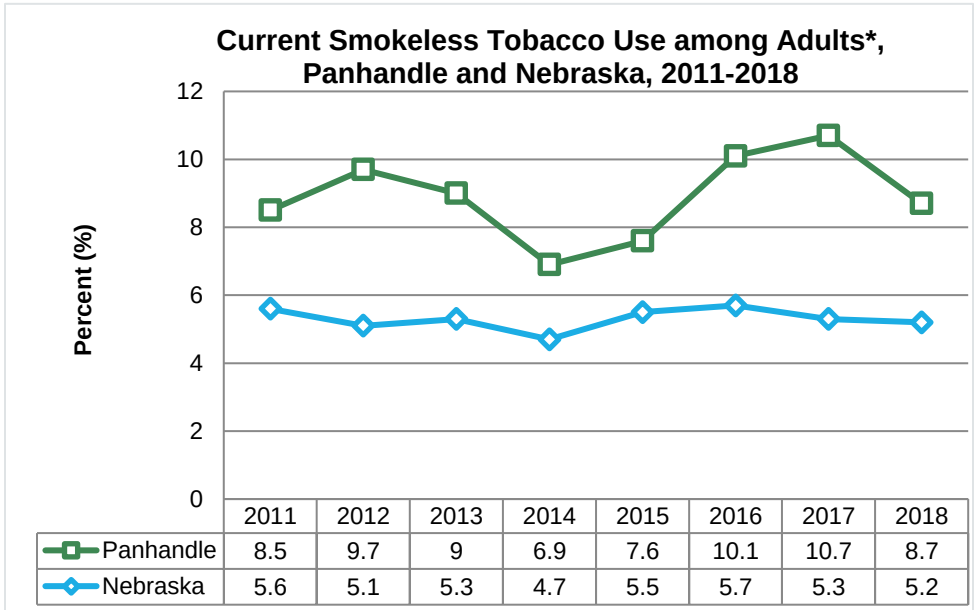
Figure 56: Current Cigarette Smoking Among Adults



	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 57: 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

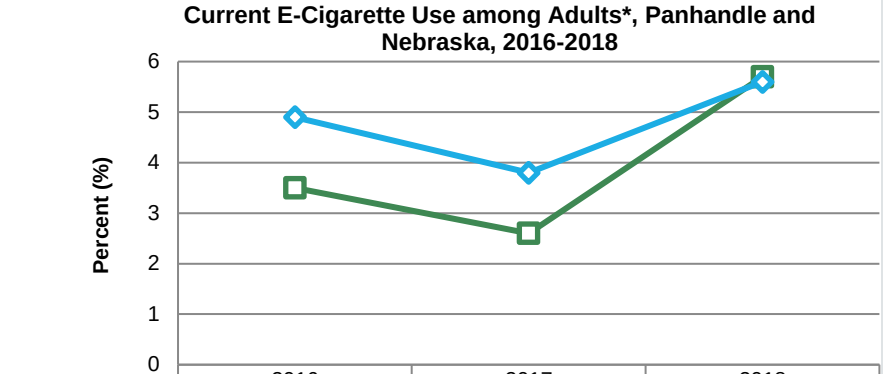
*Percentage of adults 18 and older who report that they currently use smokeless tobacco product (chewing tobacco, snuff, or snus) either every day or on some days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

[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 58: Current E-Cigarette Use Among Adults

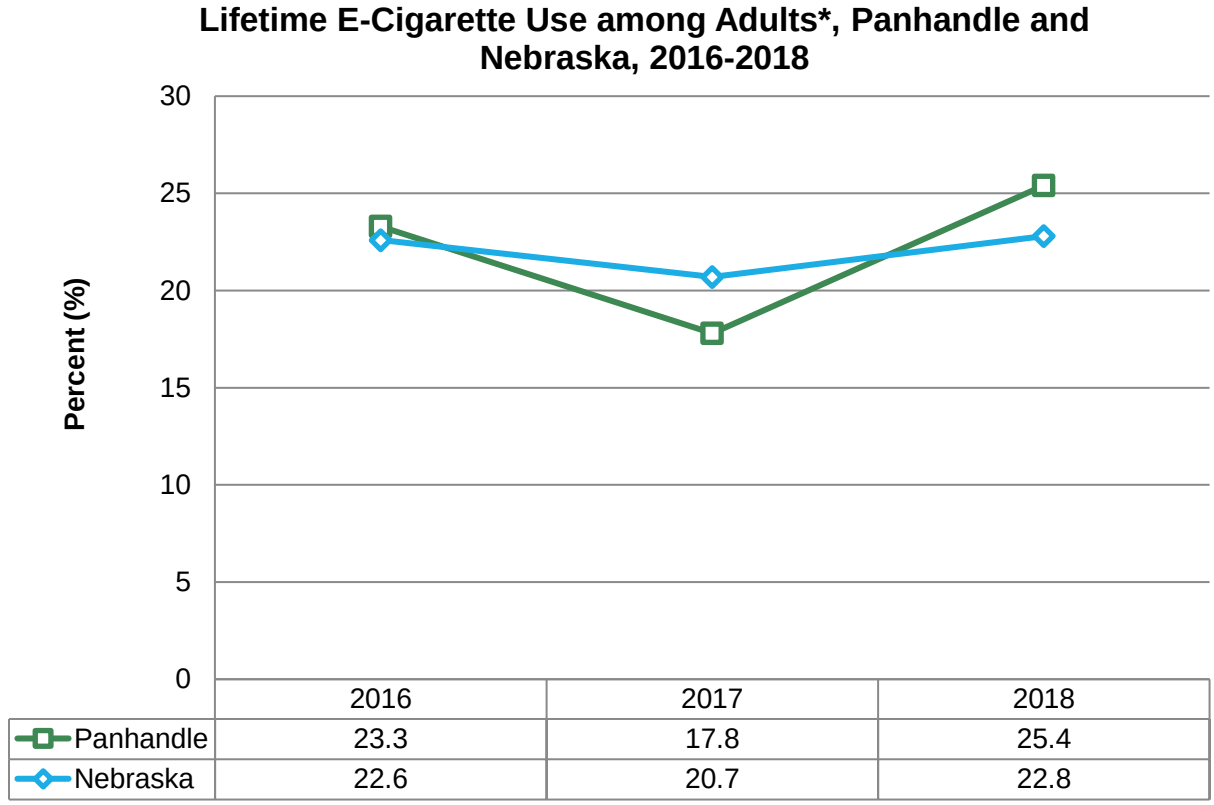


	2016	2017	2018
Panhandle	3.5	2.6	5.7
Nebraska	4.9	3.8	5.6

*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 59: Adult Lifetime E-Cigarette Use



	2016	2017	2018
Panhandle	23.3	17.8	25.4
Nebraska	22.6	20.7	22.8

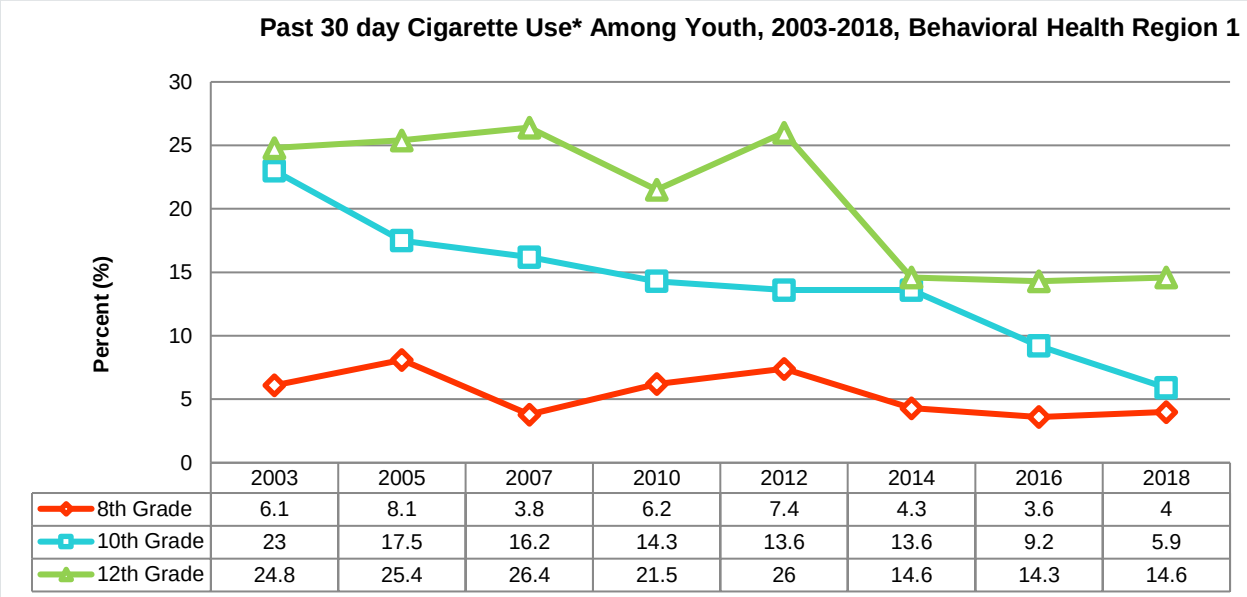
*Percentage of adults 18 and older who report that they have ever used an e-cigarette or other electronic "vaping" product, even just one time, in their entire life. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

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.

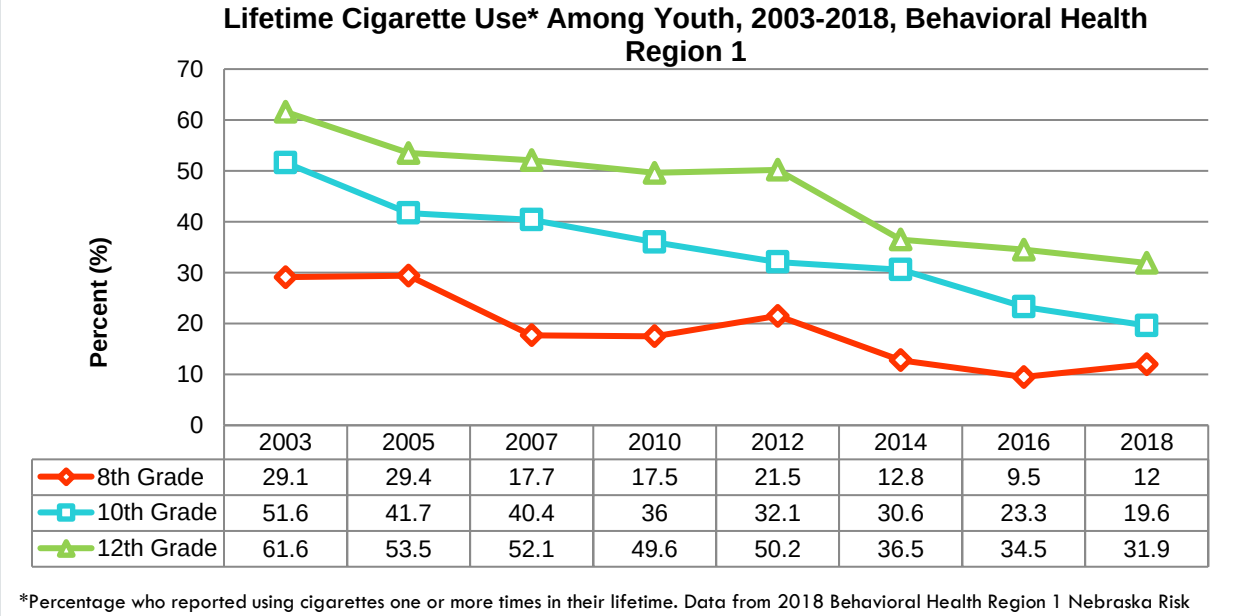
Figure 60: Past 30 Day Cigarette Use Among Youth



	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 61: Lifetime Cigarette Use Among Youth



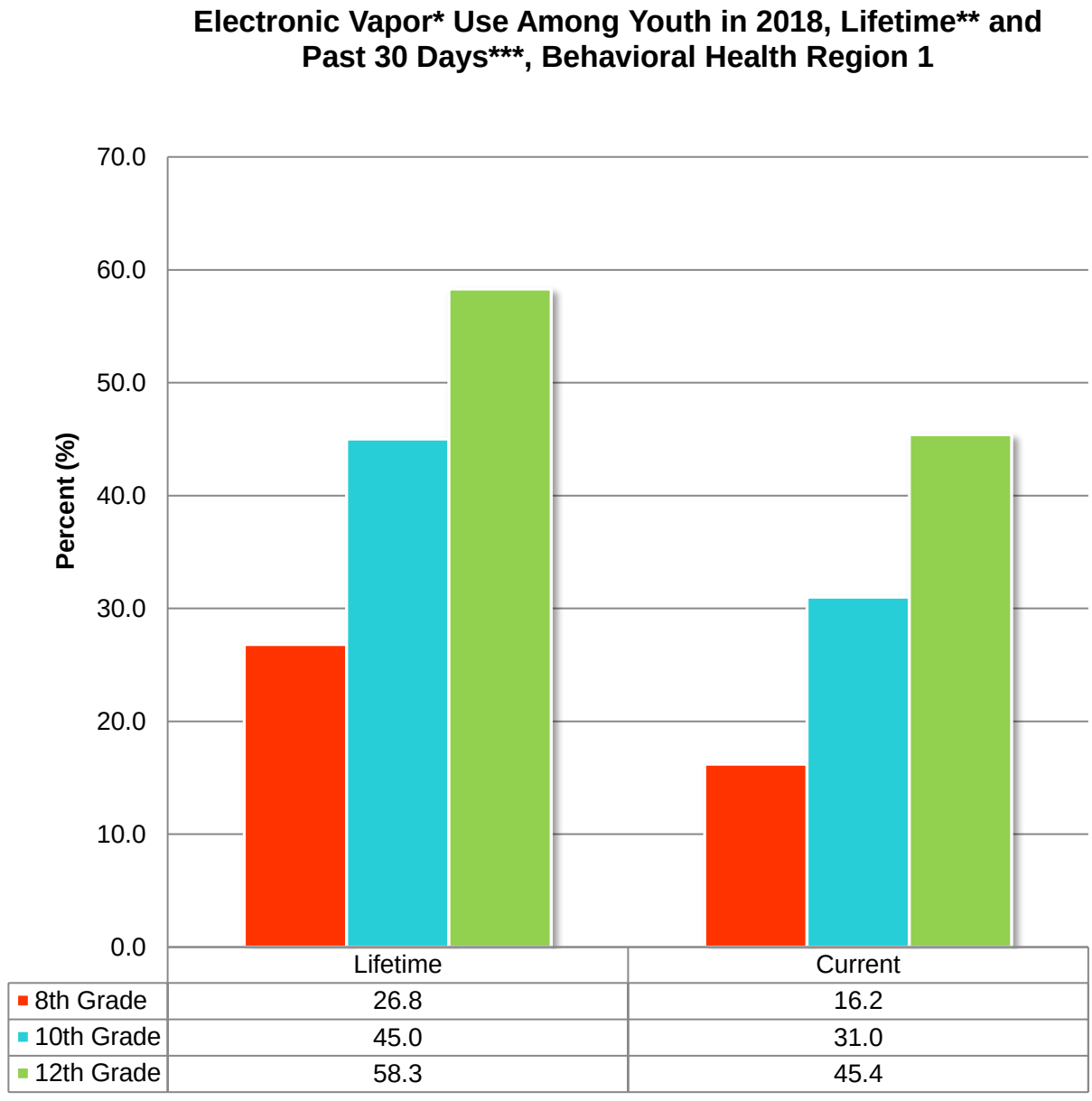
	2003	2005	2007	2010	2012	2014	2016	2018
8th Grade	29.1	29.4	17.7	17.5	21.5	12.8	9.5	12
10th Grade	51.6	41.7	40.4	36	32.1	30.6	23.3	19.6
12th Grade	61.6	53.5	52.1	49.6	50.2	36.5	34.5	31.9

*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 62: Electronic Vapor Use Among Youth in 2018, Lifetime and Past 30 Days

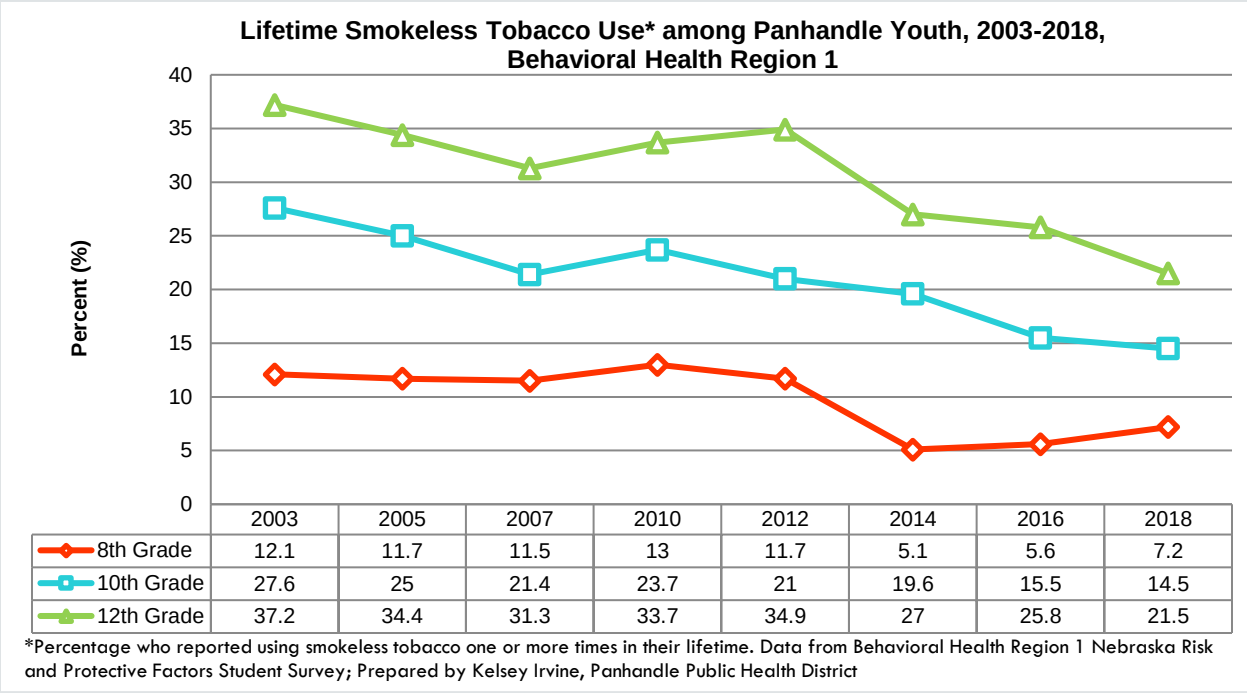


*An electronic vapor product is defined as e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookas, or hookah pens. **Percentage who reported using an electronic vaport device or or more times in their lifetime. ***Percentage who reported using an electronic vapor device one or more times 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.

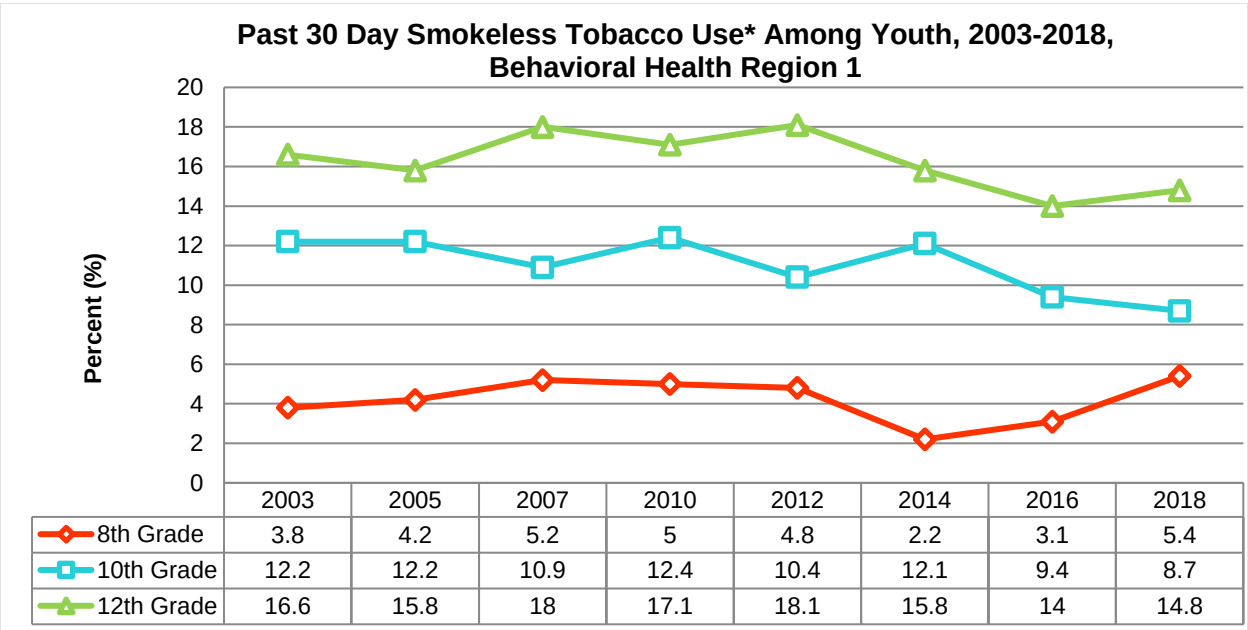
Figure 63: Lifetime Smokeless Tobacco Use Among Youth



	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 64: 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

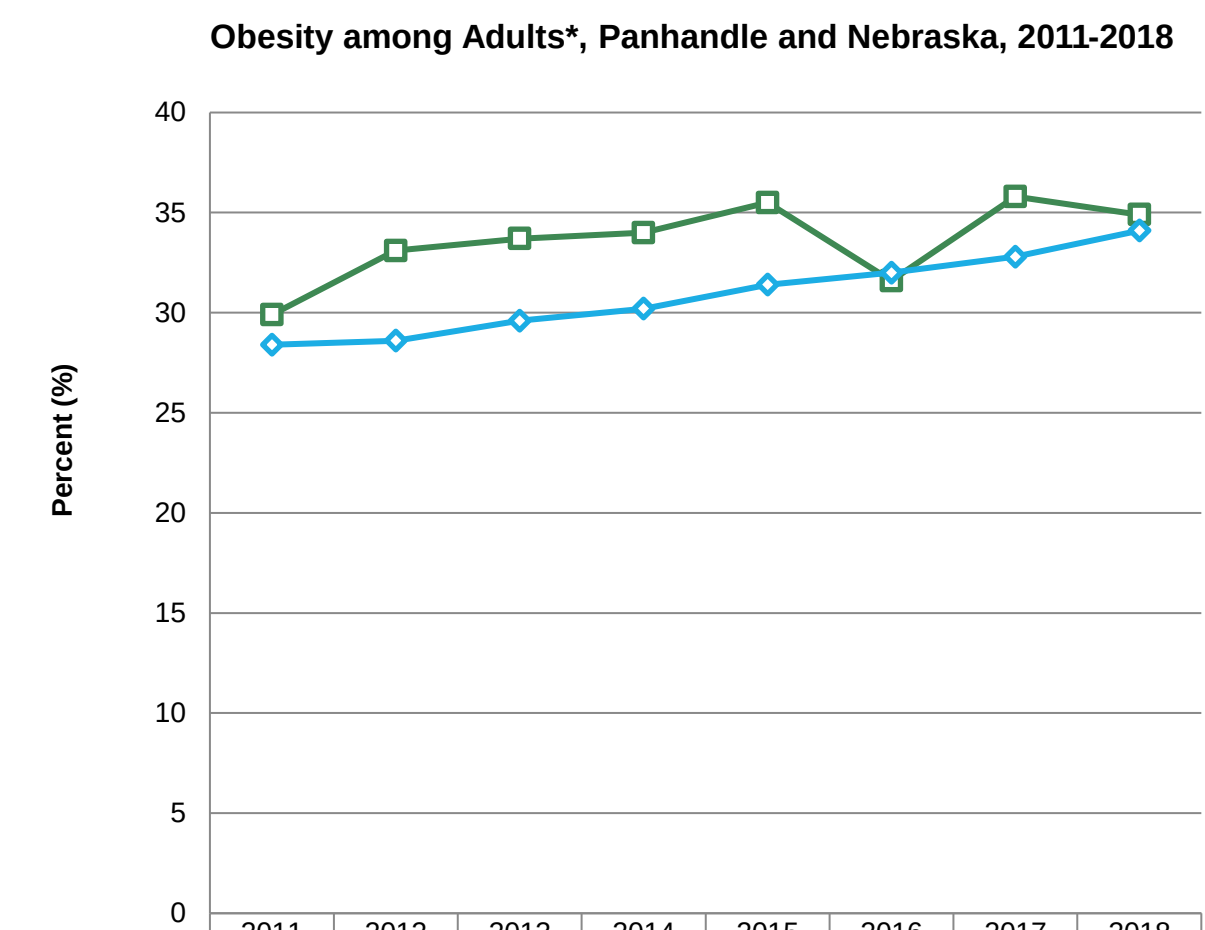
*Percentage who reported using smokeless tobacco one or more times during the past 30 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

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 65: 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

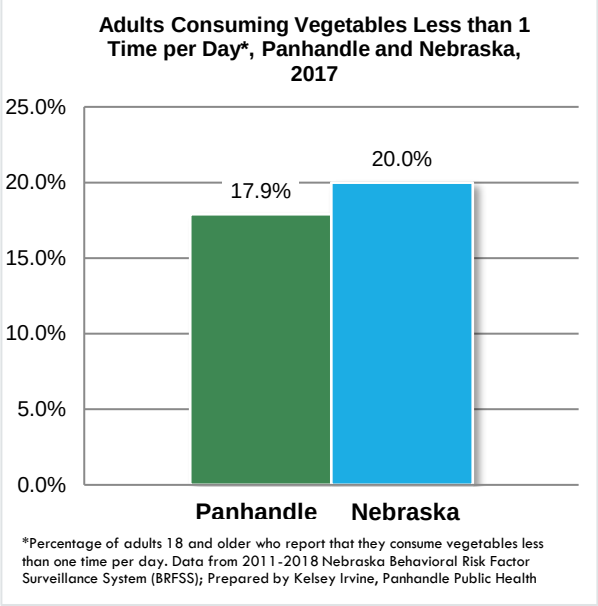
*Percentage of adults 18 and older with a body mass index (BMI) of 30.0 or greater, based on self-reported height and weight. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

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

NUTRITION

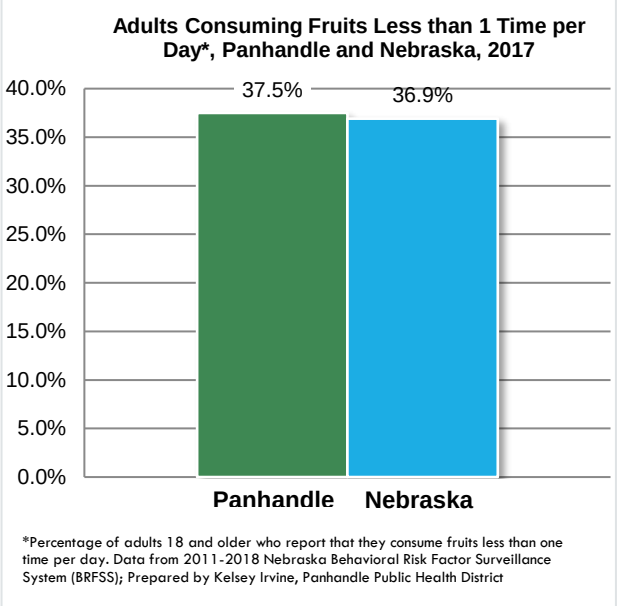
Adults are recommended to consume between 2 and 3 cups of vegetables per day and 1 and 2 cups of fruit per day. 17.9% of Panhandle adults report they consume vegetables less than one time per day, and 37.5% of Panhandle adults report they consume fruits less than one time per day.

Figure 66: 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

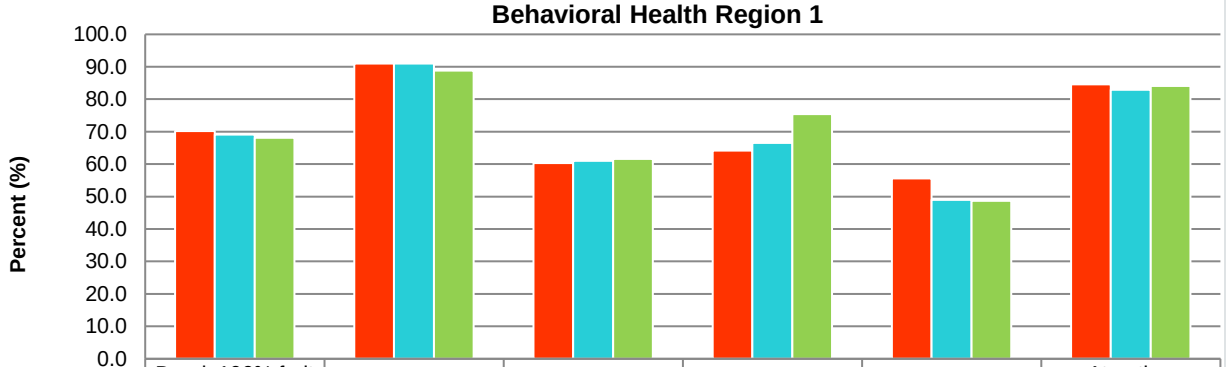
Figure 67: Adults Consuming Fruits less than 1 time per day



*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 68: 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

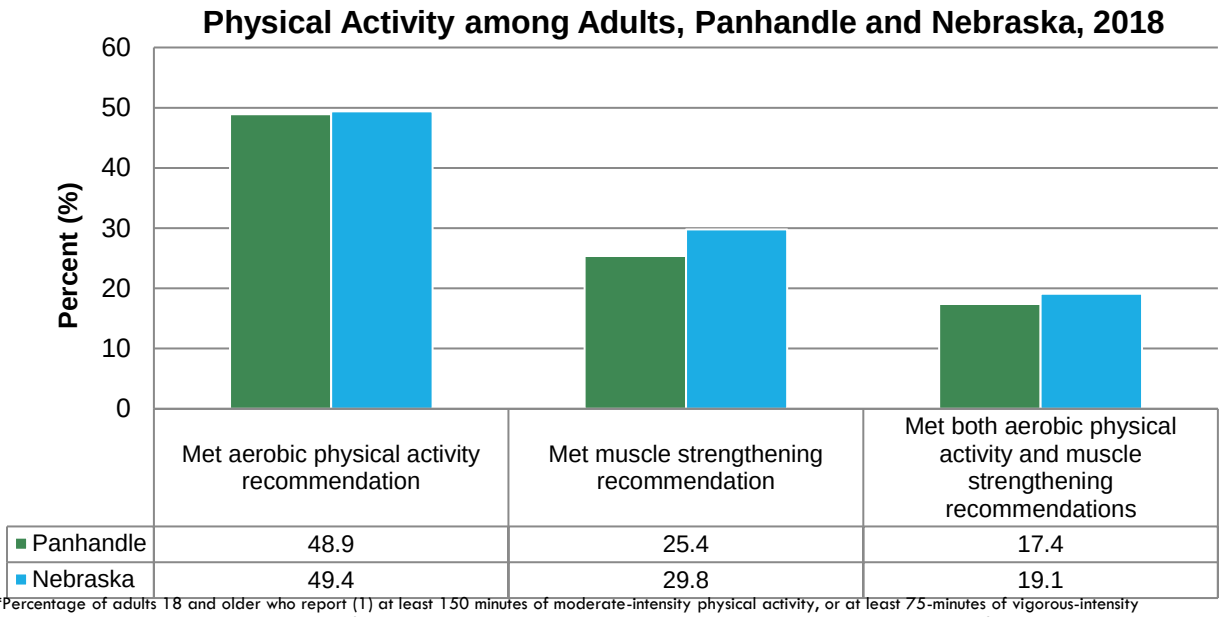
*Percentage who reported consuming the named drink or food one or more times during the past 7 days. Data from Behavioral Health Region 1 Nebraska Risk and Protective Factors Student Survey; Prepared by Kelsey Irvine, Panhandle Public Health District

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 69: Physical Activity Among Adults

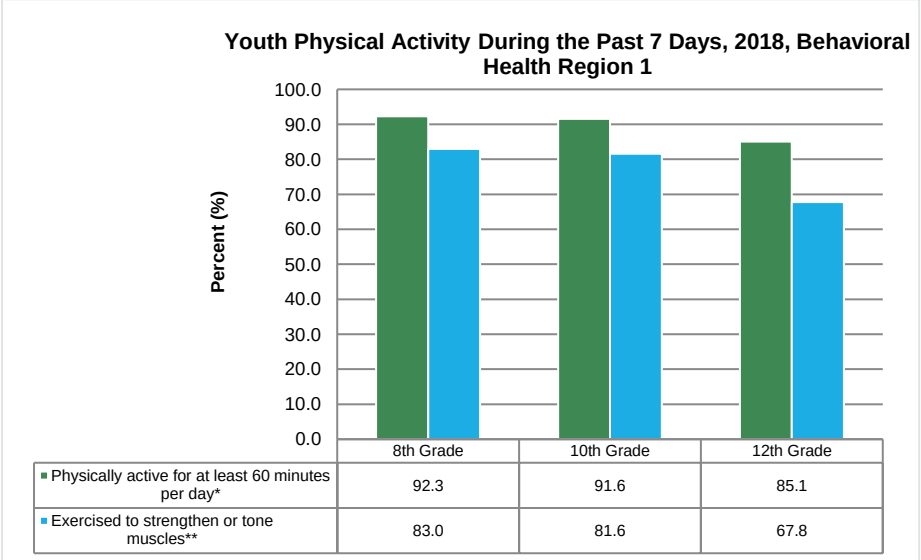


*Percentage of adults 18 and older who report (1) at least 150 minutes of moderate-intensity physical activity, or at least 75-minutes of vigorous-intensity physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity per week during the past month, (2) that they 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 70: 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

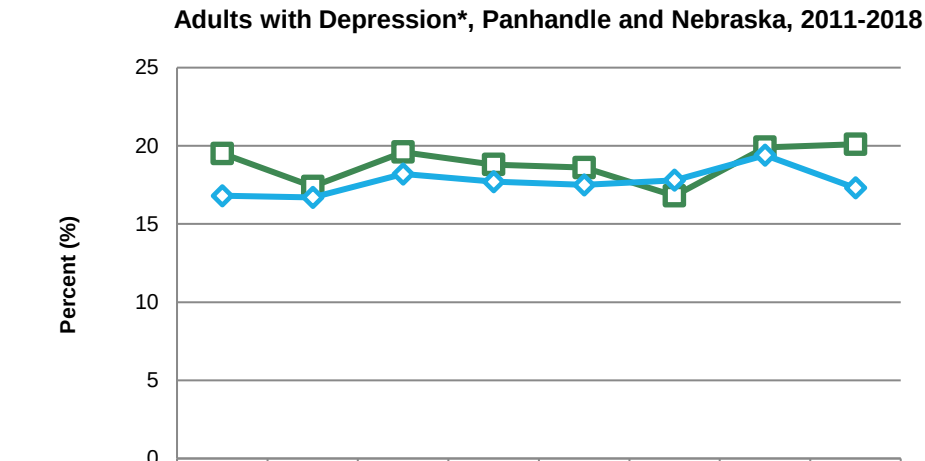
BEHAVIORAL HEALTH

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 71: Adults with Depression

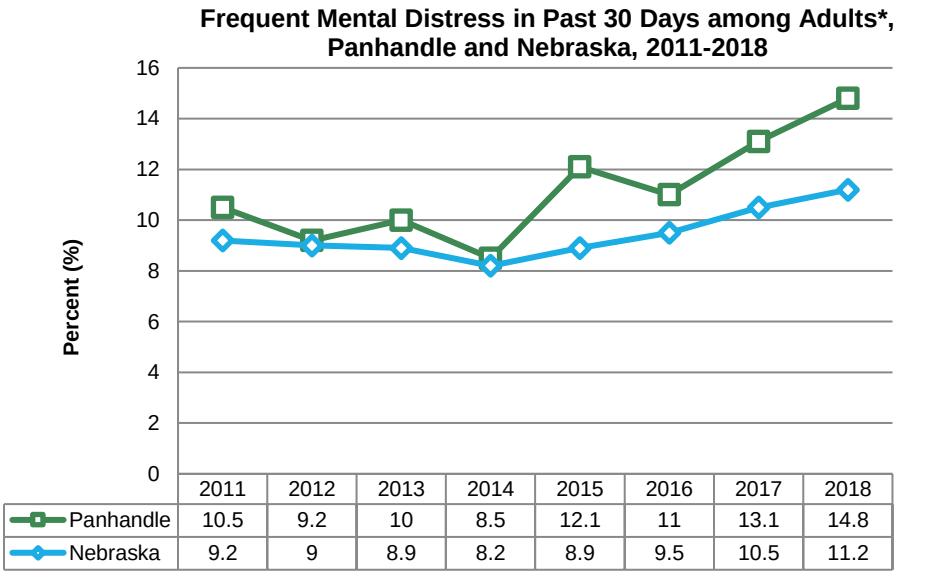


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	19.5	17.4	19.6	18.8	18.6	16.8	19.9	20.1
Nebraska	16.8	16.7	18.2	17.7	17.5	17.8	19.4	17.3

*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 72: 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

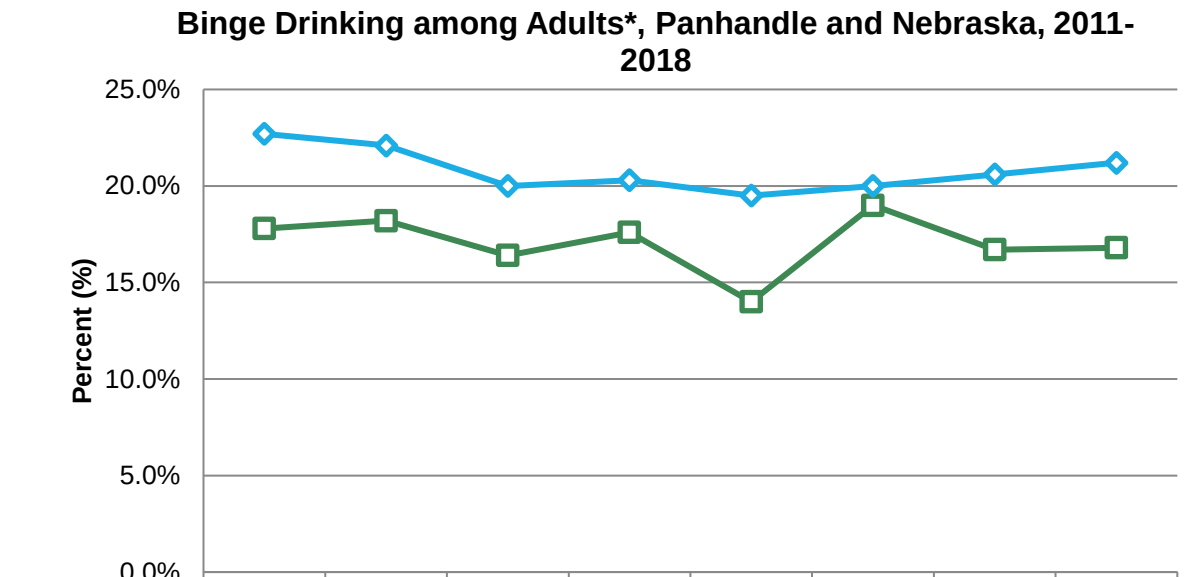
ALCOHOL

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 73: 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 74: 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

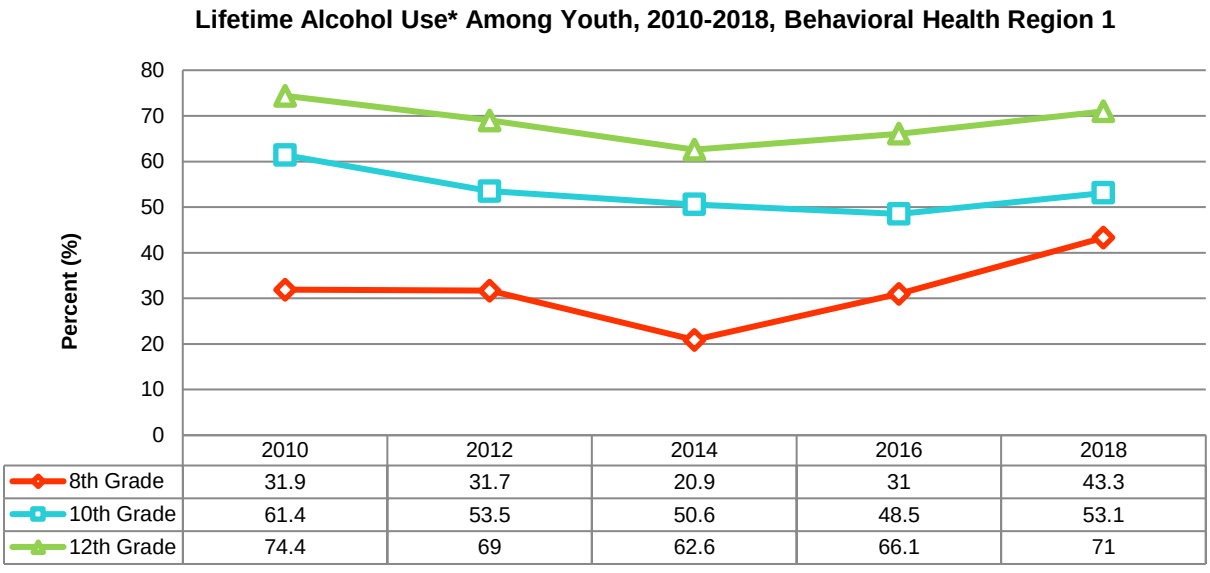
[12] CDC. (2019). Binge Drinking. Retrieved from: https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm

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.

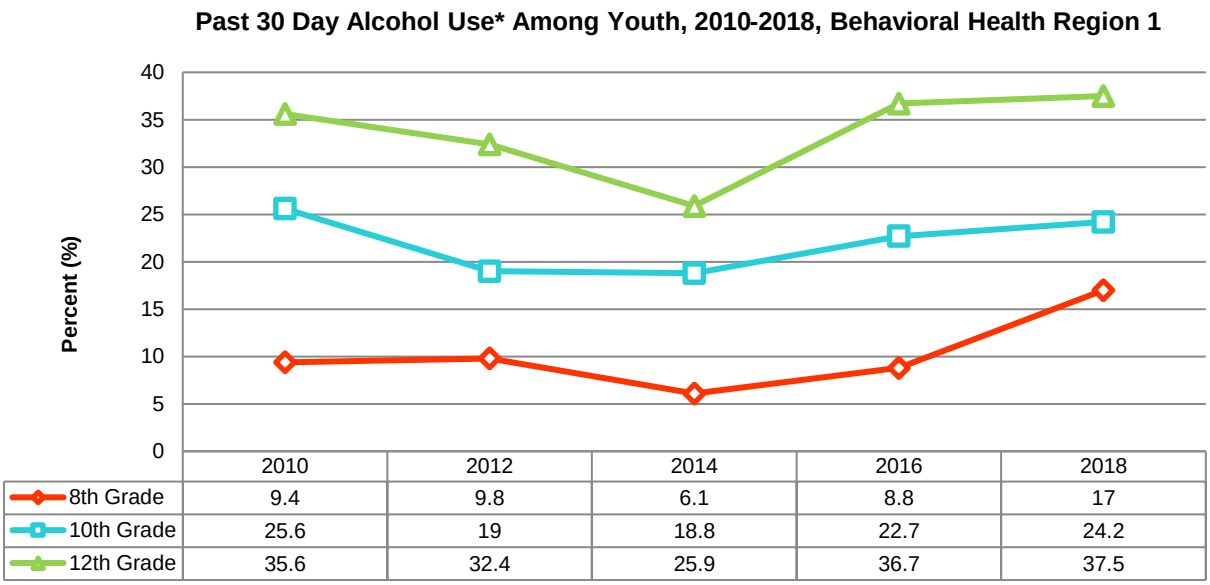
Figure 75: Youth Lifetime Alcohol Use



	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 76: Youth Current Alcohol Use

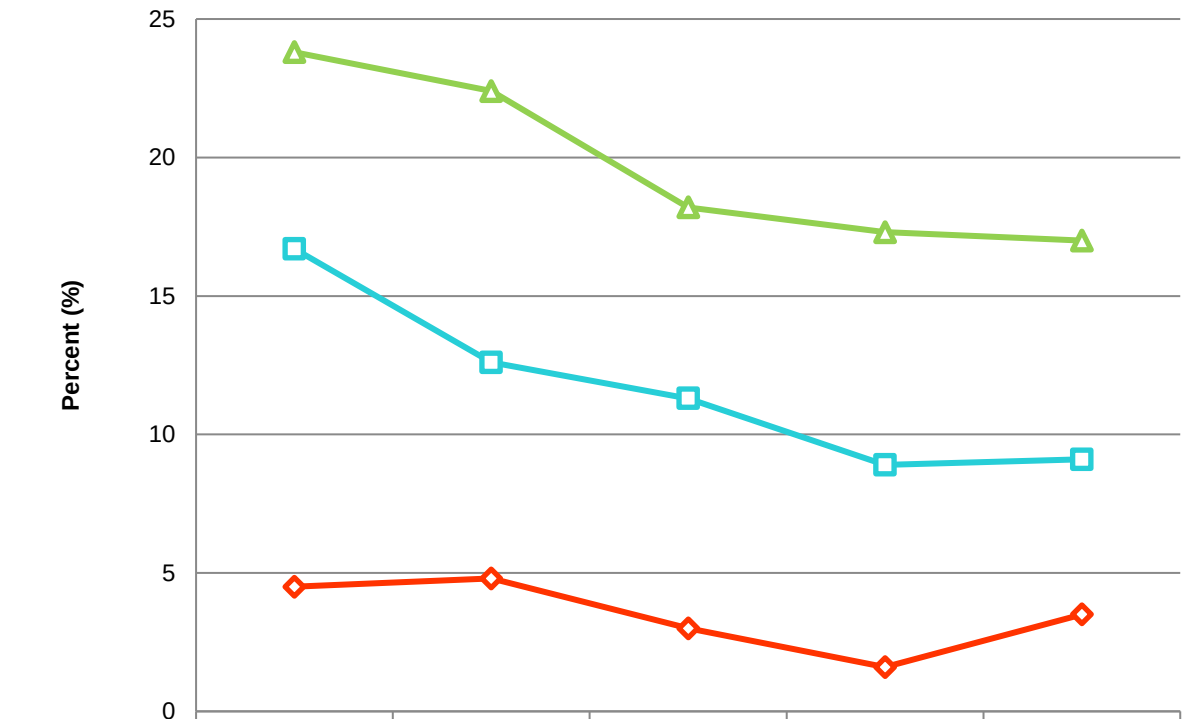


	2010	2012	2014	2016	2018
8th Grade	9.4	9.8	6.1	8.8	17
10th Grade	25.6	19	18.8	22.7	24.2
12th Grade	35.6	32.4	25.9	36.7	37.5

*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 77: Youth Binge Drinking



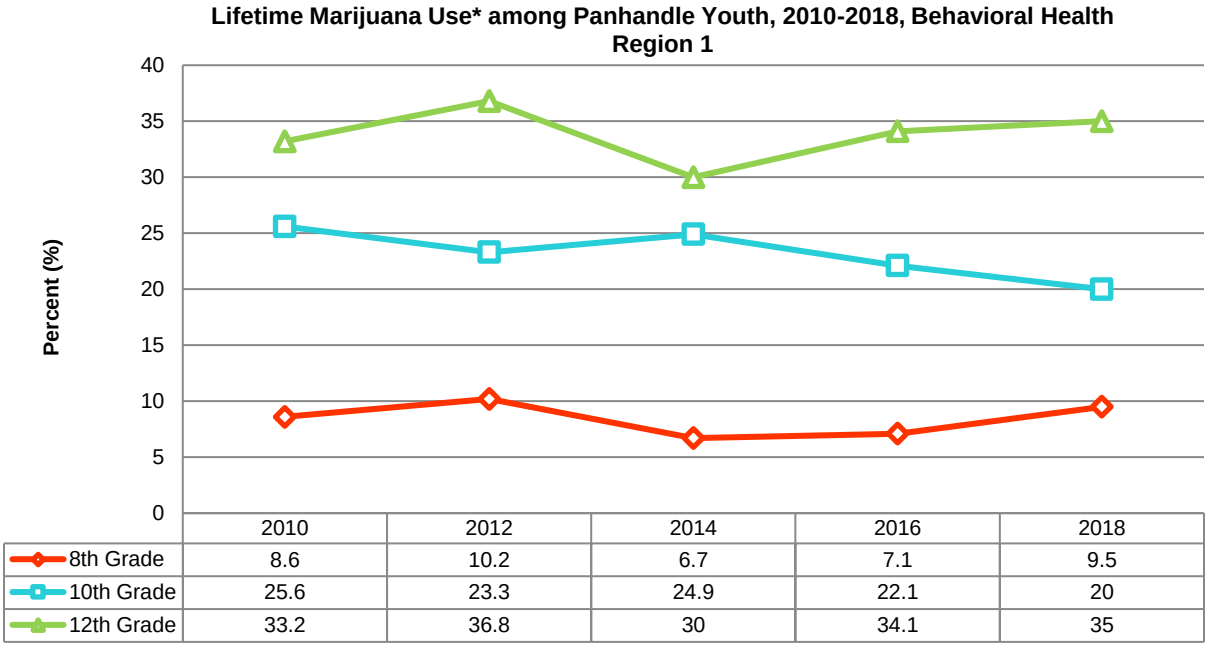
	2010	2012	2014	2016	2018
8th Grade	4.5	4.8	3	1.6	3.5
10th Grade	16.7	12.6	11.3	8.9	9.1
12th Grade	23.8	22.4	18.2	17.3	17

*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.

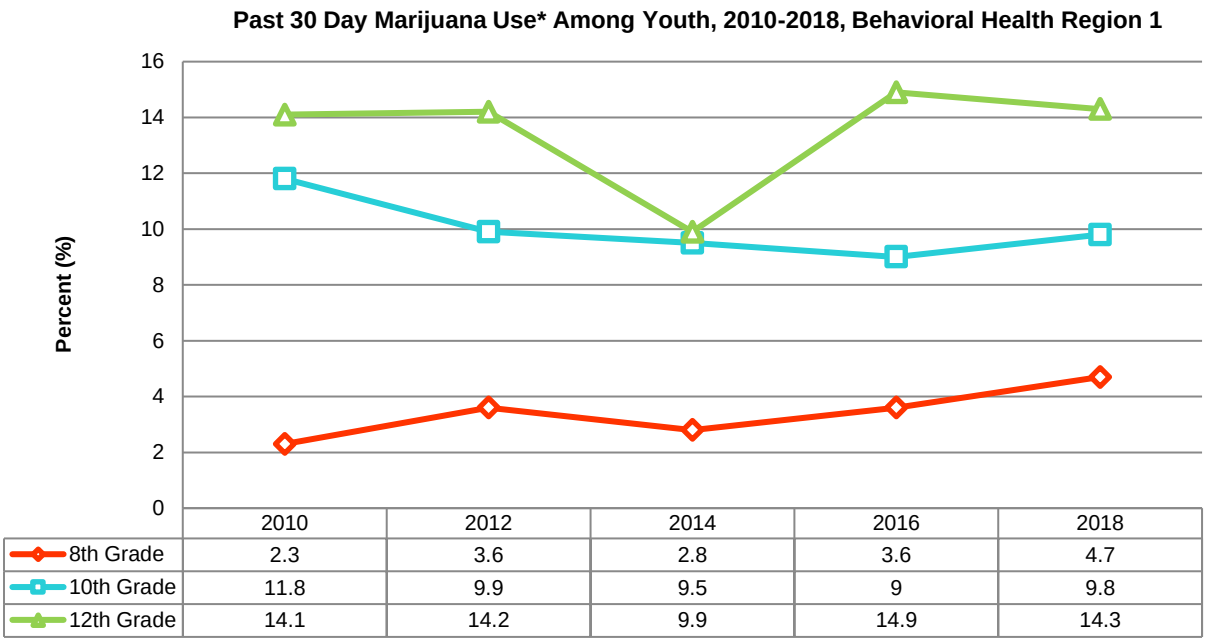
Figure 78: Youth Lifetime Marijuana Use



	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 79: 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.

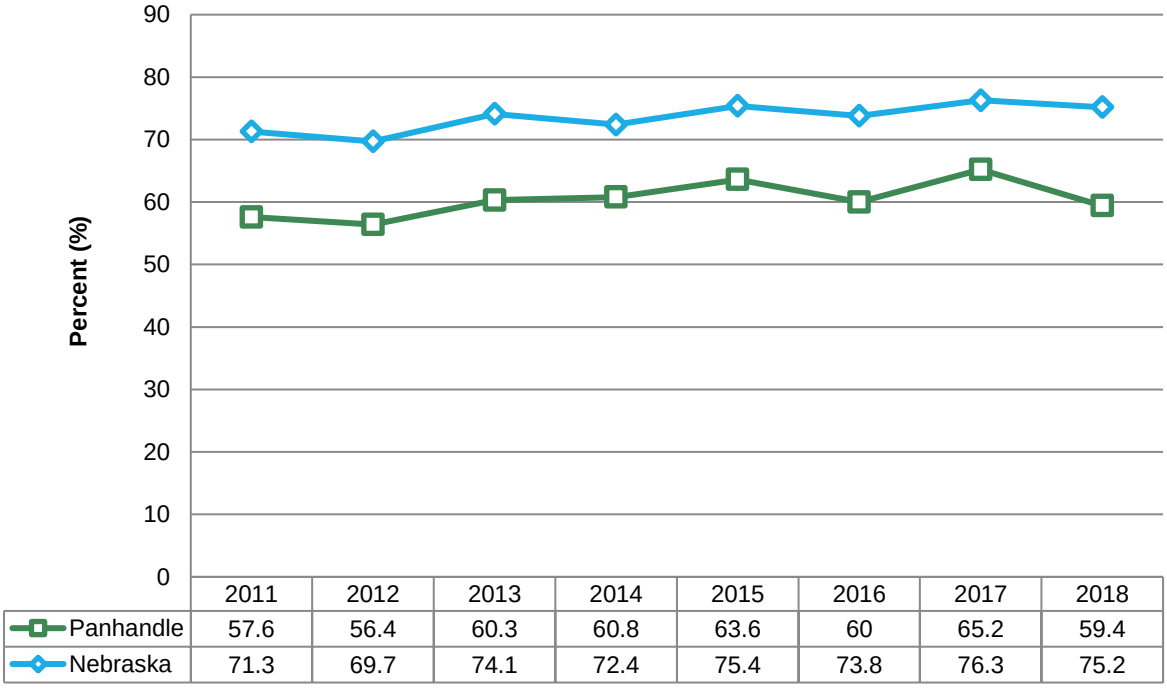
Figure 80: Panhandle Motor Vehicle Crash Data by County, 2019

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

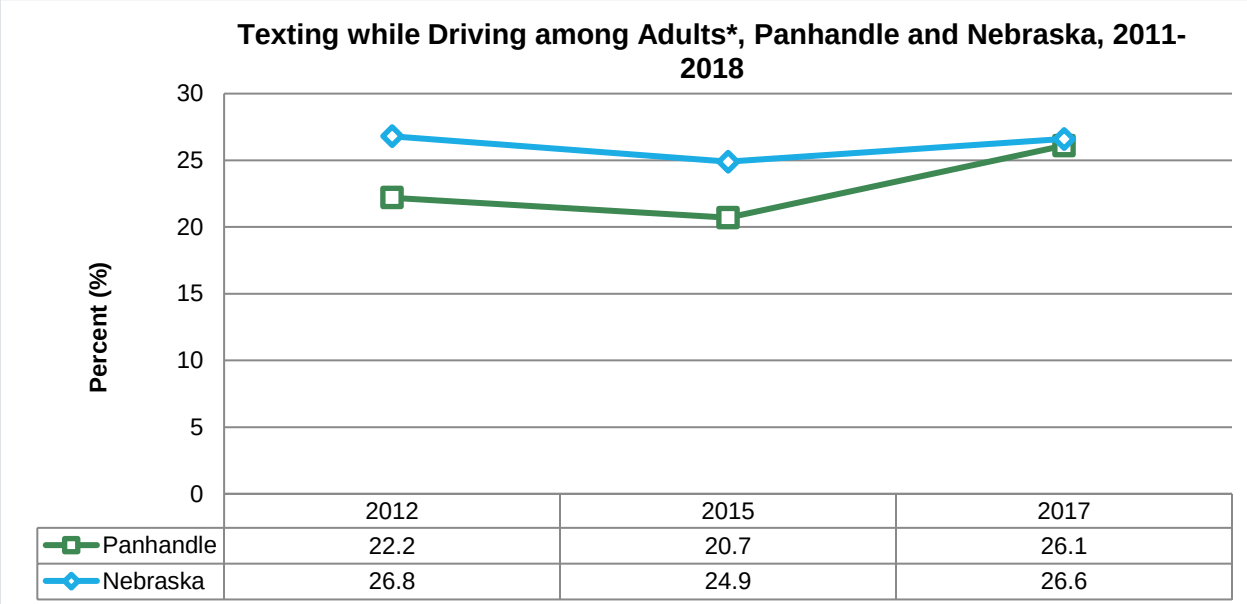
Figure 81: Adults Seatbelt Usage



*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

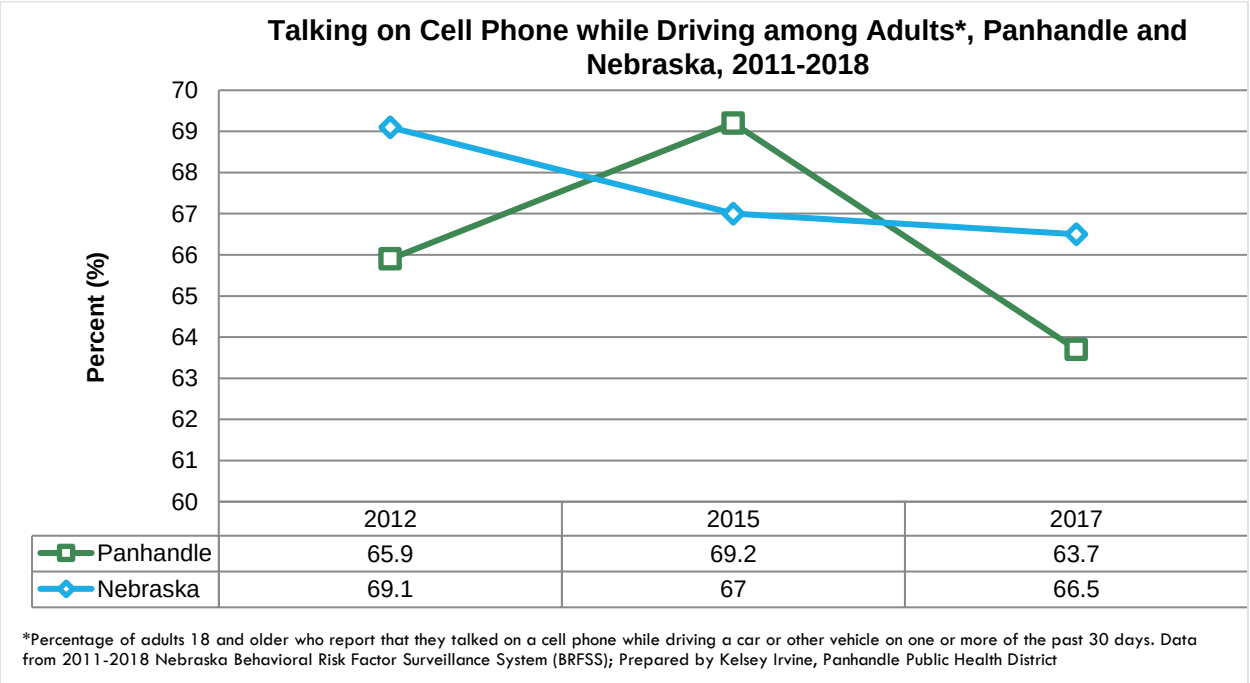
The rate of Panhandle adults that report they text while driving was lower than that of the overall state of Nebraska, but has increased in recent years to be at approximately the same rate. The proportion of adults who report they talk on the phone while driving in the Panhandle decreased from 69.2%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

Figure 82: 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 83: Adult Talking on Cell Phone While Driving

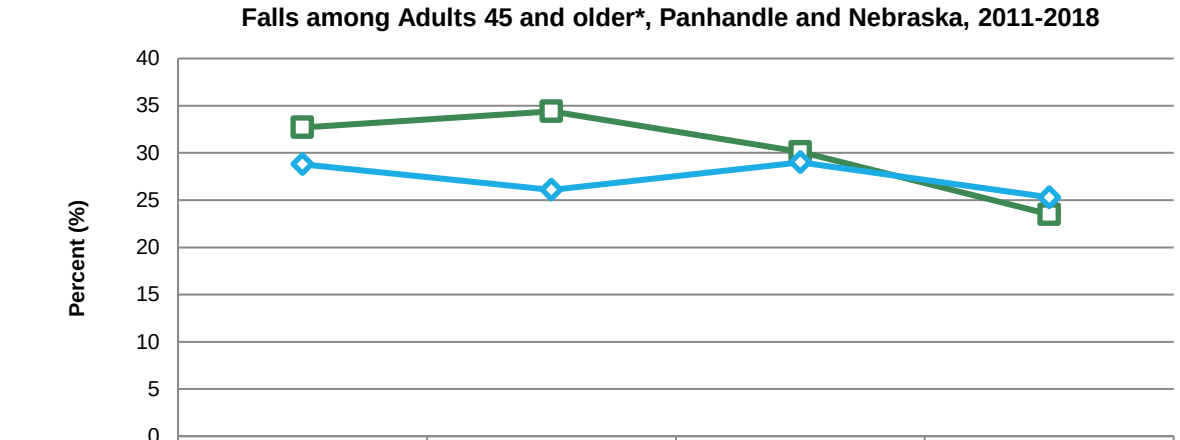


*Percentage of adults 18 and older who report that they talked on a cell phone while driving a car or other vehicle on one or more of the past 30 days. Data from 2011-2018 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsey Irvine, Panhandle Public Health District

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 84: Falls Among Adults 45+



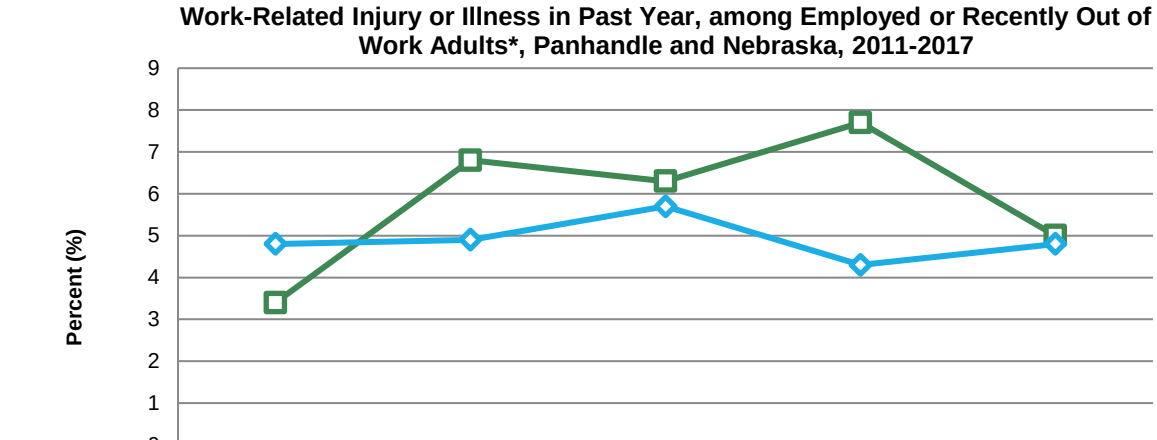
	2012	2014	2016	2018
Panhandle	32.7	34.4	30.1	23.5
Nebraska	28.8	26.1	29	25.3

*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 85: 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

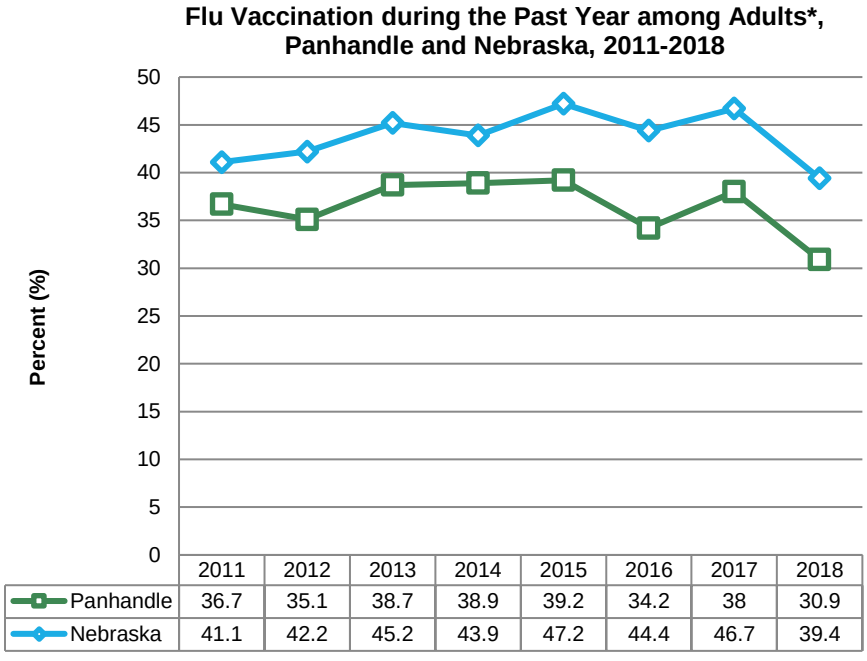
IMMUNIZATIONS

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 86: Flu Vaccination during Past Year

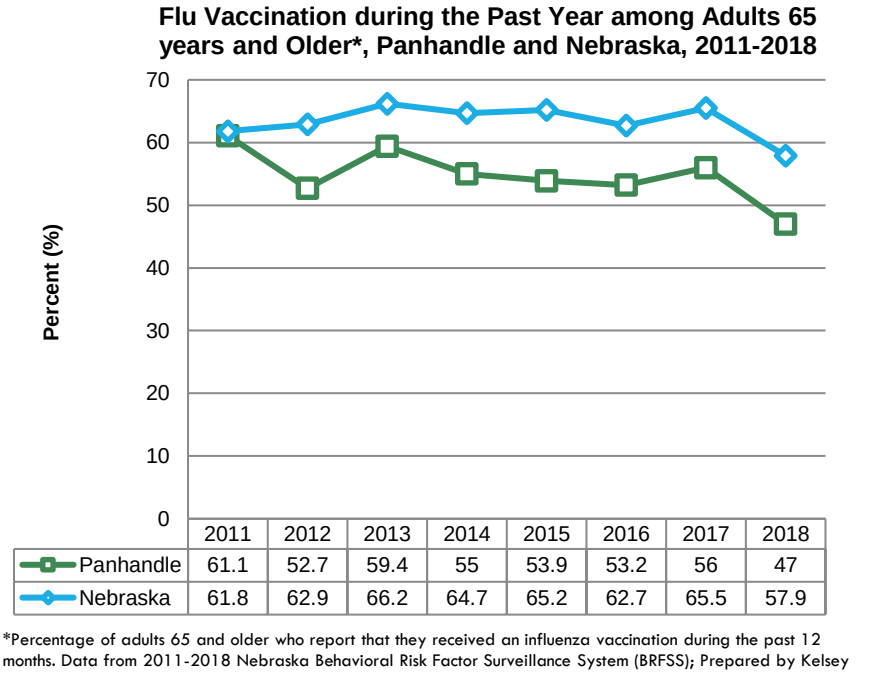


	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	36.7	35.1	38.7	38.9	39.2	34.2	38	30.9
Nebraska	41.1	42.2	45.2	43.9	47.2	44.4	46.7	39.4

*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 87: 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

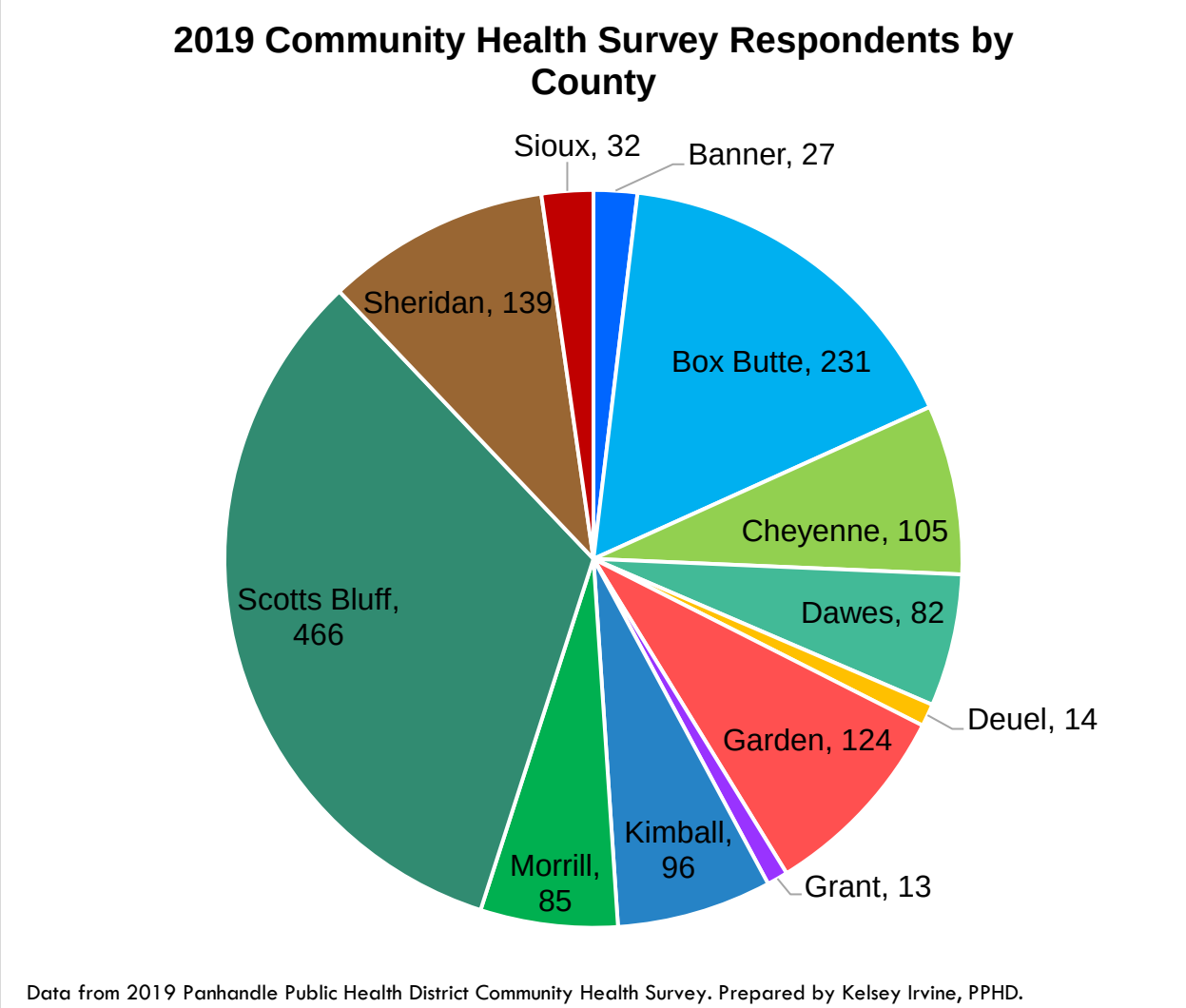
The Community Themes and Strengths Assessment is made up of two parts: the Community Health Survey and community Focus Groups. The top concerns of community members are determined from these two resources.

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.

1,414 Panhandle community members from a variety of backgrounds responded to the Community Health Survey.

Figure 88: 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 89: 2019 Community Health Survey Selected Demographic Information, N = 1,414

	#	%
Gender identity		
Male	257	18.2%
Female	1,130	79.9%
Transgender male (female to male)	0	0.0%
Transgender female (male to female)	1	0.1%
Gender non-conforming	2	0.1%
Decline to answer	23	1.6%
Other	1	0.1%
Sexual Orientation		
Heterosexual or straight	1,293	91.4%
Gay or lesbian	13	0.9%
Bisexual	29	2.1%
Decline to answer	71	5.0%
Other	8	0.6%
Highest level of education		
Less than high school graduate	23	1.6%
High school diploma or GED	371	26.2%
Associates or Technical Degree	315	22.3%
College degree or higher	672	47.5%
Decline to answer	31	2.2%
Other	2	0.1%
Race/Ethnicity		
White	1,286	90.9%
Black or African American	4	0.3%
Asian	4	0.3%
Native Hawaiian or Other Pacific Islander	0	0.0%
American Indian or Alaska Native	21	1.5%
Decline to answer	59	4.2%
Other	27	1.9%
Two or more races	13	0.9%
Hispanic/Latino	*83*	*5.9%*

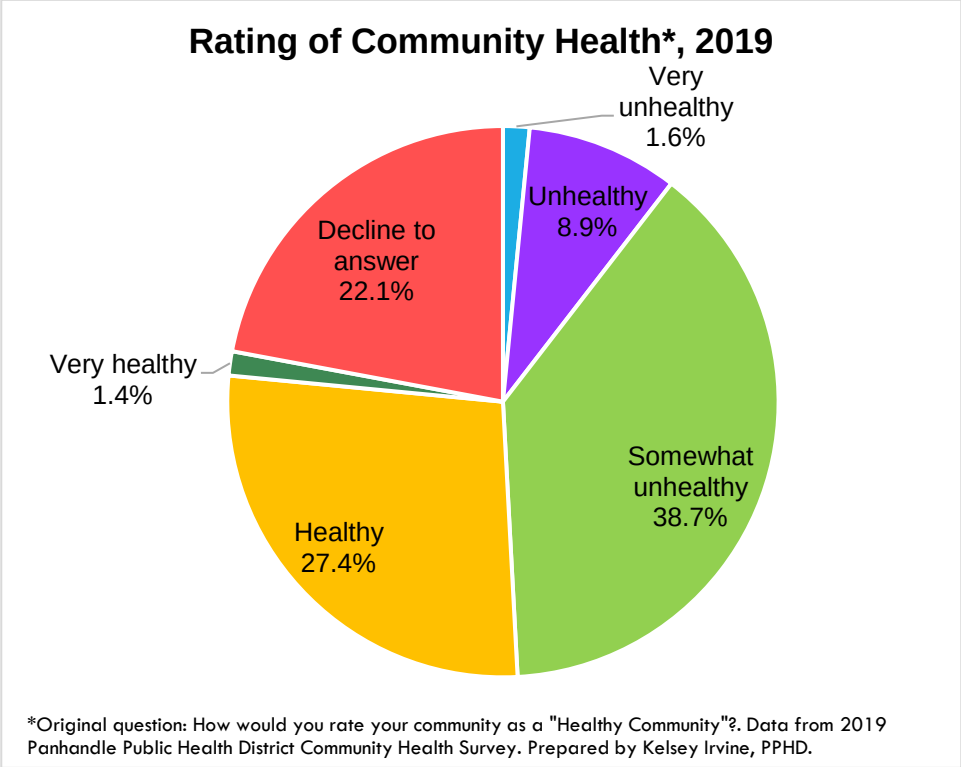
	#	%
Age		
Under 18 years	3	0.2%
18-25 years	69	4.9%
26-39 years	328	23.2%
40-54 years	401	28.4%
55-64 years	318	22.5%
65-80 years	242	17.1%
Over 80 years	30	2.1%
Decline to answer	23	1.6%
Marital Status		
Married/Partnered	984	69.6%
Divorced	153	10.8%
Never married	137	9.7%
Separated	16	1.1%
Widowed	64	4.5%
Decline to answer	58	4.1%
Other	2	0.1%
Household income		
Less than $20,000	102	7.2%
$20,000 to $29,999	145	10.3%
$30,000 to $49,999	242	17.1%
$50,000 to $74,999	314	22.2%
$75,000 to $99,999	241	17.0%
Over $100,000	216	15.3%
Decline to answer	154	10.9%

Demographic information for the respondents to the 2019 Community Health Survey can be found in the table above. The respondents were primarily female (79.9%) as opposed to male (18.2%). The age of respondents was relatively distributed, with 4.9% aged 18-25, 23.2% aged 26-39, 28.4% aged 40-54, 22.5% aged 55-64, 17.1% aged 65-80, and 2.1% aged 80 and older. The majority of respondents were married or partnered (69.6%). The majority of respondents were white (90.9%), and 5.9% indicated they were Hispanic or Latino. Survey respondents were spread across a variety of income levels, with 7.2% making less than $20,000, 10.3% $20,000-$29,999, 17.1% $30,000-$49,999, 22.2% $50,000-$74,999, 17.0% $75,000-$99,999, and 15.3% over $100,000.

RATING OF COMMUNITY HEALTH

When asked to rank the health of their community, the majority of respondents indicated that the community is somewhat unhealthy (38.7%), with a ranking of healthy coming in a close second (27.4%). 8.9% ranked community health as being unhealthy and 1.6% as very unhealthy. 22% of respondents declined to answer the question.

Figure 90: Rating of Community Health

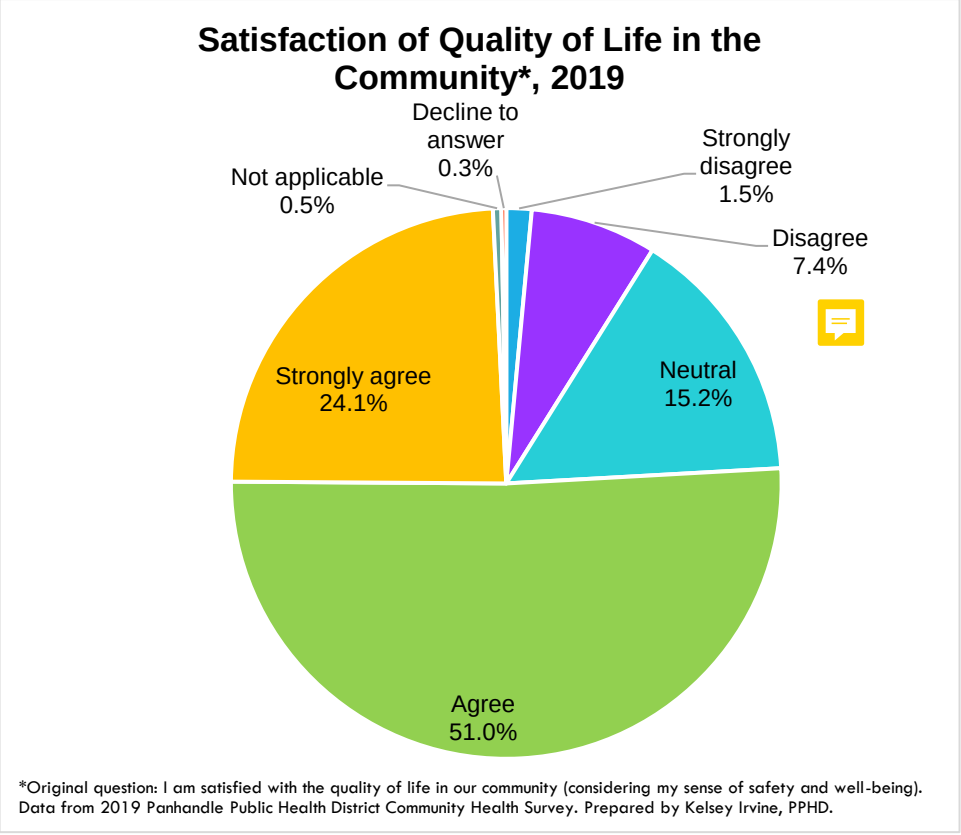


*Original question: How would you rate your community as a "Healthy Community"?. Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

Figure 91: Satisfaction of Quality of Life in the Community

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 (51.0%), and 24.1% strongly agreed. 1.25% of respondents felt neutral, 7.4% disagreed, and 1.5% strongly disagreed. 0.5% of respondents felt the question was not applicable to them, and 0.3% declined to answer.

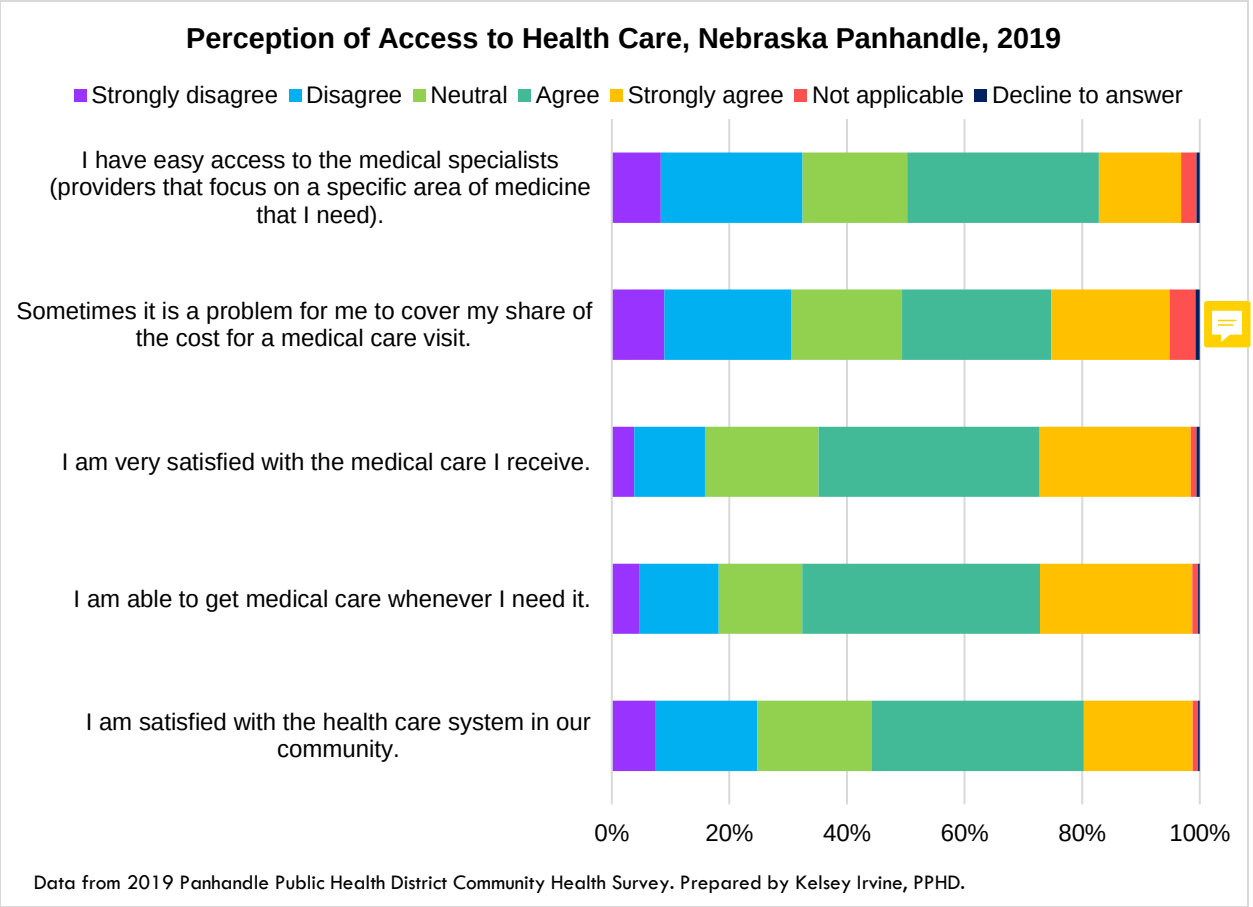


*Original question: I am satisfied with the quality of life in our community (considering my sense of safety and well-being). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

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 92: Perception of Access to Health Care



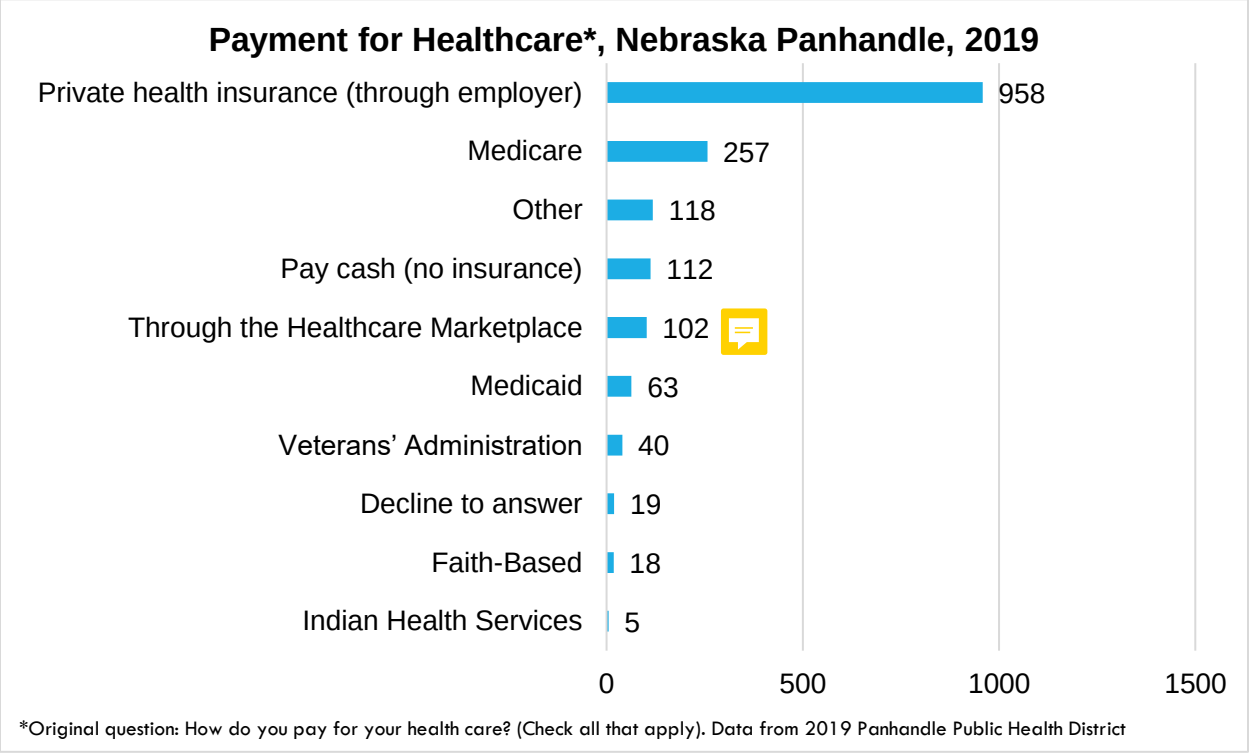
Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

	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).	8.3%	24.1%	17.8%	32.6%	14.0%	2.6%	0.6%
Sometimes it is a problem for me to cover my share of the cost for a medical care visit.	8.9%	21.6%	18.9%	25.4%	20.1%	4.5%	0.7%
I am very satisfied with the medical care I receive.	3.8%	12.0%	19.3%	37.6%	25.7%	1.0%	0.6%
I am able to get medical care whenever I need it.	4.7%	13.4%	14.2%	40.5%	25.9%	1.0%	0.3%
I am satisfied with the health care system in our community.	7.4%	17.4%	19.4%	36.1%	18.5%	0.9%	0.3%

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 93: Payment for Healthcare

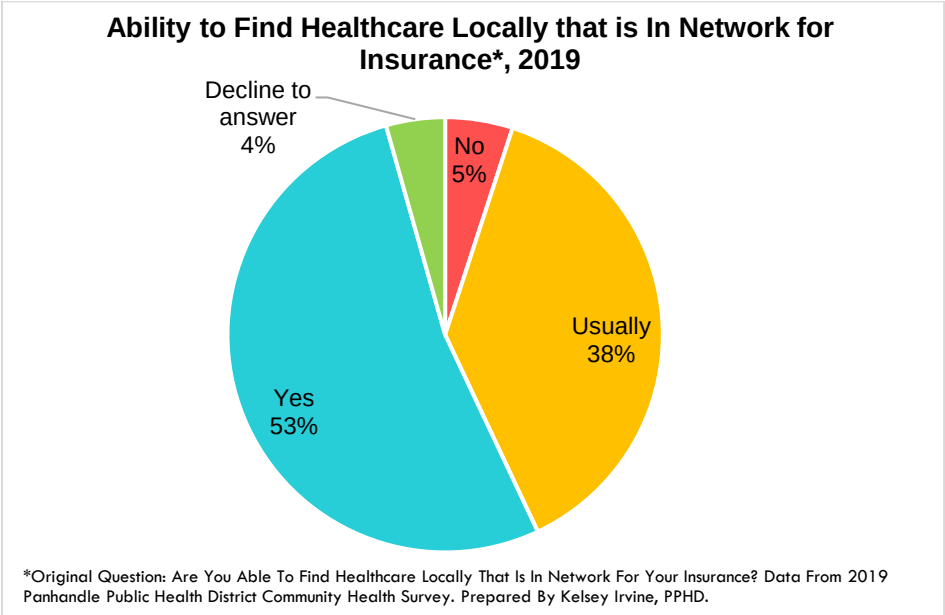


*Original question: How do you pay for your health care? (Check all that apply). Data from 2019 Panhandle Public Health District

IN NETWORK HEALTHCARE

Most respondents (53%) indicated they are able to find healthcare locally that is in-network for their insurance, and 38% indicated they can usually find healthcare locally that is in-network.

Figure 94: Ability to find Healthcare Locally that is in Network for Insurance

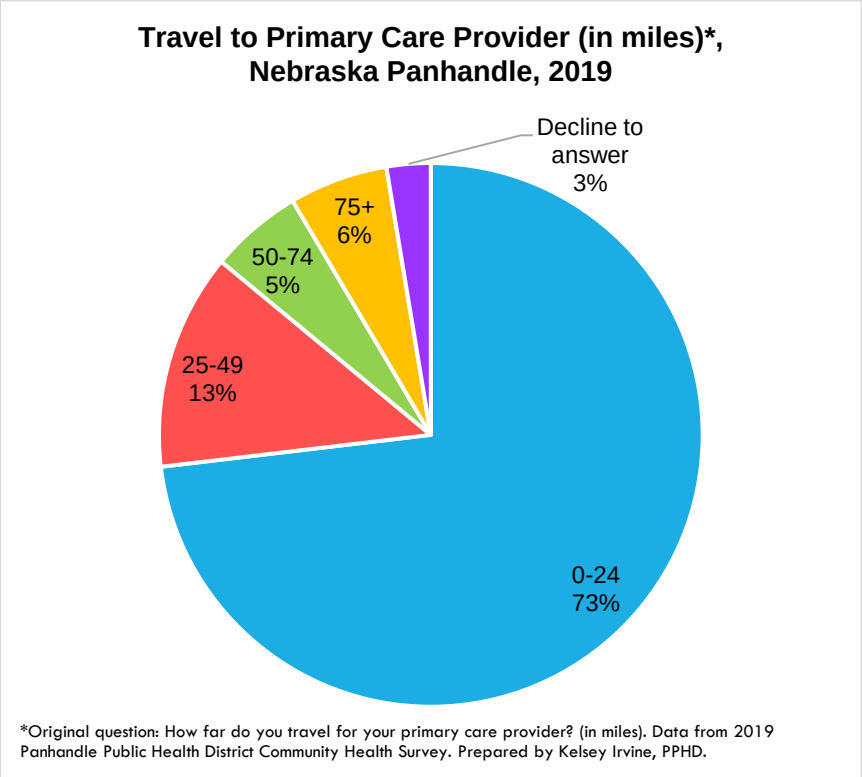


*Original Question: Are You Able To Find Healthcare Locally That Is In Network For Your Insurance? Data From 2019 Panhandle Public Health District Community Health Survey. Prepared By Kelsey Irvine, PPHD.

PRIMARY CARE

The majority of respondents (73%) travel 0-24 miles to their primary care provider. 13% indicated they travel 25 to 49 miles, and 11% indicated they travel 50 miles or more for healthcare. These findings indicate that the majority of people receive healthcare within their immediate community.

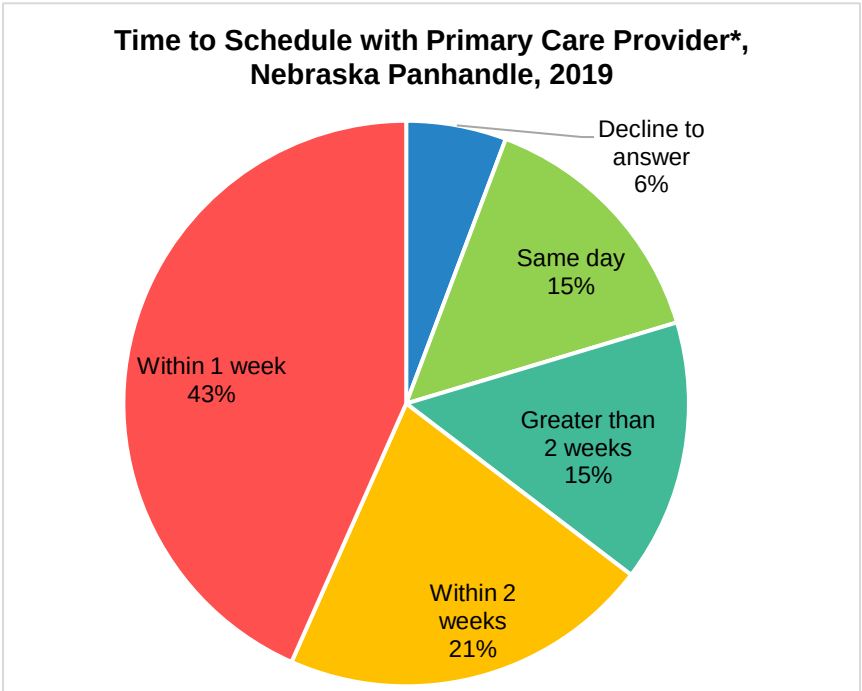
Figure 95: Travel to Primary Care Provider



*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.

Figure 96: Time to Schedule with Primary Care Provider

Most respondents are able to schedule time with their primary care provider in the same day (15%) or within one week (43%) of calling to schedule an appointment. 21% of respondents are able to make appointments within two weeks. 15% of respondents indicated it took more than two weeks to get in to see their provider.



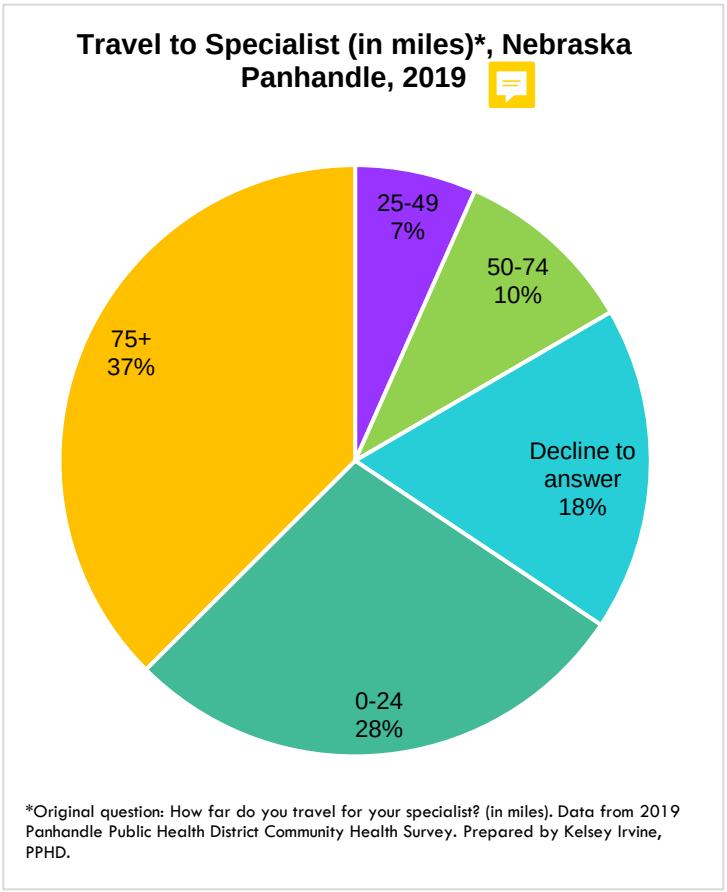
*Original question: How long, from the time you call to make an appointment, are you able to see your primary care provider? Data from 2019 Panhandle Public Health District Community Health Survey.

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. 47% of respondents travel 50 or more miles to see a specialist. 7% travel 25 to 49 miles, and 28% travel 0 to 24 miles.

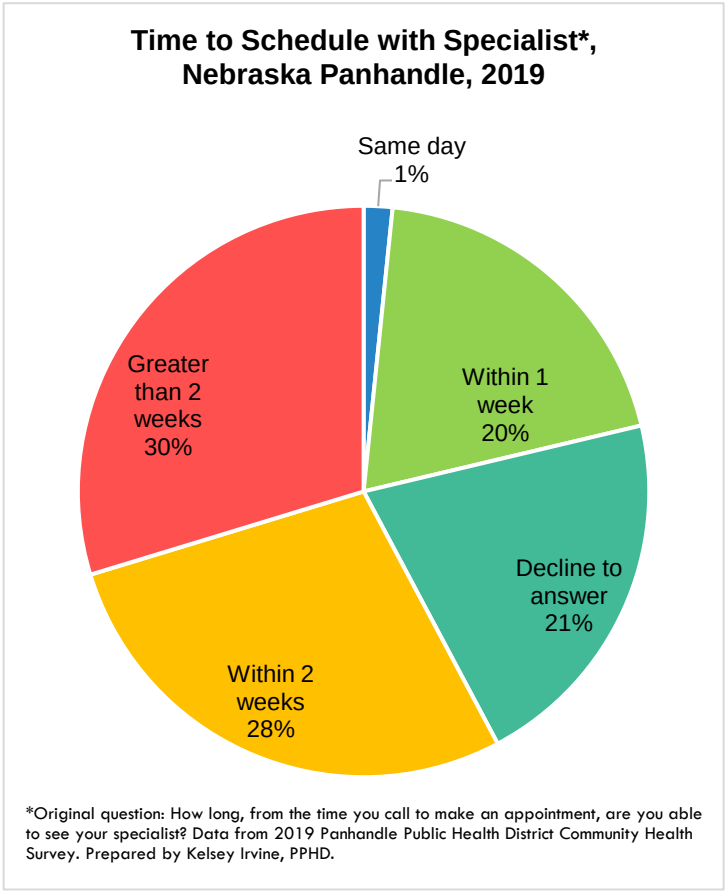
Similar to traveling longer distances to see a specialist, most respondents indicated it takes longer to get in to see a specialist. 30% of respondents indicated it takes greater than two weeks. 28% are able to see their specialists within two weeks, and 20% within one week. Only 1% of respondents indicated they were able to see their specialist on the same day as they called to make the appointment.

Figure 97: 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



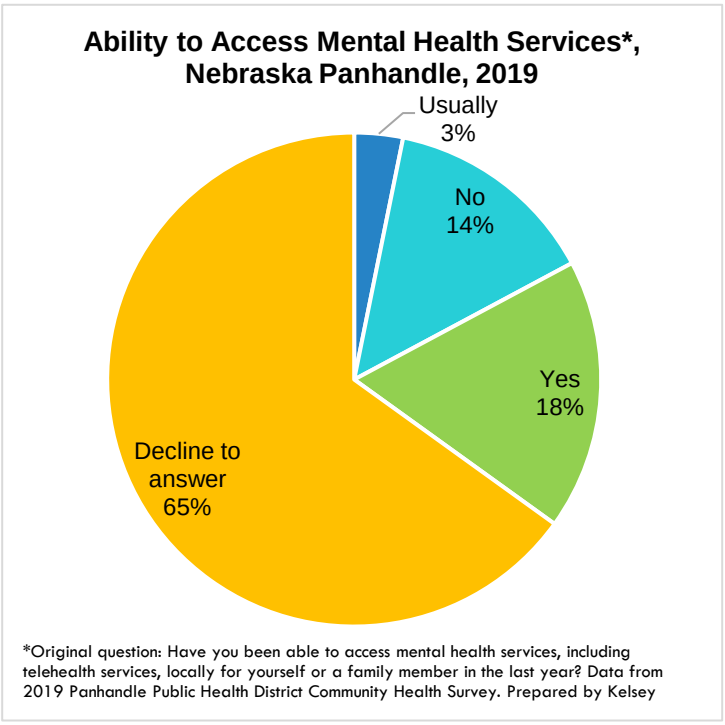
*Original question: How long, from the time you call to make an appointment, are you able to see your specialist? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

MENTAL HEALTH SERVICES

Of the respondents who responded to questions relating to mental health, most were able to access mental health services within the Panhandle. Out of 35% of respondents who answered the questions, 18% are able to access mental health services in their community, and 3% are usually able to do so. 14% indicated they are unable to access mental health services in their community.

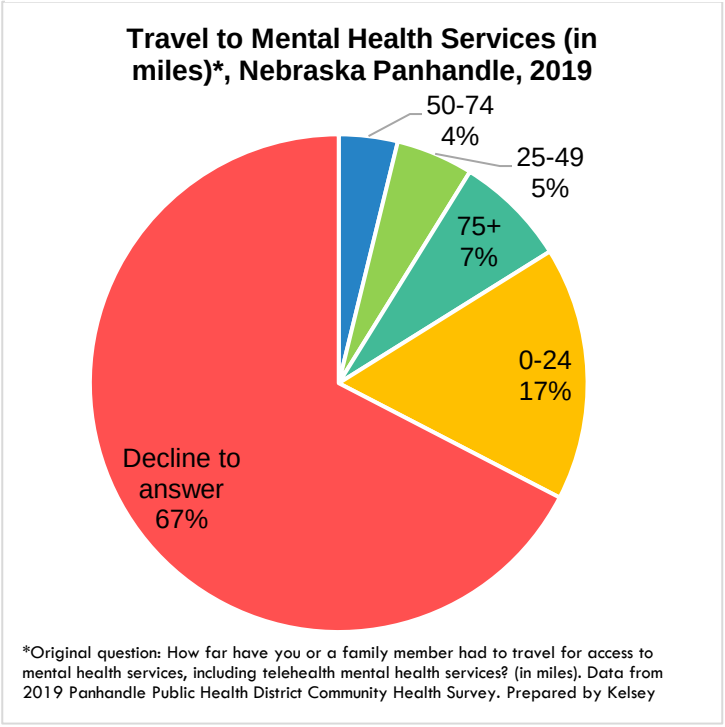
17% of respondents indicated they travel 0-24 miles to receive mental health services, suggesting they receive care in their immediate communities. The majority of those receiving mental health services travel 25 miles or more, perhaps traveling to neighboring communities.

Figure 99: 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

Figure 100: Travel to Mental Health Services

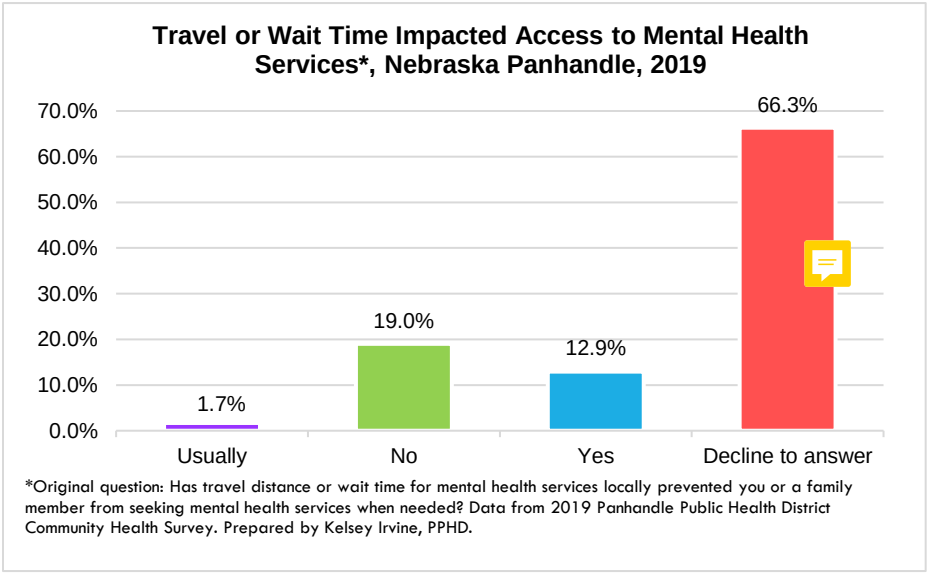


*Original question: How far have you or a family member had to travel for access to mental health services, including telehealth mental health services? (in miles). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey

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 of those who indicated travel of wait time impacted their access to mental health services versus those who indicated it did *not* impact their access to mental health services (19% and 17%, respectively).

Figure 101: Travel or Wait Time Impacted Access to Mental Health Services

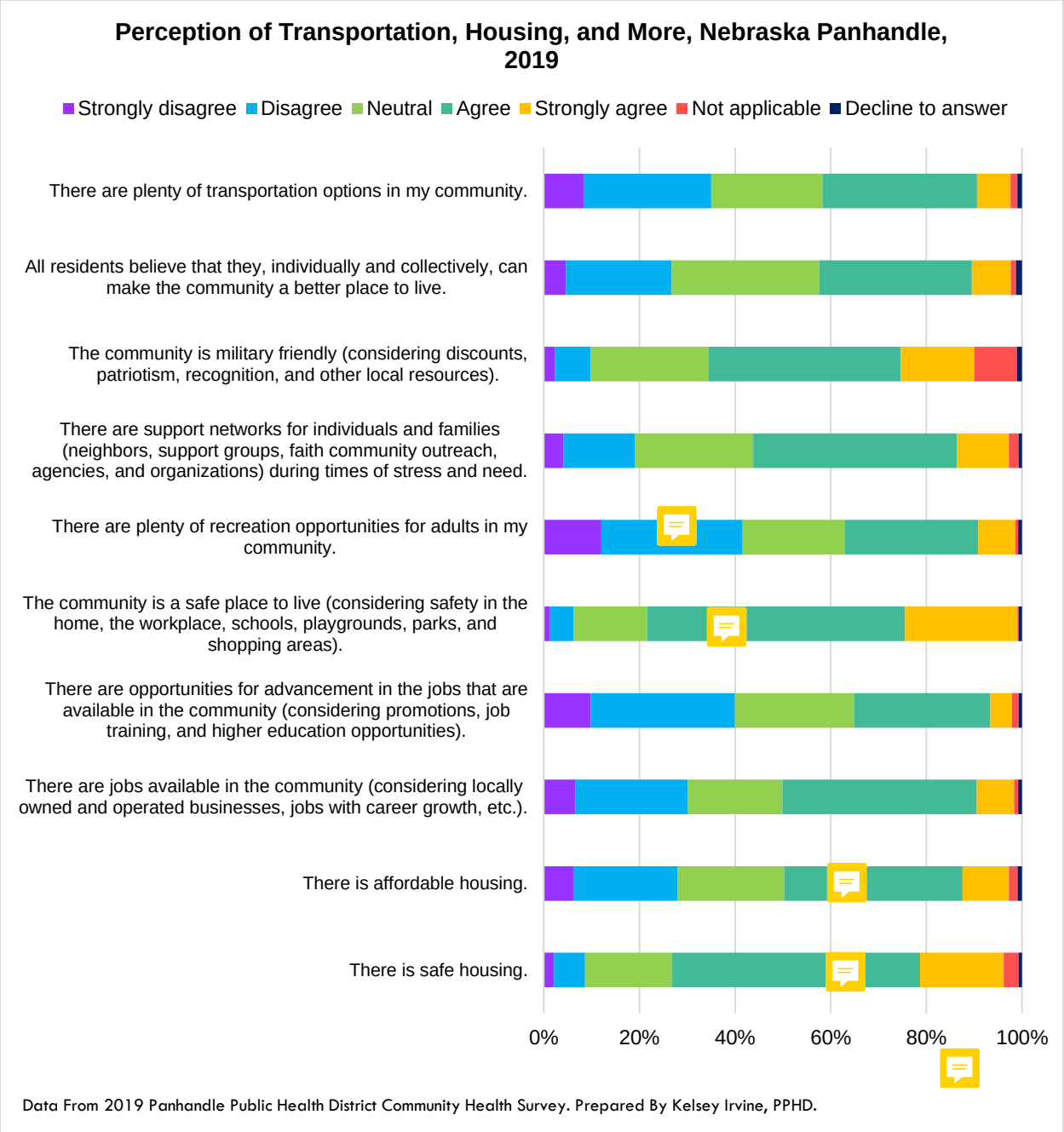


*Original question: Has travel distance or wait time for mental health services locally prevented you or a family member from seeking mental health services when needed? Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

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 not recreation opportunities for adults in communities, and few respondents feel that they are able to make the community a better place to live.

Figure 102: Perception of Transportation, Housing, and More

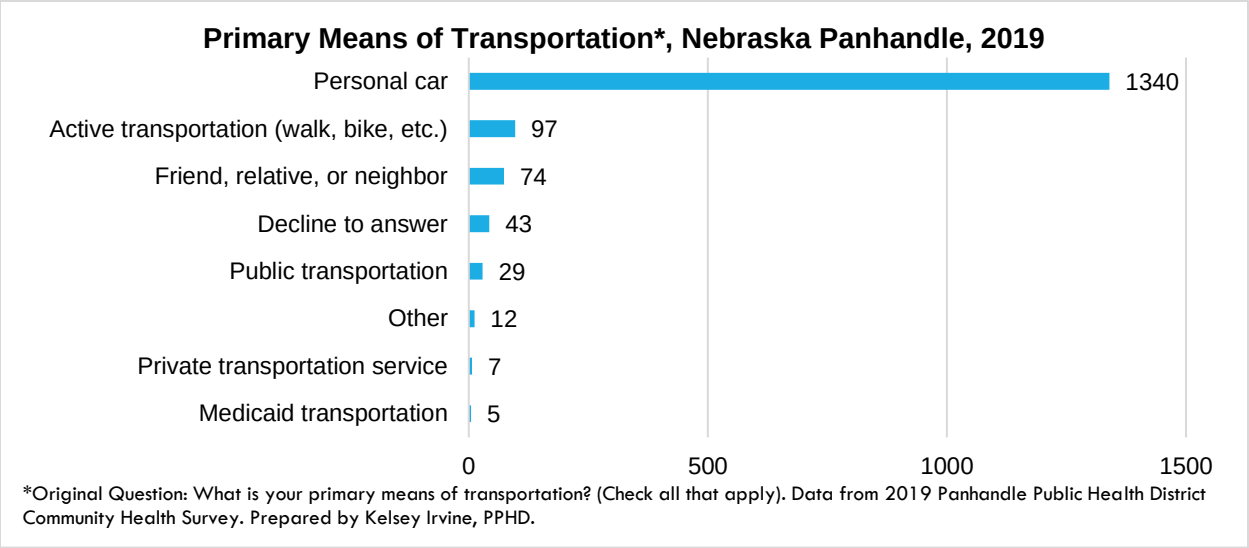


	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are plenty of transportation options in my community.	8.5%	26.5%	23.3%	32.3%	7.0%	1.4%	1.0%
All residents believe that they, individually and collectively, can make the community a better place to live.	4.7%	22.1%	30.8%	31.9%	8.2%	1.1%	1.3%
The community is military friendly (considering discounts, patriotism, recognition, and other local resources).	2.3%	7.5%	24.5%	40.2%	15.4%	8.9%	1.1%
There are support networks for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.	4.1%	15.0%	24.7%	42.6%	10.9%	2.1%	0.7%
There are plenty of recreation opportunities for adults in my community.	12.0%	29.6%	21.4%	27.8%	7.8%	0.6%	0.8%
The community is a safe place to live (considering safety in the home, the workplace, schools, playgrounds, parks, and shopping areas).	1.3%	5.0%	15.3%	53.9%	23.5%	0.3%	0.7%
There are opportunities for advancement in the jobs that are available in the community (considering promotions, job training, and higher education opportunities).	9.8%	30.1%	24.9%	28.5%	4.5%	1.4%	0.7%
There are jobs available in the community (considering locally owned and operated businesses, jobs with career growth, etc.).	6.6%	23.5%	19.8%	40.7%	7.8%	0.8%	0.8%
There is affordable housing.	6.2%	21.9%	22.3%	37.3%	9.7%	1.8%	0.9%
There is safe housing.	2.1%	6.5%	18.2%	51.8%	17.5%	3.1%	0.7%

TRANSPORTATION

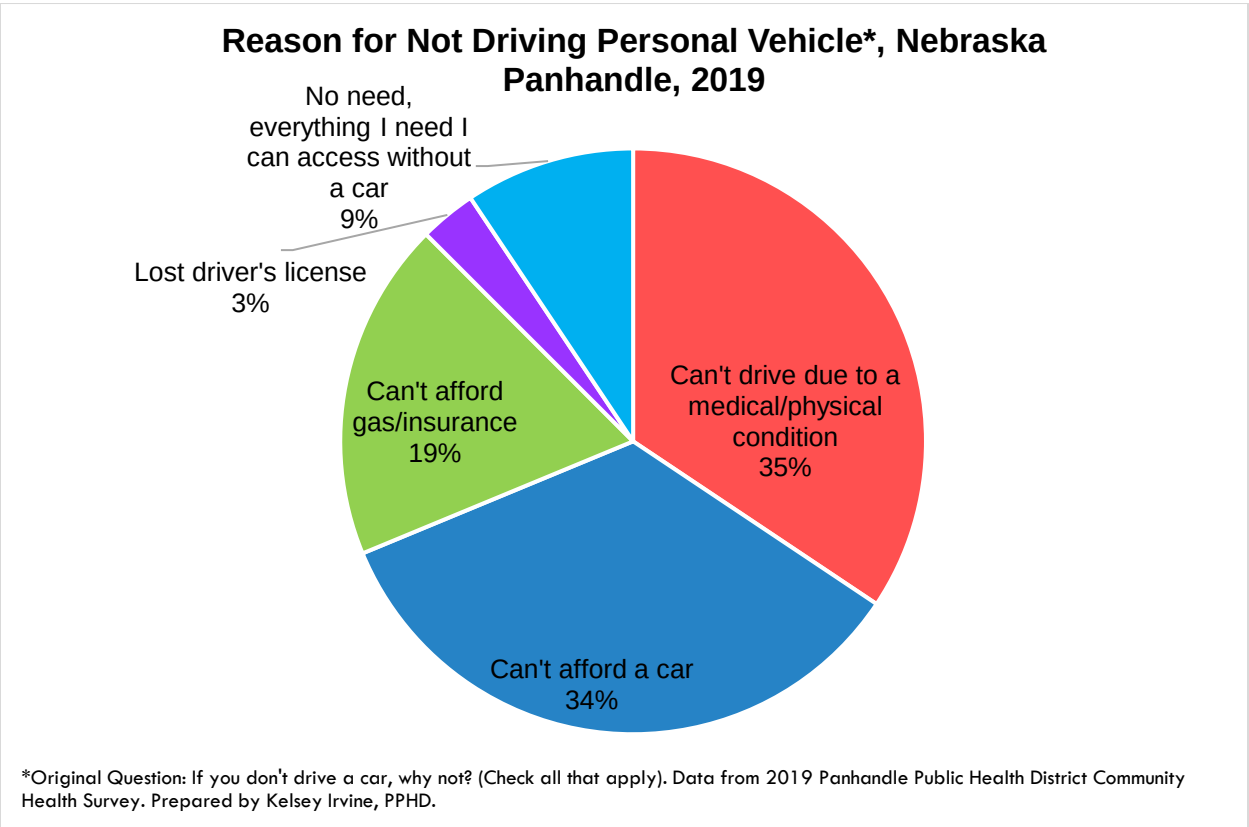
Most survey respondents indicated they drive their own vehicle as their primary means of transportation. Of respondents who do not drive a personal vehicle, the majority cannot due to a medical or physical condition (35%), with the following two reasons related to the affordability of owning a vehicle (34%) or the fuel or insurance required to drive a vehicle (19%).

Figure 103: 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.

Figure 104: Reason for Not Driving Personal Vehicle



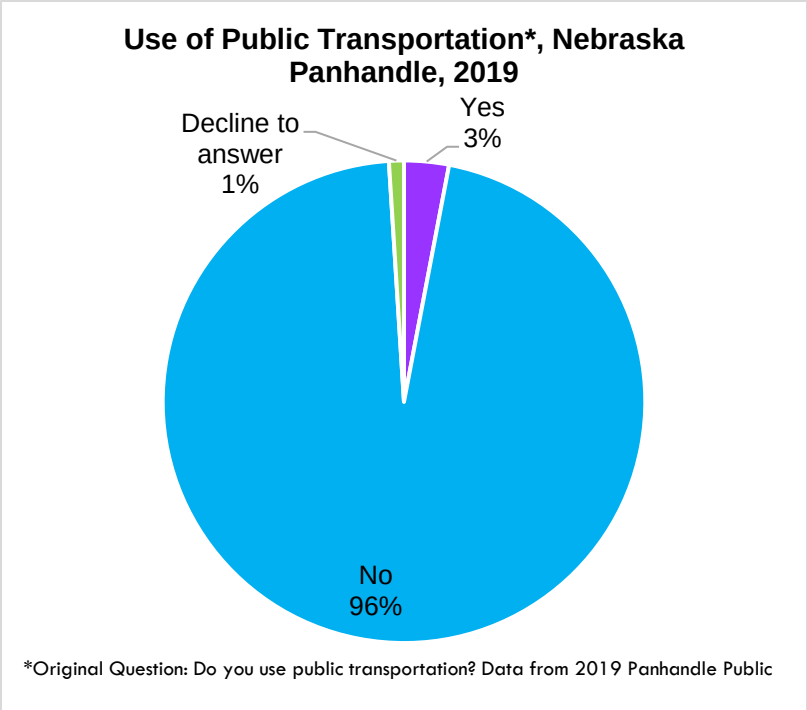
*Original Question: If you don't drive a car, why not? (Check all that apply). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

PUBLIC TRANSPORTATION

The majority of respondents (96%) do not use public transportation.

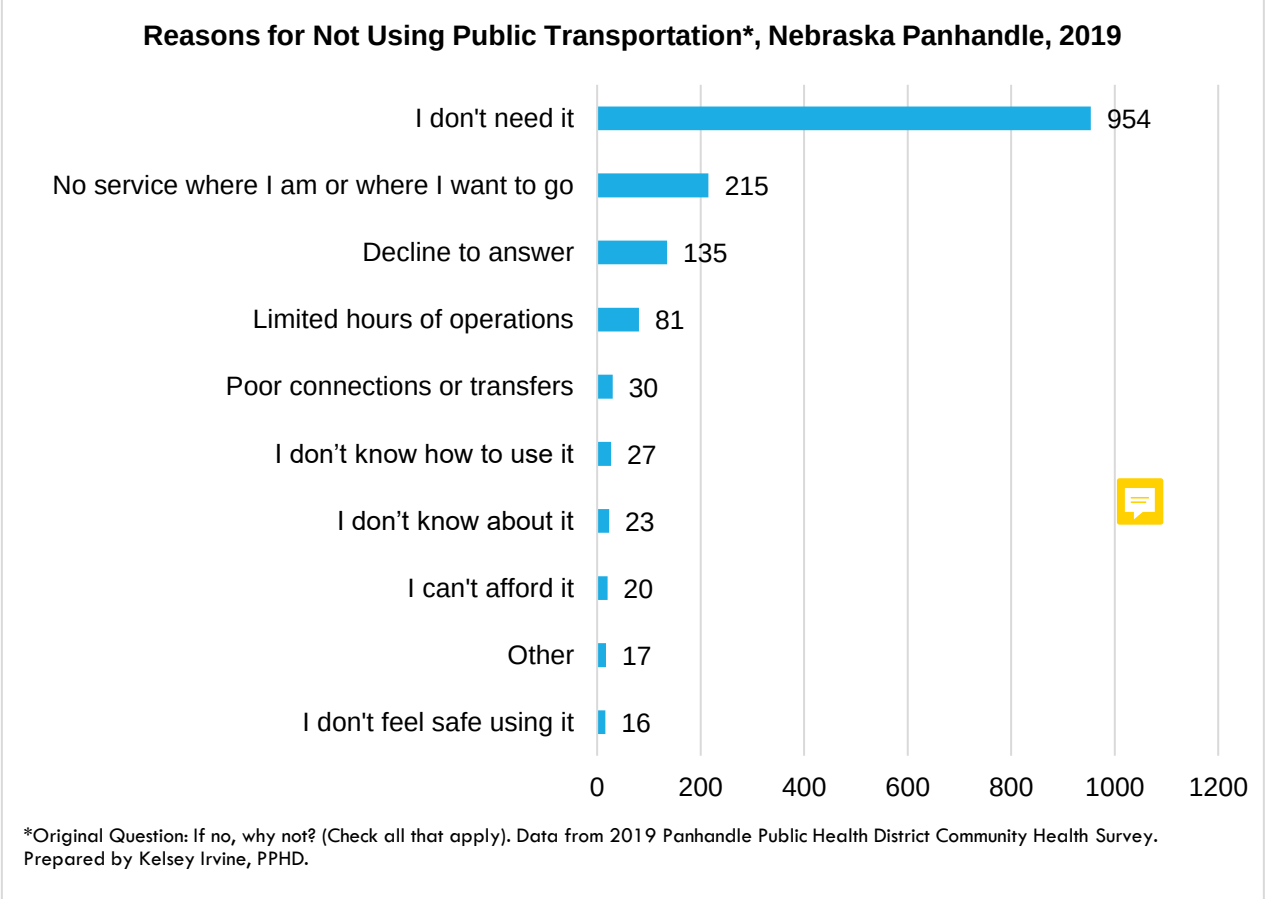
Most indicated that they do not need it (954) or there was no service where they live or where they want to go (215).

Figure 105: Use of Public Transportation



*Original Question: Do you use public transportation? Data from 2019 Panhandle Public

Figure 106: Reasons for Not Using Public Transportation

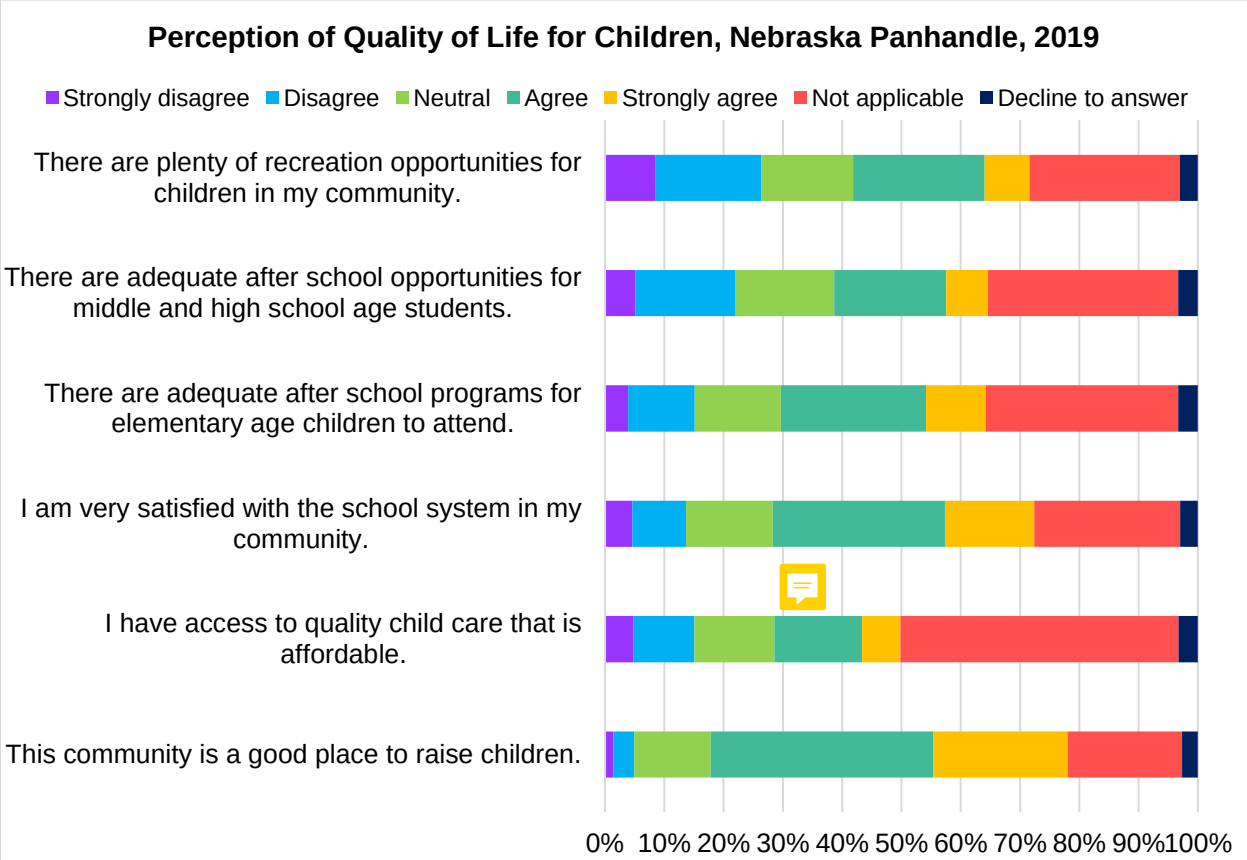


*Original Question: If no, why not? (Check all that apply). Data from 2019 Panhandle Public Health District Community Health Survey. Prepared by Kelsey Irvine, PPHD.

QUALITY OF LIFE FOR CHILDREN

The following section includes responses to questions about children, childcare, and education in the Panhandle. 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. As was seen in the 2017 CHA, many respondents felt there are not enough recreation opportunities for children and access to quality childcare is a challenge. .

Figure 107: Perception of Quality of Life for Children



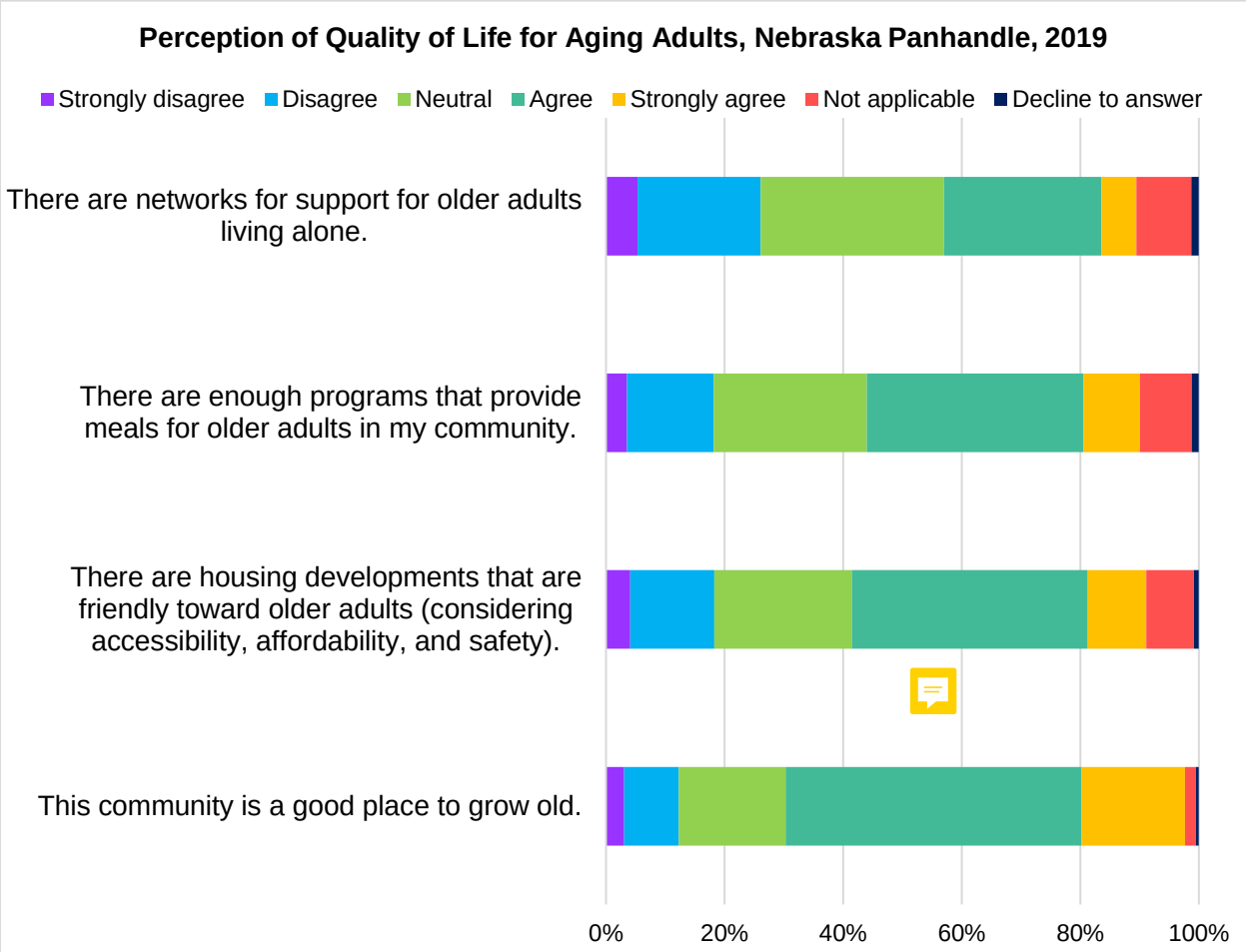
Data From 2019 Panhandle Public Health District Community Health Survey. Prepared By Kelsey Irvine, PPHD.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are plenty of recreation opportunities for children in my community.	8.6%	17.8%	15.5%	22.1%	7.6%	25.4%	3.0%
There are adequate after school opportunities for middle and high school age students.	5.2%	16.8%	16.8%	18.9%	7.0%	32.1%	3.3%
There are adequate after school programs for elementary age children to attend.	3.9%	11.2%	14.5%	24.5%	10.0%	32.5%	3.3%
I am very satisfied with the school system in my community.	4.6%	9.1%	14.6%	29.1%	15.1%	24.6%	3.0%
I have access to quality child care that is affordable.	4.7%	10.3%	13.5%	14.8%	6.5%	46.9%	3.3%
This community is a good place to raise children.	1.4%	3.5%	12.9%	37.6%	22.6%	19.3%	2.7%

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 (67.4% agreed or strongly agreed).

Figure 108: Perception of Quality of Life for Aging Adults

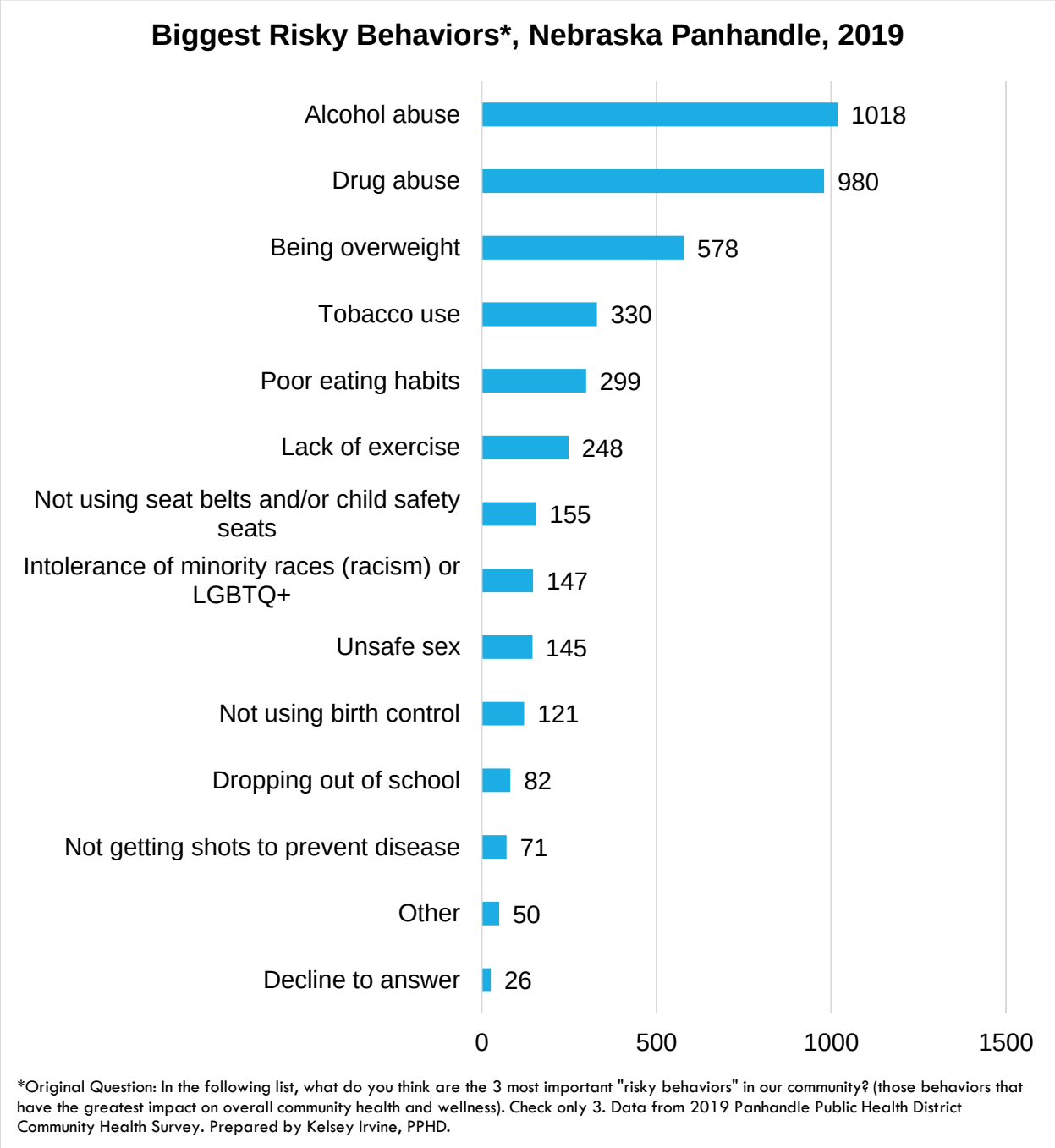


	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Not applicable	Decline to answer
There are networks for support for older adults living alone.	5.3%	20.8%	30.9%	26.6%	5.9%	9.3%	1.3%
There are enough programs that provide meals for older adults in my community.	3.5%	14.6%	25.8%	36.6%	9.5%	8.8%	1.2%
There are housing developments that are friendly toward older adults (considering accessibility, affordability, and safety).	4.1%	14.1%	23.2%	39.8%	9.9%	8.0%	0.8%
This community is a good place to grow old.	3.0%	9.3%	18.0%	49.9%	17.5%	1.8%	0.5%

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 alcohol abuse, drug abuse, and being overweight, followed by tobacco use, poor eating habits, and lack of exercise. Interestingly, the top six ranked risky behaviors in the 2017 Community Health Survey were the exact same, but with tobacco use ranked 6th, and lack of exercise and poor eating habits ranked 4th and 5th, respectively.

Figure 109: 2019 Panhandle Biggest Risky Behaviors

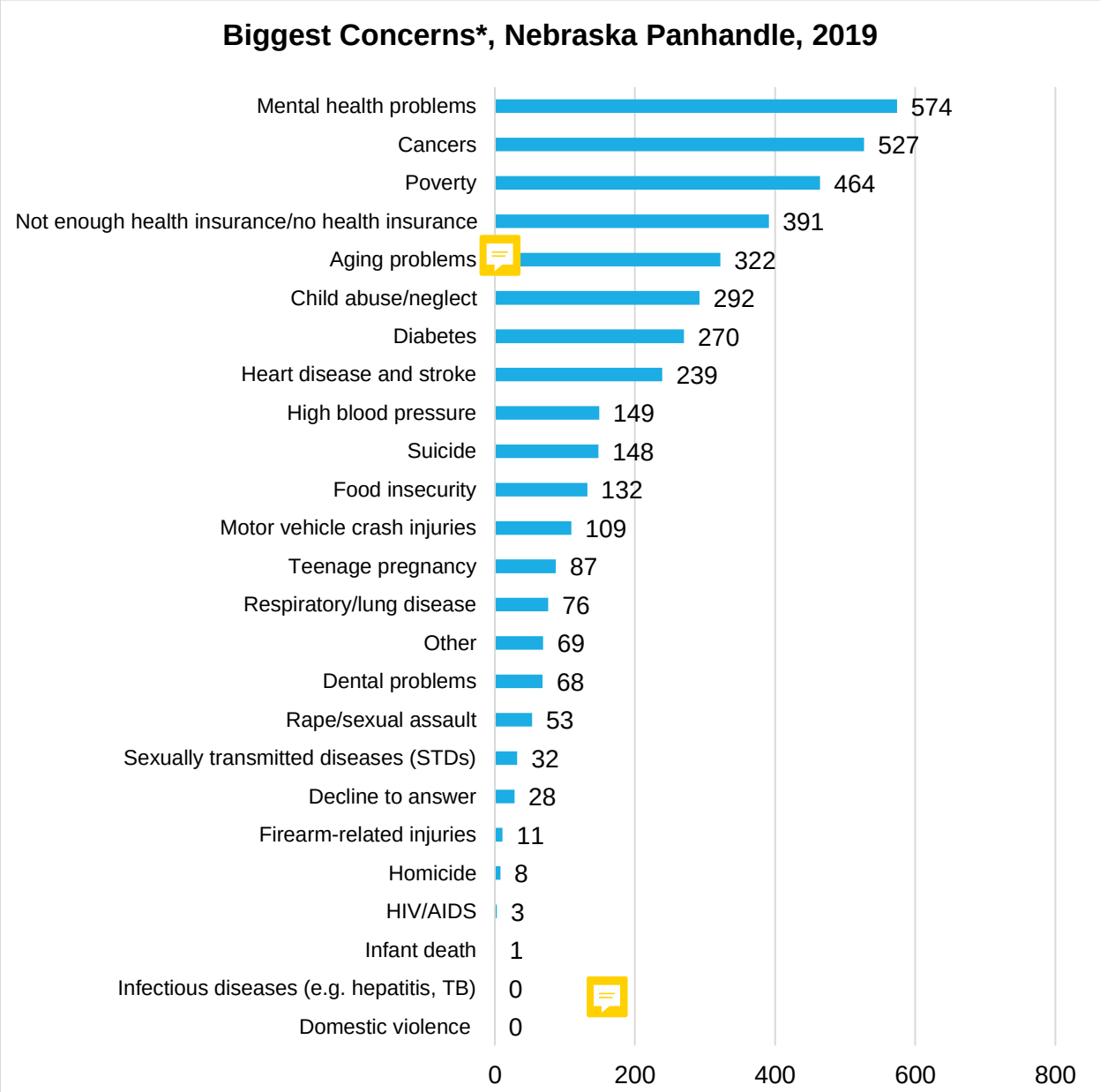


*Original Question: In the following list, what do you think are the 3 most important "risky behaviors" in our community? (those behaviors that have the greatest impact on overall community health and wellness). Check only 3. Data from 2019 Panhandle Public Health District Community Health Survey. Prepared 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 poverty, followed by not enough health insurance/underinsurance, aging problems, and child abuse/neglect. As with risky behaviors, the 2017 survey elicited similar results. The top three concerns from the 2017 survey were poverty, mental health problems, and cancers, followed by not enough health insurance/underinsurance, aging problems, 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? (concertns 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.

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 Panhandle is a geographically large region, 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 Panhandle is composed of **small communities**, in both geographical **size** and the **closeness of the residents**. Communities are **close-knit** and **welcoming**.
- The communities are full of **caring people**, that are **giving**, **friendly**, **helpful**, and **supportive**.
- **Opportunities for recreation** abound in the region, including both **outdoor access** and **community recreation**.
- The Panhandle is **family friendly**. It is a **safe**, **quiet**, and **relaxed** place to raise children.
- A consistent theme across all Panhandle communities are the **strong school systems**.
- **Lack of local health care** was noted in multiple communities.
- The region is largely **rooted in agriculture**.
- Communities are **isolated**, both geographically and from larger health care opportunities.
- The population in the Panhandle is **aging**.
- Communities are **growing**, as people return with their families and embrace new developments.
- The Panhandle is a **diverse** community, made up of different races and ages.
- The region has a **rich history**.

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**.
- **Opportunities for recreation** abound in the region, including both **outdoor access** and **community recreation**.
- A consistent theme across all Panhandle communities are the **strong school systems**.

Some strengths were new:

- The Panhandle has a lot of **community resources**, including shopping, businesses, and community assistance programs.
- Many Panhandle communities have strong **local healthcare** opportunities, including local **hospitals** and **clinics**. An emerging strength in healthcare is **mental health resources**.
- It is **welcoming** to newcomers.
- It has a **low cost of living** and is very affordable.
- It is **safe** and has low crime.
- There are options for **housing for older adults**.
- An emerging strength is **public transportation** within communities.

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. Out-migration led to **smaller class sizes in schools** and **aging communities**.
- **Schools declined** in many communities, largely due to **smaller class sizes, smaller tax base** (because of out-migration), and **less parent involvement**. However, some communities—particularly those small in size—indicated that **schools improved**.
- **Inadequate housing**, including low housing stock and run-down homes, increased.
- **Internet** has become widely available and has benefited employment in local businesses and home-based work.
- **Community resources** and **community recreation** are available.
- Although many communities experienced out-migration, some smaller communities experienced **in-migration** of new people.
- **Community pride** has grown.

COMMUNITY NEEDS

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

- **Employment** needs, including **lack of local job opportunities, lack of local workforce,** and **low wages**
- **Healthcare** needs, including complete lack of healthcare, **limited hours,** lack of **behavioral health** options (for mental health, alcohol, and drug use), and lack of **emergency care** options.
- **Senior care** options (both brick and mortar and **in-home care**) and **senior housing** options.
- **Local businesses**, such as **retail shopping, grocery stores,** and **restaurants**.
- **Community resources** to help those in need, specifically centered around minority populations, housing, and poverty.
- **Housing**, including low housing stock, cost of housing, and quality of housing.
- **Childcare** in general, and more specifically for those who work irregular hours.
- **Public transportation**, both within and between communities.
- **Community recreation**, such as local pools, recreation centers, and more.
- **Community pride** to keep communities maintained and in good shape.
- Enhance **travel to local communities** from other areas, via building roads or highways and maintaining or improving available lodging for out of town guests.

COMMUNITY INTERACTIONS

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

- Overall, the Panhandle is **accepting** and **racially diverse**.
- However, there are still instances of **discrimination** toward **minority races, LGBTQ+ individuals,** and those of lower **socioeconomic status**.
- **Older adults may engender discrimination** more than younger adults.
- Some community members report areas that are **lacking diversity** and are **slow to change**.
- **Differently-abled individuals do not face discrimination**, but although they find themselves accepted, they still struggle with local infrastructure (e.g., sidewalks that are not wheelchair friendly).
- The Panhandle possesses some large **political divides**.
- Panhandle communities experience **geographical divides**, where minority or lower income individuals may live in specific pockets of the community.

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.

Community members discussed their biggest concern (ordered most important to least important):

1. **Behavioral health**, including **drug abuse, alcohol abuse**, and **mental health needs**.
2. **Access to healthcare.**
3. **Overweight**, **obesity**, and **poor nutrition**.
4. **Cancer.**
5. **Poverty.**
6. **Tobacco use.**
7. **Aging-related problems.**

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.
- **Diabetes** and **access to healthy foods**.
- **Local healthcare**, especially in the more rural communities.
- **Behavioral health**, specifically **alcohol abuse, mental health,** and **suicide**.
- **Poverty**.
- **Crime**.
- **Health insurance**, including obtaining and affording health insurance.
- **Heart disease**.
- **Housing**.
- **Tobacco use**.
- **Transportation**.

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

A prioritization process to identify strategic issues to focus on in the Community Health Improvement Plan (CHIP) was completed through a virtual consensus workshop in September 2020. 39 people attended the meeting.

The agenda was as follows: Introductions, Consensus Workshop, Conclusion.

Prior to the virtual workshop, a highlight of the 2020 CHA data was distributed to those invited to the meeting, and a pre-meeting prioritization survey was completed. Respondents reviewed the data highlights and used the information to rank the potential priority areas for the CHIP. Respondents also had the opportunity to note any areas they felt were missing. The list of attendees from this meeting can be found in Appendix F.

The top priority areas from the pre-meeting survey, along with standout "missing" areas were brought forward to the prioritization meeting:

- Drug abuse
- Alcohol abuse
- Housing
- Childcare
- Being overweight
- Mental health problems
- Poverty
- Child abuse/neglect
- Cancers
- Childcare
- Homelessness
- Access to care
- Transportation for aging population

A Technology of Participation (ToP) consensus workshop was completed to narrow and name the priority areas. Final priority areas for the 2021-2023 CHIP are:

Priority Area 1:	Behavioral Health • Mental well-being • Suicide prevention & support • Substance abuse prevention
Priority Area 2:	Housing & Homelessness
Priority Area 3:	Early Childhood Care & Education
Priority Area 4:	Chronic Disease Prevention • Cancer prevention • Diabetes prevention • Heart disease prevention • Risk factors

Keeping an intentional focus on strategies that address child abuse/neglect, poverty, and access across all areas.

2021-2023 Panhandle Community Health Improvement Plan Priority Areas

Behavioral Health

- Mental Well-Being
- Suicide Prevention & Support
- Substance Abuse Prevention

Housing & Homelessness

Early Childhood Care & Education

Chronic Disease Prevention

- Cancer Prevention
- Diabetes Prevention
- Heart Disease Prevention
- Risk Factors

Strategies focusing on Child Abuse/Neglect || Poverty || Access

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 = 142)

		#	%
County	Banner	3	2.1%
	Box Butte	16	11.3%
	Cheyenne	7	4.9%
	Dawes	13	9.2%
	Deuel	6	4.2%
	Garden	9	6.3%
	Grant	5	3.5%
	Kimball	12	8.5%
	Morrill	11	7.7%
	Scotts Bluff	31	21.8%
	Sheridan	17	12.0%
	Sioux	11	7.7%
	Other	1	0.7%
Gender Identity	Male	43	30.3%
	Female	98	69.0%
	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	1	0.7%
	Other	0	0.0%
Sexual Orientation	Heterosexual or straight	140	98.6%
	Gay or lesbian	0	0.0%
	Bisexual	0	0.0%
	Decline to answer	2	1.4%
	Other	0	0.0%
Highest level of education	Less than high school graduate	2	1.4%
	High school diploma or GED	29	20.4%
	Associates or Technical Degree	31	21.8%
	College degree or higher	77	54.2%
	Decline to answer	3	2.1%
	Other	0	0.0%

		#	%
Race	White	123	86.6%
	Black or African American	1	0.7%
	Asian	2	1.4%
	Native Hawaiian or Other Pacific Islander	0	0.0%
	American Indian or Alaska Native	8	5.6%
	Decline to answer	3	2.1%
	Other	5	3.5%
Hispanic or Latino/a/x	Yes	10	7.0%
	No	127	89.4%
	Decline to answer	5	3.5%
Age	Under 18 years	2	1.4%
	18-25 years	7	4.9%
	26-39 years	32	22.5%
	40-54 years	34	23.9%
	55-64 years	35	24.6%
	65-80 years	23	16.2%
	Over 80 years	7	4.9%
	Decline to answer	0	0.0%
Marital Status	Married/Partnered	98	69.0%
	Divorced	18	12.7%
	Never married	12	8.5%
	Separated	2	1.4%
	Widowed	8	5.6%
	Decline to answer	4	2.8%
	Other	0	0.0%
Household Income	Less than $20,000	6	4.2%
	$20,000 to $29,999	4	2.8%
	$30,000 to $49,999	38	26.8%
	$50,000 to $74,999	21	14.8%
	$75,000 to $99,999	26	18.3%
	Over $100,000	25	17.6%
	Decline to answer	22	15.5%

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

APPENDIX F: PRIORITIZATION MEETING ATTENDEE LIST

Name:	Organization:
Kelsey Irvine	Panhandle Public Health District
Sara Williamson	Panhandle Public Health District
Marie Parker	Banner County School
Ginger Meyer	Chadron Public Schools
Patrick Ningen	Creek Valley Schools
Tabi Prochazka	Panhandle Public Health District
Boni Carrell	RNHN
Starr Lehl	City of Scottsbluff
Laura Bateman	Kimball Health Services
Evie Parsons	Sidney Regional Medical Center
Tammy Meier	Sidney Regional Medical Center
Kevin Spencer	Scottsbluff Police Dept.
Travis Miller	Bayard Public Schools
Jessica Davies	Panhandle Public Health District
Dan Newhoff	Box Butte General Hospital
Rhonda Theiler	Perkins County
Nicole Berosek	Panhandle Public Health District
Steph Black	United Way
Patricia Stetson-Warning	First Presbyterian Gordon
Tim Cody	Minatare Schools
Holly Brandt	Region I
Jonnie Kusek	Panhandle Trails ICB
Kim Engel	Panhandle Public Health District
Mo Hanks	Crawford Public Schools
Sandy Montague-Roes	Western Community Health Resources
Paulette Schnell	Regional West Medical Center/Scotts Bluff County Health Dept.
Dixann Krajewski	Garden Co. Commissioner
Robin Stuart	Morrill County Community Hospital
Britt Miller	Chappell Community Development
Cheri Farris	Panhandle Public Health District
Neil Hilton	Perkins County Health Services
Steve Trickler	Aging Office of Western Nebraska
Susanna Batterman	Morrill Co. Commissioner
Ashley Hobbs	Scottsbluff Public Schools
Jennie Moffat	Regional West Garden County
Tyson Lambertson	The Rock Church
Mandi Raffelson	Sidney Regional Medical Center
Kendra Dean	Cirrus House
Joshua Vesper	Western Nebraska Community College

Addendum 1:

2022

Minority Health Assessment of the Nebraska Panhandle

Approved 4/14/2022

PREPARED BY

Megan Barhafer and Kelsy Sasse
Panhandle Public Health District

IN COLLABORATION WITH

Marina Girard

Valeria Rodriguez

Jackie Guzman

Melissa Misegadis

Misty Curtis

Anna Licking

Angie Hoff

Arthur Harvey

Emily Lodahl

Richard Riley

Ladessa Heimbouch

Martin Vargas

FOR MORE INFORMATION

www.pphd.org

CONTACT

Panhandle Public Health District
P.O. Box 337
Hemingford, NE 69348

Kim Engel, Health Director
kengel@pphd.org
(308)487-3600

Panhandle
Public Health District

FORWARD

The Center for Disease Control defines health disparities as preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

PPHD was given the opportunity in 2021 and 2022 to take a deeper dive into assessing non-white and white/Hispanic populations in the Panhandle. Mobilizing for Action through Planning and Partnership was used as the evidence-based process for assessment and planning. Our first step was to form a Minority Health Advisory Committee to guide the work. PPHD would like to recognize the committee members listed on the previous page and express our sincere gratitude for sharing their time, wisdom, and experiences.

The findings of this assessment, and the strategies selected to address the priority areas, will be integrated into the Regional 2020 Community Health Assessment and 2021 Community Health Improvement Plan. The goal of MAPP is optimal community health – a community where all residents are healthy, safe, and have a high quality of life.

We want to thank you for your participation and encourage you to continue to be engaged in helping solve these complex issues.

Kim Engel
Director

Contents

FIGURES

INTRODUCTION

Panhandle Public Health District (PPHD) was awarded a grant through the Nebraska Office of Health Disparities and Health Equity in the summer of 2021. The grant intended to conduct community health needs assessment for the non-white and white/Hispanic populations in the Panhandle. This assessment improves on efforts by the public health district to include racially minoritized communities in the community health assessment conducted every 3 years. Throughout this assessment, you will see data from both this cycle of data collection and data from the regional community health assessment completed in 2020. This assessment follows the Mobilizing for Action through Planning and Partnership methods.

The needs of the communities surveyed echo the themes present in the community health needs assessment. Thus, some work is being done for the general population to address the challenges brought up in both assessments. However, during this process, PPHD was better able to pull out the specific needs identified by the minoritized populations in the Panhandle. PPHD would like to thank the communities that participated in the surveys and focus groups for sharing their stories.

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 Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) development process in the Panhandle since 2011 and continued to be used for this Minority Health Needs Assessment (MHNA). 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 implementation plans.

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

The Health in Disproportionately Affected Community advisory committee (referred to henceforth as advisory committee) was formed in October of 2021. The committee members were invited because of their work with minoritized communities. A charter describing the intent of the group can be found in Appendix A. Committee members guide throughout the assessment 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. This committee will be integrated into the Community Health Improvement process as their availability allows. The committee members will be invited to join the next MAPP steering committee meeting to share success and build relationships with other committee members. Additionally, MAPP steering committee and CHIP committee members will be invited to join cultural competency trainings and meetings organized by the advisory committee. This will ensure that communication between all MAPP participants is consistent, encouraging continued partnership building.

ADVISORY COMMITTEE MEMBERS

Box Butte General Hospital	Marina Girard
Empowering Families/Immigrant Legal Center	Valeria Rodriguez
Empowering Families/Panhandle Research & Extension Center	Jackie Guzman
Guardian Light Family Services	Melissa Misegadis
Gordon-Rushville Public School	Misty Curtis Anna Licking
Nebraska Commission for Blind and Visually Impaired	Angie Hoff
Nebraska Minority Resource Center	Arthur Harvey Emily Lodahl
Open Range Beef	Richard Riley
Panhandle Public Health District	Kim Engel Jessica Davies Tabi Prochazka Kelsy Sasse Megan Barhafer Vianey Zitterkopf Janet Felix Myrna Hernandez
Panhandle Equality	Ladessa Heimbouch
Regional West Medical Center	Martin Vargas

MAPP PHASE 2: VISIONING

The visioning process took place with the advisory committee members during the December meeting. The meeting minutes can be found in Appendix B.

2022 HEALTH EQUITY VISION

What does health equity look like in the Panhandle?							
Housing	**Violence Prevention and Awareness**	**Address Upstream Barriers**	**Increase Service Availability, Variety, Awareness**	**Healthcare Cost and Affordability**	**Culturally Competent Services**	**Quality of Life**	**Reducing Poverty**
• Access to safe and affordable housing • Non-discrimination in housing	• Equal treatment by the justice system • Safe environmental conditions • Emergency housing	• Preventative care • Bilingual services • Social service group to assist with language services • Interpreter advocacy for expanded services • Provider awareness of programs • Central navigation at hospitals to social services	• Easier access to healthcare via transportation and cost • More access to foster homes that are trauma-informed • Access to services • Behavioral health access • No cost to and from appointment • More • outreach • Education opportunities • Child & teen mental health services	• More reasonable sliding scale for appointments • Affordable or free options for health needs across the lifespan • Fair treatment of people needing to use sliding scale services • Availability of healthcare coverage • Equal treatment from providers	• Healthcare professionals who are representative of the community • Equal access to the health care system – language and cost • Welcoming health facilities • Culturally competent programs	• Equal priority and quality of life • Affordable and nutritious food in every community • Universal design for people with disabilities	• Fair/Living wages • Education opportunities • Jobs with benefits

As a part of the visioning process, the advisory committee helped to create a victory circle. During this process, committee members were asked to imagine themselves two years in the future and think about what had been accomplished if we were successful in achieving the vision.

Figure 1: 24 Month Victory Circle

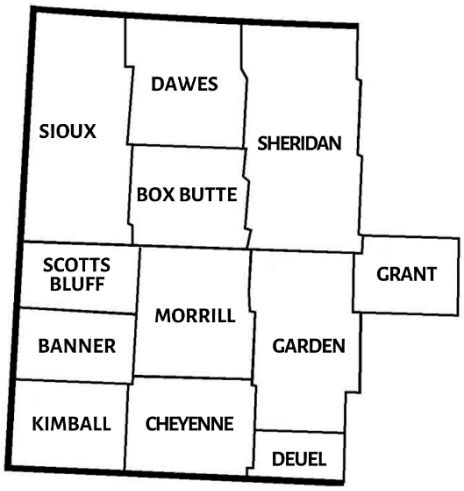
MAPP PHASE 3: FOUR MAPP ASSESSMENTS

COMMUNITY HEALTH STATUS ASSESSMENT

COMMUNITY PROFILE

The Nebraska Panhandle is a rural region on the high plains, surrounded by neighbors of Wyoming to the west, Colorado to the south, and South Dakota to the north. However, it has a significant population of Hispanic/Latino and Native American people that call this place home. Yet, racism, lack of services, and cultural differences leave gaps in the healthcare and economic systems that people in these racial groups can fall through.

The geographic Nebraska Panhandle consists of the counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Grant, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux. The PPHD service area will be referred to as the Panhandle throughout this document. Despite some counties having less than 1000 people who are non-white or white/Hispanic, it is important to consider the whole region to serve all people of color in the region. Some counties are not as well represented in the data due to small populations, but this document assumes spatial similarity in those areas.



PPHD Service Area Quick Facts:
Population: 83,841
Unemployment rate: 3.9%
Total land area: 14,963 square miles

Source: 2015-2020 American Community Survey 5-Year Estimates

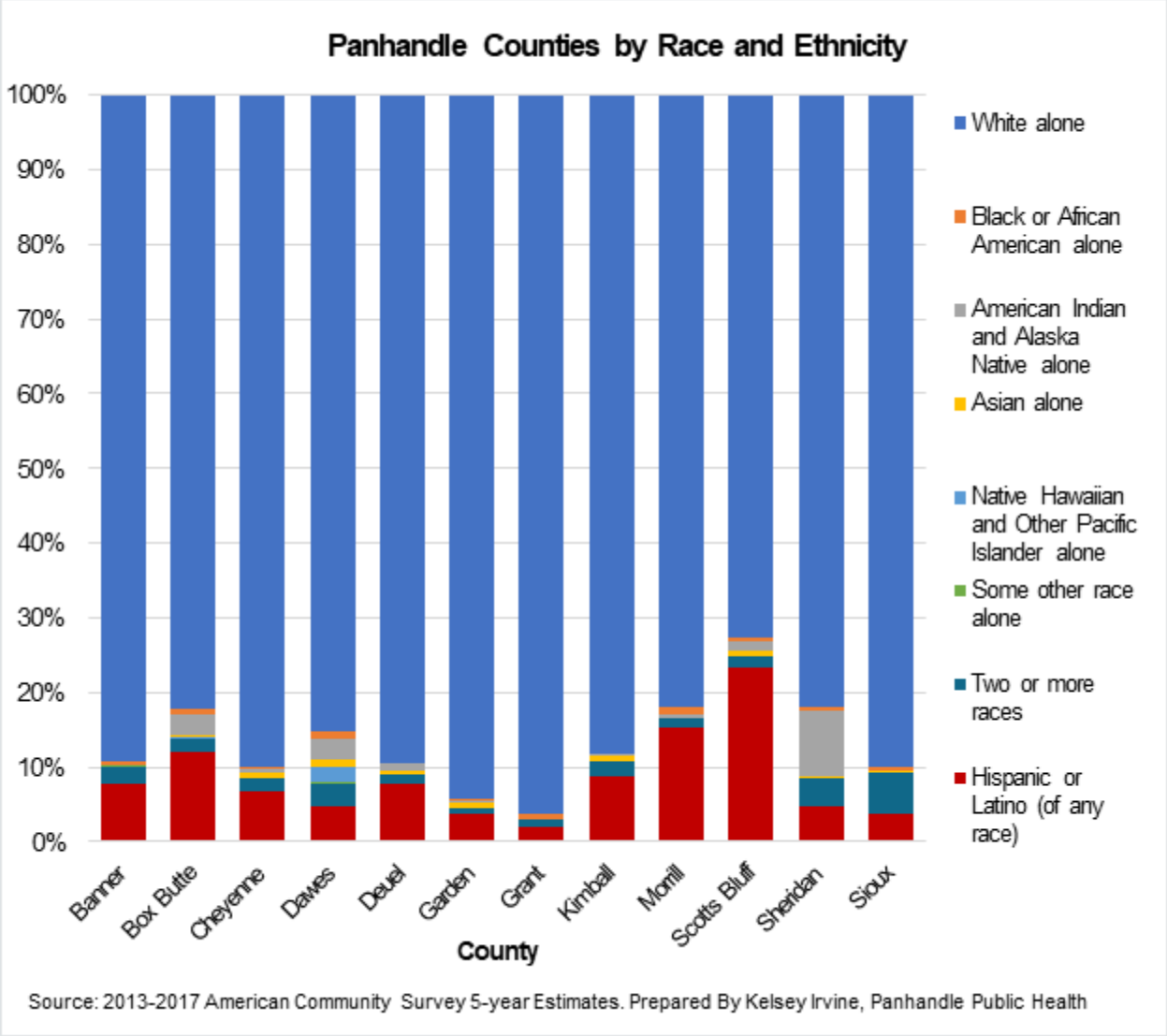
POPULATION

America's health and economic disparities have long existed along racial and ethnic lines due to systemic oppression and racist legacy. 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.

In the Nebraska Panhandle, the majority race is non-Hispanic White, but some communities have Hispanic persons making up 15 to 30 percent of their population and some also have relatively large Indigenous populations. Scotts Bluff and Morrill counties show higher Hispanic populations while Sheridan County shows an almost 10% Indigenous population. As the high English

proficiency and low foreign-born rates show, many Hispanic families have been in the area for multiple generations.

Figure 2: Panhandle Counties by Race and Ethnicity



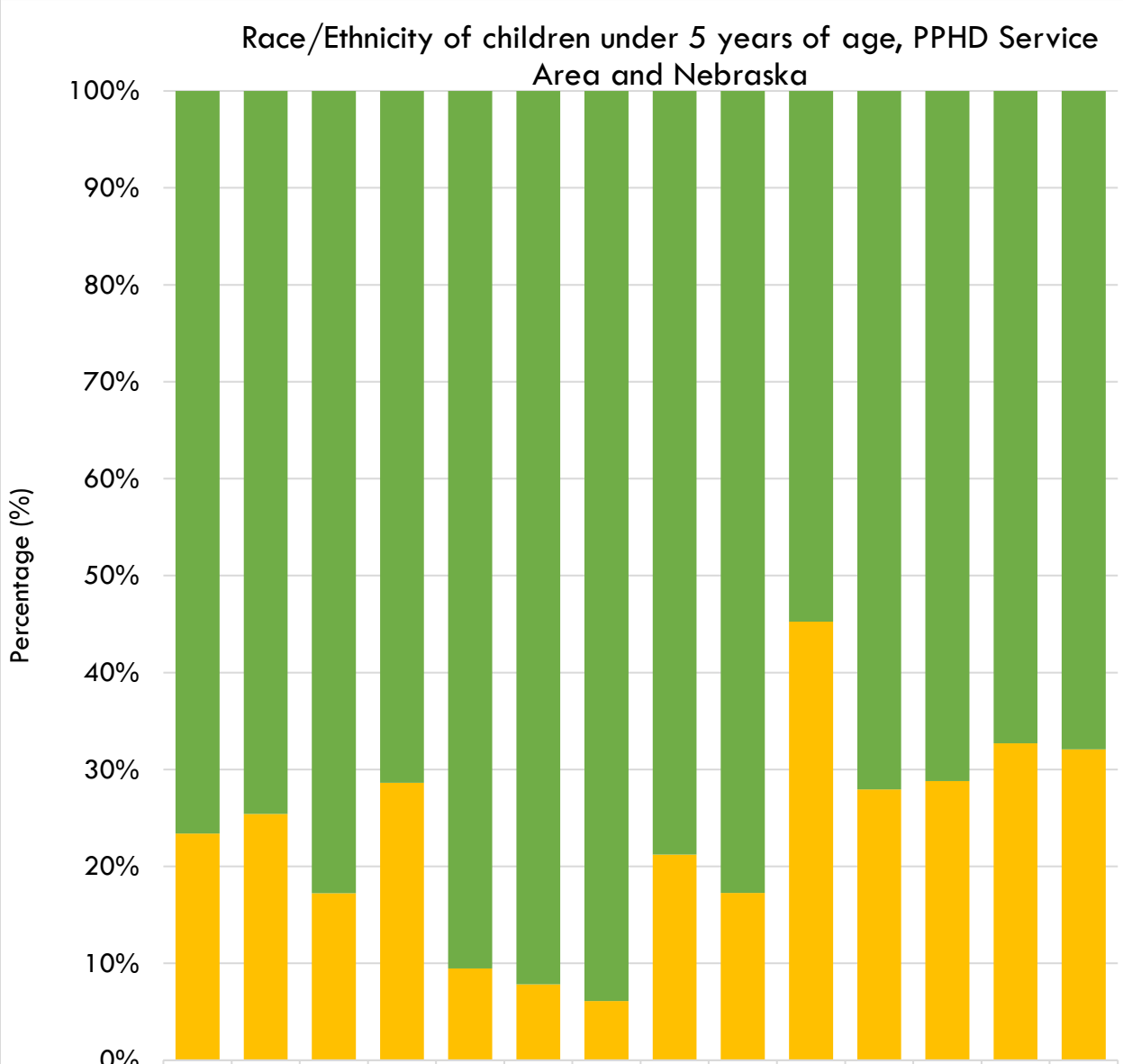
Like the rest of Nebraska, younger generations of new Nebraskans born to Hispanic or Latino families are the driver behind the growth of Hispanic or Latino populations in the region. However, unlike other parts of Nebraska, the Panhandle's Hispanic population is largely US-born and has been for decades. New generations of Nebraskans in the Panhandle born to Hispanic families are often second, third, or fourth-generation Americans. This fact often means that language barriers that do exist in our communities are overlooked or viewed as not that important. Anecdotally, the population of community members who have limited English proficiency is increasing as new populations move to the Panhandle. This is currently speculation until the 2020 Census numbers are released. By comparing the number of households that speak a language other than English at home, notably, the preferred languages are different than the languages that people can speak at high proficiency.

Table 1. English proficiency vs. language spoken at home by percentage of community members in each county. (Prepared by Megan Barhafer, Source: 2015-2020 American Community Survey)

	United States	Nebraska	Banner Co.	Box Butte Co.	Cheyenne Co.	Dawes Co.	Deuel Co.
Speak English less than "very well"	8.5%	5.0%	1.4%	0%	0%	0.2%	1.8%
Households speaking a language other than English			6.8%	10.5%	4.6%	2.6%	5.5%
	Garden Co.	**Grant Co.**	**Kimball Co.**	**Morrill Co.**	**Scotts Bluff Co.**	**Sheridan Co.**	**Sioux Co.**
Speak English less than "very well"	0.3%	0.0%	1.6%	0.9%	2.0%	0.2%	3.5%
Households speaking a language other than English	2.8%	0.7%	5%	11.7%	12.9%	6.3%	4.8%

The population in younger age groups is generally more diverse than that of the general population. In Dawes, Sheridan, and Sioux Counties nearly or over one-third of all children were counted to be of minority race or ethnicity (something other than non-Hispanic, White).

Figure 3: 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
White alone	77%	75%	83%	71%	91%	92%	94%	79%	83%	55%	72%	71%	67%	68%
Minority	23%	25%	17%	29%	9%	8%	6%	21%	17%	45%	28%	29%	33%	32%

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 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.

RACE AND POVERTY

By race, American Indian and Hispanic or Latino origin (of any race) are the largest minority groups in the Panhandle and have poverty rates higher than the area average. The white (not Hispanic) race had the lowest prevalence of poverty.

Figure 4: Percent of all Population with Income in past 12 Months Below Poverty Level, by Race and Ethnicity

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%**

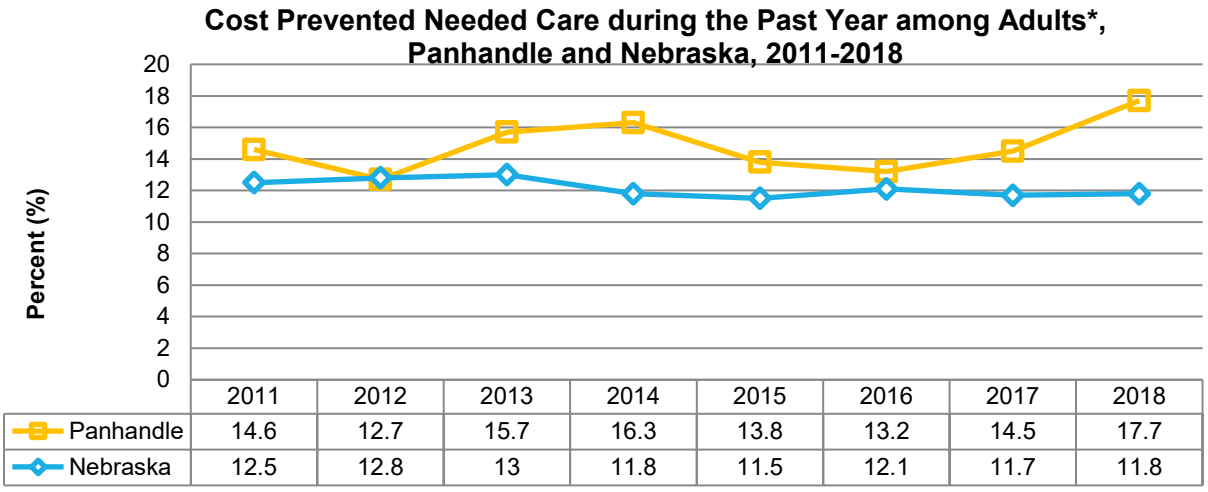
Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Prepared by Kelsey Irvine, Panhandle Public Health District.

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. Medicaid Expansion was passed in 2018 and was implemented in 2020 so data available does not reflect the impact of this legislative change.

Figure 5 Cost Prevented Needed Care During the Past Year Among Adults



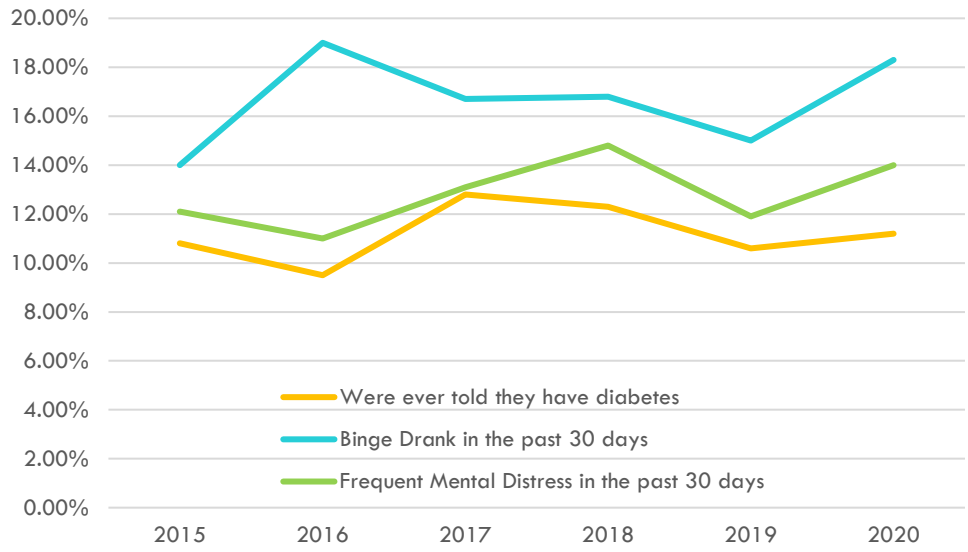
	2011	2012	2013	2014	2015	2016	2017	2018
Panhandle	14.6	12.7	15.7	16.3	13.8	13.2	14.5	17.7
Nebraska	12.5	12.8	13	11.8	11.5	12.1	11.7	11.8

*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.

CHRONIC DISEASE

From the Nebraska Behavioral Risk Factor Surveillance System, there is a slight increase over the past two years in the number of adults from the Panhandle of Nebraska, 18 and older who reported they were ever told they have diabetes (excluding pregnancy), binge drank in the past 30 days, and had experienced frequent mental distress in the past 30 days.

Figure 6 Panhandle specific BRFSS data about the top three health concerns from the MHI Survey

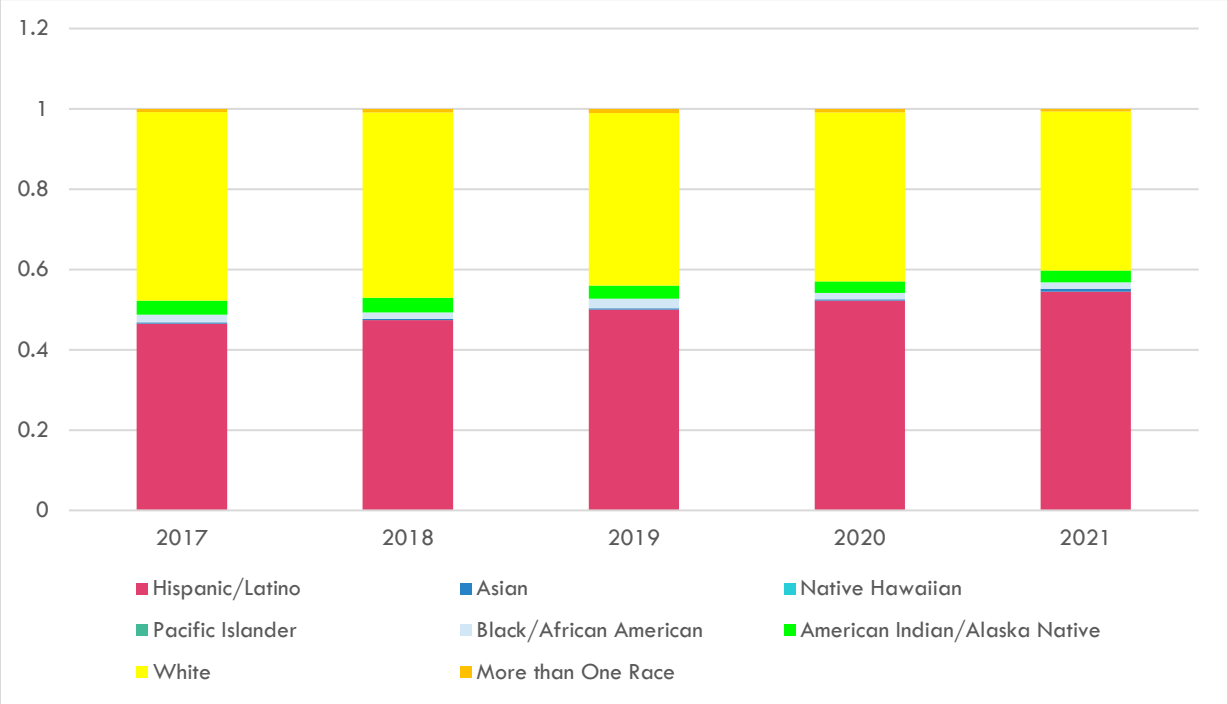


Source: 2015-2020 Nebraska Behavioral Risk Factor Surveillance System (BRFSS); Prepared by Kelsy Sasse Panhandle Public Health District

DIABETES

The Federally Qualified Heath Center in the Panhandle is called Community Action Partnership of Western Nebraska, CAPWN. CAPWN has a health center, dental clinic and behavioral health center located in Gering Nebraska. There is also a second dental clinic location in Chadron, NE. CAPWN was able to pull diabetes data from their client base that is broken out by race to better examine disparities. While not comprehensive, it provides a picture of health disparities in the Panhandle based on a population that is primarily low-income. The prevalence of clients with diabetes by race indicates that of the clients that present to the CAPWN health clinic with diabetes a higher proportion of clients who are Hispanic/Latino experience diabetes. Unfortunately, the percent of patients affected by race was not available so this could be because more Hispanic/Latino patients visit CAPWN than white patients. Over time the proportion of patients presenting with diabetes that are Hispanic/Latino has increased while the proportion of patients presenting with diabetes that are White, non-Hispanic/Latino has decreased.

Figure 7 CAPWN Client Diabetes Prevalence by Race and Ethnicity

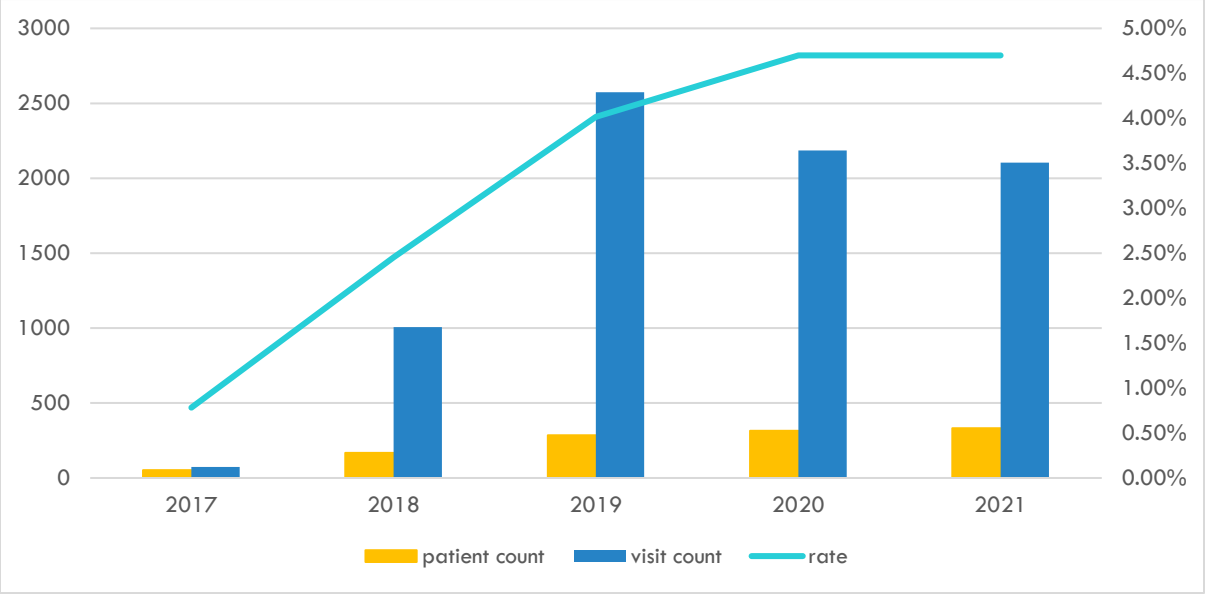


*Percentage of Adults 18-75 by race who presented to CAPWN with diabetes by race and ethnicity. Prepared by Megan Barhafer, Panhandle Public Health District.

BEHAVIORAL HEALTH

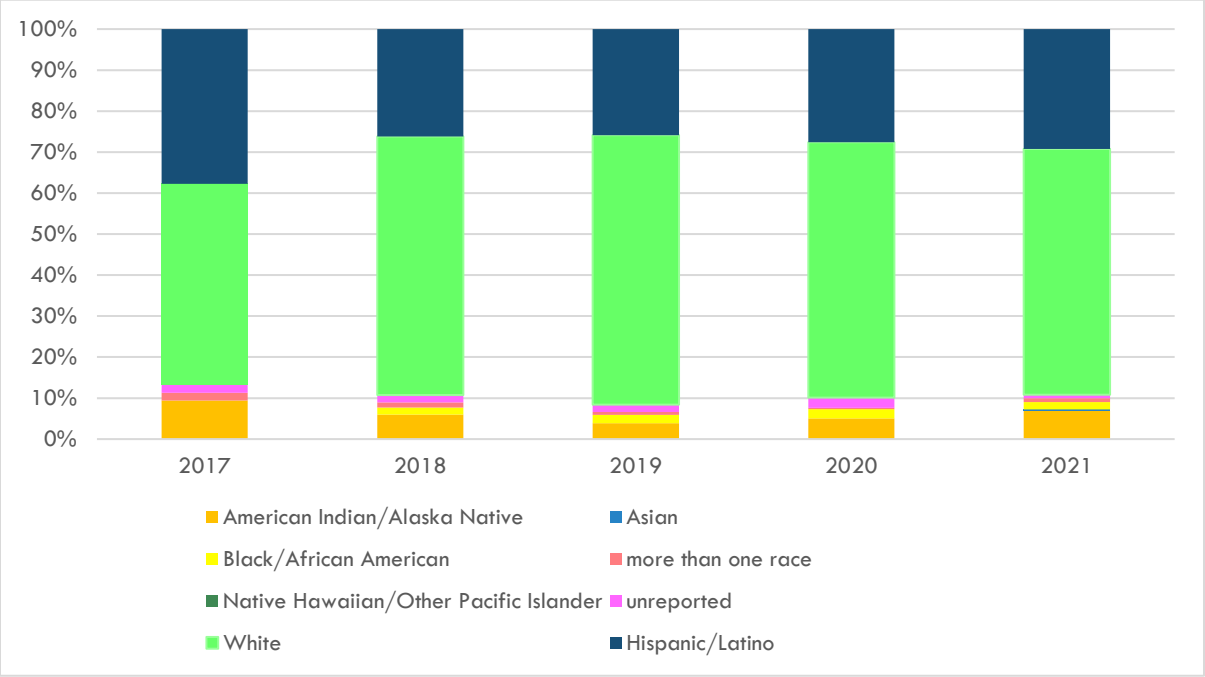
CAPWN was able to pull Alcohol-related disorder data from their client base that is broken out by race to better examine disparities. While not comprehensive, it provides a picture of health disparities in the Panhandle based on a population that is primarily low-income. Again, this data does not show the rate of alcohol related disorders by race but does show the overall rate of alcohol-related disorders experienced by CAPWN patients.

Figure 8 Alcohol-Related Disorders over Time



Source: Data from CAPWN Electronic Health Records. Prepared by: Morgan Weitzel, CAPWN

Figure 9 Alcohol-Related Disorders by Race and Ethnicity



Source: Data from CAPWN Electronic Health Records. Prepared by: Morgan Weitzel, CAPWN and Megan Barhafer, PPHD

COMMUNITY MINORITY HEALTH ASSESSMENT (Community themes and strengths assessment)

The Community Minority Health Assessment is made up of two parts: the Minority Health Survey and community Focus Groups. The top areas of concern for community members of minority populations are determined from these two resources.

MINORITY HEALTH SURVEY

The Minority Health Survey was distributed to Panhandle residents from November 2021 through February of 2022 via paper survey. See Appendix E for a copy of the survey. Paper copies of the survey were distributed by PPHD staff at 61 different locations in 12 Panhandle Counties. Counts and percentages from the survey responses were calculated using Microsoft Excel.

515 Panhandle community members, from 11 Counties (including South Dakota Residents) responded to the Minority Health Survey. Minority respondents from South Dakota were included in the findings as these surveys were collected by their employer in Sheridan County. These employees and residents work and utilize services in Sheridan County. 61% of respondents were from a racial or ethnic minority group. The data included in this report focuses solely on the data received from those minority populations.

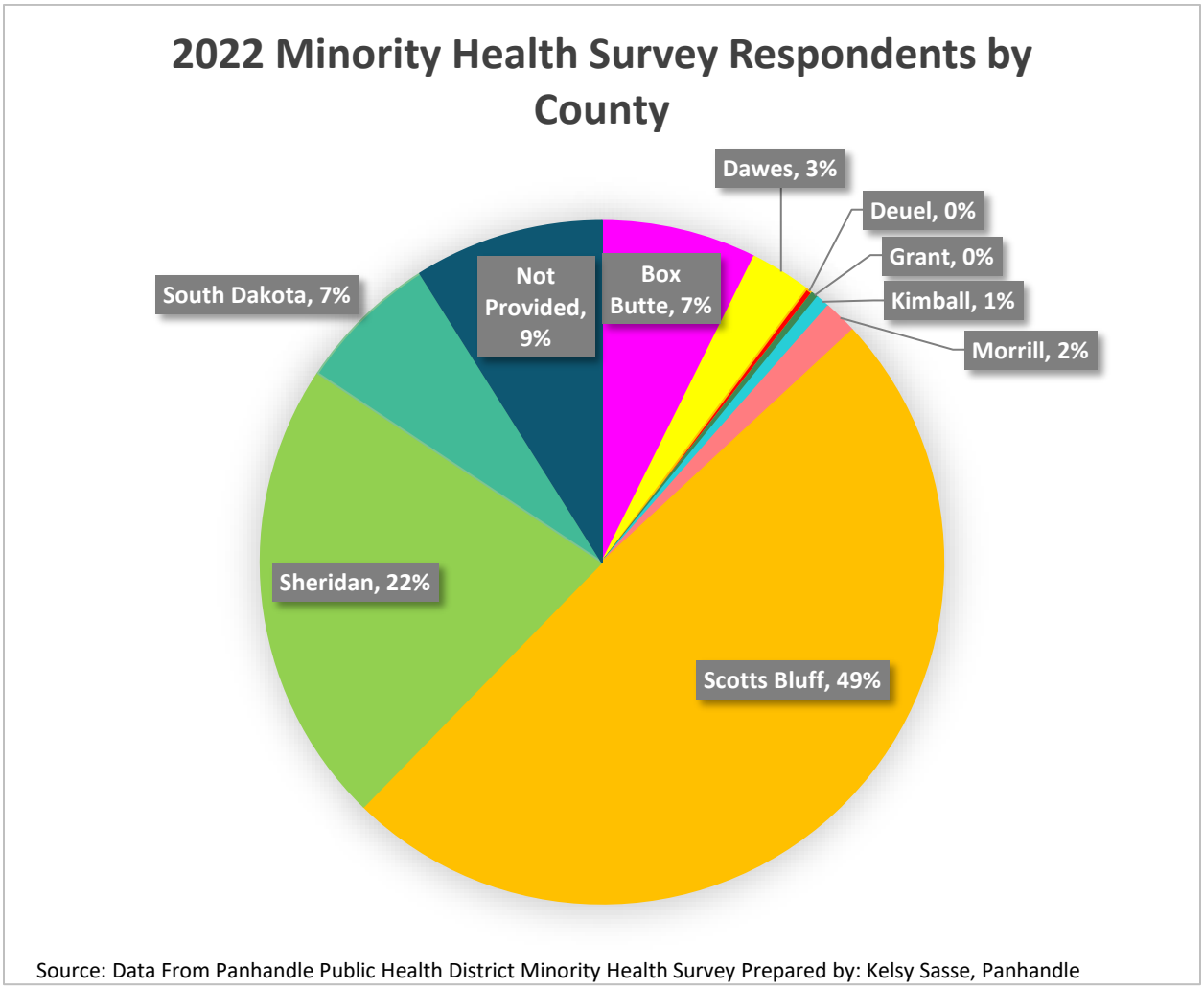


Figure 10: Minority Health Survey Respondents by County

RESPONDENT DEMOGRAPHIC INFORMATION

Figure 11: Minority Health Survey Selected Demographic Information, N= 313

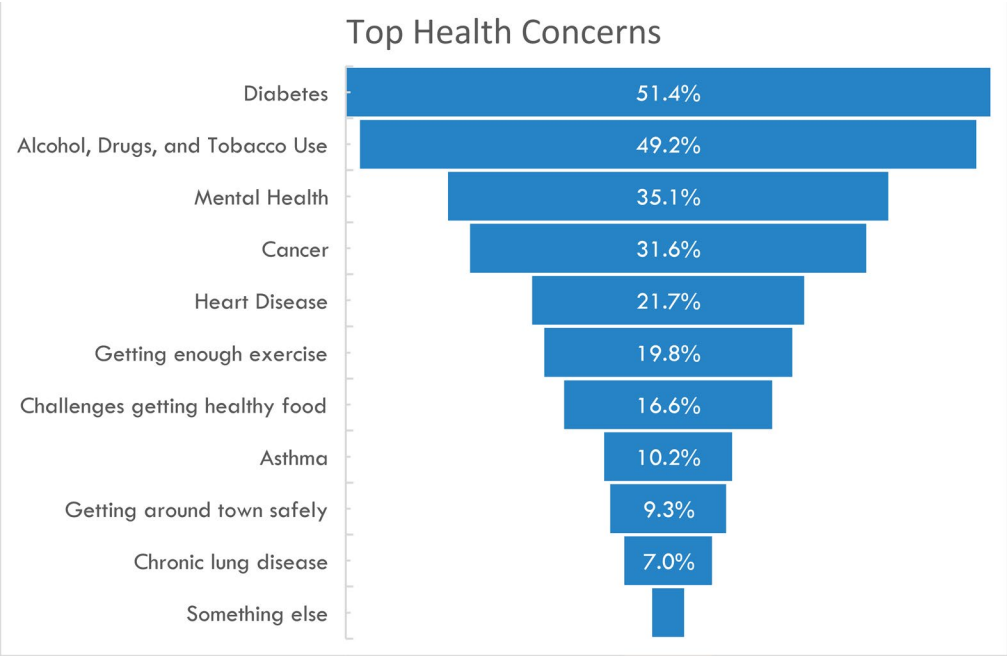
	#	%
Gender identity		
Male	87	27.8%
Female	93	29.7%
Transgender male (female to male)	1	0.3%
Transgender female (male to female)	0	0.0%
Gender non-conforming	1	0.3%
Decline to answer	131	41.9%
Other	0	0.0%
Sexual Orientation		
Heterosexual or straight	179	57.2%
Gay or lesbian	9	2.9%
Bisexual	8	2.6%
Decline to answer	113	36.1%
Other	4	1.2%

	#	%
Race/Ethnicity		
White	76	24.3%
Black or African American	9	2.9%
Asian	5	1.6%
American Indian or Alaska Native	96	30.6%
Decline to answer	67	21.4%
Other	60	19.2%
Hispanic/Latino	*192*	*61.3%*
Age		
18-25 Years	33	10.5%
26-39 Years	56	17.9%
40-54 Years	75	24.0%
55-64 Years	38	12.1%
65-80 Years	24	7.7%
Over 80 Years	4	1.3%
Decline to answer	83	26.5%

Demographic information for the respondents to the 2022 Minority Health Survey can be found in the table above. There was a relatively even balance of male (27.8%) to female respondents (29.7%). Many participants indicated that they were heterosexual or straight (57.2%) or had declined to answer that question (36.1%). There was a relatively even distribution in terms of age with 10.5% aged 18-25, 17.9% 26-39, 24% 40-54, 12.1% 55-64, 7.7% 65-80 1.3% Over 80 and 26.5% declining to answer. We had a large Native American Population surveyed at 30.6% of respondents and over half (61.3%) of respondents indicated they were of Hispanic/Latino origin.

TOP HEALTH CONCERNS

Figure 12: Top health concerns chosen by survey participants in their respective communities



Data From Q3 of PPHD Minority Health Survey. Prepared by: Kelsy Sasse

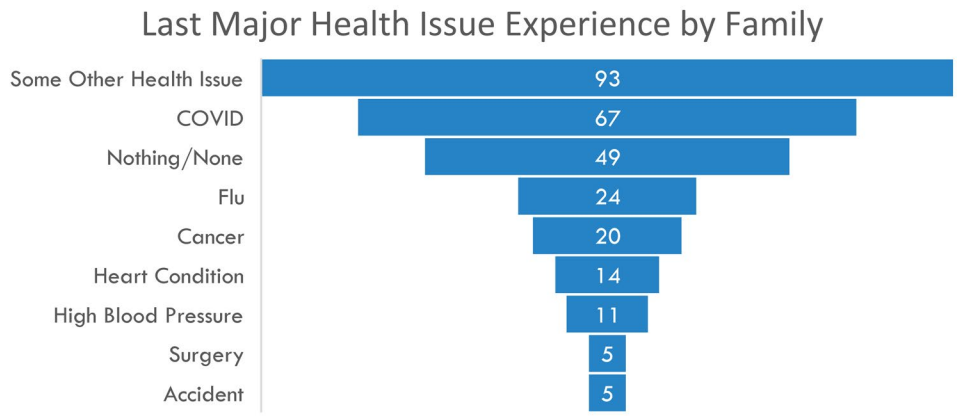
Participants were asked to choose the top three health concerns in their communities from a list of the following:

- Alcohol, Drugs and Tobacco Use
- Asthma
- Cancer
- Challenges getting healthy and affordable food
- Chronic Lung Disease (Asthma, COPD)
- Diabetes
- Getting around town safely (driving, walking, and riding)
- Getting enough exercise
- heart disease (for example, high blood pressure, stroke, etc.)
- Mental Health (for example, depression, anxiety, post-traumatic stress, suicide, eating disorders, etc.)
- Something else.

The top three health concerns were Diabetes (51.4%) Alcohol, Drugs and Tobacco Use (49.2%) and Mental Health (35.1%). This data was consistent with the data collected as part of the regional community health assessment.

MOST RECENT HEALTH ISSUE EXPERIENCED

Figure 13: Health concerns most recently experienced by respondents and/or families



Data from Q1 PPHD Minority Health Survey; Prepared by Kelsy Sasse, Panhandle Public Health District

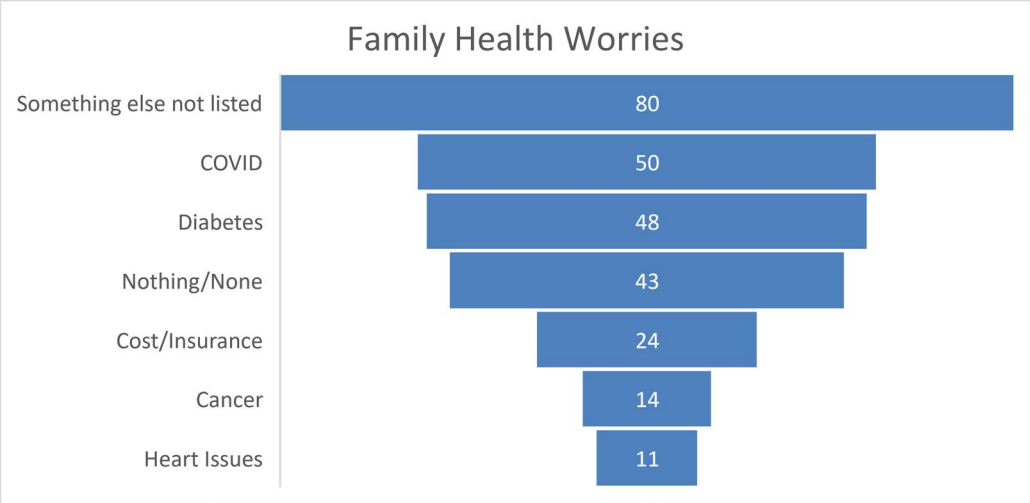
When asked what the last major health issue that they or their family experienced was, 41 survey participants did not respond to the question. 93 people listed health issues that had little or no duplication between respondents. These health issues are included in Figure 14 in a lighter color. COVID-19 was mentioned 67 times, no major health issue experienced was mentioned 49 times, diabetes was mentioned 25 times, the Flu was mentioned 24 times and Cancer was mentioned by participants 20 A small number of respondents mentioned heart conditions, high blood pressure, surgery, and an accident of some sort.

Figure 14: Words mentioned most often when describing most recent health issues

Data from Q1 PPHD Minority Health Survey; Prepared by Kelsy Sasse, Panhandle Public Health District

MOST RECENT HEALTH ISSUE EXPERIENCED

Figure 15: What worries respondents most about health or health of family



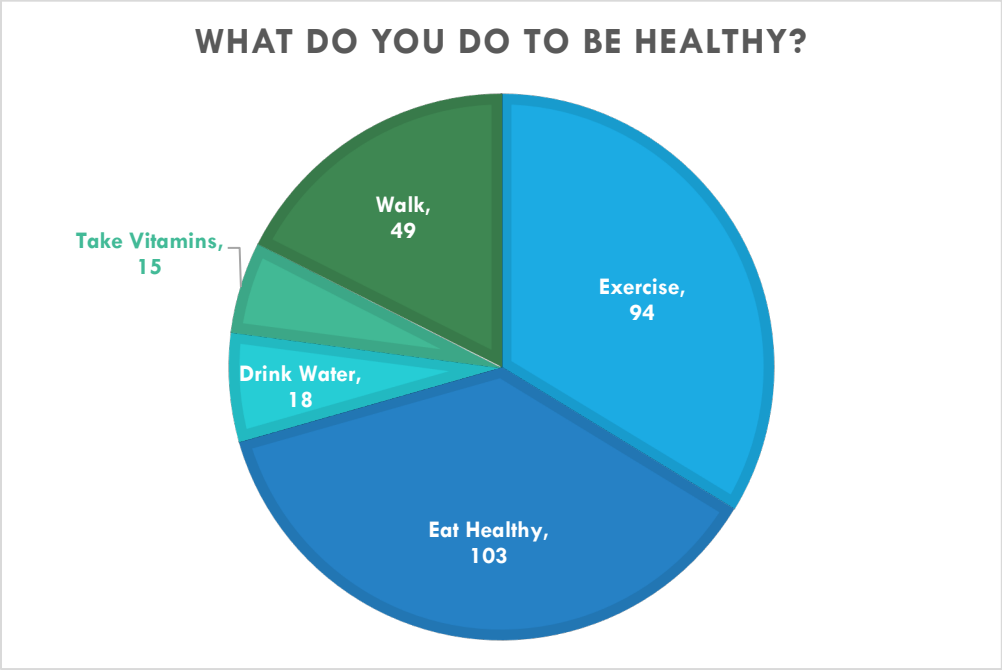
Data from Q2 PPHD Minority Health Survey; Prepared by Kelsy Sasse, Panhandle Public Health District

Similar results were found when participants were asked what worried them most about their health or the health of their family. 43 Survey participants did not respond to the question. Something else not listed in Figure 10 but can be seen mentioned in Figure 11 was mentioned 80 times. COVID-19 was mentioned 50 times, diabetes was mentioned 48 times, Nothing or no worries about health was mentioned 43 times, and healthcare cost and lack of insurance was mentioned 24 times. A small number of respondents mentioned cancer and heart issues.

Figure 16: Words mentioned most often when describing health worries and worries for family

Data from Q2 PPHD Minority Health Survey; Prepared by Kelsy Sasse, Panhandle Public Health District

Figure 17: Things or activities survey participants did to be healthy



Data from Q5 PPHD Minority Health Survey; Prepared by Kelsy Sasse, Panhandle Public Health District

When asked the question, "what is something you do to be healthy?" 32 participants did not respond to the question. Eating healthy was mentioned 103 times, Exercise or physical activity was mentioned 94 times, Walking was mentioned 49 times, drinking water was mentioned 18 times and taking vitamins and prescribed medication was mentioned 15 times.

Figure 18: Things or activities survey participants did to be healthy

Data from Q5 PPHD Minority Health Survey; Prepared by Kelsy Sasse, Panhandle Public Health District

FOCUS GROUPS

In collaboration with advisory committee members, PPHD staff reached out to community partners to schedule a series of focus groups across the Panhandle region. PPHD staff then recruited participants from minority populations via phone calls, emails, and social media to invite them to attend a focus group session. The intention for the focus groups was to collect deeper information directly from community members of underserved populations to better understand the issues they feel are important, their concerns, and their overall perception of their community. Focus groups were conducted from January to March 10th, 2022. A copy of the focus group template can be found in Appendix F As per the MAPP process, groups were intended to be made up of 8-10 people, although some variance occurred. In communities where we could not schedule a focus group due to time restrictions, weather, or lack of a strong community partner, key stakeholder interviews were conducted with a single member of that community to ensure we had representation from all areas of the panhandle.

PPHD staff facilitated the focus group sessions. Each focus group had a facilitator and a scribe and was approximately 60-90 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 by PPHD staff. Various forms and methods of content analysis were used to guide the analyzation process. Common themes and ideas were identified and compared cross-sectionally. Data was highlighted and sorted accordingly.

A total of 11 focus group sessions were held involving approximately 37 Nebraska Panhandle Residents.

DEMOGRAPHICS

	#	%
Gender identity		
Male	6	16.22%
Female	29	78.38%
Transgender male (female to male)	1	2.70%
Transgender female (male to female)	1	2.70%
Gender non-conforming	0	0.00%
Decline to answer	0	0.00%
Other	0	0.00%
Sexual Orientation		
Heterosexual or straight	26	70.27%
Gay or lesbian	4	10.81%
Bisexual	1	2.70%
Decline to answer	5	13.51%
Other	1	2.70%
Highest Level of Education		
Less than High School Graduate	5	13.51%
High School Diploma or GED	14	37.84%
Associates or Technical Degree	8	21.62%
College Degree or Higher	9	24.32%
Decline to answer	1	2.70%
Household Income		
Less than $20,000	15	40.54%
$20,000-$29,999	4	10.81%
$30,000-$49,999	5	13.51%
$50,000-$74,999	5	13.51%
$75,000-$99,999	1	2.70%
Over $100,000	1	2.70%
Decline to answer	6	16.22%

	#	%
Race/Ethnicity		
White	16	43.24%
Black or African American	0	0.00%
Asian	1	2.70%
Native Hawaiian or Pacific Islander	1	2.70%
American Indian or Alaska Native	14	37.84%
Decline to answer	1	2.70%
Other	4	10.81%
Hispanic/Latino	*15*	*40.54%*
Age		
Under 18 Years	1	2.70%
18-25 Years	1	2.70%
26-39 Years	6	16.22%
40-54 Years	12	32.43%
55-64 Years	8	21.62%
65-80 Years	7	18.92%
Over 80 Years	1	2.70%
Decline to answer	1	2.70%
Marital Status		
Married/Partnered	19	51.35%
Divorced	5	13.51%
Never Married	6	16.22%
Separated	2	5.41%
Widowed	3	8.11%
Decline to answer	1	2.70%
Other	1	2.70%
Military Status		
I serve(ed) in the Military	3	25.00%
My Husband, Wife or Significant other serves(ed) in the Military	1	8.33%
My child serves(ed) in the Military	2	16.67%
My parent serves(ed) in the Military	4	33.33%
My brother/sister serves(ed) in the Military	2	16.67%
Other	0	0.00%

Figure 19: Focus Group Demographics, N= 37

FOCUS GROUP FINDINGS

As you read through the focus group strengths and needs you will notice contradictions. This is because the Panhandle is a geographically large region, thus needs in one community may be a strength in another community, and vice versa. The blue highlighted words are phrases mentioned multiple times in the focus group while the bolded words and phrases are topics mentioned to support the blue words or phrases.

COMMUNITY DESCRIPTION

Community members described the community.

- The Panhandle is composed of **small communities**, in both geographical **size** and the **closeness of the residents**. Communities are **close-knit** and **generally pretty safe**
- **Businesses are alive** and supportive of communities. They are **involved** and help when **schools** or other organizations need donations or support
- Communities are **friendly on the surface**, but **racism and prejudice** exist beneath the surface
- Community is **very low income**, there seems to be a lot of **alcoholism and addiction.**
- Poor air quality, always smells bad because of local industry (**sugar factory**)
- There is a big **lack of housing.** It is hard for newcomers to find a place to live, housing is very old and there are a lot of **absentee land owners**. A lot of **homelessness** and not a lot of places to go in terms of a **shelter** or **temporary housing**
- There are not a lot of **things to do**, both for young people and older people. No **afterschool programs** or **senior centers** where people can go in their free time to interact with other people
- Young people are moving away and not returning to raise families, town is **aging out** and **resources are dwindling**, including access to **stores & grocery stores with healthy food**
- Rural, **farming & ranching community**. There are a lot of people who travel to the community to utilize services. **Physical boundaries expand past the city/county lines**

STRONG COMMUNITY RESOURCES

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

- The communities are full of **helpful people**, that are **willing to help in times of need**. Neighbors check on neighbors
- **Thriving businesses and schools** in several communities throughout the region

Some strengths were new:

- The Panhandle has a lot of **social service resources**, including **food pantries, HOPE center, Area 1, and Nebraska Minority Resource Center** to name some specifically called out
- A few communities had good options for **transportation** whether it be **public transit** (busses, taxis, etc.) or an organization providing a **gas voucher** for required medical travel
- Many communities throughout the region have **strong health services** such as hospitals, clinics, providers/physicians etc.
- There are **organizations** throughout the Panhandle to support **businesses** and the **agriculture community**
- Community has **Strong Faith and Churches**, members of the community hold **similar beliefs and values**

- There are options for **outdoor recreation**

COMMUNITY NEEDS

Community members described some things that may be lacking in their community. Please keep in mind that the Panhandle Region is very large and diverse and therefore a strength mentioned above, may be listed as a need in another community below:

- Some Communities lack **businesses** and a lively **downtown region.** They described their communities as **dying** and **aging out**
- **Lack of Housing,** even if new people were to move to the area, there is nothing available to **purchase** that is in **livable condition**
- No type of **Immigration Services** to help immigrants in obtaining necessary documents
- Access to **Language Services** and **Interpreters**
- Little access to **Government Services** (Medicaid, DMV, Community Grants, etc.) To receive help with these community members often must **travel to other communities**
- **No Activities for youth**, including places to hang out, after school activities, things to do in the summer etc.
- Barriers to **Transportation** including cost, hours, and destinations available
- Safe and reliable **Emergency Services**, including **police** & **ambulance.** Long response times & racial discrimination specifically pointed out
- Lack of **Mental Health Services** and **Providers** (even via telehealth)
- Many communities had **no clinic or health services** including **pharmacy, EMT's, school nurses, and specialists** OR these services are **cost prohibitive, open odd hours** or do not accept **Medicaid**

COMMUNITY CHANGES

Community members described how their community had changed in the last 5-10 years.

- **Aging Population**
- Opportunities and **things to do** for people of all ages
- Not as many **jobs**, nothing to bring **new people** to the area
- Increase in **drug and alcohol** use and abuse
- **More Crime** (theft, vandalism, violent crimes etc.) and an overall **decrease in police effectiveness**
- Many businesses are **closing** or **moving** to inaccessible parts of town leaving many **without easy access to healthy food**
- No **Mental Health Services**
- **Effects of COVID-19** (loss of income, loss of jobs, businesses closing, decline in mental health)
- Little to no access to **technology needs**, **rising costs** of basic utility services

COMMUNITY INTERACTIONS

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

- **Pretty good on the surface**
- Lack of services for **handicap individuals** and people with **disabilities**
- Strained interactions between individuals based on **Language**

- Strained interactions between individuals based on **sexual orientation or gender**
- Strained interactions between **different racial groups**
- Strained interactions based on **economic status**
- Some community members noted an increase in **openness** for **LGBTQ community**
- Little to no effort to **interact with individuals** in **senior homes** or **long-term care facilities**
- Communities were split when it came to feeling singled out because of **a certain identity individuals held**. Some **had** felt singled out and others **had not** depending on their background and the community in which they lived

COMMUNITY CONCERNS

Community members viewed the top three biggest health concerns for their specific community based off the Minority Health Survey and discussed the findings.

Community members discussed why they thought certain issues were rated as they were. Reasons were:

- **Hard to find/get fresh food** (no healthy restaurants, no available fresh food at stores, no grocery store, high cost)
- **Lack of medical insurance and high cost of care**
- People don't ask for help. **"tough it out mentality"**
- **Alcoholism** runs in families. It's what people do at **family gatherings** (weddings, funerals, holidays etc.) **"way of life"**
- People don't have access to **transportation**. Getting to and from **appointments** or the **grocery stores** is challenging
- **No childcare**
- **High cost of internet**

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

- Lack of **language services or accessible communication** (emails, computers, internet, phone service etc.)
- **Lack of Housing & Homeless shelter** (unaffordable rent, aging housing stock)
- No place to **exercise or workout**
- **Lack of providers**, specifically **mental health**, **social services**, and **addiction services**.
- No **cultural centers** or places to celebrate culture. Cultural celebrations are shut down in **schools** and **parks**
- **Effects of COVID-19**
- **Environmental Quality** and the current state of **preservation efforts**

ACCESS TO THE HEALTHCARE SYSTEM

Community members were asked if they felt they had equal access to the healthcare system. Many of the themes were recurring from previous questions:

- People don't have access to **transportation** to and from appointments
- Little to no access to **specialists,** such as **dentists, eye doctors, mental health providers** and **women's health services**

- **Lack of Insurance/High cost of services**
- **Language Barriers** or **health literacy concerns**
- No access to **technology or space** for telehealth services (personal computers, internet, private space)

A couple of themes discussed with this question were new:

- **Discriminatory interactions** from **medical providers/nursing staff/health facility staff** to patients, **unwelcoming healthcare facilities**
- **Unusually long wait times**

COMMUNITY IMPROVEMENTS

Community members were asked the questions "If you had a magic wand, what is one thing you would improve within your community?" responses were as follows:

- Increased **inclusiveness** and **racial awareness.** Individuals hold **similar beliefs and values**
- **Repair Infrastructure** (streets, housing, downtown buildings etc.)
- **More youth activities** and **resources** to support **younger generations**
- **More jobs**
- **Easier/More access to childcare options**
- **Parenting classes** and resources to support **new mothers and families**
- **More mental health resources**
- Presence of a **clinic** or **space to house telehealth services** (for individuals without a computer)
- Create a **homeless shelter** & **resolve homelessness**
- **Free** or **low-cost** place to **exercise or workout**
- **Low cost** or **free health clinic** OR increase in providers that **accept Medicaid**
- More access to **Transportation services**

FORCES OF CHANGE ASSESSMENT

The Forces of Change assessment the Minority Health Assessment team chose to do was called the Waves of Change assessment. It breaks down the context of the community using a wave metaphor to identify the following categories; Horizon (ideas that are not funded and not accepted in the Panhandle but that the committee felt should be accepted), Emerging (ideas that have some support or are experimental and are picking up momentum), Established (Ideas that are currently accepted in the community), Disappearing (Ideas that may be outdated or may have been forgotten about and need to be resuscitated), and Undertow (ideas that pull down the work the community leaders are trying to accomplish). This was completed during the January advisory committee meeting. See the next page for the full Forces of Change assessment.

HORIZON	EMERGING	ESTABLISHED	DISAPPEARING	UNDERTOW
Not Funded, Needing Acceptance	**Some Support, Experimental, Picking Up Momentum**	**Tried & True, Fully Accepted, Standard Procedure**	**Needing Resuscitation, Time has Gone, Outaded**	**Deep Patterns of Trouble, Drag us Down**
• Inclusion • Reaching out to all • Recognize community norms • Open to seeing the "not so good sides" of ourselves • Not everyone feels safe and accepted here • Healthcare sensitive to different community needs without overgeneralizing • Trans Health care	• Continuation of the child tax credit • PREP availability • Dignified work at all levels of economy • Different expectations of education, not everyone needs a four year degree • More of an availability for general providers to take on specialized care • Awareness of Medicaid expansion • Our community is stronger the closer we get to equality • Improve internet access • Towns recognize opportunity for housing improvements • Worksite Wellness • Need to collect data specific to certain groups to move the needle • Telehealth services • Lessening Stigma around seeking mental health • Outreach to the next generation	• Cultural centers, celebrations for different communities - not in all communities • If it isn't broken - don't fix it • Programs that exist don't serve everyone • Informational community based gatherings (health fairs) • Federally qualified health center • WIC • CAPWN • Family/reproductive health • Nebraska AIDS project • Free Breakfast and Lunch programs at Schools, not all schools take advantage	• Shift from idea that everyone would go to a 4 year college • Difference from coming to an office and working virtually • Needs resuscitated- faith in science • Availability of providers for mental health declining • Needs Resuscitated- Having services offered in your own community	• Political divide • Misinformation • Fear • Racism • Conspiracy theories • Social media "experts" • Historical health context (poor in our area) • Distrust in government • Us vs. Them mentality • Access issues • Lack of empathy • Desire for attention to say the right thing without doing the work

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The MAPP process includes a Local Public Health System Assessment (LPHSA), the full assessment was completed as part of the regional Community Health Improvement process in the spring and summer of 2020. A summary of the results can be found in Appendix G of the 2020 Community Health Assessment. Because this MAPP process was focusing on Minority health and health equity the Minority Health team chose to complete the Health Equity Supplement Local Public Health System Assessment (MAPP-H LPHSA).

The internal Minority Health team and PPHD leadership team participated in the LPHSA at a meeting held in March 2022. The PPHD planner facilitated the discussion among the team and took notes via Zoom. The participants had access to the document with the questions and the document was shared on the screen.

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. Ratings 2-4 were further defined for clarity as 2 = we have talked about how we would do it but aren't doing it, 3 = we are starting to work on this in some areas, but it is not integrated into our processes, and 4 = we are working on this and integrating it into all processes.

SUMMARY OF THE DATA

Overall PPHD ranked at 3 which translates into plain language that as an organization we are starting to work on incorporating health equity, but it is not integrated into our processes.

This process identified several gaps in internal efforts to work toward health equity:

1. Using data regarding health equity to impact local policies, practices, and policy changes
2. Facilitating substantive community participation in the development and implementation of research about the relationships between structural injustices and health status

These statements sparked discussion about how PPHD could work toward policy change in health equity. This is being done for rural communities, but the data is lacking in communities of color. This document fills some gaps but there is still more room for improvement in data collection.

Several areas were identified as areas of success in working toward health equity:

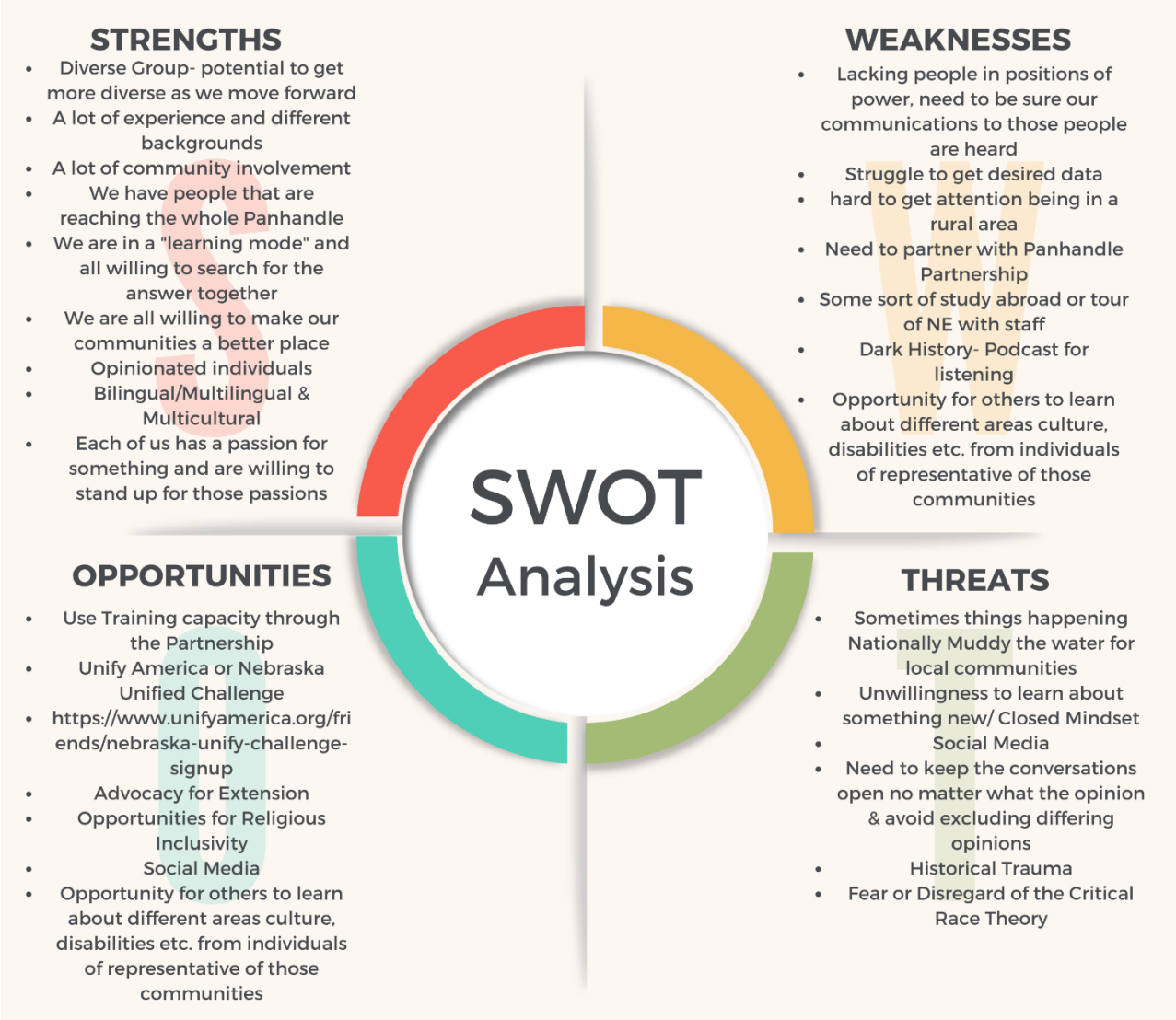
1. Engaging partners
2. Providing a way for community-based organizations and individuals to participate in decision making as it relates to the Community Health Improvement Plan
3. Conducting internal assessments to build staff capacity around health equity
4. Including staff participation in decision making
5. Recruiting and training staff members that reflect the communities they serve

These are summarized from how the statements are written in the assessment included in the Appendix. Strategies to improve PPHD's efforts in internalizing equitable health practices are included in the strategic planning.

MAPP PHASE 4: IDENTIFY STRATEGIC ISSUES

A prioritization process to identify strategic issues to focus on in the next 2 years of Minority health work. The prioritization was completed during two virtual strategic planning sessions with the advisory committee.

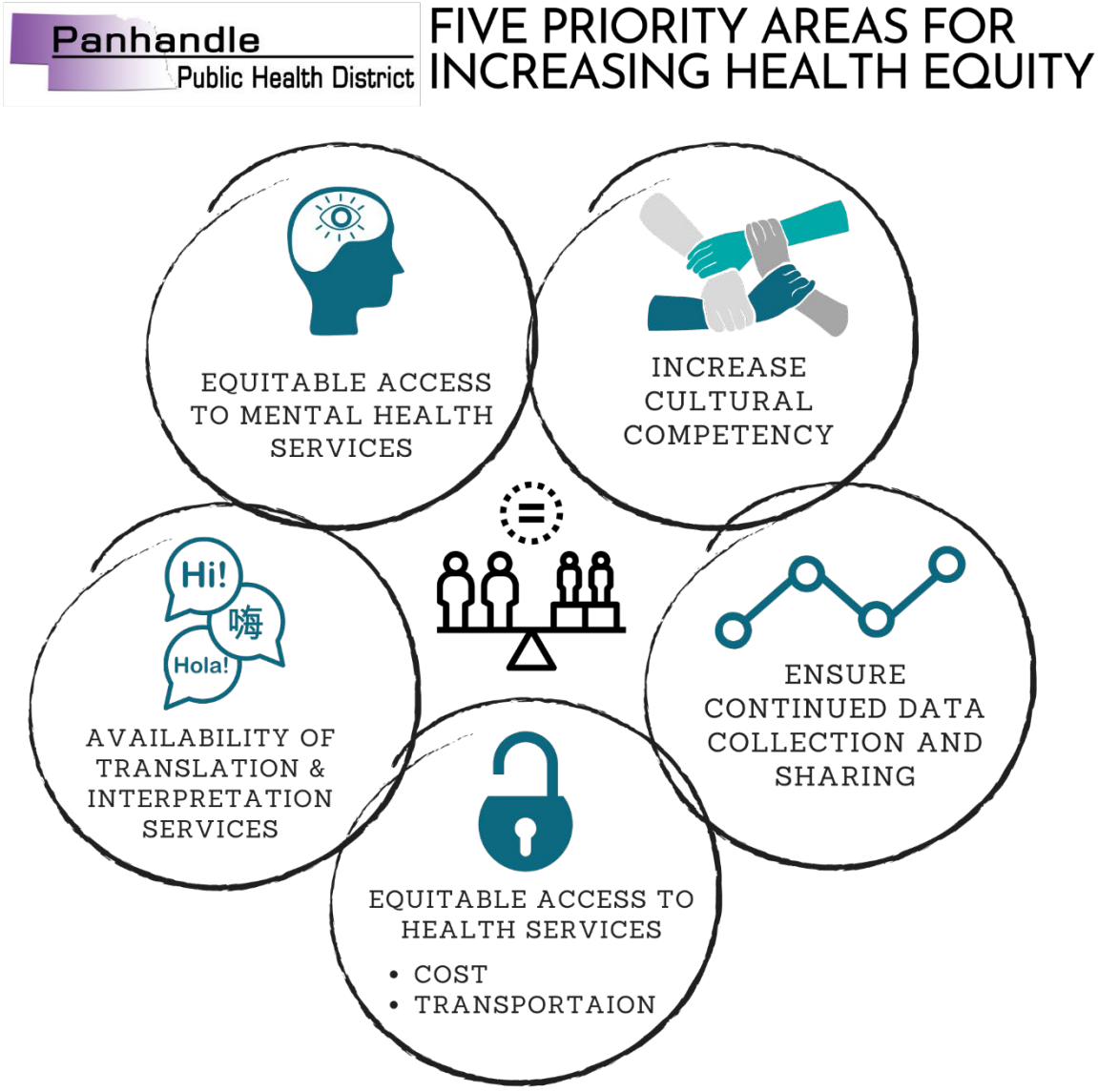
During the first of the two meetings, the internal Minority Health team facilitated a visioning and a current reality check exercise. The current reality check was a SWOT analysis.



Prior to the second strategic planning meeting, the Minority Health team summarized the information from the 4 health assessments (Phase 3). The staff noted 5 priority areas that kept coming up in all the assessments. Committee members had the opportunity to review the data and priority areas that the Minority Health team put together and to note any areas they felt were missing. The data was also reviewed during the first half of this meeting. During this meeting, the priority areas developed by the Minority Health team were approved by the advisory committee. The committee then used the strategic areas to develop objectives and strategic actions for the next 2 years.

The priority areas developed by the Minority Health team and advisory committee were:

1. Access to Mental Health
2. Translation and Interpretation
3. Cultural Competency
4. Access to Services (Cost and Transportation)
5. Ensuring Continued and Expanded Data Collection for Vulnerable Populations



MAPP PHASE 5: FORMULATE GOALS & STRATEGIES

SELECTING OBJECTIVES AND STRATEGIES

The PPHD Minority Health team pulled a list of evidence-based strategies based on the identified priority areas from Healthy People 2030, County Health Rankings, and the Community Guide. This list was sent to the advisory committee prior to the strategic planning meeting for their review and consideration.

During the second strategic planning meeting, the Minority Health team facilitated a conversation with the advisory committee to determine which objectives and strategies would be the most appropriate for the first 2 years of the Minority Health work plan. These objectives and strategies were chosen based on the following criteria:

- Availability of resources
- Community Readiness
- State Priorities
- Current CHIP Objectives and Strategies

GOAL SETTING

Due to the lack of data in the region, many of the methods of measuring success in achieving health equity in the Panhandle will be determined by whether certain programs are implemented, policies are adopted, or data sources are developed. Moving forward these strategies will be measured using the Healthy People 2030 1% improvement/year measurement.

RELATIONSHIP TO CHIP

The Minority Health team reviewed the CHIP to identify objectives that related to the priority areas identified in this assessment process. These objectives will be reviewed during Minority Health CHIP work group meetings after the assessment process is complete.

MAPP PHASE 6: TAKE ACTION

IMPLEMENTATION

Implementation will occur over the next two years, from June 2022 to June 2024. Minority Health CHIP will be implemented as a collaborative effort involving the local health department, advisory partners, community organizations, state partners, and local health systems.

EVALUATION

Evaluation will be ongoing throughout the two-year implementation period and reported on through an annual report made available by May of each year. Evaluation will consider the effectiveness of implementation strategies as well as review current processes and procedures for areas of improvement. Performance management meetings will occur for internal minority health staff quarterly and any quality improvement projects will be identified and implemented during those times. Staff will measure success through the following methods:

- Community Surveys
- Implementation of strategies (tracking when, how often, and how well they are implemented)
- State data (BRFSS, YBRSS, Justice reports, etc.)
- Local EHR data
- Quarterly Advisory Committee meetings

Certain measures will be tracked during performance management meetings and recorded on an online scorecard that is available and visible to the public called Clear Impact. Scorecards and the annual report will include revisions as necessary to the original Minority Health CHIP. Revisions may include:

- Improvement strategies
- Planned activities
- Time frames
- Targets
- Assigned responsibilities

Revisions may be based on:

- Achieved activities
- Implemented strategies
- Changing health status indicators
- Newly developing or identified health issues
- Changing level of resources

PRIORITY 1: EQUITABLE ACCESS TO MENTAL HEALTH SERVICES

OBJECTIVE 1.1: Increase the availability of mental health services that serve minority populations across the Panhandle

Activities	Partners	Due Date	Measures
Seek private funding opportunities to support flexible options for underserved communities to access mental health services	PPHD, Empowering Families, Region 1 Behavioral Health	6/30/2024	Track the number of funding opportunities awarded
Work with employers to develop policies that support access to mental health services for employees at no or minimal cost to the employee (EAP, telehealth counseling services, etc.)	PPHD, Worksite Wellness committee	6/30/2023	Track the number of policies implemented
Advocate for broadband access in rural communities and communities with limited financial ability to afford wifi	PPHD	6/30/2024	Track increase in providers via the broadband map
Work with Region 1 Behavioral health to increase access to counselors who speak Spanish	Region 1 Behavioral Health, PPHD	6/30/2023	Track number of Spanish speaking providers
Support group counseling for underserved families with youth in-need of mental health services	Panhandle Equality, PPHD	12/30/2023	Track number of support groups

OBJECTIVE 1.2: Increase the number of public schools with a counselor, social worker, and/or psychologist

Activities	Partners	Due Date	Measures
Work with schools to explore grants and funding for school counselors, social workers, and psychologists	PPHD, Panhandle District Schools, ESU 13	6/30/2024	Number of grants secured by schools
Improve process of referral to mental health professionals after a positive screen for mental illness	PPHD, Panhandle District Schools, ESU 13	6/30/2023	Process map for referrals after positive screen is finished
Build coalition with school representatives by at least one representative from each county	PPHD, Panhandle District Schools, ESU 13, Advisory Committee	6/30/2024	Number of school representatives from each county

PRIORITY 2: INCREASE AVAILABILITY OF TRANSLATION & INTERPRETATION SERVICES

OBJECTIVE 2.1: Increase number of medical interpreters in the Panhandle Region

Activities	Partners	Due Date	Measures
Plan (date/time/location) medical interpretation class	Advisory Committee, MAPP steering committee, PPHD	6/30/2023	# of medical interpretation classes offered
Advertise and recruit for medical interpretation class	Advisory Committee, PPHD, Panhandle Partnership	6/30/2023	# of participants in classes from each county
Integrate interpretation throughout the healthcare system	PPHD, Advisory Committee, MAPP steering committee	12/30/2022	# of programs with interpretation
Education to the public on their right to an interpreter at any medical facility accepting Medicare or Medicaid	PPHD, Hospital Partners	12/30/2023	# of education events held

OBJECTIVE 2.2: Decrease the proportion of adults who report poor communication with their health care provider (HP 2030 HC/HIT-02)

Activities	Partners	Due Date	Measures
Increase awareness on the communication gaps within local communities	PPHD, Advisory Committee	6/30/2023	# of educational panels held for communities
Increase health literacy throughout the medical community by hosting workshops	PPHD, Hospital Partners, MAPP steering committee	12/30/2023	# of workshops held

OBJECTIVE 2.3: Translate important written materials critical to the public access to education & health materials

Activities	Partners	Due Date	Measures
Partner with the regional Public Health Language Access Network (PHLAN) to access data base & collection of translated products	NALHD, PPHD	ongoing through 6/30/2024	# of translated materials developed
Develop process to translate material published by LHD to multiple languages	NALHD, PPHD	ongoing through 6/30/2024	Complete process document
Assist other community organizations in developing their translation processes	PPHD, Advisory committee	ongoing through 6/30/2024	# of communities with translation processes developed

PRIORITY 3: INCREASE CULTURAL COMPETENCY

OBJECTIVE 3.1: Increase Internal Cultural Competency

Activities	Partners	Due Date	Measures
Host virtual monthly staff cultural trainings	PPHD	ongoing through 6/30/2024	Staff responses to cultural trainings in annual review survey
Host annual in person cultural awareness trainings	PPHD	ongoing through 6/30/2024	Staff responses to cultural training in annual review
Provide a database of cultural training materials for staff to access	PPHD	6/30/2023	Staff responses to resources in annual review
Develop a cultural competency review team that will participate in QI processes to ensure that as programs are refined, they are inclusive and equitable	PPHD	12/30/2022	A cultural competency review team is in place

OBJECTIVE 3.2: Increase in the number of workplaces throughout the Panhandle providing DEI trainings to its employees

Activities	Partners	Due Date	Measures
Utilize the Society for Human Resource Management (SHRM) & collaborate to help organizations obtain access to Diversity, Equity, & Inclusion (DEI) Materials	Western Nebraska Human Resources Management (WNHRM), PPHD, Panhandle Worksite Wellness	12/30/2023	# of organizations adding DEI training
Educate employers on the importance of DEI trainings through worksite wellness programs	PPHD, Panhandle Worksite Wellness Council	ongoing through 6/30/2024	# of organizations adding DEI
Develop question on annual worksite wellness survey to track the number of employers who incorporate policies to support DEI	PPHD, Panhandle Worksite Wellness Council	12/30/2022	Question is developed and included on annual survey
Utilize partners to coordinate cultural training opportunities	NALHD, Panhandle Partnership, PPHD	ongoing through 6/30/2024	# of cultural trainings offered

OBJECTIVE 3.3: Increase in the number of community-based cultural training and events

Activities	Partners	Due Date	Measures
Host cultural trainings for the public to attend	NALHD, PPHD, Panhandle Partnership, Extension	ongoing through 6/30/2024	# of cultural trainings offered

PRIORITY 4: EQUITABLE ACCESS TO HEALTH SERVICES

OBJECTIVE 4.1: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, or prescription medicine by 1 percent per year

Activities	Partners	Due Date	Measures
Seek private funding opportunities to support flexible options for underserved communities to access health services	PPHD, Empowering Families, MAPP steering committee	6/30/2024	# of funding opportunities awarded
Increase awareness of Medicaid expansion by hosting Medicaid sign up sessions in each county	PPHD, Empowering Families, Panhandle Partnership, Panhandle Equality, Nebraska Minority Resource Center	12/30/2022	# of education sessions held
Increase awareness of sliding scale options by hosting workshops in each county	PPHD, Empowering Families, Panhandle Partnership, Panhandle Equality, Nebraska Minority Resource Center	12/30/2022	# of workshops held
Work with hospitals to establish a patient navigator for patients	PPHD, MAPP steering committee	12/30/2023	# of patient navigators available

OBJECTIVE 4.2: Increase awareness of and access to transportation options in the Panhandle by at least 2 percent over the next two years

Activities	Partners	Due Date	Measures
Increase awareness of how to access free or reduced cost transportation by assessing options and distributing finds in health-literate materials	PPHD, local transportation providers	12/30/2022 for assessment 6/30/2023 for dissemination	1 transportation assessment completed, # of people distributed to
Improve travel infrastructure to make travel more accessible, by advocating for complete streets policies	PPHD, Panhandle Worksite Wellness Council, local transportation providers	12/30/2024	# of complete streets policies adopted
Improve travel infrastructure to make travel more accessible, by supporting local groups working on transportation infrastructure improvements	PPHD, Empowering Families, Nebraska Minority Resource Center	12/30/2023	# of travel infrastructure project improvements that are completed

PRIORITY 5: ENSURE CONTINUED DATA COLLECTION AND SHARING

OBJECTIVE 5.1: Sustain minority health assessment process and expand partnerships

Activities	Partners	Due Date	Measures
Utilize state standardized tools to continue data collection and analysis	PPHD, local transportation providers	ongoing through 6/30/2024	# of new data sources developed
Integrate this workplan and the advisory committee team with the MAPP process, steering committee, and CHIP workplan	PPHD, Nebraska Minority Resource Center, Panhandle Equality, Empowering Families	12/30/2022	# of committee members participating in meetings
Actively seek out new partners throughout the Panhandle to assist in reaching minority populations	PPHD, Nebraska Minority Resource Center, Panhandle Equality, Empowering Families	ongoing through 6/30/2024	# of new partners participating in committee meetings

OBJECTIVE 5.2: Expand sources of data and increase data sharing

Activities	Partners	Due Date	Measures
Advocate for increase data sharing with state and local partners	PPHD, DHHS, NALHD, NMRC, Panhandle Equality, Empowering Families	ongoing through 6/30/2024	# of new data sources developed
Work with organizations serving minority populations to assist in survey writing, collection & analysis for their service population	PPHD, DHHS, NALHD, NMRC, Panhandle Equality, Empowering Families	ongoing through 6/30/2024	1 survey is distributed each year

APPENDICES

APPENDIX A: MINORITY HEALTH COMMUNITY CHARTER

Health in Disproportionately Affected Communities

Advisory Committee Charter

October 12, 2021

Purpose:

To provide guidance on public health initiatives in the Panhandle of Nebraska with an equity lens.

Advisory Committee Composition

An advisory committee composed of entities and community leaders that are members of, or serve the disproportionately affected communities in the Panhandle.

Advisory Committee Role and Responsibilities

The roles and responsibilities of the Advisory Committee include:

- Sharing information about assessment activities and recruitment for participation
- Development of common standard policies and protocols to guide the Minority Health Assessment work
- Oversight of work products
- Approve Annual Action Plan
- Review and approve community health assessment

Time Commitment

The Advisory Committee meets monthly for the first year of the grant and then quarterly during implementation and following years.

APPENDIX B: DECEMBER ADVISORY MEETING MINUTES

Panhandle Public Health District

Meeting Agenda December 2021

8:30-10 AM, December 17, 2021, | Location: Virtual via the following Zoom Link:

https://us02web.zoom.us/j/87017443422?pwd=NHY2RWk4d0ZvQTNLaGJIZFdwd0pPdz09

Agenda

Introductions
Last Meeting Follow-up- Megan Barhafer
Visioning - Megan Barhafer
Introduction to Waves of Change - Kelsy Sasse
Wrap-up and Reminders - Megan Barhafer

Last Meeting Follow-Up

- Survey Status

New Business

- N/A

Attendees

Megan Barhafer, Kelsy Sasse, Melissa M., Richard Riley, Myrna Hernandez, Tabi Prochazka, Kim Engel, Val Rodriguez, Marina Girard, Janet Felix, Vianey Zitterkopf

Minutes

Welcome & Roll Call

- *Last meeting follows up and review*
  - *Survey Distribution throughout Southern Panhandle*
  - *Focus group questions finalized - currently scheduling focus groups*

Visioning

- *Time spent in consensus workshop creating a vision answering the question: "What would health equity look like in the panhandle"*
- *Copy of virtual sticky wall with brainstorming & initial ideas can be found in the PowerPoint.*
- *We will write our vision at the start of our next advisory meeting*

Announcements from other organizations

Action Items

- Schedule Focus Groups/ outline which groups to meet with where
- Final push for surveys - please send them to your organizations!

Next Meeting Agenda Items

- Write a vision statement
- Waves of Change

APPENDIX C: FEBRUARY ADVISORY MEETING MINUTES

Panhandle Public Health District

Meeting Agenda February 2022

8:30-10 AM, February 18, 2022| Location: Virtual via the following Zoom Link:

https://us02web.zoom.us/j/87017443422?pwd=NHY2RWk4d0ZvQTNLaGJIZFdwd0pPdz09

Agenda

Introductions
Last Meeting Follow-up - Kelsy Sasse
Strategic Planning PART 1- Megan Barhafer and Kelsy Sasse
- *Victory Circle + Visioning Recap - Kelsy*
- *SWOT - Megan*

Wrap-up and Reminders - Megan Barhafer

Last Meeting Follow-Up
- MHI Waves of Change

New Business
- Strategic plan

Attendees

Megan Barhafer, Kim Engel, Jackie Guzman, Myrna Hernandez, Kelsy Sasse, Tabi Prochazka, Melissa Misegadis, Emily Lodahl, Valeria Rodriguez, Martin Vargas

Minutes

Welcome & Roll Call

- We have focused groups scheduled in Chappell, Big Springs, Scottsbluff (LGBTQ & Native American), Crawford, Rushville, Chadron & Gordon. We are offering **$50 incentives** for those locations however in order to ensure we are getting feedback from our target demographic as well as make sure we are prepared with the correct amount of gift cards, **participants MUST RSVP to a PPHD employee or an advisory committee member who will relay their RSVP to a PPHD employee in order to receive the $50.**
- Review of Waves of Change to help us see the big picture as we begin phase one of our strategic planning (final work product on PowerPoint Slide)
- Strategic Planning Part One- Victory Circle and SWOT analysis attached to PowerPoint Slide

- Timeline- We are nearing the end of our "assessment" phase of our Minority Health Project and will soon begin writing our programming proposal to DHHS. Full timeline can be seen attached to PowerPoint

Announcements from other organizations

- Martin is teaching a Medical Interpretation Class April 4th-8th (contact him for details for now, still working on marketing materials)

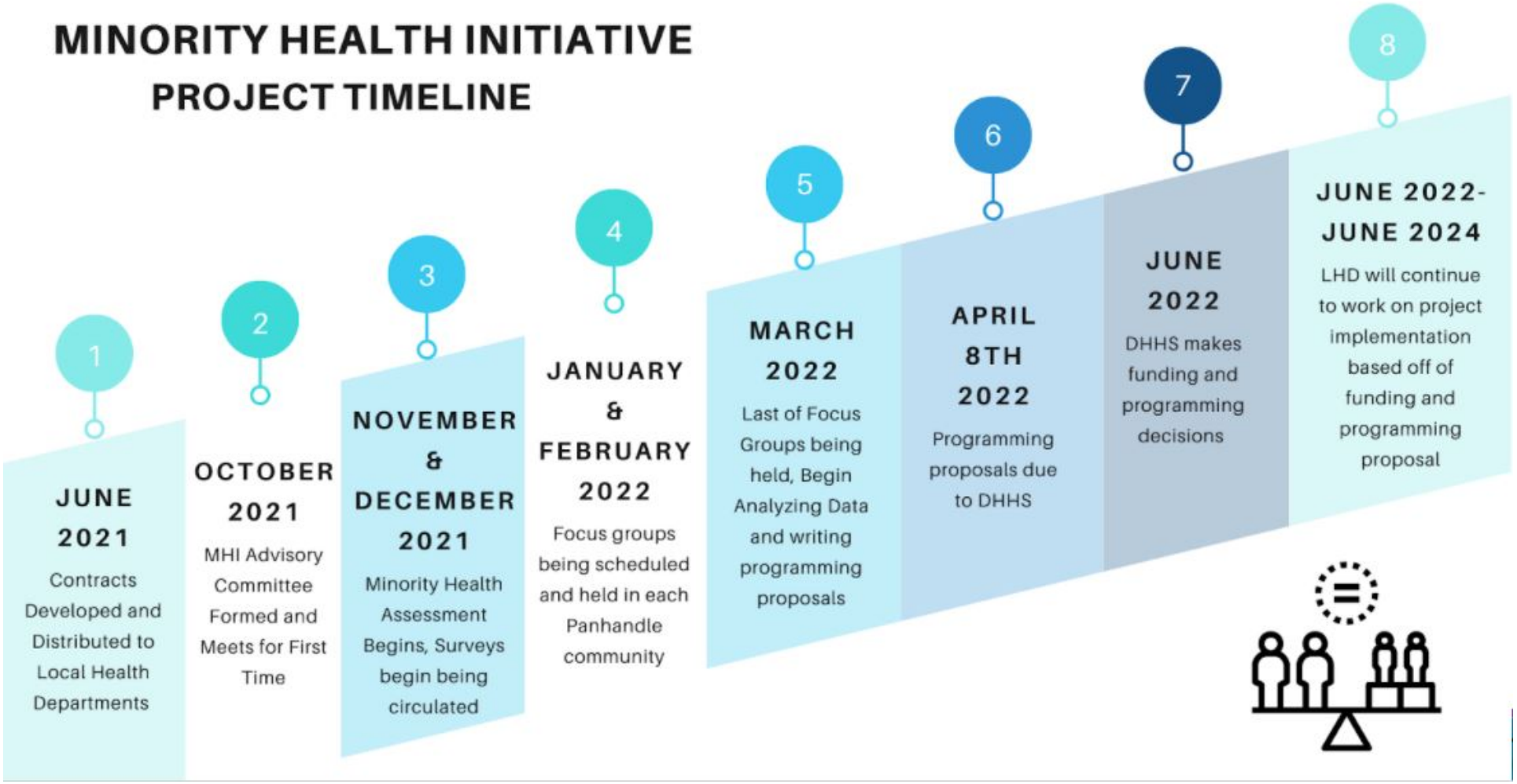
Action Items

- Completed Phase One of our Strategic Planning
- Spread the word about any focus groups in your area, seeking participants from Minority populations and offering **$50 incentives but participants MUST RSVP in order to ensure incentive**

Next Meeting Agenda Items

- Strategic Planning Phase 2 and Programming Discussion

APPENDIX D: KEY IMPORTANT DATES



WHAT AFFECTS YOUR HEALTH?

What was the last major health issue that you or your family experienced?

In your town what are the top 3 health

- ☐ Alcohol, Drugs, and Tobacco Use
- ☐ Asthma
- ☐ Cancer
- ☐ Challenges getting healthy and affordable food
- ☐ Chronic lung disease (asthma, COPD)
- ☐ Diabetes
- ☐ Getting around town safely (driving, walking, and riding)
- ☐ Getting enough exercise
- ☐ Heart Disease (for example: high blood pressure, stroke, etc.)
- ☐ Mental Health (for example: Depression, Anxiety, Post-traumatic stress, suicide, eating disorders, etc.)
- ☐ Something else _____

What worries you most about your health or the health of your family?

COVID-19 response in your area?

What has gone well?

Where can we improve?

What is something you do to be healthy?

Panhandle Public Health District

Demographics

Zip Code: _____

Birth Year: _____

What is your race?

White/Caucasian
Black or African American
Asian
American Indian or Alaska Native
Native Hawaiian or Pacific Islander
Other: _____

Are you of Hispanic or Latino origin?

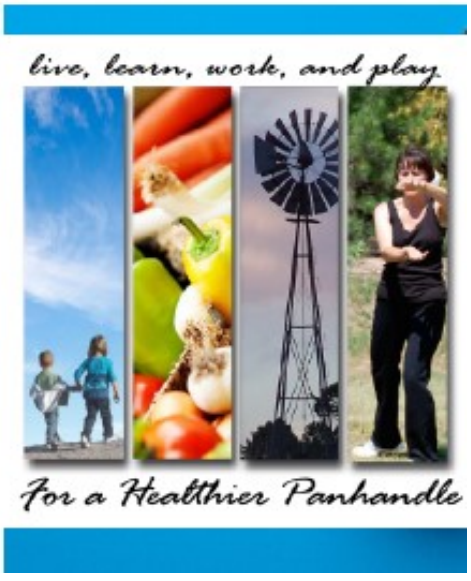
Yes
No

What is your gender?

Do you identify as a member of the transgender community? Y/N

What is your sexual orientation?

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



APPENDIX F: 2020 FOCUS GROUP GUIDE

2022 Focus Group Guide for Community Themes and Strengths Assessment

Before we get started, I'd like to take a moment to introduce ourselves. If you could please tell everyone your name and how long you have lived in the area.

I'm going to start with saying that we will be recording our conversation tonight for note taking purposes however I want to assure you all that there will be no identifying factors and your identity will be kept completely anonymous. **(Start Recording Now)** With that, 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.

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 personal 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, who are the people - specifically ask for strengths if not called out

2. **What would you consider strong resources within your community?**

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

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

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. **Have you ever felt singled out because of an identity you hold?**

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

   The top 3 biggest Health concerns were: (Listed health concerns specific to focus group location)

   1.
   2.
   3.

   a. **Why do you think these are the top concerns? (Five Whys)**

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

8. **Do you feel you have equal access to the healthcare system (language, transportation, wait times, health insurance, cultural differences, etc.)**

   a. **Is it as easy for you as it seems to be for your community members?**

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

2022 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 G: LPHSA

Local Public Health System Assessment continued

Health Equity

PHASE THREE: Four MAPP Assessments

System Contributions to Assuring Health Equity

When completing the Local Public Health System (LPHS) Assessment using the National Public Health Performance Standards (NPHPS) Instrument, your group can reframe questions about essential service delivery to identify how well the LPHS acknowledges and addresses health inequities. The following questions provide examples of how the instrument can be revised to focus on health equity.

Essential Public Health Service 1: Monitoring Health Status

At what level does the LPHS…

- Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

- Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

Essential Public Health Service 2: Diagnosing and Investigating Health Problems

At what level does the LPHS…

- Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

- Collect reportable disease information from community health professionals about health inequities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☒	☐	☐	☐

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

At what level does the LPHS…

- Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

- Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

Health Equity

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

- Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

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

At what level does the LPHS…

- Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Provide community members with access to community health data?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

Essential Public Health Service 5: Developing Policies and Plans that Support Individual Community Health Efforts

At what level does the LPHS…

- Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

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

At what level does the LPHS…

- Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

Local Public Health System Assessment continued

Health Equity

System Contributions to Assuring Health Equity

Essential Public Health Service 7: Link People to Needed Personal Health Services

At what level does the LPHS…

- Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☒	☐	☐	☐

- Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☒	☐	☐

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

At what level does the LPHS…

- Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Recruit and train staff members that reflect the communities they serve?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

PHASE THREE: Four MAPP Assessments

Health Equity

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

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

At what level does the LPHS…

- Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☒	☐	☐	☐

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

At what level does the LPHS…

- Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☒	☐	☐	☐

- Share information and strategize with other organizations invested in eliminating health inequity?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☒	☐

- Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☒	☐	☐	☐	☐

- Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?

No Activity	Minimal	Moderate	Significant	Optimal
☒	☐	☐	☐	☐

Addendum 2:

Panhandle Public Health District
Highway Safety Office Application
2022-2023 Plan Year

Summary

Panhandle Public Health District, through its extensive business and employer partnership, community and prevention partners, and five community active living coalitions, will coordinate and build capacity to implement evidence-based safety measures towards occupant protection, speed, distracted and impaired driving. This will include multi-pronged approaches at each socio-ecological model level through policy, community, organizational, interpersonal, and individual strategies.

There were 1376 motor vehicle crashes in the Panhandle in 2020, resulting in 554 injured individuals and 26 deaths. The rate of Panhandle adults that always wear a seatbelt is consistently lower than the broader state of Nebraska, by approximately 15 points.

2020 Crash Data by County						
	Crashes				Persons Killed and Injured	
County	Total	Fatal	Injury	PDO	Killed	Injured
Banner	24	1	6	17	1	7
Box Butte	142	1	40	101	1	65
Cheyenne	157	4	35	118	4	48
Dawes	121	1	28	92	1	33
Deuel	50	3	10	37	4	15
Garden	34	1	5	28	1	12
Grant	4	1	2	1	1	2
Kimball	76	3	19	54	4	33
Morrill	71	2	20	49	2	27
Scotts Bluff	595	6	192	397	7	277
Sheridan	79	0	22	57	0	31
Sioux	23	0	4	19	0	4
Total	1376	23	383	970	26	554
https://dot.nebraska.gov/media/115479/facts2020.pdf						

2020 Crash Data by County: Priority Counties						
	Crashes				Persons Killed and	
County	Total	Fatal	Injury	PDO	Killed	Injured
Box Butte	142	1	40	101	1	65
Dawes	121	1	28	92	1	33
Scotts Bluff	595	6	192	397	7	277
Totals	858	8	260	590	9	375
https://dot.nebraska.gov/media/115479/facts2020.pdf						

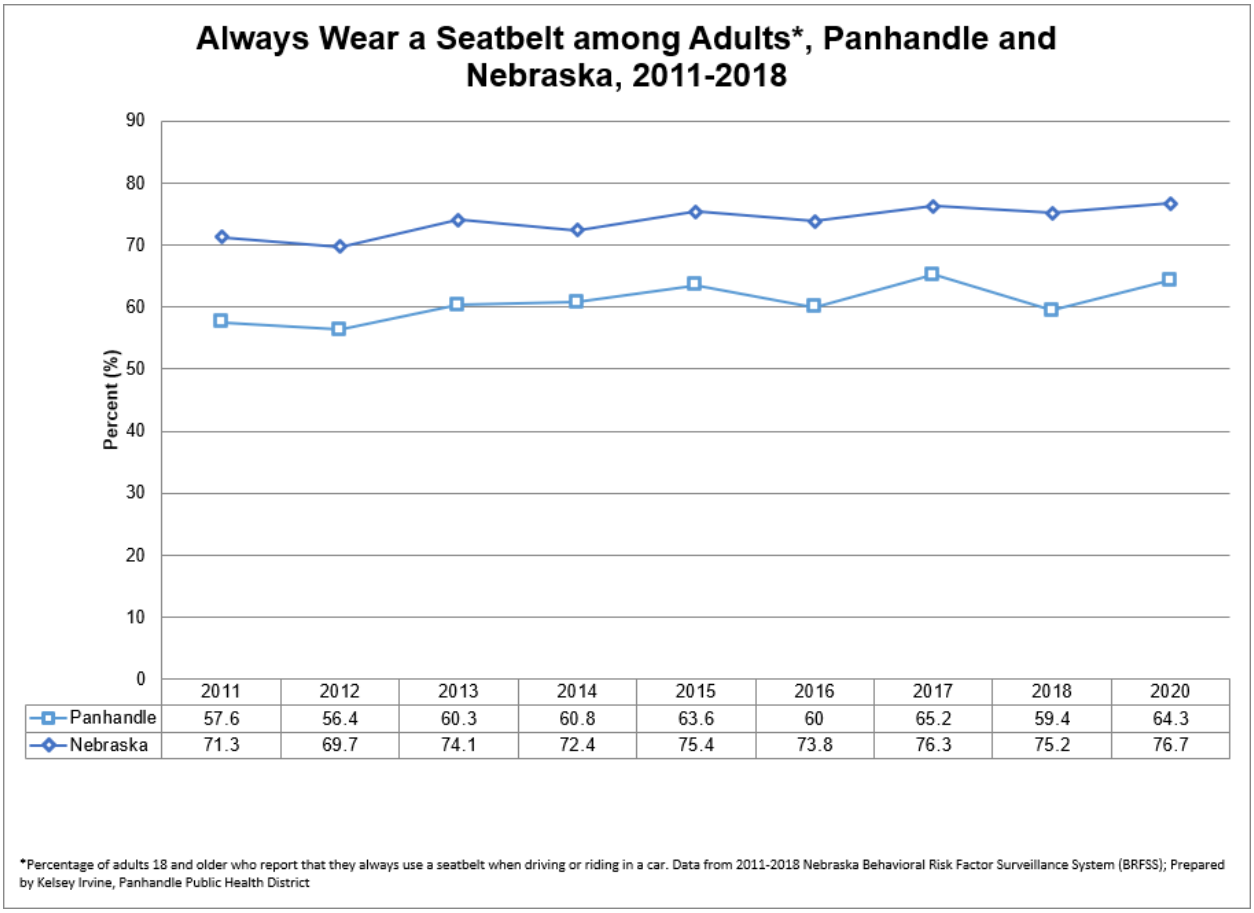
Organizational Background

Panhandle Public Health District serves the twelve counties in the rural western-most portion of Nebraska. This area encompasses 85,753 residents geographically dispersed among 15,000 square miles. We maintain office locations in Hemingford and Scottsbluff. Currently, we employ 27 full-time employees.

The health district maintains strong partnership with key collaborative community sectors, coalitions, and workgroups that will be used for strategy implementation.

Problem Identification

Seatbelt use is trending down in the Nebraska Panhandle at 64.3% of Panhandle adults in 2020, drastically lower than the state of Nebraska overall at 76.7% (Panhandle BRFSS, 2020). Rural, county roads, long distances between communities, and a high percentage of agricultural workers and truck drivers create additional contextual conditions that increase Panhandle resident risk for vehicle crashes.



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 82: Adult Texting While Driving

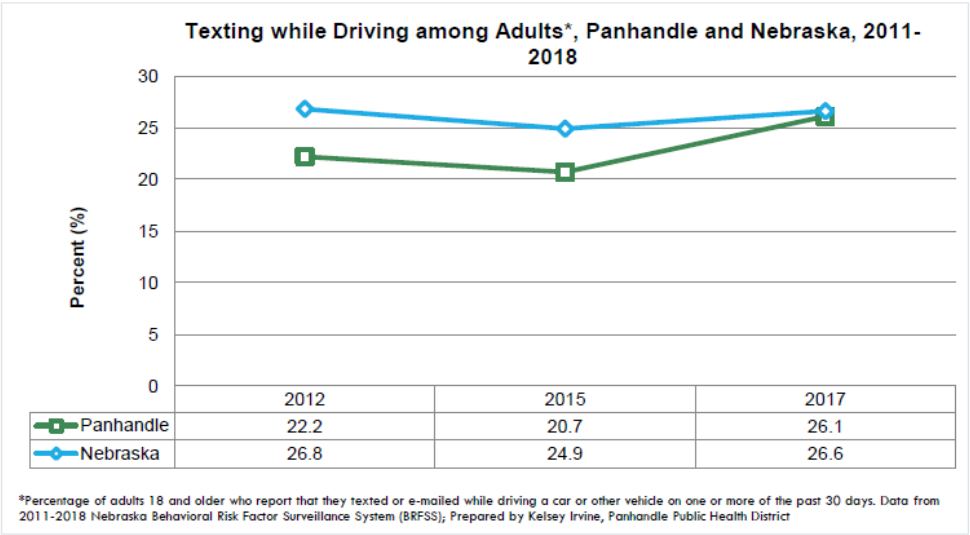
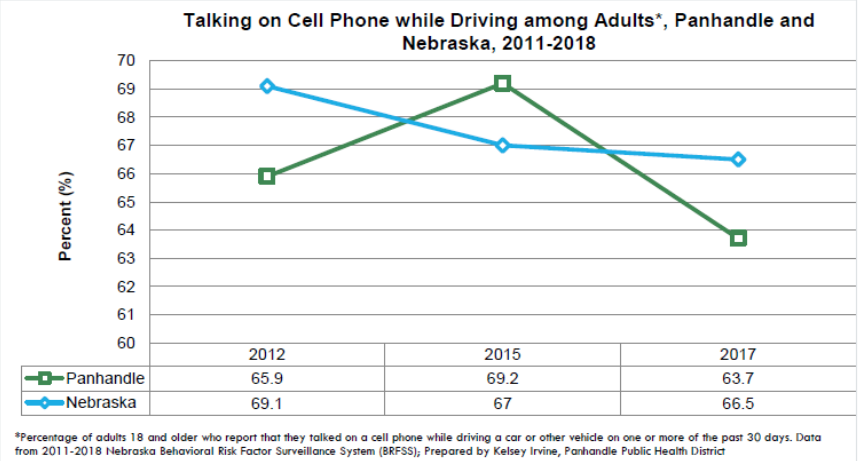


Figure 83: Adult Talking on Cell Phone While Driving



*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

The below graphs show that while accidents throughout the target area have been decreasing over the past 5 years, the number of alcohol related crashes has been increasing in every county in the target area. The last graph shows a combination of all three counties, with an increase from 5.98% of all accidents being alcohol related in 2016, to 6.20% in 2020.

TARGETS

2020 Crash Data by County						
	Crashes				Persons Killed and Injured	
County	Total	Fatal	Injury	PDO	Killed	Injured
Banner	24	1	6	17	1	7
Box Butte	142	1	40	101	1	65
Cheyenne	157	4	35	118	4	48
Dawes	121	1	28	92	1	33
Deuel	50	3	10	37	4	15
Garden	34	1	5	28	1	12
Grant	4	1	2	1	1	2
Kimball	76	3	19	54	4	33
Morrill	71	2	20	49	2	27
Scotts Bluff	595	6	192	397	7	277
Sheridan	79	0	22	57	0	31
Sioux	23	0	4	19	0	4
Total	1376	23	383	970	26	554
https://dot.nebraska.gov/media/115479/facts2020.pdf						

Panhandle Public Health District will strive for a 3% overall reduction in persons injured and killed due to motor vehicle crashes from 554 people injured in a crash to 537 and 25 people killed by September 2023.

Panhandle Public Health District will reach a minimum of 30% of the Panhandle population, or 25,726 residents, with an occupant protection, speed, distracted and impaired driving communications message by September 2023.

Panhandle Public Health District will impact a minimum of 10% (5,520 residents) of the Panhandle population residing in the Box Butte, Dawes, and Scotts Bluff Counties (Total estimated population of these communities combined is 55,200) by September 2023.

Panhandle Public Health District will work to increase the seatbelt rate among Panhandle adults by 2% from 64.3% to 64.7% by September 2023.

Objectives

Panhandle Public Health District will partner with area businesses and employers and the Panhandle Prevention Coalition to develop safe driving policies and education both on and off the job inclusive of family members. This will encompass the topics of occupant protection, speed, distracted and impaired driving.

Panhandle Public Health District will implement a mass communications campaign during key agriculture times to promote agricultural worker and truck driver safety.

Panhandle Public Health District will maintain coordination of the active living advisory committees in Gordon, Alliance, the Tri-Cities (Scottsbluff, Gering, Terrytown), Kimball, and Bridgeport and implementation of traffic calming strategies for driver and pedestrian protection.

Panhandle Public Health District will partner with schools on education around seat belts for students, families, and facility.

Finally, partner with community groups regarding alcohol education and awareness. Along with a marketing campaign targeted population of 20-55.

Strategies

1. Continue to review and research current evidence-based safety literature to determine best resources to develop education and policy recommendations. Completion Date: September 30, 2023
2. Continue to develop and update presentations/training materials to educate and raise awareness around road safety programing and the benefits to employers, employees, and employee families. Completion Date: September 30, 2023
3. Conduct a minimum of five educational presentations to employees through employer-sponsored events and prevention partners. Completion Date: September 30, 2023

4. Sponsor a speaker and educational resources at the fall Panhandle Business & Employer Safety & Wellness Conference on occupant protection, speed, distracted and impaired driving. Completion Date: September 30, 2023
5. Continue updating and revising a communications plan for safe driving policies and education both on and off the job inclusive of family members. This will encompass the topics of occupant protection, speed, distracted and impaired driving. Completion Date: September 30, 2023
6. Continue to develop and update employer resource to include policies, messaging, presentations, and support for regular safety updates. Completion Date: September 30, 2023
7. Maintain a tracking mechanism for employer policy adoption, educational sessions, and public communications impact. Completion Date: September 30, 2023
8. Maintain active living advisory committees in Gordon, Alliance, the Tri-Cities (Scottsbluff, Gering, Terrytown), Bridgeport, and Kimball to implement traffic calming strategies for driver and pedestrian protection. Completion Date: September 30, 2023
9. Work with school organizations, such as Booster Clubs, to promote the importance of safe driving around the school and community. Completion Date: September 30, 2023
10. Implement a communications campaign with area media during harvest times in the Panhandle. Ie. Wheat harvest in July, Beet harvest in September. Completion Date: September 30, 2023
11. Encompass all marketing communications, education, policy templates, and messaging in PPHD's regular communications channels and prevention partners through social media, annual report, news release distribution lists, e-newsletters, billboards, radio ads, newspaper ads, and other identified communication mediums when applicable. Completion Date: September 30, 2023
12. Submit regular updates to the Nebraska Highway Safety office as per reporting requirements. Ongoing October 1-2022-September 30, 2023
13. Impaired driving campaign - Address frequency of alcohol use in crashes in target counties. Targeting ages 20-55 as they were shown to be involved in most of the alcohol related accidents. Using mass education campaigns like Drive Sober, Get Pulled Over, including billboards, broadcast media, social media, flyers, and education. Along with presentations to educate and discourage drinking and driving. Completion Date: September 30, 2023
14. Click it or Ticket It Mini Grant Campaign addressing seatbelt use in target counties. Focusing on families and communities that we live and serve. Completion Date: September 30, 2023

Evaluation

1. Monitor and benchmark Panhandle Worksite Wellness Council annual employer survey data specific to distracted and impaired driving and seatbelt protection.
2. Monitor the PPHD Performance Management to include injury prevention: policies implemented, educational sessions, number of attendees, and changes in knowledge, attitudes, behaviors, and skills.
3. Provide the number of communications campaigns distributed, view rates, and estimated awareness and population impact.

4. Provide the number of safety strategies implemented by the community active living advisory committees.
5. Monitor Panhandle Behavioral Risk Factor Surveillance System and Nebraska Highway Safety Office data.

Budget & Budget Narrative

Personnel & Benefits	$57,016.64
Travel	$4,409.50
Presenter Fees	$4,000.00
Printing	$18,000.00
Advertising	$32,721.60
Staff Training	$500.00
Administration	$3,352.26
Total	**$120,000**

Personnel:

Wages: $41,770.56; **Benefits:** $15,246.08; **Total:** $57,016.64

- Janelle Visser, Health Educator: .30 wages – $14,763.84, benefits - $7,962.30, TOTAL $22,726.14
    - Visser will be responsible for the community and active living advisory committee partnerships and educational components.
- Nicole Berosek, Organizational Wellness Coordinator: .30 wages – $16,848.00, benefits $2,911.79, TOTAL $19,759.79
    - Berosek will be responsible for the organizational partnerships, educational, and communications components.
- Sara Williamson: CFO .05 wages - $3,376.88, benefits $1,060.90, TOTAL $4,437.78
    - Williamson will be responsible for all programmatic reporting and financial oversight
- Jessica Davies, Assistant Health Director: .05 wages - $3,630.64 benefits $1,626.38, TOTAL $5,257.02
    - Davies will be responsible for the grant contract and administrative oversight of the grant deliverables.
- Chris Fankhauser, Prevention Coordinator: .050 FTE – wages $3,151.20, benefits - $1,684.71 TOTAL $4,835.91

Travel: $4,409.50

- Staff travel within the district to provide presentations to organizations and community partners 700 x .585 = $409.50
- National conference: Conference TBD; Approval will be received from NE Dept of Transportation Highway Safety Office prior to registration. Expense will include registration fee, transportation, lodging, and per diem – $4,000.00

Presenters: $4,000.00

- Panhandle Fall Safety and Wellness Conference Speaker, date TBD – $4,000.00

Printing: $18,000.00

- Promotional materials (infographics, brochures, flyers etc.) to promote new policies, signage for businesses to remind of policies at facility entrance/exit locations: $3,000.00
- Safety items identified by local Active Living Advisory Committees based on needs assessments (pedestrian safety signage, lighted signs, etc): $2500/group x 6 groups = $15,000
- One page in the PPHD annual report distributed in February to highlight work of the project, cost estimated based on historical cost – $700.00

Advertising: $32,721.60

- Billboards, Facebook advertising, radio advertisements to promote objectives of the workplan – $35,000.00

Staff Training: $500.00

- Local training for program staff, TBD – $500.00

Administration: $3,352.26

- Expenses based on FTE allocated to each program each month, location specific costs based on staff in the location only:
    - Office Expense (rent, utilities, cleaning, etc) - $990.00
    - Communication (telephone, internet, and cell phone)- $837.61
    - General Insurance (worker's comp, umbrella, etc)- $144.65
    - Portion of audit (annual fiscal audit expense allocated at $1,000 for every $100,000 in funding spent) – $1,200.00
    - IT Support (2 hours @ $90/hour) - $180.00

Cost Assumption

Panhandle Public Health District remains committed to enhancing and building capacity towards occupant protection, speed, distracted and impaired driving in terms of policies, systems, environmental supports, partnerships, education, and mass communications. We maintain monthly meetings with our CFO to keep abreast of additional grant, braiding, and sustainable funding opportunities. This work will be included in subsequent Community Health Improvement Plans to sustain commitment as well.